DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412, 413, and 489

[BPD–847–P]

RIN 0938–AH34

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1997 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 necessary 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 prospective payment 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, 1996. We are also setting forth proposed rate-of-increase limits as well as proposing changes for hospitals and hospital units excluded from the prospective payment systems.

DATES: Comments will be considered if received at the appropriate address, as provided below, no later than 5 p.m. on July 31, 1996.

ADDRESSES: Mail written comments (an original and 3 copies) to the following address:

Health Care Financing Administration, Department of Health and Human Services, Attention: BPD–847–P, P.O. Box 7517, Baltimore, MD 21207–0517.

If you prefer, you may deliver your written comments (an original and 3 copies) to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or

Room C5–09–26, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code BPD–847–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 309–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.

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

FOR FURTHER INFORMATION CONTACT:

Nancy Edwards (410) 786–4531, Operating Prospective Payment, DRG, Wage Index Issues.

Tzvi Hefter (410) 786–4529, Capital Prospective Payment, Excluded Hospitals.

SUPPLEMENTARY INFORMATION:

I. Background

A. Summary

Under section 1886(d) of the Social Security Act (the Act), 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 was established effective with hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payment for hospital inpatient operating costs is made at a predetermined, specific rate for each hospital discharge. All discharges are classified according to a list of diagnosis-related groups (DRGs). The regulations governing the hospital inpatient prospective payment system are located in 42 CFR part 412. On September 1, 1995, we published a final rule with comment period (60 FR 45778) to implement changes to the prospective payment system for hospital operating costs beginning with Federal fiscal year (FY) 1996.

For cost reporting periods beginning before October 1, 1991, hospital inpatient operating costs were the only costs covered under the prospective payment system. Payment for capital-related costs had been made on a reasonable cost basis because, under sections 1886(a)(4) and (d)(1)(A) of the Act, those costs had been specifically excluded from the definition of inpatient operating costs. However, section 4006(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203) revised section 1886(g)(1) of the Act to require that, for hospitals paid under the prospective payment system for operating costs, capital-related costs would also be paid under a prospective payment system effective with cost reporting periods beginning on or after October 1, 1991. As required by section 1886(g) of the Act, we replaced the reasonable cost-based payment methodology with a prospective payment methodology for hospital inpatient capital-related costs. Under the new methodology, effective for cost reporting periods beginning on or after October 1, 1991, a predetermined payment amount per discharge is made for Medicare inpatient capital-related costs. (See subpart M of 42 CFR part 412, and the August 30, 1991 final rule (56 FR 43358) for a complete discussion of the prospective payment system for hospital inpatient capital-related costs.)

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. This proposed rule would be effective for discharges occurring on or after October 1, 1996. Following is a summary of the major changes that we are proposing to make:

1. Changes to the DRG Classifications and Relative Weights

As required by section 1886(d)(4)(C) of the Act, we must adjust the DRG classifications and relative weights at least annually. Our proposed changes for FY 1997 are set forth in section II of this preamble.

2. Changes to the Hospital Wage Index

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

- FY 1997 wage index update.

- Revisions to the wage index based on hospital redesignations.
- Solicitation of public comment on possible changes to the following:

—Contract labor—expansion of allowable costs.
—Revision in Puerto Rico labor market areas.

- Medicare Geographic Classification Review Board—composition and criteria.

3. Rebasing and Revision of the Hospital Market Baskets

In section IV of this preamble, we discuss our proposal to use a rebased and revised hospital market basket in developing the FY 1997 update factor for the operating prospective payment rates, the capital prospective payment rates, and the excluded hospital rate-of-increase limits.

4. Other Changes to the Prospective Payment System for Inpatient Operating Costs

In section V of this preamble, we discuss several provisions of the regulations in 42 CFR parts 412, 413, and 489 and set forth certain proposed changes concerning the following:

- Sole community hospitals.
- Rural referral centers.
- Disproportionate share adjustment.
- Direct graduate medical education programs.
- Hospital distribution of ''An Important Message from Medicare.''

5. Changes and Clarifications to the Prospective Payment System for Capital-Related Costs

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

- Use of simplified cost accounting.
- The capital Federal and hospital-specific rates.

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

In section VII of this preamble, we discuss a clarification concerning the calculation of payments to hospitals excluded from the prospective payment system.

7. 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 1997 prospective payment rates for operating costs and capital-related costs. We are also proposing update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 1997 for hospitals and hospital units excluded from the prospective payment system. In addition, we have included a detailed discussion of our methodology for setting thresholds for outlier cases. We are inviting comments on our methodology and any suggestions for changes in that methodology that could help us better predict outlier payments.

8. Impact Analysis

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

9. Capital Acquisition Model

Appendix B contains the technical appendix on the proposed FY 1997 capital acquisition model.

10. Rebased Market Basket Data Sources

Appendix C sets forth the data sources used to determine the market basket relative weights and choice of price proxies.

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

Section 1886(e)(3)(B) of the Act requires that the Secretary report to Congress on our initial estimate of an update factor for FY 1997 for both hospitals included in and hospitals excluded from the prospective payment systems. This report is included as Appendix D to this proposed rule.

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

As required by sections 1886(e)(4) and (e)(5) of the Act, Appendix E provides our recommendation of the appropriate percentage change for FY 1997 for the following:

- Large urban area and other area average standardized amounts (and hospital-specific rates applicable to sole community 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.

13. Discussion of Prospective Payment Assessment Commission Recommendations

The Prospective Payment Assessment Commission (ProPAC) is directed by section 1886(e)(2)(A) of the Act to make recommendations on the appropriate percentage change factor to be used in updating the average standardized amounts. In addition, section 1886(e)(2)(B) of the Act directs ProPAC to make recommendations regarding changes in each of the Medicare payment policies under which payments to an institution are prospectively determined. In particular, the recommendations relating to the hospital inpatient prospective payment systems are to include recommendations concerning the number of DRGs used to classify patients, adjustments to the DRGs to reflect severity of illness, and changes in the methods under which hospitals are paid for capital-related costs. Under section 1886(e)(3)(A) of the Act, the recommendations required of ProPAC under sections 1886(e)(2)(A) and (B) of the Act are to be reported to Congress not later than March 1 of each year.

We are printing ProPAC's March 1, 1996 report, which includes its recommendations, as Appendix F of this document. The recommendations, and the actions we are proposing to take with regard to them (when an action is recommended), are discussed in detail in the appropriate sections of this preamble, the addendum, or the appendices to this proposed rule. See section VIII of this preamble for specific information concerning where individual recommendations are addressed. For a brief summary of the ProPAC recommendations, we refer the reader to the beginning of the ProPAC report as set forth in Appendix F of this proposed rule. For further information relating specifically to the ProPAC report, contact ProPAC at (202) 401–8986.

II. Proposed Changes to DRG Classifications and 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 annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The proposed changes to the DRG classification system and the proposed recalibration of the DRG weights for discharges occurring on or after October 1, 1996 are discussed below.

B. DRG Reclassification

1. General

Cases are classified into DRGs for payment under the prospective payment system based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD–9–CM). The Medicare fiscal intermediary enters the information into its claims 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 492 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, principal diagnosis determines MDC assignment. However, there are five DRGs to which cases are assigned on the basis of procedure codes rather than first assigning them to an MDC based on the principal diagnosis. These are the DRGs for liver, bone marrow, and lung transplant (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 (hereafter 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 1997 and other decisions concerning DRGs are set forth below.

2. Pre-MDC DRGs

Effective October 1, 1994, ICD–9–CM procedure code 41.04, Autologous hematopoietic stem cell transplant, was created to capture the transplantation of stem cells obtained from bone marrow or peripheral blood. At that time, we designated the code as non-OR. This transplant procedure was previously assigned to procedure code 99.73, Therapeutic erythrocytapheresis, which is designated as a non-OR procedure. When we created this code, we received comments requesting that it be designated as an OR procedure and assigned to DRG 481 (Bone Marrow Transplant) based on the resource use associated with the type of transplant. However, as we stated in the September 1, 1994 final rule (59 FR 45340), when a new code is introduced, our longstanding practice is to assign it to the same DRG category as its predecessor code. One compelling reason for this practice is our inability to move the cases associated with a new code to a new DRG assignment as part of DRG reclassification and recalibration. Because we could not separately identify the stem cell transplant cases from the other cases coded with 99.73 in order to reclassify them and their charges to a new DRG, we were unable to predict the new weights of both the DRGs in which this code currently is classified and the new DRG to which it would be assigned. Therefore, we were prevented from redesignating code 41.04 as an OR procedure or assigning it to a DRG. However, we stated that we would analyze the stem cell cases as soon as the FY 1995 cases were available.

This year, the FY 1995 Medicare Provider Analysis and Review (MedPAR) file is available for use in DRG analysis and weight setting for FY 1997. In the December 1995 update to the FY 1995 MedPAR file, there are a total of 178 cases reporting the performance of a stem cell transplant. Of that number, 13 cases also reported the performance of a bone marrow transplant. Those cases were removed from our analysis because they are already classified to DRG 481. Of the remaining 165 cases, 100 cases did not meet the coverage criteria for Medicare payment. As set forth in the Medicare Coverage Issues Manual at section 35–30.1 (see Transmittal No. 84, April 1996), autologous stem cell transplants are not covered when performed for the following conditions:

- Acute leukemia not in remission (diagnosis codes 204.00, 205.00, 206.00, 207.00, and 208.00).
- Chronic granulocytic leukemia (diagnosis codes 205.10 and 205.11).
- Solid tumors (other than neuroblastomas) (diagnosis codes 140.0 through 199.1)
- Multiple myeloma (diagnosis codes 203.00, 203.01 and 238.6).

After eliminating the noncovered cases, 65 cases of stem cell transplant remained. The average standardized charge for these cases was approximately $83,000. The average standardized charge for bone marrow transplant cases in the FY 1995 MedPAR file is approximately $98,000. Thus, since the average resource use associated with stem cell transplant is similar to that associated with bone marrow transplant, we are proposing to assign procedure code 41.04 to DRG 481 effective with discharges occurring on or after October 1, 1996. The overall average charge for stem cell and bone marrow combined is just under $93,000. In addition, we propose to designate stem cell transplant as an OR procedure.

3. MDC 1 (Diseases and Disorders of the Nervous System)

a. Sleep Apnea

We have received correspondence requesting that we review the DRG assignment of cases in which surgery is performed to correct obstructive sleep apnea (diagnosis code 780.57). When coded as a principal diagnosis, sleep apnea is assigned to DRGs 34 and 35 (Other Disorders of the Nervous System)[1] in MDC 1.

Recently, new surgical interventions to correct sleep apnea have been introduced. The procedures most frequently performed for this condition are the following:

Code and Description

27.69 Other plastic repair of palate
29.4 Plastic operation on pharynx
29.59 Other repair of pharynx

Since none of these surgical procedures is assigned to MDC 1, cases of sleep apnea treated with one of these surgeries are assigned to DRG 468 (Extensive OR Procedure Unrelated to Principal Diagnosis) in the case of codes 25.59 and 78.49 or to DRG 477 (Nonextensive OR Procedure Unrelated to Principal Diagnosis) in the case of code 29.4.

We are proposing to address this situation by assigning the three surgical procedures to MDC 1. Based on the charges associated with these cases and the fact that they are not clinically similar to the other surgical DRGs in MDC 1, we are proposing to include them in DRGs 7 and 8 (Peripheral and Cranial Nerve and Other Nervous System Procedures).

b. Guillain-Barré Syndrome

Guillain-Barré syndrome (diagnosis code 357.0) is a post-infectious polyneuropathy in which severely affected patients may require ventilatory assistance and long stays in intensive care. In recognition of the high resource consumption associated with this diagnosis, effective with FY 1991, we reassigned code 357.0 from DRGs 18 and 19 (Cranial and Peripheral Nerve Disorders) to DRG 20 (Nervous System Infection Except Viral Meningitis). (See the September 4, 1990 final rule (55 FR 36024).) A commenter stated that although DRG 20 would provide a higher payment for these cases, it would still be inadequate to cover the costs of treating these patients, and we agreed that we would monitor this issue.

We have recently received requests that we again review this assignment. These commenters stated that the treatment for these cases remains very costly and often entails long hospital stays. Therefore, we conducted an analysis of the cases assigned to DRG 20 using the 10 percent random sample of the FY 1995 MedPAR file that we use for analyzing possible classification changes.

Cases coded with 357.0 comprise approximately 20 percent of the cases assigned to DRG 20. As the commenters predicted, the average standardized charges for these cases, approximately $22,400, was higher than the average charge for the DRG, approximately $17,100. However, the length of stay was only slightly higher, 9.1 days compared to 8.4. We believe that DRG 20 is the appropriate assignment clinically for Guillain-Barré cases and the average charge is well within the variation in charges for this DRG. In addition, DRG 20 is the most resource-intensive, and, thus, the highest-weighted medical DRG in MDC 1.

However, in reviewing the other cases assigned to DRG 20, we noted that the average charges for two diagnoses were significantly lower than the overall average charge. These diagnoses, herpes zoster of the nervous system (code 053.10) and herpes zoster of the nervous system, NEC (code 053.19) had average charges of only $7,700 and $7,100, respectively. They also had significantly lower average lengths of stay (4.4 and 4.2 days, respectively). Because these two diagnoses also account for approximately 20 percent of the cases in DRG 20, their low average charge has the effect of significantly lowering the average charge for the DRG. Removing these two codes from DRG 20 increases the average charge to approximately $20,000. After reviewing the remaining medical DRGs in MDC 1, we believe that reassigning codes 053.10 and 053.19 to DRGs 18 and 19 is appropriate both clinically and in terms of resource consumption. In the 10 percent MedPAR file, these DRGs had an average charge of approximately $8,000 and $5,300, respectively. Therefore, we are proposing to make this DRG classification change effective for FY 1997. This change would significantly increase the relative weight for DRG 20 and provide higher payment for the Guillain-Barré cases. The proposed weight for DRG 20 is 2.4782, an increase of 17 percent over the FY 1996 weight of 2.1157.

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

Effective for discharges occurring on or after October 1, 1995, we created a new code for insertion of a coronary artery stent (procedure code 36.06). Until creation of the new code, insertion of coronary artery stent had been included in the codes for percutaneous transluminal coronary angioplasty (PTCA) (procedure codes 36.01, 36.02, and 36.05).

As discussed above in section II.B.2, when a new code is introduced, our longstanding practice is to assign it to the same DRG category as its predecessor code or codes. Therefore, in the June 2, 1995 proposed rule, we assigned procedure code 36.06 to DRG 112 (Percutaneous Cardiovascular Procedures), the DRG to which PTCA is assigned. In response to comments received, in the September 1, 1995 final rule, we explained our policy on DRG assignment of new codes (60 FR 45785). We also stated that the resource use and other data associated with procedure code 36.06 will be available in the FY 1996 Medicare cases which are used for analysis as part of FY 1998 DRG changes. We will evaluate the DRG assignment of coronary artery stent insertion at that time.

Since publication of the September 1, 1995 final rule, we have received data on stent cases provided by the manufacturer of one of the two stent devices currently approved by the Food and Drug Administration (FDA). In addition, the manufacturer has provided us with an analysis of the charges and length of stay of approximately 7,500 Medicare patients who received stents in FY 1995. Because there was no code for the procedure during that year, the manufacturer matched its list of stent recipients with the FY 1995 MedPAR file.

The manufacturer's analysis found that the FY 1995 average charge for PTCA cases without stent is approximately $15,700 and the average charge for cases with stent is approximately $21,000. However, our analysis of the data shows that there is wide variation in the hospital standardized charges reported for cases with implant of coronary artery stent. Individual hospital average charges for these cases range from about $9,000 to over $45,000.

This inconsistency in the data illustrates why our policy of not reassigning new codes until we have collected an entire year of coded Medicare data for analysis is prudent. The uncertainty associated with using incomplete data collected outside the

[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 of patients who are age 0–17. Occasionally, a pair of DRGs is split on age>17 and age 0–17.

Medicare program that cannot be verified remains a problem. Therefore, we are not proposing any DRG assignment change for implant of coronary artery stent. As noted above, a full year of coded FY 1996 Medicare data will be available in early 1997 for analysis. We will review the data at that time, and any proposed DRG changes will be announced in the FY 1998 proposed rule.

5. MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue)

In the September 1, 1995 final rule (60 FR 45790), we responded to a comment we received regarding the DRG assignment in MDC 8 of bipolar hip replacement cases. The commenter requested that cases of bipolar hip replacement be assigned to DRGs 210, 211, and 212 (Hip and Femur Procedures Except Major Joint) rather than to its current assignment, DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity). The commenter stated that the procedure for partial hip replacement (code 81.52) is very similar to the procedure for open reduction of fracture of the femur with internal fixation (code 79.35), which is assigned to DRGs 210, 211, and 212. Further, the commenter believes that partial hip replacement patients are more frail individuals than the population that elects total hip replacement surgery and need longer hospital stays to recover.

In the September 1, 1995 final rule, we stated that we would reexamine this assignment as part of our DRG agenda for FY 1997. Using the FY 1995 MedPAR file, we compared charges and lengths of stay for cases assigned to DRG 209 in which the procedures 81.51 (total hip replacement), 81.52, and 81.53 (revision of hip replacement) were performed with the charges for the entire DRG. The average standardized charges for these cases are very similar to each other as well as the other cases assigned to DRG 209. The average charge was $18,310 for partial hip replacement, $19,924 for total hip replacement, and $23,094 for revision of hip replacement. The $1,278 difference between the average charge for partial hip replacement cases in DRG 209 and the average charge of $19,588 for all cases in DRG 209 is within the normal range of charges for that DRG. However, the average charge for cases in DRG 210 was $15,119, or $2,157 less than the partial hip replacement charges.

A comparison of lengths of stay yields slightly different results. The partial hip replacement cases in DRG 209 had an average stay of 8.6 days. The overall average lengths of stay for DRGs 209 and 210 were 6.7 days and 8.5 days, respectively. Based on these data alone, it would seem that the commenter is correct that partial hip replacement patients are more similar to the patients in DRG 210, in terms of hospital length of stay. However, we also must consider these cases' higher average charges. The higher charges of the partial hip replacement cases indicate that they are more resource-intense than the cases in DRG 210. The proposed relative weights for DRG 209 and 210 are 2.2617 and 1.8458, respectively. Therefore, we believe that DRG 209 is the most appropriate assignment for procedure code 81.52 so that payment will most closely relate to the costs of care for these patients.

6. 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 ''coronary bypass'' consists of two DRGs (DRGs 106 and 107). 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, therefore, 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, and 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, which may sometimes occur in cases involving multiple procedures, 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 the 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 this 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 below 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 would revise the surgical hierarchy for the Pre-MDC DRGs, MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth and Throat), and MDC 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders) as follows:

- In the Pre-MDC DRGs, we would reorder Tracheostomy Except for Face, Mouth and Neck Diagnoses (DRG 483) above Liver Transplant (DRG 480).
- In MDC 3, we would reorder Cleft Lip and Palate Repair (DRG 52) and Sinus and Mastoid Procedures (DRGs 53 and 54) above Tonsillectomy and Adenoidectomy, Except Tonsillectomy and/or Adenoidectomy Only (DRGs 57 and 58).
- In MDC 10, we would reorder Adrenal and Pituitary Procedures (DRG 286) above Amputation of Lower Limb for Endocrine, Nutritional, and Metabolic Disorders (DRG 285).

7. Refinement of Complications and Comorbidities List

There is a standard list of diagnoses that are considered complications or comorbidities (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, 1995 final rule (60 FR 45782), we added diagnosis code 008.49 (Bacterial enteritis) to the CC list. In response to a request from one commenter that we also add diagnosis code 008.45 (Clostridium difficile), we stated that we would review that request as part of our DRG analysis for FY 1997. We have reevaluated diagnosis code 008.45 as well as the remainder of the ''family'' of codes assigned to Intestinal infections due to other specified bacteria (008.41, 008.42, 008.43, 008.44, 008.46, and 008.47). Our analysis shows that all of these diagnoses, when present as a secondary condition, do lead to higher resource use. Therefore, we are proposing to add the following diagnosis codes to the CC list:

008.41 Intestinal infections due to staphylococcus
008.42 Intestinal infections due to pseudomonas
008.43 Intestinal infections due to campylobacter
008.44 Intestinal infections due to yersinia enterocolitica
008.45 Intestinal infections due to clostridium difficile
008.46 Intestinal infections due to other anaerobes
008.47 Intestinal infections due to other gram-negative bacteria

These diagnoses would be considered CCs for any principal diagnosis not shown in Table 6f, Additions to the CC Exclusions List (see discussion of CC Exclusions list in section V of the Addendum below).

This same commenter also requested that we add the following codes to the CC list:

331.0 Alzheimer's disease
423.9 Unspecified disease of the pericardium
348.5 Cerebral edema
333.4 Huntington's chorea
458.0 Orthostatic hypotension
458.9 Hypotension, not otherwise specified

Our analysis of these codes demonstrates that their presence as a secondary diagnosis does not significantly add to the resource use of the case. Therefore, we are not proposing to add them to the CC list.

Finally, the commenter suggested that the following diagnoses be added as cardiovascular complications for DRG 121 (Circulatory Disorders with AMI and Cardiovascular Complications, Discharged Alive):

434.xx Occlusion of cerebral arteries
436 Acute, but ill-defined, cerebrovascular disease

Using the 10 percent analysis file of the FY 1995 MedPAR data, we analyzed the cases assigned to DRG 121 that had these diagnoses coded as secondary conditions. The charges associated with those cases were indeed comparable to the other cases assigned to DRG 121. When we sought the advice of our medical specialists (physicians who work directly for or under contract with HCFA), however, they strongly opposed adding these codes to the list of conditions for DRG 121 based on the fact that these are not cardiovascular complications. Therefore, they are not clinically similar to other cases assigned to this DRG.

However, our analysis of this DRG did reveal a large variation in the charges and lengths of stay within this DRG. We believe that a close examination of the list of complicating conditions assigned to DRG 121 is needed. Therefore, we plan to perform a thorough analysis of the cases assigned to that DRG as part of our DRG analysis agenda for FY 1998. In the meantime, we are not proposing any change to DRG 121.

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); and the September 1, 1995 rule for the FY 1996 revisions (60 FR 45782).)

We are proposing a limited revision of the CC Exclusions List to take into account the changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 1996, as well as the proposed CC changes described above. (See section II.B.8, below, for a discussion of ICD–9–CM changes.) These proposed changes are being made in accordance with the principles established when we created the CC Exclusions List in 1987.

The changes discussed above have been added to Table 6g, Additions to the CC Exclusions List, in section V of the Addendum to this proposed rule.

Tables 6g and 6h in section V of the Addendum to this proposed rule contain the proposed revisions to the CC Exclusions List that would be effective for discharges occurring on or after October 1, 1996. Each table shows the principal diagnoses with proposed changes to the excluded CCs. Each of these principal diagnoses is shown with an asterisk and the additions or deletions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

CCs that are added to the list are in Table 6g—Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 1996, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

CCs that are deleted from the list are in Table 6h—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 1996, the indented diagnoses will be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

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

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, 1992, 1993, 1994, 1995, and 1996) and those in Tables 6g and 6h of this document must be incorporated into the list purchased from NTIS in order to obtain the CC Exclusions List applicable for discharges occurring on or after October 1, 1996.

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with HCFA, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 13.0, is available for $195.00, which includes $15.00 for shipping and handling. Version 14.0 of this manual, which will include the final FY 1997 DRG changes, will be available in October 1996 for $195.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road; Wallingford, Connecticut 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

8. 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, and September 1, 1995, we moved several other procedures from DRG 468 to 477. (See 55 FR 36135, 56 FR 43212, 57 FR 23625, 58 FR 46279, 59 FR 45336, and 60 FR 45783, respectively.)

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. This year's review did not identify any necessary changes; therefore, we are not proposing

to move any procedures from DRG 468 or DRG 477 to one of the surgical DRGs.

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 proposing to move one procedure from DRG 468 to DRG 477.

In reviewing the list of OR procedures that produce DRG 468 assignments, we analyzed the average charge and length of stay data for cases assigned to that DRG to identify those procedures that are more similar to the discharges that currently group to either DRG 476 or 477. We identified one procedure—Closed endoscopic biopsy of lung (code 33.27), a needle biopsy—that is significantly less resource intensive than the other procedures assigned to DRG 468. Therefore, we are proposing to move procedure code 33.27 to the list of procedures that result in assignment to DRG 477.

In reviewing the list of procedures assigned to DRG 477, we did not identify any procedures that should be assigned to either DRG 468 or 476. We did, however, identify the following procedures that we believe should be reassigned from an OR to a non-OR designation:

08.81 Linear repair of laceration of eyelid or eyebrow
08.82 Repair of laceration involving lid margin, partial-thickness
08.83 Other repair of laceration of eyelid, partial thickness
08.84 Repair of laceration involving lid margin, full-thickness
08.85 Other repair of laceration of eyelid, full-thickness
08.86 Lower eyelid rhytidectomy
08.87 Upper eyelid rhytidectomy
08.89 Other eyelid repair

Our analysis of the data associated with these eyelid repair procedures leads us to conclude that the procedures are performed following accidental injury or falls, incurred while the patient is in the hospital. These procedures, which are normally performed at bedside and do not necessitate a trip to the operating room, are significantly less resource intensive than other procedures designated as OR procedures. Therefore, we are proposing to change the procedures from OR to non-OR procedures. We note that these procedures are assigned to surgical DRGs in MDCs 2, 9, 21, 22, and 24. With this proposed change, cases in which procedure codes 08.81 through 08.89 are the only OR procedure codes listed would no longer be assigned to a surgical DRG.

All of these proposed changes would be effective with discharges occurring on or after October 1, 1996.

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

As discussed above 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 charged with the mission of maintaining and updating the ICD–9–CM. 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 Committee is co-chaired by the National Center for Health Statistics (NCHS) and HCFA. The NCHS has lead responsibility for the ICD–9–CM diagnosis codes included in *Volume 1—Diseases: Tabular List* and *Volume 2—Diseases: Alphabetic Index,* while HCFA has lead responsibility for the ICD–9–CM procedure codes included in *Volume 3—Procedures: Tabular List and Alphabetic Index.*

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 fields, such as the American Health Information Management Association (AHIMA) (formerly American Medical Record Association (AMRA)), the American Hospital Association (AHA), and various physician specialty groups as well as physicians, medical record administrators, health information management professionals, and other members of the public to contribute ideas on coding matters. After considering the opinions expressed at the public meetings and in writing, the Committee formulates recommendations, which then must be approved by the agencies.

The Committee presented proposals for coding changes at public meetings held on May 5 and November 30, 1995, and finalized the coding changes after consideration of comments received at the meetings and in writing within 30 days following the November 1995 meeting. The initial meeting for consideration of coding issues for implementation in FY 1998 will be held on June 6, 1996. Copies of the minutes of these meetings may be obtained by writing to one of the co-chairpersons representing NCHS and HCFA. 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: alb8@nch09a.em.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, Office of Hospital Policy; Division of Prospective Payment System; C5–06–27; 7500 Security Boulevard; Baltimore, Maryland 21244–1850. Comments may be sent by E-mail to: pbrooks@hcfa.gov.

The ICD–9–CM code changes that have been approved will become effective October 1, 1996. The new ICD–9–CM codes are listed, along with their proposed DRG classifications, in Tables 6a and 6b (New Diagnosis Codes and New Procedure Codes, respectively) in section V of the Addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment in the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. Therefore, we are soliciting comments only on the proposed DRG classification.

Further, the Committee has approved the expansion of certain ICD–9–CM codes to require an additional digit for valid code assignment. Diagnosis codes that have been replaced by expanded codes, other codes, or have been deleted are in Table 6c (Invalid Diagnosis Codes). The procedure codes that have been replaced by expanded codes or have been deleted are in Table 6d (Invalid Procedure Codes). These invalid diagnosis and procedure codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 1996. The

corresponding new or expanded codes are included in Tables 6a and 6b. Revisions to diagnosis and procedure code titles are in Tables 6e (Revised Diagnosis Code Titles) and 6f (Revised Procedure Code Titles), which also include the proposed DRG assignments for these revised codes.

C. Recalibration of DRG Weights

We are proposing to use the same basic methodology for the FY 1997 recalibration as we did for FY 1996. (See the September 1, 1995 final rule (60 FR 45791).) That is, we would recalibrate the weights based on charge data for Medicare discharges. However, we would use the most current charge information available, the FY 1995 MedPAR file, rather than the FY 1994 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 1995 MedPAR data, based on bills received by HCFA through December 1995, from all hospitals subject to the prospective payment system and short-term acute care hospitals in waiver States. The FY 1995 MedPAR file includes data for approximately 10.6 million Medicare discharges.

The methodology used to calculate the proposed DRG relative weights from the FY 1995 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.6, 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 costs, 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 1995 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 1997. Using the FY 1995 MedPAR data set, there are 37 DRGs that contain fewer than 10 cases. We computed the weights for the 37 low-volume DRGs by adjusting the FY 1996 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs. We note that the FY 1996 weights for the low-volume DRGs were recalculated based on non-Medicare data we acquired from 19 States. This was the first update of the weights since they were initially calculated for FY 1984 based on data from Maryland and Michigan. For a complete description of this process, see the September 1, 1995 final rule (60 FR 45781).

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.

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 by this provision, we currently define hospital labor market areas based on the definitions of Metropolitan Statistical Areas (MSAs) (and New England County Metropolitan Areas), issued by the Office of Management and Budget. In addition, as discussed below, we adjust the wage

index to take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act.

Section 1886(d)(3)(E) of the Act also requires that the wage index be updated annually beginning October 1, 1993. 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.

B. FY 1997 Wage Index Update

The proposed FY 1997 wage index (effective for hospital discharges occurring on or after October 1, 1996 and before October 1, 1997) is based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 1993 (the FY 1996 wage index is based on FY 1992 wage data). We propose to use the same categories of data that were used in the FY 1996 wage index. Therefore, the proposed FY 1997 wage index reflects the following:

- Total salaries and hours from short-term, acute care hospitals.
- Home office costs and hours.
- Fringe benefits associated with hospital and home office salaries.
- Direct patient care contract labor costs and hours.
- The exclusion of salaries and hours for nonhospital type services such as skilled nursing facility services, home health services, or other subprovider components that are not subject to the prospective payment system.

Finally, we are also proposing to make a minor revision to § 412.63(s)(1) to state clearly that we update the wage index annually as required by section 1886(d)(3)(E) of the Act.

1. Verification of Wage Data From the Medicare Cost Report

The data for the proposed FY 1997 wage index were obtained from Worksheet S–3, Part II of the Medicare cost report. The data file used to construct the proposed wage index includes FY 1993 data submitted to the Hospital Cost Report Information System (HCRIS) file as of the end of January 1996. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

Of the 5,222 hospitals in the data base, 2,814 hospitals had data elements that failed an initial edit. In mid-February 1996, intermediaries contacted hospitals to revise or verify data elements that resulted in the edit failures. Next, to check any revisions since the first edit, as well as to apply additional edits based on the distribution of the data, we subjected all of the data to edits a second time. The intermediaries were instructed to transmit any revisions in hospitals' wage data made as a result of this second review. As of March 14, 1996, only 21 hospitals still had unresolved data elements. These unresolved data elements are included in the calculation of the proposed FY 1997 wage index pending their resolution before calculation of the final FY 1997 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 June 17, 1996. We expect that all unresolved data elements will be resolved by that date, and that the revised data will be reflected in the final rule.

2. Computation of the Wage Index

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

Step 1—As noted above, we are proposing to base the FY 1997 wage index on wage data reported on the FY 1993 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, Part II of the Medicare cost report for the hospital's cost reporting periods beginning on or after October 1, 1992 and before October 1, 1993. In addition, we included data from a few hospitals that had cost reporting periods beginning in September 1992 and reported a cost reporting period exceeding 52 weeks. The data were included because no other data from these hospitals would be available for the cost reporting period described above, and particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 1993 data.

Step 2—For each hospital, we subtracted the excluded salaries (that is, direct salaries attributable to skilled nursing facility services, home health services, and other subprovider components not subject to the prospective payment system) from gross hospital salaries to determine net hospital salaries. To determine total salaries plus fringe benefits, we added direct patient care contract labor costs, hospital fringe benefits, and any home office salaries and fringe benefits reported by the hospital, to the net hospital salaries.

Step 3—For each hospital, we adjusted the total salaries plus fringe benefits resulting from Step 2 to a common period to determine total adjusted salaries. To make the wage inflation adjustment, we used the percentage change in average hourly earnings for each 30-day increment from October 14, 1992 through September 15, 1994, for hospital industry workers from Standard Industry Classification 806, Bureau of Labor Statistics Employment and Earnings Bulletin. The annual inflation rates used were 4.8 percent for FY 1992, 3.6 percent for FY 1993, and 2.7 percent for FY 1994. The inflation factors used to inflate 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
10/14/92	11/15/92	1.044482
11/14/92	12/15/92	1.041408
12/14/92	01/15/93	1.038343
01/14/93	02/15/93	1.035287
02/14/93	03/15/93	1.032240
03/14/93	04/15/93	1.029203
04/14/93	05/15/93	1.026174
05/14/93	06/15/93	1.023154
06/14/93	07/15/93	1.020143
07/14/93	08/15/93	1.017141
08/14/93	09/15/93	1.014147
09/14/93	10/15/93	1.011163
10/14/93	11/15/93	1.008920
11/14/93	12/15/93	1.006683
12/14/93	01/15/94	1.004450
01/14/94	02/15/94	1.002223
02/14/94	03/15/94	1.000000
03/14/94	04/15/94	0.997782
04/14/94	05/15/94	0.995570
05/14/94	06/15/94	0.993362
06/14/94	07/15/94	0.991159
07/14/94	08/15/94	0.988961
08/14/94	09/15/94	0.986767

For example, the midpoint of a cost reporting period beginning January 1, 1993 and ending December 31, 1993 is June 30, 1993. An inflation adjustment factor of 1.020143 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 1993 and covers a period of less than 360 days or greater 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 4—For each hospital, we subtracted the reported excluded hours from the gross hospital hours to determine net hospital hours. We

increased the net hours by the addition of any direct patient care contract labor hours and home office hours to determine total hours.

Step 5—As part of our editing process, we deleted data for eight hospitals for which we lacked sufficient documentation to verify data that failed edits because the hospitals are no longer participating in the Medicare program or are in bankruptcy status. We retained the data for other hospitals that are no longer participating in the Medicare program because these hospitals reflected the relative wage levels in their labor market areas during their FY 1993 cost reporting period.

Step 6—Each hospital was assigned to its appropriate urban or rural labor market area prior to 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 fringe benefits obtained in Step 3 for all hospitals in that area to determine the total adjusted salaries plus fringe benefits for the labor market area.

Step 7—We divided the total adjusted salaries plus fringe benefits obtained in Step 6 by the sum of the total hours (from Step 4) for all hospitals in each labor market area to determine an average hourly wage for the area.

Step 8—We added the total adjusted salaries plus fringe benefits obtained in Step 3 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 data as described above, the national average hourly wage is $19.5094.

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.

3. 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 reduces the MSA wage index value by 1 percentage point or less, the MSA 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 the wage index value of the area that results from including the wage data of the redesignated hospitals (the ''combined'' wage index value). However, the wage index value for the redesignated hospitals cannot be reduced below the wage index value for the rural areas of the State in which the hospitals are located.
- If including the wage data for the redesignated hospitals increases the MSA wage index value, the MSA and the redesignated hospitals receive the combined wage index value.
- Rural areas whose wage index values would be reduced by excluding the data for hospitals that have been redesignated to another area continue to have their wage index calculated as if no redesignation had occurred. Those 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 indexes calculated exclusive 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 for an urban area below the Statewide rural average, provided the wage index prior to reclassification was greater than the Statewide rural wage index value.
- A change in classification of hospitals from one area to another may not result in the reduction in the wage index for any urban area whose wage index is below the rural wage index for the State. This provision also applies to any urban area that encompasses an entire State.

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

The proposed revised wage index values for FY 1997 are shown in Tables 4a, 4b, and 4c in the Addendum to this proposed rule. Hospitals that are redesignated should use the wage index values shown in Table 4c. For some areas, more than one wage index value will be shown in Table 4c. This occurs when hospitals from more than one State are included in the group of redesignated hospitals, and one State has a higher Statewide rural wage index value 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, prior to the redesignation of hospitals, based on the FY 1993 wage data. (We note that in Tables 4a, 4c, and 4d, we have revised several of the titles for urban areas to be consistent with OMB titles. For example, the title for urban area 1123 is changed from Boston-Brockton-Nashua, MA–NH to Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH. These are nomenclature changes only.) In addition, Table 3C in the Addendum to this proposed rule includes the adjusted average hourly wage for each hospital based on the FY 1993 data. The MGCRB will use the average hourly wage published in the final rule to evaluate a hospital's application for reclassification, unless that average hourly wage is later revised in accordance with the wage data correction policy described in § 412.63(s)(2). In such cases, the MGCRB will use the most recent revised data used for purposes of the hospital wage index. Hospitals that choose to apply before publication of the final rule can use the proposed wage data in applying to the MGCRB for wage index reclassifications that would be effective for FY 1998. We note that in

adjudicating these wage reclassification requests during FY 1997, the MGCRB will use the average hourly wages for each hospital and labor market area that are reflected in the final FY 1997 wage index.

At the time this proposed wage index was constructed, the MGCRB had completed its review. The proposed FY 1997 wage index values incorporate all 391 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 1997. 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. The changes may affect not only the wage index value for specific geographic areas, but also whether redesignated hospitals receive the wage index value for the area to which they are redesignated, or a wage index 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 1997 must be received by the MGCRB by July 15, 1996. A hospital that requests to withdraw its application may not later request that the MGCRB decision be reinstated.

C. Requests for Wage Data Corrections

To allow hospitals more time to evaluate the wage data used to construct the proposed FY 1997 hospital wage index, we have made available to the public a diskette containing the FY 1993 hospital wage data. In a memorandum dated March 1, 1996, we instructed all Medicare intermediaries to inform the prospective payment hospitals they serve that the diskette would be available approximately mid-March 1996. The intermediaries were also instructed to advise hospitals of the alternative availability of these data either through their representative hospital organizations or directly from HCFA (using order forms provided by the intermediary). Additional details on ordering this data file are discussed below in section VIII.B of this preamble, ''Requests for Data from the Public.''

In addition, as discussed above in section III.B.3 of this preamble, 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. A hospital can verify its average hourly wage as reflected on its cost report (after taking into account any adjustments made by the intermediary) by dividing the adjusted average hourly wage in Table 3C by the applicable wage inflation adjustment factors as set forth above in Step 3 of the computation of the wage index. An updated Table 3C (along with applicable wage inflation adjustment factors) will be included in the final rule.

We believe hospitals have had ample time to ensure the accuracy of their FY 1993 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 diskette or Table 3C, a hospital believes that its FY 1993 wage data have been incorrectly reported, the hospital must submit corrections along with complete supporting documentation to its intermediary by May 15, 1996. To be reflected in the final wage index, any wage data corrections must be reviewed by the intermediary and transmitted to HCFA (through HCRIS) on or before June 17, 1996. These deadlines, which correspond to the deadlines we used last year for the FY 1996 wage index, 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 September 1, 1996. We cannot guarantee that corrections transmitted to HCFA after June 17, 1996, will be reflected in the final wage index.

After reviewing requested changes submitted by hospitals, intermediaries will transmit any revised cost reports to HCRIS and forward a copy of the revised Worksheet S–3, Part II to the hospitals. If requested changes are not accepted, fiscal intermediaries will notify hospitals in writing of reasons why the changes were not accepted. This procedure will ensure 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 the dispute. We note that the June 17 deadline also applies to these requested changes.

We have created the process described above to resolve all substantive wage data correction disputes before we finalize the wage data for the FY 1997 payment rates. Accordingly, hospitals that do not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage corrections or to dispute the intermediary's decision with respect to requested changes.

We intend to make another diskette available in mid-August that will contain the wage data that will be used to construct the wage index values in the final rule. As with the diskette made available in March 1996, HCFA will make the August diskette available to hospital associations and the public. This August diskette, however, 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 process described above, 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 second diskette.

If, after reviewing the August diskette, 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 to the intermediary and HCFA should outline why the hospital believes an error exists. These requests must be *received* by HCFA and the intermediaries no later than September 16, 1996. We have set this year's deadline one week earlier than last year's deadline because we found the later deadline made it difficult to evaluate the requests and recalculate the wage index values before the start of FY 1997 (that is, October 1, 1996). Requests should be sent to: Health Care Financing Administration; Office of Hospital Policy; Attention: Stephen Phillips, Technical Advisor; Division of Prospective Payment System; C5–06–27; 7500 Security Boulevard; Baltimore, Maryland 21244–1850. The intermediary will review requests upon receipt, and, if it is determined that an intermediary or HCFA error exists, the fiscal intermediary will notify HCFA immediately.

After mid-August, we will make changes to the hospital wage data 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 August diskette. Specifically, after that point, neither the intermediary nor HCFA will accept the following types of requests in conjunction with this process:

- Requests for wage data corrections that were submitted too late to be included in the data transmitted to the HCRIS system on or before June 17, 1996;
- Requests for correction of errors made by the hospital that were not, but could have been, identified during the hospital's review of the March 1996 data; or,
- 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 September 16, 1996) will be effective October 1, 1996.

Again, we believe the wage data correction process described above provides hospitals with sufficient opportunity to bring errors made during the preparation of the Worksheet S–3 to the intermediary's attention. Moreover, because hospitals will have access to the wage data in mid-August, they will have the opportunity to detect any data entry or tabulation errors made by the intermediary or HCFA before the implementation of the FY 1997 wage index on October 1, 1996. If hospitals avail themselves of this opportunity, the wage index implemented on October 1 should be free of such errors. Nevertheless, in the unlikely event that such errors should occur, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.63(s)(2), we may make midyear corrections to the wage index only in those limited circumstances where 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 1997 (that is, by the September 16, 1996 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.

D. Contract Labor—Costs Included in the Hospital Wage Index

Our policy concerning inclusion of contract labor costs for purposes of calculating the wage index has evolved over the past several years. Primarily, this has occurred as we recognized the role of contract labor in meeting special personnel needs of many hospitals. In addition, improvements in the wage data have allowed us to more accurately identify contract labor costs and hours. As a result, effective with the FY 1994 wage index, we included the costs of direct patient care contract services in the wage index calculation. Effective with the FY 1999 wage index, which will use data from FY 1995 cost reports, we will begin to include the costs and hours of certain management contract services.

In this proposed rule, we are soliciting comments from the public regarding further expansion of the types of contract labor costs included in the wage index. The following background discussion provides a general overview of the issues related to including contract labor costs in the wage index calculation. We also list nine specific issues for which we are seeking public comment.

In the May 9, 1990 proposed rule (55 FR 19442), we reported the results of the 1988 wage index survey which collected, among other information, data on the costs and hours associated with direct patient care contract labor. All prospective payment hospitals completed the wage survey for their cost reporting periods ending in calendar year 1988. The survey data indicated that hospitals had difficulty in tracking and recording the actual hours worked associated with the contract labor. In addition, there were reporting inconsistencies. For example, some hospitals inappropriately reported patient care services furnished directly by physicians, which are not included in the wage data because they are paid under Medicare Part B rather than Part A.

In the May 9, 1990 proposed rule, we also discussed public comments we received in response to issues we raised related to including contract labor costs in the wage index. Specifically, in the May 8, 1989 proposed rule (54 FR 19647), we requested comment on the following issues:

- Should the wage index include data on contract labor?
- Should the definition of contract services in the wage index survey be expanded to include services indirectly related to patient care, such as billing or housekeeping services?

A majority of the commenters supported the inclusion of contract services, and many argued for the expansion of contract labor services to include indirect patient care services. Those opposed to including contract services, in addition to some commenters who supported including contract service costs, were concerned about the difficulty of accurately tracking and recording hours worked for all types of contract labor. Other commenters were also concerned that if a hospital contracts for services from outside its labor market area, the contract wages could artificially increase or decrease the hospital's area wage index. Based on the comments and the overall poor quality of the 1988 survey data, we decided to exclude all contract labor from the FY 1991 wage index.

We stated that we would continue our analysis of contract labor. In addition, we announced that we would develop a new wage index survey with improved instructions and auditing criteria to facilitate the inclusion of contract labor in future wage index updates. The new survey, Worksheet S–3, Part II, was included in the hospital cost report effective with cost reporting periods beginning on or after October 1, 1989.

The Worksheet S–3, Part II consists of detailed information for use in the hospital wage index including contract labor for direct patient care services. In the instructions for completing this worksheet, contract labor costs and hours were limited to labor-related payments and hours attributable to direct patient care contract services, such as nursing services. Specifically, we instructed hospitals to exclude indirect patient care contract services (for example, management and housekeeping services), nonlabor-related expenses (for example, equipment and supplies), and any contract services for which labor-related payments and hours could not be accurately determined.

In the September 4, 1990 final rule (55 FR 36036), we discussed additional comments we received on the contract labor issue. Those commenters who supported the inclusion of contract labor stated that some hospitals, especially rural hospitals, are dependent on contract labor for nursing services, and it would be unfair not to include these wage data. Other commenters requested that the definition of contract

labor be expanded to include indirect patient care services.

We also received several comments requesting that we continue to exclude contract labor from the wage index. These commenters stated that the contract labor data are not reliable because of the difficulty in tracking and reporting hours and the lack of consistency in the reporting of contract labor. In addition, inclusion of nonlabor contract costs would inappropriately drive up labor costs, and contract labor brought in from outside the labor market area would artificially increase or decrease the area wage index value. Finally, commenters were concerned that contract labor costs are too variable, temporary, and not reflective of true wage costs. Therefore, some suggested that contract labor should not be included in the wage index.

The FY 1994 wage index, which was based on the data collected on the Worksheet S–3, Part II, was the first to include direct patient care contract labor costs. In making the decision to include these costs, we analyzed hospitals' FY 1990 data to determine if it was sufficiently complete for inclusion in the wage index calculation (see the May 26, 1993 proposed rule (58 FR 30236)). We noted that, in most labor market areas, including contract labor in the wage index computation had little effect on the average hourly wage. We further stated that, based on our analysis of the data, including direct patient care contract labor would more accurately and fairly reflect wage levels across hospitals and MSAs. In the September 1, 1993 final rule, we also responded to comments from the hospital industry expressing concern that we did not recognize the costs of certain contract management services (58 FR 46296). In particular, many rural hospitals stated they were either unable to recruit or afford top managers such as hospital administrators and must contract for these services.

In the September 1, 1994 final rule (59 FR 45355), we expanded the definition of contract labor for purposes of determining the hospital wage index to include the personnel costs and hours associated with certain contract management personnel. Contract management services would be limited to individuals working in the top four positions in the hospital: the Chief Executive Officer/Hospital Administrator, Chief Operating Officer, Chief Financial Officer, and Nursing Administrator. We noted that while exact titles may vary, individuals should be performing essentially the same duties as customarily assigned these management positions.

We further noted that, since the cost report did not provide at that time for the collection of management contract data, this revised definition would not be effective until cost reporting periods beginning on or after October 1, 1994 (FY 1995). Hospitals were instructed to continue to exclude all management contract costs and hours until the FY 1995 data were reported (these data will be used to compute the FY 1999 wage index). In addition, we began requiring hospitals to provide descriptions and aggregate totals for all management contracts and complete details on all direct patient care contracts on the Form HCFA–339 (the Provider Cost Report Reimbursement Questionnaire). A hospital must file this form with its corresponding cost report.

We continue to receive requests that we expand our contract labor definition to include more types of contract services in the wage index. In particular, we have been asked to include the costs for pharmacy and laboratory services on the basis that these services are consistent with our definition of direct patient care (see the September 1, 1995 final rule (60 FR 45792)). Others have asked that we expand our definition to include all contracted services, both direct and indirect patient care services, in order to more appropriately calculate relative hospital wage costs.

We have limited the contract services that are included in the wage index to direct patient care services and specific management services for several reasons. First, hospitals reported difficulty in accurately tracking the hours associated with contract services, especially for off-site facilities that serve more than one hospital. Second, we are concerned about the contractor's ability to separate nonlabor costs from labor costs. We believe that the generally higher costs for contract labor compared to salaried labor, due at least in part to the added costs of overhead and supplies not separately identified in most contracts, may distort the wage index. Finally, we are concerned that it is difficult to remove the costs and hours for services such as legal and accounting from total management contracts.

Our goal is to ensure that our wage index policy continues to be responsive to the changing need for contract labor, allowing those hospitals that must depend on contract labor to supply needed services to reflect those costs in their wage data. At the same time, however, we wish to avoid providing an opportunity for hospitals to inflate their average hourly wage inappropriately by including nonlabor contract costs. The advantage of our approach of including only contract labor costs and hours associated with direct patient care and specific management services is that it minimizes distortions in the wage index that are due to a hospital's inability to identify and exclude nonlabor costs. While changes to the wage index values are made in a budget neutral manner and are not expected to affect aggregate payments, we strive for policies that are equitable for all hospitals.

Finally, due to the 4-year time lag between the cost reporting period itself and the fiscal year when data for that period are used in calculating the wage index, it is important that we anticipate any need to change our policy on contract labor. Therefore, in order to formulate the most responsive and responsible policy, we are soliciting comments on the following issues:

- To what extent do hospitals rely on the use of contract services?
- For which services are contracts typically used?
- Can hospitals accurately determine hours related to contract services?
- Can hospitals accurately isolate labor-related costs from nonlabor-related costs?
- Should the contract labor definition be expanded to include contract services indirectly related to patient care?
- If contract labor remains limited to direct patient care, what categories of services, if any, in addition to those identified above, should be included?
- Would the wage index more accurately reflect relative wage levels if we did not limit contract labor to direct patient care (generally high wage) services?
- Would expanding the types of contract labor that are included in the wage index provide less incentive to hospitals to keep their labor costs low, as higher labor costs may result in a higher wage index value for that hospital or allow it to reclassify to a labor market with a higher wage index?
- What other issues should be considered in revising the policy for including contract labor in the wage index?

E. Puerto Rico Wage Index Values

For several years, hospitals in Puerto Rico have experienced large swings in their wage index values. In the September 1, 1995 final rule, we responded to two comments suggesting changes to the wage index for hospitals in Puerto Rico (60 FR 45796). One suggestion was to establish a floor for the wage index values of the Puerto Rico labor market areas while the other was to eliminate the rural area classification in Puerto Rico and classify the rural

hospitals to the nearest urban area. Although we did not adopt either of these suggestions, we stated that we would continue to study the issue of wage index values in Puerto Rico.

To evaluate the effect that these large changes in wage index values have on hospitals in Puerto Rico, we examined the most recent Medicare cost data for these hospitals. Of the 50 hospitals contained in our data base, 64 percent had improved Medicare operating margins from 1992 to 1993. Of the 26 hospitals with data available for 1994, we found that 65 percent improved financially from 1993 to 1994. Based on this analysis, we do not believe that the wage index changes have had a detrimental effect on these hospitals as a group. However, there are individual hospitals that are not faring as well.

We recognize that large shifts in the wage index values can cause shifts in the payment levels for a particular MSA. Because three of the six MSAs in Puerto Rico (Aguadilla, Arecibo, and Caguas) as well as the rural area have four or fewer hospitals, a large change in one hospital's wage data can cause a large increase or decrease in the wage index value for the entire MSA. One possible method to limit these annual swings in wage index values would be to create a single labor market area encompassing all the hospitals in Puerto Rico. That is, the six MSAs and the rural area would be combined into one area with one wage index value. A single labor market area would create a much larger set of hospitals to develop aggregate wage amounts and would mitigate situations where a change in the wage data of a single hospital has a large effect on the wage index of an MSA.

Because creating one MSA for Puerto Rico would be implemented in a budget neutral manner, the effect would be to raise wage index values for some hospitals in Puerto Rico and to lower the values for others. Using the FY 1993 wage data, the following table shows the effect this change would have on the proposed wage index levels.

Area	Number of hospitals	Proposed wage index	One area wage index	Percent change
Rural	4	0.4182	0.4555	8.92
Aguadilla	2	0.4430	0.4555	2.82
Arecibo	2	0.4661	0.4555	−2.27
Caguas	4	0.4638	0.4555	−1.79
Mayaguez	5	0.4186	0.4555	8.82
Ponce	7	0.4500	0.4555	1.22
San Juan	29	0.4616	0.4555	−1.32

Because of the negative effects on some hospitals, we are soliciting comment on this approach for mitigating the fluctuations in wage index values for hospitals in Puerto Rico. The potential change would have no impact on hospitals outside Puerto Rico.

F. Proposed Changes to the MGCRB Composition and Criteria

Under section 1886(d)(10) of the Act, the MGCRB considers applications by hospitals for geographic reclassification for purposes of payment under the prospective payment system. Guidelines concerning the criteria and conditions for hospital reclassification are located at §§ 412.230 through 412.236. The purpose of these criteria is to provide direction, to both the MGCRB and those hospitals seeking geographic reclassification, with respect to the situations that merit an exception to the rules governing the geographic classification of hospitals under the prospective payment system. The composition of the MGCRB and the procedures it follows in making reclassification determinations are set forth in §§ 412.246 through 412.280.

As discussed in detail below, we are proposing to make one change to the MGCRB regulations. In addition, we are soliciting comments on sources of data that could be used to identify the occupational mix in a given MSA.

1. MGCRB Composition (§ 412.246)

Section 1886(d)(10)(B)(i) of the Act provides that the MGCRB is composed of five members appointed by the Secretary. This provision is implemented in regulations at § 412.246(a). Two of the members must be representative of the concerns of rural hospitals and at least one member must be knowledgeable in the field of analyzing costs of providing inpatient hospital services. Under current § 412.246(b), the term of office for an MGCRB member is 3 years, and appointments are limited to two consecutive 3-year terms. This section further provides that to permit staggered terms of office, initial appointments may be for shorter terms. Finally, the Secretary is permitted to terminate a member's tenure before his or her full term has expired.

Since the establishment of the MGCRB 6 years ago, we have never modified the regulations that govern the MGCRB's composition, which were originally modeled after the procedural regulations of the Provider Reimbursement Review Board (PRRB). We believe that it is now appropriate to update the regulations that govern members' terms of office in light of agency experience.

Appointments to the Board must comply with statutory requirements concerning rural representatives and a hospital cost expert. Since the appointment of the initial Board, the Secretary has had difficulty recruiting additional, qualified persons to serve on the MGCRB. In addition, we solicited comment in the June 2, 1995 proposed rule (60 FR 29218) on the idea of eliminating the MGCRB and transferring its functions back to HCFA. This may have caused qualified members to lose interest in becoming or remaining Board members. We no longer believe that there needs to be a limitation on the number of terms a member may serve. Deleting the term limit requirement would allow for increased flexibility in appointing and recruiting qualified Board members. Flexibility in this area will allow the Secretary to ensure that Board members are in place to meet the tight statutory deadlines associated with filing and adjudicating MGCRB applications. (Under sections 1886(d)(10)(C) (ii) and (iii) of the Act, a hospital requesting a change in geographic classification must submit its application to the Board not later than the first day of the preceding fiscal year. Once the application is received the Board must render a decision within 180 days.) Therefore, we are proposing to eliminate the current requirement at § 412.246(b) that a Board member can serve for only two consecutive 3-year terms.

We also considered eliminating any requirement on the length of an individual term. However, we believe that maintaining a term of office not to exceed 3 years is appropriate. If we

deleted this requirement, then the Secretary could not periodically reevaluate membership of the Board. We would, however, propose that a term of office would not be limited only to a term of exactly 3 years. Specifically, we would revise § 412.246(b) to provide that an appointment to the MGCRB may be for any term not to exceed 3 years. We believe that both of these proposed changes would allow the Secretary maximum flexibility to recruit and retain qualified Board members.

Under the proposed revisions, the Secretary would continue to be able to terminate a member's tenure before his or her full term has expired. This provision was modeled after the provisions of the PRRB under which the Secretary has the authority to terminate a Board member for good cause. We believe that it is appropriate for the Secretary to be able to exercise a similar termination authority over the MGCRB in case a member of the MGCRB fails to carry out his or her duties under the Act and regulations. Therefore, we would retain this provision. We note that the Secretary has not invoked this authority to date with either the PRRB or the MGCRB.

2. Occupational Mix Adjustment

Section 1886(d)(10)(D)(i) of the Act requires the Secretary to publish guidelines to be utilized by the MGCRB in rendering decisions on applications submitted for geographic reclassification. Those are to include guidelines for ''comparing wages, taking into account (to the extent the Secretary determines appropriate) occupational mix, in the area in which the hospital is classified and the area in which the hospital is applying to be classified.''

Section 412.230(e) describes the criteria for hospital reclassification for purposes of the wage index. One of the criteria relates to the relationship between the hospital's wages and those of the area to which it seeks reclassification. Specifically, § 412.230(e)(1)(iv) provides that the hospital must demonstrate that its wages are at least 84 percent of the average hourly wage of hospitals in the area to which it seeks reclassification, or that the hospital's average hourly wage weighted for occupational mix is at least 90 percent of the average hourly wage of hospitals in the area to which it seeks reclassification. Under §§ 412.232(c) and 412.234(b), a group of hospitals seeking to reclassify must demonstrate that its aggregate average hourly wage is at least 85 percent of the average hourly wage of the hospitals in the area to which it seeks reclassification. These sections also provide that the threshold for occupational-mix adjusted hourly wage for hospital groups is the same as that for a single hospital, that is, 90 percent.

In the September 6, 1990 interim final rule (55 FR 36760), we stated that the acceptable sources for occupational mix data were the American Hospital Association (AHA) or the Bureau of Labor Statistics. Since publication of that document, the Bureau of Labor has discontinued its hospital wage surveys. Thus, the only currently acceptable occupational mix data source is the AHA Survey Data. We have been informed by the AHA that the survey for 1993 will be the last survey to collect information on the Hospital Personnel by Occupational Category. Therefore, requests filed on or before October 1, 1996 for FY 1998 reclassification, which use FY 1993 wage data, may be the last for which we have an appropriate source of occupational mix data.

As we stated in the June 4, 1991 final rule with comment period (56 FR 25458), the reclassification process requires the use of occupational mix data that are comparable across areas and can be consistently applied. We are unaware of any sources other than the AHA data that meet these criteria.

We have not proposed collecting occupational mix data ourselves in light of past experience. We attempted to collect such data some time ago. In the September 30, 1988 Federal Register (53 FR 38495), we reported on our efforts to collect 1986 occupational mix data as part of the Medicare National Uniform Reporting Demonstration project, to determine the feasibility of developing a wage index that would take into account occupational mix. The majority of hospitals (more than 60 percent) failed to complete or submit the survey. A number of surveys that were submitted were not filled out completely and appeared to have numerous errors. Moreover, we believe that collecting occupational mix data from hospitals would be inappropriately burdensome to the hospitals. In the past, we have received several comments from hospitals opposing HCFA's collection of occupational mix data (56 FR 43222), citing the prohibitive cost to hospitals of furnishing occupational mix data. Finally, even if we were to decide now to begin collecting occupational mix data, it would be at least 6 years before the data would be available for use.

In order to continue to allow the use of wage data weighted by occupational mix in wage index reclassification, we are seeking suggestions about any occupational mix data sources that are available on a national basis. In addition, we are willing to consider suggestions about other methods that would account for occupational mix in the wage index reclassification process.

IV. Rebasing and Revising of the Hospital Market Baskets

A. Operating Costs

1. Background

Effective for cost reporting periods beginning on or after July 1, 1979, we developed and adopted a hospital input price index (that is, the hospital ''market basket'') for operating costs. Although ''market basket'' technically describes the mix of goods and services used to produce hospital care, this term is also commonly used to denote the input price index (that is, cost category weights and price proxies combined) derived from that market basket. Accordingly, the term ''market basket'' as used in this document refers to the hospital input price index.

The percentage change in the market basket reflects the average change in the price of goods and services hospitals purchase in order to furnish inpatient care. We first used the market basket to adjust hospital cost limits by an amount that reflected the average increase in the prices of the goods and services used to furnish hospital inpatient care. This approach linked the increase in the cost limits to the efficient utilization of resources.

With the inception of the hospital inpatient prospective payment system on October 1, 1983, we continued to use the hospital market basket to update each hospital's 1981 inpatient operating cost per discharge used in establishing the FY 1984 standardized payment amounts. In addition, the projected change in the hospital market basket has been the integral component of the update factor by which the prospective payment rates are updated every year. Under section 1886(b)(3)(B)(i)(XII) of the Act, the prospective payment rates will be updated in FY 1997 by the projected increase in the hospital market basket minus 0.5 percentage points. A detailed explanation of the hospital market basket used to develop the prospective payment rates was published in the Federal Register on September 3, 1986 (51 FR 31461). For additional background information on general development of hospital input price indexes, we refer the reader to the article by Freeland, Anderson, and Schendler, ''National Hospital Input Price Index,'' *Health Care Financing Review*, Summer 1979, pp 37–61. We also refer the reader to the September 4, 1990 Federal Register (55 FR 35990) in which we discussed the previous

rebasing of the hospital input price index.

The hospital market basket is a fixed-weight, Laspeyres-type price index that is constructed in three steps. First, a base period is selected and total base period expenditures are estimated for mutually exclusive and exhaustive spending categories based upon type of expenditure. Then, the proportion of total costs that each category represents is determined. These proportions are called cost or expenditure weights. Second, each expenditure category is matched to an appropriate price/wage variable, referred to as a price proxy. These price proxies are price levels derived from a publicly available statistical series published on a consistent schedule, preferably at least on a quarterly basis. Third and finally, the price level for each spending category is multiplied by the expenditure weight for that category. The sum of these products (that is, the expenditure weights multiplied by the price levels) for all cost categories yields the composite index level in the market basket in a given year. Repeating this step for other years produces a series of market basket index levels over time. Dividing one index level by an earlier index level produces rates of growth in the input price index.

The market basket is described as a fixed-weight index because it answers the question of how much it would cost, at another time, to purchase the same mix of goods and services that was purchased in the base period. The effects on total expenditures resulting from changes in the quantity or mix of goods and services purchased subsequent to the base period are not considered. For example, shifting a traditionally inpatient type of care to an outpatient setting might affect the volume of inpatient goods and services purchased by the hospital, but would not be factored into the price change measured by a fixed weight hospital market basket.

We believe that it is desirable to rebase the market basket periodically so the cost weights reflect changes in the mix of goods and services that hospitals purchase (hospital inputs) in furnishing inpatient care. We last rebased the hospital market basket cost weights effective for FY 1991. This market basket, still used through FY 1996, reflected base year data from FY 1987 in the construction of the cost weights.

In its April 1, 1985 report to the Secretary (Appendix C of the June 10, 1985 proposed rule (50 FR 24446)), ProPAC supported HCFA's position on periodic rebasing, stating that the market basket cost weights should be recalculated or ''rebased'' at least every 5 years, or more frequently if significant changes in the weights occur. We note that there are separate market baskets for prospective payment hospitals and hospitals and hospital units excluded from the prospective payment system. The separate, excluded hospital market basket is set forth in section IV.A.5 of this preamble.

2. Rebasing and Revising the Hospital Market Basket

The terms rebasing and revising, while often used interchangeably, actually denote different activities. Rebasing means moving the base year for the structure of costs of an input price index (for example, we are proposing to move the base year cost structure from FY 1987 to FY 1992). Revising means changing data sources, cost categories, or price proxies used in the input price index.

We are proposing to use a rebased and revised hospital market basket in developing the FY 1997 update factor for the prospective payment rates. The new market basket would be rebased to reflect 1992, rather than 1987, cost data.

In developing the rebased and revised market basket, we reviewed hospital operating expenditure data for the market basket cost categories. In a change from previous methodology, we are relying primarily on Medicare hospital cost report data for the proposed rebasing. For the proposed market baskets, we used data on hospital expenditures for four major expense categories (wages and salaries, employee benefits, pharmaceuticals, and a residual ''all other'') from hospital cost reporting periods beginning in FY 1992 (that is, periods beginning on or after October 1, 1991 and before October 1, 1992). We refer to these as PPS–9 cost reports (the 9th year of the prospective payment system (PPS)). The market basket was previously based on 1987 expense data from the 1988 American Hospital Association (AHA) Annual Survey.

Expenses for wages and salaries, employee benefits, and pharmaceuticals were determined using data from PPS–9 cost reports as reported in the Hospital Cost Report Information System (HCRIS) files. We determined total professional fees using AHA Annual Survey data. Total professional fees include medical and nonmedical professional fees. Since the medical professional fees included in the compensation of provider-based physicians is paid under Medicare Part B, we analyzed HCRIS data to determine the professional component of provider-based physician compensation and subtracted it from total professional fees to obtain an estimate of nonmedical professional fees. Malpractice insurance costs were determined using the cost share for PPS–6 (cost reporting periods beginning in FY 1989), the last year these costs had to be treated separately from all other administrative and general costs, trended forward to 1992 based on the relative importance of malpractice costs found in the previous market basket. The All Other Expenses category was calculated in two steps. First, from PPS–9 cost reports, total operating expenses were tabulated by subtracting capital-related expenses, direct medical education expenses, and the medical professional fees from total expenses. Second, we subtracted the total of the five cost category expenses already determined from total operating expenses to obtain the All Other Expenses category.

After totals for these main cost categories (wages and salaries, employee benefits, professional fees, pharmaceuticals, malpractice insurance, and all other expenses) were calculated, we then determined the proportion each category represents of the total costs. These proportions represent the major rebased market basket weights. The differences between the six major categories for the proposed 1992-based index and the previous 1987-based index are summarized in Table 1 below.

TABLE 1.—COMPARISON OF 1992 AND 1987 PROSPECTIVE PAYMENT HOSPITAL OPERATING COST CATEGORIES AND WEIGHTS

Expense categories	Rebased 1992 hospital market basket	1987-based hospital market basket
Wages and Salaries	50.244	52.2
Employee Benefits	11.146	9.5
Nonmedical Professional Fees	2.127	1.6

TABLE 1.—COMPARISON OF 1992 AND 1987 PROSPECTIVE PAYMENT HOSPITAL OPERATING COST CATEGORIES AND WEIGHTS—Continued

Expense categories	Rebased 1992 hospital market basket	1987-based hospital market basket
Malpractice Insurance	1.189	1.4
Pharmaceuticals	4.162	3.9
All Other	31.132	31.4
Total	100.000	100.0

Note: Although we rounded the weights to the tenths decimal position in the 1987-based market basket as published in the September 4, 1990 final rule, we are presenting the 1992 weights in greater specificity.

Table 2 sets forth the proposed market basket cost categories, weights, and price proxies. Weights for the ''Utilities'' and the ''All Other'' cost categories, as well as the subcategories, were determined using the 1987 Department of Commerce's Bureau of Economic Analysis (BEA) Input-Output Table, from which data for the hospital industry were extracted. The BEA Input-Output database, which is updated at 5-year intervals, was most recently described in the Survey of Current Business, ''Benchmark Input-Output Accounts for the U.S. Economy, 1987'' (April 1994). We anticipate that the Department of Commerce will soon release 1992 cost data for use in determining the cost weights. If the data are released in time to be analyzed, we will use them in the final market basket for more refined estimates of cost expenditure weights.

We aged the 1987 cost shares to 1992 using historical price changes between 1987 and 1992 for each category. The aged shares were normalized to be consistent with the 1992 hospital cost report data. Relative weights for the new base year were then calculated for various expenditure categories. This work resulted in the identification of 26 separate cost categories in the rebased hospital market basket, two fewer categories than were included in the 1987-based market basket. Detailed descriptions of each category and respective price proxy are provided in Appendix C to this proposed rule.

TABLE 2.—PROPOSED 1992-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING COST CATEGORIES, WEIGHTS, AND PRICE PROXIES

Expense categories	Rebased 1992 hospital market basket	Price proxy
1. Compensation	61.390	
A. Wages and Salaries[1]	50.244	HCFA Occupational Wage Index.
B. Employee Benefits[1]	11.146	HCFA Occupational Benefits Index.
2. Professional Fees[1]	2.127	ECI—Compensation for Professional, Specialty & Technical.
3. Utilities	2.469	
A. Fuel, Oil, and Gasoline	0.345	PPI Refined Petroleum Products.
B. Electricity	1.349	PPI Commercial Electric Power.
C. Natural Gas	0.670	PPI Commercial Natural Gas.
D. Water and Sewerage	0.106	CPI–U Water & Sewerage Maintenance.
4. Professional Liability Insurance	1.189	HCFA Professional Liability Insurance Premium Index.
5. All Other	32.824	
A. All Other Products	24.033	
(1.) Pharmaceuticals	4.162	PPI Ethical (Prescription) Drugs.
(2.) Food	3.459	
a. Direct Purchase	2.363	PPI Processed Foods & Feeds.
b. Contract Service	1.096	CPI–U Food Away From Home.
(3.) Chemicals	3.795	PPI Industrial Chemicals.
(4.) Medical Instruments	3.128	PPI Medical Instruments & Equipment.
(5.) Photographic Supplies	0.399	PPI Photographic Supplies.
(6.) Rubber and Plastics	4.868	PPI Rubber & Plastic Products.
(7.) Paper Products	2.062	PPI Converted Paper & Paperboard Products.
(8.) Apparel	0.875	PPI Apparel.
(9.) Machinery and Equipment	0.211	PPI Machinery & Equipment.
(10.) Miscellaneous Products	1.074	PPI Finished Goods.
B. All Other Services	8.792	
(1.) Business Services[1]	3.823	ECI—Compensation for Private Workers in Business Services.
(2.) Computer Services[1]	1.927	AHE Computer & Data Processing Services.
(3.) Transportation Services	0.188	CPI-U Transportation.
(4.) Telephone Services	0.531	CPI-U Telephone Services.
(5.) Postage[1]	0.272	CPI-U Postage.
(6.) All Other: Labor Intensive*	1.707	ECI—Compensation for Private Service Occupations.
(7.) All Other: Nonlabor Intensive	0.344	CPI-U All Items.
Total	100.000	

[1] Labor-related.
NOTE: Due to rounding, weights may not sum to total.

The 1987-based market basket included a separate Blood Services cost category. In the 1992-based market basket, Blood Services is contained within the Chemicals cost category. In addition, the 1987-based cost category for Fuel Oil, Coal, etc. has been combined with the 1987-based Motor Gasoline cost category to form the 1992-based Fuel, Oil and Gasoline cost category. Both of these changes are based on revised cost categories from BEA. For comparison purposes, the 1987-based cost categories are set forth in Table 3.

TABLE 3.—1987-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING COST CATEGORIES, WEIGHTS, AND PRICE PROXIES

Expense categories	1987 hospital market basket	Price proxy
1. Compensation	61.7	
A. Wages and Salaries[1]	52.2	HCFA Occupational Wage Index.
B. Employee Benefits[1]	9.5	HCFA Occupational Benefits Index.
2. Professional Fees[1]	1.6	ECI—Wages & Salaries for Professional, Specialty & Technical.
3. Utilities	2.4	
A. Fuel, Oil, Coal, etc.	0.6	WPI Light Fuel Oils.
B. Electricity	1.1	WPI Industrial Power.
C. Natural Gas	0.3	WPI Natural Gas.
D. Motor Gasoline	0.2	WPI Gasoline.
E. Water and Sewerage	0.0	CPI–U Water & Sewerage Maintenance.
4. Professional Liability Insurance	1.4	HCFA Professional Liability Insurance Premiums.
5. All Other	32.8	
A. All Other Products	21.8	
(1.)Pharmaceuticals	3.9	WPI Prescription Drugs.
(2.) Food	3.3	
a. Direct Purchase	2.1	WPI Processed Foods.
b. Contract Service	1.2	CPI–U Food Away From Home.
(3.) Chemicals	3.1	WPI Industrial Chemicals.
(4.) Medical Instruments	2.7	WPI Medical Instruments & Equipment.
(5.) Photographic Supplies	2.6	WPI Photographic Supplies.
(6.) Rubber and Plastics	2.3	WPI Rubber & Plastic Products.
(7.) Paper Products	1.4	PPI Converted Paper & Paperboard Products.
(8.) Apparel	1.1	WPI Textile House furnishings.
(9.) Machinery and Equipment	0.4	WPI Machinery & Equipment.
(10.) Miscellaneous Products	0.8	WPI Finished Goods.
B. All Other Services	11.1	
(1.) Business Services[1]	3.8	AHE Business Services.
(2.) Computer Services[1]	2.0	AHE Computer & Data Processing Services.
(3.)Transportation Services	1.2	CPI–U Transportation.
(4.) Telephone Services	1.0	CPI–U Telephone Services.
(5.) Blood Services[1]	0.6	WPI Blood & Derivatives.
(6.) Postage[1]	0.4	CPI–U Postage.
(7.) All Other: Labor Intensive[1]	1.2	ECI—Wages and Salaries for Private Service Occupations.
(8.) All Other: Nonlabor Intensive	0.8	CPI–U All Items.
Total	100.0	

[1] Labor-related.
Note: Due to rounding, weights may not sum to total.

In the September 4, 1990 final rule, for purposes of determining the labor-related portion of the standardized amounts, we summed the percentages of the labor-related items (that is, wages and salaries, employee benefits, professional fees, business services, computer and data processing, blood services, postage, and all other labor-intensive services) in the hospital market basket. This summation resulted in a labor-related portion of the hospital market basket of 71.4 percent and nonlabor-related portion of 28.6 percent. 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 payments that are labor-related. Since October 1, 1990, then, we have considered 71.4 percent of costs to be labor-related for purposes of the prospective payment system.

In connection with the rebasing of the hospital market basket, we have re-estimated the labor-related share of the standardized amounts. Based on the relative weights described in Table 2, the labor-related portion that is subject to hospital wage index adjustments (based on wages and salaries, employee benefits, professional fees, business services, computer and data processing, postage, and all other labor-intensive services) is 71.246 percent and the nonlabor-related portion is 28.754 percent. To implement this change, effective with discharges occurring on or after October 1, 1996, we are proposing to recompute the labor-related and nonlabor-related shares of the large urban and other areas' standardized amounts used to establish the prospective payment rates.

The amounts in Table 4 reflect the revised labor-related and nonlabor-related portions. Due to the Bureau of Economic Analysis' reclassification of Blood Services to Chemicals, we now allocate Blood Services to a nonlabor cost category. We note that, although there are revisions of the labor and nonlabor portions, due to both weight changes and the Blood Services category change, the labor-related portions of the rates published in Table 4 have remained essentially the same. The

labor-related portion has decreased by 0.146 percentage points.

TABLE 4.—LABOR-RELATED SHARE

Cost category	Weight
Wages and Salaries	50.244
Employee Benefits	11.146
Professional Fees	2.127
Business Services	3.823
Computer Services	1.927
Postal Services	0.272
All Other Labor Intensive	1.707
Total Labor-Related	71.246
Total Nonlabor Related	28.754

3. Selection of Price Proxies

After computing the 1992 cost weights for the rebased hospital market basket, it is necessary to select appropriate wage and price proxies to monitor the rate of increase for each expenditure category. Most of the indicators are based on Bureau of Labor Statistics (BLS) data and are grouped into one of the following BLS categories:

• Producer Price Indexes—Producer Price Indexes (PPIs) measure price changes for goods sold in other than retail markets. For example, we used the PPI for ethical drugs, rather than the Consumer Price Index (CPI) for prescription drugs. PPIs are preferable price proxies for goods that hospitals purchase as inputs in producing their outputs. The PPIs we used measure price change at the final stage of production.

• Consumer Price Indexes—Consumer Price Indexes (CPIs) measure change in the prices of final goods and services bought by the typical consumer. Because they may not represent the price faced by the producer, the consumer price indexes were used if no appropriate PPI was available, or if the expenditure was more similar to that of retail consumers in general rather than a purchase at the wholesale level. For example, the CPI for food purchased away from home was used as a proxy for contracted food services.

• Employment Cost Indexes—Employment Cost Indexes (ECIs) measure the rate of change in employee wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes and strictly measure the change in wage rates and employee benefits per hour. They are not affected by shifts in employment mix.

• Average Hourly Earnings—Average Hourly Earnings (AHEs) measure the rate of change of hourly earnings for various occupations within a given industry, and, therefore, reflect a weighted occupational mix within a particular industry. The AHE series is calculated by dividing gross payrolls by total hours and measures actual earnings rather than pure wage rates. It is a current-weight series rather than a fixed-weight index and thus reflects shifts in employment mix. An AHE rather than an ECI is used when there is no corresponding ECI category that is an appropriate measure of growth for a given labor category or when the ECI does not have sufficient length of history to be useful for our purpose.

Our proposed price proxies for the rebased prospective payment hospital market basket are shown in Table 2 above and are summarized in Appendix C to this proposed rule.

4. The HCFA Blended Compensation Index

Compensation includes the two largest categories of the rebased hospital market basket. Wages and salaries account for 50.244 percent and employee benefits account for 11.146 percent of the total weight in the prospective payment hospital market basket.

The proposed HCFA Blended Compensation Index groups hospital occupations into nine broad categories. For eight of those occupational groups, we believe that hospitals compete for labor generally with employers outside the health care sector. Accordingly, we use economy-wide employment cost indexes (ECI) as price proxies for these eight occupational groups. In the case of compensation for nurses, as well as for certain other health care technicians and professionals, the hospital labor market may be predominant. However, hospitals do compete with other industries to obtain certain skilled professional and technical staff (for example, computer programmers). Therefore, for professional and technical workers, we believe a price proxy that reflects an equal blend of internal and external compensation variables is appropriate.

Similar to the methodology used for the previous rebasing, the weights for the nine cost categories in the occupational blend index were derived from the 1992 Current Population Survey (CPS) produced by BLS. Using the CPS, private hospital workers were classified into the nine occupational categories. Private hospitals better reflect the mix of occupations used to produce acute care services for the prospective payment hospital input price index. Government hospitals were excluded because their occupational mix reflects the subset of nonacute care hospitals. Once private hospital workers were sorted by occupation into one of the nine occupational groups, weights were estimated using the share of wages and salaries for each of the nine occupations. These shares formed the basis of the weights that were used for the market basket of occupational categories.

An additional adjustment was made for contract labor costs. Rather than treat contract labor as a distinct noncompensation cost category, it was integrated into the occupational blend as a component of hospitals' compensation costs for purposes of the market basket index. Thus, contract labor is treated the same as other labor expenses. Contract labor was allocated to the professional and technical and service occupation categories. After adjusting the professional and technical and service workers' shares to account for contract labor, the weights for the nine occupational blend categories were renormalized to equal 100.00 percent. The weights and proxies for the nine cost categories of the HCFA Blended Wages and Salaries Index are shown in Table 5.

TABLE 5.—HCFA BLENDED WAGES AND SALARIES INDEX (WAGES AND SALARIES COMPONENT OF THE 1992-BASED MARKET BASKET)

Cost category	Weight	Price proxy
Professional and Technical	65.729	Equal blend of ECI for wages and salaries of civilian hospital workers and ECI for wages and salaries of professional, specialty and technical workers.
Managers and Administrators	9.554	ECI for wages and salaries for executive, administrative and managerial workers.
Sales	0.402	ECI for wages and salaries for sales workers.
Clerical Workers	12.379	ECI for wages and salaries for administrative support including clerical workers.
Craft and Kindred	1.689	ECI for wages and salaries for precision production, craft and repair workers.

TABLE 5.—HCFA BLENDED WAGES AND SALARIES INDEX (WAGES AND SALARIES COMPONENT OF THE 1992-BASED MARKET BASKET)—Continued

Cost category	Weight	Price proxy
Operatives Except Transport	0.437	ECI for wages and salaries for machine operators, assemblers and inspectors.
Transport Equipment Operatives	0.122	ECI for wages and salaries for transportation and material moving workers.
Nonfarm Laborers	0.084	ECI for wages and salaries for handlers, equipment cleaners, helpers and laborers.
Service Workers	9.606	ECI for wages and salaries for service occupations.
Total Wages and Salaries	100.000	Total Weight for Wages and Salaries is 50.2.

Note: Due to rounding, weights may not sum to total.

5. Separate Market Basket for Hospitals and Hospital Units Excluded From the Prospective Payment System

In its March 1, 1990 report, ProPAC recommended that we establish a separate market basket for hospitals and hospital units excluded from the prospective payment system. Effective with FY 1991, HCFA adopted ProPAC's recommendation to implement separate market baskets. (See the September 4, 1990 final rule (55 FR 36044).) Prospective payment and excluded hospitals tend to have different case mixes, practice patterns, and composition of inputs. The fact that these hospitals are not included under the prospective payment system in part reflects these differences.

Studies completed by HCFA, ProPAC, and the hospital industry have documented different weights for excluded hospitals and prospective payment hospitals. Table 7 compares major weights in the rebased 1992 market basket for excluded hospitals with weights in the rebased 1992 market basket for prospective payment system hospitals. Wages and salaries are 52.152 percent of total operating costs for excluded hospitals compared to 50.244 percent for prospective payment hospitals. Employee benefits are 11.569 percent for excluded hospitals compared to 11.146 percent for prospective payment hospitals. As a result, compensation costs (wages and salaries plus employee benefits) for excluded hospitals are 63.721 percent of costs compared to 61.390 percent for prospective payment hospitals. Noncompensation costs are 36.279 percent for excluded hospitals and 38.610 of costs for prospective payment hospitals.

Two significant differences in the category weights occur in Pharmaceuticals and Business Services. Pharmaceuticals represent 4.162 percent of costs for prospective payment hospitals and 3.070 percent for excluded hospitals. Business services represent 3.823 percent of costs for prospective payment hospitals and 2.337 percent for excluded hospitals. The weights for the excluded hospital market basket were derived using the same data sources and methods as for the prospective payment market basket (see Appendix C to this proposed rule).

Differences in weights between the proposed excluded hospital and prospective payment hospital market baskets do not necessarily lead to significant differences in the rate of price growth for the two market baskets. If the individual wages and prices move at the approximately same annual rate, both market baskets may have about the same price growth even though weights may differ substantially because both market baskets use the same wages and prices. Also, offsetting price increases for various cost components can result in similar composite price growth in both market baskets.

The wage and price proxies are the same for the excluded hospital and prospective payment hospital market baskets. As discussed in section IV.A.2 of this preamble, all of the cost expenditure weights for both the prospective payment and excluded hospital market baskets are subject to refinement if the U.S. Department of Commerce data are released in time to be analyzed and incorporated in the final market basket.

The excluded hospital market basket is a composite set of weights for Medicare participating psychiatric, long-term care, rehabilitation, and children's hospitals. We are proposing to use cost report data for excluded hospitals and units whose Medicare average length of stay is within 15 percent (that is, 15 percent higher or lower) of the total facility average length of stay. This is a change from the 1987-based market basket, for which data for all excluded hospitals and units were used. We believe that limiting our sample to hospitals with a Medicare average length of stay within 15 percent of the total facility average length of stay provides a more accurate reflection of the structure of costs for Medicare. We note that the proposed forecast for FY 1997 would be the same even if we had included all excluded hospitals in the calculation of weights. The forecast for both the limited and full set of excluded hospitals yields a rate of change for FY 1997 of 2.7 percent.

TABLE 6.—COMPARISON OF SIGNIFICANT WEIGHTS FOR 1992–BASED EXCLUDED HOSPITAL AND PROSPECTIVE PAYMENT HOSPITAL MARKET BASKETS

Category	Excluded hospitals	Prospective payment hospitals
Wages and Salaries	52.152	50.244
Employee Benefits	11.569	11.146
Professional Fees	2.098	2.127
Pharmaceuticals	3.070	4.162
All Other	31.111	32.321
Total	100.000	100.000

TABLE 7.—PROPOSED 1992-BASED EXCLUDED HOSPITAL OPERATING COST CATEGORIES, WEIGHTS, AND PRICE PROXIES

Expense categories	Rebased 1992 excluded hospital market basket	Price proxy
1. Compensation	63.721	
A. Wages and Salaries	52.152	HCFA Occupational Wage Index.
B. Employee Benefits	11.569	HCFA Occupational Benefits Index.
2. Professional Fees	2.098	ECI—Compensation for Professional, Specialty & Technical.
3. Utilities	2.557	
A. Fuel, Oil, and Gasoline	0.357	PPI Refined Petroleum Products.
B. Electricity	1.396	PPI Commercial Electric Power.
C. Natural Gas	0.694	PPI Commercial Natural Gas.
D. Water and Sewerage	0.110	CPI–U Water & Sewerage Maintenance.
4. Professional Liability Insurance	1.081	HCFA Professional Liability Insurance Premiums Index.
5. All Other	30.543	
A. All Other Products	23.642	
(1.) Pharmaceuticals	3.070	PPI Ethical (Prescription) Drugs.
(2.) Food	3.581	
a. Direct Purchase	2.446	PPI Processed Foods & Feeds.
b. Contract Service	1.135	CPI–U Food Away From Home.
(3.) Chemicals	3.929	PPI Industrial Chemicals.
(4.) Medical Instruments	3.238	PPI Medical Instruments & Equipment.
(5.) Photographic Supplies	0.413	PPI Photographic Supplies.
(6.) Rubber and Plastics	5.039	PPI Rubber & Plastic Products.
(7.) Paper Products	2.134	PPI Converted Paper & Paperboard Products.
(8.) Apparel	0.906	PPI Apparel.
(9.) Machinery and Equipment	0.218	PPI Machinery & Equipment.
(10.) Miscellaneous Products	1.112	PPI Finished Goods.
B. All Other Services	6.901	
(1.) Business Services	2.337	ECI—Compensation for Private Workers in Business Services.
(2.) Computer Services	1.415	AHE Computer & Data Processing Services.
(3.) Transportation Services	0.195	CPI–U Transportation.
(4.) Telephone Services	0.549	CPI–U Telephone Services.
(5.) Postage	0.282	CPI–U Postage.
(6.) All Other: Labor Intensive	1.767	ECI—Compensation for Private Service Occupations.
(7.) All Other: Nonlabor Intensive	0.356	CPI–U All Items.
Total	100.000	

Note: Due to rounding, weights may not sum to total.

Table 8, below, shows what the excluded hospital weights would be if cost data for all excluded hospitals had been used.

TABLE 8.—1992 EXCLUDED HOSPITAL OPERATING COST CATEGORIES, WEIGHTS, AND PROXIES USING DATA FROM ALL EXCLUDED HOSPITALS

Expense categories	Rebased 1992 excluded hospital market basket	Price proxy
1. Compensation	68.074	
A. Wages and Salaries	55.714	HCFA Occupational Wage Index.
B. Employee Benefits	12.360	HCFA Occupational Benefits Index.
2. Professional Fees	2.073	ECI—Compensation for Professional, Specialty & Technical.
3. Utilities	2.191	
A. Fuel, Oil, and Gasoline	0.306	PPI Refined Petroleum Products.
B. Electricity	1.196	PPI Commercial Electric Power.
C. Natural Gas	0.595	PPI Commercial Natural Gas.
D. Water and Sewerage	0.094	CPI–U Water & Sewerage Maintenance.
4. Professional Liability Insurance	1.081	HCFA Professional Liability Insurance Premiums Index.
5. All Other	26.582	
A. All Other Products	20.333	
(1.) Pharmaceuticals	2.704	PPI Ethical (Prescription) Drugs.
(2.) Food	3.069	
a. Direct Purchase	2.096	PPI Processed Foods & Feeds.
b. Contract Service	0.973	CPI–U Food Away From Home.
(3.) Chemicals	3.367	PPI Industrial Chemicals.
(4.) Medical Instruments	2.775	PPI Medical Instruments & Equipment.

TABLE 8.—1992 EXCLUDED HOSPITAL OPERATING COST CATEGORIES, WEIGHTS, AND PROXIES USING DATA FROM ALL EXCLUDED HOSPITALS—Continued

Expense categories	Rebased 1992 excluded hospital market basket	Price proxy
(5.) Photographic Supplies	0.354	PPI Photographic Supplies.
(6.) Rubber and Plastics	4.319	PPI Rubber & Plastic Products.
(7.) Paper Products	1.829	PPI Converted Paper & Paperboard Products.
(8.) Apparel	0.777	PPI Apparel.
(9.) Machinery and Equipment	0.187	PPI Machinery & Equipment.
(10.) Miscellaneous Products	0.953	PPI Finished Goods.
B. All Other Services	6.248	
(1.) Business Services	2.337	ECI—Compensation for Private Workers in Business Services.
(2.) Computer Services	1.213	AHE Computer & Data Processing Services.
(3.) Transportation Services	0.167	CPI–U Transportation.
(4.) Telephone Services	0.471	CPI–U Telephone Services.
(5.) Postage	0.242	CPI–U Postage.
(6.) All Other: Labor Intensive	1.514	ECI—Compensation for Private Service Occupations.
(7.) All Other: Nonlabor Intensive	0.305	CPI–U All Items.
Total	100.000	

The relatively small differences in weights between the proposed excluded hospital market basket data from excluded hospitals that have a Medicare length of stay within 15 percent of the total facility average length of stay and the excluded hospital market basket using data from all excluded hospitals do not lead to significant changes in the rate of price growth for these two market baskets. If all individual wages and prices move at about the same annual rate, both market baskets could have about the same price growth even if weights are somewhat different. Also, offsetting price increases for various costs components can result in the price growth being the same.

To examine the sensitivity of the change to the limited set of excluded hospitals, we developed a comparison for the period 1988–1998. Using historical data and forecasts for the market baskets, we compared limited and full sets of excluded hospitals.

TABLE 9.—A COMPARISON OF THE PROPOSED EXCLUDED HOSPITAL MARKET BASKET AND THE EXCLUDED HOSPITAL MARKET BASKET REBASED USING ALL EXCLUDED HOSPITALS, PERCENT CHANGE, 1988–1998

Federal fiscal year	Proposed excluded (+/−15%) hospital market basket—1992 base	Excluded hospital market basket using all excluded hospitals—1992 base	Difference
Historical:			
1988	4.8	4.8	0.0
1989	5.5	5.5	0.0
1990	4.5	4.6	(0.1)
1991	4.3	4.4	(0.1)
1992	3.1	3.2	(0.1)
1993	3.1	3.2	(0.1)
1994	2.6	2.7	(0.1)
1995	3.3	3.2	0.1
Forecasted:			
1996	2.6	2.6	0.0
1997	2.7	2.7	0.0
1998	2.9	2.9	0.0
Historical average:			
1988–1995	3.9	4.0	(0.1)
Forecasted average:			
1996–1998	2.7	2.7	0.0

Note that the historical average rate of growth for 1988–1995 for the proposed excluded hospital market basket including only excluded hospitals with Medicare average length of stay within 15 percent of total facility average length of stay is virtually identical to that for the excluded hospital market basket with all excluded hospitals. The rates of growth using the two methodologies are identical for FY 1996, 1997, and 1998.

B. Capital Costs

Rebasing the Capital Input Price Index

1. Background

Effective for cost reporting periods beginning on or after October 1, 1995, the Capital Input Price Index (CIPI) is used to determine the price increase associated with prospective payment hospital capital-related expenses. Capital-related expenses are defined as depreciation expenses, capital-related interest expenses, and other capital-related expenses, such as insurance and taxes. The CIPI measures the input price change of these capital-related expenses, and is included in the capital prospective payment update framework to determine a rate of increase in capital prospective payments.

Like the prospective payment hospital operating input price index, the CIPI is a fixed-weight price index. A fixed-weight price index measures how much it would cost at a later date to purchase the same mix of goods and services purchased in the base period. For the prospective payment hospital operating and capital input price indexes, the base period is selected and cost category weights are determined using available data on hospitals. Next, appropriate price proxy indexes are chosen for each cost category. Then a price proxy index level for each expenditure category is multiplied by the comparable cost category weight. The sum of these products (that is, weights multiplied by price proxy index levels) for all cost categories yields the composite index level of the market basket for a given

year. Repeating the step for other years produces a time series of composite market basket index levels. Dividing an index level by a later index level produces a rate of growth in the input price index. Since the percent change is computed for the fixed mix of total capital inputs with a 1992 base, the index is called fixed-weight.

Like the operating input price index, the CIPI measures the price changes associated with costs during a given year. In order to do so, the CIPI must differ from the operating input price index in one important aspect. The CIPI must reflect 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. The most recent discussion on the CIPI and methodological background was published in the September 1, 1995 final rule (60 FR 45817). The following Federal Register documents 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).

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, both the operating input price index and the CIPI are based to FY 1987. We are proposing that the base year cost structure be updated to FY 1992, the most recent year with relatively complete data for purposes of rebasing. We explain the process of rebasing the cost structure weights for the CIPI below.

2. Rebasing the Capital Input Price Index

We are proposing to use a rebased capital input price index (CIPI) in developing the FY 1997 capital update factor for capital prospective payment rates. The new CIPI would be rebased to reflect the 1992, rather than the 1987, structure of capital costs. In developing the rebased CIPI, we reviewed hospital capital expenditure data for capital cost categories (depreciation, interest, and other). Two sets of weights had to be developed in order to compute the rebased CIPI: (1) cost category weights which identify the proportion of total hospital capital expenditures attributable to each capital expenditure category, and (2) relative vintage weights for depreciation and interest which identify the proportion of capital expenditures within a cost category that are attributable to each year over the life of capital assets in that category. Because capital expense data in the Medicare Cost Reports is not available prior to 1980 for use in computing vintage weights, the two sets of weights are measured using the best data sources available as explained below and in Appendix C to this proposed rule. The computations involved with rebasing the CIPI are explained for each of these sets of weights.

a. Capital Cost Category Weights. The capital cost category weights in Table 1 below were computed using a combination of the FY 1992 Medicare Cost Reports and 1992 AHA Annual Survey data. Fiscal Year 1992 marked the first year for expanded capital data available in the Medicare Cost Reports. After reviewing the data, we determined that much of the data had been reclassified into different expense categories. Therefore, we removed reports that appeared to have reclassified data, and matched the remaining reports to the corresponding reports in the AHA Annual Survey data set. These remaining 2724 reports were used to compute capital cost category weights and the expected life of capital, which is used in determining vintage weights for depreciation and interest.

In reviewing the data, we determined that the Medicare Cost Reports provided accurate data for depreciation and other capital expenses, but had reclassified interest data. We determined that AHA Annual Survey data more accurately reflected interest expense, based on past trends in interest rates. Therefore, we used the AHA Annual Survey interest levels along with the Medicare Cost Report levels for depreciation and other capital expenses to develop a more robust capital cost data base.

After removing depreciation, interest, and other capital expenses from total capital expenses, the remainder constitutes lease expenses. Lease expenses are not a separate cost category in the CIPI. They are distributed to the other cost categories (depreciation, interest, other), reflecting an assumption that the underlying cost structure of leases is similar to capital costs in general. We assigned 10 percent of lease expenses to the other capital expenses cost category as overhead, and the remaining lease expenses were distributed to the three cost categories based on the weights of depreciation, interest, and other capital expenses not including lease expenses. (We base this assignment of 10 percent of lease expenses to overhead on the common assumption that overhead is 10 percent of costs.)

We also used the 1992 Medicare Cost Reports to determine weights for the building and fixed equipment category and the movable equipment category. Expenses for building and fixed equipment and for movable equipment were determined using the same sample of reports as was used to compute the major cost category weights. The split between building and fixed equipment and movable equipment was also used to compute the vintage weights described below. Table 10 presents a comparison of the rebased 1992 capital cost weights and the 1987 capital cost weights.

We only used those hospital reports which we considered to have capital data that was not reclassified. Because we did not use all hospital reports, we were concerned that the hospitals used may not be representative of the universe. Therefore, we compared the distribution of costs for the hospitals used with the data re-weighted to reflect the characteristics of the total universe of hospitals. From this analysis we validated that the cost weights derived from the subset we used were representative of the cost weights for the entire universe of hospitals.

TABLE 10—COMPARISON OF 1987 AND 1992 COST CATEGORY WEIGHTS

Expense categories	FY1987	Rebased FY1992	Price proxy
Total	1.0000	1.0000	
Total depreciation	.6510	.6484	
1. Building and fixed equipment depreciation	.3054	.3009	Boeckh Institutional Construction Index—vintage weighted (22 yrs)
2. Movable equipment depreciation	.3456	.3475	PPI for Machinery and Equipment—vintage weighted (10 yrs)
Total interest	.3274	.3184	
1. Government/Non Profit Interest	.2783	.2706	Average Yield on Domestic Municipal Bonds (Bond Buyer 20 bonds)—vintage weighted (22 yrs)
2. For-Profit Interest	.0491	.0478	Average Yield on Moody's AAA Bonds—vintage weighted (22 yrs)
Other	.0216	.0332	CPI (U) for Residential Rent

Source: 1992 Medicare Cost Reports, PPS year 9; 1992 AHA Annual Survey.
Note: Due to rounding, weights may not sum to totals.

We had planned to incorporate the 1992 data from the Department of Commerce for developing capital cost category weights. However, these data were not available when we developed this proposed rule. If the data become available in time to for us to analyze it, we plan to incorporate it as a data input for the final rule.

b. Relative Vintage Weights for Prices. As we have explained in previous Federal Register documents (September 1, 1995, 60 FR 45817), the CIPI was developed to capture the vintage nature of capital; that is, because capital is acquired and consumed over time, the capital expenses in any given year are determined by past and current purchases of physical and financial capital. Therefore, a vintage-weighted CIPI was developed which used vintage weights for depreciation (physical capital) and interest (financial capital) to capture the long-term consumption of capital. These vintage weights reflect the purchase patterns of building and fixed equipment and movable equipment over time. Because depreciation and interest expenses are determined by the amount of past and current capital purchases, we use the vintage weights to compute vintage-weighted price changes associated with depreciation and interest expense, which is the purpose of the CIPI.

To compute the vintage weights for depreciation and interest expenses, we used a time series of capital purchases for building and fixed equipment and movable equipment. We found no single source that provides the best time series of capital purchases by hospitals for all of the above components of capital purchases. The Medicare Cost Reports did not have sufficient capital data to meet this need. The AHA Panel Survey provides a consistent database back to 1963. While the AHA Panel Survey data does not provide annual capital purchases, it does provide a time series of depreciation and interest expenses, which can be used to infer capital purchases over time. The process of using the AHA data to estimate a time series of capital purchases, and eventually vintage weights, is explained in detail below.

In order to estimate capital purchases from AHA data on depreciation and interest expenses, the expected life for building and fixed equipment, for movable equipment, and for debt instruments is needed. The expected life is used in the calculation of vintage weights for building and fixed equipment, movable equipment, and debt instruments as we explain below.

We used the same sample of hospitals from FY 1992 Medicare Cost Reports and the 1992 AHA Annual Survey explained above in computing cost category weights to compute the expected life of building and fixed equipment and movable equipment. (The AHA Panel Survey is a monthly survey of a sample of hospitals, while the AHA Annual Survey is a more detailed survey of all hospitals.) The expected life of any piece of equipment can be determined by dividing the historical asset cost (excluding fully depreciated assets) by the current year depreciation amount. This calculation yields the estimated useful life of an asset if depreciation continued at current year levels, assuming straight-line depreciation, which is the only depreciation method allowed under Medicare. From the FY 1992 costs reports, the expected life of building and fixed equipment was determined to be 22 years, and the expected life of movable equipment was determined to be 10 years. By comparison, the expected life using FY 1987 data was 25 years for building and fixed equipment and 10 years for movable equipment.

It was also necessary to compute the expected life of debt instruments held by hospitals. As in prior exercises, we used hospital issuances of municipal and commercial bonds from Securities Data Corporation to determine the expected life of hospital debt instruments, which is used in the estimation of vintage weights for interest expense. This data source produced a weighted average life for the two types of bonds of 22 years for FY 1992, the same expected life as was computed for the 1987-based CIPI.

An annual series of total expenses and depreciation expenses was obtained from the AHA Panel Survey. For the calculation of vintage weights, this expense data was needed back to 1963. However, the depreciation expense data in the AHA Panel survey was available only back to 1976. We noticed an increasing trend in depreciation expenses as a percentage of total expenses. We performed a regression on this percentage, and used the regression equation to estimate depreciation expenses back to 1963. We then used the fixed and movable weights derived from the FY 1992 Medicare Cost Reports to partition the AHA Panel Survey depreciation expenses into annual amounts of building and fixed depreciation and movable depreciation.

Multiplying the annual depreciation amounts by the expected life calculations from the FY 1992 Medicare cost reports, year-end asset costs for building and fixed equipment and movable equipment were determined. Then by subtracting the previous year asset costs from the current year asset costs, annual purchases of building and fixed equipment and movable equipment were estimated back to 1963. This capital purchase time series is then used to compute the vintage weights for building and fixed equipment, movable equipment, and debt instruments. Each of these sets of vintage weights is explained in detail below.

For building and fixed equipment vintage weights, the real annual capital purchase amounts for building and fixed equipment derived from the AHA Panel Survey were used. The real annual purchase amount was used to capture the actual amount of the physical acquisition, net of the effect of price inflation. This real annual purchase amount for building and fixed equipment was produced by deflating

the nominal annual purchase amount by the building and fixed equipment price proxy, the Boeckh institutional construction index. Because building and fixed equipment has an expected life of 22 years, the vintage weights for building and fixed equipment were deemed to represent the average purchase pattern of building and fixed equipment over 22-year periods. With real building and fixed equipment purchase estimates available back to 1963, nine 22-year periods could be averaged to determine the average vintage weights for building and fixed equipment. Averaging different periods produces vintage weights that are representative of average building and fixed equipment purchase patterns over time. Vintage weights for each 22-year period are calculated by dividing the real building and fixed capital purchase amount in any given year by the total amount of purchases in the 22-year period. For example, for the 22-year period of 1964–1985, the vintage weight for year 1 is calculated by dividing the real annual capital purchase amount of building and fixed equipment in 1964 into the total amount of real annual capital purchases of building and fixed equipment over the entire 1964–1985 period. This calculation is done for each year in the 22-year period, and for each of the nine 22-year periods. An average is taken of the nine 22-year periods to determine the FY 1992 average building and fixed equipment vintage weights, presented in Table 11 with the FY 1987 vintage weights.

For movable equipment vintage weights, the real annual capital purchase amounts for movable equipment derived from the AHA Panel Survey were used. The real annual purchase amount was used to capture the actual amount of the physical acquisition, net of price inflation. This real annual purchase amount for movable equipment was produced by deflating the nominal annual purchase amount by the movable equipment price proxy, the Producer Price Index for machinery and equipment. Because movable equipment has an expected life of 10 years, the vintage weights for movable equipment were deemed to represent the average purchase pattern of movable equipment over 10-year periods. With real movable equipment purchase estimates available back to 1963, 21 10-year periods could be averaged to determine the average vintage weights for movable equipment. Averaging different periods produces vintage weights which are representative of average movable equipment purchase patterns over time. Vintage weights for each 10-year period are calculated by dividing the real movable capital purchase amount for any given year by the total amount of purchases in the 10-year period. For example, for the 10-year period of 1976–1985, the vintage weight for year 1 is calculated by dividing the real annual capital purchase amount of movable equipment in 1976 into the total amount of real annual capital purchases of movable equipment over the entire 1976–1985 period. This calculation is done for each year in the 10-year period, and for each of the 21 10-year periods. The average of the 21 10-year periods is used to determine the FY 1992 average movable equipment vintage weights, presented in Table 11 with the FY 1987 vintage weights.

For interest vintage weights, the nominal annual capital purchase amounts for total equipment (building and fixed, and movable) derived from the AHA Panel Survey were used. Nominal annual purchase amounts were used to capture the value of the debt instrument. Because debt instruments have an expected life of 22 years, the vintage weights for interest were deemed to represent the average purchase pattern of total equipment over 22-year periods. With nominal total equipment purchase estimates available back to 1963, nine 22-year periods could be averaged to determine the average vintage weights for interest. Averaging different periods produces vintage weights which are representative of average capital purchase patterns over time. Vintage weights for each 22-year period are calculated by dividing the nominal total capital purchase amount for any given year by the total amount of purchases in the 22-year period. For example, for the 22-year period of 1964–1985, the vintage weight for year 1 is calculated by dividing the nominal annual capital purchase amount of total equipment in 1964 into the total amount of nominal annual capital purchases of total equipment over the entire 1964–1985 period. This calculation is done for each year in the 22-year period, and for each of the nine 22-year periods. The average of the nine 22-year periods is used to determine the FY 1992 average interest vintage weights, presented in Table 11 with the FY 1987 weights.

TABLE 11.—VINTAGE WEIGHTS FOR CAPITAL-RELATED PRICE PROXIES

Year	Building and fixed equipment		Movable equipment		Interest	
	FY1987 25 yrs	Rebased FY1992 22 yrs	FY1987 10 yrs	Rebased FY1992 10 yrs	FY1987 22 yrs	Rebased FY1992 22 yrs
1	.015	.019	.064	.069	.007	.007
2	.019	.020	.072	.075	.009	.008
3	.022	.023	.077	.083	.010	.010
4	.024	.026	.085	.091	.011	.012
5	.023	.028	.095	.097	.013	.014
6	.022	.030	.101	.103	.015	.016
7	.020	.031	.109	.109	.017	.018
8	.021	.032	.122	.115	.020	.021
9	.025	.036	.132	.124	.023	.024
10	.030	.039	.142	.133	.027	.029
11	.033	.043	.....	.....	.032	.035
12	.034	.047	.....	.....	.038	.041
13	.034	.050	.....	.....	.043	.047
14	.035	.052	.....	.....	.050	.052
15	.038	.055	.....	.....	.057	.059
16	.043	.059	.....	.....	.064	.067
17	.049	.062	.....	.....	.074	.074
18	.053	.065	.....	.....	.083	.081
19	.056	.067	.....	.....	.090	.088

TABLE 11.—VINTAGE WEIGHTS FOR CAPITAL-RELATED PRICE PROXIES—Continued

Year	Building and fixed equipment		Movable equipment		Interest	
	FY1987 25 yrs	Rebased FY1992 22 yrs	FY1987 10 yrs	Rebased FY1992 10 yrs	FY1987 22 yrs	Rebased FY1992 22 yrs
20	.057	.069	.....	.....	.098	.093
21	.060	.072	.....	.....	.105	.099
22	.066	.073	.....	.....	.114	.103
23	.071	.....	.....	.....	.....	.....
24	.075	.....	.....	.....	.....	.....
25	.077	.....	.....	.....	.....	.....
Total	1.000	1.000	1.000	1.000	1.000	1.000

Sources: AHA Panel Survey, 1963–1993; 1992 Medicare Cost Reports; Securities Data Corporation.

3. Selection of Price Proxies

After the 1992 capital cost category weights were computed, it was necessary to select appropriate price proxies to monitor the rate of increase for each expenditure category. Our proposed price proxies for the FY 1992 based CIPI are the same as those for the FY 1987 based CIPI. The rationale for selecting the price proxies is explained in the June 2, 1995 proposed rule (60 FR 29227) and the September 1, 1995 final rule (60 FR 45817). The proposed price proxies are presented in Table 10.

4. Forecast of the CIPI for Federal Fiscal Year 1997

DRI forecasts a 1.0 percent increase in the rebased 1992 CIPI for FY 1997, as indicated in Table 12. This is the outcome of a 2.5 percent increase in projected depreciation prices (building and fixed equipment, and movable equipment) and a 2.3 percent increase in other capital expense prices in FY 1997, partially offset by a 3.0 percent decline in vintage-weighted interest rates in FY 1997.

TABLE 12.—HCFA CAPITAL INPUT PRICE INDEX PERCENT CHANGES, TOTAL AND COMPONENTS, FISCAL YEARS 1979 TO 2000

Fiscal Year	Total	Depreciation			Interest	Other
		Total	Building and fixed equipment	Movable equipment		
Weights (FY92)	1.0000	0.6484	0.3009	0.3475	0.3184	0.0332
Price Changes						
1979	5.4	7.4	7.0	7.7	2.7	7.1
1980	6.9	8.0	7.3	8.5	5.4	8.6
1981	8.7	8.5	7.7	9.1	9.1	8.8
1982	9.2	8.5	8.0	9.0	10.2	8.0
1983	6.7	8.1	7.9	8.2	4.8	6.3
1984	6.3	7.3	7.6	7.1	4.9	5.0
1985	5.2	6.3	7.0	5.8	3.5	5.9
1986	3.7	5.7	6.4	5.1	0.7	6.2
1987	3.1	5.1	5.9	4.5	−0.1	4.5
1988	3.0	4.6	5.4	4.0	0.3	3.8
1989	2.6	4.4	5.2	3.7	−0.5	3.8
1990	2.3	4.0	4.9	3.2	−0.7	4.2
1991	2.0	3.6	4.6	2.7	−1.1	3.9
1992	1.5	3.2	4.4	2.1	−2.0	2.6
1993	1.1	2.9	4.1	1.8	−2.8	2.4
1994	1.1	2.7	3.9	1.7	−2.7	2.3
1995	1.3	2.6	3.8	1.6	−2.0	2.5
1996	0.9	2.5	3.7	1.5	−3.1	2.4
1997	1.0	2.5	3.5	1.5	−3.0	2.3
1998	1.0	2.5	3.4	1.5	−3.1	3.0
1999	1.0	2.4	3.4	1.5	−3.1	2.4
2000	1.1	2.4	3.4	1.5	−3.2	2.8

Source: DRI/McGraw-Hill HCC, 1st Qtr 1996; @USSIM/TREND25YR0296 @CISSIM/CONTROL961.
Released By: HCFA, OACT, Office of National Health Statistics.

5. Comparison of Percent Changes in the FY 1992 Based CIPI and the FY 1987 Based CIPI

Rebasing the CIPI from 1987 to 1992 decreased the percent change in the FY 1997 forecast by only 0.2 percentage points, from 1.2 to 1.0 as indicated in Table 4. The effect of rebasing is analyzed by comparing the 1992-based CIPI forecasted percent changes to the 1987-based CIPI forecasted percent changes using the same DRI forecast of component prices. As shown in Table 13, there is only a 0.2 percentage point difference between the percent changes in the 1992-based CIPI and the 1987-based CIPI using the first quarter 1996 forecast. The difference is caused by changes to: (1) cost category weights, (2) expected life, and (3) vintage weights. The changes to cost category weights coupled with the wide disparity in price changes between the different cost categories contributed to lowering the CIPI percent change in the FY 1997 forecast. This was the case with fixed depreciation, which has faster price growth than the other cost categories and now has a lower weight by nearly one-half of a percentage point because of rebasing to 1992. Also contributing to the 0.2 percentage point difference in FY 1997 forecast is the change in the expected life of building and fixed equipment and the change in the vintage weights for all three components: building and fixed equipment, movable equipment, and interest. The shorter expected life (22 years in 1992 versus 25 years in 1987) of building and fixed equipment slightly decreased the FY 1997 forecast CIPI percent change because years with higher price increases were not included as they had been before. The change in vintage weights also tended to decrease the FY 1997 CIPI percent change because vintage weights in all cases changed to be spread more evenly over the life of the asset, decreasing the weight of more recent years and increasing the weight of past years. In the years around FY 1997, prices for depreciation and interest are projected to increase slightly faster than prices in earlier years.

TABLE 13.—COMPARISON OF 1987 AND 1992 BASED CAPITAL INPUT PRICE INDEX USING THE SAME DRI FORECAST, PERCENT CHANGE, 1979–1997

Federal fiscal year	CIPI	
	1987	Rebased 1992
1979	5.6	5.4
1980	7.1	6.9
1981	8.8	8.7
1982	9.3	9.2
1983	6.7	6.7
1984	6.3	6.3
1985	5.1	5.2
1986	3.7	3.7
1987	3.1	3.1
1988	3.0	3.0
1989	2.7	2.6
1990	2.4	2.3
1991	2.1	2.0
1992	1.7	1.5
1993	1.3	1.1
1994	1.3	1.1
1995	1.5	1.3
1996	1.2	0.9
1997	1.2	1.0

Source: DRI/McGraw-Hill HCC, 1st Qtr 1996; @USSIM/TREND25YR0296 @CISSIM/CONTROL961.

Released by: HCFA, OACT, Office of National Health Statistics.

6. Comparison of Percent Changes in the FY 1997 CIPI Forecast in the September 1, 1995 Federal Register and the current FY 1997 CIPI Forecast

The previously published CIPI forecast for FY 1997 of 1.7 percent has been revised to 1.0 percent in this proposed rule. As explained above in section IV.B.5, 0.2 percentage points of the decline was the result of rebasing the CIPI from 1987 to 1992. The remaining 0.5 percentage point difference in FY 1997 between the 1992-based CIPI and the 1987-based CIPI previously published is the result of revised projections by DRI. Since making a forecast in the second quarter of 1995 for the September 1, 1995 Federal Register, DRI has revised their projections of price changes downward for every cost category in the CIPI. This revised projection accounts for 0.5 of the 0.7 difference between the 1992-based CIPI percent changes and the 1987-based CIPI percent changes previously published.

V. Other Decisions and Proposed Changes to the Prospective Payment System for Inpatient Operating Costs

A. Sole Community Hospital Criteria (§ 412.92)

Under the prospective payment system, special payment protections are provided to hospitals that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals, are the sole source of hospital inpatient services reasonably available to Medicare beneficiaries. The criteria a hospital must meet to be classified as a sole community hospital (SCH) as well as the special payment adjustments available are set forth in the regulations at § 412.92.

One of the ways in which a hospital can qualify for sole community status is to be located between 25 and 35 miles from other like hospitals and prove that no more than 25 percent of residents who become inpatients or no more than 25 percent of the Medicare beneficiaries who become inpatients in the hospital's ''service area'' are admitted to other like hospitals located within a 35-mile radius of the hospital (or its service area, if larger).

In the rulemaking process for FY 1989, we addressed the criteria for qualification as a sole community hospital. ProPAC had recommended that we issue guidelines before the beginning of FY 1989 to promote greater uniformity in the criteria applied by regional offices to designate sole community hospitals. In the final rule published on September 30, 1988, we stated: ''A hospital may delineate its service area by identifying the zip codes of all its inpatients for the cost reporting period ending before the date it applies for SCH status. The lowest number of zip codes accounting for at least 75 percent of its inpatients would then constitute its service area.'' (53 FR 35810–11).

In March 1990, we issued a revised manual which inadvertently reflected policy prior to October 1, 1988; specifically, section 2810 A.2.c of the Medicare Provider Reimbursement Manual, Part 1 (HCFA Pub. 15–1) stated, ''A hospital may define its service area as the lowest number of contiguous zip codes from which the hospital draws at least 75 percent of its inpatients.'' (Emphasis added.) This revision does not accurately reflect the definition of ''service area'' that we set forth in the FY 1989 final rule in response to ProPAC's recommendation that we address the criteria for SCH status. It has come to our attention that, accordingly, some hospitals have raised questions about the definition of service area. In this proposed rule, we are clarifying that, consistent with the language in the September 30, 1988 final rule, our definition of ''service area'' for purposes of determining SCH status does not require contiguous zip code areas. We have applied this definition since October 1, 1988 (the effective date of the September 30, 1988 final rule). The

current manual inadvertently reflects previous policy, and does not reflect our current policy as set forth in the Federal Register and applied since October 1, 1988. We intend to revise the current manual accordingly at our earliest opportunity.

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 are the same. However, rural referral centers continue to receive special treatment under both the disproportionate share hospital payment adjustment and the criteria for geographic reclassification.

One of the criteria under which a rural hospital may qualify as a 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 (number of discharges and case-mix index) and at least one of three optional criteria (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. In determining the proposed national and regional case-mix index values, we follow the same methodology we used in the November 24, 1986 final rule, as set forth in regulations at § 412.96(c)(1)(ii). Therefore, 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 1995 (October 1, 1994 through September 30, 1995) and include bills posted to HCFA's records through December 1995. Therefore, in addition to meeting other criteria, we are proposing that to qualify for initial rural referral center status or to meet the triennial review standards for cost reporting periods beginning on or after October 1, 1996, a hospital's case-mix index value for FY 1995 would have to be at least—

- 1.3332; or
- Equal to 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 table below:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2292
2. Middle Atlantic (PA, NJ, NY)	1.2224
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3375
4. East North Central (IL, IN, MI, OH, WI)	1.2450
5. East South Central (AL, KY, MS, TN)	1.2911
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2178
7. West South Central (AR, LA, OK, TX)	1.3080
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3284
9. Pacific (AK, CA, HI, OR, WA)	1.3333

The above numbers will be revised in the final rule to the extent required to reflect the updated MedPAR file, which will contain data from additional bills received for discharges through September 30, 1995.

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 1995 case-mix index value in Table 3C in section V 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. However, 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 1994 (that is, October 1, 1993 through September 30, 1994). That is the latest year for which we have complete discharge data available.

Therefore, in addition to meeting other criteria, we are proposing that to qualify for initial rural referral center status or to meet the triennial review standards for cost reporting periods beginning on or after October 1, 1996, the number of discharges a hospital must have for its cost reporting period that began during FY 1995 would have to be at least—

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

Region	Number of discharges.
1. New England (CT, ME, MA, NH, RI, VT)	6812
2. Middle Atlantic (PA, NJ, NY)	9067
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	6972
4. East North Central (IL, IN, MI, OH, WI)	6958
5. East South Central (AL, KY, MS, TN)	5007
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	4216
7. West South Central (AR, LA, OK, TX)	4002
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	6992
9. Pacific (AK, CA, HI, OR, WA)	5669

We reiterate that, to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 1996, an osteopathic hospital's number of discharges for its cost reporting period that began during FY 1995 would have to be at least 3,000.

3. Retention of Referral Center Status

Section 412.96(f) states that each hospital receiving the referral center adjustment is reviewed every 3 years to

determine if the hospital continues to meet the criteria for referral center status. To retain status as a referral center, a hospital must meet the criteria for classification as a referral center specified in § 412.96 (b)(1) or (b)(2) or (c) for 2 of the last 3 years, or for the current year. A hospital may meet any one of the three sets of criteria for individual years during the 3-year period or the current year. For example, a hospital may meet the two mandatory requirements in § 412.96(c)(1) (case-mix index) and (c)(2) (number of discharges) and the optional criterion in paragraph (c)(3) (medical staff) during the first year. During the second or third year, the hospital may meet the criteria under § 412.96(b)(1) (rural location and appropriate bed size).

A hospital must meet all of the criteria within any one of these three sections of the regulations in order to meet the retention requirement for a given year. That is, it will have to meet all of the criteria of § 412.96(b)(1) or § 412.96(b)(2) or § 412.96(c). For example, if a hospital meets the case-mix index standards in § 412.96(c)(1) in years 1 and 3 and the number of discharge standards in § 412.96(c)(2) in years 2 and 3, it will not meet the retention criteria. All of the standards would have to be met in the same year.

In accordance with § 412.96(f)(2), the review process is limited to the hospital's compliance during the last 3 years. Thus, if a hospital meets the criteria in effect for at least 2 of the last 3 years or if it meets the criteria in effect for the current year (that is, the criteria for FY 1997 outlined above in this section of the preamble), it will retain its status for another 3 years. We have constructed the following chart and example to aid hospitals that qualify as referral centers under the criteria in § 412.96(c) in projecting whether they will retain their status as a referral center.

Under § 412.96(f), to qualify for a 3-year extension effective with cost reporting periods beginning in FY 1997, a hospital must meet the criteria in § 412.96(c) for FY 1997 or it must meet the criteria for 2 of the last 3 years as follows:

For the cost reporting period beginning during FY	Use hospital's case-mix index for FY	Use the discharges for the hospital's cost reporting period beginning during FY	Use numerical standards as published in the FEDERAL REGISTER on
1996	1994	1994	September 1, 1995.
1995	1993	1993	September 1, 1994.
1994	1992	1992	September 1, 1993.

Example: A hospital with a cost reporting period beginning July 1 qualified as a referral center effective July 1, 1994. The hospital has fewer than 275 beds. Its 3-year status as a referral center is protected through June 30, 1997 (the end of its cost reporting period beginning July 1, 1996). To determine if the hospital should retain its status as a referral center for an additional 3-year period, we will review its compliance with the applicable criteria for its cost reporting periods beginning July 1, 1994, July 1, 1995, and July 1, 1996. The hospital must meet the criteria in effect either for its cost reporting period beginning July 1, 1997, or for two out of the three past periods. For example, to be found to have met the criteria at § 412.96(c) for its cost reporting period beginning July 1, 1995, the hospital's case-mix index value during FY 1993 must have equaled or exceeded the lower of the national or the appropriate regional standard as published in the September 1, 1994 final rule with comment period. The hospital's total number of discharges during its cost reporting year beginning July 1, 1993, must have equaled or exceeded 5,000 or the regional standard as published in the September 1, 1994 final rule with comment period.

For those hospitals that seek to retain referral center status by meeting the criteria of § 412.96(b)(1) (i) and (ii) (that is, rural location and at least 275 beds), we will look at the number of beds shown for indirect medical education purposes (as defined at § 412.105(b)) on the hospital's cost report for the appropriate year. We will consider only full cost reporting periods when determining a hospital's status under § 412.96(b)(1)(ii). This definition varies from the number of beds criterion used to determine a hospital's initial status as a referral center because we believe it is important for a hospital to demonstrate that it has maintained at least 275 beds throughout its entire cost reporting period, not just for a particular portion of the year.

C. Disproportionate Share Adjustment (§ 412.106)

Section 1886(d)(5)(F) of the Act provides for additional payments for hospitals that serve a disproportionate share of low income patients. The disproportionate share adjustment, which was added to the prospective payment system by section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272), was intended to address the higher Medicare costs associated with treating a large number of low-income patients. Under this provision, patients who are eligible for Medicaid and Supplemental Security Income (SSI) benefits were used as a proxy measure of the proportion of low-income patients.

A hospital's disproportionate share adjustment is determined by calculating the sum of two patient percentages (Medicare Part A/Supplemental Security Income (SSI) covered days to total Medicare Part A covered days, and Medicaid but not Medicare Part A covered days to total inpatient hospital days). Based on the location and size of the hospital, a formula determines if the hospital's patient percentage qualifies the hospital for an adjustment and how much that adjustment will be.

With respect to the Medicare-SSI calculation, hospitals have expressed dissatisfaction with these proxy measures, and have challenged HCFA's implementation of them in recent litigation. Since SSI beneficiary information is confidential, hospitals do not have access to lists of patients who are eligible for both Medicare Part A and SSI benefits. Hospitals are increasingly frustrated by their inability to monitor these data.

With respect to the Medicaid fraction, hospitals have complained that, because of Medicaid coverage restrictions, Medicaid covered days may not be a consistent measure of indigent care across States. Medicaid reforms under consideration by the President and Congress may further interfere with the utility of Medicaid covered days as a measure of the proportion of low-income patients.

Because of these concerns, we have been examining alternative measures of indigent care. Some of the measures we have explored using are estimates of patient income in a hospital's service area, hospital levels of bad debt, and proportion of emergency room admissions in a hospital. Because of data and other limitations, however, we have yet to find an alternative that appears promising as a replacement to

the present measure. We are, therefore, soliciting comments from the industry on better and more direct measures of indigent care than the present measure that relies on SSI and Medicaid data. Our preference would be to use data that are already available. We would, however, be open to considering measures that require new data collection if we were convinced that the result would be beneficial to hospitals and HCFA. We note that since HCFA is bound by the current statutory provisions, we cannot revise the disproportionate share adjustment without legislative action.

We note that ProPAC is also concerned with these issues. In its March 1, 1996 report, ProPAC recommended that the structure of the disproportionate share adjustment be reviewed to make certain that available funds are distributed equitably among the hospitals most in need of assistance. (Recommendation 18.) The Commission believes that Medicaid utilization has never been an optimal measure of service to low-income patients and is also concerned with the impact of possible reform in the structure of Medicaid. Thus, ProPAC recommends that a comprehensive review of the disproportionate share adjustment be undertaken, including assessment of the objectives of this payment and defining the population and scope of care to be covered. Alternative measures of low-income patient care could then be considered, including any data collection necessary. As discussed above, we agree with ProPAC that new measures should be explored. We believe that this is a first step in reforming the payment formula for the disproportionate share adjustment. We also recognize that the development of a better measure of the services hospitals provide to indigent patients may require the collection of new data.

In addition, ProPAC is concerned about the potential impact of reductions in the disproportionate share payments. (Recommendation 17.) The Commission believes that hospitals that treat a large number of the uninsured could be particularly vulnerable because of recent changes in the health care environment. ProPAC cautions against large reductions in disproportionate share payments that would threaten the continued ability of many hospitals to serve populations who depend on them for access to care. We note that the President's FY 1997 budget does not include any reduction in payment for disproportionate share hospitals.

D. Direct Graduate Medical Education (§ 413.86)

1. Initial Residency Period Limitations

We are updating the Initial Residency Period Limitations for direct graduate medical education (GME), originally published in the Federal Register on September 29, 1989 (54 FR 40286). The regulations in § 413.86(g)(1) state that, ''[e]ffective July 1, 1995, an initial residency period is defined as the minimum number of years required for board eligibility.''

The update reflects the following:

- Effective July 1, 1995, section 1886(h)(5)(F) of the Act, as amended by Public Law 103–66, defines an initial residency period as the minimum number of years required for initial board eligibility. Previously, this period had been defined as minimum number of years ''plus one.'' The prior listing had included the additional year, not to exceed five years.
- Changes in curriculum requirements regarding the number of years needed for board eligibility for previously approved programs.
- Addition of newly approved graduate medical education programs.

INITIAL RESIDENCY PERIOD LIMITATIONS

Residency type	Initial Residency Period Limitation (No. of years)
Allopathy	
ANESTHESIOLOGY	4
Critical Care Medicine	4
Pain Management	4
COLON AND RECTAL SURGERY	5
DERMATOLOGY	4
Dermatopathology	4
Clinical & Laboratory Dermatological Immunology	4
EMERGENCY MEDICINE	3/4
Sports Medicine	3
FAMILY PRACTICE	3
Geriatric Medicine	5
Sports Medicine	3
INTERNAL MEDICINE	3
Adolescent Medicine	3
Cardiovascular Disease	3
Clinical Cardiac Electrophysiology	3
Clinic & Laboratory Immunology	3
Critical Care Medicine	3
Endocrinology, Diabetes, and Metabolism	3
Gastroenterology	3
Geriatric Medicine	5
Hematology	3
Hematology and Oncology	3
Infectious Disease	3
Medical Oncology	3
Nephrology	3
Pulmonary Disease	3
Pulmonary Disease and Critical Care Medicine	3
Rheumatology	3
Sports Medicine	3
MEDICAL GENETICS	4

INITIAL RESIDENCY PERIOD LIMITATIONS—Continued

Residency type	Initial Residency Period Limitation (No. of years)
NEUROLOGICAL SURGERY	5
Pediatric Neurological Surgery	5
NEUROLOGY	4
Child Neurology	4
Clinical Neurophysiology	4
NUCLEAR MEDICINE	3
OBSTETRICS AND GYNECOLOGY	4
Critical Care Medicine	4
Gynecological Oncology	4
Maternal and Fetal Medicine	4
Reproductive Endocrinology	4
OPHTHALMOLOGY	4
ORTHOPAEDIC SURGERY	5
Adult Reconstructive Orthopaedics	5
Foot and Ankle Orthopaedics	5
Hand Surgery	5
Musculoskeletal Oncology	5
Pediatric Orthopaedics	5
Spinal Cord Injury	5
Sports Medicine	5
OTOLARYNGOLOGY	5
Neurotology/Otolaryngology	5
Pediatric Otolaryngology	5
PATHOLOGY, ANATOMIC AND CLINICAL	4
Blood Banking/Transfusion Medicine	4
Chemical Pathology	4
Cytopathology	4
Dermatopathology	4
Forensic Pathology	4
Hematology	4
Immunopathology	4
Medical Microbiology	4
Neuropathology	4
Pediatric Pathology	4
PEDIATRICS	3
Adolescent Medicine	3
Clinical and Laboratory Immunology	3
Neonatal-Perinatal Medicine	3
Pediatric Cardiology	3
Pediatric Critical Care Medicine	3
Pediatric Emergency Medicine	3
Pediatric Endocrinology	3
Pediatric Gastroenterology	3
Pediatric Hematology/Oncology	3
Pediatric Infectious Disease	3
Pediatric Nephrology	3
Pediatric Opthamology	3
Pediatric Pulmonology	3
Pediatric Rheumatology	3
Pediatric Sports Medicine	3
PHYSICAL MEDICINE AND REHABILITATION	4
PLASTIC SURGERY	5
Hand Surgery	5
PREVENTIVE MEDICINE	3
Aerospace Medicine	3
Medical Toxicology	3
Occupational Medicine	3
Public Health & General Preventive Medicine	3
PSYCHIATRY	4
Addiction Medicine	4
Child & Adolescent Psychiatry	4
Forensic Psychiatry	4
Geriatric Psychiatry	4
RADIOLOGY, DIAGNOSTIC	4
Neuroradiology	4
Nuclear Radiology	4
Pediatric Radiology	4
Vascular and Interventional Radiology	4
Radiation Oncology	4

INITIAL RESIDENCY PERIOD LIMITATIONS—Continued

Residency type	Initial Residency Period Limitation (No. of years)
SURGERY, GENERAL	5
Critical Care Medicine	5
Hand Surgery	5
Pediatric Surgery	5
Thoracic Surgery	5
Vascular Surgery	5
UROLOGY	5
Pediatric Urology	5
Osteopathy	
ANESTHESIOLOGY	4
Critical Care Medicine	4
DERMATOLOGY	4
Dermatopathology	4
MOHS Micrographic Surgery	4
EMERGENCY MEDICINE	4
Sports Medicine	4
FAMILY PRACTICE	3
Adolescent and Young Adult Medicine	3
Geriatrics	5
Sports Medicine	3
INTERNAL MEDICINE	4
Clinical Allergy and Immunology	4
Cardiology	4
Endocrinology	4
Gastroenterology	4
Hematology	4
Infectious Diseases	4
Nephrology	4
Oncology	4
Pulmonary Diseases	4
Rheumatology	4
Clinical Cardiac Electrophysiology	4
Critical Care Medicine	4
Geriatrics	6
Sports Medicine	4
NUCLEAR MEDICINE	4
In-Vivo and In-Vitro Nuclear Medicine	4
Nuclear Cardiology	4
Nuclear Imaging and Therapy	4
NEUROLOGY	4
Child Neurology	4
PSYCHIATRY	4
Child Psychiatry	4
OBSTETRICS/GYNECOLOGY	5
Maternal and Fetal Medicine	5
Gynecological Oncology	5
Reproductive Endocrinology	5
FACIAL PLASTIC SURGERY	5
OPHTHALMOLOGY	4
OTORHINO/FACIAL PLASTIC SURGERY	5
OTORHINOLARYNGOLOGY	5
ORTHOPEDIC SURGERY	5
PATHOLOGY, ANATOMIC	4
PATHOLOGY, ANATOMIC/LABORATORY MEDICINE	5
PATHOLOGY, LABORATORY MEDICINE	4
Forensic Pathology	5
Blood Banking/Transfusion Medicine	5
Chemical Pathology	5
Cytopathology	5
Dermatopathology	5
Hematology	5
Immunopathology	5
Medical Microbiology	5
Neuropathology	5
PEDIATRICS	3
Adolescent and Young Adult Medicine	3
Neonatal Medicine	3
Pediatric Allergy/Immunology	3
Pediatric Cardiology	3

INITIAL RESIDENCY PERIOD LIMITATIONS—Continued

Residency type	Initial Residency Period Limitation (No. of years)
Pediatric Hematology/Oncology	3
Pediatric Infectious Diseases	3
Pediatric Intensive Care	3
Pediatric Nephrology	3
Pediatric Pulmonology	3
Pediatric Sports Medicine	3
PREVENTATIVE MEDICINE	4
PROCTOLOGY	3
RADIATION ONCOLOGY	4
RADIOLOGY, DIAGNOSTIC	5
Angiography and Interventional Radiology	5
Diagnostic Ultrasound	5
Neuroradiology	5
Nuclear Radiology	5
Radiological Imaging	5
Pediatric Radiology	5
REHABILITATION MEDICINE	4
Sports Medicine	4
GENERAL SURGERY	5
NEUROSURGERY	5
PLASTIC AND RECONSTRUCTIVE SURGERY	5
THORACIC CARDIOVASCULAR SURGERY	5
UROLOGICAL SURGERY	5
GENERAL VASCULAR SURGERY	5
CRITICAL CARE SURGERY	5
OSTEOPATHIC MANIPULATIVE MEDICINE	3
Podiatry	
ROTATING PODIATRIC RESIDENCY (PRIMARY CARE)	2
PODIATRIC ORTHOPEDIC RESIDENCY	2
PODIATRIC SURGICAL RESIDENCY	2
Dentistry	
DENTAL PUBLIC HEALTH	1
ENDODONTICS	2
ORAL PATHOLOGY	3
ORAL AND MAXILLOFACIAL SURGERY	4
ORTHODONTICS	2
PEDIATRIC DENTISTRY	2
PERIODONTICS	3
PROSTHODONTICS	3
PROSTHODONTICS/MAXILLOFACIAL	3
GENERAL DENTISTRY	1
ADVANCED GENERAL DENTISTRY	2
Allopathy Combined Programs*	
FAMILY PRACTICE(3) AND PSYCHIATRY(4)	4
INTERNAL MEDICINE(3) & EMERGENCY MEDICINE(3)	3
INTERNAL MEDICINE(3) & FAMILY PRACTICE(3)	3
INTERNAL MEDICINE(3) & NEUROLOGY(4)	4
INTERNAL MEDICINE(3) & PEDIATRICS(3)	3
INTERNAL MED(3) & PHYS MED & REHABILITATION(4)	4
INTERNAL MEDICINE(3) & PREVENTIVE MEDICINE(3)	3
INTERNAL MEDICINE(3) & PSYCHIATRY(4)	4
NEUROLOGY(4) & PHYS MEDICINE AND REHAB(4)	4
PEDIATRICS(3) & EMERGENCY MEDICINE(3)	3
PEDIATRICS(3) & PHYSICAL MEDICINE AND REHAB(4)	4
PEDIATRICS(3)/PSYCHIATRY(4)/CHILD & ADOL PSYCH(4)	4
PSYCHIATRY(4) AND NEUROLOGY(4)	4

* For residents participating in combined programs, Medicare limits the initial residency period to the time required for individual certification in the longer of the two programs.

2. Combined Residency Programs

While updating the listing of the Initial Residency Period Limitations for GME, we noted many new programs were combined specialty residency programs. The combined programs run concurrently for a period of time that is longer than the required time for certification in either specialty, but shorter than would be required if the programs were taken sequentially. Residents completing these programs are eligible for board certification in both specialties.

We use the Internal Medicine and Pediatrics combined program as an example: Taken individually, Internal Medicine is a 3-year program and Pediatrics is also a 3-year program. However, taken as a combined program, Internal Medicine and Pediatrics is a 4-

year program, with certification in both specialties.

Currently, we are aware of 13 combined programs, including Internal Medicine/Pediatrics, Pediatrics/Emergency Medicine, Family Practice/Psychiatry, and Neurology/Physical Medicine and Rehabilitation.

Due to the increasing prevalence of combined residency programs since our September 29, 1989 final rule, we propose to clarify how the definition of initial residency period applies in such cases. While the combined programs may have advantages from an educational standpoint, the statutory limitation on payment for GME still applies. In the initial legislation for a per resident payment to hospitals for GME, Congress limited Medicare's liability for those payments to residents in their initial residency period plus one year. The plus-one-year provision allowed for payment for an additional year as a full FTE for residents who continued on in a second approved program after completing their initial certification. However, regardless of the number of additional years the second program required for certification, at most only the first year could be paid as a full FTE. All subsequent years are paid at a 0.5 FTE rate. When Congress revised section 1886(h) of the Act to remove the plus-one-year provision, Congress further restricted payment to allow payment as a full FTE for the first residency program only. All years of a subsequent program are now limited to the 0.5 FTE rate. Congress clearly wanted to further limit Medicare's payment obligations. Accordingly, we believe that the initial residency period limitation is designed to allow full Medicare payment only for the period required to train in one specialty.

For residents enrolled in combined programs, we are therefore proposing to define the initial residency period as the time required for individual certification in the longer of the two programs. Continuing to use Internal Medicine and Pediatrics as an example, we would define the initial residency for Internal Medicine and Pediatrics as 3 years. The remaining year of the combined program would be treated as 0.5 FTE, in accordance with the regulations at § 413.86(g)(3).

E. Distribution of an ''Important Message from Medicare'' (§ 489.27)

Under § 489.27 of our provider agreement regulations, all hospitals that participate in Medicare (including those not paid under the prospective payment system) must agree to furnish each Medicare beneficiary with a notice, at or about the time of admission, that explains the patient's discharge rights. This statement, entitled ''An Important Message from Medicare,'' advises a beneficiary of his or her rights to be fully informed about decisions affecting Medicare coverage or payment and about his or her appeal rights in response to any hospital's notice to the effect that Medicare will no longer cover the patient's care. The ''Important Message'' also advises the patient of what to do when he or she receives such a hospital statement and how to elicit more information.

In November 1993, the Medicare Technical Advisory Group (M–TAG) established the Beneficiary Protection and Documentation Issues Task Force. The task force consists of HCFA staff as well as representatives from health care industry organizations, beneficiary advocate groups, fiscal intermediaries, and peer review organizations (PROs). The task force was charged with reviewing various issues that impact beneficiaries and the health care community, including how to improve the effectiveness of ''An Important Message from Medicare.''

We are proposing to adopt a recommendation of this task force that would respond to numerous requests for clarification on the timing of the written notice of discharge rights that must be given to hospital inpatients. As noted above, existing § 489.27 specifies that a hospital must distribute the statement ''at or about the time of admission.'' We understand that for monitoring purposes some PROs have interpreted this requirement to mean ''within 24 hours preceding or following the admission.'' However, we agree with the task force's determination that the PRO's interpretation is unnecessarily narrow. We believe that during the first 24 hours of a patient's admission, the hospital is primarily concerned with ensuring appropriate treatment of the patient's illness or injury. Therefore, we are proposing to change § 489.27 to specify that the hospital must provide timely notice during the course of the hospital stay.

For purposes of this requirement, we would consider the course of the hospital stay to begin when the hospital provides the individual with a package of information regarding scheduled preadmission testing and registration for a planned hospital admission. This would give hospitals more flexibility in meeting the requirement, as well as encourage the distribution of the ''Important Message'' at a time when the beneficiary is better able to receive and more likely to understand its contents. In complying with the requirement to provide timely notice during the course of the patient's hospital stay, the hospital must give the patient the ''Important Message'' far enough in advance of the hospital's written notice regarding continued stay to provide the beneficiary time to appeal the hospital's decision. Finally, ''timely notice'' would also include adherence to any State requirements on the provision of patient rights notices.

The current version of the ''Important Message'' has been in use since 1988. As part of our effort to improve communication with Medicare beneficiaries, we will continue to evaluate the effectiveness of the ''Important Message'' and welcome suggestions for its improvement.

VI. Changes and Clarifications to the Prospective Payment System for Capital-Related Costs

A. Consistent Cost Finding During the Capital Transition Period (§ 412.302(d))

Section 412.302(d) of the regulations requires that, during the transition period to full prospective payment for capital-related costs, a hospital must follow consistent cost-finding methods for classifying and allocating capital-related costs. Specifically, the regulation requires that unless there is a change of ownership, a hospital must continue the same cost-finding methods for old capital costs, including its practices for direct assignment of costs and its cost-allocation bases, that were in effect in the hospital's last cost-reporting period before becoming subject to payment under the capital prospective payment transition system. A hospital may request a change in its cost-finding methods for new capital, provided that the request is made in a timely fashion as provided in the regulation, the hospital provides justification for the change, and the intermediary determines that the justification is reasonable.

It is important to note that, while the regulation does permit changes in cost-finding methods for new capital, such changes are only permitted where they do not involve any changes in cost-finding for old capital. In practice, this means that if a hospital claims any old capital, the intermediary cannot permit a change in any of the allocation bases on Worksheet B–1 of the cost report from the bases used in the last cost reporting period prior to the capital prospective payment system transition period. Otherwise, the consistency rule governing old capital cost-finding would be violated.

As we discussed in the preamble to the August 30, 1991 final rule for the capital prospective payment system (56

FR 43396), our primary reason for establishing this consistency rule was to prevent hospitals from using changes in cost-finding methodologies to shift costs to areas where payment continues to be made on a reasonable cost basis. Allowing changes in cost-finding methodologies to accomplish such cost-shifting would obviously defeat the purpose of adopting a prospective payment system.

In response to concerns expressed by the hospital industry about the costs of the recordkeeping required under the cost-reporting rules, HCFA has developed new cost reporting instructions, which will be released later this year, that permit hospitals to voluntarily adopt a simplified cost allocation methodology. This methodology reduces the number of statistical bases that a hospital is required to maintain. Under the new instructions for HCFA Form 2552–96 (the cost report instructions for FY 1996 cost reporting periods), hospitals may request the simplified cost allocation methodology. However, hospitals that elect this methodology must employ a prescribed list of statistical bases with no deviations. Hospitals may not pick and choose among the prescribed statistics for the combination that is most advantageous. Furthermore, a hospital that elects the simplified methodology must continue to use it for at least 3 years, unless a change of ownership occurs. We expect that, while election of the simplified method will always result in reduced recordkeeping costs for the hospital, it will also result frequently in reduced Medicare payment for the hospital. In fact, the instructions for HCFA Form 2552–96 will caution hospitals to compare the reduced costs of program compliance with the reduced costs of the simplified recordkeeping before electing the simplified method.

We believe this proposal to permit election of the simplified cost allocation methodology, as provided in the instructions for HCFA Form 2552–96, reasonably reconciles concerns about recordkeeping costs with the requirement of consistent cost-finding during the transition. Specifically, we propose to add a new paragraph (d)(4) to § 412.302, to provide that, hospitals may elect to adopt the simplified cost allocation methodology, as will be provided in the instructions for HCFA Form 2552–96.

B. Possible Adjustments to the Capital Prospective Payment System Federal Rate and Hospital-Specific Rates (§§ 412.308(b) and 412.328)

In the proposed and final rules for FY 1996 (60 FR 29238–29239 and 60 FR 45830–45831), we discussed the effects of the expiration of the statutory budget neutrality provision on rates and aggregate payments under the capital prospective payment system. Under the budget neutrality provision, we set the capital-prospective payment system rates during FY 1992 through FY 1995 so that payments were projected to equal 90 percent of Medicare payments that would have been made on a reasonable cost basis for each fiscal year. As a result of the provision's expiration in FY 1996, the capital-prospective payment system rates and payments under the transition system increased significantly. The FY 1996 Federal rate is 22.59 percent higher than the FY 1995 Federal rate. We now estimate that aggregate capital payments will increase 27.7 percent in FY 1996 relative to FY 1995, and that payments will exceed capital costs by 9.6 percent in FY 1996. Under current law and regulations, we estimate that aggregate payments will further increase by 7.3 percent in FY 1997, for an increase of 37.0 percent over 2 years. We do not believe that such large increases in capital payments are necessary or warranted.

During the FY 1996 rulemaking process, we solicited comments on possible revisions to the capital prospective payment rates that would have moderated these substantial increases in payments. At that time, we noted that section 1886(g) of the Act gives the Secretary broad discretion in the determination of the appropriate level of rates and payments. However, we decided not to implement any reduction to the capital rates at that time, in the expectation that Congress would be considering revisions to rates and payments under the capital prospective payment system within more comprehensive legislation dealing with Medicare and the Federal budget.

In its March 1, 1996 Report to Congress, the Prospective Payment Assessment Commission (ProPAC) observed that the base capital rate was reduced during the first 4 years of the transition to full prospective payment for capital to meet the statutory budget neutrality requirement. In the light of the large increase in rates and payments as a result of that provision's expiration in FY 1996, ProPAC recommends (Recommendation 11) that the capital payment rates should be set by developing an appropriate base payment rate and applying an annual update. The Commission notes that there are several ways to determine an appropriate base capital payment rate.

We agree with ProPAC that the large increase in rates and payments caused by the expiration of the statutory budget neutrality provision raises an issue concerning the proper level for future rates and payments. We also agree that there are several possible approaches to establishing an appropriate level for the rates. We considered a range of options in developing this proposed rule. For example, we considered proposing to freeze the inflation updates for the rates in FY 1997, on the grounds that such an update was unnecessary and unwarranted in light of the large increase in the rates for FY 1996. Alternatively, we considered proposing actual reductions in the base rates. For example, we considered proposing to implement the provision contained in the Administration's budget plan. The Administration's FY 1997 budget includes a provision to reduce the base Federal and hospital-specific rates by 15.7 percent. Such a reduction would build the budget neutrality adjustment for FY 1995 (0.8432, or –15.68 percent) permanently into the base rates, effectively using the FY 1995 base payment rate as the base for future years. The actual payment rates for future years would then be determined by applying the analytical update framework that we adopted in the final rule for FY 1996 (60 FR 45815–45829). We also considered proposing to implement a part of the Administration's proposal, that is, to reduce the standard Federal rate by 7.38 percent and the hospital-specific rates by 9.48 percent. The rationale for each of these options to reduce the base rate derives from an analysis of current data compared to data on which the rate was originally based.

Under § 412.308, HCFA determined the standard Federal rate, which is used to determine the Federal rate for each fiscal year, on the basis of an estimate of the FY 1992 national average Medicare capital cost per discharge. The FY 1992 national average Medicare capital cost per discharge was estimated by updating the FY 1989 national average Medicare capital cost per discharge by the estimated increase in Medicare inpatient capital cost per discharge. As we discussed in the preamble to the August 30, 1991 capital prospective payment system final rule (56 FR 43366–43384), HCFA used the July 1991 update of HCRIS data to estimate an FY 1989 national average Medicare cost per case of $527.22.

HCFA then updated that amount to FY 1992 by using an actuarial projection of a 31.3 percent increase in Medicare capital cost per discharge from FY 1989 to FY 1992. The standard Federal rate was thus based on an estimated FY 1992 national average Medicare capital cost per discharge of $692.24 (before the application of a transfer adjustment and a payment parameter adjustment).

Section 13501(a)(3) of Public Law 103–66 amended section 1886(g)(1)(A) of the Social Security Act to require that, for discharges occurring after September 30, 1993, the unadjusted standard Federal rate be reduced by 7.4 percent. As we discussed in the September 1, 1993 final rule for FY 1994 (58 FR 46316ff.), the purpose of that reduction was to reflect revised inflation estimates, as of May 1993, for the increases in Medicare capital costs per discharge during FY 1989 through FY 1992. By that time, the estimate of increases in Medicare inpatient capital costs per discharge from FY 1989 through FY 1992 had declined from 31.3 percent to 21.57 percent. The 7.4 percent reduction to the Federal rate was calculated to account for these revised estimates (1.2157/1.313=0.926, a 7.4 percent decrease). That provision of Public Law 103–66 also required that, for cost reporting periods beginning on or after October 1, 1993, the Secretary redetermine which hospital payment methodology should be applied under the capital prospective payment system transition rules to take into account the 7.4 percent reduction to the Federal rate.

As a result of the reduction required by Public Law 103–66, the standard Federal rate is now based on an estimated FY 1992 Medicare inpatient capital cost per case of $641.01 ($692.24×0.926). At the time of the Public Law 103–66 reduction to the Federal rate, actual cost report data on the FY 1992 Medicare capital cost per discharge were not yet available. The reduction was based on cost report data for FY 1990 and FY 1991, and a revised projection of the rate of increase in Medicare capital costs per discharge during FY 1992. We now have extensive cost report data for FY 1992. The March 1996 update of HCRIS data shows an audit-adjusted FY 1992 Medicare inpatient capital cost per discharge of $593.72, or an additional 7.38 percent lower than the estimate on which the Federal rate is currently based.

Under § 412.328, HCFA determined the FY 1992 hospital-specific rate by using a process similar to the process for determining the FY 1992 Federal rate. The intermediary determined each hospital's allowable Medicare inpatient capital cost per discharge for the hospital's latest cost reporting period ending on or before December 31, 1990. The intermediary then updated each hospital's FY 1990 allowable Medicare capital cost per discharge to FY 1992 based on the estimated increase in Medicare inpatient capital cost per case. As with the Federal rate updates, current data demonstrate that the estimates used to update the hospital specific rates from FY 1990 to FY 1992 were overstated. Specifically, the hospital-specific rates are 9.48 percent higher than they would have been if the rates of increase had reflected actual data. Thus, revising the Federal and the hospital-specific rates only for the known overestimations in the actual costs on which rates were based would call for reductions of 7.38 percent and 9.48 percent, respectively.

The proposal in the Administration's budget to reduce the rates 15.7 percent reflects the preceding factors, as well as analysis of capital cost increases before the implementation of the prospective payment system for capital-related costs. That analysis suggests that the Federal and hospital-specific rates may reflect levels of cost in excess of what can be accounted for by the rate of inflation in capital input prices, quality enhancing intensity increases, and real case mix growth. Economic theory suggests that an industry with a guaranteed return on capital (such as the hospital industry prior to prospective payment for capital-related costs) would have a tendency to be overly capitalized relative to more competitive industries. This is because the incentive for firms in such an industry is to compete on the basis of more capital-intensive production processes than firms in other industries. As a result, capital costs per case, and therefore base year prospective capital rates, may be higher than would have been consistent with capital acquisition policy in more efficiency-oriented markets.

To examine this issue, in our June 2, 1995 proposed rule (60 FR 29237) we analyzed the change in actual Medicare capital cost per case for FY 1986 through FY 1992 in relation to the change in the capital input price index (which accounts for change in the input prices for capital-related costs), and the other adjustment factors that we were then proposing to include in the framework. (The other adjustment factors are the increase in real case mix and the increase in intensity due to quality-enhancing technological change and within-DRG complexity.) We found rates of increase in actual spending per case that exceeded the rate of increase attributable to inflation in capital input prices, quality-enhancing intensity increases, and real case-mix growth. Our last analysis (60 FR 45826–45829) suggested that the FY 1992 capital costs used to set the Federal and hospital-specific capital rates exceeded by approximately 28 percent the level that could be accounted for by known factors.

We seriously considered proposing one of these options—reducing the standard (base) Federal rate either 7.38 percent to address overstated inflation estimates or 15.7 percent, as reflected in the Administration's budget proposal—in this proposed rule. We believe that either of these options is well justified on the basis of current data and analysis. As ProPAC has observed, hospitals do not seem to have been adversely affected by the level of the rates during the years in which the statutory budget neutrality provision was in effect. However, we still believe that Congress and the Administration may be able to reach an agreement on budget issues, including Medicare savings, in the near future. Therefore, as discussed in section III of the Addendum to this proposed rule, at this time we are proposing to update the capital rates in accordance with the capital update framework, without implementing any of the reductions discussed above. Our hope is that the legislative process will produce an appropriate adjustment to the rate level in time for implementation in the final rule. In the event that no such agreement is reached before the final rule for FY 1997, we may implement one of the above-described options at that time. We invite public comment on the merits of these options, and on the advisability of implementing one or the other in the final rule, in the absence of legislative action. We will reconsider all the options in the light of public comments.

C. Possible Adjustment to Capital Prospective Payment System Minimum Payment Levels

Section 412.348(b) of the regulations provides that, during the capital prospective payment system transition period, any hospital may receive an additional payment under an exceptions process if its total inpatient capital-related payments under its payment methodology (i.e., fully prospective or hold-harmless) are less than a minimum percentage of its allowable Medicare inpatient capital-related costs. The minimum payment levels are established by class of hospitals under § 412.348(c). The minimum payment

levels for portions of cost reporting periods occurring in FY 1996 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 for previous cost reporting periods exceed its cumulative minimum payment is deducted from the additional payment that would otherwise be payable for a cost reporting period.

Section 412.348(h) further provides that total estimated exceptions payments under the exceptions process may not exceed 10 percent of the total estimated capital prospective payments (exclusive of hold-harmless payments for old capital) for the same fiscal year. In the final rule implementing the prospective payment system for capital-related costs we stated that the minimum payment levels in subsequent transition years would be revised, if necessary, to keep the projected percentage of payments under the exceptions process at no more than 10 percent of capital prospective payments.

In section III of the Addendum to this proposed rule, we discuss the factors and adjustments used to develop the FY 1997 Federal and hospital-specific rates. In particular, we discuss the FY 1997 exceptions payment reduction factor. This factor adjusts the annual payment rates for the estimated amount of additional payments for exceptions in FY 1997. In this proposed rule, we estimate that exceptions will equal 6.07 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We will develop a new estimate of the level of exceptions payments in FY 1997, and revise the exceptions payment adjustment factor accordingly, on the basis of the data that becomes available to us in time for developing the final rule for FY 1997. While it is not necessary at this time to propose reductions in the minimum payment levels, it is possible that it will be necessary to implement adjustments to the minimum payment levels in the final rule. Our current projections show that it will almost certainly be necessary to adjust the minimum payment levels for FY 1998. We are therefore providing public notification that adjustments to the minimum payment levels are possible in the final rule, and almost certain for FY 1998.

When it does become necessary to adjust the minimum payment levels in accordance with § 412.348(h), our current intent is to adjust each of the existing levels (i.e., 90 percent for sole community hospitals, 80 percent for large urban DSH hospitals, and 70 percent for all other hospitals) by 5 percentage point increments until estimated exceptions payments are within the 10 percent limit. For example, we would set minimum payment levels at 85 percent for sole community hospitals, 75 percent for large urban DSH hospitals, and 65 percent for all other hospitals, provided that aggregate exceptions payments at those minimum payment levels were projected to be no more than 10 percent of total rate-based payments. If aggregate exceptions payments at those minimum payment levels still exceeded 10 percent of total rate-based payments, we would continue to reduce the minimum payment levels by 5 percentage point increments each until the requirement of § 412.348(h) was satisfied. We are providing notification of our current thinking on this issue in order to allow opportunity for public comment on the appropriate method for adjusting the minimum payment levels. We invite public comment on this matter, and will consider those comments fully whenever it becomes necessary to adjust the minimum payment levels in accordance with § 412.348(h).

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

Application of Ceiling in Calculating Payment for Hospital Inpatient Operating Costs (§ 413.40 (d) and (g))

Section 1886(b)(1)(B) of the Act provides for an additional payment to a hospital excluded from the prospective payment system when the hospital's reasonable operating costs exceed its target amount. The additional payment is based on the lesser of 50 percent of the amount by which the operating costs exceed the target amount, or 10 percent of the target amount. The Medicare statute further provides that this comparison is made ''after any exceptions or adjustments are made to such target amount for any cost reporting period.'' The regulations, at 42 CFR § 413.40(d)(3), state that the total payment to the hospital for inpatient operating costs (including the additional payment described above) is based on the lesser of the following: the ''ceiling'' (target amount multiplied by the number of Medicare discharges) plus 50 percent of the allowable net inpatient operating costs in excess of the ceiling, or 110 percent of the ceiling. However, the regulations do not explicitly include the additional statutory requirement regarding the effect of exceptions or adjustments.

It is our understanding that there are questions about the calculation of the additional payment under the regulations, which require comparison of two amounts: the ''ceiling'' plus 50 percent of the difference between allowable costs and the ceiling, and 110 percent of the ''ceiling.'' Specifically, where a hospital has received an adjustment to the target amount under § 413.40(g), there has been confusion as to whether the ''ceiling'' used for purposes of calculating the additional payment under § 413.40(d) is the unadjusted ceiling (the amount determined without consideration of any adjustments granted to the hospital) or the adjusted ceiling.

We believe that the amount of the additional payment should be determined using the adjusted ceiling when hospitals receive adjustments to the ceiling. That is, the calculation of the amounts compared—50 percent of the allowable net inpatient operating costs in excess of the ceiling, or 10 percent of the ceiling—should reflect the adjusted target amount (and adjusted ceiling). To address any confusion about these issues, we propose to revise § 413.40(d)(3) to specifically indicate that calculation of payments for hospital inpatient operating costs under that provision reflects the adjusted ceiling amount (the amount determined after an adjustment under § 413.40(g)). This would apply to all adjustments, including adjustments based on a longer average length of stay in the hospital's rate year as compared to the base year and adjustments for increased routine services.

We note that an adjusted ceiling is not used to adjust permanently the hospital's target amount or ceiling on the hospital's cost report. Instead, it is used only for purposes of calculating payments for the year the adjustment is granted. We also note that, depending on the specifics of the data in a particular case, use of an adjusted ceiling can result in either an increase or decrease in the additional payment to a hospital relative to use of an unadjusted ceiling. If the additional payment to a hospital is 50 percent of

the allowable net inpatient operating costs in excess of the ceiling, the additional payment would be lower using an adjusted ceiling (as under proposed § 413.40(d)(3)) than an unadjusted ceiling. This would occur because an adjusted ceiling reduces the difference between the hospital's costs and the ceiling. However, if the additional payment to the hospital is 10 percent of the ceiling, the additional payment would be higher using an adjusted ceiling than an unadjusted ceiling.

VIII. ProPAC Recommendations

We have reviewed the March 1, 1996 report submitted by ProPAC to Congress and have given its recommendations careful consideration in conjunction with the proposals set forth in this document. Recommendations 10 and 12, concerning the update factors for inpatient operating costs, and the update factor for hospitals excluded from the prospective payment system and distinct-part units, are discussed in Appendix F to this proposed rule. Recommendation 11, on the setting of capital payment rates, is discussed in section VI of this proposed rule. Recommendations 17 and 18, concerning disproportionate share hospitals, are discussed in section V of this proposed rule. The remaining recommendations are discussed below.

A. Slowing the Rise in Medicare Spending (Recommendation 1)

Recommendation: The Commission supports the efforts of the Congress and the President to reduce the growth in Medicare expenditures. Over time, spending for services furnished to Medicare enrollees should increase at rates comparable to those in a cost- and quality-conscious private sector.

Response: We agree with ProPAC about the importance of slowing the growth in Medicare spending. We support ProPAC's assertion that the experience in the private sector with market forces that encourage cost containment represents a useful factor in considering appropriate growth in Medicare. We also agree with those factors upon which ProPAC urges this comparison: spending growth on a per-person basis and recognizing the health care needs of an aged and disabled Medicare population. We caution, however, that while it may be appropriate to compare growth service by service, aggregate comparisons would not be meaningful due to differences in the mix of services.

Medicare and private health insurance provide a different array of services. Medicare covers more long-term care services, such as home health visits and skilled nursing facility (SNF) stays, than private insurance. Although their share of total Medicare spending is small, SNF and home health services are growing more quickly than other services within Medicare, and therefore spending for these services has been growing at a much faster rate than for other services. Data from 1992 and 1993 indicate that payments increased for SNF and home health services by 40.6 percent and 35.2 percent, respectively, whereas the growth in physician and hospital payments were only 4.5 percent and 8.3 percent, respectively. In order for Medicare and private health insurance to grow, in aggregate, at the same rate, spending for hospital and physician services would have to be growing more slowly in Medicare than in private health insurance to offset differences in long-term care growth. Due to these differences in mix of services, meaningful comparisons between Medicare and the private sector can only be made on a service-by-service basis.

B. The Failsafe Budget Mechanism (Recommendation 2)

Recommendation: Any failsafe budget mechanism should include a more effective risk adjustment factor to ensure payment equity between the Medicare capitation and traditional fee-for-service programs. In addition, changes in inflation that differ substantially from Congressional Budget Office (CBO) forecasts could require modifications to the Medicare benefit budget over time. Revisions to the proposed fee-for-service sector budget allocations could also be needed as medical practices change.

Response: We believe that using a failsafe budget mechanism (that is, an arbitrary cap on spending) to achieve targeted spending levels would be bad public policy. A failsafe mechanism would fundamentally change the nature of the Medicare program by breaking the link between benefits and payments. To meet the cap, benefits might have to be reduced, beneficiaries might have to pay more, and payments to providers might have to be reduced, all of which would impede access. A failsafe mechanism would encourage cost shifting to beneficiaries and other payers in order to achieve the targeted goal in government spending.

These arbitrary reductions in payments would make government an unreliable business partner. As Medicare moves toward a more market-oriented approach to setting payments, arbitrary reductions imposed by the government, after providers have negotiated in good faith, would sour relations and threaten the market pricing process.

The failsafe mechanism is a substitute for policy choices to achieve the desired level of spending. This arbitrary Medicare budget cap could potentially have adverse effects on the Medicare program.

We note that, while ProPAC recommends using a more effective risk adjustment factor to ensure payment equity between Medicare capitated and fee-for-service programs, no adequate case-mix measure currently exists that could serve this purpose.

C. Expanding Medicare's Capitation Program (Recommendation 3)

Recommendation: The Commission supports reforming the Medicare capitation program to control spending while expanding beneficiary choice.

Response: HCFA agrees with this recommendation and has specifically developed legislation to allow for Preferred Provider Organizations (PPOs) and Provider Sponsored Organizations (PSOs) to contract with the Medicare program. Furthermore, in October 1995, HCFA issued guidelines that notified HMOS that they were permitted to develop Point of Service (POS) Programs, which allow beneficiaries to go out of network for services. HCFA is currently conducting the Choices Demonstration, through which it is soliciting applications for the above types of provider arrangements.

D. Setting and Updating the Capitation Rates (Recommendation 4)

Recommendation: Geographic variation in the capitation rates and the volatility of the rates from year to year should be reduced. The Secretary should develop and test alternative payment methods that would allow the payment rates to reflect changes in local market conditions.

Response: We agree that geographic variations in HCFA's payment rates should be reduced. Some of the current legislative proposals would reduce the degree of variation over time.

We have been looking at ways to reduce these variations. Several demonstrations that should provide information needed to develop alternative payment methods are either currently being run or in the process of getting started. We have developed and are conducting several research and demonstration projects to review additional risk adjustors, which would modify current payment rates to reflect the health status of the members of managed care organizations. Another project would pay, from a separate pool of funds being shared by several

organizations in an area, for enrollees who have high Medicare costs. Also, HCFA is in the process of starting another project that would incorporate the payment principles associated with competitive bidding.

E. Improving Risk Adjustment Methods (Recommendation 5)

Recommendation: The risk adjustment methods used to set Medicare capitation payments should better reflect variation in the likely use of services. Even as research on the development of new methods continues, the Secretary should implement interim improvements as soon as possible.

Response: We plan to test health status risk adjusters, such as Diagnostic Cost Groups or Ambulatory Care Groups, as part of the Choices Demonstration. Furthermore, in this demonstration, we will test reinsurance and partial capitation arrangements. We are also considering demonstrations which use health status measures as part of the Adjusted Community Rate Determination, as well as part of the payment formula.

F. Medical Savings Accounts (MSAs) (Recommendation 6)

Recommendation: The Congress' high deductible/MSA option would provide an additional choice for Medicare enrollees. However, ProPAC is concerned that the current Medicare risk adjustment method is not sufficient to protect the program from adverse selection and resulting excess spending. The likelihood that rates would better reflect risk would be enhanced if Medicare enrollees were required to remain in the MSA option at least for several years.

Response: As ProPAC states, the Congressional Budget Office estimated that the MSA option would cost the Medicare program $4.6 billion over 7 years, in part because of the current state-of-the-art in risk adjustment methods (discussed in recommendation 5, above). The CBO estimate of the cost of the MSA option is consistent with the cost estimates of other reputable organizations. We fail to see the rationale for including an option that provides no new benefits but is expected to result in increased costs, particularly at a time when the public and Congress are concerned about the long-term financial viability of the Medicare program.

G. The Medicare Plus Fee-for-Service Option (Recommendation 7)

Recommendation: Enrollees choosing the fee-for-service option under the proposed Medicare Plus program could be responsible for substantially higher fees than what their plans would pay. The Secretary should monitor the impact of this option on beneficiary liability and on possible reductions in physician and other provider participation in traditional Medicare.

Response: We agree with ProPAC that beneficiaries could be responsible for substantially higher fees. We also agree that, as suggested in this recommendation, allowing physicians and other providers to elect to serve Medicare beneficiaries through private fee-for-service plans that place no limits on extra-billing amounts may well result in (1) increases in beneficiary liability and (2) reductions in physicians and other providers participating in traditional Medicare. Further, as the payment methods contained in pending legislation described in H.R. 2491 are structured, the payment increases for MedicarePlus plans, relative to those in fee-for-service Medicare, mean that MedicarePlus plans would be able to pay physicians and other providers more than fee-for-service Medicare. These higher payments would create additional incentives for physicians and other providers to cease participation in traditional Medicare. Finally, while managed care plans potentially provide value added because their organizational structure facilitates coordination of care, it is not clear what, if any, value is added by creating a private fee-for-service plan option, under which the private plans receive higher payments relative to fee-for-service Medicare and physicians and providers are permitted to charge unlimited extra-billing amounts.

H. Information for Beneficiary Health Plan Choices (Recommendation 8)

Recommendation: Medicare should make available to beneficiaries information about the performance of plans and local providers. The Secretary should identify the information beneficiaries need to make appropriate choices and develop innovative ways to improve access to it.

Response: Current HCFA initiatives to improve beneficiary information about health insurance options, which are summarized below, are consistent with ProPAC's recommendation.

Development of Prototype Materials and Strategies

We are currently engaged in two projects that will develop prototype beneficiary information strategies related to health insurance options.

The first project, which focuses mostly on managed care issues, is examining through Medicare and Medicaid beneficiary focus groups, the types of information and dissemination media that beneficiaries would find most useful in selecting health insurance plans. Based on this information, and case studies, the project will produce and test a range of prototype beneficiary information materials, including beneficiary health plan comparison booklets and charts, and informational videos. Draft prototype materials (for Medicare, pre-Medicare and Medicaid beneficiaries) are nearing completion and are scheduled for beneficiary testing in Spring 1996.

The second project will design beneficiary information and education materials and dissemination strategies to support the Medicare Open Enrollment/Competitive Pricing demonstration. This project will develop printed materials that explain the experimental open enrollment process; printed general informational materials on Medicare health insurance options; and booklets outlining the specific Medicare fee-for-service and managed care options available to beneficiaries in their area. A plan comparison chart template, which would include information on specific benefits and premiums, will also be developed, as will other information and educational approaches (including educational seminars, public service announcements (PSAs), informational videos, and a toll-free counseling phone line, all sponsored by HCFA). In addition, a dissemination strategy for HCFA and its partners in the demonstration sites will be developed (for example, Insurance Counseling and Assistance (ICA) programs and beneficiary advocacy groups).

Draft materials and strategies were tested on Medicare beneficiaries in April 1996. Final products should be available for adaptation to specific demonstration sites by Summer 1996.

Medicare Program Activities

We have currently outlined a strategy to produce and disseminate a managed care plan comparison chart to Medicare beneficiaries, initially through the HCFA Regional Offices and HCFA-sponsored ICA programs. We will use comparison chart prototypes developed (under both of the projects discussed above) as models for the comparison chart. Prototypes will be available by Spring 1996. We plan to begin dissemination of the basic comparability charts in 1996.

We may also choose to adapt some of the prototype materials for application to the Medicare program, depending on feedback and evaluations from

beneficiaries in the Open Enrollment Demonstration. These new materials could ultimately supplement or replace current materials, such as the Medicare Handbook. New prototype materials could also be provided and adapted individually by the State ICA programs. We have contributed recommendations during the development of these projects and will continue to do so.

Many of the Regional Offices have developed area specific informational materials related to Medicare managed care. The Regional Offices typically use these materials to assist in their responsibilities as the local HCFA contact for beneficiaries.

Related Major Initiatives

While current activities have centered on efforts to provide better information on health insurance options (such as focusing on comparisons of benefits, premiums, and locations), the next major steps in improving information and educational strategies will likely be in the area of quality or performance indicators.

The prototypes discussed above will include templates for eventual dissemination of quality/performance indicators for health plans. In addition, strategies for introducing the concept of indicators to Medicare and Medicaid beneficiaries will be produced. One project, short Medicare and Medicaid focused video tapes describing quality indicators using a ''grocery shopping'' analogy, has already been completed.

A final version of a set of Medicaid-specific National Committee on Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS) quality indicators is nearly completed. We are currently sponsoring the revision (with NCQA) of HEDIS version 3.0 to include Medicare-specific measures. Once both Medicare- and Medicaid-specific measures are available, HCFA will have available the basic tools necessary to report comparative quality indicators to beneficiaries. A specific dissemination strategy will then be determined.

We are currently in the developmental stages of a proposed plan-specific Medicare beneficiary satisfaction survey. When completed, we would have comparative satisfaction information on all Medicare managed care plans, which could then be disseminated to beneficiaries as a companion to plan benefit/premium comparison charts.

Based on these initiatives, HCFA should be well prepared to expand and improve both the level and types of health insurance information resources available to Medicare beneficiaries.

I. Health Plan Accountability (Recommendation 9)

Recommendation: Medicare must hold health plans accountable for the appropriate use of Medicare funds. In addition, standards must be developed and enforced to ensure that Medicare beneficiaries will receive services of appropriate quality.

Response: We agree with these recommendations and have several plans for implementing them. First, we are working with the National Committee for Quality Assurance to develop HEDIS 3.0 for the Medicare program. Second, we plan to conduct beneficiary satisfaction surveys for a significant sample of beneficiaries from each health plan participating in the Medicare HMO program. Third, we are working with the Foundation of Accountability to develop condition-specific outcome measures. Finally, we are working with Peer Review Organizations to develop several condition-specific outcome measures that will be risk adjusted.

J. Broadening Financial Support to Teaching Hospitals (Recommendation 13)

Recommendation: Explicit financial support for graduate medical education activities should not be limited to the Medicare program. Mechanisms to broaden financial support for teaching-related activities in hospitals and other locations should be developed.

Response: The Commission is concerned that Medicare is the only payer that provides explicit financial support for teaching activities. Even though private payers provide implicit support through higher prices for patient care services, funding is unrelated to the amount of actual teaching activity.

While we would agree that all payers should contribute their fair share toward physician training and particularly for the patient care services that are provided in the course of this training, we wish to emphasize that Medicare's support for graduate medical education is limited only to Medicare's share of the total cost of graduate medical education. That is, although we believe the current level of the indirect medical education adjustment is higher than necessary to compensate for the indirect costs associated with residents' involvement in patient care, it is set at a level that at one time was thought to equal those costs. Furthermore, because this adjustment is made only for Medicare prospective payment system discharges, it is inherently only associated with Medicare's share of the indirect costs of graduate medical education. In addition, the direct graduate medical education payment is calculated based on Medicare's inpatient utilization rate, thereby ensuring that it, too, reflects only Medicare's share of direct graduate medical education. In that vein, we would support a mechanism to broaden support for physician training that did not result in Medicare contributing more than its fair share, relative to the Medicare utilization rate.

We note also that some Medicaid programs explicitly pay hospitals for the indirect and direct costs of graduate medical education similar to Medicare. In addition, some States (for example, New York, through its Prospective Hospital Reimbursement Methodology) provide explicit support for teaching hospitals through private payers. Nevertheless, we join ProPAC in calling for more uniform support across all payers.

We would note that although the President's health care reform bill attempted to involve private insurers in directly supporting medical education, we do not currently have a proposal to broaden support for teaching hospitals beyond that currently provided by Medicare. We have, however, proposed to broaden financial support for teaching hospitals by changing the way Medicare funds medical education through its managed care programs. Currently, Medicare payments to HMOs are based on the average cost of providing services to Medicare patients in the fee for service part of Medicare. These payments to HMOs include Medicare's costs for medical education. The President's FY 1997 budget would revise Medicare's payments to HMOs so as not to include the portion associated with medical education and paying these funds directly to teaching hospitals and to managed care plans with teaching programs. This change would benefit teaching hospitals, as well as more appropriately target Medicare funds designated for medical education.

K. Medicare Payments for Graduate Medical Education Costs (Recommendation 14)

Recommendation: ProPAC supports changes in Medicare teaching payments that would encourage an appropriate distribution of residents across specialties and discourage inappropriate growth in the total number of residents.

Response: The Commission states that both the proposals of Congress and the President's budgets would move Medicare direct graduate medical education payments in the direction of

encouraging appropriate distribution of residents across specialties and discourage inappropriate growth in the total number of residents.

The Administration is very concerned with the issue of Medicare payments to hospitals for graduate medical education. Consistent with numerous reports that the nation has an excess of specialty physicians, and that the growth of managed care is increasing the demand for primary care physicians relative to other specialties, the focus of the President's graduate medical education proposal is to encourage greater hospital participation in primary care residencies and less in specialty residencies. In addition, a significant amount of training of residents in primary care is more appropriately done in non-hospital settings. Accordingly, the President's budget includes a cap on the total number of residents and on the number of nonprimary care residents for whom Medicare will make graduate medical education payments. We would also encourage ambulatory training by including residents who rotate to non-hospital settings in the hospital's FTE count for IME purposes. We would further encourage ambulatory training by providing direct medical education payments to facilities that are not hospitals (for example, federally qualified health centers) for residents, when the residents' salaries are not paid by hospitals.

The Administration has also proposed to create a Commission on Medical Education and Workforce Priorities within HHS to develop and recommend policies to address the preservation of academic health centers' research and educational capacity and the supply of the future health care workforce. This commission would also make recommendations regarding the most effective allocation of training resources to ensure that the numbers and competencies of health care professionals are responsive to national needs.

L. Medicare Indirect Medical Education Payments (Recommendation 15)

Recommendation: The Medicare indirect medical education adjustment should be reduced from its current 7.7 percent level to 7.0 percent.

Response: As we've said in response to similar ProPAC recommendations in previous years, we agree with ProPAC that the current level of payment for the indirect costs of medical education is too high. The President's FY 1997 budget would reduce the adjustment over 3 years to a final level of 6.0 percent effective for FY 1999. In addition, residents working in nonhospital settings could be counted in a hospital's resident count for indirect medical education purposes if the hospital incurs all, or substantially all, of the costs for the training program in that setting. Finally, the President's budget would cap the number of residents that could be included in the count, with an exception provided for primary care residents and those in the specialties of obstetrics or gynecology.

The Commission also supported the provision in the President's FY 1996 budget that would apply the direct graduate medical education resident count and weighting rules to the indirect medical education count. However, ProPAC recommended proceeding with caution as additional analysis would be needed to examine the effect of this policy on individual teaching hospitals. We note that this provision is not contained in the FY 1997 budget proposal. Therefore, residents would continue to be counted for IME as long as they are enrolled in an approved program.

M. Distributing Additional Teaching-Related Payments (Recommendation 16)

Recommendation: Funds that provide broader financial support for graduate medical education should be distributed in a way that corresponds to the additional costs incurred by teaching facilities. Providers that treat enrollees in capitation plans should receive teaching-related payments for those patients as well as for the other patients they serve.

Response: This recommendation is related to Congress' proposal to create new trust funds to provide broader support for educational activities. Congress would create new trust funds that include accounts for general direct medical education, general indirect medical education, and a Medicare Plus Incentive Account financed by new appropriations. This funding would be in addition to payments currently being made by Medicare for direct and indirect medical education. The Commission is concerned that the new funding would be distributed based on previous Medicare payment levels even though general revenues will fund the newly established trust funds. With regard to the Medicare Plus Incentive Account, ProPAC is concerned that payments should give Medicare's managed care participants an incentive to use teaching hospitals and pay providers appropriately for serving patients in capitation plans.

Like the Commission, we are concerned about appropriating general revenues to finance medical education, particularly given our concern that the indirect medical education adjustment already overcompensates hospitals and Medicare already pays its share of costs of direct medical education. The President's original proposal was to create an all payer fund to finance graduate medical education. However, this proposal was made in the context of overall health care reform. We continue to remain concerned that medical education should be supported to a greater extent by payers other than Medicare but have reservations about financing of medical education with additional Federal money.

As we explained above in Recommendation 13, under the President's FY 1997 budget, we would revise payments made through our managed care programs to ensure that teaching programs are supported more appropriately by existing Medicare resources designated for medical education. Under the President's FY 1997 budget, payments for medical education would be eliminated from HMO rates and redistributed to teaching hospitals and managed care plans with teaching programs.

N. Discharges from Hospitals to Other Facilities (Recommendation 19)

Recommendation: Medicare payments should be modified to account for the shift in services from acute to postacute settings. Broadening the definition of transfer cases, however, is not an appropriate approach.

Response: In both the September 1, 1994 and September 1, 1995 final rules, we expressed our concern that the current trend of declining average lengths of stay as hospitals discharge Medicare patients into alternative health care settings (other than acute care prospective payment hospitals) in less time may result in a misalignment of payments and costs under our existing payment systems (59 FR 45362; 60 FR 29221). In particular, we expressed concern over the potential for hospitals paid under the prospective payment system to shift costs (for which they are compensated through the DRG payments) to alternative settings, which are in turn paid on a cost basis. Although we solicited comments on possible solutions to this problem, we did not propose any change in policy.

The President's FY 1997 budget includes a proposal to redefine discharges from acute care hospitals to excluded hospitals and units and skilled nursing facilities as transfers for payment purposes. Currently, for cases transferred from one acute care hospital paid under the prospective payment system to another like hospital, the sending hospital is paid a per diem rate

instead of the full DRG amount. For cases transferred to an excluded hospital or unit or to a skilled nursing facility (as well as cases discharged home or home with home health care), hospitals receive the full DRG payment amount, regardless of the length of stay in the hospital. Under the per diem transfer payment methodology, hospitals receive a per diem amount (doubled for the first day of the stay) until the full DRG amount is reached. Therefore, under the President's budget proposal, hospitals transferring patients to excluded facilities or skilled nursing facilities prior to the geometric mean length of stay for the DRG, minus one day (to account for the double per diem on the first day), would receive less than the full DRG amount for that case.

The basis for ProPAC's opposition to this proposal is that it ''* * * thinks this policy would discourage the use of postacute providers. Moreover, it could result in longer inpatient stays, which may not be desirable or cost effective in the long run.'' We acknowledge that the change in the definition of a transfer is not the ultimate solution to this health care trend. In response to immediate concerns about overpaying hospitals for the reduced services they are providing and the rate of increase in expenditures for postacute care services, however, we believe this is an appropriate interim measure while we continue to explore long-term policy alternatives that will better integrate our payment systems for care provided to Medicare beneficiaries across the acute and postacute care settings.

O. Prospective Payment for PostAcute Care (Recommendation 20)

Recommendation: Prospective payment systems should be implemented for all postacute services. The payment method for each service should be consistent across delivery sites. The Secretary should explore methods to control volume of postacute service use, such as bundling services for a single payment.

Response: We agree that HCFA should develop prospective payment systems for all postacute services, and we have made significant progress in this area. As we discuss in our responses to Recommendations 22 and 23, we have developed detailed implementation plans for interim prospective payment systems for skilled nursing facilities (SNFs) and home health agencies (HHAs) that do not require patient classification systems. Execution of these plans will, of course, require legislative action.

Beyond our interim plan, we have developed a strategy for developing a full-fledged prospective payment system for SNFs. In the absence of legislation, we have been pursuing data that could be used to support a case-mix prospective payment system through our Multi-State Case Mix Demonstration Project. This demonstration project, now in its operational phase, is collecting data on patient case mix using a modified version of the minimum data set, the assessment tool SNFs use in developing patient care plans. Through the course of the demonstration, we hope to gather data on the full range of SNF resources needed for each resource utilization group. We are proceeding to require by regulation that all facilities provide resident assessment data. Consolidated billing of SNF services (that is, requiring SNFs to bill for all services furnished to their patients) and uniform coding of SNF services are also prerequisites for a SNF prospective payment system. Consolidated billing and uniform coding are needed to determine the appropriate payment for the ancillary services component of SNF services and to provide useful data on the range of services SNFs furnish.

We have also been working on a strategy to develop a full-fledged prospective payment system for HHAs. We have funded a project to develop outcome measures for home care that can be used for an outcome-based quality improvement system. These measures will be based largely on a core standard assessment data set that includes items measuring sociodemographic, environmental, support system, health status, functional status, and health service utilization characteristics of patients. Many of these data items included in the core standard assessment data set are not only essential for assessing patient outcomes but are also critical for designing an adequate case-mix system for payment purposes. To test and refine Medicare's approach to outcome based quality improvement for home health care, HCFA is currently sponsoring the Medicare Quality Assurance and Improvement Demonstration, which uses this instrument. We plan to publish regulations identifying the required data elements and addressing the collection of information from the core standard assessment data set. We also plan to sponsor additional research that would lead to an appropriate case-mix adjuster that can be used in a national prospective payment system.

In addition to the developmental work underway on SNF and HHA prospective payment systems, we have begun work on the preliminary steps necessary for the development of a prospective payment system for hospital inpatient rehabilitation services. The biggest obstacle we have faced in this effort is the lack of appropriate patient classification systems for the types of patients treated by rehabilitation hospitals. We have recently contracted with the Rand Corporation to evaluate a rehabilitation coding system known as the Functional Impairment Measure (FIM), which is a scoring system that measures the degree of functional independence of rehabilitation patients. These researchers will also evaluate the patient classification system known as functional related groups (FRGs), which are based on FIM, as a possible basis for a Medicare prospective payment system for rehabilitation services. If the research confirms functional status measures can be used to develop an appropriate patient classification system, we will begin the additional work necessary to put a prospective payment system into place. This would require collecting patient assessment data from Medicare rehabilitation hospitals and units and developing all the necessary components of the new payment system. It will take at least 3 years to design and implement such a system. To facilitate implementation, we are considering initiating collection of patient assessment data in advance of legislation establishing a prospective payment system. We will be seeking public input on whether to proceed with a requirement for patient assessment data in the absence of legislation and what data elements should be included in a core data set that could be used not only as the basis for a patient classification system but also to assess outcomes.

We recognize that there are advantages to a coordinated approach in developing prospective payment systems for postacute services and we will be evaluating how to make them as consistent as possible. We also recognize that the demand for implementation of prospective payment systems for post-acute services is sufficiently immediate so that there may not be time for the broad study, data collection, and research needed to develop a ''unified'' system using similar resource grouping principles. Most of the current legislative proposals, including the Administration's proposals, would require implementation dates within the next several years. It may not be feasible to develop a ''unified'' system within the time frames contemplated by the current legislative proposals. Trade-offs may be required between continuation of the interim payment systems versus

the full-blown prospective payment systems on one hand, and the separate versus ''unified'' prospective payment systems on the other hand.

P. Case-Mix Measures for PostAcute Services (Recommendation 21)

Recommendation: Reliable case-mix measurement is important in prospective payment systems to account for resource use and to analyze treatment patterns and costs across sites. The Secretary should coordinate case-mix research across postacute care settings, using consistent methods for measuring patient acuity and resource use.

Response: We are attempting to coordinate our work on case-mix adjustment for home health care, long-term and SNF care, and rehabilitative services. To develop a case-mix adjustment system for SNF care, time studies were conducted in order to measure resource utilization. Similarly, as noted above in response to Recommendation 20, we plan to fund research to identify a home health case-mix adjuster.

In addition, in the case-mix work to date for both home health care and SNF care, dependence in activities of daily living is the biggest predictor of resource utilization. Some of the other predictors differ across SNF care and home health care due to differences in the treatment settings and the availability of information for a classification system.

As also noted above in the preceding response, researchers at the University of Pennsylvania have developed a classification system based on FIMs called Function Related Groups (FIM–FRGs). This system appears promising for use in a case-mix adjusted prospective payment system for rehabilitation and long-term care facilities, and we are working with the Rand Corporation on a research project to evaluate the suitability of FIM–FRGs for this purpose.

We agree that a compatible cross-provider measure of resource use would be the best multiplier in any universal postacute system. We also believe that such measures do not now exist and to produce them would require the program to incur significant costs and impose significant data reporting and collection requirements on providers. We would prefer to obtain explicit legislative direction before we incur these costs and impose these burdens. Even so, we believe several years would be required to gather the data and develop the case-mix measures. For these reasons, we believe that interim prospective payment systems of the types contained in the President's FY 1997 budget should be put in place.

Q. Interim Fee-for-Service Payment Method for Skilled Nursing Facility Services (Recommendation 22)

Recommendation: An interim payment method should be implemented to control the growth in Medicare payments for SNF services until a comprehensive prospective payment system is established. A system based on historical data and facility-specific limits, however, may not allow facilities to respond appropriately to changes in a dynamic environment.

Response: We agree with ProPAC's recommendation that an interim payment system should be developed until a permanent system is established. Both the interim and permanent payment systems could better promote the goals of quality care, maximum access to care, and cost containment. A payment system that incorporates these goals is essential as the nursing home industry evolves toward a more eclectic mix of care levels and delivery models. In addition, the need exists for a payment system that is simpler to administer for both providers and HCFA. In order to maximize these goals, a permanent prospective payment system for SNFs should include payment for all costs (that is, routine operating, ancillary, and capital costs) and take into account actual facility case mix. However, thecase-mix and ancillary cost data necessary to accomplish this goal are not yet available.

In the interim, based on current data resources, a prospective payment system could be implemented. It would apply solely to routine costs (including routine capital costs) and utilize facility-specific payment rates subject to cost limits. We are studying various cost limit designs, such as regional limits versus national limits, to account for geographical cost differences. In addition, methodologies to ease the transition from the current payment system would be incorporated into an interim prospective payment system.

While there is agreement that a need exists to implement an interim prospective payment system for SNFs, the Commission believes that a system based on historical data and facility-specific limits may not allow facilities to respond appropriately to changes in a dynamic environment. However, we believe that a facility-specific interim prospective payment system would provide a number of advantages over the current system, and could be constructed to accommodate changes in a facility's case mix. The system would provide for greater cost containment and administrative simplicity, through predetermined pricing. In addition, the potential to earn a profit under the interim system, by holding down costs, would provide an incentive for nursing homes to participate in Medicare, or certify more beds if already participating. This would provide greater access for beneficiaries. This same incentive would produce greater efficiency in nursing home operations and would support the provision of quality care. When compared to a flat rate system, a facility-specific system would maintain an appropriate distribution of payments, since the basis of payments under the system is the nursing homes' own cost history. As a nursing home case-mix classification system is finalized and tested, and further analysis is completed on ancillary payment, these elements would be incorporated into the payment system.

In addition, we are analyzing some features of an interim system that would result in savings for the Medicare program. Specifically, in developing providers' facility-specific payment rates for routine services, the system would incorporate one set of cost limits based on freestanding costs only. The current system provides for separate (higher) limits for hospital-based facilities. Consequently, savings would result from holding down payments to these hospital-based SNFs. In addition, savings would result through the elimination of routine cost limit exemptions granted to new providers of skilled nursing services. The current system of cost limit exceptions for ''atypical nursing services'' would be eliminated as well. Finally, the Medicare Part B carrier fee schedules could be utilized for Part A SNF services as a limit on the reasonable costs of certain ancillary services. Currently, there are no limits or reasonable cost guidelines for many of these services.

We support the ProPAC view that a per-episode payment system be developed. We have noted above, however, that there are great obstacles to developing both (1) prospective payment systems that are consistent across provider types with respect to the method of measuring resource use, and (2) classifications systems for episodes of postacute care (either by provider type or in general) that account for a sufficient degree of the variability among different types of patients. Thus, our inclination would be to pursue our current plans for the prospective payment systems with the thought that

further refinements could be made when data are available.

R. Interim Fee-for-Service Payment Method for Home Health Care (Recommendation 23)

Recommendation: Until a fully prospective payment system for home health care is developed, the Commission supports adopting episode-based payment limits. In addition, beneficiary copayments, subject to an annual limit, should be introduced.

Response: There is agreement between ProPAC and HCFA that an interim cost control mechanism should be established prior to implementing a prospective payment system for home health care. We would like to highlight significant differences between the prospective payment systems proposed by the Congress and the Administration.

The congressional proposal would limit payment to 120 days of service with certain exceptions for up to 165 days of care. This provision has the potential of serious financial impact on some agencies, as well as reduced access to services for some patients with the greatest needs. The proposal also assumes the availability of data and systems to categorize and assign patients to one of the 18 ''case-mix categories'' established in Phase II of HCFA's HHA prospective payment system demonstration. Neither the data nor the systems are currently in existence, and the implementation of such a system would entail a major increase in the reporting burden on agencies. Were we able to implement such a system, we estimate that the system would be able to explain less than 10 percent of the variation in cost per episode, at best.

The Administration's interim proposal entails no increased reporting burden, as it uses data currently reported by agencies. Although that budget proposal does not provide for per-episode payments, its aggregate payment caps effectively create a per-episode cap on costs. Given the uncertainty about the resource composition of individual types of episodes, the use of an aggregate cap gives agencies an incentive to provide services in a cost effective manner by sharing savings with agencies whose costs are below their per beneficiary limitation. We note that ProPAC was also concerned that the interim proposal utilizes regional cost experience, which the Commission feels may not be appropriate. The President's FY 1997 budget includes a provision to use average national or regional cost experience in constructing the per beneficiary limitation. We agree with ProPAC that, should we find unjustified differences in regional cost experience, we would support a move to national cost experience as the basis for the per beneficiary limit.

It may be necessary to use regional rates to move individual HHAs toward a national norm over time. This would avoid major displacements. We are considering both regional and national blending.

We do not agree with the ProPAC recommendation that beneficiary copayments be introduced. Our proposed interim system of limits should adequately control the growth in service use. We do not agree with shifting costs to beneficiaries, however limited, as a method of controlling the growth in utilization.

As HCFA moves forward in designing a prospective payment system for home health care, we will consider ProPAC's recommendations to look at more uniformly defined units of services.

S. Update to the Composite Rate for Dialysis Services (Recommendation 24)

Recommendation: The Secretary should develop methods to control total Medicare per capita expenditures for end stage renal disease (ESRD) beneficiaries. In the meantime, the composite rate should be updated by 2.7 percent for hospital-based dialysis facilities and by 2.0 percent for freestanding facilities for fiscal year 1997. The Secretary should also develop reliable measures of patient severity and outcomes to analyze the relationships among treatment processes, patient outcomes, and costs. These factors should be considered in evaluating the need for and the level of future payment updates.

Response: One of ProPAC's suggestions is that HCFA consider opening enrollment for ESRD beneficiaries to participate in Medicare risk programs. The reason for this recommendation is the rapid growth in total Medicare spending for ESRD beneficiaries. A large part of this increase is attributable to the expanding ESRD population, especially older patients who require more services. These beneficiaries are using more acute inpatient, skilled nursing and other dialysis-related services than ever before. ProPAC suggests that to control these expenditures, Medicare examine the possibility of adopting a capitation payment system for ESRD services, since capitation rates have been successful in controlling expenditure growth for other populations. At a minimum, they are recommending that utilization review or other managed care techniques be used to control the total volume of services provided to ESRD beneficiaries across all sites of care.

Section 1876(d) of the Act currently prevents an individual with ESRD from enrolling in an HMO or a competitive medical plan. However, an individual who is enrolled in a prepaid health plan when he or she is determined to have ESRD may continue enrollment in that plan. A prepaid health plan may only disenroll a beneficiary as provided by regulations at 417.460.

Congress addressed the issue of paying for ESRD services in a capitation setting in legislation. Section 13567(b) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66) (August 10, 1993) amended section 2355 of Public Law 98–369 by requiring the Secretary to include the integration of acute and chronic care management for patients with ESRD through expanded community care case management services in a social health maintenance organization (SHMO). Initial legislation required the Secretary to grant demonstration waivers for SHMOs that provide for the integration of health and social services at a fixed annual prepaid capitation rate. In the January 26, 1996 Federal Register, we published a notice informing interested parties of the opportunity to apply for funds for a cooperative agreement to operate an ESRD Managed Care Demonstration (61 FR 2516). Two of the demonstration's purposes would be to test whether ESRD beneficiaries can and should be given access to HMOs during open enrollment and whether the statewide capitation rate can and should be adjusted. The demonstration would adjust rates for treatment status (such as dialysis, transplant, or a functioning graft), age groups and the cause of renal failure (for example, diabetes). As the legislation requires, rates would be based on 100 percent of the adjusted average per capita costs (AAPCC); additional non-Medicare-covered benefits would be offered by the provider to justify the additional 5 percent beyond the 95 percent of the AAPCC paid to Medicare risk-contracting HMOs on behalf of ESRD enrollees. Based on the results of this demonstration, we would make recommendations to Congress concerning the appropriateness of paying for dialysis services in a capitation setting.

To improve the quality of care ESRD patients are receiving, we are in the process of developing proposed rules for ESRD conditions for coverage. The essence of the regulation is patient-centered and outcome-oriented. The proposed conditions for coverage will focus on facilities achieving an optimal

level of health and well-being for all dialysis patients. The proposed rules will be published in Spring 1996 with expected implementation in late fiscal year 1997.

While we share ProPAC's concern that payment rates be sufficient to assure quality care for ESRD patients, we do not believe there is sufficient evidence at this point to conclude that more money is needed to provide appropriate care. Currently, the University of Michigan, as part of a National Institute of Health grant, is examining the relationship between facilities' costs and the level of KT/V. Also the National Institute of Diabetes and Digestive and Kidney Diseases is sponsoring a study on the impact of increasing dialysis as measured by KT/V and the use of high-flux-dialysis on ESRD patients. The results of these studies should help us analyze the relationship between patient outcomes and costs, and thus provide us with a basis for recommending an appropriate payment rate increase.

While we acknowledge that an increase in the composite rate may be appropriate in the next few years, we believe that any rate increase should be linked to implementation of the revised conditions for coverage. Moreover, any ESRD rate increase must be considered within the context of Medicare budgetary concerns and should have a direct link to improved patient outcomes. We will continue to monitor ESRD facility costs, and, if appropriate, we may recommend an update to the ESRD composite rate for FY 1998.

We note that ProPAC's recommendation provides for an across-the-board rate increase for all renal facilities. However, data show that high volume independent facilities (over 6,000 treatments per year) account for about 85 percent of independent dialysis treatments. These high volume facilities report margins between Medicare payments and costs that are higher than average. Therefore, in proposing a future rate increase, we would want to examine the need to adjust payment increases for volume. In addition, we believe that any update to the composite rate should include an update to the wage index currently used to adjust the labor portion of the rate. We are currently using an outdated wage index which is a blend of 1980 Bureau of Labor Statistics (BLS) and 1984 prospective payment system wage data and does not reflect the MSA revisions resulting from the 1990 census.

The Commission's final recommendation is that the Secretary closely monitor treatment patterns and patient outcomes to ensure that facilities use the payment increase to improve quality of care. The proposed ESRD conditions for coverage should address this issue. We expect the proposed rule to be published in the Federal Register before Summer 1996. Between the publication of the proposed and final rules, HCFA is planning to meet with the renal community to develop complete clinical data sets to monitor patient outcomes and medical conditions. These data will then be used to evaluate the quality of dialysis services furnished by individual facilities. Of course, this is a long-term project. In the short term, we are exploring the possibility of collecting limited patient outcome data such as KT/V and URR.

T. Prospective Payment for Hospital Outpatient Services (Recommendation 25)

Recommendation: A comprehensive prospective payment system should be developed for hospital outpatient services. Such a system should include a strategy for controlling the volume of ambulatory services.

Response: We agree with the need to implement a comprehensive prospective payment system for outpatient services. While we await legislative authority, we continue to develop and refine the Medicare-specific factors of the Ambulatory Patient Group (APG) system that we recommend using. We plan to analyze the payments that would be made across sites, for example in Ambulatory Surgical Centers (ASCs) or physician radiology practices, to ensure that we have not created unwarranted incentives to perform procedures in a given setting for financial reasons.

We are concerned as well about the potential for increases in the volume of services provided, both in outpatient departments and in other settings. We are examining approaches to volume measurement and control, including the level of packaging for ancillary services and monitoring of patterns of care. For example, we could track whether Medicare beneficiaries received more clinic visits per patient under APGs than they did under cost-based reimbursement. If so, we could take corrective action either systemically or on a hospital-specific basis. This issue clearly requires study. We welcome suggestions in this area.

U. Beneficiary Liability for Hospital Outpatient Services (Recommendation 26)

Recommendation: The growing financial burden for Medicare enrollees who receive services in hospital outpatient departments should be alleviated immediately. Beneficiary coinsurance for these services should be limited to 20 percent of the Medicare-allowed payment, as it is in other settings. For services not paid on a prospective basis, the Secretary should establish a new method for determining beneficiary copayments based on estimated allowed payments since they cannot be calculated precisely when services are delivered.

Response: We agree that the issue of beneficiary coinsurance should be addressed. In the context of the monies available to the Medicare program, we doubt that Congress would authorize that Medicare immediately assume the full cost of paying 80 percent of the cost of outpatient services. Among the approaches that could be used are: (1) Applying the savings achieved by eliminating the formula-driven overpayment to offset the beneficiaries' responsibility; (2) requiring copayments in other areas of the program, such as for home health services or laboratory services; and/or (3) moving gradually to reduce the ratio of copayments to total payments. One issue that must be considered at the same time is the rise in the Part B premium that would accompany any significant increase in program payments. This would have the effect of distributing costs over the entire range of beneficiaries, rather than having it focused only on those patients who actually use outpatient services, as it is now. We are eager to have this issue addressed and resolved, but know that it must be examined in light of broader budget decisions.

IX. Other Required Information

A. Paperwork Reduction Act

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

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the information collection requirement discussed below.

The only information collection or paperwork burden item contained in this proposed rule involves the requirement under § 489.27 that a hospital furnish each Medicare beneficiary with a notice of discharge rights supplied by HCFA, that is, 'An Important Message from Medicare.'

As discussed in section V.F of this preamble, we are revising the current requirement that a hospital must distribute the 'Important Message' to each Medicare beneficiary at or about the time of admission. In order to permit hospitals more flexibility, but still ensure that benficiaries are aware of their discharge rights, we are proposing to revise § 489.27 to specify that a hospital must provide the notice of discharge rights 'during the course of the hospital stay.' We estimate that the paperwork burden associated with the requirement that hospital personnel distribute the 'Important Message' to each Medicare beneficiary is approximately 1 minute per admission. Based on our most recent available data (1995 Data Compendium, HCFA Pub. No. 03364), there are roughly 11 million Medicare beneficiaries admitted to hospitals each year, resulting in an annual burden of approximately 183,000 hours.

This paperwork burden is not effective until it has been approved by OMB. A notice will be published in the Federal Register when approval is obtained. Organizations and individuals desiring to comment on this paperwork burden requirement should submit comments by July 30, 1996 to the Office of Management and Budget, Human Resources and Housing Branch, Room 10235, New Executive Office Building, Washington, D.C., 20503, Attention: Allison Herron Eydt, HCFA Desk Officer.

B. 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 format or cartridges; however, some files are available on diskette, and 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 which means discharges occurring October 1 through September 30.)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, a data release agreement must be signed by the purchaser before release of these data. For all files requiring a signed data release 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, usually available by the end of May. This file 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, usually available by the first week of September. This file is derived from the MedPAR file with a cutoff of 9 months after the end of the fiscal year (June file).

Media: Tape/Cartridge
File Cost: $3,415.00 per fiscal year
Periods Available: FY 1988 through FY 1995

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, a data release 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, usually available by the end of May. This file 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, usually available by the first week of September. This file is derived from the MedPAR file with a cutoff of 9 months after the end of the fiscal year (June file).

Media: Tape/Cartridge
File Cost: $1,050.00 per State per year
Periods Available: FY 1988 through FY 1995

3. HCFA Hospital Wage Index Data File

This file is composed of four separate diskettes. Included are: (1) The hospital hours and salaries for FY 1993 used to create the proposed FY 1997 prospective payment system wage indexes; (2) a history of all wage indexes used since October 1, 1983; (3) a list of State and county codes used by SSA and FIPS (Federal Information Processing Standards), county name, and Metropolitan Statistical Area (MSA); and (4) a file of hospitals that were reclassified for the purpose of the FY 1997 wage index. Two versions of these files are created each year. They support the following:

- NPRM published in the Federal Register, usually by the end of May.
- Final Rule published in the Federal Register, usually by the first week of September.

Media: Diskette/Internet
File Cost: $500.00
Periods Available: FY 1997 PPS Update

We note that the files also are available individually as indicated below.

(1) HCFA Hospital Wage Index Survey Only (usually available by the end of March for the NPRM and the middle of August for the final rule.)

(2) Urban and Rural Wage Indices Only

(3) PPS SSA/FIPS MSA State and County Crosswalk Only (usually available by the end of March)

(4) Reclassified Hospitals by Provider Only

Media: Diskette/Internet

File cost: $145.00 per file

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

The Minimum Data Set contains cost, statistical, financial, and other information 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 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 XII Minimum Data Set covering 1995 will not be available until July 31, 1996.)

File Cost: $715.00 per year

5. 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 XII Capital Data Set covering 1994 will not be available until July 31, 1996.)

File Cost: $715.00 per year

6. 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: Tape/Cartridge
File Cost: $500.00 per file
Periods Available: FY 1987 through FY 1996 (December updates)

Media: Diskette/Internet
File Cost: $265.00
Periods Available: FY 1996 PPS Update

7. 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, usually by the end of May.
- Final rule published in the Federal Register, usually by the first week of September.

Media: Diskette/Internet
Price: $145.00 per year
Periods Available: FY 1985 through FY 1995 (Internet—FY 1995)

8. Table 5 DRG File

This file contains a listing of DRGs, DRG narrative description, relative weight, geometric mean, length of stay, and day outlier trim points 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:

a. NPRM, usually published by the end of May.

b. Final rule, usually published by the first week of September.

Media: Diskette/Internet
File Cost: $145.00
Periods Available: FY 1997 PPS Update

9. 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: $145.00
Periods Available: FY 1997 PPS Update

10. 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, usually by the end of May.
- Final rule published in the Federal Register, usually by the first week of September.

Media: Diskette/Internet
File Cost: $145.00
Periods Available: FY 1997 PPS Update

11. HCFA FY 1992 Capital-Related Tax File

This file contains data used to develop a special property tax adjustment to the capital prospective payment system for capital-related costs. The data set includes a preliminary hospital-specific add-on amount for all PPS hospitals. The data set also contains the information used to propose an adjustment to the Federal rate so that the tax add-on is budget neutral. The proposed property tax adjustment provides special treatment to qualified hospitals who pay capital-related property taxes. The add-on was 10. determined using base year tax costs per discharge attributable to Medicare. The data are taken from the FY 1992 Medicare hospital cost report and a special request for validation by the fiscal intermediaries.

Media: Diskette
File cost: $145.00
Period available: FY 1992

For further information concerning these data tapes, contact Mary R. White at (410) 786–0168.

Commenters interested in obtaining or discussing any other data used in constructing this rule should contact Stephen Phillips at (410) 786–4548.

C. Public Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments concerning the provisions of this proposed rule that we receive by the date and time specified in the ''Dates'' section of this preamble and respond to those comments in the preamble to that rule. We emphasize that, given the statutory requirement under section 1886(e)(5) of the Act that our final rule for FY 1997 be published by September 1, 1996, 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 489

Health facilities, Medicare.

42 CFR chapter IV would be amended as set forth below:

A. Part 412 would be amended as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

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).

Subpart D—Basic Methodology for Determining Prospective Payment Federal Rates for Inpatient Operating Costs

2. In § 412.63(s)(1), a new sentence is added at the end to read as follows:

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

* * * * *

(s) * * *

(1) * * * The wage index is updated annually.

* * * * *

Subpart L—The Medicare Geographic Classification Review Board

3. In 412.246, paragraph (b) is revised to read as follows:

§ 412.246 MGCRB members.

* * * * *

(b) *Term of office.* The term of office for an MGCRB member may not exceed 3 years. A member may serve more than one term. The Secretary may terminate a member's tenure prior to its full term.

Subpart M—Prospective Payment System for Inpatient Hospital Capital Costs

4. In § 412.302, a new paragraph (d)(4) is added to read as follows:

§ 412.302 Introduction to capital costs.

* * * * *

(d) * * *

(4) Hospitals may elect the simplified cost allocation methodology under the terms and conditions provided in the instructions for HCFA Form 2552.

B. Part 413 would be amended as follows:

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

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

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

Subpart C—Limits on Cost Reimbursement

2. In § 413.40, paragraph (d)(3) is revised to read as follows:

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

* * * * *

(d) * * *

(3) *Net inpatient operating costs are greater than the ceiling.* For cost reporting periods beginning on or after October 1, 1991, if a hospital's allowable net inpatient operating costs exceed the hospital's ceiling (or the adjusted ceiling, if applicable), payment will be based on the lower of the—

(i) Ceiling (or the adjusted ceiling, if applicable) plus 50 percent of the allowable net inpatient operating costs in excess of the ceiling (or the adjusted ceiling, if applicable); or

(ii) One hundred-ten percent of the ceiling (or the adjusted ceiling, if applicable).

* * * * *

Subpart F—Specific Categories of Costs

3. In § 413.86, a new sentence is added at the end of paragraph (g)(1) introductory text to read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(g) * * *

(1) * * * For combined residency programs, an inital residency period is defined as the time required for individual certification in the longer of the two programs.

* * * * *

C. Part 489 would be amended as follows:

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

1. The authority citation for part 489 continues to read as follows:

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

Subpart B—Essentials of Provider Agreements

2. Section 489.27 is revised to read as follows:

§ 489.27 Beneficiary notice of discharge rights.

A hospital that participates in the Medicare program must furnish each Medicare beneficiary, or an individual acting on his or her behalf, the notice of discharge rights HCFA supplies to the hospital to implement section 1886(a)(1)(M) of the Act. The hospital must provide timely notice during the course of the hospital stay. For purposes of this paragraph, the course of the hospital stay may begin with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission. The hospital must be able to demonstrate compliance with this requirement.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: May 13, 1996.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: May 24, 1996.

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 on or After October 1, 1996 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning on or After October 1, 1996

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, 1996, except for sole community 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. For hospitals in Puerto Rico, the payment per discharge is based on the sum of 75 percent of a Puerto Rico rate and 25 percent of a national rate (section 1886(d)(9)(A) of the Act).

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. The changes, to be applied prospectively, would affect the calculation of the Federal rates. In section III, we discuss our proposed changes for determining the prospective payment rates for Medicare inpatient capital-related costs. Section IV sets forth our proposed changes for determining the rate-of-increase limits for hospitals excluded from the prospective payment system. The tables to which we refer in the preamble to the proposed rule are presented at the end of this addendum in section V.

II. Proposed Changes to Prospective Payment rates For Inpatient Operating Costs for FY 1997

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 manner in which we are changing some of the factors used for determining the prospective payment rates. The Federal and Puerto Rico rate changes, once issued as final, will be effective with discharges occurring on or after October 1, 1996. 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 1997.

In summary, the proposed standardized amounts set forth in Tables 1a and 1c of section V of this addendum reflect—

- Updates of 2.2 percent for all areas (that is, the market basket percentage increase of 2.7 percent minus 0.5 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 1996 budget neutrality factor and applying a revised factor; and
- An adjustment to apply the revised outlier offset by removing the FY 1996 outlier offsets and applying a new offset.

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 that Medicare target amounts be determined 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)(C) and (d)(9)(B)(ii) of the Act required that the updated base-year per discharge costs and, for Puerto Rico, the updated target amounts, respectively, be standardized in order to remove from the cost data the effects of certain sources of variation in cost among hospitals. These 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.

Since the standardized amounts have 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, no additional adjustments for these factors for FY 1997 were made. That is, the standardization adjustments reflected in the FY 1997 standardized amounts are the same as those reflected in the FY 1996 standardized amounts.

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, 1990, when the market basket was last rebased, we have considered 71.4 percent of costs to be labor-related for purposes of the prospective payment system. As discussed in section IV of the preamble, we are proposing to use a rebased market basket effective for FY 1997. Based on the proposed rebased market basket, we are revising the labor and nonlabor proportions of the standardized amounts. Effective with discharges occurring on or after October 1, 1996, we are proposing a labor-related proportion of 71.2 percent and a nonlabor-related proportion of 28.8 percent. The standardized amounts in Table 1a of section V of this addendum have been recomputed to reflect the revised labor-related and nonlabor-related proportions. (We are revising the Puerto Rico standardized amounts by the average labor share in Puerto Rico of 82.8 percent. We are revising the discharged-weighted national

standardized amount to reflect the proportion of discharges in large urban and other areas from the FY 1995 MedPAR file.)

2. Computing Large Urban and Other Averages Within Geographic Areas

Section 1886(d)(3) of the Act requires 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 75 percent of the applicable Puerto Rico standardized amount and 25 percent of a national standardized payment amount.

Section 1886(d)(2)(D) of the Act defines ''urban areas'' 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). 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 1995 population estimates published by the Bureau of the Census, 56 areas meet the criteria to be defined as large urban areas for FY 1997. These areas are identified by an asterisk in Table 4a.

Table 1a contains the two national standardized amounts that we are proposing be applicable to all hospitals, except for sole community hospitals and hospitals in Puerto Rico. For a number of years, Table 1b had been used to set forth the 18 regional standardized amounts applicable for hospitals located in census areas subject to the regional floor. However, as provided in section 1886(d)(1)(A)(iii)(II) of the Act, the regional floor expires effective with discharges occurring on or after October 1, 1996. Therefore, all hospitals (except sole community hospitals and hospitals in Puerto Rico) will be paid solely on the basis of the national standardized amounts. Under section 1886(d)(9)(A)(ii) of the Act, the national standardized payment amount applicable to hospitals in Puerto Rico consists of the discharge-weighted average of the national large urban standardized amount and the national other standardized amount (as set forth in Table 1a). The national average standardized amount for Puerto Rico is now set forth in Table 1b. This table also includes the two standardized amounts that would be applicable to most hospitals in Puerto Rico.

3. Updating the Average 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 1997 using the applicable percentage increases specified in section 1886(b)(3)(B)(i) of the Act. Section 1886(b)(3)(B)(i)(XII) of the Act specifies that, for hospitals in all areas, the update factor for the standardized amounts for FY 1997 is the market basket percentage increase minus 0.5 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 rebased hospital market basket increase for FY 1997 is 2.7 percent. For FY 1997, this yields an update to the average standardized amounts of 2.2 percent (2.7 percent minus 0.5 percent). (See section IV of this preamble of this proposed rule for a discussion of the market basket rebasing.)

As in the past, we are adjusting the FY 1996 standardized amounts to remove the effects of the FY 1996 geographic reclassifications and outlier payments before applying the FY 1997 updates. That is, we are increasing the standardized amounts to restore the reductions that were made for the effects of geographic reclassification and outliers. After including offsets to the standardized amounts for outliers and geographic reclassification, we estimate that there will be an actual increase of 2.3 percent to the large urban and other area standardized amounts.

Although the update factor for FY 1997 is set by law, we are required by section 1886(e)(3)(B) of the Act to report to Congress on our initial recommendation of update factors for FY 1997 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 D 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 ProPAC's recommendation concerning the update factor, are set forth as Appendix E 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 specifies that the hospital wage index must be updated on an annual basis beginning October 1, 1993. This provision also requires that any updates or adjustments to the wage index must be made 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 compared aggregate payments using the FY 1996 relative weights and wage index to aggregate payments using the proposed FY 1997 relative weights and wage index. The same methodology was used for the FY 1996 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 0.998509. This budget neutrality adjustment factor is applied to the standardized amounts without removing the effects of the FY 1996 budget neutrality adjustment. 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 continue to apply the same FY 1997 adjustment factor to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 1996, in order to ensure that we meet the statutory requirement that aggregate payments neither increase nor decrease as a result of the implementation of the FY 1997 DRG weights and updated wage index. (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. We are applying an adjustment factor of 0.994059 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 1996 budget neutrality adjustment factor. We note that the proposed FY 1997 adjustment reflects wage index and standardized amount reclassifications approved by the MGCRB or the Administrator as of March 14, 1996. The effects of any additional reclassification changes resulting from appeals and reviews of the MGCRB decisions for FY 1997 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 1997.

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) or long lengths of stay (day 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 by the same factor 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.

Beginning with FY 1995, section 1886(d)(5)(A) of the Act requires the Secretary to phase out payments for day outliers (correspondingly, payments for cost outliers would increase). Under the requirements of section 1886(d)(5)(A)(v), the proportion of day outlier payments to total outlier payments is reduced from FY 1994 levels as follows: 75 percent of FY 1994 levels in FY 1995, 50 percent of FY 1994 levels in FY 1996, and 25 percent of FY 1994 levels in FY 1997. We estimated the FY 1994 proportion of day outlier payments to total outlier payments at 31.3 percent in our September 1, 1993 final rule (58 FR 46348). Thus, the proportion of day outlier payments to total outlier payments in FY 1997 will be approximately 8 percent (25 percent of 31.3 percent). For discharges occurring after September 30, 1997, the Secretary will no longer pay for day outliers under the provisions of section 1886(d)(5)(A)(i) of the Act.

i. Proposed FY 1997 Outlier Payment Policies, Including Outlier Thresholds. For FY 1996, the day outlier threshold is the geometric mean length of stay for each DRG plus the lesser of 23 days or 3.0 standard deviations. The marginal cost factor for day outliers (the percent of Medicare's average per diem payment paid for each outlier day) is 44 percent for FY 1996. The fixed loss cost outlier threshold is equal to the prospective payment for the DRG plus $15,150 ($13,800 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 1996 standardized amounts of 0.949054 for the large urban and other areas rates and 0.9526 for the capital Federal rate.

For FY 1997, we propose to set the day outlier threshold at the geometric mean length of stay for each DRG plus the lesser of 24 days or 3.0 standard deviations. Section 1886(d)(5)(A)(iii) of the Act, as amended by section 13501(c)(3) of Public Law 103–66, provides that additional payments for day outlier cases may be reduced below the marginal cost of care to meet the requirements of section 1886(d)(5)(A)(v) of the Act. We are proposing to reduce the marginal cost factor for each outlier day from 44 percent to 35 percent in FY 1997. We estimate that our proposed policies will reduce the proportion of outlier payments paid as day outliers in FY 1997 to approximately 8 percent, in accordance with section 1886(d)(5)(A) of the Act.

We are also proposing a fixed loss cost outlier threshold in FY 1997 equal to the prospective payment rate for the DRG plus $11,050 ($10,075 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.

In accordance with section 1886(d)(5)(A)(iv) of the Act, we calculated proposed outlier thresholds so that outlier payments are projected to equal 5.1 percent of total payments based on DRG prospective payment rates. In accordance with section 1886(d)(3)(E), we reduced the proposed FY 1997 standardized amounts by the same percentage to account for the projected proportion of payments paid to outliers.

As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both inpatient operating costs and inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We project that the proposed thresholds for FY 1997 will result in outlier payments equal to 5.1 percent of operating DRG payments and 5.2 percent of capital payments based on the Federal rate.

Thus, the proposed outlier adjustment factors applied to the standardized amounts and the capital Federal rate for FY 1997 are as follows:

Operating Standardized Amounts	Capital Federal Rate
0.948968	0.9476

We would apply the proposed outlier adjustment factors after removing the effects of the FY 1996 outlier adjustment factors on the standardized amounts and the capital Federal rate.

ii. Other Changes Concerning Outliers. Table 5 of section V of this addendum contains the DRG relative weights, geometric and arithmetic mean lengths of stay, as well as the day outlier threshold for each DRG. When we recalibrate DRG weights, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight and geometric mean length of stay. DRGs that do not have at least 10 cases are considered to be low volume DRGs. For the low volume DRGs, we use the original geometric mean lengths of stay, because no arithmetic mean length of stay was calculated based on the original data.

Table 8a in section V 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 September 1, 1995 final rule (60 FR 45922), effective October 1, 1996. 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 0.24345 or greater than 1.30392 and capital cost-to-charge ratios lower than 0.013297 or greater than 0.19968. 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 for all cost reports settled during FY 1997 (regardless of the actual cost reporting period) when hospital-specific cost-to-charge ratios are either not available or outside the three standard deviations range.

iii. FY 1995 and FY 1996 Outlier Payments. In the September 1, 1995 final rule (59 FR 45408), we stated that, based on available data, we estimated that actual FY 1995 outlier payments would be approximately 4.0 percent of actual total DRG payments. This percentage was computed by simulating payments using actual FY *1994* bill data available at the time. That is, the estimate of actual outlier payments did not reflect actual FY 1995 bills but instead reflected the application of FY 1995 rates and policies to available FY 1994 bills. Our current estimate, using available FY 1995 bills, is that actual outlier payments for FY 1995 were approximately 3.7 percent of actual total DRG payments (lower than the 5.1 percent we projected in setting outlier policies for FY 1995). We note that the MedPAR file for FY 1995 discharges continues to be updated.

We currently estimate that actual outlier payments for FY 1996 will be approximately 4.2 percent of actual total DRG payments (lower than the 5.1 percent we projected in setting outlier policies for FY 1996). This estimate is based on simulations using the December 1995 update of the provider-specific file and the December 1995 update of the FY 1995 MedPAR file (discharge data for FY 1995 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 1996 by applying FY 1996 rates and policies to available FY 1995 bills.

The following discussion addresses the methodology we use to set outlier thresholds for an upcoming fiscal year and also addresses possible explanations for the difference between projected and actual outlier payment percentages in recent years.

iv. Methodology for Setting Outlier Thresholds. In previous rulemaking documents, we have discussed the methodology for setting outlier thresholds as well as our periodic refinements to that methodology. In this document, we once again describe our methodology and analyze it to suggest some possible explanations for the recent differences between projected and actual outlier percentages. We invite comments and suggestions for further refinements to the methodology.

In General. In accordance with section 1886(d)(5)(A)(iv) of the Act, we set outlier thresholds so that outlier payments are expected (projected) to equal 5.1 percent of total payments based on DRG prospective payment rates. The databases used to calculate thresholds for an upcoming fiscal year include data on discharges from a previous fiscal year as well as hospital-specific data. We update the data every year. In setting the proposed FY 1997 outlier thresholds, we used the December 1995 update of the FY 1995 MedPAR file, which contains data on FY 1995 hospital inpatient discharges, and the December 1995 update of the provider-specific file, which contains information on hospital-specific payment parameters (such as cost-to-charge ratios).

The methodology for setting outlier thresholds for an upcoming fiscal year involves analyzing the set of hospital inpatient cases in the MedPAR file and simulating payments for those cases by using the payment rates and policies that would apply in the upcoming fiscal year. For example, in calculating the proposed thresholds for FY 1997, we used the proposed payment rates and policies for FY 1997 and simulated payments for the set of cases in the FY 1995 MedPAR file.

The computer simulation calculates ''payments''—outlier payments and total payments—for all discharges for a given set of outlier thresholds. In order to achieve established objectives (for example, the projected percentage of outlier payments relative to total DRG payments is 5.1 percent, and the projected percentage of outlier payments attributable to day outliers is 8 percent for FY 1997), the methodology involves an iterative process, that is, numerous successive simulations using alternative sets of outlier thresholds. In short, then, the outlier estimation methodology involves analyzing historical discharge data, simulating payments for the discharges in the database by using the payment rates that would apply in the upcoming fiscal year, and testing alternative sets of outlier thresholds until the simulations are consistent with established objectives.

Cost Inflation Factors. In setting outlier thresholds for an upcoming fiscal year, we need to calculate the ''costs'' for each case in our database. In the payment simulations, this ''cost'' for each case is used to determine, for a given cost outlier threshold, whether a case qualifies for additional outlier payments and the amount of any such payments. (As explained above, we test alternative sets of thresholds.)

The MedPAR file includes data on billed charges, and as part of the estimation methodology, we make adjustments to convert the charges to costs, including adjusting the data for inflation. In setting the proposed outlier thresholds for FY 1997, we analyzed data for FY 1995 discharges.

As we explained in the September 1, 1993 final rule (58 FR 46347), prior to FY 1994, we used a charge inflation factor to adjust charges to costs; for example, in setting outlier thresholds for FY 1993, we adjusted the FY 1991 MedPAR file charge data by a charge inflation factor for 2 years in order to estimate FY 1993 charges and then applied the applicable cost-to-charge

ratio. Beginning with FY 1994, we have used a cost inflation factor to estimate ''costs''; that is, we adjust the charges by the cost-to-charge ratio and then adjust the resulting costs for 2 years of cost inflation. This adjustment automatically accounts for any changes in the cost-to-charge ratios that may occur, since the relevant variable is the estimated ''costs'' for a given case.

In setting the final outlier thresholds for recent years immediately prior to FY 1995, we determined cost inflation factors by analyzing cost report information to calculate moving averages of cost inflation for prior periods. (For example, in setting the FY 1994 outlier thresholds, we analyzed cost reports for cost reporting periods beginning in FY 1988 through FY 1991 to calculate a cost inflation factor, that is, the average annual increase in cost per case, of 8.3 percent.) In doing so, we made an audit adjustment for any cost report that had not been settled, based on the average ratio of submitted to final cost report data. In setting the final outlier thresholds for FYs 1995 and 1996, we determined cost inflation factors by analyzing cost report information and calculating the change in cost per case for one year, rather than the average change in cost per case over more than one year.

In setting the proposed FY 1997 outlier thresholds, we used a cost inflation factor of 0.0 percent, because it is unclear whether FY 1997 ''costs'' will be higher or lower than costs reflected in the FY 1995 MedPAR file. Analysis of recent cost report information shows that cost per case increased slightly for cost reporting periods beginning in FY 1993 relative to those beginning in FY 1992, but decreased slightly in the following year (that is, for cost reporting periods beginning in FY 1994 relative to those beginning in FY 1993). We will reevaluate this factor when we develop the final rule for FY 1997. At that time, more recent data should be available for analysis, specifically, cost report data for cost reporting periods beginning in FY 1995.

Differences Between Projected and Actual Outlier Percentages. As explained above, the cost inflation factor is an important aspect of the methodology for setting outlier thresholds, and we believe the cost inflation factor is a major reason that in recent years the actual outlier percentages (the proportion of actual outlier payments to actual total DRG payments) have been lower than projected.

In determining the cost inflation factor, we analyze historical hospital cost report information, and there is necessarily a time lag of 2 to 3 years between the cost reporting period itself and the time when data for that cost reporting period become available. For example, in setting the FY 1994 outlier thresholds, we used a cost inflation factor of 8.3 percent, derived from cost reports for cost reporting periods beginning in FY 1988 through FY 1991. We adjusted the charges from the FY 1992 MedPAR bills by the cost-to-charge ratio and then adjusted the resulting FY 1992 costs for 2 years of cost inflation (costs multiplied by 1.083 multiplied by 1.083) to estimate ''FY 1994 costs.''

However, analysis of more recent cost report information shows that cost per case increased at a much lower rate of 0.97 percent in cost reporting periods between FY 1992 and FY 1993 and actually decreased 1.77 percent in cost reporting periods between FY 1993 and FY 1994. In effect, we ''overestimated'' costs by approximately 15.4 percent. Since costs did not increase at nearly the rate we expected, actual costs in FY 1994 proved to be lower than those reflected in the simulations used to set the thresholds for FY 1994; accordingly, the proportion of outlier payments was lower than expected.

Another aspect of the outlier methodology that may have contributed to the difference between projected and actual outlier percentages concerns the payment adjustments for indirect medical education (IME) and disproportionate share hospitals (DSH). As indicated in previous rulemaking documents, for purposes of determining outlier payments, we standardize a hospital's costs for IME and DSH adjustments; that is, we reduce the hospital's costs for a given discharge to account for IME and DSH payments. The ''standardized''≥ cost for a discharge is calculated by taking total costs for the discharge and dividing it by the sum of one plus the hospital's DSH factor plus the hospital's IME factor. Therefore, the higher the IME and DSH factors, the more costs are reduced by standardization.

The factors used for purposes of setting thresholds are taken from the most recent provider-specific file. In setting the proposed FY 1997 outlier thresholds, we used information from the December 1995 update of the provider-specific file. We standardized the costs for each discharge in our database to account for IME and DSH adjustments. The proposed outlier thresholds reflect these standardized costs.

While we use the latest, most up-to-date sources of information, the ''projected'' IME and DSH factors (the factors used to set thresholds for a fiscal year) may differ from the actual IME and DSH factors used to make payments in that fiscal year. If the ''projected'' factors used to standardize costs for a given discharge are ''too low,'' then standardization does not ''sufficiently'' reduce the costs for that discharge and the resulting standardized cost is ''too high.'' If the standardized costs for the discharges analyzed to set outlier thresholds are generally ''too high,'' then in turn the thresholds would be too high; consequently, this might result in a lower than expected proportion of outlier payments. Analysis shows that, for FY 1994 for example, the ''projected'' IME and DSH factors were on average lower than the actual factors.

Conclusion. As we have done since the inception of the prospective payment system, we determine outlier thresholds based on estimates before the beginning of each fiscal year. The methodology we use involves analysis of the best data available at the time thresholds are established; however, by their nature, projections are imprecise and may differ from actual payment data for any number of reasons. We discussed above some of the numerous factors that affect payment and why these particular factors may have contributed to the difference between projected and actual outlier payments in recent years. (See also, for example, the discussion in the September 1, 1995 final rule (60 FR 45855).) We note that any difference between projected and actual outlier payment percentages in a given year does not affect standardized amounts in future years.

We continue to explore refinements to the methodology for setting outlier thresholds. We welcome comments and suggestions regarding these issues.

B. Adjustments for Area Wage Levels and Cost of Living

The adjusted standardized amounts are divided into labor and nonlabor portions. Tables 1a and 1c, as set forth in this addendum, contain the actual labor-related and nonlabor-related shares that will be used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that an adjustment be made 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 the preamble, we discuss certain revisions we are making to the wage index. This index is set forth in Tables 4a through 4e 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 1997, 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 August 1, 1996, we will publish them in the final rule and use them in determining FY 1997 payments.

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

Alaska—All areas	1.25
Hawaii:	
County of Honolulu	1.225
County of Hawaii	1.15
County of Kauai	1.20
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 V of this addendum contains the relative weights that we propose to use for discharges occurring in FY 1997. These factors have been recalibrated as explained in section II of the preamble.

D. Calculation of Prospective Payment Rates for FY 1997

General Formula for Calculation of Prospective Payment Rates for FY 1997

Prospective payment rate for all hospitals located outside Puerto Rico except sole community 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 Puerto Rico = 75 percent of the Puerto Rico rate + 25 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, 1996 and before October 1, 1997, except for sole community hospitals and hospitals in Puerto Rico, the hospital's payment is based exclusively on the Federal national rate. Section 1866(d)(1)(A)(iii) of the Act provides that the Federal rate is comprised of 100 percent of 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 Tables 1a, section V 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, section V 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, section V of this addendum).

2. Hospital-Specific Rate (Applicable Only to Sole Community 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.

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 1997. We are proposing to increase the hospital-specific rates by 2.2 percent (the hospital market basket percentage increase minus 0.5 percentage points) for sole community hospitals located in all areas in FY 1997. Section 1886(b)(3)(C)(ii) 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)(ii) of the Act, which, for FY 1997, is the market basket rate of increase minus 0.5 percentage points.

b. Calculation of Hospital-Specific Rate. For sole community hospitals, the applicable FY 1997 hospital-specific rate would be calculated by multiplying a hospital's hospital-specific rate for the preceding fiscal year by the applicable update factor (2.2 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, 0.998509) 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 is paid for its discharges beginning on or after October 1, 1996, 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, 1996 and Before October 1, 1997.

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 1b, section V of the addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate wage index (see Tables 4a and 4b, section V 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 75 percent.

Step 5—Multiply the amount from Step 4 by the appropriate DRG relative weight (see Table 5, section V 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 1b, section V of the addendum) by the appropriate wage index.

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 25 percent.

Step 4—Multiply the amount from Step 3 by the appropriate DRG relative weight (see Table 5, section V 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 Payment Rates for Inpatient Capital-Related Costs for FY 1997

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 1997. The rates will be effective for discharges occurring on or after October 1, 1996.

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. Section 412.308(c)(3) further requires that the Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for exceptions under § 412.348, and § 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 FY 1992 through FY 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.

The hospital-specific rate for each hospital 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. The hospital-specific rate is updated each year after FY 1992 for inflation and for changes in the exceptions payment adjustment factor. For FY 1992 through FY 1995, the hospital-specific rate was also adjusted by a budget neutrality adjustment factor.

To determine the appropriate budget neutrality adjustment factors 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 more fully in Appendix B.

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. These hospitals are paid a blended rate that is comprised of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. 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. Hospitals in Puerto Rico are paid based on 75 percent of the Puerto Rico rate and 25 percent of the Federal rate.

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

For FY 1996, the Federal rate is $461.96. With the changes we are proposing to the factors used to establish the Federal rate, the proposed FY 1997 Federal rate is $441.84.

In the discussion that follows, we explain the factors that were used to determine the proposed FY 1997 Federal rate. In particular, we explain why the FY 1997 Federal rate has decreased 4.36 percent compared to the FY 1996 Federal rate. Nevertheless, as explained in section VII of Appendix A, capital payments per case are estimated to increase 4.45 percent. Taking into account the effects of increases in projected discharges, we also estimate that aggregate capital payments will increase 7.28 percent.

The major factor contributing to the decrease in the proposed FY 1997 rate in comparison to the FY 1996 rate is the change in the exceptions reduction factor. We have expected the number and amount of exceptions payments generally to increase throughout the transition period.

Total payments to hospitals under the prospective payment system are relatively insensitive to 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 1997 compared to FY 1996. Specifically, we estimate that aggregate payments in FY 1997 will be 7.28 percent higher than they were in FY 1996. Changes in aggregate payments include changes in capital payments per discharge and changes in the number of discharges. Under the prospective payment system for capital-related costs, payments per discharge (or case) are estimated to increase 4.45 percent in FY 1997 compared to FY 1996.

1. Standard Federal Rate Update

Section 412.308(c)(1) has provided that 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 1997 under that framework is 1.0 percent. This proposal is based on a projected 1.0 percent increase in the CIPI, and on policy adjustment factors of zero. We explain the basis for the FY 1997 CIPI projection in section IV.B of the preamble to this proposed rule. Here we describe the policy adjustments that have been applied.

The case-mix index (CMI) 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 CMI corresponds to an equal percentage increase in hospital payments.

The CMI can change for any of several reasons: because the average resource use of Medicare patients changes (''real'' case-mix change); because changes in hospital coding of patient records result in higher weight DRG assignments (''coding effects''); and because 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 CMI. 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 CMI-related changes other than patient severity. (For example, we adjusted for the effects of the FY 1992 DRG reclassification and recalibration as part of our FY 1994 update recommendation.) The operating adjustment consists of a reduction for total observed case-mix change, an increase for the portion of case-mix change that we determine is due to real case-mix change rather than coding modifications, and an adjustment for the effect of prior DRG reclassification and recalibration changes. We have adopted this CMI adjustment in the capital update framework as well.

For FY 1997, we are projecting a 1.6 percent increase in the case-mix index. We estimate that real case-mix increase will equal projected case-mix increase in FY 1997. We do not anticipate any changes in coding behavior in our projected case-mix change. We explain the basis for this determination in Appendix D to this proposed rule. The proposed net adjustment for case-mix change in FY 1997 is therefore 0.0 percentage points.

We estimate that DRG reclassification and recalibration resulted in a 0.0 percent change in the case mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs.

The current operating 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 faced by hospitals and the forecast used in calculating the update factors. In setting a prospective payment rate under the proposed framework, we make an adjustment for forecast error only if our estimate of the capital input price index rate of increase 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. Thus, for example, we would adjust for a forecast error made in FY 1996 through an adjustment to the FY 1998 update. Because we only introduced this analytical framework in FY 1996, FY 1998 is the first year in which a forecast error adjustment could be required.

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

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI 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. We have therefore incorporated the intensity adjustment from the operating update framework into the capital update framework. In the absence of 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 1997, we have developed a Medicare-specific intensity measure based on a five-year average using FY 1991-1995. In determining case-mix constant intensity, we found that observed case-mix increase was 2.8 percent in FY 1991, 1.8 percent in FY 1992, 0.9 percent in FY 1993, 0.8 percent in FY 1994, and 1.6 percent in FY 1995. For FY 1991 and FY 1992, 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 rather 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 1991 through FY 1994. As discussed above, we have determined that all of the observed case-mix increase for FY 1995 is real.

Given estimates of real case-mix increase of 1.0 percent for FY 1991 and FY 1992, 0.9 percent for FY 1993, 0.8 percent for FY 1994, and 1.6 percent for FY 1995, we estimate that case-mix constant intensity declined by an

average 1.1 percent during FY 1991 through FY 1995, for a cumulative decrease of 5.6 percent. If we assume that real case-mix increase was 1.4 percent for FY 1991 and FY 1992, 0.9 percent for FY 1993, 0.8 percent for FY 1994, and 1.6 percent for FY 1995, we estimate that case-mix constant intensity declined by an average 1.2 percent during FY 1991 through FY 1995, for a cumulative decrease of 5.9 percent. Since we estimate that intensity has declined during that period, we are recommending a 0.0 percent intensity adjustment for FY 1997.

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, 60 percent for cost reporting periods beginning in FY 1997 for hospitals paid under the fully prospective 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 according to 100 percent of the Federal rate. For purposes of calculating the outlier thresholds and the outlier reduction factor, we model all hospitals as if 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 September 1, 1995 final rule, we estimated that outlier payments for capital in FY 1996 would equal 4.64 percent of inpatient capital-related payments based on the Federal rate. Accordingly, we applied an outlier adjustment factor of 0.9536 to the Federal rate. Based on the thresholds as set forth in section II.A.4.d of this Addendum, we estimate that outlier payments for capital will equal 5.24 percent of inpatient capital-related payments based on the Federal rate in FY 1997. We are, therefore, proposing an outlier adjustment factor of 0.9476 to the Federal rate. Thus, estimated capital outlier payments for FY 1997 represent a higher percentage of total capital standard payments than in FY 1996.

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 1997 is 0.9937 (0.9476/0.9536). Thus, the outlier adjustment decreases the FY 1997 Federal rate by 0.63 percent (0.9937 - 1) compared with the FY 1996 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 geographic adjustment factor 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 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 geographic adjustment factor. 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 geographic adjustment factor.

For FY 1996, we calculated a GAF/DRG budget neutrality factor of 0.9994. For FY 1997, we are proposing a GAF/DRG budget neutrality factor of 0.9992. 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 geographic adjustment factor. The proposed incremental change in the adjustment from FY 1996 to FY 1997 is 0.9992. The proposed cumulative change in the rate due to this adjustment is 1.0017 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996 and the proposed incremental factor for FY 1997: 0.9980×1.0053×0.9998×0.9994×0.9992 = 1.0017).

This factor accounts for DRG reclassifications and recalibration and for changes in the geographic adjustment factor. It also incorporates the effects on the geographic adjustment factor of FY 1997 geographic reclassification decisions made by the MGCRB compared to FY 1996 decisions. However, it does not account for changes in payments due to changes in the disproportionate share and indirect medical education 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 1996, we estimated that exceptions payments would equal 1.51 percent of aggregate payments based on the Federal rate and the hospital-specific rate. Therefore, we applied an exceptions reduction factor of 0.9849 (1–0.0151) in determining the Federal rate. For this proposed rule, we estimate that exceptions payments for FY 1997 will equal 6.07 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We are, therefore, proposing an exceptions payment reduction factor of 0.9393 to the Federal rate for FY 1997.

The proposed exceptions reduction factor for FY 1997 is thus 4.63 percent lower than the factor for FY 1996. We have expected the number and amount of exceptions payments generally to increase throughout the transition period.

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 1997 Federal rate is 0.9393/0.9849, or 0.9537.

5. Standard Capital Federal Rate for FY 1997

For FY 1996, the capital Federal rate was $461.96. With the changes we are proposing to the factors used to establish the Federal rate, the FY 1997

Federal rate would be $441.84. The proposed Federal rate for FY 1997 was calculated as follows:

- The proposed FY 1997 update factor is 1.0100, that is, the proposed update is 1.00 percent.
- The proposed FY 1997 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the geographic adjustment factor is 0.9992.
- The proposed FY 1997 outlier adjustment factor is 0.9476.
- The proposed FY 1997 exceptions payments adjustment factor is 0.9393.

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 geographic adjustment factor.

We are providing a chart that shows how each of the factors and adjustments for FY 1997 affected the computation of the proposed FY 1997 Federal rate in comparison to the FY 1996 Federal rate. The proposed FY 1997 update factor has the effect of increasing the Federal rate by 1.00 percent compared to the rate in FY 1996, while the proposed geographic and DRG budget neutrality factor has the effect of decreasing the Federal rate by 0.08 percent. The proposed FY 1997 outlier adjustment factor has the effect of decreasing the Federal rate by 0.63 percent compared to FY 1996. The proposed FY 1997 exceptions reduction factor has the effect of decreasing the Federal rate by 4.63 percent compared to the exceptions reduction for FY 1996. The combined effect of all the proposed changes is to decrease the proposed Federal rate by 4.36 percent compared to the Federal rate for FY 1996.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 1996 FEDERAL RATE AND PROPOSED FY 1997 FEDERAL RATE

		Change	Percent change
Update factor: [1]			
FY 1996	1.0120	.....	.....
Proposed FY 1997	1.0100	1.0100	1.00
GAF/DRG adjustment factor [1]	.....		
FY 1996	0.9994	.....	.....
Proposed FY 1997	0.9992	0.9992	−0.08
Outlier adjustment factor: [2]			
FY 1996	0.9536	.....	.....
Proposed FY 1997	0.9476	0.9937	−0.63
Exceptions adjustment factor: [2]			
FY 1996	0.9849	.....	.....
Proposed FY 1997	0.9393	0.9537	−4.63
Federal Rate:			
FY 1996	$461.96	.....	.....
Proposed FY 1997	$441.84	0.9564	−4.36

[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 1996 to FY 1997 resulting from the application of the 0.9992 GAF/DRG budget neutrality factor for FY 1997 is 0.9992.

[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 1997 exceptions reduction factor is 0.9393/0.9849, or 0.9537.

6. Special Rate for Puerto Rico Hospitals

For FY 1996, the special rate for Puerto Rico hospitals was $355.35. With the changes we are proposing to the factors used to determine the rate, the proposed FY 1997 special rate for Puerto Rico would be $339.87.

B. Determination of Hospital-Specific Rate Update

Section 412.328(e) of the regulations provides that the hospital-specific rate for FY 1997 be determined by adjusting the FY 1996 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 1997, we are proposing that the hospital-specific rate be updated by a factor of 1.0100.

2. Exceptions Payment Adjustment Factor

For FY 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 1997, we estimate that exceptions payments will be 6.07 percent of aggregate payments based on the Federal rate and the hospital-specific rate. We therefore propose that the updated hospital-specific rate be reduced by a factor of 0.9393. 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. Therefore, the proposed net adjustment to the FY 1997 hospital-specific rate is 0.9393/0.9849, or 0.9537.

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 1996 and FY 1997 and the net adjustment for each factor. It also shows that the proposed cumulative net adjustment from FY 1996 to FY 1997 is 0.9632, which represents a proposed decrease of 3.68 percent to the hospital-specific rate. The proposed FY 1997 hospital-specific rate for each hospital is determined by multiplying the FY 1996 hospital-specific rate by the cumulative net adjustment of 0.9632.

PROPOSED FY 1997 UPDATE AND ADJUSTMENTS TO HOSPITAL-SPECIFIC RATES

		Net adjustment	Percent change
Update factor:			
FY 1996	1.0120	.....	.....
Proposed FY 1997	1.0100	1.0100	1.00
Exceptions payment adjustment factor:			
FY 1996	0.9849	.....	.....
Proposed FY 1997	0.9393	0.9537	−4.63
Cumulative adjustments:			
FY 1996	0.9967	.....	.....
Proposed FY 1997	0.9601	0.9632	−3.68

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 1996 to FY 1997 is 1.0100. In contrast, the exceptions payment adjustment factor is not applied cumulatively. Thus, for example, the incremental increase in the exceptions reduction factor from FY 1996 to FY 1997 is 0.9393/0.9849, or 0.9537.

C. Calculation of Inpatient Capital-Related Prospective Payments for FY 1997

During the capital prospective payment system transition period, a hospital is paid for the inpatient capital-related costs under one of two alternative 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 geographic adjustment factor, 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)×(Geographic Adjustment Factor)×(Large Urban Add-on, if applicable)×(COLA adjustment for hospitals located in Alaska and Hawaii)×(1+Disproportionate Share Adjustment Factor+Indirect Medical Education Adjustment Factor, if applicable). The result is termed 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:

- 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 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 1997 are 60 percent of the adjusted Federal rate and 40 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 60 percent of the Federal rate for discharges occurring in cost reporting periods beginning during FY 1997. Thus, a fully prospective hospital will receive 60 percent of the capital-related outlier payment calculated for the case for discharges occurring in cost reporting periods beginning in FY 1997. 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 1997 are published in section II.A.4.c of this Addendum. For FY 1997, 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 $11,050. A case qualifies as a day outlier for FY 1997 if the length of stay is greater than the geometric mean length of stay for the DRG plus the lesser of 24 days or three standard deviations of the length of stay.

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 1997 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.

V. 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, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H, 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 1995 and Hospital Average Hourly Wage for Federal Fiscal Year 1997 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 5—List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric Mean Length of Stay, and Length of Stay Outlier Cutoff Points Used in the Prospective Payment System
Table 6A—New Diagnosis Codes
Table 6B—New Procedure Codes
Table 6C—Invalid Diagnosis Codes
Table 6D—Invalid Procedure Codes
Table 6E—Revised Diagnosis Code Titles
Table 6F—Revised Procedure Code Titles
Table 6G—Additions to the CC Exclusions List
Table 6H—Deletions to the CC Exclusions List
Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 95 MEDPAR Update 12/95 GROUPER V13.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 95 MEDPAR Update 12/95 GROUPER V14.0
Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) April 1996
Table 8B—Statewide Average Capital Cost-to-Charge Ratios (Case Weighted) April 1996

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

Large urban areas		Other areas	
Labor-related	Non-labor related	Labor-related	Non-labor related
2796.66	1131.23	2752.39	1113.33

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

	Large urban areas		Other areas	
	Labor-related	Non-labor related	Labor-related	Non-labor related
National	$2772.89	$1121.62	$2772.89	$1121.62
Puerto Rico	2501.07	521.22	2461.47	512.97

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$441.84
Puerto Rico	339.87

TABLE 3C.—HOSPITAL CASE MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 1995

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
010001	01.4400	14.82	010095	00.9230	11.25	030004	00.9824	13.49	040004	01.4485	14.83	040107	01.1923	14.95
010004	00.9600	11.10	010097	00.9405	15.20	030006	01.5576	17.52	040005	01.0380	11.59	040109	01.1692	12.69
010005	01.1609	15.40	010098	01.1941	11.02	030007	01.3158	16.41	040007	01.8761	18.12	040114	01.8513	16.64
010006	01.4752	15.23	010099	01.1210	15.49	030008	02.1095	20.42	040008	01.0325	10.77	040116	01.3895	19.25
010007	01.0986	13.12	010100	01.1688	14.77	030009	01.2993	15.58	040010	01.2298	13.78	040118	01.1313	14.29
010008	01.1366	09.54	010101	01.1127	14.21	030010	01.4160	17.75	040011	00.9298	10.75	040119	01.0914	14.34
010009	01.1377	14.82	010102	00.9529	13.63	030011	01.4747	17.66	040014	01.1929	16.07	040124	01.2238	14.30
010010	01.1330	14.33	010103	01.7534	17.01	030012	01.2246	15.81	040015	01.1944	12.12	040126	00.9617	11.74
010011	01.6185	18.94	010104	01.6892	17.87	030013	01.2459	18.99	040016	01.7330	16.43	050002	01.5554	25.91
010012	01.2666	16.27	010108	01.1189	13.68	030014	01.4394	17.86	040017	01.2569	11.68	050006	01.3983	19.15
010015	01.0512	15.63	010109	01.0527	11.48	030016	01.2462	17.09	040018	01.1686	16.66	050007	01.5848	25.29
010016	01.2643	16.76	010110	01.0168	13.44	030017	01.4929	18.98	040019	01.1618	13.52	050008	01.4998	25.48
010018	00.9017	16.19	010112	01.1253	14.09	030018	01.7989	19.57	040020	01.5987	14.08	050009	01.7211	31.63
010019	01.2868	14.99	010113	01.6374	13.69	030019	01.1962	19.31	040021	01.2277	14.69	050013	01.8099	22.05
010021	01.2388	12.20	010114	01.3174	15.37	030022	01.5055	17.41	040022	01.6951	14.73	050014	01.1741	22.55
010022	01.0109	16.89	010115	00.8385	11.98	030023	01.2640	17.64	040024	01.1709	12.16	050015	01.3882	22.18
010023	01.4760	14.71	010117	00.7880	13.54	030024	01.7809	21.04	040025	00.9214	11.81	050016	01.1598	18.51
010024	01.4014	15.62	010118	01.2475	15.07	030025	01.1633	12.76	040026	01.5547	16.35	050017	02.0618	24.39
010025	01.4390	13.16	010119	01.5429	16.36	030027	01.0875	14.69	040027	01.2889	12.56	050018	01.3434	18.49
010027	00.8352	13.55	010120	00.9668	14.32	030030	01.6651	18.19	040028	01.0903	11.40	050021	01.4146	23.75
010029	01.4957	14.84	010121	01.2269	12.92	030033	01.2475	16.40	040029	01.2557	14.12	050022	01.4601	22.63
010031	01.1808	14.58	010123	01.2421	17.47	030034	01.0430	15.89	040030	00.8925	11.09	050024	01.3952	21.31
010032	00.9478	12.45	010124	01.2927	16.15	030035	01.3403	20.77	040032	01.0056	11.18	050025	01.8000	22.00
010033	01.9143	17.61	010125	01.0247	12.86	030036	01.1393	18.23	040035	01.0240	10.24	050026	01.4525	21.79
010034	01.0751	13.48	010126	01.1770	13.13	030037	02.0161	19.60	040036	01.4976	16.45	050028	01.4395	15.33
010035	01.2397	15.13	010127	01.2999	16.29	030038	01.6125	18.82	040037	01.1101	11.55	050029	01.3830	25.55
010036	01.1252	15.34	010128	00.9565	12.34	030040	01.1885	15.88	040039	01.2411	12.23	050030	01.3324	19.24
010038	01.3397	16.48	010129	01.0795	13.29	030041	00.9963	13.68	040040	00.9953	15.73	050032	01.2735	22.76
010039	01.7029	16.14	010130	01.0352	15.28	030043	01.1937	18.25	040041	01.3946	13.95	050033	01.4136	25.47
010040	01.5335	18.21	010131	01.3636	17.75	030044	01.0291	13.19	040042	01.2978	12.03	050036	01.6162	18.61
010043	01.1036	10.35	010134	00.9206	13.36	030046	00.9134	16.38	040044	00.9622	10.04	050038	01.4553	29.05
010044	01.0919	11.01	010137	01.2516	16.36	030047	00.9471	19.91	040045	01.0301	14.28	050039	01.6127	21.04
010045	01.2121	10.79	010138	00.9485	09.85	030049	00.9741	17.30	040047	01.0939	14.78	050040	01.0842	22.92
010046	01.5291	15.51	010139	01.6592	19.67	030054	00.8723	12.63	040048	01.2149	13.48	050041	02.8656	22.21
010047	01.0243	10.05	010143	01.1921	15.83	030055	01.2014	16.85	040050	01.1013	11.66	050042	01.3081	20.20
010049	01.1121	15.66	010144	01.3104	18.42	030059	01.2776	19.95	040051	01.0923	12.64	050043	01.5723	30.15
010050	01.0635	13.48	010145	01.3376	14.59	030060	01.2095	13.90	040053	01.1093	11.67	050045	01.2649	17.11
010051	00.8549	10.24	010146	01.1772	15.59	030061	01.6462	16.75	040054	01.0301	12.44	050046	01.1888	23.81
010052	00.9858	12.78	010148	00.9969	12.83	030062	01.2267	15.56	040055	01.4506	14.51	050047	01.6388	29.15
010053	01.0653	12.67	010149	01.3527	17.75	030064	01.6191	16.92	040058	01.0617	13.61	050051	01.1104	16.63
010054	01.1726	16.17	010150	01.0473	16.29	030065	01.6407	18.87	040060	00.9896	09.85	050054	01.1961	20.55
010055	01.4846	16.35	010152	01.4762	16.29	030067	01.0515	15.92	040062	01.6181	16.66	050055	01.3742	27.54
010056	01.3970	17.99	010155	00.9996	09.42	030068	00.9514	14.04	040063	01.4673	15.67	050056	01.3374	25.23
010058	01.0881	12.96	020001	01.4712	25.53	030069	01.3354	19.11	040064	01.0523	10.49	050057	01.4835	20.22
010059	01.0165	14.17	020002	01.0281	24.16	030071	00.9488	.....	040066	01.1537	14.63	050058	01.4664	22.78
010061	01.0127	14.70	020004	01.1028	25.46	030072	00.9090	.....	040067	01.0801	11.34	050060	01.5897	24.25
010062	01.0042	13.45	020005	00.9029	28.36	030073	00.9752	.....	040069	01.1090	14.90	050061	01.4258	22.12
010064	01.7890	17.85	020006	01.1418	23.19	030074	00.8587	.....	040070	00.9433	14.98	050063	01.4029	21.44
010065	01.3668	14.30	020007	00.8909	21.82	030075	00.8660	.....	040071	01.5932	15.42	050065	01.6064	22.37
010066	00.9789	10.87	020008	01.1006	26.45	030076	00.9802	.....	040072	01.0871	13.40	050066	01.2689	24.33
010068	01.2370	18.82	020009	00.9255	21.29	030077	00.8761	.....	040074	01.2566	14.51	050067	01.3777	21.09
010069	01.1589	13.06	020010	00.9141	22.13	030078	01.1027	.....	040075	01.0668	11.57	050068	01.0839	19.05
010072	01.2161	12.72	020011	01.0488	22.27	030079	00.7787	.....	040076	01.0273	14.71	050069	01.6183	23.15
010073	00.9701	09.66	020012	01.3062	23.99	030080	01.6564	20.82	040077	00.9196	10.72	050070	01.2901	30.80
010078	01.1795	15.04	020013	01.0055	24.03	030083	01.3106	21.70	040078	01.4945	17.29	050071	01.3159	30.70
010079	01.2807	12.53	020014	01.0769	24.52	030084	00.9358	.....	040080	01.0752	15.45	050072	01.3053	31.00
010080	01.0389	12.99	020017	01.5181	26.83	030085	01.5045	20.21	040081	00.9285	09.91	050073	01.3239	31.41
010081	01.9832	16.16	020018	00.8963	.....	030086	01.3209	18.76	040082	01.2156	13.69	050074	01.2314	32.96
010083	01.0377	13.25	020019	00.8718	.....	030087	01.6153	18.77	040084	01.0963	14.83	050075	01.4037	30.72
010084	01.4816	16.61	020020	00.8398	.....	030088	01.3513	19.90	040085	01.2493	15.18	050076	01.7756	29.65
010085	01.3233	17.11	020021	00.8478	.....	030089	01.5736	18.66	040088	01.3091	13.73	050077	01.6152	22.83
010086	01.0507	13.54	020024	01.0693	22.64	030092	01.5590	20.62	040090	00.8983	13.78	050078	01.3591	24.44
010087	01.6243	16.88	020025	01.0046	24.44	030093	01.3791	18.08	040091	01.2930	18.25	050079	01.5938	28.30
010089	01.1934	14.91	020026	01.3340	.....	030094	01.2494	18.57	040093	00.9598	10.98	050080	01.2183	22.05
010090	01.5725	16.40	020027	00.9975	.....	030095	01.2183	13.09	040095	00.9069	10.56	050081	01.6564	24.01
010091	00.9195	13.43	030001	01.3076	19.28	040001	01.1308	12.37	040100	01.2465	12.81	050082	01.4989	21.34
010092	01.4209	15.17	030002	01.7918	20.25	040002	01.1644	13.07	040105	01.0068	11.90	050084	01.5611	22.33
010094	01.1410	16.76	030003	01.8923	21.05	040003	01.0704	13.19	040106	01.2448	12.84	050088	01.1538	21.94

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
050089	01.3485	19.92	050189	00.9777	21.50	050296	01.2071	22.69	050420	01.4424	25.15	050545	00.8420	20.39
050090	01.2755	21.75	050191	01.5032	20.64	050298	01.3081	20.18	050421	01.4112	24.62	050546	00.7212	21.10
050091	01.1984	24.42	050192	01.1071	18.74	050299	01.3607	22.49	050423	00.9821	19.25	050547	00.9602	20.65
050092	00.8504	16.19	050193	01.3631	22.56	050300	01.3100	18.87	050424	01.8316	22.16	050549	01.7182	25.86
050093	01.5917	22.35	050194	01.2409	25.03	050301	01.3825	21.54	050425	01.2719	30.41	050550	02.3168	23.34
050096	01.1244	12.95	050195	01.5876	31.29	050302	01.4049	24.31	050426	01.3055	23.89	050551	01.3473	24.20
050097	01.5025	18.40	050196	01.4205	16.40	050305	01.5824	29.82	050430	00.9919	15.94	050552	01.1633	22.44
050099	01.4660	22.91	050197	01.8278	29.07	050307	01.4439	20.51	050431	01.0836	22.58	050557	01.4928	21.08
050100	01.6910	29.38	050199	00.8980	19.48	050308	01.5797	29.77	050432	01.5774	23.69	050559	01.3672	24.18
050101	01.3999	25.12	050204	01.4910	23.12	050309	01.3306	23.63	050433	01.0327	17.37	050560	01.1894	.....
050102	01.4714	22.34	050205	01.3876	19.99	050310	01.2239	22.24	050434	01.1491	18.08	050561	01.2110	30.34
050103	01.6097	26.74	050207	01.2860	20.58	050312	01.9820	23.66	050435	01.2411	18.98	050564	01.2109	24.02
050104	01.3906	21.73	050208	00.9572	27.63	050313	01.1891	20.90	050436	01.0099	15.77	050565	01.1456	21.26
050107	01.4355	22.92	050211	01.3142	29.60	050315	01.1826	20.75	050438	01.6261	23.33	050566	00.8791	19.75
050108	01.5819	22.78	050213	01.3924	21.12	050317	01.3583	20.90	050440	01.4107	19.93	050567	01.6543	23.01
050109	02.3436	24.68	050214	01.4409	21.76	050320	01.3185	27.27	050441	01.9214	28.10	050568	01.4314	18.28
050110	01.2436	18.72	050215	01.5216	27.75	050324	01.8339	25.93	050443	00.9533	15.95	050569	01.3545	22.93
050111	01.3786	18.81	050217	01.3730	18.44	050325	01.2554	20.87	050444	01.3479	22.19	050570	01.7026	24.91
050112	01.5234	22.15	050219	01.3115	20.37	050327	01.5839	21.00	050446	00.8936	17.25	050571	01.4016	22.37
050113	01.2749	28.23	050222	01.5916	24.56	050328	01.4584	32.92	050447	01.0883	18.59	050573	01.6412	23.66
050114	01.3978	21.65	050224	01.5471	22.17	050329	01.3142	20.34	050448	01.1113	19.82	050575	01.2303	.....
050115	01.6146	21.11	050225	01.3284	20.67	050331	01.4090	27.22	050449	01.3527	21.99	050577	01.3652	20.32
050116	01.4542	22.73	050226	01.3349	22.58	050333	00.9767	18.66	050454	01.8309	26.10	050578	01.1731	23.70
050117	01.2871	20.93	050228	01.3665	29.90	050334	01.7683	28.22	050455	01.9292	22.89	050579	01.5656	26.94
050118	01.2840	23.24	050230	01.2972	26.22	050335	01.2505	19.62	050456	01.1314	20.24	050580	01.3595	23.47
050121	01.4060	19.96	050231	01.6364	24.14	050336	01.3398	21.04	050457	01.9435	28.66	050581	01.4162	24.63
050122	01.7066	22.90	050232	01.7628	24.17	050337	01.1726	23.87	050459	01.1929	28.20	050583	01.5880	23.08
050124	01.2730	19.72	050233	01.2974	30.88	050342	01.3686	17.55	050464	01.8776	22.62	050584	01.2006	22.39
050125	01.3140	25.98	050234	01.3251	22.00	050343	01.0325	18.56	050468	01.4046	16.26	050585	01.2357	23.70
050126	01.4704	23.23	050235	01.5105	25.00	050348	01.6030	22.83	050469	01.0879	17.33	050586	01.3647	21.76
050127	01.2952	22.89	050236	01.6626	24.28	050349	00.8988	14.28	050470	01.1148	21.29	050588	01.3703	26.55
050128	01.5405	20.97	050238	01.4959	22.95	050350	01.3856	22.68	050471	01.7202	24.07	050589	01.3124	25.37
050129	01.5583	22.11	050239	01.5085	21.24	050351	01.4774	24.81	050476	01.3437	19.12	050590	01.4086	23.00
050131	01.2652	27.83	050240	01.3951	22.82	050352	01.2941	23.35	050477	01.5136	24.50	050591	01.2861	27.01
050132	01.4397	24.55	050241	01.2374	25.78	050353	01.5622	21.45	050478	00.9225	21.73	050592	01.3408	20.34
050133	01.3513	20.16	050242	01.4698	27.10	050355	00.9696	15.53	050481	01.4166	24.85	050593	01.5583	24.40
050135	01.3794	26.86	050243	01.5323	21.58	050357	01.7247	23.17	050482	00.9451	14.55	050594	02.0151	23.81
050136	01.3772	22.75	050245	01.3837	21.74	050359	01.2172	18.78	050483	01.1666	23.89	050597	01.2786	21.91
050137	01.3802	31.46	050248	01.2124	24.50	050360	01.4656	30.15	050485	01.6275	22.34	050598	01.3940	26.87
050138	01.8728	32.07	050251	01.0753	17.68	050366	01.3174	20.47	050486	01.4180	24.94	050599	01.6829	22.70
050139	01.3396	31.14	050253	00.7232	18.87	050367	01.2881	27.02	050488	01.3879	30.41	050601	01.3075	29.03
050140	01.4139	30.76	050254	01.1940	22.13	050369	01.3323	23.30	050489	00.9718	27.10	050603	01.4252	23.50
050144	01.5835	26.03	050256	01.7700	19.70	050373	01.3964	23.83	050491	01.2797	23.76	050604	01.5933	29.56
050145	01.3571	27.67	050257	01.0715	20.65	050376	01.3932	25.86	050492	01.2458	23.05	050607	01.3006	21.79
050146	01.3245	.....	050260	01.0965	21.96	050377	00.9012	15.01	050494	01.1674	24.95	050608	01.3067	15.23
050147	00.6896	20.55	050261	01.1927	17.91	050378	01.0814	22.45	050496	01.7959	31.60	050609	01.4365	31.39
050148	01.1273	19.62	050262	01.9179	26.89	050379	01.0921	19.04	050497	00.7948	.....	050613	01.1496	22.70
050149	01.4339	19.87	050263	01.2879	24.24	050380	01.6703	28.31	050498	01.2636	22.42	050615	01.6939	23.31
050150	01.2565	23.23	050264	01.3732	26.01	050382	01.4511	20.97	050502	01.6551	23.61	050616	01.2953	20.68
050152	01.4301	24.60	050267	01.5239	24.88	050385	01.3960	24.83	050503	01.2916	23.01	050618	01.0619	19.36
050153	01.6384	30.53	050270	01.2432	23.60	050388	00.9028	14.19	050506	01.4122	25.57	050623	01.1349	24.40
050155	01.1043	23.60	050272	01.3296	19.69	050390	01.2211	20.80	050510	01.3632	30.59	050624	01.3670	25.95
050158	01.6805	27.88	050274	00.9624	18.36	050391	01.2785	21.61	050512	01.4686	31.38	050625	01.6096	24.00
050159	01.2651	22.01	050276	01.2223	26.99	050392	00.9426	17.56	050515	01.3589	30.78	050630	01.3621	21.26
050167	01.4551	21.67	050277	01.3817	21.30	050393	01.4157	21.56	050516	01.6670	24.33	050633	01.2959	21.76
050168	01.6003	24.83	050278	01.5174	23.01	050394	01.5428	20.71	050517	01.2879	19.15	050635	01.4145	31.17
050169	01.5891	24.53	050279	01.2461	20.58	050396	01.6157	21.89	050522	01.3128	30.40	050636	01.4311	20.28
050170	01.5175	21.58	050280	01.6551	22.80	050397	01.0118	19.97	050523	01.2703	27.65	050638	01.1002	24.28
050172	01.2609	19.96	050281	01.4519	22.74	050401	01.1174	19.09	050526	01.3687	24.28	050641	01.2473	12.26
050173	01.2203	23.70	050282	01.3433	21.42	050404	01.1443	16.51	050528	01.3542	16.46	050643	00.7832	.....
050174	01.6873	27.89	050283	01.1267	27.59	050406	01.1263	15.29	050531	01.3012	23.60	050644	00.9053	26.86
050175	01.3926	21.97	050286	01.0350	17.99	050407	01.3254	27.06	050534	01.3853	23.83	050660	01.3428	.....
050177	01.2994	18.76	050289	01.7845	27.38	050410	01.0706	17.45	050535	01.3827	22.46	050661	00.8831	20.21
050179	01.2600	17.29	050290	01.6330	32.31	050411	01.4042	29.35	050537	01.2622	21.30	050662	00.8549	21.17
050180	01.5539	30.12	050291	01.2553	24.46	050414	01.2846	24.32	050539	01.2184	21.90	050663	01.0604	23.51
050183	01.1940	19.09	050292	01.0963	21.20	050417	01.3037	19.65	050541	01.5870	31.06	050666	00.7423	23.76
050186	01.2694	24.12	050293	01.1312	19.93	050418	01.4191	24.24	050542	01.2270	13.79	050667	01.0672	24.88
050188	01.3467	25.25	050295	01.4144	20.86	050419	01.3136	18.88	050543	00.9214	21.68	050668	01.1532	28.20

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
050670	00.7582	20.12	060046	01.1205	16.56	080005	01.3363	16.82	100071	01.3024	16.98	100167	01.3944	20.55
050672	00.6267	23.77	060047	00.9606	11.40	080006	01.3822	20.49	100072	01.2515	17.24	100168	01.3799	19.35
050674	01.2111	29.18	060049	01.3511	17.47	080007	01.3620	17.99	100073	01.7938	20.61	100169	01.8590	18.29
050675	01.7056	16.32	060050	01.1719	14.62	090001	01.4216	19.65	100075	01.6403	17.85	100170	01.4917	16.50
050676	00.9864	13.83	060052	01.0999	18.38	090002	01.3022	20.51	100076	01.3869	17.15	100172	01.3694	13.38
050677	01.4253	32.99	060053	00.9988	13.73	090003	01.3041	24.74	100077	01.3153	16.78	100173	01.6691	16.33
050678	01.0713	24.07	060054	01.3361	16.74	090004	01.7168	23.49	100078	01.1683	15.14	100174	01.5295	18.20
050680	01.2114	26.13	060056	00.9577	13.37	090005	01.3431	27.07	100079	01.7501	16.01	100175	01.2130	16.18
050682	00.8558	14.98	060057	01.0356	21.11	090006	01.3749	19.52	100080	01.6306	19.40	100176	02.0431	21.95
050684	01.2074	21.30	060058	00.9237	12.54	090007	01.3832	19.58	100081	01.1202	13.33	100177	01.3403	18.55
050685	01.2219	26.94	060060	00.9651	12.21	090008	01.5276	24.06	100082	01.5459	17.93	100179	01.6520	19.03
050686	01.3503	30.96	060062	00.9518	15.85	090010	01.0013	21.70	100083	01.3240	17.30	100180	01.4188	17.49
050688	01.2730	27.89	060063	01.0264	11.12	090011	01.9804	24.77	100084	01.5314	16.53	100181	01.2846	17.59
050689	01.3988	29.12	060064	01.4325	20.21	090015	01.3306	.....	100085	01.4349	19.50	100183	01.3710	19.18
050690	01.4363	30.39	060065	01.3463	19.98	100001	01.5247	18.83	100086	01.3328	21.32	100186	01.4758	16.70
050693	01.9152	28.80	060066	00.9950	13.10	100002	01.4789	19.71	100087	01.8071	20.71	100187	01.4501	18.35
050694	01.3678	21.20	060068	01.2760	14.00	100004	01.0274	11.81	100088	01.6730	17.32	100189	01.3707	23.13
050695	01.1808	24.30	060070	01.0357	14.99	100005	01.0178	16.26	100090	01.4256	16.07	100191	01.3315	19.19
050696	02.0076	27.85	060071	01.2259	14.69	100006	01.5531	18.99	100092	01.4411	16.20	100199	01.4473	21.29
050697	01.1093	17.93	060073	01.0017	14.32	100007	01.8477	19.61	100093	01.5156	14.28	100200	01.3972	21.35
050698	01.1189	22.83	060075	01.3472	20.27	100008	01.7361	19.80	100098	01.1482	17.43	100203	01.2603	19.34
050699	00.5855	23.13	060076	01.3675	15.97	100009	01.5641	17.89	100099	01.2518	13.09	100204	01.6232	19.95
050700	01.4412	32.46	060085	00.9819	10.94	100010	01.5475	20.58	100102	01.1033	16.44	100206	01.3458	19.47
050701	01.3170	27.13	060087	01.6558	18.67	100012	01.6776	16.91	100103	01.1730	14.46	100207	01.4710	19.86
050702	00.8637	16.98	060088	01.0388	15.38	100014	01.4272	18.57	100105	01.4697	18.08	100208	01.6409	21.14
050704	01.2140	20.48	060090	00.9518	14.23	100015	01.2444	17.60	100106	01.0395	15.46	100209	01.6671	.....
050706	00.9234	16.16	060096	00.9724	21.69	100017	01.6489	17.18	100107	01.4676	18.26	100210	01.6647	16.51
050707	01.2237	25.62	060100	01.4045	20.95	100018	01.2869	19.94	100108	01.1017	15.45	100211	01.3441	19.17
050708	00.9493	15.13	060103	01.2269	21.10	100019	01.4930	18.81	100109	01.3522	16.81	100212	01.6646	18.54
050709	01.3030	.....	060104	01.3213	20.32	100020	01.3365	18.31	100110	01.4128	18.91	100213	01.5438	20.00
050710	01.4014	.....	070001	01.7582	24.78	100022	01.8009	23.05	100112	00.9738	10.84	100217	01.3055	17.06
050711	02.3868	.....	070002	01.8728	24.78	100023	01.3489	15.88	100113	02.0848	18.19	100220	01.9563	19.66
050712	02.1147	.....	070003	01.1239	24.50	100024	01.3583	19.54	100114	01.4930	17.73	100221	01.5644	20.68
060001	01.5550	18.95	070004	01.1696	23.70	100025	01.8825	16.22	100117	01.3334	18.18	100222	01.3723	18.80
060003	01.2961	15.85	070005	01.3792	25.45	100026	01.6477	15.52	100118	01.2737	16.03	100223	01.4892	18.53
060004	01.2624	19.46	070006	01.3529	26.73	100027	00.9736	11.53	100121	01.3068	15.44	100224	01.4648	19.77
060006	01.1955	16.19	070007	01.3475	24.08	100028	01.2678	16.38	100122	01.4565	16.39	100225	01.3368	19.52
060007	01.1900	13.06	070008	01.3124	23.47	100029	01.4029	18.94	100124	01.3643	19.41	100226	01.3383	16.58
060008	01.0198	14.31	070009	01.2830	25.01	100030	01.2690	18.25	100125	01.1630	17.77	100228	01.2947	21.09
060009	01.4621	19.88	070010	01.5535	22.46	100032	01.9188	17.39	100126	01.4954	18.74	100229	01.3211	16.27
060010	01.5276	21.10	070011	01.3259	22.80	100034	01.7338	18.34	100127	01.6870	17.42	100230	01.5471	18.97
060011	01.3023	20.75	070012	01.2576	23.38	100035	01.6138	16.46	100128	02.2417	20.13	100231	01.6613	17.46
060012	01.3852	15.79	070013	01.2822	24.01	100038	01.5951	21.18	100129	01.2509	17.45	100232	01.2675	17.64
060013	01.2654	18.83	070015	01.3569	23.82	100039	01.7158	21.15	100130	01.2008	17.45	100234	01.5324	19.03
060014	01.6915	20.52	070016	01.3194	25.46	100040	01.6731	16.31	100131	01.3922	18.44	100235	01.4827	17.51
060015	01.5657	19.33	070017	01.3781	23.54	100043	01.4570	17.78	100132	01.4189	15.67	100236	01.4442	13.79
060016	01.0954	11.42	070018	01.3719	27.83	100044	01.5045	19.01	100134	01.0741	14.50	100237	02.1446	22.65
060018	01.2199	16.36	070019	01.2169	24.04	100045	01.4032	17.12	100135	01.5224	16.11	100238	01.4858	18.68
060020	01.5176	16.73	070020	01.3709	24.32	100046	01.5110	18.53	100137	01.3279	18.42	100239	01.4622	19.34
060022	01.6695	17.89	070021	01.2987	25.47	100047	01.9163	18.62	100138	00.9478	13.00	100240	00.8437	15.06
060023	01.6463	16.65	070022	01.7641	24.30	100048	01.0025	11.69	100139	01.0496	14.54	100241	00.9433	12.47
060024	01.8181	22.01	070024	01.3541	23.81	100049	01.3263	18.03	100140	01.2518	16.87	100242	01.4135	16.29
060026	01.4223	19.44	070025	01.7842	24.06	100050	01.2227	15.06	100142	01.2004	16.68	100243	01.4119	18.82
060027	01.6577	19.01	070026	01.2223	23.07	100051	01.1532	16.60	100144	01.1466	13.65	100244	01.4339	17.32
060028	01.4947	21.29	070027	01.2599	24.31	100052	01.3772	15.60	100145	01.3481	14.87	100246	01.3465	20.92
060029	00.9485	13.93	070028	01.4783	24.67	100053	01.2886	17.36	100146	01.2770	14.27	100248	01.6989	17.88
060030	01.3165	20.36	070029	01.3524	21.65	100054	01.2923	17.44	100147	01.0996	13.43	100249	01.3543	18.87
060031	01.6115	18.95	070030	01.2990	24.71	100055	01.3679	17.47	100150	01.3759	18.64	100252	01.2419	19.21
060032	01.5777	19.35	070031	01.2706	22.24	100056	01.4655	19.83	100151	01.8572	18.63	100253	01.4755	20.60
060033	01.1561	11.96	070033	01.2881	28.25	100057	01.3455	16.78	100154	01.5689	17.95	100254	01.5854	17.50
060034	01.4958	16.90	070034	01.3752	24.74	100060	01.8491	17.71	100156	01.2204	18.65	100255	01.3322	19.00
060036	01.1712	14.37	070035	01.3469	24.31	100061	01.5100	20.88	100157	01.6134	19.31	100256	01.8955	19.32
060037	01.0382	13.22	070036	01.4320	26.98	100062	01.7185	16.94	100159	00.9856	12.76	100258	01.6509	21.12
060038	01.0192	12.25	070039	00.9213	.....	100063	01.3423	16.12	100160	01.1059	18.07	100259	01.4493	16.36
060041	00.9203	16.53	080001	01.6101	23.66	100067	01.4267	16.38	100161	01.5194	19.76	100260	01.4016	20.44
060042	01.0532	18.49	080002	01.1904	17.32	100068	01.3880	17.42	100162	01.3924	14.53	100262	01.4109	19.32
060043	00.9506	11.78	080003	01.3137	19.32	100069	01.3653	17.29	100165	01.2958	13.45	100263	01.3896	15.44
060044	01.2631	17.32	080004	01.2871	17.59	100070	01.4420	17.56	100166	01.4618	20.31	100264	01.3958	18.24

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
100265	01.3686	17.47	110063	01.0768	11.44	110156	01.0003	12.68	130011	01.2386	16.74	140045	01.0555	14.21
100266	01.2337	15.64	110064	01.2883	15.87	110161	01.3328	20.79	130012	01.0233	18.53	140046	01.3023	14.83
100267	01.3092	16.39	110065	01.0143	12.00	110162	00.8588	.....	130013	01.2416	17.21	140047	01.1406	13.20
100268	01.1990	22.00	110066	01.4374	16.30	110163	01.4549	18.52	130014	01.3094	16.43	140048	01.2744	21.50
100269	01.3605	19.07	110069	01.1706	15.22	110164	01.4190	19.63	130015	00.8608	12.43	140049	01.5796	19.35
100270	00.8185	12.95	110070	01.1733	11.37	110165	01.3107	17.47	130016	00.9300	16.18	140051	01.4912	19.14
100271	01.6614	19.27	110071	01.0308	10.29	110166	01.4995	16.67	130017	01.3710	13.03	140052	01.3150	16.77
100273	00.5356	19.72	110072	01.0243	11.53	110168	01.6538	19.22	130018	01.7015	17.60	140053	01.8914	17.88
100275	01.4206	21.96	110073	01.2050	12.67	110169	00.7308	19.70	130019	01.1172	13.74	140054	01.3616	26.25
100276	01.3027	21.94	110074	01.4803	18.11	110171	01.4451	21.21	130021	01.0324	11.96	140055	00.9382	13.00
100277	01.0093	12.71	110075	01.2149	15.29	110172	01.3290	22.83	130022	01.1917	15.44	140058	01.2318	15.26
100279	01.3786	18.35	110076	01.3902	18.01	110174	01.0473	17.57	130024	01.0580	15.25	140059	01.1334	13.52
100280	01.3831	16.93	110078	01.6637	20.46	110176	01.1251	19.42	130025	01.1537	15.21	140061	01.0878	13.80
100281	01.2517	20.85	110079	01.3869	21.08	110177	01.4857	19.21	130026	01.1747	17.89	140062	01.2451	23.10
100282	01.0482	16.99	110080	01.1544	16.86	110178	01.3702	16.78	130027	00.9528	17.18	140063	01.3960	22.48
100283	01.5478	.....	110082	02.0163	20.36	110179	01.2381	21.56	130028	01.2515	16.08	140064	01.2951	16.15
110001	01.2914	17.40	110083	01.7255	20.66	110181	00.9860	12.59	130029	01.0268	17.07	140065	01.4926	23.68
110002	01.2397	14.83	110086	01.2253	13.74	110183	01.3704	19.70	130030	01.0243	16.20	140066	01.3711	13.39
110003	01.3129	15.41	110087	01.3386	19.17	110184	01.1715	17.58	130031	01.0201	13.26	140067	01.8194	18.24
110004	01.3118	16.17	110088	00.9740	11.17	110185	01.0833	12.23	130034	01.0393	16.38	140068	01.3583	19.00
110005	01.1872	21.40	110089	01.2146	15.37	110186	01.3060	15.97	130035	01.0736	15.37	140069	01.0029	14.23
110006	01.3597	18.00	110091	01.3449	19.15	110187	01.2469	17.19	130036	01.2609	12.50	140070	01.2830	16.18
110007	01.4425	15.69	110092	01.1821	12.55	110188	01.4186	18.00	130037	01.2616	14.58	140074	00.9704	14.60
110008	01.2405	15.47	110093	01.0096	09.81	110189	01.1327	19.78	130043	00.9469	14.61	140075	01.4685	21.53
110009	01.0377	15.71	110094	00.9542	12.06	110190	01.0859	14.41	130044	01.1660	12.37	140077	01.1503	17.05
110010	02.1503	21.39	110095	01.2750	13.86	110191	01.3482	18.06	130045	01.0284	12.15	140079	01.2410	20.90
110011	01.2868	16.01	110096	01.1414	14.30	110192	01.3977	22.17	130048	01.0663	11.90	140080	01.5779	19.60
110013	01.1312	14.36	110097	01.0166	15.58	110193	01.2300	16.16	130049	01.2960	17.55	140081	01.0821	13.92
110014	01.0340	14.48	110098	01.0881	11.76	110194	00.9644	11.77	130054	00.9683	17.12	140082	01.5059	22.10
110015	01.3622	16.52	110100	01.0968	12.27	110195	01.0844	10.50	130056	00.8652	09.45	140083	01.2600	16.51
110016	01.2991	14.21	110101	01.1035	09.24	110198	01.3316	22.58	130058	01.0150	12.87	140084	01.2248	17.94
110017	00.8897	11.01	110103	00.9630	10.35	110200	01.9437	15.79	130060	01.1458	18.38	140086	01.1464	13.93
110018	01.1357	17.20	110104	01.1073	13.28	110201	01.4531	16.13	130061	00.9513	.....	140087	01.3852	17.10
110020	01.2352	17.30	110105	01.1304	15.17	110203	00.9692	14.94	140001	01.2958	14.63	140088	01.6480	23.33
110023	01.2361	17.53	110107	01.8146	17.59	110204	00.7960	13.48	140002	01.2776	17.04	140089	01.2253	15.85
110024	01.4802	18.74	110108	00.9720	11.27	110205	01.1080	11.84	140003	01.0184	13.14	140090	01.5101	23.62
110025	01.4157	16.85	110109	01.1115	12.14	110207	01.1008	15.59	140004	01.0799	13.75	140091	01.8655	17.70
110026	01.1891	13.87	110111	01.1934	14.70	110208	00.9734	14.94	140005	00.9511	09.98	140093	01.1961	17.17
110027	01.1013	14.56	110112	01.1522	15.06	110209	00.8222	.....	140007	01.4675	20.56	140094	01.2905	18.81
110028	01.5984	17.75	110113	01.1384	12.86	120001	01.7331	24.22	140008	01.4859	20.57	140095	01.3991	.....
110029	01.3374	17.71	110114	01.0749	13.75	120002	01.1971	21.46	140010	01.3888	22.14	140097	00.9102	14.15
110030	01.2807	16.60	110115	01.6188	21.82	120003	01.1450	21.82	140011	01.1465	15.31	140100	01.2229	17.62
110031	01.3367	19.58	110118	01.0422	13.18	120004	01.2653	20.56	140012	01.2840	17.59	140101	01.2108	18.04
110032	01.2298	15.31	110120	01.0800	13.35	120005	01.2656	18.34	140013	01.6579	16.49	140102	01.0422	14.09
110033	01.5204	20.32	110121	01.1802	11.84	120006	01.2116	22.75	140014	01.0745	16.31	140103	01.3357	16.66
110034	01.5019	16.64	110122	01.3550	16.03	120007	01.6278	20.27	140015	01.2937	13.45	140105	01.3085	18.25
110035	01.3991	18.53	110124	01.0703	15.32	120009	01.0061	18.05	140016	00.9317	11.59	140107	01.0869	11.63
110036	01.6840	22.81	110125	01.2217	15.97	120010	01.8369	22.11	140018	01.4564	18.85	140108	01.3663	20.00
110037	01.0904	10.18	110127	00.9066	14.43	120011	01.2382	30.31	140019	00.9926	11.80	140109	01.1410	12.95
110038	01.4674	15.04	110128	01.1920	17.54	120012	01.0209	20.30	140024	01.0178	13.59	140110	01.2359	14.51
110039	01.3709	17.93	110129	01.6749	13.01	120014	01.3556	21.25	140025	01.0795	15.88	140112	01.0953	13.55
110040	01.0270	16.26	110130	01.0721	10.57	120015	00.8375	21.01	140026	01.1409	15.58	140113	01.4647	19.21
110041	01.2250	16.43	110132	01.1433	12.87	120016	00.8558	21.94	140027	01.3182	15.96	140114	01.3202	18.95
110042	01.2103	14.63	110134	00.8944	11.65	120018	01.0071	21.16	140029	01.3782	19.62	140115	01.2339	19.32
110043	01.7167	15.17	110135	01.1981	13.83	120019	01.1834	19.48	140030	01.6711	21.46	140116	01.2862	19.68
110044	01.0960	14.31	110136	01.1213	13.57	120021	00.9888	19.68	140031	01.1749	13.02	140117	01.4895	17.63
110045	01.2388	22.04	110140	00.8182	15.03	120022	01.7240	17.83	140032	01.2531	16.44	140118	01.6767	22.66
110046	01.1993	15.07	110141	00.9067	11.65	120026	01.2802	22.30	140033	01.2640	19.10	140119	01.6872	19.58
110048	01.3128	12.97	110142	00.9806	11.15	120027	01.5395	21.16	140034	01.1800	16.74	140120	01.5073	14.72
110049	01.0704	13.71	110143	01.3994	20.07	130001	01.0424	17.21	140035	01.0305	10.70	140121	01.5215	10.91
110050	01.0669	14.00	110144	01.1678	16.44	130002	01.3774	14.66	140036	01.2388	15.03	140122	01.5566	21.02
110051	00.9865	16.35	110146	01.0299	09.43	130003	01.3112	18.11	140037	00.9794	12.24	140124	01.1139	23.06
110052	00.9774	09.11	110149	01.1319	12.17	130005	01.4396	18.19	140038	01.1510	15.00	140125	01.3450	15.60
110054	01.2816	16.57	110150	01.3658	16.56	130006	01.8983	18.19	140039	00.9224	11.51	140127	01.3522	16.83
110056	00.9765	12.61	110152	01.1295	13.06	130007	01.6434	18.60	140040	01.3093	14.34	140128	01.0595	16.10
110059	01.2900	14.39	110153	01.0212	15.33	130008	00.9857	10.28	140041	01.2320	15.01	140129	01.0555	13.18
110061	01.0143	10.61	110154	00.8337	12.68	130009	00.9627	14.78	140042	01.0524	13.30	140130	01.2738	21.67
110062	00.9181	09.73	110155	01.2376	12.27	130010	00.9403	15.04	140043	01.1790	16.37	140132	01.4146	18.58

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
140133	01.3730	19.77	140230	00.9439	15.48	150043	01.0625	16.58	150127	01.0419	14.34	160069	01.4042	16.05
140135	01.3146	14.29	140231	01.6272	19.79	150044	01.2634	17.63	150128	01.2340	18.59	160070	01.0255	13.84
140137	01.0354	13.61	140233	01.7471	16.57	150045	01.0913	15.00	150129	01.1915	20.35	160072	01.0688	12.08
140138	00.9661	12.15	140234	01.1838	15.82	150046	01.5896	16.06	150130	01.1496	15.90	160073	01.0070	11.50
140139	01.0792	13.46	140236	01.0311	12.82	150047	01.6212	17.74	150132	01.3365	19.17	160074	01.1069	12.89
140140	01.1317	13.05	140239	01.5856	18.81	150048	01.1679	16.18	150133	01.2095	14.96	160075	01.1112	13.84
140141	00.8984	13.30	140240	01.5048	20.90	150049	01.0776	13.72	150134	01.2828	16.61	160076	01.0692	16.28
140143	01.0643	15.85	140242	01.5726	22.51	150050	01.1998	14.50	150136	00.9472	18.69	160077	01.1216	10.97
140144	00.9856	16.57	140245	01.1273	13.55	150051	01.3841	16.82	150138	01.1623	.....	160079	01.4245	15.22
140145	01.2030	14.31	140246	01.0570	12.03	150052	01.0743	12.93	150139	01.4806	.....	160080	01.2082	15.41
140146	00.9666	14.85	140250	01.3165	21.35	150053	01.0618	16.69	150141	01.0859	.....	160081	01.0672	14.36
140147	01.1866	13.37	140251	01.3066	18.25	150054	01.1376	12.39	150142	02.4300	.....	160082	01.7545	17.09
140148	01.8018	16.51	140252	01.4201	21.25	150056	01.6228	21.59	150897	04.9892	.....	160083	01.5789	17.49
140150	01.5561	26.00	140253	01.4456	.....	150057	02.3179	15.06	160001	01.2719	16.39	160085	01.0916	12.79
140151	01.1119	17.61	140258	01.5345	21.07	150058	01.6930	18.64	160002	01.1888	13.13	160086	01.0283	12.56
140152	01.0750	22.48	140271	01.0260	13.54	150059	01.3218	18.91	160003	01.0221	11.87	160088	01.0017	13.10
140155	01.1854	16.91	140275	01.2294	18.20	150060	01.1281	12.79	160005	01.1072	12.93	160089	01.1591	14.12
140158	01.2597	21.41	140276	01.9589	20.48	150061	01.2957	15.86	160007	01.0085	12.02	160090	01.0066	13.98
140160	01.2326	15.34	140280	01.2769	16.16	150062	01.0670	15.20	160008	01.1043	13.93	160091	01.0987	10.56
140161	01.1373	17.05	140281	01.6388	20.19	150063	01.0538	18.88	160009	01.1577	13.54	160092	00.9736	12.93
140162	01.7778	18.38	140285	01.2063	14.75	150064	01.2100	16.48	160012	01.0588	14.05	160093	01.1351	15.20
140164	01.2855	16.01	140286	01.1491	17.59	150065	01.1505	15.94	160013	01.2189	16.64	160094	01.2168	14.79
140165	01.1085	13.06	140288	01.7781	22.47	150066	01.0021	13.75	160014	01.0459	12.72	160095	01.0266	12.30
140166	01.2889	16.62	140289	01.3089	15.67	150067	01.1221	14.35	160016	01.2911	15.68	160097	01.0785	13.47
140167	01.1636	14.64	140290	01.3385	19.21	150069	01.2347	16.53	160018	00.9429	13.19	160098	01.0760	13.90
140168	01.1840	15.02	140291	01.2645	22.64	150070	01.0350	16.16	160020	01.0963	12.11	160099	00.9737	12.80
140170	01.1280	12.39	140292	01.1678	19.04	150071	01.1562	12.69	160021	01.0439	13.85	160101	01.1220	17.71
140171	00.9149	12.53	140294	01.1864	16.10	150072	01.1914	15.32	160023	01.1458	13.66	160102	01.3668	14.31
140172	01.5065	18.29	140297	01.2589	21.42	150073	01.0044	15.49	160024	01.5710	17.39	160103	01.0113	12.95
140173	00.9721	13.11	140300	01.6785	25.11	150074	01.5934	19.00	160026	01.0986	15.21	160104	01.2335	19.21
140174	01.4333	18.89	150001	01.0846	16.95	150075	01.2247	13.82	160027	01.1671	13.22	160106	01.0829	14.18
140176	01.2617	18.83	150002	01.4319	19.23	150076	01.1512	19.89	160028	01.3407	17.78	160107	01.1437	13.78
140177	01.2945	16.44	150003	01.7075	18.32	150077	01.2659	16.21	160029	01.4962	17.46	160108	01.1602	14.09
140179	01.3297	19.51	150004	01.4226	19.99	150078	01.0834	17.20	160030	01.2338	16.67	160109	01.1631	12.01
140180	01.5189	20.22	150005	01.1932	17.16	150079	01.1390	13.01	160031	01.1797	13.26	160110	01.4994	17.76
140181	01.3046	18.82	150006	01.2074	16.72	150082	01.4965	18.33	160032	01.1573	14.66	160111	01.1019	10.75
140182	01.3248	19.11	150007	01.2302	17.95	150084	01.8737	21.80	160033	01.7246	15.82	160112	01.4123	14.45
140184	01.1967	14.20	150008	01.3398	18.38	150086	01.3006	15.72	160034	01.0681	13.81	160113	00.9561	11.39
140185	01.4505	16.35	150009	01.3365	16.97	150088	01.1917	16.71	160035	00.9375	11.91	160114	01.0697	14.13
140186	01.3274	18.01	150010	01.2041	16.10	150089	01.3985	18.99	160036	01.0756	12.83	160115	01.0280	13.87
140187	01.4861	16.33	150011	01.2190	16.76	150090	01.2596	19.34	160037	01.1621	14.80	160116	01.1691	15.46
140188	00.9575	10.54	150012	01.6875	20.57	150091	01.0611	15.60	160039	01.0670	15.23	160117	01.3337	15.63
140189	01.1712	15.74	150013	01.1675	13.09	150092	01.0673	12.44	160040	01.3537	16.04	160118	01.0360	12.42
140190	01.1195	13.36	150014	01.4216	18.85	150094	01.0035	16.65	160041	01.0646	12.88	160120	01.0091	09.94
140191	01.3775	23.16	150015	01.2264	17.85	150095	01.1144	15.78	160043	01.0338	13.38	160122	01.1669	14.96
140192	01.1869	16.51	150017	01.8448	17.26	150096	01.0971	17.15	160044	01.1574	13.36	160123	01.1780	12.18
140193	01.0112	12.24	150018	01.2919	17.47	150097	01.1277	16.53	160045	01.6987	17.48	160124	01.2526	15.35
140197	01.2709	16.05	150019	01.1266	13.09	150098	01.1300	11.81	160046	01.0369	11.92	160126	01.1504	13.82
140199	01.0139	15.13	150020	01.1554	13.19	150099	01.3115	17.10	160047	01.3602	15.87	160129	01.0228	13.07
140200	01.4295	20.12	150021	01.6718	18.22	150100	01.6839	18.15	160048	01.0179	11.76	160130	01.1652	13.04
140202	01.3141	20.09	150022	01.1381	17.62	150101	01.0868	14.46	160049	00.9842	12.04	160131	01.1087	12.63
140203	01.1570	19.02	150023	01.4914	17.81	150102	01.0903	14.61	160050	01.0246	14.12	160134	00.9843	11.37
140205	00.9221	13.88	150024	01.4448	16.96	150103	01.0416	17.63	160051	00.9907	12.90	160135	01.0019	13.24
140206	01.0864	19.58	150025	01.4616	16.32	150104	01.1413	15.09	160052	01.0589	14.80	160138	01.0588	13.48
140207	01.3743	26.85	150026	01.1878	16.69	150105	01.4085	16.61	160054	01.0231	10.82	160140	01.0939	14.86
140208	01.6111	23.73	150027	01.0647	16.04	150106	01.1373	15.58	160055	01.0477	11.48	160142	01.0237	13.60
140209	01.7011	17.46	150029	01.2733	20.57	150109	01.4583	16.04	160056	01.0409	13.16	160143	01.1324	13.03
140210	01.0690	12.87	150030	01.1956	16.20	150110	00.9896	14.72	160057	01.3309	15.92	160145	01.0880	13.74
140211	01.2233	20.44	150031	01.0590	15.93	150111	01.2056	12.88	160058	01.6642	18.42	160146	01.4124	15.32
140212	01.3189	22.65	150032	01.7894	18.85	150112	01.2207	16.78	160060	01.0892	13.82	160147	01.2670	15.41
140213	01.2806	20.44	150033	01.6083	20.07	150113	01.1860	16.78	160061	01.0020	14.19	160151	01.0767	12.75
140215	01.1642	13.22	150034	01.3961	18.15	150114	01.0330	13.44	160062	00.9619	11.95	160152	01.0085	13.30
140217	01.2322	20.90	150035	01.4087	17.90	150115	01.3933	17.31	160063	01.2910	14.24	160153	01.7014	17.05
140218	01.0541	13.64	150036	01.0486	17.35	150122	01.1412	15.83	160064	01.6406	16.37	170001	01.2028	15.90
140220	01.1056	14.22	150037	01.2673	17.06	150123	01.1642	12.81	160065	01.0735	14.51	170004	01.0851	13.18
140223	01.5438	.....	150038	01.2744	16.27	150124	01.1229	15.00	160066	01.1266	14.06	170006	01.2031	13.48
140224	01.3604	22.10	150039	01.0121	14.51	150125	01.4243	18.09	160067	01.3705	16.70	170008	00.9823	13.35
140228	01.7003	17.36	150042	01.2850	15.47	150126	01.5058	19.24	160068	01.1116	13.30	170009	01.1211	16.81

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
170010	01.2608	16.38	170090	01.1085	09.58	180012	01.3389	17.14	180104	01.5043	16.55	190064	01.5583	17.46
170011	01.4071	14.59	170092	00.8754	11.45	180013	01.4998	17.38	180105	00.9304	12.23	190065	01.4754	15.75
170012	01.4843	15.48	170093	00.9342	11.58	180014	01.6064	18.86	180106	00.9106	12.65	190071	00.8641	11.38
170013	01.3169	13.27	170094	01.0452	12.81	180015	01.2489	14.91	180108	00.8486	12.49	190077	00.9246	13.41
170014	01.0405	15.18	170095	01.0812	13.80	180016	01.3171	14.91	180115	01.0261	13.72	190078	01.1324	11.21
170015	00.9820	13.74	170097	01.0300	13.42	180017	01.2806	13.52	180116	01.3689	14.92	190079	01.2666	14.76
170016	01.6627	21.80	170098	01.0817	16.21	180018	01.2192	15.73	180117	01.1619	16.14	190081	00.8838	09.89
170017	01.1657	14.73	170099	01.3324	11.00	180019	01.3403	17.22	180118	01.0536	11.72	190083	00.9429	12.45
170018	01.0727	12.23	170100	01.0203	14.63	180020	01.0315	15.37	180120	01.0378	12.49	190086	01.3598	14.02
170019	01.1696	15.13	170101	00.9101	14.13	180021	01.1795	13.25	180121	01.2234	13.09	190088	01.1892	16.01
170020	01.3199	14.54	170102	01.0187	12.78	180023	00.8295	11.27	180122	01.0373	14.67	190089	01.1201	09.60
170022	01.1704	14.15	170103	01.2458	15.28	180024	01.3845	15.69	180123	01.4607	19.39	190090	01.0660	15.75
170023	01.4044	15.57	170104	01.4205	19.52	180025	01.1284	16.18	180124	01.4836	16.00	190092	01.3355	20.14
170024	01.1640	12.71	170105	01.0303	14.45	180026	01.1086	13.66	180125	00.9440	16.23	190095	00.9950	14.04
170025	01.1596	18.37	170106	00.8419	12.54	180027	01.2742	14.17	180126	01.1707	11.90	190098	01.5272	17.56
170026	01.0181	16.38	170108	00.9468	10.88	180028	01.0014	16.19	180127	01.2444	16.63	190099	01.1506	17.31
170027	01.3677	15.02	170109	01.0506	14.67	180029	01.2273	15.99	180128	01.1902	15.40	190102	01.5823	16.15
170030	01.0391	13.61	170110	01.0039	13.62	180030	01.1759	12.89	180129	01.0293	13.93	190103	00.8416	09.66
170031	00.9148	12.36	170112	00.9127	13.44	180031	01.0226	12.38	180130	01.4291	17.87	190106	01.1367	17.27
170032	01.1156	14.18	170113	01.1547	13.43	180032	00.9954	15.30	180132	01.2480	15.19	190109	01.2092	13.68
170033	01.3483	14.08	170114	00.9562	12.96	180033	01.1235	12.57	180133	01.2433	20.73	190110	00.9491	11.96
170034	00.9541	13.74	170115	00.9903	11.01	180034	01.0753	13.61	180134	01.0116	13.71	190111	01.5215	17.24
170035	00.9390	12.37	170116	01.0372	13.94	180035	01.5699	18.26	180136	01.5878	16.63	190112	01.5163	20.35
170036	00.8720	12.31	170117	01.0112	12.63	180036	01.2440	17.36	180137	01.6535	16.82	190113	01.3665	17.85
170037	01.1255	15.02	170119	00.9561	11.32	180037	01.2889	20.29	180138	01.2129	17.02	190114	01.0055	11.51
170038	00.9185	10.94	170120	01.2849	14.66	180038	01.4243	14.73	180139	01.0726	16.41	190115	01.2502	16.88
170039	01.1367	11.69	170122	01.8944	19.69	180040	02.0334	19.04	180140	01.0095	.....	190116	01.3017	14.97
170040	01.5625	18.21	170123	01.7747	17.69	180041	01.0945	13.03	190001	00.9375	16.35	190118	01.0495	11.87
170041	00.9823	11.41	170124	00.9503	11.92	180042	01.1163	13.43	190002	01.6513	16.28	190120	00.9247	12.89
170043	00.9081	13.41	170126	00.9191	11.07	180043	01.0156	15.31	190003	01.4519	17.16	190122	01.2572	13.85
170044	01.1101	14.73	170128	01.0769	14.31	180044	01.0359	14.68	190004	01.3759	14.75	190124	01.5739	18.80
170045	01.0299	10.95	170131	01.0980	10.54	180045	01.2057	16.78	190005	01.6645	14.94	190125	01.5811	16.74
170049	01.3313	18.05	170133	01.1443	14.09	180046	01.2012	16.81	190006	01.2072	14.50	190128	01.2060	17.04
170050	00.8380	09.63	170134	00.9114	12.10	180047	01.0191	13.79	190007	01.0078	12.79	190130	00.9913	11.74
170051	00.9598	13.31	170137	01.1842	16.81	180048	01.1403	15.53	190008	01.6528	17.79	190131	01.2797	17.33
170052	01.0682	13.31	170139	00.9877	11.66	180049	01.3563	14.47	190009	01.2058	13.40	190133	01.0482	15.09
170053	01.0069	13.09	170140	01.0533	11.17	180050	01.2697	15.58	190010	01.0884	14.69	190134	00.9967	12.16
170054	01.0848	12.86	170142	01.2641	16.10	180051	01.4187	14.35	190011	01.1233	14.08	190135	01.4063	21.99
170055	01.0698	17.05	170143	01.1251	12.53	180053	01.1091	14.22	190013	01.4220	15.27	190136	01.1262	10.66
170056	00.9402	10.99	170144	01.6112	18.74	180054	01.1611	14.02	190014	01.0578	15.36	190138	00.6897	15.62
170057	01.0566	13.75	170145	01.1694	17.02	180055	01.0370	13.61	190015	01.2421	16.38	190140	00.9431	11.60
170058	01.1738	17.54	170146	01.4168	17.58	180056	01.1099	16.68	190017	01.3736	17.22	190142	00.9421	12.20
170060	01.1313	12.73	170147	01.2245	18.33	180058	01.0090	12.85	190018	01.1816	13.78	190144	01.2097	18.82
170061	01.1593	12.59	170148	01.4763	18.35	180059	00.9670	11.98	190019	01.5042	17.57	190145	00.9824	13.77
170062	00.9501	10.45	170150	01.0726	13.13	180060	00.7427	13.48	190020	01.2002	15.83	190146	01.5901	18.99
170063	00.8965	09.30	170151	01.0012	11.69	180063	00.9649	10.28	190025	01.2859	12.36	190147	00.9911	13.30
170064	00.9513	11.38	170152	00.9801	13.27	180064	01.2906	14.40	190026	01.4470	15.65	190148	00.8975	11.81
170066	00.9908	12.26	170160	01.0468	11.25	180065	00.9809	09.05	190027	01.4852	15.62	190149	00.9959	11.02
170067	01.0357	11.05	170164	01.0426	13.87	180066	01.2068	16.87	190029	01.1320	14.09	190151	01.1518	12.30
170068	01.3949	14.01	170166	01.1504	13.49	180067	01.8783	15.96	190033	00.9721	09.64	190152	01.4522	20.50
170069	01.1769	13.20	170168	00.9486	09.97	180069	01.0397	16.08	190034	01.2434	14.93	190155	00.9203	10.54
170070	01.0225	11.83	170171	01.0889	11.15	180070	01.0977	14.86	190035	01.4128	20.27	190156	00.8945	11.89
170072	00.9565	11.53	170172	00.9841	11.07	180072	01.0513	13.80	190036	01.6475	18.96	190158	01.2308	20.36
170073	01.0984	12.66	170174	01.0890	11.58	180075	00.9736	13.08	190037	00.9653	11.05	190160	01.2187	15.56
170074	01.1552	12.86	170175	01.2928	16.30	180078	01.1230	17.35	190039	01.4080	16.41	190161	01.0441	12.98
170075	00.8720	10.55	170176	01.5021	18.40	180079	01.2486	13.22	190040	01.3863	19.03	190162	01.1806	21.04
170076	01.0770	11.15	170181	01.1668	.....	180080	01.0636	15.16	190041	01.4973	19.72	190164	01.2246	16.86
170077	00.9689	11.12	170182	00.8647	.....	180085	01.2892	17.49	190043	01.1348	12.38	190166	01.0758	14.81
170079	01.0810	11.81	170183	02.1585	.....	180087	01.0887	13.72	190044	01.1634	18.27	190167	01.2058	16.09
170080	00.9459	11.05	180001	01.2246	16.18	180088	01.5722	19.42	190045	01.3672	19.09	190170	00.9592	12.34
170081	00.9294	10.42	180002	01.0070	17.16	180092	01.0482	14.43	190046	01.4814	17.16	190173	01.4578	19.47
170082	01.0577	10.60	180004	01.0888	13.51	180093	01.3617	14.72	190048	01.0669	14.55	190175	01.2835	.....
170084	00.9862	11.06	180005	01.0390	17.40	180094	01.0163	11.93	190049	00.9644	14.74	190176	01.7028	18.06
170085	00.9109	12.01	180006	00.9063	08.63	180095	01.1664	12.78	190050	01.0420	13.90	190177	01.6125	22.02
170086	01.7190	18.04	180007	01.5485	14.17	180099	01.1988	11.72	190053	01.0567	11.98	190178	00.9868	11.20
170087	01.4582	18.87	180009	01.3310	17.70	180101	01.3486	18.84	190054	01.4052	13.67	190182	01.1720	20.12
170088	00.9139	10.59	180010	01.8382	16.91	180102	01.5215	15.95	190059	00.9447	13.58	190183	01.1294	13.43
170089	01.0037	14.21	180011	01.1737	15.71	180103	02.0850	18.62	190060	01.4907	16.51	190184	01.0550	12.13

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Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
190185	01.3116	19.03	210004	01.3245	20.30	220030	01.0852	16.42	220171	01.6972	22.55	230103	01.0124	17.37
190186	00.9539	11.69	210005	01.2407	17.70	220031	01.8518	27.21	220897	04.8084	.....	230104	01.6163	20.32
190187	00.7801	14.05	210006	01.1291	16.84	220033	01.3898	19.40	230001	01.2015	15.98	230105	01.6088	19.46
190189	00.9445	14.54	210007	01.6215	18.82	220035	01.2698	19.72	230002	01.2238	19.28	230106	01.1784	18.07
190190	00.9291	18.74	210008	01.3146	21.21	220036	01.6218	23.26	230003	01.0945	18.07	230107	00.8964	12.56
190191	01.3068	18.47	210009	01.7134	18.57	220038	01.2841	21.85	230004	01.6105	20.95	230108	01.2432	16.64
190194	01.1471	19.16	210010	01.1960	17.00	220041	01.2492	20.87	230005	01.2825	18.02	230110	01.3309	17.10
190196	00.9097	16.46	210011	01.2110	20.12	220042	01.2078	24.10	230006	01.1303	16.19	230111	00.9772	15.13
190197	01.2655	18.80	210012	01.4840	21.27	220046	01.3942	21.48	230007	01.0869	16.51	230113	00.9511	17.66
190199	01.3623	.....	210013	01.2780	20.65	220049	01.2664	21.58	230013	01.2659	20.70	230114	00.6368	23.27
190200	01.5241	21.33	210015	01.2720	18.48	220050	01.0888	17.45	230015	01.1338	18.01	230115	01.0164	15.14
190201	01.2315	18.24	210016	01.7279	20.37	220051	01.2702	19.70	230017	01.5125	20.40	230116	00.9155	15.58
190202	01.4459	18.34	210017	01.1256	15.35	220052	01.2994	22.76	230019	01.5077	20.50	230117	01.9674	23.81
190203	01.6074	19.50	210018	01.2414	20.93	220053	01.2564	18.86	230020	01.7180	21.17	230118	01.2419	17.25
190204	01.5314	20.12	210019	01.4011	17.42	220055	01.3486	20.61	230021	01.6010	17.25	230119	01.3145	21.13
190205	01.8790	17.63	210022	01.4536	20.07	220057	01.4381	20.91	230022	01.2422	17.62	230120	01.2315	19.00
190206	01.4995	21.17	210023	01.2956	20.31	220058	01.0650	17.55	230024	01.4216	21.79	230121	01.2320	19.67
190207	01.1825	19.43	210024	01.5336	18.06	220060	01.2565	24.78	230027	01.0587	16.25	230122	01.3296	18.32
190208	00.8198	10.36	210025	01.3227	17.84	220062	00.6021	19.30	230029	01.5998	20.91	230124	01.1555	16.49
190218	01.1389	15.05	210026	01.3187	24.54	220063	01.2909	18.42	230030	01.2415	16.55	230125	01.3676	12.83
190223	00.5039	09.72	210027	01.2046	17.10	220064	01.2167	20.66	230031	01.4660	18.32	230128	01.3700	19.33
190227	00.8050	30.01	210028	01.2256	16.66	220065	01.2182	20.00	230032	01.7444	18.97	230129	01.8923	19.07
190230	00.8737	.....	210029	01.3064	20.04	220066	01.2760	19.39	230034	01.1948	16.64	230130	01.6884	22.37
190231	01.2825	.....	210030	01.0993	15.77	220067	01.2944	22.82	230035	01.1377	15.84	230132	01.5373	22.92
190232	01.6623	.....	210031	01.6370	16.97	220068	00.5244	15.95	230036	01.2807	19.78	230133	01.2350	14.06
190233	01.0997	.....	210032	01.2096	18.42	220070	01.2635	17.77	230037	01.1606	16.96	230134	01.1081	15.87
200001	01.2712	15.74	210033	01.1818	17.38	220071	01.8550	24.38	230038	01.6451	21.18	230135	01.1885	19.88
200002	01.0212	16.15	210034	01.3996	20.29	220073	01.3882	25.34	230040	01.1976	18.35	230137	01.1691	17.78
200003	01.1264	15.90	210035	01.1952	17.25	220074	01.2614	21.18	230041	01.2085	18.20	230141	01.6883	20.84
200006	01.0731	14.95	210037	01.2887	16.14	220075	01.3228	20.09	230042	01.1542	19.03	230142	01.2092	18.71
200007	01.0066	15.63	210038	01.3413	19.90	220076	01.1851	22.47	230046	01.8239	24.65	230143	01.1481	15.23
200008	01.2497	18.34	210039	01.1613	15.25	220077	01.7122	22.32	230047	01.3070	19.61	230144	01.1092	21.06
200009	01.7602	19.84	210040	01.2993	20.32	220079	01.1880	21.28	230053	01.5387	23.82	230145	01.1742	15.41
200012	01.1641	16.11	210043	01.2569	20.04	220080	01.2773	17.77	230054	01.8228	19.74	230146	01.2845	19.49
200013	01.1401	15.32	210044	01.2000	20.28	220081	00.9446	23.55	230055	01.1760	17.36	230147	01.4742	19.34
200015	01.2358	17.15	210045	01.0148	11.73	220082	01.2902	19.28	230056	00.9776	14.17	230149	01.2419	14.92
200016	01.0350	16.10	210046	01.1079	12.34	220083	01.1831	19.80	230058	01.0786	17.42	230151	01.3631	21.32
200017	01.2447	16.86	210048	01.1746	22.47	220084	01.2425	22.24	230059	01.4842	19.00	230153	01.1118	15.61
200018	01.1602	14.27	210049	01.1517	16.57	220086	01.5483	24.60	230060	01.2882	16.90	230154	00.9493	12.09
200019	01.2486	18.01	210051	01.4541	13.94	220088	01.5778	21.76	230062	01.0291	10.93	230155	00.9752	13.80
200020	01.1930	19.86	210054	01.2790	20.17	220089	01.3304	22.99	230063	01.3106	18.41	230156	01.6989	21.57
200021	01.1723	17.66	210055	01.2914	22.48	220090	01.2260	20.78	230065	01.4805	18.63	230157	01.2084	19.67
200023	00.8814	14.61	210056	01.4132	16.51	220092	01.2533	20.86	230066	01.3629	17.55	230159	01.3614	18.93
200024	01.2940	19.16	210057	01.3587	.....	220094	01.2679	19.76	230068	01.4269	22.29	230162	00.9841	13.73
200025	01.2732	18.81	210058	01.6842	18.09	220095	01.2234	17.77	230069	01.1751	18.86	230165	01.8763	20.92
200026	01.0896	15.20	210059	01.2581	21.91	220098	01.2884	19.81	230070	01.4926	19.30	230167	01.3662	19.18
200027	01.1423	16.51	210060	01.1731	25.28	220099	01.1644	15.97	230071	01.1363	20.78	230169	01.4366	21.16
200028	00.9339	14.83	210061	01.0980	14.25	220100	01.2619	23.48	230072	01.2879	18.87	230171	00.9849	14.18
200031	01.2965	14.96	220001	01.1636	20.98	220101	01.5059	22.58	230075	01.5257	19.29	230172	01.3176	17.85
200032	01.3588	17.72	220002	01.5368	21.62	220104	01.2419	23.12	230076	01.3128	21.53	230174	01.3016	19.11
200033	01.7105	19.57	220003	01.0806	16.92	220105	01.2111	21.97	230077	01.9772	18.44	230176	01.2388	20.89
200034	01.1962	17.19	220004	01.1812	18.85	220106	01.2458	21.83	230078	01.0869	14.76	230178	01.0320	16.02
200037	01.2193	15.53	220006	01.4332	21.79	220107	01.1742	18.46	230080	01.1933	20.41	230180	01.0676	15.03
200038	01.1145	17.66	220008	01.2523	19.26	220108	01.1503	20.96	230081	01.2191	16.55	230184	01.2246	16.99
200039	01.2494	18.06	220010	01.2949	20.94	220110	01.9520	30.07	230082	01.1643	14.88	230186	01.3835	15.81
200040	01.0969	16.12	220011	01.1570	27.95	220111	01.2612	21.21	230085	01.1115	17.10	230188	01.1787	15.49
200041	01.2255	17.37	220012	01.3654	27.84	220116	01.9484	23.95	230086	00.9885	14.03	230189	00.8927	14.50
200043	00.5362	16.96	220015	01.1767	20.35	220118	02.0446	26.47	230087	01.0641	13.65	230190	01.0483	22.66
200050	01.2051	16.71	220016	01.3547	20.16	220119	01.3255	24.40	230089	01.3379	21.55	230191	00.8947	14.99
200051	00.9656	17.70	220017	01.4233	23.78	220123	01.0371	23.85	230092	01.3295	17.77	230193	01.2340	16.03
200052	00.9605	13.07	220019	01.1716	17.06	220126	01.3077	19.39	230093	01.2320	17.37	230194	01.2090	14.37
200055	01.1609	14.56	220020	01.2174	18.47	220128	01.1494	20.85	230095	01.2251	15.53	230195	01.2803	19.80
200062	00.9155	14.64	220021	01.3823	23.21	220133	00.8435	30.53	230096	01.1954	19.85	230197	01.2564	22.00
200063	01.1630	16.63	220023	01.1522	19.37	220135	01.2581	23.97	230097	01.5433	17.75	230199	01.1386	17.72
200066	01.1762	14.34	220024	01.1696	20.14	220153	01.0459	19.74	230099	01.2223	19.06	230201	01.2166	14.02
210001	01.4081	17.94	220025	01.1948	18.87	220154	00.8972	18.96	230100	01.1604	15.19	230204	01.3584	19.78
210002	01.9534	16.84	220028	01.4680	22.20	220162	01.0891	.....	230101	01.0566	16.79	230205	01.0607	14.54
210003	01.5503	22.97	220029	01.1933	22.25	220163	02.0719	24.73	230102	01.1047	.....	230207	01.2544	19.85

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
230208	01.1783	16.10	240047	01.5215	18.27	240132	01.2422	20.49	250034	01.5418	12.99	250138	01.3553	16.91
230211	00.9786	13.86	240048	01.2786	20.43	240133	01.1715	16.16	250035	00.9041	11.82	250140	00.9213	09.37
230212	01.0964	21.13	240049	01.7763	20.33	240135	00.8386	11.38	250036	00.9863	11.34	250141	01.2142	15.50
230213	01.0251	12.69	240050	01.1234	19.89	240137	01.2521	15.40	250037	00.8717	09.53	250144	00.9383	11.18
230216	01.5363	17.91	240051	00.9749	15.97	240138	00.8953	13.09	250038	00.9909	12.52	250145	00.9362	.....
230217	01.2142	18.06	240052	01.2480	17.21	240139	00.9551	14.24	250039	01.0004	11.71	250146	01.0020	12.89
230219	01.0153	15.18	240053	01.5190	19.67	240141	01.0836	19.12	250040	01.2911	15.65	250148	01.1589	.....
230221	01.1831	18.15	240056	01.2490	20.13	240142	01.1491	15.16	250042	01.1491	13.78	250149	00.9157	.....
230222	01.3602	18.98	240057	01.7418	22.04	240143	01.0673	12.48	250043	01.0303	10.49	260001	01.6548	15.06
230223	01.3164	19.85	240058	00.9730	09.64	240144	00.9419	13.39	250044	00.9825	13.98	260002	01.4785	20.05
230227	01.5246	22.00	240059	01.1011	17.98	240145	00.9681	12.37	250045	01.1454	17.17	260003	00.9487	12.45
230228	01.2133	17.29	240061	01.7409	20.93	240146	00.9270	17.20	250047	00.9527	09.12	260004	01.0315	11.86
230230	01.5449	20.38	240063	01.4559	20.88	240148	00.9433	11.34	250048	01.4527	13.51	260005	01.6121	19.68
230232	01.0330	15.87	240064	01.2630	18.13	240150	00.8874	11.72	250049	00.9058	09.93	260006	01.5286	16.72
230235	01.1141	14.65	240065	01.1480	11.14	240152	01.0177	17.85	250050	01.2448	12.30	260007	01.4659	16.03
230236	01.3372	21.07	240066	01.3895	19.08	240153	01.0210	14.30	250051	00.8585	09.44	260008	01.2051	13.88
230239	01.1697	16.07	240069	01.1596	18.31	240154	01.0138	13.15	250057	01.1766	14.06	260009	01.2372	15.63
230241	01.1519	17.08	240071	01.1245	18.05	240155	00.9817	14.39	250058	01.1385	13.65	260011	01.6786	16.21
230244	01.3177	20.14	240072	01.0272	16.08	240157	01.1265	13.92	250059	01.0322	12.16	260012	01.0505	11.96
230253	01.0740	17.39	240073	00.9172	15.13	240160	00.9997	14.65	250060	00.8084	12.19	260013	01.1491	12.68
230254	01.2799	22.64	240075	01.2180	18.79	240161	00.9389	14.56	250061	00.8634	10.75	260014	01.7751	17.84
230257	01.1068	19.01	240076	01.1373	19.69	240162	00.9645	15.28	250063	00.8596	12.68	260015	01.2666	13.16
230259	01.1982	19.06	240077	01.0463	14.15	240163	00.9330	14.10	250065	00.8907	11.72	260017	01.2286	13.94
230264	00.9438	16.74	240078	01.4536	21.46	240166	01.1669	14.67	250066	00.9404	12.17	260018	00.9652	09.56
230269	01.3034	21.71	240079	01.0176	12.57	240169	00.9534	15.25	250067	01.1253	14.14	260019	00.9816	12.63
230270	01.2162	20.08	240080	01.3774	20.87	240170	01.1564	14.42	250068	00.8556	11.19	260020	01.7259	18.73
230273	01.6607	22.11	240082	01.1194	14.55	240171	00.9950	14.02	250069	01.1870	13.42	260021	01.5153	17.51
230275	00.5787	16.53	240083	01.3925	16.60	240172	01.0869	14.50	250071	00.9541	08.06	260022	01.3501	18.69
230276	00.8129	16.23	240084	01.3436	17.20	240173	00.9599	14.82	250072	01.2914	16.67	260023	01.2567	15.57
230277	01.2425	21.76	240085	00.9247	14.90	240179	01.0022	14.30	250076	00.9579	10.32	260024	01.0210	12.28
230278	02.0914	19.50	240086	01.0520	15.23	240180	01.0157	10.51	250077	00.9505	11.08	260025	01.3121	13.61
230279	00.6989	.....	240087	01.0824	15.69	240184	01.0424	11.31	250078	01.4419	14.21	260027	01.5941	18.92
230280	01.0281	.....	240088	01.4444	18.10	240187	01.2617	16.56	250079	00.8562	15.12	260029	01.1264	15.76
230281	01.7080	.....	240089	01.0010	15.23	240193	01.0582	14.73	250081	01.3034	15.19	260030	01.0891	09.73
240001	01.5708	21.24	240090	01.0970	13.57	240196	00.6132	22.50	250082	01.2857	12.30	260031	01.4989	18.67
240002	01.6938	19.40	240093	01.3186	16.49	240200	00.8962	13.34	250083	01.0251	11.01	260032	01.5795	17.59
240004	01.4661	20.16	240094	01.0543	17.26	240205	00.9014	.....	250084	01.0930	13.92	260034	00.9785	14.22
240005	00.9960	13.49	240096	01.0160	14.12	240206	00.8472	.....	250085	01.0093	11.42	260035	01.0729	11.44
240006	01.1385	19.75	240097	01.1270	17.05	240207	01.2326	21.47	250088	00.9591	15.56	260036	01.0628	15.72
240007	01.1171	15.15	240098	00.9677	16.41	240210	01.2588	21.44	250089	01.0276	11.77	260037	01.4003	15.17
240008	01.0569	15.22	240099	01.1143	11.00	240211	00.9532	11.18	250093	01.1064	12.17	260039	01.1432	11.17
240009	00.9895	14.18	240100	01.3089	19.58	240212	01.9942	.....	250094	01.2377	14.41	260040	01.6075	14.92
240010	01.9742	20.17	240101	01.1581	17.32	250001	01.6688	15.91	250095	00.9795	13.57	260042	01.4257	15.65
240011	01.1400	15.69	240102	00.8915	12.27	250002	00.7926	13.34	250096	01.2945	16.48	260044	01.0361	14.29
240013	01.3150	15.90	240103	01.0772	14.10	250003	01.0305	14.13	250097	01.1910	13.83	260047	01.3634	14.19
240014	01.0820	17.79	240104	01.2345	21.68	250004	01.4613	15.12	250098	00.8668	13.73	260048	01.2847	18.05
240016	01.3076	15.46	240105	01.0028	12.70	250005	00.9643	09.15	250099	01.2680	12.73	260050	01.0968	14.71
240017	01.1439	15.15	240106	01.3245	23.78	250006	00.9651	12.27	250100	01.2315	14.53	260052	01.3337	15.95
240018	01.2866	15.82	240107	00.9788	15.07	250007	01.2618	16.88	250101	00.9408	09.89	260053	01.1331	09.46
240019	01.2275	19.58	240108	00.9539	11.64	250008	00.8996	11.36	250102	01.5414	14.80	260054	01.3206	15.14
240020	01.1482	18.11	240109	00.9922	13.59	250009	01.1809	15.04	250104	01.3619	15.58	260055	01.0378	13.67
240021	00.9369	12.49	240110	01.0305	15.18	250010	01.0381	11.07	250105	00.9206	13.13	260057	01.1548	13.85
240022	01.1174	17.33	240111	00.9867	13.06	250012	00.9568	13.77	250107	00.9087	14.16	260059	01.1275	14.17
240023	01.0074	15.86	240112	01.0531	13.30	250015	01.0942	09.75	250109	00.9352	11.54	260061	01.1793	10.87
240025	01.1734	15.02	240114	00.9888	11.13	250017	01.0107	13.77	250112	00.9947	14.22	260062	01.1602	19.89
240027	01.0011	12.60	240115	01.6063	22.30	250018	00.9603	09.81	250117	01.0705	13.28	260063	01.1913	14.82
240028	01.1386	16.50	240116	00.9465	12.43	250019	01.4259	17.43	250119	01.2047	10.80	260064	01.3295	15.38
240029	01.1610	15.70	240117	01.0697	16.21	250020	01.0082	10.70	250120	01.0645	12.04	260065	01.7778	15.31
240030	01.3037	16.78	240119	00.8486	16.93	250021	00.8579	07.74	250122	01.2735	15.87	260066	01.0927	13.19
240031	00.9361	13.50	240121	00.9008	16.90	250023	00.8647	11.22	250123	01.3262	17.72	260067	00.9820	10.43
240036	01.5543	19.05	240122	01.0504	16.80	250024	00.9894	08.25	250124	00.9137	10.69	260068	01.6715	18.49
240037	01.0408	16.40	240123	01.0498	13.30	250025	01.1455	13.58	250125	01.3231	18.35	260070	01.0862	11.09
240038	01.4454	22.37	240124	01.0139	15.71	250027	01.0256	10.40	250126	00.9923	10.22	260073	00.9681	11.58
240040	01.2251	17.67	240125	00.9399	10.75	250029	00.8872	11.87	250127	00.7630	.....	260074	01.2427	14.81
240041	01.2877	14.43	240127	01.0142	12.51	250030	00.9688	11.39	250128	01.1010	12.64	260077	01.7271	16.15
240043	01.1990	16.83	240128	01.1180	14.55	250031	01.3157	17.20	250131	01.0539	09.36	260078	01.1782	12.39
240044	01.2046	16.02	240129	01.0153	12.18	250032	01.2551	15.70	250134	00.9795	12.70	260079	00.9824	11.78
240045	01.0655	18.49	240130	01.0151	14.54	250033	00.9921	11.57	250136	00.7871	16.84	260080	00.9654	09.77

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
260081	01.4971	16.44	270004	01.6477	16.49	280026	01.1254	12.80	280115	00.9809	13.59	310017	01.3295	21.95
260082	01.1231	13.50	270006	01.0290	18.67	280028	01.0559	13.64	280117	01.2229	14.48	310018	01.2194	21.06
260085	01.5684	18.57	270007	00.9630	12.26	280029	01.0506	12.62	280118	00.9757	13.28	310019	01.6403	20.84
260086	01.0649	12.67	270009	01.0387	14.91	280030	01.7392	23.13	280119	00.8364	.....	310020	01.1974	19.66
260089	00.9614	13.31	270011	01.1242	.....	280031	01.0575	12.48	280123	00.7918	.....	310021	01.3472	21.15
260091	01.6022	18.86	270012	01.5945	17.10	280032	01.3182	15.11	290001	01.6372	22.35	310022	01.2384	19.38
260094	01.1872	14.91	270013	01.2847	16.78	280033	00.9766	13.62	290002	00.8981	17.99	310024	01.2566	22.60
260095	01.4432	16.05	270014	01.7192	15.97	280034	01.2078	13.41	290003	01.6179	21.15	310025	01.2260	21.92
260096	01.5521	21.52	270016	00.8187	11.51	280035	00.9433	11.75	290005	01.4399	19.66	310026	01.2647	21.91
260097	01.1913	15.82	270017	01.2275	18.32	280037	01.0146	13.55	290006	01.2170	16.54	310027	01.3646	18.17
260100	00.9630	13.12	270019	01.0625	13.34	280038	01.0763	13.39	290007	01.8961	25.07	310028	01.1530	20.46
260102	01.0125	16.75	270021	01.1007	15.55	280039	01.1970	14.24	290008	01.2200	17.14	310029	01.8925	20.69
260103	01.3849	16.73	270023	01.2916	18.76	280040	01.5940	18.30	290009	01.6244	21.07	310031	02.5990	24.14
260104	01.6403	19.57	270024	00.9931	11.15	280041	01.0014	10.95	290010	01.2053	19.33	310032	01.2921	20.00
260105	01.8664	19.47	270026	00.8654	11.95	280042	01.0880	13.22	290011	00.8812	14.39	310034	01.2545	19.14
260107	01.3815	18.77	270027	01.0389	12.69	280043	01.1268	12.75	290012	01.4385	19.97	310036	01.2092	18.44
260108	01.8100	17.90	270028	01.0741	14.91	280045	01.1401	13.48	290013	01.0185	14.85	310037	01.3076	24.97
260109	00.9959	11.92	270029	00.9031	14.51	280046	01.0732	11.09	290014	01.0444	16.52	310038	01.9146	22.82
260110	01.6120	14.16	270031	00.8747	09.71	280047	01.1620	15.70	290015	00.9730	15.38	310039	01.2871	20.51
260111	00.9980	08.04	270032	01.1788	16.46	280048	01.0800	11.17	290016	01.1392	18.71	310040	01.2688	23.12
260112	01.4171	17.75	270033	00.8766	11.39	280049	01.0408	13.82	290019	01.2774	17.92	310041	01.3218	22.90
260113	01.1053	14.05	270035	01.0275	15.87	280050	00.9290	13.11	290020	01.0859	17.65	310042	01.2459	21.74
260115	01.2345	14.63	270036	00.9483	10.42	280051	01.0735	13.72	290021	01.5601	19.17	310043	01.2080	20.60
260116	01.1223	13.70	270039	01.0661	11.99	280052	01.0491	11.85	290022	01.7399	22.47	310044	01.3055	20.16
260119	01.1640	14.93	270040	01.0825	17.60	280054	01.2628	17.92	290027	00.9567	14.68	310045	01.3849	25.76
260120	01.1599	15.72	270041	01.0693	11.14	280055	00.9347	11.63	290029	00.9400	.....	310047	01.3410	23.05
260122	01.1502	13.12	270044	01.1913	13.40	280056	00.9886	10.99	290032	01.4149	18.66	310048	01.1852	20.69
260123	01.0312	11.56	270046	00.9346	13.50	280057	01.0055	14.48	290038	01.1064	.....	310049	01.3294	23.54
260127	00.9514	13.71	270048	01.0940	13.30	280058	01.3123	13.75	300001	01.3957	20.70	310050	01.2677	20.88
260128	00.9851	08.95	270049	01.8346	18.19	280060	01.5884	18.35	300003	01.8607	20.92	310051	01.3207	24.26
260129	01.2124	13.51	270050	01.0380	15.96	280061	01.4628	14.76	300005	01.2620	18.65	310052	01.2545	20.53
260131	01.2940	16.32	270051	01.2980	17.65	280062	01.2187	11.92	300006	01.1221	16.24	310054	01.2880	23.19
260134	01.1526	13.82	270052	01.0663	18.02	280064	01.0759	12.61	300007	01.1527	16.76	310056	01.1826	20.11
260137	01.2614	13.71	270053	00.8678	09.53	280065	01.2879	16.22	300008	01.2481	16.95	310057	01.2933	20.10
260138	01.9711	20.66	270057	01.1715	17.35	280066	01.0191	11.38	300009	01.0977	17.45	310058	01.1025	25.35
260141	01.8695	16.53	270058	00.9411	11.20	280068	00.9659	09.31	300010	01.2364	17.80	310060	01.2116	17.55
260142	01.1566	14.50	270059	00.8676	19.21	280070	01.0724	10.75	300011	01.3481	21.53	310061	01.2085	19.85
260143	00.9463	10.52	270060	00.9702	11.92	280073	01.0386	12.78	300012	01.2749	21.64	310062	01.2936	23.90
260147	01.0469	12.81	270063	00.8933	12.94	280074	01.1165	12.87	300013	01.2241	16.87	310063	01.3528	20.78
260148	00.9572	09.33	270068	00.8629	12.38	280075	01.2096	12.90	300014	01.2293	18.41	310064	01.2956	21.35
260158	01.1275	11.80	270072	00.8605	14.88	280076	01.0719	12.54	300015	01.1807	17.56	310067	01.3198	21.14
260159	01.2924	18.02	270073	01.0764	11.06	280077	01.3635	17.36	300016	01.3137	17.41	310069	01.1292	18.19
260160	01.0663	14.07	270074	00.8832	.....	280079	01.0636	09.40	300017	01.2137	20.49	310070	01.3977	22.16
260162	01.7006	17.70	270075	00.8610	.....	280080	01.0860	11.34	300018	01.2397	18.85	310072	01.3053	20.74
260163	01.3037	14.11	270076	00.8395	.....	280081	01.5614	17.24	300019	01.2613	18.43	310073	01.5567	22.31
260164	01.0000	12.07	270079	00.9594	13.36	280082	01.0967	13.03	300020	01.2666	19.78	310074	01.4153	21.08
260166	01.2144	21.51	270080	01.1499	14.27	280083	01.0671	15.64	300021	01.1635	15.69	310075	01.2965	21.67
260172	01.0176	12.07	270081	01.0780	09.77	280084	01.0314	10.92	300022	01.0939	17.08	310076	01.3883	28.16
260173	00.9560	11.15	270082	01.0050	16.10	280085	00.7201	14.72	300023	01.3251	20.13	310077	01.5000	23.09
260175	01.1270	14.60	270083	01.1179	10.96	280088	01.8180	17.33	300024	01.2662	16.56	310078	01.3399	22.70
260176	01.6758	18.44	270084	00.9031	12.77	280089	01.0614	13.79	300028	01.2716	15.52	310081	01.2643	20.80
260177	01.3871	19.46	280001	01.0866	14.11	280090	00.9838	11.70	300029	01.3165	21.79	310083	01.2405	22.20
260178	01.4760	19.06	280003	01.9467	18.11	280091	01.1320	13.17	300033	01.1041	13.70	310084	01.2611	20.43
260179	01.5653	18.02	280005	01.3791	16.72	280092	00.8959	11.63	300034	01.9294	21.31	310086	01.1743	20.89
260180	01.7024	18.45	280009	01.7304	16.70	280094	01.1287	13.55	310001	01.7682	24.56	310087	01.2357	18.95
260183	01.6443	16.51	280011	00.9606	11.56	280097	01.0459	12.56	310002	01.7260	25.58	310088	01.2439	19.57
260186	01.2600	15.20	280012	01.2348	14.88	280098	01.0110	09.68	310003	01.2210	23.16	310090	01.1901	22.86
260188	01.2714	15.70	280013	02.0127	19.71	280101	01.1114	10.92	310005	01.2226	19.20	310091	01.2170	21.35
260189	00.9400	11.23	280014	01.0034	10.78	280102	01.1187	11.77	310006	01.2198	19.02	310092	01.3046	20.52
260190	01.2072	18.46	280015	01.0314	13.78	280104	00.9608	09.88	310008	01.2739	21.23	310093	01.2163	19.52
260191	01.1707	19.44	280017	01.1537	13.42	280105	01.2920	16.46	310009	01.2782	21.35	310096	01.9004	21.19
260193	01.2240	19.13	280018	01.1931	12.25	280106	00.9402	13.23	310010	01.2912	21.05	310105	01.1999	22.41
260195	01.1660	.....	280020	01.5257	18.97	280107	01.0294	12.36	310011	01.3017	21.71	310108	01.3824	21.08
260197	01.3182	20.38	280021	01.3499	14.01	280108	01.1461	13.26	310012	01.5940	23.47	310110	01.2143	19.69
260198	01.2213	14.98	280022	00.9770	11.07	280109	00.9501	10.61	310013	01.2768	19.91	310111	01.2557	19.70
260200	01.3554	19.14	280023	01.3780	13.73	280110	00.9942	10.88	310014	01.7025	23.69	310112	01.2426	20.58
270002	01.1911	13.92	280024	01.0114	13.22	280111	01.2372	16.06	310015	01.7776	24.34	310113	01.2089	20.70
270003	01.2465	18.65	280025	00.9810	11.07	280114	00.9353	10.26	310016	01.2225	22.93	310115	01.1943	19.78

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
310116	01.2919	21.67	330028	01.3448	23.76	330132	01.1620	13.74	330233	01.5441	29.08	330399	01.3239	29.65
310118	01.1849	21.86	330029	01.1111	17.36	330133	01.3428	28.31	330234	02.1918	24.17	340001	01.4951	19.39
310119	01.5594	27.27	330030	01.2349	14.89	330135	01.2563	16.25	330235	01.1332	17.37	340002	01.8825	18.53
310120	01.0603	17.24	330033	01.2846	13.46	330136	01.2637	20.45	330236	01.3832	26.18	340003	01.1188	16.56
310121	01.0460	16.61	330034	00.7718	36.61	330140	01.7132	17.19	330238	01.1820	14.53	340004	01.4966	17.21
320001	01.4620	16.76	330036	01.3298	21.00	330141	01.3504	23.17	330239	01.2013	15.44	340005	01.2221	14.57
320002	01.4159	21.55	330037	01.1242	15.17	330144	00.9758	13.17	330240	01.3354	26.47	340006	01.2338	14.56
320003	01.1576	15.57	330038	01.2140	14.91	330148	01.0784	14.39	330241	01.8652	20.92	340007	01.1848	14.81
320004	01.2677	17.86	330039	00.8486	13.18	330151	01.0421	13.73	330242	01.3516	18.35	340008	01.1458	16.48
320005	01.3217	17.80	330041	01.3912	27.81	330152	01.4273	27.77	330245	01.2716	17.15	340009	01.4043	18.58
320006	01.3699	15.02	330043	01.2400	25.15	330153	01.6522	17.44	330246	01.2502	22.99	340010	01.3129	16.41
320009	01.5348	16.75	330044	01.2405	16.99	330154	01.5884	.....	330247	00.7071	26.49	340011	01.1134	13.98
320011	00.9939	17.79	330045	01.4167	24.83	330157	01.3091	18.41	330249	01.2314	15.89	340012	01.2605	15.82
320012	01.0231	16.57	330046	01.5105	28.39	330158	01.3668	24.33	330250	01.3166	16.01	340013	01.2719	16.58
320013	01.2225	18.28	330047	01.2265	16.63	330159	01.3291	17.35	330252	00.9141	15.40	340014	01.5921	22.15
320014	01.0141	08.42	330048	01.2888	16.10	330160	01.4618	26.09	330254	01.0327	15.52	340015	01.2388	16.44
320016	01.1571	12.00	330049	01.2436	17.52	330161	00.7163	16.00	330258	01.4234	25.28	340016	01.1961	15.18
320017	01.2175	17.67	330053	01.1270	14.39	330162	01.2602	26.18	330259	01.4434	21.99	340017	01.2581	15.69
320018	01.4643	16.61	330055	01.5089	29.02	330163	01.2099	17.75	330261	01.2224	24.35	340018	01.1212	14.78
320019	01.4799	19.01	330056	01.4367	28.30	330164	01.3999	18.96	330263	00.9948	17.00	340019	01.0453	13.69
320021	01.7045	20.62	330057	01.7192	15.43	330166	00.9641	13.96	330264	01.2753	20.00	340020	01.1711	17.33
320022	01.1678	16.34	330058	01.3255	15.69	330167	01.6419	27.45	330265	01.3114	15.78	340021	01.2221	15.08
320023	01.0224	13.29	330059	01.6149	29.66	330169	01.4285	31.70	330267	01.2789	22.78	340022	01.0451	14.56
320030	00.9845	16.54	330061	01.2961	23.38	330171	01.2758	21.15	330268	00.9689	15.79	340023	01.3842	18.44
320031	00.8961	14.78	330062	01.1834	14.99	330175	01.1250	14.28	330270	01.9667	30.33	340024	01.2260	15.05
320032	01.0053	16.66	330064	01.3837	28.38	330177	01.0204	12.46	330273	01.2909	21.36	340025	01.1908	14.15
320033	01.1561	19.23	330065	01.1753	17.14	330179	00.8644	14.09	330275	01.2168	18.19	340027	01.2025	15.46
320035	01.0000	14.82	330066	01.2326	17.26	330180	01.1942	16.09	330276	01.1889	16.58	340028	01.5288	17.48
320037	01.2063	15.17	330067	01.3792	19.68	330181	01.3113	28.32	330277	01.1317	16.35	340030	02.0064	19.06
320038	01.1613	15.62	330072	01.3367	26.92	330182	02.5604	26.92	330279	01.2905	17.24	340031	00.9382	12.56
320046	01.1938	18.23	330073	01.1865	14.20	330183	01.4402	18.88	330285	01.8179	21.81	340032	01.3951	17.87
320048	01.3453	13.90	330074	01.1952	16.89	330184	01.3357	25.83	330286	01.3134	22.59	340035	01.1716	14.97
320056	00.9819	.....	330075	01.0925	16.48	330185	01.2303	24.23	330290	01.7595	28.28	340036	01.1656	17.04
320057	01.0612	.....	330078	01.4429	16.90	330186	00.9205	18.79	330293	01.1658	13.72	340037	01.1731	15.50
320058	00.9103	.....	330079	01.3056	16.60	330188	01.1826	17.75	330304	01.2716	25.62	340038	01.1099	14.52
320059	00.9799	.....	330080	01.4028	24.95	330189	01.3836	16.20	330306	01.4564	26.59	340039	01.2731	19.18
320060	00.9135	.....	330082	01.1164	16.29	330191	01.2642	17.14	330307	01.2198	18.33	340040	01.7730	17.75
320061	01.0790	.....	330084	00.9954	15.59	330193	01.2990	27.34	330308	01.1771	28.68	340041	01.2428	15.99
320062	00.9353	.....	330085	01.3139	18.66	330194	01.8175	26.07	330309	01.2301	24.67	340042	01.1875	13.80
320063	01.3344	15.84	330086	01.2522	24.13	330195	01.6251	29.02	330314	01.3625	21.07	340044	01.1061	13.26
320065	01.2800	16.76	330088	01.1053	24.41	330196	01.3279	25.53	330315	01.2528	24.58	340045	01.0396	10.95
320067	00.8183	09.19	330090	01.5574	16.86	330197	01.0999	14.43	330316	01.3007	26.23	340047	01.8881	17.90
320068	00.9221	17.98	330091	01.3825	17.64	330198	01.3312	22.17	330327	00.9294	15.30	340048	00.9055	09.39
320069	01.0367	09.08	330092	01.1062	13.64	330199	01.4730	24.90	330331	01.2281	27.78	340049	00.6394	15.10
320070	01.0220	.....	330094	01.2285	15.57	330201	01.5327	27.38	330332	01.2569	24.30	340050	01.1927	14.69
320074	01.1134	17.15	330095	01.2586	16.43	330202	01.4667	25.07	330333	01.3666	22.00	340051	01.2724	16.23
320079	01.1977	17.41	330096	01.0690	14.47	330203	01.4028	19.16	330336	01.3373	27.39	340052	01.0387	18.62
330001	01.1965	24.84	330097	01.1645	14.51	330204	01.4276	24.90	330338	01.1337	22.52	340053	01.6979	18.94
330002	01.4946	24.26	330100	00.6809	25.95	330205	01.1548	19.46	330339	00.8047	18.09	340054	01.0903	12.68
330003	01.3431	19.29	330101	01.7909	33.09	330208	01.2046	23.16	330340	01.2007	23.91	340055	01.2066	16.69
330004	01.2765	19.10	330102	01.2998	16.32	330209	01.1899	21.17	330350	01.8078	27.96	340060	01.1317	16.38
330005	01.8086	19.53	330103	01.2457	15.94	330211	01.2056	16.31	330353	01.3988	27.49	340061	01.7130	19.20
330006	01.3140	24.11	330104	01.3533	25.44	330212	01.1780	20.25	330354	01.3850	.....	340063	01.0618	13.01
330007	01.3275	17.39	330106	01.5693	33.04	330213	01.1258	16.19	330357	01.3770	32.07	340064	01.2274	16.89
330008	01.1201	15.74	330107	01.2581	24.38	330214	01.7374	28.82	330359	00.9481	23.70	340065	01.3093	12.82
330009	01.3524	28.08	330108	01.2108	15.85	330215	01.2093	15.65	330372	01.2689	22.53	340067	01.1980	12.84
330010	01.1699	15.34	330111	01.0835	14.62	330218	01.1561	17.16	330381	01.1775	26.80	340068	01.2347	14.09
330011	01.2484	17.22	330114	00.8917	15.48	330219	01.6451	18.39	330385	01.1714	29.27	340069	01.7147	18.31
330012	01.6092	27.82	330115	01.2026	14.46	330221	01.3287	26.57	330386	01.1388	20.82	340070	01.3855	16.89
330013	02.0610	16.84	330116	00.9205	13.82	330222	01.2641	15.28	330387	00.8466	23.28	340071	01.0722	14.30
330014	01.3839	27.12	330118	01.6256	18.16	330223	01.0773	15.10	330389	01.8147	29.95	340072	01.1441	13.86
330016	01.0259	14.55	330119	01.7361	29.88	330224	01.2693	18.85	330390	01.2508	28.38	340073	01.4620	20.47
330019	01.1269	23.60	330121	01.0046	14.35	330225	01.1710	23.34	330393	01.7066	25.24	340075	01.1488	15.98
330020	01.0498	14.20	330122	01.2006	20.92	330226	01.2690	16.53	330394	01.5060	17.27	340080	01.1232	13.55
330023	01.2458	22.76	330125	01.8084	19.69	330229	01.3174	14.90	330395	01.3465	30.16	340084	01.0577	14.51
330024	01.9139	30.03	330126	01.2271	20.35	330230	01.5132	26.44	330396	01.2729	26.86	340085	01.2634	15.46
330025	01.1935	13.80	330127	01.3930	25.99	330231	01.1306	27.57	330397	01.2901	23.98	340087	01.1402	16.80
330027	01.4632	28.56	330128	01.3068	25.26	330232	01.2194	15.46	330398	01.2229	26.59	340088	01.1242	16.32

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
340089	00.9624	12.28	350011	01.9150	17.37	360036	01.3220	17.27	360113	01.3029	18.24	360204	01.2911	16.96
340090	01.1324	15.49	350012	01.1423	12.36	360037	02.1403	20.14	360114	01.1471	16.05	360210	01.2281	19.23
340091	01.6487	18.32	350013	01.0828	14.58	360038	01.5899	17.85	360115	01.3208	18.08	360211	01.2341	17.25
340093	01.0683	11.60	350014	01.0438	14.29	360039	01.2504	15.38	360116	01.1336	16.04	360212	01.3982	20.25
340094	01.3312	16.83	350015	01.7039	14.44	360040	01.3208	17.72	360118	01.3257	17.37	360213	01.1677	15.77
340096	01.2015	17.18	350016	01.0482	10.35	360041	01.3759	18.25	360121	01.2853	16.74	360218	01.2994	16.21
340097	01.1584	16.04	350017	01.4595	14.52	360042	01.1088	16.74	360122	01.3802	17.77	360230	01.3282	20.27
340098	01.6790	19.05	350018	01.1672	10.67	360044	01.1425	15.79	360123	01.2539	17.50	360231	01.1364	12.45
340099	01.0973	13.36	350019	01.6119	18.69	360045	01.4898	19.25	360124	01.2571	17.08	360234	01.3614	17.90
340101	01.0284	11.11	350020	01.4933	17.82	360046	01.1375	18.60	360125	01.1173	16.87	360236	01.1885	18.56
340104	00.9509	10.60	350021	01.0719	10.94	360047	01.2246	13.85	360126	01.2013	18.97	360239	01.2445	18.70
340105	01.3875	17.75	350023	00.8794	15.59	360048	01.7427	21.00	360127	01.1556	16.28	360241	00.5303	17.69
340106	01.1119	17.79	350024	01.1055	13.69	360049	01.2627	17.36	360128	01.1296	13.85	360242	01.6927	.....
340107	01.3175	16.17	350025	01.0584	12.60	360050	01.1772	12.43	360129	01.0407	14.06	360243	00.7499	14.35
340109	01.3284	15.91	350027	00.9693	12.57	360051	01.5377	21.83	360130	01.1314	15.16	360244	00.7183	16.77
340111	01.1696	13.78	350029	01.0052	12.34	360052	01.7099	17.88	360131	01.4113	16.27	360245	00.8026	12.10
340112	01.2281	14.03	350030	01.0850	16.04	360054	01.2577	15.55	360132	01.2353	20.78	360246	00.8761	15.05
340113	01.9956	19.50	350033	00.9626	13.23	360055	01.2369	18.92	360133	01.4730	17.61	360247	00.4357	.....
340114	01.5144	19.16	350034	01.0422	13.58	360056	01.3471	16.92	360134	01.5906	18.25	370001	01.6940	18.41
340115	01.5599	17.23	350035	00.9058	10.11	360057	01.0323	13.04	360135	01.1609	17.12	370002	01.2409	13.60
340116	01.9326	20.30	350038	01.0433	13.26	360058	01.2713	15.35	360136	01.0537	14.73	370004	01.2787	15.30
340119	01.2864	15.21	350039	00.9735	13.53	360059	01.5326	20.00	360137	01.5595	18.98	370005	01.0310	14.12
340120	01.1407	12.33	350041	01.0473	13.05	360062	01.4664	18.40	360140	01.0061	15.47	370006	01.3098	14.88
340121	01.0454	14.52	350042	01.0545	12.39	360063	01.1442	17.19	360141	01.4435	19.84	370007	01.1454	12.80
340122	00.9955	10.30	350043	01.6433	16.58	360064	01.5484	19.65	360142	01.0217	14.99	370008	01.4101	16.02
340123	01.1301	14.07	350044	00.9167	10.01	360065	01.2285	16.97	360143	01.2936	17.74	370011	01.0535	12.51
340124	01.0290	12.27	350047	01.2270	16.64	360066	01.3888	17.16	360144	01.3153	20.19	370012	00.8431	09.22
340125	01.4128	16.94	350049	01.2236	10.38	360067	01.2739	12.11	360145	01.6266	16.84	370013	01.7649	18.61
340126	01.4341	16.23	350050	00.9361	10.25	360068	01.6561	21.91	360147	01.2668	15.55	370014	01.3220	17.14
340127	01.3124	16.30	350051	00.9479	14.13	360069	01.1403	16.38	360148	01.0725	16.50	370015	01.2733	13.84
340129	01.3428	18.65	350053	01.0745	09.47	360070	01.6756	16.57	360149	01.1481	20.33	370016	01.3805	14.25
340130	01.3270	16.03	350055	00.9216	11.50	360071	01.2663	15.42	360150	01.2805	17.70	370017	01.1032	12.14
340131	01.4309	15.77	350056	00.9559	12.92	360072	01.1415	16.29	360151	01.3134	16.55	370018	01.2603	14.06
340132	01.3108	12.41	350058	00.9358	12.18	360074	01.3554	19.15	360152	01.4800	17.65	370019	01.3065	11.91
340133	01.0442	13.87	350060	00.7458	07.59	360075	01.4959	20.80	360153	01.1489	13.64	370020	01.2921	12.53
340136	00.7885	24.45	350061	01.0638	13.77	360076	01.3053	18.84	360154	01.0301	12.39	370021	00.9804	10.01
340137	01.2184	12.68	350063	00.8926	.....	360077	01.4743	18.59	360155	01.3265	18.75	370022	01.2770	15.09
340138	01.1777	17.60	350064	00.9587	.....	360078	01.2792	18.97	360156	01.3473	16.47	370023	01.3268	14.95
340141	01.6350	18.27	350066	00.7912	.....	360079	01.7583	19.31	360159	01.1944	18.50	370025	01.3983	15.37
340142	01.2013	14.94	360001	01.3143	17.88	360080	01.1127	14.39	360161	01.2723	18.78	370026	01.4214	16.08
340143	01.3902	18.50	360002	01.1965	15.17	360081	01.3567	17.92	360162	01.2555	17.27	370028	01.8667	17.67
340144	01.4374	14.85	360003	01.7521	19.64	360082	01.3134	19.81	360163	01.8595	19.87	370029	01.2233	12.79
340145	01.3310	16.80	360006	01.7493	19.53	360083	01.2570	15.49	360164	00.8555	13.98	370030	01.2426	12.05
340146	01.0146	15.42	360007	01.0552	15.41	360084	01.6203	18.16	360165	01.2257	14.31	370032	01.5278	14.28
340147	01.2935	17.80	360008	01.2985	16.20	360085	01.8174	19.63	360166	01.1556	15.83	370033	01.0835	11.23
340148	01.4339	18.28	360009	01.3946	17.35	360086	01.4601	16.75	360169	00.9799	16.99	370034	01.2667	12.80
340151	01.1224	14.05	360010	01.2275	15.38	360087	01.4074	17.32	360170	01.2837	16.07	370035	01.6190	15.21
340153	01.9701	21.08	360011	01.2285	17.83	360088	01.2127	15.48	360172	01.3763	16.62	370036	01.0290	.....
340155	01.3926	20.91	360012	01.3020	17.61	360089	01.1680	16.92	360174	01.2365	19.24	370037	01.7236	17.83
340156	00.8066	.....	360013	01.0836	16.71	360090	01.2316	17.90	360175	01.2401	17.61	370038	00.9187	12.01
340158	01.1738	16.16	360014	01.1219	17.57	360091	01.2648	18.90	360176	01.1559	15.53	370039	01.4573	17.22
340159	01.1571	16.88	360016	01.6012	17.81	360092	01.2659	17.85	360177	01.2581	16.30	370040	01.1051	10.89
340160	01.0774	12.88	360017	01.7592	19.82	360093	01.2188	16.66	360178	01.2276	15.58	370041	01.0285	13.52
340162	01.2237	17.29	360018	01.5445	18.51	360094	01.2950	20.27	360179	01.2916	19.01	370042	00.8575	10.56
340164	01.4566	18.15	360019	01.2857	18.22	360095	01.3340	16.68	360180	02.0922	22.07	370043	00.9719	12.91
340166	01.4166	18.51	360020	01.4313	20.05	360096	01.1097	16.20	360184	00.4913	17.11	370045	01.0983	10.20
340168	00.5085	14.78	360021	01.2770	18.04	360098	01.4006	18.00	360185	01.2493	17.09	370046	00.9827	09.22
340171	01.1229	.....	360024	01.4310	17.76	360099	01.1130	16.91	360186	01.1727	15.04	370047	01.3245	15.40
350001	01.0099	11.13	360025	01.2355	17.66	360100	01.3239	15.63	360187	01.2787	16.00	370048	01.1876	13.46
350002	01.7678	16.04	360026	01.1897	15.59	360101	01.7334	19.71	360188	00.9998	14.77	370049	01.3566	15.60
350003	01.1971	15.67	360027	01.5255	19.06	360102	01.2713	19.68	360189	01.0092	15.40	370051	00.9627	13.31
350004	01.9429	17.88	360028	01.4563	15.28	360103	01.3290	18.70	360192	01.2404	19.28	370054	01.3878	14.79
350005	01.0670	13.14	360029	01.1611	16.41	360104	01.8950	20.28	360193	01.3104	16.77	370056	01.5609	15.41
350006	01.3958	16.16	360030	01.1326	14.82	360106	01.0509	13.89	360194	01.1180	16.14	370057	01.1711	15.05
350007	00.9510	12.20	360031	01.3534	18.42	360107	01.2373	16.98	360195	01.1319	17.72	370059	01.1178	13.53
350008	01.0408	15.15	360032	01.0876	16.18	360108	01.0371	15.08	360197	01.2030	16.76	370060	01.0787	12.88
350009	01.1648	15.74	360034	01.1698	13.30	360109	01.0970	17.43	360200	00.9989	13.48	370063	01.0947	13.12
350010	01.1768	12.30	360035	01.5734	19.90	360112	01.7594	21.61	360203	01.1502	15.55	370064	01.0006	10.14

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
370065	01.0475	14.76	370195	00.9505	.....	390004	01.3767	16.70	390080	01.2555	18.66	390167	01.2691	20.71
370071	01.0381	10.18	380001	01.3213	19.27	390005	01.0865	14.82	390081	01.3510	20.23	390168	01.1971	17.49
370072	00.9034	11.67	380002	01.2104	22.74	390006	01.7405	17.39	390083	01.2377	20.87	390169	01.2059	18.63
370076	01.3228	12.42	380003	01.1411	18.75	390007	01.1827	21.33	390084	01.2406	15.29	390170	01.8512	22.43
370077	01.2244	16.30	380004	01.6835	22.89	390008	01.1329	15.08	390086	01.1338	16.87	390173	01.1970	17.08
370078	01.7096	14.58	380005	01.1844	19.47	390009	01.6076	17.97	390088	01.3128	18.42	390174	01.7084	24.17
370079	00.9596	11.98	380006	01.3941	18.29	390010	01.1788	16.58	390090	01.7984	19.42	390176	01.1554	16.79
370080	00.9895	11.12	380007	01.5747	22.66	390011	01.2486	16.49	390091	01.1719	17.09	390178	01.2863	17.63
370082	00.9026	12.48	380008	01.0694	18.69	390012	01.1879	19.15	390093	01.1483	15.20	390179	01.2723	22.80
370083	00.9519	10.95	380009	01.8168	22.17	390013	01.2292	16.77	390095	01.1706	13.95	390180	01.5471	22.83
370084	01.0346	08.88	380010	01.0963	24.15	390014	01.6409	16.42	390096	01.2685	16.88	390181	01.0604	17.80
370085	00.8099	12.94	380011	01.0945	14.95	390015	01.1953	13.06	390097	01.3276	20.91	390183	01.1832	17.16
370086	01.1956	09.89	380013	01.2681	21.54	390016	01.2237	15.58	390098	01.7625	20.06	390184	01.1052	17.69
370089	01.2826	14.01	380014	01.4140	18.89	390017	01.1682	14.20	390100	01.6300	19.30	390185	01.2228	16.12
370091	01.6822	16.13	380017	01.7069	21.77	390018	01.2273	19.41	390101	01.1992	15.70	390189	01.0395	17.78
370092	01.0705	12.73	380018	01.8382	19.21	390019	01.1151	14.53	390102	01.3664	20.34	390191	01.0524	13.91
370093	01.8611	18.67	380019	01.2076	18.88	390022	01.3923	21.81	390103	01.0990	17.17	390192	01.1238	17.15
370094	01.4135	16.67	380020	01.4350	20.06	390023	01.2514	19.71	390104	01.0557	15.15	390193	01.1950	15.39
370095	00.9154	11.62	380021	01.2873	19.10	390024	00.8646	22.54	390106	01.0122	14.85	390194	01.1560	18.97
370097	01.3691	18.65	380022	01.1702	19.92	390025	00.6443	16.64	390107	01.2482	18.52	390195	01.8265	22.08
370099	01.1663	13.22	380023	01.2350	17.76	390026	01.2687	20.58	390108	01.4077	19.97	390196	01.4066	.....
370100	01.0423	13.02	380025	01.2670	21.81	390027	01.9708	23.48	390109	01.1523	14.44	390197	01.3091	18.40
370103	00.9024	11.77	380026	01.1899	16.87	390028	01.7871	18.54	390110	01.6465	17.36	390198	01.1942	15.21
370105	02.0043	17.06	380027	01.2587	20.25	390029	01.9395	18.73	390111	01.8583	26.22	390199	01.2016	14.89
370106	01.5411	16.96	380029	01.1474	17.29	390030	01.2365	16.29	390112	01.1488	12.16	390200	01.0147	14.67
370108	01.0551	10.82	380031	01.0329	15.92	390031	01.1587	16.93	390113	01.2113	16.04	390201	01.2666	18.75
370112	01.0769	12.33	380033	01.7783	22.97	390032	01.2498	17.80	390114	01.1217	21.07	390203	01.3102	20.45
370113	01.1674	12.33	380035	01.3580	18.58	390035	01.2774	17.24	390115	01.3154	21.40	390204	01.2596	20.05
370114	01.6305	14.69	380036	01.1305	17.27	390036	01.3337	17.63	390116	01.2237	19.91	390205	01.3479	22.42
370121	01.1729	15.78	380037	01.2063	18.24	390037	01.3426	18.07	390117	01.1636	15.65	390206	01.3349	19.91
370122	01.1291	09.78	380038	01.3425	21.15	390039	01.0948	15.60	390118	01.1524	16.29	390209	01.0438	15.48
370123	01.2098	14.12	380039	01.3082	18.89	390040	01.0024	12.71	390119	01.3475	17.17	390211	01.1929	16.47
370125	01.0284	11.90	380040	01.2507	19.23	390041	01.2475	16.82	390121	01.3363	18.95	390213	00.9476	14.55
370126	00.9483	10.66	380042	01.1550	18.06	390042	01.4374	20.74	390122	01.0719	16.06	390215	01.1565	20.69
370131	01.0232	12.93	380047	01.6960	19.84	390043	01.0988	15.65	390123	01.3041	20.58	390217	01.2781	17.92
370133	01.1213	09.82	380048	01.0936	13.92	390044	01.5993	18.80	390125	01.2255	15.08	390219	01.3149	18.57
370138	01.1138	14.40	380050	01.3349	16.37	390045	01.7321	17.35	390126	01.3266	20.07	390220	01.2126	19.33
370139	01.0944	10.62	380051	01.5217	19.13	390046	01.5446	18.49	390127	01.2319	20.26	390222	01.3083	20.42
370140	01.0059	11.71	380052	01.1764	16.70	390047	01.6845	18.24	390128	01.2014	17.96	390223	01.6376	23.15
370141	01.3883	19.17	380055	01.2275	23.88	390048	01.1857	16.26	390130	01.1480	16.62	390224	00.9314	13.04
370146	01.0486	12.03	380056	01.0753	15.78	390049	01.5514	19.82	390131	01.2704	16.06	390225	01.2124	15.42
370148	01.6050	19.01	380060	01.5375	21.51	390050	02.1389	21.60	390132	01.2425	20.25	390226	01.7861	23.22
370149	01.2373	15.19	380061	01.5190	22.00	390051	02.1828	24.98	390133	01.7790	20.57	390228	01.2071	18.67
370153	01.0915	13.17	380062	01.1039	15.07	390052	01.1846	16.68	390135	01.2913	19.73	390231	01.3122	21.89
370154	01.0164	12.31	380063	01.3354	21.48	390054	01.2245	14.56	390136	01.2338	15.66	390233	01.3268	16.71
370156	01.1022	13.37	380064	01.4398	18.47	390055	01.7751	21.82	390137	01.2962	17.80	390235	01.5635	23.94
370158	01.0538	12.08	380065	01.0680	19.24	390056	01.1222	15.73	390138	01.3365	17.41	390236	01.1643	15.90
370159	01.3427	13.95	380066	01.3162	17.60	390057	01.3263	18.94	390139	01.4984	23.50	390237	01.6149	20.17
370163	00.8558	10.99	380068	01.0655	19.31	390058	01.3239	17.46	390142	01.6716	22.64	390238	01.3009	16.12
370165	01.0872	11.74	380069	01.1328	17.51	390060	01.1432	16.68	390145	01.3596	18.64	390242	01.2772	18.69
370166	01.0886	15.48	380070	01.3924	21.21	390061	01.4426	20.47	390146	01.3088	16.19	390244	00.9339	13.32
370169	01.1024	10.66	380071	01.2894	18.06	390062	01.1400	15.76	390147	01.2505	19.22	390245	01.3465	23.15
370170	00.9792	.....	380072	00.9714	14.15	390063	01.7324	19.20	390149	01.2579	19.59	390246	01.2349	15.91
370171	01.0341	.....	380075	01.4281	20.90	390064	01.5561	16.25	390150	01.1065	17.50	390247	01.0497	17.22
370172	00.8587	.....	380078	01.1638	16.95	390065	01.2903	18.85	390151	01.2927	18.26	390249	01.0291	10.81
370173	01.2420	.....	380081	01.1568	17.66	390066	01.2933	17.15	390152	01.0351	17.07	390256	01.7792	23.51
370174	00.9656	.....	380082	01.2906	20.35	390067	01.8083	18.03	390153	01.2473	21.93	390258	01.2502	19.78
370176	01.1495	16.48	380083	01.2487	18.93	390068	01.3245	18.13	390154	01.1877	13.93	390260	01.1823	15.95
370177	00.9686	10.10	380084	01.2127	20.61	390069	01.3242	19.23	390155	01.2985	20.06	390262	01.9798	17.25
370178	01.0015	12.17	380087	01.0083	12.30	390070	01.2898	19.49	390156	01.4337	22.61	390263	01.4331	18.66
370179	00.8966	14.28	380088	01.0059	15.71	390071	01.1154	13.36	390157	01.3427	17.97	390265	01.3123	17.72
370180	01.0716	.....	380089	01.2909	21.87	390072	01.1133	15.76	390158	01.5891	.....	390266	01.2098	16.69
370183	01.0864	14.00	380090	01.3011	24.41	390073	01.6002	18.94	390160	01.2031	17.67	390267	01.2930	18.93
370186	01.0206	12.72	380091	01.2113	23.79	390074	01.2369	16.26	390161	01.0981	14.87	390268	01.3884	19.94
370189	00.9754	10.13	380897	04.9268	.....	390075	01.2410	15.92	390162	01.4238	19.03	390270	01.3090	15.89
370190	01.5480	17.49	390001	01.3578	18.16	390076	01.3094	20.45	390163	01.2248	16.55	390272	00.4549	.....
370192	01.1656	.....	390002	01.3668	17.03	390078	01.0633	15.98	390164	01.9412	19.14	390277	00.5643	20.34
370194	01.1343	.....	390003	01.2571	15.57	390079	01.7083	16.83	390166	01.1041	17.40	390278	00.7673	17.52

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
390279	01.0726	09.45	420005	01.2017	14.35	430013	01.2330	15.06	440029	01.2864	16.30	440148	01.1406	14.37
390281	03.1739	.....	420006	01.2785	18.90	430014	01.2742	16.77	440030	01.1989	13.21	440149	01.1993	15.19
400001	01.2170	08.68	420007	01.5103	16.31	430015	01.1801	14.41	440031	00.9653	12.29	440150	01.2853	19.58
400002	01.4586	10.39	420009	01.2131	15.70	430016	01.8185	17.59	440032	01.0553	12.65	440151	01.3706	15.86
400003	01.2378	07.14	420010	01.1070	14.35	430018	00.9882	14.06	440033	01.0675	14.84	440152	01.5616	16.91
400004	01.1516	07.34	420011	01.0905	14.89	430022	00.9656	10.91	440034	01.5798	16.64	440153	01.2607	15.10
400005	01.1122	06.10	420014	01.1343	14.11	430023	00.9173	09.95	440035	01.3176	15.65	440156	01.5650	18.85
400006	01.2005	08.16	420015	01.3145	15.96	430024	00.9117	12.28	440039	01.6355	16.76	440157	01.0913	13.64
400007	01.2599	07.55	420016	01.0635	14.39	430026	01.0798	11.36	440040	00.9697	17.03	440159	01.2358	14.83
400009	01.0253	07.68	420018	01.7204	18.94	430027	01.8117	16.54	440041	01.0374	12.35	440161	01.6916	20.58
400010	00.9067	07.94	420019	01.2221	14.90	430028	01.0938	13.68	440046	01.3271	13.59	440166	01.4407	17.80
400011	00.9999	08.65	420020	01.3908	15.98	430029	00.9886	13.10	440047	00.9568	15.31	440168	01.0199	13.03
400012	01.2156	07.09	420023	01.4241	18.07	430031	00.9673	11.31	440048	01.7988	16.64	440173	01.5155	16.91
400013	01.2969	08.96	420026	01.9266	18.05	430033	01.0218	11.90	440049	01.6566	15.62	440174	00.9837	13.30
400014	01.3613	07.51	420027	01.3790	15.50	430034	01.0752	11.58	440050	01.2035	15.14	440175	01.2366	18.06
400015	01.2211	10.88	420030	01.2885	15.83	430036	01.0398	10.11	440051	00.9285	13.29	440176	01.2916	18.36
400016	01.3614	10.48	420031	00.9586	12.15	430037	00.9784	12.89	440052	01.2226	14.15	440178	01.1880	20.20
400017	01.2405	06.27	420033	01.2216	19.24	430038	01.0179	10.77	440053	01.3071	15.64	440180	01.1517	16.68
400018	01.3516	09.35	420035	00.7985	12.43	430039	01.0871	11.53	440054	01.2182	13.84	440181	01.0190	11.75
400019	01.6737	09.48	420036	01.2011	15.38	430040	00.9098	12.17	440056	01.0857	13.45	440182	00.9568	15.33
400021	01.4421	07.62	420037	01.2778	19.65	430041	00.9376	11.91	440057	01.0155	10.77	440183	01.5296	15.06
400022	01.3098	09.79	420038	01.2852	14.43	430042	00.9807	10.63	440058	01.3158	14.95	440184	01.3494	18.63
400024	01.0265	08.62	420039	01.1511	14.52	430043	01.1938	11.97	440059	01.3336	15.98	440185	01.1231	14.24
400026	00.9430	05.90	420042	01.2035	12.15	430044	00.9249	13.17	440060	01.1799	14.76	440186	01.1885	16.21
400027	01.1317	08.32	420043	01.1800	18.82	430047	01.1381	12.24	440061	01.2121	15.46	440187	01.1952	14.85
400028	01.0328	07.14	420048	01.1376	14.26	430048	01.2063	15.01	440063	01.6136	17.43	440189	01.4819	18.81
400029	01.1287	06.64	420049	01.1769	14.55	430049	00.9360	12.66	440064	01.1860	15.05	440192	01.1489	13.99
400031	01.1446	08.00	420051	01.5568	17.99	430051	01.0355	13.48	440065	01.2301	16.18	440193	01.2852	17.88
400032	01.1257	07.75	420053	01.1378	14.03	430054	01.0034	13.13	440067	01.1879	15.54	440194	01.4249	16.89
400044	01.2430	09.09	420054	01.3709	16.39	430056	00.8479	08.93	440068	01.2130	16.43	440196	00.9475	13.32
400048	01.1320	07.91	420055	01.0623	12.51	430057	00.9205	10.47	440069	01.1874	14.17	440197	01.4007	19.15
400061	01.7050	13.68	420056	01.1625	13.41	430060	01.1594	08.46	440070	01.1257	12.52	440200	01.1917	15.41
400079	01.2488	08.95	420057	01.1395	14.96	430062	00.8739	10.31	440071	01.3946	14.87	440203	00.9346	13.17
400087	01.3761	08.90	420059	00.9844	13.96	430064	01.1205	11.89	440072	01.5118	13.92	440205	01.0962	15.86
400094	01.0405	07.41	420061	01.1517	16.16	430065	00.9527	09.93	440073	01.3464	16.95	440206	01.0340	13.82
400098	01.2435	07.17	420062	01.4444	15.65	430066	00.9685	10.93	440078	01.0260	13.28	440208	02.0269	.....
400102	01.1413	08.65	420064	01.1161	13.45	430073	01.0814	.....	440081	01.1575	15.31	450002	01.4623	19.35
400103	01.3671	08.80	420065	01.3051	16.72	430076	00.9768	09.41	440082	01.9905	20.54	450004	01.1684	12.38
400104	01.3703	08.97	420066	00.9099	14.40	430077	01.5832	16.53	440083	01.1099	10.96	450005	01.1503	13.79
400105	01.1725	08.37	420067	01.2333	16.24	430079	00.9628	11.47	440084	01.1544	11.41	450007	01.2442	13.73
400106	01.2084	08.12	420068	01.2885	16.08	430080	01.1317	08.89	440087	00.9572	14.44	450008	01.3624	14.96
400109	01.5298	09.13	420069	01.1002	13.71	430081	01.0452	.....	440090	00.9308	13.29	450010	01.3415	15.37
400110	01.1119	07.87	420070	01.2639	15.05	430082	00.8001	.....	440091	01.5472	16.53	450011	01.5000	17.43
400111	01.1553	07.98	420071	01.3110	16.13	430083	00.8672	.....	440100	01.0273	12.82	450014	01.0699	13.84
400112	01.2298	09.26	420072	01.0735	10.64	430084	00.9280	.....	440102	01.0695	12.26	450015	01.5543	14.96
400113	01.2400	07.57	420073	01.3095	18.10	430085	00.8385	.....	440103	01.2284	17.24	450016	01.6256	17.57
400114	01.0377	06.50	420074	00.8992	11.72	430087	00.9105	09.29	440104	01.6509	17.68	450018	01.6091	21.75
400115	01.0054	07.56	420075	00.9719	12.66	440001	01.1227	12.18	440105	01.3723	16.69	450020	01.0171	15.47
400117	01.1773	09.23	420078	01.8088	18.59	440002	01.5965	15.80	440109	01.1308	12.28	450021	01.8117	21.11
400118	01.1900	08.14	420079	01.5669	16.94	440003	01.0714	15.23	440110	00.9687	16.06	450023	01.4846	15.80
400120	01.3084	09.14	420080	01.2589	19.18	440006	01.6500	17.60	440111	01.3613	18.00	450024	01.3672	16.45
400121	01.0121	06.51	420082	01.3946	19.13	440007	01.0148	11.83	440114	01.0474	12.68	450025	01.5058	16.27
400122	01.0009	05.88	420083	01.2042	18.36	440008	00.9878	13.50	440115	01.1172	14.66	450028	01.6335	17.17
400123	01.1728	08.05	420084	00.7413	13.56	440009	01.1753	13.22	440120	01.5385	16.14	450029	01.3991	12.98
400124	02.6604	09.27	420085	01.3970	16.86	440010	00.9235	08.75	440125	01.4408	16.09	450031	01.5830	18.72
410001	01.3246	23.02	420086	01.3613	16.90	440011	01.2901	16.28	440130	01.1687	14.16	450032	01.2715	13.63
410004	01.3655	21.15	420087	01.5946	16.53	440012	01.4699	17.72	440131	01.1317	13.44	450033	01.6308	16.84
410005	01.3492	21.90	420088	01.1349	15.05	440014	01.0615	09.06	440132	01.1116	14.01	450034	01.6445	16.28
410006	01.2670	21.40	420089	01.2336	19.40	440015	01.6051	16.42	440133	01.5494	17.78	450035	01.4519	18.91
410007	01.6550	20.96	420091	01.2147	13.16	440016	01.0116	11.35	440135	01.3062	14.03	450037	01.6279	17.69
410008	01.1691	21.05	430004	01.0955	17.25	440017	01.6136	18.42	440137	00.9770	12.14	450039	01.3345	18.70
410009	01.2968	20.66	430005	01.3167	14.06	440018	01.4675	16.10	440141	01.0771	13.59	450040	01.5518	17.75
410010	01.0160	25.40	430007	01.0540	12.52	440019	01.6253	19.06	440142	01.0311	10.75	450042	01.6646	15.75
410011	01.2110	22.25	430008	01.1248	14.01	440020	01.2392	15.43	440143	01.1020	17.21	450043	01.4473	20.40
410012	01.7208	19.51	430009	01.0939	12.21	440022	01.2040	13.72	440144	01.3327	18.35	450044	01.6182	20.04
410013	01.3105	24.63	430010	01.1273	09.23	440023	00.9963	11.58	440145	01.0439	10.99	450046	01.3724	14.67
420002	01.3794	18.80	430011	01.3139	14.33	440024	01.3302	16.61	440146	01.0036	12.98	450047	01.1155	13.43
420004	01.8612	18.35	430012	01.3055	14.97	440025	01.1317	13.01	440147	01.1079	17.06	450050	01.0582	16.00

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
450051	01.5923	18.22	450154	01.2004	12.23	450296	01.3139	16.46	450484	01.4849	18.53	450651	01.8166	21.92
450052	01.0171	13.13	450155	01.0191	12.61	450297	01.0190	12.01	450488	01.2528	14.98	450652	00.9114	13.44
450053	01.1479	13.11	450157	01.0041	12.97	450299	01.3455	16.28	450489	00.9859	11.56	450653	01.2485	17.98
450054	01.7181	21.32	450160	00.9838	17.50	450303	00.9458	09.97	450497	01.1299	12.05	450654	01.0034	11.11
450055	01.1238	12.92	450162	01.1851	16.63	450306	01.0878	12.50	450498	01.2653	13.88	450656	01.4908	16.48
450056	01.6174	18.26	450163	01.0364	15.34	450307	00.9041	13.62	450508	01.5582	16.37	450658	00.9746	14.01
450058	01.5774	14.76	450164	01.0684	12.56	450309	01.0677	12.74	450514	01.2163	18.78	450659	01.5762	22.12
450059	01.2421	13.21	450165	00.9569	14.34	450315	01.1137	19.65	450517	01.0029	10.94	450660	01.5698	21.85
450060	01.3622	22.17	450166	00.9672	10.06	450320	01.3364	18.20	450518	01.5325	16.84	450661	01.1378	18.94
450063	00.9758	11.51	450169	00.9171	13.82	450321	00.9661	12.45	450523	01.5243	21.18	450662	01.6712	16.53
450064	01.5083	15.34	450170	00.9792	11.32	450322	00.7151	15.40	450530	01.4505	21.64	450665	00.9334	11.45
450065	01.1393	14.75	450176	01.2241	15.23	450324	01.6484	15.19	450534	00.9542	20.29	450666	01.2708	19.05
450068	01.7951	20.31	450177	01.0967	13.18	450325	01.2279	11.93	450535	01.2557	14.12	450668	01.5484	18.90
450070	01.2671	15.46	450178	01.0123	14.64	450327	00.9734	12.11	450537	01.3698	17.80	450669	01.2923	19.10
450072	01.2351	18.19	450181	01.0065	15.15	450330	01.2256	16.86	450538	01.3931	21.17	450670	01.2960	19.44
450073	01.1202	12.84	450184	01.5429	17.74	450334	01.0568	11.65	450539	01.2925	13.27	450672	01.6578	18.91
450076	01.5802	.....	450185	01.1137	08.47	450337	01.2313	17.14	450544	01.4408	22.65	450673	01.1428	11.38
450078	00.9949	11.17	450187	01.2789	16.44	450340	01.3177	14.54	450545	01.2710	14.13	450674	01.0203	22.09
450079	01.4395	19.03	450188	01.0085	12.46	450341	01.0264	16.26	450546	01.8365	18.37	450675	01.5171	17.78
450080	01.2966	15.79	450190	01.1841	19.53	450346	01.3443	16.27	450547	01.1613	15.09	450677	01.4324	19.18
450081	01.1087	12.87	450191	01.0864	15.75	450347	01.1430	15.48	450550	00.9800	17.01	450678	01.4776	20.45
450082	00.9627	12.75	450192	01.2403	15.49	450348	00.9975	10.99	450551	01.1957	13.75	450681	03.0551	17.29
450083	01.7142	17.21	450193	01.8944	21.32	450351	01.1727	18.76	450558	01.7767	17.17	450683	01.3083	20.17
450085	01.0903	14.38	450194	01.2291	18.11	450352	01.1141	16.21	450559	00.9811	12.75	450684	01.2695	18.53
450087	01.4141	19.35	450196	01.5101	17.34	450353	01.3226	16.13	450561	01.6522	17.65	450686	01.5555	14.30
450090	01.2144	12.40	450197	01.0544	19.66	450355	01.1121	11.18	450563	01.2306	21.98	450688	01.2802	18.65
450092	01.2129	13.12	450200	01.3827	16.35	450358	02.0930	20.57	450565	01.2925	15.63	450690	01.4169	21.31
450094	01.2531	19.39	450201	01.0233	15.38	450362	01.1896	17.62	450570	01.0316	11.23	450691	01.1089	14.91
450096	01.5315	19.25	450203	01.1919	16.13	450369	01.0842	10.21	450571	01.4989	14.52	450694	01.2338	15.91
450097	01.4577	18.33	450209	01.5494	16.26	450370	01.1269	13.02	450573	01.0008	13.58	450696	01.6701	23.37
450098	01.1683	13.75	450210	01.1950	12.03	450371	01.1487	11.02	450574	00.9382	13.41	450697	01.5431	16.28
450099	01.2816	17.70	450211	01.3861	14.13	450372	01.2680	20.49	450575	01.0572	16.98	450698	00.9742	11.66
450101	01.4848	15.03	450213	01.5055	16.27	450373	01.1462	13.68	450578	00.9224	12.94	450700	00.9302	12.68
450102	01.7093	21.87	450214	01.3721	18.61	450374	00.9541	12.20	450580	01.1076	12.59	450702	01.6063	17.58
450104	01.2182	13.74	450217	01.0508	12.61	450376	01.5102	16.26	450583	01.0094	12.24	450703	01.5299	20.96
450107	01.6171	18.75	450219	01.1346	14.22	450378	01.0973	21.56	450584	01.2257	12.86	450704	01.3719	17.86
450108	00.9967	14.49	450221	01.0814	14.05	450379	01.5198	21.28	450586	00.9987	11.26	450705	01.0246	16.80
450109	00.9911	15.36	450222	01.6508	17.32	450381	01.0567	12.56	450587	01.2266	16.93	450706	01.2165	21.90
450110	01.2522	19.34	450224	01.3702	15.85	450388	01.7602	17.41	450591	01.1417	16.28	450709	01.2281	20.05
450111	01.2466	18.63	450229	01.5708	14.82	450389	01.2066	16.74	450596	01.3150	17.29	450711	01.6431	17.88
450112	01.3508	13.87	450231	01.5945	16.94	450393	01.3320	20.94	450597	01.0561	14.23	450712	00.7387	15.03
450113	01.2359	16.99	450234	00.9823	11.27	450395	01.0348	14.68	450603	00.8332	16.27	450713	01.4783	18.10
450118	01.5629	20.94	450235	01.0563	13.47	450399	00.9957	13.37	450604	01.3817	13.57	450715	01.4531	17.40
450119	01.2958	16.37	450236	01.0665	14.17	450400	01.1526	13.70	450605	01.4745	17.91	450716	01.2682	19.64
450121	01.4393	18.70	450237	01.5510	16.60	450403	01.3684	19.90	450609	00.8790	12.25	450717	01.3585	22.95
450123	01.1554	17.47	450239	01.1977	12.35	450411	00.9524	11.46	450610	01.4506	15.52	450718	01.2381	19.18
450124	01.5864	19.48	450241	01.0458	15.67	450417	01.0539	12.95	450614	01.0471	12.43	450723	01.3474	18.17
450126	01.3845	11.95	450243	00.8395	11.57	450418	01.3370	17.42	450615	01.0767	11.70	450724	01.2905	16.59
450128	01.2434	14.78	450246	00.9676	15.02	450419	01.2738	22.40	450617	01.2885	20.82	450725	00.9969	20.18
450130	01.5025	15.17	450249	00.9712	10.70	450422	00.8075	23.47	450620	01.0455	12.48	450726	00.8676	14.54
450131	01.3707	19.58	450250	00.9532	09.93	450423	01.4394	21.03	450623	01.1429	17.62	450727	00.9596	09.78
450132	01.6610	16.45	450253	01.3163	13.51	450424	01.2047	16.33	450626	01.0877	14.09	450728	00.9627	14.31
450133	01.5384	16.49	450258	01.0962	11.17	450429	01.1242	13.35	450628	00.9420	15.48	450730	01.3579	21.14
450135	01.7273	21.81	450259	01.2084	17.44	450431	01.6589	17.28	450630	01.6424	20.60	450733	01.3470	16.91
450137	01.5099	24.28	450264	00.8643	11.94	450438	01.1793	14.39	450631	01.7535	18.05	450735	00.8720	11.91
450140	00.8414	16.46	450269	01.1388	12.62	450446	00.8625	13.07	450632	01.0125	11.17	450742	01.3448	21.43
450142	01.4366	19.50	450270	01.1746	10.16	450447	01.3505	17.69	450633	01.5938	19.18	450743	01.4622	18.40
450143	01.0982	12.23	450271	01.2762	14.41	450450	01.0872	.....	450634	01.6943	21.57	450746	01.0500	13.39
450144	01.1175	16.23	450272	01.2923	16.29	450451	01.1254	20.23	450637	01.3647	18.24	450747	01.3619	16.51
450145	00.8692	12.46	450276	01.0996	10.44	450457	01.7832	17.14	450638	01.5844	22.52	450749	01.0128	12.35
450146	00.9881	16.53	450278	00.8495	18.12	450460	01.0299	12.06	450639	01.4141	21.41	450750	01.0228	11.86
450147	01.4175	17.66	450280	01.5286	20.58	450462	01.8354	17.99	450641	01.0224	12.60	450751	01.3246	21.80
450148	01.3079	19.02	450283	01.0519	12.09	450464	00.9825	13.41	450643	01.2796	17.60	450754	00.8884	13.19
450149	01.3501	19.33	450286	01.0373	14.54	450465	01.3178	14.66	450644	01.4715	20.30	450755	01.1540	13.66
450150	00.8919	13.62	450288	01.2105	12.58	450467	00.9653	14.39	450646	01.6143	19.59	450757	00.9784	13.32
450151	01.1057	13.27	450289	01.4907	17.37	450469	01.3736	16.94	450647	02.0240	19.98	450758	01.2423	.....
450152	01.2645	16.04	450292	01.2051	20.15	450473	01.0047	17.83	450648	01.0382	11.36	450760	01.2068	16.97
450153	01.5803	17.10	450293	00.9746	13.55	450475	01.1363	14.13	450649	01.0756	14.64	450761	01.0642	09.63

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
450763	01.0163	15.68	460047	01.7740	19.49	490067	01.2062	14.95	500029	00.9339	14.30	500141	01.3258	21.93
450766	02.3234	14.24	460049	01.9207	17.05	490069	01.3990	15.10	500030	01.4753	22.13	500143	00.7662	14.92
450769	01.0378	13.28	460050	01.3106	20.35	490071	01.4398	17.56	500031	01.2905	20.19	500146	01.0318	.....
450770	00.9496	13.59	460051	01.1901	.....	490073	01.3538	21.49	500033	01.2047	18.05	510001	01.7139	17.08
450771	01.9690	17.01	470001	01.2043	17.11	490074	01.3343	16.00	500036	01.3185	19.11	510002	01.2708	16.31
450774	00.9708	23.99	470003	01.8136	17.82	490075	01.3332	16.62	500037	01.1216	17.63	510004	00.9183	12.62
450775	01.1940	19.26	470004	01.1118	14.18	490077	01.1636	16.87	500039	01.3772	21.32	510005	01.0028	13.71
450776	00.9251	.....	470005	01.2608	18.71	490079	01.3187	14.30	500041	01.2872	22.09	510006	01.2565	17.08
450777	01.0014	15.01	470006	01.1898	17.05	490083	00.6451	14.63	500042	01.3735	20.95	510007	01.4707	17.81
450779	01.3450	20.59	470008	01.2516	15.41	490084	01.2535	15.96	500043	01.2939	16.56	510008	01.1226	15.33
450780	01.6140	19.78	470010	01.1804	18.58	490085	01.2071	13.36	500044	01.8920	20.56	510012	01.0670	14.26
450781	01.4783	16.23	470011	01.1610	19.30	490088	01.2024	13.97	500045	01.1167	20.65	510013	01.1365	15.10
450785	01.0516	26.08	470012	01.2651	17.52	490089	01.0748	14.37	500048	00.9122	16.01	510015	00.9706	12.51
450788	01.4208	.....	470013	01.1682	18.28	490090	01.1783	14.25	500049	01.4708	19.34	510016	00.9917	11.27
450792	01.3306	.....	470015	01.0806	16.29	490091	01.2045	20.14	500050	01.4079	20.41	510018	01.1351	14.40
450793	01.6623	.....	470018	01.1930	17.37	490092	01.2038	14.32	500051	01.6292	22.71	510020	01.0494	10.16
450794	01.4602	.....	470020	00.9884	14.50	490093	01.2927	15.31	500052	01.2781	.....	510022	01.7998	19.52
450795	00.8520	.....	470023	01.2947	17.20	490094	01.0700	14.57	500053	01.2686	20.10	510023	01.1454	15.14
450797	00.6382	.....	470024	01.1136	17.08	490095	01.4745	16.13	500054	01.8788	20.41	510024	01.4093	17.94
450798	00.8871	.....	490001	01.0799	19.41	490097	01.1333	13.69	500055	01.0886	20.32	510026	00.9392	12.19
450799	01.3895	.....	490002	01.0625	13.61	490098	01.3132	11.69	500057	01.3490	16.24	510027	00.9669	13.86
450800	01.3919	.....	490003	00.6018	17.55	490099	00.9348	15.29	500058	01.5095	19.82	510028	01.0731	14.90
450801	01.4818	.....	490004	01.2303	16.67	490100	01.3757	16.69	500059	01.1588	20.02	510029	01.2953	16.69
450802	01.2487	.....	490005	01.5364	16.10	490101	01.1933	23.64	500060	01.4869	20.70	510030	01.0968	14.87
450803	00.8537	.....	490006	01.1569	13.27	490104	00.9110	14.46	500061	00.9842	17.95	510031	01.3367	16.27
450804	01.5293	.....	490007	02.0310	17.19	490105	00.7427	16.55	500062	01.0856	17.16	510033	01.2624	14.42
450805	01.1693	.....	490009	01.8204	18.08	490106	00.9047	14.86	500064	01.5371	21.69	510035	01.1467	16.46
450807	00.9104	.....	490010	01.0912	17.08	490107	01.3155	22.64	500065	01.3049	17.67	510036	01.0129	09.34
450809	01.6570	.....	490011	01.4170	17.03	490108	00.8737	13.78	500068	01.0186	17.17	510038	01.1610	13.71
450897	04.8548	.....	490012	01.1990	15.55	490109	00.9185	14.09	500069	01.1665	18.62	510039	01.3580	15.02
460001	01.7866	19.82	490013	01.2514	14.82	490110	01.3986	15.90	500071	01.3666	19.46	510043	00.9310	11.33
460003	01.7210	18.38	490014	01.3584	21.04	490111	01.2348	16.79	500072	01.1952	21.19	510046	01.2605	15.26
460004	01.7712	20.68	490015	01.4630	17.30	490112	01.7326	19.07	500073	01.0859	16.85	510047	01.2074	17.37
460005	01.5499	18.80	490017	01.3623	16.44	490113	01.3003	20.96	500074	01.1671	14.80	510048	01.0733	17.39
460006	01.4322	18.21	490018	01.2580	16.83	490114	01.0988	15.00	500075	03.7376	20.25	510050	01.4642	15.34
460007	01.5450	19.27	490019	01.2006	15.60	490115	01.2451	14.25	500077	01.3913	21.63	510053	01.0396	13.50
460008	01.3609	16.02	490020	01.1565	14.16	490116	01.2251	15.61	500079	01.4055	19.87	510055	01.2246	19.41
460009	01.8852	18.11	490021	01.1505	17.11	490117	01.1729	13.62	500080	00.8427	11.56	510058	01.2002	16.23
460010	01.9161	20.15	490022	01.4063	17.59	490118	01.7642	21.32	500084	01.1439	20.05	510059	01.2290	13.65
460011	01.3884	16.16	490023	01.2234	17.03	490119	01.3467	16.41	500085	01.0619	17.19	510060	01.1538	15.36
460013	01.5056	18.54	490024	01.7803	17.06	490120	01.3270	16.88	500086	01.4244	18.48	510061	01.0749	12.59
460014	01.0358	15.38	490027	01.1310	13.11	490122	01.5152	20.86	500088	01.3586	22.86	510062	01.1797	15.38
460015	01.2592	19.75	490028	01.3516	18.42	490123	01.1414	14.80	500089	00.9469	13.99	510063	01.0126	10.63
460016	00.8970	13.58	490030	01.1033	11.16	490124	01.1521	16.99	500090	01.1042	12.60	510065	01.0089	12.04
460017	01.4549	16.52	490031	01.1369	12.61	490126	01.3837	14.72	500092	01.0798	15.65	510066	01.1288	12.02
460018	00.9760	13.59	490032	01.7249	19.08	490127	01.0179	14.44	500094	00.9177	15.53	510067	01.2496	15.91
460019	01.1515	12.90	490033	01.1854	15.21	490130	01.3118	16.58	500096	01.0950	17.13	510068	01.1196	14.01
460020	01.0589	14.21	490035	01.2179	09.64	490131	01.0427	14.06	500097	01.1371	16.12	510070	01.2210	16.05
460021	01.3873	19.20	490037	01.1278	13.27	500001	01.3342	20.92	500098	00.9192	13.66	510071	01.2767	14.49
460022	00.9374	19.41	490038	01.2195	12.54	500002	01.4828	18.75	500101	01.0080	17.84	510072	01.0650	13.50
460023	01.1831	20.75	490040	01.4100	.....	500003	01.4073	21.28	500102	00.9391	18.43	510077	01.1079	14.36
460024	00.8662	13.51	490041	01.3633	16.88	500005	01.8398	22.52	500104	01.2622	18.71	510080	01.1530	09.35
460025	00.8105	12.63	490042	01.3475	15.18	500007	01.4207	20.14	500106	00.9247	15.53	510081	01.0320	13.19
460026	01.0881	16.98	490043	01.3704	16.74	500008	01.8411	22.88	500107	01.1321	15.58	510082	01.0578	12.08
460027	00.9430	18.61	490044	01.3658	16.65	500009	01.2857	21.07	500108	01.6669	21.40	510084	00.9741	12.87
460029	01.0255	15.71	490045	01.1319	18.60	500011	01.3718	21.44	500110	01.2887	18.75	510085	01.2422	17.99
460030	01.2141	15.78	490046	01.4645	17.24	500012	01.5217	20.94	500118	01.1240	20.88	510086	01.0448	15.65
460032	01.0120	19.00	490047	01.0663	16.34	500014	01.5715	22.36	500119	01.3333	20.48	520002	01.2873	17.24
460033	00.9450	18.22	490048	01.4906	17.53	500015	01.3714	20.92	500122	01.1925	20.27	520003	01.1635	15.19
460035	00.9610	10.93	490050	01.4363	20.06	500016	01.4877	22.76	500123	00.8543	14.78	520004	01.1581	16.53
460036	00.9397	19.41	490052	01.6013	15.06	500019	01.3295	19.82	500124	01.3292	22.39	520006	01.0583	18.05
460037	01.0502	15.92	490053	01.2501	14.14	500021	01.5380	20.77	500125	00.9834	10.72	520007	01.2469	14.14
460039	01.0976	21.08	490054	01.1101	13.91	500023	01.1763	19.09	500129	01.7339	22.41	520008	01.5546	20.54
460041	01.2179	18.29	490057	01.5486	17.02	500024	01.6324	21.06	500132	01.0006	19.79	520009	01.5961	16.88
460042	01.4657	16.14	490059	01.5727	18.24	500025	01.8715	21.69	500134	00.7903	15.75	520010	01.1768	19.39
460043	00.9888	20.44	490060	01.0661	16.72	500026	01.4324	22.42	500137	00.7110	19.99	520011	01.2031	16.46
460044	01.2018	19.41	490063	01.6611	22.34	500027	01.5334	23.68	500138	03.4209	.....	520013	01.2909	17.88
460046	00.7432	10.23	490066	01.2178	17.42	500028	01.0839	14.76	500139	01.4763	21.33	520014	01.2083	15.55

Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage	Provider	Case mix index	Avg. hour wage
520015	01.1174	16.65	520107	01.2599	17.46	530026	01.0473	14.63						
520016	01.0872	12.75	520109	00.9937	17.25	530027	00.8416	09.56						
520017	01.1927	16.87	520110	01.1756	16.47	530029	00.9590	13.49						
520018	01.0801	15.88	520111	00.9841	14.44	530031	00.8745	10.95						
520019	01.2873	16.65	520112	01.0805	18.15	530032	01.1558	17.33						
520021	01.3538	19.16	520113	01.1645	17.80									
520024	01.0377	13.33	520114	01.1037	12.61									
520025	01.1242	15.19	520115	01.3222	15.89									
520026	01.1051	17.48	520116	01.2576	17.66									
520027	01.2244	19.22	520117	01.0303	15.40									
520028	01.3261	17.60	520118	00.9469	10.95									
520029	00.9657	16.70	520120	00.8647	11.95									
520030	01.6772	20.19	520121	00.9763	14.18									
520031	01.1054	16.11	520122	00.9894	13.96									
520032	01.1683	14.56	520123	01.1427	16.55									
520033	01.1820	15.91	520124	01.1255	14.34									
520034	01.1271	17.17	520130	01.0776	12.60									
520035	01.2587	14.67	520131	01.0620	15.82									
520037	01.6518	18.23	520132	01.1878	14.31									
520038	01.4916	17.14	520134	01.0269	15.14									
520039	00.9998	16.24	520135	00.9427	13.84									
520040	01.4327	20.05	520136	01.4778	18.87									
520041	01.1487	14.54	520138	01.8773	18.18									
520042	01.0742	16.25	520139	01.2893	18.50									
520044	01.3803	16.09	520140	01.6143	19.31									
520045	01.6794	17.97	520141	01.1223	15.63									
520047	01.0211	14.50	520142	00.9152	12.48									
520048	01.4410	17.67	520144	01.0302	16.10									
520049	01.9925	17.97	520145	00.9155	16.57									
520051	02.0296	19.41	520146	01.0749	13.71									
520053	01.1007	14.78	520148	01.1668	15.34									
520054	01.0919	16.40	520149	00.9581	13.31									
520056	01.3164	17.77	520151	01.0803	14.43									
520057	01.1308	16.08	520152	01.1177	16.38									
520058	01.0511	17.87	520153	00.9775	13.19									
520059	01.3130	18.17	520154	01.1520	16.15									
520060	01.2970	15.15	520156	01.1216	16.37									
520062	01.2707	16.18	520157	00.9447	13.70									
520063	01.2571	17.61	520159	00.9412	16.25									
520064	01.7132	18.60	520160	01.7643	17.77									
520066	01.4169	17.73	520161	01.0283	14.76									
520068	00.8891	15.82	520170	01.2367	18.51									
520069	01.1915	16.75	520171	00.9904	13.69									
520070	01.6012	16.93	520173	01.1609	17.36									
520071	01.1175	17.71	520174	01.3641	20.57									
520074	01.1086	14.96	520177	01.6458	20.33									
520075	01.4753	17.44	520178	01.0634	14.61									
520076	01.1296	14.40	520186	02.5906	.....									
520077	01.0286	14.50	530002	01.1932	18.07									
520078	01.5021	17.89	530003	00.9310	12.59									
520082	01.3454	15.25	530004	01.0270	13.17									
520083	01.5871	21.59	530005	01.1389	13.19									
520084	01.0883	15.73	530006	01.1268	16.83									
520087	01.6162	17.16	530007	01.0516	11.52									
520088	01.2469	17.56	530008	01.2810	17.75									
520089	01.5230	18.79	530009	00.9688	20.60									
520090	01.2710	16.16	530010	01.2195	16.30									
520091	01.3709	17.25	530011	01.0899	15.27									
520092	01.1124	15.11	530012	01.5874	17.25									
520094	01.0158	16.07	530014	01.3289	15.01									
520095	01.3510	18.56	530015	01.1500	19.22									
520096	01.4979	17.78	530016	01.2060	11.87									
520097	01.3308	17.90	530017	01.0038	16.09									
520098	01.7143	19.40	530018	01.0645	14.57									
520100	01.2350	15.91	530019	00.9449	14.32									
520101	01.0947	15.75	530022	01.1147	15.94									
520102	01.2141	19.00	530023	00.8514	17.76									
520103	01.3242	17.70	530025	01.3686	18.12									

Note: Case mix indexes do not include discharges from PPS-exempt units. Case mix indexes include cases received in HCFA central office through December 1995.

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS

Urban area (constituent counties or county equivalents)	Wage index	GAF
0040 Abilene, TX	0.8055	0.8623
Taylor, TX		
0060 Aguadilla, PR	0.4430	0.5726
Aguada, PR		
Aguadilla, PR		
Moca, PR		
0080 Akron, OH	0.9875	0.9914
Portage, OH		
Summit, OH		
0120 Albany, GA	0.8353	0.8841
Dougherty, GA		
Lee, GA		
0160 Albany-Schenectady-Troy, NY	0.8510	0.8954
Albany, NY		
Montgomery, NY		
Rensselaer, NY		
Saratoga, NY		
Schenectady, NY		
Schoharie, NY		
0200 Albuquerque, NM	0.9390	0.9578
Bernalillo, NM		
Sandoval, NM		
Valencia, NM		
0220 Alexandria, LA	0.8213	0.8739
Rapides, LA		
0240 Allentown-Bethlehem-Easton, PA	1.0014	1.0160
Carbon, PA		
Lehigh, PA		
Northampton, PA		
0280 Altoona, PA	0.9531	0.9676
Blair, PA		
0320 Amarillo, TX	0.8557	0.8988
Potter, TX		
Randall, TX		
0380 Anchorage, AK	1.3285	1.3104
Anchorage, AK		
0440 Ann Arbor, MI	1.1688	1.1218
Lenawee, MI		
Livingston, MI		
Washtenaw, MI		
0450 Anniston, AL	0.7848	0.8471
Calhoun, AL		
0460 Appleton-Oshkosh-Neenah, WI	0.8910	0.9240
Calumet, WI		
Outagamie, WI		
Winnebago, WI		
0470 Arecibo, PR	0.4631	0.5903
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
0480 Asheville, NC	0.9365	0.9561
Buncombe, NC		
Madison, NC		
0500 Athens, GA	0.9259	0.9771
Clarke, GA		
Madison, GA		
Oconee, GA		
0520 *Atlanta, GA	1.0089	1.0363
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	1.1102	1.0742
Atlantic, NJ		
Cape May, NJ		
0600 Augusta-Aiken, GA–SC	0.8849	0.9197
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Edgefield, SC		
0640 Austin-San Marcos, TX	0.9252	0.9482
Bastrop, TX		
Caldwell, TX		
Hays, TX		
Travis, TX		
Williamson, TX		
0680 Bakersfield, CA	1.0202	1.0168
Kern, CA		
0720 *Baltimore, MD	0.9820	1.0173
Anne Arundel, MD		
Baltimore, MD		
Baltimore City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Anne's, MD		
0733 Bangor, ME	0.9412	0.9594
Penobscot, ME		
0743 Barnstable-Yarmouth, MA	1.3682	1.2395
Barnstable, MA		
0760 Baton Rouge, LA	0.8442	0.8905
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
0840 Beaumont-Port Arthur, TX	0.8578	0.9003
Hardin, TX		
Jefferson, TX		
Orange, TX		
0860 Bellingham, WA	1.1342	1.0901
Whatcom, WA		
0870 Benton Harbor, MI	0.8553	0.8985
Berrien, MI		
0875 *Bergen-Passaic, NJ	1.1717	1.1146
Bergen, NJ		
Passaic, NJ		
0880 Billings, MT	0.8903	0.9235
Yellowstone, MT		
0920 Biloxi-Gulfport-Pascagoula, MS	0.8573	0.8999
Hancock, MS		
Harrison, MS		
Jackson, MS		
0960 Binghamton, NY	0.8842	0.9192
Broome, NY		
Tioga, NY		
1000 Birmingham, AL	0.9047	0.9337
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
1010 Bismarck, ND	0.7976	0.8565
Burleigh, ND		
Morton, ND		
1020 Bloomington, IN	0.8619	0.9303
Monroe, IN		
1040 Bloomington-Normal, IL	0.8921	0.9248
McLean, IL		
1080 Boise City, ID	0.9269	0.9493
Ada, ID		
Canyon, ID		
1123 *Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1639	1.1428
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		
1125 Boulder-Longmont, CO	0.9383	0.9573
Boulder, CO		
1145 Brazoria, TX	0.8865	0.9208
Brazoria, TX		
1150 Bremerton, WA	1.0926	1.0625
Kitsap, WA		
1240 Brownsville-Harlingen-San Benito, TX	0.8561	0.8991
Cameron, TX		
1260 Bryan-College Station, TX	0.8760	0.9133
Brazos, TX		
1280 *Buffalo-Niagara Falls, NY	0.9123	0.9673
Erie, NY		
Niagara, NY		
1303 Burlington, VT	0.9126	0.9393
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
1310 Caguas, PR	0.4661	0.5929
Caguas, PR		
Cayey, PR		
Cidra, PR		
Gurabo, PR		
San Lorenzo, PR		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
1320 Canton-Massillon, OH	0.8667	0.9067
Carroll, OH		
Stark, OH		
1350 Casper, WY	0.8841	0.9191
Natrona, WY		
1360 Cedar Rapids, IA	0.8477	0.8930
Linn, IA		
1400 Champaign-Urbana, IL	0.9413	0.9594
Champaign, IL		
1440 Charleston-North Charleston, SC	0.8984	0.9293
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
1480 Charleston, WV	0.9547	0.9688
Kanawha, WV		
Putnam, WV		
1520 *Charlotte-Gastonia-Rock Hill, NC–SC	0.9631	1.0038
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Union, NC		
York, SC		
1540 Charlottesville, VA	0.9175	0.9427
Albemarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
1560 Chattanooga, TN-GA	0.8867	0.9210
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
1580 Cheyenne, WY	0.7695	0.8357
Laramie, WY		
1600 *Chicago, IL	1.0756	1.0827
Cook, IL		
DeKalb, IL		
DuPage, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		
Will, IL		
1620 Chico-Paradise, CA	1.0441	1.0300
Butte, CA		
1640 *Cincinnati, OH–KY–IN	0.9477	0.9928
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	0.7733	0.8386
Christian, KY		
Montgomery, TN		
1680 *Cleveland-Lorain-Elyria, OH	0.9908	1.0235
Ashtabula, OH		
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Lorain, OH		
Medina, OH		
1720 Colorado Springs, CO	0.9456	0.9624
El Paso, CO		
1740 Columbia, MO	0.8919	0.9246
Boone, MO		
1760 Columbia, SC	0.9178	0.9430
Lexington, SC		
Richland, SC		
1800 Columbus, GA–AL	0.7655	0.8328
Russell, AL		
Chattanoochee, GA		
Harris, GA		
Muscogee, GA		
1840 *Columbus, OH	0.9699	1.0087
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
1880 Corpus Christi, TX	0.8641	0.9048
Nueces, TX		
San Patricio, TX		
1900 Cumberland, MD–WV	0.8613	0.9028
Allegany, MD		
Mineral, WV		
1920 *Dallas, TX	0.9530	0.9966
Collin, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Henderson, TX		
Hunt, TX		
Kaufman, TX		
Rockwall, TX		
1950 Danville, VA	0.8516	0.8958
Danville City, VA		
Pittsylvania, VA		
1960 Davenport-Moline-Rock Island, IA–IL	0.8407	0.8880
Scott, IA		
Henry, IL		
Rock Island, IL		
2000 Dayton-Springfield, OH	0.9582	0.9858
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
2020 Daytona Beach, FL	0.8891	0.9296
Flagler, FL		
Volusia, FL		
2030 Decatur, AL	0.8403	0.8877
Lawrence, AL		
Morgan, AL		
2040 Decatur, IL	0.7866	0.8484
Macon, IL		
2080 *Denver, CO	1.0291	1.0504
Adams, CO		
Arapahoe, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
2120 Des Moines, IA	0.8772	0.9142
Dallas, IA		
Polk, IA		
Warren, IA		
2160 *Detroit, MI	1.0748	1.0822
Lapeer, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
St. Clair, MI		
Wayne, MI		
2180 Dothan, AL	0.7758	0.8404
Dale, AL		
Houston, AL		
2190 Dover, DE	0.9017	0.9595
Kent, DE		
2200 Dubuque, IA	0.8149	0.8692
Dubuque, IA		
2240 Duluth-Superior, MN–WI	0.9437	0.9611
St. Louis, MN		
Douglas, WI		
2281 Dutchess County, NY	1.0604	1.0488
Dutchess, NY		
2290 Eau Claire, WI	0.8698	0.9089
Chippewa, WI		
Eau Claire, WI		
2320 El Paso, TX	0.9486	0.9645
El Paso, TX		
2330 Elkhart-Goshen, IN	0.8820	0.9176
Elkhart, IN		
2335 Elmira, NY	0.8436	0.8901
Chemung, NY		
2340 Enid, OK	0.7879	0.8494
Garfield, OK		
2360 Erie, PA	0.9137	0.9401
Erie, PA		
2400 Eugene-Springfield, OR	1.1503	1.1006
Lane, OR		
2440 Evansville-Henderson, IN–KY	0.8990	0.9297
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2520 Fargo-Moorhead, ND–MN	0.9010	0.9311

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Clay, MN		
Cass, ND		
2560 Fayetteville, NC	0.9025	0.9322
Cumberland, NC		
2580 Fayetteville-Springdale-Rogers, AR	0.7236	0.8013
Benton, AR		
Washington, AR		
2620 Flagstaff, AZ–UT	0.9039	0.9331
Coconino, AZ		
Kane, UT		
2640 Flint, MI	1.1273	1.0964
Genesee, MI		
2650 Florence, AL	0.8157	0.8698
Colbert, AL		
Lauderdale, AL		
2655 Florence, SC	0.8614	0.9029
Florence, SC		
2670 Fort Collins-Loveland, CO	1.0628	1.0426
Larimer, CO		
2680 *Ft. Lauderdale, FL	1.0968	1.0973
Broward, FL		
2700 Fort Myers-Cape Coral, FL	0.9093	0.9370
Lee, FL		
2710 Fort Pierce-Port St. Lucie, FL	1.0192	1.0131
Martin, FL		
St. Lucie, FL		
2720 Fort Smith, AR–OK	0.7885	0.8498
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
2750 Fort Walton Beach, FL	0.9186	0.9435
Okaloosa, FL		
2760 Fort Wayne, IN	0.8819	0.9175
Adams, IN		
Allen, IN		
DeKalb, IN		
Huntington, IN		
Wells, IN		
Whitley, IN		
2800 *Forth Worth-Arlington, TX	1.0095	1.0367
Hood, TX		
Johnson, TX		
Parker, TX		
Tarrant, TX		
2840 Fresno, CA	1.1202	1.0808
Fresno, CA		
Madera, CA		
2880 Gadsden, AL	0.8901	0.9234
Etowah, AL		
2900 Gainesville, FL	0.9455	0.9623
Alachua, FL		
2920 Galveston-Texas City, TX	1.1022	1.0796
Galveston, TX		
2960 Gary, IN	0.9176	0.9428
Lake, IN		
Porter, IN		
2975 Glens Falls, NY	0.8560	0.8990
Warren, NY		
Washington, NY		
2980 Goldsboro, NC	0.8412	0.8883
Wayne, NC		
2985 Grand Forks, ND–MN	0.9228	0.9465
Polk, MN		
Grand Forks, ND		
2995 Grand Junction, CO	0.8847	0.9195
Mesa, CO		
3000 Grand Rapids-Muskegon-Holland, MI	1.0088	1.0060
Allegan, MI		
Kent, MI		
Muskegon, MI		
Ottawa, MI		
3040 Great Falls, MT	0.9007	0.9309
Cascade, MT		
3060 Greeley, CO	0.9712	0.9802
Weld, CO		
3080 Green Bay, WI	0.9387	0.9576
Brown, WI		
3120 *Greensboro-Winston-Salem-High Point, NC	0.9327	0.9820
Alamance, NC		
Davidson, NC		
Davie, NC		
Forsyth, NC		
Guilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
3150 Greenville, NC	0.9098	0.9373
Pitt, NC		
3160 Greenville-Spartanburg-Anderson, SC	0.8947	0.9266
Anderson, SC		
Cherokee, SC		
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
3180 Hagerstown, MD	0.9195	0.9441
Washington, MD		
3200 Hamilton-Middletown, OH	0.9515	0.9665
Butler, OH		
3240 Harrisburg-Lebanon-Carlisle, PA	1.0181	1.0124
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
3283 *Hartford, CT	1.2395	1.1931
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
3285 Hattiesburg, MS	0.7269	0.8038
Forrest, MS		
Lamar, MS		
3290 Hickory-Morganton-Lenoir, NC	0.7945	0.8542
Alexander, NC		
Burke, NC		
Caldwell, NC		
Catawba, NC		
3320 Honolulu, HI	1.1487	1.1776
Honolulu, HI		
3350 Houma, LA	0.7843	0.8518
Lafourche, LA		
Terrebonne, LA		
3360 *Houston, TX	0.9790	1.0151
Chambers, TX		
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
3400 Huntington-Ashland, WV–KY–OH	0.9194	0.9441
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
3440 Huntsville, AL	0.8145	0.8689
Limestone, AL		
Madison, AL		
3480 *Indianapolis, IN	0.9950	1.0265
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Madison, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
3500 Iowa City, IA	0.9382	0.9573
Johnson, IA		
3520 Jackson, MI	0.9066	0.9351
Jackson, MI		
3560 Jackson, MS	0.7906	0.8514
Hinds, MS		
Madison, MS		
Rankin, MS		
3580 Jackson, TN	0.8340	0.8831
Madison, TN		
3605 Jacksonville, FL	0.9018	0.9317
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
3605 Jacksonville, NC	0.7071	0.7887
Onslow, NC		
3610 Jamestown, NY	0.7679	0.8346
Chautaqua, NY		
3620 Janesville-Beloit, WI	0.8664	0.9065
Rock, WI		
3640 Jersey City, NJ	1.1408	1.1236
Hudson, NJ		
3660 Johnson City-Kingsport-Bristol, TN–VA	0.8921	0.9248
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Bristol City, VA		
Scott, VA		
Washington, VA		
3680 Johnstown, PA	0.8417	0.8887
Cambria, PA		
Somerset, PA		
3710 Joplin, MO	0.7409	0.8144
Jasper, MO		
Newton, MO		
3720 Kalamazoo-Battlecreek, MI	1.0565	1.0384
Calhoun, MI		
Kalamazoo, MI		
Van Buren, MI		
3740 Kankakee, IL	0.8998	0.9582
Kankakee, IL		
3760 *Kansas City, KS–MO	0.9522	0.9960
Johnson, KS		
Leavenworth, KS		
Miami, KS		
Wyandotte, KS		
Cass, MO		
Clay, MO		
Clinton, MO		
Jackson, MO		
Lafayette, MO		
Platte, MO		
Ray, MO		
3800 Kenosha, WI	0.9166	0.9421
Kenosha, WI		
3810 Killeen-Temple, TX	1.0415	1.0282
Bell, TX		
Coryell, TX		
3840 Knoxville, TN	0.8520	0.8961
Anderson, TN		
Blount, TN		
Knox, TN		
Loudon, TN		
Sevier, TN		
Union, TN		
3850 Kokomo, IN	0.8609	0.9025
Howard, IN		
Tipton, IN		
3870 La Crosse, WI–MN	0.8638	0.9046
Houston, MN		
La Crosse, WI		
3880 Lafayette, LA	0.8183	0.8717
Acadia, LA		
Lafayette, LA		
St. Landry, LA		
St. Martin, LA		
3920 Lafayette, IN	0.8824	0.9179
Clinton, IN		
Tippecanoe, IN		
3960 Lake Charles, LA	0.8052	0.8621
Calcasieu, LA		
3980 Lakeland-Winter Haven, FL	0.8677	0.9074
Polk, FL		
4000 Lancaster, PA	0.9605	0.9786
Lancaster, PA		
4040 Lansing-East Lansing, MI	1.0016	1.0011
Clinton, MI		
Eaton, MI		
Ingham, MI		
4080 Laredo, TX	0.7092	0.7903
Webb, TX		
4100 Las Cruces, NM	0.8516	0.8958
Dona Ana, NM		
4120 *Las Vegas, NV–AZ	1.0894	1.0922
Mohave, AZ		
Clark, NV		
Nye, NV		
4150 Lawrence, KS	0.8616	0.9301
Douglas, KS		
4200 Lawton, OK	0.8339	0.8830
Comanche, OK		
4243 Lewiston-Auburn, ME	0.9431	0.9607
Androscoggin, ME		
4280 Lexington, KY	0.8387	0.8865
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Madison, KY		
Scott, KY		
Woodford, KY		
4320 Lima, OH	0.8752	0.9128
Allen, OH		
Auglaize, OH		
4360 Lincoln, NE	0.9193	0.9440
Lancaster, NE		
4400 Little Rock-North Little Rock, AR	0.8616	0.9030
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
4420 Longview-Marshall, TX	0.8633	0.9042
Gregg, TX		
Harrison, TX		
Upshur, TX		
4480 *Los Angeles-Long Beach, CA	1.2396	1.1932
Los Angeles, CA		
4520 Louisville, KY–IN	0.9445	0.9617
Clark, IN		
Floyd, IN		
Harrison, IN		
Scott, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
4600 Lubbock, TX	0.8525	0.8965
Lubbock, TX		
4640 Lynchburg, VA	0.8036	0.8609
Amherst, VA		
Bedford, VA		
Bedford City, VA		
Campbell, VA		
Lynchburg City, VA		
4680 Macon, GA	0.8836	0.9187
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Twiggs, GA		
4720 Madison, WI	1.0048	1.0033
Dane, WI		
4800 Mansfield, OH	0.8543	0.8978
Crawford, OH		
Richland, OH		
4840 Mayaguez, PR	0.4186	0.5508
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
Sabana Grande, PR		
San German, PR		
4880 McAllen-Edinburg-Mission, TX	0.8502	0.8948
Hidalgo, TX		
4890 Medford-Ashland, OR	1.0213	1.0145
Jackson, OR		
4900 Melbourne-Titusville-Palm Bay, FL	0.9089	0.9507
Brevard, FL		
4920 *Memphis, TN–AR–MS	0.8185	0.8980
Crittenden, AR		
DeSoto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4940 Merced, CA	1.0684	1.0463
Merced, CA		
5000 *Miami, FL	0.9240	0.9757
Dade, FL		
5015 *Middlesex-Somerset-Hunterdon, NJ	1.0777	1.0842
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
5080 *Milwaukee-Waukesha, WI	0.9667	1.0064
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
5120 *Minneapolis-St. Paul, MN–WI	1.0785	1.0847
Anoka, MN		
Carver, MN		
Chisago, MN		
Dakota, MN		
Hennepin, MN		
Isanti, MN		
Ramsey, MN		
Scott, MN		
Sherburne, MN		
Washington, MN		
Wright, MN		
Pierce, WI		
St. Croix, WI		
5160 Mobile, AL	0.7999	0.8582
Baldwin, AL		
Mobile, AL		
5170 Modesto, CA	1.0135	1.0092
Stanislaus, CA		
5190 *Monmouth-Ocean, NJ	1.0842	1.0569
Monmouth, NJ		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Ocean, NJ		
5200 Monroe, LA	0.8234	0.8754
Ouachita, LA		
5240 Montgomery, AL	0.7949	0.8545
Autauga, AL		
Elmore, AL		
Montgomery, AL		
5280 Muncie, IN	0.9736	1.0113
Delaware, IN		
5330 Myrtle Beach, SC	0.7798	0.8434
Horry, SC		
5345 Naples, FL	1.0222	1.0151
Collier, FL		
5360 *Nashville, TN	0.9065	0.9630
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
5380 *Nassau-Suffolk, NY	1.2852	1.2231
Nassau, NY		
Suffolk, NY		
5483 *New Haven-Bridgeport-Stamford-Waterbury-	1.2778	1.2183
Danbury, CT		
Fairfield, CT		
New Haven, CT		
5523 New London-Norwich, CT	1.2345	1.1898
New London, CT		
5560 *New Orleans, LA	0.9434	0.9897
Jefferson, LA		
Orleans, LA		
Plaquemines, LA		
St. Bernard, LA		
St. Charles, LA		
St. James, LA		
St. John The Baptist, LA		
St. Tammany, LA		
5600 *New York, NY	1.4041	1.2995
Bronx, NY		
Kings, NY		
New York, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
5640 *Newark, NJ	1.1057	1.1034
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Warren, NJ		
5660 Newburgh, NY–PA	1.0829	1.0561
Orange, NY		
Pike, PA		
5720 *Norfolk-Virginia Beach-Newport News, VA–NC	0.8326	0.9086
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 *Oakland, CA	1.5113	1.3666
Alameda, CA		
Contra Costa, CA		
5790 Ocala, FL	0.8999	0.9303
Marion, FL		
5800 Odessa-Midland, TX	0.8552	0.8984
Ector, TX		
Midland, TX		
5880 *Oklahoma City, OK	0.8463	0.9188
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
5910 Olympia, WA	1.0713	1.0483
Thurston, WA		
5920 Omaha, NE–IA	0.9425	0.9603
Pottawattamie, IA		
Cass, NE		
Douglas, NE		
Sarpy, NE		
Washington, NE		
5945 *Orange County, CA	1.1929	1.1622
Orange, CA		
5960 *Orlando, FL	0.9491	0.9938
Lake, FL		
Orange, FL		
Osceola, FL		
Seminole, FL		
5990 Owensboro, KY	0.7578	0.8270
Daviess, KY		
6015 Panama City, FL	0.8080	0.8642
Bay, FL		
6020 Parkersburg-Marietta, WV–OH	0.7895	0.8506
Washington, OH		
Wood, WV		
6080 Pensacola, FL	0.8212	0.8738
Escambia, FL		
Santa Rosa, FL		
6120 Peoria-Pekin, IL	0.8923	0.9249
Peoria, IL		
Tazewell, IL		
Woodford, IL		
6160 *Philadelphia, PA–NJ	1.1197	1.1129
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Salem, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
6200 *Phoenix-Mesa, AZ	0.9832	1.0181
Maricopa, AZ		
Pinal, AZ		
6240 Pine Bluff, AR	0.7904	0.8512
Jefferson, AR		
6280 *Pittsburgh, PA	0.9726	1.0106
Allegheny, PA		
Beaver, PA		
Butler, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
6323 Pittsfield, MA	1.0570	1.0387
Berkshire, MA		
6360 Ponce, PR	0.4500	0.5788
Guayanilla, PR		
Juana Diaz, PR		
Penuelas, PR		
Ponce, PR		
Villalba, PR		
Yauco, PR		
6403 Portland, ME	0.9615	0.9735
Cumberland, ME		
Sagadahoc, ME		
York, ME		
6440 *Portland-Vancouver, OR–WA	1.1267	1.1177
Clackamas, OR		
Columbia, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Clark, WA		
6483 Providence-Warwick-Pawtucket, RI	1.1116	1.0751
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
6520 Provo-Orem, UT	1.0139	1.0095
Utah, UT		
6560 Pueblo, CO	0.8302	0.8804
Pueblo, CO		
6580 Punta Gorda, FL	0.8284	0.8790
Charlotte, FL		
6600 Racine, WI	0.8855	0.9201
Racine, WI		
6640 Raleigh-Durham-Chapel Hill, NC	0.9740	0.9821
Chatham, NC		
Durham, NC		
Franklin, NC		
Johnston, NC		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
Orange, NC		
Wake, NC		
6660 Rapid City, SD	0.8493	0.8942
Pennington, SD		
6680 Reading, PA	0.9467	0.9728
Berks, PA		
6690 Redding, CA	1.1631	1.1090
Shasta, CA		
6720 Reno, NV	1.1043	1.0703
Washoe, NV		
6740 Richland-Kennewick-Pasco, WA	0.9993	0.9995
Benton, WA		
Franklin, WA		
6760 Richmond-Petersburg, VA	0.9189	0.9437
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 *Riverside-San Bernardino, CA	1.1251	1.1166
Riverside, CA		
San Bernardino, CA		
6800 Roanoke, VA	0.8721	0.9105
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
6820 Rochester, MN	1.0452	1.0307
Olmsted, MN		
6840 *Rochester, NY	0.9611	1.0024
Genesee, NY		
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
6880 Rockford, IL	0.9015	0.9315
Boone, IL		
Ogle, IL		
Winnebago, IL		
6895 Rocky Mount, NC	0.8951	0.9269
Edgecombe, NC		
Nash, NC		
6920 *Sacramento, CA	1.2382	1.1923
El Dorado, CA		
Placer, CA		
Sacramento, CA		
6960 Saginaw-Bay City-Midland, MI	0.9605	0.9728
Bay, MI		
Midland, MI		
Saginaw, MI		
6980 St. Cloud, MN	0.9478	0.9640
Benton, MN		
Stearns, MN		
7000 St. Joseph, MO	0.8570	0.8997
Andrews, MO		
Buchanan, MO		
7040 *St. Louis, MO–IL	0.8926	0.9529
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 Salem, OR	0.9749	0.9901
Marion, OR		
Polk, OR		
7120 Salinas, CA	1.3835	1.2489
Monterey, CA		
7160 *Salt Lake City-Ogden, UT	0.9677	1.0071
Davis, UT		
Salt Lake, UT		
Weber, UT		
7200 San Angelo, TX	0.7594	0.8282
Tom Green, TX		
7240 *San Antonio, TX	0.8365	0.9115
Bexar, TX		
Comal, TX		
Guadalupe, TX		
Wilson, TX		
7320 *San Diego, CA	1.2183	1.1791
San Diego, CA		
7360 *San Francisco, CA	1.4210	1.3102
Marin, CA		
San Francisco, CA		
San Mateo, CA		
7400 *San Jose, CA	1.4435	1.3244
Santa Clara, CA		
7440 *San Juan-Bayamon, PR	0.4616	0.6066
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	1.1587	1.1061
San Luis Obispo, CA		
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.1267	1.0851
Santa Barbara, CA		
7485 Santa Cruz-Watsonville, CA	1.3551	1.2313
Santa Cruz, CA		
7490 Santa Fe, NM	1.0847	1.0573
Los Alamos, NM		
Santa Fe, NM		
7500 Santa Rosa, CA	1.2558	1.1688
Sonoma, CA		
7510 Sarasota-Bradenton, FL	0.9770	0.9842
Manatee, FL		
Sarasota, FL		
7520 Savannah, GA	1.0089	1.0061
Bryan, GA		
Chatham, GA		
Effingham, GA		
7560 Scranton–Wilkes-Barre–Hazleton, PA	0.8767	0.9138
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Wyoming, PA		
7600 *Seattle-Bellevue-Everett, WA	1.1410	1.1274
Island, WA		
King, WA		
Snohomish, WA		
7610 Sharon, PA	0.8764	0.9136
Mercer, PA		
7620 Sheboygan, WI	0.7782	0.8422
Sheboygan, WI		
7640 Sherman-Denison, TX	0.8650	0.9055
Grayson, TX		
7680 Shreveport-Bossier City, LA	0.9379	0.9570
Bossier, LA		
Caddo, LA		
Webster, LA		
7720 Sioux City, IA–NE	0.8331	0.8825
Woodbury, IA		
Dakota, NE		
7760 Sioux Falls, SD	0.8606	0.9023
Lincoln, SD		
Minnehaha, SD		
7800 South Bend, IN	0.9957	0.9971
St. Joseph, IN		

TABLE 4A.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR URBAN AREAS—Continued

Urban area (constituent counties or county equivalents)	Wage index	GAF
7840 Spokane, WA .... Spokane, WA	1.0548	1.0372
7880 Springfield, IL .... Menard, IL Sangamon, IL	0.8783	0.9150
7920 Springfield, MO Christian, MO Greene, MO Webster, MO	0.7840	0.8465
8003 Springfield, MA Hampden, MA Hampshire, MA	1.0609	1.0552
8050 State College, PA ..... Centre, PA	0.8875	0.9215
8080 Steubenville-Weirton, OH–WV ..... Jefferson, OH Brooke, WV Hancock, WV	0.8244	0.9024
8120 Stockton-Lodi, CA ..... San Joaquin, CA	1.1417	1.0997
8140 Sumter, SC ..... Sumter, SC	0.7716	0.8373
8160 Syracuse, NY .... Cayuga, NY Madison, NY Onondaga, NY Oswego, NY	0.9406	0.9589
8200 Tacoma, WA ..... Pierce, WA	1.0891	1.0655
8240 Tallahassee, FL Gadsden, FL Leon, FL	0.8332	0.8825
8280 *Tampa-St. Petersburg-Clearwater, FL ..... Hernando, FL Hillsborough, FL Pasco, FL Pinellas, FL	0.9322	0.9817
8320 Terre Haute, IN Clay, IN Vermillion, IN Vigo, IN	0.8611	0.9027
8360 Texarkana, AR-Texarkana, TX ..... Miller, AR Bowie, TX	0.8484	0.8935
8400 Toledo, OH ..... Fulton, OH Lucas, OH Wood, OH	1.0383	1.0445
8440 Topeka, KS ..... Shawnee, KS	1.0108	1.0074
8480 Trenton, NJ ..... Mercer, NJ	1.0572	1.0388
8520 Tucson, AZ ..... Pima, AZ	0.9050	0.9339
8560 Tulsa, OK ..... Creek, OK Osage, OK Rogers, OK Tulsa, OK Wagoner, OK	0.8113	0.8666
8600 Tuscaloosa, AL	0.7723	0.8378
8640 Tyler, TX ..... Smith, TX	1.0158	1.0108
8680 Utica-Rome, NY Herkimer, NY Oneida, NY	0.8421	0.8890
8720 Vallejo-Fairfield-Napa, CA ..... Napa, CA Solano, CA	1.3483	1.2271
8735 Ventura, CA ..... Ventura, CA	1.1169	1.0786
8750 Victoria, TX ..... Victoria, TX	0.8478	0.8931
8760 Vineland-Millville-Bridgeton, NJ ..... Cumberland, NJ	1.0015	1.0010
8780 Visalia-Tulare-Porterville, CA ..... Tulare, CA	1.0174	1.0119
8800 Waco, TX ..... McLennan, TX	0.7789	0.8427
8840 *Washington, DC–MD–VA–WV ..... District of Columbia, DC Calvert, MD Charles, MD Frederick, MD Montgomery, MD Prince Georges, MD Alexandria City, VA Arlington, VA Clarke, VA Culpepper, VA Fairfax, VA Fairfax City, VA Falls Church City, VA Fauquier, VA Fredericksburg City, VA King George, VA Loudoun, VA Manassas City, VA Manassas Park City, VA Prince William, VA Spotsylvania, VA Stafford, VA Warren, VA	1.0842	1.0886
8920 Waterloo-Cedar Falls, IA ..... Black Hawk, IA	0.8724	0.9108
8940 Wausau, WI ..... Marathon, WI	1.0347	1.0236
8960 West Palm Beach-Boca Raton, FL ..... Palm Beach, FL	1.0016	1.0036
9000 Wheeling, OH–WV ..... Belmont, OH Marshall, WV Ohio, WV	0.7580	0.8313
9040 Wichita, KS ..... Butler, KS Harvey, KS Sedgwick, KS	0.9447	0.9618
9080 Wichita Falls, TX Archer, TX Wichita, TX	0.8070	0.8634
9140 Williamsport, PA Lycoming, PA	0.8487	0.8937
9160 Wilmington-Newark, DE–MD ..... New Castle, DE Cecil, MD	1.1341	1.1063
9200 Wilmington, NC New Hanover, NC Brunswick, NC	0.9072	0.9355
9260 Yakima, WA ..... Yakima, WA	1.0049	1.0034
9270 Yolo, CA ..... Yolo, CA	1.1470	1.0985
9280 York, PA ..... York, PA	0.9124	0.9391
9320 Youngstown-Warren, OH ..... Columbiana, OH Mahoning, OH Trumbull, OH	0.9764	0.9838
9340 Yuba City, CA .... Sutter, CA Yuba, CA	1.0437	1.0297
9360 Yuma, AZ ..... Yuma, AZ	0.9518	0.9667

*Large Urban Area

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS

Nonurban area	Wage index	GAF
Alabama	0.7160	0.7955
Alaska	1.2472	1.2550
Arizona	0.7946	0.8543
Arkansas	0.7000	0.7833
California	0.9991	1.0010
Colorado	0.8156	0.8697
Connecticut	1.2788	1.2189
Delaware	0.9464	0.9630
Florida	0.8677	0.9084
Georgia	0.7659	0.8331
Hawaii	1.0268	1.0771
Idaho	0.8356	0.8843
Illinois	0.7567	0.8286
Indiana	0.8119	0.8718
Iowa	0.7394	0.8132
Kansas	0.7113	0.7922
Kentucky	0.7772	0.8419
Louisiana	0.7284	0.8055
Maine	0.8335	0.8827
Maryland	0.8446	0.8908
Massachusetts	1.0794	1.0537
Michigan	0.8837	0.9188
Minnesota	0.8161	0.8704
Mississippi	0.6808	0.7685
Missouri	0.7249	0.8044

TABLE 4B.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR RURAL AREAS—Continued

Nonurban area	Wage index	GAF
Montana	0.8137	0.8683
Nebraska	0.7245	0.8020
Nevada	0.8795	0.9158
New Hampshire	0.9776	0.9895
New Jersey [1]	.....	.....
New Mexico	0.7873	0.8489
New York	0.8565	0.8994
North Carolina	0.7945	0.8565
North Dakota	0.7370	0.8114
Ohio	0.8349	0.8909
Oklahoma	0.6963	0.7805
Oregon	0.9715	0.9813
Pennsylvania	0.8480	0.8939
Puerto Rico	0.4182	0.5505
Rhode Island [1]	.....	.....
South Carolina	0.7679	0.8356
South Dakota	0.7085	0.7898
Tennessee	0.7372	0.8116
Texas	0.7430	0.8166
Utah	0.8854	0.9200
Vermont	0.8941	0.9287
Virginia	0.7760	0.8422
Washington	0.9956	0.9978
West Virginia	0.7943	0.8541
Wisconsin	0.8449	0.8914
Wyoming	0.8202	0.8731

[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 reclassified to	Wage index	GAF
Abilene, TX	0.8055	0.8623
Albuquerque, NM	0.9390	0.9578
Alexandria, LA	0.8213	0.8739
Amarillo, TX	0.8557	0.8988
Anchorage, AK	1.3285	1.2147
Asheville, NC	0.9365	0.9561
Atlanta, GA	0.9986	0.9990
Bangor, ME	0.9412	0.9594
Baton Rouge, LA	0.8442	0.8905
Benton Harbor, MI	0.8553	0.8985
Benton Harbor, MI (Rural Michigan Hosp.)	0.8837	0.9188
Billings, MT	0.8903	0.9235
Birmingham, AL	0.9047	0.9337
Bismarck, ND	0.7976	0.8565
Boise City, ID	0.9269	0.9493
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1639	1.1095
Caguas, PR	0.4661	0.5929
Champaign-Urbana, IL	0.8999	0.9303
Charleston-North Charleston, SC	0.8984	0.9293
Charlotte-Gastonia-Rock Hill, NC–SC	0.9631	0.9746
Charlottesville, VA	0.9006	0.9308
Chattanooga, TN–GA	0.8867	0.9210
Chicago, IL	1.0653	1.0443
Cincinnati, OH–KY–IN	0.9477	0.9639
Cleveland-Lorain-Elyria, OH	0.9908	0.9937
Columbia, MO	0.8919	0.9246
Columbus, OH	0.9699	0.9793
Dallas, TX	0.9530	0.9676
Davenport-Moline-Rock Island, IA–IL	0.8407	0.8880
Denver, CO	1.0291	1.0198
Des Moines, IA	0.8772	0.9142
Duluth-Superior, MN–WI	0.9437	0.9611
Dutchess County, NY	1.0309	1.0211
Elkhart-Goshen, IN	0.8820	0.9176
Eugene-Springfield, OR	1.1503	1.1006
Fargo-Moorhead, ND–MN	0.8860	0.9205
Fayetteville, NC	0.8658	0.9060
Flagstaff, AR–UT	0.8848	0.9196
Flint, MI	1.1273	1.0855
Florence, AL	0.8157	0.8698
Florence, SC	0.8614	0.9029
Fort Lauderdale, FL	1.0968	1.0653
Fort Pierce-Port St. Lucie, FL	1.0049	1.0034
Fort Smith, AR–OK	0.7885	0.8498
Fort Walton Beach, FL	0.8978	0.9288
Fort Worth-Arlington, TX	1.0095	1.0065
Gadsden, AL	0.8901	0.9234
Gary, IN	0.9176	0.9428
Grand Forks, ND–MN	0.9228	0.9465
Grand Junction, CO	0.8847	0.9195
Grand Rapids-Muskegon-Holland, MI	1.0088	1.0060
Great Falls, MT	0.9007	0.9309
Greeley, CO	0.9409	0.9591
Green Bay, WI	0.9387	0.9576
Greensboro-Winston-Salem-High Point, NC	0.9327	0.9534
Greenville-Spartanburg-Anderson, SC	0.8947	0.9266
Hartford, CT	1.2218	1.1470
Honolulu, HI	1.1487	1.0996
Houston, TX	0.9790	0.9856
Huntington-Ashland, WV–KY–OH	0.9194	0.9441
Huntsville, AL	0.8040	0.8612
Indianapolis, IN	0.9833	0.9885
Jackson, MS	0.7906	0.8514
Jacksonville, FL	0.9018	0.9317
Johnson City-Kingsport-Bristol, TN–VA	0.8921	0.9248
Joplin, MO	0.7409	0.8144
Kalamazoo-Battlecreek, MI	1.0462	1.0314
Kansas City, KS–MO	0.9522	0.9670
Knoxville, TN	0.8520	0.8961
Lafayette, LA	0.8183	0.8717
Lansing-East Lansing, MI	1.0016	1.0011
Las Vegas, NV–AZ	1.0894	1.0604
Lexington, KY	0.8387	0.8865
Lima, OH	0.8752	0.9128
Lincoln, NE	0.9059	0.9346
Little Rock-North Little Rock, AR	0.8616	0.9030
Longview-Marshall, TX	0.8495	0.8943
Los Angeles-Long Beach, CA	1.2396	1.1585
Louisville, KY–IN	0.9445	0.9617
Macon, GA	0.8460	0.8918
Madison, WI	1.0048	1.0033
Mansfield, OH	0.8543	0.8978
Medford-Ashland, OR	1.0213	1.0145
Memphis, TN–AR–MS	0.8185	0.8718
Middlesex-Somerset-Hunterdon, NJ	1.0777	1.0526
Milwaukee-Waukesha, WI	0.9667	0.9771
Minneapolis-St. Paul, MN–WI	1.0785	1.0531
Modesto, CA	1.0135	1.0092
Monmouth-Ocean, NJ	1.0572	1.0388
Montgomery, AL	0.7949	0.8545
Nashville, TN	0.9065	0.9350
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2778	1.1828
New London-Norwich, CT	1.2345	1.1552
New Orleans, LA	0.9434	0.9609
New York, NY	1.4041	1.2616
Newark, NJ	1.0956	1.0645
Oakland, CA	1.5113	1.3268
Odessa-Midland, TX	0.8552	0.8984
Oklahoma City, OK	0.8463	0.8920
Omaha, NE–IA	0.9425	0.9603
Orange County, CA	1.1929	1.1284
Peoria-Pekin, IL	0.8923	0.9249
Philadelphia, PA–NJ	1.1197	1.0805
Pittsburgh, PA	0.9564	0.9699
Portland, ME	0.9615	0.9735
Portland-Vancouver, OR–WA	1.1267	1.0851
Provo-Orem, UT	1.0139	1.0095
Raleigh-Durham-Chapel Hill, NC	0.9615	0.9735
Rapid City, SD	0.8493	0.8942
Roanoke, VA	0.8721	0.9105
Rochester, MN	1.0452	1.0307
Rockford, IL	0.9015	0.9315
Sacramento, CA	1.2382	1.1576
Saginaw-Bay City-Midland, MI	0.9605	0.9728
St. Cloud, MN	0.9478	0.9640
St. Louis, MO–IL	0.8926	0.9251
Salt Lake City-Ogden, UT	0.9677	0.9778
San Diego, CA	1.2183	1.1448
San Francisco, CA	1.4210	1.2720
San Jose, CA	1.4435	1.2858
Santa Rosa, CA	1.2430	1.1606
Sarasota-Bradenton, FL	0.9770	0.9842
Seattle-Bellevue-Everett, WA	1.1410	1.0945
Sharon, PA	0.8764	0.9136
Sherman-Denison, TX	0.8650	0.9055
Sioux Falls, SD	0.8606	0.9023
South Bend, IN	0.9957	0.9971
Springfield, IL	0.8783	0.9150
Springfield, MO	0.7840	0.8465
Stockton-Lodi, CA	1.1417	1.0950
Syracuse, NY	0.9406	0.9589
Tacoma, WA	1.0891	1.0602
Tampa-St. Petersburg-Clearwater, FL	0.9322	0.9531

TABLE 4C.—WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) FOR HOSPITALS THAT ARE RECLASSIFIED—Continued

Area reclassified to	Wage index	GAF
Texarkana, AR-Texarkana, TX	0.8484	0.8935
Toledo, OH	1.0383	1.0261
Topeka, KS	0.9817	0.9874
Tucson, AZ	0.9050	0.9339
Tulsa, OK	0.8113	0.8666
Tyler, TX	0.9717	0.9805
Victoria, TX	0.8259	0.8772
Washington, DC–MD–VA–WV	1.0842	1.0569
Waterloo-Cedar Falls, IA	0.8601	0.9019
Wausau, WI	0.9720	0.9807
Wichita, KS	0.9282	0.9503
Rural Alabama	0.7160	0.7955
Rural Florida	0.8677	0.9074
Rural Kentucky	0.7772	0.8415
Rural Louisiana	0.7284	0.8049
Rural Michigan	0.8837	0.9188
Rural Minnesota	0.8161	0.8701
Rural New Hampshire	0.9776	0.9846
Rural North Carolina	0.7945	0.8542
Rural Virginia	0.7760	0.8406
Rural Washington	0.9956	0.9970
Rural West Virginia	0.7943	0.8541
Rural Wyoming	0.8202	0.8731

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS

Urban area	Average hourly wage
Abilene, TX	15.4795
Aguadilla, PR	8.6418
Akron, OH	19.2662
Albany, GA	16.2968
Albany-Schenectady-Troy, NY	16.6016
Albuquerque, NM	18.3100
Alexandria, LA	15.8746
Allentown-Bethlehem-Easton, PA	19.5376
Altoona, PA	18.5951
Amarillo, TX	16.6936
Anchorage, AK	25.8567
Ann Arbor, MI	22.8035
Anniston, AL	15.3104
Appleton-Oshkosh-Neenah, WI	17.3835
Arecibo, PR	9.0343
Asheville, NC	18.2517
Athens, GA	18.0640
Atlanta, GA	19.6832
Atlantic-Cape May, NJ	21.6594
Augusta-Aiken, GA–SC	17.2642
Austin-San Marcos, TX	18.0500
Bakersfield, CA	19.9031
Baltimore, MD	19.1581
Bangor, ME	18.3630
Barnstable-Yarmouth, MA	26.6928
Baton Rouge, LA	16.4700
Beaumont-Port Arthur, TX	16.7355
Bellingham, WA	22.1285
Benton Harbor, MI	16.5971
Bergen-Passaic, NJ	22.8591
Billings, MT	17.3702
Biloxi-Gulfport-Pascagoula, MS	16.7252
Binghamton, NY	17.2505
Birmingham, AL	17.6503

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Bismarck, ND	15.0933
Bloomington, IN	16.8155
Bloomington-Normal, IL	17.4035
Boise City, ID	18.0695
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	22.7069
Boulder-Longmont, CO	18.3061
Brazoria, TX	17.9908
Bremerton, WA	21.3152
Brownsville-Harlingen-San Benito, TX	16.7030
Bryan-College Station, TX	17.0898
Buffalo-Niagara Falls, NY	17.7977
Burlington, VT	17.8037
Caguas, PR	9.0488
Canton-Massillon, OH	16.9098
Casper, WY	17.2484
Cedar Rapids, IA	16.5386
Champaign-Urbana, IL	18.3634
Charleston-North Charleston, SC	17.5265
Charleston, WV	18.6261
Charlotte-Gastonia-Rock Hill, NC–SC	18.7900
Charlottesville, VA	17.9005
Chattanooga, TN–GA	17.2991
Cheyenne, WY	15.0126
Chicago, IL	20.9843
Chico-Paradise, CA	20.3689
Cincinnati, OH–KY–IN	18.4886
Clarksville-Hopkinsville, TN–KY	15.0873
Cleveland-Lorain-Elyria, OH	19.3306
Colorado Springs, CO	18.4479
Columbia, MO	17.4002
Columbia, SC	17.9066
Columbus, GA–AL	14.9336
Columbus, OH	18.9232
Corpus Christi, TX	16.8587
Cumberland, MD–WV	16.8031
Dallas, TX	18.5928
Danville, VA	16.6152
Davenport-Moline-Rock Island, IA–IL	16.4021
Dayton-Springfield, OH	18.6930
Daytona Beach, FL	17.3459
Decatur, AL	16.3934
Decatur, IL	15.3452
Denver, CO	20.0780
Des Moines, IA	17.1139
Detroit, MI	20.9694
Dothan, AL	15.1351
Dover, DE	17.5916
Dubuque, IA	15.8987
Duluth-Superior, MN–WI	18.4105
Dutchess County, NY	20.6881
Eau Claire, WI	16.9692
El Paso, TX	18.5059
Elkhart-Goshen, IN	17.2083
Elmira, NY	16.4576
Enid, OK	15.3724
Erie, PA	17.8263
Eugene-Springfield, OR	22.0384
Evansville, Henderson, IN–KY	17.5397
Fargo-Moorhead, ND–MN	17.5775
Fayetteville, NC	17.6077
Fayetteville-Springdale-Rogers, AR	14.1177
Flagstaff, AZ–UT	17.6344
Flint, MI	21.9933
Florence, AL	15.5886

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Florence, SC	16.8047
Fort Collins-Loveland, CO	20.7345
Fort Lauderdale, FL	20.5796
Fort Myers-Cape Coral, FL	17.7400
Fort Pierce-Port St. Lucie, FL	19.8836
Fort Smith, AR–OK	15.3772
Fort Walton Beach, FL	17.9217
Fort Wayne, IN	17.2046
Fort Worth-Arlington, TX	19.6953
Fresno, CA	21.8549
Gadsden, AL	17.3656
Gainesville, FL	18.4465
Galveston-Texas City, TX	21.5032
Gary, IN	18.8135
Glens Falls, NY	16.6999
Goldsboro, NC	16.4109
Grand Forks, ND–MN	17.6200
Grand Junction, CO	16.2899
Grand Rapids-Muskegon-Holland, MI	19.6810
Great Falls, MT	16.9748
Greeley, CO	18.9481
Green Bay, WI	17.6730
Greensboro-Winston-Salem-High Point, NC	18.1974
Greenville, NC	17.7503
Greenville-Spartanburg-Anderson, SC	17.4547
Hagerstown, MD	17.9394
Hamilton-Middletown, OH	18.5631
Harrisburg-Lebanon-Carlisle, PA	19.8630
Hartford, CT	24.1823
Hattiesburg, MS	14.1809
Hickory-Morganton-Lenoir, NC	16.8672
Honolulu, HI	22.4099
Houma, LA	15.3009
Houston, TX	19.1004
Huntington-Ashland, WV–KY–OH	17.9378
Huntsville, AL	15.8903
Indianapolis, IN	19.4109
Iowa City, IA	18.3037
Jackson, MI	17.6864
Jackson, MS	15.3259
Jackson, TN	16.2704
Jacksonville, FL	17.5917
Jacksonville, NC	13.7955
Jamestown, NY	14.9815
Janesville-Beloit, WI	16.9030
Jersey City, NJ	22.2562
Johnson City-Kingsport-Bristol, TN–VA	17.3717
Johnstown, PA	16.4213
Joplin, MO	14.3989
Kalamazoo-Battlecreek, MI	20.6127
Kankakee, IL	17.5542
Kansas City, KS–MO	18.5772
Kenosha, WI	17.8819
Killeen-Temple, TX	20.3189
Knoxville, TN	16.6222
Kokomo, IN	16.7962
La Crosse, WI–MN	16.8513
Lafayette, LA	15.9607
Lafayette, IN	17.1635
Lake Charles, LA	15.7084
Lakeland-Winter Haven, FL	17.1559
Lancaster, PA	18.7384
Lansing-East Lansing, MI	19.5408
Laredo, TX	13.8360
Las Cruces, NM	16.6145

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Las Vegas, NV–AZ	21.2545
Lawrence, KS	16.8098
Lawton, OK	16.2681
Lewiston-Auburn, ME	18.3998
Lexington, KY	16.3501
Lima, OH	17.0746
Lincoln, NE	17.9352
Little Rock-North Little Rock, AR	16.8095
Longview-Marshall, TX	16.8433
Los Angeles-Long Beach, CA	24.1067
Louisville, KY–IN	18.4271
Lubbock, TX	16.6316
Lynchburg, VA	15.6776
Macon, GA	17.2388
Madison, WI	19.6027
Mansfield, OH	16.6677
Mayaguez, PR	8.1673
McAllen-Edinburg-Mission, TX	16.5870
Medford-Ashland, OR	19.6857
Melbourne-Titusville-Palm Bay, FL	17.7314
Memphis, TN–AR–MS	15.9681
Merced, CA	20.8439
Miami, FL	19.3734
Middlesex-Somerset-Hunterdon, NJ	21.0732
Milwaukee-Waukesha, WI	18.8591
Minneapolis-St. Paul, MN–WI	21.0411
Mobile, AL	15.6052
Modesto, CA	20.7262
Monmouth-Ocean, NJ	21.1523
Monroe, LA	16.0633
Montgomery, AL	15.5087
Muncie, IN	18.9936
Myrtle Beach, SC	15.2138
Naples, FL	19.9423
Nashville, TN	17.6844
Nassau-Suffolk, NY	26.4295
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	24.8405
New London-Norwich, CT	23.9754
New Orleans, LA	18.4047
New York, NY	27.3928
Newark, NJ	22.9650
Newburgh, NY–PA	21.1274
Norfolk-Virginia Beach-Newport News, VA–NC	16.2433
Oakland, CA	29.3295
Ocala, FL	17.5573
Odessa-Midland, TX	16.5854
Oklahoma City, OK	16.5112
Olympia, WA	20.9003
Omaha, NE–IA	18.3867
Orange County, CA	23.3969
Orlando, FL	18.5157
Owensboro, KY	14.7838
Panama City, FL	15.7629
Parkersburg-Marietta, WV–OH	15.4018
Pensacola, FL	16.0203
Peoria-Pekin, IL	17.4092
Philadelphia, PA–NJ	21.8450
Phoenix-Mesa, AZ	19.1821
Pine Bluff, AR	15.4205
Pittsburgh, PA	18.9757
Pittsfield, MA	20.6216
Ponce, PR	8.7784
Portland, ME	18.7580
Portland-Vancouver, OR–WA	21.9821
Providence-Warwick, RI	21.6876
Provo-Orem, UT	19.7809

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Pueblo, CO	16.1970
Punta Gorda, FL	16.1612
Racine, WI	17.2751
Raleigh-Durham-Chapel Hill, NC	19.0031
Rapid City, SD	16.5325
Reading, PA	18.4690
Redding, CA	22.6922
Reno, NV	21.5443
Richland-Kennewick-Pasco, WA	19.4956
Richmond-Petersburg, VA	17.9271
Riverside-San Bernardino, CA	22.2324
Roanoke, VA	17.0151
Rochester, MN	20.3908
Rochester, NY	18.7505
Rockford, IL	17.5872
Rocky Mount, NC	17.4626
Sacramento, CA	24.1558
Saginaw-Bay City-Midland, MI	18.5818
St. Cloud, MN	18.4907
St. Joseph, MO	16.7196
St. Louis, MO–IL	17.4144
Salem, OR	19.0205
Salinas, CA	26.9904
Salt Lake City-Ogden, UT	18.8799
San Angelo, TX	14.8158
San Antonio, TX	16.3206
San Diego, CA	23.7299
San Francisco, CA	27.8220
San Jose, CA	28.2911
San Juan-Bayamon, PR	9.0059
San Luis Obispo-Atascadero-Paso Robles, CA	22.6053
Santa Barbara-Santa Maria-Lompoc, CA	21.9816
Santa Cruz-Watsonville, CA	26.4364
Santa Fe, NM	21.1622
Santa Rosa, CA	24.4999
Sarasota-Bradenton, FL	19.0607
Savannah, GA	19.6834
Scranton-Wilkes Barre-Hazleton, PA	17.1047
Seattle-Bellevue-Everett, WA	22.2595
Sharon, PA	17.0979
Sheboygan, WI	15.1817
Sherman-Denison, TX	16.8423
Shreveport-Bossier City, LA	18.2987
Sioux City, IA–NE	16.2539
Sioux Falls, SD	16.7892
South Bend, IN	19.4248
Spokane, WA	20.5788
Springfield, IL	17.1355
Springfield, MO	15.2957
Springfield, MA	20.6983
State College, PA	17.3139
Steubenville-Weirton, OH–WV	16.0839
Stockton-Lodi, CA	22.1532
Sumter, SC	15.0540
Syracuse, NY	18.3462
Tacoma, WA	21.2353
Tallahassee, FL	16.2555
Tampa-St. Petersburg-Clearwater, FL	18.0837
Terre Haute, IN	16.7989
Texarkana, AR-Texarkana, TX	16.5261
Toledo, OH	20.2562
Topeka, KS	19.7210
Trenton, NJ	20.6250
Tucson, AZ	17.6383
Tulsa, OK	15.8281

TABLE 4D.—AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

Urban area	Average hourly wage
Tuscaloosa, AL	15.0679
Tyler, TX	19.8177
Utica-Rome, NY	16.4296
Vallejo-Fairfield-Napa, CA	27.2883
Ventura, CA	22.5369
Victoria, TX	16.5405
Vineland-Millville-Bridgeton, NJ	19.5394
Visalia-Tulare-Porterville, CA	19.8483
Waco, TX	15.1959
Washington, DC–MD–VA–WV	21.1518
Waterloo-Cedar Falls, IA	17.0208
Wausau, WI	20.1856
West Palm Beach-Boca Raton, FL	19.9482
Wheeling, OH–WV	14.7877
Wichita, KS	18.4305
Wichita Falls, TX	15.7442
Williamsport, PA	16.5567
Wilmington-Newark, DE–MD	22.1249
Wilmington, NC	17.6987
Yakima, WA	19.6049
Yolo, CA	22.3769
York, PA	17.8006
Youngstown-Warren, OH	19.0484
Yuba City, CA	20.3622
Yuma, AZ	18.5693

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS

Nonurban area	Average hourly wage
Alabama	13.9126
Alaska	24.3314
Arizona	15.5017
Arkansas	13.6566
California	19.4927
Colorado	15.9126
Connecticut	24.9480
Delaware	18.4636
Florida	16.9290
Georgia	14.9414
Hawaii	20.0330
Idaho	16.3016
Illinois	14.7630
Indiana	15.8402
Iowa	14.4246
Kansas	13.8771
Kentucky	15.1633
Louisiana	14.1714
Maine	16.2618
Maryland	16.4778
Massachusetts	21.0582
Michigan	17.2254
Minnesota	15.9225
Mississippi	13.2817
Missouri	14.1433
Montana	15.8750
Nebraska	14.1342
Nevada	17.1588
New Hampshire	19.0608
New Jersey [1]	.....
New Mexico	15.3596
New York	16.7103
North Carolina	15.4962
North Dakota	14.3775
Ohio	16.2883

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
Oklahoma	13.5853
Oregon	18.9527
Pennsylvania	16.5230
Puerto Rico	8.1591
Rhode Island [1]	
South Carolina	14.9812

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
South Dakota	13.8219
Tennessee	14.3822
Texas	14.4957
Utah	17.2737
Vermont	17.4440
Virginia	15.1073

TABLE 4E.—AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

Nonurban area	Average hourly wage
Washington	19.4229
West Virginia	15.4577
Wisconsin	16.4842
Wyoming	16.0015

[1] All counties within the State are classified as urban.

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
1	01	SURG	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	3.0445	7.7	11.1	32
2	01	SURG	CRANIOTOMY FOR TRAUMA AGE >17	3.0241	8.4	11.5	32
3	01	SURG	*CRANIOTOMY AGE 0–17	1.9159	12.7	12.7	37
4	01	SURG	SPINAL PROCEDURES	2.3330	5.9	9.1	30
5	01	SURG	EXTRACRANIAL VASCULAR PROCEDURES	1.5149	3.3	4.4	26
6	01	SURG	CARPAL TUNNEL RELEASE	.7359	2.4	3.4	25
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC.	2.4935	8.2	12.6	32
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC.	1.1419	2.8	4.1	27
9	01	MED	SPINAL DISORDERS & INJURIES	1.2522	5.4	7.7	29
10	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2209	5.7	8.1	30
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	.8020	3.5	5.0	28
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	.9435	5.4	7.6	29
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.7799	5.0	6.3	29
14	01	MED	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA.	1.2003	5.5	7.5	30
15	01	MED	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL OCCLUSIONS.	.7232	3.5	4.4	27
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.0390	4.9	6.6	29
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC.	.6308	3.0	4.0	26
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	.9345	4.8	6.4	29
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.6258	3.4	4.5	27
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS.	2.4782	8.5	11.5	33
21	01	MED	VIRAL MENINGITIS	1.4972	5.8	7.9	30
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	.8356	3.8	4.9	28
23	01	MED	NONTRAUMATIC STUPOR & COMA	.8053	3.6	5.1	28
24	01	MED	SEIZURE & HEADACHE AGE >17 W CC	.9707	4.2	5.8	28
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	.5791	3.0	3.9	24
26	01	MED	SEIZURE & HEADACHE AGE 0–17	.7381	3.3	4.6	27
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3186	3.7	6.3	28
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC.	1.2075	4.8	7.2	29
29	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC.	.6382	3.0	4.1	27
30	01	MED	*TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	.3240	2.0	2.0	17
31	01	MED	CONCUSSION AGE >17 W CC	.8367	3.7	5.4	28
32	01	MED	CONCUSSION AGE >17 W/O CC	.4887	2.3	3.2	21
33	01	MED	*CONCUSSION AGE 0–17	.2036	1.6	1.6	9
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0639	4.6	6.5	29
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.6112	3.2	4.3	27
36	02	SURG	RETINAL PROCEDURES	.6156	1.3	1.6	6
37	02	SURG	ORBITAL PROCEDURES	.9280	2.7	4.0	27
38	02	SURG	PRIMARY IRIS PROCEDURES	.4217	1.8	2.5	16
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.5162	1.5	2.0	10
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17.	.7094	2.2	3.4	26
41	02	SURG	*EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17.	.3298	1.6	1.6	7
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS.	.5821	1.6	2.2	13
43	02	MED	HYPHEMA	.4448	3.2	4.1	27

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.6234	4.7	5.7	29
45	02	MED	NEUROLOGICAL EYE DISORDERS	.6514	3.1	3.8	22
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	.7595	4.0	5.5	28
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.4703	2.8	3.8	27
48	02	MED	*OTHER DISORDERS OF THE EYE AGE 0–17	.2906	2.9	2.9	27
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.7253	4.1	5.6	28
50	03	SURG	SIALOADENECTOMY	.7677	1.7	2.1	9
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY.	.7358	1.9	3.0	21
52	03	SURG	CLEFT LIP & PALATE REPAIR	1.0971	2.1	3.6	26
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.0116	2.2	3.6	26
54	03	SURG	*SINUS & MASTOID PROCEDURES AGE 0–17	.4711	3.2	3.2	22
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES.	.7844	1.9	3.0	22
56	03	SURG	RHINOPLASTY	.8247	2.1	2.8	18
57	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	.9413	2.7	4.1	27
58	03	SURG	*T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	.2674	1.5	1.5	4
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	.7521	2.3	3.7	26
60	03	SURG	*TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	.2037	1.5	1.5	4
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.2155	2.7	5.3	27
62	03	SURG	*MYRINGOTOMY W TUBE INSERTION AGE 0–17	.2884	1.3	1.3	5
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES.	1.2217	3.2	4.7	27
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1699	4.7	7.5	29
65	03	MED	DYSEQUILIBRIUM	.5192	2.7	3.4	20
66	03	MED	EPISTAXIS	.5358	2.9	3.6	21
67	03	MED	EPIGLOTTITIS	.8452	3.4	4.2	24
68	03	MED	OTITIS MEDIA & URI AGE >17 W CC	.7075	3.8	4.8	27
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	.5244	3.1	3.8	20
70	03	MED	OTITIS MEDIA & URI AGE 0–17	.3839	2.6	3.1	15
71	03	MED	LARYNGOTRACHEITIS	.7959	3.1	4.2	27
72	03	MED	NASAL TRAUMA & DEFORMITY	.6466	3.1	4.4	27
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17.	.7483	3.7	5.0	28
74	03	MED	*OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17.	.3276	2.1	2.1	20
75	04	SURG	MAJOR CHEST PROCEDURES	3.1904	8.8	11.1	33
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.6018	9.1	12.5	33
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.1577	3.8	5.5	28
78	04	MED	PULMONARY EMBOLISM	1.4291	7.0	8.3	31
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC.	1.6310	7.2	9.3	31
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC.	.9481	5.4	6.6	29
81	04	MED	*RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17.	.9716	6.1	6.1	30
82	04	MED	RESPIRATORY NEOPLASMS	1.3347	5.7	7.9	30
83	04	MED	MAJOR CHEST TRAUMA W CC	.9738	4.9	6.4	29
84	04	MED	MAJOR CHEST TRAUMA W/O CC	.5335	2.9	3.7	24
85	04	MED	PLEURAL EFFUSION W CC	1.2229	5.6	7.4	30
86	04	MED	PLEURAL EFFUSION W/O CC	.7175	3.4	4.5	27
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3587	5.1	6.8	29
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	.9831	4.9	6.1	29
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.1158	5.8	7.1	30
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.6995	4.3	5.1	24
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	.7883	3.7	4.7	28
92	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.2053	5.6	7.3	30
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	.7551	4.0	5.0	28
94	04	MED	PNEUMOTHORAX W CC	1.1764	5.3	7.1	29
95	04	MED	PNEUMOTHORAX W/O CC	.6035	3.3	4.1	25
96	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	.8254	4.5	5.5	29
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	.6013	3.6	4.3	22
98	04	MED	BRONCHITIS & ASTHMA AGE 0–17	.8036	3.1	4.5	27
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	.6868	2.7	3.5	22
100 ...	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5126	2.0	2.4	12
101 ...	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	.8735	3.8	5.2	28

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
102 ...	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC ...	.5330	2.4	3.1	20
103 ...	05	SURG	HEART TRANSPLANT	15.2952	28.1	39.4	52
104 ...	05	SURG	CARDIAC VALVE PROCEDURES W CARDIAC CATH	7.3389	12.0	14.6	36
105 ...	05	SURG	CARDIAC VALVE PROCEDURES W/O CARDIAC CATH ...	5.6012	9.0	10.9	33
106 ...	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.5599	10.3	11.7	34
107 ...	05	SURG	CORONARY BYPASS W/O CARDIAC CATH	4.0741	7.8	8.8	32
108 ...	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.9226	9.8	12.6	34
109 ...	.....		NO LONGER VALID	.0000	.0	.0	0
110 ...	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.1674	8.2	10.9	32
111 ...	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.2863	5.9	6.7	30
112 ...	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES	2.0962	3.5	4.7	27
113 ...	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	2.6919	10.6	14.4	35
114 ...	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS.	1.5122	6.8	9.5	31
115 ...	05	SURG	PERM CARDIAC PACEMAKER IMPLANT W AMI, HEART FAILURE OR SHOCK.	3.6844	9.1	11.4	33
116 ...	05	SURG	OTH PERM CARDIAC PACEMAKER IMPLANT OR AICD LEAD OR GENERATOR PROC.	2.4158	3.9	5.4	28
117 ...	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.	1.1774	2.7	4.1	27
118 ...	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.5782	2.1	3.2	25
119 ...	05	SURG	VEIN LIGATION & STRIPPING	1.1378	3.3	5.5	27
120 ...	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.9321	5.4	9.2	29
121 ...	05	MED	CIRCULATORY DISORDERS W AMI & C.V. COMP DISCH ALIVE.	1.6473	6.4	7.8	30
122 ...	05	MED	CIRCULATORY DISORDERS W AMI W/O C.V. COMP DISCH ALIVE.	1.1617	4.4	5.3	28
123 ...	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.4519	2.7	4.7	27
124 ...	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.3264	3.8	5.0	28
125 ...	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	.9259	2.3	3.1	20
126 ...	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.5380	11.0	14.3	35
127 ...	05	MED	HEART FAILURE & SHOCK	1.0268	4.8	6.2	29
128 ...	05	MED	DEEP VEIN THROMBOPHLEBITIS	.7861	5.9	6.7	27
129 ...	05	MED	CARDIAC ARREST, UNEXPLAINED	1.1239	2.0	3.4	26
130 ...	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	.9357	5.3	6.7	29
131 ...	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.6045	4.3	5.2	28
132 ...	05	MED	ATHEROSCLEROSIS W CC	.6834	2.9	3.6	20
133 ...	05	MED	ATHEROSCLEROSIS W/O CC	.5543	2.3	2.9	16
134 ...	05	MED	HYPERTENSION	.5799	3.0	3.9	23
135 ...	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC.	.8797	3.7	5.0	28
136 ...	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.	.5597	2.6	3.2	18
137 ...	05	MED	*CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17.	.7996	3.3	3.3	27
138 ...	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC.	.8009	3.5	4.6	27
139 ...	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC.	.4975	2.4	2.9	16
140 ...	05	MED	ANGINA PECTORIS	.6210	2.8	3.5	20
141 ...	05	MED	SYNCOPE & COLLAPSE W CC	.7129	3.4	4.5	27
142 ...	05	MED	SYNCOPE & COLLAPSE W/O CC	.5289	2.5	3.2	18
143 ...	05	MED	CHEST PAIN	.5233	2.1	2.6	14
144 ...	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.0850	4.1	5.7	28
145 ...	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC ...	.6217	2.5	3.3	20
146 ...	06	SURG	RECTAL RESECTION W CC	2.6401	9.8	11.3	34
147 ...	06	SURG	RECTAL RESECTION W/O CC	1.6115	6.7	7.4	27
148 ...	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.3693	11.2	13.4	35
149 ...	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC.	1.6038	7.1	7.7	25
150 ...	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.6786	9.5	11.7	34
151 ...	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.2959	5.2	6.5	29
152 ...	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9381	7.6	9.0	32
153 ...	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC.	1.1550	5.6	6.2	24
154 ...	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	4.1880	11.6	15.0	36

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
155 ...	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.4070	4.6	5.9	29
156 ...	06	SURG	*STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17.	.8235	6.0	6.0	30
157 ...	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.1331	4.2	5.8	28
158 ...	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.6106	2.3	2.9	18
159 ...	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.2263	4.0	5.3	28
160 ...	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	.7032	2.4	3.0	16
161 ...	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC.	1.0089	3.0	4.4	27
162 ...	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC.	.5710	1.7	2.2	11
163 ...	06	SURG	*HERNIA PROCEDURES AGE 0–17	.7703	2.1	2.1	11
164 ...	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC.	2.3299	8.0	9.3	32
165 ...	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC.	1.2576	5.1	5.8	25
166 ...	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC.	1.4512	4.5	5.7	29
167 ...	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC.	.8496	2.8	3.2	15
168 ...	03	SURG	MOUTH PROCEDURES W CC	1.0951	3.2	4.9	27
169 ...	03	SURG	MOUTH PROCEDURES W/O CC	.6828	2.0	2.6	15
170 ...	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.7448	8.5	12.5	33
171 ...	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC.	1.1297	4.0	5.4	28
172 ...	06	MED	DIGESTIVE MALIGNANCY W CC	1.2934	5.7	8.2	30
173 ...	06	MED	DIGESTIVE MALIGNANCY W/O CC	.6736	3.0	4.3	27
174 ...	06	MED	G.I. HEMORRHAGE W CC	.9962	4.4	5.6	28
175 ...	06	MED	G.I. HEMORRHAGE W/O CC	.5492	2.9	3.5	17
176 ...	06	MED	COMPLICATED PEPTIC ULCER	1.0874	4.7	6.2	29
177 ...	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	.8353	4.0	5.0	28
178 ...	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.6122	3.0	3.6	19
179 ...	06	MED	INFLAMMATORY BOWEL DISEASE	1.1219	5.5	7.2	30
180 ...	06	MED	G.I. OBSTRUCTION W CC	.9202	4.7	6.1	29
181 ...	06	MED	G.I. OBSTRUCTION W/O CC	.5346	3.3	4.0	22
182 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC.	.7791	3.8	5.0	28
183 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	.5570	2.8	3.5	20
184 ...	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17.	.5366	2.7	3.8	26
185 ...	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	.8467	3.7	5.2	28
186 ...	03	MED	*DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17.	.3139	2.9	2.9	23
187 ...	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	.7211	3.1	4.3	27
188 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC.	1.0593	4.5	6.1	28
189 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC.	.5629	2.7	3.7	27
190 ...	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	.8364	3.9	4.9	28
191 ...	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.4227	12.0	16.2	36
192 ...	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.8016	6.2	8.0	30
193 ...	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.2582	11.4	13.9	35
194 ...	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.7596	6.8	8.4	31
195 ...	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.6806	8.8	10.5	33
196 ...	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6252	5.9	6.8	30
197 ...	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	2.2636	7.5	9.1	31
198 ...	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.1769	4.3	5.0	23
199 ...	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY.	2.3744	8.3	11.1	32
200 ...	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NONMALIGNANCY.	2.9783	7.6	11.9	32

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
201 ...	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES.	3.6216	12.1	16.6	36
202 ...	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3286	5.7	7.7	30
203 ...	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS.	1.2511	5.5	7.7	30
204 ...	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.2003	5.1	6.7	29
205 ...	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC.	1.2099	5.3	7.3	29
206 ...	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC.	.7211	3.6	4.8	28
207 ...	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0500	4.4	5.8	28
208 ...	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	.6053	2.6	3.5	21
209 ...	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.	2.2617	5.9	6.7	23
210 ...	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	1.8458	7.2	8.5	31
211 ...	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.2747	5.6	6.3	23
212 ...	08	SURG	*HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17.	1.1483	11.1	11.1	35
213 ...	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.7045	7.0	9.6	31
214 ...	08	SURG	BACK & NECK PROCEDURES W CC	1.9259	4.9	6.5	29
215 ...	08	SURG	BACK & NECK PROCEDURES W/O CC	1.1135	3.0	3.7	20
216 ...	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	2.0775	7.9	11.1	32
217 ...	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS.	2.8715	10.2	15.3	34
218 ...	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.	1.4562	4.8	6.2	29
219 ...	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC.	.9560	3.1	3.8	19
220 ...	08	SURG	*LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17.	.5704	5.3	5.3	29
221 ...	08	SURG	KNEE PROCEDURES W CC	1.8379	5.8	8.2	30
222 ...	08	SURG	KNEE PROCEDURES W/O CC	1.0223	3.1	4.1	27
223 ...	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	.8726	2.2	2.9	16
224 ...	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC.	.7418	1.9	2.3	10
225 ...	08	SURG	FOOT PROCEDURES	1.0019	3.3	5.0	27
226 ...	08	SURG	SOFT TISSUE PROCEDURES W CC	1.3708	4.4	6.7	28
227 ...	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.7458	2.3	3.0	18
228 ...	08	SURG	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC.	.9381	2.3	3.6	26
229 ...	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC.	.6495	1.8	2.4	14
230 ...	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.0592	3.3	5.2	27
231 ...	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES EXCEPT HIP & FEMUR.	1.2285	3.3	5.1	27
232 ...	08	SURG	ARTHROSCOPY	1.0901	2.6	4.5	27
233 ...	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC.	1.9951	6.4	9.0	30
234 ...	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC.	1.0684	3.1	4.2	27
235 ...	08	MED	FRACTURES OF FEMUR	.8353	4.6	6.9	29
236 ...	08	MED	FRACTURES OF HIP & PELVIS	.7613	4.7	6.4	29
237 ...	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH.	.5622	3.3	4.4	27
238 ...	08	MED	OSTEOMYELITIS	1.3857	7.6	10.1	32
239 ...	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	1.0096	5.8	7.6	30
240 ...	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.2107	5.5	7.5	30
241 ...	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.6063	3.5	4.6	28
242 ...	08	MED	SEPTIC ARTHRITIS	1.0535	5.8	7.7	30
243 ...	08	MED	MEDICAL BACK PROBLEMS	.7241	4.3	5.6	28
244 ...	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	.7221	4.3	5.8	28
245 ...	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC.	.4965	3.2	4.2	27

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
246 ...	08	MED	NON-SPECIFIC ARTHROPATHIES	.5901	3.6	4.6	28
247 ...	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	.5539	2.9	4.0	27
248 ...	08	MED	TENDONITIS, MYOSITIS & BURSITIS	.7363	3.9	5.3	28
249 ...	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	.6514	2.9	4.3	27
250 ...	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	.6808	3.5	4.9	28
251 ...	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	.4625	2.5	3.3	22
252 ...	08	MED	*FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17.	.2478	1.8	1.8	15
253 ...	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W CC.	.7438	4.3	5.8	28
254 ...	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC.	.4433	2.9	3.9	25
255 ...	08	MED	*FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17.	.2885	2.9	2.9	27
256 ...	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	.7724	4.0	5.7	28
257 ...	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	.9021	2.8	3.4	17
258 ...	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.7099	2.2	2.5	10
259 ...	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	.8673	2.3	3.5	26
260 ...	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.6083	1.6	1.9	8
261 ...	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	.8342	1.9	2.4	12
262 ...	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY.	.7694	2.7	3.9	27
263 ...	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC.	2.1157	9.8	13.9	34
264 ...	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.1308	6.0	8.4	30
265 ...	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.4949	4.8	7.7	29
266 ...	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	.7650	2.6	3.7	27
267 ...	09	SURG	PERIANAL & PILONIDAL PROCEDURES	.8086	2.7	4.1	27
268 ...	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES.	.9935	2.5	4.0	27
269 ...	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.6361	6.2	9.1	30
270 ...	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	.7016	2.4	3.4	26
271 ...	09	MED	SKIN ULCERS	1.0791	6.6	8.5	31
272 ...	09	MED	MAJOR SKIN DISORDERS W CC	1.0212	5.6	7.5	30
273 ...	09	MED	MAJOR SKIN DISORDERS W/O CC	.6358	4.1	5.5	28
274 ...	09	MED	MALIGNANT BREAST DISORDERS W CC	1.0713	5.3	7.8	29
275 ...	09	MED	MALIGNANT BREAST DISORDERS W/O CC	.4984	2.5	3.6	27
276 ...	09	MED	NON-MALIGANT BREAST DISORDERS	.6443	3.9	5.1	28
277 ...	09	MED	CELLULITIS AGE >17 W CC	.8532	5.5	6.7	29
278 ...	09	MED	CELLULITIS AGE >17 W/O CC	.5775	4.3	5.1	25
279 ...	09	MED	*CELLULITIS AGE 0–17	.7187	4.2	4.2	24
280 ...	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC.	.6765	3.7	5.1	28
281 ...	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC.	.4566	2.7	3.7	24
282 ...	09	MED	*TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17.	.2508	2.2	2.2	19
283 ...	09	MED	MINOR SKIN DISORDERS W CC	.7034	4.1	5.5	28
284 ...	09	MED	MINOR SKIN DISORDERS W/O CC	.4375	2.9	3.9	27
285 ...	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS.	2.1948	9.5	13.5	34
286 ...	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.3858	6.6	8.7	31
287 ...	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.9722	9.4	13.4	33
288 ...	10	SURG	O.R. PROCEDURES FOR OBESITY	2.0537	5.3	7.0	29
289 ...	10	SURG	PARATHYROID PROCEDURES	1.0231	2.7	3.9	27
290 ...	10	SURG	THYROID PROCEDURES	.8827	2.1	2.8	15
291 ...	10	SURG	THYROGLOSSAL PROCEDURES	.5221	1.4	1.8	8
292 ...	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC.	2.6435	8.4	12.7	32

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
293 ...	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC.	1.2415	4.4	6.4	28
294 ...	10	MED	DIABETES AGE >35	.7604	4.3	5.7	28
295 ...	10	MED	DIABETES AGE 0–35	.7171	3.3	4.3	27
296 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC.	.8939	4.7	6.4	29
297 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC.	.5374	3.3	4.3	26
298 ...	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17.	.5036	2.3	3.0	19
299 ...	10	MED	INBORN ERRORS OF METABOLISM	.8211	3.8	5.4	28
300 ...	10	MED	ENDOCRINE DISORDERS W CC	1.1005	5.5	7.3	30
301 ...	10	MED	ENDOCRINE DISORDERS W/O CC	.6193	3.4	4.4	27
302 ...	11	SURG	KIDNEY TRANSPLANT	3.9210	10.4	12.3	34
303 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.6364	8.4	10.2	32
304 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.3744	7.5	10.3	31
305 ...	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1797	3.9	4.9	28
306 ...	11	SURG	PROSTATECTOMY W CC	1.2243	4.3	6.2	28
307 ...	11	SURG	PROSTATECTOMY W/O CC	.6709	2.4	3.0	15
308 ...	11	SURG	MINOR BLADDER PROCEDURES W CC	1.5260	4.6	7.0	29
309 ...	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.8858	2.3	3.0	18
310 ...	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.0013	3.1	4.6	27
311 ...	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.5663	1.8	2.2	11
312 ...	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	.9118	3.1	4.8	27
313 ...	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.5211	1.7	2.3	13
314 ...	11	SURG	*URETHRAL PROCEDURES, AGE 0–17	.4835	2.3	2.3	26
315 ...	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0606	5.3	9.3	29
316 ...	11	MED	RENAL FAILURE	1.3066	5.4	7.6	29
317 ...	11	MED	ADMIT FOR RENAL DIALYSIS	.4837	2.0	2.8	19
318 ...	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1233	5.0	7.2	29
319 ...	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.5801	2.3	3.2	24
320 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC.	.9052	5.1	6.4	29
321 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC.	.6094	3.9	4.7	24
322 ...	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	.5265	3.6	4.4	24
323 ...	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	.7490	2.7	3.6	24
324 ...	11	MED	URINARY STONES W/O CC	.4161	1.7	2.1	10
325 ...	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC.	.6397	3.4	4.6	27
326 ...	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC.	.4346	2.4	3.5	19
327 ...	11	MED	*KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17.	.2340	3.1	3.1	27
328 ...	11	MED	URETHRAL STRICTURE AGE >17 W CC	.6929	3.1	4.3	27
329 ...	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.4536	2.1	2.8	16
330 ...	11	MED	*URETHRAL STRICTURE AGE 0–17	.3114	1.6	1.6	9
331 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC.	.9926	4.6	6.2	29
332 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC.	.6170	2.8	3.9	27
333 ...	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17.	.8641	4.3	5.9	28
334 ...	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.6656	5.3	6.0	23
335 ...	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.2596	4.1	4.6	17
336 ...	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	.8859	3.2	4.1	24
337 ...	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.6149	2.3	2.7	11
338 ...	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.0534	3.5	5.3	27
339 ...	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.0213	3.1	4.9	27
340 ...	12	SURG	*TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	.2768	2.4	2.4	13
341 ...	12	SURG	PENIS PROCEDURES	1.0701	2.3	3.2	21
342 ...	12	SURG	CIRCUMCISION AGE >17	.7579	2.6	4.0	27
343 ...	12	SURG	*CIRCUMCISION AGE 0–17	.1503	1.7	1.7	6
344 ...	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	1.0086	2.3	3.5	25
345 ...	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	.8396	2.7	4.0	27

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
346 ...	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	.9564	4.8	6.8	29
347 ...	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC.	.5161	2.4	3.4	26
348 ...	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	.7102	3.5	4.9	28
349 ...	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.4048	2.2	3.0	21
350 ...	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM.	.6631	3.9	4.8	24
351 ...	12	MED	*STERILIZATION, MALE	.2309	1.3	1.3	5
352 ...	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.5889	2.8	4.0	27
353 ...	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.9266	6.7	8.4	31
354 ...	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ ADNEXAL MALIG W CC.	1.4646	5.2	6.3	28
355 ...	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ ADNEXAL MALIG W/O CC.	.9065	3.6	3.9	11
356 ...	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	.7377	2.6	3.0	12
357 ...	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.3847	8.0	9.8	32
358 ...	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC.	1.1713	4.0	4.7	19
359 ...	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/ O CC.	.8289	3.0	3.3	10
360 ...	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.8470	2.9	3.5	17
361 ...	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.1284	2.5	3.5	23
362 ...	13	SURG	*ENDOSCOPIC TUBAL INTERRUPTION	.2950	1.4	1.4	5
363 ...	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY.	.6887	2.6	3.5	20
364 ...	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	.6823	2.6	3.6	27
365 ...	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES.	1.7253	5.3	8.1	29
366 ...	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.1948	5.3	7.7	29
367 ...	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC.	.5173	2.3	3.3	24
368 ...	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.0303	5.3	6.9	29
369 ...	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	.5504	2.6	3.8	27
370 ...	14	SURG	CESAREAN SECTION W CC	1.0444	4.3	5.6	26
371 ...	14	SURG	CESAREAN SECTION W/O CC	.6865	3.2	3.6	11
372 ...	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.5471	2.4	3.3	19
373 ...	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3584	1.6	1.9	7
374 ...	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.6083	2.0	2.4	9
375 ...	14	SURG	*VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/ OR D&C.	.6696	4.4	4.4	28
376 ...	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	.5972	2.4	3.5	26
377 ...	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	.8078	2.0	3.2	26
378 ...	14	MED	ECTOPIC PREGNANCY	.8157	2.5	3.0	15
379 ...	14	MED	THREATENED ABORTION	.3573	2.0	2.9	20
380 ...	14	MED	ABORTION W/O D&C	.4988	1.8	2.3	13
381 ...	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY.	.5212	1.6	2.3	14
382 ...	14	MED	FALSE LABOR	.2100	1.3	1.7	7
383 ...	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS.	.4672	2.8	4.1	27
384 ...	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	.4140	1.9	3.3	24
385 ...	15		*NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.3437	1.8	1.8	26
386 ...	15		*EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	4.4311	17.9	17.9	42
387 ...	15		*PREMATURITY W MAJOR PROBLEMS	3.0264	13.3	13.3	37
388 ...	15		*PREMATURITY W/O MAJOR PROBLEMS	1.8261	8.6	8.6	33
389 ...	15		FULL TERM NEONATE W MAJOR PROBLEMS	2.2247	8.0	10.7	32
390 ...	15		NEONATE W OTHER SIGNIFICANT PROBLEMS	1.4188	3.8	5.0	28
391 ...	15		*NORMAL NEWBORN	.1489	3.1	3.1	11
392 ...	16	SURG	SPLENECTOMY AGE >17	3.2602	8.9	11.7	33
393 ...	16	SURG	*SPLENECTOMY AGE 0–17	1.3163	9.1	9.1	33

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
394 ...	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.5902	4.5	7.9	28
395 ...	16	MED	RED BLOOD CELL DISORDERS AGE >17	.8360	3.9	5.4	28
396 ...	16	MED	RED BLOOD CELL DISORDERS AGE 0–17	.7226	2.8	3.9	27
397 ...	16	MED	COAGULATION DISORDERS	1.2574	4.4	6.1	28
398 ...	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC.	1.2106	5.2	6.6	29
399 ...	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC.	.7061	3.5	4.4	27
400 ...	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE	2.5606	6.6	10.3	31
401 ...	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC.	2.4945	8.5	12.4	32
402 ...	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	1.0299	3.1	4.7	27
403 ...	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6925	6.5	9.3	30
404 ...	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.8070	3.7	5.1	28
405 ...	17		*ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17.	1.8661	4.9	4.9	29
406 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC.	2.6923	8.1	11.2	32
407 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC.	1.1822	3.8	4.9	28
408 ...	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC.	1.7412	5.0	8.2	29
409 ...	17	MED	RADIOTHERAPY	.9708	4.7	6.7	29
410 ...	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	.7524	2.6	3.4	20
411 ...	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.3780	2.1	2.6	14
412 ...	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.4133	2.2	3.1	24
413 ...	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC.	1.3263	5.9	8.3	30
414 ...	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC.	.7442	3.8	5.2	28
415 ...	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES.	3.4473	11.4	15.7	35
416 ...	18	MED	SEPTICEMIA AGE >17	1.4862	6.2	8.2	30
417 ...	18	MED	SEPTICEMIA AGE 0–17	.7936	3.7	4.7	28
418 ...	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	.9678	5.3	6.8	29
419 ...	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	.8993	4.4	5.7	28
420 ...	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6253	3.5	4.3	24
421 ...	18	MED	VIRAL ILLNESS AGE >17	.7157	3.6	4.6	28
422 ...	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17.	.5217	2.9	3.7	23
423 ...	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES.	1.5864	6.3	8.7	30
424 ...	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS.	2.3596	10.9	17.8	35
425 ...	19	MED	ACUTE ADJUST REACT & DISTURBANCES OF PSYCHOSOCIAL DYSFUNCTION.	.7078	3.5	4.9	27
426 ...	19	MED	DEPRESSIVE NEUROSES	.5715	4.0	5.5	28
427 ...	19	MED	NEUROSES EXCEPT DEPRESSIVE	.5544	3.7	5.3	28
428 ...	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	.7352	5.2	8.5	29
429 ...	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	.9063	5.9	8.9	30
430 ...	19	MED	PSYCHOSES	.8422	6.9	9.8	31
431 ...	19	MED	CHILDHOOD MENTAL DISORDERS	.6694	5.0	7.5	29
432 ...	19	MED	OTHER MENTAL DISORDER DIAGNOSES	.7228	3.9	6.3	28
433 ...	20		ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.3007	2.5	3.4	24
434 ...	20		ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W CC.	.7152	4.4	5.8	28
435 ...	20		ALC/DRUG ABUSE OR DEPEND, DETOX OR OTH SYMPT TREAT W/O CC.	.4178	3.8	4.8	28
436 ...	20		ALC/DRUG DEPENDENCE W REHABILITATION THERAPY.	.8199	12.1	14.8	36
437 ...	20		ALC/DRUG DEPENDENCE, COMBINED REHAB & DETOX THERAPY.	.7714	9.2	10.9	33
438 ...	.....		NO LONGER VALID	.0000	.0	.0	0
439 ...	21	SURG	SKIN GRAFTS FOR INJURIES	1.6153	5.8	8.9	30
440 ...	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.7631	6.3	9.8	30
441 ...	21	SURG	HAND PROCEDURES FOR INJURIES	.9344	2.4	4.4	26
442 ...	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.1659	5.6	8.7	30

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				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
443 ...	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.8851	2.5	3.5	26
444 ...	21	MED	TRAUMATIC INJURY AGE >17 W CC	.7310	4.0	5.3	28
445 ...	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	.4754	2.8	3.8	24
446 ...	21	MED	*TRAUMATIC INJURY AGE 0–17	.2893	2.4	2.4	22
447 ...	21	MED	ALLERGIC REACTIONS AGE >17	.4908	2.1	2.8	17
448 ...	21	MED	ALLERGIC REACTIONS AGE 0–17	.0759	1.0	1.0	1
449 ...	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC.	.7907	3.0	4.4	27
450 ...	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC.	.4276	1.8	2.3	13
451 ...	21	MED	*POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	.2569	2.1	2.1	17
452 ...	21	MED	COMPLICATIONS OF TREATMENT W CC	.9448	3.8	5.4	28
453 ...	21	MED	COMPLICATIONS OF TREATMENT W/O CC	.4853	2.4	3.2	20
454 ...	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC.	.8536	3.4	5.1	27
455 ...	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC.	.4445	2.1	2.8	18
456 ...	22		BURNS, TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.8816	4.0	8.4	28
457 ...	22	MED	EXTENSIVE BURNS W/O O.R. PROCEDURE	1.4446	2.4	4.8	26
458 ...	22	SURG	NON-EXTENSIVE BURNS W SKIN GRAFT	3.5465	12.0	17.0	36
459 ...	22	SURG	NON-EXTENSIVE BURNS W WOUND DEBRIDEMENT OR OTHER O.R. PROC.	1.6693	6.7	10.3	31
460 ...	22	MED	NON-EXTENSIVE BURNS W/O O.R. PROCEDURE	.9554	4.6	6.6	29
461 ...	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	.9981	2.5	4.9	27
462 ...	23	MED	REHABILITATION	1.4294	11.0	14.0	35
463 ...	23	MED	SIGNS & SYMPTOMS W CC	.7074	3.8	5.2	28
464 ...	23	MED	SIGNS & SYMPTOMS W/O CC	.5040	2.8	3.7	24
465 ...	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.5611	2.3	3.9	26
466 ...	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.5728	2.5	4.7	27
467 ...	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.4588	2.4	4.1	26
468 ...	.....		EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.5858	10.6	15.3	35
469 ...	.....		**PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS.	.0000	.0	.0	0
470 ...	.....		**UNGROUPABLE	.0000	.0	.0	0
471 ...	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.	3.6043	6.8	8.0	31
472 ...	22	SURG	EXTENSIVE BURNS W O.R. PROCEDURE	11.1357	17.3	30.7	41
473 ...	17		ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17.	3.5669	8.5	14.7	32
474 ...	.....		NO LONGER VALID	.0000	.0	.0	0
475 ...	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT.	3.6736	8.6	12.3	33
476 ...	.....	SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2362	10.3	13.8	34
477 ...	.....	SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.7153	5.8	9.2	30
478 ...	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.2890	5.6	8.3	30
479 ...	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4113	3.5	4.6	27
480 ...	.....	SURG	LIVER TRANSPLANT	12.8388	22.5	29.7	47
481 ...	.....	SURG	BONE MARROW TRANSPLANT	11.2985	29.1	32.1	53
482 ...	.....	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES.	3.6598	11.4	15.0	35
483 ...	.....	SURG	TRACHEOSTOMY EXCEPT FOR FACE, MOUTH & NECK DIAGNOSES.	16.0114	35.9	46.2	60
484 ...	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA ...	5.5711	10.4	15.5	34
485 ...	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR.	3.1619	9.1	11.6	33
486 ...	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.	4.8009	9.0	13.5	33
487 ...	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.9999	6.1	9.0	30
488 ...	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.2773	12.9	17.6	37
489 ...	25	MED	HIV W MAJOR RELATED CONDITION	1.7436	7.0	10.4	31
490 ...	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0106	4.4	6.6	28
491 ...	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.6358	3.6	4.3	19

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC MEAN LENGTH OF STAY, AND LENGTH OF STAY OUTLIER CUTOFF POINTS USED IN THE PROSPECTIVE PAYMENT SYSTEM—Continued

				Relative weights	Geometric mean LOS	Arithmetic mean LOS	Outlier threshold
492 ...	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	4.0624	11.2	17.4	35
493 ...	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC.	1.7085	4.2	5.9	28
494 ...	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC.	.9186	1.8	2.4	15
495 ...	.....	SURG	LUNG TRANSPLANT	9.8070	18.4	23.8	42

*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 used only to determine payment for outlier cases.
Note: relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
079.6	Respiratory syncytial virus (RSV)	N	15	387[1], 389 [1]
			18	421, 422
291.81	Alcohol withdrawal	Y	20	434, 435, 436, 437
291.89	Other specified alcoholic psychosis, not elsewhere classified	Y	20	434, 435, 436, 437
293.84	Organic anxiety syndrome	Y	19	429
300.82	Undifferentiated somatoform disorder	N	19	427
315.32	Receptive language disorder (mixed)	N	19	431
414.04	Coronary atherosclerosis of artery bypass graft	N	5	132, 133
414.05	Coronary atherosclerosis of unspecified type of bypass graft	N	5	132, 133
466.11	Acute bronchiolitis due to respiratory syncytial virus (RSV)	N	4	96, 97, 98
466.19	Acute bronchiolitis due to other infectious organisms	N	4	96, 97, 98
483.1	Pneumonia due to Chlamydia	Y	4	89, 90, 91
			15	387,[1] 389[1]
574.60	Calculus of gallbladder and bile duct with acute cholecystitis without mention of obstruction.	Y	7	207, 208
574.61	Calculus of gallbladder and bile duct with acute cholecystitis with obstruction	Y	7	207, 208
574.70	Calculus of gallbladder and bile duct with other cholecystitis without mention of obstruction.	Y	7	207, 208
574.71	Calculus of gallbladder and bile duct with other cholecystitis with obstruction	Y	7	207, 208
574.80	Calculus of gallbladder and bile duct with acute and chronic cholecystitis without mention of obstruction.	Y	7	207, 208
574.81	Calculus of gallbladder and bile duct with acute and chronic cholecystitis with obstruction.	Y	7	207, 208
574.90	Calculus of gallbladder and bile duct without cholecystitis without mention of obstruction.	Y	7	207, 208
574.91	Calculus of gallbladder and bile duct without cholecystitis with obstruction	Y	7	207, 208
575.10	Cholecystitis, unspecified	N	7	207, 208
575.11	Chronic cholecystitis	N	7	207, 208
575.12	Acute and chronic cholecystitis	Y	7	207, 208
752.51	Undescended testis	N	12	352
752.52	Retractile testis	N	12	352
752.61	Hypospadias	N	12	352
752.62	Epispadias	N	12	352
752.63	Congenital chordee	N	12	352
752.64	Micropenis	N	12	352
752.65	Hidden penis	N	12	352
752.69	Other penile anomalies	N	12	352
753.20	Unspecified obstructive defect of renal pelvis and ureter	N	11	331, 332, 333
753.21	Congenital obstruction of ureteropelvic junction	N	11	331, 332, 333
753.22	Congenital obstruction of ureterovesical junction	N	11	331, 332, 333
753.23	Congenital ureterocele	N	11	331, 332, 333
753.29	Obstructive defects of renal pelvis and ureter, not elsewhere classifed	N	11	331, 332, 333
758.81	Other conditions due to sex chromosome anomalies	N	12	352
			13	358, 359, 369
758.89	Other conditions due to chromosome anomalies, not elsewhere classified	N	12	352
			13	358, 359, 369
922.31	Back contusion	N	9	280, 281, 282
922.32	Buttock contusion	N	9	280, 281, 282
922.33	Interscapular region contusion	N	9	280, 281, 282
995.50	Child abuse, unspecified	N	21	454, 455
995.51	Child emotional/psychological abuse	N	21	454, 455

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
995.52	Child neglect (nutritional)	N	21	454, 455
995.53	Child sexual abuse	N	21	454, 455
995.54	Child physical abuse	N	21	454, 455
995.55	Shaken infant syndrome	N	21	454, 455
995.59	Child maltreatment syndrome, not elsewhere classified	N	21	454, 455
995.80	Adult maltreatment, unspecified	N	21	454, 455
995.82	Adult emotional/psychological abuse	N	21	454, 455
995.83	Adult sexual abuse	N	21	454, 455
995.84	Adult neglect (nutritional)	N	21	454, 455
995.85	Other adult abuse and neglect	N	21	454, 455
998.11	Hemorrhage complicating a procedure	Y	21	452, 453
998.12	Hematoma complicating a procedure	Y	21	452, 453
998.13	Seroma complicating a procedure	Y	21	452, 453
998.51	Infected postoperative seroma	Y	18	418
998.59	Other postoperative infection	Y	18	418
998.83	Non-healing surgical wound	Y	21	452, 453
V15.41	History of physical abuse	N	23	467
V15.42	History of emotional abuse	N	23	467
V15.49	Psychological trauma, not elsewhere classified	N	23	467
V61.10	Counseling for marital and partner problems, unspecified	N	23	467
V61.11	Counseling for victim of spousal and partner abuse	N	23	467
V61.12	Counseling for perpetrator of spousal and partner abuse	N	23	467
V61.22	Counseling for perpetrator of parental child abuse	N	23	467
V62.83	Counseling for perpetrator of physical/sexual abuse	N	23	467
V66.7	Encounter for palliative care	N	23	467

[1] Diagnosis code is classified as a ''major problem'' in these DRGs.

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
36.17	Abdominal-coronary artery bypass	Y	5	106, 107
39.90	Insertion of non-coronary artery stent or stents	N	.....	
47.01	Laparoscopic appendectomy	Y	6	164, 165, 166, 167
47.09	Other appendectomy	Y	6	164, 165, 166, 167
47.11	Laparoscopic incidental appendectomy	Y	13	365
			21	442, 443
			24	486
47.19	Other incidental appendectomy	Y	13	365
			21	442, 443
			24	486
51.21	Other partial cholecystectomy	Y	7	193, 194
			17	400, 406,
			17	407
			21	442, 443
			24	486
51.24	Laparoscopic partial cholecystectomy	Y	7	193, 194
			17	400, 406,
			17	407,
			21	442, 443
			24	486
52.84	Autotransplantation of cells of Islets of Langerhans	N	.....	
52.85	Allotransplantation of cells of Islets of Langerhans	N	.....	
52.86	Transplantation of cells of Islets of Langerhans, not otherwise specified	N	.....	
54.51	Laparoscopic lysis of peritoneal adhesions	Y	6	150, 151
			7	201
			13	365
			21	442, 443
			24	486
54.59	Other lysis of peritoneal adhesions	Y	6	150, 151
			7	201
			13	365
			21	442, 443
			24	486
59.03	Laparoscopic lysis of perirenal or periureteral adhesions	Y	11	303, 304, 305
			12	344, 345
			13	365
			17	400
			17	406, 407

TABLE 6B.—NEW PROCEDURE CODES—Continued

Procedure code	Description	OR	MDC	DRG
			21	442, 443
			24	486
59.12	Laparoscopic lysis of perivesical adhesions	Y	11	308, 309
			12	344, 345
			13	365
			17	400
			17	406, 407
			21	442, 443
			24	486
65.01	Laparoscopic oophorotomy	Y	13	354, 355, 357, 358, 359
65.09	Other oophorotomy	Y	13	354, 355, 357, 358, 359
65.13	Laparoscopic biopsy of ovary	Y	13	354, 355, 357, 358, 359
65.14	Other laparoscopic diagnostic procedures on ovaries	Y	13	354, 355, 357, 358, 359
65.23	Laparoscopic marsupialization of ovarian cyst	Y	13	354, 355, 357, 358, 359
65.24	Laparoscopic wedge resection of ovary	Y	10	292, 293
			13	354, 355, 357, 358, 359
65.25	Other laparoscopic local excision or destruction of ovary	Y	13	354, 355, 357, 358, 359
65.31	Laparoscopic unilateral oophorectomy	Y	13	354, 355, 357, 358, 359
65.39	Other unilateral oophorectomy	Y	13	354, 355, 357, 358, 359
65.41	Laparoscopic unilateral salpingo-oophorectomy	Y	13	354, 355, 357, 358, 359
65.49	Other unilateral salpingo-oophorectomy	Y	13	354, 355, 357, 358, 359
65.53	Laparoscopic removal of both ovaries at same operative episode	Y	9	269, 270
			13	354, 355,
			13	357, 358, 359
65.54	Laparoscopic removal of remaining ovary	Y	9	269, 270
			13	354, 355,
			13	357, 358, 359
65.63	Laparoscopic removal of both ovaries and tubes at same operative episode	Y	9	269, 270
			13	354, 355,
			13	357, 358, 359
65.64	Laparoscopic removal of remaining ovary and tube	Y	13	354, 355, 357, 358, 359
65.74	Laparoscopic simple suture of ovary	Y	13	354, 355,
			13	357, 358,
			21	359
			24	442, 443, 486
65.75	Laparoscopic reimplantation of ovary	Y	13	354, 355,
			13	357, 358,
			21	359
			24	442, 443, 486
65.76	Laparoscopic salpingo-oophoroplasty	Y	13	354, 355,
			13	357, 358,
			21	359
			24	442, 443, 486
65.81	Laparoscopic lysis of adhesions of ovary and fallopian tube	Y	13	354, 355,
			13	357, 358,
			21	359
			24	442, 443, 486
65.89	Other lysis of adhesions of ovary and fallopian tube	Y	13	354, 355,
			13	357, 358,
			21	359
			24	442, 443, 486
68.23	Endometrial ablation	Y	13	354, 355, 357, 358, 359
68.51	Laparoscopically assisted vaginal hysterectomy (LAVH)	Y	13	354, 355,
			13	357, 358,
			14	359, 375
68.59	Other vaginal hysterectomy	Y	13	354, 355,
			13	357, 358,
			14	359, 375

TABLE 6C.—TABLE DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
291.8	Other specified alcoholic psychosis	Y	20	434, 435, 436, 437
466.1	Acute bronchiolitis	N	4	96, 97, 98
575.1	Other cholecystitis	N	7	207, 208
752.5	Undescended testicle	N	12	352
752.6	Hypospadias and epispadias	N	12	352
753.2	Obstructive defects of renal pelvis and ureter	N	11	331, 332, 333
758.8	Other conditions due to sex chromosome anomalies	N	12	352
			13	358, 359, 369
922.3	Contusion of back	N	9	280, 281,
			9	282
			24	484, 486, 487
995.5	Child maltreatment syndrome	N	21	454, 455
998.1	Hemorrhage or hematoma complicating a procedure	Y	15	387[1], 389[1]
			21	452, 453
998.5	Postoperative infection	Y	15	387[1], 389[1]
			18	418
V15.4	Psychological trauma	N	23	467
V61.1	Marital problems	N	23	467

[1] Diagnosis code is classified as a ''major problem'' in these DRGs.

TABLE 6D.—INVALID PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
47.0	Appendectomy	Y	6	164, 165, 166, 167
47.1	Incidental appendectomy	Y	13	365,
			21	442, 443,
			24	486
54.5	Lysis of peritoneal adhesions	Y	6	150, 151
			7	201
			13	365
			21	442, 443
			24	486
59.01	Ureterolysis with freeing or repositioning of ureter for retroperitoneal fibrosis	Y	11	303, 304,
			11	305
			12	344, 345
			13	365
			17	400, 406,
			17	407
			21	442, 443
			24	486
65.0	Oophorotomy	Y	13	354, 355, 357, 358, 359
65.3	Unilateral oophorectomy	Y	13	354, 355, 357, 358, 359
65.4	Unilateral salpingo-oophorectomy	Y	13	354, 355, 357, 358, 359
65.8	Lysis of adhesions of ovary and fallopian tube	Y	13	354, 355,
			13	357, 358,
			21	359
			24	442, 443, 486
68.5	Vaginal hysterectomy	Y	13	354, 355,
			13	357, 358,
			13	359
			14	375

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
414.00	Coronary atherosclerosis of unspecified type of vessel, native or graft	N	5	132, 133
995.81	Adult physical abuse	N	21	454, 455
997.60	Amputation stump complication, unspecified complication	N	8	256
997.61	Amputation stump complication, neuroma of amputation stump	N	8	256
997.62	Amputation stump complication, infection (chronic)	Y	8	256
997.69	Amputation stump complication, not elsewhere classified	N	8	256

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES—Continued

Diagnosis code	Description	CC	MDC	DRG
V61.20	Counseling for parent-child problem, unspecified	N	23	467
V61.21	Counseling for victim of child abuse	N	23	467
V67.4	Follow-up examination, following treatment of healed fracture	N	23	465, 466

TABLE 6F.—REVISED PROCEDURE CODE TITLES

Procedure code	Description	OR	MDC	DRG
59.11	Other lysis of perivesical adhesions	Y	11	308, 309
			12	344, 345
			13	365
			17	400, 406,
			17	407
			21	442, 443
			24	486
65.51	Other removal of both ovaries at same operative episode	Y	9	269, 270
			13	354, 355
			13	357, 358, 359
65.52	Other removal of remaining ovary	Y	9	269, 270
			13	354, 355
			13	357, 358, 359
65.61	Other removal of both ovaries and tubes at same operative episode	Y	9	269, 270
			13	354, 355,
			13	357, 358, 359
65.62	Other removal of remaining ovary and tube	Y	13	354, 355, 357, 358, 359
65.71	Other simple suture of ovary	Y	13	354, 355,
			13	357, 358,
			13	359
			21	442, 443
			24	486
65.72	Other reimplantation of ovary	Y	13	354, 355,
			13	357, 358,
			21	359
			24	442, 443, 486
65.73	Other salpingo-oophoroplasty	Y	11	308, 309,
			12	344, 345
			13	365
			17	400, 406,
			17	407
			21	442, 443
			24	486

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST

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CCs that are added to the list are in Table 6G—Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

*0011	00844	*00800	00844	*0085	00844	*01133	*01182
00841	00845	00841	00845	00841	00845	4831	4831
00842	00846	00842	00846	00842	00846	*01134	*01183
00843	00847	00843	00847	00843	00847	4831	4831
00844	*0061	00844	*00841	00844	*0088	*01135	*01184
00845	00841	00845	00841	00845	00841	4831	4831
00846	00842	00846	00842	00846	00842	*01136	*01185
00847	00843	00847	00843	00847	00843	4831	4831
*0020	00844	*00801	00844	*00861	00844	*01140	*01186
00841	00845	00841	00845	00841	00845	4831	4831
00842	00846	00842	00846	00842	00846	*01141	*01190
00843	00847	00843	00847	00843	00847	4831	4831
00844	*0062	00844	*00842	00844	*0090	*01142	*01191
00845	00841	00845	00841	00845	00841	4831	4831
00846	00842	00846	00842	00846	00842	*01143	*01192
00847	00843	00847	00843	00847	00843	4831	4831
*0029	00844	*00802	00844	*00862	00844	*01144	*01193
00841	00845	00841	00845	00841	00845	4831	4831
00842	00846	00842	00846	00842	00846	*01145	*01194
00843	00847	00843	00847	00843	00847	4831	4831
00844	*0069	00844	*00843	00844	*01100	*01146	*01195
00845	00841	00845	00841	00845	4831	4831	4831
00846	00842	00846	00842	00846	*01101	*01150	*01196
00847	00843	00847	00843	00847	4831	4831	4831
*0030	00844	*00803	00844	*00863	*01102	*01151	*01200
00841	00845	00841	00845	00841	4831	4831	4831
00842	00846	00842	00846	00842	*01103	*01152	*01201
00843	00847	00843	00847	00843	4831	4831	4831
00844	*0071	00844	*00844	00844	*01104	*01153	*01202
00845	00841	00845	00841	00845	4831	4831	4831
00846	00842	00846	00842	00846	*01105	*01154	*01203
00847	00843	00847	00843	00847	4831	4831	4831
*0049	00844	*00804	00844	*00864	*01106	*01155	*01204
00841	00845	00841	00845	00841	4831	4831	4831
00842	00846	00842	00846	00842	*01110	*01156	*01205
00843	00847	00843	00847	00843	4831	4831	4831
00844	*0072	00844	*00845	00844	*01111	*01160	*01206
00845	00841	00845	00841	00845	4831	4831	4831
00846	00842	00846	00842	00846	*01112	*01161	*01210
00847	00843	00847	00843	00847	4831	4831	4831
*0050	00844	*00809	00844	*00865	*01113	*01162	*01211
00841	00845	00841	00845	00841	4831	4831	4831
00842	00846	00842	00846	00842	*01114	*01163	*01212
00843	00847	00843	00847	00843	4831	4831	4831
00844	*0073	00844	*00846	00844	*01115	*01164	*01213
00845	00841	00845	00841	00845	4831	4831	4831
00846	00842	00846	00842	00846	*01116	*01165	*01214
00847	00843	00847	00843	00847	4831	4831	4831
*0051	00844	*0081	00844	*00866	*01120	*01166	*01215
00841	00845	00841	00845	00841	4831	4831	4831
00842	00846	00842	00846	00842	*01121	*01170	*01216
00843	00847	00843	00847	00843	4831	4831	4831
00844	*0078	00844	*00847	00844	*01122	*01171	*01280
00845	00841	00845	00841	00845	4831	4831	4831
00846	00842	00846	00842	00846	*01123	*01172	*01281
00847	00843	00847	00843	00847	4831	4831	4831
*0052	00844	*0082	00844	*00867	*01124	*01173	*01282
00841	00845	00841	00845	00841	4831	4831	4831
00842	00846	00842	00846	00842	*01125	*01174	*01283
00843	00847	00843	00847	00843	4831	4831	4831
00844	*0079	00844	*00849	00844	*01126	*01175	*01284
00845	00841	00845	00841	00845	4831	4831	4831
00846	00842	00846	00842	00846	*01130	*01176	*01285
00847	00843	00847	00843	00847	4831	4831	4831
*0060	00844	*0083	00844	*00869	*01131	*01180	*01286
00841	00845	00841	00845	00841	4831	4831	4831
00842	00846	00842	00846	00842	*01132	*01181	*01480
00843	00847	00843	00847	00843	4831	4831	00841

00842 4831 29382 29284 *29212 29383 29614 29181
00843 *11285 29383 29289 29181 29384 29634 29189
00844 00841 29384 2929 29189 7105 29644 29384
00845 00842 30300 29381 29384 *29389 29654 *30420
00846 00843 30301 29382 *2922 29181 29664 29181
00847 00844 30302 29383 29181 29189 2980 29189
*01481 00845 30390 29384 29189 29384 2983 29384
00841 00846 30391 30300 29384 *2939 2984 *30421
00842 00847 30392 30301 *29281 29181 29900 29181
00843 *11505 30400 30302 29181 29189 29910 29189
00844 4831 30401 30390 29189 29384 29980 29384
00845 *11515 30402 30391 29384 *2940 29990 *30422
00846 4831 30410 30392 *29282 29181 *30300 29181
00847 *11595 30411 30400 29181 29189 29181 29189
*01482 4831 30412 30401 29189 29384 29189 29384
00841 *1221 30420 30402 29384 *2941 29384 *30423
00842 4831 30421 30410 *29283 29181 *30301 29181
00843 *129 30422 30411 29181 29189 29181 29189
00844 00841 30440 30412 29189 29384 29189 29384
00845 00842 30441 30420 29384 *2948 29384 *30430
00846 00843 30442 30421 *29284 29181 *30302 29181
00847 00844 30450 30422 29181 29189 29181 29189
*01483 00845 30451 30440 29189 29384 29189 29384
00841 00846 30452 30441 29384 *2949 29384 *30431
00842 00847 30460 30442 *29289 29181 *30303 29181
00843 *1304 30461 30450 29181 29189 29181 29189
00844 4831 30462 30451 29189 29384 29189 29384
00845 *1363 30470 30452 29384 *30082 29384 *30432
00846 4831 30471 30460 *2929 29500 *30390 29181
00847 *2910 30472 30461 29181 29501 29181 29189
*01484 29181 30480 30462 29189 29502 29189 29384
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00843 *2911 30490 30472 29181 29510 29181 29189
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*01486 29181 30551 30540 29189 29534 29189 29384
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*01790 2910 30590 30562 2911 29562 29189 29384
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*01793 29189 2912 30592 2919 29573 *30410 29181
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*01794 2920 2914 29181 29211 29580 29189 29384
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*01795 29212 29189 29384 2922 29582 *30411 29181
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*01796 29281 2920 29181 29282 29584 29189 29384
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*0212 29283 29212 29384 29284 29591 *30412 29181
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*0391 29381 29283 29384 29382 29604 *30413 29181

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*30462 29181 29189 29534 *4824 01182 5081 4831
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*53200 99811 00842 00843 *56203 57471 57441 57441
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TABLE 6H.—DELETIONS TO THE CC EXCLUSIONS LIST

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CCs that are deleted from the list are in Table 6H—Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

*2910	30502	2918	2918	2918	9981	57421
2918	30530	*30303	*30471	*30563	*53261	57430
*2911	30531	2918	2918	2918	9981	57431
2918	30532	*30390	*30472	*30570	*53300	57440
*2912	30540	2918	2918	2918	9981	57441
2918	30541	*30391	*30473	*30571	*53301	57450
*2913	30542	2918	2918	2918	9981	57451
2918	30550	*30392	*30480	*30572	*53320	5750
*2914	30551	2918	2918	2918	9981	*5780
2918	30552	*30393	*30481	*30573	*53321	9981
*2915	30560	2918	2918	2918	9981	*5781
2918	30561	*30400	*30482	*30580	*53340	9981
*2918	30562	2918	2918	2918	9981	*5789
2910	30570	*30401	*30483	*30581	*53341	9981
2911	30571	2918	2918	2918	9981	*7526
2912	30572	*30402	*30490	*30582	*53360	5970
2913	30590	2918	2918	2918	9981	5981
2914	30591	*30403	*30491	*30583	*53361	5982
2918	30592	2918	2918	2918	9981	5994
2919	*2919	*30410	*30492	*30590	*53400	*7532
2920	2918	2918	2918	2918	9981	5845
29211	*2920	*30411	*30493	*30591	*53401	5846
29212	2918	2918	2918	2918	9981	5847
2922	*29211	*30412	*30500	*30592	*53420	5849
29281	2918	2918	2918	2918	9981	585
29282	*29212	*30413	*30501	*30593	*53421	5996
29283	2918	2918	2918	2918	9981	78820
29284	*2922	*30420	*30502	*4560	*53440	78829
29289	2918	2918	2918	9981	9981	*7724
2929	*29281	*30421	*30503	*45620	*53441	9981
29381	2918	2918	2918	9981	9981	*7903
29382	*29282	*30422	*30520	*53081	*53460	2918
29383	2918	2918	2918	9981	9981	*99791
30300	*29283	*30423	*30521	*53082	*53461	9981
30301	2918	2918	2918	9981	9981	9985
30302	*29284	*30430	*30522	*53083	*53501	*99799
30390	2918	2918	2918	9981	9981	9981
30391	*29289	*30431	*30523	*53089	*53511	9985
30392	2918	2918	2918	9981	9981	*9980
30400	*2929	*30432	*30530	*53100	*53521	9981
30401	2918	2918	2918	9981	9981	*9981
30402	*2930	*30433	*30531	*53101	*53531	9585
30410	2918	2918	2918	9981	9981	9954
30411	*2931	*30440	*30532	*53120	*53541	9980
30412	2918	2918	2918	9981	9981	9981
30420	*29381	*30441	*30533	*53121	*53551	*9985
30421	2918	2918	2918	9981	9981	9985
30422	*29382	*30442	*30540	*53140	*53561	*99881
30440	2918	2918	2918	9981	9981	9981
30441	*29383	*30443	*30541	*53141	*53783	9985
30442	2918	2918	2918	9981	9981	*99889
30450	*29389	*30450	*30542	*53160	*56202	9981
30451	2918	2918	2918	9981	9981	9985
30452	*2939	*30451	*30543	*53161	*56203	*9989
30460	2918	2918	2918	9981	9981	9981
30461	*2940	*30452	*30550	*53200	*56212	9985
30462	2918	2918	2918	9981	9981	
30470	*2941	30453	*30551	*53201	*56213	
30471	2918	2918	2918	9981	9981	
30472	*2948	*30460	*30552	*53220	*5693	
30480	2918	2918	2918	9981	9981	
30481	*2949	*30461	*30553	*53221	*56985	
30482	2918	2918	2918	9981	9981	
30490	*30300	*30462	*30560	*53240	*5751	
30491	2918	2918	2918	9981	57400	
30492	*30301	*30463	*30561	*53241	57401	
30500	2918	2918	2918	9981	57410	
30501	*30302	*30470	*30562	*53260	57411	

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY

[FY95 MEDPAR Update 12/95 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	32723	11.0372	3	4	8	14	23
2	6165	11.5178	3	5	8	14	23
3	1	10.0000	10	10	10	10	10
4	5866	9.1202	2	3	6	11	20
5	95896	4.4060	2	2	3	5	9
6	444	3.3581	1	1	2	4	7
7	10526	12.5752	3	5	8	14	25
8	2248	4.1348	1	1	3	5	9
9	1655	7.5287	2	3	5	9	16
10	19194	7.9610	2	3	6	10	16
11	2866	4.9215	1	2	4	6	10
12	23355	7.5868	2	3	5	9	14
13	5969	6.2406	2	4	5	7	11
14	351205	7.4178	2	3	6	9	14
15	138882	4.4367	1	2	3	5	8
16	11877	6.5858	2	3	5	8	12
17	3217	4.0258	1	2	3	5	7
18	22783	6.3682	2	3	5	8	12
19	7433	4.5271	1	2	4	6	8
20	5990	11.2129	3	5	9	15	22
21	1114	7.8905	2	3	6	10	16
22	2585	4.8584	2	2	4	6	9
23	5720	5.0336	1	2	4	6	10
24	53620	5.8059	2	3	4	7	11
25	21830	3.8592	1	2	3	5	7
26	46	4.6087	1	2	3	6	10
27	3475	6.2774	1	1	4	7	15
28	11179	7.0945	1	3	5	9	14
29	3684	4.0581	1	2	3	5	8
31	3167	5.4436	1	2	4	6	10
32	1723	3.1573	1	1	2	4	6
34	16272	6.4700	2	3	5	8	12
35	3648	4.2928	1	2	3	5	8
36	9010	1.5970	1	1	1	2	3
37	1878	4.0213	1	1	3	5	8
38	234	2.5385	1	1	2	3	5
39	3289	1.9663	1	1	1	2	4
40	2779	3.3843	1	1	2	4	7
42	7351	2.2049	1	1	1	2	5
43	97	4.0928	1	2	3	5	8
44	1614	5.7038	2	3	5	7	10
45	2412	3.8163	1	2	3	5	7
46	2952	5.4814	1	2	4	7	10
47	1333	3.7802	1	2	3	5	7
49	2139	5.6396	1	2	4	7	11
50	3347	2.1138	1	1	2	2	3
51	308	2.9870	1	1	1	3	7
52	78	3.6282	1	1	2	3	8
53	3340	3.5548	1	1	2	4	8
54	1	1.0000	1	1	1	1	1
55	1924	2.9569	1	1	2	3	6
56	704	2.7514	1	1	2	3	6
57	637	4.0973	1	1	3	5	8
59	88	3.7045	1	1	2	4	7
60	3	1.0000	1	1	1	1	1
61	217	5.2535	1	1	2	7	14
62	1	2.0000	2	2	2	2	2
63	3996	4.6652	1	2	3	5	10
64	3351	7.5067	1	2	5	9	16
65	29525	3.4147	1	2	3	4	6
66	6479	3.5658	1	2	3	4	6
67	510	4.2039	2	2	3	5	8
68	9443	4.7605	2	3	4	6	9
69	3062	3.7606	1	2	3	5	7
70	30	3.0667	1	2	3	3	5
71	90	4.1556	1	2	3	5	8
72	561	4.3529	1	2	3	5	9
73	6017	4.9493	1	2	4	6	9
75	39401	11.1088	4	6	8	14	21
76	38785	12.4555	3	6	10	15	24

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 12/95 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
77	2331	5.5268	1	2	4	8	12
78	28979	8.2306	4	5	7	10	13
79	207606	9.2488	3	5	7	11	17
80	8932	6.6160	2	4	5	8	12
81	9	7.2222	1	2	6	11	12
82	68573	7.8881	2	3	6	10	16
83	6976	6.3817	2	3	5	8	12
84	1430	3.7217	1	2	3	5	7
85	18398	7.3317	2	3	6	9	14
86	1372	4.5117	1	2	4	6	9
87	58612	6.7959	1	3	6	9	13
88	345365	6.0658	2	3	5	7	11
89	415072	7.0754	3	4	6	9	12
90	40306	5.1392	2	3	4	6	9
91	50	4.5800	2	2	3	6	8
92	11849	7.2524	2	4	6	9	13
93	1262	4.9374	1	3	4	6	9
94	12531	7.0527	2	3	5	9	14
95	1365	4.1341	1	2	3	5	8
96	60887	5.5101	2	3	5	7	10
97	25835	4.2614	2	2	4	5	7
98	19	4.4737	1	1	3	6	10
99	25241	3.4914	1	2	3	4	7
100	10191	2.4244	1	1	2	3	4
101	19810	5.1725	1	2	4	7	10
102	4399	3.1298	1	1	2	4	6
103	445	39.3528	10	15	29	53	80
104	22854	14.5510	6	8	12	18	26
105	19821	10.9286	5	7	9	13	19
106	96166	11.7202	6	8	10	14	19
107	61255	8.8314	5	6	7	10	14
108	6560	12.5834	4	7	10	15	23
110	59173	10.7795	3	6	9	13	20
111	5800	6.6512	3	5	6	8	10
112	191511	4.6987	1	2	4	6	9
113	45003	14.3320	4	6	10	17	28
114	8788	9.4467	2	4	7	12	18
115	10395	11.3715	4	6	9	14	20
116	81298	5.4177	1	2	4	7	11
117	4482	4.1142	1	1	2	5	8
118	6687	3.1952	1	1	2	4	7
119	1705	5.4985	1	1	3	7	13
120	40465	9.1860	1	2	6	12	21
121	158928	7.4120	2	4	6	9	13
122	87089	5.0036	1	3	5	6	9
123	46281	4.6510	1	1	2	6	11
124	138564	4.8885	1	2	4	6	9
125	59232	3.0694	1	1	2	4	6
126	4619	13.9985	4	7	11	17	29
127	670461	6.2113	2	3	5	8	12
128	19612	6.7259	3	4	6	8	11
129	4584	3.4271	1	1	1	4	9
130	91826	6.6818	2	4	6	8	12
131	25592	5.1808	1	3	5	7	8
132	127274	3.5716	1	2	3	4	6
133	5813	2.9696	1	1	2	4	5
134	28493	3.9142	1	2	3	5	7
135	7141	4.9779	1	2	4	6	9
136	1014	3.2209	1	2	3	4	6
138	195932	4.5466	1	2	3	6	8
139	67345	2.9337	1	1	2	4	5
140	175930	3.4831	1	2	3	4	6
141	76111	4.4923	1	2	3	5	8
142	35701	3.1999	1	2	2	4	6
143	132318	2.6077	1	1	2	3	5
144	66761	5.6816	1	2	4	7	11
145	6735	3.2413	1	1	2	4	6
146	8626	11.2570	6	7	9	13	18
147	1624	7.3651	4	6	7	9	11
148	140141	13.4097	6	8	11	16	24

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 12/95 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
149	15769	7.7194	4	6	7	9	11
150	22516	11.6884	4	7	10	14	21
151	4518	6.4748	2	4	6	8	11
152	4469	9.0257	4	6	8	10	15
153	1710	6.1655	3	4	6	8	9
154	35661	14.9524	5	8	12	18	28
155	4557	5.8824	2	3	5	8	10
156	4	15.7500	4	4	10	22	27
157	11419	5.7824	1	2	4	7	11
158	5082	2.9124	1	1	2	4	6
159	17132	5.3155	1	2	4	7	10
160	9971	2.9553	1	1	2	4	5
161	14786	4.3655	1	2	3	5	9
162	7990	2.1914	1	1	2	3	4
163	5	2.2000	1	1	1	3	5
164	4995	9.2993	4	6	8	11	16
165	1674	5.7575	3	4	5	7	9
166	3283	5.7286	2	3	4	7	10
167	2284	3.2439	1	2	3	4	6
168	1739	4.8562	1	2	3	6	10
169	1025	2.5473	1	1	2	3	5
170	12463	12.4436	2	5	9	15	25
171	1157	5.4105	1	2	4	7	11
172	30820	8.1481	2	3	6	10	16
173	2188	4.2870	1	2	3	5	9
174	231782	5.5456	2	3	4	7	10
175	23071	3.5073	1	2	3	4	6
176	16011	6.1346	2	3	5	7	11
177	11991	4.9873	2	3	4	6	9
178	4174	3.6195	1	2	3	5	7
179	11198	7.1657	2	4	6	9	14
180	79145	6.0471	2	3	5	7	11
181	22152	3.9606	1	2	3	5	7
182	226099	4.9591	2	2	4	6	9
183	72147	3.4552	1	2	3	4	6
184	67	3.7463	1	2	2	4	6
185	3804	5.1966	1	2	4	6	10
186	1	2.0000	2	2	2	2	2
187	832	4.2524	1	2	3	6	8
188	61112	6.1262	2	3	5	8	12
189	7787	3.6773	1	1	3	5	7
190	62	4.8548	1	3	4	6	10
191	10459	16.1606	5	8	12	20	32
192	880	7.9625	2	4	7	9	14
193	8477	13.8662	5	8	11	17	25
194	805	8.4348	3	5	7	10	15
195	9196	10.4533	4	6	9	12	18
196	796	6.7651	3	4	6	8	11
197	28016	9.1380	4	5	7	11	16
198	7906	4.9586	2	3	4	6	8
199	2208	11.1005	3	5	9	14	22
200	1525	11.8413	2	4	8	14	25
201	1466	16.5750	4	7	13	21	34
202	25094	7.6794	2	3	6	9	15
203	28743	7.6566	2	3	6	10	15
204	49035	6.6942	2	3	5	8	13
205	21512	7.2152	2	3	5	9	14
206	1692	4.7305	1	2	4	6	10
207	35330	5.7193	2	3	4	7	11
208	10251	3.4474	1	2	3	4	6
209	328015	6.6569	3	4	6	7	10
210	131592	8.5557	4	5	7	10	14
211	25325	6.2610	3	4	6	7	10
212	9	5.0000	2	3	4	5	8
213	6788	9.6117	3	4	7	12	19
214	51282	6.4551	2	3	5	8	12
215	41115	3.6816	1	2	3	5	7
216	6435	11.0449	2	5	8	14	22
217	19341	15.2991	3	6	10	18	31
218	21844	6.2064	2	3	5	7	11

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 12/95 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
219	17973	3.7492	1	2	3	5	6
220	2	5.5000	5	5	6	6	6
221	4962	8.1475	2	4	6	10	16
222	3560	4.0573	1	2	3	5	8
223	18306	2.8650	1	1	2	3	5
224	7946	2.2699	1	1	2	3	4
225	6199	5.0045	1	2	3	6	11
226	5349	6.7080	1	2	4	8	14
227	4604	2.9622	1	1	2	4	6
228	3014	3.5551	1	1	2	4	7
229	1345	2.4007	1	1	2	3	5
230	2455	5.1548	1	2	3	6	11
231	10331	5.0624	1	2	3	6	11
232	576	4.5017	1	1	2	5	10
233	4538	8.9595	2	4	7	11	18
234	2220	4.1730	1	2	3	5	8
235	5543	6.7231	1	3	4	7	13
236	37803	6.2862	2	3	5	7	12
237	1510	4.4139	1	2	3	5	8
238	7538	10.0649	3	5	7	12	19
239	59581	7.6027	2	4	6	9	14
240	12047	7.4987	2	3	5	9	15
241	3019	4.6277	1	2	4	6	9
242	2528	7.6606	2	4	6	9	15
243	79979	5.6107	2	3	4	7	10
244	11456	5.8092	2	3	4	7	11
245	4259	4.2158	1	2	3	5	8
246	1312	4.5899	1	2	4	6	9
247	10591	3.9716	1	2	3	5	8
248	6767	5.2815	1	2	4	6	10
249	10077	4.2995	1	2	3	5	9
250	3178	4.9091	1	2	3	6	9
251	2090	3.2933	1	1	3	4	6
252	1	1.0000	1	1	1	1	1
253	17469	5.8164	2	3	4	7	11
254	9208	3.8588	1	2	3	5	7
255	1	2.0000	2	2	2	2	2
256	4600	5.7178	1	2	4	7	11
257	23640	3.4239	1	2	3	4	6
258	18784	2.4905	1	2	2	3	4
259	4010	3.5077	1	1	2	3	7
260	4868	1.8683	1	1	1	2	3
261	2334	2.3500	1	1	2	3	4
262	712	3.9284	1	1	2	5	8
263	29088	13.8669	4	6	10	16	28
264	3559	8.3442	2	4	6	10	17
265	4274	7.6467	1	2	5	9	16
266	2712	3.6855	1	1	3	5	7
267	222	4.0811	1	1	3	5	9
268	891	4.0000	1	1	2	4	9
269	10173	9.1218	2	3	7	12	18
270	3456	3.3958	1	1	2	4	8
271	21515	8.4984	3	4	7	10	15
272	5863	7.4481	2	3	6	9	14
273	1426	5.5035	2	2	4	7	11
274	2526	7.7458	2	3	5	9	15
275	250	3.5040	1	1	2	4	8
276	889	5.0472	1	2	4	6	9
277	79054	6.7240	3	4	5	8	12
278	26008	5.1420	2	3	4	6	9
279	5	4.8000	2	2	3	4	12
280	13098	5.1142	1	2	4	6	9
281	5890	3.6448	1	2	3	4	7
283	5233	5.4888	2	2	4	7	10
284	1755	3.8632	1	2	3	5	7
285	4886	13.5014	3	6	10	16	26
286	1918	8.7195	3	4	6	9	16
287	6284	13.3908	3	6	9	16	26
288	957	7.0449	2	4	5	7	11
289	4992	3.9732	1	2	2	4	8

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 12/95 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
290	8514	2.8404	1	1	2	3	5
291	86	1.7558	1	1	1	2	3
292	5046	12.6958	2	5	9	16	25
293	294	6.4456	1	3	5	8	14
294	86024	5.6681	2	3	4	7	10
295	3712	4.2826	1	2	3	5	8
296	218940	6.3561	2	3	5	8	12
297	31455	4.2781	1	2	3	5	8
298	95	3.0211	1	1	2	4	5
299	868	5.3652	1	2	4	7	10
300	14115	7.3032	2	3	6	9	14
301	2146	4.3877	1	2	3	6	9
302	7567	12.3190	6	7	9	14	21
303	18462	10.1938	4	6	8	12	18
304	12867	10.2970	3	5	7	13	21
305	2526	4.9097	1	3	4	6	9
306	11305	6.2204	2	2	4	8	13
307	2596	2.9819	1	2	2	3	5
308	9137	7.0113	1	2	5	9	15
309	3371	3.0009	1	1	2	4	6
310	28549	4.6077	1	2	3	6	9
311	9697	2.1734	1	1	2	3	4
312	1995	4.7895	1	2	3	6	10
313	745	2.2644	1	1	2	3	5
314	1	5.0000	5	5	5	5	5
315	27722	9.2695	1	2	6	12	20
316	69941	7.4958	2	3	6	9	15
317	779	2.8434	1	1	2	3	6
318	5981	7.1195	2	3	5	9	14
319	506	3.2174	1	1	2	4	7
320	169078	6.4297	2	3	5	8	11
321	25512	4.7020	2	3	4	6	8
322	81	4.3580	2	2	4	6	8
323	17690	3.5573	1	2	3	4	7
324	8755	2.0870	1	1	2	3	4
325	7381	4.5898	1	2	3	5	9
326	2186	3.4492	1	1	2	4	6
327	8	3.1250	1	2	2	2	4
328	817	4.2742	1	2	3	5	9
329	109	2.7523	1	1	2	3	5
330	1	1.0000	1	1	1	1	1
331	38181	6.1753	2	3	5	8	12
332	4687	3.8835	1	2	3	5	8
333	357	5.8319	1	3	4	7	13
334	19011	6.0503	3	4	5	7	9
335	9821	4.5786	2	3	4	6	7
336	60748	4.1251	1	2	3	5	8
337	38538	2.6717	1	2	2	3	4
338	4813	5.2703	1	2	3	6	11
339	2302	4.9392	1	2	3	6	10
340	2	3.0000	1	1	5	5	5
341	6427	3.2367	1	1	2	4	6
342	224	4.0089	1	1	2	5	8
344	3820	3.4652	1	1	2	4	7
345	1355	3.9734	1	2	3	4	9
346	5343	6.7477	1	3	5	8	14
347	418	3.3349	1	1	2	4	7
348	3021	4.8875	1	2	4	6	9
349	684	2.9956	1	1	2	4	6
350	6884	4.7451	2	3	4	6	8
352	576	3.9392	1	2	3	5	8
353	2621	8.3564	3	5	6	10	15
354	9693	6.3330	3	4	5	7	11
355	5607	3.8639	2	3	4	4	6
356	28647	3.0247	1	2	3	4	5
357	6526	9.8462	4	5	8	12	18
358	26797	4.7425	2	3	4	5	8
359	27392	3.2715	2	3	3	4	5
360	16717	3.5393	1	2	3	4	6
361	618	3.4644	1	1	2	4	7

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 12/95 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
363	4355	3.4953	1	2	2	3	6
364	1778	3.6310	1	1	2	5	8
365	2396	8.1123	2	3	5	10	18
366	4470	7.6707	2	3	5	10	16
367	544	3.3107	1	1	2	4	7
368	2285	6.9190	2	3	5	9	13
369	2409	3.7410	1	1	3	5	7
370	1083	5.5568	3	3	4	5	9
371	950	3.5874	2	3	3	4	5
372	809	3.3498	1	2	2	3	6
373	3637	1.9249	1	1	2	2	3
374	116	2.3621	1	2	2	2	3
375	5	2.2000	1	1	2	3	4
376	151	3.4834	1	1	2	4	8
377	26	3.2308	1	1	1	3	8
378	163	2.9755	1	2	3	3	5
379	309	2.9256	1	1	2	3	5
380	71	2.3239	1	1	2	3	4
381	194	2.2835	1	1	1	2	5
382	47	1.6596	1	1	1	1	3
383	1455	4.0460	1	2	3	5	8
384	123	3.3496	1	1	1	3	7
385	3	17.0000	1	1	1	49	49
389	24	10.6667	3	4	8	10	18
390	10	5.0000	1	2	3	6	9
392	2467	11.6700	4	6	8	15	24
394	1642	7.8831	1	2	5	9	16
395	65671	5.3672	1	2	4	7	10
396	18	3.9444	1	1	3	7	8
397	15421	6.0683	2	3	4	7	12
398	16602	6.5798	2	3	5	8	12
399	1424	4.4347	1	2	4	6	8
400	7470	10.3424	2	4	7	13	23
401	6368	12.3990	2	5	9	16	25
402	1542	4.6984	1	1	3	6	10
403	34812	9.2838	2	4	7	12	19
404	3946	5.0867	1	2	4	7	10
406	3264	11.1468	3	5	8	14	23
407	723	4.9267	1	2	4	6	9
408	2949	8.2035	1	2	5	10	18
409	5649	6.6516	2	3	4	6	14
410	85873	3.3544	1	2	3	4	5
411	50	2.5600	1	1	2	3	7
412	35	3.0857	1	1	2	4	8
413	8421	8.2956	2	3	6	10	17
414	797	5.2070	1	2	4	7	11
415	38804	15.6974	4	7	12	19	31
416	192133	8.2122	2	4	7	10	15
417	45	4.6222	1	2	4	7	10
418	18663	6.7433	2	3	5	8	13
419	15677	5.6580	2	3	4	7	10
420	2871	4.3006	2	2	4	5	8
421	11386	4.6473	2	2	4	6	8
422	89	3.6854	1	2	3	4	7
423	9118	8.6534	2	4	6	10	18
424	1990	17.7397	3	6	12	20	34
425	15247	4.8955	1	2	3	6	10
426	4721	5.4938	1	2	4	7	11
427	1773	5.2775	1	2	4	7	11
428	904	8.4303	1	3	5	10	18
429	38861	8.9079	2	3	6	10	17
430	53430	9.7495	2	4	7	12	19
431	190	7.4632	1	3	5	9	14
432	430	6.3395	1	2	4	6	11
433	7843	3.4051	1	1	2	4	7
434	20810	5.8148	2	3	4	7	11
435	15477	4.8166	1	3	4	6	8
436	2915	14.5413	4	8	14	21	28
437	14205	10.8943	4	6	10	14	20
439	867	8.9262	2	3	6	11	18

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 12/95 Grouper V13.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
440	4751	9.7838	2	3	6	12	21
441	611	4.4386	1	1	2	4	7
442	13818	8.7372	1	3	6	11	18
443	3299	3.5335	1	1	2	5	7
444	3319	5.3203	1	3	4	6	10
445	1321	3.7858	1	2	3	5	7
446	1	1.0000	1	1	1	1	1
447	3816	2.7953	1	1	2	3	5
448	84	1.0000	1	1	1	1	1
449	28775	4.4101	1	2	3	5	9
450	6807	2.3364	1	1	2	3	5
451	7	6.1429	2	3	4	5	7
452	19382	5.4066	1	2	4	6	11
453	3636	3.1876	1	1	2	4	6
454	5132	5.1046	1	2	3	6	10
455	1092	2.8333	1	1	2	3	5
456	194	8.3711	1	1	4	9	21
457	127	4.7953	1	1	2	5	10
458	1550	16.9387	4	7	13	22	35
459	533	10.3471	2	4	7	13	22
460	2303	6.6309	1	3	5	8	13
461	3040	4.8862	1	1	2	5	12
462	9360	13.7955	5	6	12	18	26
463	11987	5.1410	1	2	4	6	10
464	3079	3.7347	1	2	3	5	7
465	197	3.9086	1	1	2	4	7
466	1838	4.6366	1	1	2	4	10
467	1722	4.1057	1	1	2	4	8
468	58649	15.1829	3	7	12	19	30
471	9111	8.0289	4	5	6	9	13
472	150	30.6667	2	9	28	41	62
473	8217	14.3113	2	4	8	21	35
475	89514	12.1394	2	5	10	16	24
476	6875	13.7876	3	7	11	17	25
477	28128	8.8453	1	3	6	11	18
478	117755	8.2916	1	3	6	10	17
479	17758	4.5591	1	2	4	6	9
480	359	29.7159	10	13	22	37	61
481	119	35.0000	21	23	30	39	59
482	6754	14.9011	5	8	11	17	28
483	36200	45.7958	15	23	37	56	84
484	327	15.3364	2	6	11	21	32
485	3165	11.5893	4	6	9	13	21
486	2045	13.3482	1	6	11	18	28
487	3765	8.8770	1	3	7	11	17
488	1593	17.5267	5	8	13	22	35
489	17612	10.3989	2	4	7	13	22
490	4999	6.5719	1	2	4	8	14
491	9441	4.2777	2	3	3	5	7
492	2029	17.3834	3	5	10	28	37
493	52260	5.8809	1	2	5	8	11
494	27127	2.4245	1	1	2	3	5
495	107	23.7944	10	13	18	29	41
	10571233						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY

[FY95 MEDPAR Update 12/95 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	32723	11.0372	3	4	8	14	23
2	6165	11.5178	3	5	8	14	23
3	1	10.0000	10	10	10	10	10
4	5866	9.1202	2	3	6	11	20
5	95896	4.4060	2	2	3	5	9
6	444	3.3581	1	1	2	4	7
7	10526	12.5752	3	5	8	14	25

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 12/95 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
8	2248	4.1348	1	1	3	5	9
9	1655	7.5287	2	3	5	9	16
10	19194	7.9610	2	3	6	10	16
11	2866	4.9215	1	2	4	6	10
12	23355	7.5868	2	3	5	9	14
13	5969	6.2406	2	4	5	7	11
14	351205	7.4178	2	3	6	9	14
15	138882	4.4367	1	2	3	5	8
16	11877	6.5858	2	3	5	8	12
17	3217	4.0258	1	2	3	5	7
18	22783	6.3682	2	3	5	8	12
19	7433	4.5271	1	2	4	6	8
20	5990	11.2129	3	5	9	15	22
21	1114	7.8905	2	3	6	10	16
22	2585	4.8584	2	2	4	6	9
23	5720	5.0336	1	2	4	6	10
24	53620	5.8059	2	3	4	7	11
25	21830	3.8592	1	2	3	5	7
26	46	4.6087	1	2	3	6	10
27	3475	6.2774	1	1	4	7	15
28	11179	7.0945	1	3	5	9	14
29	3684	4.0581	1	2	3	5	8
31	3167	5.4436	1	2	4	6	10
32	1723	3.1573	1	1	2	4	6
34	16272	6.4700	2	3	5	8	12
35	3648	4.2928	1	2	3	5	8
36	9010	1.5970	1	1	1	2	3
37	1878	4.0213	1	1	3	5	8
38	234	2.5385	1	1	2	3	5
39	3289	1.9663	1	1	1	2	4
40	2779	3.3843	1	1	2	4	7
42	7351	2.2049	1	1	1	2	5
43	97	4.0928	1	2	3	5	8
44	1614	5.7038	2	3	5	7	10
45	2412	3.8163	1	2	3	5	7
46	2952	5.4814	1	2	4	7	10
47	1333	3.7802	1	2	3	5	7
49	2139	5.6396	1	2	4	7	11
50	3347	2.1138	1	1	2	2	3
51	308	2.9870	1	1	1	3	7
52	78	3.6282	1	1	2	3	8
53	3340	3.5548	1	1	2	4	8
54	1	1.0000	1	1	1	1	1
55	1924	2.9569	1	1	2	3	6
56	704	2.7514	1	1	2	3	6
57	637	4.0973	1	1	3	5	8
59	88	3.7045	1	1	2	4	7
60	3	1.0000	1	1	1	1	1
61	217	5.2535	1	1	2	7	14
62	1	2.0000	2	2	2	2	2
63	3996	4.6652	1	2	3	5	10
64	3351	7.5067	1	2	5	9	16
65	29525	3.4147	1	2	3	4	6
66	6479	3.5658	1	2	3	4	6
67	510	4.2039	2	2	3	5	8
68	9443	4.7605	2	3	4	6	9
69	3062	3.7606	1	2	3	5	7
70	30	3.0667	1	2	3	3	5
71	90	4.1556	1	2	3	5	8
72	561	4.3529	1	2	3	5	9
73	6017	4.9493	1	2	4	6	9
75	39401	11.1088	4	6	8	14	21
76	38785	12.4555	3	6	10	15	24
77	2331	5.5268	1	2	4	8	12
78	28979	8.2306	4	5	7	10	13
79	207606	9.2488	3	5	7	11	17
80	8932	6.6160	2	4	5	8	12
81	9	7.2222	1	2	6	11	12
82	68573	7.8881	2	3	6	10	16
83	6976	6.3817	2	3	5	8	12

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 12/95 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
84	1430	3.7217	1	2	3	5	7
85	18398	7.3317	2	3	6	9	14
86	1372	4.5117	1	2	4	6	9
87	58612	6.7959	1	3	6	9	13
88	345365	6.0658	2	3	5	7	11
89	415072	7.0754	3	4	6	9	12
90	40306	5.1392	2	3	4	6	9
91	50	4.5800	2	2	3	6	8
92	11849	7.2524	2	4	6	9	13
93	1262	4.9374	1	3	4	6	9
94	12531	7.0527	2	3	5	9	14
95	1365	4.1341	1	2	3	5	8
96	60887	5.5101	2	3	5	7	10
97	25835	4.2614	2	2	4	5	7
98	19	4.4737	1	1	3	6	10
99	25241	3.4914	1	2	3	4	7
100	10191	2.4244	1	1	2	3	4
101	19810	5.1725	1	2	4	7	10
102	4399	3.1298	1	1	2	4	6
103	445	39.3528	10	15	29	53	80
104	22854	14.5510	6	8	12	18	26
105	19821	10.9286	5	7	9	13	19
106	96166	11.7202	6	8	10	14	19
107	61255	8.8314	5	6	7	10	14
108	6560	12.5834	4	7	10	15	23
110	59173	10.7795	3	6	9	13	20
111	5800	6.6512	3	5	6	8	10
112	191511	4.6987	1	2	4	6	9
113	45003	14.3320	4	6	10	17	28
114	8788	9.4467	2	4	7	12	18
115	10395	11.3715	4	6	9	14	20
116	81298	5.4177	1	2	4	7	11
117	4482	4.1142	1	1	2	5	8
118	6687	3.1952	1	1	2	4	7
119	1705	5.4985	1	1	3	7	13
120	40465	9.1860	1	2	6	12	21
121	158928	7.4120	2	4	6	9	13
122	87089	5.0036	1	3	5	6	9
123	46281	4.6510	1	1	2	6	11
124	138564	4.8885	1	2	4	6	9
125	59232	3.0694	1	1	2	4	6
126	4619	13.9985	4	7	11	17	29
127	670461	6.2113	2	3	5	8	12
128	19612	6.7259	3	4	6	8	11
129	4584	3.4271	1	1	1	4	9
130	91826	6.6818	2	4	6	8	12
131	25592	5.1808	1	3	5	7	8
132	127274	3.5716	1	2	3	4	6
133	5813	2.9696	1	1	2	4	5
134	28493	3.9142	1	2	3	5	7
135	7141	4.9779	1	2	4	6	9
136	1014	3.2209	1	2	3	4	6
138	195932	4.5466	1	2	3	6	8
139	67345	2.9337	1	1	2	4	5
140	175930	3.4831	1	2	3	4	6
141	76111	4.4923	1	2	3	5	8
142	35701	3.1999	1	2	2	4	6
143	132318	2.6077	1	1	2	3	5
144	66761	5.6816	1	2	4	7	11
145	6735	3.2413	1	1	2	4	6
146	8626	11.2570	6	7	9	13	18
147	1624	7.3651	4	6	7	9	11
148	140141	13.4097	6	8	11	16	24
149	15769	7.7194	4	6	7	9	11
150	22516	11.6884	4	7	10	14	21
151	4518	6.4748	2	4	6	8	11
152	4469	9.0257	4	6	8	10	15
153	1710	6.1655	3	4	6	8	9
154	35661	14.9524	5	8	12	18	28
155	4557	5.8824	2	3	5	8	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 12/95 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
156	4	15.7500	4	4	10	22	27
157	11419	5.7824	1	2	4	7	11
158	5082	2.9124	1	1	2	4	6
159	17132	5.3155	1	2	4	7	10
160	9971	2.9553	1	1	2	4	5
161	14786	4.3655	1	2	3	5	9
162	7990	2.1914	1	1	2	3	4
163	5	2.2000	1	1	1	3	5
164	4995	9.2993	4	6	8	11	16
165	1674	5.7575	3	4	5	7	9
166	3283	5.7286	2	3	4	7	10
167	2284	3.2439	1	2	3	4	6
168	1739	4.8562	1	2	3	6	10
169	1025	2.5473	1	1	2	3	5
170	12463	12.4436	2	5	9	15	25
171	1157	5.4105	1	2	4	7	11
172	30820	8.1481	2	3	6	10	16
173	2188	4.2870	1	2	3	5	9
174	231782	5.5456	2	3	4	7	10
175	23071	3.5073	1	2	3	4	6
176	16011	6.1346	2	3	5	7	11
177	11991	4.9873	2	3	4	6	9
178	4174	3.6195	1	2	3	5	7
179	11198	7.1657	2	4	6	9	14
180	79145	6.0471	2	3	5	7	11
181	22152	3.9606	1	2	3	5	7
182	226099	4.9591	2	2	4	6	9
183	72147	3.4552	1	2	3	4	6
184	67	3.7463	1	2	2	4	6
185	3804	5.1966	1	2	4	6	10
186	1	2.0000	2	2	2	2	2
187	832	4.2524	1	2	3	6	8
188	61112	6.1262	2	3	5	8	12
189	7787	3.6773	1	1	3	5	7
190	62	4.8548	1	3	4	6	10
191	10459	16.1606	5	8	12	20	32
192	880	7.9625	2	4	7	9	14
193	8477	13.8662	5	8	11	17	25
194	805	8.4348	3	5	7	10	15
195	9196	10.4533	4	6	9	12	18
196	796	6.7651	3	4	6	8	11
197	28016	9.1380	4	5	7	11	16
198	7906	4.9586	2	3	4	6	8
199	2208	11.1005	3	5	9	14	22
200	1525	11.8413	2	4	8	14	25
201	1466	16.5750	4	7	13	21	34
202	25094	7.6794	2	3	6	9	15
203	28743	7.6566	2	3	6	10	15
204	49035	6.6942	2	3	5	8	13
205	21512	7.2152	2	3	5	9	14
206	1692	4.7305	1	2	4	6	10
207	35330	5.7193	2	3	4	7	11
208	10251	3.4474	1	2	3	4	6
209	328015	6.6569	3	4	6	7	10
210	131592	8.5557	4	5	7	10	14
211	25325	6.2610	3	4	6	7	10
212	9	5.0000	2	3	4	5	8
213	6789	9.6170	3	4	7	12	19
214	51282	6.4551	2	3	5	8	12
215	41115	3.6816	1	2	3	5	7
216	6435	11.0449	2	5	8	14	22
217	19341	15.2991	3	6	10	18	31
218	21844	6.2064	2	3	5	7	11
219	17973	3.7492	1	2	3	5	6
220	2	5.5000	5	5	6	6	6
221	4962	8.1475	2	4	6	10	16
222	3560	4.0573	1	2	3	5	8
223	18306	2.8650	1	1	2	3	5
224	7946	2.2699	1	1	2	3	4
225	6199	5.0045	1	2	3	6	11

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 12/95 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
226	5349	6.7080	1	2	4	8	14
227	4604	2.9622	1	1	2	4	6
228	3014	3.5551	1	1	2	4	7
229	1345	2.4007	1	1	2	3	5
230	2455	5.1548	1	2	3	6	11
231	10331	5.0624	1	2	3	6	11
232	576	4.5017	1	1	2	5	10
233	4538	8.9595	2	4	7	11	18
234	2220	4.1730	1	2	3	5	8
235	5543	6.7231	1	3	4	7	13
236	37803	6.2862	2	3	5	7	12
237	1510	4.4139	1	2	3	5	8
238	7538	10.0649	3	5	7	12	19
239	59580	7.6024	2	4	6	9	14
240	12047	7.4987	2	3	5	9	15
241	3019	4.6277	1	2	4	6	9
242	2528	7.6606	2	4	6	9	15
243	79979	5.6107	2	3	4	7	10
244	11456	5.8092	2	3	4	7	11
245	4259	4.2158	1	2	3	5	8
246	1312	4.5899	1	2	4	6	9
247	10591	3.9716	1	2	3	5	8
248	6767	5.2815	1	2	4	6	10
249	10077	4.2995	1	2	3	5	9
250	3178	4.9091	1	2	3	6	9
251	2090	3.2933	1	1	3	4	6
252	1	1.0000	1	1	1	1	1
253	17469	5.8164	2	3	4	7	11
254	9208	3.8588	1	2	3	5	7
255	1	2.0000	2	2	2	2	2
256	4600	5.7178	1	2	4	7	11
257	23640	3.4239	1	2	3	4	6
258	18784	2.4905	1	2	2	3	4
259	4010	3.5077	1	1	2	3	7
260	4868	1.8683	1	1	1	2	3
261	2334	2.3500	1	1	2	3	4
262	712	3.9284	1	1	2	5	8
263	29088	13.8669	4	6	10	16	28
264	3559	8.3442	2	4	6	10	17
265	4274	7.6467	1	2	5	9	16
266	2712	3.6855	1	1	3	5	7
267	222	4.0811	1	1	3	5	9
268	891	4.0000	1	1	2	4	9
269	10174	9.1235	2	3	7	12	18
270	3456	3.3958	1	1	2	4	8
271	21515	8.4984	3	4	7	10	15
272	5863	7.4481	2	3	6	9	14
273	1426	5.5035	2	2	4	7	11
274	2526	7.7458	2	3	5	9	15
275	250	3.5040	1	1	2	4	8
276	889	5.0472	1	2	4	6	9
277	79054	6.7240	3	4	5	8	12
278	26008	5.1420	2	3	4	6	9
279	5	4.8000	2	2	3	4	12
280	13098	5.1142	1	2	4	6	9
281	5890	3.6448	1	2	3	4	7
283	5233	5.4888	2	2	4	7	10
284	1755	3.8632	1	2	3	5	7
285	4886	13.5014	3	6	10	16	26
286	1918	8.7195	3	4	6	9	16
287	6284	13.3908	3	6	9	16	26
288	957	7.0449	2	4	5	7	11
289	4992	3.9732	1	2	2	4	8
290	8514	2.8404	1	1	2	3	5
291	86	1.7558	1	1	1	2	3
292	5046	12.6958	2	5	9	16	25
293	294	6.4456	1	3	5	8	14
294	86024	5.6681	2	3	4	7	10
295	3712	4.2826	1	2	3	5	8
296	218940	6.3561	2	3	5	8	12

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 12/95 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
297	31455	4.2781	1	2	3	5	8
298	95	3.0211	1	1	2	4	5
299	868	5.3652	1	2	4	7	10
300	14115	7.3032	2	3	6	9	14
301	2146	4.3877	1	2	3	6	9
302	7567	12.3190	6	7	9	14	21
303	18462	10.1938	4	6	8	12	18
304	12867	10.2970	3	5	7	13	21
305	2526	4.9097	1	3	4	6	9
306	11305	6.2204	2	2	4	8	13
307	2596	2.9819	1	2	2	3	5
308	9137	7.0113	1	2	5	9	15
309	3371	3.0009	1	1	2	4	6
310	28549	4.6077	1	2	3	6	9
311	9697	2.1734	1	1	2	3	4
312	1995	4.7895	1	2	3	6	10
313	745	2.2644	1	1	2	3	5
314	1	5.0000	5	5	5	5	5
315	27722	9.2695	1	2	6	12	20
316	69941	7.4958	2	3	6	9	15
317	779	2.8434	1	1	2	3	6
318	5981	7.1195	2	3	5	9	14
319	506	3.2174	1	1	2	4	7
320	169078	6.4297	2	3	5	8	11
321	25512	4.7020	2	3	4	6	8
322	81	4.3580	2	2	4	6	8
323	17690	3.5573	1	2	3	4	7
324	8755	2.0870	1	1	2	3	4
325	7381	4.5898	1	2	3	5	9
326	2186	3.4492	1	1	2	4	6
327	8	3.1250	1	2	2	2	4
328	817	4.2742	1	2	3	5	9
329	109	2.7523	1	1	2	3	5
330	1	1.0000	1	1	1	1	1
331	38181	6.1753	2	3	5	8	12
332	4687	3.8835	1	2	3	5	8
333	357	5.8319	1	3	4	7	13
334	19011	6.0503	3	4	5	7	9
335	9821	4.5786	2	3	4	6	7
336	60748	4.1251	1	2	3	5	8
337	38538	2.6717	1	2	2	3	4
338	4813	5.2703	1	2	3	6	11
339	2302	4.9392	1	2	3	6	10
340	2	3.0000	1	1	5	5	5
341	6427	3.2367	1	1	2	4	6
342	224	4.0089	1	1	2	5	8
344	3820	3.4652	1	1	2	4	7
345	1355	3.9734	1	2	3	4	9
346	5344	6.7500	1	3	5	8	14
347	418	3.3349	1	1	2	4	7
348	3021	4.8875	1	2	4	6	9
349	684	2.9956	1	1	2	4	6
350	6884	4.7451	2	3	4	6	8
352	576	3.9392	1	2	3	5	8
353	2621	8.3564	3	5	6	10	15
354	9693	6.3330	3	4	5	7	11
355	5607	3.8639	2	3	4	4	6
356	28647	3.0247	1	2	3	4	5
357	6526	9.8462	4	5	8	12	18
358	26797	4.7425	2	3	4	5	8
359	27392	3.2715	2	3	3	4	5
360	16717	3.5393	1	2	3	4	6
361	618	3.4644	1	1	2	4	7
363	4355	3.4953	1	2	2	3	6
364	1778	3.6310	1	1	2	5	8
365	2396	8.1123	2	3	5	10	18
366	4471	7.6741	2	3	5	10	16
367	545	3.3266	1	1	2	4	7
368	2285	6.9190	2	3	5	9	13
369	2409	3.7410	1	1	3	5	7

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 12/95 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
370	1083	5.5568	3	3	4	5	9
371	950	3.5874	2	3	3	4	5
372	809	3.3498	1	2	2	3	6
373	3637	1.9249	1	1	2	2	3
374	116	2.3621	1	2	2	2	3
375	5	2.2000	1	1	2	3	4
376	151	3.4834	1	1	2	4	8
377	26	3.2308	1	1	1	3	8
378	163	2.9755	1	2	3	3	5
379	309	2.9256	1	1	2	3	5
380	71	2.3239	1	1	2	3	4
381	194	2.2835	1	1	1	2	5
382	47	1.6596	1	1	1	1	3
383	1455	4.0460	1	2	3	5	8
384	123	3.3496	1	1	1	3	7
385	3	17.0000	1	1	1	49	49
389	24	10.6667	3	4	8	10	18
390	10	5.0000	1	2	3	6	9
392	2467	11.6700	4	6	8	15	24
394	1642	7.8831	1	2	5	9	16
395	65671	5.3672	1	2	4	7	10
396	18	3.9444	1	1	3	7	8
397	15421	6.0683	2	3	4	7	12
398	16601	6.5794	2	3	5	8	12
399	1424	4.4347	1	2	4	6	8
400	7468	10.3293	2	4	7	13	23
401	6365	12.3829	2	5	9	16	25
402	1542	4.6984	1	1	3	6	10
403	34765	9.2628	2	4	7	12	19
404	3944	5.0822	1	2	4	7	10
406	3264	11.1468	3	5	8	14	23
407	723	4.9267	1	2	4	6	9
408	2949	8.2035	1	2	5	10	18
409	5649	6.6516	2	3	4	6	14
410	85871	3.3540	1	2	3	4	5
411	50	2.5600	1	1	2	3	7
412	35	3.0857	1	1	2	4	8
413	8422	8.2992	2	3	6	10	17
414	797	5.2070	1	2	4	7	11
415	38804	15.6974	4	7	12	19	31
416	192133	8.2122	2	4	7	10	15
417	45	4.6222	1	2	4	7	10
418	18663	6.7433	2	3	5	8	13
419	15677	5.6580	2	3	4	7	10
420	2871	4.3006	2	2	4	5	8
421	11386	4.6473	2	2	4	6	8
422	89	3.6854	1	2	3	4	7
423	9118	8.6534	2	4	6	10	18
424	1990	17.7397	3	6	12	20	34
425	15247	4.8955	1	2	3	6	10
426	4721	5.4938	1	2	4	7	11
427	1773	5.2775	1	2	4	7	11
428	904	8.4303	1	3	5	10	18
429	38861	8.9079	2	3	6	10	17
430	53430	9.7495	2	4	7	12	19
431	190	7.4632	1	3	5	9	14
432	430	6.3395	1	2	4	6	11
433	7843	3.4051	1	1	2	4	7
434	20810	5.8148	2	3	4	7	11
435	15477	4.8166	1	3	4	6	8
436	2915	14.5413	4	8	14	21	28
437	14205	10.8943	4	6	10	14	20
439	867	8.9262	2	3	6	11	18
440	4751	9.7838	2	3	6	12	21
441	611	4.4386	1	1	2	4	7
442	13818	8.7372	1	3	6	11	18
443	3299	3.5335	1	1	2	5	7
444	3319	5.3203	1	3	4	6	10
445	1321	3.7858	1	2	3	5	7
446	1	1.0000	1	1	1	1	1

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY95 MEDPAR Update 12/95 Grouper V14.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
447	3816	2.7953	1	1	2	3	5
448	84	1.0000	1	1	1	1	1
449	28775	4.4101	1	2	3	5	9
450	6807	2.3364	1	1	2	3	5
451	7	6.1429	2	3	4	5	7
452	19382	5.4066	1	2	4	6	11
453	3636	3.1876	1	1	2	4	6
454	5132	5.1046	1	2	3	6	10
455	1092	2.8333	1	1	2	3	5
456	194	8.3711	1	1	4	9	21
457	127	4.7953	1	1	2	5	10
458	1550	16.9387	4	7	13	22	35
459	533	10.3471	2	4	7	13	22
460	2303	6.6309	1	3	5	8	13
461	3040	4.8862	1	1	2	5	12
462	9360	13.7955	5	6	12	18	26
463	11987	5.1410	1	2	4	6	10
464	3079	3.7347	1	2	3	5	7
465	197	3.9086	1	1	2	4	7
466	1838	4.6366	1	1	2	4	10
467	1722	4.1057	1	1	2	4	8
468	56350	15.2546	3	7	12	19	30
471	9111	8.0289	4	5	6	9	13
472	150	30.6667	2	9	28	41	62
473	8211	14.3041	2	4	8	21	35
475	89514	12.1394	2	5	10	16	24
476	6875	13.7876	3	7	11	17	25
477	30427	9.1915	1	3	7	12	19
478	117755	8.2916	1	3	6	10	17
479	17758	4.5591	1	2	4	6	9
480	359	29.7159	10	13	22	37	61
481	177	32.0678	19	22	28	35	52
482	6754	14.9011	5	8	11	17	28
483	36200	45.7958	15	23	37	56	84
484	327	15.3364	2	6	11	21	32
485	3165	11.5893	4	6	9	13	21
486	2045	13.3482	1	6	11	18	28
487	3765	8.8770	1	3	7	11	17
488	1593	17.5267	5	8	13	22	35
489	17612	10.3989	2	4	7	13	22
490	4999	6.5719	1	2	4	8	14
491	9441	4.2777	2	3	3	5	7
492	2029	17.3834	3	5	10	28	37
493	52260	5.8809	1	2	5	8	11
494	27127	2.4245	1	1	2	3	5
495	107	23.7944	10	13	18	29	41
	10571233						

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) APRIL 1996

State	Urban	Rural
ALABAMA	0.421	0.476
ALASKA	0.505	0.795
ARIZONA	0.426	0.567
ARKANSAS	0.539	0.501
CALIFORNIA	0.408	0.544
COLORADO	0.509	0.595
CONNECTICUT	0.553	0.551
DELAWARE	0.533	0.523
DISTRICT OF COLUMBIA	0.525	.....
FLORIDA	0.414	0.414
GEORGIA	0.527	0.532
HAWAII	0.484	0.567

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) APRIL 1996—Continued

State	Urban	Rural
IDAHO	0.563	0.639
ILLINOIS	0.490	0.588
INDIANA	0.565	0.628
IOWA	0.546	0.685
KANSAS	0.457	0.651
KENTUCKY	0.507	0.562
LOUISIANA	0.478	0.538
MAINE	0.589	0.590
MARYLAND	0.765	0.816
MASSACHUSETTS	0.579	0.600
MICHIGAN	0.514	0.619

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) APRIL 1996—Continued

State	Urban	Rural
MINNESOTA	0.565	0.655
MISSISSIPPI	0.524	0.527
MISSOURI	0.460	0.532
MONTANA	0.513	0.622
NEBRASKA	0.526	0.696
NEVADA	0.322	0.550
NEW HAMPSHIRE	0.597	0.615
NEW JERSEY	0.479	.....
NEW MEXICO	0.484	0.546
NEW YORK	0.595	0.684
NORTH CAROLINA	0.546	0.501

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) APRIL 1996—Continued

State	Urban	Rural
NORTH DAKOTA	0.651	0.693
OHIO	0.567	0.606
OKLAHOMA	0.494	0.572
OREGON	0.573	0.649
PENNSYLVANIA	0.437	0.585
PUERTO RICO	0.495	0.642
RHODE ISLAND	0.587	.....
SOUTH CAROLINA	0.476	0.497
SOUTH DAKOTA	0.571	0.629
TENNESSEE	0.534	0.577
TEXAS	0.463	0.565
UTAH	0.578	0.665
VERMONT	0.638	0.596
VIRGINIA	0.499	0.538
WASHINGTON	0.636	0.686
WEST VIRGINIA	0.579	0.541
WISCONSIN	0.607	0.686
WYOMING	0.495	0.735

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) APRIL 1996

State	Ratio
ALABAMA	0.055
ALASKA	0.077
ARIZONA	0.051
ARKANSAS	0.055
CALIFORNIA	0.040
COLORADO	0.053
CONNECTICUT	0.037
DELAWARE	0.054
DISTRICT OF COLUMBIA	0.042
FLORIDA	0.051
GEORGIA	0.052
HAWAII	0.051
IDAHO	0.067
ILLINOIS	0.045
INDIANA	0.059
IOWA	0.062
KANSAS	0.055
KENTUCKY	0.056
LOUISIANA	0.069
MAINE	0.045
MARYLAND	0.013
MASSACHUSETTS	0.060
MICHIGAN	0.053
MINNESOTA	0.055
MISSISSIPPI	0.056
MISSOURI	0.053
MONTANA	0.064
NEBRASKA	0.058
NEVADA	0.034
NEW HAMPSHIRE	0.065
NEW JERSEY	0.045
NEW MEXICO	0.055
NEW YORK	0.059
NORTH CAROLINA	0.050
NORTH DAKOTA	0.074
OHIO	0.056
OKLAHOMA	0.058
OREGON	0.051
PENNSYLVANIA	0.045
PUERTO RICO	0.078
RHODE ISLAND	0.039

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) APRIL 1996—Continued

State	Ratio
SOUTH CAROLINA	0.053
SOUTH DAKOTA	0.064
TENNESSEE	0.057
TEXAS	0.055
UTAH	0.055
VERMONT	0.050
VIRGINIA	0.058
WASHINGTON	0.063
WEST VIRGINIA	0.060
WISCONSIN	0.048
WYOMING	0.067

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 the Secretary certifies 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 Social Security Act (the Act) requires the Secretary to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Public Law 98-21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the 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.

II. Objectives

The primary objective of the 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 deficit reduction and restraints on government spending in general.

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, in general, reasonable and equitable while avoiding or minimizing unintended adverse consequences.

III. Limitations of Our Analysis

As has been the case in 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 1997, 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 46 Indian Health Service hospitals in our data base, 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 April 1996, we have included 5,130 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 proposed policy changes on these hospitals are discussed below.

V. Impact on Excluded Hospitals and Units

As of April 1996, there were 1,141 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. In addition, there were 2,258 psychiatric and rehabilitation units in hospitals otherwise subject to the prospective payment system. These excluded units are also paid in accordance with § 413.40.

In accordance with section 1886(b)(3)(B)(ii)(V) of the Act, the update factor applicable to the rate-of-increase limit for excluded hospitals and units for FY 1997 would be 1.7 percent (excluded hospital market basket minus 1.0 percentage points), adjusted to account for the relationship between the hospital's allowable operating cost per case and its target amounts.

The impact on excluded hospitals and units of the proposed update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital and excluded 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 limit, the major effect will be the amount of excess costs that the hospitals would have to absorb.

In this context, we note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed the rate-of-increase limit is allowed to receive the lower of its rate-of-increase ceiling plus 50 percent of reasonable costs in excess of the ceiling, or 110 percent of its ceiling. In addition, under the various provisions set forth in § 413.40, excluded hospitals and units can obtain payment adjustments for significant, 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 have prepared separate analyses of the proposed changes to each system, beginning with changes to the operating prospective payment system.

The data used in developing the quantitative analyses presented below are taken from the FY 1995 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 create some of the variables by which hospitals are categorized. 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 1995 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 1997 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 diagnosis-related group (DRG) relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of changes in hospitals' wage index values reflecting the wage index update (FY 1993 data).
- The effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB) that will be effective in FY 1997.
- The effects of phasing out payments for extraordinarily lengthy cases (day outlier cases) with a corresponding increase in payments for extraordinarily costly cases (cost outliers), in accordance with section 1886(d)(5)(A)(v) of the Act.
- The total change in payments based on FY 1997 policies relative to payments based on FY 1996 policies.

To illustrate the impacts of the FY 1997 proposed changes, our analysis begins with an FY 1997 baseline simulation model using: the FY 1996 GROUPER (version 13.0); the FY 1996 wage indexes; no MGCRB reclassifications; and current outlier policy (50 percent phase out of day outlier payments). Outlier payments are assumed to be 5.1 percent of total DRG payments.

Each policy change is then added incrementally to this baseline model, finally arriving at an FY 1997 model incorporating all of the proposed changes. This allows us to isolate the effects of each proposed change.

Our final comparison illustrates the percent change in payments per case from FY 1996 to FY 1997. Four factors not displayed in the previous five columns have significant impacts here. 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 1997 using the most recently forecasted hospital market basket increase for FY 1997 of 2.7 percent, minus 0.5 percentage points. Thus, the update to the large urban and other areas standardized amounts is 2.2 percent. 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) and essential access community hospitals (EACHs) (which are treated as SCHs for

payment purposes) is also the market basket increase minus 0.5 percent, or 2.2 percent.

A second significant factor impacting changes in hospitals' payments per case from FY 1996 to FY 1997 is a change in MGCRB reclassification status from one year to the next. That is, hospitals reclassified in FY 1996 that are no longer reclassified in FY 1997 may have a negative payment impact going from FY 1996 to FY 1997; conversely, hospitals not reclassified in FY 1996 that are reclassified in FY 1997 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 1996 will be 4.2 percent of actual total DRG payments. When the FY 1996 final rule was published, we projected FY 1996 outlier payments would be 5.1 percent of total DRG payments, and the standardized amounts were reduced correspondingly. The effects of the lower than expected outlier payments during FY 1996 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 1996 payments per case to estimated FY 1997 payments per case.

Finally, the regional floor provision (section 1886(d)(1)(A)(iii)(II) of the Act) expires effective with discharges occurring on or after October 1, 1996. Under this provision (applicable during FY 1996), hospitals within any census division having a regional standardized amount greater than the national standardized amount (large urban or other, depending on which amount was applicable) received a blend of 85 percent of the national amount and 15 percent of the regional amount. Hospitals in census divisions where the regional floor was applicable during FY 1996 will be negatively impacted by its expiration when comparing FY 1996 to FY 1997.

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 5,130 hospitals included in the analysis. This is 77 fewer hospitals than were included in the impact analysis in the FY 1996 final rule (60 FR 45924). Data for 107 hospitals that were included in last year's analysis were not available for analysis this year; however, data were available this year for 30 hospitals for which data were not available last year.

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 2,878 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,597 hospitals located in large urban areas (populations over 1 million), and 1,281 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,252 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 1997 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 the numbers of hospitals being paid based on these categorizations (after consideration of geographic reclassifications), are 2,978, 1,793, 1,185, and 2,152, 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 indirect medical education (IME) adjustment), receive disproportionate share (DSH) payments, or some combination of these two adjustments. There are 4,057 nonteaching hospitals in our analysis, 841 teaching hospitals with fewer than 100 residents, and 232 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. (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 four rows examine the impacts of the proposed changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and EACHs), as well as rural hospitals not receiving a special payment designation. Rural hospitals reclassified for FY 1997 for purposes of the standardized amount are not included here.

The RRCs (90), SCH/EACHs (641), and SCH/EACH and RRCs (39) shown here were not reclassified for purposes of the standardized amount. There are four EACHs included in our analysis and five EACH/RRCs.

There are two RRCs and three SCHs that will be reclassified for the standardized amount in FY 1997 that, therefore, are not included in these rows. There are significantly fewer reclassifications among these groups than there were in FY 1996, owing to the new criterion under § 412.230(a)(5)(ii) that a hospital may not be reclassified for purposes of the standardized amount if the area to which the hospital seeks reclassification does not have a higher standardized amount than that currently received by the hospital. (See the September 1, 1995 final rule (60 FR 45799).) Before this change (effective with reclassifications for FY 1997), some rural hospitals reclassified to other urban areas in order to qualify for urban DSH payments. For other rural hospitals that already qualified for DSH payments, the urban designation enabled them to qualify for a higher DSH adjustment than they would receive as a rural hospital.

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 1994 Medicare cost report files, if available (otherwise FY 1993 data are used). Data needed to calculate Medicare utilization percentages were unavailable for 131 hospitals. For the most part, these are either new hospitals or hospitals filing manual cost reports that are not yet entered into the data base.

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 either FY 1996 or FY 1997, or for both years, by urban/rural status. The next rows illustrate the overall number of FY 1997 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 1997 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent changes in payments per case]

	Number of hosps.[1] (0)	DRG re-calibration[2] (1)	New wage data[3] (2)	MGCRB re-classification[4] (3)	Day outlier policy changes[5] (4)	All FY 97 changes[6] (5)
(By Geographic Location)						
All hospitals	5,130	0.1	−0.1	0.0	0.0	3.1
Urban hospitals	2,878	0.1	0.0	−0.4	−0.1	3.2
Large urban	1,597	0.1	0.0	−0.5	−0.2	3.1
Other urban	1,281	0.1	−0.1	−0.2	0.1	3.3
Rural hospitals	2,252	0.0	−0.1	2.3	0.1	2.7
Bed size (urban):						
0–99 beds	716	0.0	−0.3	−0.5	0.2	3.0
100–199 beds	938	0.0	−0.2	−0.4	0.1	2.9
200–299 beds	577	0.1	−0.1	−0.4	0.0	3.1
300–499 beds	479	0.1	0.0	−0.4	−0.1	3.4
500 or more beds	168	0.1	0.1	−0.2	−0.4	3.4
Bed size (rural):						
0–49 beds	1,173	−0.1	0.0	0.0	0.1	2.8
50–99 beds	663	−0.1	−0.1	1.1	0.2	2.8
100–149 beds	241	0.0	−0.1	3.1	0.2	2.9
150–199 beds	99	0.0	−0.1	2.8	0.1	2.8
200 or more beds	76	0.1	−0.2	4.9	0.1	2.2
Urban by census division:						
New England	160	0.1	0.0	−0.1	−0.1	2.4
Middle Atlantic	434	0.1	0.6	−0.3	−1.1	3.5
South Atlantic	419	0.1	−0.2	−0.5	0.1	3.3
East North Central	483	0.1	0.3	−0.2	0.2	2.9
East South Central	163	0.1	−0.3	−0.5	0.2	3.4
West North Central	193	0.1	−0.4	−0.5	0.3	3.4
West South Central	375	0.1	−0.4	−0.5	0.4	3.6
Mountain	125	0.2	−0.4	−0.4	0.3	3.3
Pacific	478	0.1	−0.5	−0.4	0.2	2.9
Puerto Rico	48	−0.1	−0.7	−0.5	0.0	2.6
Rural by census division:						
New England	53	0.1	−1.0	2.0	0.3	2.1
Middle Atlantic	85	0.1	−0.5	0.8	−0.2	1.9
South Atlantic	297	0.0	−0.5	3.1	0.1	2.6
East North Central	304	0.1	0.2	2.1	0.2	2.9
East South Central	278	−0.1	0.2	2.5	0.2	2.2
West North Central	525	0.0	−0.1	2.1	0.2	2.8
West South Central	351	−0.1	0.2	3.1	0.2	3.2
Mountain	213	0.1	−0.2	0.8	0.1	3.0
Pacific	141	0.1	0.5	2.4	0.2	4.0
Puerto Rico	5	−0.2	−2.1	2.7	−0.1	3.8
(by payment categories)						
Urban hospitals	2,978	0.1	0.0	−0.3	−0.1	3.2
Large urban	1,793	0.1	0.0	−0.2	−0.2	3.2
Other urban	1,185	0.1	−0.1	−0.4	0.1	3.3
Rural hospitals	2,152	0.0	−0.1	1.9	0.1	2.6
Teaching status:						
Non-teaching	4,057	0.0	−0.2	0.3	0.2	3.1
Less than 100 res.	841	0.1	0.0	−0.4	0.0	3.2
100+ residents	232	0.1	0.2	−0.1	−0.5	3.2
Disproportionate Share Hospitals (DSH)						
Non-DSH	3,200	0.1	−0.2	0.2	0.1	3.2
Urban DSH:						
100 beds or more	1,410	0.0	0.0	−0.3	−0.2	3.2
Fewer than 100 beds	111	−0.3	−0.4	−0.5	0.3	2.5
Rural DSH:						
Sole community (SCH)	146	−0.1	−0.1	0.2	0.0	3.3
Referral centers (RRC)	25	0.0	−0.1	3.9	−0.1	3.7
Over 65	1,353	0.0	−0.1	0.1	0.1	3.1
Unknown	131	−0.1	0.9	−0.4	−1.4	3.1
Hospitals Reclassified by the Medicare Geographic Review Board						
Reclassification status during FY96 and FY97						
Reclassified during both FY96 and FY97	381	0.1	0.1	5.9	0.0	3.1

TABLE I.—IMPACT ANALYSIS OF CHANGES FOR FY 1997 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case]

	Number of hosps.[1] (0)	DRG recalibration[2] (1)	New wage data[3] (2)	MGCRB reclassification[4] (3)	Day outlier policy changes[5] (4)	All FY 97 changes[6] (5)
Urban	133	0.1	0.3	3.6	−0.2	3.4
Rural	248	0.0	−0.2	9.1	0.1	2.8
Reclassified during FY97 only	103	0.1	0.3	3.5	−0.4	8.6
Urban	34	0.2	0.4	2.4	−0.5	8.0
Rural	69	0.0	−0.2	7.1	0.1	10.5
Reclassified during FY96 only	251	0.1	−0.6	−1.3	0.1	−0.5
Urban	88	0.1	−0.9	−2.0	0.0	0.8
Rural	163	0.0	−0.2	−0.4	0.2	−2.1
FY 97 Reclassifications:						
All reclassified hosp.	484	0.1	0.1	5.3	−0.1	4.3
Stand. amount only	120	0.1	0.0	1.7	0.1	3.1
Wage index only	274	0.1	−0.3	8.1	−0.1	3.9
Both	90	0.1	0.8	4.4	−0.2	5.9
Nonreclassified	4,619	0.1	−0.1	−0.6	0.0	3.0
All urban reclass.	167	0.1	0.3	3.3	−0.3	4.6
Stand. amount only	63	0.1	0.1	0.9	0.0	3.3
Wage index only	30	0.2	−0.6	6.7	−0.6	4.5
Both	74	0.1	0.9	3.1	−0.2	5.6
Nonreclassified	2,711	0.1	−0.1	−0.6	−0.1	3.1
All rural reclass.	317	0.0	−0.2	8.8	0.1	3.8
Stand. amount only	57	0.0	−0.3	4.6	0.3	2.7
Wage index only	244	0.0	−0.1	8.8	0.1	3.6
Both	16	0.1	−0.4	18.8	0.2	9.1
Nonreclassified	1,908	0.0	−0.1	−0.4	0.1	2.2
Other reclassifed:						
Hospitals (section 1886(d)(8)(B))	27	0.1	−0.1	0.8	0.2	3.1

[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 1995, and hospital cost report data are from reporting periods beginning in FY 1993 and FY 1994.

[2] This column displays the payment impacts of the recalibration of the DRG weights, based on FY 1995 MedPAR data and the DRG classification 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 1993 cost reports. The percentage changes displayed here reflect the impacts of the wage and recalibration budget neutrality factor (0.998509).

[4] Shown here are the combined effects of geographic reclassification by the Medicare Geographic Classification Review Board (MGCRB). The effects shown here demonstrate the FY 1997 payment impacts of going from no reclassifications to the reclassifications scheduled to be in effect for FY 1997. Reclassification for prior years has no bearing on the payment impacts shown here.

[5] This column illustrates the payment impacts of changes in outlier payments, in accordance with section 1886(d)(5) of the Act.

[6] This column shows changes in payments from FY 1996 to FY 1997. It incorporates all of the changes displayed in columns 1 through 5. It also displays the impacts of the updates to the FY 1997 standardized amounts, changes in hospitals' reclassification status in FY 1997 compared to FY 1996, the expiration of the regional floor provision at section 1886(d)(1)(A)(iii)(II) of the Act, and the difference in outlier payments from FY 1996 to FY 1997. The sum of the first five columns plus these effects may be different from the percentage changes shown here due to changes in hospitals' geographic reclassification status from FY 1996 to FY 1997, rounding errors and interactive effects.

B. The Impact of the Proposed Changes to the DRG Classifications and 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 each year to 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.

The impact of 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) specifies that any updates or adjustments to the wage index are budget neutral. As pointed out in the Addendum to this proposed rule, we compared aggregate payments using the FY 1996 DRG relative weights and the wage index effective October 1, 1995 to aggregate payments using the proposed FY 1997 DRG relative weights and wage index. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 0.998509. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index (the All Hospitals row of columns 1 and 2) demonstrate that the net effect of these changes are budget neutral. That is, the 0.1 percent increase for all hospitals due to the DRG changes is negated by the 0.1 percent decrease for all hospitals with the new wage data.

Consistent with the minor changes we are proposing for the FY 1997 GROUPER, the redistributional impacts across hospital groups are very small (an increase of 0.1 for large and other urban hospitals). Among other hospital categories, the net effects are slightly negative changes for small (up to 99 beds) rural hospitals and slightly positive changes for larger (over 200 beds) rural and urban hospitals.

The largest single effect on any of the hospital categories examined is a 0.3 percent decrease in payments for smaller (100 or fewer beds) urban and rural hospitals that receive DSH payments. We note that the only other hospital category to experience a

decrease of more than 0.1 percent is rural hospitals in Puerto Rico.

We attribute these negative changes to the increasing gap between the relative weights for medical, diagnostic, and less complicated surgical DRGs and the weights for the more complicated surgical DRGs. Since the cases associated with the former DRGs tend to be treated more often in smaller hospitals with fewer resources available, lowering the relative weights associated with those cases would disproportionately affect these hospitals. In general, small hospitals that serve a disproportionate share of low-income patients and hospitals in rural Puerto Rico fit this definition. We note, however, that these negative impacts are relatively minor and do not result solely from the limited DRG revisions we are proposing for FY 1997.

C. The 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 1997 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1992 and before October 1, 1993. 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 1996 wage index before geographic reclassifications based on FY 1992 wage data to a model using the FY 1997 prereclassification wage index based on FY 1993 wage data.

As noted above, to comply with the requirements that the DRG and wage index changes be implemented in a budget neutral manner, we compute a budget neutrality adjustment factor to apply to the standardized amounts. The 0.1 percent decrease for all hospitals in this column reflects the wage and recalibration budget neutrality factor of 0.998509. This decrease, combined with the 0.1 percent increase for all hospitals in column 1, demonstrates that the net effect on aggregate payments of the proposed DRG and wage index changes are budget neutral.

The results indicate that the new wage data do not have a significant overall impact on hospital payments. (It should be noted that the percentage changes attributed here to the new wage data are generally reduced by 0.2 percentage points due to the budget neutrality factor.) Thus, hospitals with significant changes in their wage indexes are not concentrated within any particular hospital group. Some of the largest changes are found among both urban and rural hospitals grouped by census division. In almost all cases, payments change by less than 1 percent. Our review of the wage data (as described below) indicates that these changes were attributable to improved reporting, as well as relative changes in labor costs.

In the 50 States and the District of Columbia, among the urban hospitals, the largest increase (0.6 percent) is in the Middle Atlantic census division. Significantly, New York City's wage index rises by over 1.6 percent (this also contributes to the 0.2 percent increase among major teaching hospitals and the 0.9 percent increase in the Unknown category under the Medicare Utilization rows). Last year, the Middle Atlantic experienced one of the largest decreases (0.6 percent), which contributed to the 0.4 percent decline among major teaching hospitals—New York City's wage index fell by nearly 2.0 percent in FY 1996 (60 FR 45929). The largest decrease among urban hospitals occurs in the Pacific census division, with a decline of 0.5 percent.

Among the rural hospitals, the largest increase (0.5 percent) is in the Pacific census division; the largest decrease (1.0 percent) is in the New England census division. This decrease is primarily due to a 2.5 percent decrease in the wage index for rural Connecticut hospitals and a 2.4 percent decrease in the wage index for rural New Hampshire hospitals. The Pacific rural hospitals also experienced one of the greatest increases (0.6 percent) among rural hospitals last year.

In Puerto Rico, payments decline by 2.1 percent for the five rural hospitals and by 0.7 percent for the urban hospitals. The average hourly wages reported in FY 1993 by two rural Puerto Rico hospitals fell from those reported in FY 1992 by 22.4 percent and 18.1 percent, leading to the 2.1 percent overall decline. Of the six urban areas in Puerto Rico, two experience increases in wage index values while four experience decreases. Among these four, three experience a decline of more than 5 percent. These MSAs have relatively few hospitals (two, five, and seven hospitals). The decreases appear to be the result of one or two hospitals in each area with a decrease of more than 5 percent in average hourly wages.

The proposed FY 1997 wage index represents the fourth annual update to the wage data, and will continue to include salaries, fringe benefits, home office salaries, and certain contract labor costs. In the past, updates to the wage data have resulted in significant payment shifts among hospitals. Since the wage index is now updated annually, we expect these payment fluctuations will decrease.

This expectation is borne out by comparing the proposed FY 1997 wage index (after reclassifications under sections 1886(d)(8)(B) and 1886(d)(10) of the Act) to the FY 1996 wage index. The following chart compares the shifts in wage index values (after reclassifications) for labor markets for FY 1997 with those from FY 1996. The majority of labor market areas (339) experience less than a 5 percent change. Only 25 labor market areas experience a change between 5 and 10 percent; 13 of those experience increases. Still fewer labor markets experience a change of more than 10 percent; two experience increases and two experience decreases. For FY 1996, by comparison, 10 labor market areas experienced an increase in their wage index value of more than 10 percent. We reviewed the data for any area that experienced a wage index change of 10 percent or more to determine the reason for the fluctuation.

Percentage change in area wage index values	Number of labor market areas	
	FY 1997	FY 1996
Increase more than 10 percent	2	10
Increase between 5 and 10 percent, (inclusive)	13	21
Increase/decrease below 5 percent	339	331
Decrease between 5 and 10 percent, (inclusive)	12	6
Decrease more than 10 percent	2	0

Under the proposed FY 1997 wage index, 96.2 percent of urban hospitals and 92.7 percent of rural hospitals would experience a change in their wage index of less than 5 percent. Approximately 5.9 percent (3.1 percent of urban hospitals and 2.8 percent of rural hospitals) would experience a change of between 5 and 10 percent, and 5.3 percent (0.8 percent of urban hospitals and 4.5 percent of rural hospitals) would experience a change of more than 10 percent. The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Percent of hospitals (by Urban/Rural)	
	Urban	Rural
Increase more than 10 percent	0.4	2.5
Increase between 5 and 10 percent (inclusive)	1.5	0.9
Increase or decrease less than 5 percent	96.2	2.7
Decrease between 5 and 10 percent (inclusive)	1.6	1.9
Decrease more than 10 percent	0.4	2.0

ANote: The sum of the columns may not total to 100 due to rounding.

D. The Impact of MGCRB Reclassifications (Column 3)

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 RRCs and hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 3 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 1997. 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 also qualify to be treated as urban for purposes of the DSH adjustment.

By March 30 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. The MGCRB may reclassify a hospital for the purpose of using the other area's standardized amount, wage index value, or both. (RRCs and SCHs are exempt from the proximity requirement.) Effective FY 1997, rural hospitals can no longer be reclassified to an other urban area for purposes of the standardized amount under section 1886(d)(10) of the Act.

The proposed FY 1997 wage index values incorporate all of the MGCRB's reclassification decisions for FY 1997. The wage index values also reflect any decisions made by the HCFA Administrator through the appeals and review process for MGCRB decisions as of March 29, 1996. 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 1997.

The overall effect of geographic reclassification is required to be budget neutral by section 1886(d)(8)(D) of the Act. Therefore, we applied an adjustment of 0.994059 to ensure that the effects of reclassification are budget neutral. (See section II.A.4 of the Addendum to this proposed rule).

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.3 percent, while payments to urban hospitals decline 0.4 percent. Large urban hospitals lose 0.5 percent because, as a group, they have the smallest percentage of hospitals that are reclassified (fewer than 3 percent of large urban hospitals are reclassified). There are enough hospitals in other urban areas that are reclassified to limit the decrease in payments to urban hospitals stemming from the budget neutrality offset to 0.2 percent. Among urban hospital groups generally (that is, bed size, census division, and special payment status), payments fall between 0.2 and 0.5 percent.

A positive impact is evident among all rural hospital groups except rural hospitals with up to 49 beds, which experience a 0.0 percent impact. The smallest effect among all rural census divisions is 0.8 percent for the Middle Atlantic and Mountain divisions. These divisions have relatively fewer MGCRB reclassifications. Among urban census divisions, New England displays the smallest negative impact, 0.1 percent.

Among rural hospitals designated as RRCs, 50 hospitals are reclassified for purposes of the wage index only and experience a 9.5 percent increase in payments overall. This positive impact on RRCs is also reflected in the category of rural hospitals with 200 or more beds, which have a 4.9 percent increase in payments.

Rural hospitals reclassified for FY 1996 and FY 1997 experience a 9.1 percent increase in payments, the greatest of any group in the category. 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 1997 only experience a 7.1 percent increase in payments while rural hospitals reclassified for FY 1996 only experience a 0.4 decrease in payments. This is due to the budget neutrality adjustment, since the changes in this column reflect FY 1997 payments relative to no reclassifications, rather than to FY 1996 reclassifications. Urban hospitals reclassified for FY 1996 but not FY 1997 experience a 2.0 percent decline in payments overall. This appears to be due to the combined impacts of the budget neutrality adjustment and a number of hospitals in this category that experience a 6 percent drop in their wage index after reclassification. Urban hospitals reclassified for FY 1997 but not for FY 1996 experience a 2.4 percent increase in payments.

The FY 1997 Reclassification rows of Table I show the changes in payments per case for all FY 1997 reclassified and nonreclassified hospitals in urban and rural locations for each of the three reclassification categories (standardized amount only, wage index only, or both). The table illustrates that the largest impact for reclassified rural hospitals is for those hospitals reclassified for both the standardized amount and the wage index. These hospitals receive an 18.8 percent increase in payments. The number of hospitals in this category has declined from 42 in FY 1996 to 16 in FY 1997. In addition, rural hospitals reclassified for the wage index receive an 8.8 percent payment increase. The overall impact on reclassified hospitals is to increase their payments per case by an average of 5.3 percent for FY 1997.

Among the 27 rural hospitals deemed to be urban under section 1886(d)(8)(B) of the Act, payments increase 0.8 percent due to MGCRB reclassification. This is because, although these hospitals are treated as being attached to an urban area in our baseline (their redesignation is ongoing, rather than annual like the MGCRB reclassifications), they are eligible for MGCRB reclassification. For FY 1997, one hospital in this category reclassified to a large urban area, resulting in a net increase due to reclassifications of 0.8 percent.

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 0.6 percent, which corresponds closely with the geographic reclassification budget neutrality factor. Rural nonreclassified hospitals decrease slightly less, experiencing a 0.4 percent decrease. This occurs because the wage index values in some rural areas increase after reclassified hospitals are excluded from the calculation of those index values.

The number of reclassifications for purposes of the standardized amount, or for both the standardized amount and the wage index, has declined from 358 in FY 1996 to 210 in FY 1997. This is not surprising because of the elimination of standardized amount

reclassifications from rural to other urban areas for individual hospitals. Individual rural hospitals can continue to reclassify to large urban areas for purposes of the standardized amount. The number of wage index only reclassifications increased slightly from 260 in FY 1996 to 274 in FY 1997.

The foregoing analysis was based on MGCRB and HCFA Administrator decisions made by March 29 of this year. 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.

E. Outlier Changes (Column 4)

Medicare provides extra payment in addition to the basic DRG payment amount for extremely costly or extraordinarily lengthy cases (cost outliers and day outliers, respectively). Section 1886(d)(5)(A)(v) of the Act requires the Secretary to phase out payment for day outliers from FY 1994 day outlier levels in 25 percent increments beginning in FY 1995. Day outliers in FY 1997 should account for approximately 8 percent of total outlier payments (25 percent of FY 1994 levels). This reduction in day outlier payments will be offset by an increase in cost outlier payments.

As discussed in the Addendum, for FY 1997, we are proposing a day outlier threshold equal to the geometric mean length of stay for each DRG plus the lesser of 24 days or 3.0 standard deviations. The proposed marginal cost factor for day outliers is 35 percent. For FY 1997, we are proposing that a case would receive cost outlier payments if its costs exceed the DRG amount plus $11,050. We are also proposing to maintain the marginal cost factor for cost outliers at 80 percent.

The payment impacts of these changes are minimal. Hospital categories negatively affected by phasing out day outliers are consistent with the categories negatively affected in previous years: urban New England (0.1 percent decline); urban and rural Middle Atlantic census divisions (1.1 percent and 0.2 percent declines, respectively); urban hospitals with 500 or more beds (0.4 percent decline); teaching hospitals with 100 or more residents (0.5 percent decline); and hospitals for which data were unavailable to calculate Medicare utilization rates (1.4 percent decline). As noted in the wage index discussion previously, this last category contains a number of New York City hospitals. Because the changes to outlier policy result in a shift in payments from cases paid as day outliers to cases paid as cost outliers, this indicates that these categories have higher percentages of day outliers. The largest positive impact is among urban hospitals in the West South Central census division (0.4 percent increase).

F. All Changes (Column 5)

Column 5 compares our estimate of payments per case incorporating all of our proposed changes for FY 1997 to our estimate of payments per case in FY 1996. It also includes the effects of the 2.2 percent update to the standardized amounts and the hospital-specific rates for SCHs and EACHs, and the 0.9 percentage point difference between the percentage of projected outlier payments in FY 1997 (5.1 percent) and the current estimate of the percentage of actual outlier payments in FY 1996 (4.2 percent), as described in the introduction to this Appendix and the Addendum.

We also note that column 5 includes the impacts of FY 1997 MGCRB reclassifications compared to the payment impacts of FY 1996 reclassifications. Therefore, when comparing FY 1997 payments to FY 1996, the percent changes due to FY 1997 reclassifications shown in column 3 need to be offset by the effects of reclassification on hospitals' FY 1996 payments (column 4 of Table 1, September 1, 1995 final rule; 60 FR 45926). That is, column 3 of Table 1 shows the impacts of going from no MGCRB reclassifications to the FY 1997 reclassifications. When comparing FY 1996 and FY 1997 payments, hospitals similarly reclassified during FY 1996 would not experience the full extent of the change shown in column 3. For example, the impact of MGCRB reclassifications on rural hospitals' FY 1996 payments was approximately a 2.3 percent increase, equal to the 2.3 percent increase for FY 1997. Therefore, the net increase in FY 1997 payments due to reclassification for rural hospitals is 0 percent.

In addition, eliminating the regional floor provision effective for discharges occurring on or after October 1, 1996, results in approximately a 0.2 percent lower average payment in FY 1997 than would occur otherwise. Of course, this effect is attributable to particular census divisions, as discussed below.

Finally, the FY 1996 standardized amounts were adjusted by a budget neutrality factor of 0.997575, in accordance with section 1886(d)(5)(I) of the Act, so that the change to the transfer payment methodology we implemented last year (doubling the per diem payment for the first day of a transfer) would not affect aggregate payments. As we indicated in last year's final rule (60 FR 45854), this adjustment was applied on a one-time basis to the FY 1996 standardized amounts. After FY 1996, there will be no need for a further budget neutrality adjustment unless or until we make further changes to the transfer payment methodology. As a result, the FY 1997 standardized amounts are relatively higher (0.2 percent).

A single geographic reclassification budget neutrality factor of 0.994059 was applied to the proposed FY 1997 standardized amounts, compared to the FY 1996 factor of 0.994011. The budget neutrality adjustment factor for the updated wage index and the DRG recalibration is 0.998509, compared to the FY 1996 factor of 0.999306. Although the net effect of these changes is small, they are reflected in the payment differences shown in this column.

There may 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 5 may not equal the sum of the previous columns plus the other impacts that we are able to identify.

The overall payment increase from FY 1997 to FY 1996 for all hospitals is a 3.1 percent increase. This reflects the 0.0 percent net change in total payments due to the proposed changes for FY 1997 shown in columns 1 through 4, the 2.2 percent update for FY 1997, and the 0.9 percent higher outlier payments in FY 1997 compared to FY 1996, as discussed above.

Hospitals in urban areas experience a 3.2 percent rise in payments per case over FY 1996. Similar to all hospitals nationally, this is primarily due to the factors discussed above: the 2.2 percent update; a 0.9 percent higher level of outlier payments estimated for FY 1997; and the offsetting effects of eliminating the regional floor and the FY 1996 transfer budget neutrality factor. Urban hospitals benefit 0.1 percent from DRG recalibration, while losing 0.1 percent due to the phase out of the day outlier policy. Their 0.4 negative impact in FY 1997 due to reclassification is offset by a similar impact from FY 1996 reclassifications.

Hospitals in large and other urban areas experience 3.1 percent and 3.3 percent increases, respectively. The lower increase for hospitals in large urban areas appears to be attributable primarily to the 0.2 percent negative impact of the continuing phase out of day outliers.

Hospitals in rural areas experience a 2.7 percent increase. Their FY 1997 payments are estimated to be 0.6 percent higher than for FY 1996 due to higher outlier payments. Like urban hospitals, the impact of geographic reclassification in FY 1997 is offset by an identical 2.3 percent increase in FY 1996.

Among urban bed size groups, column 5 shows changes in payments are higher for the largest urban hospitals compared to smaller urban hospitals. The relatively smaller increases for the smaller urban hospitals appear to be due to the negative impacts of the new wage data, as shown in column 2. Among rural bed size groups, the impacts range from 2.8 percent to 2.9 percent, with the exception of rural hospitals with 200 or more beds. Payments per case for this group of hospitals is estimated to increase 2.2 percent during FY 1997. This below average rate of increase appears to be attributable primarily to a smaller, though still significant, impact of MGCRB reclassifications during FY 1997 compared to FY 1996. In column 3 the FY 1997 impact of reclassification is shown to be 4.9 percent. For FY 1996, however, this impact was 5.4 percent. Thus, the rate of increase is 0.5 percent less for FY 1997 due to a smaller reclassification impact.

As discussed previously, effective for discharges on or after October 1, 1996, the regional floor, which benefitted certain census divisions, expires. The regional floor provided that, in those census divisions where the regional standardized amount exceeded the national standardized amount, hospitals would be paid a blend of 85 percent of the national amount and 15 percent of the regional amount. The census divisions affected by the regional floor during FY 1996 are New England and East North Central. In New England, the impacts of eliminating the regional floor are a 0.7 percent decrease for urban hospitals and a 0.6 percent decrease among rural hospitals. In the East North Central region, the impacts are a 1.0 percent reduction for urban hospitals, and a 0.7 percent reduction for rural hospitals. The negative impacts of losing the regional floor for urban hospitals in the East North Central region are largely offset by higher estimated outlier payments in FY 1997 compared to FY 1996, the 0.3 percent higher payments due to the FY 1993 wage data (column 2), and the 0.2 percent increase due to the phase-out of day outliers (column 4). On the other hand, urban New England hospitals' higher outlier payments in FY 1997 are offset entirely by the negative impacts of the expiration of the regional floor. Rural New England hospitals also see a 1.0 percent decrease in payments stemming from the FY 1993 wage data.

Other census divisions below the average payment increase are urban Pacific, urban Puerto Rico, rural Middle Atlantic, rural South Atlantic, rural East South Central, and rural Mountain. With the exception of the rural Middle Atlantic and rural East South Central, the below average overall payment impacts of these census divisions are related to negative impacts of introducing the FY 1993 wage data. In the rural Middle Atlantic, the negative impact of the new wage data is combined with a smaller impact stemming from MGCRB reclassifications in FY 1997 (0.8 percent compared to 1.5 percent in FY 1996). A smaller FY 1997 reclassification impact (2.5 percent compared with 3.7 percent in FY 1996) is also the reason for the small (2.2 percent) rate of increase in the rural East South Central census division.

Conversely, the urban Middle Atlantic, urban West South Central, rural Pacific, and rural Puerto Rico census divisions all have overall rates of increase at least 0.4 percent above the national average. The urban West South Central gains from the continued phase-out of day outliers, as well as higher estimated FY 1997 outlier payments compared to FY 1996. As noted previously, the urban Middle Atlantic benefits significantly from the updated wage index data. These hospitals also have higher estimated FY 1997 outlier payments, which offset their 1.1 percent decrease due to the phase-out of day outliers. Rural Pacific hospitals benefit from geographic reclassification in FY 1997, with 12 hospitals being reclassified that were not reclassified in FY 1996.

The only hospital groups with negative payment impacts from FY 1996 to FY 1997 are hospitals that were reclassified for FY 1996 and are not reclassified for FY 1997. Overall, these hospitals lose 0.5 percent. The urban hospitals in this category actually experience slight payment increases over FY 1996 (0.8 percent), while the rural hospitals lose 2.1 percent. On the other hand, hospitals reclassified for FY 1997 that were not reclassified for FY 1996 would experience the greatest payment increases: 10.5 percent for 69 rural hospitals in this category and 8.0 percent for 34 urban hospitals.

Reclassification appears to be a significant factor influencing the payment increases for a number of rural hospital groups with above average overall payment increases in column 5. For example, among hospital groups identified in the discussion of the impacts of MGCRB reclassifications for FY 1997 (column 3), almost all have overall increases of 3.6 percent or greater. This outcome highlights the redistributive effects of reclassification decisions upon hospital payments. This impact is illustrated even more clearly when one examines the rows categorizing hospitals by their reclassification status for FY 1997. All nonreclassified hospitals have an average payment increase of 3.0 percent. The average payment increase for all reclassified hospitals is 4.3 percent.

Among SCH/EACHs, the payment increase is 2.7 percent. The primary reason for this below average increase is that there is minimal impact upon these hospitals from the higher estimated FY 1997 outlier payments. Because these hospital groups receive their hospital-specific rate if it exceeds the applicable Federal amount (including outliers), there is less of an impact due to changes in outlier payment levels, which are not applied to the hospital-specific rate. In addition, nonspecial status rural hospitals experience only a 2.1 percent increase. This is largely attributable to a much smaller reclassification impact for FY 1997 among these hospitals.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 1997 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per case]

	Number of hospitals (1)	Average FY 1996 payment percase (2) [1]	Average FY 1997 payment percase (3) [1]	All changes (4)
(By Geographic Location)				
All hospitals	5,130	6,470	6,673	3.1
Urban hospitals	2,878	7,004	7,229	3.2
Large urban areas	1,597	7,524	7,761	3.1
Other urban areas	1,281	6,317	6,524	3.3
Rural areas	2,252	4,302	4,419	2.7
Bed size (urban):				
0–99 beds	716	4,721	4,862	3.0
100–199 beds	938	5,939	6,112	2.9
200–299 beds	577	6,521	6,722	3.1
300–499 beds	479	7,410	7,660	3.4
500 or more beds	168	9,150	9,457	3.4
Bed Size (rural):				
0–49 beds	1,173	3,540	3,639	2.8
50–99 beds	663	3,996	4,108	2.8
100–149 beds	241	4,462	4,593	2.9
150–199 beds	99	4,582	4,713	2.8
200 or more beds	76	5,417	5,537	2.2
Urban by Census div.:				
New England	160	7,508	7,686	2.4
Middle Atlantic	434	7,686	7,953	3.5
South Atlantic	419	6,664	6,887	3.3
East North Central	483	6,742	6,940	2.9
East South Central	163	6,185	6,395	3.4
West North Central	193	6,652	6,880	3.4
West South Central	375	6,524	6,756	3.6
Mountain	125	6,774	6,996	3.3
Pacific	478	8,077	8,313	2.9
Puerto Rico	48	2,584	2,652	2.6
Rural by Census div.:				
New England	53	5,236	5,344	2.1
Middle Atlantic	85	4,695	4,785	1.9
South Atlantic	297	4,476	4,591	2.6
East North Central	304	4,328	4,454	2.9
East South Central	278	3,960	4,048	2.2
West North Central	525	4,008	4,121	2.8
West South Central	351	3,876	4,001	3.2
Mountain	213	4,575	4,712	3.0
Pacific	141	5,306	5,519	4.0
Puerto Rico	5	2,042	2,118	3.8
(By Payment Categories)				
Urban hospitals	2,978	6,960	7,184	3.2
Large urban areas	1,793	7,352	7,586	3.2
Other urban areas	1,185	6,322	6,528	3.3
Rural areas	2,152	4,269	4,379	2.6
Teaching status:				
Non-teaching	4,057	5,293	5,458	3.1
Fewer than 100 residents	841	6,900	7,118	3.2
100 or more residents	232	10,565	10,901	3.2
Disproportionate Share Hospitals (DSH):				
Non-DSH	3,200	5,602	5,779	3.2
Urban DSH:				
100 beds or more	1,410	7,595	7,835	3.2
Fewer than 100 beds	111	4,811	4,929	2.5
Rural DSH:				
Sole community (SCH)	146	4,478	4,625	3.3
Referral centers (RRC)	25	5,216	5,409	3.7
Other rural DSH hosp.:				
100 beds or more	89	4,235	4,280	1.1
Fewer than 100 beds	149	3,412	3,497	2.5
Urban Teaching and DSH:				
Both teaching and DSH	682	8,576	8,843	3.1
Teaching and no DSH	337	7,094	7,324	3.2

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 1997 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Number of hospitals (1)	Average FY 1996 payment percase (2)[1]	Average FY 1997 payment percase (3)[1]	All changes (4)
No Teaching and DSH	839	6,093	6,292	3.3
No teaching and no DSH	1,120	5,479	5,663	3.4
Rural hospital types:				
Nonspecial Status Hospitals	1,382	3,901	3,984	2.1
RRC	90	5,068	5,249	3.6
SCH/Each	641	4,415	4,536	2.7
SCH/Each and RRC	39	5,200	5,345	2.8
Type of ownership:				
Voluntary	3,084	6,634	6,846	3.2
Proprietary	691	5,917	6,093	3.0
Government	1,355	6,030	6,207	2.9
Medicare utilization as a percent of inpatient days				
0–25	256	8,577	8,803	2.6
25–50	1,285	7,877	8,124	3.1
50–65	2,105	5,944	6,133	3.2
Over 65	1,353	5,062	5,220	3.1
Unknown	131	7,372	7,597	3.1
Hospitals Reclassified by the Medicare Geographic Review Board				
Reclassification status during FY96 and FY97:				
Reclassified during both FY96 and FY97	381	5,864	6,046	3.1
Urban	133	6,750	6,976	3.4
Rural	248	5,003	5,143	2.8
Reclassified during FY97 only	103	6,150	6,679	8.6
Urban	34	7,091	7,658	8.0
Rural	69	4,374	4,831	10.5
Reclassified during FY96 only	251	5,658	5,630	−0.5
Urban	88	7,131	7,189	0.8
Rural	163	4,515	4,421	−2.1
FY 97 Reclassifications: All reclassified hosp.	484	5,922	6,176	4.3
Stand. amt. Only	120	5,764	5,944	3.1
Wage index only	274	5,839	6,065	3.9
Both	90	6,205	6,571	5.9
Nonreclass.	4,619	6,548	6,745	3.0
All urban reclass.	167	6,837	7,150	4.6
Stand. amt. only	63	6,230	6,433	3.3
Wage index only	30	9,311	9,728	4.5
Both	74	6,370	6,727	5.6
Nonreclass.	2,711	7,018	7,235	3.1
All rural reclass.	317	4,909	5,096	3.8
Stand. amt. only	57	4,623	4,749	2.7
Wage index only	244	4,968	5,146	3.6
Both	16	4,898	5,345	9.1
Nonreclass.	1,908	4,063	4,152	2.2
Other reclassifed:				
Hospitals (section 1886(d)(8)(B))	27	4,611	4,756	3.1

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

Table II presents the projected impact of the proposed changes for FY 1997 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 1997 with the average estimated per case payments for FY 1996, 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 I equal the percentage changes in average payments from column 5 of Table I.

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

A. General Considerations

We now have data that were unavailable in previous impact analyses for the capital prospective payment system. Specifically, we have cost report data for the third year of the capital prospective payment system (cost reports beginning in FY 1994) available through the March 1996 update of the Hospital Cost Report Information System (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 such 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.
- Moreover, 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 1997 capital cost projections. We discuss in Appendix B the assumptions and computations we employ to generate the amount of obligated capital commitments for use in the FY 1997 capital cost projections.

In Table III of this appendix, we present the redistributive effects that are expected to occur between ''hold-harmless'' hospitals and ''fully prospective'' hospitals in FY 1997. In addition, we have integrated sufficient hospital-specific information into our actuarial model to project the impact of the proposed FY 1997 capital payment policies by the standard prospective payment system hospital groupings. We caution that 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 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 1997 capital costs for individual hospitals, but with the more recent data on the experience to date under the capital prospective payment system, there is adequate information to estimate the aggregate impact on most hospital groupings.

We present the transition payment methodology by hospital grouping in Table IV. In Table V we present the results of the cross-sectional analysis using the results of our actuarial model. This table presents the aggregate impact of the FY 1997 payment policies.

B. Projected Impact Based on the Proposed FY 1997Actuarial Model

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 1996 to FY 1997 using a capital acquisition model. The FY 1997 model, 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 1994 received through the March 1996 update of the Hospital Cost Reporting Information System (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, 1996 in the Provider-Specific file. We used this data to determine the proposed FY 1997 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 1993, and we age that capital by a formula described in Appendix B. We therefore need to randomly generate only new capital acquisitions for any year after FY 1993. All Federal rate payment parameters are assigned to the applicable hospital.

For purposes of this impact analysis, the FY 1997 actuarial model includes the following assumptions:

- Medicare inpatient capital costs per discharge will increase at the following rates during these periods:

AVERAGE PERCENTAGE INCREASE IN CAPITAL

Fiscal year	Costs per discharge
1995	−1.50
1996	5.05
1997	5.21

- The Medicare case-mix index will increase by 1.6 percent in FY 1996 and FY 1997.
- The Federal capital rate as well as the hospital-specific rate is 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 1997 update for inflation is 1.00 percent (see Addendum, Part III).

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 1996 to FY 1997. 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, 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

Type of hospital	Percent of hospitals	FY 1997 percent of discharges	FY 1997 percent of capital costs	FY 1997 percent of capital payments
Low Cost Hospital	66	62	53	56
High Cost Hospital	34	38	47	44

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 in 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 have continued 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 1996 to FY 1997 using the above described actuarial model.

TABLE III.—IMPACT OF PROPOSED CHANGES FOR FY 1997 ON PAYMENTS PER DISCHARGE

FY 1996 payments per discharge

	Number of hospitals	Discharges	Adjusted federal payment	Average federal percent	Hospital specific payment	Hold harmless payment	Exceptions payment	Total payment
Low Cost Hospitals	3,367	6,543,036	$413.51	55.01	$200.60	$15.30	$16.59	$646.01
Fully Prospective	1,472	2,953,665	373.96	50.00	236.94	.....	11.59	622.49
Rebase—Fully Prospective	1,561	2,777,809	373.98	50.00	220.57	.....	23.17	617.72
Rebase—100% Federal Rate	237	633,924	798.96	100.00	.....	.....	0.05	799.00
Rebase—Hold Harmless	97	177,638	313.93	44.64	.....	563.62	55.92	933.48
High Cost Hospitals	1,737	4,044,123	665.47	85.61	.....	152.51	16.36	834.35
100% Federal Rate	1,126	2,842,423	788.87	100.00	.....	.....	2.30	791.18
Hold Harmless	611	1,201,700	373.59	49.81	.....	513.26	49.61	936.46
Total Hospitals	5,104	10,587,159	509.76	66.94	123.98	67.71	16.50	717.95

FY 1997 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
Low Cost Hospitals	3,367	6,720,494	$472.14	64.07	$157.08	$12.37	$38.44	$680.03	5.27
Fully Prospective	1,472	3,033,773	438.87	60.00	185.55	.....	34.06	658.48	5.78
Rebase—Fully Prospective	1,561	2,853,148	440.66	60.00	172.70	.....	45.15	658.50	6.60
Rebase—100% Federal Rate	243	657,828	785.22	100.00	.....	.....	0.58	785.81	-1.65
Rebase—Hold Harmless	91	175,744	385.79	55.77	.....	473.19	146.68	1,005.66	7.73
High Cost Hospitals	1,737	4,153,806	691.63	89.42	.....	123.03	48.28	862.93	3.43
100% Federal Rate	1,164	2,988,949	780.85	100.00	.....	.....	11.02	791.87	0.09
Hold Harmless	573	1,164,856	462.69	61.34	.....	438.70	143.88	1,045.27	11.62
Total Hospitals	5,104	10,874,300	555.98	74.04	97.08	54.64	42.20	749.90	4.45

Under section 1886(g)(1)(A) of the Act, aggregate payments under the capital prospective payment system for FY 1992 through 1995 respectively, were projected to equal 90 percent of payments that would have been payable on a reasonable cost basis in each year. With the expiration of the capital budget neutrality provision, we now estimate that there was an aggregate 27.73 percent increase in FY 1996 Medicare capital payments over the FY 1995 payments. With the proposed Federal rate, we estimate aggregate Medicare capital payments will increase by 7.28 percent in FY 1997.

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average increase in payments per case of 5.27 percent, and high capital cost hospitals will experience an average increase of 3.43 percent.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 50 percent to 60 percent and the hospital-specific rate payment percentage will decrease from 50 to 40 percent in FY 1997. 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 hospitals receiving a hold-harmless payment for old capital will increase from 49.81 percent to 61.34 percent. We estimate the percentage of hold-harmless hospitals paid based on 100 percent of the Federal rate will increase from 65.8 percent to 67.9 percent.

We expect that the average hospital-specific rate payment per discharge will decrease from $123.98 in FY 1996 to $97.08 in FY 1997. This is partly due to the 3.68 percent decrease in the FY 1997 hospital-specific rate compared to FY 1996.

We are proposing no changes in our exceptions policies for FY 1997. 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 2.30 percent of total capital payments in FY 1996 to 5.63 percent of payments in FY 1997. The number and amount of exceptions payments is expected to increase throughout the transition period. The projected distribution of the payments is shown in the table below:

ESTIMATED FY 1997 EXCEPTIONS PAYMENTS

Type of hospital	Number of hospitals	Percent of exceptions payments
Low Capital Cost	450	58
High Capital Cost	331	42
Total	781	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	5,104	13.0	27.6	59.4
Large urban areas (populations over 1 million)	1,584	15.6	34.5	49.9
Other urban areas (populations of 1 million or fewer)	1,271	15.1	33.4	51.5
Rural areas	2,249	10.0	19.4	70.6
Urban hospitals	2,855	15.4	34.0	50.6
0–99 beds	698	16.2	27.7	56.2
100–199 beds	933	19.3	36.8	43.9
200–299 beds	577	13.9	37.3	48.9
300–499 beds	479	11.5	32.6	55.9
500 or more beds	168	6.5	37.5	56.0
Rural hospitals	2,249	10.0	19.4	70.6
0–49 beds	1,171	7.1	14.3	78.7
50–99 beds	662	12.8	21.9	65.3
100–149 beds	241	14.5	30.3	55.2
150–199 beds	99	16.2	22.2	61.6
200 or more beds	76	7.9	39.5	52.6
By Region:				
Urban by Region	2,855	15.4	34.0	50.6
New England	160	7.5	25.0	67.5
Middle Atlantic	434	9.9	30.0	60.1
South Atlantic	417	19.2	41.0	39.8
East North Central	480	11.3	28.5	60.2
East South Central	162	19.8	36.4	43.8
West North Central	190	17.4	28.4	54.2
West South Central	366	25.7	47.5	26.8
Mountain	124	15.3	42.7	41.9
Pacific	474	13.3	30.4	56.3
Puerto Rico	48	18.8	16.7	64.6
Rural by Region	2,249	10.0	19.4	70.6

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)	
New England	53	7.5	15.1	77.4
Middle Atlantic	84	6.0	19.0	75.0
South Atlantic	297	13.1	25.3	61.6
East North Central	304	8.6	13.5	78.0
East South Central	278	10.1	30.6	59.4
West North Central	525	7.2	15.0	77.7
West South Central	349	10.0	24.1	65.9
Mountain	213	15.5	12.7	71.8
Pacific	141	11.3	15.6	73.0
Large urban areas (populations over 1 million)	1,780	15.3	34.3	50.4
Other urban areas (populations of 1 million or fewer)	1,175	15.4	32.3	52.3
Rural areas	2,149	9.8	19.4	70.8
Teaching Status:				
Non-teaching	4,031	13.7	26.6	59.7
Fewer than 100 Residents	841	11.1	32.0	57.0
100 or more Residents	232	7.8	28.4	63.8
Disproportionate share hospitals (DSH):				
Non-DSH	3,175	12.7	23.8	63.5
Urban DSH:				
100 or more beds	1,410	15.0	36.2	48.8
Less than 100 beds	110	11.8	25.5	62.7
Rural DSH:				
Sole Community (SCH/EACH)	146	9.6	20.5	69.9
Referral Center (RRC/EACH)	25	8.0	32.0	60.0
Other Rural:				
100 or more beds	89	13.5	39.3	47.2
Less than 100 beds	149	6.7	25.5	67.8
Urban teaching and DSH:				
Both teaching and DSH	682	9.1	32.8	58.1
Teaching and no DSH	337	13.6	27.6	58.8
No teaching and DSH	838	19.3	37.6	43.1
No teaching and no DSH	1,098	16.7	32.7	50.6
Rural Hospital Types:				
NON special status hospitals	1,379	7.6	19.5	72.9
RRC/EACH	90	8.9	37.8	53.3
SCH/EACH	641	14.5	16.4	69.1
SCH, RRC and EACH	39	12.8	20.5	66.7
Type of Ownership:				
Voluntary:				
Voluntary	3,058	12.8	27.7	59.5
Proprietary	691	23.6	46.2	30.2
Government	1,355	8.1	17.9	74.0
Medicare Utilization as a Percent of Inpatient Days:				
0–25	256	14.8	25.0	60.2
25–50	1,285	14.6	33.1	52.3
50–65	2,105	12.9	27.8	59.3
Over 65	1,353	10.4	22.2	67.3

As we explain in Appendix B, we were not able to determine a hospital-specific rate for 26 of the 5,130 hospitals in our data base. Consequently, the payment methodology distribution is based on 5,104 hospitals. This 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 under the hold-harmless methodology.

The percentage of hospitals paid fully Federal (100 percent of the Federal rate) as hold-harmless hospitals is expected to increase to 27.6 percent in FY 1997.

Table IV indicates that 59.4 percent of hospitals are paid under the fully prospective payment methodology. (This figure, unlike the figure of 66 percent for low cost capital hospitals in the previous section, takes account of 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 (70.8 percent and 74.0 percent, respectively by payment classification) are being paid under the fully prospective methodology. This is a reflection of their lower than average capital costs

per case. In contrast, only 30.2 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 1997 actuarial model to estimate the potential impact of our proposed changes for FY 1997 on total capital payments per case, using a universe of 5,104 hospitals. The individual hospital payment parameters are taken from the best available data, including: the January 1, 1996 update to the Provider-Specific file, cost report data, and audit information supplied by intermediaries. Table V presents estimates of payments per case under our model for FY 1996 and FY 1997 (columns 2 and 3). Column 4 shows the total percentage change in payments from FY 1996 to FY 1997. Column 5 presents the percentage change in payments that can be attributed to Federal rate changes alone.

Federal rate changes represented in Column 5 include the 4.36 percent decrease in the Federal rate, a 1.6 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 Medicare Geographic Classification Review Board. Column 4 includes the effects of the Federal rate changes represented in Column 3. Column 4 also reflects the effects of all other changes, including: the change from 50 percent to 60 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 and (2) payment classification and payment region.

The simulation results show that, on average, capital payments per case can be expected to increase 4.4 percent in FY 1997. The results show that the effect of the Federal rate changes alone is to decrease payments by 0.9 percent. The decrease attributable to the Federal rate changes is more than offset by a 5.3 percent increase is attributable to the effects of all other changes.

Our comparison by geographic location shows that capital payments per case to urban and rural hospitals experience similar rates of increase (4.4 percent and 4.8 percent, respectively). Payments per case for urban hospitals will decrease at about the same rate as payments per case for rural hospitals (0.8 percent and 1.3 percent, respectively) from the Federal rate changes alone. Urban hospitals will gain slightly less than rural hospitals (5.2 percent compared to 6.1 percent) from the effects of all other changes.

By region, there is relatively little variation compared to some previous years. All regions are estimated to receive increases in total capital payments per case, due to the increased share of payments that is based on the Federal rate (from 50 to 60 percent). Changes by region vary from a low of 2.1 percent increase (Middle Atlantic rural region) to a high of 15.6 percent increase (rural hospitals of the New England region).

By type of ownership, government hospitals are projected to have the largest rate of increase (5.1 percent, -1.1 percent due to Federal rate changes and a 6.2 percent positive offset from the effects of all other changes). Payments to voluntary hospitals will increase 4.5 percent (a 0.9 percent decrease due to Federal rate changes and a 5.4 percent positive offset from the effects of all other changes) and payments to proprietary hospitals will increase 3.8 percent (a 0.7 percent decrease due to Federal rate changes and a 4.5 percent positive offset from the effects of all other changes).

Section 1886(d)(10) of the Act established the Medicare Geographic Classification Review Board (MGCRB). Hospitals may apply for reclassification for purposes of the standardized amount, wage index, or both. 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 1997 compared to the effects of reclassification for FY 1996, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 1997 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 during FY 1997 as a whole are projected to experience a 5.3 percent increase in payments (a 0.3 percent decrease attributable to Federal rate changes and a 5.6 percent positive offset attributable to the effects of all other changes). Payments to nonreclassified hospitals will increase slightly less (4.3 percent) than reclassified hospitals (5.3 percent) overall. Payments to nonreclassified hospitals will decrease slightly more than reclassified hospitals from the Federal rate changes (1.0 percent compared to 0.3 percent), but they will gain about the same from the effects of all other changes (5.3 percent compared to 5.6 percent).

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 1996 Payments Compared to FY 1997 Payments]

	Number of hospitals	Average FY 1996 payments/case	Average FY 1997 payments/case	All changes	Portion attibutable to federal rate change
By Geographic Location:					
All hospitals	5,104	718	750	4.4	−0.9
Large urban areas (populations over 1 million)	1,584	823	858	4.3	−0.9
Other urban areas (populations of 1 million of fewer)	1,271	714	747	4.5	−0.8
Rural areas	2,249	479	503	4.8	−1.3
Urban hospitals	2,855	776	810	4.4	−0.8

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 1996 Payments Compared to FY 1997 Payments]

	Number of hospitals	Average FY 1996 payments/case	Average FY 1997 payments/case	All changes	Portion attibutable to federal rate change
0–99 beds	698	570	594	4.3	−0.9
100–199 beds	933	703	731	4.1	−1.0
200–299 beds	577	744	776	4.2	−0.9
300–499 beds	479	800	838	4.8	−0.8
500 or more beds	168	944	984	4.3	−0.5
Rural hospitals	2,249	479	503	4.8	−1.3
0–49 beds	1,171	368	389	5.8	−1.5
50–99 beds	662	445	468	5.0	−1.2
100–149 beds	241	512	536	4.7	−1.3
150–199 beds	99	517	543	4.9	−1.0
200 or more beds	76	609	633	3.9	−1.5
By Region:					
Urban by Region	2,855	776	810	4.4	−0.8
New England	160	780	818	4.9	−1.5
Middle Atlantic	434	816	855	4.8	−0.8
South Atlantic	417	777	809	4.2	−0.8
East North Central	480	730	759	4.0	−0.7
East South Central	162	707	744	5.3	−0.5
West North Central	190	768	807	5.1	−0.8
West South Central	366	794	825	3.8	−0.3
Mountain	124	774	804	3.8	−1.1
Pacific	474	856	890	4.1	−1.3
Puerto Rico	48	291	313	7.5	−1.1
Rural by Region	2,249	479	503	4.8	−1.3
New England	53	605	699	15.6	−1.8
Middle Atlantic	84	489	499	2.1	−2.4
South Atlantic	297	501	518	3.4	−1.5
East North Central	304	479	506	5.7	−0.9
East South Central	278	453	471	4.0	−1.5
West North Central	525	449	471	5.0	−1.4
West South Central	349	447	467	4.4	−0.9
Mountain	213	507	540	6.4	−0.5
Pacific	141	549	582	6.1	−0.9
By Payment Classification:					
All hospitals	5,104	718	750	4.4	−0.9
Large urban areas (populations over 1 million)	1,780	808	842	4.3	−0.9
Other urban areas (populations of 1 million of fewer)	1,175	714	747	4.6	−0.8
Rural areas	2,149	473	495	4.8	−1.4
Teaching Status:					
Non-teaching	4,031	623	647	3.9	−1.0
Fewer than 100 Residents	841	756	791	4.7	−0.9
100 or more Residents	232	1,039	1,096	5.5	−0.7
Urban DSH:					
100 or more beds	1,410	814	850	4.5	−0.9
Less than 100 beds	110	557	587	5.4	−1.1
Rural DSH:					
Sole Community (SCH/EACH)	146	458	495	8.1	−1.9
Referral Center (RRC/EACH)	25	544	560	2.9	−0.2
Other Rural:					
100 or more beds	89	501	519	3.6	−1.9
Less than 100 beds	149	365	385	5.5	−1.6
Urban teaching and DSH:.					
Both teaching and DSH	682	879	919	4.6	−0.8
Teaching and no DSH	337	786	827	5.3	−0.8
No teaching and DSH	838	712	743	4.4	−0.9
No teaching and no DSH	1,098	672	695	3.4	−0.8
Rural Hospital Types:					
Non special status hospitals	1,379	439	458	4.3	−1.7
RRC/EACH	90	559	574	2.5	−0.8
SCH/EACH	641	471	506	7.4	−1.2
SCH, RRC and EACH	39	577	608	5.4	−1.0
Hospitals Reclassified by the Medicare Geographic Classification Review Board:					
Reclassification Status During FY96 and FY97:					
Reclassified During Both FY96 and FY97	381	668	698	4.5	−1.1
Reclassified During FY97 Only	103	678	736	8.6	2.9
Reclassified During FY96 Only	228	631	640	1.4	−3.6
FY97 Reclassifications:					
All Reclassified Hospitals	484	670	706	5.3	−0.3

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 1996 Payments Compared to FY 1997 Payments]

	Number of hospitals	Average FY 1996 payments/case	Average FY 1997 payments/case	All changes	Portion attibutable to federal rate change
All Nonreclassified Hospitals	4,593	725	756	4.3	−1.0
All Urban Reclassified Hospitals	167	762	799	4.9	−0.3
Urban Nonreclassified Hospitals	2,688	777	811	4.3	−0.9
All Reclassified Rural Hospitals	317	568	602	6.0	−0.3
Rural Nonreclassified Hospitals	1,905	443	463	4.3	−1.8
Other Reclassified Hospitals (Section 1886 (D)(8)(B))	27	552	575	4.1	−1.3
Type of Ownership:					
Voluntary	3,058	732	765	4.5	−0.9
Proprietary	691	748	776	3.8	−0.7
Government	1,355	618	649	5.1	−1.1
Medicare Utilization as a Percent of Inpatient Days:					
0–25	256	793	847	6.8	−1.4
25–50	1,285	844	880	4.2	−0.8
50–65	2,105	675	706	4.6	−0.9
Over 65	1,353	603	628	4.1	−1.0

Appendix B: Technical Appendix on the Capital Acquisition 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 expires 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. We continue to use the capital acquisition model to determine these factors.

The following data are used in the capital acquisition model for FY 1997: the March 8, 1996 update of the cost reports for PPS–IX (cost reporting periods beginning in FY 1992), PPS–X (cost reporting periods beginning in FY 1993) and PPS–XI (cost reporting periods beginning in FY 1994), the January 1, 1996 update of the provider-specific file, and the March 1994 update of the intermediary audit file. The available data still lack certain items that were required for the determination of budget neutrality, including each hospital's projected new capital costs for each year, its projected old capital costs for each year, and the projected obligated capital amounts that will be put in use for patient care services and recognized as old capital each year.

Since hospitals under alternative payment system waivers (that is, hospitals in Maryland) are currently excluded from the capital prospective payment system, we excluded these hospitals from our model.

We then developed FY 1992, FY 1993, FY 1994, FY 1995, and FY 1996 hospital-specific rates using the provider-specific file, the intermediary audit file, and, when available, cost reports. (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 also ensured that the FY 1993 increase in the hospital-specific rate was at least 0.62 percent (the net FY 1993 update), that the FY 1994 hospital-specific rate was at least as large as the FY 1993 hospital-specific rate decreased by 2.16 percent (the net FY 1994 update), that the FY 1995 increase in the hospital-specific rate was at least 0.05 percent (the net FY 1995 update), and that the FY 1996 increase in the hospital-specific rate was at least 21.10 percent (the net FY 1996 update). We were able to match hospitals to the files as shown in the following table.

Source	Number of hospitals
Provider-Specific File Only	101
Provider-Specific and Audit File	5029
Total	5130

Sixty-eight of these hospitals had unusable or missing data. We were able to backfill a hospital-specific rate for 42 of these hospitals from the cost reports as shown in the following table.

Source	Number of hospitals
PPS–VII Cost Reports	1
PPS–VIII Cost Reports	2
PPS–IX Cost Reports	3
PPS–X Cost Reports	7
PPS–XI Cost Reports	29
Total	42

We did not have data for 26 hospitals, and had to eliminate them from the capital analysis. These hospitals likely are new hospitals or hospitals with very few Medicare admissions. This leaves us with 5104 hospitals and should not affect the precision of the required adjustment factors.

Next, we determined old and new capital amounts for FY 1992 using the PPS–IX cost reports as the first source of data. For FY 1993 amounts, we used PPS–IX and PPS–X cost reports as the first source of data, weighting each cost report by the number of days in FY 1993. For FY 1994 amounts, we used PPS–X and PPS–XI cost reports as the first source of data, weighting each cost report by the number of days in FY 1994. We were able to match 5,049 PPS–IX cost reports, 5,062 PPS–X cost reports, and 4,654 PPS–XI cost reports. In cases where cost reports could not be matched, we used the provider-specific file for old capital information. Even in cases where a cost report was available, the breakout of old and new capital was not always available. In these cases, we used the old capital amounts and new capital ratios from the provider-specific file. If these were missing, we derived

the old capital amount from the hospital-specific rate.

Finally, we used the intermediary audit file to develop obligated capital amounts. Since the obligated amounts are aggregate projected amounts, we computed a Medicare capital cost per admission associated with these amounts. We adjusted the aggregate amounts by the following factors:

(1) Medicare inpatient share of capital. This was derived from cost reports and was limited to the Medicare share of total inpatient days. It was necessary to limit the Medicare share because of data integrity problems. Medicare share of inpatient days is a reasonably good proxy for allocating capital. However, it may be understated if Medicare utilization is high, and may be overstated because it does not reflect the outpatient share of capital.

(2) Capitalization factor. This factor allocates the aggregate amount of obligated capital to depreciation and interest amounts. Consistent with the assumptions in the capital input price index, we used a 25-year life for fixed capital and a 10-year life for movable capital, and an average projected interest rate of 6.7 percent. We also assumed that fixed capital acquisitions are about one-half of total capital. In conjunction with the useful life and interest rate assumptions, the resulting capitalized fixed capital is about one-half of total capitalization. This is consistent with the allocations between fixed and movable capital found on the cost reports. The ratio we developed is 0.137, which produces the first year capitalization based on the aggregate amount.

(3) A divisor of Medicare admissions to derive the capital costs per discharge amount. Since we must project capital amounts for each hospital, we continued to use a Monte Carlo simulation to develop these amounts. (This model is described in detail in the August 30, 1991 final rule (56 FR 43517).) The Monte Carlo simulation is now used only to project capital costs per discharge amounts for each hospital. We analyzed the distributions of capital increases, and noted a slightly negative correlation between the dollar level of capital cost per admission, and the rate of increase in capital. To determine the rate of increase in capital cost per admission, we multiplied the lesser of $3,000 or the capital cost per admission by .00006 and subtracted this result from 1.2. (Increases for capital levels over $3,000 were not influenced by the level of capital, so this part of the calculation was capped at $3,000.) We selected a random number from the normal distribution, multiplied it by 0.17 (the standard deviation) and added it to −0.04 (the mean) and then added 1 to create a multiplier. This random result was multiplied by the previous result to assign a rate of increase factor which was multiplied by the prior year's capital per discharge amount to develop a capital per discharge amount for the projected year.

To model a projected year, we used the old and new capital for the prior year multiplied by 0.85 (aging factor). The 0.85 aging factor is the average of changes in capital over its life due to the gradual decrease in interest payments and the retirement of fully depreciatiated capital. The aged new and old capital is subtracted from the projected capital described in the previous paragraph. The difference represents newly acquired capital. If the hospital has obligated capital, any increase in ''old'' capital up to the total amount of obligated capital in FY 1993 and FY 1994 is assigned to obligated capital. Any remaining obligated capital is assigned to FY 1995 up to the amount of the modeled increase in capital for FY 1995. Even though obligated capital must be put in use for patient care by October 1, 1994, the use of the obligated capital may have started late in FY 1994 with only part of the ''first year'' depreciation and interest realized in FY 1994. The remainder of the ''first year'' depreciation and interest would be realized in FY 1995. With the exception of certain hospitals about whom we have information to the contrary, we assume that hospitals would meet the expiration dates provided under the obligated capital provision. Hence, no obligated capital is assigned to years FY 1996 and later. Once obligated capital is assigned, it is included with the ''old'' capital and is capitalized into future years as part of ''old'' capital. The on-line obligated amounts are added to old capital and subtracted from the newly acquired capital to yield residual newly acquired capital, which is then added to new capital. The residual newly acquired capital is never permitted to be less than zero.

Next, we computed the average total capital cost per discharge from the capital costs that were generated by the model and compared the results to total capital costs per discharge that we had projected independently of the model. We adjusted the newly acquired capital amounts proportionately, so that the total capital costs per discharge generated by the model match the independently projected capital costs per discharge.

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. If available, the model uses the payment methodology indicated in the PPS–IX cost reports or the provider-specific file. Otherwise, the model determines the methodology by comparing the hospital's FY 1992 hospital-specific rate to the adjusted Federal rate applicable to the hospital. 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 1995 MedPAR file using the FY 1997 DRG relative weights published in this proposed rule. The case-mix index is increased each year after FY 1995 based on analysis of past experiences in case-mix increases.

We analyzed the case-mix increases for the recent past and found that case-mix increases have decelerated to about 1.53 percent in FY 1992, 0.80 percent in FY 1993, and 0.75 percent in FY 1994. It appears that the case-mix increase for FY 1995 accelerated to around 1.6 percent. Early indications show that FY 1996 case-mix is increasing at FY 1995 level, around 1.6 percent. It appears that the deceleration of case-mix increases in FY 1993 and FY 1994 were anomalous, rather than the beginning of a trend. Therefore, in the model we are using the recent experience and have used a case-mix increase of 1.6 percent in FY 1995 and a projected case-mix increase of 1.6 percent in both FY 1996 and FY 1997. (Since we are using FY 1995 cases for our analysis, the FY 1995 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 1886(g)(1)(A) of the Act requires that, for discharges occurring after September 30, 1993, the unadjusted standard Federal rate be reduced by 7.4 percent. Consequently, the model reduces the unadjusted standard Federal rate by 7.4 percent effective in FY 1994. Since budget neutrality expires effective with FY 1996, this adjustment affects the adjusted Federal rate starting in FY 1996.

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 1996, the budget neutrality adjustment factor was 1.0025. To determine the factor for FY 1997, we first determined the portion of the Federal rate that would be paid for each hospital in FY 1997 based on its applicable payment methodology. Using our model, we then compared estimated aggregate Federal rate payments based on the FY 1996 DRG relative weights and the FY 1996 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 1997 relative weights and the FY 1997 geographic adjustment factor. In making the comparison, we held the FY 1997 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 geographic adjustment factor and DRG classifications and relative weights, an incremental budget neutrality adjustment of 0.9992 for FY 1997 should be applied to the previous cumulative FY 1996 adjustment of 1.0025 (the product of the FY 1993 incremental adjustment of 0.9980, the FY 1994 incremental adjustment of 1.0053, the FY 1995 incremental adjustment of 0.9998, and the FY 1996 incremental adjustment of 0.9994), yielding a cumulative adjustment of 1.0017 through FY 1997.

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 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.

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 FY 1992, FY 1993, FY 1994, FY 1995, FY 1996, the proposed FY 1997 factor, and the estimated factors that would be applicable through FY 2001. We caution that, except with respect to FY 1992, FY 1993, FY 1994, FY 1995 and FY 1996, these are estimates only, and are subject to revisions resulting from continued methodological refinements, more recent data, and any payment policy changes that may occur. In this regard, we note that in making these projections we have assumed that the cumulative DRG/GAF adjustment factor will remain at 1.0017 for FY 1997 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 1997.

The projections are as follows:

Fiscal year	Update factor	Exceptions reduction factor	Budget neutrality factor	Federal rate (after outlier) reduction)
1992	N/A	0.9813	0.9602	415.59
1993	6.07	.9756	.9162	[1] 417.29
1994	3.04	.9485	.8947	[2] 378.34
1995	3.44	.9734	.8432	[3] 376.83
1996	1.20	.9849	N/A	[4] 461.96
1997	1.00	.9393	N/A	[5] 441.84
1998	1.00	.9161	N/A	435.23
1999	1.00	.9228	N/A	442.80
2000	1.10	.9155	N/A	444.13
2001	1.10	N/A[6]	N/A	490.46

[1] **Note:** Includes the DRG/GAF adjustment factor of 0.9980 and the change in the outlier adjustment from 0.9497 in FY 1992 to 0.9496 in FY 1993.

[2] **Note:** Includes the 7.4 percent reduction in the unadjusted standard Federal rate. Also includes the DRG/GAF adjustment factor of 1.0033 and the change in the outlier adjustment from 0.9496 in FY 1993 to 0.9454 in FY 1994.

[3] **Note:** Includes the DRG/GAF adjustment factor of 1.0031 and the change in the outlier adjustment from 0.9454 in FY 1994 to 0.9414 in FY 1995.

[4] **Note:** Includes the the transfer adjustment of .9972. Also includes the DRG/GAF adjustment factor of 1.0025 and the change in the outlier adjustment from 0.9414 in FY 1995 to 0.9536 in FY 1996.

[5] **Note:** Includes the DRG/GAF adjustment factor of 1.0017 and the change in the outlier adjustment from 0.9536 in FY 1996 to 0.9476 in FY 1997. 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: Rebased Market Basket Data Sources I. Data Sources Used To Determine the Market Basket Relative Weights and Choice of Price Proxy Variables for the Operating Hospital Input Price Indexes

As discussed in section IV of the preamble to this proposed rule, we are rebasing and revising the hospital market baskets. This appendix describes the technical features of the 1992-based indexes that we are proposing in this rule. For both the prospective payment and excluded hospital market baskets, the differences between the proposed 1992-based market basket and the previous 1987-based market basket are noted. In the September 4, 1990 final rule (55 FR 36170), we discussed in detail the 1987-based hospital market baskets.

We present this description of the hospital operating market baskets in three steps:

- A synopsis of the structural differences between the 1987-based market baskets and the proposed 1992-based market baskets.
- A description of the methodology used to develop the cost category weights in the 1992-based market baskets, making note of the differences from the methodology used to develop the 1987-based market baskets.
- A description of the data sources used to measure price change for each component of the 1992-based market baskets, making note of the differences from the price proxies used in the 1987-based hospital market baskets.

A. Synopsis of Structural Changes Adopted in the Rebased 1992 Operating Hospital Market Baskets

Three major structural differences exist between the 1987-based and the proposed 1992-based operating hospital market baskets.

- The proposed hospital market baskets are based on more recent hospital expenditure data. The 1987-based market baskets contained skeletal cost shares that were derived from the 1987 cost data from the 1988 Annual Survey of the American Hospital Association (AHA). The 1992-based market baskets use data from the hospital cost reports for cost reporting periods beginning on or after October 1, 1991 and before October 1, 1992.
- Some cost categories have been combined, namely Fuel, Oil, Coal, and Other Fuel with Motor Gasoline, and Blood Services with Chemicals. These category mergers reflect the Bureau of Economic Analysis (BEA) reclassification decisions in the 1987 update of the BEA Input-Output Tables.
- In the proposed 1992-based market basket, the sample of excluded hospitals is restricted to more closely reflect the average Medicare length of stay in excluded hospitals. We have used cost report data for excluded hospitals from only those hospitals in which the Medicare average length of stay is within 15 percent of the total average length of stay to more accurately reflect the structure of costs for Medicare cases. This is a change from the FY 1987-based market basket, for which data from all excluded hospitals were used.

B. Methodology for Developing the Cost Category Weights

Cost category weights for the 1992-based market baskets were developed in four stages. First, base weights for three (Wages and Salaries, Employee Benefits, Pharmaceuticals) of the six main categories were derived from the 1992 Medicare cost reports for operating costs. Second, the weight for Nonmedical Professional Fees was developed by subtracting Medical Professional Fees reported in the Hospital Cost Report Information System (HCRIS) file from AHA Annual Survey Total Professional Fees to obtain Nonmedical Professional Fees, and the weight for Professional Liability Insurance was developed using 1989 HCRIS data trended forward to 1992, using the relative importance values in the previous market baskets. Third, the sum of Wages and Salaries, Employee Benefits, Pharmaceuticals, Nonmedical Professional Fees, and Professional Liability Insurance was subtracted from total expenses to obtain All Other Expenses. Finally, the weight for All Other Expenses was divided into subcategories using cost shares from the 1987 Input-Output Table for the hospital industry, produced by the U.S. Department of Commerce, Bureau of Economic Analysis, aged to 1992 using price changes. We will incorporate 1992 data from the U.S. Department of Commerce into the final market basket if the data are released in time to be analyzed in developing the final rule.

Below, we describe the source of the six main category weights and their subcategories in the 1992-based market baskets. We make note of the differences between the methodologies used to develop the 1987-based and the 1992-based market baskets.

1. Wages and Salaries: The cost weight for the Wages and Salaries category was derived using the 1992 Medicare cost reports. Contract Labor, which is also derived from the 1992 Medicare cost reports, is split between the Wages and Salaries and Employee Benefits cost categories, using the relationship for employed workers. Examples of Contract Labor are registered nurses and workers in hospital food service or security who are employed and paid by firms that contract for their work with the hospital. The Wages and Salaries cost category was disaggregated into nine occupational subcategories (professional and technical, managers and administration, sales, clerical, craft and kindred, operatives excluding transport, transport equipment operatives, nonfarm laborers and service workers) to reflect the mix of occupational inputs used by hospitals. The Contract Labor wages and salaries component was allocated proportionally to Professional-Technical and Service occupations. The 1987-based weights were developed from the 1987 Current Population Survey, while the 1992-based weights were developed from the 1992 Current Population Survey.

2. Employee Benefits: The cost weight for the employee benefits category was derived from the 1992 cost reports. Like wages and salaries, the employee benefit weight in each 1992-based market basket is a composite of nine labor subcategories. The employee benefits categories in the 1987-based market baskets were developed from the 1987 AHA Annual Survey and used the 1987 Current Population Survey. In 1987 Contract Labor's implied fringe benefits were allocated proportionally to Professional and Technical occupations, while in 1992 they were allocated to Professional-Technical and Service occupations.

3. Nonmedical Professional Fees: The cost weight for the nonmedical professional fees category was derived from the 1992 Medicare Cost Reports and AHA Annual Survey data. Total professional fees were split into the subcategories medical and other (nonmedical) fees using AHA Total Professional Fees minus HCRIS Medical Professional Fees to equal Nonmedical Professional Fees. The 1987-based nonmedical professional fees cost category was derived from the 1987 AHA Annual Survey and American Medical Association (AMA) data. It was split into the subcategories medical and other fees using data derived from the American Medical Association. The medical professional fees category is excluded from the hospital market basket since it is paid under Medicare Part B.

4. Professional Liability Insurance: The 1987-based market baskets have weights for professional liability insurance that were derived from the June 30 and December 31, 1987 HAS/Monitrend surveys. The cost weight for

the 1992-based professional liability insurance category was derived from 1989 HCRIS cost shares trended to 1992 using the change in the relative importance factor for professional liability insurance (malpractice) from the previous 1987-based prospective payment hospital and excluded hospital market baskets.

5. Utilities: For the 1987-based market baskets, the cost weight for utilities was derived by extrapolating the 1985 AHA Annual Survey utilities cost weight forward to 1987 using the rate of growth in the HAS/Monitrend cost weight for utilities between 1985 and 1987. The 1987 Utility subcategory weights were aged from their 1982-based index subcategory weights using price changes from 1982 to 1987. The 1992-based market basket cost weights for the subcategories (fuel, oil and gasoline; electricity; natural gas; and water and sewage) were derived from the Bureau of Economic Analysis' 1987 Input-Output table for the hospital industry, aged forward to 1992 by price changes and summed to a weight for utilities.

6. All Other Goods and Services: The all other goods and services category has more subcategories than any other market basket category. Goods found in this category include: direct service food, contract service food, pharmaceuticals, chemicals, medical instruments, photo supplies, rubber and plastics, paper products, apparel, machinery and equipment and miscellaneous products. Services found in this category include: business services, computer services, transportation and shipping, telephone, postage, other labor-intensive services, and other nonlabor-intensive services. The share for pharmaceuticals was derived from the 1992 Medicare cost reports. Relative shares for the other subcategories were derived from the 1987 Bureau of Economic Analysis' Input-Output table for the hospital industry and were aged forward to 1992 using price changes. As noted above, if more recent U.S. Department of Commerce data become available for these categories and we have time to analyze these data before the publication of the final rule, they will be incorporated into the final market baskets.

C. Price Proxies Used to Measure Cost Category Growth

1. Wages and Salaries: For measuring price growth in the 1992-based market basket, 10 price proxies are applied to the 9 occupational subcategories within the wages and salaries component. As in the 1987-based market basket, the professional and technical subcategory was split in half. An Employee Cost Index (ECI) for hourly wages paid to civilian hospital workers was applied to one half. An ECI of hourly wages and salaries paid to professional and technical workers in private industry was applied to the other half of the professional and technical component. The other eight occupations subcategories of the wages and salaries component were proxied using ECIs for wages and salaries for private industry workers in their respective occupational categories.

2. Employee Benefits: The 1992-based hospital market baskets use occupation-specific ECIs for employee benefits. The distribution of weights and price proxies is the same as for wages and salaries discussed above, but occupation-specific employee benefit ECIs replace occupation-specific wages and salaries ECIs. The components are summed into a composite index, just as was done for the 1987-based market basket.

3. Nonmedical Professional Fees: The ECI for compensation for professional and technical workers in private industry is applied to this category. This is a revision from the 1987-based market basket in which the ECI for wages and salaries for professional and technical workers in private industry was used.

4. Fuel, Oil, and Gasoline: The percentage change in the price of refined petroleum products as measured by the Producer Price Index (PPI) (Commodity Code #057) was applied to this component. This is a revision from the 1987-based indexes in which the PPIs for Light Fuel Oil (Commodity Code #0573) and Gasoline (Commodity Code #0571) were used.

5. Electricity: The percentage change in the price of commercial electric power as measured by the PPI (Commodity Code #0542) was applied to this component. This is a revision from the 1987-based indexes in which the PPI for industrial power (Commodity Code #0543) was used.

6. Natural Gas: The percentage change in the price of gas fuels as measured by the PPI (Commodity Code #0552) was applied to this component. This is a revision from the 1987-based indexes in which the PPI for Natural Gas (Commodity Code #0531) was used.

7. Water and Sewerage: The percentage change in the price of water and sewerage maintenance as measured by the Consumer Price Index (CPI) for all urban consumers was applied to this component. The same price measure was used in the 1987-based market baskets.

8. Professional Liability Insurance: The percentage change in the hospital professional liability insurance price as estimated by hospital industry professional liability insurance premium increase was applied to this component. The same price measure was used in the 1987-based market baskets.

9. Pharmaceuticals: The percentage change in the price of ethical preparations as measured by the PPI (Commodity Code #0635) was applied to this variable. The same price measure was used in the 1987-based market baskets.

10. Food, Direct Purchases: The percentage change in the price of processed foods and feeds as measured by the PPI (Commodity Code #02) was applied to this component. The same price measure was used in the 1987-based market baskets.

11. Food, Contract Services: The percentage change in the price of food purchased away from home as measured by the CPI for all urban consumers was applied to this component. The same price measure was used in the 1987-based market baskets.

12. Chemicals: The percentage change in the price of industrial chemical products as measured by the PPI (Commodity Code #061) was applied to this component. The same price measure was used in the 1987-based market baskets.

13. Surgical and Medical Equipment: The percentage change in the price of medical and surgical instruments as measured by the PPI (Commodity Code #1562) was applied to this component. The same price measure was used in the 1987-based market baskets.

14. Photographic Supplies: The percentage change in the price of photographic supplies as measured by the PPI (Commodity Code #1542) was applied to this component. The same price measure was used in the 1987-based market baskets.

15. Rubber and Plastics: The percentage change in the price of rubber and plastic products as measured by the PPI (Commodity Code #07) was applied to this component. The same price measure was used in the 1987-based market baskets.

16. Paper Products: The percentage change in the price of converted paper and paperboard products as measured by the PPI (Commodity Code # 0915) was used. This is a revision from the 1987-based indexes in which a weighted average of the percentage change in the price of converted paper and paperboard products and the percentage change in the price of paper excluding newsprint and packaging paper (Commodity Code #091301) was used.

17. Apparel: The percentage change in the price of apparel as measured by the PPI (Commodity Code #381) was applied to this component. This is a revision from the 1987-based indexes in which the PPI for textile house furnishings (Commodity Code #0382) was used.

18. Minor Machinery and Equipment: The percentage change in the price of machinery and equipment as measured by the PPI (Commodity Code #11) was applied to this component. The same price measure was used in the 1987-based market baskets.

19. Miscellaneous Products: The percentage change in the price of all finished goods as measured by the PPI was applied to this component. The same price measure was used in the 1987-based market baskets.

20. Business Services: The ECI for compensation for workers in the business services industry was applied to this component. This is a revision from the 1987-based indexes in which the percentage change in the AHE for wages and salaries for production and nonsupervisory workers in the business services industry as measured by the Bureau of Labor Statistics (SIC Code 73) was used.

21. Computer and Data Processing Services: The percentage change in the AHE of production and nonsupervisory workers engaged in firms furnishing computer data processing services (SIC Code 737) was applied to this component. The same price measure was used in the 1987-based market baskets.

22. Transportation and Shipping: The percentage change in the transportation component of the CPI for all urban consumers was applied to this component. The same price measure was used in the 1987-based market baskets.

23. Telephone: The percentage change in the price of telephone services as measured by the CPI for all urban consumers was applied to this component. The same price measure was used in the 1987-based market baskets.

24. Postage: The percentage change in the price of postage as measured by the CPI for all urban consumers was applied to this component. The same price measure was used in the 1987-based market baskets.

25. All Other Services, Labor Intensive: The percentage change in the ECI for compensation paid to service workers employed in private industry was applied to this component. This is a revision from the 1987-based indexes in which the ECI for wages and salaries paid to service workers employed in private industry was used.

26. All Other Services, Nonlabor Intensive: The percentage change in the all-items component of the CPI for all urban consumers was applied to this component. The same price measure was used in the 1987-based market baskets.

For further discussion of the rationale for choosing specific price proxies, we refer the reader to the September 3, 1986 final rule (51 FR 31582).

II. Data Sources Used to Determine the Cost Category Weights and Vintage Weights, and Choices of Price Proxy Variables for the Hospital Capital Input Price Index

In the preamble to this proposed rule, we discuss the rebasing of the capital input price index (CIPI). This appendix describes certain technical features of the 1992-based index that we are proposing in this rule, as well as differences between the proposed 1992-based CIPI and the current 1987-based CIPI. We discussed the 1987-based CIPI in the September 1, 1995 final rule (60 FR 45817.)

This discussion has the following three parts:

- A synopsis of the differences between the 1987-based CIPI and the proposed 1992-based CIPI.
- A description of the methodology used to develop the cost category weights and vintage weights in the 1992-based CIPI, making note of the differences from the methodology used to develop the 1987-based CIPI.
- A description of the data sources used to measure price change for each component of the 1992-based CIPI, making note of the differences from the price proxies used in the 1987-based CIPI.

A. Synopsis of Changes Adopted in the Rebased 1992 CIPI

We made no structural changes in the 1992-based CIPI. The only major change is the use of more recent hospital capital expenditure data in the proposed 1992-based CIPI.

The 1987-based CIPI contained cost category weights that were derived from 1987 Medicare cost report data and the 1987 Annual Survey of the AHA. The 1992-based CIPI uses data from the hospital Medicare cost reports for cost periods beginning between October 1, 1991 and September 30, 1992. The 1992-based CIPI also uses data from the 1992 Annual Survey of the AHA.

The 1987-based CIPI contained vintage weights that were derived from 1987 Medicare cost report data, the 1963-1987 Panel Survey of the AHA, and the 1980–1989 Securities Data Corporation data on hospital bonds. The 1992-based CIPI uses data from the 1992 Medicare cost reports, the 1963–1992 Panel Survey of the AHA, and 1980–1992 Securities Data Corporation data on hospital bonds.

B. Methodology for Developing Cost Category Weights and Vintage Weights for the 1992-based CIPI

There are five cost categories in the CIPI: building and fixed equipment depreciation, movable equipment depreciation, capital-related interest expense from government/nonprofit debt instruments, capital-related interest expense from for-profit debt instruments, and other capital-related expenses, such as taxes and insurance. The methodology for developing each of these cost category weights is described below:

1. Building and Fixed Equipment Depreciation: The 1992-based cost weight for building and fixed equipment depreciation was derived using the 1992 Medicare cost reports. The proportion of lease expenses attributable to building and fixed equipment was included in the cost weight based on the proportion of overall capital expenses allocated to building and fixed equipment depreciation. The 1987-based weight was developed from the 1987 Medicare cost reports and the 1987 AHA Annual Survey.

2. Movable Equipment Depreciation: The 1992-based cost weight for movable equipment depreciation was derived using the 1992 Medicare Cost Reports. The proportion of lease expenses attributable to movable equipment was included in the cost weight based on the proportion of overall capital expenses allocated to movable equipment depreciation. The 1987-based weight was developed from the 1987 Medicare cost reports and the 1987 AHA Annual Survey.

3. Government/Nonprofit Interest: The 1992-based cost weight for government/nonprofit interest was derived using the 1992 AHA Annual Survey data. The government/nonprofit interest is 85 percent of total interest, reflecting the relative debts of the government/nonprofit hospital sector and the for-profit hospital sector. The proportion of lease expenses attributable to government/nonprofit interest was included in the cost weight based on the proportion of overall capital expenses allocated to government/non-profit interest expense. The 1987-based weight was developed from the 1987 AHA Annual Survey.

4. For-Profit Interest: The 1992-based cost weight of for-profit interest was

derived using the 1992 AHA Annual Survey data. The for-profit interest is 15 percent of total interest, reflecting the relative debts of the government/nonprofit hospital sector and the for-profit hospital sector. The proportion of lease expenses attributable to for-profit interest was included in the cost weight based on the proportion of overall capital expenses allocated to for-profit interest expense. The 1987-based weight was developed from the 1987 AHA Annual Survey.

5. Other Capital-Related Expenses: The 1992-based cost weight for other capital-related expenses was derived using 1992 Medicare cost reports. The proportion of lease expenses attributable to other capital-related expenses was included in the cost weight based on the proportion of overall capital expenses allocated to other capital-related expenses. The 1987-based weight was developed from the 1987 Medicare cost reports and the 1987 Capital Expenditure Survey.

There are three sets of vintage weights in the CIPI: building and fixed equipment depreciation, movable equipment depreciation, and interest expense. The methodology for developing each of these vintage weights is described below.

1. Building and Fixed Equipment: The 1992-based building and fixed equipment vintage weights were derived from the 1992 Medicare cost reports and the 1963–1992 AHA Panel Survey. The 1987-based weights were developed from the 1987 Medicare cost reports and the 1963–1987 AHA Panel Survey.

2. Movable Equipment: The 1992-based movable equipment vintage weights were derived from the 1992 Medicare cost reports and the 1963–1992 AHA Panel Survey. The 1987-based weights were developed from the 1987 Medicare cost reports and the 1963–1987 AHA Panel Survey.

3. Capital-Related Interest: The 1992-based movable equipment vintage weights were derived from the 1980–1992 Securities Data Corporation data on hospital bonds and the 1963–1992 AHA Panel Survey. The 1987-based weights were developed from the 1980–1989 Securities Data Corporation data on hospital bonds and the 1963–1987 AHA Panel Survey.

C. Price Proxies Used to Measure Cost Category Growth in the CIPI

1. Building and Fixed Equipment Depreciation: The percentage change in the vintage-weighted price of building and fixed equipment depreciation as measured by the Boeckh institutional construction index was applied to this category in the 1992-based CIPI. The same price proxy was used in the 1987-based CIPI.

2. Movable Equipment Depreciation: The percentage change in the vintage-weighted price of movable equipment depreciation as measured by the Producer Price Index (PPI) for machinery and equipment was applied to this category in the 1992-based CIPI. The same price proxy was used in the 1987-based CIPI.

3. Government/Nonprofit Interest Expense: The percentage change in the vintage-weighted price of government/nonprofit interest expense as measured by the Average yield on Domestic Municipal Bonds from the Bond Buyer index of 20 bonds was applied to this category in the 1992-based CIPI. The same price proxy was used in the 1987-based CIPI.

4. For-Profit Interest Expense: The percentage change in the vintage-weighted price of for-profit interest expense as measured by the Average yield on Moody's AAA Bonds was applied to this category in the 1992-based CIPI. The same price proxy was used in the 1987-based CIPI.

5. Other Capital-Related Expenses: The percentage change in the price of other capital-related expenses as measured by the CPI for all urban consumers for residential rent was applied to this category in the 1992-based CIPI. The same price proxy was used in the 1987-based CIPI.

We provided more detailed discussion of the rationale for the choice of these price proxies in the June 2, 1995 proposed rule (60 FR 29227) and in the September 1, 1995 final rule (60 FR 45815).

The Honorable Albert Gore, Jr.
President of the Senate
Washington, D.C. 20510

Dear Mr. President: Section 1886(e)(3)(B) of the Social Security Act (the Act) requires me to report to Congress the initial estimate of the applicable percentage increase in inpatient hospital payment rates for Federal Fiscal Year (FY) 1997 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 of the market basket rate of increase minus 0.5 percentage points. The President's FY 1997 budget includes an update for PPS hospitals in both large urban areas and other areas equal to the market basket rate of increase minus 1.5 percentage points. The President's FY 1997 budget estimated the PPS market basket rate of increase for FY 1997 to be 3.6 percent. Based on this estimate, we recommend an update for hospitals in both large urban and other areas of 2.1 percent. However, recent data from ProPAC and other sources suggest that the final PPS market basket rate of increase for FY 1997 will be lower.

Sole community hospitals (SCHs) are the sole source of care in their area and are afforded special payment protection to maintain access to services for Medicare beneficiaries. SCHs are paid the higher of a hospital-specific rate or the Federal PPS rate. Current law mandates an update for sole community hospitals of the market basket rate of increase minus 0.5 percentage points. Consistent with the President's FY 1997 budget, we recommend an update to hospital-specific rates equal to the increase for all PPS hospitals; that is, the market basket rate of increase of 3.6 percent minus 1.5 percentage points, or 2.1 percent.

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 (TEFRA) of 1982. Current law mandates an update for all hospitals and distinct part hospital units excluded from PPS equal to the rate of increase in the excluded hospital market basket minus 1.0 percentage point, although the update can be higher for certain hospitals and units with costs that are greater than their target amounts. The President's FY 1997 budget incorporates an increase in the TEFRA limit equal to the rate of increase in the excluded hospital market basket (3.6 percent) minus 1.5 percentage points. Therefore, we recommend an increase in the TEFRA limit of 2.1 percent.

My recommendation for the updates is based on cost projections used in the President's FY 1997 budget. A final recommendation on the appropriate percentage increases for FY 1997 will be made nearer the beginning of the new Federal Fiscal Year based on the most current market basket projection available at that time. The final recommendation will incorporate our analysis of the latest estimates of all relevant factors, including recommendations by the Prospective Payment Assessment Commission (ProPAC). We currently expect that the final estimate of the market basket rate of increase will be lower than the estimate used in the President's FY 1997 budget.

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 1997.

I am pleased to provide this recommendation to you. I am also sending a copy of this letter to the Speaker of the House of Representatives.

Sincerely,

Donna E. Shalala

The Honorable Newt Gingrich
Speaker of the House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker: Section 1886(e)(3)(B) of the Social Security Act (the Act) requires me to report to Congress the initial estimate of the applicable percentage increase in inpatient hospital payment rates for Federal Fiscal Year (FY) 1997 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 of the market basket rate of increase minus 0.5 percentage points. The President's FY 1997 budget includes an update for PPS hospitals in both large urban areas and other areas equal to the market basket rate of increase minus 1.5 percentage points. The President's FY 1997 budget estimated the PPS market basket rate of increase for FY 1997 to be 3.6 percent. Based on this estimate, we recommend an update for hospitals in both large urban and other areas of 2.1 percent. However, recent data from ProPAC and other sources suggest that the final PPS market basket rate of increase for FY 1997 will be lower.

Sole community hospitals (SCHs) are the sole source of care in their area and are afforded special payment protection to maintain access to services for Medicare beneficiaries. SCHs are paid the higher of a hospital-specific rate or the Federal PPS rate. Current law mandates an update for sole community hospitals of the market basket rate of increase minus 0.5 percentage points. Consistent with the President's FY 1997 budget, we recommend an update to hospital-specific rates equal to the increase for all PPS hospitals; that is, the market basket rate of increase of 3.6 percent minus 1.5 percentage points, or 2.1 percent.

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 (TEFRA) of 1982. Current law mandates an update for all hospitals and distinct part hospital units excluded from PPS equal to the rate of increase in the excluded hospital market basket minus 1.0 percentage point, although the update can be higher for certain hospitals and units with costs that are greater than their target amounts. The President's FY 1997 budget incorporates an increase in the TEFRA limit equal to the rate of increase in the excluded hospital market basket (3.6 percent) minus 1.5 percentage points. Therefore, we recommend an increase in the TEFRA limit of 2.1 percent.

My recommendation for the updates is based on cost projections used in the President's FY 1997 budget. A final recommendation on the appropriate percentage increases for FY 1997 will be made nearer the beginning of the new Federal Fiscal Year based on the most current market basket projection available at that time. The final recommendation will incorporate our analysis of the latest estimates of all relevant factors, including recommendations by the Prospective Payment Assessment Commission (ProPAC). We currently expect that the final estimate of the market basket rate of increase will be lower than the estimate used in the President's FY 1997 budget.

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 1997.

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

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

I. Background

Several provisions of the Social Security Act (the Act) address the setting of update factors for inpatient services furnished in FY 1997 by hospitals subject to the prospective payment system and those excluded from the prospective payment system. Section 1886(b)(3)(B)(i)(XII) of the Act sets the FY 1997 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket minus 0.5 percentage points for prospective payment hospitals in all areas. Section 1886(b)(3)(B)(iv) of the Act sets the FY 1997 percentage increase in the hospital-specific rates applicable to sole community 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 0.5 percentage points. Section 1886(b)(3)(B)(ii) of the Act sets the FY 1997 percentage increase in the rate of increase limits for hospitals excluded from the prospective payment system equal to the rate of increase in the excluded hospital market basket minus the applicable reduction or, in the case of a hospital in a fiscal year for which the hospital's update adjustment percentage is at least 10 percent, the excluded hospital market basket percentage increase. Under section 1886(b)(3)(B)(v) of the Act, a hospital's update adjustment percentage increase for FY 1997 is the percentage increase by which the hospital's allowable operating costs of inpatient hospital services recognized under this title for the cost reporting period beginning in FY 1990 exceed the hospital's target amount for such cost reporting period, increased for each fiscal year (beginning with FY 1994) by the sum of any of the hospital's applicable reductions for previous years. The applicable reduction with respect to a hospital for FY 1997 is the lesser of 1 percentage point or the percentage point difference between 10 percent and the hospital's update adjustment percentage for FY 1997.

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 for the prospective payment system as provided in section 1886(b)(3)(B) of the Act. Based on the first quarter 1996 forecast of the FY 1997 rebased market basket increase of 2.7 percent for hospitals subject to the prospective payment system, the proposed updates in the standardized amounts are 2.2 percent for hospitals in both large urban and other areas. The proposed update in the hospital-specific rate applicable to sole community hospitals is 2.2 percent (that is, the market basket rate of increase of 2.7 percent minus 0.5 percentage points). The proposed update for hospitals excluded from the prospective payment system is based on the percentage increase in the excluded hospital market basket (currently estimated at 2.7 percent) minus the applicable reduction factor. The applicable reduction factor is the lesser of 1 percentage point or the percentage point difference between 10 percent and the hospital's update adjustment percentage. Therefore, for excluded hospitals, the hospital-specific proposed update can vary between 1.7 and 2.7 percent.

Sections 1886(e)(2)(A) and (3)(A) of the Act require that the Prospective Payment Assessment Commission (ProPAC) recommend to the Congress by March 1, 1996 an update factor that takes into account changes in the market basket rate of increase index, hospital productivity, technological and scientific advances, the quality of health care provided in hospitals, and long-term cost effectiveness in the provision of inpatient hospital services.

In its March 1, 1996 report, ProPAC recommended update factors to the standardized amounts equal to the percentage increase in the market basket minus 0.7 to 2.0 percentage points for hospitals in both large urban and other areas (Recommendation 10). Based on its market basket rate of increase estimate of 2.7 percent, ProPAC's recommended update to the standardized amounts equals 2.0 to 0.7 percent for hospitals in both large urban and other areas. (ProPAC's market basket is still using the 1987-based weights.) ProPAC did not make a separate recommendation for the hospital-specific rates applicable to sole community hospitals. The components of ProPAC's update factor recommendations are described in detail in the ProPAC report, which is published as Appendix F to this document. We discuss ProPAC's recommendations concerning the update factors and our responses to these recommendations below.

Section 1886(e)(4) of the Act requires that the Secretary, taking into

consideration the recommendations of ProPAC, 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 ProPAC recommendations concerning the update factors.

II. Secretary's Recommendations

Under section 1886(e)(4) of the Act, we are recommending that the standardized amounts be increased by an amount equal to the market basket rate of increase minus 1.5 percentage points for hospitals located in large urban and other areas. We are also recommending an update of the market basket rate of increase minus 1.5 percentage points to the hospital-specific rate for sole community hospitals. These figures are consistent with the President's FY 1997 budget recommendation, which continues the reductions imposed by section 13501 of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), that is, reductions in the hospital market basket of 2.5 percentage points for FYs 1994 and 1995 and 2.0 percentage points for FY 1996. We believe these recommended changes in the update factor 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 3.6 percent. As noted above, this proposed recommendation is based on the most recent forecast of the proposed rebased market basket. (See section IV of the preamble to this proposed rule for a detailed discussion of the market basket.)

We recommend that hospitals excluded from the prospective payment system receive an update equal to the percentage increase in the proposed rebased market basket that measures input price increases for services furnished by excluded hospitals minus 1.5 percentage points. That market basket rate of increase is currently forecast at 2.7 percent. Subtracting 1.5 percentage points would result in an update for hospitals excluded from the prospective payment system of 1.2 percent. This recommendation is consistent with the President's budget, acknowledging that the market basket rate of increase for these hospitals also was forecast at 3.6 percent at the time the budget was submitted.

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

III. ProPAC Recommendation for Updating the Prospective Payment System Standardized Amounts

For FY 1997, ProPAC's update framework would support an update between 0.7 percentage points and 2.0 percentage points less than the increase in the hospital market basket index. The methodology employed by the Commission in previous years would lead to a recommendation of about market basket minus 1.5 percentage points, roughly corresponding to the midpoint of that range. In light of the significant changes occurring in health care delivery, the Commission believes that the increase in the prospective payment system rates could be held to market basket minus 2.0 percentage points for the next year or two. However, it is concerned about the potential effects of continuing updates at that level on hospitals' financial health. Low updates over an extended period of time could affect a hospital's ability to provide quality care to Medicare beneficiaries, compromise access, and impede the diffusion of quality-enhancing technological advances.

Based on the market basket estimate of 2.7 percent, ProPAC recommends that hospitals in large urban and other areas receive an update between 0.7 to 2.0 percent.

Response: We are recommending an update that is consistent with the Administration's budget proposal. Our recommendation is that the update for FY 1997 for prospective payment system hospitals located in large urban and other areas be equal to the market basket rate of increase forecast minus 1.5 percentage points. Based on HCFA's current forecast of the market basket rate of increase (2.7 percent), we recommend an update for FY 1997 for large urban and other hospitals equal to 1.2 percent. 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:

- *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. ProPAC has also estimated cumulative service productivity growth to be 4.9 percent from 1985–1989, or 1.2 percent annually. At the same time, the Commission estimates total output growth at 3.4 percent annually, implying a ratio of service productivity growth to output growth of 0.35. Our Medicare Provider Analysis and Review (MedPAR) file analysis indicates total Medicare service output (charges per admission, adjusted for CPI change) increased 10.7 percent from 1987–1995, or an approximate average annual increase of 1.2 percent. 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 an 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 higher in years that output growth is larger than the historical trend. 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, and expected quality enhancing intensity growth, 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 (2.7 percent for FY 1997), and projected real case-mix growth (1.6 percent), or 4.3 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 (4.3 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 (0.614) provides our productivity standard of 0.8 to 0.9 percent.

ProPAC also believes hospitals should be given an incentive for additional productivity improvement. ProPAC measures productivity as the ratio of hospital admissions (adjusted for case mix and outpatient services) per FTE employee (adjusted for changes in skill mix). ProPAC includes in its productivity measurement the effect of changes in practice patterns. We treat practice pattern changes as a portion of our intensity adjustment, described below. ProPAC's latest estimate indicate that hospital productivity increased as much as 2.3 percent in 1994. Given this improvement, ProPAC believes a productivity adjustment in the range of –0.7 to –1.2 percentage points would be reasonable in fiscal year 1997. The adjustment is intended to share productivity equally between hospitals and Medicare. In the near future, ProPAC believes there may be even greater productivity improvements, as hospitals strive to stay competitive and financially viable.

- *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 1997, 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. 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.

The quality enhancing technology component is intended to recognize the use of services that increase cost but whose value in terms of enhanced health-status is commensurate with these costs. Such services may result from technological change, or in some cases, increased use of existing technologies. The latter recognizes that as cost and medical effectiveness studies become available, some increased use of existing, as well as new, services may be warranted.

The component for reduction of cost-ineffective practice recognizes that some improvements in practice patterns could be made so that the intensity of services provided is more consistent with the efficient use of limited resources. That is, improvements could be made so that the number of services provided during an inpatient stay, and their complexity, produce an improvement in health status that is consistent with the cost of care. This component of our update recommendation is intended to encourage both hospitals and physicians to more carefully consider the cost-effectiveness of medical care. This component of the framework also accounts for real within-DRG change, since that should be directly reflected in the CMI-adjusted growth in real charges per case.

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 FY 1991–1995 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 FY 1991 and FY 1992, we estimate that 1.0 to 1.4 percent of observed case-mix increase was real. This estimate 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 suggests that real case-mix change was not dependent on total change, but was rather a fairly steady 1.0 to 1.5 percent per year. In the past we have used 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. For FY 1993 and FY 1994, we assumed that all of the observed case-mix increases of 0.9 and 0.8 percent, respectively, were real. For FY 1995, we assumed that all of the observed case-mix increase of 1.6 percent was real. We note that this assumed increase in real case mix is higher than our previously assumed upper bound of 1.4 percent. Based on its analysis of the FY 1995 MedPAR data, the Office of the Actuary has concluded that the apparent shifting of some cases to the outpatient setting and activity in the cardiovascular DRGs has contributed to a higher than expected increase in real case mix.

Given estimates of real case-mix increase of 1.0 percent for FY 1991–1992, 0.9 percent for FY 1993, 0.8 percent for FY 1994, and 1.6 percent for FY 1995, we estimate case-mix constant intensity declined by an average 1.1 percent during FY 1991 through 1995, for a cumulative decrease of 5.6 percent. If we assume that real case-mix increase was 1.4 percent for FYs 1991 and 1992, 0.9 percent for FY 1993, 0.8 percent for FY 1994, and 1.6 percent for FY 1995, we estimate case-mix constant intensity declined by an average of 1.2 percent during FY 1991 through 1994, for a cumulative decrease of 5.9 percent. Since we estimate that intensity has declined during FY 1991–1995 period, we are recommending a 0.0 percent intensity adjustment for FY 1997.

- *Quality Enhancing New Science and Technology:* For FY 1997, ProPAC has computed the adjustment for scientific and technological advances to be a future-oriented policy target intended to provide additional funds for hospitals to adopt quality-enhancing, cost increasing health care innovations.

While in the past the Commission has included an adjustment ranging from 0.3 to 1.0 percentage points, the current range is lower because there is little evidence of significant new cost-increasing advances ready for implementation. Moreover, the cost-competitive environment now faced by hospitals may dampen the adoption of new technologies as they closely evaluate their relative costs and benefits. Therefore, the Commission recommends an adjustment of 0.1 to 0.6 percentage points for the increase in operating costs due to scientific and technological advances.

• *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 1997 update recommendation, we are projecting a 1.6 percent increase in the case-mix index. We define real case-mix increase as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher-weighted DRGs but do not reflect greater resource requirements. For FY 1997, we believe that real case-mix increase is equal to our projected change in case mix. We do not see any changes in coding behavior in our projected case-mix change. Our net adjustment to case-mix change for FY 1997 is 0.0 percentage points.

The −1.0 to −0.9 percent figure used in the ProPAC framework represents ProPAC's projection for observed case-mix change. ProPAC projects a 0.8 to 0.9 percentage points increase in real case-mix change across DRG's and a 0.0 to 0.2 percentage points increase in within-DRG case-complexity change. ProPAC's net adjustment for case mix is −0.2 to 0.0 percentage points.

• *Effect of FY 1995 DRG Reclassification and Recalibration:* We estimate that DRG reclassification and recalibration for FY 1995 resulted in a 0.0 percent increase 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. ProPAC does not make an adjustment for DRG reclassification and recalibration in its update recommendation.

• *Correction for Market Basket Forecast Error:* The estimated market basket percentage increase used to update the FY 1995 payment rates was 3.6 percent. Our most recent data indicate the actual FY 1995 increase was 3.0 percent, reflecting that the actual increase in wages was lower than projected. The resulting forecast error in the FY 1995 market basket rate of increase is 0.6 percentage points. Under our update framework, we make a forecast error correction if our estimate is off by 0.25 percentage points or more. Therefore, we are recommending an adjustment of −0.6 percentage points to reflect this overestimation of the FY 1995 market basket rate of increase. The following is a summary of the update ranges supported by our analyses compared to ProPAC's framework.

TABLE 1.—COMPARISON OF FY 1997 UPDATE RECOMMENDATIONS

	HHS	ProPAC
Market Basket	MB	MB
Difference Between HCFA & ProPAC Market Baskets	.....	–0.1 to 0.0
Subtotal	MB	MB to MB–0.1
Policy Adjustment Factors		
Productivity	–0.9 to –0.8	–1.2 to –0.7
Intensity:	0.0	.....
Science and Technology	.....	0.1 to 0.6
Practice Patterns	.....	(1)
Real Within DRG Change	.....	(2)
Subtotal	–0.9 to –0.8	–1.1 to –0.1
Case-Mix Adjustment Factors		
Projected Case-Mix Change	–1.6	–1.0 to –0.9
Real Across DRG Change	1.6	0.8 to 0.9
Real Within DRG Change	(3)	0.0 to 0.2
Subtotal	0.0	–0.2 to 0.0
Effect of 1995 Reclassification and Recalibration	0.0	.....
Forecast Error Correction	–0.6	–0.6
Total Recommended Update	MB–1.5 to MB–1.4	MB–2.0 to MB–0.7

[1] Included in ProPAC's Productivity Measure.
[2] Included in ProPAC's Case-Mix Adjustment.
[3] Included in HHS' Intensity Factor.

The above analysis would support a recommendation that the update be between market basket minus 1.4 and market basket minus 1.5 percentage points. We are recommending an update of market basket minus 1.5 percentage points, consistent with President Clinton's FY 1997 budget proposal. We also recommend that the hospital-specific rates applicable to sole community hospitals be increased by the same update, market basket minus 1.5 percentage points.

V. ProPAC Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals

ProPAC recommends an update factor equal to the market basket rate of increase minus 0.6 percentage points for excluded hospitals and units (Recommendation 12). The 0.6 percentage points reduction represents a

reduction of 0.6 percentage points to account for the forecast error in the FY 1995 market basket rate of increase for excluded units, no increase to reflect the different compensation price proxies used by ProPAC, and no allowance for new technology. ProPAC believes that major changes in the excluded hospitals' target amounts should not be made at this time. Rather, a prospective payment system for excluded hospitals and units should be implemented as soon as possible.

Response: We recommend that hospitals excluded from the prospective payment system receive an update equal to the percentage increase in the market basket that measures input price increases for services furnished by excluded hospitals minus 1.5 percentage points. The reduction is consistent with the updates provided under President Clinton's budget proposal. The market basket rate of increase for excluded hospitals is currently forecast at 2.7 percent. Subtracting 1.5 percentage points would result in an update of 1.2 percent for excluded hospitals and units.

As noted by ProPAC, HCFA has contracted with the RAND Corporation to analyze a classification system for rehabilitation patients that appears to have the potential to serve as the basis for a prospective payment system for rehabilitation hospitals and units. However, even if this classification system is found to be suitable, it would be several years before we could fully implement any prospective payment system for these facilities. In addition, we have been less successful in our pursuit of a suitable classification system for the other types of excluded hospitals. Therefore, as an interim measure, the President's budget contains a proposal to rebase the target amounts for excluded hospitals and units on more recent cost data. Changes would also be made to the conditions under which facilities would receive additional payment when they exceed their limits. Incentive payments for facilities whose costs are below their target amounts would be eliminated.

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PROSPECTIVE PAYMENT
ASSESSMENT COMMISSION

REPORT AND RECOMMENDATIONS TO THE CONGRESS

MARCH 1, 1996

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

The Prospective Payment Assessment Commission, created in 1983 by the legislation that established the Medicare prospective payment system for inpatient hospital services, advises the Congress and the Secretary of Health and Human Services on policies affecting Medicare payments to hospitals and other facilities. The Commission also studies industrywide effects of Medicare policies and important trends in the health care delivery system. On March 1 of each year, the Commission submits a report to the Congress with recommendations for improvements in Medicare policies and related subjects.

Prospective Payment Assessment Commission

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March 1, 1996

The Honorable Albert Gore, Jr.
President of the Senate
United States Senate
Washington, D.C. 20510

Dear Mr. President:

I am hereby transmitting to the Congress the annual report of the Prospective Payment Assessment Commission as required by Section 1886(e)(3) of the Social Security Act as amended by Public Law 101-508. This report presents a discussion of health care spending and its impact on the Medicare program, as well as major reforms proposed for Medicare. In addition, 26 recommendations concerning Medicare payment policies are included. The report reflects the Commission's judgment about issues of substantial importance to the Medicare program and beneficiaries, hospitals, and other providers.

Sincerely,

Stuart H. Altman, Ph.D.
Chairman

Enclosure

Prospective Payment Assessment Commission

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March 1, 1996

The Honorable Newt Gingrich
Speaker of the House
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

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Sincerely,

Stuart H. Altman, Ph.D.
Chairman

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Executive Summary

Since its inception in 1965, the Medicare program has provided health insurance coverage for the elderly and disabled. But this protection has come at a substantial cost to the Federal government. Between 1967 and 1993, total program expenditures climbed more than 30-fold. Medicare payments per person increased, on average, 8 percent annually over the same period. Total program spending reached an estimated $177 billion in 1995, accounting for 12 percent of the Federal budget.

The rise in Medicare spending threatens the solvency of the program's Hospital Insurance Trust Fund, its primary source of income. Moreover, it has been a major contributor to the Federal budget deficit. Payment reforms have been implemented in the past to control spending and extend the solvency of the program. This year, the Congress has focused renewed attention on Medicare spending in its plan to balance the Federal budget by 2002. Both the Congress and the President have proposed Medicare savings that would be substantially greater than any previously achieved. Their proposals, however, reflect different views on the role of the Federal government in financing care for Medicare beneficiaries.

Both the Congress and the President would expand Medicare's reliance on capitation, because of its apparent success in slowing private sector health care spending. Under Medicare's capitation option, called the risk contracting program, Medicare makes an annual per capita payment to a contracting health plan to cover a defined set of services for enrolled beneficiaries. This shifts the responsibility for payment for covered services from the Federal government to the health plans. Medicare's spending for beneficiaries enrolled in the capitation program, therefore, is predictable and limited to the per capita payment. Further, health plans have incentives to manage service use and control their costs.

As currently designed, however, Medicare's risk contracting program does not fully realize the potential benefits associated with capitation. The program's per capita rates appear to be too high in some markets, resulting in overpayment to plans, and too low in others, discouraging plan participation in those areas. To remedy this, the Congress and the President propose changing the payment rate setting method to generate more savings from the risk program and increase the number of plans available to beneficiaries. In addition, the Congress specifies annual increases to the capitation rates to reduce spending growth further.

Even with increased emphasis on capitation arrangements, the vast majority of Medicare services will continue to be purchased on a fee-for-service basis. Both the President and the Congress would make significant changes to Medicare's traditional fee-for-service payment methods and, in fact, would achieve most of their Medicare savings through this part of the program. In addition, the Congress would implement a savings enforcement tool called the "failsafe budget mechanism." For the first time in Medicare's history, total spending per enrollee in both the capitation and fee-for-service programs would be capped each year at a congressionally mandated amount, regardless of the number or types of services provided or the underlying rate of general inflation.

At the same time that these significant changes to Medicare are being considered, private sector financing and delivery of medical care are undergoing substantial changes. After years of rapid cost growth, underwritten by payment increases from private payers, hospitals are facing intense pressure to constrain their costs. They have successfully responded by holding cost growth below the level of inflation. As a group, hospitals have been able to maintain their financial condition. But some facilities, because of commitments to teaching or providing care to the poor, may be limited in their ability to continue to meet payer demands for constrained cost growth. Both the Congress and the President propose reductions to Medicare's teaching and disproportionate share adjustments. In light of these changes, the distribution of Medicare payments becomes more critical to ensure appropriate access and adequate quality of care for beneficiaries.

As hospitals have struggled to constrain their costs, the share of Medicare expenditures devoted to post-acute and ambulatory care providers has climbed. Medicare has imposed ever-tighter constraints on payments per service, but has failed to adequately address utilization. Volume control in these settings is particularly difficult because services can be provided in various sites. Payment constraints applied to one provider are likely to cause higher use in another. The Congress and the President begin to address this problem in two sectors with particularly high growth—skilled nursing facilities and home health agencies—by mandating prospective payment systems that bundle a set of services for a single payment.

The significant Medicare savings proposed by the Congress and the President, as well as Medicaid reforms and private sector cost-control efforts, will require health care providers to continue to modify their practices. In this dynamic environment, the challenge will be for Medicare to monitor the impact of these changes and appropriately adjust its policies to ensure continued protection of its beneficiaries.

RECOMMENDATIONS FOR FISCAL YEAR 1996

The Prospective Payment Assessment Commission (ProPAC) is responsible for advising the Congress and the Secretary of Health and Human Services on Medicare's payment policies for all health care facilities and their effects on beneficiaries and the facilities themselves. In addition, the Commission monitors important trends in the nation's health care system. In this report, ProPAC discusses the major reforms proposed for the Medicare program and the ramifications these might have for beneficiaries and providers alike. The Commission presents 26 recommendations covering a range of topics related to these reforms, in the context of promoting more efficient operation of the health care system while maintaining access to quality care for Medicare enrollees.

Recommendation 1: Slowing the Rise in Medicare Spending

The Commission supports the efforts of the Congress and the President to reduce the growth in Medicare expenditures. Over time, spending for services furnished to Medicare enrollees should increase at rates comparable to those in a cost- and quality-conscious private sector.

Recommendation 2: The Failsafe Budget Mechanism

Any failsafe budget mechanism should include a more effective risk adjustment factor to ensure payment equity between the Medicare capitation and traditional fee-for-service programs. In addition, changes in inflation that differ substantially from CBO forecasts could require modifications to the Medicare benefit budget over time. Revisions to the proposed fee-for-service sector budget allocations could also be needed as medical practices change.

Recommendation 3: Expanding Medicare's Capitation Program

The Commission supports reforming the Medicare capitation program to control spending while expanding beneficiary choice.

Recommendation 4: Setting and Updating the Capitation Rates

Geographic variation in the capitation rates and the volatility of the rates from year to year should be reduced. The Secretary should develop and test alternative payment methods that would allow the payment rates to reflect changes in local market conditions.

Recommendation 5: Improving Risk Adjustment Methods

The risk adjustment methods used to set Medicare capitation payments should better reflect variation in the likely use of services. Even as research on the development of new methods continues, the Secretary should implement interim improvements as soon as possible.

Recommendation 6: Medical Savings Accounts

The Congress's high deductible/MSA option would provide an additional choice for Medicare enrollees. ProPAC is concerned, however, that the current Medicare risk adjustment method is not sufficient to protect the program from adverse selection and resulting excess spending. The likelihood that

rates would better reflect risk would be enhanced if Medicare enrollees were required to remain in the MSA option at least for several years.

Recommendation 7: The MedicarePlus Fee-for-Service Option

Enrollees choosing the fee-for-service option under the proposed MedicarePlus program could be responsible for substantially higher fees than what their plans would pay. The Secretary should monitor the impact of this option on beneficiary liability and on possible reductions in physician and other provider participation in traditional Medicare.

Recommendation 8: Information for Beneficiary Health Plan Choices

Medicare should make available to beneficiaries information about the performance of plans and local providers. The Secretary should identify the information beneficiaries need to make appropriate choices and develop innovative ways to improve access to it.

Recommendation 9: Health Plan Accountability

Medicare must hold health plans accountable for the appropriate use of Medicare funds. In addition, standards must be developed and enforced to ensure that Medicare beneficiaries will receive services of appropriate quality.

Recommendation 10: Updating PPS Operating Rates

ProPAC's update framework would support an update between 0.7 percentage points and 2.0 percentage points less than the increase in the hospital market basket index. The methodology employed by the Commission in previous years would lead to a recommendation of about market basket minus 1.5 percentage points, roughly corresponding to the midpoint of that range. In light of the significant changes occurring in health care delivery, the Commission believes that PPS payment rate increases could be held to market basket minus 2.0 percentage points for the next year or two. However, it is concerned about the potential effects of continuing updates at that level on hospitals' ability to provide quality care to Medicare beneficiaries and other populations.

Recommendation 11: Setting Capital Payment Rates

Prospective per discharge payment rates for inpatient capital costs should be set by developing an appropriate base payment rate and applying an annual update. The capital update should reflect the prices of capital assets, capital financing costs, and other factors related to the capital costs hospitals incur in efficiently providing inpatient care to Medicare beneficiaries.

Recommendation 12: Updating Payments to PPS-Excluded Hospitals and Distinct-Part Units

ProPAC's update framework would support an average update to the TEFRA target amounts equal to the projected increase in the market basket index minus 0.6 percentage points for fiscal year 1997. This average is within the range of facility-specific updates in the Congress's proposal, which is between the market basket increase and 2.5 percentage points below market basket. Major changes to the TEFRA target amounts should not be made at this time. Rather, a prospective payment system for PPS-excluded hospitals and distinct-part units should be implemented as soon as practicable.

Recommendation 13: Broadening Financial Support to Teaching Hospitals

Explicit financial support for graduate medical education activities should not be limited to the Medicare program. Mechanisms to broaden financial support for teaching-related activities in hospitals and other locations should be developed.

Recommendation 14: Medicare Payments for Graduate Medical Education Costs

ProPAC supports changes in Medicare teaching payments that would encourage an appropriate distribution of residents across specialties and discourage inappropriate growth in the total number of residents.

Recommendation 15: Medicare Indirect Medical Education Payments

The Medicare indirect medical education adjustment should be reduced from its current 7.7 percent level to 7.0 percent.

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Recommendation 16: Distributing Additional Teaching-Related Payments

Funds that provide broader financial support for graduate medical education should be distributed in a way that corresponds to the additional costs incurred by teaching facilities. Providers that treat enrollees in capitation plans should receive teaching-related payments for those patients as well as for the other patients they serve.

Recommendation 17: Disproportionate Share Hospital Payments

The Commission is concerned about the potential impact of reductions in DSH payments. Hospitals that treat a large number of the uninsured could be particularly vulnerable because of recent changes in the health care environment. Large reductions in DSH payments would threaten the continued ability of many of these hospitals to serve populations who depend on them for access to care.

Recommendation 18: Method for Distributing Disproportionate Share Payments

The structure of the DSH adjustment should be reviewed to make certain that available funds are distributed equitably among the hospitals most in need of assistance. This may require collecting new data to develop a better measure of the services hospitals provide to indigent patients.

Recommendation 19: Discharges from PPS Hospitals to Other Facilities

Medicare payments should be modified to account for the shift in services from acute to post-acute settings. Broadening the definition of transfer cases, however, is not an appropriate approach.

Recommendation 20: Prospective Payment for Post-Acute Care

Prospective payment systems should be implemented for all post-acute services. The payment method for each service should be consistent across delivery sites. The Secretary should explore methods to control volume of post-acute service use, such as bundling services for a single payment.

Recommendation 21: Case-Mix Measures for Post-Acute Services

Reliable case-mix measurement is important in prospective payment systems to account for resource use and to analyze treatment patterns and costs across sites. The Secretary should coordinate case-mix research across post-acute care settings, using consistent methods for measuring patient acuity and resource use.

Recommendation 22: Interim Fee-for-Service Payment Method for Skilled Nursing Facility Services

An interim payment method should be implemented to control the growth in Medicare payments for SNF services until a comprehensive prospective payment system is established. A system based on historical data and facility-specific limits, however, may not allow facilities to respond appropriately to changes in a dynamic environment.

Recommendation 23: Interim Fee-for-Service Payment Method for Home Health Care

Until a fully prospective payment system is developed, the Commission supports adopting episode-based payment limits. In addition, beneficiary copayments, subject to an annual limit, should be introduced.

Recommendation 24: Update to the Composite Rate for Dialysis Services

The Secretary should develop methods to control total Medicare per capita expenditures for ESRD beneficiaries. In the meantime, the composite rate should be updated by 2.7 percent for hospital-based dialysis facilities and by 2.0 percent for freestanding facilities for fiscal year 1997. The Secretary should also develop reliable measures of patient severity and outcomes to analyze the relationships among treatment processes, patient outcomes, and costs. These factors should be considered in evaluating the need for and the level of future payment updates.

Recommendation 25: Prospective Payment for Hospital Outpatient Services

A comprehensive prospective payment system should be developed for hospital outpatient ser-

vices. Such a system should include a strategy for controlling the volume of ambulatory services.

Recommendation 26: Beneficiary Liability for Hospital Outpatient Services

The growing financial burden for Medicare enrollees who receive services in hospital outpatient departments should be alleviated immediately. Beneficiary coinsurance for these services should be limited to 20 percent of the Medicare-allowed payment, as it is in other settings. For services not paid on a prospective basis, the Secretary should establish a new method for determining beneficiary copayments based on estimated allowed payments since they cannot be calculated precisely when services are delivered.

Chapter 1

Reforming the Medicare Program

For 30 years, Medicare has fulfilled its promise of protecting the elderly, and subsequently the disabled, from financial impoverishment due to illness. This protection, however, has come at a substantial cost to the Federal government and taxpayers as well as to some Medicare beneficiaries. In 1967, the program covered 19.5 million people at a cost of $4.8 billion.[1] By 1993, program spending had increased more than 30-fold to $151.1 billion, with the number of enrollees almost doubling to 36.3 million. Medicare beneficiaries have felt the effects of the spending increases, with their cost-sharing responsibilities during 1993 exceeding $30 billion.[2] Out-of-pocket costs for non-covered services also have climbed sharply.

Medicare program spending reached an estimated $177 billion in fiscal year 1995, accounting for 12 percent of the Federal budget. The Congressional Budget Office (CBO) projects that, under current law, program spending will grow to $332 billion by fiscal year 2002.[3] Furthermore, the Federal share of Medicaid payments is expected to climb from $89 billion to $173 billion over this time. Consequently, spending for Medicare and Medicaid in 2002 is projected to consume more than one-fourth of the total Federal budget.

The rise in the cost of these entitlement programs is a major contributor to the projected growth in the Federal budget deficit. The relentless increases in Medicare spending for hospital, skilled nursing facility (SNF), home health, and other services also have led to the recent warning that Medicare's primary source of income, the Hospital Insurance (HI) Trust Fund, will not be able to cover anticipated expenses beginning in 2002.

This year, as it has periodically over the past 15 years, the Congress has taken steps to rein in the growth in Medicare spending, extend the solvency of the HI Trust Fund, and balance the Federal budget. The reductions in spending growth now being considered by the Congress and the President, however, are substantially greater than those previously enacted. In addition, the proposal passed by the Congress—and vetoed by the President—embodies a major philosophical change in the role and responsibilities of the Federal government and the nature of the Medicare and Medicaid entitlements.[4]

The President supports the objectives of slowing the rise in Medicare spending, strengthening the financial integrity of the HI Trust Fund, and balancing the Federal budget. His approach, however, varies in fundamental ways from that of the Congress. The President's proposal reflects different budget priorities, allowing larger increases in Medicare and Medicaid spending and favoring smaller tax reductions.[5] His approach also does not incorporate many structural changes to Medicare and Medicaid, such as those proposed by the Congress.

In this chapter of its annual report to the Congress, the Prospective Payment Assessment Commission (ProPAC) examines the Medicare and Medicaid spending trends that led the Congress to conclude that major reforms of these programs were necessary. Past Medicare expenditure patterns and projected spending through 2002 are described. The next sections review the impact of expenditure growth on beneficiaries' financial liabilities, the HI Trust Fund, and the Federal budget deficit. The steps considered by the Congress and the President to modify the Medicare program and slow the rise in spending are then discussed. The chapter concludes with the Commission's recommendations regarding reform of the Medicare program.

In Chapter 2, ProPAC describes and provides its views and recommendations to the Congress on the existing Medicare capitation option and the MedicarePlus program. This program would replace

Medicare's risk-based contracting policies. It also reflects substantial changes in the Congress's view of how Medicare's capitation program should operate. The next two chapters examine changes in the traditional Medicare fee-for-service program. Chapter 3 presents the Commission's recommendations regarding payment policies for inpatient hospital services. In Chapter 4, the rapidly growing areas of post-acute and ambulatory services are discussed, along with recommended changes to their payment policies.

HEALTH CARE SPENDING

Total national health care expenditures are expected to exceed $1 trillion in 1995.[6] The Federal government, the largest single payer for health care, will pay a third of the bill for medical services (see Table 1-1). The Medicare and Medicaid programs will account for $346 billion of this spending, providing health coverage to 66 million people.

The responsibility for funding personal health care services has changed dramatically in the past 35 years, as government and private health insurance programs have expanded. Between 1960 and 1993, individual out-of-pocket spending rose from about $13 billion to almost $158 billion (see Table 1-2). As a share of personal health care spending, however, out-of-pocket expenditures declined from 56 percent to 20 percent, while private sector and government expenditures increased rapidly. Private sector expenditures climbed from about $5 billion to $288 billion. By 1993, the Federal government was spending $259 billion, about 33 percent of personal health care spending, primarily due to rapid expansion of the Medicare and Medicaid programs.

The enactment of Medicare and Medicaid in 1965 was followed by a rapid escalation in the health care portion of Federal, state, and local budgets (see Table 1-3). Health care expenditures increased from 7.6 percent of state and local government spending in 1965 to 12.4 percent in 1993. The effects on the Federal budget were more striking, with health expenditures rising from 3.9 percent to 18.6 percent of total Federal outlays over this period.

The drafters of the original Medicare legislation intended that the Federal government would provide most of the financing for care received by the elderly, but that services would be furnished through the existing private delivery system. The financing was to come primarily through payroll taxes, enrollee premiums and cost sharing, and general revenues. The Congress designed Medicare to pay for hospital and physician services without significantly altering the existing health care financing and delivery system.[7] Thus, many of Medicare's payment policies were modeled after those in the private insurance market. The most important of these were the reliance on fee-for-service payment for physician services and cost-based reimbursement for hospital care.

These policies succeeded in guaranteeing needed care for Medicare beneficiaries. They also improved the financial condition of providers. But

Table 1-1. National Health Expenditures by Source of Funds, Selected Years

	In Billions of Dollars				As a Percentage of Total Expenditures			
		Government				Government		
Year	Private	Federal	State and Local	Total	Private	Federal	State and Local	Total
1965	$ 31	$ 5	$ 5	$ 42	75.3%	11.6%	13.2%	100%
1980	146	72	33	251	58.1	28.7	13.3	100
1985	259	123	52	434	59.7	28.4	11.9	100
1990	410	196	91	697	58.9	28.1	13.0	100
1993	496	281	107	884	56.1	31.7	12.1	100
1995*	552	334	121	1,008	54.8	33.2	12.0	100
2000*	770	528	174	1,472	52.3	35.8	11.8	100
2005*	1,051	821	247	2,119	49.6	38.8	11.6	100

Note: National health expenditures include all spending in the health care sector.

* Projected.

SOURCE: Congressional Budget Office.

Table 1-2. Personal Health Care Expenditures by Source of Funds, Selected Years (In Billions)

Year	Total	Out-of-Pocket	Private	Government	
				Federal	State and Local
1960	$ 23.9	$ 13.4	$ 5.4	$ 2.1	$ 3.0
1970	64.8	25.4	16.9	14.7	7.8
1980	220.1	61.3	71.8	63.4	23.6
1985	380.5	98.8	133.7	111.3	36.7
1990	612.4	138.3	230.7	178.1	65.3
1991	670.8	143.3	250.0	206.0	71.6
1992	729.7	150.6	269.8	234.0	75.3
1993	782.5	157.5	288.0	259.0	78.1

Note: Personal health care expenditures exclude research and construction, administration of public programs and net cost of private health insurance, and government public health activities.

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

they greatly expanded service capacity and led to the rapid adoption of new and costly technologies, which contributed to the acceleration in Medicare expenditures.

Medicare Program Expenditures

In 1967—its first full year of operation—Medicare spent $4.8 billion on behalf of its enrollees (see Table 1-4). Eligibility for the Medicare program was expanded in 1972 to people who were disabled as well as to those with end-stage renal disease. By 1980, spending had reached $36.4 billion. Between 1980 and 1993, Medicare expenditures climbed on average more than 11 percent annually, to $151.1 billion. Part of this rise can be attributed to the growth in Medicare enrollees. From 1966 to 1993, the number of enrollees 65 or over rose about 2 percent a year and, since 1973, the number of disabled enrollees has gone up about 4 percent annually. The total Medicare-covered population expanded from 19.5 million in 1967 to 36.3 million in 1993.

Table 1-3. Government Health Expenditures as a Percentage of Total Government Expenditures, Selected Years

Year	Federal	State and Local
1960	3.1%	7.8%
1965	3.9	7.6
1966	5.2	7.5
1967	7.3	7.6
1970	8.5	7.8
1975	10.0	8.5
1980	11.7	9.9
1985	12.7	11.0
1990	15.4	12.9
1991	16.9	12.8
1992	17.4	12.6
1993	18.6	12.4

SOURCE: Health Care Financing Administration, Office of the Actuary and Office of National Health Statistics; and Department of Commerce, Bureau of Economic Analysis.

In addition to the continuing increases in enrollees, the share of Medicare beneficiaries using services paid for by the program has risen sharply over the years. This has occurred partly because the growth in the Part B deductible has not kept pace with the rise in health care costs. Consequently, a growing number of beneficiaries meet the deductible requirements. Only 37 percent of enrollees, about 7 million people, had Medicare payments made on their behalf in 1967. By 1980, 18 million enrollees were being served, representing 63 percent of the Medicare population. In 1993 about 80 percent of the Medicare population, 29 million enrollees, used services paid for by the program. It is not surprising, therefore, that Medicare spending has increased. But this does not tell the full story.

Medicare program payments for each person served also have escalated at a rapid pace, from $593 in 1967 to $4,387 in 1993—an 8 percent average annual rate of increase.[8] This rise is substantially larger than can be explained by general inflation during this time. In part, the growth in payments per person reflects medical inflation above that in the general economy. More important, however, are the continuing increases in the number and complexity of services furnished to Medicare beneficiaries.

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Table 1-4. Personal Health Care Expenditures Under Medicare and Medicaid, Selected Years

Year	Medicare		Medicaid	
	Spending (In Billions)	Enrollees (In Millions)	Spending* (In Billions)	Recipients (In Millions)
1967	$ 4.8	19.5	$ 3.0	—
1970	7.3	20.5	5.1	—
1973	10.2	23.5	9.1	19.6
1980	36.4	28.5	24.8	21.6
1985	70.3	31.1	39.2	21.8
1990	109.6	34.2	71.7	25.3
1993	151.1	36.3	112.8	33.4

* Includes Federal and state shares.

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

Changes in Medicare policies will have different effects on beneficiaries, since a relatively small number of them account for a large portion of expenditures. In 1993, 53 percent had payments of less than $500 made on their behalf.[9] By contrast, 10 percent had payments of $10,000 or more, representing almost three-quarters of all Medicare program spending. Slightly more than 3 percent had payments of $25,000 or more; this group accounted for 39 percent of all spending.

Medicaid Program Expenditures

Medicaid is a joint Federal and state program intended to provide medical care to low-income people who meet certain requirements. States are given substantial flexibility, within Federal guidelines, to determine eligibility and benefits for their residents. Consequently, eligibility, coverage, and payment rules vary greatly among the states. Medicare enrollees are eligible for Medicaid if they meet the income and asset standards set by a state. About 12 percent of the Medicare population was dually eligible for both programs in 1993. In addition, state Medicaid programs are required to pay Medicare premiums and cost-sharing amounts for certain low-income persons, called Qualified Medicare Beneficiaries.

The Medicaid program has experienced substantial growth, adding pressure to state and Federal budgets. Medicaid spending spiraled from $3.0 billion in 1967 to $112.8 billion in 1993. During the 1980s, Medicaid program spending growth was relatively stable. In the early 1990s, however, expenditures jumped, in large part because of expansions in eligibility, states' use of provider tax and donation programs to increase Federal matching payments, and changes in legislation that allowed states to increase payments dramatically to certain hospitals serving a disproportionate share of low-income patients.

Though more than 70 percent of Medicaid recipients were children and low-income adults in 1993, they accounted for only 30 percent of Medicaid payments. About 15.5 million children—almost half of all Medicaid recipients—received covered services. These children, however, generated only 16 percent of Medicaid payments. By contrast, about 27 percent of Medicaid enrollees were aged, blind, or disabled. This group, which included many Medicare beneficiaries, accounted for nearly 70 percent of total Medicaid spending, much of which was for long-term nursing home care. Hence, the Medicaid program serves important needs for the low-income Medicare population.

MEDICARE BENEFICIARY COST SHARING

The rapid rise in the cost of medical services has increased the financial burden for many Medicare enrollees, especially those with limited incomes. Medicare beneficiaries generally are responsible for paying a certain amount of the bill for the services they receive, and as program spending has gone up, so have their liabilities. These cost-sharing responsibilities include the inpatient hospital deductible, coinsurance requirements, and balance billing payments to certain physicians whose charges are higher than the payment allowed by Medicare. Beneficiaries must also pay for all of Medicare's allowed amount for physician and other Part B services until they reach a certain deductible.

Between 1977 and 1993, beneficiary liability as a share of overall Medicare spending dropped modestly, from 18 percent to 15 percent. Total beneficiary out-of-pocket spending for services covered by Medicare, however, rose more than five-fold.[10]

Over time the pattern of cost sharing has changed, reflecting differences in the types of providers used and the costs of various services. The share of beneficiary out-of-pocket spending for

Part A services, especially hospital and SNF care, has accelerated. Part B liability, which accounted for about 76 percent of cost sharing in 1977, fell to about 67 percent in 1993. A major factor in this decline was the limit on balance billing that the Congress enacted as part of physician payment reform in 1989. In addition, the increase in the Part B deductible, from $60 to $100 during this time, lagged far behind the rise in program spending or general inflation. The decrease in the deductible as a portion of Part B liability, however, was offset by the substantial growth in the share of coinsurance payments.

The average yearly cost-sharing liability per Medicare enrollee went from $174 in 1977 to $626 in 1993. This figure hides large differences in payments among beneficiaries for Medicare-covered services. Almost 65 percent of enrollees incurred a liability of less than $500 in 1992, but 6 percent were responsible for more than $2,000 in out-of-pocket spending. A small group of beneficiaries, 1.7 percent, confronted payments of $5,000 or more. Thus, for certain beneficiaries the financial protection from the costs of major illness offered by the Medicare program falls far short of the need.

In addition to these cost-sharing liabilities, Medicare beneficiaries are responsible for payment of the Part B premium if they elect this coverage, as almost all do. There also are substantial gaps in Medicare coverage for certain services (especially medications) that the elderly and disabled frequently require. Most Medicare beneficiaries must pay for these non-covered services directly or through private supplemental insurance.

To reduce the risk of significant out-of-pocket spending, about 75 percent of Medicare enrollees relied on private insurance to supplement their Medicare coverage in 1992. Another 12 percent were dually eligible for Medicaid, which provides financial assistance in meeting these extra costs. About 11 percent of Medicare enrollees had no supplemental coverage and were at full risk for cost-sharing expenses, while the rest were covered by other programs. The increase in out-of-pocket spending also may contribute to the growth in the number of beneficiaries who are choosing plans in Medicare's capitation program. Many of these plans require little or no cost sharing. They also frequently supplement their benefit packages with services such as prescription drugs, which Medicare does not cover.

THE SOLVENCY OF THE MEDICARE TRUST FUNDS

The Medicare program is financed through a variety of mechanisms, with funding channeled through two trust funds. The primary source of income for the Hospital Insurance Trust Fund is a dedicated payroll tax, paid by employers, employees, and the self-employed. Although Medicare is an entitlement, this fund must be solvent to pay claims on behalf of beneficiaries receiving Part A services, because trust fund balances limit spending authority. If the trust fund became insolvent, Part A Medicare payments would be limited to the money that accrued to the fund from current payroll tax receipts.

By contrast, the Part B Supplementary Medical Insurance Trust Fund is financed primarily through general revenues and enrollee premiums. General revenues and premiums each contributed about 49 percent of the fund's income in 1972. By 1993, the general revenue share was 72 percent, with premiums adding 25 percent. Although spending from this fund has been growing rapidly, insolvency is not a problem since general revenues are required to cover expected outlays that exceed premiums and other receipts. The growth in Part B Medicare spending, therefore, increases the Federal budget and contributes to the deficit.

The trust funds' trustees issue an annual report projecting revenues and expenses and evaluating the actuarial condition of each fund. To arrive at their conclusions, the trustees make assumptions about the growth in taxable wages and salaries, future rates of inflation, the number and life expectancy of Medicare enrollees, and patterns of service use. They base their projections on current Medicare statutory authority. In their 1995 report, the trustees projected that the HI Trust Fund would begin to run a deficit in 1996 and would be insolvent in 2002, seven years from the release of the report.[11]

While projections of trust fund insolvency are not a new occurrence, they have received much more attention this year. Since 1970, on several occasions the trustees have projected insolvency of

the HI Trust Fund within seven years (see Table 1-5). Their projections have not materialized, primarily because the Congress has taken action to avert the impending insolvency. In 1972, the Congress raised the Medicare payroll tax rates and increased the ceiling on the level of earnings to which the tax is applied. The Congress also has enacted many provisions intended to control Part A expenditures by curbing the growth in payments to hospitals and other providers. In 1983, the Congress enacted the Medicare prospective payment system (PPS) for inpatient hospital services and other initiatives intended to slow expenditure growth. Steps also were taken that year, and again in 1990 and 1993, to increase HI Trust Fund revenues.

Because Medicare has relied primarily on a fee-for-service payment system, initiatives to slow the rise in spending have focused on reducing the price that Medicare pays for each service furnished.

Table 1-5. Number of Years from Trustees' Projection Until Insolvency of the Hospital Insurance Trust Fund

Year of Trustees' Report	Year of Insolvency
1970	2
1971	2
1972	4
1973	None indicated
1974	None indicated
1975	About 20*
1976	About 15*
1977	About 10*
1978	12
1979	13
1980	14
1981	10
1982	5
1983	7
1984	7
1985	13
1986	10
1986 amended	12
1987	15
1988	17
1989	None indicated
1990	13
1991	14
1992	10
1993	6
1994	7
1995	7

* Projections for 1975, 1976, and 1977 put the dates of insolvency, respectively, in "the late 1990s," "the early 1990s," and "the late 1980s."

SOURCE: Henry J. Aaron and Robert D. Reischauer, "The Medicare Reform Debate: What Is the Next Step?" *Health Affairs*, Winter 1995.

These actions have had less effect on the overall program budget, as the number and complexity of services provided have burgeoned, perpetuating the rise in program expenditures.

HI Trust Fund solvency remains threatened over the long term, in spite of past efforts to shore up the fund temporarily and reductions in spending growth currently considered by the Congress and the President. This is because the ratio of workers paying Medicare taxes to Medicare enrollees is declining as the baby boom generation ages into Medicare.

MEDICARE, MEDICAID, AND THE FEDERAL BUDGET

The Congressional Budget Office estimates that total Federal revenues in fiscal year 1995 will reach almost $1.36 trillion (see Table 1-6). Expected outlays will be just under $1.52 trillion, resulting in a $161 billion budget deficit for the year. The cumulative Federal debt, as a result of years of deficit spending, now stands at $4.9 trillion. The 1995 deficit is the smallest since 1989, but CBO projects that it will rise steadily over the next decade if current budgetary policies remain unchanged.

Federal spending is divided into mandatory and discretionary categories. Interest on the national debt is treated separately. Defense, international affairs, transportation, and domestic programs such as biomedical research funding are examples of discretionary spending. This spending is subject to review in the annual appropriations process. In addition, under current law it is subject to spending limits through 1998. Consequently, total discretionary spending is controlled, and policy makers must make trade-offs among competing programs. CBO projects that total discretionary spending will decrease from 35 percent of total Federal outlays in 1996 to 30 percent in 2002, if the current spending limits expire in 1998 as scheduled.

By contrast, mandatory entitlement programs like Medicare and Medicaid are not subject to annual review, the appropriations process, or spending limits. In 1996, total mandatory spending will account for 55 percent of Federal outlays. CBO estimates that the share of mandatory expenditures will climb to 62 percent in 2002. Medicare

Table 1-6. Selected Congressional Budget Office Projections, Fiscal Years 1995-2002 (In Billions)

Budget Category	1995	1996	1997	1998	1999	2000	2001	2002
Total revenues	$1,357	$1,423	$1,487	$1,553	$1,625	$1,703	$1,783	$1,871
Total outlays	1,518	1,595	1,668	1,736	1,820	1,907	1,994	2,100
Deficit	161	172	182	183	195	204	211	228
Medicare[a]	177	196	216	236	258	281	305	332
Medicaid[b]	89	97	107	118	130	143	157	173

[a] Mandatory outlays.

[b] Federal share of Medicaid payments.

SOURCE: Congressional Budget Office.

and Medicaid outlays will be responsible for 17 percent of Federal spending in 1996. Under current policies, these programs are expected to consume 27 percent of the Federal budget in 2002. CBO points to the rapid growth in Medicare and Medicaid spending as the major factor driving up its deficit projections.

The Congress, intent on eliminating the Federal deficit by 2002, has looked to mandatory spending—and especially the rapidly growing health entitlement programs—for substantial budget savings. The Congress can control Medicare spending by changing eligibility policies or reducing benefits. It also can require higher beneficiary cost sharing or raise taxes. These approaches are regarded as politically unattractive, however. Consequently, over the past decade as it struggled with the Federal deficit, the Congress has looked primarily to reductions in payments to providers as the method of slowing Medicare spending growth. The current proposals generally continue to follow that path.

RENEWED ACTION BY THE CONGRESS

In November 1994, the American public elected, for the first time in several decades, a Republican-controlled Congress. The 104th Congress began its work in early 1995, determined to balance the Federal budget by 2002. The first formal step in the process was the passage of a budget resolution for fiscal year 1996. The Congress laid out its spending priorities and identified the broad program areas that it would target to balance the budget by 2002. The legislative process requires an independent projection of baseline expenditures and an assessment of the savings that can be expected from congressional proposals. The Congressional Budget Office is charged with these responsibilities.

CBO's spending baseline reflects assumptions regarding economic growth and the level of future spending under current laws. The December 1995 update of the baseline projected that the budget deficit would rise from $161 billion in 1995 to $228 billion in 2002. To reduce the deficit, it is necessary for the Congress to enact legislation containing budget savings. CBO credits a legislative proposal with savings if it will result in reductions from the forecasted baseline growth. Thus, savings may be achieved even if spending continues to rise.

Medicare Savings

CBO projects that under current law, Medicare outlays (before subtracting offsetting premium receipts) will rise from about $177 billion in 1995 to almost $332 billion in 2002, or 9.4 percent annually (see Table 1-7). As a major contributor to the deficit, the Medicare program was initially targeted by the Congress for $270 billion in savings over the next seven years. Revised CBO baseline estimates, however, projected slower Medicare spending growth. Consequently, the estimate of the savings in the bill passed by the Congress fell to $227 billion.[12] Under this proposal, Medicare expenditures would rise at an annual rate of 7.2 percent.

By contrast, the President's proposal would result in $102 billion in total savings and an annual growth rate of 7.6 percent. A separate bill (H.R. 2530), supported by a coalition of members of the House of Representatives, contains $153 billion in Medicare reductions. The coalition's proposal would result in Medicare mandatory spending increases of 7.5 percent annually.[13]

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Table 1-7. Medicare and Medicaid Baseline Spending and Estimates Under Alternative Proposals, 1995-2002 (In Billions)

Proposal	Mandatory Outlays				Total Net	
	1995	1996	2002	Annual Increase 1995-2002	Outlays[a] 1996-2002	Savings[a] 1996-2002
Medicare:						
Baseline	$177.4	$196.4	$331.8	9.4%	$1,679.5	—
Congress[b]	177.4	192.9	288.6	7.2	1,452.8	$226.7
President[c]	177.4	196.4	296.4	7.6	1,578.0	101.5
Coalition[d]	177.4	192.2	294.1	7.5	1,526.8	152.7
Republican offer[e]	177.4	196.4	292.0	7.4	1,511.5	168.0
President's budget[f]	—	—	—	—	1,555.3	124.2
Medicaid:						
Baseline	89.1	97.2	172.6	9.9	924.1	—
Congress[b]	89.1	97.1	127.4	5.2	791.4	132.7
President[c]	89.1	97.2	154.0	8.1	872.4	51.7
Coalition[d]	89.1	97.2	162.5	9.0	877.9	46.2

Note: Baseline spending and other estimates based on Congressional Budget Office December 1995 budget baseline.

[a] Includes effect of premium increases.

[b] H.R. 2491, the "Balanced Budget Act of 1995," passed by the Congress on November 20, 1995.

[c] The "Balanced Budget Act of 1995 for Economic Growth and Fairness," released by the President on December 7, 1995.

[d] H.R. 2530, the "coalition budget," introduced on October 25, 1995.

[e] Republican offer presented to the President on January 5, 1996, as estimated by the House of Representatives, Budget Committee.

[f] President's 1997 budget released on February 5, 1996, based on savings estimated by the Office of Management and Budget.

SOURCE: Congressional Budget Office; House of Representatives, Budget Committee; and Office of Management and Budget.

The Republican leadership in the Congress and the President have attempted to arrive at an agreement resolving the differences in their proposals. As part of their negotiations, the Republican leadership submitted an "offer" that would reduce the total savings in their plan from $227 billion to $168 billion. The President also has revised his proposal, increasing Medicare savings from $102 billion to $124 billion.

The annual increase in Medicare spending is similar in all the proposals, ranging from 7.2 percent to 7.6 percent. The variation in total savings, however, is much greater due to differences in the growth of Part B premiums among the proposals.

Medicaid Savings

Because of its substantial growth, the Medicaid program also is a target for spending reductions. CBO projects that the Federal share of this program will climb from roughly $89 billion in 1995 to nearly $173 billion in 2002, an annual rate of 9.9 percent. The legislation passed by the Congress would slow this rate to 5.2 percent over the seven-year period, saving just under $133 billion.

Medicaid spending under the President's proposal would increase, on average, 8.1 percent a year, saving almost $52 billion. The coalition's approach is similar, leading to 9.0 percent annual growth and about $46 billion in expenditure reductions.

The MedicarePlus Program

The Congress is especially interested in expanding Medicare's capitation program. This would achieve both of the Congress's primary goals: slowing Medicare entitlement spending and reducing government control over the program.

Under Medicare's existing capitation program, participating health maintenance organizations contract to provide all covered services for enrolled beneficiaries in return for a predetermined

monthly payment per enrollee. This arrangement shifts the responsibility for payment for individual services furnished to beneficiaries from the Federal government to private plans. The proposed MedicarePlus program would expand the variety of health plans available to Medicare enrollees. It also would sever the connection between the capitation amount and spending in the fee-for-service program. The annual update to the capitation rate would be set in law to achieve the Medicare spending level desired by the Congress. The Congress has also expressed its dissatisfaction with the current administration of the capitation program. Its proposal would move program management from the Health Care Financing Administration to another entity within the Department of Health and Human Services.

The MedicarePlus program would include a wide range of options that meet the desire of many members of the Congress to eliminate Federal government involvement in the care Medicare beneficiaries receive. Especially noteworthy are the options to allow beneficiaries to join a private fee-for-service program or to select a medical savings account. Both of these choices would represent a significant change in the responsibilities of the Medicare program.

The Traditional Fee-for-Service Program

The traditional fee-for-service program continues to account for most of Medicare's spending. Consequently, almost 70 percent of the savings in the congressional proposal comes from this program (see Table 1-8). The 1995 base year spending and the projected increases over the next seven years differ greatly across types of providers (see Table 1-9). The savings would be spread across hospitals, physicians, and other providers and suppliers generally in proportion to projected spending increases. The bill also would move payment for home health services from a cost to a prospective payment basis, create facility-specific payment limits for ancillary services furnished in skilled nursing facilities, and provide for a SNF prospective payment system beginning in fiscal year 1998. Although the proposal slows the growth in Medicare payments to teaching hospitals, it provides new funding from general revenues for a Teaching Hospital and Graduate Medical Education Trust Fund.

Table 1-8. Estimated Savings from the Congressional Proposal, by Category, 1996-2002 (In Billions)

Category	Estimated Savings
Fee-for-service:	
Inpatient hospital	$ 64.7
Outpatient hospital and ambulatory	19.1
Physicians	12.6
Home health	17.0
Skilled nursing	10.0
Other services	19.0
Total fee-for-service	142.4
Failsafe	11.5
Part B premiums	54.2
MedicarePlus	18.6
Total	226.7

SOURCE: Congressional Budget Office.

A NEW PHILOSOPHY

The legislation agreed to by the Congress includes stronger controls than any previously enacted to ensure that spending for the care furnished to Medicare beneficiaries does not exceed specific targets. The effects of the proposal, however, could extend far beyond its budgetary impact. The approach represents a fundamental change in the nature of the Medicare program. The bill would take a major step in moving the Medicare program from open-ended spending for covered services to a predetermined annual government payment per enrollee. To meet its budget target, the Congress spelled out specific spending rates of increase per enrollee in the MedicarePlus program. As a result, spending for these enrollees would be predictable and controlled.

This is not now the case in the traditional fee-for-service program, which pays hospitals, physicians, and other providers for the care they furnish. The more care these providers give, the more they are paid. Consequently, even when Medicare controls the price it pays for each unit of service, its spending escalates as the number of services increases. The reductions in fee-for-service payment growth contained in the congressional proposal fall short of meeting the seven-year budget

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Table 1-9. Selected Congressional Budget Office Medicare Spending Estimates, Fiscal Years 1995-2002

Category	1995	1996	1997	1998	1999	2000	2001	2002
Total mandatory (in billions)	$177.4	$196.4	$215.9	$236.4	$258.1	$280.7	$305.3	$331.8
Part A enrollment (in millions)	37.0	37.6	38.2	38.7	39.2	39.8	40.2	40.7
Part A benefits (in billions)	$113.6	$124.8	$136.0	$147.2	$159.0	$171.2	$184.2	$197.7
Hospitals	80.2	84.5	88.8	93.9	99.5	105.2	111.0	116.7
PPS hospitals	68.9	72.4	75.6	79.3	83.2	87.2	91.2	95.3
Indirect medical education	4.3	4.6	5.2	5.8	6.4	7.0	7.7	8.5
Graduate medical education*	1.9	2.1	2.3	2.5	2.7	2.8	3.0	3.2
Disproportionate share	3.4	3.5	3.6	3.8	3.9	4.1	4.3	4.4
Inpatient capital*	7.9	9.6	10.4	11.1	11.8	12.6	13.1	13.6
Home health	14.7	17.2	19.8	22.2	24.2	26.2	28.3	30.6
Skilled nursing facility	9.0	10.8	12.2	13.3	14.5	15.7	17.0	18.4
Part B enrollment (in millions)	35.7	36.3	36.8	37.2	37.7	38.1	38.5	39.0
Part B benefits (in billions)	$ 63.5	$ 71.2	$ 79.6	$ 88.9	$ 98.7	$109.1	$120.8	$133.8
Physicians	32.2	36.0	38.8	42.1	45.2	47.9	50.8	53.8
Hospital outpatient	10.6	12.1	13.7	15.5	17.6	19.8	22.4	25.2

Note: Based on December 1995 budget baseline.

* Includes PPS and other hospitals.

SOURCE: Congressional Budget Office.

target by $11.5 billion (after offsetting premium increases); that is, if spending rises at CBO's projected rate, outlays would exceed the target by this much. To make certain that spending is not more than the predetermined annual amount for each Medicare enrollee in the fee-for-service program, the Congress would impose a method to enforce the budget limits.

THE FAILSAFE BUDGET MECHANISM

An important aspect of the bill passed by the Congress is a savings enforcement tool called the "failsafe budget mechanism." For the first time in Medicare's history, total spending per enrollee in both the capitation and fee-for-service programs would be capped each year at a congressionally mandated amount. Medicare would still make payments to providers on behalf of beneficiaries. But total Medicare spending would be the same, even if the number of services provided grew or the rate of inflation changed.

Medicare Benefit Budget and Budget Allotment

The failsafe mechanism contains a specific annual Medicare benefit budget for fiscal years 1996 through 2002. This budget reflects the spending levels contained in the Congress's proposal. It includes all Medicare benefit payments and would meet the congressional objective of reducing Medicare spending growth by $227 billion through 2002.

After 2002, an update formula would be applied to the budget for the preceding year. This would result in 5 percent annual Medicare spending growth per enrollee after 2002, regardless of the rate of inflation or service use. This same annual growth rate per enrollee would apply to beneficiaries in both the fee-for-service and the MedicarePlus programs.

Each year, the Secretary would estimate a Medicare budget allotment for the fee-for-service program by removing from the benefit budget projected payments under the MedicarePlus program. The resulting budget allotment would be used as the basis for the failsafe requirements.

Sector Allocation

The Medicare fee-for-service budget allotment would be allocated to each of nine sectors (such as inpatient hospital and home health services). For

fiscal year 1996, baseline projected spending for each sector would equal the sector's fiscal year 1995 expenditures inflated by the sector's annual growth rate, as defined in the legislation. In subsequent years, each sector's legislated growth rate would be applied to the prior year's baseline.

Beginning in fiscal year 1998, the Secretary would reduce payments for all services in any sector that exceeded its target. The payment reduction would be proportional to the amount by which the Secretary estimates spending would exceed the sector target. The percentage reductions would be the same for all services within a sector, but would likely differ across sectors. The Secretary also would be responsible for adjusting payments in all sectors to ensure that aggregate spending would be consistent with the overall fee-for-service budget allotment. In addition, there is authority for a "look-back" adjustment to reflect actual fee-for-service and MedicarePlus expenditures when final data become available. If the President submitted a proposal to revise the baseline annual growth rates for fee-for-service sectors, the Congress would have to consider it under an expedited procedure.

Impact on Fee-for-Service Spending

The bill passed by the Congress would require $11.5 billion in failsafe payment reductions between 1998 and 2002, according to CBO estimates. The ability of fee-for-service providers to avoid triggering the failsafe reductions depends critically on the number and intensity of services they furnish. CBO's estimates of projected spending include assumptions about annual increases in the number and intensity of hospital and SNF admissions, physician visits, and other services. Thus, to avoid these additional reductions, providers would have to furnish fewer services than CBO estimated.

Inflation rates that exceed CBO projections also could trigger subsequent payment reductions. The benefit budget is spelled out in specific dollar amounts between 1996 and 2002. After that, the update formula is a fixed percentage plus growth in the number of Medicare enrollees. There is no mechanism to account for changes in inflation. Annual payment updates for fee-for-service providers, however, are generally linked to a market basket that measures inflation. Substantial increases in inflation would increase payment updates but could subsequently cause large payment reductions. The failsafe budget mechanism would not sunset, although fee-for-service payment updates generally would return to a market basket increase after 2002. Consequently, failsafe reductions could occur even when inflation or the number of services rose slightly.

Fee-for-service providers would be at further risk if healthier Medicare beneficiaries enrolled in MedicarePlus, while sicker beneficiaries remained in the fee-for-service program. The methods Medicare uses to adjust capitation payments explain very little of the variation in expected enrollee spending. The expansion of capitation plan options (especially medical savings accounts) may encourage beneficiaries who expect to use less than the average amount of services to enroll. The failsafe mechanism does not provide for adjustments to growth rates if healthier enrollees select MedicarePlus, leaving costlier ones in the fee-for-service program.

CHANGES IN THE HEALTH CARE ENVIRONMENT

The proposed reform of the Medicare program comes at a time when private sector financing and delivery of medical care are undergoing substantial change. Employers and other buyers of insurance are demanding lower premiums. In response, third-party payers are moving from fee-for-service policies to capitation and other managed care methods to control their costs, while providers are grappling with stepped-up competition for patients. Competition has altered the way providers do business, with the price of services assuming increased importance.

The restructuring of the nation's health care delivery system already has had an impact. National health care expenditures rose about 6 percent in 1994, among the lowest rates in the past three decades. In addition, surveys of employer health care costs show premium increases at historic lows.

The recent reports of private sector success in checking medical care expenditure growth have not been overlooked by those in the Congress who are intent on shifting governmental activities to the private sector. During the debate on the congressional

proposal, many members indicated they thought that the private sector could manage Medicare beneficiaries' care more efficiently than the Federal government could. If this were so, they reasoned, Medicare spending growth could be moderated without adversely affecting the care beneficiaries receive.

Analysts differ, however, in their assessment of the relative success of the government and private payers in restraining the rise in spending. CBO estimates that in 1995, national health care expenditures grew by 6.8 percent. Private sector spending went up 5.5 percent, while Federal outlays rose 9.1 percent. But interpreting such findings is complicated by the lack of good information on the number and health status of enrollees, where they live, and the benefits and services they receive. Further, expenditure levels in prior years must be considered.

When real spending (removing the effects of inflation) per Medicare enrollee is compared with private health insurance spending per insured person, the findings are mixed (see Table 1-10). Between 1979 and 1983, the private sector appears to have outperformed Medicare. From 1983 to 1991, though, the pattern reversed as the Medicare program implemented policies to curb the rise in expenditures. Since 1991, Medicare spending per enrollee again has surged, while private insurance spending per insured person has risen more slowly. The private sector's improved performance likely is related to the rapid move to capitation in recent years. The Medicare program, by contrast, continues to rely predominantly on traditional fee-for-service methods.

Table 1-10. Real Change in Medicare Spending Per Enrollee and Private Health Insurance Spending Per Insured Person, 1979-1993 (In Percent)

Spending Category	1979-1983	1983-1987	1987-1991	1991-1993
Personal health care				
Private insurance	6.3%	6.9%	5.2%	4.7%
Medicare	7.6	2.9	3.8	6.5
Hospital care				
Private insurance	4.8	2.5	3.8	4.4
Medicare	7.0	1.1	2.3	5.9
Physicians' services				
Private insurance	7.0	10.8	5.8	5.1
Medicare	8.8	7.4	2.7	0.3

SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of the Actuary.

While the Medicare program has successfully kept the payment per unit of service furnished in check, it has not been able to control increases in service volume and intensity. The private sector has relied more heavily on capitation, which allows plans to control costs by actively negotiating the price they will pay providers and by managing the services their enrollees receive. There is disagreement on how long the recent private sector cost-control trends can be maintained. CBO projects that private spending growth will again begin to rise, reaching 6.9 percent annually by 2000. This increase is still substantially lower than CBO's forecast of growth in Federal government spending under current law.

The moderation in expenditure growth for public programs, together with restraints in private health care spending, will require providers to continue to change their traditional ways of doing business. Hospitals and other providers are positioning themselves to compete in a health care system where total resources will grow much less rapidly than they have for many decades. Consequently, providers strongly support the provisions in the congressional proposal allowing them to develop provider-sponsored networks to compete with health plans.

THE UNINSURED POPULATION

The Congress's plan for modifications in the Medicare and Medicaid entitlements coincides with a decline in the proportion of people receiving health insurance through the workplace. Currently, about 15 percent of the population, almost 40 million people, lack health insurance coverage.

The Medicaid program provides an important safety net for those who would otherwise be uninsured. CBO projects that the number of Medicaid recipients will increase from 35.4 million in 1995 to 43.6 million in 2002 under current law. Medicaid spending reductions and other policy changes in the Congress's proposal could slow this growth substantially, and perhaps actually reduce the number of people eligible for Medicaid. Hence, the proposal—together with a declining share of the population covered by private insurance—could leave millions more uninsured.

Many of the uninsured receive hospital and other medical services. Traditionally, third-party payers have subsidized much of the cost of this uncompensated care. Under the price-competitive health care system that the Congress and private payers are encouraging, however, providers may be unwilling or unable to continue to subsidize such care. In addition, the Congress has proposed reducing the funds the Medicare program has provided to hospitals that care for a disproportionate share of low-income patients. In view of these developments, the problems related to the rising number of uninsured will probably be exacerbated. At some point, they are likely to require further action by the Congress.

CONCLUSIONS AND RECOMMENDATIONS

The Congress and the President continue to attempt to resolve differences in their approaches to curbing the rise in Medicare and Medicaid expenditures, strengthening the HI Trust Fund, and balancing the Federal budget. This chapter concludes with the Commission's recommendations on Medicare spending and the failsafe mechanism in the Congress's proposal.

Recommendation 1: Slowing the Rise in Medicare Spending

The Commission supports the efforts of the Congress and the President to reduce the growth in Medicare expenditures. Over time, spending for services furnished to Medicare enrollees should increase at rates comparable to those in a cost- and quality-conscious private sector.

The continuing escalation in Medicare costs is a threat to the solvency of the HI Trust Fund, a major contributor to the Federal deficit, and a financial burden for many enrollees. In ProPAC's view, the growth in spending for medical care in a private sector with market forces that encourage cost containment is an appropriate benchmark for the Medicare program. Judgments regarding appropriate spending levels and rates of increase should be based on several years' experience to account for short-term factors that may create a misleading picture of the trends. In addition, spending growth should be compared on a per person basis and should recognize the health care needs of an aging and disabled Medicare population.

There are major deficiencies, however, in the data currently used to compare and forecast Medicare and private sector spending growth. The Commission plans to examine available data and alternative methods that could be used to assess trends in Medicare and private health care expenditures and will share these with the Congress.

Recommendation 2: The Failsafe Budget Mechanism

Any failsafe budget mechanism should include a more effective risk adjustment factor to ensure payment equity between the Medicare capitation and traditional fee-for-service programs. In addition, changes in inflation that differ substantially from CBO forecasts could require modifications to the Medicare benefit budget over time. Revisions to the proposed fee-for-service sector budget allocations could also be needed as medical practices change.

The failsafe mechanism in the Congress's proposal would allocate a fixed benefit budget for Medicare's capitation and fee-for-service programs. However, the risk adjustment methods currently used in Medicare's risk contracting program are limited. (See Chapter 2, Recommendation 5.) The lack of a robust risk adjustment method may result in higher-than-intended capitation payments. Further, there is no mechanism to adjust the fee-for-service budget to account for increases in average patient complexity and severity of illness that are likely to result if healthier enrollees select Medicare's capitation program. Consequently, per enrollee capitation payments could be too high and fee-for-service payments too low.

The failsafe mechanism lacks a provision to adjust the benefit budget if general inflation differs notably from CBO's forecast. Future increases in per enrollee spending in both programs may require modifications to reflect changes in inflation. In addition, future allocations of spending across the fee-for-service sectors will be based on spending projections that do not reflect the impact of the proposed legislation. The failsafe mechanism thus could lead to payment inequities among

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provider groups as patterns of care continue to change. Adjustments in sector budget allocations may be necessary over time to maintain access to quality care for Medicare beneficiaries.

Notes to Chapter 1

1. This figure reflects Medicare program payments, which include payments from Medicare for covered services, but not administrative costs or beneficiary cost-sharing amounts.

2. This figure includes beneficiary deductibles, copayments, and balance billing amounts, but not Part B premiums. See Prospective Payment Assessment Commission, *Medicare and the American Health Care System, Report to Congress,* June 1995, 67.

3. Congressional Budget Office estimates of baseline spending and projected savings, December 1995. CBO makes a distinction between mandatory outlays for benefit payments and discretionary outlays for administrative costs. The estimates cited here include mandatory but not discretionary outlays. They do not reflect offsetting premium receipts. Net Medicare outlays, which include mandatory plus discretionary outlays less premium receipts, are projected to increase from $160 billion in 1995 to $308 billion in 2002.

4. The Medicare provisions are in H.R. 2491, the "Balanced Budget Act of 1995," passed by the Congress on November 20, 1995. This legislation also is referred to as "the conference agreement." The specific provisions referred to are included in Title 8, entitled "The Medicare Preservation Act of 1995."

5. The Medicare provisions of the President's proposal are included in Title 11 of draft legislation, entitled the "Balanced Budget Act of 1995 for Economic Growth and Fairness." This proposal was released by the President on December 7, 1995. It has not been introduced in the Congress.

6. National health expenditures include all spending in the health care sector. Personal health care expenditures exclude research and construction, administration of public programs and net cost of private health insurance, and government public health activities.

7. Medicare Hospital Insurance, called Part A, finances inpatient hospital care, as well as skilled nursing facility, home health, and hospice care. Supplementary Medical Insurance, or Part B, pays for physician services; outpatient services furnished by hospitals, dialysis facilities, and other ambulatory providers; and durable medical equipment and supplies.

8. Health Care Financing Administration, *Medicare and Medicaid Statistical Supplement, 1995* (Washington, DC: U.S. Government Printing Office) 176.

9. Ibid., 182.

10. Ibid., 176.

11. Board of Trustees of the Federal Hospital Insurance Trust Fund, *1995 Annual Report* (Washington, DC).

12. The savings estimates in all the proposals include those resulting from reductions in the growth of Medicare mandatory outlays and, where applicable, premium increases.

13. The Medicare and Medicaid provisions of the proposal are in H.R. 2530, introduced on October 25, 1995. This proposal also is referred to as the "coalition budget" proposal.

Chapter 2

Medicare's Capitation Program

Adoption of capitation payment methods by employers and some state Medicaid programs is widely credited with reducing the growth in their health care spending. Under capitation, the payer makes a predetermined payment per enrollee to a health plan that agrees to cover a defined set of services over a specified period, regardless of the number, type, or cost of services enrollees actually use. This contrasts with the fee-for-service payment method, under which payment is made for each service rendered. Capitation allows the payer to budget for health care spending over a year and eliminates its risk of spending any more than is budgeted. Additionally, capitation gives plans a financial incentive to reduce health care costs.

Medicare's largest capitation program, called the risk contracting program, has some of the cost-containment characteristics of capitation. Yet various aspects of the program design prevent Medicare from fully realizing the benefits of this payment method. Both the Congress and the President have proposed expanding and modifying Medicare's use of capitation. The legislation recently passed by the Congress (H.R. 2491) would broaden the range of private plans that could participate and modify the calculation of capitation amounts to curb the growth in Medicare's spending. The President's proposal would alter and increase the size of the risk program, but would not fundamentally change the way capitation rates are determined.

Refinements to the risk contracting program could contribute to Medicare's cost-control efforts while expanding the health plan choices available to its beneficiaries. To accomplish this, improved risk adjustment methods should be implemented and technical changes made to the calculation of the capitation rates. Further, Medicare needs to act as beneficiaries' agent in providing health plan information and monitoring plan performance. This is critically important because of the financial incentive plans have to limit health care costs.

This chapter first reviews policy issues relating to the existing Medicare risk program. Next, it provides an overview of the Congress's and the President's proposals to change the program. It concludes with the Prospective Payment Assessment Commission's (ProPAC's) recommendations to the Congress about setting the capitation rates, adjusting for risk, offering different types of plans, disseminating information to beneficiaries, and holding plans accountable for the services they provide.

THE MEDICARE RISK PROGRAM

In 1985 Medicare implemented its risk contracting program, under which health maintenance organizations (HMOs) receive a full capitation payment. The risk program was intended to allow Medicare to enjoy some of the advantages of capitation arrangements with health plans, among them predictable spending and savings. Enrollees also gain because many plans cover additional benefits and have low cost-sharing requirements.

Medicare has not taken full advantage of capitation's potential for savings, however. The program's capitation rates appear to be too high in some markets and too low in others, discouraging plan participation. Further, it appears that healthier beneficiaries are likelier than others to enroll, and the payment rates do not adequately reflect this lower risk of illness. Thus, Medicare may pay more for beneficiaries in its risk program than it would have had they stayed in the fee-for-service program.

Capitation Rates

The level of Medicare's capitation rates is tied closely to the program's traditional fee-for-service spending experience in each county. The annual growth in these rates mirrors this experience as well. Because HMOs are expected to furnish services through their provider networks more economically than Medicare does under its fee-for-service program, Medicare pays 95 percent of the estimated

amount it would have spent under the traditional program. Medicare retains the other 5 percent as savings. If plan payments are higher than projected plan costs (which include allowed profits), these savings are returned to enrollees in the form of additional benefits. These include, for instance, paying for services Medicare does not cover or reducing cost sharing for Medicare-covered services.

Level, Growth, and Variation—Obtaining the full potential savings from capitation requires continuous interaction between payers and plans. Those that purchase coverage can realize one-time savings by moving from higher premium fee-for-service plans to lower premium plans that accept capitation. They may enjoy ongoing savings if they can use their purchasing power to negotiate favorable premium rates. Some purchasers (other than Medicare) negotiate formally with plans; others have more informal processes for holding down annual premium increases. Some purchasers limit their premium contribution so that enrollees (who pay the difference between the premium and the employer's contribution) are more likely to choose lower priced plans.

Current law does not allow Medicare to use any of these approaches to limit the growth in capitation rates. This is true despite evidence that many plans in the risk program furnish all Medicare-covered services at costs significantly below their capitation rate. In 1994, the average Medicare capitation payment was $26 a month higher than plans' expected average costs of providing Medicare services to beneficiaries. In certain markets with the highest rates, this difference was even greater—more than $110 per enrollee per month.[1] However, in those areas without Medicare risk contracts (and there are many) rates may be too low to induce plans to participate.

Because Medicare's capitation rates are tied to fee-for-service spending experience, the program does not use information about plans' costs to set its rates in a market. Even though Medicare receives this information, it cannot negotiate lower rates in areas where the rates are higher than plan costs. At the same time, in areas where no plans participate in the Medicare program, it cannot raise capitation rates even if they are too low to cover plans' anticipated costs.

The linking of capitation rates to fee-for-service spending at the county level leads to substantial variability in the rates across areas. Further, there have been significant changes in some of these rates from year to year. This has been a particular problem in rural counties, since spending fluctuations are driven by the experience of relatively few beneficiaries. The instability of Medicare's rates over time may have dissuaded plans from participating in the risk program in certain counties, even when they serve other purchasers there.

Risk Adjustment—Voluntary choice among health plans raises the likelihood of risk selection. Plans may have a mix of enrollees whose relative risk of incurring medical expenses does not represent the group of people covered by a particular purchaser. Plans that attract beneficiaries with lower-than-average risk are less likely to experience financial losses. This can occur either through enrollee or plan action, or both. For example, some plans will pay only for services furnished by limited networks of providers. Enrollees who are healthier, and thus lack longstanding relationships with providers, may be more willing to join plans that limit provider choice, resulting in favorable selection to these plans.

If, because of risk selection, the capitation rate is too high relative to the services used by its members, the plan profits at the purchaser's expense. If it is too low, the plan loses financially. For these reasons, there has been considerable interest in developing a risk adjustment method that would allow the capitation payments to reflect more accurately differences in the likely need to use services among individuals.

The variation in patterns of health care use and spending among individuals is explained by both systematic and random risk. Systematic risk reflects expenditure variation associated with measured characteristics, such as age, sex, or chronic conditions, that are predictably related to use. Random risk is variation not associated with measured characteristics. The distinction between systematic and random risk is important, because risk adjustment methods account only for sources of systematic variation. Research suggests that about one-fifth of the variation in annual health spending is systematic, while the rest is random.[2] If this is correct, then even the best risk adjustment method would not

explain about 80 percent of the variability in health expenditures across individuals.

Available risk adjustment methods have been unable to account for much of the systematic variation. When used to predict individual annual expenditures, basic demographic adjustments (such as those used for Medicare capitation rates) explain little of the overall variation in resource use across individuals. Self-reported health status measures do slightly better. Methods that use prior claims information are among the best predictors of use, but they still account only for about one-eighth of individual variation in annual health care spending.[3]

Evidence indicates that Medicare risk plans have enjoyed favorable selection not accounted for by the program's risk adjustment method.[4] The risk adjustment method Medicare uses pays plans different amounts according to their enrollees' demographic and other characteristics (see Table 2-1). For example, the capitation rate for hospital and other facility services for an 85-year-old female eligible for both Medicare and Medicaid is twice the average capitation rate. This risk adjustment method does not account for differences in the likely need for services among beneficiaries with the same demographic characteristics.

Medicare's month-to-month disenrollment policy, intended to attract beneficiaries who otherwise would be unwilling to try a capitation arrangement, may contribute to favorable risk selection for plans. Recent evidence indicates that those who disenroll from risk plans use a disproportionate number of certain types of services after they return to the fee-for-service program.[5] This may be due to beneficiaries disenrolling from their plans to use providers or services available through fee-for-service Medicare.

Medicare may be benefiting from the rising proportion of beneficiaries in risk plans in some markets. This is because, as the risk program's share of enrollment grows, the mix of beneficiaries is more likely to reflect the general Medicare population, making risk plans less likely to experience favorable selection than they had in the past. Moreover, increases in the proportion of people enrolled in HMOs appear to influence medical practice patterns. Providers may adopt cost-conscious ways of delivering care that are encouraged by capitation even for their patients who are in fee-for-service plans.[6]

Enrollment and Plan Participation

The early years of the Medicare risk program were marked by declining plan participation and gradual growth in beneficiary enrollment (see Table 2-2). However, the number of risk contracts and program enrollment both rose in 1993, 1994, and 1995. More plans have joined the risk program as capitation has become more widespread in the employer insurance market. Increasingly, plans are competing for members and looking to Medicare as

Table 2-1. Selected Demographic Group Risk Adjustment Factors to the Medicare Capitated Risk Payment, 1995

	Female			
Age Group	Non-Medicaid Non-Working	Working Aged	Medicaid	Institutionalized
Part A				
65-69	0.55	0.30	0.85	1.50
70-74	0.70	0.40	1.10	1.80
75-79	0.85	0.50	1.40	2.05
80-84	1.05	0.70	1.65	2.05
85+	1.15	0.75	2.00	2.05
Part B				
65-69	0.70	0.35	1.05	1.50
70-74	0.85	0.50	1.15	1.65
75-79	0.95	0.70	1.25	1.65
80-84	0.95	0.75	1.25	1.65
85+	1.00	0.80	1.25	1.65

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

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Table 2-2. Medicare Risk Program Participation, 1990-1996

Year	Enrollees: Number (In Millions)	Enrollees: As a Percentage of Total Medicare Enrollment	Contracts
1990	1.2	3.5%	95
1991	1.3	3.7	85
1992	1.5	4.2	83
1993	1.7	4.7	90
1994	2.1	5.7	109
1995	2.9	7.7	154
1996	—	—	189

Note: Enrollment data are as of September each year; contract data are as of January each year.

SOURCE: Health Care Financing Administration, Office of the Actuary and Office of Managed Care.

a potential source. Further, some plans are entering markets that formerly had no Medicare risk options, thereby expanding beneficiaries' choices. Entrants to competitive Medicare markets are stimulating existing plans' marketing activities, which may attract additional enrollees.

Medicare is taking steps to expand the risk program even further. One is to distribute information about risk plans to beneficiaries. Except in some regions, Medicare has left information dissemination largely to plans, making it difficult for beneficiaries to compare their choices. The Health Care Financing Administration (HCFA), which administers the risk program, is planning a new initiative to produce comparative information on premiums and benefits offered by participating risk plans in 1996. In addition, Medicare's exclusive reliance on HMOs with a limited provider network may be preventing it from realizing the program's full potential. In 1995, HCFA developed guidelines for out-of-network provider options for Medicare contracting HMOs. The agency is also conducting a demonstration program to determine whether beneficiaries are interested in joining other types of plans.

Plan Accountability

In return for its payments, a plan provides a defined set of services to its members. This obligation is particularly important under capitation arrangements. Under fee-for-service payment methods, plans and providers usually profit when the payment and volume of services increase. Capitation, by contrast, creates incentives to limit the number and the cost of health care services. Plans that keep costs below their capitation payments retain the balance—and thus gain from lowering costs. But such an incentive creates concerns about how costs are constrained. Ideally, plans and providers will reduce services of marginal value by developing more effective and efficient modes of care. On the other hand, they could lower costs by failing to provide needed services.

Although Medicare has the authority to hold risk plans to their contractual obligations, it collects limited information on the care plans provide.[7] Most of the data relate to plans' ability to meet an array of contractual requirements and comply with policies and procedures. HCFA has been trying to update its evaluations of plans by participating in several private sector initiatives to develop plan performance measures. These include both the Foundation for Accountability and the National Committee for Quality Assurance's exploration of cost, quality, and access measures appropriate for Medicare risk enrollees.

PROPOSED CHANGES TO MEDICARE CAPITATION ARRANGEMENTS

The Congress and the Administration have developed proposals to reform the existing risk program. Both would change the payment rate setting method to generate more savings from the risk program and increase the range of plans available to beneficiaries. The Congress's proposed changes would greatly expand the types of plans that could accept Medicare capitation payments and would break the link between the capitation rates and fee-for-service spending.

The Congressional Proposal: MedicarePlus

The Congress has proposed replacing the risk program with an expanded capitation program, called MedicarePlus. This program would permit Medicare beneficiaries to select from a wider choice of health plans. Under MedicarePlus, the method for setting the capitation rate would be changed to reduce rates in areas where Medicare fee-for-service spending has been high and to increase rates where it has been low. Growth in the rates would no longer be tied to increases in spending under traditional fee-for-service Medicare.

Changes to the payment method are designed to allow MedicarePlus to produce savings for Medicare. Whether or not the savings materialize, however, total program spending (for both MedicarePlus and the traditional fee-for-service program) would be limited by the combination of the legislated rates and a budgeting tool called the "failsafe mechanism." (See Chapter 1.) This mechanism would automatically impose additional payment reductions on providers in traditional Medicare if spending exceeded preset expenditure targets.

Plan Choices—MedicarePlus would allow a broad array of managed care plans, including preferred provider organizations (PPOs), to participate. Fee-for-service plans also would be permitted. New options not widely available in the private market, such as medical savings accounts (MSAs) and provider-sponsored networks, also could be offered to beneficiaries. All MedicarePlus plans would receive a capitation payment from Medicare.

This menu of plans would give Medicare beneficiaries more choices. Conceivably, they could choose any type of plan that met Medicare standards and that was open for enrollment in their area. Plans would be granted flexibility in product design and benefits, beyond Medicare-covered services. States would have a prominent role in monitoring product offerings under MedicarePlus.

Fee-for-Service Option—The Congress's proposal defines MedicarePlus fee-for-service plans as insurers that "reimburse hospitals, physicians, and other providers on the basis of a privately determined fee schedule or other basis."[8] These plans would be required to pay non-contracting providers at least as much as the providers were paid in the traditional fee-for-service Medicare program. If these providers' fees were higher than the plan's payments, they would be permitted to bill Medicare beneficiaries for the difference.

Medical Savings Accounts—One choice in the congressional proposal would combine a high deductible insurance policy with a medical savings account. The MSA is a designated account to which Medicare would make an annual contribution and from which the beneficiary could draw for medical expenses. A beneficiary selecting this option would purchase a high deductible health insurance plan and receive the rest of his or her Medicare capitation (less the price of the plan's premium) in the form of a cash contribution to the MSA. High deductible plans would be required to cover all Medicare-approved expenses after the enrollee met a deductible of up to $6,000.[9] Beneficiaries could use MSA funds for any qualified medical expenses. They could also withdraw money from the account for non-medical spending (albeit with a tax penalty). Medicare beneficiaries in high deductible plans would not be permitted to buy insurance (other than long-term care insurance) to cover the cost of deductible expenses or additional services they might need.

MSAs are intended to make consumers bear more of the consequences of their choices to use health care services, while still offering catastrophic protection from the risk of a major expense. Supporters of MSAs believe they can lower the use of health services. They argue that if consumers had to pay the full price of medical care up to the deductible, they would make better decisions about the use of health care than they do when insurance masks the cost. A decline in the demand for medical services would drive down overall health expenditures directly by reducing utilization. Further, providers might respond to their patients' price sensitivity by constraining their prices. Since Medicare would make a fixed payment, however, any savings resulting from using fewer services—at least in the short run—would go to the beneficiary and the high deductible plan, rather than to the program.

Beneficiaries electing this option would be strongly motivated to control their medical service use if they thought of the balance in their account as savings. If they took this view, spending from the account would seem the same as other spending. On the other hand, they might regard MSA funds as an account for health services.[10] This would tend to reduce beneficiaries' restraint in purchasing health services.[11] In any case, the lack of experience with this option makes it hard to predict how Medicare beneficiaries with MSAs would behave.

Most beneficiaries who selected the Medicare MSA option probably would benefit financially. Beneficiaries who did not anticipate using health services would be attracted to this option, because they would expect to keep unspent MSA funds.

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Without adequate risk adjustment to the capitation rate, healthy beneficiaries choosing the MSA option could receive more funds from Medicare than the program would have spent had they remained in the traditional fee-for-service program. If this happened, Medicare expenditures would rise, increasing the likelihood that the failsafe mechanism would be triggered. Favorable selection into the MedicarePlus MSA option could thus result in reduced payments to traditional fee-for-service Medicare providers. Favorable selection may be exacerbated by beneficiaries' ability to opt out of this option every year. Because they can anticipate at least some of their medical expenses and can delay some treatments, beneficiaries could change to more comprehensive coverage when they needed it.

Not all beneficiaries selecting the high deductible/MSA option would be able to profit from their choice. They would risk significant out-of-pocket costs in the event of high spending. The financial risks would be especially great for enrollees in high deductible plans designed as fee-for-service arrangements, because providers' charges would not be limited to the amounts established by the traditional Medicare fee-for-service program. Thus, there would be only partial stop-loss protection for the beneficiary in these types of plans.

Providers might find they would incur more bad debt from treating patients with medical savings accounts, since they would need to collect payments directly from their patients. This would be particularly likely if beneficiaries depleted their MSA funds before reaching their deductible. In this situation, beneficiaries would be required to use their own money to pay for care.

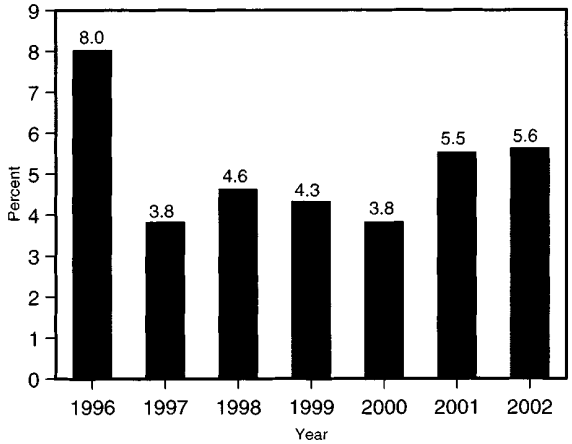
Benefits—Under the MedicarePlus program, participating plans would provide, at a minimum, services covered under traditional Medicare. These services could be furnished through a managed care provider network, and plans could employ utilization management to determine medical necessity and appropriateness.

Plans would still be allowed to return the difference between their expected payments and costs to beneficiaries in the form of additional benefits. The Congress's proposal also would allow plans to rebate this difference to beneficiaries in cash. As in the current risk program, these additional benefits could induce beneficiaries to enroll in MedicarePlus plans. Plans thus would be able to compete with one another based on benefit package and provider network, as well as on price and beneficiaries' perception of plan quality.

As they do now, plans could charge beneficiaries premiums for supplemental benefits and for the actuarial value of whatever cost sharing beneficiaries would have incurred under the fee-for-service program. MedicarePlus plans would also be permitted to charge beneficiaries for the costs of covered Medicare services when the plans' estimated costs for these exceeded their MedicarePlus capitation payments.[12]

Payments to MedicarePlus Plans—The payment system under MedicarePlus is designed to allow savings to accrue to the Medicare program because the per person payment rates would be updated by legislated rates of increase (see Figure 2-1). These rates are below those currently projected for the Medicare program. As long as MedicarePlus enrollees were as likely to use services as other beneficiaries (or the risk adjustment method fully reflected differences in risk), the MedicarePlus program would reduce Medicare expenditures (see Table 2-3). Under these circumstances, savings from this component of Medicare would be driven by the number of beneficiaries

Figure 2-1. MedicarePlus National Average Growth Percentages, 1996-2002



Note: For all subsequent years the update is 5.0 percent.

SOURCE: H.R. 2491.

Table 2-3. Estimated MedicarePlus Enrollment, Savings, and Costs, 1996-2002

Year	MedicarePlus Enrollment (In Millions)	Percentage of Total Medicare Enrollment	Savings From Non-MSA Plans[a] (In Billions)	High Deductible/ MSA Costs[b] (In Billions)	Total Savings (In Billions)
1996	3.0	8.0%	$ -0.1	$0.0	$ -0.1
1997	3.8	10.0	-1.0	0.5	-0.5
1998	6.8	17.5	-1.8	0.6	-1.2
1999	7.7	19.5	-3.3	0.7	-2.6
2000	8.5	21.3	-5.8	0.8	-5.0
2001	9.3	23.2	-8.2	0.9	-7.3
2002	10.3	25.3	-11.3	1.1	-10.2
1996-2002	—	—	-31.4	4.6	-26.9

Note: The Congressional Budget Office constructed the capitation rates used in these estimates with Part A enrollment only. All capitation rates are expressed in calendar years. Numbers may not sum to total due to rounding. MSA = medical savings account.

[a] Reflects savings from beneficiaries enrolled in non-MSA arrangements, including risk contractors.

[b] The capitation rates and costs for new enrollees in high deductible/MSA plans reflect assumptions that these enrollees would be relatively young and would receive lower age-adjusted payments.

SOURCE: Congressional Budget Office.

who joined MedicarePlus plans. But if MedicarePlus experienced favorable selection (and risk adjustment did not correct for this), actual savings would be smaller than anticipated. Estimated savings from the MedicarePlus program would be somewhat reduced by anticipated costs due to enrollees in MedicarePlus high deductible/MSA arrangements. Regardless of the MedicarePlus enrollment or risk selection experience, however, overall Medicare spending targets would be achieved because of the failsafe budget mechanism.

Capitation rates under MedicarePlus would vary less across geographic areas than do rates in the current risk program. County rates would be blended with national ones, going up or down depending on the area's payment experience. Payment rate floors would further raise payments in areas where costs were especially low. Both the legislated updates and the blending would, in effect, uncouple the capitation amount from spending in traditional Medicare.

The MedicarePlus base payment rate would be the 1995 payment rates for risk plans in the existing program. Thus, the base rates would incorporate the geographic variation in service use patterns and health care prices as reflected in the 1995 rates. Each year, the Secretary of Health and Human Services would update these county-specific base rates using the legislated update factor for that year. Then, the Secretary would calculate the national rate, which would be the average of all updated county rates weighted by the proportion of Medicare beneficiaries in each county.

The capitation rate for each county would be a blend of its own and the national rate. In 1996, 90 percent of payment would be the county rate. The national rate, adjusted for input price levels in that county, would account for the other 10 percent. Beginning in 1998, the blend proportion would be changed by 5 percentage points each year until the national rate made up 30 percent of the total. Finally, each county's blended rate would be compared with two payment rate floors. In 1996, each county's payment rate would be the highest of its blended rate, $300, or 102 percent of the previous year's rate.

Blending the county with the national rate would reduce payments in areas with higher fee-for-service utilization and payments and boost payment rates in areas where use of services is lower. Plans could pass these gains to beneficiaries by providing additional benefits or cash rebates, or could retain them internally. Such flexibility could translate into increased plan participation and higher enrollment in areas where service use is lower. This payment method also would have the advantage of limiting the volatility of the rates, because the local and national components of the blend would be updated by a fixed national rate of increase specified in the law. Increases in payment rates in some areas,

however, would result in higher outlays under the MedicarePlus program than would be the case under the current payment system.

Risk Adjustment—The congressional proposal does not require the Secretary to modify Medicare's existing risk adjustment methodology, although the Secretary would have the authority to do so. Medicare's inadequate risk adjustment method would fail to account for risk selection differences among MedicarePlus plans. Nor would it fully reflect variation in use between those who enrolled in MedicarePlus and those who did not.

The limitations of the current risk adjustment method also have implications for spending in the traditional fee-for-service program. Suppose that a disproportionate number of healthier beneficiares joined MedicarePlus, leaving the sicker and frailer in traditional Medicare. Then, fee-for-service spending per beneficiary would be higher, increasing any payment reductions in traditional Medicare required by the failsafe mechanism.

Enrollment and Disenrollment—MedicarePlus would discontinue month-to-month enrollment and disenrollment after a transition period. For each county, this period would start when the first plan was available for enrollment and end in October 1997. After this date, beneficiaries choosing to enroll in MedicarePlus would be locked into their plan for a year. They would still be able to drop out of a plan within 90 days of initial enrollment, or if they moved out of the plan's service area, or if the plan were found guilty of misconduct. Annual enrollment periods with a one-year lock-in provision could reduce favorable risk selection in MedicarePlus plans, increasing total savings and lowering the likelihood of payment reductions under the failsafe mechanism.

Beneficiaries generally would select MedicarePlus plans during annual open enrollment periods. The Congress's proposal would require the Secretary to conduct a coordinated information dissemination campaign before each open enrollment period. This could spur enrollment as beneficiaries learned about the MedicarePlus choices. On the other hand, eliminating the monthly disenrollment option might discourage reluctant beneficiaries from trying a MedicarePlus plan.

Accountability—The congressional proposal would strengthen current reporting standards and improve plan accountability by adding data reporting requirements similar to those that private purchasers impose. Beneficiaries would receive better information to compare MedicarePlus plans with each other and with the traditional program. Plans would report more specific information on factors that affect quality. An electronic data set would be established to provide uniform information on all participating plans. Many of the proposed requirements already exist in regulation. The proposal would strengthen these standards by putting them in statutory language, and would require more specific information to improve health plan accountability.

The Administration's Proposal

The President also has proposed expanding the risk program, but the changes would be less comprehensive than those the Congress has envisioned under MedicarePlus.[13] Beneficiaries would be able to enroll in qualified PPOs and provider-sponsored organizations as well as HMOs. Most enrollees would be able to join one of these plans only during annual open enrollment periods. Private fee-for-service plans and high deductible plans combined with MSAs would not be among the available options. As an alternative to the full capitation payment, the Secretary would have the authority to pay plans using a partial capitation approach.

As in the existing risk program, participating plans would be required to cover, at a minimum, Medicare-covered services. Plans would have to demonstrate that the benefits they were providing, together with the premiums charged to enrollees, were at least actuarially equivalent to the benefits in the traditional Medicare program. Additional benefits offered by plans would have to conform to one of the standardized benefit packages the Secretary would design. Standardization would help beneficiaries evaluate price and benefit differences among plans.

The Administration's proposal addresses some shortcomings of the capitation rates in the current Medicare risk program. The proposal would limit variation in Part B payment rates (which cover physician services, medical supplies, and other outpatient treatment) across counties by raising those

that are low and capping those that have been inflated by high service use rates in the fee-for-service program. The annual growth in the rates, however, would continue to be linked to that in the fee-for-service program.

Other modifications would make the capitation rates more reflective of actual plan costs. Because fee-for-service claims are used to calculate Medicare's capitation rates, the rates include hospital payments for graduate medical education and for treating a disproportionate share of low-income patients. Plans that receive capitation payments may not incur such costs. The proposal would reduce capitation amounts to reflect these hospital payments, and Medicare would retain 25 percent of the amount saved. The rest would be distributed to both Medicare risk plans that contracted with academic medical centers and the academic medical centers themselves. This change in methodology would reduce the variation in the rates, since areas where beneficiaries in fee-for-service Medicare use teaching and disproportionate share hospitals generally have higher capitation rates.

A partial capitation approach would also be introduced. Plans would be paid using fee-for-service methods, but the amounts would be lowered 5 percent on each claim. At the end of the year, plans' per person payments would be compared with the capitation rate. Plans that had kept their spending below the targets would be rewarded with additional payments; those that had exceeded the targets would be required to return some of the excess to Medicare.

In the Administration's proposal, beneficiaries could enroll in plans under three circumstances only: during an annual open enrollment period, when they first became eligible for Medicare coverage, or when their plan opted out of Medicare. Beneficiaries could continue to disenroll from plans on a monthly basis. The Secretary would be directed to distribute comparative plan information to beneficiaries.

CONCLUSIONS AND RECOMMENDATIONS

Both the Congress and the Administration have proposed changes to Medicare's capitation program to address some of its shortcomings. The Congress would go further in expanding beneficiary choices and modifying the payment method. In addition, it would create a link between the capitation program savings and payment rates in Medicare's traditional fee-for-service program through the failsafe budget mechanism. This chapter concludes with ProPAC's recommendations for improving Medicare's risk program as well as the Congress's and the Administration's proposals to change it.

Recommendation 3: Expanding Medicare's Capitation Program

The Commission supports reforming the Medicare capitation program to control spending while expanding beneficiary choice.

The Congress and the President have proposed ways to expand the role of capitation under Medicare. Capitation contains incentives for plans to control the cost and volume of the services they furnish. Further, such methods limit Medicare outlays to the per capita amounts.

Medicare beneficiaries should have a wider range of health plan options. Under the current program, beneficiary choice is largely limited to the traditional fee-for-service program and, where available, an HMO option. Additional alternatives would let Medicare beneficiaries choose the type of plan that best meets their needs and would permit new beneficiaries enrolled in a particular type of plan before retirement to stay in that arrangement. In addition, more alternatives could increase plan competition for Medicare beneficiaries on the basis of additional benefits and quality.

Recommendation 4: Setting and Updating the Capitation Rates

Geographic variation in the capitation rates and the volatility of the rates from year to year should be reduced. The Secretary should develop and test alternative payment methods that would allow the payment rates to reflect changes in local market conditions.

Medicare sets a capitation rate for each county based on its historical spending for resident beneficiaries in the traditional Medicare fee-for-service

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program. The direct linkage to fee-for-service spending patterns in narrowly defined payment areas has led to substantial variability in the payment rates among counties and excessive annual changes in the rates for many areas. Private plans have been discouraged from participating in the risk program in areas with low capitation rates, as well as in those that have experienced high rate volatility. At the same time, risk plans located in counties with high capitation rates often have been paid substantially more than their actual costs of providing basic program benefits to Medicare beneficiaries. Further, since changes in rates and in local fee-for-service spending are linked, the Medicare risk program generally has not achieved the cost savings attained by private health plans.

The Congress proposes to reduce the geographic variability of the rates. It would do so by blending the local historical fee-for-service spending experience with the input price-adjusted national average and by setting payment rate floors. The annual volatility of the payment rates would be lowered by updating them with legislated growth factors. The President's proposal would decrease variability by removing special payments from the rates and by setting ceilings and floors on a portion of the payment rates. The President's proposal would have only a limited impact on volatility in the rates over time.

Neither proposal would allow the rates to vary with changes in the costs faced by plans. ProPAC believes alternative payment methods should be developed and tested that would better reflect the evolution and impact of market forces in each area. To accomplish this, information would have to be collected on the cost performance of individual plans to enhance the Secretary's understanding of markets and lay the foundation for implementing alternative payment methods, such as competitive bidding. The Commission wishes to emphasize that these data are not intended to support restricting plan profits or other regulatory activities.

Recommendation 5: Improving Risk Adjustment Methods

The risk adjustment methods used to set Medicare capitation payments should better reflect variation in the likely use of services. Even as research on the development of new methods continues, the Secretary should implement interim improvements as soon as possible.

Effective risk adjustment of payments to health plans participating in the Medicare program is crucial to prevent rewarding or penalizing plans unwarrantably. It is equally essential to ensure that the financial burden of caring for Medicare beneficiaries is allocated fairly between the capitation program and the traditional fee-for-service program. These issues will become even more important if the risk program is modified to expand beneficiaries' choices among plans and plan participation.

The current knowledge base is not adequate to support highly effective risk adjustment methods. Moreover, health risks and the variations in propensity to use health services may never be sufficiently understood to adjust fully for differences in expected spending among individuals. Nevertheless, the methods used in the Medicare risk program could be improved. For example, information about the presence of specific chronic conditions, such as certain types of cancer or heart disease, enhances predictions about future health care spending levels for individuals. The Secretary should implement marginal improvements rather than wait for potentially better methods that may not be developed for many years.

While continuing to support further research on risk adjustment methods, the Secretary should also evaluate other features of capitation program design that may contribute to the risk selection problem. Enrollment and disenrollment policies, for example, may further concentrate particular groups of beneficiaries in the capitation program or in certain plans. Other policies regarding reinsurance or partial capitation may protect plans from adverse selection. Given the likelihood of continuing limitations in risk adjustment methods, these kinds of policies may be especially important as a source of auxiliary protection against the impact of risk selection.

Recommendation 6: Medical Savings Accounts

The Congress's high deductible/MSA option would provide an additional choice for Medicare enrollees. ProPAC is concerned,

however, that the current Medicare risk adjustment method is not sufficient to protect the program from adverse selection and resulting excess spending. The likelihood that rates would better reflect risk would be enhanced if Medicare enrollees were required to remain in the MSA option at least for several years.

Medicare payments for beneficiaries choosing the high deductible/MSA option proposed by the Congress could be higher than the costs that would have been incurred if those beneficiaries had remained in the traditional program. This is particularly likely if risk adjustment methods are not improved or if longer participation requirements are not imposed. In fact, the Congressional Budget Office estimates that beneficiaries in this type of arrangement would cost the program $4.6 billion between 1996 and 2002. These costs could trigger the failsafe mechanism in traditional Medicare.

The Secretary should move quickly to improve the risk adjustment method. In addition, further research on the high deductible/MSA option is needed to assess the effects of various plan designs and to improve this option over time. Issues requiring a closer look include the amount deposited in the MSA, the length of time before disenrollment is allowed, and the features of the high deductible plan.

Recommendation 7: The MedicarePlus Fee-for-Service Option

Enrollees choosing the fee-for-service option under the proposed MedicarePlus program could be responsible for substantially higher fees than what their plans would pay. The Secretary should monitor the impact of this option on beneficiary liability and on possible reductions in physician and other provider participation in traditional Medicare.

Current policies limit the amount that most providers can bill Medicare beneficiaries above Medicare's payment. ProPAC is concerned that beneficiaries who choose the MedicarePlus fee-for-service option will be subjected to unanticipated out-of-pocket liabilities. The Commission also is concerned about provider behavior resulting from these arrangements: Some providers may decide not to see those with traditional Medicare coverage by limiting their practice to patients who can pay high charges. This phenomenon could limit access of Medicare beneficiaries—particularly those with low incomes.

Recommendation 8: Information for Beneficiary Health Plan Choices

Medicare should make available to beneficiaries information about the performance of plans and local providers. The Secretary should identify the information beneficiaries need to make appropriate choices and develop innovative ways to improve access to it.

The risk contracting program distributes only limited information to beneficiaries about plans. Soon, however, HCFA will expand the data it distributes to include plans' benefits and premiums. The Secretary should continue efforts to identify the information beneficiaries need to make informed health plan choices and the most appropriate format for it. This is even more critical as health plan choices are expanded for Medicare beneficiaries. The Secretary should explore initiatives that would, for example, measure the satisfaction of beneficiaries who used services, describe total benefits available in an area (including those covered under insurance policies offered as supplements to Medicare), and document performance of individual providers within a plan.

As the number of choices under Medicare increases either through the current program or expansions, private entities likely will begin distributing information about these choices to beneficiaries. Although this is appropriate, Medicare should not abandon its responsibility to ensure that beneficiaries receive unbiased, comparable, and reliable data.

Recommendation 9: Health Plan Accountability

Medicare must hold health plans accountable for the appropriate use of Medicare funds. In addition, standards must be developed and enforced to ensure that Medicare beneficiaries will receive services of appropriate quality.

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Under capitation, a health plan arranges with providers for coverage of services. Health plans have an incentive to limit the types and number of services delivered to each member when they receive a capitation payment. As a purchaser, therefore, Medicare needs to be particularly vigilant in ensuring that plans meet their contractual obligations to provide appropriate care.

The Commission recognizes that HCFA is working with the private sector to develop measures of health plan performance. These relate to patient satisfaction, plans' financial stability, and other factors. Efforts to date have shown promise, but they still have not succeeded in providing definitive information on service use or health outcomes. Ideally, Medicare should be able to evaluate plan performance through risk-adjusted outcomes measures. Additional resources most likely will be necessary to implement an evaluation program that incorporates these measures.

Notes to Chapter 2

1. Prospective Payment Assessment Commission and Physician Payment Review Commission, *Joint Report to the Congress on Medicare Managed Care* (Washington, DC: ProPAC and PPRC, 1995).

2. Joseph Newhouse and others, "Adjusting Capitation Rates Using Objective Health Measures and Prior Utilization," *Health Care Financing Review* 10(3): 41-54, Spring 1989.

3. Several studies have examined claims-based risk adjustment systems, which include ambulatory care groups (ACGs) and diagnostic cost groups (DCGs). ACGs classify claims based on diagnoses in ambulatory settings, or all settings combined, as well as age and other factors. DCGs classify by diagnosis and other variables from previous hospital inpatient stays.

4. Randall Brown and others, *The Medicare Risk Program for HMOs—Final Summary Report on Findings from the Evaluation* (Princeton, NJ: Mathematica Policy Research, February 18, 1993).

5. Physician Payment Review Commission, "Biased Selection and Medicare HMOs: Analysis of the 1989-1994 Experience," unpublished paper, December 1995.

6. Prospective Payment Assessment Commission, "Relationship Between AAPCC Payments and Medicare Risk Plan Costs," unpublished paper, April 1995.

7. General Accounting Office, *Medicare: Increased HMO Oversight Could Improve Quality and Access to Care* (Washington, DC: GAO, August 1995).

8. H.R. 2491, Title 8, Subtitle A, Section 8001.

9. Costs for Medicare-covered services would have to count toward the deductible. Plans would have the discretion to count supplemental services toward the deductible or cover them once the deductible was reached.

10. American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, Public Policy Monograph #1 (Washington, DC: American Academy of Actuaries, May 1995).

11. Joseph White, "Medical Savings Accounts: Fact vs. Fiction" (Washington, DC: Brookings Institution Occasional Papers).

12. This policy reflects a clarification to the language in H.R. 2491, which was ambiguous on this issue.

13. This description reflects the proposal released in December 1995. The President subsequently may have changed this proposal.

Chapter 3

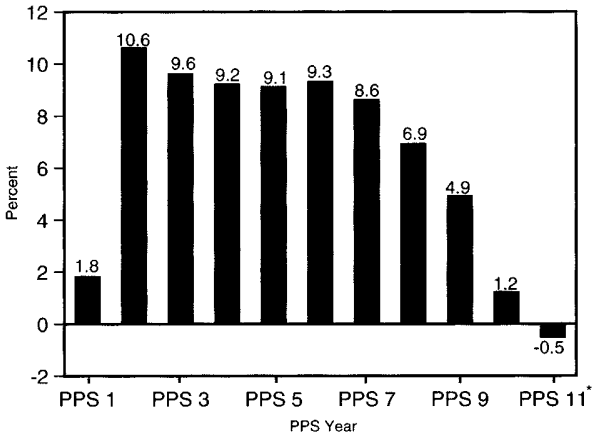
Acute Care Hospital Payments

Although both the Congress and the President propose to expand Medicare's use of capitation, most beneficiaries will likely remain in the traditional fee-for-service program for the foreseeable future. Based on this expectation, most of the proposed Medicare savings under either plan would be obtained through changes to the fee-for-service program. The majority of these savings would come from payments to acute care hospitals, including those paid under the prospective payment system (PPS) and those excluded from PPS.[1]

Since its inception, the Prospective Payment Assessment Commission (ProPAC) has provided the Congress with recommendations on PPS payment updates, the structure of other PPS payment components, and the cost limits for PPS-excluded facilities. In fulfilling this responsibility, ProPAC considers the overall level of Medicare expenditures, the equity of payments across hospitals, and the adequacy of payments for ensuring appropriate quality of care. To support its decision making, the Commission examines not only hospitals' Medicare costs, payments, and margins for inpatient services, but also total margins and other indicators that reflect the larger environment in which hospitals operate. This information is used to develop ProPAC's recommendations, to evaluate the impact of payment policy changes, and to assess the need for further policy improvements. The data from recent years indicate that the hospital industry is changing in response to the incentives of PPS and the financial pressures imposed by other payers.

After nearly a decade of annual increases averaging around 9 percent per year, the growth in PPS operating costs per discharge began to moderate in the early 1990s. In 1992, the ninth year of PPS, the increase was down to 4.9 percent, and preliminary data for 1994 show that PPS costs per discharge actually decreased for the first time (see Figure 3-1). This 0.5 percent decline is more than 3 percentage points below the growth rate of the market basket index, which reflects the prices of goods and services that hospitals purchase.

Figure 3-1. Annual Change in Medicare Operating Costs Per Discharge, First 11 Years of PPS (In Percent)



* Based on preliminary data and subject to revision

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

The reduction in per unit cost growth in recent years has been much greater for inpatient care than for other hospital services like outpatient and skilled nursing care, due primarily to declines in length of stay. Moreover, the drop in length of stay has been steeper for aged patients (who make up the vast majority of the Medicare population) than for the non-aged—18 percent compared to 13 percent since 1989. The rapid fall of Medicare length of stay may partially reflect a trend toward discharging some patients to post-acute settings earlier in the course of their treatment, representing a change in the hospital product. This has led to concern about how Medicare pays for patients who are discharged from PPS hospitals to inpatient post-acute care providers.

The substantial drop in hospital cost growth commonly is attributed to payers' resistance to continuing escalation in their payments. For a number of years, payment pressure was applied primarily by

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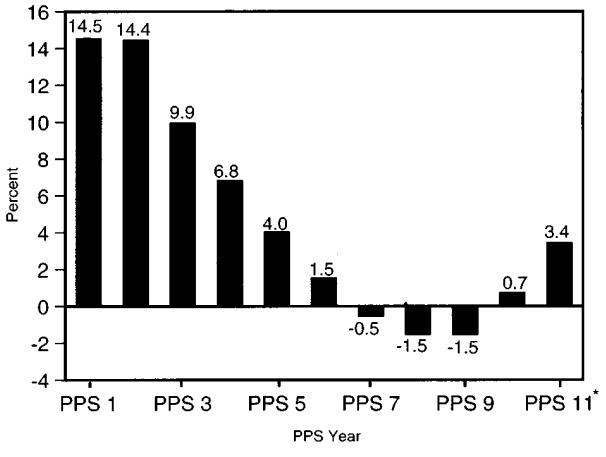
Medicare and to some extent Medicaid. From the second through the eighth PPS years, the annual increase in Medicare payments per case was less than the corresponding per case cost increase, which resulted in steadily declining PPS margins (see Figure 3-2).[2]

During this period, hospitals generally were able to obtain the revenue they needed to cover additional losses from treating Medicare patients by cost shifting to private insurers.[3] This was accomplished by obtaining payment increases from private payers that exceeded the corresponding cost increases. As a result, the average payment to cost ratio for private payers went from 116 percent in 1986 to 131 percent in 1992.[4] Primarily because of cost shifting, hospitals were able to maintain fairly stable total margins, which reflect gains and losses from all payers as well as from non-patient care activities. Although the total margin for all community hospitals dipped by nearly a percentage point between the third and fourth years, it was back at 4.3 percent by the eighth year of PPS (see Figure 3-3).

In the early 1990s, more private insurers began to actively limit their payments to hospitals, and the combined pressure from public and private payers appears to have had a dramatic effect. In 1992, the ninth year of PPS, the Medicare per case cost and payment increases were the same. Over the next two years, despite payment increases as low as at any time since PPS began, cost increases that were even lower resulted in rising PPS margins.

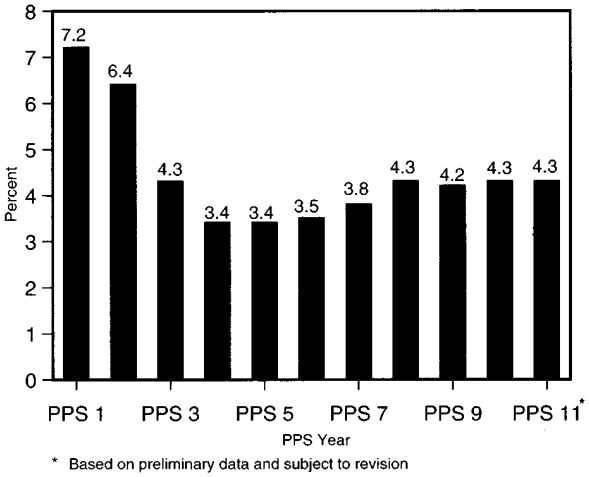
Figure 3-2. PPS Margins for All Hospitals, First 11 Years of PPS (In Percent)



* Based on preliminary data and subject to revision

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

Figure 3-3. Total Margins for All Hospitals, First 11 Years of PPS (In Percent)



* Based on preliminary data and subject to revision

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

During this period, Medicaid and uncompensated care losses stayed relatively stable. Consequently, hospitals were able to absorb smaller payment increases from private insurers without experiencing deterioration in overall financial status. The payment to cost ratio for private payers declined from its peak of 131 percent to 124 percent in 1994, while total margins remained virtually constant.

These trends portray a hospital industry adapting to an increasingly competitive environment. This has implications for how hospitals operate, how they interact with other types of facilities, and how accessible services are for Medicare beneficiaries and other populations. In the context of these changes, ProPAC presents the following discussion of payment issues and recommendations for improving Medicare policies.

The chapter begins by examining several payment update issues. Next, payments for teaching hospitals and facilities that treat low-income patients are addressed, followed by payments for discharges from PPS hospitals to inpatient post-acute providers. The chapter concludes with Commission recommendations in each of these areas.

All the payment components discussed are associated with provisions of the congressional or presidential proposals designed to reduce projected Medicare expenditures.

PAYMENT UPDATES

The Prospective Payment Assessment Commission is mandated by law to report to the Congress on the appropriate update to inpatient hospital payment rates under Medicare's PPS. In this section, the Commission discusses its views on updates to the PPS operating rates, PPS capital rates, and payments for PPS-excluded hospitals and units.

PPS Operating Rates

In developing and presenting its annual update recommendation for PPS operating rates, ProPAC uses a consistent framework to evaluate the likely impact of various factors that may affect hospital costs. These factors include hospital input price inflation, scientific and technological advances, productivity improvements, and changes in patient complexity. The Commission also looks at the potential impact of its decision on access and quality of care. The update recommendation traditionally has been for one year and for a specific rate of increase.

The Congress has proposed to set annual updates to PPS payment rates for fiscal years 1997 through 2002 at the market basket rate of increase minus 2.0 percentage points. By contrast, the President would set these increases at market basket minus 1.0 percentage points in fiscal years 1997 through 2000, and at market basket minus 1.5 percentage points in fiscal years 2001 and 2002. Recent experience suggests that actual per case payments will go up an additional percentage point each year due to changing patient acuity as measured by the case-mix index.

The Commission's update framework provides a foundation for evaluating these proposed updates. The framework begins with a forecast of hospital input price inflation in the coming year. This is based on a projection of the PPS hospital market basket index, which measures changes in the prices of a fixed basket of goods and services hospitals use as inputs to provide inpatient care. The market basket is also the basis for the annual hospital payment updates set by the Congress. The most recent forecast of the market basket is an increase of 2.9 percent in fiscal year 1997, and slightly higher growth rates in later years.

The Commission's update framework also includes two adjustments related to the market basket. The first reflects differences between ProPAC and the Health Care Financing Administration (HCFA) in the construction of the index. ProPAC believes the index should equally reflect hospital industry wages and benefits and those in the economy as a whole. This requires giving more weight to the industry price proxies and less to general wages and benefits than HCFA does. Even so, the current forecasts for fiscal year 1997 yield the same result, 2.9 percent. If hospital wages and benefits continue to grow more slowly than compensation in the general economy—as they have recently—then future forecasts of ProPAC's market basket may be less than HCFA's.

The second adjustment is needed because the market basket forecast is subject to error. The Commission believes substantial forecast errors should be corrected when the actual market basket increase becomes available. The fiscal year 1995 payment rates were updated based on a market basket forecast of 3.6 percent. The actual increase, however, was 3.0 percent. This resulted in payment rates that were 0.6 percentage points too high, and this discrepency should be removed in this year's update calculation. For the past few years, forecast errors have resulted in overstated payment rates, requiring later downward adjustments. This trend may last for another year or so. However, because the latest long-range market basket estimates are so low, future forecast errors might require a positive adjustment, especially if there is a resurgence of inflation.

The adjustment for scientific and technological advances is a future-oriented policy target intended to provide additional funds for hospitals to adopt quality-enhancing, cost-increasing health care innovations. The Commission has included adjustments ranging from 0.3 to 1.0 percentage points in past update recommendations. The current range likely is lower because there is little evidence of significant new cost-increasing advances ready for implementation. Moreover, the cost-competitive environment this industry now faces may dampen

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the adoption of new technologies as hospitals closely evaluate their relative costs and benefits. A reasonable range for the increase in operating costs due to scientific and technological advances in 1997 is 0.1 to 0.6 percentage points. There is uncertainty about the appropriateness of this range for future years, however.

The productivity adjustment, also a future-oriented policy target, is intended to give hospitals an incentive to improve productivity. ProPAC generally expects hospitals to achieve productivity gains similar to those seen in the general economy. In the past, the Commission has expected productivity growth of anywhere from 0.5 percent to 2.0 percent per year. The adjustment in the update framework is intended to share productivity savings equally between hospitals and Medicare. The productivity adjustment thus has ranged from −0.3 to −1.0 percentage points. The near future might see even greater productivity improvements, as hospitals strive to stay competitive and financially viable. ProPAC's latest estimates indicate that hospital productivity increased as much as 2.3 percent in 1994. Given this improvement, a productivity adjustment in the range of −0.7 to −1.2 percentage points would be reasonable in fiscal year 1997.

Some of the apparent productivity improvements that have been observed may be due to hospitals shifting care traditionally provided in the hospital to other settings, such as skilled nursing facilities and rehabilitation hospitals and units. This site-of-care shift results in lower per case hospital costs, but not lower PPS payments. The update should reflect this site-of-care shift, which represents a change in the hospital product.

The final component in the Commission's traditional update framework is the case-mix adjustment. Under PPS, hospital payments go up automatically with increases in the case-mix index. But the case-mix index measures both real growth in patient complexity and growth due to coding improvements that are not associated with greater patient complexity. On the other hand, the index does not capture case-complexity changes within diagnosis-related groups (DRGs). Payment should reflect only real changes in patient complexity, in ProPAC's view. The case-mix adjustment in the update framework allows payments to reflect both real across-DRG case-mix change and real within-DRG case-complexity change.

During the first few years of PPS, the national average case-mix index went up substantially, both because hospitals were coding more accurately and because patient complexity was increasing. This growth resulted in the need for rather large case-mix adjustments in the Commission's update framework, ranging from −0.7 to −1.0 percentage points. More recently, though, growth in the case-mix index has slowed, as hospitals' ability to improve their coding has diminished. This has led to smaller adjustments for case-mix change in the update framework over the past few years, ranging from −0.2 to 0.0 percentage points. The net effect of the case-mix adjustment on future updates is likely to remain small unless the DRGs are substantially revised.

Based on ProPAC's update framework, a payment update between market basket minus 2.0 and market basket minus 0.7 percentage points would be appropriate to compensate hospitals for expected cost growth for fiscal year 1997 (see Table 3-1). Moreover, substantial changes in health care financing and delivery in recent years should also be considered in setting an appropriate update. Hospitals face a more competitive environment as they vie for managed care contracts and patients. Further, private payers increasingly have resisted cost shifting, forcing hospitals to contain their costs to avoid deterioration in total margins. They have responded by holding their per case cost growth below the market basket increase. As a result, the aggregate PPS margin has increased and is now well above zero.

As a prudent purchaser, Medicare should respond to these changes by holding its price increases down and thereby sharing in the apparent productivity improvements hospitals are achieving. ProPAC's examination of the available data indicates Medicare should be able to keep its per case payment increase for PPS hospitals down to the market basket increase minus 2.0 percentage points for the next year or two without undue effects on the industry. After years of cost growth well above inflation, there should be substantial room for hospitals and the health care industry to generate lower rates of cost growth.

The Congress, however, proposes updates of market basket minus 2.0 percentage points for fiscal years 1997 through 2002. Maintaining such

Table 3-1. Update Framework for PPS Hospital Operating Payments, Fiscal Year 1997

Components of the update	
Fiscal year 1997 HCFA PPS market basket forecast	MB[a]
Adjustment for difference between HCFA and ProPAC market baskets	-0.1 to 0.0
Correction for fiscal year 1995 forecast error	-0.6
Allowance for scientific and technological advances	0.1 to 0.6
Adjustment for productivity	-1.2 to -0.7
Adjustments for case-mix change (fiscal year 1996)	
Total DRG case-mix index change	-1.0 to -0.9
Real across-DRG case-mix change	0.8 to 0.9
Within-DRG case-complexity change	0.0 to 0.2
Net adjustment for case-mix change	-0.2 to 0.0[b]
Total PPS operating update	MB -2.0 to MB -0.7

Note: MB = market basket.

[a] The most recent market basket forecast should be used to set the PPS update, which for fiscal year 1997 is 2.9 percent. This market basket forecast was provided by the Health Care Financing Administration, Office of the Actuary, December 1995.

[b] The range for the net adjustment for case-mix change does not reflect the sum of the three case-mix change components, but rather was developed in consideration of those values.

updates throughout this period could have a severe impact on hospitals. The required restraint on cost growth may not be feasible or desirable. Low updates over an extended period could affect hospitals' financial health and compromise access and quality of care. They also could impede the diffusion of quality-enhancing technological advances.

PPS Capital Payment Rates

Since fiscal year 1992, Medicare has paid for its share of hospital capital costs, which consist primarily of interest and depreciation, using prospective per case rates. During a 10-year transition period ending in 2001, payments are based on a blend of hospital-specific rates and a single Federal rate.

Initially, the base Federal payment rate was set equal to the 1989 national average Medicare-allowable capital cost per discharge updated to 1992. Similarly, each facility's hospital-specific payment rate was its 1989 cost per discharge updated to 1992. From 1992 through 1995, HCFA updated base payment rates using a moving average of capital cost increases in previous years. During this period, however, the Congress required HCFA to adjust the payment rates in each year so that anticipated aggregate capital payments would equal 90 percent of anticipated aggregate costs. This budget neutrality requirement meant that the effective payment rate was below the updated base payment rate in each year, with a growing discrepancy between the two. The expiration of budget neutrality at the end of September 1995 resulted in a 20.6 percent increase in the Federal capital payment rate for fiscal year 1996.

The congressional proposal would not alter the system for updating capital payment rates. However, it would continue the budget neutrality requirement through 2002 and lower payments to 85 percent of anticipated costs in each year. Thus, year-to-year increases in the effective capital payment rate would continue to be tied to changes in anticipated capital costs. Both the President and the Congress would reduce the Federal rate by 7.47 percent and the hospital-specific rates by 8.27 percent. These changes reflect information from hospitals' Medicare Cost Reports indicating that the 1992 base rates were overstated because the projection for cost growth between 1989 and 1992 was inaccurate.

ProPAC has recommended an alternative approach. An update framework, such as that developed by the Commission, would be applied to an appropriate base payment rate to determine the rate for the coming year. This would be similar to the method used to update PPS operating payment

rates and would finally break the link between aggregate capital costs and payments.

There are several ways to determine an appropriate base capital payment rate. For example, the 1995 effective rates—the prevailing payment amounts at that time—could be used as a base for future years. Hospitals have received these rates as capital reimbursement for the care of Medicare beneficiaries and appear not to have been adversely affected. Another method would be to rebase the 1992 capital payment rates as HCFA has suggested and update them to the current year using an analytic framework.

The ProPAC capital update framework is similar to the operating update framework described earlier. It includes factors for capital asset price changes (the capital market basket), forecast error correction, scientific and technological advances, productivity, and case-mix change. Some of these components have different values when applied to capital. ProPAC's framework also includes a discretionary financing policy adjustment for use in extended periods of unusually high or low interest rates. The application of such an update to an appropriate base payment rate would be part of a prospective payment system that provides incentives to hold costs down while recognizing the factors that determine capital cost increases for efficient hospitals.

Payments to PPS-Excluded Hospitals and Distinct-Part Units

Five types of hospitals (rehabilitation, psychiatric, long-term care, children's, and cancer) and two types of distinct-part units in general hospitals (rehabilitation and psychiatric) are exempt from PPS. These providers are excluded primarily because DRGs fail to predict their resource costs accurately.

PPS-excluded hospitals and distinct-part units are subject to the payment limitations and incentives established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Each provider is paid on the basis of its current Medicare-allowable inpatient operating costs per discharge relative to a target amount. Each provider's target amount is its allowable costs per discharge in a base year, trended to the current year by an annual update factor. Medicare's share of allowable capital costs is paid in its entirety.

Under TEFRA, a facility with Medicare-allowable inpatient operating costs that are below its ceiling (its target amount times the number of Medicare discharges) receives its costs plus an incentive payment. This payment is equal to half the difference between its costs and ceiling or 5 percent of the ceiling, whichever is less. A facility with inpatient operating costs above its ceiling receives its ceiling plus half the difference between its ceiling and costs. Payments may not exceed 110 percent of the ceiling, however. Further, TEFRA provides an exceptions process whereby facilities may receive payment adjustments if their costs are unusually high due to extraordinary circumstances.

The update to the target amounts is set prospectively by statute. Under current law, facility-specific updates range from the forecast increase in the PPS-excluded market basket to the market basket increase minus 1.0 percentage points through fiscal year 1997. Facilities that had higher costs relative to their target amounts in fiscal year 1990 receive higher updates. In 1998 and beyond, all facilities would receive the full market basket increase.

The Congress initially excluded these hospitals and distinct-part units from PPS with the understanding that a separate prospective payment system would be applied at a later date. Such a system has not been implemented primarily because appropriate patient classification systems have not yet been developed.[5] Nevertheless, interest in revising Medicare's payment system for these facilities persists owing to widespread concern about the long-term applicability of TEFRA.[6] A major issue relates to payment disparities between new and old providers.

The use of historical costs to set target amounts systematically rewards providers that had relatively high base year costs. To the extent that these facilities restrain cost increases or lower their costs in subsequent years, they benefit by receiving incentive payments. By contrast, providers that had relatively low base year costs are penalized by having a low target amount. These facilities are less likely to benefit from incentive payments because they may be less able to realize additional efficiency gains in later years. Accordingly, the financial outcome for

the latter group becomes heavily dependent on the annual update to the target amount. The update also does not reflect certain factors that affect facility costs, such as changes in case mix or treatment patterns. Hence, target amounts are less likely to reflect the reasonable costs of providing services over time. Providers that have been subject to TEFRA longer, therefore, may be disadvantaged relative to new ones entering the market.

Recent ProPAC analyses suggest that, in aggregate, rehabilitation hospitals and distinct-part units have done well financially under TEFRA. For most other excluded facility types, though, aggregate operating payments are at or below aggregate operating costs. Further, substantial variation in the extent to which facilities' costs exceed their target amounts was found across and within all provider types.

Although aggregate Medicare payment to cost ratios generally improved for psychiatric, long-term care, and children's facilities in recent years, this was due primarily to the influx of new providers. Facilities that first received TEFRA payments after fiscal year 1989 had higher payments (as well as higher payments relative to costs) than facilities that were subject to TEFRA before 1990. Because it does not have data on exceptions payments, however, the Commission cannot draw definite conclusions about financial performance.[7] Anecdotal evidence suggests that certain facilities, particularly long-term care hospitals, receive large lump-sum exceptions payments. Therefore, reported losses are likely to be overstated, but by how much is unknown.

Both the Congress's and the President's proposals contain provisions to mitigate the payment disparities between new and old providers as well as generate savings for the Medicare program. The Congress would apply a facility-specific update to the target amount ranging from the projected increase in the PPS-excluded market basket to the market basket increase minus 2.5 percentage points for fiscal years 1996 through 2002. The reduction from the market basket projection would depend on the extent to which a facility's current costs exceed its target—the higher a facility's costs are relative to its target, the larger the update. Facilities with allowable costs substantially below the ceiling in a given year would not receive an update. These low-cost providers generally would receive the same incentive payment, however. The Congress also would reduce capital payments, which are based on each facility's Medicare-allowable costs, by 10 percent.

The Congress also proposes to apply a floor to the target amounts for rehabilitation facilities and long-term care hospitals that first received Medicare payments before October 1, 1995, and a ceiling for those that first received payments on or after that date. Further, a new base year would be assigned to certain long-term care hospitals that serve a disproportionate share of low-income patients and had costs above their targets in fiscal years 1993 and 1994.

The President proposes to update the TEFRA target amounts for all providers by the projected increase in the market basket minus 1.0 percentage points for fiscal years 1996 through 2000. In 2001 and 2002, the update would equal the market basket increase minus 1.5 percentage points. Further, facilities would receive 85 percent of their Medicare-allowable capital costs in fiscal years 1996 through 2005.

To account for the widening disparity between costs and payments for certain providers, the Administration proposes to rebase the target amounts for all PPS-excluded facilities using more recent cost report data, subject to floor and ceiling limits. The proposal also includes revisions to the basic TEFRA payment method such that only certain facilities would be eligible for exceptions adjustments. Additionally, only those providers whose costs exceed 110 percent of the target amount would receive payments greater than their target. Finally, the President would impose a moratorium on certification of new long-term care hospitals.

TEFRA modified cost-based payments to encourage providers to operate more efficiently and restrain cost increases. It is expected, therefore, that some facilities will be winners, while others will lose. But by its very design, TEFRA systematically creates an inequitable payment distribution. These inequities may be mitigated by the exceptions process, which provides additional payments to facilities when events or circumstances beyond their control significantly increase their costs. However, the potential availability of exceptions may weaken TEFRA's cost-containment incentives.

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The Commission therefore believes that Medicare should move more quickly toward implementing a prospective payment system for these facilities. Such a system, in which payments are based on national or regional average costs rather than on facility-specific costs, would promote efficiency among providers. It also would recognize certain cost differences that are beyond providers' control and accommodate changes in case mix and practice patterns.

In the interim, ProPAC 's analytic framework can be used to update TEFRA target amounts. This approach is similar to the Commission's framework for PPS payment updates, but modified to reflect differences between TEFRA and PPS. Hence, the update is determined primarily by the projected increase in the PPS-excluded market basket index.

Medicare automatically shares in savings from productivity improvements under the TEFRA system, and payments are not case-mix adjusted. Consequently, adjustments for these factors are not needed to determine an appropriate update. Scientific and technological advances, while considered, were not included because they are not likely to increase costs significantly in the coming year. Therefore, the Commission's methodology results in an update for fiscal year 1997 equal to the market basket increase minus 0.6 percentage points to account for previous forecast error.

Although this framework yields an average update for all PPS-excluded providers, the Commission supports the notion of a facility-specific update as contained in current law and in the congressional proposal. By allowing for differential updates depending on the costliness of care, such an update recognizes that, in some cases, rising costs may be beyond a hospital's control.

TEACHING HOSPITALS

Medicare is the only payer that makes explicit payments for hospitals' teaching-related costs: the indirect medical education (IME) adjustment and the direct graduate medical education (GME) payment. Other payers have traditionally paid higher rates to teaching institutions for these costs. The Congress and the President propose to make several changes to Medicare's payments. The Congress also would establish a Teaching Hospital and Graduate Medical Education Trust Fund to provide additional explicit support for teaching-related costs.

Teaching hospitals incur higher costs than other facilities because of their education and research missions. Many carry the added financial burden of caring for a disproportionate share of poor or uninsured patients. Higher costs may put these facilities at a disadvantage relative to other hospitals, particularly in areas with excess inpatient capacity. Because Medicare provides additional funds to teaching and disproportionate share hospitals, the PPS margins for these facilities are much higher than those for other hospitals. Their total margins, however, are lower than average. The Commission is concerned about maintaining the financial viability of teaching hospitals because of the special role they play in the health care system.

These concerns are heightened by the changes now occuring in the health care marketplace. Teaching hospitals may have added difficulties obtaining patient volume or contracts from increasingly cost-conscious insurers and health plans. As these financial pressures grow, the Medicare program needs to ensure that its payments accurately account for the added costs teaching hospitals face. The appropriate role of other payers in supporting these social goals needs to be reassessed as well. It also is critical that funds be distributed to those facilities that make the largest contributions and have the greatest need.

The distribution of teaching-related payments can influence the number and mix of physicians across specialties. Medicare inpatient payments go up for each resident a hospital trains, which could provide incentives to substitute residents for other personnel. Further, certain specialties may be more attractive to hospitals because they can generate greater faculty practice plan revenues than others. These factors may distort the hospital market for residents and may impede movement toward an appropriate mix and number of physicians. The distribution of teaching-related funds therefore must encourage, or at least be consistent with, the right balance.

Both the Congress and the President would substantially reduce Medicare's teaching-related spending, with cumulative savings between fiscal

years 1996 and 2002 of almost $13 billion under the congressional proposal and $10 billion under the President's. The size of the Medicare teaching payment reductions would be the same under both proposals in fiscal year 2002: about $3.2 billion, according to the Congressional Budget Office. The financial effects of these reductions, along with other changes in Medicare payment, need to be monitored to make sure they do not adversely affect teaching hospitals. The Medicare payment reductions in the congressional proposal would be offset, however, by general revenue payments from the new Teaching Hospital and Graduate Medical Education Trust Fund, whose cumulative contributions would total $13.5 billion through fiscal year 2002.

Direct Graduate Medical Education Payments

When PPS was implemented, Medicare's share of the direct costs of residency training programs (salaries and benefits of residents and faculty, classroom costs, and associated overhead) was reimbursed on a reasonable cost basis. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) changed this to a hospital-specific per resident payment amount based on reported costs from the first year of PPS. This amount is updated annually by the increase in the consumer price index, although the payment amounts were frozen for non-primary care residents in fiscal years 1994 and 1995. Medicare's payment is determined by multiplying a hospital's updated per resident payment amount by the weighted count of residents and then by Medicare's share of inpatient days. Residents who have completed their initial residency period are counted as half a full-time equivalent (FTE) resident. The initial residency period is the minimum number of years required for board eligibility in a specialty or five years, whichever is less.

One issue of concern is the wide variation in the per resident payment amounts across hospitals, caused by differences in reported base year costs. This variation may be the result of differences in resident salaries, teaching physician costs, or allocated overhead expenses. These base year cost differences, however, may also reflect variation in hospital cost reporting practices. Resident counts and the use of weighting factors to pay less for certain residents is another issue. Medicare does not limit the number of residents who can be counted for payment, and there is concern that this may encourage hospitals to expand their training programs. Weighting factors are used in the current direct GME payment to discourage hospitals from training residents in subspecialties. It is unclear, though, whether the current weighting factors influence hospitals in their specialty mix decisions.

Medicare GME payments would remain unchanged under the congressional proposal, except that residents who are past their initial residency period would count only as a quarter of an FTE. In addition, the aggregate number of residents used in calculating payments would be frozen, although this would affect only hospitals that experienced an increase in residents.

The President's proposal would extend through fiscal year 2000 the freeze on per resident payment amounts for residents who are in non-primary care specialties. This proposal also would freeze, on a hospital-specific basis, both the number of non-primary care residents and the total number of residents who could be counted for payment. In addition, the Administration's proposal would allow direct GME payments to non-hospital providers for primary care residents in other settings when the hospital is not paying for the resident's salary in those sites.

Indirect Medical Education Payments

The indirect medical education adjustment is intended to compensate teaching hospitals for their higher Medicare patient care costs. These costs may be due to greater patient acuity, a broader scope of services available, more intensive treatment, and a costlier mix of staff than in other facilities. They may also be attributable to the expense of developing and improving diagnostic and therapeutic technologies or to the less efficient practice style of residents.

Since 1987, the indirect medical education adjustment to PPS operating payments has been set at 7.7 percent for every 10 percent increment of teaching intensity, as measured by the ratio of interns and residents to hospital beds. On the basis of several years of analysis, the Commission believes the technically appropriate rate is 4.5 percent. Recognizing, however, that a sharp reduction

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in IME payments could seriously affect teaching institutions, ProPAC in 1995 recommended lowering the adjustment from 7.7 percent to 6.7 percent in fiscal year 1996 and making further reductions only after reviewing the financial effects of this change. This recommendation was made in the context of the payment provisions in effect at the time.

The Congress has proposed reducing the IME adjustment to 6.7 percent in fiscal year 1996. The adjustment would then continue to decline gradually each year to a final level of 5.0 percent in fiscal year 2000. In addition, the proposal would establish a medical education trust fund that would provide additional payments to teaching hospitals based on each hospital's share of Medicare IME payments over a three-year base period. Funding for this new payment would come from general revenues, thus broadening the source of payment for teaching costs.

The President's proposal would lower the IME adjustment to 7.2 percent in 1996, after which it would decline in stages to 6.0 percent in fiscal year 2001. In addition, residents who were beyond their initial residency period would be counted as half an FTE for determining IME payments, as they are for GME payments. Under the proposal, residents who work in non-hospital settings also would be included in the hospital's IME resident count.

The IME adjustment continues to be higher than what the Commission has recommended in past years. Both the Congress and the President would reduce this adjustment from its current level. The President's proposal would lower it more slowly, but would also apply Medicare GME resident count and weighting rules to the IME resident counts. Treating the IME resident counts like those for GME would strengthen incentives to train residents in primary care specialties. The Commission is intrigued by such a policy, but has not examined its potential financial impact on hospitals. Such a policy could also affect the technically appropriate level for the IME adjustment. ProPAC plans to study this issue further. Finally, it is important that the impact of reducing IME payments, together with any reduced funding for disproportionate share payments, be closely monitored to make sure that Medicare beneficiaries' access to quality care is maintained.

Other Support for Teaching-Related Costs

The Congress's proposal would establish a Teaching Hospital and Graduate Medical Education Trust Fund to help support the cost of training residents. A total of $13.5 billion would be appropriated to the fund from general revenues between fiscal years 1997 and 2002, establishing a broader source of public support for residency training. A specified percentage of the general revenue funds would be allocated to a MedicarePlus Incentive Account. The remaining money would be allocated to the General Indirect-Cost Medical Education Account and General Direct-Cost Medical Education Account, based on the share of Medicare spending in fiscal year 1994 for IME and GME, respectively.[8]

The MedicarePlus Incentive Account would distribute funds to teaching hospitals based on their share of MedicarePlus admissions among all teaching hospitals. Thus, the size of a hospital's teaching program and the complexity of its patient population would not affect these payments. Hospitals with many MedicarePlus patients would be greatly rewarded for having only a few residents. Hospitals with a large teaching commitment, however, would receive the same per case payment as these other hospitals. Moreover, because the size of the fund is fixed, the actual per case payment would depend on the total number of MedicarePlus admissions to teaching hospitals. Consequently, if few beneficiaries entered the MedicarePlus program or if few of these enrollees used teaching hospitals, the per case payment would likely be much higher than the associated costs. The reverse would be true if there were significant MedicarePlus participation, particularly in teaching hospitals.

The General Indirect-Cost Medical Education Account would distribute funds to teaching hospitals based on the share of total Medicare IME payments each hospital received over a three-year base period (1992 to 1994). Payments would not be affected by changes in the number of residents trained or the number and mix of patients treated. The General Direct-Cost Medical Education Account would distribute funds in a similar manner, based on a hospital's share of Medicare direct graduate medical education payments over the 1992 to 1994 period. The general direct-cost payment would thus depend on the hospital's per resident payment amount, resident count, and Medicare share of inpatient days in the

base period. It would not be adjusted, however, for changes in these factors between the base year and the time payments are made.

Distributing these two new accounts based on past Medicare spending for teaching may not be an effective way to provide broader general support for teaching-related expenses. This is because hospitals with high levels of Medicare teaching payments would also receive a large portion of these new general revenue payments. Conversely, hospitals with a low share of Medicare teaching payments, such as children's hospitals and some urban public hospitals, would receive little financial support from these general funds, even though they may have the same overall number of residents. The Commission is exploring a number of alternatives for distributing these funds. ProPAC will forward to the Congress later this year its views on how best to distribute general revenue payments so that they provide broader financial support for teaching-related activities in all settings.

The President's proposal would provide funds for teaching-related costs for Medicare beneficiaries in capitation programs. It would remove teaching-related payments from the Medicare capitation rates and return 75 percent of these funds to health maintenance organizations, hospitals, and other providers that operate teaching programs for the teaching costs of care provided to beneficiaries enrolled in capitation plans. This would result in lower capitation rates, particularly in some areas with a large number of teaching hospitals. Medicare participating health plans would need to adjust to these rates by reducing extra benefits, renegotiating provider contracts, accepting lower profits, or in other ways.

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

The disproportionate share (DSH) adjustment originally was intended to offset the cost-increasing effect of treating low-income patients. In recent years, its purpose has been viewed more broadly as preserving access to care for low-income populations by financially assisting the hospitals they use.

The amount of DSH payment each hospital receives is determined by a complex formula and each hospital's disproportionate share patient percentage. This percentage is derived as the sum of two ratios: Medicaid patient days as a share of total patient days and patient days for Medicare patients eligible to receive Supplemental Security Income cash payments as a percentage of total Medicare patient days. Most DSH payments go to urban hospitals.

The congressional proposal would not change the method of distributing DSH payments, but would substantially reduce funding for the adjustment. The cutback would be implemented in annual increments, beginning at 5 percent in 1996 and reaching 30 percent in 2000. The President's proposal includes a smaller funding reduction—10 percent—beginning in 1999.

These reductions would be implemented at a time when hospitals relying heavily on the DSH adjustment are facing competitive pressures that make it increasingly difficult to generate funds to cover their uncompensated care costs. Moreover, the number of people unable to pay for hospital care is likely to increase in the coming years. Even with insurance premiums rising more slowly than in the past, additional employers may drop health insurance coverage for their employees. Further, under the comprehensive Medicaid reforms proposed by the Congress, some states might elect to scale back Medicaid eligibility and service coverage. Finally, many local governments operating hospitals are facing their own financial pressures, which may make it difficult for them to maintain the level of operating subsidies they formerly provided.

Reductions in funding for the DSH adjustment highlight the importance of ensuring that the hospitals with the greatest need receive payments. However, optimizing the allocation of DSH funds is complicated by the use of a Medicaid variable in the distribution formula.

Medicaid utilization has never been a good measure of service to the poor, because the proportion of the low-income population covered by the program varies substantially from state to state, and the hospitals that provide the most care to uninsured low-income patients do not necessarily treat the most Medicaid patients. The misallocation may have been exacerbated in recent years by reforms a number of states have undertaken. Of particular

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concern is the substantial expansion in eligibility for Medicaid in Oregon and Tennessee, with little or no indication of change in these states' low-income populations.[9] Moreover, the accuracy of a Medicaid patient day count in representing the amount of care provided to the poor may deteriorate even further under the expanded state role envisioned by the Congress. With much greater control over the design of their programs, some states may broaden eligibility and service coverage while others scale them back—all with virtually no relationship to the amount of care needed by the poor.

Because of these problems, it will be essential to improve the accuracy of the data used to distribute DSH payments. This should be done in the context of a comprehensive review of the objectives of the DSH adjustment and the methods available to best accomplish them. One important methodological issue is what populations to include, as the measure now used for distributing payments does not reflect a significant portion of hospitals' low-income patient loads. It will also be important to define the scope of patient care to be covered, such as whether DSH payments should apply to outpatient care or to hospital services provided in Medicare capitation programs.

The most appropriate measure of low-income patient care must then be identified. The primary choice here is between a measure of the amount of care provided to low-income patients and the losses incurred in treating the poor. Data collection methods would also need to be assessed, since most of the likely options for distributing payments would require new data. This presents a trade-off between the level of hospital reporting burden and the ability to allocate DSH monies among providers in the desired manner. In addition, it may be necessary to deal with the difficult issue of measuring charity care.

Revamping the DSH adjustment is potentially a complex process. However, inasmuch as the facilities now relying on DSH payments face growing pressure from private payers, Medicaid, and Medicare, the distribution of available funds will be crucial in protecting access to care for vulnerable populations.

DISCHARGES FROM PPS HOSPITALS TO OTHER FACILITIES

A per case payment system like PPS provides hospitals with a strong incentive to reduce length of stay. Hospitals can shorten stays by changing their practices to provide care more efficiently. They also can reduce the amount of care furnished in the inpatient setting by moving patients out of the hospital to other locations. When PPS began, there was evidence of this site-of-care substitution. Hospitals began conducting more preoperative tests in the outpatient setting, for example, instead of admitting the patient to the hospital the day before surgery.

The recent growth in the use of post-acute services, together with declines in PPS inpatient length of stay, raises the issue of whether site-of-care substitution is now occurring at the end of the hospital stay. (See Chapter 4 for a more complete discussion of this trend.) Many of the services delivered in post-acute settings may formerly have been provided in PPS hospitals. If payments are not adjusted to reflect any shift in site-of-care delivery, Medicare may be paying twice for the same service: once in the hospital, where the DRG payment rate reflects the cost of services no longer provided, and again in the post-acute care setting, where the service is now furnished. Although the DRG weights eventually reflect the relative resources required to treat the average case in a DRG, aggregate PPS payments do not reflect the shifting of these services from the hospital unless the PPS update accounts for this change in the hospital's product.

The President proposes to apply Medicare's transfer payment policy to patients who are discharged to PPS-excluded hospitals and units and to skilled nursing facilities. Hospitals that discharge patients to one of these facilities after a stay of at least a day less than the average for the DRG would receive a graduated per diem payment instead of the full DRG amount. Thus, PPS payments would be reduced when services were transferred from the hospital to post-acute sites. In addition, the proposal would stabilize the weights for DRGs with significant site-of-care shifts. This would allow the DRG weights to better reflect the cost of care provided to patients who were not discharged to another setting.

The Administration's proposal, however, would reduce hospitals' incentive to discharge patients to post-acute settings. This could result in longer hospital stays, even though the cost of providing care might be lower and the level of care might be more

appropriate in post-acute sites. This proposal could substantially weaken PPS incentives to shorten inpatient lengths of stay, leading to a less appropriate continuum of care for Medicare beneficiaries. Therefore, the likely effects of such a policy on hospital behavior need to be better understood before implementation proceeds.

CONCLUSIONS AND RECOMMENDATIONS

The Commission has developed recommendations in each of the policy areas addressed above. These include updates for the operating and capital components of PPS and PPS-excluded hospital payments, teaching and disproportionate share payments, and payment for discharges from PPS hospitals to post-acute facilities. Despite the emphasis on capitation programs in both the congressional and presidential proposals, these payment policies will continue to govern the majority of Medicare payments for inpatient hospital services.

Recommendation 10: Updating PPS Operating Rates

ProPAC's update framework would support an update between 0.7 percentage points and 2.0 percentage points less than the increase in the hospital market basket index. The methodology employed by the Commission in previous years would lead to a recommendation of about market basket minus 1.5 percentage points, roughly corresponding to the midpoint of that range. In light of the significant changes occurring in health care delivery, the Commission believes that PPS payment rate increases could be held to market basket minus 2.0 percentage points for the next year or two. However, it is concerned about the potential effects of continuing updates at that level on hospitals' ability to provide quality care to Medicare beneficiaries and other populations.

ProPAC's update framework accounts for the effects of inflation on hospital costs, adjusting for case-mix change, scientific and technological advances, and productivity improvements. The congressional proposal of market basket minus 2.0 percentage points falls within the range that results from applying the Commission's framework. The Congress, however, would set the update at this level through 2002.

In the short run, hospitals should be able to continue their recent productivity growth, and thus should not be adversely affected by an update that is 2.0 percentage points below the hospital market basket increase. Payers are applying pressure on providers—particularly hospitals—to restructure the way they operate and constrain the growth in their costs. Hospital occupancy rates remain relatively low in aggregate, indicating substantial system overcapacity and ongoing opportunities for hospital productivity improvements. Hospitals can continue to better the efficiency of staffing and capital purchasing as well. In view of the changes now occurring in the health care market, hospitals should still be able to provide quality care for the immediate future, despite this constrained rate of growth.

If updates are held to this level through 2002, though, hospitals may not be able to continue providing access to quality care. It is unclear, for instance, how long they will be able to support the productivity improvements needed to keep cost per case increases down to the level required by the proposed updates. Furthermore, some of the changes other payers are making, such as controlling the use of inpatient hospital services, will reduce hospital volume. This could raise per case costs for hospitalized patients. Moreover, a continuation of cost constraint at this level could require hospitals to forego technological advances that may significantly improve quality and patient outcomes. Finally, there is the basic uncertainty about the future. The Commission is concerned that once the updates become law, it would be extremely difficult to increase them to respond to deteriorating quality and hospital financial condition, should that occur.

Recommendation 11: Setting Capital Payment Rates

Prospective per discharge payment rates for inpatient capital costs should be set by developing an appropriate base payment rate and applying an annual update. The capital update should reflect the prices of capital assets, capital financing costs, and

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other factors related to the capital costs hospitals incur in efficiently providing inpatient care to Medicare beneficiaries.

The capital payment rates currently in effect are based on estimated fiscal year 1992 hospital capital costs per discharge, updated by historical capital cost increases through 1995 and a prospective update framework for 1996. ProPAC has long opposed the use of historical cost increases, proposing instead that a prospective framework similar to that applied to PPS operating payments be used.

In the first four years of capital prospective payment, the effective capital payment rate has differed from the base payment rate due to a congressional requirement that total anticipated capital payments equal 90 percent of total anticipated capital costs. When this budget neutrality requirement expired at the end of fiscal year 1995, actual capital payment rates for 1996 went up more than 20 percent.

The Congress has proposed extending the budget neutrality requirement through fiscal year 2002 and setting payment rates so that total capital payments equal 85 percent of total anticipated capital costs. While this would eliminate the large increase in capital payments in 1996, it would continue the relationship between capital payments and costs in each year. The Commission believes that Medicare should move to a fully prospective capital payment system, severing the link between payments and costs.

Recommendation 12: Updating Payments to PPS-Excluded Hospitals and Distinct-Part Units

ProPAC's update framework would support an average update to the TEFRA target amounts equal to the projected increase in the market basket index minus 0.6 percentage points for fiscal year 1997. This average is within the range of facility-specific updates in the Congress's proposal, which is between the market basket increase and 2.5 percentage points below market basket. Major changes to the TEFRA target amounts should not be made at this time. Rather, a prospective payment system for PPS-excluded hospitals and distinct-part units should be implemented as soon as practicable.

ProPAC's update framework for payments to PPS-excluded hospitals and distinct-part units reflects the market basket increase for these facilities, corrected for previous forecast error. Unlike the Commission's approach for updating PPS payments, this framework does not include adjustments for productivity or case-mix change. It does reflect an allowance for scientific and technological advances, although this was zero for fiscal year 1997. Given the structural changes occurring in the hospital industry, the Commission believes PPS-excluded hospitals and distinct-part units should be able to successfully constrain their cost increases and still provide access to quality care within the provisions of the congressional proposal, at least for the next year or two.

Financial performance varies widely among PPS-excluded hospitals and distinct-part units, particularly between new facilities and those that have been operating for many years, according to ProPAC analyses. Much of this variation is related to the design of the TEFRA payment system rather than to hospital behavior. TEFRA is not suited—and was not intended—for long-term application. Rebasing the target amounts, however, would not solve the system's inherent problems. Assigning a more recent base year would increase payments to older facilities, which would improve payment equity somewhat. Yet older facilities would still be at a competitive disadvantage because recent costs would reflect past spending patterns that were constrained by the annual updates. A prospective payment system would recognize appropriate cost differences and reward efficient facilities, particularly older ones that have responded to TEFRA's incentives.

Because there is no acceptable measure of case mix, implementation of a prospective payment system in the near term is not feasible. The development of a patient classification system for rehabilitation hospitals and distinct-part units is progressing, but few advances have been made for other PPS-excluded providers. The Secretary should accelerate efforts to develop effective patient classification systems that can form the basis of a prospective payment system for these providers. (See Recommendations 20 and 21.)

In the meantime, the formulas for updating the TEFRA target amounts under current law and in the congressional proposal appropriately recognize that all facilities do not realize identical cost increases and allow for differential updates across providers according to individual experience. The Commission will continue to examine the TEFRA payment system and its effect on providers.

Recommendation 13: Broadening Financial Support to Teaching Hospitals

> **Explicit financial support for graduate medical education activities should not be limited to the Medicare program. Mechanisms to broaden financial support for teaching-related activities in hospitals and other locations should be developed.**

Medicare is the only payer that explicitly pays hospitals for the direct and indirect costs of teaching activities. Although other payers have implicitly provided funding for these activities by paying higher prices for patient care services, there is no direct connection between the amount of payment and the size or structure of the teaching program. Moreover, because the implicit support for teaching activities is not separable from the price of patient care at teaching hospitals, these facilities are at a disadvantage relative to non-teaching hospitals because of higher prices related to their teaching mission. As hospital markets become more competitive with the growth of managed care and other structural changes, it will be increasingly difficult for teaching hospitals to compete for patients from price-sensitive insurers.

To allow teaching hospitals to compete fairly with other institutions, the Commission supports the concept of an all-payer fund to help underwrite teaching activities at hospitals and in other settings. The Teaching Hospital and Graduate Medical Education Trust Fund proposed by the Congress would provide broader support for these activities by using both general revenues and Medicare payments. As centers for training future physicians, leaders in research, and providers to underserved populations, teaching hospitals are an integral part of this nation's health care delivery system. It is important that they remain viable in this role.

Recommendation 14: Medicare Payments for Graduate Medical Education Costs

> **ProPAC supports changes in Medicare teaching payments that would encourage an appropriate distribution of residents across specialties and discourage inappropriate growth in the total number of residents.**

Medicare payments should foster an appropriate specialty balance and supply of future practicing physicians. Both the President's and the Congress's proposals for Medicare direct GME payments would move in this direction. The President's proposal would provide greater incentives for training primary care residents than for those in other specialties, which is desirable. The Congress would discourage the growth in the number of residents while relying more on market forces to determine the number and distribution of physicians. Medicare payments should reflect the desired change in direction, rather than impeding these changes.

Recommendation 15: Medicare Indirect Medical Education Payments

> **The Medicare indirect medical education adjustment should be reduced from its current 7.7 percent level to 7.0 percent.**

Ultimately, the Medicare IME adjustment should be reduced from its current 7.7 percent level to one that corresponds more closely to the actual relationship between teaching intensity and costs. The final level of the adjustment, however, should depend on what other changes are made in the Medicare program. The Commission therefore recommends an initial reduction of the IME adjustment to 7.0 percent. As the adjustment is reduced, it will be important to monitor teaching hospitals' financial condition and the effect on access to their services.

ProPAC also supports the concept of basing IME payments on resident counts and weighting factors consistent with those used in GME payment. Additional analysis is needed to examine the effect of this policy on individual teaching hospitals, however. The Commission recommends proceeding cautiously with such a change. It is also important to point out that the technically appropriate level of

the teaching adjustment would change with such a policy. ProPAC plans to examine in more detail the impact of this policy on hospitals and on the empirical relationship between teaching intensity and hospital costs.

Recommendation 16: Distributing Additional Teaching-Related Payments

Funds that provide broader financial support for graduate medical education should be distributed in a way that corresponds to the additional costs incurred by teaching facilities. Providers that treat enrollees in capitation plans should receive teaching-related payments for those patients as well as for the other patients they serve.

ProPAC is concerned about how general revenues would be disbursed through the General Indirect-Cost Medical Education Account and the General Direct-Cost Medical Education Account. The distribution of payments from these accounts would be based on previous Medicare payment levels, even though the funds would come from general revenues. Hospitals with a high share of Medicare teaching payments would receive a proportionately higher share of these new payments compared to hospitals with the same amount of teaching activity but a low share of Medicare patients. Payments based on prior Medicare utilization may not achieve their broader purpose. Over the coming year, ProPAC will examine how best to provide general support for teaching-related activities.

Additionally, funding mechanisms are needed so that teaching hospitals can compete effectively in the managed care market. Such mechanisms should give participants in Medicare's capitation program an incentive to use teaching hospitals when needed while paying providers appropriately for serving capitation patients. How funds would be disbursed to hospitals under the Congress's proposed MedicarePlus Incentive Account concerns the Commission. First, these payments would not account for differences in the intensity or size of hospital residency programs. Second, because the total payments available through this account would be fixed, they would not reflect Medicare beneficiaries' use of the proposed MedicarePlus program. Payments from a fund like this one should reflect the amount of teaching activity in a hospital and other teaching settings. Further, total payments made through such a mechanism should depend on Medicare beneficiaries' participation in capitation programs.

Recommendation 17: Disproportionate Share Hospital Payments

The Commission is concerned about the potential impact of reductions in DSH payments. Hospitals that treat a large number of the uninsured could be particularly vulnerable because of recent changes in the health care environment. Large reductions in DSH payments would threaten the continued ability of many of these hospitals to serve populations who depend on them for access to care.

With increasing numbers of people lacking health insurance and contraction in many state and local programs designed to fund care for them, hospitals' uncompensated care burdens will likely be higher than ever in the coming years. Many of the hospitals that treat large numbers of uninsured patients are teaching institutions, which are facing stepped-up price competition in the private market along with substantial cutbacks in their IME payments. But some non-teaching hospitals also have significant low-income patient shares, and even among those involved in medical education, the amount of service to the poor frequently does not correspond to the level of teaching intensity. The financial integrity of many hospitals that play a critical role in ensuring access to care for low-income patients may be affected by changes occurring in the public and private financing of medical care. The role they serve will, if anything, become more important in the near future and should be protected.

Recommendation 18: Method for Distributing Disproportionate Share Payments

The structure of the DSH adjustment should be reviewed to make certain that available funds are distributed equitably among the hospitals most in need of assistance. This may require collecting new data to develop a better measure of the services hospitals provide to indigent patients.

The distribution of DSH payments is determined partly by each hospital's Medicaid patient days as a

percentage of total days. Medicaid utilization has never been an optimal measure of service to low-income patients, and its accuracy is deteriorating even further with changes taking place in the structure of the Medicaid programs in several states. Moreover, this problem would be exacerbated by the Medicaid reforms the Congress has proposed.

An alternative method of distributing DSH payments should be considered, but in the context of a comprehensive review. This review should begin by assessing the objectives of the DSH adjustment. It should also extend to defining the low-income population to be covered and identifying the scope of patient care to be included (for example, outpatient care or services furnished under the Medicare capitation program). Alternative measures of low-income patient care could then be considered, including the data collection each would require.

Recommendation 19: Discharges from PPS Hospitals to Other Facilities

Medicare payments should be modified to account for the shift in services from acute to post-acute settings. Broadening the definition of transfer cases, however, is not an appropriate approach.

PPS provides hospitals with a strong financial incentive to reduce length of stay by moving care to other settings, since in most cases payments are the same regardless of whether the full course of treatment is provided in the hospital. Although the DRG weights eventually reflect this shift in services, aggregate Medicare payments do not. Constrained updates due to expected productivity improvements may appropriately adjust aggregate payments, but they will not account for cost differences between patients who use post-acute services and those who do not.

The President proposes to treat as transfers those cases who are discharged to skilled nursing facilities and PPS-excluded hospitals and units. The Commission, however, thinks this policy would discourage the use of post-acute providers. Moreover, it could result in longer inpatient stays, which may not be desirable or cost effective in the long run. The expanded transfer policy, therefore, should not be implemented without additional analysis of its impact. Other policies that would better integrate the payment system across settings need to be studied. One would be to bundle acute and post-acute services for certain DRGs into a single payment rate. Another would be to develop DRGs that reflect the use of post-acute services. The Commission will continue to examine methods to better integrate the fee-for-service payment system and will work with the Secretary on this endeavor.

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Notes to Chapter 3

1. The Congress's Medicare provisions are in H.R. 2491, the "Balanced Budget Act of 1995." The Medicare provisions of the President's plan are in Title 11 of draft legislation, called the "Balanced Budget Act of 1995 for Economic Growth and Fairness." Released on December 7, 1995, this proposal has not been introduced in the Congress.

2. The PPS margin is the difference between the PPS operating payments a hospital receives and the operating costs of treating its Medicare patients, taken as a percentage of the payments.

3. ProPAC views cost shifting as a dynamic process whereby changes in payments relative to costs for some payers are offset by changes for other payers. During the late 1980s, increasing losses from Medicare, Medicaid, and uncompensated care were offset by increasing gains from private payers. For more information on this issue, see Prospective Payment Assessment Commission, *The Relationship of Hospital Costs and Payments by Source of Revenue, 1980-1991*, ProPAC Intramural Report I-95-01, October 1995.

4. Prospective Payment Assessment Commission, *Hospital Costs and Payments by Revenue Source: The Impact of Medicaid Payment Increases in 1992*, ProPAC Intramural Report I-95-05, October 1995.

5. The rehabilitation industry and the research community have developed a patient classification system for rehabilitation hospitals and distinct-part units (referred to as functional-related groups) that is based on patient functional status. HCFA is evaluating how well this technique works in grouping patients.

6. The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to propose either a prospective payment system for PPS-excluded providers or modifications to the current TEFRA system. The Act also required ProPAC to analyze and comment on the proposal. Absent the Secretary's proposal, the Commission submitted an interim report to the Congress that examined the financial condition of PPS-excluded providers and explored broad alternative payment methods. Prospective Payment Assessment Commission, *Interim Report on Payment Reform for PPS-Excluded Facilities*, Congressional Report C-92-05, October 1992.

7. Data on the amount of payment adjustments received through the exceptions process are not systematically collected or automated. In addition, there is a considerable lag between the time an exception is granted and when it appears as a higher target amount on the cost report.

8. The trust fund would also receive revenue from Medicare to support the Medicare Indirect-Cost Medical Education Account and the Medicare Direct-Cost Medical Education Account. Money from these two accounts would be used to finance indirect medical education adjustment payments and direct graduate medical education payments to certain hospitals that operate graduate training programs for interns and residents.

9. HCFA has attempted to minimize the bias resulting from the major reform in Tennessee and plans to do so for Oregon. Under HCFA's directive, Tennessee's Medicaid agency furnishes each hospital with a list of its patients who would have been eligible for Medicaid under the prior criteria. The hospitals then use this information to provide the Medicare fiscal intermediary with a restricted count of Medicaid days. This is an administratively difficult procedure, and does not appear to be a realistic approach for ensuring consistent Medicaid utilization data in the future.

Chapter 4

Post-Acute and Ambulatory Care Providers

As the share of Medicare expenditures devoted to hospital inpatient services declines, the share devoted to post-acute and ambulatory care continues to rise. This shift in spending primarily reflects major changes in the volume and mix of services used. Revisions in Medicare's coverage policies explain some of the increased use of post-acute services, but Medicare payment policies also encourage the growth of both post-acute and ambulatory care. Medicare's prospective payment system (PPS) provides incentives for hospitals to reduce costs by shifting services from inpatient to other settings. At the same time, the way that Medicare pays for post-acute and ambulatory facilities offers few incentives for providers to reduce their costs and control the volume of services they furnish.

Medicare has instituted many changes to its post-acute and ambulatory payment policies to contain its cost per service. An effective volume control measure has remained elusive, however. The overlap of services delivered across settings and the lack of a uniform definition of service units contribute to the difficulty in addressing this problem. Both the Congress and the President propose implementing prospective payment systems for services provided by skilled nursing facilities (SNFs) and home health agencies, the most significant sources of post-acute expenditures.[1] The prospective payment amount would apply to all the services furnished by the facility for an episode of care.

This chapter presents background information to support the Prospective Payment Assessment Commission's (ProPAC's) recommendations for payments to post-acute and ambulatory care providers. The recommendations reflect the Commission's concerns about expenditure growth within and across treatment settings. The first section focuses on rehabilitation facilities and long-term care hospitals, skilled nursing facilities, and home health agencies. It documents spending growth, payment policies, and proposed changes for each type of provider, concluding with ProPAC's recommendations. The second section contains comparable information for dialysis facilities and hospital outpatient departments.

POST-ACUTE CARE PROVIDERS

Payments to post-acute care providers are the fastest growing component of Medicare expenditures. Rehabilitation facilities, long-term care hospitals, skilled nursing facilities, and home health agencies accounted for more than 22 percent of Medicare Part A spending (including both program and beneficiary contributions) in 1993, up from about 7 percent in 1986 (see Table 4-1).

Post-acute care expenditures have been driven by a rapid growth in service utilization. Rehabilitation facility admissions per 1,000 beneficiaries, for example, climbed 148 percent between 1986 and 1993 (see Table 4-2). The increase in beneficiaries receiving care in a skilled nursing facility was similar over this period. Use rates for long-term care hospitals and home health agencies experienced marked growth as well.

Higher utilization is partly attributable to practice pattern changes resulting from Medicare coverage policies: Medicare relaxed restrictions on the coverage of home health and SNF services in the late 1980s, expanding the number of beneficiaries eligible to receive post-acute care. But payment policies for both acute care hospitals and post-acute care providers also contributed to greater use.

Medicare's PPS rewards acute care hospitals for reducing costs per admission. The most direct way for hospitals to lower costs is to shorten stays. In 1984, the Medicare average length of stay in a PPS hospital was 8.8 days. It fell to 8.1 days in 1991

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Table 4-1. Distribution of Total Medicare and Beneficiary Payments for Selected Part A Services, 1986-1993

Year	Share of Part A Payments (In Percent)					Total Part A Payments (In Millions)
	PPS Hospital	Rehabilitation	Long-Term Care	Skilled Nursing	Home Health	
1986	91.2%	1.5%	0.2%	1.5%	3.7%	$ 53.3
1987	90.6	1.8	0.2	1.5	3.5	54.3
1988	89.3	2.0	0.3	2.2	3.6	59.0
1989	85.6	2.2	0.3	5.5	4.0	65.1
1990	84.1	2.6	0.3	4.8	5.4	72.4
1991	81.9	3.0	0.3	4.8	7.0	81.2
1992	78.1	3.4	0.3	6.3	8.7	91.3
1993	74.3	3.6	0.5	7.9	10.4	102.5

Note: The percentages do not add to 100 percent because shares for hospices, cancer hospitals, children's hospitals, and psychiatric facilities are not shown. All numbers include both program and beneficiary payments.

SOURCE: ProPAC analysis using Medicare Cost Reports and other data from the Health Care Financing Administration.

and by another 13.1 percent to 7.1 days by 1994. Often the shortened stays were accomplished by providing some services that once were part of the hospitalization in a post-acute setting. In fact, ProPAC analysis found that for the 12 diagnosis-related groups (DRGs) most likely to result in post-acute service use, acute hospital length of stay reductions were greater than the average for all DRGs. From 1991 to 1994, length of stay for these DRGs fell more than 16 percent and as much as 28 percent, significantly more than the overall drop.

In 1995, about 58 percent of PPS hospitals had a skilled nursing facility, SNF swing beds, or a rehabilitation unit. ProPAC analysis showed that for the 12 DRGs with high post-acute use, hospitals with post-acute units had shorter lengths of stay than those without units. The difference may be that post-acute services were more readily available in hospitals that had such units. In addition to being able to lower costs subject to the PPS rate, hospitals that own post-acute units gain other financial advantages. They can raise the occupancy of the facility overall, thus providing a larger patient base over which to spread fixed costs. Other resources, such as expensive equipment or certain specialized personnel, also can be used more efficiently over a larger patient base and thus can lower per unit costs.

Table 4-2. Medicare Utilization for Selected Part A Services, 1986-1993

Year	Admissions Per 1,000 Beneficiaries[a]			Persons Served Per 1,000 Beneficiaries[b]	
	PPS Hospital	Rehabilitation	Long-Term Care	Skilled Nursing	Home Health
1986	316.5	2.9	0.4	9.6	49.8
1987	304.4	3.3	0.4	9.1	47.9
1988	298.7	3.7	0.5	11.7	48.1
1989	288.0	4.0	0.5	19.0	50.3
1990	285.6	5.0	0.5	18.7	56.8
1991	284.7	5.9	0.5	19.3	63.9
1992	285.5	6.6	0.6	22.1	71.0
1993	285.3	7.2	0.7	24.0	80.1
Percent change 1986-1993	-9.9%	148.3%	75.0%	150.0%	60.8%

[a] Admissions per 1,000 beneficiaries counts all admissions, not the number of beneficiaries who were hospitalized at any time during the year.

[b] Persons served per 1,000 beneficiaries counts the number of beneficiaries who were provided the service in a given year, not the number of admissions.

SOURCE: ProPAC analysis of Medicare Cost Reports and data from the Health Care Financing Administration.

Medicare's payment policies for post-acute providers also have contributed to the expansion of post-acute service use and expenditures. Rehabilitation facilities and long-term care hospitals receive cost-based payments at least for their first two years of operation, after which payments are limited by a facility-specific cap. This payment method encourages the development of new facilities and rewards those that have high costs. Skilled nursing facilities also are paid their incurred costs up to a limit for routine services, such as room, board, and nursing care. However, because of varying definitions of the costs subject to these limits and open-ended cost reimbursement for ancillary services, payments per beneficiary have increased substantially. Further, despite per visit home health payment limits, the number and scope of services provided are not restrained and as a result have grown.

Medicare's post-acute facility payment methods have been modified over the years to control expenditures. Several characteristics of post-acute providers, however, make it difficult to slow spending. One is the overlap of services delivered across sites. All of these facilities provide therapy—speech, physical, and occupational—as well as more medically related nursing services. At least a portion of the patient population in any of these settings could be treated in another site. Yet because the payment methods and rates vary across providers, the Medicare program pays different amounts for the same or similar services, depending on where they are delivered.

Service payment units are not measured consistently across settings, which also contributes to the difficulty in controlling costs. Rehabilitation hospitals, for example, receive a per stay payment. By contrast, skilled nursing facilities are subject to per diem cost limits for routine services, and ancillary services are paid separately. As a result of the various payment definitions and methods, the total costs for an episode of care cannot be compared across sites. Thus, it is difficult to ensure that Medicare's policies encourage the most cost-effective methods of care. Even the payment modifications proposed by the Congress and the President would not facilitate comparisons of service volume, patient mix, or case severity across post-acute providers.

An additional complication is the changing nature of service delivery and organization. Increasingly, many of these providers are offering a level of care labeled "subacute." Less intensive than the care traditionally offered in a hospital, subacute care may describe the set of services formerly provided at the end of a hospital stay. Some beneficiaries who bypassed an acute care hospital to receive rehabilitation services or to be admitted to a long-term care hospital may be receiving subacute care. Because Medicare's payment methods vary across provider type, they do not consistently reflect the type or level of care a patient receives. Consequently, Medicare payments frequently do not reflect new patterns of service delivery.

Rehabilitation Facilities and Long-Term Care Hospitals

Rehabilitation facilities and long-term care hospitals are paid in accordance with the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Under TEFRA, payments for inpatient operating costs are based on each facility's current Medicare-allowable costs or a facility-specific limit. The limit (or target amount) equals the facility's allowable costs per discharge in a base year, trended to the current year by an annual update factor. Capital payments are based on reasonable costs. (See Chapter 3 for a complete description of the TEFRA payment method.)

When TEFRA was enacted in 1982, it applied to all hospitals. The Congress intended it to be a temporary measure to slow hospital expenditure growth until a fully prospective payment system could be implemented. When PPS began on October 1, 1983, however, certain types of hospitals and distinct-part units were excluded because DRGs and payments based on national average costs were not appropriate for them. The Congress expected that a separate prospective payment system for these facilities would be implemented within a few years.

PPS-excluded facilities have continued under the TEFRA payment system for longer than expected, however. This is because adequate patient classification systems, which are needed for a prospective payment system, have not been developed. Consequently, several flaws inherent in TEFRA that would have had little significance in the short run have led to growth in aggregate Medicare utilization and expenditures over time, as well as substantial inequities across providers.

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Of primary concern is the use of facility-specific costs to set base payment limits. Because the expense of opening a new facility is higher today than in the past, facilities with more recent base years automatically have higher limits and receive higher payments. The incentive to open a facility is strengthened by the fact that newly certified PPS-excluded hospitals or units are exempt from the TEFRA limits for their first two 12-month cost reporting periods. During this time, Medicare pays on the basis of reasonable costs; the second cost reporting period is designated as the base year.[2] Consequently, new providers have no incentive to avoid high start-up costs because these result in higher base year costs and higher future cost limits.

Moreover, acute care hospitals that treat a large number of long-stay cases or patients who require rehabilitative care have a strong incentive to establish rehabilitation distinct-part units or separate long-term care hospitals within hospitals. By doing this, an acute care hospital can lower its costs subject to PPS and reallocate some expenses to its specialty hospital or to a unit that receives cost-based reimbursement. To the extent that the TEFRA payment for long-stay or rehabilitation cases is greater than the regular DRG payment plus any outlier payment under PPS, the financial benefit could be substantial.

Growth in Facilities, Utilization, and Expenditures—The number of Medicare-certified rehabilitation and long-term care facilities has grown rapidly over the last decade (see Table 4-3). Between 1986 and 1994, rehabilitation hospitals and distinct-part units grew by 160 percent and 75 percent, respectively. After dipping in the late 1980s, the number of long-term care hospitals increased from 90 in 1990 to 146 in 1994. Similarly, Medicare discharges from rehabilitation hospitals and units combined rose by 39 percent from 1990 to 1993, and long-term care hospital discharges grew by 48 percent over the same period (see Table 4-4).

The proliferation of providers and the growth in discharges have led to a marked increase in aggregate Medicare spending for rehabilitation and long-term care facility services (see Table 4-5). Total payments to rehabilitation hospitals and units combined rose from $1.9 billion in 1990 to $3.7 billion in 1993—a 95 percent increase. Although Medicare payments to long-term care hospitals are comparatively small, they grew by 150 percent over the same period.

The TEFRA payment system was designed to moderate the growth in Medicare hospital payments by giving facilities an incentive to constrain cost increases. Recent ProPAC analyses indicate that lengths of stay in rehabilitation and long-term care facilities have declined and annual per case cost increases have slowed for certain groups of facilities. Yet aggregate Medicare inpatient operating payments per discharge for these providers have risen, on average, faster than the market basket. In fact, aggregate operating payments to long-term care hospitals grew by about 15 percent per year from 1990 to 1993. This is primarily due to the large number of new providers that entered the TEFRA payment system with higher costs, resulting in higher aggregate payments.

Proposed Payment Changes—The Congress's and the President's proposals contain provisions to curb TEFRA payment increases through lower updates to the target amount, capital payment reductions, limits on exceptions adjustments, and restrictions on additional payments for facilities

Table 4-3. Medicare-Certified Rehabilitation and Long-Term Care Facilities, Selected Years

Facility Type	1986	1988	1990	1992	1994	Percent Change 1986-1994
Rehabilitation	545	697	813	923	1,019	87%
Hospitals	75	106	135	164	195	160
Distinct-part units	470	591	678	759	824	75
Long-term care	94	82	90	102	146	55

SOURCE: Health Care Financing Administration, Office of Survey and Certification.

Table 4-4. Medicare Discharges from Rehabilitation and Long-Term Care Facilities, 1990-1993

Facility Type	1990	1991	1992	1993	Percent Change 1990-1993
Rehabilitation	169,491	198,423	223,948	235,212	39%
Hospitals	55,814	65,248	73,479	68,297	22
Distinct-part units	113,677	133,175	150,469	166,915	47
Long-term care	15,262	16,474	18,334	22,514	48

Note: Due to missing and inaccurate data, these figures do not represent total Medicare discharges.

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

with operating costs above their target amounts. (See Chapter 3 for more information regarding these proposals.) Neither proposal, however, addresses the need to control utilization, although the President proposes to place a moratorium on certifying new long-term care hospitals.

Skilled Nursing Facility Services

The Medicare Part A SNF benefit provides up to 100 days of post-acute care per spell of illness. To be eligible, Medicare beneficiaries must have completed a minimum three-day hospital stay within 30 days prior to the SNF admission and be in need of skilled nursing or rehabilitative services on a daily basis.

For payment purposes, Medicare separates SNF costs into routine, capital, and ancillary service categories. Medicare payments for routine costs, which include room, board, and skilled nursing services, are based on facility-specific costs, subject to an input price-adjusted national average per diem cost limit. Separate limits apply for hospital-based and freestanding facilities. These limits usually are updated each year, but were frozen for fiscal years 1994 and 1995. Capital costs and those for ancillary services, such as physical therapy, occupational therapy, speech therapy, laboratory tests, and radiology procedures, are reimbursed on a facility-specific cost basis.[3] Although most ancillary services are provided by SNFs and paid under Part A, there are situations when they are reimbursed under Part B.

Growth in Facilities, Utilization, and Expenditures—Between 1986 and 1994, the number of hospital-based SNFs increased by 163 percent, from 652 to 1,718 (see Table 4-6). The number of freestanding SNFs rose by 29 percent, while hospitals with SNF swing beds rose by 65 percent. During this period, many hospitals responded to declining average lengths of stay for Medicare beneficiaries and other patients by developing new lines of business, including hospital-based SNFs. Less restrictive state planning requirements for converting hospital acute-care beds to SNF beds contributed to their rapid growth.

Similar patterns are found in utilization and expenditures. In 1986, some 304,000 Medicare beneficiaries received care in skilled nursing facilities, and Medicare program payments totaled $600 million (see Table 4-7). By 1994, 925,000 beneficiaries received SNF care, and payments reached $8.3 billion. Numerous incremental legislative and administrative changes to SNF coverage and payment

Table 4-5. Medicare Rehabilitation and Long-Term Care Facility Payments, 1990-1993 (In Billions)

Facility Type	1990	1991	1992	1993*	Percent Change 1990-1993
Rehabilitation	$1.9	$2.4	$3.1	$3.7	95%
Long-term care	0.2	0.2	0.3	0.5	150

Note: Includes program payments and beneficiary payments. Does not include exceptions payments.

* Payments for facilities with cost reporting periods beginning on or after October 1, 1993, and before January 1, 1994, are estimated.

SOURCE: ProPAC analysis of Medicare Cost Reports and other data from the Health Care Financing Administration.

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Table 4-6. Types of Medicare-Certified Skilled Nursing Facilities, Selected Years

Facility Type	1986	1990	1994	Percent Change 1986-1994
Hospital-based	652	1,145	1,718	163%
Freestanding	8,414	8,120	10,818	29
Swing-bed hospitals	812	1,243	1,342	65

SOURCE: Health Care Financing Administration, Office of Survey and Certification.

policies have contributed to utilization and payment growth. The most significant ones were a lawsuit that resulted in broadening SNF coverage guidelines in April 1988, along with the passage of the Medicare Catastrophic Coverage Act (MCCA) of 1988, and its repeal in 1990.[4] The impact of these changes can be seen in the increase in Medicare-covered days and program payments in 1989, followed by a decrease in 1990. Although covered days have grown at an average annual rate of 10 percent since 1990, Part A program payments for SNF services have gone up even faster, at an average annual rate of 35 percent.

Some of the recent rise in Medicare program payments may be attributable to higher prices for inputs. Inflation alone, however, cannot account for the disparity between growth in use and payments. One source of the higher rise in payments has been the greater use of therapy and other ancillary services provided to Medicare patients. In 1988, charges for physical, occupational, speech, and respiratory therapy services were about 15 percent of total Medicare SNF charges. By 1994, therapy services represented more than 30 percent of charges. Even though final payments for these and other ancillary services are based on costs rather than charges, these estimates suggest a large increase in their contribution to the overall growth of Medicare payments for SNF services.

Because of cost-based payment, greater ancillary use results in higher Medicare payments. Further, SNFs may cite high ancillary service use to justify an exemption from routine service cost limits, thereby increasing routine service payments.

Proposed Payment Changes—Many factors have contributed to the dramatic rise in Medicare expenditures for SNF services. The Congress and the President agree that the most appropriate long-term method for controlling SNF spending is to establish a comprehensive prospective payment system. Both have proposed legislation to do this. They differ, however, in their timing for implementing the comprehensive system and their methods for constraining Medicare payments under interim measures.

The Congressional Proposal—The Congress proposes significant changes to Medicare's payment for skilled nursing facility services. It would

Table 4-7. Medicare Skilled Nursing Facility Payments and Utilization, 1983-1994

Year of Service	Skilled Nursing Facility		People Served		Days	
	Payments (In Billions)	Percent Change	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per Person Served
1983	$0.5	—	265	9	9,314	35.1
1984	0.6	6.9%	299	10	9,640	32.2
1985	0.6	2.9	314	10	8,927	28.4
1986	0.6	0.2	304	10	8,160	26.8
1987	0.6	8.8	293	9	7,445	25.4
1988	0.9	47.1	384	12	10,667	27.8
1989	3.5	275.7	636	19	29,780	46.8
1990	2.5	-29.0	638	19	25,200	39.5
1991	2.9	18.4	671	20	23,700	35.3
1992	4.5	55.3	785	22	28,960	36.9
1993	6.5	42.8	870	24	34,437	39.6
1994*	8.3	28.5	925	25	36,865	39.9

Note: Payments represent program liabilities incurred during the year and do not include beneficiary copayments.

* Estimated.

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

require the Secretary of Health and Human Services to establish a prospective payment system for SNF services to be implemented on October 1, 1997. Under this system, a SNF would receive a fixed payment for each episode of care; the payment would cover all routine, nonroutine, and capital costs. Payment rates could vary by case mix, patient acuity, or any other appropriate factors. Aggregate payments, however, could not exceed 90 percent of what would have been paid under the current system. In addition, the prospective payment rates would be reduced to take into account beneficiary coinsurance.

An interim payment system for services provided on or after October 1, 1995, would be established until a prospective payment system was implemented. Since much of the recent growth in SNF spending is due to increased ancillary service use, payment for these services would be limited. Routine services would be subject to the per diem limits, and nonroutine services would be subject to facility-specific aggregate per stay cost limits. Nonroutine services would include all therapies, prescription drugs, complex medical equipment, intravenous therapy and solutions, radiation therapy, and diagnostic services. All other services, including some now considered ancillary, would be regarded as routine.

For fiscal year 1996 and beyond, the Secretary would recalculate the per diem routine cost limits, taking into account the expanded definition of routine services. To maintain the savings associated with the fiscal year 1994 and 1995 freeze on routine cost limits, any changes in the costs of services that occurred during these years would not be included in the new limits.

Payments for nonroutine services would be based on facility-specific costs, subject to facility-specific aggregate per stay cost limits.[5] This would provide an incentive for SNFs to restrict ancillary service use while allowing for variation across facilities in costs related to patient mix and input prices. For fiscal years 1996 through 2002, Medicare payments for SNF capital costs would be reduced by 10 percent.

The congressional proposal would also require the Secretary to establish a separate per stay amount for patients who need intensive nursing or therapy services and to implement an annual exceptions payment application period. In addition, Part B billing would be restricted, and SNFs would have to submit all claims for beneficiaries in their care. SNFs would be required to document on their Medicare Cost Report all nonroutine services provided to Medicare SNF patients, beginning in fiscal year 1996. This would include the number and type of therapy services, laboratory tests, and radiology and diagnostic procedures.

The Administration's Proposal—The Administration's proposal would also significantly alter Medicare payment for skilled nursing facility services. A prospective payment system for SNFs would be implemented beginning in fiscal year 1999. It would be based on fixed payments for all routine, ancillary, and capital costs. Budget-neutral rates would be calculated so that aggregate fiscal year 1999 payments would not exceed 93 percent of aggregate fiscal year 1998 payments.

Beginning in fiscal year 1997 and until the establishment of the comprehensive prospective payment system, SNFs would be reimbursed under an interim system. Payments for routine services would be based on facility-specific prospective per diem payment rates. They would be calculated using Medicare Cost Report data, adjusted to maintain the savings associated with the freeze on routine cost limits during fiscal years 1994 and 1995. These rates would be subject to regional limits, adjusted to reflect differences in input prices. Although these limits would be applied to all SNFs, they would be calculated using data for freestanding facilities only, rather than including hospital-based SNFs, which tend to have higher costs. The per diem rates could be adjusted to reflect changes in the mix of patients treated by a SNF. However, these adjustments would be made prospectively and in a budget-neutral manner.

Ancillary services would continue to be reimbursed on a facility-specific cost basis, but only up to the amount that would have been paid under the fee schedule rates used by Medicare to pay other facilities for similar services. Salaries for therapists who provide contracted services would be limited as well. Capital costs would continue to be reimbursed on a facility-specific cost basis.

Beginning in fiscal year 1997, SNFs could no longer receive exceptions payments for costs in

excess of their limits. In addition, new facilities would no longer be granted an exemption from routine cost limits for their first few years of operation. Prospective per diem payment rates for routine services in new facilities would be based on the mean payment for SNFs in the same geographic area. SNFs would also have to submit all claims for Part B services for their patients and use consistent coding.

Home Health Services

Beneficiaries qualify for home health services if they are homebound and under the care of a physician who prescribes part-time or intermittent skilled nursing services, physical therapy, or speech therapy. Once authorized, beneficiaries may receive an unlimited number of these qualifying services, as well as home health aide visits, medical social services, or occupational therapy. Coverage is not tied to a prior hospitalization, and no copayment is required.

Under Medicare's payment method for home health services, agencies are paid the lower of their aggregate costs or limits. The limits are equal to 112 percent of the average cost per visit for each of six types of visits, computed separately for rural and urban areas. The labor portion of each limit is adjusted by the hospital wage index. These cost limits are frozen for cost reporting periods beginning between July 1, 1994, and June 30, 1996. Because this payment method is largely cost-based, agencies have little incentive to control the cost or volume of services delivered.

Growth in Facilities, Utilization, and Expenditures—The increased availability of home health providers has contributed to the growth in use and Medicare expenditures for these services. The number of licensed agencies climbed by 50 percent between 1990 and 1995 (see Table 4-8). Freestanding proprietary agencies, which accounted for about half of all agencies in 1995, rose 65 percent. Hospital-based agencies also grew substantially, from 1,543 in 1990 to 2,346 in 1995.

Home health visits have increased dramatically in the last decade, from about 37 million in 1983 to 209 million in 1994 (see Table 4-9). The number of beneficiaries using home health climbed from 45 per 1,000 Medicare enrollees to 87 per 1,000 enrollees during this period. Use levels also surged from an average of 28 to 65 visits per person. Much of this increase is due to changes in coverage guidelines. These revisions allowed beneficiaries who needed part-time care (fewer than eight hours a day) or intermittent care (four or fewer days per week) to qualify for services. This expanded both the number of people receiving the benefit and the number of services used.

Home health episodes of care have also become longer. A home health episode is defined as a series of visits, preceded and followed by a period without visits. Using a gap of 60 days to define new episodes, the proportion of short episodes (those lasting 30 or fewer days) fell from 39 percent in 1990 to 32 percent in 1993 (see Table 4-10). Episodes lasting 121 days or longer went from 19 percent to 25 percent of all episodes. Longer episodes tended to include a higher proportion of the less costly home health aide visits. For example, 50 percent of the visits in very long episodes (those lasting at least 166 days) were aide visits, whereas aide services accounted for only 21 percent of the visits in short episodes (see Table 4-11). Further, compared with shorter episodes, longer ones were characterized by a higher proportion of aide visits throughout the episode.

Medicare's spending for home health services has grown at least 20 percent a year since the late 1980s. The rate of growth has declined, however, since the 53 percent spike in 1990. Still, home health's share of Medicare program expenditures has continued rising.

Proposed Payment Changes—The Congress and the Administration both have proposed establishing prospective payment systems for home health services. The congressional proposal would set prospective rates for each type of home health visit but limit total payments per episode, as of fiscal year 1997. By contrast, the Administration's proposal would establish episode-based payments effective in fiscal year 2000. Measures to limit spending in the intervening years also would be introduced.

In addition, both proposals would retain the savings from the two-year freeze on the cost limits and would make other interim modifications to the current payment system to reduce Medicare spending.

Table 4-8. Types of Medicare-Certified Home Health Agencies, 1990-1995

Agency Type	1990	1991	1992	1993	1994	1995	Percent Change 1990-1995
Visiting Nurse Association	476	515	595	596	575	570	20%
Government	981	1,089	1,240	1,205	1,208	1,191	21
Hospital-based	1,543	1,601	1,786	1,998	2,207	2,346	52
Rehabilitation facility-based	10	4	1	1	3	3	-70
Skilled nursing facility-based	105	90	106	117	127	145	38
Freestanding proprietary*	2,678	2,650	2,691	3,234	3,937	4,407	65
Total	5,793	5,949	6,419	7,151	8,057	8,662	50

* Includes a small number of freestanding, private, not-for-profit agencies that are not Visiting Nurse Associations (26 percent).

SOURCE: Health Care Financing Administration, Office of Survey and Certification.

The Congressional Proposal—The Congress proposes replacing cost-based payments with prospective rates for each of the six types of home health visits beginning in fiscal year 1997. These rates would be based on national average costs in cost reporting periods ending on or before June 30, 1994. They would be updated for each succeeding year by the home health market basket increase minus 2.0 percentage points. Rates would be recalculated using the most recent data every five years beginning in October 1999.

Total payments for the first 165 days of care would be limited to the lower of actual per visit payments or aggregated, episode-based limits. To determine the episode limits, visits would be aggregated into patient-level episodes of care. Each episode would be classified into one of 18 case-mix categories. For each case-mix category, regional limits would be calculated based on the average cost of up to 120 days of care. Each agency's limit would equal the number of episodes it provided in each case-mix category times the regional case-mix limit.

Agencies with aggregate payments below their limit would receive an incentive payment equal to 50 percent of this difference up to 5 percent of their aggregate payments. Basing the payment limit on 120 days of care and sharing part of the payment difference would give agencies an incentive to reduce the number of services provided during an episode.

The episode limit would be applied to the first 165 days in an episode. The prospective payments for the subsequent visits in an episode would not be included in the episode-based payment limit. The

Table 4-9. Medicare Home Health Care Payments and Utilization, 1983-1994

Year of Service	Medicare		People Served		Visits		
	Payments (In Billions)	Percent Change	Number (In Thousands)	Per 1,000 Enrollees	Number (In Thousands)	Per 1,000 Enrollees	Per Person Served
1983	$ 1.6	—	1,318	45	36,898	1,234	28
1984	1.9	17.5%	1,498	50	40,422	1,330	27
1985	1.9	4.0	1,549	50	39,449	1,274	25
1986	1.9	-0.5	1,571	50	38,000	1,204	24
1987	1.9	-1.2	1,544	48	35,591	1,104	23
1988	2.1	8.6	1,582	48	37,132	1,130	23
1989	2.6	23.8	1,685	50	46,199	1,379	27
1990	3.9	53.2	1,940	57	69,565	2,038	36
1991	5.7	44.2	2,223	64	100,044	2,875	45
1992	7.9	39.5	2,523	71	134,844	3,796	53
1993	10.7	34.6	2,900	80	173,953	4,804	60
1994*	13.0	22.1	3,220	87	209,149	5,765	65

Note: Payments represent program liabilities incurred during the year and do not include beneficiary copayments.

* Estimated.

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

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Table 4-10. Distribution of Home Health Episode Lengths, 1990 and 1993

Episode Length	Percent of All Episodes 1990	Percent of All Episodes 1993	Percent Change
All episodes	100%	100%	
Short	39	32	-7%
Medium	43	44	1
Long	19	25	6
121-165 days	5	—	—
166+ days	14	—	—

Note: Short episodes lasted 30 days or fewer; medium episodes exceeded 30 days but lasted fewer than 121 days; long episodes exceeded 120 days.

SOURCE: ProPAC analysis of 1990 and 1993 home health claims from the Health Care Financing Administration.

patient would, however, have to be certified as requiring continuing care. New episodes would begin after a period of 60 days without services.

The congressional proposal would also limit aggregate exceptions and exemptions payments to the amounts paid in fiscal year 1994, increased by the market basket percentage change for each year.

The Administration's Proposal—The Administration's proposal also would establish an episode-based prospective payment system for home health services, but not until fiscal year 2000. The Secretary would develop both a prospective payment rate for an episode of care and a reliable case-mix adjuster in the interim. The episode payment amounts would be updated by the market basket. If a beneficiary received services from multiple agencies, each agency's payment would be prorated. Payment rates would incorporate a 15 percent reduction in cost limits that would be in effect on September 30, 1999.

The Administration's proposal also contains some interim changes to the payment system for fiscal years 1997 through 1999. Agency payments would be the lower of aggregate cost limits, agency-specific per beneficiary amounts, or actual costs. Cost limits would be reduced from 112 percent of the mean to 105 percent of the median. The per beneficiary amount would be determined by blending 1994 agency-specific costs with the national average cost. Alternatively, the Secretary could substitute a utilization measure in this formula. Agencies could receive bonus payments up to 5 percent of their aggregate payments if their costs or utilization were below 125 percent of the 1994 national average or regional aggregate experience.

Other changes would base payments on the service delivery area instead of the agency's geographic

Table 4-11. Number and Type of Home Health Visits, by Episode Length

Episode Length	Total Number of Visits	When Visits Occur in Episode	Mean Visits Per Episode	Share of Visits in Episode: Skilled Nursing	Aide	Physical Therapy	Other
Short	6,930,600	100%	9	60%	21%	15%	4%
Medium	35,158,905	100	33	49	31	16	3
First 30 days		72		50	29	16	6
Days 31-120		28		45	36	15	4
Long	10,139,625	100	74	47	38	11	4
First 30 days		37		49	33	12	6
Days 31-120		56		45	40	11	4
Days 121-165		7		46	42	9	3
Very Long	83,114,840	100	163	42	50	6	2
First 30 days		18		49	38	9	4
Days 31-120		29		43	47	7	3
Days 121-165		14		41	57	5	3
Days 166 or more		39		38	57	4	1

Note: Short episodes lasted 30 days or fewer; medium episodes exceeded 30 days but lasted fewer than 121 days; long episodes exceeded 120 days. These data are for episodes beginning between July 1, 1993, and June 30, 1994.

SOURCE: ProPAC analysis of 1990 and 1993 home health claims from the Health Care Financing Administration.

location. Interim payments, which currently are provided to home health agencies, would be eliminated. The proposal also would require that, beginning in fiscal year 1997, only the services provided during the first 100 days following a hospitalization would be paid under Part A. Visits after that period or any that were not associated with a hospital stay would be paid under Part B.

Conclusions and Recommendations

Both the Congress's and the President's proposals attempt to restrict the growth in Medicare's post-acute care spending. The average payment updates under the TEFRA payment system would be lower than those under current law. Skilled nursing and home health payments would be changed from cost-based reimbursement to prospective payment systems. Each proposal contains interim measures to restrict payments. However, neither one fully addresses the rising use of post-acute services. Following are the Commission's recommendations on the general approach to improve payments to post-acute providers and to help control the growth in Medicare spending.

Recommendation 20: Prospective Payment for Post-Acute Care

Prospective payment systems should be implemented for all post-acute services. The payment method for each service should be consistent across delivery sites. The Secretary should explore methods to control the volume of post-acute service use, such as bundling services for a single payment.

The post-acute care industry is characterized by substantial growth in the numbers of providers, people receiving services, and the services used by each recipient. These factors have contributed to the double-digit increase in Medicare's expenditures and the ever-larger share of Medicare payments for post-acute services. Some of this growth is due to site substitution between hospitals and post-acute providers. A large part of it, however, is due to the absolute increase in post-acute services provided to beneficiaries.

Prospective payment systems for post-acute services are needed to ensure that only necessary services are provided and to improve Medicare's ability to track and compare service use. Further, broadening the payment unit to include all the services furnished during an episode of care would encourage providers to be more efficient. These payment changes, however, should be accompanied by mechanisms to make certain that facilities have the capacity to provide quality services appropriate to the patient's needs.

The Health Care Financing Administration (HCFA) has sponsored demonstration projects to develop prospective payment systems for skilled nursing facilities and home health agencies that have been in progress for several years. In addition, it is supporting research to develop prospective payment for rehabilitation services. Despite the overlap in the types of services delivered by each of these providers, the research projects have been managed, tested, and evaluated independently of each other. The Secretary should coordinate these efforts to develop consistent service units and prospective payment systems.

Recommendation 21: Case-Mix Measures for Post-Acute Services

Reliable case-mix measurement is important in prospective payment systems to account for resource use and to analyze treatment patterns and costs across sites. The Secretary should coordinate case-mix research across post-acute care settings, using consistent methods for measuring patient acuity and resource use.

Reliable case-mix measurement systems strengthen prospective payment by accounting for patient characteristics that affect resource use. Further, they allow for comparisons of service use and expenditures across beneficiaries and treatment settings. HCFA is sponsoring research to measure the intensity of services provided in rehabilitation, skilled nursing, and home health settings. It is essential that these studies be coordinated. Many of the same services, particularly nursing and therapies, are delivered by each of these providers, yet the units for measuring resource use differ in each demonstration. Thus, accurate comparisons of treatments or costs are not possible. HCFA should coordinate its efforts to produce a reliable system that consistently

classifies patients served and the number and types of services provided across delivery sites.

Recommendation 22: Interim Fee-for-Service Payment Method for Skilled Nursing Facility Services

An interim payment method should be implemented to control the growth in Medicare payments for SNF services until a comprehensive prospective payment system is established. A system based on historical data and facility-specific limits, however, may not allow facilities to respond appropriately to changes in a dynamic environment.

The Congress's and the President's proposals differ in their approaches to limiting Medicare payments for SNF services until a prospective payment system is implemented. They are similar, however, in that each would impose facility-specific and national limits. Both proposals would use Medicare Cost Report data, updated by the SNF market basket, to calculate limits or rates. Therefore, payments would reflect historical costs, patient mix, and treatment patterns. To account for the lack of a case-mix measurement system, the congressional plan would require the Secretary to develop a separate method for reimbursing SNFs for patients with intensive nursing or therapy needs. Likewise, the President's proposal would allow the Secretary to adjust the per diem rates to reflect changes in patient severity.

The Commission believes that interim payment limits should be designed to provide appropriate constraints on Medicare outlays without unduly restricting this evolving industry. Facility-specific limits would allow SNFs that had high costs during the base year to maintain higher payments year after year, while those that experienced low costs during the base year would be restricted to these lower levels. On the other hand, payment limits based on average costs would not reflect legitimate cost differences across facilities. Further, historical data would not account for the higher costs associated with the changing acuity of SNF patients. Alternative methods for calculating payment limits, such as using a larger geographic area or blending facility-specific and national rates, should be explored.

Recommendation 23: Interim Fee-for-Service Payment Method for Home Health Care

Until a fully prospective payment system is developed, the Commission supports adopting episode-based payment limits. In addition, beneficiary copayments, subject to an annual limit, should be introduced.

The Commission recognizes that a prospective payment system for home health care will take time to implement. In the interim, other mechanisms should be established to constrain the growth in service use. Instituting episode-based payment limits, as proposed by the Congress and the Administration, would encourage providers to deliver services more efficiently. In addition, adopting copayments would increase beneficiaries' involvement in home health treatment decisions, consistent with their financial responsibility for other Medicare-covered services. Beneficiary out-of-pocket costs should be limited, however, so that the copayments do not restrict access inappropriately. Further, Medicare needs to explore other means, such as case management and utilization review, to control use.

In developing prospective payment rates, characteristics of the current home health delivery system should be considered. Units of service are not uniformly defined across agencies. Consistent definitions would allow the Secretary to better monitor and evaluate Medicare's expenditures and quality of care. In addition, both the Congress and the President propose blending national and regional costs to establish payment limits. While the Commission believes these proposals would improve the current cost-based system, it is concerned that maintaining regional variation in the limits would perpetuate unjustified differences in utilization and expenditures. ProPAC supports a transition from regional to national rates, as was used in establishing hospital prospective payment rates, to eliminate this type of unexplained variation.

AMBULATORY CARE PROVIDERS

Medicare spending for ambulatory care, whether furnished in outpatient facilities or in physicians' offices, increased from 30 percent of total program expenditures in 1983 to 32 percent in 1994. Part B payments to outpatient facilities alone reached

$14.1 billion in 1994.[6] Outpatient care is provided in hospital outpatient departments, freestanding ambulatory surgical centers, independent clinical laboratories, comprehensive outpatient rehabilitation facilities, and hospital-based and freestanding dialysis centers. However, 85 percent of Medicare outpatient spending goes to hospital outpatient departments and dialysis centers. This section focuses on services provided by these facilities.

Outpatient Dialysis Services

The 1972 amendments to the Social Security Act extended all Medicare Part A and Part B benefits to people with end-stage renal disease (ESRD). Virtually all patients of any age who are diagnosed with ESRD are eligible. ESRD is marked by the irreversible loss of kidney (renal) function. It is treated either with organ transplantation or permanent renal dialysis. The vast majority of ESRD enrollees are treated with either hemodialysis or peritoneal dialysis on an outpatient basis.[7] Consequently, there is a strong incentive for these beneficiaries to purchase Part B coverage.

Benefits for a kidney transplant patient generally start the month in which the transplant is performed, whereas dialysis benefits generally begin three months after eligibility is established. For an ESRD enrollee who also is covered by an employer-sponsored group health plan, all medical claims during the first 18 months of Medicare eligibility are paid first by the employer's plan. If the employer's plan does not pay in full, Medicare will make secondary payments up to its specified limits or the billed amount, whichever is lower. This is known as the Medicare secondary payer provision.

Most dialysis patients receive hemodialysis in either hospital-based or freestanding dialysis centers. Others dialyze at home under the supervision of a local facility. When coverage for ESRD patients began, Medicare paid hospital-based and freestanding dialysis providers their reasonable costs and reasonable charges, respectively, limited to $138 per treatment. Beginning in 1983, the payment methodology was changed to a prospective rate per dialysis treatment.

The prospective payment, called the composite rate, covers the bundle of services, tests, drugs, and supplies routinely required for a dialysis treatment (hemodialysis or peritoneal dialysis) whether it is provided in a facility or performed by the beneficiary at home. It represents the national median cost per treatment, weighted by the percentage of patients dialyzing in each site.

The composite rate was calculated in 1983 based on a sample of Medicare Cost Reports from 1977 through 1979. Therefore, it reflects the mix and costs of inputs and the proportion of patients dialyzing in different sites at that time. The labor portion of the base rate is adjusted for geographic differences in wages; however, payments may not exceed $139 per treatment.[8] Hospital-based facilities receive a slightly higher composite rate than freestanding facilities.

Unlike Medicare payments to other types of providers, the composite rate has not been updated annually. Aside from a $2 decrease implemented in 1986 and a $1 increase in 1991, the composite rates have not changed. When accounting for inflation, therefore, the real payment per treatment has declined substantially. The Omnibus Budget Reconciliation Act (OBRA) of 1990 requires ProPAC to examine the payment for dialysis services and recommend an update factor each year.

Even though the composite rate has changed very little since it was implemented, total Medicare payments to dialysis facilities have increased rapidly. This is largely due to a 10 percent annual growth in the number of beneficiaries receiving dialysis. Rising use of certain extra billable dialysis-related items, among them nonroutine drugs and some diagnostic and laboratory tests, has contributed as well.

Moreover, aggregate Medicare expenditures for all beneficiaries with ESRD (including transplant recipients) have escalated, from 3.8 percent of total program payments in 1985 to 5.0 percent in 1994. This includes spending for acute and post-acute care for other conditions in addition to dialysis-related services. Consequently, aggregate payments per ESRD enrollee rose from $28,158 to $39,431 during this period, while the size of this group grew rapidly (from 0.3 percent of the Medicare population to more than 0.6 percent). In 1994, Medicare payments per person with ESRD were almost nine times greater than for other beneficiaries. This reflects the high annual cost of dialysis as well as the high overall morbidity of these patients.

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Proposed Payment Changes—Neither the Congress's nor the President's proposal includes an update to the composite rate. Both would, however, extend the Medicare secondary payer provision. Under current law, the 18-month period will revert to 12 months on October 1, 1998. The President proposes to set it at 18 months indefinitely. The Congress would permanently extend it to 30 months.

While these proposals would not affect the composite rate payment methodology, they would achieve savings for the Medicare program. The exact amount of savings is uncertain, but it could be substantial. When the Medicare secondary payer provision was extended from 12 to 18 months (under OBRA 1990), the General Accounting Office (GAO) estimated that Medicare would shift $87 million to employer plans each year.[9] In addition, GAO estimated that dialysis providers would receive $41 million more annually. This is because most private health plans pay on the basis of charges, which generally are substantially higher than Medicare's composite rate.

Update Framework—Dialysis providers have continued to treat a growing Medicare ESRD population, even though the inflation-adjusted payment rate has declined substantially. Moreover, freestanding facilities have prospered, largely because of dramatic gains in productivity that lowered service costs. Between 1983 and 1987, facilities achieved substantial productivity improvements through changes in staffing patterns, the use of high flux and high efficiency dialysis (which led to shorter dialysis sessions), dialyzer reuse, and price discounts from suppliers.[10] Scientific and technological advances, on the other hand, raised per treatment costs by 0.8 percent annually, on average.

Between 1987 and 1991, however, productivity gains had a much smaller effect on the cost per hemodialysis treatment (although still greater than that for scientific and technological advances). During this period, treatment sessions became more intensive, requiring more sophisticated techniques and equipment and a richer mix of staff to monitor patient outcomes. Scientific and technological advances continued to increase per treatment costs, but only by about 0.2 percent annually.

More recent data show that dialysis facilities' costs are rising, though more slowly than inflation in the goods and services they purchase. Medicare costs for both hemodialysis and peritoneal dialysis in hospital-based facilities increased, on average, by 1.4 percent per year from 1991 to 1994. By contrast, ProPAC's market basket index for hospital-based facilities averaged 3.3 percent annual growth over the same time.[11] Medicare costs in freestanding facilities rose by 2.2 percent annually from 1991 to 1993, compared with a 3.7 percent average market basket increase.[12]

On average, Medicare costs in hospital-based facilities were about 45 percent higher in 1994 than those in freestanding facilities. Aggregate Medicare payments to hospital-based facilities covered only

Table 4-12. Payment to Cost Ratios for Hospital-Based and Freestanding Dialysis Facilities, All Dialysis Treatments, 1990-1994

	Hospital-Based Facilities					Freestanding Facilities				
Hospital Category	1990	1991	1992	1993	1994	1990	1991	1992	1993	1994
All	0.86	0.80	0.80	0.77	0.77	1.12	1.13	1.11	1.08	1.05
Rural	0.85	0.79	0.77	0.78	0.78	1.10	1.09	1.07	1.02	0.98
Urban	0.86	0.80	0.80	0.76	0.76	1.12	1.14	1.12	1.09	1.06
Nonprofit	0.85	0.80	0.80	0.77	0.77	1.08	1.06	1.03	1.04	1.05
Profit	1.00	0.85	0.85	0.68	0.68	1.13	1.15	1.13	1.09	1.05
Small	0.72	0.72	0.71	0.64	0.64	1.04	1.04	1.02	0.97	0.92
Medium	0.85	0.77	0.77	0.75	0.75	1.12	1.11	1.09	1.06	1.02
Large	0.91	0.85	0.85	0.80	0.80	1.15	1.18	1.16	1.13	1.10

Note: 1994 ratios are based on estimated payments and costs for freestanding facilities. Includes both hemodialysis and peritoneal dialysis treatments.

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

77 percent of reported costs (see Table 4-12). By contrast, Medicare payments were approximately 5 percent above freestanding facilities' reported Medicare costs.[13] For both types of providers, larger facilities (those that treated the highest volumes of patients) had lower costs per treatment and therefore better financial performance.

It appears that freestanding dialysis facilities in particular—which account for about 64 percent of all facilities and serve about 69 percent of all dialysis patients—performed well through 1994. As the costs of providing dialysis services have slowly risen, however, Medicare payment to cost ratios have gradually declined. Additionally, cost report data suggest that facilities recently have achieved only modest cost savings through productivity improvements (see Table 4-13). In 1994, hemodialysis treatments per station and total treatments per full-time equivalent employee were no longer increasing as they had in the past, while staffing mix was stable.

Some observers are concerned that continued attempts to achieve productivity gains—primarily through shorter dialysis sessions—may adversely affect the quality of care provided to Medicare ESRD beneficiaries. Adjusted survival rates have improved among dialysis patients in recent years, despite the fact that they are older and sicker than before.[14] Survival has increased for all age, race, ethnic, and diagnosis groups, as well as for all dialytic modalities. But rates still may not be as high as they should.

A measure of dialysis adequacy is Kt/V (the fraction of a patient's total body water cleared of urea during a dialysis session).[15] Recent studies have found that almost 50 percent of hemodialysis patients had a Kt/V of less than 1.0, placing them at higher risk for morbidity and mortality. One reason may be that many patients are not dialyzed long enough. Treatment times fell, on average, from 15 to 18 hours a week in the 1970s to 12 to 15 hours a week in the 1980s. During the early 1990s, average lengths of hemodialysis slipped even further, although recently they have begun to rise. Improved technology may account for shorter treatment times, but economic incentives to save on labor and capital costs as well as patient preferences also contribute to the phenomenon.

Mortality rates for dialysis patients generally are believed to be greater in the United States than in Europe or Japan. Studies have found that the higher mortality in this country cannot be explained by differences in patient age, gender, race, or the presence of diabetes. These studies, however, continue to be limited by inadequate measures of patient severity.

More definitive studies are needed, but recent evidence suggests that treatment factors heavily influence mortality rates. For example, prescribed

Table 4-13. Median Productivity Indicators for Hospital-Based and Freestanding Dialysis Facilities, 1990-1994

Facility Type	Total Treatment Per FTE	Staff Mix	Hemodialysis Treatments Per Station	Length of Dialysis (In Hours)	Dialyzer Reuse
Hospital-based					
1990	550	0.67	599	4.5	—
1991	561	0.64	618	4.5	—
1992	563	0.64	621	4.5	—
1993	587	0.63	645	4.5	—
1994	588	0.63	642	4.5	—
Freestanding					
1990	659	0.33	539	4.5	9.1
1991	625	0.35	555	4.5	10.0
1992	633	0.34	566	4.5	11.2
1993	617	0.35	563	4.5	12.0

Note: 1994 data are not available for freestanding facilities. FTE = full-time equivalent. Staff mix = ratio of registered nurses to all direct patient care staff, including registered and licensed practical nurses, nursing assistants, and technicians. Dialyzer reuse measures average number of times dialyzers are reused.

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

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Kt/V in Europe appears to be higher than in the United States, and dialyzer reuse—which may decrease urea clearance—is less common in other countries.[16] Nations also differ in the extent to which they use in-facility hemodialysis, which has been associated with a lower survival rate compared with peritoneal dialysis. Even within the United States, the relative use of these modalities varies among facility types. This reinforces the concern that treatment variation may be driving differences in mortality rates.

ProPAC's ongoing analysis of dialysis costs indicates that input prices can be expected to rise by about 3.2 percent between fiscal years 1996 and 1997. Scientific and technological advances are expected to increase per treatment costs by 0.7 percent over the same period.[17] Although this industry is not likely to repeat the marked productivity improvements experienced in the 1980s, the Commission believes that gains consistent with the hospital industry can be achieved.

Despite rising costs and declining financial performance, the number of dialysis providers continues to grow by about 6 percent per year. This may reflect the continued increase in the number of ESRD beneficiaries. However, freestanding facilities—particularly proprietary ones—have grown by about 9 percent annually, a rate much faster than that for hospital-based providers.

Many industry experts have raised concerns about whether this industry can continue to provide quality dialysis services without higher payments. There is no conclusive evidence that the quality of care has actually declined or that there are quality differences across facility types. Nonetheless, recent studies indicate that a substantial percentage of hemodialysis patients in the United States may be underdialyzed and that treatment is a major factor affecting patient outcomes. If facilities must extend treatment times to ensure that Medicare patients receive adequate dialysis, their costs are likely to increase further.

Hospital Outpatient Services

Medicare payments for many hospital outpatient services are based at least partially on the providers' reasonable costs of furnishing the service. For certain ambulatory surgeries, radiology services, and diagnostic procedures, the total payment is the lowest of the hospital's reasonable costs, charges, or a blended amount that combines the lesser of costs or charges with a prospective payment amount for the same service in another setting. Payment for some other services, such as clinic and emergency room visits, is the lesser of the hospital's costs or charges. Still others (laboratory tests, for example) are paid for using a fee schedule, without regard to the provider's actual costs.

The use of multiple payment methods not only creates conflicting incentives for hospitals, but imposes an administrative burden. Moreover, different payment methods and amounts are applied for the same service across sites of care. This may inappropriately influence the choice of treatment setting.

In addition, cost-based payment methods provide weak incentives to constrain the cost and volume of services furnished. As a result, Medicare outlays for hospital outpatient services have increased rapidly. In response, the Congress mandated in OBRA 1990 that the Secretary of Health and Human Services develop a prospective payment system for hospital outpatient services. The Secretary's report, released in 1995, recommended implementation of prospective payment in several phases.[18] In its response to that report, the Commission expressed concern about several issues.

First, if prospective payment were implemented on an incremental basis, hospitals and Medicare would bear the costs associated with adopting a new payment system while receiving few of the desired benefits. Partial implementation would do little to promote simplicity or predictability of payment, or to reduce the administrative burden on hospitals or the program. Such a policy also would create opportunities for providers to increase their revenues by altering billing practices or reallocating overhead costs to services that remain under cost-based payment. Second, even a comprehensive prospective payment system would retain fee-for-service payment, with little incentive for providers to control the burgeoning volume of services.

Given these concerns, the Commission recommended that the incremental hospital outpatient prospective payment system proposed by the Secretary not be enacted. ProPAC continued to support the concept of a comprehensive payment system

for hospital outpatient services, but recommended that the Congress require the Secretary to submit a fully detailed legislative proposal for implementing such a system. In addition, the Commission recommended coupling prospective payment with a strategy to control the growth in overall outpatient service volume. As most outpatient services can be provided in multiple settings, imposing volume controls only on hospital outpatient services probably would shift them to other sites.

Beneficiary Liability—Because Medicare payments for hospital outpatient services are based partially on costs, final payments are not known until providers' annual cost reports are settled. Consequently, under current law, the beneficiary copayment is set at 20 percent of charges rather than 20 percent of the total payment, as it is for other Part B services.

Basing copayments on hospital charges results in savings to the Medicare program. Since beneficiary liability is subtracted from the total payment to determine Medicare's contribution, rising copayments defray some program spending. At the same time, however, charge-based copayments impose an ever-greater financial burden on Medicare enrollees who use hospital outpatient services. Moreover, this burden is increasingly uneven across types of services and settings.

According to the most recent estimates, beneficiaries are responsible, on average, for 37 percent of the total payments to hospitals for Medicare-covered outpatient services. For certain surgeries, radiology, and diagnostic procedures, beneficiaries pay about 53 percent of the total. For other cost-based outpatient services, it is about 30 percent. These shares are considerably higher than if the same services were provided in other ambulatory settings.

These differences in cost sharing unfairly penalize beneficiaries who receive care in hospital outpatient facilities. In addition, they provide strong incentives for physicians, acting on behalf of patients, to choose a site of care on the basis of financial considerations rather than clinical appropriateness. These incentives are mitigated for many beneficiaries because they have supplemental insurance policies or are eligible for Medicaid benefits that cover most copayments. About 11 percent of Medicare beneficiaries, however, lack such coverage. Those who have private policies indirectly carry the growing burden of cost sharing through rising insurance premiums. Setting beneficiary copayments at 20 percent of payments instead of 20 percent of charges would increase program spending, but would eliminate this source of adverse incentives and growing inequity in the payment burden.

Formula-Driven Overpayment—Medicare's share of the payment for certain ambulatory surgeries, radiology services, and some diagnostic services is supposed to be the total amount minus the beneficiary copayment. For facilities paid the blended amount, however, program payments are not reduced by the entire copayment.[19] Thus, total payments to hospitals for outpatient services are higher than the Congress intended. In addition, this problem with the formula provides a strong incentive for hospitals to raise charges, which increases beneficiary liability and total payments to hospitals.

ProPAC previously recommended changing the formula so that the beneficiary copayment is subtracted after the total amount is calculated. This correction would result in savings for Medicare, which should be used to offset spending increases caused by reducing beneficiary copayments.

Proposed Payment Changes—The Congress's proposal would correct the formula-driven overpayment in a manner that is consistent with past ProPAC recommendations. However, it does not address prospective payment for hospital outpatient services or the issue of beneficiary liability. The President's proposal contains no provision regarding Medicare payment for hospital outpatient services.

Conclusions and Recommendations

The Commission's analyses of Medicare policies regarding ambulatory care providers have focused on dialysis facilities and hospital outpatient departments not only because of ProPAC's statutory obligations, but also because these facilities account for the vast majority of Medicare outpatient spending. In making recommendations, however, the Commission is mindful of how changes to Medicare's payment policies will affect other ambulatory care providers and expenditures for other services.

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Recommendation 24: Update to the Composite Rate for Dialysis Services

The Secretary should develop methods to control total Medicare per capita expenditures for ESRD beneficiaries. In the meantime, the composite rate should be updated by 2.7 percent for hospital-based dialysis facilities and by 2.0 percent for freestanding facilities for fiscal year 1997. The Secretary should also develop reliable measures of patient severity and outcomes to analyze the relationships among treatment processes, patient outcomes, and costs. These factors should be considered in evaluating the need for and the level of future payment updates.

The rapid growth in total Medicare spending for ESRD beneficiaries is a major concern. A large part of this increase is due to an expanding ESRD population. But these beneficiaries are also using more acute inpatient, skilled nursing, home health, and dialysis-related services than ever before. A comprehensive payment method that encompasses a broader set of services should be explored. Capitation has been successful in controlling expenditure growth for other populations. Most ESRD beneficiaries, though, are not eligible to enroll in the Medicare risk program. The Secretary should either open enrollment to this group or consider implementing a separate capitation program. At a minimum, utilization review or other managed care techniques should be used to control the total volume of services provided to ESRD beneficiaries across all sites of care.

Until major policy changes are made, Medicare should consider the adequacy of its current payment rates. Unlike program payments to other types of health care providers, the composite rate for outpatient dialysis services is not updated annually. That Medicare treats dialysis facilities differently is of some concern. This is heightened by the fact that neither the Congress's nor the President's proposal contains a provision to update the composite rates. Under these proposals, dialysis facilities would not receive payment increases for the next seven years.

Dialysis facilities have treated a growing Medicare ESRD population, even though the inflation-adjusted payment rate has declined substantially. The Medicare program is responsible for making certain that payments for services furnished to its beneficiaries are adequate to ensure quality care. Recent evidence suggests that input costs are rising and that large productivity gains may no longer be possible. Consequently, these facilities may be unable to continue to provide quality dialysis services without a payment rate increase. Given widespread concern about the quality of dialysis services, the composite rate should be updated as suggested by ProPAC's update framework. Differential updates would help to account for cost differences between hospital-based and freestanding facilities. Further, the Secretary should closely monitor treatment patterns and patient outcomes to ensure that facilities use the payment increase to improve quality of care.

Recommendation 25: Prospective Payment for Hospital Outpatient Services

A comprehensive prospective payment system should be developed for hospital outpatient services. Such a system should include a strategy for controlling the volume of ambulatory services.

A prospective payment system for all hospital outpatient services should be implemented as soon as possible. Prospective payment would create incentives for controlling costs by offering providers the opportunity for profits as well as the risk of financial loss. Because almost all services provided in the hospital outpatient setting can be obtained in other ambulatory settings, the Secretary should strive to create consistent payment policies across all sites and providers.

ProPAC analyses indicate that much of the rise in Medicare spending for outpatient services is due to rapid increases in utilization. To constrain future growth in outpatient service use, a strategy for limiting use should be developed. Imposing volume controls on hospital outpatient services only, however, probably would lead to a shift in use to other sites. Ultimately, therefore, volume control methods should apply to all ambulatory care settings.

Recommendation 26: Beneficiary Liability for Hospital Outpatient Services

The growing financial burden for Medicare enrollees who receive services in hospital

outpatient departments should be alleviated immediately. Beneficiary coinsurance for these services should be limited to 20 percent of the Medicare-allowed payment, as it is in other settings. For services not paid on a prospective basis, the Secretary should establish a new method for determining beneficiary copayments based on estimated allowed payments since they cannot be calculated precisely when services are delivered.

Under current law, the beneficiary's copayment for hospital outpatient services is 20 percent of charges rather than 20 percent of the total payment, as it is for virtually all other Part B services. Because hospital charges generally are higher than total payments, beneficiaries are responsible for substantially more than 20 percent of total payments. In addition, because hospitals' charges have grown more rapidly than total payments, beneficiary cost sharing has increased disproportionately. If this continues, the beneficiary's share of outpatient payment soon will overtake the program's share.

Beneficiary liability for hospital outpatient services is higher than it would be if the services were provided in another setting. Such differences in cost sharing unfairly penalize beneficiaries who receive care in hospital outpatient facilities.

Until a prospective payment system is implemented, copayments should be based on estimated payments. This could be done in several ways. Copayments could equal a lower percentage of charges, for example. Alternatively, HCFA could use an estimate of each hospital's payment to charge ratio, to determine the coinsurance amount for each service.

Reducing beneficiary coinsurance would raise Medicare outlays. The Commission therefore recommends that the reduction in program payments resulting from correcting the blended payment formula, as specified in the Congress's proposal, partially offset this increase. If necessary, the change in beneficiary liability could be phased in over several years.

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Notes to Chapter 4

1. The Medicare provisions passed by the Congress are in H.R. 2491, the "Balanced Budget Act of 1995." The Medicare provisions of the President's proposal are in Title II of draft legislation, called the "Balanced Budget Act of 1995 for Economic Growth and Fairness." Released on December 7, 1995, it has not been introduced in the Congress.

2. Rehabilitation and psychiatric distinct-part units newly certified by Medicare are exempt from TEFRA limits only for their first full 12-month cost reporting period. The first full year of operation is designated as the base year for these facilities.

3. The only restriction on ancillary service costs, other than meeting Medicare's definition of reasonableness, is that when physical and respiratory therapy services are provided "under arrangement" by an external facility, the therapists' salaries must be below HCFA's state-level salary guidelines.

4. In the lawsuit, Fox v. Bowen, 656 F. Supp. 1236 (D. Conn. 1986), the Court held that the Secretary's practice of using arbitrary rules to deny physical therapy benefits delivered by SNFs violated Medicare statutes and regulations and the due process clause of the U.S. Constitution. MCCA removed the prior hospital stay requirement, decreased the SNF copayment, and broadened coverage by changing the maximum benefit to 150 days per year.

5. The nonroutine cost limits would be calculated by determining the average costs *per stay* of nonroutine services during the last (12-month) cost report submitted on or before December 31, 1994. This amount would then be updated by the SNF market basket to fiscal year 1996 and multiplied by the number of stays that the SNF had during the year. Per stay amounts would be updated by the SNF market basket minus 2 percentage points in fiscal year 1997 and in each subsequent year until the implementation of the prospective payment system. Estimates of Medicare Part B payments for SNF services provided to beneficiaries eligible for Part A during the 1994 cost reporting period would be included in the facility-specific limits. In addition, facilities that did not submit a cost report in 1994 would be assigned *per stay* limits based on the national average cost for nonroutine services.

6. Health Care Financing Administration, Office of the Actuary.

7. As the number of kidney transplants performed and graft survival rates has risen over time, the proportion of all Medicare ESRD beneficiaries with a functioning transplant has increased—from 10.8 percent in 1978 to 22.0 percent in 1991. Still, dialysis patients accounted for a large majority of ESRD enrollees in 1991.

8. The payment limit was increased to $139 under OBRA 1990.

9. U.S. Congress, General Accounting Office, *Medicare: Impact of OBRA-90's Dialysis Provisions on Providers and Beneficiaries*, GAO/HEHS-94-65 (Washington, DC: U.S. Government Printing Office, April 1994).

10. Project HOPE's Center for Health Affairs, *Identifying Changes in the Factors of Production for Dialysis Services*, ProPAC Extramural Technical Report, No. E-93-01, March 1993.

11. ProPAC's dialysis facility market basket contains four cost components—capital, labor, other direct costs, and overhead. Because cost shares for these components differ for hospital-based and freestanding facilities, the Commission developed separate market baskets. Price proxies were derived from the components of HCFA's input price indexes for PPS hospitals, skilled nursing facilities, and home health agencies.

12. HCFA introduced a new cost report for freestanding dialysis facilities effective for cost reporting periods beginning on or after October 1, 1993 (fiscal year 1994 and after). The revised cost report corrects for certain errors that led to data quality problems. Unfortunately, the 1994 data for these facilities were not available for ProPAC's analysis.

13. The composite rate is intended to cover the portion of facility costs that is allowable in accordance with Medicare principles of reimbursement. HCFA's audit of fiscal year 1991 cost reports found that Medicare-allowable costs in freestanding dialysis facilities were 12.2 percent lower than reported costs, whereas those in hospital-based facilities were 4.6 percent lower. After adjusting reported costs by HCFA's audit correction factors, payment to cost ratios are substantially higher.

14. Project HOPE's Center for Health Affairs, *Quality of Dialysis in the United States*, ProPAC Extramural Technical Report, forthcoming.

15. Kt/V (where *K* is the dialyzer clearance of urea, *t* is the time of dialysis, and *V* is the patient's urea volume) measures the intensity of dialysis relative to the patient's size, describing the fractional removal of urea.

16. Past studies found that inadequate manual reprocessing of dialyzers was associated with a higher risk of morbidity and mortality, although this no longer appears to be a problem.

17. Each year, ProPAC estimates how Medicare costs are affected by the dialysis industry's adoption of new cost-increasing, quality-enhancing scientific and technological advances. The Commission's most recent analysis indicates that these innovations will raise facilities' total operating and capital costs by $26.6 million, or 0.7 percent, in fiscal year 1997. Abt Associates, *The Incremental Impact of Scientific and Technological Advances on Cost Increases in Dialysis Facilities*, ProPAC Extramural Technical Report, No. E-96-01, January 1996.

18. U.S. Department of Health and Human Services, *Report to Congress: Medicare Hospital Outpatient Prospective Payment*, March 17, 1995.

19. The blended amount is determined by a two-part formula: the hospital-specific portion (the lesser of costs or charges minus 20 percent of charges) and the prospective portion (80 percent of the applicable prospective rate). The prospective rate for ambulatory surgery is the amount for the relevant procedure category used to pay freestanding ambulatory surgical centers. For radiology and diagnostic services, it is that portion of the physician fee schedule intended to represent the technical expense of providing that service.

    The second part of the forumula inappropriately assumes that 20 percent of the prospective rate equals 20 percent of charges (the copayment). In fact, charges are usually much higher than the prospective rate. Because the full contribution of beneficiary cost sharing is not captured, Medicare's share of hospital payments is overstated.

Appendix A. Technical Report Series

Appendix A lists the Prospective Payment Assessment Commission's (ProPAC's) extramural and intramural technical reports. These reports provide documentation related to the Commission's March and June annual reports to the Congress. The congressional reports are prepared upon request by the Congress. Each technical report is numbered according to type and year of publication. Numbers missing from the sequence refer to studies that have been replaced with more recent reports. Commission reports can be obtained from the Prospective Payment Assessment Commission, 300 7th Street, S.W., Suite 301B, Washington, D.C. 20024, or by calling the office at 202/401-8986.

EXTRAMURAL TECHNICAL REPORT SERIES

E-87-01: Improving the Definition of Hospital Labor Market Areas and Wage Indexes (Abt Associates, Inc.)

Methods for improving the definition of hospital labor market areas were investigated. This report identifies urban and rural labor market areas with the greatest amount of wage variation. It also examines the sources of wage variation within current labor markets and possible improvements in the area wage adjustment. Appended are step-by-step instructions for assigning hospitals within metropolitan statistical areas to urbanized areas as defined by the Bureau of the Census. (formerly E-87-12)(2/87)

E-87-03: Measures of Complexity of Illness Within DRGs (SysteMetrics/McGraw-Hill, Inc.)

The goal of this research was to refine the Commission's method of monitoring continuing changes in DRG case mix and case complexity (changes within DRGs). This study refines the Commission's methodology for estimating the annual component of real case-mix change within DRGs. The methodology was used to develop annual estimates of within-DRG case-mix change for Medicare patients from 1984 to 1986. It was also used by the Commission to estimate this component of real case-mix change in future years as additional Medicare data became available. Estimates from this study were used to analyze the indirect medical education adjustment. (3/89)

E-87-06: Assessing the Adequacy of the Medicare Cost Report Data (SysteMetrics/McGraw-Hill,Inc.)

This report provides information on perceived strengths and weaknesses of the Medicare Cost Report. Hospital financial officers, fiscal intermediaries, and industry representatives were surveyed. In general, the results of this study indicate that most hospitals believe that the cost report is acceptable as a reimbursement tool. Most hospitals thought, however, that the cost report does not accurately measure the cost of care for Medicare beneficiaries because bad debt, charity care, patient telephones, and so forth are not recognized. PPS has resulted in changes in reporting practices. Particular attention is given to passthrough items like capital and direct medical education. (4/88)

E-87-08: Trends in the Concentration of Six Surgical Procedures Under PPS and Their Implications for Patient Mortality and Medicare Cost (Project HOPE)

This report examines trends in hospitals' volumes of six specialized surgical procedures and the impact of those trends on mortality and costs. The six procedures are coronary artery bypass grafting, total hip replacement, abdominal aneurysm repair, intestinal resection, transurethral prostatectomy, and carotid endarterectomy. (6/88)

E-87-11: Small Isolated Rural Hospitals: Alternative Criteria for Identification in Comparison with Current Sole Community Hospitals (SysteMetrics/McGraw-Hill, Inc.)

This study determines how many facilities become eligible for sole community hospital (SCH) status. The contractor also examines how the distribution of SCHs would change if the SCH criteria were altered. This study also provides information used to analyze the financial vulnerability of small isolated rural hospitals. (6/88)

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E-88-01: Subacute Care in Hospitals: Synthesis of Findings from the 1987 Survey of Hospitals and Case Studies in Five States (Lewin/ICF)

This document is the final report of an 18-month study of subacute care in hospitals, often referred to as transitional care. Results of a representative national survey of hospitals are presented, along with findings from case studies in five states (California, Louisiana, New York, North Carolina, and Washington). Information is also presented on other types of transitional care, such as home health and skilled nursing care. (9/88)

E-88-02: An Analysis of Hospital Sensitivity to DRG Price Variation in the Medicare Prospective Payment System (SysteMetrics/McGraw-Hill, Inc.)

This study provides information on whether hospital behavior in rendering care and assigning resources is sensitive to differences between hospital costs and PPS prices. The contractor interviewed health care consultants and hospital administrators to identify the extent and objectives of hospital strategies to concentrate in or discontinue selected services. Second, the contractor assessed whether these strategies were in direct response to variations in the DRG prices or other factors influencing hospital management. Third, it examined the use of product line management and service costing in hospitals' responses to DRG price variations. (8/88)

E-89-01: Urban and Rural Cost Differences: Literature Synthesis and Review (SysteMetrics/McGraw-Hill, Inc.)

The reasons for differences in urban and rural hospitals' costs per case are synthesized from current research in this report. Specifically, the basis for the lower costs of rural hospitals compared with urban hospitals is explored, and further research suggested. (3/89)

E-89-02: Treatment of Certain Hospital Labor Expenses in the PPS Market Baske (SysteMetrics/McGraw-Hill, Inc.)

This report examines certain hospital labor expenses not directly measured by the PPS market basket (contract labor, employee bonuses, recruitment costs, employee benefits, overtime and part-time employment, and changes in employee skill mix). The project examines how these costs are currently measured in the market basket and changes in these expenses between 1985 and 1988. Estimates were made of the effect these labor expenses would have on market basket increases if the expenses were directly measured in the market basket wage component. The calculations of the Average Hourly Earnings for Non-Supervisory Hospital Workers and the Employment Cost Index for Hospitals are also described in the study. (2/89)

E-90-01: The Relationship Between Declining Use of Rural Hospitals and Access to Inpatient Services for Medicare Beneficiaries in Rural Areas (Codman Research Group, Inc.)

This study examines hospital utilization patterns for Medicare beneficiaries living in defined rural and urban hospital market areas of five states—Alabama, California, Illinois, Montana, and Texas—from 1984 to 1986. The study examines Medicare beneficiary care according to the market area where the beneficiary lives. Cases are divided into eight DRG groups to examine whether access is impaired for some services and not others. The study also examines how these changes in utilization affect admissions and market share of rural and urban hospitals. (1/90)

E-90-02: Alternative Hospital Market Area Definitions (SysteMetrics/McGraw-Hill, Inc.)

This report examines alternative methods for defining hospital market areas through an extensive literature search and contact with experts in the field. The study reviews the role market areas play in PPS. It also reviews numerous alternatives that have been used for defining market areas, exploring options that have not been used for hospitals. Finally, the study provides an evaluation of the alternative methodologies and their potential applicability to PPS for defining hospital labor and product markets. (3/90)

E-90-04: The Dynamics of Hospital Services Changing Patterns in the Services Provided by Hospitals from 1980 to 1987 (Kirsten Iversen)

The level of services and facilities provided by hospitals is dynamic, changing over time and across settings. This analysis describes patterns in the

changing levels of services provided by different groups of hospitals from 1980 to 1987. (3/90)

E-90-05: Methodology for Measuring Case-Mix Change: How Much Change in the Case Mix Is DRG Creep? (The RAND Corporation)

ProPAC assisted the Health Care Financing Administration in a medical record reabstraction study. This study develops a method to distinguish case-mix increases caused by changes in coding practices from changes in treatment patterns and patient mix. It also provides information for developing and refining alternative ongoing data collection methods to monitor case-mix change over time. The Commission helped fund this project and provided support in designing, implementing, and monitoring the study. (4/90)

E-90-07: How Services and Costs Vary by Day of Stay for Medicare Hospital Stays (The RAND Corporation)

This study describes how the cost of services provided during Medicare hospital stays varies throughout the stay. It also examines how patterns of daily costs vary with clinical characteristics, hospital characteristics, and the types of services provided. The study was based on data on the daily services billed to Medicare patients between May 1987 and April 1988 from a sample of 105 hospitals, and was the first time such data had been used in this way. (3/90)

E-90-08: Comparative Analysis of Annual Survey and Medicare Cost Report Margin Data (American Hospital Association)

This study presents the results of a comparative analysis of total hospital margin data derived from a matched sample of Medicare Cost Reports and corresponding American Hospital Association (AHA) annual surveys. Initially, the national average Medicare Cost Report margin was significantly higher than the corresponding annual survey margin. After editing, however, the cost report margin was found to be slightly lower than the AHA figure. A telephone survey was used to investigate the reasons for the cost report/AHA discrepancies. The study analyzes the discrepancies by type of hospital and categorizes the reasons they occur. The study concludes that properly edited cost report income statement data are usable in research applications. Only one source of bias was documented as significantly affecting calculation of average total margins by hospital group. This was the failure of some public hospitals to report government subsidies as revenue on their Medicare Cost Reports. (9/90)

E-90-09: Hospital Cost Variations Under PPS (Center for Health Policy Studies, Georgetown University)

This study explores the impact of PPS and other factors in accounting for variations in total costs among hospitals during the 1980s. The goal was to understand the extent to which PPS has affected hospital costs, and the mechanisms that have produced those effects. The impact of PPS was isolated by analyzing a time-series of cost data for a sample of hospitals, while controlling for the effects of other factors, such as input prices, mix of outputs, volume of outputs, local competition, and health insurance coverage. The study also focuses on the roles of staffing, service mix, patient volume, and financial pressure to identify the mechanisms that have operated to produce PPS effects. These analyses were conducted separately for all sample hospitals and for important subgroups of the hospital industry, including urban and rural hospitals. (9/90)

E-91-01: Classification Systems for PPS-Excluded and Non-PPS Providers (Project HOPE)

This study provides an overview and evaluation of systems that measure the case mix or resource complexity of patients treated in hospitals excluded from Medicare's PPS or patients treated by non-PPS providers. PPS-excluded hospitals include psychiatric and rehabilitation hospitals and distinct-part units as well as children's, long-term, and cancer hospitals. Non-PPS providers include home health agencies and skilled nursing facilities. The report identifies and describes available research on patient classification systems, case-mix measurement systems, and payment systems for each type of provider. Each system is evaluated using a set of criteria related to patient classification such as administrative feasibility, ability to explain variations in resource use, and clinical validity. Other criteria are applied to the evaluation of payment systems. Among the criteria used are administrative feasibility, equity of the system, and system effectiveness. (1/91)

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E-91-02: Study of Health Care Access in Counties Where the Only Hospital Closed (Abt Associates, Inc.)

This report describes a study of access to health services in 22 rural counties where the only hospital closed between 1987 and 1989. These counties are compared with a similar group of counties that did not have a hospital between 1980 and 1989. Access to health care services is evaluated on two dimensions. First, distances and travel times (from the population center of each county) to the nearest hospitals in contiguous counties are identified, and second, the types and numbers of health care providers (facilities and practitioners) in each of the counties are noted. This was accomplished using telephone surveys of county health department personnel and analysis of the Area Resource File. (5/91)

E-91-03: Utilization of Inpatient Hospital Services by Rural Medicare Beneficiaries (Codman Research Group, Inc.)

This study updates a previous analysis (E-90-01) on inpatient hospital utilization for Medicare beneficiaries living in rural and urban market areas of five states: Alabama, California, Illinois, Montana, and Texas. The analysis expands on the earlier study by looking at utilization patterns for rural beneficiaries using refined DRG case-type groupings and by separately examining utilization patterns for younger and older Medicare beneficiaries. The findings from the analysis are consistent with the earlier study, in that access to inpatient hospital services does not appear too constrained for rural Medicare beneficiaries. The study, however, raised concerns about access to ambulatory care in these communities. (5/91)

E-91-04: Volume Adjustments Used in State Medicaid Programs and Rate Setting Systems (Abt Associates, Inc.)

This report presents information about volume adjustments used to adjust payments to hospitals by state Medicaid programs. The contractor surveyed states to determine the number that use a volume adjustment, how the adjustment is calculated, eligibility requirements, whether there are upper and lower thresholds for the adjustment, and the formula used to calculate the adjustment. The contractor also laid out a theoretical framework for considering volume adjustments, and outlined the relationships between policy goals and characteristics of these adjustments. (7/91)

E-91-05: Medicaid Payment Methodologies for Inpatient Hospital Services (Abt Associates, Inc.)

This report describes state Medicaid inpatient hospital payment methodologies in effect as of July 1, 1991. The information was collected through telephone interviews with knowledgeable staff at state Medicaid offices, rate setting commissions, and hospital associations. The survey attempted to identify, describe, and document key concepts used to develop Medicaid payment systems for inpatient hospital services. (8/91)

E-91-06: An Evaluation of Winners and Losers Under Medicare's Prospective Payment System: A Synthesis of the Literature (Lewin/ICF)

This report summarizes the academic and popular literature on (1) hospital characteristics affecting hospital financial performance under Medicare; (2) the design features that affect winning and losing, and how hospitals responded to the incentives of PPS; and (3) the environmental and community characteristics of a hospital's local market that affect hospital financial performance. In addition, it outlines some of the perceived gaps in the literature and includes an extensive bibliography. (10/91)

E-92-01: Certification Requirements for Nursing Homes (Abt Associates, Inc.)

This report presents descriptive information on current Medicaid certification and state licensure requirements for nursing homes. It focuses on those requirements that are expected to impose significant costs on facilities and result in cost variations across states. (3/92)

E-92-02: An Evaluation of Winners and Losers Under Medicare's Prospective Payment System: Final Report (Lewin/ICF)

This report summarizes the findings of a series of case studies conducted by Lewin/ICF examining why, controlling for similar hospital characteristics, some hospitals do well under PPS while others do not. Factors examined include hospital behavior, such as successful management strategies; hospitals'

responses to PPS; and broader environmental factors that shape hospital performance. The degree to which performance is within a hospital's control is discussed. Individual hospital descriptions are not provided. Rather, the report integrates site visit findings and synthesizes the similarities and differences between successful and unsuccessful hospitals. (5/92)

E-92-03: Report on Quality Assurance in Non-PPS Settings (Abt Associates, Inc.)

This study describes mechanisms used to ensure and monitor quality in settings in which Medicare services are reimbursed. Among these are skilled nursing facilities, home health agencies, and hospitals not paid under PPS (psychiatric hospitals and rehabilitation hospitals). The study also looks at quality assurance in selected outpatient facilities, including ambulatory surgical centers, hospital outpatient departments, ambulatory care centers, cardiac catheterization laboratories, freestanding clinical laboratories, dialysis facilities, diagnostic imaging centers, lithotripsy centers, and comprehensive outpatient rehabilitation facilities. Quality assurance mechanisms including certification, accreditation and monitoring by Federal, state, and voluntary organizations are described. Quality indicators are classified by structure, process, or outcome. (8/92)

E-92-04: Within DRG Case Complexity Change in Fiscal Year 1990 (SysteMetrics/McGraw-Hill, Inc.)

ProPAC annually recommends to the Congress an update factor for increasing the standardized payment amounts under PPS. This update factor reflects changes in the cost of providing services, including changes in the cost of hospital inputs; the effects of scientific and technological advances; productivity increases; and changes in the mix of patients that hospitals treat. The distribution of cases across DRGs is captured by the Medicare case-mix index, which directly affects the payment that hospitals receive for each case. This study measures the change in the distribution of cases by complexity level within DRGS. The study uses Medicare data for fiscal years 1988 through 1990 to develop estimates of within-DRG case complexity change and examines changes in coding of secondary diagnoses, both by overall and by hospital group. (4/92)

E-93-01: Identifying Changes in the Factors of Production for Dialysis Services (Project HOPE)

This report describes an historical cost study of the factors of production for outpatient hemodialysis and peritoneal dialysis services. The study examines how the use or cost of inputs changed between 1983 and 1991, and estimates the incremental or decremental impact that the change in each input has on the cost per dialysis treatment. The study focuses on the incremental effects of scientific and technological advances in the dialysis industry and ensuing productivity improvements. (3/93)

E-93-02: Within DRG Case Complexity Change, 1991 (SysteMetrics, Inc.)

This study measures the change in within-DRG case complexity from 1989 to 1990 and from 1990 to 1991. It also examines changes in the number of secondary diagnoses and complications and comorbidities from 1989 to 1991. This information is used for ProPAC's within-DRG case-complexity adjustment. The within-DRG case-complexity adjustment is designed to capture increases in patient complexity that are not measured by the DRGs. It is part of the case-mix adjustment in ProPAC's annual PPS operating and capital update recommendation to the Congress. The case-mix adjustment allows hospital payments to increase for real case-mix change, while removing payment increases that are due to changes in medical record documentation or coding practices. (2/93)

E-93-03: Exploring the Growth of Hospital Outpatient Surgeries (Abt Associates, Inc.)

This report identifies and assesses the principal factors that contributed to the growth observed between 1988 and 1990 in the use of five groups of procedures performed in the hospital outpatient department. The five groups selected were knee arthroscopy, YAG laser, lithotripsy, sigmoidoscopy and colonoscopy, and breast biopsies. These families of procedures were selected because as a group they represented varying levels of complexity, exemplified a variety of clinical problems, were in the top 50 most frequently performed ASC-approved procedures, and had a high growth rate between 1988-90. The factors affecting increased procedure volume were physician practice patterns and treatment approaches, technology requirements, the capacity of physicians and hospitals to

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perform the procedure, shifts in setting in which the procedure is performed, and reimbursement practices. (3/93)

E-93-04: Analysis of the Effect of the Economic Stabilization Program (Abt Associates, Inc.)

This report describes the effect of the economic stabilization program (1971-1974) on health care prices and expenditures. Previous studies of the program are reviewed and compared. Additionally, descriptive data on health care expenditures by type of service and program, health care prices, and hospital revenues and expenditures are displayed. (5/93)

E-93-05: State Regulations and Policies that Affect the Provision of Post-Acute Care (Abt Associates, Inc.)

This report presents descriptive information about state regulations and policies that affect the staffing requirements, services provided, and patient mix of Medicare-certified skilled nursing facilities and home health agencies. (5/93)

E-93-06: Development of Hospital Efficiency Measures (Jenifer Ehreth, Ph.D.)

This report evaluates several measures of how efficiently hospitals use their capital assets and compares asset efficiency and hospital financial performance across types of hospitals. Descriptive statistics and factor analysis are used to assess the reliability and validity of several measures over a three-year period. Three measures—the current ratio, the long-term debt to net fixed assets ratio, and an asset efficiency measure using data envelopment analysis techniques—are evaluated in more detail because they appear promising for analyzing the impact of payment policies on asset efficiency. (8/93)

E-94-01: Within DRG Case Complexity Change, 1992 (SysteMetrics, Inc.)

This study measures the change in within-DRG case complexity from 1990 to 1991 and from 1991 to 1992. It also examines changes in the number of secondary diagnoses, complications and comorbidities from 1990 to 1992. ProPAC uses this information to estimate the annual amount of real case mix change within DRGs, which is not measured by the case mix index (CMI). Unlike previous studies of within-DRG case complexity change, this study investigates the long run trend for within-DRG case complexity change between 1985 and 1992, by hospital group. Potential explanations for the observed long run trend are discussed. (3/94)

E-94-02: The Incremental Impact of Scientific and Technological Advances on Operating Costs in PPS Hospitals and PPS-Excluded Facilities (FY 1995) (Abt Associates, Inc.)

This report provides supportive material for one component of ProPAC's update recommendations to the Congress: the allowance for scientific and technological advances (S&TA). It details the revised approach to estimating incremental costs attributable to technological change projected for fiscal year 1995. Two S&TA estimates were developed: one for changes in operating costs incurred by PPS hospitals and another for facilities excluded from PPS that are subject to the payment system established in the Tax Equity and Fiscal Responsibility Act of 1982. (1/94)

E-94-03: The Incremental Impact of Scientific and Technological Advances on Capital Costs in PPS Hospitals (FY 1995) (Abt Associates, Inc.)

This report provides supportive material for one component of ProPAC's PPS capital update recommendation to the Congress: the allowance for scientific and technological advances. It details the revised approach to estimating incremental capital costs attributable to technological change projected for fiscal year 1995. (1/94)

E-94-04: The Incremental Impact of Scientific and Technological Advances on Cost Increases in Dialysis Facilities (FY 1995) (Abt Associates, Inc.)

This report provides supportive material for one component of ProPAC's composite rate update recommendation to the Congress: the allowance for scientific and technological advances. It details the revised approach to estimating incremental costs attributable to technological change projected for fiscal year 1995. (1/94)

E-94-05: Discussion Report: Assessing the Impact of Cost-Decreasing Technological Change on Medicare Inpatient Costs (Abt Associates, Inc.)

To support its PPS payment update recommendations submitted to the Congress each year,

ProPAC uses a technology-specific methodology to assess changes in the cost-increasing effects of emerging technologies. This report provides discussion of the feasibility of applying this methodology to an analysis of the financial impact of cost-decreasing technologies used in the care provided to Medicare beneficiaries in the inpatient setting. (7/94)

E-94-06: Discussion Report: Assessing the Cost Impact of Technological Change on Medicare and Non-Medicare Populations Across Settings (Abt Associates, Inc.)

To support its PPS payment update recommendations submitted to the Congress each year, ProPAC uses a technology-specific methodology to assess changes in the cost-increasing effects of emerging technologies. The methodology is specific to the technologies used in the care provided to Medicare beneficiaries in the inpatient setting. This report provides discussion of the feasibility of applying this methodology to an analysis that would consider changes in the cost of technologies used in the care of Medicare and non-Medicare beneficiaries across settings: in the inpatient setting as well as other sites of care, including nursing homes, outpatient departments, and home health agencies. (7/94)

E-94-07: Medicaid Reimbursement Methodologies and Payment Rates for Home Health Agencies (Abt Associates, Inc.)

This study presents survey results on state Medicaid programs' reimbursement methodologies and payment rates for home health care services. Information is presented in table format for each service (skilled nursing; physical, speech, and occupational therapies; medical social services; and home health aides). Each table includes information on the following items: payment rates; rate-setting methodologies; whether the rate is agency-specific, class-based, or flat; cost components that are treated separately in the payment process; and payment update factors. (1/94)

E-94-08: Quality-Oriented State Licensing Requirements for Non-PPS Facilities (Abt Associates, Inc.)

This two-volume study presents survey results on state licensing requirements for 15 long-term care, home health, and ambulatory care providers. Information is presented on state standards for organizational structure and administration, personnel, service provision, medical documentation, internal quality assurance processes, minimum access and transfer affiliations, equipment, and certificate of need. Licensure requirements that differ from Medicare certification are emphasized. (7/94)

E-95-01: A Comparison of Cost Definitions (Project HOPE)

This report provides a comparison of cost definitions between Medicare principles of reimbursement and generally accepted accounting principles. It documents cost items pertaining to acute care hospital services and outpatient dialysis services that are nonallowable in accordance with Medicare payment policy. In addition, the report discusses providers' contests of Medicare's determination of allowable costs, where applicable, and the results of those cases. (2/95)

E-95-02: Medicaid Managed Care Program Access Requirements (Project HOPE)

This report examines seven states' strategies for ensuring access to health services for Medicaid-eligible people who are enrolled in managed care plans. It summarizes approaches states are using to ensure that enrollees receive medically appropriate services without facing geographic, cultural, or linguistic barriers to care. This report presents information gathered from both state Medicaid agencies and Medicaid managed care contractors. (4/95)

E-96-01: The Incremental Impact of Scientific and Technological Advances on Cost Increases in Dialysis Facilities (FY 1997) (Abt Associates, Inc.)

Each year, ProPAC recommends to the Congress an update to the composite rate for dialysis services. The Commission's update framework includes an allowance for the incremental impact of scientific and technological advances. This report describes ProPAC's estimate of the increase in operating and capital costs that will result from the diffusion of new and emerging dialysis-related technologies in fiscal year 1997. (1/96)

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Pending

Quality of Dialysis in the United States (Project HOPE)

This report is a critical review of the current literature relevant to the quality of outpatient dialysis services. It addresses issues related to the epidemiology and treatment of end-stage renal disease, defining and measuring quality of care, assessing patient outcomes, and comparing mortality rates between the United States and other countries. (Forthcoming)

Hospital-Physician Relations: A Multivariate Analysis of Hospital Financial Performance (Project HOPE).

This report will examine the association between hospital-physician relations and hospital financial performance. Data from ProPAC's Hospital-Physician Relations study (I-95-02) were combined with secondary data on hospital market characteristics and hospital financial performance and analyzed using both univariate and multivariate techniques. (Forthcoming)

INTRAMURAL TECHNICAL REPORT SERIES

I-88-02: Recalibration Analysis Comparing Charge-Based and Cost-Based DRG Weights

ProPAC analyzed the two methods of recalibrating the DRG relative weights, using charges only (charge-based) and using charges that are adjusted by costs (cost-based). This report provides a detailed description of the data, methods, and results of ProPAC's comparisons. (3/88)

I-89-03: Review of Medicare Cost Report Data for Policy Analysis

This report summarizes the Commission's work on the use of the Medicare Cost Report data for decision making. The major activity the Commission initiated to identify improvements in the use of existing cost data for policy analysis was to convene a panel to discuss the strengths and weaknesses of the Medicare Cost Report. The report also summarizes ProPAC monitoring of HCFA's three-year demonstration assessing the costs and benefits of adding to the cost report financial and utilization information regarding other payers. (3/89)

I-89-04: Payment Adjustments—Indirect Teaching and Disproportionate Share Hospitals

ProPAC analyzed the effect of teaching effort on Medicare costs. The objectives of the analysis were to estimate the relationship between teaching effort and Medicare cost per case using the most recent Medicare Cost Report data available. ProPAC also examined the overlap between the indirect medical education and the disproportionate share payment adjustments and evaluated the financial impact of revising the indirect medical education adjustment. The report describes the methods and results of the analysis. (7/89)

I-90-01: Medicare-Dependent Hospitals Under PPS

The Omnibus Budget Reconciliation Act of 1989 required the Commission to study the appropriateness of making a Medicare payment adjustment to hospitals that treat a high proportion of Medicare discharges. Information on this topic was also included in ProPAC's June 1990 report, *Medicare Prospective Payment and the American Health Care System.* (6/90)

I-90-02: Adjusting the Area Wage Index for Occupational Mix

Currently, the area wage index does not account for geographic differences in occupational mix. ProPAC studied the effect of adjusting the area wage index for occupational mix and the relationship of occupational mix to case mix. This report describes the methods and results of the analysis. The results include metropolitan statistical area, regional, and urban/rural estimates of the impact. The report also calculates how payments would be affected by adjusting the wage index for occupational mix. (8/90)

I-90-04: Financial Status of High Case Mix Hospitals

The Omnibus Budget Reconciliation Act of 1989 required the Commission to study the financial status of high case mix hospitals with special attention devoted to capital investment. Information on this topic was included in ProPAC's June 1990 report, *Medicare Prospective Payment and the American Health Care System.* (9/90)

I-91-01: Hospital Closures: 1985-1988

This report contains descriptive statistics on hospitals that closed between 1985 and 1988. Data are from the American Hospital Association Annual Survey of Hospitals, Medicare Cost Reports, and the Area Resource File. Rural and urban hospitals that closed are analyzed separately and compared with open rural and urban hospitals having fewer than 200 beds. (1/91)

I-91-02: The Role of Profitability and Community Characteristics in Hospital Closures, an Urban and Rural Analysis

This study investigates hospital closures that occurred from 1985 through 1988. The analysis focuses on the relationship between profitability and closure. Further, the analysis evaluates the impact on profitability of characteristics related to the hospital's mission and standing in the community. In addition, the analysis is extended by examining the factors that influence profitability and its components: revenue per case, cost per case, and total cases. This report provides a detailed description of the data, methods, and results of the study. (2/91)

I-91-03: Improving the Area Wage Index: The Area Wage Index and the Mix of Occupations Across Areas

Currently, the area wage index incorporates differences in the price of labor, as well as the mix of occupations across areas. This report presents the results of ProPAC's study on the effect of adjusting the area wage index for occupational mix. The results are presented separately for metropolitan statistical areas and rural areas. The study is based on Uniform Reporting System data collected from California hospitals. The report also describes the method used in California to collect data by occupational category. (7/91)

I-91-04: The Trend and Distribution of Hospital Uncompensated Care Costs, 1980-1989

This report presents the results of an analysis of uncompensated care costs for both PPS and PPS-excluded hospitals. Uncompensated care for this study is defined as the sum of charity care and bad debts, and uncompensated care costs are measured both with and without an offset for subsidies received from state and local governments. The study is based on data from the American Hospital Association Annual Survey of Hospitals over the period 1980 to 1989. Both the trend and distribution of uncompensated care costs are measured by hospital group. In addition, the relationship between uncompensated care costs and indirect medical education and disproportionate share payments under Medicare is examined. (10/91)

I-92-01: Winners and Losers Under PPS

Although the aggregate margin of hospitals under PPS has declined, some hospitals continue to perform well. In this report, ProPAC analyzes the characteristics of hospitals with consistently high and consistently low margins under PPS in 1986, 1987, and 1988. The characteristics are broken into three groups: payment adjustments, factors within the hospital's control, and factors outside of the hospital's control. The focus of the study is to determine the relative role of these factors in performance under PPS. This report provides a detailed description of the data, methods, and results of the study. (6/92)

I-92-02: The Effect of the OBRA 1989 Payment Provisions for Small Rural Medicare-Dependent Hospitals

In 1989 and 1990, ProPAC analyzed the financial status of hospitals with high Medicare shares. The ProPAC analysis, described in *Medicare-Dependent Hospitals Under PPS* (TRS I-90-01), indicated that the classification of hospitals into groups based on Medicare dependence is arbitrary and inconsistent over time. Further, although hospitals with high Medicare shares tend to perform more poorly under PPS, this poor performance appears to be related to characteristics other than Medicare share, notably low occupancy rates and long average lengths of stay. Based on these findings, the Commission recommended that no payment adjustment be made for Medicare-dependent hospitals. In the Omnibus Budget Reconciliation Act (OBRA) of 1989, Congress provided special treatment under PPS for small rural Medicare-dependent hospitals for three years (cost reporting periods beginning on or after April 1, 1990, and ending on or before March 31, 1993). This provision expired in 1993. However, the Congress extended it through fiscal year 1994. This report describes an analysis of the financial performance of small rural Medicare-dependent hospitals as defined in OBRA 1989 and

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the impact of the special provision on Medicare payment of these hospitals. (7/92)

I-93-01: The Accuracy of Cost Measures Derived from Medicare Cost Report Data

This report summarizes the findings and policy implications of a study conducted by the Center for Health Policy Studies. The primary objective of the study was to assess the accuracy of the hospital-level and DRG-level cost measures that can be constructed using Medicare Cost Report data. The first part of the study tested the impact of potential refinements in the Medicare Cost Report cost finding approach, such as using a standard cost center configuration or a multiple allocation technique. These types of changes were found to have relatively little impact. The second part compared values from advanced hospital cost accounting systems with values from the cost reports of the same hospitals. Substantial differences were documented for total Medicare costs, routine and ancillary costs, and average cost per case by DRG. (3/93)

I-95-01: The Relationship Between Hospital Costs and Payments by Source of Revenue, 1980-1991

This report presents an analysis of community hospital losses and gains by source of revenue, including Medicare, Medicaid, uncompensated care, private payers, and non-patient revenue. The data for the analysis are from the American Hospital Association Annual Survey of Hospitals. The report includes trend data on payments, costs, and charges. Data from 1991 are used to analyze the distribution of gains and losses for the different revenue sources, the relationship between these losses and hospital margins, and state-by-state differences. The report also compares the characteristics of hospitals that are and are not able to recover significant losses from uncompensated care, Medicaid, and Medicare through cost shifting. (10/95)

I-95-02: Hospital-Physician Relations: A National Survey of Hospital Chief Executive Officers and Chiefs of Medical Staffs

In an effort to identify factors that affect the financial performance of hospitals, ProPAC has undertaken a study of the financial effects of different organizational structures and mechanisms hospitals use to influence physician behavior. In the first phase of the project, ProPAC sponsored a national survey of hospital chief executive officers (CEOs) and chiefs of medical staff (CMSs) to evaluate the various aspects of hospital-physician relations. The survey explored the organization of hospital services; physician recruitment, retention, and evaluation; physician roles and responsibilities within hospitals; and hospital-physician financial arrangements. It also sought to ascertain how CEOs and CMSs perceived the respective roles they play and the influence of hospital management and physician staff within the hospital environment. The report describes survey methods and results, including differences in approaches to hospital-physician relations employed by different types of hospitals. The next phase, a multivariate analysis, will link hospital financial data with data from the national survey. (11/95)

I-95-03: Medicare Transfer Payment Policy

This report presents the results of an analysis of Medicare's payment for transfer cases. Currently, the transferring hospital is paid a uniform per diem payment up to the full DRG amount. The receiving hospital is paid the full DRG payment if it is the final discharging hospital. The analysis examines the relationship between payments and costs for these cases. In addition, it examines the characteristics of hospitals and cases involved in a transfer sequence. The study also includes information on trends in transfer rates since 1984. (6/95)

I-95-04: A Review of ProPAC's Allowances for Scientific and Technological Advances

This report describes the study ProPAC conducted to support the Commission's decisions regarding the allowances for scientific and technological advances (S&TA) for the PPS operating and capital payment update recommendations for fiscal year 1996. The Commission used a qualitative approach to assess S&TA costs, evaluating more generally whether any changes in technology costs have altered the trend established in previous years. This report reviews previous allowances, the technologies assessed, advances that may affect Medicare costs, and, finally, the Commission's decisions for the two PPS S&TA allowances for fiscal year 1996. It also discusses how ProPAC's technology-specific methodology differs from other approaches to technology costing, and evaluates how well the

methodology captures the information intended by the S&TA allowance. (4/95)

I-95-05: Hospital Costs and Payments by Revenue Source: The Impact of Medicaid Payment Increases in 1992

This report supplements ProPAC's recent report on hospital losses and gains by source of revenue (TRS I-95-01). Like the first report, this one analyzes the trend in payments relative to costs by payer, as well as differences by type of hospital and by state. The focus throughout this report, however, is the impact of substantial increases in revenue received by many hospitals in 1992 from Medicaid disproportionate share payments. This includes the impact on overall Medicaid payments and on the pattern of cost shifting to the private sector. (10/95)

Joint Report to the Congress on Medicare Managed Care

The Prospective Payment Assessment Commission and the Physician Payment Review Commission prepared this joint report on the role of managed care within the Medicare program. It describes program policies and analyzes options concerning beneficiary enrollment, plan participation, payment policy, access and quality, and data constraints. (10/95)

Pending

Medicare Per Capita Expenditures and Costs

This report will present a descriptive analysis of the variation in 1991 per capita expenditures for elderly beneficiaries by state and between the rural and urban areas of each state. Four per capita measures are being developed: (1) Medicare spending, (2) Medicare payments standardized to the national level (which will isolate geographic differences in utilization), (3) the provider production costs associated with Medicare spending, and (4) production costs adjusted for geographic price differences. All four of these measures will be broken down by setting, with physician services attributed to the setting in which they were provided. Geographic comparison will also be enhanced in the second and fourth measures by controlling for age and sex differences and by adding an estimated value for care provided to the elderly in military and Department of Veterans Affairs hospitals. (Forthcoming)

CONGRESSIONALLY MANDATED REPORTS

C-88-01: An Evaluation of the Department of HHS Report to Congress on Studies of Urban-Rural and Related Geographical Adjustments in the Medicare PPS

The Omnibus Budget Reconciliation Act of 1987 required ProPAC to report to the Congress on its evaluation of the Secretary's study on the feasibility and impact of eliminating or phasing out separate urban and rural payment rates. The report is organized into four major sections: background and definition of issues, summary of the Secretary's study methods and findings, ProPAC's evaluation of the Secretary's study, and future direction of Commission activities. (6/88)

C-88-02: Linking Medicare Capital Payments to Hospital Occupancy Rates

The Omnibus Budget Reconciliation Act of 1987 required ProPAC to report to the Congress on the suitability and feasibility of linking Medicare capital payments to hospital occupancy rates. This was addressed by reviewing current Medicare capital payment principles, examining historical trends in capital costs and occupancy rates, and analyzing the relationship between capital costs and occupancy. (4/88)

C-88-03: Outlier Payment Alternatives for Burn Cases

The Omnibus Budget Reconciliation Act of 1987 required ProPAC to study alternative payment methods for burn outlier cases under the prospective payment system. In this report, the Commission examines costs and PPS payments for all burn cases, as well as those for outlier cases only. Differences between payments and costs for burn hospitals and units and other PPS hospitals are examined. (7/88)

C-88-04: The Views of the Prospective Payment Assessment Commission on Developing Medicare Payment for Hospital Outpatient Surgery

The Omnibus Budget Reconciliation Act of 1987 required the Secretary of Health and Human Services to solicit ProPAC's views in developing outpatient payment systems and to include these views

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in a series of reports to Congress. This report focuses on the facility component of payment for surgeries performed in hospital outpatient settings. (8/88)

C-88-05: Separate PPS Payment Rates for Hospitals in Large Urban Areas and Other Urban Areas

The Omnibus Budget Reconciliation Act of 1987 required ProPAC to "evaluate the desirability of maintaining separate DRG prospective payment rates for hospitals located in large urban areas...and in other urban areas." The report first describes how PPS currently treats hospitals in different sized urban areas. Descriptive information comparing hospitals in these areas is then presented. This is followed by a discussion of the PPS policy implication of variation in costs and margins by metropolitan statistical area size. (12/88)

C-89-01: Medicare Payment for Hospital Outpatient Surgery: The Views of the Prospective Payment Assessment Commission

The Omnibus Budget Reconciliation Act of 1987 required the Secretary of Health and Human Services to solicit the Commission's views on prospective payment for hospital outpatient surgery. This report contains ProPAC's recommendations and related rationale on such payment policy beginning in fiscal year 1990. It also presents background information used by the Commission in its deliberations, including the findings of ProPAC's analysis of hospital outpatient surgery costs. (4/89)

C-89-02: Payment Rates for Hospitals Redesignated from Rural to Urban: Analysis and Recommendations

The Technical and Miscellaneous Revenue Act of 1988 required ProPAC to study and report to Congress on the appropriate PPS payment for hospitals redesignated as urban in the Omnibus Budget Reconciliation Act of 1987. This study evaluates the payment policy and the treatment of wage and wage-related costs in computing area hospital wage indexes. The financial impact of various policy options on both the redesignated hospitals and on other hospitals located in the affected urban and rural areas is also assessed. (8/89)

C-89-03: Adjustment to the Non-Labor-Related Portion of the Standardized Amounts

The Omnibus Budget Reconciliation Act of 1987 required ProPAC to analyze the feasibility and appropriateness of a geographic adjustment to the non-labor-related portion of the PPS standardized amounts. Price data for non-labor components of the hospital market basket are compiled from available data sources to determine whether non-labor prices vary by geographic area. The report contains this information and the Commission's determination of whether such an adjustment is feasible and appropriate. (8/89)

C-89-04: Adequacy of PPS Payment for Medicare Beneficiaries with Hemophilia

The House Ways and Means Committee asked ProPAC to assess the adequacy of PPS payment for Medicare inpatients with hemophilia. This report studies the population size, trends in the price of the clotting factor, and the financial impact on hospitals for treating these patients. (10/89)

C-90-01: Medicare Payments to Rural Sole Community Hospitals and Small Rural Hospitals

The Omnibus Budget Reconciliation Act of 1989 required the Commission to submit a report to Congress on the feasibility and desirability of using a cost-based reimbursement system for paying small rural hospitals and sole community hospitals. Further, ProPAC was to assess the impact of using alternative market share definitions to determine eligibility for sole community hospital classification, and of accounting for decreases in admissions in determining payments to small rural hospitals or their costs. This report summarizes the Commission's findings. (5/90)

C-90-02: Hospital Outpatient Services Background Report

The Omnibus Budget Reconciliation Act of 1989 required the Commission to submit a report to Congress on several issues related to outpatient payments. This report examines the growth in hospital outpatient services and the revenues generated by outpatient visits. The costs of providing services in hospital outpatient departments are compared to those associated with freestanding centers. Last, outpatient quality assurance and peer review are discussed. (7/90)

Medicare-Dependent Hospitals

The Omnibus Budget Reconciliation Act of 1989 required the Commission to study the appropriateness of making an adjustment to Medicare payments to hospitals that treat a high proportion of Medicare discharges. Information on this topic was included in ProPAC's June 1990 report, *Medicare Prospective Payment and the American Health Care System.* (6/90)

Financial Status of High Case Mix Hospitals

The Omnibus Budget Reconciliation Act of 1989 required the Commission to study the financial status of high case mix hospitals with special attention devoted to capital investment. Information on this topic was included in ProPAC's June 1990 report, *Medicare Prospective Payment and the American Health Care System.* (6/90)

Area Wage Index

The Omnibus Budget Reconciliation Act of 1990 required ProPAC to examine available data from states and other sources measuring earnings and paid hours of employment of hospital workers by occupational category. The impact of variation in occupational mix on the computation of the area wage index is included. Information on this topic was included in ProPAC's March 1991 *Report and Recommendations to the Congress.* (3/91)

Nurse Practitioners and Other Non-Physician Providers

The Senate Committee on Appropriations asked that ProPAC study the use of nurse practitioners and other non-physician providers in settings other than acute care facilities and long-term care institutions. Information on this topic was included in ProPAC's June 1991 report, *Medicare and the American Health Care System.* (6/91)

C-91-01: Medicare's Capital Payment Policy

This report summarizes the Commission's analyses of hospital capital costs and views on Medicare's capital payment policy. ProPAC's objectives for evaluating capital payment, along with supporting data and opinions, are presented. The Commission also comments on the Secretary of Health and Human Services' prospective payment proposal. (5/91)

C-91-02: Medicaid Hospital Payment

The Omnibus Budget Reconciliation Act of 1990 required the Commission to conduct a study of Medicaid hospital payment rates. The study examines the relationship between Medicaid and Medicare payments, and the financial condition of the hospitals receiving Medicaid payments. Special attention is given to hospitals in urban areas that treat large numbers of people eligible for Medicaid and other low-income persons. (10/91)

C-91-03: Rural Hospitals Under Medicare's Prospective Payment System

The Senate Committee on Appropriations requested a report examining the changes made in rural hospital payment policies and their fiscal impacts. The report includes an analysis of the impact of 1991 payment rules on 1984 and 1989 hospital margins and assesses the relative importance of individual policy changes. In addition, ProPAC was asked to study the effect of low volume on overhead costs and payments. The report includes a discussion of the relationship between volume and financial performance, and case mix and performance. The adequacy of national DRG weights for rural hospitals and differences between sole community and other small rural hospitals' characteristics and financial condition are also discussed. Finally, the report includes a profile of services offered by rural hospitals. (10/91)

C-91-04: Passthrough Payments for Hemophilia Inpatients

The Omnibus Budget Reconciliation Act of 1989 required the Commission to submit a report to Congress that contains recommendations on paying for the cost of administering blood clotting factors to inpatients with hemophilia. This report summarizes the Commission's findings. (6/91)

C-92-01: Prospective Payment System for Medicare's Skilled Nursing Facility Payment Reform

The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to develop a proposal to modify the current system under which skilled nursing facilities receive payment for extended care services under Medicare Part A or a proposal to replace this system with a prospective payment system. The

Commission is required to submit an analysis of and comments on the proposal. This background report describes the Medicare SNF benefit, payment method, and beneficiary utilization. A cost function analysis provides information on variations in costs across facilities. Federal and state regulations affecting facility costs and use of the benefit also are discussed. This report concludes with recommendations concerning the need for a nursing facility wage index and case-mix adjustment in Medicare's payment policy. When the Secretary's report is released, the Commission will submit comments to the Senate Committee on Finance and the House Committee on Ways and Means. (3/92)

C-92-02: Medicare Payment for Hospital Outpatient Services: The Views of the Prospective Payment Assessment Commission

The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to develop a model system for Medicare payment for hospital outpatient services. The Commission is required to submit an analysis of and comments on the proposal. This background report describes Medicare's outpatient payment policies, which may vary by site of care and type of service. Ambulatory surgery and radiology are used to discuss problems with the current payment policy. The report concludes with nine recommendations for outpatient payment policy reform. When the Secretary's report is released, the Commission will submit its comments. (3/92)

C-92-03: Optional Hospital Payment Rates for Private Payers Based on Medicare's Methods (As specified in H.R. 3626)

This report addresses the development and impact of a system of Medicare-based rates for optional use by private insurers to control the growth in their payments to hospitals. The first part of the report discusses the design decisions that would need to be made, the steps necessary for orderly implementation of the system, and the administrative processes for ongoing operation of the system. The second part presents data on cost shifting in the hospital industry, and then uses these and other data to estimate the savings that would result from using optional rates under several different sets of assumptions. It also includes a discussion of the effects of optional rates on hospitals, private and government insurers, other providers, and patients. (3/92)

C-92-04: End-Stage Renal Disease Payment Policy

The Omnibus Budget Reconciliation Act of 1990 required the Commission to conduct a study to determine the costs, services, and profits associated with various modalities of dialysis treatments provided to end-stage renal disease patients. This study is the basis for recommendations regarding the method and level of payments for the facility component of dialysis services beginning in fiscal year 1993. The methodology to be used to update payment for subsequent fiscal years is included. As part of its annual March report, starting with fiscal year 1993, ProPAC is required to report its recommendations to Congress on an appropriate payment update factor. (6/92)

C-92-05: Interim Report on Payment Reform for PPS-Excluded Facilities

The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to develop a proposal to modify the current system under which PPS-excluded hospitals receive payment for the operation and capital-related costs of inpatient hospital services under Part A of the Medicare program. Alternatively, the Secretary could propose a system with payments made on the basis of nationally determined average standardized amounts. Although the Secretary has not submitted her proposal, the Commission prepared this background report. When the Secretary's report is released, the Commission will analyze it and submit comments to the Senate Committee on Finance and the House Committees on Ways and Means, and Energy and Commerce. (10/92)

C-93-01: Global Budgeting: Design and Implementation Issues

In response to a request from the House Committee on Ways and Means, Subcommittee on Health, the Commission examined the implementation of a global budgeting system. ProPAC focused on the system's application to hospitals and other institutional health care services. The report addresses issues involved in the allocation of a national budget among types of health care services, the availability of data to support the system, and the

mechanisms for ensuring that budget targets are met. (7/93)

C-94-01: Analysis of Medicaid Disproportionate Share Payment Adjustments

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) required ProPAC to conduct a study of Medicaid disproportionate share payment adjustments. This study examines the feasibility and desirability of establishing maximum and minimum payment adjustments for hospitals deemed disproportionate share hospitals. It also assesses criteria (other than existing ones) that are appropriate for designating disproportionate share hospitals under Section 1923 of the Social Security Act. The report was submitted to the Senate Committee on Finance and the House Committee on Energy and Commerce. (1/94)

C-94-02: Interim Analysis of Payment Reform for Home Health Services

The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to develop a proposal to modify the current system under which Medicare pays for home health services or a proposal to replace such system with a prospective payment system. The Commission is required to submit an analysis of and comments on the proposal to the Senate Committee on Finance and the House Committee on Ways and Means. This background report describes Medicare's home health benefit, payment method, use, and agency costs and payments. Federal and state regulations affecting access and quality of care also are discussed. When the Secretary's report is released, the Commission will submit comments to the Senate Committee on Finance and the House Committee on Ways and Means. (3/94)

C-95-01: Analysis of the Secretary's Proposal for Medicare Payment for Hospital Outpatient Services

The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to develop, and the Commission comment on, a model system for Medicare payment for hospital outpatient services. This report describes Medicare's payment policies for outpatient services, documents the increase in outpatient expenditures, and identifies problems related to the current payment system. The Secretary's proposed reforms are discussed, and three recommendations for the Congress and the Secretary are included. (7/95)

Pending

Analysis of the Secretary's Proposal for Skilled Nursing Facility Payment Reform

The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to develop a proposal to modify the current system under which skilled nursing facilities receive payment for extended care services under Medicare Part A or a proposal to replace this system with a prospective payment system. The Commission is required to submit an analysis of and comments on the proposal to the Senate Committee on Finance and the House Committees on Ways and Means, and Energy and Commerce. (This report will be issued after the Secretary's proposal becomes available.)

Analysis of the Secretary's Proposal for Payment Reform for PPS-Excluded Facilities

The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to develop a proposal to modify the current system under which PPS-excluded hospitals receive payment for the operation and capital-related costs of inpatient hospital services under Part A of the Medicare program. Alternatively, the Secretary could propose a system with payments made on the basis of nationally determined average standardized amounts. The Commission is required to submit an analysis of and comments on the Secretary's proposal to the Senate Committee on Finance and the House Committees on Ways and Means, and Energy and Commerce. (This report will be issued after the Secretary's proposal becomes available.)

Analysis of the Secretary's Proposal for Home Health Service Payment Reform

The Omnibus Budget Reconciliation Act of 1990 required the Secretary of Health and Human Services to develop a proposal to modify the current system under which Medicare pays for home health services or a proposal to replace such system with a prospective payment system. The Commission is

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required to submit an analysis of and comments on the proposal to the Senate Committee on Finance and the House Committee on Ways and Means. (This report will be issued after the Secretary's proposal becomes available.)

Analysis of the Secretary's Legislative Proposal Eliminating Separate Average Standardized Amounts

The Omnibus Budget Reconciliation Act of 1989 required the Secretary of Health and Human Services to prepare a legislative proposal eliminating separate average standardized amounts for hospitals located in large urban, other urban, and rural areas. It also directed ProPAC to submit a report to Congress analyzing this proposal and its impact on hospitals. (This report will be issued after the Secretary's proposal becomes available. It should be noted that in OBRA 1990, Congress mandated the elimination of the separate rural standardized payment amount by fiscal year 1995.)

Appendix B. Biographical Sketches of Commissioners

Stuart H. Altman, Chairman

Stuart H. Altman is the Sol C. Chaikin Professor of National Health Policy at the Florence Heller Graduate School of Social Policy at Brandeis University. An economist whose research interests are primarily in the area of Federal health policy, he has been at Brandeis since 1977. Between 1971 and 1976, Dr. Altman was deputy assistant secretary for planning and evaluation/health at the Department of Health, Education, and Welfare (now the Department of Health and Human Services). From 1973 to 1974, he also served as the deputy director for health of the President's Cost of Living Council, where he was responsible for developing the council's program on health care cost containment. Dr. Altman is a member of the Institute of Medicine of the National Academy of Sciences and a former member of its governing council, and serves on the board of Beth Israel Hospital (Boston). He is a past president of the Association for Health Services Research and a former board member of the Robert Wood Johnson Clinical Scholars Program. He has testified before the Congress on a wide range of health policy issues and has written an array of articles in the field. Dr. Altman received a B.B.A. from the City College of New York, and both an M.A. and a Ph.D. in economics from the University of California, Los Angeles.

Susan S. Bailis

Susan S. Bailis is president and chief operating officer of The A•D•S Group, which specializes in long-term care and senior living. From 1983 to 1985, Ms. Bailis was associate director of New England Medical Center, where she managed the hospital's entry into the long-term care field. Earlier, she was director of social services at the medical center. Ms. Bailis has held a number of academic appointments, most recently as assistant professor of psychiatry at Tufts University School of Medicine. She serves on the boards of several hospitals and has held leadership positions in many local and national professional and community organizations. These include the executive committee of the American Health Care Association, president of the Massachusetts Federation of Nursing Homes, the board of the Alzheimer's Disease and Related Disorders Association, the board of Simmons College, the board of overseers of the Florence Heller School at Brandeis University, secretary of the National Association of Social Workers, and president-elect of the Society for Hospital Social Work Directors of the American Hospital Association. She is a member of the Business Leadership Forum and Women's Leadership Forum of the Democratic National Committee. She also served as a member of the Massachusetts Medicaid State Advisory Board. Ms. Bailis has published and lectured widely on health care and social welfare policy. She received a B.A. from Brandeis University and an M.S.W. from Simmons College School of Social Work.

James D. Bernstein

James D. Bernstein is director of the North Carolina Office of Rural Health and Resources Development, which has established 65 community-based health centers and recruited more than 1,100 providers to the state since 1973. Previously, Mr. Bernstein administered a 40-bed hospital and eight health centers for the Indian Health Service. He has held a variety of professional positions, including chairman of the Rural Health Care Advisory Panel of the Office of Technology Assessment. He currently is national program director for the Robert Wood Johnson Foundation initiative, Practice Sites: State Primary Care Development Strategies. Mr. Bernstein received a B.A. from the Johns Hopkins University and an M.H.A. from the University of Michigan.

Clay D. Edmands

Clay D. Edmands is president of Salina Regional Health Center in Salina, Kansas, an acute care rural referral center. His prior experience includes several years with the Fairview Hospital System in Minneapolis, Minnesota, where he held various positions, among them administrator for development and operations of regional health management and supportive services. Mr. Edmands was on the board of the Kansas Hospital Association from 1980 to

1992, serving as chairman, treasurer, and member of the executive committee. In addition to two terms on a regional policy advisory board of the American Hospital Association, Mr. Edmands has been board president of the Health Systems Agency of Western Kansas. Other community involvements include the Salina health education board and Voluntary Hospitals of America. Currently a preceptor for the University of Kansas program in health care administration and chair of the university's health care services advisory board, Mr. Edmands formerly was a faculty preceptor for the University of Minnesota independent study program in hospital administration. He holds a B.S. in business administration from the University of Kansas and an M.H.A. from the University of Minnesota.

Spencer Johnson

Spencer Johnson has been president of the Michigan Health and Hospitals Association since 1985. Previously, he was executive vice president of the Hospital Association of New York State. Mr. Johnson's prior experience includes staff positions on the U.S. Senate Committee on Human Resources and in the U.S. House of Representatives. He was associate director of the Domestic Council for Health, Social Security, and Income Assistance from 1976 to 1977, where he was responsible for policy planning and development for President Gerald Ford. Mr. Johnson has been a member of the American Hospital Association's State Issues Forum and Council on Allied and Government Relations. He has served on various boards, including those of the Albany Medical College, Washington Hospital Center, the Alpha Center for Health Planning, and the Genesee Regional Health Planning Council. Mr. Johnson received a B.A. in journalism from St. Bonaventure University and an M.P.A. in health policy and planning from Cornell University.

Clark E. Kerr

Clark E. Kerr is president of ConsumerFirst, a nonprofit public benefit corporation, and is chief executive officer of ConsumerFirst Television. He chairs the California Health Policy and Data Advisory Commission and the State of California Health Information Committee. He also chairs the Consumer Experience Studies Committee of the Health Benefits Advisory Council for the California Public Employees Retirement System. In addition, Mr. Kerr is executive producer and cohost of Health Upbeat, a television series providing information on health care quality, access, and costs to the public. Before joining ConsumerFirst, he held various positions at Bank of America, including vice president of government relations, manager of corporate health programs, and manager of benefits planning. He is the immediate past president of the California Business Group on Health. Mr. Kerr received a B.A. from the University of California, Davis, and an M.B.A. from the University of California, Berkeley.

James R. Kimmey

James R. Kimmey is vice president for health sciences and professor of public health at the St. Louis University Health Sciences Center, as well as professor of community and family medicine at the St. Louis University School of Medicine. In addition, Dr. Kimmey serves as chair and chief executive officer of SLUCare, the clinical services division of the university. He has taught at the University of Wisconsin, the Johns Hopkins University, New York University, and Columbia University. He was administrator of the Division of Health Policy and Planning of the state of Wisconsin and executive director of the American Public Health Association in New York and Washington State. Dr. Kimmey served as president of the American Health Planning Association (1980–81) and as a member of its board of directors. Former editor of *Health Planning Memorandum* and managing editor of the *American Journal of Public Health*, he has written extensively on health planning and other health policy topics. Dr. Kimmey received B.S., M.S., and M.D. degrees from the University of Wisconsin and an M.P.H. from the University of California, Berkeley.

Judith R. Lave

Judith R. Lave is professor of health economics and codirector of the Center for Research on Health Care at the University of Pittsburgh. Her primary academic appointment is in the Graduate School of Public Health, but she holds secondary appointments in the Department of Psychiatry, Department of Economics, and the Katz Graduate School of Business. She is a member of the research study section of the Agency for Health Care Policy and

Research and of the Institute of Medicine's report review committee. Formerly, Dr. Lave was a faculty member at Carnegie-Mellon University. At the Department of Health and Human Services, she was director of the Division of Economic and Quantitative Analysis in the Office of the Deputy Assistant Secretary and director of the Office of Research in the Health Care Financing Administration. A charter member of the Federal government's Senior Executive Service, Dr. Lave is also a member of the Institute of Medicine of the National Academy of Sciences and the National Academy of Social Insurance. She is a past president of the Association for Health Services Research and the Foundation for Health Services Research. In addition, Dr. Lave chaired the technical panel on health and was a member of the expert panel on income and health care for the Advisory Council on Social Security. She serves on the editorial boards of both the *Journal of Health Politics, Policy and Law* and the Health Administration Press. Dr. Lave has served as a consultant to private and public agencies in the United States and Canada. She received a B.A. from Queens University in Canada, from which she also holds an honorary LL.D., and a Ph.D. in economics from Harvard University.

Hugh W. Long

Hugh W. Long is associate professor of health systems management at the Tulane University School of Public Health and Tropical Medicine. He also holds appointments with Tulane's Freeman School of Business, School of Law, and Graduate Faculty. Dr. Long has taught at Yale University, Stanford University, San Jose State University, and Ohio State University. He is a member of the Medicare Geographic Classification Review Board. Dr. Long has served as a witness and ad hoc adviser on health care financing to the U.S. House of Representatives' Committee on Ways and Means and to the U.S. Senate Committee on Finance. He has written numerous articles on health care financing and management and serves on the editorial board of *Decisions in Imaging Economics*. Dr. Long is the faculty director of Tulane's Master of Medical Management degree program for physicians. He is a member of the Louisiana bar. Dr. Long received a B.A. from Ohio State University, an M.B.A. and a Ph.D. in business administration and finance from Stanford University, and a J.D. from the Tulane University School of Law.

Robert J. Myers

Robert J. Myers was chief actuary of the Social Security Administration from 1947 to 1970 and deputy commissioner of Social Security from 1981 to 1982. Currently, he is a member of the Committee of Actuaries of the United Nations Joint Staff Pension Fund, as well as president of the International Fisheries Commissions Pension Society. A trustee for several organizations, including the investment program (mutual funds) of the American Association of Retired Persons, Dr. Myers also serves on the board of advisers of Studies on Smoking. An active participant in retirement and pension plan issues, Dr. Myers chaired the Commission on Railroad Retirement Reform (1988–90) and the Railroad Unemployment Compensation Committee (1983–85). He served on the Commission on the Social Security "Notch" Issue (1993–94) and was executive director of the National Commission on Social Security Reform (1982–83). In addition, Dr. Myers has served as an actuarial consultant to various congressional committees, as a technical adviser on Social Security and pension programs to numerous foreign countries, and as president of both the American Academy of Actuaries and the Society of Actuaries. He has published widely on topics related to Social Security and retirement, and is professor emeritus at Temple University. He received a B.S. degree from Lehigh University, an M.S. degree from the University of Iowa, and honorary degrees from Lehigh University and Muhlenberg College.

Donald R. Oder

Donald R. Oder is executive vice president and chief operating officer of Rush-Presbyterian-St. Luke's Medical Center in Chicago, where he formerly was senior vice president. Before that, he was audit manager with Arthur Andersen & Co. in Chicago. Mr. Oder has held various academic appointments and currently is a professor in the Department of Health Systems Management at the Rush University College of Health Sciences. He is a member of and has held leadership positions in several professional associations, including the American College of Healthcare Executives, the American Hospital Association, the Illinois Hospital Association, Voluntary Hospitals of America, the American Institute of Certified Public Accountants, and the Illinois C.P.A. Society. He has served

on the board of directors of the Better Business Bureau of Metropolitan Chicago, Inc., and on the occupational health committee of the Chicago Association of Commerce and Industry. Mr. Oder received a B.S. from Wichita State University, a C.P.A. certificate from the University of Illinois, and an M.B.A. from the University of Chicago.

Glenda Rosenbloom

Glenda Rosenbloom has been vice president of prospective payment for American Medical International since 1983. Previously, she was health care consulting manager at Ernst & Whinney, where she was responsible for training hospital personnel implementing the Medicare prospective payment system. From 1972 to 1982, Ms. Rosenbloom was senior director for Medicare provider payment at the Blue Cross Blue Shield Association. Before that, she was audit supervisor at Peat, Marwick, Mitchell. She cochaired the Medicare Technical Advisory Group, which includes senior officials from the Health Care Financing Administration, the hospital industry, peer review organizations, and fiscal intermediaries. Ms. Rosenbloom served on the board of the Federation of American Health Systems, chaired its legislative committee, and was vice chair of its health care financing committee. She received a B.S. from the University of Illinois and is a certified public accountant.

J. Michael Sadaj

J. Michael Sadaj is a physician in private practice and a member of Rocky Mountain Clinic in Butte, Montana, where he specializes in internal medicine and pulmonary diseases. He is vice president and treasurer of the Montana Physicians Organization's medical service organization. He has served as secretary-treasurer, vice president, and president of St. James Community Hospital medical staff, as well as chief of the Department of Medicine, and is currently chairman of the credentialing committee. From 1979 to 1990, Dr. Sadaj was medical director of respiratory therapy and the pulmonary laboratory at St. James. For several years, he has served on the Occupational Diseases Board of the state of Montana. A past president of the Montana Medical Association (1988–89), Dr. Sadaj was a member of the executive committee from 1985 to 1995. In addition, he has served as a delegate to the American Medical Association Resident Physician Section, Young Physician Section, and the House of Delegates, and from 1977 to 1979, was the resident member on the organization's Council on Constitution and Bylaws. Dr. Sadaj is a founding member of the board of directors of the Montana Professional Assistance Program and was a member of the Rural Physician Retention Trust Fund Advisory Board. In 1984, he was elected to the Butte-Silver Bow Government Study Commission. From 1974 to 1979, Dr. Sadaj was a resident in internal medicine and a fellow in pulmonary diseases at the University of Nebraska Medical Center. He received B.S. and M.D. degrees from the University of Nebraska.

Gerald M. Shea

Gerald M. Shea is assistant to the president for government affairs of the American Federation of Labor-Congress of Industrial Organizations. Previously, he has served as executive assistant to the president, executive assistant to the secretary-treasurer, and director of the employee benefits department of the A.F.L.-C.I.O., as well as head of the A.F.L.-C.I.O.'s health care reform campaign. His prior experience includes 12 years with the national office of the Service Employees International Union, where he held various positions, including assistant to the president for government affairs and health care division director. Before that, he was executive director and business manager of two local union offices. Mr. Shea is a member of the Advisory Council on Social Security. He received a B.A. from Boston College.

Roxane B. Spitzer

Roxane B. Spitzer is professor and associate dean for Practice Management at Vanderbilt University School of Nursing, professor of management at the Owen School of Vanderbilt, and executive director of University Community Health Systems. Previously, she was vice president of managed care at MEDICUS Systems. She also has been corporate vice president of St. Joseph Health System in Orange, California, and chief operating officer of the Good Samaritan Hospital in Los Angeles. She holds various professorships at Texas Tech University Health Sciences Center; University of Southern California; University of California, Los Angeles; and Vanderbilt University. From 1981 to 1988, Dr. Spitzer was vice president, patient care services, at

Cedars-Sinai Medical Center. Previously, she was director of nursing and practiced nursing in both inpatient and public health settings. She is a fellow of the American Academy of Nursing, a diplomate of the American College of Healthcare Executives, and serves on many other boards. Dr. Spitzer has written and spoken extensively on such issues as managing nonprofit organizations, cost containment, quality and productivity, nursing in the 1990s, and strategic management and leadership. She received a B.S. from Adelphi University, an M.A. in nursing service administration from Columbia University, and both an M.A. in management and an M.B.A. from Claremont Graduate School. Dr. Spitzer holds a Ph.D. in management from the Peter Drucker Management Center, Claremont Graduate School.

James R. Tallon Jr.

James R. Tallon Jr. is president of the United Hospital Fund of New York. He also chairs the Kaiser Commission on the Future of Medicaid and is a visiting lecturer at the Harvard University School of Public Health. In addition, he is a member of the board of commissioners of the Joint Commission on the Accreditation of Healthcare Organizations. Prior to joining the United Hospital Fund, he was the majority leader of the New York State Assembly, where he served for 19 years beginning in 1975. Mr. Tallon was a member of the executive committee of the National Academy for State Health Policy and served as liaison to the President's Task Force on Health Care Reform from the National Conference of State Legislatures. He also was a member of the Governor's Health Care Advisory Board's Task Force on the President's Health Care Plan in New York and chaired the committee on Medicaid of the Health Policy Agenda for the American People. Before his election to the Assembly, Mr. Tallon was the executive director of the NY-PENN Health Planning Council, one of New York's eight regional health planning agencies. Mr. Tallon received a B.A. from Syracuse University and completed graduate work at the Maxwell School of Citizenship and Public Affairs. He received an M.A. from Boston University.

Jae L. Wittlich

Jae L. Wittlich is president and chief operating officer, group operations, CNA Insurance Companies. He also served as vice president of the group benefits department from 1985 to 1990 and as vice president of the group operations division from 1977 to 1985. Before joining CNA Insurance, Mr. Wittlich was with Allstate for 12 years, most recently as assistant vice president of group life and health operations. He is currently vice chairman of the board of directors of the Health Insurance Association of America. Besides being a member of the executive committee and board of directors of the Association of Private Pension and Welfare Plans, he serves on the boards of directors of AmeriChoice Corporation; the Foundation for Health Enhancement; Managed Healthcare Systems of New York; and Private Healthcare Systems, Inc. In addition, Mr. Wittlich has served on many other industry association committees and lectured frequently on health care topics. He received the 1990 Health Insurance Association of America's Founders Medal. Mr. Wittlich is a fellow of the Society of Actuaries and a member of the American Academy of Actuaries. He holds B.A. and M.A. degrees from the University of Michigan.

Appendix C. Statutory Mandate of the Commission

The Congress established the Prospective Payment Assessment Commission (ProPAC) in Public Law 98-21 (the Social Security Amendments of 1983) on April 20, 1983. The current responsibilities of ProPAC are set forth in sections 1862(a) and 1886 of the Social Security Act. Further responsibilities are set forth in various Acts and conferences reports. Below are the passages of the relevant legislative sources, as amended through 1994.

Section 1886(d) of the Social Security Act

(4)(C)(i) The Secretary shall adjust the classifications and weighting factors established under subparagraphs (A) and (B) [DRG classifications], for discharges in fiscal year 1988 and at least annually thereafter, to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources.

(ii) For discharges in fiscal year 1990, the Secretary shall reduce the weighting factor for each diagnosis-related group by 1.22 percent.

(iii) Any such adjustment under clause (i) for discharges in a fiscal year (beginning with fiscal year 1991) shall be made in a manner that assures that the aggregate payments under this subsection for discharges in the fiscal year are not greater or less than those that would have been made for discharges in the year without such adjustment.

(iv) The Secretary shall include recommendations with respect to adjustments to weighting factors under clause (i) in the annual report to Congress required under subsection (e)(3)(B).

Section 1886(e)(2) through (6) of the Social Security Act

(2)(A) The Director of the Congressional Office of Technology Assessment (hereinafter in this subsection referred to as the "Director" and the "Office," respectively) shall provide for appointment of a Prospective Payment Assessment Commission (hereinafter in this subsection referred to as the "Commission"), to be composed of independent experts appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service). The Commission shall review the applicable percentage increase factor described in subsection (b)(3)(B) and make recommendations to the [Congress] on the appropriate percentage change which should be effected for hospital inpatient discharges under subsections (b) and (d) for fiscal years beginning with fiscal year 1986. In making its recommendations, the Commission shall take into account changes in the hospital market-basket described in subsection (b)(3)(B), hospital productivity, technological and scientific advances, the quality of health care provided in hospitals (including the quality and skill level of professional nursing required to maintain quality care), and long-term cost-effectiveness in the provision of inpatient hospital services.

(B) In order to promote the efficient and effective delivery of high-quality health care services, the Commission shall, in addition to carrying out its functions under subparagraph (A), study and make recommendations for each fiscal year regarding changes in each existing reimbursement policy under this title under which payments to an institution are based upon prospectively determined rates and the development of new institutional reimbursement policies under this title, including recommendations related to payments during such fiscal year under the prospective payment system established under this section for determining payments for the operating costs of inpatient hospital services, including changes in the number of diagnosis-related groups used to classify inpatient hospitals discharges under subsection (d), adjustments to such groups to reflect severity of illness, and changes in the methods by which hospitals are reimbursed for capital-related costs, together with general recommendations on the effectiveness and quality of health care delivery systems in the United States and the effects on such systems of institutional reimbursements under this title.

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(C) By not later than June 1 of each year, the Commission shall submit a report to Congress containing an examination of issues affecting health care delivery in the United States, including issues relating to—

(i) trends in health care costs;

(ii) the financial condition of hospitals and the effect of the level of payments made to hospitals under this title on such condition;

(iii) trends in the use of health care services; and

(iv) new methods used by employers, insurers, and others to constrain growth in health care costs.

(3)(A) The Commission, not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1986) shall report its recommendations to Congress on an appropriate change factor which should be used for inpatient hospital services in that fiscal year, together with its general recommendations under paragraph (2)(B) regarding the effectiveness and quality of health care delivery systems in the United States.

(B) The Secretary, not later than April 1, 1987, for fiscal year 1988 and not later than March 1, before the beginning of each fiscal year (beginning with fiscal year 1989), shall report to the Congress the Secretary's initial estimate of the percentage change that the Secretary will recommend under paragraph (4) with respect to that fiscal year.

(4)(A) Taking into consideration the recommendations of the Commission, the Secretary shall recommend for each fiscal year (beginning with fiscal year 1988) an appropriate change factor for inpatient hospital services for discharges in that fiscal year which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. The appropriate change factor may be different for all large urban subsection (d) hospitals, other urban subsection (d) hospitals, urban subsection (d) Puerto Rico hospitals, rural subsection (d) hospitals, and rural subsection (d) Puerto Rican hospitals, and all other hospitals and units not paid under subsection (d), and may vary among such other hospitals and units.

(B) In addition to the recommendation made under subparagraph (A), the Secretary shall, taking into consideration the recommendations of the Commission under paragraph (2)(B), recommend for each fiscal year (beginning with fiscal year 1992) other appropriate changes in each existing reimbursement policy under this title under which payments to an institution are based upon prospectively determined rates.

(5) The Secretary shall cause to have published in the *Federal Register*, not later than—

(A) the May 1 before each fiscal year (beginning with fiscal year 1986), the Secretary's proposed recommendations under paragraph (4) for that fiscal year for public comment, and

(B) the September 1 before such fiscal year after such consideration of public comment on the proposal as is feasible in the time available, the Secretary's final recommendations under such paragraph for that year.

The Secretary shall include in the publication referred to in subparagraph (A) for a fiscal year the report of the Commission's recommendations submitted under paragraph (3) for that fiscal year. To the extent that the Secretary's recommendations under paragraph (4) differ from the Commission's recommendations for that fiscal year, the Secretary shall include in the publication referred to in subparagraph (A) an explanation of the Secretary's grounds for not following the Commission's recommendations.

(6)(A) The Commission shall consist of 17 individuals. Members of the Commission shall first be appointed no later than April 1, 1984, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than seven members may expire in any one year.

(B) The membership of the Commission shall include individuals with national recognition for their expertise in health economics, health facility management, reimbursement of health facilities or other providers of services which reflect the scope of the Commission's responsibilities, and other related fields, who provide a mix of different professional, broad geographic representation, and a balance between urban and rural representatives, including physicians and registered professional

nurses, employers, third party payors, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and individuals having expertise in the research and development of technological and scientific advances in health care.

(C) Subject to such review as the Office deems necessary to assure the efficient administration of the Commission, the Commission may—

(i) employ and fix the compensation of an Executive Director (subject to the approval of the Director of the Office) and such other personnel (not to exceed 25) as may be necessary to carry out its duties (without regard to the provisions of the title 5, United States Code, governing appointments in the competitive service);

(ii) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(iii) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(iv) make advance, progress, and other payments which relate to the work of the Commission;

(v) provide transportation and subsistence for persons serving without compensation; and

(vi) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

Section 10(a)(1) of the Federal Advisory Committee Act shall not apply to any portion of a Commission meeting if the Commission, by majority vote, determines that such portion of such meeting should be closed.

(D) While serving on the business of the Commission (including travel-time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and his regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

(E) In order to identify medically appropriate patterns of health resources use in accordance with paragraph (2), the Commission shall collect and assess information on medical and surgical procedures and services, including information on regional variations of medical practice and lengths of hospitalization and on other patient-care data, giving special attention to treatment patterns for conditions which appear to involve excessively costly or inappropriate services not adding to the quality of care provided. In order to assess the safety, efficacy, and cost-effectiveness of new and existing medical and surgical procedures, the Commission shall, in coordination to the extent possible with the Secretary, collect and assess factual information, giving special attention to the needs of updating existing diagnosis-related groups, establishing new diagnosis-related groups, and making recommendations on relative weighting factors for such groups to reflect appropriate differences in resource consumption in delivering safe, efficacious, and cost-effective care. In collecting and assessing information, the Commission shall—

(i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this paragraph;

(ii) carry out, award grants or contracts for, original research and experimentation, including clinical research, where existing information is inadequate for the development of useful and valid guidelines by the Commission; and

(iii) adopt procedures allowing any interested party to submit information with respect to medical

and surgical procedures and services (including new practices, such as the use of new technologies and treatment modalities), which information the Commission shall consider in making reports and recommendations to the Secretary and Congress.

(F) The Commission shall have access to such relevant information and data as may be available from appropriate Federal agencies and shall assure that its activities, especially the conduct of original research and medical studies, are coordinated with the activities of Federal agencies.

(G)(i) The Office shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon its request.

(ii) In order to carry out its duties under this paragraph, the Office is authorized to expend reasonable and necessary funds as mutually agreed upon by the Office and the Commission. The Office shall be reimbursed for such funds by the Commission from the appropriations made with respect to the Commission.

(H) The Commission shall be subject to periodic audit by the General Accounting Office.

(I)(i) There are authorized to be appropriated such sums as may be necessary to carry out the provision of this paragraph.

(ii) Eighty-five percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 15 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

(J) The Commission shall submit requests for appropriations in the same manner as the Office submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Office.

Section 1862(a) of the Social Security Act

(a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,

(B) in the case of items and services described in section 1861(s)(10), which are not reasonable and necessary for the prevention of illness,

(C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness,

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the Prospective Payment Assessment Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1886(e)(6), . . .

Section 1135(d) of the Social Security Act

(6)(A) The Secretary shall develop a model system for the payment for outpatient hospitals services other than ambulatory surgery.

(B) The Secretary shall submit to Congress a report on the model payment system under subparagraph (A) by January 1, 1991.

(7) The Secretary shall solicit the views of the Prospective Payment Assessment Commission in developing the systems under paragraphs (1) and (6), and shall include in the Secretary's reports under this subsection any views the Commission may submit with respect to such systems.

Section 9114 of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99-272

(a) Disclosure of Information.—The Secretary of Health and Human Services shall make available to the Prospective Payment Assessment Commission, the Congressional Budget Office, and the Congressional Research Service the most current information on the payments being made under section 1886 of the Social Security Act to individual hospitals. Such information shall be made available in a manner that permits examination of the impact of such section on such hospitals.

(b) Confidentiality.—Information disclosed under subsection (a) shall be treated as confidential

and shall not be subject to further disclosure in a manner that permits the identification of individual hospitals.

Section 6003(i) of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239: Legislative Proposal Eliminating Separate Average Standardized Amounts

(1) In General.—The Secretary of Health and Human Services (hereafter referred to as the "Secretary") shall design a legislative proposal eliminating the system of determining separate standardized amounts for subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act) classified as being located in large urban, other urban, or rural areas under section 1886(d)(2)(D) of such Act, and shall include in such proposal the following—

(A) A transition period beginning in fiscal year 1992 during which a single rate for determining payment to hospitals in all areas shall be phased in with such single rate to be completely in effect by fiscal year 1995.

(B) Recommendations, where appropriate, for modifying or maintaining additional payments or adjustments under title XVIII of the Social Security Act for teaching hospitals, rural referral centers, sole community hospitals, disproportionate share hospitals, and outlier cases, and for creating additional payments or adjustments where deemed appropriate by the Secretary.

(C) Recommendations with respect to recalculating standardized amounts to reflect information from more recent cost reporting periods.

(D) Recommendations, where appropriate, for modifying reimbursement for hospitals that are not subsection (d) hospitals under title XVIII of such Act.

(E) A recommendation for a methodology to reflect the severity of illness of different patients within the same diagnosis related group (as determined in section 1886(d)(4)(B) of such Act).

(2) Report to Congress and ProPAC.—(A) Not later than October 1, 1990, the Secretary shall submit the proposal described in paragraph (1) and an accompanying analysis of the impact of the proposed elimination of separate average standardized amounts on various categories of hospitals to Congress and the Prospective Payment Assessment Commission.

(B) Not later than February 1, 1991, the Prospective Payment Assessment Commission and the Director of the Congressional Budget Office shall each prepare and submit to Congress a report analyzing the legislative proposal submitted under subparagraph (A), and shall include in such report an analysis of the probable impact of such legislation on hospitals participating in the Medicare program.

Section 6003(j) of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239: ProPac Study of Payments to Rural Sole Community Hospitals and Small Rural Hospitals

(1) Study.— The Prospective Payment Assessment Commission (hereinafter referred to as the "Commission") shall conduct a study of the feasibility and desirability of—

(A) using a cost-based reimbursement system to determine the amount of payments to be made under the Medicare program to small rural hospitals and rural sole community hospitals for the operating costs of inpatient hospital services;

(B) developing and applying alternative definitions of market share for use in determining the eligibility of hospitals for classification as sole community hospitals under section 1886(d)(5) of the Social Security Act; and

(C) developing and applying a method for accounting for decreases in the number of inpatients served in determining payment to small rural hospitals under section 1886(d) of the Social Security Act for the operating costs of inpatient hospital services.

(2) Report.—By not later than May 1, 1990, the Commission shall submit a report to Congress on the study conducted under paragraph (1).

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Section 6011 of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239 Pass Through Payments for Hemophilia Inpatients

(a) Pass Through Payment for Hemophilia Inpatients.—The second sentence of section 1886(a)(4) of the Social Security Act . . . is amended to read as follows—

> For purposes of this section, the term "operating cost of inpatient hospital services" . . . does not include . . . costs with respect to administering blood clotting factors to individual with hemophilia.

(b) Determining Payment Amount.—The Secretary of Health and Human Services shall determine the amount of payment made to hospitals under part A of title XVIII of the Social Security Act for the costs of administering blood clotting factors to individuals with hemophilia by multiplying a predetermined price per unit of blood clotting factor (determined in consultation with the Prospective Payment Assessment Commission) by the number of units provided to the individual.

(c) Recommendations on Payments.—The Prospective Payment Assessment Commission and the Health Care Financing Administration shall develop recommendations with respect to payments under part A of title XVIII of the Social Security Act for the costs of administering blood clotting factors to individuals with hemophilia, and shall submit such recommendations to Congress not later than 18 months after the date of enactment of this Act.

Section 6137 of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239: ProPAC Study of Payments for Services in Hospital Outpatient Departments

(a) In General.—The Prospective Payment Assessment Commission shall conduct a study on payment under title XVIII of the Social Security Act for hospital outpatient services. Such study shall include an examination of—

(1) the sources of growth in spending for hospital outpatient services;

(2) the differences between the costs of delivering services in a hospital outpatient department as opposed to providing similar services in other appropriate settings (including ambulatory surgery centers and physician offices);

(3) the effects on outpatient hospital costs of the step-down method used to allocate hospital capital between inpatient and outpatient departments and the extent to which hospital outpatient costs were affected by the implementation of the prospective payment system of payment for inpatient hospital services and by increased review of such services by peer review organizations; and

(4) alternative methods for reimbursing hospitals for services in outpatient departments under the Medicare program, including prospective payment methods, fee schedules, and other such methods as the Commission may consider appropriate.

(b) Reports.—(1) By not later than July 1, 1990, the Commission shall submit a report to Congress on the study conducted under section (a) with respect to the portions of the study described in paragraphs (1), (2), and (3) of such subsection, and shall include in the report such recommendations as the Commission deems appropriate.

(2) By not later than March 1, 1991, the Commission shall submit a report to Congress on the study conducted under subsection (a) with respect to the portion of the study described in paragraph (4) of such subsection, and shall include such recommendations as the Commission deems appropriate.

Section 4002(d)(2) of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508: Study of the Area Wage Index Adjustments Based on Professional Occupational Component

(A) Study.—The Prospective Payment Assessment Commission shall examine available data from States and other sources measuring earnings and paid hours of employment of hospital workers by occupational category, and shall include in such examination an analysis of the impact of variation in occupational mix on the computation of the area wage index determined under section 1886(d)(3(E) of the Social Security Act.

(B) Report to Congress.—In its March 1991 report, the Commission shall include recommendations regarding the feasibility and desirability of modifying such area wage index to take into account occupational mix, including variations in occupational mix resulting from differences in State codes and requirements.

Section 4002(g)(4) of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508: ProPAC Study of Medicaid Payments to Hospitals

(A) Study.—The Prospective Payment Assessment Commission shall conduct a study of hospital payment rates under State plans for medical assistance under title XIX of the Social Security Act, and shall specifically examine in such study the relationship between payments under such plans and payments made to hospitals under title XVIII of such Act, and the financial condition of hospitals receiving payments under such plans, with particular attention to hospitals in urban areas which treat large number of individuals eligible for medical assistance under title XIX of such Act and other low-income individuals.

(B) Report.—By not later than October 1, 1991, the Commission shall submit a report to Congress on the study conducted under subparagraph (A) and shall include in such report such recommendations relating to requirements for payments to hospitals under title XIX of such Act as the Commission deems appropriate.

Section 4005(b) of the of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508: Development of National Prospective Payment Rates for Current Non-PPS Hospitals

(1) Development of Proposal.—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which hospitals that are not subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act) receive payment for the operating and capital-related costs of inpatient hospital services under part A of the Medicare program or a proposal to replace such system with a system under which such payments would be made on the basis of nationally-determined average standardized amounts. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the Medicare program;

(B) provide for adjustments to prospectively determined rates to account for changes in a hospital's case mix, severity of illness of patients, volume of cases, and the development of new technologies and standards of medical practice;

(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of stay or costs of treatment greatly exceed the length of stay or cost of treatment provided for under the applicable prospectively determined payment rate;

(D) take into consideration the need to adjust payments under the system to take into account factors such as a disproportionate share of low-income patients, costs related to graduate medical education programs, differences in wages and wage-related costs among hospitals located in various geographic areas, and other factors the Secretary considers appropriate, and

(E) provide for the appropriate allocation of operating and capital-related costs of hospitals not subject to the new prospective payment system and distinct units of such hospitals that would be paid under such system.

(2) Report.—(A) By not later than April 1, 1992, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(B) By not later than June 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

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Section 4008(k) of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508: Prospective Payment System for Skilled Nursing Facilities

(1) Development of Proposal.—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which skilled nursing facilities receive payment for extended care services under part A of the Medicare program or a proposal to replace such system with a system under which such payments would be made on the basis of prospectively determined rates. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the Medicare program without jeopardizing access to extended care services for individuals unable to care for themselves;

(B) provide for adjustments to prospectively determined rates to account for changes in a facility's case mix, volume of cases, and the development of new technologies and standards of medical practice;

(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of stay or costs of treatment greatly exceed the length of stay or cost of treatment provided for under the applicable prospectively determined payment rate;

(D) take into consideration the need to adjust payments under the system to take into account factors such as a disproportionate share of low-income patients, differences in wages and wage-related costs among facilities located in various geographic areas, and other factors the Secretary considers appropriate; and

(E) take into consideration the appropriateness of classifying patients and payments upon functional disability, cognitive impairment, and other patient characteristics.

(2) Reports.—(A) By not later than April 1, 1991, the Secretary (acting through the Administrator of the Health Care Financing Administration) shall submit any research studies to be used in developing the proposal under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(B) By not later than September 1, 1991, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(C) By not later than March 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

Section 4151(b)(2) of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508: Prospective Payment System for Hospital Outpatient Services

(A) Development of Proposal.—The Secretary of Health and Human Services shall develop a proposal to replace the current system under which payment is made for hospital outpatient services under title XVIII of the Social Security Act with a system under which such payments would be made on the basis of prospectively determined rates. In developing any proposal under this paragraph, the Secretary shall consider—

(i) the need to provide for appropriate limits on increases in expenditures under the Medicare program;

(ii) the need to adjust prospectively determined rates to account for changes in a hospital's outpatient case mix, severity of illness of patients, volume of cases, and the development of new technologies and standards of medical practice;

(iii) providing hospitals with incentives to control the costs of providing outpatient services;

(iv) the feasibility and appropriateness of including payment for outpatient services not currently paid on a cost-related basis under the Medicare

program (including clinical diagnostic laboratory tests and dialysis services) in the system;

(v) the need to increase payments under the system to hospitals that treat a disproportionate share of low-income patients, teaching hospitals, and hospitals located in geographic areas with high wages and wage-related costs;

(vi) the feasibility and appropriateness of bundling services into larger units, such as episodes or visits, in establishing the basic unit for making payments under the system; and

(vii) the feasibility and appropriateness of varying payments under the system on the basis of whether services are provided in a free-standing or hospital-based facility.

(B) Reports.—(i) By not later than January 1, 1991, the Administrator of the Health Care Financing Administration shall submit research findings relating to prospective payments for hospital outpatient services to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives. . . .

(ii) By not later than September 1, 1991, the Secretary shall submit the proposal developed under subparagraph (A) to such Committees.

(iii) By not later than March 1, 1992, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under subparagraph (A) to such Committees.

Section 4201(b) of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508: ProPAC Study on ESRD Composite Rates

(1) In General.—(A) Study.—The Prospective Payment Assessment Commission (in this subsection referred to as the "Commission") shall conduct a study to determine the costs and services and profits associated with various modalities of dialysis treatments provided to end stage renal disease patients provided under title XVIII of the Social Security Act.

(B) Recommendations.—Based on information collected for the study described in subparagraph (A), the Commission shall make recommendations to Congress regarding the method or methods and the levels at which the payments made for the facility component of dialysis services by providers of service and renal dialysis facilities under title XVIII of the Social Security Act should be established for dialysis services furnished during fiscal year 1993 and the methodology to be used to update such payments for subsequent fiscal years. In making recommendations concerning the appropriate methodology the Commission shall consider—

(i) hemodialysis and other modalities of treatment,

(ii) the appropriate services to be included in such payments,

(iii) the adjustment factors to be incorporated including facility characteristics, such as hospital versus free-standing facilities, urban versus rural, size and mix of services,

(iv) adjustments for labor and non-labor costs,

(v) comparative profit margins for all types of renal dialysis providers of service and renal dialysis facilities,

(vi) adjustments for patient complexity, such as age, diagnosis, case mix, and pediatric services, and

(vii) efficient costs related to high quality of care and positive outcomes for all treatment modalities.

(2) Report.—Not later than June 1, 1992, the Commission shall submit a report to the Committee on Finance of the Senate, and the Committees on Ways and Means and Energy and Commerce of the House of Representatives on the study conducted under paragraph (1)(A) and shall include in the report the recommendations described in paragraph (1)(B), taking into account the factors described in paragraph (1)(B).

(3) Annual Report.—The Commission, not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1993) shall report its recommendations to the Committee on Finance of the Senate and the Committees on Ways and

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Means and Energy and Commerce of the House of Representatives on an appropriate change factor which should be used for updating payments for services rendered in that fiscal year. The Commission in making such report to Congress shall consider conclusions and recommendations available from the Institute of Medicine.

Section 4207(c) of the Omnibus Budget Reconciliation Act of 1990, Pub. L. 101-508: Development of Prospective Payment System for Home Health Services

(1) Development of Proposal.—The Secretary of Health and Human Services shall develop a proposal to modify the current system under which payment is made for home health services under title XVIII of the Social Security Act or a proposal to replace such system with a system under which such payments would be made on the basis of prospectively determined rates. In developing any proposal under this paragraph to replace the current system with a prospective payment system, the Secretary shall—

(A) take into consideration the need to provide for appropriate limits on increases in expenditures under the Medicare program;

(B) provide for adjustments to prospectively determined rates to account for changes in a provider's case mix, severity of illness of patients, volume of cases, and the development of new technologies and standards of medical practice;

(C) take into consideration the need to increase the payment otherwise made under such system in the case of services provided to patients whose length of treatment or costs of treatment greatly exceed the length or cost of treatment provided for under the applicable prospectively determined payment rate;

(D) take into consideration the need to adjust payments under the system to take into account factors such as differences in wages and wage-related costs among agencies located in various geographic areas and other factors the Secretary considers appropriate; and

(E) analyze the feasibility and appropriateness of establishing the episode of illness as the basic unit for making payments under the system.

(2) Reports.—(A) By not later than April 1, 1993, the Secretary of Health and Human Services shall submit the research findings upon which the proposal described in paragraph (1) shall be based to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(B) By not later than September 1, 1993, the Secretary shall submit the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

(C) By not later than March 1, 1994, the Prospective Payment Assessment Commission shall submit an analysis of and comments on the proposal developed under paragraph (1) to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives.

H.R. Rep. No. 964, 101st Cong., 1st Sess. (1990)

(Report of the Committee of Conferees, Pub. L. 101-508)

In performing this function [developing and modification of reimbursement policies], the conferees intend that ProPAC would include in its analysis and recommendations, proposals for changes in policies regarding: (1) payment for inner-city hospitals, including appropriate recognition of bad debt and charity care costs; (2) payment for rural hospitals including recommendations on appropriate responses to issues affecting access to health care services in rural areas; and (3) policies which help constrain the costs of health care to employers, including changes in Medicare and its payment policies which may affect other payers.

S.R. Rep. No. 516, 101st Cong., 2nd Sess. (1990)

(Report of the Senate Committee on Appropriations, H.R. 5257)

The Committee, therefore, requests that ProPAC issue a report listing (1) the adjustments that have been made to PPS since its inception (for example changes in standardized amount, outlier pool, consideration of part-time labor); and (2) the amount of increased payments (taking inflation into

account) for PPS years 1-5 and what rural hospitals would have received if these adjustments had been in place from the system's beginning.

In addition, the Committee request that ProPAC in its 1991 report address in detail the impact of less-than-average patient volume on overhead costs and reimbursement, especially on small hospitals. This Committee remains concerned that the PPS system, which is based on averages, inherently is inappropriate to small-volume hospitals.

Given the history of inequitable inpatient payments and the widespread concern over new systems of outpatient payments, the Committee finds it is necessary to investigate whether outpatient payment systems also will be biased against smaller rural providers. The Committee requests that ProPAC in its 1991 report identify all potential outpatient payment biases against small rural hospitals, and recommend actions to correct them.

The Committee is concerned that the Federal Office of Rural Health Policy lacks essential resources such as computer capability in order to fulfill its statutory mandate to provide impact analyses of proposed Medicare and Medicaid regulations. The Committee instructs ProPAC to provide its resources to the Office of Rural Health Policy in order to facilitate these analyses. The Committee expects The Commission to provide technical assistance to the Office of Rural Health Policy.

The Committee urges ProPAC to continue to study the use of nurse practitioners and other nonphysician providers in alternative settings to acute care and long-term institutional care.

Section 3(d) of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. 102-234: Study of Medicaid DSH Payment Adjustments

(1) In General.—The Prospective Payment Assessment Commission shall conduct a study concerning—

(A) the feasibility and desirability of establishing maximum and minimum payment adjustments under section 1923(c) of the Social Security Act for hospitals deemed disproportionate share hospitals under State medicaid plans, and

(B) criteria (other than criteria described in clause (i) or (ii) of section 1923(f)(1)(D) of such Act) that are appropriate for the designation of disproportionate share hospitals under section 1923 of such Act.

(2) Items Included In Study.—The Commission shall include in the study—

(A) a comparison of the payment adjustments for hospitals made under such section and the additional payments made under title XVIII of such Act for hospitals serving a significantly disproportionate number of low-income patients under the medicare program; and

(B) an analysis of the effect the establishment of limits on such payment adjustments will have on the ability of the hospitals to be reimbursed for the resource costs incurred by the hospitals in treating individuals entitled to medical assistance under State medicaid plans and other low-income patients.

(3) Report.—Not later than January 1, 1994, the Commission shall submit a report on the study conducted under paragraph (1) to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives. Such report shall include such recommendations respecting the designation of disproportionate share hospitals and the establishment of maximum and minimum payment adjustments for such hospitals under section 1923 of the Social Security Act as may be appropriate.

H.R. Rep. No. 103-213, 103rd Cong., 1st Sess. (1993)

(Report of the Conference Committee, Omnibus Budget Reconciliation Act of 1993, Pub. L. 103-66)

The conferees note that the Prospective Payment Assessment Commission has expressed concern that the Secretary's outlier policy penalizes hospitals that receive a large number of transfer cases. The conferees expect that the Commission will evaluate whether the changes in outlier policy required by this Act will be sufficient to reduce the risk of large losses on transfer cases for such hospitals and make recommendations regarding whether additional changes in payment methodology would be appropriate.

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