DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412, 413, 483, and 485

[HCFA–1053–P]

RIN 0938–AJ50

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2000 Rates

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

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs to implement changes arising from our continuing experience with the systems. In addition, in the addendum to this proposed rule, we are describing proposed changes in the amounts and factors necessary to determine rates for Medicare hospital inpatient services for operating costs and capital-related costs. These changes would be applicable to discharges occurring on or after October 1, 1999. We also are setting forth proposed rate-of-increase limits as well as proposed policy changes for hospitals and hospital units excluded from the prospective payment systems. Finally, we are proposing changes to the policies governing payment to hospitals for the direct costs of graduate medical education.

DATES: Comments will be considered if received at the appropriate address, as provided below, no later than 5 p.m. on July 6, 1999.

ADDRESSES: Mail written comments (an original and three copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1053–P P.O. Box 7517, Baltimore, MD 21207.

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

Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201, or

Room C5–11–03, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850

FOR FURTHER INFORMATION CONTACT:

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

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

SUPPLEMENTARY INFORMATION:

Comments, Procedures, Availability of Copies, and Electronic Access

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1053–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 445–G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

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

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

Health Care Financing Administration, Office of Information Services, Security Standards Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Attn: John Burke HCFA–1053–P.

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I. Background

A. Summary

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

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

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

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

On July 31, 1998, we published a final rule in the **Federal Register** (63 FR 40954) that implemented both statutory requirements and other changes to the Medicare hospital inpatient prospective

payment systems for both operating costs and capital-related costs, as well as changes addressing payment for excluded hospitals and payments for GME costs. Generally, these changes were effective for discharges occurring on or after October 1, 1998.

In addition, on February 25, 1999, we published in the **Federal Register** (64 FR 9378) a final rule that implemented revised wage index values, geographic adjustment factors, operating standardized amounts, and capital Federal rates for hospitals subject to the inpatient hospital prospective payment system. These changes are effective for discharges occurring on or after March 1, 1999.

B. Major Contents of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare hospital inpatient prospective payment systems for both operating costs and capital-related costs. We also are proposing changes concerning GME costs and excluded hospitals and units, including critical access hospitals (CAHs). This proposed rule would be effective for discharges occurring on or after October 1, 1999.

We note that the efforts that we are undertaking to make the Medicare computer systems compliant on January 1, 2000, will not delay our ability to make timely and updated payments to hospitals under the FY 2000 prospective payment system final rule that will follow this proposed rule. The following is a summary of the major changes that we are proposing to make.

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

Section 1886(d)(4)(C) of the Act requires us to adjust the DRG classifications and relative weights at least annually. In order to avoid compromising our ability to process and pay hospital claims during the period leading up to and immediately following January 1, 2000, we are not implementing any revisions to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) coding system. The changes that we are proposing to make relating to DRG reclassifications and recalibrations for FY 2000 are set forth in section II of is preamble.

2. Proposed Changes to the Hospital Wage Index

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

- The FY 2000 wage index update, using FY 1996 wage data.
- The exclusion from the wage index of Part A physician wage costs that are teaching-related, as well as resident and Part A certified registered nurse anesthetist (CRNA) costs.
- Revisions to the wage index based on hospital redesignations.

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

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

- Sole community hospitals.
- Rural referral centers.
- Indirect medical education adjustment.
- Medicare Geographic Classification Review Board (MGCRB) decisions.
- Direct GME programs.

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

In section V of this preamble, we discuss the special exceptions process for certain eligible hospitals to receive additional payments for major construction or renovation projects that began soon after the start of the capital prospective payment system.

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

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

- Limits on and adjustments to the proposed target amounts for FY 2000.
- Changes in bed size or status of excluded hospitals or hospital units.
- Payment for services furnished at satellite hospital locations.
- Responsibility for care of patients in hospitals within hospitals.
- The allowable emergency response time for CAHs located in frontier or other specifically defined remote areas.
- Compliance with minimum data set requirements by CAHs with swing bed approval.

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

In the addendum to this proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 2000 prospective payment rates for operating costs and capital-related costs. We also address update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2000 for hospitals and hospital units excluded from the prospective payment system.

7. Impact Analysis

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

8. Capital Acquisition Model

Appendix B contains the technical appendix on the proposed FY 2000 capital cost model.

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

Section 1886(e)(3)(B) of the Act requires the Secretary to report to Congress on our initial estimate of a recommended update factor for FY 2000 for both hospitals included in and hospitals excluded from the prospective payment systems. This report is included as Appendix C to this proposed rule.

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

As required by sections 1886(e)(4) and (e)(5) of the Act, Appendix D provides our recommendation of the appropriate percentage change for FY 2000 for the following:

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

11. Discussion of Medicare Payment Advisory Commission Recommendations

Under section 1805(b) of the Act, the Medicare Payment Advisory Commission (MedPAC) is required to submit a report to Congress, not later than March 1 of each year, that reviews and makes recommendations on Medicare payment policies. The March 1, 1999 report made several recommendations concerning hospital inpatient payment policies. These recommendations, and the action we are proposing to take with regard to them

(when an action is recommended) are discussed in detail in this document. See section VII of this preamble for specific information. For further information relating specifically to the MedPAC March 1 report or to obtain a copy of the report, contact MedPAC at (202) 653–7220.

II. Proposed Changes to DRG Reclassifications and Recalibrations of Relative Weights

A. Background

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

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

As discussed in more detail in section II.B.8 of this preamble, we are not implementing any revisions to the ICD–9–CM codes. We have undertaken, and continue to undertake, major efforts to ensure that all of the Medicare computer systems are ready to function on January 1, 2000. If we were to implement changes to the ICD–9–CM codes on October 1, 1999, we would endanger the functioning of the Medicare computer systems, and, specifically, we might compromise our ability to process hospital bills. We can, however, reclassify existing codes into different DRGs, if appropriate. The proposed changes to the DRG classification system, and the proposed recalibration of the DRG weights for discharges occurring on or after October 1, 1999, are discussed below.

B. DRG Reclassification

1. General

Cases are classified into DRGs for payment under the prospective payment system based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using ICD–9–CM codes. The Medicare fiscal intermediary enters the information into its claims processing system and subjects it to a series of automated screens called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before classification into a DRG can be accomplished.

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

Currently, cases are assigned to one of 499 DRGs in 25 major diagnostic categories (MDCs). Most MDCs are based on a particular organ system of the body (for example, MDC 6, Diseases and Disorders of the Digestive System); however, some MDCs are not constructed on this basis since they involve multiple organ systems (for example, MDC 22, Burns).

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

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

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

The changes we are proposing to make to the DRG classification system for FY 2000 and other decisions concerning DRGs are set forth below.

2. MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period)

Based on inquiries we have received, we reviewed the appropriateness of including diagnosis codes V29.2 (Newborn observation for suspected respiratory condition) and V29.3 (Newborn observation for other genetic problem) in the list of allowable secondary diagnoses under DRG 391 (Normal Newborn). Currently, when one of these codes is the only secondary diagnosis for an otherwise healthy newborn, the case is assigned to DRG 390 (Neonate with Other Significant Problems).

Diagnosis codes V29.2 and V29.3 are used to indicate that the newborn was observed for a suspected condition but none was found. Other newborn observation codes in this series (V29.0, V29.1, V29.8, and V29.9) are included in the allowable secondary diagnoses under DRG 391. We believe that the presence of diagnosis code V29.2 or V29.3 should not exclude a newborn from being classified as normal. Therefore, we are proposing to include diagnosis codes V29.2 and V29.3 in the list of allowable secondary diagnosis under DRG 391.

3. MDC 19 (Mental Diseases and Disorders)

We have received correspondence about the title of DRG 425, ''Acute Adjustment Reaction and Disturbances of Psychosocial Dysfunction'' under MDC 19. The correspondents state that the use of the terms ''disturbances'' and ''dysfunction'' is redundant since the terms have similar meanings. They suggested that we remove the term ''disturbances.''

We agree with the correspondents and are proposing to revise the title of DRG 425 to read ''Acute Adjustment Reaction and Psychological Dysfunction.''

4. MDC 22 (Burns)

In the FY 1999 final prospective payment system rule that was effective October 1, 1998 (63 FR 40957), we implemented an extensive redesign of the DRGs for burns to more appropriately capture the variation in resource use associated with different classes of burn patients. The redesigned DRGs, 504 through 511, are split on such factors as whether there is an extensive burn, a full-thickness burn, or an inhalation injury, as well as other factors such as skin graft, trauma, or presence of a CC. DRGs 504 and 505 are assigned to cases with extensive third degree burns; that is, cases in which the burns cover at least 20 percent of body surface area combined with a third degree burn covering at least 10 percent of body surface area. DRGs 506 through 509 are assigned to all other cases with full-thickness burns (that is, a third degree burn). Finally, DRGs 510 and 511 are assigned to cases with nonextensive burns (that is, only first and second degree burns).

After these DRGs went into effect on October 1, 1998, we were contacted by several hospitals about our inclusion of the following codes as full-thickness burns:

948.00 Body burn involving less than 10 percent of body surface, third degree less than 10 percent or unspecified
948.10 Body burn involving 10 to 19 percent of body surface, third degree less than 10 percent or unspecified
948.20 Body burn involving 20 to 29 percent of body surface, third degree less than 10 percent or unspecified
948.30 Body burn involving 30 to 39 percent of body surface, third degree less than 10 percent or unspecified
948.40 Body burn involving 40 to 49 percent of body surface, third degree less than 10 percent or unspecified
948.50 Body burn involving 50 to 59 percent of body surface, third degree less than 10 percent or unspecified
948.60 Body burn involving 60 to 69 percent of body surface, third degree less than 10 percent or unspecified
948.70 Body burn involving 70 to 79 percent of body surface, third degree less than 10 percent or unspecified
948.80 Body burn involving 80 to 89 percent of body surface, third degree less than 10 percent or unspecified
948.90 Body burn involving 90 percent or more of body surface, third degree less than 10 percent or unspecified

The hospitals are concerned that the use of the fifth digit ''0'' on codes 948.10 through 948.90 can capture cases in which there actually is no third degree burn. The hospitals requested that we consider removing from the full-thickness burn DRGs 506 through 509 all codes in the 948 category with a fifth digit of ''0''.

We agree that the codes in category 948 with a fifth digit of ''0'' should not be assigned to DRGs 506 through 509 as full-thickness burns since not all of these cases will have a third degree burn. Therefore, we are proposing to remove these codes from DRGs 506 through 509 and to add them to DRG 510 (Nonextensive Burns with CC or Significant Trauma) and DRG 511 (Nonextensive Burns without CC or Significant Trauma).

If a case with a code of 948.10 is a full-thickness burn, this information would be captured in the burn code for the site of the burn (for example, 943.35 (Third degree burn of shoulder)) and the case would be correctly assigned to a full-thickness burn DRG. Hospitals have been instructed in *Coding Clinic for ICD–9–CM*, Fourth Quarter, 1994 (pages 22 through 28) to code the site of the burn first (940 through 947), when known. Codes from category 948 may be used as a principal diagnosis only when the site of the burn is not specified. Category 948 is used as an additional code to provide information on the percentage of total body that is burned or to show the percentage of burn that was third degree. When hospitals report codes properly, full-thickness burns will be assigned to a code for burn of the specific site (940 through 947). This site code also shows the degree of the burn. Furthermore, for those rare cases where the site is not provided, but it is known that 10 percent or more of the body has a third degree burn, hospitals may report this information through the use of category 948 with a fifth digit of ''1'' through ''9''. All of these cases will be classified as full-thickness burns in DRGs 506 through 509. Therefore, our proposal to remove codes 948.1 through 948.9 with a fifth digit of ''0'' will not prevent cases from being assigned to one of the full-thickness DRGs when there is a third degree burn and the case is correctly coded.

5. Surgical Hierarchies

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

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

A surgical class can be composed of one or more DRGs. For example, in MDC 5, the surgical class ''heart transplant'' consists of a single DRG (DRG 103) and the class ''major cardiovascular procedures'' consists of two DRGs (DRGs 110 and 111). Consequently, in many cases, the surgical hierarchy has an impact on more than one DRG. The methodology for determining the most resource-intensive surgical class involves weighting each DRG for frequency to determine the average resources for each surgical class.

For example, assume surgical class A includes DRGs 1 and 2 and surgical class B includes DRGs 3, 4, and 5. Assume also that the average charge of DRG 1 is higher than that of DRG 3, but the average charges of DRGs 4 and 5 are higher than the average charge of DRG 2. To determine whether surgical class A should be higher or lower than surgical class B in the surgical hierarchy, we would weight the average charge of each DRG by frequency (that is, by the number of cases in the DRG) to determine average resource consumption for the surgical class. The surgical classes would then be ordered from the class with the highest average resource utilization to that with the lowest, with the exception of ''other OR procedures'' as discussed below.

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

We note that, notwithstanding the foregoing discussion, there are a few instances when a surgical class with a lower average relative weight is ordered above a surgical class with a higher average relative weight. For example, the ''other OR procedures'' surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the relative weight for the DRG or

DRGs in that surgical class may be higher than that for other surgical classes in the MDC. The ''other OR procedures'' class is a group of procedures that are least likely to be related to the diagnoses in the MDC but are occasionally performed on patients with these diagnoses. Therefore, these procedures should only be considered if no other procedure more closely related to the diagnoses in the MDC has been performed.

A second example occurs when the difference between the average weights for two surgical classes is very small. We have found that small differences generally do not warrant reordering of the hierarchy since, by virtue of the hierarchy change, the relative weights are likely to shift such that the higher-ordered surgical class has a lower average weight than the class ordered below it.

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

At this time, we propose to revise the surgical hierarchy for the Pre-MDC DRGs and MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth and Throat) as follows:

- In the Pre-MDC DRGs, we would reorder Lung Transplant (DRG 495) above Bone Marrow Transplant (DRG 481).
- In MDC 3, we would reorder Tonsil and Adenoid Procedure Except Tonsillectomy and/or Adenoidectomy Only (DRGs 57 and 58) above Cleft Lip and Palate Repair (DRG 52).

6. Refinement of Complications and Comorbidities (CC) List

There is a standard list of diagnoses that are considered CCs. We developed this list using physician panels to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In previous years, we have made changes to the standard list of CCs, either by adding new CCs or deleting CCs already on the list. At this time, we do not propose to delete any of the diagnosis codes on the CC list.

In the September 1, 1987 final notice concerning changes to the DRG classification system (52 FR 33143), we modified the GROUPER logic so that certain diagnoses included on the standard list of CCs would not be considered a valid CC in combination with a particular principal diagnosis. Thus, we created the CC Exclusions List. We made these changes to preclude coding of CCs for closely related conditions, to preclude duplicative coding or inconsistent coding from being treated as CCs, and to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair.

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

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

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

In addition, as discussed in detail in section II.B.8 of this preamble, because we are not making changes to the ICD–9–CM codes for FY 2000, we do not need to modify the current list for new or deleted codes. Therefore, there are no proposed revisions to the CC Exclusions List for FY 2000.

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

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

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

60.0 Incision of prostate
60.12 Open biopsy of prostate
60.15 Biopsy of periprostatic tissue

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

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

a. Adding Procedure Codes to MDCs. We annually conduct a review of procedures producing DRG 468 or 477 assignments on the basis of volume of cases in these DRGs with each procedure. Our medical consultants then identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. Based on this year's review, we identified several procedures that we are proposing to move from DRG 468 to one of the surgical DRGs. We did not identify any necessary changes in procedures under DRG 477 and are, therefore, not proposing to move any procedures from DRG 477 to one of the surgical DRGs.

First, we are proposing to move three codes from DRG 468 to MDC 1 (Diseases and Disorders of the Nervous System), all of which would be assigned to DRGs 7 and 8 (Peripheral and Cranial Nerve and Other Nervous System Procedure).[1] Procedure code 38.7 (Interruption of the vena cava) is sometimes performed in conjunction with treatment for the principal diagnosis 434.11 (Cerebral embolism with infarction), which is assigned to MDC 1. Under the current configuration, procedure code 38.7 is not assigned to MDC 1. Therefore when this procedure is performed by a neurological condition, such as a cerebral embolism with infarction, the discharge does not group to one of the surgical DRGs within MDC 1. It is assigned instead to DRG 468 as an unrelated procedure. Since our medical advisors tell us that procedure code 38.7 is appropriately performed for neurological conditions, we are proposing to add it to DRGs 7 and 8.

Second, we are also proposing that procedure codes 83.92 (Insertion or replacement of skeletal muscle stimulator) and 83.93 (Removal of skeletal muscle stimulator) both be categorized with other procedures on the nervous system. These procedures can be performed on patients with a principal diagnosis in MDC 1, such as 344.00 (Quadriplegia unspecified) or 344.31 (Monoplegia of lower limb, affecting dominant side). Therefore, these two codes would also be assigned to DRGs 7 and 8.

Third, procedure code 39.50 (Angioplasty or atherectomy of noncoronary vessel) is not currently assigned to MDC 4 (Diseases and Disorders of the Respiratory System). This procedure can be performed for patients who develop pulmonary embolism. The principal diagnosis for pulmonary embolism is in MDC 4, and, to increase clinical coherence, we propose to add procedure code 39.50 to that MDC in DRGs 76 and 77 (Other Respiratory System OR Procedures).

Fourth, insertion of totally implantable infusion pump (procedure code 86.06) is not assigned to MDC 5 (Diseases and Disorders of the Circulatory System) in the current DRG configuration. Infusion pumps should be assigned to all MDCs where subcutaneous insertion of the pump is appropriate. Procedure code 86.06 may be performed on patients with a principal diagnosis in MDC 5 such as 451.83 (Phlebitis and thrombophlebitis of the deep veins of other extremities). Therefore, we are proposing to add procedure code 86.06 to DRG 120 (Other Circulatory System OR Procedures) in MDC 5.

b. Reassignment of Procedures Among DRGs 468, 476, and 477. We also reviewed the list of procedures that produce assignments to DRGs 468, 476, and 477 to ascertain if any of those procedures should be moved from one of these DRGs to another based on average charges and length of stay. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data. Based on our review this year, we are not proposing to move any procedures from DRG 468 to DRGs 476 or 477, from DRG 476 to DRGs 468 or 477, or from DRG 477 to DRGS 468 or 476.

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

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

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

The Committee encourages participation in the above process by health-related organizations. In this regard, the Committee holds public meetings for discussion of educational issues and proposed coding changes. These meetings provide an opportunity for representatives of recognized organizations in the coding field, such as the American Health Information Management Association (AHIMA) (formerly American Medical Record Association (AMRA)), the American Hospital Association (AHA), and various physician specialty groups as

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

well as physicians, medical record administrators, health information management professionals, and other members of the public to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes for FY 2000 at public meetings held on June 14 and November 2, 1998. Even though the Committee conducted public meetings and considered approval of coding changes for FY 2000 implementation, we are not implementing any changes to ICD–9–CM codes for FY 2000. We have undertaken, and continue to undertake, major efforts to ensure that all of the Medicare computer systems are ready to function on January 1, 2000. If we were to make system changes to capture additions, deletions, and modifications to ICD–9–CM codes for FY 2000, we would endanger the functioning of the Medicare computer systems, and, specifically, we might compromise our ability to process hospital bills. Therefore, the code proposals presented at the public meetings held on June 14 and November 2, 1998, that (if approved) ordinarily would have been included as new codes for October 1, 1999, will not be included in this proposed rule. These code changes to ICD–9–CM will be considered for inclusion in the next annual update for FY 2001. The initial meeting for consideration of coding changes for implementation in FY 2001 will be held on May 13, 1999.

Copies of the minutes of the 1998 meetings can be obtained from the HCFA Home Page at http://www.hcfa.gov/pubaffr.htm, under the ''What's New'' listing. Paper copies of these minutes are no longer available and the mailing list has been discontinued. We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; NCHS; Room 1100; 6525 Belcrest Road; Hyattsville, Maryland 20782. Comments may be sent by E-mail to: dfp4@cdc.gov.

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

9. Other Issue: Implantation of Muscle Stimulator

In the July 31, 1998 final rule, we responded to a comment on the DRG assignment for implantation of a muscle stimulator (63 FR 40964). In that document, we stated that we would readdress this issue after reviewing the FY 1998 MedPAR file.

There is concern in the manufacturing industry that the current DRG assignment for the implantation of a muscle stimulator and the associated tendon transfer for quadriplegics is inappropriate. When the procedures are performed during two separate admissions, the tendon transfer (procedure code 82.56 (Other hand tendon transfer or transplantation)) is assigned to DRGs 7 and 8 and the insertion of the muscle stimulator (procedure code 83.92 (Insertion or replacement of skeletal muscle stimulator)) is assigned to DRG 468. However, when both procedures are performed in the same admission, the case is assigned to DRGs 7 and 8.

As discussed in section II.B.7.a of this preamble, we are proposing to assign code 83.92 to DRGs 7 and 8 in MDC 1. Therefore, if a case involves either procedure code 82.56 or 83.92, or both procedure codes, the case would be assigned to DRGs 7 and 8.

A presentation on one type of muscle stimulator was made by a device manufacturer before the ICD–9–CM Coordination and Maintenance Committee on November 2, 1998. The manufacturer strongly suggested that a new code assignment be made for the procedure for insertion of this stimulator and that it be placed in category 04.9 (Other operations on cranial and peripheral nerves). However, based on comments received by the Committee, there was an overwhelming response from the coding community that a new code should not be created. The commenters believe that these codes (82.56 and 83.92) adequately described the procedures since the patient receives a tendon transfer in addition to the skeletal muscle stimulator insertion. This is done so that the quadriplegic patient can achieve some hand grasping ability where there was none before. Some quadriplegic patients receive the tendon transfer on one admission and the stimulator insertion on a subsequent admission. Others have both procedures performed on the same admission. Since the tendon transfer and stimulator insertion are being performed on quadriplegic patients, a condition found in MDC 1, we propose to add procedure codes 82.56 and 83.92 to DRGs 7 and 8.

C. Recalibration of DRG Weights

We are proposing to use the same basic methodology for the FY 2000 recalibration as we did for FY 1999. (See the July 31, 1998 final rule (63 FR 40965).) That is, we would recalibrate the weights based on charge data for Medicare discharges. However, we propose to use the most current charge information available, the FY 1998 MedPAR file. (For the FY 1999 recalibration, we used the FY 1997 MedPAR file.) The MedPAR file is based on fully-coded diagnostic and surgical procedure data for all Medicare inpatient hospital bills.

The proposed recalibrated DRG relative weights are constructed from FY 1998 MedPAR data, based on bills received by HCFA through December 1998, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1998 MedPAR file includes data for approximately 11.2 million Medicare discharges.

The methodology used to calculate the proposed DRG relative weights from the FY 1998 MedPAR file is as follows:

- To the extent possible, all the claims were regrouped using the proposed DRG classification revisions discussed above in section II.B of this preamble. As noted in section II.B.5, due to the unavailability of revised GROUPER software, we simulate most major classification changes to approximate the placement of cases under the proposed reclassification. However, there are some changes that cannot be modeled.
- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education and disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.
- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG.
- We then eliminated statistical outliers, using the same criteria as was used in computing the current weights. That is, all cases that are outside of 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG.
- The average charge for each DRG was then recomputed (excluding the statistical outliers) and divided by the national average standardized charge per case to determine the relative weight. A transfer case is counted as a

fraction of a case based on the ratio of its length of stay to the geometric mean length of stay of the cases assigned to the DRG. That is, a 5-day length of stay transfer case assigned to a DRG with a geometric mean length of stay of 10 days is counted as 0.5 of a total case.

- We established the relative weight for heart and heart-lung, liver, and lung transplants (DRGs 103, 480, and 495) in a manner consistent with the methodology for all other DRGs except that the transplant cases that were used to establish the weights were limited to those Medicare-approved heart, heart-lung, liver, and lung transplant centers that have cases in the FY 1998 MedPAR file. (Medicare coverage for heart, heart-lung, liver, and lung transplants is limited to those facilities that have received approval from HCFA as transplant centers.)
- Acquisition costs for kidney, heart, heart-lung, liver, and lung transplants continue to be paid on a reasonable cost basis. Unlike other excluded costs, the acquisition costs are concentrated in specific DRGs (DRG 302 (Kidney Transplant); DRG 103 (Heart Transplant for heart and heart-lung transplants); DRG 480 (Liver Transplant); and DRG 495 (Lung Transplant)). Because these costs are paid separately from the prospective payment rate, it is necessary to make an adjustment to prevent the relative weights for these DRGs from including the effect of the acquisition costs. Therefore, we subtracted the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We propose to use that same case threshold in recalibrating the DRG weights for FY 2000. Using the FY 1998 MedPAR data set, there are 39 DRGs that contain fewer than 10 cases. We computed the weights for the 39 low-volume DRGs by adjusting the FY 1999 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs.

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

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

D. Use of Non-MedPAR Data for Reclassification and Recalibration of the DRGs

1. Introduction

As in past years, in the DRG reclassification and recalibration process for the FY 2000 proposed rule, we used the MedPAR file, which consists of data for approximately 11 million Medicare discharges. In the FY 1999 rulemaking process, we used the FY 1997 MedPAR file to recalibrate DRGs and evaluate possible changes to DRG classifications; for this FY 2000 proposed rule, we used the FY 1998 MedPAR file. The Conference Report that accompanied the Balanced Budget Act of 1997 stated that ''in order to ensure that Medicare beneficiaries have access to innovative new drug therapies, the conferees believe that HCFA should consider, to the extent feasible, reliable, validated data other than Medicare Provider Analysis and Review (MedPAR) data in annually recalibrating and reclassifying the DRGs.'' (H. R. Conf. Rep. No. 105–217 at 734 (1997)).

Consistent with that language, we considered non-MedPAR data both in the rulemaking process for FY 1999 and in developing this proposed rule. We received non-MedPAR data from entities on behalf of the manufacturer of a specific drug, platelet inhibitors; the manufacturer is seeking to obtain a new DRG assignment for cases involving platelet inhibitors. The non-MedPAR data purported to show cases involving platelet inhibitors. As discussed further below, we concluded it was not feasible to use the non-MedPAR data submitted to us because, among other things, we did not have information to verify that the cases actually involved the drug, nor did we have information to verify that the cases reflected a representative sample (and did not simply reflect high cost cases).

Effective October 1, 1998, we implemented a code for platelet inhibitors, but until we receive bills for Medicare discharges occurring during FY 1999, the MedPAR data do not enable us to distinguish between cases with platelet inhibitors and cases without platelet inhibitors (63 FR 40963). Representatives of the pharmaceutical company first presented us with non-MedPAR data during the rulemaking process for FY 1999. The data was compiled by a health information company, and purported to show, for cases from a sample of hospitals, the average standardized charges (as calculated by the health information company) for different classes of patients.

In the FY 1999 final rule, we stated a number of reasons why we rejected the non-MedPAR data we had received. First, we could not validate whether the data reflected Medicare beneficiaries. Second, the data came from a limited number of hospitals (83) having an information sharing contract with the health information company that compiled the database; the company failed to provide us with information that would enable us to verify whether the data reflected a representative sample of hospitals or claims. Third, for over 90 percent of the cases, the company failed to provide us with information on which hospital furnished the treatment. This means that we could not validate the data on standardized charges nor could we use the data to determine an appropriate DRG weight for the DRG *from which* the cases would be reclassified. For these reasons (and others), we concluded in the July 31, 1998 final rule that we could not use the data to change the DRG assignment of cases involving platelet inhibitor drug therapy from DRG 112 (Percutaneous Cardiovascular Pacemaker Procedures) to DRG 116 (Other Permanent Cardiac Pacemaker Implant or PTCA with Coronary Artery Stent Implant).

After publication of the July 31, 1998 final rule, we met and corresponded on several occasions with the manufacturers, vendors, and legal representatives of the pharmaceutical company in an effort to resolve data issues. We reiterated that, among other things, we needed to know for each case

the hospital that furnished the services. We have not received information necessary to validate the data itself or its representativeness.

We remain open to considering non-MedPAR data in the DRG reclassification and recalibration process, but, consistent with the Conference Report, as well as our longstanding policies, the data must be ''reliable'' and ''validated.'' The July 31, 1998 final rule reflects the major factors that we consider in evaluating whether data are feasible, reliable, and validated, but we believe it might be useful to discuss these issues in greater detail.

2. The DRG Reclassification and Recalibration Process

In order to understand whether it is feasible to use non-MedPAR data, and whether the data are reliable and validated, it is critical to understand the DRG recalibration and reclassification process. As described earlier, one of the first steps in the annual DRG recalibration is that the Medicare hospital inpatient claims (in the MedPAR file) from the preceding Federal fiscal year are classified using the DRG classification system (proposed or final) for the upcoming year. Cases are classified into DRGs based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. Each case is classified into one and only one DRG.

As the term suggests, the relative weight for each DRG reflects *relative* resource use. The recalibration process requires data that enable us to compare resource use across DRGs. As explained earlier, as part of the recalibration process, we standardize the charges reflected on each Medicare claim to remove the effects of area wage differences, the IME adjustment, and the DSH adjustment; in order to standardize charges, we need to know which hospital furnished the service. For each DRG, we calculate the average of the standardized charges for the cases classified to the DRG. To calculate DRG relative weights, we compare average standardized charges across DRGs.

In evaluating whether it is appropriate to reclassify cases from one DRG to another, we examine the average standardized charges for those cases. The recalibration process and the reclassification process are integrally related; to evaluate whether cases involving a certain procedure should be reclassified, we need to have information that (1) enables us to identify cases that involve the procedure and cases that do not involve the procedure, and (2) enables us to determine appropriate DRG relative weights if certain cases are reclassified.

3. Feasible, Reliable, Validated Data

As indicated earlier, the Conference Report reflected the conferees' belief that, ''to the extent feasible,'' HCFA should consider ''reliable, validated data'' in recalibrating and reclassifying DRGs. The concepts of reliability and validation are closely related. In order for us to use non-MedPAR data, the non-MedPAR data must be reliable in and of itself in that the data must be independently validated. When an entity submits non-MedPAR data, we must be able to independently review the medical records and verify that a particular procedure was performed for each of the cases that purportedly involved the procedure. This verification requires the identification of a particular Medicare beneficiary and the hospital where the beneficiary was treated, as well as the dates involved. Although it is unlikely that we would review 100 percent of thousands of cases submitted for review, at a minimum, we must be able to validate data through a random sampling methodology. We must also be able to verify the charges that are reflected in the data.

Independent validation is particularly critical in part because the non-MedPAR data might be submitted by (or on behalf of) entities that have a financial interest in obtaining a new DRG assignment and in obtaining the highest possible DRG relative weight. If we receive non-MedPAR data that purport to reflect cases involving a certain procedure and a certain level of charges, we must have some way to verify the data.

Even if non-MedPAR data are reliable and verifiable, that does not mean it is necessarily ''feasible'' to use the data for purposes of recalibration and reclassification. In order to be feasible for these purposes, the non-MedPAR data must enable us to appropriately measure relative resource use across DRGs. It is critical that cases are classified into one *and only one* DRG in the recalibration process, and that we have information that enables us to standardize charges for each case and determine appropriate DRG relative weights. Moreover, the data must reflect a complete set of cases or, at a minimum, a representative sample of hospitals and claims.

If cases are classified into more than one DRG (or into the incorrect DRG) in the recalibration process, or if the non-MedPAR data reflect an unrepresentative sample of cases, the measure of relative resource would be distorted. For example, cases of percutaneous transluminal coronary angioplasty (PTCA) treated with GPIIb/IIIa platelet inhibitors (procedure code 99.20) are currently classified to DRG 112. The drug manufacturer has provided us with information on the average charges for a sample of cases that purportedly involve PTCA, for the purpose of evaluating whether these cases should be moved to the higher-weighted DRG 116. However, without adequate identification of the cases to allow us to specifically identify all of the cases treated with platelet inhibitors, the relative weight for DRG 112 would reflect the costs of platelet inhibitor cases. This distortion would result in excessive payments under DRG 112, and thus undermine the integrity of the recalibration process.

Therefore, in order for the use of non-MedPAR data to be feasible, generally we must be able to accurately and completely identify all of the cases to be reclassified from one DRG to another. At a minimum, we must have some mechanism for ensuring that DRG weights are not inappropriately inflated (or deflated) to the extent that a DRG weight reflects cases that would be reclassified to a different DRG.

In short, then, for use of non-MedPAR data to be feasible for purposes of DRG recalibration and reclassification, the data must, among other things (1) be independently verifiable, (2) reflect a complete set of cases (or a representative sample of cases), and (3) enable us to calculate appropriate DRG relative weights and ensure that cases are classified to the ''correct'' DRG, and to one DRG only, in the recalibration process.

Applying this analysis, the non-MEDPAR data we have received with respect to platelet inhibitors are unreliable and its use is not feasible. The health information company, on behalf of the pharmaceutical company, has provided us with a sample of cases that purported to reflect platelet inhibitors, and also purported to reflect the standardized charges for those cases, but the company has failed to provide us with information that would enable us to verify that the cases actually involved platelet inhibitors or verify the level of charges.

Moreover, the data are not useful for purposes of measuring relative resource use. We have not received sufficient information to verify whether the hospitals are representative of all hospitals in the country and whether the non-MedPAR data reflects a representative sample of all cases involving platelet inhibitors. Also, we have not received sufficient information

to use the non-MedPAR data to calculate appropriate DRG relative weights.

4. Submission of Data

Finally, in order for use of non-MEDPAR data to be feasible, we must have sufficient time to evaluate and test the data. The time necessary to do so depends upon the nature and quality of the data submitted. Generally, however, a significant sample of the data should be submitted by August 1, approximately 8 months prior to the publication of the proposed rule, so that we can test the data and make a preliminary assessment as to the feasibility of its use. Subsequently, a complete database should be submitted no later than December 1 for consideration in conjunction with the next year's proposed rule.

5. How the Prospective Payment System Ensures Access to New Technologies

As noted at the outset of this discussion, the Conference Report that accompanied the BBA indicated that we should consider non-MEDPAR data, to the extent feasible, ''in order to ensure that Medicare beneficiaries have access to innovative new drug therapies.'' (H. R. Conf. Rep. No. 105–217 at 734 (1997)) There seems to be a concern that, if a new technology is introduced, and if the new technology is costly, then Medicare would not make adequate payment if the new technology is not immediately placed in a new DRG. This concern is unfounded. As explained below, the Medicare hospital inpatient prospective payment does ensure access to new drug therapies, and new technologies in general.

First, to the extent a case involving a new technology is extremely costly relative to the cases reflected in the DRG relative weight, the hospital might qualify for outlier payments, additional payments over and above the standard PPS payment.

Second, Medicare promotes access to new technologies by making payments under the propsective payment system that are designed to ensure that Medicare payments for a hospital's cases *as a whole* are adequate. We establish DRGs based on factors such as clinical coherence and resource utilization. Each diagnosis-related group encompasses a variety of cases, reflecting a range of services and a range of resources. Generally, then, each DRG reflects some higher cost cases and some lower cost cases.

For some cases, the hospital's costs might be higher than the payment under the propsective payment system; this does not mean that the DRG classifications are ''inappropriate.'' For other cases, the hospital's costs will be lower than the payment under the prospective payment system. We believe that Medicare makes appropriate payments for a hospital's cases as a whole.

Each year we examine the best data available to assess whether DRG changes are appropriate and to recalibrate DRG relative weights. As we have indicated on numerous occasions, it usually takes 2 years from the time a procedure is assigned a code to collect the appropriate MedPAR data and then make an assessment as to whether a DRG change is appropriate. This timetable applies to reclassifications that would lead to decreased payment as well as those that would increase payment. In fact, the introduction of new technologies itself might lead to either higher than average costs or *lower* costs.

Our ability to evaluate and implement potential DRG changes depends on the availability of validated, representative data. We believe that our policies ensure access to new technologies and are critical to the integrity of the recalibration process. As explained above, we remain open to using non-MedPAR data if the data are reliable and validated and enable us to appropriately measure relative resource use.

III. Proposed Changes to the Hospital Wage Index

A. Background

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

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

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

B. FY 2000 Wage Index Update

The proposed FY 2000 wage index values in section VI of the Addendum to this proposed rule (effective for hospital discharges occurring on or after October 1, 1999 and before October 1, 2000) are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 1996 (the FY 1999 wage index was based on FY 1995 wage data).

We note that the FY 1999 wage index published in the July 31, 1998 final rule was further revised on February 25, 1999 (64 FR 9378) to reflect approved revisions to the hospital wage data used to compute the wage index. In that final rule, we implemented revised wage index values, geographic adjustment factors, operating standardized amounts, and capital Federal rates for hospitals subject to the inpatient hospital prospective payment system. These changes are effective for discharges occurring on or after March 1, 1999.

The proposed FY 2000 wage index includes the following categories of data associated with costs paid under the

hospital inpatient prospective payment system (as well as outpatient costs), which were also included in the FY 1999 wage index:

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

Consistent with the wage index methodology for FY 1999, the proposed wage index for FY 2000 also continues to exclude the direct and overhead salaries and hours for services not paid through the inpatient prospective payment system such as skilled nursing facility services, home health services, or other subprovider components that are not subject to the prospective payment system.

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

C. FY 2000 Wage Index Proposals

In the July 31, 1998 final rule, we reiterated our position that, to the greatest degree possible, the hospital wage index should reflect the wage costs associated with the areas of the hospital included under the hospital inpatient prospective payment system (63 FR 40970). That final rule contained a detailed discussion concerning the costs related to teaching physicians, residents, and CRNAs, all of which are paid by Medicare separately from the prospective payment system. For reasons outlined in detail in that final rule, we decided not to remove those costs from the calculation of the FY 1999 wage index, but to review updated data and consider removing them in developing the FY 2000 wage index.

In response to concerns within the hospital industry related to the removal of these costs from the wage index calculation, the American Hospital Association (AHA) convened a workgroup to develop a consensus recommendation. The workgroup, which consisted of representatives from national and state hospital associations, recommended that costs related to teaching physicians, residents, and CRNAs should be phased out of the wage index calculation over a 5-year period. As discussed in more detail below, based upon our analysis of hospitals' FY 1996 wage data, and consistent with the AHA workgroup's recommendation, we are proposing to phase out these costs from the calculation of the wage index over a 5-year period. The proposed FY 2000 wage index is based on a blend of 80 percent of an average hourly wage including these costs, and 20 percent of an average hourly wage excluding these costs.

1. Teaching Physician Costs

Before FY 1999, we included direct physician Part A costs and excluded contract physician Part A costs from the wage index calculation. Since some States prohibit hospitals from directly employing physicians, hospitals in these States were unable to include physician Part A costs because they were incurred under contract rather than directly. Therefore, for cost reporting periods beginning in 1995, we began separately collecting physician Part A costs (both direct and contract) so we could evaluate how to best handle these costs in the wage index calculation. Based on our analysis of the 1995 wage data, we decided to include the contract physician salaries in the wage index beginning with FY 1999.

In the July 31, 1998 final rule, in response to comments regarding the inclusion in physician Part A costs of teaching physician costs for which teaching hospitals are already compensated through the Medicare GME payment, we stated that we would collect teaching physician data ''as expeditiously as possible in order to analyze whether it is feasible to separate teaching physician costs from other physician Part A costs'' (63 FR 40968). Excluding teaching physician costs from the wage index calculation is consistent with our general policy to exclude from that calculation those costs that are paid separately from the prospective payment system.

Because the FY 1996 cost reports did not identify teaching physician salaries and hours separately from physician Part A costs, we instructed our fiscal intermediaries to collect, through a survey, teaching physician costs and hours from the teaching hospitals they service. Specifically, we requested collection of data on the costs and hours related to teaching physicians that were included in Line 4 (salaried), Line 10 (contracted), Line 12 (home office and related organizations), and Line 18 (wage-related costs) of the Worksheet S–3, Part II. In our instructions accompanying the survey, we indicated that these teaching-related costs are those payable under the per resident amounts (§ 413.86) and reported on Worksheet A, Line 23 of the hospital's cost report.

The survey data collected as of the last week of January 1999 are included in the preliminary public use file made available on the Internet on February 5, 1999. At that time, we had received completed surveys for over one-half of teaching hospitals reporting physician Part A costs on their Worksheet S–3, Part II (372 out of 700). In early February 1999, we instructed intermediaries to review the survey data for consistency with the Supplemental Worksheet A–8–2 of the hospitals' cost reports. Supplemental Worksheet A–8–2 is used to apply the reasonable compensation equivalency limits to the costs of provider-based physicians, itemizing these costs by the corresponding line number on Worksheet A.

When we notified the fiscal intermediaries (and the fiscal intermediaries notified the hospitals) of the availability to review the survey data on the Internet, we also established deadlines of March 5, 1999 for hospitals to request changes to the teaching survey data, and April 5, 1999, for the fiscal intermediaries to submit the data to HCRIS. The additional data collected from the hospitals through the fiscal intermediaries by April 5 will be included in the final wage data file released in May 1999.

Due to the extraordinary effort needed to collect these data and the importance of accurately removing teaching physician costs, we will consider requests from a hospital to revise its teaching survey data as reflected on the final wage data file released in May 1999. (We are not extending the deadline for requests for revisions to cost report data.) Requests must be received by HCFA and the hospital's fiscal intermediary no later than June 7, 1999, and must include all necessary supporting documentation. As described above, these data were not originally collected on the FY 1996 cost report. The deadlines established under our annual process for editing and verifying the wage data reflect the fact that hospitals prepare and submit their cost reports at least 1 year, and generally more than 1 year, before the deadline for requesting changes. Because the timeframe in which the survey data were collected was considerably shorter, we have extended the deadline for revising those data.

Since we published the July 31, 1998 final rule, we have received a recommendation from the hospital industry concerning the methodology that could be used to exclude physician

teaching-related costs from the wage index. The industry recommended that we implement a 5-year phase-out of all physician Part A wage costs that are teaching-related, as well as all resident and Part A CRNA costs. In FY 2000, the first year of the phase-out, the applicable wage index would be based on a blend of 80 percent of the current policy, which would include all physician Part A costs, and 20 percent of the new policy, which would exclude teaching physician Part A, resident, and CRNA costs. The percentages would be adjusted 20 percent each year until FY 2004, when all teaching physician, resident, and CRNA costs would be eliminated from the wage index calculation.

The workgroup also recommended that if the teaching data collected by the intermediaries are not accurate or reliable, HCFA would include only 20 percent of reported physician Part A costs in the calculation, based on the assumption that 80 percent of total physician Part A costs are related to teaching physicians.

We appreciate the industry's willingness to work with us on this issue and recommend a reasonable and practical solution. In developing our proposed FY 2000 wage index, we have adopted most of the components of this recommendation.

In developing the proposed FY 2000 wage index, we calculated the teaching costs to be removed from the wage index as follow. If we had complete survey data for a hospital, that amount was subtracted from the amount reported on the Worksheet S–3 for physician Part A costs. However, relying solely on the survey data would have resulted in the removal of no teaching physician costs for many hospitals.

As noted above, the hospital industry recommended that if HCFA believes the survey data are not reliable or accurate, it should remove 80 percent of the total physician Part A costs and hours. Although we considered this option, we believe that removing 80 percent of the total physician Part A costs and hours across the board would not recognize the variations among hospitals in terms of the percentage of their physician Part A costs consisting of teaching physician costs. Of the hospitals for which we have survey data, teaching physician costs, as reflected on the survey, amount to, on average, approximately 68 percent. If we adopted the recommended methodology, we would not only negate the efforts of those hospitals and their fiscal intermediaries that did complete the teaching physician survey, we would also actually penalize hospitals that cooperated in completing the survey by removing an amount in excess of actual teaching physician Part A costs they reported.

Therefore, under our proposal, for any hospital that completed the survey, we removed from the wage data the physician Part A teaching costs and hours reported on the survey form. These data had been verified by the fiscal intermediary before submission to HCFA. If we did not have survey data for a teaching hospital as of February 22, 1999, we removed 80 percent of the hospital's reported total physician Part A costs and hours for the proposed wage index. Based upon our communications with fiscal intermediaries, we believe we will have a substantially higher response rate for the survey data by the time we calculate the final FY 2000 wage index values. As discussed above, we have instructed the fiscal intermediaries to undertake a further attempt to collect these data for those hospitals that initially did not report survey data. We believe that since the average percentage of teaching costs compared to total physician Part A costs is less than 80 percent, it would be an advantage to a hospital to complete the survey.

Although removing 80 percent from the amount reported on the Worksheet S–3 for physician Part A costs allows an estimate of teaching physician costs to be removed in the majority of cases in which survey data are not available, there are instances in which a teaching hospital did not report either survey data or any physician Part A costs on its Worksheet S–3. We have identified 72 such teaching hospitals in our database. For purposes of calculating the proposed FY 2000 wage index for these 72 hospitals, we subtracted the costs reported on Line 23 of the Worksheet A, Column 1 (Resident and Other Program Costs) from Line 1 of the Worksheet S–3. These costs (from Line 23, Column 1 of Worksheet A) are included in Line 1 of the Worksheet S–3, which is the sum of Column 1, Worksheet A. They also represent costs for which the hospital is paid through the per resident amount under the direct GME payment. Therefore, we believe it is appropriate to remove these costs from the wage index calculation in situations in which hospitals have failed to otherwise identify their teaching physician costs. To determine the hours to be removed, we divided the costs reported on Line 23 of the Worksheet A, Column 1 by the national average hourly wage for physician Part A costs based upon Line 4 of the Worksheet S–3 (the national average hourly wage is $54.48). We have indicated these 72 hospitals by an asterisk in Table 3C of this proposed rule.

We invite comments as to whether the proposed method we have used to remove teaching-related costs based on the amount included in Line 23, Column 1 of Worksheet A would be an appropriate method for removing GME costs in the future (and perhaps other excluded area costs as well). We are especially concerned that the earliest cost report on which we will be able to make the necessary changes to capture the separate reporting of teaching physician Part A costs would be cost reports that would be submitted for cost reporting periods beginning during FY 1998. Therefore, we are considering the potential for subtracting the costs in Lines 20, 22, and 23 of Worksheet A from Line 1 of Worksheet S–3, Part II, in calculating the FY 2001 wage index. The current Worksheet S–3 is not designed to net out of Line 1 costs that are otherwise included in Column 1 of Worksheet A, but it would be possible to use data from the Worksheet A in a manner similar to that described above.

2. Resident and CRNA Part A Costs

The wage index presently includes salaries and wage-related costs for residents in approved medical education programs and for CRNAs employed by hospitals under the rural pass-through provision (§ 412.113(c)). Because Medicare pays for these costs outside the prospective payment system, removing these costs from the wage index calculation would be consistent with our general policy to exclude costs that are not paid through the prospective payment system. However, because these costs were not separately identifiable before the FY 1995 wage data, we could not remove them.

We began collecting the resident and CRNA wage data separately on the FY 1995 cost report. However, there were data reporting problems associated with these costs. For example, the original FY 1995 cost report instructions for reporting resident costs on Line 6 of Worksheet S–3, Part III, erroneously included teaching physician salaries and other teaching program costs. Also, the FY 1995 Worksheet S–3 did not provide for separate reporting of CRNA wage-related costs. These problems were corrected in the reporting instructions for the FY 1996 cost report, and we are now proposing to remove CRNA and resident costs over a 5-year period.

3. Transition Period

The proposed FY 2000 wage index is based on a blend of 80 percent of

hospitals' average hourly wages without removing the costs and hours associated with teaching physician Part A, residents, and CRNAs, and 20 percent of the average hourly wage after removing these costs and hours from the wage index calculation. This methodology is consistent with the recommendation of the industry workgroup for a 5-year phase-out of these costs. The transition methodology is discussed in detail in section III.E of this preamble.

D. Verification of Wage Data From the Medicare Cost Report

The data for the proposed FY 2000 wage index were obtained from Worksheet S–3, Parts II and III of the FY 1996 Medicare cost reports. The data file used to construct the proposed wage index includes FY 1996 data submitted to the Health Care Provider Cost Report Information System (HCRIS) as of early February 1999. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

From mid-January to mid-February 1999, we asked our fiscal intermediaries to revise or verify data elements that resulted in specific edit failures. Some unresolved data elements are included in the calculation of the proposed FY 2000 wage index pending their resolution before calculation of the final FY 2000 wage index. We have instructed the intermediaries to complete their verification of questionable data elements and to transmit any changes to the wage data (through HCRIS) no later than April 5, 1999. We expect that all unresolved data elements will be resolved by that date. The revised data will be reflected in the final rule.

Also, as part of our editing process, we removed data for eight hospitals that failed edits. For four of these hospitals, we were unable to obtain sufficient documentation to verify or revise the data because the hospitals are no longer participating in the Medicare program or are in bankruptcy status. Two hospitals had negative average hourly wages after allocating overhead to their excluded areas, and were therefore removed from the calculation. The data from the remaining two hospitals were removed because inclusion of their data would have significantly distorted the wage index values. The data for these hospitals will be included in the final wage index if we receive corrected data that pass our edits. As a result, the proposed FY 2000 wage index is calculated based on FY 1996 wage data for 5,035 hospitals.

E. Computation of the Wage Index

The method used to compute the proposed FY 2000 wage index is as follows:

Step 1—As noted above, we are proposing to base the FY 2000 wage index on wage data reported on the FY 1996 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 1995 and before October 1, 1996. In addition, we included data from a few hospitals that had cost reporting periods beginning in September 1995 and reported a cost reporting period exceeding 52 weeks. These data were included because no other data from these hospitals would be available for the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 1996 data.

Step 2—Salaries—The method used to compute a hospital's average hourly wage is a blend of 80 percent of the hospital's average hourly wage including all teaching physician Part A, resident, and CRNA costs, and 20 percent of the hospital's average hourly wage after eliminating all teaching physician, resident, and CRNA costs.

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

We then calculated a hospital's salaries plus wage-related costs by subtracting from total salaries the salaries plus wage-related costs for teaching physicians (see section III.C.1 of this preamble for a detail discussion of this policy), Part A CRNAs (Lines 2 and 16), and residents (Lines 6 and 20).

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

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

Step 5—For each hospital, we adjusted the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimated the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 1995 through April 15, 1997 for private industry hospital workers from the Bureau of Labor Statistics' Compensation and Working Conditions. We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor
10/14/95	11/15/95	1.023163
11/14/95	12/15/95	1.021153
12/14/95	01/15/96	1.019151
01/14/96	02/15/96	1.017157
02/14/96	03/15/96	1.015246
03/14/96	04/15/96	1.013489

MIDPOINT OF COST REPORTING PERIOD—Continued

After	Before	Adjustment factor
04/14/96	05/15/96	1.011888
05/14/96	06/15/96	1.010428
06/14/96	07/15/96	1.009099
07/14/96	08/15/96	1.007900
08/14/96	09/15/96	1.006788
09/14/96	10/15/96	1.005719
10/14/96	11/15/96	1.004695
11/14/96	12/15/96	1.003653
12/14/96	01/15/97	1.002529
01/14/97	02/15/97	1.001325
02/14/97	03/15/97	1.000000
03/14/97	04/15/97	0.998514

For example, the midpoint of a cost reporting period beginning January 1, 1996 and ending December 31, 1996 is June 30, 1996. An adjustment factor of 1.009099 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 1996 and covers a period of less than 360 days or more than 370 days, we annualized the data to reflect a 1-year cost report. Annualization is accomplished by dividing the data by the number of days in the cost report and then multiplying the results by 365.

Step 6—Each hospital was assigned to its appropriate urban or rural labor market area before any reclassifications under sections 1886(d)(8)(B) or 1886(d)(10) of the Act. Within each urban or rural labor market area, we added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in that area to determine the total adjusted salaries plus wage-related costs for the labor market area.

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

Because the proposed FY 2000 wage index is based on a blend of average hourly wages, we then added 80 percent of the average hourly wage calculated without removing teaching physician Part A, residents, and CRNA costs, and 20 percent of the average hourly wage calculated with these costs removed.

Step 8—We added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the nation and then divided the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage (using the same blending methodology described in Step 7). Using the data as described above, the national average hourly wage is $20.9675.

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

Step 10—Following the process set forth above, we developed a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We added the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage of $9.96607 for Puerto Rico. For each labor market area in Puerto Rico, we calculated the hospital wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of the BBA provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State. Furthermore, this wage index floor is to be implemented in such a manner as to assure that aggregate prospective payment system payments are not greater or less than those that would have been made in the year if this section did not apply. For FY 2000, this change affects 185 hospitals in 39 MSAs. The MSAs affected by this provision are identified in Table 4A by a footnote.

F. Revisions to the Wage Index Based on Hospital Redesignation

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

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

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

We note that, except for those rural areas in which redesignation would reduce the rural wage index value, the wage index value for each area is computed exclusive of the wage data for hospitals that have been redesignated from the area for purposes of their wage index. As a result, several urban areas listed in Table 4A have no hospitals

remaining in the area. This is because all the hospitals originally in these urban areas have been reclassified to another area by the MGCRB. These areas with no remaining hospitals receive the prereclassified wage index value. The prereclassified wage index value will apply as long as the area remains empty.

The proposed revised wage index values for FY 2000 are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this proposed rule. Hospitals that are redesignated should use the wage index values shown in Table 4C. Areas in Table 4C may have more than one wage index value because the wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located. When the wage index value of the area to which a hospital is redesignated is lower than the wage index value for the rural areas of the State in which the hospital is located, the redesignated hospital receives the higher wage index value, that is, the wage index value for the rural areas of the State in which it is located, rather than the wage index value otherwise applicable to the redesignated hospitals.

Tables 4D and 4E list the average hourly wage for each labor market area, before the redesignation of hospitals, based on the FY 1996 wage data. In addition, Table 3C in the Addendum to this proposed rule includes the adjusted average hourly wage for each hospital based on the preliminary FY 1996 data as of February 22, 1999. The MGCRB will use the average hourly wage published in the final rule to evaluate a hospital's application for reclassification for FY 2001, unless that average hourly wage is later revised in accordance with the wage data correction policy described in § 412.63(w)(2). In such cases, the MGCRB will use the most recent revised data used for purposes of the hospital wage index. We note that in adjudicating these wage index reclassification requests during FY 2000, the MGCRB will use the average hourly wages for each hospital and labor market area that are reflected in the final FY 2000 wage index.

At the time this proposed wage index was constructed, the MGCRB had completed its review of FY 2000 reclassification requests. The proposed FY 2000 wage index values incorporate all 441 hospitals redesignated for purposes of the wage index (hospitals redesignated under section 1886(d)(8)(B) or 1886(d)(10) of the Act) for FY 2000. The final number of reclassifications may be different because some MGCRB decisions are still under review by the Administrator and because some hospitals may withdraw their requests for reclassification.

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

Under § 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of this **Federal Register** document. The request for withdrawal of an application for reclassification that would be effective in FY 2000 must be received by the MGCRB by June 21, 1999. A hospital that requests to withdraw its application may not later request that the MGCRB decision be reinstated.

G. Requests for Wage Data Corrections

To allow hospitals time to evaluate the wage data used to construct the proposed FY 2000 hospital wage index, we made available to the public a data file containing the FY 1996 hospital wage data. As stated in section II.D of this preamble, the data file used to construct the proposed wage index includes FY 1996 data submitted to HCRIS as of early February 1999. In a memorandum dated February 1, 1999, we instructed all Medicare intermediaries to inform the prospective payment hospitals that they serve of the availability of the wage data file and the process and timeframe for requesting revisions. The wage data file was made available February 5, 1999 through the Internet at HCFA's home page (http://www.hcfa.gov). We also instructed the intermediaries to advise hospitals of the availability of these data either through their representative hospital organizations or directly from HCFA. Additional details on ordering this data file are discussed in section IX.A of this preamble, ''Requests for Data from the Public.''

In addition, Table 3C in the Addendum to this proposed rule contains each hospital's adjusted average hourly wage used to construct the proposed wage index values. It should be noted that the hospital average hourly wages shown in Table 3C do not reflect any changes made to a hospital's data after February 22, 1999. Changes approved by a hospital's fiscal intermediary and forwarded to HCRIS by April 5, 1999 will be reflected on the final public use wage data file scheduled to be made available May 7, 1999.

We believe hospitals have had ample time to ensure the accuracy of their FY 1996 wage data. Moreover, the ultimate responsibility for accurately completing the cost report rests with the hospital, which must attest to the accuracy of the data at the time the cost report is filed. However, if, after review of the wage data file released February 5, 1999, a hospital believed that its FY 1996 wage data were incorrectly reported, the hospital was to submit corrections along with complete, detailed supporting documentation to its intermediary by March 5, 1999. Hospitals were notified of this deadline, and of all other possible deadlines and requirements, through written communications from their fiscal intermediaries in early February 1999.

Any wage data corrections to be reflected in the final wage index must have been reviewed and verified by the intermediary and transmitted to HCFA on or before April 5, 1999. (The deadline for hospitals to request changes from their fiscal intermediaries was March 5, 1999.) These deadlines are necessary to allow sufficient time to review and process the data so that the final wage index calculation can be completed for development of the final prospective payment rates to be published by August 1, 1999. We cannot guarantee that corrections transmitted to HCFA after April 5, 1999 will be reflected in the final wage index.

After reviewing requested changes submitted by hospitals, intermediaries transmitted any revised cost reports to HCRIS and forwarded a copy of the revised Worksheet S–3, Parts II and III to the hospitals. In addition, fiscal intermediaries were to notify hospitals of the changes or the reasons that changes were not accepted.

This procedure ensures that hospitals have every opportunity to verify the data that will be used to construct their wage index values. We believe that fiscal intermediaries are generally in the best position to make evaluations regarding the appropriateness of a particular cost and whether it should be included in the wage index data. However, if a hospital disagrees with the intermediary's resolution of a requested change, the hospital may

contact HCFA in an effort to resolve policy disputes. We note that the April 5 deadline also applies to these requested changes. We will not consider factual determinations at this time, as these should have been resolved earlier in the process.

We have created the process described above to resolve all substantive wage data correction disputes before we finalize the wage data for the FY 2000 payment rates. Accordingly, hospitals that do not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage data corrections or to dispute the intermediary's decision with respect to requested changes.

The final wage data public use file will be released by May 7, 1999. Hospitals should examine both Table 3C of this proposed rule and the May 7 final public use wage data file (which reflects revisions to the data used to calculate the values in Table 3C) to verify the data HCFA is using to calculate the wage index. Hospitals will have until June 7, 1999 to submit requests to correct errors in the final wage data due to data entry or tabulation errors by the intermediary or HCFA. The correction requests that will be considered at that time will be limited to errors in the entry or tabulation of the final wage data that the hospital could not have known about before the release of the final wage data public use file.

The final wage data file released on May 7, 1999 will contain the wage data that will be used to construct the wage index values in the final rule. As noted above in section III.C of this preamble, this file will include hospitals' teaching survey data as well as cost report data. As with the file made available in February 1999, HCFA will make the final wage data file released in May 1999 available to hospital associations and the public (on the Internet). However, with the exception of the teaching survey data, this file is being made available only for the limited purpose of identifying any potential errors made by HCFA or the intermediary in the entry of the final wage data that result from the correction process described above (with the March 5 deadline), not for the initiation of new wage data correction requests. Hospitals are encouraged to review their hospital wage data promptly after the release of the final file.

If, after reviewing the final file, a hospital believes that its wage data are incorrect due to a fiscal intermediary or HCFA error in the entry or tabulation of the final wage data, it should send a letter to both its fiscal intermediary and HCFA. The letters should outline why the hospital believes an error exists and provide all supporting information, including dates. These requests must be *received* by HCFA and the intermediaries no later than June 7, 1999. Requests mailed to HCFA should be sent to: Health Care Financing Administration; Center for Health Plans and Providers; Attention: Stephen Phillips, Technical Advisor; Division of Acute Care; C4–07–07; 7500 Security Boulevard; Baltimore, MD 21244–1850. Each request must also be sent to the hospital's fiscal intermediary. The intermediary will review requests upon receipt and contact HCFA immediately to discuss its findings.

At this point in the process, changes to the hospital wage data will be made only in those very limited situations involving an error by the intermediary or HCFA that the hospital could not have known about before its review of the final wage data file. (As noted above, however, we are also allowing hospitals to request changes to their teaching survey data. These requests must comply with all of the documentation and deadline requirements as otherwise specified in this proposed rule.) Specifically, neither the intermediary nor HCFA will accept the following types of requests at this stage of the process:

- Requests for wage data corrections that were submitted too late to be included in the data transmitted to HCRIS on or before April 5, 1999.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 1999 wage data file.
- Requests to revisit factual determinations or policy interpretations made by the intermediary or HCFA during the wage data correction process.

Verified corrections to the wage index received timely (that is, by June 7, 1999) will be incorporated into the final wage index to be published by July 30, 1999 and effective October 1, 1999.

Again, we believe the wage data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage data to the intermediary's attention. Moreover, because hospitals will have access to the final wage data by early May 1999, they will have the opportunity to detect any data entry or tabulation errors made by the intermediary or HCFA before the development and publication of the FY 2000 wage index by July 30, 1999 and the implementation of the FY 2000 wage index on October 1, 1999. If hospitals avail themselves of this opportunity, the wage index implemented on October 1 should be free of these errors. Nevertheless, in the unlikely event that errors should occur after that date, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.63(w)(2), we may make midyear corrections to the wage index only in those limited circumstances in which a hospital can show (1) that the intermediary or HCFA made an error in tabulating its data; and (2) that the hospital could not have known about the error, or did not have an opportunity to correct the error, before the beginning of FY 2000 (that is, by the June 7, 1999 deadline). As indicated earlier, since a hospital will have the opportunity to verify its data, and the intermediary will notify the hospital of any changes, we do not foresee any specific circumstances under which midyear corrections would be made. However, should a midyear correction be necessary, the wage index change for the affected area will be effective prospectively from the date the correction is made.

In the September 1, 1994 **Federal Register**, we stated that we did not believe that a ''formal appeals process'' regarding intermediary decisions denying hospital requests for wage data revisions was necessary, given the numerous opportunities provided to hospitals to verify and revise their data (59 FR 45351). We continue to believe that the process described above provides hospitals more than adequate opportunity to ensure that their data are correct. Nevertheless, we wish to clarify that, while there is no formal appeals process that culminates before the publication of the final rule and that is described above, hospitals may later seek formal review of denials of requests for wage data revisions made as a result of that process.

Once the final wage index values are calculated and published in the **Federal Register**, the last opportunity for a hospital to seek to have its wage data revised is under the limited circumstances described in § 412.63(w)(2). As we noted in the September 1, 1995 **Federal Register**, however, hospitals are entitled to appeal any denial of a request for a wage data revision made as a result of HCFA's wage data correction process to the Provider Reimbursement Review Board (PRRB), consistent with the rules for PRRB appeals found at 42 CFR part 405, Subpart R (60 FR 45795). As we also stated in the 1995 **Federal Register**, and as the regulation at § 412.63(w)(5) provides, any subsequent reversal of a denial of a wage revision request that

results from a hospital's appeal to the PRRB or beyond will be given effect by paying the hospital under a revised wage index that reflects the revised wage data at issue. The revised wage data will not, however, be used for purposes of revisiting past adjudications of requests for geographic reclassification.

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

A. Sole Community Hospitals (SCHs)(§ 412.92)

If a hospital is classified as a SCH because, by reason of certain factors, it is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries in a geographic area, the hospital is paid based on the highest of the following: the applicable adjusted Federal rate; the updated hospital-specific rate based on a 1982 base period; or the updated hospital-specific rate based on a 1987 base period. Under our existing rules, urban hospitals within 35 miles of another hospital cannot qualify as SCHs. Since 1983, we have consistently defined an ''urban'' area for purposes of determining if a hospital qualifies for SCH status as a MSA or NECMA as defined by OMB.

In the past, we have considered and rejected two alternatives to the MSA definitions of an urban area for SCH purposes. These alternatives were the urbanized areas as defined by the Census Bureau and the health facility planning areas (HFPAs) as used by the Health Resource Services Administration. We have concluded that the MSA definition continues to be the most appropriate geographic delimiter available at this time. Therefore, we propose to continue to apply the MSA definition of an urban area for SCH status purposes.

We propose to continue our current policy for several reasons. First, as we have previously noted, since OMB considers local commuting patterns in establishing urban definitions, we believe that residents in urban areas have access to hospital services either by living in close proximity to a hospital or by establishing a heavy commuting pattern to an area in which a hospital is located (48 FR 39780, September 1, 1983). We do not believe that either Census Bureau urbanized areas or HFPAs take commuting patterns into account in the way that OMB's MSAs do. We believe commuting patterns serve as an important indicia of whether a hospital is the sole hospital reasonably accessible by Medicare beneficiaries in an area.

In addition, we note that our use of MSAs to define urban areas for SCH status purposes has direct statutory support. Section 1886(d)(2)(D) of the Act specifically authorizes us to use OMB's MSA definition of urban areas for purposes of calculating the prospective payment system standardized amounts. SCH status represents an adjustment to the usual prospective payment that a hospital would receive, and since that prospective payment is based on the standardized amount, among other factors, we believe it would be anomalous to employ one definition of urban area for purposes of calculating the standardized amount and another for purposes of determining if the hospital qualified as a SCH. To do so would be to use one set of geographic delimiters in applying the general rule (payment under the prospective payment system based on the standardized amount) but a different set in determining exceptions to the rule (payment under the prospective payment system adjusted to take into account SCH status). We do not think this would be appropriate. For this reason, also, we propose to continue to define ''urban'' for SCH purposes as meaning MSAs as defined by OMB, not as meaning either Census Bureau urbanized areas or HFPAs.

B. Rural Referral Centers (§ 412.96)

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

One of the criteria under which a rural hospital may qualify as a rural referral center is to have 275 or more beds available for use. A rural hospital that does not meet the bed size criterion can qualify as a rural referral center if the hospital meets two mandatory criteria (specifying a minimum case-mix index and a minimum number of discharges) and at least one of the three optional criteria (relating to specialty composition of medical staff, source of inpatients, or volume of referrals). With respect to the two mandatory criteria, a hospital may be classified as a rural referral center if its—

- Case-mix index is at least equal to the lower of the median case-mix index for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median case-mix index for all urban hospitals nationally; and
- Number of discharges is at least 5,000 discharges per year or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year.)

1. Case-Mix Index

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

These values are based on discharges occurring during FY 1998 (October 1, 1997 through September 30, 1998) and include bills posted to HCFA's records through December 1998. Therefore, we are proposing that, in addition to meeting other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1999, must have a case-mix index value for FY 1998 that is at least—

- 1.3438; or
- The median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by HCFA for the census region in which the hospital is located.

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

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2480
2. Middle Atlantic (PA, NJ, NY)	1.2504

Region	Case-mix index value
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3269
4. East North Central (IL, IN, MI, OH, WI)	1.2593
5. East South Central (AL, KY, MS, TN)	1.2772
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1871
7. West South Central (AR, LA, OK, TX)	1.3003
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3280
9. Pacific (AK, CA, HI, OR, WA)	1.3277

The preceding numbers will be revised in the final rule to the extent required to reflect the updated FY 1998 MedPAR file, which will contain data from additional bills received through March 31, 1999.

For the benefit of hospitals seeking to qualify as referral centers or those wishing to know how their case-mix index value compares to the criteria, we are publishing each hospital's FY 1998 case-mix index value in Table 3C in section IV of the Addendum to this proposed rule. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that HCFA will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. We are proposing to update the regional standards. The proposed regional standards are based on discharges for urban hospitals' cost reporting periods that began during FY 1997 (that is, October 1, 1996 through September 30, 1997). That is the latest year for which we have complete discharge data available.

Therefore, we are proposing that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 1999, must have as the number of discharges for its cost reporting period that began during FY 1998 a figure that is at least—

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

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	6672
2. Middle Atlantic (PA, NJ, NY)	8635
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	7753
4. East North Central (IL, IN, MI, OH, WI)	7390
5. East South Central (AL, KY, MS, TN)	6741
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	5662
7. West South Central (AR, LA, OK, TX)	5344
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	7993
9. Pacific (AK, CA, HI, OR, WA)	5993

We note that the number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals. These numbers will be revised in the final rule based on the latest FY 1997 cost report data.

We reiterate that an osteopathic hospital, if it is to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 1999, must have at least 3,000 discharges for its cost reporting period that began during FY 1997.

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

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

In the August 29, 1997 final rule (62 FR 46029), we redesignated the previous § 412.105(g) as § 412.105(f), and added a new paragraph (g) to implement section 1886(d)(5)(B) of the Act as revised by section 4621 of the Balanced Budget Act of 1997. However, when we redesignated paragraph (g) as paragraph (f), we inadvertently did not revise all of the relevant cross-references to reflect this redesignation. Specifically, at § 412.105(f)(1)(iii), there are three cross-references to paragraph (g)(1)(ii). These cross-references are incorrect in light of the redesignation of previous paragraph (g) as paragraph (f). We are proposing to revise § 412.105(f)(1)(iii) to correct these cross-references.

D. Medicare Geographic Classification Review Board: Conforming Changes §§ 412.256 and 412.276

In the May 12, 1998 final rule (63 FR 26321), we revised the regulations governing the timeframes for submittal of applications by hospitals to the MGCRB for geographic reclassifications and for MGCRB decisions to take into consideration the revised statutory publication schedule for the annual prospective payment policies and rates (that is, August 1 instead of September 1) implemented by the BBA. In making those changes, we inadvertently omitted conforming changes to two other sections of the regulations that also specify timeframes that are affected by the change to an August 1 publication date—§§ 412.256 and 412.276. We propose to revise § 412.256(c)(2) to specify that at the request of the hospital, the MGCRB may, for good cause, grant a hospital that has submitted an application by September 1 (instead of October 1) an extension beyond September 1 (instead of October 1) to complete its application. In addition, we propose to revise § 412.276(a) to specify that the MGCRB notifies the parties in writing, with a copy to HCFA, and issues a decision within 180 days after the ''first day of the 13-month period preceding the Federal fiscal year for which the hospital had filed a completed application'' for reclassification, to make the language consistent with the statute and the May 1998 changes made to the application deadline in § 412.256(a)(2).

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

Under section 1886(h) of the Act, Medicare pays hospitals for the direct costs of graduate medical education (GME). The payments are based on the number of residents trained by the hospital. The BBA revised section 1886(h) of the Act to cap the number of residents that hospitals may count for direct GME. We have issued rules to implement the caps for GME (62 FR 46002, August 29, 1997; 63 FR 26327, May 12, 1998; and 63 FR 40986, July 31, 1998). Since the publication of these rules we have received a number of questions relating to GME. In addition, we have received information related to other aspects of our GME policies. In response to these questions and information, we are clarifying certain GME policies and also making some technical changes to the regulations text. In addition, we are proposing certain changes in GME policy.

1. Approved Geriatric Programs

Under sections 1886(h)(5)(F) and (G) of the Act and § 413.86(g), Medicare counts each resident within an initial residency period as a 1.0 full-time equivalent (FTE) for purposes of determining GME payments. Each resident beyond the initial residency period is counted as 0.5 full-time equivalent. Section 1886(h)(5)(F) of the Act extends the initial residency period by up to 2 years if an individual is in a geriatric or preventive medicine residency or fellowship. At § 413.86(b), we specify that an ''approved geriatric program'' is ''a fellowship program of one or more years in length that is approved by the Accreditation Council for Graduate Medical Education (ACGME) under the ACGME's criteria for geriatric fellowship programs.'' In recent years, geriatric programs have been approved by other national organizations. Consistent with the statute, we are proposing to clarify the definition of approved geriatric programs at § 413.86(b) to include fellowship programs approved by the American Osteopathic Association, the Commission on Dental Accreditation, and the Council on Podiatric Medical Education. These organizations, in addition to ACGME, are recognized by HCFA as the accrediting bodies for determining approved educational activities. We also would make a conforming change to § 413.86(g)(1)(iii) to recognize approved geriatric programs accredited by all national approving organizations.

2. Hospital Payment for Resident Training in Nonhospital Settings

Under sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act, hospitals may count residents working in nonhospital sites for indirect and direct medical education respectively if the hospital incurs ''all or substantially all'' of these education costs. The requirements for counting the time residents spend training in nonhospital settings are addressed at § 413.86(f)(4). Currently, the requirements for hospital payment under this provision are that the resident spend his or her time in patient care activities and that a written agreement exist between the hospital and the nonhospital site. This written agreement must indicate that the hospital will incur the cost of the residents' salaries and fringe benefits while the residents are training in the nonhospital site and that the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. In addition, the written agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

Under the statute, the time residents spend at nonhospital sites may be counted ''if the hospital incurs all, or substantially all, of the costs of the training program in that setting.'' The existing regulations text, however, is framed in terms of the hospital having an agreement that it ''will incur'' the costs in the nonhospital setting. We are proposing to make a technical change to the regulations text by adding a new § 413.86(f)(4)(iii), to clarify that in order to count residents at a nonhospital site, the hospital must actually incur all or substantially all of the costs for the training program, as defined in § 413.86(b), in the nonhospital site. This definition of all or substantially all requires the hospital to incur the expenses of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME.

3. New Residency Programs

In the regulations we published on August 29, 1997 and May 12, 1998, we established special rules for adjusting the full-time equivalent (FTE) resident caps for indirect and direct GME for new medical residency programs. In general, the special rules allow for adjustments to the caps based on a number of residents participating in the program in its third year of existence. In §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii), we set forth a methodology for adjusting hospital FTE caps for new medical residency training programs established on or after January 1, 1995. We are proposing the following clarifications, technical changes, and policy changes:

a. In § 413.86(g)(6)(i), we specify that, if a hospital had no residents before January 1, 1995, the adjustments for new programs are based on the highest number of residents in any program year during the third year of the newly established program. However, § 413.86(g)(6)(ii) does not explicitly state the methodology for adjusting caps for hospitals that did have residents in the most recent cost reporting period ending before January 1, 1995. The adjustments of the caps for programs established on or after January 1, 1995 and on or before August 5, 1997, also are made based on the number of residents in the third year of the new program. We are proposing to revise § 413.86(g)(6)(ii) to clarify that, for a hospital that did have residents in the most recent cost reporting period ending on or before December 31, 1996 (the proposed revised date described in section IV.E.3.d. of this preamble), the adjustment is based on the highest number of residents in any program year in the third year of the new program.

b. Sections 413.86(g)(6)(i) and 413.86(g)(6)(ii) specify that the adjustment to the cap is also based on the number of years in which residents are expected to complete each program based on the minimum accredited length for the type of program. We are proposing to add language to clarify how to account for situations in which the residents spend an entire program year (or years) at one hospital and the remaining year (or years) of the program at another hospital. In this situation, the adjustment to the FTE cap is based on the number of years the residents are training at each hospital, not the minimum accredited length for the type of program. If we were to use the minimum accredited length for the program in this case, the total adjustment to the cap might exceed the total accredited slots available to the hospitals participating in the program. In the May 12, 1998 final rule (63 FR 26334), we specified that the adjustment to the FTE cap may not exceed the number of accredited resident slots available.

c. It was brought to our attention that the regulations do not explicitly address how to apply the cap during the first 3 years of a new program before the adjustments to the cap are established. We are proposing to clarify our policy on new residency programs by adding language in §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii) to specify how to determine the hospital's cap in the first 3 years of a new residency program, before the implementation of the hospital's permanent adjustment to its FTE cap effective beginning with the fourth year of the program. We are proposing to specify that the cap may be adjusted during each year of the first 3 years of the hospital's new residency program, using the actual number of residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

d. As discussed above, on August 29, 1997, we implemented the hospital-specific caps on the number of residents that a hospital can count for purposes of GME payments in a final rule with comment period (62 FR 46002). In both the May 12, 1998 and July 31, 1998 final rules (63 FR 26327 and 63 FR 40954), we responded to comments we received on this provision. We did not receive any comments about hospitals that participated in residency training in the

past, had terminated their participation prior to the hospitals' cost reporting period ending in calendar year 1996, and have now again begun a new residency program. After publication of the July 31, 1998 final rule, we were contacted by representatives of some hospitals that had a resident cap of zero because they had temporarily terminated their GME programs in the past and had no residents training during the cost reporting period ending in 1996. Based on the existing regulations, these hospitals have FTE caps of zero. There is no provision in the existing regulations for making adjustments to the cap to allow these hospitals to receive payment for indirect and direct GME for allopathic and osteopathic residents.

To address this issue, we are proposing to revise § 413.86(g)(6)(i) to allow for an adjustment to a hospital's FTE cap if the hospital had no allopathic and osteopathic residents in its cost reporting period ending during calendar year 1996. This change would allow all hospitals that did not participate in allopathic and osteopathic resident training in the cost reporting period ending in calendar year 1996 to receive adjustments to the indirect and direct GME FTE caps for new residency programs. We believe it is appropriate to revise the regulations to allow for payment during the first 3 years of the new program and for an adjustment to the FTE cap 3 years after these hospitals restart participation in residency training, similar to the existing adjustment for hospitals that never participated in residency training. We propose to revise § 413.86(g)(6)(i) to allow a hospital that has zero residents for the cost reporting period ending during the calendar year 1996 to receive an adjustment. This change would be effective for discharges occurring on or after October 1, 1999, for purposes of the IME adjustment and for cost reporting periods beginning on or after October 1, 1999, for purposes of direct GME.

In addition, we are proposing to make a change in § 413.86(g)(6)(ii) to make the language similar to that in § 413.86(g)(6)(i) to specify that hospitals that did have residents in the cost reporting period ending on or before December 31, 1996, are allowed adjustments to the cap for new programs begun on or after January 1, 1995, and on or before August 5, 1997. Currently, § 413.86(g)(6)(ii) refers to a hospital that did have residents in its most recent cost reporting period ending on or before January 1, 1995. The regulation states that these hospitals also may qualify for an adjustment to the caps, but only for medical residency programs created on or after January 1, 1995, and on or before August 5, 1997. Since we are proposing to revise § 413.86(g)(6)(i) to indicate that a hospital may qualify for an adjustment to the cap under that paragraph if it did not have residents in the cost reporting period ending during calendar year 1996, we are proposing to make a similar change in § 413.86(g)(6)(ii) to indicate that this paragraph provides for an adjustment to the cap for hospitals that did have residents in its most recent reporting period ending on or before December 31, 1996. We are proposing this revision to make the language of these two paragraphs consistent. Hospitals may qualify either under § 413.86(g)(6)(i) or § 413.86(g)(6)(ii). For hospitals that qualify under § 413.86(g)(6)(i), the FTE caps are established 3 years after the hospital either begins or restarts participation in residency training for programs that began on or after January 1, 1995. However, for hospitals that qualify under § 413.86(g)(6)(ii), adjustments to the cap are limited to those programs that began on or after January 1, 1995 and on or before August 5, 1997.

e. We are proposing to make technical changes to §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii), which refer to whether a hospital had residents in its most recent cost reporting period on or before December 31, 1996. Instead of simply specifying ''residents,'' we are proposing to reference ''allopathic and osteopathic residents,'' because the FTE cap applies only to allopathic and osteopathy residents. There is no FTE cap on the number of podiatry and dentistry residents. Therefore, we are proposing to add the words ''allopathic and osteopathic'' in §§ 413.86(g)(6)(i) and 413.86(g)(6)(ii) before the word ''resident''.

4. Adjustment to GME Caps for Certain Hospitals To Account for Residents in New Medical Residency Training Programs

Section 4623 of the BBA amended section 1886(h) of the Act to provide for ''special rules'' in applying FTE caps for medical residency training programs established on or after January 1, 1995. In the August 29, 1997 and May 12, 1998 final rules (62 FR 46002 and 63 FR 26327), we implemented special rules to account for residents in new medical residency training programs. We are proposing to implement another special rule to permit an adjustment to the FTE cap for a hospital if the entire facility was under construction prior to August 5, 1997 (the date of enactment of the BBA) and if the hospital sponsored a new medical residency training program but the residents temporarily trained at another hospital.

Under current policies, if a new medical residency training was established on or after January 1, 1995, a hospital may receive an adjustment to its FTE cap to account for residents in the new program. If the residents in the new program begin training in one hospital and are subsequently ''transferred'' to another hospital, the second hospital does *not* receive an adjustment to its FTE cap; if we made an adjustment for the second hospital, then two hospitals would receive an adjustment for the same resident.

We believe, however, that an adjustment for the second hospital might be appropriate in certain limited circumstances. If the second hospital sponsored a new medical residency training program but the residents in the new program temporarily trained at the first hospital because the second hospital was still being built, then we believe it might be appropriate to permit an adjustment for the second hospital. Otherwise, the second hospital's FTE cap would be zero, and the hospital would not receive any GME or IME payments.

We are proposing to permit an adjustment under this policy only if the second hospital (the sponsor of the new program) began construction of its entire facility prior to the date of enactment of the BBA. Prior to August 5, 1997, a hospital would not have had knowledge of the provisions of the BBA and thus would not have known that a decision to temporarily train residents at another hospital might have resulted in the hospital being unable to receive GME and IME payments in the future. In contrast, a hospital that began construction of an entirely new facility on or after August 5, 1997 would have had notice of changes in the law prior to making a decision to temporarily train residents at another hospital.

Thus, we are proposing to add a new § 413.86(g)(7) (existing § 413.86(g)(7) would be redesignated as § 413.86(g)(9)) to address application of the FTE caps with regard to a hospital that began construction of an entire facility prior to August 5, 1997, sponsored medical residency training programs, and temporarily trained those residents at another hospital(s) until the new facility was completed. For hospitals that meet these criteria, we propose that the FTE caps will be determined in a manner similar to those hospitals that qualify for an adjustment to the FTE cap under § 413.86(g)(6)(i). That is, the hospital's cap would equal the lesser of (a) the product of the highest number of

residents in any program year during the third year of the first program's existence for all new residency training programs at either the newly constructed facility or the temporary training site and the number of years in which residents are expected to complete the programs based on the minimum accredited length for each type of program; or (b) the number of accredited slots available for each year of the program. If the medical residency training programs sponsored by the newly constructed hospital have been in existence for 3 years or more by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap would be the number of residents training in the third year of the first of those programs begun at the a temporary training site. If the medical residency training programs sponsored by the newly constructed hospital have been in existence for less than 3 years when the residents begin training at the newly constructed hospital, the hospital's cap would be based on the number of residents training at the newly constructed hospital in the third year of the first of those programs (including the years at the temporary training site). This provision would be effective for portions of cost reporting periods occurring on or after October 1, 1999.

5. Temporary Adjustments to FTE Cap To Reflect Residents Affected by Hospital Closure

In the May 12, 1998 prospective payment system final rule (63 FR 26330), we indicated that we would allow a temporary adjustment to a hospital's resident cap under limited circumstances and if certain criteria are met when a hospital assumes the training of additional residents because of another hospital's closure. The temporary adjustment to the FTE cap is available to the hospital only for the period of time necessary to train those displaced residents. Once the residents leave the hospital or complete their programs, the hospital cap would be based solely on the statutory base year (with any applicable adjustments for new medical residency training programs or affiliated group arrangements).

Under current policies, we permit a temporary adjustment to the FTE cap for a hospital only if it assumed additional medical residents from a hospital that closed in the July 1996–June 1997 residency training year. We are proposing to allow adjustments to address hospital closures after this period. Thus, we would allow an adjustment for a hospital if it takes on additional residents from a hospital that closes at any time on or after July 1, 1996. This adjustment is intended to account for residents who may have partially completed a medical residency training program and would be unable to complete their training without a residency position at another hospital.

We are proposing this change because hospitals have indicated a reluctance to accept additional residents from a closed hospital without a temporary adjustment to their caps. Therefore, we are proposing to add a new § 413.86(g)(8) to allow a temporary adjustment to a hospital's FTE cap to reflect residents added because of a hospital's closure at any time on or after July 1, 1996. We would allow an adjustment to a hospital's FTE cap if the hospital meets the following criteria: (a) the hospital is training additional residents from a hospital that closed on or after July 1, 1996; and (b) the hospital that is training the additional residents who are assumed from the closed hospital submits a request to its fiscal intermediary at least 60 days before the beginning of training of the residents for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment to its FTE cap by identifying the residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specifies the length of time that the adjustment is needed. After the displaced residents leave the hospital's training program or complete their residency program, the hospital's cap would be based solely on the statutory base year (with any applicable adjustments for new medical residency training programs or affiliated group arrangements).

6. Determining the Weighted Number of FTE Residents

Section 413.86(g)(1)(ii) states that for residency programs in osteopathy, dentistry, and podiatry, the minimum requirement for certification in a specialty or subspecialty is the minimum number of years of formal training necessary to satisfy the requirements of the appropriate approving body listed in § 415.200(a). This reference is incorrect. The correct section in which approving bodies for residency programs are listed is § 415.152. We propose to make this correction.

Section 413.86(g)(1)(i) specifies that the initial residency period is the minimum number of years of formal training necessary to satisfy board eligibility in the particular specialty for which the resident is training, as specified in the 1985–1986 Directory of Residency Training Programs. Section 1886(h)(5)(G)(iii) of the Act allows the Secretary to increase or decrease the initial residency period if the minimum number of years of formal training specified in a later edition of the directory is different from the period specified in the 1985–1986 Directory of Residency Training Programs. We are proposing to revise the regulations text to state that the initial residency period is determined using the most recently published edition of the Graduate Medical Education Directory, not the 1985–1986 Directory.

7. Clarification of a Statement in the Preamble of the May 12, 1998 Final Rule Relating to Affiliated Groups

In the May 12, 1998 final rule (63 FR 26341), in the third column of page 26341, in the sentence prior to section ''O. Payment to Managed Care Plans for Graduate Medical Education,'' we stated, ''If the combined FTE counts for the individual hospitals that are members of the same affiliated group do not exceed the aggregate cap, we will pay each hospital based on its FTE cap as adjusted per agreements.'' The phrase ''do not exceed'' should have read ''exceed.'' Thus, the sentence should have read, ''If the combined FTE counts for individual hospitals that are members of the same affiliated group exceed the aggregate cap, we will pay each hospital based on its FTE cap as adjusted per agreements.'' We regret any confusion that resulted from this misstatement.

V. Proposed Changes to the Prospective Payment System for Capital-Related Costs: Special Exceptions Process

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

Generally, during the transition period, inpatient capital-related costs will be paid on a per discharge basis, and the amount of payment depends on the relationship between the hospital-specific rate and the Federal rate during the hospital's base year. A hospital with

a base year hospital-specific rate less than the Federal rate will be paid under the fully prospective payment methodology during the transition period. This method is based on a dynamic blend percentage of the hospital's hospital-specific rate and the applicable Federal rate for each year during the transition period. A hospital with a base period hospital-specific rate greater than the Federal rate will be paid under the hold harmless payment methodology during the transition period. A hospital paid under the hold harmless payment methodology receives the higher of (1) a blended payment of 85 percent of reasonable cost for old capital plus an amount for new capital based on a portion of the Federal rate or (2) a payment based on 100 percent of the adjusted Federal rate. The amount recognized as old capital is generally limited to the allowable Medicare capital-related costs that were in use for patient care as of December 31, 1990. Under limited circumstances, capital-related costs for assets obligated prior to December 31, 1990, but put in use for patient care after December 31, 1990 may also be recognized as old capital if certain conditions are met. These costs are known as obligated capital costs. New capital costs are generally defined as allowable Medicare capital-related costs for assets put in use for patient care after December 31, 1990. Beginning in FY 2001, at the conclusion of the transition period for the capital prospective payment system, capital payments will be based solely on the Federal rate for most hospitals.

In the August 30, 1991 final rule, we also established a capital exceptions policy, which provides for exceptions payments during the transition period (§ 412.348). We also indicated that we would carefully monitor the impact of the capital prospective payment system in order to determine whether some type of permanent exceptions process was necessary and the circumstances under which additional payments would be made.

In the Conference Report that accompanied the Omnibus Budget Reconciliation Act (OBRA) of 1993 (Pub. L. 103–66), Congress addressed obligated capital criteria for hospitals in States with a lengthy certificate of need (CON) process. The language states, ''The conferees note that in the proposed rule for fiscal year 1994 changes to the hospital inpatient prospective payment system that was published in the **Federal Register** on May 26, 1993, the Secretary indicated that insufficient information was available to complete a systematic evaluation of the obligated capital criteria for hospitals in states with a lengthy Certificate-of-Need process in time to consider appropriate changes during the fiscal year 1994 rulemaking process. The conferees expect the Secretary to complete the assessment in time for consideration in the fiscal year 1995 rulemaking process and that appropriate changes in payment policy will be made to address the problems of hospitals subject to a lengthy Certificate-of-Need review process or subject to other circumstances which are not fully addressed in the current rules. In addition, the conferees believe the Secretary should evaluate whether current policies provide adequate protection to sole community hospitals and hospitals that serve a disproportionate share of low income patients.'' (H.R. Conf. Rep. No. 103–66, at 744 (1993)).

In the May 27, 1994 proposed hospital inpatient prospective payment rule (59 FR 27744), we described our analysis of provisions related to obligated capital for hospitals subject to lengthy CON processes and proposed a change to the deadline for putting an asset into use for patient care (§ 412.302(c)(2)(i)(D)). We proposed changing the deadline from ''the earlier of'' September 30, 1996, or 4 years from the date of CON approval to ''the later of'' September 30, 1996, or 4 years from the date of CON approval.

In addition, in the May 27, 1994 proposed rule, we noted that the same hospitals that had asked for changes in the obligated capital provisions had also recommended changes to the capital exceptions policy, which would provide exceptions payments after the conclusion of the capital prospective payment transition period. These hospitals had asked that the minimum payment level for urban hospitals with at least 100 beds and a DSH percentage of at least 20.2 percent be guaranteed through the rest of the transition and extended for at least 10 years after the transition. We noted that we had tried to address the concerns of these hospitals in developing the proposed special exceptions process that was discussed in the same proposed rule.

In the September 1, 1994 final rule (59 FR 45376), we adopted the proposed change to the deadline for putting an asset into use in the obligated capital regulations (§ 412.348). We also implemented the capital special exceptions process and adopted qualifying criteria for the classes of eligible hospitals. The classes of eligible hospitals include urban hospitals with a DSH percentage of 20.2 percent and at least 100 beds and sole community hospitals.

Under the special exceptions provision at § 412.348(g), an additional payment may be made for up to 10 years beyond the end of the capital prospective payment system transition period for eligible hospitals that meet (1) a project need requirement, (2) a project size requirement, and (3) in the case of certain urban hospitals, an excess capacity test. In the September 1, 1994 final rule, we described the special exceptions process as ''* * * narrowly defined, focusing on a small group of hospitals who found themselves in a disadvantaged position. The target hospitals were those who had an immediate and imperative need to begin major renovations or replacements just after the beginning of the capital prospective payment system. These hospitals would not be eligible for protection under the old capital and obligated capital provisions, and would not have been allowed any time to accrue excess capital prospective payments to fund these projects.'' (59 FR 45385)

In addition to sole community hospitals and urban hospitals with at least 100 beds that have a DSH percentage of at least 20.2 percent, hospitals eligible for special exceptions include urban hospitals with at least 100 beds that receive at least 30 percent of their revenue from State or local funds for indigent care, and hospitals with a combined inpatient Medicare and Medicaid utilization of at least 70 percent.

To qualify for a special exceptions payment, a hospital must satisfy a project need requirement as described at § 412.348(g)(2) and a project size requirement as described at § 412.348(g)(5). For hospitals in States with CON requirements, the project need requirement is satisfied by obtaining a CON approval. For other hospitals, the project need requirement is satisfied by meeting an age of assets test. The project size requirement is satisfied if the hospital completes the qualifying project between the period beginning on or after its first cost reporting period beginning on or after October 1, 1991, and the end of its last cost reporting period beginning before October 1, 2001, and the project costs are (1) at least $200 million or (2) at least 100 percent of the hospital's operating cost during the first 12-month cost reporting period beginning on or after October 1, 1991. The minimum payment level under special exceptions for all qualifying hospitals is 70 percent of allowable capital-related costs. Special exception payments are offset against positive Medicare capital and operating margins.

When we established the special exceptions process, we selected the hospital's cost reporting period beginning before October 1, 2001, as the project completion date in order to limit cost-based exceptions payments to a period of not more than 10 years beyond the end of the transition to the fully Federal capital prospective payment system. Because hospitals are eligible to receive special exceptions payments for up to 10 years from the year in which they complete their project (but for not more than 10 years after September 30, 2001, the end of the capital prospective payment transition), if a project is completed by September 30, 2001, exceptions payments could continue up to September 30, 2011. In addition, we believed that for projects completed after the September 30, 2001, hospitals would have had the opportunity to reserve their prior years' capital prospective payment system payments for financing projects.

In the July 31, 1998 final rule (63 FR 40999), we stated that a few hospitals had expressed concern with the required completion date of October 1, 2001, and other qualifying criteria for the special exceptions payment. Therefore, we solicited certain information from hospitals on major capital construction projects that might qualify for the capital special exceptions payments so we could determine if any changes in the special exceptions criteria or process were necessary.

Four hospitals responded timely with information on their major capital construction projects. The hospitals submitted information about their location, the cost of the project, the date that the certificate of need approval was received, the start date of the project, and the anticipated completion date.

Some hospitals suggested that we change the existing project completion date criterion, that is, the criterion that the qualifying projects must be completed between the hospital's first cost reporting period beginning on or after October 1, 1991, and the end of its last cost reporting period beginning before October 1, 2001. They proposed that, as an alternative, a hospital be eligible for the special exceptions payment if the hospital had received its CON approval for the qualifying project by September 1, 1995, and had spent $750,000 or 10 percent of total project cost by that date, and that the project completion date be changed to December 31, 2005 (which would be well beyond the 10 years we have established for the capital prospective payment system transition). However, other hospitals recommended that we not institute a date by which a hospital must have received its CON approval.

In addition, some hospitals have suggested other ways in which the special exceptions process could be revised. Some of these hospitals expressed concern about the project size requirement and stated that small community-based institutions were unlikely to be able to support debt in the range of $200 million.

We understand that a few hospitals may not meet the DSH percentage requirement of at least 20.2 percent. Some of these hospitals suggested lowering the qualifying percentage to 15 percent. They also suggested changing the payment level for special exceptions from 70 percent to 85 percent and changing the requirement at § 412.348(g)(8)(ii)(B) that special exception payments be offset against positive Medicare operating and capital margins. They suggested limiting the offset provision to capital margins. In addition, some of these hospitals suggested capping special exceptions payments that result from changes to the current special exceptions process at $40 million annually.

While we have no specific proposal at this time to revise the special exceptions process, we specifically invite comments from hospitals and other interested parties on the suggestions and recommendations discussed above. We note that, since the capital special exceptions process is budget neutral, any liberalization of the policy would require a commensurate reduction in the capital rate paid to all hospitals. Even after the end of the capital prospective payment system transition, we will continue to make an adjustment to the capital Federal rate in a budget neutral manner to pay for exceptions, as long as an exceptions policy is in force. Currently, the limited special exceptions policy will allow for exceptions payments through September 30, 2011.

We have little information about the impact of any of the recommended changes, since no hospitals are currently being paid under the special exceptions process. Until FY 2001, the special exceptions provision pays either the same as the regular exceptions process or less for high DSH and sole community hospitals. We will attempt to obtain information on projects that may qualify for special exceptions payments through our fiscal intermediaries during the comment period. However, we are reluctant to place a significant data gathering burden on fiscal intermediaries at this time because of their current workload resulting from the major efforts to make the Medicare computer systems compliant on January 1, 2000. Based on comments that we receive from hospitals and any data received from the fiscal intermediaries, we may address changes to the special exceptions criteria in the final rule, or we may propose changes in the criteria in the FY 2001 hospital inpatient prospective payment system proposed rule.

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

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

1. Updated Caps

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

A discussion of how the caps on the target amounts were calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46018); the May 12, 1998 final rule (63 FR 26344); and the July 31, 1998 final rule (64 FR 41000). For purposes of calculating the caps, the statute requires us to calculate the 75th percentile of the target amounts for each class of hospital (psychiatric, rehabilitation, or long-term care) for cost reporting periods ending during FY 1996. The resulting amounts are updated by the market basket percentage to the applicable fiscal year.

The current estimate of the market basket increase for excluded hospitals and units for FY 2000 is 2.6 percent. Accordingly, the proposed caps on target amounts for cost reporting periods beginning in FY 2000 are as follows:

- Psychiatric hospitals and units: $11,067
- Rehabilitation hospitals and units: $20,071
- Long-term care hospitals: $39,596

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

a. Updated Caps for New Hospitals and Units. Section 1886(b)(7) of the Act establishes a payment methodology for new psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals. Under the statutory methodology, for a hospital that is within a class of hospitals specified in the statute and that first

receives payments as a hospital or unit excluded from the prospective payment system on or after October 1, 1997, the amount of payment will be determined as follows. For the first two 12-month cost reporting periods, the amount of payment is the lesser of (1) the operating costs per case, or (2) 110 percent of the national median of target amounts for the same class of hospitals for cost reporting periods ending during FY 1996, updated to the first cost reporting period in which the hospital receives payments and adjusted for differences in area wage levels.

The proposed amounts included in the following table reflect the updated 110 percent of the wage neutral national median target amounts for each class of excluded hospitals and units for cost reporting periods beginning during FY 2000. These figures are updates to the final FY 1999 figures by the estimated market basket increase of 2.6 percent. For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	Labor-related share	Nonlabor-related share
Psychiatric	$6,376	$2,536
Rehabilitation	12,537	4,984
Long-Term Care	16,158	6,424

b. Multicampus Excluded Hospitals. Section 1886(b) of the Act, as amended by the BBA, provides for caps on target amounts for certain classes of excluded hospitals, and also provides a statutory payment methodology for new excluded hospitals. A question has arisen regarding the appropriate target amount to be used for an excluded hospital or unit that was part of a multicampus hospital but alters its organizational structure so that it is no longer part of that multicampus hospital. The question was raised by long-term care hospitals that are seeking alternate structures due to the application of the cap on hospital-specific target amounts specified in § 413.40(c)(4)(iii).

In these cases, to determine the appropriate target amount, we must determine whether the excluded hospital or unit established under the organizational restructure is a new provider. Under § 413.40(f)(1), a new excluded hospital or unit is a provider of hospital inpatient services that (1) has operated as the type of hospital or unit for which HCFA granted it approval to participate in the Medicare program, under present or previous ownership (or both), for less than 1 full year; and (2) has provided the type of hospital inpatient services for which HCFA granted it approval to participate for less than 2 full years. For a new children's hospital, a 2-year exemption from the application of the target amount is permitted (§ 413.40(f)(2)(i)). For the first two 12-month cost reporting periods, a new psychiatric or rehabilitation hospital or unit or a long-term care hospital receives the lower of its new inpatient operating cost per case or 110 percent of a national median of target amounts for the class of hospital, updated and adjusted for area wages (§ 413.40(f)(2)(ii)).

If the entity that separated itself from the multicampus hospital provides inpatient services of a different type than it had when it was part of the multicampus hospital so that it qualifies as a different class of excluded hospital or unit (for example, from long-term care to rehabilitation), we would calculate a new target amount per discharge for the newly created hospital or unit. However, if the entity does not operate as a different class of hospital or unit, it does not meet the criteria at § 413.40(f)(1) to qualify as a new provider. Instead, if the entity replaces a hospital or unit that had been excluded from the prospective payment system (for example, the entity had previously been a long-term care hospital before becoming part of the multicampus hospital), the previously established hospital-specific target amount for the hospital prior to becoming part of the multicampus hospital would again be applicable. This is consistent with our current policy for a hospital or unit excluded from the prospective payment system that has periods in which the hospital or unit is not subject to the target amount, as specified at § 413.40(b)(1)(i). The target amount established earlier for the hospital or unit is again applicable despite intervening cost reporting periods during which the hospital or unit was not subject to that target amount due to other provisions of the law or regulations that applied while it was part of the multicampus hospital. In contrast, we propose to revise § 413.40(b)(1)(iii) to specify that if the entity continues to operate as the same class of hospital that is excluded from the prospective payment system, but does not replace a provider that existed prior to being part of a multicampus hospital (for example, a newly created long-term care hospital became part of a multicampus hospital and subsequently separates from the multicampus hospital to operate separately), the base period for calculating a hospital-specific target amount for the newly separated hospital is the first cost reporting period of at least 12 months effective with the revised Medicare certification.

3. Exceptions

The August 29, 1997 final rule with comment period (62 FR 46018) specified that a hospital that has a hospital-specific target amount that is capped at the 75th percentile of target amounts for hospitals in the same class (psychiatric, rehabilitation, or long-term care) would not be granted an adjustment payment (also referred to as an exception payment) based solely on a comparison of its costs or patient mix in its base year to its costs or patient mix in the payment year. Since the hospital's target amount would not be determined based on its own experience in a base year, any comparison of costs or patient mix in its base year to costs or patient mix in the payment year would be irrelevant.

In addition, the July 31, 1998 final rule (63 FR 41001) revised § 413.40(g)(1) to specify, under paragraph (g)(1)(iv), that in the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the amount of the adjustment payment may not exceed the applicable limit amounts for hospitals of the same class.

Similarly, for hospitals and units with a FY 1998 hospital-specific revised target amount established under the rebasing provision at § 413.40(b)(1)(iv), in determining whether the hospital qualifies for an adjustment and the amount of the adjustment, we compare the hospital's operating costs to the average costs and statistics for the cost reporting periods used to determine the FY 1998 revised target amount. Since the rebased FY 1998 target amount is an average of three cost reporting periods, as described in § 413.40(b)(1)(iv), comparisons of costs from the cost year to the FY 1998 cost period would be inaccurate. Therefore, as specified in the August 29, 1997 final rule with comment period (62 FR 46018), a determination of whether the hospital qualifies for an adjustment and the amount of an adjustment is based on a comparison of the hospital's operating costs and its costs used to calculate the FY 1998 rebased target amount.

The conditions that must be met to qualify for an adjustment remain unchanged, as specified in Chapter 30 of the Provider Reimbursement Manual. Making comparisons between the base year and the cost year requires that each particular inpatient service be

compared. For example, to determine whether the hospital qualifies for an adjustment and the amount of an adjustment for increased routine services or an increase in a particular ancillary service, we compare the costs incurred by the hospital in the cost year to the hospital's routine services or ancillary services in the base year. Therefore, for hospitals that have been rebased under the provisions of § 413.40(b)(1)(iv) and qualify for an adjustment under the provisions of § 413.40(g), the base year figures used for costs, utilization, length-of-stay, etc., are determined based on the average of the costs and utilization statistics from the same 3 cost reporting years used in calculating the FY 1998 rebased target amount. While we recognize that additional calculations are necessary to prepare an adjustment payment request in this manner, we believe it is the most equitable means of determining an adjustment payment. We also point out that the averaging calculation for the various cost centers and utilization statistics must only be performed the first year a provider requests an adjustment after FY 1998, and thereafter those averaged calculations may be utilized for subsequent years' adjustment requests.

Therefore, once these averages are calculated, the same values will be used for determining the amount of any subsequent year adjustments.

We propose to revise § 413.40(g)(1) to clarify these limitations on the adjustment payments.

4. Development of Case-Mix Adjusted Prospective Payment System for Rehabilitation Hospitals and Units

Section 4421 of the BBA added a new section 1886(j) to the Act which mandates the phase-in of a case-mix adjusted prospective payment system for inpatient rehabilitation services (freestanding hospitals and units) for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2002. The prospective payment system will be fully implemented for cost reporting periods beginning on or after October 1, 2002.

As provided in section 1886(j)(3)(A) of the Act, the prospective payment rates will be based on the inpatient operating and capital costs of rehabilitation facilities. Payments will be adjusted for case-mix using patient classification groups, area wages, inflation, and outlier and any other factors the Secretary determines necessary. We will set prospective payment amounts so that total payments under the system during FY 2001 and FY 2002 are projected to equal 98 percent of the amount of payments that would have been made under the current payment system. Outlier payments in a fiscal year may not be projected or estimated to exceed 5 percent of the total payments based on the rates for that fiscal year.

B. Changes in Bed Size or Status of Hospital Units Excluded Under the Prospective Payment System

Existing regulations (§§ 412.25(b) and (c)) specify that, for purposes of payment to a psychiatric or rehabilitation unit that is excluded from the prospective payment system, changes in the bed size or the status of excluded hospital units will be recognized only at the beginning of a cost reporting period. These regulations have been in effect since the inception of the inpatient hospital prospective payment system and were intended to simplify administration of the exclusion provisions of the prospective payment systems by establishing clear rules for the timing of changes in these excluded units.

Recently, a number of hospitals have suggested that we consider a change in our policy to recognize, for purposes of exclusion from the prospective payment system, reductions in number of beds in, or entire closure of, units at any time during a cost reporting period. They indicated that the bed capacity made available as a result of these changes could be used, as they need them, to provide additional services to meet patient needs in the acute care part of the hospital that is paid under the prospective payment system.

We have evaluated the concerns of the hospitals and the effect on the administration of the Medicare program and the health care of beneficiaries of making these payment changes. As a result of this evaluation, we believe it is reasonable to adopt a more flexible policy on recognition of hospitals' changes in the use of their facilities. However, we note that whenever a hospital establishes an excluded unit within the hospital, our Medicare fiscal intermediary must be able to determine costs of the unit separately from costs of the part of the hospital paid under the prospective payment system. The proper determination of costs ensures that the hospital is paid the correct amount for services in each part of the facility, and that payments under the prospective payment system do not duplicate payments made under the rules applicable to excluded hospitals and units, or vice versa. For this reason, we do not believe it would be appropriate to recognize, for purposes of exclusion from the prospective payment system, changes in the bed size or status of an excluded unit that are so frequent that they interfere with the ability of the intermediary to accurately determine costs.

Moreover, section 1886(d)(1)(B) of the Act authorizes exclusion from the prospective payment system of specific types of hospitals and units, but not of specific admissions or stays, such as admissions for rehabilitation or psychiatric care, in a hospital paid under the prospective payment system. Without limits on the frequency of changes in excluded units for purposes of proper Medicare payment, there is the potential for some hospitals to adjust the status or size of their excluded units so frequently that the units would no longer be distinct entities and the exclusion would effectively apply only to certain types of care.

To provide more flexibility to hospitals while not recognizing changes that undermine statutory requirements and principles, we propose to revise §§ 412.25(b) and (c) to provide that, for purposes of exclusion from the prospective payment system, the number of beds and square footage of an excluded unit may be decreased, or an excluded unit may be closed in its entirety, at any time during a cost reporting period under certain conditions. The hospital would be required to give the fiscal intermediary and the HCFA Regional Office a 30-day advance written notice of the intended change and to maintain all information needed to accurately determine costs attributable to the excluded unit and proper payments. However, any unit that is closed during a cost reporting period could not be paid again as a unit excluded from the prospective payment system until the start of the next cost reporting period. If the number of beds or square footage of a unit excluded from the prospective payment system is decreased during a cost reporting period, that decrease would remain in effect for the remainder of that period.

We note that the number of beds and square footage of the part of the hospital paid under the prospective payment system may also be affected by a change in the size or status of a unit that is excluded from the prospective payment system. If the bed capacity and square footage were previously part of the excluded unit and are then included in the part of the hospital paid under the prospective payment system and are used to treat acute patients rather than excluded unit patients, the additional bed capacity and square footage would, starting with the effective date of the change, be counted as part of the

hospital paid under the prospective payment system. We would count the bed capacity and square footage for purposes of calculating available bed-days and the number of beds under §§ 412.105 and 412.106, relating to payments for the indirect costs of GME and service to a disproportionate share of low-income patients. On the other hand, if the bed capacity and square footage are taken out of service or added to another Medicare provider, such as a distinct-part SNF, they would not be counted as part of the hospital paid under the prospective payment system.

C. Payment for Services Furnished at Satellite Hospital Locations

Under Medicare, each hospital is treated, for purposes of certification, coverage, and payment, as a single institution. That is, each entity that is approved to participate in Medicare as a ''hospital'' must separately comply with applicable health and safety requirements as a condition of participation under regulations at Part 482, with provider agreement requirements specified in regulations at Part 489, and with requirements relating to the scope of benefits under Medicare Part A and B specified in parts 409 and 410. Our policies that involve the movement of patients from one hospital to another, or from outpatient to inpatient status at a same hospital, are premised on the assumption that each hospital is organized and operated as a separate institution.

Section 412.22(e) of the regulations permits an entity that is located in the same building or in separate buildings on the same campus as another hospital to be treated, for purposes of exclusion under the prospective payment systems, as a ''hospital within a hospital.'' This status is available, however, only when the entity meets specific, stringent criteria designed to ensure that the hospital-within-a-hospital is organized as a separate entity and operates as a separate entity.

Recently, we have received several requests for approval of ''satellite'' arrangements, under which an existing hospital that is excluded under the prospective payment system, and that is either a freestanding hospital or a hospital-within-a-hospital under § 412.22(e), wishes to lease space in a building or on a campus occupied by another hospital, and, in some cases, to have most or all services to patients furnished by the other hospital under contractual agreements, including arrangements permitted under section 1861(w)(1) of the Act. In most cases, a hospital intends to have several of these satellite locations so that the hospital would not exist at any single location, but only as an aggregation of beds located at several sites. Generally, the excluded hospital seeks to have the satellite facility treated as if the satellite facility were ''part of'' the excluded hospital.

The fundamental problem with satellite arrangements is that the satellite facility might be ''part of'' the excluded hospital only on a nominal basis (that is, only on paper). The satellite facility might not operate as part of the excluded hospital, but instead might effectively be a ''part of'' the hospital within which it is located, or might effectively be its own separate entity. From a payment perspective, if the satellite facility is effectively *not* part of the excluded hospital, then Medicare would make inappropriately high payments if Medicare treats the satellite facility as part of the excluded hospital.

Perhaps most significantly, if Medicare treated the satellite facility as part of the excluded hospital, the services in the satellite facility might inappropriately be paid by Medicare on the basis of reasonable costs (subject to limits) when they should be paid on the basis of prospective payment. If the satellite facility operates as ''part of'' the prospective payment system hospital in which it is located, and not as part of the excluded hospital with which it is affiliated, then the considerations underlying exclusion from the prospective payment system do not apply to the services furnished in satellite facilities. Thus, if the satellite facility is effectively part of the prospective payment system hospital, then the services should be paid under the prospective payment system.

Satellite arrangements can lead to inappropriate Medicare payments in a number of ways. For example, an excluded long-term care hospital might set up a satellite facility within an acute care hospital paid under the prospective payment system. Such a configuration could make it relatively easy for the prospective payment hospital to discharge a patient prematurely to the excluded long-term care hospital satellite location that is in its building or on its campus. The result could be inappropriate duplication of payment, in that the prospective payment system hospital would receive full payment under the DRG system even if it did not complete the acute treatment of the patient, and the hospital excluded under the prospective payment systems would receive payment for some services that should have been furnished in the prospective payment system hospital and paid under the prospective payment system. While the discharge and transfer regulations at § 412.4 provide disincentives to these inappropriate transfers in some 10 DRGs, there are many other cases not assigned to these DRGs in which such transfers could occur.

Another potential abuse related to duplication of Medicare payment could occur with respect to the preadmission payment window provisions of section 1886(a)(4) of the Act (implemented under regulations at §§ 412.2(c)(5) and 413.40(c)(2)). Under the regulations, services provided by the hospital or by an entity wholly owned or operated by the hospital within the 3 calendar days before admission to a prospective payment system hospital, or within 1 calendar day before admission to a hospital excluded from the prospective payment system, are treated for payment purposes as if they had been furnished during the inpatient stay. For prospective payment system hospitals, the provision is designed to prevent services historically furnished by hospitals during the early parts of inpatient stays from being ''unbundled'' and furnished just prior to admission and billed on an outpatient basis. If this situation were to occur, the result would be that outpatient payment under Medicare Part B would be made for services for which Part A payment is provided under the prospective payment system, that is, duplication of payments for outpatient and inpatient services. For hospitals excluded from the prospective payment system, the payment window provision is intended to minimize beneficiary liability for Part B deductible and coinsurance amounts while encouraging use of outpatient facilities rather than inpatient facilities when appropriate.

If excluded hospitals were able to set up satellite facilities within hospitals paid under the prospective payment system and obtain exclusion from the prospective payment system for the satellite facilities, the two hospitals could easily circumvent the preadmission payment window requirements by setting up outpatient departments of both hospitals at each site where both have inpatient facilities, and scheduling patients who are to be admitted to one hospital to receive preadmission care at the outpatient department of the other hospital. Thus, exclusion of satellite facilities could result in payments that are inconsistent with the purpose of the payment window. (We note that this abuse could also occur, at least theoretically, if the satellite facilities were not excluded from the prospective payment system. However, allowing exclusion from the

prospective payment system of satellites increases the likelihood that such arrangements will actually be set up.)

There also is a potential for satellite facilities to be used as a means to avoid the effects of section 4416 of the BBA, which is implemented in regulations at § 413.40(f)(2)(ii). This section limits the target amounts for psychiatric and rehabilitation hospitals and units and long-term care hospitals that are first paid as hospitals excluded from the prospective payment system on or after October 1, 1997, to 110 percent of the national median of the target amounts of similarly classified hospitals. This limitation applies to the hospital's first two 12-month cost reporting periods. Section 413.40(c)(4)(iii), which implements provisions of section 4414 of the BBA, sets the 75th percentile of the target amounts of similarly classified hospitals as a limit on costs for psychiatric and rehabilitation hospitals and units and long-term care hospitals excluded from the prospective payment system before October 1, 1997. If we permitted exclusion of satellite facilities, a hospital chain could set up new locations and avoid the limits applicable to new providers by characterizing the new locations as satellites of existing hospitals. This result would effectively nullify the anticipated budgetary savings of section 4416 of the BBA in such situations.

While many hospitals furnish care to cancer patients, exclusion from the prospective payment system as a cancer hospital is not available to a facility unless it was classified as such on or before December 31, 1991 (section 1886(d)(10)(B)(v) of the act and regulations at § 412.23(f)). The statute effectively prohibits recognition of newly established hospitals as cancer hospitals. If we were to permit satellite locations of excluded hospitals to be set up within prospective payment system hospitals and to be excluded from the prospective payment system, existing cancer hospitals might set up satellite locations in prospective payment hospitals, thus avoiding the prohibition on new cancer hospitals. This practice would be inconsistent with section 1886(d)(10)(B)(v) and its implementing regulations. It also could potentially allow a hospital under the prospective payment system to admit or transfer all high-cost cancer patients to the ''cancer hospital satellite'' while making a profit on the low-cost cancer patients remaining at the prospective payment system hospital.

Finally, we note that rehabilitation units that are excluded from the prospective payment system are required to have a medical director of rehabilitation who furnishes services to the unit or its patients at least 20 hours per week (§ 412.29(f)(1)). However, this requirement presumably would not apply if the facility is described not as a unit of the hospital in which it is based, but as a satellite of an existing rehabilitation hospital, since that hospital would already have its medical director. The existence of a high level of physician oversight of rehabilitation is a key identifier of the kind of unit that provides inpatient hospital-level rehabilitation care as its primary activity, not merely as an adjunct or extension of acute care. We believe allowing satellites of rehabilitation hospitals to be set up in prospective payment system hospitals and excluded from the prospective payment system would undermine the requirement for that level of physician oversight, and limit our ability to exclude only those units providing the appropriate level of rehabilitation services.

We believe that a number of excluded hospitals are seeking satellite arrangements so that the services furnished in the satellite facility are inappropriately paid on an excluded basis when they should be paid on a prospective basis. We also believe that a number of excluded hospitals are seeking satellite arrangements in order to avoid the effect of the payment caps that apply to new hospitals and would apply to the satellite facility if the satellite facility received separate certification. And, as discussed above, satellite arrangements can lead to other problems. To prevent inappropriate Medicare payment for services furnished in satellite facilities, we propose to revise §§ 412.22 and 412.25 to provide for payment to satellite facilities of hospitals and units that are excluded from the prospective payment system under specific rules. With respect to both hospitals and units, we would define ''satellite facility'' as a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more buildings on the same campus as buildings also used by another hospital, but is not a ''hospital-within-a-hospital,'' since it is also part of another hospital. If the satellite facility is located in a hospital that is paid under the prospective payment system, Medicare would pay for services furnished at the satellite facility by using the same rates that apply to the prospective payment hospital within which the satellite is located. As explained earlier, we believe that, if the satellite facility is effectively ''part of'' the prospective payment system hospital, then it should be paid under the prospective payment system.

If the satellite facility is located in a hospital excluded from the prospective payment system, then Medicare would pay for the services furnished in the satellite facility as follows: we would examine the discharges of the satellite facility and we would apply the target amount for the excluded hospital *in which the hospital is located,* subject to the applicable cap for the hospital *of which the satellite is a part.* Also, when the satellite facility is established, we would treat the satellite facility as a new hospital for payment purposes. That is, for the satellite's first two 12-month cost reporting periods, the satellite would be subject to the cap that applies to new hospitals of the same class as the hospital of which the satellite is a part. We believe that application of the cap for new hospitals is appropriate because we believe that a number of hospitals are attempting to avoid the new hospital caps by characterizing entities as satellites rather than new hospitals.

Under our proposal, satellite facilities excluded from the prospective payment system prior to the effective date of the revised regulations (October 1, 1999) would not be subject to those new regulations as long as they operate under the same terms and conditions in effect on September 30, 1999. We would make this exception available only to those facilities that can document to the HCFA regional offices that they are operating as satellite facilities excluded from the prospective payment system as of that date, not to facilities that might be excluded from the prospective payment system as of that date and at some later time enter into satellite arrangements. The proposed rules for payments to satellite facilities would not apply to multicampus arrangements, that is, those in which a hospital has several locations but does not share a building or a campus with any other hospital at any location.

We also solicit comment on a possible further exception. In section 4417 of the BBA, Congress extended the long-term care hospital exclusion to a hospital ''that first received payment under this subsection [subsection 1886(d)(1)(B)(iv) of the Act] in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual Medicare inpatient discharges with a principal diagnosis of neoplastic disease in the 12-month cost reporting period ending in fiscal year 1997.'' In view of the specific provision made for a hospital meeting these requirements, we are considering whether a satellite facility opened by such a hospital

should be exempt from the proposed rules on satellites on this preamble. We welcome comment on this issue and on whether such an exclusion could be implemented without compromising the effectiveness of the proposed changes.

We recognize that there may be some operational difficulties differentiating services, costs, and discharges of the satellite facilities from those of the existing hospital that is excluded from the prospective payment system. If these operational problems cannot be overcome, we might, in the final rule, revise §§ 412.22 and 412.25 to prohibit exclusion of any hospital or hospital unit from the prospective payment system that is structured, entirely or in part, as a satellite facility in a hospital paid under the prospective payment system. The effect of this change would be that all Medicare payments to such a hospital or hospital unit with a satellite facility would be made under the prospective payment system.

Before deciding to propose these changes, we considered whether the hospital-within-a-hospital rules in § 412.22(e) provide adequate protection against abuses of the prospective payment system exclusion by satellite facilities. For the reasons described below, we concluded that they do not.

The current hospital-within-a-hospital criteria were issued through proposed rules published in the **Federal Register** on May 27, 1994 (59 FR 27708) and final rules published on September 1, 1994 (59 FR 45330). In those documents, we explained that the DRG system is based on an averaging concept that provides appropriate payment for the type and mix of cases treated by acute care hospitals, but that the averaging concept underlying the DRG system does not apply to long-stay hospitals, which have few short-stay or low-cost cases and might be systematically underpaid if the prospective payment system were applied to them. We explained that it would not be appropriate to make prospective payment system exclusion available to long-stay units of acute hospitals, since those units account for only part of the hospital's patient load and the principles underlying the prospective payment system do apply to the larger hospital. We also stated that the hospital-within-a-hospital criteria, now codified at § 412.22(e), ensure that facilities structured as hospitals-within-hospitals are sufficiently separate from the host hospitals to warrant exclusion from the prospective payment system as separate hospitals.

The considerations that make it inappropriate to exclude long-stay units of general hospitals from the prospective payment system also make it inappropriate, in our view, to allow exclusion from prospective payment system of facilities that treat only a part of the patient load of the larger prospective payment system hospitals in which they are located, but are presented as satellites of another facility. In responding to a comment in the September 1, 1994 final rule, we stated that we believe that the hospital-within-a-hospital criteria should have application in all cases involving joint occupancy of a building or campus by an applicant long-term hospital and another hospital (59 FR 45330). After further review of the issue, however, we have now concluded that while the hospital-within-a-hospital criteria are designed to prevent potential abuses similar to those posed by satellites, the criteria themselves cannot be effectively applied to satellite arrangements. This is because the criteria are designed to apply to hospitals that exist only in one location. For example, under § 412.22(e)(5)(ii), one criterion for showing separate operation of a hospital-within-a-hospital is that the hospital's costs of services obtained under contracts or other arrangements from the host hospital (or from a controlling third entity) be no more than 15 percent of the hospital's total inpatient operating cost. Because a satellite facility would integrate its costs with those of the hospital with which it is affiliated, it is possible that the entire hospital could meet this test even though all costs of the satellite facility were incurred under contracts or arrangements. Likewise, the criterion regarding the source of inpatient referrals (§ 412.22(e)(5)(iii)) could be met by an entire hospital, even though most or all patients treated at a satellite facility were referred from the hospital in which the satellite is located. Thus, existing hospital-within-a-hospital criteria are not adequate to deal with satellite issues.

D. Responsibility for Care of Patients in Hospitals Within Hospitals

Normally, hospitals that admit patients, including hospitals subject to the prospective payment system and ''hospitals-within-hospitals'' that are excluded from the prospective payment system, accept overall responsibility for the patients' care and furnish all services they require. In accordance with section 1886(d)(5)(I) of the Act and implementing regulations at § 412.4, for payment purposes, the prospective payment system distinguishes between ''discharges'' (situations in which a patient leaves an acute care hospital paid under the prospective payment system after receiving complete acute care treatment) and ''transfers'' (situations in which acute care treatment is not completed at the first hospital and the patient is transferred to another acute care hospital for continued, related care). The payment rules at § 413.30, which apply to hospitals excluded from the prospective payment system, also are premised on the assumption that discharges occur only when the excluded hospital's care of the patient is complete.

It has come to our attention that, given the co-location of prospective payment system facilities and facilities excluded from the prospective payment system in a hospital-within-a-hospital, and the absence of clinical constraints on the movement of patients, there may be situations where, in such settings, patients appear to have been moved from one facility to another for financial rather than clinical reasons. The excluded hospital-within-a-hospital might have incentives to inappropriately discharge patients early (to the prospective payment system hospital within which it is located) in order to minimize its overall costs and in turn to minimize its cost per discharge. If the excluded hospital-within-a-hospital inappropriately discharges patients to the prospective payment system hospital without providing a complete episode of the type of care furnished by the excluded hospital, then Medicare would make inappropriate payments to the hospital-within-a-hospital. This is the case because payments made to an excluded hospital are made on a per-stay basis, up to the hospital's per discharge target amount, and any artificial decrease in the hospital's cost per stay could lead to the hospital inappropriately avoiding its target amount cap mandated by section 4414 of the BBA and receiving inappropriate bonus and relief payments under section 4415 of the BBA.

For example, if a long-term care hospital has an average length of stay of 30 days and incurs a cost per patient-day of $1,500, its average cost per stay is $45,000 ($1,500 × 30). If that hospital discharged 20 percent of its patients to a prospective payment system hospital before the 30th day of their stay at the long-term care hospital, the patients might still stay, on average, a total of 30 days at the two hospitals. However, by transferring an increased number of patients early during the period, the long-term care hospital would be able to reduce its cost per discharge.

If the hospital's cap on its target amount is $38,593 and the hospital's cost per discharge is $45,000, then the hospital's payments would be based on

a target amount of $38,593. If, as a result of the inappropriate discharges, the cost per stay is $37,500, Medicare payment to the hospital would be based on a target amount of $37,500, plus an additional amount under the bonus provisions of § 413.40(d)(2). In addition, a separate DRG payment would be made to the prospective payment system hospital that completed the treatment at the satellite location. Thus, Medicare payments for a 30-day period of inpatient care would increase without any additional quality of care or benefit to the patient. The additional payment would merely be a result of artificially decreasing the long-term care hospital's cost per discharge and adding a second payment to the prospective payment system hospital.

We believe it is important to address possible financial incentives for inappropriate early discharges from excluded hospitals-within-hospitals to prospective payment system hospitals. Therefore, we considered several approaches for preventing inappropriate Medicare payments to an excluded hospital-within-a-hospital for inappropriate discharges to the prospective payment system hospital in which it is located. One approach would be to provide that, if an excluded hospital-within-a-hospital transfers patients from its beds to beds of the prospective payment system hospital with which it is located, the hospital-within-a-hospital would not qualify for exclusion in the next cost reporting period. We recognize that this approach might ''penalize'' hospitals for transfers that are medically appropriate. However, we need to balance (1) our concern with preventing inappropriate Medicare payment and (2) our need to have a rule that is administratively feasible.

A second possible approach would be to provide that the hospital-within-a-hospital would qualify for exclusion only if it transfers patients to the prospective payment system hospital only when the services the patients require cannot be furnished by the hospital-within-a-hospital. This approach has the advantage of specifically targeting inappropriate early discharges, but it has the significant disadvantage of being difficult if not impossible to administer because of the extent of case review that would be required to implement it.

After considering these options, we have decided to propose a third approach. Under this approach, we would deny exclusion to a hospital-within-a-hospital for a cost reporting period if, during the most recent cost reporting period for which information is available, the excluded hospital-within-a-hospital transferred more than 5 percent of its inpatients to the prospective payment system hospital in which it is located. We believe that a 5-percent allowance of transfers under this approach would (1) avoid the need for administratively burdensome case review, (2) provide adequate flexibility for transfers in those cases where the hospital-within-a-hospital is not equipped or staffed to provide the services required by the patient, and (3) limit the extent to which patients may be transferred inappropriately.

We welcome comments on our proposed approach as well as suggestions on other ways to address the possible incentives for inappropriate transfers in a manner that is administratively feasible.

E. Critical Access Hospitals (CAHS)

1. Emergency Response Time Requirements for CAHs in Frontier and Remote Areas

Because of the high cost of staffing rural hospital emergency rooms and the low volume of services in those facilities, we do not require CAHs to have emergency personnel on site at all times. Thus, for CAHs, the regulations at § 485.618(d) require a doctor of medicine or a doctor of osteopathy, a physician assistant, or a nurse practitioner with training and experience in emergency care to be on call and immediately available by telephone or radio contact, and available on site within 30 minutes, on a 24-hour basis. We included this requirement because we recognize the need of rural residents to have reasonable access to emergency care in their local communities.

Section 1820(h) of the Act, as added by section 4201 of the BBA, states that any medical assistance facility (MAF) in Montana shall be deemed to have been certified by the Secretary as a CAH if that facility is otherwise eligible to be designated by the State as a CAH. However, under the current requirements, following the initial transition of a MAF to CAH status, the former MAF would be subject to the CAH requirements during any subsequent review, one of which is the 30-minute emergency response time for emergency services currently required under § 485.518(d).

Recently, some facilities have suggested that in many ''frontier'' areas (that is, those having fewer than six residents per square mile), the requirement of a 30-minute response might be too restrictive for CAHs, especially those MAFs transitioning to CAH status.

We are aware it is costly and difficult to recruit and train the personnel needed to operate emergency rooms in the most remote, sparsely populated rural areas. On the other hand, in contemplating any changes to the emergency response timeframe for CAHs, we must ensure that the response time is not extended to the point that patient health and safety are jeopardized.

In order to recognize the special needs of sparsely populated rural areas in meeting beneficiaries' health needs, and at the same time to protect patients' health and safety, we are proposing to revise § 485.618(d) to allow a response time of up to 60 minutes for a CAH if (1) it is located in an area of the State that is defined as a frontier area (that is, having fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or meets other criteria for a remote location adopted by the State and approved by HCFA under criteria specified in its rural health care plan under section 1820(b) of the Act; (2) the State determines that, under its rural health care plan, allowing the longer emergency response time is the only feasible method of providing emergency care to residents of the area; and (3) the State maintains documentation showing that a response time up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time required to stabilize the patient in an emergency. The criteria for remote location would, like other parts of the rural health care plan, be subject to review and approval by the HCFA Regional Office, as would the State's documentation regarding the emergency response time.

We note that, under the terms of the Montana State Code applicable to MAFs, at times when no emergency response person is available to come to the facility, a MAF's director of nursing is permitted to come to the facility and authorize the transfer of a patient seeking emergency services to another facility. Under one possible reading of the State requirement, this activity could be seen as an alternative way of complying with the emergency services requirement and the MAF's (and CAH's) responsibilities under section 1867 of the Act (the Emergency Medical Treatment and Active Labor Amendments Provision) to provide emergency medical screening and stabilization services to patients who come to the hospital seeking emergency treatment. We request comments on

whether the Medicare regulations in §§ 485.618(d) and 489.24 should be further revised to explicitly permit this practice to continue following the transition of a MAF to CAH status. We are particularly interested in obtaining comment from practitioners on the risks and benefits involved in adoption of this practice.

2. Compliance With Minimum Data Set (MDS) Requirements by CAHs With Swing-Bed Approval

Existing regulations allow CAHs to obtain approval from HCFA to use their inpatient beds to provide posthospital SNF care (§ 485.645). To obtain such approval, however, the CAH must agree to meet specific requirements that also apply to SNFs, including the comprehensive assessment requirements at § 483.20(b) of the SNF conditions of participation.

Section 483.20(b)(1) specifies that a SNF must make a comprehensive assessment of a resident's needs, using the resident assessment instrument specified by the State. Section 483.20(b)(2) further specifies that, subject to the timeframes in § 413.343(b), the assessments must be conducted within 14 calendar days after the patient is admitted; within 14 days after the facility determines, or should have determined, that there is a significant change in the patient's physical or mental condition; and at least once every 12 months. Section 413.343(b) specifies that in accordance with the methodology in § 413.337(c) related to the adjustment of the Federal rates for case-mix (the SNF prospective payment system), patient assessments must be performed on the 5th, 14th, 30th, 60th, and 90th days following admission.

It is clear that the timeframes for patient assessments required under § 413.343(b) are linked to the prospective payment system for SNFs. The methodology specifically referenced in § 413.337(c) refers to the SNF prospective payment system. Therefore, it is apparent that the patient assessments and concomitant timeframes for performing such assessments are inextricably intertwined with the case-mix adjustment under the SNF prospective payment system. CAHs with swing-bed approval are not paid for their services to SNF-level patients under that SNF prospective payment system but are paid under the payment method described in § 413.114, which does not include a case-mix adjustment. Therefore, the timeframes for patient assessments as dictated by § 413.343(b) are not applicable to CAHs and are not required to be met by CAHs. Nevertheless, to make it explicit that the patient assessment timeframes required under § 413.343(b) do not apply, we propose to revise § 485.645 to state that the requirements in § 413.343(b), and the timeframes specified in § 483.20, do not apply to CAHs.

VII. MedPAC Recommendations

We have reviewed the March 1, 1999 report submitted by MedPAC to Congress and have given its recommendations careful consideration in conjunction with the proposals set forth in this document. Recommendations 3A and 3B concerning the update factors for inpatient hospital operating costs and for hospitals and hospital distinct-part units excluded from the prospective payment system are discussed in Appendix D to this proposed rule. Other recommendations are discussed below.

A. Excluded Hospitals and Hospital Units (Recommendations 4B and 4C)

Recommendation: The Congress should adjust the wage-related portion of the excluded hospital target amount caps (the 75th percentile of target amounts for hospitals in the same class (psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospitals)) to account for geographic differences in labor costs. The Commission presumes legislation would be necessary to adjust the caps for wages.

Response: We previously addressed this issue in the May 12, 1998 final rule (63 FR 26345). In that discussion, we explain why we believe the statutory language, the statutory scheme, and the legislative history, viewed together, strongly argue against making a wage adjustment in applying the target amount caps under the current statute.

Recommendation: Additional research in case-mix classification systems for psychiatric patients should be encouraged, with the aim of developing a case-mix adjusted prospective payment system for psychiatric patients in the future.

Response: As MedPAC indicated in its recommendation discussion, prior research has indicated substantial difficulties in developing a psychiatric case-mix classification system. Another issue is the adequate identification of a system that reflects the unique characteristics of psychiatric care for the Medicare population, primarily the elderly. During the past year, we have met with industry representatives to discuss further research efforts on this issue as well as understand the initial impacts of the recent legislative changes to excluded hospital payment system on psychiatric hospitals and units. We will continue these efforts in FY 2000.

B. Disproportionate Share Hospitals (DSH) (Recommendations 3C, 3D, and 3E)

Recommendations: The Congress should require that disproportionate share payments be distributed according to each hospital's share of low-income patient costs, defined broadly to include all care to the poor. The measure of low-income costs should reflect: (1) Medicare patients eligible for Supplemental Security Income, Medicaid patients, patients sponsored by other indigent care programs, and uninsured and underinsured patients as represented by uncompensated care (both charity and bad debts); and (2) services provided in both inpatient and outpatient settings.

As under current policy, disproportionate share payment should be made in the form of an adjustment to the per-case payment rate. In this way, the total payment each hospital receives will reflect its volume of Medicare patients.

Through a minimum threshold for low-income share, the formula for distributing disproportionate share payments should concentrate payments among hospitals with the highest shares of poor patients. A reasonable range for this threshold would be levels that make between 50 percent and 60 percent of hospitals eligible for a payment. The size of the payment adjustment, however, should increase gradually from zero at the threshold. The same distribution formula should apply to all hospitals covered by prospective payment.

The Secretary should collect the data necessary to revise the disproportionate share payment system from all hospitals paid under prospective payment system.

Response: We continue to give careful consideration to MedPAC's recommendations concerning the DSH adjustment made to operating payments under the prospective payment system.

We are in the process of preparing a report to Congress on the Medicare DSH adjustment that includes several options for amending the statutory disproportionate share adjustment formula. We believe that any adjustment to the DSH formula or data sources should be directed and supported by the Congress.

The MedPAC option involves collecting data on uncompensated care, that is, charity and bad debts. Ideally, this would be a direct measure of a hospital's indigent care burden. However, there are problems associated with verification of such data and

consistency of reporting nationally. We appreciate the Commission's recommendations about and assistance with the Medicare DSH adjustment as we formulate our legislative proposal and await Congressional action.

VIII. Other Required Information

A. Requests for Data From the Public

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

1. Expanded Modified MEDPAR-Hospital (National)

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

- Notice of Proposed Rulemaking (NPRM) published in the **Federal Register**. This file, scheduled to be available by the end of April, is derived from the MedPAR file with a cutoff of 3 months after the end of the fiscal year (December file).
- Final Rule published in the **Federal Register**. The FY 1998 MedPAR file used for the FY 2000 final rule will be cutoff 6 months after the end of the fiscal year (March file) and is scheduled to be available by the end of April.

Media: Tape/Cartridge
File Cost: $3,655.00 per fiscal year
Periods Available: FY 1988 through FY 1998

2. Expanded Modified MedPAR-Hospital (State)

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

- NPRM published in the **Federal Register**. This file, scheduled to be available by the end of April, is derived from the MedPAR file with a cutoff of 3 months after the end of the fiscal year (December file).
- Final Rule published in the **Federal Register**. The FY 1998 MedPAR file used for the FY 2000 final rule will be cutoff 6 months after the end of the fiscal year (March file) and is scheduled to be available by the end of April.

Media: Tape/Cartridge
File Cost: $1,130.00 per State per year
Periods Available: FY 1988 through FY 1998

3. HCFA Wage Data

This file contains the hospital hours and salaries for 1996 used to create the proposed FY 2000 prospective payment system wage index. The file will be available by the beginning of February for the NPRM and the beginning of May for the final rule.

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

These files support the following:

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

Media: Diskette/most recent year on the Internet
File Cost: $165.00 per year
Periods Available: FY 2000 PPS Update

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

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

Media: Diskette/most recent year on the Internet
File Cost: $165.00 per year
Periods Available: FY 2000 PPS Update

5. PPS SSA/FIPS MSA State and County Crosswalk

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

Media: Diskette/Internet
File Cost: $165.00 per year
Periods Available: FY 2000 PPS Update

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

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

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

Media: Diskette/Internet
File Cost: $165.00 per year
Periods Available: FY 2000 PPS Update

7. PPS–IV to PPS–XII Minimum Data Sets

The Minimum Data Set contains cost, statistical, financial, and other information from Medicare hospital cost reports. The data set includes only the most current cost report (as submitted,

final settled, or reopened) submitted for a Medicare participating hospital by the Medicare fiscal intermediary to HCFA. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

MEDIA: TAPE/CARTRIDGE

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

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

File Cost: $770.00 per year

8. PPS–IX to PPS–XII Capital Data Set

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

MEDIA: TAPE/CARTRIDGE

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

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

File Cost: $770.00 per year

9. PPS–XIII and PPS–XIV Hospital Data Set

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

Media: Diskette/Internet
File Cost: $2,500.00

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

10. Provider-Specific File

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

Media: Diskette/Internet
File Cost: $265.00
Periods Available: FY 2000 PPS Update

11. HCFA Medicare Case-Mix Index File

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

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

Media: Diskette/most recent year on Internet
Price: $165.00 per year/per file
Periods Available: FY 1985 through FY 1998

12. DRG Relative Weights (Formerly Table 5 DRG)

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

- NPRM.
- Final rule.

Media: Diskette/Internet
File Cost: $165.00
Periods Available: FY 2000 PPS Update

13. PPS Payment Impact File

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

Media: Diskette/Internet
File Cost: $165.00
Periods Available: FY 2000 PPS Update

14. AOR/BOR Tables

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

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

Media: Diskette/Internet
File Cost: $165.00
Periods Available: FY 2000 PPS Update

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

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

B. Public Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments concerning the provisions of this proposed rule that we receive by the date and time specified in the **DATES** section of this preamble and respond to those comments in the preamble to that rule. We emphasize that, given the statutory requirement under section 1886(e)(5) of the Act that our final rule for FY 2000 be published by August 1, 1999, we will consider only those

comments that deal specifically with the matters discussed in this proposed rule.

List of Subjects

42 CFR Part 412

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

42 CFR Part 413

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

42 CFR Part 483

Grant programs-health, Health facilities, Health professions, Health records, Medicaid, Medicare, Nursing homes, Nutrition, Reporting and recordkeeping requirements, Safety.

42 CFR Part 485

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

42 CFR Chapter IV is amended as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

A. Part 412 is amended as follows:

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

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

2. Section 412.22 is amended by adding new paragraphs (e)(6) and (h) to read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(e) *Hospitals-within-hospitals.* * * *

(6) *Responsibility for care of patients.* During the most recent cost reporting period for which information is available, the hospital transferred no more than 5 percent of its inpatients to the prospective payment system hospital within which it is located.

* * * * *

(h) *Satellite facilities.* (1) For purposes of paragraphs (h)(2) through (h)(5) of this section, a satellite facility is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

(2) Effective for cost reporting periods beginning on or after October 1, 1999, payment for services furnished in satellite facilities of hospitals excluded from the prospective payment systems is made in accordance with the rules specified in paragraphs (h)(3) and (h)(4) of this section.

(3) If the satellite facility occupies space in the same building or on the same campus as a hospital paid under the prospective payment system, payment for services furnished at the satellite facility is based on the same rates that apply to the prospective payment system hospital within which the satellite is located.

(4) If the satellite facility occupies space in the same building or on the same campus as a hospital excluded from the prospective payment systems, payment for services furnished at the satellite facility is made as follows:

(i) For the first two 12-month cost reporting periods during which the satellite facility treats patients, payment for services furnished at the satellite facility is made in accordance with the provisions of § 413.40(f)(2) of this subchapter.

(ii) For subsequent cost reporting periods, payment for services furnished at the satellite facility is made based on the target amount of the excluded hospital in which the satellite is located, but is subject to the cap at the hospital of which the satellite is a part.

(5) The provisions of paragraphs (h)(2) through (h)(4) of this section do not apply to any hospital or entity structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the hospital continues operating under the same terms and conditions, including the number of beds and square footage considered, for purposes of Medicare participation and payment, to be part of the hospital, in effect on September 30, 1999.

3. Section 412.25 is amended by revising paragraphs (b) and (c) and adding a new paragraph (e) to read as follows:

§ 412.25 Excluded hospital units: common requirements.

* * * * *

(b) *Changes in the size of excluded units.* For purposes of exclusions from the prospective payment systems under this section, changes in the number of beds and square footage considered to be part of each excluded unit are allowed as specified in paragraphs (b)(1) and (b)(2) of this section.

(1) *Increase in size.* The number of beds and square footage of an excluded unit may be increased only at the start of a cost reporting period.

(2) *Decrease in size.* The number of beds and square footage of an excluded unit may be decreased at any time during a cost reporting period if the hospital notifies the fiscal intermediary and the HCFA Regional Office in writing of the planned decrease at least 30 days before the date of the decrease, and maintains the information needed to accurately determine costs that are attributable to the excluded unit. Any decrease in the number of beds or square footage considered to be part of an excluded unit made during a cost reporting period continues in effect for the remainder of that period.

(c) *Changes in the status of hospital units.* For purposes of exclusions from the prospective payment systems under this section, the status of each hospital unit (excluded or not excluded) is determined as specified in paragraphs (c)(1) and (c)(2) of this section.

(1) The status of a hospital unit may be changed from not excluded to excluded only at the start of a cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the prospective payment systems before the start of a hospital's next cost reporting period.

(2) The status of a hospital unit may be changed from excluded to not excluded at any time during a cost reporting period, but only if the hospital notifies the fiscal intermediary and the HCFA Regional Office in writing of the change at least 30 days before the date of the change, and maintains the information needed to accurately determine costs that are or are not attributable to the excluded unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period continues in effect for the remainder of that period.

* * * * *

(e) *Satellite facilities.* (1) For purposes of paragraphs (e)(2) through (e)(5) of this section, a satellite facility is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.

(2) Effective for cost reporting periods beginning on or after October 1, 1999, payment for services furnished in psychiatric or rehabilitation units that are structured, entirely or in part, as satellite facilities are made in accordance with the rules specified in paragraphs (e)(3) and (e)(4) of this section.

(3) If the satellite facility occupies space in the same building or on the same campus as a hospital paid under the prospective payment systems,

payment for services furnished at the satellite facility is based on same rates that apply to the prospective payment system hospital within which the satellite is located.

(4) If the satellite facility occupies space in the same building or on the same campus as a hospital excluded from the prospective payment systems, payment for services furnished at the satellite facility is made as follows:

(i) For the first two 12-month cost reporting periods during which the satellite facility treats patients, payment for services furnished at the satellite facility is made in accordance with the provisions of § 413.40(f)(2) of this subchapter.

(ii) For subsequent cost reporting periods, payment for services furnished at the satellite facility is made based on the target amount of the excluded hospital in which the satellite is located, but is subject to the cap of the hospital of which the satellite is a part.

(5) The provisions of paragraph (e)(2) through (e)(4) of this section do not apply to any unit structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the unit continues operating under the same terms and conditions, including the number of beds and square footage considered to be part of the unit, in effect on September 30, 1999.

§ 412.105 [Amended]

4. Section 412.105 is amended by revising the cross reference ''paragraph (g)(1)(ii) of this section'' in paragraphs (f)(1)(iii) (three times) and (f)(2)(v) to read ''paragraph (f)(1)(ii) of this section''.

§ 412.256 [Amended]

5. In § 412.256, paragraph (c)(2), the date ''October 1'', appearing in two places, is revised to read ''September 1''.

6. Section 412.276 is amended by revising paragraph (a) to read as follows:

§ 412.276 Timing of MGCRB decision and its appeal.

(a) *Timing.* The MGCRB notifies the parties in writing, with a copy to HCFA, and issues a decision within 180 days after the first day of the 13-month period preceding the Federal fiscal year for which a hospital has filed a complete application. The hospital has 15 days from the date of the decision to request Administrator review.

* * * * *

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

B. Part 413 is amended as follows:

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

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

2. Section 413.40 is amended by revising paragraphs (b)(1)(iii) and (g)(1) to read as follows:

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

* * * * *

(b) *Cost reporting periods subject to the rate-of-increase ceiling.* (1) *Base period.* * * *

(iii) When the operational structure of a hospital or unit changes (that is, a freestanding hospital becomes a unit or vice versa, or an entity of a multicampus hospital becomes a newly created hospital or unit or vice versa), the base period for the hospital or unit that changed its operational structure is the first cost reporting period of at least 12 months effective with the revised Medicare certification classification.

* * * * *

(g) *Adjustment.* (1) *General rules.* (i) HCFA may adjust the amount of the operating costs considered in establishing the rate-of-increase ceiling for one or more cost reporting periods, including both periods subject to the ceiling and the hospital's base period, under the circumstances specified in paragraphs (g)(2), (g)(3), and (g)(4) of this section.

(ii) When an adjustment is requested by the hospital, HCFA makes an adjustment only to the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified separately, identified by the hospital and verified by the intermediary.

(iii) When an adjustment is requested by the hospital, HCFA makes an adjustment only if the hospital's operating costs exceed the rate-of-increase ceiling imposed under this section.

(iv) In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the amount of payment under paragraph (g)(3) of this section may not exceed the payment amount based on the target amount determined under paragraph (c)(4)(iii) of this section.

(v) In the case of a hospital or unit that received a revised FY 1998 target amount under the rebasing provisions of paragraph (b)(1)(iv) of this section, the amount of an adjustment payment for a cost reporting period is based on a comparison of the hospital's operating costs for the cost reporting period to the average costs and statistics for the cost reporting periods used to determine the FY 1998 rebased target amount.

* * * * *

§ 413.86 [Amended]

3. Section 413.86 is amended as follows:

a. In paragraph (b), the definition of ''approved geriatric program'' is revised to read: ''*Approved geriatric program* means a fellowship program of one or more years in length that is approved by one of the national organizations listed in § 415.152 of this chapter under that respective organization's criteria for geriatric fellowship programs.''

b. In paragraph (b), under paragraph (1) of the definition of ''approved medical residency program'', the reference ''§ 415.200(a) of this chapter'' is revised to read ''§ 415.152 of this chapter''.

c. In paragraph (e)(1)(ii)(C), the reference ''paragraph (j)(2) of this section'' is revised to read ''paragraph (k)(1) of this section''.

d. In paragraph (e)(1)(iv), the reference, ''paragraph (j)(1) of this section'', is revised to read ''paragraph (k)(1) of this section''.

e. A new paragraph (f)(4)(iii) is added, paragraphs (g)(1) (i), (ii), and (iii), (g)(6) introductory text and (g)(6) (i) and (ii) are revised, paragraph (g)(7) is redesignated as paragraph (g)(9), and new paragraphs (g)(7) and (g)(8) are added to read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(f) *Determining the total number of FTE residents.* * * *

(4) * * *

(iii) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in paragraph (b) of this section.

(g) *Determining the weighted number of FTE residents.* * * *

(1) * * *

(i) For residency programs other than those specified in paragraphs (g)(1)(ii) and (g)(1)(iii) of this section, the initial residency period is the minimum

number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training, as specified in the most recently published edition of the Graduate Medical Education Directory.

(ii) For residency programs in osteopathy, dentistry, and podiatry, the minimum requirement for certification in a specialty or subspecialty is the minimum number of years of formal training necessary to satisfy the requirements of the appropriate approving body listed in § 415.152 of this chapter.

(iii) For residency programs in geriatric medicine accredited by the appropriate approving body listed in § 415.152 of this chapter, these programs are considered approved programs on the later of—

(A) The starting date of the program within a hospital; or

(B) The hospital's cost reporting periods beginning on or after July 1, 1985.

* * * * *

(6) If a hospital establishes a new medical residency training program as defined in paragraph (g)(9) of this section on or after January 1, 1995, the hospital's FTE cap described under paragraph (g)(4) of this section may be adjusted as follows:

(i) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it establishes a new medical residency training program on or after January 1, 1995, the hospital's unweighted FTE resident cap under paragraph (g)(4) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.

(A) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(B) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program(s), the hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program using the actual number of residents participating in the new program. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

(C) Except for rural hospitals, the cap will not be adjusted for new programs established more than 3 years after the first program begins training residents.

(D) Rural hospitals that qualify for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section are permitted to be part of the same affiliated group for purposes of an aggregate FTE limit.

(ii) If a hospital had allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, the hospital's unweighted FTE cap may be adjusted for new medical residency training programs established on or after January 1, 1995 and on or before August 5, 1997. The adjustment to the hospital's FTE resident limit for the new program is based on the product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete each program based on the minimum accredited length for the type of program.

(A) If the residents are spending an entire program year (or years) at one hospital and the remainder of the program at another hospital, the adjustment to each respective hospital's cap is equal to the product of the highest number of residents in any program year during the third year of the first program's existence and the number of years the residents are training at each respective hospital.

(B) Prior to the implementation of the hospital's adjustment to its FTE cap beginning with the fourth year of the hospital's residency program, the hospital's cap may be adjusted during each of the first 3 years of the hospital's new residency program, using the actual number of residents in the new programs. The adjustment may not exceed the number of accredited slots available to the hospital for each program year.

* * * * *

(7) A hospital that began construction of its facility prior to August 5, 1997, sponsored new medical residency training programs, and temporarily trained those residents at another hospital(s) until the facility was completed may receive an adjustment to its FTE cap.

(i) The newly constructed hospital's FTE cap is equal to the lesser of:

(A) The product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the programs based on the minimum accredited length for each type of program; or

(B) The number of accredited slots available to the hospital for each year of the programs.

(ii) If the medical residency training programs sponsored by the newly constructed hospital have been in existence for 3 years or more by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training in the third year of the first of those programs begun at the temporary training site.

(iii) If the medical residency training programs sponsored by the newly constructed hospital have been in existence for less than 3 years by the time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training at the newly constructed hospital in the third year of the first of those programs (including the years at the temporary training site).

(iv) The provisions of this paragraph (g)(7) are applicable during portions of cost reporting periods occurring on or after October 1, 1999.

(8) A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of another hospital's closure if the hospital meets the following criteria:

(i) The hospital is training additional residents from a hospital that closed on or after July 1, 1996.

(ii) At least 60 days before the hospital begins to train the residents, the hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment by identifying the residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specifies the length of time the adjustment is needed.

* * * * *

PART 483—REQUIREMENTS FOR STATES AND LONG-TERM CARE FACILITIES

C. Part 483 is amended as set forth below:

1. The authority citation for Part 483 continues to read as follows:

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

2. In § 483.20, the introductory text of paragraph (b)(2) is revised to read as follows:

§ 483.20 Resident assessment.

* * * * *

(b) *Comprehensive assessments.*

* * *

(2) *When required.* Subject to the timeframes prescribed in § 413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii). However, the timeframes prescribed in § 413.343(b) of this chapter do not apply to CAHs.

* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

D. Part 485 is amended as follows:

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

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

2. Section 485.618 is amended by revising paragraph (d) to read as follows:

§ 485.618 Conditions of participation: Emergency services.

* * * * *

(d) *Standard: Personnel.* There must be a doctor of medicine or osteopathy, a physician assistant, or a nurse practitioner with training or experience in emergency care on call and immediately available by telephone or radio contact, and available on site within the following timeframes:

(1) Within 30 minutes, on a 24-hour a day basis, if the CAH is located in an area other than an area described in paragraph (d)(2) of this section; or

(2) Within 60 minutes, on a 24-hour a day basis, if the following requirements are met:

(i) The CAH is located in an area designated as frontier (that is, an area having fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets criteria for a remote location adopted by the State in its rural health care plan, and approved by HCFA, under section 1820(b) of the Act;

(ii) The State has determined under criteria in its rural health care plan that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the CAH; and

(iii) The State maintains documentation showing that the response time of up to 60 minutes at a particular CAH it designates are justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.

* * * * *

3. In § 485.645, the introductory text of paragraph (d) is republished and paragraph (d)(6) is revised to read as follows:

§ 485.645 Special requirements for CAH providers of long-term care services (“swing beds”).

* * * * *

(d) *SNF services.* CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:

* * * * *

(6) Comprehensive assessment, comprehensive care plan, and discharge planning (§ 483.20(b), (d), and (e) of this chapter, except that the CAH is not required to comply with the requirements for frequency, scope and number of assessments prescribed in § 413.343(b)).

* * * * *

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

Dated: April 9, 1999.

Nancy Ann DeParle,

Administrator, Health Care Financing Administration.

Dated: April 26, 1999.

Donna E. Shalala,

Secretary.

(Editorial Note: The following addendum and appendixes will not appear in the Code of Federal Regulations.)

Addendum—Proposed Schedule of Standardized Amounts Effective With Discharges Occurring On or After October 1, 1999; Payment Amounts for Blood Clotting Factor Effective for Discharges Occurring On or After October 1, 1999; and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 1999

I. Summary and Background

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

For discharges occurring on or after October 1, 1999, except for sole community hospitals, Medicare-dependent, small rural hospitals, and hospitals located in Puerto Rico, each hospital’s payment per discharge under the prospective payment system will be based on 100 percent of the Federal national rate.

Sole community hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate, the updated hospital-specific rate based on FY 1982 cost per discharge, or the updated hospital-specific rate based on FY 1987 cost per discharge. Medicare-dependent, small rural hospitals are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 cost per discharge, whichever is higher. For hospitals in Puerto Rico, the payment per discharge is based on the sum of 50 percent of a Puerto Rico rate and 50 percent of a national rate.

As discussed below in section II, we are proposing to make changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2000. The changes, to be applied prospectively, would affect the calculation of the Federal rates. In section III of this addendum, we are proposing updates to the payments per unit for blood clotting factor provided to hospital inpatients who have hemophilia. We also are proposing to add another product (clotting factor, porcine (HCPCS code J7191)) to the list of clotting factors that would be paid under this benefit.

In section IV of this addendum, we discuss our proposed changes for

determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2000. Section V of this addendum sets forth our proposed changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system for FY 2000. The tables to which we refer in the preamble to the proposed rule are presented at the end of this addendum in section VI.

II. Proposed Changes to Prospective Payment Rates for Inpatient Operating Costs for FY 2000

The basic methodology for determining prospective payment rates for inpatient operating costs is set forth at § 412.63 for hospitals located outside of Puerto Rico. The basic methodology for determining the prospective payment rates for inpatient operating costs for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below, we discuss the proposed factors used for determining the prospective payment rates. The Federal and Puerto Rico rate changes, once issued as final, would be effective with discharges occurring on or after October 1, 1999. As required by section 1886(d)(4)(C) of the Act, we must also adjust the DRG classifications and weighting factors for discharges in FY 2000.

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

- Updates of 0.9 percent for all areas (that is, the market basket percentage increase of 2.7 percent minus 1.8 percentage points);
- An adjustment to ensure budget neutrality as provided for in sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act by applying new budget neutrality adjustment factors to the large urban and other standardized amounts;
- An adjustment to ensure budget neutrality as provided for in section 1886(d)(8)(D) of the Act by removing the FY 1999 budget neutrality factor and applying a revised factor;
- An adjustment to apply the revised outlier offset by removing the FY 1999 outlier offsets and applying a new offset; and
- An adjustment in the Puerto Rico standardized amounts to reflect the application of a Puerto Rico-specific wage index.

A. Calculation of Adjusted Standardized Amounts

1. Standardization of Base-Year Costs or Target Amounts

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

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

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

Under sections 1886(d)(2)(H) and (d)(3)(E) of the Act, in making payments under the prospective payment system, the Secretary estimates from time to time the proportion of costs that are wages and wage-related costs. Since October 1, 1997, when the market basket was last revised, we have considered 71.1 percent of costs to be labor-related for purposes of the prospective payment system. The average labor share in Puerto Rico is 71.3 percent. We are proposing to revise the discharge-weighted national standardized amount for Puerto Rico to reflect the proportion of discharges in large urban and other areas from the FY 1998 MedPAR file.

2. Computing Large Urban and Other Area Averages

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

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

Based on 1997 population estimates published by the Bureau of the Census, 61 areas meet the criteria to be defined as large urban areas for FY 2000. These areas are identified by a footnote in Table 4A.

3. Updating the Average Standardized Amounts

Under section 1886(d)(3)(A) of the Act, we update the area average standardized amounts each year. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are proposing to update the large urban areas' and the other areas' average standardized amounts for FY 2000 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. Section 1886(b)(3)(B)(i)(XV) of the Act specifies that, for hospitals in all areas, the update factor for the standardized amounts for FY 2000 is equal to the market basket percentage increase minus 1.8 percentage points.

The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the proposed hospital market basket increase for FY 2000 is 2.7 percent. Thus, for FY 2000,

the proposed update to the average standardized amounts equals 0.9 percent.

As in the past, we are adjusting the FY 1999 standardized amounts to remove the effects of the FY 1999 geographic reclassifications and outlier payments before applying the FY 2000 updates. That is, we are increasing the standardized amounts to restore the reductions that were made for the effects of geographic reclassification and outliers. We then apply the new offsets to the standardized amounts for outliers and geographic reclassifications for FY 2000.

Although the update factor for FY 2000 is set by law, we are required by section 1886(e)(3) of the Act to report to the Congress on our initial recommendation of update factors for FY 2000 for both prospective payment hospitals and hospitals excluded from the prospective payment system. For general information purposes, we have included the report to Congress as Appendix C to this proposed rule. Our proposed recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act), as well as our responses to MedPAC's recommendation concerning the update factor, are set forth as Appendix D to this proposed rule.

4. Other Adjustments to the Average Standardized Amounts

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

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

To comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that DRG reclassification and recalibration of the relative weights be budget neutral, and the requirement in section 1886(d)(3)(E) of the Act that the updated wage index be budget neutral, we used historical discharge data to simulate payments and compared aggregate payments using the FY 1999 relative weights and wage index to aggregate payments using the proposed FY 2000 relative weights and wage index. The same methodology was used for the FY 1999 budget neutrality adjustment. (See the discussion in the September 1, 1992 final rule (57 FR 39832).) Based on this comparison, we computed a budget neutrality adjustment factor equal to 0.997393. We also adjust the Puerto Rico-specific standardized amounts for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor for Puerto Rico-specific standardized amounts equal to 0.999910. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 1999 budget neutrality adjustments. We do not remove the prior budget neutrality adjustment because estimated aggregate payments after the changes in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy this condition.

In addition, we are proposing to apply these same adjustment factors to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 1999. (See the discussion in the September 4, 1990 final rule (55 FR 36073).)

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

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that total aggregate payments under the prospective payment system after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. To calculate this budget neutrality factor, we used historical discharge data to simulate payments, and compared total prospective payments (including IME and DSH payments) prior to any reclassifications to total prospective payments after reclassifications. Based on these simulations, we are applying an adjustment factor of 0.994453 to ensure that the effects of reclassification are budget neutral.

The adjustment factor is applied to the standardized amounts after removing the effects of the FY 1999 budget neutrality adjustment factor. We note that the proposed FY 2000 adjustment reflects wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of February 26, 1999. The effects of any additional reclassification changes resulting from appeals and reviews of the MGCRB decisions for FY 2000 or from a hospital's request for the withdrawal of a reclassification request will be reflected in the final budget neutrality adjustment required under section 1886(d)(8)(D) of the Act and published in the final rule for FY 2000.

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

For FY 1999, the fixed loss cost outlier threshold is equal to the prospective payment for the DRG plus $11,100 ($10,129 for hospitals that have not yet entered the prospective payment system for capital-related costs). The marginal cost factor for cost outliers (the percent of costs paid after costs for the case exceed the threshold) is 80 percent. We applied an outlier adjustment to the FY 1999 standardized amounts of 0.948740 for the large urban and other areas rates and 0.9392 for the capital Federal rate.

In accordance with section 1886(d)(5)(A)(iv) of the Act, we calculated proposed outlier thresholds for FY 2000 so that outlier payments are projected to equal 5.1 percent of total payments based on DRG prospective

payment rates. In accordance with section 1886(d)(3)(E), we reduced the proposed FY 2000 standardized amounts by the same percentage to account for the projected proportion of payments paid to outliers. To calculate FY 2000 outlier thresholds, we simulated payments by applying FY 2000 rates and policies to the December 1998 update of the FY 1998 MedPAR file and the December 1998 update of the provider-specific file. As we have explained in the past, to calculate outlier thresholds we apply a cost inflation factor to update costs for the cases used to simulate payments. For FY 1998, we used a cost inflation factor of minus 2.005 percent (a cost per case decrease of 2.005 percent). For FY 1999, we used a cost inflation factor of minus 1.724 percent. To set the proposed FY 2000 outlier thresholds, we used a cost inflation factor (or cost adjustment factor) of zero percent. This factor reflects our analysis of the best available cost report data as well as calculations (using the best available data) indicating that the percentage of actual outlier payments for FY 1998, is higher than we projected before the beginning of FY 1998, and that the percentage of actual outlier payments for FY 1999 will likely be higher than we projected before the beginning of FY 1999. The calculations of ''actual'' outlier payments are discussed further below. Based on these simulations, we are proposing a fixed loss cost outlier threshold in FY 2000 equal to the prospective payment rate for the DRG plus $14,575 ($13,309 for hospitals that have not yet entered the prospective payment system for capital-related costs). In addition, we are proposing to maintain the marginal cost factor for cost outliers at 80 percent.

As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both inpatient operating costs and inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We project that the proposed thresholds for FY 2000 will result in outlier payments equal to 5.1 percent of operating DRG payments and 6.0 percent of capital payments based on the Federal rate.

The proposed outlier adjustment factors applied to the standardized amounts for FY 2000 are as follows:

	Operating standardized amounts	Capital Federal rate
National	0.948934	0.9397
Puerto Rico	0.969184	0.9334

We apply the proposed outlier adjustment factors after removing the effects of the FY 1999 outlier adjustment factors on the standardized amounts.

Table 8A in section VI of this addendum contains the updated Statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals to be used in calculating cost outlier payments for those hospitals for which the intermediary is unable to compute a reasonable hospital-specific cost-to-charge ratio. These Statewide average ratios would replace the ratios published in the July 31, 1998 final rule (63 FR 41099), effective October 1, 1999. Table 8B contains comparable Statewide average capital cost-to-charge ratios. These average ratios would be used to calculate cost outlier payments for those hospitals for which the intermediary computes operating cost-to-charge ratios lower than 0.212473 greater than 1.280336 and capital cost-to-charge ratios lower than 0.0130310 or greater than 0.17166. This range represents 3.0 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals. We note that the cost-to-charge ratios in Tables 8A and 8B would be used during FY 2000 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or outside the three standard deviations range.

In the July 31, 1998 final rule (63 FR 41009), we stated that, based on available data, we estimated that actual FY 1998 outlier payments would be approximately 5.4 percent of actual total DRG payments. This was computed by simulating payments using actual FY 1997 bill data available at the time. That is, the estimate of actual outlier payments did not reflect actual FY 1998 bills but instead reflected the application of FY 1998 rates and policies to available FY 1997 bills. Our current estimate, using available FY 1998 bills, is that actual outlier payments for FY 1998 were approximately 6.5 percent of actual total DRG payments. We note that the MedPAR file for FY 1998 discharges continues to be updated. Thus, the data indicate that, for FY 1998, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 1998 (and thus exceeds the percentage by which we reduced the standardized amounts for FY 1998). In fact, the data indicate that the proportion of actual outlier payments for FY 1998 exceeds 6 percent. Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the prospective payment system, we do not plan to recoup money and make retroactive adjustments to outlier payments for FY 1998.

We currently estimate that actual outlier payments for FY 1999 will be approximately 6.2 percent of actual total DRG payments, higher than the 5.1 percent we projected in setting outlier policies for FY 1999. This estimate is based on simulations using the December 1998 update of the provider-specific file and the December 1998 update of the FY 1998 MedPAR file (discharge data for FY 1998 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 1999 by applying FY 1999 rates and policies to available FY 1998 bills.

5. FY 2000 Standardized Amounts

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

B. Adjustments for Area Wage Levels and Cost of Living

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

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act requires that we make an adjustment to the labor-related portion of the prospective payment rates to account for area differences in hospital wage levels. This

adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III of this preamble, we discuss the data and methodology for the proposed wage index. The proposed wage index is set forth in Tables 4A through 4F of this addendum.

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

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2000, we propose to adjust the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below. If the Office of Personnel Management releases revised cost-of-living adjustment factors before July 1, 1999, we will publish them in the final rule and use them in determining FY 2000 payments.

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

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

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

C. DRG Relative Weights

As discussed in section II of the preamble, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section VI of this addendum contains the relative weights that we propose to use for discharges occurring in FY 2000. These factors have been recalibrated as explained in section II of the preamble.

D. Calculation of Prospective Payment Rates for FY 2000

General Formula for Calculation of Prospective Payment Rates for FY 2000

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

Prospective payment rate for sole community hospitals = Whichever of the following rates yields the greatest aggregate payment: 100 percent of the Federal rate, 100 percent of the updated FY 1982 hospital-specific rate, or 100 percent of the updated FY 1987 hospital-specific rate.

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

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

1. Federal Rate

For discharges occurring on or after October 1, 1999 and before October 1, 2000, except for sole community hospitals, Medicare-dependent, small rural hospitals, and hospitals in Puerto Rico, the hospital's payment is based exclusively on the Federal national rate.

The payment amount is determined as follows:

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

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

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

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

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

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

Sections 1886(d)(5)(D)(i) and (b)(3)(C) of the Act provide that sole community hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate, the updated hospital-specific rate based on FY 1982 cost per discharge, or the updated hospital-specific rate based on FY 1987 cost per discharge.

Sections 1886(d)(5)(G) and (b)(3)(D) of the Act provide that Medicare-dependent, small rural hospitals are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate or the Federal rate plus 50 percent of the difference between the Federal rate and the greater of the updated hospital-specific rate based on FY 1982 and FY 1987 cost per discharge.

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

a. *Updating the FY 1982 and FY 1987 Hospital-Specific Rates for FY 2000.* We are proposing to increase the hospital-specific rates by 0.9 percent (the hospital market basket percentage increase of 2.7 percent minus 1.8 percentage points) for sole community hospitals and Medicare-dependent, small rural hospitals located in all areas for FY 2000. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for sole community hospitals equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2000, is the market basket rate of increase minus 1.8 percentage points. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for Medicare-dependent, small rural hospitals equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2000, is the market basket rate of increase minus 1.8 percentage points.

b. Calculation of Hospital-Specific Rate. For sole community hospitals and

Medicare-dependent, small rural hospitals, the applicable FY 2000 hospital-specific rate would be calculated by increasing the hospital's hospital-specific rate for the preceding fiscal year by the applicable update factor (0.9 percent), which is the same as the update for all prospective payment hospitals. In addition, the hospital-specific rate would be adjusted by the budget neutrality adjustment factor (that is, 0.997393) as discussed in section II.A.4.a of this Addendum. This resulting rate would be used in determining under which rate a sole community hospital or Medicare-dependent, small rural hospital is paid for its discharges beginning on or after October 1, 1999, based on the formula set forth above.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 1999 and Before October 1, 2000.

a. Puerto Rico Rate. The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate adjusted average standardized amount considering the large urban or other designation of the hospital (see Table 1C of section VI of the addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate Puerto Rico-specific wage index (see Table 4F of section VI of the addendum).

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the result in Step 3 by 50 percent.

Step 5—Multiply the amount from Step 4 by the appropriate DRG relative weight (see Table 5 of section VI of the addendum).

b. National Rate. The national prospective payment rate is determined as follows:

Step 1—Multiply the labor-related portion of the national average standardized amount (see Table 1C of section VI of the addendum) by the appropriate national wage index (see Tables 4A and 4B of section VI of the addendum).

Step 2—Add the amount from Step 1 and the nonlabor-related portion of the national average standardized amount.

Step 3—Multiply the result in Step 2 by 50 percent.

Step 4—Multiply the amount from Step 3 by the appropriate DRG relative weight (see Table 5 of section VI of the addendum).

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico.

III. Proposed Changes to the Payment Rates for Blood Clotting Factor for Hemophilia Inpatients

As discussed in our August 29, 1997 final rule with comment period (62 FR 46002) and our May 12, 1998 final rule (63 FR 26327), section 4452 of Public Law 105–33 amended section 6011(d) of Public Law 101–239 to reinstate the add-on payment for the costs of administering blood clotting factor to Medicare beneficiaries who have hemophilia and who are hospital inpatients for discharges occurring on or after October 1, 1997.

We are proposing to calculate the add-on payment for FY 2000 using the same methodology we described in the August 29, 1997 and May 12, 1998 final rules. That is, we are proposing to establish a price per unit of clotting factor based on the average wholesale price (AWP). To identify the AWP, we are using the most recent data available from First DataBank, a commercial source of AWPs in electronic format. The add-on payment amount for each clotting factor, as described by HCFA's Common Procedure Coding System (HCPCS), is based on the median AWP of the several products available in that category of factor, discounted by 15 percent.

We also are proposing to add HCPCS code J7191 (clotting factor, porcine) to the list of clotting factors that will be paid under this benefit. This code was recently reestablished in the HCPCS coding system because it represents a unique product that is different from the other clotting factors listed.

Based on the methodology described above, we are proposing the following prices per unit of factor for FY 2000:

J7190 Factor VIII (antihemophilic factor, human)	0.79
J7191 Factor VIII (antihemophilic factor, porcine)	1.87
J7192 Factor VIII (antihemophilic factor, recombinant)	1.03
J7194 Factor IX (complex)	0.45
J7196 Other hemophilia clotting factors (for example, anti-inhibitors)	1.43
Q0160 Factor IX (antihemophilic factor, purified, nonrecombinant)	0.97
Q0161 Factor IX (antihemophilic factor, purified, recombinant)	1.00

These prices for blood clotting factor administered to inpatients who have hemophilia would be effective for discharges beginning on or after October 1, 1999 through September 30, 2000. Payment will be made for blood clotting factor only if there is an ICD–9–CM diagnosis code for hemophilia included on the bill.

IV. Proposed Changes to Payment Rates for Inpatient Capital-Related Costs for FY 2000

The prospective payment system for hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period and during a 10-year transition period extending through FY 2001, hospital inpatient capital-related costs are paid on the basis of an increasing proportion of the capital prospective payment system Federal rate and a decreasing proportion of a hospital's historical costs for capital.

The basic methodology for determining Federal capital prospective rates is set forth at §§ 412.308 through 412.352. Below we discuss the factors that we used to determine the proposed Federal rate and the hospital-specific rates for FY 2000. The rates would be effective for discharges occurring on or after October 1, 1999.

For FY 1992, we computed the standard Federal payment rate for capital-related costs under the prospective payment system by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the standard Federal rate, as provided in § 412.308(c)(1), to account for capital input price increases and other factors. Also, § 412.308(c)(2) provides that the Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the Federal rate to total capital payments under the Federal rate. In addition, § 412.308(c)(3) requires that the Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for exceptions under § 412.348. Furthermore, § 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral. For FYs 1992 through 1995, § 412.352 required that the Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the rate made in FY 1996 as a result of

the revised policy of paying for transfers. In the FY 1998 final rule with comment period (62 FR 45966) we implemented section 4402 of the BBA, which requires that for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted standard Federal rate is reduced by 17.78 percent. A small part of that reduction will be restored effective October 1, 2002. As a result of the February 25, 1999 final rule (64 FR 9378), the Federal rate changed effective March 1, 1999, because of revisions to the GAF.

For each hospital, the hospital-specific rate was calculated by dividing the hospital's Medicare inpatient capital-related costs for a specified base year by its Medicare discharges (adjusted for transfers), and dividing the result by the hospital's case mix index (also adjusted for transfers). The resulting case-mix adjusted average cost per discharge was then updated to FY 1992 based on the national average increase in Medicare's inpatient capital cost per discharge and adjusted by the exceptions payment adjustment factor and the budget neutrality adjustment factor to yield the FY 1992 hospital-specific rate. Since FY 1992, the hospital-specific rate has been updated annually for inflation and for changes in the exceptions payment adjustment factor. For FYs 1992 through 1995, the hospital-specific rate was also adjusted by a budget neutrality adjustment factor. For discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted hospital-specific rate is reduced by 17.78 percent. A small part of this reduction will be restored effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the exceptions payment adjustment factor, we developed a dynamic model of Medicare inpatient capital-related costs, that is, a model that projects changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the model is still used to estimate the exceptions payment adjustment and other factors. The model and its application are described in greater detail in Appendix B of this proposed rule.

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

A. Determination of Federal Inpatient Capital-Related Prospective Payment Rate Update

In the July 31, 1998 final rule (63 FR 41011) we established a capital Federal rate of $378.05 for FY 1999. As of the March 1, 1999 revision, the Federal rate for FY 1999 is $378.10. As a result of the changes we are proposing to the factors used to establish the Federal rate in this preamble, the proposed FY 2000 Federal rate is $374.31.

In the discussion that follows, we explain the factors that were used to determine the proposed FY 2000 capital Federal rate. In particular, we explain why the proposed FY 2000 Federal rate has decreased 1.00 percent compared to the FY 1999 Federal rate. Even though the proposed FY 2000 Federal capital rate is less than the FY 1999 Federal rate, we estimate aggregate capital payments will increase by 2.66 percent during this same period. This increase is primarily due to the increase in the Federal blend percentage from 80 to 90 percent for fully prospective payment hospitals.

Total payments to hospitals under the prospective payment system are relatively unaffected by changes in the capital prospective payments. Since capital payments constitute about 10 percent of hospital payments, a 1 percent change in the capital Federal rate yields only about 0.1 percent change in actual payments to hospitals. Aggregate payments under the capital prospective payment transition system are estimated to increase in FY 2000 compared to FY 1999.

1. Standard Federal Rate Update

a. Description of the Update Framework. Under section 412.308(c)(1), the standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index and other factors. The update framework consists of a capital input price index (CIPI) and several policy adjustment factors. Specifically, we have adjusted the projected CIPI rate of increase as appropriate each year for case-mix index related changes, for intensity, and for errors in previous CIPI forecasts. The proposed update factor for FY 2000 under that framework is −0.6 percent. This proposal is based on a projected 0.5 percent increase in the CIPI, a −0.7 percent adjustment for the FY 1998 DRG reclassification and recalibration, and a forecast error correction of −0.4 percent. We explain the basis for the FY 2000 CIPI projection in section II.D of this addendum. Here we describe the policy adjustments that have been applied.

The case-mix index is the measure of the average DRG weight for cases paid under the prospective payment system. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patients changes (''real'' case-mix change);
- Changes in hospital coding of patient records result in higher weight DRG assignments (''coding effects''); and
- The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher-weighted DRGs but do not reflect higher resource requirements. In the update framework for the prospective payment system for operating costs, we adjust the update upwards to allow for real case-mix change, but remove the effects of coding changes on the case-mix index. We also remove the effect on total payments of prior changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than patient severity. (For example, we adjusted for the effects of the FY 1998 DRG reclassification and

recalibration as part of our FY 2000 update recommendation.) We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 2000, we are projecting a 0.5 percent increase in the case-mix index. We estimate that real case-mix increase will equal 0.5 percent in FY 2000. Therefore, the proposed net adjustment for case-mix change in FY 2000 is 0.0 percentage points.

We estimate that FY 1998 DRG reclassification and recalibration resulted in a 0.7 percent change in the case mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we are making a −0.7 percent adjustment for DRG reclassification and recalibration in the proposed update for FY 2000.

The capital update framework contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. A forecast error of −0.4 percentage points was calculated for the FY 1998 update. That is, current historical data indicate that the FY 1998 CIPI used in calculating the forecasted FY 1998 update factor overstated realized price increases by 0.4 percent. Therefore, we are making a −0.4 percent adjustment for forecast error in the proposed update for FY 2000.

Under the capital prospective payment system update framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data as in the framework for the operating prospective payment system. The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, changes in within-DRG severity, and expected modification of practice patterns to remove cost-ineffective services.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI hospital component), and changes in real case mix. The use of total charges in the calculation of the proposed intensity factor makes it a total intensity factor, that is, charges for capital services are already built into the calculation of the factor. Therefore, we have incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity, we assume, as in the revised operating update framework, that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity to allow for within-DRG severity increases and the adoption of quality-enhancing technology.

For FY 2000, we have developed a Medicare-specific intensity measure based on a 5-year average using FY 1994–1998 data. In determining case-mix constant intensity, we found that observed case-mix increase was 0.8 percent in FY 1994, 1.7 percent in FY 1995, 1.6 percent in FY 1996, 0.3 percent in FY 1997, and −0.4 percent in FY 1998. For FY 1995 and FY 1996, we estimate that real case-mix increase was 1.0 to 1.4 percent each year. The estimate for those years is supported by past studies of case-mix change by the RAND Corporation. The most recent study was ''Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988'' by G. M. Carter, J.P. Newhouse, and D.A. Relles, R–4098–HCFA/ProPAC (1991). The study suggested that real case-mix change was not dependent on total change, but was usually a fairly steady 1.0 to 1.5 percent per year. We use 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment. Following that study, we consider up to 1.4 percent of observed case-mix change as real for FY 1994 through FY 1998. Based on this analysis, we believe that all of the observed case-mix increase for FY 1994, FY 1997 and FY 1998 is real. The increases for FY 1995 and FY 1996 were in excess of our estimate of real case mix increase.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI hospital component), and changes in real case-mix. Given estimates of real case mix of 0.8 percent for FY 1994, 1.0 percent for FY 1995, 1.0 percent for FY 1996, 0.3 percent for FY 1997, and −0.4 for FY 1998, we estimate that case-mix constant intensity declined by an average 1.3 percent during FYs 1994 through 1998, for a cumulative decrease of 6.3 percent. If we assume that real case-mix increase was 0.8 percent for FY 1994, 1.4 percent for FY 1995, 1.4 percent for FY 1996, 0.3 percent for FY 1997, and −0.4 for FY 1998, we estimate that case-mix constant intensity declined by an average 1.5 percent during FYs 1994 through 1998, for a cumulative decrease of 7.1 percent. Since we estimate that intensity has declined during that period, we are recommending a 0.0 percent intensity adjustment for FY 2000.

b. Comparison of HCFA and MedPAC Update Recommendations. MedPAC recommends a −1.1 to 1.8 percent update to the standard capital Federal rate and we are recommending a −0.6 percent update. There are some significant differences between the HCFA and MedPAC update frameworks, which account for the difference in the respective update recommendations. A major difference is the input price index that each framework uses as a beginning point to estimate the change in input prices since the previous year. The HCFA capital input price index (the CIPI) includes price measures for interest expense, which are an indicator of the interest rates facing hospitals during their capital purchasing decisions. The MedPAC capital market basket does not include interest expense; instead the MedPAC update framework includes a financing policy adjustment when necessary to account for the prolonged changes in interest rates. HCFA's CIPI is vintage-weighted, meaning that it takes into account price changes from past purchases of capital when determining the current period update. MedPAC's capital market basket is not vintage-weighted, accounting only for the current year price changes. This year, due to the difference between HCFA's and MedPAC's input price index, the percentage change in HCFA's CIPI is 0.5 percent, and the percentage change in MedPAC's market basket is 1.9 percent.

MedPAC and HCFA also differ in the adjustments they make to their price indices. (See Table 1 for a comparison

of HCFA and MedPAC's update recommendations.) MedPAC makes an adjustment for productivity, while HCFA has not adopted an adjustment for capital productivity or efficiency. MedPAC employs the same productivity adjustment in its operating and capital framework. We have identified a total intensity factor but have not identified an adequate total productivity measure. For the FY 2000 update, the Commission is also including a site-of-care substitution adjustment to account for the decline in the average length of Medicare acute inpatient stays. This adjustment is designed to shift funding along with associated costs when Medicare patients are discharged to postacute settings that replace acute impatient days. Other factors, such as technological advances that allow for a decreased need in follow-up care and BBA mandated policy on payment for transfer cases that limits payments within certain DRGs, are reflected in the site-of-care substitution adjustment as well. A negative intensity adjustment would capture the site of care substitution accounted for in MedPAC's update framework. However, we did not make a negative adjustment for intensity this year. We may examine the appropriateness of adopting a negative intensity adjustment at a later date.

MedPAC recommends a −1.8 to a −0.9 adjustment for site-of-care substitutions for FY 2000. For FY 2000, MedPAC recommends a −1.0 to a 0.0 adjustment for productivity. We recommend a 0.0 intensity adjustment. Additionally, since long-term interest rates are low by historical standards, MedPAC recommends a −0.3 to a 0.0 adjustment to the update for FY 2000, to reflect changes in the real interest rates.

We recommend a 0.0 total case mix adjustment since we are projecting a 0.5 percent increase in the case mix index and we estimate that real case-mix increase will equal 0.5 percent in FY 2000. MedPAC makes a two-part adjustment for case mix changes, which takes into account changes in case mix in the past year. They recommend a 0.0 adjustment for coding change and an 0.0 to 0.2 adjustment for within-DRG complexity change. We recommend a −0.4 adjustment for forecast error correction, and MedPAC recommends a −0.4 adjustment for forecast error correction.

The net result of these adjustments is that MedPAC has recommended a −1.1 to 1.8 percent update to the capital Federal rate for FY 2000. MedPAC believes that the annual updates to the capital and operating payments under the prospective payment system should not differ substantially, even though they are determined separately, since they correspond to costs generated by providing the same inpatient hospital services to the same Medicare patients. This range for the capital update is consistent with the prospective payment system operating update range of 0.0 to 2.6 recommended by the Commission. We describe the basis for our proposed −0.6 percent total update in the preceding section. Our recommendation is within the range recommended by MedPAC.

Also, MedPAC argued that the distinction between inpatient operating and capital payment rates is arbitrary and does not foster efficient overall decision making about the allocation of resources. Accordingly, MedPAC recommended that once the transition to fully perspective capital payment is completed, a single PPS payment rate should be developed for hospital inpatient services to Medicare beneficiaries. MedPAC indicated that a single PPS payment rate for both operating and capital PPS costs would be consistent with the way that hospitals purchase a majority of goods and services.

We responded to a similar comment in the July 31, 1998 final rule (63 FR 41013) and in the September 1, 1995 final rule (60 FR 45816). In those rules, we stated that our long-term goal was to develop a single update framework for operating and capital prospective payments and that we would begin development of a unified framework. We indicated that, in the meantime, we would maintain as much consistency as possible between the current operating and capital frameworks in order to facilitate the eventual development of a unified framework. In addition, we stated that because of the similarity of the update frameworks, the update frameworks could be combined without too much difficulty. We maintain our goal of combining the update frameworks at the end of the capital transition period and may examine combining the payment systems after the conclusion of the capital prospective payment transition period.

TABLE 1.—HCFA'S FY 2000 UPDATE FACTOR AND MEDPAC'S RECOMMENDATION

	HCFA's update factor	MedPAC's recommendation
Capital Input Price Index Financing Policy Adjustment	0.5	1.9
Financing Policy Adjustment	.....	−0.3 to 0.0
Policy Adjustment Factors:		
Productivity	.....	−1.0 to 0.0
Intensity	0.0	.....
Science and Technology	.....	0.5 to 1.0
Intensity	.....	(1)
Real within DRG Change	.....	(2)
Site-of-Care Substitution	.....	−1.8 to −0.9
Subtotal	0.0	−2.3 to 0.1
Case-Mix Adjustment Factors:	.....	.....
Projected Case-Mix Change	−0.5	.....
Real Across DRG Change	0.5	.....
Coding Change	.....	0.0
Real within DRG Change	(3)	0.0 to 0.2
Subtotal	0.0	0.0 to 0.2
Effect of FY 1998 Reclassification and Recalibration	0.7	.....
Forecast Error Correction	−0.4	−0.4

TABLE 1.—HCFA'S FY 2000 UPDATE FACTOR AND MEDPAC'S RECOMMENDATION—Continued

	HCFA's update factor	MedPAC's recommendation
Total Update	−0.6	−1.1 to 1.8

[1] Included in MedPAC's productivity measure.
[2] Included in MedPAC's case-mix adjustment.
[3] Included in HCFA's intensity factor.

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made only on the portion of the Federal rate that is used to calculate the hospital's inpatient capital-related payments (for example, 90 percent for cost reporting periods beginning in FY 2000 for hospitals paid under the fully prospective payment methodology). Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of outlier payments under the Federal rate to total inpatient capital-related payments under the Federal rate. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating DRG payments. The inpatient capital-related outlier reduction factor reflects the inpatient capital-related outlier payments that would be made if all hospitals were paid 100 percent of the Federal rate. For purposes of calculating the outlier thresholds and the outlier reduction factor, we model payments as if all hospitals were paid 100 percent of the Federal rate because, as explained above, outlier payments are made only on the portion of the Federal rate that is included in the hospital's inpatient capital-related payments.

In the July 31, 1998 final rule, we estimated that outlier payments for capital in FY 1999 would equal 6.08 percent of inpatient capital-related payments based on the Federal rate (63 FR 41013). Accordingly, we applied an outlier adjustment factor of 0.9392 to the Federal rate. Based on the thresholds as set forth in section II.A.4.d of this Addendum, we estimate that outlier payments for capital will equal 6.03 percent of inpatient capital-related payments based on the Federal rate in FY 2000. Therefore, we are proposing an outlier adjustment factor of 0.9397 to the Federal rate. Thus, estimated capital outlier payments for FY 2000 represent a lower percentage of total capital standard payments than in FY 1999.

The outlier reduction factors are not built permanently into the rates; that is, they are not applied cumulatively in determining the Federal rate. Therefore, the proposed net change in the outlier adjustment to the Federal rate for FY 2000 is 1.0005 (0.9397/0.9392). The outlier adjustment increases the FY 2000 Federal rate by 0.05 percent compared with the FY 1999 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the Geographic Adjustment Factor

Section 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that aggregate payments for the fiscal year based on the Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the Federal rate without such changes. We use the actuarial model, described in Appendix B of this proposed rule, to estimate the aggregate payments that would have been made on the basis of the Federal rate without changes in the DRG classifications and weights and in the GAF. We also use the model to estimate aggregate payments that would be made on the basis of the Federal rate as a result of those changes. We then use these figures to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF.

For FY 1999, we calculated a GAF/DRG budget neutrality factor of 1.0027. In the February 25, 1999 final rule (64 FR 9381), we adopted an incremental GAF/DRG budget neutrality factor of 1.0028 for discharges on or after March 1, 1999. For FY 2000, we are proposing a GAF/DRG budget neutrality factor of 0.9986. The GAF/DRG budget neutrality factors are built permanently into the rates; that is, they are applied cumulatively in determining the Federal rate. This follows from the requirement that estimated aggregate payments each year be no more than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The proposed incremental change in the adjustment from FY 1999 to FY 2000 is 0.9986. The proposed cumulative change in the rate due to this adjustment is 1.0015 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996, FY 1997, FY 1998, FY 1999, and the proposed incremental factor for FY 2000: $0.9980 \times 1.0053 \times 0.9998 \times 0.9994 \times 0.9987 \times 0.9989 \times 1.0028 \times 0.9986 = 1.0015$).

This proposed factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 2000 geographic reclassification decisions made by the MGCRB compared to FY 1999 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of additional payments for exceptions under § 412.348 relative to total payments under the hospital-specific rate and Federal rate. We use the model originally developed for determining the budget neutrality adjustment factor to determine the exceptions payment adjustment factor. We describe that model in Appendix B to this proposed rule.

For FY 1999, we estimated that exceptions payments would equal 2.17 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we applied an exceptions reduction factor of 0.9783 (1–0.0217) in determining the Federal rate. For this proposed rule, we estimate that exceptions payments for FY 2000 will equal 2.48 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we are proposing an exceptions payment reduction factor of 0.9752 to the Federal rate for FY 2000. The proposed

exceptions reduction factor for FY 2000 is 0.32 percent lower than the factor for FY 1999.

The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. Therefore, the proposed net adjustment to the FY 2000 Federal rate is 0.9752/0.9783, or 0.9968.

5. Standard Capital Federal Rate for FY 2000

For FY 1999 (effective March 1, 1999), the capital Federal rate was $378.10. As a result of changes we are proposing to the factors used to establish the Federal rate, the proposed FY 2000 Federal rate is $374.31. The proposed Federal rate for FY 2000 was calculated as follows:

- The proposed FY 2000 update factor is 0.9940; that is, the proposed update is −0.60 percent.
- The proposed FY 2000 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the GAF is 0.9986.
- The proposed FY 2000 outlier adjustment factor is 0.9397.
- The proposed FY 2000 exceptions payments adjustment factor is 0.9752.

Since the Federal rate has already been adjusted for differences in case mix, wages, cost of living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we propose to make no additional adjustments in the standard Federal rate for these factors other than the budget neutrality factor for changes in the DRG relative weights and the GAF.

We are providing a chart that shows how each of the factors and adjustments for FY 2000 affected the computation of the proposed FY 2000 Federal rate in comparison to the FY 1999 Federal rate. The proposed FY 2000 update factor has the effect of decreasing the Federal rate by 0.60 percent compared to the rate in FY 1999, while the proposed geographic and DRG budget neutrality factor has the effect of decreasing the Federal rate by 0.14 percent. The proposed FY 2000 outlier adjustment factor has the effect of increasing the Federal rate by 0.05 percent compared to FY 1999. The proposed FY 2000 exceptions reduction factor has the effect of decreasing the Federal rate by 0.32 percent compared to the exceptions reduction for FY 1999. The combined effect of all the proposed changes is to decrease the proposed Federal rate by 1.00 percent compared to the Federal rate for FY 1999.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 1999 FEDERAL RATE AND PROPOSED FY 2000 FEDERAL RATE

	FY 1999	Proposed FY 2000	Change	Percent change
Update factor [1]	1.0010	0.9940	0.9940	−0.60
GAF/DRG Adjustment Factor [1]	1.0028	0.9986	0.9986	−0.14
Outlier Adjustment Factor [2]	0.9392	0.9397	1.0005	0.05
Exceptions Adjustment Factor [2]	0.9783	0.9752	0.9968	−0.32
Federal Rate	$378.10	$374.31	0.9900	−1.00

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the rates. Thus, for example, the incremental change from FY 1999 to FY 2000 resulting from the application of the 0.9986 GAF/DRG budget neutrality factor for FY 2000 is 0.9986.

[2] The outlier reduction factor and the exceptions reduction factor are not built permanently into the rates; that is, these factors are not applied cumulatively in determining the rates. Thus, for example, the net change resulting from the application of the FY 2000 outlier reduction factor is 0.9397/0.9392, or 1.0005.

6. Special Rate for Puerto Rico Hospitals

As explained at the beginning of section IV of this Addendum, hospitals in Puerto Rico are paid based on 50 percent of the Puerto Rico rate and 50 percent of the Federal rate. The Puerto Rico rate is derived from the costs of Puerto Rico hospitals only, while the Federal rate is derived from the costs of all acute care hospitals participating in the prospective payment system (including Puerto Rico). To adjust hospitals' capital payments for geographic variations in capital costs, we apply a geographic adjustment factor (GAF) to both portions of the blended rate. The GAF is calculated using the operating PPS wage index and varies depending on the MSA or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital blended rate and the national wage index to determine the GAF for the national part of the blended rate.

Since we implemented a separate GAF for Puerto Rico in 1998, we also propose to apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. The Puerto Rico GAF budget neutrality factor is 1.0015, while the DRG adjustment is 1.0001, for a combined cumulative adjustment of 1.0016.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the rate (50 percent) is multiplied by the Puerto Rico-specific GAF for the MSA in which the hospital is located, and the national portion of the rate (50 percent) is multiplied by the national GAF for the MSA in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico rate as a result of the BBA. For FY 1999, before application of the GAF, the special rate for Puerto Rico hospitals was $181.10. With the changes we are proposing to the factors used to determine the rate, the proposed FY 2000 special rate for Puerto Rico is $174.15.

B. Determination of Hospital-Specific Rate Update

Section 412.328(e) of the regulations provides that the hospital-specific rate for FY 2000 be determined by adjusting the FY 1999 hospital-specific rate by the following factors:

1. Hospital-Specific Rate Update Factor

The hospital-specific rate is updated in accordance with the update factor for the standard Federal rate determined under § 412.308(c)(1). For FY 2000, we are proposing that the hospital-specific rate be updated by a factor of 0.9940.

2. Exceptions Payment Adjustment Factor

For FYs 1992 through FY 2001, the updated hospital-specific rate is multiplied by an adjustment factor to account for estimated exceptions payments for capital-related costs under § 412.348, determined as a proportion of the total amount of payments under the hospital-specific rate and the Federal rate. For FY 2000, we estimate that

exceptions payments will be 2.48 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we propose that the updated hospital-specific rate be reduced by a factor of 0.9752. The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the hospital-specific rate. The proposed net adjustment to the FY 2000 hospital-specific rate is 0.9752/0.9783, or 0.9968.

3. Net Change to Hospital-Specific Rate

We are providing a chart to show the net change to the hospital-specific rate. The chart shows the factors for FY 1999 and FY 2000 and the net adjustment for each factor. It also shows that the proposed cumulative net adjustment from FY 1999 to FY 2000 is 0.9908, which represents a proposed decrease of 0.92 percent to the hospital-specific rate. For each hospital, the proposed FY 2000 hospital-specific rate is determined by multiplying the FY 1999 hospital-specific rate by the cumulative net adjustment of 0.9908.

PROPOSED FY 2000 UPDATE AND ADJUSTMENTS TO HOSPITAL-SPECIFIC RATES

	FY 1999	Proposed FY 2000	Net adjustment	Percent change
Update Factor	1.0010	0.9940	0.9940	−0.60
Exceptions Payment Adjustment Factor	0.9783	0.9752	0.9968	−0.32
Cumulative Adjustments	0.9793	0.9703	0.9908	−0.92

Note: The update factor for the hospital-specific rate is applied cumulatively in determining the rates. Thus, the incremental increase in the update factor from FY 1999 to FY 2000 is 0.9940. In contrast, the exceptions payment adjustment factor is not applied cumulatively. Thus, for example, the incremental increase in the exceptions reduction factor from FY 1999 to FY 2000 is 0.9752/0.9783, or 0.9968.

C. Calculation of Inpatient Capital-Related Prospective Payments for FY 2000

During the capital prospective payment system transition period, a hospital is paid for the inpatient capital-related costs under one of two payment methodologies—the fully prospective payment methodology or the hold-harmless methodology. The payment methodology applicable to a particular hospital is determined when a hospital comes under the prospective payment system for capital-related costs by comparing its hospital-specific rate to the Federal rate applicable to the hospital's first cost reporting period under the prospective payment system. The applicable Federal rate was determined by making adjustments as follows:

- For outliers by dividing the standard Federal rate by the outlier reduction factor for that fiscal year; and,
- For the payment adjustment factors applicable to the hospital (that is, the hospital's GAF, the disproportionate share adjustment factor, and the indirect medical education adjustment factor, when appropriate).

If the hospital-specific rate is above the applicable Federal rate, the hospital is paid under the hold-harmless methodology. If the hospital-specific rate is below the applicable Federal rate, the hospital is paid under the fully prospective methodology.

For purposes of calculating payments for each discharge under both the hold-harmless payment methodology and the fully prospective payment methodology, the standard Federal rate is adjusted as follows:

(Standard Federal Rate) × (DRG weight) × (GAF) × (Large Urban Add-on, if applicable) ×
(COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable).

The result is the adjusted Federal rate.

Payments under the hold-harmless methodology are determined under one of two formulas. A hold-harmless hospital is paid the higher of the following:

- 100 percent of the adjusted Federal rate for each discharge; or
- An old capital payment equal to 85 percent (100 percent for sole community hospitals) of the hospital's allowable Medicare inpatient old capital costs per discharge for the cost reporting period plus a new capital payment based on a percentage of the adjusted Federal rate for each discharge. The percentage of the adjusted Federal rate equals the ratio of the hospital's allowable Medicare new capital costs to its total Medicare inpatient capital-related costs in the cost reporting period.

Once a hospital receives payment based on 100 percent of the adjusted Federal rate in a cost reporting period beginning on or after October 1, 1994 (or the first cost reporting period after obligated capital that is recognized as old capital under § 412.302(c) is put in use for patient care, if later), the hospital continues to receive capital prospective payment system payments on that basis for the remainder of the transition period.

Payment for each discharge under the fully prospective methodology is the sum of the following:

- The hospital-specific rate multiplied by the DRG relative weight for the discharge and by the applicable hospital-specific transition blend percentage for the cost reporting period; and
- The adjusted Federal rate multiplied by the Federal transition blend percentage.

The blend percentages for cost reporting periods beginning in FY 2000 are 90 percent of the adjusted Federal rate and 10 percent of the hospital-specific rate.

Hospitals may also receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. Outlier payments are made only on that portion of the Federal rate that is used to calculate the hospital's inpatient capital-related payments. For fully prospective hospitals, that portion is 90 percent of the Federal rate for discharges occurring in cost reporting periods beginning during FY 2000. Thus, a fully prospective hospital will receive 90 percent of the capital-related outlier payment calculated for the case for discharges occurring in cost reporting periods beginning in FY 2000. For hold-harmless hospitals paid 85 percent of their reasonable costs for old inpatient capital, the portion of the Federal rate that is included in the hospital's outlier payments is based on the hospital's ratio of Medicare inpatient costs for new capital to total Medicare inpatient capital costs. For hold-harmless hospitals that are paid 100 percent of the Federal rate, 100 percent of the Federal rate is included in the hospital's outlier payments.

The proposed outlier thresholds for FY 2000 are in section II.A.4.c of this

Addendum. For FY 2000, a case qualifies as a cost outlier if the cost for the case (after standardization for the indirect teaching adjustment and disproportionate share adjustment) is greater than the prospective payment rate for the DRG plus $14,575.

During the capital prospective payment system transition period, a hospital may also receive an additional payment under an exceptions process if its total inpatient capital-related payments are less than a minimum percentage of its allowable Medicare inpatient capital-related costs. The minimum payment level is established by class of hospital under § 412.348. The proposed minimum payment levels for portions of cost reporting periods occurring in FY 2000 are:

- Sole community hospitals (located in either an urban or rural area), 90 percent;
- Urban hospitals with at least 100 beds and a disproportionate share patient percentage of at least 20.2 percent; and
- Urban hospitals with at least 100 beds that qualify for disproportionate share payments under § 412.106(c)(2), 80 percent; and
- All other hospitals, 70 percent.

Under § 412.348(d), the amount of the exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital prospective payment system to the cumulative minimum payment levels applicable to the hospital for each cost reporting period subject to that system. Any amount by which the hospital's cumulative payments exceed its cumulative minimum payment is deducted from the additional payment that would otherwise be payable for a cost reporting period.

New hospitals are exempted from the capital prospective payment system for their first 2 years of operation and are paid 85 percent of their reasonable costs during that period. A new hospital's old capital costs are its allowable costs for capital assets that were put in use for patient care on or before the later of December 31, 1990 or the last day of the hospital's base year cost reporting period, and are subject to the rules pertaining to old capital and obligated capital as of the applicable date. Effective with the third year of operation, we will pay the hospital under either the fully prospective methodology, using the appropriate transition blend in that Federal fiscal year, or the hold-harmless methodology. If the hold-harmless methodology is applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period.

D. Capital Input Price Index

1. Background

Like the prospective payment hospital operating input price index, the Capital Input Price Index (CIPI) is a fixed-weight price index that measures the price changes associated with costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

Using Medicare cost reports, AHA data, and Securities Data Corporation data, a vintage-weighted price index was developed to measure price increases associated with capital expenses. We periodically update the base year for the operating and capital input prices to reflect the changing composition of inputs for operating and capital expenses. Currently, the CIPI is based to FY 1992 and was last rebased in 1997. The most recent explanation of the CIPI was discussed in the final rule with comment period for FY 1998 published in the August 29, 1997 **Federal Register** (62 FR 46050). The following **Federal Register** documents also describe development and revisions of the methodology involved with the construction of the CIPI: September 1, 1992 (57 FR 40016), May 26, 1993 (58 FR 30448), September 1, 1993 (58 FR 46490), May 27, 1994 (59 FR 27876), September 1, 1994 (59 FR 45517), June 2, 1995 (60 FR 29229), and September 1, 1995 (60 FR 45815), May 31, 1996 (61 FR 27466), August 30, 1996 (61 FR 46196), June 2, 1997 (62 FR 29953), August 29, 1997 (62 FR 46050), May 8, 1998 (63 FR 25619), and July 31, 1998 (63 FR 41017).

2. Forecast of the CIPI for Federal Fiscal Year 2000

We are forecasting the CIPI to increase 0.5 percent for FY 2000. This reflects a projected 1.6 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.2 percent increase in other capital expense prices in FY 2000, partially offset by a 3.2 percent decline in vintage-weighted interest rates in FY 2000. The weighted average of these three factors produces the 0.5 percent increase for the CIPI as a whole.

V. Proposed Changes to Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

A. Rate-of-Increase Percentages for Excluded Hospitals and Hospital Units

The inpatient operating costs of hospitals and hospital units excluded from the prospective payment system are subject to rate-of-increase limits established under the authority of section 1886(b) of the Act, which is implemented in regulations at § 413.40. Under these limits, a hospital-specific target amount (expressed in terms of the inpatient operating cost per discharge) is set for each hospital, based on the hospital's own historical cost experience trended forward by the applicable rate-of-increase percentages (update factors). In the case of a psychiatric hospital or hospital unit, rehabilitation hospital or hospital unit, or long-term care hospital, the target amount may not exceed the updated figure for the 75th percentile of target amounts for hospitals and units in the same class (psychiatric, rehabilitation, and long-term care) for cost reporting periods ending during FY 1996. The target amount is multiplied by the number of Medicare discharges in a hospital's cost reporting period, yielding the ceiling on aggregate Medicare inpatient operating costs for the cost reporting period.

Each hospital-specific target amount is adjusted annually, at the beginning of each hospital's cost reporting period, by an applicable update factor.

Section 1886(b)(3)(B) of the Act, which is implemented in regulations at § 413.40(c)(3)(vii), provides that for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000, the update factor depends on the hospital's or hospital unit's costs in relation to the ceiling. For hospitals with costs exceeding the ceiling by 10 percent or more, the update factor is the market basket increase. For hospitals with costs exceeding the ceiling by less than 10 percent, the update factor is the market basket minus .25 percent for each percentage point by which costs are less than 10 percent over the ceiling. For hospitals with costs equal to or less than the ceiling but greater than 66.7 percent of the ceiling, the update factor is the greater of 0 percent or the market basket minus 2.5 percent. For hospitals with costs that do not exceed 66.7

percent of the ceiling, the update factor is 0.

The most recent forecast of the market basket increase for FY 2000 for hospitals and hospital units excluded from the prospective payment system is 2.6 percent. Therefore, the update to a hospital's target amount for its cost reporting period beginning in FY 2000 would be between 0 and 2.6 percent.

In addition, § 413.40(c)(4)(iii) requires that for cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000, the target amount for each psychiatric hospital or hospital unit, rehabilitation hospital or hospital unit, and long-term care hospital cannot exceed a cap on the target amounts for hospitals in the same class. For cost reporting periods beginning in FY 2000, the proposed caps are $11,076 for psychiatric hospitals and hospital units, $20,071 for rehabilitation hospitals and hospital units, and $39,596 for long-term care hospitals. Regulations at § 413.40(d) specify the formulas for determining bonus and relief payments for excluded hospitals and specify established criteria for an additional bonus payment for continuous improvement. Regulations at § 413.40(f)(2)(ii) specify the payment methodology for new hospitals and hospital units (psychiatric, rehabilitation, and long-term care) effective October 1, 1997.

VI. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this Addendum. For purposes of this proposed rule, and to avoid confusion, we have retained the designations of Tables 1 through 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1A, 1C, 1D, 3C, 4A, 4B, 4C, 4D, 4E, 4F, 5, 7A, 7B, 8A, and 8B are presented below. The tables presented below are as follows:

Table 1A—National Adjusted Operating Standardized Amounts, Labor/Nonlabor

Table 1C—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor

Table 1D—Capital Standard Federal Payment Rate

Table 3C—Hospital Case Mix Indexes for Discharges Occurring in Federal Fiscal Year 1998 and Hospital Average Hourly Wage for Federal Fiscal Year 2000 Wage Index

Table 4A—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas

Table 4B—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas

Table 4C—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified

Table 4D—Average Hourly Wage for Urban Areas

Table 4E—Average Hourly Wage for Rural Areas

Table 4F—Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF)

Table 5—List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric Mean Length of Stay, and Arithmetic Mean Length of Stay Points Used in the Prospective Payment System

Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 98 MEDPAR Update 12/98 GROUPER V16.0

Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 98 MEDPAR Update 12/98 GROUPER V17.0

Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) March 1999

TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
2,804.51	1,139.95	2,760.12	1,121.90

TABLE 1C.—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National	2,780.77	1,130.30	2,780.77	1,130.30
Puerto Rico	1,335.82	537.70	1,314.67	529.19

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	374.31
Puerto Rico	174.15

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX

Prov.	Case mix index	Avg. hourly wage
010001	1.4554	15.85
010004	0.9916	15.02
010005	1.1743	16.26
010006	1.4464	17.31
010007	1.1415	14.80
010008	1.1818	17.65
010009	1.0947	17.53
010010	1.0813	15.91
010011	1.5845	20.63
010012	1.2638	19.30
010015	1.0478	18.35
010016	1.2449	16.13
010018	0.9705	18.96
010019	1.2752	15.49
010021	1.2478	14.63
010022	0.9572	20.51
010023	1.6841	16.26
010024	1.4253	16.03
010025	1.3495	14.53
010027	0.8128	14.93
010029	1.5973	16.41
010031	1.4197	18.02
010032	0.8709	12.65
010033	1.9994	19.23
010034	1.0469	14.73
010035	1.2391	17.48
010036	1.0924	22.58
010038	1.2343	18.33
010039*	1.6327	18.81
010040	1.4992	19.10
010043	1.0500	16.20
010044	1.0251	17.02
010045	1.1784	15.01
010046	1.4732	17.18
010047	0.9281	16.38
010049	1.1802	14.48
010050	1.0767	15.42
010051	0.8974	9.94
010052	1.0154	13.86
010053	1.0510	13.18
010054	1.1343	17.12
010055	1.4214	18.19
010056	1.3310	19.08
010058	1.0341	12.78
010059	1.0571	18.19
010061	1.1108	15.92
010062	1.0103	13.57
010064	1.7507	20.90
010065	1.3275	15.64
010066	0.8966	12.07
010068	1.3058	18.74
010069	1.1341	13.57
010072	1.0767	14.35
010073	0.8779	12.83
010078	1.2917	17.71
010079	1.1849	16.87
010080	.....	13.85
010081	1.6352	10.92
010083	1.0573	16.21
010084	1.5014	18.78
010085	1.3174	23.43

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
010086	1.0101	14.93
010087	1.7240	18.39
010089	1.2016	16.61
010090	1.6543	18.11
010091	0.9852	16.36
010092	1.4229	16.25
010094	1.1553	18.56
010095	1.0478	11.90
010097	0.8658	12.90
010098	0.9903	14.28
010099	1.1704	15.93
010100	1.2946	15.48
010101	1.0189	15.42
010102	0.9304	12.73
010103	1.8373	19.09
010104	1.6940	17.84
010108	1.1487	8.43
010109	1.0505	14.09
010110	0.9677	15.91
010112	1.1430	15.11
010113	1.6124	17.24
010114	1.2547	17.26
010115	0.8486	13.75
010118	1.2460	17.93
010119	0.8454	18.17
010120	0.9887	17.03
010121	1.2837	15.18
010123	1.1677	18.16
010124	1.2293	16.27
010125	1.0592	14.42
010126	1.1226	17.64
010127	1.3140	19.61
010128	0.9181	12.57
010129	1.0657	14.43
010130	1.0438	16.35
010131	1.3316	17.91
010134	0.8091	10.78
010138	0.9201	12.13
010139	1.6352	19.95
010143	1.2331	15.67
010144	1.4122	17.12
010145	1.3320	19.99
010146	1.1893	18.86
010148	0.9793	14.64
010149	1.2499	17.08
010150	1.0444	16.87
010152	1.2458	15.08
010155	1.0820	16.70
020001	1.5225	27.97
020001	0.8749	.....
020002	1.0518	26.91
020004	1.1822	26.40
020005	0.8955	29.01
020006	1.1279	26.77
020007	0.8238	24.96
020009	0.8160	23.18
020010	0.9401	18.64
020011	0.9160	29.47
020012	1.2784	23.92
020013	0.9595	26.82
020014	1.1175	24.09

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
020014	1.4452	18.50
020017	1.4913	24.97
020018	0.9175	.....
020019	0.7991	.....
020021	0.7833	.....
020024	1.1070	22.73
020025	0.8911	27.15
020026	1.2510	.....
020027	0.9446	.....
030001	1.2609	19.47
030002	1.8047	21.41
030003	2.2773	23.68
030004	0.9879	17.73
030006	1.5274	17.64
030007	1.2554	18.56
030008	2.1835	.....
030009	1.2480	17.93
030010	1.3865	18.80
030011	1.4370	20.08
030012	1.2400	19.28
030012	1.3439	17.62
030013	1.2707	21.02
030014	1.5090	19.47
030016	1.2344	20.56
030017	1.4184	19.80
030018	1.8588	18.91
030019	1.2360	19.91
030022	1.4920	15.79
030023	1.4956	22.44
030024*	1.7461	21.86
030025	0.9555	17.67
030027	0.9637	17.56
030030	1.6444	21.62
030033	1.2359	16.84
030034	0.9867	19.09
030035	1.1565	19.72
030036	1.2807	18.94
030037	2.0840	21.43
030038	1.6154	22.08
030040	1.0766	17.97
030041	0.8876	17.44
030043	1.2210	20.58
030044	0.8783	16.47
030047	0.8953	19.69
030049	0.8732	19.09
030054	0.8646	14.49
030055	1.2321	18.28
030059	1.2861	21.05
030060	1.1438	16.77
030061	1.6876	17.35
030062	1.1773	17.48
030064	1.7545	18.54
030065	1.8106	19.93
030067	1.0273	15.62
030068	1.0198	17.35
030069	1.3658	19.00
030071	0.9615	.....
030073	1.0330	.....
030074	0.8723	.....
030075	0.8002	.....
030076	0.8839	.....

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
030077	0.8563	.....
030078	1.1466	.....
030079	0.9065	.....
030080	1.3765	19.99
030083	1.2782	23.64
030084	1.1334	.....
030085	1.4665	17.84
030087	1.6818	20.39
030088	1.3654	19.58
030089	1.6757	19.50
030092	1.5829	21.56
030093	1.4182	19.47
030094	1.2704	19.78
030095	1.1383	14.25
030099	0.9405	18.07
030100	2.0377	.....
030101	1.4091	.....
030102	2.6049	.....
040001	1.0898	15.57
040002	1.1548	14.09
040003	1.1009	14.00
040004	1.6240	17.29
040005	1.0392	12.88
040007	1.6923	19.52
040008	1.0369	12.70
040011	0.9437	12.27
040014	1.3239	15.39
040015	1.2153	14.60
040016	1.6757	17.54
040017	1.1681	14.95
040018	1.2213	17.56
040019	1.0343	25.71
040020	1.6155	14.81
040021	1.1803	16.28
040022	1.4732	16.00
040024	0.9967	15.73
040025	0.9089	10.95
040026	1.5803	18.24
040027	1.2533	14.54
040028	1.0058	12.84
040029	1.2994	17.78
040030	0.8774	14.15
040032	0.9640	13.33
040035	0.9449	11.21
040036	1.4553	17.91
040037	1.0573	13.48
040039	1.2280	13.84
040040	0.9016	17.43
040041	1.2600	13.36
040041	1.3395	22.59
040042	1.1970	14.66
040044	1.0388	11.44
040045	1.0120	18.77
040047	1.0272	16.39
040048	.....	15.82
040050	1.1538	11.79
040051	1.0863	16.28
040053	1.0741	15.82
040054	0.9793	15.04
040055	1.4239	16.10
040058	1.0515	15.67

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
040060	0.9756	11.47
040062	1.6588	17.28
040064	1.0572	12.40
040066	1.0456	17.64
040067	1.0993	13.49
040069	1.0282	16.11
040070	0.9322	15.48
040071	1.6635	16.12
040072	1.0381	15.84
040074	1.2312	17.38
040075	1.0116	12.75
040076	1.0811	18.55
040077	1.0517	12.46
040078	1.5208	17.86
040080	1.0062	15.74
040081	0.8665	10.68
040082	1.0845	16.51
040084	1.1071	17.25
040085	1.1521	15.78
040088	1.3888	15.67
040090	0.8936	17.55
040091	1.1718	17.04
040093	0.9205	12.90
040100	1.1466	14.97
040105	0.9914	14.24
040106	0.9670	15.40
040107	1.0684	19.62
040109	1.1501	13.98
040114	1.8323	18.31
040116	1.1343	19.57
040118	1.4187	17.43
040119	1.1546	14.62
040124	1.0493	17.25
040126	0.9485	11.68
040132	.....	13.18
040134	2.7108	.....
040135	2.3711	.....
050002	1.4958	27.60
050006	1.4137	19.53
050007	1.4826	29.54
050008	1.4218	25.86
050009	1.6817	26.25
050013	1.9898	24.85
050014	1.2086	24.53
050015	1.4488	25.38
050016	1.1530	20.15
050017*	2.0931	23.63
050018	1.3662	14.66
050021	.....	28.50
050022	1.6635	22.55
050024	1.3224	20.34
050025*	1.7835	20.30
050026*	1.5148	28.57
050028	1.3534	16.45
050029	1.4007	23.29
050030	1.3133	21.01
050033	1.4634	24.56
050036	1.7263	20.47
050038	1.3484	27.83
050039	1.6233	22.25
050040	1.1965	30.67

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
050042	1.2702	22.23
050043	1.4929	33.51
050045	1.2651	20.73
050046	1.1767	26.35
050047	1.5561	29.44
050051	1.1204	17.84
050054	1.1916	19.37
050055	1.2420	29.09
050056	1.3412	23.82
050057	1.6051	21.27
050058	1.4966	25.37
050060	1.5503	20.92
050061	1.4118	23.74
050063*	1.3493	23.07
050065	1.6823	21.18
050066	1.3020	21.42
050067	1.2472	21.30
050068	1.1039	28.48
050069	1.6089	29.30
050070	1.2353	32.60
050071	1.3248	33.14
050072	1.3875	32.97
050073	1.2629	34.61
050074	0.8073	.....
050075	1.3484	33.52
050076	2.0314	33.88
050077	1.5621	23.22
050078	1.2974	25.98
050079	1.4850	30.03
050082	1.6712	21.70
050084	1.6107	23.10
050088	0.9686	24.06
050089	1.3384	19.12
050090	1.2640	23.81
050091	1.0925	22.22
050092	0.8469	15.38
050093	1.5659	24.08
050095	.....	33.38
050096	1.1356	21.67
050097	1.5113	22.61
050099	1.4590	23.66
050100	1.6407	30.06
050101	1.3575	30.01
050102	1.3583	21.29
050103*	1.5762	25.38
050104	1.4490	25.44
050107	1.4605	21.76
050108	1.8355	26.46
050109	.....	26.48
050110	1.2159	20.18
050111	1.2944	21.74
050112	1.3623	26.31
050113	1.3163	27.73
050114	1.3788	25.91
050115	1.4961	20.94
050116	1.5241	24.81
050117	1.3978	20.44
050118	1.1846	23.94
050121	1.2928	18.94
050122	1.5685	.....
050124	1.2796	23.02

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
050125	1.3663	24.04
050126	1.4556	23.84
050127	1.2518	19.76
050128	1.6084	24.18
050129	1.7494	13.86
050131	1.2640	29.06
050132	1.3640	22.91
050133	1.2704	24.40
050135	1.4808	27.03
050136	1.3536	24.43
050137	1.2990	30.07
050138	2.0444	37.41
050139	1.2535	31.38
050140	1.3204	33.66
050144	1.4207	25.75
050145	1.3756	33.06
050146	1.5841	.....
050148	1.1044	21.06
050149	1.4969	21.91
050150	1.2679	23.48
050152	1.3293	28.42
050153	1.6402	29.59
050155	1.0988	22.94
050158	1.2998	27.67
050159	1.3323	25.21
050167	1.3726	21.68
050168	1.5375	24.56
050169	1.4739	24.64
050170	1.4500	22.20
050172	1.2520	17.70
050173	1.3744	23.33
050174	1.7008	31.21
050175	1.2719	27.38
050177	1.1869	20.25
050179	1.2306	19.29
050180	1.5813	32.19
050183	1.2743	19.98
050186	1.3455	21.91
050188	1.4391	27.44
050189	0.9661	23.24
050191	1.4683	19.96
050193	1.1582	23.73
050194	1.2312	28.27
050195	1.5639	34.54
050196	1.2815	16.69
050197	1.9562	31.26
050204	1.5299	24.39
050205	1.2841	24.02
050211	1.3183	31.15
050213	1.5713	20.73
050214	1.5448	20.87
050215	1.5700	29.63
050215	1.2334	23.00
050217	1.2876	19.89
050219	1.1425	25.47
050219	.....	26.32
050222	1.5157	27.04
050224	1.5832	23.79
050225	1.5625	20.93
050225	1.0612	20.15
050226	1.3274	24.24

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
050228	1.3089	30.16
050230	1.4112	25.30
050231	1.6440	25.63
050232	1.5636	23.38
050233	.....	31.40
050234	1.1512	27.98
050235	1.5544	25.86
050236	1.5146	26.27
050238	1.5288	24.00
050239*	1.5967	20.55
050240	1.5246	25.18
050241	1.1378	27.22
050242	1.4446	30.14
050243	1.5312	22.91
050245	1.5041	22.10
050248	1.2054	25.99
050251	1.1113	18.50
050253	1.4184	19.76
050254	1.1991	19.69
050256	1.7681	21.74
050257	0.9509	19.59
050260	0.9690	23.52
050261	1.2103	20.45
050262	1.8148	28.30
050264	1.3466	29.45
050267	1.6936	24.75
050270	1.3630	23.83
050272	1.3986	21.44
050274	0.9467	21.19
050276	1.1725	28.51
050276	1.4351	23.14
050277	1.4815	22.31
050278	1.5070	23.84
050279	1.2886	21.06
050280	1.6534	24.46
050282	1.3492	23.98
050286	0.9172	17.80
050289	1.7279	28.87
050290	1.6741	26.37
050291	1.1709	26.49
050292	1.1236	22.38
050293	1.0656	19.18
050295	1.4569	20.28
050296	1.2171	25.32
050298	1.3268	20.52
050299	1.3252	25.26
050300	1.4143	22.46
050301	1.2326	26.03
050302	.....	29.19
050305	1.5862	32.71
050307	1.2747	24.39
050308	1.5099	28.40
050309	1.2834	24.40
050310	.....	20.62
050312	1.9696	23.79
050313	1.1560	23.10
050315	1.3473	21.92
050317	.....	19.45
050320	1.2371	30.56
050324	2.0030	26.27
050327	1.6651	22.32

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
050329	1.2991	19.54
050331	1.3646	25.53
050334	1.7493	32.02
050335	1.4570	21.04
050336	1.3561	20.10
050342	1.2512	21.90
050343	0.9711	17.24
050348	1.7865	20.71
050349	0.8866	15.05
050350	1.4046	23.77
050351	1.4821	24.94
050352	1.3151	23.59
050353	1.6183	23.25
050355	0.8385	17.16
050357	1.3583	23.64
050359	1.2481	20.40
050360	1.4309	31.76
050366	1.3334	21.40
050367	1.2586	29.48
050369	1.3031	19.87
050373	1.4037	21.92
050376	1.4260	25.30
050377	1.0300	25.64
050377	0.8258	.....
050378	1.0916	22.24
050379	1.0223	16.90
050380	1.6105	30.58
050382	1.3610	21.00
050385	1.3408	25.92
050388	0.8708	13.20
050390	1.1966	22.39
050391	1.3438	22.42
050392	0.9321	21.93
050394	1.5689	22.32
050396	1.6448	23.63
050397	0.9378	20.77
050401	1.1055	17.78
050404	1.0623	19.28
050406	1.0266	17.12
050407	1.2842	30.12
050410	1.0721	16.47
050411	1.3571	32.24
050414	1.3002	24.34
050417	1.3224	21.89
050419	1.3788	23.12
050420	1.3048	22.68
050421	1.2343	.....
050423	1.0115	22.33
050424	1.8351	23.78
050425	1.2290	33.69
050426	1.3912	23.71
050427	0.9378	20.07
050430	1.0036	21.14
050432	1.5223	21.50
050433	0.9711	16.80
050434	1.0630	15.63
050435	1.1647	32.99
050436	1.0075	16.36
050436	0.9233	18.33
050438	1.7365	24.08
050440	1.2718	30.82

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
050441	1.9387	29.05
050443	0.8693	16.43
050444	1.3199	24.67
050446	0.8088	20.54
050447	1.0794	18.34
050448	1.1060	20.08
050449	1.2885	22.13
050454*	1.7746	28.69
050455	1.7950	19.92
050455	1.2816	23.39
050456	1.2213	17.62
050457	1.9135	31.18
050459	1.5161	37.09
050464	1.7086	22.31
050468	1.5610	23.17
050469	1.1462	19.84
050470	1.1450	17.03
050470	1.2419	24.35
050471	1.8998	24.29
050476	1.3673	23.14
050477	1.4363	27.71
050478	0.9815	23.05
050481	1.3946	22.95
050482	1.0697	16.93
050483	2.2575	21.60
050483	1.5954	26.32
050485	1.6061	23.70
050486	.....	24.50
050488	1.3254	32.86
050491	1.1970	24.15
050492	1.4174	21.42
050494	1.2385	25.41
050496	1.7580	33.02
050498	1.2265	24.87
050502	1.7255	22.63
050503	1.3465	23.59
050506	1.3628	21.22
050510	1.2780	33.46
050512	1.4414	34.31
050515	1.3431	35.04
050516	1.5018	25.14
050517	1.2038	20.37
050522	1.1580	31.73
050523	1.2445	28.42
050526	1.2949	23.19
050528	1.1896	18.69
050531	1.1101	20.73
050534	1.2830	23.31
050535	1.5228	24.23
050537	1.3702	22.21
050539	1.3242	22.78
050541	1.5636	34.62
050542	0.9778	19.06
050543	0.8445	20.38
050545	0.7605	27.57
050546	0.6961	27.76
050547	0.9021	27.08
050548	.....	26.59
050549	1.6004	27.34
050550	1.3676	25.54
050551	1.3528	24.05

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
050552	1.2749	22.87
050557	1.5186	21.92
050559	1.2852	24.67
050561	1.2134	33.93
050564	1.3221	24.51
050565	1.3123	22.88
050567	1.5510	24.23
050568	1.3424	20.73
050569	1.2039	24.94
050570	1.6495	24.50
050571	1.3940	24.37
050573	1.5642	25.14
050575	1.1445	.....
050577	1.3610	20.52
050578	1.2810	30.24
050579	1.4312	30.07
050581	1.4505	23.58
050583	1.6150	23.36
050584	1.2149	23.16
050585	1.2567	26.50
050586	1.3530	23.84
050588	1.2804	30.39
050590	1.3223	.....
050591	1.3152	22.29
050592	1.2657	26.05
050594	1.6258	22.78
050597	1.2269	22.78
050598	1.3408	28.11
050601	1.6473	32.87
050603	1.4112	22.61
050604	1.4593	33.32
050607	.....	24.10
050608	1.2805	16.15
050609	1.4876	31.93
050613	1.1408	22.73
050615	1.5445	23.61
050616	1.3408	22.80
050618	1.0867	21.70
050623	1.6040	30.32
050624	1.3287	20.88
050625	1.6313	24.43
050630	1.2732	24.10
050633	1.2945	21.98
050635	.....	37.85
050636	1.4342	20.83
050638	1.1056	23.63
050641	1.2985	21.30
050643	0.9493	.....
050644	1.0737	23.12
050660	1.4981	.....
050661	.....	20.48
050662	0.8152	28.29
050663	1.1713	23.71
050667	1.0811	24.11
050668	1.1187	39.90
050670	0.7555	21.88
050674	1.2384	36.24
050675	2.2195	15.84
050676	1.0018	17.53
050677	1.3671	33.71
050678	1.2889	19.79

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
050680	1.1161	27.32
050682	0.9235	17.97
050684	1.2411	21.81
050685	1.1904	32.13
050686	1.2873	33.25
050688	1.1889	30.00
050689	1.4877	34.19
050690	1.4194	33.83
050693	1.3143	33.30
050694	1.3869	22.23
050695	1.0637	23.52
050696	2.1089	26.41
050697	1.3282	21.47
050699	0.5913	28.48
050700	.....	28.45
050701	1.3166	27.62
050702	.....	12.25
050704	1.0850	20.76
050707	0.9714	27.51
050708	1.4521	21.91
050709	1.2542	19.42
050710	1.3382	26.81
050713	0.7909	15.30
050714	1.3545	.....
050715	.....	19.12
050717	1.2615	.....
050718	0.7586	.....
050719	3.1984	.....
050720	0.9144	.....
060001	1.6827	19.81
060003	1.2712	19.32
060004	1.2022	21.79
060006	1.2559	17.86
060007	1.1616	16.38
060008	1.0845	17.09
060009	1.5000	21.18
060010	1.6680	22.72
060011	1.3912	22.01
060012	1.3799	19.77
060013	1.3198	19.14
060014	1.8158	20.45
060015	1.6295	23.57
060016	1.1644	15.96
060018	1.2890	22.76
060020	1.6161	17.73
060022	1.5680	19.65
060023	1.6349	19.68
060024	1.7013	21.98
060027	1.6853	21.67
060028	1.5673	22.25
060029	0.8934	21.41
060030	1.3522	20.03
060031	1.5399	19.40
060032	1.4830	22.37
060033	1.1419	13.82
060034	1.5815	21.41
060036	1.1374	19.24
060037	1.0041	14.05
060038	0.9494	14.31
060041	0.9290	14.83
060042	1.0390	20.08

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
060043	0.8765	13.05
060044	1.1677	18.54
060046	1.0277	20.44
060047	0.9573	15.12
060049	1.3269	20.83
060050	1.2499	16.80
060052	1.0358	12.55
060053	1.0148	14.94
060054	1.4104	19.39
060056	0.9009	17.05
060057	1.0271	23.38
060058	0.9425	16.91
060058	1.3708	24.88
060060	0.9192	14.89
060062	0.8672	14.94
060063	.....	15.09
060064	1.4858	20.93
060065	1.2927	24.30
060066	0.9930	14.07
060068	.....	19.64
060070	1.1240	16.58
060071	1.2070	16.95
060073	0.9583	15.84
060075	1.2386	22.85
060076	1.4334	19.29
060087	.....	21.03
060088	1.0054	16.67
060090	0.9024	14.51
060096	1.1102	23.11
060100	1.5342	22.00
060103	1.3190	22.34
060104	1.2281	22.30
060107	1.1971	13.64
060109	1.0979	.....
070001	1.7556	26.51
070002	1.8370	25.46
070003	1.1151	26.09
070004	1.2021	17.57
070005	1.4405	25.57
070006	1.3841	28.71
070007	1.3504	20.38
070008	1.2547	26.03
070010	1.6964	25.94
070011	1.3837	18.74
070012	1.1748	23.84
070015	1.3856	21.37
070016	1.4249	26.23
070017	1.3692	25.33
070018	1.3688	28.88
070019	1.1852	24.70
070020	1.3279	25.66
070021	1.2354	27.20
070022	1.8624	25.08
070024	1.3266	24.98
070025*	1.8697	21.03
070026	.....	18.79
070027	1.3119	23.11
070028	1.5539	24.76
070029	1.3338	22.75
070030	1.2872	25.55
070031	1.2430	21.66

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
070033	1.4104	28.06
070034	1.3899	27.67
070035	1.4195	23.06
070036	1.7249	28.95
070038	0.7820	.....
070039	0.9541	29.07
080001	1.7050	25.28
080001	1.3001	16.14
080002	.....	15.60
080003	1.3859	22.40
080004	1.2655	19.76
080005	.....	14.43
080006	1.2940	22.26
080007	1.4146	20.38
090001	1.6063	25.97
090002	1.3508	19.70
090003*	1.3694	28.74
090004	1.7901	24.54
090006	1.3157	20.08
090007	1.3060	21.66
090008	1.5079	21.25
090010	1.0721	15.87
090011	2.1212	27.37
100001*	1.5321	17.59
100002	1.4384	21.32
100004	1.0139	15.25
100006	1.6140	20.63
100007	1.8868	21.89
100008	1.6004	20.72
100009	1.4674	24.29
100010	1.5057	21.91
100012	1.6358	18.17
100014	1.4840	19.83
100015	1.4801	18.24
100017	1.5926	17.77
100018	1.5487	21.46
100019	1.5570	19.81
100020	1.3913	26.18
100022*	1.7896	25.89
100023	1.3582	21.11
100024	1.3508	20.78
100025	1.7579	19.12
100026	1.5828	20.78
100027	1.0140	12.94
100028	1.2109	19.75
100029	1.3427	19.18
100030	1.2532	18.82
100032	1.8549	19.32
100034	1.7609	18.23
100035	1.5876	19.58
100038	1.6639	24.78
100039	1.5294	20.25
100040	1.7522	18.37
100043	1.3301	17.46
100044	1.3902	21.14
100045	1.3907	20.04
100046	1.4313	.....
100047	1.8501	18.89
100048	0.9391	13.50
100049	1.2657	18.57
100050	1.1486	16.60

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
100051	1.2376	18.84
100052	1.3877	16.19
100053	1.2157	18.71
100054	1.2782	18.19
100055	1.3757	17.62
100056	1.4971	23.65
100057	1.3578	18.92
100060	1.8350	22.39
100060	1.5612	21.03
100061	1.4669	21.79
100062	1.7286	17.96
100063	1.1599	16.23
100067	1.3589	17.40
100068	1.3616	18.65
100070	1.4351	20.33
100071	1.2326	16.48
100072	1.2524	19.22
100073	1.7197	18.16
100075	1.5968	18.05
100076	1.3003	16.25
100077	1.3909	19.62
100078	1.0296	18.15
100079	1.3325	.....
100080	1.6003	21.16
100081	1.1021	13.83
100082	1.4970	19.80
100084	1.3481	20.40
100085	1.4397	21.08
100086	1.2342	21.16
100087	1.8333	22.84
100088	1.6475	19.90
100088	1.3183	18.47
100090	1.3787	17.88
100092	1.5757	18.19
100093	1.5959	16.63
100098	1.0984	19.03
100099	1.2201	15.30
100102	1.0153	19.33
100103	0.9381	18.10
100105	1.4533	21.50
100106	1.0265	19.31
100107	1.3135	18.01
100108	0.9981	11.47
100109	1.3849	22.76
100110	1.3691	19.64
100112	0.9729	9.77
100113	1.9447	22.26
100114	1.3410	23.45
100117	1.1881	18.73
100118	1.2985	19.76
100121	1.1822	19.34
100122	1.2062	18.06
100124	1.2948	18.95
100125	1.2698	17.33
100126	1.4687	17.90
100127	1.6571	19.87
100128	2.2008	21.37
100129	1.2934	18.57
100130	1.1799	19.10
100131	1.3441	22.17
100132	1.2951	16.90

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
100134	0.9749	13.47
100135	1.5663	18.14
100137	1.2769	19.05
100138	1.0055	11.01
100139	1.0923	15.64
100140	1.2176	17.39
100142	1.2184	18.68
100144	1.1622	15.02
100145	.....	19.11
100146	0.9700	17.87
100146	1.3080	19.02
100147	1.0087	14.68
100150	1.3244	21.02
100151	1.7633	19.41
100154	1.5916	19.85
100156	1.1116	17.13
100159	0.9604	16.38
100160	1.2033	21.63
100161	1.7011	21.50
100162	1.3957	19.52
100165	1.1517	15.32
100166	1.4343	19.96
100167	1.3554	21.81
100168	1.3364	20.13
100169	1.7635	20.78
100170*	1.4176	15.12
100172	1.4427	15.18
100173	1.6517	17.34
100174	1.3757	20.51
100175	1.1552	16.74
100176	2.0762	24.70
100177	1.2940	22.00
100179	1.7112	20.91
100180	1.4416	18.48
100181	1.1072	24.57
100183	1.1925	20.84
100187	1.4354	20.69
100189	1.3293	21.01
100199	1.3519	23.37
100200	1.2394	22.26
100203	.....	18.86
100204	1.6275	19.93
100206	1.3738	20.31
100207	.....	15.92
100208	1.3742	20.83
100209	1.4794	19.73
100210	1.5725	19.18
100211	1.3995	25.53
100212	1.6223	25.34
100213	1.5101	19.12
100217	1.2750	19.87
100220	1.6359	19.82
100221	1.8123	27.48
100222	0.9440	21.20
100223	1.4649	18.76
100224	1.3348	24.70
100225	1.3371	20.64
100226	1.3524	24.83
100228	1.2825	23.70
100229	1.3301	18.21
100230	1.3524	20.60

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
100231	1.6807	17.40
100232	1.2520	17.32
100234	1.2585	21.58
100235	.....	17.66
100236	1.3919	15.54
100237	2.1914	22.93
100238	1.5456	17.63
100239	1.4273	19.76
100240	1.0888	17.93
100241	0.8966	13.83
100242	1.4285	17.12
100243	1.4081	20.24
100244	1.3741	17.41
100246	1.3684	21.10
100248	1.5873	31.86
100252	1.2004	17.87
100253	1.4328	20.60
100254	1.5393	20.91
100255	1.2547	21.02
100256	2.0100	24.26
100258	1.6900	21.88
100259	1.3406	19.86
100260	1.4566	21.20
100262	1.3401	19.59
100263	.....	16.90
100264	1.3627	17.61
100265	1.2933	19.80
100266	1.3562	17.73
100267	1.3062	17.10
100268	1.1954	23.59
100269	1.4338	21.20
100270	1.0126	19.86
100271	1.7709	19.92
100275	1.3951	21.33
100276	1.2359	21.98
100277	1.0352	16.14
100279	1.2735	21.84
100280	1.2949	16.58
100281	1.2798	22.02
100282	1.0837	18.66
100284	1.0788	.....
110001	1.2556	17.87
110002	1.2532	17.37
110003	1.3668	16.02
110004	1.3570	20.11
110005	1.1963	19.26
110006	1.4200	20.13
110007	1.6126	14.39
110008	1.2429	18.26
110009	1.1330	14.82
110010	2.1782	24.55
110011	1.1632	18.28
110013	1.0596	16.03
110014	0.9440	16.12
110015	1.1403	19.48
110016	1.2276	15.77
110017	0.9321	10.54
110018	1.1960	21.04
110020	1.1927	18.44
110023	1.3373	18.54
110024	1.3655	19.75

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
110025	1.3797	18.65
110026	1.1361	16.14
110027	1.1146	14.83
110028	1.7778	19.89
110029	1.3534	20.05
110030	1.2999	17.68
110031	1.2251	21.58
110032	1.2506	16.19
110033	1.4221	22.19
110034	1.5852	18.24
110035	1.3916	20.98
110036	1.8560	23.78
110038	1.4425	16.38
110039	1.4188	20.77
110040	1.0642	16.40
110041	1.1822	16.69
110042	1.1544	20.55
110043	1.8078	17.16
110044	1.1887	19.60
110045	1.1386	19.94
110046	1.2456	19.23
110048	1.2374	15.65
110049	1.0998	14.21
110050	1.1806	18.76
110051	1.0250	15.75
110052	.....	15.06
110054	1.3606	19.32
110056	1.0843	16.50
110059	1.2164	17.70
110061	1.0960	13.72
110062	0.9058	12.21
110063	1.0542	17.97
110064	1.4839	18.24
110065	1.0322	13.32
110066	1.4496	20.65
110069	1.2569	18.35
110070	1.1398	18.23
110071	1.0981	14.83
110072	0.9722	12.43
110073	1.1437	15.14
110074	1.4973	20.04
110075	1.3226	17.01
110076	1.4639	20.40
110078	1.7586	24.70
110079	1.4465	20.14
110080	1.3579	23.43
110082	2.0915	22.01
110083*	1.7615	21.27
110086	1.2837	14.98
110087	1.3551	20.54
110089	1.2041	18.58
110091	1.2791	21.38
110092	1.0878	15.09
110094	0.9920	13.87
110095	1.3537	15.95
110096	1.0806	16.32
110097	1.0653	15.62
110098	0.9870	14.04
110100	1.0558	20.38
110101	1.1014	11.73
110103	0.9309	11.94

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
110104	1.0963	15.32
110105	1.2997	16.52
110107	1.8897	17.41
110108	0.9511	15.14
110109	1.1080	20.99
110111	1.2038	17.37
110112	0.9917	19.13
110113	1.0478	15.19
110114	1.0441	15.13
110115	1.7526	24.79
110118	1.1376	15.40
110120	1.0386	16.08
110121	1.2784	15.58
110122	1.3818	18.82
110124	1.2091	17.13
110125	1.2562	17.33
110127	0.8873	13.76
110128	1.1933	18.97
110130	1.0064	13.08
110132	1.1478	15.02
110134	0.9656	11.56
110135	1.3363	17.07
110136	1.0986	16.17
110140	1.0445	17.88
110141	0.9996	12.51
110142	0.9525	12.30
110142	0.9525	12.30
110142	1.0382	12.54
110143	1.4339	21.45
110144	1.0712	17.98
110146	1.0854	17.61
110150	1.4073	18.77
110152	1.0430	14.77
110153	1.0912	18.69
110154	0.9773	14.81
110155	1.1399	17.14
110156	1.0511	15.14
110161	1.3149	20.87
110162	0.7514	.....
110163	1.4628	18.99
110164	1.4190	19.40
110165	1.4270	19.00
110166	1.4482	19.85
110168	1.6676	19.82
110169	1.2028	18.72
110171	1.6118	20.18
110172	1.3576	25.44
110174	0.9161	14.30
110176	3.7291	22.39
110177	1.5099	19.66
110178	.....	16.92
110179	1.1507	20.38
110181	0.9038	13.72
110183	1.3120	21.44
110184	1.2434	20.72
110185	1.1874	16.25
110186	1.2548	17.21
110187	1.2728	21.45
110188	1.3549	19.95
110189	1.1692	18.84
110190	1.0644	19.43

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
110191	1.3076	19.11
110192	1.4458	20.77
110193	1.2436	18.78
110194	0.8938	15.09
110195	1.0992	10.52
110198	1.2884	26.19
110200	1.8855	17.14
110201	1.5094	19.24
110203	0.9314	20.30
110204	0.8249	20.57
110205	1.0578	26.12
110207	1.0103	12.87
110208	0.9617	14.89
110209	0.7100	20.46
110209	0.9560	17.78
110210	.....	11.07
110211	0.9611	21.82
110212	1.0043	12.66
110213	.....	13.20
110215	1.0941	.....
110216	2.1653	.....
110217	2.8336	.....
120001*	1.8196	26.74
120002	1.2037	24.38
120003	1.1393	23.85
120004	1.2630	24.05
120005	1.2464	20.54
120006	1.2735	23.72
120007	1.7320	23.27
120009	0.9632	19.02
120010*	1.8265	25.40
120011	1.3581	33.55
120012	0.8391	22.52
120014	1.2760	24.05
120016	1.0574	29.41
120018	.....	25.61
120019	1.3200	21.92
120019	0.9579	14.67
120021	0.9290	19.42
120022*	1.6850	17.94
120022*	1.6850	17.94
120022*	1.2230	15.96
120022*	1.2230	15.96
120024	1.0727	22.28
120025	.....	19.02
120026	1.2644	23.22
120027	1.4120	24.55
120028	1.2471	22.84
130001	0.9699	24.95
130002	1.3252	16.19
130003	1.3332	19.97
130005	1.4390	20.19
130006	1.8346	18.87
130007	1.6708	19.84
130008	0.9590	12.92
130009	0.9294	18.30
130010	0.8911	21.43
130011	1.2864	19.08
130012	0.9929	22.62
130013	1.3310	19.22
130014	1.3257	17.98

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
130015	0.8827	15.27
130016	1.0155	17.00
130017	1.1012	16.88
130018	1.6256	17.97
130019	1.1193	17.23
130021	0.9513	12.26
130022	1.2324	19.50
130024	1.1558	18.38
130025	1.0970	15.27
130026	1.1726	20.55
130027	0.9243	20.70
130028	1.2865	18.21
130029	1.0707	19.87
130030	0.8409	18.40
130031	1.0121	17.65
130034	1.0325	18.82
130034	1.8152	18.40
130035	1.1048	20.47
130036	1.3946	13.79
130037	1.3076	17.74
130043	0.9605	16.07
130044	0.9724	13.18
130045	0.9752	16.47
130048	0.9815	15.09
130049	1.2325	20.05
130049	1.5824	20.72
130056	0.8528	15.66
130058	.....	17.75
130060	1.2796	20.85
130061	1.2950	16.78
130061	1.1145	17.32
130062	0.6352	15.11
130063	1.3116	.....
140001	1.2277	15.44
140002	1.2578	19.26
140003	1.0026	16.59
140004	1.1657	17.52
140005	0.9695	10.87
140007	1.4700	22.40
140007	1.4015	21.54
140008	1.4683	20.79
140010	1.3722	24.43
140011	1.2029	17.28
140012	1.2779	20.11
140013	1.5702	17.35
140014	1.1734	20.76
140015	1.2861	15.02
140018	1.2551	20.84
140019	1.1122	15.34
140025	1.0822	16.43
140027	1.2700	17.50
140027	1.3076	18.47
140029	1.3389	21.03
140030	1.8231	22.44
140031	1.2022	15.82
140032	1.3343	17.34
140033	1.2879	22.56
140034	1.1842	18.96
140035	0.9867	13.00
140036	1.2425	17.04
140036	1.1031	25.40

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
140037	1.0365	12.50
140038	1.1040	16.59
140040	1.2582	16.25
140041	1.1609	17.28
140042	1.0170	15.61
140043	1.1892	18.95
140045	1.0337	20.65
140046	1.3056	16.46
140047	1.0942	15.68
140048	1.3053	20.58
140049	1.6549	18.31
140051	1.5123	21.59
140052	1.3010	19.60
140053	2.0144	17.82
140054	1.3340	26.64
140055	1.0128	14.80
140058	1.2361	17.27
140059	1.1346	15.39
140061	1.0918	15.96
140062	1.2453	27.09
140063	1.4369	22.39
140064	1.3182	19.26
140065	1.4623	22.75
140066	1.1771	16.14
140068	1.2906	18.87
140069	1.0478	17.29
140070	1.2528	19.30
140074	1.0760	19.01
140075	1.3678	22.51
140077	1.2460	16.64
140079	1.2649	24.08
140081	1.0822	15.51
140082	1.3677	22.62
140083	1.2487	18.13
140084	1.2530	19.97
140087	1.3481	18.36
140088	1.7061	24.19
140089	1.2734	17.21
140090*	1.5241	22.31
140091	1.9064	20.70
140093	1.1684	19.15
140094	1.3427	19.89
140097	0.9518	16.90
140100	1.3290	19.06
140101	1.2258	26.09
140102	1.0431	15.13
140103	1.4249	17.86
140105	1.2912	22.56
140107	1.0115	12.76
140108	1.3343	30.11
140109	1.1455	15.47
140110	1.2406	18.68
140112	1.1571	16.24
140113	1.5610	17.92
140114	1.3330	20.11
140116	1.2349	21.83
140117	1.5621	19.72
140118	1.7257	23.06
140119	1.7733	26.00
140120	1.3738	14.84
140121	1.3603	9.53

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
140122	1.5424	23.75
140125	1.3486	17.10
140127	1.4176	19.42
140128	1.0297	17.67
140129	1.1653	15.25
140130	1.2502	23.77
140132	1.4907	22.86
140133	1.4008	19.88
140135	1.2769	17.69
140137	1.0216	16.51
140138	1.0656	14.59
140139	1.1054	16.58
140140	1.1358	15.30
140141	1.2625	15.18
140143	1.0965	18.76
140144	0.9972	20.02
140145	1.1515	16.61
140146	1.0726	23.74
140147	1.2513	24.82
140148	1.8284	19.50
140150	1.6430	27.88
140151	1.0622	19.30
140152	1.1938	20.67
140155	1.3261	17.52
140158	1.3600	22.27
140160	1.1729	17.88
140161	1.2205	19.04
140162	1.6991	18.42
140164	1.4369	18.09
140165	1.0868	15.42
140166	1.1672	17.58
140167	1.0995	16.17
140168	1.1300	16.46
140170	1.1305	14.14
140171	0.9892	14.73
140172	1.5894	20.07
140173	0.8708	18.48
140174	1.6068	19.89
140176	1.2498	21.41
140177	1.2111	18.17
140179	1.3636	20.88
140180	1.4489	23.25
140181	1.4225	19.95
140182	1.3614	20.48
140184	1.2130	15.88
140185	1.4938	17.36
140186	1.3433	17.49
140187	1.5860	17.72
140188	0.9891	14.84
140189	1.2539	19.08
140190	1.0732	15.88
140191	1.4402	24.74
140193	1.0284	15.52
140197	1.2538	17.98
140199	1.0796	18.83
140200	1.4770	21.65
140202	1.3288	22.18
140203	1.1563	20.78
140205	0.9505	17.24
140206	1.2043	20.39
140207	1.2975	20.20

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
140208	1.7189	23.94
140209	1.6299	17.79
140210	1.1139	12.66
140211	1.2088	21.49
140213	1.2799	26.20
140215	0.9874	14.45
140217	1.3239	22.26
140218	0.9885	15.08
140220	1.1219	16.73
140223	1.5500	21.28
140224	1.4304	22.99
140228	1.6774	18.67
140230	0.9389	16.60
140231	1.5601	21.61
140233	1.7821	18.39
140234	1.2228	18.72
140236	1.0843	13.13
140239	1.7286	18.88
140240	1.3944	21.83
140242	1.6388	22.64
140246	1.0612	12.82
140250	1.3284	23.41
140251	1.3090	20.54
140252	1.4991	24.55
140253	1.1636	16.74
140258	1.5756	16.51
140271	0.9729	15.36
140275	1.2733	17.96
140276	2.0648	25.46
140280	1.3777	18.84
140285	1.2740	14.71
140286	1.1868	19.84
140288	1.6194	20.59
140289	1.3449	16.45
140290	1.3397	25.88
140291	1.3337	22.44
140292	1.2935	22.71
140297	.....	21.47
140300	1.4604	23.46
150001	1.1062	21.70
150002	1.4495	18.66
150003	1.7952	19.31
150004	1.5197	19.70
150005	1.1497	19.00
150006	1.2614	20.04
150007	1.1968	19.53
150009	1.3657	17.53
150010	1.3618	18.48
150011	1.2157	19.19
150012	1.6189	20.52
150013	1.1006	16.00
150014	1.6067	21.28
150015	1.2931	22.06
150017	1.9040	18.89
150018	1.4570	18.62
150019	1.0936	15.29
150020	1.1517	14.46
150021	1.6877	.....
150022	1.0903	17.92
150023	1.5766	18.71
150024	1.3391	17.83

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
150025	1.4398	18.15
150026	1.2090	20.51
150029	1.3389	21.74
150030	1.2446	17.33
150031	1.0811	18.01
150032	.....	20.64
150033	1.5737	21.69
150034	1.4854	21.29
150035	1.4921	19.82
150036	0.9960	20.38
150037	1.2881	17.79
150039	1.0016	17.42
150042	1.2830	17.12
150043	1.1042	17.98
150044	1.2625	17.64
150044	1.2486	18.32
150045	1.0927	17.04
150046	1.3943	17.32
150047	1.5983	20.57
150048	1.1912	16.96
150049	1.2166	16.85
150050	1.1659	17.14
150051	1.5099	18.20
150052	1.0909	15.36
150053	0.9867	18.75
150054	1.1350	17.33
150054	1.0816	15.23
150056	1.8874	23.30
150057	2.2401	16.86
150058	1.7056	20.94
150059	1.3586	20.80
150060	1.1860	16.01
150061	1.2108	17.21
150062	1.1076	18.41
150063	1.0891	21.09
150064	1.1810	16.88
150065	1.1695	19.01
150066	1.0226	14.60
150067	1.1260	17.08
150069	1.2233	17.39
150070	0.9579	17.20
150071	1.0955	14.73
150072	1.1997	16.11
150073	1.0623	19.03
150074	1.6321	18.80
150075	1.1204	14.98
150076	1.1815	22.34
150077	0.8126	17.58
150078	1.0515	19.01
150079	1.1737	15.45
150082	1.5261	17.88
150084	1.9911	22.92
150086	1.2506	17.34
150088	1.3443	19.45
150089	1.4584	22.79
150090	1.3311	19.06
150091	1.0358	19.89
150092	1.0071	15.92
150094	0.9754	18.34
150095	1.0873	17.12
150096	1.0067	20.03

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
150097	1.0922	18.31
150098	1.1583	14.30
150099	.....	19.05
150100	1.6560	17.45
150101	1.0932	17.56
150102	1.0786	11.50
150103	0.9709	17.31
150104	1.1262	17.26
150105	1.3363	19.17
150106	1.0512	18.91
150109	1.3950	18.23
150109	0.9960	14.44
150110	0.9833	18.58
150111	1.1623	16.17
150112	1.2432	19.82
150113	1.2363	19.30
150114	0.9759	16.96
150115	1.3380	17.06
150122	1.1564	19.35
150123	1.1155	15.16
150124	1.0883	15.07
150125	1.4626	20.31
150126	1.4875	20.33
150126	1.0382	15.85
150127	1.0281	22.81
150129	1.1879	23.39
150130	1.3446	16.19
150132	1.4200	19.37
150132	1.4200	19.37
150133	1.1908	16.49
150134	1.1980	17.06
150136	0.9556	19.28
160001	1.2605	19.03
160002	1.0936	15.37
160003	0.9983	15.77
160007	1.0218	15.66
160008	1.1414	14.97
160009	1.2218	16.09
160012	1.0466	16.54
160013	1.1370	17.06
160014	1.0250	15.09
160014	1.0321	14.26
160016	1.1679	18.37
160018	0.9632	14.16
160020	1.0694	13.91
160021	1.1170	15.49
160023	1.0888	14.20
160024	1.6094	18.95
160026	1.0266	18.66
160027	1.0851	15.74
160028	1.2340	20.44
160029	1.5289	20.40
160030	1.3882	17.99
160031	1.1181	15.28
160032	1.1544	16.18
160033	1.9173	18.37
160034	1.1493	14.51
160035	0.8438	15.92
160036	1.0544	18.91
160037	1.0584	18.40
160039	1.0389	17.63

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
160040	1.2661	16.83
160041	1.0648	15.58
160043	0.9893	15.63
160044	1.2182	16.04
160045	1.8186	20.12
160046	1.0239	14.77
160047	1.3703	16.93
160048	1.2473	13.14
160049	0.9262	13.36
160050	1.0709	16.42
160051	0.8978	14.27
160052	0.9936	17.55
160054	1.0281	15.71
160055	0.9846	14.06
160056	1.0679	15.38
160057	1.2435	17.41
160058	1.8383	20.34
160060	1.0430	15.95
160061	1.0815	17.57
160063	1.1620	16.30
160064	1.5348	19.94
160065	1.0510	16.51
160066	1.1016	16.26
160067	1.4226	17.85
160068	1.0237	15.85
160069	1.5362	18.49
160070	0.9937	15.66
160072	1.0339	14.19
160073	0.9954	15.05
160075	1.0796	17.89
160076	1.0993	17.31
160077	1.1152	11.40
160079	1.4125	17.71
160079	1.4017	16.15
160081	1.1531	16.51
160082	1.9254	18.80
160083	1.6684	18.41
160085	1.0030	18.55
160086	0.9493	16.46
160088	1.1546	17.53
160089	1.1915	16.74
160090	1.0124	16.60
160091	1.0383	12.19
160092	1.0124	15.80
160093	1.0155	15.95
160094	1.1043	16.56
160097	1.0774	15.21
160098	0.9397	15.54
160099	0.9650	13.79
160101	1.0852	17.87
160102	1.3435	18.36
160103	0.9416	17.15
160104	1.3010	19.76
160106	1.1089	16.66
160107	1.1508	16.56
160108	1.0237	15.42
160109	1.0167	16.49
160110	1.5117	19.93
160111	0.9983	13.17
160112	1.3773	16.28
160113	1.0930	14.58

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
160114	0.9786	14.95
160115	0.9774	15.76
160116	1.1196	16.69
160117	1.4123	17.29
160118	0.9961	15.84
160120	0.9938	12.56
160122	1.1131	18.52
160124	1.2998	17.16
160126	0.9654	17.74
160129	0.9727	15.89
160130	1.1286	15.45
160131	1.0444	14.69
160134	0.9506	13.32
160135	1.0170	16.33
160138	1.0149	15.71
160140	1.1324	18.80
160142	1.0194	16.14
160143	1.1242	15.92
160145	1.0697	15.17
160146	1.4409	13.50
160147	1.2762	18.39
160151	1.0545	15.74
160152	0.9384	15.22
160153	1.7613	19.69
170001	1.2074	17.52
170004	1.0753	13.06
170006	1.1961	19.31
170008	1.0034	13.90
170009	1.1438	19.59
170010	1.3587	17.90
170012	1.4141	16.76
170013	1.2829	17.89
170014	1.0333	17.34
170015	0.9812	16.34
170016	1.7067	18.60
170017	1.2014	17.87
170018	1.1012	14.36
170019	1.2360	16.56
170022	1.0526	17.85
170023	1.4684	19.36
170024	1.0663	13.06
170025	1.1917	16.37
170026	1.0818	13.89
170027	1.3172	16.39
170030	1.0591	15.24
170031	0.8922	13.47
170032	1.0128	14.48
170033	1.4150	16.05
170034	1.0335	15.02
170035	0.8966	15.62
170036	.....	14.17
170038	0.8998	14.21
170039	1.0943	14.30
170040	1.5837	17.97
170041	1.0521	11.47
170044	0.9951	14.78
170045	1.0889	12.11
170049	1.3499	18.64
170051	0.9890	14.16
170052	1.0435	14.62
170053	0.9336	9.03

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
170054	1.0324	12.77
170055	0.9801	14.99
170056	0.8854	14.87
170057	.....	15.09
170058	1.1572	18.17
170060	1.0218	17.23
170061	1.1583	14.14
170063	0.8974	11.49
170064	.....	12.42
170066	0.9451	14.48
170067	0.9987	12.71
170068	1.2647	15.82
170070	1.0543	13.37
170072	0.9012	13.34
170073	1.0417	16.47
170074	1.2016	14.40
170075	0.9266	11.26
170076	1.0220	13.58
170077	0.9136	13.11
170079	0.9666	14.21
170080	0.9657	12.20
170081	0.9118	12.51
170082	0.9428	12.39
170084	0.8978	12.16
170085	0.8828	14.51
170086	1.6770	19.85
170088	0.9319	11.37
170089	0.9738	18.08
170090	0.9616	11.27
170092	.....	12.85
170093	0.8913	12.79
170094	0.9571	17.71
170095	1.0123	15.75
170097	0.9071	15.66
170098	1.1366	14.10
170099	1.1582	13.55
170100	.....	14.47
170101	0.9709	13.16
170102	0.9675	13.35
170103	1.3238	16.66
170104	1.4841	19.76
170105	1.0598	15.93
170106	0.9341	14.68
170109	0.9347	16.87
170110	0.9851	15.55
170112	1.1373	13.39
170113	1.0737	13.25
170114	0.9511	14.51
170115	0.9965	13.03
170116	1.0601	15.76
170117	0.9782	15.28
170119	0.9547	13.97
170120	1.2724	15.91
170122	1.7580	18.62
170124	0.9913	10.21
170126	0.9316	12.13
170128	0.9622	14.99
170131	.....	13.10
170133	1.1289	16.90
170134	0.8746	12.90
170137	1.1809	17.42

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
170139	0.9898	13.28
170142	1.3140	17.32
170143	1.1148	15.88
170144	1.5078	16.09
170145	1.1143	16.75
170146	1.4429	19.97
170147	1.1965	16.28
170148	1.3707	17.25
170150	1.1488	15.43
170151	0.9381	13.37
170152	1.0039	13.68
170160	0.9959	13.31
170164	0.9827	15.25
170166	1.1079	17.57
170171	1.0545	13.81
170175	1.3046	16.60
170176	1.6707	20.32
170182	1.4297	14.20
170183	1.9808	19.09
170184	.....	27.01
180001	1.3847	19.52
180002	1.0822	18.13
180004	1.1128	15.99
180005	1.1971	20.63
180006	0.9090	11.23
180007	1.4645	17.20
180009	1.3630	20.81
180010	1.9327	17.55
180011	1.3163	16.93
180012	1.4400	18.74
180012	0.8766	13.61
180013	1.4541	17.35
180014	1.6943	19.54
180016	1.3332	18.84
180017	1.3056	15.17
180018	1.2982	18.92
180019	1.1910	16.76
180020	1.1105	17.78
180021	1.0495	15.16
180023	0.9502	15.22
180024	1.4092	15.33
180025	1.2023	17.17
180026	1.2026	14.16
180027	1.2506	14.89
180028	1.0909	19.35
180030	1.1726	17.02
180031	1.1189	13.79
180032	1.0597	16.09
180033	1.0978	13.77
180034	1.0888	17.32
180035	1.6441	19.45
180036	1.1569	19.12
180037	1.3126	19.85
180038	1.4604	16.19
180040*	1.9257	19.33
180041	1.1796	15.17
180042	1.1689	16.29
180043	1.1236	16.76
180044	1.1974	17.82
180045	1.4022	17.73
180046	1.0438	17.91

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
180047	0.9987	15.04
180048	1.2470	19.58
180049	1.3488	16.08
180050	1.2186	18.48
180051	1.3835	15.68
180053	1.0555	14.63
180054	1.0903	16.39
180055	1.2207	14.64
180056	1.1035	16.62
180058	1.0460	14.36
180059	0.8719	14.26
180060	.....	7.21
180063	1.0712	11.91
180064	1.1788	14.49
180065	1.0766	14.41
180066	1.0776	18.56
180067	1.8904	18.53
180069	1.1224	17.30
180070	1.1057	13.84
180072	1.1158	17.85
180075	.....	15.07
180078	1.0782	19.16
180079	1.1805	13.41
180080	1.0799	16.48
180087	1.2301	14.97
180088	1.6075	21.86
180088	1.4138	21.69
180092	1.2224	16.31
180093	1.4101	16.70
180094	1.0268	12.51
180095	1.1318	13.40
180099	1.0392	13.29
180101	1.1741	19.56
180102	1.4371	17.88
180103	2.3154	19.79
180104	1.5469	19.20
180105	0.8827	14.00
180108	0.8257	14.62
180115	0.9594	17.11
180116	1.2331	16.94
180117	1.1147	18.38
180118	0.9643	12.15
180120	1.0167	17.81
180121	1.1698	14.51
180122	1.0642	16.97
180123	1.3539	18.53
180124	1.3287	18.41
180125	1.1259	19.73
180126	1.1152	12.40
180127	1.2902	17.35
180128	1.0669	17.05
180129	0.9818	17.86
180130	1.4359	19.11
180132	1.2721	17.26
180133	1.3322	21.66
180134	1.0885	13.63
180136	1.8166	17.71
180138	1.1992	18.51
180139	1.0560	18.77
180140	0.9768	20.40
180141	1.8575	19.04

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
180141	1.1972	12.59
180142	1.7800	.....
190001	0.8866	16.91
190002	1.6874	18.84
190003	1.3295	22.15
190004	1.4230	17.54
190005	1.5174	16.71
190006	1.4666	17.73
190007	1.0552	13.60
190008	1.6186	16.89
190009	1.2882	14.21
190010	1.2081	17.02
190011	1.1424	15.17
190013	1.3002	16.57
190014	1.1875	17.02
190014	0.9519	12.03
190015	1.2666	17.44
190017	1.3398	15.79
190018	1.1056	16.98
190019	1.7887	17.40
190020	1.1956	17.31
190025	1.3076	16.07
190026	1.5552	17.21
190027	1.5165	16.19
190029	1.1492	17.11
190033	0.9722	10.74
190034	1.1705	16.68
190036*	1.6847	19.96
190037	0.9649	12.02
190039	1.4112	17.17
190040	1.3287	20.32
190041	1.6088	17.90
190043	1.0328	12.57
190044	1.1661	17.20
190046	1.4251	19.35
190048	1.1957	16.34
190049	0.9392	16.42
190050	1.0736	15.38
190053	1.1486	12.50
190054	1.2942	16.47
190059	0.8905	15.84
190060	1.3931	18.37
190064	1.5246	19.90
190065	1.4989	19.39
190071	0.8369	13.59
190077	0.8858	12.83
190078	1.1110	13.50
190079	1.3557	17.29
190081	0.8865	12.02
190083	1.0658	16.14
190086	1.3284	14.93
190088	1.2141	19.63
190089	1.1099	12.79
190090	1.0416	16.56
190092	.....	18.07
190095	0.9939	15.73
190098	1.5397	19.22
190099	1.1795	18.92
190102	1.6352	15.80
190103	0.9074	15.57
190106	1.1251	17.75

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
190109	1.2494	14.53
190110	0.9774	11.08
190111*	1.5870	20.05
190112	1.6970	19.21
190113	1.3935	18.99
190114	1.0147	12.91
190115	1.2775	20.49
190118	0.9963	12.95
190120	0.9962	13.69
190122*	1.2965	14.84
190124	1.6278	22.38
190125	1.4991	18.63
190128	1.1982	19.71
190130	0.9925	12.43
190131	1.2614	19.60
190133	1.0847	13.48
190134	1.0023	12.68
190135	1.4331	20.93
190136	0.9971	11.33
190138	.....	22.71
190142	0.9232	14.98
190144	1.1836	16.84
190145	0.9751	13.99
190146	1.5262	20.09
190147	0.9769	14.32
190148	0.9448	14.02
190149	0.9966	15.19
190151	1.0782	11.92
190152	1.5096	20.40
190155	.....	11.08
190156	0.9565	12.48
190158	1.2674	19.62
190160	1.2596	18.47
190161	1.0853	12.58
190162	1.2971	17.97
190164	1.1850	16.33
190167	1.1284	16.29
190170	0.9050	13.58
190173	1.3272	18.83
190175	1.4238	20.69
190176	1.6021	16.67
190177	1.7143	20.32
190178	0.9276	10.49
190182	1.3004	20.03
190183	1.1923	16.11
190184	0.9965	14.86
190185	1.3089	19.37
190186	0.9403	16.36
190189	.....	26.54
190190	0.9141	18.68
190191	1.1473	18.14
190196	0.9516	14.87
190197	1.1818	17.92
190199	1.0597	12.58
190200	1.4899	19.41
190201	1.0997	19.14
190202	1.1256	17.90
190203	1.4061	21.43
190204	1.4939	21.21
190205	1.9208	18.10
190206	1.6291	19.82

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
190207	1.2579	17.67
190208	0.8059	14.61
190218	1.0606	18.16
190223	.....	19.26
190227	1.0049	12.11
190231	1.5614	16.89
190235	.....	16.80
190236	1.4216	22.18
190237	2.4934	.....
190238	1.6330	.....
190239	1.1544	.....
190240	0.9642	.....
200001	1.3472	17.49
200002	1.1142	18.77
200003	1.0982	16.74
200006	1.0868	16.34
200007	1.0197	17.62
200008	1.2216	20.50
200009	1.8812	20.62
200012	1.1783	17.01
200013	1.1139	16.49
200015	.....	20.11
200016	1.0407	17.66
200017	.....	19.70
200018	1.2072	17.24
200019	1.2519	18.48
200020	1.1541	20.60
200021	1.1958	18.88
200023	0.8402	14.92
200024	1.4798	18.65
200025	1.2493	19.07
200026	0.9915	17.28
200027	1.2369	18.28
200028	0.9205	16.93
200031	1.2258	15.90
200032	1.3282	17.92
200033	1.7813	21.40
200034	1.2763	19.13
200037	1.2272	18.24
200038	1.1414	19.21
200039	1.2559	20.29
200040	1.1170	19.13
200041	1.1252	17.66
200043	0.8031	16.54
200050	1.2072	18.08
200051	0.9896	19.48
200052	0.9958	15.12
200055	1.0875	17.13
200062	0.9507	16.51
200063	1.2430	19.67
200066	1.1419	16.32
210001	1.4438	18.73
210002	2.0439	22.84
210003	1.6821	25.37
210004	1.3607	23.44
210005	1.2933	19.62
210006	1.1140	17.77
210007	1.8016	21.54
210008	1.3069	19.50
210009	1.8548	21.81
210010	1.1378	26.83
210011	1.3632	21.24
210012	1.6193	23.43
210013	1.3591	18.85
210015	1.3063	16.69
210016	1.8523	22.01
210017	1.2499	17.17
210018	1.2636	21.41
210019	1.6163	19.09
210022	1.4875	21.32
210023	1.4502	21.80
210024	1.6941	19.56
210025	1.3279	19.57
210026	1.3217	11.64
210027	1.2802	18.49
210028	1.1693	18.86
210029	1.2777	21.43
210030	1.2555	21.02
210031	1.3110	15.59
210032	1.1730	18.50
210033	1.2407	19.91
210034	1.3165	16.12
210035	1.3414	20.61
210037	1.2643	18.74
210038	1.4181	23.26
210039	1.1915	20.73
210040	1.3180	25.08
210043	1.2815	40.60
210044	1.3645	22.24
210045	1.0892	9.88
210048	1.2893	22.39
210049	1.1702	17.67
210051	1.4024	20.76
210054	1.3673	23.51
210055	1.3658	20.09
210056	1.3928	20.94
210057	1.3587	22.57
210058	1.5007	21.37
210059	1.1847	23.13
210060	1.2753	.....
210061	1.1313	20.02
220001	1.2879	26.32
220002	1.4678	22.58
220003	1.1104	19.14
220004	.....	20.01
220006	1.3867	22.04
220008	1.2973	21.89
220010	1.3481	22.06
220011	1.0947	23.85
220012	1.3117	28.24
220015	1.1691	21.73
220016	1.3445	21.30
220017	1.3512	24.90
220019	1.1561	19.13
220020	1.2448	20.00
220023	0.6351	18.76
220024	1.2167	21.59
220025	1.1442	19.94
220028*	1.4573	22.18
220029	1.1595	21.19
220030	1.1073	14.54
220031	1.9074	22.82
220033	1.2602	20.83
220035	1.3063	22.00
220036	1.6289	24.16
220038	1.3130	23.31
220041	1.1893	22.83
220042	1.2662	25.28
220046	1.3199	23.90
220049	1.2823	17.27
220050	1.1667	20.83
220051	1.1784	20.48
220052	1.2993	23.01
220053	1.1637	21.27
220055	1.2850	21.57
220055	1.2703	19.76
220057	1.3594	21.93
220060	1.2295	26.98
220062	0.5638	20.06
220063	1.2671	20.91
220064	1.2833	17.90
220065	1.3711	20.10
220066	1.3459	19.43
220067	1.2869	25.74
220068	.....	6.45
220070	1.2165	16.72
220071	1.9239	24.67
220073	1.3015	26.08
220074	1.3358	15.22
220075	1.7972	19.96
220076	1.2501	20.83
220077	1.8283	24.48
220079	1.0997	21.01
220080	1.3044	17.16
220081	0.9163	25.77
220082	1.2658	20.02
220083	1.1887	20.93
220084	1.2481	24.66
220086	1.7933	30.00
220088	1.6455	22.71
220089	1.2583	21.81
220090	1.2260	21.42
220092	1.1838	17.04
220094	.....	21.99
220095	1.1894	21.45
220098	1.3175	20.34
220098	1.2347	20.43
220100	1.3674	25.39
220101	1.4449	24.15
220104	1.4666	26.76
220105	1.2706	21.69
220106	1.2167	24.34
220107	.....	20.14
220108	1.1915	22.52
220110	2.1015	29.15
220111	1.2455	23.07
220116	1.9143	27.64
220118	.....	30.02
220119	1.2616	22.78
220123	1.0317	17.74
220126	1.2498	20.96
220128	.....	21.92
220133	0.7187	24.34

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
220135	1.2824	25.08
220153	1.0071	15.97
220154	0.9023	14.84
220162	1.4831	.....
220163	2.0302	27.35
220171	1.6811	23.43
230001	1.1539	19.20
230002	1.2731	21.91
230003	1.1409	19.61
230004	1.6874	22.42
230005	1.2532	19.40
230006	1.0501	18.47
230007	.....	19.43
230012	0.9650	18.67
230012	1.9036	23.94
230013	1.3748	20.12
230015	1.0768	20.43
230017	1.6133	20.40
230019	1.5299	19.05
230020	1.7464	21.04
230021	1.5000	18.57
230021	1.1691	18.89
230024	1.4282	27.96
230027	1.0357	18.03
230029	1.5743	21.12
230030	1.3405	17.29
230031	1.4291	17.00
230032*	1.7456	20.08
230034	1.2673	17.23
230035	1.0750	17.56
230035	1.6288	23.05
230036	1.2559	21.76
230037	1.1615	19.07
230038	1.7574	23.40
230040	1.1346	20.39
230041	1.2536	19.03
230042	1.2327	19.49
230046	1.9231	25.91
230047	1.3568	20.64
230053	1.5887	22.22
230054	1.8405	19.54
230055	1.1698	19.84
230056	0.8968	16.41
230058	1.1023	18.23
230059	1.4582	18.96
230060	1.3307	17.87
230062	0.9642	16.30
230063	1.2587	20.22
230065	1.3139	21.28
230066	1.3669	21.51
230069	1.1982	22.49
230070	1.6490	20.06
230071	1.1156	22.16
230075	1.5045	19.43
230076	1.4082	23.82
230077	2.0553	20.39
230078	1.1150	16.25
230078	1.1358	15.56
230080	1.2452	18.91
230081	1.2102	18.04
230082	1.1207	17.74

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
230085	1.2359	17.54
230086	0.9482	16.98
230087	1.0847	15.77
230089	1.2859	21.39
230092	1.3590	18.96
230093	1.2299	19.99
230095	1.1731	16.78
230096	1.1072	22.56
230097	1.6199	20.10
230099	1.1231	20.25
230100	1.1427	13.11
230101	1.0672	18.61
230103	1.0527	20.76
230104	1.5554	23.47
230105	1.7966	20.88
230106	1.1826	18.35
230107	0.9423	14.67
230108	1.2079	17.42
230110	1.3163	17.65
230113	0.8490	11.17
230115	1.0580	16.87
230116	0.8654	16.36
230118	1.1403	21.71
230119	1.3594	23.96
230120	1.1248	19.64
230121	1.2279	19.37
230122	1.3518	18.09
230125	.....	15.35
230128	1.4028	23.58
230130	1.6932	22.52
230132	1.3334	26.17
230133	1.2298	17.57
230134	.....	15.32
230135	1.2320	22.74
230137	.....	18.34
230142	1.2837	20.04
230143	1.2803	16.45
230144	1.1223	21.00
230145	1.1219	16.60
230146	1.2603	18.63
230147	1.4098	20.40
230149	1.1317	14.17
230151	1.4140	20.89
230153	1.0658	17.33
230154	0.8898	14.58
230155	1.0298	16.99
230156	1.7470	23.28
230157	1.1677	19.72
230159	1.0227	18.61
230162	0.9532	17.77
230165	1.9359	23.23
230167	1.7502	20.32
230169	1.3613	22.75
230171	1.0817	14.96
230172	1.1873	20.22
230174	1.3724	20.85
230175	2.3801	21.81
230176	1.2168	21.86
230178	0.9485	16.08
230180	1.1229	15.48
230184	1.2534	17.29

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
230188	1.1197	15.56
230189	0.9464	15.91
230190	0.8801	23.71
230191	0.9321	17.12
230193	1.3023	20.18
230195	1.3569	22.37
230197	1.4043	21.62
230199	1.0833	18.40
230201	1.2527	15.32
230204	1.3728	21.89
230205	0.9894	13.89
230207	1.2522	20.46
230208	1.3046	17.15
230211	0.9159	17.51
230212	1.0559	22.18
230213	0.9300	15.32
230216	1.5737	19.59
230217	1.2657	20.95
230219	0.8632	20.70
230221*	.....	21.55
230222	1.3904	20.79
230223	1.2692	21.50
230227	1.4208	21.21
230230	1.5877	22.53
230232	.....	12.64
230235	1.0880	15.95
230236*	1.3245	23.22
230239	1.1705	19.23
230241	1.1942	18.85
230244	1.4114	21.08
230253	0.9600	21.95
230254	1.2928	21.28
230257	0.9141	20.47
230259	1.1398	21.15
230264	1.6552	15.18
230269	1.3095	22.81
230270	1.2029	20.08
230273	1.5232	23.40
230275	0.5244	17.60
230276	0.5657	18.55
230277	1.2488	22.50
230278	.....	16.66
230279	0.6538	16.04
230280	1.0995	14.22
230283	2.2297	.....
240001	1.5271	22.84
240002	1.7570	23.02
240004*	1.5922	16.53
240005	0.8861	16.98
240006	1.1644	27.11
240007	1.0673	16.98
240008	1.1466	21.81
240009	0.9419	16.69
240010	1.9784	22.62
240011	1.1515	18.96
240013	1.2854	18.97
240014	1.0968	21.86
240016	1.3901	19.86
240017	1.1526	17.23
240018	1.2687	19.07
240019	1.1859	21.13

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
240020	1.1172	19.57
240021	0.9884	17.40
240022	1.1049	19.16
240023	0.9789	20.39
240025	1.0980	17.25
240027	1.0711	16.25
240028	1.1581	19.38
240029	1.1501	17.99
240030	1.2802	18.44
240031	0.9276	18.07
240036	1.5871	20.12
240037	1.0154	18.46
240038	1.5017	26.35
240040	1.2684	19.90
240041	1.1728	19.21
240043	1.2228	17.31
240044	1.1357	18.92
240045	1.1584	20.99
240047*	1.5726	21.86
240048	.....	23.31
240049	.....	22.13
240050	1.2114	24.50
240051	0.9654	18.23
240052	1.3024	19.22
240053	1.4855	21.29
240056	1.2541	22.29
240057	1.8364	23.24
240058	0.9292	14.91
240059	1.0456	21.96
240061	1.7666	24.44
240063	1.4484	23.54
240064	1.3259	20.76
240065	1.1496	12.55
240066	1.2838	22.05
240069	1.1917	19.18
240071	1.1069	19.19
240072	1.0236	18.00
240073	0.9003	15.63
240075	1.2015	21.19
240076	1.0725	21.07
240077	0.9002	14.95
240078	1.5426	22.71
240079	0.9545	17.82
240080*	1.6152	23.73
240082	1.1235	18.03
240083	1.2898	19.29
240084	1.3236	19.61
240085	1.0306	18.02
240086	1.0482	15.33
240087	1.1607	17.06
240088	1.4006	21.02
240089	0.9225	18.42
240090	1.1288	18.05
240093	1.2970	18.62
240094	0.9639	20.57
240096	0.9900	18.34
240096	1.2640	23.33
240097	1.1145	23.62
240098	0.9270	20.60
240099	1.0725	14.36
240099	1.6247	18.12

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
240100	1.2887	19.19
240101	1.2099	17.75
240102	0.9273	15.56
240103	1.2125	16.88
240103	1.2125	16.88
240103	1.2687	16.60
240104	1.1691	24.02
240105	.....	14.79
240106	1.3931	25.05
240107	0.9756	19.03
240108	0.9778	16.46
240109	0.9814	13.15
240110	0.9389	17.28
240111	0.9906	17.04
240112	0.9763	15.31
240114	0.9379	15.49
240115	1.6118	22.16
240116	0.9248	15.18
240117	1.1441	17.57
240119	0.8604	22.50
240121	0.9071	21.37
240122	1.0827	18.04
240123	1.0205	15.60
240124	0.9613	19.05
240125	0.9698	13.15
240127	1.0079	14.77
240128	1.1138	16.08
240129	0.9949	15.42
240130	0.9322	15.65
240132	1.2724	24.50
240133	1.2207	18.52
240135	0.9181	13.60
240137	1.1748	19.18
240138	0.9322	13.74
240139	0.9615	17.02
240141	1.1553	21.99
240142	1.0125	20.61
240142	0.9881	16.75
240143	0.9663	14.28
240144	1.0451	15.87
240145	0.9125	15.00
240145	1.5277	15.71
240146*	0.9085	16.79
240148	1.0240	11.48
240150	0.8795	12.83
240152	1.0247	20.20
240153	1.0015	15.61
240154	1.0211	17.06
240155	0.9166	20.42
240157	1.0227	14.69
240160	1.0601	16.60
240161	1.0376	15.42
240163	0.9706	17.87
240166	1.1526	16.39
240169	0.9599	18.62
240170	1.1056	17.65
240171	1.0083	16.72
240172	0.9741	14.91
240173	0.9979	16.74
240179	1.0343	16.65
240184	0.9677	14.40

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
240187	1.2492	17.51
240193	1.0038	16.30
240200	0.8955	14.73
240205	0.9180	.....
240206	0.8312	.....
240210*	1.2515	24.03
240211	0.9639	20.55
250002	0.8834	15.58
250003	0.9935	15.66
250004	1.5311	16.96
250006	0.9628	15.70
250007	1.2280	19.16
250008	1.0292	13.32
250009	1.2659	16.18
250010	1.0112	13.34
250012	0.9335	18.48
250015	1.0386	11.07
250017	1.0281	17.30
250018	0.9366	13.47
250019	1.4832	17.15
250020	0.9513	13.88
250021	0.8379	9.08
250023	0.8948	13.54
250024	0.8937	11.59
250025	1.1497	17.72
250027	0.9761	12.42
250029	0.8705	14.85
250030	0.9210	13.63
250031	1.2477	18.77
250032	1.2190	17.26
250033	1.0137	15.76
250034	1.5454	18.13
250035	0.8365	17.41
250036	0.9962	13.79
250037	0.8845	10.32
250038	0.9382	13.62
250039	0.9970	16.51
250040	1.3147	15.64
250042	1.2629	16.47
250043	0.8997	13.65
250045	1.2675	19.48
250045	1.6478	19.71
250047	0.9058	31.60
250049	0.8840	10.76
250050	1.2669	13.92
250051	0.9264	9.60
250057	1.1777	13.76
250058	1.1857	15.42
250059	1.0828	14.23
250060	0.7514	7.99
250061	0.8571	13.97
250063	0.8311	14.97
250065	0.8934	12.68
250066	0.9138	14.33
250067	1.1596	15.29
250068	0.8244	11.43
250069	1.2682	15.77
250071	0.8972	11.21
250072	1.4321	16.93
250077	0.9343	11.41
250078	1.5470	15.50

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
250079	0.8546	19.06
250081	1.2791	28.31
250082	1.4189	13.84
250083	0.9426	9.20
250084	1.0988	19.74
250085	0.9829	13.85
250088	0.9803	16.69
250089	1.0904	13.05
250093	1.1718	15.09
250094	1.3373	17.85
250095	0.9932	16.36
250096	1.2105	17.07
250097	1.2848	18.41
250098	0.9421	14.30
250099	1.2923	14.41
250101	0.8831	16.31
250102	1.5195	20.02
250104	1.4439	17.54
250105	0.9369	14.60
250107	0.8803	13.63
250109	0.8900	14.55
250109	1.7757	18.47
250112	0.9912	14.20
250117	1.0628	14.52
250119	1.0603	12.74
250120	1.0638	14.41
250122	1.1763	17.72
250123	1.2209	17.41
250124	0.9344	12.67
250125	1.2793	14.49
250126	0.9351	14.71
250127	0.9230	.....
250128	1.0367	13.00
250131	1.0826	10.28
250134	0.9667	17.98
250136	0.9182	18.05
250138	1.2054	17.60
250141	1.2067	17.12
250145	0.8696	11.40
250146	0.9386	13.28
250148	1.2354	11.98
250149	0.9690	12.98
250150	1.2560	.....
260001	1.6327	17.55
260002	1.4385	20.59
260003	1.1303	14.33
260004	0.9725	13.75
260004	1.4534	18.46
260006	1.5184	18.53
260008	0.9887	16.25
260009	1.2916	17.94
260011	1.5348	18.32
260012	1.0036	14.46
260013	1.1872	15.54
260015	1.1793	21.33
260017	1.1724	15.80
260018	0.8885	12.23
260019	1.1438	23.67
260020	1.8100	21.86
260020	1.0367	11.27
260021	1.4386	17.57

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
260022	1.2556	19.35
260023	1.4179	15.82
260024	0.9716	13.47
260025	1.3037	14.94
260027	1.6145	21.01
260029	1.1888	17.47
260030	1.1362	11.24
260031	1.5358	18.30
260032	1.7220	20.92
260034	1.0233	17.22
260035	1.0045	12.59
260036	1.0042	18.31
260039	1.0672	14.20
260040	1.6796	15.08
260042	1.2519	17.44
260044	1.0069	17.12
260047	1.6390	17.28
260048	1.2487	21.43
260050	1.0545	18.74
260052	1.3663	17.86
260053	1.1247	12.01
260054	1.3540	17.37
260055	0.9667	17.76
260057	1.0072	15.33
260059	1.2431	15.79
260061	1.1196	15.01
260062	1.1845	20.26
260063	1.0723	16.85
260064	1.3319	16.50
260066	1.0139	14.42
260067	0.8926	12.16
260068	1.6802	19.83
260070	1.0377	21.69
260073	1.0843	13.01
260074	1.2962	15.42
260077	1.7288	18.26
260078	1.1814	15.48
260079	1.0620	14.83
260080	0.9887	12.56
260081	1.6619	18.96
260082	1.1478	15.79
260085	1.5799	19.51
260086	0.9285	14.87
260091	1.6909	19.61
260094	1.1873	15.87
260095	1.3659	19.77
260096	1.5613	21.72
260097	1.1415	15.79
260100	1.0128	15.73
260102	0.9990	16.37
260103	1.3189	17.35
260104	1.7127	19.02
260105	1.8623	20.80
260108	1.8507	20.92
260109	0.9915	13.44
260110	1.6688	15.72
260113	1.2254	14.79
260115	1.2279	17.90
260116	1.1034	14.57
260119	1.2149	16.20
260120	1.1954	17.13

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
260122	1.0917	14.54
260123	1.0482	14.00
260127	1.0625	15.95
260129	.....	14.64
260131	1.2658	19.75
260134	1.1709	16.58
260137	1.7105	15.22
260138	1.9075	21.41
260141	1.9978	17.96
260142	1.1255	16.03
260143	0.9900	11.94
260147	0.9530	13.66
260148	0.9021	10.34
260158	1.0544	12.40
260159	1.0116	18.22
260160	1.1476	16.19
260162	1.5659	20.71
260163	1.2449	14.81
260164	0.9182	14.31
260166	1.2191	19.53
260172	0.9615	12.49
260173	1.0061	11.98
260175	1.1279	16.29
260176*	1.7243	19.59
260177	1.3381	20.75
260178	1.4663	21.20
260179	1.6090	20.76
260180	1.6591	18.54
260183	1.6570	17.65
260186	1.5847	18.06
260188	1.2749	18.58
260189	0.9425	10.75
260190	1.1964	18.16
260191	1.2874	19.34
260193	1.2224	20.51
260195	1.2469	15.95
260197	1.0913	16.37
260198	1.2980	17.64
260200	1.2109	18.88
260205	1.1102	.....
260206	2.6705	.....
270002	1.2837	17.19
270003	1.2133	22.13
270004	1.6933	29.28
270006	0.8808	16.19
270007	1.0011	13.17
270009	1.0272	17.75
270011	1.0451	19.82
270012	1.6015	23.08
270013	.....	20.40
270014	1.8492	18.48
270016	0.9184	19.77
270017	1.2649	19.58
270019	1.0264	12.78
270021	1.1688	16.65
270023	1.2657	20.40
270026	0.9058	16.07
270027	1.0591	9.78
270028	1.1731	17.21
270029	0.9220	17.89
270032	1.1300	17.03

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
270033	0.8642	16.46
270035	1.0008	17.65
270036	0.9192	14.08
270039	1.0442	15.35
270040	1.1242	19.19
270041	1.0456	16.78
270044	1.1398	13.46
270046	.....	17.10
270048	1.0107	15.84
270049	1.7664	21.17
270050	0.9917	18.04
270051	1.3153	20.23
270052	1.0056	14.80
270057	1.2986	20.01
270058	0.9229	14.07
270059	0.7512	15.60
270060	0.9524	14.02
270063	0.9338	14.23
270073	1.0809	15.53
270074	0.8747	.....
270075	0.8274	.....
270079	0.9338	17.80
270080	1.1410	11.35
270081	0.9579	15.52
270082	1.1020	16.13
270083	1.0098	20.82
270084	0.9151	16.66
280001	1.0632	17.89
280003	2.1214	22.00
280005	1.3518	18.75
280009	1.7680	18.70
280010	0.8073	16.54
280011	0.8552	13.96
280012	.....	16.41
280013	1.7249	22.18
280014	0.9006	15.24
280015	1.0730	14.64
280017	1.0693	14.19
280020	1.8118	19.40
280021	1.1765	16.69
280022	0.9681	15.71
280023	1.3951	21.30
280024	0.9612	13.91
280025	0.9725	14.27
280025	0.9215	13.56
280026	1.0478	16.06
280028	1.0763	15.89
280029	1.2096	19.46
280030*	1.7665	33.26
280031	0.9937	13.22
280032	1.3465	19.18
280033	1.0807	14.93
280034	.....	15.28
280035	0.9131	15.33
280037	1.0308	16.17
280038	1.0606	16.47
280039	1.0637	15.19
280040	1.7299	18.97
280041	0.9617	13.39
280042	1.0305	15.30
280043	0.9752	15.79

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
280045	1.0415	14.23
280046	1.0475	13.72
280046	0.9996	17.09
280047	1.1206	18.37
280048	1.1137	14.07
280049	1.0856	15.63
280050	0.8924	15.34
280052	1.0652	13.65
280054	1.2488	17.58
280055	0.9146	12.99
280056	0.9322	14.02
280057	0.9635	15.76
280058	1.2363	17.88
280060	1.6236	28.61
280061	1.4119	17.95
280062	1.1814	13.67
280064	1.0153	15.51
280065	1.2669	18.53
280066	1.0217	11.64
280068	0.9304	10.13
280070	0.9912	13.74
280073	0.9848	14.79
280074	0.9716	15.22
280075	1.1052	13.79
280076	1.0343	13.92
280077	1.3025	19.01
280077	1.3234	23.89
280079	1.0819	9.91
280080	1.0579	14.35
280081	1.7240	20.92
280082	1.0785	13.13
280083	1.0611	17.55
280084	0.9595	11.69
280085	0.8186	21.58
280088	.....	21.64
280089	0.8837	17.16
280090	0.8017	14.72
280091	1.0928	15.15
280092	0.9075	14.20
280092	1.2667	17.95
280094	0.9966	15.89
280097	1.0876	14.30
280098	0.8804	10.17
280101	1.0046	17.42
280102	.....	12.94
280104	0.9207	13.38
280105	1.2360	18.78
280106	1.0160	15.54
280107	1.1351	13.46
280108	1.0618	17.22
280109	0.9496	11.06
280110	0.9845	12.30
280111	1.2660	23.10
280115	0.9779	16.43
280117	1.0965	16.82
280118	0.9029	16.92
280119	0.9435	.....
280123	.....	20.77
280125	1.2266	.....
290001	1.6951	22.42
290002	0.9418	16.63

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
290003	1.6685	23.40
290005	1.3281	17.80
290006	1.2282	19.88
290007	1.6911	29.69
290008	1.2553	20.25
290009	1.6213	22.74
290010	1.1253	14.48
290011	1.0959	16.44
290012	1.3501	21.17
290014	1.0289	18.38
290015	0.9745	17.83
290016	1.1219	12.81
290019	1.3294	20.93
290020	0.9828	26.15
290021	1.6752	21.13
290022	1.5923	24.08
290027	0.8876	16.43
290029	0.9227	.....
290032	1.4102	22.79
290036	0.5760	18.61
290038	0.9313	23.14
290039	1.3278	25.80
290041	1.2669	.....
300001	1.4837	21.40
300003	2.0054	23.25
300005	1.3435	19.99
300006	1.1762	18.93
300007	1.0889	19.34
300008	1.2468	16.46
300009	1.0545	20.01
300010	1.2618	19.38
300011	1.3250	21.24
300011	.....	19.27
300013	1.1145	18.97
300014	1.2417	19.80
300015	1.1214	19.92
300016	1.2108	18.50
300017	1.3267	22.34
300018	1.3658	20.89
300019	1.2426	20.61
300020	1.3820	21.65
300021	1.0741	17.35
300022	1.1274	17.19
300023	1.3989	20.39
300028	1.2859	18.05
300029	1.3196	20.90
300033	1.0986	19.85
300034	2.1601	23.52
310001	1.7852	26.81
310002	1.8508	26.61
310003	1.2974	26.83
310005	1.2946	23.05
310006	1.2111	21.50
310008	1.3295	24.95
310009	1.3229	23.19
310010	1.2488	21.11
310011	1.2569	23.22
310012	1.6481	26.32
310013	1.3697	22.11
310014	1.6478	28.70
310015	2.0223	27.58

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
310016	1.2886	25.72
310017	1.3522	26.07
310018	1.0775	24.53
310019	1.6742	22.82
310020	1.3766	19.27
310021	1.5395	14.69
310022	1.3224	20.73
310024	1.3248	22.78
310025	1.1869	22.58
310026	1.2370	23.87
310027	1.3153	21.77
310028	1.2506	23.52
310029	1.9412	23.20
310031	2.7731	25.18
310032	1.3215	23.30
310034	1.2861	21.69
310036	1.1416	19.82
310037	1.3994	27.44
310038*	2.0125	25.33
310038*	2.0125	25.33
310038*	1.5187	17.94
310038*	1.5187	17.94
310039	1.2510	22.03
310040	1.2033	24.30
310041	1.3451	23.78
310042	1.2924	24.27
310043	1.1890	22.09
310044	1.3276	20.43
310045	1.4835	28.21
310047	1.3317	24.52
310048	1.2890	23.33
310049	1.2304	24.76
310050	1.2126	22.59
310051	1.3939	25.27
310052	1.3013	22.58
310054	1.3465	24.38
310057	1.3027	20.45
310058	1.1447	26.10
310060	1.1968	19.11
310061	1.2042	20.80
310063*	1.3466	21.90
310064	1.3576	22.05
310067	1.3003	22.27
310069	1.2634	24.17
310070	1.4213	25.04
310072	1.3710	22.22
310073	1.6733	25.62
310074	1.3502	24.46
310075	1.4191	26.46
310076	1.4966	28.90
310077	1.6653	25.06
310078	1.4152	23.48
310081	1.3497	23.89
310083	1.2748	23.68
310084	1.3299	24.09
310086	1.2171	21.44
310087	1.3363	20.89
310088	1.1986	22.34
310090	1.3887	24.24
310091	1.2672	21.64
310092	1.3184	22.34

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
310093	1.1947	21.23
310096	1.9874	26.30
310105	1.2351	24.49
310108	1.4307	23.23
310110	1.2698	20.05
310111	1.2535	21.72
310112	1.3035	22.52
310113	1.2899	22.95
310115	1.2997	20.07
310116	1.2877	25.24
310118	1.2498	23.69
310120	1.2025	21.69
310121	.....	18.74
320001	1.5282	17.85
320002	1.3475	18.74
320003	1.0738	15.35
320004	1.2912	17.12
320005	1.3136	19.87
320006*	1.3522	19.34
320009	1.5961	17.68
320011	1.1434	21.09
320012	1.0462	16.00
320013	1.1399	22.59
320014	1.0829	15.97
320016	1.1832	18.78
320017	1.1293	18.15
320019	1.5028	19.26
320021	1.8076	15.29
320022	1.2332	17.66
320023	1.0237	16.42
320030	1.1556	13.86
320031	0.9451	13.99
320032	0.9020	16.45
320033	1.1699	20.31
320035	1.0266	24.07
320037	1.1663	17.08
320038	1.2324	16.29
320046	1.4430	20.43
320048	1.4178	19.17
320057	0.9720	.....
320058	0.8862	.....
320059	1.0641	.....
320060	0.9268	.....
320061	1.1304	.....
320062	0.8542	.....
320063	1.2511	19.83
320065	1.2158	16.10
320067	0.8657	57.24
320068	0.8982	18.60
320069	0.9785	11.31
320070	0.9556	.....
320074	1.0897	18.65
320079	1.2128	19.42
330001	1.1867	25.21
330002	1.4494	28.92
330003	1.3431	17.65
330004	1.2951	19.59
330005	1.6834	24.28
330006	1.3333	25.46
330007	1.3686	18.65
330008	1.1791	17.76

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
330009	1.3308	30.42
330010	1.2833	14.74
330011	1.2963	17.63
330012	1.7216	29.82
330013	2.0344	19.11
330014	1.3868	27.44
330016	0.9933	17.41
330019	1.3623	32.45
330020	1.0286	14.55
330023	1.3016	24.27
330024	1.8309	33.55
330025	1.1142	16.03
330027	1.4665	32.50
330028	1.4110	27.08
330029	1.1574	16.56
330030	1.4176	15.06
330033	1.3126	16.75
330034	0.5350	30.78
330036	1.2759	24.32
330037	1.2231	16.00
330038	1.1805	16.01
330039	.....	12.47
330041	1.2877	30.42
330043	1.3072	27.15
330044	1.2664	18.70
330045	1.3750	27.17
330046	1.4572	31.91
330047	1.1976	17.53
330048	1.2590	17.62
330049	1.2689	19.31
330053	1.2232	15.67
330055	1.5716	28.99
330056	1.4640	30.21
330057	1.6852	18.34
330058	1.3123	16.98
330059	1.6000	31.58
330061	1.2766	25.07
330062	1.0980	15.28
330064	1.4278	32.87
330065	1.2356	18.37
330066	1.2664	19.12
330067	1.3300	20.94
330072	1.4065	30.35
330073	1.1715	15.88
330074	1.2824	18.18
330075	1.0926	17.26
330078	1.4535	17.49
330079	1.2821	16.76
330080	1.2129	24.70
330084	1.0650	23.03
330085	1.2897	18.78
330086	1.2267	30.69
330088	1.0497	25.62
330090	1.5603	18.68
330091	1.3782	18.53
330092	0.9905	12.65
330094	1.2369	17.72
330095	1.3277	18.34
330096	1.1197	16.60
330097	1.2448	16.96
330100	0.9996	28.11

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
330101	1.7924	29.22
330102	1.2990	17.25
330103	1.2013	16.48
330104	1.4136	28.77
330106	1.7000	35.87
330106	1.2141	17.58
330107	1.2746	28.08
330108	1.2381	17.08
330111	1.0714	15.20
330114	0.9051	18.24
330115	1.1308	16.56
330116	0.8461	24.23
330118	1.6337	20.76
330119	1.7045	34.75
330121	1.0146	14.77
330122	1.0120	21.20
330125	1.8884	22.57
330126	1.1356	22.70
330127	1.3758	28.67
330128	1.3080	26.63
330132	1.1999	14.70
330133	1.3624	32.28
330135	1.1989	18.33
330136	1.3313	17.26
330140	1.8200	19.50
330140	1.3693	29.22
330144	0.9879	12.52
330148	1.0686	15.04
330151	1.0943	13.97
330152	1.4603	29.48
330153	1.7146	17.40
330154	1.7635	.....
330157	1.3770	20.82
330159	1.2596	17.87
330160	1.4253	30.17
330162	1.2101	27.72
330163	1.2553	20.46
330164	1.3684	19.48
330166	1.0688	14.18
330167	1.7206	30.07
330169	1.4402	25.15
330171	1.3082	25.43
330177	0.9538	14.54
330179	0.8481	12.69
330180	1.2145	14.94
330181	1.3234	32.47
330182	2.5161	31.33
330184	1.3694	27.49
330185	1.2686	26.89
330188	1.2751	18.72
330189	1.1706	17.66
330191	1.3142	18.85
330193	1.3060	29.82
330194	1.8125	35.57
330194	1.3303	24.74
330196	1.2593	26.62
330197	1.1217	17.00
330198	1.3920	23.63
330199	1.3788	27.66
330201	1.6461	30.33
330202	1.3273	31.24

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
330203*	1.3894	19.24
330204	1.3574	26.81
330205	1.2183	19.46
330208	1.2533	25.82
330209	1.2122	24.88
330211	1.1003	19.10
330212	1.1260	21.18
330213	1.1307	18.51
330214	1.8224	32.20
330218	1.0787	21.71
330219	1.6427	20.48
330221	1.2963	30.00
330222	1.2742	17.71
330223	1.0460	17.28
330224	1.2634	20.89
330225	1.1993	25.80
330226	1.2803	17.67
330229	1.2988	16.25
330230	1.3375	28.86
330230	1.3883	30.32
330231	1.0207	26.61
330232	1.2609	19.50
330233	1.4708	33.48
330234	2.3386	32.95
330235	1.1656	19.45
330236	1.3899	29.54
330238	1.2178	14.80
330239	1.2090	17.28
330241	2.0171	22.60
330242	1.2839	24.74
330245	1.4700	17.28
330245	1.3066	17.65
330246	1.3232	26.51
330247*	0.8513	27.71
330249	1.1964	16.48
330250	1.2370	19.20
330252	.....	17.04
330254	1.1706	16.73
330258	1.2649	30.47
330259	1.4768	23.87
330261	1.3026	26.17
330263	1.0017	19.64
330264	1.1964	23.14
330265	1.3296	15.62
330267	1.3404	23.56
330268	0.9562	14.62
330270	2.0235	28.24
330273	1.2927	25.89
330275	1.3100	17.41
330275	1.5329	17.72
330276	1.1583	17.75
330277	1.1061	17.16
330279	1.2903	19.91
330285	1.8644	22.47
330286	1.3310	25.09
330290	1.7051	31.84
330293	1.1270	15.38
330304	1.2324	29.51
330306	1.3441	27.62
330307	1.3062	20.74
330308	.....	36.84

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
330327	0.8784	16.97
330331	1.3609	31.04
330332	1.2164	27.16
330333	1.2125	36.77
330333	1.1649	18.57
330336	1.3036	30.17
330338	1.2490	22.14
330339	0.9024	19.67
330340	1.1793	26.92
330350	1.7306	30.38
330353	1.3031	33.55
330354	1.5849	.....
330357	1.3385	34.68
330359	.....	29.29
330372	1.2176	22.50
330381	1.2997	29.24
330385	1.1314	26.39
330386	1.1741	24.67
330387	0.7617	.....
330389	1.7689	30.82
330390	1.3621	29.79
330393	1.7194	27.99
330394	1.5580	18.54
330395	1.3507	36.12
330396	1.1230	28.11
330397	1.3749	31.00
330399	1.2641	35.55
330400	0.8760	.....
340001	1.4552	18.47
340002	1.8350	18.79
340002	1.6766	19.97
340003	1.1378	21.97
340004	1.5051	17.89
340005	1.1264	14.09
340006	1.0454	15.57
340007	1.1632	17.17
340008	1.1038	18.38
340009	.....	20.50
340011	1.1008	14.92
340012	1.1768	16.66
340013	1.2426	17.43
340014	1.5356	19.86
340015	1.2423	19.01
340016	1.1688	16.40
340017	1.2562	19.22
340018	1.1436	15.16
340019	0.9955	11.80
340020	1.2435	16.75
340021	1.2560	19.67
340022	1.1245	16.72
340023	1.3399	15.75
340024	1.1416	16.64
340025	1.2473	16.82
340027	1.2113	17.30
340030	2.0492	20.05
340031	0.9575	12.39
340031	1.2347	19.73
340032	1.3541	20.47
340035	1.0956	18.10
340036	1.1309	16.97
340037	1.0053	15.53

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
340038	1.1024	17.01
340039	1.2595	20.01
340040	1.7834	20.07
340041	1.2546	18.97
340042	1.1890	16.63
340044	1.1035	16.37
340045	1.0223	12.42
340047*	1.8843	19.30
340048	0.6134	13.11
340049	0.7590	16.50
340051	1.2900	18.60
340051	1.8432	20.66
340052	0.9876	21.37
340053	1.6323	19.49
340054	1.1763	14.47
340055	1.2604	18.18
340060	1.0860	17.83
340061	1.7099	20.76
340063	1.0057	17.19
340064	1.1560	17.26
340065	1.3378	18.32
340067	1.0061	18.61
340068	1.2336	16.70
340069	1.8138	20.05
340070	1.2544	18.38
340071	1.1438	16.37
340072	1.1338	15.60
340073	1.3879	20.69
340075	1.2367	18.21
340080	0.9831	16.85
340084	1.1281	21.78
340085	1.1702	16.24
340087	1.1121	16.70
340088	1.2513	19.83
340089	0.9805	13.86
340090	1.1718	17.47
340093	1.0391	15.16
340094	1.3870	18.39
340096	1.1754	17.98
340097	1.1310	18.42
340098	1.5829	20.17
340099	1.1295	15.09
340101	1.0709	15.36
340104	0.8681	15.87
340105	1.3491	18.91
340106	1.1393	18.08
340107	1.2314	16.95
340109	1.3469	17.96
340111	1.1160	14.49
340112	0.9984	14.52
340113	1.8531	21.03
340114	1.6133	20.82
340115	1.5465	18.67
340116	1.8578	19.23
340119	1.2151	16.85
340120	1.1381	14.38
340121	1.0491	15.97
340123	1.1262	16.22
340124	1.1113	14.05
340125	1.4577	19.63
340126	1.3187	17.72

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
340127	1.3001	17.28
340130	1.3606	19.40
340131	1.5381	18.94
340132	1.2828	16.94
340133*	1.0724	14.35
340137	1.2697	.....
340138	1.0673	19.28
340141	1.7101	22.23
340142	1.1894	16.09
340143	1.4503	20.95
340144	1.2523	15.98
340145	1.3242	19.20
340146	1.0434	13.01
340147	1.2397	19.11
340148	1.3626	19.61
340151	1.2105	16.57
340155	1.3964	20.42
340156	0.7272	.....
340158	1.0734	17.26
340159	1.1779	16.80
340160	1.1654	15.53
340162	.....	16.64
340164	1.3649	19.68
340166	1.3051	19.22
340168	0.4822	14.75
340171	1.1342	20.05
340173	1.2028	20.21
350001	0.9646	15.10
350002	1.8458	17.28
350003	1.2077	17.43
350004	1.9288	17.90
350005	1.0897	16.03
350006	1.3848	16.62
350007	0.9036	13.28
350008	0.9721	21.70
350009	1.1842	18.28
350010	1.1308	15.28
350011	1.9255	18.49
350012	1.0794	12.73
350013	1.0590	16.68
350014	1.0303	15.79
350015	1.7237	15.87
350016	.....	11.63
350017	1.3344	17.78
350018	1.0338	13.64
350019	1.7223	19.40
350021	0.9859	12.69
350023	0.9505	13.34
350024	1.0054	14.37
350025	0.9807	16.24
350027	1.0099	17.12
350029	0.8409	12.80
350030	1.0670	17.35
350033	0.9292	14.90
350034	0.9296	18.32
350035	0.8734	10.16
350038	1.0785	18.74
350039	1.0406	17.31
350041	0.9448	14.68
350042	1.0516	16.75
350043	1.6090	17.16

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
350044	0.9036	10.53
350047	1.1408	17.93
350049	1.2037	14.53
350050	0.9242	10.57
350051	0.9872	17.53
350053	1.0058	13.94
350055	0.9910	12.37
350056	0.9210	14.67
350058	0.9553	14.35
350060	0.8626	9.60
350061	1.0444	14.59
350063	0.8913	.....
350064	0.8650	.....
350068	2.5336	.....
350069	1.1398	.....
360001	1.3040	17.61
360002	1.1823	17.40
360003	1.7502	22.03
360006	1.9071	22.09
360007	1.0921	17.10
360008	1.2559	18.28
360009	1.5436	17.53
360010	1.2815	18.09
360011	1.2938	18.95
360012	1.3003	19.22
360013	1.1471	20.81
360014	1.1215	19.88
360016	1.6714	18.71
360017	1.9258	22.50
360018*	1.6881	21.13
360019	1.2251	20.17
360020	1.4563	22.96
360024	1.3152	18.54
360025	1.3536	19.19
360026	1.3138	17.04
360027	1.4730	20.43
360028	1.4907	17.27
360029	1.1938	18.22
360030	1.3469	15.35
360031	1.1971	19.90
360032	1.1591	17.93
360034	1.3273	15.56
360035	1.6456	18.97
360036	1.3111	19.14
360037*	2.1426	22.52
360038	1.6235	19.09
360039	1.2937	17.52
360040	1.2913	18.12
360041	1.2871	18.42
360042	1.1662	16.12
360044	1.1478	16.79
360045	1.4244	21.18
360046	1.1481	19.32
360047	1.1315	15.34
360048*	1.8813	21.29
360049	1.2245	18.81
360050	1.2304	12.89
360051	1.6220	20.71
360052*	1.6960	19.75
360054	1.2429	16.19
360055	1.3166	23.27

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
360056	1.3960	18.36
360057	1.0590	13.81
360058	1.1936	17.92
360059	1.6088	20.39
360062	1.4087	20.31
360063	1.1347	22.79
360064	1.6113	20.64
360065	1.2531	19.45
360066	1.6390	20.03
360067	1.1463	14.57
360068	1.7916	21.92
360069	1.1347	17.88
360070	1.7820	17.55
360071	1.4177	23.80
360072	1.2731	17.97
360074*	1.2996	18.32
360075	1.3460	19.25
360076	1.3579	19.59
360077	1.6157	20.82
360078	1.2427	20.79
360079*	1.8438	22.00
360080	1.1427	16.66
360081	1.3387	19.64
360082	1.2779	22.86
360083	.....	18.46
360084	1.6077	20.09
360085	1.8767	20.73
360086	1.4308	17.04
360087	1.4296	20.04
360088	1.3224	22.31
360089	1.1349	20.56
360090	1.2682	20.40
360091	1.3213	21.03
360092	1.1373	15.91
360093	1.1774	18.57
360094	1.3412	18.31
360095	1.2596	18.71
360096	1.0736	17.16
360098	1.4620	18.34
360099	0.9911	16.43
360100	1.2362	17.66
360101	1.3303	22.31
360102	1.2046	16.41
360103	.....	22.66
360104	1.1889	.....
360106	1.1909	16.18
360107	1.2449	14.54
360108	1.0519	16.51
360109	1.1015	19.52
360112	1.9154	22.68
360113	1.3257	22.27
360114	1.0880	17.13
360115	1.3591	18.19
360116	1.1091	18.08
360118	1.3515	18.60
360121	1.2071	21.42
360123	1.2382	19.13
360125	1.1479	18.17
360126	1.2125	20.46
360126	1.8377	.....
360127	1.1473	16.92

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
360128	1.1568	15.58
360129	0.9446	15.42
360130	1.0122	15.34
360131	1.3308	18.29
360132	1.4132	18.27
360133	1.6508	19.03
360134	1.7520	20.24
360136	1.0180	17.85
360137	1.7424	20.26
360140	0.9460	19.13
360141	1.6432	22.85
360142	1.0527	17.32
360143	1.3343	20.44
360144	1.2946	21.92
360145	1.6897	19.39
360147	1.2436	16.59
360148	1.1482	18.89
360149	1.2611	18.79
360150	1.3025	20.63
360150	1.3486	14.24
360151	1.3908	17.49
360152	1.5270	22.00
360153	1.1281	14.89
360154	1.0435	13.78
360155	1.3677	20.90
360156	1.2714	17.92
360159	1.1769	20.71
360161*	1.3552	19.43
360162	1.0718	18.32
360163	1.8472	20.38
360164	.....	16.16
360165	1.1740	19.48
360166	.....	16.98
360170	1.4424	17.18
360172	1.3450	18.47
360172	1.0594	11.46
360174	1.2393	19.09
360175	1.1888	20.41
360176	1.1416	15.55
360177	1.3276	19.41
360178	1.3155	17.40
360179	1.4147	18.82
360180	2.1660	22.09
360184	0.5560	19.35
360185	1.2279	18.67
360186	1.0613	20.86
360187	1.4008	18.02
360188	0.9300	17.53
360188	1.3145	19.84
360189	1.0999	17.37
360192	1.3351	21.00
360193	.....	17.67
360194	1.1660	17.69
360195	1.1446	19.02
360197	1.1572	19.42
360200	0.9136	17.76
360203	1.1642	15.61
360204	1.2012	19.35
360210	1.1861	20.28
360211	1.2583	19.58
360212	1.3502	20.23

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
360213	1.2562	18.33
360218	1.3312	18.41
360230	1.5295	21.44
360231	1.1521	13.56
360234	1.3657	22.06
360236	1.2693	19.57
360239	1.2655	19.86
360241	0.4070	22.08
360243	0.6871	13.58
360244	.....	10.55
360245	0.7435	15.06
360247	0.4015	18.11
360248	.....	21.65
370001	1.7396	21.23
370002	1.2252	14.08
370004	1.1874	16.77
370005	0.9385	17.38
370006	1.1866	12.54
370007	1.1476	17.00
370008	1.3755	17.30
370011	1.0368	14.64
370012	0.8370	10.80
370013	1.8507	18.04
370014	1.1884	19.63
370015	1.1919	17.91
370016	1.3306	16.64
370017	1.1140	12.98
370019	1.3158	16.88
370020	1.2742	13.48
370021	0.8613	11.26
370022	1.3170	17.90
370023	1.2564	16.82
370025	1.3094	16.40
370026	1.4938	16.90
370028	1.8978	19.71
370029	1.1615	13.89
370030	1.1993	15.47
370032	1.5960	16.70
370033	1.0434	12.39
370034	1.2300	14.51
370034	1.1035	13.64
370035	1.7244	18.96
370037	1.7347	17.75
370038	0.9601	12.81
370039	1.1556	16.27
370040	1.0121	14.34
370041	0.9415	17.41
370042	0.8490	14.61
370043	0.9307	16.08
370045	1.0379	12.44
370046	0.9834	18.15
370047	1.4255	15.67
370048	1.2037	17.44
370051	0.9449	12.18
370054	1.3630	16.56
370056	1.5715	18.88
370057	1.0250	14.66
370059	1.1266	16.46
370060	1.0540	15.12
370063	1.1044	17.06
370064	0.9378	9.78

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
370065	0.9995	16.56
370071	1.0274	14.95
370072	0.8645	26.05
370076	1.2553	12.86
370077	.....	17.62
370078	1.6857	17.24
370079	0.9312	13.60
370080	0.9515	14.34
370082	0.8548	13.57
370083	0.9662	11.49
370084	1.0191	21.75
370085	0.8886	11.88
370086	1.1148	13.56
370089	1.2157	14.50
370091	1.6647	17.58
370092	0.9950	14.68
370093	1.7953	18.57
370094	1.4453	18.38
370095	0.9872	14.13
370097	1.3458	15.72
370099	1.1231	16.17
370100	0.9784	17.10
370103	0.9071	15.90
370105	1.9589	21.06
370106	1.5282	18.62
370108	0.9670	12.24
370112	1.0284	15.25
370113	1.2334	16.20
370114	1.6444	15.98
370121	1.0409	19.55
370122	1.0451	12.15
370123	1.4513	16.36
370125	0.9024	13.55
370126	0.9646	18.24
370131	0.9766	16.24
370133	1.0621	10.47
370138	1.0490	16.02
370139	1.0965	13.30
370140	1.0464	15.23
370141	1.3716	6.09
370146	1.0935	12.56
370148	1.4521	.....
370149	1.3479	16.72
370153	1.1151	15.32
370154	1.0475	16.29
370158	1.0197	15.09
370159	1.2547	15.49
370163	0.9790	14.56
370165	1.2623	13.22
370166	1.0457	17.82
370169	1.0462	11.80
370170	1.0246	.....
370171	1.0343	.....
370172	0.8992	.....
370173	1.0625	.....
370174	0.7213	.....
370176	1.2190	16.03
370177	0.9910	11.88
370178	0.9838	11.64
370179	0.9498	19.27
370180	0.9870	.....

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
370183	1.0383	7.62
370186	0.9785	13.35
370190	1.4695	13.70
370192	1.4803	16.74
370196	0.8822	.....
370197	.....	21.57
370198	1.4366	.....
370199	1.0307	.....
370200	1.1673	.....
380001	1.3046	22.03
380002	1.2175	19.48
380003	1.1750	24.74
380004	1.7385	23.16
380005	1.1745	23.24
380006	1.2246	20.54
380007	1.6509	24.16
380008	1.0680	21.19
380009	1.7977	25.28
380010	1.0413	19.75
380011	1.1006	21.14
380013	1.1883	20.10
380014	1.6527	23.48
380017	1.9295	23.68
380018	1.8300	22.08
380019	1.2442	20.77
380020	1.4525	21.35
380021	1.2077	20.64
380022	1.1107	21.61
380023	1.1378	19.24
380025	1.2975	24.67
380026	1.1414	19.27
380027	1.2810	20.16
380029	1.1411	18.57
380031	0.9370	22.83
380033	1.7968	22.62
380035	1.3525	21.65
380036	1.0858	19.33
380037	1.2271	21.23
380038	1.2457	25.58
380039	1.2601	22.12
380040	1.2922	21.64
380042	1.0121	19.81
380047	1.6765	21.95
380048	1.0418	18.38
380050	1.4266	18.25
380051	1.6342	21.24
380052	1.2506	17.77
380055	.....	21.25
380056	1.0970	17.16
380060	1.4584	23.48
380061	1.5207	22.63
380062	1.2197	18.52
380063	.....	19.36
380064	1.3207	19.87
380065	1.3101	22.17
380066	1.3211	20.42
380068	.....	22.76
380069	1.0679	19.58
380070	1.3454	24.71
380071	1.2327	20.47
380072	0.9961	16.32

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
380075	1.4249	22.17
380078	1.1368	19.10
380081	1.0229	20.59
380082	1.2627	22.58
380083	1.1660	21.81
380084	1.2367	23.64
380087	1.2347	16.75
380088	1.0722	19.52
380089	1.2780	23.74
380090	1.2983	27.09
380091	1.2616	22.83
390001	1.5197	16.39
390002	1.3158	18.08
390003	1.2403	17.24
390004	1.3978	18.82
390005	1.0949	15.36
390006*	1.8485	18.13
390009*	1.7387	20.16
390010	1.2504	17.42
390011	1.2787	18.07
390012	1.2197	20.00
390013	1.2401	19.33
390015	1.1331	12.94
390016	1.2482	17.95
390017	1.1848	16.22
390018	1.2431	18.98
390019	1.0762	16.40
390022	1.3535	22.86
390024	1.1793	25.03
390026	1.2757	22.18
390027	1.7878	27.37
390028*	1.8892	18.48
390030	1.2187	18.40
390031	1.2151	18.69
390032	1.2603	18.15
390035	1.2652	18.51
390036	1.5396	18.78
390039	1.1414	16.54
390040	0.9484	15.12
390041	1.2691	19.58
390042	1.5798	21.10
390043	1.1762	16.36
390044	1.6420	19.50
390045	1.7171	18.75
390046	1.6108	20.42
390047*	1.7435	23.61
390048	1.1520	18.38
390049	1.6125	21.02
390049	1.7948	24.39
390050	2.1150	21.43
390050	1.2393	20.86
390051	2.1342	26.05
390052	1.1532	17.10
390054	1.2344	17.50
390055	1.8882	25.85
390056	1.1202	17.17
390057	1.3145	19.74
390058	1.2840	19.25
390060	1.2088	13.63
390061	1.4935	16.95
390062	1.2449	16.45

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
390063	1.8347	19.51
390065	1.2323	20.00
390066	1.2608	18.70
390067	1.8041	20.18
390068	1.3029	17.55
390069	1.2663	19.76
390070	1.4168	20.07
390071	1.1082	16.23
390072	1.0501	15.56
390073	1.6668	20.64
390074	1.2477	16.60
390075	1.3927	17.27
390076	1.2793	21.43
390078	1.1506	18.23
390079	1.7570	17.76
390080	1.2902	18.82
390081	1.2995	23.99
390083	1.2055	.....
390084	1.2684	16.35
390086	1.1376	17.25
390088	1.3701	22.85
390090	1.8017	20.68
390091	1.1279	18.36
390093	1.1549	16.61
390095	1.2035	13.05
390096	1.4931	19.25
390097	1.2755	21.52
390100	1.6536	19.89
390101	1.2027	17.10
390102	1.3963	19.51
390103	1.0916	17.71
390104	1.0666	16.17
390106	1.1160	16.28
390107	1.3258	19.18
390108	1.4022	21.43
390109	1.2016	14.66
390110	1.5961	19.51
390111	1.9406	26.03
390112	1.2965	14.04
390113	1.2515	17.53
390114	1.2347	23.03
390115	1.3973	24.42
390116	1.2899	20.60
390117	1.1722	16.90
390118	1.2135	16.90
390119*	1.3898	18.48
390121	1.3957	18.64
390122	1.0603	17.46
390123	1.2758	20.44
390125	1.2067	15.94
390126	1.2899	20.94
390127	1.2286	21.88
390128	1.2202	19.99
390130	1.1343	17.33
390131	1.3302	16.83
390132	1.2935	21.10
390136	1.1431	17.61
390137	1.5156	16.54
390138	1.3212	18.86
390139	1.5084	22.94
390142*	1.6088	27.22

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
390145	1.3880	20.34
390146	1.2154	17.70
390147	1.2654	21.11
390150	1.1815	19.66
390151	1.2305	20.51
390152	1.1114	19.15
390153	1.2214	23.14
390154	1.2689	15.85
390156	1.4094	20.88
390157	1.3940	19.83
390158	.....	21.69
390160	1.2380	20.67
390161	1.1893	12.37
390162	1.5191	21.01
390163	1.2262	15.64
390164*	2.1709	21.74
390166	1.1125	19.96
390166	1.1125	19.96
390167	.....	22.91
390168	1.2596	18.99
390169	1.3383	18.99
390170	1.8481	22.99
390173	1.2222	17.82
390174*	1.6754	23.61
390176	1.1817	17.36
390178	1.3114	17.47
390179	1.3111	21.16
390180	1.4554	25.02
390181	1.0732	17.09
390183	1.1620	18.28
390184	1.1309	20.75
390185	1.2171	17.65
390189	1.1411	18.67
390191	1.1707	16.20
390192	1.1740	16.32
390193	1.1938	16.50
390194	1.1395	20.15
390195	1.8245	23.69
390196	1.5792	.....
390197	1.2825	18.99
390197	1.3365	11.12
390198*	1.2667	15.51
390199	1.2670	16.66
390200	0.9701	13.59
390201	1.2646	20.50
390203	1.3562	22.06
390204	1.2728	20.85
390206	1.4000	16.78
390206	1.4000	16.78
390209	1.0811	16.96
390211	1.2184	17.88
390213	1.1284	17.17
390215	1.2563	20.84
390217	1.2232	19.29
390219	1.3072	22.71
390220	1.1652	18.52
390222	1.3140	20.91
390223	1.7334	22.13
390224	0.8802	15.91
390225	1.1951	18.17
390226	1.6039	22.46

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
390228	1.2976	19.81
390231	1.5675	22.40
390231	1.1916	9.56
390233	1.3507	18.20
390235	1.4144	23.54
390236	1.2254	17.03
390237	1.5705	19.89
390238	1.2725	1.27
390238	1.1545	10.04
390242	.....	18.10
390244	0.9245	14.41
390245	1.3199	20.15
390246	1.1920	17.75
390247	1.0511	20.67
390249	0.9293	10.73
390256	1.8901	23.84
390258	1.4575	21.36
390258	1.3348	22.53
390260	1.0990	21.19
390262	1.9276	18.62
390263	1.4224	23.62
390265	1.2935	19.51
390266	1.2118	16.24
390267	1.2589	20.79
390268	1.3375	21.02
390270	1.3851	17.83
390272	0.4768	.....
390277	0.4015	27.10
390278	0.6660	18.99
390283	1.2887	.....
390284	1.3639	.....
400001	1.2182	9.86
400002	1.6803	9.31
400003	1.3589	10.13
400004	1.1421	8.48
400005	1.1211	7.85
400006	1.1593	8.22
400007	1.2021	7.86
400009	1.0530	8.37
400010	0.8902	11.66
400011	1.0733	7.44
400012	1.3428	7.81
400013	1.2616	8.21
400014	1.3935	9.54
400015	1.3307	10.33
400016	1.3663	12.07
400017	1.1570	8.57
400018	1.2817	9.45
400019	1.6576	10.13
400021	1.4432	11.68
400024	0.9500	7.56
400026	0.9640	7.12
400027	1.1026	8.49
400028	1.2500	8.40
400031	1.2515	9.78
400032	1.2212	9.42
400048	1.0249	9.47
400061	1.7094	16.08
400079	1.2218	.....
400087	1.4156	9.83
400094	0.9947	5.15

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
400098	1.3998	8.17
400102	1.1591	7.73
400103	1.3870	10.59
400104	1.2767	9.68
400105	1.2171	10.06
400106	1.2574	8.51
400109	1.4773	10.18
400110	1.1292	10.52
400112	1.0540	9.97
400113	1.1575	9.48
400114	1.0784	6.41
400115	1.0386	9.13
400118	1.2392	8.70
400120	1.2554	9.74
400121	0.9964	7.11
400122	1.0235	8.48
400123	1.2031	9.00
400124	2.8358	11.16
400125	1.0022	.....
410004	1.2575	22.06
410005	1.3735	21.26
410006	1.3057	21.68
410007	1.6365	20.98
410008	1.2136	22.62
410009	1.2941	24.08
410010	1.1611	27.14
410011	1.2705	24.37
410012	1.9068	21.33
410013	1.2981	25.01
420002	1.5015	20.20
420004	1.8164	19.41
420005	1.1323	15.99
420006	1.1199	18.24
420007	1.5710	17.43
420009	1.1697	17.25
420010	1.1774	17.91
420011	1.2438	14.99
420014	1.0197	16.72
420015	1.3348	17.18
420016	0.9571	18.15
420018	1.8110	19.73
420019	1.2145	15.55
420020	1.1846	20.16
420023	1.4298	20.97
420026	1.8901	21.90
420027	1.3308	18.08
420030	1.2081	17.82
420031	0.8622	13.07
420033	1.1653	21.09
420036	1.2907	19.80
420037	1.1948	21.96
420038	1.3155	16.15
420039	1.0701	16.96
420042	.....	14.66
420043	1.1867	18.36
420048	1.2366	29.62
420049	1.2046	19.23
420051	1.6466	18.25
420053	1.1427	16.48
420054	1.2398	16.55
420055	1.0585	16.18

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
420056	1.1158	14.85
420057	1.1156	14.50
420059	0.9738	19.13
420061	1.1761	17.78
420062	1.1904	18.92
420064	1.1038	16.15
420065	1.3912	19.06
420066	0.9834	15.52
420067	1.2163	18.30
420068	1.3854	17.21
420069	1.0602	16.40
420070	1.2331	17.45
420071	1.3510	18.29
420072	0.9129	12.34
420073	1.2802	19.20
420074	1.0257	13.80
420075	0.9395	16.29
420078*	1.8578	20.68
420079	1.5179	18.77
420080	1.3722	24.83
420082	1.5853	18.88
420083	1.3596	20.41
420085	1.4116	18.33
420086	1.4340	19.31
420087	1.5959	17.43
420088	1.0878	17.09
420089	1.2941	21.66
420091	1.2732	18.57
420093	1.0353	16.77
420094	.....	32.68
430004	0.9973	17.85
430005	1.3588	15.92
430007	1.0895	14.06
430008	1.0971	16.54
430010	1.1605	16.11
430011	1.2930	16.42
430012	1.3230	17.56
430013	1.2073	17.24
430014	1.3653	18.56
430015	1.2134	16.41
430016	1.8711	18.97
430018	0.8815	15.15
430022	0.8616	12.95
430023	0.8729	11.64
430024	0.9364	13.99
430026	.....	10.85
430027	1.7681	18.32
430028	1.0724	16.78
430029	0.9602	15.10
430031	0.9138	12.46
430033	0.9935	14.64
430034	0.9461	12.85
430036	0.9551	13.78
430037	0.9633	15.95
430038	1.0095	11.94
430040	1.0511	13.37
430041	0.9140	12.62
430043	1.1323	13.43
430044	0.9084	16.45
430047	1.0274	17.06
430048	1.2378	17.26

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
430049	0.8812	14.44
430051	0.9318	17.03
430054	0.9648	13.50
430056	0.8301	10.74
430057	0.8972	15.15
430060	1.0902	8.64
430062	.....	10.89
430064	1.0191	12.74
430065	.....	12.77
430066	0.9635	13.44
430073	1.0646	14.98
430076	0.9475	12.25
430076	1.3562	15.61
430077	1.6605	17.72
430079	1.0029	12.98
430081	0.8954	.....
430082	0.8549	.....
430083	0.9273	.....
430084	0.8155	.....
430085	0.7910	.....
430087	.....	10.45
430089	0.8333	17.01
430090	1.3320	.....
430091	1.4528	.....
430092	2.2007	.....
430093	0.9966	.....
440001	1.1722	15.01
440002	1.6649	24.36
440003	1.2128	17.47
440006	1.4058	20.39
440007	1.0032	7.77
440008	0.9784	14.04
440009	1.1552	15.46
440010	0.9307	13.59
440011	1.3832	17.16
440012	1.7143	18.79
440014	1.0046	14.61
440015	1.7923	21.09
440016	1.0334	14.94
440017	1.7422	20.93
440018	1.2965	18.21
440019	1.7372	28.22
440020	1.1314	14.70
440022	.....	19.02
440023	1.1030	14.14
440024	1.2947	18.10
440025	1.1538	15.28
440026	0.8073	22.92
440029	1.2585	18.52
440030	1.2098	15.57
440031	1.0300	14.30
440031	1.5024	19.61
440032	1.0048	13.60
440033	1.1602	14.04
440034	1.5621	17.93
440035	1.2301	18.16
440039	1.8871	16.52
440040	0.9687	17.50
440041	1.0284	13.63
440046	1.2336	16.83
440047	0.9254	17.00

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
440048	1.8710	18.14
440049	1.6635	15.23
440050	1.3867	16.76
440051	0.9145	14.91
440052	1.0633	16.27
440053	1.3201	17.69
440054	1.1349	12.31
440056	1.1422	14.25
440057	1.0340	12.72
440058	1.2124	18.86
440059	1.4182	17.53
440060	1.1653	15.86
440061	1.1496	16.48
440063	1.6724	18.29
440064	1.0863	17.38
440065	1.2816	18.69
440067	1.2422	28.28
440068	1.2251	17.45
440070	1.0077	15.04
440071	1.3615	16.17
440073	1.2785	18.56
440078	1.0266	13.09
440081	1.0950	17.97
440082	2.0471	19.61
440083	0.9670	59.16
440084	1.2064	13.37
440091	1.6371	19.72
440100	1.0065	13.95
440102	1.1313	13.96
440103	1.1144	19.21
440104	1.7388	22.39
440105	1.7270	16.03
440109	1.0889	14.25
440110	1.1002	15.92
440111*	1.4426	21.12
440114	1.0554	13.61
440115	1.0675	12.97
440115	1.4538	16.64
440120	1.6404	18.30
440125	1.5584	16.11
440130	1.1384	16.67
440131	1.1174	14.68
440132	1.1314	15.91
440133	1.5479	21.70
440135	1.2196	35.34
440137	1.0844	14.70
440141	0.9706	12.48
440142	1.0003	13.01
440143	1.0461	17.33
440144	1.2139	16.67
440145	0.9559	13.66
440147	1.7001	22.01
440148	1.1231	17.64
440149	1.0945	13.89
440150	1.3319	13.04
440151	1.1148	15.43
440152	2.0165	17.84
440153	1.1547	16.10
440157	1.0819	9.02
440159	1.1218	17.62
440161	1.8684	20.39

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
440162	.....	14.41
440166	1.6849	18.14
440168	1.0561	17.15
440173	1.6008	18.47
440174	1.0302	17.01
440175	1.0716	17.29
440176	1.3816	18.75
440180	1.2237	17.01
440181	0.9662	11.85
440182	0.9596	18.91
440183	1.5917	19.43
440184	1.2536	18.06
440185	1.1857	18.73
440186	1.0479	18.28
440187	1.1048	14.46
440189	1.4799	16.19
440192	1.0810	19.97
440193	1.2265	18.40
440194	1.2532	19.21
440197	1.3616	23.08
440200	1.0421	15.85
440203	0.9727	16.61
440206	0.9468	13.75
440209	.....	14.75
440210	0.8584	12.33
440211	0.7073	.....
440212	1.3679	.....
440213	2.6309	.....
440214	1.3295	.....
450002*	1.5334	19.92
450004	1.1433	15.28
450005	1.1877	15.66
450007	1.2689	15.75
450008	1.2584	15.75
450010	1.4340	16.08
450011	1.5214	17.66
450014	1.1172	18.22
450015*	1.6355	16.44
450016	1.6644	17.31
450018	1.4434	19.81
450020	0.9601	16.97
450021	1.8595	22.03
450024	1.4525	16.10
450024	1.6146	15.16
450025	1.7316	16.44
450028	1.5003	18.28
450029	1.6807	17.69
450031	1.4829	20.90
450032	1.3571	15.24
450033	1.7144	20.86
450034	1.5651	18.91
450035	1.4731	16.91
450037	1.5577	18.65
450039*	1.4262	18.83
450040	1.5483	17.52
450042	1.7715	17.01
450044	1.6187	17.61
450046*	1.3251	16.99
450047	1.1488	12.50
450050	0.9407	13.00
450051	1.5714	20.08

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
450052	1.0002	13.53
450053	1.1028	17.31
450054*	1.6343	21.98
450055	1.1125	14.81
450056	1.6257	19.22
450058	1.6338	16.98
450059	1.3021	14.21
450063	0.9097	13.81
450064	1.4200	15.43
450065	1.0265	19.61
450068	1.9331	22.90
450072	1.1764	17.34
450073	1.1207	16.62
450076	1.7329	.....
450078	0.8770	13.49
450079	1.5311	19.49
450080	1.1778	16.19
450081	1.0574	16.17
450082	0.9688	13.30
450083	1.8071	20.18
450085	1.0524	14.22
450087	1.4467	21.44
450090	1.1231	13.91
450092	1.2254	15.68
450094	1.3268	19.20
450096	1.4156	16.63
450097	1.3392	18.27
450098	1.0981	15.48
450099	1.1515	22.88
450101	1.4797	15.29
450102	1.7275	17.15
450104	1.1833	15.96
450107	1.5329	20.74
450108	1.0388	13.53
450109	0.9217	12.77
450110	.....	21.44
450111	1.2306	19.27
450112	1.2588	12.04
450113	1.3241	15.15
450118	1.6610	15.83
450119	1.4076	18.32
450121	1.5363	17.37
450123	1.1893	19.19
450124	1.6632	20.61
450126	1.3278	17.45
450128	1.1963	15.62
450130	1.5006	17.86
450131	1.2640	17.62
450132	1.6184	14.38
450133	1.6016	19.64
450137	1.5728	23.96
450140	0.9222	18.07
450143	1.0314	13.28
450144	1.0945	16.30
450145	0.8669	14.84
450146	0.9518	13.75
450147	1.3039	14.90
450148	1.2199	16.91
450149	1.4914	24.00
450150	0.9050	12.56
450151	1.1034	14.84

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
450152	1.2307	17.33
450153	1.5443	24.00
450154	1.1796	11.36
450155	1.0303	23.77
450157	1.0679	14.62
450160	0.9623	8.75
450162	1.2163	22.12
450163	1.0057	16.98
450164	1.1844	19.21
450165	1.0389	15.16
450166	0.9373	10.28
450169	.....	15.88
450170	0.9628	13.96
450176	1.2927	16.30
450177	1.2044	15.38
450178	1.0248	16.76
450181	1.0084	14.02
450184	1.4589	19.47
450185	1.0264	13.06
450187	1.1969	17.14
450188	0.9950	13.78
450191	1.0176	18.80
450192	1.1764	21.53
450193	2.0194	22.73
450194	1.3017	19.15
450196	1.4365	16.49
450200	1.4455	17.38
450201	1.0178	17.05
450203	1.1592	18.66
450209	1.5655	18.66
450210	1.0520	14.23
450211	1.3626	16.69
450213	1.7288	17.44
450214	1.3280	17.25
450217	0.9354	11.69
450219	1.0891	15.42
450221	1.1920	16.99
450222	1.4941	18.38
450224	1.3678	22.83
450229	1.5725	16.39
450231	1.6282	13.25
450234	1.0450	13.26
450235	1.0681	13.42
450236	1.1453	15.68
450237	1.5262	17.40
450239	1.0080	13.64
450241	0.9562	13.66
450243	0.9422	12.31
450246	1.0110	18.31
450249	1.0667	11.63
450250	0.9906	14.91
450253	1.1234	15.35
450258	1.0358	13.23
450259	.....	17.85
450264	0.8807	13.89
450269	0.9963	14.16
450270	1.0793	9.86
450271	1.2394	15.39
450272	1.2614	17.91
450276	1.0966	12.71
450278	0.8254	13.79
450280	1.5815	19.01
450283	1.0413	13.89
450286	.....	12.12
450288	1.1566	15.67
450289	1.4681	18.08
450293	0.9461	14.43
450296	1.3456	20.66
450299	1.5412	17.97
450303	0.9624	11.59
450306	1.0914	13.32
450307	0.7995	16.23
450309	1.0981	11.91
450315	0.9788	20.80
450320	1.2431	19.63
450321	0.9220	13.09
450322	0.5973	12.33
450324	1.5343	17.87
450327	0.9680	15.98
450330	1.1267	18.42
450334	0.9752	12.27
450337	0.9932	17.42
450340	1.4589	15.85
450341	1.0144	19.27
450346	1.5017	14.22
450347	1.2197	17.54
450348	1.1296	12.94
450352	1.1887	17.50
450353	1.1374	15.00
450355	1.0444	14.32
450358	2.0739	18.73
450362	1.0903	14.71
450369	1.0535	15.17
450370	1.2082	15.44
450371	1.2448	11.90
450372	1.2359	18.76
450373	1.1042	17.60
450374	0.8698	12.69
450378	1.1823	23.06
450379	1.5578	20.28
450381	0.9504	13.57
450388	1.7801	17.56
450389	1.2887	18.15
450393	1.2516	15.73
450395	1.0414	13.48
450400	1.3751	11.53
450411	0.9314	13.56
450417	1.0236	13.85
450418	1.3841	20.58
450419	1.2162	14.50
450422	1.0412	24.33
450423	1.5371	19.44
450424	1.2463	17.09
450429	1.1179	10.12
450431	1.5626	34.88
450438	1.1330	14.95
450446	0.7612	21.97
450447	1.3910	16.35
450451	1.1844	18.35
450457	1.8463	19.35
450460	1.0034	16.62
450462	1.7354	19.83
450464	0.9328	10.87
450465	1.3057	15.22
450467	1.0766	15.02
450469	1.3918	22.10
450473	1.0190	14.19
450475	1.0903	16.25
450484	1.4886	19.59
450488	1.3273	18.73
450489	0.9699	12.93
450497	1.1188	11.89
450498	0.9736	0.87
450508	1.3853	19.37
450514	1.0764	22.28
450517	0.9583	12.86
450518	1.5216	18.98
450523	1.4806	20.26
450530	1.1943	22.91
450534	0.9671	22.77
450535	1.2284	21.26
450537	1.3420	20.83
450538	.....	19.69
450539	1.2651	14.25
450544*	1.1442	19.38
450545	1.3928	16.97
450547	1.0633	13.81
450551	1.1045	24.23
450558	1.7912	20.15
450559	.....	11.50
450561	.....	16.82
450563	1.2647	30.37
450565	1.2567	16.45
450570	1.1346	17.71
450571	1.4908	16.80
450573	0.9885	15.61
450574	0.9302	14.24
450575	1.1445	19.06
450578	0.9365	16.87
450580	1.1534	15.36
450583	1.0350	15.50
450583	1.1976	21.38
450584	1.1771	12.42
450586	1.0584	12.79
450587	1.1745	17.11
450591	1.1460	17.92
450596	1.2182	14.82
450597	0.9687	16.18
450603	0.7880	12.77
450604	1.3023	14.47
450605	1.1873	20.15
450609	0.8938	10.73
450610	1.4674	16.49
450614	0.9889	13.25
450615	1.0755	14.75
450617	1.3306	19.54
450620	1.1230	12.27
450623	1.1390	21.83
450626	1.0109	18.56
450628	1.0152	16.83
450630	1.5199	19.19
450631	1.6593	17.56
450632	0.9391	11.63

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
450633	1.5493	19.26
450634	1.5955	20.29
450638	1.5280	21.11
450639	1.4800	20.14
450639	1.1078	14.71
450641	1.0511	13.50
450643	1.2200	17.43
450643	1.8171	18.65
450644	1.4350	20.79
450644	1.2078	17.67
450646	1.4571	19.99
450647	1.8915	22.10
450648	1.0015	12.59
450649	1.0322	15.37
450651	1.6801	20.31
450652	0.9063	15.24
450653	1.0888	19.28
450654	0.9486	13.41
450656	1.3894	18.56
450658	0.9605	15.15
450659	1.4874	20.56
450661	1.1066	20.22
450662	1.4702	18.42
450665	0.8639	13.60
450666	1.3180	19.35
450668	1.6257	18.50
450669	1.3474	22.28
450670	1.3446	18.20
450672	1.5857	21.04
450673	1.0157	13.84
450674	1.1515	20.62
450675	1.3677	23.26
450677	1.3317	18.71
450678	1.4729	20.75
450681	1.3177	.....
450683	1.2745	19.95
450684	1.2398	22.85
450686	1.5933	14.85
450688	1.3163	20.90
450690	1.3862	16.37
450694	1.1409	18.03
450696	1.3358	17.57
450697	1.3692	15.93
450698	0.9124	14.40
450700	0.9465	15.12
450702	1.5056	21.01
450703	1.1321	18.80
450704	1.2418	21.62
450705	0.8800	22.32
450705	1.7726	20.82
450709	1.1858	17.96
450711	1.6329	17.93
450712	0.5447	16.89
450713	1.4868	23.11
450715	1.4311	19.11
450716	1.2675	19.99
450716	1.3205	16.71
450717	1.2910	19.45
450718	1.1993	19.07
450723	1.4195	20.55
450724	1.2576	20.07

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
450725	.....	19.56
450727	1.0735	17.75
450728	0.8255	12.93
450730	1.3987	20.88
450733	1.4711	20.37
450735	0.8297	8.00
450742	1.2724	20.74
450743	1.4594	14.65
450746	0.9226	18.45
450747	1.3312	17.38
450749	1.0333	12.95
450750	1.0162	14.72
450751	1.2148	22.25
450754	0.9405	14.89
450757	0.8760	13.96
450761	0.9449	11.14
450763	1.0029	17.56
450766	2.0829	18.19
450769	0.8529	13.62
450770	0.9940	15.51
450771	1.9141	17.74
450774	1.6697	16.52
450775	1.3635	19.97
450776	1.0096	10.19
450777	0.9775	19.59
450779	1.2926	22.97
450780	1.7465	15.28
450785	0.9897	18.55
450788	1.5030	20.78
450794	.....	18.40
450795	0.9920	14.17
450796	3.3883	.....
450797	0.7701	18.59
450798	0.7662	9.22
450801	1.4574	16.35
450802	1.4444	18.90
450803	1.0998	16.20
450804	1.7558	20.19
450807	0.8919	13.23
450808	1.9103	45.47
450809	1.5476	12.09
450810	0.9739	.....
450811	2.4111	18.38
450812	.....	20.74
450813	0.9720	.....
450815	2.5623	.....
450817	0.6826	.....
450818	1.1788	.....
450819	1.2321	.....
450820	1.0337	.....
450822	1.2194	.....
460001	1.7791	20.63
460003	1.6039	20.60
460005	1.6610	17.58
460006	1.3361	19.65
460007	1.3066	20.57
460008	1.3692	23.97
460009*	1.8478	21.14
460010	2.0938	21.25
460013	1.4314	18.21
460014	1.2150	16.70

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
460015	1.2389	19.99
460016	0.9921	18.08
460017	1.4000	6.88
460018	0.9273	16.86
460019	1.0515	16.83
460020	0.9556	17.03
460021	1.3838	20.26
460022	0.9569	18.21
460023	1.1748	21.33
460024	.....	13.03
460025	0.8253	12.51
460026	1.0648	17.34
460027	0.9545	20.85
460029	1.0958	17.45
460030	1.1965	17.22
460032	0.9812	19.55
460033	0.9710	15.72
460035	0.9482	10.14
460036	1.0012	22.38
460037	0.9093	18.77
460039	1.0603	24.48
460041	1.3034	21.69
460042	1.3720	17.85
460043	0.9896	23.90
460044	1.1363	20.69
460046	.....	17.11
460047	1.6725	20.94
460049	1.9835	18.82
460051	1.1533	20.98
460052	1.4619	.....
470001	1.3024	19.61
470003	1.8178	22.10
470004	1.0690	18.10
470005	1.2301	21.51
470006	1.2402	18.39
470008	1.2583	19.41
470010	1.0674	19.47
470011	1.1523	21.20
470012	1.2771	18.52
470015	1.2008	19.26
470018	1.2257	20.77
470020	0.9900	18.99
470023	1.3178	20.34
470024	1.1530	20.41
490001	1.1947	24.76
490002	1.0751	12.74
490003	0.6419	18.00
490004	1.2734	18.67
490005	1.5964	16.91
490006	1.2135	15.23
490007	2.0980	18.43
490009	1.9433	22.95
490010	1.0335	18.58
490011	1.4669	18.20
490012	1.1951	13.78
490013	1.2469	16.93
490014	1.5363	24.56
490015	1.5153	19.36
490017	1.3909	15.07
490018	1.3011	17.67
490019	1.1928	16.93

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
490020	1.2250	17.67
490021	1.3802	19.45
490022	1.5525	21.01
490023	1.2187	18.87
490024	1.6719	16.89
490027	1.1135	14.46
490030	1.1907	10.50
490031	1.0746	15.82
490032*	1.7258	25.58
490033	1.1993	18.33
490037	1.2001	15.97
490038	1.2145	15.71
490040	1.4731	22.35
490041	1.2784	16.55
490042	1.2285	15.27
490043	1.3526	20.68
490044	1.3206	17.63
490045	1.2191	19.63
490046	1.5460	18.61
490047	1.1059	17.16
490048	1.5709	17.89
490050	1.4272	22.71
490052	1.6374	16.94
490053	1.3173	15.69
490054	1.0322	15.55
490057	1.5692	19.07
490059	1.5895	20.22
490060	1.0646	19.20
490063	1.7720	27.25
490066	1.3206	17.88
490067	1.2570	17.19
490069	1.4162	13.29
490071	1.4080	19.47
490074	.....	13.34
490075	1.3803	19.19
490077	1.2281	19.79
490079	1.3125	16.44
490079	1.3236	23.38
490083	.....	16.64
490084	1.1288	16.38
490085	1.1577	16.40
490088	1.1207	20.76
490089	1.0686	15.86
490090	1.1204	16.35
490091	1.2337	19.83
490092	1.2211	12.97
490093	1.4392	16.48
490094	1.0907	16.79
490097	1.2114	15.86
490098	1.2065	14.70
490099	0.9562	16.88
490100	.....	17.22
490101	1.2299	24.85
490104	0.6981	28.49
490105	0.5822	18.25
490106	0.8713	16.91
490107	1.3325	22.41
490107	1.2448	21.42
490108	0.8976	19.75
490109	0.8779	21.16
490110	1.3090	15.84

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
490111	1.2008	17.34
490112	1.6550	20.52
490112	0.9491	21.43
490113	1.3260	23.08
490114	1.1579	16.91
490115	1.1607	17.10
490116	1.1694	16.44
490117	1.1533	13.84
490119	1.3405	17.87
490122	1.3606	23.62
490123	1.1354	16.85
490124	1.0889	19.36
490126	1.3233	17.07
490127	1.0414	14.48
490129	1.0562	27.47
490130	1.3109	16.28
490132	1.0184	17.02
500001	1.4839	21.30
500002	1.4064	21.04
500003	1.3996	24.31
500005	1.7494	23.48
500007	1.3375	22.43
500007	1.7377	27.24
500008	1.9429	24.19
500011	1.3347	25.18
500012	1.5545	22.28
500014	1.5643	23.93
500015	1.3297	23.24
500016	1.4969	23.90
500019	1.3825	22.37
500019	1.0542	16.63
500021	1.4811	24.46
500023	1.2084	27.19
500024	1.6908	28.85
500025	1.9076	23.96
500026	1.4496	23.35
500027*	1.6837	25.11
500028	1.0717	18.86
500029	0.9116	17.15
500030	1.4523	24.13
500031	1.2466	23.37
500033	1.3324	21.39
500036	1.3903	21.89
500037	1.1389	19.69
500039	1.3777	23.32
500042	1.4121	22.13
500043	1.0020	20.25
500044	1.9366	23.11
500045	1.0116	22.10
500048	0.9588	19.01
500049	1.4726	22.95
500050	1.3485	20.97
500051	1.6734	24.48
500052	1.1378	.....
500053	1.3294	22.05
500054	1.8773	22.90
500055	1.1299	22.88
500057	1.3026	18.04
500058	1.4858	23.40
500059	1.0767	22.54
500060	1.3734	23.58

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
500061	1.0038	20.40
500062	1.0655	19.46
500064	1.6399	24.53
500068	1.0553	18.70
500069	1.1143	20.63
500071	1.2830	19.38
500072	1.2022	24.46
500074	1.1040	17.83
500077	1.3318	22.93
500079	1.3197	22.98
500080	0.8124	13.80
500084	1.2783	17.76
500085	0.9278	28.61
500086	1.2605	22.31
500088	1.2964	23.71
500089	1.0388	17.94
500090	0.8380	16.33
500092	1.0142	17.40
500094	0.8826	18.11
500096	0.9385	20.96
500097	1.0798	19.71
500098	1.0464	16.38
500101	1.0138	19.45
500102	0.9022	20.33
500104	1.2658	22.58
500106	0.9351	18.71
500107	1.2050	17.30
500107	1.2050	17.30
500107	1.4730	20.61
500110	1.2039	21.41
500118	1.1500	22.92
500118	1.2716	18.35
500119	1.3565	21.57
500122	1.2754	21.91
500123	0.9512	19.58
500124	1.3682	24.15
500129	1.6395	23.60
500132	0.9695	19.42
500134	0.6470	20.96
500138	3.6799	.....
500139	1.4685	20.88
500140	.....	1.00
500141	1.3697	22.94
500143	0.5986	17.60
500146	.....	17.85
510001	1.9505	17.87
510002	1.2866	17.34
510005	1.0195	14.43
510006	1.2718	17.53
510007*	1.5744	20.25
510008	1.2176	17.29
510012	1.0090	20.21
510013	1.1010	16.62
510015	0.9623	14.56
510016	.....	14.52
510018	1.0667	16.48
510020	1.0824	12.65
510022	1.8964	19.84
510023	1.2383	15.94
510024	1.5822	18.80
510026	1.0565	13.46

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
510027	0.9592	17.58
510028	1.0482	20.73
510029	1.2825	17.05
510029	1.1570	15.37
510030	1.0525	18.31
510030	1.1257	17.66
510031	1.4148	18.49
510033	1.2896	18.81
510035	1.2262	18.65
510036	0.9851	13.20
510038	1.0644	14.34
510039	1.3991	16.04
510043	0.9349	14.29
510046	1.2728	17.73
510047	1.2608	19.12
510048	1.1326	20.37
510050	1.7469	16.57
510053	1.0811	15.59
510055	1.2272	22.84
510058	1.2791	17.98
510059	1.9378	16.77
510060	1.0503	15.66
510061	1.0234	14.22
510062	1.2784	17.63
510065	.....	13.72
510066	.....	12.72
510067	1.2058	18.11
510068	1.2072	16.29
510070	1.2966	16.36
510071	1.3310	16.24
510072	1.0568	17.66
510077	1.1382	16.41
510080	1.1488	14.80
510081	1.0777	13.00
510082	1.1599	13.38
510084	1.0387	12.48
510086	1.1038	13.79
510088	1.0373	.....
520003	1.0889	16.43
520004	1.1781	18.17
520006	1.0164	20.44
520007	1.0498	13.11
520008	1.6388	23.11
520009	1.6963	18.51
520010	1.1567	20.34
520011	1.1930	20.38
520013	1.3708	21.64
520014	1.1081	16.40
520015	1.1985	18.32
520016	0.9785	13.29
520017	1.1935	19.32
520018	1.1169	18.64
520019	1.3094	18.31
520021	1.4602	19.46
520024	1.0420	14.61
520025	1.0655	18.11
520026	1.0229	19.81
520027	1.2629	18.86
520028	1.3300	19.14
520029	0.8925	16.75
520030	1.7397	20.01

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
520031	1.0727	18.71
520032	1.2635	17.84
520033	1.2390	18.77
520034	1.1068	16.69
520035	1.3242	17.10
520037	1.7020	20.05
520038	1.3352	17.71
520039	0.9971	19.60
520040	1.5273	20.48
520044	1.4160	17.79
520045	1.6446	19.67
520047	0.9370	17.87
520048	1.4946	18.61
520049	2.0474	19.57
520051*	1.8401	19.06
520053	1.1887	16.49
520054	1.0540	15.99
520057	1.1966	18.32
520058	1.1064	18.13
520059	1.4353	19.85
520060	1.4753	17.05
520062	1.2495	17.80
520063	1.1851	20.77
520064	1.5705	21.46
520066	1.4668	22.24
520068	0.9622	18.08
520069	1.2302	17.00
520070	1.5249	17.82
520071	1.2534	18.75
520074	1.0579	19.57
520075	1.4850	19.09
520076	1.1802	16.51
520077	0.9304	15.54
520078	1.6347	20.13
520082	1.1943	16.74
520083	1.7211	25.85
520084	1.0805	18.95
520087	1.6998	19.39
520088	1.2750	20.15
520090	1.2589	18.00
520091	1.2781	20.07
520092	1.0851	17.56
520094	0.7814	19.78
520095	1.2912	18.51
520096	1.3837	19.30
520097	1.3186	19.57
520098*	1.7679	20.03
520100	1.2558	18.38
520101	1.0673	17.85
520102	1.1747	19.83
520103	1.3291	21.23
520107	1.2651	20.54
520109	1.0080	18.63
520110	1.2429	20.03
520111	1.0771	17.24
520112	1.1370	18.18
520113	1.2753	20.59
520114	1.0715	17.38
520115	1.2443	17.38
520116	1.2746	18.57
520117	1.0104	17.42

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
520118	0.9267	12.44
520120	0.9639	15.62
520121	0.9809	17.58
520122	0.9984	16.76
520123	0.9687	17.41
520124	1.0565	16.39
520130	1.0658	14.49
520131	1.0212	18.80
520132	1.2099	17.28
520134	1.1056	17.61
520135	0.9696	14.47
520136*	1.5145	19.85
520138	1.8811	20.56
520139	1.2600	21.28
520140	1.6657	20.99
520141	.....	16.95
520142	0.8561	17.70
520144	1.0159	16.62
520145	0.9104	17.24
520146	1.0606	15.73
520148	1.1740	16.93
520149	0.8682	13.30
520151	1.0569	18.08
520152	1.1284	21.33
520153	0.9014	15.45
520154	1.1279	17.92
520156	1.1295	19.84
520157	1.1386	17.28
520159	0.9313	18.74
520160	1.7788	18.84
520161	0.9970	18.57
520170	1.1959	22.45
520171	0.9550	15.73
520173	1.1310	19.81
520177	1.7167	21.29
520178	1.0405	17.04
520187	0.6853	.....
530002	1.1871	17.59
530003	0.8651	15.78
530004	0.9408	16.19
530005	1.1117	15.15
530006	1.1073	19.34
530007	1.0694	18.06
530008	1.2168	19.71
530009	0.9868	19.45
530010	1.2449	18.93
530011	1.1582	17.44
530012	1.6193	19.48
530014	1.4152	17.32
530015	1.2824	22.65
530016	1.2295	17.71
530017	0.9391	13.71
530018	0.9886	17.87
530019	0.9196	16.76
530022	1.1517	17.88
530023	0.8312	20.75
530025	1.3777	20.32
530026	1.1298	18.92
530027	0.8284	29.77
530029	1.0012	17.97
530031	0.8249	13.38

Average hourly wage based on data on file as of February 22, 1999. It does not reflect any changes processed after that date.
Asterisk denotes teaching physician costs removed based on costs reported on worksheet a, col. 1, line 23 of FY 1996 cost report.

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1998; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEAR 2000 WAGE INDEX—Continued

Prov.	Case mix index	Avg. hourly wage
530032	0.9898	20.21

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) – FOR URBAN AREAS

Urban area (constituent counties)	Wage index	GAF
0040 Abilene, TX	0.8269	0.8780
Taylor, TX		
0060 Aguadilla, PR	0.4559	0.5840
Aguada, PR		
Aguadilla, PR		
Moca, PR		
0080 Akron, OH	1.0277	1.0189
Portage, OH		
Summit, OH		
0120 [2] Albany, GA	0.8189	0.8721
Dougherty, GA		
Lee, GA		
0160 [2] Albany-Schenectady-Troy, NY	0.8633	0.9042
Albany, NY		
Montgomery, NY		
Rensselaer, NY		
Saratoga, NY		
Schenectady, NY		
Schoharie, NY		
0200 [2] Albuquerque, NM	0.8613	0.9028
Bernalillo, NM		
Sandoval, NM		
Valencia, NM		
0220 Alexandria, LA	0.7988	0.8574
Rapides, LA		
0240 Allentown-Bethlehem-Easton, PA	0.9754	0.9831
Carbon, PA		
Lehigh, PA		
Northampton, PA		
0280 Altoona, PA	0.9422	0.9600
Blair, PA		
0320 Amarillo, TX	0.8150	0.8693
Potter, TX		
Randall, TX		
0380 Anchorage, AK	1.3143	1.2058
Anchorage, AK		
0440 Ann Arbor, MI	1.1565	1.1047
Lenawee, MI		
Livingston, MI		
Washtenaw, MI		
0450 Anniston, AL	0.8548	0.8981
Calhoun, AL		
0460 Appleton-Oshkosh-Neenah, WI	0.8944	0.9264
Calumet, WI		
Outagamie, WI		
Winnebago, WI		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) – FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
0470 Arecibo, PR	0.4737	0.5995
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
0480 Asheville, NC	0.8978	0.9288
Buncombe, NC		
Madison, NC		
0500 Athens, GA	0.9556	0.9694
Clarke, GA		
Madison, GA		
Oconee, GA		
0520 [1] Atlanta, GA	1.0119	1.0081
Barrow, GA		
Bartow, GA		
Carroll, GA		
Cherokee, GA		
Clayton, GA		
Cobb, GA		
Coweta, GA		
DeKalb, GA		
Douglas, GA		
Fayette, GA		
Forsyth, GA		
Fulton, GA		
Gwinnett, GA		
Henry, GA		
Newton, GA		
Paulding, GA		
Pickens, GA		
Rockdale, GA		
Spalding, GA		
Walton, GA		
0560 Atlantic-Cape May, NJ	1.1076	1.0725
Atlantic, NJ		
Cape May, NJ		
0600 Augusta-Aiken, GA–SC	0.9117	0.9387
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Edgefield, SC		
0640 [2] Austin-San Marcos, TX	0.9511	0.9663
Bastrop, TX		
Caldwell, TX		
Hays, TX		
Travis, TX		
Williamson, TX		
0680 [2] Bakersfield, CA	1.0153	1.0105
Kern, CA		
0720 [1] Baltimore, MD	1.0176	1.0120
Anne Arundel, MD		
Baltimore, MD		
Baltimore City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Anne's, MD		
0733 Bangor, ME	0.9706	0.9798
Penobscot, ME		
0743 Barnstable-Yarmouth, MA	1.3013	1.1976

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) – FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Barnstable, MA		
0760 Baton Rouge, LA	0.8796	0.9159
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
0840 Beaumont-Port Arthur, TX	0.8555	0.8986
Hardin, TX		
Jefferson, TX		
Orange, TX		
0860 Bellingham, WA	1.1509	1.1010
Whatcom, WA		
0870 [2] Benton Harbor, MI	0.8904	0.9236
Berrien, MI		
0875 [1] Bergen-Passaic, NJ	1.1861	1.1240
Bergen, NJ		
Passaic, NJ		
0880 Billings, MT	1.1802	1.1201
Yellowstone, MT		
0920 Biloxi-Gulfport-Pascagoula, MS	0.8030	0.8605
Hancock, MS		
Harrison, MS		
Jackson, MS		
0960 Binghamton, NY	0.8701	0.9091
Broome, NY		
Tioga, NY		
1000 Birmingham, AL	0.9010	0.9311
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
1010 Bismarck, ND	0.7973	0.8563
Burleigh, ND		
Morton, ND		
1020 Bloomington, IN	0.8680	0.9076
Monroe, IN		
1040 Bloomington-Normal, IL	0.9084	0.9363
McLean, IL		
1080 Boise City, ID	0.9178	0.9430
Ada, ID		
Canyon, ID		
1123 [1] Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1247	1.0838
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) – FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
1125 Boulder-Longmont, CO	1.0045	1.0031
Boulder, CO		
1145 Brazoria, TX	0.8592	0.9013
Brazoria, TX		
1150 Bremerton, WA	1.1122	1.0755
Kitsap, WA		
1240 Brownsville-Harlingen-San Benito, TX	0.9243	0.9475
Cameron, TX		
1260 Bryan-College Station, TX	0.8453	0.8913
Brazos, TX		
1280 [1] Buffalo-Niagara Falls, NY	0.9586	0.9715
Erie, NY		
Niagara, NY		
1303 Burlington, VT	1.0455	1.0309
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
1310 Caguas, PR	0.4555	0.5836
Caguas, PR		
Cayey, PR		
Cidra, PR		
Gurabo, PR		
San Lorenzo, PR		
1320 Canton-Massillon, OH	0.8722	0.9106
Carroll, OH		
Stark, OH		
1350 Casper, WY	0.9292	0.9510
Natrona, WY		
1360 Cedar Rapids, IA	0.9110	0.9382
Linn, IA		
1400 Champaign-Urbana, IL	0.9255	0.9484
Champaign, IL		
1440 Charleston-North Charleston, SC	0.8997	0.9302
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
1480 Charleston, WV	0.9187	0.9436
Kanawha, WV		
Putnam, WV		
1520 [1] Charlotte-Gastonia-Rock Hill, NC–SC	0.9522	0.9670
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Stanly, NC		
Union, NC		
York, SC		
1540 Charlottesville, VA	1.0681	1.0461
Albemarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
1560 Chattanooga, TN–GA	0.9892	0.9926
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
1580 [2] Cheyenne, WY	0.8891	0.9227
Laramie, WY		
1600 [1] Chicago, IL	1.0858	1.0580
Cook, IL		
DeKalb, IL		
DuPage, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		
Will, IL		
1620 Chico-Paradise, CA	1.0381	1.0259
Butte, CA		
1640 [1] Cincinnati, OH–KY–IN	0.9477	0.9639
Dearborn, IN		
Ohio, IN		
Boone, KY		
Campbell, KY		
Gallatin, KY		
Grant, KY		
Kenton, KY		
Pendleton, KY		
Brown, OH		
Clermont, OH		
Hamilton, OH		
Warren, OH		
1660 Clarksville-Hopkinsville, TN–KY	0.8413	0.8884
Christian, KY		
Montgomery, TN		
1680 [1] Cleveland-Lorain-Elyria, OH	0.9724	0.9810
Ashtabula, OH		
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Lorain, OH		
Medina, OH		
1720 Colorado Springs, CO	0.9311	0.9523
El Paso, CO		
1740 Columbia, MO	0.8982	0.9291
Boone, MO		
1760 Columbia, SC	0.9452	0.9621
Lexington, SC		
Richland, SC		
1800 Columbus, GA–AL	0.8565	0.8994
Russell, AL		
Chattahoochee, GA		
Harris, GA		
Muscogee, GA		
1840 [1] Columbus, OH	0.9802	0.9864
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
1880 Corpus Christi, TX	0.9318	0.9528
Nueces, TX		
San Patricio, TX		
1900 [2] Cumberland, MD–WV (Maryland Hospitals)	0.9096	0.9372
Allegany, MD		
Mineral, WV		
1900 Cumberland, MD–WV (West Virginia Hospitals)	0.8890	0.9226
Allegany, MD		
Mineral, WV		
1920 [1] Dallas, TX	0.9230	0.9466
Collin, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Henderson, TX		
Hunt, TX		
Kaufman, TX		
Rockwall, TX		
1950 Danville, VA	0.9153	0.9412
Danville City, VA		
Pittsylvania, VA		
1960 Davenport-Moline-Rock Island, IA–IL	0.8795	0.9158
Scott, IA		
Henry, IL		
Rock Island, IL		
2000 Dayton-Springfield, OH	0.9388	0.9577
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
2020 [2] Daytona Beach, FL	0.9074	0.9356
Flagler, FL		
Volusia, FL		
2030 Decatur, AL	0.9983	0.9988
Lawrence, AL		
Morgan, AL		
2040 Decatur, IL	0.8413	0.8884
Macon, IL		
2080 [1] Denver, CO	1.0247	1.0168
Adams, CO		
Arapahoe, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
2120 Des Moines, IA	0.8849	0.9197
Dallas, IA		
Polk, IA		
Warren, IA		
2160 [1] Detroit, MI	1.0463	1.0315
Lapeer, MI		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) – FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Macomb, MI		
Monroe, MI		
Oakland, MI		
St. Clair, MI		
Wayne, MI		
2180 Dothan, AL	0.7916	0.8521
Dale, AL		
Houston, AL		
2190 Dover, DE	0.9426	0.9603
Kent, DE		
2200 Dubuque, IA	0.8606	0.9023
Dubuque, IA		
2240 Duluth-Superior, MN–WI	1.0278	1.0190
St. Louis, MN		
Douglas, WI		
2281 Dutchess County, NY	0.9837	0.9888
Dutchess, NY		
2290 Eau Claire, WI	0.9049	0.9339
Chippewa, WI		
Eau Claire, WI		
2320 El Paso, TX	0.8983	0.9292
El Paso, TX		
2330 Elkhart-Goshen, IN	0.9142	0.9404
Elkhart, IN		
2335 [2] Elmira, NY	0.8633	0.9042
Chemung, NY		
2340 Enid, OK	0.8034	0.8608
Garfield, OK		
2360 Erie, PA	0.9078	0.9359
Erie, PA		
2400 Eugene-Springfield, OR	1.0761	1.0515
Lane, OR		
2440 [2] Evansville-Henderson, IN–KY (IN Hospitals)	0.8480	0.8932
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2440 Evansville-Henderson, IN–KY (KY Hospital)	0.8380	0.8860
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2520 Fargo-Moorhead, ND–MN	0.8707	0.9095
Clay, MN		
Cass, ND		
2560 Fayetteville, NC	0.8673	0.9071
Cumberland, NC		
2580 Fayetteville-Springdale-Rogers, AR	0.7852	0.8474
Benton, AR		
Washington, AR		
2620 Flagstaff, AZ–UT	1.0453	1.0308
Coconino, AZ		
Kane, UT		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) – FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
2640 Flint, MI	1.1132	1.0762
Genesee, MI		
2650 Florence, AL	0.8007	0.8588
Colbert, AL		
Lauderdale, AL		
2655 Florence, SC	0.8706	0.9095
Florence, SC		
2670 Fort Collins-Loveland, CO	1.0406	1.0276
Larimer, CO		
2680 [1] Ft. Lauderdale, FL	1.0239	1.0163
Broward, FL		
2700 [2] Fort Myers-Cape Coral, FL	0.9074	0.9356
Lee, FL		
2710 Fort Pierce-Port St. Lucie, FL	1.0240	1.0164
Martin, FL		
St. Lucie, FL		
2720 Fort Smith, AR–OK	0.7923	0.8526
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
2750 [2] Fort Walton Beach, FL	0.9074	0.9356
Okaloosa, FL		
2760 Fort Wayne, IN	0.8941	0.9262
Adams, IN		
Allen, IN		
De Kalb, IN		
Huntington, IN		
Wells, IN		
Whitley, IN		
2800 [1] Forth Worth-Arlington, TX	0.9003	0.9306
Hood, TX		
Johnson, TX		
Parker, TX		
Tarrant, TX		
2840 Fresno, CA	1.0371	1.0253
Fresno, CA		
Madera, CA		
2880 Gadsden, AL	0.8842	0.9192
Etowah, AL		
2900 Gainesville, FL	1.0181	1.0124
Alachua, FL		
2920 Galveston-Texas City, TX	0.9569	0.9703
Galveston, TX		
2960 Gary, IN	0.9449	0.9619
Lake, IN		
Porter, IN		
2975 Glens Falls, NY	0.8693	0.9085
Warren, NY		
Washington, NY		
2980 Goldsboro, NC	0.8418	0.8888
Wayne, NC		
2985 Grand Forks, ND–MN	0.9190	0.9438
Polk, MN		
Grand Forks, ND		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) – FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
2995 Grand Junction, CO	0.9291	0.9509
Mesa, CO		
3000 [1] Grand Rapids-Muskegon-Holland, MI	1.0169	1.0115
Allegan, MI		
Kent, MI		
Muskegon, MI		
Ottawa, MI		
3040 Great Falls, MT	1.0626	1.0425
Cascade, MT		
3060 Greeley, CO	0.9449	0.9619
Weld, CO		
3080 Green Bay, WI	0.9305	0.9519
Brown, WI		
3120 [1] Greensboro-Winston-Salem-High Point, NC	0.9122	0.9390
Alamance, NC		
Davidson, NC		
Davie, NC		
Forsyth, NC		
Guilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
3150 Greenville, NC	0.9570	0.9704
Pitt, NC		
3160 Greenville-Spartanburg-Anderson, SC	0.9199	0.9444
Anderson, SC		
Cherokee, SC		
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
3180 [2] Hagerstown, MD	0.9096	0.9372
Washington, MD		
3200 Hamilton-Middletown, OH	0.9080	0.9360
Butler, OH		
3240 Harrisburg-Lebanon-Carlisle, PA	0.9896	0.9929
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
3283 [1 2] Hartford, CT	1.2692	1.1773
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
3285 Hattiesburg, MS	0.7453	0.8177
Forrest, MS		
Lamar, MS		
3290 Hickory-Morganton-Lenoir, NC	0.9255	0.9484
Alexander, NC		
Burke, NC		
Caldwell, NC		
Catawba, NC		
3320 Honolulu, HI	1.1600	1.1070

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) – FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Honolulu, HI		
3350 Houma, LA	0.7916	0.8521
Lafourche, LA		
Terrebonne, LA		
3360 [1] Houston, TX	0.9286	0.9505
Chambers, TX		
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
3400 Huntington-Ashland, WV–KY–OH	0.9851	0.9898
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
3440 Huntsville, AL	0.8912	0.9242
Limestone, AL		
Madison, AL		
3480 [1] Indianapolis, IN	0.9876	0.9915
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Madison, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
3500 Iowa City, IA	0.9705	0.9797
Johnson, IA		
3520 Jackson, MI	0.8930	0.9254
Jackson, MI		
3560 Jackson, MS	0.8519	0.8960
Hinds, MS		
Madison, MS		
Rankin, MS		
3580 Jackson, TN	1.0953	1.0643
Madison, TN		
Chester, TN		
3600 [1 2] Jacksonville, FL	0.9074	0.9356
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
3605 [2] Jacksonville, NC	0.8349	0.8838
Onslow, NC		
3610 [2] Jamestown, NY	0.8633	0.9042
Chautauqua, NY		
3620 Janesville-Beloit, WI	0.9703	0.9796
Rock, WI		
3640 Jersey City, NJ	1.1718	1.1147
Hudson, NJ		
3660 Johnson City-Kingsport-Bristol, TN–VA	0.8935	0.9258
Carter, TN		
Hawkins, TN		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) – FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3680 [2] Johnstown, PA	0.8488	0.8938
Cambria, PA		
Somerset, PA		
3700 Jonesboro, AR	0.7324	0.8079
Craighead, AR		
3710 Joplin, MO	0.7756	0.8403
Jasper, MO		
Newton, MO		
3720 Kalamazoo-Battlecreek, MI	1.0095	1.0065
Calhoun, MI		
Kalamazoo, MI		
Van Buren, MI		
3740 Kankakee, IL	0.8349	0.8838
Kankakee, IL		
3760 [1] Kansas City, KS–MO	0.9301	0.9516
Johnson, KS		
Leavenworth, KS		
Miami, KS		
Wyandotte, KS		
Cass, MO		
Clay, MO		
Clinton, MO		
Jackson, MO		
Lafayette, MO		
Platte, MO		
Ray, MO		
3800 [2] Kenosha, WI	0.8842	0.9192
Kenosha, WI		
3810 Killeen-Temple, TX	1.0031	1.0021
Bell, TX		
Coryell, TX		
3840 Knoxville, TN	0.9315	0.9526
Anderson, TN		
Blount, TN		
Knox, TN		
Loudon, TN		
Sevier, TN		
Union, TN		
3850 Kokomo, IN	0.9075	0.9357
Howard, IN		
Tipton, IN		
3870 La Crosse, WI–MN	0.9024	0.9321
Houston, MN		
La Crosse, WI		
3880 Lafayette, LA	0.8160	0.8700
Acadia, LA		
Lafayette, LA		
St. Landry, LA		
St. Martin, LA		
3920 Lafayette, IN	0.8898	0.9232
Clinton, IN		
Tippecanoe, IN		
3960 Lake Charles, LA	0.7901	0.8510

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) – FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Calcasieu, LA		
3980 [2] Lakeland-Winter Haven, FL	0.9074	0.9356
Polk, FL		
4000 Lancaster, PA	0.8944	0.9264
Lancaster, PA		
4040 Lansing-East Lansing, MI	1.0091	1.0062
Clinton, MI		
Eaton, MI		
Ingham, MI		
4080 Laredo, TX	0.8407	0.8880
Webb, TX		
4100 [2] Las Cruces, NM	0.8613	0.9028
Dona Ana, NM		
4120 [1] Las Vegas, NV–AZ	1.1182	1.0795
Mohave, AZ		
Clark, NV		
Nye, NV		
4150 Lawrence, KS	0.8306	0.8806
Douglas, KS		
4200 Lawton, OK	0.8475	0.8929
Comanche, OK		
4243 Lewiston-Auburn, ME	0.8971	0.9283
Androscoggin, ME		
4280 Lexington, KY	0.8683	0.9078
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Madison, KY		
Scott, KY		
Woodford, KY		
4320 Lima, OH	0.8995	0.9300
Allen, OH		
Auglaize, OH		
4360 Lincoln, NE	0.9768	0.9841
Lancaster, NE		
4400 Little Rock-North Little Rock, AR	0.8698	0.9089
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
4420 Longview-Marshall, TX	0.8828	0.9182
Gregg, TX		
Harrison, TX		
Upshur, TX		
4480 [1] Los Angeles-Long Beach, CA	1.1903	1.1267
Los Angeles, CA		
4520 Louisville, KY–IN	0.9296	0.9512
Clark, IN		
Floyd, IN		
Harrison, IN		
Scott, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
4600 Lubbock, TX	0.8438	0.8902

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) – FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Lubbock, TX		
4640 Lynchburg, VA	0.9048	0.9338
Amherst, VA		
Bedford, VA		
Bedford City, VA		
Campbell, VA		
Lynchburg City, VA		
4680 Macon, GA	0.8615	0.9029
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Twiggs, GA		
4720 Madison, WI	1.0096	1.0066
Dane, WI		
4800 [2] Mansfield, OH	0.8722	0.9106
Crawford, OH		
Richland, OH		
4840 Mayaguez, PR	0.4862	0.6103
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
Sabana Grande, PR		
San German, PR		
4880 McAllen-Edinburg-Mission, TX	0.8152	0.8694
Hidalgo, TX		
4890 Medford-Ashland, OR	1.0600	1.0407
Jackson, OR		
4900 Melbourne-Titusville-Palm Bay, FL	0.9390	0.9578
Brevard, Fl		
4920 [1] Memphis, TN–AR–MS	0.8070	0.8634
Crittenden, AR		
DeSoto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4940 Merced, CA.		
Merced, CA	1.0615	1.0417
5000 [1] Miami, FL	1.0314	1.0214
Dade, FL		
5015 [1] Middlesex-Somerset-Hunterdon, NJ	1.1028	1.0693
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
5080 [1] Milwaukee-Waukesha, WI	0.9840	0.9890
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
5120 [1] Minneapolis-St. Paul, MN–WI	1.0630	1.0427
Anoka, MN		
Carver, MN		
Chicago, MN		
Dakota, MN		
Hennepin, MN		
Isanti, MN		
Ramsey, MN		
Scott, MN		
Sherburne, MN		
Washington, MN		
Wright, MN		
Pierce, WI		
St. Croix, WI		
5140 Missoula, MT	0.9281	0.9502
Missoula, MT		
5160 Mobile, AL	0.8301	0.8803
Baldwin, AL		
Mobile, AL		
5170 Modesto, CA	1.0183	1.0125
Stanislaus, CA		
5190 [1] Monmouth-Ocean, NJ	1.1371	1.0920
Monmouth, NJ		
Ocean, NJ		
5200 Monroe, LA	0.8304	0.8805
Ouachita, LA		
5240 [2] Montgomery, AL	0.7542	0.8243
Autauga, AL		
Elmore, AL		
Montgomery, AL		
5280 Muncie, IN	1.0869	1.0587
Delaware, IN		
5330 Myrtle Beach, SC	0.8647	0.9052
Horry, SC		
5345 Naples, FL	1.0234	1.0160
Collier, FL		
5360 [1] Nashville, TN	0.9140	0.9403
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
5380 [1] Nassau-Suffolk, NY	1.3274	1.2140
Nassau, NY		
Suffolk, NY		
5483 [1 2] New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2692	1.1773
Fairfield, CT		
New Haven, CT		
5523 [2] New London-Norwich, CT	1.2692	1.1773
New London, CT		
5560 [1] New Orleans, LA	0.9073	0.9356
Jefferson, LA		
Orleans, LA		
Plaquemines, LA		
St. Bernard, LA		
St. Charles, LA		
St. James, LA		
St. John The Baptist, LA		
St. Tammany, LA		
5600 [1] New York, NY	1.4302	1.2777
Bronx, NY		
Kings, NY		
New York, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
5640 [1] Newark, NJ	1.0873	1.0590
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Warren, NJ		
5660 Newburgh, NY–PA	1.1019	1.0687
Orange, NY		
Pike, PA		
5720 [1] Norfolk-Virginia Beach-Newport News, VA–NC	0.8378	0.8859
Currituck, NC		
Chesapeake City, VA		
Gloucester, VA		
Hampton City, VA		
Isle of Wight, VA		
James City, VA		
Mathews, VA		
Newport News City, VA		
Norfolk City, VA		
Poquoson City, VA		
Portsmouth City, VA		
Suffolk City, VA		
Virginia Beach City VA		
Williamsburg City, VA		
York, VA		
5775 [1] Oakland, CA	1.5199	1.3320
Alameda, CA		
Contra Costa, CA		
5790 Ocala, FL	0.9712	0.9802
Marion, FL		
5800 Odessa-Midland, TX	0.8016	0.8595
Ector, TX		
Midland, TX		
5880 [1] Oklahoma City, OK	0.8705	0.9094
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
5910 Olympia, WA	1.2750	1.1810
Thurston, WA		
5920 Omaha, NE–IA	1.0722	1.0489
Pottawattamie, IA		
Cass, NE		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) – FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Douglas, NE		
Sarpy, NE		
Washington, NE		
5945 [1] Orange County, CA	1.1539	1.1030
Orange, CA		
5960 [1] Orlando, FL	0.9997	0.9998
Lake, FL		
Orange, FL		
Osceola, FL		
Seminole, FL		
5990 [2] Owensboro, KY	0.8129	0.8677
Daviess, KY		
6015 Panama City, FL	0.9266	0.9491
Bay, FL		
6020 Parkersburg-Marietta, WV–OH (West Virginia Hospitals)	0.8500	0.8947
Washington, OH		
Wood, WV		
6020 [2] Parkersburg-Marietta, WV–OH (Ohio Hospitals)	0.8722	0.9106
Washington, OH		
Wood, WV		
6080 [2] Pensacola, FL	0.9074	0.9356
Escambia, FL		
Santa Rosa, FL		
6120 Peoria-Pekin, IL	0.8495	0.8943
Peoria, IL		
Tazewell, IL		
Woodford, IL		
6160 [1] Philadelphia, PA–NJ	1.1077	1.0726
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Salem, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
6200 [1] Phoenix-Mesa, AZ	0.9546	0.9687
Maricopa, AZ		
Pinal, AZ		
6240 Pine Bluff, AR	0.7689	0.8353
Jefferson, AR		
6280 [1] Pittsburgh, PA	0.9537	0.9681
Allegheny, PA		
Beaver, PA		
Butler, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
6323 Pittsfield, MA	1.0767	1.0519
Berkshire, MA		
6340 Pocatello, ID	0.9068	0.9352
Bannock, ID		
6360 Ponce, PR	0.5026	0.6243
Guayanilla, PR		
Juana Diaz, PR		
Penuelas, PR		
Ponce, PR		
Villalba, PR		
Yauco, PR		
6403 Portland, ME	0.9552	0.9691
Cumberland, ME		
Sagadahoc, ME		
York, ME		
6440 [1] Portland-Vancouver, OR–WA	1.1091	1.0735
Clackamas, OR		
Columbia, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Clark, WA		
6483 [1] Providence-Warwick-Pawtucket, RI	1.0789	1.0534
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
6520 Provo-Orem, UT	0.9786	0.9853
Utah, UT		
6560 Pueblo, CO	0.8943	0.9264
Pueblo, CO		
6580 [2] Punta Gorda, FL	0.9074	0.9356
Charlotte, FL		
6600 Racine, WI	0.9310	0.9522
Racine, WI		
6640 [1] Raleigh-Durham-Chapel Hill, NC	0.9631	0.9746
Chatham, NC		
Durham, NC		
Franklin, NC		
Johnston, NC		
Orange, NC		
Wake, NC		
6660 Rapid City, SD	0.8449	0.8910
Pennington, SD		
6680 Reading, PA	0.9526	0.9673
Berks, PA		
6690 Redding, CA	1.1392	1.0934
Shasta, CA		
6720 Reno, NV	1.0763	1.0516
Washoe, NV		
6740 Richland-Kennewick-Pasco, WA	1.1338	1.0898
Benton, WA		
Franklin, WA		
6760 Richmond-Petersburg, VA	1.0053	1.0036
Charles City County, VA		
Chesterfield, VA		
Colonial Heights City, VA		
Dinwiddie, VA		
Goochland, VA		
Hanover, VA		
Henrico, VA		
Hopewell City, VA		
New Kent, VA		
Petersburg City, VA		
Powhatan, VA		
Prince George, VA		
Richmond City, VA		
6780 [1] Riverside-San Bernardino, CA	1.0622	1.0422
Riverside, CA		
San Bernardino, CA		
6800 Roanoke, VA	0.8224	0.8747
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
6820 Rochester, MN	1.1056	1.0712
Olmsted, MN		
6840 [1] Rochester, NY	0.9448	0.9619
Genesee, NY		
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
6880 Rockford, IL	0.8861	0.9205
Boone, IL		
Ogle, IL		
Winnebago, IL		
6895 Rocky Mount, NC	0.8823	0.9178
Edgecombe, NC		
Nash, NC		
6920 [1] Sacramento, CA	1.2482	1.1640
El Dorado, CA		
Placer, CA		
Sacramento, CA		
6960 Saginaw-Bay City-Midland, MI	0.9422	0.9600
Bay, MI		
Midland, MI		
Saginaw, MI		
6980 St. Cloud, MN	0.9650	0.9759
Benton, MN		
Stearns, MN		
7000 St. Joseph, MO	0.8836	0.9187
Andrew, MO		
Buchanan, MO		
7040 [1] St. Louis, MO–IL	0.9186	0.9435
Clinton, IL		
Jersey, IL		
Madison, IL		
Monroe, IL		
St. Clair, IL		
Franklin, MO		
Jefferson, MO		
Lincoln, MO		
St. Charles, MO		
St. Louis, MO		
St. Louis City, MO		
Warren, MO		
7080 [2] Salem, OR	1.0071	1.0049

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) – FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Marion, OR		
Polk, OR		
7120 Salinas, CA	1.4706	1.3023
Monterey, CA		
7160 [1] Salt Lake City-Ogden, UT	0.9884	0.9920
Davis, UT		
Salt Lake, UT		
Weber, UT		
7200 San Angelo, TX	0.7870	0.8487
Tom Green, TX		
7240 [1] San Antonio, TX	0.8271	0.8781
Bexar, TX		
Comal, TX		
Guadalupe, TX		
Wilson, TX		
7320 [1] San Diego, CA	1.1943	1.1293
San Diego, CA		
7360 [1] San Francisco, CA	1.3976	1.2576
Marin, CA		
San Francisco, CA		
San Mateo, CA		
7400 [1] San Jose, CA	1.3714	1.2415
Santa Clara, CA		
7440 [1] San Juan-Bayamon, PR	0.4740	0.5998
Aguas Buenas, PR		
Barceloneta, PR		
Bayamon, PR		
Canovanas, PR		
Carolina, PR		
Catano, PR		
Ceiba, PR		
Comerio, PR		
Corozal, PR		
Dorado, PR		
Fajardo, PR		
Florida, PR		
Guaynabo, PR		
Humacao, PR		
Juncos, PR		
Los Piedras, PR		
Loiza, PR		
Luguillo, PR		
Manati, PR		
Morovis, PR		
Naguabo, PR		
Naranjito, PR		
Rio Grande, PR		
San Juan, PR		
Toa Alta, PR		
Toa Baja, PR		
Trujillo Alto, PR		
Vega Alta, PR		
Vega Baja, PR		
Yabucoa, PR		
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.0576	1.0391
San Luis Obispo, CA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) – FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0927	1.0626
Santa Barbara, CA		
7485 Santa Cruz-Watsonville, CA	1.4068	1.2633
Santa Cruz, CA		
7490 Santa Fe, NM	0.9115	0.9385
Los Alamos, NM		
Santa Fe, NM		
7500 Santa Rosa, CA	1.3127	1.2048
Sonoma, CA		
7510 Sarasota-Bradenton, FL	0.9928	0.9951
Manatee, FL		
Sarasota, FL		
7520 Savannah, GA	0.9892	0.9926
Bryan, GA		
Chatham, GA		
Effingham, GA		
7560 [2] Scranton-Wilkes-Barre-Hazleton, PA	0.8488	0.8938
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Wyoming, PA		
7600 [1] Seattle-Bellevue-Everett, WA	1.1390	1.0932
Island, WA		
King, WA		
Snohomish, WA		
7610 [2] Sharon, PA	0.8488	0.8938
Mercer, PA		
7620 [2] Sheboygan, WI	0.8842	0.9192
Sheboygan, WI		
7640 Sherman-Denison, TX	0.9213	0.9454
Grayson, TX		
7680 Shreveport-Bossier City, LA	0.9142	0.9404
Bossier, LA		
Caddo, LA		
Webster, LA		
7720 Sioux City, IA–NE	0.8051	0.8620
Woodbury, IA		
Dakota, NE		
7760 Sioux Falls, SD	0.8778	0.9146
Lincoln, SD		
Minnehaha, SD		
7800 South Bend, IN	0.9893	0.9927
St. Joseph, IN		
7840 Spokane, WA	1.0891	1.0602
Spokane, WA		
7880 Springfield, IL	0.8772	0.9142
Menard, IL		
Sangamon, IL		
7920 Springfield, MO	0.8003	0.8585
Christian, MO		
Greene, MO		
Webster, MO		
8003 Springfield, MA	0.9914	0.9941
Hampden, MA		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) – FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
Hampshire, MA		
8050 State College, PA	0.9249	0.9479
Centre, PA		
8080 [2] Steubenville-Weirton, OH–WV (Ohio Hospitals)	0.8722	0.9106
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8080 Steubenville-Weirton, OH–WV (West Virginia Hospitals)	0.8702	0.9092
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8120 Stockton-Lodi, CA	1.0623	1.0423
San Joaquin, CA		
8140 [2] Sumter, SC	0.8541	0.8976
Sumter, SC		
8160 Syracuse, NY	0.9527	0.9674
Cayuga, NY		
Madison, NY		
Onondaga, NY		
Oswego, NY		
8200 Tacoma, WA	1.1755	1.1171
Pierce, WA		
8240 [2] Tallahassee, FL	0.9074	0.9356
Gadsden, FL		
Leon, FL		
8280 [1] Tampa-St. Petersburg-Clearwater, FL	0.9260	0.9487
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
8320 Terre Haute, IN	0.8673	0.9071
Clay, IN		
Vermillion, IN		
Vigo, IN		
8360 Texarkana, AR-Texarkana, TX	0.8206	0.8734
Miller, AR		
Bowie, TX		
8400 Toledo, OH	0.9810	0.9870
Fulton, OH		
Lucas, OH		
Wood, OH		
8440 Topeka, KS	0.9195	0.9441
Shawnee, KS		
8480 Trenton, NJ	1.0051	1.0035
Mercer, NJ		
8520 Tucson, AZ	0.8831	0.9184
Pima, AZ		
8560 Tulsa, OK	0.7852	0.8474
Creek, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) – FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
8600 Tuscaloosa, AL	0.7994	0.8579
Tuscaloosa, AL		
8640 Tyler, TX	0.8572	0.8999
Smith, TX		
8680 [2] Utica-Rome, NY	0.8633	0.9042
Herkimer, NY		
Oneida, NY		
8720 Vallejo-Fairfield-Napa, CA	1.2783	1.1831
Napa, CA		
Solano, CA		
8735 Ventura, CA	1.0983	1.0663
Ventura, CA		
8750 Victoria, TX	0.8062	0.8628
Victoria, TX		
8760 Vineland-Millville-Bridgeton, NJ	1.0623	1.0423
Cumberland, NJ		
8780 Visalia-Tulare-Porterville, CA	1.0409	1.0278
Tulare, CA		
8800 Waco, TX	0.7561	0.8258
McLennan, TX		
8840 [1] Washington, DC–MD–VA–WV	1.1118	1.0753
District of Columbia, DC		
Calvert, MD		
Charles, MD		
Frederick, MD		
Montgomery, MD		
Prince Georges, MD		
Alexandria City, VA		
Arlington, VA		
Clarke, VA		
Culpeper, VA		
Fairfax, VA		
Fairfax City, VA		
Falls Church City, VA		
Fauquier, VA		
Fredericksburg City, VA		
King George, VA		
Loudoun, VA		
Manassas City, VA		
Manassas Park City, VA		
Prince William, VA		
Spotsylvania, VA		
Stafford, VA		
Warren, VA		
Berkeley, WV		
Jefferson, WV		
8920 Waterloo-Cedar Falls, IA	0.9039	0.9332
Black Hawk, IA		
8940 Wausau, WI	0.9545	0.9686
Marathon, WI		
8960 [1] West Palm Beach-Boca Raton, FL	1.0167	1.0114
Palm Beach, FL		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) – FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index	GAF
9000 [2] Wheeling, WV–OH (West Virginia Hospitals)	0.8206	0.8734
Belmont, OH		
Marshall, WV		
Ohio, WV		
9000 [2] Wheeling, WV–OH (Ohio Hospitals)	0.8722	0.9106
Belmont, OH		
Marshall, WV		
Ohio, WV		
9040 Wichita, KS	0.9117	0.9387
Butler, KS		
Harvey, KS		
Sedgwick, KS		
9080 Wichita Falls, TX	0.7730	0.8384
Archer, TX		
Wichita, TX		
9140 Williamsport, PA	0.8611	0.9027
Lycoming, PA		
9160 Wilmington-Newark, DE–MD	1.1388	1.0931
New Castle, DE		
Cecil, MD		
9200 Wilmington, NC	0.9962	0.9974
New Hanover, NC		
Brunswick, NC		
9260 [2] Yakima, WA	1.0474	1.0322
Yakima, WA		
9270 Yolo, CA	1.0591	1.0401
Yolo, CA		
9280 York, PA	0.9348	0.9549
York, PA		
9320 Youngstown-Warren, OH	1.0098	1.0067
Columbiana, OH		
Mahoning, OH		
Trumbull, OH		
9340 Yuba City, CA	1.0770	1.0521
Sutter, CA		
Yuba, CA		
9360 Yuma, AZ	1.0024	1.0016
Yuma, AZ		

[1] Large Urban Area.
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2000.

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS

Nonurban area	Wage index	GAF
Alabama	0.7542	0.8243
Alaska	1.2181	1.1447
Arizona	0.8610	0.9026
Arkansas	0.7290	0.8054
California	1.0153	1.0105
Colorado	0.8852	0.9199
Connecticut	1.2692	1.1773
Delaware	0.9259	0.9486

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS—Continued

Nonurban area	Wage index	GAF
Florida	0.9074	0.9356
Georgia	0.8189	0.8721
Hawaii	1.0812	1.0549
Idaho	0.8715	0.9101
Illinois	0.8121	0.8672
Indiana	0.8480	0.8932
Iowa	0.8000	0.8583
Kansas	0.7512	0.8221
Kentucky	0.8129	0.8677
Louisiana	0.7519	0.8226
Maine	0.8706	0.9095
Maryland	0.9096	0.9372
Massachusetts	0.9914	0.9941
Michigan	0.8904	0.9236
Minnesota	0.8753	0.9128
Mississippi	0.7453	0.8177
Missouri	0.7701	0.8362
Montana	0.8528	0.8967
Nebraska	0.8075	0.8638
Nevada	0.9633	0.9747
New Hampshire	0.9978	0.9985
New Jersey [1]	.....	.....
New Mexico	0.8613	0.9028
New York	0.8633	0.9042
North Carolina	0.8349	0.8838
North Dakota	0.7750	0.8398
Ohio	0.8722	0.9106
Oklahoma	0.7345	0.8095
Oregon	1.0071	1.0049
Pennsylvania	0.8488	0.8938
Puerto Rico	0.4379	0.5681
Rhode Island [1]	.....	.....
South Carolina	0.8541	0.8976
South Dakota	0.7663	0.8334
Tennessee	0.7743	0.8393
Texas	0.7008	0.7839
Utah	0.8219	0.8743
Vermont	0.9524	0.9672
Virginia	0.7938	0.8537
Washington	1.0474	1.0322
West Virginia	0.8206	0.8734
Wisconsin	0.8842	0.9192
Wyoming	0.8891	0.9227

[1] All counties within the State are classified as urban.

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED

Area	Wage index	GAF
Abilene, TX	0.8269	0.8780
Akron, OH	1.0091	1.0062
Albany, GA	0.8189	0.8721
Alexandria, LA	0.7988	0.8574
Amarillo, TX	0.8150	0.8693
Anchorage, AK	1.3143	1.2058
Ann Arbor, MI	1.1437	1.0963
Atlanta, GA	1.0119	1.0081
Austin-San Marcos, TX	0.9511	0.9663

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index	GAF
Baltimore, MD	1.0176	1.0120
Baton Rouge, LA	0.8796	0.9159
Beaumont-Port Arthur, TX	0.8555	0.8986
Bergen-Passaic, NJ	1.1861	1.1240
Billings, MT	1.1496	1.1002
Biloxi-Gulfport-Pascagoula, MS	0.8030	0.8605
Binghamton, NY	0.8701	0.9091
Birmingham, AL	0.9010	0.9311
Bismarck, ND	0.7973	0.8563
Boise City, ID	0.9178	0.9430
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1247	1.0838
Burlington, VT	1.0046	1.0031
Caguas, PR	0.4555	0.5836
Champaign-Urbana, IL	0.9255	0.9484
Charleston-North Charleston, SC	0.8997	0.9302
Charleston, WV	0.8950	0.9268
Charlotte-Gastonia-Rock Hill, NC–SC	0.9522	0.9670
Chattanooga, TN–GA	0.9586	0.9715
Chicago, IL	1.0858	1.0580
Cincinnati, OH–KY–IN	0.9477	0.9639
Clarksville-Hopkinsville, TN–KY	0.8413	0.8884
Cleveland-Lorain-Elyria, OH	0.9724	0.9810
Columbia, MO	0.8815	0.9173
Columbia, SC	0.9308	0.9521
Columbus, GA–AL	0.8379	0.8859
Columbus, OH	0.9660	0.9766
Corpus Christi, TX	0.9172	0.9425
Dallas, TX	0.9230	0.9466
Danville, VA	0.8795	0.9158
Davenport-Moline-Rock Island, IA–IL	0.8694	0.9086
Dayton-Springfield, OH	0.9284	0.9504
Denver, CO	1.0247	1.0168
Des Moines, IA	0.8849	0.9197
Dothan, AL	0.7916	0.8521
Dover, DE	1.0618	1.0419
Duluth-Superior, MN–WI	1.0278	1.0190
Elkhart-Goshen, IN	0.9142	0.9404
Eugene-Springfield, OR	1.0761	1.0515
Evansville-Henderson, IN–KY	0.8480	0.8932
Fargo-Moorhead, ND–MN (ND and SD Hospitals)	0.8707	0.9095
Fargo-Moorhead, ND–MN (MN Hospital)	0.8753	0.9128
Fayetteville, NC	0.8673	0.9071
Flagstaff, AZ–UT	0.9960	0.9973
Fort Collins-Loveland, CO	1.0301	1.0205
Fort Pierce-Port St. Lucie, FL	1.0240	1.0164
Fort Smith, AR–OK	0.7774	0.8416
Fort Walton Beach, FL	0.9005	0.9307
Forth Worth-Arlington, TX	0.9003	0.9306
Fresno, CA	1.0371	1.0253
Gadsden, AL	0.8842	0.9192
Gainesville, FL	1.0042	1.0029
Goldsboro, NC	0.8418	0.8888
Grand Forks, ND–MN	0.9190	0.9438
Grand Rapids-Muskegon-Holland, MI	1.0062	1.0042
Great Falls, MT	1.0626	1.0425
Greeley, CO	0.9292	0.9510
Green Bay, WI	0.9305	0.9519
Greensboro-Winston-Salem-High Point, NC	0.9122	0.9390
Greenville, NC	0.9313	0.9524
Greenville-Spartanburg-Anderson, SC	0.9199	0.9444
Hagerstown, MD	0.8943	0.9264
Harrisburg-Lebanon-Carlisle, PA	0.9787	0.9854
Hartford, CT	1.1220	1.0820
Hickory-Morganton-Lenoir, NC	0.9255	0.9484
Honolulu, HI	1.1600	1.1070
Houston, TX	0.9286	0.9505
Huntington-Ashland, WV–KY–OH	0.9563	0.9699
Huntsville, AL	0.8912	0.9242
Indianapolis, IN	0.9876	0.9915
Iowa City, IA	0.9556	0.9694
Jackson, MS	0.8519	0.8960
Jackson, TN	1.0339	1.0231
Jacksonville, FL	0.8993	0.9299
Johnson City-Kingsport-Bristol, TN–VA	0.8935	0.9258
Jonesboro, AR	0.7324	0.8079
Joplin, MO	0.7756	0.8403
Kalamazoo-Battlecreek, MI	1.0095	1.0065
Kansas City, KS–MO	0.9301	0.9516
Knoxville, TN	0.9315	0.9526
Kokomo, IN	0.9075	0.9357
Lafayette, LA	0.8160	0.8700
Lansing-East Lansing, MI	0.9980	0.9986
Las Vegas, NV–AZ	1.1182	1.0795
Lexington, KY	0.8683	0.9078
Lincoln, NE	0.9535	0.9679
Little Rock-North Little Rock, AR	0.8498	0.8945
Longview-Marshall, TX	0.8618	0.9032
Los Angeles-Long Beach, CA	1.1903	1.1267
Louisville, KY–IN	0.9296	0.9512
Macon, GA	0.8615	0.9029
Madison, WI	1.0096	1.0066
Memphis, TN–AR–MS	0.8070	0.8634
Merced, CA	1.0615	1.0417
Milwaukee-Waukesha, WI	0.9840	0.9890
Minneapolis-St. Paul, MN–WI	1.0630	1.0427
Missoula, MT	0.9281	0.9502
Monmouth-Ocean, NJ	1.0829	1.0561
Monroe, LA	0.8143	0.8688
Montgomery, AL	0.7542	0.8243
Myrtle Beach, SC	0.8465	0.8922
Nashville, TN	0.9008	0.9310
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2692	1.1773
New London-Norwich, CT	1.0860	1.0581
New Orleans, LA	0.9073	0.9356
New York, NY	1.4302	1.2777
Newark, NJ	1.0873	1.0590
Newburgh, NY–PA	1.0805	1.0545
Norfolk-Virginia Beach-Newport News, VA–NC	0.8378	0.8859
Oakland, CA	1.5199	1.3320
Oklahoma City, OK	0.8705	0.9094
Omaha, NE–IA	1.0722	1.0489
Orange County, CA	1.1539	1.1030
Orlando, FL	0.9997	0.9998
Peoria-Pekin, IL	0.8495	0.8943
Philadelphia, PA–NJ	1.1077	1.0726
Phoenix-Mesa, AZ	0.9546	0.9687
Pittsburgh, PA	0.9537	0.9681
Pocatello, ID	0.8715	0.9101
Portland, ME	0.9552	0.9691
Portland-Vancouver, OR–WA	1.1091	1.0735
Provo-Orem, UT	0.9786	0.9853
Raleigh-Durham-Chapel Hill, NC	0.9631	0.9746
Roanoke, VA	0.8224	0.8747
Rockford, IL	0.8861	0.9205
Sacramento, CA	1.2482	1.1640
Saginaw-Bay City-Midland, MI	0.9422	0.9600
St. Cloud, MN	0.9650	0.9759
St. Louis, MO–IL	0.9186	0.9435
Salt Lake City-Ogden, UT	0.9884	0.9920
San Diego, CA	1.1943	1.1293
Santa Fe, NM	0.9115	0.9385
Santa Rosa, CA	1.3127	1.2048
Seattle-Bellevue-Everett, WA	1.1390	1.0932
Sharon, PA	0.8488	0.8938
Sherman-Denison, TX	0.8782	0.9149
Sioux City, IA–NE	0.8051	0.8620
South Bend, IN	0.9791	0.9856
Springfield, MO	0.8003	0.8585
Syracuse, NY	0.9527	0.9674
Tallahassee, FL	0.8545	0.8979
Tampa-St. Petersburg-Clearwater, FL	0.9260	0.9487
Texarkana, AR-Texarkana, TX	0.8206	0.8734
Toledo, OH	0.9810	0.9870
Tulsa, OK	0.7852	0.8474
Tuscaloosa, AL	0.7994	0.8579
Tyler, TX	0.8572	0.8999

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area	Wage index	GAF
Vallejo-Fairfield-Napa, CA	1.2291	1.1517
Victoria, TX	0.8062	0.8628
Waco, TX	0.7561	0.8258
Washington, DC–MD–VA–WV	1.1118	1.0753
Waterloo-Cedar Falls, IA	0.9039	0.9332
Wausau, WI	0.9545	0.9686
West Palm Beach-Boca Raton, FL	1.0167	1.0114
Wichita, KS	0.8857	0.9202
Rural Colorado	0.8852	0.9199
Rural Florida	0.9074	0.9356
Rural Illinois	0.8121	0.8672
Rural Louisiana	0.7519	0.8226
Rural Michigan	0.8904	0.9236
Rural Minnesota	0.8753	0.9128
Rural Missouri	0.7701	0.8362
Rural Montana	0.8528	0.8967
Rural Oregon	1.0071	1.0049
Rural Pennsylvania (NY Hospital)	0.8633	0.9042
Rural Tennessee	0.7743	0.8393
Rural Texas (OK Hospital)	0.7345	0.8095
Rural Virginia (KY Hospital)	0.8129	0.8677
Rural Washington	1.0370	1.0252
Rural Wyoming	0.8891	0.9227

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS

Urban area	Average hourly wage
Abilene, TX	17.3384
Aguadilla, PR	9.5600
Akron, OH	21.5487
Albany, GA	15.2742
Albany-Schenectady-Troy, NY	18.0615
Albuquerque, NM	17.5627
Alexandria, LA	16.6620
Allentown-Bethlehem-Easton, PA	21.7512
Altoona, PA	19.7557
Amarillo, TX	16.8825
Anchorage, AK	27.2347
Ann Arbor, MI	24.2486
Anniston, AL	17.9235
Appleton-Oshkosh-Neenah, WI	18.7525
Arecibo, PR	9.9315
Asheville, NC	18.8257
Athens, GA	20.0661
Atlanta, GA	21.2165
Atlantic-Cape May, NJ	22.9089
Augusta-Aiken, GA–SC	19.1161
Austin-San Marcos, TX	19.9429
Bakersfield, CA	20.3276
Baltimore, MD	21.3358
Bangor, ME	20.3521

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Barnstable-Yarmouth, MA	27.2846
Baton Rouge, LA	18.4438
Beaumont-Port Arthur, TX	17.9374
Bellingham, WA	24.1321
Benton Harbor, MI	17.9119
Bergen-Passaic, NJ	25.2711
Billings, MT	24.7467
Biloxi-Gulfport-Pascagoula, MS	16.6634
Binghamton, NY	18.2442
Birmingham, AL	18.8910
Bismarck, ND	16.4329
Bloomington, IN	18.1990
Bloomington-Normal, IL	19.0474
Boise City, ID	19.1895
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	23.5756
Boulder-Longmont, CO	21.0610
Brazoria, TX	18.0160
Bremerton, WA	23.3211
Brownsville-Harlingen-San Benito, TX	19.3812
Bryan-College Station, TX	17.7233
Buffalo-Niagara Falls, NY	20.0987
Burlington, VT	21.9214
Caguas, PR	9.5514
Canton-Massillon, OH	18.5824
Casper, WY	19.4829
Cedar Rapids, IA	19.1010
Champaign-Urbana, IL	19.4065
Charleston-North Charleston, SC	18.7959
Charleston, WV	19.2624
Charlotte-Gastonia-Rock Hill, NC–SC	19.9662
Charlottesville, VA	22.3946
Chattanooga, TN–GA	20.7419
Cheyenne, WY	17.3158
Chicago, IL	22.7675
Chico-Paradise, CA	21.7666
Cincinnati, OH–KY–IN	19.8701
Clarksville-Hopkinsville, TN–KY	17.1337
Cleveland-Lorain-Elyria, OH	20.3885
Colorado Springs, CO	19.5228
Columbia, MO	18.8334
Columbia, SC	19.8182
Columbus, GA–AL	17.9587
Columbus, OH	20.5518
Corpus Christi, TX	19.5374
Cumberland, MD–WV	18.6405
Dallas, TX	19.3512
Danville, VA	19.1906
Davenport-Moline-Rock Island, IA–IL	18.4412
Dayton-Springfield, OH	19.9120
Daytona Beach, FL	18.9525
Decatur, AL	20.9325
Decatur, IL	17.6402
Denver, CO	21.4632
Des Moines, IA	18.5542
Detroit, MI	21.9391
Dothan, AL	16.5159
Dover, DE	19.7645
Dubuque, IA	18.0451
Duluth-Superior, MN–WI	21.5499
Dutchess County, NY	22.2045
Eau Claire, WI	18.9735
El Paso, TX	18.8348

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Elkhart-Goshen, IN	19.1690
Elmira, NY	18.0730
Enid, OK	16.8452
Erie, PA	19.0352
Eugene-Springfield, OR	22.0108
Evansville, Henderson, IN–KY	17.5709
Fargo-Moorhead, ND–MN	18.2572
Fayetteville, NC	17.9896
Fayetteville-Springdale-Rogers, AR	16.4641
Flagstaff, AZ–UT	21.9164
Flint, MI	23.3401
Florence, AL	16.7894
Florence, SC	18.2544
Fort Collins-Loveland, CO	21.8189
Fort Lauderdale, FL	21.5452
Fort Myers-Cape Coral, FL	18.6973
Fort Pierce-Port St. Lucie, FL	21.1349
Fort Smith, AR–OK	16.6129
Fort Walton Beach, FL	18.4550
Fort Wayne, IN	18.7461
Fort Worth-Arlington, TX	18.8776
Fresno, CA	21.7462
Gadsden, AL	18.4020
Gainesville, FL	21.3475
Galveston-Texas City, TX	20.0636
Gary, IN	19.8645
Glens Falls, NY	18.2269
Goldsboro, NC	17.6500
Grand Forks, ND–MN	19.2683
Grand Junction, CO	19.4809
Grand Rapids-Muskegon-Holland, MI	21.3218
Great Falls, MT	22.2802
Greeley, CO	19.8126
Green Bay, WI	19.3280
Greensboro-Winston-Salem-High Point, NC	19.1271
Greenville, NC	20.0665
Greenville-Spartanburg-Anderson, SC	19.2880
Hagerstown, MD	18.7266
Hamilton-Middletown, OH	18.8172
Harrisburg-Lebanon-Carlisle, PA	20.7504
Hartford, CT	23.2800
Hattiesburg, MS	16.1993
Hickory-Morganton-Lenoir, NC	19.3688
Honolulu, HI	24.3141
Houma, LA	16.5978
Houston, TX	19.4711
Huntington-Ashland, WV–KY–OH	20.6552
Huntsville, AL	18.6863
Indianapolis, IN	20.7074
Iowa City, IA	20.3481
Jackson, MI	18.7230
Jackson, MS	17.7577
Jackson, TN	22.9654
Jacksonville, FL	18.8568
Jacksonville, NC	16.6300
Jamestown, NY	16.6418
Janesville-Beloit, WI	20.3455
Jersey City, NJ	24.5703
Johnson City-Kingsport-Bristol, TN–VA	18.6209
Johnstown, PA	17.5658
Jonesboro, AR	15.3149

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Joplin, MO	16.2618
Kalamazoo-Battlecreek, MI	21.1395
Kankakee, IL	17.5067
Kansas City, KS–MO	19.5015
Kenosha, WI	18.4010
Killeen-Temple, TX	21.0317
Knoxville, TN	19.4838
Kokomo, IN	18.8885
La Crosse, WI–MN	18.9205
Lafayette, LA	16.9163
Lafayette, IN	18.6572
Lake Charles, LA	16.5668
Lakeland-Winter Haven, FL	18.6713
Lancaster, PA	18.7531
Lansing-East Lansing, MI	21.1588
Laredo, TX	17.6272
Las Cruces, NM	17.9392
Las Vegas, NV–AZ	23.4456
Lawrence, KS	17.4151
Lawton, OK	17.7694
Lewiston-Auburn, ME	18.8110
Lexington, KY	18.1825
Lima, OH	18.8613
Lincoln, NE	20.4820
Little Rock-North Little Rock, AR	18.2375
Longview-Marshall, TX	18.5109
Los Angeles-Long Beach, CA	24.8769
Louisville, KY–IN	19.4923
Lubbock, TX	17.6926
Lynchburg, VA	18.9720
Macon, GA	18.0637
Madison, WI	21.1696
Mansfield, OH	17.9415
Mayaguez, PR	10.1946
McAllen-Edinburg-Mission, TX	17.0929
Medford-Ashland, OR	22.2257
Melbourne-Titusville-Palm Bay, FL	19.6889
Memphis, TN–AR–MS	16.9175
Merced, CA	21.7673
Miami, FL	21.6256
Middlesex-Somerset-Hunterdon, NJ	23.6066
Milwaukee-Waukesha, WI	20.6321
Minneapolis-St. Paul, MN–WI	22.2877
Missoula, MT	19.1769
Mobile, AL	17.4061
Modesto, CA	21.3504
Monmouth-Ocean, NJ	23.8424
Monroe, LA	17.4115
Montgomery, AL	14.6992
Muncie, IN	22.7904
Myrtle Beach, SC	18.1305
Naples, FL	21.4581
Nashville, TN	19.1647
Nassau-Suffolk, NY	29.6122
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	26.1133
New London-Norwich, CT	22.3392
New Orleans, LA	19.0247
New York, NY	29.8414
Newark, NJ	25.1990
Newburgh, NY–PA	23.1041
Norfolk-Virginia Beach-Newport News, VA–NC	17.5474
Oakland, CA	31.7590
Ocala, FL	20.3639
Odessa-Midland, TX	16.8070
Oklahoma City, OK	18.2516
Olympia, WA	26.7328
Omaha, NE–IA	22.4822
Orange County, CA	24.1961
Orlando, FL	20.9377
Owensboro, KY	16.1873
Panama City, FL	19.4291
Parkersburg-Marietta, WV–OH	17.8217
Pensacola, FL	17.8744
Peoria-Pekin, IL	17.6840
Philadelphia, PA–NJ	23.1971
Phoenix-Mesa, AZ	20.0149
Pine Bluff, AR	16.1227
Pittsburgh, PA	19.9963
Pittsfield, MA	22.5755
Pocatello, ID	19.0128
Ponce, PR	10.5379
Portland, ME	19.9935
Portland-Vancouver, OR–WA	23.2544
Providence-Warwick, RI	22.6214
Provo-Orem, UT	20.5053
Pueblo, CO	18.7505
Punta Gorda, FL	17.9293
Racine, WI	19.5201
Raleigh-Durham-Chapel Hill, NC	20.1948
Rapid City, SD	17.7159
Reading, PA	19.9741
Redding, CA	23.8872
Reno, NV	22.5678
Richland-Kennewick-Pasco, WA	23.7721
Richmond-Petersburg, VA	21.0784
Riverside-San Bernardino, CA	22.6264
Roanoke, VA	17.2365
Rochester, MN	23.1823
Rochester, NY	19.8100
Rockford, IL	18.5789
Rocky Mount, NC	18.4997
Sacramento, CA	26.1722
Saginaw-Bay City-Midland, MI	19.6590
St. Cloud, MN	19.7777
St. Joseph, MO	18.5272
St. Louis, MO–IL	19.2606
Salem, OR	21.0721
Salinas, CA	30.8347
Salt Lake City-Ogden, UT	20.7240
San Angelo, TX	16.5012
San Antonio, TX	17.3414
San Diego, CA	24.9816
San Francisco, CA	29.7441
San Jose, CA	28.9924
San Juan-Bayamon, PR	9.9392
San Luis Obispo-Atascadero-Paso Robles, CA	22.1746
Santa Barbara-Santa Maria-Lompoc, CA	22.9107
Santa Cruz-Watsonville, CA	29.4979
Santa Fe, NM	19.0044
Santa Rosa, CA	27.5249
Sarasota-Bradenton, FL	20.8165
Savannah, GA	20.7408
Scranton-Wilkes Barre-Hazleton, PA	17.2531
Seattle-Bellevue-Everett, WA	23.8788
Sharon, PA	17.4261
Sheboygan, WI	17.3719
Sherman-Denison, TX	19.3180
Shreveport-Bossier City, LA	19.1689
Sioux City, IA–NE	16.7521
Sioux Falls, SD	18.4052
South Bend, IN	20.7423
Spokane, WA	22.8349
Springfield, IL	18.3917
Springfield, MO	16.7813
Springfield, MA	22.2268
State College, PA	19.3927
Steubenville-Weirton, OH–WV	18.2449
Stockton-Lodi, CA	22.2735
Sumter, SC	17.4486
Syracuse, NY	19.9107
Tacoma, WA	24.3185
Tallahassee, FL	18.5118
Tampa-St. Petersburg-Clearwater, FL	19.2631
Terre Haute, IN	18.1855
Texarkana, AR-Texarkana, TX	17.1104
Toledo, OH	21.0109
Topeka, KS	19.2788
Trenton, NJ	19.2422
Tucson, AZ	18.5156
Tulsa, OK	16.4631
Tuscaloosa, AL	16.7614
Tyler, TX	17.6966
Utica-Rome, NY	17.5752
Vallejo-Fairfield-Napa, CA	28.2652
Ventura, CA	24.0627
Victoria, TX	16.7918
Vineland-Millville-Bridgeton, NJ	22.2740
Visalia-Tulare-Porterville, CA	21.8242
Waco, TX	15.8347
Washington, DC–MD–VA–WV	23.3111
Waterloo-Cedar Falls, IA	18.3856
Wausau, WI	20.0138
West Palm Beach-Boca Raton, FL	21.2057
Wheeling, OH–WV	16.1880
Wichita, KS	19.1154
Wichita Falls, TX	16.2079
Williamsport, PA	18.0547
Wilmington-Newark, DE–MD	23.8786
Wilmington, NC	20.8870
Yakima, WA	21.8824
Yolo, CA	20.5840
York, PA	19.5997
Youngstown-Warren, OH	21.1722
Yuba City, CA	22.5818
Yuma, AZ	21.0182

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS

Nonurban area	Average hourly wage
Alabama	15.8142
Alaska	25.5400
Arizona	18.0528
Arkansas	15.2856
California	21.2880
Colorado	18.5603

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
Connecticut	26.6122
Delaware	19.4135
Florida	19.0250
Georgia	17.1694
Hawaii	22.6698
Idaho	18.2722
Illinois	17.0275
Indiana	17.7798
Iowa	16.7742
Kansas	15.7503
Kentucky	17.0443
Louisiana	15.5331
Maine	18.2533
Maryland	19.0722
Massachusetts	20.7873
Michigan	18.6349

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
Minnesota	18.3523
Mississippi	15.6269
Missouri	16.1473
Montana	17.8810
Nebraska	16.9308
Nevada	20.1989
New Hampshire	20.9206
New Jersey [1]	.....
New Mexico	18.0601
New York	18.1015
North Carolina	17.5057
North Dakota	16.2498
Ohio	18.2882
Oklahoma	15.4011
Oregon	21.1083
Pennsylvania	17.7969

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
Puerto Rico	9.1814
Rhode Island [1]	.....
South Carolina	17.9076
South Dakota	16.0683
Tennessee	16.2348
Texas	14.6891
Utah	17.2326
Vermont	19.9290
Virginia	16.6151
Washington	21.9605
West Virginia	17.2069
Wisconsin	18.5387
Wyoming	18.6424

[1] All counties within the State are classified as urban.

TABLE 4F.—PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF)

Area	Wage index	GAF	Wage index—reclassified hospitals	GAF—reclassified hospitals
Aguadilla, PR	0.9593	0.9719	.....	.....
Arecibo, PR	0.9965	0.9976	.....	.....
Caguas, PR	0.9584	0.9713	0.9584	0.9713
Mayaguez, PR	1.0229	1.0156	.....	.....
Ponce, PR	1.0574	1.0390	.....	.....
San Juan-Bayamon, PR	0.9973	0.9982	.....	.....
Rural Puerto Rico	0.9213	0.9454	.....	.....

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY

DRG	MDC	Type of DRG	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
1	01	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.0845	6.5	9.3
2	01	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.0989	7.4	9.9
3	01	SURG	*CRANIOTOMY AGE 0–17	1.9619	12.7	12.7
4	01	SURG	SPINAL PROCEDURES	2.3104	4.9	7.5
5	01	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.4462	2.5	3.4
6	01	SURG	CARPAL TUNNEL RELEASE	.8119	2.2	3.1
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.3667	6.6	9.8
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC.	1.3303	2.2	3.1
9	01	MED	SPINAL DISORDERS & INJURIES	1.1785	4.6	6.2
10	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2044	4.9	6.7
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	.8277	3.0	4.1
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	.8908	4.6	6.3
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.7585	4.2	5.2
14	01	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.1924	4.7	6.1
15	01	MED	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS.	.7405	3.0	3.7
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.0998	4.6	5.9
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	.6405	2.6	3.4
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	.9365	4.2	5.5
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.6504	3.0	3.8
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.6065	7.7	10.2
21	01	MED	VIRAL MENINGITIS	1.5010	5.0	6.8
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	.9637	3.8	4.9
23	01	MED	NONTRAUMATIC STUPOR & COMA	.7756	3.1	4.2
24	01	MED	SEIZURE & HEADACHE AGE >17 W CC	.9782	3.7	5.1
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	.5911	2.6	3.4
26	01	MED	SEIZURE & HEADACHE AGE 0–17	.6296	2.8	3.6

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type of DRG	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3532	3.3	5.3
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.2680	4.5	6.2
29	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	.6844	2.8	3.6
30	01	MED	*TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	.3318	2.0	2.0
31	01	MED	CONCUSSION AGE >17 W CC	.8463	3.2	4.3
32	01	MED	CONCUSSION AGE >17 W/O CC	.5282	2.1	2.7
33	01	MED	*CONCUSSION AGE 0–17	.2085	1.6	1.6
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0267	4.0	5.3
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.5931	2.7	3.5
36	02	SURG	RETINAL PROCEDURES	.6804	1.2	1.4
37	02	SURG	ORBITAL PROCEDURES	1.0261	2.6	3.9
38	02	SURG	PRIMARY IRIS PROCEDURES	.4871	1.9	2.6
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.5682	1.4	1.9
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.8131	2.2	3.3
41	02	SURG	*EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	.3378	1.6	1.6
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.6222	1.6	2.1
43	02	MED	HYPHEMA	.4416	2.5	4.1
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.6449	4.1	5.0
45	02	MED	NEUROLOGICAL EYE DISORDERS	.6946	2.8	3.4
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	.7524	3.5	4.6
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.4795	2.5	3.2
48	02	MED	*OTHER DISORDERS OF THE EYE AGE 0–17	.2975	2.9	2.9
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.8471	3.7	5.0
50	03	SURG	SIALOADENECTOMY	.8390	1.6	2.0
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY.	.8486	1.9	2.9
52	03	SURG	CLEFT LIP & PALATE REPAIR	.7954	1.6	2.0
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.1767	2.3	3.6
54	03	SURG	*SINUS & MASTOID PROCEDURES AGE 0–17	.4823	3.2	3.2
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES.	.8648	1.9	2.8
56	03	SURG	RHINOPLASTY	.8881	2.1	2.8
57	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	1.1571	3.0	4.8
58	03	SURG	*T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	.2739	1.5	1.5
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.6700	1.9	2.6
60	03	SURG	*TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	.2086	1.5	1.5
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.2529	2.9	4.8
62	03	SURG	*MYRINGOTOMY W TUBE INSERTION AGE 0–17	.2953	1.3	1.3
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.3078	3.0	4.5
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.2517	4.4	6.7
65	03	MED	DYSEQUILIBRIUM	.5270	2.3	2.9
66	03	MED	EPISTAXIS	.5551	2.6	3.2
67	03	MED	EPIGLOTTITIS	.8059	2.9	3.7
68	03	MED	OTITIS MEDIA & URI AGE >17 W CC	.6764	3.4	4.2
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	.5210	2.7	3.3
70	03	MED	OTITIS MEDIA & URI AGE 0–17	.3989	2.3	2.7
71	03	MED	LARYNGOTRACHEITIS	.6206	2.8	3.4
72	03	MED	NASAL TRAUMA & DEFORMITY	.6464	2.6	3.4
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	.7671	3.3	4.3
74	03	MED	*OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17.	.3356	2.1	2.1
75	04	SURG	MAJOR CHEST PROCEDURES	3.1078	7.8	9.9
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.6947	8.3	11.1
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.2105	3.6	5.1
78	04	MED	PULMONARY EMBOLISM	1.3898	6.1	7.1
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC.	1.6472	6.6	8.4
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC.	.9030	4.5	5.6
81	04	MED	*RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	1.5196	6.1	6.1
82	04	MED	RESPIRATORY NEOPLASMS	1.3674	5.2	7.0
83	04	MED	MAJOR CHEST TRAUMA W CC	.9723	4.3	5.5
84	04	MED	MAJOR CHEST TRAUMA W/O CC	.5250	2.6	3.2
85	04	MED	PLEURAL EFFUSION W CC	1.2450	5.0	6.5

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type of DRG	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
86	04	MED	PLEURAL EFFUSION W/O CC	.6706	2.8	3.8
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3741	4.8	6.3
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	.9431	4.3	5.3
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0887	5.1	6.1
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.6753	3.7	4.3
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	.6245	3.3	4.0
92	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.1783	5.0	6.2
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	.7624	3.5	4.3
94	04	MED	PNEUMOTHORAX W CC	1.1942	4.8	6.4
95	04	MED	PNEUMOTHORAX W/O CC	.5973	3.0	3.6
96	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	.7963	3.9	4.8
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	.5974	3.1	3.7
98	04	MED	BRONCHITIS & ASTHMA AGE 0–17	.6783	3.3	4.5
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	.6842	2.4	3.1
100	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5289	1.8	2.2
101	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	.8502	3.3	4.4
102	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5426	2.1	2.7
103	05	SURG	HEART TRANSPLANT	19.0801	35.2	56.0
104	05	SURG	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH.	7.2220	9.3	11.9
105	05	SURG	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH.	5.6426	7.6	9.4
106	05	SURG	CORONARY BYPASS W PTCA	7.3332	9.1	10.9
107	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.4624	9.3	10.5
108	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.7505	8.3	11.0
109	05	SURG	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	4.0337	6.9	7.8
110	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.1531	7.3	9.6
111	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.2236	4.9	5.7
112	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES	1.9200	2.7	3.8
113	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	2.7188	9.5	12.5
114	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS.	1.5531	6.0	8.2
115	05	SURG	PRM CARD PACEM IMPL W AMI, HRT FAIL OR SHK, OR AICD LEAD OR GNRTR PR.	3.4736	6.2	8.4
116	05	SURG	OTH PERM CARD PACEMAK IMPL OR PTCA W CORONARY ARTERY STENT IMPLNT.	2.4635	2.8	3.9
117	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.	1.2942	2.7	4.1
118	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.5475	2.0	2.9
119	05	SURG	VEIN LIGATION & STRIPPING	1.2288	3.0	4.9
120	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.0093	5.0	8.2
121	05	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE.	1.6318	5.6	6.8
122	05	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.	1.1091	3.4	4.2
123	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.5135	2.7	4.4
124	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.4018	3.4	4.5
125	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	1.0436	2.2	2.9
126	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.5151	9.3	12.1
127	05	MED	HEART FAILURE & SHOCK	1.0156	4.2	5.4
128	05	MED	DEEP VEIN THROMBOPHLEBITIS	.7656	5.1	5.9
129	05	MED	CARDIAC ARREST, UNEXPLAINED	1.0799	1.8	2.8
130	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	.9475	4.7	5.9
131	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.6057	3.7	4.5
132	05	MED	ATHEROSCLEROSIS W CC	.6723	2.5	3.1
133	05	MED	ATHEROSCLEROSIS W/O CC	.5656	1.9	2.4
134	05	MED	HYPERTENSION	.5857	2.6	3.3
135	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC.	.8643	3.3	4.4
136	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.	.6011	2.3	2.9
137	05	MED	*CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	.8188	3.3	3.3
138	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	.8164	3.1	4.0

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type of DRG	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
139 ...	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	.5087	2.1	2.5
140 ...	05	MED	ANGINA PECTORIS	.5840	2.3	2.8
141 ...	05	MED	SYNCOPE & COLLAPSE W CC	.7094	2.9	3.7
142 ...	05	MED	SYNCOPE & COLLAPSE W/O CC	.5426	2.2	2.7
143 ...	05	MED	CHEST PAIN	.5348	1.8	2.2
144 ...	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.1513	3.8	5.3
145 ...	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.6502	2.2	2.8
146 ...	06	SURG	RECTAL RESECTION W CC	2.7908	9.1	10.3
147 ...	06	SURG	RECTAL RESECTION W/O CC	1.6377	6.1	6.7
148 ...	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.4324	10.1	12.1
149 ...	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.5743	6.2	6.7
150 ...	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.8115	9.1	11.0
151 ...	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.3464	4.9	6.0
152 ...	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9571	6.9	8.3
153 ...	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.2162	5.0	5.6
154 ...	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	4.1380	10.1	13.2
155 ...	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.3793	3.5	4.5
156 ...	06	SURG	*STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17.	.8432	6.0	6.0
157 ...	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.2385	4.0	5.6
158 ...	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.6580	2.1	2.6
159 ...	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.3127	3.7	5.0
160 ...	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	.7817	2.2	2.7
161 ...	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.1002	2.9	4.2
162 ...	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC.	.6292	1.6	2.0
163 ...	06	SURG	*HERNIA PROCEDURES AGE 0–17	.8720	2.1	2.1
164 ...	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.3538	7.3	8.5
165 ...	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2706	4.4	4.9
166 ...	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4861	4.1	5.2
167 ...	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC.	.9038	2.4	2.8
168 ...	03	SURG	MOUTH PROCEDURES W CC	1.2131	3.3	4.7
169 ...	03	SURG	MOUTH PROCEDURES W/O CC	.7494	1.9	2.5
170 ...	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.8361	7.8	11.2
171 ...	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.2561	3.6	4.8
172 ...	06	MED	DIGESTIVE MALIGNANCY W CC	1.3135	5.1	6.9
173 ...	06	MED	DIGESTIVE MALIGNANCY W/O CC	.7110	2.7	3.8
174 ...	06	MED	G.I. HEMORRHAGE W CC	.9997	3.9	4.9
175 ...	06	MED	G.I. HEMORRHAGE W/O CC	.5466	2.5	2.9
176 ...	06	MED	COMPLICATED PEPTIC ULCER	1.0992	4.1	5.3
177 ...	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	.8823	3.7	4.5
178 ...	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.6525	2.7	3.2
179 ...	06	MED	INFLAMMATORY BOWEL DISEASE	1.0909	4.8	6.2
180 ...	06	MED	G.I. OBSTRUCTION W CC	.9229	4.2	5.4
181 ...	06	MED	G.I. OBSTRUCTION W/O CC	.5285	2.8	3.4
182 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC.	.7834	3.4	4.3
183 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	.5726	2.4	3.0
184 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17.	.5266	2.3	3.0
185 ...	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	.8560	3.3	4.5
186 ...	03	MED	*DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17.	.3214	2.9	2.9
187 ...	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	.7772	2.9	3.9
188 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0941	4.1	5.6
189 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	.5841	2.4	3.2
190 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	.9681	3.8	5.6
191 ...	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.3647	10.6	14.2
192 ...	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.8479	5.7	7.0

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type of DRG	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
193 ...	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.4150	10.3	12.7
194 ...	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.6394	5.4	6.6
195 ...	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.9468	8.4	10.0
196 ...	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6603	4.9	5.7
197 ...	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	2.4209	7.1	8.6
198 ...	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.2360	3.9	4.5
199 ...	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY.	2.3278	7.2	9.7
200 ...	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.	3.0720	7.2	11.1
201 ...	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.5771	10.3	14.2
202 ...	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3202	5.0	6.6
203 ...	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.3042	5.0	6.7
204 ...	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.2186	4.6	6.0
205 ...	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W CC	1.1831	4.7	6.4
206 ...	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC.	.7257	3.1	4.1
207 ...	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.1049	4.0	5.2
208 ...	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	.6473	2.3	2.9
209 ...	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.	2.1217	4.6	5.2
210 ...	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	1.8053	5.9	6.8
211 ...	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.2625	4.5	4.9
212 ...	08	SURG	*HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17.	.8468	11.1	11.1
213 ...	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.7128	6.1	8.3
214 ...	08	SURG	NO LONGER VALID	.0000	.0	.0
215 ...	08	SURG	NO LONGER VALID	.0000	.0	.0
216 ...	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	2.1374	6.9	9.5
217 ...	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS.	2.7842	8.6	12.6
218 ...	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.	1.4902	4.2	5.3
219 ...	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC.	1.0127	2.7	3.2
220 ...	08	SURG	*LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17.	.5841	5.3	5.3
221 ...	08	SURG	NO LONGER VALID	.0000	.0	.0
222 ...	08	SURG	NO LONGER VALID	.0000	.0	.0
223 ...	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	.9394	2.0	2.6
224 ...	08	SURG	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC.	.8046	1.7	2.0
225 ...	08	SURG	FOOT PROCEDURES	1.0528	3.2	4.5
226 ...	08	SURG	SOFT TISSUE PROCEDURES W CC	1.4373	4.1	6.0
227 ...	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.8175	2.1	2.8
228 ...	08	SURG	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC.	1.0502	2.4	3.6
229 ...	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC.	.7328	1.9	2.4
230 ...	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.1609	3.2	4.7
231 ...	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR.	1.3614	3.1	4.6
232 ...	08	SURG	ARTHROSCOPY	1.1675	2.4	4.1
233 ...	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	2.0314	5.3	7.5
234 ...	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC.	1.2439	2.7	3.4

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type of DRG	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
235 ...	08	MED	FRACTURES OF FEMUR	.7475	3.8	5.1
236 ...	08	MED	FRACTURES OF HIP & PELVIS	.7167	3.9	5.0
237 ...	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH.	.5445	2.9	3.6
238 ...	08	MED	OSTEOMYELITIS	1.2827	6.4	8.4
239 ...	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	.9657	4.9	6.3
240 ...	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.2316	5.0	6.7
241 ...	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.6066	3.2	4.0
242 ...	08	MED	SEPTIC ARTHRITIS	1.0152	5.1	6.6
243 ...	08	MED	MEDICAL BACK PROBLEMS	.7170	3.8	4.7
244 ...	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	.7014	3.8	4.8
245 ...	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	.4801	2.8	3.6
246 ...	08	MED	NON-SPECIFIC ARTHROPATHIES	.5573	3.0	3.7
247 ...	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	.5564	2.6	3.4
248 ...	08	MED	TENDONITIS, MYOSITIS & BURSITIS	.7566	3.6	4.6
249 ...	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	.6508	2.5	3.5
250 ...	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	.6705	3.2	4.1
251 ...	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	.4615	2.3	2.9
252 ...	08	MED	*FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17.	.2537	1.8	1.8
253 ...	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W CC.	.7273	3.7	4.8
254 ...	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC.	.4344	2.6	3.2
255 ...	08	MED	*FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17.	.2954	2.9	2.9
256 ...	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	.7645	3.8	5.1
257 ...	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	.9153	2.3	2.9
258 ...	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.7242	1.8	2.1
259 ...	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	.8671	1.9	2.8
260 ...	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.6428	1.3	1.5
261 ...	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	.9205	1.7	2.2
262 ...	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	.8409	2.7	3.9
263 ...	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC.	2.0527	8.6	11.8
264 ...	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.1213	5.3	7.1
265 ...	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.5630	4.4	7.0
266 ...	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	.8479	2.4	3.3
267 ...	09	SURG	PERIANAL & PILONIDAL PROCEDURES	.9756	2.9	4.1
268 ...	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES.	1.1919	2.4	3.8
269 ...	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.6213	5.6	7.9
270 ...	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	.7435	2.2	3.1
271 ...	09	MED	SKIN ULCERS	.9921	5.6	7.1
272 ...	09	MED	MAJOR SKIN DISORDERS W CC	.9989	4.8	6.3
273 ...	09	MED	MAJOR SKIN DISORDERS W/O CC	.6270	3.3	4.4
274 ...	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1271	4.7	6.5
275 ...	09	MED	MALIGNANT BREAST DISORDERS W/O CC	.6269	2.5	3.8
276 ...	09	MED	NON-MALIGANT BREAST DISORDERS	.6538	3.5	4.4
277 ...	09	MED	CELLULITIS AGE >17 W CC	.8323	4.7	5.8
278 ...	09	MED	CELLULITIS AGE >17 W/O CC	.5628	3.7	4.4
279 ...	09	MED	CELLULITIS AGE 0–17	.6722	4.1	5.1
280 ...	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC.	.6740	3.3	4.2
281 ...	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC.	.4577	2.4	3.1

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type of DRG	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
282	09	MED	*TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	.2569	2.2	2.2
283	09	MED	MINOR SKIN DISORDERS W CC	.7141	3.6	4.7
284	09	MED	MINOR SKIN DISORDERS W/O CC	.4375	2.5	3.2
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS.	2.0096	7.7	10.6
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.2196	5.2	6.6
287	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.8074	7.4	10.4
288	10	SURG	O.R. PROCEDURES FOR OBESITY	2.0819	4.6	5.7
289	10	SURG	PARATHYROID PROCEDURES	.9714	2.0	3.0
290	10	SURG	THYROID PROCEDURES	.9187	1.9	2.4
291	10	SURG	THYROGLOSSAL PROCEDURES	.6730	1.6	2.0
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.4603	7.1	10.4
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.1770	3.5	4.9
294	10	MED	DIABETES AGE >35	.7528	3.7	4.8
295	10	MED	DIABETES AGE 0–35	.7460	3.0	3.9
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	.8567	4.0	5.3
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC.	.5213	2.8	3.5
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	.4976	2.4	3.5
299	10	MED	INBORN ERRORS OF METABOLISM	.9448	3.8	5.4
300	10	MED	ENDOCRINE DISORDERS W CC	1.0797	4.8	6.2
301	10	MED	ENDOCRINE DISORDERS W/O CC	.5883	2.8	3.6
302	11	SURG	KIDNEY TRANSPLANT	3.5315	8.2	9.7
303	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.5381	7.2	8.7
304	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.3395	6.5	8.9
305	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1790	3.2	3.9
306	11	SURG	PROSTATECTOMY W CC	1.2476	3.7	5.4
307	11	SURG	PROSTATECTOMY W/O CC	.6587	2.0	2.4
308	11	SURG	MINOR BLADDER PROCEDURES W CC	1.5880	4.1	6.1
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.9430	2.0	2.5
310	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.0881	3.0	4.3
311	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.6130	1.6	1.9
312	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	1.0283	3.1	4.6
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.6653	1.8	2.4
314	11	SURG	*URETHRAL PROCEDURES, AGE 0–17	.4950	2.3	2.3
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0624	4.5	7.8
316	11	MED	RENAL FAILURE	1.3389	4.9	6.7
317	11	MED	ADMIT FOR RENAL DIALYSIS	.6906	2.1	3.2
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1406	4.4	6.0
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.6201	2.1	2.9
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	.8664	4.4	5.4
321	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	.5797	3.3	3.9
322	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	.5653	3.0	3.8
323	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	.7851	2.4	3.2
324	11	MED	URINARY STONES W/O CC	.4491	1.6	1.9
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC.	.6292	3.0	3.9
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC.	.4193	2.2	2.7
327	11	MED	*KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	.3541	3.1	3.1
328	11	MED	URETHRAL STRICTURE AGE >17 W CC	.7043	2.7	3.7
329	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.5215	1.7	2.5
330	11	MED	*URETHRAL STRICTURE AGE 0–17	.3189	1.6	1.6
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC.	1.0149	4.1	5.5
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC.	.6079	2.6	3.4
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	.7660	3.3	4.4
334	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.5888	4.3	5.0
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.1891	3.3	3.5
336	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	.8981	2.8	3.6
337	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.6235	2.0	2.2

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type of DRG	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
338 ...	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.1598	3.3	5.1
339 ...	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.0637	2.9	4.5
340 ...	12	SURG	*TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	.2834	2.4	2.4
341 ...	12	SURG	PENIS PROCEDURES	1.1125	2.1	3.2
342 ...	12	SURG	CIRCUMCISION AGE >17	.8606	2.6	3.5
343 ...	12	SURG	*CIRCUMCISION AGE 0–17	.1540	1.7	1.7
344 ...	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	1.0994	1.6	2.4
345 ...	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	.8850	2.5	3.7
346 ...	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	.9669	4.2	5.7
347 ...	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	.5868	2.3	3.1
348 ...	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	.6994	3.2	4.2
349 ...	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.4393	2.0	2.5
350 ...	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.6962	3.6	4.4
351 ...	12	MED	*STERILIZATION, MALE	.2363	1.3	1.3
352 ...	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.6762	2.7	3.9
353 ...	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.9662	5.4	7.1
354 ...	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC.	1.5142	4.8	5.8
355 ...	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC.	.9471	3.2	3.4
356 ...	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	.7930	2.2	2.6
357 ...	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.3678	7.0	8.7
358 ...	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.2377	3.7	4.4
359 ...	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.8724	2.7	2.9
360 ...	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.8832	2.5	3.0
361 ...	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.1850	2.4	3.4
362 ...	13	SURG	*ENDOSCOPIC TUBAL INTERRUPTION	.3020	1.4	1.4
363 ...	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.7775	2.5	3.3
364 ...	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	.7605	2.6	3.5
365 ...	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.8299	4.9	7.1
366 ...	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.2435	4.7	6.7
367 ...	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.5558	2.2	3.0
368 ...	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.0486	4.8	6.2
369 ...	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	.5540	2.4	3.2
370 ...	14	SURG	CESAREAN SECTION W CC	1.1037	4.5	6.0
371 ...	14	SURG	CESAREAN SECTION W/O CC	.7226	3.3	3.6
372 ...	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.5785	2.6	3.3
373 ...	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.4018	1.9	2.1
374 ...	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.7118	2.5	3.2
375 ...	14	SURG	*VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	.6856	4.4	4.4
376 ...	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	.5246	2.4	3.5
377 ...	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	1.3418	3.1	5.4
378 ...	14	MED	ECTOPIC PREGNANCY	.9321	2.3	2.8
379 ...	14	MED	THREATENED ABORTION	.4438	2.1	3.1
380 ...	14	MED	ABORTION W/O D&C	.3447	1.6	1.9
381 ...	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY.	.5785	1.7	2.3
382 ...	14	MED	FALSE LABOR	.2097	1.2	1.3
383 ...	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS.	.5250	2.8	4.0
384 ...	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	.3457	1.8	2.4
385 ...	15		*NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.3760	1.8	1.8
386 ...	15		*EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	4.5376	17.9	17.9
387 ...	15		*PREMATURITY W MAJOR PROBLEMS	3.0991	13.3	13.3
388 ...	15		*PREMATURITY W/O MAJOR PROBLEMS	1.8699	8.6	8.6

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type of DRG	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
389	15		*FULL TERM NEONATE W MAJOR PROBLEMS	1.8398	4.7	4.7
390	15		*NEONATE W OTHER SIGNIFICANT PROBLEMS	1.6011	3.4	3.4
391	15		*NORMAL NEWBORN	.1526	3.1	3.1
392	16	SURG	SPLENECTOMY AGE >17	3.1400	7.2	9.7
393	16	SURG	*SPLENECTOMY AGE 0–17	1.3479	9.1	9.1
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.6743	4.1	6.8
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	.8170	3.3	4.6
396	16	MED	RED BLOOD CELL DISORDERS AGE 0–17	1.0895	2.1	3.2
397	16	MED	COAGULATION DISORDERS	1.2145	3.9	5.4
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.2525	4.7	6.0
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	.7076	3.0	3.7
400	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.6450	5.9	9.1
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC.	2.6136	7.8	11.0
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	1.0641	2.8	4.2
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.7141	5.7	8.0
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.8541	3.2	4.3
405	17		*ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17	1.9110	4.9	4.9
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC.	2.7825	7.5	10.1
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC.	1.2467	3.4	4.2
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC.	1.9957	4.7	7.8
409	17	MED	RADIOTHERAPY	1.0593	4.5	6.1
410	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	.8997	2.8	3.6
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.4177	1.8	2.3
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.4028	1.5	2.0
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC.	1.3970	5.5	7.5
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC.	.7882	3.1	4.2
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.5467	10.3	14.1
416	18	MED	SEPTICEMIA AGE >17	1.5004	5.6	7.3
417	18	MED	SEPTICEMIA AGE 0–17	.8818	3.6	4.9
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	.9925	4.8	6.1
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	.8892	3.9	4.9
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6151	3.0	3.7
421	18	MED	VIRAL ILLNESS AGE >17	.6676	3.1	3.9
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	.4797	2.4	3.0
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.6009	5.7	7.7
424	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS.	2.3807	8.7	14.0
425	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION.	.6802	3.0	4.1
426	19	MED	DEPRESSIVE NEUROSES	.5384	3.4	4.7
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	.5750	3.4	5.0
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	.6910	4.4	6.8
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	.8447	4.9	6.7
430	19	MED	PSYCHOSES	.7925	6.0	8.4
431	19	MED	CHILDHOOD MENTAL DISORDERS	.7467	4.7	7.0
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES	.7113	3.3	5.2
433	20		ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.2974	2.3	3.1
434	20		ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W CC.	.7290	3.9	5.2
435	20		ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W/O CC.	.4270	3.4	4.4
436	20		ALC/DRUG DEPENDENCE W REHABILITATION THERAPY	.7934	10.7	13.6
437	20		ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY.	.6899	7.5	9.0
438			NO LONGER VALID	.0000	.0	.0
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.6217	5.0	7.4
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.9196	5.7	8.9

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type of DRG	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
441	21	SURG	HAND PROCEDURES FOR INJURIES	.9185	2.2	3.1
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.2447	5.2	7.9
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.9604	2.5	3.3
444	21	MED	TRAUMATIC INJURY AGE >17 W CC	.7068	3.3	4.3
445	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	.4796	2.4	3.0
446	21	MED	*TRAUMATIC INJURY AGE 0–17	.2962	2.4	2.4
447	21	MED	ALLERGIC REACTIONS AGE >17	.5218	1.9	2.5
448	21	MED	*ALLERGIC REACTIONS AGE 0–17	.0974	2.9	2.9
449	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	.8140	2.6	3.7
450	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	.4356	1.6	2.0
451	21	MED	*POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	.2631	2.1	2.1
452	21	MED	COMPLICATIONS OF TREATMENT W CC	.9922	3.5	4.9
453	21	MED	COMPLICATIONS OF TREATMENT W/O CC	.5065	2.2	2.9
454	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	.8161	3.2	4.5
455	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	.4661	1.9	2.6
456			NO LONGER VALID	.0000	.0	.0
457			NO LONGER VALID	.0000	.0	.0
458			NO LONGER VALID	.0000	.0	.0
459			NO LONGER VALID	.0000	.0	.0
460			NO LONGER VALID	.0000	.0	.0
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	1.1304	2.4	4.5
462	23	MED	REHABILITATION	1.3558	9.8	12.4
463	23	MED	SIGNS & SYMPTOMS W CC	.6814	3.3	4.3
464	23	MED	SIGNS & SYMPTOMS W/O CC	.4953	2.5	3.2
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.6710	2.0	3.6
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.6995	2.3	3.9
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.5054	2.1	3.3
468			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.6495	9.4	13.3
469			**PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.0000	.0	.0
470			**UNGROUPABLE	.0000	.0	.0
471	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.	3.2312	4.9	5.6
472			NO LONGER VALID	.0000	.0	.0
473	17		ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.7175	7.8	13.4
474			NO LONGER VALID	.0000	.0	.0
475	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT.	3.7064	8.0	11.2
476		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2619	8.6	11.7
477		SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.7659	5.3	8.0
478	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.3493	5.0	7.3
479	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4604	2.9	3.8
480		SURG	LIVER TRANSPLANT	10.7204	17.6	23.1
481		SURG	BONE MARROW TRANSPLANT	8.6480	22.2	25.1
482		SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	3.6326	9.9	12.9
483		SURG	TRACHEOSTOMY EXCEPT FOR FACE, MOUTH & NECK DIAGNOSES.	15.9802	32.9	40.6
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.5399	9.0	13.3
485	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA.	3.0215	7.4	9.1
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.	4.8710	8.4	12.3
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.9497	5.3	7.4
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.7592	12.0	18.2
489	25	MED	HIV W MAJOR RELATED CONDITION	1.7870	6.1	8.7
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	.9616	3.8	5.3
491	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.6696	3.0	3.5
492	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	4.4339	11.4	16.8
493	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8341	4.3	5.7

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type of DRG	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
494 ...	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.0276	2.0	2.5
495 ...	.....	SURG	LUNG TRANSPLANT	9.1249	13.1	15.9
496 ...	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	5.6734	8.4	10.8
497 ...	08	SURG	SPINAL FUSION W CC	2.8425	4.9	6.3
498 ...	08	SURG	SPINAL FUSION W/O CC	1.7943	2.8	3.4
499 ...	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC ..	1.4487	3.6	4.8
500 ...	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC.	.9837	2.3	2.8
501 ...	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.5446	8.0	10.0
502 ...	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.5591	5.2	6.3
503 ...	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2047	3.1	4.0
504 ...	22	SURG	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	12.8853	23.5	31.1
505 ...	22	MED	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT	2.1552	2.6	5.1
506 ...	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	4.1711	12.5	16.8
507 ...	22	SURG	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	1.8963	6.8	9.5
508 ...	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	1.5807	5.8	8.6
509 ...	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	.8575	3.9	5.4
510 ...	22	MED	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.3433	5.1	7.4
511 ...	22	MED	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA ...	.8283	3.5	5.2

*Medicare data have been supplemented by data from 19 states for low volume DRGS.
**DRGS 469 and 470 contain cases which could not be assigned to valid DRGS.
Note: Geometric mean is used only to determine payment for transfer cases.
Note: Arithmetic mean is presented for informational purposes only.
Note: Relative weights are based on medicare patient data and may not be appropriate for other patients.

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY

[FY98 MEDPAR Update 12/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	36506	9.2605	2	4	7	12	19
2	7109	9.8658	3	5	7	12	20
3	7	10.5714	1	4	12	12	14
4	6015	7.4519	1	3	5	9	16
5	98703	3.4164	1	1	2	4	7
6	377	3.1326	1	1	2	4	7
7	11683	9.7496	2	4	7	12	19
8	3373	3.1254	1	1	2	4	7
9	1698	6.1143	1	3	5	8	12
10	19098	6.5697	2	3	5	8	13
11	3155	4.0396	1	2	3	5	8
12	44239	6.2732	2	3	4	7	12
13	6486	5.1576	2	3	4	6	9
14	354618	6.0040	2	3	5	7	11
15	143996	3.7354	1	2	3	5	7
16	12049	5.9114	2	3	5	7	11
17	3303	3.3657	1	2	3	4	6
18	27014	5.4748	2	3	4	7	10
19	7911	3.7895	1	2	3	5	7
20	6115	9.9243	2	5	8	13	19
21	1409	6.8027	2	3	5	9	13
22	2567	4.9003	2	2	4	6	9
23	7637	4.1747	1	2	3	5	8
24	54321	5.0362	1	2	4	6	10
25	24173	3.3500	1	2	3	4	6
26	29	3.5862	1	1	3	4	6
27	3593	5.2931	1	1	3	7	12
28	11084	6.0999	1	3	5	8	12
29	3704	3.6126	1	2	3	5	7
30	1	13.0000	13	13	13	13	13
31	3126	4.3349	1	2	3	5	8

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
32	1388	2.6981	1	1	2	3	5
34	19926	5.3284	1	2	4	6	10
35	4860	3.4829	1	2	3	4	7
36	4637	1.4238	1	1	1	1	2
37	1545	3.8460	1	1	3	5	8
38	106	2.6415	1	1	2	3	5
39	1458	1.8759	1	1	1	2	4
40	1967	3.3421	1	1	2	4	7
42	3287	2.1150	1	1	1	2	4
43	84	4.0476	1	2	2	4	7
44	1346	4.9562	2	3	4	6	9
45	2489	3.4339	1	2	3	4	6
46	3035	4.5519	1	2	3	6	9
47	1196	3.1304	1	1	2	4	6
48	1	6.0000	6	6	6	6	6
49	2268	5.0004	1	2	4	6	10
50	2816	1.9950	1	1	1	2	3
51	275	2.8873	1	1	1	3	7
52	242	1.9463	1	1	1	2	3
53	2676	3.6214	1	1	2	4	8
54	1	1.0000	1	1	1	1	1
55	1548	2.8443	1	1	2	3	6
56	583	2.8405	1	1	2	3	6
57	496	4.7702	1	1	3	5	12
59	76	2.5921	1	1	2	3	6
60	4	1.2500	1	1	1	1	2
61	236	4.8051	1	1	3	6	10
62	2	2.5000	2	2	3	3	3
63	3257	4.4473	1	2	3	5	9
64	3255	6.6224	1	2	4	8	14
65	31668	2.9110	1	1	2	4	5
66	6943	3.2093	1	2	3	4	6
67	510	3.7118	1	2	3	4	7
68	13096	4.1846	2	2	3	5	7
69	4070	3.3174	1	2	3	4	6
70	38	2.7368	1	2	2	3	5
71	108	3.4259	1	2	3	4	6
72	789	3.5349	1	2	3	4	7
73	6418	4.3408	1	2	3	5	8
74	1	2.0000	2	2	2	2	2
75	40117	9.9090	3	5	7	12	19
76	40189	11.0696	3	5	9	14	21
77	2189	5.1092	1	2	4	7	10
78	29868	7.0817	3	5	6	9	12
79	203034	8.4200	3	4	7	10	16
80	8367	5.5711	2	3	5	7	10
81	9	6.1111	1	4	6	7	9
82	67396	6.9696	2	3	5	9	14
83	6816	5.4608	2	3	4	7	10
84	1499	3.2115	1	2	3	4	6
85	21440	6.5169	2	3	5	8	13
86	1715	3.7638	1	2	3	5	7
87	67211	6.2429	1	3	5	8	12
88	395665	5.2571	2	3	4	7	9
89	507777	6.1138	2	3	5	8	11
90	46106	4.3389	2	3	4	5	7
91	63	3.9683	1	2	3	5	7
92	14068	6.2258	2	3	5	8	12
93	1431	4.2851	1	2	4	6	8
94	12904	6.3868	2	3	5	8	13
95	1503	3.6334	1	2	3	4	7
96	63347	4.7647	2	3	4	6	8
97	28210	3.7386	1	2	3	5	7
98	18	4.5000	2	2	3	4	5
99	19288	3.1362	1	1	2	4	6
100	7679	2.1705	1	1	2	3	4

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
101	19908	4.4001	1	2	3	6	8
102	4712	2.7177	1	1	2	3	5
103	526	55.9620	9	15	38	81	125
104	32469	11.8910	3	6	10	15	22
105	28435	9.4345	4	6	7	11	17
106	3874	10.9174	5	7	9	13	18
107	96633	10.4780	5	7	9	12	17
108	5213	10.9714	3	6	9	14	21
109	66066	7.8103	4	5	7	9	13
110	58950	9.5307	2	5	8	11	18
111	6548	5.6188	2	4	6	7	8
112	80275	3.8243	1	1	3	5	8
113	45999	11.8933	3	5	9	15	23
114	8660	8.1865	2	4	7	10	16
115	14332	8.4104	2	4	7	11	16
116	270327	3.9279	1	1	3	5	8
117	3493	4.1457	1	1	3	5	9
118	6394	2.8907	1	1	2	4	6
119	1547	4.8946	1	1	3	6	11
120	36472	8.2124	1	2	5	11	18
121	168411	6.5102	2	4	5	8	12
122	83057	3.9825	1	2	4	5	7
123	41857	4.4094	1	1	2	6	10
124	144199	4.4338	1	2	3	6	8
125	69258	2.8460	1	1	2	4	6
126	5245	11.8471	3	6	9	15	23
127	720949	5.3848	2	3	4	7	10
128	13882	5.8857	3	4	5	7	9
129	4476	2.8132	1	1	1	3	7
130	93152	5.8377	2	3	5	7	10
131	26175	4.4798	1	3	4	6	7
132	166567	3.0916	1	2	2	4	6
133	7046	2.3686	1	1	2	3	4
134	32604	3.3402	1	2	3	4	6
135	7501	4.3393	1	2	3	5	8
136	1134	2.9365	1	1	2	4	6
138	203034	3.9942	1	2	3	5	8
139	74491	2.5373	1	1	2	3	5
140	89482	2.8042	1	1	2	3	5
141	85001	3.7313	1	2	3	5	7
142	40519	2.7087	1	1	2	3	5
143	173003	2.1910	1	1	2	3	4
144	77203	5.3186	1	2	4	7	11
145	6725	2.8174	1	1	2	4	5
146	12161	10.3049	5	7	9	12	17
147	2295	6.7115	3	5	7	8	10
148	142496	12.0975	5	7	10	14	21
149	16260	6.7259	4	5	6	8	10
150	22047	11.0292	4	6	9	14	19
151	4378	5.9826	2	3	6	8	11
152	4733	8.2766	3	5	7	10	14
153	1785	5.6112	3	4	5	7	8
154	32146	13.1977	4	7	10	16	25
155	5559	4.4970	1	2	4	6	8
156	5	10.6000	2	2	11	13	22
157	8532	5.5772	1	2	4	7	11
158	4386	2.6423	1	1	2	3	5
159	17279	4.9647	1	2	4	6	10
160	10447	2.7383	1	1	2	4	5
161	12543	4.1562	1	2	3	5	9
162	6726	1.9967	1	1	1	2	4
163	6	3.3333	1	3	3	5	5
164	5059	8.5274	4	5	7	10	14
165	1803	4.9434	2	3	5	6	8
166	3401	5.1541	2	3	4	6	10
167	2666	2.7817	1	2	2	3	5

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
168	1649	4.6731	1	2	3	6	10
169	857	2.4982	1	1	2	3	5
170	12092	11.1993	2	5	8	14	22
171	1053	4.7673	1	2	4	6	9
172	31897	6.9143	2	3	5	9	14
173	2312	3.7855	1	1	3	5	8
174	249000	4.8426	2	3	4	6	9
175	25202	2.9397	1	2	3	4	5
176	17587	5.2799	2	3	4	6	10
177	10522	4.4893	2	2	4	6	8
178	3593	3.1795	1	2	3	4	6
179	12330	6.1658	2	3	5	8	12
180	90227	5.3446	2	3	4	7	10
181	24379	3.4107	1	2	3	4	6
182	234882	4.3349	1	2	3	5	8
183	76735	2.9911	1	1	2	4	6
184	89	3.0225	1	1	2	3	7
185	4222	4.5246	1	2	3	6	9
186	7	3.2857	1	2	3	4	4
187	838	3.9224	1	2	3	5	8
188	75482	5.5481	1	2	4	7	11
189	9623	3.2219	1	1	2	4	6
190	66	5.5909	1	2	4	7	9
191	9649	14.1563	4	7	10	17	28
192	834	7.0432	2	4	6	9	12
193	6497	12.6191	5	7	10	15	23
194	742	6.5660	2	4	6	8	11
195	5896	9.9910	4	6	8	12	17
196	1262	5.6830	2	4	5	7	9
197	22829	8.6119	3	5	7	10	15
198	6333	4.5173	2	3	4	6	8
199	1863	9.6334	2	5	7	13	19
200	1177	11.0110	2	4	8	14	22
201	1502	14.0752	4	6	11	18	28
202	27309	6.5861	2	3	5	8	13
203	29813	6.7010	2	3	5	9	13
204	54942	5.9723	2	3	5	7	11
205	23086	6.3271	2	3	5	8	12
206	1713	4.1004	1	2	3	5	8
207	32550	5.1222	1	2	4	6	10
208	9792	2.9086	1	1	2	4	6
209	353744	5.1342	3	3	4	6	8
210	133786	6.7558	3	4	6	8	11
211	29098	4.9011	3	3	4	6	7
212	8	3.6250	1	2	4	5	5
213	7866	8.3354	2	4	6	10	17
216	6023	9.5177	2	4	7	12	19
217	19595	12.5727	3	5	9	15	26
218	22521	5.2767	2	3	4	6	9
219	19288	3.1965	1	2	3	4	5
220	4	9.2500	1	1	6	12	18
223	17769	2.5644	1	1	2	3	5
224	7897	2.0380	1	1	2	3	4
225	5773	4.4653	1	2	3	6	9
226	5252	5.9842	1	2	4	8	12
227	4296	2.7491	1	1	2	3	5
228	2550	3.5910	1	1	2	4	8
229	1137	2.4450	1	1	2	3	5
230	2280	4.7487	1	2	3	6	10
231	10903	4.6309	1	2	3	6	10
232	527	4.0892	1	1	2	5	9
233	4814	7.4909	2	3	5	9	16
234	2558	3.4461	1	2	3	4	7
235	5355	5.0045	1	2	4	6	9
236	39188	4.9057	1	3	4	6	9
237	1699	3.5621	1	2	3	4	6

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
238	7684	8.2965	3	4	6	10	16
239	55608	6.2447	2	3	5	8	12
240	12878	6.6378	2	3	5	8	13
241	3005	4.0090	1	2	3	5	7
242	2655	6.5646	2	3	5	8	13
243	83845	4.7270	1	3	4	6	9
244	12628	4.8210	1	3	4	6	9
245	4919	3.5727	1	2	3	4	7
246	1343	3.7312	1	2	3	5	7
247	14016	3.4163	1	2	3	4	7
248	8925	4.6222	1	2	4	6	9
249	10902	3.5356	1	1	2	4	7
250	3601	4.1172	1	2	3	5	8
251	2274	2.9081	1	1	2	4	5
253	18995	4.7535	1	3	4	6	9
254	9941	3.2011	1	2	3	4	6
256	5904	5.0899	1	2	4	6	10
257	19379	2.9197	1	2	2	3	5
258	16797	2.0623	1	1	2	2	3
259	3704	2.7608	1	1	2	3	6
260	4700	1.4715	1	1	1	2	2
261	1775	2.1808	1	1	1	3	4
262	645	3.9271	1	1	3	5	8
263	25880	11.3104	3	5	8	14	22
264	3815	7.0029	2	3	5	8	13
265	4082	6.9581	1	2	4	8	14
266	2523	3.3436	1	1	2	4	7
267	240	4.0833	1	1	3	5	9
268	873	3.7537	1	1	2	4	8
269	8758	7.8451	2	3	6	10	16
270	2727	3.0983	1	1	2	4	7
271	22440	7.0501	3	4	6	8	13
272	5622	6.2757	2	3	5	7	12
273	1342	4.3644	1	2	3	5	8
274	2431	6.4825	1	3	5	8	13
275	201	3.7612	1	1	2	5	8
276	989	4.4034	1	2	4	5	8
277	83986	5.7562	2	3	5	7	10
278	27530	4.4238	2	3	4	5	8
279	11	5.0909	1	3	4	5	8
280	14848	4.2196	1	2	3	5	8
281	6385	3.0641	1	1	3	4	6
282	1	3.0000	3	3	3	3	3
283	5325	4.7213	1	2	4	6	9
284	1773	3.1985	1	1	3	4	6
285	5979	10.5514	3	5	8	13	21
286	2145	6.6112	2	3	5	8	13
287	5999	10.4182	3	5	7	12	20
288	1972	5.7221	2	3	4	6	9
289	4787	3.0171	1	1	2	3	6
290	8532	2.4319	1	1	2	3	4
291	76	2.0132	1	1	1	2	3
292	4798	10.3558	2	4	8	13	21
293	318	4.9119	1	2	4	6	10
294	83797	4.7445	1	2	4	6	9
295	3416	3.8662	1	2	3	5	7
296	232852	5.2808	2	3	4	6	10
297	36465	3.5335	1	2	3	4	6
298	86	3.5116	1	1	2	4	7
299	1113	5.3998	1	2	4	7	11
300	16055	6.2361	2	3	5	8	12
301	2798	3.5647	1	2	3	4	7
302	7788	9.7017	5	6	7	11	17
303	19947	8.7442	4	5	7	10	15
304	12267	8.8996	2	4	7	11	18
305	2771	3.8964	1	2	3	5	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
306	9087	5.4264	1	2	3	7	12
307	2172	2.3596	1	1	2	3	4
308	8237	6.1412	1	2	4	8	13
309	4040	2.5252	1	1	2	3	5
310	25234	4.3353	1	2	3	5	9
311	7913	1.9368	1	1	1	2	4
312	1652	4.5745	1	1	3	6	10
313	636	2.4009	1	1	2	3	5
314	1	2.0000	2	2	2	2	2
315	28095	7.8214	1	2	5	10	17
316	93946	6.6586	2	3	5	8	13
317	787	3.1525	1	1	2	3	6
318	6040	5.9818	1	3	4	8	12
319	452	2.8496	1	1	2	4	6
320	182629	5.4053	2	3	4	7	10
321	26785	3.8728	2	2	3	5	7
322	66	3.7273	1	2	3	4	6
323	16620	3.2068	1	1	2	4	6
324	7588	1.9258	1	1	1	2	4
325	7746	3.8615	1	2	3	5	7
326	2359	2.6880	1	1	2	3	5
327	9	3.4444	1	2	3	6	6
328	682	3.7097	1	2	3	5	7
329	107	2.4579	1	1	1	3	5
331	44791	5.5053	1	3	4	7	11
332	4640	3.4358	1	1	3	4	7
333	264	4.4356	1	2	3	5	10
334	14143	5.0008	3	3	4	6	8
335	10325	3.5485	2	3	3	4	5
336	46390	3.6056	1	2	3	4	7
337	30864	2.2143	1	1	2	3	3
338	2138	5.1300	1	2	3	7	12
339	1797	4.5042	1	1	3	6	10
340	2	1.0000	1	1	1	1	1
341	4067	3.1913	1	1	2	3	6
342	874	3.4748	1	2	2	4	7
344	4100	2.3539	1	1	1	2	5
345	1230	3.7195	1	1	2	4	8
346	4931	5.7175	1	3	4	7	11
347	370	3.1595	1	1	2	4	7
348	3080	4.1844	1	2	3	5	8
349	591	2.5296	1	1	2	3	5
350	6519	4.3806	2	2	4	5	8
352	692	3.9263	1	1	3	5	7
353	2693	7.0791	3	4	5	8	13
354	8980	5.7827	3	3	4	7	10
355	5919	3.4087	2	3	3	4	5
356	28210	2.5548	1	2	2	3	4
357	6046	8.6508	3	5	7	10	16
358	24803	4.4161	2	3	3	5	7
359	29406	2.8913	2	2	3	3	4
360	17303	3.0327	1	2	3	3	5
361	473	3.3742	1	1	2	4	7
362	1	1.0000	1	1	1	1	1
363	3572	3.2900	1	2	2	3	7
364	1811	3.5400	1	1	2	4	7
365	2008	7.1116	2	3	5	9	15
366	4324	6.6751	1	3	5	8	14
367	466	3.0193	1	1	2	4	6
368	2756	6.2144	2	3	5	8	12
369	2740	3.2281	1	1	2	4	6
370	1120	5.9848	3	3	4	5	9
371	1192	3.6460	2	3	3	4	5
372	847	3.2621	1	2	2	3	5
373	3838	2.1449	1	2	2	2	3
374	134	3.1716	1	2	2	3	4

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
375	5	4.4000	1	1	5	5	9
376	199	3.4472	1	1	2	3	7
377	35	5.4000	1	1	3	5	13
378	173	2.7746	1	2	2	3	4
379	350	3.0914	1	1	2	3	6
380	87	1.8851	1	1	1	2	3
381	183	2.3005	1	1	1	3	5
382	54	1.2963	1	1	1	1	2
383	1486	3.9711	1	2	3	5	8
384	121	2.4132	1	1	2	3	5
385	1	2.0000	2	2	2	2	2
389	6	5.8333	1	5	5	7	7
390	9	3.3333	1	1	4	4	5
392	2630	9.6696	3	4	7	12	20
394	1779	6.8375	1	2	4	8	15
395	77187	4.5508	1	2	3	6	9
396	17	3.1765	1	1	2	4	6
397	19143	5.3427	1	2	4	7	11
398	18492	5.9583	2	3	5	7	11
399	1493	3.7173	1	2	3	5	7
400	7294	9.1058	2	3	6	11	20
401	6217	11.0227	2	5	8	14	22
402	1452	4.1887	1	1	3	5	9
403	36218	8.0041	2	3	6	10	16
404	4103	4.3359	1	2	3	6	9
406	2824	10.1331	3	5	8	13	21
407	667	4.1829	1	2	3	5	7
408	2404	7.7417	1	2	5	10	18
409	3746	6.1030	2	3	4	6	12
410	49872	3.5697	1	2	3	4	6
411	21	2.2857	1	1	2	3	4
412	28	2.0000	1	1	1	2	4
413	7391	7.4619	2	3	6	10	15
414	687	4.1499	1	2	3	5	9
415	42535	14.0456	4	6	11	17	28
416	213568	7.3051	2	4	6	9	14
417	41	4.7805	1	2	4	6	10
418	22297	6.0470	2	3	5	7	11
419	15835	4.9039	2	2	4	6	9
420	3029	3.6524	1	2	3	5	7
421	13089	3.9185	1	2	3	5	7
422	91	2.9890	1	1	2	4	6
423	9072	7.7017	2	3	6	9	16
424	1385	14.0072	2	5	10	17	27
425	15534	4.0610	1	2	3	5	8
426	4568	4.6421	1	2	3	6	9
427	1659	4.9458	1	2	3	6	11
428	855	6.7766	1	2	4	8	14
429	29447	6.5176	2	3	5	8	13
430	58875	8.3608	2	3	6	11	17
431	306	6.9869	1	3	5	8	13
432	438	5.2283	1	2	3	5	10
433	6312	3.1039	1	1	2	4	6
434	21675	5.1476	1	2	4	6	10
435	14502	4.3431	1	2	4	5	8
436	3279	13.5166	4	7	12	21	27
437	11570	8.9775	3	5	8	11	15
439	1183	7.4480	1	3	5	9	15
440	5298	8.9332	2	3	6	11	19
441	562	3.0498	1	1	2	4	7
442	15691	7.9084	1	3	6	10	16
443	3343	3.2767	1	1	2	4	7
444	5016	4.2845	1	2	3	5	8
445	2198	3.0100	1	1	2	4	6
447	4686	2.5378	1	1	2	3	5
448	2	1.5000	1	1	2	2	2

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V16.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
449	25965	3.6989	1	1	3	4	7
450	6281	2.0492	1	1	1	2	4
451	4	3.7500	1	1	2	4	8
452	22264	4.9182	1	2	3	6	10
453	4242	2.8868	1	1	2	4	5
454	5953	4.4749	1	2	3	5	9
455	974	2.6078	1	1	2	3	5
461	3446	4.5133	1	1	2	5	11
462	10911	12.2067	4	6	10	16	23
463	16562	4.2876	1	2	3	5	8
464	4467	3.1842	1	2	3	4	6
465	202	3.5693	1	1	1	4	7
466	1753	3.9395	1	1	2	4	8
467	1206	3.2629	1	1	2	4	6
468	59861	13.2552	3	6	10	17	26
471	11866	5.6302	3	3	5	6	9
473	7998	13.1317	2	3	7	19	33
475	109305	11.0583	2	5	9	15	22
476	5166	11.6465	2	6	10	15	21
477	26937	8.0048	1	3	6	10	17
478	118559	7.2875	1	3	5	9	15
479	21234	3.7671	1	2	3	5	7
480	446	23.0807	7	11	16	28	47
481	269	25.0632	11	19	23	30	40
482	6415	12.8803	4	7	10	15	23
483	42782	38.7045	14	21	32	48	70
484	392	13.2219	1	6	10	18	27
485	3148	9.0886	4	5	7	11	17
486	2027	12.1722	1	5	10	16	24
487	3604	7.3047	1	3	6	9	15
488	784	18.0982	3	7	13	23	37
489	14037	8.7084	2	3	6	11	18
490	4768	5.2685	1	2	4	7	10
491	11583	3.5480	2	2	3	4	6
492	2575	16.8287	4	5	12	27	35
493	55018	5.7173	1	3	5	7	11
494	26030	2.5108	1	1	2	3	5
495	130	15.9154	6	8	13	22	29
496	1095	10.7826	4	5	8	13	21
497	23026	6.2674	2	3	5	7	11
498	16601	3.4126	1	2	3	4	6
499	33369	4.8049	1	2	4	6	9
500	40659	2.7628	1	1	2	3	5
501	1974	10.0172	4	5	8	12	19
502	544	6.2702	3	4	5	7	11
503	5860	3.9602	1	2	3	5	7
504	121	31.1488	9	15	26	40	62
505	157	5.0446	1	1	2	6	11
506	1107	16.4625	4	7	13	22	33
507	410	9.4780	2	4	8	13	20
508	1102	7.4093	2	3	5	9	14
509	493	4.9270	1	2	3	6	11
510	1017	6.9646	2	3	5	8	15
511	301	4.7176	1	2	3	6	9
	11177104						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	36506	9.2605	2	4	7	12	19
2	7109	9.8658	3	5	7	12	20

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
3	7	10.5714	1	4	12	12	14
4	6015	7.4519	1	3	5	9	16
5	98703	3.4164	1	1	2	4	7
6	377	3.1326	1	1	2	4	7
7	11683	9.7496	2	4	7	12	19
8	3373	3.1254	1	1	2	4	7
9	1698	6.1143	1	3	5	8	12
10	19098	6.5697	2	3	5	8	13
11	3155	4.0396	1	2	3	5	8
12	44239	6.2732	2	3	4	7	12
13	6486	5.1576	2	3	4	6	9
14	354510	6.0035	2	3	5	7	11
15	143996	3.7354	1	2	3	5	7
16	12049	5.9114	2	3	5	7	11
17	3303	3.3657	1	2	3	4	6
18	27014	5.4748	2	3	4	7	10
19	7911	3.7895	1	2	3	5	7
20	6115	9.9243	2	5	8	13	19
21	1409	6.8027	2	3	5	9	13
22	2567	4.9003	2	2	4	6	9
23	7637	4.1747	1	2	3	5	8
24	54321	5.0362	1	2	4	6	10
25	24173	3.3500	1	2	3	4	6
26	29	3.5862	1	1	3	4	6
27	3593	5.2931	1	1	3	7	12
28	11084	6.0999	1	3	5	8	12
29	3704	3.6126	1	2	3	5	7
30	1	13.0000	13	13	13	13	13
31	3126	4.3349	1	2	3	5	8
32	1388	2.6981	1	1	2	3	5
34	19926	5.3284	1	2	4	6	10
35	4860	3.4829	1	2	3	4	7
36	4637	1.4238	1	1	1	1	2
37	1545	3.8460	1	1	3	5	8
38	106	2.6415	1	1	2	3	5
39	1458	1.8759	1	1	1	2	4
40	1967	3.3421	1	1	2	4	7
42	3287	2.1150	1	1	1	2	4
43	84	4.0476	1	2	2	4	7
44	1346	4.9562	2	3	4	6	9
45	2489	3.4339	1	2	3	4	6
46	3035	4.5519	1	2	3	6	9
47	1196	3.1304	1	1	2	4	6
48	1	6.0000	6	6	6	6	6
49	2268	5.0004	1	2	4	6	10
50	2816	1.9950	1	1	1	2	3
51	275	2.8873	1	1	1	3	7
52	242	1.9463	1	1	1	2	3
53	2676	3.6214	1	1	2	4	8
54	1	1.0000	1	1	1	1	1
55	1548	2.8443	1	1	2	3	6
56	583	2.8405	1	1	2	3	6
57	496	4.7702	1	1	3	5	12
59	76	2.5921	1	1	2	3	6
60	4	1.2500	1	1	1	1	2
61	236	4.8051	1	1	3	6	10
62	2	2.5000	2	2	3	3	3
63	3257	4.4473	1	2	3	5	9
64	3255	6.6224	1	2	4	8	14
65	31668	2.9110	1	1	2	4	5
66	6943	3.2093	1	2	3	4	6
67	510	3.7118	1	2	3	4	7
68	13096	4.1846	2	2	3	5	7
69	4070	3.3174	1	2	3	4	6
70	38	2.7368	1	2	2	3	5
71	108	3.4259	1	2	3	4	6

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
72	789	3.5349	1	2	3	4	7
73	6418	4.3408	1	2	3	5	8
74	1	2.0000	2	2	2	2	2
75	40117	9.9090	3	5	7	12	19
76	40189	11.0696	3	5	9	14	21
77	2189	5.1092	1	2	4	7	10
78	29868	7.0817	3	5	6	9	12
79	203034	8.4200	3	4	7	10	16
80	8367	5.5711	2	3	5	7	10
81	9	6.1111	1	4	6	7	9
82	67396	6.9696	2	3	5	9	14
83	6816	5.4608	2	3	4	7	10
84	1499	3.2115	1	2	3	4	6
85	21440	6.5169	2	3	5	8	13
86	1715	3.7638	1	2	3	5	7
87	67211	6.2429	1	3	5	8	12
88	395665	5.2571	2	3	4	7	9
89	507777	6.1138	2	3	5	8	11
90	46106	4.3389	2	3	4	5	7
91	63	3.9683	1	2	3	5	7
92	14068	6.2258	2	3	5	8	12
93	1431	4.2851	1	2	4	6	8
94	12904	6.3868	2	3	5	8	13
95	1503	3.6334	1	2	3	4	7
96	63347	4.7647	2	3	4	6	8
97	28210	3.7386	1	2	3	5	7
98	18	4.5000	2	2	3	4	5
99	19288	3.1362	1	1	2	4	6
100	7679	2.1705	1	1	2	3	4
101	19908	4.4001	1	2	3	6	8
102	4712	2.7177	1	1	2	3	5
103	526	55.9620	9	15	38	81	125
104	32469	11.8910	3	6	10	15	22
105	28435	9.4345	4	6	7	11	17
106	3874	10.9174	5	7	9	13	18
107	96633	10.4780	5	7	9	12	17
108	5213	10.9714	3	6	9	14	21
109	66066	7.8103	4	5	7	9	13
110	58950	9.5307	2	5	8	11	18
111	6548	5.6188	2	4	6	7	8
112	80275	3.8243	1	1	3	5	8
113	45978	11.8914	3	5	9	15	23
114	8660	8.1865	2	4	7	10	16
115	14332	8.4104	2	4	7	11	16
116	270327	3.9279	1	1	3	5	8
117	3493	4.1457	1	1	3	5	9
118	6394	2.8907	1	1	2	4	6
119	1547	4.8946	1	1	3	6	11
120	36569	8.2082	1	2	5	11	18
121	168411	6.5102	2	4	5	8	12
122	83057	3.9825	1	2	4	5	7
123	41857	4.4094	1	1	2	6	10
124	144199	4.4338	1	2	3	6	8
125	69258	2.8460	1	1	2	4	6
126	5245	11.8471	3	6	9	15	23
127	720949	5.3848	2	3	4	7	10
128	13882	5.8857	3	4	5	7	9
129	4476	2.8132	1	1	1	3	7
130	93152	5.8377	2	3	5	7	10
131	26175	4.4798	1	3	4	6	7
132	166567	3.0916	1	2	2	4	6
133	7046	2.3686	1	1	2	3	4
134	32604	3.3402	1	2	3	4	6
135	7501	4.3393	1	2	3	5	8
136	1134	2.9365	1	1	2	4	6
138	203034	3.9942	1	2	3	5	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
139	74491	2.5373	1	1	2	3	5
140	89482	2.8042	1	1	2	3	5
141	85001	3.7313	1	2	3	5	7
142	40519	2.7087	1	1	2	3	5
143	173003	2.1910	1	1	2	3	4
144	77203	5.3186	1	2	4	7	11
145	6725	2.8174	1	1	2	4	5
146	12161	10.3049	5	7	9	12	17
147	2295	6.7115	3	5	7	8	10
148	142496	12.0975	5	7	10	14	21
149	16260	6.7259	4	5	6	8	10
150	22047	11.0292	4	6	9	14	19
151	4378	5.9826	2	3	6	8	11
152	4733	8.2766	3	5	7	10	14
153	1785	5.6112	3	4	5	7	8
154	32146	13.1977	4	7	10	16	25
155	5559	4.4970	1	2	4	6	8
156	5	10.6000	2	2	11	13	22
157	8532	5.5772	1	2	4	7	11
158	4386	2.6423	1	1	2	3	5
159	17279	4.9647	1	2	4	6	10
160	10447	2.7383	1	1	2	4	5
161	12543	4.1562	1	2	3	5	9
162	6726	1.9967	1	1	1	2	4
163	6	3.3333	1	3	3	5	5
164	5059	8.5274	4	5	7	10	14
165	1803	4.9434	2	3	5	6	8
166	3401	5.1541	2	3	4	6	10
167	2666	2.7817	1	2	2	3	5
168	1649	4.6731	1	2	3	6	10
169	857	2.4982	1	1	2	3	5
170	12092	11.1993	2	5	8	14	22
171	1053	4.7673	1	2	4	6	9
172	31897	6.9143	2	3	5	9	14
173	2312	3.7855	1	1	3	5	8
174	249000	4.8426	2	3	4	6	9
175	25202	2.9397	1	2	3	4	5
176	17587	5.2799	2	3	4	6	10
177	10522	4.4893	2	2	4	6	8
178	3593	3.1795	1	2	3	4	6
179	12330	6.1658	2	3	5	8	12
180	90227	5.3446	2	3	4	7	10
181	24379	3.4107	1	2	3	4	6
182	234882	4.3349	1	2	3	5	8
183	76735	2.9911	1	1	2	4	6
184	89	3.0225	1	1	2	3	7
185	4222	4.5246	1	2	3	6	9
186	7	3.2857	1	2	3	4	4
187	838	3.9224	1	2	3	5	8
188	75482	5.5481	1	2	4	7	11
189	9623	3.2219	1	1	2	4	6
190	66	5.5909	1	2	4	7	9
191	9649	14.1563	4	7	10	17	28
192	834	7.0432	2	4	6	9	12
193	6497	12.6191	5	7	10	15	23
194	742	6.5660	2	4	6	8	11
195	5896	9.9910	4	6	8	12	17
196	1262	5.6830	2	4	5	7	9
197	22829	8.6119	3	5	7	10	15
198	6333	4.5173	2	3	4	6	8
199	1863	9.6334	2	5	7	13	19
200	1177	11.0110	2	4	8	14	22
201	1502	14.0752	4	6	11	18	28
202	27309	6.5861	2	3	5	8	13
203	29813	6.7010	2	3	5	9	13
204	54942	5.9723	2	3	5	7	11

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
205	23086	6.3271	2	3	5	8	12
206	1713	4.1004	1	2	3	5	8
207	32550	5.1222	1	2	4	6	10
208	9792	2.9086	1	1	2	4	6
209	353674	5.1341	3	3	4	6	8
210	133764	6.7556	3	4	6	8	11
211	29096	4.9012	3	3	4	6	7
212	8	3.6250	1	2	4	5	5
213	7866	8.3354	2	4	6	10	17
216	6023	9.5177	2	4	7	12	19
217	19595	12.5727	3	5	9	15	26
218	22521	5.2767	2	3	4	6	9
219	19288	3.1965	1	2	3	4	5
220	4	9.2500	1	1	6	12	18
223	17769	2.5644	1	1	2	3	5
224	7897	2.0380	1	1	2	3	4
225	5773	4.4653	1	2	3	6	9
226	5252	5.9842	1	2	4	8	12
227	4296	2.7491	1	1	2	3	5
228	2550	3.5910	1	1	2	4	8
229	1137	2.4450	1	1	2	3	5
230	2280	4.7487	1	2	3	6	10
231	10903	4.6309	1	2	3	6	10
232	527	4.0892	1	1	2	5	9
233	4814	7.4909	2	3	5	9	16
234	2558	3.4461	1	2	3	4	7
235	5355	5.0045	1	2	4	6	9
236	39179	4.9058	1	3	4	6	9
237	1699	3.5621	1	2	3	4	6
238	7684	8.2965	3	4	6	10	16
239	55608	6.2447	2	3	5	8	12
240	12878	6.6378	2	3	5	8	13
241	3005	4.0090	1	2	3	5	7
242	2655	6.5646	2	3	5	8	13
243	83845	4.7270	1	3	4	6	9
244	12628	4.8210	1	3	4	6	9
245	4919	3.5727	1	2	3	4	7
246	1343	3.7312	1	2	3	5	7
247	14016	3.4163	1	2	3	4	7
248	8925	4.6222	1	2	4	6	9
249	10902	3.5356	1	1	2	4	7
250	3601	4.1172	1	2	3	5	8
251	2274	2.9081	1	1	2	4	5
253	18995	4.7535	1	3	4	6	9
254	9941	3.2011	1	2	3	4	6
256	5904	5.0899	1	2	4	6	10
257	19379	2.9197	1	2	2	3	5
258	16797	2.0623	1	1	2	2	3
259	3704	2.7608	1	1	2	3	6
260	4700	1.4715	1	1	1	2	2
261	1775	2.1808	1	1	1	3	4
262	645	3.9271	1	1	3	5	8
263	25866	11.3105	3	5	8	14	22
264	3810	7.0034	2	3	5	8	13
265	4082	6.9581	1	2	4	8	14
266	2523	3.3436	1	1	2	4	7
267	240	4.0833	1	1	3	5	9
268	873	3.7537	1	1	2	4	8
269	8758	7.8451	2	3	6	10	16
270	2727	3.0983	1	1	2	4	7
271	22440	7.0501	3	4	6	8	13
272	5622	6.2757	2	3	5	7	12
273	1342	4.3644	1	2	3	5	8
274	2431	6.4825	1	3	5	8	13
275	201	3.7612	1	1	2	5	8
276	989	4.4034	1	2	4	5	8

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
277	83986	5.7562	2	3	5	7	10
278	27530	4.4238	2	3	4	5	8
279	11	5.0909	1	3	4	5	8
280	14848	4.2196	1	2	3	5	8
281	6385	3.0641	1	1	3	4	6
282	1	3.0000	3	3	3	3	3
283	5325	4.7213	1	2	4	6	9
284	1773	3.1985	1	1	3	4	6
285	5979	10.5514	3	5	8	13	21
286	2145	6.6112	2	3	5	8	13
287	5999	10.4182	3	5	7	12	20
288	1972	5.7221	2	3	4	6	9
289	4787	3.0171	1	1	2	3	6
290	8532	2.4319	1	1	2	3	4
291	76	2.0132	1	1	1	2	3
292	4798	10.3558	2	4	8	13	21
293	318	4.9119	1	2	4	6	10
294	83797	4.7445	1	2	4	6	9
295	3416	3.8662	1	2	3	5	7
296	232852	5.2808	2	3	4	6	10
297	36465	3.5335	1	2	3	4	6
298	86	3.5116	1	1	2	4	7
299	1113	5.3998	1	2	4	7	11
300	16055	6.2361	2	3	5	8	12
301	2798	3.5647	1	2	3	4	7
302	7788	9.7017	5	6	7	11	17
303	19947	8.7442	4	5	7	10	15
304	12267	8.8996	2	4	7	11	18
305	2771	3.8964	1	2	3	5	7
306	9087	5.4264	1	2	3	7	12
307	2172	2.3596	1	1	2	3	4
308	8237	6.1412	1	2	4	8	13
309	4040	2.5252	1	1	2	3	5
310	25234	4.3353	1	2	3	5	9
311	7913	1.9368	1	1	1	2	4
312	1652	4.5745	1	1	3	6	10
313	636	2.4009	1	1	2	3	5
314	1	2.0000	2	2	2	2	2
315	28095	7.8214	1	2	5	10	17
316	93946	6.6586	2	3	5	8	13
317	787	3.1525	1	1	2	3	6
318	6040	5.9818	1	3	4	8	12
319	452	2.8496	1	1	2	4	6
320	182629	5.4053	2	3	4	7	10
321	26785	3.8728	2	2	3	5	7
322	66	3.7273	1	2	3	4	6
323	16620	3.2068	1	1	2	4	6
324	7588	1.9258	1	1	1	2	4
325	7746	3.8615	1	2	3	5	7
326	2359	2.6880	1	1	2	3	5
327	9	3.4444	1	2	3	6	6
328	682	3.7097	1	2	3	5	7
329	107	2.4579	1	1	1	3	5
331	44791	5.5053	1	3	4	7	11
332	4640	3.4358	1	1	3	4	7
333	264	4.4356	1	2	3	5	10
334	14143	5.0008	3	3	4	6	8
335	10325	3.5485	2	3	3	4	5
336	46390	3.6056	1	2	3	4	7
337	30864	2.2143	1	1	2	3	3
338	2138	5.1300	1	2	3	7	12
339	1797	4.5042	1	1	3	6	10
340	2	1.0000	1	1	1	1	1
341	4067	3.1913	1	1	2	3	6
342	874	3.4748	1	2	2	4	7
344	4100	2.3539	1	1	1	2	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
345	1230	3.7195	1	1	2	4	8
346	4931	5.7175	1	3	4	7	11
347	370	3.1595	1	1	2	4	7
348	3080	4.1844	1	2	3	5	8
349	591	2.5296	1	1	2	3	5
350	6519	4.3806	2	2	4	5	8
352	692	3.9263	1	1	3	5	7
353	2693	7.0791	3	4	5	8	13
354	8980	5.7827	3	3	4	7	10
355	5919	3.4087	2	3	3	4	5
356	28210	2.5548	1	2	2	3	4
357	6046	8.6508	3	5	7	10	16
358	24803	4.4161	2	3	3	5	7
359	29406	2.8913	2	2	3	3	4
360	17303	3.0327	1	2	3	3	5
361	473	3.3742	1	1	2	4	7
362	1	1.0000	1	1	1	1	1
363	3572	3.2900	1	2	2	3	7
364	1811	3.5400	1	1	2	4	7
365	2008	7.1116	2	3	5	9	15
366	4324	6.6751	1	3	5	8	14
367	466	3.0193	1	1	2	4	6
368	2756	6.2144	2	3	5	8	12
369	2740	3.2281	1	1	2	4	6
370	1120	5.9848	3	3	4	5	9
371	1192	3.6460	2	3	3	4	5
372	847	3.2621	1	2	2	3	5
373	3838	2.1449	1	2	2	2	3
374	134	3.1716	1	2	2	3	4
375	5	4.4000	1	1	5	5	9
376	199	3.4472	1	1	2	3	7
377	35	5.4000	1	1	3	5	13
378	173	2.7746	1	2	2	3	4
379	350	3.0914	1	1	2	3	6
380	87	1.8851	1	1	1	2	3
381	183	2.3005	1	1	1	3	5
382	54	1.2963	1	1	1	1	2
383	1486	3.9711	1	2	3	5	8
384	121	2.4132	1	1	2	3	5
385	1	2.0000	2	2	2	2	2
389	6	5.8333	1	5	5	7	7
390	9	3.3333	1	1	4	4	5
392	2630	9.6696	3	4	7	12	20
394	1779	6.8375	1	2	4	8	15
395	77187	4.5508	1	2	3	6	9
396	17	3.1765	1	1	2	4	6
397	19143	5.3427	1	2	4	7	11
398	18492	5.9583	2	3	5	7	11
399	1493	3.7173	1	2	3	5	7
400	7294	9.1058	2	3	6	11	20
401	6217	11.0227	2	5	8	14	22
402	1452	4.1887	1	1	3	5	9
403	36218	8.0041	2	3	6	10	16
404	4103	4.3359	1	2	3	6	9
406	2824	10.1331	3	5	8	13	21
407	667	4.1829	1	2	3	5	7
408	2404	7.7417	1	2	5	10	18
409	3746	6.1030	2	3	4	6	12
410	49872	3.5697	1	2	3	4	6
411	21	2.2857	1	1	2	3	4
412	28	2.0000	1	1	1	2	4
413	7391	7.4619	2	3	6	10	15
414	687	4.1499	1	2	3	5	9
415	42535	14.0456	4	6	11	17	28
416	213568	7.3051	2	4	6	9	14
417	41	4.7805	1	2	4	6	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
418	22297	6.0470	2	3	5	7	11
419	15835	4.9039	2	2	4	6	9
420	3029	3.6524	1	2	3	5	7
421	13089	3.9185	1	2	3	5	7
422	91	2.9890	1	1	2	4	6
423	9072	7.7017	2	3	6	9	16
424	1385	14.0072	2	5	10	17	27
425	15534	4.0610	1	2	3	5	8
426	4568	4.6421	1	2	3	6	9
427	1659	4.9458	1	2	3	6	11
428	855	6.7766	1	2	4	8	14
429	29435	6.5167	2	3	5	8	13
430	58875	8.3608	2	3	6	11	17
431	306	6.9869	1	3	5	8	13
432	438	5.2283	1	2	3	5	10
433	6312	3.1039	1	1	2	4	6
434	21675	5.1476	1	2	4	6	10
435	14502	4.3431	1	2	4	5	8
436	3279	13.5166	4	7	12	21	27
437	11570	8.9775	3	5	8	11	15
439	1183	7.4480	1	3	5	9	15
440	5298	8.9332	2	3	6	11	19
441	562	3.0498	1	1	2	4	7
442	15691	7.9084	1	3	6	10	16
443	3343	3.2767	1	1	2	4	7
444	5016	4.2845	1	2	3	5	8
445	2198	3.0100	1	1	2	4	6
447	4686	2.5378	1	1	2	3	5
448	2	1.5000	1	1	2	2	2
449	25965	3.6989	1	1	3	4	7
450	6281	2.0492	1	1	1	2	4
451	4	3.7500	1	1	2	4	8
452	22264	4.9182	1	2	3	6	10
453	4242	2.8868	1	1	2	4	5
454	5953	4.4749	1	2	3	5	9
455	974	2.6078	1	1	2	3	5
461	3446	4.5133	1	1	2	5	11
462	10911	12.2067	4	6	10	16	23
463	16562	4.2876	1	2	3	5	8
464	4467	3.1842	1	2	3	4	6
465	202	3.5693	1	1	1	4	7
466	1753	3.9395	1	1	2	4	8
467	1206	3.2629	1	1	2	4	6
468	59764	13.2659	3	6	10	17	26
471	11866	5.6302	3	3	5	6	9
473	7998	13.1317	2	3	7	19	33
475	109305	11.0583	2	5	9	15	22
476	5166	11.6465	2	6	10	15	21
477	26937	8.0048	1	3	6	10	17
478	118559	7.2875	1	3	5	9	15
479	21234	3.7671	1	2	3	5	7
480	446	23.0807	7	11	16	28	47
481	269	25.0632	11	19	23	30	40
482	6415	12.8803	4	7	10	15	23
483	42777	38.7018	14	21	32	48	70
484	392	13.2219	1	6	10	18	27
485	3148	9.0886	4	5	7	11	17
486	2027	12.1722	1	5	10	16	24
487	3604	7.3047	1	3	6	9	15
488	784	18.0982	3	7	13	23	37
489	14037	8.7084	2	3	6	11	18
490	4768	5.2685	1	2	4	7	10
491	11583	3.5480	2	2	3	4	6
492	2575	16.8287	4	5	12	27	35
493	55018	5.7173	1	3	5	7	11
494	26030	2.5108	1	1	2	3	5

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY98 MEDPAR Update 12/98 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
495	130	15.9154	6	8	13	22	29
496	1095	10.7826	4	5	8	13	21
497	23026	6.2674	2	3	5	7	11
498	16601	3.4126	1	2	3	4	6
499	33369	4.8049	1	2	4	6	9
500	40659	2.7628	1	1	2	3	5
501	1974	10.0172	4	5	8	12	19
502	544	6.2702	3	4	5	7	11
503	5860	3.9602	1	2	3	5	7
504	121	31.1488	9	15	26	40	62
505	157	5.0446	1	1	2	6	11
506	966	16.7598	4	8	13	22	33
507	349	9.4413	2	4	8	13	19
508	599	8.5192	2	3	6	9	17
509	210	5.3000	1	2	4	7	10
510	1661	7.3323	2	3	5	9	16
511	645	5.1581	1	2	3	6	11
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TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) MARCH 1999

State	Urban	Rural
ALABAMA	0.373	0.377
ALASKA	0.507	0.732
ARIZONA	0.368	0.536
ARKANSAS	0.478	0.452
CALFORNIA	0.369	0.472
COLORADO	0.449	0.559
CONNECTICUT	0.500	0.505
DELAWARE	0.495	0.453
DISTRICT OF COLUMBIA	0.519	.....
FLORIDA	0.378	0.387
GEORGIA	0.486	0.487
HAWAII	0.492	0.556
IDAHO	0.548	0.576
ILLINOIS	0.443	0.543
INDIANA	0.559	0.596
IOWA	0.506	0.629
KANSAS	0.420	0.627
KENTUCKY	0.491	0.515
LOUISIANA	0.430	0.495
MAINE	0.615	0.570
MARYLAND	0.764	0.821
MASSACHUSETTS	0.528	0.559
MICHIGAN	0.469	0.580
MINNESOTA	0.518	0.591
MISSISSIPPI	0.472	0.488
MISSOURI	0.423	0.506
MONTANA	0.501	0.559
NEBRASKA	0.488	0.626
NEVADA	0.296	0.474
NEW HAMPSHIRE	0.575	0.595
NEW JERSEY	0.412	.....
NEW MEXICO	0.477	0.510
NEW YORK	0.545	0.620
NORTH CAROLINA	0.536	0.506
NORTH DAKOTA	0.616	0.662
OHIO	0.521	0.565
OKLAHOMA	0.438	0.531

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) MARCH 1999—Continued

State	Urban	Rural
OREGON	0.545	0.593
PENNSYLVANIA	0.407	0.531
PUERTO RICO	0.488	0.589
RHODE ISLAND	0.590	.....
SOUTH CAROLINA	0.453	0.455
SOUTH DAKOTA	0.536	0.617
TENNESSEE	0.465	0.495
TEXAS	0.415	0.517
UTAH	0.529	0.654
VERMONT	0.644	0.603
VIRGINA	0.473	0.494
WASHINGTON	0.590	0.660
WEST VIRGINIA	0.592	0.574
WISCONSIN	0.562	0.634
WYOMING	0.475	0.677

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) MARCH 1999

State	Ratio
ALABAMA	0.047
ALASKA	0.066
ARIZONA	0.042
ARKANSAS	0.051
CALIFORNIA	0.039
COLORADO	0.050
CONNECTICUT	0.039
DELAWARE	0.054
DISTRICT OF COLUMBIA	0.039
FLORIDA	0.046
GEORGIA	0.056
HAWAII	0.046
IDAHO	0.060

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) MARCH 1999—Continued

State	Ratio
ILLINOIS	0.043
INDIANA	0.059
IOWA	0.054
KANSAS	0.049
KENTUCKY	0.051
LOUISIANA	0.053
MAINE	0.040
MARYLAND	0.013
MASSACHUSETTS	0.056
MICHIGAN	0.045
MINNESOTA	0.049
MISSISSIPPI	0.048
MISSOURI	0.048
MONTANA	0.051
NEBRASKA	0.057
NEVADA	0.031
NEW HAMPSHIRE	0.066
NEW JERSEY	0.037
NEW MEXICO	0.045
NEW YORK	0.052
NORTH CAROLINA	0.050
NORTH DAKOTA	0.075
OHIO	0.052
OKLAHOMA	0.052
OREGON	0.050
PENNSYLVANIA	0.042
PUERTO RICO	0.049
RHODE ISLAND	0.035
SOUTH CAROLINA	0.047
SOUTH DAKOTA	0.060
TENNESSEE	0.055
TEXAS	0.051
UTAH	0.054
VERMONT	0.051
VIRGINIA	0.060
WASHINGTON	0.066
WEST VIRGINIA	0.056
WISCONSIN	0.056

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) MARCH 1999—Continued

State	Ratio
WYOMING	0.054

Appendix A: Regulatory Impact Analysis

I. Introduction

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless we certify that a proposed rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the hospital inpatient prospective payment system, we classify these hospitals as urban hospitals.

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

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

II. Objectives

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

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

III. Limitations of Our Analysis

As has been the case in our previously published regulatory impact analyses, the following quantitative analysis presents the projected effects of our proposed policy changes, as well as statutory changes effective for FY 2000, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case mix. As we have done in previous proposed rules, we are soliciting comments and information about the anticipated effects of these changes on hospitals and our methodology for estimating them.

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

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general, short-term, acute care hospitals that participate in the Medicare program. There were 45 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment method for these hospitals. Among other short-term, acute care hospitals, only the 50 such hospitals in Maryland remain excluded from the prospective payment system under the waiver at section 1814(b)(3) of the Act. Thus, as of February 1999, we have included 4,874 hospitals in our analysis. This represents about 82 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

The remaining 18 percent are specialty hospitals that are excluded from the prospective payment system and continue to be paid on the basis of their reasonable costs (subject to a rate-of-increase ceiling on their inpatient operating costs per discharge). These hospitals include psychiatric, rehabilitation, long-term care, children's, and cancer hospitals. The impacts of our final policy changes on these hospitals are discussed below.

V. Impact on Excluded Hospitals and Units

As of February 1999, there were 1,085 specialty hospitals excluded from the prospective payment system and instead paid on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. Broken down by speciality, there were 587 psychiatric, 191 rehabilitation, 208 long-term care, 70 childrens', 19 Christian Science Sanatoria, and 10 cancer hospitals. In addition, there were 1,494 psychiatric and 901 rehabilitation units in hospitals otherwise subject to the prospective payment system. These excluded units are also paid in accordance with § 413.40. Under § 413.40(a)(2)(i)(A), the target rate-of-increase ceiling is not applicable to the 36 specialty hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

As required by section 1886(b)(3)(B) of the Act, the update factor applicable to the rate-of-increase limit for excluded hospitals and units for FY 2000 would be between 0 and 2.6 percent, depending on the hospital's or unit's costs in relation to its limit for the most recent cost reporting period for which information is available.

The impact on excluded hospitals and units of the update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level below the percentage increases in the rate-of-increase limits since their base period, the major effect will be on the level of incentive payments these hospitals and units receive. Conversely, for excluded hospitals and units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect will be the amount of excess costs that would not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and units to restrain the growth in their spending for patient services.

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

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing policy changes and payment rate updates for the prospective payment systems for operating and capital-related costs. We estimate the total impact of these changes for FY 2000 payments compared to FY 1999 payments to be approximately a $250 million reduction. We have prepared separate impact analyses of the proposed changes to each system. This section deals with changes to the operating prospective payment system.

The data used in developing the quantitative analyses presented below are taken from the FY 1998 MedPAR file and the most current provider-specific file that is used for payment purposes. Although the analyses of the changes to the operating prospective payment system do not

incorporate cost data, the most recently available hospital cost report data were used to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to these proposed policy changes. Second, due to the interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each proposed change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. For individual hospitals, however, some miscategorizations are possible.

Using cases in the FY 1998 MedPAR file, we simulated payments under the operating prospective payment system given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the general prospective payment systems (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations. Payments under the capital prospective payment system, or payments for costs other than inpatient operating costs, are not analyzed here. Estimated payment impacts of proposed FY 2000 changes to the capital prospective payment system are discussed below in section VII of this Appendix.

The proposed changes discussed separately below are the following:

- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of changes in hospitals' wage index values reflecting the wage index update (FY 1996 data).
- The effects of fully removing from the wage index the costs and hours associated with teaching physicians Part A, residents, and CRNAs; and the effects of our proposal to implement the first year of a 5-year phase-out of these costs, by calculating a wage index based on 20 percent of hospitals' average hourly wages after removing the costs and hours associated with teaching physicians, residents, and CRNAs, and 80 percent of hospitals' average hourly wages with these costs included.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2000.
- The total change in payments based on FY 2000 policies relative to payments based on FY 1999 policies.

To illustrate the impacts of the FY 2000 proposed changes, our analysis begins with a FY 2000 baseline simulation model using: the FY 1999 GROUPER (version 16.0); the FY 1999 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total DRG plus outlier payments.

Each proposed and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2000 model incorporating all of the changes. This allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 1999 to FY 2000. Four factors have significant impacts here. The first is the update to the standardized amounts. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are proposing to update the large urban and the other areas average standardized amounts for FY 2000 using the most recently forecasted hospital market basket increase for FY 2000 of 2.7 percent minus 1.8 percentage points. Similarly, section 1886(b)(3)(C)(ii) of the Act provides that the update factor applicable to the hospital-specific rates for sole community hospitals (SCHs), essential access community hospitals (EACHs) (which are treated as SCHs for payment purposes), and Medicare-dependent, small rural hospitals (MDHs) is equal to the market basket increase of 2.7 percent minus 1.8 percentage points (for an update of 0.9 percent).

A second significant factor that impacts changes in hospitals' payments per case from FY 1999 to FY 2000 is a change in MGCRB reclassification status from one year to the next. That is, hospitals reclassified in FY 1999 that are no longer reclassified in FY 2000 may have a negative payment impact going from FY 1999 to FY 2000; conversely, hospitals not reclassified in FY 1999 that are reclassified in FY 2000 may have a positive impact. In some cases, these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage increase in payments for the category may be below the national mean.

A third significant factor is that we currently estimate that actual outlier payments during FY 1999 will be 6.2 percent of actual total DRG payments. When the FY 1999 final rule was published, we projected FY 1999 outlier payments would be 5.1 percent of total DRG plus outlier payments, and the standardized amounts were reduced correspondingly. The effects of the higher than expected outlier payments during FY 1999 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 1999 payments per case to estimated FY 2000 payments per case.

Fourth, payments per case in FY 1999 are reduced from FY 1999 for hospitals that receive the IME or the DSH adjustments. Section 1886(d)(5)(B)(ii) of the Act provides that the IME adjustment is reduced from approximately a 6.5 percent increase for every 10 percent increase in a hospital's resident-to-bed ratio in FY 1999, to a 6.0 percent increase in FY 2000. Similarly, in accordance with section 1886(d)(5)(F)(ix) of the Act, the DSH adjustment for FY 2000 is reduced by 3 percent from what would otherwise have been paid, compared to a 2 percent reduction for FY 1999.

Table I demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 4,874 hospitals included in the analysis. This is 100 fewer hospitals than were included in the impact analysis in the FY 1999 final rule with comment period (63 FR 41106).

The next four rows of Table I contain hospitals categorized according to their geographic location (all urban, which is further divided into large urban and other urban, or rural). There are 2,712 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,553 hospitals located in large urban areas (populations over 1 million), and 1,160 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,162 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2000 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the number of hospitals paid based on these categorizations (after consideration of geographic reclassifications) are 2,790, 1,628, 1,161, and 2,085, respectively.

The next three groupings examine the impacts of the proposed changes on hospitals grouped by whether or not they have residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 3,772 nonteaching hospitals in our analysis, 868 teaching hospitals with fewer than 100 residents, and 234 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural after MGCRB reclassifications. Hospitals in the rural DSH categories, therefore, represent hospitals that were not reclassified for purposes of the standardized amount or for purposes of the DSH adjustment. (They may, however, have been reclassified for purposes of the wage index.) The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the proposed changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and MDHs), as well as rural hospitals not receiving a special payment designation. The RRCs (151), SCHs (639), MDHs (353), and SCH and RRCs (58) shown here were not reclassified for purposes of the standardized amount. There are three SCHs that will be reclassified for the standardized amount in FY 2000 that, therefore, are not included in these rows.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 1997 Medicare cost report files, if available (otherwise FY 1996 data are used). Data needed to determine ownership status or Medicare utilization percentages were unavailable for 37 hospitals. For the most part, these are new hospitals.

The next series of groupings concern the geographic reclassification status of hospitals. The first three groupings display hospitals that were reclassified by the MGCRB for both FY 1999 and FY 2000, or for either of those 2 years, by urban and rural status. The next rows illustrate the overall number of FY 2000 reclassifications, as well as the numbers of reclassified hospitals grouped by urban and rural location. The final row in Table I contains hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act.

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent Changes in Payments Per Case]

	Number of hosps. [1] (0)	Drg recalib. [2] (1)	New wage date [3] (2)	Remove GME and CRNA costs [4] (3)	Blended wage index costs [5] (4)	DRG & WI changes [6] (5)	MGCRB reclassification [7] (6)	All FY 2000 changes [8] (7)
(BY GEOGRAPHIC LOCATION):								
ALL HOSPITALS	4,875	0.0	0.2	0.2	0.0	0.0	0.0	−0.6
URBAN HOSPITALS	2,712	−0.1	0.1	0.2	0.0	−0.2	−0.4	−0.8
LARGE URBAN	1,552	−0.1	−0.1	0.1	0.0	−0.4	−0.5	−1.0
OTHER URBAN	1,160	−0.1	0.4	0.4	0.1	0.1	−0.3	−0.3
RURAL HOSPITALS	2,162	0.2	0.8	0.4	0.1	0.9	2.5	0.9
BED SIZE (URBAN):								
0– 99 BEDS	679	0.2	−0.1	0.3	0.1	−0.1	−0.5	−0.3
100–199 BEDS	918	0.1	0.1	0.3	0.1	0.0	−0.5	−0.3
200–299 BEDS	553	0.0	0.2	0.3	0.1	0.0	−0.4	−0.6
300–499 BEDS	423	−0.1	0.1	0.3	0.1	−0.2	−0.3	−0.8
500 OR MORE BEDS	139	−0.2	−0.1	−0.1	0.0	−0.5	−0.4	−2.0
BED SIZE (RURAL):								
0–49 BEDS	1,194	0.5	0.6	0.4	0.1	0.9	0.2	1.5
50–99 BEDS	581	0.3	0.7	0.4	0.1	0.8	0.9	1.1
100–149 BEDS	232	0.2	0.8	0.5	0.1	0.8	3.8	0.8
150–199 BEDS	85	0.1	1.0	0.4	0.1	1.0	4.3	1.1
200 OR MORE BEDS	70	0.0	0.9	0.4	0.1	0.8	4.2	0.0
URBAN BY CENSUS DIVISION:								
NEW ENGLAND	149	0.0	0.5	0.1	0.0	0.3	−0.3	−0.6
MIDDLE ATLANTIC	416	0.0	−0.5	−0.3	−0.1	−0.8	−0.4	−2.0
SOUTH ATLANTIC	401	−0.1	0.8	0.5	0.1	0.6	−0.4	0.2
EAST NORTH CENTRAL	446	−0.1	0.7	0.0	0.0	0.4	−0.4	−0.3
EAST SOUTH CENTRAL	157	−0.1	0.8	0.4	0.1	0.6	−0.4	0.1
WEST NORTH CENTRAL	183	−0.1	−0.2	0.1	0.0	−0.5	−0.4	−1.0
WEST SOUTH CENTRAL	343	0.0	−1.2	0.5	0.1	−1.4	−0.4	−2.0
MOUNTAIN	126	−0.1	0.3	0.2	0.0	0.0	−0.4	−0.3
PACIFIC	444	−0.1	−0.3	0.7	0.1	−0.4	−0.4	−0.9
PUERTO RICO	47	0.2	0.9	0.3	0.1	0.9	−0.5	0.5
RURAL BY CENSUS DIVISION:								
NEW ENGLAND	52	0.1	0.0	0.0	0.0	−0.2	2.3	0.2
MIDDLE ATLANTIC	81	0.2	−0.5	0.2	0.0	−0.5	2.2	0.0
SOUTH ATLANTIC	285	0.2	1.7	0.6	0.1	1.8	2.7	0.8
EAST NORTH CENTRAL	301	0.2	0.8	0.5	0.1	0.8	2.0	0.8
EAST SOUTH CENTRAL	270	0.3	1.6	0.6	0.1	1.8	2.5	1.8
WEST NORTH CENTRAL	490	0.2	1.2	0.2	0.0	1.2	2.3	1.6
WEST SOUTH CENTRAL	338	0.3	−1.1	0.5	0.1	−0.9	3.5	−0.2
MOUNTAIN	201	0.3	0.5	0.3	0.1	0.5	2.0	1.4
PACIFIC	139	0.2	0.4	0.5	0.1	0.4	1.9	0.4
PUERTO RICO	5	0.2	3.2	0.4	0.1	3.2	0.7	2.5
(BY PAYMENT CATEGORIES):								
URBAN HOSPITALS	2,790	−0.1	0.1	0.2	0.0	−0.1	−0.3	−0.8
LARGE URBAN	1,628	−0.1	−0.1	0.1	0.0	−0.3	−0.4	−1.0
OTHER URBAN	1,161	−0.1	0.4	0.3	0.1	0.2	−0.3	−0.2
RURAL HOSPITALS	2,085	0.2	0.8	0.4	0.1	0.8	2.2	0.9
TEACHING STATUS:								
NON-TEACHING	3,772	0.1	0.3	0.4	0.1	0.2	0.3	0.1
LESS THAN 100 RESIDENTS	868	−0.1	0.2	0.2	0.0	−0.1	−0.3	−0.6
100+ RESIDENTS	234	−0.1	−0.1	−0.1	0.0	−0.4	−0.2	−2.0
DISPROPORTIONATE SHARE HOSPITALS (DSH):								
NON–DSH	3,048	0.0	0.3	0.3	0.1	0.1	0.2	−0.3
URBAN DSH								
100 BEDS OR MORE	1,365	−0.1	0.0	0.2	0.0	−0.2	−0.3	−0.9
FEWER THAN 100 BEDS	86	0.2	−0.3	0.5	0.1	−0.2	−0.5	−0.3
RURAL DSH								
SOLE COMMUNITY (SCH)	153	0.4	0.8	0.4	0.1	1.0	−0.1	1.5
REFERRAL CENTERS (RRC)	55	0.2	1.4	0.6	0.1	1.4	4.7	1.0
OTHER RURAL DSH HOSPITALS								
100 BEDS OR MORE	57	0.3	1.4	0.6	0.1	1.6	1.1	−0.1
FEWER THAN 100 BEDS	110	0.5	1.7	0.6	0.1	2.0	0.2	2.7
URBAN TEACHING AND DSH:								
BOTH TEACHING AND DSH	703	−0.1	0.0	0.1	0.0	−0.3	−0.4	−1.0

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent Changes in Payments Per Case]

	Number of hosps. [1]	Drg recalib. [2]	New wage date [3]	Remove GME and CRNA costs [4]	Blended wage index costs [5]	DRG & WI changes [6]	MGCRB reclassification [7]	All FY 2000 changes [8]
	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)
TEACHING AND NO DSH	337	−0.1	0.2	0.1	0.0	−0.1	−0.3	−1.0
NO TEACHING AND DSH	748	0.0	0.1	0.5	0.1	0.0	−0.2	−0.1
NO TEACHING AND NO DSH	1,002	0.0	0.2	0.3	0.1	0.1	−0.5	−0.3
RURAL HOSPITAL TYPES:								
NONSPECIAL STATUS HOSPITALS	884	0.3	1.1	0.6	0.1	1.3	1.1	0.9
RRC	151	0.1	0.9	0.5	0.1	0.9	5.6	0.3
SCH	639	0.3	0.3	0.2	0.0	0.4	0.3	1.2
MDH	353	0.4	0.6	0.4	0.1	0.9	0.3	1.3
SCH AND RRC	58	0.1	0.3	0.2	0.0	0.2	2.2	1.4
TYPE OF OWNERSHIP:								
VOLUNTARY	2,838	0.0	0.1	0.2	0.0	−0.1	−0.1	−0.7
PROPRIETARY	743	0.0	0.1	0.4	0.1	0.0	0.0	−0.3
GOVERNMENT	1,256	0.1	0.6	0.4	0.1	0.5	0.2	−0.2
UNKNOWN	37	−0.1	−0.3	−0.4	−0.1	−0.6	−0.2	−2.0
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:								
0–25	372	0.0	−0.4	0.6	0.1	−0.5	−0.1	−2.0
25–50	1,745	−0.1	0.0	0.2	0.0	−0.3	−0.2	−1.0
50–65	1,893	0.0	0.3	0.2	0.0	0.2	0.1	−0.2
OVER 65	822	0.1	0.7	0.3	0.1	0.6	0.3	0.2
UNKNOWN	42	−0.1	−0.3	−0.4	−0.1	−0.6	−0.2	−2.0
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD:								
RECLASSIFICATION STATUS DURING FY 1999 AND FY 2000:								
RECLASSIFIED DURING BOTH FY 1999 AND FY 2000	373	0.1	0.6	0.4	0.1	0.5	5.6	−0.3
URBAN	55	0.0	0.1	0.5	0.1	0.0	4.1	−2.0
RURAL	318	0.1	0.8	0.4	0.1	0.7	6.3	0.5
RECLASSIFIED DURING FY 2000 ONLY	131	0.0	1.2	0.3	0.1	1.0	3.3	4.5
URBAN	30	−0.2	1.2	0.2	0.0	0.8	2.2	2.9
RURAL	101	0.2	1.1	0.4	0.1	1.2	5.4	7.3
RECLASSIFIED DURING FY 1999 ONLY	136	0.1	0.4	0.4	0.1	0.4	−0.7	−6.0
URBAN	32	−0.1	−0.1	0.4	0.1	−0.3	−0.9	−6.0
RURAL	104	0.3	1.0	0.5	0.1	1.1	−0.4	−5.0
FY 2000 RECLASSIFICATIONS:								
ALL RECLASSIFIED HOSPITALS	504	0.0	0.7	0.4	0.1	0.6	5.1	0.8
STANDARDIZED AMOUNT ONLY	65	0.2	0.6	0.5	0.1	0.7	2.7	−0.7
WAGE INDEX ONLY	393	0.0	0.8	0.4	0.1	0.6	5.5	1.0
BOTH	46	0.1	0.4	0.4	0.1	0.3	3.8	0.2
NONRECLASSIFIED	4,344	0.0	0.1	0.2	0.0	−0.1	−0.5	−0.7
ALL URBAN RECLASSIFIED	85	−0.1	0.5	0.3	0.1	0.3	3.4	−0.1
STANDARDIZED AMOUNT ONLY	13	0.1	−0.4	0.5	0.1	−0.3	0.9	−4.0
WAGE INDEX ONLY	49	−0.2	0.8	0.3	0.1	0.5	4.3	0.5
BOTH	23	0.1	−0.2	0.4	0.1	−0.2	0.4	−0.9
NONRECLASSIFIED	2,627	−0.1	0.1	0.2	0.0	−0.2	−0.6	−0.9
ALL RURAL RECLASSIFIED	419	0.1	0.8	0.4	0.1	0.8	6.1	1.4
STANDARDIZED AMOUNT ONLY	52	0.2	1.3	0.6	0.1	1.4	4.0	1.9
WAGE INDEX ONLY	344	0.1	0.7	0.4	0.1	0.7	6.0	1.3
BOTH	23	0.1	1.4	0.4	0.1	1.3	9.3	1.8
NONRECLASSIFIED	1,717	0.3	0.8	0.4	0.1	0.9	−0.4	0.9
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	26	0.2	0.7	0.6	0.1	0.8	−0.5	−9.0

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 1998, and hospital cost report data are from reporting periods beginning in FY 1996 and FY 1997.

[2] This column displays the payment impact of the recalibration of the DRG weights based on FY 1998 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

[3] This column shows the payment effects of updating the data used to calculate the wage index with data from the FY 1996 cost reports.

[4] This column displays the impact of completely removing the costs and hours associated with teaching physicians Part A, residents, and CRNAs from the wage index calculation.

[5] This column illustrates the payment impact of phasing out the costs and hours associated with teaching physicians Part A, residents, and CRNAs, by calculating the wage index by blending 20 percent of an average hourly wage after removing these costs with 80 percent of an average hourly wage without removing these costs.

[6] This column displays the combined impact of the reclassification and recalibration of the DRGs, the updated and revised wage data used to calculate the wage index, and the budget neutrality adjustment factor for these two changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 1, 2, 3, and 4, and the FY 2000 budget neutrality factor of 0.997393.

[7] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2000 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2000. Reclassification for prior years has no bearing on the payment impacts shown here.

[8] This column shows changes in payments from FY 1999 to FY 2000. It incorporates all of the changes displayed in columns 5 and 6 (the changes displayed in columns 1, 2, and 4 are included in column 5). It also displays the impact of the FY 2000 update, changes in hospitals' reclassification status in FY 2000 compared to FY 1999, the difference in outlier payments from FY 1999 to FY 2000, and the reductions to payments through the IME and DSH adjustments taking effect during FY 2000. The sum of these columns may be different from the percentage changes shown here due to rounding and interactive effects.

B. Impact of the Proposed Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 1)

In column 1 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II of the preamble to this proposed rule. Section 1886(d)(4)(C)(i) of the Act requires us to annually make appropriate classification changes and to recalibrate the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

We compared aggregate payments using the FY 1999 DRG relative weights (GROUPER version 16) to aggregate payments using the proposed FY 2000 DRG relative weights (GROUPER version 17). Overall payments are unaffected by the DRG reclassification and recalibration. Consistent with the minor changes we are proposing for the FY 2000 GROUPER, the redistributional impacts of DRG reclassifications and recalibration across hospital groups are very small (a 0.1 percent decrease for large and other urban hospitals; a 0.2 percent increase for rural hospitals). Within hospital categories, the net effects for urban hospitals are small positive changes for small hospitals (a 0.2 percent increase for hospitals with fewer than 100 beds), and small decreases for larger hospitals (a 0.2 percent decrease for hospitals with more than 500 beds). Among rural hospitals, small hospital categories experience the largest increases, a 0.5 percent increase for hospitals with fewer than 50 beds.

The breakdown by urban census division shows that the decrease among urban hospitals is spread across most census categories. Payments to urban hospitals in New England, the Middle Atlantic, and the West South Central census divisions are unchanged, while payments to urban hospitals in Puerto Rico rise by 0.2 percent. All rural hospital census divisions experience payment increases ranging from 0.1 percent for hospitals in New England, to 0.3 percent for hospitals in the East South Central, West South Central, and Mountain census divisions. All other divisions experience a 0.2 percent increase.

This pattern of payment increases for small hospitals and decreases for larger hospitals persists among other categories. Declines in the relative weights of several specific DRGs likely contribute to this trend. Among these DRGs, the relative weight for DRG 108 (Other Cardiothoracic Procedures), declined from 5.9764 in FY 1999 to 5.7505 in this proposed rule for FY 2000. Also, the relative weight for DRG 112 (Percutaneous Cardiovascular Procedures) declined from 1.9893 in FY 1999 to 1.9200 in this proposed rule for FY 2000. Although these cardiovascular procedures are not necessarily limited to very large hospitals, we would expect they are more likely to occur in larger hospitals. As the relative weights of DRGs predominantly occurring in large hospitals decline, the relative weights of other DRGs rise, leading to the small payment increases in hospitals less likely to be affected by the declines in the DRGs noted above.

C. Impact of Updating the Wage Data (Column 2)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the proposed wage index for FY 2000 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1995 and before October 1, 1996. As with the previous column, the impact of the new data on hospital payments is isolated by holding the other payment parameters constant in the two simulations. That is, column 2 shows the percentage changes in payments when going from a model using the FY 1999 wage index (effective for discharges on or after March 1, 1999 (64 FR 9378)) based on FY 1995 wage data before geographic reclassifications to a model using the FY 2000 prereclassification wage index based on FY 1996 wage data.

The wage data collected on the FY 1996 cost reports is similar to the data used in the calculation of the FY 1999 wage index. For example, the wage index values used here include all physician Part A costs (direct and contracted), resident costs, and CRNA costs. Also, as in the calculation for the FY 1999 wage index, contract labor costs and hours for top management positions are included, and the overhead costs allocated to patient care areas excluded from the calculation of the wage index are excluded as well.

The results indicate that the new wage data have an overall impact of a 0.2 percent increase in hospital payments (prior to applying the budget neutrality factor, see column 5). Rural hospitals especially appear to benefit from the update. Their payments increase by 0.8 percent. These increases are attributable to relatively large increases in the wage index values for the rural areas of particular States; Arizona, Puerto Rico, and South Carolina all had increases greater than 6 percent in their prereclassification wage index values. At the same time, several States experience large declines due to moving to the FY 1996 wage data; Massachusetts, Texas, and Utah all had decreases greater than 6 percent.

Urban hospitals as a group are not significantly affected by the updated wage data. The gains of hospitals in other urban areas (0.4 percent increase) are offset by decreases among hospitals in large urban areas (0.1 percent decrease). Urban West South Central hospitals experience a 1.0 percent decrease, largely due to a number of MSAs in Texas with prereclassified FY 2000 wage indexes that fall by 6 percent or more. We note that the wage data used for the proposed wage index are based upon the data available as of February 22, 1999, and therefore, do not reflect revision requests received by the fiscal intermediaries after February 22, 1999. To the extent these requests are granted by hospitals' fiscal intermediaries, these revisions are likely to affect the impacts shown in the final rule. In addition, we continue to verify the accuracy of the data for hospitals with extraordinary changes in their data from the prior year.

The largest increases are seen in the rural census divisions. Rural Puerto Rico experiences the greatest positive impact, 3.2 percent. Hospitals in three other census divisions receive positive impacts over 1.0 percent; South Atlantic at 1.7 percent, East South Central at 1.6 percent, and West North Central at 1.2 percent.

D. Impact of Removing Teaching Physicians' Part A, Residents', and CRNAs' Costs (Column 3)

As discussed in section III.C of the preamble, we are proposing to revise the calculation of the wage index by phasing out the costs and hours associated with teaching physicians Part A, residents, and CRNAs. Although the proposed FY 2000 wage index is based upon a blend of 20 percent of hospitals' average hourly wages after removing these costs and 80 percent of average hourly wages calculated without removing these costs, this column displays the impacts on payments per case of completely removing these costs from the wage index calculation.

As described above in section III.C.1 of the preamble, we determined teaching physician costs by first subtracting the costs and hours attributable to teaching physicians based upon the special survey data we collected for this purpose. If these data were not available from the survey for a particular teaching hospital, 80 percent of the total physician Part A costs and hours for that hospital were removed, consistent with the recommendation of hospital (see discussion in section III.C.1 of the preamble). If a teaching hospital did not separately report its physician Part A costs on the cost report, the amount reported on Line 23, Column 1, of the Worksheet A was removed from the total wage data (as was an associated amount for hours). Resident and CRNA costs and hours were removed in their entirety, based upon the data separately attributed to these employees on the Worksheet S–3.

Column 3 shows the payment impacts of completely removing these costs, relative to wage index values calculated based on the FY 1996 wage data without removing these costs. The overall payment impact of completely removing these costs and hours from the wage index calculation would be a 0.2 percent increase in total payments (prior to applying budget neutrality). The FY 2000 proposed wage index is, however, based on a blended average hourly wage. The impacts of this blended approach are shown in column 4.

The impact of removing these costs from the wage index calculation are generally positive across the majority of hospital categories. However, examining the impacts across urban and rural census divisions indicate that urban Middle Atlantic hospitals experience a 0.3 percent decrease. This effect is attributable to the concentration of teaching hospitals in this census division. The largest positive impact occurs in the

urban Pacific census division, a 0.7 percent payment increase.

As noted above, the data used to prepare the proposed FY 2000 wage index are subject to revision. In particular, in early February 1999, we instructed the fiscal intermediaries to review the survey data on collected teaching physician costs. We have also extended the deadline for teaching hospitals to request revisions to their teaching physician survey data until June 7, 1999. The extent of these requests and the number of changes that are approved by the fiscal intermediaries may change the impacts in the final rule.

E. Impact of 5-Year Phase-Out of Teaching Physicians', Residents', and CRNA Costs (Column 4)

As described above in section III.E of this preamble, the proposed FY 2000 wage index is calculated by blending 80 percent of hospitals' average hourly wages calculated without removing teaching physician Part A, residents, or CRNA costs (and hours); and 20 percent of average hourly wages calculated after removing these costs (and hours). This constitutes the first year of a 5-year phase-out of these costs, where the proportion of the calculation based upon average hourly wages after removing these costs increases by 20 percentage points per year.

This column shows the impact of the blended wage index relative to a wage index using FY 1996 wage data without removing costs or hours of teaching physicians Part A, residents, or CRNAs. The impacts in column 4 are minimal (an increase or decrease of 0.1 percent). As expected, the hospital categories experiencing negative payment impacts in column 3 experience either negative 0.1 percent changes or no change here. The overall impact is 0.0 percent.

The combined wage index changes in Table I are determined by summing the individual impacts in columns 2 and 4. For example, the urban West South Central census division loses 1.2 percent from the new wage data, and gains 0.1 percent from the blended wage index. Therefore, the combined impact of the proposed FY 2000 wage index for these hospitals is a 1.1 percent decrease.

The following chart compares the shifts in wage index values for labor market areas for FY 2000 relative to FY 1999. This chart demonstrates the impact of the proposed changes for the FY 2000 wage index relative to the FY 1999 wage index. The majority of labor market areas (299) experience less than a 5 percent change. A total of 47 labor market areas experience an increase of more than 5 percent with 14 having an increase greater than 10 percent. A total of 28 areas experience decreases of more than 5 percent. Of those, 7 decline by 10 percent or more.

Percentage change in area wage index values	Number of labor market areas	
	FY 1999	FY 2000
Increase more than 10 percent	9	14
Increase more than 5 percent and less than 10 percent	29	33
Increase or decrease less than 5 percent	305	299
Decrease more than 5 percent and less than 10 percent	28	21
Decrease more than 10 percent	0	7

Among urban hospitals, 169 would experience an increase of between 5 and 10 percent and 40 more than 10 percent. A total of 139 rural hospitals have increases greater than 5 percent, but none greater than 10 percent. On the negative side, 130 urban hospitals and 187 rural hospitals have decreases in their wage index values of at least 5 percent but less than 10 percent. There are no rural hospitals with decreases greater than 10 percent, and 21 urban hospitals in this category. The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	40	0
Increase more than 5 percent and less than 10 percent	169	139
Increase or decrease less than 5 percent	2352	1836
Decrease more than 5 percent and less than 10 percent	130	187
Decrease more than 10 percent	21	0

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

The impact of DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this proposed rule, we compared simulated aggregate payments using the FY 1999 DRG relative weights and wage index to simulated aggregate payments using the proposed FY 2000 DRG relative weights and blended wage index. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 0.997393. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index are shown in column 5. The 0.0 percent impact for All Hospitals demonstrates that these changes, in combination with the budget neutrality factor, are budget neutral.

For the most part, the changes in this column are the sum of the changes in columns 1, 2, and 4, minus approximately 0.3 percent attributable to the budget neutrality factor. There may be some variation of plus or minus 0.1 percent due to rounding.

G. Impact of MGCRB Reclassifications (Column 6)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 6 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2000. As noted below, these decisions affect hospitals' standardized amount and wage index area assignments. In addition, rural hospitals reclassified for purposes of the standardized amount qualify to be treated as urban for purposes of the DSH adjustment.

Beginning in 1998, by February 28 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. (In previous years, these determinations were made by March 30.) The MGCRB may approve a hospital's reclassification request for the purpose of using the other area's standardized amount, wage index value, or both or for FYs 1999–2001 for purposes of

qualifying for a DSH adjustment or to receive a higher DSH payment.

The proposed FY 2000 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2000. The wage index values also reflect any decisions made by the HCFA Administrator through the appeals and review process for MGCRB decisions as of February 27, 1999. Additional changes that result from the Administrator's review of MGCRB decisions or a request by a hospital to withdraw its application will be reflected in the final rule for FY 2000.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, we applied an adjustment of 0.994453 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this proposed rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.5 percent, while payments to urban hospitals decline 0.4 percent. Hospitals in other urban areas see a decrease in payments of 0.3 percent, while large urban hospitals lose 0.5 percent. Among urban hospital groups (that is, bed size, census division, and special payment status), payments generally decline.

A positive impact is evident among all rural hospital groups. The smallest increases among the rural census divisions is 0.7 percent for Puerto Rico and 1.9 percent for Pacific. The largest increase is in rural West South Central, with an increase of 3.5 percent.

Among rural hospitals designated as RRCs, 127 hospitals are reclassified for purposes of the wage index only, leading to the 5.6 percent increase in payments among RRCs overall. This positive impact on RRCs is also reflected in the category of rural hospitals with 200 or more beds, which has a 4.2 percent increase in payments.

Rural hospitals reclassified for FY 1999 and FY 2000 experience a 6.3 percent increase in payments. This may be due to the fact that these hospitals have the most to gain from reclassification and have been reclassified for a period of years. Rural hospitals reclassified for FY 2000 only experience a 5.4 percent increase in payments, while rural hospitals reclassified for FY 1999 only experience a 0.4 percent decrease in payments. Urban hospitals reclassified for FY 1999 but not FY 2000 experience a 0.9 percent decline in payments overall. Urban hospitals reclassified for FY 2000 but not for FY 1999 experience a 3.3 percent increase in payments.

The FY 2000 Reclassification rows of Table I show the changes in payments per case for all FY 2000 reclassified and nonreclassified hospitals in urban and rural locations for each of the three reclassification categories (standardized amount only, wage index only, or both). The table illustrates that the largest impact for reclassified rural hospitals is for those hospitals reclassified for both the standardized amount and the wage index. These hospitals receive a 9.3 percent increase in payments. In addition, rural hospitals reclassified just for the wage index receive a 6.0 percent payment increase. The overall impact on reclassified hospitals is to increase their payments per case by an average of 5.1 percent for FY 2000.

The reclassification of hospitals primarily affects payment to nonreclassified hospitals through changes in the wage index and the geographic reclassification budget neutrality adjustment required by section 1886(d)(8)(D) of the Act. Among hospitals that are not reclassified, the overall impact of hospital reclassifications is an average decrease in payments per case of about 0.5 percent. Rural nonreclassified hospitals decrease by 0.4 percent, and urban nonreclassified hospitals lose 0.6 percent (the amount of the budget neutrality offset).

The foregoing analysis was based on MGCRB and HCFA Administrator decisions made by February 27, 1999. As previously noted, there may be changes to some MGCRB decisions through the appeals, review, and applicant withdrawal process. The outcome of these cases will be reflected in the analysis presented in the final rule.

H. All Changes (Column 7)

Column 7 compares our estimate of payments per case, incorporating all changes reflected in this proposed rule for FY 2000 (including statutory changes), to our estimate of payments per case in FY 1999. It includes the effects of the 0.9 percent update to the standardized amounts and the hospital-specific rates for SCHs and MDHs. It also reflects the 1.1 percentage point difference between the projected outlier payments in FY 2000 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 1999 (6.2 percent), as described in the introduction to this Appendix and the Addendum to this proposed rule.

Additional changes affecting the difference between FY 1999 and FY 2000 payments are the reductions to the IME and DSH adjustments enacted by the Balanced Budget Act of 1997. These changes initially went into effect during FY 1998 and include additional decreases in payment for each of several succeeding years. As noted in the introduction to this impact analysis, for FY 2000, IME is reduced to approximately a 6.0 percent rate of increase, and DSH is reduced by 3 percent from what hospitals otherwise would receive. We estimate the overall effect of these statutory changes to be a 0.5 percent reduction in FY 2000 payments. For hospitals receiving both IME and DSH, the impact is estimated to be a 0.8 percent reduction in payments per case.

We also note that column 8 includes the impacts of FY 2000 MGCRB reclassifications compared to the payment impacts of FY 1999 reclassifications. Therefore, when comparing FY 2000 payments to FY 1999, the percent changes due to FY 2000 reclassifications shown in column 6 need to be offset by the effects of reclassification on hospitals' FY 1999 payments (column 7 of Table 1, July 31, 1998 final rule (63 FR 41106)). For example, the impact of MGCRB reclassifications on rural hospitals' FY 1999 payments was approximately a 2.7 percent increase, more than offsetting the 2.5 percent increase in column 6 for FY 2000. Therefore, the net change in FY 2000 payments due to reclassification for rural hospitals is actually a decrease of 0.2 percent relative to FY 1999. However, last year's analysis contained a somewhat different set of hospitals, so this might affect the numbers slightly.

There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 7 may not equal the sum of the changes in columns 5 and 6, plus the other impacts that we are able to identify.

The overall payment change from FY 1999 to FY 2000 for all hospitals is a 0.6 percent decrease. This reflects the 0.9 percent update for FY 2000, the 1.1 percent lower outlier payments in FY 1999 compared to FY 1999 (5.1 percent compared to 6.2 percent); and the 0.5 percent reduction due to lower IME and DSH payments.

Hospitals in urban areas experience a 0.8 percent drop in payments per case compared to FY 1999. The 0.4 percent negative impact due to reclassification is offset by an identical negative impact for FY 1999. The impact of reducing IME and DSH is a 0.6 percent reduction in FY 2000 payments per case. Payment to hospitals in large urban areas are expected to fall 1.0 percent per case compared to 0.3 percent per case for hospitals in other urban areas.

Hospitals in rural areas, meanwhile, experience a 0.9 percent payment increase. As discussed previously, this is primarily due to the positive effect due to the wage index and DRG changes (0.9 percent increase).

Among census divisions, urban Middle Atlantic and the West South Central display the largest negative impacts, 2.0 percent decrease in payments per case for hospitals in these two divisions. These negative impacts are primarily related to the relatively large decreases attributable to the proposed wage index. Hospitals in the South Atlantic and East South Central census divisions, along with Puerto Rico, are the only urban categories grouped by census division exhibiting increases in payments per case for FY 2000. Again, this appears to be related to the proposed FY 2000 wage index.

The only rural census division to experience a negative payment impact is West South Central (0.2 percent fall), and as is generally the case, this appears to be related to a negative payment impact related to their FY 1996 wage data. The largest increases by rural hospitals are in Puerto Rico at 2.5 percent. Among rural census divisions, the largest increases are in the East South Central and West North Central, with 1.8 percent and 1.6 percent increases in their FY 2000 payments per case, respectively. As with the other impacts discussed above, this is generally due to updating the wage data. One rural census division that did not experience an increase in payments as large

as suggested by the positive impact of updating the wage data was the South Atlantic. This census division experienced a 3.8 percent payment increase due to geographic reclassification in FY 1999, but the effect of geographic reclassification in FY 2000 was only 2.7 percent.

Among special categories of rural hospitals, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) experience payment increases of 1.2 percent, 1.3 percent, and 1.4 percent, respectively. This outcome is primarily related to the fact that, for hospitals receiving payments under the hospital-specific methodology, there are no outlier payments. Therefore, these hospitals do not experience negative payment impacts from the decline in outlier payments from FY 1999 to FY 2000 (from 6.2 of total DRG plus outlier payments to 5.1 percent) as do hospitals paid based on the national standardized amounts.

The largest negative payment impacts from FY 1999 to FY 2000 are among hospitals that were reclassified for FY 1999 and are not reclassified for FY 2000. Overall, these hospitals lose 6.0 percent. The urban hospitals in this category lose 6.0 percent, while the rural hospitals lose 5.0 percent. On the other hand, hospitals reclassified for FY 2000 that were not reclassified for FY 1999 would experience the greatest payment increases: 4.5 percent overall; 7.3 percent for 101 rural hospitals in this category and 2.9 percent for 32 urban hospitals.

TABLE II—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments Per Case]

	Number of hospitals (1)	Average FY1999 payment per case (2) [1]	Average FY 2000 payment per case (3) [1]	All changes (4)
(BY GEOGRAPHIC LOCATION):				
ALL HOSPITALS	4,875	6,770	6,730	−0.6
URBAN HOSPITALS	2,712	7,346	7,285	−0.8
LARGE URBAN AREAS	1,552	7,879	7,787	−1.2
OTHER URBAN AREAS	1,160	6,623	6,604	−0.3
RURAL HOSPITALS	2,162	4,505	4,546	0.9
BED SIZE (URBAN):				
0–99 BEDS	679	4,973	4,957	−0.3
100–199 BEDS	918	6,165	6,147	−0.3
200–299 BEDS	553	6,998	6,958	−0.6
300–499 BEDS	423	7,803	7,741	−0.8
500 OR MORE BEDS	139	9,912	9,733	−1.8
BED SIZE (RURAL):				
0–49 BEDS	1,194	3,725	3,779	1.5
50–99 BEDS	581	4,226	4,274	1.1
100–149 BEDS	232	4,605	4,643	0.8
150–199 BEDS	85	4,930	4,983	1.1
200 OR MORE BEDS	70	5,734	5,733	0.0
URBAN BY CENSUS DIVISION:				
NEW ENGLAND	149	7,723	7,677	−0.6
MIDDLE ATLANTIC	416	8,278	8,110	−2.0
SOUTH ATLANTIC	401	6,990	7,001	0.2
EAST NORTH CENTRAL	446	6,994	6,973	−0.3
EAST SOUTH CENTRAL	157	6,579	6,586	0.1
WEST NORTH CENTRAL	183	7,053	6,981	−1.0
WEST SOUTH CENTRAL	343	6,785	6,660	−1.8
MOUNTAIN	126	7,016	6,996	−0.3
PACIFIC	444	8,460	8,388	−0.9
PUERTO RICO	47	3,108	3,124	0.5
RURAL BY CENSUS DIVISION:				
NEW ENGLAND	52	5,356	5,369	0.2
MIDDLE ATLANTIC	81	4,862	4,860	0.0
SOUTH ATLANTIC	285	4,681	4,721	0.8
EAST NORTH CENTRAL	301	4,559	4,596	0.8
EAST SOUTH CENTRAL	270	4,162	4,239	1.8
WEST NORTH CENTRAL	490	4,279	4,349	1.6
WEST SOUTH CENTRAL	338	4,002	3,993	−0.2
MOUNTAIN	201	4,751	4,817	1.4
PACIFIC	139	5,600	5,625	0.4
PUERTO RICO	5	2,334	2,392	2.5
(BY PAYMENT CATEGORIES):				
URBAN HOSPITALS	2,790	7,310	7,251	−0.8
LARGE URBAN	1,628	7,806	7,715	−1.2
OTHER URBAN	1,161	6,610	6,596	−0.2
RURAL HOSPITALS	2,085	4,480	4,519	0.9
TEACHING STATUS:				
NON-TEACHING	3,772	5,473	5,477	0.1
FEWER THAN 100 RESIDENTS	868	7,184	7,138	−0.6
100 OR MORE RESIDENTS	234	10,858	10,658	−1.8
DISPROPORTIONATE SHARE HOSPITALS (DSH):				

TABLE II—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments Per Case]

	Number of hospitals (1)	Average FY1999 payment per case (2) [1]	Average FY 2000 payment per case (3) [1]	All changes (4)
NON-DSH	3,048	5,792	5,775	−0.3
URBAN DSH:				
100 BEDS OR MORE	1,365	7,972	7,900	−0.9
FEWER THAN 100 BEDS	86	5,193	5,180	−0.3
RURAL DSH:				
SOLE COMMUNITY (SCH):	153	4,205	4,266	1.5
REFERRAL CENTERS (RRC)	55	5,357	5,408	1.0
OTHER RURAL DSH HOSPITALS:				
100 BEDS OR MORE	57	4,186	4,183	−0.1
FEWER THAN 100 BEDS	110	3,597	3,692	2.7
URBAN TEACHING AND DSH:				
BOTH TEACHING AND DSH	703	8,936	8,826	−1.2
TEACHING AND NO DSH	337	7,281	7,211	−1.0
NO TEACHING AND DSH	748	6,371	6,362	−0.1
NO TEACHING AND NO DSH	1,002	5,646	5,630	−0.3
RURAL HOSPITAL TYPES:				
NONSPECIAL STATUS HOSPITALS	884	3,964	3,997	0.9
RRC	151	5,225	5,243	0.3
SCH	639	4,470	4,524	1.2
MDH	353	3,757	3,805	1.3
SCH AND RRC	58	5,368	5,442	1.4
TYPE OF OWNERSHIP:				
VOLUNTARY	2,838	6,943	6,895	−0.7
PROPRIETARY	743	6,202	6,181	−0.3
GOVERNMENT	1,256	6,286	6,273	−0.2
UNKNOWN	37	9,806	9,626	−1.8
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:				
0–25	372	8,826	8,692	−1.5
25–50	1,745	7,924	7,844	−1.0
50–65	1,893	5,997	5,986	−0.2
OVER 65	822	5,272	5,285	0.2
UNKNOWN	42	9,716	9,539	−1.8
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD:				
RECLASSIFICATION STATUS DURING FY 1999 AND FY 2000:				
RECLASSIFIED DURING BOTH FY 1999 AND FY 2000	373	5,819	5,803	−0.3
URBAN	55	8,004	7,849	−1.9
RURAL	318	5,202	5,226	0.5
RECLASSIFIED DURING FY 2000 ONLY	131	6,183	6,459	4.5
URBAN	30	8,096	8,327	2.9
RURAL	101	4,362	4,682	7.3
RECLASSIFIED DURING FY 1999 ONLY	136	5,577	5,267	−5.6
URBAN	32	6,976	6,568	−5.8
RURAL	104	4,611	4,369	−5.3
FY 2000 RECLASSIFICATIONS:				
ALL RECLASSIFIED HOSPITALS	504	5,896	5,943	0.8
STANDARDIZED AMOUNT ONLY	65	4,764	4,732	−0.7
WAGE INDEX ONLY	393	5,981	6,041	1.0
BOTH	46	6,156	6,168	0.2
NONRECLASSIFIED	4,344	6,889	6,839	−0.7
ALL URBAN RECLASSIFIED	85	8,039	8,028	−0.1
STANDARDIZED AMOUNT ONLY	13	5,253	5,032	−4.2
WAGE INDEX ONLY	49	8,867	8,908	0.5
BOTH	23	6,894	6,834	−0.9
NONRECLASSIFIED	2,627	7,318	7,255	−0.9
ALL RURAL RECLASSIFIED	419	5,075	5,144	1.4
STANDARDIZED AMOUNT ONLY	52	4,468	4,551	1.9
WAGE INDEX ONLY	344	5,110	5,175	1.3
BOTH	23	5,281	5,379	1.8
NONRECLASSIFIED	1,717	4,108	4,143	0.9
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	26	4,781	4,361	−8.8

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

Table II presents the projected impact of the proposed changes for FY 2000 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the projected payments per case for FY 2000 with the average estimated per case payments for FY 1999, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from column 7 of Table I.

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

A. General Considerations

We now have cost report data for the 5th and 6th years of the capital prospective payment system (cost reports beginning in FY 1996 and in FY 1997) available through the December 1998 update of the HCRIS. We also have updated information on the projected aggregate amount of obligated capital approved by the fiscal intermediaries. However, our impact analysis of payment changes for capital-related costs is still limited by the lack of hospital-specific data on several items. These are the hospital's projected new capital costs for each year, its projected old capital costs for each year, and the actual amounts of obligated capital that will be put in use for patient care and recognized as Medicare old capital costs in each year. The lack of this information affects our impact analysis in the following ways:

- Major investment in hospital capital assets (for example, in building and major fixed equipment) occurs at irregular intervals. As a result, there can be significant variation in the growth rates of Medicare capital-related costs per case among hospitals. We do not have the necessary hospital-specific budget data to project the hospital capital growth rate for individual hospitals.
- Our policy of recognizing certain obligated capital as old capital makes it difficult to project future capital-related costs for individual hospitals. Under § 412.302(c), a hospital is required to notify its intermediary that it has obligated capital by the later of October 1, 1992, or 90 days after the beginning of the hospital's first cost reporting period under the capital prospective payment system. The intermediary must then notify the hospital of its determination whether the criteria for recognition of obligated capital have been met by the later of the end of the hospital's first cost reporting period subject to the capital prospective payment system or 9 months after the receipt of the hospital's notification. The amount that is recognized as old capital is limited to the lesser of the actual allowable costs when the asset is put in use for patient care or the estimated costs of the capital expenditure at the time it was obligated. We have substantial information regarding intermediary determinations of projected aggregate obligated capital amounts. However, we still do not know when these projects will actually be put into use for patient care, the actual amount that will be recognized as obligated capital when the project is put into use, or the Medicare share of the recognized costs. Therefore, we do not know actual obligated capital commitments for purposes of the FY 2000 capital cost projections. In Appendix B of this proposed rule, we discuss the assumptions and computations that we employ to generate the amount of obligated capital commitments for use in the FY 2000 capital cost projections.

In Table III of this section, we present the redistributive effects that are expected to occur between ''hold-harmless'' hospitals and ''fully prospective'' hospitals in FY 2000. In addition, we have integrated sufficient hospital-specific information into our actuarial model to project the impact of the proposed FY 2000 capital payment policies by the standard prospective payment system hospital groupings. While we now have actual information on the effects of the transition payment methodology and interim payments under the capital prospective payment system and cost report data for most hospitals, we still need to randomly generate numbers for the change in old capital costs, new capital costs for each year, and obligated amounts that will be put in use for patient care services and recognized as old capital each year. We continue to be unable to predict accurately FY 2000 capital costs for individual hospitals, but with the most recent data hospitals' experience under the capital prospective payment system, there is adequate information to estimate the aggregate impact on most hospital groupings.

B. Projected Impact Based on the Proposed FY 2000 Actuarial Model

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 1999 to FY 2000 using a capital cost model. The FY 2000 model, as described in Appendix B of this proposed rule, integrates actual data from individual hospitals with randomly generated capital cost amounts. We have capital cost data from cost reports beginning in FY 1989 through FY 1997 as reported on the December 1998 update of HCRIS, interim payment data for hospitals already receiving capital prospective payments through PRICER, and data reported by the intermediaries that include the hospital-specific rate determinations that have been made through January 1, 1999 in the provider-specific file. We used these data to determine the proposed FY 2000 capital rates. However, we do not have individual hospital data on old capital changes, new capital formation, and actual obligated capital costs. We have data on costs for capital in use in FY 1997, and we age that capital by a formula described in Appendix B. Therefore, we need to randomly generate only new capital acquisitions for any year after FY 1997. All Federal rate payment parameters are assigned to the applicable hospital.

For purposes of this impact analysis, the proposed FY 2000 actuarial model includes the following assumptions:

- Medicare inpatient capital costs per discharge will change at the following rates during these periods:

AVERAGE PERCENTAGE CHANGE IN CAPITAL COSTS PER DISCHARGE

Fiscal year	Percentage change
1998	−0.71
1999	−0.15
2000	0.75

- The Medicare case-mix index will increase by 1.0 percent in FY 1999 and 0.5 percent in FY 2000.
- The Federal capital rate and hospital-specific rate were updated in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs, and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The proposed FY 2000 update is −0.6 percent (see section IV of the Addendum to this proposed rule).

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 1999 to FY 2000. Table III shows the effect of the capital prospective payment system on low capital cost hospitals and high capital cost hospitals. We consider a hospital to be a low capital cost hospital if, based on a comparison of its initial hospital-specific rate and the applicable Federal rate, it will be paid under the fully prospective payment methodology. A high capital cost hospital is a hospital that, based on its initial hospital-specific rate and the applicable Federal rate, will be paid under the hold-harmless payment methodology. Based on our actuarial model, the breakdown of hospitals is as follows:

CAPITAL TRANSITION PAYMENT METHODOLOGY FOR FY 2000

Type of Hospital	Percent of hospitals	Percent of discharges	Percent of capital costs	Percent of capital payments
Low Cost Hospital	66	61	54	59
High Cost Hospital	34	39	46	41

A low capital cost hospital may request to have its hospital-specific rate redetermined based on old capital costs in the current year, through the later of the hospital's cost reporting period beginning in FY 1994 or the first cost reporting period beginning after obligated capital comes into use (within the limits established in § 412.302(e) for putting obligated capital into use for patient care). If the redetermined hospital-specific rate is greater than the adjusted Federal rate, these hospitals will be paid under the hold-harmless payment methodology. Regardless of whether the hospital became a hold-harmless payment hospital as a result of a redetermination, we continue to show these hospitals as low capital cost hospitals in Table III.

Assuming no behavioral changes in capital expenditures, Table III displays the percentage change in payments from FY 1999 to FY 2000 using the above described actuarial model. With the proposed Federal rate, we estimate aggregate Medicare capital payments will increase by 2.66 percent in FY 2000.

TABLE III.—IMPACT OF PROPOSED CHANGES FOR FY 2000 ON PAYMENTS PER DISCHARGE

	Number of hospitals	Discharges	Adjusted Federal payment	Average Federal percent	Hospital specific payment	Hold harmless payment	Exceptions payment	Total payment	Percent change over FY 1999
FY 1999 Payments per Discharge:									
Low Cost Hospitals	3,200	6,737,171	$521.48	81.42	$58.83	$3.46	$8.72	$592.49	
Fully Prospective	2,977	6,138,720	511.78	80.00	64.57	.....	8.44	584.79	.....
100% Federal Rate	193	538,418	642.90	100.00	.....	.....	4.44	647.34	.....
Hold Harmless	30	60,033	423.55	60.65	.....	388.55	75.12	887.21	.....
High Cost Hospitals	1,634	4,248,111	658.19	97.70	.....	22.81	14.66	695.65	.....
100% Federal Rate	1,424	3,876,299	677.27	100.00	.....	.....	7.26	684.53	.....
Hold Harmless	210	371,812	459.27	72.18	.....	260.63	91.71	811.60	.....
Total Hospitals	4,834	10,985,282	574.34	87.91	36.08	10.94	11.01	632.38	.....
FY 2000 Payments per Discharge:									
Low Cost Hospitals	3,200	6,785,508	573.45	90.60	29.15	2.91	10.29	615.79	3.93
Fully Prospective	2,977	6,182,772	569.26	90.00	31.99	.....	9.24	610.48	4.39
100% Federal Rate	194	543,519	632.85	100.00	.....	.....	4.51	637.36	−1.54
Hold Harmless	29	59,217	465.60	68.51	.....	333.70	173.36	972.66	9.63
High Cost Hospitals	1,634	4,278,443	649.22	98.47	.....	16.61	24.44	690.27	−0.77
100% Federal Rate	1,442	3,951,867	663.34	100.00	.....	.....	11.28	674.62	−1.45
Hold Harmless	192	326,576	478.35	78.33	.....	217.65	183.66	879.66	8.38
Total Hospitals	4,834	11,063,951	602.75	93.72	17.87	8.21	15.76	644.59	1.93

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average increase in payments per case of 4.39 percent, and high capital cost hospitals will experience an average decrease of 0.77 percent. These results are due to the change in the blended percentages to the payment system to 90 percent adjusted Federal rate and 10 percent hospital-specific rate.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 80 percent to 90 percent and the hospital-specific rate payment percentage will decrease from 20 to 10 percent in FY 2000. The Federal rate payment percentage for hospitals paid under the hold-harmless payment methodology is based on the hospital's ratio of new capital costs to total capital costs. The average Federal rate payment percentage for high cost hospitals receiving a hold-harmless payment for old capital will increase from 72.18 percent to 78.83 percent. We estimate the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate will increase from 87.1 percent to 88.2 percent. We estimate that the few remaining high cost hold-harmless hospitals (192) will experience an increase in payments of 8.38 percent from FY 1999 to FY 2000. The increase occurs because we estimate that exception payments per discharge will increase 50.1 percent from FY 1999 to FY 2000 for high cost hold-harmless hospitals. While we estimate that this group's regular hold-harmless payments for old capital will decline by 16.5 percent due to the retirement of old capital, we estimate that its high overall capital costs will cause an increase in these hospitals' exceptions payments from $91.71 per discharge in FY 1999 to $183.66 per discharge in FY 2000. This is primarily due to the estimated decrease in outlier payments, which will cause an estimated increase in exceptions payments to cover unmet capital costs.

We expect that the average hospital-specific rate payment per discharge will decrease from $64.57 in FY 1999 to $31.99 in FY 2000. This is mostly due to the decrease in the hospital-specific rate payment percentage from 20 percent in FY 1999 to 10 percent in FY 2000.

We are proposing no changes in our exceptions policies for FY 2000. As a result, the minimum payment levels would be—

- 90 percent for sole community hospitals;
- 80 percent for urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or more; or
- 70 percent for all other hospitals.

We estimate that exceptions payments will increase from 1.74 percent of total capital payments in FY 1999 to 2.45 percent of payments in FY 2000. The projected distribution of the exception payments is shown in the chart below:

ESTIMATED FY 2000 EXCEPTIONS PAYMENTS

Type of hospital	Number of hospitals	Percent of exceptions payments
Low Capital Cost	180	40
High Capital Cost	208	60
Total	388	100

C. Cross-Sectional Comparison of Capital Prospective Payment Methodologies

Table IV presents a cross-sectional summary of hospital groupings by capital prospective payment methodology. This distribution is generated by our actuarial model.

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS

	(1) Total number of hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
By Geographic Location:				
All hospitals	4,834	4.6	33.8	61.6
Large urban areas (populations over 1 million)	1,531	4.8	41.7	53.4
Other urban areas (populations of 1 million of fewer)	1,146	5.7	42.0	52.4
Rural areas	2,157	3.8	23.9	72.3
Urban hospitals	2,677	5.2	41.8	53.0
0–99 beds	650	6.5	34.3	59.2
100–199 beds	912	7.2	48.5	44.3
200–299 beds	553	4.2	42.3	53.5
300–499 beds	423	1.4	39.2	59.3
500 or more beds	139	1.4	39.6	59.0
Rural hospitals	2,157	3.8	23.9	72.3
0–49 beds	1,190	3.4	16.8	79.7
50–99 beds	580	4.5	29.5	66.0
100–149 beds	232	4.7	36.6	58.6
150–199 beds	85	3.5	30.6	65.9
200 or more beds	70	1.4	48.6	50.0
By Region:				
Urban by Region	2,677	5.2	41.8	53.0
New England	148	0.7	28.4	70.9
Middle Atlantic	412	2.7	36.4	60.9
South Atlantic	399	5.3	52.9	41.9
East North Central	444	6.1	31.8	62.2
East South Central	154	10.4	46.8	42.9
West North Central	179	3.4	40.2	56.4
West South Central	331	10.3	59.2	30.5
Mountain	123	5.7	50.4	43.9
Pacific	440	3.4	36.6	60.0
Puerto Rico	47	2.1	27.7	70.2
Rural by Region	2,157	3.8	23.9	72.3
New England	52	1.9	23.1	75.0
Middle Atlantic	80	6.3	20.0	73.8
South Atlantic	285	1.4	34.7	63.9
East North Central	300	3.3	18.3	78.3
East South Central	270	2.6	34.1	63.3
West North Central	490	3.7	15.9	80.4
West South Central	337	3.9	27.9	68.2
Mountain	200	8.5	18.0	73.5
Pacific	138	5.1	23.9	71.0
By Payment Classification:				
Large urban areas (populations over 1 million)	1,607	4.7	41.8	53.6
Other urban areas (populations of 1 million of fewer)	1,147	5.8	41.3	52.9
Rural areas	2,080	3.8	23.6	72.5
Teaching Status:				
Non-teaching	3,732	5.0	33.1	61.9
Fewer than 100 Residents	868	3.8	37.0	59.2
100 or more Residents	234	1.3	33.3	65.4

TABLE IV.—DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS—Continued

	(1) Total number of hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
Disproportionate share hospitals (DSH):.				
Non-DSH	3,014	4.6	29.9	65.5
Urban DSH:				
100 or more beds	1,362	4.4	44.6	51.0
Less than 100 beds	84	8.3	23.8	67.9
Rural DSH:				
Sole Community (SCH)	153	5.9	20.9	73.2
Referral Center (RRC)	55	3.6	43.6	52.7
Other Rural:.				
100 or more beds	57	1.8	43.9	54.4
Less than 100 beds	109	2.8	25.7	71.6
Urban teaching and DSH:				
Both teaching and DSH	703	2.7	37.7	59.6
Teaching and no DSH	337	4.5	33.8	61.7
No teaching and DSH	743	6.5	48.7	44.8
No teaching and no DSH	971	6.1	41.6	52.3
Rural Hospital Types:				
Non special status hospitals	881	1.7	25.0	73.3
RRC/EACH	151	0.7	43.0	56.3
SCH/EACH	638	7.7	21.0	71.3
Medicare-dependent hospitals (MDH)	352	2.3	16.2	81.5
SCH, RRC and EACH	58	12.1	25.9	62.1
Type of Ownership:				
Voluntary	2,826	4.0	33.4	62.6
Proprietary	721	7.6	59.1	33.3
Government	1,255	3.8	20.8	75.4
Medicare Utilization as a Percent of Inpatient Days:				
0–25	360	4.4	27.8	67.8
25–50	1,739	4.8	36.6	58.7
50–65	1,885	4.2	33.3	62.5
Over 65	817	4.7	32.9	62.4

As we explain in Appendix B of this proposed rule, we were not able to determine a hospital-specific rate for 40 of the 4,874 hospitals in our database. Consequently, the payment methodology distribution is based on 4,834 hospitals. These data should be fully representative of the payment methodologies that will be applicable to hospitals.

The cross-sectional distribution of hospital by payment methodology is presented by: (1) Geographic location; (2) region; and (3) payment classification. This provides an indication of the percentage of hospitals within a particular hospital grouping that will be paid under the fully prospective payment methodology and the hold-harmless payment methodology.

The percentage of hospitals paid fully Federal (100 percent of the Federal rate) as hold-harmless hospitals is expected to increase to 33.8 percent in FY 2000.

Table IV indicates that 61.6 percent of hospitals will be paid under the fully prospective payment methodology. (This figure, unlike the figure of 66 percent for low cost capital hospitals in the chart on ''Capital Transition Payment Methodology for FY 2000,'' in section VII.B.2. of this preamble takes into account the effects of redeterminations. In other words, this figure does not include low cost hospitals that, following a hospital-specific rate redetermination, are now paid under the hold-harmless methodology.) As expected, a relatively higher percentage of rural and governmental hospitals (72.5 percent and 75.4 percent, respectively by payment classification) are being paid under the fully prospective payment methodology. This is a reflection of their lower than average capital costs per case. In contrast, only 33.3 percent of proprietary hospitals are being paid under the fully prospective methodology. This is a reflection of their higher than average capital costs per case. (We found at the time of the August 30, 1991 final rule (56 FR 43430) that 62.7 percent of proprietary hospitals had a capital cost per case above the national average cost per case.)

D. Cross-Sectional Analysis of Changes in Aggregate Payments

We used our FY 2000 actuarial model to estimate the potential impact of our proposed changes for FY 2000 on total capital payments per case, using a universe of 4,834 hospitals. The individual hospital payment parameters are taken from the best available data, including: the January 1, 1999 update to the provider-specific file, cost report data, and audit information supplied by intermediaries. In Table V we present the results of the cross-sectional analysis using the results of our actuarial model and the aggregate impact of the proposed FY 2000 payment policies. Columns 3 and 4 show estimates of payments per case under our model for FY 1999 and FY 2000. Column 5 shows the total percentage change in payments from FY 1999 to FY 2000. Column 6 presents the percentage change in payments that can be attributed to Federal rate changes alone.

Federal rate changes represented in Column 6 include the 1.0 percent decrease in the Federal rate, a 0.5 percent increase in case mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB. Column 5 includes the effects of the Federal rate changes represented in Column 6. Column 5 also reflects the effects

of all other changes, including the change from 80 percent to 90 percent in the portion of the Federal rate for fully prospective hospitals, the hospital-specific rate update, changes in the proportion of new to total capital for hold-harmless hospitals, changes in old capital (for example, obligated capital put in use), hospital-specific rate redeterminations, and exceptions. The comparisons are provided by: (1) Geographic location, (2) region, and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 1.9 percent in FY 2000, despite the effect of the 1.4 percent decrease attributable to the reduction in the Federal rate and other factors (which include changes in the adjustment to the Federal rate, the increase in case mix, and the other components of column 6 of table V).

Our comparison by geographic location shows that urban and rural hospitals will experience slightly different rates of increase in capital payments per case (1.8 percent and 2.8 percent, respectively). This difference is due to the higher rate of decrease for urban hospitals relative to rural hospitals (1.6 percent and 0.4 percent, respectively) from the Federal rate changes alone. Urban hospitals will gain approximately the same as rural hospitals (3.4 percent versus 3.2 percent) from the effects of all other changes.

Most regions are estimated to receive increases in total capital payments per case, partly due to the increased share of payments that are based on the Federal rate (from 80 to 90 percent). Changes by region vary from a low of 1.1 percent decrease (West South Central urban region) to a high of 5.9 percent increase (West North Central rural region).

By type of ownership, government hospitals are projected to have the largest rate of increase of total payment changes (3.1 percent, a 3.9 percent increase from the effects of all other changes and a 0.8 percent decrease due to Federal rate changes). Payments to voluntary hospitals will increase 1.9 percent (a 3.3 percent increase from the effects of all other changes and a 1.4 percent decrease due to Federal rate changes), and payments to proprietary hospitals will increase 1.1 percent (a 3.1 percent increase from the effects of all other changes and a 2.0 percent decrease due to Federal rate changes).

Section 1886(d)(10) of the Act established the MGCRB. Hospitals may apply for reclassification for purposes of the standardized amount, wage index, or both and for purposes of DSH, for FY 1999–2001. Although the Federal capital rate is not affected, a hospital's geographic classification for purposes of the operating standardized amount does affect a hospital's capital payments as a result of the large urban adjustment factor and the disproportionate share adjustment for urban hospitals with 100 or more beds. Reclassification for wage index purposes affects the geographic adjustment factor, since that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2000 compared to the effects of reclassification for FY 1999, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 2000 reclassifications, we indicate those hospitals reclassified for standardized amount purposes only, for wage index purposes only, and for both purposes. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified for FY 2000 as a whole are projected to experience a 2.8 percent increase in payments (a 3.1 percent increase attributable to the effects of all other changes and a 0.3 percent decrease attributable to Federal rate changes). Payments to nonreclassified hospitals will increase slightly less (1.9 percent) than reclassified hospitals (2.8 percent) overall. Payments to nonreclassified hospitals will decrease more than reclassified hospitals from the Federal rate changes (1.5 percent compared to 0.3 percent), but they will gain about the same from the effects of all other changes (3.4 percent compared to 3.1 percent).

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 1999 Compared to FY 2000]

	Number of hospitals	Average FY 1999 payments/case	Average FY 2000 payments/case	All changes	Portion attributable to Federal rate change
By Geographic Location:					
All hospitals	4,834	632	645	1.9	−1.4
Large urban areas (populations over 1 million)	1,531	731	742	1.5	−1.8
Other urban areas (populations of 1 million or fewer)	1,146	622	636	2.3	−1.3
Rural areas	2,157	426	438	2.8	−0.4
Urban hospitals	2,677	684	697	1.8	−1.6
0–99 beds	650	501	507	1.1	−1.6
100–199 beds	912	602	609	1.2	−1.5
200–299 beds	553	660	673	2.0	−1.6
300–499 beds	423	704	720	2.3	−1.5
500 or more beds	139	892	906	1.5	−1.9
Rural hospitals	2,157	426	438	2.8	−0.4
0–49 beds	1,190	346	359	3.9	0.2
50–99 beds	580	400	413	3.4	−0.1
100–149 beds	232	439	451	2.7	−0.4
150–199 beds	85	459	479	4.3	−0.4
200 or more beds	70	549	550	0.1	−1.1
By Region:					
Urban by Region	2,677	684	697	1.8	−1.6
New England	148	693	715	3.1	−1.0
Middle Atlantic	412	751	759	1.1	−2.2
South Atlantic	399	671	692	3.1	−1.0
East North Central	444	645	663	2.7	−0.9
East South Central	154	642	662	3.1	−1.3
West North Central	179	664	672	1.3	−1.8
West South Central	331	664	657	−1.1	−2.9
Mountain	123	657	667	1.6	−1.2
Pacific	440	762	773	1.5	−1.9
Puerto Rico	47	298	295	−1.0	−1.4

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 1999 Compared to FY 2000]

	Number of hospitals	Average FY 1999 payments/case	Average FY 2000 payments/case	All changes	Portion attributable to Federal rate change
Rural by Region	2,157	426	438	2.8	−0.4
New England	52	507	515	1.6	−0.6
Middle Atlantic	80	446	458	2.7	−1.3
South Atlantic	285	439	451	2.6	−0.4
East North Central	300	441	449	1.8	−0.4
East South Central	270	391	403	3.2	0.4
West North Central	490	417	442	5.9	0.6
West South Central	337	380	381	0.3	−1.7
Mountain	200	447	466	4.3	0.5
Pacific	138	498	512	2.8	−0.7
By Payment Classification:					
All hospitals	4,834	632	645	1.9	−1.4
Large urban areas (populations over 1 million)	1,607	724	735	1.5	−1.8
Other urban areas (populations of 1 million or fewer)	1,147	620	635	2.3	−1.3
Rural areas	2,080	423	435	2.9	−0.4
Teaching Status:					
Non-teaching	3,732	532	541	1.7	−1.2
Fewer than 100 Residents	868	664	679	2.1	−1.6
100 or more Residents	234	946	967	2.2	−1.8
Urban DSH:					
100 or more beds	1,362	724	737	1.8	−1.6
Less than 100 beds	84	505	500	−0.9	−1.2
Rural DSH:					
Sole Community (SCH/EACH)	153	390	418	7.3	0.1
Referral Center (RRC/EACH)	55	484	492	1.8	−0.5
Other Rural:					
100 or more beds	57	392	396	1.1	−0.6
Less than 100 beds	109	331	348	5.3	1.4
Urban teaching and DSH:					
Both teaching and DSH	703	794	811	2.1	−1.7
Teaching and no DSH	337	681	696	2.2	−1.6
No teaching and DSH	743	607	614	1.3	−1.5
No teaching and no DSH	971	573	580	1.3	−1.5
Rural Hospital Types:					
Non special status hospitals	881	378	387	2.6	−0.4
RRC/EACH	151	490	500	1.9	−0.9
SCH/EACH	638	428	446	4.4	0.0
Medicare-dependent hospitals (MDH)	352	345	357	3.5	0.0
SCH, RRC and EACH	58	498	511	2.4	0.2
Hospitals Reclassified by the Medicare Geographic Classification Review Board:					
Reclassification Status During FY1999 and FY2000:					
Reclassified During Both FY1999 and FY2000	373	553	561	1.3	−1.3
Reclassified During FY2000 Only	131	594	642	8.1	3.1
Reclassified During FY1999 Only	136	531	513	−3.4	−6.3
FY2000 Reclassifications:					
All Reclassified Hospitals	504	562	578	2.8	−0.3
All Nonreclassified Hospitals	4,304	642	654	1.9	−1.5
All Urban Reclassified Hospitals	85	751	775	3.2	−1.1
Urban Nonreclassified Hospitals	2,592	682	694	1.7	−1.6
All Reclassified Rural Hospitals	419	489	502	2.6	0.1
Rural Nonreclassified Hospitals	1,712	381	394	3.4	−0.4
Other Reclassified Hospitals (Section 1886(D)(8)(B))	26	463	429	−7.3	−8.8
Type of Ownership:					
Voluntary	2,826	646	658	1.9	−1.4
Proprietary	721	634	641	1.1	−2.0
Government	1,255	555	572	3.1	−0.8
Medicare Utilization as a Percent of Inpatient Days:					
0–25	360	768	789	2.8	−2.1
25–50	1,739	726	737	1.5	−1.7
50–65	1,885	575	588	2.2	−1.2

Appendix B: Technical Appendix on the Capital Cost Model and Required Adjustments

Under section 1886(g)(1)(A) of the Act, we set capital prospective payment rates for FY 1992 through FY 1995 so that aggregate prospective payments for capital costs were projected to be 10 percent lower than the amount that would have been payable on a reasonable cost basis for capital-related costs in that year. To implement this requirement, we developed the capital acquisition model to determine the budget neutrality adjustment factor. Even though the budget neutrality requirement expired effective with FY 1996, we must continue to determine the recalibration and geographic reclassification budget neutrality adjustment factor and the reduction in the Federal and hospital-specific rates for exceptions payments. To determine these factors, we must continue to project capital costs and payments.

We used the capital acquisition model from the start of prospective payments for capital costs through FY 1997. We now have 6 years of cost reports under the capital prospective payment system. For FY 1998, we developed a new capital cost model to replace the capital acquisition model. This revised model makes use of the data from these cost reports.

The following cost reports are used in the capital cost model for this proposed rule: the December 31, 1998 update of the cost reports for PPS–IX (cost reporting periods beginning in FY 1992), PPS–X (cost reporting periods beginning in FY 1993), PPS–XI (cost reporting periods beginning in FY 1994), PPS–XII (cost reporting periods beginning in FY 1995), PPS–XIII (cost reporting periods beginning in FY 1996), and PPS–XIV (cost reporting periods beginning in FY 1997). In addition, to model payments, we use the January 1, 1999 update of the provider-specific file, and the March 1994 update of the intermediary audit file.

Since hospitals under alternative payment system waivers (that is, hospitals in Maryland) are currently not paid under the capital prospective payment system, we excluded these hospitals from our model.

We developed FY 1992 through FY 1999 hospital-specific rates using the provider-specific file and the intermediary audit file. (We used the cumulative provider-specific file, which includes all updates to each hospital's records, and chose the latest record for each fiscal year.) We checked the consistency between the provider-specific file and the intermediary audit file. We ensured that increases in the hospital-specific rates were at least as large as the published updates (increases) for the hospital-specific rates each year. We were able to match hospitals to the files as shown in the following table:

Source	Number of hospitals
Neither File	1
Audit File only	53
Provider-Specific File Only	103
Provider-Specific and Audit File	4717
Total	4874

Sixty-three of the 4,874 hospitals had unusable or missing data, or had no cost reports available. For 21 of the 63 hospitals, we were unable to determine a hospital-specific rate from the available cost reports. However, there was adequate cost information to determine that these hospitals were paid under the hold-harmless methodology. Since the hospital-specific rate is not used to determine payments for hospitals paid under the hold-harmless methodology, there was sufficient cost report information available to include these 21 hospitals in the analysis. We were able to estimate hospital-specific amounts from the PPS–IX cost report data for an additional 2 hospitals. Hence, we were able to use 23 of the 63 hospitals. We used 4,834 hospitals for the analysis. Forty hospitals could not be used in the analysis because of insufficient information. These hospitals account for less than 0.2 percent of admissions. Therefore, any effects from the elimination of their cost report data should be minimal.

We analyzed changes in capital-related costs (depreciation, interest, rent, leases, insurance, and taxes) reported in the cost reports. We found a wide variance among hospitals in the growth of these costs. For hospitals with more than 100 beds, the distribution and mean of these cost increases were different for large changes in bed-size (greater than ±20 percent). We also analyzed changes in the growth in old capital and new capital for cost reports that provided this information. For old capital, we limited the analysis to decreases in old capital. We did this since the opportunity for most hospitals to treat ''obligated'' capital put into service as old capital has expired. Old capital costs should decrease as assets become fully depreciated and as interest costs decrease as the loan is amortized.

The new capital cost model separates the hospitals into three mutually exclusive groups. Hold-harmless hospitals with data on old capital were placed in the first group. Of the remaining hospitals, those hospitals with fewer than 100 beds comprise the second group. The third group consists of all hospitals that did not fit into either of the first two groups. Each of these groups displayed unique patterns of growth in capital costs. We found that the gamma distribution is useful in explaining and describing the patterns of increase in capital costs. A gamma distribution is a statistical distribution that can be used to describe patterns of growth rates, with the greatest proportion of rates being at the low end. We use the gamma distribution to estimate individual hospital rates of increase as follows:

(1) For hold-harmless hospitals, old capital cost changes were fitted to a truncated gamma distribution, that is, a gamma distribution covering only the distribution of cost decreases. New capital costs changes were fitted to the entire gamma distribution, allowing for both decreases and increases.

(2) For hospitals with fewer than 100 beds (small), total capital cost changes were fitted to the gamma distribution, allowing for both decreases and increases.

(3) Other (large) hospitals were further separated into three groups:

- Bed-size decreases over 20 percent (decrease).
- Bed-size increases over 20 percent (increase).
- Other (no change).

Capital cost changes for large hospitals were fitted to gamma distributions for each bed-size change group, allowing for both decreases and increases in capital costs. We analyzed the probability distribution of increases and decreases in bed size for large hospitals. We found the probability somewhat dependent on the prior year change in bed size and factored this dependence into the analysis. Probabilities of bed-size change were determined. Separate sets of probability factors were calculated to reflect the dependence on prior year change in bed size (increase, decrease, and no change).

The gamma distributions were fitted to changes in aggregate capital costs for the entire hospital. We checked the relationship between aggregate costs and Medicare per discharge costs. For large hospitals, there was a small variance, but the variance was larger for small hospitals. Since costs are used only for the hold-harmless methodology and to determine exceptions, we decided to use the gamma distributions fitted to aggregate cost increases for estimating distributions of cost per discharge increases.

Capital costs per discharge calculated from the cost reports were increased by random numbers drawn from the gamma distribution to project costs in future years. Old and new capital were projected separately for hold-harmless hospitals. Aggregate capital per discharge costs were projected for all other hospitals. Because the distribution of increases in capital costs varies with changes in bed size for large hospitals, we first projected changes in bed size for large hospitals before drawing random numbers from the gamma distribution. Bed-size changes were drawn from the uniform distribution with the probabilities dependent on the previous year bed-size change. The gamma distribution has a shape parameter and a scaling parameter. (We used different parameters for each hospital group, and for old and new capital.)

We used discharge counts from the cost reports to calculate capital cost per discharge. To estimate total capital costs for FY 1998 (the MedPAR data year) and later, we use the number of discharges from the MEDPAR data. Some hospitals have considerably more discharges in FY 1998 than in the years for which we calculated cost per discharge from the cost report data. Consequently, a hospital with few cost report discharges would have a high capital cost per discharge, since fixed

costs would be allocated over only a few discharges. If discharges increase substantially, the cost per discharge would decrease because fixed costs would be allocated over more discharges. If the projection of capital cost per discharge is not adjusted for increases in discharges, the projection of exceptions would be overstated. We address this situation by recalculating the cost per discharge with the MedPAR discharges if the MedPAR discharges exceed the cost report discharges by more than 20 percent. We do not adjust for increases of less than 20 percent because we have not received all of the FY 1998 discharges, and we have removed some discharges from the analysis because they are statistical outliers. This adjustment reduces our estimate of exceptions payments, and consequently, the reduction to the Federal rate for exceptions is smaller. We will continue to monitor our modeling of exceptions payments and make adjustments as needed.

The average national capital cost per discharge generated by this model is the combined average of many randomly generated increases. This average must equal the projected average national capital cost per discharge, which we projected separately (outside this model). We adjusted the shape parameter of the gamma distributions so that the modeled average capital cost per discharge matches our projected capital cost per discharge. The shape parameter for old capital was not adjusted since we are modeling the aging of ''existing'' assets. This model provides a distribution of capital costs among hospitals that is consistent with our aggregate capital projections.

Once each hospital's capital-related costs are generated, the model projects capital payments. We use the actual payment parameters (for example, the case-mix index and the geographic adjustment factor) that are applicable to the specific hospital.

To project capital payments, the model first assigns the applicable payment methodology (fully prospective or hold-harmless) to the hospital as determined from the provider-specific file and the cost reports. The model simulates Federal rate payments using the assigned payment parameters and hospital-specific estimated outlier payments. The case-mix index for a hospital is derived from the FY 1998 MedPAR file using the proposed FY 2000 DRG relative weights included in section VI. of the Addendum to this proposed rule. The case-mix index is increased each year after FY 1998 based on analysis of past experiences in case-mix increases. Based on analysis of recent case-mix increases, we estimate that case-mix will increase 0.5 percent in FY 1999 and 0.5 percent in FY 2000. (Since we are using FY 1998 cases for our analysis, the FY 1998 increase in case mix has no effect on projected capital payments.)

Changes in geographic classification and revisions to the hospital wage data used to establish the hospital wage index affect the geographic adjustment factor. Changes in the DRG classification system and the relative weights affect the case-mix index.

Section 412.308(c)(4)(ii) requires that the estimated aggregate payments for the fiscal year, based on the Federal rate after any changes resulting from DRG reclassifications and recalibration and the geographic adjustment factor, equal the estimated aggregate payments based on the Federal rate that would have been made without such changes. For FY 1999, the budget neutrality adjustment factors were 1.00294 for the national rate and 1.00233 for the Puerto Rico rate.

Since we implemented a separate geographic adjustment factor for Puerto Rico, we applied separate budget neutrality adjustments for the national geographic adjustment factor and the Puerto Rico geographic adjustment factor. We applied the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 since the geographic adjustment factor for Puerto Rico was implemented in 1998.

To determine the factors for FY 2000, we first determined the portions of the Federal national and Puerto Rico rates that would be paid for each hospital in FY 2000 based on its applicable payment methodology. Using our model, we then compared, separately for the national rate and the Puerto Rico rate, estimated aggregate Federal rate payments based on the FY 1999 DRG relative weights and the FY 1999 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 1999 relative weights and the FY 2000 geographic adjustment factor. In making the comparison, we held the FY 2000 Federal rate portion constant and set the other budget neutrality adjustment factor and the exceptions reduction factor to 1.00. We determined that, to achieve budget neutrality for the changes in the national geographic adjustment factor, an incremental budget neutrality adjustment of 0.99845 for FY 2000 should be applied to the previous cumulative FY 1999 adjustment of 1.00294, yielding a cumulative adjustment of 1.00139 through FY 2000. For the Puerto Rico geographic adjustment factor, an incremental budget neutrality adjustment of 1.00151 for FY 2000 should be applied to the previous cumulative FY 1999 adjustment of 1.00233, yielding a cumulative adjustment of 1.00384 through FY 2000. We apply these new adjustments, then compare estimated aggregate Federal rate payments based on the FY 1999 DRG relative weights and the FY 2000 geographic adjustment factors to estimated aggregate Federal rate payments based on the FY 2000 DRG relative weights and the FY 2000 geographic adjustment factors. The incremental adjustment for DRG classifications and changes in relative weights would be 1.00014 nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the geographic adjustment factors through FY 2000 would be 1.00153 nationally, and 1.00398 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal year	National				Puerto Rico			
	Incremental adjustment			Cumulative	Incremental adjustment			Cumulative
	Geographic adjustment factor	DRG reclassifications and recalibration	Combined		Geographic adjustment factor	DRG reclassifications and recalibration	Combined	
1992	.....	.....	.....	1.00000	.....	.....	.....	.....
1993	.....	.....	0.99800	0.99800	.....	.....	.....	.....
1994	.....	.....	1.00531	1.00330	.....	.....	.....	.....
1995	.....	.....	0.99980	1.00310	.....	.....	.....	.....
1996	.....	.....	0.99940	1.00250	.....	.....	.....	.....
1997	.....	.....	0.99873	1.00123	.....	.....	.....	.....
1998	.....	.....	0.99892	1.00015	.....	.....	.....	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99845	1.00014	0.99859	1.00153	1.00151	1.00014	1.00165	1.00398

The methodology used to determine the recalibration and geographic (DRG/GAF) budget neutrality adjustment factor is similar to that used in establishing budget neutrality adjustments under the prospective payment system for operating costs. One difference is that, under the operating prospective payment system, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital prospective payment system, there is a single DRG/GAF budget neutrality adjustment factor (the national rate and the Puerto Rico rate are determined separately) for changes in the geographic adjustment factor (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients or the large urban add-on payments.

In addition to computing the DRG/GAF budget neutrality adjustment factor, we used the model to simulate total payments under the prospective payment system.

Additional payments under the exceptions process are accounted for through a reduction in the Federal and hospital-specific rates. Therefore, we used the model to calculate the exceptions reduction factor. This exceptions reduction factor ensures that aggregate payments under the capital prospective payment system, including exceptions payments, are projected to equal the aggregate payments that would have been made under the capital prospective payment system without an exceptions process. Since changes in the level of the payment rates change the level of payments under the exceptions process, the exceptions reduction factor must be determined through iteration.

In the August 30, 1991 final rule (56 FR 43517), we indicated that we would publish each year the estimated payment factors generated by the model to determine payments for the next 5 years. The table below provides the actual factors for FYs 1992 through 1999, the proposed factors for FY 2000, and the estimated factors that would be applicable through FY 2004. We caution that these are estimates for FYs 2000 and later, and are subject to revisions resulting from continued methodological refinements, receipt of additional data, and changes in payment policy changes. We note that in making these projections, we have assumed that the cumulative national DRG/GAF budget neutrality adjustment factor will remain at 1.00153 (1.00398 for Puerto Rico) for FY 2000 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 2000.

The projections are as follows:

Fiscal year	Update factor	Exceptions reduction factor	Budget neutrality factor	DRG/GAF adjustment factor [1]	Outlier adjustment factor	Federal rate adjustment	Federal rate (after outlier) reduction
1992	N/A	0.9813	0.9602	.....	.9497	.....	415.59
1993	6.07	.9756	.9162	.9980	.9496	.....	417.29
1994	3.04	.9485	.8947	1.0053	.9454	[2] .9260	378.34
1995	3.44	.9734	.8432	.9998	.9414	.....	376.83
1996	1.20	.9849	N/A	.9994	.9536	[3] .9972	461.96
1997	0.70	.9358	N/A	.9987	.9481	.....	438.92
1998	0.90	.9659	N/A	.9989	.9382	[4] .8222	371.51
1999	0.10	.9783	N/A	1.0028	.9392	.....	378.10
2000	−0.60	.9752	N/A	.9986	.9397	.....	374.31
2001	0.50	.9645	N/A	[5] 1.0000	[5] .9397	.....	372.06
2002	0.50	[6] 1.0000	N/A	1.0000	.9397	.....	387.68
2003	0.50	[6] 1.0000	N/A	1.0000	.9397	[4] 1.0255	399.57
2004	0.60	[6] 1.0000	N/A	1.0000	.9397	.....	401.97

[1] Note: The incremental change over the previous year.
[2] Note: OBRA 1993 adjustment.
[3] Note: Adjustment for change in the transfer policy.
[4] Note: Balanced Budget Act of 1997 adjustment.
[5] Note: Future adjustments are, for purposes of this projection, assumed to remain at the same level.
[6] Note: We are unable to estimate exceptions payments for the year under the special exceptions provision (§ 412.348(g) of the regulations) because the regular exceptions provision (§ 412.348(e)) expires.

Appendix C: Report to Congress

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

APR 1 1999

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

Dear Mr. Speaker:

Section 1886(e)(3) of the Social Security Act (the Act) requires me to report to Congress the initial estimate of the applicable percentage increase in hospital inpatient payment rates for fiscal year (FY) 2000 that I will recommend for hospitals subject to the Medicare prospective payment system (PPS) and for hospitals and units excluded from PPS. This submission constitutes the required report.

Current law mandates an update for all PPS hospitals equal to the market basket rate of increase (2.7 percent) minus 1.8 percentage points. However, based on the continuing decline in hospital operating costs and the related record levels of hospital Medicare and total operating profit margins, we recommend an update for hospitals in both large urban and other areas of zero percent.

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

Hospitals and distinct part hospital units excluded from PPS are paid based on their reasonable costs subject to a limit under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Current law mandates that the update for all hospitals and distinct part units excluded from PPS equals the rate of increase in the excluded hospital market basket less a percentage between 0 and 2.5 percentage points, depending on the hospital's costs in relation to its limit, or 0 if costs do not exceed two thirds of the limit. The President's FY 2000 budget incorporates an increase to the TEFRA limit using 2.7 percent for the excluded hospital market basket increase. Therefore, depending on the hospital's costs in relation to its limit, the update would be the market basket increase

Page 2 - The Honorable J. Dennis Hastert

minus a percentage between 0 and 2.5 percentage points, or 0. Thus, we recommend an increase in the TEFRA limits of between 0 and 2.7 percent.

My recommendation for the updates is based on cost projections used in the President's FY 2000 budget. A final recommendation on the appropriate percentage increases for FY 2000 will be made nearer the beginning of the new Federal fiscal year based on the most current market basket projection available at that time. The final recommendation will incorporate the Health Care Financing Administration's analysis of the latest estimates of all relevant factors, including recommendations by the Medicare Payment Advisory Commission.

Section 1886(d)(4)(C)(iv) of the Act also requires that I include in my report recommendations with respect to adjustments to the diagnosis-related group (DRG) weighting factors. At this time I do not anticipate recommending any adjustment to the DRG weighting factors for FY 2000.

I am pleased to provide this recommendation to you. I am also sending a copy of this letter to the President of the Senate.

Sincerely,

Donna E. Shalala

Donna E. Shalala

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

APR 1 1999

The Honorable Albert Gore, Jr.
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

Section 1886(e)(3) of the Social Security Act (the Act) requires me to report to Congress the initial estimate of the applicable percentage increase in hospital inpatient payment rates for fiscal year (FY) 2000 that I will recommend for hospitals subject to the Medicare prospective payment system (PPS) and for hospitals and units excluded from PPS. This submission constitutes the required report.

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Hospitals and distinct part hospital units excluded from PPS are paid based on their reasonable costs subject to a limit under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Current law mandates that the update for all hospitals and distinct part units excluded from PPS equals the rate of increase in the excluded hospital market basket less a percentage between 0 and 2.5 percentage points, depending on the hospital's costs in relation to its limit, or 0 if costs do not exceed two thirds of the limit. The President's FY 2000 budget incorporates an increase to the TEFRA limit using 2.7 percent for the excluded hospital market basket increase. Therefore, depending on the hospital's costs in relation to its limit, the update would be the market basket increase

Page 2 - The Honorable Albert Gore, Jr

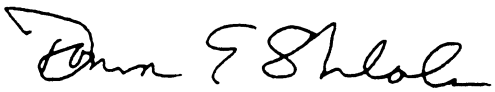
minus a percentage between 0 and 2.5 percentage points, or 0. Thus, we recommend an increase in the TEFRA limits of between 0 and 2.7 percent.

My recommendation for the updates is based on cost projections used in the President's FY 2000 budget. A final recommendation on the appropriate percentage increases for FY 2000 will be made nearer the beginning of the new Federal fiscal year based on the most current market basket projection available at that time. The final recommendation will incorporate the Health Care Financing Administration's analysis of the latest estimates of all relevant factors, including recommendations by the Medicare Payment Advisory Commission.

Section 1886(d)(4)(C)(iv) of the Act also requires that I include in my report recommendations with respect to adjustments to the diagnosis-related group (DRG) weighting factors. At this time I do not anticipate recommending any adjustment to the DRG weighting factors for FY 2000.

I am pleased to provide this recommendation to you. I am also sending a copy of this letter to the Speaker of the House of Representatives.

Sincerely,



Donna E. Shalala

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

I. Background

Several provisions of the Act address the setting of update factors for inpatient services furnished in FY 2000 by hospitals subject to the prospective payment system and those excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(XV) of the Act sets the FY 2000 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 1.8 percent for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 2000 percentage increase in the hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act, that is, the same update factor as all other hospitals subject to the prospective payment system, or the rate of increase in the market basket minus 1.8 percentage points. Under section 1886(b)(3)(B)(ii) of the Act, the FY 2000 percentage increase in the rate of increase limits for hospitals excluded from the prospective payment system ranges from the percentage increase in the excluded hospital market basket to 0 percent, depending on the hospital's costs in relation to its limit for the most recent cost reporting period for which information is available.

In accordance with section 1886(d)(3)(A) of the Act, we are proposing to update the standardized amounts, the hospital-specific rates, and the rate-of-increase limits for hospitals excluded from the prospective payment system as provided in section 1886(b)(3)(B) of the Act. Based on the first quarter 1999 forecast of the FY 2000 market basket increase of 2.7 percent for hospitals subject to the prospective payment system, the proposed updates to the standardized amounts are 0.9 percent (that is, the market basket rate of increase minus 1.8 percent percentage points) for hospitals in both large urban and other areas. The proposed update to the hospital-specific rate applicable to sole community and Medicare-dependent, small rural hospitals is also 0.9 percent. The proposed update for hospitals excluded from the prospective payment system would range from 0 percent to the percentage increase in the excluded hospital market basket (currently estimated at 2.6 percent).

Section 1886(e)(4) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), recommend update factors for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish the update factors recommended under section 1886(e)(4) of the Act. Accordingly, this appendix provides the recommendations of appropriate update factors, the analysis underlying our recommendations, and our responses to the MedPAC recommendations concerning the update factors.

In its March 1, 1999 report, MedPAC stated that the legislated update of market basket increase minus 1.8 percentage points would provide a reasonable level of payment to hospitals. Although MedPAC suggests that a somewhat lower update could be justified in light of changes in the utilization and provision of hospital inpatient care, the Commission does not believe it is necessary to recommend a lower update for FY 2000. MedPAC did not make a separate recommendation for the hospital-specific rates applicable to sole community and Medicare-dependent, small rural hospitals. We discuss MedPAC's recommendations concerning the update factors and our responses to these recommendations below.

II. Secretary's Recommendations

Under section 1886(e)(4) of the Act, we are recommending that an appropriate update factor for the standardized amounts is 0.0 percentage points for hospitals located in large urban and other areas. We are also recommending an update of 0.0 percentage points to the hospital-specific rate for sole community hospitals and Medicare-dependent, small rural hospitals. These figures are consistent with the President's FY 2000 budget recommendations. We believe these recommended update factors would ensure that Medicare acts as a prudent purchaser and provide incentives to hospitals for increased efficiency, thereby contributing to the solvency of the Medicare Part A Trust Fund. When the President's budget was submitted, the market basket rate of increase was projected at 2.7 percent. This proposed recommendation is based on a more recent forecast of the market basket, although still 2.7 percent.

We recommend that hospitals excluded from the prospective payment system receive an update of between 0 and 2.6 percentage points. The update for excluded hospitals and units is equal to the increase in the excluded hospital operating market basket less a percentage between 0 and 2.5 percentage points, or 0 percentage points, depending on the hospital's or unit's costs in relation to its rate-of-increase limit. The market basket rate of increase is currently forecast at 2.6 percent. This recommendation is consistent with the President's FY 2000 budget, although we note that the market basket rate of increase was forecast at 2.7 percent when the budget was submitted.

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

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

For FY 2000, MedPAC's update framework would support an update to the standardized amounts under the prospective payment system between the increase in the hospital market basket minus 2.5 percentage points and the increase in the hospital market basket plus 0.1 percentage points. MedPAC notes that hospital total revenue margins have continued to increase this decade and the percentage of hospitals with negative total revenue margins remains much lower than it was a decade ago. Thus, MedPAC believes the statutory update of market basket increase minus 1.8 percentage points for FY 2000 is reasonable and appropriate.

MedPAC's estimate of the market basket increase is 2.3 percent, based on the fourth quarter 1998 estimate. MedPAC's market basket estimate focuses on employee compensation changes in the hospital industry and the economy in general, while HCFA's market basket forecast gives less weight to the projected changes in the hospital industry's wages. When MedPAC published its recommendations, HCFA's market basket forecast was 2.5 percent. Thus, MedPAC's update framework reflects a 0.2 percent adjustment for this difference.

Response: Our update recommendation of 0.0 percent is within the range of updates MedPAC has suggested for the prospective payment system hospitals, albeit at the low end. Our recommendation is supported by the following analyses that measure changes in hospital productivity, scientific and technological advances, practice pattern changes, and changes in case mix:

a. *Productivity.* Service level productivity is defined as the ratio of total service output to full-time equivalent employees (FTEs). While we recognize that productivity is a function of many variables (for example, labor, nonlabor material, and capital inputs), we use a labor productivity measure since this update framework applies to operating payment. To recognize that we are apportioning the short run output changes to the labor input and not considering the nonlabor inputs, we weight our productivity measure for operating costs by the share of direct labor services in the market basket rate of increase to determine the expected effect on cost per case.

Our recommendation for the service productivity component is based on historical trends in productivity and total output for both the hospital industry and the general economy, and projected levels of future hospital service output. MedPAC's predecessor, the Prospective Payment Assessment Commission (ProPAC), estimated cumulative service productivity growth to be 4.9 percent from 1985 through 1989, or 1.2 percent annually. At the same time, ProPAC estimated total output growth at 3.4 percent annually, implying a ratio of service productivity growth to output growth of 0.35.

Since it is not possible at this time to develop a productivity measure specific to Medicare patients, we examined productivity (output per hour) and output (gross domestic product) for the economy. Depending on the exact time period, annual changes in productivity range from 0.3 to 0.35 percent of the change in output (that is, a 1.0 percent increase in output would be correlated with

a 0.3 to 0.35 percent change in output per hour).

Under our framework, the recommended update is based in part on expected productivity—that is, projected service output during the year, multiplied by the historical ratio of service productivity to total service output, multiplied by the share of labor in total operating inputs, as calculated in the hospital market basket rate of increase. This method estimates an expected labor productivity improvement in the same proportion to expected total service growth that has occurred in the past and assumes that, at a minimum, growth in FTEs changes proportionally to the growth in total service output. Thus, the recommendation allows for unit productivity to be smaller than the historical averages in years that output growth is relatively low and larger in years that output growth is higher than the historical averages. Based on the above estimates from both the hospital industry and the economy, we have chosen to employ the range of ratios of productivity change to output change of 0.30 to 0.35.

The expected change in total hospital service output is the product of projected growth in total admissions (adjusted for outpatient usage), projected real case-mix growth, expected quality enhancing intensity growth, and net of expected decline in intensity due to reduction of cost ineffective practice. Case-mix growth and intensity numbers for Medicare are used as proxies for those of the total hospital, since case-mix increases (used in the intensity measure as well) are unavailable for non-Medicare patients. Thus, expected output growth is simply the sum of the expected change in intensity (0.0 percent), projected admissions change (1.0 percent for FY 2000), and projected real case-mix growth (0.5 percent), or 1.5 percent. The share of direct labor services in the market basket rate of increase (consisting of wages, salaries, and employee benefits) is 61.4 percent.

Multiplying the expected change in total hospital service output (1.5 percent) by the ratio of historical service productivity change to total service growth of 0.30 to 0.35 and by the direct labor share percentage 61.4, provides our productivity standard of 0.3 percent, thus our recommendation includes a −0.3 percent update for improved productivity.

In past years, MedPAC's recommendation has taken into account product change. This year, while there is not a specific mention of product change in MedPAC's recommendation, similar factors do appear in their discussion of ''site of service substitution.'' HCFA takes this factor into account when measuring change in intensity, as discussed below. In addition, MedPAC's update framework contains a productivity adjustment of between −1.0 to 0.0 percent, which is slightly more optimistic than our estimate.

b. *Intensity*. We base our intensity standard on the combined effect of three separate factors: changes in the use of quality enhancing services, changes in the use of services due to shifts in within-DRG severity, and changes in the use of services due to reductions of cost-ineffective practices. For FY 2000, we recommend an adjustment of 0.0 percent. The basis of this recommendation is discussed below.

We have no empirical evidence that accurately gauges the level of quality-enhancing technology changes. A study published in the Winter 1992 issue of the *Health Care Financing Review*, ''Contributions of case mix and intensity change to hospital cost increases'' (pp. 151–163), suggests that one-third of the intensity change is attributable to high-cost technology. The balance was unexplained but the authors speculated that it is attributable to fixed costs in service delivery.

Typically, a specific new technology increases cost in some uses and decreases cost in other uses. Concurrently, health status is improved in some situations while in other situations it may be unaffected or even worsened using the same technology. It is difficult to separate out the relative significance of each of the cost increasing effects for individual technologies and new technologies.

All things being equal, per-discharge fixed costs tend to fluctuate in inverse proportion to changes in volume. Fixed costs exist whether patients are treated or not. If volume is declining, per-discharge fixed costs will rise, but the reverse is true if volume is increasing.

Following methods developed by HCFA's Office of the Actuary for deriving hospital output estimates from total hospital charges, we have developed Medicare-specific intensity measures based on a 5-year average using FYs 1994 through 1998 MedPAR billing data. Case-mix constant intensity is calculated as the change in total Medicare charges per discharge adjusted for changes in the average charge per unit of service as measured by the Medical CPI hospital component and changes in real case mix. Thus, in order to measure changes in intensity, one must measure changes in real case mix.

For FYs 1994 through 1998, observed case-mix index change ranged from a low of −.04 percent to a high of 1.7 percent, with a 5-year average change of 1.0 percent. Based on evidence from past studies of case-mix change, we estimate that real case-mix change fluctuates between 1.0 and 1.4 percent and the observed values generally fall in this range, although some years the figures fall outside this range. The average percentage change in charge per discharge was 2.9 percent and the average annual change in the medical CPI was 4.6 percent. Dividing the change in charge per discharge by the quantity of the real case-mix index change and the medical CPI, yields an average annual change in intensity of −2.9 percent. Assuming the technology/fixed cost ratio still holds, technology would account for a −1.0 percent annual decline while fixed costs would account for a −1.9 percent annual decline. The decline in fixed costs per discharge makes intuitive sense as volume, measured by total discharges, has increased during the period. Since we estimate that intensity has declined during that period, we are recommending a 0.0 percent intensity adjustment for FY 2000.

MedPAC does not make an intensity recommendation per se, but its recommendation for the FY 2000 update includes two categories that we consider to be comparable with our intensity recommendation. MedPAC is recommending a 0.5 to 1.0 update for scientific and technological advances to account for increased costs of systems conversions necessary for computer compliance on January 1, 2000. MedPAC's recommendation also takes into account the increasingly apparent trend of some acute care providers to shift care to a postacute care facility. While this can occur for many reasons, there is good reason to suspect prospective payment system payment limits. Accordingly, MedPAC recommends an adjustment of −1.8 to −0.9 for site-of-care substitution.

As we mentioned in last year's final rule, higher input prices that hospitals incur to convert computer systems to be complaint on January 1, 2000, will be accounted for through the market basket. We agree with MedPAC that the site of care substitution effect is real and believe that it is factored into our intensity recommendation.

c. *Change in Case-Mix*. Our analysis takes into account projected changes in case-mix, adjusted for changes attributable to improved coding practices. For our FY 2000 update recommendation, we are projecting a 0.5 percent increase in the case-mix index. Unlike in past years, where we differentiated between ''real'' case-mix increase and increases attributable to changes in coding behavior, we do not feel changes in coding behavior will impact the overall case-mix in FY 2000. As such, we project the entire change will be ''real.''

MedPAC also does not expect any case-mix change due to coding changes. MedPAC's estimate of overall case-mix change ranges from 0.0 to 0.2 percentage points for FY 2000.

d. *Effect of FY 1998 DRG Reclassification and Recalibration*. We estimate that DRG reclassification and recalibration for FY 1998 resulted in a 0.7 percent decrease in the case-mix index when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the GROUPER. MedPAC does not make an adjustment for DRG reclassification and recalibration in its update recommendation.

We make a forecast error correction if the actual market basket change for a previous fiscal year differs from the forecasted market basket by 0.25 percentage points or more. Our update framework for FY 2000 does not reflect a forecast error correction because, for FY 1998, there was less than a 0.25 percentage point difference between the actual market basket and the forecasted market basket.

TABLE 1.—COMPARISON OF FY 2000 UPDATE RECOMMENDATIONS

	HHS	MedPAC
Market Basket	MB	MB
Difference between HCFA & MedPAC Market Baskets		–0.4
Subtotal	MB	MB
Policy Adjustments Factors:		
Productivity	–0.3	–1.0 to 0.0
Site of Service Substitution	(3)	–1.8 to –0.9
Intensity	0.0.	
Science & Technology		0.5 to 1.0
Practice Patterns		(1)
Real Within DRG Change		(2)
Subtotal	–0.3	–2.3 to 0.1
Case-Mix Adjustment Factors:		
Projected Case-Mix Change	–0.5.	
Real Across DRG Change	0.5	0.0
Real Within DRG Change	(3)	0.0 to 0.2
Subtotal	0.0	0.0 to 0.2
Effect of 1998 Reclassification & Recalibration	–0.7.	
Forecast Error Correction	0.0	0.0
Total Recommended Update	MB –1.0	MB –2.7 to MB 0.1

[1] Included in MedPAC's Productivity Measure.
[2] Included in MedPAC's Case-Mix Adjustment.
[3] Included in HHS' Intensity Factor.

While the above analysis would support a recommendation that the update be no less than the market basket minus 1.0 percentage points, we are recommending an update of 0.0 percentage points. We note that had our framework included the negative intensity adjustment, the framework would have suggested an update in the range of market basket increase minus 3.9 percentage points and market basket increase minus 2.0 percentage points. However, consistent with past update recommendations, we did not make a negative adjustment for intensity this year. A negative intensity adjustment would capture the site of care substitution adjustment in MedPAC's recommendation. In conjunction with our Office of Actuary, we do intend to reexamine our update framework and the appropriateness of a negative intensity adjustment.

For FY 2000, we believe that a 0.0 update factor appropriately reflects current trends in health care delivery, including the recent decreases in the use of hospital inpatient services and the corresponding increase in the use of hospital outpatient and postacute care services. Our recommendation is within the range of MedPAC's recommendation. We also recommend that the hospital-specific rates applicable to sole community hospitals be increased by the same update, 0.0 percentage points.

IV. MedPAC Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals and Hospital Units (Recommendation 4A)

For hospitals and units excluded from the prospective payment system, MedPAC's recommendation is that the Secretary ''should increase the market basket amount in the target amount update formula by 0.4 percentage points for fiscal year 2000.'' For cost reporting periods beginning in FY 2000, the statute provides that the update to the target amounts for excluded hospitals or units is equal to the increase in the excluded hospital operating market basket less a percentage between 0 and 2.5 percentage points, or 0 percent, depending on the hospital's or unit's costs in relation to its target amount for the most recent cost reporting period for which information is available. MedPAC believes that the update formula for excluded hospitals should be adjusted upward by 0.4 percentage points, to reflect (1) a −0.1 percent adjustment for differences between HCFA's and MedPAC's market baskets and (2) a 0.5 percent adjustment for scientific and technological advances.

Response: We believe that the statutory update is adequate and that an upward adjustment to the statutory formula is unnecessary. Thus, we recommend that hospitals excluded from the prospective payment system receive an update between 0 percent and the increase in the market basket for excluded hospitals. Overall declines in inpatient operating costs and high levels of Medicare profit margins support our recommendation. We believe this update would ensure that Medicare acts as a prudent purchaser and would provide incentives to hospitals for increased efficiency, thereby contributing to the solvency of the Medicare Part A Trust Fund.

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