Federal Register

Tuesday,
May 18, 2004

Book 2 of 2 Books
Pages 28195–28818

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CRF Part 403, et al.

Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 412, 413, 418, 460, 480, 482, 483, 485, and 489

[CMS–1428–P]

RIN 0938–AM80

Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates

AGENCY: Centers for Medicare and Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs to implement changes arising from our continuing experience with these systems; and to implement a number of changes made by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173), enacted on December 8, 2003. In addition, in the Addendum to this proposed rule, we describe the proposed changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for operating costs and capital-related costs. These proposed changes would be applicable to discharges occurring on or after October 1, 2004. We also are setting forth proposed rate-of-increase limits as well as proposed policy changes for hospitals and hospital units excluded from the IPPS that are paid on a reasonable cost basis subject to these limits.

Among the policy changes that we are proposing to make are: Changes to the classification of cases to the diagnosis-related groups (DRGs); changes to the long-term care (LTC)-DRGs and relative weights; changes in the wage data, labor-related share of the wage index, and the geographic area designations used to compute the wage index; changes in the qualifying threshold criteria for and the proposed approval of new technologies and medical services for add-on payments; changes to the policies governing postacute care transfers; changes to payments to hospitals for the direct and indirect costs of graduate medical education; changes to the payment adjustment for disproportionate share rural hospitals; changes in requirements and payments to critical access hospitals (CAHs); changes to the disclosure of information requirements for Quality Improvement Organization (QIOs); and changes in the hospital conditions of participation for discharge planning and fire safety requirements for certain health care facilities.

DATES: Comments will be considered if received at the appropriate address, as provided below, no later than 5 p.m. on July 12, 2004.

ADDRESSES:

Submitting Comments: We welcome comments from the public on all issues set forth in this proposed rule to assist in fully considering issues and developing policies. You can assist us by referencing the file code CMS–1428–P and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Submit electronic comments to: *http://www.accessdata.fda.gov/scripts/oc/dockets/commentdocket.cfm?AGENCY=CMS* or *www.regulations.gov.*

Mail written comments (an original and three copies) to the following address only:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1428–P, P.O. Box 8010, Baltimore, MD 21244–1850.

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

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or Room C5–14–03, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the Humphrey Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for commenters who wish to retain proof of filing by stamping in and keeping an extra copy of the comments being filed.)

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Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Inspection of Public Comments: All comments received before the close of the comment period will be available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. After the close of the comment period, CMS will post all electronic comments received before the close of the period on its public Web sites. Written comments received timely will be available for public inspection as they are received, generally beginning approximately 4 weeks after publication of a document, in room C5–12–08 of the Centers for Medicare & Medicaid Services, 7500 Security Blvd., Baltimore, MD, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. Please call (410) 786–7197 to schedule an appointment to view public comments.

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

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Security and Standards Group, Office of Regulations Development and Issuances, Room C4–24–02, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Attn: Dawn Willinghan, CMS–1428–P; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3001, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer.

FOR FURTHER INFORMATION CONTACT: Jim Hart, (410) 786–9520, Operating Prospective Payment, Diagnosis-Related Groups (DRGs), Wage Index, New Medical Services and Technology, Standardized Amounts, Hospital Geographic Reclassifications, Postacute Care Transfers, and Disproportionate Share Hospital Issues.

Tzvi Hefter, (410) 786–4487, Capital Prospective Payment, Excluded Hospitals, Graduate Medical Education, Critical Access Hospitals, and Long-Term Care (LTC)—DRGs Issues.

Mary Collins, (410) 786–3189, CAH Bed Limits and Distinct Part Unit Issues.

John Eppinger, (410) 786–4518, CAH Periodic Interim Payment Issues.

Maria Hammel, (410) 786–1775, Quality Improvement Organization Issues.

Siddhartha Mazumdar, (410) 786–6673, Rural Community Hospital Demonstration Project Issues.

Jeannie Miller, (410) 786–3164, Bloodborne Pathogens Standards, Hospital Conditions of Participation for Discharge Planning, and Fire Safety Requirements Issues.

Dr. Mark Krushat, (410) 786–6809, and Dr. Anita Bhatia, (410) 786–7236 Quality Data for Annual Payment Update Issues.

SUPPLEMENTARY INFORMATION:

Availability of Copies and Electronic Access

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Acronyms

ACGME—Accreditation Council on Graduate Medical Education
AHIMA—American Health Information Management Association
AHA—American Hospital Association
AOA—American Osteopathic Association
ASC—Ambulatory Surgical Center
BBA—Balanced Budget Act of 1997, Public Law 105–33
BIPA—Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Public Law 106–554
BLS—Bureau of Labor Statistics
CAH—Critical access hospital
CART—CMS Abstraction & Reporting Tool
CBSAs—Core-Based Statistical Areas
CC—Complication or comorbidity
CMS—Centers for Medicare & Medicaid Services
CMSA—Consolidated Metropolitan Statistical Area
COBRA—Consolidated Omnibus Reconciliation Act of 1985, Public Law 99–272
CoP—Condition of Participation
CPI—Consumer Price Index
CRNA—Certified registered nurse anesthetist
DRG—Diagnosis-related group
DSH—Disproportionate share hospital
ESRD—End-stage renal disease
FDA—Food and Drug Administration
FQHC—Federally qualified health center
FSES—Fire Safety Evaluation System
FTE—Full-time equivalent
FY—Federal fiscal year
GME—Graduate medical education
HCRIS—Hospital Cost Report Information System
HIPC—Health Information Policy Council
HIPAA—Health Insurance Portability and Accountability Act of 1996, Public Law 104–191
HHA—Home health agency
HPSA—Health Professions Shortage Area
ICD–9–CM—International Classification of Diseases, Ninth Revision, Clinical Modification
ICD–10–PCS—International Classification of Diseases, Tenth Edition, Procedure Coding System
ICF/MRs—Intermediate care facilities for the mentally retarded
IME—Indirect medical education
IPPS—Acute care hospital inpatient prospective payment system
IPF—Inpatient psychiatric facility
IRF—Inpatient rehabilitation facility
JCAHO—Joint Commission on the Accreditation of Healthcare Organizations
LAMA—Left Against Medical Advice
LTC–DRG—Long-term care diagnosis-related group
LTCH—Long-term care hospital
LSC—Life Safety Code
MCE—Medicare Code Editor
MCO—Managed care organization
MDC—Major diagnostic category
MDH—Medicare-dependent small rural hospital
MedPAC—Medicare Payment Advisory Commission
MedPAR—Medicare Provider Analysis and Review File
MEI—Medicare Economic Index
MGCRB—Medicare Geographic Classification Review Board
MMA—Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173
MPFS—Medicare Physician Fee Schedule
MSA—Metropolitan Statistical Area
NECMA—New England County Metropolitan Areas
NCHS—National Center for Health Statistics
NCVHS—National Committee on Vital and Health Statistics
NFPA—National Fire Protection Association
NPR—Notice of Program Reimbursement
NQF—National Quality Forum
NVHRI—National Voluntary Hospital Reporting Initiative
OES—Occupational Employment Statistics
OIG—Office of the Inspector General
OMB—Executive Office of Management and Budget
O.R.—Operating room
OSCAR—Online Survey Certification and Reporting (System)
OSHA—Occupational Safety and Health Act
PACE—Programs of All-Inclusive Care for the Elderly
PIP—Periodic interim payment
PMS—Performance Measurement System
PMSAs—Primary Metropolitan Statistical Areas
PPS—Prospective payment system
PRA—Per resident amount
ProPAC—Prospective Payment Assessment Commission
PRRB—Provider Reimbursement Review Board
PS&R—Provider Statistical and Reimbursement System
QIO—Utilization and Quality Control Quality Improvement Organization
RHC—Rural health clinic
RHQDAPU—Reporting Hospital Quality Data for Annual Payment Update
RRC—Rural referral center
SCH—Sole community hospital
SNF—Skilled nursing facility
SOCs—Standard occupational classifications
SOM—State Operations Manual
SSA—Social Security Administration
SSI—Supplemental Security Income
TEFRA—Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97–248
UHDDS—Uniform Hospital Discharge Data Set

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I. Background

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

The base payment rate is comprised of a standardized amount that is divided into a labor-related share and a nonlabor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located; and if the hospital is located in Alaska or Hawaii, the nonlabor-related share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If the hospital treats a high percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculations.

If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid under the IPPS (known as the indirect medical education (IME) adjustment). This percentage varies, depending on the ratio of residents to beds.

Additional payments may be made for cases that involve new technologies or medical services that have been approved for special add-on payments. To qualify, a new technology or medical service must demonstrate that it is a substantial clinical improvement over technologies or services otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment.

The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payment due is added to the DRG-adjusted base payment rate, plus any DSH, IME, and new technology or medical service add-on adjustments.

Although payments to most hospitals under the IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid the higher of a hospital-specific rate based on their costs in a base year (the higher of FY 1982, FY 1987, or FY 1996) or the IPPS rate based on the standardized amount. For example, sole community hospitals (SCHs) are the sole source of care in their areas, and Medicare-dependent, small rural hospitals (MDHs) are a major source of care for Medicare beneficiaries in their areas. Both of these categories of hospitals are afforded this special payment protection in order to maintain access to services for beneficiaries (although MDHs receive only 50 percent of the difference between the IPPS rate and their hospital-specific rates if the hospital-specific rate is higher than the IPPS rate).

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services ''in accordance with a prospective payment system established by the Secretary.'' The basic methodology for determining capital prospective payments is set forth in our regulations at 42 CFR 412.308 and 412.312. Under the capital PPS, payments are adjusted by the same DRG for the case as they are under the operating IPPS. Similar adjustments are also made for IME and DSH as under the operating IPPS. In addition, hospitals may receive an outlier payment for those cases that have unusually high costs.

The existing regulations governing payments to hospitals under the IPPS are located in 42 CFR Part 412, Subparts A through M.

2. Hospitals and Hospital Units Excluded From the IPPS

Under section 1886(d)(1)(B) of the Act, as amended, certain specialty hospitals and hospital units are excluded from the IPPS. These hospitals and units are: psychiatric hospitals and units; rehabilitation hospitals and units; long-term care hospitals (LTCHs); children's hospitals; and cancer hospitals. Various sections of the Balanced Budget Act of 1997 (Pub. L. 105–33), the Medicare, Medicaid and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106–113), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554) provide for the implementation of PPSs for rehabilitation hospitals and units (referred to as inpatient rehabilitation facilities (IRFs)), psychiatric hospitals and units (referred to as inpatient psychiatric facilities (IPFs)), and LTCHs, as discussed below. Children's hospitals and cancer hospitals continue to be paid under reasonable cost-based reimbursement.

The existing regulations governing payments to excluded hospitals and

hospital units are located in 42 CFR Parts 412 and 413.

a. IRFs

Under section 1886(j) of the Act, as amended, rehabilitation hospitals and units (IRFs) have been transitioned from payment based on a blend of reasonable cost reimbursement subject to a hospital-specific annual limit under section 1886(b) of the Act and prospective payments for cost reporting periods beginning January 1, 2002 through September 30, 2002, to payment on a full prospective payment system basis effective for cost reporting periods beginning on or after October 1, 2002 (66 FR 41316, August 7, 2001; 67 FR 49982, August 1, 2002; and 68 FR 45674, August 1, 2003). The existing regulations governing payments under the IRF PPS are located in 42 CFR Part 412, Subpart P.

b. LTCHs

Under the authority of sections 123(a) and (c) of Public Law 106–113 and section 307(b)(1) of Public Law 106–554, LTCHs are being transitioned from being paid for inpatient hospital services based on a blend of reasonable cost-based reimbursement under section 1886(b) of the Act to fully Federal prospective rates during a 5-year period, beginning with cost reporting periods that start on or after October 1, 2002. For cost reporting periods beginning on or after October 1, 2006, LTCHs will be paid under the fully Federal prospective payment rate (the June 6, 2003 LTCH PPS final rule (68 FR 34122)). LTCHs may elect to be paid based on full PPS payments instead of a blended payment in any year during the 5-year transition period. The existing regulations governing payment under the LTCH PPS are located in 42 CFR part 412, Subpart O.

c. IPFs

Sections 124(a) and (c) of Public Law 106–113 provide for the development of a per diem PPS for payment for inpatient hospital services furnished in IPFs under the Medicare program, effective for cost reporting periods beginning on or after October 1, 2002. This system must include an adequate patient classification system that reflects the differences in patient resource use and costs among these hospitals and maintains budget neutrality. We published a proposed rule to implement the PPS for IPFs on November 28, 2003 (68 FR 66920). The November 28, 2003 proposed rule proposed an April 1, 2004 effective date for purposes of ratesetting and calculating impacts. However, the proposed rule was unusually complex because it proposed a completely new payment system for inpatient hospital services furnished by psychiatric hospitals and units and the public requested additional time to comment. As a result, we extended the comment period for the proposed rule. Thus, we are still in the process of analyzing public comments and developing a final rule for publication. Consequently, an April 1, 2004 effective date for the IPF PPS is no longer possible.

3. Critical Access Hospitals (CAHs)

Under sections 1814, 1820, and 1834(g) of the Act, payments are made to critical access hospitals (CAHs) (that is, rural hospitals or facilities that meet certain statutory requirements) for inpatient and outpatient services on a reasonable cost basis. Reasonable cost is determined under the provisions of section 1861(v)(1)(A) of the Act and existing regulations under 42 CFR Parts 413 and 415.

4. Payments for Graduate Medical Education (GME)

Under section 1886(a)(4) of the Act, costs of approved educational activities are excluded from the operating costs of inpatient hospital services. Hospitals with approved graduate medical education (GME) programs are paid for the direct costs of GME in accordance with section 1886(h) of the Act; the amount of payment for direct GME costs for a cost reporting period is based on the hospital's number of residents in that period and the hospital's costs per resident in a base year. The existing regulations governing payments to the various types of hospitals are located in 42 CFR part 413.

On August 1, 2003, we published a final rule in the **Federal Register** (68 FR 45346) that implemented changes to the Medicare hospital inpatient prospective payment systems for both operating cost and capital-related costs, as well as changes addressing payments for excluded hospitals and payments for GME costs. Generally these changes were effective for discharges occurring on or after October 1, 2003. On October 6, 2003, we published a document in the **Federal Register** (68 FR 57731) that corrected technical errors made in the August 1, 2003 final rule.

B. Provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

On December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, was enacted. Public Law 108–173 made a number of changes to the Act relating to prospective payments to hospitals for inpatient services, payments to excluded hospitals and units, and payments to CAHs. This proposed rule would implement amendments made by the following sections of Public Law 108–173:

Section 401, which provides that, for discharges occurring in a fiscal year beginning with FY 2004 under the IPPS, Medicare will pay hospitals in rural and small urban areas in the 50 States using the standardized amount (computed for the previous fiscal year) that would be used to pay hospitals in large urban areas (or beginning with FY 2005, for all hospitals in the previous fiscal year), increased by the appropriate market basket percentage increase. One standardized amount for hospitals in Puerto Rico would be established that would equal the amount for hospitals in large urban areas in Puerto Rico.

Section 402, which provides that for discharges occurring on or after April 1, 2004, the DSH payment adjustment for a hospital that is not a large urban or large rural hospital will be calculated using the current DSH adjustment formula for large urban hospitals, subject to a limit of 12 percent for any of these hospitals that are not rural referral centers. (There is no limit on the DSH payment percentage for rural referral centers.)

Section 403, which provides that, for discharges occurring on or after October 1, 2004, a hospital's labor-related share to which the wage index is applied will be decreased to 62 percent of the standardized amount when such a change will result in higher total payments to the hospital. This provision also applies to the labor-related share of the standardized amount for hospitals in Puerto Rico.

Section 405(a), which provides that inpatient, outpatient, and covered SNF services provided by a CAH will be reimbursed at 101 percent of reasonable costs for services furnished to Medicare beneficiaries. This provision is applicable to payments for services furnished during cost reporting periods beginning on or after January 1, 2004.

Section 405(b), which expands coverage of the costs associated with covered Medicare services furnished by on-call emergency room providers in CAHs to include services furnished by physician assistants, nurse practitioners, and clinical nurse specialists, effective for costs incurred for services furnished on or after January 1, 2005.

Section 405(c), which provides that eligible CAHs may receive payments for their inpatient services on a periodic interim payment (PIP) basis, effective

with payments made on or after July 1, 2004.

Section 405(d), which allows CAHs to elect to receive payments under the optional payment method (a payment encompassing both inpatient CAH services and physician and practitioner services to outpatients) even if some practitioners do not reassign to the CAH their rights to bill for professional services to CAH outpatients. This provision applies to cost reporting periods occurring on or after July 1, 2004, except that in the case of a CAH that made an election of the optional payment method before November 1, 2003, the provision applies to cost reporting periods beginning on or after July 1, 2001.

Section 405(e), which increases the limit on the number of beds that a CAH may have for acute care from 15 to 25 beds. This provision applies to CAH designations made before, on, or after January 1, 2004. Any election made in accordance to the regulations promulgated to implement this provision will only apply prospectively.

Section 405(g), which provides that a CAH may establish psychiatric and rehabilitation distinct part units and limits the number of beds in each unit to no more than 10. Services in these distinct part units will be paid under the reasonable cost-based methodology. This provision applies to cost reporting periods beginning on or after October 1, 2004.

Section 405(h), which terminates a State's authority to waive the location requirement for a CAH by designating the CAH as the necessary provider, effective January 1, 2006. A grandfathering provision is included for CAHs that are certified as necessary providers prior to January 1, 2006, which allows any CAH that is designated as a necessary provider in its State's rural health plan prior to January 1, 2006, to maintain its necessary provider designation.

Section 406, which provides for a graduated adjustment to the inpatient prospective payment rates to account for the higher costs associated with hospitals described under section 1886(d) of the Act that are located more than 25 road miles from another subsection (d) hospital and that have less than 800 discharges during a fiscal year, effective for discharges occurring on or after October 1, 2004. The increase in these payments may not be greater than 25 percent and the determination of the percentage payment increase is not subject to administrative or judicial review.

Section 410A, which authorizes the Secretary to establish a demonstration program to test the feasibility and advisability of the establishment of rural community hospitals to furnish covered inpatient hospital services to Medicare beneficiaries. The Secretary must select up to 15 rural community hospitals to participate in the demonstration. The Secretary must implement the demonstration program not later than January 1, 2005, but may not implement the program before October 1, 2004.

Section 422(a), which provides that a hospital's GME FTE resident cap will be reduced, and the reduction will be redistributed among other hospitals if the hospital's resident count is less than its resident cap (rural hospitals with less than 250 acute care inpatient beds will be exempt) in a particular reference period. This provision is effective for cost reporting periods occurring on or after July 1, 2005.

Section 422(b), which specifies that the formula multiplier for the IME adjustment is 0.66 for FTE residents attributable to redistributed resident positions, effective for discharges occurring on or after July 1, 2005.

Section 501, which provides the update factor for payments for the hospital inpatient operating costs for FY 2005 and subsequent fiscal years is the market basket percentage increase. For FYs 2005 through 2007, the update factor will be the market basket percentage increase minus 0.4 percentage points for any ''subsection (d) hospital'' that does not submit hospital quality data on 10 measures as specified by the Secretary.

Section 502, which modifies the IME formula multiplier to be used in the calculation of the IME adjustment for midway through FY 2004 and provides a new schedule of formula multipliers for FYs 2005 and thereafter.

Section 503(a), which includes a requirement for updating the ICD–9–CM diagnosis and procedure codes in April 1 of each year, in addition to the current process of annual updates on October 1 of each year. This change will not affect Medicare payments or DRG classifications until the fiscal year that begins after that date.

Section 503(b), which provides for changes to the threshold amount for determining eligibility of new technologies or medical services for add-on payments; provides for public input on applications for new technology or medical service add-on payments prior to the publication of a proposed rule; provides for reconsideration of applications received for FY 2004 that were denied; provides for preference in the use of DRG adjustments; and provides that new technology or medical service payments shall not be budget neutral. This provision is effective for fiscal years beginning in FY 2005.

Section 504, which increases the national portion of the operating PPS payment rate for hospitals in Puerto Rico from 50 percent of the Federal rate to 75 percent of the Federal rate and decreases the Puerto Rico portion of the operating PPS payment from 50 percent to 25 percent, effective for discharges occurring on or after October 1, 2004. For the period of April 1, 2004 through September 30, 2004, payments for hospitals in Puerto Rico will be based on 62.5 percent Federal rate and 37.5 percent of the Puerto Rico rate.

Section 505, which provides for an increase in a hospital's wage index value to take into consideration a commuter wage adjustment for hospital employees who reside in a county and work in a different area with a higher wage index.

Section 508, which provides for the establishment of a one-time process for a hospital to appeal its geographic classification for wage index purposes. By law, any reclassification resulting from this one-time appeal applies for a 3-year period to discharges occurring on or after April 1, 2004.

Section 711, which freezes the annual CPI-U updates to hospital-specific per resident amount (PRAs) for GME payments for those PRAs that exceed the ceiling, effective for cost reporting periods beginning FY 2004 through FY 2013.

Section 712, which provides for an exception to the initial residency period for purposes of direct GME payments for geriatric residency or fellowship programs that allows the 2 years spent in an approved geriatric program to be counted as part of the resident's initial training period, but not to count against any limitation on the initial residency period. This provision is effective for cost reporting periods beginning on or after October 1, 2003.

Section 713, which, during a 1-year moratorium period of January 1, 2004 through December 31, 2004, allows hospitals to count allopathic or osteopathic family practice residents training in nonhospital settings for IME and direct GME purposes, without regard to the financial arrangement between the hospital and the teaching physician practicing in the nonhospital setting to which the resident is assigned.

Section 733, which provides for the Medicare payment of routine costs, as well as costs relating to the transplantation and appropriate related items and services, for Medicare beneficiaries participating in a clinical trial involving pancreatic islet cell

transplantation, beginning no earlier than October 1, 2004.

Section 926, which requires the Secretary to make information publicly available that enables hospital discharge planners, Medicare beneficiaries, and the public to identify skilled nursing facilities (SNFs) that are participating in the Medicare program, and requires a hospital, as part of its discharge planning, to evaluate a patient's need for SNF care.

Section 947, which requires that, by July 1, 2004, hospitals not otherwise subject to the Occupational Safety and Health Act (OSHA) (or a State occupational safety and health plan that is approved under section 18(b) of that Act) must comply with the OSHA bloodborne pathogens (BBP) standard as part of their Medicare provider agreements.

C. Major Contents of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare IPPS for operating costs and for capital-related costs under the IPPS for FY 2005. We also are setting forth proposed changes relating to payments for GME costs, payments to certain hospitals and units that continue to be excluded from the IPPS and paid on a reasonable cost basis, payments for DSH, requirements and payments for CAHs, conditions of participation for hospitals relating to discharge planning and fire safety requirements, requirements for Medicare provider agreements relating to bloodborne pathogen standards, and QIO disclosure of information requirements. The changes being proposed would be effective for discharges occurring on or after October 1, 2004, unless otherwise noted.

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

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

As required by section 1886(d)(4)(C) of the Act, we are proposing annual adjustments to the DRG classifications and relative weights. Based on analyses of Medicare claims data, in section II. of this preamble, we are proposing to establish a number of new DRGs and make changes to the designation of diagnosis and procedure codes under other existing DRGs. Our proposed changes for FY 2005 are set forth in section II. of this preamble.

Among the proposed changes discussed are:

- Restructuring and retitling of several DRGs to reflect expanded coverage of heart assist systems such as ventricular assist devices (VAD) or left ventricular assist devices (LVAD) as destination (or permanent) therapy for end-stage heart failure patients who are not candidates for heart transplantation: DRG 103 (Heart Transplant or Implant of Heart Assist System) (proposed title change), DRG 104 (Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization) and DRG 105 (Cardiac Valve and Other Major Cardiothoracic Procedures Without Cardiac Catheterization), and DRG 525 (Other Heart Assist System Implant) (proposed title change).
- Addition of pacemaker device and lead procedure code combinations that could lead to the assignment of DRG 115 (Permanent Cardiac Pacemaker Implant with Acute Myocardial Infarction, Heart Failure, or Shock or ACID Lead or Generator Procedures) and DRG 116 (Other Permanent Cardiac Pacemaker Implant).
- Movement of the procedure code for 360 spinal fusion from DRG 496 (Combined Anterior/Posterior Spinal Fusion) to DRG 497 (Spinal Fusion Except Cervical With CC) and DRG 498 (Spinal Fusion Except Cervical Without CC).
- Addition of combination codes, which also include heart failure, to the list of major problems under DRG 387 (Prematurity With Major Problems) and DRG 389 (Full-Term Neonate With Major Problems).
- Modification of DRGs 504 through 509 under MDC 22 (Burns) to recognize the impact of long-term mechanical ventilation on burn cases and renaming DRG 504 as proposed title ''Extensive Burns or Full Thickness Burns With Mechanical Ventilation 96+ Hours With Skin Graft'' and DRG 505 as proposed title ''Extensive Burns or Full Thickness Burns With Mechanical Ventilation 96+ Hours Without Skin Graft.''
- Deletion of DRG 483 (Tracheostomy for Face, Mouth, and Neck Diagnoses) and splitting the assignment of cases to two proposed new DRGs on the basis of the performance of a major operating room procedure: proposed new DRGs 541 and 542 (Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnosis With and Without Major Operating Room Procedure, respectively).

We also are presenting our reevaluation of FY 2004 applicants for add-on payments for high-cost new medical services and technologies, and our analysis of FY 2005 applicants (including public input, as directed by Public Law 108–173, obtained in a town meeting).

We are proposing the annual update of the long-term care diagnosis-related group (LTC–DRG) classifications and relative weights for use under the LTCH PPS for FY 2005.

2. Proposed Changes to the Hospital Wage Index

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

- The proposed FY 2005 wage index update, using wage data from cost reporting periods that began during FY 2001.
- Proposed revised labor market areas as a result of OMB revised definitions of geographical statistical areas.
- A discussion of the collection of occupational mix data and the proposed occupational mix adjustment to the wage index that we are proposing to apply beginning October 1, 2004.
- The proposed revisions to the wage index based on hospital redesignations and reclassifications, including changes that reflect the new OMB standards for assignment of hospitals to geographic areas.
- The proposed adjustment to the wage index based on commuting patterns of hospital employees who reside in a county and work in a different area with a higher wage index, to implement section 505 of Public Law 108–173.
- A discussion of eligible hospitals reclassified under the one-time appeals process under section 508 of Public Law 108–173.
- Proposed changes to the labor-related share to which the wage index is applied in determining the PPS rate for hospitals located in specific geographic areas, to implement section 403 of Public Law 108–173.
- The revised timetable for reviewing and verifying the wage data that is in effect for the proposed FY 2005 wage index.

3. Other Decisions and Proposed Changes to the PPS for Inpatient Operating and GME Costs

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

- Proposed expansion of the current postacute care transfer policy.
- Payments for inpatient care in providers that change classification status during a patient stay.
- Proposed changes in the definitions of urban and rural areas for geographic reclassifications purposes.

- Equalization of the standardized amount for urban and rural hospitals.
- The reporting of hospital quality data as a condition for receiving the full annual payment update increase.
- Proposed revision of the regulations to reflect the revision of the labor share of the wage index.
- Proposed revision of the regulations to reflect the wage index adjustment for commuting patterns of hospital employees who live in one county and commute to work in other areas with higher level wages.
- Proposed changes in the threshold amount for eligibility for new medical services and technology add-on payments.
- Proposed revision to our policy on additional payments to hospitals with high percentages of ESRD discharges.
- Proposed changes to the IME adjustment formula multipliers, and the formula multiplier applicable to redistribution of unused numbers of FTE residents slots.
- Proposed changes in DSH adjustment payments to rural and small urban hospitals.
- Proposed payment adjustments for low-volume hospitals.
- Proposed changes in policy affecting hospitals that apply as a group for reclassification and a discussion of possible reclassifications for dominant hospitals and hospitals in single-hospital MSAs.
- Proposed changes in policies governing payments for direct GME, including the redistribution of unused FTE resident slots; changes in the GME initial residency period; extension of the update limitation on hospital-specific per resident amounts; and changes in the policies on residents training in nonhospital settings, including written agreements for teaching physician compensation.
- An announcement of the rural community hospital demonstration to be established under section 410A of Public Law 108–173 and the opportunity for eligible hospitals to apply for participation in the demonstration program.
- A solicitation of public comments on the effect of increases in malpractice insurance premiums on hospitals participating in the Medicare program and beneficiary access of services.

4. Proposed Changes to the PPS for Capital-Related Costs

In section V. of this preamble, we discuss the payment requirements for capital-related costs and propose changes relating to capital payments to hospitals located in Puerto Rico, changes in the policies on exception payments for extraordinary circumstances, treatment of hospitals previously reclassified for the operating standardized amounts, and capital payment adjustments based on the proposed changes in geographic classifications.

5. Proposed Changes for Hospitals and Hospital Units Excluded From the IPPS

In section VI. of this preamble, we discuss the following proposed revisions and clarifications concerning excluded hospitals and hospital units and CAHs:

- Proposed changes in the payment rate for new excluded hospitals.
- Proposed changes to the criteria for determining payments to hospitals-within-hospitals.
- Proposed changes to the policies governing payment to CAHs, including a change in the payment percentage for services furnished by CAHs; changes in the rules governing the election by a CAH of the optional method of payment; expansion of the payment to emergency room on-call providers to include physician assistants, nurse practitioners, and clinical nurse specialists; authorization for the making of periodic interim payments (PIPs) for CAHs for inpatient services furnished; revision of the bed count limit for CAHs from 15 to 25 acute care beds; proposed requirements for establishing psychiatric and rehabilitation distinct part units in CAHs; and termination of the location requirement for a CAH by designating the CAH as a necessary provider.

6. Proposed Changes to QIO Disclosure of Information Requirements

In section VII. of this preamble, we discuss our proposed clarification of the requirements for disclosure by QIOs of information on institutions and practitioners collected in the course of the QIO's quality improvement activities.

7. Proposed Changes Relating to Medicare Provider Agreements, Hospital Conditions of Participation, and Fire Safety Requirements for Certain Health Care Facilities

In section VIII. of this preamble, we are proposing to—

- Require hospitals, as part of the discharge planning standard under the Medicare hospital conditions of participation, to furnish a list of Medicare-participating home health agencies to patients who receive home health services after discharge and to provide information on Medicare-certified SNFs to patients who are likely to need posthospital extended care services.
- Require that Medicare provider agreements include provisions that would ensure that all hospital employees who may come into contact with human blood in the course of their duties are provided proper protection from bloodborne pathogens.
- Correct a technical error relating to the application of the 2000 edition of the Life Safety Code as the fire safety requirements for certain health care facilities; and clarify the effective date for the prohibition on the use of roller latches in these facilities.

8. 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 2005 prospective payment rates for operating costs and capital-related costs. We also establish the proposed threshold amounts for outlier cases. In addition, we address proposed update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2005 for hospitals and hospital units excluded from the PPS.

9. Impact Analysis

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

10. Recommendation of Update Factor for Hospital Inpatient Operating Costs

In Appendix B of this proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we provide our recommendations of the appropriate percentage changes for FY 2005 for the following:

- A single average standardized amount for all areas for hospital inpatient services paid under the IPPS for operating costs (and hospital-specific rates applicable to SCHs and MDHs).
- Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by hospitals and hospital units excluded from the IPPS.

11. Discussion of Medicare Payment Advisory Commission Recommendations

Under section 1805(b) of the Act, the Medicare Payment Advisory Commission (MedPAC) is required to submit a report to Congress, no later than March 1 of each year, that reviews and makes recommendations on Medicare payment policies. MedPAC's March 2004 recommendation

concerning hospital inpatient payment policies addressed only the update factor for inpatient hospital operating costs and capital-related costs under the IPPS and for hospitals and distinct part hospital units excluded from the IPPS. This recommendation is addressed in Appendix B. For further information relating specifically to the MedPAC March 1 report or to obtain a copy of the report, contact MedPAC at (202) 220–3700 or visit MedPAC's Web site at: *www.medpac.gov.*

II. Proposed Changes to DRG Classifications and Relative Weights

A. Background

Section 1886(d) of the Act specifies that the Secretary shall establish a classification system (referred to as DRGs) for inpatient discharges and adjust payments under the IPPS based on appropriate weighting factors assigned to each DRG. Therefore, under the IPPS, we pay for inpatient hospital services on a rate per discharge basis that varies according to the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case multiplies an individual hospital's payment rate per case by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that particular DRG, relative to the average resources used to treat cases in all DRGS.

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The proposed changes to the DRG classification system and the proposed recalibration of the DRG weights for discharges occurring on or after October 1, 2004, are discussed below.

B. DRG Reclassifications

[If you choose to comment on issues in this section, please include the caption ''DRG Reclassifications'' at the beginning of your comment.]

1. General

Cases are classified into DRGs for payment under the IPPS based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay. In a small number of DRGs, classification is also based on the age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM).

For FY 2004, cases are assigned to one of 522 DRGs in 25 major diagnostic categories (MDCs). Most MDCs are based on a particular organ system of the body. For example, MDC 6 is Diseases and Disorders of the Digestive System. This approach is used because clinical care is generally organized in accordance with the organ system affected. However, some MDCs are not constructed on this basis because they involve multiple organ systems (for example, MDC 22 (Burns)). The table below lists the 25 MDCs.

Major diagnostic categories (MDCs).
1—Diseases and Disorders of the Nervous System.
2—Diseases and Disorders of the Eye.
3—Diseases and Disorders of the Ear, Nose, Mouth, and Throat.
4—Diseases and Disorders of the Respiratory System.
5—Diseases and Disorders of the Circulatory System.
6—Diseases and Disorders of the Digestive System.
7—Diseases and Disorders of the Hepatobiliary System and Pancreas.
8—Diseases and Disorders of the Musculoskeletal System and Connective Tissue.
9—Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast.
10—Endocrine, Nutritional and Metabolic Diseases and Disorders.
11—Diseases and Disorders of the Kidney and Urinary Tract.
12—Diseases and Disorders of the Male Reproductive System.
13—Diseases and Disorders of the Female Reproductive System.
14—Pregnancy, Childbirth, and the Puerperium.
15—Newborns and Other Neonates with Conditions Originating in the Perinatal Period.
16—Diseases and Disorders of the Blood and Blood Forming Organs and Immunological Disorders.
17—Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms.
18—Infectious and Parasitic Diseases (Systemic or Unspecified Sites).
19—Mental Diseases and Disorders.
20—Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders.
21—Injuries, Poisonings, and Toxic Effects of Drugs.
22—Burns.
23—Factors Influencing Health Status and Other Contacts with Health Services.
24—Multiple Significant Trauma.
25—Human Immunodeficiency Virus Infections

In general, cases are assigned to an MDC based on the patient's principal diagnosis before assignment to a DRG. However, for FY 2004, there are eight DRGs to which cases are directly assigned on the basis of ICD–9–CM procedure codes. These DRGs are for heart, liver, bone marrow, lung, simultaneous pancreas/kidney, and pancreas transplants and for tracheostomies. Cases are assigned to these DRGs before they are classified to an MDC. The table below lists the current eight pre-MDCs.

Pre-Major Diagnostic Categories (Pre-MDCs)
DRG 103—Heart Transplant.
DRG 480—Liver Transplant.

Pre-Major Diagnostic Categories (Pre-MDCs)
DRG 481—Bone Marrow Transplant.
DRG 482—Tracheostomy for Face, Mouth, and Neck Diagnoses.
DRG 483—Tracheostomy with Mechanical Ventiliation 96+ Hours or Principal Diagnosis Except for Face, Mouth, and Neck Diagnoses.
DRG 495—Lung Transplant.
DRG 512—Simultaneous Pancreas/Kidney Transplant.
DRG 513—Pancreas Transplant

Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Surgical DRGs are based on a hierarchy that orders operating room (O.R.) procedures or groups of O.R. procedures by resource intensity. Medical DRGs generally are differentiated on the basis of diagnosis and age (less than or greater than 17 years of age). Some surgical and medical DRGs are further differentiated based on the presence or absence of a complication or a comorbidity (CC).

Generally, nonsurgical procedures and minor surgical procedures that are not usually performed in an operating room are not treated as O.R. procedures. However, there are a few non-O.R. procedures that do affect DRG assignment for certain principal diagnoses, for example, extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones.

Patient's diagnosis, procedure, discharge status, and demographic information is fed into the Medicare claims processing systems and subjected to a series of automated screens called the Medicare Code Editor (MCE). The MCE screens are designed to identify cases that require further review before classification into a DRG.

After patient information is screened through the MCE and any further development of the claim is conducted, the cases are classified into the appropriate DRG by the Medicare GROUPER software program. The GROUPER program was developed as a means of classifying each case into a DRG on the basis of the diagnosis and procedure codes and, for a limited number of DRGs, demographic information (that is, sex, age, and discharge status).

After cases are screened through the MCE and assigned to a DRG by the GROUPER, a base DRG payment is calculated by the PRICER software. The PRICER calculates the payments for each case covered by the IPPS based on the DRG relative weight and additional factors associated with each hospital, such as IME and DSH adjustments. These additional factors increase the payment amount to hospitals above the base DRG 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. However, in the July 30, 1999 IPPS final rule (64 FR 41500), we discussed a process for considering non-MedPAR data in the recalibration process. In order for us to consider using particular non-MedPAR data, we must have sufficient time to evaluate and test the data. The time necessary to do so depends upon the nature and quality of the non-MedPAR data submitted. Generally, however, a significant sample of the non-MedPAR data should be submitted by mid-October for consideration in conjunction with the next year's proposed rule. This allows us time to test the data and make a preliminary assessment as to the feasibility of using the data. Subsequently, a complete database should be submitted by early December for consideration in conjunction with the next year's proposed rule.

Many of the changes to the DRG classifications are the result of specific issues brought to our attention by interested parties. We encourage individuals with concerns about DRG classifications to bring those concerns to our attention in a timely manner so they can be carefully considered for possible inclusion in the next proposed rule and so any proposed changes may be subjected to public review and comment. Therefore, similar to the timetable for interested parties to submit non-MedPAR data for consideration in the DRG recalibration process, concerns about DRG classification issues should be brought to our attention no later than early December in order to be considered and possibly included in the next annual proposed rule updating the IPPS.

The changes we are proposing to the DRG classification system for the FY 2005 GROUPER version 22.0 and to the methodology used to recalibrate the DRG weights are set forth below. Unless otherwise noted in this proposed rule, our DRG analysis is based on data from the December 2003 update of the FY 2003 MedPAR file, which contains hospital bills received through December 31, 2003 for discharges in FY 2003.

2. MDC 1 (Diseases and Disorders of the Nervous System): Intracranial Hemorrhage and Stroke With Infarction

It has come to our attention that the title of DRG 14 (Intracranial Hemorrhage and Stroke With Infarction) may be misleading because it implies that a combination of conditions exists when the DRG is assigned. When we developed this title, we did not intend to imply that a combination of conditions exists. Therefore, we are proposing to change the title of DRG 14 to read ''Intracranial Hemorrhage or Cerebral Infarction''.

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

a. Heart Assist System Implant

Circulatory support devices, also known as heart assist systems, ventricular assist devices (VADs) or left ventricular assist devices (LVADs), offer a surgical alternative for end-stage heart failure patients. This type of device is often implanted near a patient's native heart and assumes the pumping function of the weakened heart's left ventricle. In many cases, heart transplantation would be the treatment of choice for this type of patient. However, the low number of donor hearts limits this treatment option.

We have reviewed the payment and DRG assignment for this type of device many times in the past. The reader is referred to the August 1, 2002 IPPS final rule (67 FR 49989) for a complete listing of those discussions.

In the August 1, 2002 final rule (67 FR 49990), we attempted to clinically and financially align VAD procedures by creating new DRG 525 (Heart Assist System Implant). We also noted that cases in which a heart transplant also occurred during the same hospitalization episode would continue to be assigned to DRG 103 (Heart Transplant). At that time, we announced that DRG 525 would consist of any principal diagnosis in MDC 5, plus one of the following surgical procedure codes:

- 37.62, Insertion of nonimplantable heart assist system
- 37.63, Repair of heart assist system

- 37.65, Implant of external heart assist system
- 37.66, Insertion of implantable heart assist system

(To avoid confusion, we note that the titles of codes 37.62, 37.63, 37.65, and 37.66 have been revised for FY 2005 through the ICD–9–CM Coordination and Maintenance Committee process as reflected in Table 6F, Revised Procedure Code Titles in the Addendum to this proposed rule.)

Commenters on the May 19, 2003 proposed rule that preceded the August 1, 2003 IPPS (FY 2004) final rule notified us that procedure code 37.66 was neither a clinical nor a financial match to the rest of the procedure codes now assigned to DRG 525. We did not modify DRG 525 for FY 2004. We agreed that we would continue to evaluate whether to make further changes to DRG 525. After publication of the August 1, 2003 final rule, we again reviewed the MedPAR data concerning DRG 525, and came to the conclusion that procedure code 37.62 is different in terms of clinical procedures and resource utilization from the other procedure codes assigned to DRG 525. Therefore, in a correction to the August 1, 2003 IPPS (FY 2004) final rule, published on October 6, 2003 (68 FR 57733), we revised the composition of DRG 525 by correcting the assignment of procedures to DRG 525 in light of the lower charges associated with procedure code 37.62. We moved code 37.62 into DRG 104 (Cardiac Valve and Other Major Cardiothoracic Procedures With Cardiac Catheterization) and DRG 105 (Cardiac Valve and Other Major Cardiothoracic Procedures Without Cardiac Catheterization), and left procedure codes 37.63, 37.65, and 37.66 in DRG 525.

In addition, we have evaluated a request for expanded coverage for VADs and LVADs as destination (or permanent) therapy for end-stage heart failure patients who are not candidates for heart transplantation. VADs and LVADs had been approved for support of blood circulation post-cardiotomy (effective for services performed on or after October 18, 1993) and as a bridge to heart transplant (effective for services performed on or after January 22, 1996) to assist a damaged or weakened heart in pumping blood. The criteria that must be fulfilled in order for Medicare coverage to be provided for these purposes have been previously discussed in the August 1, 2000 final rule (65 FR 47058), and can also be accessed online at: *www.cms.gov/manuals/pm_trans/r2ncd1.pdf.*

As a result of that review, effective for services performed on or after October 1, 2003, VADs have been approved as destination therapy for patients requiring permanent mechanical cardiac support. Briefly, VADs used for destination therapy are covered only if they have received approval from the FDA for that purpose, and the device is used according to the FDA-approved labeling instructions. VADs are covered for patients who have chronic end-stage heart failure (New York Heart Association Class IV end-stage left ventricular failure for at least 90 days with a life expectancy of less than 2 years). Implanting facilities as well as patients must also meet all of the additional conditions that are listed in the national coverage determination for artificial hearts and related devices, which is posted on the above CMS Web site.

In light of the new indication of destination therapy, we again reviewed the FY 2003 MedPAR data for all cases in which a VAD had been implanted, using the criterion of any case containing a procedure code of 37.66. We found a total of 65 cases in 3 DRGs: DRG 103 (Heart Transplant); DRG 483 (Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses); and DRG 525 (Heart Assist System Implant). The following table displays our findings:

DRG with code 37.66 reported	Count	Average length of stay	Average charges
103	14	77.36	$836,011
483	6	100.50	1,400,706
525	45	38.93	308,725

The remaining 354 cases in DRG 103 that did not report code 37.66 had average charges of $282,578. The remaining 171 cases in DRG 525 that did not contain code 37.66 had an average length of stay of 12.39 days and average charges of $168,388. The 45 cases in DRG 525 with code 37.66 accounted for 26 percent of the cases. However, the average charges for these cases are approximately $140,340 higher than the average charges for cases in DRG 525 that did not report code 37.66.

Commenters on the FY 2004 final rule suggested adding code 37.66 to DRG 103. We were concerned with the timing of that comment, as it was received after publication of the proposed rule. We noted that the commenter's suggestions on the structure of the DRGs involved were significant, and that change of that magnitude should be subject to public review and comment. We also noted that we would evaluate the suggestion further. (68 FR 45370) However, as one of the indications for this device has become destination therapy, and as this new indication is more clinically aligned with DRG 103, we are proposing to remove procedure code 37.66 from DRG 525 and assign it to DRG 103. We also are proposing to change the title of DRG 103 to ''Heart Transplant or Implant of Heart Assist System''. The proposed restructured DRG 103 would include any principal diagnosis in MDC 5, plus one of the following surgical procedure codes:

- 33.6, Combined heart-lung transplantation
- 37.51, Heart transplantation
- 37.66, Insertion of implantable heart assist system

In addition to the proposed changes to DRG 103, we are proposing to change the title of DRG 525 to ''Other Heart Assist System Implant''.

In conjunction with the above data review, we also looked at DRGs 104 and 105.

DRGs 104 and 105 had been restructured in FY 2003 by assigning code 37.62 to them. (**Note:** The code title for 37.62 has been revised, effective FY 2005, as reflected in Table 6F of the Addendum to this proposed rule). We examined the MedPAR data and found that the average charges were $113,667 and $82,899, respectively, for DRGs 104 and 105 for cases not reporting code 37.62, while cases containing code 37.62 had average charges of $124,559 and $166,129, respectively.

The removal of code 37.66 from DRG 525 would have the effect of clinically realigning that DRG to be more coherent. As a result of the proposal to remove code 37.66 from DRG 525 and assign it to DRG 103, we also are proposing to remove code 37.62 from DRGs 104 and 105 and assign it back into DRG 525. In addition, the average

charges for code 37.62 shown above in DRGs 104 and 105 ($124,559 and $166,129) more closely match the average charges reported for the 171 cases in DRG 525, absent code 37.66 ($168,388).

The proposed restructured DRG 525 would include any principal diagnosis in MDC 5, plus the following surgical procedure codes:

- 37.52, Implantation of total replacement heart system*
- 37.53, Replacement or repair of thoracic unit of total replacement heart system*
- 37.54, Replacement or repair of other implantable component of total replacement heart system*
- 37.62, Insertion of nonimplantable heart assist system
- 37.63, Repair of heart assist system
- 37.65, Implant of external heart assist system

*These codes represent noncovered services for Medicare beneficiaries. However, it is our longstanding practice to assign every code in the ICD–9–CM classification to a DRG. Therefore, they have been assigned to DRG 525.

b. Cardiac Resychronization Therapy and Heart Failure

We received a request from a manufacturer of a Cardiac Resynchronization Therapy Defibrillator (CRT–D) device for a modification to DRG 535 (Cardiac Defibrillator Implant With Cardiac Catheterization With Acute Myocardial Infarction/Heart Failure/Shock) and DRG 536 (Cardiac Defibrillator Implant With Cardiac Catheterization Without Acute Myocardial Infarction/Heart Failure/Shock). The commenter pointed out that defibrillator device implantations, including the CRT–D type of defibrillator, are assigned to DRG 535 when the patient also has a cardiac catheterization and has either an acute myocardial infarction, heart failure, or shock as a principal diagnosis. If the patient receiving the defibrillator implant and cardiac catheterization does not have a principal diagnosis of acute myocardial infarction, heart failure, or shock, the cases are assigned to DRG 536.

The commenter requested that cases be assigned to DRG 535 when the patient has heart failure as either a principal diagnosis or a secondary diagnosis. The commenter stated that patients receive a CRT–D (as opposed to other types of defibrillators) when they have both heart failure and arrhythmia. The commenter was concerned that some coders may sequence the heart failure as a secondary diagnosis, which would result in the patient being assigned to DRG 536.

As stated earlier, DRGs 535 and 536 are split based on the principal diagnosis of acute myocardial infarction, heart failure, or shock. Cases are not assigned to DRG 535 when heart failure is a secondary diagnosis.

The commenter described a scenario where a patient was admitted with heart failure for an evaluation of the need for a CRT–D implantation. The hospitalization studies indicated that the patient had a ventricular tachycardia. The commenter indicated that coders would be confused as to which code should be listed as the principal diagnosis.

CMS' review of this scenario as described would be that the heart failure led to the admission and would be the principal diagnosis. This case would properly be assigned to DRG 535. Furthermore, when two conditions are considered to be equally responsible for the admission, either one of the two conditions may be selected as the principal diagnosis.

The commenter also stated that its own study shows CRT–D patients have significantly higher charges than do other patients in DRGs 535 and 536 who receive an implantable defibrillator. This was the case whether heart failure was used as a principal or secondary diagnosis.

A cardiac catheterization is a diagnostic procedure generally performed to establish the nature of the patient's cardiac problem and determine if implantation of a cardiac defibrillator is appropriate. Generally, the cardiac catheterization can be done on an outpatient basis. Patients who are admitted with acute myocardial infarction, heart failure, or shock and have a cardiac catheterization are generally acute patients who require emergency implantation of the defibrillator. Thus, there are very high costs associated with these patients.

We examined the MedPAR file for all cases in DRGs 535 and 536 and only cases in DRG 536 in which acute myocardial infarction or heart failure was listed as a secondary diagnosis. The following chart illustrates the results of our findings:

DRGs	Count	Average length of stay	Average charges
535	6,801	9.50	$110,663.57
536—All cases	17,454	5.47	89,493.85
536—Cases With Secondary Diagnosis of Cardiac Defibrillator Implant With Cardiac Catheterization Without Acute Myocardial Infarction/Heart Failure/Shock	8,562	6.5	94,832.14

The data show that cases with a secondary diagnosis of acute myocardial infarction or heart failure have average charges ($94,832.14) closer to the overall average charges for DRG 536 ($89,493.85) where they are currently assigned. Overall charges for DRG 535 were $110,663.57. We do not believe these data support modifying DRG 535 and DRG 536 as requested. Many of the CRT–D patients who are admitted for heart failure would be assigned into DRG 535. Furthermore, modifying the DRG logic for one specific type of defibrillator (CRT–D) is not consistent with our overall policy of grouping similar types of patients together in the same DRG. In addition, to modify the DRG logic for the small percentage of cases where there might be confusion concerning the selection of the principal diagnosis does not seem prudent. Therefore, we are not proposing a modification to DRG 535 or 536 for CRT–Ds.

c. Combination Cardiac Pacemaker Devices and Lead Codes

We received a comment that recommended that we include additional combination procedure codes representing cardiac pacemaker device and lead codes under DRG 115 (Permanent Cardiac Pacemaker Implant With Acute Myocardial Infarction, Heart Failure, or Shock or ACID Lead or Generator Procedures) and DRG 116 (Other Permanent Cardiac Pacemaker Implant). DRGs 115 and 116 are assigned when a complete pacemaker unit with leads is implanted. Combinations of pacemaker devices and lead codes that would lead to the DRG assignment are listed under DRGs 115 and 116. The commenter recommended that the following pacemaker device and lead procedure code combinations be added to these two DRGs:

- 00.53 & 37.70

- 00.53 & 37.71
- 00.53 & 37.72
- 00.53 & 37.73
- 00.53 & 37.74
- 00.53 & 37.76

These codes are defined as follows:

- 00.53, Implantation or replacement of cardiac resynchronization pacemaker, pulse generator only [CRT–P]
- 37.70, Initial insertion of pacemaker lead [electrode], not otherwise specified
- 37.71, Initial insertion of transvenous lead [electrode] into ventricle
- 37.72, Initial insertion of transvenous lead [electrode] into atrium and ventricle
- 37.73, Initial insertion of transvenous lead [electrode] into atrium
- 37.74, Initial insertion or replacement of epicardial lead [electrode] into epicadium
- 37.76, Replacement of transvenous atrial and/or ventricular lead(s) [electrode]

We have consulted our medical advisors and they agree that these recommended procedure code combinations also describe pacemaker device and lead implantations and should be included under DRGs 115 and 116. Therefore, we are proposing to add the recommended procedure code combinations to the list of procedure code combinations under DRGs 115 and 116.

4. MDC 6 (Diseases and Disorders of the Digestive System): Artificial Anal Sphincter

In the FY 2003 IPPS final rule (67 FR 50242), we created two new codes for procedures involving an artificial anal sphincter, effective for discharges occurring on or after October 1, 2002: code 49.75 (Implantation or revision of artificial anal sphincter) that is used to identify cases involving implantation or revision of an artificial anal sphincter and code 49.76 (Removal of artificial anal sphincter) that is used to identify cases involving the removal of the device. In Table 6B of that final rule, we assigned both codes to one of four MDCs, based on principal diagnosis, and one of six DRGs within those MDCs. In the August 1, 2003 IPPS final rule (68 FR 45372), we discussed the assignment of these codes in response to a request we had received to consider reassignment of these two codes to different MDCs and DRGs. The requester believed that the average charges ($44,000) for these codes warranted reassignment. In the August 1, 2003 IPPS final rule, we stated that we did not have sufficient MedPAR data available on the reporting of codes 49.75 and 49.76 to make a determination on DRG reassignment of these codes. We agreed that, if warranted, we would give further consideration to the DRG assignments of these codes because it is our customary practice to review DRG assignment(s) for newly created codes to determine clinical coherence and similar resource consumption after we have had the opportunity to collect MedPAR data on utilization, average length of stay charges, and distribution throughout the system.

Therefore, we reviewed the FY 2003 MedPAR data for the presence of codes 49.75 and 49.76. We then arrayed the results by DRG, count, average length of stay, charges, and the presence or absence of a secondary diagnosis that could be classified as a CC. We found that there were a total of 13 cases in 5 total DRGs with CCs, and 9 cases in 4 total DRGs without CCs, for a total of 22 cases that reported these procedure codes. We had anticipated that the majority of cases would have been found in DRGs 157 (Anal and Stomal Procedures With CC) and 158 (Anal and Stomal Procedures Without CC), but found only 2 cases grouped to DRG 157 and 4 cases grouped to DRG 158. Our data showed average charges of $22,374 for the cases with CC, and average charges of $20,831 for the cases without CC. Average charges for DRG 157 were $18,196, while average charges for DRG 158 were $9,348.

Our medical advisors also reviewed the contents of DRGs 157 and 158. The consensus was that codes 49.75 and 49.76 are not a clinical match to the other procedure codes found in these two DRGs. The other procedure codes in DRGs 157 and 158 are for simpler and less invasive procedures. In some circumstances, these procedures could potentially be performed in an outpatient setting or in a physician's office. Our medical advisors determined that clinical coherence was not demonstrated and recommended that we move these codes to DRGs 146 (Rectal Resection With CC) and 147 (Rectal Resection Without CC), as these anal sphincter procedures more closely resemble the procedures in these DRGs. In addition, the average charges for paired DRG 146 ($33,853) and DRG 147 ($21,747) more closely resemble the actual average charges found in the MedPAR data for these cases.

Even though there are few reports of codes 49.75 and 49.76 in the MedPAR data and we do not anticipate a significant increase in utilization of these procedures, we are proposing that these two codes would only be removed from paired DRG 157 and 158 and reassigned to paired DRG 146 and 147 under MDC 6 (Diseases and Disorders of the Digestive System). All other MDC and DRG assignments for codes 49.75 and 49.76 would remain the same.

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

a. 360 Spinal Fusions

We received a comment that suggested procedure code 81.61 (360 Spinal fusion) should not be included in DRG 496 (Combined Anterior/Posterior Spinal Fusion). The commenter stated that code 81.61 does not represent the same types of cases as other codes included in DRG 496. The commenter indicated that cases reported with code 81.61 involve making only one incision, and then fusing both the anterior and posterior portion of the spine. All other cases in DRG 496 involve two separate surgical approaches used to reach the site of the spinal fusion. For these other patients, an incision is made into the patient, and a fusion is made in part of the spine. The patient is then turned over and a separate incision is made so that a fusion can be made in another part of the spine. The commenter added that these two separate incisions and fusions are more time consuming than the single incision used for code 81.61. The commenter also stated that patients receiving the two surgical approaches have a longer recovery period and use more hospital resources.

We examined data in the MedPAR file for cases assigned to DRG 496 and found the following:

DRG	Count	Average length of stay	Average charges
496—All Cases	2,706	8.0	$74,967.33
496—Cases with code 81.61	829	4.7	50,659.69
496—Cases with code 81.61 with CC	451	5.4	55,639.50
496—Cases with code 81.61 without CC	378	3.8	44,718.16
496—Cases without 81.61	1877	9.4	85,703.09

We also examined cases in related DRG 497 (Spinal Fusion Except Cervical With CC) and DRG 498 (Spinal Fusion Except Cervical Without CC) in which code 81.61 was not reported. The chart below reflects our findings.

DRG	Count	Average length of stay	Average charges
497	16,965	6.19	$49,315.27
498	11,598	3.95	37,450.68

These data clearly show that cases with code 81.61 have significantly less average charges than other cases in DRG 496 that have two surgical approaches. Cases with code 81.61 are more closely aligned with cases in DRG 497 and DRG 498. Furthermore, including code 81.61 will have the effect of lowering the relative weights for DRG 496 in future years. Therefore, we are proposing to remove code 81.61 from DRG 496 and reassign it to DRGs 497 and 498.

b. Multiple Level Spinal Fusion

On October 1, 2003 (68 FR 45596), the following new ICD–9–CM procedure codes were created to identify the number of levels of vertebra fused during a spinal fusion procedure:

- 81.62, Fusion or refusion of 2–3 vertebrae
- 81.63, Fusion or refusion of 4–8 vertebrae
- 81.64, Fusion or refusion of 9 or more vertebrae

Prior to the creation of these new codes, we received a comment recommending the establishment of new DRGs that would differentiate between the number of levels of vertebrae involved in a spinal fusion procedure. In the August 1, 2003 final rule, we discussed the creation of these new codes and the lack of sufficient MedPAR data with the new multiple level spinal fusion codes (68 FR 45369). The commenter had conducted an analysis and submitted data to support redefining the spinal fusion DRGs. The analysis found that increasing the levels fused from 1 to 2 levels to 3 levels or more levels increased the mean standardized charges by 38 percent for lumbar/thoracic fusions, and by 47 percent for cervical fusions.

The following current spinal fusion DRGs separate cases based on whether or not a CC is present: DRG 497 (Spinal Fusion Except Cervical With CC) and DRG 498 (Spinal Fusion Except Cervical Without CC); DRG 519 (Cervical Spinal Fusion With CC) and DRG 520 (Cervical Spinal Fusion Without CC). However, the difference in charges associated with the current CC split was only slightly greater than the difference attributable to the number of levels fused as found by the commenter's analysis. In addition, adopting the commenter's recommendation would have necessitated adjusting the DRG relative weights using non-MedPAR data because Medicare claims data with the new ICD–9–CM codes would not have been available until the FY 2003 MedPAR file. Therefore, at that time, we did not redefine the spinal fusion DRGs to differentiate on the basis of the number of levels of vertebrae involved in a spinal fusion procedure.

We did not yet have any reported cases utilizing the new multilevel spinal fusion codes in our data. We stated that we would wait until sufficient data with the new multilevel spinal fusion codes were available before making a final determination on whether multilevel spinal fusions should be incorporated into the spinal fusion DRG structure. The codes went into effect on October 1, 2003 and we have not received any data using these codes. Spinal surgery is an area of rapid changes. In addition, we have created a series of new procedure codes that describe a new type of spinal surgery, spinal disc replacement. (See codes 84.60 through 84.69 in Table 6B in the Addendum to this proposed rule that will go into effect on October 1, 2004.) Our medical advisors describe this new surgical procedure as a more conservative approach for back pain than the spinal fusion surgical procedure. With only limited data concerning multiple level spinal fusion and the rapid changes in spinal surgery, we believe it is more prudent not to propose the establishment of new DRGs based on the number of levels of vertebrae involved in a spinal fusion procedure at this time.

In addition, no other surgical DRG is split based on the number of procedures performed. For instance, the same DRG is assigned whether one or more angioplasties are performed on a patient's arteries. The insertion of multiple stents within an artery does not result in a different DRG assignment. Similarly, the excision of neoplasms from multiple sites does not lead to a different DRG assignment. To begin splitting DRGs based on the number of procedures performed or devices inserted could set a new and significant precedent for DRG policy. Therefore, while we will continue to study this area, we are not proposing to redefine the spinal fusion DRGs based on the number of levels of vertebrae fused at this time.

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

We continue to receive comments that MDC 15 (Newborn and Other Neonates With Conditions Originating in the Perinatal Period) does not adequately capture care provided for newborns and neonates by hospitals. The commenters point out that we have not updated the DRGs within MDC 15 as we have for other parts of the DRG system.

Our primary focus of updates to the Medicare DRG classification system is on changes relating to the Medicare patient population, not the pediatric or neonatal patient populations. However, we acknowledge the Medicare DRGs are sometimes used to classify other patient populations. Over the years, we have received comments about aspects of the Medicare newborn DRGs that appear problematic, and we have responded to these on an individual basis. In the May 9, 2002 IPPS proposed rule (67 FR 31413), we proposed extensive changes to multiple DRGs within MDC 15. Because of our limited data and experience with newborn cases under Medicare, we contacted the National Association of Children's Hospitals and Related Institutions (NACHRI) to obtain proposals for possible revisions of the DRG categories within MDC 15. We received extensive comments opposing these revisions. Therefore, we did not implement the proposals.

We advise those non-Medicare systems that need a more up-to-date system to choose from other systems that are currently in use in this country, or to develop their own modifications. As previously stated, we do not have the data or the expertise to develop more extensive newborn and pediatric DRGs. Our mission in maintaining the Medicare DRGs is to serve the Medicare population. Therefore, we will make only minor corrections of obvious errors to the DRGs within MDC 15. At this time, we do not plan to conduct a more extensive analysis involving major revisions to these DRGs.

In the IPPS final rule for FY 2004 (68 FR 45360), we added heart failure

diagnosis codes 428.20 through 428.43 to the list of secondary diagnosis of major problem under DRG 387 (Prematurity With Major Problems) and DRG 389 (Full-Term Neonate With Major Problems). We received a comment after the August 1, 2003 final rule stating that we should add the following list of combination codes, which also include heart failure, to the list of major problems under DRGs 387 and 389:

- 398.91, Rheumatic heart failure (congestive)
- 402.01, Malignant hypertensive heart disease, with heart failure
- 402.11, Benign hypertensive heart disease, with heart failure
- 402.91, Unspecified hypertensive heart disease, with heart failure
- 404.01, Malignant hypertensive heart and renal disease, with heart failure
- 404.03, Malignant hypertensive heart and renal disease, with heart failure and renal failure
- 404.11, Benign hypertensive heart and renal disease, with heart failure
- 404.13, Benign hypertensive heart and renal disease, with heart failure and renal failure
- 404.91, Unspecified hypertensive heart and renal disease, with heart failure
- 404.93, Unspecified hypertensive heart and renal disease, with heart failure and renal failure.
- 428.9, Heart failure, unspecified

We agree that the codes listed above also include heart failure and should also be added to DRGs 387 and 389 as major problems. Therefore, we are proposing to add the heart failure codes listed above to DRGs 387 and 389 as major problems.

7. MDC 20 (Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders): Drug-Induced Dementia

We received a request from a commenter that we remove the principal diagnosis code 292.82 (Drug-induced dementia) from MDC 20 (Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders) and the following DRGs under MDC 20:

- DRG 521 (Alcohol/Drug Abuse or Dependence With CC)
- DRG 522 (Alcohol/Drug Abuse or Dependence With Rehabilitation Therapy Without CC)
- DRG 523 (Alcohol/Drug Abuse or Dependence Without Rehabilitation Therapy Without CC)

The commenter indicated that a patient who has a drug-induced dementia should not be classified to an alcohol/drug DRG. However, the commenter did not propose a new DRG assignment for code 292.82.

Our medical advisors have evaluated the request and determined that the most appropriate DRG classification for a patient with drug-induced dementia would be within MDC 20. The medical advisors indicated that because this mental condition is drug induced, it is appropriately classified to DRGs 521 through 523 in MDC 20. Therefore, we are not proposing a new DRG classification for the principal diagnosis code 292.82.

8. MDC 22 (Burns): Burn Patients on Mechanical Ventilation

We have received concerns raised by hospitals treating burn patients that the current DRG payment for burn patients on mechanical ventilation is not adequate. The DRG assignment for these cases depends on whether the hospital performed the tracheostomy or the tracheostomy was performed prior to transfer to the hospital. If the hospital does not actually perform the tracheostomy, the case is assigned to one of the burn DRGs in MDC 22 (Burns). If the hospital performs a tracheostomy, the case is assigned to Pre-MDC DRG 482 (Tracheostomy for Face, Mouth, and Neck Diagnoses) or DRG 483 (Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses).

In the August 1, 2002 final rule, we modified DRGs 482 and 483 to recognize code 96.72 (Continuous mechanical ventilation for 96+ hours) for the first time in the DRG assignment (67 FR 49996). The modification was partially in response to concerns that hospitals could omit diagnosis codes indicating face, mouth, or neck diagnoses in order to have cases assigned to DRG 483 rather than the much lower paying DRG 482 (the payment for DRG 483 is more than four times greater than the DRG 482 payment weight). In addition, we noted that many patients assigned to DRG 483 did not have code 96.72 recorded. We believed this was due, in part, to the limited number of procedure codes (six) that can be submitted on the current billing form and the fact that code 96.72 did not affect the DRG assignment prior to FY 2003. The modification was the first attempt to refine DRGs 482 and 483 so that patients who receive long-term mechanical ventilation for more than 96 hours are differentiated from those who receive mechanical ventilation for less than 96 hours. The modification was intended to ensure that patients who have a tracheostomy and continuous mechanical ventilation greater than 96 hours (code 96.72) would be assigned to DRG 483. By making the GROUPER recognize long-term mechanical ventilation and assigning those patients to the higher weighted DRG 483, we encouraged hospitals to be more aware of the importance of reporting code 96.72 and to increase reporting of code 96.72 when, in fact, patients had been on the mechanical ventilator for greater than 96 hours. We stated in the August 1, 2002 final rule that, once we received more accurate data, we would give consideration to further modifying DRGs 482 and 483 based on the presence of code 96.72.

To assess the DRG payments for burn patients on mechanical ventilation, we analyzed FY 2003 MedPAR data for burn cases in the following DRGs to determine the frequency for which these burn cases were treated with continuous mechanical ventilation for 96 or more consecutive hours (code 96.72):

- DRG 483 (Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses)
- DRG 504 (Extensive 3rd Degree Burns With Skin Graft)
- DRG 505 (Extensive 3rd Degree Burns Without Skin Graft)
- DRG 506 (Full Thickness Burn With Skin Graft or Inhalation Injury With CC or Significant Trauma)
- DRG 507 (Full Thickness Burn With Skin Graft or Inhalation Injury Without CC or Significant Trauma)
- DRG 508 (Full Thickness Burn Without Skin Graft or Inhalation Injury With CC or Significant Trauma)
- DRG 509 (Full Thickness Burn Without Skin Graft or Inhalation Injury Without CC or Significant Trauma)
- DRG 510 (Nonextensive Burns With CC or Significant Trauma)
- DRG 511 (Nonextensive Burns Without CC or Significant Trauma)

The following chart summarizes those findings:

DRG	Count	Average length of stay	Average charges
483—All cases	31,754	37.68	$210,631.94
483—Cases with code 96.72 reported	19,669	36.54	195,171.66

DRG	Count	Average length of stay	Average charges
483—Cases without code 96.72 reported	12,085	39.52	235,794.39
504—All cases	98	30.54	191,645.49
504—Cases with code 97.62 reported	19	25.79	264,095.16
504—Cases without code 96.72 reported	79	31.68	174,220.89
505—All cases	119	2.96	18,619.78
505—Cases with code 96.72 reported	20	7.70	42,613.00
505—Cases without code 96.72 reported	99	2.00	13,772.67
506—All cases	754	16.15	61,370.63
506—Cases with code 96.72 reported	54	20.13	138,272.46
506—Cases without code 96.72 reported	700	15.85	55,438.20
507—All cases	236	8.78	25,891.89
507—Cases with code 96.72 reported	1	38.00	137,132.00
507—Cases without code 96.72 reported	235	8.66	25,418.53
508—All cases	448	7.02	18,332.46
508—Cases with code 96.72 reported	5	10.40	83,171.80
508—Cases without code 96.72 reported	443	6.98	17,600.64
509—All cases	117	4.32	8,994.71
509—Cases with code 96.72 reported	0	0	0
509—Cases without code 96.72 reported	117	4.32	8,994.71
510—All cases	1,209	6.90	18,457.21
510—Cases with code 96.72 reported	21	20.52	93,925.62
510—Cases without code 96.72 reported	1,188	6.66	17,123.18
511—All cases	413	4.18	10,046.89
511—Cases with code 96.72 reported	0	0	0
511—Cases without code 96.72 reported	413	4.18	10,046.89

We found 120 cases that reported code 96.72 within the 3,394 burn DRG cases (DRGs 504 through 511). Cases reporting code 96.72 have significantly longer average lengths of stay and average charges. The majority (54) of these cases that reported code 96.72 were in DRG 506. The cases with code 96.72 reported had average charges approximately 1.5 times higher than other cases in DRG 506 without code 96.72.

We noted that there were 21 cases that reported code 96.72 within DRG 510. Since the 21 patients were on continuous mechanical ventilation for 96 consecutive hours or more, it seems surprising that the principal diagnosis was listed as one of the nonextensive burn codes included in DRG 510. A closer review of these cases shows some questionable coding and reporting of information. It would appear that hospitals did not always correctly select the principal diagnosis (the reason after study that led to the hospital admission). For instance, one admission was for a second-degree burn of the ear. This patient was on a ventilator for over 96 hours. It would appear that the reason for the admission was a diagnosis other than the burn of the ear. Other cases where the patient received long-term mechanical ventilation included those with a principal diagnosis of first degree burn of the face, second degree burn of the nose, second degree burn of the lip, and an unspecified burn of the foot. These four cases reported average charges ranging from $48,551 to $186,824 and had lengths of stay ranging from 8 to 36 days.

The impact of long-term mechanical ventilation is quite clear on burn cases as was shown by the data above. Therefore, we are proposing to modify the burn DRGs 504 through 509 under MDC 22 to recognize this impact. We are proposing to modify DRG 504 and DRG 505 so that code 96.72 will be assigned to these DRGs when there is a principal diagnosis of extensive third degree burns or full thickness burns (those cases currently assigned to DRGs 504 through 509). In other words, when cases currently in DRGs 506 through 509 also have code 96.72 reported, they would now be assigned to DRGs 504 or 505. We are proposing to modify the titles of DRGs 504 and 505 to reflect the proposed changes in reporting code 96.72 as follows:

- Proposed DRG 504 (Extensive Burns or Full Thickness Burns With Mechanical Ventilation 96+ Hours With Skin Graft)
- Proposed DRG 505 (Extensive Burns or Full Thickness Burns With Mechanical Ventilation 96+ Hours Without Skin Graft)

Cases currently assigned to DRGs 504 and 505 that do not entail 96+ hours of mechanical ventilation will continue to be assigned to DRGs 504 and 505 because they would have extensive burns, as required by the DRG logic.

We are not proposing to include DRG 510 and DRG 511 within this revised DRG logic. Cases currently assigned to DRG 510 or DRG 511 that also report code 96.72 would not be reassigned to DRGs 504 and 505. We recommend that hospitals examine cases that are assigned to DRG 510 or DRG 511 and that have code 96.72 to determine if there are possible coding problems or other issues. As stated earlier, in examining reported cases within DRG 510, we noted several cases with code 96.72 that appear to have an incorrect principal diagnosis. It would appear that the principal diagnosis may more appropriately be related to an inhalation injury, if the injury was present at the time of admission.

We are specifically seeking comments on our proposal to move cases reporting code 96.72 from DRGs 506 through 509 and assign them to DRGs 504 and 505. We also are seeking comments on our proposal not to include DRGs 510 and 511 in this proposed revision.

9. Pre-MDC: Tracheostomy

In the August 1, 2002 IPPS final rule (67 FR 49996), for FY 2003, we modified DRG 482 (Tracheostomy for Face, Mouth, and Neck Diagnoses) and DRG 483 (Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses) to recognize procedure code 96.72 (Continuous mechanical ventilation 96+ hours) in the DRG 483 assignment. As discussed earlier, we were concerned about an underreporting of code 96.72 and wanted to encourage increased reporting of this code.

We examined cases in the MedPAR file in which code 96.72 was reported

within DRGs 482 and 483. The following chart illustrates the average charges and lengths of stays for cases within DRGs 482 and 483 with and without code 96.72 reported:

DRG	Count	Average length of stay	Average charges
482—All cases	3,557	11.77	$45,419.10
482—Cases with code 96.72	22	31.64	137,880.41
482—Cases without code 96.72	3,535	11.64	44,843.67
483—All cases	31,754	37.68	210,631.94
483—Cases with code 96.72	19,669	36.54	195,171.66
483—Cases without code 96.72	12,085	39.52	235,794.39

Of the 3,557 cases reported in DRG 482, only 22 cases reported code 96.72. These 22 cases did not have a tracheostomy performed. All 22 cases reported code 30.4 (Laryngectomy), which also leads to an assignment of DRG 482. It would appear that the long-term mechanical ventilation was performed through an endotracheal tube instead of through a tracheostomy. While the average charges for DRG 482 cases with code 96.72 reported were significantly higher than the average charges for other cases in the DRG, we do not believe that the very limited number of cases (22) warrants proposing a DRG modification. Therefore, we are not proposing any modification for DRG 482 at this time. We will continue to monitor cases assigned to this DRG.

In DRG 483, 19,669 cases were reported with code 96.72. However, the data were counter-intuitive. While one would expect to find higher average charges for cases reported with code 96.72, the opposite is the case. Cases in DRG 483 reported with code 96.72 had average charges that were $40,623 lower than those not reported with code 96.72. Clearly, the presence or absence of code 96.72 does not explain differences in charges for patients within DRG 483.

As stated earlier, we are concerned that hospitals may not always report code 96.72 because of space limitations. The electronic billing system limits the number of procedure codes that can be reported to six codes. We then looked at whether or not another major O.R. procedure is performed in addition to a tracheostomy. The DRG 483 logic requires that all patients assigned to DRG 483 have a tracheostomy. We examined cases in DRG 483 in the MedPAR file and discovered that those patients in DRG 483 who have a major procedure performed in addition to the tracheostomy have higher charges. A major procedure is a procedure whose code is included on the list that would be assigned to DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis), except for tracheostomy codes 31.21 and 31.29. Currently, this additional O.R. procedure does not affect the DRG assignment for cases assigned to DRG 483. The following chart reflects our findings.

DRG	Count	Average length of stay	Average Charges
483—All Cases	31,754	37.68	$210,631.94
483—Cases with major O.R. procedure	15,664	42.70	255,914.00
483—Cases without major O.R. procedure	12,867	32.7	168,890.20

We found that cases of patients assigned to DRG 483 who had a major procedure (in addition to the required tracheostomy) had average charges that were $87,023 higher than the average charges for cases without a major O.R. procedure and an average length of stay of 5 days more than those without a major O.R. procedure. We found that the performance of an additional major O.R. procedure helps to identify the more expensive patients within DRG 483.

Therefore, as a result of our findings, we are proposing to modify DRG 483 by dividing these cases into two new DRGs depending on whether or not there is a major O.R. procedure reported (in addition to the tracheostomy). We are proposing to delete DRG 483 and create two new DRGs as follows:

- Proposed new DRG 541 (Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses With Major O.R. Procedure)
- Proposed new DRG 542 (Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses Without Major O.R. Procedure)

We are specifically seeking comments on our proposal to delete DRG 483 and replace it with two proposed new DRGs by splitting the assignment of cases on the basis of the performance of a major O.R. procedure (in addition to the tracheostomy).

10. Medicare Code Editor (MCE) Changes

[If you choose to comment on issues in this section, please include the caption ''Medicare Code Editor'' at the beginning of your comment.]

As explained under section II.B.1. of this preamble, the Medicare Code Editor (MCE) is a software program that detects and reports errors in the coding of Medicare claims data. In this proposed rule, we are proposing to make changes to three of the edits in the MCE.

a. Edit 11 (Noncovered Procedures) in the MCE contains codes that describe procedures for which Medicare does not provide reimbursement. We received a request to remove procedure codes relating to stem cell transplants from Edit 11 to conform the MCE edit to our published coverage decisions in the Medicare Coverage Issues Manual. In accordance with chapter 13, section 4 of the Program Integrity Manual (PIM), contractor discretion exists to cover diagnoses that are not explicitly stated in a national coverage decision as noncovered. Specifically this section states: that ''a local medical review policy (LMRP)'' must be clear, concise, properly formatted and not restrict or conflict with NCDs or coverage provision in interpretive manuals. If an NCD or coverage provision in an interpretive manual states that a given

item is ''covered for diagnoses/conditions A, B, and C,'' contractors may not use that as a basis to develop LMRP to cover only ''diagnosis/conditions A, B, C''. When an NCD or coverage provision in an interpretive manual does not exclude coverage for other diagnoses/conditions, contractors must allow for individual consideration unless the LMRP supports automatic denial for some or all of those other diagnoses/conditions.''

The national coverage decision on stem cell transplantation provides for coverage of certain diagnoses and excludes coverage for other diagnoses. However, the vast majority of diagnoses are not mentioned as either covered or noncovered. In accordance with the above-cited provision of the PIM, contractors must allow for individual consideration of these diagnoses. Thus, they are not appropriate for inclusion in the edit for noncovered procedures.

We agree that we need to make conforming changes relating to stem cell transplants. Therefore, we are proposing the following restructure of Edit 11:

This list contains ICD–9–CM procedure codes identified as ''Noncovered Procedures'' that are always considered noncovered procedures:

- 11.71, Keratomileusis
- 11.72, Keratophakia
- 11.75, Radial keratotomy
- 11.76, Epikeratophakia
- 36.32, Other transmyocardial revascularization
- 37.35, Partial ventriculectomy
- 37.52, Implantation of total replacement heart system
- 37.53, Replacement or repair of thoracic unit of total replacement heart system
- 37.54, Replacement or repair of other implantable component of total replacement heart system
- 39.28, Extracranial-intracranial (EC–IC) vascular bypass
- 44.93, Insertion of gastric bubble (balloon)
- 50.51, Auxiliary liver transplant
- 52.83, Heterotransplant of pancreas
- 57.96, Implantation of electronic bladder stimulator
- 57.97, Replacement of electronic bladder stimulator
- 63.70, Male sterilization procedure, not otherwise specified
- 63.71, Ligation of vas deferens
- 63.72, Ligation of spermatic cord
- 63.73, Vasectomy
- 64.5, Operations for sex transformation, not elsewhere classified
- 66.21, Bilateral endoscopic ligation and crushing of fallopian tubes
- 66.22, Bilateral endoscopic ligation and division of fallopian tubes
- 66.29, Other bilateral endoscopic destruction or occlusion of fallopian tubes
- 66.31, Other bilateral ligation and crushing of fallopian tubes
- 66.32, Other bilateral ligation and division of fallopian tubes
- 66.39, Other bilateral destruction or occlusion of fallopian tubes
- 98.52, Extracorporeal shockwave lithotripsy [ESWL] of the gallbladder and/or bile duct
- 98.59, Extracorporeal shockwave lithotripsy of other sites

The following list contains ICD–9–CM procedure codes identified as ''Noncovered Procedures'' only when any of the following diagnoses are present as either a principal or secondary diagnosis.

Procedure List

- 41.01, Autologous bone marrow transplant without purging
- 41.04, Autologous hematopoietic stem cell transplant without purging
- 41.07, Autologous hematopoietic stem cell transplant with purging
- 41.09, Autologous bone marrow transplant with purging

Principal or Secondary Diagnosis List

- 204.00, Acute lymphoid leukemia, without mention of remission
- 205.00, Acute myeloid leukemia, without mention of remission
- 206.00, Acute monocytic leukemia, without mention of remission
- 207.00, Acute erythremia and erythroleukemia, without mention of remission
- 208.00, Acute leukemia of unspecified cell type, without mention of remission
- 205.10, Acute myeloid leukemia, in remission
- 205.11, Chronic myeloid leukemia, in remission

The following list contains ICD–9–CM procedure codes identified as ''Noncovered Procedures'' only when any of the following diagnoses are present as either a principal or secondary diagnosis.

Procedure List

- 41.02, Allogeneic bone marrow transplant with purging
- 41.03, Allogeneic bone marrow transplant without purging
- 41.05, Allogeneic hematopoietic stem cell transplant without purging
- 41.08, Allogeneic hematopoietic stem cell transplant with purging

Principal or Secondary Diagnosis List

- 203.00, Multiple myeloma, without mention of remission
- 203.01, Multiple myeloma, in remission

The following list contains ICD–9–CM procedure codes identified as ''Non-Covered Procedures'' except when there is at least one principal or secondary diagnosis code present from both list 1 and list 2.

Procedure List

- 52.80, Pancreatic transplant, not otherwise specified
- 52.82, Homotransplant of pancreas

Procedure List 1

- 250.00, Diabetes mellitus without mention of complication, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, not stated as uncontrolled
- 250.01, Diabetes mellitus without mention of complication, type I [insulin dependent type] [IDDM] [juvenile type], not stated as uncontrolled
- 250.02, Diabetes mellitus without mention of complication, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled
- 250.03, Diabetes mellitus without mention of complication, type I [insulin dependent type] [IDDM type] [juvenile type], uncontrolled
- 250.10, Diabetes with ketoacidosis, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, not stated as uncontrolled
- 250.11, Diabetes with ketoacidosis, type I [insulin dependent type] [IDDM] [juvenile type], not stated as uncontrolled
- 250.12, Diabetes with ketoacidosis, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled
- 250.13, Diabetes with ketoacidosis, type I [insulin dependent type] [IDDM type] [juvenile type], uncontrolled
- 250.20, Diabetes with hyperosmolarity, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, not stated as uncontrolled
- 250.21, Diabetes with hyperosmolarity, type I [insulin dependent type] [IDDM] [juvenile type], not stated as uncontrolled
- 250.22, Diabetes with hyperosmolarity, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled
- 250.23, Diabetes with hyperosmolarity, type I [insulin dependent type] [IDDM] [juvenile type], uncontrolled
- 250.30, Diabetes with other coma, type II [non-insulin dependent type]

[NIDDM type] [adult-onset type] or unspecified type, not stated as uncontrolled
- 250.31, Diabetes with other coma, type I [insulin dependent type] [IDDM] [juvenile type], not stated as uncontrolled
- 250.32, Diabetes with other coma, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled
- 250.33, Diabetes with other coma, type I [insulin dependent type] [IDDM] [juvenile type], uncontrolled, type I [insulin dependent type] [IDDM type] [juvenile type], uncontrolled
- 250.40, Diabetes with renal manifestation, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, not stated as uncontrolled
- 250.41, Diabetes with renal manifestation, type I [insulin dependent type] [IDDM] [juvenile type], not stated as uncontrolled
- 250.42, Diabetes with renal manifestation, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled
- 250.43, Diabetes with renal manifestation, type I [insulin dependent type] [IDDM type] [juvenile type], uncontrolled
- 205.50, Diabetes with ophthalmic manifestations, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, not stated as uncontrolled
- 205.51, Diabetes with ophthalmic manifestations, type I [insulin dependent type] [IDDM] [juvenile type], not stated as uncontrolled
- 205.52, Diabetes with ophthalmic manifestations, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled
- 205.53, Diabetes with ophthalmic manifestations, type I [insulin dependent type] [IDDM type] [juvenile type], uncontrolled
- 250.60, Diabetes with neurological manifestations, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, not stated as uncontrolled
- 250.61, Diabetes with neurological manifestations, type I [insulin dependent type] [IDDM] [juvenile type], not stated as uncontrolled
- 250.62, Diabetes with neurological manifestations, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled
- 250.63, Diabetes with neurological manifestations, type I [insulin dependent type] [IDDM type] [juvenile type], uncontrolled
- 250.70, Diabetes with peripheral circulatory disorders, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, not stated as uncontrolled
- 250.71, Diabetes with peripheral circulatory disorders type I [insulin dependent type] [IDDM] [juvenile type], not stated as uncontrolled
- 250.72, Diabetes with peripheral circulatory disorders, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled
- 250.73, Diabetes with peripheral circulatory disorders, type I [insulin dependent type] [IDDM type] [juvenile type], uncontrolled
- 250.80, Diabetes with other specified manifestations, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, not stated as uncontrolled
- 250.81, Diabetes with other specified manifestations, type I [insulin dependent type] [IDDM] [juvenile type], not stated as uncontrolled
- 250.82, Diabetes with other specified manifestations, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled
- 250.83, Diabetes with other specified manifestations, type I [insulin dependent type] [IDDM] [juvenile type], uncontrolled
- 250.90, Diabetes with unspecified complication, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, not stated as uncontrolled
- 250.91, Diabetes with unspecified complication, type I [insulin dependent type] [IDDM] [juvenile type], not stated as uncontrolled
- 250.92, Diabetes with unspecified complication, type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, uncontrolled
- 250.93, Diabetes with unspecified complication, type I [insulin dependent type] [IDDM] [juvenile type], uncontrolled

Diagnosis List 2

- 403.01, Malignant hypertensive renal disease, with renal failure
- 403.11, Benign hypertensive renal disease, with renal failure
- 403.91, Unspecified hypertensive renal disease, with renal failure
- 404.02, Malignant hypertensive heart and renal disease, with renal failure
- 404.03, Malignant hypertensive heart and renal disease, with heart failure and renal failure
- 404.12, Benign hypertensive heart and renal disease, with renal failure
- 404.13, Benign hypertensive heart and renal disease, with heart failure and renal failure
- 404.92, Unspecified hypertensive heart and renal disease, with renal failure
- 404.93, Unspecified hypertensive heart and renal disease, with heart failure and renal failure
- 585, Chronic renal failure
- V42.0, Organ or tissue replaced by transplant, kidney
- V43.89, Organ or tissue replaced by other means, other

b. Edit 6 (Manifestations Not Allowed As Principal Diagnosis) in the MCE contains codes that describe the manifestation of an underlying disease, not the disease itself, and therefore, should not be used as a principal diagnosis. The following codes describe manifestations of an underlying disease; they should not be used as a principal diagnosis according to ICD–9–CM coding convention. Therefore, we are proposing to add the following diagnosis codes to Edit 6:

- 289.52, Splenic sequestration
- 571.3, Acute chest syndrome
- 785.52, Septic shock

Coding conventions in the ICD–9–CM Diagnostic Tabular List specify that etiologic conditions be coded first.

c. Edit 9 (Unacceptable Principal Diagnoses) contains codes ''that describe a circumstance which influences an individual's health status but is not a current illness of injury; therefore, these codes are considered unacceptable as a principal diagnosis.'' (This definition can be found on page 1094 of the DRG Definitions Manual, Version 21.0). Therefore, these codes are considered unacceptable as a principal diagnosis. Last year, we became aware that two codes should be removed from this list, as they can be legitimate causes for inpatient admission. However, we were made aware of this too late in the process to make a change to this edit prior to FY 2004. We will now be able to make the necessary system changes before the start of FY 2005. Therefore, in this proposed rule, we are proposing to remove the following codes from Edit 9:

- V53.01, Adjustment of cerebral ventricular (communicating) shunt
- V53.02, Adjustment of neuropacemaker (brain) (peripheral nerve) (spinal cord)

11. Surgical Hierarchies

[If you choose to comment on the issues in this section, please include the caption ''Surgical Hierarchies'' at the beginning of your comment.]

Some inpatient stays entail multiple surgical procedures, each one of which, occurring by itself, could result in assignment of the case to a different DRG within the MDC to which the principal diagnosis is assigned. Therefore, it is necessary to have a decision rule within the GROUPER by which these cases are assigned to a single DRG. The surgical hierarchy, an ordering of surgical classes from most resource-intensive to least resource-intensive, performs that function. Application of this hierarchy 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 recalibrations, we reviewed the surgical hierarchy of each MDC, as we have for previous reclassifications and recalibrations, to determine if the ordering of classes coincides with the intensity of resource utilization.

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

This methodology may occasionally result in assignment of a case involving multiple procedures 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 search for the procedure in the most resource-intensive surgical class, this result is unavoidable.

We note that, notwithstanding the foregoing discussion, there are a few instances when a surgical class with a lower average charge is ordered above a surgical class with a higher average charge. For example, the ''other O.R. procedures'' surgical class is uniformly ordered last in the surgical hierarchy of each MDC in which it occurs, regardless of the fact that the average charge for the DRG or DRGs in that surgical class may be higher than that for other surgical classes in the MDC. The ''other O.R. procedures'' class is a group of procedures that are only infrequently related to the diagnoses in the MDC but are still occasionally performed on patients in the MDC with these diagnoses. Therefore, assignment to these surgical classes should only occur if no other surgical class more closely related to the diagnoses in the MDC is appropriate.

A second example occurs when the difference between the average charges for two surgical classes is very small. We have found that small differences generally do not warrant reordering of the hierarchy because, as a result of reassigning cases on the basis of the hierarchy change, the average charges are likely to shift such that the higher-ordered surgical class has a lower average charge than the class ordered below it.

Based on the preliminary recalibration of the DRGs, we are proposing modifications of the surgical hierarchy as set forth below.

At this time, we are proposing to revise the surgical hierarchy for the pre-MDC DRGs and MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue).

In the pre-MDC DRGs, we are proposing to reorder DRG 541 (Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses With Major O.R. Procedure) and DRG 542 (Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses Without Major O.R. Procedure) above DRG 480 (Liver Transplant).

In MDC 8, we are proposing to—

- Reorder DRG 496 (Combined Anterior/Posterior Spinal Fusion), DRG 497 (Spinal Fusion Except Cervical With CC), and DRG 498 (Spinal Fusion Except Cervical Without CC) above DRG 471 (Bilateral or Multiple Major Joint Procedures of the Lower Extremity).
- Reorder DRG 519 (Cervical Spinal Fusion With CC) and DRG 520 (Cervical Spinal Fusion Without CC) above DRG 216 (Biopsies of the Musculoskeletal System and Connective Tissue).
- Reorder DRG 213 (Amputation for the Musculoskeletal System and Connective Tissue Disorders) above DRG 210 (Hip and Femur Procedures Except Major Joint Age > 17 With CC), DRG 211 (Hip and Femur Procedures Except Major Joint Age > 17 Without CC), and DRG 212 (Hip and Femur Procedures Except Major Joint Age 0–17).
- Reorder DRG 499 (Back and Neck Procedures Except Spinal Fusion With CC) and DRG 500 (Back and Neck Procedures Except Spinal Fusion Without CC) above DRG 218 (Lower Extremity and Humerus Procedures Except Hip, Foot, and Femur Age > 17 With CC), DRG 219 (Lower Extremity and Humerus Procedures Except Hip, Foot, and Femor Age > 17 Without CC), and DRG 220 (Lower Extremity and Humerus Procedures Except Hip, Foot, and Femur Age 0–17).

12. Refinement of Complications and Comorbidities (CC) List

[If you choose to comment on issues in this section, please include the caption ''CC List'' at the beginning of your comment.]

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

In the May 19, 1987 proposed notice (52 FR 18877) and the September 1, 1987 final notice (52 FR 33154), 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.

• Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for the same condition should not be considered CCs for one another.

• Codes for the same condition that cannot coexist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another.

• Codes for 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. 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.[1]

We are proposing a limited revision of the CC Exclusions List to take into account the proposed changes that will be made in the ICD–9-CM diagnosis coding system effective October 1, 2004. (*See* section II.B.15. of this preamble for a discussion of ICD–9–CM changes.) We are proposing these changes in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6G and 6H in 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, 2004. Each table shows the principal diagnoses with 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, 2004, the indented diagnoses would 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, 2004, the indented diagnoses would 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 $152.50 plus 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, VA 22161; or by calling (800) 553–6847.

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2001, 2002, 2003, and 2004) and those in Tables 6G and 6H of this proposed rule for FY 2005 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, 2004. (**Note:** There was no CC Exclusions List in FY 2000 because we did not make changes to the ICD–9–CM codes for FY 2000.)

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with CMS, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 21.0, is available for $225.00, which includes $15.00 for shipping and handling. Version 22.0 of this manual, which includes the final FY 2004 DRG changes, is available for $225.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, CT 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

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

[If you choose to comment on issues in this section, please include the caption ''DRGs 468, 476, and 477'' at the beginning of your comment.]

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

DRGs 468, 476, and 477 are reserved for those cases in which none of the O.R. procedures performed are 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, not elsewhere classified
• 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
• 60.96, Transurethral destruction of prostate tissue by microwave thermotherapy
• 60.97, Other transurethral destruction of prostate tissue by other thermotherapy
• 60.99, Other operations on prostate

All remaining O.R. 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.[2]

[1] See the September 30, 1988 final rule (53 FR 38485) for the revision made for the discharges occurring in FY 1989; the September 1, 1989 final rule (54 FR 36552) for the FY 1990 revision; the September 4, 1990 final rule (55 FR 36126) for the FY 1991 revision; the August 30, 1991 final rule (56 FR 43209) for the FY 1992 revision; the September 1, 1992 final rule (57 FR 39753) for the FY 1993 revision; the September 1, 1993 final rule (58 FR 46278) for the FY 1994 revisions; the September 1, 1994 final rule (59 FR 45334) for the FY 1995 revisions; the September 1, 1995 final rule (60 FR 45782) for the FY 1996 revisions; the August 30, 1996 final rule (61 FR 46171) for the FY 1997 revisions; the August 29, 1997 final rule (62 FR 45966) for the FY 1998 revisions; the July 31, 1998 final rule (63 FR 40954) for the FY 1999 revisions, the August 1, 2000 final rule (65 FR 47064) for the FY 2001 revisions; the August 1, 2001 final rule (66 FR 39851) for the FY 2002 revisions; the August 1, 2002 final rule (67 FR 49998) for the FY 2003 revisions; and the August 1, 2003 final rule (68 FR 45364) for the FY 2004 revisions.) In the July 30, 1999 final rule (64 FR 41490), we did not modify the CC Exclusions List for FY 2000 because we did not make any changes to the ICD–9–CM codes for FY 2000.

[2] In the August 1, 2003 final rule (68 FR 45365) we moved several procedures from DRG 468 to DRGs 476 and 477 because the procedures are nonextensive. The original list of the ICD–9–CM

Continued

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

We annually conduct a review of procedures producing assignment to DRG 468 or DRG 477 on the basis of volume, by procedure, to see if it would be appropriate to move procedure codes out of these DRGs into one of the surgical DRGs for the MDC into which the principal diagnosis falls. The data are arrayed two ways for comparison purposes. We look at a frequency count of each major operative procedure code. We also compare procedures across MDCs by volume of procedure codes within each MDC.

We identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. Based on this year's review, we did not identify any procedures in DRG 477 that should be removed. Therefore, we are not proposing to move any procedures from DRG 477 to one of the surgical DRGs.

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

We also annually review the list of ICD–9–CM procedures that, when in combination with their principal diagnosis code, result in assignment to DRGs 468, 476, and 477, to ascertain if any of those procedures should be reassigned from one of these three DRGs to another of the three DRGs based on average charges and the length of stay. We look at the data for trends such as shifts in treatment practice or reporting practice that would make the resulting DRG assignment illogical. If we find these shifts, we would propose to move cases to keep the DRGs clinically similar or to provide payment for the cases in a similar manner. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data. Based on a comment we received in response to last year's proposed rule (68 FR 45366), we are proposing to move procedure code 51.23 (Laparoscopic cholecystectomy) from DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis) into DRG 477 (Nonextensive O.R. Procedure Unrelated to Principal Diagnosis).

The commenter suggested that a laparoscopic procedure was probably not an extensive O.R. procedure; it was more likely a nonextensive O.R. procedure. We agree and, therefore, are proposing this change. In addition, we are proposing to add several new procedure codes to DRGs 476 and 477. These procedures are also listed on Table 6B—New Procedure Codes in the Addendum to this proposed rule. However, DRGs 476 and 477 are not limited to one MDC, so the new codes are also included here for nonextensive cases in which the procedures are unrelated to the principal diagnosis:

- 44.67, Laparoscopic procedures for creation of esophagogastric sphincteric competence
- 44.68, Laparoscopic gastroplasty
- 44.95, Laparoscopic gastric restrictive procedure
- 44.96, Laparoscopic revision of gastric restrictive procedure
- 44.97, Laparoscopic removal of gastric restrictive device(s)
- 44.98, Laparoscopic adjustment of size of adjustable gastric restrictive device

In DRG 476, the above codes are to be added to the section ''With or Without Operating Room Procedures'' in the GROUPER logic.

We are not proposing to move any procedure codes from DRG 476 to DRGs 468 or 477, or from DRG 477 to DRGs 468 or 476.

c. Adding Diagnosis or Procedure Codes to MDCs

Based on our review this year, we are not proposing to add any diagnosis codes to MDCs.

14. Pancreatic Islet Cell Transplantation in Clinical Trials

[If you choose to comment on issues in this section, please include the caption ''Pancreatic Islet Cell Transplantation'' at the beginning of your comment.]

Section 733(a) of Public Law 108–173 directs the Secretary, acting through the National Institute of Diabetes and Digestive and Kidney Disorders (NIDDKD) to conduct a clinical investigation of pancreatic islet cell transplantation that includes Medicare beneficiaries. Section 733(b) provides for Medicare payments, beginning no earlier than October 1, 2004, for the routine costs as well as the costs of the transplantation and appropriate related items and services for Medicare beneficiaries who are participating in a clinical trial as if such transplantation were covered under Medicare Part A or Part B. Routine costs are defined as reasonable and necessary routine patient care costs (as defined in the CMS Coverage Issues Manual, Section 30–1) including immunosuppressive drugs and other followup care. Section 733(c)(2) defines transplantation and appropriate related items and services as items and services related to the acquisition and delivery of the pancreatic islet cell transplantation, notwithstanding any national noncoverage determination contained in the CMS Coverage Issues Manual.

While the DRG payment will cover the transplant injection and the subsequent hospital stay, we are considering establishing an add-on payment to the DRG payment amount to reimburse the acquisition costs associated with islet cell procurement. Historically, organ acquisition costs have been reimbursed as a cost pass-through. However, islet cell transplants are not exactly the same as solid organ transplants. While solid pancreata are procured, islet cells are not transplanted in the solid organ state as are other types of organs. Rather, the pancreata are procured by an organ procurement organization (OPO) and are then sent to an islet cell resource center that extracts the islet cells from the pancreata and sends the cells on to the transplant center. Since the procurement and processing system for islet cell transplants is not the same as for solid organ transplants, we do not intend to pay for these costs as a pass through. With the anticipated small number of beneficiaries in the clinical trial and the Medicare program's unfamiliarity with the isolation process, we believe it is most appropriate at this time to have a set payment rate for acquisition costs, rather than attempting a case-by-case determination of the reasonableness of these costs in each institution. We note there is precedent to exclude acquisition costs from the pass-through payment process. For example, stem cell transplants and corneal transplants do not have acquisition costs reimbursed as a cost pass-through payment.

The add-on payment would be a single amount that includes pre-transplant tests and services, pancreas procurement, and islet isolation services. We are proposing to use an

procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV. of the Addendum to the September 30, 1988 final rule (53 FR 38591). As part of the final rules published on September 4, 1990 (55 FR 36135), August 30, 1991 (56 FR 43212), September 1, 1992 (57 FR 23625), September 1, 1993 (58 FR 46279), September 1, 1994 (59 FR 45336), September 1, 1995 (60 FR 45783), August 30, 1996 (61 FR 46173), and August 29, 1997 (62 FR 45981), we moved several other procedures from DRG 468 to DRG 477, and some procedures from DRG 477 to DRG 468. No procedures were moved in FY 1999, as noted in the July 31, 1998 final rule (63 FR 40962); in FY 2000, as noted in the July 30, 1999 final rule (64 FR 41496); in FY 2001, as noted in the August 1, 2000 final rule (65 FR 47064); or in FY 2002, as noted in the August 1, 2001 final rule (66 FR 39852). In the August 1, 2002 final rule (67 FR 49999), we did not move any procedures from DRG 477. However, we did move procedures codes from DRG 468 and placed them in more clinically coherent DRGs.

add-on as opposed to increasing the DRG amount because the DRGs at issue are also applied in cases involving a variety of other procedures that do not include the costly islet cell acquisition required for this procedure. Thus, including these costs in the DRGs would have the potential of skewing the weights for all other DRGs. We are asking for specific comments on whether an add-on payment amount is the appropriate way to reimburse islet cell acquisition costs, or whether another methodology may be more appropriate.

In addition, while we have some data available regarding the cost of pancreas procurement, we are specifically asking for any other data that support the costs of acquisition and the costs of isolation cell resource centers.

Because we do not yet have enough data, we are unable to publish a proposed acquisition amount in this proposed rule. After analyzing data submitted during the comment period, other data acquired by CMS, and any suggested changes from the methodology proposed, we will issue the final organ acquisition payment amount in the IPPS final rule.

Pancreatic islet cell transplantation during the clinical trial will be performed to decrease or eliminate the need for insulin in patients with Type I diabetes. Islet cells are acquired from a cadaveric pancreas donor (islet allotransplantation).

As described in II.B.1. of this preamble, ICD–9–CM diagnosis and procedure codes are used to determine DRG assignments. In 1996, CMS (then HCFA) created codes for islet cell transplantation:

- 52.84, Autotransplantation of cells of islets of Langerhans
- 52.85, Allotransplantation of cells of islets of Langerhans

The Medicare GROUPER does not consider codes 52.84 and 52.85 as O.R. procedures and, therefore, these codes do not move the case from a medical DRG into a surgical DRG unless another procedure is performed. Based on the circumstances noted above under which pancreatic islet cell transplantation would be performed, we identified the three most logical DRGs to which we believe cases would be assigned. If a patient has Type I diabetes mellitus with ESRD and a pancreatectomy is performed, the case would group to DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis). If a patient has Type I diabetes mellitus with ESRD and is also receiving a kidney transplant (simultaneous kidney and islet transplantation), the case would group to DRG 302 (Kidney Transplant). If a patient has Type I diabetes mellitus with ESRD and a history of a kidney transplant and then has the islet cells inserted via an open approach, the case would group to DRG 315 (Other Kidney and Urinary Tract O.R. Procedures).

As each case is assigned to a DRG based on all of the ICD–9–CM codes reported, cases could also be assigned to DRGs other than those mentioned above. In fact, our review of FY 2003 MedPAR data revealed that codes 52.84 and 52.85 were present in only four cases, and that each case was assigned to a different DRG. We found one case each in DRG 18 (Cranial and Peripheral Nerve Disorders With CC), DRG 192 (Pancreas, Liver, and Shunt Procedures Without CC), DRG 207 (Disorders of the Biliary Tract With CC), and DRG 302 (Kidney Transplant).

We are reluctant to propose assigning the islet cell codes to one specific DRG, as the islet cell infusion will have different indications depending on the merits of each case, as is shown from the MedPAR data mentioned above. In addition, we do not currently have accurate cost data or charges for patients in this type of clinical trial, which makes it difficult to determine an appropriate DRG weight. As a result, assignment of cases to a specific DRG might have the consequence of either overpaying or underpaying the cases. We believe that both of these consequences are unacceptable. Therefore, we are not proposing that cases involved in the clinical trials be assigned to one specific DRG for payment purposes. As we believe that these cases will be assigned to DRGs 302, 315, and 468, we are proposing to establish an add-on payment for cases in these three DRGs containing procedure codes 52.84 or 52.85. As stated earlier, we will not be able to establish the amount of this add-on until we have determined procurement costs for the islet cells. We are soliciting information from transplant centers and organ procurement organizations on costs for these types of transplantations.

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

[If you choose to comment on issues in this section, please include the caption ''ICD–9–CM Coding'' at the beginning of your comment.]

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

The ICD–9–CM Manual contains the list of valid diagnosis and procedure codes. (The ICD–9–CM Manual is available from the Government Printing Office on CD–ROM for $25.00 by calling (202) 512–1800.) The NCHS has lead responsibility for the ICD–9–CM diagnosis codes included in the *Tabular List* and *Alphabetic Index for Diseases*, while CMS has lead responsibility for the ICD–9–CM procedure codes included in the *Tabular List* and *Alphabetic Index for Procedures*.

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

The Committee presented proposals for coding changes for implementation in FY 2005 at public meetings held on April 3, 2003 and December 4–5, 2003, and finalized the coding changes after consideration of comments received at the meetings and in writing by January 12, 2004. Those coding changes are announced in Tables 6A through 6F in the Addendum to this proposed rule. Copies of the minutes of the procedure codes discussions at the Committee's 2003 meetings can be obtained from the CMS Web site: *http://www.cms.gov/paymentsystems/icd9/*. The minutes of

the diagnoses codes discussions at the 2003 meetings are found at: *http://www.cdc.gov/nchs/icd9.htm.* Paper copies of these minutes are no longer available and the mailing list has been discontinued.

For a report of procedure topics discussed at the April 1–2, 2004 meeting, see the Summary Report at: *http://www.cms.hhs.gov/payment systems/icd9/.* For a report of the diagnosis topics discussed at the April 1–2, 2004 meeting, see the Summary Report at: *http:/www.cdc.gov/nchs/icd9.htm.*

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 2404, 3311 Toledo Road, Hyattsville, MD 20782. Comments may be sent by E-mail to: *dfp4@cdc.gov.*

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson, ICD–9–CM Coordination and Maintenance Committee, CMS, Center for Medicare Management, Hospital and Ambulatory Policy Group, Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850. Comments may be sent by E-mail to: *Patricia.Brooks1@cms.hhs.gov.*

The ICD–9–CM code changes that have been approved will become effective October 1, 2004. The new ICD–9–CM codes are listed, along with their DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in the Addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. In this proposed rule, we are only soliciting comments on the proposed DRG classification of these new codes.

For codes that have been replaced by new or expanded codes, the corresponding new or expanded diagnosis codes are included in Table 6A. New procedure codes are shown in Table 6B. Diagnosis codes that have been replaced by expanded codes or other codes or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2004. Table 6D usually contains invalid procedure codes, however, for FY 2005, there are no invalid procedure codes. Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles), which also includes the DRG assignments for these revised codes. Table 6F includes revised procedure code titles for FY 2005.

The first of the 2004 public meetings was held on April 1–2, 2004. In the September 7, 2001 final rule implementing the IPPS new technology add-on payments (66 FR 46906), we indicated we would attempt to include proposals for procedure codes that would describe new technology discussed and approved at the April meeting as part of the code revisions effective the following October.

Section 503(a) of Public Law 108–173 includes a requirement for updating ICD–9–CM codes twice a year instead of the current process of annual updates on October 1 of each year. This requirement is included as part of the amendments to the Act relating to recognition of new technology under the IPPS. Section 503(a) amended section 1886(d)(5)(K) of the Act by adding a new clause (vii) which states that the ''Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) * * * until the fiscal year that begins after such date.'' Because this new statutory requirement will have a significant impact on health care providers, coding staff, publishers, system maintainers, software systems, among others, we are soliciting comments on our proposals described below to implement this requirement. This new requirement will improve the recognition of new technologies under the IPPS system by providing information on these new technologies at an earlier date. Data would be available 6 months earlier than would be possible with updates occurring only once a year on October 1. Many coding changes apply to longstanding medical issues.

While the new requirement states that the Secretary shall not adjust the payment of the DRG classification for the April 1 new codes, the Department will have to update its DRG software and other systems in order to recognize and accept the new codes. We will also have to publicize the code changes and the need for a mid-year systems update by providers to capture the new codes. Hospitals will have to obtain the new code books and encoder updates, and make other system changes in order to capture and report the new codes. We are aware of the additional burden this will have on health care providers.

The ICD–9–CM Coordination and Maintenance Committee has held its meetings in April and December of each year in order to update the codes and the applicable payment and reporting systems by October 1 of each year. Items are placed on the agenda for the ICD–9–CM Coordination and Maintenance Committee meeting if the request is received at least 2 months prior to the meeting. This requirement allows time for staff to review and research the coding issues and prepare material for discussion at the meeting. It also allows time for the topic to be publicized in meeting announcements in the **Federal Register** as well as on the CMS Web site. The public decides whether or not to attend the meeting based on the topics listed on the agenda. In order to provide an update on April 1, it became clear that a December Committee meeting would not provide time to finalize and publicize these code revisions. Final decisions on code title revisions are currently made by March 1 so that these titles can be included in the IPPS proposed rule. A complete addendum describing details of all changes to ICD–9–CM, both tabular and index, are publicized on CMS and NCHS web pages in May of each year. Publishers of coding books and software companies use this information to modify their products that are used by health care providers. This 5-month time period has proved to be necessary for hospitals and other providers to update their systems.

A discussion of this timeline and the need for changes are included in the December 4–5, 2003 ICD–9–CM Coordination and Maintenance Committee minutes. The public provided comment that additional time would be needed to update hospital systems and obtain new code books and coding software. There was considerable concern expressed about the impact this new update would have on providers. Therefore, we are rescheduling the second Committee meeting for 2004. We have scheduled this meeting for October 7–8, 2004. Those who wish to have a coding issue discussed at the October Committee meeting would be required to submit their request by August 7, 2004. The Department will continue this process to accommodate all requestors who submit appropriate requests in a timely manner.

We are proposing to implement section 503(a) by developing a mechanism for approving, in time for the April update, diagnoses and procedure code revisions needed to describe new technologies and medical services for purposes of the new technology add-on payment process. We are proposing the following process for

making these determinations. Topics considered during the October ICD–9–CM Coordination and Maintenance Committee meeting would be considered for an April 1 update if a strong and convincing case is made by the requestor at the Committee's public meeting. The request must identify the reason why a new code is needed in April for purposes of the new technology process. The participants at the meeting and those reviewing the Committee meeting summary report would be provided the opportunity to comment on this expedited request. All other topics would be considered for the October 1 update. Participants at the Committee meeting would be encouraged to comment on all such requests.

We believe that this proposal captures the intent of section 503(a). This requirement was included in the provision revising the standards and process for recognizing new technology under the IPPS. In addition, the need for approval of new codes outside the existing cycle (October 1) arises most frequently and most acutely where the new codes would capture new technologies that are (or will be) under consideration for new technology add-on payments. Thus, we believe this provision was intended to expedite data collection through the assignment of new ICD–9–CM codes for new technologies seeking higher payments. Our proposal is designed to carry out that intention, while minimizing the additional administrative costs associated with mid-year changes to the ICD–9–CM codes.

The Department of Health and Human Services has been actively working on the development of new coding systems to replace the ICD–9–CM. In December 1990, the National Committee on Vital and Health Statistics (NCVHS) issued a report noting that, while the ICD–9–CM classification system had been responsive to changing technologies and identifying new diseases, there was concern that the ICD classification might be stressed to a point where the quality of the system would soon be compromised. The ICD–10–CM (for diagnoses) and the ICD–10–PCS (for procedures) were developed in response to these concerns. These efforts have become increasingly important because of the growing number of problems with the ICD–9–CM, which was implemented 25 years ago.

In November 2003, the NCVHS recommended that the Secretary prepare a notice of proposed rulemaking for the implementation of ICD–10–CM and ICD–10–PCS. A complete report on the activities of this committee can be found at: *http://www.ncvhs.hhs.gov.* The Department is studying these recommendations.

16. Other Issues

[If you choose to comment on issues in this section, please include the caption ''Other DRG Issues'' at the beginning of your comments.]

a. Craniotomy Procedures

As discussed in the August 1, 2003 IPPS final rule (68 FR 45353), for FY 2004 we conducted an analysis of the charges for various procedures and diagnoses within DRG 1 (Craniotomy Age > 17 With CC) and DRG 2 (Craniotomy Age > 17 Without CC) to determine whether further changes to these DRGs were warranted. Based on our analysis and consideration of public comments received on our May 19, 2003 IPPS proposed rule (68 FR 27161), in the August 1, 2003 IPPS final rule, we created three new DRGs: DRG 528 (Intracranial Vascular Procedures With a Principal Diagnosis of Hemorrhage) for patients with an intracranial vascular procedure and an intracranial hemorrhage; and DRGs 529 (Ventricular Shunt Procedures With CC) and 530 (Ventricular Shunt Procedures Without CC) for patients with only a vascular shunt procedure.

As discussed below, we have received further comments regarding the composition of DRGs 1 and 2 that relate to the appropriate DRG assignment of unruptured cerebral aneurysm cases and cases involving implantation of GLIADEL® chemotherapy wafers. We have also received comments on possible revisions to DRG 3 (Craniotomy Age 0–17).

(1) Unruptured Cerebral Aneurysms

In the August 1, 2003 final rule (68 FR 45354), in response to a comment that suggested we create a companion DRG to DRG 528 for intracranial vascular procedures for unruptured cerebral aneurysms, we evaluated cases in the MedPAR file involving unruptured cerebral aneurysm and determined that the average charges for unruptured cerebral aneurysm cases were consistent with the variation of charges found in DRGs 1 and 2. Therefore, we did not propose a change in the DRG classification. We indicated that we would continue to monitor cases involving unruptured cerebral aneurysms.

We now have examined cases in the FY 2003 MedPAR file that reported unruptured cerebral aneurysms. We found 657 unruptured aneurysm cases assigned to DRG 1 and 481 unruptured cerebral aneurysm cases assigned to DRG 2. The average charges for these unruptured cerebral aneurysm cases in DRG 1 ($50,879) are slightly lower than the overall charges for all cases in that DRG ($51,300). For unruptured cerebral aneurysm cases assigned to DRG 2, we found the average charges of approximately $29,524 are consistent with the overall average charges of that DRG of approximately $28,416.

Based on the results of our analysis, we still do not believe a proposal to modify the DRG assignment of unruptured cerebral aneurysm cases is warranted.

(2) GLIADEL® Chemotherapy Wafers

In the August 1, 2003 final rule (68 FR 45354), we stated that we had received comments requesting a change to the DRG assignment of cases involving implantation of GLIADEL® chemotherapy wafers to treat brain tumors. One of the commenters had offered two options: (1) Create a new DRG for cases involving implantation of GLIADEL® chemotherapy wafers; and (2) reassign these cases to DRG 484 (Craniotomy for Multiple Significant Trauma).

At that time, we had analyzed data in the March 2003 update of the FY 2003 MedPAR file and found a total of 61 cases in which procedure code 00.10 (Implantation of a chemotherapy agent) was reported for cases assigned to DRGs 1 and 2. There were 38 cases assigned to DRG 1 and 23 cases assigned to DRG 2. The GROUPER logic for these DRGs assigns cases with CCs to DRG 1 and those without CCs to DRG 2. Consistent with the GROUPER logic for these DRGs, we had found that the average standardized charges in DRGs 1 and 2 were approximately $64,864 and $42,624, respectively. However, while the estimated average charges for GLIADEL® wafer cases of $50,394 may have been higher than the average standardized charges for DRG 2, they were within the normal variation of overall charges within each DRG. In addition, the volume of cases in these two DRGs was too small to warrant the establishment of a separate new DRG for this technology. Therefore, we stated that we wanted to review a full year of data and take the time to consider alternative options that might appear warranted before proposing a change.

We have now examined more complete MedPAR data (December 2003 update for FY 2003) on cases reporting GLIADEL® chemotherapy wafers. We found a total of 127 cases in which procedure code 00.10 was reported for cases assigned to DRGs 1 and 2. There were 80 cases assigned to DRG 1 and 47 cases assigned to DRG 2. The average

charges for these cases in DRGs 1 and 2 were approximately $61,866 and $47,189, respectively. The average charges for these cases are higher than the overall charges of DRGs 1 and 2 of approximately $51,300 and $28,416, respectively. Although the average charges for the GLIADEL® wafer cases within these DRGs are higher than the average charges of all cases in these DRGs, they remain within the range of average charges for other procedures included in these DRGs. The majority of the GLIADEL® wafer cases are assigned to the second highest weighted DRG in MDC 1 behind DRG 528 (Intracranial Vascular Procedure With a Principal Diagnosis of Hemorrhage) in which the weights were derived from average charges of approximately $113,884. In DRG 1, there are 10 procedures that have higher average charges than the GLIADEL® wafer cases. However, in DRG 2, the charges associated with GLIADEL® wafer cases are the highest of the procedures included within the DRG.

DRGs are based on the principal diagnosis, secondary diagnosis, and procedures performed on the patient. DRGs are not generally created to recognize the presence or absence of specific technologies for each patient. In the past, we have made one exception to this rule. The exception was the creation of two new DRGs for drug-eluting stents: DRG 526 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent With Acute Myocardial Infarction) and DRG 527 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent Without Acute Myocardial Infarction) (67 FR 50003). We took this unprecedented approach in response to the unique circumstances surrounding the potential breakthrough nature of this technology. We currently have 59,613 drug-eluting cases annually, far more cases than the volume for GLIADEL® wafers. We believe that the volume of GLIADEL® wafer cases remains too small to warrant the taking of the exceptional step of establishing a separate new DRG for this technology.

Commenters also have proposed the reassignment of GLIADEL® wafer cases to other existing DRGs, such as DRG 484 (Craniotomy for Multiple Significant Trauma), DRG 528 (Intracranial Vascular Procedures With Principal Diagnosis of Hemorrhage), DRG 492 (Chemotherapy With Acute Leukemia as a Secondary Diagnoses or With Use of a High Dose Chemotherapeutic Agent), or DRG 481 (Bone Marrow Transplant). We have examined these alternatives, and have come to the conclusion that none of these alternatives meets the standard of clinical coherence under the DRG system. For example, reconfiguring DRG 484 to include GLIADEL® wafer cases would not produce a clinically coherent DRG because DRG 484 contains cases where craniotomy is performed in the setting of multiple significant trauma. Similarly, assigning GLIADEL® wafer cases to DRG 528 would not produce a clinically coherent DRG because DRG 528 contains cases where craniotomy is performed as part of a vascular procedure with a primary diagnosis of hemorrhage, as in the case of a ruptured aneurysm. DRG 492 is clinically inappropriate because it contains cases of acute leukemia treated with chemotherapy, and DRG 481 is clinically inappropriate because it contains cases involving bone marrow transplant. None of these DRGs contains cases of glioblastoma multiforme or other primary brain tumors. Therefore, we are not proposing to adopt any of these changes at this time.

We also considered several other approaches to reassigning GLIADEL® wafer cases in a manner that is appropriate both in terms of clinical coherence and resource use. For example, we considered the creation of a new DRG that includes GLIADEL® wafer cases along with other types of local therapy for intracerebral malignant disease. Specifically, we considered the creation of a new DRG that includes GLIADEL® wafers and a Gliasite Radiation Therapy System, a relatively new form of intracavitary brachytherapy. Such a DRG would be clinically coherent because it would contain cases of malignant brain tumors treated with local therapy. However, our analysis of existing MedPAR data suggests that such a DRG would probably not provide enhanced reimbursement for the GLIADEL® wafer cases, and that, in fact, decreased reimbursement for GLIADEL® wafer cases is a more likely result. Therefore, we are not proposing a change at this time. However, we will continue to monitor our data to determine whether a change is warranted in the future.

We recognize that the implantation of chemotherapeutically active wafers for local therapy of malignant brain tumors represents a significant medical technology that currently offers clinical benefits to patients and holds out the promise of future innovation in the treatment of these brain tumors. Therefore, we invite further comments and suggestions regarding the appropriate DRG assignment for this technology. (3) DRG 3 (Craniotomy Age 0–17)

We received a comment stating concern that DRG 3 has not been reviewed, while DRGs 1 and 2 have had some revisions. The commenter believed that, particularly with the removal of major trauma cases, age distinctions may no longer be significant for craniotomies and the other intracranial procedures classified in DRGs 1 through 3. The commenter stated that it may be more consistent, from both a clinical and resource perspective, to simply eliminate DRG 3 and redistribute the pediatric and juvenile cases to DRGs 1 and 2 based on the procedures performed and the complication or comorbidities present, instead. This analysis would require supplemental data from non-MedPAR sources.

We note that the primary focus of updates to the Medicare DRG classification system is for changes relating to the Medicare patient population, not the pediatric patient population. In the FY 2003 data, there were only two cases assigned to DRG 3. Therefore, we do not believe a proposal to address the commenter's request is warranted at this time. We are aware that the Medicare DRGs are sometimes used to classify other patient populations. We advise those non-Medicare systems that need a more up-to-date system to consider choosing from other systems that are currently in use in this country, or developing their own modifications.

b. Coronary Stent Procedures

We have received comments and recommendations from several industry representatives about the DRG assignments for coronary artery stents. These representatives expressed concern about whether the reimbursement for stents is adequate, especially for insertion of multiple stents. They also expressed concern about whether the current DRG structure represents the most clinically coherent classification of stent cases.

We received two comprehensive recommendations for refinement and restructuring of the current coronary stent DRGs. The current DRG structure incorporates stent cases into the following two pairs of DRGs, depending on whether bare metal or drug-eluting stents are used and whether acute myocardial infarction (AMI) is present:

- DRG 516 (Percutaneous Cardiovascular Procedures With AMI)
- DRG 517 (Percutaneous Cardiovascular Procedures With Nondrug-Eluting Stent Without AMI)
- DRG 526 (Percutaneous Cardiovascular Procedures With Drug-Eluting Stent With AMI)
- DRG 527 (Percutaneous Cardiovascular Procedures With Drug-Eluting Stent Without AMI)

One of the recommendations involved restructuring these DRGs to create two additional stent DRGs that are closely patterned after these existing pairs and that would reflect insertion of multiple stents with and without AMI. The manufacturer recommended incorporating either stenting code 36.06 (Insertion of nondrug-eluting coronary artery stent(s)) or code 36.07 (Insertion of drug-eluting coronary artery stent(s)) when they are reported along with code 36.05 (Multiple vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy performed during the same operation, with or without mention of thrombolytic agent). The manufacturer expressed concern that hospitals are steering patients toward coronary artery bypass graft surgery in place of stenting in order to avoid significant financial losses due to what it considered the inadequate reimbursement for inserting multiple stents.

We appreciate receiving the manufacturer's recommendation, and agree that the DRG classification of cases involving coronary stents must be clinically coherent and provide for adequate reimbursement, including adequate reimbursement of cases requiring multiple stents. We also agree that the recommendation has some merits and deserves further study. However, we believe that it is premature to act on this recommendation for two reasons. One reason is that the current coding structure for coronary artery stents cannot distinguish cases in which multiple stents are inserted from cases in which only a single stent is inserted. Current codes are able to identify performance of PTCA in more than one vessel by use of code 36.05. However, while this code indicates that PTCA was performed in more than one vessel, its use does not reflect the exact number of procedures performed or the exact number of vessels treated. Similarly, when codes 36.06 and 36.07 are used, they document the insertion of at least one stent. However, these stenting codes do not identify how many stents were inserted in a procedure, nor distinguish insertion of a single stent from insertion of multiple stents. Even the use of one of the stenting codes in conjunction with multiple-PTCA code 36.05 does not distinguish insertion of a single stent from insertion of multiple stents. The use of code 36.05 in conjunction with code 36.06 or code 36.07 indicates only performance of PTCA in more than one vessel, along with insertion of at least one stent. The precise numbers of PTCA-treated vessels, the number of vessels into which stents were inserted, and the total number of stents inserted in all treated vessels cannot be determined. Therefore, the capabilities of the current coding structure do not permit the distinction between single vessel stenting and multiple vessel stenting that would be required under the recommended restructuring of the stenting DRGs.

In addition, because the FDA approved drug-eluting stents for use in April 2003, the distinct DRGs for drug-eluting stents have only been effective for payment in the last year. The MedPAR file thus does not contain a full year of data with which to conduct the requisite analysis to evaluate the adequacy of the current structure of four stenting DRGs. Therefore, we believe that it is still premature to undertake such a thorough restructuring of the stent DRGs. Nevertheless, we will consider this recommendation as we evaluate the current DRG structure once adequate data on the current stenting DRGs become available.

The second recommendation was that we transform the current structure of stenting DRGs into two new pairs of DRGs, reclassifying stenting cases according to whether bare metal or drug-eluting stents are used (as with the present DRGs) and whether the cases are ''complex'' or ''noncomplex.'' The manufacturer indicated that complex cases are those that include certain comorbid conditions or procedural factors such as hypertensive renal failure, diabetes, AMI, and multivessel PCI. The manufacturer further indicated that this structure would provide an improvement in both clinical and resource coherence over the current structure that classifies cases according to the type of stent inserted and the presence or absence of AMI alone, without considering other complicating conditions. Specifically, the manufacturer recommended replacing the current structure with the following four DRGs:

- Recommended restructured DRG 516 (Complex percutaneous cardiovascular procedures with nondrug-eluting stents)
- Recommended restructured DRG 517 (Noncomplex percutaneous cardiovascular procedures with nondrug-eluting stents)
- Recommended restructured DRG 526 (Complex percutaneous cardiovascular procedures with drug-eluting stents)
- Recommended restructured DRG 527 (Noncomplex percutaneous cardiovascular procedures with drug-eluting stents)

The manufacturer presented an analysis based on FY 2002 MedPAR data, in which it evaluated charges and lengths of stay for cases with expected high resource use, and reclassified cases into the recommended new structure of paired ''complex'' and ''noncomplex'' DRGs. The analysis shows some evidence of clinical and resource coherence in the recommended DRG structure. However, the analysis does not yet provide a convincing case for adopting the recommended restructure. First, the analysis does not reveal significant gains in resource coherence compared to previous DRGs for stenting cases. Second, the analysis is limited in assessing the feasibility of using the recommended DRG restructure versus the current DRG structure for classification of stent cases. Because the manufacturer used FY 2002 MedPAR data in its analysis, it was not able to compare the resource coherence of the recommended structure with the current structure of four DRGs, but only with the two DRGs that preceded the approval of drug-eluting stents. While the manufacturer asserted that ''similar results would be expected'' from a comparison between its recommended DRG restructure and the current DRG structure, we do not believe that it is advisable to undertake a critical DRG restructuring without examining the recommendation against actual experience under the current structure. Nevertheless, we believe that this recommendation may have merit, and we will conduct a full analysis of the recommendation in comparison to the current DRG structure once adequate data become available.

The drug-eluting stents had not yet been FDA approved when we calculated the relative weights for DRGs 526 and 527 for the FY 2003 IPPS final rule. Therefore, in the absence of MedPAR data, we based our FY 2003 relative weight calculations on prices in countries where drug-eluting stents were already being used. A full discussion of this process can be found in the FY 2004 IPPS final rule (68 FR 45370). For computation of the proposed relative weights for FY 2005 for this proposed rule, we are using the December update of FY 2003 MedPAR data. There have been a total of 42,356 cases in DRG 526, and 33,179 cases in DRG 527, with adjustments made for transfers to other facilities. For computation of the final FY 2005 relative weights, we will use the latest update of the MedPAR data file for cases in these two DRGs. No foreign data will be used to compute the relative weights for DRGs 526 and 527 in FY 2005.

c. Severe Sepsis

We received a comment that recommended a separate DRG be assigned to the diagnosis of severe sepsis. Patients admitted with sepsis currently are assigned to DRG 416 (Septicemia Age > 17) and DRG 417 (Septicemia Age 0–17) in MDC 18 (Infectious and Parasitic Diseases, Systemic or Unspecified Sites). The commenter contended that the costs of caring for patients with severe sepsis exceed those costs associated with other types of sepsis. Therefore, the commenter indicated, severe sepsis should be given a separate, unique DRG. Furthermore, the commenter requested that all cases in which severe sepsis is present on admission, as well as those cases in which it develops after admission (which are currently classified elsewhere) be included in this new DRG. The commenter suggested using various coexisting conditions and their corresponding ICD–9–CM codes (for example, respiratory failure or hypotension and renal failure) to identify patients with severe sepsis. The conditions suggested do not describe a clinically coherent set of patients that have severe sepsis. Using this list of conditions would erroneously identify patients as having severe sepsis.

We acknowledge the high costs of caring for seriously ill patients with sepsis. However, we do not find, from a clinical perspective, that a subset of patients with severe sepsis exists to the degree that a separate DRG classification is justified. Sepsis in all forms is quite common across many DRGs in the Medicare population. In addition, we do not believe that the commenter's suggested defining criteria for severe sepsis are specific, accurate, or unique enough to warrant a new DRG classification. Therefore, at this time, we are not proposing any change to the current DRG structure for sepsis.

d. Implantable Cardiac Defibrillators

There is a range of implantable cardiac defibrillators (ICDs) available on the market from extremely complex devices with multiple leads, settings, and functions to simpler models with a single lead and simpler functions. ICDs deliver electrical shocks to the heart to eliminate the life-threatening abnormal rhythms such as ventricular fibrillation or ventricular tachycardia.

We have received a coverage request to expand the indications for implantable defibrillators to include the population studied in the Sudden Cardiac Death in Heart Failure Trial (SCD–HeFT) sponsored by the National Institutes of Health. SCD–HeFT treated heart failure patients with conventional therapy and randomized them to one of three additional treatment strategies: (1) Placebo; (2) amiodarone (drug therapy); or (3) single lead implantable defibrillator. The SCD–HeFT investigators presented results at the American College of Cardiology annual meeting that the basic single-lead implantable defibrillator is effective for saving lives in a population at low-moderate risk for sudden cardiac death. The requestor indicated that, as part of CMS' coverage decisions, CMS could expand the population eligible for implantable defibrillators. The requestor further added that CMS could restrict use of complex defibrillators to patients for whom they are medically necessary, that is, in the population at low-moderate risk for sudden cardiac death.

Given the potential increase of implantable defibrillator use in our population, we are soliciting input on how to encourage physicians to use the simpler, less costly device when advanced devices are not medically preferred. We are also soliciting input on the appropriate measures within the payment systems to accommodate payment for classes of defibrillators with very different costs. Ideally, we would like not only to align payments with relative costs, but also to align the incentives within the payment system with medically appropriate uses of different technologies.

We believe that, within the PPS for inpatient hospital operating costs, there are several ways to deal with the expanding use of simpler, lower cost defibrillators. One possibility is to maintain the current DRG configuration, under which complex, expensive devices and simpler, less costly devices would remain within the same DRGs and receive the same payment rates. This approach would encourage use of the simpler devices, which would receive relatively higher reimbursement because their lower charges would be averaged in with the higher charges for the more complex devices in setting the DRG weights. However, it could lead to complaints that the program is underpaying for the more complex, expensive devices as the lower charges for simpler, less expensive devices begin to affect (lower) the DRG weights.

Another approach would be to recognize the cost differences between various classes of defibrillators by establishing separate DRGs for basic single-lead implantable defibrillators as opposed to more complex, expensive models. This approach would prevent payments for the use of more expensive defibrillators (where medically necessary) from being diluted by the effect of the lower charges for basic single-lead implantable defibrillators on the weights within common DRGs. However, this policy would arguably provide less incentive for use of the lower cost devices: the weights for the DRGs containing the less expensive devices would be driven solely by their relatively lower charges, without being lifted by the higher charges for the more expensive models. This approach might also be criticized for departing from the averaging principle within the DRG system by basing too much on the cost differential alone in reconfiguring these DRGs.

We welcome comments on these and other approaches to paying for defibrillators under the IPPS. We discuss an application for new technology add-on payments for a Cardiac Resynchronization Therapy with Defibrillator (CRT–D) in section II.E.4.c. of this proposed rule.

C. Recalibration of DRG Weights

[If you choose to comment on issues in this section, please include the caption ''DRG Weights'' at the beginning of your comment.]

We are proposing to use the same basic methodology for the FY 2005 recalibration as we did for FY 2004 (August 1, 2003 IPPS final rule (68 FR 45373)). That is, we are proposing to recalibrate the DRG weights based on charge data for Medicare discharges using the most current charge information available (the FY 2003 MedPAR file).

The MedPAR file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills. The FY 2003 MedPAR data used in this proposed rule include discharges occurring between October 1, 2002 and September 30, 2003, based on bills received by CMS through December 31, 2003, from all hospitals subject to the IPPS and short-term acute care hospitals in Maryland (which is under a waiver from the IPPS under section 1814(b)(3) of the Act). The FY 2003 MedPAR file includes data for approximately 11,717,744 Medicare discharges. Discharges for Medicare beneficiaries enrolled in a Medicare+Choice managed care plan are excluded from this analysis. The data excludes CAHs, including hospitals that subsequently became CAHs after the period from which the data were taken.

The proposed methodology used to calculate the DRG relative weights from the FY 2003 MedPAR file is as follows:

- To the extent possible, all the claims were regrouped using the DRG classification revisions discussed in section II.B. of this preamble.

• The transplant cases that were used to establish the relative weight for heart and heart-lung, liver, and lung transplants (DRGs 103, 480, and 495) were limited to those Medicare-approved transplant centers that have cases in the FY 2001 MedPAR file. (Medicare coverage for heart, heart-lung, liver, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)

• Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to subtract 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.

• Charges were standardized to remove the effects of differences in area wage levels, indirect medical education and disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.

• The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG. A transfer case is counted as a fraction of a case based on the ratio of its transfer payment under the per diem payment methodology to the full DRG payment for nontransfer cases. That is, a transfer case receiving payment under the transfer methodology equal to half of what the case would receive as a nontransfer would be counted as 0.5 of a total case.

• Statistical outliers were eliminated by removing all cases that are beyond 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.

The proposed new weights are normalized by a proposed adjustment factor of 1.46899 so that the average case weight after recalibration is equal to the average case weight before recalibration. This proposed adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS.

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 are proposing to use that same case threshold in recalibrating the proposed DRG weights for FY 2005. Using the FY 2003 MedPAR data set, there are 42 DRGs that contain fewer than 10 cases. We are proposing to compute the weights for these low-volume DRGs by adjusting the FY 2004 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs.

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 payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years and as discussed in section II.A.4.a. of the Addendum to this proposed rule, we are proposing to make a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

D. Proposed LTC–DRG Reclassifications and Relative Weights for LTCHs for FY 2005

[If you choose to comment on issues in this section, please include the caption ''LTC–DRGs'' at the beginning of your comment.]

1. Background

In the June 6, 2003 LTCH PPS final rule (68 FR 34122), we changed the LTCH PPS annual payment rate update cycle to be effective July 1 through June 30 instead of October 1 through September 30. In addition, since the patient classification system utilized under the LTCH PPS is based directly on the DRGs used under the IPPS for acute care hospitals, in that same final rule, we explained that the annual update of the long-term care diagnosis-related group (LTC–DRG) classifications and relative weights will continue to remain linked to the annual reclassification and recalibration of the CMS–DRGs under the IPPS.

The annual update to the IPPS DRGs is based on the annual revisions to the ICD–9–CM codes and is effective each October 1. In the health care industry, annual changes to the ICD–9–CM codes are effective for discharges occurring on or after October 1 each year. The use of the ICD–9-CM coding system is also compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104–191, under 45 CFR Parts 160 and 162. Therefore, the manual and electronic versions of the GROUPER software, which are based on the ICD–9–CM codes, are also revised annually and effective for discharges occurring on or after October 1 each year. Because the LTC–DRGs are based on the patient classification system used under the IPPS (CMS–DRGs), which is updated annually and effective for discharges occurring on or after October 1 through September 30 each year, in the June 6, 2003 LTCH PPS final rule (68 FR 34128), we specified that we will continue to update the LTC–DRG classifications and relative weights to be effective for discharges occurring on or after October 1 through September 30 each year. Furthermore, we stated that we will publish the annual update of the LTC–DRGs in the proposed and final rules for the IPPS.

In this proposed rule, we are proposing revisions to the LTC–DRG classifications and relative weights and will finalize them in the IPPS final rule, to be effective October 1, 2004 through September 30, 2005. The proposed LTC–DRGs and relative weights for FY 2005 in this proposed rule are based on the IPPS DRGs (GROUPER version 22.0) discussed in section II. of this proposed rule.

2. Proposed Changes in the LTC–DRG Classifications

a. Background

Section 123 of Public Law 106–113 specifically requires that the PPS for LTCHs be a per discharge system with a DRG-based patient classification system reflecting the differences in patient resources and costs in LTCHs while maintaining budget neutrality. Section 307(b)(1) of Public Law 106–554 modified the requirements of section 123 of Public Law 106–113 by specifically requiring that the Secretary examine ''the feasibility and the impact of basing payment under such a system [the LTCH PPS] on the use of existing (or refined) hospital diagnosis-related groups (DRGs) that have been modified to account for different resource use of long-term care hospital patients as well as the use of the most recently available hospital discharge data.''

In accordance with section 307(b)(1) of Public Law 106–554 and § 412.515 of our existing regulations, the LTCH PPS uses information from LTCH patient

records to classify patient cases into distinct LTC–DRGs based on clinical characteristics and expected resource needs. The LTC–DRGs used as the patient classification component of the LTCH PPS correspond to the DRGs under the IPPS for acute care hospitals. Thus, in this proposed rule, we are proposing to use the IPPS version 22.0 GROUPER for FY 2005 to process LTCH PPS claims. The proposed changes to the IPPS DRG classification system for FY 2005 (Grouper 22.0) are discussed in section II.B. of this preamble.

Under the LTCH PPS, we determine relative weights for each of the CMS DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCH patients. In a departure from the IPPS, as we discussed in the August 30, 2002 final rule (67 FR 55985), which implemented the LTCH PPS, and the August 1, 2003 IPPS final rule (68 FR 45374), we use low-volume quintiles in determining the LTC–DRG weights for LTC–DRGs with less than 25 LTCH cases, since LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. Specifically, we group those low-volume LTC–DRGs (LTC–DRGs with fewer than 25 cases) into 5 quintiles based on average charge per discharge. (A listing of the composition of low-volume quintiles for the FY 2004 LTC–DRGs (based on FY 2002 MedPAR data) appears in section II.D.3. of the August 1, 2003 IPPS final rule (68 FR 45377—45380).) We also adjust for cases in which the stay at the LTCH is less than or equal to five-sixths of the geometric average length of stay; that is, short-stay outlier cases (§ 412.529), as discussed below in section II.D.4. of this preamble.

b. Patient Classifications Into DRGs

Generally, under the LTCH PPS, Medicare payment is made at a predetermined specific rate for each discharge; that is, payment varies by the LTC–DRG to which a beneficiary's stay is assigned. Similar to case classification for acute care hospitals under the IPPS (see section II.B. of this preamble), cases are classified into LTC–DRGs for payment under the LTCH PPS 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 ICD–9–CM.

As discussed above in section II.B. of this preamble, the CMS DRGs are organized into 25 major diagnostic categories (MDCs), most of which are based on a particular organ system of the body; the remainder involve multiple organ systems (such as MDC 22, Burns). Accordingly, the principal diagnosis determines MDC assignment. Within most MDCs, cases are then divided into surgical DRGs and medical DRGs. Some surgical and medical DRGs are further differentiated based on the presence or absence of CCs. (See section II.B. of this preamble for further discussion of surgical DRGs and medical DRGs.)

Because the assignment of a case to a particular LTC–DRG will help determine the amount that is paid for the case, it is important that the coding is accurate. As used under the IPPS, classifications and terminology used under the LTCH PPS are consistent with the ICD–9–CM and the Uniform Hospital Discharge Data Set (UHDDS), as recommended to the Secretary by the National Committee on Vital and Health Statistics (''Uniform Hospital Discharge Data: Minimum Data Set, National Center for Health Statistics, April 1980'') and as revised in 1984 by the Health Information Policy Council (HIPC) of the U.S. Department of Health and Human Services. We wish to point out again that the ICD–9–CM coding terminology and the definitions of principal and other diagnoses of the UHDDS are consistent with the requirements of the Administrative Simplification Act of 1996 of the HIPAA (45 CFR Parts 160 and 162).

The emphasis on the need for proper coding cannot be overstated. Inappropriate coding of cases can adversely affect the uniformity of cases in each LTC–DRG and produce inappropriate weighting factors at recalibration and result in inappropriate payments under the LTCH PPS. LTCHs are to follow the same coding guidelines used by the acute care hospitals to ensure accuracy and consistency in coding practices. There will be only one LTC–DRG assigned per long-term care hospitalization; it will be assigned at the discharge. Therefore, it is mandatory that the coders continue to report the same principal diagnosis on all claims and include all diagnostic codes that coexist at the time of admission, that are subsequently developed, or that affect the treatment received. Similarly, all procedures performed during that stay are to be reported on each claim.

Upon the discharge of the patient from a LTCH, the LTCH must assign appropriate diagnosis and procedure codes from the ICD–9–CM. As of October 16, 2002, a LTCH that was required to comply with the HIPAA Administrative Simplification Standards and that had not obtained an extension in compliance with the Administrative Compliance Act (Public Law 107–105) is obligated to comply with the standards at 45 CFR 162.1002 and 45 CFR 162.1102. Completed claim forms are to be submitted to the LTCH's Medicare fiscal intermediary. Medicare fiscal intermediaries enter the clinical and demographic information into their claims processing systems and subject this information to a series of automated screening processes called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before assignment into an LTC–DRG can be made.

After screening through the MCE, each LTCH claim will be classified into the appropriate LTC–DRG by the Medicare LTCH GROUPER. The LTCH GROUPER is specialized computer software based on the same GROUPER used under the IPPS. After the LTC–DRG is assigned, the Medicare fiscal intermediary determines the prospective payment by using the Medicare LTCH PPS PRICER program, which accounts for LTCH hospital-specific adjustments. As provided for under the IPPS, we provide an opportunity for the LTCH to review the LTC–DRG assignments made by the fiscal intermediary and to submit additional information within a specified timeframe (§ 412.513(c)).

The GROUPER is used both to classify past cases in order to measure relative hospital resource consumption to establish the LTC–DRG weights and to classify current cases for purposes of determining payment. The records for all Medicare hospital inpatient discharges are maintained in the MedPAR file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights during our annual update (as discussed in section II. of this preamble). The LTC–DRG relative weights are based on data for the population of LTCH discharges, reflecting the fact that LTCH patients represent a different patient mix than patients in short-term acute care hospitals.

3. Development of the Proposed FY 2005 LTC–DRG Relative Weights

a. General Overview of Development of the LTC–DRG Relative Weights

As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55981), one of the primary goals for the implementation of the LTCH PPS is to pay each LTCH an appropriate amount for the efficient delivery of care to Medicare patients. The system must be able to account adequately for each

LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. To accomplish these goals, we adjust the LTCH PPS standard Federal prospective payment system rate by the applicable LTC–DRG relative weight in determining payment to LTCHs for each case.

Under the LTCH PPS, relative weights for each LTC–DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups (§ 412.515). To ensure that Medicare patients classified to each LTC–DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each LTC–DRG that represents the resources needed by an average inpatient LTCH case in that LTC–DRG. For example, cases in a LTC–DRG with a relative weight of 2 will, on average, cost twice as much as cases in a LTC–DRG with a weight of 1.

b. Data

To calculate the proposed LTC–DRG relative weights for FY 2005 in this proposed rule, we obtained total Medicare allowable charges from FY 2003 Medicare hospital bill data from the December 2003 update of the MedPAR file, and we used the proposed Version 22.0 of the CMS GROUPER for IPPS, as discussed in section II.B. of this preamble, to classify cases. Consistent with the methodology under the IPPS, we are proposing to recalculate the FY 2005 LTC–DRG relative weights based on the best available data for the final rule.

As we discussed in the August 1, 2003 final rule (68 FR 45376), we have excluded the data from LTCHs that are all-inclusive rate providers and LTCHs that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Public Law 92–603 (42 U.S.C. 1395b–1). Therefore, in the development of the proposed FY 2005 LTC–DRG relative weights, we have excluded the data of the 22 all-inclusive rate providers and the 3 LTCHs that are paid in accordance with demonstration projects that had claims in the FY 2003 MedPAR file.

In the August 1, 2003 final rule (68 FR 45367), we discussed coding inaccuracies that were found in claims data for a large chain of LTCHs in the FY 2002 MedPAR file used to determine the LTC–DRG relative weights for FY 2004. Specifically, the principal diagnosis was not reported correctly on many of those LTCHs' claims, which resulted in those claims being incorrectly assigned to a LTC–DRG. As we explained in that same final rule, we were able to determine the correct diagnoses and procedure codes for the claims that contained the coding errors, and we used them to group each LTCH case to the appropriate LTC–DRG for determining the LTC–DRG relative weights for FY 2004. In addition, we stated that since the LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002 (FY 2003), we believe that this problem will be self-correcting as LTCHs submit more completely coded data in the future.

As we discussed in the May 7, 2004 LTCH PPS final rule (69 FR 25673), an analysis of LTCH claims data from the September 2003 update of the FY 2003 MedPAR file contained coding errors. Specifically, a large hospital chain of LTCHs continued to consistently code diagnoses inaccurately on the claims it submitted, and these coding errors were reflected in the September 2003 update of the FY 2003 MedPAR file. Upon discovering the coding errors, we notified the large chain of LTCHs whose claims contained the coding inaccuracies to request that they resubmit those claims with the correct diagnoses codes by December 31, 2003, so that those corrected claims would be contained in the December 2003 update of the FY 2003 MedPAR file. As we discussed in that same final rule, it appears that those claims were submitted timely with the correct diagnoses codes. Therefore, it was not necessary to correct the FY 2003 MedPAR data for the development of the rates and factors established in the May 7, 2004 LTCH PPS final rule. Accordingly, we are proposing to use LTCH claims data from the December 2003 update of the FY 2003 MedPAR file for the determination of the proposed FY 2005 LTC–DRG relative weights in this proposed rule.

c. Hospital-Specific Relative Value Methodology

By nature LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. Such nonarbitrary distribution of cases with relatively high (or low) charges in specific LTC–DRGs has the potential to inappropriately distort the measure of average charges. To account for the fact that cases may not be randomly distributed across LTCHs, we use a hospital-specific relative value method to calculate the LTC–DRG relative weights instead of the methodology used to determine the DRG relative weights under the IPPS described above in section II.C. of this preamble. We believe this method will remove this hospital-specific source of bias in measuring LTCH average charges. Specifically, we reduce the impact of the variation in charges across providers on any particular LTC–DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge.

Under the hospital-specific relative value method, we standardize charges for each LTCH by converting its charges for each case to hospital-specific relative charge values and then adjusting those values for the LTCH's case-mix. The adjustment for case-mix is needed to rescale the hospital-specific relative charge values (which, by definition, averages 1.0 for each LTCH). The average relative weight for a LTCH is its case-mix, so it is reasonable to scale each LTCH's average relative charge value by its case-mix. In this way, each LTCH's relative charge value is adjusted by its case-mix to an average that reflects the complexity of the cases it treats relative to the complexity of the cases treated by all other LTCHs (the average case-mix of all LTCHs).

In accordance with the methodology established under § 412.523, we standardize charges for each case by first dividing the adjusted charge for the case (adjusted for short-stay outliers under § 412.529 as described in section II.D.4. (step 3) of this preamble) by the average adjusted charge for all cases at the LTCH in which the case was treated. Short-stay outliers under § 412.529 are cases with a length of stay that is less than or equal to five-sixths the average length of stay of the LTC–DRG. The average adjusted charge reflects the average intensity of the health care services delivered by a particular LTCH and the average cost level of that LTCH. The resulting ratio is multiplied by that LTCH's case-mix index to determine the standardized charge for the case.

Multiplying by the LTCH's case-mix index accounts for the fact that the same relative charges are given greater weight in a LTCH with higher average costs than they would at a LTCH with low average costs which is needed to adjust each LTCH's relative charge value to reflect its case-mix relative to the average case-mix for all LTCHs. Because we standardize charges in this manner, we count charges for a Medicare patient at a LTCH with high average charges as less resource intensive than they would

be at a LTCH with low average charges. For example, a $10,000 charge for a case in a LTCH with an average adjusted charge of $17,500 reflects a higher level of relative resource use than a $10,000 charge for a case in a LTCH with the same case-mix, but an average adjusted charge of $35,000. We believe that the adjusted charge of an individual case more accurately reflects actual resource use for an individual LTCH because the variation in charges due to systematic differences in the markup of charges among LTCHs is taken into account.

d. Low-Volume LTC–DRGs

In order to account for LTC–DRGs with low-volume (that is, with fewer than 25 LTCH cases), in accordance with the methodology discussed in the August 1, 2002 final rule (67 FR 55984), we group those low-volume LTC–DRGs into one of five categories (quintiles) based on average charges, for the purposes of determining relative weights. For this proposed rule, using LTCH cases from the December 2003 update of the FY 2003 MedPAR file, we identified 171 LTC–DRGs that contained between 1 and 24 cases. This list of proposed LTC–DRGs was then divided into one of the five low-volume quintiles, each containing a minimum of 34 LTC–DRGs (171/5 = 34 with 1 LTC–DRG as the remainder). For FY 2005, we are proposing to make an assignment to a specific low-volume quintile by sorting the 171 low-volume proposed LTC–DRGs in ascending order by average charge. Since the number of LTC–DRGs with less than 25 LTCH cases is not evenly divisible by five, the average charge of the proposed low-volume LTC–DRG was used to determine which low-volume quintile received the proposed additional LTC–DRG. After sorting the 171 low-volume proposed LTC–DRGs in ascending order, we are proposing that the first fifth (34) of low-volume LTC–DRGs with the lowest average charge would be grouped into Quintile 1. The highest average charge cases would be grouped into Quintile 5. Since the average charge of the proposed 69th LTC–DRG in the sorted list is closer to the previous proposed LTC–DRG's average charge (assigned to Quintile 2) than to the average charge of the proposed 70th LTC–DRG in the sorted list (to be assigned to Quintile 3), we are proposing to place it into Quintile 2. This process was repeated through the remaining low-volume proposed LTC–DRGs so that 4 proposed low-volume quintiles contain 34 proposed LTC–DRGs and 1 proposed low-volume quintile contains 35 proposed LTC–DRGs.

In order to determine the proposed relative weights for the proposed LTC–DRGs with low volume for FY 2005, in accordance with the methodology described in the August 1, 2002 final rule (67 FR 55984), we are proposing to use the five proposed low-volume quintiles described above. The composition of each of the five proposed low-volume quintiles shown below in Table 1 would be used in determining the proposed LTC–DRG relative weights for FY 2005. We would determine a proposed relative weight and (geometric) average length of stay for each of the five proposed low-volume quintiles using the formula that we are proposing to apply to the regular proposed LTC–DRGs (25 or more cases), as described below in section II.D.4. of this preamble. We are proposing to assign the same proposed relative weight and proposed average length of stay to each of the proposed LTC–DRGs that make up that proposed low-volume quintile. We note that as this system is dynamic, it is possible that the number and specific type of LTC–DRGs with a low volume of LTCH cases will vary in the future. We use the best available claims data in the MedPAR file to identify low-volume LTC–DRGs and to calculate the relative weights based on our methodology.

TABLE 1.—PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES

Proposed LTC–DRG	Description
	QUINTILE 1
11	NERVOUS SYSTEM NEOPLASMS W/O CC.
43	HYPHEMA.
45	NEUROLOGICAL EYE DISORDERS.
47	OTHER DISORDERS OF THE EYE AGE >17 W/O CC.
84	MAJOR CHEST TRAUMA W/O CC.
95	PNEUMOTHORAX W/O CC.
110	MAJOR CARDIOVASCULAR PROCEDURES W CC.
119	VEIN LIGATION & STRIPPING.
143	CHEST PAIN.
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC.
178	UNCOMPLICATED PEPTIC ULCER W/O CC.
193	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.
208	DISORDERS OF THE BILIARY TRACT W/O CC.
229	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC.
241	CONNECTIVE TISSUE DISORDERS W/O CC.
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC.
273	MAJOR SKIN DISORDERS W/O CC.
284	MINOR SKIN DISORDERS W/O CC.
301	ENDOCRINE DISORDERS W/O CC.
323	URINARY STONES W CC, &/OR ESW LITHOTRIPSY.
324	URINARY STONES W/O CC.
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC .
339	TESTES PROCEDURES, NON-MALIGNANCY AGE >17.
347	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC.
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC.
404	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC.
414	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC.
433	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA.
450	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC.
479	OTHER VASCULAR PROCEDURES W/O CC.

TABLE 1.—PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES—Continued

Proposed LTC–DRG	Description
500	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC.
509	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.
522	ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC
523	ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC
QUINTILE 2	
8	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC.
22	HYPERTENSIVE ENCEPHALOPATHY.
25	SEIZURE & HEADACHE AGE >17 W/O CC.
31	CONCUSSION AGE >17 W CC.
69*	OTITIS MEDIA & URI AGE >17 W/O CC.
109	CORONARY BYPASS W/O PTCA OR CARDIAC CATH.
128	DEEP VEIN THROMBOPHLEBITIS.
129	CARDIAC ARREST, UNEXPLAINED.
140	ANGINA PECTORIS.
175	G.I. HEMORRHAGE W/O CC.
177	UNCOMPLICATED PEPTIC ULCER W CC.
181	G.I. OBSTRUCTION W/O CC.
227	SOFT TISSUE PROCEDURES W/O CC.
228	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC.
234	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC.
237	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH.
250	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.
251	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC .
276	NON-MALIGANT BREAST DISORDERS.
295	DIABETES AGE 0–35.
305	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.
307	PROSTATECTOMY W/O CC.
325	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC.
328	URETHRAL STRICTURE AGE >17 W CC.
348	BENIGN PROSTATIC HYPERTROPHY W CC.
349	BENIGN PROSTATIC HYPERTROPHY W/O CC.
399	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC.
420	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC.
427	NEUROSES EXCEPT DEPRESSIVE.
441	HAND PROCEDURES FOR INJURIES.
447	ALLERGIC REACTIONS AGE >17.
449	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC.
467	OTHER FACTORS INFLUENCING HEALTH STATUS.
511	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA
532	SPINAL PROCEDURES W/O CC
QUINTILE 3	
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC.
21	VIRAL MENINGITIS.
29	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC.
44	ACUTE MAJOR EYE INFECTIONS.
53	SINUS & MASTOID PROCEDURES AGE >17.
83	MAJOR CHEST TRAUMA W CC.
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.
136	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AG >17.
200	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.
262	BREAST BIOPSY & LOCAL EXCISION FOR NON- MALIGNANCY.
266	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.
270	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC.
275	MALIGNANT BREAST DISORDERS W/O CC.
288	O.R. PROCEDURES FOR OBESITY.
299	INBORN ERRORS OF METABOLISM.
306	PROSTATECTOMY W CC.
319*	KIDNEY & URINARY TRACT NEOPLASMS W/O CC
336	TRANSURETHRAL PROSTATECTOMY W CC.
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES.
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.
394	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.

TABLE 1.—PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES—Continued

Proposed LTC–DRG	Description
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC.
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION.
497	SPINAL FUSION EXCEPT CERVICAL W CC.
502	KNEE PROCEDURES W PDX OF INFECTION W/O CC.
517	PERC CARDIO PROC W NON-DRUG ELUTING STENT W/O AMI.
518	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI.
538	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC
539	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC
QUINTILE 4	
1	CRANIOTOMY AGE >17 W CC.
63	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES.
86*	PLEURAL EFFUSION W/O CC.
102*	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC.
108	OTHER CARDIOTHORACIC PROCEDURES.
115	PRM CARD PACEM IMPL W AMI/HR/SHOCK OR AICD LEAD OR GNRTR.
116	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT.
157	ANAL & STOMAL PROCEDURES W CC.
168	MOUTH PROCEDURES W CC.
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES.
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.
218	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.
224	SHOULDER, ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC.
226	SOFT TISSUE PROCEDURES W CC.
268	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES.
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC.
303	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.
304	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.
308	MINOR BLADDER PROCEDURES W CC.
310	TRANSURETHRAL PROCEDURES W CC.
312	URETHRAL PROCEDURES, AGE >17 W CC.
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC.
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC.
419	FEVER OF UNKNOWN ORIGIN AGE >17 W CC.
455	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC.
485	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA .
487	OTHER MULTIPLE SIGNIFICANT TRAUMA.
501	KNEE PROCEDURES W PDX OF INFECTION W CC.
503	KNEE PROCEDURES W/O PDX OF INFECTION.
505	EXTENSIVE BURNS OF FULL THICKNESS BURNS WITH MECH VENT 96+HRS WITHOUT SKIN GRAFT.
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.
519	CERVICAL SPINAL FUSION W CC
529	VENTRICULAR SHUNT PROCEDURES W CC
QUINTILE 5	
46	OTHER DISORDERS OF THE EYE AGE >17 W CC.
55	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES.
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC.
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.
118	CARDIAC PACEMAKER DEVICE REPLACEMENT.
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.
150	PERITONEAL ADHESIOLYSIS W CC.
152	MINOR SMALL & LARGE BOWEL PROCEDURES W CC.
154	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC.
171*	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC.
191	PANCREAS, LIVER & SHUNT PROCEDURES W CC.
197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.
206*	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC.
209	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.
267	PERIANAL & PILONIDAL PROCEDURES.
338	TESTES PROCEDURES, FOR MALIGNANCY.
341	PENIS PROCEDURES.
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES.
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC.

TABLE 1.—PROPOSED COMPOSITION OF LOW-VOLUME QUINTILES—Continued

Proposed LTC–DRG	Description
424	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS.
443*	OTHER O.R. PROCEDURES FOR INJURIES W/O CC.
454	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC.
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.
488	HIV W EXTENSIVE O.R. PROCEDURE.
499	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC.
515	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH.
531	SPINAL PROCEDURES W CC.
533	EXTRACRANIAL PROCEDURES W CC.
535	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK.
536	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK.

*One of the original 171 proposed low-volume LTC–DRGs initially assigned to this low-volume quintile; removed from the low-volume quintiles in addressing nonmonotonicity (see step 5 below).

4. Steps for Determining the Proposed FY 2005 LTC–DRG Relative Weights

As we noted previously, the proposed FY 2005 LTC–DRG relative weights are determined in accordance with the methodology described in the August 1, 2003 final rule (68 FR 45380). In summary, LTCH cases must be grouped in the appropriate LTC–DRG, while taking into account the low-volume LTC–DRGs as described above, before the proposed FY 2005 LTC–DRG relative weights can be determined. After grouping the cases in the appropriate proposed LTC–DRG, we are proposing to calculate the proposed relative weights for FY 2005 in this proposed rule by first removing statistical outliers and cases with a length of stay of 7 days or less. Next, we are proposing to adjust the number of cases in each proposed LTC–DRG for the effect of short-stay outlier cases under § 412.529. The short-stay adjusted discharges and corresponding charges would be used to calculate ''relative adjusted weights'' in each proposed LTC–DRG using the hospital-specific relative value method described above.

Below we discuss in detail the steps for calculating the proposed FY 2005 LTC–DRG relative weights.

Step 1—Remove statistical outliers.

The first step in the calculation of the proposed FY 2005 LTC-DRG relative weights is to remove statistical outlier cases. We define statistical outliers as cases that are outside of 3.0 standard deviations from the mean of the log distribution of both charges per case and the charges per day for each LTC–DRG. These statistical outliers would be removed prior to calculating the proposed relative weights. We believe that they may represent aberrations in the data that distort the measure of average resource use. Including those LTCH cases in the calculation of the proposed relative weights could result in an inaccurate proposed relative weight that does not truly reflect relative resource use among the proposed LTC–DRGs.

Step 2—Remove cases with a length of stay of 7 days or less.

The proposed FY 2005 LTC–DRG relative weights should reflect the average of resources used on representative cases of a specific type. Generally, cases with a length of stay 7 days or less do not belong in a LTCH because such stays do not fully receive or benefit from treatment that is typical in a LTCH stay, and full resources are often not used in the earlier stages of admission to a LTCH. If we were to include stays of 7 days or less in the computation of the proposed FY 2005 LTC–DRG relative weights, the value of many proposed relative weights would decrease and, therefore, payments would decrease to a level that may no longer be appropriate.

We do not believe that it would be appropriate to compromise the integrity of the payment determination for those LTCH cases that actually benefit from and receive a full course of treatment at a LTCH, in order to include data from these very short-stays. Thus, in determining the proposed FY 2005 LTC–DRG relative weights, we remove LTCH cases with a length of stay of 7 days or less.

Step 3—Adjust charges for the effects of short-stay outliers.

The third step in the calculation of the proposed FY 2005 LTC–DRG relative weights is to adjust each LTCH's charges per discharge for short-stay outlier cases (that is, a patient with a length of stay that is less than or equal to five-sixths the average length of stay of the LTC–DRG).

We make this adjustment by counting a short-stay outlier as a fraction of a discharge based on the ratio of the length of stay of the case to the average length of stay for the proposed LTC–DRG for nonshort-stay outlier cases. This has the effect of proportionately reducing the impact of the lower charges for the short-stay outlier cases in calculating the average charge for the proposed LTC–DRG. This process produces the same result as if the actual charges per discharge of a short-stay outlier case were adjusted to what they would have been had the patient's length of stay been equal to the average length of stay of the proposed LTC–DRG.

As we explained in the August 1, 2003 final rule (68 FR 45380), counting short-stay outlier cases as full discharges with no adjustment in determining the proposed LTC–DRG relative weights would lower the proposed LTC–DRG relative weight for affected proposed LTC–DRGs because the relatively lower charges of the short-stay outlier cases would bring down the average charge for all cases within a proposed LTC–DRG. This would result in an ''underpayment'' to nonshort-stay outlier cases and an ''overpayment'' to short-stay outlier cases. Therefore, in this proposed rule, we adjust for short-stay outlier cases under § 412.529 in this manner since it results in more appropriate payments for all LTCH cases.

Step 4—Calculate the Proposed FY 2005 LTC–DRG relative weights on an iterative basis.

The process of calculating the proposed LTC–DRG relative weights using the hospital specific relative value methodology is iterative. First, for each LTCH case, we calculate a hospital-specific relative charge value by dividing the short-stay outlier adjusted charge per discharge (see step 3) of the LTCH case (after removing the statistical outliers (see step 1)) and LTCH cases with a length of stay of 7 days or less (see step 2) by the average charge per discharge for the LTCH in which the case occurred. The resulting ratio is then multiplied by the LTCH's case-mix

index to produce an adjusted hospital-specific relative charge value for the case. An initial case-mix index value of 1.0 is used for each LTCH.

For each proposed LTC–DRG, the proposed FY 2005 LTC–DRG relative weight is calculated by dividing the average of the adjusted hospital-specific relative charge values (from above) for the proposed LTC–DRG by the overall average hospital-specific relative charge value across all cases for all LTCHs. Using these recalculated proposed LTC–DRG relative weights, each LTCH's average proposed relative weight for all of its cases (case-mix) is calculated by dividing the sum of all the LTCH's proposed LTC–DRG relative weights by its total number of cases. The LTCHs' hospital-specific relative charge values above are multiplied by these hospital specific case-mix indexes. These hospital-specific case-mix adjusted relative charge values are then used to calculate a new set of proposed LTC–DRG relative weights across all LTCHs. In this proposed rule, this iterative process is continued until there is convergence between the weights produced at adjacent steps, for example, when the maximum difference is less than 0.0001.

Step 5—Adjust the proposed FY 2005 LTC–DRG relative weights to account for nonmonotonically increasing relative weights.

As explained in section II.B. of this preamble, the proposed FY 2005 CMS DRGs, upon which the proposed FY 2005 LTC–DRGs are based, contain ''pairs'' that are differentiated based on the presence or absence of CCs. The proposed LTC–DRGs with CCs are defined by certain secondary diagnoses not related to or inherently a part of the disease process identified by the principal diagnosis, but the presence of additional diagnoses does not automatically generate a CC. As we discussed in the August 1, 2003 final rule (68 FR 45381), the value of monotonically increasing relative weights rises as the resource use increases (for example, from uncomplicated to more complicated). The presence of CCs in a proposed LTC–DRG means that cases classified into a ''without CC'' proposed LTC–DRG are expected to have lower resource use (and lower costs). In other words, resource use (and costs) are expected to decrease across ''with CC''/''without CC'' pairs of proposed LTC–DRGs.

For a case to be assigned to a proposed LTC–DRG with CCs, more coded information is called for (that is, at least one relevant secondary diagnosis), than for a case to be assigned to a proposed LTC–DRG ''without CCs'' (which is based on only one principal diagnosis and no relevant secondary diagnoses). Currently, the LTCH claims data include both accurately coded cases without complications and cases that have complications (and cost more) but were not coded completely. Both types of cases are grouped to a proposed LTC–DRG ''without CCs'' since only one principal diagnosis was coded. Since the LTCH PPS was only implemented for cost reporting periods beginning on or after October 1, 2002 (FY 2003) and LTCHs were previously paid under cost-based reimbursement, which is not based on patient diagnoses, coding by LTCHs for these cases may not have been as detailed as possible.

Thus, in developing the FY 2003 LTC–DRG relative weights for the LTCH PPS based on FY 2001 claims data, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55990), we found on occasion that the data suggested that cases classified to the LTC–DRG ''with CCs'' of a ''with CC''/''without CC'' pair had a lower average charge than the corresponding LTC–DRG ''without CCs.'' Similarly, based on FY 2003 claims data, we also found on occasion that the data suggested that cases classified to the proposed LTC–DRG ''with CCs'' of a ''with CC''/''without CC'' pair have a lower average charge than the corresponding proposed LTC–DRG ''without CCs'' for FY 2005.

We believe this anomaly may be due to coding that may not have fully reflected all comorbidities that were present. Specifically, LTCHs may have failed to code relevant secondary diagnoses, which resulted in cases that actually had CCs being classified into a ''without CC'' LTC–DRG. It would not be appropriate to pay a lower amount for the ''with CC'' LTC–DRG. Therefore, in this proposed rule, we grouped both the cases ''with CCs'' and ''without CCs'' together for the purpose of calculating the proposed FY 2005 LTC–DRG relative weights in this proposed rule. As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55990), we will continue to employ this methodology to account for nonmonotonically increasing relative weights until we have adequate data to calculate appropriate separate weights for these anomalous LTC–DRG pairs. We expect that, as was the case when we first implemented the IPPS, this problem will be self-correcting, as LTCHs submit more completely coded data in the future.

There are three types of ''with CC'' and ''without CC'' pairs that could be nonmonotonic, that is, where the ''without CC'' proposed LTC–DRG would have a higher average charge than the ''with CC'' proposed LTC–DRG. For this proposed rule, using the LTCH cases in the December 2003 update of the FY 2003 MedPAR file, we identified two of the three types of nonmonotonic LTC–DRG pairs.

The first category of nonmonotonically increasing proposed relative weights for FY 2005 LTC–DRG pairs ''with and without CCs'' contains 2 pairs of proposed LTC–DRGs in which both the proposed LTC–DRG ''with CCs'' and the proposed LTC–DRG ''without CCs'' had 25 or more LTCH cases and, therefore, did not fall into one of the 5 low-volume quintiles. For those nonmonotonic LTC–DRG pairs, we would combine the LTCH cases and compute a new proposed relative weight based on the case-weighted average of the combined LTCH cases of the proposed LTC–DRGs. The case-weighted average charge is determined by dividing the total charges for all LTCH cases by the total number of LTCH cases for the combined proposed LTC–DRG. This new proposed relative weight would then be assigned to both of the proposed LTC–DRGs in the pair. In this proposed rule, we are proposing that, for FY 2005, proposed LTC–DRGs 144 and 145 and LTC–DRGs 444 and 445 are in this category.

The second category of nonmonotonically increasing relative weights for proposed LTC–DRG pairs with and without CCs consists of zero pairs of proposed LTC–DRGs that has fewer than 25 cases, and each proposed LTC–DRG would be grouped to different proposed low-volume quintiles in which the ''without CC'' proposed LTC–DRG would be in a higher-weighted proposed low-volume quintile than the ''with CC'' proposed LTC–DRG. For those pairs, we would combine the LTCH cases and determine the case-weighted average charge for all LTCH cases. The case-weighted average charge is determined by dividing the total charges for all LTCH cases by the total number of LTCH cases for the combined proposed LTC–DRG. Based on the case-weighted average LTCH charge, we determine which low-volume quintile the ''combined LTC–DRG'' would be grouped. Both proposed LTC–DRGs in the pair would then be grouped into the same proposed low-volume quintile, and thus would have the same proposed relative weight. For FY 2005, in this proposed rule, there are no proposed LTC–DRGs that fall into this category.

The third category of nonmonotonically increasing relative weights for proposed LTC–DRG pairs with and without CCs consists of 7 pairs of proposed LTC–DRGs where one of the proposed LTC–DRGs has fewer than

25 LTCH cases and is grouped to a proposed low-volume quintile and the other proposed LTC–DRG has 25 or more LTCH cases and has its own proposed LTC–DRG relative weight, and the proposed LTC–DRG ''without CCs'' has the higher proposed relative weight. We remove the proposed low-volume LTC–DRG from the proposed low-volume quintile and combine it with the other proposed LTC–DRG for the computation of a new proposed relative weight for each of these proposed LTC–DRGs. This new proposed relative weight is assigned to both proposed LTC–DRGs, so they each have the same proposed relative weight. For FY 2005, in this proposed rule, we are proposing the following proposed LTC–DRGs would be in this category: LTC–DRGs 68 and 69; LTC–DRGs 85 and 86; LTC–DRGs 101 and 102; LTC–DRGs 170 and 171; LTC–DRGs 205 and 206; LTC–DRGs 318 and 319; and LTC–DRGs 442 and 443.

Step 6—Determine a proposed FY 2005 LTC-DRG relative weight for proposed LTC–DRGs with no LTCH cases.

As we stated above, we determine the proposed relative weight for each proposed LTC–DRG using charges reported in the December 2003 update of the FY 2003 MedPAR file. Of the 519 proposed LTC–DRGs for FY 2005, we identified 170 proposed LTC–DRGs for which there were no LTCH cases in the database. That is, based on data from the FY 2003 MedPAR file used in this proposed rule, no patients who would have been classified to those proposed LTC–DRGs were treated in LTCHs during FY 2003 and, therefore, no charge data were reported for those proposed LTC–DRGs. Thus, in the process of determining the proposed LTC–DRG relative weights, we are unable to determine proposed weights for these 170 proposed LTC–DRGs using the methodology described in steps 1 through 5 above. However, since patients with a number of the diagnoses under these proposed LTC–DRGs may be treated at LTCHs beginning in FY 2005, we assign proposed relative weights to each of the 170 ''no volume'' proposed LTC–DRGs based on clinical similarity and relative costliness to one of the remaining 349 (519 − 170 = 349) proposed LTC–DRGs for which we are able to determine proposed relative weights, based on FY 2003 claims data.

As there are currently no LTCH cases in these ''no volume'' proposed LTC–DRGs, we determine proposed relative weights for the 170 proposed LTC–DRGs with no LTCH cases in the FY 2003 MedPAR file used in this proposed rule by grouping them to the appropriate proposed low-volume quintile. This methodology is consistent with our methodology used in determining proposed relative weights to account for the proposed low-volume LTC–DRGs described above.

Our methodology for determining proposed relative weights for the ''no volume'' proposed LTC–DRGs is as follows: First, we crosswalk the proposed no volume LTC–DRGs by matching them to other similar proposed LTC–DRGs for which there were LTCH cases in the FY 2003 MedPAR file based on clinical similarity and intensity of use of resources as determined by care provided during the period of time surrounding surgery, surgical approach (if applicable), length of time of surgical procedure, post-operative care, and length of stay. We assign the proposed relative weight for the applicable proposed low-volume quintile to the proposed no volume LTC–DRG if the proposed LTC–DRG to which it is crosswalked is grouped to one of the proposed low-volume quintiles. If the proposed LTC–DRG to which the proposed no volume LTC–DRG is crosswalked is not one of the proposed LTC–DRGs to be grouped to one of the proposed low-volume quintiles, we compare the proposed relative weight of the proposed LTC–DRG to which the proposed no volume LTC–DRG is crosswalked to the proposed relative weights of each of the five quintiles and we assign the proposed no volume LTC–DRG the proposed relative weight of the proposed low-volume quintile with the closest proposed weight. For this proposed rule, a list of the proposed no volume FY 2005 LTC–DRGs and the proposed FY 2005 LTC–DRG to which it is crosswalked in order to determine the appropriate proposed low-volume quintile for the assignment of a proposed relative weight for FY 2005 is shown below in Table 2.

TABLE 2.—PROPOSED NO VOLUME LTC–DRG CROSSWALK AND PROPOSED QUINTILE ASSIGNMENT FOR FY 2005

Proposed LTC–DRG	Description	Proposed cross-walked LTC–DRG	Proposed low-volume quintile assigned.
2	CRANIOTOMY AGE >17 W/O CC	1	Quintile 4.
3	CRANIOTOMY AGE 0–17	1	Quintile 4.
6	CARPAL TUNNEL RELEASE	251	Quintile 2.
26	SEIZURE & HEADACHE AGE 0–17	25	Quintile 2.
30	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	29	Quintile 3.
32	CONCUSSION AGE >17 W/O CC	25	Quintile 2.
33	CONCUSSION AGE 0–17	25	Quintile 2.
36	RETINAL PROCEDURES	47	Quintile 1.
37	ORBITAL PROCEDURES	47	Quintile 1.
38	PRIMARY IRIS PROCEDURES	47	Quintile 1.
39	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	47	Quintile 1.
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	47	Quintile 1.
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	47	Quintile 1.
42	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	47	Quintile 1.
48	OTHER DISORDERS OF THE EYE AGE 0–17	47	Quintile 1.
49	MAJOR HEAD & NECK PROCEDURES	64	Quintile 4.
50	SIALOADENECTOMY	63	Quintile 4.
51	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	63	Quintile 4.
52	CLEFT LIP & PALATE REPAIR	63	Quintile 4.
54	SINUS & MASTOID PROCEDURES AGE 0–17	53	Quintile 3.
56	RHINOPLASTY	53	Quintile 3.
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	69	Quintile 2.
58	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	69	Quintile 2.
59	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	69	Quintile 2.
60	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	69	Quintile 2.

TABLE 2.—PROPOSED NO VOLUME LTC–DRG CROSSWALK AND PROPOSED QUINTILE ASSIGNMENT FOR FY 2005—Continued

Proposed LTC–DRG	Description	Proposed cross-walked LTC–DRG	Proposed low-volume quintile assigned.
61	MYRINGOTOMY W TUBE INSERTION AGE >17	69	Quintile 2.
62	MYRINGOTOMY W TUBE INSERTION AGE 0–17	69	Quintile 2.
66	EPISTAXIS	69	Quintile 2.
67	EPIGLOTTITIS	63	Quintile 4.
70	OTITIS MEDIA & URI AGE 0–17	69	Quintile 2.
71	LARYNGOTRACHEITIS	97	Quintile 1.
72	NASAL TRAUMA & DEFORMITY	53	Quintile 3.
74	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17	69	Quintile 2.
81	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	69	Quintile 2.
91	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	90	Quintile 2.
98	BRONCHITIS & ASTHMA AGE 0–17	97	Quintile 1.
104	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	110	Quintile 1.
105	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	110	Quintile 1.
106	CORONARY BYPASS W PTCA	110	Quintile 1.
107	CORONARY BYPASS W CARDIAC CATH	110	Quintile 1.
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	110	Quintile 1.
137	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	136	Quintile 3.
146	RECTAL RESECTION W CC	148	Quintile 5.
147	RECTAL RESECTION W/O CC	148	Quintile 5.
151	PERITONEAL ADHESIOLYSIS W/O CC	150	Quintile 5.
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	152	Quintile 5.
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	154	Quintile 5.
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17	154	Quintile 5.
158	ANAL & STOMAL PROCEDURES W/O CC	157	Quintile 4.
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	159	Quintile 3.
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	178	Quintile 1.
163	HERNIA PROCEDURES AGE 0–17	178	Quintile 1.
164	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	148	Quintile 5.
165	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	148	Quintile 5.
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	148	Quintile 5.
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	148	Quintile 5.
169	MOUTH PROCEDURES W/O CC	53	Quintile 3.
184	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17	183	Quintile 2.
186	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17	185	Quintile 3.
187	DENTAL EXTRACTIONS & RESTORATIONS	185	Quintile 3.
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	189	Quintile 3.
192	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	191	Quintile 5.
194	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	193	Quintile 1.
195	CHOLECYSTECTOMY W C.D.E. W CC	197	Quintile 5.
196	CHOLECYSTECTOMY W C.D.E. W/O CC	197	Quintile 5.
198	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	197	Quintile 5.
199	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	200	Quintile 3.
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	210	Quintile 5.
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17	210	Quintile 5.
219	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC]	218	Quintile 4.
220	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17	218	Quintile 4.
223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	224	Quintile 4.
232	ARTHROSCOPY	234	Quintile 2.
252	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	234	Quintile 2.
255	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17	234	Quintile 2.
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC	275	Quintile 3.
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	275	Quintile 3.
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	275	Quintile 3.
279	CELLULITIS AGE 0–17	273	Quintile 1.
282	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	281	Quintile 3.
286	ADRENAL & PITUITARY PROCEDURES	53	Quintile 3.
289	PARATHYROID PROCEDURES	53	Quintile 3.
290	THYROID PROCEDURES	53	Quintile 3.
291	THYROGLOSSAL PROCEDURES	53	Quintile 3.
293	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	292	Quintile 2.
298	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	297	Quintile 2.
309	MINOR BLADDER PROCEDURES W/O CC	308	Quintile 4.
311	TRANSURETHRAL PROCEDURES W/O CC	310	Quintile 4.
313	URETHRAL PROCEDURES, AGE >17 W/O CC	312	Quintile 4.
314	URETHRAL PROCEDURES, AGE 0–17	305	Quintile 2.
322	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	326	Quintile 1.
327	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	326	Quintile 1.
329	URETHRAL STRICTURE AGE >17 W/O CC	305	Quintile 2.
330	URETHRAL STRICTURE AGE 0–17	305	Quintile 2.

TABLE 2.—PROPOSED NO VOLUME LTC–DRG CROSSWALK AND PROPOSED QUINTILE ASSIGNMENT FOR FY 2005—Continued

Proposed LTC–DRG	Description	Proposed cross-walked LTC–DRG	Proposed low-volume quintile assigned.
333	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	332	Quintile 2.
334	MAJOR MALE PELVIC PROCEDURES W CC	345	Quintile 4.
335	MAJOR MALE PELVIC PROCEDURES W/O CC	345	Quintile 4.
337	TRANSURETHRAL PROSTATECTOMY W/O CC	306	Quintile 3.
340	TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	339	Quintile 1.
342	CIRCUMCISION AGE >17	339	Quintile 1.
343	CIRCUMCISION AGE 0–17	339	Quintile 1.
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	345	Quintile 4.
351	STERILIZATION, MALE	339	Quintile 1.
353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	365	Quintile 5.
354	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	365	Quintile 5.
355	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	365	Quintile 5.
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	303	Quintile 4.
357	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	303	Quintile 4.
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	303	Quintile 4.
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	303	Quintile 4.
360	VAGINA, CERVIX & VULVA PROCEDURES	303	Quintile 4.
361	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	149	Quintile 1.
362	ENDOSCOPIC TUBAL INTERRUPTION	149	Quintile 1.
363	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	367	Quintile 1.
364	D&C, CONIZATION EXCEPT FOR MALIGNANCY	367	Quintile 1.
370	CESAREAN SECTION W CC	369	Quintile 3.
371	CESAREAN SECTION W/O CC	367	Quintile 1.
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	367	Quintile 1.
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	367	Quintile 1.
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C	367	Quintile 1.
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	367	Quintile 1.
376	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	367	Quintile 1.
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	367	Quintile 1.
378	ECTOPIC PREGNANCY	369	Quintile 3.
379	THREATENED ABORTION	367	Quintile 1.
380	ABORTION W/O D&C	367	Quintile 1.
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	367	Quintile 1.
382	FALSE LABOR	367	Quintile 1.
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	367	Quintile 1.
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	367	Quintile 1.
385	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	367	Quintile 1.
386	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	367	Quintile 1.
387	PREMATURITY W MAJOR PROBLEMS	367	Quintile 1.
388	PREMATURITY W/O MAJOR PROBLEMS	367	Quintile 1.
389	FULL TERM NEONATE W MAJOR PROBLEMS	367	Quintile 1.
390	NEONATE W OTHER SIGNIFICANT PROBLEMS	367	Quintile 1.
391	NORMAL NEWBORN	367	Quintile 1.
392	SPLENECTOMY AGE >17	197	Quintile 5.
393	SPLENECTOMY AGE 0–17	197	Quintile 5.
396	RED BLOOD CELL DISORDERS AGE 0–17	399	Quintile 2.
402	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	395	Quintile 4.
405	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17	404	Quintile 1.
407	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC	408	Quintile 4.
411	HISTORY OF MALIGNANCY W/O ENDOSCOPY	367	Quintile 1.
412	HISTORY OF MALIGNANCY W ENDOSCOPY	367	Quintile 1.
417	SEPTICEMIA AGE 0–17	416	Quintile 3.
422	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	426	Quintile 1.
432	OTHER MENTAL DISORDER DIAGNOSES	427	Quintile 2.
446	TRAUMATIC INJURY AGE 0–17	445	Quintile 3.
448	ALLERGIC REACTIONS AGE 0–17	447	Quintile 2.
451	POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	455	Quintile 4.
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	236	Quintile 2.
481	BONE MARROW TRANSPLANT	394	Quintile 3.
482	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	63	Quintile 4.
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	1	Quintile 4.
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	209	Quintile 5.
492	CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT	410	Quintile 3.
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	493	Quintile 3.
498	SPINAL FUSION EXCEPT CERVICAL W/O CC	497	Quintile 3.
504	EXTENSIVE BURNS OF FULL THICKNESS BURNS WITH MECH VENT 96+HRS WITH SKIN GRAFT.	468	Quintile 5.
507	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	508	Quintile 3.
516	PERCUTANEOUS CARDIOVASC PROC W AMI	518	Quintile 3.

TABLE 2.—PROPOSED NO VOLUME LTC–DRG CROSSWALK AND PROPOSED QUINTILE ASSIGNMENT FOR FY 2005—Continued

Proposed LTC–DRG	Description	Proposed cross-walked LTC–DRG	Proposed low-volume quintile assigned.
520	CERVICAL SPINAL FUSION W/O CC	497	Quintile 3.
525	OTHER HEART ASSIST SYSTEM IMPLANT	468	Quintile 5.
526	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W AMI	517	Quintile 3.
527	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W/O AMI	517	Quintile 3.
528	INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	1	Quintile 4.
530	VENTRICULAR SHUNT PROCEDURES W/O CC	529	Quintile 4.
534	EXTRACRANIAL PROCEDURES W/O CC	500	Quintile 1.
540	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC	399	Quintile 2.

To illustrate this methodology for determining the proposed relative weights for the 170 proposed LTC–DRGs with no LTCH cases, we are providing the following examples, which refer to the no volume proposed LTC–DRGs crosswalk information for FY 2005 provided above in Table 2:

Example 1: There were no cases in the FY 2003 MedPAR file used for this proposed rule for proposed LTC–DRG 163 (Hernia Procedures Age 0–17). Since the procedure is similar in resource use and the length and complexity of the procedures and the length of stay are similar, we determined that proposed LTC–DRG 178 (Uncomplicated Peptic Ulcer Without CC), which is assigned to proposed low-volume quintile 1 for the purpose of determining the proposed FY 2005 relative weights, would display similar clinical and resource use. Therefore, we assign the same proposed relative weight of proposed LTC–DRG 178 of 0.4964 (Quintile 1) for FY 2005 (Table 11 in the Addendum to this proposed rule) to LTC–DRG 163.

Example 2: There were no LTCH cases in the FY 2003 MedPAR file used in this proposed rule for proposed LTC–DRG 91 (Simple Pneumonia and Pleurisy Age 0–17). Since the severity of illness in patients with bronchitis and asthma is similar in patients regardless of age, we determined that proposed LTC–DRG 90 (Simple Pneumonia and Pleurisy Age >17 Without CC) would display similar clinical and resource use characteristics and have a similar length of stay to LTC–DRG 91. There were over 25 cases in proposed LTC–DRG 90. Therefore, it would not be assigned to a low-volume quintile for the purpose of determining the LTC–DRG relative weights. However, under our established methodology, proposed LTC–DRG 91, with no LTCH cases, would need to be grouped to a low-volume quintile. We identified that the proposed low-volume quintile with the closest weight to proposed LTC–DRG 90 (0.7368; see Table 11 in the Addendum to this proposed rule) would be proposed low-volume quintile 2 (0.6685; see Table 11 in the Addendum to this proposed rule). Therefore, we assign proposed LTC–DRG 91 a proposed relative weight of 0.6885 for FY 2005.

Furthermore, we are proposing LTC–DRG relative weights of 0.0000 for heart, kidney, liver, lung, pancreas, and simultaneous pancreas/kidney transplants (LTC–DRGs 103, 302, 480, 495, 512, and 513, respectively) for FY 2005 because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified.

Based on our research, we found that most LTCHs only perform minor surgeries, such as minor small and large bowel procedures, to the extent any surgeries are performed at all. Given the extensive criteria that must be met to become certified as a transplant center for Medicare, we believe it is unlikely that any LTCHs would become certified as a transplant center. In fact, in the nearly 20 years since the implementation of the IPPS, there has never been a LTCH that even expressed an interest in becoming a transplant center.

However, if in the future a LTCH applies for certification as a Medicare-approved transplant center, we believe that the application and approval procedure would allow sufficient time for us to determine appropriate weights for the LTC–DRGs affected. At the present time, we would only include these six transplant LTC–DRGs in the GROUPER program for administrative purposes. Since we use the same GROUPER program for LTCHs as is used under the IPPS, removing these LTC–DRGs would be administratively burdensome.

Again, we note that as this system is dynamic, it is entirely possible that the number of proposed LTC–DRGs with a zero volume of LTCH cases based on the system will vary in the future. We used the best most recent available claims data in the MedPAR file to identify zero volume LTC–DRGs and to determine the proposed relative weights in this proposed rule.

Table 11 in the Addendum to this proposed rule lists the proposed LTC–DRGs and their respective proposed relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (to assist in the determination of short-stay outlier payments under § 412.529) for FY 2005.

E. Proposed Add-On Payments for New Services and Technologies

[If you choose to comment on issues in this section, please include the caption ''New Technology Applications'' at the beginning of your comment.]

1. Background

Sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and ensuring adequate payment for new medical services and technologies under the IPPS. Section 1886(d)(5)(K)(vi) of the Act specifies that a medical service or technology will be considered new if it meets criteria established by the Secretary after notice and opportunity for public comment. Section 1886(d)(5)(K)(ii)(I) of the Act specifies that the process must apply to a new medical service or technology if, ''based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate.''

The regulations implementing this provision establish three criteria for special treatment. First, § 412.87(b)(2) defines when a specific medical service or technology will be considered new for purposes of new medical service or technology add-on payments. The statutory provision contemplated the special payment treatment for new medical services or technologies until such time as data are available to reflect the cost of the technology in the DRG weights through recalibration. There is a lag of 2 to 3 years from the point a new medical service or technology is first introduced on the market and when data reflecting the use of the medical service or technology are used to calculate the DRG weights. For example, data from discharges occurring during FY 2003 are used to calculate the proposed FY 2005 DRG weights in this proposed rule. Section 412.87(b)(2) provides that a ''medical service or technology may be considered new within 2 or 3 years after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the new medical service or technology (depending on when a new code is assigned and data on the new medical service or technology become

available for DRG recalibration). After CMS has recalibrated the DRGs, based on available data, to reflect the costs of an otherwise new medical service or technology, the medical service or technology will no longer be considered 'new' under the criterion for this section.''

The 2-year to 3-year period would ordinarily begin with FDA approval, unless there was some documented delay in bringing the product onto the market after that approval (for instance, component production or drug production had been postponed until FDA approval due to shelf life concerns). After the DRGs have been recalibrated to reflect the costs of an otherwise new medical service or technology, the special add-on payment for new medical services or technology ceases (§ 412.87(b)(2)). For example, an approved new technology that received FDA approval in October 2003 and entered the market at that time may be eligible to receive add-on payments as a new technology until FY 2006 (discharges occurring before October 1, 2005), when data reflecting the costs of the technology would be used to recalibrate the DRG weights. Because the FY 2006 DRG weights will be calculated using FY 2004 MedPAR data, the costs of such a new technology would likely be reflected in the FY 2006 DRG weights.

Section 412.87(b)(3) further provides that, to receive special payment treatment, new medical services or technologies must be inadequately paid otherwise under the DRG system. To assess whether technologies would be inadequately paid under the DRGs, we establish thresholds to evaluate applicants for new technology add-on payments. In the August 1, 2003 final rule (68 FR 45385), we established the threshold at the geometric mean standardized charge for all cases in the DRG plus 75 percent of 1 standard deviation above the geometric mean standardized charge (based on the logarithmic values of the charges and transformed back to charges) for all cases in the DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant DRGs, if the new medical service or technology occurs in many different DRGs). Table 10 in the Addendum to the August 1, 2003 final rule (68 FR 45648) listed the qualifying threshold by DRG, based on the discharge data that we used to calculate the FY 2004 DRG weights.

However, section 503(b)(1) of Public Law 108–173 amended section 1886(d)(5)(K)(ii)(I) of the Act to provide for ''applying a threshold* * *that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation for the diagnosis-related group involved.'' The provisions of section 503(b)(1) apply to classification for fiscal years beginning with FY 2005. We have updated Table 10 from the October 6, 2003 **Federal Register** correction document, which contains the thresholds that we are using to evaluate applications for new service or technology add-on payments for FY 2005, using the section 503(b)(1) measures stated above, and posted these new thresholds on our Web site at: *www.cms.hhs.gov/providers/hipps/newtech.asp.* The thresholds published in this FY 2005 proposed rule are preliminary thresholds for FY 2006. The final thresholds published in the FY 2005 final rule will be used to evaluate applicants for new technology add-on payments during FY 2006. (Refer to section IV. D. of this preamble for a discussion of a revision of the regulations to incorporate the change made by section 503(b)(1) of Public Law 108–173.)

Section 412.87(b)(1) of our existing regulations provides that a new technology is an appropriate candidate for an additional payment when it represents an advance in medical technology that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries. For example, a new technology represents a substantial clinical improvement when it reduces mortality, decreases the number of hospitalizations or physician visits or reduces recovery time compared to the technologies previously available. (*See* the September 7, 2001 final rule (66 FR 46902) for a complete discussion of this criterion.)

The new medical service or technology add-on payment policy provides additional payments for cases with high costs involving eligible new medical services or technologies while preserving some of the incentives under the average-based payment system. The payment mechanism is based on the cost to hospitals for the new medical service or technology. Under § 412.88, Medicare pays a marginal cost factor of 50 percent for the costs of a new medical service or technology in excess of the full DRG payment. If the actual costs of a new medical service or technology case exceed the DRG payment by more than the 50-percent marginal cost factor of the new medical service or technology, Medicare payment is limited to the DRG payment plus 50 percent of the estimated costs of the new technology.

The report language accompanying section 533 of Public Law 106–554 indicated Congressional intent that the Secretary implement the new mechanism on a budget neutral basis (H.R. Conf. Rep. No. 106–1033, 106th Cong., 2nd Sess. at 897 (2000)). Section 1886(d)(4)(C)(iii) of the Act requires that the adjustments to annual DRG classifications and relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. Therefore, in the past, we accounted for projected payments under the new medical service and technology provision during the upcoming fiscal year at the same time we estimated the payment effect of changes to the DRG classifications and recalibration. The impact of additional payments under this provision was then included in the budget neutrality factor, which was applied to the standardized amounts and the hospital-specific amounts.

Section 503(d)(2) of Public Law 108–173 amended section 1886(d)(5)(K)(ii)(III) of the Act to provide that there shall be no reduction or adjustment in aggregate payments under the IPPS due to add-on payments for new medical services and technologies. Therefore, add-on payments for new medical services or technologies for FY 2005 and later years will not be budget neutral. We discuss the regulation change necessary to implement this provision in section IV.H. of this proposed rule.

Applicants for add-on payments for new medical services or technologies for FY 2006 must submit a formal request, including a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement, along with a significant sample of data to demonstrate the medical service or technology meets the high-cost threshold, no later than early October 2004. Applicants must submit a complete database no later than mid-December 2004. Complete application information, along with final deadlines for submitting a full application, will be available at our Web site after publication of the FY 2005 final rule at: *www.cms.hhs.gov/providers/hipps/default.asp.* To allow interested parties to identify the new medical services or technologies under review before the publication of the proposed rule for FY 2006, the Web site will also list the tracking forms completed by each applicant.

2. Other Provisions of Section 503 of Public Law 108–173

Section 503(b)(2) of Public Law 108–173 amended section 1886(d)(5)(K) of the Act by adding a new clause (viii) to provide for a mechanism for public input before publication of a notice of proposed rule making regarding whether a medical service or technology represents a substantial improvement or advancement. The revised process for evaluating new medical service and technology applications requires the Secretary to—

- Provide, before publication of a proposed rule, for public input regarding whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of Medicare beneficiaries.
- Make public and periodically update a list of the services and technologies for which an application for add-on payments is pending.
- Accept comments, recommendations, and data from the public regarding whether a service or technology represents a substantial improvement.
- Provide, before publication of a proposed rule, for a meeting at which organizations representing hospitals, physicians, manufacturers, and any other interested party may present comments, recommendations, and data regarding whether a new service or technology represents a substantial clinical improvement to the clinical staff of CMS.

In order to satisfy the requirements of this last provision, we published a notice in the **Federal Register** on February 27, 2004, and held a town meeting at the CMS Headquarters Office in Baltimore, MD, on March 15, 2004. In the announcement notice for the meeting, we stated that the opinions and alternatives provided during the meeting would assist us in our evaluations of applications by allowing public discussions of the substantial clinical improvement criteria for each of the FY 2005 new medical service and technology add-on payment applications before the publication of this FY 2005 IPPS proposed rule.

Approximately 70 participants registered and attended in person, while additional participants listened over an open telephone line. The participants focused on presenting data on the substantial clinical improvement aspect of their products, as well as the need for additional payments to ensure access to Medicare beneficiaries. In addition, we also received many written comments regarding the substantial clinical improvement criterion for the applicants. We have considered these comments in our evaluation of each new application for FY 2005 in this proposed rule. We have summarized these comments, or if applicable, indicated that no comments were received, at the end of the discussion of the individual applications.

Section 503(c) of Public Law 108–173 amended section 1886(d)(5)(K) of the Act by adding a new clause (ix) requiring that before establishing any add-on payment for a new medical service or technology, that the Secretary shall seek to identify one or more DRGs associated with the new technology, based on similar clinical or anatomical characteristics and the costs of the technology and assign the new technology into a DRG where the average costs of care most closely approximate the costs of care using the new technology. No add-on payment shall be made with respect to such a new technology.

At the time an application is submitted, the DRGs associated with the new technology are identified. We only determine that a new technology add-on payment is appropriate when the reimbursement under these DRGs is not adequate for this new technology. The criterion for this determination is the cost threshold, which we discuss below. We discuss the assignments of several new technologies within the DRG payment system in section II.B. of this preamble.

In this proposed rule, we evaluate whether new technology add-on payments will continue in FY 2005 for the two technologies that currently receive such payments. In accordance with section 503(e)(2) of Public Law 108–173, we also reconsider one application for new technology add-on payments that was denied last year. Finally, we present our evaluations of 10 new applications for add-on payments in FY 2005.

3. FY 2005 Status of Technology Approved for FY 2004 Add-On Payments

a. Drotrecogin Alfa (Activated)—Xigris®

Xigris®, a biotechnology product that is a recombinant version of naturally occurring Activated Protein C (APC), was approved by the FDA on November 21, 2001. In the August 1, 2002 IPPS final rule (67 FR 50013), we determined that cases involving the administration of Xigris®, (as identified by the presence of code 00.11 (Infusion of drotrecogin alfa (activated)) were eligible for additional payments in FY 2003. (The August 1, 2002 final rule contains a detailed discussion of this technology.)

In the August 1, 2003 final IPPS rule (68 FR 45387), we indicated that, for FY 2004, we would continue to make add-on payments for cases involving the administration of Xigris® as identified by the presence of code 00.11. This was because we determined that Xigris® was still within the 2-year to 3-year period before the costs of this new technology would be reflected in the DRG weights.

Xigris® became available on the market at the time of its FDA licensure on November 21, 2001. Early in FY 2005, Xigris® will be beyond the 2-year to 3-year period during which a technology can be considered new. Therefore, we are proposing that Xigris® will not continue to receive new technology add-on payments in FY 2005. During the period of 2 years and 6 months since it came onto the market, Xigris® has been used frequently in the appropriate DRGs. For FY 2005, we analyzed the number of cases involving this technology in the FY 2003 MedPAR file. We found 4,243 cases that received Xigris®, the majority of which fell appropriately into DRGs 415, 416, 475, and 483, with by far the most cases in DRG 416 (Septicemia Age >17). Accordingly, the costs of Xigris® are now well-represented in those DRGs. Therefore, we are proposing that FY 2004 will be the final year for Xigris® to receive add-on payments.

We received no public comments regarding the continuation of add-on payments for Xigris®.

The manufacturer also asked us to consider creating a DRG specifically for severe sepsis. We discuss this request in section II.B.16.c. of this proposed rule.

b. InFUSE™ (Bone Morphogenetic Proteins (BMPs) for Spinal Fusions)

InFUSE™ was approved by FDA for use on July 2, 2002, and became available on the market immediately thereafter. In the August 1, 2003 IPPS final rule (68 FR 45388), we approved InFUSE™ for add-on payments under § 412.88, effective for FY 2004. This approval was on the basis of using InFUSE™ for single-level, lumbar spinal fusion, consistent with the FDA's approval and the data presented to us by the applicant. Therefore, we limited the add-on payment to cases using this technology for anterior lumbar fusions in DRGs 497 (Spinal Fusion Except Cervical With CC) and 498 (Spinal Fusion Except Cervical Without CC). Cases involving InFUSE™ that are eligible for the new technology add-on payment are identified by assignment to DRGs 497 and 498 as a lumbar spinal fusion, with the combination of ICD–9-CM procedure codes 84.51 (Insertion of

interbody spinal fusion device) and 84.52 (Insertion of recombinant bone morphogenetic protein).

Because InFUSE™ was approved by the FDA for use on July 2, 2003, it is still within the 2-year to 3-year period during which a technology can be considered new under the regulations. Therefore, we are proposing to continue add-on payments for FY 2005 for cases receiving InFUSE™ for spinal fusions in DRGs 497 (Spinal Fusion Except Cervical With CC) and 498 (Spinal Fusion Except Cervical Without CC). We are also proposing to continue limiting the add-on payment for cases receiving InFUSE™, to those cases identified by the presence of procedure codes 84.51 and 84.52. However, we are proposing to eliminate add-on payment for the interbody fusion device that is used in combination with this recombinant human bone morphogenetic protein (rhBMP) product (procedure code 84.52). We note that currently add-on payments for InFUSE™ include costs for the interbody fusion device (the LT cage, identified by procedure code 84.51), used in the spinal fusion procedure with the InFUSE™ product. Because this device is not a new technology, but in fact has been in use for 9 years for spinal fusions, we believe that it is inappropriate to pay for this device in conjunction with the genuinely new rhBMP technology. Therefore, we are proposing no longer to pay for the interbody fusion device as bundled in the current maximum add-on payment amount of $4,450 for cases that qualify for additional payment. This proposal would reduce the add-on payment to account for no longer paying for the LT cage. This would reduce the cost of this new technology by $4,990, which results in a total cost of $3,910 for InFUSE™. Therefore, we are proposing a maximum add-on amount of $1,955 for cases that qualify for additional payment. Although we are proposing to eliminate payment for the LT cage, we would still require the presence of procedure code 84.51 (in combination with procedure code 84.52) when making add-on payments for new technology for InFUSE™. This is due to the fact that the LT cage is still required by the FDA when InFUSE™ is used for single level spinal fusions.

We received the following public comments in accordance with section 503(b)(2) of Public Law 108–173 regarding the continuation of add-on payments for this technology.

Comment: Several commenters wrote expressing support for continued add-on payments for this technology. Many of these commenters were physicians who use the device. These commenters noted that the hospitals for which they work did not allow use of the device until the new technology add-on payments began on October 1, 2003. Therefore, they encouraged the continued add-on payment to ensure continued access of the device to patients. They also argued that, because utilization remained low in FY 2003, the DRG recalibration for FY 2005 would not supply adequate payment data for the cases using the device, further jeopardizing patient access to the technology.

Response: As discussed above, we are proposing to continue payments because this technology is still within the 2-year to 3-year period during which a technology can be considered new under the regulation.

4. Reevaluation of FY 2004 Applications That Were Not Approved

Section 503(e)(2) of Public Law 108–173 requires us to reconsider all applications for new medical service or technology add-on payments that were denied for FY 2004. We received two applications for new technologies to be designated eligible for add-on payments for new technology for FY 2004. We approved InFUSE for use in spinal fusions for new technology add-on payments in FY 2004. We denied the application for new technology add-on payments for the GLIADEL® wafer.

GLIADEL® Wafer

Gliablastoma Multiforme (GBM) is a very aggressive primary brain tumor. Standard care for patients diagnosed with GBM includes surgical resection followed by radiation and, in some cases, systemic chemotherapy. According to the manufacturer, the GLIADEL® wafer is indicated for use at the time of surgery in order to prolong survival in patients with GBM. Implanted directly into the cavity that is created when a brain tumor is surgically removed, the GLIADEL® wafer delivers chemotherapy directly to the site where the tumor is most likely to recur.

The FDA gave initial approval for the GLIADEL® wafer on September 23, 1996, for use as an adjunct to surgery to prolong survival in patients with recurrent GBM for whom surgical resection is indicated. In 2003, Guilford Pharmaceuticals submitted an application for approval of the GLIADEL® wafer for add-on payments and stated that the technology should still be considered new for FY 2004, despite its approval by the FDA on September 23, 1996. The manufacturer argued that the technology was still new because it had not been possible to specifically identify cases involving use of the GLIADEL® wafer in the MedPAR data prior to the adoption of a new ICD–9–CM code 00.10 (Implantation of a chemotherapeutic agent) on October 1, 2002. However, as discussed in the September 7, 2001 final rule (66 FR 46914), the determination concerning whether a technology meets this criterion depends on the date of its availability for use in the Medicare population rather than the date a specific code may be assigned. A technology can be considered new for 2 or 3 years after data reflecting the costs of the technology begin to become available. Data on the costs of this technology began to become available in September 1996. As a result, the costs of this technology are currently reflected in the DRG weights. As discussed in the final rule for FY 2004 (68 FR 45391), on February 26, 2003, the FDA approved the GLIADEL® wafer for use in newly diagnosed patients with high-grade malignant glioma as an adjunct to surgery and radiation. However, our understanding is that many newly diagnosed patients were already receiving this therapy. To the extent that this is true, the charges associated with this use of the GLIADEL® wafer were also reflected in the DRG relative weights. Therefore, the GLIADEL® wafer did not meet this criterion for FY 2004.

Section 503(e)(2) of Public Law 108–173 required us to reconsider this application, but did not revise the criterion for determining whether a medical service or technology is new. As stated above, the FDA originally approved the GLIADEL® wafer on September 23, 1996. Therefore, this technology is beyond the period in which it can be considered new. Accordingly, we are proposing to deny this application for new technology add-on payments for FY 2005.

We received no public comments regarding our reconsideration of this application for add-on payments.

Guilford also asked us to consider reclassifying this device into another DRG. We discuss issues relating to the DRG assignment of the GLIADEL® wafer in section II.B.16.c. of this preamble.

5. FY 2005 Applicants for New Technology Add-On Payments

a. InFUSE™ Bone Graft (Bone Morphogenetic Proteins (BMPs) for Tibia Fractures)

Bone Morphogenetic Proteins (BMPs) have been shown to have the capacity to induce new bone formation and, therefore, to enhance healing. Using recombinant techniques, some BMPs

(referred to as rhBMPs) can be produced in large quantities. This has cleared the way for their potential use in a variety of clinical applications such as in delayed unions and nonunions of fractured bones and spinal fusions. One such product, rhBMP–2, is developed for use instead of a bone graft with spinal fusions.

Medtronic Sofamor Danek submitted an application for the InFUSE™ Bone Graft for use in tibia fractures for approval as a new technology eligible for add-on payments in FY 2005. Medtronic submitted a similar application for new technology add-on payments in FY 2004 for InFUSE™ Bone Graft/LT–CAGE Lumbar Tapered Fusion Device. As discussed above, we approved this application for FY 2004, and we are proposing to continue to make new technology payments for FY 2005 for InFUSE™ when used in spinal fusions (refer to section III.E.3.b. of this preamble).

In cases of open tibia fractures, InFUSE™ is applied using an absorbable collagen sponge, which is then applied to the fractured bone in order to promote new bone formation. This use currently represents an off-label use of InFUSE™. The manufacturer contends that this use is severely limited due to the greatly increased costs for treating these cases with InFUSE™ at the time of wound debridement and closure. The manufacturer has conducted a clinical trial and is awaiting FDA approval for the use of InFUSE™ for open tibia fractures. According to the manufacturer, this approval is expected before publication of the final rule. The application for add-on payments for the use of InFUSE for open tibia fractures proposes that such payment would encourage the use of InFUSE™ for treatment of these fractures of grade II or higher (up to and including grade III, which often must be amputated due to the severity of injury). The additional payment, according to the applicant, would encourage more hospitals to use the technology at the time of initial wound closure and would result in reduced rates of infection and nonunion currently associated with the treatment of these injuries.

The manufacturer submitted data on 315 cases using InFUSE™ for open tibia fractures in the FY 2002 MedPAR file, as identified by procedure code 79.36 (Reduction, fracture, open, internal fixation, tibia and fibula) and diagnosis codes of either 823.30 (Fracture of tibia alone, shaft, open) or 823.32 (Fracture of fibula and tibia, shaft, open). The applicant also submitted data for a hospital sample that included 63 cases using the same identifying codes. Based on the data submitted by the applicant, InFUSE™ would be used in four different DRGs: 217 (Wound Debridement and Skin Graft Except Hand, for Musculoskeletal and Connective Tissue Disorders), 218 and 219 (Lower Extremity and Humerus Procedures Except Hip, Foot, Femur Age > 17, With and Without CCs, respectively) and 486 (Other O.R. Procedures for Multiple Significant Trauma). The analysis performed by the applicant resulted in a case-weighted cost threshold of $27,111 for these four DRGs. The average case-weighted standardized charge for cases using InFUSE in these four DRGs would be $46,468. Therefore, the applicant maintains that InFUSE™ for open tibia fractures meets the cost criterion.

InFUSE™ was approved by the FDA for use in open tibia fractures on April 30, 2004. Because FDA approval was not received in time for full consideration of the application in this proposed rule, we are not presenting our full analysis of this application in this proposed rule. However, we have already determined that this technology still qualifies as new in the context of proposing to extend new technology add-on payments for InFUSE™ for single-level spinal fusions. We must still determine whether it is appropriate to approve add-on payments for InFUSE™ in cases of open tibia fractures in light of the cost and substantial improvement criteria. Therefore, we invite comments on whether use of InFUSE™ for open tibia fractures should qualify for add-on payments under these criteria.

We note that, in the September 7, 2001 final rule (66 FR 46915), we stated that if an existing technology was assigned to different DRGs than those in which the technology was initially used, the new use may be considered for new technology add-on payments if it also meets the substantial clinical improvement and inadequacy of payment criteria. Under the policy suggested in that rule, approval of InFUSE™ for tibia fractures would start a new period of add-on payments for the new use of this technology. However, we have some reservations about whether this result would be appropriate. It might be possible, under the policy described in the September 7, 2001 final rule, for a technology to receive new technology add-on payments for many years after it is introduced, provided that use of the technology is continually expanded to treatment of new conditions. We invite comment on whether it would be more appropriate merely to extend the existing approval of InFUSE™ for spinal fusions to cases where InFUSE™ is used for open tibia fractures, without extending the time period during which the technology will qualify for add-on payments.

We note that as part of its application, the applicant submitted evidence on the substantial clinical improvement criterion. The applicant cited data from a prospective, controlled study published on December 12, 2002 in *The Journal of Bone and Joint Surgery* (Govender, S., Crismma, C., Genant, H.K., Valentin-Opran, V., ''Recombinant Human Bone Morphogenetic Protein-2 for Treatment of Open Tibia Fractures,'' Vol. 84–A, No. 12. p. 2123). The study, also known as BESTT study group, involved 49 trauma centers in 11 countries. The study enrolled 450 patients who had sustained an open tibia shaft fracture that normally would be treated by intramedullary nail fixation and soft tissue management. The patients were randomly and blindly assigned to one of three groups: the standard of care as stated above, the standard of care plus implantation an absorbable collagen sponge soaked with .75 mg/ml of rhBmP–2, or the standard of care plus implantation of an absorbable collagen sponge soaked with 1.50 mg/ml of rhBMP–2. The study followed up with 421 (94 percent) of all patients. The applicant stated that the study found that patients who received the standard of care plus an absorbable collagen sponge soaked with 1.50 mg/ml of rhBMP–2 achieved the following results compared to the standard of care without the rhBMP: a 44-percent reduction in the rate of secondary surgery, an average of 39 days reduction in time of clinical healing and lower infection rates. As a result, the applicant maintains that InFUSE™ in tibia fractures represents a substantial clinical improvement over previously available technologies.

We are not presenting a full analysis of this application under the substantial clinical improvement criterion because the technology had not yet received FDA approval for this use in time for consideration in this proposed rule. However, we note that although the cited study does provide some evidence of clinical efficacy, we have some concerns about whether the study conclusively demonstrates substantial clinical improvement over previously available technologies because of its design. (It is important to note, as we stated in the August 1, 2002 **Federal Register** (67 FR 50015), that we do not employ FDA guidelines to determine what drugs, devices, or technologies qualify for new technology add-on payments under Medicare. Our criteria

do not depend on the standard of safety and efficacy that the FDA sets for general use, but on a demonstration of substantial clinical improvement in the Medicare population, particularly patients over age 65.) We will present our full analysis of the evidence regarding clinical improvement in the final rule.

We received no public comments regarding this application for add-on payments.

b. Norian Skeletal Repair System (SRS)® Bone Void Filler

Brigham and Women's Hospital submitted an application for approval of the Norian Skeletal Repair System (SRS)® Bone Void Filler (Norian SRS® Cement), manufactured by Synthes for new technology add-on payments for FY 2005. Synthes has been assisting the applicant with supplemental information and data to help the applicant with the application process. According to the manufacturer, Norian SRS® Cement is an injectable, fast-setting carbonated apatite cement used to fill defects in areas of compromised cancellous bone during restoration or augmentation of the skeleton. The product provides a bone void filler that resorbs and is replaced with bone during the healing process.

On December 23, 1998, the FDA approved Norian SRS® for use as an adjunct for fracture stabilization in the treatment of low impact, unstable, metaphyseal distal radius fractures, in cases where early mobilization is indicated. On December 20, 2001, the FDA approved Norian SRS® Cement for use in bony voids or defects that are not intrinsic to the stability of the bony structure. Norian SRS® Cement is intended to be placed or injected into bony voids or gaps in the skeletal system. These defects may be surgically created osseous defects or osseous defects caused by traumatic injury to the bone.

Despite the time that has elapsed since FDA approval, the manufacturer contends that Norian SRS® Cement should still be considered new for several reasons. First, until April 2002, Norian SRS® Cement was hand mixed using a mortar and pestle. Once Norian SRS® Cement was approved by the FDA in December 2001 (for the indication of use in bony voids or defects that are not intrinsic to the stability of the bony structure), the manufacturer issued a new pneumatic mixer. According to the manufacturer, this new pneumatic mixer allows for better preparation, reliability, and ease of use. In addition, a new injection syringe mechanism was developed and made available in May 2002 and replaced the ''Norian Delivery Device''. The manufacturer believes these new procedures for mixing and delivery of the product to the patient should be considered new services as stated in section 1886(d)(5)(k)(ii) of the Act and § 412.87(b)(1) of the regulations. Second, the manufacturer contends that the cement should still be considered new because there is no ICD–9–CM code to uniquely identify Norian SRS® Cement within the DRGs.

Although there have been changes in the way Norian SRS® Cement is mixed and delivered to the patient, we do not believe these changes are significant enough to regard the technology as new. While these changes may enhance the ease with which the technology is used, the product remains substantially the same as when it was initially developed. As we have indicated previously, technology can be considered new only for 2 to 3 years after data reflecting the costs of the technology begin to become available. Data on the costs of this technology began to become available after FDA approval in 1998, and these costs are currently reflected in the DRG weights. As we discussed in the September 7, 2001 final rule (66 FR 46914), the determination concerning whether a technology meets this criterion depends on the date of its availability for use in the Medicare population rather than the date a specific code may be assigned. Therefore, we are proposing that Norian SRS® Cement does not meet the criterion that a medical service or technology be considered new.

Although we are not proposing to approve this application for add-on payments because the technology does not meet the newness criterion, we note that the manufacturer submitted information on the cost criterion and the substantial clinical improvement criterion. The manufacturer submitted 52 Medicare and non-Medicare cases using Norian SRS® Cement. There are currently no ICD–9–CM codes that can distinctly identify Norian SRS® Cement within the MedPAR data; therefore, we cannot track this technology with our own analysis of MedPAR data. Based on the data submitted by the manufacturer, cases using Norian SRS'' Cement were found in 12 DRGs, with 71.1 percent of the cases in DRGs 210, 218, 219, and 225. Based on the 52 cases submitted by the applicant, the case-weighted threshold across all DRGs was $22,493. The average case-weighted standardized charge was $29,032. As a result, the applicant and manufacturer maintain that Norian SRS® Cement meets the cost criterion.

According to the manufacturer, Norian SRS® Cement represents a substantial clinical improvement for the following reasons: It enhances short-term and long-term structural support, improves the rate and durability of healing, decreases donor site morbidity, decreases risk of infection at graft site, lowers the risk of operative complications from shorter operative procedures, lowers the rate of post-treatment hospitalizations and physician visits, and finally, reduces pain.

However, we are not presenting a full evaluation of the application for add-on payments for Norian SRS® Cement under these criteria because the technology does not meet the newness criterion. Therefore, we are proposing to deny add-on payments for this technology.

We received no public comments on this application for add-on payments.

c. InSync® Defibrillator System (Cardiac Resynchronization Therapy with Defibrillation (CRT–D))

Cardiac Resynchronization Therapy (CRT), also known as bi-ventricular pacing, is a therapy for chronic heart failure. A CRT implantable system provides electrical stimulation to the right atrium, right ventricle, and left ventricle to recoordinate or resynchronize ventricular contractions and improve the oxygenated blood flow to the body (cardiac output).

Medtronic submitted an application for approval of the InSync® Defibrillator System, a cardiac resynchronization therapy with defibrillation system (CRT–D), for new technology add-on payments for FY 2005. This technology combines resynchronization therapy with defibrillation for patients with chronic, moderate-to-severe heart failure who meet the criteria for an implantable cardiac defibrillator. Unlike conventional implantable cardiac defibrillators, which treat only arrhythmias, CRT- devices have a dual therapeutic nature intended to treat two aspects of a patient's heart disease concurrently: (1) The symptoms of moderate to severe heart failure (that is, the ventricular dysynchrony); and (2) cardiac arrhythmias, as documented by an electrophysiologic testing or clinical history or both, which would cause sudden cardiac arrest.

InSync® Defibrillation System received FDA approval on June 26, 2002. However, another manufacturer, Guidant, received FDA approval for its CRT–D device on May 2, 2002. Guidant, and another competitor that has yet to receive FDA approval for its CRT–D device, have requested that their devices

be included in any approval of CRT–D for new technology add-on payments. As we discussed in the September 7, 2001 final rule (66 FR 46915), an approval of a new technology for special payment should extend to all technologies that are substantially similar. Otherwise, our payment policy would bestow an advantage to the first applicant to receive approval for a particular new technology.

The applicant contends that, despite the approval of a similar device in May 2002, the InSync® Defibrillator System should still be considered new for several reasons: First, an ICD–9–CM code was only issued in FY 2003, which falls within the 2-year to 3-year range provided in the regulations. Second, the utilization of CRT–Ds is still growing and has not reached full utilization and, therefore, CRT–Ds remain underreported within the FY 2003 MedPAR data that will be used to recalibrate the DRG weights for FY 2005. Finally, the applicant believes reporting of CRT–Ds may be insufficient to accurately recalibrate the DRGs because the new ICD–9–CM codes for CRT–Ds are unlikely to be used consistently and accurately by hospitals in the first year.

We have discussed the relationship between existence of a specific ICD–9–CM code for a technology and our determination of its status as a new technology. As discussed in the September 7, 2001 final rule (66 FR 46914), the determination of whether a technology is new depends on the date of its availability for use in the Medicare population, rather than the date a specific code may be assigned. Because CRT–Ds were available upon the initial FDA approval in May 2002, we consider the technology to be new from this date and not the date a code was assigned.

Using the December 2003 update file to the FY 2003 MedPAR file, we have identified 10,950 cases using CRT–D in the FY 2003 MedPAR database. Of these, 10,694 cases were reported in DRGs 514 and 515 (then Cardiac Defibrillator Implant With and Without Cardiac Catheter, respectively). In DRG 515, we found 3,948 cases with procedure code 00.51 (Implantation of cardiac resynchronization defibrillator, total system (CRT–D)) and 6,746 cases in DRG 514. DRG 514 is no longer valid, effective in FY 2004. In FY 2004, we assigned new cases of defibrillator implants with cardiac catheters from DRG 514 to new DRGs 535 (Cardiac Defibrillator Implant with Cardiac Catheter With Acute Myocardial Infarction (AMI) Heart Failure/Shock) and 536 (Cardiac Defibrillator Implant with Cardiac Catheter Without Acute Myocardial Infarction (AMI) Heart Failure/Shock). Using the 6,746 cases from the FY 2003 MedPAR found in DRG 514, we examined the primary diagnosis codes necessary for assignment to DRG 535 along with procedure code 00.51 and found 3,396 cases of CRT–D for DRG 535. The remaining 3,350 CRT–D cases found in DRG 514 using procedure code 00.51 fall into DRG 536. For FY 2003, the total number of cases of CRT–D found in the FY 2003 MedPAR data for DRGs 514 and 515 were 48,486. Cases reporting CRT–Ds thus represent 22 percent of all cases for these DRGs.

A medical service or technology can no longer be considered new after 2 to 3 years, when data reflecting the costs of the technology begin to become available. Data on the costs of this technology began to become available in May 2002. Our analysis of data from the FY 2003 MedPAR file also shows that the costs of CRT–D are represented by a substantial number of cases within the DRGs. However, as discussed above, the technology still remains within the 2-year to 3-year period during which it can be considered new. Therefore, we are considering whether the CRT–D technology still meets the newness criterion. We welcome comments on this issue as we analyze whether to approve this technology (which would included the InSync® application) in the final rule.

We note that the applicant submitted information on the cost and substantial clinical improvement criteria. The applicant commissioned Navigant Consulting, Inc. to collect charge data on CRT–D. Navigant found 354 Medicare cases among 30 hospitals. Cases were identified using ICD–9–CM procedure code 00.51. Of these 354 cases, 44.1 percent were reported in DRG 515, 23.7 percent were reported in DRG 535, and 32.2 percent were reported in DRG 536. These DRGs result in a case-weighted threshold of $78,674. The average case-weighted standardized charge for the 354 cases mentioned above was $79,163. Based on these data, the manufacturer contends that InSync® Defibrillator System would meet the cost criterion.

In the September 7, 2001 final rule, we stated that the data submitted must be of a sufficient sample size to demonstrate a significant likelihood that the sample mean approximates the true mean across all cases likely to receive the new technology. Using a standard statistical methodology for determining the needed (random) sample size based on the standard deviations of the DRGs identified by the applicant as likely to include cases receiving a CRT–D, we have determined that a random sample size of 354 cases can be reasonably expected to produce an estimate within $3,500 of the true mean.[3] Of course, the data submitted do not represent a random sample of all cases in these DRGs across all hospitals.

The manufacturer also contends that the added capability of the InSync® Defibrillator System device provides significant benefits over and above a conventional defibrillator. The InSync® Defibrillator System device treats both the comorbid conditions of ventricular arrhythmias and moderate to severe heart failure, and takes the place of the existing treatment of drug therapy for heart failure plus a conventional implantable cardiac defibrillator for ventricular arrhythmia. The applicant states this CRT–D is a substantial clinical improvement for patients who remain symptomatic despite drug therapy and have the comorbid condition of heart failure. According to the applicant, some of the improved outcomes that result from using a CRT–D device instead of existing treatments include: improved quality of life, improved exercise tolerance, improved homodynamic performance, and reduced hospitalizations and mortality due to chronic heart failure.

We welcome comments on whether this technology meets these criteria, but especially about whether it meets the newness criterion in the light of the extent to which it is represented cases within the relevant DRGs. We will determine whether to approve this technology in the light of these comments and our continuing analysis.

We received the following public comments in accordance with section 503(b)(2) of Public Law 108–173 regarding this application for add-on payments:

Comment: One commenter noted that CRT–D has had positive clinical outcomes by reversing remodeling of the heart and improving the heart's ability to pump more efficiently. The commenter added that CRT-D has helped decrease hospitalizations and length of stay.

Response: We appreciate the commenters' input on this criterion. We will consider these comments regarding the substantial clinical improvement criterion if we determine that the technology meets the other two criteria.

[3] The formula is $n=4\ \sigma/B^2$, where σ the standard deviation of the population, and B is the bound on the error of the estimate (the range within which the sample means can reliably predict the population mean). See Statistics for Management and Economics, Fifth Edition, by Mendenhall, W., Reinmuth, J., Beaver, R., and Duhan, D.

d. GliaSite® Radiation Therapy System (RTS)

The Pinnacle Health Group submitted an application for approval of GliaSite® Radiation Therapy System (RTS) for new technology add-on payments. GliaSite® RTS was approved by the FDA for use on April 15, 2001. The system involves several components, including a drug called Iotrex and a GliaSite® catheter. Iotrex is an organically bound liquid form of Iodine ^{125} used in intracavitary brachytherapy with GliaSite® RTS. Iotrex is a single nonencapsulated (liquid) radioactive source. The liquid is a solution of sodium ^{3}-(I^{125}) iodo-4-hydroxybenzenesulfonate and is used to deliver brachytherapy for treatment of brain cancer.

The delivery system for Iotrex is the GliaSite® RTS catheter. Iotrex is administered via injection through a self-sealing port into the primary lumen of the barium-impregnated catheter that leads to the balloon reservoir. After a malignant brain tumor has been resected, the balloon catheter (GliaSite®) is implanted temporarily inside the cavity. The patient is released from the hospital. After a period of 3 days to 3 weeks, the patient is readmitted. During the second admission, the appropriate dose (200 to 600 millicuries) of radiation is then administered. Iotrex is infused into the GliaSite® catheter and intracavitary radiation is delivered to the target area. The gamma radiation emitted by Iotrex is delivered directly to the margins of the tumor bed. After 3 to 7 days, the Iotrex is removed.

GliaSite® RTS was approved by the FDA for use on April 15, 2001. Technology is no longer considered new 2 to 3 years after data reflecting the costs of the technology begin to become available. Because data regarding this technology began to become available in 2001, we have determined that GliaSite® RTS does not meet the criterion that a medical service or technology be considered new. Therefore, we are proposing to deny approval of GliaSite® RTS for new technology add-on payments.

Although we are proposing not to approve this application because GliaSite® does not meet the newness criterion, we note that the applicant submitted information on the cost criterion and substantial clinical improvement criterion. The applicant stated that the number of cases in DRG 7 for FY 2004 was projected to be 14,782, and estimated that 10 percent (or about 1,478) of those patients would be candidates for GliaSite® RTS. The applicant estimated that the standardized charge for all cases using the technology in DRG 7 was $49,406. Based on this calculation, the manufacturer stated in its application that this figure is greater than the cost threshold of $32,115 for DRG 7. Therefore, according to the manufacturer, it appears that GliaSite® would meet the cost criterion.

The applicant also claims this way of delivering brachytherapy to the brain is significantly more patient friendly. The use of a single intracavitary applicator positioned inside the resection cavity during the initial surgery in place of an interstitial-seed implant removes the need for additional invasive procedures and the need for multiple puncture sites (up to 20). In addition, the manufacturer claims that the approach used in the GliaSite® RTS system improves dose-delivery and provides a more practical means of delivering the brachytherapy.

However, as discussed above, GliaSite® does not meet the newness criterion. Therefore, we are proposing to deny add-on payments for this technology in FY 2005.

We received no public comments on this application for add-on payments.

e. Natrecor®—Human B-Type Natriuretic Peptide (hBNP)

Scios, Inc. submitted an application for approval of Natrecor® for new technology add-on payments. Natrecor is a member of a new class of drugs, Human B-type Natriuretic Peptide (hBNP), and it is manufactured from E. coli with recombinant DNA technology. It binds to the particulate guanylate cyclase receptor of vascular smooth muscle endothelial cells, leading to increased intracellular concentrations of guanosine 3′5′-cyclic monophosphate, and therefore to enhance smooth muscle cell relaxation, ultimately causing dilation of arteries and veins. The applicant states that Natrecor® is more potent and relieves symptoms of heart failure more rapidly, while also causing less hemodynamic instability than intravenous nitroglycerin, the most commonly used vasodilator for heart failure.

Natrecor® was approved by the FDA for the treatment of acute congestive heart failure on August 10, 2001. It is indicated for the intravenous treatment of patients with acutely decompensated congestive heart failure (dyspnea). Congestive heart failure is the result of impaired pumping capacity of the heart. It causes a variety of clinical consequences, including water retention, sodium retention, pulmonary congestion, and diminished perfusion of blood to all parts of the body.

The applicant concedes that the FY 2003 MedPAR file includes hospital charge information for patients receiving Natrecor®. The manufacturer contends that Natrecor® should still be considered new for several reasons. The first reason is that these data will not provide an accurate representation of hospital utilization of this product nor an adequate reimbursement rate for hospitals treating acute congestive heart failure patients with Natrecor® in FY 2005. The FY 2003 MedPAR file represents the first full year in which the ICD–9–CM procedure code 00.13 (Injection or infusion of nesiritide) was in effect. Therefore, the manufacturer anticipates a slow increase in the accuracy of coding and billing in FY 2003. In addition, the manufacturer stated that market penetration for this product was 3 percent for FY 2003, but is expected to be significantly higher for FY 2005.

However, technology is no longer considered new 2 to 3 years after data reflecting its costs begin to become available. Because data reflecting the costs of Natrecor® began to become available in 2001, these costs are currently reflected in the DRG weights. In addition, as discussed in the September 7, 2001 final rule (66 FR 46914), the determination of whether a technology is new depends on the date of its availability for use in the Medicare population rather than the date a specific code was assigned. Because Natrecor® was available upon FDA approval, it does not meet the criterion that a medical service or technology be considered new.

Although we are proposing not to approve this application because Natrecor® does not meet the newness criterion, we note that the applicant submitted information on the cost criterion and substantial clinical improvement criterion. Scios commissioned Premier, Inc. to search its database of 196 hospitals for cases in FY 2003 that used Natrecor®. Premier identified 9,811 cases across many DRGs using National Drug Codes from pharmacy databases. The majority of cases (approximately 42 percent) were found in DRG 127 (Heart Failure and Shock), while the remaining cases were found in other DRGs that individually had a maximum of 8 percent of the 9,811 cases identified by Premier. The case-weighted threshold across all DRGs for Natrecor®, using data provided by Premier, was $26,509. (DRGs with less than 25 discharges were not included in this analysis.) The average charge for cases with Natrecor® was $70,137. The average case-weighted standardized charge across all DRGs was $43,422.

Because the average standardized charge is greater than the case-weighted threshold, the applicant stated that Natrecor® meets the cost criterion.

The manufacturer stated that Natrecor® represents a substantial clinical improvement over existing treatments for decompensated congestive heart failure because it provides novel clinical effects, leads to fewer complications, and improves overall clinical outcomes. Specifically, Natrecor® reduces left ventricular preload, afterload, and pulmonary capillary wedge pressure without inducing tachyphylaxis, and it causes a balanced vasodilation of veins, arteries, and coronary arteries that increases cardiac output. It has also been shown to significantly reduce dyspnea, and it blocks the rennin-aldosterone-angiotensin system, thereby reducing sodium retention and enhancing diuresis and natriuresis. In addition, Natrecor® is not pro-arrhythmic; it does not increase cardiac work by causing tachycardia, and it does not cause electrolyte imbalances.

However, as discussed above, Natrecor® does not meet the newness criterion. Therefore, we are proposing to deny add-on payments for this technology in FY 2005.

We received no public comments on this application for add-on payments.

f. Kinetra® Implantable Neurostimulator for Deep Brain Stimulation

Medtronic, Inc. submitted an application for approval of the Kinetra® implantable neurostimulator device for new technology add-on payments. The Kinetra® device was approved by the FDA on December 16, 2003. The Kinetra® implantable neurostimulator is designed to deliver electrical stimulation to the subthalamic nucleus (STN) or internal globus pallidus (GPi) in order to ameliorate symptoms caused by abnormal neurotransmitter levels that lead to abnormal cell-to-cell electrical impulses in Parkinson's Disease and essential tremor. Before the development of Kinetra®, treating bilateral symptoms of patients with these disorders required the implantation of two neurostimulators (in the form of a product called Soletra™ manufactured by Medtronic): One for the right side of the brain (to control symptoms on the left side of the body), the other for the left side of the brain (to control symptoms on the right side of the body). Additional procedures are required to create pockets in the chest cavity to place the two generators required to run the individual leads. The Kinetra® neurostimulator generator, implanted in the pectoral area, is designed to eliminate the need for two devices by accommodating two leads that are placed in both the left and right sides of the brain to deliver the necessary impulses. The manufacturer argues that the development of a single neurostimulator that treats bilateral symptoms provides a less invasive treatment option for patients, and for simpler implantation, followup, and programming procedures for physicians.

The device was approved by the FDA in December 2003. Therefore, it qualifies under the first criterion because it is not yet reflected in the DRG weights. Because there are no data available to evaluate costs associated Kinetra®, we conducted the cost analysis using Soletra™, the predecessor technology used to treat this condition, as a proxy for Kinetra®. The pre-existing technology provides the closest means to track cases that have actually used similar technology and serves to identify the need and use of the new device. The manufacturer informed us that the cost of the Kinetra® device is twice the price of a single Soletra™ device. Since most patients would receive two Soletra™ devices if the Kinetra® device is not implanted, data regarding the cost of Soletra™ give a good measure of the actual costs that will be incurred. Medtronic submitted data for 104 cases that involved the Soletra™ device (26 cases in DRG 1 (Craniotomy Age > 17 With CC), and 78 cases in DRG 2 (Craniotomy Age > 17 Without CC)). These cases were identified from the FY 2002 MedPAR file using procedure codes 02.93 (Implantation, intracranial neurostimulator) and 86.09 (Other incision of skin and subcutaneous tissue). In the analysis presented by the applicant, the mean standardized charges for cases involving Soletra™ in DRGs 1 and 2 were $69,018 and $44,779, respectively. The mean standardized charge for these Soletra™ cases according to Medtronic's data was $50,839.

We used the same procedure codes to identify 187 cases involving the Soletra™ device in DRGs 1 and 2 in the FY 2003 MedPAR file. Similar to the Medtronic data, 53 of the cases were found in DRG 1, and 134 cases were found in DRG 2. The average standardized charges for these cases in DRGs 1 and 2 were $51,163 and $44,874, respectively. Therefore, the case-weighted average standardized charge for cases that included implantation of the Soletra™ device was $46,656. The new cost thresholds established under the revised criteria in Public Law 108–173 for DRGs 1 and 2 are $43,245 and $30,129, respectively. Accordingly, the case-weighted threshold to qualify for new technology add-on payment using the data we identified would be $33,846. Under this analysis, Kinetra® would qualify for the cost threshold.

We note that an ICD–9–CM code was approved for dual array pulse generator devices, effective October 1, 2004, for IPPS tracking purposes. The new ICD–9–CM code that will be assigned to this device is 86.95 (Insertion or replacement of dual array neurostimulator pulse generator), which includes dual array and dual channel generators for intracranial, spinal, and peripheral neurostimulators. The code will not identify cases with this specific device and will only be used to distinguish single versus dual channel-pulse generator devices.

The manufacturer claims that Kinetra® provides a range of substantial improvements beyond previously available technology. These include a reduced rate of device-related complications and hospitalizations or physician visits and less surgical trauma because only one generator implantation procedure is required. Kinetra® has a reed switch disabling function that physicians can use to prevent inadvertent shutoff of the device, as occurs when accidentally tripped by electromagnetic inference (caused by common products such as metal detectors and garage door openers). Kinetra® also provides significant patient control, allowing patients to monitor whether the device is on or off, to monitor battery life, and to fine-tune the stimulation therapy within clinician-programmed parameters. While Kinetra® provides the ability for patients to better control their symptoms and reduce the complications associated with the existing technology, it does not eliminate the necessity for two surgeries. Because the patients who receive the device are often frail, the implantation generally occurs in two phases: The brain leads are implanted in one surgery, and the generator is implanted in another surgery, typically on another day. However, implanting Kinetra® does reduce the number of potential surgeries compared to its predecessor (which requires two surgeries to implant the two single-lead arrays to the brain).

Despite the improvement Kinetra® represents over its immediate predecessor, Soletra™, we have some concerns about whether the device is significantly different in terms of how it achieves its desired clinical result. The stimulation mechanism by which it treats patient symptoms remains substantially the same as the

predecessor device. The enhancements cited by the manufacturer are primarily to features such as control, power, monitoring, and reliability. Nevertheless, these improvements, along with the reduced number of surgeries required, may be sufficient to warrant a determination that the device represents a substantial clinical improvement. We welcome further public comment on the issue of whether the device is sufficiently different from the previously used technology to qualify as a substantially improved treatment of the same patient symptoms.

We also invite comments concerning the cost of the device. If the new device, at twice the cost of the existing technology, merely replaces the costs of two of the previous devices, then the charges for Kinetra® are not substantially different from current charges resulting from the use of either device alone. Because the costs for the predecessor device meet the statutory cost criterion, the successor technology would meet the criterion as well, at least under the manufacturer's assumption that a single Kinetra® costs twice as much as each of the two Soletras™ required to perform the same function. However, since there should be less surgery involved, more patient control, less risk of complications, and fewer office visits as a result of using Kinetra®, the costs for patients who receive the new device would be expected to drop. This suggests that it may not be appropriate to base the cost analysis for Kinetra® on the manufacturer's assumption that total costs for Soletra™ and Kinetra® are substantially the same.

In addition, we also invite public comment concerning the approval of the device for add-on payment, given the uncertainty over the frequency with which the patients receiving the device have the generator implanted in a second hospital stay, and the frequency with which this implantation occurs in an outpatient setting. Any hospital performing the implantation in two separate patient stays, whether they are both inpatient or whether one is inpatient and the second is outpatient, would be paid double for the single device. Therefore, we have some concern about the appropriateness of approving add-on payments for a device that may already receive payment at a nonbundled rate for a high percentage of patients who receive the device. We are currently investigating whether a second hospital stay is needed for implantation of Kinetra®.

Despite these issues, we are still considering whether it is appropriate to approve add-on status for Kinetra® for FY 2005. If approved for add-on payments, the device would be reimbursed up to half of the costs for the device. Since the manufacturer has stated that the cost for Kinetra® would be $16,570, the maximum add-on payment for the device would be $8,285. We will make a final determination in the light of public comments and our continuing analysis.

We received no public comments on this application for add-on payments.

We note that the manufacturer of Kinetra® also submitted an application for pass-through payments under the hospital outpatient payment system (OPPS). This application was denied for pass-through payment in OPPS because the item was already described by a previously existing category of devices for pass-through payment (C1767, Generator, neurostimulator (implantable)). Therefore, no substantial improvement determination was made for that application, although one would have been required for approval if it had met all other criteria. The manufacturer subsequently applied for assignment of deep brain stimulation with Kinetra® neurostimulator to a new technology ambulatory payment classification (APC) under the OPPS. This application is currently under consideration. These special APCs were initiated in OPPS to expedite recognition of and payment for innovative new technologies that do not qualify for pass-through payment. In contrast to the annual decisionmaking under the IPPS, applications for new technology APCs of the OPPS are accepted on an ongoing basis and updates are made quarterly.

g. Intramedullary Skeletal Kinetic Distractor (ISKD)

Orthofix, Inc. submitted an application for approval of the Intramedullary Skeletal Kinetic Distractor (ISKD) Internal Limb Lengthener for new technology add-on payments for FY 2005. The device received FDA marketing approval on May 2, 2001. The ISKD System is a ''closed'' lengthening system. There are no fixation pins exiting the skin, thus eliminating this portal for entry of infectious organisms. The device is implanted in the intramedullary canal. This provides mechanical stability and support to the bone segments during the distraction, regeneration and consolidation phases, thus reducing the opportunity for misalignment.

We reviewed the application and technology, and we have determined that the device is not new and cannot be approved for new technology add-on payments because it came on the market on May 2, 2001. The costs of the device are thus reflected in the FY 2001 MedPAR file, as acknowledged by the manufacturer's data. As a result, the costs of the device are already reflected in the DRG weights.

The manufacturer submitted charge data for cases found in the FY 2001 MedPAR file, as well as data from several hospitals that have used the device. The manufacturer identified cases using ICD–9–CM codes 78.35 (Limb lengthening procedure, femur) and 78.37 (Limb lengthening, tibia/fibula). These procedure codes occur in four DRGs: DRGs 210 and 211 (Hip and Femur Procedures Except Major Joint Procedures Age > 17, With and Without CC, respectively) and DRGs 218 and 219 (Lower Extremity and Humerus Procedures Except Hip, Foot and Femur Age > 17, With and Without CC). The average charges for cases involving these procedure codes identified by the applicant were not standardized. The average charges provided for DRGs 210, 211, 218, and 219 were $26,692, $18,187, $32,959 and $20,228, respectively. The manufacturer then added the cost of the device, which the manufacturer states is $6,750. The manufacturer projects that, in FY 2005, there will be 9 cases in DRG 210, 4 cases in DRG 211, 28 cases in DRG 218, and 19 cases in DRG 219, which results in a case-weighted threshold of $22,347. Thus, according to the manufacturer's data, because the case-weighted average standardized charges of $27,003 for the technology are greater than the cost threshold of $22,347 for these projected 60 cases, the ISKD would qualify for new technology add-on payments.

The manufacturer also asserted that the ISKD met the substantial clinical improvement criteria because, in addition to the improvements mentioned above (reduces infection rates and provides mechanical stability), lengthening with the ISKD occurs gradually and with no soft tissue impingement, reducing two factors commonly associated with pain during distraction. The manufacturer also pointed out that with the ISKD, the lengthening procedure is discreet because there are no external pins. There is no cumbersome external frame that may hinder the patient's activities of daily living, or draw further attention to the discrepant limb. In addition, the patient may have partial weight bearing during the lengthening process and resume some activities of normal living.

However, because the device is already captured in our DRG weights, we are proposing to deny the application for the ISKD device for new technology add-on payments for FY 2005.

We received no public comments on this application for add-on payments.

h. Acticon™ Neosphincter

American Medical Systems submitted an application for approval of the Acticon™ Neosphincter for new technology add-on payments for FY 2005. The Acticon™ Neosphincter is a small, fluid-filled prosthesis that is completely implanted within the body. The Acticon™ Neosphincter prosthesis has been developed to treat severe fecal incontinence (the accidental loss of solid or liquid stool at least weekly). It is designed to mimic the natural process of bowel control and bowel movements. The prosthesis consists of three components: a occlusive cuff implanted around the anal canal, a pressure-regulating balloon implanted in the prevesical space, and a control pump with septum implanted in the scrotum. All components are connected with color-coded, kink-resistant tubing.

The FDA approved the Acticon Neosphincter for use on December 18, 2001. A technology can be considered new only 2 to 3 years after data reflecting the costs of the technology begin to become available. Data on the costs of this technology began to become available after the December 2001 FDA approval. As a result, the costs of this technology are currently reflected in the DRG weights. Therefore, we have determined that Acticon™ Neosphincter does not meet this criterion.

Although we are proposing not to approve this application because Acticon™ Neosphincter does not meet the newness criterion, we note that the applicant submitted information on the cost criterion and substantial clinical improvement criterion. The applicant submitted 23 cases (that are indistinguishable as to whether they are Medicare or non-Medicare) using ICD–9–CM procedure codes 49.75 (Implantation or revision of artificial anal sphincter) and 49.76 (Removal of artificial anal sphincter) in order to identify cases where the Acticon™ Neosphincter was used. Of these cases, 9 were in DRG 157 (Anal and Stomal Procedures With CC), and 14 were in DRG 158 (Anal and Stomal Procedures Without CC). The average standardized charge per case was $16,758. The case-weighted threshold for DRGs 157 and 158 (39.1 percent of cases in DRG 157 and 60.1 percent of cases in DRG 158) for this technology is $14, 426. Therefore, according to the applicant, the Acticon™ Neosphincter meets the cost criterion.

The applicant states in its application that the Acticon™ Neosphincter represents a substantial clinical improvement for the following reasons: First, there is no other existing device in the United States that can be used to treat severe fecal incontinence. Second, self-treatment for severe fecal incontinence has proven to be largely unsuccessful and surgical options have historically been more limited, including sphincteroplasty or muscle transposition.

However, since Acticon™ Neosphincter does not meet the newness criterion, we are proposing to deny add-on payments for this new technology. The applicant also requested a DRG reclassification for this technology. In section II.B.4 of the preamble of this proposed rule, we are proposing, in MDC 6 (Diseases and Disorders of the Digestive System) only, to remove codes 49.75 and 49.76 from DRGs 157 and 158, and reassign them to DRGs 146 (Rectal Resection With CC) and 147 (Rectal Resection Without CC). All other MDC and DRG assignments for codes 49.75 and 49.76 would remain the same.

We received the following public comments in accordance with section 50(b)(2) of Pub. L. 108–173 regarding this application for add-on payments.

Comment: One commenter noted that the implant of the Acticon™ Neosphincter avoids the life-altering and disfiguring consequences of a permanent stoma. Another commenter noted that the implant of the Acticon™ Neosphincter avoids the need for a colostomy, which limits a patient's ability to travel and work due to the fact they could have a fecal accident at any time.

Response: We appreciate the commenters' input on this criterion. However, as stated above, the Acticon™ Neosphincter is no longer new. Therefore, we are proposing that it is not eligible for add-on payments for new technologies.

i. TandemHeart™ Percutaneous Left Ventricular Assist System

Brigham and Women's Hospital submitted an application for approval of the TandemHeart™ Percutaneous Ventricular Assist System (PVTA) manufactured by Cardiac Assists, Inc., for new technology add-on payments for FY 2005. Cardiac Assists, Inc. has been assisting the applicant with supplemental information and data to support the application process. According to the manufacturer, the device contains a controller, arterial and venous cannulae and the TandemHeart™ Percutaneous Ventricular Assist Device (pVAD) that works parallel with the left ventricle to provide left ventricular circulatory support. The device is intended for extracorporeal circulatory support using an extracorporeal bypass circuit. The duration of use approved by the FDA is for periods of up to 6 hours.

On November 11, 2000, FDA approved the AB–180 XC Blood Pump (also known as the TandemHeart™ pVAD) as a single use, disposable centrifugal blood pump designed to circulate blood through an extracorporeal circuit. On May 23, 2003, FDA approved the CardiacAssist Transseptal Cannula Set for transseptal catherization of the left atrium via the femoral vein for the purpose of providing a means for temporary (6 hours or less) left ventricular bypass when connected to a suitable extracorporeal blood pump unit that returns blood to the patient via the femoral artery or other appropriate site. The manufacturer stated that, although the TandemHeart™ pVAD was approved in November 2000, this device should still be considered new because the device was not marketed and sold to hospitals until the CardiacAssist Transseptal Cannula Set was approved by FDA in May 2003. We have received confirmation from hospitals that the TandemHeart™ pVAD was indeed not marketed until FDA approved the CardiacAssist Transseptal Cannula Set. Also, only half of a year's worth of data containing the TandemHeart™ pVAD is reflected within the FY 2003 MedPAR file. The manufacturer stated that approximately 60 TandemHeart™ pVADs have been used since FDA approved the Cardiac Arrest Transseptal Cannula Set in May 2003. Therefore, the costs of the TandemHeart™ pVAD are not adequately reflected within the DRGs. As a result, we consider the TandemHeart™ pVAD to be new under our criterion.

As stated above, according to the manufacturer, approximately 60 TandemHeart™ pVADs have been used since FDA approved the Cardiac Assist Transseptal Cannula Set in May 2003 (not all of these have been used in Medicare beneficiaries). However, only two actual cases were submitted by the applicant with an ICD–9–CM code of 37.65 (Implant of an external pulsatile heart assist system) used to identify the device. As stated in the September 7, 2001 final rule (66 FR 46916), data submitted by the applicant must be of a sufficient sample size to demonstrate a significant likelihood that the true mean across all cases likely to receive the technology will exceed the threshold established by CMS. Because we lack a significant sample of data reflecting the costs of this technology,

we cannot accurately determine the average charge per case for the TandemHeart™ pVAD. Neither can we determine whether this technology meets our cost criterion. If we receive sufficient data to complete our analysis in time for inclusion in the final rule, we will assess whether this technology meets the cost criterion.

Although we are not proposing to approve this application because we have insufficient data to determine whether TandemHeart™ pVAD meets the cost criterion, we note that the applicant submitted information on the substantial clinical improvement criterion. The applicant stated in its application that the TandemHeart™ pVAD represents a substantial clinical improvement because, at present, the only alternative to intra-aortic balloon pump support is the surgical implantation of a ventricular assist device. The TandemHeart™ pVAD is the only therapeutic intervention that is capable of achieving effective circulatory support to stabilize cardiogenic shock patients that could be placed via a percutaneous approach. We will present a full analysis of this technology under the significant improvement criterion if we receive sufficient data in time for the final rule to evaluate whether the technology meets the cost criterion.

The applicant also requested an ICD–9–CM code for this technology. We discuss this request in section II.B.3. of the preamble of this proposed rule.

We received no public comments on this application for add-on payments.

j. Aquadex™ System 100 Fluid Removal System (System 100)

CHF Solutions, Inc. submitted an application for the approval of the System 100 for new technology add-on payments for FY 2005. The System 100 is designed to remove excess fluid (primarily excess water) from patients suffering from severe fluid overload through the process of ultrafiltration. Fluid retention, sometimes to an extreme degree, is a common symptom of patients with chronic congestive heart failure. This technology removes excess fluid without causing hemodynamic instability. It also avoids the inherent nephrotoxicity and tachyphylaxis associated with aggressive diuretic therapy, the mainstay of current therapy for fluid overload in congestive heart failure.

The System 100 consists of: (1) An S–100 console; (2) a UF 500 blood circuit; (3) an extended length catheter (ELC); and (4) a catheter extension tubing. The System 100 is designed to monitor the extracorporeal blood circuit and to alert the user to abnormal conditions. Vascular access is established via the peripheral venous system, and up to 4 liters of excess fluid can be removed in an 8-hour period.

On June 3, 2002, FDA approved the System 100 for use with peripheral venous access. On November 20, 2003, FDA approved the System 100 for expanded use with central venous access and catheter extension use for infusion or withdrawal circuit line with other commercial applicable venous catheters. According to the applicant, although the System 100 was first approved by FDA in June 2002, the System 100 was not used by hospitals until August 2002 because it took a substantial amount of time to market and sell the device to hospitals. As a result, the applicant believes that the System 100 should still be considered new. The applicant has presented data and evidence demonstrating that the System 100 was not marketed until August 2002. Therefore, we also believe August 1, 2002 is the relevant date for determining the availability of the System 100.

The applicant estimates that 308 patients (approximately 120 cases per year) have used the System 100 since its inception and the potential population for use of the device is 60,000 cases per year. These 308 cases represent a small percentage of the potential number of cases that can utilize the System 100. Therefore, the System 100 is not adequately reflected within the DRG weights (as discussed in the September 7, 2001 final rule (66 FR 46914)). In addition, the System 100 is within the 2 to 3 year period contemplated under § 412.87(b)(2) of the regulations. Therefore, the System 100 could be considered new. However, the ultrafiltration process that the System 100 employs can also be considered to be a type of hemodialysis, which is an old and well-established technology. We have concerns about whether new technology add-on payments should be extended to a well-established technology, even when a new clinical application is developed for that technology. As discussed above, in the September 7, 2001 final rule (66 FR 46915), we noted that if an existing technology is used for treating patients not expected to be assigned to the same DRG as the patients already receiving the technology, it may be considered for approval if it also meets the other cost and clinical improvement criteria. In this case, the device does treat a different patient population of congestive heart failure than the patient population for renal dialysis. Under the policy described in the September 7, 2001 final rule, this technology may be considered new for the purposes of determining whether it qualifies for add-on payments. However, we have some concerns about whether this is an appropriate result, and about whether technologies that have been in use for many years, in some cases decades, should be able to qualify for add-on payments for new technologies. Therefore, we invite comments on whether this technology should be considered new, and on the general issue of whether existing technologies should be approved for add-on payments when new applications are developed for these technologies and whether special standards regarding, for example, clinical improvement, should be applied in such cases.

The applicant submitted five sets of data to demonstrate that the System 100 meets the cost criterion. Of these five, three sets of data were flawed in the analysis of the cost criterion. Therefore, we will discuss only the data that are most accurate and relevant. It is important to note at the outset of the cost analysis that the console is reusable and is, therefore, a capital cost. Only the circuits and catheters are components that represent operating expenses. Section 1886(d)(K)(i) of the Act requires that the Secretary establish a mechanism to recognize the costs of new medical services or technologies under the payment system established under that subsection, which establishes the system for paying for the operating costs of inpatient hospital services. The system of payment for capital costs is established under section 1886(g) of the Act, which makes no mention of any add-on payments for a new medical service or technology. Therefore, it is not appropriate to include capital costs in the add-on payments for a new medical service or technology and these costs should also not be considered in evaluating whether a technology meets the cost criterion. The applicant has applied for add-on payments only for the circuits and catheter, which represent the operating expenses of the device. However, catheters cannot be considered new technology in any sense. As a result, only the UF 500 disposable blood circuit is relevant to the evaluation of the cost criterion.

The applicant commissioned Covance to search the FY 2002 MedPAR file. The applicant used a combination of diagnosis codes to determine which cases could potentially use the System 100. Covance found 27,589 cases with the following combination of ICD–9–CM diagnosis codes: 428.0 through 428.9 (Heart Failure), 402.91 (Unspecified with Heart Failure), or 402.11

(Hypertensive Heart Disease with Heart Failure), in combination with 276.6 (Fluid Overload) and 782.3 (Edema). The 27,589 cases were found among 281 DRGs with 49.4 percent of cases mapped across DRGs 88, 89, 127, 277 and 316. The applicant eliminated those DRGs with less than 150 cases, which resulted in a total of 22,024 cases that could potentially use the System 100. The case-weighted average standardized charge across all DRGs was $14,534. The case-weighted threshold across all DRGs was $17,789. Although the case-weighted threshold is greater than the case-weighted standardized charge, it is necessary to include the standardized charge for the circuits used in each case. In order to establish the charge per circuit, the manufacturer submitted data regarding 51 actual cases that used the System 100. Based on these 51 cases, the standardized charge per circuit was $2,209. The manufacturer also stated that an average of two circuits are used per case. Therefore, adding $4,418 for the charge of the two circuits to the case-weighted average standardized charge of $14,534 results in a total case-weighted standardized charge of $18,952. This is greater than the case-weighed threshold of $17,789. We welcome comments from the public on the charge information submitted by the applicant for the circuits.

Using the FY 2003 MedPAR file, we used the same combination of diagnosis codes to identify 28,660 cases across all DRGs. As in the applicant's analysis, we eliminated those DRGs with less than 150 cases, which resulted in 22,395 cases. The case-weighted average standardized charge for these cases is $15,447. The case-weighted threshold to qualify for new technology add-on payment using the data we identified would then be $18,029. Again, as in the applicant's analysis, it was necessary to include in the charge of $4,418 for the circuits. This results in a total case-weighted average standardized charge of $19,865, which is also greater than the case-weighted threshold of $18,029. Based on these two analyses, the System 100 meets the cost criterion.

The applicant contends that the System 100 represents a substantial clinical improvement for the following reasons: It removes excess fluid without the use of diuretics; it does not lead to electrolyte imbalance, hemodynamic instability or worsening renal function; it can restore diuretic responsiveness; it does not adversely affect the renin-angiotensin system; it reduces hospital length of stay for the treatment of congestive heart failure; and it requires only peripheral venous access.

Although we lack data from a large, multicenter, randomized, prospective clinical trial, we believe the applicant has submitted data that demonstrate the use of this technology in achieving the clinical benefits cited. We believe that there is some basis for concluding that the System 100 represents a substantial clinical improvement over current standard treatment of fluid overload in congestive heart failure. However, we invite comment on whether the data submitted are indeed adequate to demonstrate significant clinical improvement.

Based on the criteria, we believe that the System 100 could be approved for new technology add-on payments for FY 2005. However, we invite comments on this application, and especially on whether the System 100 is really new and on whether it represents a new technology within the meaning of the statute and regulations. If approved for add-on payments, the device would be reimbursed up to half of the costs for the disposable portion of the device. The manufacturer has stated that the cost for the disposable blood circuit and filter would be $900. As stated above, an average two circuits are used per case, which results in a total cost of $1,800 per case. Therefore, the maximum add-on payment for the disposable parts of the device would be $900 per case. We will determine whether to approve this application in the light of the comments we receive and our continuing analysis.

We received the following public comments in accordance with section 503(b)(2) of Pub. L. 108–173 regarding this application for add-on payments.

Comment: Several commenters noted that the System 100 provides physicians a new treatment option for patients with fluid overload who are unresponsive to diuretics and has been documented in clinical studies and other published articles to effectively treat fluid overload. Another commenter noted that patients who have been treated with the System 100 seem to have improved health versus those who have lingered on diuretic therapy or have been treated by hemodialysis. The commenter also noted that the system 100 reduces hospital stays. Other commenters noted that the System 100 is safer for those patients in terms of reduced electrolyte imbalance and renal dysfunction and is a major step forward in the treatment of decompensated heart failure.

Response: As we stated above, we believe that there is some basis for concluding that the System 100 offers substantial clinical improvement. We will consider these comments as we continue to evaluate whether the System 100 meets this criterion.

III. Proposed Changes to the Hospital Wage Index

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts ''for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'' In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of statistical areas established by the Office of Management and Budget (OMB). A detailed discussion of the proposed FY 2005 hospital wage index based on the statistical areas, including OMB's revised definitions of Metropolitan Areas, appears under section III.B of this preamble.

Beginning October 1, 1993, section 1886(d)(3)(E) of the Act requires that we update the wage index annually. Furthermore, this section provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey should measure, to the extent feasible, the earnings and paid hours of employment by occupational category, and must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. The adjustment we are proposing for FY 2005 is discussed in section II.B. of the Addendum to this proposed rule.

As discussed below in section III.G. of this preamble, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating the wage index. Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the IPPS 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. The budget neutrality adjustment we are proposing for FY

2005 is discussed in section II.B. of the Addendum to this proposed rule.

Section 1886(d)(3)(E) of the Act also provides for the collection of data every 3 years on the occupational mix of employees for short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. A discussion of the initial collection of these data and the occupational mix adjustment that we are proposing to apply beginning October 1, 2004 (the FY 2005 wage index) appears under section III.C. of this preamble.

B. Revised OMB Definitions for Geographical Statistical Areas

[If you choose to comment on issues in this section, please include the caption ''Revised MSAs'' at the beginning of your comment.]

1. Current Labor Market Areas Based on MSAs

The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. In accordance with the broad discretion under section 1886(d)(3)(E) of the Act, we currently define hospital labor market areas based on the definitions of Metropolitan Statistical Areas (MSAs), Primary MSAs (PMSAs), and New England County Metropolitan Areas (NECMAs) issued by OMB. OMB also designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of one million or more, comprising two or more PMSAs (identified by their separate economic and social character). For purposes of the hospital wage index, we use the PMSAs rather than CMSAs because they allow a more precise breakdown of labor costs. If a metropolitan area is not designated as part of a PMSA, we use the applicable MSA.

These different designations use counties as the building blocks upon which they are based. Therefore, hospitals are assigned to either an MSA, PMSA, or NECMA based on whether the county in which the hospital is located is part of that area. For purposes of the IPPS wage index, we combine all of the counties in a State outside a designated MSA, PMSA, or NECMA together to calculate a statewide rural wage index.

2. Core-Based Statistical Areas

OMB reviews its Metropolitan Area (MA) definitions preceding each decennial census. In the fall of 1998, OMB chartered the Metropolitan Area Standards Review Committee to examine the MA standards and develop recommendations for possible changes to those standards. Three notices related to the review of the standards were published on the following dates in the **Federal Register**, providing an opportunity for public comment on the recommendations of the Committee: December 21, 1998 (63 FR 70526); October 20, 1999 (64 FR 56628), and August 22, 2000 (65 FR 51060).

In the December 27, 2000 **Federal Register** (65 FR 82228 through 82238), OMB announced its new standards. According to that notice, OMB defines a Core-Based Statistical Area (CBSA), beginning in 2003, as ''a geographic entity associated with at least one core of 10,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. The standards designate and define two categories of CBSAs: Metropolitan Statistical Areas and Micropolitan Statistical Areas.'' (65 FR 82235)

According to OMB, MSAs are based on urbanized areas of 50,000 or more population, and Micropolitan Statistical Areas (referred to in this discussion as Micropolitan Areas) are based on urban clusters of at least 10,000 population but less than 50,000 population. Counties that do not fall within CBSAs are deemed ''Outside CBSAs.'' In the past, OMB defined MSAs around areas with a minimum core population of 50,000, and smaller areas were ''Outside MSAs.''

The general concept of the CBSAs is that of an area containing a recognized population nucleus and adjacent communities that have a high degree of integration with that nucleus. The purpose of the standards is to provide nationally consistent definitions for collecting, tabulating, and publishing Federal statistics for a set of geographic areas. CBSAs include adjacent counties that have a minimum of 25 percent commuting to the central counties of the area. This is an increase over the minimum commuting threshold for outlying counties applied in the previous MSA definition of 15 percent.

On June 6, 2003, OMB announced the new CBSAs, comprised of MSAs and the new Micropolitan areas based on Census 2000 data. (A copy of the announcement may be obtained at the following Internet address: *http://www.whitehouse.gov/omb/bulletins/fy04/b04–03.html*.) The new definitions recognize 49 new MSAs and 565 new Micropolitan Areas, and extensively revise the construct of many of the existing MSAs. There are 1,090 counties in MSAs under these new definitions (previously, there were 848 counties in MSAs). Of these 1,090 counties, 737 are in the same MSA as they were prior to the changes, 65 are in a different MSA, and 288 were not previously designated to any MSA. There are 674 counties in Micropolitan Areas. Of these, 41 were previously in an MSA, while 633 were not previously designated to an MSA. There are five counties that previously were designated to an MSA but are no longer designated to either an MSA or a new Micropolitan Area: Carter County, KY; St. James Parish, LA; Kane County, UT; Culpepper County, VA; and King George County, VA.

3. Revised Labor Market Areas

In its June 6, 2003 announcement, OMB cautioned that these new definitions ''should not be used to develop and implement Federal, State, and local nonstatistical programs and policies without full consideration of the effects of using these definitions for such purposes. These areas should not serve as a general-purpose geographic framework for nonstatistical activities, and they may or may not be suitable for use in program funding formulas.''

We have previously examined alternatives to the use of MSAs for the purpose of establishing labor market areas for the Medicare wage index. In the May 27, 1994, proposed rule (59 FR 27724), we presented our latest research concerning possible future refinements to the labor market areas. Specifically, we discussed and solicited comment on the proposal by the Prospective Payment Assessment Commission (ProPAC, a predecessor organization to the Medicare Payment Advisory Commission (MedPAC)) for hospital-specific labor market areas based on each hospital's nearest neighbors, and our research and analysis on alternative labor market areas. Even though we found that none of the alternative labor market areas that we studied provided a distinct improvement over the use of MSAs, we presented an option using the MSA-based wage index but generally giving a hospital's own wages a higher weight than under the current system. We also described for comment a State labor market option, under which hospitals would be allowed to design labor market areas within their own State boundaries.

We described the comments we received in the June 2, 1995 proposed rule (60 FR 29219). There was no consensus among the commenters on the choice for new labor market areas. Many individual hospitals that commented expressed dissatisfaction with all of the proposals. However, several State hospital associations commented that the options merited further study. Therefore, we contacted the association representatives that

participated in our November 1993 meeting on labor market issues in which we solicited ideas for additional types of labor market research to conduct. None of the individuals we contacted suggested any ideas for further research.

Consequently, we have continued to use MSAs to define labor market areas for purposes of the wage index. While we recognize MSAs are not designed specifically to define labor market areas, we believe they do represent a useful proxy for this purpose, and our analysis and discussion here are focused on issues related to adopting the new CBSAs to define labor market areas.

a. New England MSAs

As stated above, we currently use NECMAs to define labor market areas in New England, because these are county-based designations rather than the 1990 MSA definitions for New England, which used minor civil divisions such as cities and towns. Under the previous MSA definitions, NECMAs provided more consistency in labor market definitions for New England compared with the rest of the country, where MSAs are county-based. Under the new CBSAs, OMB has defined the MSAs and Micropolitan Areas in New England on the basis of counties. OMB also established New England City and Town Areas, which are similar to the previous New England MSAs. Therefore, to maintain consistency in the definition of labor market areas between New England and the rest of the country, we are proposing to use the New England MSAs under the new CBSA definition.

b. Metropolitan Divisions

A Metropolitan Division is a county or group of counties within a CBSA that contains a core population of at least 2.5 million, representing an employment center, plus adjacent counties associated with the main county or counties through commuting ties. A county qualifies as a main county if 65 percent or more of its employed residents work within the county and the ratio of the number of jobs located in the county to the number of employed residents is at least .75. A county qualifies as a secondary county if 50 percent or more, but less than 65 percent, of its employed residents work within the county and the ratio of the number of jobs located in the county to the number of employed residents is at least .75. After all the main and secondary counties are identified and grouped, each additional county that already has qualified for inclusion in the MSA falls within the Metropolitan Division associated with the main/secondary county or counties with which the county at issue has the highest employment interchange measure. Counties in a Metropolitan Division must be contiguous. (65 FR 82236)

As noted above, in the past, OMB designated CMSAs as Metropolitan Areas with a population of one million or more and comprising two or more PMSAs. We currently use the PMSAs rather than CMSAs to define labor market areas because they comprise a smaller geographic area with potentially varying labor costs due to different local economies. Similarly, we are proposing to use the Metropolitan Divisions where applicable under the CBSA definitions.

Under the CBSA definitions, there are 11 MSAs containing Metropolitan Divisions: Boston; Chicago; Dallas; Detroit; Los Angeles; Miami; New York; Philadelphia; San Francisco; Seattle; and Washington, D.C. Although these MSAs were also CMSAs under the prior definitions, in some cases their areas have been significantly altered. Under the prior definitions, Boston was a single NECMA. It is now comprised of 4 Divisions. Los Angeles went from 4 PMSAs to 2 Divisions because 2 MSAs became separate MSAs. The New York CMSA went from 15 MSAs down to only 4 Divisions. Five PMSAs in Connecticut now become separate MSAs, and the number of PMSAs in New Jersey goes from 5 to 2, with the consolidation of 2 New Jersey PMSAs (Bergen-Passaic and Jersey City) into the New York-Wayne-White Plains, NY–NJ Division. In San Francisco, only 2 Divisions remain where there were once 6 PMSAs, some of which are now separate MSAs.

Previously, Cincinnati, Cleveland, Denver, Houston, Milwaukee, Portland, Sacramento, and San Juan were all previously designated as CMSAs, but are not any longer. As noted previously, the population threshold to be designated a CMSA was one million. In most of these cases, counties formerly in a PMSA have become a separate, independent MSA, leaving only the MSA for the core area under the new CBSA definitions.

c. Micropolitan Areas

One of the major issues with respect to the new definitions is whether to use Micropolitan Areas to define labor market areas for the purpose of the IPPS wage index. Because the new Micropolitan Areas are essentially a third area definition made up mostly of currently rural areas, but also some or all of current MSAs, how these areas are treated will have significant impacts on the calculation and application of the wage index. Treating Micropolitan Areas as separate and distinct labor market areas would affect both the wage indexes of the hospitals in the Micropolitan Areas and the hospitals in the labor market areas where those hospitals are currently located (both positively and negatively).

Because we currently use MSAs to define urban labor market areas and we group all the hospitals in counties within each State that are not assigned to an MSA together into a statewide rural labor market area, we have used the terms ''urban'' and ''rural'' wage indexes in the past for ease of reference. However, the introduction of Micropolitan Areas complicates this terminology because these areas include so many hospitals that are currently included in the statewide rural labor market areas. In order to facilitate the discussion below, we use the term ''rural'' hospitals to describe hospitals in counties that are not assigned to either an MSA or a Micropolitan Area. This should not be taken to indicate that hospitals in Micropolitan Areas are no longer ''rural'' hospitals. In fact, we are proposing that hospitals in Micropolitan Areas are included in the statewide rural labor market areas, for the reasons outlined below. The reader is referred to section IV.B. of the preamble of this proposed rule for a more specific discussion of the implications of these changes for defining urban and rural areas under § 412.62(f).

Chart 1 below demonstrates the distributions of hospitals by their current and new designations. Approximately 50 percent of hospitals currently designated rural are now in either Micropolitan Areas (691 hospitals) or MSAs (197 hospitals). The vast majority of hospitals currently in MSAs remain in an MSA (2,478, although in some cases the MSAs have been reconfigured), while 2 are now in rural areas and 65 are now in Micropolitan Areas.

CHART 1.—DISTRIBUTION OF HOSPITALS BY CURRENT AND NEW DESIGNATION

Statistical area	Currently rural	Currently MSA.
Rural	861	2
Micropolitan	691	65
MSA	197	2,478
Totals	1,749	2,545

In order to evaluate the impact of these changes, we grouped hospitals based on the county where they are located according to the new MSA and Micropolitan areas using the definitions

on the Census Bureau's Web site: *http://www.census.gov/population/www/estimates/metrodef.html.* We then compared the proposed FY 2004 wage indexes (using data from hospitals' FY 2001 cost reports) calculated based on the current MSAs, without any effects of hospital geographic reclassifications. Consistent with current policy, we applied the rural floor in the case where the statewide rural wage index is greater than the wage index for a particular urban area. We excluded Indian Health Service hospitals from the analysis due to the special characteristics of the prospective payment system for these hospitals. Hospitals in Maryland were excluded from the analysis because they remain excluded from the IPPS under the waiver at section 1814(b)(3) of the Act. Our analysis also does not reflect any changes to the Puerto Rico-specific wage index, which is applicable only to the Puerto Rico standardized amounts (the analysis does include the national wage index values for Puerto Rico hospitals).

Chart 2 below shows the impact on hospitals' wage indexes of recalculating new wage indexes based on the new MSAs, and treating the new Micropolitan Areas as separate labor market areas. Specifically, the table shows the impact of treating the new MSA and Micropolitan Areas as labor market areas and calculating a wage index for each one. The most dramatic impact of this change would be on hospitals that are currently classified as rural. Only 10 currently rural hospitals would experience no changes in their wage indexes after applying the new MSA definitions. Five of these hospitals are in Delaware and Connecticut (three and two hospitals respectively), where the only counties in the State currently considered rural are now part of Micropolitan Areas.

Approximately 62 percent (1,092 out of 1,749) of currently rural hospitals experience decreases in their wage indexes under this change. Among hospitals that remain rural after separately recognizing Micropolitan Areas (those hospitals in counties ''outside CBSAs''), rural hospitals in six States (Arizona, Florida, Idaho, Indiana, Minnesota, and Missouri) experience a positive impact after applying the new MSA definitions. These hospitals benefit because the net effect on their wage index of other hospitals moving into Micropolitan Areas is positive. The majority of the currently rural hospitals (762 out of 1,092) that experience decreases in their wage indexes are hospitals that would remain rural under the new definitions. Moreover, among the 646 rural hospitals whose wage indexes would increase under the new definitions, 547 would now be in an MSA or Micropolitan Area.

Furthermore, in many cases, the magnitude of the changes is quite large. Nearly one-half of all rural hospitals would experience payment changes of at least 5.0 percent, either negatively or positively, if we were to adopt labor market areas based in part on the new Micropolitan Areas.

In contrast, there are 938 currently urban hospitals (37 percent) with wage indexes that are unaffected by the new MSA definitions. These hospitals are in MSAs or PMSAs that are either unchanged (for example, the Austin, Buffalo, Milwaukee, Oakland, Phoenix, San Diego, and Tampa-St. Petersburg MSAs are all unchanged) or include new counties without any hospitals in those counties that are now part of the existing MSA (for example, Atlanta, Denver, Little Rock, Omaha, Portland, Richmond, Toledo, Virginia Beach-Norfolk added counties but not hospitals).

The most significant negative impact (more than a 20-percent decrease) among hospitals currently in an MSA is on those located in counties that become Micropolitan areas or rural areas. Among hospitals with the largest positive impacts (more than a 20-percent increase), the changes appear to be largely due to changes in the counties that are now included (under the CBSAs) in the MSA labor market area.

CHART 2.—IMPACT ON WAGE INDEXES OF NEW MSA, MICROPOLITAN AREAS, AND RURAL LABOR MARKET AREAS

Percent change in area wage index	Number of currently rural hospitals	Number of currently MSA hospitals	Total number of hospitals.
Decrease Greater Than 10.0	99	36	135
Decrease Between 5.0 and 10.0	420	77	497
Decrease Between 2.0 and 5.0	238	95	333
Decrease Between 0 and 02.0	335	585	920
No Change	10	938	948
Increase Between 0 and 2.0	168	495	663
Increase Between 2.0 and 5.0	138	145	283
Increase Between 5.0 and 10.0	203	139	342
Increase Greater Than 10.0	138	35	173
Total	1,749	2,545	4,294

One of the reasons Micropolitan Areas have such a dramatic impact on the wage index is, because Micropolitan Areas encompass smaller populations than MSAs, they tend to include fewer hospitals per Micropolitan Area. Currently, there are only 25 MSAs with one hospital in the MSA. However, under the new definitions, there are 373 Micropolitan Areas with one hospital, and 49 MSAs with only one hospital.

This large number of labor market areas with only one hospital and the increased potential for dramatic shifts in the wage indexes from one year to the next is a problem for several reasons. First, it creates instability in the wage index from year to year for a large number of hospitals. Second, it reduces the averaging effect of the wage index, lessening some of the efficiency incentive inherent in a system based on the average hourly wages for a large number of hospitals. In labor market areas with a single hospital, high wage costs are passed directly into the wage index with no counterbalancing averaging with lower wages paid at nearby competing hospitals. Third, it creates an arguably inequitable system when so many hospitals have wage indexes based solely on their own wages, while other hospitals' wage indexes are based on an average hourly wage across many hospitals.

For these reasons, we are proposing not to adopt Micropolitan Areas as independent labor market areas. Although we considered alternative

approaches that would aggregate Micropolitan Areas in order to reduce the number of one-hospital labor market areas, these approaches created geographically disconnected labor market areas, an undesirable outcome. Therefore, we are proposing to maintain our current policy of defining labor market areas based on the new MSAs (and Divisions, where they exist) using OMB's new criteria and the 2000 Census data.

Chart 3 displays the impacts on hospital wage indexes of this proposed approach. The most apparent difference comparing this chart to Chart 2 is the reduction in the numbers of currently rural hospitals impacted by more than 2.0 percent. Recognizing Micropolitan Areas as independent labor market areas results in negative impacts of more than 2.0 percent for 757 currently rural hospitals, while the comparative number, when recognizing only MSAs, is 256. Conversely, the number of currently rural hospitals positively impacted by more than 2.0 percent declines from 479 to 154.

The greatest negative impacts among hospitals currently designated rural are in Idaho, where the statewide rural wage index falls 6.7 percent as a result of 6 formerly rural hospitals now being included in either new or redefined MSAs. The wage index for rural Utah hospitals declines by 5.7 percent, for similar reasons. Conversely, formerly rural hospitals that are not part of an MSA generally experience positive impacts.

Among hospitals that are currently in MSAs, the number of hospitals with decreases in their wage indexes of at least 10 percent increases under this proposal from 35 to 45. These are primarily hospitals that are now located in Micropolitan Areas that are included in the statewide labor market area. There are 46 counties with 72 hospitals that are currently in an MSA that would be treated as rural under our proposal.

CHART 3.—IMPACT ON WAGE INDEXES OF NEW MSA AND RURAL LABOR MARKET AREAS

Percent change in area wage index	Number of currently rural hospitals	Number of currently MSA hospitals	Total number of hospitals.
Decrease Greater Than 10.0	0	45	45
Decrease Between 5.0 and 10.0	122	60	182
Decrease Between 2.0 and 5.0	134	73	207
Decrease Between 0 and 2.0	588	615	1,203
No Change	160	1,015	1,175
Increase Between 0 and 2.0	591	574	1,165
Increase Between 2.0 and 5.0	32	103	135
Increase Between 5.0 and 10.0	64	25	89
Increase Greater Than 10.0	58	35	93
Total	1,749	2,545	4,294

d. Transition Period

We have in the past provided for transition periods when adopting changes that have significant payment implications, particularly large negative impacts. When we recently removed the wage costs of teaching physicians and residents from the wage index data of teaching hospitals, we spread out the impact over 3 years by blending the hospitals' average hourly wages with and without the data. Similarly, the regulations at § 412.102 provide for a 3-year transition to the standardized amount and DSH adjustment payments to a hospital redesignated from urban to rural.

Given the significant payment impacts upon some hospitals of these changes, we considered options to transition from the current MSAs to the new MSAs. As noted above, the most dramatic negative impacts are among hospitals currently located in an MSA but would become rural under our proposal. Some negative impacts also occur among urban hospitals that remain in MSAs that have been reconfigured. However, these impacts are generally smaller than those among currently urban hospitals that would become rural. To help alleviate the decreased payments for currently urban hospitals that would become rural, we are proposing to allow them to maintain their assignment to the MSA where they are currently located for the 3-year period FY 2005, FY 2006, and FY 2007. Beginning in FY 2008, these hospitals would receive their statewide rural wage index, although they would be eligible to apply for reclassification by the MGCRB, both during this transition period as well as subsequent years.

We also considered the option of allowing a transition to the new MSAs for all hospitals, such as a blend of wage indexes based on the old and new MSAs for some specified period of time. Although this would help some hospitals that are negatively impacted by the changes to the MSAs, it would dampen the payment increases for those hospitals that are positively impacted by the changes. However, we are not proposing a blended transition. We note that OMB in the past has announced MSA changes on an annual basis due to population changes, and we have not transitioned these changes.

C. Proposed Occupational Mix Adjustment to Proposed FY 2005 Index

[If you choose to comment on issues in this section, please include the caption ''Occupational Mix'' at the beginning of your comment.]

As stated earlier, section 1886(d)(3)(E) of the Act provides for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index, for application beginning October 1, 2004 (the FY 2005 wage index). The purpose of the occupational mix adjustment is to control for the effect of hospitals' employment choices on the wage index. For example, hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, nursing aides, and medical assistants for the purpose of providing nursing care to their patients. The varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor.

1. Development of Data for the Occupational Mix Adjustment

In the September 19, 2003 **Federal Register** (68 FR 54905), we published a final notice of intent to collect occupational mix data from hospitals using the Medicare Wage Index Occupational Mix Survey, Form CMS–10079. (The survey and instructions may be accessed at the Web site: *http://cms.hhs.gov/providers/hipps/ippswage.asp.)* The survey requires hospitals to report the number of total paid hours for directly hired and contract employees in occupations that provide the following services: Nursing, physical therapy, occupational therapy, respiratory therapy, medical and clinical laboratory, dietary, and pharmacy. These services each include several standard occupational classifications (SOCs), as defined by the Bureau of Labor Statistics (BLS) on its Occupational Employment Statistics (OES) survey *(http://www.bls.gov/oes/2001/oes_tec.htm)*, that may be used by hospitals in different mixes to provide specific aspects of patient care. CMS decided to use BLS's SOCs to categorize employees for the occupational mix survey in an effort to ease hospitals' reporting burden; most hospitals have had experience with collecting and reporting their employment data according to the SOC definitions. The survey includes a total of 19 SOCs that provide services for the above 7 categories and an ''all other occupations'' category. The hours collected on the survey would be used to determine the proportion of a general service category total that is attributable to each of the category's SOCs, that is, the category's occupational mix.

In order to accurately reflect a hospital's employment, we initially planned to require all hospitals to provide occupational mix data collected from a 1-year period. Several hospitals and their representatives advised us that a 1-year reporting period was feasible because salary and wage data are maintained quarterly for revenue and tax reporting purposes. However, several hospitals expressed concern that their payroll and other personnel accounting systems are typically not set up to collect data on hours for contract employees. The hospitals and their representatives advised us that the approximately 2-month timeframe (*see* dates below) for collecting and submitting the occupational mix data to the fiscal intermediaries would not allow hospitals enough time to develop a year's worth of hours data for contract workers. Therefore, given the short timeframe for collecting the occupational mix data, and to reduce hospitals' reporting burden associated with the initial collection of the data, we decided to allow hospitals the option of providing their hours data for the 19 SOCs either prospectively for a 4-week period beginning on or between December 28, 2003 and January 11, 2004, and ending no later than February 7, 2004, or retrospectively for a 12-month period, that is, calendar year 2003. Although we recognize that using data from only a 4-week period increases our risk of obtaining results that reflect seasonal rather than normal employment trends, we believe that the 4-week prospective reporting period should enable hospitals to plan and provide more accurate data according to our survey instructions and definitions. (*See* the discussion below on the verification and validity of our occupational mix survey results.)

An advance copy of the occupational mix survey was provided to hospitals in mid-December 2003 so that hospitals could begin gathering their data and documentation necessary to complete the survey. The official survey was published as a CMS One-Time Notification (Pub. 100–20, R47OTN) on January 23, 2004. We instructed our fiscal intermediaries to distribute and collect completed occupational mix surveys from any hospital that is subject to IPPS, or any hospital that would be subject to IPPS if not granted a waiver. If a hospital was not an IPPS provider during FY 2001 or, otherwise, did not submit a FY 2001 cost report, the hospital was not required to submit occupational mix data. Consistent with the wage data, CAHs were excluded from the occupational mix survey. In addition, the FY 2005 wage index does not include occupational mix data for hospitals that submitted FY 2001 wage data, but terminated participation in the Medicare program as IPPS providers before calendar year 2003. For such terminated hospitals, there would be no occupational mix data to collect for our survey period.

Hospitals were to submit their completed occupational mix surveys to their fiscal intermediaries by February 16, 2004. Our initial collection of these data was completed by March 1, 2004, the deadline for fiscal intermediaries to submit hospitals' survey data to CMS. We released a public use file containing the data on March 8, 2004 (through the Internet on our Web site at: *http://cms/hhs.gov/providers/hipps/ippswage.asp*. In a memorandum also dated March 8, 2004, we instructed all fiscal intermediaries to inform the IPPS hospitals they service of the availability of the occupational mix data file and the process and timeframe for requesting corrections and revisions. If a hospital wished to request a change to its data as shown in that file, the hospital had to submit the changes to its fiscal intermediary by March 22, 2004. In addition, as this was hospitals' first experience with the occupational mix survey, we provided hospitals another opportunity, if they missed the February 16 filing deadline, to submit their completed surveys. The deadline for this one-time, final opportunity to submit occupational mix data to fiscal intermediaries for the FY 2005 wage index was also March 22, 2004. The final deadline for fiscal intermediaries to submit hospitals' data to CMS was April 16, 2004. (From April 16 until the final rule is published, the process, criteria, and timetable for correcting occupational mix data is the same as for Worksheet S–3 wage data, under Section H.) Occupational mix survey data received by us through March 15, 2004, are used in computing the proposed wage index in this proposed rule. Data received from intermediaries after March 15 through April 16, 2004 will be included in the final rule.

The response rate for the occupational mix survey, as of March 15, 2004, was 89.4 percent. We received occupational mix data from 3,593 hospitals. We expected to receive completed survey data from 4,018 hospitals that submitted cost report wage data for FY 2001 and were still IPPS hospitals during calendar year 2003 or on January 1, 2004. For any hospital that was expected to provide occupational mix data but did not, we are considering using proxy occupational mix data to adjust the hospital's wage data in the final wage index. One option would be to assume that the hospital only has employees in the highest level SOC for each of the general service categories included on the occupational mix survey. Another option would be to assume that such hospitals have the national SOC mix for each general service category. We invite public comment to this proposal. We note that the wage index in this proposed rule does not include proxy data for hospitals that did not complete and submit the occupational mix survey.

As this was the first administration of the occupational mix survey, we did not provide fiscal intermediaries an extensive program for reviewing the hours of data collected. However, hospitals were required to be able to provide any documentation that could be used by the fiscal intermediaries to verify the survey data. In addition, after reviewing the compiled survey data, we contacted fiscal intermediaries to

request corrections from a few hospitals that provided data for reporting periods that were out of range with our specified 12-month or 4-week data collection periods. As the wage index is a relative measure of labor costs across geographic areas, it is important that the data collected from hospitals reflects a common period. We also tested the validity of our occupational mix survey data by comparing our results to those of the 2001 BLS OES survey. As shown in Charts 4 and 5 below, the results of our survey are consistent with the findings of the BLS OES survey.

In addition, to compute the occupational mix adjustment, we collected data on the average hourly rates for the 19 SOCs so that we could derive a weighted average hourly rate for each labor market area. (More details about the occupational mix calculation are included in section III.C.2. of this preamble.) To decrease hospital's reporting burden for this initial collection of the occupational mix data, and to facilitate the timely collection of the data, we did not require hospitals to report data on their total wages or average hourly rates associated with the 19 SOCs. Instead, we used national average hourly rates from the BLS OES *2001 National Industry—Specific Occupational Employment and Wage Estimates, SIC—Hospitals* (accessible at Web site: *http://www.bls.gov/oes/2001/oesi3_806.htm),* as reflected in Chart 4 below.

CHART 4.—BLS NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES FOR HOSPITALS

General service categories	Number of hospital employees	Percent of service category	Percent of total employees	National average hourly wage $
Nursing Services and Medical Assistant Services				
Registered Nurses	1,307,960	68.8	25.88	23.62
Licensed Practical Nurses	194,900	10.2	3.86	14.65
Nursing Aides, Orderlies, & Attendants	351,910	18.5	6.96	10.01
Medical Assistants	47,250	2.5	0.93	11.79
Total	1,902,020	100.0	37.63	
Physical Therapy Services				
Physical Therapists	46,290	61.0	0.92	27.80
Physical Therapist Assistants	17,610	23.2	0.35	17.11
Physical Therapist Aides	12,020	15.8	0.24	10.40
Total	75,920	100.0	1.50	
Occupational Therapy Services				
Occupation Therapists	24,110	75.3	0.48	25.62
Occupation Therapist Assistants	5,690	17.8	0.11	16.81
Occupation Therapist Aides	2,220	6.9	0.04	11.60
Total	32,020	100.0	0.63	
Respiratory Therapy Services				
Respiratory Therapists	68,920	72.8	1.36	19.26
Respiratory Therapy Technicians	25,710	27.2	0.51	16.96
Total	94,630	100.0	1.87	
Pharmacy Services				
Pharmacists	48,630	48.8	0.96	34.58
Pharmacy Technicians	44,270	44.4	0.88	12.30
Pharmacy Assistants/Aides	6,810	6.8	0.13	11.52
Total	99,710	100.0	1.97	
Dietary Services				
Dieticians	16,820	56.4	0.33	20.02
Dietetic Technicians	13,020	43.6	0.26	11.64
Total	29,840	100.0	0.59	
Medical & Clinical Lab Services				
Medical & Clinical Lab Technologists	87,380	57.8	1.73	20.74
Medical & Clinical Lab Technicians	63,900	42.2	1.26	14.90
Total	151,280	100.0	2.99	

CHART 4.—BLS NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES FOR HOSPITALS—Continued

General service categories	Number of hospital employees	Percent of service category	Percent of total employees	National average hourly wage $
Total Nursing, Therapy, Pharmacy, Dietary, and Medical & Clinical Occupations	2,385,420		47.19	
All Other Occupations	2,669,400		52.81	
Total Hospital Employees	5,054,820		100.0	

Source: BLS, OES, 2001 National Industry-Specific Occupational Employment and Wage Estimates, *http://www.bls.gov/oes/2001*

CHART 5.—MEDICARE OCCUPATIONAL MIX SURVEY RESULTS

General Service Categories	Number of employee hours	Percent of service category hours	Percent of total employee hours
Nursing Services and Medical Assistant Services			
Registered Nurses	1,349,683,706.61	70.38	26.23
Licensed Practical Nurses	148,480,984.66	7.74	2.89
Nursing Aides, Orderlies, & Attendants	349,482,222.23	18.22	6.79
Medical Assistants	70,155,219.44	3.66	1.36
Total	1,917,802,132.94	100.00	37.27
Physical Therapy Services			
Physical Therapists	42,728,556.90	60.87	0.83
Physical Therapist Assistants	16,278,842.28	23.19	0.32
Physical Therapist Aides	11,192,122.93	15.94	0.22
Total	70,199,522.11	100.00	1.36
Occupational Therapy Services			
Occupation Therapists	18,016,924.74	76.46	0.35
Occupation Therapist Assistants	3,912,014.51	16.60	0.08
Occupation Therapist Aides	1,635,953.90	6.94	0.03
Total	23,564,893.16	100.00	0.46
Respiratory Therapy Services			
Respiratory Therapists	79,768,909.24	79.96	1.55
Respiratory Therapy Technicians	19,993,236.90	20.04	0.39
Total	99,762,146.14	100.00	1.94
Pharmacy Services			
Pharmacists	52,574,888.83	48.35	1.02
Pharmacy Technicians	51,947,662.82	47.77	1.01
Pharmacy Assistants/Aides	4,219,798.43	3.88	0.08
Total	108,742,350.08	100.00	2.11
Dietary Services			
Dieticians	18,221,465.33	42.23	0.35
Dietetic Technicians	24,929,864.59	57.77	0.48
Total	43,151,329.92	100.00	0.84
Medical & Clinical Lab Services			
Medical & Clinical Lab Technologists	109,938,139.37	52.07	2.14
Medical & Clinical Lab Technicians	101,208,507.21	47.93	1.97
Total	211,146,646.58	100.00	4.10
Total Nursing, Therapy, Pharmacy, Dietary, and Medical & Clinical Occupations	2,474,369,020.92	.....	48.08

CHART 5.—MEDICARE OCCUPATIONAL MIX SURVEY RESULTS—Continued

General Service Categories	Number of employee hours	Percent of service category hours	Percent of total employee hours
All Other Occupations	2,671,751,872.61		51.92
Total Hospital Employees	5,146,120,893.53		100.00

Source: Medicare Wage Index Occupational Mix Survey, Form CMS–10079

2. Proposed Calculation of the Occupational Mix Adjustment Factor and the Proposed Occupational Mix Adjusted Wage Index

The method used to calculate the proposed occupational mix adjusted wage index follows:

Step 1—For each hospital, the percentage of the general service category attributable to an SOC is determined by dividing the SOC hours by the general service category's total hours. Repeat this calculation for each of the 19 SOCs.

Step 2—For each hospital, the weighted average hourly rate for an SOC is determined by multiplying the percentage of the general service category (from Step 1) by the national average hourly rate for that SOC from the 2001 BLS OES survey (*see* Chart 4 above). Repeat this calculation for each of the 19 SOCs.

Step 3—For each hospital, the hospital's adjusted average hourly rate for a general service category is computed by summing the weighted hourly rate for each SOC within the general category. Repeat this calculation for each of the 7 general service categories.

Step 4—For each hospital, the occupational mix adjustment factor for a general service category is calculated by dividing the national adjusted average hourly rate for the category by the hospital's adjusted average hourly rate for the category. (The national adjusted average hourly rate is computed in the same manner as Steps 1 through 3, using instead, the total SOC and general service category hours for all hospitals in the occupational mix survey database.) Repeat this calculation for each of the 7 general service categories. If the hospital's adjusted rate is less than the national adjusted rate (indicating the hospital employs a less costly mix of employees within the category), the occupational mix adjustment factor will be greater than 1.0000. If the hospital's adjusted rate is greater than the national adjusted rate, the occupational mix adjustment factor will be less than 1.0000.

Step 5—For each hospital, the occupational mix adjusted salaries and wage-related costs for a general service category is calculated by multiplying the hospital's total salaries and wage-related costs (from Step 5 of the unadjusted wage index calculation in section F) by the national percentage of total hospital workers attributable to the general service category (from the occupational mix survey data; *see* Chart 5 above) and by the general service category's occupational mix adjustment factor (from Step 4 above). Repeat this calculation for each of the 7 general service categories. The remaining portion of the hospital's total salaries and wage-related costs that is attributable to all other employees of the hospital is not adjusted for occupational mix.

Step 6—For each hospital, the total occupational mix adjusted salaries and wage-related costs for a hospital are calculated by summing the occupational mix adjusted salaries and wage-related costs for the 7 general service categories (from Step 5) and the unadjusted portion of the hospital's salaries and wage-related costs for all other employees. To compute a hospital's occupational mix adjusted average hourly wage, divide the hospital's total occupational mix adjusted salaries and wage-related costs by the hospital's total hours (from Step 4 of the unadjusted wage index calculation in Section F).

Step 7—To compute the occupational mix adjusted average hourly wage for an urban or rural area, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the area, then sum the total hours for all hospitals in the area. Next, divide the area's occupational mix adjusted salaries and wage-related costs by the area's hours.

Step 8—To compute the national occupational mix adjusted average hourly wage, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the nation, then sum the total hours for all hospitals in the nation. Next, divide the national occupational mix adjusted salaries and wage-related costs by the national hours. The proposed national occupational mix adjusted average hourly wage is 26.2566.

Step 9—To compute the occupational mix adjusted wage index, divide each area's occupational mix adjusted average hourly wage (Step 7) by the proposed national occupational mix adjusted average hourly wage (Step 8).

Step 10—To compute the proposed Puerto Rico specific occupational mix adjusted wage index, follow the Steps 1 through 9 above. The proposed Puerto Rico occupational mix adjusted average hourly wage is 12.2035.

EXAMPLE OF OCCUPATIONAL MIX ADJUSTMENT

General service categories/SOCs	Number of employee hours	Percent of service category hours	Percent of total employee hours	BLS national average hourly wage
NATIONAL—Nursing and Medical Assistant Services				
Registered Nurses	1,349,683,707	70.38	26.23	$23.62.
Licensed Practical Nurses	148,480,985	7.74	2.89	14.65.
Nursing Aides, Orderlies, & Attendants	349,482,222	18.22	6.79	10.01
Medical Assistants	70,155,219	3.66	1.36	11.79 .

EXAMPLE OF OCCUPATIONAL MIX ADJUSTMENT—Continued

General service categories/SOCs	Number of employee hours	Percent of service category hours	Percent of total employee hours	BLS national average hourly wage
Total	1,917,802,133	100.00	37.27	20.01.
Hospital A:				
Registered Nurses	1,642,116	79.84		18.86.
Licensed Practical Nurses	67,860	3.30		0.48.
Nursing Aides, Orderlies, & Attendants	259,177	12.60		1.26
Medical Assistants	87,622	4.26		0.50.
Total	2,056,774	100.00		21.11
Occupational Mix Adjustment				0.9481
Hospital B:				
Registered Nurses	1,510,724	64.44		0.31
Licensed Practical Nurses	159,795	6.82		0.09
Nursing Aides, Orderlies, & Attendants	391,201	16.69		0.08
Medical Assistants	282,728	12.06		2.55
Total	2,344,449	100.00		19.31
Occupational Mix Adjustment				1.0362
NATIONAL—Physical Therapy Services				
Physical Therapists	42,728,557	60.87	0.83	27.80
Physical Therapist Assistants	16,278,842	23.19	0.32	17.11
Physical Therapist Aides	11,192,123	15.94	0.22	10.40
Total	70,199,522	100.00	1.36	22.55
Hospital A:				
Physical Therapists	94,987	61.40		17.07
Physical Therapist Assistants	36,254	23.43		4.01
Physical Therapist Aides	23,460	15.16		1.58
Total	154,701	100.00		22.66
Occupational Mix Adjustment				0.9953
Hospital B:				
Physical Therapists	60,337	57.37		15.95
Physical Therapist Assistants	22,391	21.29		3.64
Physical Therapist Aides	22,444	21.34		2.22
Total	105,173	100.00		21.81
Occupational Mix Adjustment				1.0339
NATIONAL—Occupational Therapy Services				
Occupation Therapists	18,016,925	76.46	0.35	25.62
Occupation Therapist Assistants	3,912,015	16.60	0.08	16.81
Occupation Therapist Aides	1,635,954	6.94	0.03	11.60
Total	23,564,893	100.00	0.46	23.18.
Hospital A:				
Occupation Therapists	40,366	90.06		23.07
Occupation Therapist Assistants	0	0.00		0.00
Occupation Therapist Aides	4,454	9.94		1.15
Total	44,820	100.00		24.23
Occupational Mix Adjustment				0.9568
Hospital B:				
Occupation Therapists	26,547	79.48		20.36
Occupation Therapist Assistants	1,610	4.82		0.81
Occupation Therapist Aides	5,242	15.70		1.82
Total	33,399	100.00		22.99
Occupational Mix Adjustment				1.0081
NATIONAL—Respiratory Therapy Services				
Respiratory Therapists	79,768,909	79.96	1.55	19.26
Respiratory Therapy Technicians	19,993,237	20.04	0.39	16.96
Total	99,762,146	100.00	1.94	18.80

EXAMPLE OF OCCUPATIONAL MIX ADJUSTMENT—Continued

General service categories/SOCs	Number of employee hours	Percent of service category hours	Percent of total employee hours	BLS national average hourly wage
Hospital A:				
Respiratory Therapists	75,339	97.40		18.76
Respiratory Therapy Technicians	2,008	2.60		0.44
Total	77,347	100.00		19.20
Occupational Mix Adjustment				0.9792
Hospital B:				
Respiratory Therapists	73,592	65.62		12.64
Respiratory Therapy Technicians	38,549	34.38		5.83
Total	112,141	100.00		18.47
Occupational Mix Adjustment				1.0179
NATIONAL—Pharmacy Services				
Pharmacists	52,574,889	48.35	1.02	34.58
Pharmacy Technicians	51,947,663	47.77	1.01	12.30
Pharmacy Assistants/Aides	4,219,798	3.88	0.08	11.52
Total	108,742,350	100.00	2.11	23.04
Hospital A:				
Pharmacists	65,863	48.65		16.82
Pharmacy Technicians	69,525	51.35		6.32
Pharmacy Assistants/Aides	0	0.00		0.00
Total	135,388	100.00		23.14
Occupational Mix Adjustment				0.9957
Hospital B:				
Pharmacists	45,856	39.23		13.57
Pharmacy Technicians	64,986	55.60		6.84
Pharmacy Assistants/Aides	6,039	5.17		0.60
Total	116,881	100.00		21.00
Occupational Mix Adjustment				1.0971
NATIONAL—Dietary Services				
Dieticians	18,221,465	42.23	0.35	20.02
Dietetic Technicians	24,929,865	57.77	0.48	11.64
Total	43,151,330	100.00	0.84	15.18
Hospital A:				
Dieticians	13,943	100.00		20.02
Dietetic Technicians	0	0.00		0.00
Total	13,943	100.00		20.02
Occupational Mix Adjustment				0.7582
Hospital B:				
Dieticians	27,458	16.29		3.26
Dietetic Technicians	141,148	83.71		9.74
Total	168,606	100.00		13.00
Occupational Mix Adjustment				1.1676
NATIONAL—Medical & Clinical Lab Services				
Medical & Clinical Lab Technologists	109,938,139	52.07	2.14	20.74
Medical & Clinical Lab Technicians	101,208,507	47.93	1.97	14.90.
Total	211,146,647	100.00	4.10	17.94
Hospital A:				
Medical & Clinical Lab Technologists	166,522	90.82		18.84
Medical & Clinical Lab Technicians	16,841	9.18		1.37
Total	183,363	100.00		20.20
Occupational Mix Adjustment				0.8880
Hospital B:				
Medical & Clinical Lab Technologists	295,516	47.34		9.82
Medical & Clinical Lab Technicians	328,716	52.66		7.85

EXAMPLE OF OCCUPATIONAL MIX ADJUSTMENT—Continued

General service categories/SOCs	Number of employee hours	Percent of service category hours	Percent of total employee hours	BLS national average hourly wage
Total	624,232	100.00		17.66
Occupational Mix Adjustment				1.0156
Total Nursing, Therapy, Pharmacy, Dietary, and Medical & Clinical Occupations	2,474,369,021		48.08	
All Other Occupations	2,671,751,873		51.92	
Total Hospital Employees	5,146,120,894		100.00	

In implementing an occupational mix adjusted wage index based on the above calculation, the wage index values for 18 rural areas (36.7 percent) and 166 urban areas (51.2 percent) would decrease as a result of the adjustment. Nine (9) rural areas (18.4 percent) and 89 urban areas (27.5 percent) would experience a decrease of 1 percent or greater in their wage index values. The largest negative impact for a rural area would be 2.2 percent and for an urban area, 4.5 percent. Meanwhile, 31 rural areas (63.3 percent) and 158 urban areas (48.8 percent) would experience an increase in their wage index values. Although these results show that rural hospitals would gain the most from an occupational mix adjustment to the wage index, their gains may not be as great as might have been expected. Further, it might not have been anticipated that over one-third of rural hospitals would actually fare worse under the adjustment. Overall, a fully implemented occupational mix adjusted wage index would have a redistributive effect on Medicare payments to hospitals.

D. Worksheet S–3 Wage Data for the Proposed FY 2005 Wage Index Update

[If you choose to comment on issues in this section, please include the caption ''Wage Data'' at the beginning of your comment.]

The proposed FY 2005 wage index values (effective for hospital discharges occurring on or after October 1, 2004 and before October 1, 2005) in section VI. of the Addendum to this proposed rule are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2001 (the FY 2004 wage index was based on FY 2000 wage data).

The proposed FY 2005 wage index includes the following categories of data associated with costs paid under the IPPS (as well as outpatient costs):

- Salaries and hours from short-term, acute care hospitals (including paid lunch hours and hours associated with military leave and jury duty).
- Home office costs and hours.
- Certain contract labor costs and hours (which includes direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services).
- Wage-related costs (The September 1, 1994 **Federal Register** included a list of core wage-related costs that are included in the wage index, and discussed criteria for including other wage-related costs (59 FR 45356)).

Consistent with the wage index methodology for FY 2004, the proposed wage index for FY 2005 also excludes the direct and overhead salaries and hours for services not subject to IPPS payment, such as SNF services, home health services, costs related to GME (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs), and other subprovider components that are not paid under the IPPS. The proposed FY 2005 wage index also excludes the salaries, hours, and wage-related costs of hospital-based rural health clinics (RHCs), and Federally qualified health centers (FQHCs) because Medicare pays for these costs outside of the IPPS (68 FR 45395). In addition, salaries, hours and wage-related costs of CAHs are excluded from the wage index, for the reasons explained in the FY 2004 IPPS final rule (68 FR 45397).

Data collected for the IPPS wage index are also currently used to calculate wage indexes applicable to other providers, such as SNFs, home health agencies, and hospices. In addition, they are used for prospective payments to rehabilitation, psychiatric, and long-term care hospitals, and for hospital outpatient services.

E. Verification of Worksheet S–3 Wage Data

[If you choose to comment on issues in this section, please include the caption ''Wage Data'' at the beginning of your comment.]

The wage data for the proposed FY 2005 wage index were obtained from Worksheet S–3, Parts II and III of the FY 2001 Medicare cost reports. Instructions for completing the Worksheet S–3, Parts II and III are in the Provider Reimbursement Manual, Part I, sections 3605.2 and 3605.3. The data file used to construct the proposed wage index includes FY 2001 data submitted to us as of March 15, 2004. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries to revise or verify data elements that resulted in specific edit failures. Some unresolved data elements are included in the calculation of the proposed FY 2005 wage index, pending their resolution before calculation of the final FY 2005 index. We instructed the fiscal intermediaries to complete their data verification of questionable data elements and to transmit any changes to the wage data no later than April 16, 2004. We believe all unresolved data elements will be resolved by the date the final rule is issued. The revised data will be reflected in the final rule.

In addition, as part of our editing process, we removed data for 222 hospitals from our database: 147 hospitals became critical access hospitals by the time we published the February public use file, and 75 hospitals were low Medicare utilization hospitals or failed edits that could not be corrected because the hospitals terminated the program or changed ownership. In addition, we removed the wage data for 15 hospitals with incomplete or inaccurate data resulting in zero or negative, or otherwise aberrant, average hourly wages. We have notified the fiscal intermediaries of these hospitals and will continue to work with the fiscal intermediaries to correct these data until we finalize our database to compute the final wage index. As a result, the proposed FY 2005 wage index is calculated based on FY 2001 wage data for 3,954 hospitals.

In constructing the proposed FY 2005 wage index, we include the wage data for facilities that were IPPS hospitals in FY 2001, even for those facilities that have terminated their participation in the program as hospitals, as long as those data do not fail any of our edits for reasonableness. We believe that including the wage data for these hospitals is, in general, appropriate to reflect the economic conditions in the various labor market areas during the relevant past period. However, we exclude the wage data for CAHs (as discussed in 68 FR 45397). The proposed wage index in this proposed rule excludes hospitals that are designated as CAHs by February 24, 2004, the date of the latest available Medicare CAH listing at the time we released the proposed wage index public use file on February 27, 2004.

F. Computation of the Unadjusted Wage Index

[If you choose to comment on issues in this section, please include the caption ''Wage Index'' at the beginning of your comment.]

The method used to compute the proposed FY 2005 wage index without an occupational mix adjustment follows:

Step 1—As noted above, we based the proposed FY 2005 wage index on wage data reported on the FY 2001 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 2000 and before October 1, 2001. In addition, we included data from some hospitals that had cost reporting periods beginning before October 2000 and reported a cost reporting period covering all of FY 2001. These data were included because no other data from these hospitals would be available for the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 2001 data. We note that, if a hospital had more than one cost reporting period beginning during FY 2001 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001), we included wage data from only one of the cost reporting periods, the longer, in the wage index calculation. If there was more than one cost reporting period and the periods were equal in length, we included the wage data from the later period in the wage index calculation.

Step 2—Salaries—The method used to compute a hospital's average hourly wage excludes certain costs that are not paid under the IPPS. In calculating a hospital's average salaries plus wage-related costs, we subtracted from Line 1 (total salaries) the GME and CRNA costs reported on lines 2, 4.01, 6, and 6.01, the Part B salaries reported on Lines 3, 5 and 5.01, home office salaries reported on Line 7, and excluded salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to SNF services, home health services, and other subprovider components not subject to the IPPS). We also subtracted from Line 1 the salaries for which no hours were reported. To determine total salaries plus wage-related costs, we added to the net hospital salaries the costs of contract labor for direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services (Lines 9 and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, and 18).

We note that contract labor and home office salaries for which no corresponding hours are reported were not included. In addition, wage-related costs for nonteaching physician Part A employees (Line 18) are excluded if no corresponding salaries are reported for those employees on Line 4.

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

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocated overhead costs to areas of the hospital excluded from the wage index calculation. First, we determined the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S–3, Part II) to revised total hours (Line 1 minus the sum of Part II, Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, and Part III, Line 13 of Worksheet S–3). We then computed the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S–3, Part III. Next, we computed the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) We determined the ratio of overhead hours (Part III, Line 13) to revised hours (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, and 7); (2) we computed overhead wage-related costs by multiplying the overhead hours ratio by wage-related costs reported on Part II, Lines 13, 14, and 18; and (3) we multiplied the computed overhead wage-related costs by the above excluded area hours ratio. Finally, we subtracted the computed overhead salaries, wage-related costs, and hours associated with excluded areas from the total salaries (plus wage-related costs) and hours derived in Steps 2 and 3.

Step 5—For each hospital, we adjusted the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimated the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 2000 through April 15, 2002 for private industry hospital workers from the Bureau of Labor Statistics' *Compensation and Working Conditions.* We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor.
10/14/2000	11/15/2000	1.07771
11/14/2000	12/15/2000	1.07273
12/14/2000	1/15/2001	1.06767
01/14/2001	02/15/2001	1.06245
02/14/2001	03/15/2001	1.05706
03/14/2001	04/15/2001	1.05168
04/14/2001	05/15/2001	1.04645
05/14/2001	06/15/2001	1.04139
06/14/2001	07/15/2001	1.03638
07/14/2001	08/15/2001	1.03134
08/14/2001	09/15/2001	1.02627
09/14/2001	10/15/2001	1.02133
10/14/2001	11/15/2001	1.01665
11/14/2001	12/15/2001	1.01224
12/14/2001	01/15/2002	1.00803
01/14/2002	02/15/2002	1.00395
02/14/2002	03/15/2002	1.00000
03/14/2002	04/15/2002	0.99610

For example, the midpoint of a cost reporting period beginning January 1, 2001 and ending December 31, 2001 is June 30, 2001. An adjustment factor of 1.03638 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 2001 and covered a period of less than 360 days or more than 370 days, we annualized the data to reflect a 1-year cost report. Dividing the data by the number of days in the cost report and then multiplying the results by 365 accomplish annualization.

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

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

Step 8—We added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the nation and then divided the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage. Using the data as described above, the proposed national average hourly wage is $26.2939.

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

Step 10—Following the process set forth above, we developed a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We added the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall proposed average hourly wage of 12.2038 for Puerto Rico. For each labor market area in Puerto Rico, we calculated the Puerto Rico-specific wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. Furthermore, this wage index floor is to be implemented in such a manner as to ensure that aggregate IPPS payments are not greater or less than those that would have been made in the year if this section did not apply. For FY 2005, this change affects 195 hospitals in 51 MSAs. The MSAs affected by this provision are identified by a footnote in Table 4A in the Addendum of this proposed rule.

G. Computation of the Proposed FY 2005 Blended Wage Index

[If you choose to comment on issues in this section, please include the caption ''Wage Index'' at the beginning of your comment.]

For the FY 2005 wage index, we are proposing a blend of the occupational mix adjusted wage index and the unadjusted wage index, in order to minimize the redistributive impact of the occupational mix adjustment (as discussed in section III.C.2. of this preamble) for the first year of its implementation. Specifically, we are proposing to base the FY 2005 wage index on a blend of 10 percent of an average hourly wage, adjusted for occupational mix, and 90 percent of an average hourly wage, unadjusted for occupational mix. Using this blend, the national average hourly wage is 26.2902 and the Puerto Rico specific average hourly wage is 12.2038. We chose this blend for FY 2005 in recognition that this was the first time, for the administration of the occupational mix survey, hospitals had a short timeframe for collecting their occupational mix survey data and documentation, and we could not collect optimum data (that is, wages and hours data from a 1-year period for all hospitals) within the mandatory timeframe for implementing the adjustment, and we had no baseline data to use in developing a desk review program that could ensure the accuracy of the occupational mix survey data.

In addition, we are moving cautiously with implementing the occupational mix adjustment in recognition of changing trends in the hiring of nurses, the largest group in our survey. Since the enactment of section 304(c) of Public Law 106–554, the law requiring the occupational mix adjustment to the wage index, some States have implemented laws that establish floors on the minimum level of registered nurse staffing that hospitals must maintain in order to continue to be licensed and certified by the State. In addition, some rural areas that are facing a shortage of physicians may be hiring more registered nurses as extenders or substitutes for physicians. Such trends may explain why the occupational mix impacts in section III.C.2. of this preamble are not as expected for rural areas in particular.

Further, we are proposing this blend because, although we want to minimize the immediate impact of the occupational mix adjustment on hospitals' wage index values, we do not want to nullify the value and intent of the occupational mix adjustment. We believe that the blended wage index we are proposing satisfies both of these goals. With only 10 percent of the wage index adjusted for occupational mix, the wage index values for 17 rural areas (34.7 percent) and 159 urban areas (49.1 percent) would decrease as a result of the adjustment. However, the decreases would be minimum; the largest negative impact for a rural area would be only 0.22 percent and for an urban area, 0.45 percent. Conversely, 32 rural areas (65.3 percent) and 165 urban areas (50.9 percent) would benefit from this adjustment, but each area's gain would be less than 1 percent. Overall, a wage index that has only 10 percent of the salaries adjusted for occupational mix would have a minimal redistributive effect on Medicare payments to hospitals. (See Appendix A to this proposed rule for further analyses of the impact of the proposed occupational mix adjustment on the FY 2005 wage index.)

The wage index values in Tables 4A, 4B, 4C, 4F, 4G, and 4H and the average hourly wages in Tables 2, 3A, and 3B in the Addendum to this proposed rule include the occupational mix adjustment as proposed. We note that, although we are proposing a blended wage index for FY 2005, at this time we are not proposing an incremental phase-in of the occupational mix adjustment beyond FY 2005. The application of the occupational mix adjustment beyond FY 2005 will be determined and discussed in subsequent IPPS updates.

H. Proposed Revisions to the Wage Index Based on Hospital Redesignation

[If you choose to comment on issues in this section, please include the caption ''Hospital Redesignations'' at the beginning of your comment.]

1. General

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 IPPS. Hospitals must apply to the MGCRB to reclassify by September 1 of the year preceding the year during which reclassification is sought.

Generally, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. The MGCRB issues its decisions by the end of February for reclassification to become effective for the following fiscal year (beginning October 1). The regulations applicable to reclassifications by the MGCRB are located in §§ 412.230 through 412.280.

Section 1886(d)(10)(D)(v) of the Act provides that, beginning with FY 2001, a MGCRB decision on a hospital reclassification for purposes of the wage index is effective for 3 fiscal years, unless the hospital elects to terminate the reclassification. Section 1886(d)(10)(D)(vi) of the Act provides that the MGCRB must use the 3 most recent years' average hourly wage data in evaluating a hospital's reclassification application for FY 2003 and any succeeding fiscal year.

Section 304(b) of Public Law 106–554 provides that the Secretary must establish a mechanism under which a statewide entity may apply to have all of the geographic areas in the State treated as a single geographic area for purposes of computing and applying a single wage index, for reclassifications beginning in FY 2003. The implementing regulations for this provision are located at § 412.235.

Section 1886(d)(8)(B) of the Act requires the Secretary to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA to which the greatest number of workers in the county commute if: The rural county would otherwise be considered part of an urban area under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of *all* contiguous MSAs. In light of the new CBSA definitions and the Census 2000 data, we undertook to identify those counties meeting these criteria. The eligible counties are identified below, as well as a discussion of counties that no longer meet the criteria under this provision.

2. Effects of Reclassification

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. These requirements for determining the wage index values for redesignated hospitals is applicable both to the hospitals located in rural counties deemed urban under section 1886(d)(8)(B) of the Act and hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. Therefore, as provided in section 1886(d)(8)(C) of the Act,[4] the wage index values were determined by considering the following:

- If including the wage data for the redesignated hospitals would reduce the wage index value for the area to which the hospitals are redesignated by 1 percentage point or less, the area wage index value determined exclusive of the wage data for the redesignated hospitals applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than 1 percentage point, the area wage index determined inclusive of the wage data for the redesignated hospitals (the combined wage index value) applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals increases the wage index value for the urban area to which the hospitals are redesignated, both the area and the redesignated hospitals receive the combined wage index value. Otherwise, the hospitals located in the urban area receive a wage index excluding the wage data of hospitals redesignated into the area.
- The wage data for a reclassified urban hospital is included in both the wage index calculation of the area to which the hospital is reclassified (subject to the rules described above) and the wage index calculation of the urban area where the hospital is physically located.
- Rural areas whose wage index values would be reduced by excluding the wage data for hospitals that have been redesignated to another area continue to have their wage index values calculated as if no redesignation had occurred (otherwise, redesignated rural hospitals are excluded from the calculation of the rural wage index).
- The wage index value for a redesignated rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located.

3. FY 2005 Issues

Recent policies and decisions that will affect hospitals' geographic classifications for FY 2005 are discussed below. First, we describe decisions by the MGCRB on applications received in accordance with the ongoing reclassification process described in the regulations at §§ 412.230 through 412.280. Second, we describe the implications for reclassification decisions by the MGCRB to be effective during FY 2005 of our proposal to adopt new MSA definitions for the FY 2005 wage index. Third, we discuss the new counties identified under the standards at section 1886(d)(8)(B) of the Act, based on the new CBSAs and the Census 2000 data. Fourth, we discuss the interactions of these changes with reclassifications approved under the one-time appeal process for hospital wage index reclassifications at section 508 of Public Law 108–173. Fifth, we discuss our proposed implementation of section 505 of Public Law 108–173. Under this provision, the Secretary must establish a new process, similar to the current wage index reclassification process, to make adjustments to the hospital wage index, based on commuting patterns of hospital employees.

a. FY 2005 MGCRB Reclassifications

In the August 1, 2003 IPPS final rule, we indicated that hospitals submitting applications for reclassification by the MGCRB for FY 2005 should base those applications on the current (for Medicare payment purposes) MSAs (68 FR 45401). At the time this proposed rule was constructed, the MGCRB had completed its review of FY 2005 reclassification requests. There were 339 hospitals approved for wage index reclassifications by the MGCRB for FY 2005. Because MGCRB wage index reclassifications are effective for 3 years, hospitals reclassified during FY 2003 or FY 2004 are eligible to continue to be reclassified based on prior reclassifications to current MSAs during FY 2005. There were 55 hospitals reclassified for wage index in FY 2003 and 102 hospitals reclassified for wage index in FY 2004.

In the past, hospitals have been able to apply to be reclassified for purposes of either the wage index or the standardized amount. Existing regulations at § 412.230(a)(5)(ii) state

[4] Although section 1886(d)(8)(C)(iv)(I) of the Act also provides that the wage index for an urban area may not decrease as a result of redesignated hospitals if the urban area wage index is below the wage index for rural areas in the State in which the urban area is located, this was effectively made moot by section 4410 of Public Law 105–33, which provides that the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State.

Also, section 186(d)(8)(C)(iv)(II) of the Act provides that an urban area's wage index may not decrease as a result of redesignated hospitals if the urban area is located in a State that is composed of a single urban area.

that, after 2002, 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 the standardized amount the hospital currently receives. Standardized amount reclassifications are only effective for 1 year, so hospitals must reapply every year. At the time the FY 2005 reclassification applications were due, hospitals applied on the basis that the law still provided for a higher standardized amount for hospitals in large urban areas. However, section 401 of Public Law 108–173 established that all hospitals would be paid on the basis of the large urban standardized amount beginning with FY 2004. Consequently, all hospitals will be paid on the basis of the same standardized amount, which effectively makes standardized amount reclassifications moot, at least for purposes of the standardized amount. As a result, the MGCRB denied all applications for standardized amount reclassifications for FY 2005. In light of the fact that all hospitals are now paid on the basis of the same standardized amount, we are proposing to eliminate standardized amount reclassifications (a discussion appears under section IV.C. of this preamble). Although there could still be some benefit in terms of payments for some hospitals under the DSH adjustment for operating IPPS, section 402 of Public Law 108–173 equalized DSH payments for rural and urban hospitals, with the exception that the rural DSH adjustment is capped at 12 percent (except that rural referral centers have no cap) (a detailed discussion appears in section IV.H. of this preamble).

b. Implementation of New MSAs

As discussed above, we are proposing to implement the new CBSAs for FY 2005. Under these new CBSAs definitions, many existing MSAs are reconfigured. Therefore, because hospitals applied for reclassification during FY 2005 on the basis of the MSAs currently used to define labor market areas for FY 2004, the definition of the MSA to which they have been reclassified, or the area where they are located, may have changed under our proposed implementation. Hospitals that have been reclassified for FY 2005 should verify that the reclassified wage index for the labor market area into which they have been reclassified (in Table 4C or 4D in the Addendum to this proposed rule) exceeds the wage index of the labor market area where they are located (in Table 4A or 4B in the Addendum of this proposed rule) after our proposed implementation of the new MSAs. Hospitals may withdraw their FY 2005 reclassifications within 45 days of the publication of this proposed rule.

In some cases, the new CBSA definitions result in previously existing MSAs being divided into two or more separate MSAs. In these situations, we are proposing to assign the hospital to the nearest county in the current MSA, and the hospital's FY 2005 reclassification would be to the new MSA (under the CBSA definitions) that includes that county to which it has been assigned.

For example, the Ann Arbor, MI MSA currently includes the counties of Lenawee, MI; Livingston, MI; and Washtenaw, MI. Under the new CBSA definitions, the Ann Arbor, MI MSA is comprised solely of the county of Washtenaw, MI. Lenawee, MI now comprises the Adrian, MI Micropolitan Area, and Livingston, MI is now in the Warren-Farmington Hills-Troy, MI Metropolitan Division of Detroit. Therefore, a hospital that was reclassified by the MGCRB into Ann Arbor for either FY 2003, FY 2004, or FY 2005, would be assigned to either the Ann Arbor, MI MSA or the Warren-Farmington Hills-Troy, MI Metropolitan Division, depending on whether the hospital was closer to Washtenaw or Livingston (a reclassified hospital located closest to Lenawee County would be assigned to the Ann Arbor MSA, based on Lenawee County's prior inclusion in this MSA).

Reclassified hospitals that have been assigned to a new MSA on this proposed basis are identified in Table 9 in the Addendum of this proposed rule by the identification of the county used to designate them. We have determined the hospital is in closest proximity to the county listed based on mapping data available to us at the time of the preparation of this proposed rule. Hospitals that disagree with our determination of the closest proximate county on which to assign them to a new MSA must submit a comment (as specified under the ''Comment Period'' and **ADDRESSES** sections at the beginning of this proposed rule) indicating the basis for their disagreement. Changes to a hospital's MSA assignment on the basis of a hospital's disagreement will be announced in the final rule.

c. Redesignations Under Section 1886(d)(8)(B) of the Act

Beginning October 1, 1988, section 1886(d)(8)(B) of the Act required us to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area under the standards published in the **Federal Register** on January 3, 1980 (45 FR 956) for designating MSAs (and for designating NECMAs), and if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous MSAs (or NECMAs). Hospitals that met the criteria using the January 3, 1980 version of these OMB standards were deemed urban for purposes of the standardized amounts and for purposes of assigning the wage data index.

Section 402 of Public Law 106–113 provides that, with respect to FYs 2001 and 2002, a hospital may elect to have the 1990 standards applied to it for purposes of section 1886(d)(8)(B) of the Act and that, beginning with FY 2003, hospitals will be required to use the standards published in the **Federal Register** by the Director of OMB based on the most recent decennial census. We implemented section 402 in the August 1, 2001 **Federal Register** (66 FR 39868). However, at that time, updated standards based on the Census 2000 data were not available.

We have used OMB's 2000 CBSA standards and the Census 2000 data to identify counties qualifying under section 1886(d)(8)(B) of the Act for FY 2005. The number of qualifying counties, shown in the following chart, increases from 28 to 97. On the basis of the evaluation of these data, we are proposing that, effective for discharges on or after October 1, 2004, hospitals located in the rural counties listed in the first column of the following table will be redesignated for purposes of assigning the wage index to the urban area listed in the second column.

CHART 6.—COUNTIES REDESIGNATED AS URBAN UNDER SECTION 1886(D)(8)(B) OF THE ACT

[Based on CBSAs and Census 2000 Data]

Rural county	MSA.
Cherokee, AL	Rome, GA.
Macon, AL	Auburn, AL.
Talladega, AL	Anniston, AL.
Hot Spring, AR	Hot Spring, AR.
Litchfield, CT	Hartford, CT.
Windham, CT	Hartford, CT.
Bradford, FL	Gainesville, FL.
Flagler, FL	Deltona-Daytona Beach-Ormond Beach, FL.
Hendry, FL	Miami, FL.
Levy, FL	Gainesville, FL.
Walton, FL	Ft. Walton Beach, FL.
Banks, GA	Gainesville, FL.
Chattooga, GA	Chattanooga, TN–GA.
Jackson, GA	Atlanta, GA.
Lumpkin, GA	Atlanta, GA.
Morgan, GA	Atlanta, GA.
Peach, GA	Macon, GA.
Polk, GA	Atlanta, GA.
Talbot, GA	Columbus, GA–AL.
Bingham, ID	Idaho Falls, ID.
Christian, IL	Springfield, IL.
DeWitt, IL	Bloomington-Normal, IL.
Iroquois, IL	Kankakee, IL.
Logan, IL	Springfield, IL.
Mason, IL	Peoria, IL.
Ogle, IL	Rockford, IL.
Clinton, IN	Lafayette, IN.
Henry, IN	Indianapolis, IN.
Spencer, IN	Evansville, IN–KY.
Starke, IN	Chicago, IL–IN.
Warren, IN	Lafayette, IN.
Boone, IA	Ames, IA.
Buchanan, IA	Waterloo, IA.
Cedar, IA	Iowa City, IA.
Allen, KY	Bowling Green, KY.
Assumption Parish, LA	Baton Rouge, LA.
St. James Parish, LA	Baton Rouge, LA.
Allegan, MI	Holland, MI.
Montcalm, MI	Grand Rapids, MI.
Oceana, MI	Muskegon, MI.
Shiawassee, MI	Lansing, MI.
Tuscola, MI	Saginaw, MI.
Fillmore, MN	Rochester, MN.
Dade, MO	Springfield, MO.
Pearl River, MS	Biloxi-Gulfport, MS.
Caswell, NC	Burlington, NC.
Granville, NC	Durham, NC.
Harnett, NC	Raleigh, NC.
Lincoln, NC	Charlotte NC–SC.
Polk, NC	Spartanburg, NC.
Los Alamos, NM	Sante Fe, NM.
Lyon, NV	Carson City, NV.
Cayuga, NY	Syracuse, NY.
Columbia, NY	Albany, NY.
Genesee, NY	Rochester, NY.
Greene, NY	Albany, NY.
Schuyler, NY	Ithaca, NY.
Sullivan, NY	Poughkeepsie-Newburgh, NY.
Wyoming, NY	Buffalo, NY.
Ashtabula, OH	Cleveland, OH.
Champaign, OH	Springfield, OH.
Columbiana, OH	Youngstown, OH–PA.
Cotton, OK	Lawton, OK.
Linn, OR	Corvalis, OR.
Adams, PA	York, PA.
Clinton, PA	Williamsport, PA.
Greene, PA	Pittsburgh, PA.
Monroe, PA	New York-Newark, NY–NJ–CT.
Schuylkill, PA	Reading, PA.
Susquehanna, PA	Binghamton, NY–PA.

CHART 6.—COUNTIES REDESIGNATED AS URBAN UNDER SECTION 1886(D)(8)(B) OF THE ACT—Continued

[Based on CBSAs and Census 2000 Data]

Rural county	MSA.
Clarendon, SC	Sumter, SC.
Lee, SC	Sumter, SC.
Oconee, SC	Greenville, SC.
Union, SC	Spartanburg, SC.
Meigs, TN	Cleveland, TN.
Bosque, TX	Waco, TX.
Falls, TX	Waco, TX.
Fannin, TX	Dallas-Fort Worth-Arlington, TX.
Grimes, TX	College Station-Bryan, TX.
Harrison, TX	Longview, TX.
Henderson, TX	Dallas-Fort Worth-Arlington, TX.
Milam, TX	Austin, TX.
Van Zandt, TX	Dallas-Fort Worth-Arlington, TX.
Willacy, TX	Brownsville, TX.
Buckingham, VA	Charlottesville, VA.
Floyd, VA	Blacksburg, VA.
Middlesex, VA	Virginia Beach, VA.
Page, VA	Harrisonburg, VA.
Shenandoah, VA	Winchester, VA.
Island, WA	Seattle, WA.
Mason, WA	Olympia-Lacey, WA.
Wahkiakum, WA	Longview, WA–OR.
Jackson, WV	Charleston, WV.
Roane, WV	Charleston, WV.
Green, WI	Madison, WI.
Green Lake, WI	Fond du Lac, WI.
Jefferson, WI	Milwaukee, WI.
Walworth, WI	Chicago, IL–IN.

As in the past, hospitals redesignated under section 1886(d)(8)(B) of the Act are also eligible to be reclassified to a different area by the MGCRB. Affected hospitals should compare the reclassified wage index for the labor market area in Table 4C or 4D in the Addendum of this proposed rule into which they have been reclassified by the MGCRB to the wage index for the area to which they are redesignated under section 1886(d)(8)(B) of the Act. Hospitals may withdraw from an MGCRB reclassification within 45 days of the publication of this proposed rule.

When we apply the OMB 2000 CBSA standards, 16 rural counties no longer meet the qualifying criteria, either because they are now included in a metropolitan area (with the exception of Barry, MI and Cass, MI, most of the counties are now in the metropolitan area in which they were grouped in accordance with section 402) or they fail to meet the 25-percent cumulative out-migration threshold when we apply the new OMB standards. Counties that are now identified as metropolitan are:

Chilton, AL
Macoupin, IL
Piatt, IL
Brown, IN
Carroll, IN
Jefferson, KS
Barry, MI
Cass, MI
Ionia, MI
Hartnett, NC
Preble, PA

Counties that failed to meet the 25-percent threshold are: Marshall, AL; Putnam, FL; Wilson, NC; Van Wert, OH; and Lawrence, PA.

d. Reclassifications Under Section 508 of Public Law 108–173

Under section 508 of Public Law 108–173, a qualifying hospital may appeal the wage index classification otherwise applicable to the hospital and apply for reclassification to another area of the State in which the hospital is located (or, at the discretion of the Secretary, to an area within a contiguous State). Hospitals were required to submit their applications by February 15, 2004. We implemented this process through notices published in the **Federal Register** on January 6, 2004 (69 FR 661) and February 13, 2004 (69 FR 7340). Such reclassifications are applicable to discharges occurring during the 3-year period beginning April 1, 2004 and ending March 31, 2007. Under section 508(b), reclassifications under this process do not affect the wage index computation for any area or for any other hospital and cannot be effected in a budget neutral manner.

The applications submitted under this process were reviewed and decided upon by the MGCRB. The MGCRB issued notifications of its decisions on April 16, 2004. Reclassifications under this one-time appeal process interact with: FY 2005 MGCRB reclassification decisions under the ongoing reclassification process described in the regulations at §§ 412.230 through 412.280; the proposed implementation of the new MSA definitions; and the new redesignations under section 1886(d)(8)(B) of the Act.

In the notices implementing this process, we indicated that, with limited exceptions, hospitals eligible for reclassification under section 508 of Public Law 108–173 are not otherwise reclassified, effective for discharges on or after October 1, 2004. Therefore, aside from the exceptions specified in the notices, hospitals reclassified under this one-time appeal process are not otherwise reclassified by the MGCRB for FY 2005. For those hospitals that were exempted from this requirement and that were granted reclassification under this one-time appeal process, the reclassification under the one-time appeal process takes precedence over any other MGCRB reclassification. We show the reclassifications effective under the one-time appeal process in Table 9B, in the Addendum to this proposed rule.

With regard to the proposed implementation of the new MSAs, we are proposing to apply the reclassified

wage indexes on the basis of the new MSAs. Hospitals reclassified under the one-time appeal process may terminate their reclassifications that would otherwise be effective on or after October 1, 2004, under the normal termination and withdrawal process at § 412.273 (these reclassifications may not be terminated prior to October 1, 2004). Table 9B in the Addendum to this proposed rule shows the areas to which hospitals have been reclassified under the one-time appeal process. Therefore, similar to other hospitals reclassified by the MGCRB under the ongoing reclassification process for FY 2005, hospitals reclassified under the one-time appeal process should verify that the reclassified wage index for the labor market area into which they have been reclassified (in Table 4C or 4D in the Addendum to this proposed rule) exceeds the wage index of the labor market area where they are located (in Table 4A or 4B in the Addendum to this proposed rule) after our proposed implementation of the new MSAs. Affected hospitals may withdraw their one-time appeal process reclassifications within 45 days of the publication of this proposed rule.

As we have discussed above, in some cases, the new CBSA definitions result in the division of previously existing MSAs into two or more separate MSAs. (See the example in section III.H.3.b of this preamble.) In these situations, we are proposing to assign a hospital reclassified under the one-time appeal process to the nearest county in the current MSA, and the hospital's FY 2005 reclassification would be to the new MSA (under the CBSA definitions) that includes that county to which it has been assigned. Hospitals reclassified under the one-time appeals process that have been assigned to a new MSA on this proposed basis are identified in Table 9B, column 7, in the Addendum of this proposed rule. We have determined the county to which a hospital is in closest proximity based on mapping data available to us at the time of the preparation of this proposed rule. Hospitals that disagree with our determination of the closest proximate county must submit a comment (as specified under the ''Comment Period'' and ''Addresses'' sections at the beginning of this proposed rule) indicating the basis for their disagreement. Changes to a hospital's MSA assignment on the basis of a hospital's disagreement will be announced in the final rule.

Similarly, hospitals reclassified under the section 508 one-time appeal process that are also in counties identified under the redesignation process in accordance with section 1886(d)(8)(B) of the Act should compare the wage index applicable to the area to which they were reclassified under section 508 with the wage index applicable to the area to which they are redesignated under section 1886(d)(8)(B) of the Act, if those areas are different. Again, affected hospitals may withdraw their one-time appeal process reclassifications within 45 days of the publication of this proposed rule.

e. Proposed Wage Index Adjustment Based on Commuting Patterns of Hospital Employees (Section 505 of Pub. L. 108–173)

[If you choose to comment on issues in this section, please include the caption ''Out-Migration of Hospital Employees'' at the beginning of your comment.]

Section 505 of Public Law 108–173 established new section 1886(d)(13) of the Act. The new section 1886(d)(13) requires that the Secretary establish a new process to make adjustments to the hospital wage index based on commuting patterns of hospital employees. The process provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county with a higher wage index. Such adjustments to the wage index are effective for 3 years beginning with discharges occurring on or after October 1, 2004. Adjustments under this provision are not subject to the budget neutrality requirements at section 1886(d)(3)(E) or section 1886(d)(8)(D) of the Act.

The Secretary is required to establish criteria to identify ''qualifying counties,'' and hospitals located in such qualifying counties are to receive an adjustment to their wage index. Section 1886(d)(13)(B)(i) of the Act directs the Secretary to establish a threshold percentage difference between the county's wage index and the weighted average of the wage indexes of the surrounding higher wage index area(s) to which hospital employees commute that must be met in order for the county to qualify. Section 1886(d)(13)(B)(ii) of the Act specifies that the Secretary is also to establish the minimum out-migration threshold in order to qualify, which may not be less than 10 percent. Section 1886(d)(13)(iii) of the Act requires that the average hourly wage for all hospitals in the county must be equal to or exceed the average hourly wage for all hospitals in the labor market area. Section 1886(d)(13)(E) of the Act indicates this process may be based on the process used by the MGCRB. This section also gives the Secretary the authority to require hospitals to submit data necessary to implement this provision, or to use other data sources as available.

Hospitals located in counties that qualify for the payment adjustment are to receive an increase in the wage index that is equal to a weighted average of the differences between the wage indexes of the MSA(s) with higher wage indexes and the wage index of the resident county, weighted by the overall percentage of hospital workers residing in the qualifying county who are employed in any MSA with a higher wage index. As discussed below, we have employed the prereclassified wage indexes in making these calculations. The wage index increase is effective for 3 years, unless a hospital requests to waive the application of the payment adjustment. Hospitals that receive this payment adjustment are not eligible for reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act.

(1) Data

To implement this provision, we analyzed commuting data compiled by the U.S. Census Bureau. The data derive from a special tabulation of Census 2000 journey-to-work data, compiled from responses to the long-form (sample) census survey questions on where people worked. When the Census conducts its decennial survey, each household receives either a short form or a long form. On average, about 1 in every 6 households receive the long form. The results from the long form are used to formulate descriptive population estimates. Thus, the data set is based on the Census 2000 sample and represents estimates of the actual figures that would be obtained from a complete count.

The data provide information about commuting patterns of workers at the county level for residents of the 50 States and the District of Columbia. Each record within the dataset represents a combination of a particular resident county, a workplace county, and a particular industry category. Thus, the record shows the county-of-residence by county-of-work commuter flows. The resident county represents the county where the worker resides, while the workplace county represents the county where the worker works. The industry category associated with workers is based on the 108 Industrial Structure codes developed by the Bureau of Economic Analysis. These Industrial Structure codes break down economic activities by defining industries (such as ''fabricated metal product manufacturing,'' ''legal services,'' and ''gasoline stations''). We

limited the data set to those employees working in the category designated ''hospitals'' (BEA code 622000).

Using these data, we are able to identify the total number of hospital workers who live in each county and the number of workers within that county who commute to hospitals in other counties. For example, the data can be used to determine that, from a sample of 100 hospital employees who live in County A, 50 commute to work at hospitals within County A, 20 commute to work at hospitals within County B, and 30 commute to work at hospitals within County C.

There are some intrinsic limitations to the data. The file shows the weighted worker estimate for flows using a threshold or minimum size of 50 unweighted worker (from all industry codes) records. This means that only county-to-county flows that are comprised of at least 50 unweighted worker records are shown in this file. The Census Bureau omitted all other county-to-county flows from the file for confidentiality reasons. While this could eliminate the workflows of some hospital residents, we believe the eliminations would not have a major impact on the policy.

When Census calculated this special tabulation, the estimates of workers numbering from 1 through 7 have been rounded to 4. Values of 8 or greater have been rounded to the nearest multiple of 5, unless the estimate already ended in 5 or 0, in which case it was not changed. In addition, in this special tabulation, workers are defined as people 16 years and older who were employed and at work during the Census long form reference week. This is the week prior to when the questionnaire was filled out, which was the last week of March 2000 for most people.

In addition, because these data derive from the decennial census, the data file will not change until the census is taken again in 2010. This does not mean that the list of qualifying counties will not change from year to year. The out-migration percentage for each county is a function both of the commuting data and changes in the wage index values. Because the wage indices associated with each work and resident county change each year, a county's out-migration percentages can still vary each year because a higher wage index area in one year, might not be a higher wage index area in the next year. For example, if 100 hospital employees living in County A (wage index 1.00 in FY 2004) commute to County B (wage index 1.10 in FY 2004), then County B would be a higher wage index area for 2004. If in FY 2005, County A's wage index increases to 1.02 and County B's wage index decreases to 1.01, those 100 workers commuting from County A to County B will not be commuting to a higher wage index area for 2005. Consequentially, County A's out-migration percentage would decrease from 100 percent in 2004 to 0 percent in 2005. These normal changes in wage index values could also result in a county not deemed a qualifying county for FY 2005, becoming a qualifying county in FY 2006 or later.

We believe these data provide a useable data source to implement this provision. However, we welcome and encourage comments on the availability and value of alternative data sources. Although the statute authorizes the Secretary to require all hospitals to submit data on the commuting patterns of their employees, such a requirement would be a major undertaking for the hospital industry and CMS. It was not possible to pursue this approach in time to implement the provision by FY 2005. However, in addition to welcoming comments on the merits of relying on the Census data, we welcome comments on the feasibility of surveying hospitals on the residence and commuting patterns of all their hospital employees for purposes of developing future year adjustments.

(2) Qualifying Counties

As noted previously, section 1886(d)(13)(B)(iii) of the Act requires that, to qualify for this commuting wage index adjustment, the average hourly wage for all hospitals in the county must be equal to or exceed the average hourly wage for all hospitals in the labor market area in which the county is located. To determine which counties meet this requirement, we calculated the average of hospitals' 3-year average hourly wages for all hospitals in a given county. We compared this county average 3-year average hourly wage to the 3-year average hourly wage for the labor market area where the county is located. We chose to use the 3-year average hourly wage because we believe it provides a more accurate and stable estimate for the wages paid by a given hospital over a period of time. This statutory requirement limits the number of eligible counties, as counties with a 3-year average hourly wage less than the 3-year average hourly wage of the MSA where the county is located were not considered to meet this requirement.

Some resident counties do not have average hourly wages because either there is no hospital located in the county, or the only hospital in the county is new and has not yet submitted wage data. We did not consider these counties to have met the average hourly wage criteria and thus hospitals in these counties are not yet eligible to receive an increase in wage index. This is consistent with our regulations at 42 CFR 412.230(e)(2)(iii), which require a new hospital to accumulate at least 1 year of wage data, before it is eligible to apply for reclassification.

As noted previously, section 1886(d)(13)(B)(ii) of the Act specifies that the Secretary is to establish the minimum out-migration threshold in order to qualify, which may not be less than 10 percent. To determine the out-migration percentage for each county, we identified higher wage index areas, by comparing 2005 prereclassified wage index of a resident county with the 2005 prereclassified wage index of the MSA or rural statewide area where the work county is located. We use the prereclassified wage index so that hospitals in the county are not disadvantaged by reclassification of other hospitals into the county.

Once we limited the dataset to those county-to-county flows where hospital employees were commuting to a higher wage index area, we calculated the out-migration percentage for resident counties. To calculate the out-migration percentage, we calculated the total number of hospital employees in a resident county who were commuting to a higher wage area as a percentage of the total number of hospital employees residing in the resident county. For example, there are 100 hospital employees who live in County A (wage index 1.0). Of those 100 employees, 50 commute to County B (wage index 1.10), 20 commute to County C (wage index 1.05), and 30 work within County A. Because 70 out of 100 people commute to higher wage areas (assuming County C also qualifies as a higher wage area), County A's out-migration percentage is equal to 70 percent.

To implement section 1886(d)(13)(B)(ii) of the Act, we are proposing that the out-migration threshold to qualify for this adjustment would be the statutory minimum of 10 percent. We believe that this threshold provides an opportunity for a reasonable number of hospitals that would not have recourse to the normal reclassification process to receive an appropriate adjustment to their wage index. We welcome comments on this proposed threshold.

As noted previously, section 1886(d)(13)(B)(i) of the Act directs the Secretary to establish a threshold percentage difference between the county's wage index and the weighted average wage indexes of the higher wage index areas to which hospital

employees commute. However, unlike the threshold for the level of out-migration, the statute does not designate a minimum level for this threshold. Because of the nature of the adjustment provided under this provision, we are proposing to establish that the minimum difference in the wage indexes between the resident county and the work county can be any percentage greater than zero. We are proposing this threshold because the wage index increment for hospitals in qualifying counties under the statutory formula is a function of the differences between that county's wage index and the wage indices of the areas into which resident hospital workers of that county are commuting. In those cases where that difference is very small, the adjustment to the wage index will also be very small. (*See* the discussion of the statutory formula in section III.H.3.e.(3) of this preamble.) Therefore, we believe that a threshold of anything greater than zero is justifiable and consistent with the purposes of this provision.

Our analysis indicates that 224 counties qualify under these proposed criteria. There are 411 hospitals located in these qualifying counties. Hospitals located in qualifying counties are identified in Table 4J in the Addendum to this proposed rule.

(3) The Adjustment

Hospitals located in the qualifying counties identified in Table 4J in the Addendum to this proposed rule that have not already been reclassified for purposes of the wage index would receive the wage index adjustment listed in the table. This increase is equal to the percentage of the hospital employees residing in the qualifying county who are employed in any higher wage area, multiplied by the sum of: the products, for each higher wage index area, of the difference between the wage index for such higher wage index area and the wage index of the qualifying county, and the percentage of hospital employees residing in the qualifying county who are employed in any higher wage index area who are employed in such higher wage index area. This increase in wage index is depicted using the following equation:

$$\text{Adjustment} = A * \Sigma[(B - C) * (D/E)]$$

A is the percentage of hospital employees residing in a qualifying county who are employed in any higher wage index area. B represents the wage index of the higher wage index area. C represents the wage index of the qualifying resident county. D represents the number of hospital employees residing in the qualifying county involved who are employed in such higher wage index area. E represents the total number of hospital employees residing in qualifying county who are employed in any higher wage index area.

For example, County A is identified as a qualifying county. As illustrated before, if 100 hospital employees live in County A (wage index = 1.00), 50 commute to County B (wage index = 1.10), 20 commute to County C (wage index = 1.05); and 30 commute within County A, the out-migration percentage is equal to 70 percent.

The adjustment for hospitals in County A would be:

$$= .70 * (((1.10 - 1.00)*(50/70)) + ((1.05 - 1.00)*(20/70)))$$
$$= .70 * ((.10 * .714) + (.05 * .285))$$
$$= .70 * (0.0714 + 0.01428)$$
$$= .70 * (0.0856)$$
$$= 0.05998$$

So, hospitals in County A could receive a new wage index of 1.05998, instead of 1.000.

The proposed adjustments calculated for qualifying hospitals are listed in Table 4J in the Addendum to this proposed rule. These proposed adjustments are effective for each county for a period of 3 fiscal years beginning with discharges occurring on or after October 1, 2004. The commuting adjustments for each county will remain static for the 3-year period, after which the county's status as a qualifying county and the adjustment will be recalculated.

(4) Automatic Adjustments

Section 1886(d)(13)(A) of the Act allows the Secretary to establish the process for receiving this increase in wage index through application or otherwise. Listed in Table 4J in the Addendum to this proposed rule are the counties and corresponding hospitals that qualify for an increase in wage index through our proposed implementation of the section. We are proposing that all hospitals located in qualifying counties will automatically receive the increase in wage index, unless the hospital has already been reclassified to another geographic area for purposes of the wage index amount (including reclassifications under section 508 of Pub. L. 108–173). This commuting wage index adjustment will be effective for the county for a period of 3 fiscal years, FY 2005 through FY 2007. As discussed previously, yearly changes in the wage indices associated with areas could result in changes in the out-migration percentage for a given county. Irrespective of these changes, a county will not lose its status as a qualifying county due to wage index changes during the 3-year period, and counties will receive the same wage index increase for those 3 years. However, a county that qualifies in FY 2005 may no longer qualify in FY 2008, or it may qualify but receive a different adjustment level.

We encourage comments on the automatic application of such a wage index adjustment, and whether an application process should be developed under which individual hospitals would have to apply in order to receive the adjustment. We note that, given the short timeframe before implementation of this provision on October 1, 2004, we believe that there is no practical alternative to providing for an automatic adjustment for FY 2005. However, one possibility is to employ an automatic adjustment process this year, and to replace the automatic process with an application process for future years. We invite comments on whether to establish the automatic process permanently, or to devise an application process for future years. We also invite comments on whether any application process should be the responsibility of the MGCRB or some other entity.

Hospitals receiving this wage index increase under section 1886(d)(13)(F) of the Act are not eligible for reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act. As previously noted, the wage index increase is effective for 3 years, unless a hospital elects to waive the application of the wage index adjustment. Hospitals that wish to waive the application of this wage index adjustment must notify CMS within 45 days of the publication of this proposed rule. Waiver notifications should be sent to the following address: Centers for Medicare & Medicaid Services, Center for Medicare Management, Attention: Wage Index Adjustment Waivers, Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850. However, consistent with § 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of this proposed rule in the **Federal Register**. Hospitals that have been reclassified by the MGCRB (including reclassifications under section 508 of the MMA) may terminate an existing 3-year reclassification within 45 days of the publication of this proposed rule in order to receive the wage index adjustment under this provision. Hospitals that are eligible for this adjustment and that withdraw their application for reclassification will then

automatically receive the wage index adjustment listed in Table 4J in the Addendum of this proposed rule. The request for withdrawal of an application for reclassification or termination of an existing 3-year reclassification that would be effective in FY 2005 must be received by the MGCRB within 45 days of the publication of this proposed rule. Hospitals should carefully review the wage index adjustment that they would receive under this provision (as listed in Table 2 in the Addendum to this proposed rule) in comparison with the wage index that they would receive under MGCRB reclassification (Table 9 in the Addendum to this proposed rule).

4. Proposed FY 2005 Reclassifications

The proposed wage index values for FY 2005 (except those for hospitals receiving wage index adjustments under section 505 of Pub. L. 108–173) are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this proposed rule. Hospitals that are redesignated will be required to use the wage index values shown in Table 4C. Areas in Table 4C may have more than one wage index value because the wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located. Therefore, those areas with more than one wage index shown have hospitals from more than one State reclassified into them, and the rural wage index for a State in which at least one hospital is physically located is higher than the wage index for the area to which the hospital is reclassified.

Tables 3A and 3B in the Addendum to this proposed rule list the 3-year average hourly wage for each labor market area before the redesignation of hospitals, based on FYs 1999, 2000, and 2001 cost reporting periods. Table 3A lists these data for urban areas and Table 3B lists these data for rural areas. In addition, Table 2 in the Addendum to this proposed rule includes the adjusted average hourly wage for each hospital from the FY 1999 and FY 2000 cost reporting periods, as well as the FY 2001 period used to calculate the proposed FY 2005 wage index. The 3-year averages are calculated by dividing the sum of the dollars (adjusted to a common reporting period using the method described previously) across all 3 years, by the sum of the hours. If a hospital is missing data for any of the previous years, its average hourly wage for the 3-year period is calculated based on the data available during that period.

At the time this proposed wage index was constructed, the MGCRB had completed its review of FY 2005 reclassification requests. We are including in the Addendum of this proposed rule Table 9A, which shows hospitals that have been reclassified under either section 1886(d)(8) or section 1886(d)(10)(D) of the Act. This table includes 400 hospitals reclassified for FY 2005 by the MGCRB (for wage index purposes), as well as hospitals that were reclassified for the wage index in either FY 2003 53 or FY 2004 102 and are, therefore, in either the second or third year of their 3-year reclassification. This table also includes hospitals located in urban areas that have been redesignated rural in accordance with section 1886(d)(8)(E) of the Act (17). In addition, it includes rural hospitals redesignated to urban areas under section 1886(d)(8)(B) of the Act for purposes of the wage index (98).

Under § 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of this proposed rule. The request for withdrawal of an application for reclassification or termination of an existing 3-year reclassification that would be effective in FY 2004 must be received by the MGCRB within 45 days of the publication of this proposed rule. If a hospital elects to withdraw its wage index application after the MGCRB has issued its decision but prior to the above date, it may later cancel its withdrawal in a subsequent year and request the MGCRB to reinstate its wage index reclassification for the remaining fiscal year(s) of the 3-year period (§ 412.273(b)(2)(i)). The request to cancel a prior withdrawal must be made in writing to the MGCRB no later than the deadline for submitting reclassification applications for the following fiscal year (§ 412.273(d)). For further information about withdrawing, terminating, or canceling a previous withdrawal or termination of a 3-year reclassification for wage index purposes, we refer the reader to § 412.273, as well as the August 1, 2002 IPPS final rule (67 FR 50065) and the August 1, 2001 IPPS final rule (66 FR 39887).

Any changes to the wage index that result from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process will be incorporated into the wage index values published in the final rule following this proposed rule. Therefore, the final wage indexes will likely be different from those published in this proposed rule, and in some cases, they may be quite different.

Although, as described above, the statute provides that a reclassified rural hospital may not have a lower wage index after reclassification than before, there is not similar protection for urban hospitals. Therefore, hospitals should carefully evaluate the impacts of their reclassifications prior to the deadline for withdrawing from an approved reclassification.

Applications for FY 2006 reclassifications are due to the MGCRB by September 1, 2004. We note that this is also the deadline for canceling a previous wage index reclassification withdrawal or termination under § 412.273(d). Applications and other information about MCGRB reclassifications may be obtained, beginning in mid-July 2004, via the CMS Internet Web site at: *http://cms.hhs.gov/providers/prrb/mgcinfo.asp,* or by calling the MCGRB at (410) 786–1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670.

I. Process for Requests for Wage Index Data Corrections

[If you choose to comment on issues in this section, please include the caption ''Wage Data Corrections'' at the beginning of your comment.]

1. Worksheet S–3 Wage Data

In the August 1, 2003 final rule (68 FR 27194), we revised the process and timetable for application for development of the wage index, beginning with the FY 2005 wage index. The preliminary and unaudited Worksheet S–3 wage data file was made available on October 8, 2003 through the Internet on CMS's Web site at: *http://cms.hhs.gov/providers/hipps/ippswage.asp.* In a memorandum dated October 10, 2003, we instructed all Medicare fiscal intermediaries to inform the IPPS hospitals they service of the availability of the wage data file and the process and timeframe for requesting revisions (including the specific deadlines listed below). We also instructed the fiscal intermediaries to advise hospitals that these data are also made available directly through their representative hospital organizations.

If a hospital wished to request a change to its data as shown in that wage data file, the hospital was to submit corrections along with complete, detailed supporting documentation to its intermediary by November 24, 2003. Hospitals were notified of this deadline and of all other possible deadlines and requirements, including the requirement to review and verify their data as posted on the preliminary wage data file on the Internet, through the October 10, 2003 memorandum referenced above.

The fiscal intermediaries notified the hospitals in early February of any changes to the wage data as a result of the desk reviews and the resolution of the hospitals' early November change requests. The fiscal intermediaries also submitted the revised data to CMS in early February. CMS published the proposed wage index public use file that included hospitals' revised wage data on February 27, 2004. In a memorandum also dated March 1, 2004, we instructed fiscal intermediaries to notify all hospitals regarding the availability of the proposed wage index public use file and the criteria and process for requesting corrections and revisions to the wage data. Hospitals had until March 12, 2004 to submit requests to the fiscal intermediaries for reconsideration of adjustments made by the fiscal intermediaries as a result of the desk review, and to correct errors due to CMS's or the intermediary's mishandling of the wage data. Hospitals were also required to submit sufficient documentation to support their requests.

After reviewing requested changes submitted by hospitals, fiscal intermediaries are to submit additional revisions resulting from the hospitals' reconsideration requests by April 16, 2004. The deadline for hospitals to request CMS intervention in cases where the hospital disagrees with the fiscal intermediary's policy interpretations is April 23, 2004.

Hospitals should also examine Table 2 in the Addendum to this proposed rule. Table 2 contains each hospital's adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 2001 data used to construct the proposed FY 2005 wage index. We note that the hospital average hourly wages shown in Table 2 only reflect changes made to a hospital's data and transmitted to CMS by March 15, 2004.

We will release a final wage data file in early May to hospital associations and the public on the Internet at *http://www.cms.hhs.gov/providers/hipps/ippswage.asp.* The May 2004 public use file will be made available solely for the limited purpose of identifying any potential errors made by CMS or the fiscal intermediary in the entry of the final wage data that result from the correction process described above (revisions submitted to CMS by the fiscal intermediaries by April 16, 2004). If, after reviewing the May 2004 final file, a hospital believes that its wage data are incorrect due to a fiscal intermediary or CMS error in the entry or tabulation of the final wage data, it should send a letter to both its fiscal intermediary and CMS that outlines why the hospital believes an error exists and provide all supporting information, including relevant dates (for example, when it first became aware of the error).

CMS and the fiscal intermediaries must receive these requests no later than June 11, 2004. Requests mailed to CMS should be sent to: Centers for Medicare & Medicaid Services, Center for Medicare Management, Attention: Wage Index Team, Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850. Each request also must be sent to the hospital's fiscal intermediary. The intermediary will review requests upon receipt and contact CMS immediately to discuss its findings.

At this point in the process, that is, after the release of the May 2004 wage index file, changes to the hospital wage data will only be made in those very limited situations involving an error by the intermediary or CMS that the hospital could not have known about before its review of the final wage data file. Specifically, neither the intermediary nor CMS will approve the following types of requests:

- Requests for wage data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries on or before April 16, 2004.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the March 1, 2004 wage data file (or the March 8 occupational mix data; see section III.H.2. of this preamble).
- Requests to revisit factual determinations or policy interpretations made by the intermediary or CMS during the wage index data correction process.

2. Occupational Mix Data

The process and criteria for requesting corrections to the occupational mix survey data are described in section III.C.1 of this preamble. As stated in that section, from April 16, 2004 forward, the process for correcting the final occupational mix survey data is the same, and on the same schedule, as described above for correcting the final Worksheet S–3 wage data.

3. All FY 2005 Wage Index Data

Verified corrections to the wage index received timely (that is, by June 11, 2004) will be incorporated into the final wage index in the final rule to be published by August 1, 2004, and to be effective October 1, 2004.

We created the processes described above to resolve all substantive wage index data correction disputes before we finalize the wage and occupational mix data for the FY 2005 payment rates. Accordingly, hospitals that did not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage data corrections or to dispute the intermediary's decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth above will not be permitted to challenge later, before the Provider Reimbursement Review Board, the failure of CMS to make a requested data revision (*See W. A. Foote Memorial Hospital* v. *Shalala,* No. 99–CV–75202–DT (E.D. Mich. 2001), also *Palisades General Hospital* v. *Thompson,* No. 99–1230 (D.D.C. 2003)).

Again, we believe the wage index data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage data to the fiscal intermediaries' attention. Moreover, because hospitals will have access to the final wage index data by early May 2004, they will have the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or CMS before the development and publication of the FY 2005 wage index by August 1, 2004, and the implementation of the FY 2005 wage index on October 1, 2004. If hospitals avail themselves of this opportunity, the wage index implemented on October 1 should be accurate. Nevertheless, in the event that errors are identified after that date, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.63(x)(2) of our existing regulations, we make midyear corrections to the wage index for an area only if a hospital can show: (1) That the intermediary or CMS made an error in tabulating its data; and (2) that the requesting hospital could not have known about the error or did not have an opportunity to correct the error, before the beginning of FY 2005 (that is, by the June 11, 2004 deadline). This provision is not available to a hospital seeking to revise another hospital's data that may be affecting the requesting hospital's wage index. As described earlier, the requesting hospital must show that it could not have known about the error, or that it did not have the opportunity to correct the error, before the publication of the FY 2005 wage index. As indicated earlier, since a hospital will have the opportunity to verify its data, and the fiscal intermediary will notify the hospital of any changes, we do not expect that midyear corrections will be necessary. However, if the correction of a data error

changes the wage index value for an area, the revised wage index value will be effective prospectively from the date the correction is approved.

J. Proposed Revision of the Labor-Related Share of the Wage Index

[If you choose to comment on issues in this section, please include the caption ''Labor-Related Share'' at the beginning of your comment.]

Section 1886(d)(3)(E) of the Act directs the Secretary to adjust the proportion of the national prospective payment system base payment rates that are attributable to wages and wage-related costs by a factor that reflects the relative differences in labor costs among geographic areas. It also directs the Secretary to estimate from time to time the proportion of hospital costs that are labor-related: ''The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs of the DRG prospective payment rates. * * *'' The portion of hospital costs attributable to wages and wage-related costs is referred to as the labor-related share. The labor-related share of the prospective payment rate is adjusted by an index of relative labor costs, which is referred to as the wage index. In the past, we have defined the labor-related share for prospective payment acute care hospitals as the national average proportion of operating costs that are related to, influenced by, or vary with the local labor market. The labor-related share for the acute care hospital inpatient prospective payment system has been calculated as the sum of the weights for wages and salaries, fringe benefits, nonmedical professional fees, contract labor, postage, and labor-intensive services.

In its June 2001 Report to Congress, MedPAC recommended that the Secretary ''should reevaluate current assumptions about the proportion of providers'' costs that reflect resources purchased in local and national markets.'' (Report to the Congress: Medicare in Rural America, Recommendation 4D, page 80.) MedPAC recommended that the labor-related share include the weights for wages and salaries, fringe benefits, contract labor, and other labor-related costs for locally purchased inputs only. MedPAC noted that this would likely result in a lower labor share, which would decrease the amount of the national base payment amount adjusted by the wage index. As a result, hospitals located in low-wage markets (those with a wages index less than 1.0) would receive higher payments, while those located in high-wage labor markets would receive lower payments.

In our proposed and final regulations updating the IPPS for FY 2003 (67 FR 31404, May 9, 2002 and 67 FR 49982, August 1, 2002), we discussed the methodology that we have used to determine the labor-related share. We noted that, at that time, the results of employing that methodology suggested that an increase in the labor-related share (from 71.066 percent to 72.495 percent) was warranted. However, we decided not to propose such an increase in the labor-related share until we conducted further research to determine whether a different methodology for determining the labor-related share should be adopted. The labor-related share has thus remained 71.066 percent.

Section 403 of Pub. L. 108–173 amended sections 1886(d)(3)(E) of the Act to provide that the Secretary must employ 62 percent as the labor-related share unless this ''would result in lower payments than would otherwise be made.'' However, this provision of Pub. L. 108–173 did not the change the legal requirement that the Secretary estimate ''from time to time'' the proportion of hospitals'' costs that are ''attributable to wages and wage-related costs.'' In fact, section 404 of Pub. L. 108–173 requires the Secretary to develop a frequency for revising the weights used in the hospital market basket, including the labor share, to reflect the most current data more frequently than once every 5 years. This reflects Congressional intent that hospitals will receive payment based on a 62-percent labor share, or the labor share estimated from time to time by the Secretary, whichever is higher.

Section 404 further requires us to include in the final IPPS rule for FY 2006 an explanation of the reasons for, and options considered, in determining the frequency for revising the weights used in the hospital market basket, including the labor share. In the meantime, we are also continuing our research into the assumptions employed in calculating the labor-related share. Our research involves analyzing the compensation share separately for urban and rural hospitals, using regression analysis to determine the proportion of costs influenced by the area wage index, and exploring alternative methodologies to determine whether all or only a portion of professional fees and nonlabor intensive services should be considered labor-related. We will present our analysis and conclusions regarding the frequency and methodology for updating the labor share in the proposed and final rules for FY 2006.

In section IV.F. of this preamble, we discuss our proposal to incorporate the requirements of section 403 of Pub. L. 108–173 in a new § 412.64(h) of the regulations.

As discussed above, the Secretary had determined, prior to the enactment of Pub. L. 108–173, that the labor-related share would be 71.066 percent. As a result, application of a 62-percent labor share would result in lower payments for any hospital with a wage index greater than 1.0. Therefore, we are modifying our payment system software for FY 2005 to apply wage indexes greater than 1.0 to 71.066 percent of the standardized amount, and to apply wage indexes less than or equal to 1.0 to 62 percent of the standardized amount.

IV. Other Decisions and Proposed Changes to the IPPS for Operating Costs and GME Costs

A. Postacute Care Transfer Payment Policy (§ 412.4)

[If you choose to comment on issues in this section, please include the caption ''Postacute Care Transfers'' at the beginning of your document.]

1. Background

Existing regulations at § 412.4(a) define discharges under the IPPS as situations in which a patient is formally released from an acute care hospital or dies in the hospital. Section 412.4(b) defines transfers from one acute care hospital to another, and § 412.4(c) defines transfers to certain postacute care providers. Our policy provides that, in transfer situations, full payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

The per diem rate paid to a transferring hospital is calculated by dividing the full DRG payment by the geometric mean length of stay for the DRG. Based on an analysis that showed that the first day of hospitalization is the most expensive (60 FR 45804), our policy provides for payment that is double the per diem amount for the first day (§ 412.4(f)(1)). Transfer cases are also eligible for outlier payments. The outlier threshold for transfer cases is equal to the fixed-loss outlier threshold for nontransfer cases, divided by the geometric mean length of stay for the DRG, multiplied by the length of stay for the case, plus one day.

Medicare adopted its IPPS transfer policy because, if the program were to pay the full DRG payment regardless of

whether a patient is transferred or discharged, there would be a strong incentive for hospitals to transfer patients to another IPPS hospital early in the patients' stay in order to minimize costs while still receiving the full DRG payment. The transfer policy adjusts the payments to approximate the reduced costs of transfer cases.

Previously, when a patient chose to depart from a hospital against the medical opinion of treating physicians, the case was treated as a left against medical advice (LAMA) discharge and coded as discharge status ''07-Left Against Medical Advice (LAMA)'' on the inpatient billing claim form. Because, by definition, LAMA discharges were assumed not to involve the active participation of the hospital administration, our policy had been to treat LAMA cases as discharges. This policy applied even if the patient was admitted to another hospital on the date of the LAMA discharge. Consequently, until FY 2004, we made a full DRG payment for any discharge coded as a LAMA case.

Last year, in response to an Office of Inspector General (OIG) report issued in March 2002 (A–06–99–00045), we became concerned that some hospitals were incorrectly coding transfers as LAMA cases. Therefore, in the August 1, 2003 final IPPS rule (68 FR 45405), we expanded our definition of a transfer under § 412.4(b) to include all patients who are admitted to another IPPS hospital on the same day that the patient is discharged from an IPPS hospital, unless the first (transferring) hospital can demonstrate that the patient's treatment was completed at the time of discharge from that hospital. In other words, unless the same-day readmission is to treat a condition that is unrelated to the condition treated during the original admission (for example, the beneficiary is in a car accident later that day), any situation where the beneficiary is admitted to another IPPS hospital on the same date that he or she is discharged from an IPPS hospital would be considered a transfer, even if the patient left against medical advice from the first hospital.

Hospitals are now allowed to report a patient as left against medical advice only if they have no knowledge that the patient has been admitted to another hospital on the same day. If a hospital later leans that a patient was admitted to another facility on the same day, the hospital must resubmit the claim and correctly code the patient as a ''transfer.'' This change prohibits payment of two claims for the same patient on the same day. Therefore, if a hospital believes a claim has been wrongly denied, the original discharging hospital must resubmit the claim with documentation that the discharge was appropriate and unrelated to the subsequent same-day admission.

2. Proposed Changes to DRGs Subject to the Postacute Care Transfer Policy (§§ 412.4(c) and (d))

Under section 1886(d)(5)(J) of the Act, a ''qualified discharge'' from one of 10 DRGs selected by the Secretary to a postacute care provider is treated as a transfer case beginning with discharges on or after October 1, 1998. This section required the Secretary to define and pay as transfers all cases assigned to one of 10 DRGs selected by the Secretary, if the individuals are discharged to one of the following postacute care settings:

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

In the July 31, 1998 IPPS final rule (63 FR 40975 through 40976), we specified the appropriate time period during which we would consider a discharge to postacute home health services to constitute a transfer as within 3 days after the date of discharge. In addition, in the July 31, 1998 final rule, we did not include in the definition of postacute care transfer cases patients transferred to a swing-bed for skilled nursing care (63 FR 40977).

Section 1886(d)(5)(J) of the Act directed the Secretary to select 10 DRGs based upon a high volume of discharges to postacute care and a disproportionate use of postacute care services. As discussed in the July 31, 1998 final rule, these 10 DRGs were selected in 1998 based on the MedPAR data from FY 1996. Using that information, we identified and selected the first 20 DRGs that had the largest proportion of discharges to postacute care (and at least 14,000 such transfer cases). In order to select 10 DRGs from the 20 DRGs on our list, we considered the volume and percentage of discharges to postacute care that occurred before the mean length of stay and whether the discharges occurring early in the stay were more likely to receive postacute care. We identified 10 DRGs to be subject to the postacute care transfer rule starting in FY 1999.

Section 1886(d)(5)(J)(iv) of the Act authorizes the Secretary to expand the postacute care transfer policy beyond 10 DRGs for FY 2001 or subsequent fiscal years. In the FY 2004 IPPS final rule (68 FR 45412), we expanded the postacute care transfer policy to include additional DRGs. We established the following criteria that a DRG must meet, for both of the 2 most recent years for which data are available, in order to be added to the postacute care transfer policy:

- At least 14,000 postacute care transfer cases;
- At least 10 percent of its postacute care transfers occurring before the geometric mean length of stay;
- A geometric mean length of stay of at least 3 days; and
- If a DRG is not already included in the policy, a decline in its geometric mean length of stay during the most recent 5 year period of at least 7 percent.

We identified 21 new DRGs that met these criteria. We also determined that one DRG from the original group of 10 DRGs (DRG 263) no longer met the volume criterion of 14,000 transfer cases. Therefore, we removed DRGs 263 and 264 (DRG 264 is paired with DRG 263) from the policy and the postacute care transfer policy to include payments for transfer cases in the new 21 DRGs, effective October 1, 2003. As a result, a total of 29 DRGs were subject to the postacute care transfer policy in FY 2004.

We indicated in last year's rule that we would review and update this list periodically to assess whether additional DRGs should be added or existing DRGs should be removed. We have analyzed the available data from the FY 2003 MedPAR file. For the 2 most recent years of available data (FY 2002 and FY 2003), we have found that no additional DRGs qualify under the four criteria set forth in the IPPS final rule for FY 2004. We have also analyzed the DRGs included under the policy for FY 2004 to determine if they still meet the criteria to remain under the policy. In addition, we have analyzed the special circumstances arising from a change to one of the DRGs included under the policy in FY 2004.

As discussed in section II.B.9. of this preamble, we are proposing to eliminate DRG 483. The cases that would have been placed into DRG 483 would now be split into two proposed new DRGs, 541 (Tracheostomy With Mechanical

Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses With Major O.R. Procedure) and 542 (Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses Without Major O.R. Procedure). This would be done by subdividing the cases in the existing DRG 483 based on the presence of a major O.R. procedure, in addition to the tracheotomy code that is currently required to be assigned to this DRG. Therefore, if the patient's case involves a major O.R. procedure (a procedure whose code is included on the list that is assigned to DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis), except for tracheostomy codes 31.21 and 31.29), the case would be assigned to the proposed new DRG 541. If the patient does not have an additional major O.R. procedure (that is, there is only a tracheotomy code assigned to the case), the case would be assigned to proposed new DRG 542.

Neither of the proposed new DRGs 541 and 542 would have enough cases to meet the first criterion for inclusion in the postacute care transfer policy. DRG 483 had 44,788 total cases with 15,520 transfer cases in FY 2002, and 44,618 total cases with 20,034 transfer cases in FY 2003. These cases would now split between proposed new DRG 541 (20,812 total cases) and proposed new DRG 542 (23,387 total cases). As a result, neither of these proposed new DRGs would meet the existing threshold of 14,000 transfer cases (6,779 projected transfer cases for proposed DRG 541, and 8,570 projected transfer cases for proposed DRG 542). Nevertheless, we believe the cases that would now be incorporated into these two proposed new DRGs remain appropriate candidates for application of the postacute care transfer policy. The proposed new DRGs 541 and 542 would contain the same cases that were included in existing DRG 483, which qualified for inclusion in the postacute care transfer policy. Furthermore, many of the cases in the proposed new DRGs 541 and 542 would continue to require postacute care.

When we analyzed the cases that we projected would fall into the two proposed new DRGs in the FY 2003 GROUPER Version 22.0, we found that a high proportion of cases in both the proposed new DRGs are projected to be transfer cases: 33 percent of all cases in proposed DRG 541, and 37 percent in proposed DRG 542. In addition, a high proportion of the transfer cases in these proposed new DRGs, based on the data from cases in DRG 483 in the FY 2003 MedPAR file, are projected to fall into the short-stay transfer category: 41 percent of transfer cases in proposed new DRG 541 and 42 percent of transfer cases in proposed new DRG 542 are projected to occur before the geometric mean length of stay for these proposed new DRGs. By contrast, among all DRGs, approximately 15 percent of transfer cases are short-stay transfer cases. The percentage of transfer cases that are short-stay cases that would be in both proposed new DRGs 541 and 542 would be more than 2 standard deviations above the mean percentage of short-stay cases across all DRGs. (Two standard deviations above the mean across all DRGs is 37 percent for FY 2005.) Therefore, we believe this proposed subdivision of DRG 483 should not change the original application of the postacute care transfer policy to the cases once included in that DRG. We do not believe that it is appropriate for these cases to fall outside the scope of this policy solely because of the proposed revision to the DRG structure that was driven by policy reasons unrelated to the postacute care transfer provision. The high proportion of transfer cases among all cases that would be assigned to these proposed new DRGs, along with the unusually high proportion of short-stay cases among those transfer cases, provide solid reasons for considering whether alternate criteria might better address the special circumstances that can arise from changes in DRGs unrelated to the postacute care transfer policy.

Therefore, we are proposing alternate criteria to be applied in cases where DRGs do not satisfy the existing criteria, for discharges occurring on or after October 1, 2004. These proposed new criteria are designed to address situations such as those posed by the proposed split of DRG 483, where there remain substantial grounds for inclusion of cases within the postacute care transfer policy, although one or more of the original criteria may no longer apply. Therefore, we are proposing to examine DRGs for inclusion within the policy against two sets of criteria, first, the original four criteria, and then, the proposed alternate set of criteria. DRGs that do not satisfy the first set of criteria would still be included if they satisfy the second set. Specifically, a DRG would still be subject to the postacute care transfer policy under the alternative set of criteria if, for the 2 most recent years for which data are available, there are at least 5,000 total transfers to postacute care among the cases included in the DRG, and if, among the cases included in the DRG, the percentage of transfer cases that are short-stay transfer cases is at least 2 standard deviations above the geometric mean length of stay across all DRGs (which is 37 percent for FY 2005). We would also continue to require a geometric mean length of stay of at least 3 days among the cases included in the DRG. Finally, we would require that, if a DRG is not already included in the policy, it either experienced a decline in its geometric mean length of stay during the most recent 5 year period of at least 7 percent or contains only cases that would have been included in a DRG to which the policy applied in the prior year.

Under these proposed alternate criteria, DRGs 430, 541, and 542 would qualify for inclusion in the postacute care transfer policy. DRG 430 meets the proposed threshold of 5,000 transfer cases in both of the 2 most recent years, with 11,973 transfer cases and 46 percent short-stay transfer cases in FY 2002, and 12,202 transfer cases and 38 percent short-stay transfers in FY 2003. In addition, DRG 430 experienced a 7-percent decline in length of stay from FY 2000 to FY 2004. DRG 430 also had a 5.8 day average length of stay during those years. As discussed above, the cases that would be included in proposed new DRGs 541 and 542 contain a sufficient number of transfers to meet the first alternate criterion, and among the cases that would be included in these DRGs, the percentages of transfer cases occurring before the geometric mean length of stay for these two proposed new DRGs exceed 2 standard deviations above the geometric mean length of stay for all DRGs. The average lengths of stay for the cases that would be included in proposed new DRGs 541 and 542 are 37.7 days and 28.9 days, respectively.

We are proposing to revise the regulations governing the postacute transfer policy to include the alternative criteria described above (§ 412.4(d)). We are also proposing that DRG 430 and proposed new DRGs 541 and 542 would be included in the postacute care transfer policy.

We would also like to call attention to the data concerning DRG 263, which was subject to the postacute care transfer policy until FY 2004. We removed DRG 263 from the postacute care transfer policy last year because it did not have the minimum number of cases (14,000) transferred to postacute care (13,588 transfer cases in FY 2002, with more than 50 percent of transfer cases being short-stay transfers). The FY 2003 MedPAR data show that there were 15,602 transfer cases in the DRG in FY 2003, of which 46 percent were short-stay transfers. Because we

removed the DRG from the postacute care transfer policy in FY 2004, it must meet all criteria to be included under the policy in subsequent fiscal years. Because the geometric mean length of stay for DRG 263 shows only a 6-percent decrease since 1999, DRG 263 does not qualify to be added to the policy for FY 2005 under the existing criterion that was included in last year's rule. However, DRG 263 would qualify under the volume threshold and percent of short-stay transfer cases under the proposed new alternate criteria in this proposed rule, but it still does not meet the proposed required decline in length of stay to qualify to be added to the policy in FY 2005.

The table below displays the 31 DRGs that we are proposing to include in the postacute care transfer policy, effective for discharges occurring on or after October 1, 2004. These 31 DRGs include the effects of dropping DRG 483, which we are proposing to delete from the DRG list, and adding the two proposed new DRGs 541 and 542 that would now incorporate the cases formerly assigned to DRG 483. They also include the proposed addition of DRG 430 to the list. These DRGs meet the criteria specified above during both of the 2 most recent years available prior to the publication of the FY 2005 IPPS proposed rule (FYs 2002 and 2003), as well as their paired-DRG if one of the DRGs meeting the criteria includes a CC/no-CC split.

DRG	DRG title.
12	Degenerative Nervous System Disorders.
14	Intracranial Hemorrhage and Stroke with Infarction.
24	Seizure and Headache Age > 17 With CC.
25	Seizure and Headache Age > 17 Without CC.
88	Chronic Obstructive Pulmonary Disease.
89	Simple Pneumonia and Pleurisy Age > 17 With CC.
90	Simple Pneumonia and Pleurisy Age > 17 Without CC.
113	Amputation for Circulatory System Disorders Except Upper Limb and Toe.
121	Circulatory Disorders With AMI and Major Complication, Discharged Alive.
122	Circulatory Disorders With AMI Without Major Complications Discharged Alive.
127	Heart Failure & Shock.
130	Peripheral Vascular Disorders With CC.
131	Peripheral Vascular Disorders Without CC.
209	Major Joint and Limb Reattachment Procedures of Lower Extremity.
210	Hip and Femur Procedures Except Major Joint Age > 17 With CC.
211	Hip and Femur Procedures Except Major Joint Age > 17 Without CC.
236	Fractures of Hip and Pelvis.
239	Pathological Fractures and Musculoskeletal and Connective Tissue Malignancy.
277	Cellulitis Age > 17 With CC.
278	Cellulitis Age > 17 Without CC.
294	Diabetes Age > 35.
296	Nutritional and Miscellaneous Metabolic Disorders Age > 17 With CC.
297	Nutritional and Miscellaneous Metabolic Disorders Age > 17 Without CC.
320	Kidney and Urinary Tract Infections Age > 17 With CC.
321	Kidney and Urinary Tract Infections Age > 17 Without CC.
395	Red Blood Cell Disorders Age > 17.
429	Organic Disturbances and Mental Retardation.
430	Psychoses.
468	Extensive O.R. Procedure Unrelated to Principal Diagnosis.
Proposed 541	Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses With Major O.R. Procedure.
Proposed 542	Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses Without Major O.R. Procedure.

Section 1886(d)(5)(J)(i) of the Act recognizes that, in some cases, a substantial portion of the costs of care is incurred in the early days of the inpatient stay. Similar to the policy for transfers between two acute care hospitals, the transferring hospital in a postacute care transfer receives twice the per diem rate for the first day of treatment and the per diem rate for each following day of the stay before the transfer, up to the full DRG payment. However, three of the DRGs subject to the postacute care transfer policy exhibit a disproportionate share of costs very early in the hospital stay in postacute care transfer situations. For these DRGs, hospitals receive 50 percent of the full DRG payment plus the single per diem (rather than double the per diem) for the first day of the stay and 50 percent of the per diem for the remaining days of the stay, up to the full DRG payment.

In previous years, we determined that DRGs 209 and 211 met this cost threshold and qualified to receive this special payment methodology. Because DRG 210 is paired with DRG 211, we include payment for cases in that DRG for the same reason we include paired DRGs in the postacute care transfer policy (to eliminate any incentive to code incorrectly in order to receive higher payment for those cases). The FY 2003 MedPAR data show that DRGs 209 and 211 continue to have charges on the first day of the stay that are higher than 50 percent of the average charges in the DRGs. Therefore, we are proposing to continue the special payment methodology for DRGs 209, 210, and 211 for FY 2005.

B. Payments for Inpatient Care in Providers That Change Classification Status During a Patient Stay (§§ 412.2(b)(3) and 412.521(e))

[If you choose to comment on issues in this section, please include the caption ''Crossover Patients'' at the beginning of your document.]

Different Medicare payment systems apply to care furnished to Medicare beneficiaries during inpatient stays, depending on the classification status of the provider. For example, payments made to an acute care hospital for inpatient services are made under the IPPS on a per discharge basis, using a

DRG classification system. Payments to LTCHs that are classified under section 1886(d)(1)(B)(iv)(I) and (II) of the Act are made under the LTCH PPS on a per discharge basis, using a LTC–DRG classification system. The main difference between a LTCH that is classified under section 1886(d)(1)(B)(iv)(I) of the Act and an acute care hospital is the average length of stay at the hospital. Specifically, section 1886(d)(1)(B)(iv)(I) hospitals must have a greater than 25 day average Medicare inpatient length of stay. (section 1886(d)(1)(B)(iv)(II) hospitals, among other requirements, must have a greater than 20 day Medicare and non-Medicare inpatient length of stay to qualify as LTCHs.) Situations occur in hospital inpatient care settings in which a Medicare provider changes its Medicare payment classification status during a patient's stay, for example, an acute care hospital changes to a LTCH. (We refer to the patients in these situations as ''crossover patients.'')

Questions have arisen as to how Medicare should pay for an inpatient stay in a hospital when the hospital changes its classification status during the course of the beneficiary's single hospital stay. Specifically, how should Medicare pay for an inpatient stay when a patient is in an acute care hospital and the acute care hospital changes to a LTCH during the beneficiary's hospitalization. In other words, how does Medicare pay for the first part of the stay that occurs before the change in classification status and how does Medicare pay for the part of the stay that occurs after the change in classification status. Although the situation may occur in other settings, this payment issue is most prevalent for services furnished to crossover patients in a newly established LTCH. This is because all new LTCHs begin as other provider types, generally as acute care hospitals, and generally after at least 5 months of experience showing an average length of stay in excess of 25 days, and are then paid as LTCHs. Therefore, as explained further below, we are currently addressing this problem in the context of crossover patients discharged from LTCHs.

To address payment for inpatient care for such crossover patients, we had issued instructions for hospital billing purposes (paper-based manual, Hospital Manual, HCFA Pub. 10, section 404, which has been replaced by the Medicare Claims Processing Manual, Pub. 100–4, Chapter 3, section 100.4.1) that were in effect prior to the implementation of the PPS for LTCHs (that is, prior to October 1, 2002). The manual instructed hospitals as follows: ''The hospital must submit a discharge bill with the old provider number and an admission notice with the new provider number. The date of discharge and the date of admission are the same date, which is the first day of the new fiscal period. All subsequent billings are submitted under the new provider number.''

It is important to note that at the time this manual provision was written, IPPS-excluded hospitals, including LTCHs, were reimbursed under the reasonable cost-based (TEFRA) payment system, not under other PPSs that pay on a per discharge basis. Thus, under the manual instructions, if a patient was in an acute care hospital and the hospital converted to a LTCH during the patient's stay, Medicare would then make payment for what was, in reality, only one episode of care as if it were two episodes. Specifically, the days of the stay while the facility was certified as an acute care hospital generate a full DRG payment under the IPPS; and the services provided from the time the facility was certified as a LTCH were reimbursed under the reasonable cost-based payment system. We are proposing to revisit the issue of Medicare payment for crossover patients now that there has been a fundamental change in the Medicare payment system for LTCHs. LTCHs are now paid under the discharge-based LTCH PPS which was effective for LTCHs for cost reporting periods beginning on or after October 1, 2002.

Under the LTCH PPS for crossover patients, under the existing manual instructions, Medicare makes a full DRG payment under the IPPS to the acute care hospital for the ''first portion'' of the inpatient stay, and when the acute care hospital converts to an LTCH, Medicare makes a second PPS payment under the LTCH PPS for the ''second portion'' of the stay. We believe that this results in excessive Medicare payments and results in the inappropriate use of the Medicare Trust Fund. We believe the results described above are contrary to a basic premise of a PPS, which is that a single discharge-based PPS payment is adequate and appropriate reimbursement for the entire bundle of services that a hospital provides during the course of a patient's stay. We believe the care provided prior to and after the conversion to a LTCH is really one bundle of services provided during a single hospitalization. The ''discharge'' from the acute care hospital and ''admission'' to the LTCH has only been a ''paper discharge'' that was triggered solely by a change in the Medicare payment classification of the hospital treating the inpatient. In the instant case, the beneficiary, by mere coincidence, just happened to be an inpatient of the acute care hospital when it changed status—the acute care hospital does not drastically change the medical care it provides a beneficiary during his or her single hospitalization because its classification as an acute care hospital ends on one day and changes to LTCH classification on the next day, nor does the ''discharge'' signify the completion of a discrete period of care. Under the existing manual instructions, the hospital is receiving not one payment, but two PPS payments for a bundle of services that, in fact, was furnished during a single inpatient hospital stay and should have been adequately and properly reimbursed by a single PPS payment.

In addition, presently, if the DRG assigned to the ''discharge'' from the acute care hospital for a crossover patient falls within one of the DRGs covered by the postacute care transfer policy at § 412.4(c), the provider will receive a payment under the postacute care transfer policy as if the patient, who in fact has not moved, was transferred to a postacute care provider. Payment under the postacute care transfer policy is triggered when a discharge bill with the old provider number and an admission notice with the new provider number is submitted and processed by the Medicare standard bill processing systems as a transfer. Because the patient is, in reality, at the ''same'' facility (an acute care hospital that had met the LTCH designation criteria) and is in one episode of care, we do not believe the application of the existing transfer policy is the appropriate methodology for dealing with this situation. Under the postacute care transfer policy, the payment to the transferring hospital is only affected if the patient is discharged prior to the day before the geometric mean length of stay for the DRG. Where the patient is discharged by the day before the geometric mean length of stay, the ''discharging'' acute care hospital will receive the equivalent of the full IPPS DRG payment and the LTCH hospital will also receive a full LTCH PPS payment.

Accordingly, we are proposing to revise our regulations to provide for only one Medicare program payment for LTCH crossover patients. After reconsidering the current payment policy for crossover patients, we do not believe it is appropriate to make two separate discharge-based payments under Medicare for what, in reality, is a single inpatient hospital stay. In fact, when a patient under existing policy is deemed discharged from an acute care

hospital that has met the LTCH designation requirements during the patient's stay and has now changed its classification to LTCH status, we believe the patient has been receiving one consistent course of treatment throughout his or her stay. An acute care hospital that has become a LTCH prior to being paid as a LTCH has been admitting and treating patients with the multi-cormorbidities that result in longer hospital stays that are characteristic of the patient census at a LTCH, as required by § 412.23(e). Invariably, at the time the acute care hospital becomes a LTCH, there will be patients who were admitted to the acute care hospital and who remain in the facility when it converts to a LTCH and are ultimately discharged from the LTCH. An acute care hospital's change in payment classification status to a LTCH at the start of its first cost reporting period should have no impact on the course of treatment that is already underway for the patient in what is now a LTCH and not an acute care hospital. Accordingly, we believe that only one Medicare payment should be made for the entire stay.

Therefore, we are proposing a more appropriate payment policy for crossover patients that would provide one Medicare payment for what has been treated, for payment purposes under Medicare, to be two stays, but is, in reality, one continuous and uninterrupted period of inpatient hospital care. Consistent with the authority granted to the Secretary in both section 123 of the BBRA (Pub. L. 106–113) and section 307 of the BIPA (Pub. L. 106–554) to develop a LTCH PPS DRG-based system, we are proposing, effective for a patient stay in which a patient is in an acute care hospital and that hospital is designated as a LTCH on or after October 1, 2004, to make only one LTCH payment based on the PPS of the facility that is actually discharging the patient. Under this approach, we would include those days of care and costs incurred by the hospital for the crossover patient before the facility met the LTCH status criteria, in determining payments to the LTCH for that patient under the LTCH PPS. Under this proposed policy, for example, if an acute care hospital admits a patient on December 28 and the hospital converts to a LTCH on January 1 when its cost reporting period begins, and the patient is physically discharged from the LTCH on February 5, a single Medicare payment would be made for this entire stay (December 28 through February 5), and payment would be made to the LTCH based on the LTCH–DRGs under the LTCH PPS. We are proposing to count the crossover patient's entire hospitalization (that is, all days and costs of the patient stay in the facility that occurred prior to and after conversion) in determining the applicable payment under the LTCH PPS. This proposed provision would also count all the days of the inpatient stay, that is, prior to and after conversion, as LTCH days for purposes of determining whether the facility continues to meet the average length of stay regulations for LTCH. We believe that this proposed policy is consistent with the discretionary authority granted to the Secretary at section 1886(d)(1)(B)(iv)(I) of the Act for determining average lengths of stay for LTCHs. Specifically, section 1886(d)(1)(B)(iv)(I) of the Act provides that a LTCH is a hospital that has an average length of stay (as determined by the Secretary) of greater than 25 days. Thus, the Secretary determines how a LTCH's average length of stay is to be determined.

We are also using the broad discretionary authority provided in section 1871 of the Act to not count the days of the patient's stay in the acute care hospital prior to conversion as acute care days. In addition, we are using the broad authority in section 1871 of the Act to not pay for the days of the patient's stay in the acute care hospital as acute days. Section 1871 of the Act authorizes the Secretary to promulgate regulations that are necessary to carry on the administration of the Medicare program.

In addition, we believe counting all days for the patient's stay is consistent with the policy at recently revised § 412.23(e)(3), which provides that if a LTCH patient is admitted in one cost reporting period and discharged in a second cost reporting period, all of the days of the patient's stay, even those from prior fiscal years, are counted in the cost reporting period in which the patient is discharged. In the example of a crossover patient cited above, including the days in December may result in a full LTC–DRG payment rather than the lower payment under the short-stay outlier policy (§ 412.529) based on the length of the stay. (Under the short-stay policy, we would adjust (lower) the Federal prospective payment if the payment is for a length of stay that is up to and including five-sixths of the geometric average length of stay for the LTC–DRG assigned to the case.)

Accordingly, we are proposing to add a new § 412.2(b)(3), applicable to acute care hospitals, and a new § 412.521(e), applicable to LTCHs, that specify that Medicare would make only one LTCH PPS payment for a crossover patient to the LTCH that is discharging the patient based on the entire stay, both prior to the change to LTCH status and after the change. Medicare considers all days of the patient stay in the facility (days prior to and after conversion to the LTCH status) to be a single episode of LTCH care. Medicare will not make any payment under 42 CFR Part 412, Subpart H for any part of the hospitalization. In addition, for purposes of determining the beneficiary LTCH length of stay, the days prior to and after conversion to LTCH status are included. In order to implement the proposed policy, we would create systems adjustments that would enable the single claim generated by the discharging provider to include patient days under the initial provider number. We note that our proposal to define and pay for crossover patient stays as one episode of care based on the PPS of the discharging provider is consistent with existing regulations that establish that payment under the per discharge PPS constitutes ''payment in full'' for acute care hospitals at § 412.2(b) under the IPPS and for LTCHs, at § 412.521(b) under the LTCH PPS.

In this proposal, we have specifically addressed only the situation of a crossover patient that was in an acute care hospital that meets the requirements to be paid as a LTCH. However, we believe the policy may be equally applicable to other crossover situations. For example, an acute care hospital may meet the requirements to be paid as an inpatient rehabilitation facility (under the IRF PPS) and there could be rehabilitation patients who were admitted to the acute care hospital who were not discharged from the hospital until after the facility was designated as an IRF. At this time, we are not proposing to make a change to the existing payment policy in situations other than the LTCH crossover patient. We have only addressed the LTCH crossover patient because, based on the statutory and regulatory qualifying criteria, every LTCH must first be certified as a hospital before it can meet the LTCH criteria. However, the same is not true for other hospital certifications. For example, an inpatient rehabilitation hospital can be certified as an IRF without first being certified and paid as an acute care hospital for inpatient services. However, we intend to revisit the existing crossover policy as it affects other crossover situations in the future. We also welcome comments on how Medicare payment policy should address those situations.

C. Geographic Reclassifications—Definitions of Urban and Rural Areas (§ 412.63(b) and Proposed New § 412.64(b))

[If you choose to comment on issues in this section, please include the caption ''Urban and Rural Areas Definitions'' at the beginning of your document.]

As discussed in section III.B. and III.G. of this proposed rule, we are proposing how we would implement OMB's revised standards for defining MSAs and our plan to use the New England MSAs established by OMB. These proposals relate to our policies in established regulations under § 412.63(b) governing geographic classification of hospitals for purposes of the wage index and the standardized amounts in determining the Federal rates for inpatient operating costs. In this section, we define the geographic areas for purposes of reclassification of hospitals. Therefore, consistent with our proposed changes to reflect the new definitions of CBSAs based on the Census 2000 data, effective for discharges occurring on or after October 1, 2004, we are proposing to revise § 412.63(b) and add a new § 412.64(b) to reflect the existing geographic classification definitions.

D. Equalization of Urban and Rural Standardized Amounts (§ 412.63(c) and Proposed New § 412.64)

[If you choose to comment on issues in this section, please include the caption ''Standardized Amounts'' at the beginning of your document.]

Sections 1886(d)(2)(D) and (d)(3) of the Act previously required the Secretary to compute two average standardized amounts for discharges occurring in a fiscal year: one for hospitals located in large urban areas and one for hospitals located in other areas. In addition, under sections 1886(d)(9)(B)(iii) and (d)(9)(C)(i) of the Act, the average standardized amount per discharge was determined for hospitals located in large urban and other areas in Puerto Rico. In accordance with section 1886(b)(3)(B)(i) of the Act, prior to April 1, 2003, the large urban average standardized amount was 1.6 percent higher than the other area average standardized amount. The two standardized amounts are currently equal, as discussed in the following paragraphs.

Section 402(b) of Pub. L. 108–7 required that, effective for discharges occurring on or after April 1, 2003, and before October 1, 2003, the Federal rate for all IPPS hospitals would be based on the large urban standardized amount. Subsequently, Pub. L. 108–89 extended section 402(b) of Pub. L. 108–7 to discharges occurring on or after October 1, 2003, and before April 1, 2004. Finally, section 401(a) of Pub. L. 108–173 required that, beginning with FY 2004 and thereafter, an equal standardized amount is to be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. This provision in effect makes permanent the equalization of the standardized amounts at the level of the previous standardized amount for large urban hospitals. Section 401(c) also equalizes the Puerto Rico-specific urban and other area rates.

Accordingly, we are providing in this proposed rule for a single national standardized amount and a single Puerto Rico standardized amount for FY 2005 and thereafter, as discussed in detail in the Addendum to this proposed rule. We are proposing to revise existing § 412.63 that includes the provisions related to computation of the standardized amount to make it applicable to fiscal years through FY 2004 and to establish a new § 412.64 that will include the provisions applicable to the single national standardized amount applicable for FY 2005 and subsequent years. Similarly, we are proposing to revise existing § 412.210 for Puerto Rico to make it applicable to fiscal years through FY 2004 and adding a new § 412.211 for FY 2005 and subsequent years for the Puerto Rico standardized amount. We are also proposing to make conforming changes to various other sections of the regulations to reflect the single standardized amount for the States and for Puerto Rico.

E. Reporting of Hospital Quality Data for Annual Hospital Payment Update (Proposed New § 412.64(d))

[If you choose to comment on issues in this section, please include the caption ''Hospital Quality Data'' at the beginning of your document.]

1. Background

Section 501(b) of Pub. L. 108–173 amended section 1886(b)(3)(B) of the Act to add a new subclause (vii) to revise the mechanism used to update the standardized amount for payment for inpatient hospital operating costs. Specifically, the amendment provides that the update percentage increase (also known as the market basket update) for each of FYs 2005 through 2007 will be reduced by 0.4 percentage point for any ''subsection (d) hospital'' that does not submit data on a set of 10 quality indicators established by the Secretary as of November 1, 2003. (The statutory reference to a ''subsection (d) hospital'' restricts the application of this provision to hospitals paid under the IPPS. Therefore, the provision does not apply to hospitals and hospital units excluded from the IPPS, nor to payments to hospitals under other systems such as the outpatient hospital PPS.) The statute also provides that any reduction will apply only to the fiscal year involved, and will not be taken into account in computing the applicable percentage increase for a subsequent fiscal year. This measure establishes an incentive for IPPS hospitals to submit data on the quality measures established by the Secretary.

We are proposing to implement the provisions of section 501(b) as described at the CMS Web site: *http://www.cms.hhs.gov/quality/hospital.*

At a press conference on December 12, 2002, the Secretary of HHS announced a series of steps that HHS and its collaborators are taking for public reporting of hospital quality information. These collaborators include the American Hospital Association, the Federation of American Hospitals, the Association of American Medical Colleges, the Joint Commission on Accreditation of Healthcare Organizations, the National Quality Forum, the American Medical Association, the Consumer-Purchaser Disclosure Project, the American Association of Retired Persons, the American Federation of Labor-Congress of Industrial Organizations and the Agency for Healthcare Research and Quality, as well as CMS, QIOs, and others.

CMS began the public reporting initiative in July 2003 with a professional Web site that provides data intended for health care professionals. The professional Web site will be followed by a consumer Web site. The information on the consumer Web site will include the data from the professional Web site but in an easy-to-use format for consumers. It is intended to be an important tool for individuals to use in making decisions about their health care coverage. This information will assist beneficiaries by providing comparison information for consumers who need to select a hospital. It will also serve as a way of encouraging hospitals to adopt quality improvement strategies.

The 10 measures that were employed in this voluntary initiative as of November 1, 2003, are:

- Heart Attack (Acute Myocardial Infarction)

  Was aspirin given to the patient upon arrival to the hospital?

Was aspirin prescribed when the patient was discharged?
Was a beta-blocker given to the patient upon arrival to the hospital?
Was a beta-blocker prescribed when the patient was discharged?
Was an ACE inhibitor given for the patient with heart failure?

- Heart Failure
  Did the patient get an assessment of his or her heart function?
  Was an ACE inhibitor given to the patient?
- Pneumonia
  Was an antibiotic given to the patient in a timely way?
  Had a patient received a pneumococcal vaccination?
  Was the patient's oxygen level assessed?

These measures have been endorsed by the National Quality Forum (NQF) and are a subset of the same measures currently collected for the JCAHO by its accredited hospitals. Many hospitals are currently participating in the Department's National Voluntary Hospital Reporting Initiative (NVHRI) and are already submitting data to the QIO Clinical Warehouse. The Secretary adopted collection of data on these 10 quality measures in order to: (1) Provide useful and valid information about hospital quality to the public; (2) provide hospitals a sense of predictability about public reporting expectations; (3) begin to standardize data and data collection mechanisms; and (4) foster hospital quality improvement.

2. Requirements for Hospital Reporting of Quality Data

For the hospital reporting initiative for the Medicare annual payment update provided for under section 501(b) of Public Law 108–173, we will be collecting data on the 10 clinical measures for all patients. We refer to this program as the Reporting Hospital Quality Data for the Annual Payment Update (RHQDAPU) program to distinguish it from the continuing NVHRI.

The procedures for participating in the RHQDAPU can be found on the QualityNet Exchange at the Web site: *http://qnetexchange.org* in the ''Reporting Hospital Quality Data for Annual Payment Update Reference Checklist.'' This checklist also contains all of the forms to be completed by hospitals participating in the program. In order to participate in the RHQDAPU, hospitals must follow the following steps:

- The hospital must identify a QualityNet Exchange administrator who follows the registration process and submits the information through the QIO. This must be done, regardless of whether the hospital uses a vendor for transmission of data.
- All participants must first register with the QualityNet Exchange, regardless of the method used for data submission. If a hospital is currently participating in the voluntary reporting initiative, re-registration on the QualityNet Exchange is unnecessary. However, registration includes completion of the RHQDAPU Notice of Participation form. All hospitals must send the RHQDAPU form to their QIOs no later than August 1, 2004, for the FY 2005 update.
- The hospital must collect data for all 10 measures and submit the data to the QIO Clinical Warehouse either using the CMS Abstraction & Reporting Tool (CART), the JCAHO Oryx Core Measures Performance Measurement System (PMS), or another third-party vendor who has met the measurement specification requirements for data transmission to the QualityNet Exchange. The QIO Clinical Warehouse will submit the data to CMS on behalf of the hospitals. The submission will be done through QualityNet Exchange, which is a secure site that voluntarily meets or exceeds all current Health Insurance Portability and Accountability Act (HIPAA) requirements, while maintaining QIO confidentiality as required by law. The information in the Clinical Warehouse is considered QIO data, and therefore, is subject to the stringent confidentiality regulations in 42 CFR part 480.

Hospitals must begin the submission of data under the provisions of section 1886(b)(3)(B)(vii)(II) of the Act, as added by section 501(b) of Public Law 108–173, by July 1, 2004. Because section 501(b) of Public Law 108–173 grants a 30-day grace period for submission of data with respect to FY 2005, we are proposing to allow hospitals until August 1, 2004, for completed submissions to be successfully accepted into the QIO Clinical Warehouse. Hospitals would be required to submit data for the first calendar quarter of 2004 discharges in order to meet the requirements for the FY 2005 payment update. Hospitals participating in the NVHRI that submit the required 10 measures for the fourth calendar quarter of 2003 by the CMS-established deadline of May 15, 2004, and that meet the registration requirements for the market basket update, would be given until August 15, 2004, to submit data for the first calendar quarter of 2004. There will be no chart-audit validation criteria in place for the FY 2005 payment update beyond the CART edits, currently in force, applied to data entering the QIO Clinical Warehouse. In addition, we will estimate the minimum number of discharges anticipated to be submitted by a hospital using Medicare administrative data. We will use this anticipated minimum number to establish our expectations of the number of cases for each hospital. Hospitals that do not treat a condition or have very few discharges would not be penalized and would receive the full annual payment update if they submit all the data they do possess. New hospitals should begin collecting and reporting data immediately and complete the registration requirements for the market basket update. The same standards that are applied to established hospitals will be applied to new hospitals when determining the expected number of discharges for the calendar quarters covered for each fiscal year.

The annual payment updates will be based on the successful submission of data to CMS via the QIO Clinical Warehouse by the established deadlines. Hospitals may withdraw from RHQDAPU at any time up to August 1, 2004. Hospitals withdrawing from the program will not receive the full market basket update. Instead, they will receive a 0.4 percentage point reduction in the update. By law, a hospital's actions each fiscal year will not affect its update in a subsequent fiscal year. Therefore, a hospital must meet the requirements for RHQDAPU each fiscal year the program is in effect, and failure to receive the full update in one fiscal year will not affect its update in a succeeding fiscal year.

3. Submission of Hospital Data for FYs 2006 and 2007

For FYs 2006 and 2007, we will require hospitals to submit data quarterly, starting August 15, 2004. Eligibility for the full annual payment update will be based on the most recent four quarters of data. These data would be submitted on the same schedule for data transmission currently in force for CART data. That is, data must be submitted to the QIO Clinical warehouse no later than 15 calendar days after the fourth month following the end of the calendar quarter. This schedule is available at *http://www.qnetexchange.org*. We will establish validation requirements for submitted data for FYs 2006 and 2007. Submissions would, at a minimum, need to be accurate, timely, and complete. That is—

- The hospital-submitted data must meet minimum levels of reliability through chart audit re-abstractions over all topics. At the data element level, there must be an 80 percent agreement

between the original abstraction and the re-abstraction using the CART tool.

- The submitted data must be on schedule, pass all warehouse edits, and be successfully accepted into the warehouse.
- Completeness of submitted data will be assessed to ensure the number of submitted cases corresponds to the number of bills submitted by the hospital to CMS.

We are planning to publish the most recent 12 months of discharge data (4 quarters) for all data accepted into the warehouse and passing all validation requirements. For FY 2005, we will publish as much data as we have available. Hospitals will have the opportunity to review the information prior to posting on the CMS Web site. However, there will be no opportunity to withhold the publication of the information. The preview will only be to correct obvious errors.

4. Proposed Regulation Change

We are proposing to establish a new § 412.64(d)(2) to provide that, for FYs 2005, 2006, and 2007, the applicable percentage change is reduced by 0.4 percentage point in the case of any subsection (d) hospital that does not submit data to CMS on the 10 quality indicators established by the Secretary as of November 1, 2003. Any reduction will apply only to the fiscal year involved, and will not be taken into account in computing the applicable percentage increase for a subsequent fiscal year. We will be modifying our payment software to apply the correct updates to hospitals, depending on whether they submit the requisite data on the 10 quality indicators. We show the different standardized amounts that apply to hospitals that submit the requisite quality data, and to hospitals that do not, in the Addendum to this proposed rule.

F. Proposed Revision of the Labor-Related Share for the Hospital Wage Index (§ 412.64(h))

[If you choose to comment on issues in this section, please include the caption ''Labor-Related Share'' at the beginning of your document.]

As discussed in section III. of the preamble of this proposed rule, section 1886(d)(3)(E) of the Act directs the Secretary to adjust the proportion of the national prospective payment system base payment rates that are attributable to wages and wage-related costs by a factor that reflects the relative differences in labor costs among geographic areas. It also directs the Secretary to estimate from time to time the proportion of hospital costs that are labor-related. The portion of hospital costs attributable to wages and wage-related costs is referred to as the labor-related share. The labor-related share of the prospective payment rate is adjusted by an index of relative labor costs, which is referred to as the wage index. In the past, we have defined the labor-related share for prospective payment acute care hospitals as the national average proportion of operating costs that are related to, influenced by, or vary with the local labor market. The labor-related share for the acute care hospital inpatient prospective payment system has been calculated as the sum of the weights for wages and salaries, fringe benefits, nonmedical professional fees, contract labor, postage, and labor-intensive services. For FY 2004, the labor share of the hospital wage index was established at 71.066 percent.

Section 403 of Pub. L. 108–173 amended section 1886(d)(3)(E) of the Act to provide that the Secretary must use 62 percent as the labor-related share unless application of this percentage ''would result in lower payments than would otherwise be made.'' However, this provision of Pub. L. 108–173 did not change the legal requirement that the Secretary estimate ''from time to time'' the proportion of hospitals' costs that are ''attributable to wages and wage-related costs.'' In fact, section 404 of Pub. L. 108–173 requires the Secretary to develop a frequency for revising the weights used in the hospital market basket, including the labor share, to reflect the most current data more frequently than once every 5 years. Section 404 further requires us to include in the final IPPS rule for FY 2006 an explanation of the reasons for, and options considered, in determining such frequency.

Under section III. of this preamble, we discuss our proposed implementation of section 1886(d)(3)(E) of the Act, as amended by section 403, as it applies to the development of the proposed FY 2005 wage index. In this section IV.F. of the preamble, we are proposing to incorporate the provisions of section 403 of Pub. L. 108–173 under a new § 412.64(h). Specifically, we are proposing to specify that CMS will adjust the proportion of the Federal rate for inpatient operating costs that are attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by CMS based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined the regulations) of the hospital compared to the national average level of hospital wages and wage-related costs. The wage index would continue to be updated annually. In addition, we are proposing to specify that CMS will determine the proportion of the Federal rate that is attributable to wages and labor-related costs from time to time, employing a methodology that is described in the annual regulation updating the system of payment for inpatient hospital operating costs. However, CMS would employ 62 percent as the proportion of the rate that is adjusted for the relative level of hospital wages and wage-related costs, unless employing that percentage would result in lower payments for the hospital than employing the proportion determined under the methodology described in the preceding sentence.

G. Wage Index Adjustment for Commuting Patterns of Hospital Employees (Proposed New § 412.64(i))

[If you choose to comment on issues in this section, please include the caption ''Out-Migration of Hospital Employees'' at the beginning of your document.]

As discussed in section III.G.2.e. of this preamble, section 505 of Pub. L. 108–173 established new section 1886(d)(13) of the Act. The new section 1886(d)(13) requires that the Secretary establish a new process to make adjustments to the hospital wage index based on commuting patterns of hospital employees. The process provides for an increase in the wage index for hospitals located in certain counties that have a high percentage of hospital employees who reside in the county but work in a different area with a higher wage index. These adjustments to the wage index are effective for 3 years beginning with discharges occurring on or after October 1, 2004. Adjustments under this provision are not subject to the budget neutrality requirements at section 1886(d)(3)(E) or section 1886(d)(8)(D) of the Act.

Under section III.G.3.e of this preamble, we discuss the proposed implementation of the provisions of section 505 in developing the proposed FY 2005 wage index and the proposed applicable adjustments to that index. We are proposing in this section IV.G. of the preamble to incorporate the provisions of section 505 in the regulations by adding a new § 412.64(i).

The Secretary is required to establish criteria to identify ''qualifying counties,'' and hospitals located in the qualifying counties are to receive an adjustment to their wage index. To implement this provision, we are proposing to use commuting data compiled by the U.S. Census Bureau based on a special tabulation of Census 2000 journey-to-work data. This

information is gathered from responses to the Census long-form (sample) questions on where people worked. The resulting county-of-residence by county-of-work commuter flow file uses 108 Industrial Structure codes, developed by the Bureau of Economic Analysis. Using these data, we are able to identify the total number of hospital workers who live in each county and the number of workers within that county who commute to hospitals in other counties.

Section 1886(d)(13)(B)(i) of the Act directs the Secretary to establish a threshold percentage difference between the county's wage index and a weighted wage index of the surrounding higher wage index areas that must be met in order for the county to qualify. We are proposing to establish this threshold at any percentage greater than zero, such that any increase in the wage index resulting from this provision that is greater than zero percent would be recognized. Section 1886(d)(13)(B)(ii) of the Act specifies that the Secretary is to establish the minimum out-migration threshold in order to qualify, which may not be less than 10 percent. We are proposing to establish the out-migration threshold at the minimum 10 percent.

Section 1886(d)(13)(B)(iii) of the Act requires that the average hourly wage for all hospitals in the county must be equal to or exceed the average hourly wage for all hospitals in the labor market area. Section 1886(d)(13)(E) of the Act indicates this process may be based on the process used by the MGCRB. This section also gives the Secretary the authority to require hospitals to submit data necessary to implement this provision, or to use other data sources as available. To compute this requirement, we are proposing to determine the average of hospitals' 3-year average hourly wage for all hospitals in a given county. We would compare this county average hourly wage to the 3-year average hourly wage for the labor market area where the county is located. We are proposing to use the 3-year average hourly wage because we believe it gives a better estimate for the wages paid by a given hospital over a period of time. This statutory requirement limits the number of eligible counties.

Section 1886(d)(13)(A) of the Act allows the Secretary to establish the process through application or otherwise for this adjustment to the wage index. We are proposing not to use an application process. Rather, all hospitals located in qualifying counties would automatically receive the increase in wage index, unless the hospital has already been reclassified to another geographic area for purposes of wage index or standardized amount. This wage index increase would be effective for a period of 3 fiscal years, FY 2005 through FY 2007.

Hospitals receiving this wage index increase under section 1886(d)(13)(F) of the Act are not eligible for reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act. Therefore, consistent with § 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of this proposed rule in the **Federal Register**. Similarly, hospitals may terminate an existing 3-year reclassification within 45 days of the publication of this proposed rule. Hospitals that withdraw their application for reclassification would then automatically receive the commuting wage index adjustment. The request for withdrawal of an application for reclassification or termination of an existing 3-year reclassification that would be effective in FY 2005 must be received by the MGCRB within 45 days of the publication of this proposed rule.

H. Additional Payments for New Medical Services and Technology: Proposed Policy Changes (§§ 412.87 and 412.88)

[If you choose to comment on issues in this section, please include the caption ''New Technology Threshold'' at the beginning of your document.]

As discussed in section II.D. of this proposed rule, sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and ensuring adequate payment for new medical services and technologies under the IPPS, effective for discharges beginning on or after October 1, 2001. Section 1886(d)(5)(K)(ii)(I) of the Act specifies that the process must apply to a new medical service or technology if, ''based on the estimated costs incurred with respect to discharges involving such service or technology, the DRG prospective payment rate otherwise applicable to such discharges under this subsection is inadequate.'' Section 1886(d)(5)(K)(vi) of the Act specifies that a medical service or technology will be considered ''new'' if it meets criteria established by the Secretary after notice and opportunity for public comment.

Sections 1886(d)(5)(K)(ii) through (d)(5)(K)(vi) of the Act further provide—

- For an additional payment for new medical services and technology in an amount beyond the DRG prospective payment system payment rate that adequately reflects the estimated average costs of the service or technology.
- That the requirement for an additional payment for a new service or technology may be satisfied by means of a new technology group (described in section 1886(d)(5)(L) of the Act), an add-on payment, a payment adjustment, or any other similar mechanism for increasing the amount otherwise payable with respect to a discharge.
- For the collection of data relating to the cost of a new medical service or technology for not less than 2 years and no more than 3 years after an appropriate inpatient hospital services code is issued. The statute further provides that discharges involving new services or technology that occur after the collection of these data will be classified within a new or existing DRG group with a weighting factor derived from cost data collected for discharges occurring during such period.

Section 412.87(b)(1) of our existing regulations provides that a new technology will be an appropriate candidate for an additional payment when it represents an advance in medical technology that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries (see the September 7, 2001 final rule (66 FR 46902)). Section 412.87(b)(3) provides that, to receive special payment treatment, new technologies meeting this clinical definition must be demonstrated to be inadequately paid otherwise under the DRG system.

In the August 1, 2003 final IPPS rule, we revised the threshold amount for determining if payment for a new technology or medical service is inadequate, effective for FY 2005 and subsequent fiscal years (68 FR 45392). We lowered the previously established threshold of 1 standard deviation to 75 percent of 1 standard deviation (based on the logarithmic values of the charges) beyond the geometric mean standardized charges for all cases in the DRG to which the new technology is assigned (or the case-weighted average of all relevant DRGs, if the new technology occurs in many different DRGs), transformed back to charges.

Section 503(b) of Pub. L. 108–173 amended section 1886(d)(5)(K)(ii)(I) of the Act to specify that in determining whether payments for a new technology or medical service are inadequate, the Secretary is to determine and apply a threshold amount that is the ''lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of 1 standard deviation for the DRG involved.'' As a result of enactment of section 503(b), we are proposing to revise our regulations at § 412.87(b)(3)

to incorporate the revised threshold amount.

The report language accompanying section 533 of Pub. L. 106–554 indicated Congressional intent that the Secretary implement the new mechanism on a budget neutral basis (H.R. Conf. Rep. No. 106–1033, 106th Cong., 2nd Sess., at 897 (2000)). Section 1886(d)(4)(C)(iii) of the Act requires that the adjustments to annual DRG classifications and relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. Therefore, in the past, we accounted for projected payments under the new medical service and technology provision during the upcoming fiscal year at the same time we estimated the payment effect of changes to the DRG classifications and recalibration. The impact of additional payments under this provision was then included in the budget neutrality factor, which was applied to the standardized amounts and the hospital-specific amounts.

To balance appropriately the Congressional intent to increase Medicare payments for eligible new technologies with concern that the total size of those payments not result in significantly reduced payments for other cases, we set a target limit for estimated add-on payments for new technology under the provisions of sections 1886(d)(5)(K) and (L) of the Act at 1.0 percent of estimated total operating prospective payments. In accordance with § 412.88(c) of the regulations, if the target limit was exceeded, we would reduce the level of payments for approved technologies across the board, to ensure estimated payments did not exceed the limit.

Section 503(d)(1) of Pub. L. 108–173 amended section 1886(d)(5)(K)(ii)(III) of the Act to remove the budget neutrality provision for add-on payments for a new medical service or technology. Section 503(d)(2) specifies that ''There shall be no reduction or other adjustment to payments under section 1886 of the Social Security Act because an additional payment is provided'' for new technology. Accordingly, as a result of the enactment of section 503(d) of Pub. L. 108–173, we will no longer include the impact of additional payments for new medical services and technologies in the budget neutrality factor. In addition, we are proposing to delete § 412.88(c) of the regulations.

I. Rural Referral Centers (§ 412.96)

[If you choose to comment on issues in this section, please include the caption ''Rural Referral Centers'' at the beginning of your document.]

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the IPPS 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 standardized amount rather than the rural standardized amount. Although the other urban and rural standardized amounts are the same for discharges occurring on or after October 1, 1994, rural referral centers continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Section 402 of Pub. L. 108–173 raised the DSH adjustment for other rural hospitals with less than 500 beds and rural referral centers. Other rural hospitals with less than 500 beds are subject to a 12–percent cap on DSH payments. Rural referral centers are not subject to the 12.0 percent cap on DSH payments that is applicable to other rural hospitals (with the exception of rural hospitals with 500 or more beds). Rural referral centers are not subject to the proximity criteria when applying for geographic reclassification, and they do not have to meet the requirement that a hospital's average hourly wage must exceed 106 percent of the average hourly wage of the labor market area where the hospital is located.

As discussed in **Federal Register** documents at 62 FR 45999 and 63 FR 26325, under section 4202 of Pub. L. 105–33, a hospital that was classified as a rural referral center for FY 1991 is to be considered as a rural referral center for FY 1998 and later years so long as that hospital continues to be located in a rural area and does not voluntarily terminate its rural referral center status. Effective October 1, 2000, if a hospital located in what is now an urban area was ever a rural referral center, it is reinstated to rural referral center status (65 FR 47089). Otherwise, a hospital seeking rural referral center status must satisfy the applicable criteria.

One of the criteria under which a hospital may qualify as a rural referral center is to have 275 or more beds available for use (§ 412.96(b)(1)(ii)). A rural hospital that does not meet the bed size requirement can qualify as a rural referral center if the hospital meets two mandatory prerequisites (a minimum case-mix index and a minimum number of discharges) and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume) (§ 412.96(c)(1) through (c)(5)). (*See* also the September 30, 1988 **Federal Register** (53 FR 38513)). With respect to the two mandatory prerequisites, a hospital may be classified as a rural referral center if—

- The hospital's 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
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year, as specified in section 1886(d)(5)(C)(i) of the Act.)

1. Case-Mix Index

Section 412.96(c)(1) provides that CMS will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the proposed national and regional case-mix index values is set forth in regulations at § 412.96(c)(1)(ii). The proposed national median case-mix index value for FY 2005 includes all urban hospitals nationwide, and the proposed regional values for FY 2005 are the median values of urban hospitals within each census region, excluding those hospitals with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105). These proposed values are based on discharges occurring during FY 2003 (October 1, 2002 through September 30, 2003) and include bills posted to CMS' records through December 2003.

We are proposing that, in addition to meeting other criteria, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2004, rural hospitals with fewer than 275 beds must have a case-mix index value for FY 2003 that is at least—

- 1.3550; or
- The median case-mix index value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by CMS for the census region in which the hospital is located.

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

Region	Case-mix index value.
1. New England (CT, ME, MA, NH, RI, VT)	1.2400
2. Middle Atlantic (PA, NJ, NY)	1.2387
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3249
4. East North Central (IL, IN, MI, OH, WI)	1.2661
5. East South Central (AL, KY, MS, TN)	1.2777
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1787
7. West South Central (AR, LA, OK, TX)	1.3043
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3527
9. Pacific (AK, CA, HI, OR, WA)	1.3095

The preceding numbers will be revised in the final rule to the extent required to reflect the updated FY 2001 MedPAR file, which will contain data from additional bills received through March 31, 2002.

Hospitals seeking to qualify as rural referral centers or those wishing to know how their case-mix index value compares to the criteria should obtain hospital-specific case-mix index values (not transfer-adjusted) from their fiscal intermediaries. Data are available on the Provider Statistical and Reimbursement (PS&R) System. 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 CMS will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. We are proposing to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2001 (that is, October 1, 2000 through September 30, 2001), which is the latest available cost report data we have at this time. In last year's final rule we inadvertently indicated that we relied upon data regarding discharges occurring during FY 2002. However, we have now determined that our values were based upon data regarding discharges occurring during FY 2000.

Therefore, we are proposing that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2004, must have as the number of discharges for its cost reporting period that began during FY 2001 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located, as indicated in the following table:

Region	Number of discharges.
1. New England (CT, ME, MA, NH, RI, VT)	8,212
2. Middle Atlantic (PA, NJ, NY)	9,574
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,303
4. East North Central (IL, IN, MI, OH, WI)	8,684
5. East South Central (AL, KY, MS, TN)	7,624
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	6,789
7. West South Central (AR, LA, OK, TX)	6,485
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8,489
9. Pacific (AK, CA, HI, OR, WA)	6,274

These numbers will be revised in the final rule based on the latest available cost report data.

We reiterate that if an osteopathic hospital is to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 2004, the hospital would be required to have at least 3,000 discharges for its cost reporting period that began during FY 2001.

J. Additional Payments to Hospitals With High Percentage of End-Stage Renal Disease (ESRD) Discharges (§ 412.104)

[If you choose to comment on issues in this section, please include the caption ''ESRD Discharges'' at the beginning of your document.]

Under existing regulations at § 412.104(a), CMS provides for additional Medicare payments to a hospital for inpatient dialysis provided to Medicare beneficiaries with end-stage renal disease (ESRD) if the hospital's ESRD Medicare beneficiary discharges are 10 percent or more of its total Medicare discharges. This provision states that discharges classified into DRG 302 (Kidney Transplant), DRG 316 (Renal Failure), or DRG 317 (Admit for Renal Dialysis) are excluded for purposes of determining a hospital's eligibility for this special payment. We have been informed that, under this provision, hospitals may be counting all discharges of ESRD Medicare beneficiaries towards determining the 10 percent factor rather than counting only those discharges where the ESRD beneficiary received inpatient dialysis.

When we established this regulation in the August 31, 1984 final rule (49 FR 34747), we stated that this special payment was intended to ameliorate those circumstances in which the concentration of ESRD beneficiaries receiving inpatient dialysis may be such that the hospital would not be able to absorb the entire expense with revenue from other less costly cases. We further stated that we believed those few hospitals most extremely impacted by the ESRD beneficiary population should be afforded some protection against the chance of encountering inpatient dialysis expenses that could not be offset by revenue from cases in which the DRG payment was greater than the hospital's cost. Because this special payment is intended to limit the adverse impact on hospitals delivering inpatient dialysis services to ESRD beneficiaries, we firmly believe that only those

discharges of beneficiaries who receive dialysis services during an inpatient stay should be counted in determining a hospital's eligibility for the additional payment. After a careful review of § 412.104(a), we acknowledge that hospitals may require additional guidance in appropriately determining their eligibility for this special payment. Therefore, we are proposing to revise § 412.104(a) to make it clear that, in determining a hospital's eligibility for the additional Medicare payment, only discharges involving ESRD Medicare beneficiaries who have received a dialysis treatment during an inpatient hospital stay are to be counted. This proposed change would be applied prospectively, effective for cost reporting periods beginning on or after October 1, 2004.

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

[If you choose to comment on issues in this section, please include the caption ''IME Adjustment'' at the beginning of your document.]

1. IME Adjustment Factor Formula Multipliers (Section 502(a) of Public Law 108–173 and Existing § 412.105(d)(3)(vii) and Proposed § 412.105(d)(3)(viii) Through (d)(3)(xii) of the Regulations)

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an additional payment to reflect the higher indirect costs of teaching hospitals relative to nonteaching hospitals. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105. The IME adjustment is based in part on the applicable IME adjustment factor. The IME adjustment factor is calculated using a hospital's ratio of residents to beds, which is represented as r, and a formula multiplier, which is represented as c, in the following equation: $c \times [\{1 + r\}^{.405} - 1]$. The formula is traditionally described in terms of a certain percentage increase in payment for every 10-percent increase in the resident-to-bed ratio.

Section 502(a) of Pub. L. 108–173 modified the formula multiplier c to be used in the calculation of the IME adjustment. Prior to enactment of Pub. L. 108–173, the formula multiplier was fixed at 1.35 for discharges occurring during FY 2003 and thereafter. Section 502(a) modifies the formula multiplier beginning midway through FY 2004 and provides for a new schedule of formula multipliers for FYs 2005 and thereafter as follows:

- For discharges occurring on or after April 1, 2004, and before October 1, 2004, the formula multiplier is 1.47.
- For discharges occurring during FY 2005, the formula multiplier is 1.42.
- For discharges occurring during FY 2006, the formula multiplier is 1.37.
- For discharges occurring during FY 2007, the formula multiplier is 1.32.
- For discharges occurring during FY 2008 and fiscal years thereafter, the formula multiplier is 1.35.

We are proposing to revise § 412.105(d)(3)(vii) and add § 412.105(d)(3)(viii) through (d)(3)(xii) to incorporate these changes in the formula multipliers.

2. IME Adjustment Formula Multiplier for Redistributed FTE Resident Slots (Section 422(b)(1)(C) of Pub. L. 108–173)

Under new section 1886(h)(7)(B) of the Act, added by section 422(a) of Pub. L. 108–173, a hospital may receive an increase in its FTE resident cap as a result of the agency's redistribution of unused resident positions. (This provision is discussed in detail in section IV.J.2. of the preamble of this proposed rule.) Section 422(b)(1)(C) of Pub. L. 108–173 amended section 1886(d)(5)(B) of the Act to add a new subclause (ix) to provide that, for discharges occurring on or after July 1, 2005, for a hospital whose FTE resident cap is increased as a result of a redistribution of unused resident positions, the IME adjustment factor is to be calculated using a formula multiplier of 0.66 with respect to any additional residents counted by the hospital as a result of that increase in the hospital's FTE resident cap. Thus, we are proposing that a hospital that counts additional residents as a result of an increase in its FTE resident cap under section 1886(h)(7)(B) of the Act would receive IME payments based on the sum of two different IME adjustment factors: (1) An IME adjustment factor that is calculated using the schedule of formula multipliers described in section IV.G.1. of this preamble established by section 502(a) of Pub. L. 108–173, and which also uses the hospital's number of FTE residents, not including residents attributable to an FTE cap increase under section 1886(h)(7)(B) of the Act, in the numerator of the resident-to-bed ratio; and (2) an IME adjustment factor that is calculated using the formula multiplier of 0.66, and the additional number of FTE residents that are attributable to the increase in the hospital's FTE resident cap under section 1886(h)(7)(B) of the Act in the numerator of the resident-to-bed ratio. (The number of available beds used in the denominator would be the same for both IME adjustments.)

We note that section 422(b) of Pub. L. 108–173, which addresses the application of the IME adjustment to the residents counted as a result of an increase in a hospital's FTE resident cap under section 422(a), makes no reference to section 1886(d)(5)(B)(vi) of the Act. That is, the statute does not provide for an exclusion from application of the cap on the resident-to-bed ratio at section 1886(d)(5)(B)(vi)(I) of the Act or from application of the rolling average count at section 1886(d)(5)(B)(vi)(II) of the Act for residents added as a result of FTE cap increases under section 1886(h)(7)(B). There is no specific pronouncement in section 422 exempting residents counted as a result of the FTE resident cap increases under section 422(a) from the cap on the resident-to-bed ratio and the rolling average, and we see no apparent reason to treat those residents differently for purposes of these two provisions. Therefore, we are proposing to require that if a hospital increases its IME FTE count of residents as a result of section 1886(h)(7)(B) of the Act, those FTE residents are immediately subject to the cap on the resident-to-bed ratio and the rolling average calculation. Furthermore, we believe that, given potentially significant shifts of FTE positions among hospitals as a result of the new section 1886(h)(7) of the Act, the inclusion of FTE residents added as a result of section 1886(h)(7)(B) of the Act in the cap on the resident-to-bed ratio and in the rolling average introduces a measure of stability and predictability, and mitigates radical shifts in IME payments from period to period. Thus, a hospital's increase in IME payment may be delayed for one year to the extent that the resident-to-bed ratio for the current cost reporting period is capped by the resident-to-bed ratio for the previous cost reporting period. Further, the additional FTE residents would be phased in over a 3-year period in the hospital's FTE count because they are immediately included in the rolling average calculation.

The following illustrates how the IME payment would be calculated for a hospital that receives an increase to its FTE resident cap as a result of section 1886(h)(7)(B) of the Act. For example, Hospital A has a fiscal year end (FYE) of September 30, and a 1996 IME FTE cap of 20 FTEs. During its FYEs September 30, 2003, September 30, 2004, and September 30, 2005, Hospital A trains 25 FTE residents. Effective July 1, 2005, under section 1886(h)(7)(B) of

the Act, Hospital A receives an increase to its IME 1996 cap of 5 FTEs, for a total adjusted IME cap of 25 FTEs. Hospital A has maintained an available bed count of 200 beds in FYE September 30, 2004 and throughout FYE September 30, 2005. For the FYE September 30, 2005 cost report, the IME adjustment factor is calculated as follows:

Step 1. For discharges occurring on October 1, 2004, through September 30, 2005 for residents NOT counted pursuant to section 1886(d)(5)(B)(ix) of the Act:

- Rolling average count of FTE residents: 20+20+20/3 = 20.
- Current year resident-to-bed ratio: 20/200 = .10.
- Cap on resident-to-bed ratio (from prior year): 20/200 = .10.
- Compare, and use the lower of, prior year resident-to-bed ratio and current year resident-to-bed ratio: .10 = .10.
- Compute IME adjustment factor: $1.42 \times [\{1 + .10\}^{.405} - 1] = 0.0559$.

Step 2. For discharges occurring on July 1, 2005 through September 30, 2005 for residents counted pursuant to section 1886(d)(5)(B)(ix) of the Act:

- Rolling average count of FTE residents: 25+20+20/3 = 21.7.
- Resident-to-bed ratio for 7/1/05–9/30/05: 21.7/200 = .11.
- Cap on resident-to-bed ratio (from prior year): 20/200 = .10.
- Compare, and use the lower of, prior year resident-to-bed ratio and resident-to-bed ratio for 7/1/05–9/30/05: .10 < .11. Capped by prior year ratio of .10.
- Compute IME adjustment factor: $0.66 \times [\{1 + 0\}^{.405} - 1] = 0.0$.

In this example, the addition of 5 FTE residents under section 1886(h)(7)(B) caused Hospital A's resident-to-bed ratio for discharges occurring on July 1, 2005, through September 30, 2005, to exceed the resident-to-bed ratio of .10 from the prior year. Since the multiplier of 0.66 is to be used for determining IME payment ''insofar as an additional payment amount * * * is attributable to resident positions redistributed to a hospital * * *'' under section 1886(d)(5)(B)(v) of the Act, as amended by section 422(b)(1)(C) of Pub. L. 108–173, Hospital A does not receive any IME payment attributable to the 5 FTE residents added as a result of section 1886(h)(7)(B) of the Act for discharges occurring on July 1, 2005, through September 30, 2005. As shown under the fifth bullet point in Step 2 of the example above, a resident-to-bed ratio of zero is used to compute the IME adjustment for FTE residents attributable to increases in the FTE resident cap under section 1886(h)(7)(B) of the Act for discharges occurring on or after July 1, 2005 and on or before September 30, 2005. The ratio of .10 would not be used to compute the IME adjustment for FTE residents attributable to an increase in the FTE resident cap under section 1886(h)(7)(B) because the ratio of .10 is attributable to the 20 FTE residents from the prior year, and is not related to residents added under section 1886(h)(7)(B) of the Act. (We note that a hospital's resident-to-bed ratio in the current year might decrease despite residents added as a result of section 1886(h)(7)(B) of the Act, due to an increase in the number of available beds in the denominator of the current year resident-to-bed ratio. In such a case, because the current year ratio would be less than the prior year ratio, the hospital's resident-to-bed ratio would not be capped by the prior year resident-to-bed ratio, and, therefore, the hospital could receive an IME payment in the current year (that is, there would not be a 1-year delay) relating to residents added under section 1886(h)(7)(B) of the Act).

However, an increase in the resident-to-bed ratio in the current period may establish a higher cap for the following period, and, all other things being equal, a hospital could then receive IME payment for FTE residents added as a result of section 1886(h)(7)(B) of the Act after a 1-year lag. In the example above, Hospital A would receive an IME payment for residents added as a result of section 1886(h)(7)(B) of the Act in its cost reporting period ending September 30, 2006, as follows:

Step 1. For residents NOT counted pursuant to section 1886(d)(5)(B)(ix) of the Act:

- Rolling average count of FTE residents: 20+20+20/3 = 20.
- Current year resident-to-bed ratio: 20/200 = .10.
- Cap on resident-to-bed ratio (from prior year): 20/200 = .10.
- Compare, and use the lower of, prior year resident-to-bed ratio and current year resident-to-bed ratio: .10 = .10.
- Compute IME adjustment factor: $1.37 \times [\{1 + .10\}^{.405} - 1] = 0.0559$.

Step 2. For 5 FTE residents counted pursuant to with section 1886(d)(5)(B)(ix) of the Act:

- Rolling average count of FTE residents: 25+25+20/3 = 23.3.
- Resident-to-bed ratio for FYE 9/30/06: 23.3/200 = .12.
- Cap on resident-to-bed ratio (from prior year): 25/200 = .13.
- Compare, and use the lower of, prior year resident-to-bed ratio and current year resident-to-bed ratio: .13 >.12. Current year ratio of .12 is the lower of the two.
- Take the difference between the rolling average count of FTE residents counted as a result of section 1886(h)(7)(B) of the Act, and the rolling average count of FTE residents *not* counted as a result of section 1886(h)(7)(B) of the Act, (rolling average count under step 2 minus rolling average count under step 1): 23.3 − 20 = 3.3.
- Compute current year resident-to-bed ratio attributable to residents added under section 1886(h)(7)(B): 3.3/200 = 0.02.
- Compute IME adjustment factor: $0.66 \times [\{1 + .02\}^{.405} - 1] = 0.0053$.

Step 3. Compute IME payment for FYE September 30, 2006: [Total DRG payments for discharges occurring on October 1, 2005 through September 30, 2006] × [0.0592] (that is, 0.0539 + 0.0053).

We are proposing to revise § 412.105 to incorporate these changes under proposed new paragraph (d)(4), proposed new paragraph (e)(2), proposed new paragraph (f)(1)(iv)(B), and proposed added new last sentence of paragraph (f)(1)(v).

3. Technical Changes

- In § 412.105(a)(1), introductory text, we include a cross-reference to ''paragraph (f) and (h)'' of § 412.105. Paragraph (h) no longer exists in this section. Therefore, we are proposing to remove the cross-reference to paragraph (h).
- In § 412.105(f)(1)(i)(A), we reference national organizations listed in § 415.200(a). The cross-reference to § 415.200(a) is incorrect. We are proposing to correct the cross-reference to read ''§ 415.152.''
- In section IV.O. of this preamble, we discuss our proposal to redesignate existing § 413.86 governing payments for direct costs of GME to nine separate sections. Many of the paragraphs in the existing § 413.86 are cited in § 412.105 governing the IME adjustment. We are proposing to make changes to the cross-reference in § 412.105 to conform them to these proposed redesignated separate sections.

L. Payment to Disproportionate Share Hospitals (DSHs) (Section 402 of Pub. L. 108–173 and § 412.106 of Existing Regulations)

[If you choose to comment on issues in this section, please include the caption ''DSH Adjustment'' at the beginning of your document.]

1. Enhanced DSH Adjustment for Rural Hospitals and Urban Hospitals With Fewer Than 100 Beds

Section 1886(d)(5)(F) of the Act provides for additional payments to subsection (d) hospitals that serve a disproportionate share of low-income patients. The Act specifies two methods for a hospital to qualify for the Medicare disproportionate share hospital (DSH) adjustment. Under the first method, hospitals that are located in an urban area and have 100 or more beds may receive a DSH payment adjustment if the hospital can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients. These hospitals are commonly known as ''Pickle hospitals.'' The second method, which is also the most commonly used method for a hospital to qualify, is based on a complex statutory formula under which payment adjustments are based on the level of the hospital's DSH patient percentage, which is the sum of two computations. The first computation includes the number of patient days that are furnished to patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits. This number is divided by the total number of patient days that are associated with patients entitled to benefits under Medicare Part A. The second computation includes hospital patient days that are furnished to patients who, for those days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A. This number is divided by the number of total hospital inpatient days in the same period.

Hospitals whose DSH patient percentage exceeds 15 percent are eligible for a DSH payment adjustment (prior to April 1, 2001, the qualifying DSH patient percentage varied, in part, by the number of beds (66 FR 39882)). The DSH payment adjustment may vary based on the DSH patient percentage and the type of hospital. The statute provides for different payment adjustments for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, hospitals that qualify as RRCs or SCHs, and other hospitals.

Effective April 1, 2004, section 402 of Public Law 108–173 amended section 1886(d)(5)(F) of the Act to revise the formulae used to calculate DSH payment adjustments for certain hospitals that qualify for the adjustments under the second method. Specifically, under the new section 1886(d)(5)(F)(xiv), added by section 402, for hospitals that are not large urban or large rural hospitals, DSH payments are calculated using the same DSH adjustment formula used for large urban hospitals. However, the DSH payment adjustment for most of these categories of hospitals, except for hospitals classified as RRCs, including RRCs that are also SCHs, is capped at 12 percent. In addition, the formula for large urban hospitals with 100 beds or more, and large rural hospitals with 500 beds or more, has not been revised by section 402. Finally, Pickle hospitals are not affected by this change; they will continue to receive a DSH adjustment under the alternative formula.

Effective for discharges occurring on or after April 1, 2004, the following DSH payment adjustment formulae apply for the following specified categories of hospitals:

- For urban hospitals with fewer than 100 beds and whose disproportionate patient percentage is equal to or greater than 15 percent and less than or equal to 20.2 percent: (Disproportionate patient percentage − 15 percent) (65 percent) + 2.5 percent.
- For urban hospitals with fewer than 100 beds and whose disproportionate patient percentage is greater than 20.2: (Disproportionate patient percentage − 20.2 percent) (82.5 percent) + 5.88 percent.

For urban hospitals with fewer than 100 beds, the maximum DSH payment adjustment is 12 percent.

- For rural hospitals that are SCHs and are not RRCs and whose disproportionate patient percentage is equal to or greater than 15 percent and less than or equal to 20.2 percent: (Disproportionate patient percentage − 15 percent) (65 percent) + 2.5 percent.
- For rural hospitals that are SCHs and are not RRCs and whose disproportionate patient percentage is greater than 20.2 percent: (Disproportionate patient percentage − 20.2 percent) (82.5 percent) + 5.88 percent.

For rural hospitals that are SCHs and are not RRCs, the maximum DSH payment adjustment is 12 percent.

- For RRCs whose disproportionate patient percentage is greater than or equal to 15 percent and less than or equal to 20.2 percent: (Disproportionate patient percentage − 15 percent) (65 percent) + 2.5 percent.
- For RRCs whose disproportionate patient percentage is greater than 20.2 percent: (Disproportionate patient percentage − 20.2 percent) (82.5 percent) + 5.88 percent.
- For rural hospitals that are both RRCs and SCHs and whose disproportionate patient percentage is greater than or equal to 15 percent and less than or equal to 20.2 percent: (Disproportionate patient percentage − 15 percent) (65 percent) + 2.5 percent.
- For rural hospitals that are both RRCs and SCHs whose disproportionate patient percentage is greater than 20.2 percent: (Disproportionate patient percentage − 20.2 percent) (82.5 percent) + 5.88 percent.
- For rural hospitals with fewer than 500 beds and whose disproportionate patient percentage is equal to or greater than 15 percent and less than or equal to 20.2 percent: (Disproportionate patient percentage − 15 percent) (65 percent) + 2.5 percent.
- For rural hospitals with fewer than 500 beds and whose disproportionate patient percentage is greater than 20.2 percent: (Disproportionate patient percentage − 20.2 percent) (82.5 percent) + 5.88 percent.

For rural hospitals with fewer than 500 beds, the maximum DSH payment adjustment is 12 percent.

These revised formulae, which became effective for discharges occurring on or after April 1, 2004, were implemented through a CMS One-Time Notification (CR 3158), issued on March 26, 2004. The notice describes the changes required by section 402 of Public Law 108–173. In this proposed rule, we are proposing to revise §§ 412.106 (d)(2)(ii), (d)(2)(iii), and (d)(2)(iv) of the regulations to reflect these statutory revisions.

The following DSH formulae were not affected by the changes made by section 402 of Pub. L. 108–173 and remain in effect:

- For urban hospitals with 100 beds or more and whose disproportionate patient percentage is equal to or greater than 15 percent and less than or equal to 20.2 percent: (Disproportionate patient percentage − 15 percent) (65 percent) + 2.5 percent.
- For urban hospitals with 100 beds or more and whose disproportionate patient percentage is greater than 20.2 percent: (Disproportionate patient percentage − 20.2 percent) (82.5 percent) + 5.88 percent.
- For rural hospitals with 500 beds or more and whose disproportionate patient percentage is equal to or greater than 15 percent and less than or equal to 20.2 percent: (Disproportionate patient percentage − 15 percent) (65 percent) + 2.5 percent.
- For rural hospitals with 500 beds or more and whose disproportionate patient percentage is greater than 20.2 percent: (Disproportionate patient

percentage −20.2 percent) (82.5 percent) + 5.88 percent.

2. Proposals for Available Beds and Patient Days for the DSH Adjustment

In our May 19, 2003 IPPS proposed rule for FY 2004 (68 FR 27201), we proposed changes to our policy on counting available beds and patient days for the purposes of the DSH adjustment. For the available beds policy we proposed changes to counting unoccupied beds and observation beds. In regard to patient days, we proposed changes to counting dual-eligible and Medicare+Choice (M+C) days. Due to the number and nature of the public comments received, we did not respond to the public comments on these proposals in the final rule for FY 2004 (68 FR 45415). We indicated that we would address those public comments in a separate document. We plan to address the comments regarding unoccupied beds, observation beds, dual eligible days, and M+C days in the IPPS final rule for FY 2005.

M. Payment Adjustments for Low-Volume Hospitals (Proposed New § 412.101)

[If you choose to comment on issues in this section, please include the caption ''Low-Volume Hospital Adjustment'' at the beginning of your document.]

Section 406 of Pub. L. 108–173 amended section 1886(d) of the Act to add a new subclause (12) to provide for a new payment adjustment to account for the higher costs per discharge of low-volume hospitals under the IPPS. Section 1886(d)(12)(C)(i) of the Act, as added by section 406, defines a low-volume hospital as a ''subsection (d) hospital . . . that the Secretary determines is located more than 25 road miles from another subsection (d) hospital and that has less than 800 discharges during the fiscal year.'' Section 1886(d)(12)(C)(ii) of the Act further stipulates that the term ''discharge'' refers to total discharges, and not merely to Medicare discharges. Specifically, the term refers to the ''inpatient acute care discharge of an individual regardless of whether the individual is entitled to benefits under part A.'' Finally, the provision requires the Secretary to determine an applicable percentage increase for these low-volume hospitals based on the ''empirical relationship'' between ''the standardized cost-per-case for such hospitals and the total number of discharges of these hospitals and the amount of the additional incremental costs (if any) that are associated with such number of discharges.'' The statute thus mandates the Secretary to develop an empirically justifiable adjustment formula based on the relationship between costs and discharges for these low-volume hospitals. The statute also limits the adjustment to no more than 25 percent.

MedPAC has published an analysis of the financial performance and cost profiles of low-volume hospitals (MedPAC June 2001 Report to Congress, page 66). Its analysis indicated that hospitals with 500 discharges or less generally have negative Medicare margins. Specifically, hospitals with 200 discharges or less have margins of −16.4 percent, and hospitals with 201 to 500 discharges have margins of −2.1 percent. MedPAC's analysis further revealed that hospitals with a small volume of discharges have higher costs per discharge than larger facilities, after controlling for the other cost factors recognized in the payment system. MedPAC's analysis thus indicates that low-volume providers are disadvantaged by payment rates based on average volume. In analyzing the relationship between costs per case and discharges, MedPAC also found that this relationship begins to level off and reaches zero variation at around 500 discharges. Therefore, MedPAC recommended an adjustment formula in the form of:

$1.25 = (.0005*D)$, if $D<500$ discharges

Where 1.25 represents the maximum 25-percent add-on, .0005 is the payment adjustment per case (derived by dividing .25 by 500 discharges) and ''D'' is the number of discharges.

Using FY 2001 cost report data, we found an even larger disparity than MedPAC found between low-volume providers and their higher-volume counterparts. Although Medicare margins remain healthy overall at 9.32 percent, the Medicare margin for providers with 200 or less discharges is −46.26 percent, and the margin for providers with 201 to 500 discharges is −11.74 percent. We employed a bivariate regression analysis to determine the fit between total hospital discharges and operating costs from FY 2001. For the final rule, we plan to conduct more detailed multivariate analyses. We have some concerns about whether we have sufficient information (for example, total hospital case-mix) to support valid multivariate analyses. We are continuing to examine this in preparation for the final rule.

We found a very strong correlation between costs and the total number of discharges. We then examined the variation in cost-per-case among subsection (d) hospitals, using both log and nonlog functions. When the analysis was limited to hospitals with fewer than 1,000 discharges, we found a strong relationship between cost per case and low volume. We found that the greatest variation from the mean costs per case exists between 1 and 150 discharges, indicating (as MedPAC also found) that hospitals with the lowest case volume generally experience greater costs per case than hospitals with higher volume. However, after about 150 discharges, the trend line begins to level off rapidly. The trend line reaches zero variation from mean cost per case at approximately 450 discharges (cost per case in log form) or 500 discharges (nonlog form). Immediately after that point, the trend line in both forms becomes negative, while still maintaining a very smooth line. Both because of where the trend line crosses zero and because there is very little variation from the mean after this point, we believe that 500 discharges is the appropriate cutoff for an add-on payment under this provision.

Based on these results, we are proposing to adopt a slightly revised version of MedPAC's recommended formula for an add-on payment to low-volume hospitals:

$\text{Adjustment} = 1.25 - (.0005*D)$, if $0<D\leq 500$ discharges

Where 1.25 represents the maximum 25 percent add-on, .0005 is the payment adjustment per case (derived by dividing .25 by 500 discharges) and ''D'' is the number of discharges. We are proposing to revise the MedPAC recommended formula by adding the condition that ''D>0'' in order to avoid the anomalous result that a hospital without any discharges would qualify for the maximum 25-percent adjustment.

We note that, under this formula, some hospitals that meet the statutory definition of low-volume hospital would receive no adjustment. Specifically, hospitals with more than 500 but fewer than 800 total discharges for the year would receive no adjustment under this formula. Despite the statutory definition of a low-volume hospital as a subsection (d) hospital that has less than 800 discharges during the fiscal year, the statutory provision mandating this adjustment also requires the Secretary to determine the empirical relationship between the standardized cost-per-case, the total number of discharges, and the amount of incremental costs associated with the number of discharges. In addition, the provision requires that the applicable percentage increase shall be ''based upon such relationship in a manner that

reflects * * * such incremental costs.'' We believe that the statutory language thus gives the Secretary the flexibility to set the percentage increase at zero for a given number of discharges if the empirical evidence shows that hospitals experience no higher incremental costs when they reach that number of discharges. In other words, the statute does not require the Secretary to provide an adjustment in the absence of empirical evidence that an adjustment is warranted by higher incremental costs.

While the statute defines low-volume hospitals in terms of total inpatient acute care discharges and mandates that the adjustment be based upon the amount of incremental costs associated with the number of discharges, it does not specify whether the count of discharges, either for purposes of the definition or the payment adjustment formula, should be based on the payment year or some previous year. Specifically, the statute defines low-volume hospital as ''for *a fiscal year,* a subsection (d) hospital * * * [that] has less than 800 discharges during *the fiscal year'' (emphasis added).*

We believe that this statutory language gives us the flexibility to define which fiscal year to use in determining the number of discharges, both for purposes of the definition of ''low-volume hospital'' and the payment adjustment formula. Prospective payment systems place substantial value on providing hospitals with predictability regarding payments. If the determination of whether hospitals qualify for low-volume payment adjustments and the computation of the payment adjustment amount are based on the number of discharges in the current fiscal year, neither CMS nor the hospital will know with certainty whether a hospital qualifies for the adjustment, or what the amount of the adjustment would be, until after the end of the payment year (probably not until the time of final cost report settlement for the year). In such circumstances, CMS could be faced with the prospect of recouping large overpayments in some cases or reimbursing for large underpayments in others. Hospitals would face similar uncertainties. On the other hand, if these determinations are based on discharge counts from a prior fiscal year, hospitals will know in advance whether they will be receiving a payment adjustment and what the size of the adjustment will be. Both hospitals and CMS will be able to plan accordingly.

Therefore, we are proposing to base the count of discharges, for purposes both of meeting the qualifying definition and determining the amount of the payment adjustment, on the number of inpatient acute care discharges occurring during the cost reporting period for the most recent submitted cost report. We recognize that this policy may temporarily disadvantage certain hospitals. For example, a hospital that had more than 500 discharges in its most recent submitted cost report may have fewer than 500 discharges during the first fiscal year in which this low-volume payment adjustment is available. Such a hospital would not qualify for the low-volume adjustment during the first fiscal year of the adjustment under the policy that we are proposing, but it would qualify under alternative policy of basing the discharge count on the fiscal year for which payment is made. However, even in such cases, the hospital would not be certain about whether it would receive an adjustment until its cost report for the payment year is settled. In addition, under the policy we are now proposing, the hospital would still be certain of receiving a low-volume adjustment for any fiscal year in which it had 500 or fewer discharges. The hospital would receive the adjustment during the fiscal year after the cost report is submitted for any fiscal year in which the hospital had 500 discharges or less.

A further implication of this proposed policy is that a new hospital would not receive an adjustment during its first year of operation, even if it has fewer than 500 total discharges during that year. While this approach is somewhat disadvantageous for hospitals in their first year of existence, we believe that it is justified in order to avoid setting up a settlement process to finalize payments under this new proposed adjustment. Therefore, we are proposing that new hospitals that meet the distance requirement would not be eligible for the adjustment until data become available to determine that the annual number of discharges is 500 or less. Under this approach, new hospitals would not receive a low-volume adjustment during at least the first 2 years of their existence. (This is generally the amount of time that elapses before submission of a cost report.) This treatment is consistent with the treatment of some existing hospitals, for example, hospitals that have declining numbers of discharges, and would not be eligible for the adjustment until their data show 500 or fewer discharges.

As we noted above, the statute defines a low-volume hospital as a subsection (d) hospital that the Secretary determines is located more than 25 road miles from another subsection (d) hospital and that has less than 800 discharges during the fiscal year. In order to enforce the requirement that a qualifying hospital must be located more than 25 miles from another PPS hospital, we are proposing that a hospital that wishes to qualify for the adjustment must provide its fiscal intermediary with evidence that it meets this distance requirement. The intermediary will then certify, on the basis of the evidence presented by the hospital and any other relevant evidence that it may be able to develop, that the hospital meets this requirement. Other relevant evidence may include maps, mapping software, and inquiries to State and local police, transportation officials, or other government officials.

We are proposing to add a new § 412.101 to incorporate the provisions of section 406 of Public Law 108–173.

N. Medicare Geographic Classification Review Board (MGCRB) Reclassifications (§§ 412.230, 412.234, and 412.236)

[If you choose to comment on issues in this section, please include the caption ''Hospital Reclassifications'' at the beginning of your document.]

1. Background

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

Effective with reclassifications for FY 2003, section 1886(d)(10)(D)(vi)(II) of the Act provides that the MGCRB must use the average of the 3 years of hourly wage data from the most recently published data for the hospital when evaluating a hospital's request for reclassification. The regulations at § 412.230(e)(2)(ii) stipulate that the wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes. To evaluate applications for wage index reclassifications for FY 2005, the

MGCRB used the 3-year average hourly wages published in Table 2 of the August 1, 2003 IPPS final rule (68 FR 50135). These average hourly wages are taken from data used to calculate the wage indexes for FY 2002, FY 2003, and FY 2004, based on cost reporting periods beginning during FY 1998, FY 1999, and FY 2000, respectively.

2. Standardized Amount Reclassification Provisions

As specified in § 412.230(d)(1), to be reclassified to an adjacent area for the purpose of using that area's standardized amount, an individual hospital seeking redesignation must demonstrate that its incurred costs are comparable to hospital costs in the adjacent area (that is, hospitals must demonstrate that their costs exceed their current payments by 75 percent of the additional payments they would receive through reclassification) and that it has the necessary close proximity to that area (that is, an urban hospital must be no more than 15 miles and a rural hospital no more than 35 miles from the adjacent area; or at least 50 percent of the hospital's employees must reside in the adjacent area).

Under section 402(b) of Public Law 108–7, Congress provided that all inpatient PPS hospitals be paid at the large urban average standardized amount for discharges occurring on or after April 1, 2003 and before October 1, 2003. Under Public Law 108–89, Congress extended section 402(b) of Public Law 108–7 to discharges occurring through March 31, 2004. Section 401 of Public Law 108–173 further extended the equalization of urban and rural operating standardized payment amounts. (*See* section IV.B. of this preamble for a more detailed discussion.) Section 401 also equalized the Puerto Rico-specific urban and other area rates by requiring that the Puerto Rico-specific urban and other area rates be made retroactive to October 1, 2003. The Puerto Rico-specific equalization of the urban and rural operating standardized amounts became effective for discharges beginning on or after April 1, 2004.

As a result of these legislative changes, the standardized amount reclassification criterion is no longer necessary or appropriate. Therefore, we are proposing to revise § 412.230 and § 412.234 to remove all standardized amount criteria provisions. We are proposing to remove the provisions of ''§ 412.230(d)'' (existing paragraph (e) would be redesignated as paragraph (d)), and to remove § 412.234(c) and (d)(2) (existing paragraph (d)(1) would be redesignated as paragraph (c) and revised), which contain the criterion requiring individual hospitals and urban hospital groups to demonstrate that their costs are more comparable to the average amount they would be paid if they were reclassified than the amount they would be paid under their current classification.

With the implementation of the equalization of the national adjusted operating standardized amount for large urban and other areas provision of Public Law 108–173, we also are proposing the following technical revisions to several sections under Subpart L of Part 412, which set forth the criteria and conditions for redesignations.

- We are proposing to delete the cross-reference to ''§ 412.230(d)(2)'' cited in § 412.230(a)(4) and to make redesignation changes for the existing cross-reference changes to paragraph (e), which is proposed to be redesignated as paragraph (d).
- We are proposing to delete § 412.230(a)(5)(ii) (the existing paragraphs (a)(5)(iii), (a)(5)(iv), and (a)(5)(v) would be redesignated as paragraphs (a)(5)(ii), (a)(5)(iii), and (a)(5)(iv), respectively. Under existing § 412.230(a)(5)(ii), we defined, for fiscal years 1997, 1998, and 2002, the limitation for redesignation for purposes of the standardized amount. Our policy has been that a hospital may not be redesignated for purposes of the standardized amount to an area that does not have a higher standardized amount than the standardized amount the hospital currently receives.

We are proposing to delete existing § 412.236. Section 412.236 sets forth the redesignation criteria for hospitals in a NECMA. Under the new CBSAs, OMB has defined the MSAs and Micropolitan areas in New England on the basis of counties. As discussed in section III.B. of this proposed rule, to maintain consistency in the definition of labor market areas between New England and the rest of the country, we are proposing to use the New England MSAs under the new CBSA definition. Proposing to adopt the New England MSAs requires not only that we delete the reference to NECMAs in existing definitions, but that we also delete reference to criteria applicable to hospitals located in a NECMA that apply for reclassification. In keeping with the proposal to define labor market areas as MSAs, including those in New England, the criteria and conditions for redesignation set forth in § 412.230 will be applicable to New England hospitals seeking to reclassify.

In an effort to refine the reclassification guidelines, we established §§ 412.234 and 412.236 in the existing guidelines to allow for reclassification of urban groups and New England groups, respectively (56 FR 25458). Under § 412.232(a) and § 412.234(a), we set forth similar criteria for rural and urban hospitals to be reclassified as a group, respectively. Prior to the implementation of legislation to eliminate the differential in the standardized amount, urban county groups that were interested in applying for purposes of the wage index submitted applications to the MGCRB for consideration. Many urban county group applications were unable to reclassify solely because they failed to meet the standardized amount criteria. In light of the fact that the standardized amount criteria are no longer appropriate, we believe it would be appropriate to make an adjustment to the hospital's wage index by assigning, to hospitals that were unable to reclassify in applications for both FY 2004 and FY 2005, the wage index for the MSA requested in the FY 2004 and FY 2005 group application. Section 1886(d)(5)(I)(i) of the Act provides the Secretary with broad authority to make adjustments and exceptions under the IPPS. Specifically, the section provides that the ''Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.'' Under this unique circumstance, we are proposing to exercise the broad authority under section 1886(d)(5)(I)(i) of the Act, to make an exception to the assignment of wage index value for certain hospitals that failed to reclassify as a group under § 412.234 for FY 2004 and FY 2005. Specifically, effective with discharges occurring during the 3-year period beginning October 1, 2004 through September 30, 2007, any hospital whose urban county group application under § 412.234 would have been approved by the MGCRB but for the failure to meet the requirements in § 412.234(c), would be assigned the wage index for the MSA identified in the FY 2004 and FY 2005 group application (in cases where the group identified more than one preference, the hospital would be assigned the wage index that is most advantageous). Hospitals that wish to receive the wage index of the area identified in their FY 2004 and FY 2005 group applications under this provision need only notify CMS in writing, at the address provided under the Addresses section of this proposed rule, before the close of the comment period. The notification should only contain:

- The hospital's name and street address.
- The hospital's provider number.

- The name, title, and telephone number of a contact person for communications.
- The area (name and MSA number) identified in their FY 2005 group application.
- Copies of any and all MGCRB decision notification letters for FY 2004 and FY 2005.

3. Reclassification of Urban Rural Referral Centers

Under existing regulations at § 412.230(e)(3), rural referral centers (RRCs) (including hospitals that were ever RRCs) are exempt from one of the average hourly wage criteria that apply to other hospitals seeking reclassification. Specifically, an RRC is exempt from the requirement under § 412.230(e)(1)(iii) that the hospital's 3-year average hourly wage meet a threshold percentage in relation to the average hourly wage of all the hospitals in the area in which the hospital is located. These threshold percentages are 108 percent for hospitals located in urban areas, and 106 percent for hospitals located in rural areas. However, an RRC is not exempt from another threshold requirement, namely the requirement under § 412.230(e)(1)(iv) that the hospital's 3-year average hourly wage must meet a threshold percentage of the 3-year average hourly wage of the hospitals located in the area to which the hospital seeks reclassification. As in the case of the first threshold, this threshold percentage is different for urban and rural hospitals. An urban hospital's 3-year average hourly wage must be at least 84 percent of the average hourly wage of the hospitals located in the area to which the hospital seeks reclassification, while a rural hospital's 3-year average hourly wage must be at least 82 percent of the average hourly wage of the hospitals located in the area to which the hospital seeks reclassification.

It has come to our attention that the requirement of § 412.230(e)(1)(iv) places RRCs located in urban areas on a different footing than RRCs located in rural areas. In some cases, urban RRCs that have been denied reclassification because they failed to meet the 84-percent threshold would have been able to meet the 82-percent threshold that would have applied if they were located in a rural area. RRCs play a significant role in treating Medicare beneficiaries from rural areas, whether or not a particular RRC is physically located in a rural area or an urban area. Thus, we believe that it would be more appropriate for all RRCs, whether they are actually located in urban or rural areas, to be treated on an equal basis with respect to the qualifications for geographic reclassification. Therefore, we are proposing to revise § 412.230(e)(1)(iii) of the regulations to provide that RRCs, including RRCs located in urban areas, must meet the 82-percent threshold that applies to rural hospitals rather than the 84-percent threshold that applies to urban hospitals.

Furthermore, we are aware of at least one case in which an RRC was reclassified by the MGCRB for FY 2004, but upon applying to the MGCRB for FY 2005, was found to be ineligible for reclassification because its 3-year average hourly wage was now less than 84 percent of the hospitals located in the MSA to which it applied for reclassification. In this case, the hospital's 3-year average hourly wage was still greater than 82 percent of the MSA to which it had applied for reclassification. In such a case, we believe that it would be appropriate to make an accommodation for one year, so that the hospital is not subjected to the financial strain that may be caused by receiving a lower wage index for one year until it qualifies to apply for reclassification under the revised threshold criterion that we are proposing here. Therefore, we are proposing that, in such a case, we would exercise our authority under section 1886(d)(5)(I)(i) of the Act to make an exception by assigning to the hospitals for one additional year the wage index that applied to the hospital in FY 2004 through FY 2005. We are proposing to use this authority to provide, under this unique circumstance, special protection to a small number of hospitals that would otherwise be subject to a temporary, but serious, disadvantage. Specifically, we would assign an RRC that meets the conditions described above, the wage index value of the MSA to which it was reclassified by the MGCRB in FY 2004. In order to be eligible for this exception, the hospital may not qualify for any geographic reclassification for discharges effective October 1, 2004 (under the regular rules or the special one-time appeal provision). This assignment would be valid only for FY 2005, after which the hospital would have the opportunity to apply for reclassification under the new threshold for all RRCs that we are proposing in this rule.

We are proposing to revise proposed redesignated § 412.230(d)(3) and add a new § 412.64(j) to incorporate this proposal.

4. Special Circumstances of Sole Community Hospitals (SCHs) in Low Population Density States

Medicare program policy has long provided special treatment for hospitals in rural areas. For many years, rural hospitals have experienced lower margins than other hospitals, and Congress has created several special measures to address the unique issues of hospitals in rural areas. For example, Congress created the CAH program in 1997 to ensure that beneficiaries in isolated areas had access to emergency services and certain essential inpatient services. To qualify for CAH designation, a hospital must be located more than 35 miles from the nearest similar hospital and have an average length of stay not exceeding 4 days. A CAH must provide 24-hour emergency care services and have no more than 25 acute care beds. CAHs are currently paid 101 percent of their current Medicare allowable costs for inpatient and outpatient services. Similarly, the SCH program has long served to maintain access to needed health services for beneficiaries in isolated communities. SCHs 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 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

Many rural hospitals have taken advantage of the opportunity to participate in the CAH program in recent years. We expect the number of hospitals to increase because of the changes made to the CAH program under recently enacted Public Law 108–173 (for example, increasing the reasonable cost payment rate from 100 percent to 101 percent and increasing the qualifying bed size limitation from 15 to 25). Because CAHs are paid on the basis of their reasonable costs, the wage index is not a factor in their payments, and geographic reclassification is thus not an issue for these hospitals. However, for many rural hospitals that cannot qualify for CAH status, the wage index remains an important factor in their payment, even in the case of SCHs paid on their hospital-specific rate, for which the only impact of the wage index may be on their inpatient capital and outpatient payments. The regulations governing reclassifications by the MGCRB provide special treatment for SCHs by exempting them from the normal rules that require hospitals to demonstrate a close

proximity (15 miles in the case of urban hospitals; 35 miles for rural hospitals), and allowing these hospitals to reclassify to the urban area or the rural area that is the closest to the hospital.

Wage index assignment is an especially pressing issue for hospitals in States with low population densities. In such States, employees are likely to commute greater distances to work. More distant areas are thus likely to compete for labor than is the case in more densely populated States. Because of this concern, and the program's longstanding recognition of these hospitals, we exercised our discretion in implementing the special one-time wage index reclassification appeal provision of section 508 of Pub. L. 108–173 to provide special consideration for SCHs in States with fewer than 10 people per square mile, based on 2000 census data (Alaska, Montana, North Dakota, South Dakota, and Wyoming). Specifically, we provided that SCHs in such a State could reclassify to an MSA within its State. More than 20 SCHs in those States were able to reclassify under this provision.

However, a number of SCHs from those States were precluded from reclassifying under the terms of section 508. We are concerned that these hospitals could now be placed at a serious disadvantage in comparison to other SCHs in their States and regions. Under the authority of section 1886(d)(5)(I)(i) of the Act, we are proposing to provide, under these unique and temporary circumstances, special protection to a small number of hospitals that would otherwise be subject to a temporary, but serious, disadvantage. Specifically, we are proposing to allow an SCH in one of the States with fewer than 10 people per square mile (Alaska, Montana, North Dakota, South Dakota, and Wyoming) to adopt the wage index of another geographic area within its State for 3 years.

Such wage index assignments would become effective for FY 2005 through FY 2007. Because the wage index assignments would be made in order to remedy a temporary disadvantage, the assignments would be for the 3-year period only and would not be available thereafter. In order to receive the wage index of another area under this proposal, a SCH may not qualify for reclassification (under the regular rules or the special one-time appeal provision) effective for discharges on or after October 1, 2004. SCHs in the identified States will not be required to meet proximity or access requirements similar to those required for reclassification in order to qualify for change in wage index under this provision. SCHs that wish to receive the wage index of another area within their State under this provision need only notify CMS in writing, at the address in the ''Addresses'' section provided for comments on this proposed rule, before the close of the comment period. The notification should contain:

- The hospital's name and street address.
- The hospital's provider number.
- The name, title, and telephone number of a contact person for communications.
- A statement certifying the SCH status.
- The name of the area within the State whose wage index the hospital wishes to adopt.

5. Possible Reclassifications for Dominant Hospitals and Hospitals in Single-Hospital MSAs

Representatives of individual hospitals have expressed concern about the special circumstances of dominant hospitals and hospitals in single-hospital MSAs in relation to the wage index and the rules governing geographic reclassification. The term ''dominant hospital'' generally refers to a hospital that pays a substantial proportion of all the wages paid by hospitals geographically located in the hospital's area. A dominant hospital necessarily has a preponderate influence on the wage index calculation for the area in which it is located. As a result, dominant hospitals find it difficult to meet the threshold requirements for wage index reclassification; for example, the requirement that an urban hospital's average hourly wage is at least 108 percent of the average hourly wage of hospitals in the area in which the hospital is located (§ 412.230(e)(1)(iii)(B)). Indeed, a dominant hospital would find it difficult to meet any threshold based on the ratio of the hospital's average hourly wage to the average hourly wage of hospitals in the area, unless the dominant hospital's wage data were removed from the denominator for purposes of the comparison. Dominant hospitals have argued that this places them in an unfair situation. While the lower wages of other, smaller hospitals in the area can still have the effect of holding down their wage index, their dominant position makes it difficult, or even impossible, to reclassify to another area where the wage index may more closely reflect their costs.

Hospitals in single-hospital MSAs face a situation that is similar in certain respects, but quite different in others. By definition, the wage index for the sole hospital in an MSA is based completely on that hospital's wage data. Such a hospital receives, in effect, its own unique wage index, reflecting the hospital's exact position in relation to the national average hourly wage. As a result, these hospitals cannot qualify for reclassification, unless they are exempt from the wage threshold requirements due to rural referral center status. By definition, the ratio of such a hospital's average hourly wages to the area average hourly wage is always 100 percent, and these hospitals thus cannot meet either the 108 percent threshold for urban hospitals or the 106 percent threshold for rural hospitals (§ 412.230(e)(1)(iii)(B)). Unlike dominant hospitals, hospitals in single-hospital MSAs cannot argue that they are disadvantaged by the effect that lower wage hospitals can have on the area wage index. However, these hospitals have contended that they are sometimes in the position of competing for labor with hospitals in nearby MSAs with higher wage indexes. Under these circumstances, these hospitals cannot reclasssify to the higher wage index area even if they meet the relevant distance requirements. These hospitals also contend that they cannot afford to compete with hospitals that are paid under a higher wage index, and the 3-year lag in the data used to compute the wage index can place them in a permanent position of playing catchup. On the other hand, it is also true that such a disadvantage may be only temporary because increasing wages may eventually equalize wage index values despite the temporary financial disadvantage that would accrue to these hospitals during the 3-year lag period.

We are inviting comment on the concerns raised by hospitals in these two situations and on possible methods of addressing these concerns. A number of measures might be considered to address the concerns of these hospitals. In the case of dominant hospitals, the threshold requirements for reclassification could be revised to provide that a hospital's average hourly wage is at least 108 percent (in the case of urban hospitals) or 106 percent (in the case of rural hospitals) of the average hourly wages of *all other* hospitals in the area. Removing a dominant hospital's wages from the denominator of the ratio would remove the current disadvantage imposed by their dominant status, and make it more realistic for a dominant hospital to meet the threshold requirement. An existing provision under § 412.230(e)(4) provides this treatment for certain dominant

hospitals, specifically those that were approved for reclassification each year from 1992 through 1997. We could develop a parallel provision that applies to dominant hospitals generally. The use of this revised ratio could be restricted to the special circumstances of dominant hospitals, or extended to all hospitals. We could also adopt a revised threshold for dominant hospitals, as we did in the notice setting forth the criteria for reclassification under the one-time wage index appeal provision of section 508 of Public Law 108–173 (69 FR 7342). Consistent with the criteria from that notice, a dominant hospital might be defined for this purpose as a hospital that pays at least 40 percent of all the wages paid by hospitals geographically located in the hospital's area. We are considering adopting one of these measures in the final rule, and welcome comments on the advisability of doing so.

In the case of hospitals in single-hospital MSAs, one new provision that we are proposing to implement in this proposed rule may address some of their concerns (*see* section III.G.3.2. of this preamble). Section 505 of Public Law 108–173 provides for a new wage index adjustment for hospitals in lower wage areas in cases where significant numbers of hospital workers commute from the lower wage area to higher wage areas nearby. The statute requires that at least 10 percent of the hospital workers in a county must be commuting to a higher wage area, or areas, in order for the hospitals in the county to receive the adjustment. The adjustment formula provides for an increase to the wage index for hospitals in the county, based on the differences between the wage index that applies to the county and the higher wage indexes of nearby areas, in proportion to the percentages of hospital workers commuting to the higher wage index areas. To the degree that hospitals in single-hospital MSAs experience disadvantages in competing for hospital workers with hospitals in higher wage index areas, we expect that the counties in which these hospitals are located would qualify for this adjustment. We are actively considering whether to address the concerns of these hospitals more directly. At the same time, we intend to analyze the extent to which this provision would alleviate the concerns of these hospitals. We welcome comments on the special circumstances of hospitals in single-hospital MSAs and whether their special circumstances should be addressed by revisions to the regulations governing reclassification, or other measures.

6. Special Circumstances of Hospitals in All-Urban States

Section 4410 of Public Law 105–33 (BBA) provides that, for the purposes of section 1886(d)(3)(E) of the Act, for discharges occurring on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in the State. This provision, commonly referred to as the ''rural floor,'' currently affects the payments received by 150 hospitals in 49 MSAs. For these 150 hospitals, the applicable wage index and overall payment amounts under the IPPS are higher than they would be if their wage indexes were computed solely on the basis of the wage data from their MSAs. The wage index floor is applied in a budget neutral manner, so that aggregate IPPS payments each year are not greater or less than those that would have been made in the absence of this provision.

The ''rural floor'' under section 4410 of Public Law 105–33 does not apply in the two States that have no rural areas under the labor market definitions that apply within the IPPS. Hospitals in these two States have commented that the absence of a rural floor disadvantages them for wage index purposes compared to hospitals in States where the ''rural floor'' provision can apply. Specifically, some hospitals contend that they would have higher wage indexes, and higher payments overall, if there were a rural area in their State to set a floor under the wage indexes within the State.

We are considering whether it would be appropriate to adopt some measure to address the concerns of these hospitals. For example, we are examining the ratios between the lowest and highest wage index values in States where the ''rural floor'' affects the wage indexes of some hospitals. We might consider employing the average ratio of highest-to-lowest wage indexes in those States to set an imputed ''rural floor'' for all-urban States. For example, assume the average ''lowest-to-highest'' ratio of States with rural floors is 0.9500. Assume further that the lowest wage index in an all-urban State is 1.0000, and the highest is 1.1000. The ''lowest-to-highest'' ratio for that State is 0.9091. If we apply the average ''lowest-to-highest'' ratio to the highest wage index in the all-urban State, we would multiply 0.9500 by 1.1000, which yields 1.0450. The imputed analogue to the ''rural floor'' for the all-urban State would then be 1.0450. Any hospital with a regular wage index value less than 1.0450 would then receive the new imputed floor.

We welcome comments on the position of hospitals in all-urban States relative to hospitals that receive the ''rural floor'' in other States. We also welcome comments on whether it would be advisable to adopt an imputed floor measure or some alternative measure to address the concerns of hospitals in these States. We note that, in order to be consistent with the statutory provision establishing the rural floor, we would apply any such measure in budget neutral manner, that is, we would adjust the standardized amount so that aggregate IPPS payments each year are not greater or less than those that would have been made in the absence of this provision.

O. Payment for Direct Graduate Medical Education (Existing § 413.86)

[If you choose to comment on issues in this section, please include the caption ''Graduate Medical Education'' at the beginning of your comment.]

1. Background

Section 1886(h) of the Act, as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272) and implemented in regulations at existing § 413.86, establishes a methodology for determining payments to hospitals for the costs of approved GME programs. Section 1886(h)(2) of the Act, as added by COBRA, sets forth a payment methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of October 1, 1983 through September 30, 1984). The PRA is multiplied by the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital (and nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days to determine Medicare's direct GME payments. In addition, as specified in section 1886(h)(2)(D)(ii) of the Act, for cost reporting periods beginning on or after October 1, 1993, through September 30, 1995, each hospital-specific PRA for the previous cost reporting period is not updated for inflation for any FTE residents who are not either a primary care or an obstetrics and gynecology resident. As a result, hospitals that train primary care and obstetrics and gynecology residents, as well as nonprimary care residents in FY

1994 or FY 1995, have two separate PRAs: one for primary care and obstetrics and gynecology and one for nonprimary care.

The BBRA (Pub. L. 106–113) amended section 1886(h)(2) of the Act to establish a methodology for the use of a national average PRA in computing direct GME payments for cost reporting periods beginning on or after October 1, 2000, and on or before September 30, 2005. The BBRA established a ''floor'' for hospital-specific PRAs equal to 70 percent of the locality-adjusted national average PRA. In addition, the BBRA established a ''ceiling'' that limited the annual adjustment to a hospital-specific PRA if the PRA exceeded 140 percent of the locality-adjusted national average PRA. Section 511 of the BIPA (Pub. L. 106–554) increased the floor established by the BBRA to equal 85 percent of the locality-adjusted national average PRA. Existing regulations at § 413.86(e)(4) specify that, for purposes of calculating direct GME payments, each hospital-specific PRA is compared to the floor and the ceiling to determine whether a hospital-specific PRA should be revised.

Section 1886(h)(4)(F) of the Act established caps on the number of allopathic and osteopathic residents that hospitals may count for purposes of calculating direct GME payments. For most hospitals, the caps were the number of allopathic and osteopathic FTE residents training in the most recent cost reporting period ending on or before December 31, 1996.

Note to Readers: This proposed rule includes a major redesignation of the contents of § 413.86. As a result of the numerous amendments we have made over the years, the size of § 413.86 has become voluminous and difficult to follow because of the multiple levels of coding. We are taking a first step to split the one section (§ 413.86) into nine individual sections (§§ 413.75 through 413.83). We are proposing to designate each first level paragraph under existing § 413.86 as a separate new section and vacate § 413.86. At this time, we are not proposing to make any changes in the language of these new redesignated sections, except for the changes that are discussed in section IV.O. of this preamble (which would conform to the existing language of § 413.86) and any appropriate cross-reference and conforming changes. We are providing a detailed crosswalk of the existing paragraphs of § 413.86 to the proposed new §§ 413.75 through 413.83. In addition, in any discussion of changes we are proposing to make, we are providing both the existing citation under § 413.86 and the proposed redesignated section and paragraph. At a later date, we may further refine the contents of the redesignated sections to improve readability.

2. Reductions of and Increases in Hospitals' FTE Resident Caps for GME Payment Purposes Under Section 422 of Public Law 108–173 (Proposed Redesignated § 413.79 (a Proposed Redesignation of § 413.86(g))

a. General Background on Methodology for Determining the FTE Resident Count

As we explain earlier in this preamble, Medicare makes both direct and indirect GME payments to hospitals that train residents in approved medical residency training programs. Direct GME payments are made in accordance with section 1886(h) of the Act, based generally on hospital-specific PRAs, the number of FTE residents a hospital trains, and the hospital's Medicare patient share. IME payments are made in accordance with section 1886(d)(5)(B) of the Act, based generally on the ratio of the hospital's FTE residents to the number of hospital beds. Accordingly, the calculation of both direct GME and IME payments is affected by the number of FTE residents that a hospital is allowed to count; generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive. In an attempt to end the implicit incentive for hospitals to increase the number of FTE residents, Congress instituted a cap on the number of allopathic and osteopathic residents a hospital is allowed to count for direct GME and IME purposes under the provisions of section 1886(h)(4)(F) of the Act for direct GME and section 1886(d)(5)(B)(v) of the Act for IME. Dental and podiatric residents were not included in this statutorily mandated cap.

b. Reduction of Hospitals' FTE Resident Caps Under the Provisions of Section 422 of Public Law 108–173

Medicare makes direct GME and IME payments based only on the number of FTE residents that is within a hospital's FTE resident cap. Some hospitals have trained a number of allopathic and osteopathic residents in excess of their FTE resident caps. Other hospitals have reduced their resident counts to some level below their FTE resident caps. Section 422 of Public Law 108–173 added a new section 1886(h)(7) to the Act to provide for reductions in the statutory resident caps under Medicare for certain hospitals and authorize a ''redistribution'' of the FTE resident slots resulting from the reduction in the FTE resident caps to other hospitals.

The new section 1886(h)(7)(A) of the Act provides that a hospital's FTE resident cap will be reduced if its reference resident level, as described below, is less than its otherwise applicable FTE resident cap. Rural hospitals with less than 250 acute care inpatient beds are exempt from these reductions. For other hospitals, the reduction will be equal to 75 percent of the difference between the hospital's otherwise applicable FTE resident cap and its reference resident level.

(We note that the remainder of this section IV.O. of this preamble addresses the provisions of section 1886(h)(7) of the Act, as added by section 422 of Public Law 108–173, as it relates to hospitals' FTE resident caps for direct GME and IME payment purposes. We address the provisions of section 1886(h)(7) of the Act as it relates specifically to the IME adjustment under section IV.K.2. of this preamble.)

Under the new section 1886(h)(7)(B) of the Act, the Secretary is authorized to increase the otherwise applicable FTE resident caps for certain categories of hospitals for portions of cost reporting periods occurring on or after July 1, 2005, by an aggregate number that does not exceed the estimated overall reduction in FTE resident caps for all hospitals under section 1886(h)(7)(A). A single hospital may receive an increase in its FTE resident cap of no more than 25 additional FTEs. In determining which hospitals would receive an increase in their FTE resident caps, section 1886(h)(7)(B) of the Act directs us to—

- Take into account the demonstrated likelihood of the hospital filling the additional positions within the first three cost reporting periods beginning on or after July 1, 2005.
- Establish a priority order to distribute resident slots first to programs in hospitals located in rural areas; second, to urban hospitals that are not in large urban areas; and third, to other hospitals operating a training program in a State where there is no other training program for a particular specialty in the State.

In summary, section 422 of Public Law 108–173 added a new section 1886(h)(7) of the Act that prescribes a methodology for determining reductions to certain hospitals' FTE resident caps based on unused FTE resident slots, provides for certain exceptions to the FTE resident cap reductions, and includes general criteria that CMS must consider in the redistribution, to other hospitals, of the estimated number of FTE resident slots resulting from the reductions in the FTE resident caps. In this proposed rule, we are proposing procedures for determining whether, and by what amount, a hospital's FTE resident cap is subject to a reduction under section 1886(h)(7) of the Act. We

also are proposing an application process for hospitals that seek to receive increases in their FTE resident caps and the specific criteria that we would use to determine which hospitals will receive the increases in their FTE resident caps under section 1886(h)(7)(B) of the Act.

c. Hospitals Subject to the FTE Resident Cap Reduction

As indicated earlier, section 1886(h)(7)(A) of the Act, as added by section 422 of Public Law 108–173, provides that if a hospital's ''reference resident level'' is less than its ''otherwise applicable resident limit,'' its ''otherwise applicable resident limit'' will be reduced by 75 percent of the difference between its ''otherwise applicable resident limit'' and its ''reference resident level.'' Under the amendments made by section 422, the ''reference resident level'' generally refers to the number of unweighted allopathic and osteopathic FTE residents who are training at a hospital in a given cost reporting period. The ''otherwise applicable resident limit'' refers to a hospital's FTE resident cap established under sections 1886(h)(4)(F)(i) and (h)(4)(H) of the Act. A hospital's permanent FTE cap under section 1886(h)(4)(F)(i) of the Act is based on (1) for an urban hospital, the number of unweighted allopathic or osteopathic FTE residents in the hospital's most recent cost reporting period ending on or before December 31, 1996 (the ''1996 cap''), as specified under existing regulations at § 413.86(g)(4) (proposed redesignated § 413.79(c)(2)), and, if applicable, the 1996 cap adjusted for new programs as specified under existing § 413.86(g)(6) (proposed redesignated § 413.79(e)); or (2) for a rural hospital, 130 percent of the 1996 cap increased, as specified under existing § 413.86(g)(4) and, if applicable, the 1996 cap adjusted for new programs as specified under § 413.86(g)(6), or the 1996 cap with both adjustments. We also note that a hospital's 1996 cap may be adjusted in other instances (such as temporary adjustments for program or hospital closure) if the hospital is a member of a Medicare GME affiliated group under existing § 413.86(b) (proposed redesignated § 413.75(b)), but we will discuss the applicability of affiliations under section 1886(h)(7)(A) of the Act in more detail at section IV.O.2.f.(5) of this preamble.

In our discussion of the provisions of section 422 of Public Law 108–173 under this section of this proposed rule, we will generally refer to a hospital's number of unweighted allopathic and osteopathic FTE residents in a particular period as a hospital's ''resident level.'' We will also refer to a hospital's resident level in the applicable ''reference period,'' as explained further below, as the hospital's ''reference resident level.'' In addition, we will refer to the ''otherwise applicable resident cap'' as the hospital's FTE resident cap that is applicable during a particular cost reporting period. Thus, we are proposing that if a hospital's resident level is less than the hospital's otherwise applicable resident cap in the ''reference period'' (as explained below), effective for portions of cost reporting periods occurring on or after July 1, 2005, we would permanently reduce the hospital's FTE resident cap by 75 percent of the difference between a reference resident level and the otherwise applicable FTE resident cap. For example, if a hospital's otherwise applicable FTE resident cap for the reference period is 100, and its resident level for that period is 80 FTEs, we would reduce the hospital's FTE resident cap by 15 FTEs [0.75 (100 − 80)] = 15). (Proposed redesignated § 413.79(c)(3)).

d. Exemption From FTE Resident Cap Reduction for Certain Rural Hospitals

Section 1886(h)(7)(A)(i)(II) of the Act, as added by section 422 of Public Law 108–173, specifically exempts rural hospitals (as defined in section 1886(d)(2)(D)(ii) of the Act) with less than 250 acute care inpatient beds from the possible 75 percent reduction to their FTE resident caps. Section 1886(d)(2)(D)(ii) of the Act defines a rural area as any area outside a Metropolitan Statistical Area (MSA). Under the existing regulations at § 413.62(f)(ii), an ''urban area'' means (1) a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA); or (2) the following New England counties: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. Under existing § 413.62(f)(iii), a ''rural area'' means any area outside an urban area. In addition, we note that under section III. of this preamble, which discusses wage areas, we are proposing to no longer recognize NECMAs as a distinct category of wage areas. Thus, for purposes of the amendments made by section 422, we are proposing that any hospital located in an area that is not in a MSA is a rural hospital, regardless of any reclassification under § 412.102 or § 412.103. We note that this definition of ''rural'' is consistent with our proposal under section III. of this preamble concerning designation of wage index areas.

A hospital's bed size is based on its number of available beds, as determined for IME payment purposes under § 412.105 of the regulations. For purposes of determining whether a rural hospital has less than 250 beds, we are proposing to use data from the rural hospital's most recent cost reporting period ending on or before September 30, 2002. (This information may be found on Worksheet S–3, Part I of the Medicare cost report, CMS–2552–96, column 2, the sum of lines 1 and 6 through 10, divided by the number of days in the cost reporting period.) This is the cost reporting period under section 1886(h)(7)(A)(ii)(I) of the Act that is to be used in determining a hospital's reference resident level (the unweighted allopathic and osteopathic FTE resident count) (unless a hospital makes and CMS grants a timely request under section 1886(h)(7)(A)(ii)(II) of the Act). We are proposing that if a rural hospital has less than 250 beds in its most recent cost reporting period ending on or before September 30, 2002, it would not be subject to a possible reduction to its FTE resident cap under section 1886(h)(7)(A) of the Act. However, if a rural hospital has at least 250 beds in its most recent cost reporting period ending on or before September 30, 2002, we are proposing that the rural hospital would be subject to a possible reduction to its FTE resident cap. (Proposed redesignated § 413.79(c)(3)(i)).

e. Determining the Estimated Number of FTE Resident Slots Available for Redistribution

Under section 1886(h)(7)(A) of the Act, we will determine the number of resident positions available for redistribution by estimating possible reductions to hospitals' FTE resident caps. We believe that section 422 allows us to distinguish between the FTE counts that are used to determine the number of FTE resident slots that are available for redistribution (that is, the ''resident pool''), and the actual number of FTE residents by which hospitals' FTE resident caps are ultimately reduced. We are proposing to estimate the reduction to a hospital's FTE resident cap under section 1886(h)(7)(A) of the Act for purposes of determining the number of FTEs that a hospital might contribute to the resident pool. This proposed interpretation is based on the language at section 1886(h)(7)(B)(i) of the Act, as added by section 422(a)(3), which states that the ''aggregate number of increases in the otherwise applicable

resident limits under this subparagraph may not exceed the Secretary's *estimate* of the aggregate reduction in such limits * * *'' (emphasis added). We are proposing to interpret this language to mean that we would have complied with the statute as long as the aggregate number of FTE residents by which we *increase* the FTE resident caps of qualifying hospitals under section 1886(h)(7)(B) of the Act is not more than the estimate of the aggregate number of FTE residents by which we would reduce the FTE resident caps of hospitals whose reference resident levels are less than their otherwise applicable FTE resident caps. However, we could subsequently perform an audit, as described further in section IV.O.2.f.(3) of this preamble, in order to make a final determination regarding any reductions to a hospital's FTE resident cap.

To ensure that we will begin making payments for most hospitals based on the revised FTE resident caps by July 1, 2005, we are proposing to set a date by which we will have estimated a hospital's resident level and compared it to the hospital's otherwise applicable resident cap to estimate whether, and by how much, the hospital's FTE resident cap would be reduced. We are not proposing to commit to make a final determination as to whether, and by how much, a particular hospital's FTE resident cap should be reduced as of this date, nor are we proposing to commit to inform any hospital that it will receive an increase to its FTE resident cap by this date. Rather, we are only proposing to use this date as an internal ''deadline'' to ensure that we will have sufficient time to distribute the resident pool and begin making payments for most hospitals based on the revised FTE resident caps by July 1, 2005. We are proposing that this date be May 1, 2005, and that date would apply for all hospitals for purposes of determining an estimate of whether and by how much their FTE resident caps should be reduced.

Accordingly, in the event that the fiscal intermediaries have not completed an audit (explained further under section IV.O.2.f.(3) of this preamble) by May 1, 2005, we are proposing that CMS may estimate the number of FTE residents by which a hospital's FTE resident cap should be reduced by May 1, 2005. For example, a fiscal intermediary may estimate by May 1, 2005, that Hospital A's FTE resident cap should be reduced by 10 FTEs. Thus, we would place 10 FTEs into the resident pool. It is possible that even after May 1, 2005, the fiscal intermediary may continue to audit Hospital A's relevant cost report(s) to determine if, in fact, 10 FTEs is the appropriate amount by which to reduce Hospital A's FTE resident cap, and could ultimately conclude that Hospital A's FTE resident cap should only be reduced by 8 FTEs. If the fiscal intermediary makes this final determination by May 1, 2005, we would change the number of FTE residents in the resident pool attributable to Hospital A from 10 FTEs to 8 FTEs. If the fiscal intermediary does not make this determination by May 1, 2005, based on the audit, we would only reduce Hospital A's FTE resident cap by 8 FTEs effective July 1, 2005, but the number of FTE residents in the resident pool attributable to Hospital A would remain at 10 FTEs (the estimated number as of May 1, 2005). Similarly, if the fiscal intermediary ultimately concluded that Hospital A's FTE resident cap should be reduced by 12 FTEs, but this final determination is not made by May 1, 2005, Hospital A's FTE resident cap would be reduced by 12 FTEs effective July 1, 2005, but the number of FTE residents in the resident pool attributable to Hospital A would remain at 10 FTEs.

As we stated above, because we believe that section 422 allows us to distinguish between the FTE counts that are used to determine the size of the resident pool, and the actual number of FTE residents by which hospitals' FTE resident caps are ultimately reduced, we are proposing, in certain instances, to use estimated information to determine possible reductions to hospitals' FTE resident caps. As described further below, sections 1886(h)(7)(A)(ii) and (h)(7)(A)(iii) of the Act direct CMS to adjust a hospital's reference resident level in certain instances, due to an expansion of an existing program that is not reflected on the most recent settled cost report, or to include the number of residents for which a new program was accredited, or for hospitals that are members of a Medicare GME affiliated group as of July 1, 2003. We note that, in adjusting the reference resident level in these instances, the number of FTE residents by which we adjust the reference resident level for purposes of determining possible reductions to a hospital's FTE resident cap may not be the actual or audited number of FTE residents that we would otherwise use for direct GME or IME payment purposes. For example, for expansions under newly approved programs (as explained in more detail in section IV.O.2.f.(3) of this preamble), we are proposing to adjust the reference resident level to include the number of residents for which a new program was accredited at a hospital, even though at the time the fiscal intermediary is determining possible reductions to a hospital's FTE resident cap, the hospital may not be training the full complement of residents for which the program was accredited. Thus, the number of FTE residents (including those training in the newly accredited program) for purposes of IME and direct GME payment would be dependent upon the actual number of FTEs the hospital is permitted to count in a particular cost reporting period, as determined in accordance with the regulations at § 412.105 for IME and § 413.86 for direct GME.

In addition, we realize that there may be instances where a hospital's FTE resident cap or a hospital's FTE resident count for the reference cost reporting period might be under appeal. We believe that appeals related to these issues should be resolved through the normal course of business. In the event that an appeal that may affect determinations made under section 1886(h)(7)(A) of the Act is not resolved by May 1, 2005, we are proposing that we would estimate the number of FTE residents by which a hospital's FTE resident cap should be reduced (or not reduced, as applicable) by May 1, 2005.

f. Determining the Possible Reduction to a Hospital's FTE Resident Cap

(1) Reference Resident Level—General

In order to determine if a hospital's resident level is less than the hospital's otherwise applicable FTE resident cap, section 1886(h)(7)(A)(ii) of the Act, as added by section 422 of Public Law 108–173, directs the Secretary to use one of two reference cost reporting periods. Section 1886(h)(7)(A)(ii)(I) of the Act directs CMS to use a hospital's most recent cost reporting period ending on or before September 30, 2002, ''for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary,'' as the reference period, unless we grant the hospital's timely request to use a later cost report under section 1886(h)(7)(A)(ii)(II) of the Act, as described under section IV.O.2.f.(2) of this preamble. Generally, if the hospital's resident level for either direct GME or IME is less than the hospital's otherwise applicable resident cap for direct GME or IME, respectively, for the most recent cost reporting period ending on or before September 30, 2002, the hospital's FTE resident cap for direct GME or IME will be reduced by 75 percent of the difference between the resident level and the otherwise

applicable FTE resident cap. On April 30, 2004, we issued a One-Time Notification (OTN) (Transmittal 77, CR 3247), ''Redistribution of Unused Resident Positions, Section 422 of the Medicare Modernization Act of 2003 (MMA), Public Law 108–173, for Purposes of Graduate Medical Education (GME) Payments'' that prescribed certain requirements related to the implementation of section 422 and established a deadline by which a hospital must exercise its option to request that we use of later cost report as the reference cost report. If the hospital's cost report for the most recent cost reporting period ending on or before September 30, 2002, is settled by April 30, 2004, the date on which the OTN was issued, we are proposing to use that cost report to determine if, and by how much, a hospital's FTE resident cap should be reduced. We note that the ''settled'' cost report does not necessarily mean the initial cost report settlement. The fiscal intermediary may have previously settled the cost report, reopened it to audit it, and then settled the cost report again, issuing a revised Notice of Program Reimbursement (NPR). Thus, we would refer to the more recently issued NPR. When a hospital's cost report for the most recent cost reporting period ending on or before September 30, 2002, has been settled by April 30, 2004, we are proposing to use the most recently settled cost report as of April 30, 2004, to determine any reduction to the hospital's FTE resident cap under section 1886(h)(7)(A)(ii)(I) of the Act (unless we grant the hospital's timely request under section 1886(h)(7)(A)(ii)(II) of the Act to use a later cost report, as described in section IV.O.2.f.(2) of this preamble). If the hospital's cost report for the most recent cost reporting period ending on or before September 30, 2002 has not yet been settled as of April 30, 2004, the as-submitted cost report would be used to determine any reduction in the FTE resident cap, subject to audit by the fiscal intermediary. If the cost report was initially settled, but then reopened, and the fiscal intermediary has not issued a revised NPR prior to April 30, 2004, the data from the initially settled cost report will be used to determine the possible reductions to the FTE resident caps.

(2) Expansion of an Existing Program

Section 1886(h)(7)(A)(ii)(II) of the Act, as added by section 422(a) of Public Law 108–173, provides that if a hospital's resident level increased due to an expansion of an existing program, and that expansion is not reflected on the hospital's most recent settled cost report, a hospital may make a timely request to CMS that, rather than using its most recent cost reporting period ending on or before September 30, 2002, to determine if its FTE resident cap should be reduced, CMS should use the cost report for the hospital's cost reporting period that includes July 1, 2003. For example, assume a hospital's most recent settled cost report is September 30, 2000 (that is, no NPRs were issued for subsequent year cost reports). The hospital increased its resident level due to an expansion of an existing program in its fiscal year ending September 30, 2001. The hospital may submit a timely request that CMS use its cost report that includes July 1, 2003 (which would be its cost report for the fiscal year ending September 30, 2003), to determine if and by how much the hospital's FTE resident cap should be reduced. (Proposed redesignated § 413.79(c)(3)(ii)(A)(*2*)). As explained on page 3 of the OTN, to be considered a timely and proper request, a hospital's request to use its cost reporting period that includes July 1, 2003, must be signed and dated by the hospital's chief financial officer (or equivalent) and submitted to its fiscal intermediary on or before June 4, 2004. In its timely request, the hospital must include the following:

(1) The FTE resident caps for direct GME and IME and the number of unweighted allopathic and osteopathic FTE residents for direct GME and IME in its most recently settled cost report (that is, its cost report that is more recently settled as of April 30, 2004).

(2) The FTE resident caps for direct GME and IME and the unweighted allopathic and osteopathic FTE residents for direct GME and IME for each cost report after its most recently settled cost report, up to and including its cost reporting period that includes July 1, 2003. If the cost reporting period that includes July 1, 2003, has not ended as of June 4, 2004, the hospital must report the estimated number of unweighted allopathic and osteopathic residents for that cost reporting period.

(3) If not already reported in accordance with steps 1 and 2 above, the FTE resident caps for direct GME and IME and the number of unweighted allopathic and osteopathic FTE residents for direct GME and IME in its most recent cost reporting period ending on or before September 30, 2002.

In addition, as we stated in the One-Time Notification (OTN), (Transmittal 77, CR 3247), ''Redistribution of Unused Resident Positions, Section 422 of the Medicare Modernization Act of 2003 (MMA), Public Law 108–173, for Purposes of Graduate Medical Education a hospital should refer to its most recently settled cost report as of the issuance of the OTN (that is, April 30, 2004) to determine whether the hospital believes it has expanded an existing program in a cost reporting period subsequent to the one for the most recently settled cost report.

We also are proposing that, for purposes of this provision, an ''expansion of an existing program'' means that, except for expansions due to newly approved programs, as described below in section IV.O.2.f.(4) of this preamble, the hospital's total number of unweighted allopathic and osteopathic FTE residents training in existing programs in a cost reporting period up to and including the hospital's cost report that includes July 1, 2003, is greater than the resident level in the hospital's most recent settled cost report. (Proposed redesignated § 413.79(c)(3)(ii)(A)(*3*)). In other words, generally, as long as a hospital trained more unweighted allopathic and osteopathic FTE residents in a cost reporting period after its most recent settled cost report in programs that were existing during the cost reporting period for the most recently settled cost report, it may submit a timely request that its cost report that includes July 1, 2003, be used for purposes of determining any FTE resident cap reduction under section 1886(h)(7)(A)(i) of the Act. We note that if a hospital expanded an existing program after its most recent settled cost report, and then subsequently reduced its FTE resident count to the extent that it actually trained fewer unweighted allopathic and osteopathic FTE residents in its cost report that includes July 1, 2003, than in its most recent cost reporting period ending on or before September 30, 2002, the hospital would not benefit from, and would likely not make, a timely request that its cost report that includes July 1, 2003, be used for purposes of determining a possible reduction to its FTE resident cap.

(3) Audits of the Reference Cost Reporting Periods

As mentioned under section IV.O.2.f.(1) of this preamble, to determine a possible reduction to a hospital's FTE resident cap, section 1886(h)(7)(A)(ii)(I) of the Act, as added by section 422(a) of Public Law 108–173, directs CMS to use a hospital's most recent cost reporting period ending on or before September 30, 2002, ''for which a cost report has been *settled* (or, *if not, submitted (subject to audit*), as determined by the Secretary'' (emphasis added). We are proposing to interpret

this language to mean that, if a hospital's cost report for the most recent cost reporting period ending on or before September 30, 2002, has been settled, then, unless the hospital submits a timely request to use the cost reporting period that includes July 1, 2003, we would use the hospital's settled cost report without further audit to determine possible reductions to the FTE resident caps. We also are proposing to interpret this language to mean that if a hospital's cost report for the most recent cost reporting period ending on or before September 30, 2002, has not been settled, the hospital's as-submitted cost report for the most recent cost reporting period ending on or before September 30, 2002, would be subject to audit by the fiscal intermediary. In addition, as stated under section 1886(h)(7)(A)(ii)(II) of the Act, use of a hospital's cost report that includes July 1, 2003 is made ''after audit and subject to the discretion of the Secretary.'' A hospital's cost report that includes July 1, 2003 may be at various stages of settlement, or may not even be submitted at the time this proposed rule is published. For example, if a hospital has a fiscal year end of June 30, its cost reporting period that includes July 1, 2003 would not end until June 30, 2004. This cost report is not required to be submitted until 5 months after the cost reporting period closes, which would be by December 1, 2004. In any case, the fiscal intermediary would need to make a determination as to whether a hospital has actually increased its resident level due to an expansion of an existing program that is not reflected on the most recent settled cost report. Further, the FTE resident counts that are included (or would be included) in the cost report that includes July 1, 2003, are subject to audit by the fiscal intermediary to ensure that an appropriate determination is made as to whether, and by how much, a hospital's FTE resident cap will be reduced. To facilitate these determinations, we are proposing that the fiscal intermediaries may audit the FTE resident counts as necessary in the most recently settled cost reports and in the cost reports up to and including the cost report for the cost reporting period that includes July 1, 2003.

Fiscal intermediaries will perform desk or onsite audits related to section 422, using instructions that will be issued in a separate document. As we explained in the OTN, Transmittal No. 77, CR 3247, in the interest of time and the most efficient use of audit resources, we have required that if a hospital would like CMS to use its cost report that includes July 1, 2003, as its reference period due to an expansion of an existing program, the hospital must notify the fiscal intermediary in accordance with the instructions provided in the OTN by June 4, 2004. If a hospital submits a timely request that its cost report that includes July 1, 2003, be used, the fiscal intermediary would audit that cost report and previous cost reports as necessary to determine if the hospital increased its resident level due to an expansion of an existing program that is not reflected on the most recent settled cost report. If a hospital does not submit a timely request to the fiscal intermediary that its cost report that includes July 1, 2003, be used, the fiscal intermediary would use the cost report for the most recent cost reporting period ending on or before September 30, 2002, to determine if, and by how much, a hospital's FTE resident cap should be reduced, as specified under section 1886(h)(7)(A)(ii)(I) of the Act. If the cost report that is used to determine the possible reduction to a hospital's FTE resident count is for a period of less than or more than 12 months, we are proposing that the fiscal intermediary would prorate the FTE resident caps and unweighted FTE residents to equal 12-month counts.

(4) Expansions Under Newly Approved Programs

Under section 1886(h)(7)(ii)(III) of the Act, as added by section 422(a)(3) of Public Law 108–173, a hospital may request that its reference resident level be adjusted to include residents in certain newly approved programs. Specifically, if a hospital's new program was accredited by the appropriate accrediting body (that is, the Accreditation Council on Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA)) before January 1, 2002, but was not in operation during the hospital's reference period, the hospital may submit a timely request that we adjust the reference resident level to include the number of residents for which a new program was accredited at a hospital(s). For a hospital that requests an adjustment due to a newly approved program, we are proposing to determine a hospital's reference period as we otherwise would. If a hospital received accreditation for a new medical residency training program before January 1, 2002, but the program was not in operation (that is, the hospital did not begin training residents in that program) during its reference period (which will be either the most recent cost reporting period ending on or before September 30, 2002, or the cost reporting period that includes July 1, 2003), the hospital may submit a timely request by June 4, 2004, as explained in the OTN, that its resident level for its reference period be adjusted to reflect the number of accredited slots for which that new medical residency training program was approved. We note that section 1886(h)(7)(A)(ii)(III) of the Act does not require that CMS include the number of residents for which the new program is accredited in the hospital's reference cost reporting period for purposes of determining direct GME and IME payment in that reference cost reporting period. Rather, CMS is only required to include the number of residents for which a new program was accredited in the resident level for purposes of determining if, and by how much, a hospital's FTE resident cap should be reduced.

For example, assume a hospital that has a fiscal year end of June 30 received accreditation in October 2001 to train 10 residents in a new surgery program. The hospital does not have an expansion of an existing program not reflected on its most recent settled cost report, so its reference period is the most recent cost reporting period ending on or before September 30, 2002. The hospital first begins to train residents in the new surgery program on July 1, 2002. The new surgery residents are not reflected on the hospital's June 30, 2002 cost report, which is the hospital's most recent cost reporting period ending on or before September 30, 2002. Thus, the hospital may submit a timely request that we increase its resident level for the cost report ending June 30, 2002, by 10 FTE residents to reflect the residents approved for the new surgery program for purposes of determining if the hospital's reference resident level is below its otherwise applicable resident cap. However, we note that if the hospital's fiscal year end in this example was September 30, a program accredited in October 2001 and begun on July 1, 2002, would be in operation during the hospital's cost reporting period ending on September 30, 2002, and the hospital could not receive an increase to its resident level for its cost reporting period ending September 30, 2002, to include the total number of accredited resident positions in the new surgery program. If the new program was accredited for a range of residents (for example, a hospital receives accreditation to train 6 to 8 residents in a new internal medicine program), we are proposing that the hospital may request that its resident level for its most recent cost reporting period ending on or before September 30, 2002 be

adjusted to reflect the maximum number of accredited positions (which, in this example, would be 8 internal medicine residents). We also are proposing that at the time the hospital makes the timely request to have its resident level adjusted to include the number of accredited resident positions, the new program need not be training the full complement of residents for which the program was accredited. (Proposed redesignated 413.79(c)(3)(A)(*3*)(*ii*)). In addition, if more than one hospital was approved as a training site for the residents in the newly accredited program (that is, more than one hospital sponsors the program or there are other participating institutions that serve as training sites for the residents in the program), we are proposing that the adjustment to a requesting hospital's reference resident level would reflect the appropriate portions of the FTE residents in the new program that would be training at that hospital.

Similarly, if, in addition to having accreditation for a new program, a hospital has an expansion of an existing program that is not reflected on the most recent settled cost report, that hospital may submit a timely request that its resident level for the cost reporting period that includes July 1, 2003, be adjusted to include the number of resident positions for which a new program was accredited. We are proposing that a hospital whose reference period is the one that includes July 1, 2003, may only request that its reference resident level be adjusted to include the accredited number of residents for a new program if, in accordance with section 1886(h)(7)(A)(ii)(III) of the Act, the new program was approved by the appropriate accrediting body before January 1, 2002, but was not in operation during the cost reporting period that includes July 1, 2003. This proposal is based on our interpretation of the statutory language, which states that ''the Secretary shall adjust the reference resident level *specified under subclause (I) or (II)* to include the number of residents that were approved * * * for a medical residency program * * * but which was not in operation *during the cost reporting period used under subclause (I) or (II)* * * *'' (emphasis added). Because the statute provides for an adjustment to the reference resident level ''specified under subclause I or II,'' as mentioned above, for hospitals that request an adjustment under section 1886(h)(7)(A)(ii)(III) of the Act, we are proposing to identify the applicable reference period as we otherwise would under section 1886(h)(7)(A)(ii)(I) and (II) of the Act. That is, we are proposing to use the hospital's most recent cost reporting period ending on or before September 30, 2002, as the reference cost reporting period, unless the hospital submits a timely request to use the cost reporting period that includes July 1, 2003, due to an expansion of an existing program that is not reflected on the most recent settled cost report. We also note that, as mentioned above, subclause (III) requires that the program be accredited before January 1, 2002, but not be in operation during the hospital's reference cost reporting period, or in this case, the period that includes July 1, 2003. This means that, in order for the hospital to receive an adjustment to its reference resident level under section 1886(h)(7)(A)(ii)(III) of the Act for the cost reporting period that includes July 1, 2003, the new program also cannot be in operation in the cost reporting period that includes July 1, 2003. Thus, while we believe it is possible for a hospital to qualify for this adjustment because the hospital started a new program that is not reflected on its most recent cost reporting period ending on or before September 30, 2002, we believe that few, if any, hospitals will qualify for this adjustment for a new program that was not in operation in the cost report that includes July 1, 2003, because it is unlikely that a program would receive its accreditation prior to January 1, 2002, and still not be in operation by July 1, 2003.

(5) Affiliations

Section 1886(h)(7)(A)(iii) of the Act, as added by section 422(a)(3) of Public Law 108–173, directs the Secretary to consider whether a hospital is a member of a Medicare GME affiliated group (as defined under § 413.86(b)) as of July 1, 2003, in determining whether a hospital's FTE resident cap should be reduced. As described above, some hospitals that have reduced their resident levels below their FTE resident caps may have affiliated with other hospitals that would otherwise exceed their FTE resident caps. Thus, while some hospitals were below their FTE resident caps prior to entering into a Medicare GME affiliation agreement, upon affiliating, their FTE resident caps were temporarily reduced because some or all of their excess FTE slots were temporarily added to the FTE caps of other hospitals as part of the affiliation agreement. Under the Medicare GME affiliation agreement, these otherwise ''excess'' FTE slots have been transferred for use by other hospitals, and, therefore, CMS would take into account the revised caps under the affiliation agreement for both the hospital that would otherwise be below its FTE resident cap and the revised caps of the other hospital(s) that are part of an affiliated group. In determining whether hospitals' FTE resident caps should be reduced under section 1886(h)(7)(A)(i) of the Act, section 1886(h)(7)(A)(iii) of the Act directs CMS to consider hospitals ''which are members of the same affiliated group * * * as of July 1, 2003.'' We are proposing that hospitals that are affiliated ''as of July 1, 2003'' means hospitals that have in effect a Medicare GME affiliation agreement, as defined in existing § 413.86(b), for the program year July 1, 2003 through June 30, 2004, and have submitted a Medicare GME affiliation agreement by July 1, 2003 to their fiscal intermediaries with a copy to CMS. These hospitals may have already been affiliated prior to July 1, 2003, or may have affiliated for the first time on July 1, 2003. In either case, in determining possible reductions to a hospital's FTE resident cap, we are proposing to use a hospital's cap as revised by the July 1, 2003 Medicare GME affiliation agreement. We believe this interpretation is consistent with the intent of section 1886(h)(7)(A)(iii) of the Act, as added by section 422(a)(3) of Public Law 108–173, in that a hospital's FTE resident cap should not be reduced if some or all of its excess resident slots have been transferred for use by hospitals with which it is affiliated (that is, the hospital is training at least as many FTE residents as are in its ''affiliated'' FTE resident cap).

Although hospitals in an affiliated group base the FTE cap adjustments on an aggregate FTE resident cap, we are proposing that we would determine whether a hospital's FTE resident cap should be reduced on a hospital-specific basis. Section 1886(h)(7)(A)(iii) of the Act states that ''the provisions of *clause (i)* shall be applied to hospitals which are members of the same affiliated group * * *'' (emphasis added). Clause (i) of section 1886(h)(7)(A), as described above, requires the reduction of hospitals' FTE resident caps under certain circumstances, based on the otherwise applicable FTE resident cap and the resident level in the applicable reference period, as described above (which would be either a hospital's most recent cost reporting period ending on or before September 30, 2002, or the cost reporting period that includes July 1, 2003). We are proposing to interpret this reference to clause (i) to mean that the Secretary is to use a hospital's July 1, 2003 ''affiliated'' FTE resident cap as

the otherwise applicable FTE resident cap when determining a possible reduction to the FTE resident cap. In other words, if a hospital is affiliated as of July 1, 2003, we are proposing to superimpose the ''affiliated'' FTE resident cap onto the hospital's reference cost reporting period.

Specifically, as we stated under section IV.O.2.f.(1) of this preamble, consistent with section 1886(h)(7)(A)(ii)(I) of the Act, to determine possible reductions to a hospital's FTE resident cap, we would use a hospital's most recent cost reporting period ending on or before September 30, 2002. If a hospital is part of a Medicare affiliated group for the program year beginning July 1, 2003, we are proposing to compare the hospital's July 1, 2003 ''affiliated'' FTE resident cap to its resident level on the most recent cost report ending on or before September 30, 2002. If the hospital's resident level from its most recent cost report ending on or before September 30, 2002, is below its July 1, 2003 ''affiliated'' FTE resident cap, we are proposing to permanently reduce the hospital's FTE resident cap, that is, the hospital's FTE resident cap without the temporary adjustment under the July 1, 2003 affiliation agreement, by 75 percent of the difference between the hospital's resident level and the July 1, 2003 ''affiliated'' FTE resident cap.

Alternatively, as stated above under section IV.O.2.f.(2) of this preamble, consistent with section 1886(h)(7)(A)(ii)(II) of the Act, a hospital may submit a timely request to CMS that its cost report that includes July 1, 2003, be used as the reference period to determine possible FTE resident cap reductions because of an expansion of an existing program that is not reflected on the hospital's most recent settled cost report. If a hospital is affiliated for the program year beginning July 1, 2003, and we grant the hospital's timely request to use the cost reporting period that includes July 1, 2003, because its expansion of an existing program(s) is not reflected on the most recent settled cost report, we are proposing to compare the hospital's July 1, 2003 ''affiliated'' FTE resident cap to its resident level on the cost report that includes July 1, 2003. If the hospital's resident level from its cost report that includes July 1, 2003 is below its July 1, 2003 ''affiliated'' FTE resident cap, we are proposing to permanently reduce the hospital's FTE resident cap, that is, the hospital's FTE resident cap without the temporary adjustment under the July 1, 2003 affiliation agreement, by 75 percent of the difference between the hospital's resident level and the July 1, 2003 ''affiliated'' FTE resident cap.

For example, Hospital A's most recent cost report ending on or before September 30, 2002 is FYE December 31, 2001. Hospital A has a direct GME FTE resident cap (unadjusted for an affiliation) of 100, and an IME FTE resident cap (unadjusted for an affiliation) of 90. Hospital A did not have an expansion of an existing program that was not reflected on its most recent settled cost report, and therefore, its FYE December 31, 2001 cost report is being used as the reference period for purposes of determining a possible reduction to its FTE resident caps. Hospital A's unweighted direct GME count of allopathic and osteopathic FTE residents on its December 31, 2001 cost report is 60. Hospital A's IME count of allopathic and osteopathic FTE residents on its December 31, 2001 cost report is 55.

Hospital B, with a FYE of September 30, expanded an existing program, and that expansion is not reflected on its most recent settled cost report. Hospital B has submitted, and we have granted, a timely request that its cost report that includes July 1, 2003 (that is, its FYE September 30, 2003 cost report) be used for purposes of determining a possible reduction to its FTE resident caps. Hospital B has a direct GME FTE resident cap (unadjusted for an affiliation) of 100, and an IME FTE resident cap (unadjusted for an affiliation) of 95. Hospital B's direct GME unweighted count of allopathic and osteopathic FTE residents on its September 30, 2003 cost report is 120, and its IME count of allopathic and osteopathic FTE residents for the same period is 110.

On July 1, 2003, Hospital A and Hospital B entered into a Medicare GME affiliation agreement. Under the affiliation agreement, the hospitals' FTE resident caps are revised as follows:

AFFILIATION YEAR JULY 1, 2003 THROUGH JUNE 30, 2004

	Direct GME FTE resident cap	Direct GME affiliated cap	IME FTE resident cap	IME affiliated cap.
Hospital A	100	60	90	55
Hospital B	100	140	95	130

To apply section 1886(h)(7)(A)(i) of the Act, Hospital A's affiliated FTE resident caps as of July 1, 2003, are compared to its direct GME and IME allopathic and osteopathic FTE resident counts from its FYE December 31, 2001 cost report, and Hospital B's affiliated FTE resident caps as of July 1, 2003, are compared to its direct GME and IME allopathic and osteopathic FTE resident counts from its FYE September 30, 2003 cost report, as follows:

	Affiliated direct GME cap	Unweighted allopathic and osteopathic FTE count	Unweighted count below affiliated cap?	If yes, reduce actual FTE resident cap by 75 percent of difference between affiliated cap and unweighted count.
Hospital A	60	[1] 60	No.	
Hospital B	140	[2] 120	Yes	100 − [.75(140 − 120)] = 85

[1] From FYE 12/31/01.
[2] From FYE 9/30/03.

	Affiliated IME cap	Allopathic and osteopathic FTE count	Count below affiliated cap?	If yes, reduce actual FTE resident cap by 75 percent of difference between affiliated cap and unweighted count.
Hospital A	55	[1] 55	No.	
Hospital B	130	[2] 110	Yes	95 − [.75(130 − 110)] = 80

[1] From FYE 12/31/01.
[2] From FYE 9/30/03.

Effective for portions of cost reporting periods beginning on or after July 1, 2005, Hospital A's FTE resident caps for direct GME and IME will remain at 100 and 90, respectively, while Hospital B's FTE resident caps for direct GME and IME will be reduced to 85 and 80, respectively.

We also note that there are hospitals that may have been members of a Medicare GME affiliated group in program years that coincide with or overlap the reference cost reporting periods, but these hospitals were not affiliated as of July 1, 2003. As such, they are not subject to the proposed policy described above applicable to section 1886(h)(7)(A)(iii) of the Act, as added by section 422(a)(3). For such hospitals, we are proposing to compare the resident level in the applicable reference period to the FTE resident cap as adjusted by the affiliation agreement applicable to that reference period. If a hospital's resident level is below its otherwise applicable FTE resident cap for that reference period cost report, we are proposing to permanently reduce the hospital's FTE resident cap, that is, the hospital's FTE resident cap without the temporary adjustment under the affiliation agreement for that period, by 75 percent of the difference between the hospital's resident level and the otherwise applicable FTE resident cap. (Proposed redesignated § 413.79(c)(3)(iv)(B)). For example, assume a hospital with a June 30 fiscal year end affiliated for one program year from July 1, 2001, through June 30, 2002. On its June 30, 2002 cost report (that is, its most recent cost report ending on or before September 30, 2002), its FTE resident cap is 20, its cap as revised by the affiliation agreement is 25, and its resident level is 21 FTEs. Because this hospital's resident level of 21 is below its otherwise applicable FTE resident cap of 25, the hospital's FTE resident cap of 20 will be reduced as follows: 20 − [(.75(25 − 21)] = 17. We are proposing to apply the same methodology described above in the event that the reference period is a hospital's cost report that includes July 1, 2003 (that is, for a hospital that had an expansion of a program that is not reflected on its most recent settled cost report and that made a timely request to use the period that includes July 1, 2003), if that hospital is not affiliated as of July 1, 2003, but its cost report that includes July 1, 2003 overlaps with a program year for which the hospital was affiliated. In other words, section 1886(h)(7)(A)(i) of the Act will be applied by comparing a hospital's reference resident level to the otherwise applicable FTE resident cap, as adjusted for any affiliation agreement for the reference period.

g. Criteria for Determining Hospitals That Will Receive Increases in Their FTE Resident Caps

Generally, under section 1886(h)(7) of the Act, as added by section 422(a)(3) of Public Law 108–173, CMS is to reduce by 75 percent the ''unused'' resident slots from hospitals that were below their FTE resident caps in a specific reference period, and ''redistribute'' the FTE slots for use by other hospitals. Under section 1886(h)(7)(B) of the Act, as added by section 422 of Public Law 108–173, the Secretary is authorized to increase the otherwise applicable FTE resident cap for each qualifying hospital that submits a timely application by a number that the Secretary may approve, for portions of cost reporting periods occurring on or after July 1, 2005. In implementing section 1886(h)(7)(B) of the Act, we note the difficulty in deciding which teaching hospitals are more ''deserving'' than others to receive the redistributed unused resident slots. Therefore, we are proposing a decision making process that is an objective process. In addition, we note that section 422 does not provide detailed guidance to the Secretary for deciding which hospitals should receive the unused resident slots, but rather gives the Secretary discretion in making the choice of which hospitals should qualify.

Section 1886(h)(7)(B) of the Act, as added by section 422, does establish certain parameters in the statutory language for hospitals to qualify to receive increases in their FTE resident caps. First, section 1886(h)(7)(B)(i) of the Act states that the aggregate number of increases in the otherwise applicable resident limits (caps) may not exceed the estimate of the aggregate reduction in the resident limits determined under section 1886(h)(7)(A) of the Act (as specified in section IV.O.2.e. of this preamble). Section 1886(h)(7)(B)(iv) of the Act states that in no case will any hospital receive an FTE cap increase of more than 25 FTE additional residency slots as a result of the redistribution. (Proposed redesignated 413.79(c)(4)). In addition, section 1886(h)(7)(B)(ii) of the Act specifies that in determining which hospitals will receive the increases in their FTE resident caps, the Secretary is required to take into account the demonstrated likelihood that the hospital would be able to fill the position(s) within the first three cost reporting periods beginning on or after July 1, 2005.

In setting up an application process for hospitals to apply for the unused resident slots discussed in section IV.O.2.h. of this preamble, we are proposing to implement this ''demonstrated likelihood'' requirement as an eligibility criterion that a hospital *must* meet in order for CMS to further consider the hospital's application for an increase in its FTE resident cap. Thus, we are proposing that, in order to be eligible for consideration for an increase under section 1886(h)(7)(B) of the Act, a hospital must first demonstrate the likelihood that it will able to fill the slots within the first three cost reporting periods beginning on or after July 1, 2005, by meeting at least one of the following four criteria and by providing documentation that it meets that criterion in its application for an increase in its FTE resident cap:

Demonstrated Likelihood Criterion 1. The applying hospital intends to use the additional FTEs to establish a new residency program(s) on or after July 1, 2005 (that is, a newly approved program that begins training residents on or after July 1, 2005).

The hospital must meet the requirements in provisions (1) and (2) below:

(1) In order to demonstrate that the hospital is, in fact, establishing a new residency program, the hospital must—

• Submit an application for approval of a new residency program to the ACGME or the AOA by December 1, 2004, and include a copy of that application with the application for an increase in its FTE resident cap; or

• Submit an application for approval of a new residency program to the ACGME or the AOA by December 1, 2004, and, if establishing an allopathic program, include a copy of the hospital's institutional review document or program information form concerning the new program with the application for the unused FTE resident slots; or

• Submit an application for approval of a new residency program to the ACGME or the AOA by December 1, 2004, and include written correspondence from the ACGME or AOA acknowledging receipt of the application for the new program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit).

(2) To demonstrate that the hospital will be likely to fill the slots requested, the hospital must comply with one of the following:

• If the hospital has other previously established programs, submit documentation that each of the hospital's existing residency programs had a resident fill rate of at least 95 percent in each of program years 2001 through 2003; or

• If the hospital has other previously established residency programs, submit copies of the cover page of the hospital's employment contracts with the residents who are or will be participating in the new residency program (resident specific information may be redacted); or

• If the hospital is establishing a new residency program in a particular specialty, submit documentation indicating that the specialty has a resident fill rate nationally, across all hospitals, of at least 95 percent.

Demonstrated Likelihood Criterion 2. The applying hospital intends to use the additional FTEs to expand an existing residency training program (that is, to increase the number of FTE resident slots in the program) on or after July 1, 2005, and before July 1, 2008.

The hospital must comply with the requirements in provisions (1) and (2) below:

(1) To demonstrate that the hospital intends to expand an existing program, the hospital must comply with one of the following:

• Document that the appropriate accrediting body (the ACGME or the AOA) has approved the hospital's expansion of the number of FTE residents in the program; or

• Document that the National Residency Match Program or the American Osteopathic Association Residency Match Program has accepted or will be accepting the hospital's participation in the match for the existing program that will include additional resident slots in that residency training program; or

• If expanding an allopathic program, submit a copy of the hospital's institutional review document or program information form for the expansion of the existing residency training program.

(2) To demonstrate that the hospital will be likely to fill the slots of the expanded residency program, the hospital must comply with one of the following:

• Submit copies of the cover page of the hospital's employment contracts with the residents who are or will be participating in the expanded program (resident specific information may be redacted) and copies of the cover page of the hospital's employment contracts with the residents participating in the program prior to the expansion of the program.

• If the hospital has other previously established residency programs, submit documentation that each of the residency programs had a resident fill rate of at least 95 percent in each of program years 2001 through 2003.

• If the hospital is expanding an existing program in a particular specialty, submit documentation that the specialty has a resident fill rate nationally, across all hospitals, of at least 95 percent.

• If the hospital is expanding a program in order to train residents that need a program because another hospital in the State has closed a similar program, and the applying hospital received a temporary adjustment to its FTE cap(s) (under the requirements of § 413.86(g)(9)), submit documentation of this action.

Demonstrated Likelihood Criterion 3. The hospital is applying for an increase in its FTE resident cap because the hospital is already training residents in an existing residency training program(s) in excess of its direct GME FTE cap or IME FTE cap, or both.

The hospital must submit, with its application, each of the following:

• Copies of the most recent as-submitted Medicare cost reports documenting on Worksheet E, Part A and Worksheet E3, Part IV the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.

• Copies of the 2004 residency match information concerning the number of residents the hospital intends to have in its existing programs.

• Copies of the most recent accreditation letters on all of the hospital's training programs in which the hospital trains and counts FTE residents for direct GME and IME.

Demonstrated Likelihood Criterion 4. The hospital is applying for the unused FTE resident slots because the hospital is at risk of losing accreditation of a residency training program if the hospital does not increase the number of FTE residents in the program on or after July 1, 2005.

The hospital must submit, with its application for an increase in its FTE resident cap, documentation from the appropriate accrediting body of the hospital's risk of lost accreditation as a result of an insufficient number of residents in the program.

We are proposing that *each* hospital must meet at least one of the above criteria in order to demonstrate the likelihood that it will be able to fill the additional slots associated with any increase in the hospital's FTE resident cap within the first three cost reporting periods beginning on or after July 1, 2005. In other words, each hospital that wishes to apply for an increase in its FTE resident cap must, as a preliminary matter, meet the eligibility requirement of demonstrating the likelihood that it will fill the additional positions, in order for CMS to further consider the hospital's application for an increase in its FTE resident cap.

h. Application Process for the Increases in Hospitals' FTE Resident Caps

As stated above, we are proposing an objective decision making process for determining how hospitals will be prioritized when identifying the hospitals that will receive increases in their FTE resident caps. In order for hospitals to be considered for increases in their FTE resident caps, section 1886(h)(7)(B)(i) of the Act, as added by section 422(a)(3) of Public Law 108–173, requires that each ''qualifying hospital'' submit a ''timely application.'' We are proposing that each hospital must submit the following information on its application for an increase in its FTE resident cap:

• The name and Medicare provider number of the hospital.

• The total number of requested FTE resident slots (for all residency programs at the hospital) for direct GME or IME, or both (up to 25 FTEs).

• A completed copy of the CMS Evaluation Form (as described below) for each residency program for which

the applicant hospital intends to use the requested increase in the number of FTE residents and source documentation to support the assertions made by the hospital on the Evaluation Form. (For example, if the hospital checks off on the Evaluation Form that the hospital is located in a geographic Health Professions Shortage Area (HPSA), the hospital would include documentation to support that assertion.) A copy of the blank proposed CMS Evaluation Form appears at the end of this section of the preamble.

- FTE resident counts for direct GME and IME and FTE resident caps for direct GME and IME reported by the hospital in the most recent as-filed cost report.
- An attestation, signed and dated by an officer or administrator of the hospital who signs the hospital's Medicare cost report, of the following information in the hospital's application for an increase in its FTE resident cap:

''I hereby certify that I understand that misrepresentation or falsification of any information contained in this application may be punishable by criminal, civil, and administrative action, fine and/or imprisonment under federal law. Furthermore, I understand that if services identified in this application were provided or procured through payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil, and administrative action, fines and/or imprisonment may result. I also certify that, to the best of my knowledge and belief, it is a true, correct, and complete application prepared from the books and records of the hospital in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding Medicare payment to hospitals for the training of interns and residents.''

We are further proposing that any hospital that wishes to receive an increase in its FTE resident cap(s) must submit a copy of its completed application (as described above) to the CMS Central Office and to the CMS Regional Office for the region in which the applicant hospital is located, and that the application must be received on or before December 1, 2004. (The mailing addresses for the CMS offices are indicated at the end of this section of the preamble.) We note that some hospitals' FTE counts will be subject to audit for purposes of section 1886(h)(7)(B) of the Act, and those audits may not be completed by December 1, 2004. Because the results of such an audit may be a factor in a hospital's decision whether to request an increase in its FTE resident cap under section 1886(h)(7)(B) of the Act, we are proposing to allow a later date for those hospitals to apply for increases in their FTE resident caps. Therefore, if a hospital's resident level is audited for purposes of section 1886(h)(7)(A) of the Act, and that hospital also wishes to apply for an increase in its FTE resident cap(s) available through section 1886(h)(7)(B) of the Act, we are proposing that such a hospital must submit a completed application to CMS and that the application must be received on or before March 1, 2005. We are proposing that all completed applications that are timely received according to the above deadlines will be evaluated by CMS according to the criteria described under section IV.O.2.i. of this preamble for determining the priority distribution of FTE resident slots. Hospitals that satisfy at least one of the ''demonstrated likelihood'' criteria will be further evaluated by the evaluation criteria described below. Those hospitals that are chosen to receive an increase in their FTE resident caps would be notified by CMS by July 1, 2005.

i. CMS Evaluation of Applications for Increases in FTE Resident Caps

As noted in section IV.O.2.h. of this preamble, we are proposing to require hospitals to submit, with their applications for increases in their FTE resident caps, a completed copy of the CMS Evaluation Form. As we have stated, we are proposing to make the process of evaluating the applications as objective as possible. Therefore, we are proposing to use a CMS Evaluation Form that the hospital must complete and submit as part of its application. The CMS Evaluation Form will ask the hospital to check off which of the ''demonstrated likelihood'' criteria (described above in section IV.O.2.g. of this preamble) the hospital meets. We also are proposing to require the hospital to provide the documentation that supports the ''demonstrated likelihood'' criteria it has checked off on the Evaluation Form.

Assuming that hospitals interested in applying for the increase in their FTE caps meet the eligibility criterion of ''demonstrated likelihood,'' we are proposing that applicant hospitals indicate on the CMS Evaluation Form the category(ies) for which it believes it will qualify. CMS will use this indication to prioritize the applications. Such prioritization is derived from section 1886(h)(7)(B) of the Act, as added by section 422 of Public Law 108–173. That section established the following priority order to determine the hospitals that will receive increases in their FTE caps:

First, to hospitals that are ''located in rural areas, as defined in section 1886(d)(2)(D)(ii) of the Act'' (section 1886(h)(7)(B)(iii)(I) of the Act). Section 1886(d)(2)(D)(ii) of the Act defines a rural area as any area outside a Metropolitan Statistical Area (MSA). Under the existing implementing regulations at § 413.62(f)(ii), an ''urban area'' means (1) a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA); or (2) the following New England counties: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. Under existing § 413.62(f)(iii), a ''rural area'' means any area outside an urban area. However, we note that under section III. of this preamble, which discusses proposed changes in wage areas for FY 2005, we are proposing to no longer recognize NECMAs as a distinct category of wage areas. Thus, for purposes of the amendments made by section 422, we are proposing that any hospital located in an area that is not in a MSA is a rural hospital, regardless of any reclassification under § 412.102 or § 412.103. We note that this definition of ''rural'' is consistent with our proposal under section III. of this preamble concerning designation of wage index areas.

Second, to hospitals that are located in urban areas that are not large urban areas, as defined for purposes of section 1886(d) of the Act (section 1886(h)(7)(B)(iii)(II) of the Act). Section 1886(d)(2)(D) of the Act defines ''*large* urban area'' as an ''urban area which the Secretary determines * * * has a population of more than 1,000,000.'' Existing implementing regulations at § 412.63(c)(6) state generally that the term ''large urban area'' means an MSA with a population of more than 1,000,000. Again, we note that we are proposing changes to the definition of ''urban area'' to reflect the new geographic areas designated by the Office of Management and Budget under section III. of the preamble of this proposed rule. Therefore, if the eligible hospital applying for an increase in its FTE resident cap is an urban hospital that is located in the proposed redefined MSA area with a population of less than 1,000,000, CMS will give such a hospital second priority (after all rural hospitals in the first priority category under the statute) in deciding which hospitals should receive an increase in their FTE resident caps.

Third, hospitals that currently operate, or will operate, a residency training program in a specialty for which there are not other residency training programs in the State (section 1886(h)(7)(B)(iii)(III) of the Act). We are proposing to interpret ''a specialty for which there are not other residency training programs in the State'' to mean the only specialty in either allopathy or osteopathy in a particular State. For example, if in State X, Hospital A would like to use the additional FTE residents in order to establish a new osteopathic emergency medicine program (which would be the first osteopathic emergency medicine program in State X), and Hospital B has already established an allopathic emergency medicine program in State X, Hospital A's application for an increase in its FTE resident cap(s) would be put in the third priority category because Hospital A would be establishing a new osteopathic emergency medicine program, a specialty for which there are not other osteopathic emergency medicine programs in the State. We believe that a more ''expansive'' interpretation of ''a specialty for which there are not other residency programs'' allows more hospitals to fit into this third priority category. In addition, it is our understanding that allopathic and osteopathic programs are, at least, nominally different disciplines in medicine. As a result, we believe that this more ''expansive'' interpretation for ''a specialty for which there are not other residency programs'' is the more appropriate interpretation.

As we described above, we are proposing that applicant hospitals indicate on the CMS Evaluation Form the category(ies) for which it believes it will qualify; we will use this indication to prioritize the applications. Each of the categories (described below) is derived from the priorities established by section 1886(h)(7)(B) of the Act, as added by section 422 of Public Law 108–173. We would use the following categories to determine the order in which hospitals would be eligible to receive increases in their FTE resident caps:

First Level Priority Category: The hospital is a rural hospital and has the only specialty training program in the State.

Second Level Priority Category: The hospital is a rural hospital only.

Third Level Priority Category: The hospital is a ''small'' urban hospital (that is, an urban hospital that is located in a ''not large urban area'') and has the only specialty program in the State.

Fourth Level Priority Category: The hospital is a ''small'' urban hospital only.

Fifth Level Priority Category: The hospital has the only specialty training program in the State.

Sixth Level Priority Category: The hospital meets none of the statutory priority criteria.

We believe the proposed first and third level categories are appropriate for CMS evaluation purposes (which is explained further below) because some hospitals that apply for the additional resident slots may fit into more than one of the three statutory priority categories listed in section 1886(h)(7)(B) of the Act. In addition, we are proposing to give consideration first to those hospitals that meet more than one of the statutory priority categories over those hospitals that meet only one of the statutory priorities (see second, fourth, and fifth level priority categories.) We also are proposing a sixth level priority category to identify those section 1886(d) hospitals that apply for additional resident slots, but do not fit into any of the priority categories listed in section 1886(h)(7)(B) of the Act (for example, hospitals in large urban areas).

As specified by the statute, we are proposing to put each hospital's application for an increase in its FTE resident cap (based on how the hospital describes itself on the CMS Evaluation Form) into one of the ''level priority categories'' for evaluation purposes, giving first and second priority to the rural hospitals, as defined above. In addition, we note that we are proposing that hospital applicants provide residency specialty program information as part of the application for the increase to the cap(s), as well as a CMS Evaluation Form for each residency program for which the applicant hospital intends to use the increased FTE resident slots. Our intention in proposing these requirements is for CMS to be able to discern within which level priority category the applicant hospital's application should be placed based on the residency specialty program for which the FTE cap increase is being requested. In other words, it is possible that a hospital will apply for an increase in its FTE caps for more than one residency program at the hospital. It is possible that applications for the programs would fall within different level priority categories, for example, if a hospital is applying for an increase in its cap(s) for one program that is the ''only specialty training program in the State'' (which would place the hospital's application in the fifth level priority category on the CMS Evaluation Form) and for another program that is NOT the only program in the State (which, assuming the hospital is an urban hospital, would place the hospital on that Evaluation Form in the sixth level priority category). Therefore, we are proposing that hospitals complete an Evaluation Form for each residency program for which it is requesting an increase in its FTE resident cap.

We note that section 1886(h)(7)(B)(iii) of the Act states that ''increases of residency limits within the same priority category * * * shall be determined by the Secretary.'' Therefore, we are proposing to use the following criteria for evaluating the applications for increases in hospitals' FTE resident caps within each of the six level priority categories described above:

Evaluation Criterion One. The hospital that is requesting the increase in its FTE resident cap(s) has a Medicare inpatient utilization over 60 percent, as reflected in at least two of the hospital's last three most recent audited cost reporting periods for which there is a settled cost report. We have selected 60 percent utilization because it will identify hospitals where Medicare beneficiaries will benefit the most from the presence of a residency program, and it is consistent with the utilization percentage required for Medicare-dependent, small rural hospitals (MDHs) as specified in § 412.108. In addition, it identifies a type of hospital that warrants atypical treatment by the Medicare program because it is so reliant on Medicare funding.

Evaluation Criterion Two. The hospital will use the additional slots to establish a new geriatrics residency program, or to add residents to an existing geriatrics program. We believe that, of all the medical specialties, geriatrics is the one specialty that is devoted primarily to the care of Medicare beneficiaries. In addition, we note that encouraging residency training in geriatrics is consistent with Congressional intent as expressed, among other places, in section 712 of Public Law 108–173.

Evaluation Criterion Three. The hospital does not qualify for an adjustment to its FTE caps under existing § 413.86(g)(12) (proposed to be redesignated as § 413.79(k) in this proposed rule) for a rural track residency program, but is applying for an increase in its FTE resident cap(s) under section 1886(h)(7)(B) of the Act because it rotates (or in the case of a new program, will rotate) residents for at least 25 percent of the duration of the residency program to any combination of the following: A rural area, as defined in section 1886(d)(2)(D)(ii) of the Act

and § 412.62(f)(1)(iii) of the regulations; a rural health clinic (RHC), as defined in section 1861(aa)(1) of the Act and § 491.2 of the regulations; or a Federally Qualified Health Center (FQHC), as defined in section 1861(aa)(3) of the Act and § 405.2401(b) of the regulations. We believe that Congress intended that the Secretary use section 422 to encourage resident training in rural areas, and we believe this criterion furthers this intention. We are proposing to include residency training in FQHCs in this criterion because we understand that some FQHCs are located in rural areas. In addition, we would like to encourage residency training at FQHCs because we believe that, similar to rural providers and RHCs, FQHCs provide services for medically underserved areas or populations, or both.

Evaluation Criterion Four. In portions of cost reporting periods prior to July 1, 2005, the hospital qualified for a temporary adjustment to its FTE cap under existing § 413.86(g)(9) (proposed to be redesignated as § 413.79(h) in this proposed rule) because it was training displaced residents from either a closed program or a closed hospital, and, even after the temporary adjustment, the hospital continues to train residents in the specialty(ies) of the displaced residents and is training residents in excess of the hospital's direct GME FTE cap or IME FTE cap, or both, for that reason. We believe this criterion is appropriate because it will help to sustain the level of residency training in the community.

Evaluation Criterion Five. The hospital is above its FTE caps because it was awaiting accreditation of a new program from the ACGME or the AOA during the base period for its FTE cap(s), but was not eligible to receive a new program adjustment as stated under existing § 413.86(g)(6)(ii) (proposed to be redesignated as § 413.79(e)(2) in this proposed rule). Under existing § 413.86(g)(6)(ii) and § 413 .86(g)(13) (proposed to be redesignated as § 413.79(l) in this proposed rule), a hospital that had allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996 could receive an adjustment to its unweighted FTE cap for a new medical residency training program that either received its initial accreditation or began training residents on or after January 1, 1995 and on or before August 5, 1997. If a hospital failed to meet those deadlines, it was not eligible to have its cap(s) adjusted to include residents in a new program. Under this proposed criterion, a hospital would apply for additional FTE residents if the hospital had submitted its application for a new program to the accrediting body before August 5, 1997, and received its accreditation after August 5, 1997 but before August 5, 1998. This would allow some hospitals to receive increases in their FTE resident caps in cases in which, in good faith, the hospital had submitted an application for accreditation for a new program prior to the date of enactment of FTE resident caps under the BBA, but because of the timing of the implementation of the FTE resident cap(s), had not yet received direct GME and IME payment for residents in the newly accredited program during the base period for the hospital's FTE resident cap(s).

Evaluation Criterion Six. The hospital is training residents in excess of its FTE resident caps because, despite qualifying for an FTE cap adjustment for a new program under § 413.86(g)(6)(i) or (g)(6)(ii) (proposed to be redesignated as § 413.79(e)(1) and (e)(2) in this proposed rule), it was unable to ''grow'' its program to the full complement of residents for which the program was accredited before the hospital's FTE resident cap was permanently set beginning with the fourth program year of the new program. Similar to evaluation criterion five above, this criterion would allow some hospitals that had, in good faith, started up a new residency program as required in the regulations but could not completely fill the new program within the allowed regulatory period, to receive increases in their FTE resident caps. For instance, this could have occurred because the program was a program of long duration (such as a 5-year general surgery program), and the hospital did not have the opportunity to ''grow'' the program to its full complement of residents because the regulations at §§ 413.86(g)(6)(i) or (g)(6)(ii) allow a program to grow for only 3 years before the hospital's FTE resident cap is permanently adjusted for the new program.

Evaluation Criterion Seven. The hospital is located in any one (or a combination) of the following: a geographic HPSA, as defined in 42 CFR 5.2; a population HPSA, (also defined at 42 CFR 5.2); or a Medicare physician scarcity county, as defined under section 413 of Public Law 108–173. We are proposing to use this 3-part criterion in order to capture, as objectively as possible, medically underserved areas or patient populations (many of which are Medicare beneficiaries), or both. We understand that if a particular community has been designated a HPSA (either a geographic or population HPSA), the designation information is available to hospitals from the Health Resources and Services Administration (HRSA) HPSA database at the Web site: *http://belize.hrsa.gov/newhpsa/newhpsa.cfm.* In addition, hospitals will be able to determine whether they are located in a Medicare physician scarcity county (consistent with section 413 of Pub. L. 108–173) on the CMS Internet Web site at *www.cms.hhs.gov* or upon publication of the annual final rule setting forth the Medicare physician fee schedule (which is generally published by November 1 of each year). We note that if Medicare does not publish the final rule setting forth the Medicare physician fee schedule in time for the application deadline for increases in FTE resident caps (December 1, 2004, or March 1, 2005, depending on the hospital), we are proposing that we will not use the Medicare physician scarcity county designations (as defined under section 413 of Pub. L. 108–173) for purposes of this criterion.

Evaluation Criterion Eight. The hospital is in a rural area (as defined under section 1886(d)(2)(D)(ii) of the Act) and is a training site for a rural track residency program (as specified under § 413.86(g)(12) (proposed to be redesignated as § 413.79(k) in this proposed rule)), but is unable to count all of the FTE residents training at the rural hospital in the rural track because the rural hospital's FTE cap is lower than the hospital's unweighted count of allopathic or osteopathic FTE residents beginning with portions of cost reporting periods on or after July 1, 2005.

Evaluation Criterion Nine. The hospital is affiliated with a historically Black medical college. According to the language in the Conference Report for Public Law 108–173 (pages 204–205), the Conference agreement on section 422 generally restated the three statutory priority categories described above (rural, ''small'' urban, and only specialty program in the State) in terms of giving guidance to the Secretary for deciding which hospitals should receive the redistributed FTE resident slots. However, there was one additional cited criterion that the Conference indicated the Secretary should use in evaluating the hospital applications. Specifically, the Conference agreement states that the Secretary should consider whether the hospital is a ''historically *large* medical college'' (emphasis added). Upon consideration of this particular terminology, which, on its face, seems to contradict the three statutory priority categories (that is, rural, ''small'' urban, and only specialty program in the State), we are proposing to view the reference to ''historically *large* medical colleges''

as a scrivener's error, and to read this language to refer to ''historically *Black* medical colleges.'' This proposed interpretation accomplishes two goals: first, we believe this interpretation serves the greater policy goal of encouraging residency training for the benefit of medically underserved populations. Second, we believe that this interpretation reflects the Conferees' intent in the language in the Conference Report. In addition, we are proposing to identify ''historically Black medical colleges'' as Howard University College of Medicine, Morehouse School of Medicine, Meharry Medical College, and Charles R. Drew University of Medicine and Science. These four medical schools are identified as ''historically Black medical colleges'' by the American Medical Association (see *http://www.ama–assn.org/ama/pub/category/7952.html).* We are proposing that the hospital will meet this criterion if it intends to use an increase in its FTE resident cap(s) under section 1886(h)(7)(B) of the Act to count residents in residency programs sponsored by a historically Black medical college listed above.

Evaluation Criterion Ten. The hospital is training residents in residency program(s) sponsored by a medical school(s) that is designated as a Center of Excellence for Underserved Minorities (COE) under section 736 of the Public Health Service Act in FY 2003. We understand that the COE program was established to be a catalyst for institutionalizing a commitment to underserved students and faculty, and to serve as a national resource and educational center for diversity and minority health issues. Therefore, we believe that it is appropriate to encourage hospitals to train residents in residency programs sponsored by medical schools that are designated as COEs. A hospital can verify whether it is training residents in programs sponsored by a medical school that is a COE. Medical schools that are COEs in FY 2003 are listed at the following Web site: *http://bhpr.hrsa.gov/diversity/coe/grantees2003.htm.* We note that, in FY 2003, there were 28 medical schools that were designated to be COEs.

We are proposing to use the above set of criteria to evaluate the applications by hospitals for increases in their FTE resident caps that fall within each of the six level priority categories. We would place each application in the appropriate priority level category based on the information the hospitals check off on the proposed CMS Evaluation Form for each allopathic and osteopathic specialty program requested by the applicant hospital, and the corresponding requested FTE cap increase (see the proposed form below). We are proposing to place all of these evaluation criteria on the Evaluation Form and to ask the hospital to check off on the form which criteria apply for each specialty program for which an FTE cap increase is requested. Based on the assertions checked off on the form, CMS would score each CMS Evaluation Form (one point per criterion checked off). The higher scoring CMS Evaluation Form(s) for each applicant hospital within each level priority category would be awarded the FTE resident cap increases first. As we described above, we are proposing to award the cap increases in the order of the six specified level priority categories because, as a general rule, we believe hospitals that meet more than one of the statutory priorities should be awarded the increases in their FTE resident caps first before other hospitals. However, we also believe that hospitals that meet a higher statutory priority category should receive first consideration by CMS over hospitals that meet lower statutory priorities. That is the reason, for instance, we are proposing the first level (rural hospital + only specialty program in the State) and second level (rural only) priority categories to give all rural hospitals first consideration by CMS before any small urban hospital, as required by the statute.

Thus, first level priority category hospitals that score highest on the evaluation criteria on the CMS Evaluation Form for a particular specialty program would receive the increases in their FTE resident caps first. For example, if Hospital D is a rural hospital and is establishing the first osteopathic internal medicine residency program in State Y, thereby falling within the first level priority category, and Hospital D checks off on the CMS Evaluation Form that it has a Medicare utilization of 60 percent, is located in a geographic HPSA, and is affiliated with a historically Black medical college, Hospital D would receive a score of 3 points on the completed CMS Evaluation Form for the osteopathic internal medicine residency program and accompanying application. We are proposing that we would first award FTE cap increases to hospitals whose CMS Evaluation Forms for a particular program receive 10 points based on the number of evaluation criteria checked off by the hospital for the program (if there are any) and then to those with successively fewer points within the level priority category. Hospital D would receive the increase in its FTE resident cap(s) requested on its application after all the hospitals in the first level priority category whose applications receive 10 through 4 points are awarded their requests first.

We are proposing that we would award the increases in FTE resident caps to all those hospitals that are in the first level priority category (rural hospitals + only specialty program in the State) before evaluating those hospitals in the second level priority category (rural hospital), and would award the FTE resident slots to all those hospitals in the second level priority category before evaluating those hospitals in the third level priority category (''small'' urban hospital + only specialty in the State), and so on. Once we reach an aggregate number of FTE resident cap increases from the aggregate estimated pool of FTE resident positions under section 1886(h)(7)(A) of the Act, but are unable, based on the number of remaining slots, to meet all of the requests at the next level priority category at the next score level, we are proposing to prorate any remaining estimated FTE resident slots among all the applicant hospitals within that level priority category and with the same score on the hospital's application.

For example, assume all applicant hospitals in the first through fourth level priority categories receive the requested increases in their FTE resident caps by CMS, and CMS next evaluates hospital applications and accompanying CMS Evaluation Forms in the fifth level priority category (only specialty program in the State). At the point that CMS has awarded cap increases for all the fourth level priority category hospitals that scored 5 or above on their CMS Evaluation Forms for each residency program, CMS finds that there is only a sufficient number of resident slots remaining in the estimated pool to grant half of the requests for slots from hospitals that scored 4 points. We are proposing that we would prorate all of the remaining FTEs among the 4-point CMS Evaluation Forms and accompanying applications in the fourth level priority category. Thus, if CMS could have awarded a total of 200 FTE slots for direct GME and 185 FTE slots for IME to only the first 50 percent of the 4-point CMS Evaluation Forms in the fourth level priority category at the point that the estimated pool of FTE slots is spent, we are proposing to prorate all of the 200 FTE slots for direct GME and 185 FTE slots for IME among all of the 4-point CMS Evaluation Forms and accompanying applications in that fourth priority category, no matter what level of FTE resident cap increase was requested on the individual hospital's application.

We recognize the complexity of this proposed evaluation process for the award of increases in hospital's FTE resident caps under section 1886(h)(7)(B) of the Act. Therefore, we are including some further examples depicting the proposed procedures:

Example 1: Hospital M in State Z is an urban hospital located in an MSA that has a population of less than 1 million. Hospital M can demonstrate the likelihood that it will fill the requested five FTEs resident slots for direct GME and IME because it is currently training a number of FTE residents in geriatrics that exceeds both of its FTE caps, and has attached to its application for an increase in its FTE resident caps a copy of Hospital M's past three Medicare cost reports (as filed or audited, whichever is most recent and available), which documents on Worksheet E, Part A and Worksheet E3, Part IV that, according to the resident counts and the FTE resident caps, Hospital M is training residents in excess of its caps. Hospital M has taken on residents from a teaching hospital in the community that closed, and is also located in a Medicare physician scarcity county.

Hospital M's application would be evaluated by CMS accordingly: Fourth level priority category (''small'' urban hospital); score of 3 (expanding geriatrics program, Medicare physician scarcity area, residents from a closed hospital).

Example 2: Hospital K is a large academic medical center located in an MSA with a population of greater than 1,000,000 and is in a population HPSA. Hospital K regularly trains residents in programs sponsored by Meharry Medical College, and wishes to add more residents from Meharry, and therefore, has requested accreditation from the ACGME to expand the number of Meharry residents training in both allopathic surgery and osteopathic pediatrics programs. Hospital K is above both its direct GME and IME FTE caps.

Hospital K's CMS Evaluation Forms for allopathic surgery and osteopathic pediatrics would be evaluated (separately) by CMS accordingly: Sixth level priority category (large urban hospital); can demonstrate likelihood of filling the slots (because Hospital K can document both that the hospital is above its caps and that it has requested ACGME accreditation to expand the programs); and a score of 2 (population HPSA, historically Black medical college).

Example 3: Hospital E is a rural hospital located in a Medicare physician scarcity area and a geographic HPSA. It is a rural training site for a rural track residency program that has only been a training site since 2002. Therefore, Hospital E has an FTE resident cap of zero FTEs for direct GME and IME.

Hospital E's CMS Evaluation Form for the rural track family practice program and accompanying application would be evaluated CMS accordingly: Second level priority category (rural hospital); can demonstrate the likelihood of filling slots (because Hospital E can document that it is both over its cap of zero FTEs, and that it is a training site for an accredited rural track residency program; and a score of 2 (a training site for a rural track, and a Medicare physician scarcity area, and a geographic HPSA).

Example 4: Hospital W is a rural hospital that has FTE caps of 15 FTEs for both direct GME and IME. Hospital W requests an FTE cap adjustment of 25 FTEs for both direct GME and IME; 5 FTEs to expand an existing geriatric fellowship; 20 FTEs to establish the first osteopathic emergency medicine program in State K, in which Hospital W is located. Hospital W can document that it is at its FTE caps with existing residency programs. CMS would make the following assessment for Hospital W's Evaluation Form for the geriatric fellowship: Hospital W falls into the second level priority category for being a rural hospital; can demonstrate the likelihood that it will fill the 5 FTE slots of the geriatric program by documenting that it has requested additional slots in the accreditation of the geriatrics program and that Hospital W is above its caps. Hospital W would receive a score of 1 on its CMS Evaluation Form for the geriatrics program. CMS would make the following assessment for Hospital W's CMS Evaluation Form for the new osteopathic emergency medicine program: Hospital W would meet the first level priority category for this Evaluation Form because, not only is it a rural hospital, but it is also requesting 20 FTEs for the only osteopathic emergency medicine program in the State; can demonstrate the likelihood that it will fill the 20 osteopathic emergency medicine FTEs by documenting the accreditation request and that it is over its FTE caps. Hospital W would receive a score of zero, because it did not meet any of the 10 evaluation criteria on the CMS Evaluation Form.

j. Application of Locality-Adjusted National Average Per Resident Amount (PRA)

Section 1886(h)(7)(B)(v) of the Act, as added by section 422 of Public Law 108–173, provides that, with respect to additional residency slots attributable to the increase in the hospital's FTE resident cap as a result of redistribution of resident positions, the approved FTE resident amount, or PRA, is deemed to be equal to the locality-adjusted national average per resident amount computed for that hospital. In other words, section 1886(h)(7)(B)(v) of the Act requires that, for purposes of determining direct GME payments for portions of cost reporting periods occurring on or after July 1, 2005, a hospital that receives an increase in its direct GME FTE resident cap under section 1886(h)(7)(B) of the Act will receive direct GME payments with respect to those additional FTE residents using the locality-adjusted national average PRA. Thus, we are proposing that a hospital that receives an increase in its FTE resident cap under section 1886(h)(7)(B) of the Act would receive direct GME payments based on the sum of two different direct GME calculations: one that is calculated using the hospital's actual PRAs (primary care PRA or nonprimary care PRA) applicable under existing § 413.86(e)(4) (proposed to be redesignated as § 413.77(d) in this proposed rule) and the hospital's number of FTE residents not attributable to an FTE cap increase under section 1886(h)(7)(B) of the Act; and another that is calculated using the locality-adjusted national average PRA under existing § 413.86(e)(4)(ii)(B) (proposed to be redesignated as § 413.77(d)(2)(ii) in this proposed rule) inflated to a hospital's current cost reporting period, and the hospital's number of FTE residents that is attributable to the increase in the hospital's FTE resident cap under section 1886(h)(7)(B).

Section 422(a) of Public Law 108–173 contains a cross-reference in the new section 1886(h)(7)(B)(v) of the Act to the locality adjusted national average PRA ''computed under paragraph (4)(E).'' However, section 1886(h)(4)(E) of the Act does not relate to the locality-adjusted national average PRA. Rather, it relates to the circumstances under which a hospital may count FTE resident time spent training in nonhospital sites.

We have concluded that the cross-reference to section 1886(h)(4)(E) of the Act is a legislative drafting error, or scrivener's error. Instead, we believe Congress intended to refer to section 1886(h)(2)(E), which explicitly provides for the determination of locality-adjusted national average PRAs. Because the drafting error is apparent, and a literal reading of the cross-reference as specified in the statute would produce absurd results, we are proposing to interpret the cross-reference to section 1886(h)(4)(E) of the Act in the new section 1886(h)(7)(B)(v) of the Act as if the reference were to section 1886(h)(2)(E) of the Act.

We note that section 1886(h)(7)(B)(v) of the Act, which addresses the applicability of the locality-adjusted national average PRAs with respect to redistributed slots for the direct GME payment, makes no reference to section 1886(h)(4)(G) of the Act, which is the provision concerning the rolling average count of FTE residents. That is, the statute does not provide for an exclusion from application of the rolling average for residents counted as a result of FTE cap increases under section 1886(h)(7)(B) of the Act. In light of the absence of a specific pronouncement in section 1886(h)(7)(B) of the Act exempting those residents from application of the rolling average, and with no apparent reason to treat residents counted as a result of the FTE

cap increases under section 1886(h)(7)(B) of the Act differently for purposes of the rolling average, we are proposing to require that if a hospital increases its direct GME FTE count of residents as a result of an FTE resident cap increase under section 1886(h)(7)(B) of the Act, those FTE residents are immediately subject to the rolling average calculation. Furthermore, we believe that, given potentially significant shifts of FTE slots among hospitals as a result of section 1886(h)(7) of the Act, the inclusion of FTE residents counted as a result of section 1886(h)(7)(B) of the Act in the rolling average introduces a measure of stability and predictability, and mitigates radical shifts in direct GME payments from period to period. Thus, any increase in a hospital's direct GME payment relating to an FTE cap increase under section 1886(h)(7)(B) of the Act will be phased-in over a 3-year period because the additional FTE residents are immediately included in the rolling average calculation and would only gradually be included in the hospital's FTE count.

Following is an example of how direct GME payment would be determined for a hospital that received an increase in its direct GME FTE cap under section 1886(h)(7)(B) of the Act. Hospital A has a fiscal year end (FYE) of June 30, and a direct GME FTE resident cap of 20 FTEs. During its FYEs June 30, 2004 and June 30, 2005, Hospital A trained 20 nonprimary care residents. During FYE June 30, 2006, Hospital A trains 25 nonprimary care FTE residents. Hospital A's FYE June 30, 2006 nonprimary care PRA is $100,000. The FYE June 30, 2006 locality-adjusted national average PRA for Hospital A is $84,000. Hospital A's Medicare utilization is 35 percent. Effective July 1, 2005, under section 1886(h)(7)(B) of the Act, Hospital A receives an increase to its direct GME FTE resident cap of 5 FTEs, for a total adjusted direct GME FTE resident cap of 25 FTEs. For the FYE June 30, 2006 cost report, the direct GME payment is calculated as follows:

Step 1. For residents NOT counted pursuant to section 1886(h)(7)(B) of the Act—

For July 1, 2005 through June 30 2006:

- Rolling average count: 20 + 20 + 20/3 = 20.
- Direct GME computation: $100,000 × 20 × .35 = $700,000.

Step 2. For residents counted pursuant to section 1886(h)(7)(B) of the Act—

For July 1, 2005 through June 30, 2006:

- Rolling average count: 25 + 20 + 20/3 = 21.7
- Difference between rolling average count for residents counted pursuant to section 1886(h)(7)(B) of the Act and rolling average count for residents counted not pursuant to section 1886(h)(7)(B) of the Act (rolling average count under step 2 minus rolling average count under step 1): 21.7 − 20 = 1.7.
- Direct GME computation: $84,000 × 1.7 × .35 = $49,980.

Step 3. Direct GME payment for FYE June 30, 2006: $700,000 + $49,980 = $749,980.

k. Application of Section 422 to Hospitals That Participate in Demonstration Projects or Voluntary Reduction Programs

Section 1886(h)(7)(B)(vi) of the Act, as amended by section 422(a)(3) of Public Law 108–173, states that ''Nothing in this subparagraph shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs * * * under a demonstration project approved as of October 31, 2003.'' This language is referring to the New York Medicare GME Demonstration Project and the Voluntary Resident Reduction Project (VRRP) under section 402 of Public Law 90–248. In July 1997, 42 New York teaching hospitals participated in the demonstration project. As there were two entry points for this demonstration, an additional seven hospitals joined the program in July 1998. The purpose of the demonstration project was to test reimbursement changes associated with residency training to determine whether hospitals could use time-limited transition funding to replace and reengineer the services provided by a portion of their residency trainees. In exchange for reducing its count of residents by 20 to 25 percent over a 5-year period, while maintaining or increasing its primary care-to-specialty ratio of residents, a participating hospital (or consortium of hospitals) would receive ''hold harmless payments'' for 6 years. These payments represented a declining percentage of the Medicare GME reimbursement the participating hospitals would have received had their number of residents not been reduced.

For hospitals that successfully completed the demonstration project, the Balanced Budget Act of 1997 states that if a hospital increases the number of full-time equivalent residents permitted under its reduction plan as of the completion of the plan, it is liable for repayment of the total amounts paid under the demonstration. Following the demonstration's period of performance, which ended June 30, 2003, if a hospital exceeds its post-demonstration cap and trains residents in excess of the FTE levels achieved under the demonstration, the hospital is not permitted to count those excess residents for purposes of Medicare GME payments until such time as the hold harmless funds paid under the demonstration project have been repaid in full.

Similarly, with the VRPP, hospitals could use time-limited transition funding to replace the services provided by a portion of their residents. In exchange for reducing its count of residents by 20 to 25 percent over a 5-year period, while maintaining or increasing its primary care-to-specialty ratio of residents, a VRRP participating hospital would receive ''hold harmless payments'' for 5 years. These payments represented a declining percentage of the Medicare GME reimbursement the VRRP participating hospital would have received had its number of residents not been reduced.

We believe that the language of section 1886(h)(7)(B)(vi) of the Act precludes the Secretary from redistributing residency positions that are unused due to a hospital's participation in a demonstration project or the VRRP to other hospitals that seek to increase their FTE resident caps under section 1886(h)(7)(B)(i) of the Act. That is, if we were to propose that hospitals that participated in a demonstration project or the VRRP are subject to possible reductions to their FTE resident caps under section 1886(h)(7)(A)(i) of the Act, any excess slots resulting from reductions made under section 1886(h)(7)(A)(i) of the Act attributable to the demonstration or the voluntary reduction program at these hospitals would not be allocated to the resident pool and redistributed to other hospitals. We also believe that section 1886(h)(7)(B)(vi) of the Act is silent as to whether the Secretary should apply the possible reductions under section 1886(h)(7)(A)(i) of the Act to the FTE resident caps of these hospitals. Congress recognized the unique status of reductions in FTE resident counts made by these hospitals that participated in a demonstration project under the authority of section 402 of Public Law 90–248, or a VRRP under section 1886(h)(6) of the Act, in which these hospitals received hold-harmless payments from Medicare for reducing the number of residents that they were training. Accordingly, we are proposing to recognize the unique status of FTE reductions made by these hospitals, and

are applying the discretion that Congress has granted the Secretary under section 1886(h)(7)(A)(ii) of the Act in determining the reference resident level applicable to these hospitals, to determine the extent to which section 1886(h)(7)(A)(i) of the Act applies to these hospitals.

We note that section 1886(h)(7)(B)(vi) of the Act only applies to these hospitals to the extent that a hospital's ''reductions in residency positions'' were ''*attributable*'' to its participation in the demonstration project or the VRRP. In determining the reference resident level for these hospitals, we are proposing to adjust the reference resident level for ''reductions in residency positions attributable'' to participation in the demonstration project or the VRRP. We are proposing to define ''reductions in residency positions attributable'' to participation in the demonstration project or the VRRP as the difference between the number of unweighted allopathic and osteopathic residents training at the hospital at the start of a hospital's participation in the demonstration project or the VRRP, (that is, the base number of residents as defined by the terms of the demonstration project and the VRRP,) and the number of such residents training at the hospital in the hospital's most recent cost reporting period ending on or before September 30, 2002. We are proposing that, in determining any possible adjustments to the reference resident level for hospitals that participated in the demonstration project or the VRRP, we would differentiate between hospitals that withdrew from participation *prior* to the beginning of the most recent cost reporting period ending on or before September 30, 2002, and hospitals that either have not withdrawn from participation, or withdrew sometime during or after the most recent cost reporting period ending on or before September 30, 2002.

Specifically, we are proposing that, if a hospital was participating in the demonstration project or the VRRP at any time during the hospital's most recent cost reporting period ending on or before September 30, 2002, for purposes of determining possible reductions to the FTE resident caps, we would compare the higher of the hospital's base number of residents, and the resident level in the hospital's most recent cost reporting period ending on or before September 30, 2002, to the hospital's otherwise applicable FTE resident cap. If the higher of the base number of residents or the resident level in the hospital's most recent cost reporting period ending on or before September 30, 2002, is still less than the otherwise applicable FTE resident cap, we are proposing to reduce the hospital's FTE resident cap amount by 75 percent of the difference, effective July 1, 2005. We would also use those slots in the redistribution process under section 1886(h)(7)(B) of the Act since those slots are not ''attributable'' to participation in the demonstration project or the VRRP.

Under section 1886(h)(7)(A)(ii)(II) of the Act, a hospital may submit a timely request to use its cost report that includes July 1, 2003, for purposes of determining the reference resident level if the hospital has an expansion of an existing program that is not reflected on the hospital's most recent settled cost report. If a hospital that was still participating in the demonstration project or the VRRP at some time during its most recent cost reporting period ending on or before September 30, 2002, had an expansion of an existing program that is not reflected on its most recent settled cost report, and the resident level for its cost reporting period that includes July 1, 2003, is higher than the resident level for the most recent cost reporting period ending on or before September 30, 2002, and is higher than the base number of residents, we anticipate that the hospital would submit a timely request that its resident level from its cost reporting period that includes July 1, 2003, be compared to its otherwise applicable FTE resident cap, for purposes of determining a possible reduction to the hospital's FTE resident cap. We believe that under the proposed policy discussed above, a hospital would only request that we utilize its cost reporting period that includes July 1, 2003, if the number of allopathic and osteopathic residents it trained in that cost reporting period is higher than its base number of residents and its base number of residents is less than its FTE resident cap. If we grant the hospital's request that we utilize its cost reporting period that includes July 1, 2003, and the resident level for that period is less than the FTE resident cap, we would reduce the FTE resident cap by 75 percent of the difference between the two numbers. We would also use those slots in the redistribution process under section 1886(h)(7)(B) of the Act, since those slots are not ''attributable'' to participation in the demonstration project or the VRRP.

If a hospital withdrew from participation in the demonstration project or the VRRP prior to its most recent cost reporting period ending on or before September 30, 2002, we are proposing that such a hospital would be subject to the procedures applicable to all other hospitals for determining possible reductions to the FTE resident caps. However, we note that such a hospital may still apply for an increase to its FTE caps as specified under section 1886(h)(7)(B) of the Act (the proposals for applying for the increase are described above).

l. Application of Section 422 to Hospitals That File Low Utilization Medicare Cost Reports

In general, section 422 of Public Law 108–173 applies to hospitals that are Medicare-participating providers and that train residents in approved residency programs. However, because Medicare-participating children's hospitals primarily serve a non-Medicare population and, therefore, receive minimal Medicare payments relative to other Medicare-participating hospitals, some children's hospitals choose (with approval from their fiscal intermediaries) to submit low utilization (abbreviated) Medicare cost reports. Typically, such low utilization cost reports do not include the information that would be necessary for us to calculate Medicare GME payments, such as FTE resident counts and caps. Thus, children's hospitals that submit these low utilization cost reports do not receive Medicare GME payments.

Under section 1886(h)(7)(A) of the Act, as added by section 422(a) of Public Law 108–173, we are proposing that determinations as to whether, and by how much, a children's hospital's FTE resident cap will be reduced will be made using the same methodology (that is, utilizing the same reference cost reporting periods and the same reference resident levels) that we are proposing for other Medicare-participating teaching hospitals. We note that the low utilization cost reports may be filed with or without Worksheet E–3, Part IV (the worksheet on which the Medicare direct GME payment is calculated). If a children's hospital files a low utilization cost report in a given cost reporting period, and does not file the Worksheet E–3, Part IV, for Medicare purposes, that hospital is not considered by Medicare to be a teaching hospital in that cost reporting period. (We realize that a children's hospital that files a low utilization cost report may have a ''resident cap'' that is applicable for payment purposes under the Children's Hospital Graduate Medical Education (CHGME) Payment Program, administered by the Health Resources and Services Administration (HRSA), but this resident cap is not the Medicare FTE resident cap.) As stated in the One-Time Notification published on April 30, 2004 (Transmittal 77, CR

3247), if a children's hospital filed a low utilization cost report in its most recent cost reporting period ending on or before September 30, 2002, and did not file the Worksheet E–3, Part IV, there could be no reduction under section 1886(h)(7)(A) of the Act because there is no reference resident level for such a hospital. This would be the case even in instances where such a children's hospital has a FTE resident cap (for example, from 1996) that is recognized for Medicare purposes, because there would still be no reference resident level for its most recent cost reporting period ending on or before September 30, 2002, on which to determine a possible reduction to the children's hospital FTE resident cap.

Although section 1886(h)(7)(A) of the Act does not apply to children's hospitals that filed a low utilization cost report (and no Worksheet E–3, Part IV) for the most recent cost reporting period ending on or before September 30, 2002, we are proposing that, regardless of how a children's hospital has previously filed its Medicare cost report (that is, a full cost report or an abbreviated one), or how it is treated for CHGME payment purposes, a children's hospital would be eligible to apply for an increase in its FTE resident cap under section 1886(h)(7)(B) of the Act, subject to the same demonstrated likelihood and evaluation criteria proposed above for all hospitals. However, we are proposing that, in order to receive an increase in its FTE resident cap under section 1886(h)(7)(B) of the Act, effective July 1, 2005, in addition to complying with the proposed application requirements described above, the hospital must file Worksheet E–3, Part IV, with its Medicare cost report for its cost reporting period that includes July 1, 2005. We are proposing that the children's hospital comply with this requirement because section 422 is intended to allow a hospital to increase its FTE counts for purposes of Medicare GME payments. We do not believe it would be appropriate to grant an increase in a hospital's FTE resident cap under section 1886(h)(7)(B) of the Act if the hospital does not use the slots for Medicare purposes (but only for purposes of the CHGME Payment Program) as would be evidenced by not filing a Worksheet E–3, Part IV.

m. Specific Solicitation for Public Comment on the Proposals

We specifically solicit public comment on the proposals in this section IV.O.2. In particular, in section IV.O.2.g. of this preamble on the determination of the hospitals that will receive increases in their FTE resident caps, we have considered many possible alternatives to evaluate hospital applications. We specifically solicit public comments on how hospitals should ''demonstrate the likelihood'' of filling the additional residency slots, and in a way that is documentable for all hospitals and verifiable by CMS. We also specifically solicit public comments on the criteria we have proposed for evaluating the hospital applications and are open to suggestions from the public on what other criteria we should use to determine which hospitals should receive the increases in their FTE resident caps. We ask the public to keep in mind that criteria should be documentable for all hospitals and verifiable by CMS.

n. CMS Evaluation Form

CMS Evaluation Form as Part of the Application for the Increase in a Hospital's FTE Cap(s) Under Section 422 of the Medicare Modernization Act of 2003

Directions: Please fill out the information below for each residency program for which the applicant hospital intends to use the increase in its FTE cap(s). CMS notes that the applicant hospital is responsible for complying with the other requirements listed in the FY 2005 hospital inpatient prospective payment system proposed rule in order to complete its application for the increase in its FTE cap(s) under section 422 of Public Law 108–173.

NAME OF HOSPITAL: _____

MEDICARE PROVIDER NUMBER: _____

NAME OF SPECIALTY TRAINING PROGRAM: _____

(Check one): ☐ Allopathic Program ☐ Osteopathic Program

NUMBER OF FTE SLOTS REQUESTED FOR PROGRAM:

Direct GME:_____ IME:_____

Section A: Demonstrated Likelihood of Filling the FTE Slots

(Place an ''X'' in the box for the applicable criterion and subcriteria.)

☐ A1: *Demonstrated Likelihood Criterion 1.* The hospital intends to use the additional FTEs to establish a new residency program (listed above) on or after July 1, 2005 (that is, a newly approved program that begins training residents on or after July 1, 2005).

☐ (1) Hospital is establishing this newly approved residency program. (Check one of the following.)

☐ Application for approval of the new residency program has been submitted to the ACGME or the AOA by December 1, 2004. (Copy attached.)

☐ The hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program by December 1, 2004. (Copy attached.)

☐ The hospital has received written correspondence from the ACGME or AOA acknowledging receipt of the application for the new program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit). (Copy attached.)

☐ (2) Hospital will likely fill the slots requested. (Check one of the following.)

☐ The hospital s existing residency programs had a resident fill rate of at least 95 percent in each of program years 2001 through 2003. (Documentation attached.)

☐ The hospital has the cover page of its employment contracts with the residents who are or will be participating in the new residency program (resident specific information may be redacted). (Copies attached.)

☐ The specialty program (listed above) has a resident fill rate nationally, across all hospitals, of at least 95 percent. (Documentation attached.)

☐ A2: *Demonstrated Likelihood Criterion 2.* The applying hospital intends to use the additional FTEs to expand an existing residency training program that is listed above (that is, to increase the number of FTE resident slots in the program) on or after July 1, 2005, and before July 1, 2008.

☐ (1) Hospital intends to expand an existing program. (Check one of the following.)

☐ The appropriate accrediting body (the ACGME or the AOA) has approved the hospital s expansion of the number of FTE residents in the program. (Documentation attached.)

☐ The National Residency Match Program or the American Osteopathic Association Residency Match Program has accepted or will be accepting the hospital s participation in the match for the existing program that will include additional resident slots in that residency training program. (Documentation attached.)

☐ The hospital has institutional review document or program information form for the expansion of the existing residency training program. (Copy attached.)

☐ (2) Hospital will likely fill the slots of the expanded residency program. (Check one of the following.)

☐ Hospital has employment contracts with the residents who are or will be participating in the expanded program (resident specific information may be redacted) and employment contracts with the residents participating in the program prior to the expansion of the program. (Copy of the cover page of both documents attached.)

☐ Hospital has other previously established residency programs. (Documentation attached evidencing that each of the residency programs had a resident fill rate of at least 95 percent in each of program years 2001 through 2003.)

☐ Hospital is expanding an existing program in a particular specialty. (Documentation attached evidencing that the specialty has a resident fill rate nationally, across all hospitals, of at least 95 percent.)

☐ Hospital is expanding a program in order to train residents that need a program because another hospital in the State has closed a similar program, and the applying hospital received a temporary adjustment to its FTE cap(s) (under the requirements of § 413.86(g)(9)). (Documentation attached.)

☐ A3: *Demonstrated Likelihood Criterion 3.* Hospital is applying for an increase in its FTE resident cap because the hospital is already training residents in an existing residency training program(s) in excess of its direct GME FTE cap or IME FTE cap, or both. (Copies of *EACH* of the following attached.)

- Copies of the most recent as-submitted Medicare cost reports documenting on Worksheet E, Part A and Worksheet E3, Part IV the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.
- Copies of the 2004 residency match information concerning the number of residents the hospital intends to have in its existing programs.
- Copies of the most recent accreditation letters on all of the hospital s training programs in which the hospital trains and counts FTE residents for direct GME and IME.

☐ A4: *Demonstrated Likelihood Criterion 4.* The hospital is applying for the unused FTE resident slots because the hospital is at risk of losing accreditation of a residency training program if the hospital does not increase the number of FTE residents in the program on or after July 1, 2005. (Documentation attached from the appropriate accrediting body of the hospital's risk of lost accreditation as a result of an insufficient number of residents in the program.)

Section B. Level Priority Category

☐ (Place an ''X'' in the appropriate box that is applicable to the level priority category that describes the applicant hospital.)

☐ B1: *First Level Priority Category:* The hospital is a rural hospital and has the only specialty training program in the State (for the program requested on page 1 of this CMS Evaluation Form).

☐ B2: *Second Level Priority Category:* The hospital is a rural hospital only.

☐ B3: *Third Level Priority Category:* The hospital is a small urban hospital (that is, an urban hospital that is located in a ''not large urban area'') and has the only specialty program in the State (for the program requested on this CMS Evaluation Form).

☐ B4: *Fourth Level Priority Category:* The hospital is a ''small'' urban hospital only.

☐ B5: *Fifth Level Priority Category:* The hospital has the only specialty training program in the State (for the program requested on page 1 of this CMS Evaluation Form).

☐ B6: *Sixth Level Priority Category:* The hospital meets none of the statutory priority criteria.

Section C. Evaluation Criteria

(Place an X in the box for each criterion that is appropriate for the applicant hospital and for the program for which the increase in the FTE cap is requested.)

☐ C1: *Evaluation Criterion One.* The hospital that is requesting the increase in its FTE resident cap(s) has a Medicare inpatient utilization over 60 percent, as reflected in at least two of the hospital s last three most recent audited cost reporting periods for which there is a settled cost report.

☐ C2: *Evaluation Criterion Two.* The hospital needs the additional slots to establish a new geriatrics residency program, or adding residents to an existing geriatrics program.

☐ C3: *Evaluation Criterion Three.* The hospital does not qualify for an adjustment to its FTE caps under existing § 413.86(g)(12) for a rural track residency program, but is applying for an increase in its FTE resident cap(s) under section 1886(h)(7)(B) of the Act because it rotates (or in the case of a new program, will rotate) residents for at least 25 percent of the duration of the residency program to any one (or in combination thereof) of the following: a rural area, as defined in section 1886(d)(2)(D)(ii) of the Act and § 412.62(f)(1)(iii) of the regulations; a rural health clinic (RHC), as defined in section 1861(aa)(1) of the Act and § 491.2 of the regulations; or a Federally Qualified Health Center (FQHC), as defined in section 1861(a)(3) of the Act and § 405.2401(b) of the regulations.

☐ C4: *Evaluation Criterion Four.* In portions of cost reporting periods prior to July 1, 2005, the hospital qualified for a temporary adjustment to its FTE cap under existing § 413.86(g)(9) because it was training displaced residents from either a closed program or a closed hospital, and, even after the temporary adjustment, the hospital continues to train residents in the specialty(ies) of the displaced residents and is above the hospital's direct GME FTE cap or IME FTE cap, or both, for that reason.

☐ C5: *Evaluation Criterion Five.* The hospital is above its FTE caps because it was awaiting accreditation of a new program from the ACGME or the AOA during the base period for its FTE cap(s) but was not eligible to receive a new program adjustment as stated under existing § 413.86(g)(6)(ii).

☐ C6: *Evaluation Criterion Six.* The hospital is above its FTE resident caps because, despite qualifying for an FTE cap adjustment for a new program under § 413.86(g)(6)(i) or (g)(6)(ii), it was unable to ''grow'' its program to the full complement of residents for which the program was accredited before the hospital's FTE resident cap was permanently set beginning with the fourth program year of the new program.

☐ C7: *Evaluation Criterion Seven.* The hospital is located in any one (or in combination thereof) of the following: a geographic HPSA, as defined in 42 CFR 5.2; a population HPSA (also defined at 42 CFR 5.2); or a Medicare physician scarcity county, as defined under section 413 of Public Law 108–173.

☐ C8: *Evaluation Criterion Eight.* The hospital is in a rural area (as defined under section 1886(d)(2)(D)(ii) of the Act) and is a training site for a rural track residency program (as specified under § 413.86(g)(12), but is unable to count all of the FTE residents training at the rural hospital in the rural track because the rural hospital's FTE cap is lower than the hospital's unweighted count of allopathic or osteopathic FTE residents beginning with portions of cost reporting periods on or after July 1, 2005.

☐ C9: *Evaluation Criterion Nine.* The hospital is affiliated with a historically Black medical college.

☐ C10: *Evaluation Criterion Ten:* The hospital is training residents in residency program(s) sponsored by a medical school(s) that is designated as a Center of Excellence for Underserved Minorities (COE) under section 736 of the Public Health Service Act in FY 2003.

o. CMS Central and CMS Regional Office Mailing Addresses for Applications for Increases in FTE Resident Caps

Central Office

Centers for Medicare and Medicaid Services (CMS), Director, Division of Acute Care, 7500 Security Boulevard, Mail Stop C4–08–06, Baltimore, Maryland 21244.

Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Management, Region I, JFK Federal Building, Room 2325, Boston, MA 02203, Phone: (617) 565–1185.

Region II (New York, New Jersey, U.S. Virgin Islands, and Puerto Rico)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Management, Region II, 26 Federal Plaza, 38th Floor, New York, NY 10278, Phone: (212) 264–3657.

Region III (Delaware, Maryland, Pennsylvania, Virginia and West Virginia, and the District of Columbia)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Management, Region III, Public Ledger Building, Suite 216, 150 South Independence Mall West, Philadelphia, PA 19106, Phone: (215) 861–4140.

Region IV (Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, and Tennessee)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Management, Region IV, Atlanta Federal Center, 61 Forsyth Street, SW., Suite 4T20, Atlanta, GA 30303–8909, Phone: (404) 562–7500.

Region V (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin)

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Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas)

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Region VII (Iowa, Kansas, Missouri, and Nebraska)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Management, Region VII, Richard Bolling Federal Building, Room 235, 601 East 12th Street, Kansas City, MO 64106.

Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Managment, Region VIII, Colorado State Bank Building, 1600 Broadway, Suite 700, Denver, CO 80202, Phone: (303) 844–2111.

Region IX (Arizona, California, Hawaii, and Nevada and Territories of American Samoa, Guam and the Commonwealth of the Northern Mariana Islands)

Centers for Medicare and Medicaid Services (CMS), Associate Regional Administrator, Division of Medicare Financial Management, Region IX, 75 Hawthorne St., Suite 408, San Francisco, CA 94105, Phone: (415) 744–3501.

Region X (Alaska, Idaho, Oregon, and Washington)

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3. Direct GME Initial Residency Period (Proposed New § 413.79, a Proposed Redesignation of Existing § 413.86(g))

a. Background

As we have generally described above, the amount of direct GME payment to a hospital is based in part on the number of FTE residents who are training at the hospital during a year. The number of FTE residents training at a hospital, and thus the amount of direct GME payment to a hospital, is directly affected by CMS policy on how ''initial residency periods'' are determined for residents.

Section 1886(h)(5)(A) of the Act defines ''approved medical residency training program'' as ''a residency or other postgraduate medical training program, participation in which may be counted toward certification in a specialty or subspecialty.'' This provision is implemented in regulations at existing § 413.86(b). In accordance with section 1886(h)(5)(I) of the Act, the term ''resident'' is defined to include ''an intern or other participant in an approved medical residency training program.'' Existing § 413.86(b) defines ''resident'' as an ''intern, resident, or fellow who participates in an approved medical residency training program * * * as required in order to become certified by the appropriate specialty board.''

Section 1886(h)(4)(C)(ii) of the Act provides that while a resident is in the ''initial residency period,'' the resident is weighted at 1.00 (existing § 413.86(g)(2) of the regulations). Section 1886(h)(4)(C)(iii) of the Act requires that if a resident is ''not in the resident's initial residency period,'' the resident is weighted as .50 FTE resident (existing § 413.86(g)(3) of the regulations).

Section 1886(h)(5)(F) of the Act defines ''initial residency period'' as the ''period of board eligibility,'' and, subject to specific exceptions, limits the initial residency period to an ''aggregate period of formal training'' of no more than 5 years for any individual. Section 1886(h)(5)(G) of the Act generally defines ''period of board eligibility'' for a resident as ''the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training.'' Existing § 413.86(g)(1) of the regulations generally defines ''initial residency period'' as the ''minimum number of years required for board eligibility.''Existing § 413.86(g)(1)(iv) provides that ''time spent in residency programs that do not lead to certification in a specialty or subspecialty, but that otherwise meet the definition of approved programs . . . is counted toward the initial residency period limitation.'' Section 1886(h)(5)(F) of the Act further provides that ''the initial residency period shall be determined, with respect to a resident, as of the time the resident enters the residency training program.''

The initial residency period is determined as of the time the resident enters the ''initial'' or first residency training program and is based on the period of board eligibility associated with that medical specialty. Thus, this

provision limits the amount of direct GME that Medicare pays a hospital for a resident who switches specialties to a program with a longer period of board eligibility or completes training in a specialty and then continues training in a subspecialty (for example, cardiology and gastroenterology are subspecialties of internal medicine).

b. Direct GME Initial Residency Period Limitation: Simultaneous Match Issue

CMS understands there are numerous programs, including anesthesiology, dermatology, psychiatry, and radiology, that require a year of generalized clinical training to be used as a prerequisite for the subsequent training in the particular specialty. For example, in order to become board eligible in anesthesiology, a resident must first complete a generalized training year and then complete 3 years of training in anesthesiology. This first year of generalized residency training is commonly known as the ''clinical base year.'' Commonly, the clinical base year requirement is fulfilled by completing either a preliminary year in internal medicine (although the preliminary year can also be in other specialties such as general surgery or family practice), or a transitional year program (which is not associated with any particular medical specialty).

In many cases, during the final year of medical school, medical students apply for training in specialty programs. Typically, a medical student who wants to train to become a specialist is ''matched'' to both the clinical base year program and the residency training specialty program at the same time. For example, the medical student who wants to become an anesthesiologist will apply and ''match'' simultaneously for a clinical base year in an internal medicine program for year 1 and for an anesthesiology training program in years 2, 3, and 4.

Based on our interpretation of the statute, CMS' policy is that the initial residency period is determined for a resident based on the program in which he or she participates in the resident's first year of training, without regard to the specialty in which the resident ultimately seeks board certification. Therefore, for example, a resident that chooses to fulfill the clinical base year requirement for an anesthesiology program with a preliminary year in an internal medicine program will be ''labeled'' with the initial residency period associated with internal medicine, or 3 years (3 years of training are required to become board eligible in internal medicine), even though the resident may seek board certification in anesthesiology, which requires a minimum of 4 years of training to become board eligible. As a result, this resident would be weighted at 0.5 FTE in his or her fourth year of training for purposes of direct GME payment.

We understand that some hospitals have been assigning residents that complete a clinical base year in a different specialty from the one in which they ultimately train an initial residency period and a weighting factor based on the specialty associated with second program year in which the residents train. As a result, some residents have been assigned a weighting factor of 1.0 FTE for years beyond their initial residency periods, rather than the applicable 0.5 FTE weighting factor. This error results in Medicare overpayments, the size of which is dependent upon the hospital's direct GME PRA and its Medicare utilization. In addition, we have received numerous requests from the health care industry to revise our policy concerning the initial residency period for residency programs that require a clinical base year because some entities in the industry believe that our current policy is unfair to those individuals who ''match'' simultaneously for both a preliminary year (for example, the clinical base year in internal medicine) and the longer specialty residency program (for example, anesthesiology, dermatology, or radiology).

To address these concerns, we are considering making a change in policy that addresses these ''simultaneous match'' residents. Specifically, we are considering a policy that, if a hospital can document that a particular resident matches simultaneously for a first year of training in a clinical base year in one medical specialty, and for additional year(s) of training in a different specialty program, the resident's initial residency period would be based on the period of board eligibility associated with the specialty program in which the resident matches for the subsequent year(s) of training and not on the period of board eligibility associated with the clinical base year program, for purposes of direct GME payment. In addition, we are considering a new definition of ''residency match'' to mean, for purposes of direct GME, a national process by which applicants to approved medical residency programs are paired with programs on the basis of preferences expressed by both the applicants and the program directors.

This policy could apply regardless of whether the resident completes the first year of training in a separately accredited transitional year program or in a preliminary (or first) year in another residency training program such as internal medicine.

Under such a policy, hospitals would apply a weight of 1.0 FTE (instead of 0.5) for an additional year or two to some residents who, as a prerequisite for training in a specialty program, complete a first year of training in a different specialty program. This would probably cause an increase in direct GME payments. This provision would apply to such programs as anesthesiology, dermatology, radiology, and physical medicine and rehabilitation. In 2004, there were approximately 1,840 residents in these specialties that would be affected by this proposal, as compared to the approximately 83,000 residents in total for whom Medicare makes direct GME payments. Under current policy, these 1,840 residents would be weighted at 0.5 FTE in their 4th year (and 5th year, if applicable) of training. Therefore, direct GME spending for these 1,840 residents should currently be $26.5 million ($1,840 \times 0.5 \times 82,249$ [5] $\times .35$ [6]). Under the policy CMS is considering, direct GME spending would be twice that amount at $53 million ($1,840 \times \$82,249 \times .35$). However, because we believe a number of fiscal intermediaries may have been applying current policy incorrectly and instead have been weighting approximately 920 residents at 1.0 in their 4th year (and 5th year, if applicable) of training, the cost of this change would be expected to be closer to $13.25 million ($920 \times 0.5 \times \$82,249 \times .35$). We are providing this cost impact analysis to the public for its information in consideration of any such proposed change.

We note that in the Conference Committee report that accompanied Public Law 108–173, the Committee stated: ''The conferees also clarify that under section 1886 (h)(5)(F), the initial residency period for any residency for which the ACGME requires a preliminary or general clinical year of training is to be determined in the resident's second year of training.'' (Conference Committee Agreement Accompanying Public Law 108–173, 108 Cong., 2d Sess., 276 (2003)) The Conference Committee included this language as part of its explanation of section 712 of Public Law 108–173, which clarifies an exception to the initial residency period for geriatric fellowship programs (see section IV.O.3.c. of this preamble). We are

[5] $82,249 is the estimated national average per resident amount for FY 2005.

[6] .35 is the estimated average Medicare utilization.

considering making a policy change for determining the initial residency period for a resident who participates in a clinical base year program based on the resident's second year of training, as the Conference Committee suggests. However, we understand that not all residents who participate in the clinical base year programs simultaneously match in specialty training programs before the residents' first year of training. Thus, if we were to propose a ''second year'' policy, there would be no way to distinguish in the second year of training among those residents who simultaneously matched in a specialty program prior to their first year of training; those residents who did not match simultaneously, but participated in a clinical base year and then continued on to train in a different specialty; and those residents who simply switched specialties in their second year. As we have stated earlier, the initial residency period is to be determined based on the ''initial'' or first program in which a resident trains. Section 1886(h)(5)(F) of the Act provides that ''the initial residency period shall be determined, with respect to a resident, as of the time the resident *enters* the residency training program.'' (Emphasis added.)

Therefore, we believe it is appropriate for us to consider changes to the ''simultaneous match'' policy that would allow for documentation that the residents' training program is arranged to continue in another medical specialty after the resident completes the clinical base year. However, we also specifically solicit comments concerning the issue of how to establish the initial residency period for a resident who does not match simultaneously for the first and second year, completes the first year in a preliminary program in one specialty, and then continues his or her training in a different specialty program that requires completion of a clinical base year.

We note that if we were to propose such a change in the initial residency period policy, the change, if finalized, could result in an adjustment to the PRA applicable for the direct GME payments made to the hospital for a resident in a clinical base year. By treating the first year as part of a nonprimary care specialty program (for example, anesthesiology), the hospital would be paid at the lower nonprimary care PRA rather than the higher primary care PRA, which would be used for residents training in a clinical base year in a primary care program (for example, internal medicine). We note in conjunction with our proposal that the initial residency period would be established based upon the period of board eligibility for the specialty program for residents who simultaneously match with a clinical base year and a specialty program that we believe all of the programs that require a clinical base year are nonprimary care specialties. Because we are considering a policy change that the initial residency period would be based upon the period of board eligibility for the specialty program rather than the clinical base year, we would also consider a policy change that the nonprimary care PRA would apply for the duration of their initial residency period.

Thus, we are considering making the above policy changes to address the clinical base year initial residency period issue. We specifically solicit comments on the changes we are considering to the existing initial residency period policy and other approaches to address this issue, particularly those that do not increase Medicare expenditures.

c. Exception to Initial Residency Period for Geriatric Residency or Fellowship Programs (Section 712 of Public Law 108–173 and Proposed Redesignated § 413.79(a) (a proposed redesignation of existing § 413.86(g)(1))

As explained further below, under Medicare direct GME payment rules, the initial residency period is generally defined as the minimum number of years of training required for a resident to become board eligible in a specialty (not to exceed 5 years) and is established at the time the resident enters his or her first training program. For purposes of direct GME payments, a resident's full-time equivalent (FTE) training time is weighted at 1.0 during the initial residency period and 0.5 for training that continues beyond the initial residency period. Section 1886(h)(5)(F) of the Act generally limits a resident's initial residency period to no longer than 5 years. That section also provides an exception that allows FTE training time spent by residents in an approved geriatric residency program to be treated as part of the resident's initial residency period, that is, weighted at 1.0 FTE for up to an additional 2 years after conclusion of the otherwise applicable initial residency period.

We understand, based on information provided by the American Geriatric Society (AGS), that in 1998, the American Board of Internal Medicine and the American Board of Family Physicians (hereinafter ''the Boards'') reduced the minimum number of years of formal training required for residents to become board eligible in geriatrics from 2 years to 1 year. As a result, the initial residency period, and full direct GME funding for residents in geriatric training programs, would be limited to 1 year.

However, we understand that many teaching hospitals continue to run geriatric residency or fellowship programs of at least 2 years in length (some are even 3 years). We also understand that, despite the decrease in the minimum requirements for board eligibility, the Accreditation Council for Graduate Medicare Education (ACGME) continues to accredit some geriatric training programs for the full duration of the fellowships. For example, if a hospital's geriatric fellowship is 3 years in length, the program may continue to be accredited by the ACGME for the full 3 years, but the FTE time spent by a resident training in the geriatric program would be weighted at 1.0 for the first year of the resident's training and at 0.50 for the second and third year of the fellowship. (However, we note that FTE residents' time is not weighted for purposes of IME payments.)

Effective October 1, 2003, section 712 (a) of Public Law 108–173 clarified that Congress intended to provide an exception to the initial residency period for purposes of direct GME payments for geriatric residency or fellowship programs such that ''where a particular approved geriatric training program requires a resident to complete 2 years of training to initially become board eligible in the geriatric specialty, the 2 years spent in the geriatric training program are treated as part of the resident's initial residency period, but are not counted against any limitation on the initial residency period.'' Therefore, we are proposing that, effective for cost reporting periods beginning on or after October 1, 2003, if a resident is training in an accredited geriatric residency or fellowship program of 2 (or more) years in duration, hospitals may treat training time spent during the first 2 years of the program as part of the resident's initial residency period and weight the resident's FTE time at 1.0 during that period, regardless of the fact that the minimum number of years of training required for board eligibility in geriatrics is only 1 year. We note that the statutory language quoted above does not allow a hospital to treat time spent by a resident in the second year of geriatric training as part of the resident's initial residency period in the case where the resident trained in a geriatric residency or fellowship program that is accredited as a 1-year program because, in that case, the

resident could be board eligible after only 1 year of training.

Even though Congress gave the Secretary authority to implement section 712 of Public Law 108–173 through an interim final rule with comment period, we chose to provide instructions in a One-Time Notification (OTN) to fiscal intermediaries and providers (Transmittal 61, CR 3071), ''Changes to the FY 2004 Graduate Medical Education (GME) Payments as Required by the Medicare Modernization Act of 2003 (MMA), P.L. 108–173,'' issued on March 12, 2004, and are implementing the statutory provision in our regulations through this notice and comment rulemaking process. We are proposing to revise proposed redesignated § 413.79(a) (a proposed redesignation of § 413.86(g)(1)) to incorporate the provision of section 712(a) of Public Law 108–173.

4. Per Resident Amount: Extension of Update Limitation on High-Cost Programs

(Section 711 of Public Law 108–173 and § 413.77(d)(*2*)(iii)(B)(*3*) (a proposed redesignation of existing § 413.86(e)(4)(ii)(C)(*2*)(*iii*)))

Section 1886(h)(2) of the Act, as amended by section 311 of the Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113), establishes a methodology for the use of a national average per resident amount (PRA) in computing direct GME payments for cost reporting periods beginning on or after October 1, 2000, and on or before September 30, 2005. Generally, section 1886(h)(2)(D)(ii) of the Act establishes a ''floor'' for hospital-specific PRAs at 70 percent of the locality-adjusted national average PRA. In addition, section 1886(h)(2)(D)(iv) of the Act establishes a ''ceiling'' that limits the annual adjustment of a hospital-specific PRA if the PRA exceeded 140 percent of the locality-adjusted national average PRA. Section 511 of the Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554) further amended section 1886 (h)(2) of the Act to increase the floor that was established by the BBRA to 85 percent of the locality-adjusted national average PRA. For purposes of calculating direct GME payments, each hospital-specific PRA is compared to the floor and ceiling to determine whether the hospital-specific PRA should be revised. (We direct readers to Program Memorandum A–01–38, March 21, 2001 for historical reference on calculating the floor and ceiling.)

Section 711 of Public Law 108–173 amended section 1886 (h)(2)(D)(iv) of the Act to freeze the annual CPI-U updates to hospital-specific PRAs for those PRAs that exceed the ceiling for FYs 2004 through 2013. Therefore, we are proposing that, for cost reporting periods beginning during FY 2004 through FY 2013, we would calculate a ceiling that is equal to 140 percent of the locality-adjusted national average PRA for each hospital and compare it to each hospital-specific PRA. If the hospital-specific PRA for the preceding year is greater than 140 percent of the locality-adjusted national average PRA ''ceiling'' in the current fiscal year, the hospital-specific PRA for the current year is frozen at the preceding fiscal year's hospital-specific PRA and is not updated by the CPI-U factor. We note that a hospital may have more than one PRA. Each of a hospital's PRAs must be separately compared to the ''ceiling'' PRA to determine whether that PRA should be frozen at the level for the previous year or updated by the CPI-U factor.

For example, to determine the applicable PRA for a cost reporting period beginning during FY 2004, we would compare the hospital-specific PRA from the cost reporting period that began during FY 2003 to the FY 2004 locality-adjusted national average PRA for that hospital. If the FY 2003 hospital-specific PRA exceeds 140 percent of the FY 2004 locality-adjusted national average PRA, the FY 2004 hospital-specific PRA is frozen at the level of the FY 2003 hospital-specific PRA and is not updated by the CPI–U factor for FY 2004.

Due to the effective date of the statutory provision of section 711 of Public Law 108–173, we issued a notification to fiscal intermediaries and providers regarding the provision in the OTN issued on March 12, 2004 (Transmittal 61, CR 3071). In this proposed rule, to incorporate the changes made by section 711 of Public Law 108–173 in our regulations regarding the determination of PRAs, we are proposing to: (1) revise proposed redesignated § 413.77(d)(2)(iii)(B)(*3*) (a proposed redesignation of existing § 413.86(e)(4)(ii)(C)(*2*)(*iii*)) to make it applicable only to FY 2003; (2) further redesignate proposed newly redesignated § 413.77(d)(2)(iii)(B)(*4*) (the proposed redesignation of existing § 413.86(e)(4)(ii)(C)(*2*)(*iv*)) as § 413.77(d)(2)(iii)(B)(*4*); and (3) add a proposed new § 413.77(d)(2)(iii)(B)(*4*).

5. Residents Training in Nonhospital Settings

a. Background

With respect to reimbursement of direct GME costs, since July 1, 1987, hospitals have been allowed to count the time residents spend training in sites that are not part of the hospital (referred to as ''nonprovider'' or ''nonhospital sites'') under certain conditions. Section 1886(h)(4)(E) of the Act requires that the Secretary's rules concerning computation of FTE residents for purposes of direct GME payments ''provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.'' (Section 1886(h)(4)(E) of the Act, as added by section of 9314 of the Omnibus Budget Reconciliation Act of 1986, Pub. L. 99–509.)

Regulations regarding time spent by residents training in nonhospital sites for purposes of direct GME payment were first implemented in the September 29, 1989 final rule (54 FR 40286). We stated in that rule (under § 413.86(f)(3)) that a hospital may count the time residents spend in nonprovider settings for purposes of direct GME payment if the residents spend their time in patient care activities and there is a written agreement between the hospital and the nonprovider entity stating that the hospital will incur all or substantially all of the costs of the program. The regulations at that time defined ''all or substantially all'' of the costs to include the residents' compensation for the time spent at the nonprovider setting.

Prior to October 1, 1997, for IME payment purposes, hospitals could only count the time residents spend training in areas subject to the IPPS and outpatient areas of the hospital. Section 4621(b)(2) of the Balanced Budget Act of 1997 (Pub. L. 105–33) revised section 1886(d)(5)(B) of the Act to allow providers to count time residents spend training in nonprovider sites for IME purposes, effective for discharges occurring on or after October 1, 1997. Specifically, section 1886(d)(5)(B)(iv) of the Act was amended to provide that ''all the time spent by an intern or resident in patient care activities under an approved medical residency program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.''

In the regulations at §§ 412.105(f)(1)(ii)(c) and 413.86(f)(4)

(as issued in the July 31, 1998 **Federal Register**), we specify the requirements a hospital must meet in order to include the time spent by a resident training in a nonhospital site in its FTE count for Medicare reimbursement for portions of cost reporting periods occurring on or after January 1, 1999 for both direct GME and for IME payments. The regulations at § 413.86(b) redefine ''all or substantially all of the costs for the training program in the nonhospital setting'' as the residents' salaries and fringe benefits (including travel and lodging where applicable), and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME. A written agreement between the hospital and the nonhospital site is required before the hospital may begin to count residents training at the nonhospital site; the agreement must provide that the hospital will incur the costs of the resident's salary and fringe benefits while the resident is training in the nonhospital site. The hospital must also provide reasonable compensation to the nonhospital site for supervisory teaching activities, and the written agreement must specify that compensation amount.

b. Moratorium on Disallowances of Allopathic or Osteopathic Family Practice Residents Training Time in Nonhospital Settings (Section 713 of Pub. L. 108–173 and Proposed Redesignated § 413.78 (a proposed redesignation of existing § 413.86(f))

As we mentioned above, under existing § 413.86(f)(4), for portions of cost reporting periods occurring on or after January 1, 1999, the time residents spend in nonhospital settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the hospital's number of FTE residents for purposes of calculating both direct GME and IME payments, if the following conditions are met:

(1) The resident spends his or her time in patient care activities.

(2) There is a written agreement between the hospital and the nonhospital site that indicates that the hospital will incur the costs of the resident's salary and fringe benefits while the resident is training in the nonhospital site, and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

(3) The hospital incurs ''all or substantially all'' of the costs for the training program in the nonhospital setting. ''All or substantially all'' means the residents'' salaries and fringe benefits (including travel and lodging where applicable) and the portion of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education.

In order for the hospital to incur ''all or substantially all'' of the costs in accordance with the regulations, the actual cost of the time spent by teaching physicians in supervising residents in the nonhospital setting must be compensated by the hospital. The amount of supervisory GME costs is dependent upon the teaching physician's salary and the percentage of time that he or she devotes to activities related to the residency program at the nonhospital site. As long as there are supervisory costs associated with the nonhospital training, the hospital must reimburse the nonhospital setting for those costs in order to count FTE resident time spent in the nonhospital site for purposes of IME and direct GME payments.

Many hospitals have entered into written agreements with teaching physicians that state that the teaching physician is ''volunteering'' his or her time in the nonhospital site, and, therefore, the hospital is not providing any compensation to the teaching physician. Other hospitals have paid only a nominal amount of compensation for the supervisory teaching physicians' time in the nonhospital setting. Because the existing regulations at § 413.86(f)(4) state that the hospital must incur all or substantially all of the direct GME costs, including those costs associated with the teaching physician, regardless of whether the written agreement states that the teaching physician is ''volunteering,'' we have required that the hospital must pay these costs in order to count FTE residents training in the nonhospital site, as long as these teaching physician costs exist.

However, during the 1-year period from January 1, 2004 through December 31, 2004, section 713 of Public Law 108–173, through a moratorium, allows hospitals to count allopathic or osteopathic family practice residents training in nonhospital settings for IME and direct GME purposes, without regard to the financial arrangement between the hospital and the teaching physician practicing in the nonhospital setting to which the resident is assigned. We implemented section 713 in the One-Time Notification (OTN), ''Changes to the FY 2004 Graduate Medical Education (GME) Payments as Required by the Medicare Modernization Act of 2003 (MMA)'' (CR 3071, Transmittal 61, issued on March 12, 2004). Generally, to implement the provisions of section 713, we stated in the OTN that, when settling prior year cost reports during this 1-year period, or for family practice residents actually training in nonhospital settings during this 1-year period, the fiscal intermediaries should allow the hospitals to count allopathic and osteopathic family practice residents training in the nonhospital setting for direct GME and IME payment purposes without regard to the financial arrangement between the hospital and the nonhospital site pertaining to the teaching physicians' costs associated with the residency program.

(1) Cost Reports That Are Settled Between January 1, 2004 and December 31, 2004.

When fiscal intermediaries settle cost reports during January 1, 2004 through December 31, 2004 (Calendar Year (CY) 2004), a hospital that seeks to count allopathic or osteopathic family practice FTE residents training in a nonhospital setting(s) is allowed to count those FTEs for IME and direct GME purposes, even in instances where the written agreement between the hospital and a teaching physician or a nonhospital site does not mention teaching physician compensation, specifies only a nominal amount of compensation, or states that the teaching physician is ''volunteering'' his or her time training the residents. For example, when a fiscal intermediary is settling a cost report during CY 2004 that has a fiscal year end of June 30, 2001, the fiscal intermediary will allow the hospital to count family practice FTE residents that trained in a nonhospital setting during the period covered by the June 30, 2001 cost report, regardless of the financial arrangement in place between the hospital and the teaching physician at the nonhospital site during the period covered by the June 30, 2001 cost report.

We note that this moratorium does not apply to cost reports that are *not* settled during January 1 through December 31, 2004, that do not coincide with, or overlap, the January 1 through December 31, 2004 period. For example, if a cost report for fiscal year ended December 31, 2003 (or June 30, 2003, or others) is not settled during the January 1 through December 31, 2004 period, the moratorium would not apply.

(2) Family Practice Residents That Are Training in Nonhospital Settings Between January 1, 2004 and December 31, 2004.

In addition to allowing family practice residents that trained in nonhospital settings to be counted in

cost reports that the fiscal intermediaries settle during the period of January 1, 2004 through December 31, 2004, without regard to the financial arrangements between the hospital and the teaching physician at the nonhospital site, the fiscal intermediaries are to allow family practice residents that actually are or will be training in nonhospital settings during January 1, 2004 through December 31, 2004, without regard to the financial arrangements between the hospital and the teaching physician at the nonhospital site. That is, when fiscal intermediaries settle cost reports that cover service periods of January 1, 2004 through December 31, 2004, a hospital that seeks to count allopathic or osteopathic family practice FTE residents training in a nonhospital setting(s) would be allowed to count those FTEs, even in instances where the written agreement between the hospital and a teaching physician or a nonhospital site does not mention teaching physician compensation, specifies only a nominal amount of compensation, or states that the teaching physician is ''volunteering'' his or her time training the residents. If a hospital has a fiscal year that is other than a calendar year, the hospital may count the family practice residents training in the nonhospital setting during those portions of its fiscal years that fall within the January 1, 2004 and December 31, 2004 period. For example, when a fiscal intermediary is settling a hospital's June 30, 2004 cost report, the hospital would be allowed to count family practice FTE residents that trained in a nonhospital setting during the period of January 1, 2004 through June 30, 2004, regardless of the financial arrangement between the hospital and the teaching physician at the nonhospital site from January 1 through June 30, 2004. Similarly, when a fiscal intermediary settles the hospital's June 30, 2005 cost report, the hospital would be allowed to count family practice FTE residents that trained in a nonhospital setting during the period of July 1, 2004 through December 31, 2004, regardless of the financial arrangement between the hospital and the teaching physician at the nonhospital site from July 1 through December 31, 2004. (However, we note that family practice residents that train in nonhospital settings beginning January 1, 2005, and after are not subject to the moratorium provided under section 713 of Pub. L. 108–173.)

Because we are interpreting this moratorium to apply to prior period cost reports that are settled during calendar year (CY) 2004, and to cost reports that are settled after CY 2004 that cover training that occurred during the period of January 1, 2004 through December 31, 2004, a gap in applicability of the moratorium may result for family practice residents training in nonhospital settings. For example, a hospital might be permitted to count certain FTE family practice residents that are included in its FY 2001 cost report in accordance with the moratorium because that cost report is settled during CY 2004. However, the hospital might not be permitted to count certain FTE family practice residents in its FY 2002 and FY 2003 cost reports because these cost reports would not be settled during CY 2004 and the moratorium would not apply. The hospital then could be permitted to count certain FTE family practice residents in its FY 2004 cost report in accordance with the moratorium, because the FY 2004 cost report would contain family practice residents who actually trained in a nonhospital setting during CY 2004.

Regardless of whether the fiscal intermediaries are settling prior period cost reports during CY 2004, or settling cost reports after CY 2004 that cover training during the period of January 1, 2004 through December 31, 2004, we emphasize that the moratorium provided in section 713 of Public Law 108–173 only applies for purposes of counting FTE residents in allopathic and osteopathic general family practice programs that were in existence (that is, training residents) as of January 1, 2002 and where the requirement to incur the teaching physician compensation related to direct GME may not have been met. Therefore, for residents training in nonhospital settings, we are proposing that the moratorium applies only: (1) To FTE residents in general family practice programs (and not to dental, podiatric, or other allopathic or osteopathic specialty programs); (2) to family practice programs that were in existence as of January 1, 2002; and (3) with the exception of teaching physician compensation, to training in nonhospital settings that meet the requirements in the existing regulations at § 413.86(f)(4) (proposed to be redesignated as § 413.78(d)).

We are not proposing any regulation text changes to address this provision at this time. We note that section 713(b) of Public Law 108–173 directs the Inspector General of the Department of Health and Human Services to conduct a study of the appropriateness of alternative methodologies for payment of residency training in nonhospital settings and to submit a report to Congress on the results of the study, along with recommendations, as appropriate, by December 8, 2004. We will await the release of the Inspector General's report and may consider additional policy and regulation changes at that time if they are warranted.

c. Requirements for Written Agreements for Residency Training in Nonhospital Settings (Proposed redesignated § 413.78 (a proposed redesignation of existing § 413.86(f)).

As mentioned above, under section 1886(h)(4)(E) of the Act, a hospital may count residents training in nonhospital settings for direct GME purposes (and under section 1886(d)(5)(B)(iv) of the Act, for IME purposes), if the residents spend their time in patient care activities and if ''* * * the hospital incurs all, or substantially all, of the costs for the training program in that setting.'' We believe Congress intended to facilitate residency training in nonhospital settings by requiring hospitals to commit to incur, and actually incur, all or substantially all of the costs of the training programs in the nonhospital sites. Accordingly, in implementing section 1886(h)(4)(E) of the Act, first in the regulations at § 413.86(f)(3), effective July 1, 1987, and later at § 413.86(f)(4), effective January 1, 1999, we required that, in addition to incurring all or substantially all of the costs of the program at the nonhospital setting, there must be a written agreement between the hospital and the nonhospital site stating that the hospital will incur all or substantially all of the costs of training in the nonhospital setting. The later regulations further specify that the written agreement must indicate the amount of compensation provided by the hospital to the nonhospital site for supervisory teaching activities. (We note that, in this proposed rule, § 413.86(f)(3) is proposed to be redesignated as § 413.78(c), and § 413.86(f)(4) is proposed to be redesignated as § 413.78(d).)

We required the written agreements in regulations in order to provide an administrative tool for use by the fiscal intermediaries to assist in determining whether hospitals would incur all or substantially all of the costs of the training in the nonhospital setting in accordance with Congressional intent. Furthermore, CMS policy has required that the written agreement between the hospital and the nonhospital site be in place *prior* to the time that the hospital begins to count the FTE residents training in the nonhospital site. A written agreement signed before the time the residents begin training at the nonhospital site that states that the

hospital will incur the costs of the training program at the nonhospital site indicates the hospital's ongoing commitment to incur the costs of training at that site.

In settling cost reports where hospitals have included residents training at nonhospital sites in their FTE count, the fiscal intermediaries have encountered numerous situations where hospitals have complied with the requirement to incur all or substantially all of the costs of training in nonhospital settings. However, despite our longstanding regulations that state the requirement for a written agreement, these hospitals have not met the regulatory requirements related to written agreements. For example, some hospitals had no written agreement in place during the training in the nonhospital setting, or written agreements were not timely (that is, they were prepared after the residents began or, in some cases, finished training at the nonhospital site), or the agreements did not include a specific amount of compensation to be provided by the hospital to the nonhospital site for supervisory teaching activities. As a result, hospitals have faced disallowances of direct GME and IME payments relating to FTE residents training in nonhospital settings because the hospitals did not comply with the regulatory requirements concerning written agreements.

In retrospect, we believe the regulatory requirements concerning the written agreements may not have been the most efficient aid to fiscal intermediaries in determining whether hospitals would actually incur all or substantially all of the costs of the training programs in nonhospital settings. The fiscal intermediaries have been required to ensure that hospitals are complying with the regulations regarding written agreements, in addition to determining whether a hospital actually incurred the appropriate costs. We believe it would be more appropriate and less burdensome for both fiscal intermediaries and hospitals if we instead focus the fiscal intermediaries' reviews on the statutory requirement that hospitals must incur all or substantially all of the costs of the program in the nonhospital setting. Therefore, we are proposing to revise the regulations under proposed new § 413.78 (a proposed redesignation of existing § 413.86(f)) to remove the requirement for a written agreement between the hospital and the nonhospital setting as a precondition for a hospital to count residents training in nonhospital settings for purposes of direct GME and IME payments. However, consistent with our belief that Congress intended that hospitals commit to incur, and actually incur, all or substantially all of the costs of the training programs in the nonhospital sites in order to facilitate training at nonhospital sites, we are also proposing that, in order for the hospital to count residents training in a nonhospital setting, the hospital must pay for the nonhospital site training costs concurrently with the training that occurs during the cost reporting period.

We understand that residents' rotations, including those to nonhospital settings, are generally in discrete blocks of time (for example, 4-week or 6-week rotations). Therefore, to account for various rotation lengths, we are proposing under the new proposed § 413.78(e) that, in order to count residents training in a nonhospital setting, a hospital must pay all or substantially all of the costs of the training in a nonhospital setting(s) by the end of the month following a month in which the training in the nonhospital site occurred. If a hospital is counting residents training in a nonhospital setting for direct GME and IME purposes in any month of its cost reporting period, the hospital must make payment by the end of the following month to cover all or substantially all of the costs of training in that setting attributable to the preceding month. If the residents are employed by the hospital, and receive their salary payments (and fringe benefits) every 2 weeks, the hospital may continue to pay the residents' salaries every 2 weeks during the residents' rotation to the nonhospital setting. This should still result in payment being made for residents' time spent in nonhospital settings by the end of the following month. (We also note that the hospital must pay travel and lodging expenses, if applicable.) We are proposing that the hospital would be required to pay the nonhospital site for the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME by the end of the month following the month in which the training in the nonhospital setting occurred. We are proposing that if a hospital does not pay for all or substantially all of the costs of the program in the nonhospital setting by the end of the month following the month in which the training occurred, the hospital could not count those FTE residents in the month that the training occurred. Therefore, we are proposing to determine if residents training in nonhospital sites should be counted on a month-to-month basis, depending on whether a hospital paid for the training costs of those residents by the end of the month following the month in which the training occurred.

Following are examples of how a hospital that sends residents to train in nonhospital sites would make payments concurrently with the nonhospital site training:

Example 1. Hospital A, with a fiscal year end (FYE) of December 31, trains 10 internal medicine residents and 6 family practice residents. Each January, April, July, and October, Hospital A sends 5 internal medicine FTE residents to the Physicians' Clinic for 4 weeks. Each month, Hospital A sends 2 family practice FTE residents to the Family Clinic. The residents are employed by Hospital A, and the residents receive fringe benefits from and are paid every 2 weeks by Hospital A, regardless of whether they are training in Hospital A or at a nonhospital site. In order to make payments concurrently with the training that is occurring in the nonhospital sites, Hospital A must pay the Physicians' Clinic by the end of February, May, August, and November, respectively, of each cost reporting year, to cover the costs of teaching physician compensation and fringe benefits attributable to direct GME. Similarly, because residents are training at the Family clinic each month, Hospital A must pay the Family Clinic by the end of each month for the previous month's costs of teaching physician compensation and fringe benefits attributable to direct GME. There are no travel and lodging costs associated with these rotations to nonhospital sites.

Example 2. University A will sponsor an ophthalmology program with eight residents beginning on July 1, 2005. The residents will be on the payroll of the University, but they will train at Hospital B and at the University's Eye Clinic, which is a nonhospital setting. Hospital B has a June 30 FYE. Four of the residents will train in the Eye Clinic from August 1 to October 15, and the other four residents will train in the Eye Clinic from February 15 to April 30. Thus, residents are training in the Eye Clinic during the months of August, September, October, February, March, and April. If Hospital B wishes to count these FTE residents for IME and direct GME purposes in its cost reporting year ending June 30, 2006, and onward, it must pay the Eye Clinic at the end of September, October, November, March, April, and May, respectively, for the previous month's cost of the residents' salaries and fringe benefits, and the teaching physician compensation and fringe benefits attributable to direct GME.

Example 3. Hospital C sends a resident to train at a nonhospital site from January 28 to February 20. The resident was employed by the nonhospital site during this time. Hospital C paid the nonhospital site for the cost of the resident's salary and fringe benefits and the teaching physician compensation and fringe benefits attributable to direct GME by February 28 to account for the training that occurred from January 28 through January 31. However, Hospital C did not pay the nonhospital site by March 31 to

account for the training that occurred in February. Therefore, Hospital C could not count the resident's time in the nonhospital setting from February 1 through February 20 for direct GME and IME purposes.

We note that our proposal to require hospitals to pay for the nonhospital site training costs concurrently with the training that occurs in the nonhospital site is a departure from our current policy concerning the timeframe in which a hospital must make payment for the training costs. Currently, we apply the existing regulations at § 413.100(c)(2)(i), which state that a short-term liability (such as the hospital's obligation to pay the nonhospital site for the residency training costs) must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred. However, because we are proposing to no longer require that a written agreement between the hospital and the nonhospital site be in place prior to the time that the hospital begins to count the FTE residents training in the nonhospital site, we believe that a reasonable alternative to ensure that a hospital is facilitating the training at the nonhospital site through its ongoing commitment to incur all or substantially all of the costs is to require the hospital to make payments concurrently with the training that occurs in the nonhospital site in order to count the FTE residents for purposes of direct GME and IME payments.

We are aware that there are situations where, rather than providing direct financial compensation to the nonhospital site for supervisory teaching activities, the hospital is incurring all or substantially all of the teaching physician costs through nonmonetary, in-kind arrangements. We are proposing that, in order to be considered concurrent with the nonhospital site training, in-kind arrangements must be provided or made available to the teaching physician at least quarterly, to the extent that there are residents training in a nonhospital setting(s) in a quarter.

We are proposing to revise § 413.86(f) (proposed to be redesignated as § 413.78 in this proposed rule) to add a new paragraph (§ 413.78 (e)) to state that a hospital must incur all or substantially all of the costs of training in a nonhospital setting by the end of the month following a month in which the training in the nonhospital site occurred, to the extent that there are residents training in a nonhospital setting in a month. This proposed change would be effective for portions of cost reporting periods occurring on or after October 1, 2004. We would revise paragraph (d) of the proposed redesignated § 413.78 to reflect the effective cost reporting periods of the provisions under the new paragraph (e).

P. Rural Community Hospital Demonstration Program

[If you choose to comment on issues in this section, please include the caption ''Rural Community Hospital Demonstration'' at the beginning of your comment.]

Section 410A(a) of Public Law 108–173 requires the Secretary to establish a demonstration to test the feasibility and advisability of establishing ''rural community hospitals'' for Medicare payment purposes for covered inpatient hospital services furnished to Medicare beneficiaries. A rural community hospital, as defined in section 410A(f)(1), is a hospital that—

- Is located in a rural area (as defined in section 1886(d)(8)(E) of the Act) or treated as being so located under section 1886(d)(5)(F) of the Act;
- Has fewer than 51 beds (excluding beds in a distinct part psychiatric or rehabilitation unit) as reported in its most recent cost report;
- Provides 24-hour emergency care services; and
- Is not designated or eligible for designation as a CAH.

Section 410A(a)(3) of Public Law 108–173 specifies that the Secretary is to select for participation not more than 15 rural community hospitals in rural areas of States that the Secretary identifies as having low population densities. Using 2003 data from the U.S. Census Bureau, we have identified 10 States with the lowest population density in which rural community hospitals must be located to participate in the demonstration: Alaska, Idaho, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Utah, and Wyoming. (Source: U.S. Census Bureau Statistical Abstract of the United States: 2003)

Under the demonstration, participating hospitals will be paid the reasonable costs of providing covered inpatient hospital services (other than services furnished by a psychiatric or rehabilitation unit of a hospital that is a distinct part), applicable for discharges occurring in the first cost reporting period beginning on or after implementation of the demonstration program. For discharges occurring in subsequent cost reporting periods, payment is the lesser of reasonable cost or a target amount, which is the prior year's cost or, after the second cost reporting period, the prior year's target amount, adjusted by the inpatient prospective payment update factor. Covered inpatient hospital services means inpatient hospital services (defined in section 1861(b) of the Act) and includes extended care services furnished under an agreement under section 1883 of the Act.

Sections 410A(a)(5) and (a)(6) require the demonstration to be implemented not later than January 1, 2005, but not before October 1, 2004. The demonstration is to operate for 5 years. We intend to implement the payment change for a participating hospital under this demonstration with the hospital's first cost reporting period beginning on or after October 1, 2004.

Section 410A of Public Law 108–173 requires that ''in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' Generally, when CMS implements a demonstration on a budget neutral basis, the demonstration is budget neutral in its own terms; in other words, aggregate payments to the participating providers do not exceed the amount that would be paid to those same providers in the absence of the demonstration. This form of budget neutrality is viable when, by changing payments or aligning incentives to improve overall efficiency, or both, a demonstration may reduce the use of some services or eliminate the need for others, resulting in reduced expenditures for the demonstration participants. These reduced expenditures offset increased payments elsewhere under the demonstration, thus ensuring that the demonstration as a whole is budget neutral or yields savings. However, the small scale of this demonstration, in conjunction with the payment methodology, makes it extremely unlikely that this demonstration could be viable under the usual form of budget neutrality. Specifically, cost-based payments to 15 small rural hospitals is likely to increase Medicare outlays without producing any offsetting reduction in Medicare expenditures elsewhere. Therefore, a rural community hospital's participation in this demonstration is unlikely to yield benefits to the participant if budget neutrality were to be implemented by reducing other payments for these providers.

In order to achieve budget neutrality, we are proposing to adjust national inpatient PPS rates by an amount sufficient to account for the added costs of this demonstration. In other words, we are proposing to apply budget neutrality across the payment system as

a whole rather than merely across the participants of this demonstration. We believe that the language of the statutory budget neutrality requirement permits the agency to implement the budget neutrality provision in this manner. This is because the statutory language refers merely to ensuring that ''aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration * * * was not implemented,'' and does not identify the range across which aggregate payments must be held equal. We invite public comment on this proposal. We discuss the payment rate adjustment that would be required to ensure the budget neutrality of this demonstration in the Addendum of this proposed rule.

To participate in this demonstration, a hospital must be located in one of the identified States and meet the criteria for a rural community hospital. Eligible hospitals that desire to participate in the demonstration must submit an application to CMS. Information about the demonstration and details on how to apply can be found on the CMS Web site: *www.cms.hhs.gov/researchers/demos/rch.asp.*

This demonstration has been approved by OMB under the title ''Medicare Waiver Demonstration Application,'' under OMB approval number 0938–0880, with a current expiration date of July 30, 2006.

Q. Special Circumstances of Hospitals Facing High Malpractice Insurance Rate Increases

[If you choose to comment on issues in this section, please include the caption ''Malpractice Insurance'' at the beginning of your comment.]

We have received comments from several hospitals about the effects of rapidly escalating malpractice insurance premiums on hospital financial performance and continued access for Medicare beneficiaries to high quality inpatient hospital services. We are aware that malpractice insurance premiums have increased at a high rate in some areas of the country during the last few years. While we are not aware of any specific situations in which malpractice premiums have created issues of access to inpatient hospital services for Medicare beneficiaries, some hospitals have expressed concern that they may be compelled to curtail their current operations by the rate of increase in their malpractice premiums. Therefore, we are inviting comments on the effect of increases in malpractice insurance premiums on hospitals participating in the Medicare program, and whether increasing malpractice costs may pose access problems for Medicare beneficiaries.

V. Proposed Changes to the PPS for Capital-Related Costs

[If you choose to comment on issues in this section, please include the caption ''Capital PPS'' at the beginning of your comment.]

A. Background

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient acute hospital services ''in accordance with a PPS established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the PPS for capital-related costs. We initially implemented the PPS for capital-related costs in the August 30, 1991 IPPS final rule (56 FR 43358), in which we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

Federal fiscal year (FY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital inpatient capital-related costs. For cost reporting periods beginning in FY 2002, capital PPS payments are based solely on the Federal rate for the acute care hospitals (other than certain new hospitals and hospitals receiving certain exception payments). The basic methodology for determining capital prospective payments using the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows:

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

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year as specified in § 412.312(c) of the existing regulations.

The regulations at § 412.348(f) provide that a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control. This policy was originally established for hospitals during the 10-year transition period, but as we discussed in the August 1, 2002 IPPS final rule (67 FR 50102), we revised the regulations at § 412.312 to specify that payments for extraordinary circumstances are also made for cost reporting periods after the transition period (that is, cost reporting periods beginning on or after October 1, 2001).

During the transition period, under §§ 412.348(b) through (e), eligible hospitals could receive regular exception payments. These exception payments guaranteed a hospital a minimum payment percentage of its Medicare allowable capital-related costs depending on the class of hospital (§ 412.348(c)), but were available only during the transition period. After the end of the transition period, eligible hospitals can no longer receive this exception payment. However, even after the transition period, hospitals receive additional payments under the special exceptions provisions at § 412.348(g), which guarantees all eligible hospitals a minimum payment of 70 percent of its Medicare allowable capital-related costs provided that special exceptions payments do not exceed 10 percent of total capital IPPS payments. Special exceptions payments may be made only for the 10 years from the cost reporting year in which the hospital completes its qualifying project, and the hospital must have completed the project no later than the hospital's cost reporting period beginning before October 1, 2001. Thus, an eligible hospital may receive special exceptions payments for up to 10 years beyond the end of the capital PPS transition period. Hospitals eligible for special exceptions payments were required to submit documentation to the intermediary indicating the completion date of their project. (For more detailed information regarding the special exceptions policy under § 412.348(g), refer to the August 1, 2001 IPPS final rule (66 FR 39911 through 39914) and the August 1, 2002 IPPS final rule (67 FR 50102).)

Under the PPS for capital-related costs, § 412.300(b) of the regulations defines a new hospital as a hospital that has operated (under current or previous ownership) for less than 2 years (56 FR 43418, August 30, 1991). During the 10-year transition period, a new hospital was exempt from the capital PPS for its first 2 years of operation and was paid 85 percent of its reasonable costs during that period. Originally, this provision was effective only through the transition period and, therefore, ended with cost reporting periods beginning in FY 2002. Because we believe that special protection to new hospitals is also appropriate even after the transition period, as discussed in the August 1, 2002 IPPS final rule (67 FR 50101), we revised the regulations at § 412.304(c)(2)

to provide that, for cost reporting periods beginning on or after October 1, 2002, a new hospital (defined under § 412.300(b)) is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its first 2 years of operation, unless the new hospital elects to receive fully prospective payment based on 100 percent of the Federal rate. (Refer to the August 1, 2001 IPPS final rule (66 FR 39910) for a detailed discussion of the statutory basis for the system, the development and evolution of the system, the methodology used to determine capital-related payments to hospitals both during and after the transition period, and the policy for providing exception payments.)

B. Payments to Hospitals Located in Puerto Rico

As explained in section III.G. of this preamble, operating PPS and capital PPS payments to hospitals located in Puerto Rico are currently paid based on a blend of 50 percent of the Federal rate and 50 percent of the Puerto Rico rate. The Puerto Rico capital rate is derived from the costs of Puerto Rico hospitals only, while the capital Federal rate is derived from the costs of all acute care hospitals participating in the IPPS (including Puerto Rico). As also described in the section III.G. of this preamble, section 504 of Public Law 108–173 increases the national portion of the operating IPPS payment for Puerto Rico hospitals from 50 percent to 75 percent and decreases the Puerto Rico portion of the operating IPPS payments from 50 percent to 25 percent for discharges occurring on or after October 1, 2004. Under the broad authority of section 1886(g) of the Act, for the PPS, for capital-related costs we are proposing to revise the calculations of capital IPPS payments to hospitals located in Puerto Rico, as well, to parallel the change in operating IPPS payments to hospitals located in Puerto Rico, for discharges occurring on or after October 1, 2004. Accordingly, we are proposing to revise § 412.374 of the regulations to provide that, for discharges occurring on or after October 1, 2004, payments under the PPS for capital-related costs to hospitals located in Puerto Rico would be based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate. This proposed change would increase capital IPPS payments to hospitals located in Puerto Rico because the proposed Federal capital rate is higher than the proposed Puerto Rico capital rate. In addition, we note that this proposed change is similar to the change in capital IPPS payments made to hospitals located in Puerto Rico beginning in FY 1998 that had paralleled the statutory change in the Puerto Rico blended payment amount required for operating IPPS payments to hospitals located in Puerto Rico as mandated by section 4406 of Public Law 105–33 (62 FR 46012 and 46048, August 29, 1997).

C. Exception Payment for Extraordinary Circumstances

During the transition period, hospitals were guaranteed a minimum payment of a percentage of their Medicare allowable capital-related costs, depending on the class of hospital; that is, the minimum payment level for sole community hospitals was no greater than 90 percent, for urban hospitals with at least 100 beds meeting particular disproportionate share criteria, the minimum payment level was 80 percent, and for all other hospitals, the minimum payment level was 70 percent (§§ 412.348(c)(i) through (iii)). Regular exception payments provided the means to ensure that hospitals received the minimum levels of capital payment. However, any amount by which a hospital's cumulative capital payments exceeded its cumulative minimum payment levels was deducted from the additional exception payment the hospital was eligible to receive (§ 412.348(e)). This type of exception payment ended with the end of the transition period.

In the August 1, 2002 IPPS final rule (67 FR 50102), we specified that payments to hospitals that incur capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control would be made for cost reporting periods after the transition period, that is, cost reporting periods beginning on or after October 1, 2001, as established at § 412.312(e). Generally, the exception payments for extraordinary circumstances are 85 percent of Medicare's share of allowable capital-related costs attributed to the extraordinary circumstances (100 percent for sole community hospitals). This amount is offset by any amount by which a hospital's cumulative payments exceed its cumulative minimum payment levels (adjusted for the extraordinary circumstances) under the PPS for capital-related costs. The minimum payment levels and the offsetting amounts were the same as those established for regular exceptions as indicated at § 412.348(f)(4). The regulation refers to the regular exception minimum payment levels at § 412.348(c)(1) and the offsetting amounts at § 412.348(e)(2).

Because the regulations governing the regular exception payments, which include the minimum payment levels regulations at § 412.348(c) and the offsetting amounts at § 412.348(e), were effective during the transition period only, we had not previously addressed whether or not the minimum payment levels under § 412.348(c) and the offsetting amounts at § 412.348(e) remain applicable for extraordinary circumstances exceptions in the post-transition period. In the August 1, 2002 IPPS final rule (67 FR 50102), we clarified our policy at a new § 412.312(e) that exception payments for extraordinary circumstances continued to apply to periods beginning on or after October 1, 2001. When we added § 412.312(e), we did not believe it was necessary to explain in the preamble that the minimum payment levels in § 412.348(c) or the offsetting amounts in § 412.348(e) were incorporated into § 412.312(e). However, in order to avoid any confusion, in this proposed rule, we are clarifying our current policy that although the minimum payment levels established at § 412.348(c)(1) are no longer in effect, they continue to be relevant in order to calculate the extraordinary circumstances exception payments after the end of the transition period. The extraordinary exception payment calculation incorporates the minimum payment levels as well as the offsetting deduction for cumulative payments. Thus, although the regular exception payments themselves have expired, it has always been our policy that the minimum payment levels will continue to be part of the formula for calculating extraordinary exception payments after the end of the transition period. In this proposed rule, we are proposing to amend § 412.312(e) to reflect our current policy that, for cost reporting periods beginning on or after October 1, 2001, the minimum payment levels established at § 412.348(c)(1) are part of the formula for calculating extraordinary circumstances exception payments.

Similarly, in this proposed rule, we clarify our current policy that the offsetting amounts established at § 412.348(e)(2) also are part of the formula for determining extraordinary circumstances exception payments after the end of the transition period, in spite of the fact that the regular exception payment provision that included the offsetting amounts at § 412.348(e)(2) expired at the end of the transition period. Accordingly, we are proposing to revise § 412.348(e) to clarify that, for cost reporting periods beginning on or after October 1, 2001, the offsetting

amounts established at § 412.348(e)(2) remain in effect for extraordinary circumstances exception payments.

In addition, we also are proposing to revise the period of time used to determine the offsetting amounts in § 412.348(e)(2). Under existing regulations, the additional payment for extraordinary circumstances is offset by any amount by which a hospital's cumulative payments exceed its cumulative minimum payment levels under the PPS for capital-related costs. In order to determine this offsetting amount, a hospital must keep a record of the difference between its cumulative capital payments and its cumulative minimum payment levels since it became subject to the PPS for capital-related costs. For instance, under existing regulations, if a hospital would be eligible for an additional payment for extraordinary circumstances in FY 2005 and the hospital had been subject to the PPS for capital-related cost since that PPS was implemented in FY 1992, the offsetting amount would be the difference in the hospital's cumulative capital payments and its cumulative minimum payment levels for the past 13 years. Similarly, under existing regulations, if a hospital would be eligible for an additional payment for extraordinary circumstances in FY 2012 and the hospital had been subject to the capital PPS since it was implemented in FY 1992, the offsetting amount would be the difference in the hospital's cumulative capital payments and its cumulative minimum payment levels for the past 20 years.

We believe that when the provisions for exception payments were originally implemented with the start of capital IPPS in FY 1992, it was anticipated that the offsetting amounts at § 412.348(e)(2) would be determined based on a period of no longer than 10 years. However, under existing regulations, exception payments for extraordinary circumstances are offset by the difference in the hospital's cumulative payments and its cumulative minimum payment levels since it became subject to the PPS for capital-related-costs, which for most hospitals is over 13 years. Therefore, in this proposed rule, for cost reporting periods beginning during FY 2005 and thereafter, we are proposing to revise § 412.312(e) to specify that the offsetting amounts in § 412.348(e)(2) would be based on the hospital's capital payments and minimum payment levels from the most recent 10 years rather than from the entire period of time the hospital has been subject to the PPS for capital-related costs. If a hospital has been paid under the PPS for capital-related costs for less than 10 years, the offsetting amounts would be based on the hospital's capital payments and minimum payment levels beginning with the date the hospital became subject to the PPS for capital-related costs. For example, if a hospital would be eligible for an additional payment for extraordinary circumstances in FY 2005 and the hospital had been subject to the PPS for capital-related costs since FY 1992 (13 years), the offsetting amounts used in the calculation of the extraordinary circumstances exception payment would be based on the hospital's cumulative capital PPS payments and cumulative minimum payment levels for the hospital's cost reporting period beginning during FY 1995 through FY 2004. Similarly, if a hospital would be eligible for an additional payment for extraordinary circumstances in FY 2005 and the hospital had only been subject to the PPS for capital-related costs since FY 2000 (5 years), the offsetting amounts used in the calculation of the extraordinary circumstances exception payment would be based on the hospital's cumulative capital PPS payments and cumulative minimum payment levels for the hospital's cost reporting periods beginning during FY 2000 through FY 2004.

D. Treatment of Hospitals Previously Reclassified for the Operating PPS Standardized Amounts

As we discussed in section IV.C. of this preamble, prior to April 1, 2003, the standardized amounts varied under the operating IPPS based on a hospital's geographic location (large urban versus other urban and rural areas). Furthermore, previously, a hospital could be reclassified to a large urban area by the MGCRB for the purpose of the standardized amount if certain criteria were met (as described in Part 412, Subpart L of the Medicare regulations).

Similarly, the standard capital Federal rate under the PPS for capital-related costs is adjusted to reflect the higher costs incurred by hospitals located in large urban areas (large urban add-on at § 412.316), as well as for hospitals in urban areas with at least 100 beds serving low-income patients (capital disproportionate share (DSH) adjustment at § 412.320). In the past, if a rural or other urban hospital was reclassified to a large urban area for purposes of the operating IPPS standardized amount under § 412.63, the hospital also was then eligible for a large urban add-on payment, as well as a DSH payment, under the PPS for capital-related costs.

Section 402(b) of the Consolidated Appropriations Resolution, 2003, Public Law 108–7, and section 402 of Public Law 108–89, (a Welfare Reform Act), provide that, for discharges occurring on or after April 1, 2003 and before March 31, 2004, under the operating IPPS, all hospitals are paid based on the large urban standardized amount, regardless of geographic location or MGCRB redesignation. Section 401(a) of Public Law 108–173 amended section 1886(d)(5)(A)(iv) by adding a subsection (II) that permanently equalizes the standardized amounts for large urban areas and for other urban and rural areas for discharges occurring on or after April 1, 2004.

In addition, under section 1886(d) of the Act, a hospital may reclassify under the operating IPPS only for the purpose of either its standardized amount or its wage index adjustment, or both. As further specified in regulations at § 412.230, a hospital may be reclassified for purposes of the standardized amount only if the area to which the hospital seeks redesignation has a higher standardized amount than the hospital currently receives. Because there are no longer differences in standardized amounts due to geographic classification as a result of the section 401 amendment, hospitals are no longer eligible to reclassify solely for standardized amount purposes. Accordingly, the MGCRB has denied all FY 2005 standardized amount reclassification requests. We note that although Public Law 108–7 and Public Law 108–89 also equalized the standardized amounts for all hospitals in FY 2004, because these laws were not enacted until after the MGCRB had already made its reclassification determinations for FY 2004, eligible hospitals received reclassification approval for the purposes of the standardized amount for FY 2004. However, in this case, Public Law 108–173 was enacted before the MGCRB issued its reclassification decisions for FY 2005. Therefore, no hospitals will be reclassified for the purpose of the standardized amounts in FY 2005.

The changes to the operating IPPS described above, has an effect on payments under the PPS for capital-related costs. Rural and other urban hospitals that were previously eligible to receive the large urban add-on and DSH payments under the PPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified, and therefore, will not be eligible to receive those additional

payments under the PPS for capital-related costs.

Our analysis indicates that rural and other urban hospitals will gain approximately $0.5 billion in FY 2005 in operating PPS payments due to the equalization of the standardized amounts compared to a relatively small adjustment to payments for capital-related costs under the IPPS. We understand that Congress was aware of the effect of the equalization of the standardized amounts on the rural and other urban hospitals' adjustments under the PPS for capital-related costs. This approach is consistent with section 4203 of the BBA, which prevented hospitals from reclassifying to a different area to get an additional payment solely for DSH purposes under the operating IPPS. The restriction at section 4203 clearly indicates Congress' intent to maintain the principle that reclassifications under section 1886(d) of the Act are only intended to be made for purposes of either the standardized amount or the wage index adjustment.

Therefore, in this proposed rule, we are clarifying that, beginning in FY 2005, only hospitals geographically located in a large urban area (as defined in proposed revised § 412.63(c)(6)) would be eligible for large urban add-on payments under the PPS for capital-related costs under § 412.312(b)(2)(ii) and § 412.316(b). Beginning in FY 2005, only hospitals serving low-income patients that are geographically located in an urban area (as defined in proposed new § 412.64 and discussed in section IV.D. of this preamble) with 100 or more beds (or that meet the criteria in § 412.106(c)(2)) would be eligible for DSH payments under the PPS for capital-related costs under § 412.320.

E. Geographic Classification and Definition of Large Urban Area

1. Core-Based Statistical Areas

As we discuss in greater detail in section III.B. of this preamble, we are proposing to adopt changes to the MSA criteria used to define hospital labor market areas based on the new Core-Based Statistical Areas (CBSA) definitions announced by OMB on June 6, 2003, which are based on 2000 Census data. We currently define hospital labor market areas based on the definitions of Metropolitan Statistical Areas (MSAs), Primary MSAs (PMSAs), and New England County Metropolitan Areas (NECMAs) under standards issued by OMB in 1990. In addition, OMB designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of one million or more, comprised of two or more PMSAs (identified by their separate economic and social character). Under the operating PPS, the wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. For purposes of the hospital wage index, we use the PMSAs rather than CMSAs because they allow a more precise breakdown of labor costs. However, if a metropolitan area is not designated as part of a PMSA, we use the applicable MSA.

As we discuss in sections III.B.3. and IV.C. of this preamble, we are proposing to adopt OMB's new CBSA designations to define labor market areas for discharges occurring on or after October 1, 2004, which would be set forth in regulations under a proposed new § 412.64. Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital related costs rely on the existing geographic classifications set forth at § 412.63. Because we are proposing to adopt OMB's new CBSA designations for FY 2005 and thereafter under proposed new § 412.64, we are proposing to revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.

2. Metropolitan Divisions

Under the revised MSA criteria based on CBSAs, a Metropolitan Division is a county or group of counties located within an MSA with a core population of at least 2.5 million, representing an employment center, plus adjacent counties associated with the main county or counties through commuting ties (see section III.B.3.b. of this preamble for further details). Under the proposed changes to the MSA criteria discussed in section III.B. of this preamble, we are proposing to use the Metropolitan Divisions where applicable under the CBSA definitions. Thus, similar to our treatment of PMSAs as labor market areas where applicable, we would use the Metropolitan Divisions rather than MSAs to define labor market areas.

Currently, under the existing MSA criteria, a large urban area is defined at existing § 412.63(c)(6) as an MSA with a population of more than 1.000,000 or a NECMA with a population of more than 970,000 based on the most recent available population data published by the Bureau of the Census. As noted above, we currently use the PMSAs rather than CMSAs to define labor market areas. Accordingly, we currently determine large urban areas under existing § 412.63(c)(6) based on the most recent available population data for each PMSA rather than the CMSA. Similarly, because we are proposing to treat Metropolitan Divisions of MSAs as labor market areas, under the proposed changes based on CBSA designations, we would designate large urban areas based on the most recent available population data for each Metropolitan Division, rather than the MSA.

As discussed in section III.B.3.b., under the CBSA definitions, there are 11 MSAs containing Metropolitan Divisions: Boston; Chicago; Dallas; Detroit; Los Angeles; Miami; New York; Philadelphia; San Francisco; Seattle; and Washington, D.C. There are a total of 29 Metropolitan Divisions, which would be treated as MSAs. Of those 29 MSAs, 23 meet the definition of large urban area under § 412.63(c)(6) (as denoted in Tables 4A and 4B in the Addendum to this proposed rule). Under the proposed changes to the MSA criteria, there are a total of 62 large urban areas, including those 23 Metropolitan Divisions, as denoted in Tables 4A and 4B in the Addendum to this proposed rule.

In this section, we are proposing to clarify that the current definition of large urban area at existing § 412.63(c)(6) would remain in effect for the purpose of the large urban add-on adjustment to the Federal rate under the PPS for capital-related costs under §§ 412.312(b)(2)(ii) and 412.316(b). With the equalization of the operating standardized amounts (as discussed in section IV.D. of this preamble), we are proposing to revise the regulations under § 412.63(c), and making them effective for FYs 1984 through 2004, and to add a new § 412.64 that would be applicable for FYs 2005 and thereafter. Because CMS would compute a single standardized amount for hospitals located in all areas beginning in FY 2005, the term ''large urban area'' is no longer applicable under the operating PPS and therefore, a definition of large urban area would not be included under the proposed new § 412.64. However, the term ''large urban area'' continues to be applicable under the capital PPS for the large urban add-on adjustment at §§ 412.312(b)(2)(ii) and 412.316(b). Therefore, we are proposing to revise §§ 412.312(b)(2)(ii) and 412.316(b) to state that the definition of large urban area set forth at § 412.63(c)(6) would continue to be in effect under the capital PPS for discharges occurring on or after September 30, 2004.

VI. Proposed Changes for Hospitals and Hospital Units Excluded From the IPPS

A. Payments to Excluded Hospitals and Hospital Units (§§ 413.40(c), (d), and (f))

[If you choose to comment on issues in this section, please include the caption ''Excluded Hospitals and Units'' at the beginning of your comment.]

1. Payments to Existing Excluded Hospitals and Hospital Units

Section 1886(b)(3)(H) of the Act (as amended by section 4414 of Public Law 105–33) established caps on the target amounts for certain existing hospitals and hospital units excluded from the IPPS for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002. For this period, the caps on the target amounts applied to the following three classes of excluded hospitals or units: psychiatric hospitals and units, rehabilitation hospitals and units, and LTCHs. In accordance with section 1886(b)(3)(H)(i) of the Act and effective for cost reporting periods beginning on or after October 1, 2002, payments to these classes of existing excluded hospitals or hospital units are no longer subject to caps on the target amounts.

In accordance with existing §§ 413.40(c)(4)(ii) and (d)(1)(i) and (ii), where applicable, excluded psychiatric hospitals and units continue to be paid on a reasonable cost basis, and payments are based on their Medicare inpatient operating costs, not to exceed the ceiling, up to the date that the inpatient psychiatric facility PPS described in section VII.A. of this preamble becomes effective. The ceiling is computed using the hospital's or unit's target amount from the previous cost reporting period, updated by the rate-of-increase specified in § 413.40(c)(3)(viii) of the regulations, and then multiplying this figure by the number of Medicare discharges.

Effective for cost reporting periods beginning on or after October 1, 2002, rehabilitation hospitals and units are paid in accordance with the IRF PPS at 100 percent of the Federal rate. In addition, effective for cost reporting periods beginning on or after October 1, 2002, LTCHs are no longer paid on a reasonable cost basis, but are paid under a DRG-based PPS. However, as part of the PPS for LTCHs, we have established a 5-year transition period from reasonable cost-based reimbursement to a fully Federal PPS. Under the LTCH PPS, a LTCH that is subject to the blend methodology may elect to be paid based on a 100 percent of the Federal prospective rate. We have proposed, but not finalized, an inpatient psychiatric facility (IPF) prospective payment system under which psychiatric hospitals and psychiatric units would no longer be paid on a reasonable cost basis but would be paid on a prospective per diem basis. (Sections VI.A.3, 4, and 5 of this preamble contain a more detailed discussion of the IRF PPS and the LTCH PPS and the proposed IPF PPS.)

2. Updated Caps for New Excluded Hospitals and Units

Section 1886(b)(7) of the Act established a payment limitation for new hospitals and units that fell within one of three classes of hospitals or units-psychiatric, rehabilitation, and long-term care that first receives payment as a hospital or unit excluded from the IPPS on or after October 1, 1997. A discussion of how the payment limitation was calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46019); the May 12, 1998 final rule (63 FR 26344); the July 31, 1998 final rule (63 FR 41000); and the July 30, 1999 final rule (64 FR 41529). Under the statute, a ''new'' hospital or unit is a hospital or unit that falls within one of the three classes of hospitals or units (psychiatric, rehabilitation or long-term care) that first receives payment as a hospital or unit excluded from the IPPS on or after October 1, 1997.

The amount of payment for a ''new'' psychiatric hospital or unit (as defined at 42 CFR 413.40(f)(2)(ii) would be determined as follows:

- Under existing § 413.40(f)(2)(ii), for the first two 12-month cost reporting periods, the amount of payment is the lesser of: (1) The operating costs per case; or (2) 110 percent of the national median (as estimated by the Secretary) of the target amounts for the same class of hospital or unit for cost reporting periods ending during FY 1996, updated by the hospital market basket increase percentage to the fiscal year in which the hospital or unit first receives payments under section 1886 of the Act, as adjusted for differences in area wage levels.
- Under existing § 413.40(c)(4)(v), for cost reporting periods following the hospital's or unit's first two 12-month cost reporting periods, the target amount is equal to the amount determined under section 1886(b)(7)(A)(i) of the Act for the preceding cost reporting period, updated by the applicable hospital market basket increase percentage to the third cost reporting period.

The proposed amounts included in the following table reflect the proposed updated 110 percent of the national median target amounts of new excluded psychiatric hospitals and units for cost reporting periods beginning during FY 2005. These figures are updated with the most recent data available to reflect the proposed projected market basket increase percentage of 3.3 percent. This projected percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient hospital services (as projected by the Office of the Actuary of CMS based on its historical experience with the IPPS). For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index, without regard to IPPS reclassifications, and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	Proposed FY 2005 labor-related share	Proposed FY 2005 nonlabor-related share.
Psychiatric	$7,534.70	$2,994.67

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation was no longer applicable to new LTCHs because they are paid 100 percent of the Federal rate. Accordingly, it is no longer necessary to publish an updated cap for new LTCHs.

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is also no longer applicable to new rehabilitation hospitals and units because they are paid 100 percent of the Federal prospective rate under the IRF PPS. Therefore, it is also no longer necessary to update the payment limitation for new rehabilitation hospitals or units.

3. Implementation of a PPS for IRFs

Section 1886(j) of the Act, as added by section 4421(a) of Public Law 105–33, provided for the phase-in of a case-mix adjusted PPS for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation hospital unit (referred to in the statute as rehabilitation facilities) for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2002, with a fully implemented PPS for cost reporting periods beginning on or after October 1, 2002. Section 1886(j) of the Act was amended by section 125 of Public Law 106–113 to require the Secretary to use a discharge as the payment unit under the PPS for inpatient hospital services furnished by rehabilitation facilities and to establish classes of patient discharges by functional-related groups. Section 305 of Public Law 106–554 further amended section 1886(j) of the Act to allow rehabilitation facilities, subject to the blend methodology, to elect to be paid the full Federal prospective payment rather than the transitional period payments specified in the Act.

On August 7, 2001, we issued a final rule in the **Federal Register** (66 FR 41316) establishing the PPS for inpatient rehabilitation facilities, effective for cost reporting periods beginning on or after January 1, 2002. There was a transition period for cost reporting periods beginning on or after January 1, 2002 and ending before October 1, 2002. For cost reporting periods beginning on or after October 1, 2002, payments are based entirely on the Federal prospective payment rate determined under the IRF PPS.

4. Implementation of a PPS for LTCHs

In accordance with the requirements of section 123 of Public Law 106–113, as modified by section 307(b) of Public Law 106–554, we established a per discharge, DRG-based PPS for LTCHs as described in section 1886(d)(1)(B)(iv) of the Act for cost reporting periods beginning on or after October 1, 2002, in a final rule issued on August 30, 2002 (67 FR 55954). The LTCH PPS uses information from LTCH hospital patient records to classify patients into distinct LTC-DRGs based on clinical characteristics and expected resource needs. Separate payments are calculated for each LTC-DRG with additional adjustments applied.

We published in the **Federal Register** on May 7, 2004, a final rule (69 FR 25673) that updated the payment rates for the LTCH PPS and made policy changes effective for a new LTCH PPS rate year of July l, 2004 through June 30, 2005. The 5-year transition period from reasonable cost-based reimbursement to the fully Federal prospective rate will end with cost reporting periods beginning on or after October 1, 2005 and before October 1, 2006.

5. Development of a PPS for IPFs

Section 124 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) requires the development of a per diem prospective payment system (PPS) for payment of inpatient hospital services furnished in psychiatric hospitals and psychiatric units of acute care hospitals (inpatient psychiatric facilities (IPFs)). We published a proposed rule to implement the IPF PPS on November 28, 2003 (68 FR 66920). On January 30, 2004, we published a proposed rule to implement the IPF PPS on November 28, 2003 (68 FR 66920). On January 30, 2004, we published a notice to extend the comment period for 30 additional days (69 FR 4464). The comment period closed on March 26, 2004.

Under the proposed rule, we would compute a Federal per diem base rate to be paid to all IPFs based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF adjusted for budget neutraility. The Federal per diem base rate would be adjusted to reflect certain characteristics such as age, specified DRGs, and selected high-cost comorbidities, and certain facility characteristics such as wage index adjustment, rural location, and indirect teaching costs.

The November 28, 2003 proposed rule assumed an April 1, 2004 effective date for the purpose of ratesetting and calculating impacts. However, we are still in the process of analyzing public comments and developing a final rule for publication. The effective date of the IPF PPS would occur 5 months following publication of the final rule.

6. Technical Changes Related to Establishment of Payments for Excluded Hospitals

We have become aware of a number of technical errors in the existing regulations governing how we determine payments to hospitals that are excluded from the IPPS. The existing regulations under § 413.40 set forth requirements for establishing the ceiling on the rate of increase in operating costs per case for hospital inpatient services furnished to Medicare beneficiaries that will be recognized as reasonable for purposes of determining the amount of Medicare payments. The rate-of-increase ceiling applicable to cost reporting periods has been adjusted a number of times since it was first applied for hospital cost reporting periods beginning on or after October 1, 1982. In revising the regulations over the years to reflect the different applicable adjustments for cost reporting periods for specific providers, we have inadvertently overlooked updating or conforming § 413.40 to reflect various statutory changes. We note that, although we erroneously omitted the technical changes in the regulation text, we did, in fact comply with the changes required by the statute when determining the rate-of-increase ceiling. Therefore, we are proposing to make several changes to § 413.40(c)(4)(iii) in order to conform it to section 1886(b)(3)(J) of the Act. These proposed changes are as follows: (1) In § 413.40(c)(4)(iii)(A)(*1*) and (c)(4)(iii)(B)(*4*)(*i*), the phrase ''on or after October 1, 2001'', should read ''during FY 2001''; and in § 413.40(c)(4)(iii)(A)(*2*), the phrase ''on or after October 1, 2000'' should read ''during FY 2001''. In order to include pertinent changes that were erroneously omitted from the regulatory text and to conform the text to section 1886(b)(*2*)(A) of the Act, we are proposing to delete the phrase ''and ending before October 1, 2000'' in § 413.40(d)(4)(i) because, in section 1886(b)(2)(A) of the Act, there is no ending date for the continuous improvement bonus payment. In addition, at § 413.40(d)(4)(ii), we propose to delete the word ''ending'' from the introductory phrase so that the phrase would read, ''For cost reporting periods beginning on or after October 1, 2000 and before September 30, 2001.'' The word ''ending'' in the existing language at best limits the provision to cost reporting periods beginning on October 1, 2000. The provision was intended to apply to cost reporting periods beginning during all of FY 2001.

B. Criteria for Classification of Hospitals-Within-Hospitals

[If you choose to comment on the issues in this section, please include the caption ''Hospitals-Within-Hospitals'' at the beginning of your comment.]

Existing regulations at § 412.22(e) define a hospital-within-a-hospital as a hospital that occupies space in a building as another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital. Moreover, existing § 412.22(f) provides for the grandfathering of hospitals-within-hospitals that were in existence on or before September 30, 1995.

One of the goals of our hospital-within-hospital regulations at § 412.22(e) has been to prevent a LTCH

co-located with an acute care hospital to function as a unit of that hospital, a situation precluded under section 1886(d)(1)(B) of the Act. This policy protects the integrity of the IPPS by ensuring that costly, long-stay patients who could reasonably continue treatment in that setting would not be unnecessarily discharged to an onsite LTCH, a behavior that would skew and undermine the Medicare IPPS DRG system. Further, there is concern that the hospital-within-hospital configuration could result in patient admission, treatment, and discharge patterns that are guided more by attempts to maximize Medicare payments than by patient welfare. We believe that the unregulated linking of an IPPS hospital and a hospital excluded from the IPPS could lead to two Medicare payments for what was essentially one episode of patient care.

In the September 1, 1994 IPPS final rule (59 FR 45389), we first discussed hospitals-within-hospitals, describing them as entities that were manipulating the conditions of participation (COPs) for hospitals under Medicare, set forth in regulations at 42 CFR Part 482, to permit them to receive exclusion from the prospective payment systems. Specifically, these hospitals have begun to organize what they themselves refer to as the ''hospital-within-a-hospital'' model. Under this model, an entity may operate in space leased from a hospital, and have most or all services furnished under arrangements by employees of the lessor hospital. The newly organized entity may be operated by a corporation formed and controlled by the lessor hospital, or by a third entity that controls both. In either case, the new entity seeks State licensure and Medicare participation as a hospital, demonstrates that it has an average length of stay of over 25 days, and obtains an exclusion from the IPPS. The effect of this process is to extend the long-term care hospital exclusion to what is, for all practical purposes, a ''long-term care unit.'' We noted that the averaging concept that underlies the IPPS recognizes that some patients will stay longer and consume more resources than expected, while others will have shorter, less costly stays. We envisioned that abuse of the PPSs could result if an acute care hospital under the IPPS ''diverted all long-stay cases to the excluded unit, leaving only shorter, less costly cases to be paid for under the IPPS. In such cases, hospitals would profit inappropriately from prospective payments.'' Further, we stated that we believed that the ''exclusion of long-term care 'units' was inconsistent with the statutory scheme.'' Section 1886(d)(1)(B) of the Act clearly provides for an exclusion of LTCHs from the acute care IPPS. While the statute also provides for an exclusion for psychiatric units and rehabilitation units, it does not provide for an exclusion of long-term care units. (59 FR 45389)

In addition, in that September 1, 1994 final rule, we proceeded to establish ''separateness and control'' regulations at (then) § 412.23(e) that required the two hospitals to have separate medical and administrative governance and decisionmaking and also ensured that each hospital operated as a separate facility. We believed at that time that such rules were sufficient solutions to our concerns about these new entities and, therefore, we did not preclude common ownership of the host and the LTCH at that time.

In the ensuing decade, we have revisited the issue of hospitals-within-hospitals several times (for example, 60 FR 45836, September 1, 1995; 62 FR 46012, August 29, 1997; 67 FR 56010, August 30, 2002; 67 FR 45463, August 1, 2003) during which we clarified and amplified the separateness and control requirements. In the August 29, 1997 IPPS final rule, we extended the application of these rules beyond LTCHs to include other classes of facilities that might seek exclusion from the IPPS as hospitals-within-hospitals, such as IRFs. In addition, in the August 29, 1997 final rule, we also established a ''grandfathering'' provision for hospitals-within-hospitals in existence prior to September 30, 1995, at § 412.22(f), and in the August 1, 2003 IPPS final rule, we clarified and codified the requirements for ''grandfathered'' hospitals-within-hospitals (68 FR 45463).

As stated earlier, presently, a hospital-within-a-hospital must meet the separateness and control criteria set forth at § 412.22(a). In order to be excluded from the IPPS, the hospital-within-a-hospital must have a separate governing body, a separate chief medical officer, a separate medical staff, and a separate chief executive officer. Regarding the performance of basic hospital functions (§ 412.22(e)(5)), currently, the hospital must meet at least one of the following criteria: (i) The hospital performs the basic functions through the use of employees or under contracts or other agreements with entities other than the hospital occupying space in the same building or on the same campus, or a third entity that controls both hospitals; (ii) for the same period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the cost of the services that the hospital obtained under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals, is no more than 15 percent of the hospital's total inpatient operating costs, as defined in § 412.2(c) (that is, inpatient operating costs include operating costs for routine services, such as costs of room, board, and routine nursing services; operating costs for ancillary services such as laboratory or radiology; special care unit operating costs; malpractice insurance costs related to serving inpatients; and preadmission services); or (iii) for the same period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the hospital has an inpatient population of whom at least 75 percent were referred to the hospital from a source other than another hospital occupying space in the same building or on the same campus or with a third entity that controls both hospitals.

It is our experience that the vast majority of hospitals-within-hospitals have elected to meet the second of the three criteria at § 412.22(e)(5), that is, the cost of the services that the hospital obtained from the co-located hospital or with a third entity that controls both hospitals is no more than 15 percent of its total inpatient operating costs. In establishing the 15-percent rule, we originally believed that we would be able to detect a true corporate identity and actual function and to guard against an arrangement that could undermine the statutory preclusion of long-term care units. We sought to distinguish admissions to independently operating facilities from what were, in effect, transfers of patients from one unit of the corporation to another unit of the corporation without a truly distinct and separate corporate identity. Our underlying policy rationale was that, if an entity could not be separately identified, it effectively would be functioning as a mere unit of the parent entity in violation of the statutory prohibition on long-term care units. We explained in the September 1, 1994 rule (59 FR 45390) that ''if an entity is effectively part of another hospital and the principles of the prospective payment system do apply well to the organization as a whole, then it would not be appropriate to exclude part of that organization from the prospective payment system.''

Although we have periodically revisited the phenomenon of hospitals-within-hospitals in our rules and we have revised or clarified some related

issues, we have not proposed significant changes in our policies in this area for some time. This is despite the significant changes that have been made in the payment systems for Medicare-certified, excluded hospitals and units. Medicare payments to two types of IPPS-excluded hospitals, LTCHs and IRFs, are now made on a prospective basis. We believe that, in part, the new LTCH PPS is one of the reasons for the rapidly increasing number of LTCH hospitals-within-hospitals. In its June 2003 Report to the Congress, MedPAC identified hospitals-within-hospitals as the fastest growing type of LTCHs, and specified that the number had grown from 10 in 1993 to 114 in 2002, an average annual increase of approximately 30 percent (p. 85). In the August 30, 2002 final rule that implemented the PPS for LTCHs, we noted that ''* * * we remain extremely concerned about rapid growth in LTCH hospitals-within-hospitals and will be collecting data on the relationship among host hospitals, hospitals-within-hospitals, and parent corporations in order to determine the need for additional regulation'' (67 FR 56010). We indicated that if, as a consequence of these monitoring activities, we determine the need to revisit existing regulations dealing with ownership and control of hospitals-within-hospitals, we would follow the notice and comment rulemaking process (67 FR 56011).

The LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002. We have gathered considerable anecdotal information from inquiries from the provider community, fiscal intermediaries, and, particularly, from the survey and certification divisions of our CMS Regional Offices.

We believe that existing policies regarding hospitals-within-hospitals do not sufficiently protect the Medicare program from the problems that we envisioned in the September 1, 1994 final rule. We also question the effectiveness of the ''separateness and control'' requirements alone because entities have used complex arrangements among corporate affiliates, and obtained services from those affiliates, thereby impairing or diluting the separateness of the corporate entity. While technically remaining within the parameters of the rule, these arrangements have intermingled corporate interests so that the corporate distinctness has been lost.

In corporate law, several standards are used to determine how much separateness is sufficient for a corporate autonomy to be recognized. The courts have applied a number of tests and considered a number of factors in determining when a parent corporate autonomy is liable for the acts of its subsidiary, including the parent corporate autonomy's exercise of control over the decisionmaking of the subsidiary; the subsidiary's actions as an alter ego of the parent corporate autonomy, such that recognition of a distinct corporate entity would lead to fraud or an injustice or would defeat public policy and the interrelatedness of operations. While we do not believe that it is necessary to apply any single test that might be used in the context of assigning liability, we believe that some of the same considerations apply when trying to determine whether there is functional separateness among related or affiliated organizations.

The requirement for separate governing bodies, separate medical boards, separate medical officers, and separate chief executive officers in co-located hospitals under the same ownership does not prevent, on a practical level, the establishment of admission, treatment, and discharge policies that maximize payments. Some of these co-located facilities are under common ownership, either nonprofit or for profit, and, therefore, the payments generated from care delivered at both settings affect their mutual interests.

Even when the hospital-within-a-hospital and the host hospital are separately owned, we believe that there may be incentives to prematurely discharge patients to a postacute care setting in spite of the fact that the acute care hospital could continue to provide the appropriate level of care. We find this situation even more troubling regarding LTCHs, in particular, because LTCHs are certified as acute care hospitals and the sole statutory and regulatory distinction between LTCHs and acute care hospitals is the greater than 25-day average length of stay criterion at § 412.23(e)(2). In many parts of the country, there are no LTCHs and appropriate care for patients who could otherwise be treated in LTCHs is being delivered in acute care hospitals, often followed by postacute care at SNFs. Because a similar level of care is often available in either an acute care hospital or a LTCH, we believe that, when an acute care hospital and a LTCH are co-located, there are significant inducements for patients to be moved to the provider setting that generates the highest Medicare payments.

This movement of patients is facilitated by the fact of co-location because, rather than arranging for the patient to be admitted to another offsite facility and transporting the patient by ambulance to another hospital, all that may actually be required to ''discharge'' the patient from one hospital and admit the patient to another is wheeling the patient down the hall or on and off an elevator.

Although co-location of Medicare providers, at best, may embody the positive economic benefits of sharing expensive medical equipment and provide a measure of convenience for patient families, at worst, co-location and patient-shifting can serve to undermine the basic premise of the IPPS DRG classification system and generate inappropriate Medicare payments. This is the case because payment for specific diagnoses is determined by setting DRG weights that represent a national averaging of hospital costs for each diagnosis. In addition, the Federal standardized payment amount was based on the average cost of a patient across all hospitals. This assumes that, on average, both high-cost and low-cost patients are treated at a hospital. Although Medicare might pay a hospital less than was expended for a particular case, over a period of time, the hospital would also receive more than was expended for other cases. However, an acute care hospital that consistently discharges a higher cost patient to a postacute care setting for the purpose of lowering its costs undercuts the foundation of the IPPS DRG system, which is based on averages. In this circumstance, the hospital would recoup larger payments from the Medicare system than is intended under the DRG system because the course of acute treatment has not been completed. At the same time, the patient, still under active treatment for an acute illness, will be admitted to a LTCH, thereby generating a second admission and Medicare payment that would not have taken place but for the fact of co-location.

We believe that the 15-percent policy is being sidestepped through creative corporate reconfigurations. Therefore, if the LTCH is nominally complying with the 15-percent requirement, it has not been required to meet the basic hospital function requirements at existing § 412.22(e)(5)(iii). Thus, it is free to accept even 100 percent of patients from the onsite host, and share the same basic hospital functions as the host. Reliance on meeting the 15-percent criterion has enabled the creation of LTCH hospitals-within-hospitals that rely upon affiliated entities both for their operations and for their patient referrals. This results in a situation very similar to the hospital-within-hospital serving as a LTCH unit of the acute care hospital, which is precluded by the statute.

One of the reasons we are proposing revisions to the existing criteria for hospitals-within-hospital is because we believe that determining whether a hospital has complied with the 15-percent criterion is burdensome for a fiscal intermediary on an ongoing basis. Presently, review of corporate arrangements represents a snapshot in time that may assess a particular set of business transactions but does not provide relevant details to reveal the extent of the unity of interests between the parties over time. Further, the widespread existence of such complex configurations, as well as the ongoing creation of new business arrangements, convinces us that a hospital-within-a-hospital's compliance with § 412.22(e)(5)(ii) may be fluid, unreliable, or, in some cases, nonexistent.

Another reason we are proposing revisions to the existing criteria for hospitals-within-hospitals because the concerns that we expressed in 1994 and 1995, when excluded hospitals were paid under the reasonable cost-based TEFRA system, are even more compelling with the implementation of PPSs for LTCHs and IRFs, because now one episode of care for a beneficiary could generate two full Medicare prospective payments, one under the IPPS, and another under the applicable excluded hospital PPS. In addition, the substantial increase in the number of hospitals-within-hospitals adds further urgency to reevaluation of the existing hospital-within-a-hospital policies. Therefore, it is incumbent upon us to revise our regulations in order to offer the greatest possible protection against potential abuses.

Accordingly, for qualification purposes, we are proposing to delete the 15-percent criterion at § 412.22(e)(5)(i) and the rarely elected criterion at § 412.22(e)(5)(i) that requires the hospital-within-a-hospital to perform basic hospital functions, which includes nursing services, medical records, pharmacy services, radiology, laboratory services, infection control, and discharge planning, through the use of employees or under contracts or other agreements with entities other than the host hospital or a third entity that controls them both. Because we believe that efficient use of excess space at a hospital and the sharing of medical facilities and services may represent the strongest argument for the existence of hospitals-within-hospitals, from the standpoint of efficiency and cost reduction, we do not believe that these criteria should be maintained.

We are proposing that all hospitals-within-hospitals would be required to comply only with the criterion set forth at the existing § 412.22(e)(5)(iii), which requires that at least 75 percent of the admissions to the hospital-within-a-hospital be referred from a source other than the host hospital. We believe that this ''functional separateness'' test (62 FR 46014, August 29, 1997) directly addresses our concern that the excluded hospital not function either as a vehicle to generate more favorable Medicare reimbursement for each provider or as a de facto unit. Compliance with the 75-percent criterion is a requirement that we can verify without the involvement of corporate attorneys and a yearly reevaluation of corporate documents and transactions. The goal of the proposed provisions is to diminish the possibility that a hospital-within-a-hospital could actually be functioning as a unit of an acute care hospital and generating unwarranted payments under the much more costly LTCH PPS.

Therefore, under our proposed policy, a hospital must demonstrate that it has a separate governing body, a separate chief medical officer, and a separate chief executive officer, and that at least 75 percent of its admissions originate from a source other than its host hospital, in order to be totally excluded from the IPPS. Fiscal intermediaries would reevaluate compliance with these regulations annually. In implementing our belief that separation and control can best be objectively determined by limiting compliance to the 75-percent criterion as the single ''performance of hospital functions'' test, we are proposing several policy options that are detailed below that, if not met, notwithstanding compliance with the separate governance and control requirements under existing § 412.22(e)(1) through (4), could result in the either total discontinuance of IPPS-exclusion payment status or Medicare payment adjustments for hospital-within-a-hospital patients from the host hospitals.

As noted above, DRG weights and hence payments under the IPPS are established annually based on the average concept that recognizes that, for patients with a particular diagnosis, some will stay longer and consume more hospital resources than expected, while others will have shorter, less costly stays. Under the IPPS, a full DRG payment is triggered on the first day of admission to the acute care hospital. Medicare adopted an IPPS transfer policy at § 412.4(b) in order to pay appropriately for cases that were discharged to other IPPS hospitals prior to the hospitals delivering full treatment to a beneficiary. We also promulgated the postacute care transfer policy at §§ 412.4(c) and (d) to discourage premature transfers or discharges from IPPS hospitals for particular DRGs to postacute care settings, including LTCHs (63 FR 40977, July 31, 1998, 68 FR 45469, August 1, 2003). The issues that we addressed in formulating the acute and postacute care transfer policies are similar to those we are raising as our present concerns: that the incentives of the IPPS could result in acute care hospitals shifting a portion of the cost of services that should reasonably be treated in that setting to other providers; that the acute care hospitals would still collect a full DRG payment under the IPPS for less than a full course of treatment; and that an additional and unnecessary Medicare payment would be made to the second provider. We believe that the potential for linking clinical decisions to the highest Medicare payments is even stronger when the acute care hospital and a postacute care provider are co-located and, even more so, if they are also under common ownership.

Therefore, we are also proposing to revise § 412.22(e), effective October 1, 2004, to preclude common ownership (wholly or in part) of hospitals-within-hospitals and host hospitals (proposed new § 412.22(e)(2)(ii)). However, we are also proposing to ''grandfather'' those hospitals-within-hospitals that were under common ownership with their host hospitals prior to June 30, 2004, and to continue to pay them as hospitals excluded from the IPPS, as long as they comply with the existing control criteria at § 412.22(e)(1) through (4) (as set forth in proposed new § 412.22(e)(2)(i)) and with the proposed mandatory 75-percent criterion (as set forth in proposed new § 412.22(e)(2)(iii)).

In addition, in this proposed rule, we are presenting, for public comment, three payment options that we believe would diminish the possibility of a hospital-within-a-hospital actually functioning as a unit of an acute care hospital and at the same time generating unwarranted payments under the more costly LTCH PPS.

Option 1. Under the first option, as discussed earlier, in order for a hospital-within-a-hospital to receive payment as an IPPS-excluded hospital, we are proposing to retain as the only qualifying criterion that the hospital-within-a-hospital have at least 75 percent of its admissions from a source other than the host hospital (existing § 412.22(e)(5)(iii)). The hospital-within-a-hospital would still be required to demonstrate that it meets the separateness and control criteria at § 412.22(a). Under this option, a hospital-within-hospital that admitted

more than 25 percent of its patients from the host hospital would not be paid as an IPPS-excluded hospital for any of its patients. The hospital or unit that does not meet the criteria under this option would receive payment as an acute care hospital for all of its patients.

As stated earlier, we believe that compliance with the 75-percent criterion under this option is a requirement that fiscal intermediaries would be able to evaluate annually in an efficient manner without the involvement of corporate attorneys and a yearly reevaluation of corporate documents and transactions. Further, we believe that this option would ensure increased protections to the Medicare program and greatly diminish opportunities for maximizing Medicare payments under the PPS.

Option 2. Under the second option, as proposed earlier, we would require the hospital to meet the existing qualifying 75-percent criterion under § 412.22(e)(5)(iii). However, under this option, we would allow a hospital-within-a-hospital that failed to meet the 75-percent criterion to be excluded from the IPPS to be paid as a PPS-excluded hospital only for the patients admitted to the hospital-within-a-hospital from providers other than the host hospital. For example, no payments would be made to a LTCH for those patients that had been transferred to the LTCH from the host hospital because it failed to meet this criterion. Payments for patients referred from the host acute care hospital would only be paid to the host under the IPPS. We would treat services provided by the hospital-within-a-hospital as services furnished ''under arrangement.'' Therefore, in keeping with our existing policy at § 411.15(m) that restricts separate Medicare payment to hospital services furnished under arrangements, we would make payment only to the acute care hospital from which the patients were referred for ''under arrangements'' furnished by the hospital-within-a-hospital.

Option 3. Under the third option, as proposed earlier, we would require that the hospital-within-a-hospital must meet the existing qualifying 75-percent criterion under § 412.22(e)(iii). However, under this option, we would pay the hospital-within-a-hospital directly for services, even for services provided to patients admitted to the hospital-within-a-hospital from the co-located acute care hospital. However, the payment to the hospital-within-a-hospital for those patients would be the lesser of what would be paid under the IPPS for that DRG, or what would be paid to the hospital-within-a-hospital under the applicable excluded hospital payment system. Payments to the hospital-within-a-hospital for patients admitted to the hospital-within-a-hospital from another hospital that was not the co-located hospital would be made under the hospital-within-a-hospital payment system with no adjustment. Therefore, for example, a LTCH that was a hospital-within-a-hospital and failed to meet the 75-percent criterion would be paid the lesser of the IPPS payment or the LTCH PPS payment for its patients that were admitted from its host hospital. However, for patients admitted from other hospitals, the LTCH hospital-within-a-hospital would be paid under the LTCH PPS with no adjustment.

We believe that adoption of any of these three options is within the broad discretion conferred on the Secretary by section 123 of Public Law 106–113 (BBRA) and by section 307 of Public Law 106–554 (BIPA), which grant the Secretary the authority to develop a per discharge PPS for payment of inpatient hospital services by LTCHs and to provide for appropriate adjustments to the LTCH PPS.

We are proposing to revise the existing separateness and control regulations at § 412.22(e) for hospitals-within-hospitals and to require that in order to be excluded from the IPPS, all hospitals-within-hospitals must admit no more than 25 percent of their patients from the onsite host hospital. We are also proposing to preclude common ownership of host hospitals and excluded hospitals, while grandfathering existing hospitals-within-hospitals and hosts that are under common ownership, as long as they comply with the proposed mandatory 75-percent criterion. We are further seeking comments on the options presented if the hospital-within-a-hospital fails to meet the 75-percent criterion that would either require that all of the hospital's Medicare payment would be made under the IPPS or, alternatively, to allow a hospital-within-a-hospital to still be paid as an excluded hospital for its admissions from onsite providers while applying specific payment adjustments for patients admitted from the host hospital.

We are soliciting comments on the three options presented and whether they provide sufficient protection against the phenomenon of inadequate separateness and control as described in this proposed rule. We want to emphasize that, under any of the options, nowhere is a change in physician clinical decisionmaking or a change in the manner in which a physician or hospital practices medicine intended. The policy options outlined in this proposed rule would simply address the appropriate level of payments once those decisions have been made.

Technical Change. In § 412.22(e) of our regulations, we refer to a hospital-within-a-hospital as a hospital that ''occupies space in a building also used by another hospital, or in one or more *entire* buildings located on the same campus as buildings used by another hospital'' (emphasis added). The reference to ''entire'' buildings is incorrect. We should have referred to ''separate'' buildings. Therefore, we are proposing to correct this error.

C. Critical Access Hospitals (CAHs)

[If you choose to comment on issues in this section, please include the caption ''Critical Access Hospitals'' at the beginning of your comment.]

1. Background

Section 1820 of the Act provides for the establishment of Medicare Rural Hospital Flexibility Programs, under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and meet the CAH conditions of participation in 42 CFR Part 485, Subpart F, will be certified as CAHs by CMS. Regulations governing payments to CAHs for services to Medicare beneficiaries are located in 42 CFR Part 413.

2. Payment Amounts for Inpatient CAH Services (Section 405(a) of Public Law 108–173 and §§ 413.70 and 413.114 of the Regulations)

Prior to the enactment of Public Law 108–173, section 1814(l) of the Act provides that the Medicare payment amount for inpatient services furnished by a CAH is the reasonable costs of the CAH in providing the services. Section 1834(g)(1) of the Act provides that the Medicare amount of payment for outpatient services furnished by a CAH is made on a reasonable cost basis, unless the CAH makes an election, under section 1834(g) of the Act, to receive a payment amount that is the sum of the reasonable cost of hospital outpatient facility services plus 115 percent of the amount otherwise paid for professional services. Section 1883(a)(3) of the Act provides for payment to a CAH for covered skilled nursing facility services furnished under an agreement entered into under section 1883 of the Act on the basis of the reasonable costs of such services. Regulations implementing these provisions are set forth in § 413.70(a), for inpatient CAH services; in

§ 413.70(b), for payment under the standard method for the reasonable costs of facility services, and outpatient CAH services; in § 413.70(b)(3), for the optional method of payment for outpatient services (reasonable costs for facility services plus fee schedule for professional services); and in § 413.114, for SNF services of a CAH with a swing-bed agreement.

Section 405(a) of Public Law 108–173 amended sections 1814(l), 1834(g)(1), and 1883(a)(3) of the Act to provide that, effective for services furnished during cost reporting periods beginning on or after January 1, 2004, the amount of the payment for inpatient, outpatient, and SNF services, respectively, furnished by a CAH is equal to 101 percent of the reasonable cost of the CAH in providing these services.

We are proposing to revise §§ 413.70(a)(1), (b)(2), and (b)(3) and § 413.114 of our regulations to incorporate the change in the payment percentage made by section 405(a) of Public Law 180–173. We also are proposing to make a technical correction to § 413.70(b)(2)(i) to remove paragraphs (b)(2)(i)(C) and (D). We are proposing to delete these paragraphs to conform the regulations to provisions of the outpatient hospital PPS.

We note that in the IPPS final rule published in the **Federal Register** on August 1, 2001 (66 FR 39936), we added a new paragraph (a)(1)(iv) to § 413.70. However, when the change was incorporated into the Code of Federal Regulations, paragraphs (a)(1)(i), (a)(1)(ii), and (a)(1)(iii) were inadvertently omitted. Our proposed revision of § 413.70(a)(1) would correct the omission of these three paragraphs.

3. Condition for Application of Special Professional Service Payment Adjustment (Section 405(d) of Public Law 108–173 and § 413.70(b) of the Regulations)

As stated earlier, section 1834(g) of the Act provides for two methods of payment for outpatient CAH services. Under the provisions of section 1834(g) of the Act, a CAH will be paid under a reasonable cost method unless it elects payment under an optional method. Under the reasonable cost payment method, facility services are paid on a reasonable cost payment basis by the fiscal intermediary to the CAH, and physician and other professional services to CAH outpatients are paid for under the physician fee schedule, with payments being made by the carrier. Under the optional method (frequently referred to as ''method 2''), CAHs submit bills for both facility and professional services to the fiscal intermediary. If a CAH elects the optional method of billing for outpatient services, Medicare payment for its facility services are made at the same level as would apply under the reasonable cost reimbursement method, but services of professionals to outpatients are paid for at 115 percent of the amounts that would otherwise be paid for under the physician fee schedule. To make the optional method election feasible and to help prevent possible duplicate billing, we require practitioners furnishing services to outpatients of a CAH to agree to reassign to the CAH their rights to bill the Medicare program for those services.

Existing regulations at § 413.70(b) set forth these payment options and specify that an election of the optional method, once made for a cost reporting period, remains in effect for all of that period and applies to all services furnished to CAH outpatients during that period. This means that, under existing regulations, a CAH may elect the optional method payment only if all of its practitioners agree to reassign their billing rights for outpatient services to the CAH.

Section 405(d)(1) of Public Law 108–173 amended section 1834(g)(2) of the Act by adding a sentence after paragraph (B) to specify that the Secretary may not require, as a condition for a CAH to make an election of the optional method of payment, that each physician or other practitioner providing professional services in the CAH must assign billing rights with respect to the services. However, the optional payment method does not apply to those physicians and practitioners who have not assigned such billing rights. In other words, section 405(d) amended the Medicare law to authorize CAHs to elect the optional payment method even if some practitioners do not reassign to the CAH their rights to bill for professional services to CAH outpatients. However, it also specifies that the 15-percent increase in payment for those services is not available for professional services for which billing rights are not reassigned.

The provisions of section 405(d)(1) of Public Law 108–173 are effective for cost reporting periods beginning on or after July 1, 2004. However, section 405(d)(2)(B) also states, in a special rule of application, that in the case of a CAH that made an election before November 1, 2003, the provisions of section 405(d)(1) are effective for cost periods beginning on or after July 1, 2001.

Consistent with section 405(d)(2)(B), we do not intend to attempt recovery of certain amounts paid improperly in the past to CAHs for professional services that the CAHs billed under the optional payment method, even though the CAHs had not obtained reassignments of billing rights from all physicians and other practitioners furnishing professional services to their outpatients, as required by § 413.70 as in effect at that time. However, we are proposing to clarify that the special rule of application in section 405(d)(2)(B) is not to be interpreted to permit a CAH to obtain payment under the optional payment method for any cost reporting period based on an election made for a prior period or on an optional payment method election that was withdrawn or revoked prior to the start of the cost reporting period for which it was made.

To illustrate the application of section 405(d)(2)(B), assume that on October 1, 2002, a CAH elected method 2 for its cost reporting period starting on January 1, 2003, but did not obtain reassignments from all physicians treating its outpatients, as required by regulations in effect at that time. Under section 405(d)(2)(B), CMS would not recover any amounts from the CAH for payments for services furnished during that cost reporting period (January 1, 2003, through December 31, 2004) that are attributable to that election, even though the election was inappropriate at the time it was made. Assume further that the same CAH recognized its error and did not make a method 2 election for its cost reporting period beginning January 1, 2004, thus receiving payment under method 1. The fact that the election of October 1, 2002, was made prior to November 1, 2003, is not material in this case and cannot be interpreted to justify method 2 payment for the cost reporting period beginning January 1, 2004, because that method 2 election related to an earlier cost reporting period and not to the cost reporting period beginning January 1, 2004. The same result would occur if the CAH had elected method 2 on October 1, 2003, but subsequently revoked that election on October 15, 2004.

We are proposing to revise §§ 413.70(b)(3)(i) to reflect the changes made by section 405(d) of Public Law 108–173. We would specify in § 413.70(b)(3)(i) that a CAH may elect to be paid for outpatient services in any cost reporting period beginning on or after July 1, 2004, under the method described in §§ 413.70(b)(3)(ii) and (b)(3)(iii). In § 413.70(b)(3)(i)(A), we would clarify that such an election is to be made at least 30 days before the start of the cost reporting period for which the election is made. In § 413.70(b)(3)(i)(B), we would specify

that the provision applies to all services furnished to outpatients during that cost reporting period by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with the reassignment regulations under 42 CFR part 424, Subpart F. In that paragraph, we also would specify that if a physician or other practitioner does not reassign his or her billing rights to the CAH in accordance with 42 CFR Part 424, Subpart F, payment for the physician's or practitioner's services to CAH outpatients will be made on a fee schedule or other applicable basis specified in 42 CFR Part 414, Subpart B. We would also add a new paragraph (C) to § 413.70(b)(3)(i) to state that, in case of a CAH that made an election under § 413.70(b)(3) before November 1, 2003, for a cost reporting period beginning before December 1, 2004, the rules in paragraph (b)(3)(i)(B) are effective for cost reporting periods beginning on or after July 1, 2001. We are also proposing in § 413.70(b)(3)(i)(B) to clarify that an election effective only for any cost reporting period for which it was made for the optional method does not apply to an election that was withdrawn or revoked before the start of the cost reporting period for which it was made.

4. Coverage of Costs for Certain Emergency Room On-Call Providers (Section 405(b) of Public Law 108–173 and §§ 413.70(b)(4) and 485.618 of the Regulations)

Under existing regulations at § 413.70(b)(4), which implement section 1834(g)(5) of the Act, Medicare payments to a CAH may include the costs of compensation and related costs of on-call emergency room physicians who are not present on the premises of a CAH, are not otherwise furnishing services, and are not on-call at any other provider or facility when determining the reasonable cost of outpatient CAH services.

Section 405(b) of Public Law 108–173 amended section 1834(g)(5) of the Act to expand the reimbursement of on-call emergency room providers beyond physicians to include physician assistants, nurse practitioners, and clinical nurse specialists for the costs associated with covered Medicare services furnished on or after January 1, 2005.

We are proposing to revise § 413.70(b)(4)(i) and (ii) to include the expanded list of emergency room on-call providers for whom reimbursement for reasonable compensation and related costs in a CAH would be available. We also are making a conforming change to § 485.618(d) governing the standard for emergency room personnel who are on call under the CAH conditions of participation.

5. Authorization of Periodic Interim Payments for CAHs (Section 405(c) of Public Law 108–173 and Proposed § 413.64(h)(2)(vi) and § 413.70(d) of the Regulations)

Section 1815(e)(2) of the Act provides that payments may be made on a periodic interim payment (PIP) basis for specified covered Medicare services. Section 405(c)(1) of Public Law 108–173 amended section 1815(e)(2) by adding a new subsection (E) to provide for payments for inpatient services furnished by CAHs on a PIP basis, effective for payments made on or after July 1, 2004. Section 405(c)(2) of Public Law 108–173 directs the Secretary to develop alternative methods for the timing of the payments under the PIP method.

We have already established in existing regulations under § 413.64(h) provisions for making payments under the PIP method to providers for certain Medicare covered services. The principles and rules of § 413.64 have been incorporated into regulations governing payment on a PIP basis to acute care IPPS hospitals as well as to other providers, such as SNFs and LTCHs, that are paid on a prospective basis. We believe these principles and rules could be equally applied to CAHs. Therefore, in this proposed rule, to implement the provisions of section 405(c) of Public Law 108–173, we are proposing to add a new § 413.64(h)(2)(vi) to specify inpatient services furnished by CAHs as an additional type of covered service for which PIP is available, effective for payments made on or after July 1, 2004.

It has been our longstanding policy under § 413.64(h)(6) that payment will be made biweekly under the PIP method, unless the provider requests a longer fixed interval (not to exceed 1 month) between payments. We believe that this provision grants adequate flexibility for the timing of payments under the PIP method to all qualifying providers, including CAHs. Under our proposed policy for CAHs, if a CAH chooses to receive its payments less frequently than biweekly, it could inform its Medicare fiscal intermediary. Section 413.64(h)(6) does not provide for the payments to be made more frequently than biweekly to providers for which PIP is currently available. We believe this is equally appropriate for the payments for inpatient services furnished by CAHs.

In summary, we are proposing to apply the same rules and procedures for payments under the PIP method that we apply to acute care hospitals and certain other Medicare providers. Therefore, CAHs, in applying for and receiving payments for inpatient services under the PIP provision, would be operating under the same rules as other providers for which PIP is available under § 413.64(h), including the flexibility discussed above of the timing of their payments as provided for under § 413.64(h)(6). We also are proposing to establish a new paragraph (d) under § 413.70 to provide that, for payments on or after July l, 2004, a CAH may elect to receive PIP for inpatient services furnished by CAHs, subject to the provisions of § 413.64(h). The new § 413.70(d) summarizes the application of the PIP provisions under § 413.64(h)(6) for CAH inpatient services and notes the availability of accelerated payments for CAHs that are not receiving PIPs.

Technical Changes to § 413.64. We are proposing to use this opportunity to remove §§ 413.64(h)(3)(iv) and 413.64(h)(4), which contain an outdated requirement that a provider must repay any outstanding current financing payments before being permitted to be paid under the PIP method. Current financing payments have not been available since 1973.

6. Revision of the Bed Limit for CAHs (Section 405(e) of Public Law 108–173 and §§ 485.620(a) and 485.645(a)(2) of the Regulations)

Prior to the enactment of Public Law 108–173, sections 1820(c)(2)(B)(iii) and 1820(f) of the Act restricted CAHs to 15 acute care beds and a total of 25 beds if the CAH had been granted swing-bed approval. The number of beds used at any time for acute care inpatient services could not exceed 15 beds.

Section 405(e) of Public Law 108–173 amended sections 1820(c)(2)(B)(iii) and 1820(f) of the Act to allow CAHs a maximum of 25 acute care beds for inpatient services, regardless of the swing-bed approval. This amendment is effective on January 1, 2004 and applies to CAHs designated before, on, or after this date. However, section 405(e)(3) of Public Law 108–173 also notes that any election made in accordance with the regulations promulgated to carry out the bed size amendments only applies prospectively.

We interpret this provision to mean that the increased bed size limitation is to be applied prospectively after April 1, 2004, regardless of when the CAH was designated. Accordingly, we implemented this provision via a survey and certification letter on January 1, 2004. (See Survey and Certification

Letter No. 0414, issued December 11, 2003.) Therefore, effective January 1, 2004, this provision allows any currently participating CAH, or applicant for CAH approval, to maintain up to 25 inpatient beds. If swing-bed approval has been granted, all 25 beds can be used interchangeably for acute care or swing-bed services. However, no CAH will be considered to have had 25 acute care beds prior to January 1, 2004. We are proposing to amend our regulations at §§ 485.620(a) and 485.645(a)(2) to reflect the increase in the number of beds permitted in a CAH, in accordance with the amendments made by section 405(e) of Public Law 108–173.

7. Authority To Establish Psychiatric and Rehabilitation Distinct Part Units of CAHs (Section 405(g)(1) of Public Law 108–173 and Proposed New § 485.646 of the Regulations)

As stated earlier, sections 1820(c)(2)(B) and 1861(mm) of the Act set forth the criteria for designating a CAH. Under this authority, the Secretary has established in regulations the minimum requirements a CAH must meet to participate in Medicare (42 CFR Part 485, Subpart F). The CAH designation is targeted to small rural hospitals with a low patient census and short patient stays.

Under the law in effect prior to Public Law 108–173, CAHs are excluded from operating distinct part units (that is, separate sections of hospitals that are dedicated to providing inpatient rehabilitation or psychiatric care and are paid under payment methods different from those used for the acute care areas of the hospitals). The statute (section 1886(d)(l)(B) of the Act) and implementing regulations under 42 CFR Part 412, Subpart B require distinct part units to be units of ''subsection (d) hospitals,'' which are hospitals paid under the IPPS. Because CAHs are not ''subsection (d) hospitals'' paid under IPPS, but instead are paid for inpatient care on a reasonable cost basis under section 1814(l) of the Act, they are effectively prohibited from having distinct part units.

Section 405(g)(1) of Public Law 108–173 modified the statutory requirements for CAHs under section 1814(l) and section 1820(c)(2) of the Act to allow CAHs to establish distinct part rehabilitation and psychiatric units of up to 10 beds each, which will not be included in the revised total 25 CAH bed count under section 405(e) of Public Law 108–173 (discussed in detail in section VI.D.6. of this preamble. In addition, as explained more fully below, the average 96-hour stay does not apply to the 10 beds in the distinct part units and inpatient admissions; days of inpatient care in these distinct part units are not taken into account in determining the facility's compliance with the requirement for a facility-wide average length of stay that does not exceed 96 hours.

Section 405(g)(1) of Public Law 108–173 provides under section 1820(c)(2)(E)(i) of the Act that a distinct part rehabilitation or psychiatric unit of a CAH must meet the conditions of participation that would otherwise apply to the distinct part unit of a hospital if the distinct part unit were established by a subsection (d) hospital in accordance with the matter following clause (v) of section 1886(d)(1)(B) of the Act, including any applicable regulations adopted by the Secretary. CAHs will now be permitted to operate distinct-part psychiatric and rehabilitation units, and it is clear that the law, consistent with this change, requires the same level of health and safety protection for patients in distinct part units of a CAH that is currently required for patients in distinct part units operated by an acute care hospital.

The amendments to section 405(g)(1) are effective for the cost reporting periods beginning on or after October 1, 2004.

As CAHs were excluded from operating distinct part units prior to the enactment of section 405(g), the CAH conditions of participation did not address the necessary requirements and standards for operating such units. As noted previously, section 1820(c)(2)(E)(i) of the Act makes it clear that the requirements, including conditions of participation, for operating these units in a CAH are to be the same as is currently required for these units operated by an acute care hospital. Accordingly, we are proposing that, in accordance with the requirements of section 405(g), a rehabilitation or psychiatric distinct part unit of a CAH must meet all of the hospital conditions of participation at 42 CFR Part 482, Subparts A, B, C, and D and the criteria for exclusion from the IPPS at 42 CFR Part 412 as described below. These requirements will only apply to the services provided in the distinct part unit of a CAH and not the entire CAH.

Currently, psychiatric distinct part units of hospitals are subject to specific Medicare regulations established in 42 CFR 412.27 regarding the types of patients admitted, the scope of services furnished, and the qualifications of staff. For example, psychiatric distinct part units may admit only patients whose condition requires inpatient hospital care for a psychiatric principal diagnosis. The regulations at § 412.27(b) further requires a hospital that wishes to establish a psychiatric distinct part unit to furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing, and occupational and recreational therapy. The hospital must maintain medical records for the unit that permit determination of the degree and intensity of services to individuals treated in the unit. Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program, and who is board certified in psychiatry (42 CFR 412.27(d)(2)). The distinct part unit must have a director of social services, a qualified director of psychiatric nursing services who is a registered nurse with a master's degree in psychiatric or mental health nursing, or its equivalent from an accredited school of nursing, or is qualified by education and experience in the care of individuals with mental illness. There must also be an adequate number of registered nurses to provide 24-hour coverage as well as licensed practical nurses and mental health workers. These and other applicable requirements are set forth in greater detail in § 412.27.

Rehabilitation distinct part units of hospitals are currently subject to criteria in 42 CFR 412.29. This section specifies that such a unit must meet either the requirements for new units (§ 412.30(a)) or those for existing units (§ 412.30(c)). In addition, the units must furnish through qualified personnel rehabilitation nursing, physical and occupational therapy, and as needed, speech therapy and social services or psychological services, and orthotics and prosthetics. The unit must have a director of rehabilitation services who is trained or experienced in medical management of inpatients who require rehabilitation services and is a doctor of medicine or a doctor of osteopathy. Rehabilitation distinct part units may treat only patients likely to benefit significantly from an intensive inpatient program, utilizing services such as physical, occupational, or speech therapy. These and other applicable requirements are set forth in greater detail in §§ 412.29 and 412.30.

To implement the requirements of section 1820(c)(2)(E)(i) of the Act, as added by section 405(g)(1) of Public Law 108–173, we are proposing to add a new § 485.647 to 42 CFR Part 485, Subpart F. In proposed § 485.647(a)(1), we would specify that if a CAH provides

inpatient psychiatric services in a distinct part unit, the services provided in that unit must comply with the hospital requirements specified in Subparts A, B, C, and D of Part 482, with the common requirements for IPPS-excluded units in § 412.25(a)(2) through (f), and with the additional requirements of § 412.27 for psychiatric units excluded from the IPPS. In proposed § 485.647(a)(2), we would specify that if a CAH provides inpatient rehabilitation services in a distinct part unit, the services provided in that unit must comply with the hospital requirements specified in Subparts A, B, C, and D of Part 482, with the common requirements for IPPS-excluded units in § 412.25(a)(2) through (f), and with the additional requirements of §§ 412.29 and 412.30, which relate specifically to rehabilitation units excluded from the IPPS. To provide for consistent application of section 405(g)(1) and avoid any confusion, we also are proposing to revise § 412.22, which contains the common requirements for excluded hospital units, to state that, for purposes of 42 CFR Part 412, Subpart B, the term ''hospital'' includes a CAH.

As noted earlier, sections 1820(c)(2)(E)(ii) and (c)(2)(E)(iii) of the Act, as added by section 405(g)(1) of the MMA, provide that each distinct part unit of a CAH may have up to 10 beds and that, in determining the number of beds a CAH has for purposes of compliance with the 25-bed limit described earlier, the beds in a distinct part unit are not to be taken into account. We interpret the exclusion of these beds from consideration for purposes of the 25-bed limit as also indicating that the admissions and lengths of stay in distinct part unit beds are not to be considered in determining the facility-wide average length stay of a CAH for purposes of the 96-hour limitation on CAH's average length of inpatient stay. These rules would be codified in paragraphs (b)(1) through (b)(3) of proposed § 485.647.

Section 1820(c)(2)(E)(iv) of the Act, as added by section 405(g)(1) of Public Law 108–173, imposes severe sanctions on CAHs that fail to operate their distinct part units in compliance with applicable requirements. That section states that if a psychiatric or rehabilitation unit of a CAH does not meet the requirements of section 1820(c)(2)(E)(i) with respect to a cost reporting period, no payment may be made to the CAH for services furnished in that unit for that period. Payment to the CAH for services in the unit may resume only after the unit has demonstrated to CMS that the unit meets the requirements of § 485.645. We are proposing to codify this requirement by adding a new paragraph (g) to § 412.25.70, which contains the common requirements for excluded units.

Section 405(g)(1) of Public Law 108–173 amended section 1814(l) of the Act by adding a new paragraph (2) to that provision. New section 1814(l)(2) states that, in the case of a distinct-part psychiatric or rehabilitation unit of a CAH, the amount of payment for inpatient CAH services of such a unit is to equal the amount that would be paid if these services were inpatient hospital services of a psychiatric or rehabilitation unit, respectively, of the kind described in the matter following clause (v) of section 1886(d)(1)(B) of the Act. To implement the requirements of section 1814(1)(2) of the Act, we are proposing that, for CAHs that establish rehabilitation or psychiatric distinct part units, or both, in their facility, Medicare payment for inpatient services provided in those units would be made under the applicable existing payment methodology described below for IRFs and IPFs.

Presently, IRFs are paid under a per discharge PPS that became effective for cost reporting periods beginning on or after January 1, 2002. The regulations governing the IRF PPS are located under 42 CFR Part 412, Subpart P (§§ 412.600 through 412.632).

At this time psychiatric hospitals and units that are excluded from the IPPS are paid for their inpatient operating costs on a reasonable cost basis, subject to a hospital-specific limit. However, as required by statute, a per diem PPS for Medicare payments for inpatient hospital services furnished in psychiatric hospitals and units (referred to as inpatient psychiatric facilities (IPFs)) was proposed in the **Federal Register** on November 28, 2003 (68 FR 66920). We are in the process of developing the final rule for this proposed rule. When finalized, the IPF PPS will replace the reasonable cost based payment system currently in effect.

To clarify the requirements of section 1814(1)(2) of the Act regarding payment for inpatient CAH services of a distinct part psychiatric or rehabilitation unit of a CAH, we are proposing to revise the title and first sentence of paragraph (a)(1) of § 413.70, and to add a new paragraph (a)(4) to that section, to clarify that payment for inpatient services of a CAH distinct part unit is not made in accordance with the otherwise applicable rules for payment for inpatient CAH services, but under other rules described in new § 413.70(e). We propose also in new paragraph § 413,70(e), that payment for inpatient services of distinct part rehabilitation units of CAHs is made in accordance with regulations governing the IRF PPS at 42 CFR Part 412, Subpart F (§§ 412.600 through 412.632). We also would state that payment for inpatient services of distinct part psychiatric units of CAHs is made in accordance with regulations governing IPPS-excluded psychiatric units of hospitals at 42 CFR 413.40.

8. Waiver Authority for Designation of a CAH as a Necessary Provider

Section 405(h) of Public Law 108–173 amended section 1820(c)(B)(i)(II) of the Act by adding language that terminates a State's authority to waive the location requirement for a CAH by designating the CAH as a necessary provider, effective January 1, 2006. Currently, a CAH is required to be located more than a 35-mile drive (or in the case of mountainous terrain or secondary roads, a 15-mile drive) from a hospital or another CAH, unless the CAH is certified by the State as a necessary provider of health care services to residents in the area. Under this provision, after January 1, 2006, States will no longer be able to designate a CAH based upon a determination it is a necessary provider of health care.

In addition, section 405(h) of Public Law 108–173 amended section 1820(h) of the Act to include a grandfathering provision for CAHs that are certified as necessary providers prior to January 1, 2006. Under this provision, any CAH that is designated as a necessary provider in its State's rural health plan prior to January 1, 2006, will be permitted to maintain its necessary provider designation.

In this proposed rule, we are proposing to revise our regulations at § 485.610(c) to incorporate the amendments made by section 405(h) of Public Law 108–173.

9. Payment for Clinical Diagnostic Laboratory Tests

Medicare payment for clinical diagnostic laboratory tests provided to the outpatients of CAHs was established through the regulatory process and published in the **Federal Register** as part of the FY 2004 IPPS final rule (68 FR 45346, August 1, 2003). Payment to a CAH for clinical diagnostic laboratory tests for outpatients is made on a reasonable cost basis only if the individuals for whom the tests are performed are outpatients of the CAH and are physically present at the CAH at the time specimens are collected. Otherwise, payment for these tests is made on a fee schedule basis.

We published this final rule to clarify our policy in this area and ensure that all relevant issues were publicly noted. For reasons which are set forth in detail in the FY 2004 IPPS final rule, we do not agree that providing reasonable cost payment to individuals who are not present at the CAH when the specimen is collected is appropriate. We believe that extending reasonable cost payment in these instances is inconsistent with Medicare law and regulations and duplicates existing coverage. It also creates confusion for beneficiaries and others by blurring the distinction between CAHs and other types of providers (for example, SNFs and HHAs) and increases the costs of providing care to Medicare patients without enhancing either the quality or the availability of that care.

Following publication of the FY 2004 IPPS final rule, we received a number of letters and statements in Open Door Calls indicating that some commenters continue to believe that this policy will impose a hardship on Medicare beneficiaries in rural areas. Several of these commenters argued that it might cause frail elderly nursing home patients to have to be moved to a CAH to have blood drawn or other specimen collection performed instead of sending a laboratory technician to the patient's bedside for the same purpose. We agree with the commenters that this would not be an appropriate result. However, we would note that there are also alternative ways in which specimen collection and travel are payable under Medicare (for example, the laboratory benefit under Part B or HAAs that have laboratory provider numbers). Therefore, we do not expect beneficiaries to face reduced access to services under this policy.

In response to continuing claims of potential access problems, we invited commenters to submit further, more specific comments that provide specific information on actual, rather than merely potential or anticipated access problems. In response, we received many communications asserting that these problems would occur, but no credible documentation that they actually are occurring. As a result of these responses, we are not proposing any further change in policy on this issue at this time. We would like to renew our request for specific, verifiable documentation as to any actual access problems being generated by this policy, and will review carefully any such documentation we receive to determine whether current policy should be reconsidered.

10. Proposed Technical Changes in Part 489

In several sections of Part 489, we have discovered a need to update cross-references to conform them to the redesignation of the Medicare transfer rules from § 489.24(d) to § 489.24(d). Specifically, we are proposing to correct the cross-reference to ''§ 489.24(d)'' in §§ 489.20(m) and 489.53(b)(2) to read ''§ 489.24(e)''.

VII. Proposed Changes to the Disclosure of Information Requirements for Quality Improvement Organizations (QIOs)

[If you choose to comment on issues in this section, please include the caption ''Quality Improvement Organizations'' at the beginning of your comment.]

A. Background

Section 1152 of the Act defines a utilization and quality control peer review organization (now referred to as a quality improvement organization (QIO)). Section 1153 provides for contracts with such organizations to review items and services furnished by physicians, other practitioners, and providers to Medicare patients to verify that the items and services are reasonable, medically necessary, and allowable under the Act; meet professionally recognized standards of health care; and are furnished in the appropriate setting. Section 1154 of the Act outlines the functions of a QIO, which include responsibility for: (1) Collecting and maintaining information necessary to carry out its responsibilities; (2) examining pertinent records maintained by the practitioner or provider verifying the medical necessity and quality of services provided by any practitioner or provider of health care services to Medicare patients; (3) ensuring that health care practitioners and providers maintain evidence of medical necessity and quality of health care services provided to Medicare patients; and (4) exchanging information with intermediaries, carriers, and other public or private review organizations as appropriate. Section 1160 of the Act provides that information acquired by QIOs in the exercise of their duties and functions must be held in confidence. Information cannot be disclosed except as allowed under section 1160 of the Act and the existing regulations governing the release of QIO peer review information in 42 CFR Part 480. Specifically, Part 480 sets forth the policies and procedures for disclosure of information collected, acquired, or generated by a QIO (or the review component of a QIO subcontractor) in the performance of its responsibilities under the Act and the Medicare regulations, as well as the acquisition and maintenance of information needed by a QIO to comply with its responsibilities under the Act.

QIOs assist institutions and practitioners seeking to improve the quality of care given to Medicare beneficiaries. CMS aims to ensure that adequate protections of information collected by QIOs are in place and, at the same time, to ensure that the quality improvement activities of these institutions and practitioners are not unnecessarily hindered by regulations. It has come to our attention that the existing regulations omit information disclosure procedures that would allow for the effective and efficient exchange of information that is an essential part of quality improvement activities. In addition, it has come to our attention that, although the QIO does not need the consent of the institution to release nonconfidential information, the existing 30-day advance notice requirement to an institution prior to releasing public information or any other nonconfidential information that identifies an institution, when an institution consents to or requests the release of information, impedes the ability of QIOs to conduct quality improvement work. If the institution requests or consents to the release of the information, the institution is already aware of the QIO's intention to disclose the nonconfidential information. Therefore, we see no reason to require the additional 30-day advance notice. Likewise, there is no reason to require a 30-day notice for practitioners who request the release of information for quality improvement activities or other permissible releases under the regulations.

B. Provisions of the Proposed Regulations

We are proposing to make several changes in the regulations in Part 480 to expedite the exchange of information and minimize delays and expenditures currently required of QIOs, institutions, and practitioners as discussed below.

Existing § 480.105(a) requires that a QIO must notify an identified institution of its intent to disclose nonconfidential information about the institution and provide a copy of the information at least 30 calendar days before the disclosure. Section 480.105 also includes certain notice requirements a QIO must meet before disclosing confidential information that identifies practitioners and physicians. Section 480.106 presently includes several exceptions to these notice

requirements. We are proposing to revise § 480.106 to establish additional exceptions to the notice requirements in § 480.105(a) and (b)(2). We are proposing to specify that the notice requirements in § 480.105(a) and (b)(2) would not apply if (1) the institution or practitioner has requested, in writing, that the QIO make the disclosure; (2) the institution or practitioner has provided written consent for the disclosure; or (3) the information is public information as defined in § 480.101 and specified in § 480.120.

Existing § 480.133(a)(2)(iii) specifies that a QIO may disclose to any person, agency, or organization confidential information on a particular practitioner or reviewer with the consent of that practitioner or reviewer, provided that the information does not identify other individuals. We are proposing to revise § 480.133(a)(2)(iii) to allow for the release of information at the written request of the practitioner or reviewer, in addition to information releasable with the consent of the practitioner or reviewer under the existing provision. Specifically, the proposed revised § 480.133(a)(2)(iii) would provide that a QIO may disclose confidential information about a particular practitioner or reviewer at the written request of, or with the written consent of that practitioner or reviewer. The recipient of the information would have the same redisclosure rights and responsibilities as the requesting or consenting practitioner or reviewer would, under the authority of Subpart B of Part 480. We are proposing a similar revision to § 480.140 relating to the release of quality review study information. Specifically, we are proposing to revise § 480.140 by adding a new paragraph (d) (the existing paragraphs (d) and (e) would be redesignated as paragraphs (e) and (f), respectively) to provide that a QIO may disclose quality review study information with identifiers of particular practitioners or institutions at the written request of, or with the written consent of, the identified practitioner(s) or institution(s). The recipient of the information would have the same redisclosure rights and responsibilities as the requesting or consenting practitioner or reviewer would, under the authority of Subpart B of Part 480. We believe that these proposed revisions would reduce the existing burden on practitioners, institutions, and QIOs and, at the same time, ensure that necessary protections on information remain in place. These proposed revisions would allow QIOs, institutions, and practitioners to share vital information in an effective manner and further our efforts to ensure the highest quality of care possible for Medicare beneficiaries.

C. Technical Changes

We are proposing to revise the title of Part 480 under Subchapter F of Chapter IV of 42 CFR to conform it to a previous regulatory change in the name of the organization conducting medical reviews under Medicare from a peer review organization to a quality improvement organization. The proposed new title is ''Part 480—Acquisition, Protection, and Disclosure of Quality Improvement Organization Information''.

In a final rule published in the **Federal Register** on November 24, 1999 (64 FR 66279), we redesignated Part 476 as Part 480. However, as part of the redesignation process, we inadvertently failed to make appropriate changes to the cross-references in various sections under the redesignated Part 480. In this proposed rule, we are proposing to correct those cross-references.

VIII. Proposed Policy Changes Relating to Medicare Provider Agreements for Compliance With Bloodborne Pathogens Standards, Hospital Conditions of Participation, and Fire Safety Requirements for Certain Health Care Facilities

A. Conditions of Participation for Discharge Planning

[If you choose to comment on issues in this section, please include the caption ''Discharge Planning'' at the beginning of your comment.]

1. Background

As part of the definition of ''hospital,'' sections 1861(e)(1) through (e)(8) of the Act set forth specific requirements that a hospital must meet to participate in the Medicare program. Section 1861(e)(9) of the Act specifies that a hospital also must meet other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in hospitals. Implementing regulations for section 1861(c) of the Act, setting forth the conditions of participation (CoPs) that a hospital must meet to participate in the Medicare program, are located in 42 CFR Part 482.

The purposes of these CoPs are to protect patient health and safety and to ensure that high quality care is furnished to all patients in Medicare-participating hospitals. In accordance with section 1864 of the Act, State survey agencies conduct surveys of hospitals to determine compliance with the Medicare CoPs, using interpretive guidelines and survey procedures found in the State Operations Manual (SOM), CMS Publication No. 7. In accordance with section 1865 of the Act and the implementing regulations at 42 CFR 488.5 and 488.6, hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA), or other national accreditation organizations are not routinely surveyed by States for compliance with the CoPs, but are deemed to meet most of the hospital CoPs based on their accreditation. However, all hospitals that participate in the Medicare program are required to be in compliance with the CoPs, regardless of their accreditation status. Under section 1905(a) of the Act, the hospital CoPs also apply to hospitals participating in Medicaid (§ 440.10(a)(3)(iii) and § 482.1(a)(5)).

Under § 489.10(d), a Medicare provider agreement is subject to the State survey agency's determination of whether a hospital meets the CoPs. The State survey agency makes corresponding recommendations to CMS about the hospital's certification; that is, whether the hospital has met the standards or requirements necessary to provide Medicare and Medicaid services and receives Federal and State reimbursement.

Section 4321(a) of Public Law 105–33 (BBA) amended section 1861(ee)(2) of the Act to require that Medicare-participating hospitals, as part of the discharge planning process, share with each patient, as appropriate, a list of available home health services through individuals and entities, including Medicare-certified home health agencies (HHAs) that participate in Medicare, serve the geographic area in which the patient resides, and request to be listed by the hospital as available. In addition, section 4321(a) prohibits hospitals from limiting or steering patients to any specific HHA or qualified provider that may provide posthospital home health services and requires hospitals to identify (in a form and manner specified by the Secretary) any HHA or other entity to whom the individual is referred in which the hospital has a disclosable financial interest consistent with section 1866(a)(1)(S) of the Act or which has a financial interest in the hospital if the patient is referred to that entity.

Congress enacted section 4321 of Public Law 105–33 to protect patient choice and enable Medicare beneficiaries to make more informed choices about the providers from which

they receive certain Medicare services. We believe that this provision was intended to address concerns that some hospitals were referring patients only to HHAs in which they had a financial interest, and that shared financial relationships were influencing referrals to other entities. Hospitals essentially have a captive patient population and, through the discharge planning process, can influence a patient's choice regarding who provides posthospitalization services.

Congress also enacted section 926 of Public Law 108–173 (MMA) to improve the administration of the Medicare program by protecting patient choice and enabling Medicare beneficiaries to make more informed choices about the providers from which they receive Medicare services. Section 926(a) of Public Law 108–173 requires the Secretary to publicly provide information that enables hospital discharge planners, Medicare beneficiaries, and the public to identify SNFs that are participating in the Medicare program. Section 926(b) of Public Law 108–173 amended section 1861(ee)(2)(D) of the Act to require Medicare-participating hospitals, as part of the discharge planning process, to include a discharge planning evaluation of a patient's likely need for posthospital extended care services and the availability of these services through facilities that participate in the Medicare program and that serve the geographic area in which the patient resides. The amendments to the Act made by section 926(b) of Public Law 108–173 apply to discharge plans made on or after a date specified by the Secretary, which may be no later than 6 months after the Secretary provides for the availability of information required by section 926(a) of Public Law 108–173.

2. Implementation

We implemented the requirements of section 4321(a) of Public Law 105–33 relating to information on HHAs through a HCFA (now CMS) directive that was issued to the Regional Offices and State survey agencies on October 31, 1997. Enforcement has been carried out through the State agency survey and certification process. We note that even though it was not a requirement under section 4321(a) to provide currently available information on HHAs to the public (as now required under section 1861(ee)(2)(D) of the Act, as amended), we have established a ''Home Health Compare'' link on the CMS Web site, *www.medicare.gov,* that identifies HHAs that are currently participating in the Medicare or Medicaid program.

We are now proposing to incorporate in our regulations under § 482.43 the requirements of section 4321(a) of Public Law 105–53 relating to providing information on HHAs to hospital patients as part of the discharge planning process. We note that we had previously issued a proposed rule on December 19, 1997 (62 FR 66726) to implement the provisions of section 4321(a) of Public Law 105–33. However, section 902 of Public Law 108–173 now requires us to finalize rules within 3 years after publication of the proposed rule, except under ''exceptional circumstances.'' While it is not clear whether Congress intended this policy to apply retroactively, out of an abundance of caution, we are issuing a new proposed rule because of the length of time that has elapsed since the issuance of the 1997 proposed rule. Moreover, the provisions of Public Law 108–173 contain information requirements for SNFs substantially similar to the ones required for HHAs. In developing this second proposed rule, we have taken into consideration the issues raised in the public comments we received on the December 19, 1997 proposed rule relating to HHAs.

Information on SNFs related to the requirement imposed by section 926(a) of Public Law 108–173 is currently available to the public and can be accessed at the CMS Web site, *www.medicare.gov,* by clicking on the ''Nursing Home Compare'' link or by calling 1–800–MEDICARE (800–633–4227). Nursing Home Compare, launched in November 2002, meets the statutory requirement of section 926(a) by enabling hospital discharge planners, Medicare beneficiaries, and the public to identify the 17,000 nursing homes that participate in the Medicare or Medicaid program. Nursing Home Compare can be used to locate a nursing home by State and county, by proximity (city or zip code), or by name. In addition, Nursing Home Compare provides detailed information about the past performance of every Medicare-certified and Medicaid-certified nursing home in the country. The data on this Web site describe nursing home characteristics, quality measures, inspection results, and nursing staff information. The Nursing Home Compare tool received 9.3 million page views in 2003 and was the most popular tool on *www.medicare.gov.* If an interested individual does not have access to the Internet, the individual can call 1–800–MEDICARE (800–633–4227) and request a printout of the nursing homes in a designated area.

We are proposing to amend the regulations at § 482.43 to incorporate the provisions of section 4321(a) of Public Law 105–33 and section 926(b) of Public Law 108–173 into the hospital CoPs. Specifically, we are proposing to add new paragraphs (c)(6), (c)(7), and (c)(8) to include the requirement for hospitals to provide lists of Medicare-certified HHAs and SNFs as part of the discharge planning process. The discharge planning evaluation would be required to include a list of Medicare-certified HHAs that have requested to be placed on the list as available to the patient and that serve the geographic area in which the patient resides. We are proposing to require the SNF list to include Medicare-certified SNFs located in the geographic area in which the patient requests. We are not requiring that the list of Medicare-certified SNFs contain those SNFs that are just located in the area in which the patient resides. Because many available Medicare-certified SNFs are not located in proximity to where the patient resides, especially in rural areas, we believe that a requirement that restricts a patient to SNFs in areas where the patient resides is too restrictive and would limit the availability of posthospital extended care services to Medicare beneficiaries.

Section 4321(a) of Public Law 105–33 requires listing the availability of home health services through individuals and entities. We have received inquiries regarding the identity of those individuals and entities. We are proposing that, because section 1861(m) of the Act identifies home health services as ''specific items or services furnished to an individual, who is under the care of a physician, by an HHA, or by others under arrangements with an HHA,'' section 4321(a) is referring to Medicare-participating HHAs.

We are proposing that the hospital present the list of HHAs or SNFs only to patients for whom home health care or posthospital extended care services are indicated as appropriate, as determined by the discharge planning evaluation. We do not expect that patients without a need for home health care or posthospital extended care services would receive the list. In addition, we are proposing to require the hospital to document in the patient's medical record that a list of HHAs or SNFs was presented to the patient or an individual acting on the patient's behalf. Hospitals would not have to duplicate the list in the patient's medical record. The information in the medical record would serve as documentation that the requirement was met. The hospital would have the flexibility to determine

exactly how and where in the patient's medical record this information would be documented.

We are proposing that a hospital have the flexibility to implement the requirement to present the lists in a manner that is most efficient and least burdensome in its particular setting. A hospital can simply print a list from the Home Health Compare or Nursing Home Compare site on the CMS Web site, *www.medicare.gov* or develop and maintain its own list of HHAs and SNFs. When the patient requires home health services, the CMS Web site list would be printed based on the geographic area in which the patient resides. When the patient requires posthospital extended care services, the CMS Web site list would be printed based on the geographic area requested by the patient. Or, in the rare instance when a hospital does not have Internet access, the hospital can call 1–800–MEDICARE (1–800–633–4227) to request a printout of a list of HHAs or SNFs in the desired geographic area. Information on this Web site should not be construed as an endorsement or advertisement for any particular HHA or SNF.

If a hospital chooses to develop its own list of HHAs or SNFs, the hospital would have the flexibility of designing the format of the list. However, the list should be utilized neither as a recommendation nor endorsement by the hospital of the quality of care of any particular HHA or SNF. If a HHA or SNF does not meet all of the criteria, (Medicare-certified and is located in the geographic area in which the patient resides or in the geographic area requested by the patient) for inclusion on the list, we are not proposing to require the hospital to place that HHA or SNF on the list. In addition, in accordance with the provisions of the Act, we are proposing that HHAs must request to be listed by the hospital as available. Also, we are proposing that the list must be legible and current (updated at least annually), and that the listed information be shared with the patient or an individual acting on the patient's behalf at least once during the discharge planning process. However, we would specify that information regarding the availability of HHAs or SNFs may need to be presented more than once during the discharge planning process to meet the patient's need for additional information or as the patient's needs and condition change.

We are proposing to require that, as part of the discharge planning process, the hospital must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of posthospital services and must, when possible, respect patient and family preferences when they are expressed (proposed § 482.43(c)(7)). In addition, the hospital may not use the discharge plan to specify or otherwise limit the patient's choice of qualified providers that may provide home health care or posthospital extended care services. The intent of this proposed provision is to provide the patient with the freedom of choice to determine which HHA or SNF will provide care in accordance with section 1802 of the Act, which states that beneficiaries may obtain health services from any Medicare-participating provider.

Finally, we are proposing to require the hospital to identify in each discharge plan those HHAs or SNFs to which the patient is referred that the hospital has a disclosable financial interest or HHAs or SNFs that have a financial interest in the hospital (proposed § 482.43(c)(8)). For the purposes of implementing section 4321(a) of Public Law 105–33, we are proposing to define a disclosable ''financial interest'' as any financial interest that a hospital is required to report according to the provider enrollment process, which is governed by section 1124 of the Act and implementing regulations located in 42 CFR Part 420, Subpart C, and manual provisions. If a hospital refers patients about to be discharged and in need of posthospital services only to entities it owns or controls, the hospital would be infringing on the rights of the patient to choose the facility he or she would like to go to for services. The proposed disclosable financial interest requirement is an effort to increase the beneficiary's awareness of the actual or potential financial incentives for a hospital as a result of the referral. To allow hospitals the flexibility of determining how these financial interests are disclosed to the patient, we are not requiring a specific form or manner in which the hospital must disclose financial interest. The hospital could simply highlight or otherwise identify those entities in which a financial interest exists directly on the HHA and SNF lists. Or, the hospital could choose to maintain a separate list of those entities in which a financial interest exists.

Hospitals and managed care organizations (MCOs) have expressed concern as to whether the change made by section 4321(a) of Public Law 105–33 was intended to apply to patients in managed care plans. MCO members are limited as to what services they may obtain from sources other than through the MCO. We believe that providing MCO members with a standardized list of all HHAs or SNFs in the requested geographic area could be misleading and potentially financially harmful because MCO enrollees may be liable for services that they obtain from providers other than the MCO, and patients may interpret a list of HHAs or SNFs that are not available to them under their health plan to mean that they are authorized by the MCO. This does not mean that Medicare MCO members in particular are denied the freedom of choice they are entitled to under section 1802 of the Act. Medicare beneficiaries exercise their freedom of choice when they voluntarily enroll in the MCO and agree to adhere to the plan's coverage provisions.

The list provided to MCO patients should include available and accessible HHAs or SNFs in a network of the patient's MCO. Hospitals also have the option, in the course of discussing discharge planning with patients, to determine whether the beneficiary has agreed to excluded services or benefits or coverage limitations through enrollment in a MCO. If this is the case, the hospital could inform the patient of the potential consequences of going outside the plan for services.

We also have received many inquiries about how the requirements contained in section 4321(a) of Public Law 105–33 are monitored and enforced. Once codified in the hospital CoPs, a hospital's obligations under both section 4321(a) of Public Law 105–33 and section 926(b) of Public Law 108–173 would be monitored as part of the hospital survey and certification process. Anyone aware of instances in which patients are inappropriately influenced or steered toward a particular HHA or SNF in a way that violated the regulation would have the opportunity to file a complaint with the State survey agency. The State survey agency would then investigate and follow up with the complainant. Noncompliance with the hospital CoPs may result in a hospital losing its ability to participate in the Medicare program.

Requiring hospitals to provide a list of Medicare-certified HHAs or SNFs would provide patients with more options and assist them in making informed decisions about the providers from which they receive Medicare services. Specifically, the intent of the proposed modifications to the discharge planning CoPs is to provide the patient with the freedom of choice to determine which HHA or SNF available in the geographic area in which the patient resides or the geographic area requested by the patient, would provide them care in accordance with section 1802 of the Act,

which states that beneficiaries may obtain health services from any Medicare participating provider.

B. Compliance With Bloodborne Pathogens Standards

[If you choose to comment on issues in this section, please include the caption ''Bloodborne Pathogens Standards'' at the beginning of your comment.]

Section 1866(a)(1) of the Act sets forth provider agreement requirements that Medicare-participating hospitals must meet. Implementing regulations for these requirements are set forth at 42 CFR 489.20.

Section 947 of Public Law 108–173 amended section 1866(a)(1) of the Act to require that, by July 1, 2004, hospitals not otherwise subject to the Occupational Safety and Health Act (OSHA) (or a State occupational safety and health plan that is approved under section 18(b) of that Act) must comply with the OSHA bloodborne pathogens (BBP) standards at 29 CFR 1910.1030 as part of their Medicare provider agreements. These OSHA standards can be found on OSHA's Web site at *http://www.osha.gov/SLTC/bloodbornepathogens/*. Section 947, which applies to hospitals participating in Medicare as of July 1, 2004, was enacted to ensure that all hospital employees who may come into contact with human blood or other potentially infectious materials in the course of their duties are provided proper protection from bloodborne pathogens. Section 947 further provides that a hospital that fails to comply with OSHA's BBP standards may be subject to a civil money penalty. The civil money penalty will be imposed and collected in the same manner that civil money penalties are imposed and collected under section 1128A(a) of the Act. However, failure to comply with the BBP standards will not lead to termination of a hospital's provider agreement.

Currently, most hospitals are subject either to the OSHA BBP standards or to other BBP standards (generally, State standards) that meet or exceed the OSHA standards. However, non-Federal public hospitals located in States that do not have their own BBP standards are not subject to OSHA standards, including the OSHA BBP standards. Twenty-six States and the District of Columbia, and Guam do not have their own BBP standards under an OSHA-approved State plan. Therefore, an estimated 600,000 employees of hospitals located in those 26 States, the District of Columbia, and Guam are not afforded the same protections from BBPs as employees of all other hospitals in the United States. The States and territories that would be affected by the change made by section 947 of Public Law 108–173 are Alabama, Arkansas, Colorado, Delaware, Florida, Georgia, Idaho, Illinois, Kansas, Louisiana, Maine, Massachusetts, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Texas, West Virginia, Wisconsin, District of Columbia, and Guam.

We are proposing to incorporate the provisions of Public Law 108–173 in § 489.20 of the Medicare regulations governing provider agreements by adding a new paragraph (t). Paragraph (t) would specify that hospitals not otherwise subject to the OSHA BBP standards must comply with the OSHA BBP standards at 29 CFR 1910.1030 as part of their Medicare provider agreement. The proposed regulations would further specify that if a hospital fails to comply with OSHA's BBP standards, the hospital may be subject to a civil money penalty. The civil money penalty would be imposed and collected in the same manner that civil money penalties are imposed and collected under section 1128A(a) of the Act. However, failure to comply with the BBP standards would not lead to termination of a hospital's provider agreement. The proposed regulations would also refer to the Federal Civil Penalties Inflation Adjustment Act. This reference is intended to alert the reader that the civil money penalty amounts under section 1128A(a) of the Act may, under the Federal Civil Penalties Inflation Adjustment Act, be increased to adjust for inflation.

C. Fire Safety Requirements for Certain Health Care Facilities

[If you choose to comment on issues in this section, please include the caption ''Life Safety Code'' at the beginning of your comment.]

1. Background

On January 10, 2003, we published a final rule in the **Federal Register** (68 FR 1374) that adopted the 2000 edition of the Life Safety Code (LSC) published by the National Fire Protection Association (NFPA) as the fire safety requirements (with specified exceptions) that we are applying to the following types of providers participating in the Medicare and Medicaid programs: long-term care facilities, hospitals, intermediate care facilities for the mentally retarded (ICF/MRs), ambulatory surgical centers (ASCs), hospices that provide inpatient services, religious nonmedical health care institutions, CAHs, and Programs of All-Inclusive Care for the Elderly (PACE).

In addition to adopting the 2000 edition of the LSC, we stated our intent to delete references to all previous editions of the LSC. However, as a result of a technical error, the reference to previous editions of the LSC in § 483.70(a)(1) of the regulations for long-term care facilities was not deleted. Allowing long-term care facilities to comply with the 1967, 1973, and 1981 editions of the LSC would not adequately protect long-term care facility patients from the threat of fire and other emergencies. These editions do not recognize newer technology, nor the advances in fire safety that have been developed in the ensuing years. In addition, the existing conflicting regulatory language is confusing and contrary to the best interests of long-term care facilities and their patients. Therefore, in this proposed rule, we are proposing to correct this technical error. We are not proposing to make any substantive policy change.

In the January 10, 2003 final rule, we also specified that we were not adopting the provisions of Chapter 19.3.6.3.2, exception number 2 of the LSC regarding the use of roller latches for application to religious nonmedical health care institutions, hospices, hospitals, long-term care facilities, PACE programs, ICF/MRs and CAHs. We prohibit the use of roller latches in existing and new buildings, except for ASCs under Chapter 20 and Chapter 21 of the LSC, and provide for the replacement of existing roller latches, phased in over a 3-year period beginning March 11, 2003. We indicated that allowing health care facilities to continue using roller latches would not adequately protect patients in those facilities. Through fire investigations, roller latches have proven to be an unreliable door latching mechanism requiring extensive on-going maintenance to operate properly. Many roller latches in fire situations failed to provide adequate protection to patients in their room during an emergency. Roller latches that are not maintained pose a threat to the health and safety of patients and staff. We added that we had found through our online survey, certification, and reporting (OSCAR) system data that doors that include roller latches are consistently one of our most cited deficiencies. In fact, in SNFs, roller latches in corridor doors are consistently the number one cited deficiency under the life safety requirements.

We have learned that the language regarding the date when these facilities must be in compliance with the

prohibition on the use of roller latch may be misinterpreted and needs to be clarified. In this proposed rule, we are proposing to clarify our intent by revising the regulations as discussed under section VIII.C.2. of this preamble. We are not proposing to make any substantive policy changes.

The flexibility of the January 10, 2003 final rule would remain the same. The Secretary has broad authority to grant waivers to facilities under section 1819(d)(2)(B) and section 1919(d)(2)(B) of the Act. The proposed amendments in this proposed rule would continue to allow the Secretary to grant waivers on a case-by-case basis if the safety of the patients would not be compromised and if specific provisions of the LSC would result in unreasonable hardship on the provider. The Secretary also may accept a State's fire and safety code instead of the LSC if the State's fire and safety code adequately protects patients. Further, the NFPA's Fire Safety Evaluation System (FSES), an equivalency system, provides alternatives to meeting various provisions of the LSC, thereby achieving the same level of fire protection as the LSC.

2. Proposed Changes to the Regulations

We are proposing to revise § 483.70(a) to delete references to the 1967, 1973, and 1981 editions of the LSC.

We are proposing to revise the following regulations applicable to the specified facilities to clarify that the facility must be in compliance with Chapter 19.2.9, Emergency Lighting, beginning March 13, 2006. In addition, we would also specify that, beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 (concerning roller latches), does not apply to the facility.

a. For religious nonmedical health care institutions: § 403.744(a) and (c).

b. For hospices, § 418.100(d)(1), (d)(4), and new (d)(5).

c. For PACE programs, § 460.72(b)(1)(i), (b)(3), and new (b)(4).

d. For hospitals, § 482.41(b).

e. For long-term care facilities, § 483.70(a).

f. For ICF/MRs, § 483.470(j).

g. For CAHs, § 485.623(d)(1), (d)(5), and new (d)(6).

IX. MedPAC Recommendations

[If you choose to comment on issues in this section, please include the caption ''MedPAC Recommendations'' at the beginning of your comment.]

We are required by section 1886(e)(4)(B) of the Act to respond to MedPAC's IPPS recommendations in our annual proposed IPPS rule. We have reviewed MedPAC's March 1, 2004 ''Report to the Congress: Medicare Payment Policy'' and have given it careful consideration in conjunction with the proposals set forth in this document. For further information relating specifically to the MedPAC report or to obtain a copy of the report, contact MedPAC at (202) 653–7220, or visit MedPAC's Web site at: *www.medpac.gov.*

We note that MedPAC's recommendations in its March 1, 2004 report included only one recommendation concerning Medicare inpatient hospital payment policies. MedPAC's Recommendation 3A–1 states that Congress should increase payment rates for the IPPS by the projected rate of increase in the hospital market basket for FY 2005. We note that section 501(a)(3) of Public Law 108–173 requires that the payment rates for the IPPS be increased by the market basket percentage increase for all hospitals during FYs 2005, 2006, and 2007, except that it also provides for reducing the update by 0.4 percentage points for any hospital that fails to submit data on a list of 10 quality indicators. We discuss this recommendation further in Appendix B of this proposed rule in the context of our recommendation concerning the update factor for inpatient hospital operating costs and for hospitals and hospital distinct-part units excluded from the IPPS.

X. Other Required Information

A. Requests for Data From the Public

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

1. CMS Wage Data

This file contains the hospital hours and salaries for FY 2001 used to create the proposed FY 2005 prospective payment system wage index. The file will be available by the beginning of February for the NPRM and the beginning of May for the final rule.

Processing year	Wage data year	PPS fiscal year
2004	2001	2005
2003	2000	2004
2002	1999	2003
2001	1998	2002
2000	1997	2001
1999	1996	2000
1998	1995	1999
1997	1994	1998
1996	1993	1997
1995	1992	1996
1994	1991	1995
1993	1990	1994
1992	1989	1993
1991	1988	1992

These files support the following:

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

Media: Diskette/most recent year on the Internet.

File Cost: $165.00 per year.

Periods Available: FY 2005 PPS Update.

2. CMS Hospital Wages Indices (Formerly: Urban and Rural Wage Index Values Only)

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

Media: Diskette/most recent year on the Internet.

File Cost: $165.00 per year.

Periods Available: FY 2005 PPS Update.

3. PPS SSA/FIPS MSA State and County Crosswalk

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

Media: Diskette/Internet.

File Cost: $165.00 per year.

Periods Available: FY 2005 PPS Update.

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

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

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

Media: Diskette/Internet.

File Cost: $165.00 per year.
Periods Available: FY 2005 PPS Update.

5. PPS–IV to PPS–XII Minimum Data Set

The Minimum Data Set contains cost, statistical, financial, and other information from Medicare hospital cost reports. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare participating hospital by the Medicare fiscal intermediary to CMS. 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.
File Cost: $770.00 per year.

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

(**Note:** The PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, and PPS–XIX Minimum Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, and PPS–XIX Hospital Data Set Files (refer to item 7 below).)

6. 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 CMS. 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.
File Cost: $770.00 per year.

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

(**Note:** The PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, and PPS–XIX Capital Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, and PPS–XIX Hospital Data Set Files (refer to item 7 below).)

7. PPS–XIII to PPS–XIX Hospital Data Set

The file contains cost, statistical, financial, and other data from the Medicare Hospital Cost Report. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare-certified hospital by the Medicare fiscal intermediary to CMS. The data set is updated at the end of each calendar quarter and is available on the last day of the following month.
Media: Diskette/Internet.
File Cost: $2,500.00.

	Periods beginning on or after	and before.
PPS–XIII	10/01/95	10/01/96.
PPS–XIV	10/01/96	10/01/97.
PPS–XV	10/01/97	10/01/98.
PPS–XVI	10/01/98	10/01/99.
PPS–XVII	10/01/99	10/01/00.
PPS–XVIII ...	10/01/00	10/01/01.
PPS–XIX	10/01/01	10/01/02

8. Provider-Specific File

This file is a component of the PRICER program used in the fiscal intermediary's system to compute DRG payments for individual bills. The file contains records for all prospective payment system eligible hospitals, including hospitals in waiver States, and data elements used in the prospective payment system recalibration processes and related activities. Beginning with December 1988, the individual records were enlarged to include pass-through per diems and other elements.
Media: Diskette/Internet.
File Cost: $265.00.
Periods Available: FY 2005 PPS Update.

9. CMS Medicare Case-Mix Index File

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

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

Media: Diskette/most recent year on Internet.
Price: $165.00 per year/per file.
Periods Available: FY 1985 through FY 2005.

10. DRG Relative Weights (Formerly Table 5 DRG)

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

- NPRM.
- Final rule.

Media: Diskette/Internet.
File Cost: $165.00.
Periods Available: FY 2005 PPS Update.

11. PPS Payment Impact File

This file contains data used to estimate payments under Medicare's hospital inpatient prospective payment systems for operating and capital-related costs. The data are taken from various sources, including the Provider-Specific File, Minimum Data Sets, and prior impact files. The data set is abstracted from an internal file used for the impact analysis of the changes to the prospective payment systems published in the **Federal Register**. This file is available for release 1 month after the proposed and final rules are published in the **Federal Register**.
Media: Diskette/Internet.
File Cost: $165.00.
Periods Available: FY 2005 PPS Update.

12. AOR/BOR Tables

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

Two versions of this file are created each year. They support the following:

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

Media: Diskette/Internet.
File Cost: $165.00.
Periods Available: FY 2005 PPS Update.

13. Prospective Payment System (PPS) Standardizing File

This file contains information that standardizes the charges used to

calculate relative weights to determine payments under the prospective payment system. Variables include wage index, cost-of-living adjustment (COLA), case-mix index, disproportionate share, and the Metropolitan Statistical Areas (MSAs). The file supports the following:

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

Media: Internet.

File Cost: No charge.

Periods Available: FY 2005 PPS Update.

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

Commenters interested in obtaining or discussing any other data used in constructing this rule should contact James Hart at (410) 786–9520.

B. Collection of Information Requirements

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

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

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

The following information collection requirements in this proposed rule and the associated burdens are subject to the PRA.

Section 412.22 Excluded Hospitals and Hospital Units: General Rules

In summary, this section outlines the requirements for excluded hospitals and hospital units. This section states that a LTCH that occupies space in a building used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital must notify its fiscal intermediary and CMS in writing of its co-location.

The collection requirement has not changed. While this requirement is subject to the PRA, this requirement is currently approved in OMB No. 0938–0897, with a current expiration date of July 31, 2006.

Section 412.25 Excluded Hospital Units: Common Requirements

In summary, this section proposes to apply the excluded hospital unit requirements to psychiatric or rehabilitation CAH units that are now permitted under the provisions of Public Law 108–173. This section states that if a psychiatric rehabilitation unit of a CAH does not meet the applicable requirements, payment will not be made and will resume only after the unit has demonstrated to CMS that it meets the applicable requirements.

We believe the collection requirements are exempt as defined in 5 CFR 1320.4, information collections conducted or sponsored during the conduct of a criminal or civil action, or during the conduct of an administrative action or investigation, or audit. We also believe the collection requirements to be exempt as defined in 5 CFR 1320.3(c)(4) because we believe this would affect less than 10 persons.

Section 412.64 Federal Rates for Inpatient Operating Costs for Federal Fiscal Years 2005 and Subsequent Fiscal Years

In summary, this section outlines the proposed requirements and process for determining the adjustment of the wage index to account for the commuting patterns of hospital workers. This section states that a hospital may waive the application of the wage index adjustment by notifying CMS in writing within 45 days after the publication of the annual notice of proposed rulemaking for the IPPS.

The burden associated with this requirement is the time and effort for the hospital to prepare a written notice asking to waive the application of the wage index adjustment and send the notice to CMS.

The burden associated with this requirement is estimated to be 30 minutes per hospital. Therefore, we estimate it would take 5 total annual hours (30 minutes × 10 hospitals seeking a waiver).

Section 412.103 Special Treatment: Hospitals Located in Urban Areas and That Apply for Reclassification as Rural

In summary, this section outlines the requirements and process for a rural hospital to become reclassified. This section states that a prospective payment hospital that is located in an urban area may be reclassified as a rural hospital if it submits an application in accordance with this section.

We are proposing to revise this section; however, the collection requirement remains the same. While this requirement is subject to the PRA, this requirement is currently approved in OMB No. 0938–0573, with a current expiration date of October 31, 2005.

Section 412.101 Special Treatment: Inpatient Hospital Payment Adjustment for Low-Volume Hospitals

In summary, this section outlines the proposed requirements for determining a payment adjustment for low-volume hospitals. This section states that in order to qualify for the higher incremental costs adjustment, the hospital must provide its fiscal intermediary with evidence that it meets the distance requirement to make a determination that the hospital meets the distance requirement specified in this section.

The burden associated with this requirement is the time and effort for the hospital to provide the fiscal intermediary with evidence that it meets the specified distance requirement.

The burden associated with this requirement is estimated to be 1 hour per hospital. Therefore, we estimate it would take 500 total annual hours (1 hour × 500 hospitals seeking the incremental costs adjustment).

Section 412.211 Puerto Rico Rates for Federal Fiscal Year 2004 and Subsequent Fiscal Years

In summary, this section outlines the requirements and process for determining the adjusted prospective payment rate for inpatient hospital services in Puerto Rico. This section states that a hospital may waive the application of the proposed wage index adjustment for commuting hospital employees by notifying CMS in writing within 45 days after the publication of the annual notice of proposed rulemaking for the inpatient prospective payment system.

The burden associated with this requirement is the time and effort for the hospital to prepare a written notice asking to waive the application of the wage index adjustment and send the notice to CMS.

The burden associated with this requirement is estimated to be 30 minutes per hospital. Therefore, we estimate it would take 5 total annual hours (30 minutes × 10 hospitals seeking a waiver).

Section 412.234 Criteria for All Hospitals in an Urban County Seeking Redesignation to Another Urban Area

In summary, this section outlines the requirements for determining an urban hospital's redesignation to another urban area. This section states that hospitals must submit appropriate wage data to the fiscal intermediary as outlined.

We are proposing to revise this section. However, the collection requirement remains the same. While this requirement is subject to the PRA, this requirement is currently approved in OMB No.0938–0907, with a current expiration date of December 31, 2005.

Section 413.70 Payment for Services of a CAH

In summary, this section outlines the requirements for a CAH to make an election to be paid for outpatient facility services plus the fee schedule for professional services under an optional single payment method. This section states that a CAH may make this election in any cost reporting period. This election must be made in writing, made on an annual basis, and delivered to the fiscal intermediary servicing the CAH at least 30 days before the start of each affected cost reporting period.

We are proposing to revise this section. However, the collection requirement remains the same. While this requirement is subject to the PRA, this requirement is currently approved in OMB No. 0938–0050, with a current expiration date of November 30, 2005.

Section 413.78 Direct GME Payments: Determinations of the Total Number of FTE Residents

In summary, this section outlines the requirements for the determination of the total number of FTE residents in determining direct GME payments to hospitals. Currently, this section states that, for residents who spend time in nonprovider settings, there must be a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital. This section proposes to remove the written agreement requirement.

This requirement is exempt from the PRA in accordance with Public Law 99–272 or Public Law 108–173, or both.

Section 413.79 Direct GME Payments: Determination of the Weighted Number of FTE Residents

In summary, this section outlines the requirements for the determination of the weighted number of FTE residents for direct GME payments to hospitals. This section proposes that a hospital seeking an adjustment to the limit on its unweighted resident count under section 422 of Public Law 108–173 must provide documentation justifying the adjustment. In addition, the section states that a hospital wishing to receive a temporary adjustment to its FTE resident cap because it is participating in a Medicare GME affiliated group must submit the Medicare GME affiliation agreement to the CMS fiscal intermediary and to CMS's Central Office. This section specifies the information that a request must contain.

These requirements are exempt from the PRA in accordance with Public Law 99–272 or Public Law 108–173, or both.

Section 413.80 Determination of Weighting Factors for Foreign Medical Graduates

In summary, this section specifies the information that a hospital must submit to the fiscal intermediary to include foreign medical graduates in its FTE count for a particular cost reporting period.

This requirement is exempt from the PRA in accordance with Public Law 99–272 or Public Law 108–173, or both.

Section 413.83 Adjustment of a Hospital's Target Amount or Prospective Payment Hospital-Specific Rate

In summary, this section outlines the requirements for seeking an adjustment to the hospital's target amount or hospital-specific rate. This section states that a hospital may request that the intermediary review the classification of operating costs that were previously misclassified for purposes of adjusting the hospital's target amount or hospital-specific rate. A hospital's request for review must include sufficient documentation demonstrating that an adjustment is warranted. This section also specifies the terms in which the information should be provided.

This requirement is exempt from the PRA in accordance with Public Law 99–272 or Public Law 108–173, or both.

Section 480.106 Exceptions to QIO Notice Requirements

In summary, we are proposing to revise this section to add exceptions to the notice requirements for disclosure of QIO information to any person, agency, or organization. The notice requirements would not apply if the institution or practitioner has requested, in writing, that the QIO make the disclosure; the institution or practitioner has provided, in writing, consent for the disclosure; or the information is public information.

The burden associated with these requirements is the time and effort for the institution or practitioner to provide a written request that the QIO make the disclosure or consent to the disclosure.

We believe the collection requirements are exempt as defined in 5 CFR 1320.4, information collections conducted or sponsored during the conduct of a criminal or civil action, or during the conduct of an administrative action or investigation, or audit. We also believe the collection requirements to be exempt as defined in 5 CFR 1320.3(c)(4) because we believe this would affect less than 10 persons.

Section 480.133 Disclosure of Information about Practitioners, Reviewers and Institutions

In summary, this section outlines the requirements concerning the disclosure of QIO information about practitioners, reviewers, and institutions. This section states that a QIO may disclose information on a particular practitioner or reviewer at the written request of or with the written consent of that practitioner or reviewer, with the recipient subject to the same rights and responsibilities on redisclosure as the requesting or consenting practitioner or reviewer.

We believe the collection requirements are exempt as defined in 5 CFR 1320.4, information collections conducted or sponsored during the conduct of a criminal or civil action, or during the conduct of an administrative action or investigation, or audit. We also believe the collection requirements to be exempt as defined in 5 CFR 1320.3(c)(4) because we believe this would affect less than 10 persons.

Section 480.140 Disclosure of Quality Review Study Information

In summary, this section outlines the requirements concerning the disclosure of quality review study information. This section states that a QIO may disclose quality review study information with identifiers of particular practitioners or institutions, or both, at the written request of, or with the written consent of, the identified practitioner(s) or institution(s). The consent or request must specify the information that is to be disclosed and the intended recipient of the information. The recipient would be subject to the same rights and responsibilities on redisclosure as the requesting or consenting practitioner or institution.

We believe the collection requirements are exempt as defined in 5 CFR 1320.4, information collections conducted or sponsored during the

conduct of a criminal or civil action, or during the conduct of an administrative action or investigation, or audit. We also believe the collection requirements to be exempt as defined in 5 CFR 1320.3(c)(4) because we believe this would affect less than 10 persons.

Section 482.43 Condition of Participation: Discharge Planning

In summary, this section outlines the requirements of the discharge planning process. This section states that the hospital must include in the discharge plan, a list of HHAs or SNFs that are available to the patient, that participate in the Medicare program, that serve the geographic area, and that request to be listed by the hospital as available and to maintain documentation. This section also specifies other information that the discharge plan must contain.

The burden associated with these requirements is the time and effort for the hospital to provide a list to beneficiaries, for whom home health care or posthospital extended care services are necessary, and document the patient's medical record.

The burden associated with these requirements is estimated to be 5 minutes per hospital per discharge. Therefore, we estimate the total national burden to be 327,684 hours annually to comply with these requirements (652 discharges per hospital per year × 6,031 hospitals × 5 minutes each).

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements described above. These requirements are not effective until they have been approved by OMB.

If you comment on any of these information collection and record keeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development and Issuances Group, Attn: Dawn Willinghan, CMS–1428–P, Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850; and Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, CMS Desk Officer.

Comments submitted to OMB may also be e-mailed to the following address: e-mail: *baguilar@omb.eop.gov,* or faxed to OMB at (202) 395–6974.

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.

CROSSWALK OF CONTENTS OF § 413.86

Existing section	Proposed new section.
§ 413.86(a)	§ 413.75(a).
§ 413.86(a)(1)	§ 413.75(a)(1).
§ 413.86(a)(2)	§ 413.75(a)(2).
§ 413.86(b)	§ 413.75(b).
§ 413.86(c)	§ 413.75(c).
§ 413.86(d)	§ 413.76.
§ 413.86(d), introductory text	§ 413.76, introductory text.
§ 413.86(d)(1)	§ 413.76(a).
§ 413.86(d)(2)	§ 413.76(b).
§ 413.86(d)(3)	§ 413.76(c).
§ 413.86(d)(3)(i)	§ 413.76(c)(1).
§ 413.86(d)(3)(ii)	§ 413.76(c)(2).
§ 413.86(d)(3)(iii)	§ 413.76(c)(3).
§ 413.86(d)(3)(iv)	§ 413.76(c)(4).
§ 413.86(d)(3)(v)	§ 413.76(c)(5).
§ 413.86(d)(4)	§ 413.76(d).
§ 413.86(d)(5)	§ 413.76(e).
§ 413.86(d)(5)(i)	§ 413.76(e)(1).
§ 413.86(d)(5)(ii)	§ 413.76(e)(2).
§ 413.86(d)(6)	§ 413.76(f).
§ 413.86(e)	§ 413.77.
§ 413.86(e)(1)	§ 413.77(a).
§ 413.86(e)(1)(i)	§ 413.77(a)(1).
§ 413.86(e)(1)(i)(A)	§ 413.77(a)(1)(i).
§ 413.86(e)(1)(i)(B)	§ 413.77(a)(1)(ii).
§ 413.86(e)(1)(ii)	§ 413.77(a)(2).
§ 413.86(e)(1)(ii)(A)	§ 413.77(a)(2)(i).
§ 413.86(e)(1)(ii)(B)	§ 413.77(a)(2)(ii).
§ 413.86(e)(1)(ii)(C)	§ 413.77(a)(2)(iii).
§ 413.86(e)(1)(iii)	§ 413.77(a)(3).
§ 413.86(e)(1)(iv)	§ 413.77(a)(4).
§ 413.86(e)(1)(v)	§ 413.77(a)(5).
§ 413.86(e)(2), introductory text	§ 413.77(b), introductory text.
§ 413.86(e)(2)(i)	§ 413.77(b)(1).
§ 413.86(e)(2)(ii)	§ 413.77(b)(2).
§ 413.86(e)(3), introductory text	§ 413.77(c), introductory text.
§ 413.86(e)(3)(i)	§ 413.77(c)(1).
§ 413.86(e)(3)(ii)	§ 413.77(c)(2).
§ 413.86(e)(4), introductory text	§ 413.77(d), introductory text—NEW.
§ 413.86(e)(4)(i), introductory text	§ 413.77(d)(1), introductory text.
§ 413.86(e)(4)(i)(A), introductory text	§ 413.77(d)(1)(i), introductory text.
§ 413.86(e)(4)(i)(A)(*1*)	§ 413.77(d)(1)(i)(A).

CROSSWALK OF CONTENTS OF § 413.86—Continued

Existing section	Proposed new section.
§ 413.86(e)(4)(i)(A)(*2*)	§ 413.77(d)(1)(i)(B).
§ 413.86(e)(4)(i)(A)(*3*)	§ 413.77(d)(1)(i)(C).
§ 413.86(e)(4)(i)(B)	§ 413.77(d)(1)(ii).
§ 413.86(e)(4)(ii), introductory text	§ 413.77(d)(2), introductory text—NEW.
§ 413.86(e)(4)(ii)(A)	§ 413.77(d)(2)(i).
§ 413.86(e)(4)(ii)(B)	§ 413.77(d)(2)(ii).
§ 413.86(e)(4)(ii)(C), introductory text	§ 413.77(d)(2)(iii), introductory text.
§ 413.86(e)(4)(ii)(C)(*1*)	§ 413.77(d)(2)(iii)(A).
§ 413.86(e)(4)(ii)(C)(*1*)(*i*)	§ 413.77(d)(2)(iii)(A)(*1*).
§ 413.86(e)(4)(ii)(C)(*1*)(*ii*)	§ 413.77(d)(2)(iii)(A)(*2*).
§ 413.86(e)(4)(ii)(C)(*1*)(*iii*)	§ 413.77(d)(2)(iii)(A)(*3*).
§ 413.86(e)(4)(ii)(C)(*2*), introductory text	§ 413.77(d)(2)(iii)(B), introductory text—NEW.
§ 413.86(e)(4)(ii)(C)(*2*)(*i*)	§ 413.77(d)(2)(iii)(B)(*1*).
§ 413.86(e)(4)(ii)(C)(*2*)(*ii*)	§ 413.77(d)(2)(iii)(B)(*2*).
§ 413.86(e)(4)(ii)(C)(*2*)(*iii*)	§ 413.77(d)(2)(iii)(B)(*3*)—NEW.
§ 413.86(e)(4)(ii)(C)(*2*)(*iv*)	§ 413.77(d)(2)(iii)(B)(*4*)—NEW.
	§ 413.77(d)(2)(iiii)(B)(*5*)—NEW.
§ 413.86(e)(4)(ii)(C)(*3*)	§ 413.77(d)(2)(iii)(C)—NEW.
§ 413.86(e)(5)	§ 413.77(e).
§ 413.86(e)(5)(i)	§ 413.77(e)(1).
§ 413.86(e)(5)(i)(A)	§ 413.77(e)(1)(i).
§ 413.86(e)(5)(i)(B), introductory text	§ 413.77(e)(1)(ii), introductory text.
§ 413.86(e)(5)(i)(B)(*1*)	§ 413.77(e)(1)(ii)(A).
§ 413.86(e)(5)(i)(B)(*2*)	§ 413.77(e)(1)(ii)(B).
§ 413.86(e)(5)(i)(C)	§ 413.77(e)(1)(iii).
§ 413.86(e)(5)(ii)	§ 413.77(e)(2).
§ 413.86(e)(5)(iii)	§ 413.77(e)(3).
	§ 413.77(f)—NEW.
§ 413.86(f)	§ 413.78.
§ 413.86(f), introductory text	§ 413.78, introductory text.
§ 413.86(f)(1)	§ 413.78(a).
§ 413.86(f)(2)	§ 413.78(b).
§ 413.86(f)(3), introductory text	§ 413.78(c), introductory text.
§ 413.86(f)(3)(i)	§ 413.78(c)(1).
§ 413.86(f)(3)(ii)	§ 413.78(c)(2).
§ 413.86(f)(4), introductory text	§ 413.78(d), introductory text.
§ 413.86(f)(4)(i)	§ 413.78(d)(1).
§ 413.86(f)(4)(ii)	§ 413.78(d)(2).
§ 413.86(f)(4)(iii)	§ 413.78(d)(3).
§ 413.86(f)(4)(iv)	§ 413.78(d)(4).
	§ 413.78(e), introductory text—NEW.
	§ 413.78(e)(1)—NEW.
	§ 413.78(e)(2)—NEW.
	§ 413.78(e)(3)—NEW.
§ 413.86(g), introductory text	§ 413.79.
§ 413.86(g), introductory text	§ 413.79, introductory text.
§ 413.86(g)(1)	§ 413.79(a).
§ 413.86(g)(1)	§ 413.79(a) introductory text—NEW.
§ 413.86(g)(1)	§ 413.79(a)(1)—NEW.
§ 413.86(g)(1)	§ 413.79(a)(2)—NEW.
§ 413.86(g)(1)	§ 413.79(a)(3)—NEW.
§ 413.86(g)(1)	§ 413.79(a)(4)—NEW.
§ 413.86(g)(1)	§ 413.79(a)(5)—NEW.
§ 413.86(g)(1)(i)	§ 413.79(a)(6).
§ 413.86(g)(1)(ii)	§ 413.79(a)(7).
§ 413.86(g)(1)(iii), introductory text	§ 413.79(a)(8), introductory text.
§ 413.86(g)(1)(iii)(A)	§ 413.79(a)(8)(i).
§ 413.86(g)(1)(iii)(B)	§ 413.79(a)(8)(ii).
§ 413.86(g)(1)(iv)	§ 413.79(a)(9).
§ 413.86(g)(2)	§ 413.79(b)(1).
§ 413.86(g)(3)	§ 413.79(b)(2).
	§ 413.79(c)(1), introductory text—NEW.
	§ 413.79(c)(1)(i) through (iii)—NEW.
§ 413.86(g)(4), introductory text	§ 413.79(c)(2), introductory text.
§ 413.86(g)(4)(i)	§ 413.79(c)(2)(i).
§ 413.86(g)(4)(ii)	§ 413.79(c)(2)(ii).
§ 413.86(g)(4)(iii)	§ 413.79(c)(2)(iii).
§ 413.86(g)(4)(iv)	§ 413.79(c)(2)(iv).
§ 413.86(g)(4)(v)	§ 413.79(c)(2)(v).
	§ 413.79(c)(3)(i) through (ii)—NEW.
	§ 413.79(c)(4)—NEW.
	§ 413.79(c)(5)—NEW.

CROSSWALK OF CONTENTS OF § 413.86—Continued

Existing section	Proposed new section.
§ 413.86(g)(5), introductory text	§ 413.79(d), introductory text.
§ 413.86(g)(5)(i)	§ 413.79(d)(1).
§ 413.86(g)(5)(ii)	§ 413.79(d)(2).
§ 413.86(g)(5)(iii)	§ 413.79(d)(3).
§ 413.86(g)(5)(iv)	§ 413.79(d)(4).
§ 413.86(g)(5)(v)	§ 413.79(d)(5).
§ 413.86(g)(5)(vi)	§ 413.79(d)(6).
§ 413.86(g)(5)(vii)	§ 413.79(d)(7).
§ 413.86(g)(6), introductory text	§ 413.79(e), introductory text.
§ 413.86(g)(6)(i)	§ 413.79(e)(1).
§ 413.86(g)(6)(i)(A)	§ 413.79(e)(1)(i).
§ 413.86(g)(6)(i)(B)	§ 413.79(e)(1)(ii).
§ 413.86(g)(6)(i)(C)	§ 413.79(e)(1)(iii).
§ 413.86(g)(6)(i)(D)	§ 413.79(e)(1)(iv).
§ 413.86(g)(6)(i)(E)	§ 413.79(e)(1)(v).
§ 413.86(g)(6)(ii), introductory text	§ 413.79(e)(2), introductory text.
§ 413.86(g)(6)(ii)(A)	§ 413.79(e)(2)(i).
§ 413.86(g)(6)(ii)(B)	§ 413.79(e)(2)(ii).
§ 413.86(g)(6)(iii)	§ 413.79(e)(3).
§ 413.86(g)(6)(iv)	§ 413.79(e)(4).
§ 413.86(g)(7)	§ 413.79(f).
§ 413.86(g)(7)(i)	§ 413.79(f)(1).
§ 413.86(g)(7)(ii)	§ 413.79(f)(2).
§ 413.86(g)(7)(iii)	§ 413.79(f)(3).
§ 413.86(g)(7)(iv)	§ 413.79(f)(4).
§ 413.86(g)(7)(v)	§ 413.79(f)(5).
§ 413.86(g)(8), introductory text	§ 413.79(g), introductory text.
§ 413.86(g)(8)(i), introductory text	§ 413.79(g)(1), introductory text.
§ 413.86(g)(8)(i)(A)	§ 413.79(g)(1)(i).
§ 413.86(g)(8)(i)(B)	§ 413.79(g)(1)(ii).
§ 413.86(g)(8)(ii)	§ 413.79(g)(2).
§ 413.86(g)(8)(iii)	§ 413.79(g)(3).
§ 413.86(g)(8)(iv)	§ 413.79(g)(4).
§ 413.86(g)(8)(v)	§ 413.79(g)(5).
§ 413.86(g)(9)	§ 413.79(h).
§ 413.86(g)(9)(i), introductory text	§ 413.79(h)(1), introductory text.
§ 413.86(g)(9)(i)(A)	§ 413.79(h)(1)(i).
§ 413.86(g)(9)(i)(B)	§ 413.79(h)(1)(ii).
§ 413.86(g)(9)(ii), introductory text	§ 413.79(h)(2), introductory text.
§ 413.86(g)(9)(ii)(A)	§ 413.79(h)(2)(i).
§ 413.86(g)(9)(ii)(B)	§ 413.79(h)(2)(ii).
§ 413.86(g)(9)(iii), introductory text	§ 413.79(h)(3), introductory text.
§ 413.86(g)(9)(iii)(A), introductory text	§ 413.79(h)(3)(i), introductory text.
§ 413.86(g)(9)(iii)(A)(*1*)	§ 413.79(h)(3)(i)(A).
§ 413.86(g)(9)(iii)(A)(*2*)	§ 413.79(h)(3)(i)(B).
§ 413.86(g)(9)(iii)(B), introductory text	§ 413.79(h)(3)(ii), introductory text.
§ 413.86(g)(9)(iii)(B)(*1*)	§ 413.79(h)(3)(ii)(A).
§ 413.86(g)(9)(iii)(B)(*2*)	§ 413.79(h)(3)(ii)(B).
§ 413.86(g)(10), introductory text	§ 413.79(i), introductory text.
§ 413.86(g)(10)(i)	§ 413.79(i)(1).
§ 413.86(g)(10)(ii)	§ 413.79(i)(2).
§ 413.86(g)(10)(iii)	§ 413.79(i)(3).
§ 413.86(g)(11), introductory text	§ 413.79(j), introductory text.
§ 413.86(g)(11)(i)	§ 413.79(j)(1).
§ 413.86(g)(11)(ii)	§ 413.79(j)(2).
§ 413.86(g)(11)(iii)	§ 413.79(j)(3).
§ 413.86(g)(12), introductory text	§ 413.79(k), introductory text.
§ 413.86(g)(12)(i), introductory text	§ 413.79(k)(1), introductory text.
§ 413.86(g)(12)(i)(A)	§ 413.79(k)(1)(i).
§ 413.86(g)(12)(i)(B)	§ 413.79(k)(1)(ii).
§ 413.86(g)(12)(ii), introductory text	§ 413.79(k)(2), introductory text.
§ 413.86(g)(12)(ii)(A)	§ 413.79(k)(2)(i).
§ 413.86(g)(12)(ii)(B), introductory text	§ 413.79(k)(2)(ii), introductory text.
§ 413.86(g)(12)(ii)(B)(*1*), introductory text	§ 413.79(k)(2)(ii)(A), introductory text.
§ 413.86(g)(12)(ii)(B)(*1*)(*i*)	§ 413.79(k)(2)(ii)(A)(*1*).
§ 413.86(g)(12)(ii)(B)(*1*)(*ii*)	§ 413.79(k)(2)(ii)(A)(*2*).
§ 413.86(g)(12)(ii)(B)(*2*)	§ 413.79(k)(2)(ii)(B).
§ 413.86(g)(12)(iii)	§ 413.79(k)(3).
§ 413.86(g)(12)(iv), introductory text	§ 413.79(k)(4), introductory text.
§ 413.86(g)(12)(iv)(A)	§ 413.79(k)(4)(i).
§ 413.86(g)(12)(iv)(B), introductory text	§ 413.79(k)(4)(ii), introductory text.
§ 413.86(g)(12)(iv)(B)(*1*)	§ 413.79(k)(4)(ii)(A).

CROSSWALK OF CONTENTS OF § 413.86—Continued

Existing section	Proposed new section.
§ 413.86(g)(12)(iv)(B)(*2*)	§ 413.79(k)(4)(ii)(B).
§ 413.86(g)(12)(v), introductory text	§ 413.79(k)(5), introductory text.
§ 413.86(g)(12)(v)(A)	§ 413.79(k)(5)(i).
§ 413.86(g)(12)(v)(B)	§ 413.79(k)(5)(ii).
§ 413.86(g)(12)(v)(C)	§ 413.79(k)(5)(iii).
§ 413.86(g)(12)(vi)	§ 413.79(k)(6).
§ 413.86(g)(13)	§ 413.79(l).
§ 413.86(h)	§ 413.80.
§ 413.86(h)(1), introductory text	§ 413.80(a), introductory text.
§ 413.86(h)(1)(i)	§ 413.80(a)(1).
§ 413.86(h)(1)(ii)	§ 413.80(a)(2).
§ 413.86(h)(2)	§ 413.80(b).
§ 413.86(h)(3)	§ 413.80(c).
§ 413.86(h)(4)	§ 413.80(d).
§ 413.86(h)(5)	§ 413.80(e).
§ 413.86(h)(6)	§ 413.80(f).
§ 413.86(i)	§ 413.81.
§ 413.86(i)(1), introductory text	§ 413.81(a), introductory text.
§ 413.86(i)(1)(i)	§ 413.81(a)(1).
§ 413.86(i)(1)(ii)	§ 413.81(a)(2).
§ 413.86(i)(2)	§ 413.81(b).
§ 413.86(i)(3)(i)	§ 413.81(c)(1).
§ 413.86(i)(3)(ii)	§ 413.81(c)(2).
§ 413.86(j), introductory text	§ 413.80(g), introductory text.
§ 413.86(j)(1)	§ 413.80(g)(1).
§ 413.86(j)(2)	§ 413.80(g)(2).
§ 413.86(j)(3)	§ 413.80(g)(3).
§ 413.86(j)(4)	§ 413.80(g)(4).
§ 413.86(j)(5)	§ 413.80(g)(5).
§ 413.86(j)(6)	§ 413.80(g)(6).
§ 413.86(j)(7)	§ 413.80(g)(7).
§ 413.86(k)	§ 413.82.
§ 413.86(k)(1)	§ 413.82(a).
§ 413.86(k)(2)	§ 413.82(b).
§ 413.86(k)(3)	§ 413.82(c).
§ 413.86(l)	§ 413.83.
§ 413.86(l)(1)	§ 413.83(a).
§ 413.86(l)(1)(i)	§ 413.83(a)(1).
§ 413.86(l)(1)(ii)	§ 413.83(a)(2).
§ 413.86(l)(2)(iii)	§ 413.83(a)(3).
§ 413.86(l)(2)	§ 413.83(b).
§ 413.86(l)(2)(i)	§ 413.83(b)(1).
§ 413.86(l)(2)(ii)	§ 413.83(b)(2).
§ 413.86(l)(2)(iii)	§ 413.83(b)(3).

Note to Readers: Proposed redesignated §§ 413.77, 413.78 and 413.79 are the only three sections of the proposed redesignated §§ 413.75 through 413.83 that contain proposed policy changes, as discussed in section IV. O. of the preamble of this proposed rule. Therefore, we will only consider public comments on the following paragraphs of the proposed redesignated sections:

- Sections 413.77(d) introductory text, (d)(2), (d)(2)(iii)(B), (d)(2)(iii)(B)(*3*), (d)(2)(iii)(B)(*4*), (d)(2)(iii)(B)(*5*), (d)(2)(iii)(C), and (f).
- Sections 413.78(e), (e)(1), (e)(2), and (e)(3).
- Section 413.79(a), (c)(1), (c)(2), (c)(3), (c)(4), and (c)(5).

The remaining portions of the proposed redesignated §§ 413.75 through 413.83 contain only coding, cross-reference, and conforming redesignation changes. For these remaining portions, we will consider comments on redesignation, coding, and cross-reference changes only.

List of Subjects

42 CFR Part 403

Health insurance, Hospitals, Incorporation by reference, Intergovernmental relations, Medicare, Reporting and recordkeeping requirements.

2 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 418

Health facilities, Hospice care, Incorporation by reference, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 460

Aged, Health, Incorporation by reference, Medicare, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 480

Medicare Program; Utilization and quality control, Quality Improvement Organizations (QIOs).

42 CFR Part 482

Grant program-health, Hospitals, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 483

Grant program-health, Health facilities, Health professions, Health records, Medicaid, Medicare, Nursing

homes, Nutrition, Reporting and recordkeeping requirements, Safety.

42 CFR Part 485

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

42 CFR Part 489

Health facilities, Medicare, Reporting and record keeping requirements.

For the reasons stated in the preamble of this proposed rule, the Centers for Medicare & Medicaid Services is proposing to amend 42 CFR chapter IV as follows:

A. Part 403 is amended as follows:

PART 403—SPECIAL PROGRAMS AND PROJECTS

1. The authority citation for part 403 continues to read as follows:

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

2. Section 403.744 is amended by—

A. Revising paragraph (a)(1).

B. Revising paragraph (c).

C. Removing paragraph (c)(1) and paragraph (c)(2).

The revision reads as follows:

§ 403.744 Condition of Participation: Life safety from fire.

(a) *General.* An RNHCI must meet the following conditions:

(1) Except as otherwise provided in this section—

(i) The RNHCI must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.* Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted Life Safety Code does not apply to an RNHCI.

* * * * *

(c) *Phase-in period.* Beginning March 13, 2006, an RNHCI must be in compliance with Chapter 19.2.9, Emergency Lighting. Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to RNHCIs.

B. Part 412 is 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).

2. Section 412.2 is amended by adding a new paragraph (b)(3) to read as follows:

§ 412.2 Basis for payment.

* * * * *

(b) *Payment in full.*

* * * * *

(3) If a patient is admitted to an acute care hospital and then the acute care hospital meets the criteria at § 412.23(e) to be paid as a LTCH, during the course of the patient's hospitalization, Medicare considers all the days of the patient stay in the facility (days prior to and after the designation of LTCH status) to be a single episode of LTCH care. Medicare will not make payment under subpart H for any part of the hospitalization. Payment for the entire patient stay (days prior to and after the designation of LTCH status) will be made in accordance with the requirements specified in § 412.521. The requirements of this paragraph (b)(3) apply only to a patient stay in which a patient is in an acute care hospital and that hospital is designated as a LTCH on or after October 1, 2004.

* * * * *

3. Section 412.4 is amended by revising paragraph (d) to read as follows:

§ 412.4 Discharges and transfers.

* * * * *

(d) *Qualifying DRGs.*

(1) For purposes of paragraph (c) of this section, and subject to the provisions of paragraph (d)(2) of this section, the qualifying DRGs must meet the following criteria for both of the 2 most recent fiscal years for which data are available:

(i) The DRG must have a geometric mean length of stay of at least 3 days.

(ii) The DRG must have at least 14,000 cases identified as postacute care transfer cases.

(iii) The DRG must have at least 10 percent of the postacute care transfers occurring before the geometric mean length of stay for the DRG.

(iv) If the DRG is one of a paired DRG based on the presence or absence of a comorbidity or complication, one of the DRGs meets the criteria specified under paragraphs (d)(1)(i) through (d)(1)(iii) of this section.

(v) To initially qualify, the DRG must meet the criteria specified in paragraphs(d)(1)(i) through (d)(1)(iv) of this section and must have a decline in the geometric mean length of stay for the DRG during the most recent 5-year period of at least 7 percent. Once a DRG initially qualifies, the DRG is subject to the criteria specified under paragraphs (d)(1)(i) through (d)(1)(iv) of this section for each subsequent fiscal year.

(2) Effective October 1, 2004, if a DRG fails to meet the qualifying criteria under paragraph (d)(1) of this section, the qualifying DRG must meet the following criteria for both of the 2 most recent fiscal years for which data are available:

(i) The DRG must have a geometric mean length stay of at least 3 days.

(ii) The DRG must have at least 5,000 cases identified as postacute care transfer cases.

(iii) The DRG must have a percentage of the postacute care transfer cases occurring before the geometric mean length of stay of at least 2 standard deviations above the geometric mean length of stay across all DRGs.

(iv) If the DRG is one of a paired DRG based on the presence or absence of a comorbidity or complication, one of the DRGs meets the criteria specified under paragraph (d)(2)(i) through (d)(2)(iii) of this section.

(v) To initially qualify, the DRG meets the criteria specified in paragraph (d)(2)(i) through (d)(2)(iv) of this section and must either have experienced a decline in its geometric mean length of stay during the most recent 5-year period of at least 7 percent, or contain only cases that would have been included in a DRG to which the policy applied in the prior year. Once a DRG initially qualifies, the DRG is subject to the criteria specified under paragraphs (d)(2)(i) through (d)(2)(iv) for each subsequent fiscal year.

* * * * *

4. Section 412.22 is amended by—

A. Adding a sentence at the end of paragraph (a).

B. Revising paragraph (e).

The addition and revision read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

(a) *Criteria.* * * * For purposes of this subpart, the term ''hospital'' includes a critical access hospital (CAH).

* * * * *

(e) *Hospitals-within-hospitals.* Except as provided in paragraph (f) of this section, a hospital that occupies space in a building also used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital, must meet the following criteria in order to be excluded from the prospective payment systems specified in § 412.1(a)(1):

(1) For cost reporting periods beginning on or after October 1, 1987, and before October 1, 2004—

(i) *Separate governing body.* The hospital has a governing body that is separate from the governing body of the hospital occupying space in the same building or on the same campus. The hospital's governing body is not under the control of the hospital occupying space in the same building or on the same campus, or of any third entity that controls both hospitals.

(ii) *Separate chief medical officer.* The hospital has a single chief medical officer who reports directly to the governing body and who is responsible for all medical staff activities of the hospital. The chief medical officer of the hospital is not employed by or under contract with either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(iii) *Separate medical staff.* The hospital has a medical staff that is separate from the medical staff of the hospital occupying space in the same building or on the same campus. The hospital's medical staff is directly accountable to the governing body for the quality of medical care provided in the hospital, and adopts and enforces by laws governing medical staff activities, including criteria and procedures for recommending to the governing body the privileges to be granted to individual practitioners.

(iv) *Chief executive officer.* The hospital has a single chief executive officer through whom all administration authority flows, and who exercises control and surveillance over all administrative activities of the hospital. The chief executive officer is not employed by, or under contract with, either the hospital occupying space in the same building or on the same campus or any third entity that controls both hospitals.

(v) *Performance of basic hospital functions.* The hospital meets one of the following criteria:

(A) The hospital performs the basic functions specified in §§ 482.21 through 482.27, 482.30, 482.42, 482.43, and 482.45 of this chapter through the use of employees or under contracts or other agreements with entities other than the hospital occupying space in the same building or on the same campus, or a third entity that controls both hospitals. Food and dietetic services and housekeeping, maintenance, and other services necessary to maintain a clean and safe physical environment could be obtained under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals.

(B) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of patients in § 412.23(d)(2) or the length-of-stay criterion in § 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for a period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the cost of the services that the hospital obtains under contracts or other agreements with the hospital occupying space in the same building or on the same campus, or with a third entity that controls both hospitals, is no more than 15 percent of the hospital's total inpatient operating costs, as defined in § 412.2(c). For purposes of this paragraph (e)(1)(v)(B), however, the costs of preadmission services are those specified under § 413.40(c)(2) rather than those specified under § 412.2(c)(5).

(C) For the same period of at least 6 months used to determine compliance with the criterion regarding the age of inpatients in § 412.23(d)(2) or the length-of-stay criterion in § 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for the period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the hospital has an inpatient population of whom at least 75 percent were referred to the hospital from a source other than another hospital occupying space in the same building or on the same campus.

(2) Effective for cost reporting periods beginning on or after October 1, 2004, the hospital must meet the following:

(i) *Governance and control requirements.* The hospital meets the criteria under paragraphs (e)(1)(i) through (e)(1)(iv) of this section.

(ii) *Ownership interest and control.* The hospital must not be owned, wholly or in part, by a person or party that has any ownership interest in the hospital occupying space in the same building or on the same campus, or of any third party entity that controls both hospitals. However, hospitals that were excluded from the prospective payment systems specified in § 412.1(a) as of June 30, 2004, will be deemed to these criteria.

(iii) *Admissions criteria.* For the same period of at least 6 months used to determine compliance with the criterion regarding the age of inpatients in § 412.23(d)(2) or the length-of-stay criterion in § 412.23(e)(2), or for hospitals other than children's or long-term care hospitals, for the period of at least 6 months immediately preceding the first cost reporting period for which exclusion is sought, the hospital has an inpatient population of whom at least 75 percent were referred to the hospital from a source other than another hospital occupying space in the same building or on the same campus.

(3) *Notification of co-located status.* A long-term care hospital that occupies space in a building used by another hospital, or in one or more separate buildings located on the same campus as buildings used by another hospital that meets the criteria of (e)(1) or (e)(2) of this section must notify its fiscal intermediary and CMS in writing of its co-location within 60 days of its first cost reporting period that begins on or after October 1, 2002.

* * * * *

5. Section 412.25 is amended by adding a new paragraph (g), to read as follows:

§ 412.25 Excluded hospital units: Common requirements.

* * * * *

(g) *CAH units not meeting applicable requirements.* If a psychiatric or rehabilitation unit of a CAH does not meet the requirements of § 485.645 with respect to a cost reporting period, no payment may be made to the CAH for services furnished in that unit for that period. Payment to the CAH for services in the unit may resume only after the unit has demonstrated to CMS that the unit meets the requirements of § 485.645.

6. Section 412.63 is amended by—

A. Revising the heading of the section.

B. Revising paragraph (a).

C. Adding introductory text to paragraph (b).

D. Revising paragraph (c)(1), (c)(5), and (c)(6)

E. Revising paragraph (u).

The revisions and addition read as follow:

§ 412.63 Federal rates for inpatient operating costs for Federal fiscal years 1984 through 2004.

(a) *General rule.* (1) CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal years 1985 through 2004 involving inpatient hospital service of a hospital in the United States, subject to the PPS, and determines a regional adjusted PPS rate for operating costs for such discharges in each region for which payment may be made under Medicare Part A.

(2) Each such rate is determined for hospitals located in urban or rural areas within the United States and within each such region, respectively, as described under paragraphs (b) through (u) of this section.

* * * * *

(b) *Geographic classifications.* Effective for fiscal years 1985 through 2004, the following rules apply.

* * * * *

(c) *Updating previous standardized amounts.* (1) For discharges occurring in fiscal year 1985 through fiscal year 2003, CMS computes average standardized amounts for hospitals in urban areas and rural areas within the United States, and in urban areas and rural areas within each region. For discharges occurring in fiscal year 2004, CMS computes an average standardized amount for hospitals located in all areas.

* * * * *

(5) For fiscal years 1987 through 2004, CMS standardizes the average standardized amounts by excluding an estimate of indirect medical education payments.

(6) For fiscal years 1988 through 2003, CMS computes average standardized amounts for hospitals located in large urban areas, other urban areas, and rural areas. The term *large urban area* means an MSA with a population of more than 1,000,000 or an NECMA, with a population of more than 970,000 based on the most recent available population data published by the Census Bureau. For fiscal year 2004, CMS computes an average standardized amount for hospitals located in all areas.

* * * * *

(u) *Applicable percentage change for fiscal year 2004.* The applicable percentage change for fiscal year 2004 is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas.

* * * * *

7. A new § 412.64 is added to Subpart D to read as follows:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

(a) *General rule.* CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply:

(i) The term *region* means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.

(ii) The term *urban area* means—

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the **Federal Register** on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.

(c) *Computing the standardized amount.* CMS computes an average standardized amount that is applicable to all hospitals located in all areas, updated by the applicable percentage increase specified in paragraph (d) of this section.

(d) *Applicable percentage change for fiscal year 2005 and for subsequent fiscal years.*

(1) Subject to the provisions of paragraph (d)(2) of this section, the applicable percentage change for fiscal year 2005 and for subsequent years for updating the standardized amount is the percentage increase in the market basket index for prospective payment hospitals (as defined in § 413.40(a) of this subchapter) for hospitals in all areas.

(2) For fiscal years 2005, 2006, and 2007, the applicable percentage change specified in paragraph (d)(1) of this section is reduced by 0.4 percentage points in the case of a ''subsection (d) hospital,'' as defined under section 1886(d)(1)() of the Act, that does not submit quality data on a quarterly basis to CMS, as specified by CMS. Any reduction of the percentage change will apply only to the fiscal year involved and will not be taken into account in computing the applicable percentage increase for a subsequent fiscal year.

(e) *Maintaining budget neutrality.* (1) CMS makes an adjustment to the standardized amount to ensure that—

(i) Changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to hospitals are not affected; and

(ii) The annual updates and adjustments to the wage index under paragraph (h) of this section are made in a manner that ensures that aggregate payments to hospitals are not affected.

(2) CMS also makes an adjustment to the rates to ensure that aggregate payments after implementation of reclassifications under subpart L of this part are equal to the aggregate prospective payments that would have

been made in the absence of these provisions.

(f) *Adjustment for outlier payments.* CMS reduces the adjusted average standardized amount determined under paragraph (c) through (e) of this section by a proportion equal to the proportion estimated by CMS) to the total amount of payments based on DRG prospective payment rates that are additional payments for outlier cases under subpart F of this part.

(g) *Computing Federal rates for inpatient operating costs for hospitals located in all areas.* For each discharge classified within a DRG, CMS establishes for the fiscal year a national prospective payment rate for inpatient operating costs based on the standardized amount for the fiscal year and the weighting factor determined under § 412.60(b) for that DRG.

(h) *Adjusting for different area wage levels.* CMS adjusts the proportion of the Federal rate for inpatient operating costs that are attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by CMS based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the national average level of hospital wages and wage-related costs. The adjustment described in this paragraph (h) also takes into account the earnings and paid hours of employment by occupational category.

(1) The wage index is updated annually.

(2) CMS determines the proportion of the Federal rate that is attributable to wages and labor-related costs from time to time, employing a methodology that is described in the annual regulation updating the system of payment for inpatient hospital operating costs.

(3) For discharges occurring on or after October 1, 2004, CMS employs 62 percent as the proportion of the rate that is adjusted for the relative level of hospital wages and wage-related costs, unless employing that percentage would result in lower payments for the hospital than employing the proportion determined under the methodology described in paragraph (h)(2) of this section.

(i) *Adjusting the wage index to account for commuting patterns of hospital workers.*

(1) *General criteria.* For discharges occurring on or after October 1, 2004, CMS adjusts the hospital wage index for hospitals located in qualifying counties to recognize the commuting patterns of hospital employees. A qualifying county is a county that meets all of the following criteria:

(i) Hospital employees in the county commute to work in an MSA (or MSAs) with a wage index (or wage indices) higher than the wage index of the MSA or rural statewide area in which the county is located.

(ii) At least 10 percent of the county's hospital employees commute to an MSA (or MSAs) with a higher wage index (or wage indices).

(iii) The 3-year average hourly wage of the hospital(s) in the county equals or exceeds the 3-year average hourly wage of all hospitals in the MSA or rural statewide area in which the county is located.

(2) *Amount of adjustment.* A hospital located in a county that meets the criteria under paragraphs (i)(l)(i) through (i)(1)(iii) of this section will receive an increase in its wage index that is equal to a weighted average of the difference between the prereclassified wage index of the MSA (or MSAs) with the higher wage index (or wage indices) and the prereclasssified wage index of the MSA or rural statewide area in which the qualifying county is located, weighted by the overall percentage of the hospital employees residing in the qualifying county who are employed in any MSA with a higher wage index.

(3) *Process for determining the adjustment.*

(i) CMS will use the most accurate data available, as determined by CMS, to determine the out-migration percentage for each county.

(ii) CMS will include, in its annual proposed and final notices of updates to the hospital inpatient prospective payment system, a listing of qualifying counties and the hospitals that are eligible to receive the adjustment to their wage indexes for commuting hospital employees, and the wage index increase applicable to each qualifying county.

(iii) Any wage index adjustment made under this paragraph (i) is effective for a period of 3 fiscal years, except that hospitals in a qualifying county may elect to waive the application of the wage index adjustment. A hospital may waive the application of the wage index adjustment by notifying CMS in writing within 45 days after the publication of the annual notice of proposed rulemaking for the hospital inpatient prospective payment system.

(iv) A hospital in a qualifying county that receives a wage index adjustment under this paragraph (g) is not eligible for reclassification under Subpart L of this part.

(j) *Wage index assignment for rural referral centers for FY 2005.*

(1) CMS makes an exception to the wage index assignment of a rural referral center for FY 2005 if the rural referral center meets the following conditions:

(i) The rural referral center was reclassified for FY 2004 by the MGCRB to another MSA, but, upon applying to the MGCRB for FY 2005, was found to be ineligible for reclassification because its average hourly wage was less than 84 percent (but greater than 82 percent) of the average hourly wage of the hospitals geographically located in the MSA to which the rural referral center applied for reclassification for FY 2005.

(ii) The hospital may not qualify for any geographic reclassification under subpart L of this part, effective for discharges occurring on or after October 1, 2004.

(2) CMS will assign a rural referral center that meets the conditions of paragraph (j)(1) of this section the wage index value of the MSA to which it was reclassified by the MGCRB in FY 2004.

(k) *Midyear corrections to the wage index.*

(1) CMS makes a midyear correction to the wage index for an area only if a hospital can show that—

(i) The intermediary or CMS made an error in tabulating its data; and

(ii) The hospital could not have known about the error, or did not have the opportunity to correct the error, before the beginning of the Federal fiscal year.

(2) A midyear correction to the wage index is effective prospectively from the date the change is made to the wage index.

(l) *Judicial decision.* If a judicial decision reverses a CMS denial of a hospital's wage data revision request, CMS pays the hospital by applying a revised wage index that reflects the revised wage data as if CMS's decision had been favorable rather than unfavorable.

8. Section 412.87 is amended by revising paragraph (b)(3) to read as follows:

§ 412.87 Additional payment for new medical services and technologies: General provisions.

* * * * *

(b) *Eligibility criteria.* * * *

(3) The DRG prospective payment rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate, based on application of a threshold amount to estimated charges incurred with respect to such discharges. To determine whether the

payment would be adequate, CMS will determine whether the charges of the cases involving a new medical service or technology will exceed a threshold amount that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation beyond the geometric mean standardized charge for all cases in the DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant DRGs if the new medical service or technology occurs in many different DRGs). Standardized charges reflect the actual charges of a case adjusted by the prospective payment system payment factors applicable to an individual hospital, such as the wage index, the indirect medical education adjustment factor, and the disproportionate share adjustment factor.

§ 412.88 [Amended]

9. Section 412.88 is amended by removing paragraph (c).

10. A new § 412.101 is added to read as follows:

§ 412.101 Special treatment: Inpatient hospital payment adjustment for low-volume hospitals.

(a) *General considerations.*

(1) CMS provides an additional payment to a qualifying hospital for the higher incremental costs associated with a low volume of discharges. The amount of any additional payment for a qualifying hospital is calculated in accordance with paragraph (b) of this section.

(2) In order to qualify for this adjustment, a hospital must have 500 or fewer discharges during the fiscal year, as reflected in its cost report specified in paragraph (a)(3) of this section, and be located more than 25 road miles from the nearest inpatient acute care prospective payment system hospital.

(3) The fiscal intermediary makes the determination of the discharge count for purposes of determining a hospital's qualification for the adjustment and the amount of the adjustment based on the hospital's most recent submitted cost report.

(4) In order to qualify for the adjustment, a hospital must provide its fiscal intermediary with sufficient evidence that it meets the distance requirement specified under paragraph (a)(2) of this section. The fiscal intermediary will base its determination of whether the distance requirement is satisfied upon the evidence presented by the hospital and other relevant evidence, such as maps, mapping software, and inquiries to State and local police, transportation officials, or other government officials.

(b) *Determination of the adjustment amount.* The maximum low-volume adjustment is 25 percent. Each qualifying hospital's low-volume adjustment is calculated as follows: $1.25-(.0005*D)$, where $0<D\leq 500$ discharges, and 1.25 represents the maximum 25 percent add-on amount, .0005 is the payment adjustment per case (derived by dividing .25 by 500 discharges) and ''D'' is the number of discharges determined under paragraph (a)(3) of this section.

(c) *Eligibility of new hospitals for the adjustment.* A new hospital will be eligible for a low-volume adjustment under this section once it has submitted a cost report for a cost reporting period that indicates that it meets the number of discharge requirement during the fiscal year, as specified in paragraph (a) of this section.

11. Section 412.102 is amended by revising the introductory text to read as follows:

§ 412.102 Special treatment: Hospitals located in areas that are reclassified from urban to rural as a result of a geographic redesignation.

Effective on or after October 1, 1983, a hospital reclassified as rural, as defined in subpart D of this part, may receive an adjustment to its rural Federal payment amount for operating costs for two successive fiscal years.

* * * * *

12. Section 412.103 is amended by revising paragraph (a) introductory text to read as follows:

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

* * * * *

13. Section 412.104 is amended by revising paragraph (a) to read as follows:

§ 412.104 Special treatment: Hospitals with high percentage of ESRD discharges.

(a) *Criteria for classification.* CMS provides an additional payment to a hospital for inpatient services provided to ESRD beneficiaries who receive a dialysis treatment during a hospital stay, if the hospital has established that ESRD beneficiary discharges, excluding discharges classified into DRG 302 (Kidney Transplant, DRG 316 (Renal Failure), or DRG 317 (Admit for Renal Dialysis), where the beneficiary received dialysis services during the inpatient stay, constitute 10 percent or more of its total Medicare discharges.

* * * * *

14. Section 412.105 is amended by—

A. Revising paragraph (d)(3)(vii).

B. Adding new paragraphs (d)(3)(viii) through (xii).

C. Adding a new paragraph (d)(4).

D. Redesignating the contents of paragraph (e) as paragraph (e)(1) and adding a new paragraph (e)(2).

E. Redesignating the contents of paragraph (f)(1)(iv) as paragraph (f)(1)(iv)(A) and adding new paragraphs (f)(1)(iv)(B) and (f)(1)(iv(C).

F. Adding a sentence at the end of paragraph (f)(1)(v).

Cross-Reference Changes

G. In paragraphs (a), (f), and (g) as indicated in the left column of the table below, remove the cross-reference indicated in the middle column from wherever it appears, and add the cross-reference in the right column:

Section	Remove cross-reference	Add cross-reference.
412.105(a)(1), introductory text	paragraph (f) and (h) of this section	paragraph (f) of this section..
412.105(f)(1)(i)(A)	§ 415.200(a)	§ 415.152..
412.105(f)(1)(ii)(C)	§ 413.86(f)(3) or § 413.86(f)(4)	§ 413.78(c) or § 413.78(d).
412.105(f)(1)(vi)	§ 413.86(b)	§ 413.75(b)..
412.105(f)(1)(vi)	§ 413.86(g)(7)	§ 413.79(f)..
412.105(f)(1)(vii)	§ 413.86(g)(13)	§ 413.79(l)..
412.105(f)(1)(vii)	§§ 413.86(g)(6)(i) through (iv)	§§ 413.79(e)(1) through (e)(4)..
412.105(f)(1)(viii)	§ 413.86(g)(8)	§ 413.79(g)..
412.105(f)(1)(ix)	§§ 413.86(g)(9)(i) and (g)(9)(ii)	§§ 413.79(h)(1) and (h)(2)..

Section	Remove cross-reference	Add cross-reference.
412.105(f)(1)(ix)	§§ 413.86(g)(9)(i) and (g)(9)(iii)(B)	§§ 413.79(h)(1) and (h)(3)(ii)..
412.105(f)(1)(ix)	§§ 413.86(g)(9)(i) and (g)(9)(iii)(A)	§§ 413.79(h)(1) and (h)(3)(i)..
412.105(f)(1)(x)	§ 413.86(g)(13)	§ 413.79(l)..
412.105(f)(1)(x)	§ 413.86(g)(12)	§ 413.79(k)..
412.105(f)(1)(xi)	§ 413.86(g)(10)	§ 413.79(i)..
412.105(f)(1)(xii)	§ 413.86(g)(11)	§ 413.79(j)..
412.105(g)	§§ 413.86(d)(3)(i) through (d)(3)(v)	§§ 413.76(c)(1) through (c)(5).

The revisions and additions read as follows:

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

* * * * *

(d) *Determination of education adjustment factor.*

* * * * *

(3) *Step three.* * * *

(vii) For discharges occurring on or after October 1, 2002 and before April 1, 2004, 1.35.

(viii) For discharges occurring on or after April l, 2004 and before October l, 2004, 1.47.

(ix) For discharges occurring during fiscal year 2005, 1.42.

(x) For discharges occurring during fiscal year 2006, 1.37.

(xi) For discharges occurring during fiscal year 2007, 1.32.

(xii) For discharges occurring during fiscal year 2008 and thereafter, 1.35.

(4) For discharges occurring on or after July 1, 2005, with respect to FTE residents added as a result of increases in the FTE resident cap under paragraph (f)(1)(iv)(C) of this section, the factor derived from completing steps one and two is multiplied by 'c', where 'c' is equal to 0.66.

(e) *Determination of payment amount.*

(1) * * *

(2) For discharges occurring on or after July 1, 2005, a hospital that counts additional residents as a result of an increase in its FTE resident cap under paragraph (f)(1)(iv)(C) of this section will receive indirect medical education payments based on the sum of the following two indirect medical education adjustment factors:

(i) An adjustment factor that is calculated using the schedule of formula multipliers in paragraph (d)(3) of this section and the hospital's FTE resident count, not including residents attributable to an increase in its FTE cap under paragraph (f)(1)(iv)(C) under this section; and

(ii) An adjustment factor that is calculated using the applicable formula multiplier under paragraph (d)(4) of this section, and the additional number of FTE residents that are attributable to the increase in the hospital's FTE resident cap under paragraph (f)(1)(iv)(C) in this section.

(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.*

(1) * * *

(iv)(A) * * *

(B) Effective for portions of cost reporting periods beginning on or after July l, 2005, a hospital's otherwise applicable FTE resident cap may be reduced if its reference resident level is less than its otherwise applicable FTE resident cap in a reference cost reporting period, in accordance with the provisions of § 413.79(c)(3) of this subchapter. The reduction is 75 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level.

(C) Effective for portions of cost reporting periods beginning on or after July 1, 2005, a hospital may qualify to receive an increase in its otherwise applicable FTE resident cap (up to 25 additional FTE slots) if the criteria specified in § 413.79(c)(4) of this subchapter are met.

(v) * * * If a hospital increases its FTE count of residents as a result of paragraph (f)(1)(iv)(C) of this section, effective for cost reporting periods beginning on or after July 1, 2005, the FTE residents are included in the hospital's rolling average calculation described in this paragraph (f)(1)(v).

* * * * *

15. Section 412.106 is amended by—

A. In paragraph (a)(1)(iii), removing the cross-reference ''§ 412.62(f)'' and adding in its place ''§ 412.62(f) or § 412.64''.

B. Revising paragraphs (d)(2)(ii), (d)(2)(iii), and (d)(2)(iv) to read as follows:

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

* * * * *

(d) *Payment adjustment factor.*

* * * * *

(2) *Payment adjustment factors.*

* * * * *

(ii) If the hospital meets the criteria of paragraph (c)(1)(ii) of this section, the payment adjustment factor is equal to one of the following:

(A) If the hospital is classified as a rural referral center—

(*1*) For discharges occurring before April 1, 2001, the payment adjustment factor is 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent.

(*2*) For discharges occurring on or after April 2, 2001, and before April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is greater than 19.3 percent and less than 30 percent, the applicable payment adjustment factor is 5.25 percent.

(*iii*) If the hospital's disproportionate patient percentage is greater than or equal to 30 percent, the applicable payment adjustment factor is 5.25 percent plus 60 percent of the difference between 30 percent and the hospital's disproportionate patient percentage.

(*3*) For discharges occurring on or after April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(B) If the hospital is classified as a sole community hospital—

(*1*) For discharges occurring before April 1, 2001, the payment adjustment factor is 10 percent.

(*2*) For discharges occurring on or after April 1, 2001 and before April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is equal to or greater than 19.3 percent and less than 30 percent, the applicable payment adjustment factor is 5.25 percent.

(*iii*) If the hospital's disproportionate patient percentage is equal to or greater than 30 percent, the applicable payment adjustment factor is 10 percent.

(*3*) For discharges occurring on or after April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(*iii*) The maximum payment adjustment factor is 12 percent.

(C) If the hospital is classified as both a rural referral center and a sole community hospital, the payment adjustment is—

(*1*) For discharges occurring before April 1, 2001, the greater of—

(*i*) 10 percent; or

(*ii*) 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent.

(*2*) For discharges occurring on or after April 1, 2001 and before April 1, 2004, the greater of the adjustments determined under paragraphs (d)(2)(ii)(A) or (d)(2)(ii)(B) of this section.

(*3*) For discharges occurring on or after April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(D) If the hospital is classified as a rural hospital and is not classified as either a sole community hospital or a rural referral center, and has 100 or more beds—

(*1*) For discharges occurring before April 1, 2001, the payment adjustment factor is 4 percent.

(*2*) For discharges occurring on or after April 1, 2001 and before April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between the hospital's disproportionate patient percentage and 15 percent.

(*ii*) If the hospital's disproportionate patient percentage is equal to or greater than 19.3 percent, the applicable payment adjustment factor is 5.25 percent.

(*3*) For discharges occurring on or after April 1, 2004, the following applies:

(*i*) If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*ii*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(*iii*) The maximum payment adjustment factor is 12 percent.

(iii) If the hospital meets the criteria of paragraph (c)(1)(iii) of this section—

(A) For discharges occurring before April 1, 2001, the payment adjustment factor is 5 percent.

(B) For discharges occurring on or after April 1, 2001 and before April 1, 2004, the following applies:

(*1*) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between the hospital's disproportionate patient percentage and 15 percent.

(*2*) If the hospital's disproportionate patient percentage is equal to or greater than 19.3 percent, the applicable payment adjustment factor is 5.25 percent.

(C) For discharges occurring on or after April 1, 2004, the following applies:

(*1*) If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*2*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(*3*) The maximum payment adjustment factor is 12 percent.

(iv) If the hospital meets the criteria of paragraph (c)(1)(iv) of this section—

(A) For discharges occurring before April 1, 2001, the payment adjustment factor is 4 percent.

(B) For discharges occurring on or after April 1, 2001 and before April 1, 2004, the following applies:

(*1*) If the hospital's disproportionate patient percentage is less than 19.3 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between the hospital's disproportionate patient percentage and 15 percent.

(*2*) If the hospital's disproportionate patient percentage is equal to or greater than 19.3 percent, the applicable payment adjustment factor is 5.25 percent.

(C) For discharges occurring on or after April 1, 2004, the following applies:

(*1*) If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage.

(*2*) If the hospital's disproportionate patient percentage is greater than 20.2 percent, the applicable payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage.

(*3*) The maximum payment adjustment factor is 12 percent.

* * * * *

16. Section 412.108 is amended by revising paragraph (a)(1) introductory text to read as follows:

§ 412.108 Special treatment: Medicare-dependent, small rural hospitals.

(a) *Criteria for classification as a Medicare-dependent, small rural hospital.*

(1) *General considerations.* For cost reporting periods beginning on or after

April 1, 1990 and ending before October 1, 1994, or beginning on or after October 1, 1997 and ending before October 1, 2006, a hospital is classified as a Medicare-dependent, small rural hospital if it is located in a rural area (as defined in subpart D of this part) and meets all of the following conditions:

* * * * *

17. Section 412.204 is amended by—

A. Revising the introductory text of paragraph (a).

B. Revising the title and introductory text of paragraph (b).

C. Adding new paragraphs (c) and (d).

The revision and addition read as follows:

§ 412.204 Payment to hospitals in Puerto Rico.

(a) *FY 1988 through FY 1997.* For discharges occurring on or after October 1, 1987 and before October 1, 1997, payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

* * * * *

(b) *FY 1998 through March 31, 2004.* For discharges occurring on or after October 1, 1997 and before April 1, 2004, payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

* * * * *

(c) *Period of April 1, 2004 through September 31, 2004.* For discharges occurring on or after April 1, 2004 and before October 1, 2004, payment for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

(1) 37.5 percent of the Puerto Rico prospective payment rate for inpatient operating costs, as determined under § 412.208 or § 412.210; and

(2) 62.5 percent of the national prospective payment rate for inpatient operating costs, as determined under § 412.212.

(d) *FY 2005 and thereafter.* For discharges occurring on or after October 1, 2004, payments for inpatient operating costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of—

(1) 25 percent of the Puerto Rico prospective payment rate for inpatient operating costs, as determined under § 412.208 or § 412.211; and

(2) 75 percent of a national prospective payment rate for inpatient operating costs, as determined under § 412.212.

18. Section 412.210 is amended by—

A. Revising the title of the section.

B. Revising paragraph (a)(1).

§ 412.210 Puerto Rico rates for Federal fiscal years 1989 through 2003.

(a) *General rule.* (1) CMS determines the Puerto Rico adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge occurring in Federal fiscal years 1989 through 2003 that involves inpatient hospital services of a hospital in Puerto Rico subject to the prospective payment system for which payment may be made under Medicare Part A.

* * * * *

19. New § 412.211 is added to read as follows:

§ 412.211 Puerto Rico rates for Federal fiscal year 2004 and subsequent fiscal years.

(a) *General rule.* CMS determines the Puerto Rico adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge occurring in Federal fiscal year 2004 and subsequent fiscal years that involves inpatient hospital services of a hospital in Puerto Rico subject to the prospective payment system for which payment may be made under Medicare Part A.

(b) *Geographic classifications.* (1) For purposes of this section, the following definitions apply

(i) The term *urban area* means a Metropolitan Statistical Area (MSA) as defined by the Executive Office of Management and Budget.

(ii) The term *rural* area means any area outside of an urban area.

(2) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the **Federal Register** on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(c) *Computing the standardized amount.* CMS computes a Puerto Rico standardized amount that is applicable to all hospitals located in all areas, increased by the applicable percentage change specified in § 412.64(d)(1).

(d) *Computing Puerto Rico Federal rates for inpatient operating costs for hospitals located in all areas.* For each discharge classified within a DRG, CMS establishes for the fiscal year a Puerto Rico prospective payment rate for inpatient operating costs equal to the product of—

(1) The average standardized amount for the fiscal year for hospitals located in all areas; and

(2) The weighting factor determined under § 412.60(b) for that DRG.

(e) *Adjusting for different area wage levels.* CMS adjusts the proportion of the Puerto Rico rate for inpatient operating costs that are attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by CMS based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the Puerto Rico average level of hospital wages and wage-related costs. The adjustment specified in this paragraph (e) also takes into account the earnings and paid hours of employment by occupational category.

(1) The wage index is updated annually.

(2) CMS determines the proportion of the Puerto Rico rate that is attributable to wages and labor-related costs from time to time, employing a methodology that is described in the annual update of the prospective payment system for payment of inpatient hospital operating costs published in the **Federal Register**.

(3) For discharges occurring on or after October 1, 2004, CMS employs 62 percent as the proportion of the rate that is adjusted for the relative level of hospital wages and wage-related costs, unless employing that percentage would result in lower payments for the hospital than employing the proportion determined under the methodology described in paragraph (e)(2) of this section.

(f) *Adjusting the wage index to account for commuting patterns of hospital workers.* (1) *General criteria.* For discharges occurring on or after October 1, 2004, CMS adjusts the hospital wage index for hospitals located in qualifying areas to recognize the commuting patterns of hospital employees. A qualifying area is an area that meets all of the following criteria:

(i) Hospital employees in the area commute to work in an MSA (or MSAs) with a wage index (or wage indices) higher than the wage index of the area.

(ii) At least 10 percent of the county's hospital employees commute to an MSA (or MSAs) with a higher wage index (or wage indices).

(iii) The 3-year average hourly wage of the hospital(s) in the area equals or exceeds the 3-year average hourly wage of all hospitals in the MSA or rural area in which the county is located.

(2) *Amount of adjustment.* A hospital located in an area that meets the criteria under paragraphs (f)(l)(i) through (f)(1)(iii) of this section will receive an increase in its wage index that is equal to a weighted average of the difference between the prereclassified wage index of the MSA (or MSAs) with the higher wage index (or wage indices) and the prereclassified wage index of the qualifying area, weighted by the overall percentage of the hospital employees residing in the qualifying area who are employed in any MSA with a higher wage index.

(3) *Process for determining the adjustment.*

(i) CMS will use the most accurate data available, as determined by CMS, to determine the out-migration percentage for each area.

(ii) CMS will include, in its annual proposed and final notices of updates to the hospital inpatient prospective payment system, a listing of qualifying areas and the hospitals that are eligible to receive the adjustment to their wage indexes for commuting hospital employees, and the wage index increase applicable to each qualifying area.

(iii) Any wage index adjustment made under this paragraph (f) is effective for a period of 3 fiscal years, except that hospitals in a qualifying county may elect to waive the application of the wage index adjustment. A hospital may waive the application of the wage index adjustment by notifying CMS in writing within 45 days after the publication in the **Federal Register** of the annual notice of proposed rulemaking for the hospital inpatient prospective payment system.

(iv) A hospital in a qualifying area that receives a wage index adjustment under this paragraph (f) is not eligible for reclassification under Subpart L of this part.

20. Section 412.212 is amended by revising paragraph (b) to read as follows:

§ 412.212 National rate.

* * * * *

(b) *Computing Puerto Rico standardized amounts.* (1) For Federal fiscal years before FY 2004, CMS computes a discharge-weighted average of the—

(i) National urban adjusted standardized amount determined under § 412.63(j)(1); and

(ii) National rural adjusted average standardized amount determined under § 412.63(j)(2)(i).

(2) For fiscal years 2004 and subsequent fiscal years, CMS computes a discharge-weighted average of the national adjusted standardized amount determined under § 412.64(e).

* * * * *

21. Section 412.230 is amended by—

A. Revising paragraph (a)(1).

B. Revising paragraph (a)(4).

C. Removing paragraph (a)(5)(ii) and redesignating paragraphs (a)(5)(iii), (a)(5)(iv), and (a)(5)(v) as paragraphs (a)(5)(ii), (a)(5)(iii), and (a)(5)(iv), respectively.

D. Removing paragraph (d).

E. Removing paragraph (e)(2)(i)(C).

F. Redesignating paragraph (e) as paragraph (d).

G. In redesignated paragraph (d)(1), removing the cross-reference ''paragraphs (e)(3) and (e)(4)'' and adding in its place ''paragraphs (d)(3) and (d)(4)''.

H. In redesignated paragraph (d)(2)(iii), removing the cross-reference ''paragraph (e)(2)'' and adding in its place ''paragraph (d)(2)''.

I. Revising redesignated paragraph (d)(3).

J. In redesignated paragraph (d)(4), removing the cross-reference ''paragraphs (e)(1)(i) and (e)(1)(iii)'' and adding in its place ''paragraph (d)(1)(i) and (d)(1)(iii)''.

K. In redesignated paragraph (d)(4)(iii), removing the cross-reference ''paragraph (e)'' and adding in its place ''paragraph (d)''.

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

(a) *General.* (1) *Purposes.* Except as specified in paragraph (a)(5)—

(i) For fiscal years prior to fiscal year 2005, an individual hospital may be redesignated from a rural area to an urban area, from a rural area to another rural area, or from a rural area to another urban area for the purposes of using the other area's standardized amount for inpatient operating costs, the wage index value, or both.

(ii) Effective for fiscal year 2005 and subsequent fiscal years, an individual hospital may be redesignated from a rural area to an urban area, from a rural area to another rural area, or from a rural area to another urban area for the purposes of using the other area's wage index value.

(4) *Application of criteria.* In applying the numeric criteria contained in paragraphs (b)(1), (b)(2), (d)(1)(iii), (d)(1)(iv)(A), and (d)(1)(iv)(B) of this section, rounding of numbers to meet the mileage or qualifying percentage standards is not permitted.

* * * * *

(d) *Use of urban or other rural area's wage index.* * * *

* * * * *

(3) *Rural referral center exceptions.*

(i) If a hospital was ever a rural referral center, it does not have to demonstrate that it meets the criterion set forth in paragraph (d)(1)(iii) of this section concerning its average hourly wage.

(ii) If a hospital was ever a rural referral center, it is required to meet only the criterion that applies to rural hospitals under paragraph (d)(1)(iv) of this section, whether or not it is actually located in an urban or rural area.

* * * * *

22. Section 412.232 is amended by—

A. Revising paragraph (a)(1).

B. Revising paragraph (a)(4).

C. Revising paragraph (b).

§ 412.232 Criteria for all hospitals in a rural county seeking urban redesignation.

(a) *Criteria.* * * *

(1) The county in which the hospitals are located—

(i) For fiscal years prior to fiscal year 2005, must be adjacent to the MSA or NECMA to which they seek redesignation.

(ii) For fiscal years beginning with fiscal years 2005, must be adjacent to the MSA to which they seek redesignation.

* * * * *

(4) The hospital may be redesignated only if one of the following conditions is met:

(i) The prereclassified average hourly wage for the area to which they seek redesignation is higher than the prereclassified average hourly wage for the area in which they are currently located.

(ii) For fiscal years prior to fiscal year 2005, the standardized amount for the area to which they seek redesignation is higher than the standardized amount for the area in which they are located.

(b) *Metropolitan character.* (1) For fiscal years prior to FY 2005, the group of hospitals must demonstrate that the county in which the hospitals are located meets the standards for redesignation to an MSA or an NECMA as an outlying county that were published in the **Federal Register** on March 30, 1990 (55 FR 12154) using Bureau of the Census data or Bureau of Census estimates made after 1990.

(2) For fiscal years beginning with FY 2005, the group of hospitals must demonstrate that the county in which the hospitals are located meets the standards for redesignation to an MSA as an outlying county that were published in the **Federal Register** on December 27, 2000 (65 FR 82228) using Census Bureau data or Census Bureau estimates made after 2000.

* * * * *

23. Section 412.234 is amended by—

A. Revising paragraph (a)(3).

B. Revising paragraph (a)(4).

C. Removing paragraph (c).

D. Redesignating paragraph (d) as paragraph (c) and revising the redesignated paragraph (c).

The revisions read as follows.

§ 412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.

(a) General criteria. * * *

(3) The county in which the hospital is located must be part of the CBSA that includes the urban area to which they seek redesignation.

(4) The hospital may be redesignated only if one of the following conditions is met:

(i) The prereclassified average hourly wage for the area to which they seek redesignation is higher than the prereclassified average hourly wage for the area in which they are currently located.

(ii) For fiscal years prior to fiscal year 2005, the standardized amount for the area to which they seek redesignation is higher than the standardized amount for the area in which they are located.

* * * * *

(c) *Appropriate wage data.* The hospitals must submit appropriate wage data as provided for in § 412.230(d)(2).

§ 412.236 [Removed]

24. Section 412.236 is removed.

§ 412.252 [Amended]

25. In § 412.252, paragraph (b), the phrase ''or in a NECMA'' is removed.

26. Section 412.274 is amended by revising paragraph (b)(1) to read as follows:

§ 412.274 Scope and effect of an MGCRB decision.

* * * * *

(b) *Effective date and term of the decision.*

(1) For reclassifications prior to fiscal year 2005, a standardized amount classification change is effective for 1 year beginning with discharges occurring on the first day (October 1) of the second Federal fiscal year following the Federal fiscal year in which the complete application is filed and ending effective at the end of that Federal fiscal year (the end of the next September 30).

* * * * *

27. Section 412.312 is amended by—

A. Revising paragraph (b)(2)(ii).

B. Revising paragraph (e).

The revisions read as follows.

§ 412.312 Payment based on the Federal rate.

(b) *Payment adjustment.* * * *

(2) *Geographic adjustment factor.*

* * *

(ii) *Large urban add-on.* An additional adjustment is made for hospitals located in a large urban area to reflect the higher costs incurred by hospitals located in those areas. For purposes of the payment adjustment under this paragraph, the definition of large urban area set forth at § 412.63(c)(6) continues to be in effect for discharges occurring on or after September 30, 2004.

* * * * *

(e) *Payment for extraordinary circumstances.* For cost reporting periods beginning on or after October 1, 2001—

(1) Payment for extraordinary circumstances is made as provided for in § 412.348(f).

(2) Although no longer independently in effect, the minimum payment levels established under § 412.348(c) continue to be used in the calculation of exception payments for extraordinary circumstances, according to the formula in § 412.348(f).

(3) Although no longer independently in effect, the offsetting amounts established under § 412.348(c) continue to be used in the calculation of exception payments for extraordinary circumstances. However, for cost reporting periods beginning during FY 2005 and subsequent fiscal years, the offsetting amounts in § 412.348(c) are determined based on the lesser of—

(i) The preceding 10-year period; or

(ii) The period of time under which the hospital is subject to the prospective payment system for capital-related costs.

26. Section 412.316 is amended by revising paragraph (b) to read as follows:

§ 412.316 Geographic adjustment factors.

* * * * *

(b) *Large urban location.* CMS provides an additional payment to a hospital located in a large urban area equal to 3.0 percent of what would otherwise be payable to the hospital based on the Federal rate.

(1) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location for the purpose of receiving payment under § 412.63(a). The term ''large urban area'' is defined under § 412.63(c)(6).

(2) For discharges occurring on or after October 1, 2004, the definition of large urban area under § 412.63(c)(6) continues to be in effect for purposes of the payment adjustment under this section, based on the geographic classification under § 412.64.

* * * * *

27. Section 412.320 is amended by revising paragraph (a)(1) to read as follows:

§ 412.320 Disproportionate share adjustment factor.

(a) *Criteria for classification.*

* * * * *

(1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

(i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).

(ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.

* * * * *

28. Section 412.374 is amended by—

A. Revising paragraph (a).

B. Redesignating paragraphs (b) and (c) as paragraphs (c) and (d), respectively.

C. Adding a new paragraph (b).

The revisions and addition read as follows:

§ 412.374 Payments to hospitals located in Puerto Rico.

(a) *FY 1998 through FY 2004.* Payments for capital-related costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of the following:

(1) 50 percent of the Puerto Rico capital rate based on data from Puerto Rico hospitals only, which is determined in accordance with procedures for developing the Federal rate; and

(2) 50 percent of the Federal rate, as determined under § 412.308.

(b) *FY 2005 and FYs thereafter.* For discharges occurring on or after October 1, 2004, payments for capital-related costs to hospitals located in Puerto Rico that are paid under the prospective payment system are equal to the sum of the following:

(1) 25 percent of the Puerto Rico capital rate based on data from Puerto

Rico hospitals only, which is determined in accordance with procedures for developing the Federal rate; and

(2) 75 percent of the Federal rate, as determined under § 412.308.

* * * * *

29. Section 412.521 is amended by adding a new paragraph (e) to read as follows:

§ 412.521 Basis for payment.

* * * * *

(e) *Special payment provisions for patients in acute care hospitals that change classification status to LTCH status during a patient stay.* (1) If a patient is admitted to an acute care hospital and then the acute care hospital meets the criteria at § 412.23(e) to be paid as a LTCH during the course of the patient's hospitalization, Medicare considers all the days of the patient stay in the facility (days prior to and after the designation of LTCH status) to be a single episode of LTCH care. Payment for the entire patient stay (days prior to and after the designation of LTCH status) will include the day and cost data for that patient at both the acute care hospital and the LTCH in determining the payment to the LTCH under this subpart. The requirements of this paragraph (e)(1) apply only to a patient stay in which a patient is in an acute care hospital and that hospital is designated as a LTCH on or after October 1, 2004.

(2) The days of the patient's stay prior to and after the hospital's designation as a LTCH as specified in paragraph (e)(1) of this section are included for purposes of determining the beneficiary's length of stay.

C. Part 413 is 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 is revised to read as follows:

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

2. Section 413.40 is amended by—

A. Republishing the introductory text of paragraphs (c)(4) and (c)(4)(iii) and revising paragraphs (c)(4)(iii)(A)(*1*) and (c)(4)(iii)(A)(*2*).

B. Republishing the introductory text of paragraph (c)(4)(iii)(B) and revising paragraph (c)(4)(iii)(B)(*4*)(*i*).

C. Revising the introductory text of paragraphs (d)(4)(i) and (d)(4)(ii).

The revisions read as follows:

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

* * * * *

(c) *Costs subject to the ceiling.*

* * * * *

(4) *Target amounts.* The intermediary will establish a target amount for each hospital. The target amount for a cost reporting period is determined as follows:

* * * * *

(iii) In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the target amount is the lower of the amounts specified in paragraph (c)(4)(iii)(A) or (c)(4)(iii)(B) of this section.

(A) The hospital-specific target amount.

(*1*) In the case of all hospitals and units, except long-term care hospitals for cost reporting periods beginning during FY 2001, the hospital-specific target amount is the net allowable costs in a base period increased by the applicable update factors.

(*2*) In the case of long-term care hospitals, for cost reporting periods beginning during FY 2001, the hospital-specific target amount is the net allowable costs in a base period increased by the applicable update factors multiplied by 1.25.

(B) One of the following for the applicable cost reporting period—

* * * * *

(*4*) For cost reporting periods beginning during fiscal years 2001 and 2002—

(*i*) The amounts determined under paragraph (c)(4)(iii)(B)(3)(*i*) of this section are: increased by the market basket percentage up through the subject period; or in the case of a long-term care hospital for cost reporting periods beginning during FY 2001, the amounts determined under paragraph (c)(4)(iii)(B)(*3*)(*i*) of this section, increased by the market basket percentage up through the subject period and further increased by 2 percent.

* * * * *

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

* * * * *

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

* * * * *

(ii) For cost reporting periods beginning on or after October 1, 2000, and before September 30, 2001, eligible psychiatric hospitals and units and long-term care hospitals (as defined in paragraph (d)(5) of this section) receive payments in addition to those in paragraph (d)(2) of this section, as applicable. These payments are equal to the lesser of—

* * * * *

3. Section 413.64 is amended by—

A. Revising the introductory text of paragraph (h)(2) and adding a new paragraph (h)(2)(vi).

B. Removing paragraph (h)(3)(iv).

C. Removing and reserving paragraph (h)(4).

The additions and revisions read as follows:

§ 413.64 Payments to providers: Specific rules.

* * * * *

(h) *Periodic interim payment method of reimbursement.*

* * * * *

(2) *Covered services furnished on or after July 1, 1987.* Effective with claims received on or after July l, 1987, or as otherwise specified, the periodic interim payment (PIP) method is available for the following:

* * * * *

(vi) Effective for payments made on or after July l, 2004, inpatient CAH services furnished by a CAH as specified in § 413.70. Payment on a PIP basis is described in § 413.70(d).

* * * * *

(4) [Reserved]

* * * * *

4. Section 413.70 is amended by—

A. Revising the heading of paragraph (a) and paragraph (a)(1).

B. Adding a new paragraph (a)(4).

C. Revising paragraph (b)(2)(i) introductory text, paragraph (b)(2)(i)(A), and paragraph (b)(2)(i)(B).

D. Removing paragraphs (b)(2)(i)(C) and (b)(2)(i)(D).

E. In paragraph (b)(2)(iii), remove the phrase ''on a reasonable cost basis'' and add in its place ''at 101 percent of reasonable cost''.

F. Revising the heading of paragraph (b)(3) and the contents of paragraphs (b)(3)(i) and (b)(3)(ii).

G. Revising paragraph (b)(4).

H. Adding a new paragraph (d).

I. Adding a new paragraph (e).

The revisions and additions read as follows:

§ 413.70 Payment for services of a CAH.

(a) *Payment for inpatient services furnished by a CAH (other than services of distinct part units).* (1) Effective for cost reporting periods beginning on or after January 1, 2004, payment for inpatient services of a CAH, other than services of a distinct part unit of the CAH, is 101 percent of the reasonable costs of the CAH in providing CAH services to its inpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in Part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH inpatient services:

(i) Lesser of cost or charges;

(ii) Ceilings on hospital operating costs;

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

(iv) The payment window provisions for preadmission services, specified in § 412.2(c)(5) of this subchapter and § 413.40(c)(2).

* * * * *

(4) Payment for inpatient services of distinct part psychiatric or rehabilitation units is described in paragraph (e) of this section.

(b) *Payment for outpatient services furnished by a CAH.*

* * * * *

(2) *Reasonable costs for facility services.* (i) Effective for cost reporting periods beginning on or after January 1, 2004, payment for outpatient services of a CAH is 101 percent of the reasonable costs of the CAH in providing CAH services to its outpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in Part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH outpatient services:

(A) Lesser of cost or charges; and

(B) RCE limits.

* * * * *

(3) *Election to be paid 101 percent of reasonable costs for facility services plus fee schedule for professional services.*

(i) A CAH may elect to be paid for outpatient services in any cost reporting period beginning on or after July 1, 2004 under the method described in paragraphs (b)(3)(ii) and (b)(3)(iii) of this section.

(A) The election must be made in writing, made on an annual basis, and delivered to the fiscal intermediary servicing the CAH at least 30 days before the start of the cost reporting period for which the election is made.

(B) An election of this payment method, once made for a cost reporting period, remains in effect for all of that period and, effective for cost reporting periods beginning on or after July 1, 2004, applies to all services furnished to outpatients during that period by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with 42 CFR Part 424, Subpart F of this chapter. If a physician or other practitioner does not reassign his or her billing rights to the CAH in accordance with 42 CFR Part 424, payment for the physician's or practitioner's services to CAH outpatients will be made on a fee schedule or other applicable basis as specified in Subpart B of part 414 of this subchapter.

(C) In the case of a CAH that made an election under this section before November 1, 2003, for a cost reporting period beginning before December 1, 2003, the rules in paragraph (b)(3)(i)(B) of this section are effective for cost reporting periods beginning on or after July 1, 2001.

(D) An election made under paragraph (b)(3)(i)(B) or paragraph (b)(3)(i)(C) of this section is effective only for a period for which it was made and does not apply to an election that was withdrawn or revoked prior to the start of the cost reporting period for which it was made.

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

(A) For facility services not including any services for which payment may be made under paragraph (b)(3)(ii)(B) of this section, 101 percent of the reasonable costs of the services as determined under paragraph (b)(2)(i) of this section; and

(B) For professional services that are furnished by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with Part 424, Subpart F of this chapter, and that would otherwise be payable to the physician or other practitioner if the rights to bill for them had not been reassigned, 115 percent of the amounts that otherwise would be paid for the service if the CAH had not elected payment under this method.

* * * * *

(4) *Costs of certain emergency room on-call providers.* (i) Effective for cost reporting periods beginning on or after October 1, 2001, the reasonable costs of outpatient CAH services under paragraph (b) of this section may include amounts for reasonable compensation and related costs for an emergency room physician who is on call but who is not present on the premise of the CAH involved, is not otherwise furnishing physicians' services, and is not on call at any other provider or facility. Effective for costs incurred for services furnished on or after January 1, 2005, the payment amount of 101 percent of the reasonable costs of outpatient CAH services may also include amounts for reasonable compensation and related costs for the following emergency room providers who are on call but who are not present on the premise of the CAH involved, are not otherwise furnishing physicians' services, and are not on call at any other provider or facility: physician assistants, nurse practitioners, and clinical nurse specialists.

(ii) For purposes of this paragraph (b)(4)—

(A) ''Amounts for reasonable compensation and related costs'' means all allowable costs of compensating emergency room physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on call to the extent that the costs are found to be reasonable under the rules specified in paragraph (b)(2) of this section and the applicable sections of Part 413. Costs of compensating these specified medical emergency room staff are allowable only if the costs are incurred under written contracts that require the physician, physician assistant, nurse practitioner, or clinical nurse specialist to come to the CAH when the physician's or other practitioner's presence is medically required.

(B) Effective for costs incurred on or after January 1, 2005, an ''emergency room physician, physician assistant, nurse practitioner, or clinical nurse specialist who is on call'' means a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or experience in emergency care who is immediately available by telephone or radio contact, and is available onsite within the timeframes specified in § 485.618(d) of this chapter.

* * * * *

(d) *Periodic interim payments.* Subject to the provisions of § 413.64(h), a CAH receiving payments under this section may elect to receive periodic interim payments (PIP) for Part A inpatient CAH services, effective for payments made on or after July l, 2004. Payment is made biweekly under the PIP method unless the CAH requests a longer fixed interval (not to exceed one month) between

payments. The biweekly interim payment amount is based on the total estimated Medicare payment (after estimated beneficiary deductibles and coinsurance) for the cost reporting period. Each payment is made 2 weeks after the end of a biweekly period of service, as described in § 413.64(h)(6). These PIP provisions are further described in § 413.64(h)(6). Under certain circumstances that are described in § 413.64(g), a CAH that is not receiving PIP may request an accelerated payment.

(e) *Payment for services of distinct part psychiatric and rehabilitation units of CAHs.* Payment for inpatient services of distinct part psychiatric units of CAHs is made in accordance with regulations governing IPPS-excluded psychiatric units of hospitals at § 413.40. Payment for inpatient services of distinct part rehabilitation units of CAHs is made in accordance with regulations governing the IRF PPS at Subpart F (§§ 412.600 through 412.632) of Part 412 of this subchapter.

§ 413.80 [Redesignated as § 413.89]

5. Section 413.80 is redesignated as § 413.89.

§ 413.85 [Amended]

6. In § 413.85—

A. In paragraph (b)(2), the cross-reference ''§ 413.86'' is removed and the cross-reference ''§§ 413.75 through 413.83'' is added in its place.

B. In paragraph (c)(3), in the definition ''Redistribution of costs,'' the cross-reference ''§ 413.86'' is removed and ''§ 413.75 through 413.83'' is added in its place.

7. Section 413.86 is removed and §§ 413.75 through 413.83 are added to Subpart F to read as follows:

Subpart F—Specific Categories of Costs

413.75 Direct GME payments: General requirements.
413.76 Direct GME payments: Calculation of payments for GME costs.
413.77 Direct GME payments: Determination of per resident amounts.
413.78 Direct GME payments: Determination of the total number of FTE residents.
413.79 Direct GME payments: Determination of the weighted number of FTE residents.
413.80 Direct GME payments: Determination of weighting factors for foreign medical graduates.
413.81 Direct GME payments: Application of community support and redistribution of costs in determining FTE resident counts.
413.82 Direct GME payments: Special rules for States that formerly had a waiver from Medicare reimbursement principles.
413.83 Direct GME payments: Adjustment of a hospital's target amount or prospective payment hospital-specific rate.

§ 413.75 Direct GME payments: General requirements.

(a) *Statutory basis and scope*— (1) *Basis.* This section and §§ 413.76 through 413.83 implement section 1886(h) of the Act by establishing the methodology for Medicare payment of the cost of direct graduate medical educational activities.

(2) *Scope.* This section and §§ 413.76 through 413.83 apply to Medicare payments to hospitals and hospital-based providers for the costs of approved residency programs in medicine, osteopathy, dentistry, and podiatry for cost reporting periods beginning on or after July 1, 1985.

(b) *Definitions.* For purposes of this section and §§ 413.76 through 413.83, the following definitions apply:

''*All or substantially all of the costs for the training program in the nonhospital setting*'' means the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education (GME).

Approved geriatric program means a fellowship program of one or more years in length that is approved by one of the national organizations listed in § 415.152 of this chapter under that respective organization's criteria for geriatric fellowship programs.

Approved medical residency program means a program that meets one of the following criteria:

(1) Is approved by one of the national organizations listed in § 415.152 of this chapter.

(2) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

(i) The Directory of Graduate Medical Education Programs published by the American Medical Association, and available from American Medical Association, Department of Directories and Publications, 515 North State Street, Chicago, Illinois 60610; or

(ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties, and available from American Board of Medical Specialties, One Rotary Center, Suite 805, Evanston, Illinois 60201.

(3) Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

(4) Is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

Base period means a cost reporting period that began on or after October 1, 1983 but before October 1, 1984.

Community support means funding that is provided by the community and generally includes all non-Medicare sources of funding (other than payments made for furnishing services to individual patients), including State and local government appropriations. Community support does not include grants, gifts, and endowments of the kind that are not to be offset in accordance with section 1134 of the Act.

CPI–U stands for the Consumer Price Index for All Urban Consumers as compiled by the Bureau of Labor Statistics.

Foreign medical graduate means a resident who is not a graduate of a medical, osteopathy, dental, or podiatry school, respectively, accredited or approved as meeting the standards necessary for accreditation by one of the following organizations:

(1) The Liaison Committee on Medical Education of the American Medical Association.

(2) The American Osteopathic Association.

(3) The Commission on Dental Accreditation.

(4) The Council on Podiatric Medical Education.

FMGEMS stands for the Foreign Medical Graduate Examination in the Medical Sciences (Part I and Part II).

FTE stands for full-time equivalent.

GME stands for graduate medical education.

Medicare GME affiliated group means—

(1) Two or more hospitals that are located in the same urban or rural area (as those terms are defined in § 412.62(f) of this subchapter) or in a contiguous area and meet the rotation requirements in § 413.79(g)(2).

(2) Two or more hospitals that are not located in the same or in a contiguous urban or rural area, but meet the rotation requirement in § 413.79(g)(2), and are jointly listed—

(i) As the sponsor, primary clinical site, or major participating institution for one or more programs as these terms are used in the most current publication of the *Graduate Medical Education Directory*; or

(ii) As the sponsor or is listed under ''affiliations and outside rotations'' for

one or more programs in operation in *Opportunities, Directory of Osteopathic Postdoctoral Education Programs*.

(3) Two or more hospitals that are under common ownership and, effective for all Medicare GME affiliation agreements beginning July 1, 2003, meet the rotation requirement in § 413.79(g)(2).

Medicare GME affiliation agreement means a written, signed, and dated agreement by responsible representatives of each respective hospital in a Medicare GME affiliated group, as defined in this section, that specifies—

(1) The term of the Medicare GME affiliation agreement (which, at a minimum is 1 year), beginning on July 1 of a year;

(2) Each participating hospital's direct and indirect GME FTE caps in effect prior to the Medicare GME affiliation;

(3) The total adjustment to each hospital's FTE caps in each year that the Medicare GME affiliation agreement is in effect, for both direct GME and IME, that reflects a positive adjustment to one hospital's direct and indirect FTE caps that is offset by a negative adjustment to the other hospital's (or hospitals') direct and indirect FTE caps of at least the same amount;

(4) The adjustment to each participating hospital's FTE counts resulting from the FTE resident's (or residents') participation in a shared rotational arrangement at each hospital participating in the Medicare GME affiliated group for each year the Medicare GME affiliation agreement is in effect. This adjustment to each participating hospital's FTE count is also reflected in the total adjustment to each hospital's FTE caps (in accordance with paragraph (3) of this definition); and

(5) The names of the participating hospitals and their Medicare provider numbers.

Medicare patient load means, with respect to a hospital's cost reporting period, the total number of hospital inpatient days during the cost reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days. In calculating inpatient days, inpatient days in any distinct part of the hospital furnishing a hospital level of care are included and nursery days are excluded.

Primary care resident is a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine or osteopathic general practice.

Redistribution of costs occurs when a hospital counts FTE residents in medical residency programs and the costs of the program had previously been incurred by an educational institution.

Resident means an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board.

Rural track FTE limitation means the maximum number of residents (as specified in § 413.79(l)) training in a rural track residency program that an urban hospital may include in its FTE count and that is in addition to the number of FTE residents already included in the hospital's FTE cap.

Rural track or integrated rural track means an approved medical residency training program established by an urban hospital in which residents train for a portion of the program at the urban hospital and then rotate for a portion of the program to a rural hospital(s) or a rural nonhospital site(s).

Shared rotational arrangement means a residency training program under which a resident(s) participates in training at two or more hospitals in that program.

(c) *Payment for GME costs—General rule*. Beginning with cost reporting periods starting on or after July 1, 1985, hospitals, including hospital-based providers, are paid for the costs of approved GME programs as described in §§ 413.76 through 413.83.

§ 413.76 Direct GME payments: Calculation of payments for GME costs.

A hospital's Medicare payment for the costs of an approved residency program is calculated as follows:

(a) *Step one*. The hospital's updated per resident amount (as determined under § 413.77) is multiplied by the actual number of FTE residents (as determined under § 413.79). This result is the aggregate approved amount for the cost reporting period.

(b) *Step two*. The product derived in step one is multiplied by the hospital's Medicare patient load.

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

(1) 20 percent for 1998;

(2) 40 percent for 1999;

(3) 60 percent in 2000;

(4) 80 percent in 2001; and

(5) 100 percent in 2002 and subsequent years.

(d) *Step four*. Effective for portions of cost reporting periods occurring on or after January 1, 2000, the product derived from step three is reduced by a percentage equal to the ratio of the Medicare+Choice nursing and allied health payment ''pool'' for the current calendar year as described at § 413.87(f), to the projected total Medicare+Choice direct GME payments made to all hospitals for the current calendar year.

(e) *Step five*. (1) For portions of cost reporting periods beginning on or after January 1, 1998 and before January 1, 2000, add the results of steps two and three.

(2) Effective for portions of cost reporting periods beginning on or after January 1, 2000, add the results of steps two and four.

(f) *Step six*. The product derived in step two is apportioned between Part A and Part B of Medicare based on the ratio of Medicare's share of reasonable costs excluding GME costs attributable to each part as determined through the Medicare cost report.

§ 413.77 Direct GME payments: Determination of per resident amounts.

(a) *Per resident amount for the base period*—(1) Except as provided in paragraph (d) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:

(i) Determine the allowable GME costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984. In determining these costs, GME costs allocated to the nursery cost center, research and other nonreimbursable cost centers, and hospital-based providers that are not participating in Medicare are excluded and GME costs allocated to distinct-part hospital units and hospital-based providers that participate in Medicare are included.

(ii) Divide the costs calculated in paragraph (a)(1)(i) of this section by the average number of FTE residents working in all areas of the hospital complex (including those areas whose costs were excluded under paragraph (a)(1)(i) of this section) for its cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

(2) In determining the base-period per resident amount under paragraph (a)(1) of this section, the intermediary—

(i) Verifies the hospital's base-period GME costs and the hospital's average number of FTE residents;

(ii) Excludes from the base-period GME costs any nonallowable or misclassified costs, including those previously allowed under § 412.113(b)(3) of this chapter; and

(iii) Upon a hospital's request, includes GME costs that were misclassified as operating costs during the hospital's prospective payment base year and were not allowable under § 412.113(b)(3) of this chapter during the GME base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in § 413.82(a) of this chapter.

(3) If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount.

(4) If the intermediary modifies a hospital's base-period GME costs as described in paragraph (a)(2)(ii) of this section, the hospital may request an adjustment of its prospective payment hospital-specific rate or target amount as described in § 413.82(a) of this chapter.

(5) The intermediary notifies each hospital that either had direct GME costs or received indirect education payment in its cost reporting period beginning on or after October 1, 1984, and before October 1, 1985, of its base-period average per resident amount. A hospital may appeal this amount within 180 days of the date of that notice.

(b) *Per resident amount for cost reporting periods beginning on or after July 1, 1985, and before July 1, 1986.* For cost reporting periods beginning on or after July 1, 1985, and before July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

(1) If a hospital's base period began on or after October 1, 1983, and before July 1, 1984, the amount is adjusted by the percentage change in the CPI–U that occurred between the hospital's base period and the first cost reporting period to which the provisions of this section apply. The adjusted amount is then increased by one percent.

(2) If a hospital's base period began on or after July 1, 1984 and before October 1, 1984, the amount is increased by one percent.

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

(1) Except as provided in paragraph (c)(2) of this section, each hospital's per resident amount for the previous cost reporting is adjusted by the projected change in the CPI–U for the 12-month cost reporting period. This adjustment is subject to revision during the settlement of the cost report to reflect actual changes in the CPI–U that occurred during the cost reporting period.

(2) For cost reporting periods beginning on or after October 1, 1993 through September 30, 1995, each hospital's per resident amount for the previous cost reporting period will not be adjusted for any resident FTEs who are not either a primary care resident or an obstetrics and gynecology resident.

(d) *Per resident amount for cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2013.* For cost reporting periods beginning on or after October 1, 2000 and ending on or before September 30, 2013, a hospital's per resident amount for each fiscal year is adjusted in accordance with the following provisions:

(1) *General provisions.* For purposes of this § 413.77—

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

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

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

(C) CMS calculates an average of all hospitals' standardized per resident amounts that are determined under paragraph (d)(1)(i)(B) of this section. The resulting amount is the weighted average per resident amount.

(ii) *Primary care/obstetrics and gynecology and nonprimary care per resident amounts.* A hospital's per resident amount is an amount inclusive of any CPI–U adjustments that the hospital may have received since the hospital's base year, including any CPI–U adjustments the hospital may have received because the hospital trains primary care/obstetrics and gynecology residents and nonprimary care residents as specified under paragraph (c)(2) of this section.

(2) *Adjustment beginning in FY 2001 and ending in FY 2013.* For cost reporting periods beginning on or after October 1, 2000, and ending on or before September 30, 2013, a hospital's per resident amount is adjusted in accordance with paragraphs (d)(2)(i) through (d)(2)(iv) of this section, in that order:

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

(ii) *Adjusting for locality.* The updated weighted average per resident amount determined under paragraph (d)(2)(i) of this section (the national average per resident amount) is adjusted for the locality of each hospital by multiplying the national average per resident amount by the 1999 geographic adjustment factor for the physician fee schedule area in which each hospital is located, established in accordance with § 414.26 of this chapter.

(iii) *Determining necessary revisions to the per resident amount.* The locality-adjusted national average per resident amount, as calculated in accordance with paragraph (d)(2)(ii) of this section, is compared to the hospital's per resident amount and is revised, if appropriate, according to the following three categories:

(A) *Floor.* (*1*) For cost reporting periods beginning on or after October 1, 2000, and before October 1, 2001, if the hospital's per resident amount would otherwise be less than 70 percent of the locality-adjusted national average per resident amount for FY 2001 (as determined under paragraph (d)(2)(ii) of this section), the per resident amount is equal to 70 percent of the locality-adjusted national average per resident amount for FY 2001.

(*2*) For cost reporting periods beginning on or after October 1, 2001, and before October 1, 2002, if the hospital's per resident amount would otherwise be less than 85 percent of the locality-adjusted national average per resident amount for FY 2002 (as determined under paragraph (d)(2)(ii) of this section), the per resident amount is equal to 85 percent of the locality-

adjusted national average per resident amount for FY 2002.

(*3*) For subsequent cost reporting periods beginning on or after October 1, 2002, the hospital's per resident amount is updated using the methodology specified under paragraph (c)(1) of this section.

(B) *Ceiling*. If the hospital's per resident amount is greater than 140 percent of the locality-adjusted national average per resident amount, the per resident amount is adjusted as follows for FY 2001 through FY 2013:

(*1*) *FY 2001*. For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2001, if the hospital's FY 2000 per resident amount exceeds 140 percent of the FY 2001 locality-adjusted national average per resident amount (as calculated under paragraph (d)(2)(ii) of this section), subject to the provision stated in paragraph (d)(2)(iii)(B)(*5*) of this section, the hospital's per resident amount is frozen at the FY 2000 per resident amount and is not updated for FY 2001 by the CPI–U factor.

(*2*) *FY 2002*. For cost reporting periods beginning on or after October 1, 2001, and on or before September 30, 2002, if the hospital's FY 2001 per resident amount exceeds 140 percent of the FY 2002 locality-adjusted national average per resident amount, subject to the provision stated in paragraph (d)(2)(iii)(B)(*5*) of this section, the hospital's per resident amount is frozen at the FY 2001 per resident amount and is not updated for FY 2002 by the CPI–U factor.

(*3*) *FY 2003*. For cost reporting periods beginning on or after October 1, 2002, and on or before September 30, 2003, if the hospital's per resident amount for the previous cost reporting period is greater than 140 percent of the locality-adjusted national average per resident amount for that same previous cost reporting period (for example, for cost reporting periods beginning in FY 2003, compare the hospital's per resident amount from the FY 2002 cost report to the hospital's locality-adjusted national average per resident amount from FY 2002), subject to the provision stated in paragraph (d)(2)(iii)(B)(*5*) of this section, the hospital's per resident amount is adjusted using the methodology specified in paragraph (c)(1) of this section, except that the CPI–U applied for a 12-month period is reduced (but not below zero) by 2 percentage points.

(*4*) *FY 2004 through FY 2013*. For cost reporting periods beginning on or after October 1, 2003, and on or before September 30, 2013, if the hospital's preceding year per resident amount exceeds 140 percent of the current year's locality-adjusted national average per resident amount (as calculated under paragraph (d)(2)(ii) of this section), subject to the provision stated in paragraph (d)(2)(iii)(B)(*5*) of this section, the hospital-specific per resident amount is frozen for the current year at the preceding year's hospital-specific per resident amount and is not updated by the CPI–U factor.

(*5*) *General rule for hospitals that exceed the ceiling*. For cost reporting periods beginning on or after October 1, 2000, and on or before September 30, 2013, if a hospital's per resident amount exceeds 140 percent of the hospital's locality-adjusted national average per resident amount and it is adjusted under any of the criteria under paragraphs (d)(2)(iii)(B)(*1*) through (d)(2)(iii)(B)(*3*) of this section, the current year per resident amount cannot be reduced below 140 percent of the locality-adjusted national average per resident amount.

(C) *Per resident amounts greater than or equal to the floor and less than or equal to the ceiling*. For cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2013, if a hospital's per resident amount is greater than or equal to 70 percent and less than or equal to 140 percent of the hospital's locality-adjusted national average per resident amount for each respective fiscal year, the hospital's per resident amount is updated using the methodology specified in paragraph (c)(1) of this section.

(e) *Exceptions*—(1) *Base period for certain hospitals*. If a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after July 1, 1985, the intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. Any GME program costs incurred by the hospital before that cost reporting period are reimbursed on a reasonable cost basis. The per resident amount is based on the lower of the amount specified in paragraph (e)(1)(i) or in paragraph (e)(1)(ii) of this section, subject to the provisions of paragraph (e)(1)(iii) of this section.

(i) The hospital's actual costs, incurred in connection with the GME program for the hospital's first cost reporting period in which residents were on duty during the first month of the cost reporting period.

(ii) Except as specified in paragraph (e)(1)(iii)of this section—

(A) For base periods that begin before October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area, as that term is used in the prospective payment system under Part 412 of this chapter.

(B) For base periods beginning on or after October 1, 2002, the updated weighted mean value of per resident amounts of all hospitals located in the same geographic wage area is calculated using all per resident amounts (including primary care and obstetrics and gynecology and nonprimary care) and FTE resident counts from the most recently settled cost reports of those teaching hospitals.

(iii) If, under paragraph (e)(1)(ii)(A) or paragraph (e)(1)(ii)(B) of this section, there are fewer than three existing teaching hospitals with per resident amounts that can be used to calculate the weighted mean value per resident amount, for base periods beginning on or after October 1, 1997, the per resident amount equals the updated weighted mean value of per resident amounts of all hospitals located in the same census region as that term is used in § 412.62(f)(1)(i) of this chapter.

(2) *Short or long base-period cost reporting periods.* If a hospital's base-period cost reporting period reflects GME costs for a period that is shorter than 50 weeks or longer than 54 weeks, the intermediary converts the allowable costs for the base period into a daily figure. The daily figure is then multiplied by 365 or 366, as appropriate, to derive the approved per resident amount for a 12-month base-period cost reporting period. If a hospital has two cost reporting periods beginning in the base period, the later period serves as the base-period cost reporting period.

(3) *Short or long cost reporting periods beginning on or after July 1, 1985.* If a hospital's cost reporting period is shorter than 50 weeks or longer than 54 weeks, the hospital's intermediary should contact CMS Central Office to receive a special CPI–U adjustment factor.

(f) *Special use of locality-adjusted national average per resident amount.* Effective for portions of cost reporting periods beginning on or after July 1, 2005, a hospital that counts additional residents as a result of an increase in its FTE resident cap under § 413.79(c)(4) will receive direct GME payments based on those additional FTE residents using the locality-adjusted national average per resident amount, as determined under paragraph (d)(2)(ii) of this

section. The hospital will receive direct GME payments based on the sum of the following two direct GME calculations:

(1) A calculation using the hospital's per resident amount(s) as determined under paragraph (d) of this section and the hospital's number of FTE residents that are not attributable to an FTE resident cap increase under § 413.79(c)(4); and

(2) A calculation using the locality-adjusted national average per resident amount, as determined under paragraph (d)(2)(ii) of this section, inflated to the hospital's current cost reporting period, and the hospital's number of FTE residents that is attributable to the increase in the hospital's FTE resident cap under § 413.79(c)(4).

§ 413.78 Direct GME payments: Determination of the total number of FTE residents.

Subject to the weighting factors in §§ 413.79 and 413.80, and subject to the provisions of § 413.81, the count of FTE residents is determined as follows:

(a) Residents in an approved program working in all areas of the hospital complex may be counted.

(b) No individual may be counted as more than one FTE. A hospital cannot claim the time spent by residents training at another hospital. Except as provided in paragraphs (c), (d), and (e) of this section, if a resident spends time in more than one hospital or in a nonprovider setting, the resident counts as partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.

(c) On or after July 1, 1987, and for portions of cost reporting periods occurring before January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(1) The resident spends his or her time in patient care activities.

(2) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.

(d) For portions of cost reporting periods occurring on or after January 1, 1999, and before October 1, 2004, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(1) The resident spends his or her time in patient care activities.

(2) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

(3) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in § 413.75(b).

(4) The hospital is subject to the principles of community support and redistribution of costs as specified in § 413.81.

(e) For portions of cost reporting periods occurring on or after October 1, 2004, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(1) The resident spends his or her time in patient care activities.

(2) The hospital must incur all or substantially all of the costs of the training program in a nonhospital setting(s) (in accordance with the definition under § 413.75(b)) attributable to training that occurs during a month by the end of the month following the month in which the training in the nonhospital site occurred.

(3) The hospital is subject to the principles of community support and redistribution of costs as specified in § 413.81.

§ 413.79 Direct GME payments: Determination of the weighted number of FTE residents.

Subject to the provisions in § 413.80, CMS determines a hospital's number of FTE residents by applying a weighting factor to each resident and then summing the resulting numbers that represent each resident. The weighting factor is determined as follows:

(a) *Initial residency period.* Generally, for purposes of this section, effective July 1, 1995, an initial residency period is defined as the minimum number of years required for board eligibility.

(1) Prior to July 1, 1995, the initial residency period equals the minimum number of years required for board eligibility in a specialty or subspecialty plus 1 year. An initial residency period may not exceed 5 years in order to be counted toward determining FTE status except in the case of a resident in an approved geriatric program whose initial residency period may last up to 2 additional years.

(2) Effective October 1, 2003, for a resident who trains in an approved geriatric program that requires the residents to complete 2 years of training to initially become board eligible in the geriatric specialty, the 2 years spent in the geriatrics program are treated as part of the resident's initial residency period.

(3) Effective July 1, 2000, for residency programs that began before, on, or after November 29, 1999, the period of board eligibility and the initial residency period for a resident in an approved child neurology program is the period of board eligibility for pediatrics plus 2 years.

(4) Effective August 10, 1993, residents or fellows in an approved preventive medicine residency or fellowship program also may be counted as a full FTE resident for up to 2 additional years beyond the initial residency period limitations.

(5) For combined residency programs, an initial residency period is defined as the time required for individual certification in the longer of the programs. If the resident is enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training primary care residents (as defined in § 413.75(b)) or obstetrics and gynecology residents, the initial residency period is the time required for individual certification in the longer of the programs plus 1 year.

(6) For residency programs other than those specified in paragraphs (a)(2) through (a)(4) of this section, the initial residency period is the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training, as specified in the most recently published edition of the Graduate Medical Education Directory.

(7) For residency programs in osteopathy, dentistry, and podiatry, the minimum requirement for certification in a specialty or subspecialty is the minimum number of years of formal

training necessary to satisfy the requirements of the appropriate approving body listed in § 415.152 of this chapter.

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

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

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

(9) The time spent in residency programs that do not lead to certification in a specialty or subspecialty, but that otherwise meet the definition of approved programs, as described in § 413.75(b), is counted toward the initial residency period limitation.

(b) *Weighting factor*—(1) If the resident is in an initial residency period, the weighting factor is one.

(2) If the resident is not in an initial residency period, the weighting factor is 1.00 during the period beginning on or after July 1, 1985 and before July 1, 1986, .75 during the period beginning on or after July 1, 1986 and before July 1, 1987, and .50 thereafter without regard to the hospital's cost reporting period.

(c) *Unweighted FTE counts.*

(1) *Definitions.* As used in this paragraph (c):

(i) *Otherwise applicable resident cap* refers to a hospital's FTE resident cap that is determined for a particular cost reporting period under paragraph (c)(2) of this section.

(ii) *Reference resident level* refers to a hospital's resident level in the applicable reference period specified under paragraph (c)(3)(ii) of this section.

(iii) *Resident level* refers to the number of unweighted allopathic and osteopathic FTE residents who are training in a hospital in a particular cost reporting period.

(2) *Determination of the FTE resident cap.* Subject to the provisions of paragraphs (c)(3) and (c)(4) of this section and § 413.81, for purposes of determining direct GME payment—

(i) For cost reporting periods beginning on or after October 1, 1997, a hospital's resident level may not exceed the hospital's unweighted FTE count (or, effective for cost reporting periods beginning on or after April 1, 2000, 130 percent of the unweighted FTE count for a hospital located in a rural area) for these residents for the most recent cost reporting period ending on or before December 31, 1996.

(ii) If a hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 1997, and before October 1, 2001, exceeds the limit described in this section, the hospital's total weighted FTE count (before application of the limit) will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.

(iii) If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section, the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.

(iv) Hospitals that are part of the same Medicare GME affiliated group (as described under § 413.75(b)) may elect to apply the limit on an aggregate basis as described under paragraph (f) of this section.

(v) The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph (c) of this section based on the equivalent of a 12-month cost reporting period.

(3) *Determination of the reduction to the FTE resident cap due to unused FTE resident slots.* If a hospital's reference resident level is less than its otherwise applicable FTE resident cap as determined under paragraph (c)(2) of this section or paragraph (e) of this section in the reference cost reporting period (as described under paragraph (c)(3)(ii) of this section), for portions of cost reporting periods beginning on or after July 1, 2005, the hospital's otherwise applicable FTE resident cap is reduced by 75 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level. Under this provision—

(i) *Exemption for certain rural hospitals.* Rural hospitals, as defined at § 412.62(f)(iii), with less than 250 beds (as determined at § 412.105(b)) in its most recent cost reporting period ending on or before September 30, 2002, are exempt from the reduction to the otherwise applicable FTE resident cap limit under paragraph (c)(3) of this section.

(ii) *Reference cost reporting periods.*

(A) To determine a hospital's reference resident level, CMS uses one of the following periods:

(*1*) A hospital's most recent cost reporting period ending on or before September 30, 2002, for which a cost report has been settled or if the cost report has not been settled, the as-submitted cost report (subject to audit); or

(*2*) A hospital's cost reporting period that includes July 1, 2003 if the hospital increased its resident level due to an expansion of an existing program and that expansion is not reflected on the hospital's most recent settled cost report; and if the hospital makes a request to use that cost reporting period within a timeframe designated by CMS. An expansion of an existing program means that, except for expansions due to newly approved programs under paragraph (c)(3)(ii)(A)(*3*) of this section, the number of unweighted allopathic and osteopathic FTE residents, regardless of specialty, in any cost reporting period after the hospital's most recent settled cost report, up to and including the hospital's cost report that includes July 1, 2003, is greater than the number of unweighted allopathic and osteopathic FTE residents in the hospital's most recent settled cost report.

(*3*) A hospital may submit a request, within the timeframe designated by CMS, that CMS adjust the resident level for purposes of determining any reduction under paragraph (c)(3) of this section.

(*i*) In the hospital's reference cost reporting period under paragraph (c)(3)(ii)(A)(*1*) of this section, to include the number of FTE residents for which a new program was accredited by the appropriate allopathic or osteopathic accrediting body (listed under § 415.152 of this chapter) before January 1, 2002, if the program was not in operation during the reference cost reporting period under paragraph (c)(3)(ii)(A)(*1*) or (c)(3)(ii)(A)(*2*) of this section; or

(*ii*) In the hospital's reference cost reporting period under paragraph (c)(3)(ii)(A)(*2*) of this section, to include the number of FTE residents for which a new program was accredited by the appropriate allopathic or osteopathic accrediting body (listed under § 415.152 of this chapter) before January 1, 2002, if the program was not in operation during the cost reporting period that includes July 1, 2003, and if the hospital also qualifies to use its cost report under paragraph (c)(3)(ii)(A)(*2*) of this section due to an expansion of an existing program.

(B) If the cost report that is used to determine a hospital's otherwise

applicable FTE resident cap in the reference period is not equal to 12 months, the fiscal intermediary may make appropriate modifications to apply the provisions of paragraph (c)(3)(i)(A) of this section based on the equivalent of a 12-month cost reporting period.

(iii) If the new program described in paragraph (c)(3)(ii)(A)(3)(i) or paragraph (c)(3)(ii)(A)(ii) was accredited for a range of residents, the hospital may request that its reference resident level in its applicable reference cost reporting period under paragraph (c)(3)(ii)(A)(*1*) or (c)(3)(ii)(A)(*2*) of this section be adjusted to reflect the maximum number of accredited slots.

(iv) *Consideration of Medicare GME affiliated group agreements.* For hospitals that are members of the same affiliated group for the program year July 1, 2003 through June 30, 2004, in determining whether a hospital's otherwise applicable resident FTE resident cap is reduced under paragraph (c)(3) of this section, CMS utilizes a hospital's otherwise applicable FTE resident cap as revised by a Medicare GME affiliation agreement for hospitals that are members of the same affiliated group (as described under § 413.75(b)) for the program year July 1, 2003 through June 30, 2004. Possible reductions to a hospital's otherwise applicable FTE resident cap are made on a hospital-specific basis. If the hospital's reference resident level is below its otherwise applicable FTE resident cap as adjusted by the July 1, 2003 Medicare GME affiliation agreement, the hospital's otherwise applicable FTE resident cap is reduced by 75 percent of the difference between the hospital's reference resident level and the otherwise applicable FTE resident cap as adjusted by the July 1, 2003 Medicare GME affiliation agreement.

(4) *Determination of an increase in otherwise applicable resident cap.* For portions of cost reporting periods beginning on or after July 1, 2005, a hospital may receive an increase in its otherwise applicable FTE resident cap up to an additional 25 FTEs (as determined by CMS) if the hospital meets the requirements and qualifying criteria of section 1886(h)(7) of the Act and implementing instructions issued by CMS and if the hospital submits an application to CMS within the timeframe specified by CMS.

(5) *Special rules for hospitals that participate in demonstration projects or voluntary resident reduction plans.*

(i) If a hospital was participating in a demonstration project under section 402 of Public Law 90–248 or the voluntary reduction plan under § 413.88 at any time during the hospital's most recent cost reporting period ending on or before September 30, 2002, for purposes of determining a possible reduction to the FTE resident caps under paragraph (c)(3) of this section, CMS compares the higher of the hospital's base number of residents or the hospital's reference resident level to the hospital's otherwise applicable resident cap determined under paragraph (c)(2) of this section.

(ii) If a hospital withdrew its participation in the demonstration project or the voluntary resident reduction plan prior to its most recent cost reporting period ending on or before September 30, 2002, the special rules in paragraph(c)(5)(i) do not apply, and the hospital is subject to the procedures applicable to all other hospitals for determining possible reductions to the FTE resident caps under paragraph (c)(3) of this section.

(iii) CMS will not redistribute residency positions that are attributable to a hospital's participation in a demonstration project or a voluntary resident reduction plan to other hospitals that seek to increase their FTE resident caps under paragraph (c)(4) of this section.

(d) *Weighted FTE counts.* Subject to the provisions of § 413.81, for purposes of determining direct GME payment—

(1) For the hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding cost reporting period.

(2) For cost reporting periods beginning on or after October 1, 1998, and before October 1, 2001, the hospital's weighted FTE count is equal to the average of the weighted FTE count for the payment year cost reporting period and the preceding two cost reporting periods.

(3) For cost reporting periods beginning on or after October 1, 2001, the hospital's weighted FTE count for primary care and obstetrics and gynecology residents is equal to the average of the weighted primary care and obstetrics and gynecology counts for the payment year cost reporting period and the preceding two cost reporting periods, and the hospital's weighted FTE count for nonprimary care residents is equal to the average of the weighted nonprimary care FTE counts for the payment year cost reporting period and the preceding two cost reporting periods.

(4) The fiscal intermediary may make appropriate modifications to apply the provisions of this paragraph (d) based on the equivalent of 12-month cost reporting periods.

(5) If a hospital qualifies for an adjustment to the limit established under paragraph (c)(2) of this section for new medical residency programs created under paragraph (e) of this section, the count of the residents participating in new medical residency training programs above the number included in the hospital's FTE count for the cost reporting period ending during calendar year 1996 is added after applying the averaging rules in this paragraph (d), for a period of years. Residents participating in new medical residency training programs are included in the hospital's FTE count before applying the averaging rules after the period of years has expired. For purposes of this paragraph (d), for each new program started, the period of years equals the minimum accredited length for each new program. The period of years begins when the first resident begins training in each new program.

(6) Subject to the provisions of paragraph (h) of this section, FTE residents that are displaced by the closure of either another hospital or another hospital's program are added to the FTE count after applying the averaging rules in this paragraph (d), for the receiving hospital for the duration of the time that the displaced residents are training at the receiving hospital.

(7) Subject to the provisions under paragraph (k) of this section, effective for cost reporting periods beginning on or after April 1, 2000, FTE residents in a rural track program at an urban hospital are included in the urban hospital's rolling average calculation described in this paragraph (d).

(8) Subject to the provisions under paragraph(c)(4) of this section, effective for portions of cost reporting periods beginning on or after July 1, 2005, FTE residents added by a hospital as a result of an increase in a hospital's FTE resident cap under paragraph (c)(4) of this section are included in the hospital's rolling average calculation described in this paragraph (d).

(e) *New medical residency training programs.* If a hospital establishes a new medical residency training program as defined in paragraph (l) of this section on or after January 1, 1995, the hospital's FTE cap described under paragraph (c) of this section may be adjusted as follows:

(1) If a hospital had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it establishes a new medical residency training program on or after January 1, 1995, the hospital's unweighted FTE

resident cap under paragraph (c) of this section may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program. The adjustment to the cap may not exceed the number of accredited slots available to the hospital for the new program.

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

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

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

(iv) An urban hospital that qualifies for an adjustment to its FTE cap under paragraph (e)(1) of this section is not permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap.

(v) A rural hospital that qualifies for an adjustment to its FTE cap under paragraph (e)(1) of this section is permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap.

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

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

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

(3) If a hospital with allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, is located in a rural area (or other hospitals located in rural areas that added residents under paragraph (e)(1) of this section), the hospital's unweighted FTE limit may be adjusted in the same manner described in paragraph (e)(2) of this section to reflect the increase for residents in the new medical residency training programs established after August 5, 1997. For these hospitals, the limit will be adjusted for additional new programs but not for expansions of existing or previously existing programs.

(4) A hospital seeking an adjustment to the limit on its unweighted resident count policy must provide documentation to its fiscal intermediary justifying the adjustment.

(f) *Medicare GME affiliated group.* A hospital may receive a temporary adjustment to its FTE cap, which is subject to the averaging rules under paragraph (e)(3) of this section, to reflect residents added or subtracted because the hospital is participating in a Medicare GME affiliated group (as defined under § 413.75(b)). Under this provision—

(1) Each hospital in the Medicare GME affiliated group must submit the Medicare GME affiliation agreement, as defined under § 413.75(b) of this section, to the CMS fiscal intermediary servicing the hospital and send a copy to CMS's Central Office no later than July 1 of the residency program year during which the Medicare GME affiliation agreement will be in effect.

(2) Each hospital in the Medicare GME affiliated group must have a shared rotational arrangement, as defined in § 413.75(b), with at least one other hospital within the Medicare GME affiliated group, and all of the hospitals within the Medicare GME affiliated group must be connected by a series of such shared rotational arrangements.

(3) During the shared rotational arrangements under a Medicare GME affiliation agreement, as defined in § 413.75(b), more than one of the hospitals in the Medicare GME affiliated group must count the proportionate amount of the time spent by the resident(s) in its FTE resident counts. No resident may be counted in the aggregate as more than one FTE.

(4) The net effect of the adjustments (positive or negative) on the Medicare GME affiliated hospitals' aggregate FTE cap for each Medicare GME affiliation agreement must not exceed zero.

(5) If the Medicare GME affiliation agreement terminates for any reason, the FTE cap of each hospital in the Medicare GME affiliated group will revert to the individual hospital's pre-affiliation FTE cap that is determined under the provisions of paragraph (c) of this section.

(g) *Newly constructed hospitals.* A hospital that began construction of its facility prior to August 5, 1997, and sponsored new medical residency training programs on or after January 1, 1995, and on or before August 5, 1997, that either received initial accreditation by the appropriate accrediting body or temporarily trained residents at another hospital(s) until the facility was completed, may receive an adjustment to its FTE cap.

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

(i) The product of the highest number of residents in any program year during the third year of the newly established program and the number of years in which residents are expected to complete the programs based on the minimum accredited length for each type of program; or

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

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

(3) If the new medical residency training programs sponsored by the newly constructed hospital have been in existence for less than 3 years by the

time the residents begin training at the newly constructed hospital, the newly constructed hospital's cap will be based on the number of residents training at the newly constructed hospital in the third year of the programs (including the years at the temporary training site).

(4) A hospital that qualifies for an adjustment to its FTE cap under this paragraph (g) may be part of an affiliated group for purposes of establishing an aggregate FTE cap.

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

(h) *Closure of hospital or hospital residency program.*

(1) *Definitions.* For purposes of this section—

(i) *Closure of a hospital* means the hospital terminates its Medicare agreement under the provisions of § 489.52 of this chapter.

(ii) *Closure of a hospital residency training program* means the hospital ceases to offer training for residents in a particular approved medical residency training program.

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

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

(ii) No later than 60 days after the hospital begins to train the residents, the hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that the hospital is eligible for this temporary adjustment by identifying the residents who have come from the closed hospital and have caused the hospital to exceed its cap, and specifies the length of time the adjustment is needed.

(3) *Closure of a hospital's residency training program.* If a hospital that closes its residency training program voluntarily agrees to temporarily reduce its FTE cap according to the criteria specified in paragraph (h)(3)(ii) of this section, another hospital(s) may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of the residency training program if the criteria specified in paragraph (h)(3)(i) of this section are met.

(i) *Receiving hospital(s).* A hospital may receive a temporary adjustment to its FTE cap to reflect residents added because of the closure of another hospital's residency training program if—

(A) The hospital is training additional residents from the residency training program of a hospital that closed a program; and

(B) No later than 60 days after the hospital begins to train the residents, the hospital submits to its fiscal intermediary a request for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the residents who have come from another hospital's closed program and have caused the hospital to exceed its cap, specifies the length of time the adjustment is needed, and submits to its fiscal intermediary a copy of the FTE reduction statement by the hospital that closed its program, as specified in paragraph (h)(3)(ii)(B) of this section.

(ii) *Hospital that closed its program(s).* A hospital that agrees to train residents who have been displaced by the closure of another hospital's program may receive a temporary FTE cap adjustment only if the hospital with the closed program—

(A) Temporarily reduces its FTE cap based on the FTE residents in each program year training in the program at the time of the program's closure. This yearly reduction in the FTE cap will be determined based on the number of those residents who would have been training in the program during that year had the program not closed; and

(B) No later than 60 days after the residents who were in the closed program begin training at another hospital, submit to its fiscal intermediary a statement signed and dated by its representative that specifies that it agrees to the temporary reduction in its FTE cap to allow the hospital training the displaced residents to obtain a temporary adjustment to its cap; identifies the residents who were in training at the time of the program's closure; identifies the hospitals to which the residents are transferring once the program closes; and specifies the reduction for the applicable program years.

(i) *Additional FTEs for residents on maternity or disability leave or other approved leave of absence.* Effective for cost reporting periods beginning on or after November 29, 1999, a hospital may receive an adjustment to its FTE cap of up to three additional resident FTEs, if the hospital meets the following criteria:

(1) The additional residents are residents of a primary care program that would have been counted by the hospital as residents for purposes of the hospital's FTE cap but for the fact that the additional residents were on maternity or disability leave or a similar approved leave of absence during the hospital's most recent cost reporting period ending on or before December 31, 1996;

(2) The leave of absence was approved by the residency program director to allow the residents to be absent from the program and return to the program after the leave of absence; and

(3) No later than 6 months after August 1, 2000, the hospital submits to the fiscal intermediary a request for an adjustment to its FTE cap, and provides contemporaneous documentation of the approval of the leave of absence by the residency director, specific to each additional resident that is to be counted for purposes of the adjustment.

(j) *Residents previously trained at VA hospitals.* For cost reporting periods beginning on or after October 1, 1997, a non-Veterans Affairs (VA) hospital may receive a temporary adjustment to its FTE cap to reflect residents who had previously trained at a VA hospital and were subsequently transferred to the non-VA hospital, if that hospital meets the following criteria:

(1) The transferred residents had been training previously at a VA hospital in a program that would have lost its accreditation by the ACGME if the residents continued to train at the VA hospital;

(2) The residents were transferred to the hospital from the VA hospital on or after January 1, 1997, and before July 31, 1998; and

(3) The hospital submits a request to its fiscal intermediary for a temporary adjustment to its FTE cap, documents that it is eligible for this temporary adjustment by identifying the residents who have come from the VA hospital, and specifies the length of time those residents will be trained at the hospital.

(k) *Residents training in rural track programs.* Subject to the provisions of § 413.81, an urban hospital that establishes a new residency program, or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks, in addition to the residents subject to its FTE cap specified under paragraph (c) of this section. An urban hospital with a rural track residency program may count residents in those rural tracks up to a rural track FTE limitation if the hospital complies with the conditions specified in paragraphs (k)(2) through (k)(6) of this section.

(1) If an urban hospital rotates residents to a separately accredited rural track program at a rural hospital(s) for two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2003, or for more than

one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital. The urban hospital may include in its FTE count those residents in the rural track training at the urban hospital, not to exceed its rural track FTE limitation, determined as follows:

(i) For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average at paragraph (d)(7) of this section, training in the rural track at the urban hospital.

(ii) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of the highest number of residents, in any program year, who during the third year of the rural track's existence are training in the rural track at the urban hospital or the rural hospital(s) and are designated at the beginning of their training to be rotated to the rural hospital(s) for at least two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2002, or for more than one-half of the duration of the program effective for cost reporting periods beginning on or after October 1, 2003, and the number of years those residents are training at the urban hospital.

(2) If an urban hospital rotates residents to a separately accredited rural track program at a rural nonhospital site(s) for two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under § 413.78(d). The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

(i) For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average specified in paragraph (d)(7) of this section, training in the rural track at the urban hospital and the rural nonhospital site(s).

(ii) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of—

(A) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at—

(*1*) The urban hospital and are designated at the beginning of their training to be rotated to a rural nonhospital site(s) for at least two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003; and

(*2*) The rural nonhospital site(s); and

(B) The number of years in which the residents are expected to complete each program based on the minimum accredited length for the type of program.

(3) If an urban hospital rotates residents in the rural track program to a rural hospital(s) for less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the rural hospital may not include those residents in its FTE count (if the rural track is not a new program under paragraph (e)(3) of this section, or if the rural hospital's FTE count exceeds that hospital's FTE cap), nor may the urban hospital include those residents when calculating its rural track FTE limitation.

(4) If an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for period of time is less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under § 413.78(d). The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track limitation, determined as follows:

(i) For the first 3 years of the rural track's existence, the rural track FTE limitation for the urban hospital will be the actual number of FTE residents, subject to the rolling average specified in paragraph (d)(7) of this section, training in the rural track at the rural nonhospital site(s).

(ii) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of—

(A) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the rural nonhospital site(s) or are designated at the beginning of their training to be rotated to the rural nonhospital site(s) for a period that is less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2002, and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003; and

(B) The length of time in which the residents are being training at the rural nonhospital site(s) only.

(5) All urban hospitals that wish to count FTE residents in rural tracks, not to exceed their respective rural track FTE limitation, must also comply with all of the following conditions:

(i) An urban hospital may not include in its rural track FTE limitation or (assuming the urban hospital's FTE count exceeds its FTE cap) FTE count residents who are training in a rural track residency program that were already included as part of the hospital's FTE cap.

(ii) The hospital must base its count of residents in a rural track on written contemporaneous documentation that each resident enrolled in a rural track program at the hospital intends to rotate for a portion of the residency program to a rural area.

(iii) All residents that are included by the hospital as part of its rural track FTE count (not to exceed its rural track FTE limitation) must train in the rural area. However, where a resident begins to train in the rural track program at the urban hospital but leaves the program before completing the total required portion of training in the rural area, the urban hospital may count the time the resident trained in the urban hospital if another resident fills the vacated FTE slot and completes the training in the rural portion of the rural track program. An urban hospital may not receive GME payment for the time the resident trained at the urban hospital if another resident fills the vacated FTE slot and first begins to train at the urban hospital.

(6) If CMS finds that residents who are included by the urban hospital as part of its FTE count did not actually complete the training in the rural area, CMS will reopen the urban hospital's cost report within the 3-year reopening period as specified in § 405.1885 of this chapter and adjust the hospital's Medicare GME payments (and, where applicable, the hospital's rural track FTE limitation).

(l) For purposes of this section, a new medical residency training program means a medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995.

§ 413.80 Direct GME payments: Determination of weighting factors for foreign medical graduates.

(a) The weighting factor for a foreign medical graduate is determined under the provisions of § 413.79 if the foreign medical graduate—

(1) Has passed FMGEMS; or

(2) Before July 1, 1986, received certification from, or passed an examination of, the Educational Committee for Foreign Medical Graduates.

(b) Before July 1, 1986, the weighting factor for a foreign medical graduate is 1.0 times the weight determined under the provisions of § 413.79. On or after July 1, 1986, and before July 1, 1987, the weighting factor for a graduate of a foreign medical school who was in a residency program both before and after July 1, 1986 but who does not meet the requirements set forth in paragraph (a) of this section is .50 times the weight determined under the provisions of § 413.79.

(c) On or after July 1, 1987, these foreign medical graduates are not counted in determining the number of FTE residents.

(d) During the cost reporting period in which a foreign medical graduate passes FMGEMS, the weighting factor for that resident is determined under the provisions of § 413.79 for the part of the cost reporting period beginning with the month the resident passes the test.

(e) On or after September 1, 1989, the National Board of Medical Examiners Examination, Parts I and II, may be substituted for FMGEMS for purposes of the determination made under paragraphs (a) and (d) of this section.

(f) On or after June 1, 1992, the United States Medical Licensing Examination may be substituted for the FMGEMS for purposes of the determination made under paragraphs (a) and (d) of this section. On or after July 1, 1993, only the results of steps I and II of the United States Medical Licensing Examination will be accepted for purposes of making this determination.

(g) To include a resident in the FTE count for a particular cost reporting period, the hospital must furnish the following information. The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.

(1) The name and social security number of the resident.

(2) The type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs.

(3) The dates the resident is assigned to the hospital and any hospital-based providers.

(4) The dates the resident is assigned to other hospitals, or other freestanding providers, and any nonprovider setting during the cost reporting period, if any.

(5) The name of the medical, osteopathic, dental, or podiatric school from which the resident graduated and the date of graduation.

(6) If the resident is an FMG, documentation concerning whether the resident has satisfied the requirements of this section.

(7) The name of the employer paying the resident's salary.

§ 413.81 Direct GME payments: Application of community support and redistribution of costs in determining FTE resident counts.

(a) For purposes of determining direct GME payments, the following principles apply:

(1) *Community support.* If the community has undertaken to bear the costs of medical education through community support, the costs are not considered GME costs to the hospital for purposes of Medicare payment.

(2) *Redistribution of costs.* The costs of training residents that constitute a redistribution of costs from an educational institution to the hospital are not considered GME costs to the hospital for purposes of Medicare payment.

(b) *Application.* A hospital must continuously incur costs of direct GME of residents training in a particular program at a training site since the date the residents first began training in that program in order for the hospital to count the FTE residents in accordance with the provisions of §§ 413.78, 413.79 (c) through (e), and 413.79(k). This rule also applies to providers that are paid for direct GME in accordance with § 405.2468 of this chapter, § 422.270 of this subchapter, and § 413.70.

(c)(1) *Effective date.* Subject to the provisions of paragraph (c)(2) of this section, payments made in accordance with determinations made under the provisions of paragraphs (a) and (b) of this section will be effective for portions of cost reporting periods occurring on or after October 1, 2003.

(2) *Applicability for certain hospitals.* With respect to an FTE resident who begins training in a residency program on or before October 1, 2003, and with respect to whom there has been a redistribution of costs or community support determined under the provisions of paragraphs (a) and (b) of this section, the hospital may continue to count the FTE resident until the resident has completed training in that program, or until 3 years after the date the resident began training in that program, whichever comes first.

§ 413.82 Direct GME payments: Special rules for States that formerly had a waiver from Medicare reimbursement principles.

(a) Effective for cost reporting periods beginning on or after January 1, 1986, hospitals in States that, prior to becoming subject to the prospective payment system, had a waiver for the operation of a State reimbursement control system under section 1886(c) of the Act, section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b–1 or section 222(a) of the Social Security Amendment of 1972 (42 U.S.C. 1395b–1 (note)) are permitted to change the order in which they allocate administrative and general costs to the order specified in the instructions for the Medicare cost report.

(b) For hospitals making this election, the base-period costs for the purpose of determining the per resident amount are adjusted to take into account the change in the order by which they allocate administrative and general costs to interns and residents in approved program cost centers.

(c) Per resident amounts are determined for the base period and updated as described in § 413.77. For cost reporting periods beginning on or after January 1, 1986, payment is made based on the methodology described in § 413.76.

§ 413.83 Direct GME payments: Adjustment of a hospital's target amount or prospective payment hospital-specific rate.

(a) *Misclassified operating costs*—(1) *General rule.* If a hospital has its base-period GME costs reduced under § 413.77(a) of this section because those costs included misclassified operating costs, the hospital may request that the intermediary review the classification of the affected costs in its rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(2) *Request for review.* The hospital must request review of the classification

of its rate-of-increase ceiling or prospective payment base year costs no later than 180 days after the date of the notice by the intermediary of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that adjustment of the hospital's hospital-specific rate or target amount is warranted.

(3) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate or the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

(b) *Misclassification of GME costs*—(1) *General rule.* If costs that should have been classified as GME costs were treated as operating costs during both the GME base period and the rate-of-increase ceiling base year or prospective payment base year and the hospital wishes to receive benefit for the appropriate classification of these costs as GME costs in the GME base period, the hospital must request that the intermediary review the classification of the affected costs in the rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(2) *Request for review.* The hospital must request review of the classification of its costs no later than 180 days after the date of the intermediary's notice of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that modification of the adjustment of the hospital's hospital-specific rate or target amount is warranted.

(3) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate and the adjustment of the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

§ 413.87 [Amended]

8. In § 413.87—

A. In paragraph (e), the cross-reference ''§ 413.86(d)(4)'' is removed and the cross-reference ''413.76(d)'' is added in its place.

B. In paragraph (f)(1)(i), the cross-reference ''413.86(d)(3)'' is removed and the cross-reference ''413.76(c)'' is added in its place.

§ 413.88 [Amended]

9. In § 413.88—

A. In paragraph (b)(1), the cross-reference ''413.86(b)'' is removed and the cross-reference ''§ 413.75(b)'' is added in its place.

B. In paragraph (b)(2), the cross-reference ''§ 413.86(b)'' is removed and the cross-reference ''§ 413.75(b)'' is added in its place.

C. In paragraph (d)(7), the reference ''413.86(b)'' is removed and the cross-reference ''§ 413.75(b)'' is added in its place.

D. In paragraphs (g)(1)(i)(A) and (B), the cross-reference ''§ 413.86(g)'' is removed and the cross-reference ''§ 413.79'' is added in its place, wherever it appears.

E. In paragraph (h)(1)(i), the cross-reference ''§ 413.86(d)'' (2 times) is removed and the cross-reference ''§ 413.76'' (2 times) is added in its place.

10. Section 413.114 is amended by revising the last sentence of paragraph (a)(2) to read as follows:

§ 413.114 Payment for posthospital SNF care furnished by a swing-bed hospital.

(a) * * *

(2) *Services furnished in cost reporting periods beginning on and after July 1, 2002.* * * * Posthospital SNF care furnished in general routine inpatient beds in CAHs is paid based on reasonable cost for cost reporting periods beginning on and after July l, 2002 and before January 1, 2004, and is paid based on 101 percent of reasonable cost for cost reporting periods beginning on and after January 1, 2004, in accordance with the provisions of subparts A through G of this part (other than paragraphs (c) and (d) of this section).

* * * * *

11. Section 413.302 is amended by revising the definition of ''Urban area'' to read as follows:

§ 413.302 Definitions.

For purposes of this subpart I—

* * * * *

Urban area means—

(1) Prior to October 1, 2004, a Metropolitan Statistical Area (MSA), or New England County Metropolitan Area (NECMA), as defined by the Office of Management and Budget, or a New England county deemed to be an urban area as listed in § 412.62(f)(1)(ii)(B) of this chapter.

(2) Effective October 1, 2004, a Metropolitan Statistical Area (MSA), as defined by the Office of Management and Budget, or a New England county deemed to be an urban area as specified under § 412.64.

D. Part 418 is amended as follows:

PART 418—HOSPICE CARE

1. The authority citation for part 418 continues to read as follows:

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

Section 418.100 is amended as follows:

A. Revising paragraph (d)(1).

B. Revising paragraph (d)(4).

C. Adding a new paragraph (d)(5).

The revision and addition read as follows:

§ 418.100 Condition of Participation: Hospices that provide inpatient care directly.

* * * * *

(d) *Standard: Fire protection.* (1) Except as otherwise provided in this section—

(i) The hospice must meet the provisions applicable to nursing homes of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov./federal_register/code_of_federal_regulations/ibr_locations.html.* Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to a hospice.

* * * * *

(4) Beginning March 13, 2006, a hospice must be in compliance with Chapter 9.2.9, Emergency Lighting.

(5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to hospices.

* * * * *

E. Part 460 is amended as follows:

PART 460—PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

1. The authority citation for part 460 continues to read as follows:

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

Subpart E—PACE Administrative Requirements

2. Section 460.72 is amended by—

A. Revising paragraph (b)(1).

B. Revising paragraph (b)(3).

C. Adding paragraph (b)(4).

The revision and addition read as follows:

§ 460.72 Physical environment.

* * * * *

(b) *Fire safety.* (1) *General rule.* Except as otherwise provided in this section—

(i) A PACE center must meet the applicable provisions of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association that apply to the type of setting in which the center is located. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov./federal_register/code_of_federal_regulations/ibr_locations.html.* Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to PACE centers.

* * * * *

(3) Beginning March 13, 2006, a PACE center must be in compliance with Chapter 9.2.9, Emergency Lighting.

(4) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to PACE centers.

* * * * *

F. The title of Part 480 under Subchapter F is revised to read as follows:

PART 480—ACQUISITION, PROTECTION, AND DISCLOSURE OF QUALITY IMPROVEMENT ORGANIZATION INFORMATION

G. Part 480 is amended as follows:

1. The authority citation for Part 480 continues to read:

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

2. Section 480.106 is amended by adding a new paragraph (c) to read as follows:

§ 480.106 Exceptions to QIO notice requirements.

* * * * *

(c) *Other.* The notification requirements in § 480.105(a) and (b)(2) do not apply if:

(1) The institution or practitioner has requested, in writing, that the QIO make the disclosure;

(2) The institution or practitioner has provided, in writing, consent for the disclosure; or

(3) The information is public information as defined in § 480.101(b) and specified under § 480.120.

3. Section 480.133 is amended by revising paragraph (a)(2)(iii) to read as follows:

§ 480.133 Disclosure of information about practitioners, reviewers and institutions.

(a) * * *

(2) *Disclosure to others.* * * *

(iii) A QIO may disclose to any person, agency, or organization information on a particular practitioner or reviewer at the written request of or with the written consent of that practitioner or reviewer. The recipient of the information has the same redisclosure rights and responsibilities as the requesting or consenting practitioner or reviewer as provided under this Subpart B.

* * * * *

4. Section 480.140 is amended by redesignating paragraphs (d) and (e) as paragraphs (e) and (f), respectively, and adding a new paragraph (d) to read as follows:

§ 480.140 Disclosure of quality review study information.

* * * * *

(d) A QIO may disclose quality review study information with identifiers of particular practitioners or institutions, or both, at the written request of, or with the written consent of, the identified practitioner(s) or institution(s).

(1) The consent or request must specify the information that is to be disclosed and the intended recipient of the information.

(2) The recipient of the information has the same redisclosure rights and responsibilities as the requesting or consenting practitioner or reviewer as provided under this Subpart B.

* * * * *

5. Cross-Reference Changes

§§ 480.101, 480.104, 480.105, 480.106, 480.120, 480.121, 480.130, 480.132, 480.133, 480.136, 480.137, 480.138, 480.141, 480.142 [Amended]

In the table below, for each section indicated in the left column, remove the cross-reference indicated in the middle column from wherever it appears in the section, and add the cross-reference in the right column:

Section	Remove	Add.
480.101(b), under the definition "Patient representative"	§ 476.132(c)(3)	§ 480.132(c)(3).
§ 480.104(a)(1)	§ 476.105	§ 480.105.
§ 480.104(a)(2)	§ 476.106	§ 480.106.
§ 480.104(a)(2)	§ 476.107	§ 480.107.
§ 480.104(d)	§ 476.120(a)(6)	§ 480.120(a)(6).
§ 480.105(a)	§ 476.106	§ 480.106.
§ 480.105(b)(1)	§ 476.132	§ 480.132.
§ 480.105(b)(2)	§§ 476.137 and 476.138	§§ 480.137 and 480.138.
§ 480.105(b)(2)	§ 476.106	§ 480.106.
§ 480.106(a)	§ 476.105	§ 480.105.

Section	Remove	Add.
§ 480.106(b)	§ 476.105	§ 480.105.
§ 480.120, introductory text	§§ 476.104 and 476.105	§§ 480.104 and 480.105.
§ 480.120(a)(5)	§ 476.139	§ 480.139.
§ 480.121	§ 476.105	§ 480.105.
§ 480.121	§ 476.120	§ 480.120.
§ 480.130	§§ 476.139(a) and 476.140	§§ 480.139(a) and 480.140.
§ 480.132(b)(2)	§ 476.139(a)	§ 480.139(a).
§ 480.132(b)(3)	§ 476.140	§ 480.140.
§ 480.133(a)(2)(ii)	§§ 476.137 and 476.138	§§ 480.137 and 480.138.
§ 480.133(b)(2)	§ 476.139(a)	§ 480.139(a).
§ 480.133(b)(3)	§ 476.140	§ 480.140.
§ 480.136(a), introductory text	§§ 476.139(a) and 476.140	§§ 480.139(a) and 480.140.
§ 480.137(a), introductory text	§§ 476.139(a) and 476.140	§§ 480.139(a) and 480.140.
§ 480.138(b)(2)	§§ 476.139(a) and 476.140	§§ 480.139(a) and 480.140.
§ 480.141	§§ 476.104 and 476.105	§§ 480.104 and 480.105.
§ 480.142(b)	§ 476.137	§ 480.137

H. Part 482 is amended as follows:

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

1. The authority citation for part 482 continues to read as follows:

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

2. Section 482.41 is amended by-revising paragraph (b).

§ § 482.41 Conditions of participation: Physical environment.

* * * * *

(b) *Standard: Life safety from fire.* (1) Except as otherwise provided in this section—

(i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.* Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospitals.

(2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients.

(3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals.

(4) Beginning March 13, 2006, a hospital must be in compliance with Chapter 19.2.9, Emergency Lighting.

(5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to hospitals.

(6) The hospital must have procedures for the proper routine storage and prompt disposal of trash.

(7) The hospital must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and cooperation with fire fighting authorities.

(8) The hospital must maintain written evidence of regular inspection and approval by State or local fire control agencies.

* * * * *

3. Section 482.43 is amended by adding new paragraphs (c)(6), (c)(7), and (c)(8) to read as follows:

§ 482.43 Conditions of participation: Discharge planning.

* * * * *

(c) * * *

(6) The hospital must include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.

(i) This list must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.

(ii) The hospital must document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.

(7) The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of home health services and posthospital extended care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not exclude qualified providers that are available to the patient.

(8) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare. Financial interests that are disclosable under Medicare are determined in accordance with the provisions of Part 420, Subpart C, of this chapter.

I. Part 483 is amended as follows:

PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

The authority citation for part 483 continues to read as follows:

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

2. Section 483.70 is amended by revising paragraph (a) to read as follows.

§ 483.70 Physical environment.

* * * * *

(a) *Life safety from fire.*

(1) Except as otherwise provided in this section—

(i) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov./federal_register/code_of_federal_regulations/ibr_locations.html.* Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to long-term care facilities.

(2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients.

(3) The provisions of the Life Safety Code do not apply in a State where CMS finds, in accordance with applicable provisions of sections 1819(d)(2)(B)(ii) and 1919(d)(2)(B)(ii) of the Act, that a fire and safety code imposed by State law adequately protects patients, residents and personnel in long term care facilities.

(4) Beginning March 13, 2006, a long-term care facility must be in compliance with Chapter 19.2.9, Emergency Lighting.

(5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to long-term care facilities.

* * * * *

3. Section 483.470 is amended by revising paragraph (j) to read as follows:

§ 483.470 Condition of participation: Physical environment.

* * * * *

(j) *Standard: Fire protection.*

(1) *General.* Except as otherwise provided in this section—

(i) The facility must meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov./federal_register/code_of_federal_regulations/ibr_locations.html.* Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted LSC does not apply to a facility.

(2) The State survey agency may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.

(3) A facility that meets the LSC definition of a residential board and care occupancy must have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the Fire Safety Evaluation System for Board and Care facilities (FSES/BC).

(4) If CMS finds that the State has a fire and safety code imposed by State law that adequately protects a facility's clients, CMS may allow the State survey agency to apply the State's fire and safety code instead of the LSC.

(5) Beginning March 13, 2006, a facility must be in compliance with Chapter 19.2.9, Emergency Lighting.

(6) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to a facility.

(7) *Facilities that meet the LSC definition of a health care occupancy.* After consideration of State survey agency recommendations, CMS may waive, for appropriate periods, specific provisions of the Life Safety Code if the following requirements are met:

(i) The waiver would not adversely affect the health and safety of the clients.

(ii) Rigid application of specific provisions would result in an unreasonable hardship for the facility.

* * * * *

J. Part 485 is amended as follows:

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

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

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

2. Section 485.610 is amended by revising paragraph (c) to read as follows:

§ 485.610 Condition of participation: Status and location.

* * * * *

(c) *Standard: Location relative to other facilities or necessary provider certification.* The CAH is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH, or before January 1, 2006, the CAH is certified by the State as being a necessary provider of health care services to residents in the area. A CAH that is designated as a necessary provider as of January 1, 2006, will maintain its necessary provider designation after January 1, 2006.

3. Section 485.618 is amended by—

A. Revising paragraph (d)(1) introductory text.

B. In paragraph (d)(2)(iv), removing the cross-reference ''paragraph (d)(2)(ii)'' and adding in its place the cross-reference ''paragraph (d)(2)(iii)''.

C. In paragraph (d)(3), removing the cross-reference ''paragraph (d)(2)(ii)'' and adding in its place the cross-reference ''paragraph (d)(2)(iii)''.

The revision reads as follows:

§ 485.618 Condition of participation: Emergency services.

* * * * *

(d) *Standard: Personnel.* (1) Except as specified in paragraph (d)(2) of this section, there must be a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or experience in emergency care on call and immediately available by telephone

or radio contact, and available onsite within the following timeframes:

* * * * *

4. Section 485.620 is amended by revising paragraph (a) to read as follows:

§ 485.620 Condition of participation: Number of beds and average length of stay.

(a) *Standard: Number of beds.* Except as permitted for CAHs having distinct part units under § 485.646, the CAH maintains no more than 25 inpatient beds after January 1, 2004, that can be used for either inpatient or swing-bed services.

* * * * *

5. Section 485.623 is amended by—

A. Revising paragraph (d)(1)

B. Revising paragraph (d)(5).

C. Adding a new paragraph (d)(6).

The revisions and addition read as follows.

§ 485.623 Condition of participation: Physical plant and environment.

* * * * *

(d) *Standard: Life safety from fire.*

(1) Except as otherwise provided in this section—

(i) The CAH must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov./federal_register/code_of_federal_regulations/ibr_locations.html.* Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the **Federal Register** to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the Life Safety Code does not apply to a CAH.

* * * * *

(5) Beginning March 13, 2006, a critical access hospital must be in compliance with Chapter 9.2.9, Emergency Lighting.

(6) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to critical access hospitals.

6. Section 485.645 is amended by republishing the introductory text of paragraph (a) and revising paragraph (a)(2) to read as follows:

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

* * * * *

(a) *Eligibility.* A CAH must meet the following eligibility requirements:

* * * * *

(2) The facility provides not more than 25 inpatient beds. Any bed of a unit of the facility that is licensed as a distinct-part SNF at the time the facility applies to the State for designation as a CAH is not counted under paragraph (a) of this section.

* * * * *

7. A new § 485.647 is added in subpart F to read as follows:

§ 485.647 Condition of participation: psychiatric and rehabilitation distinct part units.

(a) *Conditions.*

(1) If a CAH provides inpatient psychiatric services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in Subparts A, B, C, and D of Part 482 of this subchapter, the common requirements of § 412.25(a)(2) through (f) of Part 412 of this chapter for hospital units excluded from the prospective payment systems, and the additional requirements of § 412.27 of Part 412 of this chapter for excluded psychiatric units.

(2) If a CAH provides inpatient rehabilitation services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in Subparts A, B, C, and D of Part 482 of this subchapter, the common requirements of § 412.25(a)(2) through (f) of Part 412 of this chapter for hospital units excluded from the prospective payments systems, and the additional requirements of §§ 412.29 and § 412.30 of Part 412 of this chapter related specifically to rehabilitation units.

(b) *Eligibility requirements.*

(1) To be eligible to receive Medicare payments for psychiatric or rehabilitation services as a distinct part unit, the facility provides no more than 10 beds in the distinct part unit.

(2) The beds in the distinct part are excluded from the 25 inpatient-bed count limit specified in § 485.620(a).

(3) The average annual 96-hour length of stay requirement specified under § 485.620(b) does not apply to the 10 beds in the distinct part units specified in paragraph (b)(1) of this section, and admissions and days of inpatient care in the distinct part units are not taken into account in determining the CAH's compliance with the limits on the number of beds and length of stay in § 485.620.

K. Part 489 is amended as follows:

PART 489—PROVIDER AGREEMENT 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).

2. Section 489.20 is amended as follows:

A. In paragraph (m), the cross-reference ''§ 489.24(d)'' is removed and the cross-reference ''§ 489.24(e)'' is added in its place.

B. A new paragraph (t) is added.

§ 489.20 Basic commitments.

* * * * *

(t) Hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970 (or a State occupational safety and health plan that is approved under section 18(b) of the Occupational Safety and Health Act) must comply with the bloodborne pathogens (BBP) standards under 29 CFR 1910.1030. A hospital that fails to comply with the BBP standards may be subject to a civil money penalty in accordance with section 17 of the Occupational Safety and Health Act of 1970, including any adjustments of the civil money penalty amounts under the Federal Civil Penalties Inflation Adjustment Act, for a violation of the BBP standards. A civil money penalty will be imposed and collected in the same manner as civil money penalties under section 1128A(a) of the Social Security Act.

§ 489.53 [Amended]

3. In § 489.53 (b)(2), the cross-reference ''489.24 (d)'' is removed and the cross-reference ''489.24 (e)'' is added in its place.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

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

Dated: May 4, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services

Dated: May 7, 2004.

Tommy G. Thompson,

Secretary.

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

Addendum—Proposed Schedule of Standardized Amount Effective With Discharges Occurring on or After October 1, 2004 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2004

[If you choose to comment on issues in this section, please include the caption ''Operating Payment Rates'' at the beginning of your comment.]

I. Summary and Background

In this Addendum, we are setting forth the proposed amounts and factors for determining prospective payment rates for Medicare hospital inpatient operating costs and Medicare hospital 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 IPPS.

For discharges occurring on or after October 1, 2004, except for SCHs, MDHs, and hospitals located in Puerto Rico, each hospital's payment per discharge under the IPPS will be based on 100 percent of the Federal national rate, which will be based on the national adjusted standardized amount. This amount reflects the national average hospital costs per case from a base year, updated for inflation.

SCHs 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 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

Under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever is higher. MDHs do not have the option to use their FY 1996 hospital-specific rate.

For hospitals in Puerto Rico, the payment per discharge is based on the sum of 25 percent of a Puerto Rico rate that reflects base year average costs per case of Puerto Rico hospitals and 75 percent of the Federal national rate. (See section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are proposing to make changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2005. The proposed changes, to be applied prospectively effective with discharges occurring on or after October 1, 2004, affect the calculation of the Federal rates. In section III. of this Addendum, we discuss our proposed changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2005. Section IV. of this Addendum sets forth our proposed changes for determining the rate-of-increase limits for hospitals excluded from the IPPS for FY 2004. Section V. of this Addendum sets forth policies on payment for blood clotting factor administered to hemophilia patients. The tables to which we refer in the preamble of this proposed rule are presented in section VI. of this Addendum.

II. Proposed Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for FY 2005

The basic methodology for determining prospective payment rates for hospital inpatient operating costs is set forth at existing § 412.63 and proposed new § 412.64. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for hospitals located in Puerto Rico is set forth at existing §§ 412.210 and 412.212 and proposed new § 412.211. Below, we discuss the factors used for determining the prospective payment rates.

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

- The requirements of section 401 of Public Law 108–173, equalizing the standardized amounts for urban and other areas at the level computed for urban hospitals during FY 2004, updated by the applicable percentage increase required under section 501(a) of Public Law 108–173;
- The requirements of section 403 of Public Law 108–173, establishing two labor-related shares that are applicable to the standardized amounts depending on whether the hospital's payments would be higher with a lower (in the case of a wage index below 1.0000) or higher (in the case of a wage index above 1.0000) labor share;
- Updates of 3.3 percent for all areas (that is, the full market basket percentage increase of 3.3 percent, as required by section 501(a) of Public Law 108–173), and reflecting the requirements of section 501(b) of Public Law 108–173, to reduce the applicable percentage increase by 0.4 percentage points for hospitals that fail to submit data in a form and manner specified by the Secretary, relating to the quality of inpatient care furnished by the hospital;
- An adjustment to ensure the proposed DRG recalibration and wage index update and changes are budget neutral, as provided for under sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act, by applying new budget neutrality adjustment factors to the standardized amount;
- An adjustment to ensure the effects of geographic reclassification are budget neutral, as provided for in section 1886(d)(8)(D) of the Act, by removing the FY 2004 budget neutrality factor and applying a revised factor;
- An adjustment to apply the new outlier offset by removing the FY 2004 outlier offsets and applying a new offset;
- An adjustment to ensure the effects of the rural community hospital demonstration required under section 410A of Public Law 108–173 are budget neutral, as required under section 410A(c)(2) of Public Law 108–173.

A. Calculation of the Adjusted Standardized Amount

1. Standardization of Base-Year Costs or Target Amounts

The national standardized amount is based on per discharge averages of adjusted hospital costs from a base period (section 1886(d)(2)(A) of the Act) or, for Puerto Rico, adjusted target amounts from a base period (section 1886(d)(9)(B)(i) of the Act), updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. The preamble to the September 1, 1983 interim final rule (48 FR 39763) contained a detailed explanation of how base-year cost data (from cost reporting periods ending during FY 1981) were established in the initial development of standardized amounts for the IPPS. The September 1, 1987 final rule (52 FR 33043, 33066) contains a detailed explanation of how the target amounts were determined, and how they are used in computing the Puerto Rico rates.

Sections 1886(d)(2)(B) and (d)(2)(C) of the Act require us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, indirect medical education

costs, and costs to hospitals serving a disproportionate share of low-income patients.

Under sections 1886(d)(2)(H) and (d)(3)(E) of the Act, the Secretary estimates from time-to-time the proportion of costs that are wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the proportion considered the labor-related amount is adjusted by the wage index. The current labor-related share is 71.1 percent. The current labor-related share in Puerto Rico is 71.3 percent.

Section 403 of Public Law 108–173 revises the proportion of the standardized amount that is considered labor-related. Specifically, section 403 requires that 62 percent of the standardized amount be adjusted by the wage index, unless doing so would result in lower payments to a hospital than would otherwise be made (section 403(b) extends this provision to the Puerto Rico standardized amounts). As a consequence, we are adjusting 62 percent of the national and Puerto Rico standardized amount by the wage index for all hospitals whose wage indexes are less than or equal to 1.0000; otherwise, the wage index is applied to 71.1 percent of the standardized amount.

2. Computing the Average Standardized Amount

Sections 1886(d)(2)(D) and (d)(3) of the Act previously required the Secretary to compute two average standardized amounts for discharges occurring in a fiscal year: one for hospitals located in large urban areas and one for hospitals located in other areas. In addition, under sections 1886(d)(9)(B)(iii) and (d)(9)(C)(i) of the Act, the average standardized amount per discharge was determined for hospitals located in large urban and other areas in Puerto Rico. In accordance with section 1886(b)(3)(B)(i) of the Act, the large urban average standardized amount was 1.6 percent higher than the other area average standardized amount.

Section 402(b) of Public Law 108–7 required that, effective for discharges occurring on or after April 1, 2003, and before October 1, 2003, the Federal rate for all IPPS hospitals would be based on the large urban standardized amount. Subsequently, Public Law 108–89, extended section 402(b) of Public Law 108–7 beginning with discharges on or after October 1, 2003 and before March 31, 2004. Finally, section 401(a) of Public Law 108–173 requires that, beginning with fiscal year 2004 and thereafter, an equal standardized amount is to be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. This provision in effect makes permanent the equalization of the standardized amounts at the level of the previous standardized amount for large urban hospitals. Section 401(c) also equalizes the Puerto Rico-specific urban and other area rates. Accordingly, we are providing in this proposed rule for a single national standardized amount, and a single Puerto Rico standardized amount, for FY 2005 and thereafter.

3. Updating the Average Standardized Amount

In accordance with section 1886(d)(3)(A)(iv) of the Act, we are proposing to update the equalized standardized amount for FY 2005 by the full estimated market basket percentage increase for hospitals in all areas, as specified in section 1886(b)(3)(B)(i)(XIX) of the Act, as amended by section 501 of Public Law 108–173. The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital market basket increase for FY 2005 is 3.3 percent. Thus, for FY 2005, the proposed update to the average standardized amount equals 3.3 percent for hospitals in all areas.

As discussed above in section IV.E. of this proposed rule, section 501(b) of Public Law 108–173 amended section 1886(b)(3)(B) of the Act to add a new subclause (vii) to revise the mechanism used to update the standardized amount for payment for inpatient hospital operating costs. Specifically, the amendment provides for a reduction of 0.4 percentage points to the update percentage increase (also known as the market basket update) for each of FYs 2005 through 2007 for any ''subsection (d) hospital'' that does not submit data on a set of 10 quality indicators established by the Secretary as of November 1, 2003. The statute also provides that any reduction will apply only to the fiscal year involved, and will not be taken into account in computing the applicable percentage increase for a subsequent fiscal year. This measure establishes an incentive for hospitals to submit data on quality measures established by the Secretary. The standardized amount in Tables 1A through 1D of section VI. of this addendum reflect these differential amounts.

Although the update factors for FY 2005 are set by law, we are required by section 1886(e)(3) of the Act to report to the Congress our initial recommendation of update factors for FY 2005 for both IPPS hospitals and hospitals excluded from the IPPS. Our recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth as Appendix B of this proposed rule.

4. Other Adjustments to the Average Standardized Amount

As in the past, we are proposing to adjust the FY 2005 standardized amount to remove the effects of the FY 2004 geographic reclassifications and outlier payments before applying the FY 2005 updates. We then apply the new offsets for outliers and geographic reclassifications to the standardized amount for FY 2005.

We do not remove the prior year's budget neutrality adjustments for reclassification and recalibration of the DRG weights and for updated wage data because, in accordance with section 1886(d)(4)(C)(iii) of the Act, 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.

Budget neutrality is determined by comparing aggregate IPPS payments before and after making the changes that are required to be budget neutral (for example, reclassifying and recalibrating the DRGs, updating the wage data, and geographic reclassifications). We include outlier payments in the payment simulations because outliers may be affected by changes in these payment parameters.

We are also proposing to adjust the standardized amount this year by an amount estimated to ensure that aggregate IPPS payments do not exceed the amount of payments that would have been made in the absence of the rural community hospital demonstration required under section 410A of Public Law 108–173. This demonstration is required to be budget neutral under section 410A(c)(2) of Public Law 108–173.

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. However, 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 payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, we are proposing to make a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. For FY 2005, we are proposing to apply an occupational mix adjustment to the wage index. We describe our proposed occupational mix adjustment in section III.C. of this proposed rule. Since section 1886(d)(3)(E) of the Act requires us to update the wage index on a budget neutral basis, we are including the effects of this proposed occupational mix adjustment on the wage index in our budget neutrality calculations.

Section 4410 of Public Law 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State. This provision is required by section 4410(b) of Public Law 105–33 to be budget neutral. Therefore, we include the effects of this provision in our calculation of the wage update budget neutrality factor.

Section 1886(d)(5)(K)(ii)(III) of the Act previously required that we adjust the rates to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act be budget neutral. However, section 503(d)(2) of Public Law 108–173 has repealed this requirement. We discuss this provision in section II.E. of this proposed rule. In accordance with this provision, we are proposing no budget neutrality adjustment to account for approval of new technologies for add-on payments in FY 2005.

To comply with the requirement that DRG reclassification and recalibration of the relative weights be budget neutral, and the requirement that the updated wage index be budget neutral, we used FY 2003 discharge data to simulate payments and compared aggregate payments using the FY 2004 relative weights and wage index to aggregate payments using the proposed FY 2005 relative weights and wage index. The same methodology was used for the FY 2004 budget neutrality adjustment (although the FY 2004 adjustment included the effects of new technology add-on payments).

Based on this comparison, we computed a proposed budget neutrality adjustment factor equal to 0.998969. We also are proposing to adjust the Puerto Rico-specific standardized amount for the effect of DRG reclassification and recalibration. We computed a proposed budget neutrality adjustment factor for Puerto Rico-specific standardized amount equal to 0.999326. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2004 budget neutrality adjustments.

In addition, we are proposing to apply these same adjustment factors to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 2004. (See the discussion in the September 4, 1990 final rule (55 FR 36073)).

b. Reclassified Hospitals—Budget Neutrality Adjustment

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

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amount to ensure that aggregate payments under the IPPS 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. (Neither the wage index reclassifications provided under section 508 of Public Law 108–173, nor the wage index adjustments provided under section 505 of Public Law 108–173, are budget neutral. Section 508(b) provides that the wage index reclassifications approved under section 508(a) ''shall not be effected in a budget neutral manner.'' Section 505(a) similarly provides that any increase in a wage index under that section shall not be taken into account ''in computing any budget neutrality adjustment with respect to such index under'' section 1886(d)(8)(D) of the Act.) To calculate this budget neutrality factor, we used FY 2003 discharge data to simulate payments, and compared total IPPS payments prior to any reclassifications under sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act to total IPPS payments after such reclassifications. Based on these simulations, we are proposing to apply an adjustment factor of 0.994295 to ensure that the effects of this reclassification are budget neutral.

The proposed adjustment factor is applied to the standardized amount after removing the effects of the FY 2004 budget neutrality adjustment factor. We note that the proposed FY 2005 adjustment reflects proposed FY 2005 wage index reclassifications approved by the MGCRB or the Administrator, and the effects of MGCRB reclassifications approved in FY 2003 and FY 2004 (section 1886(d)(10)(D)(v) of the Act makes wage index reclassifications effective for 3 years).

c. Outliers

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments, for ''outlier'' cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outlier payment). To determine whether the costs of a case exceed the fixed-loss threshold, a hospital's cost-to-charge ratio is applied to the total covered charges for the case to convert the charges to costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the costs above the threshold.

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 operating DRG payments plus outlier payments. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amount by a 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 reduce the average standardized amounts applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases.

i. Proposed FY 2005 outlier fixed-loss cost threshold. In the August 1, 2003 IPPS final rule (68 FR 45476–45478), we established a threshold for FY 2004 that was equal to the prospective payment rate for the DRG, plus any IME and DSH payments and any additional payments

for new technology, plus $31,000. The marginal cost factor (the percent of costs paid after costs for the case exceed the threshold) was 80 percent.

To calculate the proposed FY 2005 outlier thresholds, we simulated payments by applying proposed FY 2005 rates and policies using cases from the FY 2003 MedPAR file. Therefore, in order to determine the appropriate proposed FY 2005 threshold, it was necessary to inflate the charges on the MedPAR claims by 2 years, from FY 2003 to FY 2005. We are proposing to use a 2-year average annual rate of change in charges per case to inflate FY 2003 charges to approximate FY 2005 charges. The 2-year average annual rate of change in charges per case from FY 2000 to FY 2001, and from FY 2001 to FY 2002, was 12.5978 percent annually or 26.8 percent over 2 years.

We are proposing to continue to use the 2-year average annual rate of change in charges per case to establish the proposed FY 2005 threshold. The 2-year average annual rate of change in charges per case from FY 2001 to FY 2002, and from FY 2002 to FY 2003, was 14.5083 percent annually, or 31.1 percent over 2 years. As we have done in the past, we are using hospital cost-to-charge ratio from the most recently Provider Specific File, in this case the December 2003 update. This file includes cost-to-charge ratios reflecting implementation of changes we made last year to the policy affecting the applicable cost-to-charge ratios (68 FR 34494). As of October 1, 2003, fiscal intermediaries use either the most recent settled or the most recent tentative settled cost report, whichever is from the latest reporting period. Because in the past cost-to-charge ratios were taken from the latest settled cost reports and for some hospitals there were delays in settling their cost reports, the cost-to-charge ratios on the Provider Specific File may have been from cost reporting periods that were several years prior. This change results in more up-to-date and, generally, lower cost-to-charge ratios.

Using this methodology, we are proposing to establish a fixed-loss cost outlier threshold equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $35,085. This single threshold would be applicable to qualify for both operating and capital outlier payments. We also are proposing to maintain the marginal cost factor for cost outliers at 80 percent.

This proposed outlier threshold for FY 2005 may be higher than might have been anticipated on the basis of the more up-to-date and, generally, lower cost-to-charge ratios that we are now employing. We believe that a significant factor in this result may be the 2-year average annual rates of change that we are employing to update charges in the MedPAR data from FY 20003 to FY 2005. As we discussed above, we are employing the 2-year average annual rate of change in charges per case from FY 2001 to FY 2002, and from FY 2002 to FY 2003, which is 14.5083 percent annually, or 31.1 percent over 2 years. These rates of increase derive from the period before the changes we made last year to the policy affecting the applicable cost-to-charge ratios (68 FR 34494). In fact, they derive from the years just prior to the adoption of the policy changes, when some hospitals were increasing charges at a rapid rate in order to increase their outlier payments. Therefore, they represent rates of increase that may be higher than the rates of increase under our new policy. We have always used actual data from prior years, rather than projections, to update charges for purposes of determining the outlier threshold. In light of the increase in the proposed outlier threshold for FY 2005, compared to the threshold previously in effect, we welcome comments on the data we are using to update charges for purposes of computing the threshold. We especially encourage commenters to provide any recommendations for data that might better reflect current trends in charge increases.

ii. Other changes concerning outliers. As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both hospital inpatient operating costs and hospital 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 lower percentage of outlier payments for capital-related costs than for operating costs. We project that the proposed thresholds for FY 2005 would result in outlier payments equal to 5.10 percent of operating DRG payments and 5.03 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we reduced the proposed FY 2005 standardized amount by the same percentage to account for the projected proportion of payments paid to outliers.

The proposed outlier adjustment factors to be applied to the standardized amount for FY 2005 are as follows:

	Operating standardized amounts	Capital Federal rate
National	0.948994	0.949706
Puerto Rico	0.974692	0.9747329

We apply the outlier adjustment factors after removing the effects of the FY 2004 outlier adjustment factors on the standardized amount.

To determine whether a case qualifies for outlier payments, we apply hospital-specific cost-to-charge ratios to the total covered charges for the case. Operating and capital costs for the case are calculated separately by applying separate operating and capital cost-to-charge ratios. These costs are then combined and compared with the fixed-loss outlier threshold.

The June 9, 2003 outlier final rule (68 FR 34494) eliminated the application of the statewide average for hospitals whose cost-to-charge ratios fall below 3 standard deviations from the national mean cost-to-charge ratio. However, for those hospitals for which the fiscal intermediary computes operating cost-to-charge ratios greater than 1.460 or capital cost-to-charge ratios greater than 0.173, or hospitals for whom the fiscal intermediary is unable to calculate a cost-to-charge ratio (as described at § 412.84(i)(3)), we are still using statewide average ratios to calculate costs to determine whether a hospital qualifies for outlier payments.[7] Table 8A in section VI. of this Addendum contains the statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals for which the fiscal intermediary is unable to compute a hospital-specific cost-to-charge ratio within the above range. These statewide average ratios would replace the ratios published in the August 1, 2003 IPPS final rule (68 FR 45637). Table 8B in section VI. of this Addendum contains the proposed comparable statewide average capital cost-to-charge ratios. Again, the proposed cost-to-charge ratios in Tables 8A and 8B would be used during FY 2005 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or are outside the range noted above.

iii. FY 2003 and FY 2004 outlier payments. In the August 1, 2003 IPPS final rule (68 FR 45478), we stated that, based on available data, we estimated that actual FY 2003 outlier payments would be approximately 6.5 percent of actual total DRG payments. This estimate was computed based on

[7] These figues represent 3.0 standard deviations from the mean of the log distribution of cost-to-charge ratios for all hospitals.

simulations using the FY 2002 MedPAR file (discharge data for FY 2002 bills). That is, the estimate of actual outlier payments did not reflect actual FY 2003 bills, but instead reflected the application of FY 2003 rates and policies to available FY 2002 bills.

Our current estimate, using available FY 2003 bills, is that actual outlier payments for FY 2003 were approximately 5.7 percent of actual total DRG payments. Thus, the data indicate that, for FY 2003, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 2003 (and, thus, exceeds the percentage by which we reduced the standardized amounts for FY 2003). Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not plan to make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2003 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2004 will be approximately 4.4 percent of actual total DRG payments, 0.7 percentage points lower than the 5.1 percent we projected in setting outlier policies for FY 2004. This estimate is based on simulations using the FY 2003 MedPAR file (discharge data for FY 2003 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2004 by applying FY 2004 rates and policies, including an outlier threshold of $31,000 to available FY 2003 bills.

d. Section 410A Rural Community Hospital Demonstration Program Adjustment

Section 410A of Public Law 108–173 requires the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to fifteen small rural hospitals. Section 410A(c)(2) requires that ''in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' As discussed in section IV.P. of this proposed rule, we are proposing to satisfy this requirement by adjusting national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment that will be made to each participating hospital under the demonstration will be approximately $1,120,000. We based this estimate on the recent historical experience of the difference between inpatient cost and payment for hospitals that would be eligible for the demonstration. For 15 participating hospitals, the total annual impact of the demonstration program is estimated to be $16,820,148. We estimate that there will be an average decrease in payment per discharge of approximately $0.83. The required adjustment as a result of the demonstration to the Federal rate in calculating Medicare inpatient prospective payments is 0.999818.

In order to achieve budget neutrality, we are proposing to adjust national IPPS rates by an amount sufficient to account for the added costs of this demonstration. We are proposing, in other words, to apply budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration. We believe that the language of the statutory budget neutrality requirement permits the agency to implement the budget neutrality provision in this manner. This is because the statutory language requires ''aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration * * * was not implemented,'' but does not identify the range across which aggregate payments must be held equal. We invite public comment on this proposal.

5. Proposed FY 2005 Standardized Amount

The adjusted standardized amount is divided into labor and nonlabor portions. Tables 1A and 1B in section VI. of this Addendum contain the national standardized amount that we are proposing to apply to all hospitals, except hospitals in Puerto Rico. The amounts shown in the two tables differ only in that the labor-related share applied to the standardized amounts in Table 1A is 71.1 percent, and the labor-related share applied to the standardized amounts in Table 1B is 62 percent. As described in section II.A.1. of this Addendum, we are proposing to implement section 403 of Public Law 108–173, which provides that the labor-related share is 62 percent, unless the application of that percentage would result in lower payments to a hospital than would otherwise be made. The effect of this provision is that the labor-related share of the standardized amount is 62 percent for all hospitals whose wage indexes are less than or equal to 1.0000. However, the labor-related share of the standardized amount remains 71.1 percent (reflecting the Secretary's current estimate of the proportion of costs that are wages and wage-related costs) for hospitals whose wage indexes are greater than 1.0000. In addition, both tables include standardized amounts reflecting the full 3.3 percent update for FY 2005, and standardized amounts reflecting the 0.4 percentage point reduction to the update applicable for hospitals that fail to submit quality data consistent with section 501(b) of Public Law 108–173. (Tables 1C and 1D show the new standardized amounts for Puerto Rico, reflecting the different labor shares that apply, that is, 71.3 percent or 62 percent.)

The following tables illustrate the proposed changes from the FY 2004 national average standardized amount. The first column shows the proposed changes from the 2004 standardized amounts for hospitals that satisfy the quality data submission requirement for receiving the full update (3.3 percent). The second column shows the proposed changes for hospitals receiving the reduced update (2.9 percent). The first row in the table shows the updated (through FY 2003) average standardized amount after restoring the FY 2004 offsets for outlier payments and geographic reclassification budget neutrality. The DRG reclassification and recalibration and wage index budget neutrality factor is cumulative. Therefore, the FY 2004 factor is not removed from the amount in the table. We have added separate rows to this table to reflect the different labor-related shares that apply to hospitals.

COMPARISON OF FY 2004 STANDARDIZED AMOUNTS TO PROPOSED FY 2005 SINGLE STANDARDIZED AMOUNT WITH FULL UPDATE AND REDUCED UPDATE

	Full update (3.3 percent)	Reduced update (2.9 percent).
FY 2004 Base Rate (after removing reclassification budget neutrality and outlier offset).	Labor: $3,331.33 Nonlabor: $1,354.09	Labor: $3,331.33 Nonlabor: $1,354.09.
Proposed FY 2005 Update Factor	1.033	1.029.

COMPARISON OF FY 2004 STANDARDIZED AMOUNTS TO PROPOSED FY 2005 SINGLE STANDARDIZED AMOUNT WITH FULL UPDATE AND REDUCED UPDATE—Continued

	Full update (3.3 percent)	Reduced update (2.9 percent).
Proposed FY 2005 DRG Recalibrations and Wage Index Budget Neutrality Factor.	0.998969	0.998969.
Proposed FY 2005 Reclassification Budget Neutrality Factor	0.994295	0.994295.
Adjusted for Blend of FY 2004 DRG Recalibration and Wage Index Budget Neutrality Factors*.	Labor: $3,418.04 Nonlabor: $1,389.33	Labor: $3,404.81 Nonlabor: $1,383.95.
Proposed FY 2005 Outlier Factor	0.948994	0.948994.
Proposed Rural Demo Budget Neutrality Factor	0.999818	0.999818.
Proposed Rate for FY 2005 (after multiplying FY 2004 base rate by above factors) where the wage index is less than or equal to 1.0000.	Labor: $2,828.03 Nonlabor: $1,733.30	Labor: $2,817.08 Nonlabor: $1,726.59.
Proposed Rate for FY 2005 (after multiplying FY 2004 base rate by above factors) where the wage index is greater than 1.0000.	Labor: $3,243.10 Nonlabor: $1,318.22	Labor: $3,230.55 Nonlabor: $1,313.12

*In order to calculate this adjustment correctly, it is necessary to multiply on the DRG recalibration and wage index budget neutrality factor of 1.002608 (1.002588 from October 1, 2003 through March 31, 2004; 1.002628 from April 1, 2004 through September 30, 2004) and divide off the factor of 1.002628 from the second half of FY 2004. This is to account for the fact that it was necessary to employ different budget neutrality adjustments for the first and second halves of FY 2004 due to the extension of the extension of the standardized amount equalization, effective April 1, 2004.

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount (as set forth in Table 1A). The labor and nonlabor portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C of section VI. of this Addendum. This table also includes the Puerto Rico standardized amounts. The labor share applied to the Puerto Rico standardized amount is 71.3 percent, or 62 percent, depending on which is more advantageous to the hospital. (Section 403(b) of Public Law 108–173 provides that the labor-related share for hospitals in Puerto Rico will be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

B. Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1D, as set forth in section VI. of this Addendum, contain the labor-related and nonlabor-related shares that we are proposing to use 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 proposed prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, 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 to this proposed rule, we discuss the data and methodology for the proposed FY 2005 wage index. The proposed FY 2005 wage index is set forth in Tables 4A, 4B, 4C, and 4F of section VI. 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 2005, we are proposing to adjust the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amount by the appropriate adjustment factor contained in the table below. If the Office of Personnel Management releases revised cost-of-living adjustment factors before July 1, 2004, we will publish them in the final rule and use them in determining FY 2005 payments.

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

Area	Cost of living adjustment factor.
Alaska-All areas	1.25.
Hawaii:	.
County of Honolulu	1.25.

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

Area	Cost of living adjustment factor.
County of Hawaii	1.165.
County of Kauai	1.2325.
County of Maui	1.2375.
County of Kalawao	1.2375

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

C. DRG Relative Weights

As discussed in section II. of the preamble, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section VI. of this Addendum contains the relative weights that we are proposing to use for discharges occurring in FY 2005. These factors have been recalibrated as explained in section II. of the preamble of this proposed rule.

D. Calculation of Proposed Prospective Payment Rates for FY 2005

General Formula for Calculation of Proposed Prospective Payment Rates for FY 2005

The proposed operating prospective payment rate for all hospitals paid under the IPPS located outside of Puerto Rico, except SCHs and MDHs, equals the Federal rate based on the corresponding amounts in Table 1A or Table 1B in section VI. of this Addendum.

The proposed prospective payment rate for SCHs equals the higher of the applicable Federal rate (from Table 1A or Table 1B) or the hospital-specific rate as described below. The proposed prospective payment rate for MDHs equals the higher of the Federal rate, or the Federal rate plus 50 percent of the difference between the Federal rate and the hospital-specific rate as described below. The proposed prospective payment rate for Puerto Rico equals 25 percent of the Puerto Rico rate plus 75 percent of the applicable national rate from Table 1C or Table 1D in section VI. of this Addendum.

1. Federal Rate

For discharges occurring on or after October 1, 2004 and before October 1, 2005, except for SCHs, MDHs, and hospitals in Puerto Rico, payment under the IPPS is based exclusively on the Federal rate.

The Federal rate is determined as follows:

Step 1—Select the appropriate average standardized amount considering the applicable wage index (Table 1A for wage indexes greater than 1.0000 and Table 1B for wage indexes less than or equal to 1.0000) and whether the hospital has submitted qualifying quality data (full update for qualifying hospitals, update minus 0.4 percent for nonqualifying hospitals).

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 or the area to which the hospital is reclassified (see Tables 4A, 4B, and 4C of section VI. of this Addendum).

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

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

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

The Federal rate as determined in Step 5 may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment.

2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that SCHs 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 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

Section 1886(d)(5)(G) of the Act provides that MDHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate or the Federal rate plus 50 percent of the difference between the Federal rate and the greater of the updated hospital-specific rates based on either FY 1982 or FY 1987 costs per discharge. MDHs do not have the option to use their FY 1996 hospital-specific rate.

Hospital-specific rates have been determined for each of these hospitals based on either the FY 1982 costs per discharge, the FY 1987 costs per discharge or, for SCHs, the FY 1996 costs per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); the September 4, 1990 final rule (55 FR 35994); and the August 1, 2000 final rule (65 FR 47082). In addition, for both SCHs and MDHs, the hospital-specific rate is adjusted by the proposed budget neutrality adjustment factor (that is, by 0.998969) as discussed in section II.A.4.a. of this Addendum. The resulting rate would be used in determining the payment rate an SCH or MDH would receive for its discharges beginning on or after October 1, 2004.

b. Updating the FY 1982, FY 1987, and FY 1996 Hospital-Specific Rates for FY 2005

We are proposing to increase the hospital-specific rates by 3.3 percent (the hospital market basket percentage increase) for SCHs and MDHs for FY 2005. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for SCHs is equal to the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for SCHs in FY 2005, is the market basket rate of increase. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for MDHs also equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2005, is the market basket rate of increase.

3. General Formula for Calculation of Proposed Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2004 and Before October 1, 2005

Section 504 of Public Law 108–173 changes the current blend of 50 percent the Puerto Rico national prospective payment rate and 50 percent of the Puerto Rico-specific prospective payment rate to 62.5 percent Puerto Rico national and 37.5 percent Puerto Rico-specific effective for discharges occurring on or after April 1, 2004 and before October 1, 2004. Effective for discharges occurring on or after October 1, 2004, the effective blend is 75 percent of the Puerto Rico national prospective payment rate and 25 percent of the Puerto Rico-specific rate.

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate average standardized amount considering the applicable wage index (Table 1C for wage indexes greater than 1.0000 and Table 1D for wage indexes less than or equal to 1.0000).

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

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

Step 4—Multiply the result in Step 3 by 25 percent.

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

b. National Rate

The national prospective payment rate is determined as follows:

Step 1—Select the appropriate average standardized amount considering the applicable wage index (Table 1C for wage indexes greater than 1.0000 and Table 1D for wage indexes less than or equal to 1.0000).

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 75 percent.

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

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

further adjusted if the hospital qualifies for either the IME or DSH adjustment.

III. Proposed Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2005

The PPS for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period, hospitals were paid during a 10-year transition period (which extended through FY 2001) to change the payment methodology for Medicare acute care hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The basic methodology for determining Federal capital prospective rates is set forth in regulations at §§ 412.308 through 412.352. Below we discuss the factors that we are proposing to use to determine the capital Federal rate for FY 2005, which would be effective for discharges occurring on or after October 1, 2004. The 10-year transition period ended with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002). Therefore, for cost reporting periods beginning in FY 2002, all hospitals (except ''new'' hospitals under §§ 412.304(c)(2) and 412.324(b)) are paid based on 100 percent of the capital Federal rate.

For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS 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 capital standard Federal rate, as provided at § 412.308(c)(1), to account for capital input price increases and other factors. The regulations at § 412.308(c)(2) provides that the capital Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the capital Federal rate to total capital payments under the capital Federal rate. In addition, § 412.308(c)(3) requires that the capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for (regular and special) exception under § 412.348. Section 412.308(c)(4)(ii) requires that the capital standard Federal rate be adjusted so that the effects of the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral.

For FYs 1992 through 1995, § 412.352 required that the capital Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the capital rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the capital rate made in FY 1996 as a result of the revised policy of paying for transfers. In FY 1998, we implemented section 4402 of Public Law 105–33, which requires that, for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted capital standard Federal rate is reduced by 17.78 percent. As we discussed in the August 1, 2002 IPPS final rule (67 FR 50102) and implemented in § 412.308(b)(6)), a small part of that reduction was restored effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the regular exceptions payment adjustment during the 10-year transition period, we developed a dynamic model of Medicare inpatient capital-related costs; that is, a model that projected changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the capital cost model was only used to estimate the regular exceptions payment adjustment and other factors during the transition period. As we explained in the August 1, 2001 IPPS final rule (66 FR 39911), beginning in FY 2003, an adjustment for regular exception payments is no longer necessary because regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001 (see § 412.348(b)). Because, effective with cost reporting periods beginning in FY 2002, payments are no longer being made under the regular exception policy, we no longer use the capital cost model. The capital cost model and its application during the transition period are described in Appendix B of the August 1, 2001 IPPS final rule (66 FR 40099).

In accordance with section 1886(d)(9)(A) of the Act, under the IPPS for acute care hospital operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended capital rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1997, in accordance with section 4406 of Public Law 105–33, operating payments to hospitals in Puerto Rico are based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges on or after October 1, 1997, we also revised the methodology for computing capital payments to hospitals in Puerto Rico and computing capital payments based on a blend of 50 percent of the Puerto Rico capital rate and 50 percent of the capital Federal rate.

As we discuss in section VI. of this Addendum to the proposed rule, section 504 of Public Law 108–173 increases the national portion of the operating IPPS payment for Puerto Rico hospitals from 50 percent to 62.5 percent and decreases the Puerto Rico portion of the operating IPPS payments from 50 percent to 37.5 percent for discharges occurring on or after April 1, 2004 through September 30, 2004 (see the March 26, 2004 One-Time Notification (Change Request 3158)). In addition, section 504 of Public Law 108–173 provides that the national portion of operating IPPS payments for Puerto Rico hospitals is equal to 75 percent and the Puerto Rico portion of operating IPPS payments is equal to 35 percent for discharges occurring on or after October 1, 2004. Consistent with this change in operating IPPS payment to hospitals in Puerto Rico for FY 2005, as we discuss in section V.B. of this Addendum to this proposed rule, we are proposing to revise methodology for computing capital IPPS payments to hospitals located in Puerto Rico. We are proposing that we would compute capital payments to hospitals located in Puerto Rico based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate for discharges occurring on or after October 1, 2004.

Section 412.374 provides for the use of a blended payment system for payments to Puerto Rico hospitals under the PPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital IPPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs.

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

In the final IPPS rule published in the **Federal Register** on August 1, 2003 (68 FR 45346), we established a capital Federal rate of $415.47 for FY 2004. However, a correction notice to the FY 2004 IPPS final rule issued in the **Federal Register** on October 6, 2003 (68 FR 57731) contains corrections and revisions to the wage index and geographic adjustment factor (GAF). In conjunction with the change to the wage index and GAF corrections, we established a revised capital PPS standard Federal rate of $414.18 effective for discharges occurring in FY 2004. Furthermore, the One-Time Notification (Change Request 3158), issued on March 26, 2004, implemented various changes in operating IPPS payments required by sections 401, 402 and 504 of Public Law 108–173. As a result of these changes to payments under the operating IPPS, the fixed loss amount for determining the cost outlier threshold was revised effective for discharges occurring on or after April 1, 2004, through September 30, 2004. Because the regulations at § 412.312(c) establish a unified outlier methodology for inpatient operating and capital-related costs, a single set of thresholds are used to identify outlier cases under both the operating IPPS and the capital IPPS. As a result of the revision to the fixed loss amount used for determining the cost outlier threshold effective for discharges occurring on or after April 1, 2004, through September 30, 2004, we established a new capital IPPS standard Federal rate of $413.48 effective for discharges occurring on or after April 1, 2004, through September 30, 2004.

Because there are two capital IPPS standard Federal rates in effect during FY 2004 ($414.18 from October 2003 through March 2004 and $413.48 from April 2004 through September 2004), we are proposing to use an average of the rates effective for the first half of FY 2004 (October 1, 2003 through March 31, 2004) ($414.18) and the second half FY 2004 (April 1, 2004 through September 30, 2004) ($413.48) to determine the proposed FY 2005 capital Federal rate. (The proposed average is $413.83 (($414.18 + $413.48)/2.) As a result of the changes that we are proposing to the factors used to determine the proposed capital Federal rate that are explained in this Addendum, the proposed FY 2005 capital standard Federal rate is $416.59.

In the discussion that follows, we explain the factors that were used to determine the proposed FY 2005 capital Federal rate. In particular, we explain why the proposed FY 2005 capital Federal rate has increased 0.67 percent compared to the FY 2004 capital Federal rate. We also estimate aggregate capital payments will remain constant from FY 2004 to FY 2005. We are projecting aggregate capital PPS to remain unchanged primarily due to a projected decrease in Medicare Part A (fee-for-service) admissions. We are projecting a decrease in Medicare Part A enrollment, in part, because we are projecting an increase in Medicare managed care (M+C) enrollment as a result of implementing several sections of Public Law 108–173.

Total payments to hospitals under the IPPS are relatively unaffected by changes in the capital prospective payments. Since capital payments constitute about 10 percent of hospital payments, a 1-percent change in the capital Federal rate yields only about 0.1 percent change in actual payments to hospitals. Aggregate payments under the capital PPS are estimated to increase in FY 2005 compared to FY 2004.

1. Proposed Capital Standard Federal Rate Update

a. Description of the Update Framework

Under § 412.308(c)(1), the capital standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and several other 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 2005 under that framework is 0.7 percent based on the best data available at this time. The proposed update factor is based on a projected 0.7 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a 0.0 percent adjustment for the FY 2003 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. We explain the basis for the FY 2005 CIPI projection in section III.C. of this Addendum. Below we describe the proposed policy adjustments that have been applied.

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

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

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

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher weighted DRGs but do not reflect higher resource requirements. In the update framework for the PPS for operating costs, we adjust the update upwards to allow for real case-mix change, but remove the effects of coding changes on the case-mix index. We also remove the effect on total payments of prior year changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than patient severity. (For example, we adjusted for the effects of the FY 2003 DRG reclassification and recalibration as part of our update for FY 2005.) We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 2005, we are projecting a 1.0 percent total increase in the case-mix index. We estimate that the real case-mix increase would equal 1.0 percent in FY 2005. The net adjustment for change in case-mix is the difference between the projected total increase in case-mix and the projected increase in real case-mix change. Therefore, the net adjustment for case-mix change in FY 2005 is 0.0 percentage points.

We estimate that FY 2003 DRG reclassification and recalibration would result in a 0.0 percent change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we are making a 0.0 percent adjustment for DRG reclassification and recalibration in the update for FY 2005 to maintain budget neutrality.

The capital update framework contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update

factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. A forecast error of 0.0 percentage points was calculated for the FY 2003 update. That is, current historical data indicate that the forecasted FY 2003 CIPI used in calculating the FY 2003 update factor (0.7 percent) slightly overstated the actual realized price increases (0.6 percent) by 0.1 percentage points. This slight overprediction was mostly due to an underestimation of the interest rate cuts by the Federal Reserve Board in 2003, which impacted the interest component of the CIPI. However, since this estimation of the change in the CIPI is less than 0.25 percentage points, it is not reflected in the update recommended under this framework. Therefore, we are making a 0.0 percent adjustment for forecast error in the update for FY 2005.

Under the capital PPS system framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data that are used in the framework for the operating PPS. 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, for changes in within-DRG severity, and for expected modification of practice patterns to remove noncost-effective services.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services) and changes in real case-mix. The use of total charges in the calculation of the intensity factor makes it a total intensity factor, that is, charges for capital services are already built into the calculation of the factor. Therefore, we have incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity, we assume, as in the 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.

We have developed a Medicare-specific intensity measure based on a 5-year average. Past studies of case-mix change by the RAND Corporation (''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)) suggest that real case-mix change was not dependent on total change, but was usually a fairly steady 1.0 to 1.4 percent per year. 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.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix. As we noted above, in accordance with § 412.308(c)(1)(ii), we began updating the capital standard Federal rate in FY 1996 using an update framework that takes into account, among other things, allowable changes in the intensity of hospital services. For FYs 1996 through 2001, we found that case-mix constant intensity was declining and we established a 0.0 percent adjustment for intensity in each of those years. For FYs 2001 and 2002, we found that case-mix constant intensity was increasing and we established a 0.3 percent adjustment and 1.0 percent adjustment for intensity, respectively.

Using the methodology described above, for FY 2005 we examined the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix for FYs 1999 through 2003. We found that, over this period and in particular the last 4 years of this period (FYs 2000 through 2003), the charge data appear to be skewed. More specifically, we found a dramatic increase in hospital charges for FYs 2000 through 2003 without a corresponding increase in hospital case-mix index. These findings are similar to the considerable increase in hospitals charges we found when we were determining the intensity factor in the FY 2004 update recommendation as discussed in the August 1, 2003 final rule (69 FR 45482). If hospitals were treating new or different types of cases, which would result in an appropriate increase in charges per discharge, then we would expect hospitals' case-mix to increase proportionally.

As we discussed in the August 1, 2003 final rule (68 FR 45482), because our intensity calculation relies heavily upon charge data and we believe that this charge data may be inappropriately skewed, we established a 0.0 percent adjustment for intensity for FY 2004. In that same final rule, we stated that we believe that it is appropriate to propose a zero intensity adjustment until we believe that any increase in charges can be tied to intensity rather then to attempts to maximize outlier payments. As discussed above, based on the most recent available data, we believe that the charge data used to make this determination may still be inappropriately skewed. Since our intensity calculation relies heavily upon charge data (which may be inappropriately skewed), we are proposing a 0.0 percent adjustment for intensity for FY 2005 in this proposed rule. We note that, in past FYs (1996 through 2000) when we found intensity to be declining, we believed a zero (rather then negative) intensity adjustment was appropriate. Similarly, we believe that it is appropriate to propose a zero intensity adjustment for FY 2005 until we believe that any increase in charges can be tied to intensity rather than to attempts to maximize outlier payments.

Above we described the basis of the components used to develop the proposed 0.7 percent capital update factor for FY 2005 as shown in the table below.

CMS'S PROPOSED FY 2005 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE

Capital Input Price Index	0.7.
Intensity	0.0.
Case-Mix Adjustment Factors:.	
Projected Case-Mix Change	1.0
Real Across DRG Change	−1.0.
Subtotal	0.0.
Effect of FY 2003 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0.
Total Proposed Update	0.7

b. Comparison of CMS and MedPAC Update Recommendation

In the past, MedPAC has included update recommendations for capital PPS in a Report to Congress. In its March 2004 Report to Congress, MedPAC did not make an update recommendation for capital PPS payments for FY 2005. However, in that same report, MedPAC made an update

recommendation for hospital inpatient and outpatient services (page 87). MedPAC reviews inpatient and outpatient services together since they are so closely interrelated. MedPAC's recommendation of the full market basket update for both the inpatient and outpatient PPSs is based on their assessment of beneficiaries' access to care, volume growth, access to capital, quality, and the relationship of Medicare payments to costs in the hospital sector.

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. 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 capital related outlier payments to total inpatient capital-related PPS payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating DRG payments.

In the August 1, 2003 IPPS final rule (68 FR 45482), we estimated that outlier payments for capital in FY 2004 would equal 4.79 percent of inpatient capital-related payments based on the FY 2004 capital Federal rate. Accordingly, we applied an outlier adjustment factor of 0.9521 to the FY 2004 capital Federal rate. However, as we noted above, we published a correction notice in the **Federal Register** on October 6, 2003 (68 FR 57731), which established revised rates and factors for FY 2004. In that same correction notice (68 FR 57734), we estimated that outlier payments for capital in FY 2004 would equal 4.77 percent of inpatient capital-related payments based on the FY 2004 capital Federal rate. Accordingly, we established a revised outlier adjustment of 0.9523 for use in determining the FY 2004 capital Federal rate. In addition, as we noted above, a One-Time Notification (Change Request 3158) issued on March 26, 2004, implemented various changes in operating IPPS payments required by sections 401, 402, and 504 of Public Law 108–173, effective for discharges on or after April 1, 2004, through September 30, 2004. As a result of changes made to payments under the operating IPPS, the rates and some of the factors, including the outlier adjustment, under the capital IPPS were also revised effective for discharges on or after April 1, 2004, through September 30, 2004. The revised outlier adjustment effective for the second half of FY 2004 (April 2004 through September 2004) is 0.9508.

Based on the thresholds as set forth in section II.A.4.c. of this Addendum, we estimate that outlier payments for capital would equal 5.03 percent of inpatient capital-related payments based on the proposed capital Federal rate in FY 2005. Therefore, we are proposing an outlier adjustment factor of 0.9497 to the capital Federal rate. Thus, the percentage of capital outlier payments to total capital standard payments for FY 2005 is higher than the percentages estimated for the first half (4.77 percent for October 2003 through March 2004) and the second half (4.92 percent for April 2004 through September 2004) of FY 2004.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. As we discussed above, there were two outlier adjustment factors applied during FY 2004 (0.9523 from October 2003 through March 2004 and 0.9508 from April 2004 through September 2004). The proposed FY 2005 outlier adjustment of 0.9497 is a –0.19 percent change from the average FY 2004 outlier adjustment of 0.9515 (the mean of the factors for the first half of FY 2004 (0.9523) and the second half of FY 2004 (0.9508) calculated from unrounded numbers). The proposed net change in the outlier adjustment to the capital Federal rate for FY 2005 is 0.9981 (0.9497/0.9515). Thus, the proposed outlier adjustment decreases the FY 2005 capital Federal rate by 0.19 percent compared with the average FY 2004 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 capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the geographic adjustment factor (GAF) are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes.

Since we implemented a separate geographic adjustment factor for Puerto Rico, we apply separate budget neutrality adjustments for the national geographic adjustment factor and the Puerto Rico geographic adjustment factor. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier fiscal years since the geographic adjustment factor for Puerto Rico was implemented in FY 1998.

In the past, we used the actuarial capital cost model (described in Appendix B of the August 1, 2001 IPPS final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of the capital Federal rate with and without changes in the DRG classifications and weights and in the GAF to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF. During the transition period, the capital cost model was also used to estimate the regular exception payment adjustment factor. As we explain in section III.A.4. of this Addendum, beginning in FY 2002, an adjustment for regular exception payments is no longer necessary. Therefore, we are no longer using the capital cost model. Instead, we are using historical data based on hospitals' actual cost experiences to determine the exceptions payment adjustment factor for special exceptions payments.

To determine the proposed factors for FY 2005, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2004 DRG relative weights and the average FY 2004 GAF (that is, the mean of the GAFs applied from October 2003 through March 2004 and the GAFs applied from April 2004 through September 2004) to estimated aggregate capital Federal rate payments based on the proposed FY 2005 relative weights and the proposed FY 2005 GAF. For the first half of FY 2004 (October 1, 2003 through March 31, 2004), the budget neutrality adjustment factors were 0.9908 for the national capital rate and 0.9974 for the Puerto Rico capital rate (see the October 6, 2003 correction notice). For the second half of FY 2004 (April 1, 2004 through September 30, 2004), the budget neutrality adjustment factor was revised to 0.9907 for the national capital rate. The budget neutrality factor for the Puerto Rico capital rate remained unchanged (0.9974). In making the comparison, we set the regular and special exceptions reduction factors to 1.00.

To achieve budget neutrality for the changes in the national GAF, based on calculations using updated data, we are proposing to apply an incremental budget neutrality adjustment of 1.0018 for FY 2005 to the average of the previous cumulative FY 2004

adjustments of 0.9908 ((0.99083 + 0.99072)/2), yielding a proposed cumulative adjustment of 0.9925 through FY 2005 (calculations were done with unrounded numbers). For the Puerto Rico GAF, we are proposing to apply an incremental budget neutrality adjustment of 0.9989 for FY 2005 to the average of the previous cumulative FY 2004 adjustment of 0.9974, yielding a proposed cumulative adjustment of 0.9963 through FY 2005.

We then compared estimated aggregate capital Federal rate payments based on the FY 2004 DRG relative weights and the average FY 2004 GAF to estimated aggregate capital Federal rate payments based on the proposed FY 2005 DRG relative weights and the proposed FY 2005 GAF. The proposed incremental adjustment for DRG classifications and changes in relative weights is 0.9997 both nationally and for Puerto Rico. The proposed cumulative adjustments for DRG classifications and changes in relative weights and for changes in the GAF through FY 2005 are 0.9922 nationally and 0.9960 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

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BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal Year	National				Puerto Rico			
	Incremental Adjustment			Cumulative	Incremental Adjustment			Cumulative
	Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined		Geographic Adjustment Factor	DRG Reclassifications and Recalibration	Combined	
1992	---	---	---	1.00000	---	---	---	---
1993	---	---	0.99800	0.99800	---	---	---	---
1994	---	---	1.00531	1.00330	---	---	---	---
1995	---	---	0.99980	1.00310	---	---	---	---
1996	---	---	0.99940	1.00250	---	---	---	---
1997	---	---	0.99873	1.00123	---	---	---	---
1998	---	---	0.99892	1.00015	---	---	---	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001[1]	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508
2001[2]	0.99771[3]	1.00009[3]	0.99780[3]	0.99922	1.00365[3]	1.00009[3]	1.00374[3]	1.00508
2002	0.99666[4]	0.99668[4]	0.99335[4]	0.99268	0.98991[4]	0.99668[4]	0.99662[4]	0.99164
2003[5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003[6]	0.99896[7]	0.99662[7]	0.99558[7]	0.98830	1.00809[7]	0.99662[7]	1.00468[7]	0.99628
2004[8]	1.00175[9]	1.00081[9]	1.00256[9]	0.99083	1.00028[9]	1.00081[9]	1.00109[9]	0.9973[6]
2004[10]	1.00164[9]	1.00081[9]	1.00245[9]	0.99072	1.00028[9]	1.00081[9]	1.00109[9]	0.99736
2005	1.00175[11]	0.99970	1.00145[11]	0.99222	0.99891[11]	0.99970	0.99861[11]	0.99597

[1]Factors effective for the first half of FY 2001 (October 2000 through March 2001).
[2]Factors effective for the second half of FY 2001 (April 2001 through September 2001).
[3]Incremental factors are applied to FY 2000 cumulative factors.
[4]Incremental factors are applied to the cumulative factors for the first half of FY 2001.
[5]Factors effective for the first half of FY 2003 (October 2002 through March 2003).
[6]Factors effective for the second half of FY 2003 (April 2003 through September 2003).
[7]Incremental factors are applied to FY 2002 cumulative factors.
[8]Factors effective for the first half of FY 2004 (October 2003 through March 2004).
[9]Incremental factors are applied to the cumulative factors for the second half of FY 2003.
[10]Factors effective for the second half of FY 2004 (April 2004 through September 2004).
[11]Incremental factors are applied to average of the cumulative factors for the first half (October 1, 2003 through March 31, 2004) and second half (April 1, 2004 through September 30, 2004) of FY 2004.

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The methodology used to determine the proposed recalibration and geographic (DRG/GAF) budget neutrality adjustment factor for FY 2005 is similar to that used in establishing budget neutrality adjustments under the PPS for operating costs. One difference is that, under the operating PPS, 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 PPS, there is a single DRG/GAF budget neutrality adjustment factor (the national capital rate and the Puerto Rico capital rate are determined separately) for changes in the GAF (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, indirect medical education payments, or the large urban add-on payments.

In the August 1, 2003 IPPS final rule (68 FR 45346), we calculated a GAF/DRG budget neutrality factor of 1.00591 for FY 2004. As we noted above, as a result of the revisions to the GAF effective for FY 2004 in the October 6, 2003 correction notice, we calculated a GAF/DRG budget neutrality factor of 1.00256 for discharges occurring in FY 2004. As we also noted above, as a result of implementing sections 401, 402, and 504 of Public Law 108–173, we calculated a GAF/DRG budget neutrality factor of 1.00245 for discharges occurring on or after April 1, 2004 through September 30, 2004. Furthermore, as noted above, the average of capital rates and factors in effect for the first half (October 2003 through March 2004) and second half (April 2004 through September 2004) of FY 2004 was used in determining the FY 2005 capital rates.

For FY 2005, we are proposing a GAF/DRG budget neutrality factor of 1.0015. The GAF/DRG budget neutrality factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows from the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The proposed incremental change in the adjustment from FY 2004 to FY 2005 is 1.0015. The proposed cumulative change in the capital Federal rate due to this adjustment is 0.9922 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996, FY 1997, FY 1998, FY 1999, FY 2000, FY 2001, FY 2002, FY 2003, average FY 2004 and the proposed incremental factor for FY 2005: $0.9980 \times 1.0053 \times 0.9998 \times 0.9994 \times 0.9987 \times 0.9989 \times 1.0028 \times 0.9985 \times 0.9979 \times 0.9934 \times 0.9956 \times 1.0025 \times 1.0015 = 0.9922$).

This proposed factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 2005 geographic reclassification decisions made by the MGCRB compared to FY 2004 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the capital standard Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under § 412.348 relative to total capital PPS payments. In estimating the proportion of regular exception payments to total capital PPS payments during the transition period, we used the actuarial capital cost model originally developed for determining budget neutrality (described in Appendix B of the August 1, 2001 IPPS final rule (66 FR 40099)) to determine the exceptions payment adjustment factor, which was applied to both the Federal and hospital-specific capital rates.

An adjustment for regular exception payments is no longer necessary in determining the FY 2005 capital Federal rate because, in accordance with § 412.348(b), regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001. Accordingly, as we explained in the August 1, 2001 IPPS final rule (66 FR 39949), in FY 2002 and subsequent fiscal years, no payments will be made under the regular exceptions provision. However, in accordance with § 412.308(c), we still need to compute a budget neutrality adjustment for special exception payments under § 412.348(g). We describe our methodology for determining the special exceptions adjustment used in calculating the FY 2005 capital Federal rate below.

Under the special exceptions provision specified at § 412.348(g)(1), eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. An eligible hospital may receive special exceptions payments if it meets (1) a project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test as described at § 412.348(g)(4); (2) an age of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

Based on information compiled from our fiscal intermediaries, six hospitals have qualified for special exceptions payments under § 412.348(g). Since we have cost reports ending in FY 2003 for all of these hospitals, we calculated the proposed adjustment based on actual cost experience. Using data from cost reports ending in FY 2003 from the March 2004 update of the HCRIS data, we divided the capital special exceptions payment amounts for the six hospitals that qualified for special exceptions by the total capital PPS payment amounts (including special exception payments) for all hospitals. Based on the data from cost reports ending in FY 2003, this ratio is rounded to 0.0004. Because we have not received all cost reports ending in FY 2003, we also divided the FY 2003 special exceptions payments by the total capital PPS payment amounts for all hospitals with cost reports ending in FY 2002. This ratio also rounds to 0.0004. Because special exceptions are budget neutral, we are proposing to offset the capital Federal rate by 0.04 percent for special exceptions payments for FY 2005. Therefore, the proposed exceptions adjustment factor is equal to 0.9996 (1–0.0004) to account for special exceptions payments in FY 2005.

In the August 1, 2003 IPPS final rule (68 FR 45384) for FY 2004, we estimated that total (special) exceptions payments would equal 0.05 percent of aggregate payments based on the capital Federal rate. Therefore, we applied an exceptions adjustment factor of 0.9995 (1–0.0005) in determining the FY 2004 capital Federal rate. (We note that the special exceptions adjustment factor for FY 2004 was not revised in either the October 6, 2003 correction notice or the March 26, 2004 One-Time Notification.) As we stated above, we estimate that exceptions payments in FY 2005 would equal 0.04 percent of aggregate payments based on the FY 2005 capital Federal rate. Therefore, we are proposing to apply an exceptions payment adjustment factor of 0.9996 to the capital Federal rate for FY 2005. The proposed exceptions adjustment factor for FY 2005 is 0.01 percent higher than the factor for FY 2004 published in the August 1, 2003 IPPS final rule (68 FR 45346). The exceptions reduction factors are not built permanently into the capital rates; that is, the factors are not applied cumulatively in determining the capital Federal rate. Therefore, the proposed net change in the exceptions adjustment factor used in determining the proposed FY 2005 capital Federal rate is 1.0001 (0.9996/0.9995).

5. Proposed Capital Standard Federal Rate for FY 2005

In the August 1, 2003 IPPS final rule (68 FR 45346) we established a capital Federal rate of $415.47 for FY 2004. As we noted above, as a result of the revisions to the GAF for FY 2004, in the October 6, 2003 correction notice, we established a capital Federal rate of $414.18 for discharges occurring in FY 2004. As we also discussed above, a One-Time Notification issued on March 26, 2004, which implemented various

changes in operating IPPS payments required by sections 401, 402, and 504 of Public Law 108–173, resulted in a revised capital Federal rate of $413.48 effective for discharges occurring on or after April 1, 2004 through September 30, 2004. Because there are two capital IPPS standard Federal rates in effect during FY 2004 ($414.18 from October 2003 through March 2004 and $413.48 from April 2004 through September 2004), we are proposing to use an average of the rates effective for the first half ($414.18) and the second half ($413.48) of FY 2004 of $413.83 (($414.18 + $413.48)/2) in determining the proposed FY 2005 capital Federal rate. In this proposed rule, we are proposing to establish a capital Federal rate of $416.59 for FY 2005. The proposed capital Federal rate for FY 2005 was calculated as follows:

- The proposed FY 2005 update factor is 1.007; that is, the update is 0.7 percent.
- The proposed FY 2005 budget neutrality adjustment factor that is applied to the capital standard Federal payment rate for changes in the DRG relative weights and in the GAF is 1.0015.
- The proposed FY 2005 outlier adjustment factor is 0.9497.
- The proposed FY 2005 (special) exceptions payment adjustment factor is 0.9996.

Because the proposed capital 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 are proposing to make no additional adjustments in the capital standard Federal rate for these factors, other than the budget neutrality factor for changes in the DRG relative weights and the GAF.

We are providing a chart that shows how each of the proposed factors and adjustments for FY 2005 affected the computation of the proposed FY 2005 capital Federal rate in comparison to the average FY 2004 capital Federal rate. The proposed FY 2005 update factor has the effect of increasing the capital Federal rate by 0.70 percent compared to the average FY 2004 Federal rate. The proposed GAF/DRG budget neutrality factor has the effect of increasing the capital Federal rate by 0.15 percent. The proposed FY 2005 outlier adjustment factor has the effect of decreasing the capital Federal rate by 0.19 percent compared to the average FY 2004 capital Federal rate and the proposed FY 2005 exceptions payment adjustment factor has the effect of increasing the capital Federal rate by 0.01 percent compared to the exceptions payment adjustment factor for the FY 2004 capital Federal rate. The combined effect of all the proposed changes is to increase the capital Federal rate by 0.67 percent compared to the average FY 2004 capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2004 CAPITAL FEDERAL RATE [1] AND PROPOSED FY 2005 CAPITAL FEDERAL RATE

	FY 2004 [1]	Proposed FY 2005	Change	Percent change
Update factor [2]	1.0070	1.0070	1.0070	0.70
GAF/DRG Adjustment Factor [2]	1.0025	1.0015	1.0015	0.15
Outlier Adjustment Factor [3]	0.9515	0.9497	0.9981	−0.19
Exceptions Adjustment Factor [3]	0.9995	0.9996	1.0001	0.01
Capital Federal Rate	$413.83	$416.59	1.0067	0.67

[1] Because there are two capital IPPS standard Federal rates in effect during FY 2004 ($414.18 from October 2003 through March 2004 and $413.48 from April 2004 through September 2004), an average of the rates and factors effective for the first half (October 2003 through March 2004) and the second half (April 2004 through September 2004)) of FY 2004 were used.

[2] The update factor and the GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the incremental change from FY 2004 to FY 2005 resulting from the application of the proposed 1.0015 GAF/DRG budget neutrality factor for FY 2005 is 1.0015.

[3] The outlier reduction factor and the exceptions adjustment factor are not built permanently into the capital rates; that is, these factors are not applied cumulatively in determining the capital rates. Thus, for example, the net change resulting from the application of the proposed FY 2005 outlier adjustment factor is 0.9497/0.9515, or 0.9981.

6. Special Capital Rate for Puerto Rico Hospitals

As discussed above, beginning in FY 1998, hospitals in Puerto Rico are currently paid based on 50 percent of the Puerto Rico capital rate and 50 percent of the capital Federal rate. The Puerto Rico capital rate is derived from the costs of Puerto Rico hospitals only, while the capital Federal rate is derived from the costs of all acute care hospitals participating in the PPS (including Puerto Rico). Section 504 of Public Law 108–173 increases the national portion of the operating IPPS payment for Puerto Rico hospitals from 50 percent to 75 percent and decreases the Puerto Rico portion of the operating IPPS payments for hospitals located in Puerto Rico from 50 percent to 37.5 percent for discharges occurring on or after April 1, 2004, through September 30, 2004. In addition, section 504 of Public Law 108–173 provides that the national portion of operating IPPS payments for Puerto Rico hospitals is equal to 75 percent and the Puerto Rico portions of the operating IPPS payments is equal to 37.5 percent for discharges occurring on or after October 1, 2004. As discussed in section V.B. of the preamble of this proposed rule, under the broad authority of section 1886(g) of the Act, we are proposing for FY 2005 to increase the national portion of the capital IPPS payment to hospitals located in Puerto Rico from 50 percent to 75 percent, as well. Therefore, for discharges occurring on or after October 1, 2004, capital payments to hospitals in Puerto Rico would be based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate.

To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended capital rate. The GAF is calculated using the operating PPS wage index and varies, depending on the MSA or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended capital rate.

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. As we stated above in section III.A.4. of this Addendum, for Puerto

Rico the proposed GAF budget neutrality factor is 0.9989, while the proposed DRG adjustment is 0.9997, for a proposed combined cumulative adjustment of 0.9960.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the capital rate (currently 50 percent; 25 percent proposed for FY 2005 and thereafter) is multiplied by the Puerto Rico-specific GAF for the MSA in which the hospital is located, and the national portion of the capital rate (currently 50 percent; 75 percent proposed for FY 2005 and thereafter) is multiplied by the national GAF for the MSA in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico capital rate as a result of Public Law 105–33. In FY 2003, a small part of that reduction was restored.

For FY 2004, before application of the GAF, the special capital rate for Puerto Rico hospitals was $203.17 for discharges occurring on or after October 1, 2003 through March 31, 2004 (see the October 6, 2003 correction notice) and $202.96 for discharges occurring on or after April 1, 2004 through September 30, 2004 (see the March 26, 2004 One-Time Notification). With the changes we are proposing to the factors used to determine the capital rate, the proposed FY 2005 special capital rate for Puerto Rico is $200.52.

B. Calculation of Inpatient Capital-Related Prospective Payments for FY 2005

Because the 10-year capital PPS transition period ended in FY 2001, all hospitals (except ''new'' hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid based on 100 percent of the capital Federal rate in FY 2005. The applicable proposed capital Federal rate was determined by making adjustments as follows:

- For outliers, by dividing the proposed capital standard Federal rate by the proposed outlier reduction factor for that fiscal year; and
- For the payment adjustments applicable to the hospital, by multiplying the hospital's proposed GAF, disproportionate share adjustment factor, and IME adjustment factor, when appropriate.

For purposes of calculating payments for each discharge during FY 2005, the capital standard Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted capital Federal rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The proposed outlier thresholds for FY 2005 are in section II.A.4.c. of this Addendum. For FY 2005, a case qualifies as a cost outlier if the cost for the case plus the IME and DSH payments is greater than the prospective payment rate for the DRG plus $35,085.

An eligible hospital may also qualify for a special exceptions payment under § 412.348(g) for up through the 10th year beyond the end of the capital transition period if it meets: (1) a project need requirement described at § 412.348(g)(2), which in the case of certain urban hospitals includes an excess capacity test as described at § 412.348(g)(4); and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include sole community hospitals, urban hospitals with at least 100 beds that have a DSH patient percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals that have a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Under § 412.348(g)(8), the amount of a special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital PPS to the cumulative minimum payment level. This amount is offset by: (1) Any amount by which a hospital's cumulative capital payments exceed its cumulative minimum payment levels applicable under the regular exceptions process for cost reporting periods beginning during which the hospital has been subject to the capital PPS; and (2) any amount by which a hospital's current year operating and capital payments (excluding 75 percent of operating DSH payments) exceed its operating and capital costs. Under § 412.348(g)(6), the minimum payment level is 70 percent for all eligible hospitals.

During the transition period, new hospitals (as defined under § 412.300) were exempt from the capital PPS for their first 2 years of operation and were paid 85 percent of their reasonable costs during that period. Effective with the third year of operation through the remainder of the transition period, under § 412.324(b) we paid the hospital under the appropriate transition methodology. If the hold-harmless methodology were 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. As discussed in section VI.A. of the preamble of this proposed rule, under § 412.304(c)(2), for cost reporting periods beginning on or after October 1, 2002, we pay a new hospital 85 percent of their reasonable costs during the first 2 years of operation unless it elects to receive payment based on 100 percent of the capital Federal rate. Effective with the third year of operation, we pay the hospital based on 100 percent of the capital Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

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

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. The CIPI was last rebased to FY 1997 in the August 1, 2002 final rule (67 FR 50044).

2. Forecast of the CIPI for Federal Fiscal Year 2005

Based on the latest forecast by Global Insight, Inc. (first quarter of 2004), we are forecasting the CIPI to increase 0.7 percent in FY 2005. This reflects a projected 1.2 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.0 percent increase in other capital expense prices in FY 2005, partially offset by a 2.5 percent decline in vintage-weighted

interest expenses in FY 2005. The weighted average of these three factors produces the 0.7 percent increase for the CIPI as a whole in FY 2005.

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

[If you choose to comment on issues in this section, please include the caption ''Excluded Hospitals Rate of Increase'' at the beginning of your comment.]

As discussed in section VI. of the preamble of this proposed rule, in accordance with section 1886(b)(3)(H)(i) of the Act and effective for cost reporting periods beginning on or after October 1, 2002, payments to existing psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals excluded from the IPPS are no longer subject to limits on a hospital-specific target amount (expressed in terms of the inpatient operating cost per discharge) that are set for each hospital, based on the hospital's own historical cost experience trended forward by the applicable rate-of-increase percentages (update factors).

Effective for cost reporting periods beginning on or after October 1, 2002, rehabilitation hospitals and units are paid 100 percent of the IRF PPS Federal rate. Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs also are no longer paid on a reasonable cost basis, but are paid under a LTCH DRG-based PPS. As part of the payment process for LTCHs, we established a 5-year transition period from reasonable cost-based reimbursement to a fully Federal PPS. However, a LTCH may elect to be paid based on 100 percent of the Federal prospective payment rate. We have proposed, but not finalized, an IPF PPS under which psychiatric hospitals and units would no longer be paid on a reasonable cost basis but would be paid on a prospective per diem basis. (68 FR 66920, November 28, 2003)

In accordance with existing §§ 413.40(c)(4)(ii) and (d)(1)(i) and (ii), where applicable, excluded psychiatric hospitals and units continue to be paid on a reasonable cost basis, payments are based on their Medicare inpatient operating costs, not to exceed the ceiling (as defined in § 413.40(a)(3)). In addition, LTCHs that are paid under a blend methodology will have the TEFRA portion subject to the ceiling as well.

Section 1886(b)(7) of the Act had established a payment limitation for new rehabilitation hospitals and units, psychiatric hospitals and units, and long-term care hospitals that first received payment as a hospital or unit excluded from the IPPS on or after October 1, 1997. However, effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new rehabilitation hospitals or units because they are paid 100 percent of the Federal prospective rate under the IRF PPS. Also, effective for cost reporting periods beginning on or after October 1, 2002, new LTCHs are paid based on 100 percent of the fully Federal prospective rate. In contrast, those ''new'' LTCHs that meet the definition of ''new'' under § 412.40(f)(2)(ii) and that have their first cost reporting periods beginning on or after October 1, 1997 and before October 1, 2002, may be paid under the LTCH PPS transition methodology. Since those hospitals by definition would have been considered new before October 1, 2002, they would have been subject to the updated payment limitation on new hospitals that was published in the FY 2003 IPPS final rule (67 FR 50103). A discussion of how the payment limitation was calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46019); the May 12, 1998 final rule (63 FR 26344); the July 31, 1998 final rule (63 FR 41000); and the July 30, 1999 final rule (64 FR 41529).

The amount of payment for a ''new'' psychiatric hospital or unit would be determined as follows:

- Under existing § 413.40(f)(2)(ii), for the first 12-month cost reporting periods beginning on or after October 1, 1997, the amount of payment for a new hospital or unit that was not paid as an excluded hospital or unit before October 1, 1997, is the lower of: (1) The hospital's net inpatient operating costs per case; or (2) 110 percent of the national median of the target amounts for the same class of excluded hospitals and units, adjusted for differences in wage levels and updated to the first cost reporting period in which the hospital receives payment. The second 12-month cost reporting period is subject to the same target amount applied to the first cost reporting period.
- In the case of a hospital that received payments under § 413.40(f)(2)(ii) as a newly created hospital or unit, to determine the hospital's or unit's target amount for the hospital's or unit's third 12-month cost reporting period, the payment amount determined under § 413.40(f)(2)(ii)(A) for the preceding cost reporting period is updated to the third cost reporting period.

The amounts included in the following table reflect the proposed updated 110 percent of the national median target amounts of new excluded psychiatric hospitals and units for cost reporting periods beginning during FY 2005. These figures are updated with the most recent data available to reflect the projected market basket increase percentage of 3.3 percent. This projected percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient hospital services (as projected by CMS' Office of the Actuary based on its historical experience with the IPPS). For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index, without regard to IPPS reclassifications, and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	Proposed FY 2005 labor-related share	Proposed FY 2005 nonlabor-related share.
Psychiatric	$7,534.70	$2,994.67

This payment limitation is no longer applicable to new LTCHs that meet the definition of § 412.23(e)(4) since they will be paid 100 percent of the Federal rate. (Section 412.23(e)(4) states that for purposes of payment under the LTCH PPS, a new LTCH is a provider of inpatient services that meets the qualifying criteria in paragraphs (e)(1) and (e)(2) of this section and, under present or previous ownership (or both), its first cost reporting period as a LTCH begins on or after October 1, 2002). Under the LTCH PPS, new LTCHs are based on 100 percent of the fully Federal prospective rate (they may not participate in the 5-year transition from cost-based reimbursement to

prospective payment). In contrast, those ''new'' LTCHs that meet the definition of ''new'' under § 413.40(f)(2)(ii) and that have their first cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, may be paid under the LTCH PPS transition methodology. Because those hospitals by definition would have been considered new before October 1, 2002, they would have been subject to the updated payment limitation on new hospitals that was published in the FY 2003 IPPS final rule (67 FR 50103). Under existing regulations at § 413.40(f)(2)(ii), the ''new'' hospital would be subject to the same cap in its second cost reporting period; this cap would not be updated for the new hospital's second cost reporting year. Thus, since the same cap is to be used for the ''new'' LTCH's first two cost reporting periods, it is no longer necessary to publish an updated cap.

V. Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

[If you choose to comment on issues in this section, please include the caption ''Payment for Blood Clotting Factor'' at the beginning of your comment.]

In December 2002, the Department implemented a policy that established the Single Drug Pricer (SDP) to correct identified discrepancies, further the legislative goal of establishing a uniform payment allowance as a reflection of the average wholesale price (AWP), and otherwise apply the existing stature and regulation more accurately and efficiently (CMS Program Memorandum AB–02–174, December 3, 2002, which can be accessed at: *http://www.cms.hhs.gov/manuals*). Under the SDP, CMS will establish prices centrally, thereby resulting in greater consistency in drug pricing nationally. The SDP instruction applies to blood clotting factors furnished to hospital inpatients. The payment allowance for the single national drug price for each Medicare covered drug is based on 95 percent of the AWP, except for drugs billed to durable medical equipment regional carriers (DMERCs) and hospital outpatient drugs billed to fiscal intermediaries. We are publishing this notice here because we previously have addressed the add-on payment for the costs of administering blood clotting factor in the IPPS annual rule (see the August 1, 2000 IPPS final rule (65 FR 47116).

On a quarterly basis, CMS will furnish three SDP files to all fiscal intermediaries. Each fiscal intermediary must accept the SDP files and process claims for any drug identified on the files on the basis of the price shown on the applicable file. Previously, the fiscal intermediary performed annual update calculations based on the most recent AWP data available to the carrier. The fiscal intermediary should use the SDP to price the blood clotting factors.

VI. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this Addendum. Tables 1A, 1B, 1C, 1D, 2, 3A, 3B, 4A, 4B, 4C, 4F, 4G, 4H, 4J, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H, 7A, 7B, 8A, 8B, 9A, 9B, 10, and 11 are presented below. The tables presented below are as follows:

Table 1A--National Adjusted Operating Standardized Amounts, Labor/Nonlabor (71.1 Percent Labor Share/28.9 Percent Nonlabor Share if Wage Index Is Greater than 1)

Table 1B-- National Adjusted Operating Standardized Amounts, Labor/Nonlabor (62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Is Less Than or Equal To 1)

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

Table 1D--Capital Standard Federal Payment Rate

Table 2--Hospital Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 2003; Hospital Average Hourly Wage for Federal Fiscal Years 2003 (1999 Wage Data), 2004 (2000 Wage Data), and 2005 (2001 Wage Data) Wage Indexes and 3-Year Average of Hospital Average Hourly Wages

Table 3A--3-Year Average Hourly Wage for Urban Areas

Table 3B--3-Year Average Hourly Wage for Rural Areas

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

Table 4G--Pre-Reclassified Wage Index for Urban Areas

Table 4H--Pre-Reclassified Wage Index for Rural Areas

Table 4J--Wage Index Adjustment for Commuting Hospital Employees (Out-Migration) in Qualifying Counties--FY 2005

Table 5--List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric and Arithmetic Mean Length of Stay

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 from the CC Exclusions List

Table 7A--Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2003 MedPAR Update December 2003 GROUPER V21.0

Table 7B--Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2003 MedPAR Update December 2003 GROUPER V22.0

Table 8A--Statewide Average Operating Cost-to-Charge Ratios--March 2004

Table 8B--Statewide Average Capital Cost-to-Charge Ratios--March 2004

Table 9A--Hospital Reclassifications and Redesignations by Individual Hospital--FY 2005

Table 9B--Hospital Reclassifications and Redesignations by Individual Hospital Under Section 508 of Pub. L. 108-173--FY 2004

Table 10--Geometric Mean Plus the Lesser of .75 of the National Adjusted Operating Standardized Payment Amount (Increased to Reflect the Difference Between Costs and Charges) or .75 of One Standard Deviation of Mean Charges by Diagnosis-Related Groups (DRGs)--March 2004

Table 11--Proposed FY 2005 LTC-DRGs, Relative Weights, Geometric Average Length of Stay, and 5/6ths of the Geometric Average Length of Stay

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

(71.1 Percent Labor Share/28.9 Percent Nonlabor Share If Wage Index Greater Than 1)

Full Update (3.3 Percent)		Reduced Update (2.9 Percent)	
Labor-related	**Nonlabor-related**	**Labor-related**	**Nonlabor-related**
$3,243.10	$1,318.22	$3,230.55	$1,313.12

TABLE 1B.--NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

(62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Less Than or Equal to 1)

Full Update (3.3 Percent)		Reduced Update (2.9 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$2,828.02	$1,733.30	$2,817.08	$1,726.59

Table 1C.--ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR PUERTO RICO, LABOR/NONLABOR

	Rates if Wage Index Greater Than 1		Rates if Wage Index Less Than or Equal to 1	
	Labor	Nonlabor	Labor	Nonlabor
National	$3,243.10	$1,318.22	$2,828.02	$1,733.30
Puerto Rico	1,559.07	627.57	1,355.72	830.92

TABLE 1D.--CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$416.59
Puerto Rico	$200.52

Table 2.--HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2003; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2003 (1999 WAGE DATA), 2004 (2000 WAGE DATA), AND 2005 (2001 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
010001	1.4637	17.9841	19.4061	20.6491	19.3568
010004	***	20.1613	22.2674	22.7585	21.6609
010005	1.1675	19.9733	19.6063	20.4656	20.0195
010006	1.3939	18.3931	19.0976	21.0729	19.5183
010007	1.1120	16.0781	17.5462	16.8668	16.8314
010008	1.0019	19.0182	19.6573	23.7870	20.8787
010009	1.0257	19.7273	20.4309	21.6421	20.5897
010010	1.0196	17.7348	19.2644	22.2640	19.7233
010011	1.6227	24.8922	25.8231	24.7868	25.1453
010012	1.2100	20.3375	20.0896	21.7702	20.7452
010015	0.9478	19.8205	18.8890	20.4628	19.7642
010016	1.2929	20.3175	21.7918	23.0466	21.7904
010018	1.3120	19.5519	19.2071	20.5734	19.7665
010019	1.2196	17.6414	18.9177	20.0986	18.8712
010021	1.1852	25.3335	17.7596	20.7947	20.7098
010022	0.9282	22.1250	22.2267	25.8599	23.4393
010023	1.7460	18.4567	20.4901	23.7739	20.7059
010024	1.6397	17.3746	18.5942	19.9864	18.6204
010025	1.2132	17.4702	19.3649	20.2596	19.0036
010027	0.7657	16.5157	14.0975	18.5904	16.4412
010029	1.5332	19.3393	20.9868	21.6392	20.7095
010031	***	19.2612	21.0176	20.9463	20.4044
010032	0.8719	16.3968	16.4713	18.4657	17.1465
010033	2.0684	21.9828	24.5088	25.5277	23.9953
010034	0.9861	14.9379	14.9333	16.8073	15.5467
010035	1.1993	20.7808	21.6182	23.1319	21.8768
010036	1.0900	18.7157	19.2501	20.5001	19.4694
010038	1.1722	19.6887	18.6578	20.3646	19.6017
010039	1.6402	21.3550	23.0339	23.4156	22.6372
010040	1.4862	20.4486	20.7779	21.6657	20.9781
010043	0.9615	17.3567	19.9012	19.5358	18.9628
010044	1.0235	23.4576	25.8560	23.0008	24.0434
010045	1.1021	18.7569	22.7713	18.8154	19.9260
010046	1.6180	18.8741	19.6754	20.8465	19.8858

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
010047	0.9111	13.4130	16.1695	19.5927	16.1762
010049	1.1146	16.3349	16.2973	17.7737	16.8052
010050	1.0485	20.3028	20.7398	21.5311	20.8821
010051	0.8835	12.3280	14.3006	14.7000	13.7705
010052	0.8885	19.8289	11.9019	21.2748	16.4680
010053	1.0735	15.4156	17.3238	17.4020	16.6975
010054	1.0487	20.9656	20.6382	23.2022	21.5932
010055	1.4922	19.5667	18.9664	19.1769	19.2269
010056	1.4728	20.5645	21.1104	22.7087	21.5157
010058	0.8802	16.1265	17.7800	20.3710	18.0149
010059	1.0553	19.1270	20.5534	23.6575	21.1101
010061	1.0170	18.5320	17.0447	20.7779	18.7145
010062	1.0887	16.9721	17.1786	18.1202	17.4289
010064	1.7182	20.5650	22.2280	22.5727	21.7158
010065	1.3826	17.0557	17.2698	19.9799	18.1332
010066	0.8084	14.8904	14.8696	17.0110	15.5840
010068	1.2158	23.4322	18.3308	17.5471	20.1766
010069	1.0382	15.4497	17.0957	19.6377	17.4498
010072	1.1042	16.5652	18.8807	21.5354	18.9480
010073	0.9208	13.5594	14.9826	16.4093	14.9392
010078	1.2364	18.5127	20.1447	21.0576	19.8871
010079	1.1551	17.1612	20.7401	20.4172	19.3304
010083	1.2137	18.4282	19.8524	20.1972	19.4438
010084	1.5505	19.8773	21.6522	22.5131	21.4068
010085	1.2551	21.5860	22.5282	23.6946	22.6186
010086	1.0347	16.8886	18.0122	19.4214	18.0598
010087	1.8021	18.7915	19.7620	21.6082	20.0002
010089	1.2093	19.5241	19.5783	22.2443	20.4301
010090	1.6809	19.5635	20.0287	21.4326	20.3545
010091	0.9693	17.1775	17.4672	19.4122	18.0392
010092	1.4405	18.5478	19.9351	22.0602	20.1795
010095	0.8398	12.3064	12.5243	13.4245	12.7641
010097	0.7697	14.2675	15.1593	17.1350	15.4735
010098	0.9775	15.5763	15.1629	19.7955	16.5605
010099	1.0669	15.9232	16.3307	18.2047	16.8448
010100	1.5258	18.3755	19.8146	19.9973	19.4260
010101	1.1217	18.9525	19.0718	21.0036	19.6847
010102	0.9253	15.7778	16.4637	19.8843	17.3425
010103	1.8015	22.0802	22.5709	24.2124	22.9343

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
010104	1.6738	21.9457	20.9391	24.1901	22.2736
010108	1.1065	19.1596	20.7787	23.7794	21.1823
010109	0.9806	15.9627	18.2235	21.7007	18.5954
010110	0.7479	15.5817	16.0015	19.2198	17.3073
010112	0.9610	15.6041	17.9243	17.2895	16.8959
010113	1.6566	18.2774	19.4106	20.4135	19.3892
010114	1.3471	19.3772	20.1763	21.5308	20.3326
010115	0.8448	15.3510	15.7872	17.5189	16.1884
010118	1.2579	17.4621	19.5302	18.8400	18.5460
010119	***	19.5163	20.5245	21.8402	20.6344
010120	0.9961	18.9975	19.4368	20.5619	19.6601
010121	***	15.2345	17.1640	17.0329	16.5712
010125	1.0377	16.5117	16.8622	16.8394	16.7407
010126	1.0880	19.5933	19.9647	23.1798	20.9518
010128	0.8525	16.6898	14.7646	17.9373	16.3922
010129	1.0616	16.7609	16.4905	18.7775	17.4245
010130	0.9771	17.4614	18.7190	18.4887	18.2474
010131	1.2917	19.0492	22.9969	24.2160	22.1715
010134	0.8697	18.5178	17.7717	*	*
010137	1.2519	21.3573	28.9402	29.7665	26.1994
010138	0.7624	14.1368	14.2025	13.4602	13.9680
010139	1.5033	20.5708	22.8390	24.9226	22.7721
010143	1.1937	18.9084	20.5639	22.1291	20.5531
010144	1.5359	18.8272	19.1497	20.6246	19.5483
010145	1.2431	20.8157	22.1394	23.1927	22.0817
010146	1.0661	18.3666	21.3083	19.9832	19.8744
010148	0.8711	18.4590	17.6829	18.5134	18.2391
010149	1.2941	19.0199	21.0086	23.0155	20.9444
010150	1.0643	19.4819	21.2360	20.6860	20.4829
010152	1.3149	19.8990	21.6038	22.1601	21.2033
010155	***	13.6137	*	*	*
010157	1.1365	17.7373	19.6977	21.0135	19.4692
010158	1.0904	18.6052	18.5464	22.0614	19.6503
010159	***	19.3950	*	*	*
010161	***	*	*	27.5119	*
010162	1.5932	*	*	*	*
020001	1.7054	28.6530	30.1452	31.6018	30.2366
020002	***	28.2758	*	*	*
020004	1.2062	29.2351	27.3516	29.9705	28.8316

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
020005	0.8979	35.0860	32.7936	*	*
020006	1.1682	33.0843	31.2673	33.4108	32.5582
020007	***	27.7271	*	*	*
020008	1.2509	31.8877	33.4543	34.5892	33.3657
020009	***	18.5594	*	*	*
020010	0.9035	23.7276	20.7929	*	*
020011	***	27.5062	*	*	*
020012	1.3521	26.7586	27.9955	29.3199	28.0993
020013	0.9687	29.5647	30.6423	*	*
020014	1.0783	27.7870	29.6805	32.0699	29.9009
020017	1.8817	28.8753	30.3017	32.9293	30.7981
020018	0.9022	*	*	*	*
020019	0.8662	*	*	*	*
020020	0.6517	*	*	*	*
020021	0.8840	*	*	*	*
020024	1.0793	25.5933	28.0930	27.9798	27.2883
020025	***	29.4374	*	*	*
020026	1.4512	*	*	*	*
020027	0.9778	*	*	*	*
030001	1.2129	22.8996	25.7513	27.7339	25.2866
030002	1.9990	23.1450	25.6038	27.9646	25.6022
030003	***	23.9850	22.1436	*	*
030004	1.0093	13.8452	*	*	*
030006	1.6633	20.5019	23.2881	24.0011	22.4602
030007	1.3941	22.2473	26.1551	26.9386	25.2383
030009	1.0818	19.1258	19.9131	21.4160	20.1283
030010	1.3881	19.8496	20.7204	22.8552	21.1614
030011	1.4805	19.8141	21.0028	22.8375	21.2099
030012	1.2784	21.1099	24.2366	25.5123	23.7995
030013	1.3512	19.9517	21.9766	23.5066	21.8745
030014	1.4617	20.3017	23.3663	25.1039	22.9519
030016	1.3052	22.2526	24.3380	27.0685	24.6484
030017	1.6989	23.1702	21.8792	24.3847	23.1472
030018	1.2004	21.8067	24.9216	24.4297	23.7391
030019	1.1894	22.0341	23.2973	28.4290	24.3646
030022	1.6721	22.3351	24.9941	25.1543	24.3012
030023	1.6126	25.4626	28.6627	28.4041	27.6198
030024	2.1195	23.7663	26.7641	28.3377	26.1891
030025	***	20.2690	*	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
030027	0.9785	18.5500	19.4583	21.0527	19.7088
030030	1.5829	23.1280	25.2425	24.5986	24.2275
030033	1.2649	20.3034	26.3814	26.6005	24.3843
030034	***	19.5578	*	*	*
030035	***	20.5339	*	*	*
030036	1.2017	22.2690	24.9432	26.5615	24.6293
030037	2.1365	23.7325	23.0542	30.3142	25.3166
030038	1.6026	23.4477	25.2632	26.5014	25.0954
030040	0.8710	19.3707	21.2717	22.5411	21.0444
030041	***	18.4749	*	*	*
030043	1.2788	20.5653	23.5172	26.0733	23.4382
030044	0.9554	18.6781	21.9503	19.5714	19.9272
030047	***	22.7385	*	*	*
030049	***	19.7315	*	*	*
030054	***	15.7974	*	*	*
030055	1.3105	20.8373	22.8612	23.1740	22.3589
030059	***	27.3929	*	24.7017	*
030060	1.1854	19.5021	21.7685	22.3512	21.2211
030061	1.6185	21.1013	22.9706	23.4613	22.5374
030062	1.1987	19.2670	21.1639	21.9700	20.8268
030064	1.8856	21.6435	22.8009	24.6500	23.0164
030065	1.6015	22.2846	24.6064	25.6738	24.2585
030067	0.9665	17.6414	18.4003	19.0935	18.3368
030068	1.0853	18.9718	19.7097	19.6894	19.4914
030069	1.3527	23.4903	24.5432	25.6021	24.5912
030071	0.9806	*	*	*	*
030072	0.8152	*	*	*	*
030073	1.0825	*	*	*	*
030074	0.9735	*	*	*	*
030075	0.9438	*	*	*	*
030076	0.9192	*	*	*	*
030077	0.8214	*	*	*	*
030078	1.2000	*	*	*	*
030079	0.8644	*	*	*	*
030080	1.4342	21.2299	22.8953	24.6205	22.9960
030083	1.3106	23.5049	24.3273	24.9394	24.3034
030084	1.0337	*	*	*	*
030085	1.5606	21.6542	21.8196	23.2140	22.2960
030087	1.5894	23.1339	25.6351	26.3868	25.1079

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
030088	1.3869	21.4491	23.5761	23.2457	22.8024
030089	1.5269	22.0850	24.5055	26.2171	24.3653
030092	1.4232	19.6625	24.0515	25.3985	23.2445
030093	1.2650	21.7195	23.2485	23.5543	22.9132
030094	1.3212	21.8049	24.5992	26.9766	24.3914
030095	***	20.5222	*	*	*
030099	0.9039	19.8092	20.3310	26.8745	22.1919
030100	1.9573	23.5868	27.6299	*	*
030101	1.3405	21.1029	23.7661	25.0020	23.1642
030102	2.4903	21.5405	27.9419	*	*
030103	1.6219	28.9308	29.1105	28.2554	28.7314
030104	***	32.8669	34.6028	*	*
030105	2.6217	*	*	27.7238	*
030106	2.3801	*	*	30.4541	*
030107	2.2375	*	*	*	*
030108	3.3938	*	*	*	*
030110	0.9117	*	*	*	*
040001	1.1000	16.3882	18.7141	23.1148	19.5319
040002	1.1713	16.1353	18.0776	19.3081	17.8141
040003	1.0895	15.5186	16.3918	18.5210	16.7560
040004	1.5912	19.0105	21.2335	23.3331	21.3169
040005	***	16.5465	*	*	*
040007	1.5780	22.5319	23.3992	23.4445	23.1067
040008	***	20.2122	*	*	*
040010	1.4184	19.8251	20.7114	22.0711	20.8858
040011	0.9692	17.1337	18.8346	19.0540	18.5430
040014	1.3024	19.3996	22.4970	24.0468	21.9371
040015	0.9857	17.9601	18.8513	18.0682	18.2913
040016	1.6512	19.8087	21.2198	24.4997	21.7401
040017	1.1125	16.5648	17.7545	19.4027	17.8801
040018	1.0649	18.8203	22.0408	23.8572	21.6023
040019	1.1471	21.0465	21.1711	21.5183	21.2563
040020	1.5208	17.6056	18.6419	20.1577	18.8190
040021	1.1656	21.3321	23.5620	24.7623	23.3227
040022	1.5767	19.2393	21.4194	23.7427	21.2562
040024	1.0422	17.1507	17.5750	20.0694	18.2920
040025	***	14.8070	*	*	*
040026	1.5997	21.0143	22.7699	24.2937	22.7294
040027	1.3842	17.7161	19.3388	19.9305	18.9800

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
040028	***	15.2850	*	*	*
040029	1.5080	22.5094	22.1882	22.8629	22.5212
040030	***	16.5488	*	*	*
040032	0.9639	13.8013	16.2781	18.5183	16.1507
040035	0.8935	11.0611	11.8237	13.4314	12.0590
040036	1.5005	21.1066	21.6742	24.2648	22.3432
040037	***	15.4985	*	*	*
040039	1.2709	15.2811	15.9673	17.7499	16.3631
040040	***	19.6705	*	*	*
040041	1.1718	17.7783	20.4646	21.9346	20.0629
040042	1.3096	16.6875	16.2285	18.9522	17.2467
040044	***	17.1869	*	*	*
040045	0.9625	16.6648	19.5572	18.8083	18.2634
040047	1.0550	18.6295	21.6323	21.5187	20.6425
040050	1.1104	14.2087	15.1428	15.5033	14.9422
040051	1.0254	18.2152	17.6964	18.8828	18.2844
040053	0.9984	14.1508	19.2586	20.7695	17.5650
040054	1.0406	16.5217	16.5573	16.6693	16.5817
040055	1.4785	17.4236	19.7336	22.2235	19.7619
040058	***	19.3124	*	*	*
040060	***	15.4220	*	*	*
040062	1.5578	19.4255	21.9336	21.6394	20.9787
040064	***	13.3479	*	*	*
040066	1.0431	19.5619	21.7766	23.4844	21.6258
040067	1.0543	15.0081	16.0516	15.0467	15.3625
040069	1.1116	18.9754	20.5968	21.7708	20.4646
040070	1.0039	18.6066	*	*	*
040071	1.5350	18.4956	19.4324	22.9353	20.2396
040072	1.0820	21.3320	19.3079	20.8263	20.4865
040074	1.1343	20.8465	22.0800	22.5929	21.8212
040075	0.9804	14.6681	15.7875	16.2417	15.5594
040076	1.0129	21.8010	23.5947	21.0522	22.0847
040077	0.9880	14.7230	16.7832	18.2791	16.5425
040078	1.5287	19.6363	21.4854	24.4264	21.9012
040080	0.9911	22.8154	18.4470	21.3503	20.6742
040081	0.8323	12.4797	13.2797	13.6607	13.1436
040082	***	16.4840	*	*	*
040084	1.1175	18.3410	20.1163	22.6348	20.4366
040085	0.9990	14.1782	15.5811	18.0589	15.8148

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
040088	1.3507	18.3159	20.0032	21.2914	19.8348
040090	***	16.6619	*	*	*
040091	1.2823	20.2904	20.6688	23.0196	21.3236
040093	***	14.7132	*	*	*
040100	1.3430	17.0271	17.8889	19.3365	18.1774
040105	1.0287	14.8936	15.4697	15.7349	15.3796
040106	***	19.0936	*	*	*
040107	0.9108	20.6852	17.6695	*	*
040109	1.1408	16.2496	17.1706	18.8545	17.4404
040114	1.7710	21.3826	21.6849	23.5925	22.2222
040118	1.4218	19.6248	21.7913	24.2463	22.0116
040119	1.3570	18.6028	19.9013	20.1478	19.5617
040126	0.8739	16.3391	13.3832	12.6211	13.8692
040132	***	24.6947	29.2343	36.5495	30.3503
040134	2.4488	22.1291	24.4646	*	*
040136	***	21.4138	*	*	*
040137	1.1778	*	24.7813	23.3978	*
040138	1.1841	*	22.3523	23.3689	*
040140	***	*	*	25.1224	*
040141	0.9031	*	*	*	*
040142	1.2502	*	*	*	*
040143	1.3679	*	*	*	*
040144	2.0272	*	*	*	*
050002	1.4128	30.2629	30.9729	31.9783	31.0809
050006	1.5606	22.4890	25.4604	27.5983	25.4592
050007	1.4811	31.6270	34.1406	37.5545	34.4698
050008	1.3641	28.2021	32.4067	37.0082	32.5916
050009	1.8799	28.3021	30.2740	35.5341	31.4455
050013	2.0281	27.2552	29.8401	31.7311	29.6342
050014	1.1589	25.1664	27.7646	29.5413	27.4962
050015	1.2396	28.2204	27.5652	30.1398	28.6270
050016	1.1474	22.7014	25.5508	25.5766	24.6671
050017	2.0023	25.7403	28.4911	30.5755	28.2381
050018	1.1586	16.5909	17.9621	20.3049	18.3476
050022	1.5790	26.2574	28.1312	28.2833	27.6306
050024	1.1174	21.5230	25.1425	26.9262	24.7222
050025	1.7728	26.0161	29.8262	31.7019	29.2495
050026	1.5397	23.4651	24.2564	26.6326	24.8799
050028	1.2329	17.9421	18.7866	21.5895	19.5247

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble of this proposed rule.
*Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.
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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
050029	***	26.6783	30.2538	34.3934	29.9982
050030	1.2575	21.8639	21.9251	22.9183	22.2399
050032	***	24.4176	28.8046	*	*
050033	***	31.1768	*	*	*
050036	1.6469	24.8017	25.3885	27.4857	25.9252
050038	1.5641	32.1757	36.1619	32.5808	33.6162
050039	1.5347	23.8478	26.8993	29.8159	26.9389
050040	1.1801	30.1153	30.7426	31.9041	30.9730
050042	1.2548	25.4903	27.6765	29.3938	27.5263
050043	1.5670	38.8988	37.3217	39.7109	38.6626
050045	1.1885	21.0356	22.1691	22.6437	21.9289
050046	1.1559	25.3067	25.5490	25.2784	25.3769
050047	1.6458	31.6959	34.4427	39.4324	35.3370
050051	***	17.9266	*	*	*
050054	1.1788	19.2395	21.3495	27.1663	22.2877
050055	1.2267	32.0923	36.1182	36.8147	35.0454
050056	1.4128	24.7994	27.1458	29.3993	27.1745
050057	1.6165	22.2584	24.2759	26.1957	24.3425
050058	1.5851	24.8366	25.9389	27.3556	26.0720
050060	1.5621	21.9971	22.9491	26.4650	23.9173
050061	1.5036	23.9906	25.3042	*	*
050063	1.3797	25.5798	28.6093	32.0440	28.7928
050065	1.8237	27.6677	28.8369	33.8507	30.2656
050066	***	26.3920	*	*	*
050067	1.2271	22.1250	27.8867	29.6982	25.7491
050068	***	19.2325	21.9031	*	*
050069	1.5813	25.8560	27.2744	28.6607	27.2525
050070	1.2563	36.4136	39.5178	40.7316	38.9699
050071	1.2272	36.4834	40.1344	41.1880	39.3476
050072	1.3588	36.1146	39.2529	40.9043	38.8894
050073	1.2872	36.1054	38.6763	41.3567	38.8562
050075	1.2474	37.8104	40.2265	43.8124	40.8107
050076	2.0518	37.0415	40.8075	43.1658	40.3474
050077	1.6263	25.3481	27.1234	29.6020	27.3262
050078	1.2403	23.0613	24.1091	25.6581	24.2964
050079	1.5176	36.5455	38.8981	42.7359	39.7407
050082	1.7362	23.7718	27.5022	28.9177	26.6030
050084	1.5709	25.1155	26.0607	28.2672	26.5595
050088	0.8235	25.2282	27.1103	26.4093	26.2305

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
050089	1.3267	23.4120	24.7857	29.4784	25.8427
050090	1.2945	25.4545	27.4193	31.1307	27.9424
050091	1.1085	26.6463	29.2522	30.1546	28.7343
050092	***	17.1883	*	*	*
050093	1.5352	27.2048	29.2642	31.0669	29.2796
050095	***	29.2228	*	*	*
050096	1.3911	22.5034	23.0525	24.2389	23.2032
050097	***	24.2548	24.6726	26.6788	25.1549
050099	1.5029	26.2363	27.1282	28.7627	27.4131
050100	1.7730	23.9877	25.6798	28.0260	25.8962
050101	1.3670	33.1232	32.9866	35.5439	33.9231
050102	1.2745	22.6741	25.5763	24.9302	24.3279
050103	1.4672	23.5946	27.8079	28.7181	26.6485
050104	1.3868	27.3260	26.1592	29.1295	27.5156
050107	1.3812	22.2745	22.6900	27.5894	24.3509
050108	1.9322	25.6983	28.5244	31.3888	28.5190
050110	1.2761	21.3399	21.9297	19.9232	20.9446
050111	1.2331	21.0813	23.7715	26.6246	23.8167
050112	1.5150	29.1268	31.9797	34.0126	31.8113
050113	1.2990	32.4493	32.6932	34.2632	33.1674
050114	1.3401	27.6486	28.1938	29.2563	28.3919
050115	1.5333	24.3748	24.1481	27.5372	25.3737
050116	1.6000	27.0331	28.2924	28.8170	28.0720
050117	1.3499	23.0697	24.7555	28.2115	25.4419
050118	1.1582	24.9094	28.9358	33.0074	29.1504
050121	1.3706	18.8430	25.0858	25.5948	22.9064
050122	1.5617	26.9048	29.1534	29.7080	28.6085
050124	1.2906	23.9379	23.0843	26.6899	24.5742
050125	1.3431	33.3290	35.6573	40.9260	36.7511
050126	1.3577	26.9718	27.7126	29.6157	28.1256
050127	1.3506	20.5928	21.8719	23.6208	21.9780
050128	1.5049	26.2519	28.7668	28.3278	27.7857
050129	1.8110	23.7432	25.2780	27.8430	25.6026
050131	1.2126	33.0979	37.7845	38.7569	36.6937
050132	1.3804	24.1582	27.8805	29.4343	27.1442
050133	1.4622	23.9479	25.1948	27.4463	25.6414
050135	0.9470	23.2750	*	24.9415	*
050136	1.2430	28.0754	31.6146	35.2414	31.6718
050137	1.2923	33.7489	35.0503	36.5242	35.0896

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
050138	1.8479	40.8913	43.0858	43.8606	42.6433
050139	1.2122	35.1492	33.8749	35.0589	34.6945
050140	1.3963	36.7096	36.1708	37.5379	36.8203
050144	1.4209	29.8983	30.3679	32.2969	30.9099
050145	1.2873	37.5003	37.5722	39.5495	38.2483
050146	1.7293	*	*	*	*
050148	1.0681	21.1621	17.3908	24.6528	20.7289
050149	1.5373	25.8880	28.0500	30.1615	27.8853
050150	1.1779	25.9494	26.7728	31.5140	28.0145
050152	1.3718	34.5096	34.5694	39.7355	36.3605
050153	1.5696	33.3333	34.5870	40.4348	36.0494
050155	1.0414	23.2119	21.2068	21.8829	22.1262
050158	1.2964	28.9764	30.6598	33.5639	31.1858
050159	1.2630	26.6140	27.4051	30.7905	28.2871
050167	1.3399	21.9596	23.2022	25.9726	23.7775
050168	1.6846	27.1971	27.5313	30.7349	28.4751
050169	1.4018	24.7737	25.6896	26.2734	25.5938
050170	***	27.7692	29.4075	*	*
050172	1.2735	22.0400	24.5849	27.1341	24.5740
050173	1.1995	*	27.7070	27.5610	*
050174	1.7575	31.6888	33.5204	36.2235	33.9840
050175	1.3024	26.0146	26.9627	31.5476	28.1464
050177	1.2195	22.5039	23.1575	24.7531	23.4567
050179	1.1763	22.8941	23.0583	25.7858	23.9592
050180	1.6060	34.0900	36.9905	40.7642	37.3461
050186	***	25.0791	27.6638	*	*
050188	1.3391	30.6007	34.1503	39.3431	34.8237
050189	0.9824	28.3295	32.3513	20.0480	25.6260
050191	1.5117	29.4162	28.1689	*	*
050192	1.0034	19.0400	19.5327	21.2448	19.9850
050193	1.1547	25.5293	24.6307	30.6901	26.9809
050194	1.2814	28.5389	28.1413	38.6513	31.6120
050195	1.4811	39.1617	42.1735	43.9603	41.8198
050196	1.1358	19.4304	20.7257	25.2108	21.6054
050197	1.9506	34.6878	*	26.6971	*
050204	1.4379	23.0192	24.9458	25.2407	24.4680
050205	1.2611	24.1275	25.2841	28.0676	25.8250
050207	1.3222	23.7774	25.1863	27.0083	25.3168
050211	1.2914	33.2481	34.3396	36.9337	34.8080

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
050214	1.4707	21.1480	22.4773	24.4785	22.6170
050215	1.6870	31.6895	36.6063	41.5473	36.5597
050217	1.2169	21.3026	22.2055	23.6386	22.3948
050219	1.0862	21.7637	21.8649	22.9225	22.2450
050222	1.6931	23.0670	25.2922	26.3841	24.9600
050224	1.7017	24.8431	26.2108	26.7824	26.0014
050225	1.4136	22.0981	25.0219	29.5233	25.5557
050226	1.5535	26.1959	26.0826	29.1912	27.1802
050228	1.3638	36.0632	38.6751	40.1232	38.2919
050230	1.3448	26.7963	30.0380	34.1345	30.4296
050231	1.6272	27.4697	27.8896	30.1155	28.5288
050232	1.4646	25.8640	25.3439	24.4059	25.1797
050234	1.1540	25.0104	24.0754	26.1434	25.1875
050235	1.5728	26.0323	27.2838	27.8674	27.0716
050236	1.3318	27.7406	27.0687	28.2138	27.6568
050238	1.4806	25.1796	26.0312	29.1437	26.8173
050239	1.6091	24.9469	27.0866	28.2225	26.8396
050240	1.6508	28.8910	32.8542	35.1937	32.6172
050242	1.4001	33.5646	34.4412	39.7341	35.9557
050243	1.5898	26.0256	28.5626	31.7419	28.8559
050245	1.3353	24.6092	25.7585	27.0653	25.8475
050248	1.0809	28.4413	29.1192	31.6240	29.7919
050251	0.9424	27.9530	24.4552	26.5133	26.1473
050253	0.8940	21.0399	23.9246	22.2450	22.4112
050254	1.1636	22.3414	23.3358	24.1599	23.3257
050256	1.7636	25.1104	26.8618	27.8020	26.5937
050257	0.9836	15.6379	17.4909	20.8309	18.0031
050260	***	30.1623	*	*	*
050261	1.2557	19.4649	21.4693	25.2857	22.0240
050262	1.9518	30.8866	33.0425	34.7716	32.9517
050264	1.3450	33.2270	37.4742	41.3295	37.1595
050267	***	27.8394	26.6558	26.7060	27.0912
050270	1.2890	26.4092	27.9871	30.0354	28.2636
050272	1.4264	23.3443	24.0921	25.5905	24.3572
050276	1.2173	34.0633	34.7422	41.2135	36.8041
050277	1.2574	23.6065	35.6323	35.8193	32.0751
050278	1.5379	24.9699	26.0331	28.0165	26.3835
050279	1.2706	22.2776	23.5145	25.5294	23.7870
050280	1.6783	26.3392	28.5504	30.7242	28.5843

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
050281	1.4362	25.2698	25.7832	26.2204	25.8110
050282	***	26.4698	*	*	*
050283	1.5523	32.3270	35.1831	38.5367	35.4661
050286	***	20.6190	19.7352	19.4973	19.9061
050289	1.5979	32.2125	34.9645	37.3862	34.8251
050290	1.6322	31.5000	31.9510	32.6314	32.0326
050291	1.7571	30.9334	28.3451	29.4516	29.5147
050292	1.0301	21.4357	27.6114	27.0743	25.2743
050293	***	17.1935	*	*	*
050295	1.5629	25.4405	25.4332	31.5929	27.0233
050296	1.1551	30.0984	33.5948	34.9707	32.9100
050298	1.1246	22.4000	26.1707	25.8045	24.7445
050299	1.3316	24.6751	26.9870	27.7521	26.5347
050300	1.6020	26.0298	26.3182	28.3839	26.9430
050301	1.2409	24.7987	25.7167	28.5819	26.4103
050305	1.4712	36.6981	38.7597	41.1112	38.8963
050308	1.4325	30.3887	31.6790	38.8936	33.6870
050309	1.3840	25.5221	25.5367	28.7754	26.6470
050312	1.6026	26.0172	28.2557	32.6056	29.2005
050313	1.1701	28.9125	25.3372	27.4649	27.1514
050315	1.4156	22.5906	23.6638	26.0529	24.1601
050320	1.2885	31.6571	31.4570	36.3148	33.3071
050324	1.9576	26.8313	28.4931	30.9946	28.8742
050325	1.2782	22.6352	26.6325	30.1887	26.1858
050327	1.6397	31.1527	33.0549	29.8350	31.2225
050329	1.3076	24.2134	26.6341	26.7359	25.9202
050331	1.2585	25.2110	21.5193	20.9847	22.6062
050333	1.1237	14.1808	15.6929	15.3119	15.0561
050334	1.7067	34.3956	37.2336	39.3732	37.0749
050335	1.4822	22.9335	24.9274	27.3630	25.1227
050336	1.2563	22.0202	23.2687	25.3154	23.5052
050342	1.1801	22.4510	23.0282	24.7287	23.4273
050348	1.6450	29.3364	28.9864	33.2555	30.6090
050349	0.9529	15.4536	15.6043	16.9143	15.9650
050350	1.3277	27.2368	27.2573	29.4215	27.9411
050351	1.4888	25.2436	27.4042	28.3706	27.0890
050352	1.2217	27.7489	32.6572	24.2820	27.8907
050353	1.5504	24.1009	25.4309	26.6343	25.4251
050355	0.8275	41.4707	*	11.2498	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
050357	1.3327	24.3540	25.2126	26.6395	25.4063
050359	1.1560	19.7653	22.9175	23.4554	22.0826
050360	1.4076	33.3592	35.9032	38.0639	35.8750
050366	1.1501	22.0442	23.4696	25.7637	23.8592
050367	1.3941	31.7487	32.6760	33.9945	32.8210
050369	1.2699	26.6627	28.0909	27.1393	27.3086
050373	1.4089	29.9749	30.7301	31.9105	30.8679
050376	1.4022	28.4026	30.3530	30.7426	29.8249
050377	***	11.6463	14.3892	20.2484	13.8073
050378	1.0557	27.8389	30.4937	33.8772	30.6931
050379	0.9219	24.2409	27.5151	31.7645	27.7551
050380	1.6069	31.5962	35.8014	37.9972	35.0614
050382	1.3427	26.3968	26.8950	26.0770	26.4581
050385	1.3057	27.1692	*	25.5673	*
050388	***	17.6762	*	*	*
050390	1.1789	25.8556	25.7881	28.5470	26.7025
050391	1.1866	19.0832	20.2887	21.3012	20.1817
050392	1.0939	24.9004	21.8139	22.8802	23.1098
050393	1.2977	25.4028	26.4918	28.2389	26.7648
050394	1.4940	23.1641	25.1869	26.0039	24.8511
050396	1.6234	25.7580	28.4161	30.3133	28.2376
050397	0.8571	23.3213	24.7279	27.4646	25.1198
050404	***	16.4845	*	*	*
050406	***	21.5282	*	*	*
050407	1.2436	32.0753	33.2894	35.5873	33.6757
050410	***	17.1718	19.8436	19.4967	18.7451
050411	1.3462	33.1718	35.5207	37.3356	35.3526
050414	1.3059	24.5471	28.2381	28.8310	27.2745
050417	1.2224	23.3862	24.5360	25.1781	24.3368
050419	1.4049	25.1449	26.4357	28.4127	26.6451
050420	1.2171	26.4201	26.7537	26.1844	26.4541
050423	0.9497	24.8113	26.5188	28.5722	26.7955
050424	1.9102	25.9378	27.5273	29.8727	27.7702
050425	1.3290	33.7276	37.7347	38.5790	36.8547
050426	1.3392	26.7941	30.9610	30.0028	29.2312
050427	***	31.4156	*	*	*
050430	0.9070	25.2322	31.5170	24.6678	26.2978
050432	1.4364	26.0686	28.1105	30.3379	28.2644
050433	0.8921	17.7979	14.3846	20.7425	17.5472

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
050434	1.1178	24.0017	*	25.9590	*
050435	1.0976	22.5428	22.6618	32.2191	25.4598
050438	1.5747	25.3763	26.5535	26.4586	26.1427
050440	***	25.4767	*	*	*
050441	1.9956	33.4696	36.6680	38.2611	36.1745
050443	***	16.8897	*	*	*
050444	1.3817	22.6469	23.5299	26.3952	24.0887
050446	***	20.3611	*	*	*
050447	0.8754	24.4339	25.7274	21.8230	23.7743
050448	1.1270	22.6612	26.6967	25.0853	24.6924
050454	1.8580	30.3063	34.4813	36.8214	33.8860
050455	1.6547	20.5575	24.1694	24.5242	23.0053
050456	1.2353	17.5845	23.7594	22.1675	20.7473
050457	1.6198	34.2116	37.4570	40.2449	37.1137
050464	1.7390	25.8092	31.4768	37.0779	31.7271
050468	1.5118	22.9771	17.8128	29.4259	22.5153
050469	1.0786	*	25.7995	27.3180	*
050470	1.0755	15.7765	21.6981	18.4578	18.4105
050471	1.7253	29.4705	32.3570	34.5377	32.1330
050476	1.3100	25.9458	26.0482	31.0673	27.6591
050477	1.4184	30.8781	32.1676	34.5956	32.6741
050478	1.0317	28.1830	28.3894	30.2542	28.9511
050481	1.4183	28.5320	30.3890	31.9297	30.3606
050482	***	21.6091	*	*	*
050485	1.6080	25.2723	27.1437	28.8026	27.0164
050488	1.2691	33.8291	37.2438	40.6205	37.3316
050491	0.9854	27.7413	29.2987	30.6461	29.2417
050492	1.4747	23.4977	23.7384	27.4471	25.0721
050494	1.3206	30.2876	30.8706	35.0467	32.0627
050496	1.7290	32.7474	35.7115	38.2795	35.5403
050497	***	*	14.4481	15.9501	*
050498	1.3226	27.6099	28.2196	28.2229	28.0219
050502	1.6841	27.2724	28.0102	28.7107	28.0078
050503	1.4270	25.7668	26.7924	29.1917	27.2800
050506	1.6059	27.1555	30.4731	32.4477	30.0709
050510	1.1532	36.2548	39.6005	44.4730	40.2108
050512	1.3353	36.0785	39.0767	41.9858	39.1491
050515	1.3027	37.3440	36.3131	37.4516	37.0401
050516	1.4971	25.3450	30.0985	29.4863	28.0913

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
050517	1.1036	23.6067	23.4131	23.5118	23.5131
050522	***	37.0295	38.9157	*	*
050523	1.2615	32.1272	33.8053	34.9992	33.6952
050526	1.2516	26.8814	29.0004	29.9502	28.6530
050528	1.1587	21.1741	23.9177	28.6226	24.7875
050531	1.1534	*	22.7311	24.9997	*
050534	1.3184	24.4038	26.7941	29.7003	27.0973
050535	1.2895	27.7626	29.7904	32.3737	30.2197
050537	1.3116	26.2342	25.1291	27.0478	26.1289
050539	1.3009	23.7778	25.3328	28.1076	25.6815
050541	1.4832	37.0551	41.1980	43.8251	40.7762
050542	0.9477	21.8129	21.2846	*	*
050543	0.7387	22.4134	24.0334	25.7161	24.1159
050545	0.9025	33.6302	33.4322	42.9477	35.7945
050546	0.6823	39.4267	42.8052	52.4159	44.1397
050547	0.9059	37.7632	40.6483	45.2200	40.9733
050548	0.6741	30.3337	32.3944	36.8587	33.0890
050549	1.5517	30.0948	31.8525	33.8471	32.0288
050550	1.3473	26.5515	29.0938	31.1656	29.0817
050551	1.2893	26.1042	28.6834	31.6313	28.9561
050552	1.1041	20.6068	24.9755	26.8274	24.4067
050557	1.5692	23.8340	25.8719	28.2488	26.1279
050559	***	26.3798	25.3299	26.9662	26.1992
050561	1.3890	34.2065	35.9611	37.5194	35.9163
050566	***	21.7712	*	*	*
050567	1.6003	26.2588	27.8475	30.1146	28.1131
050568	1.3377	21.9313	20.8324	22.4961	21.7437
050569	1.3075	27.3294	27.7955	30.4702	28.5449
050570	1.5532	26.8965	29.9470	32.7109	29.9963
050571	1.3009	26.2226	29.1716	32.1700	29.2919
050573	1.7372	25.9380	27.2328	30.5003	27.9515
050575	1.2343	27.8579	23.1358	23.2447	24.4730
050577	1.3037	25.2861	26.4806	28.7060	26.7920
050578	1.6280	32.0554	30.4934	31.5002	31.3236
050579	1.3265	32.0245	34.9794	40.2037	35.9543
050580	1.2812	22.7522	27.2431	29.4255	26.2772
050581	1.4070	26.0580	28.9696	32.0628	29.1136
050583	1.5334	26.2664	30.0427	33.5019	30.2058
050584	1.4614	24.5294	24.5544	24.6016	24.5616

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
050585	1.2329	26.4446	26.0595	27.3051	26.6515
050586	1.1619	*	25.7172	25.3311	*
050588	1.3124	27.0506	30.5453	32.3354	30.1230
050589	1.2147	23.7918	27.9845	30.6416	27.4253
050590	1.3266	25.1100	27.0620	31.5987	27.5768
050591	1.1668	26.7662	28.6151	28.5195	28.0410
050592	1.1944	23.8267	25.9545	32.4914	27.1414
050594	1.9108	28.7415	30.8028	34.6782	31.6056
050597	1.2461	23.1209	24.5542	25.4822	24.3957
050598	***	25.1623	24.6875	*	*
050599	1.9040	26.3782	27.7684	30.8328	28.3320
050601	1.5341	29.7734	32.3033	35.0373	32.5254
050603	1.4297	24.9032	25.0996	28.6764	26.2932
050604	1.2470	36.4669	42.0018	45.5002	41.4088
050608	1.3399	20.9171	20.7955	22.1442	21.3485
050609	1.4685	34.8949	37.4563	38.4995	36.9431
050613	1.1061	34.9769	*	*	*
050615	1.3116	25.8697	29.4323	32.8639	29.5275
050616	1.3525	25.0016	23.1748	28.5227	25.5170
050618	0.9507	22.3548	22.3481	25.4234	23.4291
050623	1.1279	28.6475	29.9553	29.6550	29.3955
050624	1.2578	22.4030	23.3492	28.1924	24.4721
050625	1.7307	29.3665	30.8013	33.5079	31.2769
050630	***	25.2915	27.7051	28.0726	27.0318
050633	1.2927	27.8165	30.2883	33.4517	30.5604
050636	1.3518	25.0213	23.2573	27.2215	25.2066
050638	***	15.6375	*	*	*
050641	1.1925	17.9379	21.5030	20.4710	20.2328
050644	1.0047	*	28.4054	25.6595	*
050660	1.4772	*	*	*	*
050662	0.7412	38.9591	40.9242	46.7482	41.8792
050663	0.9484	22.7770	22.9161	25.1493	23.5792
050667	0.8872	26.9236	31.4906	25.9878	28.1126
050668	1.0239	57.8627	55.9594	*	*
050670	***	24.1626	*	*	*
050674	1.2952	33.7845	36.8871	38.4957	36.5076
050676	***	16.3947	*	*	*
050677	1.3897	34.0936	36.2702	37.3022	35.9067
050678	1.2458	25.2143	27.1337	29.1054	27.2899

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
050680	1.2842	31.9166	32.7065	35.6386	33.4930
050682	0.8527	19.8107	23.0984	21.7264	21.4166
050684	1.1624	24.2792	23.7443	24.8871	24.3207
050685	***	30.4194	*	*	*
050686	1.3301	34.8278	37.3033	38.5552	36.9349
050688	1.2048	34.9937	36.5555	37.0327	36.2240
050689	1.5967	34.0571	37.5449	40.4150	37.6472
050690	1.2893	36.7516	41.1385	44.0436	40.8102
050693	1.2864	29.1213	32.6638	34.8004	32.4512
050694	1.3022	25.1963	25.8298	26.6273	25.9170
050695	1.0723	26.2838	27.8742	30.1339	28.1742
050696	2.1046	29.6684	29.9410	36.8941	32.4650
050697	1.0862	24.1116	18.6962	19.2594	20.3262
050698	***	24.9559	*	*	*
050699	***	23.4611	26.0909	25.5361	24.9031
050701	1.2788	26.4901	28.4650	29.6704	28.2678
050704	1.0020	25.6565	24.6072	24.5708	24.9438
050707	1.2630	28.2637	27.7366	32.4119	29.4923
050708	1.6680	24.5607	22.1606	21.2163	22.6876
050709	1.2153	21.8770	22.7897	21.9079	22.1851
050710	1.2897	30.5918	33.7204	34.8829	33.2435
050713	0.9680	18.2822	19.0071	20.7173	19.3317
050714	1.2117	30.3290	30.3263	32.3424	31.0159
050717	1.1805	31.5021	33.0719	34.5932	33.0577
050718	1.3650	22.5990	21.7835	15.4037	18.3570
050719	***	*	22.0998	*	*
050720	0.8499	*	26.1941	24.8117	*
050722	1.0449	*	*	*	*
050723	1.2317	32.0291	33.0797	34.9386	33.4893
050724	2.0758	*	23.7567	*	*
050725	1.0352	*	20.6592	22.0946	*
050726	1.6186	*	25.8742	27.1186	*
050727	1.0537	*	*	23.5510	*
050728	1.3368	*	*	31.5345	*
050729	1.5025	*	*	*	*
050730	1.2881	*	*	*	*
060001	1.5731	21.4562	23.1548	24.9396	23.3099
060003	1.4153	21.9043	23.0807	24.7879	23.3634
060004	1.2157	22.9265	25.0037	28.0582	25.4856

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
060006	1.2999	21.0003	21.8609	22.7446	21.9062
060007	1.0674	19.3071	21.4244	21.4491	20.7272
060008	1.1117	18.7098	19.8803	21.7990	20.1603
060009	1.4707	23.9272	24.7920	27.0445	25.2839
060010	1.7228	24.2735	25.8475	27.2272	25.7961
060011	1.5110	22.2058	25.8919	26.2159	24.7855
060012	1.4373	21.2980	22.6374	24.1490	22.6818
060013	1.3657	23.5248	23.3954	24.9265	23.7898
060014	1.8575	25.7701	27.0326	29.6855	27.4615
060015	1.6557	23.6015	27.6338	30.0938	27.1914
060016	1.1660	20.2361	22.9300	23.9437	22.4108
060018	1.2526	21.8479	21.0581	23.6782	22.1842
060020	1.5781	19.7348	20.9025	22.1920	20.9986
060022	1.6046	22.8059	24.7928	25.7743	24.5022
060023	1.6122	22.4731	24.3749	26.6950	24.5750
060024	1.7660	24.3658	25.2409	28.7196	26.1522
060027	1.5356	22.1717	25.1480	26.6348	24.7867
060028	1.4701	24.2985	27.1303	27.9631	26.4597
060029	0.9357	19.8498	19.7379	*	*
060030	1.3466	21.2612	22.8309	25.3388	23.2710
060031	1.5526	23.3995	23.8781	25.6396	24.3467
060032	1.4886	24.7678	27.1783	28.2353	26.8086
060033	0.9981	17.8514	16.7266	*	*
060034	1.5113	24.3652	26.1602	28.4680	26.4115
060036	1.1600	18.6521	19.4144	20.4635	19.5159
060037	***	15.7495	*	*	*
060038	***	16.6526	*	*	*
060041	0.8935	19.5871	20.8746	22.6550	21.0118
060042	1.1052	19.3967	*	*	*
060043	0.9786	15.4074	19.1085	20.0626	18.2852
060044	1.1231	21.3102	25.6112	25.2315	24.5548
060046	***	22.6819	*	*	*
060047	***	17.9172	*	*	*
060049	1.3454	25.9592	25.3425	26.7934	26.0724
060050	1.1932	*	20.4386	21.9108	*
060052	***	16.0543	*	*	*
060053	***	19.4746	*	*	*
060054	1.4073	19.7753	21.1281	23.5803	21.4905
060056	***	21.9586	*	*	*

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060057	1.0332	24.6599	24.3982	26.9631	25.4368
060058	***	16.4504	*	*	*
060060	***	19.4418	*	*	*
060062	***	17.1032	*	*	*
060064	1.4124	28.8746	29.1806	30.1094	29.4519
060065	1.3032	24.4554	29.2377	28.5330	27.4063
060066	***	17.5556	*	*	*
060070	1.0125	19.2220	22.6894	*	*
060071	1.2109	17.6452	20.1385	20.2424	19.3759
060073	***	18.4971	*	*	*
060075	1.2670	25.0552	27.7835	30.7085	27.8545
060076	1.3182	22.9426	23.6266	25.5241	24.0946
060085	***	10.9724	*	*	*
060088	***	20.7211	*	*	*
060090	1.0058	16.5321	*	*	*
060096	1.5953	21.9950	26.4167	27.4047	25.3332
060100	1.6385	24.8116	28.0561	29.7826	27.6273
060103	1.2692	24.4962	26.6863	28.8055	26.7652
060104	1.3509	24.4248	26.7683	30.8646	27.4543
060107	1.2642	*	*	26.8692	*
060108	***	19.1327	19.0011	*	*
060109	***	27.3180	*	*	*
060110	***	*	29.8561	*	*
060111	***	*	*	31.2571	*
060112	1.2267	*	*	*	*
070001	1.6512	27.7441	29.9592	32.2310	29.9001
070002	1.8031	26.6881	28.1101	29.0525	27.9396
070003	1.0887	28.1722	29.8684	31.2152	29.7851
070004	1.2288	25.4310	25.7207	27.2653	26.1053
070005	1.4072	27.6733	29.8173	29.3138	28.9306
070006	1.3263	33.6291	33.3814	33.9210	33.6519
070007	1.2987	28.0875	29.0336	30.3586	29.1824
070008	1.2749	25.1362	24.3907	24.9099	24.8196
070009	1.2826	24.9408	25.6072	28.8711	26.4676
070010	1.8095	28.3168	30.4192	33.1329	30.6722
070011	1.3667	24.8206	24.9457	27.5180	25.7061
070012	1.2553	37.5917	34.9099	40.3324	37.5687
070015	1.4869	29.2693	30.0614	30.9407	30.0850
070016	1.4037	28.4833	29.7505	29.6389	29.2619

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070017	1.4019	27.5514	29.2978	30.3835	29.0689
070018	1.3665	32.6301	33.8654	35.7002	34.1641
070019	1.2638	26.2348	27.9838	29.6136	27.9803
070020	1.3573	26.6203	28.4084	29.9397	28.3905
070021	1.2279	29.4597	30.3254	31.4280	30.4572
070022	1.8150	27.2423	29.7376	32.1851	29.7205
070024	1.4169	26.3544	28.3460	30.8308	28.5554
070025	1.8752	27.3592	28.3017	29.2451	28.3023
070027	1.3268	25.9279	36.9700	27.3385	29.2688
070028	1.6192	26.7286	28.2078	29.5363	28.1734
070029	1.3121	23.8427	25.8107	26.3861	25.3716
070031	1.2502	25.6347	25.5880	27.2193	26.1692
070033	1.3795	34.1591	34.3904	35.5346	34.7138
070034	1.3932	30.0744	32.8074	35.6847	32.8182
070035	1.3187	24.5996	26.1693	27.1885	25.9581
070036	1.6441	31.2961	35.0701	34.0570	33.4577
070038	***	26.3126	*	31.1133	*
070039	0.9251	*	32.6059	34.7319	*
080001	1.6725	26.8887	28.0859	30.1960	28.4271
080002	***	20.9385	23.7309	26.3937	23.6165
080003	1.5389	24.8200	24.8199	27.1105	25.5229
080004	1.3749	21.7344	24.2251	25.1831	23.7712
080006	1.2869	20.9399	23.6838	24.4111	23.0215
080007	1.3971	21.5415	23.4964	24.6343	23.2309
090001	1.7571	23.0365	29.5432	31.3519	27.7721
090002	***	20.6550	23.5158	29.6780	23.4282
090003	1.3657	27.1087	22.7014	27.0339	25.4641
090004	1.8860	25.9717	28.7417	29.9707	28.4360
090005	1.3624	26.8690	28.6142	30.2406	28.6919
090006	1.4043	22.9658	23.7241	25.8963	24.2036
090007	***	24.6668	25.8430	30.1419	26.6936
090008	1.4869	*	19.3212	29.6560	*
090010	***	25.9373	*	*	*
090011	2.0592	27.6038	31.7710	32.3880	30.6229
100001	1.4492	22.0101	22.6150	25.2230	23.3817
100002	1.3594	21.5772	22.5982	22.1276	22.1103
100004	0.9449	16.1638	15.6306	16.2376	16.0123
100006	1.6072	21.6922	23.3745	26.1274	23.8428
100007	1.6891	22.5317	24.3305	25.4293	24.1998

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
100008	1.6499	21.6416	22.7706	25.7359	23.4543
100009	1.4670	22.6370	24.7811	24.4449	23.9810
100010	***	23.9581	25.5614	26.9486	25.4664
100012	1.6343	22.0244	24.2602	24.6464	23.6548
100014	1.3624	21.9875	21.7566	20.3960	21.3137
100015	1.3110	18.9383	22.1272	22.5718	21.2616
100017	1.5400	20.1417	21.1905	22.9174	21.4916
100018	1.6036	22.6587	24.1885	27.8495	24.9735
100019	1.6344	25.8297	24.2888	25.5530	25.1953
100020	1.2344	21.7421	23.5303	23.6106	23.0052
100022	1.6900	27.4235	27.9072	29.0404	28.1417
100023	1.3238	20.2034	21.8111	21.3884	21.1364
100024	1.2863	22.9872	24.4070	27.6186	25.0248
100025	1.6657	20.1360	21.2568	21.1175	20.8749
100026	1.6312	21.3742	20.1602	21.3584	20.9453
100027	0.9284	20.5889	23.8982	11.9809	18.2775
100028	1.2749	20.3751	21.8879	23.7627	22.0183
100029	1.1311	22.2553	24.6814	26.8992	24.5481
100030	1.2696	19.5604	21.8567	22.4723	21.4278
100032	1.7987	20.6543	21.6415	23.0034	21.7834
100034	1.7713	20.0099	23.1111	24.4011	22.5964
100035	1.5913	21.3519	22.6349	25.3565	23.0855
100038	1.8234	24.9548	25.7948	27.4329	26.1296
100039	1.4040	23.3111	23.8060	26.6213	24.6180
100040	1.6331	19.5154	22.4679	23.5316	21.8845
100043	1.2891	20.7688	21.7738	22.8204	21.8136
100044	1.4112	22.9474	23.9952	26.3110	24.3991
100045	1.3117	22.8096	25.2285	22.9402	23.5845
100046	1.2294	23.2027	24.2746	26.5953	24.8340
100047	1.6907	21.4971	24.3522	24.3801	23.4918
100048	0.8988	17.3663	17.5533	18.3503	17.7435
100049	1.1422	20.9490	21.8679	22.9209	21.9301
100050	1.1899	17.8960	20.0405	20.6613	19.5372
100051	1.3312	19.3258	20.0231	22.3169	20.6966
100052	1.3743	19.6620	20.5916	20.9095	20.3903
100053	1.2563	21.6634	23.7837	27.2585	24.2776
100054	1.2246	20.9612	22.0352	25.7322	23.0253
100055	1.3190	19.1325	19.6350	22.0971	20.2272
100056	***	23.1737	25.9245	25.7945	24.9651

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*Denotes wage data not available for the provider for that year.
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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
100057	1.3805	22.3406	24.6417	22.3296	23.0301
100061	1.4604	24.5277	26.1273	26.7623	25.8502
100062	1.7417	21.9054	24.9807	24.1257	23.6250
100063	1.3201	19.2510	21.5620	21.4987	20.8156
100067	1.4584	19.2168	23.8892	23.9150	22.4678
100068	1.5818	19.9648	23.7840	22.8937	22.6075
100069	1.2866	18.5789	19.6037	22.4256	20.3417
100070	1.5627	20.9592	23.5524	23.7647	22.8874
100071	1.2036	20.7461	21.7675	23.4114	22.1901
100072	1.3340	22.0317	23.5362	24.2822	23.3645
100073	1.7667	22.2425	23.5843	25.3600	23.7818
100075	1.5208	20.4604	22.3890	23.2521	22.0467
100076	1.2252	18.4815	19.6444	21.0746	19.7241
100077	1.4119	20.9482	22.3755	24.3602	22.5929
100078	***	16.6004	*	*	*
100079	1.6995	*	*	*	*
100080	1.7038	22.9720	22.8704	26.3551	24.1096
100081	1.1444	16.5149	16.8087	16.9052	16.7466
100084	1.7427	24.5682	24.1122	26.9168	25.2365
100086	1.1822	24.3067	25.2375	26.4931	25.3841
100087	1.9324	22.1764	26.5915	25.9850	24.9406
100088	1.7075	20.6667	23.6270	24.8533	23.1064
100090	1.3864	21.0431	22.5894	24.0343	22.5839
100092	1.4934	21.4601	25.4630	26.0339	24.1400
100093	1.7056	18.7153	20.2949	21.1767	20.0943
100098	1.0437	21.1723	20.0639	21.2488	20.8477
100099	1.0898	16.5271	18.5287	20.4355	18.3883
100102	1.1224	19.0193	21.6772	22.8816	21.1681
100103	0.9372	19.1222	20.3633	21.7631	20.3821
100105	1.4246	22.7793	24.5464	24.9362	24.0849
100106	0.9773	21.4342	20.3417	20.2678	20.7105
100107	1.1826	21.7553	23.3789	24.4236	23.1749
100108	0.8251	18.4126	14.8039	16.3944	16.3568
100109	1.2846	20.6007	23.0779	23.8603	22.5599
100110	1.5430	22.8127	24.4533	28.3717	25.4730
100112	***	16.2110	*	*	*
100113	1.8685	23.3380	24.3614	19.1243	21.7228
100114	1.3173	22.5326	25.3699	27.7088	25.1003
100117	1.2150	21.3085	23.9134	25.9401	23.8497

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
100118	1.2720	21.7067	24.1104	24.2050	23.2924
100121	1.1795	19.9033	23.1100	24.0718	22.4356
100122	1.1929	24.9765	24.1820	21.2503	23.2056
100124	1.1496	20.0867	24.3048	21.6407	21.9282
100125	1.1740	20.3232	22.4185	25.3570	22.8163
100126	1.5113	21.4349	21.7977	23.2637	22.1796
100127	1.6083	20.5153	21.0153	21.2439	20.9299
100128	2.1401	23.5835	24.4104	25.6554	24.6142
100130	1.2687	21.0023	20.2478	22.8194	21.3553
100131	1.2819	24.6184	25.4811	25.8268	25.3367
100132	1.2195	19.5259	21.1538	23.0359	21.2669
100134	0.8763	16.9302	18.3391	19.5771	18.3033
100135	1.5307	19.7675	20.4915	22.3000	20.8373
100137	1.1476	20.9014	20.4007	23.3597	21.6008
100138	***	14.9759	*	*	*
100139	0.8449	15.7378	18.2204	14.4819	16.1776
100140	1.1449	20.2288	22.5124	24.7406	22.5883
100142	1.2107	17.7250	20.0689	20.6728	19.4344
100146	***	20.8381	*	*	*
100147	0.9367	17.1566	17.1045	*	*
100150	1.2881	25.4269	22.9194	25.6837	24.6288
100151	1.7653	26.6143	26.6470	26.1573	26.4451
100154	1.4214	21.6715	23.0820	26.3665	23.7864
100156	1.1170	20.0348	20.6928	22.2704	21.0419
100157	1.5884	24.2188	23.1045	25.8971	24.3980
100159	***	15.0634	*	*	*
100160	1.2102	22.6942	23.4877	27.1966	24.5457
100161	1.5802	23.3612	24.6268	28.3666	25.5861
100162	***	24.2950	23.8001	*	*
100166	1.4355	22.2419	23.7419	24.4205	23.4458
100167	1.2448	25.7675	26.4517	26.8684	26.3895
100168	1.3694	23.0121	24.6276	26.1321	24.6161
100169	***	21.6397	23.4575	*	*
100170	***	21.2469	*	*	*
100172	1.3863	15.7827	17.6051	18.4802	17.2852
100173	1.7341	18.3828	19.7190	22.4798	20.1739
100175	1.0247	21.2532	21.0474	22.0620	21.4363
100176	1.9059	24.6595	26.8740	29.8279	27.1329
100177	1.2514	25.1037	24.5078	25.0854	24.8943

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
100179	1.7493	23.9633	24.1801	26.6646	25.0104
100180	1.3810	22.7781	24.9433	26.3293	24.8071
100181	1.0668	17.9048	18.1320	19.5036	18.4712
100183	1.1485	22.2063	24.4575	26.6942	24.4546
100187	1.2702	21.4988	23.4760	26.1008	23.7172
100189	1.3045	27.1295	26.6846	26.5830	26.7733
100191	1.3508	22.0526	24.1911	24.3492	23.5358
100200	1.3819	24.8878	24.8120	28.0951	25.9382
100204	1.5175	21.1922	22.2613	24.4667	22.6933
100206	1.2765	20.3436	22.8782	22.9842	22.0361
100208	***	20.4678	24.1482	24.9854	23.3245
100209	1.4200	22.8236	23.8502	25.0545	23.9848
100210	1.4664	23.0431	26.0933	28.5960	25.9471
100211	1.2434	21.6367	24.3243	*	*
100212	1.4883	21.7239	22.6584	24.2500	22.8979
100213	1.5530	22.0176	24.4467	25.1939	23.9291
100217	1.2442	22.7116	24.0291	25.2570	24.0195
100220	1.6448	24.6234	24.9733	25.0087	24.8717
100221	***	23.2263	*	*	*
100223	1.5626	21.8962	21.2434	23.4587	22.2554
100224	1.2382	22.3567	23.0804	23.3523	22.9462
100225	1.1833	22.4619	23.9971	27.9221	24.8193
100226	1.2827	22.7301	23.8701	27.7858	24.8427
100228	1.3230	24.9691	26.2593	27.2904	26.2491
100229	***	19.7259	21.0038	*	*
100230	1.4027	23.4169	25.0518	26.3549	25.1693
100231	1.7467	21.5712	23.5418	24.6828	23.2366
100232	1.2097	20.1459	21.8105	23.9126	21.9821
100234	1.3941	24.3355	24.9141	25.2496	24.8560
100236	1.3742	21.7886	23.9781	25.9200	23.8823
100237	1.9641	23.2712	26.7664	25.6138	25.1675
100238	1.5668	23.3747	24.6513	27.1703	25.0739
100239	1.3103	23.2242	25.0509	26.9614	25.1190
100240	0.8900	21.3495	23.0650	23.4931	22.6504
100241	***	14.1059	*	*	*
100242	1.3889	19.1097	20.4681	21.5144	20.4346
100243	1.5053	22.4496	23.2812	25.2916	23.7155
100244	1.3351	21.4386	23.4876	24.2009	23.1055
100246	1.6101	23.5614	26.7630	27.6304	26.0266

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
100248	1.4864	22.1553	23.8742	25.9179	24.0075
100249	1.2477	18.4932	21.3942	23.3932	21.0081
100252	1.1648	22.0976	22.6475	24.9742	23.2743
100253	1.3552	22.6517	23.6939	24.3937	23.6273
100254	1.5443	20.4410	23.2794	24.9942	23.0461
100255	1.1822	20.7228	22.9793	22.1929	21.9491
100256	2.0168	22.4844	24.1969	26.0705	24.2525
100258	1.4925	22.0790	24.5699	31.8510	25.8585
100259	1.2364	21.4991	24.1148	24.9268	23.5809
100260	1.3797	21.2413	23.5164	25.2543	23.4267
100262	***	22.7137	23.8006	26.3954	24.2596
100264	1.2388	21.7410	22.4800	25.0125	23.1517
100265	1.2830	20.2664	21.0688	23.4147	21.6664
100266	1.3394	20.2821	21.5258	22.6565	21.5554
100267	1.2521	22.8054	23.3760	26.5054	24.2859
100268	1.1393	23.5414	26.0297	29.8447	26.5227
100269	1.3823	26.0271	24.9002	25.3257	25.3781
100270	***	20.8217	*	*	*
100271	2.2310	21.9823	*	*	*
100275	1.2498	23.2920	23.1419	24.2899	23.6115
100276	1.2104	24.8251	25.4557	27.2766	25.8629
100277	1.1368	14.9157	25.2985	46.6758	21.4395
100279	1.2454	23.1776	24.8484	25.4946	24.4828
100280	***	19.0157	*	*	*
100281	1.2592	23.4729	25.3382	27.0711	25.4439
100282	***	20.9257	*	*	*
100284	1.0898	18.5716	22.3046	22.5700	21.1616
100286	1.5080	*	*	*	*
100287	1.3211	*	*	28.1999	*
100288	1.4668	*	*	37.4886	*
100289	1.7921	*	*	28.4482	*
100290	1.1228	*	*	*	*
100291	1.2603	*	*	*	*
100292	1.1656	*	*	*	*
100293	2.0213	*	*	*	*
100294	1.8712	*	*	*	*
100295	1.7017	*	*	*	*
110001	1.2580	22.4535	24.0561	24.5384	23.7127
110002	1.2907	20.2149	20.4502	21.8600	20.8253

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
110003	1.2841	18.2793	19.7061	20.0990	19.3821
110004	1.2258	20.6096	21.8791	22.7835	21.7834
110005	1.1425	21.8105	23.6146	22.3718	22.6414
110006	1.5052	22.0325	23.8762	25.0788	23.6565
110007	1.6673	25.9135	28.2025	30.7390	28.3385
110008	1.3525	20.4972	22.6308	24.8182	22.8088
110009	***	16.6452	*	*	*
110010	2.1550	25.1930	27.2029	28.7468	27.0519
110011	1.1982	20.4028	23.2149	25.4567	23.0818
110013	***	16.7833	*	*	*
110014	0.9800	18.4463	*	*	*
110015	1.1634	21.2601	23.2280	25.5697	23.5194
110016	1.2305	14.7571	18.8228	18.8149	17.3175
110017	***	21.2969	*	*	*
110018	1.1809	23.0577	24.7007	25.6922	24.5478
110020	1.1697	20.9687	23.3004	24.8735	23.0386
110023	1.3744	21.6512	23.5673	25.3707	23.6641
110024	1.4242	21.3945	22.1471	23.7934	22.4700
110025	1.4475	20.2493	29.0965	31.5173	25.9538
110026	1.1205	16.9160	19.3201	20.5726	18.9278
110027	1.0746	19.8976	19.8351	19.2243	19.6329
110028	1.7753	28.1695	25.9474	25.1207	26.3134
110029	1.5825	21.3694	22.7981	25.1968	23.1944
110030	1.2756	20.4656	22.2341	25.0666	22.6163
110031	1.2385	20.9219	22.8695	24.1247	22.7257
110032	1.1804	19.2685	18.0744	20.7042	19.3514
110033	1.4400	23.1939	24.1447	25.8735	24.3233
110034	1.6557	23.0724	24.0791	24.4055	23.8129
110035	1.5038	21.8646	24.2581	25.7486	24.0426
110036	1.8235	22.5481	24.4788	25.3919	24.1945
110038	1.5313	18.4508	20.1710	20.5885	19.7424
110039	1.4717	18.9817	17.0608	19.3925	18.4946
110040	1.0591	17.7798	17.3095	18.7810	17.9643
110041	1.1731	20.1398	20.8080	21.5406	20.8654
110042	1.0418	25.0535	25.5588	26.7843	25.8439
110043	1.7781	21.2714	22.7589	25.2581	23.1367
110044	1.1799	17.5905	19.2562	19.7167	18.8407
110045	1.1266	22.2424	19.7746	21.3761	21.0825
110046	1.2464	22.8820	21.6201	23.9946	22.8858

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
110048	***	18.8751	*	*	*
110049	1.0170	17.1396	18.9096	19.8330	18.6790
110050	1.1492	18.9048	*	24.1937	*
110051	1.1264	17.2050	17.6816	19.0195	17.9832
110054	1.4590	20.7825	20.5387	22.2362	21.1722
110056	0.9430	17.9037	21.7608	23.0080	20.9242
110059	1.1150	17.8076	19.9802	18.6847	18.8249
110061	0.9467	17.4601	18.6696	*	*
110062	***	17.9422	*	*	*
110063	1.0964	18.0256	19.4401	20.3855	19.3480
110064	1.4486	18.8742	21.7636	23.8706	21.4759
110065	***	16.9829	*	*	*
110066	***	23.4554	*	*	*
110069	1.1899	21.1513	21.0518	22.2892	21.5071
110070	***	19.6361	*	*	*
110071	0.9993	21.5042	15.2336	13.3536	15.9871
110072	***	13.6626	*	*	*
110073	1.0532	17.9372	15.2711	16.3418	16.3910
110074	1.5006	24.4924	24.4094	26.8348	25.2658
110075	1.2696	20.1604	20.4634	20.9887	20.5391
110076	1.4226	23.6127	23.8211	25.3239	24.3025
110078	2.0440	25.7416	28.2149	27.8468	27.2856
110079	1.3461	22.3641	22.8017	21.9387	22.3487
110080	1.5323	19.4635	24.1958	21.5449	21.5970
110082	1.9169	22.7015	27.2931	28.9728	26.1070
110083	1.9429	22.2609	24.6460	26.2560	24.4251
110086	1.3437	19.0163	18.8751	20.8536	19.5399
110087	1.4200	24.0994	25.7908	26.2221	25.4387
110089	1.1345	19.0453	20.6757	21.2013	20.3266
110091	1.3003	23.7110	24.3354	26.3849	24.8614
110092	1.0360	15.9178	16.9116	18.7397	17.2529
110094	***	16.8890	*	*	*
110095	1.4153	18.9904	20.1024	21.8657	20.3868
110096	1.0640	18.0418	18.5513	19.4369	18.6929
110097	***	17.8454	*	*	*
110098	***	16.7800	*	*	*
110100	0.9723	18.6821	15.1316	16.6013	16.8334
110101	1.0218	13.8787	13.3943	14.4375	13.9166
110103	***	21.5685	*	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
110104	1.0444	16.6322	17.9805	19.5489	18.0877
110105	1.2594	18.1306	19.2156	20.6180	19.3285
110107	1.8387	21.2267	21.8167	26.0284	23.0165
110108	***	20.1141	*	*	*
110109	1.0376	16.5977	18.7397	20.4726	18.5175
110111	1.1227	18.4274	20.9535	20.5624	20.0378
110112	0.9497	18.9574	20.4565	21.0612	20.1809
110113	1.0599	16.0942	18.0770	16.7544	16.9624
110114	***	16.8297	*	*	*
110115	1.7350	26.5759	26.3274	29.8695	27.5186
110118	1.0120	17.5714	17.7344	*	*
110120	1.0949	18.4738	20.3098	*	*
110121	1.1023	18.8744	19.5230	21.2404	19.8951
110122	1.4488	20.6070	20.4184	22.0191	21.0491
110124	1.0817	19.4093	19.7004	20.8244	19.9910
110125	1.1361	19.5666	19.8695	22.1216	20.5792
110127	***	16.1108	*	*	*
110128	1.2164	20.3047	28.4943	23.2565	23.6768
110129	1.5421	20.9442	21.8204	22.3983	21.7575
110130	0.9157	16.6915	17.5272	17.6547	17.3168
110132	1.0969	17.1821	17.2924	18.9969	17.8320
110134	***	19.0305	*	*	*
110135	1.2039	15.6668	18.5125	20.0001	17.8201
110136	1.0841	20.7827	21.1235	22.6469	21.5052
110141	***	13.2711	*	*	*
110142	0.9660	14.1203	16.3359	17.3328	15.9707
110143	1.3841	22.4254	24.3898	25.4833	24.1166
110144	***	17.5678	*	*	*
110146	1.0695	17.8499	17.2250	19.8927	18.2218
110149	1.2572	25.2525	25.3619	24.7667	25.1219
110150	1.2404	22.8322	22.7366	23.7999	23.1470
110152	***	16.3837	*	*	*
110153	1.1136	20.6972	21.5300	22.8322	21.6598
110154	***	16.5286	*	*	*
110155	***	16.4757	16.1785	*	*
110156	***	16.0759	*	*	*
110161	1.4728	24.5776	26.4200	27.4258	26.1943
110163	1.4647	20.1183	21.9411	25.5369	22.4246
110164	1.5195	22.6605	23.7801	26.4381	24.2350

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*Denotes wage data not available for the provider for that year.
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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
110165	1.4274	22.5604	23.4071	27.7051	24.6235
110166	2.0118	22.3822	23.6665	25.2264	23.5687
110168	1.8690	22.3181	23.3426	24.6365	23.4827
110169	***	23.3749	24.7083	*	*
110171	***	24.5313	32.6386	*	*
110172	1.3247	24.7005	25.2396	27.0201	25.6114
110177	1.6397	22.7831	24.0700	24.9976	24.0210
110179	***	24.3673	26.0365	26.1173	25.4991
110181	***	13.9591	*	*	*
110183	1.2732	24.2899	26.4248	27.5699	26.1344
110184	1.2288	22.2761	24.3379	25.5240	24.0919
110185	***	17.3330	*	*	*
110186	1.2998	19.7172	21.1176	23.2131	21.4458
110187	1.2645	22.8248	23.2571	22.5756	22.8802
110188	***	22.0258	24.4785	*	*
110189	1.1409	19.8453	21.4255	23.9176	21.7699
110190	1.0754	20.7292	21.9008	19.1054	20.4860
110191	1.3028	21.3404	24.0572	25.8310	23.7828
110192	1.3276	22.9684	24.3823	25.7295	24.4467
110193	1.3253	22.1477	25.1779	27.8015	25.0900
110194	0.9364	15.8129	16.8075	16.1321	16.2450
110195	***	10.9444	*	*	*
110198	1.3381	24.8275	28.0634	30.8316	28.0381
110200	1.8867	17.9632	20.1816	21.2000	19.8603
110201	1.4218	21.9313	24.1171	26.9601	24.1406
110203	0.9491	24.2061	30.2609	25.7969	26.4858
110204	***	35.3698	*	*	*
110205	1.1014	20.1405	23.1969	20.5537	21.2718
110207	***	14.6045	*	*	*
110208	***	15.0350	*	*	*
110209	0.6023	20.0630	17.4145	19.1245	18.8634
110211	***	20.1023	*	*	*
110212	0.9750	15.8420	18.7651	20.8802	18.2295
110214	2.0521	*	*	*	*
110215	1.2614	21.0263	22.5679	23.9607	22.6997
110218	***	*	*	26.1073	*
110219	1.3953	*	*	27.1531	*
110220	1.3772	*	*	*	*
120001	1.6955	29.4126	30.0871	31.6835	30.3692

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
120002	1.2464	23.5667	24.2715	26.9232	24.9724
120003	***	24.6238	*	*	*
120004	1.2926	26.1398	26.8010	28.3489	27.1050
120005	1.3261	22.3213	23.0113	26.8292	24.1060
120006	1.1938	26.6302	28.1562	29.6673	28.1631
120007	1.7879	22.7179	27.8497	28.7704	26.1865
120009	***	16.7629	*	*	*
120010	1.8780	24.9089	25.4050	27.0266	25.7190
120011	1.4118	35.2051	30.9308	31.7472	32.4437
120012	***	22.0372	*	*	*
120014	1.2196	25.3557	25.3682	27.7835	26.1639
120016	***	43.5064	39.1173	51.9928	44.5070
120019	1.1323	23.8536	24.4036	28.9260	25.6463
120021	***	36.8291	*	*	*
120022	1.8211	22.2781	22.4951	24.2012	23.0147
120024	0.8663	21.9657	*	*	*
120025	0.7128	40.1342	40.2473	48.2831	43.0233
120026	1.3593	25.7023	26.3653	28.4804	26.8895
120027	1.2416	23.1434	24.9464	26.4309	24.7043
120028	1.2903	27.5365	29.5070	31.3039	29.4763
130001	***	19.6328	*	*	*
130002	1.3448	18.5746	20.1143	21.6537	20.1709
130003	1.4030	23.0994	23.9403	25.4863	24.1986
130005	***	22.6364	24.4844	25.2550	24.0521
130006	1.7405	21.4640	22.8567	24.3844	22.9849
130007	1.7610	22.0895	22.8475	24.8663	23.3218
130008	0.9741	19.3392	*	*	*
130009	0.9211	20.8748	*	*	*
130010	***	17.7826	*	*	*
130011	1.1708	22.1125	23.1120	22.9290	22.7122
130012	***	24.2451	*	*	*
130013	1.3480	22.6624	23.5316	26.3132	24.2167
130014	1.2427	19.8240	21.6495	23.4694	21.6560
130015	***	16.4136	*	*	*
130016	***	20.1221	*	*	*
130017	***	19.9511	*	*	*
130018	1.5609	20.0563	22.2249	23.9713	22.1183
130019	***	19.5147	*	*	*
130021	0.8818	14.4430	18.0006	18.9400	16.8542

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
130022	1.1111	19.7814	21.5602	*	*
130024	1.1794	19.9934	22.1610	21.7627	21.3263
130025	1.2217	17.5989	18.7814	19.6000	18.6764
130026	1.1698	23.2094	24.4976	25.3882	24.3549
130027	***	20.6641	*	*	*
130028	1.3074	21.2217	21.1492	25.2918	22.5336
130029	***	22.9242	*	*	*
130030	***	18.5826	*	*	*
130031	***	20.4144	*	*	*
130034	***	20.5802	*	*	*
130035	***	17.2864	*	*	*
130036	***	15.1590	18.5921	16.7907	16.7949
130037	***	19.2108	*	*	*
130043	***	17.6920	*	*	*
130044	***	18.7068	*	*	*
130045	0.9503	17.5152	19.0270	*	*
130049	1.3525	22.0520	23.7212	24.5700	23.4802
130054	***	16.4674	*	*	*
130056	***	28.8005	*	*	*
130060	***	23.2512	24.6773	26.7516	24.9541
130062	0.8368	19.8264	24.0494	16.7951	20.0540
130063	1.5188	18.4797	18.8782	20.9726	19.4976
130064	1.4418	*	*	*	*
130065	1.7533	*	*	*	*
140001	1.1666	18.1511	20.0247	21.4638	19.9460
140002	1.3083	20.9959	23.0207	24.4820	22.8131
140003	1.0489	18.0163	19.2097	22.6376	19.9703
140004	1.2045	18.9713	*	*	*
140005	0.9238	12.4144	13.2365	*	*
140007	1.3183	24.9847	25.1836	26.6937	25.6147
140008	1.4531	24.2634	26.3287	26.5339	25.6947
140010	1.4515	28.0863	29.0224	29.8588	29.0988
140011	1.1615	18.4052	19.0903	20.6202	19.4165
140012	1.1837	22.5885	24.4070	24.3649	23.8338
140013	1.3488	20.3147	19.9800	22.5832	20.9721
140014	***	22.2945	*	*	*
140015	1.3002	20.3540	21.4328	22.2242	21.3900
140016	1.0411	15.4453	16.3417	17.1000	16.2885
140018	1.3601	23.4062	24.3285	28.6378	25.3823

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
140019	0.9960	16.1180	17.4206	18.4429	17.2762
140024	0.9880	16.1032	15.6616	16.9424	16.2536
140025	***	21.7775	*	*	*
140026	1.1687	19.7839	20.4084	21.6687	20.6180
140027	1.1759	20.5979	20.9855	22.6063	21.3964
140029	1.5551	28.5670	25.0485	27.7192	27.0333
140030	1.7093	25.3715	26.5733	28.7703	26.9381
140031	***	16.9650	*	*	*
140032	1.1930	19.8033	20.6273	22.8160	21.1075
140033	1.2766	22.8705	23.4279	26.1405	24.1524
140034	1.2124	19.7711	20.9635	22.0595	20.8924
140035	***	17.4515	*	*	*
140036	1.1832	21.2366	*	*	*
140037	0.9231	14.3082	15.5578	*	*
140038	***	19.8197	*	*	*
140040	1.2030	18.0342	19.2160	20.0241	19.1098
140041	***	18.8043	*	*	*
140042	0.9886	16.1157	*	*	*
140043	1.2000	21.7356	23.3751	26.0317	23.7565
140045	1.0215	17.4262	18.9587	20.9464	19.1659
140046	1.4596	20.0859	21.7969	22.4818	21.4756
140047	***	16.6672	*	*	*
140048	1.3041	23.8652	25.9122	27.1913	25.6724
140049	1.5749	26.7160	21.9546	26.6350	25.1811
140051	1.5819	24.7180	24.2472	27.9826	25.6398
140052	1.1900	21.0450	21.8161	22.2545	21.6979
140053	1.8927	20.9768	22.6099	23.5393	22.3747
140054	1.4086	23.9459	35.5659	31.6780	30.3981
140055	***	15.8756	*	*	*
140058	1.3711	19.1199	20.5089	22.1032	20.5782
140059	1.1871	18.2593	19.9777	22.7071	20.2886
140061	0.9554	18.4264	22.7515	30.9838	22.9429
140062	1.2110	28.6390	30.7005	31.2251	30.2184
140063	1.3751	29.6998	30.5430	26.5590	28.8348
140064	1.1940	19.6954	20.6505	21.7677	20.7029
140065	1.4047	25.5939	26.3521	26.1891	26.0498
140066	1.2215	15.4818	18.0915	20.4347	17.7144
140067	1.7778	20.7511	21.9579	23.6201	22.1552
140068	1.2010	22.3622	24.1316	25.8800	24.0747

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
140069	***	17.7785	*	*	*
140070	***	25.2646	25.2960	*	*
140074	***	22.2563	*	*	*
140075	1.3211	21.8472	26.5350	26.9004	24.7672
140077	1.0229	17.3236	18.0487	19.0877	18.1988
140079	***	22.7046	25.7090	29.3040	25.9482
140080	1.4870	22.0682	24.4056	26.0108	24.1401
140081	***	18.1746	*	*	*
140082	1.5006	26.5960	25.0474	26.8313	26.1239
140083	1.1849	20.7703	23.2822	24.6472	22.8426
140084	1.2134	23.0263	25.4818	27.6476	25.4075
140086	***	19.1815	*	*	*
140087	***	21.4593	*	*	*
140088	1.8677	26.5258	28.4219	31.0300	28.5964
140089	1.2461	19.3230	20.7632	22.1055	20.7412
140090	***	28.0530	35.0300	*	*
140091	1.7934	23.5559	23.7560	26.1093	24.5328
140093	1.1506	20.7564	21.5376	22.1298	21.6265
140094	1.1452	22.8892	24.2166	25.3599	24.1716
140095	1.2864	25.5716	24.7706	28.4485	26.3914
140097	***	21.8418	*	*	*
140100	1.3467	23.8226	27.1868	32.8563	28.2901
140101	1.2007	23.1418	24.6106	25.4511	24.4547
140102	1.0396	18.6328	19.8678	21.2305	19.9161
140103	1.3424	19.1834	21.2404	21.7499	20.7497
140105	1.2508	23.8258	27.3323	26.2992	25.7660
140107	***	11.5827	*	*	*
140108	***	27.9140	*	*	*
140109	1.0762	15.9178	16.4261	17.7999	16.7276
140110	1.0572	20.9631	21.9880	25.5579	22.8786
140112	***	18.1119	*	*	*
140113	1.5274	26.2393	25.6621	23.5162	25.1057
140114	1.3953	23.0383	24.1926	25.8005	24.3774
140115	1.0671	20.4587	25.3410	26.5203	24.0121
140116	1.2912	25.5980	26.8924	30.4997	27.7879
140117	1.5055	22.0889	23.3531	26.2363	23.9128
140118	1.7061	25.3249	26.7350	27.7306	26.5923
140119	1.8045	30.6468	31.3486	33.5571	31.8294
140120	1.2155	17.7667	20.3237	22.2920	20.0772

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
140121	1.2420	16.2607	17.6019	*	*
140122	1.4032	26.7882	26.8595	26.4856	26.7065
140124	1.0998	30.6820	30.9648	35.2532	32.2662
140125	1.1847	17.8190	19.5359	20.7004	19.3488
140127	1.6068	20.8397	21.3102	22.8124	21.6925
140128	***	23.5481	*	*	*
140129	1.0370	21.6253	21.6495	*	*
140130	1.2475	26.0464	25.7324	26.3411	26.0443
140132	***	23.7046	23.0595	*	*
140133	1.2898	20.1740	24.0458	26.1610	23.3567
140135	1.3873	18.2479	19.7919	21.0493	19.7702
140137	1.0529	20.4807	21.6017	20.4894	20.8483
140138	***	14.5771	*	*	*
140140	1.0635	18.8186	19.1636	21.4650	19.8034
140141	1.0549	20.2605	20.3706	23.0334	21.2226
140143	1.1159	19.9885	22.0009	23.7665	21.7795
140144	0.9561	24.8854	26.9258	27.8046	26.5266
140145	1.0818	19.4509	19.6429	21.6032	20.2628
140146	***	19.4272	*	*	*
140147	1.1682	17.1013	18.2692	19.5865	18.3217
140148	1.7632	19.7630	21.5777	22.9990	21.4863
140150	1.6856	28.9853	32.9291	33.7894	31.9240
140151	0.8246	20.8820	21.5167	22.4801	21.6369
140152	1.2367	28.3946	28.5468	29.6891	28.9130
140155	1.2648	24.2906	25.2034	27.6288	25.6540
140158	1.3798	23.7428	22.5638	23.8488	23.3690
140160	1.1817	19.8825	20.9986	22.6674	21.1814
140161	1.1483	21.2045	22.2191	24.1177	22.5629
140162	1.5923	21.6901	22.6426	25.7911	23.4300
140164	1.7062	19.8246	19.7774	22.0378	20.5895
140165	1.0547	16.3700	17.0666	15.9333	16.4263
140166	1.1534	19.3672	20.7849	21.7740	20.5845
140167	1.0597	18.8532	19.5959	19.7462	19.4012
140168	1.1482	18.2896	18.7504	20.0224	19.0252
140170	0.9715	17.6901	17.0665	17.2039	17.3362
140171	0.9425	15.2617	17.3214	*	*
140172	1.3549	24.8587	27.3372	27.1004	26.5914
140173	0.8466	16.0030	*	*	*
140174	1.4928	22.0418	23.6893	24.7011	23.4906

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
140176	1.2281	26.3468	25.6824	28.9122	27.0988
140177	0.9818	20.3142	20.8526	19.3950	20.1528
140179	1.3371	22.7345	24.1539	26.3178	24.4157
140180	1.3188	22.7508	25.4022	27.4312	25.1644
140181	1.1867	22.6643	23.7308	23.5719	23.3403
140182	1.4769	25.1302	32.1969	28.0295	28.3804
140184	1.2065	17.9169	20.6499	20.1192	19.5924
140185	1.4746	18.8573	20.0903	22.0141	20.3358
140186	1.4875	25.6807	26.0970	27.8092	26.5717
140187	1.5974	19.4049	20.5829	22.0434	20.6419
140189	1.1677	21.1515	22.5875	25.6919	23.0896
140190	1.0849	16.6674	17.9193	18.8374	17.7806
140191	1.3282	27.4166	24.5446	25.2664	25.6365
140193	1.0287	18.5651	20.5958	22.9100	20.6702
140197	1.2694	19.9407	19.2980	21.8041	20.3226
140199	1.0523	18.5409	19.7888	21.3406	19.8885
140200	1.4434	22.4627	24.1358	24.9216	23.8647
140202	1.5824	25.2777	26.2460	27.4308	26.4001
140203	1.0644	24.8870	26.5789	28.2090	26.6803
140205	2.1121	*	25.1010	*	*
140206	1.1116	22.8223	24.7616	27.5167	24.9369
140207	1.3539	25.4539	23.3197	25.7341	24.9519
140208	1.6847	28.3112	27.4671	27.6477	27.7930
140209	1.5586	20.2433	22.0813	22.4397	21.6228
140210	1.1291	15.5345	15.5339	16.6626	15.8981
140211	1.2500	22.8852	25.8556	29.5074	26.1996
140213	1.2064	25.6839	27.4607	29.0574	27.4642
140215	***	18.5503	18.6962	22.3097	19.7686
140217	1.4055	25.9030	24.7146	29.4057	26.7109
140218	***	17.4171	*	*	*
140220	***	19.3915	*	*	*
140223	1.4799	26.2168	27.4355	29.2513	27.6773
140224	1.4135	25.6766	27.1725	19.0263	23.2488
140228	1.5708	21.8627	22.9899	24.9690	23.2997
140230	***	12.3494	*	*	*
140231	1.4681	26.0208	25.5536	30.7028	27.4414
140233	1.5672	24.4419	24.7103	27.3163	25.5572
140234	1.0705	19.7266	20.8676	23.2486	21.3570
140239	1.5357	21.6074	23.9205	24.1881	23.2367

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
140240	1.3754	25.1418	25.0325	27.2556	25.8235
140242	1.4800	26.1850	28.8686	30.3947	28.5576
140245	0.9876	15.1320	15.2537	16.0896	15.4915
140246	0.9890	15.0650	16.1305	*	*
140250	1.2505	25.3410	25.5501	27.4422	26.1152
140251	1.3780	23.5128	24.8256	26.6877	25.0061
140252	1.4227	26.4715	28.3479	30.2532	28.4191
140253	***	18.4567	*	*	*
140258	1.5166	25.0743	27.5741	27.9502	26.9121
140271	0.8694	16.0351	17.5174	18.8515	17.5328
140275	1.2795	22.9656	23.1871	25.2574	23.7684
140276	1.8186	26.1713	25.3222	27.5854	26.3387
140280	1.5091	20.0763	21.7004	21.9017	21.2298
140281	1.6360	26.5197	27.9115	29.2966	27.9701
140285	1.2857	15.7435	*	17.7824	*
140286	1.1623	24.0369	25.5805	28.4380	26.0736
140288	1.5418	25.8717	26.3572	27.0696	26.4612
140289	1.3751	17.7886	20.7506	22.6747	20.4459
140290	1.3626	26.5055	29.9098	28.6867	28.4167
140291	1.2239	26.8629	27.6675	27.6672	27.4152
140292	1.1257	26.8610	26.4077	26.1602	26.4515
140294	1.1476	19.4218	21.7473	22.6108	21.2208
140300	1.3162	28.9830	30.5172	33.3725	30.9555
140301	1.2195	*	*	*	*
140303	2.0854	*	*	*	*
150001	1.1492	22.6875	25.4897	27.0939	25.2101
150002	1.4223	20.7353	22.3327	23.3673	22.1461
150003	1.6795	21.4649	21.0944	23.3039	21.9863
150004	1.5138	22.8061	23.6169	24.8861	23.7397
150005	1.2245	22.8149	23.8818	25.4443	24.1126
150006	1.2544	21.8435	23.1779	24.8869	23.3383
150007	1.3407	21.2811	22.1098	23.5826	22.4135
150008	1.3397	23.0208	23.8916	23.6847	23.5294
150009	1.3358	19.5869	19.4763	20.4744	19.8508
150010	1.3623	21.2466	22.5445	23.9253	22.6250
150011	1.1443	19.9096	22.1559	23.2153	21.7770
150012	1.6010	21.7903	23.1644	22.9279	22.6404
150013	0.9579	17.5531	19.8564	19.7578	19.0827
150014	1.4309	22.8402	24.3754	26.5785	24.5423

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
150015	1.3174	24.2370	23.1616	24.2821	23.8759
150017	1.8494	20.6758	22.7979	23.7128	22.4347
150018	1.5720	22.8922	24.6138	24.6945	24.1106
150019	1.1592	19.8341	17.3170	*	*
150020	1.0363	15.9405	18.4689	*	*
150021	1.6981	23.3800	24.3658	27.8008	25.1782
150022	1.0572	18.7751	22.2973	22.7806	21.5434
150023	1.5373	20.3015	20.6926	23.1231	21.3427
150024	1.4249	19.8368	21.7593	24.7780	22.0652
150026	1.3246	21.9448	23.2169	23.7678	22.9916
150027	1.0739	19.4238	21.5766	21.2424	20.7832
150029	1.3567	24.8939	25.2067	23.3920	24.3903
150030	1.1851	20.7256	23.0196	24.4278	22.7625
150031	1.1068	21.3494	18.9180	*	*
150033	1.7207	23.0756	24.1701	25.8493	24.3646
150034	1.4761	23.3718	22.8812	23.9213	23.3959
150035	1.4769	22.3779	23.5468	26.0952	24.0002
150036	***	22.1464	*	*	*
150037	1.2929	22.3699	24.4997	27.6777	24.7982
150038	1.1535	20.3454	21.6608	24.4105	22.0751
150039	1.1313	16.0227	*	*	*
150042	1.3736	18.0185	23.7838	21.9774	21.0614
150043	1.0188	20.6301	*	*	*
150044	1.2937	19.8951	20.5156	23.1153	21.1599
150045	1.0883	20.6406	23.0361	24.2731	22.7342
150046	1.3808	19.4146	20.3453	21.0291	20.2940
150047	1.6973	21.9824	24.8786	24.5358	23.7779
150048	1.2364	21.1441	22.5181	24.5574	22.7765
150049	1.2006	21.6309	18.4942	20.2187	20.1027
150050	***	18.0411	*	*	*
150051	1.5963	20.6895	21.4009	22.6815	21.6305
150052	1.0848	18.8345	19.1070	19.6084	19.1811
150053	***	18.3494	*	*	*
150054	***	19.3424	*	*	*
150056	1.8804	23.0603	24.7841	27.6665	25.1849
150057	2.0634	17.4043	28.0884	22.7564	22.2709
150058	1.5631	23.0273	24.9479	26.9734	25.0074
150059	1.5642	23.1398	25.6738	26.9387	25.2778
150060	1.1041	19.5011	19.8990	23.2301	20.8316

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
150061	1.1799	19.4014	19.2826	21.3487	20.0248
150062	1.1804	21.2607	22.9214	23.5337	22.5623
150063	***	24.8588	24.4091	19.0377	22.9018
150064	1.1581	20.6232	21.2512	21.6324	21.1735
150065	1.1231	21.4572	23.0636	24.4340	23.0147
150066	0.9008	19.6845	*	*	*
150067	1.0678	20.5000	21.4374	*	*
150069	1.1934	23.5510	23.8353	25.2843	24.1350
150070	0.9378	18.9332	20.7413	22.5178	20.8055
150071	***	16.4179	*	*	*
150072	1.1779	18.5813	18.5447	20.3144	19.1849
150073	***	19.8034	14.8287	*	*
150074	1.5197	21.3500	22.9598	24.2367	22.8871
150075	1.1302	17.2267	20.1119	24.2030	20.3051
150076	1.1974	23.3724	25.4519	24.1237	24.3066
150078	0.9881	20.2068	20.1259	21.2494	20.5693
150079	1.0895	18.3667	19.3860	20.6486	19.4947
150082	1.7378	19.6881	21.0651	22.2064	21.0727
150084	1.8285	24.9529	27.8354	28.5103	27.1663
150086	1.2204	19.7763	21.5815	22.4399	21.3215
150088	1.2977	22.3055	22.2627	23.0611	22.5509
150089	1.5120	21.5664	21.6806	22.6476	21.9816
150090	1.3559	21.9803	24.9021	24.6667	23.7855
150091	1.1533	26.5235	26.4248	27.8100	26.8604
150092	***	18.2592	*	*	*
150094	***	16.8351	*	*	*
150095	***	22.3214	*	*	*
150096	0.9585	*	19.7975	21.9132	*
150097	1.0597	21.1462	22.4564	24.4148	22.7758
150098	1.1551	16.4763	*	*	*
150100	1.7181	18.7289	21.2980	22.2614	20.6224
150101	1.0201	21.2025	26.1271	27.9907	24.4151
150102	1.1003	20.8817	21.3313	22.6659	21.6402
150103	***	19.3652	*	*	*
150104	1.0493	21.3141	21.0799	21.8124	21.4091
150105	***	21.6975	*	*	*
150106	0.9588	18.7088	19.1976	20.9925	19.6777
150109	1.4072	21.7870	23.4642	24.3752	23.2282
150111	1.3006	24.1560	*	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
150112	1.3940	22.1939	23.5151	24.9031	23.5191
150113	1.2237	20.5871	21.2412	23.0445	21.6916
150114	***	18.3097	*	*	*
150115	1.2818	18.1308	20.3863	20.5129	19.6957
150122	1.1287	20.7540	22.2752	24.2446	22.4827
150123	0.9457	16.2897	15.5997	15.3050	15.7485
150124	1.1122	16.2104	17.9063	18.8304	17.6490
150125	1.4432	22.0299	23.1464	24.3819	23.2279
150126	1.4369	24.0000	24.1917	25.5428	24.5810
150127	***	18.0533	*	*	*
150128	1.3560	20.4742	20.9869	23.1696	21.6102
150129	1.1681	29.9888	34.3166	35.4457	33.2419
150130	1.0451	18.3852	18.5578	21.5659	19.4347
150132	1.3725	21.2747	22.2707	24.2364	22.6117
150133	1.2373	20.0320	21.8807	21.8769	21.2843
150134	1.0638	20.2764	20.7680	22.1057	21.0769
150136	1.1430	22.9091	25.8467	25.7004	24.8117
150146	0.9983	*	25.1827	26.1314	*
150147	0.9266	*	*	32.2661	*
150148	***	*	26.2188	27.1956	*
150149	0.9999	*	*	23.8010	*
150150	1.2121	*	*	26.5287	*
150152	1.2345	*	*	*	*
150153	2.5449	*	*	*	*
150154	2.7783	*	*	*	*
150155	2.1639	*	*	*	*
160001	1.2072	20.1699	22.8426	24.1031	22.3649
160002	1.1502	17.6600	19.9607	*	*
160003	1.0315	17.5429	17.5050	18.9790	18.0199
160005	1.1486	19.3348	20.3313	21.1127	20.2412
160007	***	14.9137	*	*	*
160008	1.0539	16.7863	17.9463	19.8026	18.1453
160009	***	19.0664	*	*	*
160012	0.9609	17.9236	*	*	*
160013	1.1963	20.3023	21.0541	23.0121	21.4334
160014	0.9571	18.7253	18.3097	19.2436	18.7637
160016	1.5212	21.6050	21.8400	21.2800	21.5647
160018	***	16.0794	*	*	*
160020	1.0844	15.7960	16.6092	18.9697	17.1457

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
160021	***	16.7921	*	*	*
160023	***	15.3855	*	*	*
160024	1.5650	20.5622	22.4256	24.2339	22.3837
160026	1.0139	20.4567	22.8967	24.1944	22.5167
160027	***	18.2082	*	*	*
160028	1.3015	22.9000	25.1998	25.9920	24.7012
160029	1.5669	22.2106	23.7268	24.9311	23.6500
160030	1.2499	21.6899	23.3687	24.9835	23.3759
160031	0.9946	16.8957	17.8994	18.5207	17.7850
160032	1.0500	19.2464	20.5024	22.3763	20.7008
160033	1.7651	20.1916	22.2660	23.4136	21.9596
160034	0.9398	17.3644	19.0684	19.4799	18.6049
160035	***	17.0165	*	*	*
160036	***	20.2598	*	*	*
160037	0.9941	19.5067	*	*	*
160039	0.9715	19.1998	19.8851	20.9544	20.0245
160040	1.2598	19.6339	20.0567	21.8190	20.4961
160041	***	18.7943	*	*	*
160043	0.9233	16.7840	15.5765	*	*
160044	1.1446	19.5552	19.0956	19.5535	19.3921
160045	1.7266	21.4757	22.1285	24.4960	22.7181
160046	***	16.8665	*	*	*
160047	1.3794	20.4259	22.1550	24.4878	22.4477
160048	1.0872	17.2709	18.1174	19.5339	18.3192
160049	0.9487	15.3233	*	*	*
160050	1.0248	21.1184	21.6247	23.8796	22.1789
160051	***	15.8213	*	*	*
160052	***	22.1933	*	*	*
160054	***	16.5258	*	*	*
160055	***	17.6177	*	*	*
160056	***	17.9534	*	*	*
160057	1.3029	19.6802	20.8345	21.8628	20.7959
160058	1.9010	22.2812	23.5663	25.4892	23.7974
160060	***	17.7489	*	*	*
160061	***	17.2064	*	*	*
160062	***	18.8162	*	*	*
160063	***	17.3770	*	*	*
160064	1.6399	25.2962	23.8367	27.6150	25.5498
160065	***	17.0609	*	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
160066	1.1156	19.3203	20.4609	21.4405	20.4173
160067	1.3343	17.6602	19.9422	21.9464	19.6034
160068	***	20.5994	*	*	*
160069	1.4989	20.5989	21.7197	22.7319	21.6742
160070	***	17.7856	*	*	*
160072	1.0171	15.3384	15.8236	*	*
160073	***	15.5946	*	*	*
160074	1.0071	18.4624	22.2988	20.2165	20.2534
160075	***	20.7843	*	*	*
160076	0.9967	19.1590	20.1603	20.9631	20.1225
160077	***	15.0468	*	*	*
160079	1.5223	20.5010	21.6562	22.5231	21.5658
160080	1.1999	19.6680	21.1713	23.5571	21.3784
160081	1.1788	19.1442	20.4415	21.3564	20.2883
160082	1.7883	20.7306	21.6230	23.8127	22.0402
160083	1.6292	21.3221	23.4670	25.0503	23.2686
160085	***	19.1929	*	*	*
160086	***	19.0477	*	*	*
160088	***	23.8098	*	*	*
160089	1.2694	18.3526	19.9688	21.5623	19.9645
160090	1.0261	18.4210	19.6767	21.2590	19.8159
160091	0.9731	14.8904	16.1660	18.0622	16.3558
160092	1.0684	17.9251	20.4731	22.0453	20.1119
160093	0.9714	19.5732	22.8553	*	*
160094	***	18.7835	*	*	*
160095	***	16.4927	*	*	*
160097	***	17.7860	*	*	*
160098	***	16.8997	*	*	*
160099	***	16.0710	*	*	*
160101	1.0856	19.6314	22.1741	24.2302	21.9994
160102	***	14.4837	*	*	*
160103	***	19.6169	*	*	*
160104	1.2917	21.0059	23.2832	23.9681	22.7655
160106	1.0586	19.4385	19.8905	21.4711	20.2628
160107	1.0414	18.8937	19.5111	21.3467	19.8975
160108	***	17.7577	*	*	*
160109	0.9390	18.2938	*	*	*
160110	1.6793	20.9959	21.9299	24.1664	22.4211
160111	***	15.1104	*	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
160112	1.2596	19.6950	20.4038	21.8767	20.6739
160113	0.9625	14.9448	16.7574	18.6664	16.7980
160114	0.9716	18.0532	19.1743	*	*
160115	1.0364	16.9992	17.6815	19.5745	18.0162
160116	1.0378	18.4261	19.6923	22.1581	20.1076
160117	1.2943	20.1682	22.3228	23.4148	21.9506
160118	1.0133	17.1480	16.9466	18.3308	17.5240
160120	***	15.0576	*	*	*
160122	1.0446	18.8470	21.2843	22.9417	21.0804
160124	1.1723	19.9144	21.2279	22.7017	21.2950
160126	0.9906	17.8643	20.0149	20.3611	19.3943
160129	***	18.0113	*	*	*
160130	0.9267	16.2628	*	*	*
160131	0.9566	16.5397	18.0486	*	*
160134	***	14.6396	*	*	*
160135	***	18.3973	*	*	*
160138	***	18.3956	*	*	*
160140	0.9928	19.6154	22.1666	22.5055	21.4598
160142	***	17.2792	*	*	*
160143	1.0672	18.1287	19.0623	*	*
160145	***	17.8887	*	*	*
160146	1.4016	19.0576	20.6638	20.9493	20.2176
160147	1.2380	21.6062	22.7993	26.6470	23.7361
160151	***	18.3398	*	*	*
160152	***	17.0751	*	*	*
160153	1.6570	22.7004	23.5212	26.3629	24.2211
170001	1.1807	18.5120	19.8149	20.9687	19.7945
170004	***	17.2262	*	*	*
170006	1.2074	19.1982	19.4488	20.0678	19.5802
170008	0.9241	17.7062	18.2352	*	*
170009	1.0734	25.0508	25.8246	29.1896	26.7837
170010	1.2006	19.5990	20.6294	21.2083	20.4771
170012	1.6311	20.2412	21.8587	22.6810	21.5827
170013	1.6069	20.1852	21.4954	23.1106	21.5960
170014	1.0120	19.6044	21.3416	22.9733	21.2373
170015	0.9529	17.2443	18.0485	19.1231	18.1360
170016	1.6858	22.1023	22.9479	24.2180	23.1092
170017	1.1352	19.7908	21.6323	23.2928	21.6159
170018	0.9045	14.8793	16.9169	17.9369	16.6430

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble of this proposed rule.
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***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
170019	1.2070	17.4699	18.7916	20.3115	18.8375
170020	1.5343	19.1418	20.6658	22.2482	20.7411
170022	1.1954	20.3269	21.1947	22.9529	21.4906
170023	1.4404	19.6533	21.6273	23.2799	21.5276
170024	0.9817	15.0081	16.1196	*	*
170025	1.1405	19.1721	19.2123	*	*
170026	0.9204	16.9094	17.0836	*	*
170027	1.3787	18.4466	20.7776	21.4590	20.2790
170030	0.9888	12.9413	*	*	*
170031	***	16.4661	*	*	*
170032	***	15.2207	*	*	*
170033	1.3964	20.4533	20.0627	20.0739	20.1982
170034	0.8426	17.8240	18.1074	*	*
170035	***	19.8334	*	*	*
170038	***	15.2505	*	*	*
170039	0.9619	18.5780	18.4473	20.1914	19.0791
170040	1.9219	23.1014	24.5234	27.1753	25.0765
170041	0.9658	9.9263	13.9709	*	*
170045	0.9920	20.5454	*	*	*
170049	1.4642	21.2917	22.9404	24.1126	22.8608
170051	***	16.9003	*	*	*
170052	1.1623	16.0948	15.8809	17.3499	16.4527
170053	***	14.3629	*	*	*
170054	1.0198	15.2814	18.5239	17.5449	17.1062
170055	***	18.1782	*	*	*
170056	0.8503	19.7369	17.1872	*	*
170058	1.0986	20.1090	23.0648	22.0381	21.7483
170060	0.9073	17.5289	*	*	*
170061	1.0019	15.6413	*	*	*
170063	***	13.7611	*	*	*
170066	***	16.8010	*	*	*
170067	***	20.7945	*	*	*
170068	1.2000	19.2629	20.5512	20.8513	20.2278
170070	1.0667	14.8349	15.0539	16.4616	15.4405
170073	***	17.7586	*	*	*
170074	1.1354	17.6543	18.5446	20.4772	18.9410
170075	0.8663	14.4939	15.6809	16.1656	15.4831
170076	0.9108	14.9393	*	*	*
170077	0.8861	14.1376	14.6377	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
170079	***	16.7227	*	*	*
170080	0.9403	13.6793	15.0079	*	*
170081	***	15.0840	*	*	*
170082	0.8969	14.8154	15.9973	*	*
170084	***	13.6517	*	*	*
170085	0.8822	21.8907	17.2585	18.4829	19.3020
170086	1.5624	20.7298	22.1067	22.7592	21.8814
170089	***	20.2263	*	*	*
170090	0.9576	23.6839	16.3550	15.9807	17.8436
170093	0.8275	14.7803	15.0307	16.8749	15.5800
170094	0.9972	21.2484	20.1253	20.3410	20.6215
170095	0.9779	16.1078	*	*	*
170097	0.9058	18.6023	18.9865	20.2992	19.3012
170098	1.1165	17.3479	18.6676	20.0053	18.6183
170099	1.1270	16.5248	15.8117	*	*
170101	0.8750	17.3382	17.9291	*	*
170102	***	14.4499	*	*	*
170103	1.2107	18.6172	20.1263	21.4941	20.1218
170104	1.5004	22.0671	23.6589	26.1829	23.9916
170105	1.0874	18.2788	18.3824	19.6685	18.7981
170109	0.9722	18.3483	20.7580	22.6925	20.6824
170110	1.0077	21.0637	16.5883	21.8119	19.8668
170112	***	15.8097	*	*	*
170113	1.0174	16.4939	19.9957	*	*
170114	0.8681	13.9726	17.4688	18.1754	16.3820
170115	***	13.0254	*	*	*
170116	1.0230	19.4278	20.8800	23.1002	21.1344
170117	***	16.8301	*	*	*
170119	***	15.1981	*	*	*
170120	1.2184	18.2832	18.5895	19.8690	18.9124
170122	1.6152	21.4588	22.2681	24.5363	22.7218
170123	1.6507	25.2122	25.0073	26.4791	25.5888
170124	***	16.3925	*	*	*
170126	***	14.5527	*	*	*
170128	***	17.6258	*	*	*
170133	1.0624	19.9778	20.0593	21.7735	20.5953
170134	***	15.1932	*	*	*
170137	1.2731	19.3344	21.4394	22.7652	21.1710
170139	***	14.8156	*	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
170142	1.3108	19.0547	19.8269	22.4061	20.4128
170143	1.1355	16.3258	18.0308	19.7615	18.0782
170144	***	20.8488	23.9180	24.4259	22.7916
170145	1.0832	20.1494	20.5143	21.4441	20.7110
170146	1.4838	25.2520	27.0312	28.1868	26.9312
170147	1.2522	18.4634	18.2480	23.1504	19.8708
170148	***	24.4828	26.3491	*	*
170150	1.1212	14.9718	16.3724	17.4600	16.2665
170151	0.9404	14.5001	15.7242	*	*
170152	***	16.0930	*	*	*
170160	***	17.0628	*	*	*
170164	***	17.0792	*	*	*
170166	0.9226	16.5113	17.8131	18.6620	17.6333
170171	***	14.7050	14.7251	*	*
170175	1.3411	20.8671	22.5605	23.6185	22.2640
170176	1.3103	23.5743	25.5404	24.2357	24.4363
170180	***	*	25.0935	12.9140	*
170182	1.4729	21.9797	23.2115	24.3851	23.2232
170183	1.9494	16.6577	19.6919	22.8422	19.7588
170185	1.1229	26.8136	26.8307	24.8583	26.0747
170186	2.9514	33.2457	28.5602	30.5157	30.5405
170187	1.2282	*	20.8289	21.0920	*
170188	2.1282	*	25.2504	27.2225	*
170189	***	*	28.1996	*	*
170190	0.9116	*	*	22.4455	*
170191	1.0067	*	*	24.8635	*
170192	2.0341	*	*	*	*
170193	1.3217	*	*	*	*
170194	1.4986	*	*	*	*
180001	1.1939	20.8169	22.2674	24.7712	22.5907
180002	1.0155	19.8195	20.5135	21.7028	20.6926
180004	1.1197	18.0494	19.8552	19.0747	18.9830
180005	1.1851	23.4941	22.6704	22.8749	23.0117
180006	0.9823	11.2872	14.4066	15.7060	13.5701
180007	1.4070	18.6823	21.3545	21.8567	20.6397
180009	1.5872	21.7746	22.4450	24.0913	22.8134
180010	1.9099	19.4210	22.6846	23.0083	21.7409
180011	1.4276	22.6798	18.8056	22.3195	21.2456
180012	1.4983	19.6614	20.2758	22.9071	20.9570

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
180013	1.4564	20.0950	21.0512	21.4695	20.9068
180014	***	23.0067	*	*	*
180016	1.2943	19.7242	20.5203	22.2077	20.8529
180017	1.2912	16.7649	18.0329	19.0266	17.9602
180018	1.3809	18.1529	17.5670	18.3329	18.0205
180019	1.1191	19.5953	20.8416	22.0309	20.8073
180020	1.0653	19.4391	20.9964	22.3692	20.9107
180021	1.1252	16.5377	17.6331	17.9160	17.3679
180023	***	19.0574	*	*	*
180024	1.1511	19.6313	22.3922	23.6774	22.0419
180025	1.0661	17.1875	18.3306	17.4743	17.6743
180026	1.0944	13.9960	15.5354	15.8301	15.1086
180027	1.2628	19.6928	20.5017	22.0920	20.7738
180028	0.8928	26.2221	20.6324	21.4985	22.4326
180029	1.2508	20.0841	20.4262	21.1326	20.5737
180030	***	17.5043	*	*	*
180031	***	17.1003	*	*	*
180032	***	17.2362	*	*	*
180033	***	17.0499	*	*	*
180034	***	17.0349	*	*	*
180035	1.5540	22.4651	24.3874	26.7614	24.5877
180036	1.1991	20.6951	22.2389	23.1616	22.0886
180037	1.2832	21.0177	22.7893	24.4158	23.0037
180038	1.3954	19.3837	20.6888	22.2688	20.8069
180040	2.0740	22.2270	23.2341	24.5526	23.3791
180041	1.1107	17.5950	19.1325	18.5443	18.3886
180042	***	15.5660	*	*	*
180043	1.1976	17.2414	20.6498	18.8471	18.9213
180044	1.4362	21.1057	21.8163	21.6756	21.5288
180045	1.2191	20.7498	22.1027	24.5923	22.4443
180046	1.0376	21.6955	23.1139	24.7514	23.2137
180047	0.8991	17.8625	17.8574	20.4780	18.7745
180048	1.2895	18.3151	20.0114	24.1443	20.6747
180049	1.3602	17.8418	18.5188	19.4356	18.5911
180050	1.1066	19.4992	19.9082	21.7345	20.3833
180051	1.3822	18.3028	18.8186	19.2279	18.7815
180053	1.0088	17.3167	17.6239	18.6463	17.8709
180054	1.0214	17.4354	19.1340	19.0538	18.6165
180055	1.1438	16.6072	17.8704	21.1744	18.4952

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
180056	1.0607	18.7038	19.4072	21.4615	19.8891
180058	***	14.8840	*	*	*
180059	***	17.2541	*	*	*
180063	1.1783	14.7338	15.5078	15.9085	15.4250
180064	1.1472	16.3894	21.1067	15.3751	17.4760
180065	***	11.0966	*	*	*
180066	1.0626	20.7907	21.1884	24.6354	22.2655
180067	1.9843	20.2762	22.0056	24.0921	22.0267
180069	1.0674	19.0836	20.3982	20.8878	20.1301
180070	1.0967	15.4643	16.9892	17.3956	16.6366
180072	***	17.0576	17.5411	*	*
180078	1.1008	23.7765	23.4616	25.3999	24.2131
180079	1.1180	18.1683	18.0472	19.5352	18.5853
180080	1.3471	17.6735	18.9582	20.1601	18.9469
180087	1.1898	16.2378	16.4726	17.7659	16.8477
180088	1.5836	22.8908	23.7217	24.6049	23.9258
180092	1.1286	18.8964	19.6790	22.4727	20.3802
180093	1.4407	17.7592	18.8469	19.2577	18.6254
180094	0.9148	14.3306	15.7640	*	*
180095	1.1205	15.4477	15.9881	17.1383	16.2000
180099	0.9402	14.0464	14.0115	*	*
180101	1.1832	21.0704	22.4094	24.2142	22.6082
180102	1.5459	18.8169	20.1885	19.1124	19.3386
180103	2.1714	20.9598	21.3867	25.1531	22.5160
180104	1.6076	20.2731	21.3866	22.8857	21.5429
180105	0.8514	18.2975	18.3521	19.5282	18.7435
180106	0.9468	15.5278	15.4937	15.7724	15.6068
180108	0.9045	14.8720	16.7327	*	*
180115	0.9651	18.0951	19.2396	19.8256	19.0702
180116	1.2016	19.2389	20.5453	21.8674	20.5628
180117	0.9906	20.7961	17.7885	20.5948	19.6296
180118	***	17.9018	*	*	*
180120	0.8431	16.4226	20.4507	*	*
180121	1.0665	16.9571	16.9881	*	*
180122	***	18.7549	*	*	*
180123	***	21.5962	*	*	*
180124	1.3192	19.7138	20.5369	21.4248	20.5266
180125	***	22.6610	*	*	*
180126	1.1798	14.8501	14.5644	15.1827	14.8752

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
180127	1.2280	18.0498	20.0059	21.4351	19.8768
180128	0.9596	18.7194	19.8502	20.5434	19.7336
180129	0.8654	15.6637	14.1861	*	*
180130	1.6479	21.9413	23.4982	24.8362	23.4693
180132	1.3563	19.8393	19.9358	22.2049	20.6440
180133	***	23.2679	*	*	*
180134	1.0686	16.5901	*	17.3395	*
180138	1.2250	19.8524	23.0996	25.1698	22.6718
180139	1.0386	20.3816	20.6287	21.3716	20.8085
180140	***	14.6466	*	*	*
180141	1.8978	20.3404	22.6722	24.2696	22.3765
180143	1.3411	21.3196	20.1309	23.1741	21.6012
180144	2.5183	*	*	*	*
190001	1.0808	18.8583	20.4946	19.5751	19.6588
190002	1.7366	20.6057	20.7172	21.6843	21.0095
190003	1.3997	19.5115	20.7505	21.8123	20.6831
190004	1.3525	19.6755	20.5272	22.1615	20.7560
190005	1.4812	19.0994	20.0551	20.7949	19.9596
190006	1.6063	17.7333	18.8115	19.4659	18.6487
190007	1.1734	16.3633	17.9392	18.7349	17.7588
190008	1.7018	22.4797	20.3278	21.4072	21.3673
190009	1.1851	16.0395	17.5144	18.8324	17.3670
190010	1.1194	17.7616	18.1797	19.9792	18.6287
190011	1.0082	15.7319	15.4699	18.1536	16.3894
190013	1.3684	16.7770	18.7538	19.6280	18.3877
190014	1.1074	18.6929	17.0630	17.4731	17.7508
190015	1.3331	19.7673	20.6167	22.1070	20.8730
190017	1.3415	19.8449	18.3528	18.6945	18.8908
190018	1.1542	13.1355	19.2055	*	*
190019	1.6773	18.7344	20.8193	23.0583	20.8965
190020	1.0806	18.7252	18.5659	19.8404	19.0337
190025	1.2414	18.1892	19.9969	20.4631	19.5538
190026	1.5043	19.0130	19.9229	21.3327	20.1104
190027	1.5987	18.4070	19.4057	21.1783	19.6544
190029	***	18.7344	*	*	*
190034	1.2081	19.2007	16.8439	17.4936	17.8284
190036	1.6252	21.2960	23.3903	23.7273	22.8482
190037	0.9453	14.1323	15.6062	16.8639	15.4342
190039	1.5095	18.7625	20.4900	23.3103	20.8377

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
190040	1.3648	23.1819	22.9262	23.7942	23.2873
190041	1.5207	19.5511	21.9983	23.9028	21.6299
190043	1.0065	15.5644	15.7333	16.8983	16.0961
190044	1.1746	17.6788	17.7460	19.5159	18.3493
190045	1.6451	22.0065	22.8709	24.0397	23.0208
190046	1.4109	20.2414	21.1019	22.3053	21.1974
190048	1.0510	16.6848	18.1698	18.6364	17.8476
190049	1.0046	18.5902	19.3768	20.1198	19.3725
190050	1.1110	16.9053	18.6663	18.5145	18.0304
190053	1.1218	13.4768	13.8037	15.7015	14.3747
190054	1.2693	17.7269	19.9370	20.3499	19.3615
190059	0.8505	17.8651	18.3334	19.2464	18.4840
190060	1.4282	19.9121	20.2207	21.9903	20.7245
190064	1.5660	19.7215	21.1262	21.5537	20.8030
190065	1.4748	18.3280	20.3583	23.0520	20.5320
190071	***	16.3822	*	*	*
190077	0.8605	16.8829	17.0480	18.3107	17.4122
190078	1.0714	19.5879	19.8607	21.5673	20.3820
190079	1.0906	18.8187	20.5000	21.8158	20.3442
190081	0.8947	14.7919	11.4756	14.9009	13.7391
190083	0.9081	16.2970	18.4954	19.0730	18.0523
190086	1.3158	17.6237	18.2005	18.8059	18.2050
190088	1.1232	20.4726	18.6738	22.4915	20.4225
190089	1.0057	15.2055	15.5151	16.2612	15.6789
190090	1.0956	19.8201	19.0519	20.0678	19.6568
190095	***	17.3637	16.9519	18.7302	17.6733
190098	1.5635	21.4328	20.7537	23.0761	21.7286
190099	1.0726	19.0545	23.1606	21.1589	21.1121
190102	1.6811	21.1614	22.0190	23.4565	22.2690
190103	***	15.6415	*	*	*
190106	1.1191	19.9117	20.3114	21.5641	20.6057
190109	1.1271	16.3641	16.6515	17.4819	16.8438
190110	0.9507	15.2652	16.5007	19.1122	16.9559
190111	1.5891	21.3622	24.4380	25.2268	23.7264
190112	***	24.2806	*	*	*
190113	***	19.0411	*	*	*
190114	1.0486	13.5044	13.6101	14.5841	13.8922
190115	1.2390	24.0098	25.4984	26.0586	25.1127
190116	1.3365	18.3223	17.8297	18.6032	18.2474

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***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
190118	0.9438	17.8543	17.5060	19.0261	18.1455
190120	***	17.6709	*	*	*
190122	1.2769	16.7189	17.7811	19.3125	17.8792
190124	1.6333	22.8245	23.3859	23.4759	23.2281
190125	1.6621	20.1401	21.5692	22.3963	21.3592
190128	1.1994	21.5869	23.8786	24.7773	23.4686
190130	0.9489	14.5586	15.2678	16.6598	15.5489
190131	1.1827	19.7483	21.3154	22.5009	21.1767
190133	0.8596	15.7835	13.4062	14.3308	14.4753
190135	1.4406	23.0214	24.4908	26.9633	24.8393
190136	***	15.6286	*	*	*
190140	1.0131	14.8738	15.4030	17.0145	15.7624
190142	***	19.0464	*	*	*
190144	1.1583	18.3513	21.3838	21.1623	20.3034
190145	0.9292	16.4403	17.4407	17.3397	17.0886
190146	1.5853	20.9312	22.1502	23.7619	22.2919
190147	0.8887	15.2732	16.3596	*	*
190148	0.9584	19.4518	19.3245	20.8364	19.8500
190149	0.9131	16.5153	18.4197	17.1613	17.3327
190151	1.0027	16.2783	17.3402	17.8181	17.1475
190152	1.3493	22.7142	25.1136	27.4592	25.2116
190156	0.8585	17.6573	18.0528	18.3195	18.0102
190158	1.1791	21.6307	23.2361	26.1861	23.8513
190160	1.4934	19.3139	19.8428	20.0025	19.7550
190161	1.0873	15.7807	16.5322	17.8627	16.7038
190162	1.0184	20.9645	20.7350	22.2014	21.2975
190164	1.1315	19.0474	20.2791	21.4107	20.3624
190167	1.1940	15.5795	17.2643	17.8331	16.8817
190170	***	16.2045	*	*	*
190175	1.3579	23.0144	22.7574	24.6625	23.4177
190176	1.7046	21.7051	25.2536	25.8370	24.3197
190177	1.6559	20.3679	22.3318	25.4646	22.7944
190182	1.2830	23.1997	23.6016	25.0672	23.9830
190183	1.1704	16.7402	17.1805	18.3120	17.3975
190184	0.9475	18.6583	20.6096	21.3014	20.0934
190185	1.3028	20.7351	29.7870	24.4124	24.5651
190186	***	16.7272	*	*	*
190190	0.8717	13.7951	16.2819	13.9834	14.3872
190191	1.2765	19.7218	21.9141	22.3568	21.3592

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
190196	0.8709	19.1961	20.7601	21.9324	20.7015
190197	1.3167	20.9871	21.6908	22.9401	21.9400
190199	1.2118	17.8288	19.7776	18.3884	18.5981
190200	1.4065	22.3510	24.1667	26.4221	24.3376
190201	1.2789	21.7185	21.4335	22.5513	21.9187
190202	1.4014	22.4701	22.4062	21.8644	22.2622
190203	1.4035	23.0636	24.9518	26.9077	25.0989
190204	1.5276	22.9134	26.1231	28.8480	26.2005
190205	1.8101	18.8750	20.2374	21.7575	20.3525
190206	1.6269	21.7867	24.2892	26.8606	24.4805
190207	***	20.7024	21.5325	*	*
190208	0.7697	17.6834	23.0838	24.7966	20.9481
190218	1.0364	20.7290	21.6206	23.9237	22.1737
190236	1.4458	22.5796	24.4661	23.8152	23.6466
190240	0.9373	16.0658	15.4026	14.0059	15.1620
190241	1.2981	*	24.2462	28.9828	*
190242	1.1895	*	18.6672	20.5906	*
190243	***	*	*	30.6060	*
190245	1.4685	*	*	*	*
190246	1.3659	*	*	*	*
190247	2.2150	*	*	*	*
190248	1.2521	*	*	*	*
190249	1.6568	*	*	*	*
190250	2.7106	*	*	*	*
190251	0.9936	*	*	*	*
190252	1.0303	*	*	*	*
190253	0.9678	*	*	*	*
190254	1.2191	*	*	*	*
200001	1.3035	19.7904	21.6050	23.2177	21.5700
200002	1.1002	22.3145	22.0700	24.1507	22.9019
200003	1.2180	18.5780	*	*	*
200006	***	18.9818	*	*	*
200007	1.0718	19.0388	21.0603	22.3794	20.8250
200008	1.2419	23.2883	25.1115	25.1578	24.5637
200009	1.8733	23.3090	24.9041	28.1353	25.4624
200012	1.1795	20.5141	21.8529	24.1121	22.1841
200013	1.0993	20.3793	22.8909	23.9025	22.4191
200016	***	16.2939	*	*	*
200018	1.2079	19.8848	21.1330	24.3273	21.8503

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
200019	1.2999	21.1893	23.1114	24.0873	22.8160
200020	1.2599	24.7433	27.0798	28.7429	26.9810
200021	1.1907	22.0144	24.9925	25.0916	24.0933
200024	1.4358	21.0633	22.9698	24.6414	22.9151
200025	1.1614	21.4247	22.9023	24.3248	22.8794
200026	1.0242	18.1459	19.7172	21.9939	19.9737
200027	1.3201	20.2100	21.0156	23.2862	21.4951
200028	1.0252	19.8886	21.2180	24.2761	21.7904
200031	1.2782	17.7875	18.8262	20.6171	19.0729
200032	1.1915	20.9148	23.0487	24.2160	22.7765
200033	1.9097	23.6298	25.1723	26.8607	25.2822
200034	1.3208	21.8266	23.5415	26.3780	24.0280
200037	1.1450	19.5004	22.6534	23.3367	21.7227
200038	***	22.9220	*	*	*
200039	1.2739	21.5695	22.1333	24.0294	22.6135
200040	1.2774	20.7744	21.8528	23.6685	22.1213
200041	1.1454	20.2986	21.3816	23.6740	21.9027
200043	***	20.0281	*	*	*
200050	1.2941	23.0314	23.4391	25.5050	24.0708
200052	1.1286	18.9290	19.0535	22.7400	20.2949
200055	***	19.4998	*	*	*
200062	***	18.0949	*	*	*
200063	1.2062	22.5265	23.0135	25.0568	23.5445
200066	1.2028	18.4281	19.5890	21.6320	19.8604
210001	1.4595	21.5280	22.6614	26.2944	23.5415
210002	2.1092	26.5907	25.6975	25.2927	25.8041
210003	1.6800	22.3090	23.0790	32.3193	25.5748
210004	1.4281	27.2278	29.4841	29.4228	28.7738
210005	1.3058	22.5304	24.7185	27.1232	24.8443
210006	1.1031	20.8607	24.7327	25.6303	23.6931
210007	1.9347	23.4582	27.5104	28.5168	26.5329
210008	1.3319	21.0767	24.6569	26.3017	24.1788
210009	1.8325	20.8476	23.4889	24.5742	23.0323
210010	1.0808	20.4097	23.7761	24.5030	22.9026
210011	1.4010	20.4017	22.3262	24.8353	22.5091
210012	1.6215	24.8430	25.2892	25.7800	25.3041
210013	1.3848	23.1649	23.0151	22.4553	22.8668
210015	1.3234	23.9651	23.8419	25.8386	24.5651
210016	1.8301	24.7441	27.2632	28.7454	26.9741

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
210017	1.1885	18.2963	19.0248	21.3807	19.5724
210018	1.2626	23.6442	25.3112	27.4864	25.4728
210019	1.7248	21.5429	23.5259	24.9204	23.3904
210022	1.4276	25.6728	27.6680	30.5407	28.0246
210023	1.4897	24.4815	26.7837	29.0892	26.8155
210024	1.7320	24.7858	24.8939	27.1674	25.6917
210025	1.2068	21.4910	22.8882	23.8756	22.7455
210026	***	20.7985	*	*	*
210027	1.5010	16.2219	19.3517	23.9024	19.4887
210028	1.1125	20.4027	22.4054	24.1209	22.3623
210029	1.3041	24.7605	26.2082	31.2881	27.3675
210030	1.2856	21.9547	20.7802	27.5427	23.2775
210032	1.1642	20.0825	20.3407	25.6962	22.0562
210033	1.2023	22.8303	25.0301	26.5976	24.9129
210034	1.3021	22.6812	22.8827	26.3834	23.9069
210035	1.3080	21.6662	21.6973	24.5219	22.6683
210037	1.2068	21.1659	23.5536	24.1910	22.9904
210038	1.3182	25.9701	26.5696	28.3244	26.9777
210039	1.1622	23.3583	24.0987	25.8281	24.4709
210040	1.2781	23.7067	25.4729	28.3699	25.9312
210043	1.3250	22.9504	22.2177	24.2912	23.1947
210044	1.3788	22.9540	23.8101	24.8135	23.8512
210045	1.1025	13.5654	11.8350	15.0867	13.6815
210048	1.2930	24.9381	24.4328	25.0576	24.8067
210049	1.1952	21.1056	24.7148	25.9198	24.1671
210051	1.3592	24.8949	25.7103	27.4080	26.0568
210054	1.3202	25.1694	27.3551	24.6678	25.7182
210055	1.2608	23.8025	27.4218	27.9906	26.3713
210056	1.3892	22.6958	23.5881	26.6792	24.4399
210057	1.4078	25.6142	27.3520	29.2982	27.4865
210058	1.3028	17.4250	22.0351	24.8689	21.2987
210060	1.1844	26.4566	25.8377	28.6870	27.1132
210061	1.2418	20.8975	22.5455	24.1364	22.7019
220001	1.2323	23.4091	25.8030	27.6049	25.6108
220002	1.3410	25.4158	26.3348	28.9516	26.9151
220003	1.0241	17.6069	18.8150	20.5768	18.9361
220006	1.4085	23.8920	27.1576	29.5763	26.9384
220008	1.2535	24.2393	25.6647	27.1701	25.7570
220010	1.3244	23.4009	24.5020	27.3207	25.1186

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
220011	1.1575	20.6390	32.2266	32.5178	28.2248
220012	1.4282	31.1041	32.0521	32.5497	31.9449
220015	1.2071	24.1348	25.0272	25.5474	24.9578
220016	1.1805	24.6149	25.7740	26.8646	25.7213
220017	1.3280	25.9000	28.9024	28.7792	27.8319
220019	1.1850	19.9268	21.6620	22.1991	21.2654
220020	1.1904	22.5375	23.5737	24.2449	23.4846
220024	1.2577	23.8620	24.1071	25.5676	24.5111
220025	1.0034	22.0003	23.2374	24.5114	23.2391
220028	1.4391	24.1251	31.4858	31.3193	28.7644
220029	1.1363	25.7660	27.4792	28.1319	27.1269
220030	1.0929	18.9012	20.0816	23.6292	20.9199
220031	1.5783	28.3832	30.8324	32.1953	30.4695
220033	1.1676	21.8156	25.4500	26.6959	24.7339
220035	1.2359	25.7456	26.8486	27.5141	26.6944
220036	1.5386	25.5771	28.2182	30.1380	27.9111
220038	1.0474	22.9821	*	*	*
220041	***	28.6790	28.8184	29.7464	29.0350
220042	***	28.4675	*	*	*
220046	1.3310	24.1931	26.1955	27.7555	26.0576
220049	1.1830	25.4358	26.7688	26.9855	26.4013
220050	1.0904	23.3330	23.7326	24.9978	24.0458
220051	1.2259	22.4827	22.2965	30.4862	24.9821
220052	1.1926	25.4091	26.3043	28.0536	26.7681
220057	***	26.2944	*	*	*
220058	0.9251	21.6814	22.4885	24.8984	23.0458
220060	1.2154	28.3950	29.6960	30.8125	29.6996
220062	0.6021	22.5567	22.6598	21.9780	22.3731
220063	1.1818	21.8365	23.3704	25.5724	23.5958
220064	***	24.0982	*	*	*
220065	1.1993	21.5657	22.4143	24.8545	22.9388
220066	1.3404	24.5463	27.5575	26.2541	26.1623
220067	1.1991	28.2685	22.4968	28.9290	26.2501
220070	1.1941	23.9850	26.2697	28.8242	26.9583
220071	1.8304	27.7679	27.7773	31.4503	29.0548
220073	1.2117	27.4778	27.9309	29.2336	28.2226
220074	1.2961	25.3331	25.7840	27.5662	26.2544
220075	1.3892	24.6982	26.0527	27.8335	26.2163
220076	1.1248	24.1224	24.8040	26.2152	25.0557

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
220077	1.7057	27.1503	27.0946	28.0892	27.4562
220079	***	25.7305	*	*	*
220080	1.2035	22.9911	24.7399	27.1532	25.0242
220081	***	31.1325	*	*	*
220082	1.2775	23.2818	23.9542	24.7345	23.9880
220083	1.1635	27.2605	28.3533	29.8544	28.4977
220084	1.2598	26.0395	26.8596	29.9488	27.6691
220086	1.6867	28.7324	29.4911	29.3227	29.1729
220088	1.8326	25.0671	26.5849	28.2028	26.6365
220089	1.1824	25.3521	28.9252	32.4478	29.0257
220090	1.1772	26.0265	26.5552	29.7867	27.5270
220092	***	29.4173	*	*	*
220095	1.1192	22.6828	23.7629	24.9768	23.8261
220098	1.1929	24.7180	26.2287	26.8348	25.9231
220100	1.2757	26.8001	27.0265	26.8182	26.8859
220101	1.2728	28.0856	26.9992	31.0554	28.6693
220105	1.2104	25.5692	26.7570	30.0807	27.5624
220106	***	27.6811	*	*	*
220108	1.2222	24.5939	26.0166	29.0649	26.5182
220110	2.0824	30.6173	33.0445	35.5604	33.1261
220111	1.2423	26.7573	27.7395	28.8938	27.7625
220116	1.9225	28.5716	30.9871	32.2243	30.6812
220119	1.1858	24.6344	25.9789	27.8081	26.1918
220123	***	29.6084	*	*	*
220126	1.1658	23.8123	26.9853	26.7178	25.9125
220133	***	29.8367	33.0819	31.2981	31.4484
220135	1.3193	29.6837	31.9159	28.7630	30.1107
220153	0.9189	*	*	18.9267	*
220154	0.9201	23.3590	25.6069	30.9009	26.3094
220162	1.6806	*	*	*	*
220163	1.6185	29.3552	29.9312	30.4939	30.0336
220171	1.7065	27.3487	27.2647	28.9643	27.8472
220174	1.1783	*	*	30.3286	*
230001	1.1492	23.3051	22.0875	24.3379	23.2296
230002	1.3049	24.3116	23.7972	27.0391	25.0850
230003	1.2266	21.6493	22.4322	25.2323	23.1365
230004	1.7511	22.4538	23.0827	25.5383	23.7334
230005	1.2479	20.5596	20.3750	22.0154	21.0857
230006	1.1091	20.6985	22.0733	22.7436	21.8686

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
230013	1.3461	20.0954	20.4633	22.6932	21.0656
230015	1.0761	21.9499	21.7640	22.9131	22.2121
230017	1.6625	25.7900	26.1609	27.3159	26.4677
230019	1.5606	23.8779	24.7472	27.6508	25.4656
230020	1.7228	28.8869	25.8267	26.8453	27.1400
230021	1.5159	20.9145	22.0757	23.4564	22.1503
230022	1.1897	21.8808	22.2179	22.2419	22.1147
230024	1.5994	26.2155	24.7364	27.6730	26.1329
230027	1.0399	22.5115	21.2223	22.3661	22.0362
230029	1.6627	24.9754	26.7646	27.8860	26.5321
230030	1.2739	19.2441	19.9853	20.6505	19.9865
230031	1.3865	19.4675	22.1874	23.2777	21.7612
230032	***	22.8436	23.8366	25.1103	23.9550
230034	1.1862	17.9276	18.5768	20.9197	19.0910
230035	1.2487	20.5906	18.0735	20.9280	19.7780
230036	1.3269	25.1507	25.9801	26.5642	25.9137
230037	1.2627	22.7382	24.4115	23.9750	23.7054
230038	1.7465	20.9389	23.4685	25.2298	23.4717
230040	1.1589	20.2451	21.8062	21.9730	21.3545
230041	1.4880	23.2870	24.2297	25.2405	24.2291
230042	1.2437	20.7745	21.8241	24.3608	22.3333
230046	1.8567	26.1787	28.2320	29.2671	27.8844
230047	1.3610	23.7178	24.3622	26.2389	24.8007
230053	1.6306	23.5702	26.1415	28.2644	25.9510
230054	2.0185	22.2105	23.0818	24.0157	23.1233
230055	1.1659	20.8930	20.9350	23.7649	21.9268
230056	***	17.3516	*	*	*
230058	1.1761	21.6619	22.4516	21.9252	22.0206
230059	1.4749	20.6540	21.2743	23.1393	21.6922
230060	1.4048	20.5120	22.3512	24.4959	22.5065
230062	***	18.2283	*	*	*
230065	1.4037	23.3413	26.3217	27.9196	25.8401
230066	1.2953	23.2790	23.9696	25.8733	24.3569
230069	1.2325	25.0212	26.0438	27.6639	26.3075
230070	1.5573	21.2476	22.8588	25.1574	23.0388
230071	1.1072	23.6398	23.6674	24.7307	24.0060
230072	1.2998	22.6533	22.9626	24.3053	23.3353
230075	1.3951	22.3632	22.6799	24.1504	23.1044
230076	***	26.9662	*	*	*

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***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
230077	1.9656	22.6781	29.2041	27.2055	26.2379
230078	0.9997	19.1638	20.5427	22.3632	20.6517
230080	1.2565	19.1810	20.2405	21.2751	20.2412
230081	1.2053	20.0464	20.4289	20.6806	20.3879
230082	1.0387	18.2165	21.3100	23.1263	20.5952
230085	1.1640	24.5765	24.2802	22.2177	23.8134
230086	1.1850	20.1461	27.8923	20.8865	22.7193
230087	***	20.6619	22.2688	18.0436	20.1972
230089	1.2969	23.1023	23.3847	23.9311	23.4899
230092	1.3106	22.3437	22.3122	24.3560	22.9957
230093	1.0804	21.0274	25.1213	24.4873	23.6121
230095	1.3734	18.0582	19.1810	19.2384	18.8360
230096	1.2138	24.3004	26.7156	26.7605	25.9266
230097	1.7843	22.5006	22.9902	25.2071	23.5885
230099	1.2181	22.3422	23.5490	25.0193	23.6265
230100	1.0939	18.2477	19.8016	20.2775	19.4021
230101	1.1302	22.5159	22.3310	23.0761	22.6479
230103	0.9871	18.5254	19.4434	18.3999	18.7916
230104	1.5641	25.5606	27.4119	27.8956	26.9402
230105	1.8519	23.0086	23.9851	24.6781	23.8821
230106	1.1173	22.9909	23.1962	24.0814	23.4503
230107	***	18.9985	*	*	*
230108	1.1878	21.4593	19.9842	22.4508	21.3094
230110	1.2012	21.0925	21.5523	22.7522	21.8181
230115	***	21.0360	*	*	*
230116	***	15.6064	*	*	*
230117	1.8269	25.5154	28.1220	29.6236	27.8152
230118	1.1287	20.2769	22.2208	21.4750	21.2956
230119	1.3556	23.9898	25.3562	29.2525	26.0778
230120	1.1007	20.6105	22.7243	21.7860	21.6889
230121	1.2521	21.4616	22.3708	23.4159	22.3752
230124	1.2508	20.9641	22.0097	23.0350	22.0179
230128	***	24.4952	*	*	*
230130	1.7164	23.5123	23.7854	26.9569	24.7717
230132	1.4077	27.3637	29.0292	29.8974	28.7409
230133	1.4265	19.0770	20.4801	21.2182	20.3309
230135	0.7730	18.4193	19.8290	23.8683	20.7643
230141	1.6729	24.4560	23.9885	30.4292	26.1737
230142	1.3166	25.0282	22.9036	25.5992	24.5015

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
230143	1.2298	18.2700	19.5446	19.5433	19.0828
230144	2.0414	23.3294	23.6959	*	*
230145	1.1369	17.9811	15.8192	17.2071	17.0000
230146	1.2723	22.3838	21.3539	24.3806	22.7296
230147	***	26.5260	*	*	*
230149	0.9660	19.9577	20.8933	21.4751	20.6964
230151	1.3474	24.3705	23.8527	26.4518	24.9083
230153	1.1216	20.0098	22.8584	22.3219	21.7519
230154	***	16.7152	*	*	*
230155	1.0101	20.7546	18.0743	24.0078	20.6721
230156	1.6267	27.2254	27.7164	29.4860	28.1772
230162	***	22.7983	*	*	*
230165	1.7542	24.7959	25.9534	27.3141	26.0324
230167	1.5892	24.1344	24.7935	26.6749	25.1728
230169	0.8789	28.1039	24.9265	27.1172	26.6659
230171	1.0522	16.1129	19.9097	22.0941	19.3042
230172	1.3458	22.1709	23.0023	24.0061	23.0857
230174	1.4004	23.5025	24.4671	26.2704	24.7855
230175	***	14.4932	22.5964	*	*
230176	1.2894	24.9032	24.6675	25.6838	25.0819
230178	***	17.3428	*	*	*
230180	1.1071	19.6062	20.9832	22.5233	21.0986
230184	1.1426	20.6406	21.4031	21.9561	21.3362
230186	***	19.1289	21.6147	27.1126	21.8760
230188	0.9095	16.8687	18.8076	*	*
230189	0.9949	19.1989	22.7783	20.8364	20.9017
230190	0.8672	24.4643	27.3430	28.8066	26.8748
230191	***	20.6633	*	*	*
230193	1.2631	21.5358	22.8916	24.3056	22.8710
230195	1.4231	23.4647	25.3285	27.1425	25.3506
230197	1.5617	25.5311	26.9840	28.3163	26.9298
230199	1.4403	22.4592	*	*	*
230201	***	18.2486	*	*	*
230204	1.2841	24.5127	24.4095	25.9811	24.9344
230205	***	18.1552	*	*	*
230207	1.3822	20.9059	22.2848	22.2781	21.8164
230208	1.1476	17.8118	20.3171	20.9374	19.5914
230211	***	21.1245	*	*	*
230212	0.9971	24.6420	26.0656	27.3711	26.0106

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
230213	***	17.1061	*	*	*
230216	1.6147	22.2137	23.4262	26.1380	23.9865
230217	1.2779	24.1455	24.3650	26.7355	25.1372
230219	***	18.1278	*	*	*
230222	1.3420	23.2545	24.6101	24.8520	24.2263
230223	1.3204	25.2666	28.5549	27.1393	26.9892
230227	1.4736	25.8826	27.7510	28.0859	27.3077
230230	1.5014	22.1703	23.9568	25.4352	23.8520
230235	1.0333	17.5940	19.9118	19.6336	19.0198
230236	1.3766	25.3251	25.7463	26.4114	25.8467
230239	1.1771	18.9790	19.8370	21.1469	20.0227
230241	1.1878	21.8472	24.2063	25.8655	24.0170
230244	1.3538	23.1175	23.9004	25.3682	24.0983
230253	***	22.7706	*	*	*
230254	1.2924	23.3714	24.2594	26.4279	24.6681
230257	1.0022	23.1794	24.8069	25.3985	24.4090
230259	1.1938	23.1768	24.8598	24.1922	24.0969
230264	1.7309	18.6598	17.4847	19.9834	18.8176
230269	1.3076	24.3772	25.3367	27.4589	25.8005
230270	1.2475	25.2665	22.8842	25.1725	24.4410
230273	1.4608	24.1279	25.8466	30.2104	26.7147
230275	0.4945	32.0039	29.4180	30.1358	30.4630
230276	***	22.3312	23.4928	*	*
230277	1.3472	24.3351	25.3378	26.9236	25.5300
230279	0.5661	18.3256	21.2467	23.1756	20.9434
230283	1.5139	*	25.0038	24.9284	*
230286	***	47.5929	*	*	*
230287	***	22.5420	*	*	*
230288	***	*	30.3422	*	*
230290	***	*	*	29.4792	*
230292	2.0562	*	*	*	*
230293	0.5548	*	*	*	*
230294	1.5889	*	*	*	*
230295	1.3425	*	*	*	*
240001	1.5267	26.6372	28.2239	29.9126	28.3422
240002	1.8221	24.2214	24.7674	26.9577	25.3554
240004	1.5562	25.6238	26.8197	27.8882	26.8140
240005	***	20.2390	*	*	*
240006	1.0803	25.7288	29.5789	30.2071	28.5494

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
240007	1.2492	20.7188	21.4367	23.7567	21.9944
240008	***	22.7436	*	*	*
240009	***	17.4517	*	*	*
240010	1.9438	28.3796	29.0955	30.3816	29.3060
240011	1.0676	22.5188	24.0364	22.9482	23.1438
240013	1.2855	25.1560	27.3855	28.7086	27.0893
240014	0.9830	25.2306	26.5144	28.3788	26.7740
240016	1.2985	23.3773	25.2629	24.9026	24.5262
240017	1.2393	19.3431	21.6243	23.3041	21.4243
240018	1.1983	23.6092	27.3634	27.9193	26.3268
240019	1.1449	24.0613	25.1331	27.5515	25.5165
240020	1.0781	20.6819	24.7516	28.1464	24.1994
240021	0.8748	19.0470	23.9568	23.5366	22.0449
240022	1.1030	23.0394	23.4702	23.7368	23.4177
240023	***	22.3002	*	*	*
240025	1.1252	20.7672	21.2597	27.8656	23.1173
240027	0.9413	18.3837	18.3340	20.0685	18.9392
240029	1.0499	23.0440	21.2342	24.2989	22.7222
240030	1.2770	20.9799	22.0200	23.3708	22.1615
240031	0.9602	21.7621	23.4389	26.7242	23.9687
240036	1.6286	22.5436	23.4857	27.0547	24.4801
240037	1.0058	21.4275	21.8392	24.3878	22.5943
240038	1.5299	26.4513	28.9676	29.8469	28.4071
240040	1.1090	22.8191	21.3870	28.6009	24.1349
240041	***	21.9055	*	*	*
240043	1.1958	18.0186	19.5532	20.7176	19.4900
240044	1.1114	22.5751	22.7482	23.2441	22.8705
240045	1.1197	24.2936	25.9223	26.1743	25.4770
240047	1.5662	25.3233	29.6184	29.1003	27.9291
240050	1.0725	23.1109	24.7589	26.6754	24.8819
240051	***	23.2612	*	*	*
240052	1.2659	22.3485	23.5898	24.9803	23.6617
240053	1.5132	24.4191	26.7122	28.4655	26.5822
240056	1.2337	24.8549	28.5169	30.8574	28.2749
240057	1.8427	25.3984	27.7600	29.4752	27.5494
240058	***	19.0505	*	*	*
240059	1.0830	25.3847	27.0517	28.6194	27.0607
240061	1.7793	27.9151	28.7372	29.9864	28.9298
240063	1.5294	25.8594	26.7960	29.9587	27.5199

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
240064	1.2106	24.6785	24.9928	26.6996	25.4635
240065	***	14.4624	*	*	*
240066	1.3497	25.5163	27.4066	30.2453	27.7627
240069	1.1677	23.3373	25.6943	27.5064	25.5975
240071	1.1320	22.6332	24.8036	26.4755	24.6446
240072	***	21.5455	*	*	*
240073	***	17.9013	*	*	*
240075	1.2092	21.9159	24.4084	26.6466	24.3284
240076	1.0006	23.6159	26.7112	28.4324	26.3581
240077	0.9793	22.1508	18.9735	*	*
240078	1.5754	26.2576	27.5066	30.5367	28.0688
240079	0.9616	18.2929	20.6644	20.9465	19.9389
240080	1.6965	26.3071	27.8807	29.6299	27.9932
240082	***	20.2018	*	*	*
240083	1.3055	22.3484	24.4352	25.0002	23.9378
240084	1.1217	23.1951	23.9942	24.7729	23.9967
240085	***	20.7535	*	*	*
240086	***	18.1497	*	*	*
240087	0.9803	21.2116	20.1002	24.8479	21.9890
240088	1.2736	24.6260	25.5587	27.6243	25.9680
240089	0.9611	21.3950	23.4028	*	*
240090	***	21.0856	*	*	*
240093	1.3152	20.7138	22.3968	23.7663	22.3717
240094	1.0302	22.5923	24.4166	27.3579	24.9657
240096	***	20.2993	*	*	*
240097	***	29.7596	34.2810	*	*
240098	***	23.9626	*	*	*
240099	***	18.8140	*	*	*
240100	1.2472	24.1875	24.7500	25.3259	24.7713
240101	1.1438	22.1328	24.3455	26.6078	24.4827
240102	***	15.5114	*	*	*
240103	1.0711	21.0182	20.2324	22.5416	21.3014
240104	1.1792	25.1139	27.4946	30.1117	27.7777
240106	1.4162	23.9677	25.5890	27.5094	25.6873
240107	0.9096	21.2164	24.5583	25.4425	23.6683
240108	***	17.6501	*	*	*
240109	1.0020	15.1369	14.5892	15.2076	14.9741
240110	***	21.7341	*	*	*
240111	0.7418	19.9711	*	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
240112	***	17.2437	*	*	*
240114	***	18.3415	*	*	*
240115	1.6048	24.6529	27.0312	29.0368	26.9152
240116	***	17.3461	*	*	*
240117	1.1382	18.6677	20.1436	22.0582	20.2908
240119	***	23.0231	*	*	*
240121	0.9253	22.4857	24.5455	*	*
240122	0.9814	20.7795	23.5331	21.9140	22.0517
240123	1.0026	18.9494	20.0721	20.5651	19.8638
240124	0.9733	21.2023	23.5139	23.9297	22.9159
240125	***	17.3846	*	*	*
240127	***	16.4293	19.3857	24.4824	19.3629
240128	1.0764	17.5611	20.1960	21.2534	19.6224
240129	***	17.7243	*	*	*
240130	***	17.7634	*	*	*
240132	1.2707	24.5633	26.7063	29.5335	26.9740
240133	1.1819	20.8958	23.6068	26.1798	23.5516
240135	***	15.6297	17.8573	16.1837	16.4756
240137	1.1446	21.6644	23.1752	23.8333	22.9500
240138	***	19.1677	*	*	*
240139	1.0698	21.0164	22.4473	23.7746	22.3912
240141	1.0579	23.6498	25.1597	26.7119	25.2922
240142	***	24.0719	*	*	*
240143	0.8468	20.7306	18.9442	20.8866	20.1836
240144	***	23.1661	*	*	*
240145	0.8953	17.6748	22.6063	*	*
240146	0.9301	17.3275	*	*	*
240148	***	19.5373	*	*	*
240150	***	23.3860	*	*	*
240152	0.9075	24.1819	25.4031	27.3426	25.8001
240153	1.0152	18.6556	*	*	*
240154	0.9963	21.5860	21.3809	23.9549	22.3124
240155	***	23.6945	*	*	*
240157	***	20.0572	*	*	*
240160	***	16.4991	*	*	*
240161	***	18.0542	*	*	*
240162	1.1169	19.3296	20.4807	22.2931	20.7300
240163	***	22.2008	*	*	*
240166	1.1711	19.4496	21.5002	23.4013	21.5015

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
240170	1.1160	21.5993	*	*	*
240171	***	19.6732	*	*	*
240172	***	20.3700	*	*	*
240173	***	18.3184	*	*	*
240179	0.9060	17.7558	19.8249	20.8449	19.5680
240184	***	17.6979	*	*	*
240187	1.1821	23.2471	24.8879	26.5058	24.9001
240193	***	26.6383	*	*	*
240196	0.8038	26.2793	27.2901	28.9278	27.4899
240200	***	18.7518	*	*	*
240205	0.8904	*	*	*	*
240206	0.9900	*	*	*	*
240207	1.1685	26.0927	27.4330	29.2442	27.6792
240210	1.2430	25.6060	26.6545	29.7321	27.3601
240211	0.9535	34.7852	32.8801	44.6993	36.8936
240213	1.2618	*	27.5104	31.4042	*
250001	1.8172	20.2019	20.9338	21.9183	21.0359
250002	0.8972	19.6081	21.6643	20.1269	20.4853
250003	1.1025	18.7332	*	*	*
250004	1.7625	19.2913	20.9295	20.6725	20.3099
250005	***	13.7341	*	*	*
250006	1.0495	19.4531	20.3061	21.3866	20.4220
250007	1.2471	20.9757	21.2226	23.6885	21.9434
250008	***	15.8096	*	*	*
250009	1.2606	18.0463	19.7610	20.4265	19.4044
250010	0.9634	16.0234	17.6204	19.4374	17.6763
250012	0.9275	17.4032	15.6117	20.0601	17.5685
250015	1.0126	16.6522	19.3794	20.6847	18.8191
250017	1.1204	18.8850	19.0436	18.0850	18.7049
250018	0.8029	14.7291	16.8783	17.0812	16.2011
250019	1.5375	19.9070	22.9085	22.8194	21.8600
250020	0.9889	19.6575	19.1877	19.3523	19.3892
250021	***	12.7242	15.8485	15.1242	14.6970
250023	0.8247	13.8210	14.7355	16.2237	14.8695
250024	***	14.8395	*	*	*
250025	1.0679	21.9075	21.2651	20.6784	21.3382
250027	0.9812	15.1789	17.5937	17.3461	16.6061
250029	***	14.8216	*	*	*
250030	0.9455	25.5090	27.2140	*	*

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***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
250031	1.2021	19.8778	21.0894	22.0893	21.0405
250033	***	16.9131	*	*	*
250034	1.5734	18.8231	20.3681	20.6725	19.9893
250035	0.8864	18.3861	17.1071	14.5831	16.8601
250036	0.9914	17.6247	17.0469	17.8158	17.5031
250037	0.9173	14.3993	16.6347	17.4500	16.0680
250038	0.9193	18.8434	16.8610	17.9411	17.8700
250039	0.9201	16.4502	16.8729	15.2658	16.1617
250040	1.4244	19.6513	20.8178	21.3365	20.5864
250042	1.1977	18.3858	19.4367	21.3232	19.6652
250043	0.9671	18.4025	17.7554	18.3292	18.1735
250044	1.0250	19.0321	20.3711	21.1167	20.1819
250045	1.1087	22.7225	25.3236	25.0818	24.3759
250047	***	16.0108	*	*	*
250048	1.5220	19.4976	19.3635	21.6498	20.2092
250049	0.8819	12.8275	13.4396	17.6905	14.4468
250050	1.2474	16.0234	16.6723	18.3072	16.9550
250051	0.8651	10.1213	10.5027	10.6436	10.4144
250057	1.1814	16.6316	19.0571	19.6755	18.3954
250058	1.2571	16.2623	16.5565	17.5033	16.7835
250059	1.0277	17.9507	19.0733	17.6283	18.1832
250060	0.8054	12.6893	14.0155	20.8669	15.6796
250061	0.8751	12.0186	11.4573	15.2971	12.6271
250063	***	15.0894	*	*	*
250065	0.8422	15.0507	16.2010	16.2582	15.8136
250066	0.8718	17.2712	16.1044	*	*
250067	1.0620	18.3773	20.0430	20.1140	19.5210
250068	0.7989	13.2644	16.3759	16.9538	15.3548
250069	1.4667	18.5782	21.2224	21.6598	20.4333
250071	0.8654	13.1934	13.7056	17.4654	14.5202
250072	1.4461	21.0601	20.7827	22.9280	21.5375
250077	0.9182	13.9478	14.0318	14.2076	14.0609
250078	1.5883	17.4118	17.5186	18.6566	17.8896
250079	0.8794	16.1482	21.3506	27.3493	21.8281
250081	1.2423	18.1848	20.4513	21.3788	19.9226
250082	1.3415	17.3096	19.5962	20.5109	19.1694
250083	0.9278	16.3054	19.5217	19.9433	18.7771
250084	1.2236	21.0870	22.4632	21.7863	21.7608
250085	0.8959	16.7377	18.0473	18.7241	17.7971

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
250088	1.1295	19.3976	*	*	*
250089	1.0852	15.0238	16.0203	*	*
250093	1.0885	16.8646	17.4413	18.7878	17.6849
250094	1.5259	18.9681	19.9619	22.3206	20.3803
250095	1.0089	18.4943	18.6616	19.9050	19.0192
250096	1.0961	19.3631	20.7246	22.7194	20.9764
250097	1.2395	16.3328	18.8399	19.4489	18.1749
250098	0.9037	18.8163	17.9561	*	*
250099	1.2220	15.9867	18.2504	18.9916	17.7784
250100	1.3669	19.7559	18.8877	22.0209	20.2397
250101	***	17.6704	*	21.2234	*
250102	1.5322	19.8487	21.3213	22.5462	21.2751
250104	1.4158	19.0165	20.5035	21.4358	20.3477
250105	0.9275	16.1480	17.0136	17.9324	17.0561
250107	0.8749	16.5635	16.7104	16.6398	16.6396
250109	1.0420	24.5759	*	*	*
250112	0.9324	16.6447	16.8696	19.6258	17.7505
250117	1.0648	15.9335	18.8863	19.9672	18.1774
250119	1.0071	16.5700	17.1373	*	*
250120	1.0261	18.1428	22.9071	22.7610	21.1121
250122	1.0508	19.8033	19.7966	23.6867	21.1074
250123	1.2456	22.1376	22.2184	22.0282	22.1222
250124	0.8840	14.4008	15.6866	15.3674	15.1586
250125	1.2979	21.9366	25.3415	26.8381	24.7516
250126	0.9208	19.0168	20.1118	20.2720	19.8378
250127	0.9638	*	*	*	*
250128	0.9139	15.9957	15.8352	15.8187	15.8830
250131	0.9083	11.2470	11.5396	*	*
250134	0.7548	21.4489	22.0310	23.1639	22.1449
250136	0.9183	20.0333	21.9977	22.5932	21.5589
250138	1.2817	19.3446	21.2490	22.7844	21.2019
250141	1.5254	21.6835	22.5187	24.5735	23.0792
250145	***	11.2021	*	*	*
250146	0.8725	15.4061	16.9341	17.2005	16.4655
250148	***	23.1460	*	*	*
250149	0.8932	15.7537	16.4228	15.0415	15.7601
250151	0.8377	*	20.4581	21.6695	*
250152	1.6606	*	*	*	*
250153	1.6891	*	*	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
250154	0.8963	*	*	*	*
250155	1.4014	*	*	*	*
260001	1.6842	20.9620	22.6646	25.3043	22.9803
260002	2.0064	23.4259	24.6812	27.1769	25.2486
260003	1.0030	16.2023	16.5931	17.6368	16.8066
260004	0.9711	15.2735	16.4423	16.7458	16.1486
260005	1.4681	22.5860	25.5927	24.6090	24.3101
260006	1.4960	22.1692	24.1078	26.5050	24.2970
260008	***	18.2114	21.6256	17.8606	19.0916
260009	1.2056	19.0655	20.1679	21.2595	20.1515
260011	1.3632	20.3279	21.1625	21.4373	20.9989
260012	1.0632	17.3810	17.7854	19.3352	18.1973
260013	1.0765	17.3772	18.4857	19.1933	18.3326
260015	1.0356	18.3849	21.7581	22.4039	20.7761
260017	1.2106	17.9796	20.7837	21.1273	19.9964
260018	1.0458	13.6120	14.3278	14.8393	14.3185
260019	***	18.3629	*	*	*
260020	1.7544	21.0314	22.4709	24.9040	22.9023
260021	1.3635	23.3527	27.2478	27.8232	26.1565
260022	1.2538	18.7707	20.5417	20.9568	20.0110
260023	1.2549	18.5665	19.6324	21.1785	19.7822
260024	1.1363	15.6095	16.9968	17.4882	16.7531
260025	1.3072	18.2804	19.3535	20.0849	19.2433
260027	1.6128	23.1505	22.9973	24.7561	23.6595
260029	1.0864	20.1832	22.0390	22.2717	21.4882
260030	***	12.8349	*	*	*
260031	***	22.5379	24.3626	24.2877	23.7143
260032	1.8517	20.3847	21.8830	23.1180	21.7970
260034	0.9445	20.5440	21.6108	23.3034	21.8987
260035	0.9312	15.1611	15.0468	16.8565	15.6323
260036	0.9985	20.1242	19.4559	20.1279	19.8943
260039	***	15.9689	*	*	*
260040	1.5708	18.5132	20.0422	21.2171	19.9913
260042	***	20.8821	*	*	*
260044	0.9493	16.7879	18.2413	20.0491	18.3915
260047	1.4621	20.2724	22.4585	22.6110	21.7772
260048	1.3269	22.4800	26.6363	25.7929	25.0070
260050	1.1796	17.8143	20.8510	20.6395	19.7740
260052	1.3335	19.1044	21.1297	22.5668	20.9659

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
260053	1.1441	17.4111	18.9606	19.9975	18.8322
260054	***	23.0188	*	*	*
260055	***	17.9547	*	*	*
260057	1.0593	16.5704	15.8404	16.4430	16.2840
260059	1.1772	16.2074	17.2807	18.6300	17.4803
260061	1.0955	17.1343	18.7280	19.6206	18.5246
260062	1.1981	22.0091	25.2958	26.0465	24.4863
260063	1.0470	19.7231	21.1284	22.0751	20.9907
260064	1.4165	18.3749	17.5188	19.1639	18.3604
260065	1.7435	20.6671	22.0058	23.7056	22.1591
260066	***	15.3139	*	*	*
260067	0.8958	14.5499	14.9792	16.4763	15.4013
260068	1.7353	20.7947	22.0951	23.9310	22.3197
260070	0.9439	18.7384	11.2251	14.4037	14.6311
260073	1.0152	16.9496	17.8185	19.2390	18.0877
260074	1.1968	20.4033	18.7639	23.9235	20.9358
260077	1.6316	20.5831	21.9947	23.5706	22.0631
260078	1.2329	16.0586	16.9217	18.4068	17.1608
260079	***	16.4817	*	*	*
260080	0.9038	13.1618	13.6815	*	*
260081	1.5115	20.2471	22.6627	23.5892	22.2491
260082	***	18.2853	*	*	*
260085	1.5970	21.5137	22.7394	24.6060	22.9731
260086	0.9144	16.7579	17.2048	17.0824	17.0086
260091	1.5497	22.0772	23.9975	26.1165	24.1625
260094	1.5233	19.7308	20.1043	20.6621	20.1858
260095	1.3792	21.6999	22.8156	23.8573	22.7866
260096	1.4819	22.8259	23.5009	25.9924	24.2361
260097	1.1852	18.6965	19.6203	21.5035	20.0502
260100	***	16.5439	*	*	*
260102	0.8589	21.2133	24.1041	22.9199	22.8364
260103	***	19.9144	21.6192	23.3175	21.6496
260104	1.5277	21.6625	22.4769	23.4974	22.6575
260105	1.7025	22.8005	24.6572	28.4314	25.2688
260107	1.3543	22.5214	23.1564	24.1945	23.2691
260108	1.8712	20.9029	22.7975	24.0818	22.6626
260109	***	15.9723	*	*	*
260110	1.7043	19.5633	22.0026	22.2657	21.2755
260113	1.1122	16.1346	16.3440	19.2469	17.1861

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
260115	1.1760	19.3873	20.4880	21.7422	20.5265
260116	1.0970	16.0187	16.9807	17.2673	16.7686
260119	1.2778	18.0725	18.7959	22.1554	20.4439
260120	***	17.6811	18.7651	*	*
260122	1.1431	16.3700	16.1637	17.3234	16.6573
260123	1.0104	15.2927	17.7996	16.2150	16.4306
260127	0.9437	18.1343	19.7946	22.3903	20.0166
260128	***	13.2941	*	*	*
260131	***	18.0395	*	*	*
260134	1.0868	17.1341	18.4511	18.1629	17.8613
260137	1.6273	19.5976	20.7638	21.3326	20.6027
260138	1.8868	23.6502	25.6579	27.6928	25.6698
260141	1.8599	19.0444	21.0771	20.9379	20.3097
260142	1.1122	18.2023	18.6412	19.6210	18.8545
260143	***	15.4688	*	*	*
260147	0.8675	15.8522	16.1171	17.2302	16.3857
260148	***	12.6651	*	*	*
260158	0.8897	13.9789	*	*	*
260159	0.5650	20.9636	23.1093	26.8352	23.1422
260160	1.0245	18.4007	18.8723	19.4997	18.8893
260162	1.4711	20.7331	22.5705	24.1143	22.5605
260163	1.2052	16.8300	18.1310	16.3896	17.1105
260164	1.0826	16.3874	16.9403	19.5689	17.5147
260166	1.2386	22.4070	22.8409	25.5229	23.6574
260172	0.9078	16.4854	17.1504	18.1235	17.2645
260173	***	15.5733	*	*	*
260175	1.1026	18.3632	19.7939	21.1230	19.7851
260176	1.5771	23.2414	25.7802	29.1891	26.2693
260177	1.2001	22.9112	24.0550	24.9653	24.0338
260178	1.6825	20.8189	21.7704	21.4505	21.3753
260179	1.5565	21.4470	23.2824	24.8035	23.1918
260180	1.6223	19.5983	21.8585	21.9667	21.1225
260183	1.6572	23.7057	24.2330	23.3877	23.7486
260186	1.5694	21.0675	21.6620	23.4102	22.1373
260188	***	23.7476	*	*	*
260190	1.2109	21.6995	24.5014	25.1683	23.8722
260191	1.2982	19.6784	21.1331	22.4368	21.1554
260193	1.1748	22.2030	22.9556	24.4696	23.3152
260195	1.2658	*	20.0889	20.1390	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
260198	1.1618	21.7925	25.3390	27.6029	24.8982
260200	1.2342	21.7031	22.3913	25.1087	23.2857
260207	1.1048	*	18.5247	19.2580	*
260208	***	*	28.3158	*	*
260209	1.1197	*	*	21.8068	*
260210	1.1787	*	*	*	*
260211	1.5906	*	*	*	*
270002	1.1929	19.0221	19.7588	20.7884	19.8661
270003	1.2352	20.7277	23.0396	24.2723	22.5761
270004	1.6926	20.1821	21.5577	22.8951	21.5930
270006	0.8901	15.1006	*	*	*
270007	1.0065	15.5781	*	*	*
270009	0.9567	20.7031	21.5655	*	*
270011	1.0259	21.8086	21.4031	22.0747	21.7620
270012	1.5174	20.7913	21.7634	23.3814	21.9663
270014	1.8947	20.4321	20.3456	25.1005	21.8515
270016	***	17.9985	*	*	*
270017	1.2879	22.1046	23.2320	24.6217	23.3322
270019	***	18.5112	*	*	*
270021	0.9956	18.0515	21.1624	21.6686	20.2168
270023	1.5341	22.7162	23.7486	25.5229	24.0310
270026	0.7927	20.1673	*	*	*
270027	0.9441	17.2005	*	*	*
270028	***	19.6212	*	*	*
270029	***	18.2097	*	*	*
270032	1.0683	19.3937	20.1801	18.2309	19.2829
270033	***	20.7060	*	*	*
270035	***	17.9822	*	*	*
270036	0.8683	16.1030	18.8785	21.5168	18.9065
270039	***	20.3801	*	*	*
270040	1.1558	20.1887	20.7240	*	*
270044	***	19.2939	*	*	*
270048	1.0311	17.4506	*	*	*
270049	1.6949	22.0263	22.9524	24.6477	23.2702
270050	1.0503	19.6317	21.0901	22.4320	21.0292
270051	1.5439	20.0386	22.2580	26.4186	22.8859
270052	***	17.1933	*	*	*
270057	1.2891	20.1507	21.9997	22.6131	21.6461
270058	***	18.4781	*	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
270059	***	16.9302	*	*	*
270060	0.9372	21.3776	*	*	*
270063	1.0420	16.4554	*	*	*
270073	1.1432	16.6082	*	*	*
270074	0.8857	*	*	*	*
270075	0.8915	*	*	*	*
270079	0.9262	19.5493	*	21.4785	*
270080	***	16.6010	*	*	*
270081	0.9484	18.0544	15.6833	17.2622	17.0322
270082	0.9988	23.3209	21.0150	19.5905	21.5317
270083	***	16.8421	*	*	*
270084	1.0522	15.7062	19.6104	22.6550	19.2295
270086	1.2079	*	*	*	*
280001	***	18.7137	*	*	*
280003	1.9136	23.6058	26.0937	27.2862	25.9547
280005	***	22.8981	23.9753	*	*
280009	1.8747	23.2300	23.8046	25.3018	24.1110
280010	***	22.0137	23.8325	22.6516	22.8505
280011	***	16.2281	*	*	*
280013	1.7716	24.0852	23.4920	24.5177	24.0414
280014	***	16.7109	*	*	*
280015	1.1211	18.0207	*	*	*
280017	***	16.9884	*	*	*
280018	***	16.6439	*	*	*
280020	2.0304	21.9587	23.4577	25.7330	23.8294
280021	1.0641	19.1263	21.5215	22.2723	20.9790
280022	***	15.3785	*	*	*
280023	1.4182	21.5761	19.6265	22.7214	21.3405
280024	***	15.8747	*	*	*
280025	***	22.2213	*	*	*
280026	***	18.7258	*	*	*
280028	***	19.1080	*	*	*
280029	***	17.1350	*	*	*
280030	1.8385	26.3542	29.2221	32.5881	29.4502
280031	***	9.6951	*	*	*
280032	1.3371	20.5246	21.5150	22.6450	21.6049
280033	***	17.9841	*	*	*
280035	***	18.6088	*	*	*
280037	***	14.8049	*	*	*

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble of this proposed rule.
*Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.
***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
280038	***	18.9305	*	*	*
280039	***	17.0153	*	*	*
280040	1.6025	21.5426	23.6597	25.2810	23.5430
280041	***	16.6890	*	*	*
280042	***	16.4684	*	*	*
280043	***	16.8186	*	*	*
280045	***	17.7407	*	*	*
280046	***	17.9751	*	*	*
280047	1.1555	21.3143	19.5815	*	*
280048	***	17.9319	*	*	*
280049	***	19.4589	*	*	*
280051	***	19.6206	*	*	*
280052	***	14.9903	*	*	*
280054	1.0885	19.4049	23.1191	22.3509	21.7211
280055	***	14.2046	*	*	*
280056	***	15.6441	*	*	*
280057	0.8173	21.4754	22.5481	23.6612	22.5885
280058	***	22.8105	*	*	*
280060	1.6142	22.4677	23.1128	25.2296	23.6233
280061	1.4131	20.2066	21.2901	23.9045	21.8368
280062	***	16.1708	*	*	*
280064	***	18.2196	*	*	*
280065	1.2744	21.6999	23.8128	27.9857	24.5292
280066	***	12.2224	*	*	*
280068	***	10.5104	*	*	*
280070	***	18.7211	*	*	*
280073	***	18.3495	*	*	*
280074	***	13.6025	*	*	*
280075	0.9362	13.3154	*	*	*
280076	***	16.1940	*	*	*
280077	1.3617	21.1883	22.7244	24.0321	22.6640
280079	***	17.1518	*	*	*
280080	***	16.1902	*	*	*
280081	1.7319	23.3805	24.3199	25.1845	24.3073
280082	***	15.4420	*	*	*
280083	***	20.8995	*	*	*
280084	***	13.2158	*	*	*
280085	***	20.8532	21.8473	*	*
280089	***	19.9004	*	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
280091	***	16.3456	*	*	*
280092	***	13.3032	*	*	*
280094	***	16.9179	*	*	*
280097	***	14.1870	*	*	*
280098	***	12.4995	*	*	*
280101	***	10.5153	*	*	*
280104	***	15.5949	*	*	*
280105	1.3264	23.7103	25.1401	25.0454	24.6743
280106	***	16.3564	*	*	*
280108	1.0474	18.5135	20.9016	22.5129	20.6067
280110	***	13.0279	*	*	*
280111	1.2168	19.7688	20.7398	22.1307	20.9188
280114	***	17.1155	*	*	*
280115	***	18.3465	*	*	*
280117	1.0482	20.3820	20.5464	22.0275	21.0060
280118	0.9412	17.8892	19.3466	*	*
280119	0.8182	*	*	*	*
280123	0.9634	23.6682	24.3539	27.1659	25.0566
280125	1.4670	17.2718	20.0643	21.8328	19.6610
280126	***	*	33.8918	*	*
280127	1.7875	*	*	*	*
280128	2.9793	*	*	*	*
290001	1.7080	24.3681	25.9590	27.3070	25.9815
290002	0.9020	16.7948	16.8363	16.9227	16.8552
290003	1.7352	25.4303	27.4732	27.1161	26.7062
290005	1.3694	22.7804	24.6877	27.1501	24.9511
290006	1.2060	22.4832	24.2211	26.3653	24.4745
290007	1.5472	34.9911	35.1020	35.4336	35.1866
290008	1.0991	26.9216	27.0115	26.3939	26.7789
290009	1.8891	24.8816	26.9020	27.5987	26.5267
290010	1.1004	20.8387	25.4598	23.8733	23.4339
290011	***	19.7409	*	*	*
290012	1.3165	25.5647	25.8036	27.2556	26.1708
290013	***	20.2915	*	*	*
290014	***	20.2762	*	*	*
290015	***	20.2335	*	*	*
290016	1.0164	21.8030	22.5111	25.1728	23.2082
290019	1.4022	22.5584	25.1684	27.2406	25.0243
290020	0.9415	19.5038	24.2373	21.3099	21.5240

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
290021	1.7738	24.1396	26.2510	28.3852	26.2453
290022	1.5997	25.3914	27.5364	29.8518	27.5516
290027	0.9739	13.1462	13.5031	17.7335	14.5440
290029	1.0420	*	*	*	*
290032	1.3923	26.9846	27.5425	29.4206	28.0310
290038	***	26.0836	*	*	*
290039	1.5112	26.6283	28.7599	29.7036	28.5485
290041	1.3263	27.7740	28.6294	30.1283	28.9808
290042	0.8932	18.7669	*	*	*
290044	0.9108	*	*	*	*
290045	1.5312	*	26.5644	26.9512	*
300001	1.5532	25.7142	27.1312	29.4038	27.4942
300003	2.0765	25.3252	26.7859	27.7984	26.6898
300005	1.4094	22.3258	22.8163	25.1659	23.4641
300006	1.1100	22.2642	22.0187	20.6843	21.6257
300007	1.2724	21.3633	23.6919	25.3027	23.5164
300008	***	20.9207	*	*	*
300009	1.1468	20.1486	*	*	*
300010	1.1387	21.0316	24.6295	26.9112	24.1816
300011	1.3299	23.8390	25.0979	27.3336	25.4689
300012	1.4086	25.8581	26.3914	28.3935	27.0249
300013	1.0736	20.0269	21.3397	23.1301	21.3797
300014	1.2056	21.6705	23.7144	25.5105	23.7433
300015	1.1613	22.8966	24.4869	24.0618	23.8264
300016	1.3050	15.1310	18.9756	24.5498	19.6714
300017	1.3728	23.9651	26.1104	28.3927	26.2971
300018	1.3909	22.8379	25.7851	28.0272	25.7116
300019	1.2520	20.5801	23.8076	23.4538	22.6307
300020	1.2076	23.0806	24.8189	26.8075	24.9911
300021	***	20.2585	*	*	*
300022	1.1234	20.1209	22.3918	23.5899	22.1255
300023	1.4005	22.1896	24.9992	25.4805	24.2751
300024	1.2270	22.2235	22.4883	23.8663	22.8510
300028	***	21.4207	*	*	*
300029	1.8574	23.8415	24.5772	26.9497	25.2564
300033	***	17.4836	*	*	*
300034	2.1212	25.2355	26.9093	28.5370	26.9063
310001	1.7399	31.1568	30.1786	33.9158	31.7862
310002	1.8612	28.7786	33.9058	35.4210	32.8034

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
310003	1.2273	29.3522	30.4234	31.0957	30.3252
310005	1.3412	23.9477	26.0227	27.5608	25.8762
310006	1.2079	24.1538	25.9000	27.0144	25.6711
310008	1.2942	26.4989	28.0970	29.5844	28.0434
310009	1.2740	23.2420	24.6353	29.7691	25.9668
310010	1.2575	24.5471	26.7889	25.3107	25.5655
310011	1.2465	25.4900	26.1586	28.5014	26.7316
310012	1.7084	28.1367	31.1705	33.1483	30.8448
310013	1.3070	23.2424	25.0951	28.5080	25.6684
310014	1.7018	31.0834	29.1931	32.7133	31.0129
310015	1.9127	29.1340	30.1767	32.5044	30.6184
310016	1.2733	26.0738	25.7368	28.9563	26.9537
310017	1.2832	25.1634	25.2636	28.0855	26.1895
310018	1.1931	24.1428	25.9108	26.9413	25.6855
310019	1.5693	28.5952	26.8663	31.0465	28.8059
310020	1.4192	25.0803	25.0147	29.3232	26.3977
310021	1.6795	27.8958	29.4003	29.6206	28.9563
310022	1.2264	23.3412	26.7487	26.1553	25.4326
310024	1.3854	27.0459	26.9499	27.5166	27.1525
310025	1.1942	25.5227	26.8719	27.7873	26.7064
310026	1.2387	23.2895	24.6697	25.2942	24.3708
310027	1.3221	24.4437	22.1935	27.0913	24.4064
310028	1.2111	26.1931	25.7246	29.0766	27.0192
310029	1.9116	24.4290	25.9606	29.1195	26.5022
310031	2.9784	26.7174	29.5581	30.1987	28.8181
310032	1.2935	24.9133	25.7088	27.8777	26.3280
310034	1.3292	24.8567	26.5224	27.8425	26.3584
310036	***	23.0320	*	*	*
310037	1.3737	28.7738	30.1264	32.1252	30.3714
310038	2.0255	28.1756	32.3865	32.2007	30.9549
310039	1.2559	23.6604	24.6045	27.1066	25.2006
310040	1.2799	26.5769	27.4041	28.6980	27.6154
310041	1.2709	23.8857	26.8145	29.7146	26.9275
310042	1.1854	24.9702	26.9695	29.0207	26.9949
310043	***	24.0238	*	*	*
310044	1.3138	23.1489	25.1618	27.7716	25.4029
310045	1.5721	29.4877	31.7376	32.6137	31.3312
310047	1.3360	25.9777	26.1353	28.3218	26.8443
310048	1.2862	23.4189	27.4050	28.4357	26.4067

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
310049	***	25.6733	26.5332	34.2018	26.5715
310050	1.3126	23.7735	25.3772	27.2298	25.4620
310051	1.3741	28.6248	29.2386	32.0084	29.9773
310052	1.3078	24.9773	27.0324	28.1476	26.6602
310054	1.3064	27.6290	28.1880	30.6686	28.8549
310057	1.3251	22.2630	26.3903	26.4605	25.1234
310058	1.1027	25.3983	28.1753	26.4058	26.6758
310060	1.3037	21.4455	22.1914	23.2119	22.2629
310061	1.2205	23.4283	24.9678	27.4974	25.2356
310063	1.4387	21.2618	25.9868	28.3401	24.9249
310064	1.5138	25.9350	27.8388	28.5924	27.5121
310067	0.8041	24.1943	26.3624	26.8068	25.5496
310069	1.2975	25.3464	25.7690	27.9477	26.3266
310070	1.4018	29.5101	30.1917	32.1636	30.6585
310072	***	24.4480	25.3145	26.3520	25.4066
310073	1.8248	26.7954	28.8791	29.6458	28.4509
310074	1.3734	24.2009	27.6789	28.4302	26.8002
310075	1.2819	23.9771	25.7726	26.1633	25.2968
310076	1.6291	29.6667	32.4533	34.9297	32.3570
310077	1.6795	26.7092	28.7352	30.7396	28.7711
310078	1.3080	24.5862	24.7753	26.9255	25.4292
310081	1.2575	23.3310	24.6083	26.4217	24.8132
310083	1.2705	25.0191	25.2465	24.7003	24.9907
310084	1.2148	25.4946	27.3680	29.9337	27.6687
310086	1.2458	23.4966	25.2751	27.3534	25.3981
310087	***	20.6847	*	*	*
310088	1.1934	23.0610	23.7846	25.4624	24.0882
310090	1.2917	23.6661	25.3640	27.1603	25.4143
310091	1.2459	24.5357	25.6405	27.0895	25.7543
310092	1.4307	22.9721	23.2226	25.7046	23.9315
310093	1.1885	23.9404	24.6942	25.8779	24.8108
310096	2.1817	26.6588	28.4705	30.3214	28.4648
310105	1.1877	28.1317	28.7333	30.9859	29.2954
310108	1.3890	25.1368	24.9090	29.1466	26.3853
310110	1.3057	23.3461	26.4175	27.8631	26.0722
310111	1.2076	23.3646	26.2496	28.8606	26.1980
310112	1.2408	24.2999	27.8796	28.9841	27.1321
310113	1.2467	24.2708	25.9143	27.2414	25.8703
310115	1.1802	23.5148	24.5413	26.2671	24.8187

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***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
310116	1.2399	24.2696	25.1189	26.6143	25.2804
310118	1.3862	26.8760	28.0517	28.1185	27.6741
310119	1.8338	29.1045	34.7468	35.6607	33.0083
310120	1.1112	22.6526	24.7078	27.1702	24.6745
320001	1.5369	21.5564	23.0290	26.3404	23.6504
320002	1.4278	25.5144	26.7332	28.6906	27.0247
320003	1.1549	16.4961	20.7939	22.3899	19.8180
320004	1.3954	21.3681	19.4799	24.0435	21.7853
320005	1.3845	22.4178	22.1677	21.2164	21.8840
320006	1.3433	19.8672	21.1222	22.5526	21.1706
320009	1.5208	20.3783	21.5870	24.4246	22.0789
320011	1.1658	19.1476	20.7714	23.1360	20.9982
320012	***	17.1317	*	*	*
320013	1.2073	25.5403	19.4487	27.8329	23.6380
320014	1.0865	22.9026	19.7656	26.7207	22.9187
320016	1.1191	18.8763	19.9326	21.6286	20.2007
320017	1.2757	20.4390	22.5460	23.5111	22.2068
320018	1.5545	20.3141	21.4650	23.0910	21.6543
320019	1.4206	25.1210	26.6900	31.2050	27.8129
320021	1.6530	20.0089	21.0913	24.4779	21.6970
320022	1.1402	20.9797	20.7919	22.1299	21.3089
320030	1.0381	18.1556	16.8696	18.0990	17.7109
320031	***	18.2244	*	*	*
320032	***	21.4815	*	*	*
320033	1.1736	21.9804	24.2703	24.1155	23.5040
320035	***	17.8059	*	*	*
320037	1.2146	17.6724	19.6466	21.6080	19.6916
320038	1.2376	23.1987	19.2962	21.2181	21.2842
320046	1.1239	19.4732	21.5915	22.8588	21.2985
320057	0.9655	*	*	*	*
320058	0.7992	*	*	*	*
320059	1.0041	*	*	*	*
320060	0.9322	*	*	*	*
320061	1.1752	*	*	*	*
320062	0.7951	*	*	*	*
320063	1.2931	18.5600	20.7804	20.7567	19.9876
320065	1.1536	22.5428	19.9012	21.2937	21.1161
320067	0.8945	16.8015	13.9459	20.1841	17.0467
320068	***	15.6864	*	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
320069	1.1001	15.7349	18.5375	19.7296	18.0124
320070	0.9695	*	*	*	*
320074	0.9881	22.3403	28.3086	35.5864	28.6477
320079	1.0475	20.2473	21.9090	23.8116	22.0042
320083	2.4524	*	20.6771	*	*
320084	1.0693	*	*	*	*
320085	1.5769	*	*	*	*
330001	1.2192	28.6213	30.8509	31.1091	30.2228
330002	1.5630	27.1811	28.0882	29.2923	28.1668
330003	1.2788	19.3972	20.2744	21.6485	20.4222
330004	1.1921	22.5082	24.3703	24.0015	23.6297
330005	1.5906	22.6137	24.3578	25.9071	24.2492
330006	1.3553	26.2970	28.3904	29.7391	28.0758
330008	1.1429	19.6770	20.6816	21.3201	20.5677
330009	1.2715	30.9087	33.3605	35.8195	33.3036
330010	***	17.8935	19.8211	17.9386	18.5289
330011	1.3306	18.7995	19.8035	20.3591	19.6542
330013	2.1318	19.0995	21.2063	23.8689	21.3500
330014	1.2909	32.4496	32.0824	35.3924	33.3225
330016	0.9882	18.7194	18.1603	18.9314	18.6060
330019	1.3431	31.5927	31.9042	32.3137	31.9510
330020	***	16.6952	*	*	*
330023	1.5351	26.6997	29.4538	29.2340	28.5297
330024	1.6839	35.7485	35.3598	36.5526	35.8801
330025	1.0691	17.6169	18.7663	19.7582	18.7404
330027	1.3988	35.1046	34.1281	35.0894	34.7722
330028	1.3808	31.7699	31.8452	30.0728	31.2289
330029	0.6848	19.4377	18.4354	18.6623	18.8626
330030	1.3991	18.0866	22.0574	22.4309	21.1320
330033	1.1694	19.5836	18.6316	21.3898	19.8592
330034	***	38.2451	*	*	*
330036	1.1562	25.5888	27.0970	27.6339	26.7553
330037	1.0830	18.3260	18.3557	19.6357	18.7772
330038	***	16.2997	*	*	*
330041	1.1994	29.5305	34.5461	36.2290	33.2272
330043	1.3362	28.9622	31.7873	34.0813	31.5974
330044	1.2560	19.9807	22.0465	23.1386	21.9861
330045	1.3233	28.5267	30.9046	34.4813	31.3467
330046	1.4348	38.1184	41.6759	42.0549	40.5850

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble of this proposed rule.
*Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.
***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
330047	1.2464	19.5561	20.1646	21.1304	20.2933
330048	***	19.6129	*	*	*
330049	1.2954	22.1523	24.7766	25.6976	24.1396
330053	1.1228	17.9161	18.1728	19.6682	18.5819
330055	1.6049	34.2159	34.9709	34.3686	34.5213
330056	1.5145	29.8377	32.0982	32.9018	31.5619
330057	1.6946	20.0995	20.9282	22.6437	21.2734
330058	1.2797	18.1008	19.2916	19.5441	18.9794
330059	1.5745	35.0121	36.4176	38.0909	36.5140
330061	1.2292	26.8580	28.6725	32.7395	29.4500
330062	1.0993	18.4662	20.0222	21.0505	19.7157
330064	1.1766	35.1422	36.0976	39.3201	36.8762
330065	1.2148	20.1615	20.5958	21.9090	20.8896
330066	1.3168	19.3644	20.9990	23.0879	21.1802
330067	1.3670	23.6836	24.8927	34.8585	26.9037
330072	1.4225	30.3737	32.9665	32.7734	32.0092
330073	1.1437	16.5166	18.4162	19.0764	18.2211
330074	1.2714	18.9326	21.7299	20.2892	20.2932
330075	1.1605	19.2938	19.9781	22.0131	20.4360
330078	1.4768	18.0362	20.8379	22.7727	20.5277
330079	1.2918	18.9398	21.1153	22.0979	20.7058
330080	1.2200	34.6880	33.5537	36.1219	34.7950
330084	1.1205	19.0262	19.2135	22.6485	20.2775
330085	1.1656	20.9332	21.8271	23.1920	21.9973
330086	1.2500	26.2979	27.1585	28.8944	27.4184
330088	1.0173	26.7583	29.5181	31.2536	29.1933
330090	1.3957	20.1344	20.9327	22.7670	21.3012
330091	1.3800	21.6004	22.9396	22.5659	22.3537
330092	***	17.2083	*	*	*
330094	1.3404	18.8941	21.3659	21.9542	20.7004
330095	***	21.1809	28.9794	28.9914	24.2022
330096	1.0998	20.0370	21.1648	22.4777	21.2694
330097	1.1453	16.1946	18.6291	19.2223	17.9353
330100	1.0418	28.9956	31.5775	32.8754	31.1384
330101	1.8255	35.3618	38.4810	39.1766	37.6158
330102	1.3750	21.0057	23.5254	23.6063	22.6517
330103	1.1076	17.3511	17.9017	18.8969	18.0512
330104	1.3473	31.9746	36.8451	33.7542	34.2516
330106	1.7337	36.2526	38.7822	39.8344	38.2978

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble of this proposed rule.
*Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.
***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
330107	1.2294	28.9225	29.1958	31.8393	29.9557
330108	1.1567	18.5849	20.2536	21.4851	20.0856
330111	1.0214	13.3352	17.7020	17.6256	16.0065
330114	***	19.1163	19.2566	*	*
330115	1.1677	18.5911	18.5544	20.4994	19.2426
330116	***	16.8567	*	*	*
330119	1.7698	33.5653	34.6591	36.5770	34.9429
330121	0.8869	17.1869	17.9757	19.8011	18.3119
330122	***	23.0384	25.6500	26.3849	25.0295
330125	1.7758	20.5922	22.8078	24.6929	22.6732
330126	1.3073	25.1175	27.7155	29.4059	27.4539
330127	1.3036	40.0112	42.2836	43.6516	42.0097
330128	1.2765	34.3468	32.7050	34.5175	33.8539
330132	1.0669	14.8704	16.0311	16.3216	15.7581
330133	1.3452	37.5191	35.3136	44.0439	38.5716
330135	1.2476	23.5662	25.6504	26.9726	25.3807
330136	1.4716	20.4124	21.4225	22.5581	21.4768
330140	1.8395	21.1841	21.1787	23.5567	21.9686
330141	1.3455	27.5960	29.3283	30.6353	29.2252
330144	0.9858	17.1513	17.3920	20.1743	18.1401
330148	1.0134	16.7251	17.6560	18.5375	17.5822
330151	1.1158	15.2233	16.4028	17.5141	16.3624
330152	1.3454	33.5587	32.3332	32.0633	32.6481
330153	1.7812	19.4417	21.2843	21.9699	20.8552
330154	1.7779	*	*	*	*
330157	1.3659	23.1743	23.5522	23.6776	23.4628
330158	1.5756	29.3163	32.7159	33.0064	31.6475
330159	1.3365	20.2753	22.5580	24.1929	22.2885
330160	1.5729	30.7893	32.1266	34.0318	32.2882
330162	1.3019	27.9705	29.6042	31.3787	29.6800
330163	1.2267	21.4143	21.1517	22.4711	21.6535
330164	1.3631	22.0699	23.5427	24.4156	23.4150
330166	1.0972	17.0637	18.4262	18.8744	18.1232
330167	1.7619	32.0541	30.9667	33.7168	32.2975
330169	1.4323	36.3690	36.2725	38.3457	36.9751
330171	1.1144	25.1567	25.9946	27.7964	26.2524
330175	1.1598	18.8701	20.4628	21.1346	20.1428
330177	0.9280	16.6059	19.0005	20.0496	18.5542
330179	***	16.0113	*	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
330180	1.2782	19.2670	19.8951	21.9585	20.3504
330181	1.3957	34.6065	37.1218	35.8817	35.8734
330182	2.3636	33.3363	35.2416	36.3706	35.0333
330183	***	20.3520	*	*	*
330184	1.4159	28.4726	30.7479	33.2871	30.7477
330185	1.2879	27.8894	28.9787	30.9876	29.3799
330188	1.2262	20.2849	21.1196	22.6756	21.4074
330189	1.0849	23.5589	19.0726	19.2437	20.4111
330191	1.2996	19.5623	20.9392	22.3680	20.9769
330193	1.2748	32.5496	36.2427	36.9620	35.2720
330194	1.8390	35.6486	38.5372	39.9110	38.0904
330195	1.6672	34.4689	36.4249	38.6734	36.4181
330196	1.3231	28.9488	31.1915	31.8566	30.6608
330197	1.0756	19.2237	20.8386	22.3117	20.8064
330198	1.3735	25.6668	25.3622	29.1533	26.7566
330199	1.1012	28.0374	34.1354	32.7977	31.5421
330201	1.7611	30.0524	29.3745	33.2737	30.8484
330202	1.2861	35.4943	30.7990	34.3684	33.6811
330203	1.4554	25.9211	24.7422	26.2315	25.6037
330204	1.3130	31.1366	30.3699	30.3317	30.6085
330205	1.2529	24.9040	29.0622	29.9742	27.9796
330208	1.2096	27.3170	30.6158	28.2644	28.6880
330209	1.1641	27.0257	27.7071	28.6988	27.8224
330211	1.0936	20.0006	20.8224	21.1084	20.6572
330212	1.3741	24.8554	24.9434	27.0585	25.3302
330213	1.0764	20.1166	20.7967	21.7150	20.8869
330214	1.8990	32.3130	32.7647	33.7253	32.9484
330215	1.2836	19.0726	19.9226	20.6361	19.8745
330218	1.1072	21.4747	20.6012	21.4002	21.1598
330219	1.5889	25.1792	28.7448	27.6888	27.1738
330221	1.3237	32.5044	34.9345	34.6848	34.0453
330222	1.2773	19.3148	23.5491	25.9701	22.9124
330223	1.0445	19.1604	18.8253	18.4185	18.7918
330224	1.2897	20.5881	22.7847	23.9370	22.4032
330225	1.2002	28.0523	29.1744	29.2081	28.7972
330226	1.3628	21.6368	23.5405	23.4720	23.0348
330229	1.1746	18.2554	18.5590	19.5654	18.7988
330230	0.9637	30.6937	32.5997	32.1006	31.7892
330231	1.0954	32.4164	30.2184	33.9449	32.2344

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
330232	1.2473	20.0924	21.1277	21.4682	20.9217
330233	1.4588	43.1186	39.5133	41.9873	41.5572
330234	2.3146	35.8327	37.7135	36.8942	36.8000
330235	1.1465	20.1255	21.4643	22.0797	21.2189
330236	1.3892	32.1246	31.8491	32.6891	32.2254
330238	1.1812	17.8867	18.3846	19.2375	18.5483
330239	1.2249	18.9953	19.7561	20.4919	19.7486
330240	1.2405	35.6576	37.3866	40.5848	37.8168
330241	1.9233	24.7545	26.7598	27.7143	26.4586
330242	1.3095	28.3561	30.5172	32.2100	30.3494
330245	1.8532	20.7605	20.2037	21.6998	20.9113
330246	1.3687	29.8777	31.8857	31.6651	31.1487
330247	1.1466	32.5858	25.6063	32.1805	30.2145
330249	1.1966	17.6846	19.1469	21.4345	19.4505
330250	1.2803	20.8742	22.1272	23.0563	22.0651
330254	***	15.7864	*	*	*
330258	***	32.6745	*	*	*
330259	1.4789	26.3620	27.4131	30.0380	27.9466
330261	1.2643	30.0489	30.4771	30.9326	30.5034
330263	1.0075	19.5057	20.0831	20.8421	20.1529
330264	1.1446	24.9713	26.3652	28.1281	26.4692
330265	1.2729	21.1215	18.2547	19.9434	19.7500
330267	1.4062	27.8255	29.0499	30.3600	29.1135
330268	0.9582	16.8358	18.7991	18.9086	18.2266
330270	2.0669	33.0375	36.5976	38.2613	36.0499
330273	1.2984	27.0454	28.8548	29.5064	28.4598
330276	1.1254	19.6572	20.7973	21.7878	20.7588
330277	1.1264	20.7851	21.8866	25.1306	22.6176
330279	1.4003	21.7827	23.8793	23.4751	23.0772
330285	1.9076	24.5388	26.0446	27.1230	25.9576
330286	1.3842	28.0995	31.1344	32.3086	30.5672
330290	1.6884	34.3439	35.5617	36.3494	35.4190
330293	***	17.3180	17.6506	19.0290	18.0111
330304	1.2954	29.2207	31.1146	33.4314	31.2920
330306	1.4680	29.6641	30.4426	30.7691	30.3010
330307	1.2575	23.2838	23.8583	25.7515	24.3335
330314	1.1741	25.5405	26.2954	26.0545	25.9625
330316	1.2858	27.9277	33.7857	33.1454	31.5955
330327	***	20.1705	19.3465	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
330331	1.2404	32.3249	34.6302	34.6752	33.8656
330332	1.1937	27.6954	30.5104	31.8157	30.2426
330333	0.9896	28.8819	29.7725	33.7637	30.4380
330336	***	27.9163	32.9548	*	*
330338	1.2966	23.6142	25.4319	27.3859	25.4439
330339	0.9863	20.2382	20.8424	22.2696	21.1344
330340	1.1996	28.2732	29.8140	31.4275	29.8406
330350	1.4754	33.5493	35.5656	39.2811	36.2198
330353	1.2154	34.2260	35.6821	38.6602	36.2568
330354	1.9377	*	*	*	*
330357	1.3546	36.8598	36.5461	34.3854	35.8559
330372	1.2942	23.5381	28.2490	30.1479	27.2480
330385	1.0948	37.5523	44.3387	42.6512	41.4701
330386	1.1967	21.4363	25.2064	25.9275	24.2207
330389	1.9329	33.1192	32.2112	34.7410	33.3781
330390	1.1551	31.7344	32.7450	33.2817	32.5568
330393	1.6665	31.9272	33.0953	34.8339	33.3334
330394	1.6139	19.6892	21.3678	23.3422	21.4820
330395	1.3699	33.2318	32.1089	35.4602	33.4104
330396	1.3023	32.8517	31.2429	32.5472	32.2204
330397	1.3600	34.6435	40.0884	34.4840	36.2318
330399	1.1566	32.7149	32.1248	33.6692	32.8657
330400	***	16.8168	*	*	*
330401	1.2282	*	33.8633	35.7115	*
330402	0.8005	*	*	16.5587	*
330403	0.8414	*	*	*	*
340001	1.5015	22.0257	21.6113	23.2379	22.3123
340002	1.6836	22.9425	24.0145	25.0591	24.0402
340003	1.1240	19.6545	20.8205	21.4589	20.6698
340004	1.4400	23.0890	23.3756	24.1984	23.5828
340005	1.0395	16.6909	20.8150	22.9751	19.8752
340006	***	16.1378	*	*	*
340007	0.5551	18.3760	19.5208	21.1519	19.6545
340008	1.1038	22.6570	22.7338	24.1997	23.1997
340009	***	20.6154	*	*	*
340010	1.3397	20.6547	21.3024	23.1243	21.6987
340011	1.0481	17.4534	18.1926	18.1768	17.9545
340012	1.2403	19.3651	19.6350	21.7841	20.2748
340013	1.2342	21.5130	21.0066	22.4735	21.6578

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***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
340014	1.5841	21.9804	22.6757	24.4580	23.0700
340015	1.3512	20.3493	24.3410	24.3825	22.9707
340016	1.1851	19.4160	20.2859	22.7559	20.8327
340017	1.2637	20.6263	21.7083	22.8798	21.7803
340018	1.1188	16.4611	17.3480	20.3714	18.0695
340019	0.9997	15.9037	16.7901	17.8874	16.8633
340020	1.1590	19.2392	21.3385	24.1708	21.6581
340021	1.2674	22.0220	22.9208	23.1575	22.7229
340022	1.0225	20.6484	19.9078	*	*
340023	1.3646	19.9023	22.3590	23.2170	21.8621
340024	1.1586	19.1430	20.4906	21.2972	20.3235
340025	1.2657	19.1770	20.2864	20.9687	20.1527
340027	1.1573	19.4907	21.0975	22.5985	21.0054
340028	1.5531	20.6496	22.2028	24.6779	22.5084
340030	2.0465	23.9505	26.7753	27.2566	25.9937
340031	***	15.4935	*	*	*
340032	1.4543	22.0245	23.2204	24.7393	23.3876
340035	0.9995	18.5883	16.4821	21.2313	18.5565
340036	1.1522	18.4203	20.8313	22.1934	20.6291
340037	1.0468	18.3655	21.9524	22.4800	21.0666
340038	1.2065	20.3091	13.9936	13.9917	15.4378
340039	1.2284	22.4020	24.8246	25.6544	24.3305
340040	1.8892	21.1397	22.4777	24.1414	22.5921
340041	1.1969	16.3200	17.6319	23.0186	18.8357
340042	1.1156	19.1386	21.1107	22.1036	20.7500
340044	0.9394	18.9562	18.2154	21.7166	19.4498
340045	1.0180	20.2642	17.4066	*	*
340047	1.9490	21.5178	22.5199	25.3590	23.1918
340049	1.9648	17.2986	21.2734	22.2833	20.5028
340050	1.0463	20.6831	20.3262	21.4466	20.8320
340051	1.2263	19.0282	20.3057	21.9008	20.4720
340052	***	26.2243	*	*	*
340053	1.5639	23.2410	24.9768	26.9290	25.0102
340054	***	16.6208	*	*	*
340055	1.1566	20.8254	23.2990	23.9532	22.7328
340060	1.0454	20.8570	20.8077	22.4228	21.3695
340061	1.8311	23.7173	25.1081	26.6965	25.1968
340063	***	26.4131	*	*	*
340064	1.0980	17.6106	19.4523	22.3523	19.7509

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**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.
***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
340065	1.2501	23.2605	20.3296	20.7757	21.2674
340067	***	22.4054	22.2565	*	*
340068	1.1677	18.8758	19.4487	20.8495	19.7346
340069	1.8652	22.5995	24.4650	27.5128	24.9527
340070	1.2789	21.3511	22.2605	23.3479	22.3446
340071	1.1148	19.3679	19.9561	22.1812	20.5330
340072	1.1441	18.7920	19.2773	21.2882	19.7593
340073	1.3583	24.0794	26.6829	29.4060	26.8776
340075	1.2290	19.7450	23.2904	24.1111	22.3997
340084	1.1115	19.6087	20.8175	21.2699	20.5657
340085	1.1637	20.3684	21.7112	23.0769	21.7406
340087	1.1837	20.2445	17.8215	18.4157	18.8412
340088	1.3306	22.6462	22.8687	24.2998	23.2567
340089	***	16.1321	*	*	*
340090	1.1640	18.7701	20.3261	21.7172	20.3118
340091	1.5167	21.2665	23.1430	24.9197	23.1373
340093	***	16.5452	*	*	*
340094	***	21.0091	*	*	*
340096	1.2570	20.9686	22.1174	23.6285	22.2283
340097	1.1350	20.0302	20.8690	22.5479	21.1915
340098	1.5211	23.4949	24.2262	25.5135	24.4538
340099	1.2275	16.9979	17.5114	20.0185	18.2220
340101	***	20.7841	*	*	*
340104	0.9366	12.1845	12.9949	14.1582	13.1527
340106	1.0941	19.1147	20.1076	22.6817	20.7304
340107	1.2591	20.7601	21.0960	22.5430	21.4835
340109	1.2434	19.3357	20.4341	22.3823	20.7534
340111	***	17.2127	*	*	*
340112	1.1575	16.9592	*	*	*
340113	1.8737	24.4222	25.0729	26.0420	25.2029
340114	1.5472	21.7750	19.9142	25.4401	22.2517
340115	1.5439	24.7924	23.8284	25.1872	24.5993
340116	1.6484	21.6744	23.9643	26.1231	23.9799
340119	1.1662	20.5394	21.2239	22.4830	21.4450
340120	1.0826	16.9847	19.9860	21.8453	19.6470
340121	1.0264	19.0420	19.9409	20.3623	19.8058
340123	1.1734	21.5041	22.3711	23.1811	22.4153
340124	1.0798	17.5411	17.5691	18.3830	17.8282
340126	1.2423	21.2045	21.4271	23.5337	22.0668

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble of this proposed rule.
*Denotes wage data not available for the provider for that year.
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***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
340127	1.1333	21.4797	22.9672	24.2767	22.9934
340129	1.2685	21.0773	22.3260	24.1345	22.7247
340130	1.3670	20.5851	22.7687	23.0899	22.1946
340131	1.4551	23.2478	24.1370	25.2817	24.2547
340132	1.2067	17.7110	17.8771	20.4154	18.6787
340133	1.0005	17.5170	23.1444	22.1430	20.7557
340137	1.0467	39.9826	33.1751	29.9309	33.7661
340138	0.8754	*	29.5286	27.4265	*
340141	1.5910	23.2961	24.2033	24.8075	24.1634
340142	1.1894	18.1824	20.4320	22.1062	20.2921
340143	1.4526	21.9304	23.0416	24.8562	23.2046
340144	1.2454	22.8634	25.4598	25.6536	24.6619
340145	1.3465	21.5958	21.8120	23.6738	22.3382
340146	1.0581	19.1306	20.7252	18.8354	19.5242
340147	1.2324	21.5912	22.6057	23.9854	22.7348
340148	1.3447	20.6790	20.8156	22.4198	21.3542
340151	1.1859	19.0779	19.2593	22.2153	20.1433
340153	1.8743	21.7375	23.7426	25.7077	23.6657
340155	1.4154	25.0965	26.3663	28.8572	26.7431
340156	0.8303	*	*	*	*
340158	1.0774	20.0921	21.7489	23.4733	21.9065
340159	1.1203	19.4992	21.2983	22.1826	21.0123
340160	1.2684	17.1963	18.7569	19.1294	18.4030
340166	1.3444	22.0519	22.8349	25.7514	23.6472
340168	0.5170	15.4249	16.8278	16.7791	16.3472
340171	1.1581	22.7304	25.9603	27.2194	25.4072
340173	1.1924	23.3690	23.7037	26.6199	24.7069
340176	***	*	26.5277	*	*
340177	1.0009	*	*	*	*
340178	2.3968	*	*	*	*
340179	1.7551	*	*	*	*
340180	2.3417	*	*	*	*
340181	1.7104	*	*	*	*
340182	1.3385	*	*	*	*
350001	***	15.6193	*	*	*
350002	1.7338	19.1931	20.4398	20.6401	20.1063
350003	1.1634	20.0664	21.0585	25.3236	21.9726
350004	***	25.1976	28.3773	27.5891	26.8643
350005	***	20.7468	*	*	*

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**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.
***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
350006	1.6241	19.1257	19.7577	19.5822	19.5012
350007	***	13.9966	*	*	*
350008	***	23.4052	*	*	*
350009	1.0912	19.3668	20.2558	20.6956	20.1082
350010	1.0981	16.7774	17.2489	18.5644	17.5049
350011	1.9547	20.6809	21.9111	22.4165	21.6839
350012	***	16.0990	*	*	*
350013	***	17.8145	*	*	*
350014	1.0090	18.6787	16.1718	18.5599	17.8217
350015	1.7546	17.5658	18.5437	18.6459	18.2663
350017	1.4093	18.0840	19.1952	20.1542	19.1508
350018	***	16.3211	*	*	*
350019	1.6880	20.6743	21.3589	24.2279	22.0630
350021	***	16.3394	*	*	*
350023	***	18.3252	*	*	*
350024	***	15.7510	*	*	*
350025	***	14.6098	*	*	*
350027	1.0451	17.5881	17.6731	14.0524	16.0740
350030	0.9887	18.7993	18.8822	19.2137	18.9687
350033	***	16.0903	*	*	*
350035	***	12.6495	*	*	*
350038	***	19.5497	*	*	*
350039	***	14.8599	*	*	*
350041	***	23.1151	*	*	*
350042	***	19.3370	*	*	*
350043	***	17.6722	18.8378	20.9732	19.2355
350044	***	10.9690	*	*	*
350047	***	19.9749	*	*	*
350049	***	16.8321	*	*	*
350050	***	25.2746	*	*	*
350051	***	16.9202	*	*	*
350053	***	16.7455	*	*	*
350055	***	16.1690	*	*	*
350056	***	15.7752	*	*	*
350058	0.9724	16.1013	15.0196	16.7209	15.9862
350060	***	10.5325	*	*	*
350061	1.0122	19.6460	18.8494	18.6563	19.0766
350063	0.8437	*	*	*	*
350064	0.8005	*	*	*	*

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*Denotes wage data not available for the provider for that year.
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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
350070	1.9961	*	*	24.4516	*
360001	1.2742	20.3515	22.2387	23.7783	22.1160
360002	1.1570	19.6145	20.7586	22.6791	21.0304
360003	1.8387	23.2905	24.4144	26.3315	24.6840
360006	2.0805	22.6333	24.0814	25.6953	24.2247
360007	***	15.3656	19.1315	*	*
360008	1.2656	19.8034	21.3795	23.2529	21.5447
360009	1.6072	19.6277	22.4076	23.2560	21.7221
360010	1.2600	20.5934	20.6290	22.0224	21.1170
360011	1.2851	19.5383	21.4293	22.4233	21.0548
360012	1.3956	23.0125	24.3618	25.5784	24.3932
360013	1.1575	22.3407	24.4232	26.0824	24.3438
360014	1.1883	22.9930	22.9372	23.8214	23.2602
360016	1.4501	21.3967	22.8430	24.6625	22.9729
360017	1.8201	22.7446	23.6181	25.5012	24.0997
360018	***	24.6694	29.9085	*	*
360019	1.2331	21.4708	23.3006	24.1132	22.9695
360020	1.6279	21.6607	21.5085	22.3980	21.8631
360024	***	20.9408	22.5356	24.0612	22.4920
360025	1.4130	20.9266	21.6676	23.6489	22.1124
360026	1.2535	18.6739	20.8825	22.3371	20.6505
360027	1.5276	22.8098	23.5907	24.6807	23.7107
360029	1.1267	19.7466	20.4924	20.8548	20.3779
360030	1.3419	19.0551	*	*	*
360031	***	21.0481	24.3482	24.4324	23.1415
360032	1.0940	19.8366	21.1743	22.9395	21.3358
360034	1.0603	19.4981	21.5621	25.0672	22.0656
360035	1.7054	22.6982	24.2433	25.6818	24.2462
360036	1.1859	21.4486	22.3567	25.0879	22.9952
360037	1.4119	23.7504	32.6245	25.1496	26.4347
360038	1.4403	21.4804	23.4855	24.8277	23.3529
360039	1.4602	19.3703	23.4642	22.5861	21.7359
360040	1.1721	19.9750	21.3307	22.8657	21.3883
360041	1.4621	21.9093	22.1352	23.2495	22.4492
360042	***	19.3774	*	*	*
360044	1.1454	17.8417	19.7212	20.4631	19.3231
360045	***	22.8112	*	*	*
360046	1.2016	21.4291	22.8425	23.8636	22.7247
360047	1.0199	15.8279	17.5885	17.1923	16.8929

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
360048	1.7773	25.6259	24.7150	27.2036	25.8483
360049	1.1500	*	22.4939	24.2605	*
360050	***	15.6847	*	*	*
360051	1.5845	21.2225	23.0658	25.1673	23.2090
360052	1.4509	19.8037	22.5005	23.3245	21.9545
360054	1.2298	17.5714	19.2884	20.3016	19.0742
360055	1.4141	22.8755	23.5586	25.1421	23.8561
360056	1.5307	23.4405	22.4475	23.9764	23.2343
360057	***	16.0395	*	*	*
360058	1.1185	19.0439	21.0768	22.9130	20.9635
360059	1.4997	23.2129	23.0775	25.5140	23.9077
360062	1.4679	24.4898	24.5746	26.8060	25.3822
360063	***	20.2671	*	*	*
360064	1.5902	20.7659	21.3424	22.8754	21.7157
360065	1.1290	22.3443	22.9727	24.0631	23.1604
360066	1.5472	24.1295	24.6806	25.2164	24.7018
360067	***	17.3734	*	*	*
360068	1.8432	22.6027	22.1110	23.7852	22.8531
360069	1.1473	18.5382	20.5349	25.6397	21.5059
360070	1.6776	19.4700	21.8228	23.1117	21.4522
360071	1.1959	19.6873	21.4478	21.6152	20.8977
360072	1.3911	20.8819	21.3736	23.0407	21.8032
360074	1.3430	19.9947	22.2368	23.6087	22.0080
360075	1.2395	27.6991	23.8492	24.7570	26.5964
360076	1.3890	21.0402	22.5863	22.5981	22.0947
360077	1.5074	22.2964	23.3686	24.6968	23.4712
360078	1.2280	22.7743	23.3799	24.6706	23.6245
360079	1.8007	23.9491	25.9623	25.8723	25.3107
360080	1.0868	18.0392	18.7213	19.5328	18.7842
360081	1.3186	20.7477	22.1973	25.1287	22.6269
360082	1.3592	22.9390	25.2254	27.4267	25.3364
360084	1.6104	22.1699	23.3257	25.1571	23.6299
360085	2.0333	24.8010	24.6618	27.5734	25.7374
360086	1.4982	20.5858	21.5983	22.2940	21.4722
360087	1.4276	21.1621	23.9638	25.9151	23.6962
360088	***	20.5703	*	*	*
360089	1.1414	19.5261	21.0229	21.0238	20.5480
360090	1.5167	21.2072	22.6236	24.4189	22.7747
360091	1.2686	22.6510	23.5759	26.0178	24.1070

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
360092	1.2019	20.9588	21.9732	23.2006	22.0937
360093	1.0904	21.0134	21.4623	23.8229	22.1098
360094	***	21.1952	22.6440	27.1864	23.2312
360095	1.3050	21.3505	23.6518	23.9950	23.0074
360096	1.1032	20.9838	22.0673	22.2229	21.7647
360098	1.4690	20.8049	22.7644	23.6383	22.4014
360099	0.9935	20.8801	20.8524	*	*
360100	1.2092	19.9768	21.5911	19.0466	20.0849
360101	1.3621	24.1551	26.2875	27.7531	26.2721
360102	1.0708	*	*	*	*
360106	1.0824	18.9779	19.8658	21.6416	20.1682
360107	1.0542	21.9938	23.6880	24.5279	23.4413
360108	***	19.0649	*	*	*
360109	1.0849	17.3565	23.0178	24.3053	21.3894
360112	1.8986	25.7920	25.5910	26.7785	26.0524
360113	1.2179	22.8088	22.3348	23.5154	22.8743
360114	1.0799	19.4212	*	*	*
360115	1.3569	21.0104	22.3926	24.0150	22.5054
360116	1.1443	20.1408	21.3809	23.3961	21.6562
360118	1.5279	21.0235	23.0070	24.2494	22.8092
360121	1.2610	21.9111	23.2515	25.1778	23.4543
360123	1.3542	21.9985	23.1310	24.1662	23.2057
360125	1.2092	21.6675	21.1408	22.6807	21.8317
360126	***	*	22.2409	*	*
360127	***	18.2150	*	*	*
360128	1.0292	17.5556	18.0356	18.5886	18.0872
360129	0.9207	17.2309	17.9151	19.5293	18.2732
360130	1.4423	19.8906	20.1257	21.7115	20.5194
360131	1.2855	20.4123	21.7838	23.1601	21.8013
360132	1.2637	21.0162	23.4179	25.8028	23.4745
360133	1.6741	22.1957	22.0958	23.8970	22.7628
360134	1.6457	21.6081	23.6817	25.2942	23.5585
360136	***	18.5687	*	*	*
360137	1.7468	23.1867	23.8947	25.7593	24.2695
360140	***	18.3463	*	*	*
360141	1.6762	23.5979	25.1442	31.0481	26.6113
360142	0.9547	19.6189	20.6728	21.2031	20.5503
360143	1.2783	20.9158	22.2275	23.8931	22.3916
360144	1.3169	20.9386	24.7973	26.7081	24.2319

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
360145	1.8420	21.2931	22.4813	23.4757	22.4347
360147	1.3295	18.7258	20.0409	22.7060	20.5962
360148	1.0943	20.3120	21.3211	24.4383	21.9951
360150	1.2510	23.1859	24.8485	25.8591	24.6040
360151	1.4367	20.5594	21.7215	22.2082	21.4865
360152	1.4390	20.9704	22.9352	24.9866	22.8590
360153	1.0296	16.1021	17.3367	19.0627	17.4146
360154	0.9928	14.9605	16.2416	17.1251	16.0889
360155	1.4550	22.3347	23.0020	23.9386	23.1260
360156	1.1474	19.9382	21.2853	22.6611	21.3258
360159	1.2800	22.7992	23.3359	25.7205	23.9579
360161	1.3327	19.6266	21.5114	22.6039	21.2852
360163	1.8691	22.1012	23.1500	25.8047	23.6667
360165	***	19.6205	*	*	*
360170	1.1042	19.7980	22.2815	22.9261	21.6941
360172	1.3809	22.3294	22.7104	23.4628	22.8427
360174	1.2317	20.5874	21.7129	22.8115	21.7468
360175	1.1820	22.0274	22.7887	24.6117	23.1819
360176	0.9906	17.6743	*	*	*
360177	1.1905	19.6992	20.8194	23.4115	21.3476
360178	1.1917	18.0773	18.2393	*	*
360179	1.5283	21.3520	23.0678	25.9324	23.3966
360180	2.3358	22.9260	25.1499	26.8604	25.0655
360185	1.1583	20.0848	21.1245	21.8609	21.0479
360186	***	18.1254	*	*	*
360187	1.5736	20.8423	21.9499	23.8278	22.2141
360188	***	16.4330	*	*	*
360189	1.1236	19.0481	20.0275	24.2395	21.0607
360192	1.3033	23.9969	24.9995	26.2913	25.1254
360194	1.1454	19.3901	20.3677	22.3001	20.7097
360195	1.0480	21.2801	23.1897	25.7991	23.5275
360197	1.1042	21.6110	23.1378	24.7361	23.1805
360200	***	19.5866	*	*	*
360203	1.1065	17.9698	19.3642	21.5528	19.6788
360210	1.2272	21.5961	25.0811	26.5695	24.3959
360211	1.5074	22.0011	22.4529	23.0729	22.5303
360212	1.3586	21.0632	22.8041	24.5219	22.7950
360213	***	20.5448	*	*	*
360218	1.1980	20.7709	22.8060	24.4700	22.7100

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
360230	1.5575	21.2417	24.7681	26.6424	24.2471
360231	***	12.7388	*	*	*
360234	1.2357	21.0472	22.1787	23.3339	22.1978
360236	1.1619	20.5683	22.8821	21.3752	21.6046
360239	1.2563	20.9440	23.5802	24.4390	23.1380
360241	0.4470	23.7678	23.4061	24.8089	23.8245
360242	2.0421	*	*	*	*
360245	0.6131	16.7956	18.1015	18.7521	17.9525
360247	0.3999	*	*	*	*
360250	***	50.5105	*	*	*
360253	2.1835	*	31.3006	28.2476	*
360254	***	*	30.0792	*	*
360255	***	*	15.0963	*	*
360257	1.1153	*	*	17.9730	*
360258	2.2239	*	*	*	*
360259	1.2234	*	*	*	*
360260	1.7159	*	*	*	*
360261	1.7779	*	*	*	*
360262	1.2806	*	*	*	*
360263	1.3044	*	*	*	*
360264	2.1627	*	*	*	*
370001	1.6937	22.0586	25.5838	26.2114	24.5679
370002	1.2284	16.1854	18.9544	19.7555	18.3326
370004	1.0773	22.5027	21.5041	24.7468	22.8791
370006	1.1184	15.7367	15.6333	16.9108	16.0795
370007	1.1451	14.4961	16.7598	17.2044	16.1189
370008	1.4320	18.5253	22.1596	22.7314	21.1276
370011	1.0519	16.1757	17.1458	19.2234	17.5757
370012	***	13.3824	*	*	*
370013	1.5194	19.3237	21.1512	22.6317	21.1046
370014	1.0691	22.7976	21.8473	24.8087	23.1688
370015	0.9782	18.9169	20.3966	21.1785	20.1465
370016	1.5388	20.0888	20.4407	24.2703	21.4944
370018	1.3990	18.7928	20.8357	23.4158	20.9822
370019	1.2863	16.1367	18.1260	19.6688	17.9615
370020	1.2272	15.6057	16.8631	17.4791	16.6370
370022	1.2044	18.2109	20.2432	18.4113	18.9674
370023	1.2614	18.1255	19.3386	20.5953	19.3760
370025	1.3201	19.1013	20.2845	22.0156	20.4852

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble of this proposed rule.
*Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.
***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
370026	1.4802	18.6982	21.9140	22.5835	21.1395
370028	1.8586	22.1766	24.1009	24.8536	23.7345
370029	1.0889	19.3285	19.5811	22.1072	20.3504
370030	1.0389	18.4568	18.6541	20.2972	19.1131
370032	1.5103	18.9050	20.0827	21.5979	20.2635
370033	***	15.3857	*	*	*
370034	1.1651	16.2204	16.1540	17.6046	16.6595
370036	0.9955	11.7668	16.5844	16.7246	14.6770
370037	1.6574	20.6493	21.0719	23.0757	21.6756
370038	***	15.4551	*	*	*
370039	1.0958	22.7015	20.3137	21.0806	21.3268
370040	0.9924	16.8127	18.9981	21.0740	18.9758
370041	0.8153	14.7346	19.0144	22.0055	18.4505
370042	0.9123	15.9006	14.0899	15.1945	15.0996
370043	0.9218	20.0992	20.2929	21.4513	20.6322
370045	0.9759	11.6163	12.6613	14.6620	13.0088
370047	1.3882	18.4743	19.4856	19.7081	19.2313
370048	1.0579	17.0785	15.4768	17.6937	16.7315
370049	1.2974	20.3405	20.4826	21.6808	20.8316
370051	1.0698	11.4943	12.0397	14.6124	12.6791
370054	1.3449	19.2294	20.3788	21.5471	20.4039
370056	1.6571	19.2867	20.4872	21.7376	20.4888
370057	0.9715	16.0301	17.3020	17.9823	17.1056
370059	***	21.3104	*	*	*
370060	0.9088	17.9469	23.1897	20.0017	20.3902
370064	0.9218	11.6347	11.9044	14.1371	12.5454
370065	1.0301	18.2405	18.3966	20.7046	19.0963
370072	0.7991	12.5765	12.5765	14.5102	13.1529
370076	***	15.4067	19.0230	21.5461	18.6317
370078	1.5678	15.2513	22.2318	23.9374	19.9513
370079	***	17.5915	*	*	*
370080	0.8972	14.3546	16.1444	17.4520	15.9872
370082	0.8881	16.9716	12.6060	*	*
370083	0.9135	15.6824	18.5669	15.2840	16.4357
370084	0.9836	15.6184	16.1278	17.1490	16.3719
370085	***	13.7216	*	*	*
370089	1.0960	17.9243	18.0505	19.8953	18.6197
370091	1.7265	20.8536	24.2117	22.8160	22.5525
370092	1.0054	16.8432	*	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
370093	1.6800	22.1966	23.5685	25.7313	23.9079
370094	1.3686	19.5565	20.6507	22.0361	20.8189
370095	0.8688	14.5909	14.3563	16.3181	15.0879
370097	1.3120	19.3793	20.3218	21.7042	20.5540
370099	1.0717	18.1468	20.2001	20.4951	19.6408
370100	0.9260	12.9784	13.0681	14.1863	13.4287
370103	0.9189	23.1347	15.6110	16.1167	18.5578
370105	1.8767	25.1252	22.4493	22.0976	23.1001
370106	1.4021	21.8937	24.1115	24.2436	23.4318
370108	0.9335	14.0191	13.8170	*	*
370112	0.9227	14.3385	16.5965	15.4411	15.4023
370113	1.1234	20.3439	21.4267	23.2745	21.6981
370114	1.5714	17.9757	19.4933	21.0662	19.5572
370121	***	20.5488	*	*	*
370123	1.2398	19.7958	20.5180	22.8174	20.9622
370125	0.8961	14.4664	17.9240	16.9326	16.3684
370133	***	16.1855	*	*	*
370138	1.0150	17.4574	19.0403	19.8230	18.8061
370139	0.9541	16.0897	16.3224	17.9027	16.7580
370140	***	17.4950	*	*	*
370141	***	19.8607	24.7859	*	*
370146	***	13.9900	*	*	*
370148	1.5096	22.6237	22.8526	24.6125	23.4064
370149	1.2146	18.0699	18.2260	20.6817	19.0254
370153	1.0749	16.5267	17.9692	18.5897	17.6702
370154	1.0061	16.6687	17.4760	*	*
370156	1.0240	15.4303	15.9647	16.6333	16.0271
370158	1.0246	16.3637	17.3412	17.3068	17.0048
370159	***	25.5592	*	*	*
370165	***	12.9569	*	*	*
370166	1.0132	19.4219	21.3628	21.8599	20.8727
370169	0.9497	14.8385	16.5607	15.7955	15.6672
370170	1.0234	*	*	*	*
370171	1.0448	*	*	*	*
370172	0.9119	*	*	*	*
370173	1.0078	*	*	*	*
370174	0.8416	*	*	*	*
370176	1.2050	19.6537	22.1456	22.9862	21.6386
370177	1.0463	14.1303	14.0279	15.6322	14.5963

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
370178	0.9204	9.8655	12.9635	14.9497	12.3391
370179	0.8928	23.8404	21.9673	22.7266	22.7202
370180	1.0541	*	*	*	*
370183	1.0590	16.6061	17.9270	20.4715	18.2609
370186	0.9334	16.3671	16.3879	*	*
370190	1.5083	20.6399	22.3326	24.9218	22.7450
370192	1.8186	21.8343	24.3832	26.1498	24.2016
370196	0.8685	*	23.6334	29.4383	*
370199	0.8244	*	20.7075	23.7495	*
370200	1.2105	18.3941	16.7164	18.1106	17.7396
370201	1.7651	18.2548	18.9906	23.1481	20.2520
370202	1.6160	16.5384	24.0239	24.4820	21.7306
370203	1.3744	23.5454	19.8772	21.2365	21.3870
370206	1.4972	*	22.3471	27.4303	*
370207	***	*	26.3746	*	*
370209	***	*	*	32.8278	*
370210	2.1988	*	*	20.0264	*
370211	0.9770	*	*	*	*
370212	1.5043	*	*	*	*
370213	1.2330	*	*	*	*
370214	0.9094	*	*	*	*
370215	2.4287	*	*	*	*
370216	2.0982	*	*	*	*
370217	1.3945	*	*	*	*
380001	1.2234	25.1542	20.9585	27.8093	24.5303
380002	1.2011	23.2479	25.2629	26.2975	24.9706
380003	1.0626	23.8074	24.6377	*	*
380004	1.7481	24.5418	27.5184	28.2286	26.8980
380005	1.3209	24.7476	26.3472	28.1048	26.4838
380006	1.2146	20.5914	24.7492	26.0130	23.9003
380007	1.7740	25.9239	30.0497	31.5260	29.2622
380008	1.0409	21.6134	24.6149	25.4379	23.9186
380009	1.9585	25.1040	26.0012	30.4063	27.2654
380010	0.9991	24.1931	25.5234	27.5291	25.7081
380011	1.2142	20.6759	21.9382	*	*
380013	1.1697	19.9607	24.1491	*	*
380014	1.7931	26.6038	28.4536	27.7295	27.6296
380017	1.7819	21.9236	29.2543	31.7279	27.7944
380018	1.7238	24.8661	27.5171	27.8887	26.7526

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
380019	1.0552	21.1743	*	*	*
380020	1.3579	23.9978	23.7066	25.8278	24.5405
380021	1.4212	24.4365	28.0334	29.2813	27.3717
380022	1.1741	25.6255	26.4794	27.8601	26.7206
380023	1.1117	23.4328	23.0079	23.6918	23.3858
380025	1.3695	26.9398	28.8525	29.5786	28.5449
380026	1.1248	22.7561	23.8666	26.5129	24.4120
380027	1.2748	22.2573	21.5822	23.8735	22.6063
380029	1.1343	22.0371	24.2939	26.1864	24.3179
380031	***	23.7634	*	*	*
380033	1.6494	26.6899	30.4783	29.7994	29.0661
380035	1.0772	25.6016	26.2434	26.4725	26.1342
380037	1.1749	23.4798	25.0200	27.1706	25.3970
380038	1.2119	28.1436	29.1804	30.5780	29.3622
380039	1.1083	25.7614	27.5115	30.1544	27.7918
380040	1.1608	22.6412	21.5958	28.4537	23.9641
380042	***	21.6793	*	*	*
380047	1.7433	25.2591	26.5017	27.8477	26.6232
380048	***	18.2774	*	*	*
380050	1.3846	22.1089	23.1332	24.2346	23.1820
380051	1.6182	24.4081	26.2384	28.1207	26.2391
380052	1.1536	20.7431	21.2567	22.6661	21.5596
380056	0.9887	20.7895	22.3571	24.8853	22.7434
380060	1.4094	23.0107	27.8551	29.6391	26.9580
380061	1.5956	24.1121	27.3827	29.5081	27.3025
380062	***	26.1368	*	*	*
380064	***	27.0628	*	*	*
380065	***	23.3147	*	*	*
380066	1.2276	23.1175	23.3581	27.5323	24.6896
380069	***	21.2057	*	*	*
380070	1.0913	29.9706	34.1039	*	*
380071	1.3157	25.9113	27.9055	29.5642	27.8139
380072	0.8877	20.6569	21.9516	22.5672	21.7596
380075	1.3282	23.1910	25.1930	27.4684	25.5305
380078	***	22.6995	*	*	*
380081	1.1097	22.9805	22.1822	21.0630	22.0510
380082	1.1950	23.7927	28.0668	30.2326	27.4557
380083	***	22.4058	*	*	*
380084	***	31.0111	*	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
380087	1.0529	21.3119	*	*	*
380088	***	24.8158	*	*	*
380089	1.3123	26.1967	29.6989	30.8511	28.9815
380090	1.2657	30.4223	31.8702	33.6729	32.0257
380091	1.3678	28.7846	31.2807	35.6625	31.8614
390001	1.7216	20.3350	21.5154	22.4346	21.4370
390002	1.2323	20.8831	22.0646	23.0091	22.0042
390003	1.2148	18.0436	19.1857	21.3569	19.5117
390004	1.4422	20.0557	21.3475	23.4009	21.6563
390005	0.9988	19.0218	19.0727	19.0318	19.0406
390006	1.8552	21.7867	23.0378	23.3982	22.7707
390008	1.1025	19.5439	19.9417	20.9823	20.1752
390009	1.8020	22.5580	21.9459	24.2783	22.9309
390010	1.2124	18.1275	19.4377	21.6184	19.7640
390011	1.3749	18.2751	18.6548	19.8491	18.9226
390012	1.2657	22.2060	28.5114	*	*
390013	1.2087	20.2186	22.1679	23.2011	21.9199
390015	***	14.3138	*	*	*
390016	1.2224	17.4931	18.1536	19.9705	18.5323
390017	0.9847	18.5869	19.1962	20.6575	19.3772
390018	***	20.0672	19.9117	*	*
390019	1.1514	18.7609	21.2806	21.5311	20.5448
390022	1.2760	25.2980	27.5504	31.1700	27.9052
390023	1.2504	23.9246	25.3767	27.1464	25.5041
390024	0.9274	27.7643	25.9806	37.4334	27.8096
390025	0.5044	14.0077	14.8690	14.9919	14.6139
390026	1.2176	23.6317	24.0326	27.0665	24.8980
390027	1.4868	29.4334	33.2139	28.8552	30.3784
390028	1.7232	22.7820	24.6796	23.6594	23.7164
390029	***	24.4753	*	24.4276	*
390030	1.2180	18.9122	20.0598	20.9818	20.0070
390031	1.1879	19.2040	20.3568	21.6531	20.3945
390032	1.1908	18.5545	20.8450	20.9954	20.2270
390035	1.2374	21.9325	23.2173	24.7161	23.2779
390036	1.4620	20.2103	20.5751	23.3828	21.3719
390037	1.3405	19.9175	20.1665	22.8934	20.9859
390039	1.1105	17.6181	18.4580	17.7225	17.9328
390040	***	17.4450	20.5371	23.1807	20.2698
390041	1.2799	19.6159	21.0074	20.6708	20.4512

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
390042	1.4526	22.0668	22.2351	23.9477	22.7639
390043	1.1866	17.6739	19.8641	20.9857	19.5462
390044	1.6872	21.3382	22.4235	24.0072	22.6191
390045	1.5545	20.2107	20.2082	22.2502	20.9199
390046	1.5544	21.3960	23.1271	24.1282	22.9409
390048	1.0813	18.9776	20.3523	23.6622	20.8911
390049	1.5944	22.8196	24.0933	25.4052	24.1177
390050	2.1283	24.9156	22.6951	24.5691	24.0272
390052	1.1961	21.2729	22.1380	21.6669	21.6911
390054	1.1732	19.4686	19.8602	21.4830	20.2442
390055	1.8647	25.7327	23.5292	25.5675	24.9295
390056	1.0851	21.4121	21.4239	*	*
390057	1.2621	21.6693	24.8235	25.4872	24.0527
390058	1.2511	20.7930	22.0113	25.3332	22.6773
390061	1.5750	22.8728	24.4550	25.4434	24.2367
390062	1.1178	17.4710	17.6303	19.0411	18.1048
390063	1.8165	20.1696	21.7120	23.5462	21.8616
390065	1.2668	20.2930	23.1384	23.5072	22.4583
390066	1.2729	19.0132	21.7717	22.5879	21.0978
390067	1.8800	21.9885	23.5136	25.4523	23.6201
390068	1.3244	21.6408	21.1177	25.9829	22.9735
390070	1.3645	22.7909	24.4403	26.9128	24.7140
390071	1.0584	18.9416	17.8117	20.9265	19.1749
390072	1.0262	16.9445	20.0561	22.0170	19.6415
390073	1.6527	22.2703	22.7073	24.7912	23.2301
390074	1.1657	19.7446	21.8456	21.0874	20.9115
390075	***	19.5840	19.9775	21.8803	20.4571
390076	1.3013	19.7719	21.2039	18.1239	19.5525
390078	***	20.6483	*	*	*
390079	1.9354	19.5982	19.9169	21.4303	20.3283
390080	1.2558	22.2449	23.3742	25.0773	23.5679
390081	1.2418	25.6575	28.1056	28.7795	27.6309
390083	***	26.1660	*	*	*
390084	1.2468	17.0197	18.3551	20.7589	18.7200
390086	1.5557	19.7645	19.6488	20.7475	20.0585
390090	1.9314	20.5433	22.4688	20.5942	21.1991
390091	1.1509	19.0355	19.7361	20.8146	19.8597
390093	1.1848	20.0135	19.9209	21.0220	20.3346
390095	1.1683	17.9697	18.3939	21.0740	19.1547

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
390096	1.4992	22.2974	22.9502	24.4089	23.2490
390097	1.1775	24.7853	24.5304	25.2703	24.8833
390100	1.8079	21.1186	23.4155	26.7222	23.8477
390101	1.2861	19.0180	20.1271	20.1766	19.7954
390102	1.3385	19.3111	20.9807	21.6658	20.7259
390103	1.0499	20.4422	21.0637	18.7112	20.1382
390104	1.0273	16.2440	16.5081	19.1803	17.3735
390106	***	17.4747	*	*	*
390107	1.3505	20.6024	21.5852	23.0901	21.7992
390108	1.2678	22.0444	23.7842	24.7475	23.4860
390109	1.1626	17.4539	17.2667	18.7377	17.8310
390110	1.5524	21.6005	22.3968	23.3760	22.4619
390111	2.0531	27.1429	30.5814	30.6695	29.4086
390112	1.1723	14.8634	15.6710	16.5768	15.6978
390113	1.2883	19.9496	20.1160	21.7459	20.6141
390114	1.3103	19.8004	23.6162	22.6588	22.0256
390115	1.4577	22.3545	24.1951	26.4838	24.3642
390116	1.2861	22.6783	24.9581	28.5309	25.3760
390117	1.1876	18.9764	19.0983	19.9930	19.3610
390118	1.1495	17.2669	17.8460	19.3321	18.1495
390119	1.3107	19.3946	20.3034	21.2721	20.3751
390121	1.6429	20.6253	20.8017	22.0429	21.1726
390122	1.1747	15.5438	18.5130	21.6893	18.4182
390123	1.2507	21.8897	23.2232	25.1960	23.4504
390125	1.2270	17.0975	18.2411	19.4406	18.2772
390127	1.2089	22.8787	25.0836	28.8947	25.7738
390128	1.1675	19.9764	21.3668	21.8774	21.0731
390130	1.1669	18.5519	19.4835	21.0934	19.6358
390131	1.2699	19.1931	19.5296	21.2095	20.0419
390132	1.4729	24.1878	24.6889	26.8098	25.2632
390133	1.6867	24.1590	25.2110	26.1132	25.1771
390135	1.2206	22.2501	24.0445	*	*
390136	1.0537	16.8505	21.9531	24.8558	20.8431
390137	1.4606	19.4769	19.5457	21.6719	20.1958
390138	1.1862	20.7726	21.4705	22.7239	21.7029
390139	1.3728	24.8347	26.3622	28.1691	26.4919
390142	1.5678	28.4680	29.8874	32.0776	30.1663
390145	1.4558	20.4964	20.6580	22.4222	21.2132
390146	1.2457	20.1788	21.4580	22.3238	21.2944

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble of this proposed rule.
*Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.
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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
390147	1.2232	21.7600	22.3135	23.6249	22.5709
390150	1.1089	20.8970	20.0261	24.5126	21.8818
390151	1.2577	23.6072	24.7843	25.1226	24.5339
390152	0.9948	20.2581	21.5474	11.7927	16.4315
390153	1.3887	23.9039	25.3391	27.5234	25.6622
390154	1.3181	17.8774	19.1300	20.4320	19.1515
390156	1.3361	24.0034	25.0801	27.8026	25.6198
390157	1.2867	20.2647	20.6933	22.0278	21.0071
390160	1.2542	19.4793	19.3598	19.5910	19.4781
390162	1.5385	21.3379	24.0291	*	*
390163	1.2577	18.1831	18.8585	19.8797	18.9815
390164	2.1067	26.1698	24.2334	25.1256	25.1313
390166	1.2149	19.8899	19.8531	20.9322	20.2205
390168	1.4826	19.6875	20.6777	21.9272	20.8063
390169	1.4025	22.7920	22.7695	24.1731	23.2443
390173	1.1716	18.8265	20.6958	21.6499	20.4145
390174	1.7402	26.3891	28.4490	30.3603	28.4583
390176	1.1749	21.7650	18.0752	17.1387	19.0248
390178	1.3265	17.1142	17.2384	19.2695	17.9054
390179	1.3840	21.5792	24.0501	24.8322	23.5274
390180	1.4154	26.7743	28.4842	30.4141	28.6301
390181	1.0369	18.8681	*	25.7089	*
390183	1.0854	17.4535	21.6811	21.9804	20.2942
390184	1.0618	21.1941	21.1962	21.3407	21.2460
390185	1.2404	20.3301	20.4476	21.8832	20.8610
390189	1.1204	19.6186	20.1365	21.2595	20.3588
390191	1.1521	17.1919	18.5972	19.2220	18.2790
390192	1.0699	16.6469	19.1883	20.0536	18.6979
390193	0.9732	17.3804	18.9764	18.5516	18.2455
390194	1.1934	21.0549	21.5850	23.1539	21.9732
390195	1.6282	24.2891	26.2024	28.3334	26.3095
390196	1.7321	*	*	*	*
390197	1.4713	22.1974	22.8349	24.9126	23.2809
390198	1.1630	16.6803	17.3937	16.7799	16.9504
390199	1.2087	17.7782	18.9787	19.9450	18.9271
390200	0.9555	18.2456	19.4471	23.1844	20.2511
390201	1.2194	21.3291	22.7849	24.8067	22.9791
390203	1.5709	22.4685	26.9436	28.2581	26.1174
390204	1.2494	22.7282	23.9673	25.6155	24.1053

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
390209	***	16.8200	*	*	*
390211	1.3111	19.4552	21.0450	22.4522	21.0309
390213	***	20.1152	*	*	*
390215	***	23.5953	25.2617	26.4180	25.0589
390217	1.1773	19.7578	21.4058	21.3233	20.8231
390219	1.2703	20.1311	20.0594	22.8559	21.0258
390220	1.1194	22.7618	23.4385	24.7325	23.5931
390222	1.2545	22.7491	24.9345	27.0092	24.9284
390223	1.9015	18.9493	22.8725	27.7423	23.0769
390224	0.8619	17.2173	16.1289	18.1271	17.1810
390225	1.2144	19.0364	20.9232	23.4864	21.2582
390226	1.7520	22.8588	25.6917	26.9929	25.2125
390228	1.3378	19.6212	21.0164	22.5906	21.1187
390231	1.4530	21.0757	24.7757	27.0360	24.3203
390233	1.3278	20.5801	21.8043	22.8092	21.7459
390235	***	19.9925	23.7068	*	*
390236	1.1855	19.1427	19.8687	21.9199	20.3483
390237	1.5414	21.7847	23.2054	24.6327	23.2306
390238	***	18.1956	19.2171	26.4748	21.1243
390244	***	14.2137	*	*	*
390246	1.1544	22.3892	22.0687	23.2749	22.5829
390249	0.8544	14.1062	14.7215	*	*
390256	1.8489	22.3540	22.6146	24.2209	23.1305
390258	1.6143	23.8318	25.0634	27.1964	25.4237
390262	***	18.8943	21.3264	*	*
390263	1.4807	20.6348	22.0008	23.4012	22.0869
390265	1.4473	20.4760	20.5948	21.6720	20.9424
390266	1.2786	17.6223	18.2424	19.2605	18.3863
390267	1.2120	20.2424	21.4801	22.4653	21.3626
390268	1.2936	22.2046	23.1124	24.1968	23.1929
390270	1.5396	20.7957	22.5258	24.0705	22.5559
390272	0.5610	*	*	*	*
390278	0.5691	18.5776	21.1387	21.7380	20.4435
390279	1.0713	15.8080	16.0510	15.3569	15.7368
390285	1.7088	29.1270	30.6300	33.5945	31.0860
390286	1.1655	22.9746	25.4499	27.4194	25.2602
390287	1.4859	30.3252	32.9709	35.8307	33.0682
390288	1.1453	26.9662	28.0957	28.5076	27.6303
390289	1.3074	22.8963	25.1658	28.4577	25.4209

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
390290	1.9362	30.5037	31.0967	36.6581	32.7365
390291	0.9597	20.0272	21.0057	21.3015	20.7433
390293	***	23.5284	*	*	*
390294	***	*	33.3537	*	*
390295	***	*	26.8862	*	*
390296	***	*	25.6981	*	*
390297	***	*	25.7318	*	*
390298	***	*	*	26.8290	*
390299	***	*	*	31.9423	*
390300	***	*	*	40.4697	*
390301	1.6664	*	*	*	*
390302	2.2239	*	*	*	*
390303	2.3543	*	*	*	*
390304	1.1685	*	*	*	*
400001	1.2776	10.7531	11.7572	15.1755	12.3718
400002	1.6592	13.3684	11.6804	14.8649	13.2484
400003	1.3929	11.2726	10.5963	13.0543	11.6228
400004	1.1574	9.0781	11.4041	10.4716	10.2554
400005	1.0735	9.7802	10.5356	10.2866	10.1679
400006	1.1481	10.4988	9.2852	8.9919	9.5595
400007	1.1920	8.1974	8.6022	8.7152	8.4943
400009	1.0549	8.7341	9.4413	9.2007	9.1221
400010	0.9139	9.1359	9.2799	10.9204	9.7087
400011	1.0979	8.6253	8.9111	8.5542	8.6910
400012	1.5105	8.6538	9.0740	8.3580	8.6862
400013	1.3896	9.8197	9.9905	9.5584	9.7808
400014	1.4328	10.2712	11.4580	11.7095	11.1005
400015	1.2168	15.5827	*	15.6066	*
400016	1.3377	13.7001	14.6491	15.3689	14.5946
400017	1.1908	9.9167	10.7475	10.1238	10.2629
400018	1.1914	10.5583	10.8254	10.7948	10.7210
400019	1.3576	12.1251	13.7007	14.9583	13.4954
400021	1.3773	12.7462	13.5224	13.8848	13.3947
400022	1.3191	13.0915	15.2904	16.0595	14.7618
400024	0.8702	9.0826	9.8650	9.1316	9.3569
400026	1.0267	7.4280	5.9206	5.2204	6.0639
400028	1.2392	8.9567	9.5266	10.3353	9.5962
400032	1.1887	10.1898	10.7100	10.7367	10.5532
400044	1.2984	12.8671	9.0275	10.7971	11.1564

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
400048	1.1432	11.5104	10.8618	14.0607	12.1877
400061	1.8567	10.3664	16.5895	15.1599	13.5858
400079	1.1704	8.7218	8.7218	9.4218	8.9758
400087	1.2140	8.6480	10.7118	9.5860	9.7657
400094	***	9.4600	9.2871	8.8646	9.2684
400098	1.3329	10.4312	13.8036	13.7730	12.4180
400102	1.1616	8.5289	10.9973	10.1795	9.9095
400103	1.7251	11.8454	11.5797	12.8271	11.9668
400104	1.2143	7.9552	7.1781	8.2758	7.7122
400105	1.3208	10.6028	11.5608	12.7725	11.5397
400106	1.2181	9.8694	10.1241	9.6855	9.8860
400109	1.5289	12.2080	12.8921	14.1539	13.0622
400110	1.1671	10.7228	12.0159	11.8434	11.5358
400111	1.1076	12.3311	12.7701	13.4767	12.8570
400112	1.1300	11.0634	12.2859	8.9469	10.5739
400113	1.2571	9.3000	10.4416	10.0722	10.0500
400114	1.0870	9.9477	9.7444	12.1920	10.5611
400115	1.1198	7.2203	7.0411	9.1141	7.7510
400117	1.0891	11.3351	9.7314	10.2911	10.4382
400118	1.1963	11.4317	12.4590	11.9254	11.9482
400120	1.3584	10.9315	11.8837	11.9699	11.5873
400121	0.9203	8.7584	8.3575	8.6665	8.5907
400122	1.2393	9.1638	9.6644	9.6463	9.4879
400123	1.2757	10.9047	10.5643	11.4028	10.9561
400124	2.8783	12.7323	14.3496	17.2799	14.7329
400125	1.2218	10.5997	10.6642	10.7470	10.6987
400126	1.3130	*	*	13.4293	*
400127	1.9702	*	*	*	*
410001	1.3047	22.4972	24.0033	27.0339	24.5154
410004	1.2677	23.5408	23.6409	25.4538	24.2447
410005	1.3108	24.0086	24.6522	27.1115	25.2290
410006	1.2908	22.8959	26.1372	27.1638	25.4444
410007	1.6934	24.9846	27.7171	30.1003	27.5961
410008	1.2267	24.4792	25.4183	28.3980	26.0984
410009	1.3555	24.3760	26.9135	27.7297	26.3689
410010	1.1631	29.7315	30.3860	30.7655	30.3051
410011	1.3417	27.4880	29.7664	28.5841	28.6102
410012	1.7800	26.4570	28.1791	32.1726	29.0194
410013	1.1911	25.3688	28.9386	31.7350	28.6841

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
420002	1.5728	22.6182	25.1067	27.9316	25.2811
420004	1.9051	22.4680	23.4579	26.0253	23.9910
420005	1.0229	17.8202	19.5521	19.4207	18.9548
420006	0.9876	18.7153	22.7896	22.8651	20.8860
420007	1.6178	19.0199	22.0228	23.3120	21.5148
420009	1.3466	21.2566	18.6866	22.1189	20.5789
420010	1.1299	19.3267	19.1746	21.6318	20.1025
420011	1.1156	16.7523	17.7300	19.9954	18.1351
420014	1.0448	19.0455	21.2045	21.5468	20.5919
420015	1.3066	20.8736	23.1274	24.0946	22.7929
420016	0.9864	16.6448	17.0051	17.3360	17.0110
420018	1.7448	20.7779	20.4649	23.1858	21.4034
420019	1.0964	19.0199	19.6836	19.8839	19.5330
420020	1.2402	20.5801	22.1616	23.4084	22.1442
420023	1.6342	20.8600	23.2568	24.3580	22.8740
420026	1.8493	23.3073	23.7406	28.7353	25.1482
420027	1.5125	19.7322	21.0637	22.8431	21.2369
420030	1.2258	22.5159	22.6766	23.3233	22.8634
420031	***	15.3604	*	*	*
420033	1.1130	23.7974	26.2711	27.5828	25.9512
420036	1.2189	19.8285	20.6649	21.9591	20.8115
420037	1.1896	23.5244	25.5492	26.8717	25.3931
420038	1.2512	19.9829	21.6133	21.0397	20.8779
420039	0.9962	18.0055	21.9737	23.1188	20.7929
420043	1.1089	19.6835	21.8816	22.9673	21.4962
420048	1.2661	20.5531	21.9517	22.2027	21.6143
420049	1.2154	20.1765	21.2604	21.5249	21.0147
420051	1.4796	19.8549	20.6629	22.8630	21.1363
420053	1.1893	19.0780	19.9013	21.0114	20.0431
420054	1.0648	20.2275	20.8471	24.0597	21.6954
420055	1.0618	18.6782	19.6817	19.1076	19.1565
420056	1.3030	16.5491	20.0527	19.4126	18.7265
420057	1.0694	22.1312	17.6727	18.4194	19.5523
420059	1.0991	18.2093	20.2917	21.0623	19.7529
420061	1.0693	17.7048	19.9789	20.1224	19.3074
420062	1.0499	20.9032	17.4764	25.6688	20.9148
420064	1.1739	19.7067	20.9057	21.3793	20.7653
420065	1.3774	19.2150	22.0784	22.8685	21.4489
420066	0.9870	19.5366	20.7782	20.1834	20.1545

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
420067	1.2721	20.8524	22.8104	24.0249	22.6453
420068	1.3920	20.2580	21.7257	22.2591	21.4197
420069	1.0160	18.9017	17.6291	19.6999	18.7440
420070	1.2800	19.2186	20.3664	21.1891	20.2758
420071	1.3648	20.1897	21.8579	21.7614	21.2988
420072	1.0511	18.2531	16.2578	17.3085	17.2103
420073	1.3434	20.2697	21.4718	23.0499	21.5504
420074	***	18.1839	18.7010	*	*
420075	0.8787	15.0133	15.9889	15.9205	15.6479
420078	1.7659	22.7157	24.3273	24.6022	23.8754
420079	1.4739	21.3177	23.3992	24.4417	23.1145
420080	1.4228	23.2871	26.7489	28.4579	26.2856
420082	1.4853	22.8516	23.6936	26.1137	24.1929
420083	1.4331	24.4499	24.8508	25.3043	24.8899
420085	1.6004	22.0071	24.4040	24.2373	23.6127
420086	1.4403	23.5303	24.5760	23.1864	23.7668
420087	1.8071	20.8217	22.4526	23.2083	22.1548
420088	***	21.8979	23.5174	23.1273	22.7509
420089	1.2807	21.3954	23.3240	25.2918	23.4254
420091	1.3684	21.8367	23.7936	22.5739	22.7216
420093	1.0607	19.1299	21.4678	23.8470	21.4406
420095	***	33.4634	*	*	*
420096	***	26.4864	*	*	*
420097	***	*	*	24.7809	*
420098	1.1388	*	*	*	*
430004	***	19.2737	*	*	*
430005	1.2131	17.3401	18.2647	19.9379	18.5021
430007	1.1935	15.1494	*	*	*
430008	1.0751	18.5234	20.0124	20.9317	19.8443
430010	***	16.5751	*	*	*
430011	1.2762	18.3648	19.9835	20.6453	19.6221
430012	1.3119	19.2921	21.2588	22.7314	21.0785
430013	1.1659	18.8978	21.3389	22.9712	21.0296
430014	1.2555	20.9118	22.0285	25.5303	22.7991
430015	1.0880	18.8998	20.5849	23.1932	20.8455
430016	1.5961	22.7585	24.2450	26.1461	24.3983
430018	0.9210	15.9423	17.9850	*	*
430022	***	14.0661	*	*	*
430023	0.9536	16.7850	18.8816	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
430024	0.9797	17.4815	18.8357	*	*
430027	1.6978	20.8666	22.1807	23.8370	22.3015
430028	***	18.2829	*	*	*
430029	0.9455	17.4931	18.9464	20.2548	18.9475
430031	0.9276	13.2104	15.2321	15.5004	14.6333
430033	0.9016	18.3978	21.6254	*	*
430034	***	13.8535	*	*	*
430036	***	16.7826	*	*	*
430037	***	18.7008	*	*	*
430040	***	14.7860	*	*	*
430043	1.1464	17.0193	17.9672	17.2531	17.3880
430047	0.9880	17.5377	18.2774	21.9073	19.2349
430048	1.2426	19.0261	20.0607	21.1716	20.1126
430049	***	14.9025	*	*	*
430051	***	18.8696	*	*	*
430054	0.8992	15.0100	17.8871	*	*
430056	***	14.1913	*	*	*
430057	***	18.8777	*	*	*
430060	0.9402	9.7677	10.6492	10.2749	10.2222
430064	0.9757	13.8666	14.3407	16.4013	14.8773
430066	***	14.5958	*	*	*
430073	***	16.5112	*	*	*
430076	***	15.2453	*	*	*
430077	1.6565	20.4361	21.6786	23.4888	21.9099
430079	***	14.4155	*	*	*
430081	0.8974	*	*	*	*
430082	0.7847	*	*	*	*
430083	0.9078	*	*	*	*
430084	0.8871	*	*	*	*
430085	0.8374	*	*	*	*
430089	1.3704	17.5100	19.8572	21.1679	19.6074
430090	1.4036	23.5180	25.6873	26.1562	25.2068
430091	2.6049	21.6239	22.2824	23.8972	22.8442
430092	1.8922	19.7645	19.7354	20.2570	19.9313
430093	1.1976	23.3009	23.8820	23.2784	23.4808
430094	1.3886	*	20.8743	18.4419	*
430095	2.4128	*	*	24.7004	*
430096	1.6684	*	*	*	*
440001	1.1553	17.2283	18.9833	17.4881	17.8537

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
440002	1.6647	21.4299	22.0178	23.2100	22.2386
440003	1.1694	20.3756	21.6336	24.5018	22.2269
440006	1.3645	23.1483	24.3173	26.7920	24.8004
440007	0.9739	14.0611	14.8015	13.6776	14.1538
440008	0.9587	20.3303	20.9237	22.1244	21.0877
440009	1.1298	18.4068	19.6564	21.1055	19.7715
440010	0.9465	13.3692	16.7270	16.9089	15.5478
440011	1.3668	19.3165	20.5036	21.6726	20.5670
440012	1.4643	19.8949	21.1213	21.4800	20.8349
440014	***	15.0657	*	*	*
440015	1.8853	21.6106	23.4485	22.5514	22.4922
440016	0.9830	14.6142	20.1504	20.1085	17.9866
440017	1.7917	20.4705	21.8033	22.5332	21.6070
440018	1.1883	18.1620	21.2242	20.4650	19.9932
440019	1.7754	22.8463	21.8854	23.8665	22.8732
440020	1.0801	20.2188	21.1075	23.1641	21.5514
440023	0.9452	15.6603	15.5410	17.0227	16.1030
440024	1.2255	18.4276	19.9751	20.3574	19.4804
440025	1.1707	17.0996	19.1478	19.5840	18.6528
440026	***	25.6489	25.1655	26.9149	25.8839
440029	1.3244	22.2889	24.1379	25.9915	24.1789
440030	1.2288	17.6297	19.9056	19.9687	19.2080
440031	1.0381	17.2555	17.0289	18.0718	17.4653
440032	0.9807	13.9785	14.7683	16.0653	14.9352
440033	1.0664	16.4679	17.2637	18.7912	17.5597
440034	1.5318	21.1672	22.2478	23.1082	22.1441
440035	1.3554	20.4168	21.4990	22.3185	21.4440
440039	1.9412	22.4158	25.0874	26.4514	24.7933
440040	0.9440	17.6781	16.9886	17.7075	17.4583
440041	0.9621	14.6684	15.5784	17.2756	15.8986
440046	1.1663	20.5562	22.3380	25.5260	22.6858
440047	0.9141	18.7469	18.7962	20.4758	19.3484
440048	1.8275	21.6132	23.1553	24.3279	22.8906
440049	1.5479	19.6920	21.1930	23.0054	21.3435
440050	1.2843	19.7915	21.1397	21.8864	20.9827
440051	0.9780	17.7067	19.0165	20.7911	19.1290
440052	0.9890	18.6589	18.1935	20.2043	19.0465
440053	1.2502	21.5253	22.0345	23.9002	22.5613
440054	1.1226	15.2154	15.4208	20.6132	16.7318

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
440056	1.0916	20.4902	19.3108	20.4055	20.0580
440057	1.0149	14.4363	14.1477	14.6144	14.4020
440058	1.1430	20.7722	21.7512	22.6005	21.7213
440059	1.4868	20.8882	22.4248	23.8698	22.4810
440060	1.1057	20.7627	20.2189	22.7207	21.2591
440061	1.1249	16.9234	19.5458	21.1801	19.1834
440063	1.6836	18.8072	19.7468	21.3363	19.9631
440064	1.0115	18.2678	19.4020	20.9640	19.5517
440065	1.2201	19.2282	19.9099	21.4646	20.2464
440067	1.1052	18.2973	19.5643	22.1325	20.0634
440068	1.1397	19.5428	20.9188	23.1667	21.2874
440070	1.0006	18.0065	18.3717	19.0977	18.4972
440072	1.2631	20.0692	19.6579	20.8541	20.2101
440073	1.2798	19.6290	20.7181	22.2856	20.9161
440078	***	17.1646	*	*	*
440081	1.1261	17.2905	18.3141	19.0354	18.2545
440082	2.1544	22.5590	26.1497	28.7773	25.7834
440083	0.8867	13.7630	15.7015	16.0860	15.2167
440084	1.1960	13.8085	15.0510	15.2445	14.7259
440091	1.6679	20.1359	23.0296	26.0868	23.0348
440100	***	15.9969	*	*	*
440102	1.1194	16.0783	16.6548	17.4956	16.7638
440104	1.7684	21.7135	21.9870	23.1989	22.3421
440105	0.9786	18.1375	19.2902	20.8059	19.4288
440109	0.9984	17.6398	17.3578	18.2394	17.7570
440110	1.0370	18.4998	19.9715	20.9025	19.8790
440111	1.2916	23.2111	24.9883	25.8700	24.7401
440114	0.9955	18.5327	20.1152	21.4309	20.0409
440115	0.9636	18.7054	18.5389	20.0657	19.1245
440120	1.6062	19.8997	22.4031	23.8959	22.1523
440125	1.5808	20.0599	21.1018	21.9259	21.0487
440130	1.1604	19.0905	20.6363	21.6350	20.4227
440131	1.1981	19.9883	21.0640	22.4044	21.1855
440132	1.1910	17.9186	18.9580	20.5652	19.2202
440133	1.5984	22.2257	23.3600	27.7798	24.4215
440135	1.1133	22.5452	23.9749	25.3946	24.0432
440137	1.0373	15.3530	16.5529	18.1769	16.7508
440141	0.9510	17.6818	19.2607	19.5012	18.8780
440142	0.9909	17.1483	17.7587	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
440143	1.0373	18.6844	19.2978	21.0382	19.6717
440144	1.2283	18.8127	19.7938	22.3450	20.3274
440145	0.9560	18.3850	18.2019	20.9753	19.1726
440147	***	25.3766	25.0780	28.7733	26.2779
440148	1.0875	19.3769	20.7693	23.0302	21.1342
440149	1.0162	19.8304	18.1316	19.7731	19.2382
440150	1.3284	21.2942	22.8733	25.6307	23.2986
440151	1.1212	19.8977	21.1576	23.2942	21.4099
440152	1.9445	21.7382	22.7498	25.9513	23.4910
440153	1.0781	18.1781	19.9486	22.7538	20.3291
440156	1.4506	21.9374	23.7799	25.6285	23.8558
440157	***	15.5316	*	*	*
440159	1.4850	21.4914	20.5719	21.1073	21.0376
440161	1.7826	23.6805	26.1354	28.6818	26.2406
440162	***	19.8075	20.3909	*	*
440166	1.5391	19.6632	23.1692	27.1430	23.2663
440168	0.9454	21.1946	21.2113	22.1507	21.4966
440173	1.6286	21.0284	20.8442	20.8630	20.9070
440174	0.9083	19.3966	19.2201	20.7942	19.8078
440175	1.0407	19.9022	22.3331	23.9924	22.1358
440176	1.3098	19.8448	20.4861	21.2080	20.5581
440180	1.1382	20.2057	21.2398	21.9578	21.1140
440181	0.9345	19.0915	19.6133	21.1291	19.9792
440182	0.9039	18.1953	19.3928	20.2487	19.3005
440183	1.5325	22.2401	24.9282	27.7264	25.1329
440184	0.9947	18.6891	21.4484	20.8252	20.2536
440185	1.2169	21.1227	22.1845	23.4009	22.3371
440186	1.0401	20.8601	23.0193	24.6767	22.8365
440187	1.0886	18.3730	19.9478	21.7283	20.0014
440189	1.5086	22.2555	23.2866	24.7624	23.4651
440192	1.0144	19.1977	21.3228	25.1201	21.9741
440193	1.2739	19.9078	22.0345	24.3086	22.1471
440194	1.3022	21.9609	24.4508	26.2397	24.3062
440197	1.2943	22.5282	24.2660	26.4938	24.4586
440200	0.9334	18.7301	16.7752	17.0971	17.5512
440203	0.9689	16.9819	*	17.7371	*
440210	***	12.7622	*	*	*
440217	1.2869	19.2834	23.3544	25.9475	22.9369
440218	0.8943	*	20.1377	26.3666	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
440220	***	*	21.9117	*	*
440222	0.9411	*	*	28.3879	*
440225	0.8180	*	*	*	*
440226	1.5552	*	*	*	*
450002	1.4395	21.5141	24.0411	25.4519	23.7453
450004	***	15.9452	*	*	*
450005	1.1747	16.6354	21.7110	23.3856	20.4507
450007	1.2515	18.0269	18.3738	19.2831	18.5815
450008	1.3672	19.3745	20.1816	22.0885	20.5740
450010	1.5206	19.8998	20.3023	22.3966	20.8412
450011	1.6029	20.2963	22.1472	21.5062	21.3020
450014	1.0630	19.8845	20.6936	22.3614	20.9628
450015	1.4796	22.9820	23.9526	24.0763	23.7021
450016	***	19.1522	20.1232	22.1368	20.5103
450018	1.4023	21.9921	22.9019	24.6466	23.1870
450020	0.9671	18.4643	19.1087	17.6436	18.3469
450021	1.8181	23.7663	25.0769	28.5567	25.8175
450023	1.4511	19.2808	19.1645	21.0055	19.8402
450024	1.3735	19.5584	20.7727	22.1882	20.7920
450028	1.5484	19.5905	22.7775	25.4933	22.5694
450029	1.5558	19.9505	19.9198	22.1521	20.6463
450031	1.4366	29.6772	21.7621	27.0379	25.7468
450032	1.1939	20.8525	20.5217	20.8414	20.7429
450033	1.5842	21.3765	26.5990	29.0722	25.5977
450034	1.6117	19.5233	21.6097	22.9689	21.4072
450035	1.5082	20.3146	24.1860	25.4444	23.2638
450037	1.5538	19.6532	23.1179	23.1111	21.9823
450039	1.3884	20.4660	22.0058	23.2839	21.9180
450040	1.7875	24.8621	21.2990	23.8041	23.2127
450042	1.6505	20.6041	21.8886	22.6910	21.7542
450044	1.6304	23.4476	24.1127	25.8302	24.4736
450046	1.5545	20.2917	20.9239	22.0614	21.1265
450047	0.8525	15.9525	21.8840	22.7242	19.8728
450050	0.9344	19.1390	19.5171	21.5755	19.9836
450051	1.7010	23.0010	24.5533	27.2516	25.0046
450052	0.9676	20.3702	17.6543	19.6544	19.3127
450053	0.9368	19.3347	18.6556	19.5005	19.1913
450054	1.6811	25.3285	23.2915	25.1237	24.5399
450055	1.1824	16.4789	18.2235	20.4941	18.3202

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
450056	1.6560	22.5341	24.4197	25.6618	24.2934
450058	1.5100	20.0424	22.0158	24.7589	22.0851
450059	1.3119	21.4873	22.8792	26.8135	23.7073
450063	***	15.1780	*	*	*
450064	1.4071	21.3929	19.1271	24.2703	21.5311
450065	***	23.8471	*	*	*
450068	2.0546	22.5626	24.0925	26.2836	24.3336
450072	1.1657	20.0134	20.3683	22.5121	20.9494
450073	0.9802	23.7700	19.2398	19.8428	21.0185
450076	1.7655	*	*	*	*
450078	0.9172	13.9324	14.8285	17.1923	15.1963
450079	1.4874	22.0609	24.0085	27.0420	24.3547
450080	1.1306	19.8414	21.0353	21.2008	20.7135
450081	1.0129	19.0276	19.2632	*	*
450082	1.1096	18.0688	16.6566	20.9014	18.5364
450083	1.7438	20.7446	22.5063	24.9160	22.7487
450085	1.0016	17.5001	18.1922	19.4259	18.3367
450087	1.3782	23.4141	24.5976	26.4190	24.9036
450090	1.2560	15.6090	17.1073	17.6187	16.7677
450092	1.1493	17.2058	16.0199	20.4692	17.8000
450094	1.1342	25.2158	25.8313	25.3618	25.4717
450096	1.4288	19.4430	19.8012	22.8758	20.7435
450097	1.4786	20.7653	22.2467	24.9142	22.7824
450098	0.9530	19.8469	20.4795	22.9161	21.0424
450099	1.1799	19.3493	21.4482	24.0261	21.5844
450101	1.5655	17.6368	20.1473	20.6343	19.4504
450102	1.6773	21.4361	20.9900	23.1658	21.9084
450104	1.1389	17.8219	19.7126	22.3155	19.9012
450107	1.4716	24.5035	23.2209	23.8633	23.8375
450108	1.1087	17.9596	18.8084	19.3727	18.7314
450109	0.9128	18.1084	15.1459	*	*
450112	***	17.9624	20.2627	22.5552	20.0426
450113	0.9213	20.7782	37.8944	*	*
450119	1.3043	20.1436	20.8840	24.1341	21.7215
450121	1.5430	22.0485	24.6090	25.8778	24.1004
450123	1.1672	17.5051	17.8629	19.5872	18.3311
450124	1.7078	22.9853	24.2788	26.0140	24.5266
450126	1.2753	22.9423	24.1961	27.2502	24.7382
450128	1.2450	18.7067	*	21.4037	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
450130	1.2838	20.2613	19.6199	20.2715	20.0555
450131	1.1971	18.1401	20.0434	23.2179	20.4940
450132	1.5746	20.8908	22.4680	26.8410	23.2990
450133	1.5773	24.5319	25.3928	25.0972	25.0119
450135	1.6235	21.7038	22.5673	24.3562	22.8912
450137	1.5189	22.8653	24.9732	26.9956	24.8427
450140	0.8460	19.6205	18.3835	22.4695	20.0510
450143	0.9930	17.8206	18.4204	19.7739	18.6816
450144	1.0694	21.9135	21.3896	20.9511	21.4313
450145	***	18.0437	*	*	*
450146	0.9977	17.4391	16.6808	*	*
450147	1.3332	20.3019	21.7248	24.6197	22.3282
450148	1.1463	21.4982	22.1351	23.5220	22.3911
450149	***	22.6138	*	*	*
450150	***	17.8804	*	*	*
450151	1.1296	16.3279	17.9127	21.0271	18.2795
450152	1.1742	19.6105	20.0146	21.6315	20.4920
450153	***	20.9651	*	*	*
450154	1.3283	16.8748	16.5204	18.6076	17.3249
450155	0.9532	20.2582	18.4021	17.9218	18.7964
450157	1.0526	16.8569	17.8764	17.8697	17.5440
450160	0.9280	18.7780	20.7736	21.9118	20.5083
450162	1.2612	20.5032	26.0570	31.0521	25.3214
450163	0.9655	19.7675	19.8194	20.3086	19.9673
450164	***	18.7104	*	*	*
450165	1.0512	16.1010	16.1632	20.2241	17.6273
450166	***	12.6626	*	*	*
450170	***	15.8526	*	*	*
450176	1.2754	19.2397	19.1823	20.9337	19.8366
450177	1.1523	16.4504	17.2637	19.7603	17.8418
450178	0.9729	15.8597	19.1186	20.3097	18.3550
450181	***	18.3601	*	*	*
450184	1.4886	22.7744	24.0596	25.3808	24.1389
450185	0.9014	13.2016	14.3594	15.5146	14.3457
450187	1.1659	20.8105	22.6275	24.2774	22.5601
450188	0.9458	16.9800	17.6158	18.9255	17.8372
450191	1.1323	20.5883	23.2261	25.8384	23.4040
450192	1.0653	20.8315	20.1718	22.5320	21.2038
450193	2.0532	25.1215	26.6580	29.2736	27.0511

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**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.
***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
450194	1.3320	20.7152	22.7310	22.0999	21.8821
450196	1.4051	21.1226	20.1938	23.6118	21.9762
450200	1.4009	19.6496	20.4656	22.0739	20.7772
450201	0.9458	18.0646	19.5907	20.3155	19.3165
450203	1.1988	19.7978	22.9226	23.3799	22.0416
450209	1.8813	21.3218	23.4794	24.5270	23.1249
450210	1.0210	16.8532	16.7851	19.6348	17.7680
450211	1.3950	18.7305	20.0280	20.7666	19.8629
450213	1.7482	19.3440	21.1280	21.7759	20.7531
450214	1.1942	21.3448	22.4543	23.8987	22.5552
450217	***	13.1840	*	*	*
450219	0.9773	18.5534	21.0691	20.7608	19.8472
450221	1.2222	16.2308	19.6778	20.6979	18.8546
450222	1.4714	23.2778	23.5033	26.2966	24.4615
450224	1.5280	20.1723	20.4453	22.1691	20.9772
450229	1.5938	17.0346	17.9811	19.7903	18.2352
450231	1.5335	20.7709	21.3086	23.9590	21.9623
450234	1.0267	17.9478	22.3954	23.6160	20.9214
450235	0.9348	17.0143	18.7028	19.0615	18.1689
450236	1.1048	18.4551	17.7373	19.2828	18.4375
450237	1.6878	21.6497	22.4477	25.1444	23.0525
450239	0.9387	18.8416	19.3655	21.8150	19.9466
450241	0.9592	16.6047	17.4151	18.1153	17.3547
450243	0.9498	11.2034	13.0790	13.7168	12.6275
450246	***	22.7940	*	*	*
450249	0.9902	10.6467	13.1222	16.5616	13.2706
450250	0.8234	18.3361	13.3731	*	*
450253	1.0244	14.5493	16.6523	19.6275	16.7593
450258	1.0230	17.0724	*	*	*
450264	0.9202	17.2826	13.5345	15.2155	15.1177
450269	1.1027	12.2970	12.6907	14.8216	13.1637
450270	0.9003	13.8881	13.9053	15.0879	14.2216
450271	1.1467	17.9570	18.3659	19.3765	18.6013
450272	1.2351	20.5888	21.4520	23.7568	21.9749
450276	0.9030	14.0779	12.8895	16.2711	14.4519
450278	***	14.3933	*	*	*
450280	1.6008	22.2648	23.1664	27.4484	24.3266
450283	1.0894	15.8223	17.1013	19.7851	17.8034
450288	0.9655	17.4817	*	*	*

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
450289	1.3068	22.4656	23.7108	27.3769	24.5100
450292	1.2567	21.1511	23.4257	23.5611	22.6476
450293	0.8984	16.4077	17.7673	20.0161	18.1052
450296	1.0956	21.5998	20.4483	29.1927	23.4391
450299	1.4956	21.2754	22.9849	25.8068	23.3353
450303	0.8085	14.3353	16.1330	*	*
450306	0.9742	13.6333	17.6821	14.6634	14.8570
450307	***	17.6758	*	*	*
450309	***	16.0363	*	*	*
450315	0.7527	23.8151	26.4677	27.9780	26.0395
450320	***	24.8601	26.8089	*	*
450321	***	17.2290	*	*	*
450322	***	28.9837	*	*	*
450324	1.5054	20.9081	23.8523	23.6518	22.8285
450327	0.9476	11.0984	14.3848	*	*
450330	1.2445	21.0921	22.9947	24.4159	22.8901
450334	***	13.9812	*	*	*
450340	1.3886	19.2611	20.0621	22.7801	20.7364
450341	***	20.8814	*	*	*
450346	1.3993	19.2769	20.1921	21.9680	20.5488
450347	1.1289	20.1899	21.7142	22.8241	21.6326
450348	1.0160	15.0069	15.6324	17.0286	15.8296
450351	1.2312	21.2842	22.2597	23.6159	22.4251
450352	1.1044	21.2035	21.8138	23.4196	22.1851
450353	1.2413	17.3274	19.5263	20.9149	19.2812
450355	***	12.8876	*	*	*
450358	2.0243	25.5767	25.9105	29.3061	26.8686
450362	0.9871	18.7687	20.6340	22.0238	20.5416
450369	0.9637	16.0667	16.5636	17.3972	16.6509
450370	1.2668	18.7540	19.0340	22.5167	20.0240
450371	***	17.7591	17.3415	*	*
450372	1.3427	21.4051	22.9079	26.7931	23.4989
450373	0.9144	18.5716	17.7955	20.5630	18.8698
450374	0.9515	15.0145	15.0670	17.3100	15.8834
450378	1.4948	24.4143	25.8048	29.4627	26.7246
450379	1.3274	25.1931	29.0865	31.1266	28.5889
450381	0.8991	16.7237	19.0584	20.9341	19.1316
450388	1.6817	20.7989	22.4441	24.1490	22.5175
450389	1.2488	19.3156	20.7160	22.3669	20.8787

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
450393	0.7394	21.4405	23.8237	24.6126	23.0144
450395	1.0287	17.5236	19.1938	23.9535	20.2439
450399	0.9406	16.3333	19.1571	19.6351	18.3766
450400	1.2209	19.1345	20.1376	21.9856	20.4883
450403	1.2476	24.7656	24.6215	27.8834	25.7482
450411	0.9447	15.9165	16.9558	17.5475	16.8021
450417	0.8674	15.2713	16.1957	17.6324	16.3987
450418	1.3001	22.2511	25.1306	27.0283	24.8277
450419	1.1543	22.9522	26.7662	28.4953	25.9105
450422	1.2683	28.0395	29.0032	29.5556	28.8833
450424	1.2708	20.7634	22.0682	23.1225	22.0468
450431	1.5751	22.6766	22.9545	24.7310	23.4863
450438	1.1361	21.0474	19.2165	21.8657	20.7242
450446	0.6621	13.8011	14.1684	14.5956	14.2251
450447	1.2378	19.7532	21.0247	22.5212	21.1020
450451	1.0841	18.9518	21.1046	22.3428	20.8040
450460	0.9424	15.9446	17.9487	19.4107	17.8206
450462	1.6893	22.5413	24.0081	25.6867	24.1193
450464	0.8945	15.8120	16.1987	*	*
450465	1.1326	19.3927	19.4486	22.9340	20.5761
450467	***	18.9388	*	*	*
450469	1.4316	22.0389	24.0794	26.6726	24.4834
450473	***	18.3814	18.6002	*	*
450475	0.9825	19.0010	20.9443	20.7948	20.2419
450484	1.4184	19.5505	23.2881	23.0612	21.9997
450488	1.2120	22.0927	22.5650	22.3465	22.3342
450489	1.0238	17.8778	18.5941	19.4860	18.6203
450497	1.0671	15.9654	17.1327	17.6575	16.9055
450498	0.8938	15.9479	19.2984	16.3191	17.0883
450508	1.3836	19.3274	20.8183	23.4925	21.2737
450514	1.1104	20.7064	21.0116	21.3756	21.0738
450517	0.9475	17.6011	14.4246	15.2843	15.8379
450518	1.6577	20.7355	21.1015	22.2513	21.3724
450523	***	23.8270	22.3034	28.6387	24.7751
450530	1.1340	21.8988	23.3005	26.1953	23.9161
450534	0.8880	19.7411	22.5156	20.3577	20.7648
450535	***	21.5449	23.7255	29.4427	24.8048
450537	1.2972	20.8849	22.5972	24.0129	22.6018
450539	1.1771	19.3681	18.4299	20.0279	19.2814

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
450544	***	22.7282	*	*	*
450545	***	21.0792	21.7762	22.8130	21.8739
450547	0.9874	20.5049	22.6557	21.7528	21.5765
450551	***	16.1437	*	*	*
450558	1.8307	21.3116	21.4201	25.0874	22.5749
450563	1.2926	21.9935	27.5671	27.9456	25.9415
450565	1.2382	17.8058	17.2171	22.1903	18.9297
450571	1.5804	19.5325	21.5688	20.9565	20.6535
450573	1.0599	17.6157	18.6233	21.7245	19.2344
450574	***	14.8549	*	*	*
450575	***	24.0386	*	*	*
450578	0.8816	17.2864	17.3010	20.0590	18.1466
450580	1.1742	17.8225	18.5225	20.4230	18.9317
450583	***	15.9429	*	*	*
450584	1.0436	14.9237	16.9021	19.0078	16.8665
450586	0.9745	14.7433	14.9061	14.6574	14.7690
450587	1.1792	18.0014	19.0648	19.9631	19.0120
450591	1.2401	18.6714	19.6229	22.4855	20.2752
450596	1.1141	21.9445	24.3714	24.7329	23.6801
450597	0.9408	19.0641	19.9596	22.9427	20.7308
450603	0.6645	23.4923	20.6138	*	*
450604	1.2990	18.7465	19.5288	20.5198	19.6547
450605	1.0608	19.7400	22.0210	23.8820	21.8483
450609	0.9630	14.1776	16.6870	18.3943	16.4117
450610	1.6636	23.5626	24.7706	22.5425	23.6798
450614	***	*	18.5895	*	*
450615	0.9799	15.0622	17.2717	18.2089	16.8481
450617	1.4060	21.5004	22.7514	25.2159	23.2992
450620	0.9750	16.4330	17.1333	18.1469	17.2370
450623	1.0941	25.1122	25.1400	28.3336	26.1667
450626	1.0406	20.5225	17.7454	21.4046	19.7223
450628	***	20.0411	*	*	*
450630	1.4299	23.1839	24.8096	27.8599	25.4022
450631	***	21.8940	22.8637	24.5409	23.2078
450632	0.9340	15.1416	*	*	*
450634	1.5667	23.0470	24.8258	27.0185	25.1420
450638	1.5154	23.8335	26.3653	29.5150	26.6991
450639	1.4719	23.0496	24.2919	27.3640	24.9672
450641	1.0068	15.3652	17.4072	17.0732	16.6293

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
450643	1.4032	18.9087	20.2000	20.9594	20.0664
450644	1.3938	24.5834	24.4574	27.2059	25.5194
450646	1.4204	23.1240	21.8500	22.6492	22.5256
450647	1.8246	25.0549	26.8276	28.8925	26.9843
450648	0.9360	14.4884	17.3678	18.2826	16.5630
450649	0.9182	16.8505	17.5761	18.1185	17.5215
450651	1.5823	25.4679	26.9215	28.9974	27.2397
450653	1.0611	20.2436	22.7236	21.8630	21.6438
450654	0.8773	15.5858	16.3057	19.6054	17.1762
450656	1.3784	18.5874	20.7824	22.6425	20.6957
450658	0.8912	19.4139	19.6855	19.9788	19.6946
450659	1.4402	22.9344	26.0224	28.8082	26.1395
450661	1.8478	19.5504	20.0716	21.5471	20.4082
450662	1.5223	20.7973	26.3794	24.5735	23.8605
450665	0.8494	14.5158	15.8571	17.2058	15.8811
450668	1.4825	21.2002	24.0081	26.3874	23.8649
450669	1.2345	22.5150	25.0200	25.6418	24.4548
450670	1.3044	19.7696	19.9621	21.9903	20.6521
450672	1.6849	23.2623	25.3106	26.7602	25.1283
450673	0.9333	14.9115	16.3319	19.4030	16.8314
450674	0.9907	21.9624	24.8137	*	*
450675	1.3601	23.3954	24.8661	26.1503	24.9223
450677	1.3673	21.7366	22.9529	24.0189	22.9639
450678	1.4638	25.1841	28.1917	30.1180	27.9564
450683	1.1542	22.1965	24.5013	24.0105	23.5698
450684	1.2176	22.2380	23.8945	26.2870	24.1774
450686	1.5878	17.4746	17.9181	21.0565	18.8784
450688	1.2668	21.7691	21.7922	23.7687	22.5032
450690	1.4204	27.2400	33.1576	28.6823	29.3866
450694	1.0991	18.5520	21.4784	22.2655	20.6217
450697	1.3518	19.4424	20.8951	21.2357	20.5232
450698	0.8878	16.5111	18.1764	18.4298	17.6873
450700	0.9313	14.2055	17.3458	18.6080	16.7844
450702	1.5178	19.8094	22.2953	24.8664	22.2921
450704	***	18.1835	*	*	*
450705	***	18.7139	*	*	*
450706	***	22.4329	*	*	*
450709	1.3100	22.0123	23.4246	25.0784	23.5980
450711	1.6265	20.8047	22.1489	24.8129	22.7137

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
450712	***	11.1086	18.4547	*	*
450713	1.5105	23.6189	24.4002	26.7105	25.0000
450715	1.2949	24.8068	*	16.1897	*
450716	1.2348	20.8913	24.8614	28.7922	24.9249
450717	***	22.0243	*	*	*
450718	1.1687	23.0051	24.9162	27.6622	25.3824
450723	1.4018	22.0633	24.1618	26.9969	24.6187
450724	***	23.3800	21.9630	*	*
450727	0.9877	24.6125	16.0843	*	*
450728	***	14.9265	*	*	*
450730	1.2135	24.5952	27.8476	30.7568	27.8691
450733	***	21.9921	23.8143	25.5624	23.9940
450742	1.1791	22.8135	25.1295	26.3219	24.8547
450743	1.4558	20.5017	23.7424	24.7332	23.1004
450746	0.9294	14.6684	11.1672	16.9209	13.8671
450747	1.2285	20.3871	21.5883	24.2518	22.2672
450749	0.9830	18.7138	17.8696	18.3998	18.3320
450751	1.2619	19.8170	23.3154	22.9070	21.7213
450754	0.9240	17.8496	19.2827	21.0084	19.2905
450755	0.9598	20.0667	19.2768	19.4674	19.6425
450757	***	15.6425	*	*	*
450758	1.5231	22.6196	22.8713	23.9956	23.2243
450760	1.2714	20.4209	23.2959	25.7453	22.5615
450761	0.8352	14.6511	15.5151	16.0661	15.4370
450763	1.0962	18.9713	19.8939	21.4050	20.1068
450766	2.0207	25.4057	27.2499	28.8504	27.1592
450769	***	17.9878	*	*	*
450770	1.1442	20.0632	19.9412	19.7128	19.8982
450771	1.7098	21.6946	25.0490	26.1554	24.4866
450774	1.7702	*	21.7906	24.8814	*
450775	1.2357	22.6526	23.6621	25.3749	23.9614
450776	0.9359	13.4263	14.6695	*	*
450777	***	18.3118	*	*	*
450779	1.2073	22.6216	23.8882	22.5949	23.0162
450780	1.9387	20.0825	21.9046	22.8119	21.6331
450788	1.5618	19.9817	21.4467	24.2481	21.8331
450795	0.9719	27.0250	19.1371	28.1448	24.2717
450796	1.3957	26.8540	22.4973	24.7791	24.6249
450797	0.6550	20.2356	18.6839	23.8667	20.8787

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
450801	1.5179	18.0598	19.7790	22.2281	20.0102
450802	***	18.2461	*	*	*
450803	1.2415	37.0925	23.8343	26.2968	26.9602
450804	1.7574	20.5225	22.8275	25.9853	23.2139
450806	***	20.7906	*	*	*
450807	***	18.4410	*	*	*
450808	1.6675	18.1728	18.6555	22.8212	19.8151
450809	1.5710	21.9845	23.8758	24.7747	23.5884
450811	1.8539	21.6115	22.7583	23.0992	22.8679
450813	1.1164	15.3780	21.7208	21.8605	19.1618
450817	***	*	28.4441	*	*
450820	1.2534	24.6543	26.9121	27.9232	26.6833
450822	1.1662	24.8702	26.7821	29.7088	27.2633
450823	***	17.9757	*	*	*
450824	2.1416	25.7488	24.5885	*	*
450825	1.6991	16.0793	18.8510	18.5358	17.9780
450827	1.4852	20.1309	29.5838	20.9728	23.1601
450828	1.2216	19.2902	20.9509	21.4000	20.5851
450829	1.5522	14.7122	14.4463	18.3023	15.8868
450830	0.9905	*	24.7834	26.1344	*
450831	1.3471	*	*	20.0496	*
450832	1.1650	*	24.8572	26.4643	*
450833	1.1506	*	18.3196	26.1120	*
450834	1.3748	*	21.7217	22.8310	*
450835	***	*	24.8374	*	*
450837	***	*	24.2964	*	*
450838	1.0153	*	*	15.0454	*
450839	0.9401	*	*	21.0510	*
450840	0.9863	*	*	29.6612	*
450841	1.5337	*	*	17.6635	*
450842	***	*	*	23.0945	*
450844	1.2662	*	*	34.4296	*
450845	1.8945	*	*	26.5040	*
450846	***	*	*	24.0791	*
450847	1.2040	*	*	26.8868	*
450848	1.1906	*	*	26.5588	*
450850	1.8551	*	*	*	*
450851	2.0008	*	*	*	*
450852	1.4493	*	*	*	*

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble of this proposed rule.
*Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.
***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
450853	1.5344	*	*	*	*
450854	1.5642	*	*	*	*
450855	1.4913	*	*	*	*
450856	1.7893	*	*	*	*
450857	1.8137	*	*	*	*
450858	1.6970	*	*	*	*
450859	1.4381	*	*	*	*
450860	1.8520	*	*	*	*
450861	1.6160	*	*	*	*
450862	0.9722	*	*	*	*
450863	1.5024	*	*	*	*
450864	1.8916	*	*	*	*
450865	1.3072	*	*	*	*
450866	1.7760	*	*	*	*
450867	1.1572	*	*	*	*
450868	2.2536	*	*	*	*
450869	1.2144	*	*	*	*
450870	1.1320	*	*	*	*
460001	1.8668	23.5485	24.8844	25.6886	24.7215
460003	1.5958	22.9549	26.5141	24.3168	24.5504
460004	1.5983	23.1289	24.3409	25.2185	24.2474
460005	1.4693	23.0188	25.0063	22.6832	23.5132
460006	1.3068	22.1648	23.4200	24.4131	23.3370
460007	1.3426	22.0409	23.3603	24.2782	23.2549
460008	1.2713	22.6808	24.8233	24.3852	24.0485
460009	1.8793	23.1933	24.5865	25.1215	24.3471
460010	2.0753	24.0907	25.1240	26.2281	25.1700
460011	1.2757	25.3817	21.2634	22.3370	22.7274
460013	1.4514	21.2360	23.1467	23.4564	22.6016
460014	1.0521	*	22.6125	23.9508	*
460015	1.2612	22.4872	23.1068	24.0238	23.2226
460016	1.0658	19.0911	18.7453	*	*
460017	1.3201	19.0724	20.7789	21.6999	20.4647
460018	0.8691	17.0384	16.7143	18.8916	17.5460
460019	1.1070	19.3442	18.1995	20.3559	19.3065
460020	1.0124	18.1541	15.2162	19.4537	17.3695
460021	1.4597	23.1368	23.8565	24.9621	24.0247
460022	***	20.7539	*	*	*
460023	1.2289	24.1825	25.0874	25.0259	24.7747

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble of this proposed rule.
*Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.
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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
460025	0.7371	17.4069	22.3098	18.7978	19.3343
460026	0.9797	21.1759	21.9316	22.7429	21.9560
460027	***	21.4834	*	*	*
460029	0.9585	23.7147	24.4379	*	*
460030	1.2008	18.7655	21.2546	22.6070	20.8702
460032	1.0269	21.0286	21.2715	22.8795	21.8067
460033	0.9354	20.2389	21.7216	22.6821	21.5672
460035	1.0160	15.6979	16.9657	16.9019	16.5037
460036	1.1592	24.2650	23.9910	25.2631	24.5553
460037	0.9531	19.0115	20.0323	19.8481	19.6326
460039	1.0511	24.5133	26.3795	27.5876	26.1505
460041	1.3120	21.6676	23.5132	23.9822	23.1454
460042	1.3212	19.7531	22.0844	23.5643	21.8336
460043	1.3596	25.1366	26.0277	26.7013	25.9706
460044	1.1619	23.6604	24.7138	25.7159	24.7209
460047	1.6569	23.5447	24.9214	25.1648	24.5779
460049	1.9781	21.5241	21.9357	23.0776	22.1730
460051	1.1295	21.8950	22.7540	23.4194	22.7193
460052	1.4348	20.1989	23.1717	24.0882	22.5874
460053	***	*	23.2274	*	*
460054	1.8236	*	*	23.4376	*
470001	1.2963	21.7774	23.5882	24.5424	23.3360
470003	1.8832	23.3612	24.1739	24.6470	24.0935
470004	***	17.3576	*	*	*
470005	1.3090	22.6589	24.9625	25.7221	24.4968
470006	1.1578	21.0835	21.6036	26.0647	22.9786
470008	1.2165	20.3833	20.7659	21.8798	20.9985
470010	1.1250	22.3913	23.2072	22.9839	22.8685
470011	1.2229	24.1306	24.6034	25.9134	24.8957
470012	1.2150	19.8831	20.5072	22.9160	21.1606
470015	***	21.8204	*	*	*
470018	1.1902	24.8493	21.2904	25.9190	23.8983
470020	***	21.9910	*	*	*
470023	1.2996	22.5334	24.1395	26.7298	24.4618
470024	1.1814	23.2738	22.4659	23.7823	23.1792
490001	1.0863	21.4952	22.3622	20.5062	21.4432
490002	0.9979	16.5198	17.5098	18.5097	17.5091
490003	***	20.7688	20.9783	23.8112	21.7944
490004	1.2691	20.7616	22.7154	24.4488	22.6337

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*Denotes wage data not available for the provider for that year.

**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.

***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
490005	1.6617	23.1708	25.2213	27.6387	25.3807
490006	1.1986	19.8978	13.4277	16.7607	16.7017
490007	2.1670	20.7896	22.2526	24.9005	22.6556
490009	1.9262	24.7602	25.2181	27.5850	25.9238
490011	1.4783	19.8179	20.0136	22.4386	20.8019
490012	1.0596	16.0994	15.8346	18.3644	16.7373
490013	1.2476	18.3901	19.5094	21.4918	19.8115
490014	***	27.8907	*	*	*
490015	***	21.4500	21.2557	22.5641	21.8030
490017	1.4374	19.6594	20.7691	22.9611	21.1548
490018	1.2435	19.8955	22.0810	23.2154	21.7540
490019	1.1201	21.6789	23.3077	24.4269	23.1795
490020	1.2673	20.9212	21.2094	23.6576	21.9399
490021	1.4495	21.2263	22.2537	23.5785	22.3380
490022	1.4603	24.3008	24.4682	25.0406	24.6143
490023	1.2355	22.8400	24.9734	28.8383	25.6986
490024	1.7016	19.7491	21.2619	21.3617	20.8202
490027	1.0375	17.5178	20.3644	19.8062	19.2252
490031	1.0655	17.4262	18.4826	22.4265	19.4604
490032	1.8378	22.2041	23.6489	23.0443	22.9638
490033	1.0685	23.2088	24.4370	27.5541	25.2432
490037	1.1899	17.2117	17.5104	19.0735	17.9121
490038	1.1787	18.6012	18.1405	19.6329	18.8057
490040	1.4678	25.5461	27.0513	30.1726	27.6965
490041	1.3610	17.9942	19.9314	22.2906	20.1352
490042	1.2740	18.1864	19.5127	20.5730	19.4742
490043	1.1783	23.5367	25.4354	28.2902	25.8816
490044	1.4053	18.4845	20.8739	22.1255	20.5266
490045	1.2681	22.5238	24.7131	27.1957	25.0493
490046	1.5841	19.8518	22.0040	24.5553	22.1909
490047	1.0651	20.1660	19.8220	21.9017	20.5673
490048	1.4809	20.9110	22.3138	24.2170	22.5157
490050	1.4533	23.8519	26.1521	29.4460	26.5871
490052	1.6497	18.5693	19.2480	21.3944	19.7923
490053	1.2637	17.7363	18.6541	20.9298	19.1025
490054	***	22.5137	*	*	*
490057	1.5762	21.1871	22.1612	25.1593	22.8867
490059	1.5786	24.1516	23.3895	26.1525	24.6051
490060	1.0416	19.3525	20.6028	21.0801	20.3604

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
490063	1.8653	28.0906	31.0162	29.6511	29.5953
490066	1.3389	21.5920	22.1034	23.3603	22.4055
490067	1.2184	18.6469	20.4058	21.8558	20.3004
490069	1.5108	18.8335	20.6957	24.4454	21.4737
490071	1.3280	24.1882	25.4678	27.0352	25.7262
490073	1.5442	*	27.6711	25.2837	*
490075	1.4150	20.5801	22.3230	23.1139	22.0447
490077	1.2609	21.9175	22.2643	24.8126	23.0606
490079	1.3208	17.5839	19.2196	19.8027	18.8726
490084	1.2089	18.9679	19.8598	22.7774	20.5930
490085	1.1119	19.4261	*	*	*
490088	1.0834	19.1924	19.7549	21.4476	20.1693
490089	1.0408	19.7936	21.1522	21.1986	20.7285
490090	1.1415	19.2094	20.3015	21.3219	20.2815
490091	***	23.7493	*	*	*
490092	1.1166	27.1805	23.8364	21.6500	23.7961
490093	1.3985	19.1131	20.7388	23.6229	21.1732
490094	1.0141	20.2020	21.9886	26.0647	22.9823
490097	1.0628	16.6563	18.1022	23.4973	19.1676
490098	1.2154	18.5133	19.7116	20.9765	19.7206
490099	***	19.2604	*	*	*
490101	1.2442	25.7804	28.5200	30.1636	28.2642
490104	0.8197	17.1683	28.0286	33.1215	23.5098
490105	0.6547	28.7831	40.6821	38.6932	34.3808
490106	0.8754	31.8566	31.6541	30.4576	31.2829
490107	1.2812	23.9962	26.5312	28.7317	26.4976
490108	0.9859	24.8596	28.7277	28.0237	27.1237
490109	0.9712	23.0609	28.0978	27.9085	26.0953
490110	1.2750	18.8042	23.6080	21.3081	21.1192
490111	1.2973	19.9552	19.4041	20.6360	19.9966
490112	1.6861	23.2843	23.6028	25.8371	24.2930
490113	1.3227	26.1839	28.0893	29.1683	27.8313
490114	0.9841	18.8920	19.9725	20.0676	19.6682
490115	1.1759	18.4499	19.9151	20.3640	19.5851
490116	1.1295	18.2935	19.7007	21.5214	19.7880
490117	1.1332	17.1723	15.6078	17.3902	16.7319
490118	1.6700	24.2668	25.2230	26.8910	25.5537
490119	1.3160	18.9535	21.3883	23.7231	21.3306
490120	1.4149	20.6828	22.2389	23.1525	22.0427

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
490122	1.4078	26.6681	27.3509	28.7078	27.6140
490123	1.0989	20.0920	20.9506	22.9307	21.3170
490124	***	23.6526	21.3713	29.7939	25.0114
490126	1.2889	19.0782	20.4660	23.1303	20.8198
490127	1.1273	17.6437	17.8070	19.4019	18.3221
490130	1.2559	18.6406	18.6038	22.0748	19.7780
490132	0.9895	19.1742	19.5849	*	*
500001	1.5836	25.3478	26.6420	26.7242	26.2427
500002	1.4167	22.9942	24.0374	25.0466	24.0331
500003	1.2850	25.1200	27.3435	28.4173	27.0189
500005	1.8199	26.2066	28.9512	31.4101	28.8141
500007	1.3590	24.7889	23.5774	26.1094	24.8269
500008	1.9627	27.2852	28.9380	31.0007	29.1362
500011	1.2887	25.7263	27.6762	28.3417	27.2640
500012	1.6615	24.5450	26.2263	29.1918	26.7704
500014	1.6644	25.0490	27.4248	30.0855	27.6380
500015	1.3421	25.9465	27.3397	30.1011	27.7969
500016	1.6902	25.1227	27.7863	29.3451	27.4775
500019	1.2353	23.5730	25.7691	26.9408	25.5038
500021	1.3273	25.9403	26.4648	28.5913	27.0868
500023	1.1404	32.3079	23.9513	27.3344	27.4103
500024	1.6792	26.2112	27.2967	29.3928	27.6308
500025	1.6615	27.3697	29.0400	31.7099	29.3106
500026	1.4496	26.6107	28.7532	31.3774	28.8698
500027	1.5632	27.7429	30.6901	29.5800	29.3629
500028	0.9873	19.0262	*	*	*
500029	***	19.3130	*	*	*
500030	1.5092	28.5297	29.0487	30.7463	29.4910
500031	1.2090	25.8542	26.0740	28.5104	26.8128
500033	1.3121	23.8994	25.4345	26.6734	25.3762
500036	1.3888	25.1255	25.4753	26.0223	25.5683
500037	1.0789	22.1773	23.5414	24.6270	23.4689
500039	1.3804	25.4225	26.1409	27.9620	26.5966
500041	1.2861	24.7070	24.9004	26.7652	25.5095
500043	***	24.1746	*	*	*
500044	1.9538	24.7816	27.0880	27.0429	26.3510
500045	***	24.6265	*	*	*
500048	***	20.6332	*	*	*
500049	1.3573	26.5857	26.6407	25.6000	26.2300

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Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
500050	1.4315	23.0804	25.0907	26.8958	25.0813
500051	1.7594	26.7628	26.9538	28.8635	27.5598
500052	1.6069	*	*	*	*
500053	1.2944	24.2492	26.0112	26.7830	25.7617
500054	2.0598	25.7815	27.1965	28.7589	27.2635
500055	1.2108	23.7988	25.3095	*	*
500057	1.3159	20.5812	21.0357	21.4501	21.0475
500058	1.6331	26.5679	27.3411	28.4223	27.4791
500059	1.0800	25.3528	*	*	*
500060	1.3413	29.6030	31.7480	33.4126	31.6512
500061	***	24.5910	*	*	*
500062	0.9638	19.1685	*	*	*
500064	1.7503	27.5791	29.2539	31.1037	29.3257
500065	1.2265	24.0966	26.5880	26.0558	25.5820
500068	***	20.9277	*	*	*
500069	***	22.4158	*	*	*
500071	1.2555	22.3252	23.2071	*	*
500072	1.1629	25.7734	27.5706	29.4677	27.6464
500073	***	22.5221	*	*	*
500074	1.1524	20.6120	21.9019	*	*
500077	1.4700	24.5695	26.5692	27.8865	26.4096
500079	1.3478	24.7946	27.1775	28.4995	26.8627
500080	***	18.8186	*	*	*
500084	1.1925	25.0556	26.5864	27.6161	26.4958
500085	***	20.7422	*	*	*
500086	1.2735	24.2556	25.9705	*	*
500088	1.3557	26.4212	30.1689	31.2831	29.2857
500089	***	20.3478	*	*	*
500090	***	21.7715	*	*	*
500092	1.0339	20.3057	20.8601	23.2671	21.5415
500094	***	17.6624	*	*	*
500096	***	25.1135	*	*	*
500097	***	21.4424	*	*	*
500098	0.9576	17.8453	*	*	*
500101	***	19.8615	*	*	*
500102	***	23.1306	*	*	*
500104	1.2180	24.7875	26.8007	27.0063	26.2078
500106	***	17.1066	*	*	*
500107	1.2664	17.4641	*	*	*

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***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
500108	1.6686	26.1609	27.4156	28.7165	27.5238
500110	1.2247	23.5940	24.8448	25.4696	24.6488
500118	1.1255	24.7875	26.1971	28.0880	26.3710
500119	1.3733	23.9939	25.1576	27.2482	25.5011
500122	1.1736	24.4462	26.9006	27.4136	26.2950
500123	***	21.7133	*	*	*
500124	1.3848	24.6591	24.8357	28.6316	26.0775
500125	***	15.6304	*	*	*
500129	1.5824	25.2082	27.8351	30.0303	27.7415
500132	***	21.9915	*	*	*
500134	0.4723	15.9791	21.3921	24.3500	19.3634
500138	2.5854	*	*	*	*
500139	1.5358	23.7993	27.7281	29.2260	26.9583
500141	1.3055	28.1014	28.2968	30.7459	29.0873
500143	0.4865	18.7523	19.0982	20.7036	19.5700
500147	1.0420	*	*	16.5073	*
500148	1.0894	*	*	18.1676	*
510001	1.9196	20.2514	21.4247	22.9251	21.5897
510002	1.1376	19.1516	20.9822	22.4698	20.8558
510005	0.9082	13.8641	*	*	*
510006	1.2072	19.9760	21.0214	22.2918	21.1199
510007	1.5854	22.9326	23.4411	24.3425	23.5750
510008	1.1714	19.9176	22.7595	24.5196	22.4904
510012	1.0111	15.8596	16.7710	18.5646	17.0336
510013	1.0972	18.3486	19.7937	19.9632	19.3721
510015	0.8455	17.1595	17.9040	18.9813	18.0404
510018	1.0373	18.3023	19.9490	21.8405	19.9617
510020	***	15.7513	*	*	*
510022	1.8836	21.4336	22.7534	24.1430	22.8144
510023	1.2547	17.6516	17.9267	19.4262	18.3466
510024	1.6424	19.6521	21.3662	22.9261	21.3413
510026	1.0318	14.8785	16.5389	18.0989	16.4033
510027	***	20.5222	*	*	*
510028	0.9920	22.4826	24.6544	22.9511	23.3167
510029	1.2799	18.9000	19.8202	21.7430	20.1907
510030	1.1165	19.2558	19.8220	22.3592	20.5043
510031	1.3471	19.3049	20.5743	21.7592	20.6110
510033	1.2454	19.6900	19.6921	21.0614	20.1575
510035	***	21.8290	*	*	*

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble of this proposed rule.
*Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.
***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
510036	***	15.0266	*	*	*
510038	1.0286	15.9821	16.1016	16.8650	16.3309
510039	1.2293	17.4002	17.6173	19.1822	18.0662
510043	0.9021	14.4202	15.5857	16.0675	15.3739
510046	1.2889	18.7424	19.2802	21.2815	19.7483
510047	1.1345	21.2885	22.1953	23.2091	22.2287
510048	1.1260	15.2886	16.3761	17.6740	16.3557
510050	1.5468	18.3964	18.9990	20.1952	19.1826
510053	1.1792	18.1046	18.1054	20.7484	19.0333
510055	1.3790	25.6333	27.7422	29.4027	27.5840
510058	1.2522	18.6025	20.1104	22.2526	20.3497
510059	0.8951	17.3845	18.1543	18.7668	18.1308
510061	1.0409	14.6773	14.8848	15.3175	14.9560
510062	1.1729	19.7202	21.3405	21.1823	20.7648
510067	1.1342	17.8816	18.0113	22.1464	19.3193
510068	1.1308	19.4299	19.9056	19.9778	19.7811
510070	1.1887	18.6226	20.0974	21.1997	19.9519
510071	1.2639	18.8766	19.4029	21.5340	19.9685
510072	1.1019	16.5279	18.4566	19.7850	18.2954
510077	1.1003	20.4521	20.9153	22.7887	21.4003
510080	***	19.7132	*	*	*
510081	***	10.4972	*	*	*
510082	1.0854	16.0014	17.2891	16.4575	16.5862
510084	***	14.9683	*	*	*
510085	1.1966	19.0175	20.6364	22.7022	20.8015
510086	1.1379	16.3413	16.3051	17.8217	16.8053
510088	1.0405	16.2850	16.4373	18.3488	16.9674
520002	1.2613	20.2691	22.0838	23.7338	22.0959
520003	1.2258	18.7507	20.4234	21.8477	20.4041
520004	1.3404	21.1549	22.8530	24.4627	22.8092
520006	***	22.4098	*	*	*
520007	***	18.3959	*	*	*
520008	1.6248	24.4927	26.0931	27.8025	26.2077
520009	1.7108	19.8142	21.5169	23.4149	21.4859
520010	1.1069	25.5623	26.3965	28.5280	26.8594
520011	1.1708	21.6945	22.7880	23.7797	22.7762
520013	1.3691	22.1009	23.1173	24.1667	23.1824
520014	1.0859	19.2760	20.4281	22.1014	20.5973
520015	1.1497	21.0428	22.8094	23.0394	22.3077

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble of this proposed rule.
*Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.
***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
520016	***	19.5656	*	*	*
520017	1.1172	21.1409	21.7542	23.3985	22.1292
520018	***	22.1929	*	*	*
520019	1.3165	21.8870	22.6895	24.9633	23.2412
520021	1.4632	22.8484	24.1284	25.4628	24.1652
520024	1.0681	16.4879	17.5368	18.5054	17.5406
520025	1.1649	21.9529	*	*	*
520026	1.0408	22.4778	25.0504	26.1010	24.6780
520027	1.3030	22.1450	22.2089	26.2472	23.6633
520028	1.2455	22.0333	24.3592	25.7721	24.0820
520029	***	21.5561	*	*	*
520030	1.7468	22.7239	23.9474	25.3575	24.1052
520031	***	21.2809	*	*	*
520032	1.1786	24.1093	22.7220	25.3161	24.0580
520033	1.2757	21.0088	22.2650	23.9750	22.4455
520034	1.1672	21.5275	22.6160	23.6498	22.7387
520035	1.2914	19.8917	20.8563	23.2564	21.3834
520037	1.7731	23.0801	25.0587	28.6754	25.6869
520038	1.2508	21.4207	23.1036	24.6459	23.0812
520039	1.0367	21.1719	*	*	*
520040	1.4878	23.0710	21.5671	23.8463	22.8312
520041	1.1123	18.2997	22.6216	22.8285	21.1938
520042	1.0462	20.6354	21.9935	24.0799	22.2805
520044	1.3454	21.4913	22.7627	24.9350	23.0809
520045	1.4920	21.9812	24.1624	24.5562	23.5581
520047	0.9218	21.0370	22.5686	25.3579	22.9203
520048	1.5890	20.3488	20.5069	23.1618	21.3220
520049	2.1371	21.8271	22.7424	24.0988	22.9252
520051	1.7128	23.4366	27.6695	28.8229	26.6233
520053	1.0751	18.9512	*	*	*
520054	***	16.6278	*	*	*
520057	1.1630	20.6959	21.2729	23.3187	21.7613
520058	0.9854	23.6795	23.2907	*	*
520059	1.2264	22.1618	24.1863	26.5675	24.3593
520060	1.2763	20.3357	21.1271	21.7581	21.0703
520062	1.2794	21.2865	23.7166	24.9833	23.4247
520063	1.1755	21.2774	23.3037	25.3600	23.3802
520064	1.5789	23.8181	24.3043	27.1105	25.0676
520066	1.5834	25.4528	23.9212	25.8618	25.0454

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble of this proposed rule.
*Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.
***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
520068	0.8840	20.6112	21.4413	23.4591	21.8640
520069	***	21.7234	32.6484	*	*
520070	1.7453	20.0096	22.0590	23.9883	22.0408
520071	1.2133	22.0066	23.4832	26.3143	23.9769
520074	***	21.6636	*	*	*
520075	1.5271	22.1894	23.7322	26.0559	24.0621
520076	1.2195	20.6155	22.2993	24.0554	22.3341
520077	***	18.1078	*	*	*
520078	1.4908	21.7414	23.4414	25.7530	23.6562
520083	1.7179	24.2401	25.7108	26.9612	25.6574
520084	1.0963	21.8102	24.7909	25.6183	24.0871
520087	1.6496	22.2579	22.8974	24.5320	23.2920
520088	1.2372	22.3921	23.8938	26.0821	24.1790
520089	1.4851	23.2335	24.4435	26.5954	24.7961
520090	***	20.9070	*	*	*
520091	1.2773	22.2218	22.8914	23.3479	22.8075
520092	1.0770	19.7181	21.8662	23.3966	21.6935
520094	0.7099	21.3082	22.3925	25.3166	23.0681
520095	1.2464	21.9177	25.1402	28.6278	25.2173
520096	1.3971	21.6803	21.1759	22.9953	21.9971
520097	1.3751	22.2375	23.6512	25.1079	23.7323
520098	2.0575	25.0055	25.8184	28.0642	26.3405
520100	1.2845	20.5366	21.7072	24.5830	22.3042
520101	***	20.0164	*	*	*
520102	1.0937	22.3640	23.7739	25.6099	23.9623
520103	1.4570	22.2765	23.5984	25.5250	23.8354
520107	1.2053	23.8421	25.7379	27.7129	25.6934
520109	1.0887	20.3208	20.6357	22.4025	21.1679
520110	***	22.3923	*	*	*
520111	***	18.2745	26.9666	26.3095	23.4810
520112	1.1228	17.6226	19.1409	20.4034	19.0701
520113	1.3251	23.1852	24.0822	26.7881	24.7162
520114	1.1312	18.5767	21.9847	22.0709	20.8166
520115	***	21.4279	*	*	*
520116	1.1279	22.2741	23.9066	26.5620	24.3222
520117	1.0223	19.3653	21.9915	22.0039	21.1636
520118	***	13.9919	*	*	*
520121	***	20.9423	*	*	*
520122	***	16.9906	*	*	*

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***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
520123	0.9859	19.8134	21.2360	22.2471	21.0907
520124	***	19.2621	*	*	*
520130	1.0387	18.8845	20.0277	*	*
520131	***	21.0400	*	*	*
520132	1.0677	18.2634	19.5140	21.5957	19.7105
520134	1.0383	19.6881	20.8502	*	*
520135	0.9266	18.1027	18.8254	18.5356	18.4881
520136	1.6028	21.3966	23.2573	25.5086	23.3610
520138	1.8920	23.1498	25.1434	26.9071	25.1031
520139	1.2482	22.8070	23.7727	25.4271	24.0402
520140	1.7041	22.5459	23.9176	26.1606	24.1379
520142	***	21.4119	*	*	*
520144	***	20.5863	*	*	*
520145	***	20.3461	25.0770	*	*
520146	***	18.6337	*	*	*
520148	1.1614	20.5075	22.4299	26.2220	23.1736
520149	***	13.8615	*	*	*
520151	0.9887	19.3362	20.1995	22.8874	20.8206
520152	1.1189	26.2403	22.5440	23.2387	23.6463
520153	***	18.5986	*	*	*
520154	1.2431	21.0486	23.2635	23.7011	22.6593
520156	1.0496	20.7808	23.7157	24.9179	23.1748
520157	***	21.6822	*	*	*
520159	***	21.8784	*	*	*
520160	1.7485	21.5871	22.9475	24.3408	23.0109
520161	0.9827	21.4038	22.1857	24.0514	22.5630
520170	1.2955	23.0867	25.5470	25.5956	24.7768
520171	***	18.1843	*	*	*
520173	1.0998	23.2955	24.4723	25.7041	24.4974
520177	1.7555	25.0908	27.5560	28.4358	27.1337
520178	1.0016	23.1510	22.3193	23.0459	22.8422
520189	1.2183	22.0889	23.1658	26.3176	23.9819
520192	***	*	22.5641	*	*
520193	1.6941	*	*	*	*
520195	0.3934	*	*	*	*
520196	1.4398	*	*	*	*
530002	1.1362	23.0582	23.8852	25.2649	24.1476
530003	***	17.1646	*	*	*
530004	***	17.4672	19.7857	*	*

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble of this proposed rule.
*Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2003, 2004, and 2005.
***Denotes MedPAR data not available for the provider for FY 2003.

Provider No.	Case-Mix Index	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage FY 2005[1]	Average hourly wage **(3 yrs)
530005	***	18.4391	*	*	*
530006	1.1195	20.7660	21.3429	22.8578	21.7176
530007	1.1217	18.5286	22.3309	19.3476	20.0667
530008	1.1951	19.5386	21.8714	23.8266	21.6877
530009	0.9321	23.5840	22.0450	23.9849	23.1082
530010	1.1956	17.8687	21.4890	23.9187	21.1202
530011	1.0798	19.9212	22.5720	24.2274	22.2575
530012	1.6320	22.5084	22.4716	24.4534	23.1390
530014	1.5365	20.0422	21.7314	23.7623	21.9411
530015	1.3543	24.6527	25.3915	26.4595	25.5096
530016	1.2796	20.3647	21.0666	21.1852	20.8633
530017	0.8948	20.9407	19.5630	23.2049	21.1541
530018	1.0595	20.1225	*	*	*
530019	0.8190	18.1492	*	*	*
530022	1.0845	19.7903	*	*	*
530023	1.2340	21.6352	22.5535	22.7700	22.3866
530025	1.3112	22.4816	25.4693	28.0914	25.3815
530026	1.0519	20.9918	21.0732	*	*
530029	0.9971	20.3045	19.9691	*	*
530031	0.8719	23.2766	16.8825	17.4307	19.3320
530032	***	20.9856	19.4449	22.6763	21.0178

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble of this proposed rule.
*Denotes wage data not available for the provider for that year.
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***Denotes MedPAR data not available for the provider for FY 2003.

TABLE 3A.--FY 2005 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS

[*Based on the sum of the Salaries and Hours Computed for Federal Fiscal Years 2003, 2004, and 2005]

Urban area	FY 2005 average hourly wage	3-Year average hourly wage
Abilene, TX	20.7192	18.9824
Aguadilla-Isabela-San Sebastián, PR	11.2655	10.7453
Akron, OH	23.8325	22.9962
Albany, GA	29.7233	27.0817
Albany-Schenectady-Troy, NY	22.8339	21.1332
Albuquerque, NM	26.7304	23.7887
Alexandria, LA	21.5523	19.8721
Allentown-Bethlehem-Easton, PA-NJ	25.0787	23.9067
Altoona, PA	22.2721	21.8268
Amarillo, TX	24.2098	22.4647
Ames, IA	24.9835	23.3759
Anchorage, AK	32.0618	30.6014
Anderson, IN	23.0539	22.1872
Anderson, SC	22.8431	21.2369
Ann Arbor, MI	29.0908	27.7788
Anniston-Oxford, AL	20.8110	19.8344
Appleton, WI	23.9687	22.3453
Asheville, NC	24.2317	23.1925
Athens-Clarke County, GA	26.3163	24.7864
Atlanta-Sandy Springs-Marietta, GA	26.0968	24.7895
Atlantic City, NJ	28.1913	26.9178
Auburn-Opelika, AL	21.6392	20.7095
Augusta-Richmond County, GA-SC	24.1049	23.7946
Austin-Round Rock, TX	25.2889	23.8238
Bakersfield, CA	26.4694	24.5972
Baltimore-Towson, MD	26.0377	24.5999
Bangor, ME	26.1851	24.5706
Barnstable Town, MA	31.4568	31.4010
Baton Rouge, LA	21.9357	20.6202
Battle Creek, MI	24.0082	23.1843
Bay City, MI	25.2405	24.2291

Urban area	FY 2005 average hourly wage	3-Year average hourly wage
Beaumont-Port Arthur, TX	22.5157	20.9402
Bellingham, WA	30.7463	29.4910
Bend, OR	27.9273	26.2021
Bethesda-Frederick-Gaithersburg, MD	28.9018	27.1525
Billings, MT	23.6440	22.3010
Binghamton, NY	22.3058	20.8442
Birmingham-Hoover, AL	23.9518	22.6209
Bismarck, ND	19.7855	19.3431
Blacksburg-Christiansburg-Radford, VA	21.0452	20.0679
Bloomington, IN	22.6815	21.6305
Bloomington-Normal, IL	23.9217	22.3486
Boise City-Nampa, ID	24.6083	23.0621
Boston-Quincy, MA	30.6248	29.0263
Boulder, CO	26.4802	24.7280
Bowling Green, KY	21.4593	20.8100
Bremerton-Silverdale, WA	27.9620	26.5966
Bridgeport-Stamford-Norwalk, CT	33.8515	32.2888
Bristol, VA	20.9298	19.1025
Brownsville-Harlingen, TX	26.7592	24.2502
Brunswick, GA	31.5173	25.9538
Buffalo-Niagara Falls, NY	24.5833	23.3255
Burlington, NC	23.3479	22.3446
Burlington-South Burlington, VT	24.5519	23.9875
Cambridge-Newton-Framingham, MA	29.4435	27.2369
Camden, NJ	28.0847	26.6655
Canton-Massillon, OH	23.4424	22.2411
Cape Coral-Fort Myers, FL	24.6614	23.8158
Carson City, NV	27.2406	25.0243
Casper, WY	24.4534	23.1390
Cedar Rapids, IA	23.6258	22.2100
Champaign-Urbana, IL	25.0781	24.7625
Charleston, WV	23.3325	21.9766
Charleston-North Charleston, SC	24.6576	23.0430
Charlotte-Gastonia-Concord, NC-SC	25.6333	24.3300
Charlottesville, VA	27.1238	25.4502
Chattanooga, TN-GA	24.2726	22.6360
Cheyenne, WY	23.7623	21.9411
Chicago-Naperville-Joliet, IL	28.4445	27.1142

Urban area	FY 2005 average hourly wage	3-Year average hourly wage
Chico, CA	27.8014	25.3690
Cincinnati-Middletown, OH-KY-IN	25.0591	23.3569
Clarksville, TN-KY	21.1036	20.3476
Cleveland, TN	20.7027	19.6847
Cleveland-Elyria-Mentor, OH	25.4150	23.9998
Coeur d'Alene, ID	24.5700	23.4802
College Station-Bryan, TX	22.3591	21.7365
Colorado Springs, CO	25.7626	24.4544
Columbia, MO	21.9565	21.0526
Columbia, SC	23.8491	22.4081
Columbus, GA-AL	22.9004	21.3117
Columbus, IN	24.9031	23.5191
Columbus, OH	25.6517	24.0771
Corpus Christi, TX	22.7808	21.3078
Corvallis, OR	27.7295	27.6296
Cumberland, MD-WV	22.7893	20.3329
Dallas-Plano-Irving, TX	26.5316	24.9176
Dalton, GA	24.5022	23.5790
Danville, IL	22.1298	21.6265
Danville, VA	23.1139	22.0447
Davenport-Moline-Rock Island, IA-IL	23.0728	21.9290
Dayton, OH	24.5023	23.1075
Decatur, AL	23.4374	22.1047
Decatur, IL	21.2982	20.0769
Deltona-Daytona Beach-Ormond Beach, FL	22.7892	22.0973
Denver-Aurora, CO	28.6847	26.7513
Des Moines, IA	24.4196	22.5843
Detroit-Livonia-Dearborn, MI	27.2854	25.8075
Dothan, AL	19.9523	19.1936
Dover, DE	25.1831	23.7712
Dubuque, IA	22.9987	21.7824
Duluth, MN-WI	27.4696	25.6665
Durham, NC	27.1096	25.6687
Eau Claire, WI	23.9598	22.4824
Edison, NJ	29.3402	27.5086
El Centro, CA	23.4586	22.4957
El Paso, TX	24.2125	22.8475
Elizabethtown, KY	22.9071	20.9570

Urban area	FY 2005 average hourly wage	3-Year average hourly wage
Elkhart-Goshen, IN	24.4124	23.7579
Elmira, NY	22.3147	20.8650
Erie, PA	28.0402	26.1158
Essex County, MA	28.7902	27.8766
Eugene-Springfield, OR	22.1001	20.6171
Evansville, IN-KY	29.3199	28.0993
Fairbanks, AK	10.5531	10.3744
Fajardo, PR	24.0221	23.5747
Fargo, ND-MN	21.2164	21.8840
Farmington, NM	24.6779	22.5084
Fayetteville, NC	22.8043	20.8321
Fayetteville-Springdale-Rogers, AR-MO	28.4041	27.6198
Flagstaff, AZ	29.4095	27.3393
Flint, MI	20.8152	19.3461
Florence, AL	22.4510	21.3335
Florence, SC	26.0821	24.1790
Fond du Lac, WI	26.6637	25.0766
Fort Collins-Loveland, CO	26.7632	25.3385
Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	21.8487	20.2453
Fort Smith, AR-OK	23.1492	22.6355
Fort Walton Beach-Crestview-Destin, FL	25.8298	23.9115
Fort Wayne, IN	25.0153	23.3197
Fort Worth-Arlington, TX	28.0138	25.8765
Fresno, CA	21.2676	20.4740
Gadsden, AL	19.8501	21.8864
Gainesville, FL	25.1968	23.1944
Gainesville, GA	24.5239	23.3155
Gary, IN	22.3680	20.9769
Glens Falls, NY	23.1243	21.6987
Goldsboro, NC	24.1051	21.9885
Grand Forks, ND-MN	26.1549	24.0220
Grand Junction, CO	24.8623	23.4427
Grand Rapids-Wyoming, MI	23.3814	21.9663
Great Falls, MT	24.9396	23.3099
Greeley, CO	25.2440	23.6155
Green Bay, WI	24.2613	22.8768
Greensboro-High Point, NC	24.4124	23.7579
Greenville, NC	24.1414	22.5921

Urban area	FY 2005 average hourly wage	3-Year average hourly wage
Greenville, SC	24.4160	23.4426
Guayama, PR	10.5559	9.9125
Gulfport-Biloxi, MS	23.5390	22.4842
Hagerstown-Martinsburg, MD-WV	25.6718	23.1815
Hanford-Corcoran, CA	24.5762	21.7460
Harrisburg-Carlisle, PA	24.6512	23.0614
Harrisonburg, VA	24.4488	22.6337
Hartford-West Hartford-East Hartford, CT	29.2036	28.2830
Hattiesburg, MS	19.4249	18.4478
Hickory-Lenoir-Morganton, NC	24.9978	22.9254
Hinesville-Fort Stewart, GA	20.3855	19.3480
Holland-Grand Haven, MI	24.9271	23.6522
Honolulu, HI	28.9110	27.6426
Hot Springs, AR	24.4130	22.4838
Houma-Bayou Cane-Thibodaux, LA	20.4523	19.7139
Houston-Baytown-Sugar Land, TX	26.2765	24.3806
Huntington-Ashland, WV-KY-OH	25.1999	24.0420
Huntsville, AL	23.2679	22.2981
Idaho Falls, ID	23.8241	22.0793
Indianapolis, IN	26.5576	24.6427
Iowa City, IA	25.4051	23.7752
Ithaca, NY	25.7515	24.3335
Jackson, MI	24.0606	22.7959
Jackson, MS	21.8345	20.7075
Jackson, TN	23.4297	22.4121
Jacksonville, FL	25.1358	23.5679
Jacksonville, NC	22.1036	20.7500
Janesville, WI	25.2849	23.7717
Jefferson City, MO	21.9580	21.3716
Johnson City, TN	21.0075	19.8585
Johnstown, PA	22.0755	21.0851
Jonesboro, AR	21.0310	19.4623
Joplin, MO	22.9927	21.5121
Kalamazoo-Portage, MI	28.1681	26.8790
Kankakee-Bradley, IL	27.7396	26.1968
Kansas City, MO-KS	25.3052	23.9705
Kennewick-Richland-Pasco, WA	27.6830	26.9371
Killeen-Temple-Fort Hood, TX	24.4525	23.7215

Urban area	FY 2005 average hourly wage	3-Year average hourly wage
Kingsport-Bristol, TN-VA	21.7068	20.9083
Kingston, NY	23.3310	22.8485
Knoxville, TN	22.5696	21.8145
Kokomo, IN	23.7604	22.5267
La Crosse, WI-MN	24.4486	23.0910
Lafayette, IN	23.8521	22.6294
Lafayette, LA	21.8711	20.8396
Lake Charles, LA	20.8252	19.5207
Lake County-Kenosha County, IL-WI	27.1905	25.6826
Lakeland, FL	23.5669	22.3605
Lancaster, PA	26.0776	23.4410
Lansing-East Lansing, MI	25.4363	24.0043
Laredo, TX	21.8037	20.4902
Las Cruces, NM	23.0910	21.6543
Las Vegas-Paradise, NV	29.9181	29.0021
Lawton, OK	21.7250	20.5120
Lebanon, PA	22.5879	21.0978
Lewiston, ID-WA	24.5156	23.4734
Lewiston-Auburn, ME	25.2729	23.3141
Lexington-Fayette, KY	23.8558	21.9407
Lima, OH	24.5295	23.5975
Lincoln, NE	26.8321	25.2305
Little Rock-North Little Rock, AR	23.7449	22.2587
Logan, UT-ID	23.9292	23.2359
Longview, TX	23.1966	21.8904
Longview, WA	26.7652	25.5095
Los Angeles-Long Beach-Glendale, CA Metropolitan Div	30.8382	29.3226
Louisville, KY-IN	24.0460	22.8315
Lubbock, TX	23.1292	21.9599
Lynchburg, VA	23.7883	22.5784
Macon, GA	26.1161	23.3172
Madera, CA	22.4666	21.5471
Madison, WI	27.1443	25.4986
Manchester-Nashua, NH	27.7970	26.1531
Mansfield, OH	24.2494	22.8092
Mayagüez, PR	11.7074	11.2316
McAllen-Edinburg-Pharr, TX	22.6720	21.2111
Medford, OR	27.7639	26.3299

Urban area	FY 2005 average hourly wage	3-Year average hourly wage
Memphis, TN-MS-AR	24.3194	22.4212
Merced, CA	27.1731	24.6543
Miami-Miami Beach-Kendall, FL	26.4073	24.6105
Michigan City-La Porte, IN	24.5851	23.6069
Midland, TX	24.7346	24.4654
Milwaukee-Waukesha-West Allis, WI	26.5679	24.7859
Minneapolis-St. Paul-Bloomington, MN-WI	29.1136	27.2452
Missoula, MT	25.2650	22.6543
Mobile, AL	21.0774	19.9429
Modesto, CA	31.5679	28.1097
Monroe, LA	20.8428	19.7851
Monroe, MI	25.0193	23.6265
Montgomery, AL	21.8534	19.6944
Morgantown, WV	22.9253	21.5156
Morristown, TN	20.4952	19.5595
Mount Vernon-Anacortes, WA	27.8164	26.4332
Muncie, IN	22.6476	21.9816
Muskegon-Norton Shores, MI	25.6847	24.0160
Myrtle Beach-Conway-North Myrtle Beach, SC	22.5894	22.0416
Napa, CA	32.9951	30.3948
Naples-Marco Island, FL	27.8495	24.9735
Nashville-Davidson--Murfreesboro, TN	26.5923	24.4382
Newark-Union, NJ-PA	31.0966	29.3258
New Haven-Milford, CT	23.9702	22.5635
New Orleans-Metairie-Kenner, LA	35.0299	33.8042
New York-Wayne-White Plains, NY-NJ	30.7799	28.6257
Niles-Benton Harbor, MI	23.4564	22.1503
Norwich-New London, CT	30.5636	28.9104
Oakland-Fremont-Hayward, CA	40.0963	37.4101
Ocala, FL	24.1700	23.3534
Ocean City, NJ	28.5014	26.7316
Odessa, TX	25.8218	22.7836
Ogden-Clearfield, UT	24.2790	23.6339
Oklahoma City, OK	23.6748	22.2955
Olympia, WA	29.0091	27.1952
Omaha-Council Bluffs, NE-IA	25.6722	24.3668
Orlando, FL	25.7100	24.0572
Oshkosh-Neenah, WI	23.8900	22.4593

Urban area	FY 2005 average hourly wage	3-Year average hourly wage
Owensboro, KY	22.2688	20.8069
Oxnard-Thousand Oaks-Ventura, CA	29.2604	27.4878
Palm Bay-Melbourne-Titusville, FL	25.3166	24.4546
Panama City-Lynn Haven, FL	21.4149	20.7673
Parkersburg-Marietta, WV-OH	22.0522	20.3637
Pascagoula, MS	21.0129	20.2767
Pensacola-Ferry Pass-Brent, FL	21.9457	21.2533
Peoria, IL	23.1144	21.7408
Philadelphia, PA	28.6035	26.8410
Phoenix-Mesa-Scottsdale, AZ	26.3143	24.7648
Pine Bluff, AR	22.9353	20.2396
Pittsburgh, PA	22.9852	22.2476
Pittsfield, MA	28.2766	25.8438
Pocatello, ID	25.2790	23.0882
Ponce, PR	13.1955	12.2999
Portland-South Portland-Biddeford, ME	26.4924	24.6939
Portland-Vancouver-Beaverton, OR-WA	26.6238	24.6954
Port St. Lucie-Fort Pierce, FL	29.9284	27.5978
Poughkeepsie-Newburgh-Middletown, NY	29.9575	27.8180
Prescott, AZ	26.0843	24.3852
Providence-New Bedford-Fall River, RI-MA	28.7646	26.9631
Provo-Orem, UT	25.2290	24.3330
Pueblo, CO	23.0560	21.7707
Punta Gorda, FL	24.9044	23.3102
Racine, WI	23.8692	22.5330
Raleigh-Cary, NC	26.4490	23.8614
Rapid City, SD	23.5206	22.0026
Reading, PA	24.1151	22.7873
Redding, CA	31.1709	28.5235
Reno-Sparks, NV	27.5368	26.3026
Richmond, VA	24.7694	23.3257
Riverside-San Bernardino-Ontario, CA	28.9108	27.8355
Roanoke, VA	21.9573	21.1792
Rochester, MN	30.2629	29.1844
Rochester, NY	24.4689	23.3450
Rockford, IL	25.3001	23.8777
Rockingham County-Strafford County, NH	26.9005	25.0922
Rocky Mount, NC	23.7044	22.4921

Urban area	FY 2005 average hourly wage	3-Year average hourly wage
Rome, GA	23.3383	22.1831
Sacramento--Arden-Arcade--Roseville, CA	30.7769	28.6803
Saginaw-Saginaw Township North, MI	25.9729	24.2444
Salem, OR	27.7944	25.9246
Salinas, CA	36.6654	35.4103
Salisbury, MD	24.0152	22.6054
Salt Lake City, UT	25.2083	24.4086
San Angelo, TX	21.5431	20.6794
San Antonio, TX	23.7158	21.9397
San Diego-Carlsbad-San Marcos, CA	29.6165	27.7504
San Francisco-San Mateo-Redwood City, CA	37.8648	35.5059
San Germán-Cabo Rojo, PR	13.8117	13.3968
San Jose-Sunnyvale-Santa Clara, CA	38.2329	35.7808
San Juan-Caguas-Guaynabo, PR	12.2140	11.6037
San Luis Obispo-Paso Robles, CA	29.2883	27.9302
Sandusky, OH	23.7799	22.2393
Santa Ana-Anaheim-Irvine, CA	30.5694	28.5166
Santa Barbara-Santa Maria-Goleta, CA	28.2108	26.2466
Santa Cruz-Watsonville, CA	38.8735	34.1822
Santa Fe, NM	28.6906	27.0247
Santa Rosa-Petaluma, CA	34.0679	32.4622
Sarasota-Bradenton-Venice, FL	25.3305	23.9836
Savannah, GA	24.8959	23.4451
Scranton--Wilkes-Barre, PA	22.4217	21.1520
Seattle-Bellevue-Everett, WA	30.2247	28.5300
Sheboygan, WI	23.6199	21.7331
Sherman-Denison, TX	25.3558	23.6878
Shreveport-Bossier City, LA	24.0625	22.4763
Sioux City, IA-NE-SD	23.8643	22.3353
Sioux Falls, SD	24.8121	23.2534
South Bend-Mishawaka, IN-MI	24.8646	23.9958
Spartanburg, SC	23.7540	22.2281
Spokane, WA	28.0624	26.7830
Springfield, IL	23.0154	21.7482
Springfield, MA	26.8243	26.0789
Springfield, MO	22.2360	20.9588
Springfield, OH	23.0371	21.8250
St. Cloud, MN	26.7982	24.3631

Urban area	FY 2005 average hourly wage	3-Year average hourly wage
St. George, UT	24.9621	24.0247
St. Louis, MO-IL	23.8362	22.2550
State College, PA	22.3097	21.5709
Stockton, CA	27.8806	26.0627
Suffolk County-Nassau County, NY	34.0869	32.5664
Sumter, SC	21.1891	20.2758
Syracuse, NY	24.9860	23.7102
Tacoma, WA	29.1965	27.4453
Tallahassee, FL	22.8474	21.2591
Tampa-St. Petersburg-Clearwater, FL	23.8900	22.4996
Terre Haute, IN	22.4475	20.9616
Texarkana, TX-Texarkana, AR	22.1678	20.3845
Toledo, OH	25.0701	23.6845
Topeka, KS	23.4381	22.4553
Trenton-Ewing, NJ	27.0639	25.7890
Tucson, AZ	23.5858	22.0873
Tulsa, OK	22.8973	21.5543
Tuscaloosa, AL	21.9743	20.2439
Tyler, TX	25.0645	23.6477
Utica-Rome, NY	21.9234	20.8668
Valdosta, GA	21.9663	20.8793
Vallejo-Fairfield, CA	37.5290	35.5583
Vero Beach, FL	25.0096	24.0705
Victoria, TX	22.3222	20.7461
Vineland-Millville-Bridgeton, NJ	27.8777	26.3280
Virginia Beach-Norfolk-Newport News, VA-NC	23.5054	21.6059
Visalia-Porterville, CA	26.4987	24.4049
Waco, TX	21.4724	20.3429
Warner Robins, GA	22.3821	21.5347
Warren-Farmington Hills-Troy, MI	26.6333	24.9325
Washington-Arlington-Alexandria, DC-VA-MD-WV	29.0848	27.2173
Waterloo-Cedar Falls, IA	22.7467	20.6136
Wausau, WI	25.3575	24.1052
Weirton-Steubenville, WV-OH	21.8008	21.0217
Wenatchee, WA	24.7862	25.4005
West Palm Beach-Boca Raton-Boynton Beach, FL	26.4844	24.6697
Wheeling, WV-OH	19.6453	18.6517
Wichita, KS	24.9131	23.2912

Urban area	FY 2005 average hourly wage	3-Year average hourly wage
Wichita Falls, TX	22.0290	20.6773
Williamsport, PA	22.1676	20.8109
Wilmington, DE-MD-NJ	29.2092	27.2898
Wilmington, NC	24.3139	23.5805
Winchester, VA-WV	27.6387	25.3807
Winston-Salem, NC	24.7904	22.9844
Worcester, MA	29.0090	27.6763
Yakima, WA	27.1916	25.8563
Yauco, PR	11.8434	11.5358
York-Hanover, PA	23.4402	22.3569
Youngstown-Warren-Boardman, OH-PA	24.3356	22.4714
Yuba City, CA	27.2687	25.5014
Yuma, AZ	23.5066	21.8745

TABLE 3B.--FY 2004 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS

(*BASED ON THE SUM OF THE SALARIES AND HOURS COMPUTED FOR FEDERAL FISCAL YEARS 2002, 2003, AND 2004)

Nonurban Area	FY 2004 Average Hourly Wage	3-Year Average Hourly Wage
Alabama	20.1782	18.9213
Alaska	30.9208	29.8364
Arizona	23.5745	22.1823
Arkansas	19.5928	18.5056
California	27.4464	25.4191
Colorado	24.6447	23.3167
Connecticut	29.7400	28.3381
Delaware	25.0398	23.2794
Florida	22.5590	21.4483
Georgia	20.4374	19.4858
Hawaii	27.7334	25.4619
Idaho	21.6877	20.6739
Illinois	21.9903	20.6044
Indiana	22.8057	21.6824
Iowa	22.3354	21.0249
Kansas	21.3803	20.2214
Kentucky	20.5212	19.6562
Louisiana	19.4518	18.6473
Maine	23.8136	22.1360
Maryland	24.3144	22.5196
Massachusetts[1]	-------	-------
Michigan	23.1145	22.1575
Minnesota	24.5549	23.1002

Nonurban Area	FY 2004 Average Hourly Wage	3-Year Average Hourly Wage
Mississippi	20.1509	19.1564
Missouri	21.0590	19.8970
Montana	23.0768	21.6793
Nebraska	23.8141	22.1728
Nevada	24.4776	23.4949
New Hampshire	26.5959	25.1455
New Jersey[1]	-------	-------
New Mexico	22.5875	21.1442
New York	21.5048	20.4849
North Carolina	22.5751	21.3508
North Dakota	20.3511	19.4160
Ohio	22.8923	21.6085
Oklahoma	20.2994	19.0302
Oregon	26.0952	24.7198
Pennsylvania	21.9121	20.7279
Puerto Rico[1]	-------	-------
Rhode Island[1]	-------	-------
South Carolina	22.2123	21.1368
South Dakota	22.1068	20.4046
Tennessee	20.7986	19.5328
Texas	21.0610	19.6998
Utah	21.8568	20.9922
Vermont	24.6559	23.2458
Virginia	21.2021	20.1152
Washington	27.1841	25.9266
West Virginia	20.7760	19.4773

Nonurban Area	FY 2004 Average Hourly Wage	3-Year Average Hourly Wage
Wisconsin	24.9371	23.1890
Wyoming	24.1605	22.7876

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

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

CBSA code	Urban area (Constituent counties)	Wage index	GAF
10180	[2]Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8011	0.8591
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.4285	0.5597
10420	Akron, OH Portage County, OH Summit County, OH	0.9065	0.9350
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	1.1306	1.0877
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8685	0.9080
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	1.0167	1.0114
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8198	0.8728

CBSA code	Urban area (Constituent counties)	Wage index	GAF
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9539	0.9682
11020	Altoona, PA Blair County, PA	0.8472	0.8927
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.9209	0.9451
11180	Ames, IA Story County, IA	0.9503	0.9657
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2195	1.1456
11300	Anderson, IN Madison County, IN	0.8790	0.9155
11340	Anderson, SC Anderson County, SC	0.8689	0.9083
11460	Ann Arbor, MI Washtenaw County, MI	1.1065	1.0718
11500	Anniston-Oxford, AL Calhoun County, AL	0.7967	0.8559
11540	[2]Appleton, WI Calumet County, WI Outagamie County, WI	0.9485	0.9644
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9217	0.9457
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	1.0010	1.0007

CBSA code	Urban area (Constituent counties)	Wage index	GAF
12060	[1]Atlanta-Sandy Springs-Marietta, GA Barrow County, GA Bartow County, GA Butts County, GA Carroll County, GA Cherokee County, GA Clayton County, GA Cobb County, GA Coweta County, GA Dawson County, GA DeKalb County, GA Douglas County, GA Fayette County, GA Forsyth County, GA Fulton County, GA Gwinnett County, GA Haralson County, GA Heard County, GA Henry County, GA Jasper County, GA Lamar County, GA Meriwether County, GA Newton County, GA Paulding County, GA Pickens County, GA Pike County, GA Rockdale County, GA Spalding County, GA Walton County, GA	0.9926	0.9949
12100	Atlantic City, NJ Atlantic County, NJ	1.0723	1.0490
12220	Auburn-Opelika, AL Lee County, AL	0.8231	0.8752
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	0.9169	0.9423

CBSA code	Urban area (Constituent counties)	Wage index	GAF
12420	[1]Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	0.9619	0.9737
12540	[2]Bakersfield, CA Kern County, CA	1.0440	1.0299
12580	[1]Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	0.9904	0.9934
12620	Bangor, ME Penobscot County, ME	0.9960	0.9973
12700	Barnstable Town, MA Barnstable County, MA	1.1965	1.1307
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA	0.8344	0.8834
12980	Battle Creek, MI Calhoun County, MI	0.9132	0.9397
13020	Bay City, MI Bay County, MI	0.9601	0.9725
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8564	0.8993
13380	Bellingham, WA Whatcom County, WA	1.1695	1.1132
13460	Bend, OR Deschutes County, OR	1.0623	1.0423

CBSA code	Urban area (Constituent counties)	Wage index	GAF
13644	[1]Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.0993	1.0670
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8993	0.9299
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8484	0.8935
13820	[1]Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.9111	0.9382
13900	[2]Bismarck, ND Burleigh County, ND Morton County, ND	0.7741	0.8392
13980	[2]Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford city, VA	0.8065	0.8631
14020	[2]Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.8675	0.9072
14060	Bloomington-Normal, IL McLean County, IL	0.9099	0.9374
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9360	0.9557
14484	[1]Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.1649	1.1102
14500	Boulder, CO Boulder County, CO	1.0072	1.0049

CBSA code	Urban area (Constituent counties)	Wage index	GAF
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8162	0.8702
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0636	1.0431
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2876	1.1890
14980	[2]Bristol, VA Washington County, VA Bristol city, VA	0.8065	0.8631
15180	Brownsville-Harlingen, TX Cameron County, TX	1.0178	1.0122
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	1.1988	1.1322
15380	[1]Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9351	0.9551
15500	Burlington, NC Alamance County, NC	0.8881	0.9219
15540	[2]Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9469	0.9633
15764	[1]Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1199	1.0806
15804	[1]Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0683	1.0463
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8917	0.9245
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9380	0.9571
16180	Carson City, NV Carson City, NV	1.0362	1.0247
16220	Casper, WY Natrona County, WY	0.9367	0.9562

CBSA code	Urban area (Constituent counties)	Wage index	GAF
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8987	0.9295
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	0.9597	0.9722
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8875	0.9215
16700	Charleston-North Charleston, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9379	0.9570
16740	[1]Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9750	0.9828
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville city, VA	1.0317	1.0216
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.9233	0.9468
16940	[2]Cheyenne, WY Laramie County, WY	0.9190	0.9438

CBSA code	Urban area (Constituent counties)	Wage index	GAF
16974	[1]Chicago-Naperville-Joliet, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL	1.0819	1.0554
17020	Chico, CA Butte County, CA	1.0575	1.0390
17140	[1]Cincinnati-Middletown, OH-KY-IN Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY Grant County, KY Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH	0.9533	0.9678
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8131	0.8679
17420	[2]Cleveland, TN Bradley County, TN Polk County, TN	0.7911	0.8517
17460	[1]Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9667	0.9771

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17660	Coeur d'Alene, ID Kootenai County, ID	0.9346	0.9547
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.8505	0.8950
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9799	0.9862
17860	Columbia, MO Boone County, MO Howard County, MO	0.8352	0.8840
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.9071	0.9354
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.8711	0.9098
18020	Columbus, IN Bartholomew County, IN	0.9472	0.9635
18140	[1]Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH	0.9757	0.9833
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8665	0.9065
18700	Corvallis, OR Benton County, OR	1.0547	1.0371

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19060	[2]Cumberland, MD-WV (MD Hospitals) Allegany County, MD Mineral County, WV	0.9248	0.9479
19060	Cumberland, MD-WV (WV Hospitals) Allegany County, MD Mineral County, WV	0.8668	0.9067
19124	Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX	1.0092	1.0063
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.9320	0.9529
19180	Danville, IL Vermilion County, IL	0.8418	0.8888
19260	Danville, VA Pittsylvania County, VA Danville city, VA	0.8792	0.9156
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8776	0.9145
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9322	0.9531
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.8915	0.9244
19500	[2]Decatur, IL Macon County, IL	0.8364	0.8848
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8685	0.9080

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19740	[1]Denver-Aurora, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO	1.0911	1.0615
19780	Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9288	0.9507
19804	[1]Detroit-Livonia-Dearborn, MI Wayne County, MI	1.0379	1.0258
20020	[2]Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7675	0.8343
20100	[2]Dover, DE Kent County, DE	0.9651	0.9760
20220	Dubuque, IA Dubuque County, IA	0.8748	0.9125
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0449	1.0305
20500	Durham, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	1.0312	1.0213
20740	[2]Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9485	0.9644

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20764	[1]Edison, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1160	1.0781
20940	[2]El Centro, CA Imperial County, CA	1.0440	1.0299
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8713	0.9100
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9286	0.9505
21300	Elmira, NY Chemung County, NY	0.8488	0.8938
21340	El Paso, TX El Paso County, TX	0.9210	0.9452
21500	Erie, PA Erie County, PA	0.8708	0.9096
21604	Essex County, MA Essex County, MA	1.0666	1.0451
21660	Eugene-Springfield, OR Lane County, OR	1.0951	1.0642
21780	[2]Evansville, IN-KY (IN Hospitals) Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8675	0.9072
21780	Evansville, IN-KY (KY Hospitals) Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8406	0.8879
21820	[2]Fairbanks, AK Fairbanks North Star Borough, AK	1.1761	1.1175
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.4014	0.5352

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22020	[2]Fargo, ND-MN Clay County, MN Cass County, ND	0.9340	0.9543
22140	[2]Farmington, NM San Juan County, NM	0.8592	0.9013
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9387	0.9576
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8687	0.9081
22380	Flagstaff, AZ Coconino County, AZ	1.0804	1.0544
22420	Flint, MI Genesee County, MI	1.1187	1.0798
22460	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.7917	0.8522
22500	Florence, SC Darlington County, SC Florence County, SC	0.8540	0.8976
22540	Fond du Lac, WI Fond du Lac County, WI	0.9921	0.9946
22660	Fort Collins-Loveland, CO Larimer County, CO	1.0214	1.0146
22744	[1]Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0408	1.0278
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.8311	0.8810
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.8805	0.9165
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9825	0.9880

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23104	[1]Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9515	0.9665
23420	Fresno, CA Fresno County, CA	1.0656	1.0445
23460	Gadsden, AL Etowah County, AL	0.8182	0.8716
23540	[2]Gainesville, FL Alachua County, FL Gilchrist County, FL	0.8581	0.9005
23580	Gainesville, GA Hall County, GA	0.9584	0.9713
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9328	0.9535
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8508	0.8953
24140	Goldsboro, NC Wayne County, NC	0.8796	0.9159
24220	[2]Grand Forks, ND-MN (MN Hospitals) Polk County, MN Grand Forks County, ND	0.9340	0.9543
24220	Grand Forks, ND-MN (ND Hospitals) Polk County, MN Grand Forks County, ND	0.9169	0.9423
24300	Grand Junction, CO Mesa County, CO	0.9949	0.9965
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9457	0.9625
24500	Great Falls, MT Cascade County, MT	0.8908	0.9239
24540	Greeley, CO Weld County, CO	0.9758	0.9834

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24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9602	0.9726
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9228	0.9465
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9200	0.9445
24860	Greenville, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9287	0.9506
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.4015	0.5353
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.8954	0.9271
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9765	0.9838
25260	[2]Hanford-Corcoran, CA Kings County, CA	1.0440	1.0299
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9377	0.9569
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg city, VA	0.9300	0.9515
25540	[1,2]Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1312	1.0881

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25620	[2]Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7665	0.8335
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.9508	0.9660
25980	[2]Hinesville-Fort Stewart, GA Liberty County, GA Long County, GA	0.7774	0.8416
26100	Holland-Grand Haven, MI Ottawa County, MI	0.9482	0.9642
26180	Honolulu, HI Honolulu County, HI	1.1018	1.0686
26300	Hot Springs, AR Garland County, AR	0.9286	0.9505
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.7779	0.8420
26420	[1]Houston-Baytown-Sugar Land, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX	0.9995	0.9997
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9585	0.9714
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.8861	0.9205

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26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9062	0.9348
26900	[1]Indianapolis, IN Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN	1.0102	1.0070
26980	Iowa City, IA Johnson County, IA Washington County, IA	0.9663	0.9768
27060	Ithaca, NY Tompkins County, NY	0.9795	0.9859
27100	Jackson, MI Jackson County, MI	0.9152	0.9411
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8305	0.8806
27180	Jackson, TN Chester County, TN Madison County, TN	0.8912	0.9242
27260	[1]Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9574	0.9706
27340	[2]Jacksonville, NC Onslow County, NC	0.8587	0.9009
27500	Janesville, WI Rock County, WI	0.9618	0.9737

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27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8352	0.8840
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.7991	0.8576
27780	Johnstown, PA Cambria County, PA	0.8397	0.8872
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.8078	0.8640
27900	Joplin, MO Jasper County, MO Newton County, MO	0.8746	0.9123
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0714	1.0484
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0551	1.0374
28140	[1]Kansas City, MO-KS Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO	0.9625	0.9742
28420	Kennewick-Richland-Pasco, WA Benton County, WA Franklin County, WA	1.0530	1.0360

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28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.9301	0.9516
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Scott County, VA	0.8257	0.8771
28740	Kingston, NY Ulster County, NY	0.8874	0.9215
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.8585	0.9008
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9038	0.9331
29100	[2]La Crosse, WI-MN (MN Hospitals) Houston County, MN La Crosse County, WI	0.9340	0.9543
29100	[2]La Crosse, WI-MN (WI Hospitals) Houston County, MN La Crosse County, WI	0.9485	0.9644
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9073	0.9356
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8319	0.8816
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.7921	0.8525
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0342	1.0233
29460	Lakeland, FL Polk County, FL	0.8964	0.9278
29540	Lancaster, PA Lancaster County, PA	0.9919	0.9944

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29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	0.9675	0.9776
29700	Laredo, TX Webb County, TX	0.8293	0.8797
29740	Las Cruces, NM Dona Ana County, NM	0.8783	0.9150
29820	[1]Las Vegas-Paradise, NV Clark County, NV	1.1380	1.0926
30020	Lawton, OK Comanche County, OK	0.8264	0.8776
30140	Lebanon, PA Lebanon County, PA	0.8592	0.9013
30300	[2]Lewiston, ID-WA (ID Hospitals) Nez Perce County, ID Asotin County, WA	0.9325	0.9533
30300	Lewiston, ID-WA (WA Hospitals) Nez Perce County, ID Asotin County, WA	1.0340	1.0232
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9613	0.9733
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9074	0.9356
30620	Lima, OH Allen County, OH	0.9330	0.9536
30700	Lincoln, NE Lancaster County, NE Seward County, NE	1.0206	1.0141
30780	Little Rock-North Little Rock, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.9032	0.9327

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30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.9102	0.9376
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8823	0.9178
31020	[2]Longview, WA Cowlitz County, WA	1.0340	1.0232
31084	[1]Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA	1.1730	1.1155
31140	[1]Louisville, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Jefferson County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.9146	0.9407
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.8798	0.9160
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford city, VA Lynchburg city, VA	0.9048	0.9338

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31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9934	0.9955
31460	[2]Madera, CA Madera County, CA	1.0440	1.0299
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.0325	1.0221
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0573	1.0389
31900	Mansfield, OH Richland County, OH	0.9224	0.9462
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.4453	0.5746
32580	McAllen-Edinburg-Pharr, TX Hidalgo County, TX	0.8624	0.9036
32780	Medford, OR Jackson County, OR	1.0561	1.0381
32820	[1]Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9250	0.9480
32900	[2]Merced, CA Merced County, CA	1.0440	1.0299
33124	[1]Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0045	1.0031
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9351	0.9551
33260	Midland, TX Midland County, TX	0.9408	0.9591

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33340	[1]Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0106	1.0072
33460	[1]Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.1074	1.0724
33540	Missoula, MT Missoula County, MT	0.9657	0.9764
33660	Mobile, AL Mobile County, AL	0.8017	0.8595
33700	Modesto, CA Stanislaus County, CA	1.2007	1.1334
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.7928	0.8530
33780	Monroe, MI Monroe County, MI	0.9517	0.9667
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8312	0.8811
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8720	0.9105

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34100	[2]Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7911	0.8517
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0581	1.0394
34620	[2]Muncie, IN Delaware County, IN	0.8675	0.9072
34740	Muskegon-Norton Shores, MI Muskegon County, MI	0.9770	0.9842
34820	Myrtle Beach-Conway-North Myrtle Beach, SC Horry County, SC	0.8592	0.9013
34900	Napa, CA Napa County, CA	1.3537	1.2305
34940	Naples-Marco Island, FL Collier County, FL	1.0593	1.0402
34980	Nashville-Davidson--Murfreesboro, TN Cannon County, TN Cheatham County, TN Davidson County, TN Dickson County, TN Hickman County, TN Macon County, TN Robertson County, TN Rutherford County, TN Smith County, TN Sumner County, TN Trousdale County, TN Williamson County, TN Wilson County, TN	1.0115	1.0079
35084	[1]Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1708	1.1140
35300	New Haven-Milford, CT New Haven County, CT	1.1828	1.1218

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35380	[1]New Orleans-Metairie-Kenner, LA Jefferson Parish, LA Orleans Parish, LA Plaquemines Parish, LA St. Bernard Parish, LA St. Charles Parish, LA St. John the Baptist Parish, LA St. Tammany Parish, LA	0.9118	0.9387
35644	[1]New York-Wayne-White Plains, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	1.3324	1.2172
35660	Niles-Benton Harbor, MI Berrien County, MI	0.8922	0.9249
35980	Norwich-New London, CT New London County, CT	1.1625	1.1086
36084	[1]Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.5387	1.3433
36100	Ocala, FL Marion County, FL	0.9194	0.9441
36140	Ocean City, NJ Cape May County, NJ	1.0841	1.0569
36220	Odessa, TX Ector County, TX	0.9822	0.9878
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9303	0.9517

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36420	[1]Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.9005	0.9307
36500	Olympia, WA Thurston County, WA	1.1034	1.0697
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE	0.9765	0.9838
36740	[1]Orlando, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9779	0.9848
36780	[2]Oshkosh-Neenah, WI Winnebago County, WI	0.9485	0.9644
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8470	0.8925
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.1130	1.0761
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9630	0.9745
37460	[2]Panama City-Lynn Haven, FL Bay County, FL	0.8581	0.9005

CBSA code	Urban area (Constituent counties)	Wage index	GAF
37620	[2]Parkersburg-Marietta, WV-OH (OH Hospitals) Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.8708	0.9096
37620	Parkersburg-Marietta, WV-OH (WV Hospitals) Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.8388	0.8866
37700	Pascagoula, MS George County, MS Jackson County, MS	0.7993	0.8578
37860	[2]Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8581	0.9005
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.8853	0.9200
37964	[1]Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.0880	1.0595
38060	[1]Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0009	1.0006
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.8724	0.9108

CBSA code	Urban area (Constituent counties)	Wage index	GAF
38300	[1]Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8743	0.9121
38340	Pittsfield, MA Berkshire County, MA	1.0756	1.0512
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9615	0.9735
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.5019	0.6237
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	1.0127	1.0087
38900	[1]Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.1384	1.0928
38940	Port St. Lucie-Fort Pierce, FL Martin County, FL St. Lucie County, FL	1.0117	1.0080
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1395	1.0935
39140	Prescott, AZ Yavapai County, AZ	0.9922	0.9947

CBSA code	Urban area (Constituent counties)	Wage index	GAF
39300	[1]Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	1.0941	1.0635
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9762	0.9836
39380	[2]Pueblo, CO Pueblo County, CO	0.9374	0.9567
39460	Punta Gorda, FL Charlotte County, FL	0.9473	0.9636
39540	[2]Racine, WI Racine County, WI	0.9485	0.9644
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	1.0060	1.0041
39660	Rapid City, SD Meade County, SD Pennington County, SD	0.8947	0.9266
39740	Reading, PA Berks County, PA	0.9173	0.9426
39820	Redding, CA Shasta County, CA	1.1856	1.1237
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0474	1.0322

CBSA code	Urban area (Constituent counties)	Wage index	GAF
40060	[1]Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights city, VA Hopewell city, VA Petersburg city, VA Richmond city, VA	0.9422	0.9600
40140	[1]Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.0997	1.0672
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke city, VA Salem city, VA	0.8390	0.8867
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1511	1.1012
40380	[1]Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.9307	0.9520

CBSA code	Urban area (Constituent counties)	Wage index	GAF
40420	Rockford, IL Boone County, IL Winnebago County, IL	0.9623	0.9740
40484	Rockingham County-Strafford County, NH Rockingham County, NH Strafford County, NH	1.0232	1.0158
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9016	0.9315
40660	Rome, GA Floyd County, GA	0.8877	0.9217
40900	[1]Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.1709	1.1141
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.9879	0.9917
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.0193	1.0132
41100	St. George, UT Washington County, UT	0.9495	0.9651

CBSA code	Urban area (Constituent counties)	Wage index	GAF
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO (pt.)* Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis city, MO	0.9067	0.9351
41420	Salem, OR Marion County, OR Polk County, OR	1.0572	1.0388
41500	Salinas, CA Monterey County, CA	1.3946	1.2558
41540	[2]Salisbury, MD Somerset County, MD Wicomico County, MD	0.9248	0.9479
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9588	0.9716
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8194	0.8725
41700	[1]San Antonio, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.9021	0.9319

CBSA code	Urban area (Constituent counties)	Wage index	GAF
41740	[1]San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.1265	1.0850
41780	Sandusky, OH Erie County, OH	0.9045	0.9336
41884	[1]San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.4403	1.2838
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.5254	0.6436
41940	[1]San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.4543	1.2924

CBSA code	Urban area (Constituent counties)	Wage index	GAF
41980	[1]San Juan-Caguas-Guaynabo, PR Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR Comerío Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR	0.4646	0.5916

CBSA code	Urban area (Constituent counties)	Wage index	GAF
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.1140	1.0767
42044	[1]Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.1728	1.1153
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.0731	1.0495
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.4786	1.3071
42140	Santa Fe, NM Santa Fe County, NM	1.0913	1.0617
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.2958	1.1942
42260	Sarasota-Bradenton-Venice, FL Manatee County, FL Sarasota County, FL	0.9635	0.9749
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9470	0.9634
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8529	0.8968
42644	[1]Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1497	1.1002
43100	[2]Sheboygan, WI Sheboygan County, WI	0.9485	0.9644
43300	Sherman-Denison, TX Grayson County, TX	0.9645	0.9756
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.9153	0.9412
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9077	0.9358

CBSA code	Urban area (Constituent counties)	Wage index	GAF
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9438	0.9612
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9458	0.9626
43900	Spartanburg, SC Spartanburg County, SC	0.9035	0.9329
44060	Spokane, WA Spokane County, WA	1.0674	1.0457
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.8754	0.9129
44140	[2]Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0432	1.0294
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8458	0.8916
44220	Springfield, OH Clark County, OH	0.8763	0.9135
44300	State College, PA Centre County, PA	0.8486	0.8937
44700	Stockton, CA San Joaquin County, CA	1.0605	1.0410
44844	[1]Suffolk-Nassau, NY Nassau County, NY Suffolk County, NY	1.2966	1.1947
44940	[2]Sumter, SC Sumter County, SC	0.8449	0.8910
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9504	0.9658
45104	Tacoma, WA Pierce County, WA	1.1105	1.0744

CBSA code	Urban area (Constituent counties)	Wage index	GAF
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8690	0.9083
45300	[1]Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9087	0.9365
45460	[2]Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.8675	0.9072
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8457	0.8916
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9536	0.9680
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8915	0.9244
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0294	1.0200
46060	Tucson, AZ Pima County, AZ	0.8971	0.9283
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8709	0.9097

CBSA code	Urban area (Constituent counties)	Wage index	GAF
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8358	0.8844
46340	Tyler, TX Smith County, TX	0.9534	0.9678
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8339	0.8830
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8355	0.8842
46700	Vallejo-Fairfield, CA Solano County, CA	1.4275	1.2760
46940	Vero Beach, FL Indian River County, FL	0.9513	0.9664
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8491	0.8940
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0604	1.0410
47260	[1]Virginia Beach-Norfolk-Newport News, VA-NC Currituck County, NC Gloucester County, VA Isle of Wight County, VA James City County, VA Mathews County, VA Surry County, VA York County, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA	0.8941	0.9262
47300	[2]Visalia-Porterville, CA Tulare County, CA	1.0440	1.0299

CBSA code	Urban area (Constituent counties)	Wage index	GAF
47380	Waco, TX McLennan County, TX	0.8167	0.8705
47580	Warner Robins, GA Houston County, GA	0.8513	0.8956
47644	[1]Warren-Farmington Hills-Troy, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	1.0131	1.0090
47894	[1]Washington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV	1.1063	1.0716
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8652	0.9056
48140	Wausau, WI Marathon County, WI	1.0121	1.0083
48260	[2]Weirton-Steubenville, WV-OH (OH Hospitals) Jefferson County, OH Brooke County, WV Hancock County, WV	0.8708	0.9096

CBSA code	Urban area (Constituent counties)	Wage index	GAF
48260	Weirton-Steubenville, WV-OH (WV Hospitals) Jefferson County, OH Brooke County, WV Hancock County, WV	0.8292	0.8796
48300	[2]Wenatchee, WA Chelan County, WA Douglas County, WA	1.0340	1.0232
48424	[1]West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	1.0074	1.0051
48540	[2]Wheeling, WV-OH (OH Hospitals) Belmont County, OH Marshall County, WV Ohio County, WV	0.8708	0.9096
48540	[2]Wheeling, WV-OH (WV Hospitals) Belmont County, OH Marshall County, WV Ohio County, WV	0.7903	0.8512
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.9476	0.9638
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.8379	0.8859
48700	Williamsport, PA Lycoming County, PA	0.8432	0.8898
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.1110	1.0747
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9248	0.9479
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0513	1.0349

CBSA code	Urban area (Constituent counties)	Wage index	GAF
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9430	0.9606
49340	Worcester, MA Worcester County, MA	1.1034	1.0697
49420	Yakima, WA Yakima County, WA	1.0343	1.0234
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.4505	0.5792
49620	York-Hanover, PA York County, PA	0.8916	0.9244
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.9257	0.9485
49700	[2]Yuba City, CA Sutter County, CA Yuba County, CA	1.0440	1.0299
49740	[2]Yuma, AZ Yuma County, AZ	0.8967	0.9281

[1]Large urban area

[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2005.

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

Nonurban Area	Wage index	GAF
Alabama	0.7675	0.8343
Alaska	1.1761	1.1175
Arizona	0.8967	0.9281
Arkansas	0.7453	0.8177
California	1.0440	1.0299
Colorado	0.9374	0.9567
Connecticut	1.1312	1.0881
Delaware	0.9651	0.9760
Florida	0.8581	0.9005
Georgia	0.7774	0.8416
Hawaii	1.0549	1.0373
Idaho	0.8249	0.8765
Illinois	0.8364	0.8848
Indiana	0.8675	0.9072
Iowa	0.8496	0.8944
Kansas	0.8132	0.8680
Kentucky	0.7806	0.8440
Louisiana	0.7399	0.8136
Maine	0.9058	0.9345
Maryland	0.9248	0.9479
Massachusetts[1]	1.0432	1.0294
Michigan	0.8792	0.9156
Minnesota	0.9340	0.9543
Mississippi	0.7665	0.8335
Missouri	0.8011	0.8591

Nonurban Area	Wage index	GAF
Montana	0.8778	0.9146
Nebraska	0.9058	0.9345
Nevada	0.9311	0.9523
New Hampshire	1.0116	1.0079
New Jersey[1]	-------	-------
New Mexico	0.8592	0.9013
New York	0.8192	0.8723
North Carolina	0.8587	0.9009
North Dakota	0.7741	0.8392
Ohio	0.8708	0.9096
Oklahoma	0.7721	0.8377
Oregon	1.0182	1.0124
Pennsylvania	0.8335	0.8827
Puerto Rico[1]	-------	-------
Rhode Island[1]	-------	-------
South Carolina	0.8449	0.8910
South Dakota	0.8409	0.8881
Tennessee	0.7911	0.8517
Texas	0.8011	0.8591
Utah	0.8314	0.8812
Vermont	0.9469	0.9633
Virginia	0.8065	0.8631
Washington	1.0340	1.0232
West Virginia	0.7903	0.8512
Wisconsin	0.9485	0.9644
Wyoming	0.9190	0.9438

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

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

Area	Wage index	GAF
Abilene, TX	0.8011	0.8591
Akron, OH	0.9065	0.9350
Albany-Schenectady-Troy, NY	0.8685	0.9080
Albuquerque, NM	0.9936	0.9956
Alexandria, LA	0.8198	0.8728
Allentown-Bethlehem-Easton, PA	0.9539	0.9682
Altoona, PA	0.8472	0.8927
Amarillo, TX	0.9209	0.9451
Anchorage, AK	1.2195	1.1456
Anderson, IN	0.8790	0.9155
Ann Arbor, MI	1.0777	1.0526
Anniston-Oxford, AL	0.7967	0.8559
Asheville, NC	0.9217	0.9457
Athens-Clarke County, GA	0.9835	0.9887
Atlanta-Sandy Springs-Marietta, GA	0.9819	0.9876
Auburn-Opelika, AL	0.8080	0.8642
Augusta-Richmond County, GA-SC	0.8977	0.9288
Austin-Round Rock, TX	0.9619	0.9737
Bangor, ME	0.9960	0.9973
Barnstable Town, MA	1.1965	1.1307
Baton Rouge, LA	0.8344	0.8834
Bay City, MI	0.9601	0.9725
Bethesda-Frederick-Gaithersburg, MD	1.0613	1.0416
Binghamton, NY	0.8484	0.8935
Birmingham-Hoover, AL	0.9111	0.9382
Bloomington-Normal, IL	0.9099	0.9374
Bowling Green, KY	0.8162	0.8702
Buffalo-Niagra Falls, NY	0.9351	0.9551
Burlington, NC	0.9124	0.9391
Cambridge-Newton-Framingham, MA	1.1199	1.0806
Carson City, NV	0.9927	0.9950
Casper, WY	0.9367	0.9562
Champaign-Urbana, IL	0.9597	0.9722
Charleston, WV (OH Hospitals)	0.8708	0.9096
Charleston, WV (WV Hospitals)	0.8581	0.9005
Charleston-North Charleston, S	0.9379	0.9570
Charlotte-Gastonia-Concord, NC-SC	0.9620	0.9738
Charlottesville, VA	0.9955	0.9969

Chattanooga, TN-GA	0.9233	0.9468
Chicago-Naperville-Joliet, IL	1.0688	1.0466
Cincinnati-Middletown, OH-KY-IN	0.9533	0.9678
Clarksville, TN-KY	0.8131	0.8679
Cleveland-Elyria-Mentor, OH	0.9667	0.9771
College Station-Bryan, TX	0.8505	0.8950
Columbia, MO	0.8352	0.8840
Columbia, SC	0.8952	0.9270
Columbus, GA-AL	0.8373	0.8855
Columbus, OH	0.9627	0.9743
Corvallis, OR	1.0360	1.0245
Dallas-Plano-Irving, TX	1.0092	1.0063
Davenport-Moline-Rock Island, IA-IL	0.8624	0.9036
Dayton, OH	0.9322	0.9531
Decatur, AL	0.8915	0.9244
Deltona-Daytona Beach-Ormond Beach, FL	0.8685	0.9080
Denver-Aurora, CO	1.0709	1.0480
Des Moines, IA	0.9160	0.9417
Duluth, MN-WI	1.0449	1.0305
Durham, NC	1.0204	1.0139
Elkhart-Goshen, IN	0.9161	0.9418
Erie, PA	0.8512	0.8955
Eugene-Springfield, OR	1.0565	1.0384
Evansville, IN-KY	0.8229	0.8750
Fargo, ND-MN (MN Hospitals)	0.9340	0.9543
Fargo, ND-MN (ND, SD Hospitals)	0.9217	0.9457
Fayetteville, NC	0.9025	0.9322
Fayetteville-Springdale-Rogers, AR-MO	0.8687	0.9081
Flagstaff, AZ	1.0591	1.0401
Fond du Lac, WI	0.9485	0.9644
Fort Collins-Loveland, CO	1.0214	1.0146
Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0408	1.0278
Fort Smith, AR-OK	0.8076	0.8639
Fort Walton Beach-Crestview-Destin, FL	0.8621	0.9034
Fort Worth-Arlington, TX	0.9515	0.9665
Gadsden, AL	0.8182	0.8716
Gainesville, FL	0.8581	0.9005
Grand Rapids-Wyoming, MI	0.9457	0.9625
Great Falls, MT	0.8908	0.9239
Greeley, CO	0.9758	0.9834
Green Bay, WI	0.9602	0.9726
Greenville, NC	0.9200	0.9445
Greenville, SC	0.9287	0.9506

Gulfport-Biloxi, MS	0.8783	0.9150
Harrisburg-Carlisle, PA	0.9221	0.9460
Hartford-West Hartford-East Hartford, CT (CT Hospitals)	1.1312	1.0881
Hartford-West Hartford-East Hartford, CT (MA Hospitals)	1.0981	1.0662
Hickory-Morganton-Lenoir, NC	0.9346	0.9547
Holland-Grand Haven, MI	0.9482	0.9642
Honolulu, HI	1.1018	1.0686
Houston-Baytown-Sugar Land, TX	0.9995	0.9997
Huntington-Ashland, WV-KY-OH	0.9032	0.9327
Huntsville, AL	0.8861	0.9205
Idaho Falls, ID	0.9062	0.9348
Indianapolis, IN	1.0102	1.0070
Iowa City, IA	0.9492	0.9649
Ithaca, NY	0.9383	0.9573
Jackson, MS	0.8305	0.8806
Jackson, TN	0.8727	0.9110
Jacksonville, FL	0.9574	0.9706
Jonesboro, AR	0.8078	0.8640
Joplin, MO	0.8571	0.8998
Kalamazoo-Portage, MI	1.0714	1.0484
Kankakee-Bradley, IL	1.0075	1.0051
Kansas City, MO-KS	0.9625	0.9742
Kennewick-Richland-Pasco, WA (OR Hospitals)	1.0276	1.0188
Kennewick-Richland-Pasco, WA (WA Hospitals)	1.0340	1.0232
Kingsport-Bristol-Bristol, TN-VA	0.8257	0.8771
Knoxville, TN	0.8585	0.9008
Lafayette, IN	0.9073	0.9356
Lafayette, LA	0.8319	0.8816
Lakeland, FL	0.8964	0.9278
Lansing-East Lansing, MI	0.9675	0.9776
Las Vegas-Paradise, NV	1.1227	1.0825
Lexington-Fayette, KY	0.8755	0.9130
Lima, OH	0.9330	0.9536
Lincoln, NE	0.9743	0.9823
Little Rock-North Little Rock, AR	0.9032	0.9327
Longview, TX	0.8589	0.9011
Los Angeles-Long Beach-Glendale, CA	1.1730	1.1155
Louisville, KY-IN	0.9146	0.9407
Lubbock, TX	0.8798	0.9160
Lynchburg, VA	0.8906	0.9237
Macon, GA	0.9826	0.9881

Madison, WI	1.0217	1.0148
Manchester-Nashua, NH	1.0573	1.0389
Medford, OR	1.0274	1.0187
Memphis, TN-MS-AR	0.8895	0.9229
Miami-Miami Beach-Kendall, FL	1.0045	1.0031
Midland, TX	0.9225	0.9463
Milwaukee-Waukesha-West Allis, WI	0.9976	0.9984
Minneapolis-St. Paul-Bloomington, MN-WI	1.1074	1.0724
Missoula, MT	0.9657	0.9764
Mobile, AL	0.8017	0.8595
Modesto, CA	1.2007	1.1334
Montgomery, AL	0.8312	0.8811
Muskegon-Norton Shores, MI	0.9770	0.9842
Napa, CA	1.3537	1.2305
Nashville-Davidson--Murfreesboro, TN	0.9823	0.9878
Newark-Union, NJ-PA	1.1708	1.1140
New Orleans-Metairie-Kenner, LA	0.9118	0.9387
New York-Wayne-White Plains, NY-NJ	1.3324	1.2172
San Francisco-Oakland-Fremont,	1.5387	1.3433
Ocala, FL	0.8981	0.9290
Ocean City, NJ	1.0049	1.0034
Odessa, TX	0.9322	0.9531
Ogden-Clearfield, UT	0.9303	0.9517
Oklahoma City, OK	0.9005	0.9307
Olympia, WA	1.1034	1.0697
Omaha-Council Bluffs, NE-IA	0.9765	0.9838
Orlando, FL	0.9779	0.9848
Peoria, IL	0.8853	0.9200
Phoenix-Mesa-Scottsdale, AZ	1.0009	1.0006
Pine Bluff, AR	0.8402	0.8876
Pittsburgh, PA	0.8743	0.9121
Pittsfield, MA	1.0231	1.0158
Pocatello, ID	0.9235	0.9470
Portland-South Portland-Biddeford, ME	0.9842	0.9892
Portland-Vancouver-Beaverton, OR-WA)	1.1384	1.0928
Port St. Lucie-Fort Pierce, FL	1.0117	1.0080
Poughkeepsie-Newburgh-Middleton, NY	1.1063	1.0716
Provo-Orem, UT	0.9762	0.9836
Raleigh-Cary, NC	0.9690	0.9787
Reading, PA	0.9036	0.9329
Redding, CA	1.1719	1.1147
Reno-Sparks, NV	1.0474	1.0322
Roanoke, VA	0.8390	0.8867

Rochester, MN	1.1511	1.1012
Rochester, NY	0.9307	0.9520
Rockford, IL	0.9500	0.9655
Rockingham County-Strafford County, NH	1.0232	1.0158
Sacramento--Arden-Arcade--Roseville, CA	1.1709	1.1141
Saginaw-Saginaw Township North, MI	0.9403	0.9587
St. Cloud, MN	1.0060	1.0041
St. Louis, MO-IL	0.8965	0.9279
San Antonio, TX	0.9021	0.9319
Santa Ana-Anaheim-Irvine, CA	1.1728	1.1153
Santa Fe, NM	1.0090	1.0062
Santa Rosa-Petaluma, CA	1.2958	1.1942
Savannah, GA	0.9470	0.9634
Seattle-Bellevue-Everett, WA	1.1497	1.1002
Sherman-Denison, TX	0.9129	0.9395
Shreveport-Bossier City, LA	0.8977	0.9288
Sioux City, IA-NE-SD	0.9058	0.9345
Sioux Falls, SD	0.9438	0.9612
South Bend-Mishawaka, IN-MI	0.9458	0.9626
Spartanburg, SC	0.9035	0.9329
Spokane, WA	1.0489	1.0332
Springfield, IL	0.8754	0.9129
Springfield, MO	0.8188	0.8721
Springfield, OH	0.8763	0.9135
State College, PA	0.8335	0.8827
Sumter, SC	0.8449	0.8910
Syracuse, NY	0.9290	0.9508
Texarkana, TX-Texarkana, AR	0.8457	0.8916
Toledo, OH	0.9536	0.9680
Topeka, KS	0.8915	0.9244
Tulsa, OK	0.8709	0.9097
Tuscaloosa, AL	0.8358	0.8844
Tyler, TX	0.9349	0.9549
Virginia Beach-Norfolk-Newport News, VA-NC	0.8941	0.9262
Waco, TX	0.8167	0.8705
Warren-Farmington Hills-Troy, MI	1.0131	1.0090
Washington-Arlington-Alexandria, DC-VA-MD-WV	1.1063	1.0716
Waterloo-Cedar Falls, IA	0.8652	0.9056
Wausau, WI	1.0121	1.0083
Wichita, KS	0.9189	0.9437
Williamsport, PA	0.8432	0.8898
Wilmington, NC	1.0817	1.0553
Wilmington, NC	0.9092	0.9369

Winchester, VA-WV	1.0034	1.0023
Winston-Salem, NC	0.9271	0.9495
Worcester, MA	1.1034	1.0697
Youngstown-Warren-Boardman, OH	0.9088	0.9366
Rural Florida	0.8449	0.8910
Rural Illinois	0.8364	0.8848
Rural Indiana	0.8675	0.9072
Rural Massachusetts	0.8921	0.9248
Rural Minnesota	0.9340	0.9543
Rural Missouri	0.8011	0.8591
Rural Nebraska	0.9058	0.9345
Rural Nevada	0.8801	0.9163
Rural New Hampshire	1.0116	1.0079
Rural New York	0.8192	0.8723
Rural Texas	0.8011	0.8591
Rural Washington	1.0233	1.0159
Rural Wyoming	0.9190	0.9438

TABLE 4F.--PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF)l

Area	Wage index	GAF
Aguadilla-Isabela-San Sebastián, PR	0.9231	0.9467
Fajardo, PR	0.8647	0.9052
Guayama, PR	0.8650	0.9055
Mayagüez, PR	0.9593	0.9719
Ponce, PR	1.0813	1.0550
San Germán-Cabo Rojo, PR	1.1318	1.0885
San Juan-Caguas-Guaynabo, PR	1.0008	1.0005
Yauco, PR	0.9705	0.9797

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS

CBSA code	Urban area (Constituent counties)	Wage index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8011
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.4285
10420	Akron, OH Portage County, OH Summit County, OH	0.9065
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	1.1306
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8685
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	1.0167
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8198

CBSA code	Urban area (Constituent counties)	Wage index
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9539
11020	Altoona, PA Blair County, PA	0.8472
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.9209
11180	Ames, IA Story County, IA	0.9503
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.2195
11300	Anderson, IN Madison County, IN	0.8769
11340	Anderson, SC Anderson County, SC	0.8689
11460	Ann Arbor, MI Washtenaw County, MI	1.1065
11500	Anniston-Oxford, AL Calhoun County, AL	0.7916
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9485
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9217
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	1.0010

CBSA code	Urban area (Constituent counties)	Wage index
12060	[1]Atlanta-Sandy Springs-Marietta, GA Barrow County, GA Bartow County, GA Butts County, GA Carroll County, GA Cherokee County, GA Clayton County, GA Cobb County, GA Coweta County, GA Dawson County, GA DeKalb County, GA Douglas County, GA Fayette County, GA Forsyth County, GA Fulton County, GA Gwinnett County, GA Haralson County, GA Heard County, GA Henry County, GA Jasper County, GA Lamar County, GA Meriwether County, GA Newton County, GA Paulding County, GA Pickens County, GA Pike County, GA Rockdale County, GA Spalding County, GA Walton County, GA	0.9926
12100	Atlantic City, NJ Atlantic County, NJ	1.0723
12220	Auburn-Opelika, AL Lee County, AL	0.8231
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	0.9169

CBSA code	Urban area (Constituent counties)	Wage index
12420	[1]Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	0.9619
12540	Bakersfield, CA Kern County, CA	1.0440
12580	[1]Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	0.9904
12620	Bangor, ME Penobscot County, ME	0.9960
12700	Barnstable Town, MA Barnstable County, MA	1.1965
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA	0.8344
12980	Battle Creek, MI Calhoun County, MI	0.9132
13020	Bay City, MI Bay County, MI	0.9601
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8564
13380	Bellingham, WA Whatcom County, WA	1.1695
13460	Bend, OR Deschutes County, OR	1.0623

CBSA code	Urban area (Constituent counties)	Wage index
13644	[1]Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.0993
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8993
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8484
13820	[1]Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.9111
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7741
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford city, VA	0.8065
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.8675
14060	Bloomington-Normal, IL McLean County, IL	0.9099
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9360
14484	[1]Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.1649
14500	Boulder, CO Boulder County, CO	1.0072

CBSA code	Urban area (Constituent counties)	Wage index
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8162
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0636
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2876
14980	Bristol, VA Washington County, VA Bristol city, VA	0.8065
15180	Brownsville-Harlingen, TX Cameron County, TX	1.0178
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	1.1988
15380	[1]Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9351
15500	Burlington, NC Alamance County, NC	0.8881
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9378
15764	[1]Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1199
15804	[1]Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0683
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8917
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9380
16180	Carson City, NV Carson City, NV	1.0362
16220	Casper, WY Natrona County, WY	0.9301

CBSA code	Urban area (Constituent counties)	Wage index
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8987
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	0.9539
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8875
16700	Charleston-North Charleston, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9379
16740	[1]Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9750
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville city, VA	1.0317
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.9233
16940	Cheyenne, WY Laramie County, WY	0.9190

CBSA code	Urban area (Constituent counties)	Wage index
16974	[1]Chicago-Naperville-Joliet, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL	1.0819
17020	Chico, CA Butte County, CA	1.0575
17140	[1]Cincinnati-Middletown, OH-KY-IN Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY Grant County, KY Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH	0.9532
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8027
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.7911
17460	[1]Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9667

CBSA code	Urban area (Constituent counties)	Wage index
17660	Coeur d'Alene, ID Kootenai County, ID	0.9346
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.8505
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9799
17860	Columbia, MO Boone County, MO Howard County, MO	0.8352
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.9071
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.8711
18020	Columbus, IN Bartholomew County, IN	0.9472
18140	[1]Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH	0.9757
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8665
18700	Corvallis, OR Benton County, OR	1.0547

CBSA code	Urban area (Constituent counties)	Wage index
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.9248
19124	Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX	1.0092
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.9320
19180	Danville, IL Vermilion County, IL	0.8418
19260	Danville, VA Pittsylvania County, VA Danville city, VA	0.8792
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8776
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9320
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.8915
19500	Decatur, IL Macon County, IL	0.8364
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8668

CBSA code	Urban area (Constituent counties)	Wage index
19740	[1]Denver-Aurora, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO	1.0911
19780	Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9288
19804	[1]Detroit-Livonia-Dearborn, MI Wayne County, MI	1.0379
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7675
20100	Dover, DE Kent County, DE	0.9579
20220	Dubuque, IA Dubuque County, IA	0.8748
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0449
20500	Durham, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	1.0312
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9485

CBSA code	Urban area (Constituent counties)	Wage index
20764	[1]Edison, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1160
20940	El Centro, CA Imperial County, CA	1.0440
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8713
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9286
21300	Elmira, NY Chemung County, NY	0.8488
21340	El Paso, TX El Paso County, TX	0.9210
21500	Erie, PA Erie County, PA	0.9034
21604	Essex County, MA Essex County, MA	0.8708
21660	Eugene-Springfield, OR Lane County, OR	1.0666
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	1.0951
21820	Fairbanks, AK Fairbanks North Star Borough, AK	0.8675
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	1.1761
22020	Fargo, ND-MN Clay County, MN Cass County, ND	0.4014
22140	Farmington, NM San Juan County, NM	0.9340
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.8592

CBSA code	Urban area (Constituent counties)	Wage index
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.9387
22380	Flagstaff, AZ Coconino County, AZ	0.8674
22420	Flint, MI Genesee County, MI	1.0804
22460	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	1.1187
22500	Florence, SC Darlington County, SC Florence County, SC	0.7917
22540	Fond du Lac, WI Fond du Lac County, WI	0.8540
22660	Fort Collins-Loveland, CO Larimer County, CO	0.9921
22744	[1]Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0142
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	1.0180
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.8311
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.8805
23104	[1]Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9825
23420	Fresno, CA Fresno County, CA	0.9515

CBSA code	Urban area (Constituent counties)	Wage index
23460	Gadsden, AL Etowah County, AL	1.0656
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.8090
23580	Gainesville, GA Hall County, GA	0.8581
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9584
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.9328
24140	Goldsboro, NC Wayne County, NC	0.8508
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.8796
24300	Grand Junction, CO Mesa County, CO	0.9340
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9949
24500	Great Falls, MT Cascade County, MT	0.9457
24540	Greeley, CO Weld County, CO	0.8894
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9486
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9602
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9228

CBSA code	Urban area (Constituent counties)	Wage index
24860	Greenville, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9183
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.9287
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.4015
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.8954
25260	Hanford-Corcoran, CA Kings County, CA	0.9765
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	1.0440
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg city, VA	0.9377
25540	[1]Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	0.9300
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	1.1312
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.7665
25980	Hinesville-Fort Stewart, GA Liberty County, GA Long County, GA	0.9508

CBSA code	Urban area (Constituent counties)	Wage index
26100	Holland-Grand Haven, MI Ottawa County, MI	0.7774
26180	Honolulu, HI Honolulu County, HI	0.9482
26300	Hot Springs, AR Garland County, AR	1.0997
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.9286
26420	[1]Houston-Baytown-Sugar Land, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX	0.7779
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9995
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9585
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.8850

CBSA code	Urban area (Constituent counties)	Wage index
26900	[1]Indianapolis, IN Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN	0.9062
26980	Iowa City, IA Johnson County, IA Washington County, IA	1.0102
27060	Ithaca, NY Tompkins County, NY	0.9663
27100	Jackson, MI Jackson County, MI	0.9795
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.9152
27180	Jackson, TN Chester County, TN Madison County, TN	0.8305
27260	[1]Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.8912
27340	Jacksonville, NC Onslow County, NC	0.9561
27500	Janesville, WI Rock County, WI	0.8587
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8180

CBSA code	Urban area (Constituent counties)	Wage index
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.9618
27780	Johnstown, PA Cambria County, PA	0.8352
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.7991
27900	Joplin, MO Jasper County, MO Newton County, MO	0.8397
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	0.8000
28100	Kankakee-Bradley, IL Kankakee County, IL	0.8746
28140	[1]Kansas City, MO-KS Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO	1.0714
28420	Kennewick-Richland-Pasco, WA Benton County, WA Franklin County, WA	1.0551
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.9625

CBSA code	Urban area (Constituent counties)	Wage index
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Scott County, VA	1.0530
28740	Kingston, NY Ulster County, NY	0.9301
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.8257
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.8874
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.8585
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9038
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.9340
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.9073
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	0.8319
29460	Lakeland, FL Polk County, FL	0.7921
29540	Lancaster, PA Lancaster County, PA	1.0342
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	0.8964
29700	Laredo, TX Webb County, TX	0.9919

CBSA code	Urban area (Constituent counties)	Wage index
29740	Las Cruces, NM Dona Ana County, NM	0.9675
29820	[1]Las Vegas-Paradise, NV Clark County, NV	0.8293
29940	Lawrence, KS Douglas County, KS	0.8783
30020	Lawton, OK Comanche County, OK	1.1380
30140	Lebanon, PA Lebanon County, PA	0.8264
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.8592
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9325
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9613
30620	Lima, OH Allen County, OH	0.9074
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9330
30780	Little Rock-North Little Rock, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	1.0206
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.9032
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.9102

CBSA code	Urban area (Constituent counties)	Wage index
31020	Longview, WA Cowlitz County, WA	0.8823
31084	[1]Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA	1.0340
31140	[1]Louisville, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Jefferson County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	1.1730
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.9146
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford city, VA Lynchburg city, VA	0.8798
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9048
31460	Madera, CA Madera County, CA	0.9934
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.0440

CBSA code	Urban area (Constituent counties)	Wage index
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0325
31900	Mansfield, OH Richland County, OH	1.0573
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.9224
32580	McAllen-Edinburg-Pharr, TX Hidalgo County, TX	0.4453
32780	Medford, OR Jackson County, OR	0.8624
32820	[1]Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	1.0561
32900	Merced, CA Merced County, CA	0.9250
33124	[1]Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0440
33140	Michigan City-La Porte, IN LaPorte County, IN	1.0045
33260	Midland, TX Midland County, TX	0.9351
33340	[1]Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	0.9408

CBSA code	Urban area (Constituent counties)	Wage index
33460	[1]Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.0106
33540	Missoula, MT Missoula County, MT	1.1074
33660	Mobile, AL Mobile County, AL	0.9610
33700	Modesto, CA Stanislaus County, CA	0.8017
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	1.2007
33780	Monroe, MI Monroe County, MI	0.7928
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.9517
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8312
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.8720
34580	Mount Vernon-Anacortes, WA Skagit County, WA	0.7911
34620	Muncie, IN Delaware County, IN	1.0581

CBSA code	Urban area (Constituent counties)	Wage index
34740	Muskegon-Norton Shores, MI Muskegon County, MI	0.8675
34820	Myrtle Beach-Conway-North Myrtle Beach, SC Horry County, SC	0.9770
34900	Napa, CA Napa County, CA	0.8592
34940	Naples-Marco Island, FL Collier County, FL	1.2550
34980	Nashville-Davidson--Murfreesboro, TN Cannon County, TN Cheatham County, TN Davidson County, TN Dickson County, TN Hickman County, TN Macon County, TN Robertson County, TN Rutherford County, TN Smith County, TN Sumner County, TN Trousdale County, TN Williamson County, TN Wilson County, TN	1.0593
35084	[1]Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.0115
35300	New Haven-Milford, CT New Haven County, CT	1.1708

CBSA code	Urban area (Constituent counties)	Wage index
35380	[1]New Orleans-Metairie-Kenner, LA Jefferson Parish, LA Orleans Parish, LA Plaquemines Parish, LA St. Bernard Parish, LA St. Charles Parish, LA St. John the Baptist Parish, LA St. Tammany Parish, LA	1.1828
35644	[1]New York-Wayne-White Plains, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	0.9118
35660	Niles-Benton Harbor, MI Berrien County, MI	1.3324
35980	Norwich-New London, CT New London County, CT	0.8922
36084	[1]Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.1625
36100	Ocala, FL Marion County, FL	1.5251
36140	Ocean City, NJ Cape May County, NJ	0.9194
36220	Odessa, TX Ector County, TX	1.0841
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9822

CBSA code	Urban area (Constituent counties)	Wage index
36420	[1]Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.9235
36500	Olympia, WA Thurston County, WA	0.9005
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE	1.1034
36740	[1]Orlando, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9765
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9779
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.9485
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	0.8470
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	1.1130
37460	Panama City-Lynn Haven, FL Bay County, FL	0.9630

CBSA code	Urban area (Constituent counties)	Wage index
37620	Parkersburg-Marietta, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.8581
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8708
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.7993
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.8581
37964	[1]Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	0.8792
38060	[1]Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0880
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	1.0009
38300	[1]Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8724
38340	Pittsfield, MA Berkshire County, MA	0.8743

CBSA code	Urban area (Constituent counties)	Wage index
38540	Pocatello, ID Bannock County, ID Power County, ID	1.0756
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.9615
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	0.5019
38900	[1]Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.0127
38940	Port St. Lucie-Fort Pierce, FL Martin County, FL St. Lucie County, FL	1.1384
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.0077
39140	Prescott, AZ Yavapai County, AZ	1.1395
39300	[1]Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	0.9922
39340	Provo-Orem, UT Juab County, UT Utah County, UT	1.0941
39380	Pueblo, CO Pueblo County, CO	0.9596

CBSA code	Urban area (Constituent counties)	Wage index
39460	Punta Gorda, FL Charlotte County, FL	0.9374
39540	Racine, WI Racine County, WI	0.9473
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	0.9485
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.0060
39740	Reading, PA Berks County, PA	0.8947
39820	Redding, CA Shasta County, CA	0.9173
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.1856
40060	[1]Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights city, VA Hopewell city, VA Petersburg city, VA Richmond city, VA	1.0474
40140	[1]Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	0.9422

CBSA code	Urban area (Constituent counties)	Wage index
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke city, VA Salem city, VA	1.0997
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	0.8352
40380	[1]Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	1.1511
40420	Rockford, IL Boone County, IL Winnebago County, IL	0.9307
40484	Rockingham County-Strafford County, NH Rockingham County, NH Strafford County, NH	0.9623
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	1.0232
40660	Rome, GA Floyd County, GA	0.9016
40900	[1]Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	0.8877
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	1.1707
41060	St. Cloud, MN Benton County, MN Stearns County, MN	0.9879
41100	St. George, UT Washington County, UT	1.0193

CBSA code	Urban area (Constituent counties)	Wage index
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	0.9495
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO (pt.)* Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis city, MO	0.9067
41420	Salem, OR Marion County, OR Polk County, OR	1.0572
41500	Salinas, CA Monterey County, CA	1.3946
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9248
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9588
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8194

CBSA code	Urban area (Constituent counties)	Wage index
41700	[1]San Antonio, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.9021
41740	[1]San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.1265
41780	Sandusky, OH Erie County, OH	0.9045
41884	[1]San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.4403
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.5254
41940	[1]San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.4543

CBSA code	Urban area (Constituent counties)	Wage index
41980	[1]San Juan-Caguas-Guaynabo, PR Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR Comerío Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR	0.4646

CBSA code	Urban area (Constituent counties)	Wage index
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.1140
42044	[1]Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.1628
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.0731
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.4786
42140	Santa Fe, NM Santa Fe County, NM	1.0913
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.2958
42260	Sarasota-Bradenton-Venice, FL Manatee County, FL Sarasota County, FL	0.9635
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9470
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8529
42644	[1]Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1497
43100	Sheboygan, WI Sheboygan County, WI	0.9485
43300	Sherman-Denison, TX Grayson County, TX	0.9645
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.9153
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9077

CBSA code	Urban area (Constituent counties)	Wage index
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9438
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9458
43900	Spartanburg, SC Spartanburg County, SC	0.9035
44060	Spokane, WA Spokane County, WA	1.0674
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.8754
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0432
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8458
44220	Springfield, OH Clark County, OH	0.8763
44300	State College, PA Centre County, PA	0.8486
44700	Stockton, CA San Joaquin County, CA	1.0605
44844	[1]Suffolk-Nassau, NY Nassau County, NY Suffolk County, NY	1.2966
44940	Sumter, SC Sumter County, SC	0.8449
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9504
45104	Tacoma, WA Pierce County, WA	1.1105

CBSA code	Urban area (Constituent counties)	Wage index
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8690
45300	[1]Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9087
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.8675
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8432
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9536
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8915
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0294
46060	Tucson, AZ Pima County, AZ	0.8971
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8709

CBSA code	Urban area (Constituent counties)	Wage index
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8358
46340	Tyler, TX Smith County, TX	0.9534
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8339
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8355
46700	Vallejo-Fairfield, CA Solano County, CA	1.4275
46940	Vero Beach, FL Indian River County, FL	0.9513
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8491
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0604
47260	[1]Virginia Beach-Norfolk-Newport News, VA-NC Currituck County, NC Gloucester County, VA Isle of Wight County, VA James City County, VA Mathews County, VA Surry County, VA York County, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA	0.8941
47300	Visalia-Porterville, CA Tulare County, CA	1.0440

CBSA code	Urban area (Constituent counties)	Wage index
47380	Waco, TX McLennan County, TX	0.8167
47580	Warner Robins, GA Houston County, GA	0.8513
47644	[1]Warren-Farmington Hills-Troy, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	1.0131
47894	[1]Washington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV	1.1063
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8652
48140	Wausau, WI Marathon County, WI	0.9645
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.8708

CBSA code	Urban area (Constituent counties)	Wage index
48300	Wenatchee, WA Chelan County, WA Douglas County, WA	1.0340
48424	[1]West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	1.0074
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.8708
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.9476
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.8379
48700	Williamsport, PA Lycoming County, PA	0.8432
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.1110
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9248
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0513
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9430
49340	Worcester, MA Worcester County, MA	1.1034
49420	Yakima, WA Yakima County, WA	1.0343

CBSA code	Urban area (Constituent counties)	Wage index
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.4505
49620	York-Hanover, PA York County, PA	0.8916
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.9257
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.0440
49740	Yuma, AZ Yuma County, AZ	0.8967

[1]Large urban area

TABLE 4H.--PRE-RECLASSIFIED WAGE INDEX FOR RURAL AREAS

Nonurban Area	Wage Index
Alabama	0.7675
Alaska	1.1761
Arizona	0.8967
Arkansas	0.7453
California	1.0440
Colorado	0.9374
Connecticut	1.1312
Delaware	0.9524
Florida	0.8581
Georgia	0.7774
Hawaii	1.0549
Idaho	0.8249
Illinois	0.8364
Indiana	0.8675
Iowa	0.8496
Kansas	0.8132
Kentucky	0.7806
Louisiana	0.7399
Maine	0.9058
Maryland	0.9248
Massachusetts	1.0432
Michigan	0.8792
Minnesota	0.9340
Mississippi	0.7665
Missouri	0.8010
Montana	0.8778

Nonurban Area	Wage Index
Nebraska	0.9058
Nevada	0.9311
New Hampshire	1.0116
New Jersey[1]	-------
New Mexico	0.8592
New York	0.8180
North Carolina	0.8587
North Dakota	0.7741
Ohio	0.8708
Oklahoma	0.7721
Oregon	0.9926
Pennsylvania	0.8335
Puerto Rico[1]	-------
Rhode Island[1]	-------
South Carolina	0.8449
South Dakota	0.8409
Tennessee	0.7911
Texas	0.8011
Utah	0.8314
Vermont	0.9378
Virginia	0.8065
Washington	1.0340
West Virginia	0.7903
Wisconsin	0.9485
Wyoming	0.9190

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

TABLE 4J.--WAGE INDEX ADJUSTMENT FOR COMMUTING HOSPITAL EMPLOYEES (OUT-MIGRATION) IN QUALIFYING COUNTIES--FY 2005

The following hospitals are located in qualifying counties and thus are eligible to have their wage indices adjusted by the increases listed in this table. Hospitals that have not been reclassified will automatically receive this adjustment unless they choose to waive the application of this adjustment. Reclassified hospitals will not automatically receive this adjustment, unless they terminate their reclassification status with the MGCRB.

Provider Number	Wage Index Increase	Qualifying County Name
010005	0.0258	MARSHALL
010008	0.0203	CRENSHAW
010010	0.0258	MARSHALL
010012	0.0204	DE KALB
010022	0.0700	CHEROKEE
010025	0.0196	CHAMBERS
010029	0.0143	LEE
010035	0.0364	CULLMAN
010045	0.0158	FAYETTE
010072	0.0295	TALLADEGA
010101	0.0295	TALLADEGA
010143	0.0364	CULLMAN
040014	0.0178	WHITE
040019	0.0700	ST. FRANCIS
040047	0.0065	RANDOLPH
040066	0.0382	CLARK
040069	0.0130	MISSISSIPPI
040070	0.0130	MISSISSIPPI
040071	0.0057	JEFFERSON
040076	0.1127	HOT SPRING
040100	0.0178	WHITE
050008	0.0058	SAN FRANCISCO
050014	0.0137	AMADOR
050042	0.0228	TEHAMA
050047	0.0058	SAN FRANCISCO
050055	0.0058	SAN FRANCISCO
050065	0.0022	ORANGE
050069	0.0022	ORANGE
050076	0.0058	SAN FRANCISCO
050084	0.0553	SAN JOAQUIN
050090	0.0264	SONOMA
050117	0.0472	MERCED

Provider Number	Wage Index Increase	Qualifying County Name
050118	0.0553	SAN JOAQUIN
050122	0.0553	SAN JOAQUIN
050133	0.0177	YUBA
050136	0.0264	SONOMA
050150	0.0328	NEVADA
050152	0.0058	SAN FRANCISCO
050167	0.0553	SAN JOAQUIN
050168	0.0022	ORANGE
050173	0.0022	ORANGE
050174	0.0264	SONOMA
050193	0.0022	ORANGE
050224	0.0022	ORANGE
050226	0.0022	ORANGE
050228	0.0058	SAN FRANCISCO
050230	0.0022	ORANGE
050253	0.0022	ORANGE
050291	0.0264	SONOMA
050313	0.0553	SAN JOAQUIN
050325	0.0179	TUOLUMNE
050331	0.0264	SONOMA
050335	0.0179	TUOLUMNE
050336	0.0553	SAN JOAQUIN
050348	0.0022	ORANGE
050385	0.0264	SONOMA
050407	0.0058	SAN FRANCISCO
050426	0.0022	ORANGE
050444	0.0472	MERCED
050454	0.0058	SAN FRANCISCO
050457	0.0058	SAN FRANCISCO
050476	0.0262	LAKE
050491	0.0022	ORANGE
050494	0.0328	NEVADA
050497	0.0472	MERCED
050526	0.0022	ORANGE
050528	0.0472	MERCED
050535	0.0022	ORANGE
050539	0.0262	LAKE
050543	0.0022	ORANGE
050547	0.0264	SONOMA
050548	0.0022	ORANGE
050550	0.0022	ORANGE

Provider Number	Wage Index Increase	Qualifying County Name
050551	0.0022	ORANGE
050567	0.0022	ORANGE
050568	0.0067	MADERA
050570	0.0022	ORANGE
050580	0.0022	ORANGE
050585	0.0022	ORANGE
050589	0.0022	ORANGE
050592	0.0022	ORANGE
050594	0.0022	ORANGE
050603	0.0022	ORANGE
050609	0.0022	ORANGE
050668	0.0058	SAN FRANCISCO
050678	0.0022	ORANGE
050690	0.0264	SONOMA
050693	0.0022	ORANGE
050695	0.0553	SAN JOAQUIN
050720	0.0022	ORANGE
050728	0.0264	SONOMA
060001	0.0288	WELD
060003	0.0203	BOULDER
060027	0.0203	BOULDER
060103	0.0203	BOULDER
070003	0.0055	WINDHAM
070006	0.0045	FAIRFIELD
070010	0.0045	FAIRFIELD
070018	0.0045	FAIRFIELD
070020	0.0150	MIDDLESEX
070021	0.0055	WINDHAM
070028	0.0045	FAIRFIELD
070033	0.0045	FAIRFIELD
070034	0.0045	FAIRFIELD
100014	0.0157	VOLUSIA
100017	0.0157	VOLUSIA
100045	0.0157	VOLUSIA
100047	0.0021	CHARLOTTE
100068	0.0157	VOLUSIA
100072	0.0157	VOLUSIA
100077	0.0021	CHARLOTTE
100118	0.0251	FLAGLER
100232	0.0131	PUTNAM
100236	0.0021	CHARLOTTE

Provider Number	Wage Index Increase	Qualifying County Name
100252	0.0210	OKEECHOBEE
110023	0.0464	GORDON
110027	0.0357	FRANKLIN
110029	0.0054	HALL
110041	0.0772	HABERSHAM
110063	0.0287	LIBERTY
110069	0.0472	HOUSTON
110124	0.0429	WAYNE
110136	0.0260	BALDWIN
110150	0.0260	BALDWIN
110153	0.0472	HOUSTON
110187	0.1157	LUMPKIN
110189	0.0029	FANNIN
110190	0.0181	MACON
110205	0.0743	GILMER
130003	0.0179	NEZ PERCE
130011	0.0334	LATAH
130024	0.0527	BONNER
130049	0.0352	KOOTENAI
140012	0.0215	LEE
140026	0.0337	LA SALLE
140033	0.0136	LAKE
140043	0.0046	WHITESIDE
140084	0.0136	LAKE
140100	0.0136	LAKE
140110	0.0337	LA SALLE
140130	0.0136	LAKE
140160	0.0284	STEPHENSON
140161	0.0142	LIVINGSTON
140173	0.0046	WHITESIDE
140202	0.0136	LAKE
140234	0.0337	LA SALLE
140291	0.0136	LAKE
150002	0.0242	LAKE
150004	0.0242	LAKE
150008	0.0242	LAKE
150030	0.0198	HENRY
150034	0.0242	LAKE
150035	0.0079	PORTER
150062	0.0160	DECATUR
150065	0.0156	JACKSON

Provider Number	Wage Index Increase	Qualifying County Name
150076	0.0191	MARSHALL
150090	0.0242	LAKE
150122	0.0203	RIPLEY
150125	0.0242	LAKE
150126	0.0242	LAKE
150132	0.0242	LAKE
150147	0.0242	LAKE
160013	0.0218	MUSCATINE
160026	0.0499	BOONE
160080	0.0049	CLINTON
160140	0.0367	PLYMOUTH
170137	0.0560	DOUGLAS
180012	0.0083	HARDIN
180066	0.0562	LOGAN
180127	0.0285	FRANKLIN
180128	0.0280	LAWRENCE
190001	0.0641	WASHINGTON
190003	0.0106	IBERIA
190010	0.0398	TANGIPAHOA
190015	0.0398	TANGIPAHOA
190049	0.0641	WASHINGTON
190054	0.0106	IBERIA
190095	0.0641	WASHINGTON
190099	0.0448	AVOYELLES
190147	0.0398	TANGIPAHOA
190148	0.0448	AVOYELLES
200002	0.0128	LINCOLN
200013	0.0185	WALDO
200016	0.0341	OXFORD
200024	0.0066	ANDROSCOGGIN
200032	0.0341	OXFORD
200034	0.0066	ANDROSCOGGIN
200050	0.0139	HANCOCK
210001	0.0133	WASHINGTON
210004	0.0031	MONTGOMERY
210016	0.0031	MONTGOMERY
210018	0.0031	MONTGOMERY
210022	0.0031	MONTGOMERY
210023	0.0214	ANNE ARUNDEL
210043	0.0214	ANNE ARUNDEL
210048	0.0296	HOWARD

Provider Number	Wage Index Increase	Qualifying County Name
210057	0.0031	MONTGOMERY
230003	0.0031	OTTAWA
230015	0.0359	ST. JOSEPH
230037	0.0371	HILLSDALE
230041	0.0125	BAY
230072	0.0031	OTTAWA
230093	0.0083	MECOSTA
230096	0.0359	ST. JOSEPH
230099	0.0360	MONROE
230106	0.0029	NEWAYGO
230121	0.0697	SHIAWASSEE
230174	0.0031	OTTAWA
240011	0.0512	MC LEOD
240013	0.0205	MORRISON
240014	0.0459	RICE
240018	0.1212	GOODHUE
240064	0.0154	ITASCA
240069	0.0422	STEELE
240071	0.0459	RICE
240089	0.1212	GOODHUE
240133	0.0306	MEEKER
240152	0.0743	KANABEC
240154	0.0154	ITASCA
240187	0.0512	MC LEOD
240205	0.0154	ITASCA
240211	0.0742	PINE
250040	0.0294	JACKSON
250045	0.0041	HANCOCK
260074	0.0143	RANDOLPH
260097	0.0427	JOHNSON
260127	0.0156	PIKE
280054	0.0137	GAGE
280077	0.0090	DODGE
280123	0.0137	GAGE
290019	0.0026	CARSON CITY
300017	0.0327	ROCKINGHAM
300023	0.0327	ROCKINGHAM
300029	0.0327	ROCKINGHAM
310010	0.0278	MERCER
310014	0.0070	CAMDEN
310021	0.0278	MERCER

Provider Number	Wage Index Increase	Qualifying County Name
310022	0.0070	CAMDEN
310029	0.0070	CAMDEN
310032	0.0078	CUMBERLAND
310038	0.0396	MIDDLESEX
310039	0.0396	MIDDLESEX
310044	0.0278	MERCER
310070	0.0396	MIDDLESEX
310086	0.0070	CAMDEN
310092	0.0278	MERCER
310108	0.0396	MIDDLESEX
310110	0.0278	MERCER
320018	0.0059	DONA ANA
320085	0.0059	DONA ANA
330004	0.1014	ULSTER
330008	0.1161	WYOMING
330094	0.0795	COLUMBIA
330191	0.0025	WARREN
330224	0.1014	ULSTER
330276	0.0226	FULTON
330386	0.1140	SULLIVAN
330402	0.1014	ULSTER
340020	0.0240	LEE
340039	0.0175	IREDELL
340069	0.0047	WAKE
340070	0.0475	ALAMANCE
340073	0.0047	WAKE
340088	0.0114	TRANSYLVANIA
340114	0.0047	WAKE
340126	0.0162	WILSON
340127	0.0948	GRANVILLE
340129	0.0175	IREDELL
340138	0.0047	WAKE
340144	0.0175	IREDELL
340173	0.0047	WAKE
360013	0.0202	SHELBY
360019	0.0107	SUMMIT
360020	0.0107	SUMMIT
360024	0.0087	ERIE
360025	0.0087	ERIE
360027	0.0107	SUMMIT
360034	0.0265	WAYNE

Provider Number	Wage Index Increase	Qualifying County Name
360036	0.0265	WAYNE
360063	0.0142	HURON
360065	0.0142	HURON
360078	0.0159	PORTAGE
360086	0.0167	CLARK
360093	0.0142	DEFIANCE
360095	0.0087	HANCOCK
360099	0.0087	HANCOCK
360107	0.0215	SANDUSKY
360150	0.0107	SUMMIT
360156	0.0215	SANDUSKY
360175	0.0162	CLINTON
360187	0.0167	CLARK
360197	0.0093	LOGAN
360241	0.0107	SUMMIT
360260	0.0107	SUMMIT
370004	0.0195	OTTAWA
370014	0.0838	BRYAN
370015	0.0455	MAYES
370023	0.0084	STEPHENS
370043	0.0296	MARSHALL
370065	0.0119	CRAIG
370113	0.0205	DELAWARE
370179	0.0446	OKFUSKEE
380002	0.0137	JOSEPHINE
380008	0.0211	LINN
380022	0.0211	LINN
390044	0.0213	BERKS
390052	0.0031	CLEARFIELD
390065	0.0426	ADAMS
390066	0.0339	LEBANON
390086	0.0031	CLEARFIELD
390096	0.0213	BERKS
390138	0.0324	FRANKLIN
390146	0.0051	WARREN
390150	0.0188	GREENE
390151	0.0324	FRANKLIN
390201	0.1056	MONROE
420007	0.0028	SPARTANBURG
420020	0.0017	GEORGETOWN
420027	0.0151	ANDERSON

Provider Number	Wage Index Increase	Qualifying County Name
420030	0.0135	COLLETON
420054	0.0027	MARLBORO
420068	0.0097	ORANGEBURG
420070	0.0089	SUMTER
420083	0.0028	SPARTANBURG
420093	0.0028	SPARTANBURG
440008	0.0667	HENDERSON
440024	0.0389	BRADLEY
440025	0.0026	GREENE
440030	0.0077	HAMBLEN
440035	0.0445	MONTGOMERY
440047	0.0502	GIBSON
440050	0.0026	GREENE
440056	0.0350	JEFFERSON
440060	0.0502	GIBSON
440063	0.0040	WASHINGTON
440067	0.0077	HAMBLEN
440073	0.0520	MAURY
440105	0.0040	WASHINGTON
440114	0.0527	LAUDERDALE
440115	0.0502	GIBSON
440143	0.0454	MARSHALL
440148	0.0575	DE KALB
440174	0.0375	HAYWOOD
440181	0.0411	HARDEMAN
440184	0.0040	WASHINGTON
440185	0.0389	BRADLEY
450039	0.0094	TARRANT
450050	0.0755	WARD
450059	0.0074	COMAL
450064	0.0094	TARRANT
450087	0.0094	TARRANT
450099	0.0182	GRAY
450113	0.0329	ANDERSON
450121	0.0094	TARRANT
450135	0.0094	TARRANT
450137	0.0094	TARRANT
450144	0.0576	ANDREWS
450163	0.0136	KLEBERG
450187	0.0265	WASHINGTON
450194	0.0329	CHEROKEE

Provider Number	Wage Index Increase	Qualifying County Name
450214	0.0370	WHARTON
450224	0.0413	WOOD
450246	0.0436	MATAGORDA
450347	0.0428	WALKER
450362	0.0488	BURNET
450370	0.0259	COLORADO
450395	0.0486	POLK
450419	0.0094	TARRANT
450438	0.0259	COLORADO
450447	0.0359	NAVARRO
450451	0.0624	SOMERVELL
450465	0.0436	MATAGORDA
450547	0.0413	WOOD
450563	0.0094	TARRANT
450597	0.0080	DE WITT
450623	0.0495	FANNIN
450626	0.0307	JACKSON
450639	0.0094	TARRANT
450672	0.0094	TARRANT
450675	0.0094	TARRANT
450677	0.0094	TARRANT
450694	0.0370	WHARTON
450747	0.0329	ANDERSON
450763	0.0240	HUTCHINSON
450779	0.0094	TARRANT
450813	0.0329	ANDERSON
450840	0.0094	TARRANT
460017	0.0391	BOX ELDER
460036	0.0704	WASATCH
460039	0.0391	BOX ELDER
470015	0.0368	WINDSOR
470018	0.0368	WINDSOR
470023	0.0151	CALEDONIA
490047	0.0201	PAGE
490053	0.0050	WASHINGTON
490084	0.0173	ESSEX
490110	0.0064	MONTGOMERY
500039	0.0173	KITSAP
500041	0.0106	COWLITZ
500118	0.0289	MASON
510018	0.0207	JACKSON

Provider Number	Wage Index Increase	Qualifying County Name
510028	0.0138	FAYETTE
510047	0.0262	MARION
510088	0.0138	FAYETTE
520028	0.0164	GREEN
520059	0.0206	RACINE
520071	0.0250	JEFFERSON
520094	0.0206	RACINE
520096	0.0206	RACINE
520102	0.0302	WALWORTH
520116	0.0250	JEFFERSON

TABLE 5.--LIST OF DIAGNOSIS DELATED GROUPS (DRGs), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)

DRG	MDC	Type	DRG Title	Relative Weights	Geometric mean LOS	Arithmetic mean LOS
1	1	SURG	CRANIOTOMY AGE >17 W CC	3.5672	7.8	10.5
2	1	SURG	CRANIOTOMY AGE >17 W/O CC	1.9813	3.7	4.7
3	1	SURG	*CRANIOTOMY AGE 0-17	1.9912	12.7	12.7
4	1	SURG	NO LONGER VALID	0.0000	0.0	0.0
5	1	SURG	NO LONGER VALID	0.0000	0.0	0.0
6	1	SURG	CARPAL TUNNEL RELEASE	0.7875	2.3	3.4
7	1	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.6542	6.6	9.6
8	1	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	1.5618	1.9	2.7
9	1	MED	SPINAL DISORDERS & INJURIES	1.2492	4.3	5.9
10	1	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2279	4.7	6.2
11	1	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	0.8804	2.9	3.9
12	1	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.9124	4.3	5.6
13	1	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.8203	4.0	4.9
14	1	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCT	1.2668	4.6	5.9
15	1	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	0.9505	3.7	4.7
16	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.2487	4.7	6.2
17	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.7013	2.5	3.2
18	1	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.9949	4.1	5.4
19	1	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.7077	2.8	3.5
20	1	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.8416	8.0	10.4
21	1	MED	VIRAL MENINGITIS	1.5257	5.0	6.7
22	1	MED	HYPERTENSIVE ENCEPHALOPATHY	1.1188	4.0	5.1
23	1	MED	NONTRAUMATIC STUPOR & COMA	0.8381	3.2	4.2
24	1	MED	SEIZURE & HEADACHE AGE >17 W CC	1.0148	3.6	4.9
25	1	MED	SEIZURE & HEADACHE AGE >17 W/O CC	0.6161	2.5	3.2
26	1	MED	SEIZURE & HEADACHE AGE 0-17	0.5700	2.4	3.2
27	1	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3545	3.2	5.1
28	1	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.3288	4.4	6.0

*Medicare data have been supplemented by data from 19 States for low-volume DRGs.
**DRGs 469 and 470 contain cases that could not be assigned to valid DRGs.
Note 1: Geometric mean is used only to determine payment for transfer cases.
Note 2: Arithmetic mean is presented for informational purposes only.
Note 3: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

DRG	MDC	Type	DRG Title	Relative Weights	Geometric mean LOS	Arithmetic mean LOS
29	1	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.7055	2.6	3.4
30	1	MED	*TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.3368	2.0	2.0
31	1	MED	CONCUSSION AGE >17 W CC	0.9342	3.0	4.0
32	1	MED	CONCUSSION AGE >17 W/O CC	0.5975	2.0	2.6
33	1	MED	*CONCUSSION AGE 0-17	0.2115	1.6	1.6
34	1	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9825	3.6	4.8
35	1	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.6466	2.5	3.1
36	2	SURG	RETINAL PROCEDURES	0.6766	1.3	1.6
37	2	SURG	ORBITAL PROCEDURES	1.1544	2.7	3.9
38	2	SURG	PRIMARY IRIS PROCEDURES	0.5289	1.7	2.3
39	2	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.6326	1.6	2.2
40	2	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.9638	2.9	4.1
41	2	SURG	*EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.3428	1.6	1.6
42	2	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.7420	2.0	2.8
43	2	MED	HYPHEMA	0.6477	2.7	3.5
44	2	MED	ACUTE MAJOR EYE INFECTIONS	0.6603	4.0	4.9
45	2	MED	NEUROLOGICAL EYE DISORDERS	0.7302	2.6	3.2
46	2	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	0.7776	3.3	4.3
47	2	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.5509	2.5	3.2
48	2	MED	*OTHER DISORDERS OF THE EYE AGE 0-17	0.3020	2.9	2.9
49	3	SURG	MAJOR HEAD & NECK PROCEDURES	1.7496	3.3	4.6
50	3	SURG	SIALOADENECTOMY	0.8749	1.5	1.9
51	3	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	0.8005	1.8	2.9
52	3	SURG	CLEFT LIP & PALATE REPAIR	0.7913	1.6	2.2
53	3	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.2165	2.2	3.6
54	3	SURG	*SINUS & MASTOID PROCEDURES AGE 0-17	0.4895	3.2	3.2
55	3	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	0.9092	1.9	2.9
56	3	SURG	RHINOPLASTY	0.9080	1.9	2.8
57	3	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	1.0343	2.5	3.9
58	3	SURG	*T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.2779	1.5	1.5

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DRG	MDC	Type	DRG Title	Relative Weights	Geometric mean LOS	Arithmetic mean LOS
59	3	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.6462	1.8	2.5
60	3	SURG	*TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.2116	1.5	1.5
61	3	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.5494	3.4	5.8
62	3	SURG	*MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.2997	1.3	1.3
63	3	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.3926	3.0	4.4
64	3	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.3161	4.2	6.6
65	3	MED	DYSEQUILIBRIUM	0.5977	2.3	2.8
66	3	MED	EPISTAXIS	0.5875	2.4	3.1
67	3	MED	EPIGLOTTITIS	0.8352	2.8	3.5
68	3	MED	OTITIS MEDIA & URI AGE >17 W CC	0.6673	3.0	3.7
69	3	MED	OTITIS MEDIA & URI AGE >17 W/O CC	0.4972	2.4	2.9
70	3	MED	OTITIS MEDIA & URI AGE 0-17	0.4712	2.4	2.9
71	3	MED	LARYNGOTRACHEITIS	0.5243	3.0	3.6
72	3	MED	NASAL TRAUMA & DEFORMITY	0.7378	2.7	3.5
73	3	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.8325	3.3	4.5
74	3	MED	*OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.3407	2.1	2.1
75	4	SURG	MAJOR CHEST PROCEDURES	3.0441	7.6	9.9
76	4	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.8264	8.3	11.0
77	4	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.2263	3.5	4.7
78	4	MED	PULMONARY EMBOLISM	1.2520	5.5	6.5
79	4	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.5913	6.6	8.4
80	4	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.8515	4.3	5.4
81	4	MED	*RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.5423	6.1	6.1
82	4	MED	RESPIRATORY NEOPLASMS	1.3772	5.1	6.8
83	4	MED	MAJOR CHEST TRAUMA W CC	0.9791	4.3	5.3
84	4	MED	MAJOR CHEST TRAUMA W/O CC	0.5530	2.6	3.2
85	4	MED	PLEURAL EFFUSION W CC	1.2341	4.8	6.4
86	4	MED	PLEURAL EFFUSION W/O CC	0.7017	2.8	3.6
87	4	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3525	4.8	6.4
88	4	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.9105	4.1	5.0

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DRG	MDC	Type	DRG Title	Relative Weights	Geometric mean LOS	Arithmetic mean LOS
89	4	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0500	4.8	5.8
90	4	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.6192	3.3	3.9
91	4	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.6302	2.9	3.4
92	4	MED	INTERSTITIAL LUNG DISEASE W CC	1.1983	4.9	6.2
93	4	MED	INTERSTITIAL LUNG DISEASE W/O CC	0.7152	3.2	4.0
94	4	MED	PNEUMOTHORAX W CC	1.1503	4.6	6.2
95	4	MED	PNEUMOTHORAX W/O CC	0.6070	3.0	3.7
96	4	MED	BRONCHITIS & ASTHMA AGE >17 W CC	0.7453	3.6	4.4
97	4	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5447	2.8	3.4
98	4	MED	BRONCHITIS & ASTHMA AGE 0-17	0.5526	2.7	3.1
99	4	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	0.7186	2.4	3.2
100	4	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.5455	1.8	2.1
101	4	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8719	3.3	4.3
102	4	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.5489	2.0	2.5
103	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	17.9858	24.5	40.1
104	5	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	7.9437	12.4	14.7
105	5	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	5.8201	8.3	10.0
106	5	SURG	CORONARY BYPASS W PTCA	7.3320	9.6	11.3
107	5	SURG	CORONARY BYPASS W CARDIAC CATH	5.3967	9.3	10.6
108	5	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.2103	6.9	9.6
109	5	SURG	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	3.9690	6.8	7.8
110	5	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	3.9766	6.1	8.7
111	5	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.4620	2.8	3.7
112	5	SURG	NO LONGER VALID	0.0000	0.0	0.0
113	5	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	3.0263	10.4	13.3
114	5	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.6956	6.3	8.7
115	5	SURG	PRM CARD PACEM IMPL W AMI/HR/SHOCK OR AICD LEAD OR GNRTR	3.6050	4.6	7.0
116	5	SURG	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	2.3639	3.0	4.3
117	5	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.3645	2.7	4.4

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118	5	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.6813	2.0	3.0
119	5	SURG	VEIN LIGATION & STRIPPING	1.4347	3.2	5.4
120	5	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.3143	5.6	8.9
121	5	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	1.6249	5.3	6.6
122	5	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	1.0163	2.9	3.6
123	5	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.5461	2.9	4.7
124	5	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.4620	3.3	4.5
125	5	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	1.1183	2.2	2.8
126	5	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.6159	9.0	11.5
127	5	MED	HEART FAILURE & SHOCK	1.0415	4.1	5.2
128	5	MED	DEEP VEIN THROMBOPHLEBITIS	0.7506	4.6	5.5
129	5	MED	CARDIAC ARREST, UNEXPLAINED	1.0348	1.7	2.7
130	5	MED	PERIPHERAL VASCULAR DISORDERS W CC	0.9582	4.5	5.6
131	5	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	0.5673	3.3	4.0
132	5	MED	ATHEROSCLEROSIS W CC	0.6453	2.3	2.9
133	5	MED	ATHEROSCLEROSIS W/O CC	0.5418	1.8	2.2
134	5	MED	HYPERTENSION	0.6113	2.5	3.2
135	5	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.9291	3.4	4.5
136	5	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.5940	2.1	2.6
137	5	MED	*CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.8309	3.3	3.3
138	5	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.8442	3.1	4.0
139	5	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5251	2.0	2.5
140	5	MED	ANGINA PECTORIS	0.5291	2.0	2.5
141	5	MED	SYNCOPE & COLLAPSE W CC	0.7642	2.8	3.5
142	5	MED	SYNCOPE & COLLAPSE W/O CC	0.5947	2.1	2.5
143	5	MED	CHEST PAIN	0.5662	1.7	2.1
144	5	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.2508	4.0	5.7
145	5	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.5873	2.0	2.6
146	6	SURG	RECTAL RESECTION W CC	2.6584	8.6	10.1
147	6	SURG	RECTAL RESECTION W/O CC	1.5239	5.4	6.0

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148	6	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.3988	10.0	12.2
149	6	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.4404	5.6	6.1
150	6	SURG	PERITONEAL ADHESIOLYSIS W CC	2.7593	8.9	11.0
151	6	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.3017	4.3	5.4
152	6	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.8869	6.6	8.0
153	6	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.1117	4.6	5.1
154	6	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	4.0702	9.9	13.3
155	6	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.2755	3.1	4.1
156	6	SURG	*STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	0.8557	6.0	6.0
157	6	SURG	ANAL & STOMAL PROCEDURES W CC	1.2913	4.0	5.6
158	6	SURG	ANAL & STOMAL PROCEDURES W/O CC	0.6588	2.1	2.6
159	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	1.3898	3.8	5.1
160	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	0.8248	2.2	2.7
161	6	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.1864	3.0	4.4
162	6	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.6662	1.6	2.0
163	6	SURG	*HERNIA PROCEDURES AGE 0-17	0.7021	2.1	2.1
164	6	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.3016	6.9	8.3
165	6	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.1913	3.7	4.3
166	6	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4790	3.5	4.7
167	6	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	0.9003	2.0	2.3
168	3	SURG	MOUTH PROCEDURES W CC	1.2513	3.2	4.7
169	3	SURG	MOUTH PROCEDURES W/O CC	0.7546	1.9	2.5
170	6	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.8708	7.5	10.8
171	6	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.1856	3.2	4.3
172	6	MED	DIGESTIVE MALIGNANCY W CC	1.4006	5.1	7.0
173	6	MED	DIGESTIVE MALIGNANCY W/O CC	0.7457	2.7	3.7
174	6	MED	G.I. HEMORRHAGE W CC	1.0145	3.8	4.8
175	6	MED	G.I. HEMORRHAGE W/O CC	0.5722	2.5	2.9

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176	6	MED	COMPLICATED PEPTIC ULCER	1.1167	4.1	5.3
177	6	MED	UNCOMPLICATED PEPTIC ULCER W CC	0.9365	3.7	4.6
178	6	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	0.6822	2.6	3.1
179	6	MED	INFLAMMATORY BOWEL DISEASE	1.1073	4.6	5.9
180	6	MED	G.I. OBSTRUCTION W CC	0.9786	4.2	5.4
181	6	MED	G.I. OBSTRUCTION W/O CC	0.5553	2.8	3.4
182	6	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.8274	3.4	4.4
183	6	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.5858	2.3	2.9
184	6	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.4971	2.5	3.3
185	3	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.9144	3.4	4.7
186	3	MED	*DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	0.3262	2.9	2.9
187	3	MED	DENTAL EXTRACTIONS & RESTORATIONS	0.8101	3.1	4.3
188	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.1172	4.1	5.5
189	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.5942	2.4	3.1
190	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.5363	3.4	4.4
191	7	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.0575	9.3	13.2
192	7	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.6359	4.2	5.6
193	7	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	3.4292	10.3	12.7
194	7	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	1.5709	5.5	6.6
195	7	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.9012	8.5	10.2
196	7	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.5888	4.6	5.5
197	7	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.5198	7.4	9.1
198	7	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	1.1815	3.8	4.4
199	7	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3560	6.8	9.5
200	7	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	2.9686	6.4	10.3
201	7	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.7570	10.2	14.1
202	7	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3416	4.7	6.3
203	7	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.3881	5.0	6.7

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204	7	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.1478	4.3	5.7
205	7	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W CC	1.2148	4.5	6.1
206	7	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC	0.7278	3.0	3.8
207	7	MED	DISORDERS OF THE BILIARY TRACT W CC	1.1906	4.1	5.3
208	7	MED	DISORDERS OF THE BILIARY TRACT W/O CC	0.6948	2.3	2.9
209	8	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY	2.0158	4.2	4.8
210	8	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.8645	6.0	6.9
211	8	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.2612	4.4	4.8
212	8	SURG	*HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.4266	11.1	11.1
213	8	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.8842	6.6	9.1
214	8	SURG	NO LONGER VALID	0.0000	0.0	0.0
215	8	SURG	NO LONGER VALID	0.0000	0.0	0.0
216	8	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.9579	3.9	6.7
217	8	SURG	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS	2.9817	9.0	13.1
218	8	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC	1.5787	4.3	5.5
219	8	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC	1.0233	2.7	3.2
220	8	SURG	*LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17	0.5928	5.3	5.3
221	8	SURG	NO LONGER VALID	0.0000	0.0	0.0
222	8	SURG	NO LONGER VALID	0.0000	0.0	0.0
223	8	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	1.0806	2.2	3.1
224	8	SURG	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	0.8005	1.6	1.9
225	8	SURG	FOOT PROCEDURES	1.1991	3.7	5.3
226	8	SURG	SOFT TISSUE PROCEDURES W CC	1.5363	4.4	6.5
227	8	SURG	SOFT TISSUE PROCEDURES W/O CC	0.8379	2.1	2.7
228	8	SURG	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC	1.1692	2.8	4.2
229	8	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.7381	1.9	2.5
230	8	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.3517	3.7	5.7

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231	8	SURG	NO LONGER VALID	0.0000	0.0	0.0
232	8	SURG	ARTHROSCOPY	0.9960	1.9	2.8
233	8	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.9555	5.3	7.6
234	8	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	1.1666	2.5	3.4
235	8	MED	FRACTURES OF FEMUR	0.7486	3.7	4.8
236	8	MED	FRACTURES OF HIP & PELVIS	0.7496	3.8	4.7
237	8	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.6083	3.0	3.8
238	8	MED	OSTEOMYELITIS	1.3700	6.5	8.5
239	8	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	1.0793	5.0	6.3
240	8	MED	CONNECTIVE TISSUE DISORDERS W CC	1.3537	4.9	6.6
241	8	MED	CONNECTIVE TISSUE DISORDERS W/O CC	0.6689	3.0	3.7
242	8	MED	SEPTIC ARTHRITIS	1.1562	5.3	6.9
243	8	MED	MEDICAL BACK PROBLEMS	0.7731	3.7	4.6
244	8	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.7156	3.6	4.6
245	8	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4758	2.6	3.3
246	8	MED	NON-SPECIFIC ARTHROPATHIES	0.6029	2.9	3.7
247	8	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5839	2.6	3.3
248	8	MED	TENDONITIS, MYOSITIS & BURSITIS	0.8443	3.8	4.8
249	8	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.7012	2.6	3.8
250	8	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.6943	3.2	4.0
251	8	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.4840	2.3	2.8
252	8	MED	*FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.2574	1.8	1.8
253	8	MED	FX, SPRN, STRN & DISL OF UP ARM, LOW LEG EX FOOT AGE >17 W CC	0.7677	3.7	4.6
254	8	MED	FX, SPRN, STRN & DISL OF UPARM, LOW LEG EX FOOT AGE >17 W/O CC	0.4554	2.5	3.1
255	8	MED	*FX, SPRN, STRN & DISL OF UP ARM,LOW LEG EX FOOT AGE 0-17	0.2998	2.9	2.9
256	8	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.8234	3.9	5.1
257	9	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9157	2.1	2.7

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DRG	MDC	Type	DRG Title	Relative Weights	Geometric mean LOS	Arithmetic mean LOS
258	9	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7174	1.6	1.8
259	9	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9851	1.8	2.8
260	9	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7010	1.2	1.4
261	9	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	0.9767	1.6	2.1
262	9	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.9745	3.2	4.8
263	9	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	2.0406	8.3	11.3
264	9	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.0698	4.9	6.5
265	9	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.6052	4.2	6.7
266	9	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	0.8632	2.3	3.2
267	9	SURG	PERIANAL & PILONIDAL PROCEDURES	0.9068	2.8	4.5
268	9	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.2132	2.4	3.7
269	9	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.7615	6.1	8.6
270	9	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.8199	2.6	3.7
271	9	MED	SKIN ULCERS	1.0186	5.5	7.0
272	9	MED	MAJOR SKIN DISORDERS W CC	1.0227	4.5	5.9
273	9	MED	MAJOR SKIN DISORDERS W/O CC	0.5978	2.9	3.7
274	9	MED	MALIGNANT BREAST DISORDERS W CC	1.1251	4.6	6.3
275	9	MED	MALIGNANT BREAST DISORDERS W/O CC	0.5807	2.2	3.0
276	9	MED	NON-MALIGANT BREAST DISORDERS	0.7219	3.7	4.7
277	9	MED	CELLULITIS AGE >17 W CC	0.8885	4.7	5.7
278	9	MED	CELLULITIS AGE >17 W/O CC	0.5541	3.5	4.2
279	9	MED	*CELLULITIS AGE 0-17	0.7842	4.2	4.2
280	9	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.7260	3.2	4.1
281	9	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.4954	2.3	2.9
282	9	MED	*TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.2607	2.2	2.2
283	9	MED	MINOR SKIN DISORDERS W CC	0.7565	3.5	4.7
284	9	MED	MINOR SKIN DISORDERS W/O CC	0.4307	2.3	3.0
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS	2.0661	7.9	10.3

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DRG	MDC	Type	DRG Title	Relative Weights	Geometric mean LOS	Arithmetic mean LOS
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	1.9411	4.2	5.6
287	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.9093	7.4	10.0
288	10	SURG	O.R. PROCEDURES FOR OBESITY	2.1468	3.5	4.5
289	10	SURG	PARATHYROID PROCEDURES	0.9669	1.7	2.6
290	10	SURG	THYROID PROCEDURES	0.9058	1.6	2.2
291	10	SURG	THYROGLOSSAL PROCEDURES	0.6983	1.3	1.5
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.7302	7.1	10.2
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.4139	3.3	4.7
294	10	MED	DIABETES AGE >35	0.7832	3.4	4.5
295	10	MED	DIABETES AGE 0-35	0.7686	2.9	3.8
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.8429	3.8	4.9
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.5002	2.6	3.2
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.5474	2.6	3.5
299	10	MED	INBORN ERRORS OF METABOLISM	0.9278	3.8	5.3
300	10	MED	ENDOCRINE DISORDERS W CC	1.0988	4.6	6.0
301	10	MED	ENDOCRINE DISORDERS W/O CC	0.6455	2.8	3.5
302	11	SURG	KIDNEY TRANSPLANT	3.1748	7.0	8.2
303	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	2.3287	6.1	7.7
304	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	2.3598	6.0	8.6
305	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	1.1688	2.7	3.3
306	11	SURG	PROSTATECTOMY W CC	1.2651	3.4	5.4
307	11	SURG	PROSTATECTOMY W/O CC	0.6143	1.7	2.1
308	11	SURG	MINOR BLADDER PROCEDURES W CC	1.5952	3.8	6.0
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	0.9053	1.6	2.0
310	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.1707	3.0	4.4
311	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	0.6311	1.5	1.8
312	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	1.0761	3.1	4.6
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	0.6610	1.7	2.2
314	11	SURG	*URETHRAL PROCEDURES, AGE 0-17	0.5024	2.3	2.3
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0957	3.7	6.8
316	11	MED	RENAL FAILURE	1.2859	4.9	6.5
317	11	MED	ADMIT FOR RENAL DIALYSIS	0.8084	2.3	3.3

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DRG	MDC	Type	DRG Title	Relative Weights	Geometric mean LOS	Arithmetic mean LOS
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1515	4.2	5.8
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.6132	2.1	2.7
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.8790	4.2	5.3
321	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.5695	3.1	3.7
322	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.5089	3.0	3.6
323	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.8360	2.4	3.2
324	11	MED	URINARY STONES W/O CC	0.4931	1.6	1.9
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.6652	2.9	3.8
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4396	2.1	2.6
327	11	MED	*KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.3757	3.1	3.1
328	11	MED	URETHRAL STRICTURE AGE >17 W CC	0.6819	2.5	3.4
329	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	0.4540	1.7	2.2
330	11	MED	*URETHRAL STRICTURE AGE 0-17	0.3236	1.6	1.6
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0633	4.2	5.6
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.6051	2.4	3.3
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.9499	3.8	5.4
334	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.4336	3.7	4.4
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.0919	2.6	2.9
336	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	0.8574	2.5	3.3
337	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	0.5845	1.7	2.0
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.2176	3.4	5.7
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.2149	3.2	5.3
340	12	SURG	*TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.2876	2.4	2.4
341	12	SURG	PENIS PROCEDURES	1.2743	1.9	3.0
342	12	SURG	CIRCUMCISION AGE >17	0.7950	2.4	3.2
343	12	SURG	*CIRCUMCISION AGE 0-17	0.1563	1.7	1.7
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.3060	1.6	2.5
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	1.1942	3.1	4.9

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DRG	MDC	Type	DRG Title	Relative Weights	Geometric mean LOS	Arithmetic mean LOS
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	1.0911	4.5	6.0
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.5253	2.0	2.7
348	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	0.7317	3.2	4.1
349	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	0.4474	2.0	2.5
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.7511	3.6	4.5
351	12	MED	*STERILIZATION, MALE	0.2398	1.3	1.3
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.7585	3.0	4.1
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.8936	4.8	6.4
354	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.5372	4.7	5.8
355	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	0.9003	2.9	3.1
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	0.7443	1.7	2.0
357	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	2.2409	6.6	8.3
358	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1743	3.3	4.1
359	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	0.8060	2.3	2.5
360	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	0.8702	2.1	2.7
361	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.1296	2.2	3.5
362	13	SURG	*ENDOSCOPIC TUBAL INTERRUPTION	0.3065	1.4	1.4
363	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.9776	2.7	3.9
364	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.9890	3.1	4.4
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	2.0664	5.2	8.0
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.2702	4.9	6.8
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.5502	2.4	3.2
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.1992	5.2	6.8
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.6243	2.4	3.3
370	14	SURG	CESAREAN SECTION W CC	0.8993	4.2	5.4
371	14	SURG	CESAREAN SECTION W/O CC	0.6263	3.2	3.5

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DRG	MDC	Type	DRG Title	Relative Weights	Geometric mean LOS	Arithmetic mean LOS
372	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.5488	2.7	3.5
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.3607	2.0	2.2
374	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.6718	2.6	3.3
375	14	SURG	*VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.5853	4.4	4.4
376	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.5345	2.5	3.6
377	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.1120	3.1	4.7
378	14	MED	ECTOPIC PREGNANCY	0.7781	1.9	2.2
379	14	MED	THREATENED ABORTION	0.3787	2.0	3.0
380	14	MED	ABORTION W/O D&C	0.3593	1.6	1.9
381	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.6677	1.5	2.2
382	14	MED	FALSE LABOR	0.2425	1.5	2.1
383	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.5102	2.7	3.8
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.2927	1.6	2.0
385	15	MED	*NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.3967	1.8	1.8
386	15	MED	*EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	4.6055	17.9	17.9
387	15	MED	*PREMATURITY W MAJOR PROBLEMS	3.1454	13.3	13.3
388	15	MED	*PREMATURITY W/O MAJOR PROBLEMS	1.8979	8.6	8.6
389	15	MED	*FULL TERM NEONATE W MAJOR PROBLEMS	3.2310	4.7	4.7
390	15	MED	*NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1435	3.4	3.4
391	15	MED	*NORMAL NEWBORN	0.1548	3.1	3.1
392	16	SURG	SPLENECTOMY AGE >17	3.2374	6.7	9.4
393	16	SURG	*SPLENECTOMY AGE 0-17	1.3680	9.1	9.1
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.8777	4.4	7.2
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	0.8428	3.2	4.4
396	16	MED	RED BLOOD CELL DISORDERS AGE 0-17	2.5635	5.3	10.9
397	16	MED	COAGULATION DISORDERS	1.2312	3.7	5.1
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.2383	4.6	5.9
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.6633	2.6	3.3
400	17	SURG	NO LONGER VALID	0.0000	0.0	0.0

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401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.9681	8.0	11.5
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	1.1611	2.8	4.1
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.8217	5.7	8.0
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.8966	3.0	4.1
405	17	MED	*ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.9396	4.9	4.9
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	2.7686	6.8	9.7
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.2082	3.3	4.0
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	2.2105	4.9	8.3
409	17	MED	RADIOTHERAPY	1.3277	4.4	6.0
410	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1.1206	3.1	4.0
411	17	MED	*HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.3980	4.7	4.7
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	0.6474	1.2	1.6
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.3997	5.4	7.3
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.6449	2.9	3.8
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.6319	10.2	14.1
416	18	MED	SEPTICEMIA AGE >17	1.6019	5.5	7.4
417	18	MED	SEPTICEMIA AGE 0-17	1.4305	3.8	5.4
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.0734	4.8	6.2
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.8906	3.6	4.6
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.6036	2.7	3.3
421	18	MED	VIRAL ILLNESS AGE >17	0.8131	3.2	4.2
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.5984	2.5	3.3
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.7774	5.8	8.1
424	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.4474	7.6	13.0
425	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.6864	2.8	3.8
426	19	MED	DEPRESSIVE NEUROSES	0.4851	3.1	4.2
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.5150	3.3	4.7

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428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.8650	4.8	8.0
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.8242	4.4	5.8
430	19	MED	PSYCHOSES	0.6650	5.6	7.8
431	19	MED	CHILDHOOD MENTAL DISORDERS	0.4899	3.9	5.6
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES	0.6524	3.1	4.5
433	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.2855	2.2	2.9
434	20	MED	NO LONGER VALID	0.0000	0.0	0.0
435	20	MED	NO LONGER VALID	0.0000	0.0	0.0
436	20	MED	NO LONGER VALID	0.0000	0.0	0.0
437	20	MED	NO LONGER VALID	0.0000	0.0	0.0
438	20	--	NO LONGER VALID	0.0000	0.0	0.0
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.8762	5.2	8.5
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.8377	5.7	8.8
441	21	SURG	HAND PROCEDURES FOR INJURIES	0.8721	2.1	3.1
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.4877	5.8	8.8
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	1.0096	2.6	3.4
444	21	MED	TRAUMATIC INJURY AGE >17 W CC	0.7707	3.1	4.1
445	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	0.5124	2.2	2.8
446	21	MED	*TRAUMATIC INJURY AGE 0-17	0.3007	2.4	2.4
447	21	MED	ALLERGIC REACTIONS AGE >17	0.5458	1.9	2.6
448	21	MED	*ALLERGIC REACTIONS AGE 0-17	0.0989	2.9	2.9
449	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.8545	2.6	3.7
450	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.4329	1.6	2.0
451	21	MED	*POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.2669	2.1	2.1
452	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0428	3.5	5.0
453	21	MED	COMPLICATIONS OF TREATMENT W/O CC	0.5232	2.2	2.8
454	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.8424	3.0	4.2
455	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.4776	1.8	2.4
456	22		NO LONGER VALID	0.0000	0.0	0.0
457	22	MED	NO LONGER VALID	0.0000	0.0	0.0
458	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
459	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
460	22	MED	NO LONGER VALID	0.0000	0.0	0.0

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**DRGs 469 and 470 contain cases that could not be assigned to valid DRGs.
Note 1: Geometric mean is used only to determine payment for transfer cases.
Note 2: Arithmetic mean is presented for informational purposes only.
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DRG	MDC	Type	DRG Title	Relative Weights	Geometric mean LOS	Arithmetic mean LOS
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.2123	2.2	3.6
462	23	MED	REHABILITATION	0.9037	8.8	10.9
463	23	MED	SIGNS & SYMPTOMS W CC	0.7079	3.1	4.0
464	23	MED	SIGNS & SYMPTOMS W/O CC	0.5136	2.4	3.0
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.5715	2.0	2.8
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6197	2.4	4.0
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.5479	2.0	3.1
468		--	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	3.9382	9.6	13.1
469		--	**PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
470		--	**UNGROUPABLE	0.0000	0.0	0.0
471	8	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	3.0612	4.6	5.3
472	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
473	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.5463	7.6	13.1
474	4	SURG	NO LONGER VALID	0.0000	0.0	0.0
475	4	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	3.6165	7.9	11.2
476		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.2519	7.7	10.8
477		SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.0520	5.6	8.5
478	5	SURG	OTHER VASCULAR PROCEDURES W CC	2.4066	4.8	7.3
479	5	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4460	2.3	3.1
480	PRE	SURG	LIVER TRANSPLANT	9.6485	13.1	18.5
481	PRE	SURG	BONE MARROW TRANSPLANT	6.5278	19.1	22.5
482	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	3.2115	9.3	11.9
483	PRE	SURG	NO LONGER VALID DIAGNOSES	0.0000	0.0	0.0
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.1309	9.1	13.1
485	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA	3.1499	7.9	9.7
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	4.7560	8.8	12.8
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.9689	5.3	7.4
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	5.0248	12.0	17.4
489	25	MED	HIV W MAJOR RELATED CONDITION	1.7852	5.9	8.3

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DRG	MDC	Type	DRG Title	Relative Weights	Geometric mean LOS	Arithmetic mean LOS
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0515	3.8	5.3
491	8	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.7099	2.7	3.3
492	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT	3.8457	9.4	14.9
493	7	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8433	4.5	6.1
494	7	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.0262	2.1	2.7
495	PRE	SURG	LUNG TRANSPLANT	8.7218	13.6	16.5
496	8	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	6.1320	7.1	9.4
497	8	SURG	SPINAL FUSION EXCEPT CERVICAL W CC	3.5013	5.2	6.1
498	8	SURG	SPINAL FUSION EXCEPT CERVICAL W/O CC	2.6706	3.6	3.9
499	8	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.4487	3.2	4.5
500	8	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	0.9459	1.9	2.3
501	8	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.4329	8.0	10.0
502	8	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.4379	5.1	6.0
503	8	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2189	2.9	3.8
504	22	SURG	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/SKIN GRAFT	12.9730	23.0	29.2
505	22	MED	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/O SKIN GRAFT	2.0519	2.4	4.7
506	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	4.0393	11.6	16.2
507	22	SURG	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	1.8639	6.6	9.2
508	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	1.3353	5.1	7.3
509	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	0.6872	3.4	4.7
510	22	MED	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.2759	4.5	6.8
511	22	MED	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.7071	2.9	4.1
512	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	6.0819	11.4	14.0
513	PRE	SURG	PANCREAS TRANSPLANT	6.3181	9.0	10.1
514	5	SURG	NO LONGER VALID	0.0000	0.0	0.0

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DRG	MDC	Type	DRG Title	Relative Weights	Geometric mean LOS	Arithmetic mean LOS
515	5	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	5.4485	2.7	4.7
516	5	SURG	PERCUTANEOUS CARDIOVASC PROC W AMI	2.6578	3.7	4.6
517	5	SURG	PERC CARDIO PROC W NON-DRUG ELUTING STENT W/O AMI	2.1189	1.8	2.5
518	5	SURG	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	1.7569	2.3	3.5
519	8	SURG	CERVICAL SPINAL FUSION W CC	2.4164	3.1	4.9
520	8	SURG	CERVICAL SPINAL FUSION W/O CC	1.6353	1.6	2.1
521	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.7011	4.2	5.6
522	20	MED	ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC	0.4951	7.6	9.5
523	20	MED	ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC	0.3902	3.2	3.9
524	1	MED	TRANSIENT ISCHEMIA	0.7439	2.7	3.3
525	5	SURG	OTHER HEART ASSIST SYSTEM IMPLANT	11.3012	8.0	15.5
526	5	SURG	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W AMI	2.9819	3.4	4.3
527	5	SURG	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W/O AMI	2.3358	1.6	2.1
528	1	SURG	INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	6.8788	13.8	17.0
529	1	SURG	VENTRICULAR SHUNT PROCEDURES W CC	2.2277	5.2	8.2
530	1	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC	1.2000	2.5	3.3
531	1	SURG	SPINAL PROCEDURES W CC	3.1021	6.5	9.6
532	1	SURG	SPINAL PROCEDURES W/O CC	1.4709	2.9	3.9
533	1	SURG	EXTRACRANIAL PROCEDURES W CC	1.6576	2.6	4.0
534	1	SURG	EXTRACRANIAL PROCEDURES W/O CC	1.0559	1.6	1.9
535	5	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	7.7359	6.2	9.3
536	5	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	6.2669	3.5	5.4
537	8	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W CC	1.8020	4.7	6.9
538	8	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC	0.9975	2.1	2.9
539	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC	3.3809	7.4	11.4
540	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC	1.2915	2.9	4.0
541	PRE	SURG	TRACH W MV 96+HRS OR PDX EXC MTH, FACE & NECK DX W/MAJOR OR	19.3416	37.7	44.9

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DRG	MDC	Type	DRG Title	Relative Weights	Geometric mean LOS	Arithmetic mean LOS
542	PRE	SURG	TRACH W MV 96+HRS OR PDX EXC FACE, MTH, & NECK DX W/O MAJOR OR	12.8367	28.9	35.1

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TABLE 6A.--NEW DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	DRG
066.40	West Nile Fever, unspecified	N	18	421, 422
066.41	West Nile Fever with encephalitis	N	18	421, 422
066.42	West Nile Fever with other neurologic manifestation	N	18	421, 422
066.49	West Nile Fever with other complications	N	18	421, 422
070.70	Unspecified viral hepatitis C without hepatic coma	Y	7	205, 206
070.71	Unspecified viral hepatitis C with hepatic coma	Y	7	205, 206
252.00	Hyperparathyroidism, unspecified	N	10	300, 301
252.01	Primary hyperparathyroidism	N	10	300, 301
252.02	Secondary hyperparathyroidism, non-renal	N	10	300, 301
252.08	Other hyperparathyroidism	N	10	300, 301
273.4	Alpha-1-antitrypsin deficiency	N	10	299
277.85	Disorders of fatty acid oxidation	N	10	299
277.86	Peroxisomal disorders	N	10	299
277.87	Disorders of mitochondrial metabolism	N	10	299
347.00	Narcolepsy, without cataplexy	N	1	34, 35
347.01	Narcolepsy, with cataplexy	N	1	34, 35
347.10	Narcolepsy in conditions classified elsewhere, without cataplexy	N	1	34, 35
347.11	Narcolepsy in conditions classified elsewhere, with cataplexy	N	1	34, 35
380.03	Chondritis of pinna	N	8	256
453.40	Venous embolism and thrombosis of unspecified deep vessels of lower extremity	Y	5	130, 131
453.41	Venous embolism and thrombosis of deep vessels of proximal lower extremity	Y	5	130, 131
453.42	Venous embolism and thrombosis of deep vessels of distal lower extremity	Y	5	130, 131
477.2	Allergic rhinitis, due to animal (cat) (dog) hair and dander	N	3	68, 69, 70
491.22	Obstructive chronic bronchitis with acute bronchitis	Y	4	88

Diagnosis Code	Description	CC	MDC	DRG
521.06	Dental caries pit and fissure	N	PRE3	482 185, 186, 187
521.07	Dental caries of smooth surface	N	PRE 3	482 185, 186, 187
521.08	Dental caries of root surface	N	PRE 3	482 185, 186, 187
521.10	Excessive attrition, unspecified	N	PRE 3	482 185, 186, 187
521.11	Excessive attrition, limited to enamel	N	PRE 3	482 185, 186, 187
521.12	Excessive attrition, extending into dentine	N	PRE 3	482 185, 186, 187
521.13	Excessive attrition, extending into pulp	N	PRE 3	482 185, 186, 187
521.14	Excessive attrition, localized	N	PRE 3	482 185, 186, 187
521.15	Excessive attrition, generalized	N	PRE 3	482 185, 186, 187
521.20	Abrasion, unspecified	N	PRE 3	482 185, 186, 187
521.21	Abrasion, limited to enamel	N	PRE 3	482 185, 186, 187
521.22	Abrasion, extending into dentine	N	PRE 3	482 185, 186, 187
521.23	Abrasion, extending into pulp	N	PRE 3	482 185, 186, 187
521.24	Abrasion, localized	N	PRE 3	482 185, 186, 187
521.25	Abrasion, generalized	N	PRE 3	482 185, 186, 187
521.30	Erosion, unspecified	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
521.31	Erosion, limited to enamel	N	PRE 3	482 185, 186, 187
521.32	Erosion, extending into dentine	N	PRE 3	482 185, 186, 187
521.33	Erosion, extending into pulp	N	PRE 3	482 185, 186, 187
521.34	Erosion, localized	N	PRE 3	482 185, 186, 187
521.35	Erosion, generalized	N	PRE 3	482 185, 186, 187
521.40	Pathological resorption, unspecified	N	PRE 3	482 185, 186, 187
521.41	Pathological resorption, internal	N	PRE 3	482 185, 186, 187
521.42	Pathological resorption, external	N	PRE 3	482 185, 186, 187
521.49	Other pathological resorption	N	PRE 3	482 185, 186, 187
523.20	Gingival recession, unspecified	N	PRE 3	482 185, 186, 187
523.21	Gingival recession, minimal	N	PRE 3	482 185, 186, 187
523.22	Gingival recession, moderate	N	PRE 3	482 185, 186, 187
523.23	Gingival recession, severe	N	PRE 3	482 185, 186, 187
523.24	Gingival recession, localized	N	PRE 3	482 185, 186, 187
523.25	Gingival recession, generalized	N	PRE 3	482 185, 186, 187
524.07	Excessive tuberosity of jaw	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
524.20	Unspecified anomaly of dental arch relationship	N	PRE 3	482 185, 186, 187
524.21	Angle's class I	N	PRE 3	482 185, 186, 187
524.22	Angle's class II	N	PRE 3	482 185, 186, 187
524.23	Angle's class III	N	PRE 3	482 185, 186, 187
524.24	Open anterior occlusal relationship	N	PRE 3	482 185, 186, 187
524.25	Open posterior occlusal relationship	N	PRE 3	482 185, 186, 187
524.26	Excessive horizontal overlap	N	PRE 3	482 185, 186, 187
524.27	Reverse articulation	N	PRE 3	482 185, 186, 187
524.28	Anomalies of interarch distance	N	PRE 3	482 185, 186, 187
524.29	Other anomalies of dental arch relationship	N	PRE 3	482 185, 186, 187
524.30	Unspecified anomaly of tooth position	N	PRE 3	482 185, 186, 187
524.31	Crowding of teeth	N	PRE 3	482 185, 186, 187
524.32	Excessive spacing of teeth	N	PRE 3	482 185, 186, 187
524.33	Horizontal displacement of teeth	N	PRE 3	482 185, 186, 187
524.34	Vertical displacement of teeth	N	PRE 3	482 185, 186, 187
524.35	Rotation of teeth	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
524.36	Insufficient interocclusal distance of teeth (ridge)	N	PRE 3	482 185, 186, 187
524.37	Excessive interocclusal distance of teeth	N	PRE 3	482 185, 186, 187
524.39	Other anomalies of tooth position	N	PRE 3	482 185, 186, 187
524.50	Dentofacial functional abnormality, unspecified	N	PRE 3	482 185, 186, 187
524.51	Abnormal jaw closure	N	PRE 3	482 185, 186, 187
524.52	Limited mandibular range of motion	N	PRE 3	482 185, 186, 187
524.53	Deviation in opening and closing of the mandible	N	PRE 3	482 185, 186, 187
524.54	Insufficient anterior guidance	N	PRE 3	482 185, 186, 187
524.55	Centric occlusion maximum intercuspation discrepancy	N	PRE 3	482 185, 186, 187
524.56	Non-working side interference	N	PRE 3	482 185, 186, 187
524.57	Lack of posterior occlusal support	N	PRE 3	482 185, 186, 187
524.59	Other dentofacial functional abnormalities	N	PRE 3	482 185, 186, 187
524.64	Temporomandibular joint sounds on opening and/or closing the jaw	N	PRE 3	482 185, 186, 187
524.75	Vertical displacement of alveolus and teeth	N	PRE 3	482 185, 186, 187
524.76	Occlusal plane deviation	N	PRE 3	482 185, 186, 187
524.81	Anterior soft tissue impingement	N	PRE 3	482 185, 186, 187

Diagnosis Code	Description	CC	MDC	DRG
524.82	Posterior soft tissue impingement	N	PRE 3	482 185, 186, 187
524.89	Other specified dentofacial anomalies	N	PRE 3	482 185, 186, 187
525.20	Unspecified atrophy of edentulous alveolar ridge	N	PRE 3	482 185, 186, 187
525.21	Minimal atrophy of the mandible	N	PRE 3	482 185, 186, 187
525.22	Moderate atrophy of the mandible	N	PRE 3	482 185, 186, 187
525.23	Severe atrophy of the mandible	N	PRE 3	482 185, 186, 187
525.24	Minimal atrophy of the maxilla	N	PRE 3	482 185, 186, 187
525.25	Moderate atrophy of the maxilla	N	PRE 3	482 185, 186, 187
525.26	Severe atrophy of the maxilla	N	PRE 3	482 185, 186, 187
528.71	Minimal keratinized residual ridge mucosa	N	PRE 3	482 185, 186, 187
528.72	Excessive keratinized residual ridge mucosa	N	PRE 3	482 185, 186, 187
528.79	Other disturbances of oral epithelium, including tongue	N	PRE 3	482 185, 186, 187
530.86	Infection of esophagostomy	Y	6	188, 189, 190
530.87	Mechanical complication of esophagostomy	Y	6	188, 189, 190
588.81	Secondary hyperparathyroidism (of renal origin)	N	11	331, 332, 333
588.89	Other specified disorders resulting from impaired renal function	N	11	331, 332, 333
618.00	Unspecified prolapse of vaginal walls	N	13	358, 359, 369
618.01	Cystocele, midline	N	13	358, 359, 369
618.02	Cystocele, lateral	N	13	358, 359, 369
618.03	Urethrocele	N	13	358, 359, 369

Diagnosis Code	Description	CC	MDC	DRG
618.04	Rectocele	N	13	358, 359, 369
618.05	Perineocele	N	13	358, 359, 369
618.09	Other prolapse of vaginal walls without mention of uterine prolapse	N	13	358, 359, 369
618.81	Incompetence or weakening of pubocervical tissue	N	13	358, 359, 369
618.82	Incompetence or weakening of rectovaginal tissue	N	13	358, 359, 369
618.83	Pelvic muscle wasting	N	13	358, 359, 369
618.89	Other specified genital prolapse	N	13	358, 359, 369
621.30	Endometrial hyperplasia, unspecified	N	13	358, 359, 369
621.31	Simple endometrial hyperplasia without atypia	N	13	358, 359, 369
621.32	Complex endometrial hyperplasia without atypia	N	13	358, 359, 369
621.33	Endometrial hyperplasia with atypia	N	13	358, 359, 369
622.10	Dysplasia of cervix, unspecified	N	13	358, 359, 369
622.11	Mild dysplasia of cervix	N	13	358, 359, 369
622.12	Moderate dysplasia of cervix	N	13	358, 359, 369
629.20	Female genital mutilation status, unspecified	N	13	358, 359, 369
629.21	Female genital mutilation Type I status	N	13	358, 359, 369
629.22	Female genital mutilation Type II status	N	13	358, 359, 369
629.23	Female genital mutilation Type III status	N	13	358, 359, 369
692.84	Contact dermatitis and other eczema due to animal (cat) (dog) dander	N	9	283, 284
705.21	Primary focal hyperhidrosis	N	9	283, 284
705.22	Secondary focal hyperhidrosis	N	9	283, 284
707.00	Decubitus ulcer, unspecified site	Y	5 9	121[1] 263, 264, 271
707.01	Decubitus ulcer, elbow	Y	5 9	121[1] 263, 264, 271
707.02	Decubitus ulcer, upper back	Y	5 9	121[1] 263, 264, 271
707.03	Decubitus ulcer, lower back	Y	5 9	121[1] 263, 264, 271

Diagnosis Code	Description	CC	MDC	DRG
707.04	Decubitus ulcer, hip	Y	5 9	121[1] 263, 264, 271
707.05	Decubitus ulcer, buttock	Y	5 9	121[1] 263, 264, 271
707.06	Decubitus ulcer, ankle	Y	5 9	121[1] 263, 264, 271
707.07	Decubitus ulcer, heel	Y	5 9	121[1] 263, 264, 271
707.09	Decubitus ulcer, other site	Y	5 9	121[1] 263, 264, 271
758.31	Cri-du-chat syndrome	N	19	429
758.32	Velo-cardio-facial syndrome	N	19	429
758.33	Other microdeletions	N	19	429
758.39	Other autosomal deletions	N	19	429
780.58	Sleep related movement disorder	N	19	432
788.38	Overflow incontinence	N	11	325, 326, 327
790.95	Elevated C-reactive protein (CRP)	N	23	463, 464
795.03	Papanicolaou smear of cervix with low grade squamous intraepithelial lesion (LGSIL)	N	13	358, 359, 369
795.04	Papanicolaou smear of cervix with high grade squamous intraepithelial lesion (HGSIL)	N	13	358, 359, 369
795.05	Cervical high risk human papillomavirus (HPV) DNA test positive	N	13	358, 359, 369
795.08	Nonspecific abnormal papanicolaou smear of cervix, unsatisfactory smear	N	13	358, 359, 369
796.6	Nonspecific abnormal findings on neonatal screening	N	23	463, 464
V01.71	Contact or exposure to varicella	N	23	467
V01.79	Contact or exposure to other viral diseases	N	23	467
V01.83	Contact or exposure to escherichia coli (E. coli)	N	23	467
V01.84	Contact or exposure to meningococcus	N	23	467
V46.11	Dependence on respirator, status	Y	23	467
V46.12	Encounter for respirator dependence during power failure	Y	23	467

Diagnosis Code	Description	CC	MDC	DRG
V49.83	Awaiting organ transplant status	Y	23	467
V58.44	Aftercare following organ transplant	N	23	465-466
V58.66	Long-term (current) use of aspirin	N	23	465-466
V58.67	Long-term (current) use of insulin	N	23	465-466
V69.4	Lack of adequate sleep	N	23	467
V72.31	Routine gynecological examination	N	23	467
V72.32	Encounter for Papanicolaou cervical smear to confirm findings of recent normal smear following initial abnormal smear	N	23	467
V72.40	Pregnancy examination or test, pregnancy unconfirmed	N	23	467
V72.41	Pregnancy examination or test, negative result	N	23	467
V84.01	Genetic susceptibility to malignant neoplasm of breast	N	23	467
V84.02	Genetic susceptibility to malignant neoplasm of ovary	N	23	467
V84.03	Genetic susceptibility to malignant neoplasm of prostate	N	23	467
V84.04	Genetic susceptibility to malignant neoplasm of endometrium	N	23	467
V84.09	Genetic susceptibility to other malignant neoplasm	N	23	467
V84.8	Genetic susceptibility to other disease	N	23	467

[1] Assigned to the Secondary Diagnosis list that defines a Major Complication

TABLE 6B.--NEW PROCEDURES CODES

Procedure Code	Description	OR	MDC	DRG
00.16	Pressurized treatment of venous bypass graft [conduit] with pharmaceutical substance	N		
00.17	Infusion of vasopressor agent	N		
00.21	Intravascular imaging of extracranial cerebral vessels	N		
00.22	Intravascular imaging of intrathoracic vessels	N		
00.23	Intravascular imaging of peripheral vessels	N		
00.24	Intravascular imaging of coronary vessels	N		
00.25	Intravascular imaging of renal vessels	N		
00.28	Intravascular imaging, other specified vessel(s)	N		
00.29	Intravascular imaging, unspecified vessel(s)	N		
00.31	Computer assisted surgery with CT/CTA	N		
00.32	Computer assisted surgery with MR/MRA	N		
00.33	Computer assisted surgery with fluoroscopy	N		
00.34	Imageless computer assisted surgery	N		
00.35	Computer assisted surgery with multiple datasets	N		
00.39	Other computer assisted surgery	N		
00.61	Percutaneous angioplasty or atherectomy of precerebral (extracranial) vessel(s)	Y	1 5 21 24	533, 534 478, 479 442, 443 486
00.62	Percutaneous angioplasty or atherectomy of intracranial vessel(s)	Y	1 5 21 24	533, 534 478, 479 442, 443 486
00.63	Percutaneous insertion of carotid artery stent(s)	N		
00.64	Percutaneous insertion of other precerebral (extracranial) artery stent(s)	N		

Procedure Code	Description	OR	MDC	DRG
00.65	Percutaneous insertion of intracranial vascular stent(s)	N		
00.91	Transplant from live related donor	N		
00.92	Transplant from live non-related donor	N		
00.93	Transplant from cadaver	N		
27.64	Insertion of palatal implant	N		
37.68	Insertion of percutaneous external heart assist device	Y	5	104, 105
37.90	Insertion of left atrial appendage device	N*	5	518
44.38	Laparoscopic gastroenterostomy	Y	5 6 7 10 17	120 154, 155, 156 201 288 406, 407, 539, 540
44.67	Laparoscopic procedures for creation of esophagogastric sphincteric competence	Y	6 21 24	154, 155, 156 442, 443 486
44.68	Laparoscopic gastroplasty	Y	6 10 21 24	154, 155, 156 288 442, 443 486
44.95	Laparoscopic gastric restrictive procedure	Y	10	288
44.96	Laparoscopic revision of gastric restrictive procedure	Y	10	288
44.97	Laparoscopic removal of gastric restrictive device(s)	Y	10	288
44.98	(Laparoscopic) adjustment of size of adjustable gastric restrictive device	Y	10	288
81.65	Vertebroplasty	Y	8 21 24	233, 234 442, 443 486

Procedure Code	Description	OR	MDC	DRG
81.66	Kyphoplasty	Y	8 21 24	233, 234 442, 443 486
84.53	Implantation of internal limb lengthening device with kinetic distraction	N		
84.54	Implantation of other internal limb lengthening device	N		
84.55	Insertion of bone void filler	N		
84.59	Insertion of other spinal devices	Y	8	499, 500
84.60	Insertion of spinal disc prosthesis, not otherwise specified	Y	8	499, 500
84.61	Insertion of partial spinal disc prosthesis, cervical	Y	8	499, 500
84.62	Insertion of total spinal disc prosthesis, cervical	Y	8	499, 500
84.63	Insertion of spinal disc prosthesis, thoracic	Y	8	499, 500
84.64	Insertion of partial spinal disc prosthesis, lumbosacral	Y	8	499, 500
84.65	Insertion of total spinal disc prosthesis, lumbosacral	Y	8	499, 500
84.66	Revision or replacement of artificial spinal disc prosthesis, cervical	Y	8	499, 500
84.67	Revision or replacement of artificial spinal disc prosthesis, thoracic	Y	8	499, 500
84.68	Revision or replacement of artificial spinal disc prosthesis, lumbosacral	Y	8	499, 500
84.69	Revision or replacement of artificial spinal disc prosthesis, not otherwise specified	Y	8	499, 500
86.94	Insertion or replacement of single array neurostimulator pulse generator	Y	1	7, 8
86.95	Insertion or replacement of dual array neurostimulator pulse generator	Y	1	7, 8
86.96	Insertion or replacement of other neurostimulator pulse generator	Y	1	7, 8
89.49	Automatic implantable cardioverter/defibrillator (AICD) check	N		

Procedure Code	Description	OR	MDC	DRG
99.78	Aquapheresis	N		

*Non-operating room procedure, but affects DRG assignment.

TABLE 6C.--INVALID DIAGNOSIS CODES

Diagnosis Code	Description	CC	MDC	DRG
066.4	West Nile Fever	N	18	421, 422
252.0	Hyperparathyroidism	N	10	300, 301
347	Cataplexy and narcolepsy	N	1	34, 35
521.1	Excessive attrition	N	PRE 3	482 185, 186, 187
521.2	Abrasion	N	PRE 3	482 185, 186, 187
521.3	Erosion	N	PRE 3	482 185, 186, 187
521.4	Pathological resorption	N	PRE 3	482 185, 186, 187
523.2	Gingival recession	N	PRE 3	482 185, 186, 187
524.2	Anomalies of dental arch relationship	N	PRE 3	482 185, 186, 187
524.3	Anomalies of tooth position	N	PRE 3	482 185, 186, 187
524.5	Dentofacial functional abnormalities	N	PRE 3	482 185, 186, 187
524.8	Other specified dentofacial anomalies	N	PRE 3	482 185, 186, 187
525.2	Atrophy of edentulous alveolar ridge	N	PRE 3	482 185, 186, 187
528.7	Other disturbances of oral epithelium, including tongue	N	PRE 3	482 185, 186, 187
588.8	Other specified disorders resulting from impaired renal function	N	11	331, 332, 333
618.0	Prolapse of vaginal walls without mention of uterine prolapse	N	13	358, 359, 369
618.8	Other specified genital prolapse	N	13	358, 359, 369
621.3	Endometrial cystic hyperplasia	N	13	358, 359, 369
622.1	Dysplasia of cevix (uteri)	N	13	358, 359, 369
707.0	Decubitus ulcer	Y	5 9	121[1] 263, 264, 271
758.3	Autosomal deletion syndromes	N	19	429
V01.7	Other viral diseases	N	23	467
V46.1	Respirator	Y	23	467
V72.3	Gynecological examination	N	23	467

Diagnosis Code	Description	CC	MDC	DRG
V72.4	Pregnancy examination or test, pregnancy unconfirmed	N	23	467

[1] Assigned to theSecondary Diagnosis list that defines a Major Complication

TABLE 6D.--INVALID PROCEDRURE CODES

There are no invalid procedure codes for FY 2005.

TABLE 6E.--REVISED DIAGNOSIS CODE TITLES

Diagnosis Code	Description	CC	MDC	DRG
041.82	Bacteroides fragilis	N	18	423
070.41	Acute hepatitis C with hepatic coma	Y	7 15	205, 206 387[1], 389[1]
070.51	Acute hepatitis C without mention of hepatic coma	Y	7 15	205, 206 387[1], 389[1]
250.00	Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled	N	PRE 10	512, 513 294, 295
250.01	Diabetes mellitus without mention of complication, type I [juvenile type], not stated as uncontrolled	Y	PRE 10	512, 513 294, 295
250.02	Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled	Y	PRE 10	512, 513 294, 295
250.03	Diabetes mellitus without mention of complication, type I [juvenile type], uncontrolled	Y	PRE 10	512, 513 294, 295
250.10	Diabetes with ketoacidosis, type II or unspecified type, not stated as uncontrolled	N	PRE 10	512, 513 294, 295
250.11	Diabetes with ketoacidosis, type I [juvenile type], not stated as uncontrolled	Y	PRE 10	512, 513 294, 295
250.12	Diabetes with ketoacidosis, type II or unspecified type, uncontrolled	Y	PRE 10	512, 513 294, 295
250.13	Diabetes with ketoacidosis, type I [juvenile type], uncontrolled	Y	PRE 10	512, 513 294, 295
250.20	Diabetes with hyperosmolarity, type II or unspecified type, not stated as uncontrolled	N	PRE 10	512, 513 294, 295
250.21	Diabetes with hyperosmolarity, type I [juvenile type], not stated as uncontrolled	Y	PRE 10	512, 513 294, 295
250.22	Diabetes with hyperosmolarity, type II or unspecified type, uncontrolled	Y	PRE 10	512, 513 294, 295

Diagnosis Code	Description	CC	MDC	DRG
250.23	Diabetes with hyperosmolarity, type I [juvenile type], uncontrolled	Y	PRE 10	512, 513 294, 295
250.30	Diabetes with other coma, type II or unspecified type, not stated as uncontrolled	N	PRE 10	512, 513 294, 295
250.31	Diabetes with other coma, type I [juvenile type], not stated as uncontrolled	Y	PRE 10	512, 513 294, 295
250.32	Diabetes with other coma, type II or unspecified type, uncontrolled	Y	PRE 10	512, 513 294, 295
250.33	Diabetes with other coma, type I [juvenile type], uncontrolled	Y	PRE 10	512, 513 294, 295
250.40	Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled	N	PRE 11	512, 513 331, 332, 333
250.41	Diabetes with renal manifestations, type I [juvenile type], not stated as uncontrolled	Y	PRE 11	512, 513 331, 332, 333
250.42	Diabetes with renal manifestations, type II or unspecified type, uncontrolled	Y	PRE 11	512, 513 331, 332, 333
250.43	Diabetes with renal manifestations, type I [juvenile type], uncontrolled	Y	PRE 11	512, 513 331, 332, 333
250.50	Diabetes with ophthalmic manifestations, type II or unspecified type, not stated as uncontrolled	N	PRE 2	512, 513 46, 47, 48
250.51	Diabetes with ophthalmic manifestations, type I [juvenile type], not stated as uncontrolled	Y	PRE 2	512, 513 46, 47, 48
250.52	Diabetes with ophthalmic manifestations, type II or unspecified type, uncontrolled	Y	PRE 2	512, 513 46, 47, 48
250.53	Diabetes with ophthalmic manifestations, type I [juvenile type], uncontrolled	Y	PRE 2	512, 513 46, 47, 48

Diagnosis Code	Description	CC	MDC	DRG
250.60	Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled	N	PRE 1	512, 513 18, 19
250.61	Diabetes with neurological manifestations, type I [juvenile type], not stated as uncontrolled	Y	PRE 1	512, 513 18, 19
250.62	Diabetes with neurological manifestations, type II or unspecified type, uncontrolled	Y	PRE 1	512, 513 18, 19
250.63	Diabetes with neurological manifestations, type I [juvenile type], uncontrolled	Y	PRE 1	512, 513 18, 19
250.70	Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled	N	PRE 5	512, 513 130, 131
250.71	Diabetes with peripheral circulatory disorders, type I [juvenile type], not stated as uncontrolled	Y	PRE 5	512, 513 130, 131
250.72	Diabetes with peripheral circulatory disorders, type II or unspecified type, uncontrolled	Y	PRE 5	512, 513 130, 131
250.73	Diabetes with peripheral circulatory disorders, type I [juvenile type], uncontrolled	Y	PRE 5	512, 513 130, 131
250.80	Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled	N	PRE 10	512, 513 294, 295
250.81	Diabetes with other specified manifestations, type I [juvenile type], not stated as uncontrolled	Y	PRE 10	512, 513 294, 295
250.82	Diabetes with other specified manifestations, type II or unspecified type, uncontrolled	Y	PRE 10	512, 513 294, 295
250.83	Diabetes with other specified manifestations, type I [juvenile type], uncontrolled	Y	PRE 10	512, 513 294, 295
250.90	Diabetes with unspecified complication, type II or unspecified type, not stated as uncontrolled	N	PRE 10	512, 513 294, 295

Diagnosis Code	Description	CC	MDC	DRG
250.91	Diabetes with unspecified complication, type I [juvenile type], not stated as uncontrolled	Y	PRE 10	512, 513 294, 295
250.92	Diabetes with unspecified complication, type II or unspecified type, uncontrolled	Y	PRE 10	512, 513 294, 295
250.93	Diabetes with unspecified complication, type I [juvenile type], uncontrolled	Y	PRE 10	512, 513 294, 295
286.5	Hemorrhagic disorder due to intrinsic circulating anticoagulants	Y	16	397
290.40	Vascular dementia, uncomplicated	N	19	429
290.41	Vascular dementia, with delirium	N	19	429
290.42	Vascular dementia, with delusions	N	19	429
290.43	Vascular dementia, with depressed mood	N	19	429
291.1	Alcohol-induced persisting amnestic disorder	Y	20	521, 522, 523
291.2	Alcohol-induced persisting dementia	Y	20	521, 522, 523
291.3	Alcohol-induced psychotic disorder with hallucinations	Y	20	521, 522, 523
291.5	Alcohol-induced psychotic disorder with delusions	N	20	521, 522, 523
291.89	Other specified alcohol-induced mental disorders	Y	20	521, 522, 523
291.9	Unspecified alcohol-induced mental disorders	Y	20	521, 522, 523
292.0	Drug withdrawal	Y	15 20	387[1], 389[1] 521, 522, 523
292.11	Drug-induced psychotic disorder with delusions	Y	20	521, 522, 523
292.12	Drug-induced psychotic disorder with hallucinations	Y	20	521, 522, 523
292.82	Drug-induced persisting dementia	Y	20	521, 522, 523

Diagnosis Code	Description	CC	MDC	DRG
292.83	Drug-induced persisting amnestic disorder	Y	20	521, 522, 523
292.84	Drug-induced mood disorder	Y	20	521, 522, 523
293.0	Delirium due to conditions classified elsewhere	N	19	425
293.81	Psychotic disorder with delusions in conditions classified elsewhere	Y	19	429
293.82	Psychotic disorder with hallucinations in conditions classified elsewhere	Y	19	429
293.83	Mood disorder in conditions classified elsewhere	Y	19	429
293.84	Anxiety disorder in conditions classified elsewhere	Y	19	429
293.89	Other specified transient mental disorders due to conditions classified elsewhere, other	N	19	429
293.9	Unspecified transient mental disorder in conditions classified elsewhere	N	19	425
294.0	Amnestic disorder in conditions classified elsewhere	N	19	429
294.8	Other persistent mental disorders due to conditions classified elsewhere	N	19	429
294.9	Unspecified persistent mental disorders due to conditions classified elsewhere	N	19 25	429 489[2]
295.40	Schizophreniform disorder, unspecified	Y	19	430
295.41	Schizophreniform disorder, subchronic	Y	19	430
295.42	Schizophreniform disorder, chronic	Y	19	430
295.43	Schizophreniform disorder, subchronic with acute exacerbation	Y	19	430
295.44	Schizophreniform disorder, chronic with acute exacerbation	Y	19	430
295.45	Schizophreniform disorder, in remission	N	19	430
295.60	Schizophrenic disorders, residual type, unspecified	Y	19	430

Diagnosis Code	Description	CC	MDC	DRG
295.61	Schizophrenic disorders, residual type, subchronic	Y	19	430
295.62	Schizophrenic disorders, residual type, chronic	Y	19	430
295.63	Schizophrenic disorders, residual type, subchronic with acute exacerbation	Y	19	430
295.64	Schizophrenic disorders, residual type, chronic with acute exacerbation	Y	19	430
295.65	Schizophrenic disorders, residual type, in remission	N	19	430
295.70	Schizoaffective disorder, unspecified	Y	19	430
295.71	Schizoaffective disorder, subchronic	Y	19	430
295.72	Schizoaffective disorder, chronic	Y	19	430
295.73	Schizoaffective disorder, subchronic with acute exacerbation	Y	19	430
295.74	Schizoaffective disorder, chronic with acute exacerbation	Y	19	430
295.75	Schizoaffective disorder, in remission	N	19	430
296.00	Bipolar I disorder, single manic episode, unspecified	N	19	430
296.01	Bipolar I disorder, single manic episode, mild	N	19	430
296.02	Bipolar I disorder, single manic episode, moderate	N	19	430
296.03	Bipolar I disorder, single manic episode, severe, without mention of psychotic behavior	N	19	430
296.04	Bipolar I disorder, single manic episode, severe, specified as with psychotic behavior	Y	19	430
296.05	Bipolar I disorder, single manic episode, in partial or unspecified remission	N	19	430
296.06	Bipolar I disorder, single manic episode, in full remission	N	19	430
296.40	Bipolar I disorder, most recent episode (or current) manic, unspecified	N	19	430

Diagnosis Code	Description	CC	MDC	DRG
296.41	Bipolar I disorder, most recent episode (or current) manic, mild	N	19	430
296.42	Bipolar I disorder, most recent episode (or current) manic, moderate	N	19	430
296.43	Bipolar I disorder, most recent episode (or current) manic, severe, without mention of psychotic behavior	N	19	430
296.44	Bipolar I disorder, most recent episode (or current) manic, severe, specified as with psychotic behavior	Y	19	430
296.45	Bipolar I disorder, most recent episode (or current) manic, in partial or unspecified remission	N	19	430
296.46	Bipolar I disorder, most recent episode (or current) manic, in full remission	N	19	430
296.50	Bipolar I disorder, most recent episode (or current) depressed, unspecified	N	19	430
296.51	Bipolar I disorder, most recent episode (or current) depressed, mild	N	19	430
296.52	Bipolar I disorder, most recent episode (or current) depressed, moderate	N	19	430
296.53	Bipolar I disorder, most recent episode (or current) depressed, severe, without mention of psychotic behavior	N	19	430
296.54	Bipolar I disorder, most recent episode (or current) depressed, severe, specified as with psychotic behavior	Y	19	430
296.55	Bipolar I disorder, most recent episode (or current) depressed, in partial or unspecified remission	N	19	430
296.56	Bipolar I disorder, most recent episode (or current) depressed, in full remission	N	19	430
296.60	Bipolar I disorder, most recent episode (or current) mixed, unspecified	N	19	430
296.61	Bipolar I disorder, most recent episode (or current) mixed, mild	N	19	430
296.62	Bipolar I disorder, most recent episode (or current) mixed, moderate	N	19	430

Diagnosis Code	Description	CC	MDC	DRG
296.63	Bipolar I disorder, most recent episode (or current) mixed, severe, without mention of psychotic behavior	N	19	430
296.64	Bipolar I disorder, most recent episode (or current) mixed, severe, specified as with psychotic behavior	Y	19	430
296.65	Bipolar I disorder, most recent episode (or current) mixed, in partial or unspecified remission	N	19	430
296.66	Bipolar I disorder, most recent episode (or current) mixed, in full remission	N	19	430
296.7	Bipolar I disorder, most recent episode (or current) unspecified	N	19	430
296.80	Bipolar disorder, unspecified	N	19	430
296.89	Other and unspecified bipolar disorders, other	N	19	430
296.90	Unspecified episodic mood disorder	N	19	430
296.99	Other specified episodic mood disorder	N	19	430
297.1	Delusional disorder	N	19	430
297.3	Shared psychotic disorder	N	19	430
299.00	Autistic disorder, current or active state	Y	19	429
299.01	Autistic disorder, residual state	N	19	429
299.10	Childhood disintegrative disorder, current or active state	Y	19	429
299.11	Childhood disintegrative disorder, residual state	N	19	429
299.80	Other specified pervasive developmental disorders, current or active state	Y	19	430
299.81	Other specified pervasive developmental disorders, residual state	N	19	430
299.90	Unspecified pervasive developmental disorder, current or active state	Y	19	430
299.91	Unspecified pervasive developmental disorder, residual state	N	19	430
300.01	Panic disorder without agoraphobia	N	19	425
300.12	Dissociative amnesia	N	19	425

Diagnosis Code	Description	CC	MDC	DRG
300.13	Dissociative fugue	N	19	425
300.14	Dissociative identity disorder	N	19	428
300.16	Factitious disorder with predominantly psychological signs and symptoms	N	19	425
300.21	Agoraphobia with panic disorder	N	19	427
300.29	Other isolated or specific phobias	N	19	427
300.4	Dysthymic disorder	N	19	426
300.6	Depersonalization disorder	N	19	427
300.89	Other somatoform disorders	N	19	427
300.9	Unspecified nonpsychotic mental disorder	N	19	425
301.22	Schizotypal personality disorder	N	19	428
301.4	Obsessive-compulsive personality disorder	N	19	428
301.81	Narcissistic personality disorder	N	19	428
301.82	Avoidant personality disorder	N	19	428
301.83	Borderline personality disorder	N	19	428
302.0	Ego-dystonic sexual orientation	N	19	432
302.3	Transvestic fetishism	N	19	432
302.6	Gender identity disorder in children	N	19	432
302.71	Hypoactive sexual desire disorder	N	19	432
302.73	Female orgasmic disorder	N	19	432
302.74	Male orgasmic disorder	N	19	432
302.75	Premature ejaculation	N	19	432
302.76	Dyspareunia, psychogenic	N	19	432
302.85	Gender identity disorder in adolescents or adults	N	19	432
304.10	Sedative, hypnotic or anxiolytic dependence, unspecified	Y	20	521, 522, 523
304.11	Sedative, hypnotic or anxiolytic dependence, continuous	Y	20	521, 522, 523
304.12	Sedative, hypnotic or anxiolytic dependence, episodic	Y	20	521, 522, 523
304.13	Sedative, hypnotic or anxiolytic dependence, in remission	N	20	521, 522, 523

Diagnosis Code	Description	CC	MDC	DRG
305.40	Sedative, hypnotic or anxiolytic abuse, unspecified	Y	20	521, 522, 523
305.41	Sedative, hypnotic or anxiolytic abuse, continuous	Y	20	521, 522, 523
305.42	Sedative, hypnotic or anxiolytic abuse, episodic	Y	20	521, 522, 523
305.43	Sedative, hypnotic or anxiolytic abuse, in remission	N	20	521, 522, 523
307.0	Stuttering	N	19	432
307.21	Transient tic disorder	N	1	34, 35
307.22	Chronic motor or vocal tic disorder	N	1	34, 35
307.23	Tourette's disorder	N	1	34, 35
307.3	Stereotypic movement disorder	N	19	432
307.45	Circadian rhythm sleep disorder	N	19	432
307.46	Sleep arousal disorder	N	19	432
307.51	Bulimia nervosa	N	19	432
307.53	Rumination disorder	N	19	427
307.89	Other, pain disorder related to psychological factors	N	19	427
309.0	Adjustment disorder with depressed mood	N	19	426
309.24	Adjustment disorder with anxiety	N	19	427
309.28	Adjustment disorder with mixed anxiety and depressed mood	N	19	427
309.3	Adjustment disorder with disturbance of conduct	N	19	427
309.4	Adjustment disorder with mixed disburbance of emotions and conduct	N	19	427
309.81	Posttraumatic stress disorder	N	19	427
310.1	Personality change due to conditions classified elsewhere	N	19	429
313.23	Selective mutism	N	19	431
313.81	Oppositional defiant disorder	N	19	431
313.9	Unspecified emotional disturbance of childhood or adolescence	N	19	431
315.1	Mathematics disorder	N	19	431

Diagnosis Code	Description	CC	MDC	DRG
315.31	Expressive language disorder	N	19	431
315.32	Mixed receptive-expressive language disorder	N	19	431
315.4	Developmental coordination disorder	N	19	431
521.7	Intrinsic posteruptive color changes	N	PRE 3	482 185, 186, 187
760.70	Noxious influences affecting fetus or newborn via placenta or breast milk, unspecified noxious substance	N	15	390
760.71	Noxious influences affecting fetus or newborn via placenta or breast milk, alcohol	N	15	390
760.72	Noxious influences affecting fetus or newborn via placenta or breast milk, narcotics	N	15	390
760.73	Noxious influences affecting fetus or newborn via placenta or breast milk, hallucinogenic agents	N	15	390
760.74	Noxious influences affecting fetus or newborn via placenta or breast milk, anti-infectives	N	15	390
760.75	Noxious influences affecting fetus or newborn via placenta or breast milk, cocaine	N	15	390
760.76	Noxious influences affecting fetus or newborn via placenta or breast milk, diethylstilbestrol [DES]	N	15	390
760.79	Noxious influences affecting fetus or newborn via placenta or breast milk, other	N	15	390
780.8	Generalized hyperhidrosis	N	9 25	283-284 490
795.00	Abnormal glandular Papanicolaou smear of cervix	N	13	358, 359, 369
795.01	Papanicolaou smear of cervix with atypical squamous cells of undetermined significance (ASC-US)	N	13	358, 359, 369

Diagnosis Code	Description	CC	MDC	DRG
795.02	Papanicolaou smear of cervix with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H)	N	13	358, 359, 369
795.09	Other abnormal Papanicolaou smear of cervix and cervical HPV	N	13	358, 359, 369
V07.4	Hormone replacement therapy (postmenopausal)	N	23	467

[1]Classified as a Major Problem.
[2]Classified as a Major Related Condition.

TABLE 6F.--REVISED PROCEDURE CODE TITLES

Procedure Code	Description	OR	MDC	DRG
00.55	Insertion of drug-eluting peripheral vessel stent(s)	N		
01.22	Removal of intracranial neurostimulator lead(s)	Y	1 17 17	1, 2, 3 406, 407, 539, 540
02.93	Implantation or replacement of intracranial neurostimulator lead(s)	Y	1 17 21 24	1, 2, 3 406, 407, 539, 540 442, 443 486
03.93	Implantation or replacement of spinal neurostimulator lead(s)	Y	1 8 11 12 13 17 21 24	531, 532 499, 500 315 344, 345 365 406, 407, 539, 540 442, 443 486
03.94	Removal of spinal neurostimulator lead(s)	Y	1 8 11 12 13 21 24	531, 532 499, 500 315 344, 345 365 442, 443 486

Procedure Code	Description	OR	MDC	DRG
04.92	Implantation or replacement of peripheral neurostimulator lead(s)	Y	1 3 8 11 12 13 21 24	7,8 63 233, 234 315 344, 345 365 442, 443 486
04.93	Removal of peripheral neurostimulator lead(s)	Y	1 3 8 12 13 21 24	7, 8 63 233, 234 344, 345 365 442, 443 486
36.11	(Aorto)coronary bypass of one coronary artery	Y	5	106, 107, 109
36.12	(Aorto)coronary bypass of two coronary arteries	Y	5	106, 107, 109
36.13	(Aorto)coronary bypass of three coronary arteries	Y	5	106, 107, 109
36.14	(Aorto)coronary bypass of four or more coronary arteries	Y	5	106, 107, 109
37.62	Insertion of non-implantable heart assist system	Y	5	525
37.63	Repair of heart assist system	Y	5	525
37.65	Implant of external heart assist system	Y	5	525
37.66	Insertion of implantable heart assist system	Y	5	103

Procedure Code	Description	OR	MDC	DRG
39.50	Angioplasty or atherectomy of other non-coronary vessel(s)	Y	1	533, 534
			4	76, 77
			5	478, 479
			6	170, 171
			7	201
			8	233, 234
			9	269, 270
			10	292, 293
			11	315
			21	442, 443
			24	486
39.90	Insertion of non-drug-eluting peripheral vessel stents(s)	N		
86.05	Incision with removal of foreign body or device from skin and subcutaneous tissue	N		

TABLE 6G.--ADDITIONS TO THE CC EXCLUSIONS LIST

[This table contains CCs that are added to the CC Exclusions List. Each of the principal diagnosis codes 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 code.]

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TABLE 6G.--ADDITIONS TO THE CC EXCLUSIONS LIST

[This table contains CCs that are added to the CC Exclusions List. Each of the principal diagnosis codes 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 code.]

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TABLE 6H.--DELETIONS FROM THE CC EXCLUSIONS LIST

[This table contains CCs that are deleted from the CC Exclusions List. Each of the principal diagnosis codes 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 code.]

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TABLE 7A.--MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY [FY 2003 MEDPAR UPDATE DECEMBER 2003 GROUPER V21.0]

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
1	27,050	10.5	3	5	8	14	21
2	10,753	4.7	1	2	4	6	9
3	2	5.0	5	5	5	5	5
6	367	3.4	1	1	2	4	7
7	15,257	9.6	2	4	7	12	19
8	3,911	2.7	1	1	2	3	6
9	1,790	5.8	1	2	4	8	11
10	18,888	6.2	2	3	5	8	12
11	3,378	3.9	1	2	3	5	8
12	53,417	5.5	2	3	4	7	10
13	7,051	4.9	2	3	4	6	8
14	241,535	5.8	2	3	5	7	11
15	82,855	4.7	1	2	4	6	8
16	10,715	6.2	2	3	5	8	12
17	2,800	3.1	1	1	2	4	6
18	30,819	5.4	2	3	4	7	10
19	8,737	3.5	1	2	3	5	7
20	6,545	10.1	3	5	8	13	20
21	2,179	6.7	2	3	5	8	13
22	3,177	5.1	2	2	4	6	10
23	11,835	4.2	1	2	3	5	8
24	60,883	4.8	1	2	4	6	9
25	28,359	3.1	1	2	3	4	6
26	32	3.2	1	1	2	3	5
27	4,965	5.1	1	1	3	6	11
28	15,853	5.9	1	3	4	8	12
29	5,782	3.4	1	1	3	4	7
31	4,609	4.0	1	2	3	5	8
32	1,932	2.5	1	1	2	3	5
34	25,258	4.8	1	2	4	6	9
35	7,882	3.1	1	1	3	4	6
36	1,615	1.6	1	1	1	1	3
37	1,371	3.9	1	1	3	5	9
38	78	2.3	1	1	2	2	4
39	546	2.2	1	1	1	2	5
40	1,510	4.1	1	1	3	5	8
42	1,252	2.8	1	1	2	3	6

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
43	125	3.4	1	2	3	5	6
44	1,238	4.9	2	3	4	6	9
45	2,835	3.2	1	2	3	4	6
46	3,556	4.3	1	2	3	5	8
47	1,382	3.2	1	1	3	4	6
48	1	1.0	1	1	1	1	1
49	2,326	4.6	1	2	3	6	9
50	2,252	1.9	1	1	1	2	3
51	233	2.9	1	1	1	3	7
52	174	2.2	1	1	1	2	4
53	2,238	3.6	1	1	2	4	8
55	1,453	2.9	1	1	1	3	7
56	466	2.8	1	1	2	3	5
57	721	3.9	1	1	2	4	8
59	118	2.5	1	1	1	3	6
60	5	1.2	1	1	1	1	2
61	259	5.8	1	1	3	8	12
62	2	2.0	2	2	2	2	2
63	2,756	4.4	1	1	3	5	9
64	3,215	6.5	1	2	4	8	14
65	40,968	2.8	1	1	2	4	5
66	7,906	3.1	1	1	2	4	6
67	406	3.5	1	2	3	5	6
68	8,818	3.7	1	2	3	5	7
69	2,974	2.9	1	2	2	4	5
70	26	2.9	1	2	2	3	5
71	67	3.6	2	2	3	4	6
72	1,214	3.5	1	2	3	4	7
73	7,933	4.5	1	2	3	6	9
75	43,470	9.9	3	5	7	12	20
76	46,205	11.0	3	5	9	14	21
77	2,329	4.7	1	2	4	7	9
78	42,890	6.4	3	4	6	8	11
79	173,152	8.3	3	4	7	11	16
80	7,909	5.4	2	3	4	7	10
81	2	13.5	1	1	26	26	26
82	65,401	6.8	2	3	5	9	13
83	6,870	5.3	2	3	4	7	10
84	1,482	3.2	1	2	3	4	6
85	22,472	6.3	2	3	5	8	12
86	2,063	3.6	1	2	3	5	7

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
87	66,941	6.4	2	3	5	8	12
88	396,746	5.0	2	3	4	6	9
89	519,475	5.7	2	3	5	7	10
90	43,918	3.9	2	2	3	5	7
91	45	3.4	2	2	3	4	6
92	16,588	6.2	2	3	5	8	12
93	1,662	4.0	1	2	3	5	7
94	13,110	6.2	2	3	5	8	12
95	1,590	3.7	1	2	3	5	7
96	50,944	4.4	2	2	4	6	8
97	26,138	3.4	1	2	3	4	6
98	15	3.1	1	2	3	4	5
99	21,779	3.2	1	1	2	4	6
100	7,581	2.1	1	1	2	3	4
101	23,051	4.3	1	2	3	5	8
102	5,493	2.5	1	1	2	3	5
103	475	40.4	9	12	21	49	94
104	20,986	14.7	6	8	12	18	26
105	30,692	10.0	4	6	8	12	18
106	3,490	11.3	5	7	10	14	19
107	78,304	10.6	5	7	9	12	17
108	7,025	9.6	1	5	8	12	19
109	54,443	7.8	4	5	6	9	13
110	55,446	8.7	1	4	7	11	18
111	9,421	3.7	1	1	3	5	7
113	38,552	12.5	4	6	10	16	24
114	8,354	8.7	2	4	7	11	17
115	21,802	7.0	1	2	6	9	14
116	117,540	4.3	1	1	3	6	9
117	4,883	4.3	1	1	2	5	10
118	8,379	3.0	1	1	2	4	7
119	1,103	5.3	1	1	3	7	13
120	36,814	8.9	1	3	6	12	19
121	164,174	6.2	2	3	5	8	12
122	70,707	3.4	1	2	3	4	6
123	36,215	4.7	1	1	3	6	11
124	134,205	4.4	1	2	3	6	9
125	92,985	2.8	1	1	2	4	5
126	5,597	11.3	3	6	9	14	21
127	693,364	5.2	2	3	4	6	10
128	6,143	5.4	2	3	5	7	9

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
129	3,979	2.7	1	1	1	3	6
130	90,145	5.5	2	3	5	7	10
131	25,688	3.9	1	2	4	5	7
132	128,455	2.8	1	1	2	4	5
133	7,547	2.2	1	1	2	3	4
134	42,604	3.1	1	2	2	4	6
135	7,486	4.4	1	2	3	6	9
136	1,093	2.6	1	1	2	3	5
137	1	3.0	3	3	3	3	3
138	204,771	4.0	1	2	3	5	8
139	82,144	2.5	1	1	2	3	5
140	45,881	2.5	1	1	2	3	5
141	114,689	3.5	1	2	3	4	7
142	52,608	2.5	1	1	2	3	5
143	245,783	2.1	1	1	2	3	4
144	96,762	5.7	1	2	4	7	12
145	6,693	2.6	1	1	2	3	5
146	10,875	10.1	5	6	8	12	17
147	2,695	6.0	3	4	6	7	9
148	136,089	12.2	5	7	10	15	22
149	19,920	6.1	3	4	6	7	9
150	22,088	11.0	4	6	9	14	20
151	5,280	5.4	1	3	5	7	10
152	4,795	8.0	3	5	7	9	14
153	2,121	5.1	3	4	5	6	8
154	28,540	13.3	3	6	10	17	26
155	6,467	4.1	1	2	3	6	8
156	8	9.9	3	5	6	13	15
157	8,310	5.6	1	2	4	7	11
158	4,124	2.6	1	1	2	3	5
159	18,762	5.1	1	2	4	7	10
160	12,033	2.7	1	1	2	4	5
161	10,717	4.4	1	2	3	6	9
162	5,954	2.0	1	1	1	2	4
163	9	3.9	2	3	4	4	5
164	5,817	8.2	3	5	7	10	15
165	2,466	4.3	2	3	4	6	7
166	4,484	4.7	1	2	4	6	9
167	4,355	2.3	1	1	2	3	4
168	1,537	4.7	1	2	3	6	10
169	837	2.5	1	1	2	3	6

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
170	17,027	10.8	2	5	8	14	22
171	1,452	4.3	1	2	3	6	8
172	31,983	6.9	2	3	5	9	14
173	2,554	3.7	1	1	3	5	7
174	259,489	4.8	2	3	4	6	9
175	33,849	2.9	1	2	3	4	5
176	13,024	5.3	2	3	4	7	10
177	8,752	4.6	2	2	4	6	8
178	3,219	3.1	1	2	3	4	6
179	14,063	5.9	2	3	5	7	11
180	92,889	5.4	2	3	4	7	10
181	26,564	3.4	1	2	3	4	6
182	292,053	4.4	1	2	3	5	8
183	90,835	2.9	1	1	2	4	5
184	59	3.3	1	1	2	4	6
185	5,701	4.7	1	2	3	6	9
186	5	5.8	2	2	4	7	13
187	740	4.2	1	2	3	6	8
188	88,403	5.5	1	2	4	7	11
189	13,059	3.0	1	1	2	4	6
190	71	4.4	1	2	3	6	10
191	9,925	13.2	3	6	9	16	27
192	1,346	5.6	1	3	5	7	10
193	4,428	12.7	5	7	10	15	24
194	532	6.6	2	4	6	8	12
195	3,749	10.2	4	6	9	13	18
196	817	5.5	2	3	5	7	9
197	18,070	9.1	3	5	7	11	16
198	4,916	4.4	2	3	4	6	8
199	1,547	9.5	2	4	7	12	20
200	958	10.2	1	3	7	13	23
201	2,613	14.1	3	6	11	18	28
202	25,957	6.3	2	3	5	8	12
203	31,115	6.7	2	3	5	9	13
204	70,047	5.7	2	3	4	7	11
205	31,075	6.0	2	3	4	7	12
206	2,043	3.8	1	2	3	5	7
207	34,796	5.2	1	2	4	7	10
208	10,055	2.9	1	1	2	4	6
209	427,161	4.7	3	3	4	5	7
210	126,340	6.8	3	4	6	8	11

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
211	28,537	4.8	3	3	4	6	7
212	2	1.5	1	1	2	2	2
213	10,231	9.1	2	4	7	12	18
216	12,806	6.7	1	1	4	9	15
217	17,860	13.1	3	5	9	16	27
218	26,917	5.5	2	3	4	7	10
219	21,382	3.2	1	2	3	4	5
220	1	4.0	4	4	4	4	4
223	13,718	3.1	1	1	2	4	6
224	11,615	1.9	1	1	1	2	3
225	6,364	5.3	1	2	4	7	11
226	6,521	6.5	1	3	4	8	14
227	5,122	2.7	1	1	2	3	5
228	2,679	4.2	1	1	3	5	9
229	1,158	2.5	1	1	2	3	5
230	2,384	5.7	1	2	4	7	12
232	764	2.8	1	1	1	3	6
233	10,125	7.5	1	3	6	9	15
234	4,901	3.4	1	1	2	5	7
235	5,067	4.7	1	2	4	6	9
236	41,984	4.6	1	3	4	5	8
237	1,889	3.8	1	2	3	5	7
238	9,565	8.5	3	4	6	10	16
239	44,768	6.2	2	3	5	7	12
240	12,498	6.6	2	3	5	8	13
241	2,981	3.7	1	2	3	5	7
242	2,760	6.8	2	3	5	8	14
243	100,379	4.6	1	2	4	6	8
244	15,653	4.6	1	2	4	6	8
245	5,887	3.3	1	2	3	4	6
246	1,413	3.7	1	2	3	4	7
247	21,517	3.3	1	2	3	4	6
248	14,485	4.7	1	2	4	6	9
249	13,538	3.8	1	1	3	5	8
250	3,918	3.9	1	2	3	5	7
251	2,330	2.8	1	1	2	4	5
253	23,304	4.6	2	3	4	6	8
254	10,669	3.1	1	2	3	4	5
256	6,960	5.1	1	2	4	6	10
257	14,340	2.7	1	1	2	3	5
258	13,122	1.8	1	1	2	2	3

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
259	3,182	2.8	1	1	1	3	7
260	3,633	1.4	1	1	1	1	2
261	1,628	2.1	1	1	1	2	4
262	634	4.7	1	1	3	6	10
263	25,663	11.3	3	5	8	14	22
264	3,975	6.5	2	3	5	8	12
265	4,044	6.7	1	2	4	8	14
266	2,492	3.2	1	1	2	4	7
267	239	4.5	1	1	3	5	11
268	916	3.7	1	1	2	4	8
269	10,258	8.6	2	4	7	11	17
270	2,821	3.7	1	1	2	5	8
271	20,261	7.0	2	3	6	8	13
272	5,835	5.9	2	3	5	7	11
273	1,351	3.7	1	2	3	5	7
274	2,284	6.3	1	3	5	8	13
275	177	3.0	1	1	2	4	6
276	1,370	4.7	1	3	4	6	8
277	109,102	5.6	2	3	5	7	10
278	33,196	4.1	2	2	4	5	7
279	7	13.3	2	3	5	10	12
280	18,541	4.1	1	2	3	5	8
281	7,274	2.9	1	1	3	4	5
283	6,117	4.7	1	2	3	6	9
284	1,861	3.0	1	1	2	4	6
285	7,117	10.3	3	5	8	13	20
286	2,617	5.6	2	3	4	6	11
287	6,411	10.0	3	5	7	12	19
288	8,422	4.5	2	3	3	5	7
289	6,753	2.6	1	1	1	2	5
290	10,266	2.2	1	1	1	2	4
291	70	1.5	1	1	1	2	2
292	6,928	10.2	2	4	8	13	21
293	342	4.7	1	2	3	6	10
294	99,250	4.4	1	2	3	5	8
295	3,732	3.8	1	2	3	5	7
296	260,811	4.9	1	2	4	6	9
297	47,634	3.1	1	2	3	4	6
298	107	3.5	1	2	2	4	7
299	1,413	5.2	1	2	4	7	10
300	19,630	6.0	2	3	5	7	11

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
301	3,837	3.5	1	2	3	4	7
302	8,975	8.2	4	5	6	9	14
303	22,984	7.7	3	4	6	9	14
304	13,239	8.6	2	3	6	11	18
305	3,069	3.3	1	2	3	4	6
306	7,039	5.4	1	2	3	7	13
307	1,910	2.1	1	1	2	2	3
308	7,447	6.0	1	2	4	8	13
309	3,850	2.0	1	1	1	2	4
310	25,572	4.4	1	1	3	6	10
311	6,909	1.8	1	1	1	2	3
312	1,528	4.6	1	1	3	6	10
313	545	2.2	1	1	1	3	4
314	1	1.0	1	1	1	1	1
315	35,921	6.8	1	1	4	9	16
316	150,585	6.4	2	3	5	8	13
317	2,483	3.3	1	1	2	4	7
318	5,872	5.8	1	2	4	7	12
319	394	2.7	1	1	2	3	6
320	211,017	5.2	2	3	4	6	9
321	31,275	3.6	1	2	3	4	6
322	59	3.6	1	2	3	4	8
323	20,601	3.2	1	1	2	4	6
324	6,225	1.9	1	1	1	2	3
325	9,624	3.8	1	2	3	5	7
326	2,757	2.6	1	1	2	3	5
327	2	2.5	2	2	3	3	3
328	679	3.4	1	1	3	4	7
329	64	2.2	1	1	1	2	5
331	53,566	5.5	1	3	4	7	11
332	4,675	3.2	1	1	2	4	6
333	246	5.4	1	2	4	7	12
334	10,248	4.4	2	3	4	5	7
335	12,393	2.9	1	2	3	3	4
336	33,334	3.3	1	2	2	4	7
337	26,361	2.0	1	1	2	2	3
338	712	5.7	1	2	3	8	13
339	1,439	5.3	1	1	3	6	12
341	3,605	3.0	1	1	2	3	6
342	629	3.2	1	1	2	4	7
344	3,132	2.5	1	1	1	2	6

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
345	1,349	4.9	1	1	3	6	11
346	4,522	6.0	2	3	5	8	12
347	280	2.7	1	1	2	3	6
348	3,355	4.1	1	2	3	5	8
349	537	2.5	1	1	2	3	5
350	7,028	4.5	2	2	4	6	8
352	1,078	4.1	1	2	3	5	8
353	2,650	6.4	2	3	4	7	13
354	7,437	5.8	2	3	4	7	10
355	5,264	3.1	2	2	3	4	5
356	25,335	2.0	1	1	2	2	3
357	5,594	8.3	3	4	6	10	16
358	21,135	4.1	2	2	3	4	7
359	29,879	2.5	1	2	2	3	4
360	15,512	2.7	1	1	2	3	4
361	296	3.5	1	1	2	4	8
363	2,431	3.9	1	2	2	4	8
364	1,460	4.4	1	2	3	6	9
365	1,667	8.0	1	3	5	10	18
366	4,683	6.7	1	3	5	9	14
367	459	3.2	1	1	2	4	6
368	3,887	6.8	2	3	5	9	14
369	3,549	3.3	1	1	2	4	7
370	1,606	5.4	2	3	4	5	9
371	1,964	3.5	2	3	3	4	5
372	1,063	3.5	2	2	2	3	5
373	4,459	2.2	1	2	2	3	3
374	120	3.3	2	2	2	3	5
375	4	5.0	2	2	3	6	9
376	308	3.6	1	2	2	4	5
377	57	4.7	1	1	3	6	10
378	185	2.2	1	1	2	3	4
379	428	3.0	1	1	2	3	5
380	90	1.9	1	1	1	2	3
381	202	2.2	1	1	1	2	4
382	30	2.1	1	1	1	2	5
383	2,299	3.8	1	1	3	4	8
384	136	2.0	1	1	1	2	4
389	1	6.0	6	6	6	6	6
390	3	1.0	1	1	1	1	1
392	2,132	9.4	2	4	7	12	20

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
394	2,620	7.2	1	2	5	9	15
395	111,146	4.3	1	2	3	5	8
396	10	10.9	1	2	3	11	28
397	19,314	5.1	1	2	4	6	10
398	17,821	5.9	2	3	5	7	11
399	1,646	3.2	1	2	3	4	6
401	5,897	11.5	2	5	8	15	23
402	1,450	4.1	1	1	3	5	10
403	31,795	7.9	2	3	6	10	16
404	4,044	4.1	1	2	3	5	8
406	2,384	9.7	2	4	7	12	20
407	575	4.0	1	2	4	5	7
408	2,128	8.3	1	2	5	10	20
409	2,040	6.0	1	3	4	6	12
410	28,228	4.0	1	2	3	5	6
411	7	1.7	1	1	1	2	3
412	14	1.6	1	1	1	1	3
413	5,542	7.3	2	3	6	9	14
414	574	3.8	1	2	3	5	7
415	46,405	14.1	4	6	10	18	28
416	210,582	7.3	2	3	6	9	14
417	26	5.3	1	2	3	6	10
418	27,431	6.2	2	3	5	8	12
419	16,785	4.6	1	2	4	6	9
420	2,917	3.3	1	2	3	4	6
421	10,624	4.2	1	2	3	5	8
422	68	3.3	1	2	2	4	5
423	8,340	8.1	2	3	6	10	17
424	1,234	12.9	1	4	8	16	27
425	15,505	3.8	1	2	3	5	7
426	4,178	4.2	1	2	3	5	8
427	1,423	4.7	1	2	3	6	9
428	779	8.0	1	3	5	9	17
429	27,428	5.6	2	3	4	7	10
430	68,814	7.8	2	3	6	10	15
431	260	5.5	1	2	4	7	12
432	395	4.5	1	2	3	5	10
433	5,514	2.9	1	1	2	3	6
439	1,673	8.5	1	3	5	10	18
440	5,876	8.8	2	3	6	11	19
441	711	3.1	1	1	2	4	6

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
442	17,402	8.8	2	3	6	11	18
443	3,663	3.4	1	1	3	5	7
444	6,022	4.1	1	2	3	5	8
445	2,393	2.8	1	1	2	3	5
447	6,398	2.6	1	1	2	3	5
449	35,504	3.7	1	1	3	4	7
450	7,563	2.0	1	1	1	2	4
451	4	2.3	1	1	1	1	6
452	27,211	4.9	1	2	3	6	10
453	5,538	2.8	1	1	2	3	5
454	4,314	4.2	1	2	3	5	8
455	967	2.4	1	1	2	3	4
461	5,020	3.6	1	1	2	4	8
462	8,380	10.8	4	6	9	14	20
463	29,075	4.0	1	2	3	5	8
464	7,556	3.0	1	1	2	4	5
465	205	3.0	1	1	2	4	6
466	1,788	4.1	1	1	2	4	8
467	1,180	3.1	1	1	2	3	6
468	52,902	12.6	3	6	10	16	25
471	14,356	5.3	3	3	4	6	8
473	8,561	12.7	2	3	7	18	33
475	111,093	11.1	2	5	9	15	22
476	3,227	10.8	2	5	9	15	21
477	26,151	8.2	1	3	6	11	17
478	110,169	7.3	1	3	5	9	15
479	23,803	3.0	1	1	2	4	6
480	710	18.5	6	8	12	21	38
481	858	22.5	12	16	20	25	36
482	5,129	11.8	4	6	9	14	22
483	45,206	38.3	14	21	32	47	69
484	407	13.1	2	6	10	18	26
485	3,312	9.7	4	5	7	11	18
486	2,262	12.7	2	6	10	17	26
487	4,208	7.3	1	3	6	9	15
488	795	17.3	4	7	13	23	37
489	13,723	8.3	2	3	6	10	17
490	5,209	5.3	1	2	4	7	10
491	17,264	3.3	1	2	3	4	6
492	3,336	14.9	3	5	7	24	34
493	61,195	6.1	1	3	5	8	12

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
494	27,202	2.6	1	1	2	3	5
495	245	16.5	8	9	13	19	33
496	4,535	7.5	3	4	5	8	15
497	25,034	6.2	3	4	5	7	10
498	16,905	3.9	2	3	4	5	6
499	37,450	4.4	1	2	3	5	9
500	50,876	2.3	1	1	2	3	4
501	2,808	10.0	4	5	8	12	19
502	705	6.0	3	4	5	7	10
503	5,948	3.8	1	2	3	5	7
504	129	31.0	7	15	30	43	56
505	159	3.1	1	1	1	3	7
506	1,010	16.4	4	7	13	21	33
507	321	9.2	2	4	7	13	19
508	637	7.2	1	3	5	9	15
509	165	4.6	1	2	3	7	9
510	1,749	6.8	1	2	4	8	14
511	622	4.1	1	1	3	5	9
512	529	14.0	6	8	10	15	25
513	174	10.1	6	7	8	11	18
515	13,163	4.7	1	1	2	6	12
516	79,894	4.6	2	2	4	5	9
517	181,948	2.5	1	1	1	3	5
518	48,717	3.5	1	1	2	4	8
519	10,133	4.9	1	1	3	6	11
520	13,969	2.1	1	1	1	2	4
521	32,084	5.6	2	3	4	7	11
522	5,923	9.4	4	4	7	12	19
523	15,548	3.9	1	2	3	5	7
524	123,804	3.3	1	2	3	4	6
525	284	19.6	2	5	11	23	48
526	11,127	4.3	1	2	3	5	8
527	48,486	2.1	1	1	1	2	4
528	1,763	16.9	5	9	15	22	30
529	3,902	8.2	1	2	5	11	19
530	2,371	3.3	1	1	2	4	6
531	4,009	9.6	2	4	7	12	20
532	3,102	3.9	1	1	3	5	8
533	43,418	4.0	1	1	2	5	9
534	50,974	1.9	1	1	1	2	3
535	9,817	9.2	1	3	8	12	19

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
536	25,511	5.4	1	2	4	7	12
537	7,572	6.9	1	3	5	8	14
538	6,346	2.9	1	1	2	4	6
539	4,514	11.3	2	4	8	14	24
540	1,901	4.0	1	2	3	5	8
	11,894,468						

TABLE 7B.--MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY
[FY 2003 MEDPAR UPDATE DECEMBER 2003 GROUPER V22.0]

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
1	27,050	10.5	3	5	8	14	21
2	10,753	4.7	1	2	4	6	9
3	2	5.0	5	5	5	5	5
6	367	3.4	1	1	2	4	7
7	15,257	9.6	2	4	7	12	19
8	3,911	2.7	1	1	2	3	6
9	1,790	5.8	1	2	4	8	11
10	18,888	6.2	2	3	5	8	12
11	3,378	3.9	1	2	3	5	8
12	53,417	5.5	2	3	4	7	10
13	7,051	4.9	2	3	4	6	8
14	241,535	5.8	2	3	5	7	11
15	82,855	4.7	1	2	4	6	8
16	10,715	6.2	2	3	5	8	12
17	2,800	3.1	1	1	2	4	6
18	30,819	5.4	2	3	4	7	10
19	8,737	3.5	1	2	3	5	7
20	6,545	10.1	3	5	8	13	20
21	2,179	6.7	2	3	5	8	13
22	3,177	5.1	2	2	4	6	10
23	11,835	4.2	1	2	3	5	8
24	60,883	4.8	1	2	4	6	9
25	28,359	3.1	1	2	3	4	6
26	32	3.2	1	1	2	3	5
27	4,965	5.1	1	1	3	6	11
28	15,853	5.9	1	3	4	8	12
29	5,782	3.4	1	1	3	4	7
31	4,609	4.0	1	2	3	5	8
32	1,932	2.5	1	1	2	3	5
34	25,258	4.8	1	2	4	6	9
35	7,882	3.1	1	1	3	4	6
36	1,615	1.6	1	1	1	1	3
37	1,371	3.9	1	1	3	5	9
38	78	2.3	1	1	2	2	4
39	546	2.2	1	1	1	2	5
40	1,510	4.1	1	1	3	5	8
42	1,252	2.8	1	1	2	3	6
43	125	3.4	1	2	3	5	6

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
44	1,238	4.9	2	3	4	6	9
45	2,835	3.2	1	2	3	4	6
46	3,556	4.3	1	2	3	5	8
47	1,382	3.2	1	1	3	4	6
48	1	1.0	1	1	1	1	1
49	2,326	4.6	1	2	3	6	9
50	2,252	1.9	1	1	1	2	3
51	233	2.9	1	1	1	3	7
52	174	2.2	1	1	1	2	4
53	2,238	3.6	1	1	2	4	8
55	1,453	2.9	1	1	1	3	7
56	466	2.8	1	1	2	3	5
57	721	3.9	1	1	2	4	8
59	118	2.5	1	1	1	3	6
60	5	1.2	1	1	1	1	2
61	259	5.8	1	1	3	8	12
62	2	2.0	2	2	2	2	2
63	2,756	4.4	1	1	3	5	9
64	3,215	6.5	1	2	4	8	14
65	40,968	2.8	1	1	2	4	5
66	7,906	3.1	1	1	2	4	6
67	406	3.5	1	2	3	5	6
68	8,818	3.7	1	2	3	5	7
69	2,974	2.9	1	2	2	4	5
70	26	2.9	1	2	2	3	5
71	67	3.6	2	2	3	4	6
72	1,214	3.5	1	2	3	4	7
73	7,933	4.5	1	2	3	6	9
75	43,470	9.9	3	5	7	12	20
76	46,205	11.0	3	5	9	14	21
77	2,329	4.7	1	2	4	7	9
78	42,890	6.4	3	4	6	8	11
79	173,152	8.3	3	4	7	11	16
80	7,909	5.4	2	3	4	7	10
81	2	13.5	1	1	26	26	26
82	65,401	6.8	2	3	5	9	13
83	6,870	5.3	2	3	4	7	10
84	1,482	3.2	1	2	3	4	6
85	22,472	6.3	2	3	5	8	12
86	2,063	3.6	1	2	3	5	7
87	66,941	6.4	2	3	5	8	12
88	396,746	5.0	2	3	4	6	9

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
89	519,475	5.7	2	3	5	7	10
90	43,918	3.9	2	2	3	5	7
91	45	3.4	2	2	3	4	6
92	16,588	6.2	2	3	5	8	12
93	1,662	4.0	1	2	3	5	7
94	13,110	6.2	2	3	5	8	12
95	1,590	3.7	1	2	3	5	7
96	50,944	4.4	2	2	4	6	8
97	26,138	3.4	1	2	3	4	6
98	15	3.1	1	2	3	4	5
99	21,779	3.2	1	1	2	4	6
100	7,581	2.1	1	1	2	3	4
101	23,051	4.3	1	2	3	5	8
102	5,493	2.5	1	1	2	3	5
103	553	40.0	9	12	22	50	93
104	20,896	14.6	6	8	12	18	26
105	30,639	9.9	4	6	8	12	18
106	3,490	11.3	5	7	10	14	19
107	78,304	10.6	5	7	9	12	17
108	7,025	9.6	1	5	8	12	19
109	54,443	7.8	4	5	6	9	13
110	55,446	8.7	1	4	7	11	18
111	9,421	3.7	1	1	3	5	7
113	38,552	12.5	4	6	10	16	24
114	8,354	8.7	2	4	7	11	17
115	21,814	7.0	1	2	6	9	14
116	117,554	4.3	1	1	3	6	9
117	4,883	4.3	1	1	2	5	10
118	8,353	3.0	1	1	2	4	7
119	1,103	5.3	1	1	3	7	13
120	36,814	8.9	1	3	6	12	19
121	164,174	6.2	2	3	5	8	12
122	70,707	3.4	1	2	3	4	6
123	36,215	4.7	1	1	3	6	11
124	134,205	4.4	1	2	3	6	9
125	92,985	2.8	1	1	2	4	5
126	5,597	11.3	3	6	9	14	21
127	693,364	5.2	2	3	4	6	10
128	6,143	5.4	2	3	5	7	9
129	3,979	2.7	1	1	1	3	6
130	90,145	5.5	2	3	5	7	10
131	25,688	3.9	1	2	4	5	7

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
132	128,455	2.8	1	1	2	4	5
133	7,547	2.2	1	1	2	3	4
134	42,604	3.1	1	2	2	4	6
135	7,486	4.4	1	2	3	6	9
136	1,093	2.6	1	1	2	3	5
137	1	3.0	3	3	3	3	3
138	204,771	4.0	1	2	3	5	8
139	82,144	2.5	1	1	2	3	5
140	45,881	2.5	1	1	2	3	5
141	114,689	3.5	1	2	3	4	7
142	52,608	2.5	1	1	2	3	5
143	245,783	2.1	1	1	2	3	4
144	96,762	5.7	1	2	4	7	12
145	6,693	2.6	1	1	2	3	5
146	10,879	10.1	5	6	8	12	17
147	2,702	6.0	3	4	6	7	9
148	136,089	12.2	5	7	10	15	22
149	19,920	6.1	3	4	6	7	9
150	22,088	11.0	4	6	9	14	20
151	5,280	5.4	1	3	5	7	10
152	4,795	8.0	3	5	7	9	14
153	2,121	5.1	3	4	5	6	8
154	28,540	13.3	3	6	10	17	26
155	6,467	4.1	1	2	3	6	8
156	8	9.9	3	5	6	13	15
157	8,306	5.6	1	2	4	7	11
158	4,117	2.6	1	1	2	3	5
159	18,762	5.1	1	2	4	7	10
160	12,033	2.7	1	1	2	4	5
161	10,717	4.4	1	2	3	6	9
162	5,954	2.0	1	1	1	2	4
163	9	3.9	2	3	4	4	5
164	5,817	8.2	3	5	7	10	15
165	2,466	4.3	2	3	4	6	7
166	4,484	4.7	1	2	4	6	9
167	4,355	2.3	1	1	2	3	4
168	1,537	4.7	1	2	3	6	10
169	837	2.5	1	1	2	3	6
170	17,027	10.8	2	5	8	14	22
171	1,452	4.3	1	2	3	6	8
172	31,983	6.9	2	3	5	9	14
173	2,554	3.7	1	1	3	5	7

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
174	259,489	4.8	2	3	4	6	9
175	33,849	2.9	1	2	3	4	5
176	13,024	5.3	2	3	4	7	10
177	8,752	4.6	2	2	4	6	8
178	3,219	3.1	1	2	3	4	6
179	14,063	5.9	2	3	5	7	11
180	92,889	5.4	2	3	4	7	10
181	26,564	3.4	1	2	3	4	6
182	292,053	4.4	1	2	3	5	8
183	90,835	2.9	1	1	2	4	5
184	59	3.3	1	1	2	4	6
185	5,701	4.7	1	2	3	6	9
186	5	5.8	2	2	4	7	13
187	740	4.2	1	2	3	6	8
188	88,403	5.5	1	2	4	7	11
189	13,059	3.0	1	1	2	4	6
190	71	4.4	1	2	3	6	10
191	9,925	13.2	3	6	9	16	27
192	1,346	5.6	1	3	5	7	10
193	4,428	12.7	5	7	10	15	24
194	532	6.6	2	4	6	8	12
195	3,749	10.2	4	6	9	13	18
196	817	5.5	2	3	5	7	9
197	18,070	9.1	3	5	7	11	16
198	4,916	4.4	2	3	4	6	8
199	1,547	9.5	2	4	7	12	20
200	958	10.2	1	3	7	13	23
201	2,613	14.1	3	6	11	18	28
202	25,957	6.3	2	3	5	8	12
203	31,115	6.7	2	3	5	9	13
204	70,047	5.7	2	3	4	7	11
205	31,075	6.0	2	3	4	7	12
206	2,043	3.8	1	2	3	5	7
207	34,796	5.2	1	2	4	7	10
208	10,055	2.9	1	1	2	4	6
209	427,161	4.7	3	3	4	5	7
210	126,340	6.8	3	4	6	8	11
211	28,537	4.8	3	3	4	6	7
212	2	1.5	1	1	2	2	2
213	10,231	9.1	2	4	7	12	18
216	12,806	6.7	1	1	4	9	15
217	17,860	13.1	3	5	9	16	27

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
218	26,917	5.5	2	3	4	7	10
219	21,382	3.2	1	2	3	4	5
220	1	4.0	4	4	4	4	4
223	13,718	3.1	1	1	2	4	6
224	11,615	1.9	1	1	1	2	3
225	6,364	5.3	1	2	4	7	11
226	6,521	6.5	1	3	4	8	14
227	5,122	2.7	1	1	2	3	5
228	2,679	4.2	1	1	3	5	9
229	1,158	2.5	1	1	2	3	5
230	2,384	5.7	1	2	4	7	12
232	764	2.8	1	1	1	3	6
233	10,125	7.5	1	3	6	9	15
234	4,901	3.4	1	1	2	5	7
235	5,067	4.7	1	2	4	6	9
236	41,984	4.6	1	3	4	5	8
237	1,889	3.8	1	2	3	5	7
238	9,565	8.5	3	4	6	10	16
239	44,768	6.2	2	3	5	7	12
240	12,498	6.6	2	3	5	8	13
241	2,981	3.7	1	2	3	5	7
242	2,760	6.8	2	3	5	8	14
243	100,379	4.6	1	2	4	6	8
244	15,653	4.6	1	2	4	6	8
245	5,887	3.3	1	2	3	4	6
246	1,413	3.7	1	2	3	4	7
247	21,517	3.3	1	2	3	4	6
248	14,485	4.7	1	2	4	6	9
249	13,538	3.8	1	1	3	5	8
250	3,918	3.9	1	2	3	5	7
251	2,330	2.8	1	1	2	4	5
253	23,304	4.6	2	3	4	6	8
254	10,669	3.1	1	2	3	4	5
256	6,960	5.1	1	2	4	6	10
257	14,340	2.7	1	1	2	3	5
258	13,122	1.8	1	1	2	2	3
259	3,182	2.8	1	1	1	3	7
260	3,633	1.4	1	1	1	1	2
261	1,628	2.1	1	1	1	2	4
262	634	4.7	1	1	3	6	10
263	25,663	11.3	3	5	8	14	22
264	3,975	6.5	2	3	5	8	12

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
265	4,044	6.7	1	2	4	8	14
266	2,492	3.2	1	1	2	4	7
267	239	4.5	1	1	3	5	11
268	916	3.7	1	1	2	4	8
269	10,258	8.6	2	4	7	11	17
270	2,821	3.7	1	1	2	5	8
271	20,261	7.0	2	3	6	8	13
272	5,835	5.9	2	3	5	7	11
273	1,351	3.7	1	2	3	5	7
274	2,284	6.3	1	3	5	8	13
275	177	3.0	1	1	2	4	6
276	1,370	4.7	1	3	4	6	8
277	109,102	5.6	2	3	5	7	10
278	33,196	4.1	2	2	4	5	7
279	7	13.3	2	3	5	10	12
280	18,541	4.1	1	2	3	5	8
281	7,274	2.9	1	1	3	4	5
283	6,117	4.7	1	2	3	6	9
284	1,861	3.0	1	1	2	4	6
285	7,117	10.3	3	5	8	13	20
286	2,617	5.6	2	3	4	6	11
287	6,411	10.0	3	5	7	12	19
288	8,422	4.5	2	3	3	5	7
289	6,753	2.6	1	1	1	2	5
290	10,266	2.2	1	1	1	2	4
291	70	1.5	1	1	1	2	2
292	6,928	10.2	2	4	8	13	21
293	342	4.7	1	2	3	6	10
294	99,250	4.4	1	2	3	5	8
295	3,732	3.8	1	2	3	5	7
296	260,811	4.9	1	2	4	6	9
297	47,634	3.1	1	2	3	4	6
298	107	3.5	1	2	2	4	7
299	1,413	5.2	1	2	4	7	10
300	19,630	6.0	2	3	5	7	11
301	3,837	3.5	1	2	3	4	7
302	8,975	8.2	4	5	6	9	14
303	22,984	7.7	3	4	6	9	14
304	13,239	8.6	2	3	6	11	18
305	3,069	3.3	1	2	3	4	6
306	7,039	5.4	1	2	3	7	13
307	1,910	2.1	1	1	2	2	3

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
308	7,447	6.0	1	2	4	8	13
309	3,850	2.0	1	1	1	2	4
310	25,572	4.4	1	1	3	6	10
311	6,909	1.8	1	1	1	2	3
312	1,528	4.6	1	1	3	6	10
313	545	2.2	1	1	1	3	4
314	1	1.0	1	1	1	1	1
315	35,921	6.8	1	1	4	9	16
316	150,585	6.4	2	3	5	8	13
317	2,483	3.3	1	1	2	4	7
318	5,872	5.8	1	2	4	7	12
319	394	2.7	1	1	2	3	6
320	211,017	5.2	2	3	4	6	9
321	31,275	3.6	1	2	3	4	6
322	59	3.6	1	2	3	4	8
323	20,601	3.2	1	1	2	4	6
324	6,225	1.9	1	1	1	2	3
325	9,624	3.8	1	2	3	5	7
326	2,757	2.6	1	1	2	3	5
327	2	2.5	2	2	3	3	3
328	679	3.4	1	1	3	4	7
329	64	2.2	1	1	1	2	5
331	53,566	5.5	1	3	4	7	11
332	4,675	3.2	1	1	2	4	6
333	246	5.4	1	2	4	7	12
334	10,248	4.4	2	3	4	5	7
335	12,393	2.9	1	2	3	3	4
336	33,334	3.3	1	2	2	4	7
337	26,361	2.0	1	1	2	2	3
338	712	5.7	1	2	3	8	13
339	1,439	5.3	1	1	3	6	12
341	3,605	3.0	1	1	2	3	6
342	629	3.2	1	1	2	4	7
344	3,132	2.5	1	1	1	2	6
345	1,349	4.9	1	1	3	6	11
346	4,522	6.0	2	3	5	8	12
347	280	2.7	1	1	2	3	6
348	3,355	4.1	1	2	3	5	8
349	537	2.5	1	1	2	3	5
350	7,028	4.5	2	2	4	6	8
352	1,078	4.1	1	2	3	5	8
353	2,650	6.4	2	3	4	7	13

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
354	7,437	5.8	2	3	4	7	10
355	5,264	3.1	2	2	3	4	5
356	25,335	2.0	1	1	2	2	3
357	5,594	8.3	3	4	6	10	16
358	21,135	4.1	2	2	3	4	7
359	29,879	2.5	1	2	2	3	4
360	15,512	2.7	1	1	2	3	4
361	296	3.5	1	1	2	4	8
363	2,431	3.9	1	2	2	4	8
364	1,460	4.4	1	2	3	6	9
365	1,667	8.0	1	3	5	10	18
366	4,683	6.7	1	3	5	9	14
367	459	3.2	1	1	2	4	6
368	3,887	6.8	2	3	5	9	14
369	3,549	3.3	1	1	2	4	7
370	1,606	5.4	2	3	4	5	9
371	1,964	3.5	2	3	3	4	5
372	1,063	3.5	2	2	2	3	5
373	4,459	2.2	1	2	2	3	3
374	120	3.3	2	2	2	3	5
375	4	5.0	2	2	3	6	9
376	308	3.6	1	2	2	4	5
377	57	4.7	1	1	3	6	10
378	185	2.2	1	1	2	3	4
379	428	3.0	1	1	2	3	5
380	90	1.9	1	1	1	2	3
381	202	2.2	1	1	1	2	4
382	30	2.1	1	1	1	2	5
383	2,299	3.8	1	1	3	4	8
384	136	2.0	1	1	1	2	4
389	1	6.0	6	6	6	6	6
390	3	1.0	1	1	1	1	1
392	2,132	9.4	2	4	7	12	20
394	2,620	7.2	1	2	5	9	15
395	111,146	4.3	1	2	3	5	8
396	10	10.9	1	2	3	11	28
397	19,314	5.1	1	2	4	6	10
398	17,821	5.9	2	3	5	7	11
399	1,646	3.2	1	2	3	4	6
401	5,897	11.5	2	5	8	15	23
402	1,450	4.1	1	1	3	5	10
403	31,795	7.9	2	3	6	10	16

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
404	4,044	4.1	1	2	3	5	8
406	2,384	9.7	2	4	7	12	20
407	575	4.0	1	2	4	5	7
408	2,128	8.3	1	2	5	10	20
409	2,040	6.0	1	3	4	6	12
410	28,228	4.0	1	2	3	5	6
411	7	1.7	1	1	1	2	3
412	14	1.6	1	1	1	1	3
413	5,542	7.3	2	3	6	9	14
414	574	3.8	1	2	3	5	7
415	46,405	14.1	4	6	10	18	28
416	210,582	7.3	2	3	6	9	14
417	26	5.3	1	2	3	6	10
418	27,431	6.2	2	3	5	8	12
419	16,785	4.6	1	2	4	6	9
420	2,917	3.3	1	2	3	4	6
421	10,624	4.2	1	2	3	5	8
422	68	3.3	1	2	2	4	5
423	8,340	8.1	2	3	6	10	17
424	1,234	12.9	1	4	8	16	27
425	15,505	3.8	1	2	3	5	7
426	4,178	4.2	1	2	3	5	8
427	1,423	4.7	1	2	3	6	9
428	779	8.0	1	3	5	9	17
429	27,428	5.6	2	3	4	7	10
430	68,814	7.8	2	3	6	10	15
431	260	5.5	1	2	4	7	12
432	395	4.5	1	2	3	5	10
433	5,514	2.9	1	1	2	3	6
439	1,673	8.5	1	3	5	10	18
440	5,876	8.8	2	3	6	11	19
441	711	3.1	1	1	2	4	6
442	17,402	8.8	2	3	6	11	18
443	3,663	3.4	1	1	3	5	7
444	6,022	4.1	1	2	3	5	8
445	2,393	2.8	1	1	2	3	5
447	6,398	2.6	1	1	2	3	5
449	35,504	3.7	1	1	3	4	7
450	7,563	2.0	1	1	1	2	4
451	4	2.3	1	1	1	1	6
452	27,211	4.9	1	2	3	6	10
453	5,538	2.8	1	1	2	3	5

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
454	4,314	4.2	1	2	3	5	8
455	967	2.4	1	1	2	3	4
461	5,020	3.6	1	1	2	4	8
462	8,380	10.8	4	6	9	14	20
463	29,075	4.0	1	2	3	5	8
464	7,556	3.0	1	1	2	4	5
465	205	3.0	1	1	2	4	6
466	1,788	4.1	1	1	2	4	8
467	1,180	3.1	1	1	2	3	6
468	48,879	12.8	3	6	10	17	25
471	14,356	5.3	3	3	4	6	8
473	8,561	12.7	2	3	7	18	33
475	111,093	11.1	2	5	9	15	22
476	3,227	10.8	2	5	9	15	21
477	30,174	8.5	1	3	6	11	18
478	110,169	7.3	1	3	5	9	15
479	23,803	3.0	1	1	2	4	6
480	710	18.5	6	8	12	21	38
481	858	22.5	12	16	20	25	36
482	5,129	11.8	4	6	9	14	22
484	407	13.1	2	6	10	18	26
485	3,312	9.7	4	5	7	11	18
486	2,262	12.7	2	6	10	17	26
487	4,208	7.3	1	3	6	9	15
488	795	17.3	4	7	13	23	37
489	13,723	8.3	2	3	6	10	17
490	5,209	5.3	1	2	4	7	10
491	17,264	3.3	1	2	3	4	6
492	3,336	14.9	3	5	7	24	34
493	61,195	6.1	1	3	5	8	12
494	27,202	2.6	1	1	2	3	5
495	245	16.5	8	9	13	19	33
496	2,755	9.3	3	4	7	11	19
497	25,973	6.1	3	4	5	7	10
498	17,746	3.9	2	3	4	5	6
499	37,450	4.4	1	2	3	5	9
500	50,876	2.3	1	1	2	3	4
501	2,808	10.0	4	5	8	12	19
502	705	6.0	3	4	5	7	10
503	5,948	3.8	1	2	3	5	7
504	174	29.1	8	16	25	41	54
505	191	4.7	1	1	2	5	11

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
506	942	16.1	4	7	13	21	33
507	318	9.1	2	4	7	13	19
508	631	7.2	1	3	5	9	15
509	165	4.6	1	2	3	7	9
510	1,749	6.8	1	2	4	8	14
511	622	4.1	1	1	3	5	9
512	529	14.0	6	8	10	15	25
513	174	10.1	6	7	8	11	18
515	13,163	4.7	1	1	2	6	12
516	79,894	4.6	2	2	4	5	9
517	181,948	2.5	1	1	1	3	5
518	48,717	3.5	1	1	2	4	8
519	10,133	4.9	1	1	3	6	11
520	13,969	2.1	1	1	1	2	4
521	32,084	5.6	2	3	4	7	11
522	5,923	9.4	4	4	7	12	19
523	15,548	3.9	1	2	3	5	7
524	123,804	3.3	1	2	3	4	6
525	349	15.1	1	4	8	16	27
526	11,127	4.3	1	2	3	5	8
527	48,486	2.1	1	1	1	2	4
528	1,763	16.9	5	9	15	22	30
529	3,902	8.2	1	2	5	11	19
530	2,371	3.3	1	1	2	4	6
531	4,009	9.6	2	4	7	12	20
532	3,102	3.9	1	1	3	5	8
533	43,418	4.0	1	1	2	5	9
534	50,974	1.9	1	1	1	2	3
535	9,817	9.2	1	3	8	12	19
536	25,511	5.4	1	2	4	7	12
537	7,572	6.9	1	3	5	8	14
538	6,346	2.9	1	1	2	4	6
539	4,514	11.3	2	4	8	14	24
540	1,901	4.0	1	2	3	5	8
541	21,263	43.4	17	25	37	54	77
542	23,943	33.8	13	19	28	42	60
	11,894,468						

TABLE 8A.--STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS--MAY 2004

State	Urban	Rural
Alabama	0.296	0.362
Alaska	0.460	0.784
Arizona	0.310	0.499
Arkansas	0.381	0.419
California	0.279	0.392
Colorado	0.341	0.511
Connecticut	0.472	0.534
Delaware	0.542	0.465
District of Columbia	0.385	--
Florida	0.271	0.318
Georgia	0.401	0.459
Hawaii	0.391	0.472
Idaho	0.505	0.560
Illinois	0.359	0.459
Indiana	0.460	0.493
Iowa	0.446	0.557
Kansas	0.344	0.529
Kentucky	0.425	0.421
Louisiana	0.316	0.403
Maine	0.538	0.531
Maryland	0.757	0.836
Massachusetts	0.488	--
Michigan	0.410	0.519
Minnesota	0.427	0.539
Mississippi	0.381	0.402
Missouri	0.350	0.436
Montana	0.471	0.499
Nebraska	0.388	0.521
Nevada	0.259	0.519
New Hampshire	0.501	0.551
New Jersey	0.219	--
New Mexico	0.447	0.440
New York	0.400	0.537
North Carolina	0.500	0.459
North Dakota	0.555	0.478
Ohio	0.423	0.563
Oklahoma	0.359	0.460
Oregon	0.513	0.517
Pennsylvania	0.326	0.509

State	Urban	Rural
Puerto Rico	0.480	--
Rhode Island	0.452	--
South Carolina	0.345	0.369
South Dakota	0.424	0.514
Tennessee	0.360	0.435
Texas	0.328	0.419
Utah	0.456	0.591
Vermont	0.569	0.653
Virginia	0.408	0.445
Washington	0.479	0.544
West Virginia	0.539	0.510
Wisconsin	0.466	0.537
Wyoming	0.442	0.634

TABLE 8B.--STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS--MAY 2004

State	Ratio
Alabama	0.032
Alaska	0.049
Arizona	0.032
Arkansas	0.037
California	0.022
Colorado	0.032
Connecticut	0.035
Delaware	0.045
District of Columbia	0.029
Florida	0.027
Georgia	0.038
Hawaii	0.035
Idaho	0.052
Illinois	0.031
Indiana	0.045
Iowa	0.038
Kansas	0.036
Kentucky	0.039
Louisiana	0.034
Maine	0.037
Maryland	0.013
Massachusetts	0.039
Michigan	0.039
Minnesota	0.038
Mississippi	0.033
Missouri	0.032
Montana	0.041
Nebraska	0.040
Nevada	0.022
New Hampshire	0.042
New Jersey	0.017
New Mexico	0.036
New York	0.036
North Carolina	0.046
North Dakota	0.052
Ohio	0.037
Oklahoma	0.034
Oregon	0.043

State	Ratio
Pennsylvania	0.029
Puerto Rico	0.037
Rhode Island	0.025
South Carolina	0.031
South Dakota	0.049
Tennessee	0.037
Texas	0.033
Utah	0.044
Vermont	0.046
Virginia	0.042
Washington	0.040
West Virginia	0.039
Wisconsin	0.042
Wyoming	0.049

TABLE 9A.--HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL--FY 2005

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
010005	01	1000	01	13820		
010008	01	5240	01	33860		
010022	01	2880	01	23460		
010029	01	1800	12220	17980		
010035	01	1000	01	13820		
010065	01	0580	01	12220		
010072	01		45180	11500	LUGAR	
010089	01	1000	13820	13820		
010101	01		45180	11500	LUGAR	
010118	01	5240	01	33860		
010120	01	5160	01	33660		Baldwin
010126	01	5240	01	33860		
010143	01	1000	01	13820		
010158	01	2030	01	19460		
020005	02	0380	02	11260		
020006	02	0380	11260	11260		
030007	03	2620	39140	22380		
030012	03	6200	39140	38060		
030033	03	2620	03	22380		
040014	04	4400	04	30780		
040017	04	7920	04	44180		
040019	04	4920	04	32820		
040020	04	4920	27860	32820		
040026	04	4400	26300	30780		
040027	04	7920	04	44180		
040041	04	4400	04	30780		
040045	04	8600	04	46220		
040047	04	26	04	26		
040063	04	4400	04	30780		
040069	04	4920	04	32820		
040072	04	4400	04	30780		
040076	04	4400	04	30780		
040078	04	4400	26300	30780		
040080	04	3700	04	27860		
040088	04	7680	04	43340		Bossier
040091	04	8360	04	45500		
040119	04	4400	04	30780		
050014	05	6920	05	40900		
050042	05	6690	05	39820		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
050046	05	4480	37100	31084		
050071	05	5775	41940	36084		
050073	05	5775	46700	36084		
050076	05	5775	41884	36084		
050082	05	4480	37100	31084		
050150	05	6920	05	40900		
050159	05	4480	37100	31084		
050174	7500	8720	42220	34900		Napa
050177	05	4480	37100	31084		
050228	05	5775	41884	36084		
050236	05	4480	37100	31084		
050251	05	6720	05	39900		
050296	05	7400	41940	41940		
050325	05	5170	05	33700		
050394	05	4480	37100	31084		
050419	05	6690	05	39820		
050430	05	6720	05	39900		
050510	05	5775	41884	36084		
050541	05	5775	41884	36084		
050569	05	7500	05	42220		
050609	05	4480	42044	31084		
050616	05	4480	37100	31084		
050668	05	5775	41884	36084		
050686	05	5945	40140	42044		
050690	7500	8720	42220	34900		Napa
060001	06	2080	24540	19740		
060003	06	2080	14500	19740		
060023	06	6520	24300	39340		
060027	06	2080	14500	19740		
060044	06	2080	06	19740		
060049	06	2670	06	22660		
060096	06	2080	06	19740		
060103	06	2080	14500	19740		
070003	07		48740	25540	LUGAR	
070004	07		45860	25540	LUGAR	
070006	07	5600	14860	35644		
070011	07		45860	25540	LUGAR	
070015	07	5600	07	35644		
070018	07	5600	14860	35644		
070021	07		48740	25540	LUGAR	
070026	07		45860	25540	LUGAR	
080004	08	9160	20100	48864		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
080007	08	0560	08	36140		Cape May
100022	10	2680	33124	22744		
100023	10	5690	10	36100		
100024	10	5000	10	33124		
100045	10	5960	19660	36740		
100049	10	3980	10	29460		
100081	10		10	23020	LUGAR	
100103	10		10	23540	LUGAR	
100105	10	2710	46940	38940		
100109	10	5960	10	36740		
100118	10		37380	19660	LUGAR	
100139	10		10	23540	LUGAR	
100150	10	5000	10	33124		
100176	10	2710	48424	38940		
100217	10	2710	46940	38940		
100232	10	5790	10	36100		
100249	10	5790	10	36100		
110001	11	0520	19140	12060		
110002	11	0520	11	12060		
110003	11	3600	11	27260		
110009	11		22980	31420	LUGAR	
110016	11	1800	11	17980		
110023	11	0520	11	12060		
110025	11	3600	15260	27260		
110029	11	0520	23580	12060		
110038	11	10	11	10		
110040	11		11	12060	LUGAR	
110041	11	0500	11	12020		
110052	11		44900	16860	LUGAR	
110054	11	0520	40660	12060		
110074	11	0500	12020	12020		
110075	11	7520	11	42340		
110088	11		11	12060	LUGAR	
110117	11		16340	12060	LUGAR	
110120	11		16340	12060	LUGAR	
110122	11	10	46660	10		
110128	11	7520	11	42340		
110150	11	4680	11	31420		Jones
110168	11	0520	40660	12060		
110187	11	0520	11	12060		
110205	11	0520	11	12060		
120026	12	3320	26180	26180		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
130002	13	29	13	29		
130003	13	50	30300	50		
130018	13	6340	26820	38540		
130022	13		13940	26820	LUGAR	
130026	13	6340	13	38540		
130028	6340	7160	38540	36260		Weber
130049	13	7840	17660	44060		
140004	14		30660	44100	LUGAR	
140012	14	1600	14	16974		Dekalb
140015	14	7040	14	41180		
140027	14	1960	14	19340		
140032	14	7040	14	41180		
140034	14	7040	14	41180		
140038	14		40300	40420	LUGAR	
140040	14	1960	14	19340		
140043	14	6880	14	40420		Winnebago
140046	14	7040	14	41180		
140058	14	7880	14	44100		
140102	14		45380	44100	LUGAR	
140110	14	6120	14	37900		
140112	14		14	37900	LUGAR	
140137	14	7040	41180	41180		
140143	14	6120	14	37900		
140146	14		14	14060	LUGAR	
140160	14	6880	14	40420		Winnebago
140161	14	1600	14	16974		Grundy
140164	14	7040	14	41180		
140167	14		14	28100	LUGAR	
140189	14	1400	14	16580		
140234	14	6120	14	37900		
140236	14		14	28100	LUGAR	
140271	14		45380	44100	LUGAR	
150002	2960	1600	23844	16974		Cook
150004	2960	1600	23844	16974		Cook
150006	15	7800	33140	43780		
150008	2960	1600	23844	16974		Cook
150011	15	3480	15	11300		Madison
150012	18	4520	43780	31140		Oldham
150015	15	1600	33140	16974		
150027	15	15	26900	15		
150030	15		35220	26900	LUGAR	
150043	15		23140	29140	LUGAR	

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
150048	15	2000	15	19380		Montgomery
150051	15	1020	14020	14020		
150069	15	1640	15	17140		
150076	15	7800	15	43780		
150090	2960	1600	23844	16974		Cook
150102	15	7800	15	43780		
150103	15		15	29140	LUGAR	
150112	15	3480	18020	26900		Brown
150125	2960	1600	23844	16974		Cook
150126	2960	1600	23844	16974		Will
150132	2960	1600	23844	16974		Cook
150133	15	2330	15	21140		
150146	15	2330	15	21140		
150147	2960	1600	23844	16974		Cook
160001	16	2120	16	19780		
160016	16	2120	16	19780		
160026	16	2120	16	19780		
160030	16	2120	11180	19780		
160037	16	24	16	24		
160057	16	3500	16	26980		
160080	16	6880	16	40420		Winnebago
160086	16		16	47940	LUGAR	
160089	16	2120	16	19780		
160147	16	2120	16	19780		
170006	17	3710	17	27900		
170010	17	8560	17	46140		
170012	17	9040	17	48620		
170013	17	9040	17	48620		
170014	17	3760	28140	28140		
170020	17	9040	17	48620		
170023	17	9040	17	48620		
170033	17	9040	17	48620		
170045	17	8440	17	45820		
170058	17	3710	17	27900		
170060	17	28	17	28		
170094	17	8440	17	45820		
170120	17	3710	17	27900		
170145	17	8560	17	46140		
170175	17	9040	17	48620		
180005	18	3400	18	26580		Wayne
180011	18	4280	18	30460		Clark
180013	18	5360	14540	34980		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
180016	18	4520	31140	31140		Jefferson
180018	18	4280	18	30460		Bourbon
180027	18	1660	18	17300		
180028	18	3400	18	26580		Wayne
180029	18	3660	18	28700		Scott
180044	18	3400	18	26580		Wayne
180066	18	5360	18	34980		
180069	18	3400	18	26580		Wayne
180075	18		18	14540	LUGAR	
180078	18	3400	18	26580		Wayne
180080	18	4280	18	30460		Clark
180093	18	2440	18	21780		
180102	18	1660	18	17300		
180104	18	1660	18	17300		
180116	18	1660	18	17300		
180127	18	4520	18	31140		Jefferson
180132	18	4280	18	30460		Jessamine
180139	18	4280	18	30460		Clark
190001	19	5560	19	35380		St Tammany
190003	19	3880	19	29180		St. Martin
190015	19	5560	19	35380		St John the Baptist
190029	19		5560	12940	LUGAR	
190054	19	3880	19	29180		St. Martin
190086	19	7680	19	43340		Bossier
190099	19	3880	19	29180		St. Landry
190106	19	3880	19	29180		Acadia
190131	19	5560	12940	35380		St John the Baptist
190155	19		38200	12940	LUGAR	
190164	19	0220	19	10780		
190223	19		5560	12940	LUGAR	
200002	20	6403	20	38860		
200020	6403	1123	38860	40484		Strafford
200024	20	6403	30340	38860		
200034	20	6403	30340	38860		
200039	20	6403	20	38860		
200040	20	6403	38860	38860		
200050	20	0733	20	12620		
200063	20	6403	20	38860		
220060	22	0743	14484	12700		
220077	8003	3283	44140	25540		Hartford
230030	23	6960	23	40980		Saginaw

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
230035	23		23	24340	LUGAR	
230037	23	0440	23	11460		Washtenaw
230042	23		10880	26100	LUGAR	
230054	23	3080	23	24580		
230080	23	6960	23	40980		Saginaw
230093	23	3000	23	24340		
230096	23	3720	23	28020		Kalamazoo
230105	23	6960	23	13020		Bay
230121	23		37020	29620	LUGAR	
230134	23		10880	26100	LUGAR	
230155	23		23	24340	LUGAR	
230171	23		23	34740	LUGAR	
230178	23		23	24340	LUGAR	
230188	23		23	40980	LUGAR	
230208	23		23	24340	LUGAR	
230235	23		23	40980	LUGAR	
230253	23	2160	23	47644		Lapeer
240011	24	5120	24	33460		
240013	24	5120	24	33460		
240016	24	2520	24	22020		
240018	24	5120	24	33460		
240030	24	6980	24	41060		
240045	24	2240	20260	20260		
240052	24	2520	24	22020		
240064	24	2240	24	20260		
240069	24	6820	24	40340		
240071	24	5120	24	33460		
240075	24	6980	24	41060		
240088	24	6980	24	41060		
240093	24	5120	24	33460		
240105	24		24	40340	LUGAR	
240121	24	2240	20260	20260		
240150	24		24	40340	LUGAR	
240152	24	5120	24	33460		
240187	24	5120	24	33460		
240211	24	5120	24	33460		
250004	25	4920	25	32820		
250009	25	3580	25	27180		
250023	25		38100	25060	LUGAR	
250030	25	3560	25	27140		
250031	25	3560	25	27140		
250034	25	4920	25	32820		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
250042	25	4920	25	32820		
250069	25	3560	25	27140		
250081	25	3560	25	27140		
250082	25	6240	25	38220		
250094	3285	0920	25620	25060		Hancock
250097	25	0760	25	12940		
250099	25	3560	25	27140		
250100	25	8600	25	46220		
250104	25	3560	25	27140		
250117	25		38100	25060	LUGAR	
250126	25	4920	32820	32820		
260009	26	3760	26	28140		
260011	26	1740	27620	17860		
260015	26	3700	26	27860		
260017	26	7040	26	41180		
260022	26	1740	26	17860		
260025	26	7040	26	41180		
260034	26	3760	28140	28140		
260047	26	1740	27620	17860		
260049	26		26	44180	LUGAR	
260064	26	1740	26	17860		
260078	26	7920	26	44180		
260094	26	7920	26	44180		
260110	26	7040	26	41180		
260113	26	14	26	14		
260116	26	14	26	14		
260183	26	7040	26	41180		
260186	26	1740	26	17860		
260195	26	7920	44180	44180		
270003	27	3040	27	24500		
270011	27	3040	27	24500		
270017	27	5140	27	33540		
270051	27	5140	27	33540		
270082	27	3040	27	24500		
280009	28	4360	28	30700		
280023	28	4360	28	30700		
280032	28	4360	28	30700		
280054	28	4360	28	30700		
280057	28	4360	28	30700		
280061	28	53	28	53		
280065	28	3060	28	24540		
280077	28	5920	28	36540		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
280125	28	7720	28	43580		
290002	29		29	16180	LUGAR	
290008	29	4120	29	29820		Nye
290019	29	6720	16180	39900		
300003	30	1123	30	31700		Hillsborough
300005	30	1123	30	40484		
300019	30	22	30	22		
310002	31	5600	35084	35644		
310003	31	5600	35644	35644		
310005	5015	5640	35084	35084		Hunterdon
310015	31	0875	35084	35644		
310032	8760	6160	47220	48864		Salem, NJ
310034	5190	5015	20764	20764		Middlesex
310038	31	5600	20764	35644		
310045	31	5600	35644	35644		
310048	5015	5640	20764	35084		Hunterdon
310070	31	5600	20764	35644		
310073	5190	5015	20764	20764		Middlesex
310075	5190	5015	20764	20764		Middlesex
310076	31	5600	35084	35644		
310111	5190	5015	20764	20764		Middlesex
310112	5190	5015	20764	20764		Middlesex
310119	31	5600	35084	35644		
320005	32	0200	22140	10740		
320006	32	7490	32	42140		Santa Fe
320013	32	7490	32	42140		Santa Fe
320033	32		31060	42140	LUGAR	
320063	32	5800	32	36220		Ector
320065	32	5800	32	36220		Ector
330001	33	0875	39100	35644		
330004	33	5660	28740	39100		Orange
330008	33		33	15380	LUGAR	
330023	2281	5660	39100	39100		Dutchess
330038	33		12860	40380	LUGAR	
330062	33		33	27060	LUGAR	
330073	33		12860	40380	LUGAR	
330084	33	1303	33	15540		
330085	33	8160	33	45060		Madison
330094	33		26460	10580	LUGAR	
330136	33	8160	33	45060		Madison
330157	33	8160	33	45060		Oswego
330181	33	5600	44844	35644		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
330182	33	5600	44844	35644		
330209	33	0875	39100	35644		
330224	33	3283	28740	25540		Hartford
330235	33	8160	33	45060		
330239	33	2360	33	21500		
330250	33	1303	33	15540		
330307	33	8160	27060	45060		Onondaga
330359	33		33	39100	LUGAR	
330386	33	5660	33	39100		Orange
340008	34	2560	34	22180		
340010	2980	6640	24140	39580		Johnston
340013	34	1520	34	16740		
340018	34		34	43900	LUGAR	
340021	34	1520	34	16740		
340023	34	0480	11700	11700		
340027	34	3150	34	24780		
340039	34	1520	34	16740		
340050	34	2560	34	22180		
340051	34	3290	34	25860		
340068	34	9200	34	48900		
340071	34		20380	39580	LUGAR	
340088	34	0480	34	11700		
340109	34	5720	34	47260		
340115	34	6640	34	20500		Chatham
340124	34		20380	39580	LUGAR	
340127	34	6640	34	20500		Person
340129	34	1520	34	16740		
340131	34	3150	34	24780		
340136	34		34	20500	LUGAR	
340144	34	1520	34	16740		
340145	34		30740	16740	LUGAR	
340147	6895	6640	40580	39580		Franklin
350009	35	2520	35	22020		
360008	36	3400	36	26580		Greenup
360010	36	0080	36	10420		
360011	36	1840	36	18140		
360014	36	1840	36	18140		
360025	36	1680	41780	17460		
360036	36	1680	36	17460		
360039	36	1840	36	18140		
360042	36		11780	17460	LUGAR	
360046	36	1640	17140	17140		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
360054	36	1480	36	16620		
360065	36	1680	36	17460		
360076	36	1640	17140	17140		
360078	36	1680	10420	17460		
360081	36	8400	45780	45780		
360088	36		46500	44220	LUGAR	
360090	36	8400	45780	45780		
360095	36	4320	36	30620		Allen
360096	36		20620	49660	LUGAR	
360107	36	8400	36	45780		
360112	8400	0440	45780	11460		Washtenaw
360121	36	0440	36	11460		Washtenaw
360125	36		11780	17460	LUGAR	
360127	36		11780	17460	LUGAR	
360132	36	1640	17140	17140		
360159	36	1840	36	18140		
360175	36	1840	36	18140		
360185	36		20620	49660	LUGAR	
360197	36	1840	36	18140		
360211	36	8080	48260	48260		
360238	36		20620	49660	LUGAR	
360245	36		11780	17460	LUGAR	
370004	37	3710	37	27900		
370014	37	7640	37	43300		
370015	37	8560	37	46140		
370018	37	8560	37	46140		
370025	37	8560	37	46140		
370034	37	2720	37	22900		
370043	37	7640	37	43300		
370047	37	7640	37	43300		
370049	37	5880	37	36420		Lincoln
370054	37	5880	36420	36420		Grady
370060	37	8560	46140	46140		
370099	37	8560	37	46140		
370103	37	45	37	45		
370113	37	2580	37	22220		
370200	37	5880	37	36420		Lincoln
380001	38	6440	38	38900		
380008	38		10540	18700	LUGAR	
380022	38	1890	38	18700		
380027	38	2400	38	21660		
380035	38	6740	38	28420		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
380040	38	2400	13460	21660		
380047	38	2400	13460	21660		
380050	38	4890	38	32780		
380051	38	7080	41420	41420		
380070	38	6440	38	38900		
390006	39	3240	39	25420		Dauphin
390013	39	3240	39	25420		Dauphin
390030	39	0240	39	10900		
390031	39		39060	39740	LUGAR	
390048	39	3240	39	25420		Perry
390052	39	0280	39	11020		
390065	39	8840	39	13644	LUGAR	Frederick
390071	39		30820	48700	LUGAR	
390086	39	8050	39	44300		
390091	39	6280	39	38300		
390093	39	6280	39	38300		
390110	39	6280	27780	38300		
390113	39	9320	39	49660		Mercer
390138	39	8840	39	13644		Frederick
390150	39		39	38300	LUGAR	
390151	39	8840	39	13644		Frederick
390163	39	6280	38300	38300		
390181	39		39060	39740	LUGAR	
390183	39		39060	39740	LUGAR	
390201	39		20700	10900	LUGAR	Warren
390224	39		39	13780	LUGAR	
390244	39		30820	48700	LUGAR	
390246	39	33	39	33		
390249	39		39	13780	LUGAR	
400120	1310	7440	41980	41980		Caguas
410001	6483	1123	39300	39300		Bristol, MA
410004	6483	1123	39300	39300		Bristol, MA
410005	6483	1123	39300	39300		Bristol, MA
410006	6483	1123	39300	39300		Bristol, MA
410007	6483	1123	39300	39300		Bristol, MA
410008	6483	1123	39300	39300		Bristol, MA
410009	6483	1123	39300	39300		Bristol, MA
410011	6483	1123	39300	25027		Worcester
410012	6483	1123	39300	39300		Bristol, MA
410013	6483	1123	39300	39300		Bristol, MA
420009	42		42860	24860	LUGAR	
420020	42	1440	42	16700		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
420028	42		42	44940	LUGAR	
420030	42	1440	42	16700		
420036	42	1520	42	16740		
420039	42		46420	43900	LUGAR	
420068	42	0600	42	12260		
420069	42		42	44940	LUGAR	
420070	42	1760	44940	17900		
420071	42	0600	42	12260		
420080	42	7520	42	42340		
420085	42	9200	34820	48900		
430012	43	7760	43	43620		
430014	43	2520	43	22020		
430094	43	53	43	53		
440008	44	3580	44	27180		
440020	44	3440	44	26620		
440050	44	0480	44	11700		
440058	44	1560	44	16860		
440059	44	5360	44	34980		
440060	44	3580	44	27180		
440067	44	3840	34100	28940		Knox
440068	44	1560	44	16860		
440072	44	4920	44	32820		
440073	44	5360	44	34980		
440148	44	5360	44	34980		
440151	44	5360	44	34980		
440175	44	3440	44	26620		
440180	44	3840	44	28940		Union
440185	44	1560	17420	16860		
440186	44	5360	34980	34980		
440192	44	5360	44	34980		
440200	44	5360	34980	34980		
450007	45	7240	45	41700		
450014	45	8750	47020	47020		
450032	45		32220	30980	LUGAR	
450052	45		45	47380	LUGAR	
450073	45	0040	45	10180		
450080	45	4420	45	30980		Usphur
450098	45	4420	45	30980		Usphur
450099	45	0320	45	11100		
450144	45	5800	45	36220		Ector
450187	45	3360	45	26420		
450192	45	1920	45	19124		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
450194	45	1920	45	19124		
450196	45	1920	45	19124		
450211	45	3360	45	26420		
450214	45	3360	45	26420		
450224	45	8640	45	46340		
450286	45		45	17780	LUGAR	
450347	45	3360	45	26420		
450348	45		45	47380	LUGAR	
450351	45	2800	45	23104		
450400	45	8800	45	47380		
450447	45	1920	45	19124		
450451	45	2800	45	23104		
450484	45	3360	45	26420		
450508	45	8640	45	46340		
450534	45	0320	45	11100		
450547	45	1920	45	19124		
450563	45	1920	23104	19124		
450623	45	1920	45	19124		
450648	45		45	12420	LUGAR	
450653	45	5800	45	33260		Midland
450656	45	8640	45	46340		
450694	45	3360	45	26420		
450747	45	1920	45	19124		
450755	45	4600	45	31180		
450770	45	0640	45	12420		
450830	45	5800	45	36220		Ector
460021	46	4120	41100	29820		Mohave
460029	46	6520	46	39340		
460036	46	6520	46	39340		
460039	46	7160	46	36260		Weber
470001	47	30	47	30		
470011	47	1123	47	15764		
470012	47	6323	47	38340		
470018	47	1123	47	31700		Hillsborough
490004	49	1540	25500	16820		
490005	49	8840	49020	47894		Clarke
490006	49		49	49020	LUGAR	
490013	49	4640	49	31340		
490018	49	1540	49	16820		
490047	49	8840	49	47894		Warren
490079	49	3120	49	49180		Stokes
490092	49	5720	49	47260		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
490126	49	6800	49	40220		
500002	50	6740	50	28420		
500003	50	7600	34580	42644		Snohomish
500016	50	7600	48300	42644		King
500031	50	5910	50	36500		
500039	1150	7600	14740	42644		King
500041	50	6440	31020	38900		
500059	50	7600	50	42644		King
500072	50	7600	50	42644		Snohomish
500079	50	8200	45104	45104		
500118	50		43220	36500	LUGAR	
510001	51	6280	34060	38300		
510002	51	6800	51	40220		
510006	51	6280	51	38300		
510018	51		51	16620	LUGAR	
510024	51	6280	34060	38300		
510028	51	1480	51	16620		
510046	51	1480	51	16620		
510047	51	6280	51	38300		
510048	51	3400	51	26580		Wayne
510070	51	1480	51	16620		
510071	51	1480	51	16620		
510081	51		51	16620	LUGAR	
520002	52	8940	52	48140		
520021	3800	1600	29404	29404		Lake
520028	52	4720	52	31540		
520032	52	4720	31540	31540		
520037	52	8940	52	48140		
520059	52	5080	39540	33340		
520060	52		52	22540	LUGAR	
520066	52	4720	27500	31540		
520071	52		48020	33340	LUGAR	
520076	52	4720	52	31540		
520084	52	4720	31540	31540		
520088	52	5080	22540	33340		
520094	52	5080	39540	33340		
520096	52	5080	39540	33340		
520102	52		48580	33340	LUGAR	
520107	52	3080	52	24580		
520113	52	3080	52	24580		
520116	52		48020	33340	LUGAR	
520152	52	3080	52	24580		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
520173	52	2240	52	20260		
520189	3800	1600	29404	29404		Lake
530002	53	1350	53	16220		
530009	53	1350	53	16220		
530016	53	6340	53	38540		
530025	53	2670	53	22660		

TABLE 9B.--HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUB. L. 108-173--FY 2004

Provider No.	Actual MSA or rural area	Wage index MSA 508 Reclassification	Actual CBSA or rural area	Wage index CBSA 508 Reclassification	Nearest County	Own Wage Index
020008			02			1.3157
060075			06			1.1681
070036			25540			1.2954
160064			16			1.0504
330106			44844			1.5152
380090			38			1.2808
410010			39300			1.1702
530015			53			1.0064
390001	7560	0240	42540	10900		
390003	7560	0240	39	10900		
390072	7560	0240	39	10900		
390095	7560	0240	42540	10900		
390109	7560	0240	42540	10900		
390119	7560	0240	42540	10900		
390137	7560	0240	42540	10900		
390169	7560	0240	42540	10900		
390185	7560	0240	42540	10900		
390192	7560	0240	42540	10900		
390237	7560	0240	42540	10900		
230053	2160	0440	19804	11460		
230089	2160	0440	19804	11460		
230104	2160	0440	19804	11460		
230119	2160	0440	19804	11460		
230135	2160	0440	19804	11460		
230146	2160	0440	19804	11460		
230165	2160	0440	19804	11460		
230176	2160	0440	19804	11460		
230270	2160	0440	19804	11460		
230273	2160	0440	19804	11460		
230097	23	3720	23	12980		
270014	27	0880	33540	13740		
270021	27	0880	27	13740		
270023	5140	0880	33540	13740		
270032	27	0880	27	13740		
270050	27	0880	27	13740		
270057	27	0880	27	13740		
160040	8920	1360	47940	16300		
160067	8920	1360	47940	16300		

Provider No.	Actual MSA or rural area	Wage index MSA 508 Reclassification	Actual CBSA or rural area	Wage index CBSA 508 Reclassification	Nearest County	Own Wage Index
160110	8920	1360	47940	16300		
340002	0480	1520	11700	16740		
150034	2960	1600	23844	16974	Cook	
010150	01	1800	01	17980		
490024	6800	1950	40220	19260		
060057	06	2080	06	19740		
350002	1010	2520	13900	22020		
350003	1010	2520	35	22020		
350006	1010	2520	35	22020		
350010	1010	2520	35	22020		
350014	1010	2520	35	22020		
350015	1010	2520	13900	22020		
350017	1010	2520	35	22020		
350030	1010	2520	35	22020		
350061	1010	2520	35	22020		
230013	2160	2640	47644	22420		
230019	2160	2640	47644	22420		
230029	2160	2640	47644	22420		
230036	23	2640	23	22420		
230071	2160	2640	47644	22420		
230130	2160	2640	47644	22420		
230151	2160	2640	47644	22420		
230207	2160	2640	47644	22420		
230223	2160	2640	47644	22420		
230254	2160	2640	47644	22420		
230269	2160	2640	47644	22420		
230277	2160	2640	47644	22420		
230020	2160	0440	19804	23		
230092	3520	3000	27100	24340	Kent	
250122	25	0920	25	25060		
250002	25	0920	25	25060	Stone	
120025	12	3320	12	26180		
450072	1145	3360	26420	26420		
450591	1145	3360	26420	26420		
230003	3000	3720	26100	28020		
230004	3000	3720	34740	28020		
230038	3000	3720	24340	28020		
230059	3000	3720	24340	28020		
230066	3000	3720	34740	28020		
230072	3000	3720	26100	28020		
230106	23	3720	24340	28020		
230174	3000	3720	26100	28020		

Provider No.	Actual MSA or rural area	Wage index MSA 508 Reclassification	Actual CBSA or rural area	Wage index CBSA 508 Reclassification	Nearest County	Own Wage Index
230236	3000	3720	24340	28020		
390054	7560	4000	42540	29540		
390270	7560	4000	42540	29540		
490001	49	4640	49	31340		
450010	9080	4880	48660	32580		
070010	5483	5600	14860	35644		
070028	5483	5600	14860	35644		
310021	8480	0875	45940	35644		
310028	5640	5600	35084	35644		
310050	5640	5600	35084	35644		
310051	5640	5600	35084	35644		
310060	5640	5600	10900	35644		
310115	5640	5600	10900	35644		
310120	5640	5600	35084	35644		
330049	2281	5600	39100	35644		
330067	2281	5600	39100	35644		
330126	5660	5600	39100	35644		
330135	5660	5600	39100	35644		
330205	5660	5600	39100	35644		
220046	6323	1123	38340	39300		
430003	43	6660	43	39660		
470003	1303	1123	15540	40484	Strafford	
050494	05	7500	05	42220		
050549	8735	7500	37100	42220		
190218	19	7680	19	43340		
430015	43	7760	43	43620		
430048	43	7760	43	43620		
430060	43	7760	43	43620		
430064	43	7760	43	43620		
430077	6660	7760	39660	43620		
430091	6660	7760	39660	43620		
070001	5483	5380	35300	44844		
070005	5483	5380	35300	44844		
070016	5483	5380	35300	44844		
070017	5483	5380	35300	44844		
070019	5483	5380	35300	44844		
070022	5483	5380	35300	44844		
070031	5483	5380	35300	44844		
070039	5483	5380	35300	44844		
330264	5660	5380	39100	44844		
230024	2160	0440	19804	47644		

TABLE 10.--GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG)-- MARCH 2004[1]

DRG	Cases	Threshold
1	27,031	$47,002.39
2	10,732	$31,748.57
3	2	$19,676.36
6	365	$14,216.11
7	15,230	$35,032.97
8	3,903	$25,342.93
9	1,781	$20,676.56
10	18,839	$21,127.62
11	3,363	$16,545.74
12	53,119	$16,149.67
13	7,034	$15,112.29
14	240,596	$21,843.58
15	81,926	$17,439.59
16	10,689	$21,398.25
17	2,792	$13,087.07
18	30,720	$18,183.79
19	8,687	$13,191.63
20	6,517	$35,168.52
21	2,167	$23,496.76
22	3,159	$19,811.32
23	11,729	$15,291.01
24	60,606	$18,209.19
25	28,207	$11,476.16
26	32	$10,545.98
27	4,954	$20,791.90
28	15,806	$21,493.63
29	5,770	$13,143.20
31	4,575	$17,139.90
32	1,913	$11,205.82
34	25,154	$17,698.06
35	7,835	$12,075.68
36	1,612	$12,459.21
37	1,371	$20,781.81
38	77	$9,593.25
39	541	$11,755.20
40	1,507	$18,078.12

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
42	1,249	$13,813.36
43	124	$12,443.22
44	1,229	$11,918.47
45	2,825	$13,674.93
46	3,537	$14,378.35
47	1,367	$10,363.16
49	2,326	$27,283.68
50	2,241	$16,015.46
51	233	$14,624.53
52	174	$14,473.99
53	2,234	$21,124.20
55	1,452	$16,281.07
56	464	$16,655.86
57	721	$18,825.34
59	118	$11,884.64
60	5	$5,786.80
61	259	$22,669.12
62	2	$8,491.37
63	2,752	$22,186.10
64	3,201	$20,017.01
65	40,661	$11,144.79
66	7,854	$10,622.12
67	402	$15,110.54
68	8,724	$12,283.42
69	2,946	$9,247.28
70	26	$9,049.66
71	65	$9,640.64
72	1,209	$13,587.86
73	7,896	$15,166.28
75	43,424	$41,163.58
76	46,113	$36,811.23
77	2,323	$22,216.62
78	42,684	$22,814.85
79	171,939	$24,702.33
80	7,813	$15,834.71
81	2	$54,685.58
82	65,114	$22,257.80
83	6,834	$18,156.12
84	1,467	$10,279.57
85	22,304	$21,149.82
86	2,046	$13,052.05
87	66,500	$22,338.54
88	393,514	$16,620.74
89	514,251	$19,133.24

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
90	43,239	$11,379.69
91	45	$11,624.14
92	16,504	$21,182.00
93	1,649	$13,385.99
94	13,031	$20,213.17
95	1,578	$11,282.92
96	50,507	$13,779.32
97	25,905	$10,092.48
98	15	$10,799.59
99	21,593	$13,290.51
100	7,491	$10,230.15
101	22,842	$15,981.17
102	5,443	$10,224.62
103	553	$189,772.22
104	20,843	$104,458.91
105	30,394	$78,675.65
106	3,467	$98,542.18
107	77,946	$75,223.03
108	6,932	$66,115.26
109	53,663	$57,201.65
110	55,231	$51,781.18
111	9,346	$37,634.69
113	38,458	$37,360.01
114	8,334	$25,185.45
115	21,728	$51,055.67
116	116,937	$37,562.07
117	4,853	$21,562.25
118	8,318	$28,595.12
119	1,099	$22,312.22
120	36,767	$30,317.70
121	163,217	$25,452.34
122	70,183	$18,391.79
123	36,041	$22,203.56
124	133,834	$25,310.50
125	92,607	$20,563.74
126	5,578	$34,579.82
127	688,254	$18,767.22
128	6,048	$13,709.83
129	3,945	$18,358.95
130	89,614	$17,242.04
131	25,476	$10,399.71
132	127,723	$11,755.33
133	7,450	$10,110.86
134	42,191	$11,330.68

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
135	7,450	$16,684.99
136	1,087	$11,129.78
138	203,383	$15,387.73
139	81,394	$9,766.36
140	45,268	$9,751.21
141	114,091	$14,147.95
142	52,298	$11,078.77
143	244,158	$10,527.19
144	96,381	$20,213.64
145	6,642	$10,916.56
146	10,860	$38,450.11
147	2,695	$27,177.69
148	135,660	$44,046.76
149	19,836	$26,192.87
150	22,019	$38,184.38
151	5,257	$24,163.73
152	4,788	$28,703.59
153	2,115	$20,415.43
154	28,467	$48,307.36
155	6,442	$23,488.27
156	8	$32,766.38
157	8,277	$21,514.75
158	4,096	$12,163.36
159	18,692	$23,589.13
160	11,972	$15,324.36
161	10,666	$21,177.95
162	5,903	$12,395.96
163	9	$18,720.43
164	5,785	$34,027.40
165	2,448	$21,754.82
166	4,467	$25,429.28
167	4,328	$16,567.05
168	1,535	$21,028.28
169	834	$14,029.00
170	16,985	$36,624.14
171	1,448	$22,119.85
172	31,819	$22,160.02
173	2,535	$14,010.09
174	257,892	$18,593.66
175	33,622	$10,574.15
176	12,966	$20,349.86
177	8,710	$17,368.96
178	3,197	$12,742.36
179	14,005	$19,746.18

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
180	92,184	$17,710.39
181	26,288	$10,337.66
182	289,801	$15,126.47
183	90,068	$10,985.43
184	59	$9,160.48
185	5,677	$16,314.88
186	5	$16,873.70
187	740	$14,702.24
188	88,106	$19,443.67
189	13,004	$11,125.54
190	71	$10,301.87
191	9,919	$47,572.13
192	1,345	$26,911.62
193	4,408	$44,465.67
194	531	$26,940.41
195	3,735	$41,071.33
196	812	$27,990.64
197	17,975	$35,447.24
198	4,880	$22,267.62
199	1,543	$32,025.81
200	954	$34,258.27
201	2,608	$44,334.23
202	25,857	$21,306.01
203	31,007	$22,209.42
204	69,666	$19,787.03
205	30,919	$19,844.21
206	2,029	$13,607.73
207	34,527	$20,795.67
208	9,964	$13,037.50
209	425,259	$34,127.94
210	125,963	$30,514.92
211	28,402	$22,540.97
212	2	$7,355.68
213	10,211	$27,163.94
216	12,739	$30,372.38
217	17,820	$35,501.93
218	26,845	$26,652.32
219	21,291	$18,810.17
223	13,655	$19,875.52
224	11,536	$14.778.06
225	6,339	$21,693.69
226	6,507	$24,280.94
227	5,108	$15,428.75
228	2,664	$21,222.14

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
229	1,154	$13,819.07
230	2,374	$22,392.39
232	759	$18,057.24
233	10,121	$29,290.06
234	4,878	$22,029.70
235	5,040	$13,329.56
236	41,647	$13,170.57
237	1,874	$11,228.94
238	9,487	$21,967.28
239	44,475	$19,224.03
240	12,429	$20,574.30
241	2,958	$12,285.38
242	2,720	$19,546.78
243	99,609	$14,231.73
244	15,557	$13,197.00
245	5,830	$8,939.17
246	1,392	$11,170.70
247	21,341	$10,808.37
248	14,413	$15,478.46
249	13,478	$12,574.01
250	3,896	$12,748.37
251	2,307	$8,976.97
253	23,152	$13,847.26
254	10,589	$8,397.67
256	6,933	$14,946.82
257	14,266	$16,559.89
258	13,040	$13,107.81
259	3,178	$17,757.99
260	3,611	$12,872.76
261	1,623	$17,861.85
262	632	$18,015.69
263	25,548	$27,612.63
264	3,959	$19,571.13
265	4,036	$23,933.29
266	2,482	$16,017.53
267	237	$16,324.12
268	913	$21,175.50
269	10,224	$25,713.15
270	2,810	$15,072.68
271	20,028	$18,468.64
272	5,793	$18,208.92
273	1,338	$11,075.51
274	2,267	$19,271.15
275	176	$11,393.03

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
276	1,363	$13,211.04
277	108,396	$16,002.90
278	32,917	$10,158.40
279	7	$22,806.38
280	18,381	$13,279.57
281	7,203	$9,159.98
283	6,085	$13,626.51
284	1,847	$7,930.23
285	7,103	$29,265.27
286	2,617	$30,127.88
287	6,388	$25,800.77
288	8,409	$32,539.03
289	6,748	$17,169.70
290	10,239	$16,348.17
291	70	$12,899.83
292	6,921	$34,879.20
293	341	$23,427.99
294	98,525	$13,992.93
295	3,712	$13,696.73
296	258,871	$15,146.57
297	47,144	$9,203.21
298	107	$10,109.54
299	1,403	$16,424.37
300	19,544	$19,634.78
301	3,822	$12,094.21
302	8,975	$45,005.94
303	22,962	$33,813.19
304	13,234	$32,022.59
305	3,065	$21,940.67
306	7,024	$21,550.41
307	1,898	$11,199.49
308	7,423	$24,440.37
309	3,832	$16,895.99
310	25,531	$21,027.50
311	6,892	$11,653.46
312	1,527	$19,680.21
313	543	$12,303.00
315	35,826	$29,162.47
316	149,953	$20,893.69
317	2,476	$14,474.57
318	5,837	$19,894.30
319	394	$11,791.98
320	209,533	$15,804.98
321	30,937	$10,465.82

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
322	59	$9,524.25
323	20,476	$15,513.89
324	6,150	$9,278.69
325	9,540	$12,134.95
326	2,739	$8,138.23
327	2	$8,447.36
328	677	$12,839.19
329	64	$8,638.22
331	53,339	$18,819.19
332	4,649	$11,308.47
333	246	$16,947.79
334	10,242	$25,613.56
335	12,368	$19,768.65
336	33,267	$15,411.08
337	26,288	$10,593.53
338	712	$21,009.04
339	1,436	$20,358.75
341	3,600	$22,459.66
342	623	$14,302.37
344	3,129	$23,468.31
345	1,347	$19,813.56
346	4,494	$19,198.11
347	277	$10,231.81
348	3,342	$13,561.37
349	537	$8,354.79
350	6,976	$13,696.92
352	1,076	$14,032.50
353	2,641	$26,992.52
354	7,420	$25,471.56
355	5,235	$16,214.46
356	25,159	$13,588.35
357	5,581	$32,195.38
358	21,024	$21,104.25
359	29,642	$14,662.21
360	15,423	$15,733.75
361	295	$20,316.37
363	2,428	$17,959.37
364	1,454	$17,846.39
365	1,662	$27,368.43
366	4,670	$20,542.99
367	454	$10,294.82
368	3,872	$20,189.73
369	3,529	$11,584.10
370	1,601	$15,956.72

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
371	1,957	$11,240.71
372	1,059	$9,648.69
373	4,436	$6,542.14
374	120	$12,070.47
375	4	$21,387.53
376	308	$9,449.90
377	57	$19,575.54
378	185	$14,463.79
379	426	$6,888.28
380	90	$6,622.99
381	202	$11,561.98
382	30	$4,628.53
383	2,295	$9,153.45
384	136	$5,497.24
390	3	$4,742.50
392	2,128	$40,317.17
394	2,617	$25,745.93
395	110,334	$15,171.69
396	10	$23,522.47
397	19,186	$19,140.99
398	17,730	$20,886.30
399	1,634	$12,537.31
401	5,892	$36,723.72
402	1,444	$21,449.62
403	31,701	$25,072.16
404	4,032	$16,919.41
406	2,378	$35,405.65
407	573	$22,348.47
408	2,126	$28,195.75
409	2,038	$20,956.09
410	28,217	$20,187.74
411	7	$9,450.53
412	14	$12,399.99
413	5,517	$22,073.56
414	570	$12,354.88
415	46,295	$41,324.13
416	209,607	$23,731.70
417	26	$19,476.46
418	27,283	$18,827.06
419	16,685	$16,194.08
420	2,883	$11,247.80
421	10,530	$14,449.59
422	68	$10,520.24
423	8,259	$23,511.55

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
424	1,234	$31,774.00
425	15,393	$12,505.87
426	4,139	$8,905.56
427	1,419	$9,653.86
428	776	$13,956.81
429	27,266	$14,686.89
430	68,690	$12,244.61
431	259	$9,078.72
432	391	$11,939.08
433	5,503	$5,189.45
439	1,669	$24,681.73
440	5,865	$24,660.92
441	707	$16,041.06
442	17,359	$31,204.37
443	3,652	$18,898.91
444	5,957	$14,056.84
445	2,359	$9,534.38
447	6,368	$9,484.48
449	35,333	$15,103.83
450	7,504	$7,975.20
451	4	$9,065.77
452	27,134	$18,327.65
453	5,517	$9,748.26
454	4,271	$15,174.33
455	958	$8,817.44
461	5,008	$20,801.47
462	8,298	$16,692.51
463	28,808	$12,925.78
464	7,467	$9,493.03
465	204	$11,033.67
466	1,767	$11,383.22
467	1,171	$9,667.23
468	48,780	$47,697.03
470	103	$91,840.13
471	14,292	$47,665.58
473	8,547	$33,295.66
475	110,694	$43,696.83
476	3,225	$31,764.02
477	30,086	$28,309.01
478	109,888	$33,959.22
479	23,657	$25,851.04
480	710	$106,291.19
481	858	$78,625.60
482	5,121	$41,198.92

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
484	407	$64,297.49
485	3,303	$41,564.30
486	2,260	$58,108.75
487	4,198	$26,874.92
488	795	$53,106.00
489	13,707	$23,948.06
490	5,193	$18,332.24
491	17,179	$30,209.74
492	3,336	$38,463.77
493	60,972	$29,240.46
494	27,013	$18,965.29
495	245	$102,454.71
496	2,740	$80,122.92
497	25,887	$50,109.13
498	17,577	$40,873.71
499	37,340	$24,783.78
500	50,555	$17,315.20
501	2,798	$35,284.32
502	703	$25,794.66
503	5,918	$22,488.22
504	174	$138,645.34
505	191	$23,723.13
506	940	$44,335.78
507	317	$27,338.37
508	625	$19,960.30
509	162	$12,757.05
510	1,742	$18,224.19
511	618	$12,020.90
512	529	$75,535.80
513	173	$90,032.33
515	13,087	$75,948.65
516	79,502	$40,813.46
517	180,301	$34,347.81
518	48,469	$28,659.81
519	10,097	$36,201.05
520	13,883	$28,903.52
521	31,960	$12,650.51
522	5,922	$9,014.09
523	15,485	$7,135.31
524	122,956	$13,734.97
525	349	$124,086.74
526	11,090	$45,187.80
527	48,097	$37,682.36
528	1,759	$88,921.60

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
529	3,900	$31,367.19
530	2,368	$21,987.80
531	4,006	$38,694.03
532	3,088	$24,563.32
533	43,215	$26,418.52
534	50,588	$19,294.43
535	9,757	$104,895.67
536	25,303	$87,258.63
537	7,555	$27,282.28
538	6,315	$18,500.43
539	4,508	$39,649.40
540	1,899	$22,907.08
541	21,234	$219,932.31
542	23,921	$142,121.46

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

TABLE 11.--PROPOSED FY 2005 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY

Proposed LTC-DRG	Description	Proposed Relative Weight	Proposed Geo-metric Average Length of Stay	Proposed 5/6ths of the Geo-metric Average Length of Stay
1	[4] CRANIOTOMY AGE >17 W CC	1.2467	30.4	25.3
2	[8] CRANIOTOMY AGE >17 W/O CC	1.2467	30.4	25.3
3	[8] CRANIOTOMY AGE 0-17	1.2467	30.4	25.3
6	[8] CARPAL TUNNEL RELEASE	0.6685	21.6	18.0
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	1.4502	35.8	29.8
8	[2] PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	0.6685	21.6	18.0
9	SPINAL DISORDERS & INJURIES	1.0731	30.9	25.7
10	NERVOUS SYSTEM NEOPLASMS W CC	0.8921	25.2	21.0
11	[1] NERVOUS SYSTEM NEOPLASMS W/O CC	0.5076	18.2	15.1
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.7559	25.6	21.3
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.7955	24.6	20.5
14	INTRACRANIAL HEMORRHAGE OR STROKE W INFARCT	0.8498	26.1	21.7
15	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	0.8015	27.0	22.5
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.8855	25.6	21.3
17	[3] NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.8854	24.2	20.1
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.7954	24.8	20.6
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.6487	21.1	17.5
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.0894	26.5	22.0
21	[3] VIRAL MENINGITIS	0.8854	24.2	20.1
22	[2] HYPERTENSIVE ENCEPHALOPATHY	0.6685	21.6	18.0
23	NONTRAUMATIC STUPOR & COMA	1.0661	26.6	22.1
24	SEIZURE & HEADACHE AGE >17 W CC	0.6855	22.4	18.6
25	[2] SEIZURE & HEADACHE AGE >17 W/O CC	0.6685	21.6	18.0
26	[8] SEIZURE & HEADACHE AGE 0-17	0.6685	21.6	18.0
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.1611	29.3	24.4
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	0.9883	29.9	24.9
29	[3] TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.8854	24.2	20.1
30	[8] TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.8854	24.2	20.1
31	[2] CONCUSSION AGE >17 W CC	0.6685	21.6	18.0
32	[8] CONCUSSION AGE >17 W/O CC	0.6685	21.6	18.0
33	[8] CONCUSSION AGE 0-17	0.6685	21.6	18.0
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.8545	24.0	20.0
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.7118	23.1	19.2
36	[8] RETINAL PROCEDURES	0.5076	18.2	15.1
37	[8] ORBITAL PROCEDURES	0.5076	18.2	15.1
38	[8] PRIMARY IRIS PROCEDURES	0.5076	18.2	15.1
39	[8] LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.5076	18.2	15.1
40	[8] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.5076	18.2	15.1
41	[8] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.5076	18.2	15.1

Proposed LTC-DRG	Description	Proposed Relative Weight	Proposed Geo-metric Average Length of Stay	Proposed 5/6ths of the Geo-metric Average Length of Stay
42	[8] INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.5076	18.2	15.1
43	[1] HYPHEMA	0.5076	18.2	15.1
44	[3] ACUTE MAJOR EYE INFECTIONS	0.8854	24.2	20.1
45	[1] NEUROLOGICAL EYE DISORDERS	0.5076	18.2	15.1
46	[5] OTHER DISORDERS OF THE EYE AGE >17 W CC	1.8895	35.9	29.9
47	[1] OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.5076	18.2	15.1
48	[8] OTHER DISORDERS OF THE EYE AGE 0-17	0.5076	18.2	15.1
49	[8] MAJOR HEAD & NECK PROCEDURES	1.2467	30.4	25.3
50	[8] SIALOADENECTOMY	1.2467	30.4	25.3
51	[8] SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	1.2467	30.4	25.3
52	[8] CLEFT LIP & PALATE REPAIR	1.2467	30.4	25.3
53	[3] SINUS & MASTOID PROCEDURES AGE >17	0.8854	24.2	20.1
54	[8] SINUS & MASTOID PROCEDURES AGE 0-17	0.8854	24.2	20.1
55	[5] MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	1.8895	35.9	29.9
56	[8] RHINOPLASTY	0.8854	24.2	20.1
57	[8] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.6685	21.6	18.0
58	[8] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.6685	21.6	18.0
59	[8] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.6685	21.6	18.0
60	[8] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.6685	21.6	18.0
61	[8] MYRINGOTOMY W TUBE INSERTION AGE >17	0.6685	21.6	18.0
62	[8] MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.6685	21.6	18.0
63	[4] OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.2467	30.4	25.3
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.2155	26.8	22.3
65	DYSEQUILIBRIUM	0.4050	16.0	13.3
66	[8] EPISTAXIS	0.6685	21.6	18.0
67	[8] EPIGLOTTITIS	1.2467	30.4	25.3
68	OTITIS MEDIA & URI AGE >17 W CC	0.6055	20.7	17.2
69	[7] OTITIS MEDIA & URI AGE >17 W/O CC	0.6055	20.7	17.2
70	[8] OTITIS MEDIA & URI AGE 0-17	0.6685	21.6	18.0
71	[8] LARYNGOTRACHEITIS	0.5076	18.2	15.1
72	[8] NASAL TRAUMA & DEFORMITY	0.8854	24.2	20.1
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.9500	23.6	19.6
74	[8] OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.6685	21.6	18.0
75	MAJOR CHEST PROCEDURES	2.0300	31.0	25.8
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.2783	39.7	33.0
77	[5] OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.8895	35.9	29.9
78	PULMONARY EMBOLISM	0.7686	22.1	18.4
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	0.9565	23.8	19.8
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.9118	26.1	21.7
81	[8] RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	0.6685	21.6	18.0
82	RESPIRATORY NEOPLASMS	0.8099	20.5	17.0
83	[3] MAJOR CHEST TRAUMA W CC	0.8854	24.2	20.1

Proposed LTC-DRG	Description	Proposed Relative Weight	Proposed Geo-metric Average Length of Stay	Proposed 5/6ths of the Geo-metric Average Length of Stay
84	[1] MAJOR CHEST TRAUMA W/O CC	0.5076	18.2	15.1
85	PLEURAL EFFUSION W CC	0.8357	22.6	18.8
86	[7] PLEURAL EFFUSION W/O CC	0.8357	22.6	18.8
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.6493	30.0	25.0
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.7458	20.2	16.8
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.7915	21.2	17.6
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.7368	20.9	17.4
91	[8] SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.6685	21.6	18.0
92	INTERSTITIAL LUNG DISEASE W CC	0.7737	20.7	17.2
93	INTERSTITIAL LUNG DISEASE W/O CC	0.5597	15.2	12.6
94	PNEUMOTHORAX W CC	0.8207	20.7	17.2
95	[1] PNEUMOTHORAX W/O CC	0.5076	18.2	15.1
96	BRONCHITIS & ASTHMA AGE >17 W CC	0.7535	20.0	16.6
97	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5461	16.4	13.6
98	[8] BRONCHITIS & ASTHMA AGE 0-17	0.5076	18.2	15.1
99	RESPIRATORY SIGNS & SYMPTOMS W CC	1.0737	26.1	21.7
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.8055	22.1	18.4
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8857	22.4	18.6
102	[7] OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.8857	22.4	18.6
103	[6] HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	0.0000	0.0	0.0
104	[8] CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	0.5076	18.2	15.1
105	[8] CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	0.5076	18.2	15.1
106	[8] CORONARY BYPASS W PTCA	0.5076	18.2	15.1
107	[8] CORONARY BYPASS W CARDIAC CATH	0.5076	18.2	15.1
108	[4] OTHER CARDIOTHORACIC PROCEDURES	1.2467	30.4	25.3
109	[2] CORONARY BYPASS W/O PTCA OR CARDIAC CATH	0.6685	21.6	18.0
110	[1] MAJOR CARDIOVASCULAR PROCEDURES W CC	0.5076	18.2	15.1
111	[8] MAJOR CARDIOVASCULAR PROCEDURES W/O CC	0.5076	18.2	15.1
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	1.3267	36.0	30.0
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.1827	32.8	27.3
115	[4] PRM CARD PACEM IMPL W AMI/HR/SHOCK OR AICD LEAD OR GNRTR	1.2467	30.4	25.3
116	[4] OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	1.2467	30.4	25.3
117	[5] CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.8895	35.9	29.9
118	[5] CARDIAC PACEMAKER DEVICE REPLACEMENT	1.8895	35.9	29.9
119	[1] VEIN LIGATION & STRIPPING	0.5076	18.2	15.1
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.1803	32.2	26.8
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	0.8989	22.8	19.0
122	[3] CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	0.8854	24.2	20.1
123	CIRCULATORY DISORDERS W AMI, EXPIRED	1.0031	19.7	16.4

Proposed LTC-DRG	Description	Proposed Relative Weight	Proposed Geo-metric Average Length of Stay	Proposed 5/6ths of the Geo-metric Average Length of Stay
124	[3] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	0.8854	24.2	20.1
125	[5] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	1.8895	35.9	29.9
126	ACUTE & SUBACUTE ENDOCARDITIS	0.8746	24.8	20.6
127	HEART FAILURE & SHOCK	0.7761	21.7	18.0
128	[2] DEEP VEIN THROMBOPHLEBITIS	0.6685	21.6	18.0
129	[2] CARDIAC ARREST, UNEXPLAINED	0.6685	21.6	18.0
130	PERIPHERAL VASCULAR DISORDERS W CC	0.7399	22.9	19.0
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.5973	20.7	17.2
132	ATHEROSCLEROSIS W CC	0.7209	22.6	18.8
133	ATHEROSCLEROSIS W/O CC	0.5703	19.4	16.1
134	HYPERTENSION	0.6789	21.5	17.9
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.9173	24.6	20.5
136	[3] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.8854	24.2	20.1
137	[8] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.8854	24.2	20.1
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.8117	22.7	18.9
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5656	19.7	16.4
140	[2] ANGINA PECTORIS	0.6685	21.6	18.0
141	SYNCOPE & COLLAPSE W CC	0.5363	21.7	18.0
142	SYNCOPE & COLLAPSE W/O CC	0.4921	22.4	18.6
143	[1] CHEST PAIN	0.5076	18.2	15.1
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.8212	22.2	18.5
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.8212	22.2	18.5
146	[8] RECTAL RESECTION W CC	1.8895	35.9	29.9
147	[8] RECTAL RESECTION W/O CC	1.8895	35.9	29.9
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.1502	34.9	29.0
149	[1] MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	0.5076	18.2	15.1
150	[5] PERITONEAL ADHESIOLYSIS W CC	1.8895	35.9	29.9
151	[8] PERITONEAL ADHESIOLYSIS W/O CC	1.8895	35.9	29.9
152	[5] MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.8895	35.9	29.9
153	[8] MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.8895	35.9	29.9
154	[5] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	1.8895	35.9	29.9
155	[8] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.8895	35.9	29.9
156	[8] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	1.8895	35.9	29.9
157	[4] ANAL & STOMAL PROCEDURES W CC	1.2467	30.4	25.3
158	[8] ANAL & STOMAL PROCEDURES W/O CC	1.2467	30.4	25.3
159	[3] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	0.8854	24.2	20.1
160	[8] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	0.8854	24.2	20.1
161	[5] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.8895	35.9	29.9
162	[8] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.5076	18.2	15.1

Proposed LTC-DRG	Description	Proposed Relative Weight	Proposed Geo-metric Average Length of Stay	Proposed 5/6ths of the Geo-metric Average Length of Stay
163	[8] HERNIA PROCEDURES AGE 0-17	0.5076	18.2	15.1
164	[8] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.8895	35.9	29.9
165	[8] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.8895	35.9	29.9
166	[8] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.8895	35.9	29.9
167	[8] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	1.8895	35.9	29.9
168	[4] MOUTH PROCEDURES W CC	1.2467	30.4	25.3
169	[8] MOUTH PROCEDURES W/O CC	0.8854	24.2	20.1
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	1.7302	31.9	26.5
171	[7] OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.7302	31.9	26.5
172	DIGESTIVE MALIGNANCY W CC	0.9392	23.2	19.3
173	DIGESTIVE MALIGNANCY W/O CC	0.6558	22.0	18.3
174	G.I. HEMORRHAGE W CC	0.7465	21.9	18.2
175	[2] G.I. HEMORRHAGE W/O CC	0.6685	21.6	18.0
176	COMPLICATED PEPTIC ULCER	1.0117	23.8	19.8
177	[2] UNCOMPLICATED PEPTIC ULCER W CC	0.6685	21.6	18.0
178	[1] UNCOMPLICATED PEPTIC ULCER W/O CC	0.5076	18.2	15.1
179	INFLAMMATORY BOWEL DISEASE	0.8398	22.4	18.6
180	G.I. OBSTRUCTION W CC	0.9502	22.2	18.5
181	[2] G.I. OBSTRUCTION W/O CC	0.6685	21.6	18.0
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.8565	23.3	19.4
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.6964	20.4	17.0
184	[8] ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.6685	21.6	18.0
185	[3] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.8854	24.2	20.1
186	[8] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	0.8854	24.2	20.1
187	[8] DENTAL EXTRACTIONS & RESTORATIONS	0.8854	24.2	20.1
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0108	24.2	20.1
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.8596	22.0	18.3
190	[8] OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.8854	24.2	20.1
191	[5] PANCREAS, LIVER & SHUNT PROCEDURES W CC	1.8895	35.9	29.9
192	[8] PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.8895	35.9	29.9
193	[1] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	0.5076	18.2	15.1
194	[8] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	0.5076	18.2	15.1
195	[8] CHOLECYSTECTOMY W C.D.E. W CC	1.8895	35.9	29.9
196	[8] CHOLECYSTECTOMY W C.D.E. W/O CC	1.8895	35.9	29.9
197	[5] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	1.8895	35.9	29.9
198	[8] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	1.8895	35.9	29.9
199	[8] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	0.8854	24.2	20.1
200	[3] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	0.8854	24.2	20.1

Proposed LTC-DRG	Description	Proposed Relative Weight	Proposed Geo-metric Average Length of Stay	Proposed 5/6ths of the Geo-metric Average Length of Stay
201	[4] OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	1.2467	30.4	25.3
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	0.7449	23.0	19.1
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	0.8291	21.4	17.8
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	0.8615	21.3	17.7
205	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W CC	0.7857	23.7	19.7
206	[7] DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC	0.7857	23.7	19.7
207	DISORDERS OF THE BILIARY TRACT W CC	0.7284	20.3	16.9
208	[1] DISORDERS OF THE BILIARY TRACT W/O CC	0.5076	18.2	15.1
209	[5] MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY	1.8895	35.9	29.9
210	[5] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.8895	35.9	29.9
211	[8] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.8895	35.9	29.9
212	[8] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.8895	35.9	29.9
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.1933	33.0	27.5
216	[4] BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.2467	30.4	25.3
217	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS	1.2972	36.2	30.1
218	[4] LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC	1.2467	30.4	25.3
219	[8] LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC	1.2467	30.4	25.3
220	[8] LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17	1.2467	30.4	25.3
223	[8] MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	1.2467	30.4	25.3
224	[4] SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	1.2467	30.4	25.3
225	FOOT PROCEDURES	1.0761	30.4	25.3
226	[4] SOFT TISSUE PROCEDURES W CC	1.2467	30.4	25.3
227	[2] SOFT TISSUE PROCEDURES W/O CC	0.6685	21.6	18.0
228	[2] MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC	0.6685	21.6	18.0
229	[1] HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.5076	18.2	15.1
230	[5] LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.8895	35.9	29.9
232	[8] ARTHROSCOPY	0.6685	21.6	18.0
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.5004	32.8	27.3
234	[2] OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	0.6685	21.6	18.0
235	FRACTURES OF FEMUR	0.8403	31.5	26.2
236	FRACTURES OF HIP & PELVIS	0.7462	26.7	22.2
237	[2] SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.6685	21.6	18.0
238	OSTEOMYELITIS	0.9541	28.6	23.8
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	0.6965	21.7	18.0
240	CONNECTIVE TISSUE DISORDERS W CC	0.7411	23.6	19.6
241	[1] CONNECTIVE TISSUE DISORDERS W/O CC	0.5076	18.2	15.1

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242	SEPTIC ARTHRITIS	0.8090	26.1	21.7
243	MEDICAL BACK PROBLEMS	0.6273	22.4	18.6
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.5978	22.4	18.6
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.5243	19.4	16.1
246	NON-SPECIFIC ARTHROPATHIES	0.6048	21.4	17.8
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.6172	21.7	18.0
248	TENDONITIS, MYOSITIS & BURSITIS	0.8250	24.6	20.5
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.7034	23.9	19.9
250	[2] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.6685	21.6	18.0
251	[2] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.6685	21.6	18.0
252	[8] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.6685	21.6	18.0
253	FX, SPRN, STRN & DISL OF UPARM, LOW LEG EX FOOT AGE >17 W CC	0.8384	28.1	23.4
254	FX, SPRN, STRN & DISL OF UPARM, LOW LEG EX FOOT AGE >17 W/O CC	0.7025	26.7	22.2
255	[8] FX, SPRN, STRN & DISL OF UPARM, LOW LEG EX FOOT AGE 0-17	0.6685	21.6	18.0
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.7696	23.3	19.4
257	[8] TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.8854	24.2	20.1
258	[8] TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.8854	24.2	20.1
259	[8] SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.8854	24.2	20.1
260	[1] SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.5076	18.2	15.1
261	[5] BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	1.8895	35.9	29.9
262	[3] BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.8854	24.2	20.1
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.3533	38.2	31.8
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.0444	32.2	26.8
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.4183	35.1	29.2
266	[3] SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	0.8854	24.2	20.1
267	[5] PERIANAL & PILONIDAL PROCEDURES	1.8895	35.9	29.9
268	[4] SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.2467	30.4	25.3
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.4068	38.1	31.7
270	[3] OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.8854	24.2	20.1
271	SKIN ULCERS	0.9665	28.3	23.5
272	MAJOR SKIN DISORDERS W CC	0.8595	25.5	21.2
273	[1] MAJOR SKIN DISORDERS W/O CC	0.5076	18.2	15.1
274	MALIGNANT BREAST DISORDERS W CC	0.9153	27.4	22.8
275	[3] MALIGNANT BREAST DISORDERS W/O CC	0.8854	24.2	20.1
276	[2] NON-MALIGANT BREAST DISORDERS	0.6685	21.6	18.0
277	CELLULITIS AGE >17 W CC	0.7065	21.8	18.1
278	CELLULITIS AGE >17 W/O CC	0.5717	19.1	15.9

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279	[8] CELLULITIS AGE 0-17	0.5076	18.2	15.1
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.9491	27.4	22.8
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.8513	29.0	24.1
282	[8] TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.8854	24.2	20.1
283	MINOR SKIN DISORDERS W CC	0.7632	22.8	19.0
284	[1] MINOR SKIN DISORDERS W/O CC	0.5076	18.2	15.1
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS	1.3618	35.5	29.5
286	[8] ADRENAL & PITUITARY PROCEDURES	0.8854	24.2	20.1
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.1635	32.0	26.6
288	[3] O.R. PROCEDURES FOR OBESITY	0.8854	24.2	20.1
289	[8] PARATHYROID PROCEDURES	0.8854	24.2	20.1
290	[8] THYROID PROCEDURES	0.8854	24.2	20.1
291	[8] THYROGLOSSAL PROCEDURES	0.8854	24.2	20.1
292	[4] OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	1.2467	30.4	25.3
293	[8] OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	0.6685	21.6	18.0
294	DIABETES AGE >35	0.7721	23.7	19.7
295	[2] DIABETES AGE 0-35	0.6685	21.6	18.0
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.8128	23.8	19.8
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.5910	20.5	17.0
298	[8] NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.6685	21.6	18.0
299	[3] INBORN ERRORS OF METABOLISM	0.8854	24.2	20.1
300	ENDOCRINE DISORDERS W CC	0.8070	24.6	20.5
301	[1] ENDOCRINE DISORDERS W/O CC	0.5076	18.2	15.1
302	[6] KIDNEY TRANSPLANT	0.0000	0.0	0.0
303	[4] KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	1.2467	30.4	25.3
304	[4] KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	1.2467	30.4	25.3
305	[2] KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	0.6685	21.6	18.0
306	[3] PROSTATECTOMY W CC	0.8854	24.2	20.1
307	[2] PROSTATECTOMY W/O CC	0.6685	21.6	18.0
308	[4] MINOR BLADDER PROCEDURES W CC	1.2467	30.4	25.3
309	[8] MINOR BLADDER PROCEDURES W/O CC	1.2467	30.4	25.3
310	[4] TRANSURETHRAL PROCEDURES W CC	1.2467	30.4	25.3
311	[8] TRANSURETHRAL PROCEDURES W/O CC	1.2467	30.4	25.3
312	[4] URETHRAL PROCEDURES, AGE >17 W CC	1.2467	30.4	25.3
313	[8] URETHRAL PROCEDURES, AGE >17 W/O CC	1.2467	30.4	25.3
314	[8] URETHRAL PROCEDURES, AGE 0-17	0.6685	21.6	18.0
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	1.4466	33.5	27.9
316	RENAL FAILURE	0.9336	23.5	19.5
317	ADMIT FOR RENAL DIALYSIS	0.9224	22.0	18.3
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	0.7867	22.6	18.8
319	[7] KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.7867	22.6	18.8

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320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.6852	22.2	18.5
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.5719	21.6	18.0
322	[8] KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.5076	18.2	15.1
323	[1] URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.5076	18.2	15.1
324	[1] URINARY STONES W/O CC	0.5076	18.2	15.1
325	[2] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.6685	21.6	18.0
326	[1] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.5076	18.2	15.1
327	[8] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.5076	18.2	15.1
328	[2] URETHRAL STRICTURE AGE >17 W CC	0.6685	21.6	18.0
329	[8] URETHRAL STRICTURE AGE >17 W/O CC	0.6685	21.6	18.0
330	[8] URETHRAL STRICTURE AGE 0-17	0.6685	21.6	18.0
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	0.8428	23.1	19.2
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.6742	23.6	19.6
333	[8] OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.6685	21.6	18.0
334	[8] MAJOR MALE PELVIC PROCEDURES W CC	1.2467	30.4	25.3
335	[8] MAJOR MALE PELVIC PROCEDURES W/O CC	1.2467	30.4	25.3
336	[3] TRANSURETHRAL PROSTATECTOMY W CC	0.8854	24.2	20.1
337	[8] TRANSURETHRAL PROSTATECTOMY W/O CC	0.8854	24.2	20.1
338	[5] TESTES PROCEDURES, FOR MALIGNANCY	1.8895	35.9	29.9
339	[1] TESTES PROCEDURES, NON-MALIGNANCY AGE >17	0.5076	18.2	15.1
340	[8] TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.5076	18.2	15.1
341	[5] PENIS PROCEDURES	1.8895	35.9	29.9
342	[8] CIRCUMCISION AGE >17	0.5076	18.2	15.1
343	[8] CIRCUMCISION AGE 0-17	0.5076	18.2	15.1
344	[8] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.2467	30.4	25.3
345	[4] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	1.2467	30.4	25.3
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	0.7748	22.5	18.7
347	[1] MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.5076	18.2	15.1
348	[2] BENIGN PROSTATIC HYPERTROPHY W CC	0.6685	21.6	18.0
349	[2] BENIGN PROSTATIC HYPERTROPHY W/O CC	0.6685	21.6	18.0
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.8258	23.7	19.7
351	[8] STERILIZATION, MALE	0.5076	18.2	15.1
352	[3] OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.8854	24.2	20.1
353	[8] PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.8895	35.9	29.9
354	[8] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.8895	35.9	29.9
355	[8] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	1.8895	35.9	29.9
356	[8] FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.2467	30.4	25.3
357	[8] UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	1.2467	30.4	25.3
358	[8] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.2467	30.4	25.3

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359	[8] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	1.2467	30.4	25.3
360	[8] VAGINA, CERVIX & VULVA PROCEDURES	1.2467	30.4	25.3
361	[8] LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	0.5076	18.2	15.1
362	[8] ENDOSCOPIC TUBAL INTERRUPTION	0.5076	18.2	15.1
363	[8] D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.5076	18.2	15.1
364	[8] D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.5076	18.2	15.1
365	[5] OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.8895	35.9	29.9
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	0.9991	24.0	20.0
367	[1] MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.5076	18.2	15.1
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.7054	21.9	18.2
369	[3] MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.8854	24.2	20.1
370	[8] CESAREAN SECTION W CC	0.8854	24.2	20.1
371	[8] CESAREAN SECTION W/O CC	0.5076	18.2	15.1
372	[8] VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.5076	18.2	15.1
373	[8] VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.5076	18.2	15.1
374	[8] VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.5076	18.2	15.1
375	[8] VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.5076	18.2	15.1
376	[8] POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.5076	18.2	15.1
377	[8] POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	0.5076	18.2	15.1
378	[8] ECTOPIC PREGNANCY	0.8854	24.2	20.1
379	[8] THREATENED ABORTION	0.5076	18.2	15.1
380	[8] ABORTION W/O D&C	0.5076	18.2	15.1
381	[8] ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.5076	18.2	15.1
382	[8] FALSE LABOR	0.5076	18.2	15.1
383	[8] OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.5076	18.2	15.1
384	[8] OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.5076	18.2	15.1
385	[8] NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0.5076	18.2	15.1
386	[8] EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	0.5076	18.2	15.1
387	[8] PREMATURITY W MAJOR PROBLEMS	0.5076	18.2	15.1
388	[8] PREMATURITY W/O MAJOR PROBLEMS	0.5076	18.2	15.1
389	[8] FULL TERM NEONATE W MAJOR PROBLEMS	0.5076	18.2	15.1
390	[8] NEONATE W OTHER SIGNIFICANT PROBLEMS	0.5076	18.2	15.1
391	[8] NORMAL NEWBORN	0.5076	18.2	15.1
392	[8] SPLENECTOMY AGE >17	1.8895	35.9	29.9
393	[8] SPLENECTOMY AGE 0-17	1.8895	35.9	29.9
394	[3] OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	0.8854	24.2	20.1
395	RED BLOOD CELL DISORDERS AGE >17	0.7705	23.6	19.6
396	[8] RED BLOOD CELL DISORDERS AGE 0-17	0.6685	21.6	18.0
397	COAGULATION DISORDERS	0.8482	20.6	17.1

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398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.8052	21.7	18.0
399	[2] RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.6685	21.6	18.0
401	[4] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	1.2467	30.4	25.3
402	[8] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	1.2467	30.4	25.3
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	0.9015	21.7	18.0
404	[1] LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.5076	18.2	15.1
405	[8] ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	0.5076	18.2	15.1
406	[5] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	1.8895	35.9	29.9
407	[8] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.2467	30.4	25.3
408	[4] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	1.2467	30.4	25.3
409	RADIOTHERAPY	0.9116	22.5	18.7
410	[3] CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	0.8854	24.2	20.1
411	[8] HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.5076	18.2	15.1
412	[8] HISTORY OF MALIGNANCY W ENDOSCOPY	0.5076	18.2	15.1
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	0.8586	20.3	16.9
414	[1] OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.5076	18.2	15.1
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	1.5369	35.7	29.7
416	SEPTICEMIA AGE >17	0.9186	24.0	20.0
417	[8] SEPTICEMIA AGE 0-17	0.8854	24.2	20.1
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	0.8880	24.6	20.5
419	[4] FEVER OF UNKNOWN ORIGIN AGE >17 W CC	1.2467	30.4	25.3
420	[2] FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.6685	21.6	18.0
421	VIRAL ILLNESS AGE >17	1.0559	25.9	21.5
422	[8] VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.5076	18.2	15.1
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	0.9625	22.6	18.8
424	[5] O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	1.8895	35.9	29.9
425	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.5590	21.0	17.5
426	DEPRESSIVE NEUROSES	0.5495	24.7	20.5
427	[2] NEUROSES EXCEPT DEPRESSIVE	0.6685	21.6	18.0
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.6631	27.6	23.0
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.6037	24.7	20.5
430	PSYCHOSES	0.4854	22.6	18.8
431	CHILDHOOD MENTAL DISORDERS	0.4978	22.0	18.3
432	[8] OTHER MENTAL DISORDER DIAGNOSES	0.6685	21.6	18.0
433	[1] ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.5076	18.2	15.1
439	SKIN GRAFTS FOR INJURIES	1.1415	34.9	29.0
440	WOUND DEBRIDEMENTS FOR INJURIES	1.2555	31.6	26.3
441	[2] HAND PROCEDURES FOR INJURIES	0.6685	21.6	18.0

Proposed LTC-DRG	Description	Proposed Relative Weight	Proposed Geo-metric Average Length of Stay	Proposed 5/6ths of the Geo-metric Average Length of Stay
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.4562	37.4	31.1
443	[7] OTHER O.R. PROCEDURES FOR INJURIES W/O CC	1.4562	37.4	31.1
444	TRAUMATIC INJURY AGE >17 W CC	0.8665	24.9	20.7
445	TRAUMATIC INJURY AGE >17 W/O CC	0.8665	24.9	20.7
446	[8] TRAUMATIC INJURY AGE 0-17	0.8854	24.2	20.1
447	[2] ALLERGIC REACTIONS AGE >17	0.6685	21.6	18.0
448	[8] ALLERGIC REACTIONS AGE 0-17	0.6685	21.6	18.0
449	[2] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.6685	21.6	18.0
450	[1] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.5076	18.2	15.1
451	[8] POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	1.2467	30.4	25.3
452	COMPLICATIONS OF TREATMENT W CC	0.9995	25.2	21.0
453	COMPLICATIONS OF TREATMENT W/O CC	0.7129	22.4	18.6
454	[5] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	1.8895	35.9	29.9
455	[4] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	1.2467	30.4	25.3
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.2539	34.4	28.6
462	REHABILITATION	0.6791	23.4	19.5
463	SIGNS & SYMPTOMS W CC	0.6793	23.5	19.5
464	SIGNS & SYMPTOMS W/O CC	0.5659	22.7	18.9
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6881	20.2	16.8
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.7402	22.2	18.5
467	[2] OTHER FACTORS INFLUENCING HEALTH STATUS	0.6685	21.6	18.0
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.1227	40.1	33.4
469	[6] PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
470	[6] UNGROUPABLE	0.0000	0.0	0.0
471	[8] BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	0.6685	21.6	18.0
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	0.8704	20.7	17.2
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	2.0199	33.2	27.6
476	[3] PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	0.8854	24.2	20.1
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.5119	34.2	28.5
478	OTHER VASCULAR PROCEDURES W CC	1.3685	31.8	26.5
479	[1] OTHER VASCULAR PROCEDURES W/O CC	0.5076	18.2	15.1
480	[6] LIVER TRANSPLANT	0.0000	0.0	0.0
481	[8] BONE MARROW TRANSPLANT	0.8854	24.2	20.1
482	[8] TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	1.2467	30.4	25.3
484	[8] CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	1.2467	30.4	25.3
485	[4] LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA	1.2467	30.4	25.3
486	[5] OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	1.8895	35.9	29.9
487	[4] OTHER MULTIPLE SIGNIFICANT TRAUMA	1.2467	30.4	25.3
488	[5] HIV W EXTENSIVE O.R. PROCEDURE	1.8895	35.9	29.9

Proposed LTC-DRG	Description	Proposed Relative Weight	Proposed Geo-metric Average Length of Stay	Proposed 5/6ths of the Geo-metric Average Length of Stay
489	HIV W MAJOR RELATED CONDITION	1.0345	24.1	20.0
490	HIV W OR W/O OTHER RELATED CONDITION	1.1004	22.0	18.3
491	[8] MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.8895	35.9	29.9
492	[8] CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT	0.8854	24.2	20.1
493	[3] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	0.8854	24.2	20.1
494	[8] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	0.8854	24.2	20.1
495	[6] LUNG TRANSPLANT	0.0000	0.0	0.0
496	[3] COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	0.8854	24.2	20.1
497	[3] SPINAL FUSION EXCEPT CERVICAL W CC	0.8854	24.2	20.1
498	[8] SPINAL FUSION EXCEPT CERVICAL W/O CC	0.8854	24.2	20.1
499	[5] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.8895	35.9	29.9
500	[1] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	0.5076	18.2	15.1
501	[4] KNEE PROCEDURES W PDX OF INFECTION W CC	1.2467	30.4	25.3
502	[3] KNEE PROCEDURES W PDX OF INFECTION W/O CC	0.8854	24.2	20.1
503	[4] KNEE PROCEDURES W/O PDX OF INFECTION	1.2467	30.4	25.3
504	[8] EXTENSIVE BURNS OF FULL THICKNESS BURNS WITH MECH VENT 96+HRS WITH SKIN GRAFT	1.8895	35.9	29.9
505	[4] EXTENSIVE BURNS OF FULL THICKNESS BURNS WITH MECH VENT 96+HRS WITHOUT SKIN GRAFT	1.2467	30.4	25.3
506	[4] FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	1.2467	30.4	25.3
507	[8] FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	0.8854	24.2	20.1
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	0.7778	25.8	21.5
509	[1] FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	0.5076	18.2	15.1
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	0.9218	25.8	21.5
511	[2] NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.6685	21.6	18.0
512	[6] SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	0.0000	0.0	0.0
513	[6] PANCREAS TRANSPLANT	0.0000	0.0	0.0
515	[5] CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	1.8895	35.9	29.9
516	[8] PERCUTANEOUS CARDIOVASC PROC W AMI	0.8854	24.2	20.1
517	[3] PERC CARDIO PROC W NON-DRUG ELUTING STENT W/O AMI	0.8854	24.2	20.1
518	[3] PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	0.8854	24.2	20.1
519	[4] CERVICAL SPINAL FUSION W CC	1.2467	30.4	25.3
520	[8] CERVICAL SPINAL FUSION W/O CC	0.8854	24.2	20.1
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.6544	21.4	17.8
522	[1] ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC	0.5076	18.2	15.1
523	[1] ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC	0.5076	18.2	15.1
524	TRANSIENT ISCHEMIA	0.6494	22.4	18.6
525	[8] OTHER HEART ASSIST SYSTEM IMPLANT	1.8895	35.9	29.9
526	[8] PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W AMI	0.8854	24.2	20.1

Proposed LTC-DRG	Description	Proposed Relative Weight	Proposed Geo-metric Average Length of Stay	Proposed 5/6ths of the Geo-metric Average Length of Stay
527	[8] PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W/O AMI	0.8854	24.2	20.1
528	[8] INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	1.2467	30.4	25.3
529	[4] VENTRICULAR SHUNT PROCEDURES W CC	1.2467	30.4	25.3
530	[8] VENTRICULAR SHUNT PROCEDURES W/O CC	1.2467	30.4	25.3
531	[5] SPINAL PROCEDURES W CC	1.8895	35.9	29.9
532	[2] SPINAL PROCEDURES W/O CC	0.6685	21.6	18.0
533	[5] EXTRACRANIAL PROCEDURES W CC	1.8895	35.9	29.9
534	[8] EXTRACRANIAL PROCEDURES W/O CC	0.5076	18.2	15.1
535	[5] CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	1.8895	35.9	29.9
536	[5] CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	1.8895	35.9	29.9
537	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W CC	1.3141	36.3	30.2
538	[3] LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC	0.8854	24.2	20.1
539	[3] LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC	0.8854	24.2	20.1
540	[8] LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC	0.6685	21.6	18.0
541	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE, MOUTH & NECK DX WITH MAJOR OR	3.4223	54.8	45.6
542	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE, MOUTH & NECK DX WITHOUT MAJOR OR	2.9398	44.3	36.9

[1] Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to proposed low-volume quintile 1.
[2] Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to proposed low-volume quintile 2.
[3] Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to proposed low-volume quintile 3.
[4] Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to proposed low-volume quintile 4.
[5] Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to proposed low-volume quintile 5.
[6] Proposed relative weights for these proposed LTC-DRGs were assigned a value of 0.0000.
[7] Proposed relative weights for these proposed LTC-DRGs were determined after adjusting to account for nonmonotonicity (see step 5 above).
[8] Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to the appropriate proposed low volume quintile because they had no LTCH cases in the FY 2003 MedPAR file.

Appendix A—Regulatory Analysis of Impacts

[If you choose to comment on issues in this section, please include the caption ''Impact Analyses'' at the beginning of your comment.]

I. Background and Summary

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined that this proposed rule is a major rule as defined in 5 U.S.C. 804(2). Based on the overall percentage change in payments per case estimated using our payment simulation model (a 4.9 percent increase), we estimate that the total impact of these proposed changes for FY 2005 payments compared to FY 2004 payments to be approximately a $4.3 billion increase. As a result, total IPPS payments will increase from approximately $100 billion to approximately $104.3 billion. This amount does not reflect changes in hospital admissions or case-mix intensity, which would also affect overall payment changes.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million to $25 million in any 1 year. For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This 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 previously defined 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). However, under the new labor market definitions that we are proposing to adopt, we no longer employ NECMAs to define urban areas in New England. Therefore, we now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the IPPS, we continue to classify these hospitals as urban hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any proposed rule (or a final rule that has been preceded by a proposed rule) that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. This proposed rule would not mandate any requirements for State, local, or tribal governments.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this proposed rule in light of Executive Order 13132 and have determined that it would not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments.

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

The following analysis, in conjunction with the remainder of this document, demonstrates that this proposed rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The proposed rule would affect payments to a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some hospitals may be significant.

II. Objectives

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

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

III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our proposed policy changes, as well as statutory changes effective for FY 2005, 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 proposed 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 proposed changes on hospitals and our methodology for estimating them. Any comments that we receive in response to this proposed rule will be addressed in the final rule.

IV. Hospitals Included in and Excluded From the IPPS

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 39 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment method for these hospitals. Among other short-term, acute care hospitals, only the 47 such hospitals in Maryland remain excluded from the IPPS under the waiver at section 1814(b)(3) of the Act.

As of April 2004, there are 3,904 IPPS hospitals to be included in our analysis. This represents about 65 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals. There are also approximately 898 critical access hospitals (CAHs). These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. There are also 1,194 specialty hospitals and units that are excluded from the IPPS. These specialty hospitals include psychiatric hospitals and units, rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals. The impacts of our proposed policy changes on these hospitals are discussed below.

V. Impact on Excluded Hospitals and Hospital Units

As of April 2004, there were 1,194 specialty hospitals excluded from the IPPS. Of these 1,194 specialty hospitals, 478 psychiatric hospitals, 80 children's, 11 cancer hospitals, and less than 10 percent of the LTCHs are being paid on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. The remaining providers—216 rehabilitation, and approximately 90 percent of the 331 LTCHs are paid 100 percent of the Federal rate under the IRF and LTCH PPS', respectively. In addition, there were 1,381 psychiatric units (paid on a reasonable cost basis) and 999 rehabilitation units (paid under the IRF PPS) in hospitals otherwise subject to the IPPS. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 47 specialty hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

In the past, hospitals and units excluded from the IPPS have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Hospitals that continue to be paid based on

their reasonable costs are subject to TEFRA limits for FY 2005. For these hospitals, the proposed update is the percentage increase in the excluded hospital market basket, currently estimated at 3.3 percent.

Inpatient rehabilitation facilities (IRFs) are paid under a prospective payment system (IRF PPS) for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2005, the IRF PPS is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually. Therefore, these hospitals would not be impacted by this proposed rule.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs are paid under an LTCH PPS, based on the adjusted Federal prospective payment amount, updated annually. LTCHs will receive a blended payment (Federal prospective payment and a reasonable cost-based payment) over a 5-year transition period. However, under the LTCH PPS, an LTCH may also elect to be paid at 100 percent of the Federal prospective rate at the beginning of any of its cost reporting periods during the 5-year transition period. For purposes of the update factor, the portion of the LTCH PPS transition blend payment based on reasonable costs for inpatient operating services would be determined by updating the LTCH's TEFRA limit by the estimate of the excluded hospital market basket (or 3.3 percent).

Section 124 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) requires the development of a per diem prospective payment system (PPS) for payment of inpatient hospital services furnished in psychiatric hospitals and psychiatric units of acute care hospitals (inpatient psychiatric facilities (IFPs)). We published a proposed rule to implement the IPF PPS on November 28, 2003 (68 FR 66920). On January 30, 2004, we published a notice to extend the comment period for 30 additional days (69 FR 4464). The comment period closed on March 26, 2004.

Under the proposed rule, CMS would compute a Federal per diem base rate to be paid to all IPFs based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF adjusted for budget neutrality. The Federal per diem base rate would be adjusted to reflect certain patient characteristics such as age, specified DRGs, and selected high-cost comorbidities, and certain facility characteristics such as a wage index adjustment, rural location, and indirect teaching costs.

The November 28, 2003 proposed rule assumed an April 1, 2004 effective date for the purpose of ratesetting and calculating impacts. However, we are still in the process of analyzing public comments and developing a final rule for publication. The effective date of the IPF PPS would occur 5 months following publication of the final rule.

The impact on excluded hospitals and hospital units of the update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level below the rate-of-increase limits since their base period, the major effect is on the level of incentive payments these hospitals and hospital units receive. Conversely, for excluded hospitals and hospital units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect is the amount of excess costs that will not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and hospital units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and hospital units to restrain the growth in their spending for patient services.

VI. Quantitative Impact Analysis of the Proposed Policy Changes Under the IPPS for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing policy changes and payment rate updates for the IPPS for operating and capital-related costs. Based on the overall percentage change in payments per case estimated using our payment simulation model (a 4.9 percent increase), we estimate the total impact of these proposed changes for FY 2005 payments compared to FY 2004 payments to be approximately a $4.3 billion increase. This amount does not reflect changes in hospital admissions or case-mix intensity, which would also affect overall payment changes.

We have prepared separate impact analyses of the proposed changes to each system. This section deals with proposed changes to the operating prospective payment system. Our payment simulation model relies on the most recent available data to enable us to estimate the impacts on payments per case of certain changes we are proposing in this proposed rule. However, there are other changes we are proposing for which we do not have data available that would allow us to estimate the payment impacts using this model. For those proposed changes, we have attempted to predict the payment impacts of those proposed changes based upon our experience and other more limited data.

The data used in developing the quantitative analyses of changes in payments per case presented below are taken from the FY 2003 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Although the analyses of the changes to the operating PPS do not incorporate cost data, data from the most recently available hospital cost report were used to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to the proposed policy changes, and we do not adjust for future changes in such variables as admissions, lengths of stay, or case-mix. Second, due to the interdependent nature of the IPPS payment components, 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. However, for individual hospitals, some miscategorizations are possible.

Using cases in the FY 2003 MedPAR file, we simulated payments under the operating IPPS given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the IPPSs (Indian Health Service hospitals and hospitals in Maryland) were excluded from the simulations. The impact of payments under the capital IPPS, or the impact of payments for costs other than inpatient operating costs, are not analyzed in this section. Estimated payment impacts of proposed FY 2005 changes to the capital IPPS are discussed in section VIII. of this Appendix.

The proposed changes discussed separately below are the following:

- The effects of the proposed annual reclassification of diagnoses and procedures and the recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of applying a lower labor-related share for hospitals with wage indexes less than or equal to 1.0, as required under section 403 of Public Law 108–173.
- The effects of the proposed adoption of the new MSAs as announced by OMB in June 2003.
- The effects of the proposed changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 2001, compared to the FY 2000 wage data.
- The effects of adjusting hospitals' wage data to reflect the occupational mix based on our survey of hospitals.
- The effect of the proposed wage and DRG recalibration budget neutrality factors.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2005.
- The effects of the proposed implementation of section 505 of Public Law 108–173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in areas with higher wage indexes.
- The total change in payments based on proposed FY 2005 policies and MMA-imposed changes relative to payments based on FY 2004 policies.

To illustrate the impacts of the proposed FY 2005 changes, our analysis begins with an FY 2005 baseline simulation model using: the proposed update of 3.3 percent; the FY 2004 DRG GROUPER (version 21.0); the MSA designations for hospitals based on OMB's MSA definitions prior to June 2003; the FY 2004 wage index; and no MGCRB

reclassifications. Outlier payments are set at 5.1 percent of total operating DRG and outlier payments.

The baseline simulation model also reflects changes enacted by Public Law 108–173 to the IME and DSH adjustments. Section 402 provides that, for discharges occurring on or after April 1, 2004, all hospitals that qualify will receive DSH payments using the prior (before April 1, 2004) DSH adjustment formula for urban hospitals with 100 or more beds. Except for urban hospitals with 100 or more beds and rural referral centers, the DSH adjustment is capped at 12 percent. Section 502 modifies the IME adjustment for midway through FY 2004 and provides a new schedule of formula multipliers for FYs 2005 and thereafter.

Section 501(b) provides that, for FYs 2005 through 2007, the update factors will be reduced by 0.4 percentage point for any hospital that does not submit quality data. For purposes of the FY 2005 simulations in this proposed impact analysis, we are assuming all hospitals will qualify for the full update. Hospitals are not required to begin submitting these data in order to qualify for a full update until July 2004, and we are therefore unable to determine the rate of compliance with this requirement of receiving the full update.

Each proposed and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2005 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 2004 to FY 2005. Five factors not discussed separately above have significant impacts here. The first is the update to the standardized amount. In accordance with section 1886(b)(3)(B)(i) of the Act, we are proposing to update the standardized amount for FY 2005 using the most recently forecasted hospital market basket increase for FY 2005 of 3.3 percent. (Hospitals that fail to comply with the quality data submission requirement to receive the full update will receive an update reduced by 0.4 percentage points to 2.9 percent.) Under section 1886(b)(3)(B)(iv) of the Act, the updates to the hospital-specific amounts for sole community hospitals (SCHs) and for Medicare-dependent small rural hospitals (MDHs) are also equal to the market basket increase, or 3.3 percent.

A second significant factor that impacts changes in hospitals' payments per case from FY 2004 to FY 2005 is the change in MGCRB status from one year to the next. That is, hospitals reclassified in FY 2004 that are no longer reclassified in FY 2005 may have a negative payment impact going from FY 2004 to FY 2005; conversely, hospitals not reclassified in FY 2004 that are reclassified in FY 2005 may have a positive impact. In some cases, these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage change in payments for the category may be below the national mean. However, this effect is alleviated by section 1886(d)(10)(D)(v) of the Act, which provides that reclassifications for purposes of the wage index are for a 3-year period.

A third significant factor is that we currently estimate that actual outlier payments during FY 2004 will be 4.4 percent of total DRG payments. When the FY 2004 final rule was published, we projected FY 2004 outlier payments would be 5.1 percent of total DRG plus outlier payments; the average standardized amounts were offset correspondingly. The effects of the lower than expected outlier payments during FY 2004 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 2004 payments per case to estimated FY 2005 payments per case (with outlier payments projected to equal 5.1 percent of total DRG payments).

Fourth, as noted above, sections 402 and 502 of Public Law 108–173 establish higher DSH and IME payments, respectively. As a result, payments for these factors will be higher in FY 2005 than in FY 2004.

Fifth, section 508 of Public Law 108–173 established a one-time appeal process for hospitals to be reclassified in order to receive a higher wage index for a period of 3 years beginning with discharges on or after April 1, 2004.

B. Analysis of Table I

Table I displays 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 3,904 hospitals included in the analysis. This number is 145 fewer hospitals than were included in the impact analysis in the FY 2004 final rule (68 FR 45661). There are 94 new CAHs that were excluded from this year's analysis. The remaining 51 cases represent hospitals that have closed or hospitals for which we have no data.

The next four rows of Table I contain hospitals categorized according to their geographic location: all urban, which is further divided into large urban and other urban; and rural. We previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA or NECMA. However, under the new labor market definitions that we are proposing to adopt, we no longer employ NECMAs to define urban areas in New England. Therefore, we will now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA. There are 2,696 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,424 hospitals located in large urban areas (populations over 1 million), and 1,272 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 1,208 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 and are also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2005 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the number of hospitals paid based on these categorizations after consideration of geographic reclassifications are 2,624, 1,405, 1,219, and 1,280, respectively.

The next three groupings examine the impacts of the final changes on hospitals grouped by whether or not they have GME residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 2,787 nonteaching hospitals in our analysis, 916 teaching hospitals with fewer than 100 residents, and 201 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 for DSH purposes. Previously, hospitals in the rural DSH categories in the impact table represented hospitals that were not reclassified for purposes of the standardized amount. (However, they may have been reclassified for purposes of the wage index.) However, reclassification for purposes of the standardized amount has been terminated as a result of the equalization of the standardized amounts. As a result, there are no longer cases in which reclassifications change the status of rural hospitals for DSH purposes. There is little or no impact from the termination of standardized amount reclassification under the operating IPPS, since there are few concrete cases in which change from rural to urban status now would have any effect under the revised DSH payment formulas. The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the proposed changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and Medicare dependant hospitals (MDHs)), as well as rural hospitals not receiving a special payment designation. There were 137 RRCs, 454 SCHs, 211 MDHs, and 73 hospitals that are both SCH and RRC.

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 2001 Medicare cost report files, if available (otherwise FY 2000 data are used). Data needed to determine ownership status were unavailable for 68 hospitals. Similarly, the data needed to determine Medicare utilization were unavailable for 173 hospitals. The next two rows compare the impacts on those hospitals that converted from urban MSAs to rural CBSAs and for the hospitals that converted from rural MSAs to urban CBSAs.

The next series of groupings concern the geographic reclassification status of hospitals. The first grouping displays all hospitals that were reclassified by the MGCRB for FY 2005. The next two groupings separate the hospitals in the first group by urban and rural status. The final row in Table I contains hospitals located in rural counties

but deemed to be urban under section 1886(d)(8)(B) of the Act.

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2005 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent Changes in Payments per Case]

	No. of hosps.[1]	DRG recal[2]	Labor share split[3]	Core based stat. areas[4]	New wage data[5]	Occupational mix[6]	DRG & wage index changes[7]	MGCRB reclassification[8]	Out-migration data[9]	All FY 2005 changes[10]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
By Geographic Location:										
All hospitals	3,904	0.1	0.5	0.0	0.0	0.0	0.0	0.0	0.0	4.9
Urban hospitals	2,696	0.0	0.5	0.1	0.0	0.0	0.0	−0.3	0.0	4.7
Large urban areas (populations over 1 million)	1,424	0.0	0.3	0.1	0.0	0.0	−0.1	−0.4	0.0	4.5
Other urban areas (populations of 1 million or fewer)	1,272	0.1	0.7	0.1	0.0	0.0	0.1	−0.2	0.1	5.0
Rural hospitals	1,208	0.2	1.1	−0.2	0.0	0.0	0.2	1.9	0.0	6.0
Bed Size (Urban):										
0–99 beds	684	0.2	0.5	0.4	0.0	0.0	0.3	−0.4	0.1	5.7
100–199 beds	966	0.1	0.5	−0.1	0.0	0.0	0.0	−0.3	0.1	4.6
200–299 beds	500	0.0	0.4	0.1	−0.2	0.0	−0.2	−0.2	0.0	4.4
300–499 beds	415	0.0	0.5	0.1	0.1	0.0	0.1	−0.3	0.0	4.8
500 or more beds	131	0.0	0.3	0.0	−0.1	0.0	−0.1	−0.4	0.0	4.9
Bed Size (Rural):										
0–49 beds	549	0.4	1.0	−0.1	0.2	0.0	0.5	0.4	0.1	6.3
50–99 beds	393	0.3	0.9	−0.2	0.1	0.0	0.3	1.0	0.1	6.1
100–149 beds	163	0.2	1.2	−0.3	0.1	0.1	0.3	2.6	0.1	6.0
150–199 beds	57	0.2	1.3	−0.3	−0.1	0.1	0.0	3.2	0.0	5.9
200 or more beds	46	0.1	1.1	−0.1	−0.1	0.0	−0.1	2.9	0.0	5.6
Urban by Region:										
New England	137	0.2	0.0	−0.4	−0.2	0.0	−0.2	−0.3	0.0	3.6
Middle Atlantic	397	0.0	0.3	0.2	−0.7	0.0	−0.8	−0.1	0.1	3.7
South Atlantic	419	0.1	0.5	0.2	0.1	0.0	0.1	−0.3	0.0	5.0
East North Central	450	0.0	0.3	0.0	0.1	0.0	0.1	−0.3	0.0	4.7
East South Central	175	0.1	1.2	0.2	0.1	0.0	0.2	−0.3	0.1	5.5
West North Central	160	0.1	0.6	0.1	0.2	0.0	0.2	−0.5	0.0	5.1
West South Central	346	0.0	0.9	0.0	0.5	0.0	0.5	−0.5	0.0	5.7
Mountain	140	0.0	0.2	0.2	−0.4	0.0	−0.4	−0.1	0.0	3.8
Pacific	421	0.1	0.0	0.1	0.1	0.0	0.2	−0.3	0.1	4.9
Puerto Rico	51	−0.4	6.2	−0.1	−0.2	0.0	−0.7	−0.5	0.0	14.3
Rural by Region:										
New England	34	0.2	0.3	0.3	0.3	0.0	0.3	1.3	0.0	3.9
Middle Atlantic	57	0.3	1.0	−0.4	−0.2	0.0	0.0	1.8	0.0	4.2
South Atlantic	176	0.2	1.1	−0.7	−0.1	0.1	0.1	2.0	0.0	5.8
East North Central	160	0.2	0.8	−0.1	0.1	0.0	0.2	1.4	0.0	4.5
East South Central	192	0.2	2.0	0.0	−0.3	0.1	−0.1	2.8	0.1	9.4
West North Central	206	0.3	0.8	−0.1	0.3	0.0	0.5	1.3	0.0	5.7
West South Central	228	0.2	1.7	0.0	0.1	0.1	0.4	3.0	0.1	7.2
Mountain	93	0.3	0.4	−0.2	0.2	0.0	0.4	0.5	0.1	4.4
Pacific	62	0.2	0.0	0.0	0.3	0.0	0.5	0.8	0.1	4.5
By Payment Classification:										
Urban hospitals	2,624	0.0	0.5	0.1	0.0	0.0	0.0	−0.3	0.0	4.7
Large urban areas (populations over 1 million)	1,405	0.0	0.3	0.1	0.0	0.0	−0.1	−0.4	0.0	4.5
Other urban areas (populations of 1 million or fewer)	1,219	0.1	0.7	0.1	0.0	0.0	0.1	−0.2	0.1	5.0
Rural areas	1,280	0.3	1.0	−0.2	0.0	0.0	0.2	1.7	0.0	5.9
Teaching Status:										
Non-teaching	2,787	0.1	0.7	0.1	0.0	0.0	0.1	0.3	0.1	5.2
Fewer than 100 Residents	916	0.0	0.5	0.1	0.1	0.0	0.0	−0.2	0.0	4.8
100 or more Residents	201	0.0	0.2	−0.1	−0.2	0.0	−0.3	−0.3	0.0	4.5
Urban DSH:										
Non-DSH	1,156	0.1	0.4	0.1	0.0	0.0	0.0	−0.1	0.0	4.7
100 or more beds	1,465	0.0	0.5	0.0	0.0	0.0	−0.1	−0.3	0.0	4.7
Less than 100 beds	335	0.3	0.7	0.9	0.0	0.0	0.4	−0.4	0.1	7.0
Rural DSH:										
Sole Community (SCH)	482	0.3	0.6	−0.1	0.1	0.0	0.3	0.4	0.0	4.9
Referral Center (RRC)	157	0.2	1.3	−0.2	−0.1	0.1	0.0	3.6	0.0	6.1
Other Rural:										
100 or more beds	68	0.3	1.7	0.2	−0.2	0.1	0.1	1.1	0.1	8.9
Less than 100 beds	241	0.4	1.8	−0.3	−0.1	0.1	0.2	1.2	0.1	10.1
Urban teaching and DSH:										
DSH	800	0.0	0.4	0.0	0.0	0.0	−0.1	−0.3	0.0	4.6
Teaching and no DSH	250	0.1	0.3	0.0	0.1	0.0	0.0	−0.3	0.1	4.8
No teaching and DSH	1,000	0.1	0.6	0.2	0.0	0.0	0.1	−0.2	0.1	5.1
No teaching and no DSH	574	0.1	0.4	0.2	−0.1	0.0	0.0	−0.3	0.0	4.6
Rural Hospital Types:										
Non special status hospitals	400	0.4	1.6	−0.1	0.0	0.1	0.3	1.1	0.1	8.6
RRC	137	0.2	1.7	−0.3	−0.1	0.1	0.0	4.6	0.0	6.4
SCH	454	0.2	0.4	−0.1	0.1	0.0	0.2	0.2	0.0	4.0
Medicare-dependent hospitals (MDH)	211	0.4	1.6	−0.2	0.3	0.1	0.6	0.9	0.1	8.1

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2005 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent Changes in Payments per Case]

	No. of hosps.[1]	DRG recal[2]	Labor share split[3]	Core based stat. areas[4]	New wage data[5]	Occupational mix[6]	DRG & wage index changes[7]	MGCRB reclassification[8]	Out-migration data[9]	All FY 2005 changes[10]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
SCH and RRC	73	0.1	0.5	−0.2	0.1	0.0	0.1	1.4	0.0	4.5
Type of Ownership:										
Voluntary	2,343	0.1	0.5	0.1	0.0	0.0	0.0	0.0	0.0	4.7
Proprietary	717	0.0	0.7	−0.1	0.1	0.0	0.1	0.0	0.0	5.3
Government	776	0.1	0.7	0.1	−0.1	0.0	0.0	0.2	0.1	5.4
Unknown	68	−0.1	0.7	0.0	0.1	0.0	0.1	−0.5	0.0	5.1
Medicare Utilization as a Percent of Inpatient Days:										
0–25	227	−0.1	0.2	0.1	−0.1	0.0	−0.3	−0.2	0.0	4.4
25–50	1,122	0.0	0.4	0.0	0.1	0.0	0.0	−0.3	0.0	4.7
50–65	1,445	0.1	0.7	0.1	0.0	0.0	0.1	0.2	0.1	5.1
Over 65	937	0.1	0.7	0.0	−0.1	0.0	0.0	0.3	0.0	4.9
Unknown	173	0.0	0.4	0.1	−0.1	0.0	−0.2	−0.2	0.0	4.8
Rural Converted to Urban	164	0.2	1.2	3.6	−0.3	0.0	0.0	1.2	0.0	6.4
Urban Converted to Rural	69	0.2	0.7	−0.2	−0.1	0.0	0.1	0.3	0.0	4.8
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2005 Reclassifications:										
All Reclassified Hospitals	485	0.2	0.9	0.3	0.0	0.0	0.1	3.7	0.0	5.2
Nonreclassified Hospitals	3,326	0.1	0.5	0.0	0.0	0.0	0.0	−0.5	0.0	4.8
All Reclassified Urban Hospitals	118	0.1	0.6	1.1	0.0	0.0	0.0	3.8	0.0	14.3
Urban Nonreclassified Hospitals	2,486	0.0	0.4	0.0	0.0	0.0	0.0	−0.5	0.0	4.7
All Reclassified Rural Hospitals	367	0.2	1.1	−0.2	0.0	0.0	0.2	3.7	0.0	5.9
Rural Nonreclassified Hospitals	840	0.3	1.0	−0.2	0.1	0.0	0.3	−0.3	0.1	6.2
Other Reclassified Hospitals (Section 1886(D)(8)(B))	93	0.2	0.5	0.4	−0.3	0.0	−0.1	−0.3	0.0	4.4

[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 2003, and hospital cost report data are from reporting periods beginning in FY 2001 and FY 2000.

[2] This column displays the payment impact of the recalibration of the DRG weights based on FY 2003 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

[3] This column displays the payment impact of applying a lower labor-related share for hospitals with wage indexes less than or equal to 1.0, as required under section 403 of Public Law 108–173.

[4] This column displays the impact of the proposed adoption of the new MSAs as announced by OMB in June 2003.

[5] This column displays the impact of updating the wage index with wage data from hospitals' FY 2001 cost reports.

[6] This column displays the effects of adjusting hospitals' wage data to reflect the occupational mix based on our survey of hospitals.

[7] This column shows the payment impact of the budget neutrality adjustment factor for DRG and wage index changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 2, 3, 4 and 5, and the proposed FY 2005 budget neutrality factor of 0.994295 (the change to the labor-related share shown in column 3 is not included in the budget neutrality calculation).

[8] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2005 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2005. Reclassification for prior years has no bearing on the payment impacts shown here.

[9] This column displays the impact of the proposed implementation of section 505 of Public Law 108–173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.

[10] This column shows changes in payments from FY 2004 to FY 2005. It incorporates all of the changes displayed in columns 3, 7, 8 and 9 (the changes displayed in columns 2, 4, 5 and 6 are included in column 7). It also reflects the impact of the FY 2005 update, changes in hospitals' reclassification status in FY 2005 compared to FY 2004, and the changes in payments as a result of implementing Section 508 of the MMA. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effect.

C. Impact of the Proposed Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 2)

In column 2 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 annually 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.

We compared aggregate payments using the FY 2004 DRG relative weights (GROUPER version 21.0) to aggregate payments using the proposed FY 2005 DRG relative weights (GROUPER version 22.0). We note that, consistent with section 1886(d)(4)(C)(iii) of the Act, we have applied a budget neutrality factor to ensure that the overall payment impact of the DRG changes (combined with the wage index changes) is budget neutral. This proposed budget neutrality factor of 0.994295 is applied to payments in Column 7. Because this is a combined DRG reclassification and recalibration and wage index budget neutrality factor, it is not applied to payments in this column.

The major DRG classification changes we are proposing include: reassigning the procedure code for left ventricular assist devices (LVADs) from DRG 525 to DRG 103 (now titled ''Heart Transplant or Implant of Heart Assist System''); reassigning the procedure codes involving artificial anal sphincters from DRGs 157 and 158 to DRGs 146 (Rectal Resection With CC) and 147 (Rectal Resection Without CC); modifying the ventilation by reassigning all those cases to DRGs 504 and 505; splitting the DRG 483 into two new DRGs based on the presence or absence of major OR procedures, DRG 541 (Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses With Major Operating Room Procedure) and 542 (Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses Without Major Operating Room Procedure). In the aggregate, these proposed changes would result in 0.1 percent change in overall payments to hospitals. On average, the impacts of these changes on any particular hospital group are very small. The largest impact is a 0.2 percent increase among rural hospitals. This is likely primarily attributable to a 1.46 percent increase in DRG 127 (Heart Failure and Shock). This high-volume DRG comprises a disproportionate percentage of cases in small rural hospitals. Ten Puerto Rico hospitals also experience case mix declines of greater than 1 percent in this

column, leading to a 0.4 percent decrease overall for this row.

D. Impact of the Change in the Labor-Related Share

Section 403 of the MMA provides that, for discharges occurring on or after October 1, 2004, a hospital's labor-related share of the standardized amount will be decreased to 62 percent of the standardized amount unless such a change will result in lower total payments to the hospital. This provision also applies to the labor-related share of the standardized amount for hospitals in Puerto Rico. The overall impact of implementing this provision is a 0.5 percent payment increase to all hospitals (approximately $500 million). Large urban hospitals would experience a 0.3 percent increase while other urban hospitals would experience a 0.7 percent increase. Rural hospitals are expected to benefit from this provision with a 1.1 percent increase in payments in FY 2005.

Among regions, hospitals in Puerto Rico experience the largest increase of 6.2 percent (due to the relatively low national wage index levels in Puerto Rico). The smallest change among urban hospitals is in the New England and Pacific regions with a 0.0 percent change. The largest increase among rural regions is expected to be East South Central, with a 2.0 percent increase in payments.

E. Impact of Changing to New Labor Market Areas (Core Based Statistical Areas) From MSAs (Column 4)

In accordance with the broad discretion under section 1886(d)(3)(E) of the Act, we currently define hospital labor market areas based on the definitions of Metropolitan Statistical Areas (MSAs), Primary MSAs (PMSAs), and New England County Metropolitan Areas (NECMAs) issued by OMB. On June 6, 2003, OMB announced new Core Based Statistical Areas (CBSAs), comprised of MSAs and the new Micropolitan Statistical Areas based on Census 2000 data. CMS is proposing to adopt the new MSA definitions, including the 49 new Metropolitan areas designated under the new definitions. We are also proposing to adopt MSA definitions in New England in place of NECMAs. We are not adopting the newly defined Micropolitan Statistical Areas for use in the payment system: as a result, Micropolitan Statistical Areas will remain part of the statewide rural areas for purposes of IPPS payments. (However, as discussed in section III.B.1.d. of the preamble to this proposed rule, we are proposing a special transition policy for hospitals that were formerly in urban areas, but are now in areas considered rural or Micropolitan under the OMB definitions.) There are 46 counties with 72 hospitals that are currently in an MSA that would be treated as rural under our proposal to update the MSA definitions using only the new MSAs. To help alleviate the decreased payments for currently urban hospitals that would become rural, we are proposing to allow them to maintain their assignment to the MSA where they are currently located for the 3-year period including FY 2005, FY 2006, and FY 2007.

The impact of these changes to the new CBSAs is isolated in column 4 by holding the other payment parameters constant in this simulation. That is, column 4 shows the percentage changes in payments when going from a model using the current MSA designations to a model using the new CBSA designations (for Metropolitan areas only). Overall, the new CBSAs would lead to a zero percent change. Urban hospitals' wage indexes would increase by 0.1 percent. Rural hospitals would experience a 0.2 percent decrease in overall payments as a result of this provision. Among regions, the largest impact of updating the wage data is seen in the rural South Atlantic region (a 0.7 percent decrease). Rural hospitals in the Middle Atlantic would experience the next largest impact, with a 0.4 percent decrease.

Among urban hospitals, New England would experience a 0.4 percent decrease. These impacts result primarily from dividing the previously amalgamated Boston NECMA into four Metropolitan Divisions and several other small Metropolitan Statistical Areas. The counties that previously comprised the Boston MSA now form all or part of the Boston-Quincy, MA Metropolitan Division, the Cambridge-Newton-Framingham, MA Metropolitan Division, the Essex County, MA Metropolitan Division, the Rockingham County-Strafford County Metropolitan Division, the Manchester-Nashua Metropolitan Statistical Area, the Providence-New Bedford-Fall River, RI-MA Metropolitan Statistical Area, and the Worcester, MA Metropolitan Statistical Area. The Rockingham County-Strafford County Metropolitan Division, Manchester-Nashua MSA, and Boston-Quincy Metropolitan Division experience 9.4, 6.9, and 5.7 percent decreases, respectively.

As described in section III of the preamble to this proposed rule, to help alleviate the decreased payments for currently urban hospitals that would become rural, we are proposing to allow them to maintain their assignment to the MSA where they are currently located for the 3-year period including FY 2005, FY 2006, and FY 2007. The impact upon these hospitals is shown in the row labeled ''Urban to Rural Hospitals.'' Conversely, the row labeled ''Rural to Urban Hospitals'' displays formerly rural hospitals that are now in MSAs under the new definitions.

F. Impact of Proposed Wage Index Changes (Columns 5 and 6)

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 2005 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001. The impact of the new data on hospital payments is isolated in column 5 by holding the other payment parameters constant in this simulation. That is, column 5 shows the percentage changes in payments when going from a model using the FY 2004 wage index, based on FY 2000 wage data, to a model using the FY 2005 pre-reclassification wage index, based on FY 2001 wage data. The wage data collected on the FY 2001 cost report is the same as the FY 2000 wage data that were used to calculate the FY 2004 wage index. However, for the FY 2005 wage index, we added an occupational mix adjustment to the wage index. The occupational mix adjustment is based on data collected on the Medicare Wage Index Occupational Mix Survey, Form–CMS–10079. The data collection period for the survey was calendar year 2003 through February 7, 2004. The effects of the occupational mix adjustment are shown in the next column (6).

Column 5 shows the impacts of updating the wage data using FY 2001 cost reports. Overall, the new wage data would lead to a 0.0 percent change. Urban hospitals' wage indexes would not change (0.0 percent), and rural hospitals' wage indexes would also remain the same (0.0 percent). Among regions, the largest declines from updating the wage data are seen in urban Middle Atlantic and Mountain regions (a 0.7 and 0.4 percent decreases, respectively). In the Middle Atlantic, there are 352 hospitals (New York, Pennsylvania, and New Jersey) that are experiencing a drop in their wage index relative to last year with the introduction of the new wage data. Kingston, NY experiences a drop of 5.8 percent, while Buffalo sees a 2.8 percent drop. Additionally, two of the areas are divisions of New York City, including the Manhattan area (New York-Wayne-White Plains, NY) and Suffolk-Nassau, NY. While these areas do not necessarily experience a significant drop (2.5 and 1.5 percent), they include a large number of inpatient hospitals. Pittsburgh, PA, Rochester, NY, and Allentown, PA also see decreases due to this change. We note that this is due to below average increases in their average hourly wage and not as a result of real average hourly wage declines. Urban hospitals in the West South Central region would experience the next largest impact, with a 0.5 percent increase. The rural East South Central and Middle Atlantic regions experience 0.3 and 0.2 percent decreases, respectively while the Pacific, West South Central, and New England regions each experience a 0.3 percent increase.

The national average hourly wage increased 6.41 percent compared to FY 2004. Therefore, the only manner in which to maintain or exceed the previous year's wage index was to match the national 6.41 increase in average hourly wage. Of the 3,887 hospitals with wage index values in both FYs 2004 and 2005, 1,937, or 49.8 percent, also experienced an average hourly wage increase of 6.41 percent or more.

The following chart compares the shifts in wage index values for hospitals for FY 2005 relative to FY 2004. Among urban hospitals, 89 would experience an increase of between 5 percent and 10 percent and 45 would experience an increase of more than 10 percent. A total of 7 rural hospitals would experience increases greater than 5 percent, but none would experience increases of greater than 10 percent. On the negative side, 36 urban hospitals would experience decreases in their wage index values of at least 5 percent, but less than 10 percent. Two urban hospitals would experience decreases in their wage index values greater than 10 percent.

The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	No. of hospitals	
	Urban	Rural.
Increase more than 10 percent	45	0.
Increase more than 5 percent and less than 10 percent	89	7.
Increase or decrease less than 5 percent	2,625	1,609.
Decrease more than 5 percent and less than 10 percent	36	0.
Decrease more than 10 percent	2	1

The next column (6) shows the impacts on the calculation of the FY 2005 wage index of adjusting for occupational mix. Section 1886(d)(3)(E) of the Act provides for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index, beginning with the FY 2005 wage index. A complete discussion of the initial collection of these data and the occupational mix adjustment that we are proposing to apply, beginning October 1, 2004 (the FY 2005 wage index), appears under section III.C. of this preamble. The calculation of the wage index now includes a blended rate of 90 percent of an unadjusted wage index and 10 percent of a wage index adjusted for occupational mix. We project an overall change increase of 0.0 percent for all hospitals. The biggest change is in the rural urban hospitals in the South Atlantic, East South Central, and West South Central regions, which are projected to experience a 0.1 percent increase for FY 2005.

G. Combined Impact of Proposed DRG and Wage Index Changes, Including Budget Neutrality Adjustment (Column 7)

The impact of the DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this proposed rule, we compared simulated aggregate payments using the FY 2004 DRG relative weights and wage index to simulated aggregate payments using the proposed FY 2005 DRG relative weights and blended wage index.

We computed a proposed wage and recalibration budget neutrality factor of 0.994295. The 0.0 percent impact for all hospitals demonstrates that these proposed changes, in combination with the budget neutrality factor, are budget neutral. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index are shown in column 7. The proposed changes in this column are the sum of the final changes in columns 2, 5, and 6 combined with the budget neutrality factor and the wage index floor for urban areas required by section 4410 of Pub. L. 105–33, to be budget neutral (the change to the labor share in column 3 is not subject to budget neutrality. There also may be some variation of plus or minus 0.1 percentage point due to rounding.

Among urban regions, the largest impacts are in the Middle Atlantic and Puerto Rico, with 0.8 and 0.7 percent declines, respectively. The West South Central region experiences the largest increase of 0.5 percent. Among rural regions, the West North Central and Pacific regions benefit the most with 0.5 percent increases, while East South Central is the only region to experience a decline (0.1 percent).

H. Impact of MGCRB Reclassifications (Column 8)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 8 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2005. These decisions affect hospitals' standardized amount and wage index area assignments.

By February 28 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. The MGCRB may approve a hospital's reclassification request for the purpose of using another area's wage index value. The proposed FY 2005 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2005. The wage index values also reflect any decisions made by the CMS Administrator through the appeals and review process through February 28, 2004. 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 2005.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, we applied an adjustment of 0.994295 to ensure that the effects of reclassification are budget neutral. (*See* section II.A.4.b. of the Addendum to this proposed rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments would rise 1.9 percent in column 8. Payments to urban hospitals would decline 0.3 percent. Hospitals in other urban areas would experience an overall decrease in payments of 0.2 percent, while large urban hospitals would also lose 0.4 percent. Among urban hospital groups (that is, bed size, census division, and special payment status), payments generally would decline.

A positive impact is evident among most of the rural hospital groups. The smallest increases among the rural census divisions are 0.5 percent in the Mountain region and 1.3 percent each for the New England and West North Central regions. The largest increases are in the rural East South Central region, with an increase of 2.8 percent and in the West South Central region that would experience an increase of 3.0 percent.

Among all the hospitals that were reclassified for FY 2005 (including hospitals that received wage index reclassifications in FY 2003 or FY 2004 that extend for 3 years), the MGCRB changes are estimated to provide a 3.7 percent increase in payments. Urban hospitals reclassified for FY 2005 are expected to receive an increase of 3.8 percent, while rural reclassified hospitals are expected to benefit from the MGCRB changes with a 3.7 percent increase in payments. Payments to urban and rural hospitals that did not reclassify are expected to decrease slightly due to the MGCRB changes, decreasing by 0.5 percent for urban hospitals and 0.3 percent for rural hospitals.

I. Impacts of Implementing the Wage Index Adjustment for Out-Migration (Column 9)

Section 505 of Public Law 108–173 established new section 1886(d)(13) of the Act. Section 1886(d)(13) requires that the Secretary establish a new process to make adjustments to the hospital wage index based on commuting patterns of hospital employees. The process provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different area with a higher wage index. Hospitals located in counties that qualify for the payment adjustment would receive an increase in the wage index that is equal to a weighted average of the difference between the wage index of the resident county and the higher wage index work area(s) weighted by the overall percentage of workers who are employed in an area with a higher wage index. Using our proposed criteria, 224 counties and 411 hospitals qualify to receive a commuting adjustment.

Due to the statutory formula to calculate the adjustment and the small number of counties that qualify, the impact on hospitals would be minimal, with an overall impact on all hospitals of 0.0 percent. However, some regions would experience a discernible impact. For example, urban hospitals in the Middle Atlantic region would experience a 0.1 percent increase due to this provision. This is due in part to the fact that a hospital in that region would experience the largest increase for any hospital under this provision. A hospital located in Ulster County, New York would receive an increase in its wage index value of 0.1014. Hospital employees living in Ulster County commute to Albany, Columbia, Dutchess, Greene, New York, Orange, Rockland, Sullivan, and Westchester counties. Dutchess, New York, Orange, Rockland and Westchester counties are located in higher wage index areas. Thus, for FY 2005, this hospital's wage index would increase from 0.8874 to 0.9888.

J. All Changes (Column 10)

Column 10 compares our estimate of payments per case, incorporating all changes reflected in this proposed rule for FY 2005 (including statutory changes), to our estimate of payments per case in FY 2004. This

column includes all of the proposed policy changes. Because the reclassifications shown in column 8 do not reflect FY 2004 reclassifications, the impacts of FY 2005 reclassifications only affect the impacts from FY 2004 to FY 2005 if the reclassification impacts for any group of hospitals are different in FY 2005 compared to FY 2004.

Column 10 reflects all FY 2005 changes relative to FY 2004, shown in columns 2 through 9 and those not applied until the final rates are calculated. The average increase for all hospitals is approximately 4.9 percent. This increase includes the effects of the 3.3 percent market basket update. It also reflects the 0.7 percentage point difference between the projected outlier payments in FY 2004 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2004 (4.4 percent), as described in the introduction to this Appendix and the Addendum to this proposed rule. As a result, payments are projected to be 0.7 percent lower in FY 2004 than originally estimated resulting in a 0.7 percent higher increase for FY 2005 than would otherwise occur. It also includes the impact of adjusting the labor share, shown in column 3, of approximately 0.5 percent. The remaining 0.4 percent increase is attributable to the indirect medical education formula changes for teaching hospitals; changes in payments due to the wage reclassifications under section 508 of the MMA, in effect for the whole year; and increased payments to Puerto Rico hospitals as a result of section 504 of the MMA, which changed the mix of the Federal standardized amount and the Puerto Rico-specific standardized amount. The overall increase also reflects changes to payments that resulted from implementing other changes as required by Public Law 108–173. These changes are discussed in other rules and in many sections of the preamble to this proposed rule.

Section 213 of Public Law 106–554 provides that all SCHs may receive payment on the basis of their costs per case during their cost reporting period that began during 1996. For FY 2005, eligible SCHs receive 100 percent of their 1996 hospital-specific rate. The impact of this provision is modeled in column 10 as well. Additionally, section 402 of Public Law 108–173 increases the disproportionate share hospital (DSH) adjustment for certain hospitals that serve a disproportionate share of low-income Medicare and Medicaid patients, which includes rural hospitals and urban hospitals with fewer than 100 beds, sole community hospitals, rural referral centers, and rural hospitals with less than 500 beds. The increase in DSH payments became effective for discharges occurring on or after April 1, 2004. As provided in the new Medicare law, the cap on DSH payment adjustments increase from 5.25 percent to 12 percent for urban hospitals fewer than 100 beds, sole community hospitals, and rural hospitals with less than 500 beds. There is no cap on rural referral centers, large urban hospitals over 100 beds, or rural hospitals over 500 beds.

We are no longer required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. However, we are still providing an estimate of the payment increases here, as they will have a significant impact on total payments made in FY 2005. As discussed in section II.E. of the preamble of this proposed rule, we are proposing to maintain the new technology status of the InFUSE™ Bone Graft/LT-CAGE™ Lumbar Tapered Fusion Device for spinal fusions. We estimate the total add-on payments associated with cases involving this new device for FY 2005 would be $4.7 million. In addition, several other technologies may receive approval if we receive appropriate supplemental data from the applicants (as discussed in the preamble) and after public comments are taken into consideration for approval or denial of the technologies for FY 2005. If we receive the necessary supplemental data for all of the devices that could be approved were to be approved, the total estimated increase in payments for FY 2005 could be $369 million.

There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 10 may not equal the sum of the changes described above.

The overall change in payments per case for hospitals in FY 2005 would increase by 4.9 percent. Hospitals in urban areas would experience a 4.7 percent increase in payments per case compared to FY 2004. Hospitals in rural areas, meanwhile, would experience a 6.0 percent payment increase. Hospitals in large urban areas would experience a 4.5 percent increase in payments and hospitals in other urban areas would experience a 5.0 percent increase in payments.

Among urban census divisions, the largest payment increase would be 14.3 percent in Puerto Rico. This is due largely to the change in calculation of their payment rate to 75 percent of the National amount and the increase to the standardized amount to large urban hospitals. Additionally, the change to CBSAs makes all hospitals in Puerto Rico classify as urban hospitals instead of rural. (Because of these changes, we have deleted from Table I, the column included in prior years that shows the impacts on rural Puerto Rico hospitals.) Hospitals in the urban East South Central and West South Central regions would experience overall increases of 5.5 percent and 5.7 percent, respectively. The smallest increase would occur in the New England region, with an increase of 3.6 percent.

Among rural regions in column 10, no hospital category would experience overall payment decreases. The East South Central and West South Central regions would benefit the most, with 9.4 and 7.2 percent increases, respectively. The smallest increase would occur in the New England region, with 3.9 percent increases in payments.

Among special categories of rural hospitals in column 10, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) would experience payment increases of 4.0 percent, 8.1 percent, and 4.5 percent, respectively. This outcome is primarily related to the fact that, for hospitals receiving payments under the hospital-specific methodology, there were several increases to payments made in relation to implementation of the Public Law 108–173.

Hospitals that were reclassified for FY 2005 are estimated to receive a 5.2 percent increase in payments. Urban hospitals reclassified for FY 2005 are anticipated to receive an increase of 4.3 percent, while rural reclassified hospitals are expected to benefit from reclassification with a 5.9 percent increase in payments. Those hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act are expected to receive an increase in payments of 4.4 percent.

TABLE II.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2005 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per Case]

	Number of hospitals	Average FY 2004 payment per case [1]	Average FY 2005 payment per case [1]	All FY 2005 changes
	(1)	(2)	(3)	(4).
By Geographic Location:.				
All hospitals	3,904	7812	8193	4.9.
Urban hospitals	2,696	8121	8504	4.7.
Large urban areas (populations over 1 million)	1,424	8513	8896	4.5.
Other urban areas (populations of 1 million of fewer)	1,272	7684	8067	5.0.
Rural hospitals	1,208	6110	6475	6.0.
Bed Size (Urban):.				
0–99 beds	684	5812	6142	5.7.
100–199 beds	966	6914	7233	4.6.

TABLE II.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2005 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per Case]

	Number of hospitals (1)	Average FY 2004 payment per case [1] (2)	Average FY 2005 payment per case [1] (3)	All FY 2005 changes (4).
200–299 beds	500	7967	8316	4.4.
300–499 beds	415	8839	9266	4.8.
500 or more beds	131	10221	10718	4.9.
Bed Size (Rural):.				
0–49 beds	549	5199	5527	6.3.
50–99 beds	393	5751	6100	6.1.
100–149 beds	163	6048	6412	6.0.
150–199 beds	57	6636	7027	5.9.
200 or more beds	46	7837	8275	5.6.
Urban by Region:.				
New England	137	8688	8997	3.6.
Middle Atlantic	397	8809	9136	3.7.
South Atlantic	419	7762	8147	5.0.
East North Central	450	7830	8195	4.7.
East South Central	175	7482	7896	5.5.
West North Central	160	8008	8416	5.1.
West South Central	346	7632	8063	5.7.
Mountain	140	8066	8376	3.8.
Pacific	421	9612	10080	4.9.
Puerto Rico	51	3525	4028	14.3.
Rural by Region:.				
New England	34	8037	8354	3.9.
Middle Atlantic	57	6138	6398	4.2.
South Atlantic	176	6087	6439	5.8.
East North Central	160	5998	6266	4.5.
East South Central	192	5241	5735	9.4.
West North Central	206	6514	6883	5.7.
West South Central	228	5514	5913	7.2.
Mountain	93	6918	7219	4.4.
Pacific	62	8934	9336	4.5.
By Payment Classification:.				
Urban hospitals	2,624	8148	8533	4.7.
Large urban areas (populations over 1 million)	1,405	8530	8915	4.5.
Other urban areas (populations of 1 million of fewer)	1,219	7716	8101	5.0.
Rural areas	1,280	6104	6462	5.9.
Teaching Status:.				
Non-teaching	2,787	6542	6880	5.2.
Fewer than 100 Residents	916	8172	8561	4.8.
100 or more Residents	201	12131	12672	4.5.
Urban DSH:.				
Non-DSH	1,156	7020	7347	4.7.
100 or more beds	1,465	8695	9101	4.7.
Less than 100 beds	335	5540	5927	7.0.
Rural DSH:	482	6592	6914	4.9.
Sole Community (SCH)..				
Referral Center (RRC)	157	6735	7147	6.1.
Other Rural:.				
100 or more beds	68	5131	5588	8.9.
Less than 100 beds	241	4483	4937	10.1.
Urban teaching and DSH:	800	9558	9997	4.6.
Both teaching and DSH..				
Teaching and no DSH	250	8015	8399	4.8.
No teaching and DSH	1,000	6963	7315	5.1.
No teaching and no DSH	574	6512	6810	4.6.
Rural Hospital Types:.				
Non special status hospitals	400	4754	5163	8.6.
RRC	137	6179	6572	6.4.
SCH	454	7181	7467	4.0.
Medicare-dependent hospitals (MDH)	211	4434	4792	8.1.
SCH and RRC	73	7676	8019	4.5.
Type of Ownership:.				
Voluntary	2,343	7926	8298	4.7.
Proprietary	717	7125	7503	5.3.
Government	776	7958	8385	5.4.
Unknown	68	7853	8256	5.1.

TABLE II.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2005 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per Case]

	Number of hospitals (1)	Average FY 2004 payment per case [1] (2)	Average FY 2005 payment per case [1] (3)	All FY 2005 changes (4).
Medicare Utilization as a Percent of Inpatient Days:.				
0–25	227	10405	10866	4.4.
25–50	1,122	8578	8985	4.7.
50–65	1,445	6956	7307	5.1.
Over 65	937	6900	7240	4.9.
Unknown	173	9887	10358	4.8.
Rural Converted to Urban	164	6473	6888	6.4.
Urban Converted to Rural	69	6097	6387	4.8.
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2005 Reclassifications:.				
All Reclassified Hospitals	485	7316	7699	5.2.
All Nonreclassified Hospitals	3,326	7909	8291	4.8.
All Reclassified Urban Hospitals	118	8258	8612	4.3.
Urban Nonreclassified Hospitals	2,486	8151	8538	4.7.
All Reclassified Rural Hospitals	367	6816	7215	5.9.
Rural Nonreclassified Hospitals	840	5402	5734	6.2.
Other Reclassified Hospitals (Section 1886(d)(8)(B))	93	5971	6237	4.4

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

Table II presents the projected impact of the proposed changes for FY 2005 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated payments per case for FY 2004 with the average estimated per case payments for FY 2005, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from column 10 of Table I.

VII. Impact of Other Proposed Policy Changes

In addition to those proposed changes discussed above that we are able to model using our IPPS payment simulation model, we are proposing various other changes in this proposed rule. Generally, we have limited or no specific data available with which to estimate the impacts of these proposed changes. Our estimates of the likely impacts associated with these other proposed changes are discussed below.

A. Impact of Proposed Change to Postacute Care Transfer Payment Policy

Existing regulations at § 412.4(b) define transfers from one acute care hospital to another, and § 412.4(c) defines transfers to certain postacute care providers. The per diem rate paid to a transferring hospital is calculated by dividing the full DRG payment by the geometric mean length of stay for the DRG. The transferring hospital receives a per diem payment for cases that are transferred prior to the geometric mean length of stay for the DRG (§ 412.4(f)(1)). Under section IV.A. of the preamble of this proposed rule, we discuss our proposal to provide alternate criteria for determining which DRGs are included within the scope of the postacute care transfer policy. The occasion for this proposed revision is our decision to delete DRG 483, and to assign the cases that previously were included within DRG 483 to two new DRGs, 541 and 542. As a result of these proposed revised criteria, three additional DRGs would fall within the scope of the policy. These are the two proposed new DRGs, 541 and 542, along with DRG 430. We estimate that the net effect of these proposed changes will be to reduce Medicare program payments by approximately $25 million per year. The proposed change is entirely due to the effect of adding DRG 430 to the policy. The proposed inclusion of proposed new DRGs 541 and 542 will have no effect on payments, because all of the cases included within those proposed DRGs were previously included within DRG 483 and, thus, already fall within the policy.

B. Impact of Proposed LTC-DRG Reclassifications and Relative Weights for LTCHs

In section II.D. of the preamble of this proposed rule, we discuss the proposed changes in the LTC-DRG relative weights for FY 2005 on the proposed version 22.0 of the CMS GROUPER. We estimate that the proposed changes would result in an aggregate decrease in LTCH payments of approximately a $55 million based on LTCH cases in the FY 2003 MedPAR file. As we discuss in further detail in the 2005 LTCH PPS rate year final rule published on May 7, 2004, based on an analysis of LTCH claims data in the FY 2003 MedPAR file. We have found that the average LTC-DRG relative weight has increased due to an increase of cases being assigned to LTC-DRGs with higher relative weights. This increase may be attributable to a number of factors, including improvements in coding practices, which are typically found when moving from a reasonable cost-based payment system to a PPS. The impact of including cases with relatively lower charges into LTC-DRGs that have a relatively higher relative weight in the GROUPER version 21.0 (FY 2004) is a decrease in the average relative weight for those LTC-DRGs in proposed GROUPER version 22.0. We believe that the proposed changes in the LTC-DRG relative weights, which include a number of proposed LTC-DRGs with lower proposed relative weights, would result in a slight decrease in LTCH PPS payments.

C. Impact of Proposed Policy on Payments for Inpatient Care in Providers That Change Classification Status During a Patient Stay

In section IV.B. of the preamble to this proposed rule, we discuss our proposal to change our policy to preclude making more than one payment under Medicare for cases in which a Medicare provider changes its Medicare payment classification during a patient's stay. Although this situation may occur in other settings, this payment issue is most prevalent for services furnished to cross-over patients in a newly established LTCH. Currently, when this situation arises, Medicare makes two payments for what is essentially only one beneficiary episode of care, one under the IPPS and one under the LTCH PPS. The intent of this proposed policy is to eliminate the Medicare payments for the single episode of care of such patients. While we believe that this proposed policy may generate savings for the Medicare program, we do not have readily available data to precisely estimate the effect of this proposed change. Because these proposed revisions would only affect new hospitals, we are unable to estimate the number of hospitals that would be affected. Furthermore, we cannot estimate the specific

DRGs that would be affected at those hospitals.

D. Impact on Proposed Policy Reporting of Hospital Quality Data for Annual Hospital Payment Update

In section IV.E. of the preamble to this proposed rule, we discuss the implementation of section 501(a) of Public Law 108–173, which provides that, the update factor for the operating payments for FY 2005 and subsequent fiscal years is the market basket percentage increase. Section 501(b) also provides that, for FYs 2005 through 2007, the update factor will be the market basket percentage increase minus 0.4 percentage points for any hospital that does not submit quality data as specified in the law. We are unable to precisely estimate the effect of this provision because, while receiving the full update for those years is conditional upon the submission of quality data by a hospital, submission of the data is not mandated unconditionally. Furthermore, hospitals will not begin to submit the quality data until very late in the process of developing the final rule for FY 2005. The Congressional Budget Office, in its analysis of Public Law 108–173, assumed that a significant number of hospitals would not provide the data required for a full payment update, and therefore estimated savings to the Medicare program of approximately $100 million per year. However, there has been a steady increase in the number of hospitals that are voluntarily submitting the specified quality data under the National Voluntary Hospital Reporting Initiative. We have also made efforts to ensure that QIOs provide assistance to all hospitals that wish to submit data. Therefore, we believe that a high proportion of hospitals will respond to the incentive provided by section 501(b) and submit quality data in order to receive the full update. For purposes of this proposed rule, we are assuming that no appreciable savings will result from this provision.

E. Impact of Proposed Policy on Threshold Criteria for Add-On Payments for New Technology and Medical Services

In section IV.H. of the preamble of this proposed rule, we discuss our proposal to revise the threshold amount for determining whether a new technology or medical service is an appropriate candidate for an add-on payment if it is inadequately paid otherwise under the DRG system. Furthermore, we are no longer required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. However, these payments will have a significant impact on total payments made in FY 2005. As discussed in section II.E. of the preamble of this proposed rule, we are proposing to maintain the new technology status of the INFUSE™ Bone Graft/LT-CAGE™ Lumbar Tapered Fusion Device for spinal fusions. We estimate the total add-on payments associated with cases involving this new device for FY 2005 would be $4.7 million. In addition, several other technologies may receive approval if we receive appropriate supplemental data from the applicants (as discussed in the preamble) and other interested parties. Therefore, if we approve all the devices that may warrant approval, the total estimated increase in payments for FY 2005 could be $369 million.

F. Impact of Proposed Policy on Additional Payments to Hospitals With High Percentage of End-Stage Renal Disease Discharge

In section IV.J. of the preamble of this proposed rule, we discuss our proposal to revise our regulations to state that, in determining whether a hospital qualifies for additional Medicare payments for hospitals with high percentages of ESRD discharges, only discharges involving ESRD Medicare beneficiaries who have received a dialysis treatment during an inpatient hospital stay are to be counted.

This proposed revision to the policy would reduce the number of hospitals that will qualify for this additional payment. Specifically, discharges of Medicare ESRD beneficiaries who have not received dialysis treatment during the course of their hospital stays will no longer be counted in determining whether hospitals meet the threshold for receiving this additional payment. Some hospitals that have previously qualified for this extra payment would not qualify under this proposed revised policy. Therefore, the effect of this change would be a reduction in Medicare program expenditures. However, we are unable to quantify the level of program savings because we lack data on the proportion of the discharges previously counted toward the threshold determination under this provision that involved Medicare ESRD beneficiaries who did not receive dialysis services during their hospital stays. Overall program expenditures under this provision have been approximately $15 million annually to approximately 41 hospitals. We estimate that, the savings due to this policy change will only be some proportion of that figure since some portion of these hospitals, which currently qualify for the adjustment, will no longer qualify for these payments under the revised criteria.

G. Impact of Proposed Policy on Payment Adjustments for Low-Volume Hospitals

In section IV.M. of the preamble of this proposed rule, we discuss our proposal to implement section 406 of Public Law 108–173, which provides for a new payment adjustment to account for the higher costs per discharge of low-volume hospitals under the IPPS.

Based on the empirical analysis, we are limiting the adjustment to hospitals with 500 or fewer discharges. It is difficult to estimate precisely the impact of this provision. While there were approximately 400 hospitals with 500 or fewer total discharges in the most recent year for which we have data, many of these hospitals may qualify for CAH status under the revised bed count threshold (under section 405(e) of Pub. L. 108–173). Furthermore, we have not yet determined which hospitals satisfy the requirement that the hospital be located more than 25 road miles from another subsection (d) hospital. We are proposing to require that a hospital that wishes to qualify for the adjustment must provide its fiscal intermediary with evidence that it meets this distance requirement. Until intermediaries are able to make these determinations, we are unable to determine how many hospitals qualify for the adjustment.

However, the aggregate impact of this provision is likely to be relatively small. Hospitals with fewer than 500 total discharges in a year are likely to have correspondingly few Medicare discharges, perhaps 200 Medicare discharges or fewer. The largest percentage adjustments under the proposed formula that we have developed would be realized by the smallest hospitals. For example, a hospital with 50 total discharges will receive an adjustment on each Medicare discharge (probably 20 to 25 Medicare discharges annually) of 22.5 percent. A hospital with 499 total discharges would receive an adjustment of only 0.05 percent on each Medicare discharge. The Congressional Budget Office's estimated that this provision would increase Medicare program expenditures by less than $50 million annually. In the absence of a more precise estimate for the reasons indicated above, we agree with the Congressional Budget Office's determination.

H. Impact of Proposed Policy on MGCRB Hospital Reclassifications

Sections 1886(d)(2)(D) and (d)(3) of the Act previously required the Secretary to compute two average standardized amounts for discharges occurring in a fiscal year: one for hospitals located in large urban areas and one for hospitals located in other areas. In addition, under sections 1886(d)(9)(B)(iii) and (d)(9)(C)(i) of the Act, the average standardized amount per discharge was determined for hospitals located in large urban and other areas in Puerto Rico. In accordance with section 1886(b)(3)(B)(i) of the Act, the large urban average standardized amount was 1.6 percent higher than the other area average standardized amount.

Section 402(b) of Public Law 108–7 required that, effective for discharges occurring on or after April 1, 2003, and before October 1, 2003, the Federal rate for all IPPS hospitals would be based on the large urban standardized amount. Subsequently, Public Law 108–89, extended section 402(b) of Public Law 108–7 beginning with fiscal year 2004 and thereafter, and equal standardized amount is to be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. This provision in effect makes permanent the equalization of the standardized amounts at the level of the previous standardized amount for large urban hospitals. As a result of this legislative change, the standardized amount reclassification criterion is no longer necessary or appropriate. Therefore, as discussed in section IV.N. of this proposed rule, we are proposing to remove all standardize amount criteria provisions from the regulations governing geographic reclassification. Specifically, we are proposing to remove the provisions that contain the criterion requiring individual hospitals and urban hospital groups to demonstrate that their costs are more comparable to the average amount they would be paid if they were reclassified than

the amount they would be paid if they were reclassified than the amount they would be paid under their current classification.

In conjunction with this change, we are proposing under the Secretary's general authority to make exceptions that any hospital whose urban county group application under § 412.234 would have been approved by the MGCRB for FY 2004 and FY 2005, but for the failure to meet the requirements in § 412.234(c), will be assigned the wage index for the MSA identified in the FY 2004 and FY 2005 group application (in cases where the group identified more than one preference, the hospital will be assigned the wage index that is most advantageous).

For our proposal to remove all standardized amount criteria provisions from the regulations, we are unable to quantify the impact of this change precisely. The deletion of the standardized amount criterion may allow more hospital group applications to qualify for reclassification. However, we cannot determine how many groups would be affected by this change, and, of those, how many groups would actually organize to apply under the revised standard. This change would not affect the aggregate level of Medicare expenditures since reclassification decisions are budget neutral under section 1886(d)(8)(B) of the Act. However, the exercise of the Secretary's exception authority to assign a new wage index to certain hospitals that failed to be approved for reclassification in FY 2004 and FY 2005 is not budget neutral. Our review of the group reclassification applications for those years indicates that only a very small number of hospitals would qualify for a new wage index assignment under this proposed exception. While we are unable to be certain about the exact number of hospitals that would qualify, we believe that the aggregate impact on program payments would be in the range of $10 million to $20 million annually for the three years during which this exception would be in place.

In addition, we are unable to quantify the precise impact of the proposed change precisely to the average hourly wage threshold for rural referral centers. Only a limited number of rural referral centers are actually located in urban areas. Effective October 1, 2000, if a hospital located in what is now an urban area was ever a rural referral center, it is reinstated to rural referral center status (65 FR 47089). We are unable to determine how many of these rural referral centers that would not otherwise have qualified for reclassification would now be able to meet the 82 percent threshold. However, this change would not affect the aggregate level of Medicare expenditures since reclassification decisions are budget neutral under section 1886(d)(8)(B) of the Act. The exercise of the Secretary's exception authority to assign a new wage index to certain rural referral centers that failed to be approved for reclassification in FY 2005 is not budget neutral. Our review of the reclassification applications indicates that only a very small number of hospitals would qualify for a new wage index assignment under this proposed exception. While we are unable to be certain about the exact number of hospitals that would qualify, we believe that the aggregate impact on program payments would be in the range of $10 million to $20 million for the one-year during which this exception would be in effect.

Further, we anticipate that our proposed use of the authority in section 1886(d)(5)(I)(i) of the statute, to provide special protection to a small number of hospitals in States with fewer than 10 people per square mile (as determined using 2000 census data) would only increase Medicare program expenditures by $3 million to $5 million at the maximum. We believe that Medicare expenditures associated with this change would not exceed this level because many of the SCHs in the States where the exception would be applied have already qualified for reclassification effective for discharges on or after October 1, 2004. Furthermore, these hospitals are relatively small, and some of them are paid under their hospital specific rates, which restricts the gain from reclassification in most cases to capital PPS payments and payments for outpatient services.

I. Impact of Proposed Policy on Payment for Direct Costs of Graduate Medical Education

1. Redistribution of Unused Resident Slots

As discussed in section IV.O.2.b. of this preamble, section 422 of Public Law 108–173 added a new section 1886(h)(7) to the Act that provides for reductions in the statutory FTE resident caps under Medicare for certain hospitals and authorizes a ''redistribution'' of the FTE resident slots resulting from the reduction in the FTE resident caps to other hospitals.

For purposes of this proposed rule, we have estimated the impact of section 422 on hospitals for FY 2005, making assumptions about update factors, geographic (locality) adjustment factors, and the number of unused residency positions for each hospital. For purposes of calculating the impact for direct GME payments, we used the projected national average per resident amount (PRA) for FY 2005 of $82,249, as determined in accordance with existing § 413.86(e)(4)(ii)(B) (proposed to be redesignated as § 413.77(d)(2)(ii) in this proposed rule), since section 1886(h)(7)(B)(v) of the Act requires that a hospital that receives an increase in its direct GME FTE resident cap under section 1886(h)(7)(B) of the Act will receive direct GME payments with respect to those additional FTE residents using the locality-adjusted national average PRA. Based on our analysis of hospitals' FTE resident caps and FTE resident counts from the Hospital Cost Report Information System (HCRIS) for the most recent cost reporting periods ending on or before September 30, 2002, and making assumptions for hospitals that submit a timely request to use their cost report that includes July 1, 2003, we estimate that approximately 2,600 FTE resident slots that were previously unfilled (and therefore, no direct GME or IME payments were made for those slots) would be redistributed to and filled by hospitals that request an increase to their FTE residents caps under section 1886(h)(7)(B). (We note that this estimate of 2,600 slots is not necessarily the same as the estimate we would ultimately use to redistribute resident positions under section 1886(h)(7)(B)). Since payments for direct GME are determined based on a hospital's Medicare inpatient utilization, for purposes of this impact, we have applied a factor of .35 as the average Medicare inpatient utilization. Accordingly, for FY 2005, we estimate an increase of $75.6 million in direct GME payments.

For purposes of estimating the impact on IME payments, we used an IME formula multiplier of 0.66, since section 1886(d)(5)(B)(ix) states that for a hospital whose FTE resident cap is increased as a result of a redistribution of unused resident positions, the IME adjustment factor is to be calculated using a formula multiplier of 0.66 with respect to any additional residents counted by the hospital as a result of that increase in the hospital's FTE resident cap. Based on an estimate of unused resident positions using FTE resident data from HCRIS for the most recent cost reporting periods ending on or before September 30, 2002, and making assumptions for hospitals that submit a timely request to use their cost report that includes July 1, 2003, we estimate that for FY 2005, IME payments would increase by approximately $66.5 million. Thus, since section 422 is not effective until the fourth quarter of FY 2005 (that is, July 1, 2005), the estimated total increase in Medicare payments for FY 2005 attributable to section 422 is $35.53 million ([$75.6 million + $66.5 million] divided by 4).

2. Per Resident Amount: Extension of Update Limitation on High-Cost Programs

In section IV.O.4. of the preamble of this proposed rule, we discuss our proposal to implement section 711 of Public Law 108–173, which freezes the annual CPI–U inflation factors to hospital-specific PRAs for direct GME payments for those PRAs that exceed the established ceiling for FYs 2004 through 2013. Under existing regulations, for FY 2005, if a hospital's PRA for the previous cost reporting period would be greater than 140 percent of the locality-adjusted national average PRA for that same previous cost reporting period, the hospital's PRA would be updated for inflation, except that the CPI–U applied for a 12-month period is reduced by 2 percentage points. Under the new provisions of section 711 of Pub. L. 108–173 for FY 2005, if a hospital-specific PRA for the previous cost period would be greater than 140 percent of the locality-adjusted national average PRA for that same previous cost reporting period, the hospital-specific PRA would be frozen at the FY 2004 PRA, and not updated for inflation. Therefore, the impact in direct GME payments for FY 2005 (attributable to section 711 of the Public Law 108–173) is the difference between updating the PRAs by the applicable CPI–U inflation factor minus 2 percentage points, and not updating the PRAs by any CPI–U inflation factor. We have calculated an impact for this provision, but the resulting savings are negligible (less than $100,000).

3. Residents Training in Nonhospital Settings

In section IV.O.5. of the preamble of this proposed rule, we discuss our proposal to implement section 713 of Public Law 108–173, which, through a moratorium, allows hospitals to count allopathic or osteopathic

family practice residents training in nonhospital settings for IME and direct GME without regard to the financial arrangements between the hospital and the teaching physician practicing in the nonhospital setting in which the resident is assigned. We are unable to quantify the impact of these provisions because we do not know the number of residents or programs that are affected by these changes.

In addition, under IV.O.5. of this preamble, we discuss our proposed changes related to requirements for written agreements for residency training in nonhosital settings. We are proposing to revise the regulations to remove the requirement for a written agreement between the hospital and the nonhospital setting as a precondition for a hospital to count residents training in nonhospital settings for purposes of direct GME and IME payments. We are also proposing that, in order for the hospital to count residents training in a nonhospital setting, the hospital must pay for the nonhospital site training costs concurrently with the training that occurs during the cost reporting period. There is no monetary impact related to this proposed change because this proposal is administrative in nature, and does not affect a hospital's direct GME or IME payments.

J. Impact of Proposed Policy on Rural Community Hospital Demonstration Program

In section IV.P. of the preamble of this proposed rule, we discuss our proposal to implement section 410A of Public Law 108–173 requiring the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) requires that ''in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' As discussed in section IV.P. of this proposed rule, we are proposing to satisfy this requirement by adjusting national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment that would be made to each participating hospital under the demonstration would be approximately $1,120,000. We based this estimate on the recent historical experience of the difference between inpatient cost and reasonable cost payment for hospitals that would be eligible for the demonstration. For 15 participating hospitals, the total annual impact of the demonstration program is estimated to be $16,820,148. We estimate that there will be an average decrease in payment per discharge of approximately $0.83 in order to achieve budget neutrality. We describe the budget neutrality adjustment required for this purpose in the Addendum to this proposed rule.

K. Impact of Proposed Criteria for Hospitals-Within-Hospitals

In section VI.B. of the preamble of this proposed rule, we discuss three options for revising and strengthening the criteria to be used to classify hospitals-within-hospitals for purposes of payments that are excluded from the IPPS. The intent of our policies requiring separateness of administrative and medical governance and decision-making between the hospital-within-a-hospital and its host has been to discourage patient shifting between the excluded hospital-within-a-hospital and its host for financial rather than medical purposes. In 2002, there were 114 hospitals-within-hospitals, and these entities are increasing at an average annual rate of 30 percent (MedPAC, June 2003, p.85). To the extent that these proposed revisions would eliminate hospital-within-hospital arrangements that circumvented our existing requirements, the Medicare program would avoid making unnecessary payments under the more costly excluded hospital PPSs. We cannot estimate the numbers of existing entities that would be affected by these proposed revisions, nor can we estimate the specific DRGs that would be affected at those hospitals. In addition, we do not know the number of new applications for this status that would be subject to review under these new proposed standards. Therefore, we are unable to quantify the effect these propose changes would have upon Medicare expenditures. However, we believe that this proposed change in policy would likely result in a savings to the Medicare program.

L. Impact of Proposed Policy Changes Related to CAHs

In section VI.C.2. through VI.C.5. of the preamble of this proposed rule, we discuss our proposal to implement provisions in section 405 of Public Law 108–173 relating to payments to CAHs which include the percentage of change in the reasonable cost payment amount for certain services; the revised condition for a CAH's election of the optional payment method; the availability to CAHs of the periodic interim payment method (PIP); and expansion of types of emergency room providers who may be on call at CAHs.

These changes, taken together with the increase in the number of beds permitted to CAHs for acute care inpatient services discussed below, increase the incentive for conversion to CAH status by allowing larger rural hospitals and those with specialized units to become CAHs without materially reducing the size and scope of their activities. The added 1 percent reimbursement and flexibility to allow some physicians to opt out of method 2 for CAH billing should also increase the rate of conversion, while at the same time increasing the cost of CAHs to the Medicare program. The two payment methods are described in detail in section V.I.D.3. of the preamble and at § 413.70(b). The Congressional Budget Office's official estimate was that section 405 of Public Law 108–173 would increase Medicare program expenditures by approximately $100 million annually. We do not have the information to quantify the extent of the anticipated increase more precisely or to determine how much each provision of section 405 might contribute to that increase.

In section VI.C.6. of this preamble, we discuss our proposal to our regulations to reflect the provisions of section 405(e) of Pub. L. 108–173, which provides for an increase in the number of beds permitted to CAHs for acute care inpatient services, from 15 to 25 beds. We anticipate that both Medicare providers and beneficiaries would welcome this change. The increase in the number of beds would benefit CAHs that experience seasonal increases in patient census due to weather conditions and tourism. With the increase, more Medicare beneficiaries may have access to health care in their communities without the need to be transferred to another hospital because the CAH is at capacity for acute care beds. In addition, the bed size increase would eliminate an obstacle for some small rural hospitals that, except for the bed size restriction of 15 acute care beds, could qualify for CAH status. Although we anticipate that these changes would increase the rate at which hospitals convert to CAH status we do not have the information needed to make quantitative estimates of the extent of this increase.

In section VI.C.7. of the preamble of this proposed rule, we discuss our proposal to implement section 405(g) of Public Law 108–173, which grants authority for CAHs to establish psychiatric and rehabilitation distinct part units. This proposed rule would allow CAHs the option of providing rehabilitation and psychiatric services in such units.

Although we view the anticipated results of the proposed regulations as beneficial to the Medicaid and Medicare programs as well as to Medicare and Medicaid beneficiaries and State governments, we recognize that some of the provisions could be controversial and that some affected entities may respond unfavorably. We also recognize that not all of the potential effects of these provisions can definitely be anticipated, especially in view of their interaction with other Federal, State, and local activities regarding outpatient services. In particular, considering the effects of our simultaneous efforts to improve the delivery of outpatient services, it is impossible to quantify meaningfully a projection of the future effect of these provisions on a CAH's operating costs or on the frequency of substantial noncompliance and termination procedures.

We estimate that only those facilities that have the capabilities to operate a distinct part unit prior to becoming a CAH will elect to operate such a unit. Hospitals that currently operate a distinct part unit and wish to continue providing psychiatric and rehabilitation services to the community can continue to do so after converting to a CAH. Allowing a facility that converts to a CAH to continue providing inpatient rehabilitation and psychiatric services in rural areas would help to ensure availability of services that are disproportionately located in urban areas. Distinct-part units may be less common in rural areas due to the challenge of finding the resources needed to operate a distinct part unit. The United States General Accounting Office (GAO), in its September 2003 Report to Congress, entitled ''Modest Eligibility Expansion for Critical Access Hospital Program Should Be Considered,'' reported that a distinct part unit might provide a

financial benefit to the hospital because it enables the hospital to spread its fixed costs over more services. CAHs potentially can experience a net gain on their Medicare payments.

Among the existing CAHs, 25 previously operated a distinct part unit but had to close it as part of becoming a CAH. GAO identified 683 rural hospitals as ''potential CAHs'' based on their having an annual average of no more than 15 acute care patients per day. About 14 percent (93) of these potential CAHs operate an inpatient psychiatric or rehabilitation distinct part unit, which they previously would have had to close to convert to CAH status. Among the potential CAHs that operate a distinct part, about half had a net loss on Medicare services, indicating they might benefit from CAH conversion.[8]

Based on the GAO data, we estimate that approximately 50 hospitals that currently operate distinct part units would not incur any additional expense to convert to a CAH and, in fact, may increase their revenue. Therefore, we are only estimating burden for current CAHs (approximately 27) that might want to operate a distinct part unit due to their previous experience in operating a distinct part unit.

Inpatient psychiatric services in a CAH's distinct-part unit must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program, and who is board certified in psychiatry. The distinct part unit must also have a director of nursing services who is a registered nurse with a master's degree in psychiatric or mental health nursing or its equivalent from a school of accreditation by the National League of Nursing, who is qualified by education and experience in the care of persons with mental illness, and a director of social services. There must also be an adequate number of registered nurses to provide 24-hour coverage as well as licensed practical nurses and mental health workers.

A rehabilitation distinct-part unit of a CAH would be required to provide rehabilitation nursing, physical and occupational therapy, and, as needed, speech therapy, social services or psychological services and orthotics and prosthetics. The distinct part unit also must have a director of rehabilitation who, among other requirements, is experienced in rehabilitation and is a doctor of medicine or a doctor of osteopathy.

In addition, a CAH must comply with the common requirements for excluded units at § 412.25. Therefore, both psychiatric and rehabilitation distinct part units would be required to meet those requirements, including written admission criteria that are applied uniformly to both Medicare and non-Medicare having patients and have admission and discharge records that are separately identified from those of the CAH in which it is located and are readily available. Both of these distinct part units also must have policies specifying that necessary clinical information be transferred to the unit and have utilization review standards applicable for the type of care offered in the unit. Psychiatric distinct part units would also have to meet requirements of § 412.22, including maintenance of medical records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the unit. Each patient must also have an individual comprehensive treatment plan. Section 412.29 requires individuals having rehabilitation distinct part units to also have to meet the criteria of a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an inpatient program. The unit must have also a plan of treatment for each inpatient. Notwithstanding the above discussion, we are not attributing burden for these requirements because they are industry standards for providing quality care and are already required conditions for both rehabilitation and psychiatric units.

Hours/estimated salary/number of CAHs	Annual cost
Estimated Costs for Psychiatric Distinct Part Units	
Clinical Director or service chief; annual salary of $75,000 × 27 CAHs	$2,025,000
24-hours nursing coverage—1 RN per 12 hour shift (2 RNs total) = Annual salary of $52,120 × 2;	2,814,480
One LPN per 12 hour shift = Annual salary of $32,500 × 2 = $65,000 × 27 CAHs;	1,755,000
Director of nursing—Annual salary of $60,000 × 27 = $1,620,000	1,620,000
Director of social services—Annual salary of $53,000 × 27 = $1,431,000	1,431,000
Psychiatric aides—Annual salary of $25,650 x 2=$51,300 × 27 CAHs	1,385,100
Total	11,050,580
Estimated Costs for Rehabilitation Distinct Part Units	
Director of Rehabilitation—Annual salary $75,000 × 27 = $2,025,000	2,025,000
Occupational Therapist—Annual salary $53,300 × 27 = $1,439,100	1,439,100
Physical Therapist—Annual salary $55,800 × 27 = $1,506,600	1,506,600
Speech Therapist—Annual salary $52,800 × 27 = $1,425,600	1,425,600
Rehabilitation nurse—Annual salary $32,500 × 27 =	877,500
Total	7,273,800

In section VI.C.8. of the preamble of this proposed rule, we are proposing to implement section 405(h) of Public Law 108–173 which terminates a State's authority to waive the location requirement of more than a 35-mile drive (or in the case of mountainous terrain or secondary roads, a 15-mile drive) for a CAH by designating the CAH as a necessary provider. We do not have the information to quantify the extent of the anticipated increase more precisely or to determine how much this provision might contribute to that increase.

M. Impact of Proposed Policy Change Regarding Disclosure of Information by QIOs.

In section VII.A. of this proposed rule, we are proposing to revise our regulations to add provisions to allow QIOs to disclose information about practitioners and institutions and information from quality review studies if the practitioner or institution consents to or requests the disclosure of the information in writing. This disclosure would be in addition to the existing disclosure previously based on written consent of the institution or practitioner. In addition, we are proposing exceptions to the 30-day advance notice requirement to an institution or practitioner by a QIO of its intent to disclose confidential and nonconfidential information on a practitioner or an institution is at the request of or consent of the institution or practitioner. We are proposing to specify that the notification requirements would not apply if the institution or practitioner has requested in writing that the QIO make the disclosure, has provided written consent for the disclosure, or the information is public information.

[8] Information from United States General Accounting Office's Report to Congress, ''Modest Eligibility Expansion for Critical Access Hospital Program Should be Considered,'' GAO–03–948, September 2003.

We believe that these proposed revisions would reduce the existing burden on practitioners, institutions, and QIOs and, at the same time, ensure that necessary protections on information are retained. These provisions would allow QIOs, institutions, and practitioners to share vital information in an effective manner and further our efforts to ensure the highest quality of care for Medicare beneficiaries.

N. Impact of Policy Change for Medicare Hospital Conditions of Participation for Discharge Planning

In section VIII.A. of the preamble of this proposed rule, we discuss our proposal to amend the regulations at § 482.43 to incorporate the provisions of section 4321(a) of Public Law 105–33 and section 926(b) of Public Law 108–173 into the hospital conditions of participation. We are proposing to include the requirement for hospitals to provide lists of Medicare-certified HHAs and SNFs to patients or their representatives as part of the discharge planning process. We are proposing to require the SNF list to include Medicare-certified SNFs located in a geographic area chosen by the patient. We are not requiring that the list of Medicare-certified SNFs contain only those SNFs that are located in the area in which the patient resides. Because many available Medicare-certified SNFs are not located near where the patient resides, especially in rural areas, we believe that a requirement that restricts a patient to SNFs in areas where the patient resides is too restrictive and would limit the choices of posthospital extended care services for Medicare beneficiaries.

The nature of the proposed regulatory provision is such that this minimal regulatory burden would be placed upon hospitals, HHAs and SNFs exclusively. Therefore, we did not consider any regulatory relief options. We also certify that this proposed provision would not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

Compliance with section 4321(a) of the BBA and section 926(b) of Public Law 108–173 requires a hospital to collect on an initial and ongoing basis information to develop and maintain a current list of HHAs and SNFs available to Medicare beneficiaries. We anticipate that this effort would be minimal because hospitals currently access this information as an essential component of the discharge planning process. We do not anticipate that the operations of a substantial number of small rural hospitals would be significantly impacted. The impact would be even further minimized if a hospital chooses to access this information via the Home Health Compare or Nursing Home Compare tools on the CMS Web site, *http://www.medicare.gov,* or if the hospital calls 1–800–MEDICARE (1–800–633–4227) to request a printout of the HHAs or SNFs in the desired geographic area.

The anticipated effects on patients would be an enhanced ability to make informed choices about the care they receive from HHAs or SNFs upon discharge from a hospital. Based on 2003 CMS data, there are approximately 6,000 Medicare-certified hospitals, 6,900 Medicare-certified HHAs, and 17,000 SNFs.

The requirements set forth in this proposed provision would place minimal burdens on hospitals, HHAs, and SNFs. A possible outcome of the implementation of all parts of the rule may be to influence hospital referral patterns, thus having an impact on HHAs and SNFs receiving post-hospitalization referrals. The information made available to maintain compliance with the statute and this proposed provision might impact patient choices about who furnishes Medicare services to them and, in turn, may have an indeterminable impact on entities that provide, or do not provide services to Medicare beneficiaries as a result.

This proposed provision would improve our information campaign to assist beneficiaries in making informed choices for health care delivery. Patient choice under the Medicaid program may be similarly affected if the providers on these lists also participate in that program.

We considered developing a standardized process, format, and timeframe for all hospitals to use in developing, maintaining, and updating a current list of HHAs and SNFs. Instead, we have chosen a less prescriptive approach. Hospitals have the flexibility to define a process for developing, maintaining, and updating their list of HHAs or SNFs in a manner that makes the most sense for both the hospital and the patients they serve. The hospital would have the flexibility to develop and maintain their own list of HHAs and SNFs, or simply print a list from the Home Health Compare or Nursing Home Compare site at the CMS Web site, *http://www.medicare.gov,* based on the geographic area requested by the patient. Or, in the rare instance when a hospital does not have Internet access, the hospital can call 1–800–MEDICARE (1–800–633–4227) to request a printout of the list of HHAs or SNFs in the desired geographic area. In this way, hospitals would be able to develop and implement systems and processes that are the most effective and efficient in providing quality care and meeting the needs of their patients, as well as complying with the requirements of the proposed regulation.

In summary, this proposed provision would establish a process for implementing the statutory requirements under section 4321(a) of the BBA and section 926(b) of the MMA. This approach would enhance the information made available to Medicare beneficiaries and place minimal burdens on all entities that may be directly or indirectly affected.

O. Impact of Proposed Policy Changes Relating to Medicare Provider Agreements for Compliance with Bloodborne Pathogens Standards for Medicare-Participating Hospitals

In section VIII.B. of the preamble to this proposed rule, we discuss our proposal to implement section 947 of Public Law 108–173 under which hospitals not otherwise subject to the Occupational Safety and Health Act (OSHA) (or a State occupational safety and health plan that is approved under section 18(b) of that Act) must comply with the OSHA bloodborne pathogens standard as part of their Medicare provider agreements, effective July l, 2004.

Given that the Occupational Safety and Health Administration (OSHA) has already prepared a Regulatory Impact and Regulatory Flexibility Analysis for the Bloodborne Pathogens standard that was published December 6, 1991 (56 FR 64004), we have included relevant portions of their analyses in our estimate. However, we have pulled out the numbers that are relevant to this regulation and up-dated the numbers to make them current as of January, 2004. Thus, the impact of this proposed rule on the public hospitals included in the 26 States without state plans, as well as the District of Columbia, and Guam has been assessed.

OSHA noted that most hospitals perform a great variety of services, and there are many different exposure scenarios. One frequently reported exposure was needlestick, with the greatest potential for exposure occurring during needle recapping. Other hospital procedures that are associated with frequent exposure include phlebotomy, IV line placement, bronchoscopy, intubation, airway suction, endoscopy, colonoscopy, and proctosigmoidoscopy. Areas with the greatest potential for exposure include the emergency room, surgical suite, hemodialysis center, and intensive care unit. Laundry workers and janitors may also be exposed, particularly when handling soiled linen or refuse.

OSHA's standard for reducing worker exposure to bloodborne pathogens is based on the adoption of universal precautions as a method of infection control. This approach, which is fundamentally different from traditional procedures that isolate known infectious individuals and materials in the health care setting, assumes that all human blood and body fluids are potentially infectious for HIV, HBV, and other bloodborne pathogens. The rationale for this approach is that carriers of these diseases are not always identifiable in the health care setting, and that contaminated materials are not always properly labeled. Thus, the exposed worker can be at great risk without warning.

OSHA estimated that 6,197 hospitals with a total of 2,386,165 employees would be affected by the BBP standards. However, OSHA found that most hospitals had already implemented measures to protect workers from occupational exposure to blood and other potentially infectious materials, and that many were very close to full compliance with the standard. OSHA's estimates of the number of affected hospitals and the number of employees did not include state and local government hospitals located in states without occupational safety and health plans in place, that is, the hospitals that would be affected by our proposed rule.

Net compliance costs were estimated for each provision of the standard based on OSHA surveys and information submitted in response to the rulemaking docket. The costs represented the additional costs of fully complying with the requirements of the standard, after deducting from total cost the current baseline activities that already voluntarily occurred at affected facilities. Personal protective equipment accounted for

the largest amount of net compliance costs. Training, vaccine and post-exposure follow-up, and housekeeping were also found to be significant cost components. One-time costs were annualized to reflect the opportunity cost of capital. OSHA estimated the total annual costs to the affected hospitals to be approximately $321,913,697 or $51,947 per hospital annually.

The magnitude of cost increases associated with the standard was estimated to be relatively small, and OSHA stated that they should not create significant economic hardship for most affected hospitals. OSHA predicted that the costs would be passed through the system, with resultant minor price increases to patients, customers and other downstream recipients of health services. However, OSHA noted that without the BBP standards, the economic impact of inadequate protections from BBP would fall on hospital employees and the general public.

OSHA stated that, in general, the economic impacts of the standard were not judged to be of sufficient magnitude to threaten the existence of any affected sector, nor were impacts judged sufficient to disrupt or otherwise adversely alter industry structure. OSHA did not believe that productivity of hospital employees would be significantly affected by the BBP requirements. OSHA stated that it believed familiarization with the requirements and techniques would restrict time lost and that any decrease in productivity would be offset by the peace of mind associated with a safer work setting.

Based on OSHA'S conclusions, we did not deem it necessary to update the 1989 cost data used in their analysis. Although the costs of meeting the BBP standards would have increased over time, we note that at the time, OSHA found most hospitals had already implemented measures to protect workers from exposure to blood and other potentially infectious materials and that many hospitals were very close to full compliance. We expect that hospitals not covered under the BBP standards (that is, hospitals that would be affected by our proposed rule) also had implemented measures to protect their employees from exposure to blood and other potentially infectious materials and that many hospitals were already close to full compliance with the BBP standards. We also expect that in the intervening years, hospitals that would be affected by this proposed rule would have further increased their worker protections. It is likely that many of the hospitals that would be affected by this proposed rule are already very close to full compliance with the BBP standards.

While smaller hospitals' limited ability to diversify could be a potential disadvantage in their attempts to pass compliance costs forward, OSHA concluded that it did not appear that they would lag behind larger hospitals to any significant extent in their ability to provide employees with protection against infectious hazards.

On January 18, 2001, OSHA published a final rule that added two new recordkeeping requirements to the BBP standards (66 FR 48250). First, the amended standard requires employers to ''establish and maintain a sharps injury log for the recording of percutaneous injuries''. Second, any employer ''who is required to establish an Exposure Control Plan'' must ''solicit input from non-managerial employees responsible for direct patient care who are potentially exposed to injuries from contaminated sharps in the identification, evaluation, and selection of effective engineering and work practice controls and shall document the solicitation in the exposure-control plan.

According to OSHA's analysis, the maximum total annual cost of the two requirements would be $33,892,653, consisting of $1,294,352 associated with maintaining a sharps injury log and $32,598,300 associated with soliciting and documenting employee input into the Exposure Control Plan. This would amount to $67 per hospital annually, which would not cause significant economic impact on either large or small affected establishments.

The requirements set forth in this proposed rule would place minimal burden on hospitals. A possible outcome of the implementation of all parts of the rule may be to influence hospitals' use of proper mechanisms and supplies necessary to ensure employee protection from BBPs.

The anticipated effects on employees would be the assurance that provisions are made to reduce the potential for contact with BBPs when performing work-related duties. Based on 2003 CMS data, there are approximately 6,000 Medicare-certified hospitals of which 849 are non-federal, government-owned hospitals located in states that do not have their own health and safety standards.

This proposed rule would improve the quality of working conditions for employees who care for Medicare beneficiaries in these non-federal, government-owned hospitals and would ensure hospital employee safety while performing their duties in Medicare participating hospitals while placing minimal burden on all affected entities directly and on entities that may be indirectly affected.

P. Impact of Proposed Fire Safety Requirements for Certain Health Care Facilities.

In section VIII. of the preamble of this proposed rule, we discuss our proposal to clarify that long-term care facilities must be in compliance with Chapter 19.2.9, Emergency Lighting, beginning March 13, 2006. In addition, we also specify that beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 will no longer apply to these facilities.

In the January 10, 2003 final rule adopting the 2000 edition of the Life Safety Code, we examined the overall economic impact and the impact on small entities and rural hospitals as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980 Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) and Executive Order 13132. We also examined the anticipated effects of the rule. We determined that the 2003 final rule did not meet the criteria to be considered economically significant or to be a major rule. Furthermore, we examined the Federalism implication of the 2003 final rule and determined that the rule would not have a substantial effect on State, local, or tribal governments. The correcting amendments in this proposed rule would merely bring the Code of Federal Regulations language into conformity with the analyses that we have already conducted and described in the Regulatory Impact Statement section of the 2003 final rule. (*See* 68 FR 1374, January 10, 2003).

VIII. Impact of Proposed Changes in the Capital PPS

A. General Considerations

Fiscal year 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: fully prospective or hold harmless. Under the fully prospective methodology, hospitals were paid a blend of the capital Federal rate and their hospital-specific rate (*see* § 412.340). Under the hold-harmless methodology, unless a hospital elected payment based on 100 percent of the capital Federal rate, hospitals were paid 85 percent of reasonable costs for old capital costs (100 percent for SCHs) plus an amount for new capital costs based on a proportion of the capital Federal rate (see § 412.344). As we state in section V. of the preamble of this proposed rule, with the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), beginning in FY 2002 capital prospective payment system payments for most hospitals are based solely on the capital Federal rate. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

In accordance with § 412.312, the basic methodology for determining a capital prospective payment system payment is:

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

In addition, hospitals may also receive outlier payments for those cases that qualify under the threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the December 2003 update of the FY 2003 MedPAR file and the December 2003 update of the Provider Specific File that is used for payment purposes. Although the analyses of the changes to the capital prospective payment system do not incorporate cost data, we used the December 2003 update of the most recently available hospital cost report data (FY 2001) to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response

to policy changes. Second, due to the interdependent nature of the PPS, it is very difficult to precisely quantify the impact associated with each change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases (for instance, 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 sources overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the December 2003 update of the FY 2003 MedPAR file, we simulated payments under the capital PPS for FY 2004 and FY 2005 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general IPPS (Indian Health Service Hospitals and hospitals in Maryland) are excluded from the simulations.

As we explain in section III.A.4. of the Addendum of this proposed rule, payments will no longer be made under the regular exceptions provision under §§ 412.348(b) through (e). Therefore, we are no longer using the actuarial capital cost model (described in Appendix B of the August 1, 2001 final rule (66 FR 40099)). We modeled payments for each hospital by multiplying the capital Federal rate by the GAF and the hospital's case-mix. We then added estimated payments for indirect medical education, disproportionate share, large urban add-on, and outliers, if applicable. For purposes of this impact analysis, the model includes the following assumptions:

- We estimate that the Medicare case-mix index would increase by 1.0 percent in both FY 2004 and FY 2005.
- We estimate that the Medicare discharges will be 14.5 million in FY 2004 and 14.0 million in FY 2005 for a 3.4 percent decrease from FY 2004 to FY 2005. (We are projecting a decrease in Medicare Part A fee-for-service admissions, in part, because we are projecting an increase in Medicare managed care enrollment as a result of the implementation of several provisions of Public Law 108–173.
- The capital Federal rate was updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The proposed FY 2005 update is 0.7 percent (*see* section III.A.1.a. of the Addendum to this proposed rule).
- In addition to the proposed FY 2005 update factor, the proposed FY 2005 capital Federal rate was calculated based on a GAF/DRG budget neutrality factor of 1.0015, an outlier adjustment factor of 0.9497, and a (special) exceptions adjustment factor of 0.9996.

Results

In the past, in this impact section we presented the redistributive effects that were expected to occur between ''hold-harmless'' hospitals and ''fully prospective'' hospitals and a cross-sectional summary of hospital groupings by the capital PPS transition period payment methodology. We are no longer including this information because all hospitals (except new hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid 100 percent of the capital Federal rate in FY 2005.

We used the actuarial model described above to estimate the potential impact of our proposed changes for FY 2005 on total capital payments per case, using a universe of 3,871 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the December 2003 update of the FY 2003 MedPAR file, the December 2003 update to the Provider-Specific File, and the most recent cost report data from the December 2003 update of HCRIS. In Table III, we present a comparison of total payments per case for FY 2004 compared to FY 2005 based on the proposed FY 2005 payment policies. Column 2 shows estimates of payments per case under our model for FY 2004. Column 3 shows estimates of payments per case under our model for FY 2005. Column 4 shows the total percentage change in payments from FY 2004 to FY 2005. The change represented in Column 4 includes the 0.7 percent update to the capital Federal rate, a 1.0 percent increase in case-mix, changes in the adjustments to the capital Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB, as well as changes in special exception payments. The comparisons are provided by: (1) Geographic location; (2) region; and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 4.3 percent in FY 2005. In addition to the 0.7 percent increase due to the capital market basket update, this projected increase in capital payments per case is largely attributable to the proposed changes in the GAF values (which include the increase to hospital wage index values provided for by sections 505 and 508 of Pub. L. 108–173) and estimated increase in outlier payments in FY 2005. Our comparison by geographic location shows that urban hospitals are expected to experience a 4.6 percent increase in capital payments per case, while rural hospitals are only expected to experience a 2.1 percent increase in capital payments per case. This difference is mostly due to a projection that urban hospitals will experience a larger increase in payments due to changes in the proposed GAF values and larger projected increase in outlier payments from FY 2004 to FY 2005 compared to rural hospitals.

Most regions are estimated to receive an increase in total capital payments per case. Changes by region vary from a minimum increase of 0.7 percent (South Atlantic rural region) to a maximum increase of 5.5 percent (Pacific urban region). This relatively small increase in projected capital payments per discharge for hospitals located in the South Atlantic rural region is largely attributable to the proposed changes in the GAF values (that is, the proposed GAFs for most of these hospitals for FY 2005 are lower than the average of the GAFs for FY 2004) and a projected decrease in DSH payments (mostly because the rural hospitals that previously qualified for capital DSH payments because they reclassified for the purpose of the operating IPPS standardized amounts would no longer be eligible to receive capital DSH payments with the equalization of the operating IPPS standardized amounts, as discussed in section IV.D. of the preamble of this proposed rule). The relatively large increase in capital payments per discharge for hospitals located in the Pacific urban region is largely due to the proposed changes in the GAF values (that is, the proposed GAFs for most of these hospitals for FY 2005 are higher than the average of the GAFs for FY 2004) and an increase in projected outlier payments.

Hospitals located in Puerto Rico are expected to experience an increase in total capital payments per case of 8.0 percent. This relatively large increase in payment per case for hospitals located in Puerto Rico is largely due to the proposed change in the Federal portion (from 50 percent to 75 percent) of the blended payments to Puerto Rico hospitals beginning in FY 2005.

By type of ownership, proprietary hospitals are projected to have the largest rate of increase of total payment changes (4.7 percent). Similarly, payments to voluntary and government hospitals are expected to increase 4.3 percent. As noted above, this slightly larger projected increase in capital payments per case for proprietary hospitals is mostly due to the proposed changes in the GAF values for FY 2005.

Section 1886(d)(10) of the Act established the MGCRB. Previously, hospitals could apply for reclassification for purposes of the standardized amount, wage index, or both. Section 401(c) of Public Law 108–173 equalized the standardized amounts under the operating IPPS. Therefore, beginning in FY 2005, there is no longer reclassification for the purposes of the standardized amounts; hospitals may apply for reclassification for purposes of the wage index in FY 2005. Reclassification for wage index purposes also affects the geographic adjustment factor because that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2005 compared to the effects of reclassification for FY 2004, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified for FY 2005 as a whole are projected to experience a 2.8 percent increase in payments. Payments to nonreclassified hospitals in FY 2005 are expected to increase 4.5 percent. Hospitals reclassified during both FY 2004 and FY 2005 are projected to experience a slight increase in payments of 2.6 percent. Hospitals reclassified during FY 2005 only are projected to receive an increase in payments of 4.9 percent. This increase is primarily due to proposed changes in the GAF (wage index).

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2004 Payments Compared to Proposed FY 2005 Payments]

	Number of hospitals	Average FY 2004 payments/ case	Average FY 2005 payments/ case	Change.
By Geographic Location:.				
All hospitals	3,871	709	740	4.3
Large urban areas (populations over 1 million)	1,411	790	838	6.1
Other urban areas (populations of 1 million of fewer)	1,253	704	723	2.7
Rural areas	1,207	485	495	2.1
Urban hospitals	2,664	750	784	4.6
0–99 beds	674	540	563	4.4
100–199 beds	945	642	670	4.2
200–299 beds	499	736	766	4.2
300–499 beds	415	812	851	4.8
500 or more beds	131	934	982	5.2
Rural hospitals	1,207	485	495	2.1
0–49 beds	548	406	416	2.5
50–99 beds	393	452	462	2.2
100–149 beds	163	492	501	1.9
150–199 beds	57	536	545	1.6
200 or more beds	46	610	622	2.0
By Region:				
Urban by Region	2,664	750	784	4.6
New England	134	815	839	2.9
Middle Atlantic	390	813	848	4.2
South Atlantic	407	720	752	4.4
East North Central	442	742	777	4.8
East South Central	175	677	709	4.7
West North Central	160	752	786	4.5
West South Central	344	698	734	5.2
Mountain	140	746	772	3.5
Pacific	421	850	897	5.5
Puerto Rico	51	321	346	8.0
Rural by Region	1,207	485	495	2.1
New England	34	618	629	1.9
Middle Atlantic	57	511	516	1.0
South Atlantic	176	479	483	0.7
East North Central	160	514	522	1.4
East South Central	192	446	457	2.6
West North Central	206	500	517	3.3
West South Central	228	434	446	2.7
Mountain	92	486	500	2.9
Pacific	62	558	578	3.6
By Payment Classification:				
All hospitals	3,871	709	740	4.3
Large urban areas (populations over 1 million)	1,399	791	839	6.1
Other urban areas (populations of 1 million or fewer)	1,216	707	726	2.7
Rural areas	1,256	484	494	2.0
Teaching Status:				
Non-teaching	2,759	588	610	3.8
Fewer than 100 Residents	911	750	782	4.3
100 or more Residents	201	1,090	1,151	5.6
Urban DSH:				
100 or more beds	1,457	786	822	4.7
Less than 100 beds	335	494	517	4.7
Rural DSH:				
Sole Community (SCH/EACH)	478	440	451	2.4
Referral Center (RRC/EACH)	149	548	558	1.8
Other Rural:				
100 or more beds	64	464	470	1.3
Less than 100 beds	241	411	419	1.9
Urban teaching and DSH:				
Both teaching and DSH	800	862	903	4.9
Teaching and no DSH	250	773	808	4.5
No teaching and DSH	992	631	658	4.3
No teaching and no DSH	573	642	669	4.3
Rural Hospital Types:				
Non special status hospitals	394	439	446	1.6
RRC/EACH	129	559	565	1.2
SCH/EACH	451	454	465	2.5
Medicare-dependent hospitals (MDH)	209	408	419	2.7
SCH, RRC and EACH	70	551	566	2.9

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 2004 Payments Compared to Proposed FY 2005 Payments]

	Number of hospitals	Average FY 2004 payments/ case	Average FY 2005 payments/ case	Change.
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
Reclassification Status During FY 2004 and FY 2005:				
Reclassified During Both FY 2004 and FY 2005	423	615	631	2.6
Reclassified During FY 2005 Only	62	547	574	4.9
Reclassified During FY 2004 Only	186	672	687	2.2
FY 2005 Reclassifications:				
All Reclassified Hospitals	485	610	627	2.8
All Nonreclassified Hospitals	3,325	724	757	4.5
All Urban Reclassified Hospitals	118	748	773	3.4
Urban Nonreclassified Hospitals	2,486	752	787	4.7
All Reclassified Rural Hospitals	367	536	548	2.3
Rural Nonreclassified Hospitals	839	433	441	1.8
Other Reclassified Hospitals (Section 1886(D)(8)(B))	61	487	490	0.7
Type of Ownership:				
Voluntary	2,322	727	758	4.3
Proprietary	717	647	677	4.7
Government	764	676	705	4.3
Medicare Utilization as a Percent of Inpatient Days:				
0–25	226	888	939	5.7
25–50	1,122	772	809	4.8
50–65	1,428	630	654	3.8
Over 65	922	630	654	3.7

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

[If you choose to comment on issues in this section, please include the caption ''Update Factors'' at the beginning of your comment.]

I. Background

Section 1886(e)(4)(A) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), recommend update factors for inpatient hospital services 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 proposed update factors recommended by the Secretary in the proposed rule, and the final update factors recommended by the Secretary in the final rule. Accordingly, this Appendix provides the recommendations of appropriate update factors for the IPPS standardized amount, the hospital-specific rates for SCHs and MDHs, and the rate-of-increase limits for hospitals and hospital units excluded from the IPPS. We also discuss our update framework and respond to MedPAC's recommendations concerning the update factors.

II. Secretary's Recommendations

Section 1886(b)(3)(B)(i)(XIX) of the Act sets the FY 2005 percentage increase in the operating cost standardized amount equal to the rate of increase in the hospital market basket for IPPS hospitals in all areas. Based on the Office of the Actuary's first quarter 2004 forecast of the FY 2005 market basket increase, the proposed update to the standardized amount is 3.3 percent (that is, the market basket rate of increase) for hospitals in all areas.

Section 1886(b)(3)(B)(iv) of the Act sets the FY 2005 percentage increase in the hospital-specific rates applicable to SCHs and MDHs equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act (that is, the same update factor as all other hospitals subject to the IPPS, or the rate of increase in the market basket). Therefore, the proposed update to the hospital-specific rate applicable to SCHs and MDHs is also 3.3 percent.

Section 1886(b)(3)(B)(ii) of the Act sets the FY 2005 percentage increase in the rate-of-increase limits for hospitals and hospital units excluded from the IPPS (psychiatric hospitals and units (now referred to as inpatient psychiatric facilities (IPFs)), rehabilitation hospitals and units (now referred to as IRFs), LTCHs, cancer hospitals, and children's hospitals) equal to the market basket percentage increase. In the past, hospitals and hospital units excluded from the IPPS have been paid based on their reasonable costs subject to limits as established by TEFRA. However, some of these categories of excluded hospitals and units have begun to be paid under their own prospective payment systems. Hospitals and units that receive any hospital-specific payments will have those payments subject to TEFRA limits for FY 2005. For these hospitals, the proposed update is the percentage increase in the excluded hospital market basket (currently estimated at 3.3 percent).

IRFs are paid under the IRF PPS for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2004, the Federal prospective payment for IRFs is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually.

Effective for cost reporting periods beginning during FY 2003, LTCHs are paid under the LTCH PPS under which they receive payment based on a 5-year transition period (see the August 30, 2002 final rule (67 FR 55954)). A LTCH may elect to be paid on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition period. For purposes of the update factor, the portion of the LTCH PPS transition blend payment based on reasonable costs for inpatient operating services is determined by updating the LTCH's TEFRA limit by the current estimate of the excluded hospital market basket (or 3.3 percent).

CMS recently published a proposed regulation regarding inpatient psychiatric facilities (IPFs) in which CMS would compute a Federal per diem base rate to be paid to all IPFs based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF adjusted for budget neutrality. The Federal per diem base rate would be adjusted to reflect certain patient characteristics such as age, specified DRGs, and selected high-cost comorbidities, and certain facility characteristics such as a wage index adjustment, rural location, and indirect teaching costs. The November 28, 2003 proposed rule assumed an April 1, 2004 effective date for the purpose of ratesetting and calculating impacts. However, we are still in the process of analyzing public comments and developing a final rule for publication. The effective date of the IPF PPS would occur 5 months following publication of the final rule.

III. Update Framework

Consistent with current law, we are proposing an update recommendation equal to the full market basket percentage increase for the IPPS operating cost standardized amounts for FY 2005. We also have analyzed changes in hospital productivity, scientific and technological advances, practice pattern changes, changes in case-mix, the effect of reclassification on recalibration, and forecast error correction. A discussion of this analysis is below.

A. Productivity

Service level labor productivity is defined as the ratio of total service output to full-time equivalent employees (FTEs). While we recognize that productivity is a function of many variables (for example, labor, nonlabor material, and capital inputs), we use the portion of productivity attributed to direct labor since this update framework applies to operating payment. To recognize that we are apportioning the short-run output changes to the labor input and not considering the nonlabor inputs, we weight our productivity measure by the share of direct labor services in the market basket to determine the expected effect on cost per case.

Our recommendation for the service productivity component is based on historical trends in productivity and total output for both the hospital industry and the general economy, and projected levels of future hospital service output. MedPAC's predecessor, the Prospective Payment Assessment Commission (ProPAC), estimated cumulative service productivity growth to be 4.9 percent from 1985 through 1989 or 1.2 percent annually. At the same time, ProPAC estimated total output growth at 3.4 percent annually, implying a ratio of service productivity growth to output growth of 0.35.

Absent 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 0.30 to 0.35 percent of the change in output (that is, a 1.0 percent increase in output would be correlated with a 0.30 percent to a 0.35 percent change in output per hour).

Under our framework, the recommended update is based in part on expected productivity—that is, projected service output during the year, multiplied by the historical ratio of service productivity to total service output, multiplied by the share of direct labor in total operating inputs, as calculated in the hospital market basket. This method estimates an expected productivity improvement in the same proportion to expected total service growth that has occurred in the past and assumes that, at a minimum, growth in FTEs changes proportionally to the growth in total service output. Thus, the recommendation allows for unit productivity to be smaller than the historical averages in years during which output growth is relatively low and larger in years during which output growth is higher than the historical averages. Based on the above estimates from both the hospital industry and the economy, we have chosen to employ the range of ratios of productivity change to output change of 0.30 to 0.35.

The expected change in total hospital service output is the product of projected growth in total admissions (adjusted for outpatient usage), projected real case-mix growth, expected quality-enhancing intensity growth, and net of expected decline in intensity due to reduction of cost-ineffective practice. Case-mix growth and intensity numbers for Medicare are used as proxies for those of the total hospital, since case-mix increases (used in the intensity measure as well) are unavailable for non-Medicare patients. Normally, the expected FY 2005 hospital output growth would be simply the sum of the expected change in intensity (zero percent), projected admissions change (0.9 percent), and projected real case-mix growth (1.0 percent—a definition of real case mix growth appears below), or 1.9 percent. As discussed below and in relation to the proposed capital update, we believe our intensity estimate is skewed by hospitals' charge data. We are including only the projected changes in admissions and real case-mix in our calculation of productivity gains. However, the expected change in intensity is zero. Therefore, excluding the intensity estimate has no effect on the result. This results in an estimate of 1.9 percent.

The share of direct labor services in the market basket (consisting of wages, salaries, and employee benefits) is 61.7 percent. Multiplying the expected change in total hospital service output (1.9 percent) by the ratio of historical service productivity change to total service growth of 0.30 to 0.35 and by the direct labor share percentage of 61.7 provides our productivity standard of -0.8 to -0.7 percent. Because productivity gains hold down the rate of increase in hospitals' costs, this factor is applied as a negative offset to the market basket increase.

B. Intensity

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 non-cost-effective services. Under the capital IPPS framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data that are used in the framework for the operating IPPS.

We calculate case-mix constant intensity as the change in total Medicare charges per admission, adjusted for price level changes (the Consumer Price Index (CPI) for hospital and related services) and changes in real case-mix. The use of total charges in the calculation of the intensity factor makes it a total intensity factor, that is, charges for both operating and capital services are already built into the calculation of the factor.

However, as discussed above in relation to the proposed capital update, because our intensity calculation relies heavily upon charge data and we believe that this charge data may be inappropriately inflated due to manipulation of charges to maximize outlier payments, we are proposing a zero percent adjustment for intensity in FY 2005. In past fiscal years (1996 through 2000) when we found intensity to be declining, we believed a zero (rather than negative) intensity adjustment was appropriate. Similarly, we believe that it is appropriate to propose a zero intensity adjustment for FY 2005 until we determine that any increase in charges can be tied to intensity, rather than to attempts to maximize outlier payments.

C. Change in Case-Mix

Our analysis takes into account projected changes in real case-mix, less the changes attributable to improved coding practices. We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients, as opposed to changes in coding behavior that result in assignment of cases to higher-weighted DRGs but do not reflect greater resource requirements. For our FY 2005 update recommendation, we are projecting a 1.0 percent increase in the case-mix index. We do not believe changes in coding behavior will impact the overall case-mix in FY 2005. As such, for FY 2005, we estimate that real case-mix is equal to projected change in case-mix. Thus, we are recommending a 1.0 percent adjustment for case-mix.

D. Effect of FY 2003 DRG Reclassification and Recalibration

We estimate that DRG reclassification and recalibration for FY 2003 (GROUPER version 20.0) resulted in a zero percent change in the case-mix index when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the GROUPER (version 19.0). Therefore, we are recommending a zero percent adjustment for the effect of FY 2003 DRG reclassification and recalibration.

E. Forecast Error Correction

We make a forecast error correction if the actual market basket changes differ from the forecasted market basket by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of forecast error. The estimated market basket percentage increase used to update the FY 2003 payment rates was 3.5 percent. Our most recent data indicates the actual FY 2003 increase was 3.9 percent. The resulting forecast error in the FY 2003 market basket rate of increase is 0.4 percentage points. This underestimate was due largely to an underestimation of increases in the compensation components in the market basket. More specifically, the burden for benefit costs was expected to shift more to workers, given the soft job market. However, not as much of a shift occurred as was expected, and the measure for benefits increased faster than originally forecast. In addition, higher than expected growth in natural gas prices, mainly due to higher than expected demand last winter that depleted surplus reserves, caused the energy component to be underestimated.

The following is a summary of the update range supported by our analyses:

HHS'S FY 2005 UPDATE RECOMMENDATION

Projected FY 2005 Market Basket Increase	3.3.
Policy Adjustment Factors	0.0.
Productivity	−0.8 to −0.7
Intensity	0.0.
Subtotal	−0.8 to −0.7.
Case-Mix Adjustment Factors:.	
Projected Case-Mix Change	1.0
Real Across DRG Change	−1.0.
Subtotal	0.0.
Effect of FY 2003 DRG Reclassification and Recalibration	0.0.
Forecast Error Correction	0.4.
Total Recommendation Update	2.9 to 3.0

IV. MedPAC Recommendations for Assessing Payment Adequacy and Updating Payments in Traditional Medicare

In the past, MedPAC has suggested specific adjustments to its update recommendation for each of the factors discussed under section III. of this Appendix. In its March 2004 Report to Congress, MedPAC assesses the adequacy of current payments and costs and the relationship between payments and an appropriate cost base, utilizing an established methodology used by the Commission in the past few years. MedPAC stresses that the issue at hand is whether payments are too high or too low, and not how they became either too high or too low.

In the first portion of MedPAC's analysis on the assessment of payment adequacy, the Commission reviews the relationship between costs and payments (typically represented as a margin). Based on the latest cost report data available, MedPAC estimated an inpatient hospital Medicare operating margin for FY 2002 of 4.7 percent (down from 8.1 percent and 10.7 percent for FY 2001 and FY 2000, respectively).

MedPAC also projects margins through FY 2003, making certain assumptions about changes in payments and costs. On the payment side, MedPAC applied the annual payment updates (as specified by law for FYs 2001 through 2003) and then modeled the effects of other policy changes that have affected the level of payments. On the cost side, MedPAC estimated the increases in cost per unit of output over the same time period at the rate of inflation as measured by the applicable market basket index generated by CMS, adjusted downward, anticipating improvements in productivity.

In addition to considering the relationship between estimated payments and costs, MedPAC also considered the following three factors to assess whether current payments are adequate:

- Changes in access to or quality of care,
- Changes in the volume of services or number of providers; and
- Change in providers access to capital.

MedPAC s assessment of aggregate Medicare payments finds that payments were at least adequate as of FY 2004.

MedPAC's recommendation is to update payments under the IPPS by the full rate of increase in the hospital market basket for FY 2005. MedPAC focuses on the fact that it is extremely difficult to determine the status of cost growth among hospitals, given the complexity of ascertaining the impact of the implementation of provisions of Pub. L. 108–173. MedPAC believes it is sensible to refrain from applying their expected net effect based on their standard model, as there is a great deal of uncertainty regarding the costs and payments faced by providers. MedPAC is not abandoning its methodology regarding the update framework, but it has concluded that, under the circumstances, the current market conditions and factors that determine the cost behavior and outcomes of hospitals are too uncertain to rely on current trends for estimation.

Response: As described above, we are recommending a full market basket update for FY 2005 consistent with current law. We believe this will appropriately balance incentives for hospitals to operate efficiently with the need to provide sufficient payments to maintain access to quality care for Medicare beneficiaries.

Because the operating and capital prospective payment systems remain separate, CMS continues to use separate updates for operating and capital payments. The proposed update to the capital payment rate is discussed in section III. of the Addendum to this proposed rule.

[FR Doc. 04–10932 Filed 5–11–04; 1:00 pm]

BILLING CODE 4120–01–P