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42 CFR Parts 412 and 413

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412 and 413

[CMS–1470–F]

RIN 0938–AL89

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates

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

ACTION: Final rule.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital costs to implement changes arising from our continuing experience with these systems. In addition, in the Addendum to this final rule, we are describing changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for operating costs and capital-related costs. These changes are applicable to discharges occurring on or after October 1, 2003. We also are setting forth rate-of-increase limits as well as policy changes for hospitals and hospital units excluded from the IPPS that are paid on a cost basis subject to these limits.

Among other changes that we are making are: changes to the classification of cases to the diagnosis-related groups (DRGS); changes to the long-term care (LTC)–DRGs and relative weights; the introduction of updated wage data used to compute the wage index; the approval of new technologies for add-on payments; changes to the policies governing postacute care transfers; payments to hospitals for the direct and indirect costs of graduate medical education; pass-through payments for nursing and allied health education programs; determination of hospital beds and patient days for payment adjustment purposes; and payments to critical access hospitals (CAHs).

EFFECTIVE DATES: The provisions of this final rule, except the provisions of § 412.230(e)(2)(ii)(A) (because it grants an exemption) and § 412.278(f)(2)(i), are effective on October 1, 2003. The provisions of § 412.230(e)(2)(ii)(A) and § 412.278(f)(2)(i) are effective on August 1, 2003. This rule is a major rule as defined in 5 U.S.C. 804(2). Pursuant to 5 U.S.C. 801(a)(1)(A), we are submitting a report to Congress on this rule on August 1, 2003.

FOR FURTHER INFORMATION CONTACT:

Stephen Phillips, (410) 786–4548, Operating Prospective Payment, Diagnosis-Related Groups (DRGs), Wage Index, New Medical Services and Technology, Patient Transfers, Counting Beds and Patient Days, and Hospital Geographic Reclassifications Issues.

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Sandra Hetrick, (410) 786–4542, RCE Limits.

SUPPLEMENTARY INFORMATION:

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Acronyms

AHIMA American Health Information Management Association
AHA American Hospital Association
CAH Critical access hospital
CBSAs Core Based Statistical Areas
CC Complication or comorbidity
CMS Centers for Medicare & Medicaid Services
CMSA Consolidated Metropolitan Statistical Areas
COBRA Consolidated Omnibus Reconciliation Act of 1985, Pub. L. 99–272
CPI Consumer Price Index
CRNA Certified registered nurse anesthetist
DRG Diagnosis-related group
DSH Disproportionate share hospital
FDA Food and Drug Administration
FQHC Federally qualified health center
FTE Full-time equivalent
FY Federal fiscal year
GME Graduate medical education
HIPC Health Information Policy Council
HIPAA Health Insurance Portability and Accountability Act, Pub. L. 104–191
HHA Home health agency
ICD–9–CM International Classification of Diseases, Ninth Revision, and Clinical Modification
ICD–10–PCS International Classification of Diseases Tenth Edition, and Procedure Coding System
IME Indirect medical education
IPPS Acute care hospital inpatient prospective payment system
IRF Inpatient Rehabilitation Facility
LDP Labor, delivery, and postpartum
LTC–DRG Long-term care diagnosis-related group
LTCH Long-term care hospital
MCE Medicare Code Editor
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
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
O.R. Operating room
PPS Prospective payment system
PRA Per resident amount
ProPAC Prospective Payment Assessment Commission
PRRB Provider Reimbursement Review Board
RCE Reasonable compensation equivalent

RHC Rural health center
RRC Rural referral center
SCH Sole community hospital
SNF Skilled nursing facility
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248
UHDDS Uniform Hospital Discharge Data Set

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I. Background

A. Summary

1. Acute Care Hospital Inpatient Prospective Payment System (IPPS)

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 that have been approved for special add-on payments. To qualify, a new technology must demonstrate that it is a substantial clinical improvement over technologies 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 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, 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. Inpatient Rehabilitation Facilities

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 and 67 FR 49982, August 1, 2002). 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. Psychiatric Hospitals and Units

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 psychiatric hospitals and units 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 maintain budget neutrality. We are in the process of developing a proposed rule, to be followed by a final rule, to implement the PPS for psychiatric hospitals and units (referred to as inpatient psychiatric facilities (IPFs).

3. Critical Access Hospitals

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

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.

B. Summary of the Provisions of the May 19, 2003 Proposed Rule

On May 19, 2003, we published a proposed rule in the **Federal Register** (68 FR 27154) that set forth proposed changes to the Medicare IPPS for operating costs and for capital-related costs in FY 2004. We also set forth proposed changes relating *to* payments for GME costs, payments to CAHs, and payments to providers classified as psychiatric hospitals and units that continue to be excluded from the IPPS and paid on a reasonable cost basis. These changes were proposed to be effective for discharges occurring on or after October 1, 2003.

The following is a summary of the major changes that we proposed and the issues we addressed in the May 19, 2003 proposed rule:

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

As required by section 1886(d)(4)(C) of the Act, we proposed annual adjustments to the DRG classifications and relative weights. Based on analyses of Medicare claims data, we proposed to establish a number of new DRGs and make changes to the designation of diagnosis and procedure codes under other existing DRGs.

Among the proposed changes discussed were:

- Expansion of the number of DRGs that are split on the basis of the presence or absence of complications or comorbidities (CCs). The DRGs we proposed to split were: DRG 4 (Spinal Procedures) into proposed new DRGs 531 and 532 (Spinal Procedures With and Without CC, respectively); DRG 5 (Extracranial Vascular Procedures) into proposed new DRGs 533 and 534 (Extracranial Vascular Procedures With and Without CC, respectively); DRG 231 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur) into proposed new DRGs 537 and 538 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur With and Without CC, respectively); and DRG 400 (Lymphoma and Leukemia With Major O.R. Procedure) into proposed new DRGs 539 and 540 (Lymphoma and Leukemia With Major O.R. Procedure With and Without CC, respectively).
- Creation of a new DRG for patients with an intracranial vascular procedure and an intracranial hemorrhage. The DRG we proposed to create was DRG 528 (Intracranial Vascular Procedure With a Principal Diagnosis of Hemorrhage).
- Creation of two new DRGs, differentiated on the basis of the presence or absence of a CC, for craniotomy patients with only a vascular shunt procedure. The DRGs we proposed to create were DRGs 529 and 530 (Ventricular Shunt Procedure With CC and Without CC, respectively).
- Creation of two new DRGs to differentiate current DRG 514 (Cardiac Defibrillator Implant With Cardiac Catheterization) on the basis of whether the patient does or does not experience any of the following symptoms: acute myocardial infarction, heart failure, or shock. The new DRGs we proposed were DRG 535 (Cardiac Defibrillator Implant With Cardiac Catheterization and With Acute Myocardial Infarction, Heart Failure, or Shock) and DRG 536 (Cardiac Defibrillator Implant With Cardiac Catheterization and Without Acute Myocardial Infarction, Heart Failure, or Shock)
- Changes in the DRG assignment of certain congenital anomalies that currently result in patients being assigned to newborn DRGs even when the patient is actually an adult. We also proposed adding to the list of major problems in newborns that affect DRG assignment.
- Modification of DRG 492 (Chemotherapy With Acute Leukemia as

Secondary Diagnosis) to include in this DRG cases receiving high-dose Interleukin-2 (IL–2) chemotherapy for patients with advanced renal cell cancer and advanced melanoma.

We also presented our analysis of applicants for add-on payments for high-cost new medical technologies and proposed a revision to the high-cost threshold for a new technology or medical service to qualify for add-on payments.

- We proposed to continue to make add-on payments for Xigris.
- We discussed new applications for add-on payments for FY 2004.
- We proposed to reduce the high-cost threshold for a new technology or medical service to qualify for add-on payments from 1 standard deviation above the geometric mean standardized charge for cases in the DRGs to which the new technology is assigned to 75 percent of 1 standard deviation.

2. Changes to the Hospital Wage Index

We proposed revisions to the wage index and the annual update of the wage data. Specific issues addressed in this section included the following:

- The FY 2004 wage index update, using wage data from cost reporting periods that began during FY 2000.
- Exclusion of the wage data for rural health centers (RHCs) and Federally qualified health centers (FQHCs) from the calculation of the FY 2004 wage index.
- Exclusion of paid hours associated with military and jury duty leave from the wage index calculation, and request for comments on possible exclusion of paid lunch or meal break hours.
- Revisions to the wage index based on hospital redesignations and reclassifications.
- Amendments to the timetable for reviewing and verifying the wage data that will be in effect for the FY 2005 wage index.

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

In the proposed rule, we discussed several provisions of the regulations in 42 CFR Parts 412 and 413 and set forth certain proposed changes concerning the following:

- Expansion of the current postacute transfer policy to 19 additional DRGs.
- Clarification of our policies that would be applied to counting hospital beds and patient days, in particular with regard to the treatment of swing-beds and observation beds, for purposes of the IME and DSH adjustments.
- Changes in our policy relating to nursing and allied health education payments to wholly owned subsidiary educational institutions of hospitals.
- Clarification of our policy relating to application of redistribution of costs and community support funds in determining a hospital's resident training costs.
- A change in the amount of rural training time required for an urban hospital to qualify for an increase in the rural track FTE limitation.
- Inclusion of FTE residents training in rural tracks in a hospital's rolling average calculation.

4. PPS for Capital-Related Costs

We discussed the payment requirements for capital-related costs. We did not propose any changes to the policies on payments to hospitals for capital-related costs.

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

We discussed the following proposed revisions and clarifications concerning excluded hospitals and hospital units and CAHs:

- Revisions to the operation of excluded grandfathered hospitals-within-hospitals in effect on September 30, 1999.
- Clarification of the classification criteria for LTCHs.
- Clarification of the policy on payments for laboratory services provided by a CAH to patients outside a CAH.

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

In the Addendum to the May 19, 2003 proposed rule, we proposed changes to the amounts and factors for determining the FY 2004 prospective payment rates for operating costs and capital-related costs. We also established the proposed threshold amounts for outlier cases. In addition, we addressed update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2004 for hospitals and hospital units excluded from the PPS.

7. 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.

8. Recommendation of Update Factor for Hospital Inpatient Operating Costs

In Appendix B of the proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we provided our recommendations of the appropriate percentage changes for FY 2004 for the following:

- Large urban area and other area average standardized amounts (and hospital-specific rates applicable to SCHs and MDHs) for hospital inpatient services paid under the IPPS for operating costs.
- Target rate-of-increase limits to the allowable operating costs of hospital inpatient services furnished by hospitals and hospital units excluded from the IPPS.

9. 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. In the proposed rule, we discussed the MedPAC recommendations concerning hospital inpatient payment policies and presented our response to those recommendations. 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: *http://www.medpac.gov.*

C. Public Comments Received in Response to the May 19, 2003 IPPS Proposed Rule

We received approximately 4,200 timely items of correspondence containing multiple comments on the May 19, 2003 proposed rule. Summaries of the public comments and our responses to those comments are set forth below under the appropriate heading.

II. 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. Changes to the DRG classification system and the recalibration of the DRG weights for discharges occurring on or after October 1, 2003 are discussed below.

B. DRG Reclassification

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 2003, cases are assigned to one of 510 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
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 2003, 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 (DRGs 103, 480, 481, 495, 512, and 513, respectively) and for tracheostomies (DRGs 482 and 483). Cases are assigned to these DRGs before they are classified to an MDC.

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 having 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, 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 the feasibility of 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.

In the May 19, 2003 proposed rule, we proposed numerous changes to the DRG classification system for FY 2004. The changes we proposed to the DRG classification system for FY 2004, the public comments we received concerning the proposed changes, the final DRG changes, and the methodology used to recalibrate the DRG weights are set forth below. The changes we are implementing in this final rule will be reflected in the revised FY 2004 GROUPER version 21.0 and effective for discharges occurring on or after October 1, 2003. Unless otherwise noted in this final rule, our DRG analysis is based on data from the March 2002 update of the FY 2002 MedPAR file, which contains hospital bills received through March 31, 2002, for discharges in FY 2002.

2. Review of DRGs for a Split Based on Presence or Absence of a CC

In an effort to improve the clinical and cost cohesiveness of the DRG classification system, we have evaluated whether additional DRGs should be split based on the presence or absence of a CC. There are currently 116-paired DRGs that reflect a split based on the presence or absence of a CC. We last performed a systematic evaluation and considered changes to the DRGs to recognize the within-DRG cost differences based on the presence or absence of CCs in 1994 (May 27, 1994 IPPS proposed rule, 59 FR 27715). In the May 27, 1994 IPPS proposed rule, we described a refined DRG system based on a list of secondary diagnoses that have a major effect on the resources that hospitals use to treat patients across DRGs. We analyzed how the presence of the secondary diagnosis affected resource use compared to other secondary diagnoses, and classified these secondary diagnoses as non-CC, CC, or major CC. After finalizing the classification of secondary diagnoses, we evaluated which collapsed DRGs should be split based on the presence of a major CC, other CC, or both.[1] However, we did not implement this refined system because we did not believe it would be prudent policy to make changes for which we could not predict the effect on the case-mix (the average DRG relative weight for all cases) and, thus, payments (60 FR 29209). We were concerned that we would be unable to fulfill the requirement of section 1886(d)(4)(C)(iii) of the Act that aggregate payments may not be affected by DRG reclassification and recalibration of weighting factors. That is, our experience has been that hospitals respond to major changes to the DRGs by changing their coding practices in ways that increase total payments (for example, by beginning to include ICD–9–CM codes that previously did not affect payment for a case). Because changes in coding behavior do not represent a real increase in the severity of the overall mix of cases, total payments should not increase. We believe that the only way to ensure this behavioral response does not lead to higher total payments is to make an offsetting adjustment to the system in advance of the fiscal year for which the changes are effective.

Section 301(e) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554) authorized the Secretary to make such a prospective adjustment to the average standardized amounts for discharges occurring on or after October 1, 2001, to ensure the total payment impacts of changes to the DRGs do not result in any more or less total spending than would otherwise occur without the changes (budget neutrality).

We are not proceeding with implementing a refined DRG system at this time, pending a decision whether to replace the ICD–9–CM coding system with another classification system. The refined DRG system discussed in the May 1994 IPPS proposed rule involved a complete and thorough assessment of all of the ICD–9–CM diagnosis codes in order to establish an illness severity level associated with each code. Rather than undertaking the time-consuming process of establishing illness severity levels for all ICD–9–CM codes at this time, we believe the more prudent course would be to delay this evaluation pending the potential replacement of ICD–9–CM. For example, the National Committee on Health and Vital Statistics (NCHVS) is considering making a recommendation to the Secretary on whether to recommend the adoption of the ICD–10–CM and the ICD–10—Procedure Coding System (PCS) as the national uniform standard coding system for inpatient reporting.

In the meantime, we have undertaken an effort to identify additional DRGs where a CC split appears most justified. Our analysis identified existing DRGs that meet the following criteria: a reduction in variance in charges within the DRG of at least 4 percent; fewer than 75 percent of all patients in the current DRG would be assigned to the with-CC DRG; and the overall payment impact (higher payments for cases in the with-CC DRG offset by lower payments for cases in the without-CC DRG) is at least $40 million.

The following four DRGs meet these criteria: DRG 4 (Spinal Procedures) and

[1] The complete description of the analysis was published in the *Health Care Financing Review* (Edwards, N., Honemann, D., Burley, D., Navarro, M., ''Refinement of the Medicare Diagnosis-Related Groups to Incorporate a Measure of Severity,'' *Health Care Financing Review,* Winter 1994, Vol. 16, No. 2, p. 45).

DRG 5 (Extracranial Vascular Procedures) in MDC 1 (Diseases and Disorders of the Nervous System); DRG 231 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur) in MDC 8 (Diseases and Disorders of the Musculoskeletal and Connective Tissue); and DRG 400 (Lymphoma and Leukemia with Major O.R. Procedure) in MDC 17 (Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms).

The following data indicate that the presence or absence of a CC was found to have a significant impact on patient charges and on average lengths of stay in these four DRGs.

DRG	Number of cases	Average charges	Average length of stay
DRG 4 (Current)	4,488	$35,074	7.3
With CC	2,514	46,071	10.0
Without CC	1,974	21,070	3.9
DRG 5 (Current)	64,942	18,613	2.9
With CC	29,296	23,213	4.1
Without CC	35,646	14,833	2.0
DRG 231 (Current)	8,971	20,147	4.9
With CC	4,565	25,948	6.9
Without CC	4,406	14,136	2.9
DRG 400 (Current)	4,275	39,953	9.0
With CC	2,990	49,044	11.2
Without CC	1,285	18,799	4.0

Therefore, we proposed to establish the following new DRGs: proposed DRG 531 (Spinal Procedures With CC) and proposed DRG 532 (Spinal Procedures Without CC) in MDC 1; proposed DRG 533 (Extracranial Procedures With CC) (the proposed rule incorrectly included ''Vascular'' in the title) and proposed DRG 534 (Extracranial Procedures Without CC) (the proposed rule incorrectly included ''Vascular'' in the title) in MDC 1; proposed DRG 537 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur With CC) and proposed DRG 538 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur Without CC) in MDC 8; and proposed DRG 539 (Lymphoma and Leukemia With Major O.R. Procedure With CC) and DRG 540 (Lymphoma and Leukemia With Major O.R. Procedure Without CC) in MDC 17. We proposed that DRGs 4, 5, 231, and 400 would become invalid.

Comment: Seven commenters supported the proposed expansion of the number of DRGs related to spinal procedures and extracranial vascular procedures and the removal of internal fixation devices. One commenter commended CMS for the proposed change to payments for implanting spinal code stimulation devices. Referring to proposed new DRGs 531 and 532, the commenter stated that most inpatients receiving a spinal cord stimulator implant have a comorbid condition, which adds significantly to the cost of care and can serve as a barrier to patient access. Another commenter specifically supported the new DRGs 533 and 534 for extracranial vascular procedures.

One commenter expressed support for CMS' recognition of cost differences within a given DRG based on the presence or absence of a CC and encouraged CMS to continue to consider secondary diagnoses that can have a substantial effect on hospital resources when restructuring DRGs based on cost considerations.

Response: We appreciate the support for these proposals and are adopting them as final without further modification.

We are establishing new DRGs 531, 532, 533, 534, 537, 538, 539, and 540, effective for discharges occurring on or after October 1, 2003. As a result of establishing these new DRGS, DRGs 4, 5, 231, and 400 are invalid, effective October 1, 2003. We will continue to monitor whether additional DRGs should be split based on the presence or absence of a CC.

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

a. Revisions of DRGs 1 and 2

In the FY 2003 IPPS final rule, we split DRGs 1 and 2 (Craniotomy Age > 17 With and Without CC, respectively) based on the presence or absence of a CC (67 FR 49986). We have received several proposals related to devices or procedures that are used in a small subset of cases from these DRGS. These proposals argue that the current payment for these devices or procedures under DRGs 1 and 2 is inadequate.

Therefore, we conducted an analysis of the charges for various procedures and diagnoses within DRGs 1 and 2 to assess whether further changes to these DRGs may be warranted. Currently, the average charges for cases assigned to DRGs 1 and 2 are approximately $55,000 and $30,000, respectively. In the May 19, 2003 proposed rule, we proposed to create two separate new DRGs for: (1) cases with an intracranial vascular procedure and a principal diagnosis of an intracranial hemorrhage; and (2) craniotomy cases with a ventricular shunt procedure (absent another procedure). The former set of cases are much more expensive than those presently in DRGs 1 and 2; the latter set of cases are much less expensive.

(1) Intracranial Vascular Procedures

Our analysis indicated that patients with an intracranial vascular procedure and a principal diagnosis of an intracranial hemorrhage were significantly more costly than other cases in DRGS 1 and 2. These patients have an acute condition with a high severity of illness and risk of mortality. There were 917 cases in DRGs 1 and 2 with an intracranial vascular procedure and a principal diagnosis of hemorrhage with average charges of approximately $113,884, which are much higher than the average charges of DRGS 1 and 2 noted above.

We also found 890 cases that had an intracranial vascular procedure without a principal diagnosis of hemorrhage (for example, nonruptured aneurysms). These cases are generally less acutely ill than those involving ruptured aneurysms, and have a lower risk of mortality. Among these 890 cases, the average charges were approximately $52,756, which are much more similar to the average charges for all cases in DRGs 1 and 2.

Based on this analysis, we proposed to create new DRG 528 (Intracranial Vascular Procedure With a Principal Diagnosis of Hemorrhage) for patients with an intracranial vascular procedure and an intracranial hemorrhage. We proposed that cases involving intracranial vascular procedures without a principal diagnosis of hemorrhage would remain in DRGs 1 and 2.

We indicated that proposed new DRG 528 would have the following principal diagnoses:

- 094.87, Syphilitic ruptured cerebral aneurysm
- 430, Subarachnoid hemorrhage
- 431, Intracerebral hemorrhage
- 432.0, Nontraumatic extradural hemorrhage
- 432.1, Subdural hemorrhage
- 432.9, Unspecified intracranial hemorrhage

And operating room procedures:

- 02.13, Ligation of meningeal vessel
- 38.01, Incision of vessel, intracranial vessels
- 38.11, Endarterectomy, intracranial vessels
- 38.31, Resection of vessel with anastomosis, intracranial vessels
- 38.41, Resection of vessel with replacement, intracranial vessels
- 38.51, Ligation and stripping of varicose veins, intracranial vessels
- 38.61, Other excision of vessels, intracranial vessels
- 38.81, Other surgical occlusion of vessels, intracranial vessels
- 39.28, Extracranial-intracranial (EC–IC) vascular bypass
- 39.51, Clipping of aneurysm
- 39.52, Other repair of aneurysm
- 39.53, Repair of arteriovenous fistula
- 39.72, Endovascular repair or occlusion of head and neck vessels
- 39.79, Other endovascular repair of aneurysm of other vessels

(2) Ventricular Shunt Procedures

We also found that craniotomy patients who had a ventricular shunt procedure (absent another procedure) were significantly less costly than other craniotomy patients in DRGs 1 and 2. Ventricular shunts are normally performed for draining intracranial fluid. A ventricular shunt is a less extensive procedure than the other intracranial procedures in DRGs 1 and 2. As a result, if a ventricular shunt is the only intracranial procedure performed, these cases will typically be less costly.

There were 4,373 cases in which only ventricular shunt procedures were performed. These cases had average charges of approximately $27,188. However, the presence or absence of a CC had a significant impact on patient charges and lengths of stay. There were 2,533 cases with CC, with average charges of approximately $33,907 and an average length of stay of 8.2 days. In contrast, there were 1,840 cases without CC, with average charges of approximately $17,939 and an average length of stay of 3.7 days.

Therefore, we proposed to create two new DRGs, splitting with CC and without CC, for patients with only a vascular shunt procedure: proposed new DRG 529 (Ventricular Shunt Procedures With CC) and proposed new DRG 530 (Ventricular Shunt Procedures Without CC).

We indicated that proposed new DRG 529 would consist of any principal diagnosis in MDC 1 (erroneously cited as MDC 5 in the proposed rule), with the presence of a CC and one of the following operating room procedures:

- 02.31, Ventricular shunt to structure in head and neck
- 02.32, Ventricular shunt to circulatory system
- 02.33, Ventricular shunt to thoracic cavity
- 02.34, Ventricular shunt to abdominal cavity and organs
- 02.35, Ventricular shunt to urinary system
- 02.39, Other operations to establish drainage of ventricle
- 02.42, Replacement of ventricular shunt
- 02.43, Removal of ventricular shunt

We proposed that the proposed new DRG 530 would consist of any principal diagnosis in MDC 1 (erroneously cited as MDC 5 in the proposed rule) with one of the operating room procedures listed above for the proposed new DRG 529, but without the presence of a CC.

Comment: Four commenters supported the proposed creation of two DRGs to capture ventricular shunt procedures. Ten commenters supported the proposed creation of new DRG 528 for an intracranial vascular procedure with a principal diagnosis of hemorrhage.

Two commenters requested that CMS verify its GROUPER analysis and clarify in the final rule the estimated number of cases that will be assigned to DRG 528. One commenter also believed that CMS is underestimating the volume of hemorrhagic cases that would be assigned to this new DRG. The commenter indicated that its analysis of MedPAR 2001 data demonstrated 1,550 cases.

Response: We conducted an analysis based on later available MedPAR data and found 1,596 cases that would be assigned to DRG 528 (based on a full year of MedPAR data). This volume is consistent with the commenter's analysis, although different MedPAR files were used in the analysis. In the proposed rule (68 FR 27161), we reported 917 cases based on preliminary data (6 months' worth of cases) that we analyzed when we considered the proposed change in the DRG classification. There were actually 1,354 cases grouped to the proposed new DRG 528 for the proposed rule.

Comment: One commenter suggested the creation of a new companion DRG to DRG 528 for intracranial vascular procedures for unruptured cerebral aneurysms. The commenter was concerned that the charges for endovascular repair of unruptured aneurysms is higher than other procedures currently assigned to DRG 2.

Response: The average charges for unruptured aneurysm cases varied according to the DRG to which the cases were assigned. The average charges for these cases in DRG 1 were slightly higher than the overall charges for that DRG, of approximately $69,682 and $54,900, respectively. However, we found that these charges are consistent with the variation of charges within this DRG and, therefore, did not propose a change in the DRG reclassification. Similarly, for cases assigned to DRG 2, we found the average charges of approximately $36,077 are consistent with the overall average charges of that DRG of approximately $32,000. We will continue to monitor these cases.

Comment: Three commenters requested a change to the DRG assignment of cases involving implantation of GLIADEL® chemotherapy wafers to treat brain tumors.[2] One of the commenters offered two options: create a new DRG or reassign these cases to DRG 484 (Craniotomy for Multiple Significant Trauma). The commenter cited an example in which CMS has in the past grouped together in the same DRG cases that are clinically dissimilar but similar in resource intensity when there were no other options available. For FY 1998 (62 FR 45974), coronary stent cases were moved from DRG 112 (Percutaneous Cardiovascular Procedures) to DRG 116 (Other Permanent Cardiac Pacemaker Implant or PTCA with Coronary Artery Stent Implant). In that instance, CMS concluded that, although coronary artery stent cases are not clinically similar to the pacemaker cases in DRG 116, the resource consumption of these

[2] We also discuss this issue later in this preamble under section II.E.3.b. relative to the application for new technology add-on payments for the GLIADEL® wafer.

cases is very similar. The commenter contended that, absent another appropriate craniotomy DRG, the same argument could be applied to assigning cases with GLIADEL® wafer to DRG 484.

In a comment on the proposed rule, the manufacturer of this implant provided estimated FY 2003 average costs and charges for these cases. Its report indicated that the costs of the cases of $24,280 would be the same for cases assigned to DRG 1 and DRG 2, and the charges of the cases of $50,394 would be the same for both DRGs. The manufacturer requested that we analyze the available data in the FY 2003 MedPAR file to identify GLIADEL® cases. The manufacturer believed these data support the need for a DRG change.

One commenter agreed with our determination that this technology is currently reflected within the DRG weights and does not meet the definition of a new technology.

Response: In our analysis of the data from the March 2003 update of the FY 2003 MedPAR file, we found a total of 61 cases in which the ICD–9–CM procedure code 00.10 (Implantation of a chemotherapeutic 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. Consistent with the GROUPER logic for these DRGs that splits cases based on the presence or absence of CCs, we found that the average standardized charges in DRGs 1 and 2 were approximately $64,864 and $42,624, respectively. We believe that while the charges for GLIADEL® wafer cases may be higher than the average standardized charges for DRG 2, they are within the normal variation of the overall charges within each DRG.

We note that the DRGs are a system of averages, and there is expected to be variation in the average charges for different procedures and services across all DRGs. Hospitals are expected to be able to finance some higher cost procedures with lower cost procedures within the same DRG as well as across DRGs. Although the average charges of the cases we identified in our analysis are somewhat higher than the average charges of all cases in these DRGs, they are within the range of other procedures included in these DRGs. By way of comparison, we are creating a new DRG for cases with an intracranial vascular procedure and a principal diagnosis of an intracranial hemorrhage on the basis of our analysis that showed the average charges for these cases were $113,884. This is approximately $59,000 more than the average charges in DRG 1 (more than the total charges for the GLIADEL® cases reported by the commenter) and approximately $84,000 more than the average charges in DRG 2.

We also are concerned that there may be insufficient volume of cases to warrant the establishment of a new DRG for this technology. Thus, before considering the creation of a new DRG for these cases, we would like to review a full year of data, as well as consider alternative options if they appear warranted. It would also be necessary to provide opportunity for public comment on any potential changes to the DRG assignment of these cases before proceeding with a final change.

Currently, DRG 484 includes complex, multiple significant trauma cases; that is, patients with a principal diagnosis of trauma and at least two significant trauma diagnosis codes (either as principal or secondary diagnosis) from different body site categories. While this DRG includes craniotomy, it is assigned to MDC 24 (Multiple Significant Trauma). While the treatment for glioblastoma multiforme is significant, we do not believe these cases are clinically similar to other cases currently assigned to DRG 484.

We also are concerned that there may be insufficient volume to warrant the establishment of a new DRG for this technology, and we would like to review a full year of data, as well as consider alternative options if they appear warranted. It also would be necessary to provide opportunity for public comment on any potential changes before proceeding with a final change.

Comment: Two commenters pointed out a typographical error in our proposal. The commenters indicated that we proposed new DRGs 529 and 530 for placement in MDC 5; the correct MDC should have been MDC 1.

Response: We agree with the commenters and have corrected this placement, as indicated in the discussion above.

After consideration of the comments received, we are adopting as final the three new proposed DRGs 528, 529, and 530. These DRGS will be effective for discharges occurring on or after October 1, 2003.

b. DRG 23 (Nontraumatic Stupor and Coma)

In DRG 23 (Nontraumatic Stupor and Coma), there are currently six principal diagnoses identified by the following ICD–9–CM diagnosis codes: 348.4, Compression of the brain; 348.5, Cerebral edema; 780.01, Coma; 780.02, Transient alteration of awareness; 780.03, Persistent vegetative state; and 780.09, Other alteration of consciousness. Code 780.02 is often used to describe the diagnosis of psychiatric patients rather than the diagnosis of patients with severe neurological disorders. The treatment plan for a patient with ''transient alteration of awareness'' is clinically very different from the treatment plan for a coma patient. Furthermore, many patients with this diagnosis are treated in psychiatric facilities rather than in acute care hospitals.

Although there are neurological patients who present with the complaint of ''transient alteration of awareness,'' the cause of this alteration of consciousness is commonly identified, and the principal diagnosis for the hospital admission is the etiology of the alteration of consciousness rather than the symptom itself. For the few remaining neurological patients for whom the cause is not identified and for whom code 780.02 is assigned as the principal diagnosis, we believe that the care of these patients is different than the care of patients with coma or cerebral edema.

Because we believe the patients with a principal diagnosis of ''transient alteration of consciousness'' are more clinically related to the patients in DRG 429 (Organic Disturbances and Mental Retardation) in MDC 19 (Mental Diseases and Disorders), we proposed that patients who are assigned a principal diagnosis of code 780.02 would be assigned to DRG 429 instead of DRG 23. DRG 429 also contains similar diagnoses, such as code 293.81, Organic delusional syndrome and code 293.82, Organic hallucinosis syndrome. (We note that the charges for the patient cases in DRGs 23 and 429 are very similar ($11,559 and $11,713, respectively), so the proposed movement of code 780.02 from DRG 23 to DRG 429 would have minimal payment impact.) Moving this diagnosis code as proposed would also consolidate diagnoses treated frequently in psychiatric hospitals in those DRGs that are likely to be a part of the upcoming proposed Medicare psychiatric facility PPS.

Comment: An organization representing hospitals supported our proposed change, while other commenters opposed the change. The commenters who opposed the change stated that code 780.02 is included in the ICD–9–CM chapter for signs and symptoms of ill-defined conditions. The commenters believed that since this code is included in a chapter with ill-defined conditions, it would be inappropriate to move the code to DRG 429. The commenters stated that this

code does not describe a mental disorder; and disagreed with our statement in the proposed rule that code 780.02 was similar to codes 293.81 and 293.82. The commenters further stated that they disagreed with our assertion that many patients with a diagnosis of transient alteration of awareness are treated in psychiatric facilities.

Response: Our review of claims data indicates that code 780.02 is a frequent diagnosis for patients admitted to psychiatric hospitals. Many patients are likely to present with transient alteration of awareness at the time of admission to a psychiatric hospital. The cause of this transient alteration is likely to be diagnosed during the stay, leading to the assignment of another, more specific principal diagnosis.

However, in many patients, this is not the case, and no underlying cause for the transient alteration of awareness is determined. When a more definitive diagnosis cannot be made, the patient is left with the diagnosis of alteration of awareness. We recognize the difficulty in assigning symptoms such as these to the most appropriate DRG. However, we will note that the average charges for DRG 23 (where the code is currently assigned) and DRG 429 are similar.

Therefore, we are proceeding with the assignment of code 780.02 to DRG 429 based on a review of psychiatric hospital data as well as a clinical comparison of cases already assigned to DRG 429.

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

a. DRG 478 (Other Vascular Procedures With CC) and DRG 479 (Other Vascular Procedures Without CC)

Code 37.64 (Removal of heart assist system) in DRGs 478 and 479 describes the operative, as opposed to bedside, removal of a heart assist system. Based on comments we received suggesting that code 37.64 was inappropriately assigned to DRGs 478 and 479, we reviewed the MedPAR data for both DRGs 478 and 479 and DRG 110 (Major Cardiovascular Procedures With CC) and DRG 111 (Major Cardiovascular Procedures Without CC) to assess the appropriate assignment of code 37.64.

We found that there were only 17 cases of code 37.64 in DRGs 478 and 479, with an average length of stay of 14.1 days and average charges of $105,153. There were a total of 90,591 cases in DRGs 478 and 479 that did not contain code 37.64. These cases had an average length of stay of 6.6 days and average charges of $31,879. In DRGs 110 and 111, we found an average length of stay of 8.1 days, with average charges of $54,653.

We proposed to remove code 37.64 from DRGs 478 and 479 and reassign it to DRGs 110 and 111. The surgical removal of a heart assist system is a major cardiovascular procedure and, therefore, more appropriately assigned to DRGs 110 and 111. Accordingly, we believe this DRG assignment for this procedure is more clinically and financially appropriate.

We received two comments in support of this change. Therefore, we are adopting as final our proposal to remove code 37.64 from DRGs 478 and 479 and assign it to DRGs 110 and 111.

b. DRGs 514 (Cardiac Defibrillator Implant With Cardiac Catheterization) and 515 (Cardiac Defibrillator Implant Without Cardiac Catheterization)

(1) Cardiac Defibrillator Implant With Cardiac Catheterization With Acute Myocardial Infarction

Prior to the publication of the proposed rule, we received a recommendation to modify DRG 514 (Cardiac Defibrillator Implant With Cardiac Catheterization) and DRG 515 (Cardiac Defibrillator Implant Without Cardiac Catheterization) so that these DRGs are split based on the presence or absence of acute myocardial infarction, heart failure, or shock as a principal diagnosis. We note that the increased cost of treating cardiac patients with acute myocardial infarction, heart failure, or shock is recognized in the payment logic for pacemaker implants (DRG 115 (Permanent Cardiac Pacemaker Implant With Acute Myocardial Infarction, Heart Failure or Shock, or AICD Lead or Generator) and DRG 116 (Other Permanent Cardiac Pacemaker Implant)).

We examined FY 2002 MedPAR data regarding the number of cases and the average charges for DRGs 514 and 515. The results of our examination are summarized in the following table.

DRG	Number of cases	Average charges	With AMI, heart failure, or shock count	Average charges
514	16,743	$97,133	3,623	$120,852
515	4,674	76,537	935	84,140

A cardiac catheterization is 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 found that the average charges for patients with cardiac catheterizations who also were admitted with acute myocardial infarction, heart failure, or shock were $120,852, compared to the average charges for all DRG 514 cases of $97,133. Therefore, we proposed to split DRG 514 and create a new DRG for patients receiving a cardiac defibrillator implant with cardiac catheterization and with a principal diagnosis of acute myocardial infarction, heart failure, or shock.

Patients without cardiac catheterization generally have had the need for the defibrillator established on an outpatient basis prior to admission. We found 935 cases with acute myocardial infarction, heart failure, or shock, with average charges of $84,140. The average charges for all cases in DRG 515 were $76,537. Because of the relatively small number of patients and the less-than-10-percent charge difference for patients in DRG 515 who have acute myocardial infarction, heart failure, or shock, we did not propose to create a separate DRG for patients with a cardiac defibrillator implant without cardiac catheterization with acute myocardial infarction, heart failure, or shock.

Specifically, we proposed to create two new DRGs that would replace the current DRG 514. We indicated that the two proposed new DRGs would have the same procedures currently listed for DRG 514, but would be split based on the presence or absence of acute myocardial infarction, heart failure, or

shock as a principal diagnosis. We proposed to establish new DRG 535 (Cardiac Defibrillator Implant With Cardiac Catheterization and With Acute Myocardial Infarction, Heart Failure, or Shock) and new DRG 536 (Cardiac Defibrillator Implant With Cardiac Catheterization and Without Acute Myocardial Infarction, Heart Failure, or Shock). Proposed new DRG 536 would exclude the following principal diagnosis codes from MDC 5 associated with acute myocardial infarction, heart failure, or shock.

- 398.91, Rheumatic heart failure
- 402.01, Malignant hypertensive heart disease with heart failure
- 402.11, Benign hypertensive heart disease with heart failure
- 402.91, Hypertensive heart disease not otherwise specified 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, Hypertensive heart and renal disease not otherwise specified with heart failure
- 404.93, Hypertensive heart and renal disease not otherwise specified with heart failure and renal failure
- 410.01, AMI anterolateral, initial
- 410.11, AMI anterior wall, initial
- 410.21, AMI inferolateral, initial
- 410.31, AMI inferopost, initial
- 410.41, AMI inferior wall, initial
- 410.51, AMI lateral not elsewhere classified, initial
- 410.61, True posterior infarction, initial
- 410.71, Subendocardial infarction, initial
- 410.81, AMI not elsewhere classified, initial
- 410.91, AMI not otherwise specified, initial
- 428.0, Congestive heart failure, not otherwise specified
- 428.1, Left heart failure
- 428.20, Systolic heart failure, not otherwise specified
- 428.21, Acute systolic heart failure
- 428.22, Chronic systolic heart failure
- 428.23, Acute on chronic systolic heart failure
- 428.30, Diastolic heart failure, not otherwise specified
- 428.31, Acute diastolic heart failure
- 428.32, Chronic diastolic heart failure
- 428.33, Acute on chronic diastolic heart failure
- 428.40, Combined systolic and diastolic heart failure not otherwise specified
- 428.41, Acquired combined systolic and diastolic heart failure
- 428.42, Chronic combined systolic and diastolic heart failure
- 428.43, Acute on chronic combined systolic and diastolic heart failure
- 428.9, Heart failure, not otherwise specified
- 785.50, Shock, not otherwise specified
- 785.51, Cardiogenic shock

(2) Cardiac Resynchronization Therapy (CRT)

Prior to the publication of the proposed rule, we received a comment from a provider who pointed out that we did not include the following combination of codes under the list of procedure combinations that would lead to an assignment of DRG 514 or DRG 515:

- 37.95, Implantation of automatic cardioverter/defibrillator lead(s) only
- 00.54, Implantation or replacement of cardiac resynchronization defibrillator, pulse generator device only [CRT–D]

The commenter pointed out that cases are assigned to DRGs 514 and 515 when a total cardiodefibrillator or CRT–D system is implanted. In addition, cases are assigned to DRGs 514 and 515 when implantation of a variety of combinations of defibrillator leads and device combinations is reported. The commenter indicated that a total defibrillator and CRT–D system may be replaced with a completely new system or all new devices and leads, and added that it is also possible to replace a generator, a lead, or a combination of generators and up to three leads.

When the CRT–D generator (code 00.54) and one of the cardioverter/defibrillator leads are replaced, the case currently is assigned to DRG 115 (Permanent Cardiac Pacemaker Implant with AMI, Heart Failure, or Shock or AICD Lead or Generator Procedure). The commenter recommended that we include the combination of codes 37.95 and 00.54 as a combination that would result in assignment to DRG 514 or DRG 515, as do other combinations of generators and leads. Our medical advisors agree with this recommendation. As discussed previously, we proposed to delete DRG 514 and replace it with proposed new DRGs 535 and 536. Therefore, we proposed to add codes 37.95 and 00.54 to the list of procedure combinations that would result in assignment to DRG 515 or new proposed DRGs 535 and 536.

Comment: Several commenters supported our proposed revision to DRG 514 so that it would be split based on the presence or absence of a principal diagnosis of acute myocardial infarction, heart failure, or shock.

One commenter pointed out a typographical error in the proposed rule in the code number cited for the procedure, Implantation of automatic cardioverter/defibrillator lead(s) only. The code number should have been 37.95 instead of 39.75.

Response: We appreciate the support for our proposed revision of DRG 514. We have corrected the code number for Implantation of automatic cadioverter/defibrillator lead(s) only to 37.95 in the description of this issue above.

Comment: Several commenters supported the addition of codes 37.95 and 00.54 to the list of procedure combinations that would lead to an assignment of DRG 515 and new DRGs 535 and 536. However, one commenter suggested that, in addition to this combination, codes 37.97 (Replacement of automatic cardioverter/defibrillator lead(s) only and 00.54 also should be added to the procedure combination list under DRG 515 and new DRGs 535 and 536. The commenter pointed out that both procedures would involve the insertion of a pulse generator and a lead so that resources required are equivalent to those for a total system implant.

Response: We agree with the commenter that the combination of codes 37.97 and 00.54 also would involve the implantation of a pulse generator and a lead. Therefore, in this final rule, we are adding the combination of procedure codes 37.97 and 00.54 to the list of procedure combinations that will lead to assignment to DRG 515 and new DRGs 535 and 536.

Comment: One commenter recommended that CMS also consider modifying DRGs 115 and 116 to recognize more combination groups of devices and leads. Specifically, the commenter recommended adding the following combination of codes to the list of procedure combinations under DRGs 115 and 116:

- 00.53, Implantation or replacement of CRT–P pulse generator only
- 37.74, Implantation or replacement of epicardial pacemaker lead.

Response: DRGs 115 and 116 have one of the most complex assignment structures of all the DRGs. The DRG logic for DRGs 115 and 116 involves three separate combinations of code groups that can possibly lead to these DRG assignments. Before making a

modification to one of the combination groups (particularly the procedure combinations), we believe we should analyze the impact of a modification to the currently existing types of device, lead, and diagnosis combinations. In the future, we will undertake a close review of DRGs 115 and 116 to determine if additional modifications, such as the one suggested, are needed.

Comment: Two commenters supported the proposal to restructure DRG 514 through the creation of new DRGs 535 and 536. One of the commenters supported the division of these new DRGs based on the presence or absence of acute myocardial infarction, heart failure, or shock. However, the commenter believed that this new structure would lead to significant confusion among hospital coders with respect to the coding of CRT–Ds. The commenter stated that hospital coders may be confused when a patient is admitted with one diagnosis, but then develops an acute myocardial infarction, heart failure, or shock after the admission but prior to discharge. In these cases, the acute myocardial infarction, heart failure, or shock would be a secondary diagnosis. The split of DRGs 535 and 536 is based on these conditions when they are the principal diagnosis (reason for the hospital admission). To eliminate the potential for misunderstanding, the commenter requested that the definition of DRG 535 be modified so that patients who receive CRT–D devices are assigned to DRG 535 when an ICD–9–CM diagnosis code for heart failure is present as either a principal or secondary diagnosis.

Response: We appreciate the support from the commenters for our proposal to modify DRG 514 through the creation of new DRGs 535 and 536. We note that the issue of coding the implantation of CRT–Ds has been covered through extensive articles in the American Hospital Association's *Coding Clinic for ICD–9–CM.* In the past, the coding of cases with acute myocardial infarction, heart failure, or shock has not been problematic for hospital coding specialists. However, should the DRG modifications lead to coding questions on CRT–D cases, we will ask the American Hospital Association to provide additional guidance in its *Coding Clinic for ICD–9–CM.* Furthermore, the DRG splits for an acute myocardial infarction, heart failure, or shock, which currently are included in DRGs 115 and 116, are based on these conditions being the principal diagnosis. As a result, this is a longstanding DRG logic precedent. We do not believe that replicating the logic used for splitting DRGs 115 and 116 and using it for DRGs 535 and 536 would create confusion for hospital coders. Rather, we believe hospital coders would easily recognize this type of longstanding DRG logic.

Comment: Another commenter supported the proposal to split DRG 514 into DRGs 535 and 536 based on the presence or absence of acute myocardial infarction, heart failure, or shock. The commenter stated that this split would ensure greater consistency within the DRG system and ensure adequate payment to hospitals for the higher costs patients receiving implantable cardioverter-defibrillator implants. However, the commenter recommended that DRG 515 undergo a similar split based on the presence or absence of acute myocardial infarction, heart failure, or shock. The commenter stated that the creation of these additional new DRGs would fully align payment logic across all pacemaker and implantable cardioverter-defibrillator implant devices. The manufacturer also believed that differences between average charges and average length of stay for these cases within DRG 515 would warrant this additional splitting of the DRG.

Response: We appreciate the support for the revisions involving DRGs 514, 535, and 536. However, when we examined the data for DRGs 514 and 515, we found that there were almost three times as many cases with an acute myocardial infarction, heart failure, or shock cases in DRG 515 as in DRG 514. Those cases in DRG 514 with a principal diagnosis of an acute myocardial infarction, heart failure, or shock, had average charges approximately 20 percent greater than the average charges for all cases in DRG 514. However, cases with a principal diagnosis of an acute myocardial infarction, heart failure, or shock in DRG 515 had average charges that were only about 10 percent greater than all cases in this DRG. Therefore, there is a significantly greater need for the DRG split for DRG 514. We will continue to examine cases within this area, and specifically DRG 515, to determine if additional DRG refinements are needed in the future.

Comment: One commenter, who supported the revisions to DRG 514 through the new DRGs 535 and 536, expressed concern about our coverage decisions on automatic implantable cardioverter-defibrillators. The commenter believed the coverage was extremely restricted.

Response: We appreciate the support of the commenter for new DRGs 535 and 536. We will share the concerns relating to coverage decisions on automatic implantable cardioverter-defibrillators with our coverage staff.

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

Prior to the issuance of the proposed rule, we received a comment that two codes for cervical fusion of the spine are not included within DRG 519 (Cervical Spinal Fusion With CC) and DRG 520 (Cervical Spinal Fusion Without CC). The two cervical fusion codes are:

- 81.01, Atlas-axis spinal fusion
- 81.31, Refusion of atlas-axis

The atlas-axis includes the first two vertebrae of the cervical spine (C1 and C2). These two cervical fusion codes are currently assigned to DRG 497 (Spinal Fusion Except Cervical With CC) and DRG 498 (Spinal Fusion Except Cervical Without CC). Because codes 81.01 and 81.31 involve the cervical spine, we proposed to remove these codes from DRGs 497 and 498 and reassign them to DRGs 519 and 520.

We did not receive any comments on this proposal. Therefore, we are adopting as final our proposal to remove codes 81.01 and 81.31 from DRGs 497 and 498 and reassign them to DRGs 519 and 520, effective for FY 2004.

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

a. Nonneonate Diagnoses

As indicated earlier, ICD–9–CM diagnosis codes are assigned to MDCs based on 25 groupings corresponding to a single organ system or etiology and, in general, are associated with a particular medical specialty. MDC 15 is comprised of diagnoses that relate to newborns and other neonates with conditions originating in the perinatal period. Some of the codes included in MDC 15 consist of conditions that originate in the neonatal period but can persist throughout life. These conditions are referred to as congenital anomalies. When an older (not neonate) population is treated for a congenital anomaly, DRG assignment problems can arise. For instance, if a patient is over 65 years old and is admitted with a congenital anomaly, it is not appropriate to assign the patient to a newborn DRG. This situation occurs when a congenital anomaly code is classified within MDC 15.

Prior to the publication of the proposed rule, we received a recommendation to move the following congenital anomaly codes from MDC 15 and reassign them to other appropriate MDCs based on the body system being treated:

- 758.9, Chromosome anomaly, not otherwise specified
- 759.4, Conjoined twins

- 759.7, Multiple congenital anomalies, not elsewhere classified
- 759.81, Prader-Willi syndrome
- 759.83, Fragile X syndrome
- 759.89, Specified congenital anomalies, not elsewhere classified
- 759.9, Congenital anomaly, not otherwise specified
- 779.7, Periventricular leukomalacia
- 795.2, Abnormal chromosomal analysis

Each of the congenital anomaly diagnosis codes recommended for reassignment represents a condition that is frequently addressed beyond the neonatal period. In addition, the assignment of these congenital anomaly codes as principal diagnosis currently results in assignment to MDC 15.

We evaluated the recommendation and agreed that each of the identified codes represents a condition that is frequently addressed beyond the neonate period and should therefore be removed from the list of principal diagnoses that result in assignment to MDC 15. Therefore, we proposed to change the MDC and DRG assignments of the congenital anomaly codes as specified in the following table. The table shows the principal diagnosis code for the congenital anomaly and the proposed MDC and DRG to which the code would be assigned.

Principal diagnosis code in MDC 15	Code title	Proposed MDC assignment	Proposed DRG assignment
758.9	Chromosome anomaly, not otherwise specified	23	467 (Other Factors Influencing Health Status).
759.4	Conjoined twins	6	188, 189, and 190 (Other Digestive System Diagnoses, Age >17 with CC, Age >17 without CC, and Age 0–17, respectively).
759.7	Multiple congenital anomalies, not elsewhere classified.	8	256 (Other Musculoskeletal System and Connective Tissue Diagnoses).
759.81	Prader-Willi syndrome	8	256 (Other Musculoskeletal System and Connective Tissue Diagnoses).
759.83	Fragile X syndrome	19	429 (Organic Disturbances and Mental Retardation).
759.89	Specified congenital anomalies, not elsewhere classified.	8	256 (Other Musculoskeletal System and Connective Tissue Diagnoses).
759.9	Congenital anomaly, not otherwise specified	23	467 (Other Factors Influencing Health Status).
779.7	Periventricular leukomalacia	1	34 and 35 (Other Disorders of Nervous System with CC, and without CC, respectively).
795.2	Abnormal chromosomal analysis	23	467 (Other Factors Influencing Health Status).

Comment: Several commenters supported all of the proposed changes relating to congenital anomalies. One commenter supported the changes in general, but mentioned several concerns. While this commenter agreed that it was feasible to move these congenital conditions out of MDC 15, the commenter suggested that those patients who are still in the neonatal period (first 28 days of life) when admitted should continue to be classified to MDC 15.

In addition, this commenter questioned whether the proposed DRG assignments were correct for codes 759.4 (Conjoined twins), code 759.7 (Multiple congenital anomalies, not elsewhere classified), and 759.89 (Specified congenital anomalies, not elsewhere classified). The commenter stated that although the proposed DRG assignments for these three DRGs may be appropriate based on the body system being treated for most cases, these DRGs do not necessarily reflect the body system affected or being treated. The commenter did not suggest alternative DRG assignments.

Response: We acknowledge the commenter's point that, for a minority of cases, the admission will, in fact, be in the neonatal period. However, the majority of cases will continue to be patients well beyond the neonatal period. The proposed DRG modifications will correct the majority of inappropriate DRG assignments that occur when adults are assigned to MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period). In the future, we will examine other means to further refine this area, such as making new DRG assignments for congenital anomalies based on the age of the patient. However, at this point, we are attempting to resolve the problems created for the majority of patients.

Regarding the commenter's concern that codes 759.4, 759.7, and 759.89 may not always be appropriately assigned according to our proposal, the commenter did not suggest an alternative. The commenter agreed that many cases with these three codes will be assigned to the appropriate body system by using our proposed DRG assignments. We recognize that reassignment of these codes will not resolve all problems, and some cases may be assigned to the wrong body system based on the patient's actual condition. However, we note that these three codes are vague and do not specify a precise congenital anomaly by body system. Therefore, we had to rely on our medical advisors to determine the most appropriate DRG for the majority of cases. Our main concern was to correct the DRG assignment that resulted in adults being assigned to a neonatal DRG when they had a congenital anomaly. We will continue to examine the data for these cases to determine if additional modifications are needed in the future.

Therefore, we are adopting the proposed revisions as final without modification.

b. Heart Failure Codes for Newborns and Neonates

Under MDC 15, cases of newborns and neonates with major problems may be assigned to DRG 387 (Prematurity With Major Problems) or DRG 389 (Full-Term Neonate With Major Problems). Existing DRG 387 has three components: (1) Principal or secondary diagnosis of prematurity; (2) principal or secondary diagnosis of major problem (these are the diagnoses that define MDC 15); or (3) secondary diagnosis of major problem (these are diagnoses that do not define MDC 15, so they will only be secondary diagnosis codes for patients assigned to MDC 15). To be assigned to DRG 389, the neonate must have one of the principal or secondary diagnoses listed under the DRG.

Prior to the publication of the proposed rule, we received correspondence suggesting that the following diagnosis codes for heart failure, which are currently in MDC 5, be added to the list of secondary diagnosis of major problems for neonates under MDC 15.

Diagnosis code	Title
428.20	Systolic heart failure, not otherwise specified.
428.21	Acute systolic heart failure.
428.22	Chronic systolic heart failure.
428.23	Acute on chronic systolic heart failure.
428.30	Diastolic heart failure, not otherwise specified.
428.31	Acute diastolic heart failure.
428.32	Chronic diastolic heart failure.
428.33	Acute on chronic diastolic heart failure.
428.40	Systolic/diastolic heart failure, not otherwise specified.
428.41	Acute systolic/diastolic heart failure.
428.42	Chronic systolic/diastolic heart failure.
428.43	Acute on chronic systolic/diastolic heart failure.

These heart failure-related diagnosis codes were new codes as of October 1, 2002. They were an expansion of the previous 4-digit codes for heart failure and provided additional detail about the specific type of heart failure. The codes for heart failure that existed prior to October 1, 2002, are classified as secondary diagnoses of major problems within MDC 15 and are currently assigned to DRGs 387 and DRG 389. We stated in the proposed rule that these other heart failure diagnosis codes should be included as principal diagnosis of major problem codes within MDC 15. However, these heart failure codes are currently listed in the secondary, not principal, diagnoses of major problems within MDC 15.

We agree that diagnosis codes 428.20 through 428.43 listed in the chart above should be included as secondary diagnosis of major problem codes within MDC 15, as are the other heart failure codes. Therefore, we proposed to add them to DRG 387 and 389.

Comment: Several commenters supported the proposal to add codes 428.20 through 428.43 (codes for heart failure that became effective October 1, 2002, listed in the chart above) to DRGs 387 and 389. The commenters agreed that the heart failure codes created on October 1, 2002, should be assigned to DRGs 387 and 389 in the same fashion as were those heart failure codes created prior to October 1, 2002.

One commenter indicated that we incorrectly described the addition of diagnosis codes 428.20 through 428.43 listed in the chart to the list of ''principal'' diagnosis of major problem codes. The commenter stated that we should have indicated that these codes would be added to the list of ''secondary'' diagnoses of major problem codes because this category is where the other heart failure codes are currently assigned.

Response: We agree that the codes should have been described as an addition to the list of secondary diagnoses of major problem codes within DRGs 387 and 389. We have clarified this point in the description above.

Comment: One commenter who supported the addition of the heart failure-related diagnosis codes (428.20 through 428.43) to DRGs 387 and 389, asked for clarification of how diagnoses for combined codes that include congestive heart failure will be handled. The commenter mentioned code 402.91 (Hypertensive heart disease with heart failure, unspecified benign or malignant) as an example.

Response: We will conduct an additional review of DRGs 387 and 389 to determine if additional codes should be added to the list of secondary diagnoses of major problems for FY 2005. We encourage commenters to send their recommendations to us to assist in this review.

We are adopting our proposal as final, with the clarification that the major problem codes are secondary, not principal, codes. Accordingly, we are adding codes 428.20 through 428.43 listed above to the list of secondary diagnoses of major problem codes within DRGs 387 and 389.

7. MDC 17 (Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms)

High-dose Interleukin-2 (IL–2) Chemotherapy is a hospital inpatient-based regimen requiring administration by experienced oncology professionals. It is used for the treatment of patients with advanced renal cell cancer and advanced melanoma. Unlike traditional cytotoxic chemotherapies that attack cancer cells themselves, Interleukin-2 is designed to enhance the body's defenses by mimicking the way natural IL–2 activates the immune system and stimulates the growth and activity of cancer-killing cells. The Food and Drug Administration (FDA) approved the IL–2 product on the market for use in 1992.

High-dose IL–2 therapy is performed only in very specialized treatment settings, such as an intensive care unit or a bone marrow transplant unit. This therapy requires oversight by oncology health care professionals experienced in the administration and management of patients undergoing this intensive treatment because of the severity of the side effects. Unlike most cancer therapies, high-dose IL–2 therapy is associated with predictable toxicities that require extensive monitoring. Often patients require one-on-one nursing or physician care for extended portions of their stay.

High-dose IL–2 therapy is significantly different from conventional chemotherapy in terms of the resources required to administer it. Conventional chemotherapy may be given to patients either on an outpatient basis or through a series of short (that is, 1 to 3 day) inpatient stays.

High-dose IL–2 therapy is given during two separate hospital admissions. For the first cycle, the IL–2 is administered every 8 hours over 5 days. Patients are then discharged to rest at home for several days and are admitted for the second cycle of therapy during which the same regimen and dosing is repeated. The two cycles complete the first course of high-dose IL–2 therapy. This regimen may be repeated at 8 to 12 weeks if the patient is responding. The maximum number of courses for any one patient is predicted to be five courses.

Not all patients with end-stage renal cell carcinoma or end-stage melanoma are appropriate candidates for high-dose IL–2 chemotherapy. It is estimated that there are between 15,000 and 20,000 patients in the United States who have one of these two types of cancer. However, only 20 percent of those patients will be appropriate candidates for the rigors of the treatment regimen. It is further estimated that, annually, approximately 1,300 of these patients will be Medicare beneficiaries. However, we have been informed by industry sources that, allegedly due to the level of payment for the DRGs to which these cases are currently assigned, only 100 to 200 Medicare patients receive the treatment each year. According to these industry sources, several treatment centers have had to discontinue their high-dose IL–2 therapy programs for end-stage renal cell carcinoma or end-stage melanoma because of the low Medicare payment.

According to industry sources, the wholesale cost of IL–2 is approximately $700 per vial. Dosages range between 15 and 20 vials per treatment, or between $10,500 and $14,000 per patient, per cycle, for the cost of the IL–2 drug alone. There is no ICD–9–CM procedure code that currently identifies patients receiving this therapy. Therefore, it is not possible to identify directly these cases in the MedPAR data. Currently, this therapy is coded using the more general ICD–9–CM code 99.28 (Injection or infusion of biologic response modifier). When we addressed this issue previously in the August 1, 2000 IPPS final rule (65 FR 47067) by examining cases for which procedure code 99.28

was present, our analysis was inconclusive due to the wide range of cases identified (1,179 cases across in 136 DRGs). However, recent data collected by the industry on 30 Medicare beneficiaries who received high-dose IL–2 therapy during FY 2002 show average charges for these cases of approximately $54,000.

Depending on the principal diagnosis reported, patients receiving high-dose IL–2 therapy may be assigned to one of the following five DRGs: DRG 272 (Major Skin Disorder With CC) and DRG 273 (Major Skin Disorder Without CC) in MDC 9; DRG 318 (Kidney and Urinary Tract Neoplasms With CC) and DRG 319 (Kidney and Urinary Tract Neoplasms Without CC) in MDC 11; and DRG 410 (Chemotherapy Without Leukemia as Secondary Diagnosis) in MDC 17. The following table illustrates the average charges for patients in these DRGs.

DRG	Average charges
272	$14,997
273	9,128
318	16,892
319	9,583
410	16,103

Because of the need to identify the subset of patients receiving this type of treatment, the ICD–9–CM Coordination and Maintenance Committee determined, based on its consideration at the December 6, 2002 public meeting, that a new code for high-dose IL–2 therapy was warranted. Therefore, a new code has been created in the 00 Chapter of ICD–9–CM (Procedures and Interventions, Not Elsewhere Classified), in category 00.1 (Pharmaceuticals) at 00.15 (High-dose infusion Interleukin-2 (IL–2)). The code is effective for cases discharged on or after October 1, 2003.

We believe patients receiving high-dose IL–2 therapy are clinically similar to other cases currently assigned to DRG 492 (Chemotherapy With Acute Leukemia as Secondary Diagnosis) in MDC 17. The average charge for patients currently assigned to DRG 492 is $55,581. Currently, DRG 492 requires one of the following two principal diagnoses:

- V58.1, Encounter for chemotherapy
- V67.2, Followup examination following chemotherapy

And one of the following secondary diagnoses:

- 204.00, Acute lymphoid leukemia without mention of remission
- 204.01, Acute lymphoid leukemia with remission
- 205.00, Acute myeloid leukemia without mention of remission
- 205.01, Acute myeloid leukemia with remission
- 206.00, Acute monocytic leukemia without mention of remission
- 206.01, Acute monocytic leukemia with remission
- 207.00, Acute erythremia and erythroleukemia without mention of remission
- 207.01, Acute erythremia and erythroleukemia with remission
- 208.00, Acute leukemia of unspecified cell type without mention of remission
- 208.01, Acute leukemia of unspecified cell type without mention of remission

We proposed to modify DRG 492 by adding new procedure code 00.15 to the logic. We indicated that assignment to this DRG would require the same two V-code principal diagnosis codes listed above (V58.1 and V67.2), but would require either one of the leukemia codes listed as a secondary diagnosis, or would require the procedure code 00.15. In addition, we proposed to change the title of DRG 492 to ''Chemotherapy With Acute Leukemia or With Use of High Dose Chemotherapy Agent''.

In the proposed rule, we indicated that we would monitor cases with procedure code 00.15 as these data became available, and consider potential further refinements to DRG 492 as necessary.

Comment: Five commenters supported our proposed change. One commenter who opposed the proposed change believed that classifying high-dose IL–2 therapy as chemotherapy would be a violation of coding advice published in the American Hospital Association's coding publication, *Coding Clinic for ICD–9–CM*, because IL–2 therapy is a biologic response modifier and is considered immunotherapy, not chemotherapy. Therefore, the commenter asserted that the use of either V58.1 or V67.2 as principal diagnosis codes for these cases would result in erroneous coding advice. The commenter added that *Coding Clinic, Fourth Quarter,* page 51, indicates that when a patient is admitted for immunotherapy, the code for the neoplasm should be assigned as the principal diagnosis.

Response: We acknowledge the commenter's points concerning correct selection of principal diagnosis, as well as the advice published previously in *Coding Clinic*. However, the discussion of this topic has raised some concerns among the Cooperating Parties of AHA's Editorial Advisory Board. The advice given in the Fourth Quarter 1994 *Coding Clinic* predates the new treatment technology now available, which calls into question the correctness of the published advice. Therefore, this topic will be included on the agenda of an upcoming AHA Editorial Advisory Board meeting for further discussion and clarification. It is likely that new instructions will be issued in the next several months to clarify these coding instructions.

Therefore, in anticipation of this clarification, we are adopting as final the proposed changes to DRG 492. We will continue to monitor this DRG for shifts in resource consumption and validity of DRG assignment, and will specifically monitor code 00.15 for appropriate placement in DRG 492.

8. MDC 23 (Factors Influencing Health Status and Other Contacts With Health Services)

a. Implantable Devices

Prior to the publication of the proposed rule, we received a comment regarding three ICD–9–CM diagnosis codes that are currently assigned to MDC 23: V53.01 (Fitting and adjustment of cerebral ventricular (communicating) shunt); V53.02 (Neuropacemaker (brain) (peripheral nerve) (spinal cord)); and V53.09 (Fitting and adjustment of other devices related to nervous system and special senses). The commenter suggested that we move these three codes from MDC 23 to MDC 1 (Diseases and Disorders of the Nervous System) because these codes are used as the principal diagnosis for admissions involving removal, replacement, and reprogramming of devices such as cerebral ventricular shunts, neurostimulators, intrathecal infusion pumps and thalamic stimulators.

Currently, if these diagnosis codes are reported alone without an O.R. procedure, the case would be assigned to DRG 467 (Other Factors Influencing Health Status). However, if an O.R. procedure is reported with the principal diagnosis of V53.01, V53.02, or V53.09, the case would be assigned to DRG 461 (O.R. Procedure with Diagnoses of Other Contact with Health Services).

In our analysis of the MedPAR data, we found 30 cases assigned to DRG 467 and 179 cases assigned to DRG 461 with one of these codes as principal diagnosis. We found that the procedures reported with one of these diagnosis codes were procedures in MDC 1. The most frequent procedure was 86.06 (Insertion of totally implantable infusion pump).

Because the procedures that are routinely used with these codes are in MDC 1, we believe it would be

appropriate to assign these diagnosis codes to MDC 1. As the commenter also stated, this assignment would be consistent with how fitting and adjustments of devices are handled within other MDCs, such as in MDC 5 (Diseases and Disorders of the Circulatory System) and MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract). Diagnosis codes V53.31 (Cardiac pacemaker), V53.32 (Automatic implantable cardiac defibrillator), and V53.39 (Other cardiac device) are used for fitting and adjustment of cardiac devices and are assigned to MDC 5. Diagnosis code V53.6 (Urinary devices) is used for fitting and adjustment of urinary devices and is assigned to MDC 11.

Therefore, we proposed to move V53.01, V53.02, and V53.09 from MDC 23 to MDC 1 when an O.R. procedure is performed. If no O.R. procedure is performed, these diagnosis codes would be assigned to DRG 34 (Other Disorders of Nervous System With CC) or DRG 35 (Other Disorders of Nervous System Without CC). If an O.R. procedure is performed on a patient assigned with one of these codes as the principal diagnosis, the case would be assigned to the DRG in MDC 1 to which the O.R. procedure is assigned.

We received three comments that supported our proposal to move diagnosis codes V53.01, V53.02, and V53.09 from MDC 23 to MDC 1. Accordingly, we are adopting as final the proposed reassignment, effective for discharges occurring on or after October 1, 2003.

b. Malignancy Codes

Prior to the issuance of the proposed rule, we received correspondence that indicated that when we recognized code V10.48 (History of malignancy, epididymis) as a new code for FY 2002, we did not include the code as a history of malignancy code in DRG 465 (Aftercare with History of Malignancy as Secondary Diagnosis). All other history of malignancy codes were included in DRG 465.

We agree that code V10.48 should have been included in the list of history of malignancy codes within DRG 465. Therefore, we proposed to add it to the list of secondary diagnoses in DRG 465.

We received several comments that supported this DRG modification. Accordingly, we are adopting the proposal as final without modification.

9. Medicare Code Editor (MCE) Change

As explained under section II.B.1. of this preamble, the MCE is a software program that detects and reports errors in the coding of Medicare claims data.

We received a request to examine the MCE edit ''Adult Diagnosis—Age Greater than 14'' because currently the edit rejects claims for patients under age 15 who are being treated for gall bladder disease. We reviewed this issue with our pediatric consultants and determined that, although incidence is rare, gallbladder disease does occur in patients under age 15. Therefore, in the May 19, 2003 proposed rule, we proposed to modify the MCE by removing the following codes from the edit ''Adult Diagnosis—Age Greater Than 14'':

- 574.00, Calculus of gallbladder with acute cholecystitis without mention of obstruction
- 574.01, Calculus of gallbladder with acute cholecystitis with obstruction
- 574.10, Calculus of gallbladder with other cholecystitis without mention of obstruction
- 574.11, Calculus of gallbladder with other cholecystitis with obstruction
- 574.20, Calculus of gallbladder without mention of cholecystitis without mention of obstruction
- 574.21, Calculus of gallbladder without mention of cholecystitis with obstruction
- 574.30, Calculus of bile duct with acute cholecystitis without mention of obstruction
- 574.31, Calculus of bile duct with acute cholecystitis with obstruction
- 574.40, Calculus of bile duct with other cholecystitis without mention of obstruction
- 574.41, Calculus of bile duct with other cholecystitis with obstruction
- 574.50, Calculus of bile duct without mention of cholecystitis without mention of obstruction
- 574.51, Calculus of bile duct without mention of cholecystitis with obstruction
- 574.60, Calculus of gallbladder and bile duct with acute cholecystitis without mention of obstruction
- 574.61, Calculus of gallbladder and bile duct with acute cholecystitis with obstruction)
- 574.70, Calculus of gallbladder and bile duct with other cholecystitis without mention of obstruction
- 574.71, Calculus of gallbladder and bile duct with other cholecystitis with obstruction
- 574.80, Calculus of gallbladder and bile duct with acute and chronic cholecystitis without mention of obstruction
- 574.81, Calculus of gallbladder and bile duct with acute and chronic cholecystitis with obstruction
- 574.90, Calculus of gallbladder and bile duct without cholecystitis without mention of obstruction
- 574.91, Calculus of gallbladder and bile duct without cholecystitis with obstruction
- 575.0, Acute cholecystitis
- 575.10, Cholecystitis, not otherwise specified
- 575.11, Chronic cholecystitis
- 575.12, Acute and chronic cholecystitis
- 575.2, Obstruction of gallbladder
- 575.3, Hydrops of gallbladder
- 576.0, Postcholecystectomy syndrome
- 577.1, Chronic pancreatitis

Comment: Four commenters agreed in general with our decision to remove the above listed codes from the MCE in the edit ''Adult Diagnosis—Age Greater than 14.'' However, one commenter recommended that all ICD–9–CM codes in the 575 through 577 range be removed from the edit and listed several codes that appeared to be missing from our list. These codes were 575.4 (Perforation of gallbladder), 577.0 (Acute pancreatitis), and 577.1 (Chronic pancreatitis). In addition, three commenters pointed out that code 574.90 had been erroneously listed twice with different narrative descriptions.

Response: We appreciate the commenters' interest in the correctness of the MCE. We also have received many telephone calls and e-mails concerning the typographical error with code 574.90. We have corrected the list above to reflect the correct code number, 574.91. As noted, the second narrative listing in the proposed rule correctly described code 574.91, not 574.90 (68 FR 27166).

With regard to the comment concerning the absence of codes 575.4 and 577.0 from the above list, we note that these codes are not included in the MCE edit. That is, these codes were never part of the MCE edit. With regard to code 577.1, this code is the last one on the list and was printed correctly in the proposed rule (68 FR 27166, third column).

Accordingly, we are adopting as final the proposal to remove the listed codes from the MCE edit ''Adult Diagnosis—Age Greater than 14,'' with the correction of the fifth digit of code 574.91 (Calculus of gallbladder and bile duct without cholecystitis with obstruction).

10. Surgical Hierarchies

Some inpatient stays entail multiple surgical procedures, each one of which, occurring by itself, could result in assignment of the case to a different DRG within the MDC to which the principal diagnosis is assigned. Therefore, it is necessary to have a

decision rule 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, in the May 19, 2003 proposed rule, we proposed modifications of the surgical hierarchy as set forth below.

We proposed to revise the surgical hierarchy for the pre-MDC DRGs, MDC 1 (Diseases and Disorders of the Nervous System), MDC 5 (Diseases and Disorders of the Circulatory System), MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue), and MDC 17 (Myeloproliferative Disease and Disorders, Poorly Differentiated Neoplasms for Lymphoma and Leukemia) as follows:

- In the pre-MDC DRGs, we proposed to reorder DRG 513 (Pancreas Transplant) above DRG 512 (Simultaneous Pancreas/Kidney Transplant).
- In MDC 1, we proposed to reorder DRG 3 (Craniotomy Age 0–17) above DRG 528 (Intracranial Vascular Procedures with Principal Diagnosis Hemorrhage); DRG 528 above DRGs 1 and 2 (Craniotomy Age >17 With and Without CC, respectively); DRGs 1 and 2 above DRGs 529 and 530 (Ventricular Shunt Procedures With and Without CC, respectively); DRGs 529 and 530 above DRGs 531 and 532 (Spinal Procedures With and Without CC, respectively); DRGs 531 and 532 above DRGs 533 and 534 (Extracranial Procedures With and Without CC, respectively); and DRGs 533 and 534 above DRG 6 (Carpal Tunnel Release).
- In MDC 5, we proposed to reorder DRG 535 (Cardiac Defibrillator Implant With Cardiac Catheterization With AMI, Heart Failure, or Shock) above DRG 536 (Cardiac Defibrillator Implant With Cardiac Catheterization Without AMI, Heart Failure, or Shock), and DRG 536 above DRG 515 (Cardiac Defibrillator Implant Without Cardiac Catheterization).
- In MDC 8, we proposed to reorder DRGs 537 and 538 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur With and Without CC, respectively) above DRG 230 (Local Excision and Removal of Internal Fixation Devices of Hip and Femur).
- In MDC 17, we proposed to reorder DRGs 539 and 540 (Lymphoma and Leukemia With Major O.R. Procedure With and Without CC, respectively) above DRGs 401 and 402 (Lymphoma and Non-Acute Leukemia With Other O.R. Procedures With and Without CC, respectively).

In the proposed rule, we were unable to test the effects of the proposed revisions to the surgical hierarchy and reflect these changes in the proposed relative weights because the revised GROUPER software was unavailable at the time the proposed rule was published. Rather, we simulated most major classification changes to approximate the placement of cases under the proposed reclassification, and then determined the average charge for each DRG. These average charges served as our best estimate of relative resources used for each surgical class. We have now tested the proposed surgical hierarchy changes using the revised GROUPER software, and are reflecting the final changes in the DRG relative weights in this final rule. Further, as discussed in section II.C. of the preamble of this final rule, the final recalibrated weights are different from the proposed weights because they were based on more complete data.

Based on a test of the proposed revisions using the March 2003 update of the FY 2002 MedPAR file and the revised GROUPER software, we have found that the proposed change in the pre-MDC DRGs to reorder DRG 513 (Pancreas Transplant) above DRG 12 (Simultaneous Pancreas/Kidney Transplant) was not supported by the data. If this proposal were finalized, no cases would be assigned to DRG 512. The other proposed revisions are still supported by the data.

Comment: Two commenters expressed support for the proposed

change in the surgical hierarchy. Another commenter requested a change in the surgical hierarchy for a case in which a spinal fusion with subsequent debridement is performed during the same admission. This case is assigned to DRG 217 (Wound Debridement and Skin Graft Except Hand, for Musculoskeletal and Connective Tissue Disease). The commenter requested that this case be reassigned to DRG 497 (Spinal Fusion Except Cervical With CC) because it has a higher DRG weight than DRG 217.

Response: The surgical hierarchy places a patient with multiple procedures in the most resource intensive class, but this does not necessarily mean that the patient is assigned to the most resource intensive DRG. In this scenario, one surgical class is actually one DRG, and another surgical class is back and neck procedures. These classes encompass 7 DRGs (DRGs 496–500 and DRGs 519 and 520). The average charges for DRG 217 are approximately $15,000 more than the back and neck procedures class. DRG 217 is hierarchically ordered higher in the surgical group than DRG 497, which is the reason the case is assigned to DRG 217.

Therefore, we are adopting the proposed changes in MDCs 1, 5, 8, and 17 as final. We are not making any changes in the pre-MDC DRGs.

11. Refinement of Complications and Comorbidities (CC) List

In the September 1, 1987 final notice (52 FR 33143) concerning changes to the DRG classification system, we modified the GROUPER logic so that certain diagnoses included on the standard list of CCs would not be considered 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. As we proposed in the May 19, 2003 proposed rule, we are not deleting any of the diagnosis codes on the CC list.

As explained in the May 19, 1989 proposed rule (52 FR 18877) and the September 1, 1987 final notice (52 FR 33154), 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.[3]

We proposed 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, 2003. (See section II.B.13. of this preamble for a discussion of ICD–9–CM changes.) We proposed 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 final rule contain the revisions to the 13 CC Exclusions List that will be effective for discharges occurring on or after October 1, 2003. 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, 2003, the indented diagnoses will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

CCs that are deleted from the list are in Table 6H—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 2003, the indented diagnoses will be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

Comment: One commenter indicated that it was unable to provide meaningful comments on Tables 6G and 6H because of formatting errors in the printed tables. In addition, the commenter suggested that the changes in the tables should not be effective until a revised version was made available for public comment.

Response: We apologize for the errors in the format of the tables, which were printer's errors. However, we note that the tables did contain the correct codes, even though the format of the columns was distorted. Therefore, we do not believe a delay in the effective date of the changes is warranted.

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 $133.00 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, 2000, 2002, and 2003) and those in Tables 6G and 6H of this final rule for FY 2004 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, 2003. (**Note:** There was no CC Exclusions List in FY 2001 because we did not make changes to the ICD–9–CM codes for FY 2001.)

Alternatively, the complete documentation of the GROUPER logic,

[3] 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; and the August 1, 2002 final rule (67 FR 49998) for the FY 2003 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.

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 20.0, is available for $225.00, which includes $15.00 for shipping and handling. Version 21.0 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.

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

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
- 60.99 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. The original list of the ICD–9–CM procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV. of the Addendum to the September 30, 1988 final rule (53 FR 38591). As part of the final rules published on September 4, 1990 (55 FR 36135), August 30, 1991 (56 FR 43212), September 1, 1992 (57 FR 23625), September 1, 1993 (58 FR 46279), September 1, 1994 (59 FR 45336), September 1, 1995 (60 FR 45783), August 30, 1996 (61 FR 46173), and August 29, 1997 (62 FR 45981), we moved several other procedures From DRG 468 to 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.

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 necessary changes in procedures under DRG 477. Therefore, we did not propose moving any procedures from DRG 477 to one of the surgical DRGs in this final rule.

However, in the proposed rule, we identified a necessary proposed change under DRG 468 relating to code 50.29 (Other destruction of lesion of liver). We were contacted by a hospital about the fact that code 50.29 is not currently included in MDC 6 (Diseases and Disorders of the Digestive System). The hospital pointed out that it is not uncommon for patients to have procedures performed on the liver when they are admitted for a condition that is classified in MDC 6. For example, DRGs 170 and 171 (Other Digestive System O.R. Procedures With and Without CC, respectively) in MDC 6 currently include liver procedures such as biopsy of the liver. The hospital disagreed with the assignment of code 50.29 to DRG 468 when performed on a patient with a principal diagnosis in MDC 6. We believe that the commenter is correct. Therefore, we proposed to assign code 50.29 to DRGs 170 and 171 in MDC 6.

We received several comments of support for our proposal to assign code 50.29 to DRGs 170 and 171 in MDC 6. Therefore, we are adopting the proposal as final without modification. As a result, code 50.29 will not result in assignment to DRG 468 when this procedure is performed on patient with a principal diagnosis in MDC 6.

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 our review this year, we did not propose moving any procedures from DRG 476 to DRGs 468 or 477, or from DRG 477 to DRGs 468 or 476.

However, in the proposed rule, we identified several procedures that we proposed to move from DRG 468 and add to DRGs 476 and 477 because the procedures are nonextensive:

- 38.21, Biopsy of blood vessel
- 77.42, Biopsy of scapula, clavicle and thorax [ribs and sternum]
- 77.43, Biopsy of radius and ulna
- 77.44, Biopsy of carpals and metacarpals
- 77.45, Biopsy of femur
- 77.46, Biopsy of patella

- 77.47, Biopsy of tibia and fibula
- 77.48, Biopsy of tarsals and metatarsals
- 77.49, Biopsy of other bones
- 92.27, Implantation or insertion of radioactive elements

We note that the above codes being moved from DRG 468 to DRGs 476 and 477 were erroneously listed in the May 19, 2003 proposed rule under section II.B.12.c., which related to adding diagnosis or procedure codes to MDCs, instead of section II.B.12.b., which discussed the reassignment of procedures among DRGs 468, 476, and 477. We regret any inconvenience this inadvertent listing may have caused.

Comment: One commenter asked us to consider moving procedure code 51.23, Laparoscopic cholecystectomy, from DRG 468 and adding it to DRG 477. The commenter indicated that this procedure is often performed in the outpatient setting.

Response: We believe that the commenter's request has merit. We will perform the necessary data analysis and will consider proposing this change in next fiscal year's rule if we find that the data support this change.

c. Adding Diagnosis or Procedure Codes to MDCs

Based on our review this year, we did not propose adding any diagnosis codes to MDCs in this final rule. We did not receive any comments on the proposal.

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

As described in section II.B.1. of this preamble, the ICD–9–CM is a coding system that is used for the reporting of diagnoses and procedures performed on a patient. In September 1985, the ICD–9–CM Coordination and Maintenance Committee was formed. This is a Federal interdepartmental committee, co-chaired by the National Center for Health Statistics (NCHS) and 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 $23.00 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 2004 at a public meeting held on December 6, 2002, and finalized the coding changes after consideration of comments received at the meetings and in writing by January 10, 2003. Those coding changes are announced in Tables 6A and 6B of this final rule. Copies of the minutes of the procedure codes discussions at the Committee's 2002 meetings can be obtained from the CMS Web site: *http://www.cms.gov/paymentsystems/icd9/.* The minutes of the diagnoses codes discussions at the 2002 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.

The first of the 2003 public meetings was held on April 3, 2003. 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 all proposals discussed and approved at the April meeting as part of the code revisions effective the following October. Because the proposed rule was published after the April meeting, we were able to include all new procedure codes that were approved subsequent to that meeting in Table 6B of the Addendum to the proposed rule, including the DRG assignments. However, the National Center for Health Statistics (NCHS) created and finalized three new severe acute respiratory syndrome (SARS) related codes after the proposed rule was published. These new codes, which were not listed in Table 6A of the Addendum to the proposed rule, have been included in Table 6A of the Addendum to this final rule. The new codes are as follows:

- 079.82, SARS-associated coronavirus
- 480.3, Pneumonia due to SARS-associated coronavirus
- V01.82, Exposure to SARA-associated coronavirus

These new codes have been identified with a footnote (1) in Table 6A of the Addendum to this final rule.

For a report of procedure topics discussed at the April 2003 meeting, see the Summary Report at: *http://www.cms.hhs.gov/paymentsystems/icd9/.* For a report of the diagnosis topics discussed at the April 2003 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: *pbrooks1@cms.hhs.gov.*

The ICD–9–CM code changes that have been approved will become effective October 1, 2003. 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 final 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. Accordingly, in the May 19, 2003 proposed rule, we only solicited comments on the proposed DRG classification of these new codes.

Comment: One commenter expressed concern about the MDC and DRG designations for new diagnosis code 752.89 (Other specified anomalies of genital organs) that was included in

Table 6A of the Addendum to the proposed rule. We had proposed assigning this new code to MDC 12 (Diseases and Disorders of the Male Reproductive System), and DRG 352 (Other Male Reproductive System Diagnoses). The commenter pointed out that this new code could apply to both males and females. Its predecessor code was assigned to MDC 12, DRG 352, as well as to MDC 13 (Diseases and Disorders of the Female Reproductive System) and DRGs 358 (Uterine and Adnexa Procedure for Non-Malignancy with CC), 359 (Uterine and Adnexa Procedure for Non-Malignancy without CC), and 369 (Menstrual and Other Female Reproductive System Disorders).

Response: The commenter is correct. Diagnosis code 752.89 would apply to both males and females and should have been included in both MDC 12 and MDC 13. In this final rule, we are assigning diagnosis code 752.89 to MDC 13 under DRGs 358, 359, and 369 and have modified Table 6A of the Addendum to this final rule accordingly.

Comment: One commenter pointed out a typographical error for the code title for V15.87. The commenter indicated that the word ''membrance'' should be changed to ''membrane''; that is, the title should read ''History of Extracorporeal Membrane Oxygenation (ECMO).''

Response: We agree with the commenter and have corrected the title in Table 6A of the Addendum to this final rule.

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, 2003. Table 6D contains 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 2004.

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 24 years ago.

Implementing ICD–10–PCS as a national standard was discussed at the December 6, 2002, ICD–9–CM Coordination and Maintenance Committee meeting. A complete report of the meeting, including examples of letters supporting and opposing ICD–10–PCS, can be found at the CMS Web site: *http://www.cms.hhs.gov/paymentsystems/icd9/.* Also, the Secretary has asked the NCVHS to recommend whether or not the country should replace ICD–9–CM as a national coding standard with 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.*

Comment: Several commenters supported the move to ICD–10–CM and ICD–10–PCS as national coding standards. One commenter representing hospitals supported moving to these systems expeditiously. The commenter stated that ICD–10–CM and ICD–10–PCS are a vast improvement over ICD–9–CM and would provide greater specificity and detail in coding. Another commenter believed that the new systems would offer immediate and long-term benefits for specifying illness severity and accommodating a diverse array of new technologies that warrant expedited assignment under the DRG system.

Response: We appreciate the support from many in the health care industry for ICD–10–CM and ICD–10–PCS. We agree with the importance of having and maintaining medical coding systems that accurately capture the patient's conditions and medical procedures. We also agree that ICD–9–CM is seriously constrained because of its structure and space limitations. We recognize that over 30 countries have implemented ICD–10 to better capture medical conditions. Countries such as Canada and Australia have successfully implemented ICD–10 without serious ramifications to their data or reimbursement systems. We agree that it is important to capture information on new technologies. It is becoming increasingly difficult to do so using ICD–9–CM. We will continue working with NCVHS and the health care industry to determine if these new systems should be named as national coding standards.

14. Other Issues

In addition to the specific topics discussed in section II.B.1. through 13. of this preamble, we considered a number of other DRG-related issues in the May 19, 2003 proposed rule. Below is a summary of the issues that were addressed.

a. Cochlear Implants

Cochlear implants were first covered by Medicare in 1986 and were assigned to DRG 49 (Major Head and Neck Procedures) in MDC 3 (Diseases and Disorders of the Ear, Nose, Mouth, and Throat). This is the highest weighted surgical DRG in MDC 3. However, prior to the publication of the proposed rule, commenters contended that this DRG assignment is clinically and economically inappropriate for cochlear implants and requested a more specific DRG. The commenters contend that, like heart assist systems (for which we created a new DRG last year, DRG 525 (Heart Assist System Implant) in MDC 5), cochlear implants are low incidence procedures with disproportionately high costs compared to other procedures within DRG 49.

As we stated in the FY 2003 final rule in our discussion regarding the creation of DRG 525 (67 FR 49989), we found 185 heart assist system cases in DRG 104 (Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization) and 90 cases in DRG 105 (Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization). The average charges for these cases were approximately $36,000 and $85,000 higher than the average charges for cases in DRGS 104 and 105, respectively. However, these cases represented only a small fraction of all cases in these DRGs (1.3 percent and 0.5 percent, respectively). Therefore, despite the drastically higher average charges for heart assist systems, the relative volume was insufficient to affect the DRG weight to any great degree.

In our analysis of the FY 2002 MedPAR file, we found 134 cochlear implant cases out of 1,637 cases assigned to DRG 49, which represent more than 8 percent of the total cases in DRG 49. Compared to the situation with the heart assist system implant cases in DRGs 104 and 105, cochlear implants do have a greater effect on the relative weight for DRG 49. Also, while average charges for cochlear implant cases are significantly more than other cases in DRG 49 (average charges for cochlear implant cases were $51,549 compared to

$25,052 for noncochlear implant cases), this difference is much less than the $36,000 and $85,000 differences for heart assist systems cited above.

Although we are concerned about the disparity between the average costs and payments for cochlear implant patients, we also have concerns about establishing a separate DRG for these cases. Doing so could create an incentive for some of these procedures to be shifted from outpatient settings, where most are currently performed. Even among current cochlear implant cases, our analysis found the average length of stay for Medicare patients receiving this procedure in the inpatient setting was just over 1 day, indicating minimal inpatient care is necessary for these cases. It is unclear whether a shift toward more inpatient stays would be appropriate.

We also are concerned whether the volume of cochlear implant cases across all hospitals performing this procedure warrants establishing a new DRG. The DRG relative weights reflect an average cost per case, with the costs of some procedures above the DRG mean costs and some below the mean. It is expected that hospitals will offset losses for certain procedures with payment gains for other procedures, while responding to incentives to maintain efficient operations. An excessive proliferation of new DRGs for specific technologies would fundamentally alter this averaging concept.

Accordingly, for the reasons cited above, we did not propose to change the DRG assignment of cochlear implants in the May 19, 2003 proposed rule. However, we did encourage public comments as to whether a new DRG for cochlear implants (or some other solution) is warranted.

Comment: Several commenters urged CMS to reassign cochlear implantation procedures to a DRG that has a weight appropriate to reflect the costs of cochlear implantation. The commenters stated that while a hospital's acquisition cost of the device itself averages approximately $23,800, the proposed payment for FY 2004 is approximately $8,233. While most cochlear implants have been and will continue to be performed on an outpatient basis, a small, but significant portion, particularly for Medicare beneficiaries, need to be conducted as an inpatient procedure. The commenters stated that the low volume of inpatient cases is a direct result of the inadequate payment rate.

The commenters stated that cochlear implantation is clinically incongruent and economically inconsistent with the other procedures in DRG 49. The commenters believed that cochlear implants do not meaningfully affect the weighting of DRG 49 and proposed two options: Create a new DRG specifically for cochlear implants, or reassign cochlear implants cases to DRG 482 (Tracheostomy for Face, Mouth, and Neck Diagnoses).

Response: We requested public input on possible solutions for these cases because we recognize the data indicate the charges for these cases are much higher than for other cases in DRG 49. However, we are concerned that the options suggested by commenters are not workable solutions. As we alluded to in the proposed rule, we have concerns about creating a new DRG for this procedure. We appreciate the point made by commenters that only those patients requiring inpatient care would receive the procedure in an inpatient setting, even if the DRG payment were increased. However, as we have stated previously, we are reluctant to create new DRGs for specific, low-volume procedures. Doing so would create a proliferation of DRGs and a loss of some of the efficiency incentives inherent in the current system. Hospitals are generally able to offset any losses on such procedures through corresponding payment advantages from other, less expensive procedures.

The second option suggested, to reassign these cases to DRG 482, is inconsistent with the structure of that DRG, which requires that a tracheostomy be performed in order to be assigned to this DRG. Assigning cochlear implants to this DRG would fundamentally alter its structure, which could not be done without first proposing such a change for public review and comment.

However, as we indicated above, we recognize the disparity in average charges for these cases compared to other cases in DRG 49, and will continue to evaluate possible reclassification options for FY 2005.

b. Burn Patients on Mechanical Ventilation

Prior to the publication of the proposed rule, concerns were 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 DRG 482 (Tracheostomy for Face, Mouth, and Neck Diagnoses) or DRG 483 (Tracheostomy with Mechanical Ventilation 96 + Hours, 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 consecutive hours or more) for the first time in the DRG assignment (67 FR 49996). 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). We stated that we would give future consideration to further modifying DRGs 482 and 483 based on the presence of code 96.72. We anticipate that cases of patients receiving 96 or more hours of continuous mechanical ventilation are more expensive than other tracheostomy patients. Once code 96.72 is reported more frequently, we will be better able to assess the need for future revisions to DRGs 482 and 483.

To assess the payment for burn patients on mechanical ventilation when the hospital did not perform the tracheostomy, we analyzed data on cases reporting both code 96.72 and diagnosis code V44.0 (Tracheostomy status). We had hoped that these cases would show patients on long-term ventilation who were admitted to the hospital with a tracheostomy in place. Our data did not include any cases reported in any of the burn DRGs with codes 96.72 and V44.0. We then analyzed data on the frequency of cases reporting code 96.72 along with diagnosis code V46.1 (Respirator dependence). We found only 5 of these cases in the burn DRGs. With so few cases reporting code 96.72, it is difficult for us to determine the effect of long-term ventilation on reimbursement for burn cases.

All hospitals, including those that treat burn patients, are encouraged to increase the reporting of code 96.72 for patients who are on continuous mechanical ventilation for 96 or more hours. With better data, we would be able to determine how best to make any future DRG modification for all patients on long-term mechanical ventilation.

We received one comment from an organization representing coders that agreed with the importance of reporting code 96.72 and the need for further education on this issue. We will continue to monitor our data to assess

the payment for burn patients on mechanical ventilation in the future.

c. Multiple Level Spinal Fusion

Prior to the publication of the proposed rule, 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. The commenter noted that the ICD–9–CM Coordination and Maintenance Committee discussed adding a new series of codes to identify multiple levels of spinal fusions at its December 6, 2002 meeting.

The following codes were approved by the Committee, effective for October 1, 2003, and are listed in Table 6B in the Addendum to this final rule:

- 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

The commenter conducted an analysis to support redefining the spinal fusion DRGs using these new ICD–9–CM codes. Using the CMS FY 2001 Standard Analytical File data for physicians and hospitals as the basis for its analysis, the commenter linked a 5-percent sample of hospital spinal fusion cases with the corresponding physician claims. Because there were no ICD–9–CM codes to identify multiple level fusions in 2001, multiple level fusions were identified using Current Procedural Terminology (CPT) codes on the physician claims.

The analysis found that increasing the levels fused from 1 to 2 levels to 3 or more levels increased the mean standardized charges by 38 percent for lumbar/thoracic fusions, and by 47 percent for cervical fusions. The commenter then recommended redefining the spinal fusion DRGs to differentiate between 1 to 2 level spinal fusions and multilevel spinal 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); and DRG 519 (Cervical Spinal Fusion With CC) and DRG 520 (Cervical Spinal Fusion Without CC). The difference in charges associated with the current CC split is only slightly greater than the difference attributable to the number of levels fused as found by the commenter's analysis. Therefore, in the May 19, 2003 proposed rule, we did not propose to redefine these DRGs to differentiate on the basis of the number of levels fused.

We note that adopting the commenter's recommendation would necessitate adjusting the DRG relative weights using non-MedPAR data, because Medicare claims data with the new ICD–9–CM codes will not be available until the FY 2003 MedPAR file. Although we considered this possibility, we believe the more prudent course, given that the current DRG structure actually appears to differentiate appropriately among these cases, is to wait until sufficient data with the new multilevel spinal fusion codes are available before making a final determination on whether multilevel spinal fusions should be incorporated into the DRG structure.

Comment: Several commenters supported our proposal to wait for data using the new ICD–9–CM procedure codes for multiple level spinal fusions prior to making revisions to the spinal fusion DRGs. One commenter representing hospitals supported our proposal to continue with the current DRG classification system until sufficient data are available to evaluate a potential DRG change. Several commenters expressed their appreciation for the creation of the new codes for multiple level spinal fusion. They recognized the difficult challenge that was involved in developing this new classification system as part of ICD–9–CM.

One commenter requested us to proceed with a DRG revision for multiple level spinal fusion without waiting for data using the new codes. This commenter stated that there are significant costs involved with increased instrumentation and hardware when multiple level spinal fusions are performed, and requested that we consider using non-MedPAR data to establish relative weights for new DRGs based on the levels of vertebrae involved. In addition, the commenter stated that there is a need to distinguish between fusions and refusions within the DRGs. The commenter stated that refusions vary significantly due to the existence of scar tissue and implants that need to be removed and replaced. Further, the commenter recommended that we split DRG 496 Combined anterior/posterior spinal fusion based on the presence or absence of a complication or comorbidity.

Response: We appreciate the support of commenters that we wait for data from the reporting of the new codes for multiple level spinal fusion prior to proposing revisions to the spinal DRGs (rather than using non-MedPAR data prior to the availability of data using the new codes). We also appreciate the comments concerning the extensive effort it took on our part to develop a set of ICD–9–CM codes that could capture this type of information. We believe it is important to carefully examine hospital data prior to making any revisions for multiple level spinal fusions. Therefore, we will look at this data as we receive it and evaluate any need for DRG revisions. We will consider all the points raised by the commenters as we consider additional DRG revisions for spinal fusions in the future.

d. Heart Assist System Implant

During the comment period for the FY 2003 IPPS proposed rule on which the FY 2003 IPPS final rule was based, we received a suggestion from a commenter that we develop a new heart transplant DRG entitled ''Heart Transplant with Left Ventricular Assist Device (LVAD).'' The commenter stated that, because a great number of LVAD cases remain inpatients until heart transplant occurs, there is a disparity in costs between heart transplant patients who receive LVADs during the stay and those who do not. Cases in which heart transplantation occurs during the hospitalization are assigned to DRG 103 (Heart Transplant). Therefore, the costs of these LVAD cases where a heart transplant is also performed during the same hospitalization are included in the DRG relative weight for DRG 103. Accordingly, we did not create a new DRG for these cases. However, we noted that we would continue to monitor these types of cases.

When we reviewed the FY 2002 MedPAR data, we identified only 21 cases in DRG 103 that listed a procedure code indicating the use of any heart assist system. We do not believe that 21 cases is a sufficient number of cases to support creation of an additional DRG. Therefore, in the May 19, 2003 proposed rule, we did not propose a change to the structure of either DRG 103 or DRG 525.

Comment: Two commenters argued that procedure code 37.66 (Implant of an implantable, pulsatile heart assist system) does not fit clinically or financially with the following other procedure codes in DRG 525:

- 37.62, Implant of other heart assist system,
- 37.63, Replacement and repair of heart assist system,
- 37.65, Implant of an external, pulsatile heart assist system
- 37.66, Implant of an implantable, pulsatile heart assist system.

One commenter indicated that, according to an analysis that it performed, Medicare data on procedure code 37.66 demonstrates that average charges ($342,725) and length of stay

(40.1 days) are significantly higher than data on all other procedures in DRG 525 (average charges ranging from $112,748 to $190,672) and (average length of stay ranging from 10.9 to 16.7). According to the commenter, the implantable pulsatile technology represents a different class of device and procedure (long-term support) compared to the less resource intensive, short-term devices used in other procedures in DRG 525.

The commenters requested three possible alternatives for the reclassification of procedure code 37.66: (1) Create a unique DRG for this procedure; (2) add this procedure code to DRG 103 (Heart Transplant); or (3) add a new technology add-on payment for code 37.66 to DRG 525.

Response: In response to comments we received on the creation of new DRG 525 last year, we noted that these four codes represent the most expensive cases in MDC 5 (67 FR 49991). However, the specific point made by the commenters this year, that procedure code 37.66 is significantly different in terms of clinical procedures and resource utilization from the other procedures in DRG 525, was not raised prior to this year's proposed rule.

While we recognize the significant disparities referenced by the commenter warrant further consideration, the potential solutions suggested by the commenter are significant changes to the DRG system that warrant public comment. In particular, the reassignment of code 37.66 to DRG 103 would result in inclusion of nontransplant cases in this existing single-procedure DRG. Therefore, in light of the significant impacts of each of the commenters' suggestions on the structure of the DRGs involved and the need to submit any such significant impacts to public review and comment, we are not changing DRG 525 for FY 2004. We appreciate the commenter bringing this issue to our attention. We will evaluate whether to make further changes to DRG 525 in light of the information that there is significant disparity in the costs of the different procedures included in the DRG. We note that the outlier payment policy will help to offset extraordinarily expensive costs.

Furthermore, the volume and mix of cases in this DRG is likely to change over the next year. Currently, CMS has approved the use of LVADs in two instances. They can be used as either a bridge to heart transplant or for support of blood circulation postcardiotomy (the period following open-heart surgery). In these two applications, the LVAD is used as temporary mechanical circulatory support. CMS is currently reviewing a request for expanded coverage for these devices as destination (or permanent) therapy for end-stage heart failure patients who are not candidates for heart transplantation. Destination therapy means that the patient will use the LVAD for the remainder of his or her life.

We believe it will be helpful to have data on the resources and volume associated with any potential destination therapy cases prior to revising DRG 525.

e. Drug-Eluting Stents

In the August 1, 2002 final rule, we created two new temporary DRGs to reflect cases involving the insertion of a drug-eluting coronary artery stent as signified by the presence of code 36.07 (Insertion of drug-eluting coronary artery stent): DRG 526 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent With AMI); and DRG 527 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent Without AMI). We expect that when claims data are available that reflect the use of these stents, we will combine drug-eluting stent cases with other cases in DRGs 516 and 517.

In the absence of MedPAR data reflecting the use of drug-eluting stents, it was necessary to undertake several calculations to establish the FY 2003 DRG relative weights for these two new DRGs. First, based on prices in countries where drug-eluting stents were already being used compared to the average price of nondrug-eluting stents in those countries, we calculated a price differential of approximately $1,200. When we apply average overall hospital charge markups to this technology (based on weighted average cost-to-charge ratios), we estimated that the charge differential between nondrug-eluting and drug-eluting stents would be approximately $2,664 per stent. However, we recognize that some cases involve more than one stent. Using an average of 1.5 stents per procedure, we estimated that the net incremental charge for cases that would receive drug-eluting stents is $3,996.

In order to determine accurately the DRG relative weights for these two new DRGs relative to all other DRGs, we also must estimate the volume of drug-eluting stent cases likely to occur. We used the manufacturer's estimate that as many as 43 percent of current stent patients will receive drug-eluting stents during FY 2003 to calculate the FY 2003 DRG relative weights, although we prorated this percentage since the new DRGs did not become active until April 1, 2003.[4]

In determining the FY 2004 DRG relative weights for DRGs 526 and 527, we assumed that 43 percent of coronary stent cases (those with code 36.06 (Insertion of nondrug-eluting coronary artery stent)) from DRGs 516 and 517 would be reassigned to new DRGs 526 and 527 (with code 36.07), and the charges for these cases would be increased $3,996 per case, to approximate the higher charges associated with the drug-eluting stents in DRGs 526 and 527. The relative weights for DRGs 516 and 517 are calculated based on the charges of the cases estimated to remain in these two DRGs.

Comment: In response to our statement in the proposed rule that we would use the best available data to establish the FY 2004 relative weights for DRGs 526 and 527, one commenter (the manufacturer of the only FDA-approved drug-eluting stents at this time) commissioned an independent accounting firm to collect costs, charges, and utilization data from hospitals on drug-eluting and nondrug-eluting stents.

The data were collected from a randomized, statistically significant sample of United States hospitals with interventional cardiac catherization laboratories. First, the firm identified those hospitals that performed coronary angioplasty on Medicare beneficiaries. The method used to identify these hospitals was first to review MedPAR data to isolate those hospitals with average volume in DRGs with a placement of coronary artery stent, ICD–9–CM procedure code (36.06). From this list of hospitals, it was necessary to eliminate those that appeared to have quality issues with the data. This resulted in a list of 1,033 hospitals for the ''population'' group from which the sample was drawn.

A sample size sufficient to achieve a confidence level of 95 percent that the results would be within 5 percent of the actual distribution (assuming a normal distribution) was then determined, and a randomized selection within each state identified 279 hospitals. An additional 30 hospitals from a preliminary phase of the study were added because these hospitals had already supplied nondrug-eluting stent data and had committed to supply drug-

[4] Even though the DRG became active on April 1, 2003, we expect that hospitals did not use this technology before FDA approval. (We intend to identify and review any cases with the code 36.07 that occurred prior to FDA approval.) Therefore, no payments are expected to have been made under these DRGs for cases occurring before FDA approval.

eluting stent data. Therefore, the total sample size for the survey instrument was 309 hospitals.

At the time of the survey, 83 of the selected hospitals had not yet received shipments of the drug-eluting stents and, hence, were not able to complete the survey because they had no cost or charge data for drug-eluting stents. The final number of completed surveys was 119 (or 53 percent of the sample).

The survey was designed to collect data regarding costs, charges, and utilization for drug-eluting stents at three different points in time: currently; October 1, 2003; and at full-maturity (defined as that point in time in which the hospital has achieved a stable and consistent usage of the drug-eluting stent). The data were submitted (including a sample of invoices) under a request for confidential treatment under the Freedom of Information Act.

Based on the data collected, the commenter recommended that CMS increase the harge differential between nondrug-eluting and drug-eluting stents to create a payment differential of $3,024. This represents the cost per case differential between nondrug-eluting stent and drug-eluting stent cases anticipated by surveyed hospitals on October 1, 2003. The current cost differential reported by the sample of hospitals was $2,721. The commenter estimated that our proposed methodology results in a payment differential of $1,451 and $1,495 between DRGs 516 and 526, and DRGs 517 and 527, respectively. The surveyed hospitals reported average current and anticipated stents used per case of 1.4 and 1.5, respectively. Average projected utilization of drug-eluting stents relative to all stents was reported in the survey to currently be 33 percent, and by October 1, 2003, utilization is projected to be 69 percent.

Another commenter noted that the actual cost per stents is 59 percent higher than our projection of $1,200. The commenter also noted that most cases use 2 stents instead of the projected 1.5 stents, and, therefore, the net incremental charge difference should be $5,554 instead of the $3,996 projected by CMS.

Response: The data submitted was extensively detailed and helped us better understand the costs, charges, and utilization for all types of stents. As noted above, we stated in the proposed rule that we would use the best available data at the time of the final rule to establish the FY 2004 relative weights for DRGs 526 and 527, and these data are much more detailed and current than any other sources available to us at this time. These data are extremely useful to assess the appropriateness of our proposed methodology to determine the relative weights for DRGs 526 and 527.

The commenter recommended that CMS establish a payment differential between DRGs for nondrug-eluting stents and drug-eluting stents of $3,024 to account for the estimated cost difference between the two types of stents. However, the DRG relative weights are established using the average charges per case of each DRG relative to the national average. Therefore, we examined the charge per case data from the sample.

The commenter referred to a mean charge differential per case of $5,721, based on anticipated costs per drug-eluting stent on October 1, 2003. However, we do not believe it is appropriate to use anticipated October 1, 2003 charges for several reasons. First, these data cannot be substantiated. As noted above, we received a sampling of current invoices that allowed us to verify the current costs per drug-eluting stent. These invoices cannot verify the $300 average per stent cost increase that reportedly will occur between the time the survey was conducted and October 1, 2003. Second, for all other DRGs, we are using charge data reflective of FY 2002 charges. Although we are establishing the FY 2004 relative weights in this final rule, using anticipated FY 2004 charge data would result in 2-year later charge data being used to establish the DRG 526 and 527 relative weights, while FY 2002 charge data are used to establish all other relative weights. Therefore, we believe the current data more closely approximate the data used to determine the FY 2004 relative weights for the remainder of the DRGs. Finally, hospitals must rely upon the manufacturer of the only currently available drug-eluting stents for information on future pricing. We believe this raises questions as to the validity of the data due to the lack of independently verifiable pricing data for the future.

Therefore, we are basing our evaluation of our proposed methodology on the sample data from the current period. The commenter reported a mean differential in charges per case of $4,859 for the current period. However, we are concerned that the mean differential in charges per case is unduly influenced by extraordinarily high charge markups reported on the part of some hospitals. For example, one hospital reported charging $28,000 per drug-eluting stent, while its costs per stent were only $3,023. This same hospital reported charges of $9,500 for nondrug-eluting stents, with costs per stent of $1,010. To control the distorting impact such a hospital would have on the mean charge differential, we examined the geometric mean charge differential based on current charges per case.

The survey data showed that, for seven hospitals, the charge per case was higher for nondrug-eluting stent cases. In order to calculate the geometric mean differential charge per case, it was necessary to remove these seven negative differentials. The result was a current geometric mean differential charge per case of $4,186. As an alternative to removing these seven negative numbers, we set them to a $1 differential, and calculated a geometric mean differential charge per case of $2,291. Based on the range of these results, we believe our proposed charge differential of $3,996 represents a reasonable approximation of the differential in charges per case, and we are proceeding to establish the DRG relative weights for DRGs 526 and 527 for FY 2004 using this amount.

We note that there is a difference between CMS and the commenter on the current cost difference between drug-eluting stents and nondrug-eluting stents (our estimate began with a $1,200 per stent differential, while the survey found a $2,721 current differential). It appears that the reason our charges per case for drug-eluting stents and nondrug-eluting stents are not substantially different from the charges in the survey data, despite the discrepancy in the cost differential, is due to the fact that hospitals are not marking up drug-eluting stents by the same proportion as nondrug-eluting stents. From the data submitted by the commenter, we found the average charge increase for nondrug-eluting stents is 183 percent. The average charge increase for drug-eluting stents is 124 percent. This lower markup reduces the differential in charges relative to the actual costs hospitals may incur.

Based on data submitted to us last year by the commenter, we proposed that 43 percent of stent cases from DRGs 516 and 517 would be reassigned to DRGs 526 and 527. However, based on the survey data, for FY 2004 we are changing our estimate to assume that 69 percent of coronary stent cases will be reassigned from DRGs 516 and 517 to DRGs 526 and 527, respectively. We note that, although this percentage is based on anticipated utilization on October 1, 2003, it is not based on data that is only available from the manufacturer. We are continuing to assume a utilization rate of 1.5 stents per case.

Comment: Many commenters argued that the proposed payment for drug-eluting stents is inadequate and asked that CMS consider the data it has received to date from hospital claims to determine whether the proposed FY 2004 payment rate for drug-eluting stents is adequate. Other commenters requested that CMS use the most current United States data available (as opposed to data from the United Kingdom) to establish the DRG weights for FY 2004.

Some commenters noted that current DRG weights account for 1.5 stents per case, but that the number of stents per case is expected to rise because the insertion of drug-eluting stents is more technically challenging in comparison to competitive products. The commenters also noted that because drug-eluting stents are able to treat smaller vessels, more diffuse disease in diabetics, and longer lesions, a rise is expected in the stent per patient ratio. The commenters asked that CMS adjust its ratio of 1.5 stents per case to an amount closer to 2 stents per case when recalibrating the DRG weights. Another commenter explained that, based on their analysis, an average of 1.7 drug-eluting stents is used per procedure and the average cost per drug-eluting stent is $3,195. The commenter requested that these amounts be used to compute the relative weights for DRGs 526 and 527. The commenter also noted that the payment rates for FY 2003 are higher than the payment rates for FY 2004 due to the decline in the DRG relative weights.

One commenter suggested as an alternative to increasing the weights for drug-eluting stents that payment be contingent on the type and number of stents used per procedure. The commenter recommended that CMS set up revenue codes to indicate the type and number of stents used per case and make payment approximately $1,000 above the cost per stent.

Another commenter also noted that the demand from hospitals for drug-eluting stents is much higher than the projected 43 percent of coronary artery stent cases. The commenter estimated that 85 to 90 percent of all stent cases should be reassigned from DRGs 516 and 517 to DRGs 526 and 527. Another commenter explained that drug-eluting stents, compared with nondrug-eluting stents, have already been shown to decrease angiographic restenosis in coronary arteries by more than half, which should reduce the need for repeat procedure rates from 20 percent of cases to less than 5 percent. As a result, demand for drug-eluting stents is expected to increase and the commenter estimated that 70 percent of all coronary artery stent cases will involve the use of drug-eluting stents. Therefore, 70 percent of all stent cases should be moved to DRGs 526 and 527 to account for drug-eluting stents instead of the 43 percent proposed by CMS.

One commenter explained that there are many added costs of using drug-eluting stents, such as that the area of blockage to be treated is to be predilated with an angioplasty balloon before and after implanting the stent, the use of intravascular ultrasound to ensure proper positioning and deployment of stents in certain cases, and increased length of time a patient spends in the cardiac catheterization laboratory. The commenter also added that percutaneous transluminal coronary angioplasty volume is expected to increase due to obesity, smoking, sedentary lifestyle, and diabetes. Therefore, the commenter recommended that CMS ensure that drug-eluting stents are adequately paid.

Response: As described above, we used data submitted to us from a survey of U.S. hospitals to evaluate our proposed methodology. Our analysis indicates that the proposed charge differential and the number of stents per procedure in our methodology are appropriate. However, we have increased our assumed utilization rate of drug-eluting stents to 69 percent from 43 percent, based on these data.

With respect to the decline in the proposed FY 2004 DRG relative weights compared to FY 2003, every year we recalibrate the DRG weights comparing the average charge per DRG to all other DRGs. The weights of one DRG can change for numerous reasons (for example, increase or decrease in total cases or increase or decrease in charges) and cause weights from other DRGs to increase or decrease due to budget neutrality.

As we proposed, we are maintaining DRGs 526 and 527 for FY 2004, and adopting the same methodology to establish the relative weights as we used for FY 2003. We have used the best available data to establish the final FY 2004 relative weights for DRGs 526 and 527 included in this final rule. We will continue to evaluate the appropriate assignment of these cases in the future.

Comment: One commenter recommended that CMS move drug-eluting stents to DRGs 516 and 517 and adjust the weights, because CMS should not provide a financial incentive for hospitals to favor one therapy when other alternatives with equal or better outcomes are available. The commenter stated further that CMS should not create an incentive that promotes a more expensive treatment for which risks and benefits are not yet completely known. Another commenter suggested that drug-eluting stents should receive add-on payments for new technology instead of receiving their own DRG payment.

Response: We explained our rationale for creating new DRGs 525 and 526 (instead of assigning these cases to DRGs 516 or 517 or approving a new technology add-on) in the August 1, 2002 IPPS final rule (67 FR 50005) and refer the commenters to that rule for our response. We appreciate the commenter's continual input and interest in these issues.

f. Artificial Anal Sphincter

The ICD–9–CM Coordination and Maintenance Committee created two new codes to describe procedures involving an artificial anal sphincter for use for discharges occurring on or after October 1, 2002. One code (49.75, Implantation or revision of artificial anal sphincter) is used to identify cases involving implantation or revision of an artificial anal sphincter. The second code (49.76, Removal of artificial anal sphincter) is used to identify cases involving the removal of the device. In Table 6B of the August 1, 2002 IPPS final rule (67 FR 50242), we assigned both codes to one of four MDCs based on principal diagnosis, and to one of six DRGs within those MDCs as follows: MDC 6 (Diseases and Disorders of the Digestive System), DRG 157 (Anal and Stomal Procedures With CC) and DRG 158 (Anal and Stomal Procedures Without CC); MDC 9 (Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast), DRG 267 (Perianal and Pilonidal Procedures); MDC 21 (Injuries, Poisonings, and Toxic Effect of Drugs), DRG 442 (Other O.R. Procedures for Injuries With CC) and DRG 443 (Other O.R. Procedures for Injuries Without CC); and MDC 24 (Multiple Significant Trauma), DRG 486 (Other O.R. Procedures for Multiple Significant Trauma).

Prior to the publication of the proposed rule, we received a request that we review these DRG assignments. According to the requester, the artificial anal sphincter procedures are expensive and the payment does not adequately cover a hospital's costs in the most likely occurring DRGs: DRG 157 and DRG 158. The requester submitted data showing cases involving artificial anal sphincters with average charges of $44,000, and suggested that we assign codes 49.75 and 49.76 in MDC 6 to DRG 170 (Other Digestive System O.R. Procedures With CC) and DRG 171 (Other Digestive System O.R. Procedures Without CC) because DRG

170 and DRG 171 are higher weighted than DRGs 157 and 158.

In the May 19, 2003 proposed rule, we did not propose to assign these cases to DRGs 170 and 171. Although we recognized that the data submitted by the commenter appear to show this procedure is associated with above average costs in the DRGs to which these cases are assigned, we stated that we believe the current assignment is the most clinically appropriate at this time. As noted above, the procedure codes to identify the implantation, revision, or removal of these devices were effective beginning on October 1, 2002. Therefore, we proposed to monitor the costs of these cases using actual Medicare cases with these codes included from the FY 2003 MedPAR that will be used for the FY 2004 DRG relative weights.

Comment: Two commenters expressed concern that the procedures for insertion and removal of an artificial anal sphincter are assigned to DRG groupings that do not cover the cost of the device. In addition, one commenter stated that, as the surgeon must operate on two distinct areas of the patient's body, these procedures are more resource-intensive and, therefore, are not clinically coherent with other procedures of low complexity in DRGs 157 and 158.

Response: As noted above, the codes describing the implantation, revision, or removal of artificial anal sphincters were created for use beginning on October 1, 2002. Therefore, we do not have data on cases assigned to codes 49.75 and 49.76. Accordingly, we are not making any changes to the DRG assignments of these codes at this time. However, we will continue to monitor this procedure in the upcoming MedPAR data and will, in the future, consider modifications relating to DRG assignment(s) if warranted.

C. Recalibration of DRG Weights

As we proposed, in this final rule we used the same basic methodology for the FY 2004 recalibration as we did for FY 2003 (August 1, 2002 IPPS final rule (67 FR 50008). That is, we recalibrated the DRG weights based on charge data for Medicare discharges using the most current charge information available (the FY 2002 MedPAR file).

The MedPAR file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills. The FY 2002 MedPAR data used in this final rule include discharges occurring between October 1, 2001 and September 30, 2002, based on bills received by CMS through March 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 2002 MedPAR file includes data for approximately 11,496,239 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. This is a change from the recalibration methodology in the proposed rule, where hospitals that subsequently became CAHs were included in the data. In this final rule, we changed the recalibration methodology for consistency with our change that excluded these CAHs from the data used to construct the wage index.

The methodology used to calculate the DRG relative weights from the FY 2002 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 2000 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 new weights are normalized by an adjustment factor (1.45726) so that the average case weight after recalibration is equal to the average case weight before recalibration. This adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS.

As noted below in section IV.A.2. of the preamble of this final rule, we are expanding the transfer policy applicable to postacute care transfers to a total of 29 DRGs (the current 10 DRGs, minus 2, plus 21 additional DRGs), beginning in FY 2004. Because we count a transfer case as a fraction of a case as described above in the recalibration process, the expansion of the postacute care transfer policy to additional DRGs affects the relative weights for those DRGs. Therefore, we calculated the final FY 2004 normalization factor comparing: the case-mix using the final FY 2004 DRG relative weights in which we treated postacute care transfer cases in the additional DRGs for the postacute transfer policy for FY 2004 as a fraction of a case with the case-mix using the FY 2003 DRG relative weights without treating cases in these additional DRGs as transfer cases.

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 used that same case threshold in recalibrating the final DRG weights for FY 2004. Using the FY 2002 MedPAR data set, there are 42 DRGs that contain fewer than 10 cases. We computed the weights for these low-volume DRGs by adjusting the FY 2003 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs.

Comment: Commenters questioned the fact that the proposed weights for several DRGs declined from the prior fiscal year.

Response: As described above, the relative weight for each DRG is

calculated by comparing the average charge for cases within each DRG (after removing statistical outliers) with the national average charge per case. Therefore, there are several factors that can cause a shift in the relative weight of a DRG from one fiscal year to the next. For example, even though the average charges of cases within a particular DRG may have increased, if they did not increase by an equal or greater percentage than the national average, the DRG relative weight would decline. In this final rule, the weights for 223 DRGs for FY 2004 decline from those for FY 2003 (all but 38 DRGs by less than 5 percent), while the weights for 299 DRGs for FY 2004 increased from those for FY 2003 (all but 39 DRGs by less than 5 percent).

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 final rule, we are making a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Comment: One commenter expressed concern that the impact of the proposed DRG recalibration is a $3 million decrease in payments to its hospitals. The commenter was hopeful that the budget neutrality adjustment to ensure that the normalization of DRG weights is achieved will somehow restore the estimated negative impact.

Response: As explained above and in the proposed rule, section 1886(d)(4)(C)(iii) of the Act requires that the changes made through DRG reclassification and recalibration be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payment that would have been made without the changes. However, this requirement refers to aggregate national payments. Therefore, for individual hospitals, the impacts of these changes may be either positive or negative.

D. LTC–DRG Reclassifications and Relative Weights for LTCHs for FY 2004

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), Pub. L. 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.

As we explained in the May 19, 2003 IPPS proposed rule (68 FR 27173), we proposed revisions to the LTC–DRG classifications and relative weights and indicated that we would finalize them in the IPPS final rule, to be effective October 1, 2003 through September 30, 2004. The final LTC–DRGs and relative weights for FY 2004 in this final rule are based on the IPPS DRGs (GROUPER version 21.0) discussed in section II. of this final rule.

2. Changes in the LTC–DRG Classifications

a. Background

Section 123 of Pub. L. 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 Pub. L. 106–554 modified the requirements of section 123 of Pub. L. 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 Pub. L. 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, under this final rule, we will use the IPPS version 21.0 GROUPER for FY 2004 to process LTCH PPS claims. The changes to the IPPS DRG classification system for FY 2004 (Grouper 21.0) are discussed in section II.B. of this preamble.

Under the LTCH PPS, we determine relative weights for each of the IPPS 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 both the May 19, 2003 proposed rule (68 FR 27174) and the June 6, 2003 LTCH PPS final rule (68 FR 34132), 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. In order to deal with the large number of low volume LTC–DRGs (LTC–DRGs with fewer than 25 cases), as we discussed in the May 19, 2003 proposed rule (68 FR 27176), we group those low volume LTC–DRGs 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 this final

rule.) 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 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 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 (Pub. L. 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 a 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 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 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 FY 2004 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 LTC–DRG relative weights 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 LTC–DRG relative weights for FY 2004 in this final rule, we obtained total Medicare allowable charges from FY 2002 Medicare hospital bill data from the December 2002 update of the MedPAR file, and we used Version 21.0 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 recalculated the FY 2004 LTC–DRG

relative weights based on the best available data for this final rule.

As we discussed in the May 19, 2003 proposed rule (68 FR 27151), 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 Pub. L. 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Pub. L. 92–603 (42 U.S.C. 1395b–1). Therefore, in the development of the FY 2004 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.

In addition, as we discussed in that same proposed rule, a data problem regarding the proposed FY 2003 LTC–DRG relative weight values that were determined using MedPAR (claims) data for FYs 2000 and 2001 was brought to our attention. Following notification of this problem, we researched the commenter's claims and determined that, given the long stays at LTCHs, some providers had submitted multiple bills for payment under the reasonable cost-based reimbursement system for the same stay. Based upon our research, we became aware of the following situation: In certain LTCHs, hospital personnel apparently reported a different principal diagnosis on each bill since, under the reasonable cost-based reimbursement system, payment was not dependent upon principal diagnosis, as it is under a DRG-based system. These claims from the MedPAR file were run through the LTCH GROUPER and used in determining the proposed FY 2003 relative weights for each LTC–DRG.

After this issue was brought to our attention, we discovered that only data from the final bills were being extracted for the MedPAR file. Therefore, it was possible that the original MedPAR file was not receiving the correct principal diagnosis. In the August 30, 2002 final rule (67 FR 55989), we addressed the problem by identifying all LTCH cases in the FY 2001 MedPAR file for which multiple bills were submitted. For each of these cases, beginning with the first bill and moving forward consecutively through subsequent bills for that stay, we recorded the first unique diagnosis codes up to 10 and the first unique procedure codes up to 10. We then used these codes to appropriately group each LTCH case to a LTC–DRG for FY 2003.

As we noted above, we are using LTCH claims data from the FY 2002 MedPAR file for the determination of the FY 2004 LTC–DRG relative weights. Since at the time (FY 2002) LTCHs were still reimbursed under the reasonable cost-based system, some LTCHs also had submitted multiple bills for Medicare payment for the same stay. Thus, in certain LTCHs, hospital personnel were apparently still reporting a different principal diagnosis on each bill since, under the reasonable cost-based reimbursement system in FY 2002, payment was not dependent upon principal diagnosis as it is under a DRG-based system. Therefore, as we explained in the May 19, 2003 proposed rule (68 FR 27151), we are following the same methodology outlined above to determine the appropriate diagnosis and procedure codes for those multiple bill LTCH cases in the FY 2002 MedPAR files, and we are using these codes to group each LTCH case to a LTC–DRG for FY 2004. 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.

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 May 19, 2003 proposed rule (68 FR 27176), 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 final rule, using LTCH

cases from the FY 2002 MedPAR file, we identified 173 LTC–DRGs that contained between 1 and 24 cases. This list of LTC–DRGs was then divided into one of the five low volume quintiles, each containing a minimum of 34 LTC–DRGs (173/5 = 34 with 3 LTC–DRGs as the remainder). For FY 2004, as we described in that same proposed rule, we are making an assignment to a specific low volume quintile by sorting the 173 low volume 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 low volume LTC–DRG was used to determine which low volume quintile received the additional LTC–DRG. After sorting the 173 low volume LTC–DRGs in ascending order, we grouped the first fifth (34) of low volume LTC–DRGs with the lowest average charge into Quintile 1. The highest average charge cases are grouped into Quintile 5. Since the average charge of the 69th LTC–DRG in the sorted list is closer to the previous LTC–DRG's average charge (assigned to Quintile 2) than to the average charge of the 70th LTC–DRG in the sorted list (to be assigned to Quintile 3), we placed it into Quintile 2. This process was repeated through the remaining low volume LTC–DRGs so that 3 low volume quintiles contain 35 LTC–DRGs and 2 low volume quintiles contain 34 LTC–DRGs.

In order to determine the relative weights for the LTC–DRGs with low volume for FY 2004, in accordance with the methodology described in the May 19, 2003 proposed rule (68 FR 27176), we used the five low volume quintiles described above. The composition of each of the five low volume quintiles shown below in Table 1 is used in determining the LTC–DRG relative weights for FY 2004. We determine a relative weight and (geometric) average length of stay for each of the five low volume quintiles using the formula that we apply to the regular LTC–DRGs (25 or more cases), as described below in section II.D.4. of this preamble. We assign the same relative weight and average length of stay to each of the LTC–DRGs that make up that 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.—COMPOSITION OF LOW VOLUME QUINTILES

LTC-DRG	Description
Quintile 1	
44	ACUTE MAJOR EYE INFECTIONS.
46	OTHER DISORDERS OF THE EYE AGE >17 W CC.
47	OTHER DISORDERS OF THE EYE AGE >17 W/O CC.
65	DYSEQUILIBRIUM.
66	EPISTAXIS.
69	OTITIS MEDIA & URI AGE >17 W/O CC.
93	INTERSTITIAL LUNG DISEASE W/O CC.
95	PNEUMOTHORAX W/O CC.
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC.
178	UNCOMPLICATED PEPTIC ULCER W/O CC.
192	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC.
273	MAJOR SKIN DISORDERS W/O CC.
276	NON-MALIGANT BREAST DISORDERS.
284	MINOR SKIN DISORDERS W/O CC.
305	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON–NEOPL W/O CC.
311	TRANSURETHRAL PROCEDURES W/O CC.
319	KIDNEY & URINARY TRACT NEOPLASMS W/O CC.
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC.
342	CIRCUMCISION AGE >17.
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.
348	BENIGN PROSTATIC HYPERTROPHY W CC.
349	BENIGN PROSTATIC HYPERTROPHY W/O CC.
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC.
376	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.
399	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC.
414	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC.
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL.
431	CHILDHOOD MENTAL DISORDERS.
432	OTHER MENTAL DISORDER DIAGNOSES.
433	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA.
467	OTHER FACTORS INFLUENCING HEALTH STATUS.
511	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA.
538	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITHOUT CC.
540	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITHOUT CC.
Quintile 2	
21	VIRAL MENINGITIS.
22	HYPERTENSIVE ENCEPHALOPATHY.
31**	CONCUSSION AGE >17 W CC.
53	SINUS & MASTOID PROCEDURES AGE >17.
61	MYRINGOTOMY W TUBE INSERTION AGE >17.
72	NASAL TRAUMA & DEFORMITY.
84	MAJOR CHEST TRAUMA W/O CC.
128	DEEP VEIN THROMBOPHLEBITIS.

TABLE 1.—COMPOSITION OF LOW VOLUME QUINTILES—Continued

LTC-DRG	Description
177	UNCOMPLICATED PEPTIC ULCER W CC.
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.
193	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.
194*	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.
200	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.
206***	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC.
208***	DISORDERS OF THE BILIARY TRACT W/O CC.
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.
232	ARTHROSCOPY.
237	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH.
275	MALIGNANT BREAST DISORDERS W/O CC.
301	ENDOCRINE DISORDERS W/O CC.
309	MINOR BLADDER PROCEDURES W/O CC.
323	URINARY STONES W CC, &/OR ESW LITHOTRIPSY.
324	URINARY STONES W/O CC.
339	TESTES PROCEDURES, NON-MALIGNANCY AGE 17.
341	PENIS PROCEDURES.
420	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC.
421	VIRAL ILLNESS AGE >17.
454	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC.
455	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC.
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.
502	KNEE PROCEDURES W PDX OF INFECTION W/O CC.
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.
507*	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC OR SIG TRAUMA.
508	FULL THICKNESS BURN W/O SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.
509	FULL THICKNESS BURN W/O SKIN GRAFT OR INH INJ W/O CC OR SIG TRAUMA.
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA.
529	VENTRICULAR SHUNT PROCEDURES WITH CC.
QUINTILE 3	
31*	CONCUSSION AGE >17 W CC.
32*	CONCUSSION AGE >17 W/O CC.
63	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES.
83	MAJOR CHEST TRAUMA W CC.
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.
129	CARDIAC ARREST, UNEXPLAINED.
158	ANAL & STOMAL PROCEDURES W/O CC.
194**	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.
197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.
218	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.
223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.
225	FOOT PROCEDURES.
226**	SOFT TISSUE PROCEDURES W CC.
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC.
234	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC.
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC.
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY.
295	DIABETES AGE 0–35.
299	INBORN ERRORS OF METABOLISM.
317	ADMIT FOR RENAL DIALYSIS.
325	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC.
347***	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O 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.
402	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R. PROC.
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.
419	FEVER OF UNKNOWN ORIGIN AGE >17 W CC.
447	ALLERGIC REACTIONS AGE >17.
449	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC.
450*	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC.
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17.
497	SPINAL FUSION W CC.
498*	SPINAL FUSION W/O CC.
503	KNEE PROCEDURES W/O PDX OF INFECTION.
507**	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.
518	PERCUTANEOUS CARDIVASCULAR PROC W/O CORONARY ARTERY STENT OR AMI.
532	SPINAL PROCEDURES WITHOUT CC.

TABLE 1.—COMPOSITION OF LOW VOLUME QUINTILES—Continued

LTC-DRG	Description
	QUINTILE 4
119	VEIN LIGATION & STRIPPING.
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.
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.
157	ANAL & STOMAL PROCEDURES W CC.
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >7 W CC.
171	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC.
191	PANCREAS, LIVER & SHUNT PROCEDURES W CC.
195	CHOLECYSTECTOMY W C.D.E. W CC.
209	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE>17 W CC.
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.
226*	SOFT TISSUE PROCEDURES W CC.
227	SOFT TISSUE PROCEDURES W/O CC.
228	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC.
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.
266***	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC.
308	MINOR BLADDER PROCEDURES W CC.
310	TRANSURETHRAL PROCEDURES W CC.
312	URETHRAL PROCEDURES, AGE >17 W CC.
360	VAGINA, CERVIX & VULVA PROCEDURES.
424	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS.
427	NEUROSES EXCEPT DEPRESSIVE.
443	OTHER O.R. PROCEDURES FOR INJURIES W/O CC.
479***	OTHER VASCULAR PROCEDURES W/O CC.
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC.
494*	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC.
498**	SPINAL FUSION W/O CC.
500	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC.
505	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT.
517	PERCUTANEOUS CARDIVASCULAR PROC W NON-DRUG ELUTING STENT W/O AMI.
519	CERVICAL SPINAL FUSION W CC.
531	SPINAL PROCEDURES WITH CC.
537	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITH CC.
	QUINTILE 5
1	CRANIOTOMY AGE >17 W CC.
8***	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC.
32**	CONCUSSION AGE >17 W/O CC.
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17.
75	MAJOR CHEST PROCEDURES.
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC.
108	OTHER CARDIOTHORACIC PROCEDURES.
110	MAJOR CARDIOVASCULAR PROCEDURES W CC.
115	PRM CARD PACEM IMPL W AMI, HRT FAIL OR SHK, OR AICD LEAD OR GNRTR P.
116	OTH PERM CARD PACEMAK IMPL OR PTCA W CORONARY ARTERY STENT IMPLNT.
118	CARDIAC PACEMAKER DEVICE REPLACEMENT.
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC.
154	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.
168	MOUTH PROCEDURES W CC.
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES.
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.
268	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES.
288	O.R. PROCEDURES FOR OBESITY.
304	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES.
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC.
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.
441	HAND PROCEDURES FOR INJURIES.
450**	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC.
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.
482	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES.
488	HIV W EXTENSIVE O.R. PROCEDURE.
494**	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC.
499	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC.

TABLE 1.—COMPOSITION OF LOW VOLUME QUINTILES—Continued

LTC-DRG	Description
501	KNEE PROCEDURES W PDX OF INFECTION W CC.
515	CARDIAC DEFIBRILATOR IMPLANT W/O CARDIAC CATH.
533	EXTRACRANIAL VASCULAR PROCEDURES WITH CC.
536	CARDIAC DEFIB IMPLANT WITH CARDIAC CATH WITHOUT AMI/HF/SHOCK.

*One of the original 173 low volume LTC–DRGs initially assigned to a different low volume quintile; reassigned to this low volume quintile in addressing nonmonotonicity (*see* step 5 below).

**One of the original 173 low volume LTC–DRGs initially assigned to this low volume quintile; reassigned to a different low volume quintile in addressing nonmonotonicity (*see* step 5 below).

***One of the original 173 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 FY 2004 LTC–DRG Relative Weights

As we noted previously, the FY 2004 LTC–DRG relative weights are determined in accordance with the methodology described in the May 19, 2003 proposed rule (68 FR 27179). 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 FY 2004 LTC–DRG relative weights can be determined. After grouping the cases in the appropriate LTC–DRG, we calculate the relative weights for FY 2004 in this final rule by first removing statistical outliers and cases with a length of stay of 7 days or less. Next, we adjust the number of cases in each LTC–DRG for the effect of short-stay outlier cases under § 412.529. The short-stay adjusted discharges and corresponding charges are used to calculate ''relative adjusted weights'' in each LTC–DRG using the hospital-specific relative value method described above.

Below we discuss in detail the steps for calculating the FY 2004 LTC–DRG relative weights.

Step 1—Remove Statistical Outliers

The first step in the calculation of the FY 2004 LTC–DRG relative weights is to remove statistical outlier cases. As we discussed in the May 19, 2003 proposed rule (68 FR 27179), 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 are removed prior to calculating the 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 relative weights could result in an inaccurate relative weight that does not truly reflect relative resource use among the LTC–DRGs.

Step 2—Remove Cases With a Length of Stay of 7 Days or Less

The FY 2004 LTC–DRG relative weights reflect the average of resources used on representative cases of a specific type. Generally, as we discussed in the May 19, 2003 proposed rule (68 FR 27179), 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 FY 2004 LTC–DRG relative weights, the value of many 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 FY 2004 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 FY 2004 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).

As we discussed in the May 19, 2003 proposed rule (68 FR 27179), 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 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 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 LTC–DRG.

As we explained in that same proposed rule, counting short-stay outlier cases as full discharges with no adjustment in determining the LTC–DRG relative weights would lower the LTC–DRG relative weight for affected LTC–DRGs because the relatively lower charges of the short-stay outlier cases would bring down the average charge for all cases within a LTC–DRG. This would result in an ''underpayment'' to nonshort-stay outlier cases and an ''overpayment'' to short-stay outlier cases. Therefore, in this final 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 FY 2004 LTC–DRG Relative Weights on an Iterative Basis

As we discussed in the May 19, 2003 proposed rule (68 FR 27180), the process of calculating the 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 LTC–DRG, the FY 2004 LTC–DRG relative weight is calculated by dividing the average of the adjusted hospital-specific relative charge values (from above) for the LTC–DRG by the

overall average hospital-specific relative charge value across all cases for all LTCHs. Using these recalculated LTC–DRG relative weights, each LTCH's average relative weight for all of its cases (case-mix) is calculated by dividing the sum of all the LTCH's 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 LTC–DRG relative weights across all LTCHs. In this final 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 FY 2004 LTC–DRG Relative Weights to Account for Nonmonotonically Increasing Relative Weights

As explained in section II.B. of this preamble, the FY 2004 CMS DRGs, upon which the FY 2004 LTC–DRGs are based, contain ''pairs'' that are differentiated based on the presence or absence of CCs. The 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 May 19, 2003 proposed rule (68 FR 27180), 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 LTC–DRG means that cases classified into a ''without CC'' 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 LTC–DRGs.

For a case to be assigned to a 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 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 LTC–DRG ''without CCs'' since only one principal diagnosis was coded. Since 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 2002 claims data, we also found on occasion that the data suggested that cases classified to the LTC–DRG ''with CCs'' of a ''with CC''/''without CC'' pair have a lower average charge than the corresponding LTC–DRG ''without CCs'' for FY 2004.

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, as we discussed in the May 19, 2003 proposed rule (68 FR 27180), we grouped both the cases ''with CCs'' and ''without CCs'' together for the purpose of calculating the FY 2004 LTC–DRG relative weights in this final rule. We 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'' LTC–DRG would have a higher average charge than the ''with CC'' LTC–DRG. For this final rule, using the LTCH cases in the December 2002 update of the FY 2002 MedPAR file, we identified three of the types of nonmonotonic LTC–DRG pairs.

The first category of nonmonotonically increasing relative weights for FY 2004 LTC–DRG pairs ''with and without CCs'' contains 1 pair of LTC–DRGs in which both the LTC–DRG ''with CCs'' and the LTC–DRG ''without CCs'' had 25 or more LTCH cases and, therefore, did not fall into one of the 5 low volume quintiles. For that type of nonmonotonic LTC–DRG pair, as discussed in the May 19, 2003 proposed rule (68 FR 27180), we combine the LTCH cases and compute a new relative weight based on the case-weighted average of the combined LTCH cases of the 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 LTC–DRG. This new relative weight is then assigned to both of the LTC–DRGs in the pair. In this final rule, for FY 2004, LTC–DRGs 180 and 181 are in this category.

The second category of nonmonotonically increasing relative weights for LTC–DRG pairs with and without CCs consists of 7 pairs of LTC–DRGs that has fewer than 25 cases, and each LTC–DRG is grouped to different low volume quintiles in which the ''without CC'' LTC–DRG is in a higher-weighted low volume quintile than the ''with CC'' LTC–DRG. For those pairs, as we discussed in the May 19, 2003 proposed rule (68 FR 27181), we 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 LTC–DRG. Based on the case-weighted average LTCH charge, we determine which low volume quintile the ''combined LTC–DRG'' is grouped. Both LTC–DRGs in the pair are then grouped into the same low volume quintile, and thus would have the same relative weight. For FY 2004, in this final rule, the following LTC–DRGs are in this category: LTC–DRGs 31 and 32 (low volume quintile 3); LTC–DRGs 193 and 194 (low volume quintile 2); LTC–DRGs 226 and 227 (low volume quintile 4); LTC–DRGs 449 and 450 (low volume quintile 3); LTC–DRGs 493 and 494 (low volume quintile 4); LTC–DRGs 497 and 498 (low volume quintile 3); and LTC–DRGs 506 and 507 (low volume quintile 2).

The third category of nonmonotonically increasing relative weights for LTC–DRG pairs with and without CCs consists of 6 pairs of LTC–DRGs where one of the LTC–DRGs has fewer than 25 LTCH cases and is grouped to a low volume quintile and the other LTC–DRG has 25 or more LTCH cases and has its own LTC–DRG relative weight, and the LTC–DRG ''without CCs'' has the higher relative weight. As we discussed in the May 19, 2003 proposed rule (68 FR 27181), we remove the low volume LTC–DRG from the low volume quintile and combine it with the other LTC–DRG for the computation of a new relative weight for

each of these LTC–DRGs. This new relative weight is assigned to both LTC–DRGs, so they each have the same relative weight. For FY 2004, in this final rule, the following LTC–DRGs are in this category: LTC–DRGs 7 and 8; LTC–DRGs 205 and 206; LTC–DRGs 207 and 208; LTC–DRGs 265 and 266; LTC–DRGs 346 and 347; and LTC–DRGs 478 and 479.

Step 6—Determine a FY 2004 LTC–DRG Relative Weight for LTC–DRGs With No LTCH Cases

As we stated above, we determine the relative weight for each LTC–DRG using charges reported in the December 2002 update of the FY 2002 MedPAR file. Of the 518 LTC–DRGs for FY 2004, we identified 167 LTC–DRGs for which there were no LTCH cases in the database. That is, based on data from the FY 2002 MedPAR file used in this final rule, no patients who would have been classified to those LTC–DRGs were treated in LTCHs during FY 2002 and, therefore, no charge data were reported for those LTC–DRGs. Thus, in the process of determining the LTC–DRG relative weights, we are unable to determine weights for these 167 LTC–DRGs using the methodology described in steps 1 through 5 above. However, since patients with a number of the diagnoses under these LTC–DRGs may be treated at LTCHs beginning in FY 2004, we assign relative weights to each of the 167 ''no volume'' LTC–DRGs based on clinical similarity and relative costliness to one of the remaining 354 (518 − 167 = 351) LTC–DRGs for which we are able to determine relative weights, based on FY 2002 claims data.

As there are currently no LTCH cases in these ''no volume'' LTC–DRGs, as we discussed in the May 19, 2003 proposed rule (68 FR 27181), we determine relative weights for the 167 LTC–DRGs with no LTCH cases in the FY 2002 MedPAR file used in this final rule by grouping them to the appropriate low volume quintile. This methodology is consistent with our methodology used in determining relative weights to account for the low volume LTC–DRGs described above.

Our methodology for determining relative weights for the ''no volume'' LTC–DRGs is as follows: First, we crosswalk the no volume LTC–DRGs by matching them to other similar LTC–DRGs for which there were LTCH cases in the FY 2002 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 relative weight for the applicable low volume quintile to the no volume LTC–DRG if the LTC–DRG to which it is crosswalked is grouped to one of the low volume quintiles. If the LTC–DRG to which the no volume LTC–DRG is crosswalked is not one of the LTC–DRGs to be grouped to one of the low volume quintiles, we compare the relative weight of the LTC–DRG to which the no volume LTC–DRG is crosswalked to the relative weights of each of the five quintiles and we assign the no volume LTC–DRG the relative weight of the low volume quintile with the closest weight. For this final rule, a list of the no volume FY 2004 LTC–DRGs and the FY 2004 LTC–DRG to which it is crosswalked in order to determine the appropriate low volume quintile for the assignment of a relative weight for FY 2004 is shown below in Table 2.

TABLE 2.—NO VOLUME LTC-DRG CROSSWALK AND QUINTILE ASSIGNMENT FOR FY 2004

LTC-DRG	Description	Cross-walked LTC-DRG	Low volume quintile assigned
2	CRANIOTOMY AGE > 17 W/O CC	1	Quintile 5
3	CRANIOTOMY AGE 0–17	1	Quintile 5
6	CARPAL TUNNEL RELEASE	251	Quintile 1
26	SEIZURE & HEADACHE AGE 0–17	25	Quintile 2
30	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	29	Quintile 3
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
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	47	Quintile 1
42	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	47	Quintile 1
43	HYPHEMA	47	Quintile 1
45	NEUROLOGICAL EYE DISORDERS	46	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 3
51	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	63	Quintile 3
52	CLEFT LIP & PALATE REPAIR	63	Quintile 3
54	SINUS & MASTOID PROCEDURES AGE 0–17	63	Quintile 3
55	MISCELLANEOUS EAR, NOSE, MOUTH & THROAD PROCEDURES	63	Quintile 3
56	RHINOPLASTY	72	Quintile 2
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	63	Quintile 3
58	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	63	Quintile 3
59	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	63	Quintile 3
60	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	63	Quintile 3
62	MYRINGOTOMY W TUBE INSERTION AGE 0–17	63	Quintile 3
67	EPIGLOTTITIS	63	Quintile 3
70	OTITIS MEDIA & URI AGE 0–17	69	Quintile 1
71	LARYNGOTRACHEITIS	97	Quintile 1
74	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17	69	Quintile 1
81	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	69	Quintile 1
91	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	90	Quintile 2
98	BRONCHITIS & ASTHMA AGE 0–17	97	Quintile 1
104	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH	110	Quintile 5
105	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH	110	Quintile 5

TABLE 2.—NO VOLUME LTC-DRG CROSSWALK AND QUINTILE ASSIGNMENT FOR FY 2004—Continued

LTC-DRG	Description	Cross-walked LTC-DRG	Low volume quintile assigned
106	CORONARY BYPASS W PTCA	110	Quintile 5
107	CORONARY BYPASS W CARDIAC CATH	110	Quintile 5
109	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	110	Quintile 5
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	110	Quintile 5
137	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	136	Quintile 2
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 4
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC 155 STOMACH, ESOPHAGEAL & DUODENAL.	152	Quintile 4
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	171	Quintile 4
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17	171	Quintile 4
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	161	Quintile 4
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	161	Quintile 4
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	149	Quintile 1
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	148	Quintile 5
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	149	Quintile 1
169	MOUTH PROCEDURES W/O CC	72	Quintile 2
184	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17	183	Quintile 2
186	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17	185	Quintile 2
187	DENTAL EXTRACTIONS & RESTORATIONS	185	Quintile 2
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	189	Quintile 2
196	CHOLECYSTECTOMY W C.D.E. W/O CC	197	Quintile 3
198	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	197	Quintile 3
199	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	200	Quintile 2
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17	211	Quintile 2
219	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC	218	Quintile 3
220	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17	218	Quintile 3
224	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	234	Quintile 3
229	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	234	Quintile 3
252	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	234	Quintile 3
255	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17	234	Quintile 3
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	257	Quintile 3
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	257	Quintile 3
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	257	Quintile 3
267	PERIANAL & PILONIDAL PROCEDURES	158	Quintile 3
279	CELLULITIS AGE 0–17	78	Quintile 3
282	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	281	Quintile 2
286	ADRENAL & PITUITARY PROCEDURES	53	Quintile 2
289	PARATHYROID PROCEDURES	53	Quintile 2
290	THYROID PROCEDURES	53	Quintile 2
291	THYROGLOSSAL PROCEDURES	53	Quintile 2
293	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	63	Quintile 3
298	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	297	Quintile 2
303	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	304	Quintile 5
306	PROSTATECTOMY W CC	310	Quintile 4
307	PROSTATECTOMY W/O CC	310	Quintile 4
313	URETHRAL PROCEDURES, AGE >17 W/O CC	311	Quintile 1
314	URETHRAL PROCEDURES, AGE 0–17	311	Quintile 1
322	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	326	Quintile 1
327	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	326	Quintile 1
328	URETHRAL STRICTURE AGE >17 W CC	311	Quintile 1
329	URETHRAL STRICTURE AGE >17 W/O CC	311	Quintile 1
330	URETHRAL STRICTURE AGE 0–17	311	Quintile 1
333	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	332	Quintile 1
334	MAJOR MALE PELVIC PROCEDURES W CC	345	Quintile 5
335	MAJOR MALE PELVIC PROCEDURES W/O CC	345	Quintile 5
336	TRANSURETHRAL PROSTATECTOMY W CC	341	Quintile 2
337	TRANSURETHRAL PROSTATECTOMY W/O CC	341	Quintile 2
338	TESTES PROCEDURES, FOR MALIGNANCY	339	Quintile 2
340	TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	339	Quintile 2
343	CIRCUMCISION AGE 0–17	339	Quintile 2
351	STERILIZATION, MALE	339	Quintile 2
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	360	Quintile 4
357	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	360	Quintile 4

TABLE 2.—NO VOLUME LTC-DRG CROSSWALK AND QUINTILE ASSIGNMENT FOR FY 2004—Continued

LTC-DRG	Description	Cross-walked LTC-DRG	Low volume quintile assigned
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	360	Quintile 4
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	360	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
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	367	Quintile 1
378	ECTOPIC PREGNANCY	369	Quintile 3
379	THREATENED ABORTION	376	Quintile 1
380	ABORTION W/O D&C	376	Quintile 1
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	376	Quintile 1
382	FALSE LABOR	376	Quintile 1
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	376	Quintile 1
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	376	Quintile 1
385	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	367	Quintile 1
386	EXTREME IMMATURITY	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	376	Quintile 1
392	SPLENECTOMY AGE >17	194	Quintile 2
393	SPLENECTOMY AGE 0–17	194	Quintile 2
396	RED BLOOD CELL DISORDERS AGE 0–17	399	Quintile 1
405	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17	404	Quintile 2
407	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC	408	Quintile 3
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	420	Quintile 2
446	TRAUMATIC INJURY AGE 0–17	445	Quintile 2
448	ALLERGIC REACTIONS AGE 0–17	455	Quintile 2
451	POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	455	Quintile 2
481	BONE MARROW TRANSPLANT	394	Quintile 3
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	1	Quintile 5
485	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR	209	Quintile 4
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	209	Quintile 4
492	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	410	Quintile 3
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	210	Quintile 4
504	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	468	Quintile 5
516	PERCUTANEOUS CARDIOVASCULAR PROCEDURE W AMI	518	Quintile 3
520	CERVICAL SPINAL FUSION W/O CC	498	Quintile 3
525	HEART ASSIST SYSTEM IMPLANT	468	Quintile 5
526	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W AMI	517	Quintile 4
527	PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W/O AMI	517	Quintile 4
528	INTRACRANIAL VASCULAR PROCEDURES WITH PDX HEMORRHAGE	1	Quintile 5
530	VENTRICULAR SHUNT PROCEDURES WITHOUT CC	529	Quintile 2
534	EXTRACRANIAL VASCULAR PROCEDURES WITHOUT CC	500	Quintile 4
535	CARDIAC DEFIB IMPLANT WITH CARDIAC CATH WITH AMI/HF/SHOCK	515	Quintile 5
539	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITH CC	401	Quintile 5

To illustrate this methodology for determining the relative weights for the 164 LTC–DRGs with no LTCH cases, we are providing the following examples, which refer to the no volume LTC–DRGs crosswalk information for FY 2004 provided above in Table 2:

Example 1: There were no cases in the FY 2002 MedPAR file used for this final rule for 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 LTC–DRG 178 (Uncomplicated Peptic Ulcer Without CC), which is assigned to low volume quintile 1 for the purpose of determining the FY 2004 relative weights, would display similar clinical and resource use. Therefore, we assign the same relative weight of LTC–DRG 178 of 0.4964 (Quintile 1) for FY 2004 (Table 11 in the Addendum to this final rule) to LTC–DRG 163.

Example 2: There were no LTCH cases in the FY 2002 MedPAR file used in this final rule for 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 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 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, LTC–DRG 91, with no LTCH cases, would need to be grouped to a low volume quintile. We identified that the low volume quintile with the closest weight to LTC–DRG 90 (0.7318; *see* Table 11 in the Addendum to this final rule) would be low volume quintile 2 (0.7372; *see* Table 11 in the Addendum to this final rule). Therefore, we assign LTC–DRG 91 a relative weight of 0.7372 for FY 2004.

Furthermore, we are providing 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 2004 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 are only including 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 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 relative weights in this final rule.

Table 11 in the Addendum to this final rule lists the LTC–DRGs and their respective 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 2004.

E. Add-On Payments for New Services and Technologies

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)(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.

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. As discussed below, for applicants for new technology add-on payments for FY 2005, we are establishing the criteria that will be applied to assess whether technologies would be inadequately paid under the DRGs 75 percent of 1 standard deviation (based on the logarithmic values of the charges and transformed back to charges) beyond the geometric mean standardized charge for all cases in the DRGs 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). Table 10 in the Addendum to this final rule lists the qualifying criteria by DRG, based on the discharge data that we used to calculate the FY 2004 DRG weights. The thresholds that are published in this final rule for FY 2004 will be used to evaluate applicants for new technology add-on payments during FY 2005.

In addition to the clinical and cost criteria, we established that, in order to qualify for the new technology add-on payments, a specific technology must be ''new'' under the requirements of § 412.87(b)(2) of our regulations. The statutory provision contemplated the special payment treatment for new technologies until such time as data are available to reflect the cost of the technology in the DRG weights through recalibration (no less than 2 years and no more than 3 years). There is a lag of 2 to 3 years from the point a new technology is first introduced on the market and when data reflecting the use of the technology are used to calculate the DRG weights. For example, data from discharges occurring during FY 2002 are used to calculate the FY 2004 DRG weights in this final rule.

Technology may be considered ''new'' for purposes of this provision within 2 or 3 years after the point at which data begin to become available reflecting the costs of the technology. After we have recalibrated the DRGs to reflect the costs of an otherwise new technology, the special add-on payment for new technology will cease (§ 412.87(b)(2)). For example, an approved new technology that received FDA approval in October 2002 would be eligible to receive add-on payments as a new technology at least until FY 2005 (discharges occurring before October 1, 2004), when data reflecting the costs of the technology would be used to recalibrate the DRG weights. Because the FY 2005 DRG weights will be calculated using FY 2003 MedPAR data, the costs of such a new technology would likely be reflected in the FY 2005 DRG weights.

Similar to the timetable for applying for new technology add-on payments during FY 2004, applicants for FY 2005 must submit a formal request, including a full description of the clinical applications of the technology and the results of any clinical evaluations demonstrating that the new technology represents a substantial clinical improvement, along with a significant sample of data to demonstrate the technology meets the high-cost threshold, no later than early October 2003. Applicants must submit a complete database no later than mid-December 2003. Complete application information is available at our Web site at: *http://www.cms.hhs.gov/providers/hipps/default.asp.* To allow interested parties to identify the technologies under review before the publication of

the annual proposed rule, the Web site also lists the tracking forms completed by each applicant.

The new technology add-on payment policy provides additional payments for cases with high costs involving eligible new 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 technology. Under § 412.88, Medicare pays a marginal cost factor of 50 percent for the costs of the new technology in excess of the full DRG payment. If the actual costs of a new technology case exceed the DRG payment by more than the estimated costs of the new 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 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, we account for projected payments under the new technology provision during the upcoming fiscal year at the same time we estimate the payment effect of changes to the DRG classifications and recalibration. The impact of additional payments under this provision would then be included in the budget neutrality factor, which is applied to the standardized amounts and the hospital-specific amounts.

Because any additional payments directed toward new technology under this provision must be offset to ensure budget neutrality, it is important to consider carefully the extent of this provision and ensure that only technologies representing substantial advances are recognized for additional payments. In that regard, we indicated that we would discuss in the annual proposed and final rules those technologies that were considered under this provision; our determination as to whether a particular technology meets our criteria to be considered new; whether it is determined further that cases involving the new technology would be inadequately paid under the existing DRG payment; and any assumptions that went into the budget neutrality calculations related to additional payments for that new technology, including the expected number, distribution, and costs of these cases.

To balance appropriately the Congress' intent to increase Medicare's 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.

If the target limit is exceeded, we would reduce the level of payments for approved technologies across the board, to ensure estimated payments do not exceed the limit. Using this approach, all cases involving approved new technologies that would otherwise receive additional payments would still receive special payments, albeit at a reduced amount. Although the marginal payment rate for individual technologies would be reduced, this reduction would be offset by large overall payments to hospitals for new technologies under this provision.

Comment: Some commenters asked that CMS ensure that the necessary software changes be made to accommodate newly approved technologies so that hospitals experience no delay in receiving add-on payments for new technologies. Commenters noted that, at the time they prepared their comments, it was unclear whether hospitals were receiving any new technology add-on payments for FY 2003. Given that $74.8 million was carved out of the FY 2003 standardized amount, it is critical that a reliable system be put in place to ensure that hospitals receive these add-on payments.

Response: We regret the delay any hospital may be experiencing in receiving add-on payments for FY 2003. On December 13, 2002, we issued Program Memorandum A–02–124 that requested fiscal intermediaries to implement the new technology payment mechanism into the claims processing system by April 1, 2003. The changes outlined in this program memorandum were delayed until July 16, 2003, in order to ensure that the claims processing system could properly process these add-on payments.

Comment: Several commenters pointed out that new ICD–9–CM codes are being created for procedures that were not typically captured and reported using ICD–9–CM coding. The commenters specifically mentioned the creation of new codes for types of drugs. Commenters are concerned about the types of medical record documentation that may be required for the administration of these drugs to be assigned an ICD–9–CM code. They asked if a physician order for a drug and a notation on a medical sheet that a nurse had in fact injected the drug were sufficient documentation. The commenters indicated that further guidance is needed regarding documentation requirements for ICD–9–CM codes for new services and technologies that have not traditionally been reported through the use of ICD–9–CM coding.

One commenter recommended that the approval process for new technologies be revised to include a requirement that the applicant must barcode such item with appropriate detailed information. The commenter stated that the use of barcoding would reduce medical errors. The commenter also was concerned that the limit of 6 procedure codes that can be reported on the billing form may become problematic as more new technologies are approved in the future.

Response: We have asked the AHA to schedule this topic for discussion by the Cooperating Parties for ICD–9–CM and the Editorial Advisory Board for Coding Clinic for ICD–9–CM. AHA agrees that this is a timely topic and has scheduled it for discussion in one of its upcoming ICD–9–CM meetings.

We would like to explore further the commenter's suggestion to require applicants for new technology add-on payments to barcode the technology. We recognize the potential limitations of the current claims form, as well as the overall limitations of ICD–9–CM. As we have stated previously, we believe ICD–10–PCS offers great potential improvement for more specific coding that may limit the use of multiple ICD–9–CM codes to identify certain classes of patients.

Comment: Commenters asked that CMS present a full and clear accounting for estimated and actual new technology add-on payments and their impact on the DRG base rate in each proposed and final rule in order to ensure that hospitals receive these add-on payments in full. Another commenter recommended that, similar to outlier payments, CMS should report every year on the extent to which the actual add-on payments per case exceeded or were lower than the amount removed from the standardized amounts.

One commenter was concerned that additional payments might be carved out of the standardized amount for new technologies to ensure budget neutrality, and those payments might not be made because CMS' projection of spending for the add-on payments was too high or because hospitals failed to bill properly for add-on payments. The commenter recommended that CMS

split the budget neutrality adjustment for DRG reclassification and recalibration into two components in order to isolate the reduction associated with add-on payments for new technologies.

Commenters did not agree that add-on payments for new technology should be budget neutral, and explained that the purpose of having additional payments for high-cost items was to compensate a hospital for its unrecovered cost. Because of budget neutrality, these high-cost items are not being properly paid. The commenter also noted that these high-cost items are also the cause of a higher than expected outlier payment.

One commenter recommended that CMS develop a separate pool of money to fund new technology and remove it from the budget neutrality calculation. The commenter explained that, while the technology is new, there should be money set aside and accessed only by those hospitals utilizing that technology.

Response: When we approve a new technology for add-on payments, we conduct an analysis based on the latest data available to estimate the total add-on payments that will be made for the new technology during the upcoming fiscal year and include the results in the annual proposed and final rules. Analyses of technologies approved for add-on payments for FY 2004 are presented below. These analyses include our analysis of available FY 2003 MedPAR data on the utilization of Xigris® and the basis for our estimated payments for new technologies approved for FY 2004. We also discuss this analysis in our description of budget neutrality in section II.A.4.a. of the Addendum to this final rule. We note that, based on our analysis, we have reduced considerably our estimate of add-on payments for Xigris® from the FY 2003 level, which led to a smaller budget neutrality offset to the standardized amounts.

As we stated above, the Congressional Report language accompanying section 533 of Pub. L. 106–554 clearly indicated Congress' intent that this provision be implemented in a budget neutral manner. Therefore, Congress is the appropriate body to consider concerns about the budget neutrality of this provision.

We do not believe it necessary to establish a separate budget neutrality calculation or pool for these payments. The amount of the payments is clearly identified in the final rule. Like all of the budget neutrality calculations, it is a prospective estimate.

Comment: Commenters recommended that CMS eliminate the use of case-weighted averages in the calculation of the cost threshold for technologies that occur in more than one DRG. The commenter believed that the goal of add-on payments is to provide adequate payment for new technologies in the DRGs in which the technology is used. The commenter added that the use of a case-weighted average biases the cost threshold against technologies that occur in more than one DRG and places hospitals at a disadvantage in DRGs where the threshold would otherwise be met except for application of the case-weighted average.

Commenters argued that our criteria for what is considered a new technology is not consistent with section 1886(d)(5)(K)(ii)(II) of the Act. The commenter stated that this provision was intended to provide for the collection of data with respect to the costs of a new medical service or technology for a period of not less than 2 years and not more than 3 years, ''beginning on the date on which an inpatient hospital code is issued with respect to the service or technology.'' Therefore, the commenter recommended that, instead of no longer considering technologies new because the related charges are already captured in the MedPAR data, CMS should only view a technology as ineligible on the grounds that it is no longer new if the agency can specifically identify a significant sample of cases involving use of the technology in the MedPAR data. One commenter noted that sufficient charge data to assess whether the new technology meets the cost threshold criterion are often only available through the MedPAR data after the new ICD–9–CM code becomes effective. Some commenters also recommended that CMS raise the add-on payment amount from 50 percent of the cost of the new technology to an 80-percent or 100-percent marginal cost factor.

Another commenter asked CMS to provide established clinical requirements or criteria that would control substantial clinical improvement determinations.

One commenter recommended that CMS deem products that fall within one of the following categories designated by the FDA to have met the substantial clinical improvement criterion: Drugs or biologicals that obtain fast track or accelerated approval; and drugs or biologicals approved after priority review or approved for orphan indication. The commenter recommended that CMS defer to the clinical expertise of the FDA with respect to these products and find that any product falling in the above categories satisfy the substantial clinical improvement criterion without further CMS analysis.

In addition, many commenters addressed the proposed change to the cost threshold criterion. (We are addressing these comments in our discussion of specific proposals later in this section of the preamble.)

Response: We appreciate the interest of the many stakeholders in ensuring that Medicare beneficiaries have full access to improvements in medical technology. We have previously discussed our position on each of the issues raised by the commenters on the proposed rule in detail in the September 7, 2001 final rule (66 FR 46905) and the August 1, 2002 final rule (67 FR 50009). Our rationales for these policies have not changed since we discussed them in those final rules, and we did not propose changes to these policies in the May 19, 2003 proposed rule. Therefore, readers are referred to the September 7, 2001 final rule and the August 1, 2002 final rule for our responses to these comments. However, we will continue to assess each of these policies and would appreciate the commenters' continued input on these issues.

Comment: One commenter suggested that CMS conduct a historical review of technologies that would have likely met the ''new'' and substantial improvement criteria and determine the relationship between the costs of those items and the new technology cost threshold. The commenter noted that such an analysis might provide useful insights as to whether a more flexible cost criterion is needed.

Response: We will take this suggestion under consideration.

2. FY 2004 Status of Technology Approved for FY 2003 Add-On Payments: Drotrecogin Alfa (Activated)—Xigris®

In the August 1, 2002 IPPS final rule, we stated that cases involving the administration of Xigris® (a biotechnology product that is a recombinant version of naturally occurring Activated Protein C (APC)) as identified by the presence of code 00.11 (Infusion of drotrecogin alfa (activated)) are eligible for additional payments of up to $3,400 (50 percent of the average cost of the drug) (67 FR 50013). (The August 1, 2002 final rule contains a detailed discussion of this technology.) Although Xigris® was approved by the FDA in November 2001, it did not qualify for add-on payments until discharges on or after October 1, 2002. Consequently, FY 2002 discharges (between October 1, 2001 and September 30, 2002) may not reflect full

utilization of the technology due to the absence of the add-on payment.

Therefore, for FY 2004, we will continue to make add-on payments for cases involving the administration of Xigris® as identified by the presence of code 00.11. Based on preliminary analysis of the incidence of Xigris® in the first quarter FY 2003 MedPAR file, in the May 19, 2003 proposed rule, we proposed to revise downward our estimate of total add-on payments for Xigris®. For FY 2003, we estimated that total add-on payments would be approximately $74.8 million (22,000 Medicare patients who would be eligible for a $3,400 add-on payment). For FY 2004, we estimated in the proposed rule the total add-on payments would be approximately $50 million (based on 14,000 Medicare patients who would be eligible for a $3,400 add-on payment). We indicated that this proposed additional payment would be included in the DRG reclassification and recalibration budget neutrality factor, which is applied to the standardized amounts and the hospital-specific amounts. However, we indicated that, before the publication of the FY 2004 IPPS final rule, we would reevaluate our assumptions regarding this estimate based on preliminary claims data from the FY 2003 MedPAR file.

We have analyzed the claims from the March 2003 update to the FY 2003 MedPAR file. We identified claims that had received Xigris® based on the inclusion of procedure code 00.11. We identified only 1,500 claims from this file. Although the March 2003 update of the FY 2003 MedPAR probably only realistically includes about 5 months' worth of claims, it appears that a lower than expected number of cases are receiving this new technology at the present time.

Therefore, in this final rule for FY 2004, we are lowering the total payments in proportion to the cases that have actually received this drug. We are doubling the number of cases in our March 2003 MedPAR update to an estimated 3,000 cases that will receive Xigris® in FY 2003. We recognize there may actually be more cases than this by the end of the year, as only about 5 months of data are accounted for in our analysis. Also, this estimate does not account for future increased use of the drug. However, these potential underestimates are offset by the fact that we are assuming all cases will qualify for the full $3,400 add-on payment. We believe these effects will largely offset one another. Therefore, the final projected costs for add-on payments are estimated to be $10 million. We will use this estimate in our budget neutrality calculations.

Comment: One commenter supported our decision to continue paying add on payments for Xigris®, but disagreed with the proposed estimated decline in add-on payments in FY 2004 from $74.8 million to $50 million. The commenter explained that this conclusion was made using only first quarter FY 2003 MedPAR data and, since this technology is still in its infancy, the commenter believed FY 2003 MedPAR data will reflect an upward trend in its use and overall availability.

Some commenters were concerned that first year utilization of any new technology is an inappropriate measure for CMS to rely on in determining the full extent of use of a new technology. They asserted that the gradual adoption of new technology and the time required for hospitals to adapt their coding and charge structures to new technologies make it difficult to base projections of the ultimate utilization and costs of new technology immediately following its introduction. In addition, one commenter explained that CMS' system delays in processing claims have led to a negative impact on both uptake of the technology and the data collection associated with its use.

Also, the commenter explained that Congress required data relating to the cost of the technology be collected for not less than 2 years and not more than 3 years after an appropriate inpatient hospital service code is established. The commenter added that, because CMS publishes its proposed and final rules before the completion of a fiscal year, CMS would make its decision for FY 2005 with less than 2 full year's worth of data. As a result, the commenters recommended that CMS make additional payments for the full 3 years so when it moves a new technology into a DRG, it does so based on accurate and reliable information about its cost and clinical use.

Response: Before each fiscal year, we use the latest available data to determine if we should continue to pay add-on payments for approved new technologies. As stated above, we are continuing to pay for Xigris® for FY 2004 because FY 2002 discharges may not reflect full utilization of the technology. Based on the March update of the FY 2003 MedPAR file, we lowered our cost estimates from the proposed rule because a lower than projected number of cases is receiving this technology at the present time. Before FY 2005, we will again use the latest available data to determine whether we would propose to continue to make add-on payments for Xigris® for FY 2005.

3. FY 2004 Applicants for New Technology Add-On Payments

We received two applications for new technologies to be designated eligible for inpatient add-on payments for new technology for FY 2004. A discussion of these applications and our determinations appear below.

a. Bone Morphogenetic Proteins (BMPs) for Spinal Fusions

An application was submitted for the InFUSE™ Bone Graft/LT–CAGE™ Lumbar Tapered Fusion Device (InFUSE™) for approval as a new technology eligible for add-on payments. A similar application was submitted last year. However, we denied it because, based on the available data, the technology did not exceed the 1 standard deviation threshold above the average charges for the DRGs to which the technology is assigned.

The product is applied through use of an absorbable collagen sponge and an interbody fusion device, which is then implanted at the fusion site. The patient undergoes a spinal fusion, and the product is placed at the fusion site to promote bone growth. This procedure is done in place of the more traditional use of autogenous iliac crest bone graft. For a more detailed discussion about InFUSE™, see the August 1, 2002 IPPS final rule (67 FR 50016).

On July 2, 2002, the FDA approved InFUSE™ for spinal fusion procedures in skeletally mature patients at one level. Therefore, based on the FDA's approval, multilevel use of this technology would be off-label. In the August 1, 2002 IPPS final rule (67 FR 50017), we stated this technology would meet the cost threshold only if the added costs of multilevel fusions were taken into account. Because the FDA had not approved this technology for multilevel fusions, and the applicant had not submitted data to demonstrate this technology is a substantial clinical improvement for multilevel fusions (the clinical trial upon which the application was based was a single-level fusion trial), we could not issue a substantial clinical improvement determination for multilevel fusions and, consequently, did not consider the costs associated with multilevel fusions in our analysis of whether this technology met the cost threshold. Therefore, because the average charges for this new technology, when used for single-level spinal fusions, did not exceed the threshold to qualify for new technology add-on payment, we denied this application for

add-on payments for FY 2003. For similar reasons, we did not consider data on the charges for multilevel fusions in our analysis of whether this technology meets the cost threshold for FY 2004.

In its application for add-on payments for FY 2004, the applicant used data from the CMS FY 2001 Standard Analytical File for physicians and hospitals. The analysis linked a 5-percent sample of hospital spinal fusions cases with the corresponding physician claims. Because there were no ICD–9–CM codes to identify multilevel fusions in 2001, multilevel fusions were identified using CPT codes on the physician claims. Average charges were taken from actual cases used in clinical trials.

After grouping these cases into one, two, and three or more levels fused in DRGs 497 and 498 (Spinal Fusion Except Cervical With and Without CC, respectively), the applicant then calculated average charges assuming the use of the InFUSE™ for these cases. For DRG 497, the estimated single-level fusion average charge was $41,321; for DRG 498, the estimated single-level fusion average charge was $37,200. Because these DRGs are not currently split for different numbers of fusion levels involved, Medtronic has calculated its own standard deviation of average charges to determine the threshold for these DRGs using the 5-percent sample data. For DRG 497, the threshold (calculated by Medtronic) was $45,646, which is greater than the estimated average charge of $41,321 for single-level fusions noted above. For DRG 498, the threshold (calculated by Medtronic) was $36,935, which is less than the average charges for single-level fusions in this DRG as noted above.

However, we note the thresholds to qualify for the new technology add-on payments for FY 2003 published in Table 10 of the August 1, 2002 IPPS final rule for DRGs 497 and 498 were $58,040 and $41,923, respectively. These thresholds were computed based on all cases assigned to these DRGs, and do not differentiate between the number of spinal levels fused. Because we are not redefining these DRGs to differentiate cases on the basis of the number of levels of the spine fused in the manner suggested by the applicant's analysis, the thresholds published in last year's final rule are applicable for a new technology to qualify for add-on payments in these DRGs for FY 2004. Therefore, because the averages calculated by the applicant for single-level fusions do not exceed the published thresholds, as proposed, we did not approve this technology on the basis of this analysis.

The applicant also submitted data from actual cases involving the InFUSE™ with single level fusions only. The data submitted included 31 claims from 4 hospitals (only one Medicare patient was included in the sample). All 31 cases were from DRG 498. The average standardized charge for these cases was $47,172. Based on these data, the average standardized charge exceeds the threshold for DRG 498. However, we note that this limited sample excludes any cases from DRG 497.

For discharges occurring on or after October 1, 2002, ICD–9–CM codes 84.51 (Insertion of interbody spinal fusion device) and 84.52 (Insertion of recombinant bone morphogenetic protein) are effective to identify cases involving this technology. Therefore, in an effort to resolve the difficulties in obtaining sufficient data upon which to determine whether this technology exceeds the applicable threshold in the May 19, 2003 proposed rule, we stated our intention to review available MedPAR data for the first several months of FY 2003 to identify these cases and calculate their average standardized charges to compare with the thresholds. We noted that some of these cases would involve multilevel spinal fusions, and that it would be necessary to adjust for those cases in order to remove them from the calculation of the average charges.

We have analyzed data from the March update of FY 2003 MedPAR, containing claims data for the first 6 months of FY 2003. As discussed above, accounting for a lag time in claims processing, we are assuming that this data accounts for approximately 5 months of FY 2003 discharges. We identified InFUSE™ cases by the presence of the two new ICD–9–CM codes 84.51 and 84.52, used in combination with each other. We identified 117 and 88 cases in the March 2003 MedPAR data for DRGs 497 and 498, respectively.

We standardized the charges 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, and calculated an average standardized charge of $64,931 for the 117 cases in DRG 497. For DRG 498, the average standardized charge was $58,266 for the 88 cases in our data. The average standardized charge across both DRGs was $62,752. As we noted in the proposed rule, we anticipate that some of these cases will involve multilevel spinal fusions. Based on the applicant's analysis of FY 2001 Standard Analytical File data in which they were able to distinguish between one, two, and three or more levels fused by using CPT codes on the physician claims, we determined that the average charges of single level fusions were about 78 percent of the average charges across all spinal fusions in the analysis. (It was not possible to independently match records from the Standard Analytical File in the time available after we attained the March 2003 MedPAR data.) However, as noted above, these data are from FY 2001 and did not include any cases involving InFUSE™. Therefore, we anticipate more of the cases in our data will be single-fusion cases, consistent with the FDA approval, and that the total charges in our data for single-level fusion cases will be higher than 78 percent of the average for all InFUSE™ cases in our data. Given the relatively recent approval by the FDA of this product, we anticipate the majority of uses are in accordance with the FDA's approval criteria. Therefore, to estimate the average standardized charges of the single-level spinal fusion cases in our data, we estimated 90 percent of the average standardized charges of all the InFUSE™ cases in our data would approximate the charges for single-level cases.

Finally, because these were FY 2003 cases compared to FY 2002 thresholds (based on FY 2001 cases), we adjusted the average charges (by the market basket) to be consistent with the FY 2002 thresholds. The resulting average standardized charge for the cases from our FY 2003 MedPAR data for all InFUSE™ cases across both DRGs 497 and 498 was $53,376.

We then calculated the case-weighted threshold amount across DRGs 497 and 498 based on the proportion of cases in our data in each DRG. Since 57 percent of the cases we identified in our database were in DRG 497, we applied this percentage to the threshold amount for DRG 497 of $58,040. We then added this amount to 43 percent of the threshold amount for DRG 498, for a combined threshold amount of $51,121. Because our data indicates that the average standardized charge for single-level InFUSE™ cases exceeds this threshold amount, this technology has met the cost criteria to qualify for new technology add-on payments.

Because the technology meets the cost threshold based on the MedPAR data, we evaluated whether it qualifies as a substantial clinical improvement. According to the applicant:

''InFUSE™ Bone Graft is more appropriate to use and has been proven

more effective in its use than autogenous iliac crest bone graft, when either is placed in the LT-Cage™ Lumbar Tapered Fusion Device for anterior lumbar interbody fusion. Use of InFUSE™ Bone Graft instead of autogenous iliac crest bone graft:

- Obviates iliac crest bone graft donor site morbidity.
- Reduces operative time, blood loss and hospitalization.
- Results in greater fusion success.
- We found that the Oswestry Low Back Pain Disability score and SF–36 Physical Component and Pain Index score were consistently 10 percent better in the InFUSE™ Bone Graft group than the autogenous iliac bone graft group.
- Enables earlier return to work.''

As indicated in the May 19, 2003 proposed rule, among the issues we planned to consider were: does avoiding the complications associated with the iliac crest bone harvesting procedure constitute a substantial clinical improvement; and, with the increased rate of osteoarthritis and osteoporosis in the Medicare population, is there evidence that the technology represents a substantial clinical improvement in spinal fusions among this population? In the May 19, 2003 proposed rule, we indicated we were particularly interested in data on the results of aged Medicare patients who have been treated with BMP, and any basic biology bench data on the results of using BMP in osteoporotic bones.

Since the May 19, 2003 proposed rule, we received from the sponsor of this application an analysis, prepared by an orthopedic surgeon, that showed limited evidence of results in a series of patients older than 65, all with good or better fusion results than the younger age group. That analysis presented evidence that older patients typically have better results than younger patients in the standard iliac crest bone harvesting fusion procedure. Finally, it included the results of bench testing of mesenchymal and osteoblastic cells that demonstrated response to rhBMP–2, including cells from elderly patients.

The sum of this evidence does not preclude generalizing the results of InFUSE™ trials to Medicare aged beneficiaries. In addition, the small series of Medicare-aged patients treated with InFUSE™ technology, as well as the bench science on the response of elderly mesenchymal cells to rhBMP–2, do provide some positive, though limited, evidence for generalizability. These results, combined with the benefits of the elimination of the need to harvest bone from the iliac crest (and the associated complications), lead us to conclude that InFUSE™ does meet the substantial improvement criteria. Therefore, we are approving InFUSE™ for add-on payments under § 412.88, to be effective for FY 2004.

This approval is on the basis of using InFUSE™ for a single-level, lumbar spinal fusions, consistent with the FDA's approval and the data presented to us by the applicant. Therefore, we intend to limit the add-on payment to cases using this technology for anterior lumbar fusions in DRGs 497 and 498. Cases involving InFUSE™ that are eligible for the new technology add-on payment will be identified by assignment to DRGs 497 or 498 as a lumbar spinal fusion, with the combination of ICD–9–CM procedure codes 84.51 and 84.52.

As explained above, we are limiting our approval of this technology to uses consistent with our substantial clinical improvement decision. Therefore, add-on payments are only available for use of the technology at a single-level. The average cost of the InFUSE™ is reported to be $8,900, and a single level fusion requires two of the products. Therefore, the total cost for the InFUSE™ for a single-level fusion is expected to be $17,800. Under § 412.88(a)(2), new technology add-on payments are limited to the lesser of 50 percent of the average cost of the device or 50 percent of the costs in excess of the DRG payment for the case. As a result, the maximum add-on payment for a case involving the InFUSE™ is $8,900.

For purposes of budget neutrality, it is necessary to estimate the additional payments that would be made under this provision during FY 2004. We identified 205 cases in DRGs 497 and 498 in the March 2003 update of the FY 2003 MedPAR data. For our FY 2004 budget neutrality estimate, we are projecting this number will grow to 500. Given this estimate and the maximum add-on payment of $8,900, we estimate the total amount of the add-on payments for the InFUSE™ for FY 2004 will be $4.4 million dollars.

Comment: One commenter asked that CMS reconsider the decision to exclude multilevel fusions with InFUSE™ from the cost threshold calculation. The commenter noted that excluding multilevel fusions with InFUSE™ is inconsistent with FDA guidance, clinical practice and other CMS payment decisions for new technologies (notably the creation of DRGs for drug-eluting stents based on the presence of a condition not indicated on the product label, that is, acute myocardial infarction).

Response: As stated previously, because the FDA has not approved this technology for multilevel fusions and the applicant has not submitted data to demonstrate this technology is a substantial clinical improvement for multilevel fusions, we cannot issue a substantial clinical improvement for multilevel fusions. In the September 7, 2001 final rule implementing this provision (66 FR 46913), we stated our position that the special payments under this provision should be limited to those new technologies that have been demonstrated to represent a substantial improvement in caring for Medicare beneficiaries. Where such an improvement is not demonstrated, we continue to believe the incentives of the DRG system provide a useful balance to the introduction of new technologies, and no new technology add-on payment is necessary.

Comment: In the proposed rule, we stated that, if InFUSE™ meet the cost threshold, we would evaluate whether it qualifies as a substantial clinical improvement. One commenter noted that, assuming InFUSE™ does meet the cost threshold, CMS would make a determination on whether the technology meets the substantial clinical improvement criterion without public input or the opportunity to address concerns that CMS may have. The commenter noted that these actions are inconsistent with the Administrative Procedure Act and CMS's pledge to be more open in its policy making.

Response: Because of the many questions that remained at the time of the proposed rule, we were unable to determine if InFUSE™ qualified as a substantial clinical improvement. However, in order to receive comments on this determination, we indicated certain issues we would consider when determining if InFUSE™ qualifies as a substantial clinical improvement. As noted above, we received additional information that enabled us to approve this technology as a substantial clinical improvement. Therefore, we believe interested parties had sufficient information to provide informed comments.

Comment: One commenter, a designer, manufacturer, and supplier of orthopedic devices and supplies, explained that the applicant's analysis probably includes cases for both posterior approaches or posterior instrumentation, or both, which are considered off-label uses from the indications approved by the FDA. Therefore, the commenter requested that cases that do not meet FDA approved indications, once identified, be eliminated from the analysis.

The commenter also noted that once claims of InFUSE™ can be identified

with MedPAR data, DRG weights become eligible for recalibration in order to reflect the appropriate payment within the assigned DRG. Once the weights of a DRG can be evaluated, a technology should no longer be classified as new. Also, the commenter stated that clinical trial results counter the claim of significant improvement, because information presented at the FDA Orthopedics and Rehabilitation Devices Panel public meeting on January 20, 2002, indicated that the InFUSE™ product resulted in an equivalency to that of traditional bone grafting techniques. Although there was a decrease in donor site pain in a small number of subjects in the BMP group, compared with the control group, the commenter questioned whether this factor meets the criteria of substantial clinical improvement. The commenter also questioned the results of a published article on this technology.

Response: One of the criteria for a substantial clinical improvement classification is avoidance of surgery. CMS determined that InFUSE™ should be classified as a substantial improvement if the results of the clinical trials demonstrated outcomes at least equivalent to bone grafting, and the bone harvesting procedure was avoided. CMS clinical staff reviewed the literature and concluded that the current evidence did support grafting equivalence for the FDA approved indications and, therefore, InFUSE™ met the substantial improvement standard. As described above, we did not rely on the applicant's analysis to determine the technology met the high-cost threshold, but conducted direct analysis of available FY 2003 MedPAR data.

b. GLIADEL® Wafer

Glioblastoma Multiforme (GBM) is the most common and most aggressive of the primary brain tumors. Standard care for patients diagnosed with GBM is surgical resection and radiation. According to the manufacturer, the GLIADEL® Wafer is indicated for use as an adjunct to surgery to prolong survival in patients with recurrent GBM. Implanted directly into the cavity that is created when a brain tumor is surgically removed, GLIADEL® delivers chemotherapy directly to the site where tumors are most likely to recur.

The FDA approved 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 announcing its approval, the FDA indicated that GLIADEL® was approved: ''* * * based on the results of a multi-center placebo controlled study in 222 patients who had recurrent malignant glioma after initial treatment with surgery and radiation therapy. Following surgery to remove the tumor, half of the patients were treated with GLIADEL® implants and half with placebo. In patients with glioblastoma multiforme, the 6-month survival rate increased from 36 percent with placebo to 56 percent with GLIADEL® Median survival increased from 20 weeks with placebo to 28 weeks with GLIADEL®. In patients with pathologic diagnoses other than glioblastoma multiforme, GLIADEL® had no effect on survival.''

Guilford Pharmaceuticals has requested that GLIADEL® still be considered new because, until a new ICD–9–CM code (00.10 Implementation of Chemotherapeutic Agent) was established on October 1, 2002, it was not possible to identify specifically these cases in the MedPAR data. However, as noted previously, technology will no longer be considered new after the costs of the technology are reflected in the DRG weights. Because the costs of GLIADEL® are currently reflected in the DRG weights (despite the absence of a specific code), GLIADEL® does not meet our criterion that a medical service or technology be ''new''. That is, FY 2002 MedPAR data used to calculate the DRG weights for FY 2004 in this final rule include cases where GLIADEL® was administered (and the corresponding charges of these cases include charges associated with GLIADEL®). On February 26, 2003, the FDA approved GLIADEL® 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 this is true, the charges associated with this use of GLIADEL® are also reflected in the DRG relative weights.

According to Guilford's application, the current average wholesale price of GLIADEL® is $10,985. Guilford submitted charge data for 23 Medicare patients at 7 hospitals from FY 2000. The charges were then standardized and adjusted for inflation using the hospital market basket inflation factor (from 2000 to 2003) in order to determine an inflated average standardized charge of $33,002. Guilford points out that this charge narrowly misses the DRG 2 threshold published in Table 10 of the August 1, 2002 IPPS final rule of $34,673. However, we note that, according to the manufacturer, as many as 60 percent of current GLIADEL® cases may be assigned to DRG 1 based on the presence of CCs. Based on this assumption, the qualifying threshold for GLIADEL® would be $54,312 (60 percent of the DRG 1 threshold of $67,404, and 40 percent of the DRG 2 threshold of $34,673).

As mentioned in section II.B.3.a of the May 19, 2003 proposed rule and above in this final rule, we examined the definitions of DRGs 1 and 2 to determine whether they could be improved. As proposed, we are creating a new DRG for patients with an intracranial vascular procedure and an intracranial hemorrhage and two new DRGs for patients with only a vascular shunt procedure (splitting on the presence or absence of a CC). We also compared the data submitted in the application for add-payments regarding the charges for GLIADEL® cases with the charges of other procedures in DRGs 1 and 2. We found that, although the $33,002 average standardized charge reported is just below the qualifying threshold in DRG 2, it is actually well below the mean average standardized charge for DRG 1 ($42,092). As noted previously, as many as 60 percent of current GLIADEL® cases may be assigned to DRG 1 based on the presence of CCs. Therefore, we do not believe that any change to the DRG assignment of cases receiving GLIADEL® is warranted at this time. However, we will continue to monitor our data to determine whether a change is warranted in the future.

Comment: One commenter supported CMS' determination that this technology is currently reflected within the DRG weights and does not meet the criteria of being called ''new.'' Another commenter commented that CMS' interpretation of whether a technology is ''new'' is inconsistent with the current statute. The commenter explained that section 1886 (d)(5)(K)(ii)(II) of Act states that CMS should collect data on new technologies ''for a period of not less than 2 years and not more than 3 years beginning on the date on which an inpatient hospital code is issued for the technology.'' Accordingly, the commenter believed it is inconsistent with the intent of Congress to deny new technology status to a product that has been on the market but for which there is no unique ICD–9 code that allows CMS to track the costs of cases in which it is utilized. The commenter urged CMS to reconsider its interpretation of the statute and approve GLIADEL® as a new technology, making clear that a technology will be considered new for 2 to 3 years from the date that an ICD–9–CM code, specific to the technology, becomes available.

Response: As stated above, we discussed our position on this issue in detail in the September 7, 2001 final rule (66 FR 46905). Our rationale for this policy has not changed since we discussed it in that final rule, and we did not propose changes to this policy in the May 19, 2003 proposed rule. Therefore, we are denying this application for add-on payments for FY 2004.

4. Review of the High-Cost Threshold

The current cost threshold for a new technology to qualify for add-on payments is that the average standardized charges of cases involving the new technology must be demonstrated to exceed 1 standard deviation beyond the geometric mean of the standardized charges of the DRG to which the new technology will be assigned. If the new technology is assigned to more than one DRG, the qualifying threshold is equal to the case-weighted (based on the proportion of cases involving the new technology estimated to be assigned to each DRG) average threshold across all relevant DRGs. When we established this threshold in the September 7, 2001 final rule, we expressed our belief that it is important to establish a threshold that recognizes the variability in costs per case within DRGs and maintains the fundamental financial incentives of the IPPS (66 FR 46917).

In commenting on this approach, MedPAC and some hospital associations supported the 1 standard deviation threshold. However, others, particularly representatives of the manufacturers of new technology, have argued this threshold is too high, and that virtually no new technology would qualify for the special payment provision.

We are concerned that establishing higher payments for a great number of new technologies may be inflationary because the add-on payments reduce the efficiency incentives hospitals face when new technologies must otherwise be financed out of current payments for similar cases. Traditionally, under the IPPS, new technologies were required to compete with existing treatment methods on clinical and cost criteria. Add-on payments are intended to give new technologies a competitive boost relative to existing treatment methods with the goal of encouraging faster and more widespread adoption of new technologies.

Much of the current variation around the mean within any particular DRG is due to the range of procedures contained within each DRG. Generally, some of these procedures will be more expensive than the mean and some will be less expensive. The threshold should be set high enough to ensure that it identifies truly high-cost technologies. If the threshold were set too low (for example, at $2,500, as some have suggested), additional technologies may qualify merely by association with a procedure only slightly more costly than the mean for the DRG.

For example, consider a DRG with five different procedures and mean charges of $15,000. The mean charges for each procedure are distributed around $15,000, as illustrated in the following table. A qualifying threshold of $2,500 would result in any new technology that is only used for the fifth procedure automatically qualifying for new technology add-on payments (unless the new technology had the unlikely effect of lowering the mean cost for cases with this procedure by at least $2,500). This is because the average charge of $20,000 for cases in this procedure already exceeds the mean charges for the DRG plus $2,500.

Procedure	Mean charge
1	$10,000
2	12,000
3	15,000
4	17,000
5	20,000

At the same time, we recognize that the very limited number of applications that have been submitted the past 2 years (five for FY 2003; two for FY 2004) may indicate that only a very small number of the new technologies that come onto the market every year are costly enough even to apply for new technology add-on payments. Therefore, for FY 2005 and subsequent fiscal years, in the May 19, 2003 proposed rule, we proposed to reduce the threshold to 75 percent of 1 standard deviation beyond the geometric mean standardized charge for all cases in the DRG to which the new medical service or technology is assigned (§ 412.87(b)(3)).

Based on our analysis of the thresholds for FY 2004, this proposed change would reduce the average threshold across all DRGs to qualify for the add-on payments from approximately $9,900 above the mean standardized charges for each DRG to approximately $7,400. This reduction would maintain the averaging principles of the IPPS while easing the requirement somewhat to allow more technologies to qualify. Furthermore, the situation illustrated above, where a technology qualifies on the basis of its association with a high cost procedure, is much less likely to occur as a result of this reduction than if the threshold were reduced dramatically.

Comment: Some commenters were concerned that the revised threshold of 75 percent of the standard deviation remains too high. The commenters noted that even with the revised cost threshold, few technologies would qualify for add-on payments.

On the assumption that the vast majority of technologies that would qualify for add-on payments would be identified by a new ICD–9–CM procedure code, one commenter identified a total of 26 ICD–9–CM procedure codes issued between the years of 1998 and 2001. The commenter then analyzed 2001 MedPAR data and found that only 2 of the 26 procedures will exceed either the current 1 standard deviation threshold, and 4 would exceed the a threshold at 75 percent of 1 standard deviation. The commenter also explained that the proposed reduction of the threshold is only an 8-percent reduction, and continues to block eligibility for add-on-payments for important new technologies, even where costs increase by 70 percent. The commenter recommended that CMS use a threshold based upon 75 percent of the standardized amount inflated to charges, plus the geometric mean charges for the DRG. The commenter identified 13 of the 26 procedures that would qualify using this threshold.

Another commenter asked that CMS consider adopting separate criteria for biologics and devices, because they have different price levels and pricing patterns relative to drugs and relative to DRG standardized amounts. Other commenters recommended a threshold where the cost of the technology must exceed the cost of existing technologies by at least 50 percent of the DRG standardized amount, multiplied by the DRG weight, but not to exceed $7,500.

One commenter was concerned that, because of budget neutrality, any reduction to the threshold for new technologies would allow more technologies to qualify for add-on payments and would therefore reduce payments for all other hospital inpatient services. The commenter explained that shifting money within the IPPS leaves some hospitals without additional money they need to ensure beneficiaries have access to the newest medical tests and treatments. Therefore, the commenter recommended that add-on payments continue to be limited to new, cutting-edge, breakthrough technologies with significant cost implications.

Response: As stated in the August 1, 2002 final rule (67 FR 50011), it is our intention to implement this provision without fundamentally disrupting the

IPPS. A substantial number of cases receiving extra cost-based payments (or substantial disaggregation of the DRGs into smaller units of payment) would undermine the efficiency incentives of the DRG payment system. Also, we continue to believe a threshold based on the standard deviation is appropriate for this purpose. (For further reading on this, see the September 7, 2001 final rule (66 FR 46917).)

The DRG system is an average-based system under which hospitals expect to finance costly cases through less costly cases. We believe the add-on policy envisioned by some commenter, that would reduce the maximum threshold across all DRGs to 75 percent of the standardized amount (approximately $3,300) adjusted to charges, would significantly disrupt the averaging principles of the IPPS. By assuming only 26 new technologies over a 4-year span, the analysis presented by the commenter dramatically underestimates the annual volume of new technologies that would be likely to meet such a reduced threshold. Industry sources cite over 1,000 companies producing medical devices, diagnostic products, and medical information systems in the U.S., producing over $70 billion worth of products annually. A very limited number of these products receive specific ICD–9–CM procedure codes, particularly in years prior to the establishment of the IPPS new technology add-on policy. A more accurate estimate of the number of technologies likely to be approved under this revised threshold could be attained by listing the technologies approved during that period with the average wholesale price.

As stated above, we recognize the limited number of applications for add-on payments that have been submitted in the past 2 years and, therefore, we are lowering the threshold. We believe this new threshold is a fair balance that maintains the averaging principles of the IPPS while easing the qualifying requirement. Therefore, for FY 2005 and subsequent fiscal years, we are reducing the threshold 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 medical service or technology is assigned, transformed back to charges.

We disagree with the commenter's suggestion that we establish separate thresholds for biologics and devices. We believe the IPPS is intended to pay hospitals for their costs to treat patients, and physicians select from a range of options based on the medical needs of the patients. The payment system should be neutral with respect to those options. We are concerned that establishing separate thresholds for biologics and devices would indicate an inappropriate payment preference for one or the other option.

Comment: Other commenters representing hospitals approved of the threshold proposed by CMS. One commenter explained that a threshold that limits the number of new technologies is necessary, as the administrative burden for hospitals and the program is significant for each additional item qualifying. Given the finite pool of funds, an abundance of qualifying technologies could result in prorata reductions, such as those that were experienced under the outpatient prospective payment system. With that in mind, the commenter asked that CMS look at other approval mechanisms that would direct the funds to be focused on significantly expensive new technologies that also have significant volumes nationally. For example, national expenditures projected by CMS for each technology seeking approval should exceed $30 million. Assuming national total expenditures of $75 billion with a 1 percent set aside at $750 million, and a marginal cost at 50 percent, 25 technologies could be approved by CMS.

As an alternative, the commenter recommended that CMS incorporate new technologies into the appropriate DRG without having to specifically code the new technology. The DRG weights would then be adjusted to reflect the increased costs associated with such new technologies rather than making a separate add-on payment. The commenter believed this would be a reasonable compromise between the need to incorporate new technologies into the DRGs, while avoiding an unduly burdensome coding and billing process.

Response: We believe the incremental costs to hospitals associated with this provision should be minimal. Specifically, the additional payments are triggered by the presence of an ICD–9–CM code on the bill, information already required to process the claim for normal DRG payments. Accordingly, there should be little need for training or other operational changes in response to the approval of a new technology for add-on payments.

Also, adding further criteria as suggested by the commenter would make it even more difficult for new technologies to qualify for add-on payments. In this final rule, it is our intention to lower the threshold in order to increase the number of applications we receive each year for add-on payments. With respect to the commenter's suggestion to incorporate a new technology in a DRG and raise the weight of the DRG based on the increased cost of the new technology, we are concerned that this suggestion would have the potential to create possibly large imbalances in the DRG weights if the predicted volume of a particular technology turns out to be inaccurate. We believe an add-on payment is the most appropriate methodology to provide additional payments for qualifying high cost new technologies, while still maintaining the overall integrity of the DRG system.

5. Technical Changes

Subpart H of part 412 describes payments to hospitals under IPPS. We have become aware of references to the calculation of IPPS payments in this subpart that inadvertently omit references to new technology add-on payments. For example, § 412.112(c) describes the basis for per case payments. This section refers to outlier payments under subpart F, but was not revised to reflect the implementation of the new technology add-on payments. Therefore, in the May 19, 2003 proposed rule, we proposed to amend § 412.112(c) to add a new paragraph (d) to include a reference to additional payments for new medical services or technologies under subpart F.

We did not receive any comments on this proposal and, therefore, are adopting it as final.

Section 412.116(e) currently states that payments for outlier cases are not made on an interim basis. That is, for hospitals receiving payments under a biweekly, lump-sum payment methodology, outlier payments are not included in the calculation of the lump-sum payment amounts. Rather, outlier payments are calculated on a case-by-case basis. Similarly, due to the unique nature of the new technology add-on payments, in the May 19, 2003 proposed rule, we proposed that they would also be calculated on a case-by-case basis rather than included in the calculation of interim payment amounts. Therefore, we proposed to revise § 412.116(e) to include this policy.

We did not receive any comments on this proposal. Therefore, in this final rule, we are adopting the proposal as final without modification.

III. Changes to the Hospital Wage Index

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the

standardized amounts ''for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'' In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of Metropolitan Statistical Areas (MSAs), Primary MSAs (PMSAs), and New England County Metropolitan Areas (NECMAs) issued by the Office of Management and Budget (OMB). OMB also designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of one million or more, 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. For purposes of the IPPS wage index, rural areas are counties outside a designated MSA, PMSA, or NECMA. For purposes of the wage index, we combine all of the rural counties in a State to calculate a rural wage index for that State.

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

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

On June 6, 2003, the Office of Management and Budget (OMB) issued OMB Bulletin No. 03–04, announcing revised definitions of Metropolitan Statistical Areas and new definitions of Micropolitan Statistical Areas and Combined Statistical Areas. A copy of the bulletin may be obtained at the following Internet address: *http://www.whitehouse.gov/omb/bulletins/b03–04.html.* According to OMB, ''(t)his bulletin provides the definitions of all Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the United States and Puerto Rico based on the standards published on December 27, 2000, in the **Federal Register** (65 FR 82228–82238) and Census 2000 data.''

In the proposed rule, we stated that we would evaluate the new area designations and their possible effects on the Medicare hospital wage index. In addition, we proposed that the earliest usage of these new definitions would be the FY 2005 wage index.

The new definitions recognize 49 new Metropolitan Statistical Areas and 565 new Micropolitan Statistical Areas, as well as extensively revising the construct of many of the existing Metropolitan Areas. For example, according to OMB's previous definition of the Asheville, NC MSA, this Metropolitan Statistical Area was comprised of Buncombe and Madison counties. When we apply the new definitions, Asheville's Metropolitan Statistical Area includes both Buncombe and Madison counties, as well as Henderson and Haywood counties. An example of a Micropolitan Statistical Area is that of Elizabeth City, NC which includes Camden, Pasquotank, and Perquimans counties. These were non-Metropolitan Statistical Area counties in previous OMB definitions.

In order to implement these changes for the IPPS, it is necessary to identify the new area designation for each county and hospital in the country. Because this process will have to be extensively reviewed and verified, we are unable to undertake it before publication of this final rule. In addition, because we wish to engage in notice and comment rulemaking, prior to adopting these changes, it would be impractical to have done so prior to this final rule. (We note that the OMB Bulletin was issued during the comment period and we did not receive any comments regarding whether the new definitions should be applied to the FY 2004 wage index or objecting to our proposed policy of implementing the changes in FY 2005 at the earliest.)

Finally, geographic reclassification decisions for FY 2004 have already been made based on the previous Metropolitan Statistical Area definitions. These decisions would have to be individually reevaluated if we were to adopt the new OMB definitions for FY 2004. This would not be possible to accomplish while complying with the requirement of section 1886(d)(6) of the Act to publish this annual IPPS update final rule by August 1. For these reasons, at this time, we are not applying these new definitions to the FY 2004 wage index.

Comment: Several commenters recommended that when CMS does implement OMB's new definitions, it should adopt the new 49 MSAs as outlined in the OMB Bulletin. However, the commenters mentioned that the adoption of the MSAs for FY 2004 would be premature, given the magnitude of the policy change. One commenter encouraged CMS to issue a rule or to elaborate on plans for the new Metropolitan and Micropolitan Statistical Area definition changes as soon as possible to allow time for impact analysis, as well as public comments and input. One commenter raised concerns with respect to the criteria that OMB used to define the new MSAs.

Response: We indicated in the proposed IPPS rule that we would need to assess these new definitions before adopting them. In order to implement such a change, it will be necessary to identify the new area designation for each county and hospital in the country, requiring extensive review and verification. We will undertake this analysis as soon as possible. We intend to move very deliberately and expeditiously regarding these potentially vast changes. Any changes would be made through notice and comment rulemaking. Therefore, we are not addressing technical comments relating to the new MSAs in this document.

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. This adjustment is discussed in section II.4.a. of the Addendum to this final rule.

As discussed below in section III.F. of this preamble, we also take into account the geographic reclassification of

hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating the wage index. 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. This adjustment is discussed in section II.4.b. of the Addendum to this final 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 each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. The initial collection of these data must be completed by September 30, 2003, for application beginning October 1, 2004 (the FY 2005 wage index). In the April 4, 2003 **Federal Register** (68 FR 16516), we published a notice of intent to collect calendar year 2002 data from hospitals.

Many commenters on the April 4, 2003 notice requested that CMS publish a more detailed proposed methodology, illustrating how the occupational mix index will be calculated and how it will be used to adjust the overall wage index. Other comments on the April 4, 2003 notice included: CMS should develop or expand more categories to include all hospital employees; CMS should develop and publish a more reasonable timeframe for the hospitals to complete the survey, and a more reasonable timeframe for fiscal intermediaries to audit the occupational mix survey; CMS should clarify the relationship between the current annual cost report wage index schedule and the proposed occupational mix survey.

We plan to publish a final notice of intent in the **Federal Register**, with a 30-day comment period. The notice will include any revisions to the survey published on April 4, 2003 based on the comments we received, a detailed timetable, and all audit guidelines. Subsequent to that, we plan to send the surveys to all IPPS hospitals (and hospitals in Maryland that are under a waiver from the IPPS) through the fiscal intermediaries, with the intent to collect these data to be incorporated in the FY 2005 wage index.

Comment: In response to the May 19, 2003 IPPS proposed rule, commenters requested that we publish a detailed proposed methodology, for comment, illustrating how the occupational mix index will be calculated and how it will be used to adjust the overall wage index.

Response: Although our approach will not be finalized until publication of the FY 2005 rule, one possible approach to computing an occupational mix adjusted index is to first calculate, based on the hours collected for each occupational category from all hospitals nationally, a national average percentage attributable to each occupational category. Next, for each hospital, the total dollars and hours for each category would be summed, and an average hourly wage would be determined for each category by dividing dollars by hours. Each hospital's occupational mix adjusted average hourly wage would be calculated by multiplying each category's average hourly wage by the applicable weighting factors and then summing the results across all categories. Similar calculations would then be performed at the labor market level and the national level to construct an index.

We intend to analyze the impacts of implementing an occupational mix adjusted index in the proposed rule for FY 2005. Based on the estimated impacts, we will also evaluate at that time the possibilities for blending such an index with the FY 2005 wage index calculated using our current methodology based on data from the Worksheet S–3, Part II of the Medicare cost report.

B. FY 2004 Wage Index Update

The FY 2004 wage index values (effective for hospital discharges occurring on or after October 1, 2003 and before October 1, 2004) in section VI. of the Addendum to this final rule are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2000 (the FY 2003 wage index was based on FY 1999 wage data).

The data for the FY 2004 wage index were obtained from Worksheet S–3, Parts II and III of the FY 2000 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 FY 2004 wage index includes the following categories of data associated with costs paid under the IPPS (as well as outpatient costs), which were also included in the FY 2003 wage index:

- Salaries and hours from short-term, acute care hospitals.
- Home office costs and hours.
- Certain contract labor costs and hours (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 2003, the wage index for FY 2004 also excludes the direct and overhead salaries and hours for services not subject to IPPS payment, such as skilled nursing facility (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.

These wage data are also currently used to calculate wage indexes applicable to other providers, such as SNFs, home health agencies, and hospices. They are also used for prospective payments to rehabilitation and long-term care hospitals, and for hospital outpatient services.

C. FY 2004 IPPS Wage Index

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

In the FY 2001 IPPS final rule, we discussed removing from the wage index 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 (65 FR 47074). We noted that because RHC and FQHC costs were not previously separately reported on Worksheet S–3 of the Medicare cost report, we could not exclude these costs from the prior wage indexes. We further noted that we would evaluate the exclusion of RHC and FQHC wage data in developing the FY 2004 wage index.

We revised the FY 2000 Worksheet S–3 so that it now allows for the separate reporting of RHC and FQHC wage costs and hours. In the May 19, 2003 proposed rule, we proposed to exclude the wage and hours data for RHCs and FQHCs from the hospital wage index calculation beginning with the FY 2004 wage index.

We received several comments, all supporting this proposal. Therefore, beginning with the FY 2004 wage index, we are excluding the salaries, hours and wage-related costs associated with RHCs and FQHCs. This change is consistent with others we have implemented in our continuous effort to limit the wage index as much as possible to costs for which hospitals receive payment under

IPPS. An analysis of the effects of this change is included in the Appendix A of this final rule.

2. Paid Hours

It has been the longstanding policy of CMS to calculate the wage index using paid hours rather than hours worked (*see* the September 1, 1993 **Federal Register**, 58 FR 46299). This policy reflects our belief that paid hours more appropriately reflect a hospital's total wage costs, which include amounts paid for actual time worked and for covered leave periods (for example, annual, sick, and holiday leave). Therefore, the inclusion of paid lunch hours in the wage index is consistent with our inclusion of other paid nonworking hours.

Several hospitals have requested that we exclude paid lunch or meal break hours from the wage index calculation. At these hospitals, the typical workday is 7½ working hours, plus a ½ hour paid meal break, for a total of 8 paid hours. These hospitals, some of which are municipal-owned and required by their overarching union contracts to provide paid lunch hours, believe they are disadvantaged by a wage index policy that requires paid lunch hours to be included in calculating the wage index.

The hospitals argue that their practice of paying employees for meal breaks is not substantially different, in practice, from other hospitals whose employees do not receive paid lunch hours but who are on call during their lunch periods. These hospitals further argue that this policy causes them, in some cases due to union contracts beyond their control, to be the only hospitals with this category of nonproductive hours included in their wage index.

In the May 19, 2003 proposed rule, we solicited comments on our policy that paid lunch hours should be excluded from the wage index. Specifically, we were interested in a broader understanding of the issue of whether some hospitals may, in fact, be truly disadvantaged by this policy through no fault of their own. We indicated that any change in our policy would not be implemented until, at the earliest, the FY 2005 wage index.

Some hospitals and associations have also recommended that we exclude the paid hours associated with military and jury duty leave from the wage index calculation. They state that, unlike other paid leave categories for which workers are usually paid at their full hourly rates (for example, annual, sick, and holiday), hospitals typically pay employees on military or jury duty only a fraction of their normal pay. The amount that the hospital pays is intended to only supplement the earnings that the employee receives from the government so that, while performing military or civic duties, the employee can continue to be paid the same salary level, as if he or she were still working at the hospital.

The hospitals and associations believe that including lower pay rates associated with employees' military and jury duty leave unfairly decreases a hospital's average hourly wage and, therefore, its wage index value. Therefore, we proposed to exclude from the wage index the paid hours associated with military and jury duty leave, beginning with the FY 2005 wage index. We also proposed that the associated salaries would continue to be reported on Worksheet S–3, Part II, Line 1 of the Medicare cost report.

Comment: A few commenters agreed that paid lunch hours and hours associated with military and jury duty leave should be removed from the wage index. Many more commenters, including some national and state hospital associations and Medicare fiscal intermediaries, opposed or expressed concern about whether excluding paid lunch hours and hours associated with military and jury duty leave would result in a more accurate wage index.

Those commenters who opposed the proposal to exclude paid lunch hours and hours associated with military and jury duty leave expressed concern that these changes would further complicate the wage index and that the additional data collection effort for providers might outweigh any benefits achieved through these changes. Further, the commenters believed that paid lunch hours, military, and jury leave affect all providers in the same way, so the changes would likely be immaterial. One commenter also expressed concern that excluding paid hours could cause hospitals to rewrite existing contracts to raise their wage index. In addition, some commenters cautioned that excluding these paid hours would be difficult for intermediaries to apply consistently; excluding these hours would require estimations because most payroll systems do not capture this data. Many commenters indicated that CMS had not published data to provide support that these changes are warranted.

One commenter suggested that, if CMS excludes paid lunch hours, CMS should set a standard for hospitals to qualify for excluding the hours, such as the Fair Labor Standards Act requirements for payment. Another suggested that the determination of excluding paid lunch hours should be based on whether lunch is included for the purpose of computing the hourly wage rate used to pay for overtime. If paid lunch hours are included in the overtime payment computation, and excluding them would result in an hourly rate that is higher than what is usually used for overtime, the paid lunch hours should be excluded. If the paid lunch hours are not included in computing the hourly wage for overtime, and excluding them would result in the correct hourly wage rate that should be used for overtime, the lunch hours should be excluded. Two commenters recommended that the wage index should also exclude time associated with paid breaks from the wage index, but acknowledged that paid breaks are not usually tracked in payroll systems. One commenter recommended that CMS allow all hospitals in an area to include paid hours on a standard basis in order to eliminate differences that are more a matter of how hours are reported rather than actual difference in wages.

Those commenters who opposed the exclusion of paid lunch hours were generally concerned that hospitals do not currently track paid lunch hours. They indicated that it would be a major burden for hospitals to change their systems to accommodate reporting the hours and the benefits are likely to be minimum.

A few commenters suggested that, if a hospital pays its employees at the full rate for military and jury duty leave, the full associated hours should be included. However, they added that if a hospital pays its employees at a reduced rate for these leave categories, the hospital should exclude hours based on the fraction of the salary that is not paid. If the hospital does not pay for any military or jury duty leave, all of the associated hours should be excluded. The commenters believed that this treatment would be consistent with our longstanding policy to include hours associated with paid time off, while a hospital's average hourly rate would not be negatively impacted by the reduced rates that some hospitals pay for military and jury duty leave. One commenter recommended that CMS permit hospitals to exclude the hours, but not require such reporting.

Several commenters opposed excluding paid hours associated with military and jury duty because they believe that military and jury duty leave affect all providers in the same way. Therefore, they believed that any changes in the wage index would likely be immaterial. Two commenters expressed concern that, if paid hours are excluded and wages are not, the wage index would be overstated. The

commenters recommended that, if CMS excludes paid hours associated with military and jury duty leave, for consistency, CMS should also exclude the related wages. Alternatively, the commenters recommended that CMS collect data on the wages and hours associated with military and jury duty first, so that the impact of excluding the hours can be determined before the policy is implemented. One commenter believed that CMS should only include in the wage index, hours associated with regular hours, overtime, and sick leave, because these paid leave or paid time off categories are consistently offered among hospitals. The commenter also believed other paid leave or paid time off categories such as vacation hours, maternity leave, bereavement leave, and vacation hours should be excluded because they are not consistently offered among hospitals. In addition, the commenter believed that when hospitals are competing for employees in the labor market, if offered, these paid leave or paid time off hours could vary from hospital to hospital. For example, hospital A will only pay 2 weeks for paid vacation leave, while hospital B will pay 4 weeks for paid vacation leave. Therefore, the commenter believed these other paid leave or paid time off leave hours should be excluded from the wage index.

Response: As we stated above and in the proposed rule, it has been our longstanding policy to include paid hours in the calculation of the wage index because they more appropriately reflect a hospital's total wage costs. We solicited comments on the possible exclusion of paid lunch hours and proposed to exclude the paid hours associated with military and jury duty hours because of our concern that there were significant issues with the consistent treatment of these issues across hospitals that may impact the validity of the wage index. However, the comments indicate to us there is substantial disagreement with respect to whether either category of paid hours should be excluded from the wage index calculation. Therefore, we are not proceeding with either change at this time. We intend to explore a more comprehensive assessment of the use of paid hours in a future rule. For the FY 2005 final wage index, we are including paid lunch hours, and hours associated with military leave and jury duty.

D. Verification of Wage Data From the Medicare Cost Reports

The data file used to construct the wage index includes FY 2000 data submitted to us as of June 27, 2003. 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 constructed the proposed FY 2004 wage index based on the wage data for facilities that were IPPS hospitals in FY 2000, even for those facilities that have terminated their participation in the program as hospitals or have since been designated as a critical access hospital (CAH), as long as those data do not fail any of our edits for reasonableness. We stated 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.

Prior to the proposed rule, we had received correspondence suggesting that the wage data for hospitals that have subsequently been redesignated as CAHs should be removed from the wage index calculation because CAHs are a separate provider type and are unique compared to other short-term, acute care hospitals. CAHs are limited to only 15 acute care beds. An additional 10 beds may be designated as swing-beds, but only 15 beds can be used at one time to serve acute care patients. CAHs tend to be located in isolated, rural areas. In the May 19, 2003 proposed rule, we solicited comments on whether we should exclude wage data from such hospitals from the wage index calculation. However, we included the data for current CAHs in the proposed FY 2004 wage index if the CAH was paid under the IPPS during FY 2000 as an acute care hospital.

Comment: Commenters, including national hospital associations, generally supported the removal of CAH wage data from the wage index. One commenter agreed that CAHs are dissimilar to IPPS hospitals and described a situation in which including a CAH has a negative impact on the other hospitals' wage index. One commenter agreed that CMS should exclude the costs, but expressed concern about the immediate financial impact that excluding CAHs might have on all hospitals in FY 2004. The commenter recommended that CMS examine the impact of removing CAH wage data from the wage index and make this analysis available for public comment. Another commenter recommended that CMS establish a date prior to the release of the wage index public use file that the facility must be certified as a CAH to be excluded from the wage index calculation.

Several commenters opposed excluding CAH data from the wage index. Some commenters indicated that CMS does not exclude hospitals that converted to CAH status subsequent to the year used to derive DRG weights. Another commenter opposed excluding CAHs from the wage index because the commenter believed that the wage index should reflect conditions of a labor market at a specific point in time. The commenter believed that other conditions, such as closures, mergers, or expansions, are analogous circumstances and warned that excluding these hospitals would also distort the wage index. Another commenter recommended that CMS apply a hold-harmless policy.

Response: CAHs represent a substantial number of hospitals with significantly different labor costs in many labor market areas where they exist. Using data collected for the proposed FY 2004 wage index, we found that, in 89 percent of all labor market areas with hospitals that converted to CAH status some time after FY 2000, the average hourly wage for CAHs is lower than the average hourly wage for other short-term hospitals in the area. In 79 percent of the labor market areas with CAHs, the average hourly wage for CAHs is lower than the average hourly wage for other short-term hospitals by 5 percent or greater. These results suggest that the wage data for CAHs, in general, are significantly different from other short-term hospitals.

Further, we found that removing CAHs from the wage index would have a minimal redistributive effect on Medicare payments to hospitals. The majority of the labor market areas would decrease by only 0.30 percent in their wage index value. The actual payment impact would be even smaller because the wage index is applied to only the labor-related portion of the average standardized amount. Only 10 areas would experience a decrease in their wage index values greater than 0.30 percent. The greatest negative impact is 9.57 percent. Meanwhile, positive impacts occur in 48 areas, 30 of which are in rural areas. Overall, removing CAHs from the wage index would have a minimal redistributive effect on Medicare payments to hospitals.

We believe that removing CAHs from the wage index is prudent policy, given the substantial negative impact these hospitals have on the wage indexes in the areas where they are located and the minimal impact they have on the wage indexes of other areas. We note that we would continue to include the wage data for other terminating or converting hospitals for the period preceding their change in Medicare provider status, as long as those data do not fail any of our edits for reasonableness. This is because

we continue to believe that the wage data for these hospitals, unlike CAHs, are not necessarily unique compared to other short-term hospitals, and these terminating or converting hospitals provide an accurate reflection of the labor market area during the relevant past period.

Therefore, beginning with the FY 2004 wage index, we are excluding from the wage index the wages and hours for all hospitals that are currently designated as a CAH, even if the hospital was paid under the IPPS during the cost reporting period used in calculating the wage index. We believe that this change improves the overall equity of the wage index. Therefore, it is important to proceed with this change for FY 2004. Consistent with our general approach to wage index changes, we are not holding other hospitals' payments harmless for this change.

As recommended, any hospital that is designated as a CAH by 7 days prior to the publication of the preliminary wage index public use file are excluded from the calculation of the wage index. Hospitals receiving designation after this date will remain in the wage index calculation.

We asked our fiscal intermediaries to revise or verify data elements that resulted in specific edit failures. The unresolved data elements that were included in the calculation of the proposed FY 2004 wage index have been resolved and are reflected in the calculation of the final FY 2004 wage index. For the final FY 2004 wage index in this final rule, we removed data for 23 hospitals that failed edits. For 9 of these hospitals, we were unable to obtain sufficient documentation to verify or revise the data because the hospitals are no longer participating in the Medicare program, are under new ownership, or are in bankruptcy status, and supporting documentation is no longer available. We identified 14 hospitals with incomplete or inaccurate data resulting in zero or negative, or otherwise aberrant, average hourly wages. Therefore, these hospitals were removed from the calculation. As a result, the final FY 2004 wage index is calculated based on FY 2000 wage data for 4,087 hospitals.

E. Computation of the FY 2004 Wage Index

The method used to compute the FY 2004 wage index follows:

Step 1—As noted above, we based the FY 2004 wage index on wage data reported on the FY 2000 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, 1999 and before October 1, 2000. In addition, we included data from some hospitals that had cost reporting periods beginning before October 1999 and reported a cost reporting period covering all of FY 2000. These data were included because no other data from these hospitals are 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 2000 data. We note that, if a hospital had more than one cost reporting period beginning during FY 2000 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000), 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, and 6, 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, 9.01, 9.02, 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, 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, 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, 1999 through April 15, 2001 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
10/14/1999	11/15/1999	1.06794
11/14/1999	12/15/1999	1.06447
12/14/1999	01/15/2000	1.06083
01/14/2000	02/15/2000	1.05713
02/14/2000	03/15/2000	1.05335
03/14/2000	04/15/2000	1.04954
04/14/2000	05/15/2000	1.04571
05/14/2000	06/15/2000	1.04186
06/14/2000	07/15/2000	1.03786
07/14/2000	08/15/2000	1.03356
08/14/2000	09/15/2000	1.02898
09/14/2000	10/15/2000	1.02425
10/14/2000	11/15/2000	1.01953
11/14/2000	12/15/2000	1.01482
12/14/2000	01/15/2001	1.01004
01/14/2001	02/15/2001	1.00509
02/14/2001	03/15/2001	1.00000
03/14/2001	04/15/2001	0.99491

For example, the midpoint of a cost reporting period beginning January 1, 2000 and ending December 31, 2000 is June 30, 2000. An adjustment factor of 1.03786 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 2000 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. Annualization is accomplished by dividing the data by the number of days in the cost report and then multiplying the results by 365.

Step 6—Each hospital was assigned to its appropriate urban or rural labor market area before any reclassifications under section 1886(d)(8)(B) or section 1886(d)(10) of the Act. Within each urban or rural labor market area, we added the total adjusted salaries plus wage-related costs obtained in Step 5 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 national average hourly wage is $24.8076.

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

Step 10—Following the process set forth above, we developed a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We added the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage of $11.5905 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 2004, this change affects 150 hospitals in 49 MSAs. The MSAs affected by this provision are identified by a footnote in Table 4A in the Addendum of this final rule.

Comment: One commenter indicated that there are serious deficiencies in the payment rates to Iowa hospitals under IPPS because of the development and application of the wage index, and, accordingly, CMS must make revisions to the wage index in this final rule. The comment suggested that CMS should: reduce the labor-related portion of the standardized amount to which the wage index is applied; adjust the wage index upward to account for low Medicare payments; or utilize a wage index floor or compress the wage index.

Response: We appreciate the concerns expressed by this commenter about the impact of the wage index upon Iowa's hospitals. We strive each year to ensure the wage index accurately reflects the relative wage differences across labor market areas. Further, the methodology we use to compute the wage index values is the same for all urban and rural hospitals. Therefore, the wage index values we include in the proposed and final rules for Iowa hospitals reflect the actual wage costs that are reported by these hospitals relative to those reported by hospitals across the nation.

With respect to the commenter's specific recommendations, we address comments related to the labor-related portion of the standardized amounts in section VII. of the preamble of this final rule. With respect to the other recommendations raised, these were not proposed and, therefore, we do not wish to implement them in this final rule. We are willing to explore these and other options in the future and to work with the commenter to address the concerns expressed.

Comment: One commenter indicated that we failed to address the problem associated with the exclusion of indirect patient care contract labor in the proposed rule. The commenter indicated that we recognized this problem in the FY 2002 final rule (67 FR 50022), but failed to carry out our commitment to address it.

Response: We indicated last year it would be necessary to revise the cost report form and instructions in order to collect the data necessary to separately identify the costs and hours associated with the following contracted overhead services: administrative and general; housekeeping; and dietary. In Transmittal Number 10 of the Medicare cost report, we revised Worksheet S–3, Part II to collect contract labor costs associated with these services, effective with cost reporting periods beginning on or after October 1, 2003.

We also indicated our final decision on whether to include contract indirect patient care labor costs in our calculation of the wage index will depend on the outcome of our analyses of the data collected and public comments.

F. Revisions to the Wage Index Based on Hospital Redesignation

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 can elect to reclassify for the wage index or the standardized amount, or both, and as individual hospitals or as rural groups. 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. Hospitals must apply for reclassification to the MGCRB. 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 Pub. L. 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 permits a hospital located in a rural county adjacent to one or more urban areas to be designated as being located in the MSA to which the greatest number of workers in the county commute (1) if the rural county would otherwise be considered part of an urban area under the standards published in the **Federal Register** for designating MSAs (and for designating NECMAs), and (2) if the commuting rates used in determining outlying counties (or, for New England, similar recognized area) 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 meet these criteria are deemed urban for purposes of the standardized amounts and for purposes of assigning the wage index.

Revised MSA standards were published in the December 27, 2000 **Federal Register** (65 FR 82228). We are working with the Census Bureau to compile a list of hospitals that meet the new standards based on the 2000 census data; however, that work was not yet complete at the time of publication of the proposed rule.

As noted above, OMB announced the new Metropolitan and Micropolitan Statistical Area designations and definitions on June 6, 2003. These new designations have extensively revised the construct of many of the existing Metropolitan Areas and created many new designated areas. In order to implement these changes, we need to carefully evaluate the implications of these changes for each county and hospital nationwide. As a result, we are unable to incorporate these new standards for redesignating hospitals and, therefore, we are not implementing the new standards for purposes of redesignation for FY 2004 under section 1886(d)(8)(B) of the Act. As a result, to qualify for redesignation under this section in FY 2004, hospitals must be located in counties that meet the 1990 standards.

2. Effects of Reclassification

The methodology for determining the wage index values for redesignated hospitals is applied jointly to the hospitals located in those rural counties that were deemed urban under section 1886(d)(8)(B) of the Act and those hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the area to which they have been redesignated. Therefore, as provided in section 1886(d)(8)(C) of the Act,[5] the wage index values were determined by considering the following:

- If including the wage data for the redesignated hospitals would reduce the age 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.

The wage index values for FY 2004 are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this final rule. Hospitals that are redesignated must 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 of this final rule list the 3-year average hourly wage for each labor market area before the redesignation of hospitals, based on FYs 1998, 1999, and 2000 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 final rule includes the adjusted average hourly wage for each hospital from the FY 1998 and FY 1999 cost reporting periods, as well as the FY 2000 period used to calculate the final FY 2004 wage index. The 3-year averages are calculated by dividing the sum of the dollars (adjusted to a common reporting

[5] 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 areas of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State.

Also, section 1886(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.

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.

Table 9 in the Addendum of this final rule shows hospitals that have been reclassified under either section 1886(d)(8) or section 1886(d)(10)(D) of the Act. This table includes hospitals reclassified for FY 2004 by the MGCRB (68 for wage index, 31 for the standardized amount, and 34 for both the wage index and the standardized amount), as well as hospitals that were reclassified for the wage index in either FY 2002 (451) or FY 2003 (55) and are, therefore, in either the second or third year of their 3-year reclassification. In addition, it includes rural hospitals redesignated to an urban area under section 1886(d)(8)(B) of the Act for purposes of the standardized amount and the wage index (42). Since publication of the May 19 proposed rule, the number of reclassifications has changed because some MGCRB decisions were still under review by the Administrator and because some hospitals decided to withdraw their requests for reclassification.

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

Applications for FY 2005 reclassifications are due to the MCGRB by September 2, 2003. 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 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.

As noted previously, OMB announced its new Metropolitan and Micropolitan Statistical Area definitions on June 6, 2003. However, as noted previously as well as in the proposed rule, in order to implement these changes for the IPPS, it is necessary to identify the new area designations for each county and hospital in the country. This is not possible by the September 2, 2003 deadline for reclassification by the MCGRB for FY 2005. Therefore, hospitals submitting applications for reclassification by the MCGRB for FY 2005 should base those applications on the current MSAs. We plan to move deliberately in determining the implications the new definitions will have on hospitals' reclassification requests, and we are considering addressing these implications in the FY 2005 proposed rule.

G. Requests for Wage Data Corrections

In the May 19, 2003 proposed rule, we described the process for hospitals to review and revise their FY 2000 wage data. The preliminary wage data file was made available on January 10, 2003 (and subsequently on February 4, 2003), through the Internet on CMS's Web site at: *http://www.cms.hhs.gov/providers/hipps/default.asp.* At that time, we also made available, at the same Internet address, a file showing each MSA's and rural areas's FY 2004 average hourly wage based on data then available compared to its FY 2003 average hourly wage. In a memorandum dated December 31, 2002, 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 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 February 17, 2003 (this deadline was initially announced as February 10, 2003, but was changed due to the need to repost some of the data). 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 December 31, 2002 memorandum referenced above.

After reviewing requested changes submitted by hospitals, fiscal intermediaries transmitted any revised cost reports to CMS and forwarded a copy of the revised Worksheet S–3, Parts II and III to the hospitals by April 4, 2003. In addition, fiscal intermediaries were to notify hospitals of the changes or the reasons that changes were not accepted. These deadlines were necessary to allow sufficient time to review and process the data so that the final wage index calculation could be completed for the development of the final FY 2004 prospective payment rates to be published by August 1, 2003.

If a hospital disagreed with the fiscal intermediary's resolution of a policy issue (for example, whether a general category of cost is allowable in the wage data), the hospital could have contacted CMS in an effort to resolve the issue. We note that the April 4, 2003 deadline also applied to these requests. Requests were required to be sent to CMS at the address below (with a copy to the hospital's fiscal intermediary). The request must have fully documented all attempts by the hospital to resolve the dispute through the process described above, including copies of relevant correspondence between the hospital and the fiscal intermediary. During review, we do not consider issues such as the adequacy of a hospital's supporting documentation, as we believe that fiscal intermediaries are generally in the best position to make evaluations regarding the appropriateness of these types of issues (which should have been resolved earlier in the process).

The final wage data public use file was released in May 2003. Hospitals had an opportunity to examine both Table 2 of the proposed rule and the May 2003 final public use wage data file (which reflected revisions to the data used to calculate the values in Table 2) to verify the data CMS used to calculate the wage index.

As with the file made available in January 2003, we made the final wage data released in May 2003 available to hospital associations and the public on the internet. However, the May 2003 public use file was 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 (with the February 2003 deadline). Hospitals were encouraged to review their hospital wage data promptly after the release of the May 2003 file. Data presented at that time could not be used by hospitals to initiate new wage data correction requests.

If, after reviewing the May 2003 final file, a hospital believed that its wage data were incorrect due to a fiscal

intermediary or CMS error in the entry or tabulation of the final wage data, it was provided an opportunity to send a letter to both its fiscal intermediary and CMS that outlined why the hospital believed an error existed and provided all supporting information, including relevant dates (for example, when it first became aware of the error). These requests had to be received by CMS and the fiscal intermediaries no later than June 6, 2003.

Changes to the hospital wage data were only 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, at this stage of the process, neither the intermediary nor CMS accepted 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 4, 2003.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the January 2003 wage data file.
- Requests to revisit factual determinations or policy interpretations made by the intermediary or CMS during the wage data correction process.

Verified corrections to the wage index received timely (that is, by June 6, 2003) are incorporated into the final wage index in the final rule to be published by August 1, 2003, and to be effective October 1, 2003.

We have created the process described above to resolve all substantive wage data correction disputes before we finalize the wage data for the FY 2004 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 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 had access to the final wage data by early May 2003, they had 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 2004 wage index in this final rule, and the implementation of the FY 2004 wage index on October 1, 2003. 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 publication in the final rule, 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 only in those limited circumstances in which a requesting 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 2004 (that is, by the June 6, 2003 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 indicated earlier, since a hospital had the opportunity to verify its data, and the fiscal intermediary notified the hospital of any changes, we do not expect that midyear corrections would 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.

Comment: One commenter requested that CMS release all of the assumptions used in developing the MSA average hourly wage file posted on the Internet, including the midpoint of cost reporting period adjustment factors. The commenter also requested that CMS release a file with the average hourly wage by hospital prior to the proposed rule. The commenter believed that this information would facilitate a hospital's review of its wage data.

Response: We agree that providing all of the assumptions used in calculating the wage index would be useful for hospitals and other interested parties. This year, we added to our Web site a spreadsheet that can be used to calculate a hospital's average hourly wage. Beginning with the release of the FY 2005 wage index, we will also publish on our Web site the midpoint of cost reporting period adjustment factors and a file that includes the average hourly wage for each hospital.

Comment: One commenter recommended that CMS establish a wage index list server similar to those available for the various open door forums. The list server would allow CMS to e-mail interested parties when items, such as the wage index PUF and program memoranda, are released.

Response: We currently notify all hospitals, through the fiscal intermediaries, regarding all public use files and program memorandum releases pertaining to the wage index. We also post this information on the IPPS Web site (*http://cms.hhs.gov/providers/hipps/ippswage.asp*). In addition, we make announcements regarding the wage index at the hospital open door forums. To supplement these efforts, we will also begin announcing the availability of wage index files and new program memoranda on the hospital open door forum Web site, at *http://www.cms.hhs.gov/opendoor/*. Those registered with the hospital open door forum list server will be automatically notified when there are announcements at this site pertaining to the wage index. Information on registering with the hospital open door forum list server is located at the open door forum Web site.

Comment: One commenter expressed concern regarding the average hourly wage calculator available on the Internet, stating that they were unable to replicate the average hourly wage published in the proposed rule for its area hospitals using the May public use file data and the online calculator.

Response: The average hourly wage values printed in the proposed rule, published on May 19, 2003 in the **Federal Register**, reflect the data saved in our database as of February 17, 2003. Alternatively, the May public use file was updated based on data collected through May 5, 2003. Therefore, calculating an average hourly wage using the May data could yield discrepancies between the value published in the proposed rule and the number generated by the online calculator.

H. Modification of the Process and Timetable for Updating the Wage Index

In the May 19, 2003 proposed rule, we stated that although the wage data correction process described in section III.G. of the preamble of this final rule has proven successful in the past for ensuring that the wage data used each year to calculate the wage indexes are generally reliable and accurate, we continue to be concerned about the growing volume of wage data revisions initiated by hospitals after the release of the first public use file in February. This issue has been discussed previously in

the FY 1998 IPPS proposed rule (62 FR 29918) and in the FY 2002 IPPS proposed rule (66 FR 22682). In each discussion, we described the increasing number of revisions to wage data between the proposed rule and the final rule.

Currently, the fiscal intermediaries are required to conduct initial desk reviews on or before November 15 in advance of the preparation of the preliminary wage data public use file in early January (see Program Memorandum A–02–94, October 4, 2002). Furthermore, fiscal intermediaries are required to explain and attempt to resolve items that fall outside the established thresholds. This may involve further review of the supplementary documentation or contacting the hospital for additional documentation. In addition, fiscal intermediaries are required to notify State hospital associations regarding hospitals that fail to respond to issues raised during the desk review. These actions are to be completed in advance of sending the data to CMS to prepare the preliminary wage data public use file in early January. However, as we have indicated in prior **Federal Register**s, nearly 30 percent of hospitals subsequently request revisions to their data after the preliminary wage data file is made available.

This high volume of revisions results in an additional workload for the fiscal intermediaries. In particular, much of a fiscal intermediary's efforts prior to submitting the data to prepare the preliminary public use file may be in vain if the hospital subsequently revises all of its data prior to the early February deadline (which is the hospital's right at that point). Therefore, in the May 19 proposed rule, we proposed to modify the process to release the preliminary wage data file prior to requiring the fiscal intermediaries to conduct their initial desk reviews on the data. We proposed that this unaudited data would be available on the Internet by early October rather than early January. Hospitals would review this file to ensure it contains their correct data as submitted on their cost reports and request any changes by early November. At that time, the fiscal intermediaries would review the revised requests and conduct desk reviews of the data including all approved changes.

Under the proposed revised timetable, the fiscal intermediaries would notify 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 would also submit the revisions to CMS in early February. Hospitals would then have until early March to submit requests to the fiscal intermediaries for reconsideration of adjustments made by the fiscal intermediaries as a result of the desk review. Other than requesting reconsideration of desk review adjustments, hospitals would not be able to submit new requests for additional changes that were not submitted by early November. By early April, the fiscal intermediaries would notify all hospitals of their decisions regarding the hospitals' requests to reconsider desk review adjustments and submit all of the revised wage data to CMS. From this point (early April) until the publication of the final rule, the process would be identical to the current timetable. Similar to the current timetable, hospitals would also have the opportunity in early April to request CMS consideration of policy disputes.

Therefore, we proposed to revise the schedule to improve the quality of the wage index by initiating hospitals' review of their data sooner and allowing the fiscal intermediaries to focus their reviews on the final data submitted by hospitals to be included in the wage index. In addition, we would receive the revised data in time to incorporate them into the wage indexes published in the proposed rule, resulting in fewer changes from the proposed rule to the final rule. This will improve the ability of hospitals to assess whether they should request a withdrawal from a MGCRB reclassification. Because the decision of whether to withdraw a wage index reclassification must be made prior to publication of the final rule, the proposed schedule should decrease the likelihood that the final wage index will be dramatically different from the proposed wage index.

Comment: Commenters stated their appreciation of the desire to expedite the process and reduce the workload of its fiscal intermediaries, but some were concerned about the additional workload these timeframes would place on hospitals.

Some commenters were concerned about the 30-day review period for the hospitals, stating it would not be enough time to conduct a thorough and complete review of the detailed data, adding that a 45-day comment period should be the minimum review time for providers. Commenters also stated their concerns about adjusting to a new timetable while also collecting and submitting occupational mix data, and the possible adoption of the new MSA definitions for the FY 2005 wage index. They believe any changes to the timeline should be postponed until the FY 2006 wage index.

Other commenters were concerned about the additional workloads for hospitals whose fiscal year ends on June 30. These hospitals would most likely be preparing cost reports for the fiscal year just ended and this would be an additional burden. Another commenter expressed concern that the proposed rule did not mention the State hospital association notification for hospitals failing desk review edits and that the new deadlines would not afford hospitals any recourse to ensure accurate data. One commenter cited the major role its fiscal intermediary played in the delay of revisions to its wage index.

Several other commenters generally supported the proposal to modify the wage index timetable, but with some modification. The commenters asked that hospitals have 75 days from the proposed October release of the public use file to submit revised data to the fiscal intermediaries and that CMS finalize the timetable in June rather than waiting until the final rule is published. The commenters believed this would allow virtually all hospitals the time they need to do a thorough and complete review to determine the accuracy of the detail data needed to compute an accurate wage index. Commenters also believed this would give fiscal intermediaries time to respond to hospital issues raised during the desk review period.

Finally, other commenters expressed support for the timetable changes. These commenters believed the hospitals will have more time to review their wage data and there will be less of an administrative burden on fiscal intermediaries. Another commenter believed auditors' and hospitals' resources will be better utilized and this could help eliminate the problem of reauditing wage index data after revisions are submitted. Another commenter added that hospitals would be able to better determine how they compare to other hospitals and whether a reclassification would be appropriate using much more accurate data. Also, aberrant data would become more apparent earlier in the process.

Response: Although hospitals will be required to review the data sooner, they are not being asked to perform any more reviews or work than currently. Therefore, we do not believe this change will be burdensome to hospitals. Hospitals will still have sufficient time to complete a thorough review of the data, because the data for the FY 2005 wage index values will be taken from cost reporting periods beginning during FY 2001. These cost reports should have already been thoroughly reviewed

before being submitted to their fiscal intermediary and sent to CMS earlier this year.

Further, since the ultimate goal is improvement of the wage index, we believe this will be achieved with a more streamlined process in which fiscal intermediary work is not duplicated and is instead focused on the final data submitted by hospitals instead of preliminary data, of which nearly 40 percent ends up being revised under the current timetable. As noted above, these revisions under the current process often nullify the desk reviews performed by the fiscal intermediary.

We recognize the commenters' concern with respect to the interaction of this process with the collection of occupational mix data and the potential adoption of OMB's new MSA definitions. As we proceed with developing the details of the occupational mix data collection for the FY 2005 wage index, we intend to schedule that collection effort in a way that accommodates this revised timetable. The details of that schedule will be forthcoming shortly.

Finally, as previously discussed, the ability of hospitals to assess whether they should request a withdrawal from a MGCRB reclassification will also be improved, thereby decreasing the likelihood that the final wage index will be dramatically different from the proposed wage index. For these reasons, we are adopting as final the proposed revisions to the wage data development timeline and will use the revised timeline for the development of the FY 2005 wage index.

However, in order to address commenter concerns about the 30-day review period being too short, we are modifying the timetable to have the preliminary public use file on the CMS Web site in mid-September, thereby giving hospitals approximately 45 days instead of 30 days to review the preliminary wage data. Further instructions and a detailed timeline will be released in the form of a Program Memorandum.

The following table illustrates the timetable that will be applicable for the development of the FY 2005 wage index:

Timeframe	Steps in wage index development process
Mid-September	Preliminary and unaudited wage data file published as a public use file (PUF) on CMS Web site.
Mid-November	Deadline for hospitals to send requests for revisions to their fiscal intermediaries.
Early February	Fiscal intermediaries review revisions and desk review wage data; notify hospitals of changes and resolution of revision requests; and submit preliminary revised data to CMS.
Early March	Deadline for hospitals to request wage data reconsideration of desk review adjustments and provide adequate documentation to support the request.
Early April	Deadline for the fiscal intermediaries to submit additional revisions resulting from the hospitals' reconsideration requests. This is also the deadline for hospitals to request CMS intervention in cases where the hospital disagrees with the fiscal intermediary's policy interpretations.
Early May*	Release of final wage data PUF on CMS Web site.
Early June*	Deadline for hospitals to submit correction requests, to both CMS and their fiscal intermediary, for errors due to the mishandling of the final wage data by CMS or the fiscal intermediary.
August 1*	Publication of the final rule.
October 1*	Effective date of updated wage index.

*Indicates no change from prior years.

IV. Other Decisions and Changes to the IPPS for Operating Costs and GME Costs

A. Transfer Payment Policy (§ 412.4)

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.

1. Transfers to Another Acute Care Hospital (§ 412.4(b))

Medicare adopted its IPPS transfer policy because, if we 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 their 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.

Currently, when a patient chooses to depart from a hospital against the medical opinion of treating physicians, the case is 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 are assumed not to involve the active participation of the hospital administration, our policy has been to treat LAMA cases as discharges. This policy applies even if the patient is admitted to another hospital on the date of the LAMA discharge. Consequently, we currently make a full DRG payment for any discharge coded as a LAMA case.

However, we are concerned that some hospitals may be incorrectly coding transfers as LAMA cases. The Office of Inspector General (OIG) issued a report in March 2002 (A–06–99–00045), asserting that of the approximately 60,000 LAMA discharges annually, 1,500 patients were subsequently admitted to another IPPS hospital the same day. The OIG performed a detailed review of the medical records at selected hospitals and found evidence that the hospitals actively participated in transferring the patients to a different IPPS hospital, yet the hospital coded the claim as a LAMA. OIG cited several examples of these cases:

''In the first example, the transferring hospital did not have an inpatient room available for the patient, who had been in the emergency room for 24 hours. The medical record showed that the treating physician contacted another PPS hospital to determine whether the hospital could accept the patient. Specifically, the medical record stated: 'Upon request of the patient, [hospital name] was contacted since there is a good possibility of transferring patient to [name of hospital]. At present, he has been in emergency room for 24 hours waiting for a bed.' ''

In this example, despite the overt participation of the physician in securing the admission to the other IPPS hospital and the fact that the transferring hospital did not have an inpatient room available for the patient, the claim was submitted as a LAMA discharge, rather than as a transfer to another IPPS hospital.

''In the second example, the patient was brought to the first hospital by ambulance. Subsequently, the patient's family indicated that they wanted a neurologist at another hospital to render the treatment needed by the patient. The attending physician contacted the neurologist in order to determine if the neurologist would accept, admit, and treat the patient. The medical record contained ample evidence of knowledge and participation of the transferring hospital, and the discharge should have been reported as a PPS transfer. Specifically, the medical record stated: 'Patient's family wanted to sign the patient out against medical advice and take her to [name of hospital]. The physician spoke with the neurologist at [name of hospital], who agreed to accept the patient. The patient's family signed the patient discharged against medical advice. All the risks of self-discharge were explained.' ''

In this case, although the medical record indicated the patient wanted to leave against medical advice, there is also evidence that the patient's attending physician at the hospital participated in the transfer to another IPPS hospital. While we do not wish to discourage such participation and cooperation in cases where a transfer occurs, this situation would seem almost indistinguishable from other transfer situations. For instance, we have long recognized situations where patients are transferred from a rural hospital to an urban hospital for a surgical procedure, then back to the rural hospital to complete the recuperative care, as appropriate transfer situations as long as the transfers are medically appropriate. In such a case, the rural hospital would receive a payment under the transfer policy for the first portion of the stay, the urban hospital would also receive payment under the transfer policy for the care it provided, and the rural hospital would receive a full DRG payment as the discharging hospital for the recuperative care it provided upon the patient's return from the urban hospital. In such situations, each portion of the stay may be assigned a different DRG.

Therefore, in the May 19, 2003 proposed rule, we proposed to expand 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.

Although we considered proposing a policy that would be based on whether the hospital actively participated in the transfer, and exempting from the transfer definition cases where the hospital had absolutely no knowledge that the patient intended to go to another hospital, we did not propose such a policy for two reasons. First, it would be difficult to administer equitably a policy that required a determination as to whether the hospital or the physician had knowledge of the patient's intentions. Such a policy would require fiscal intermediaries to make a difficult judgment call in many cases. Second, if we were to base the determination of whether a case is a transfer on the level of involvement of the hospital and the physician caring for the patient, we would be creating a financial disincentive to hospitals for ensuring an efficient and cooperative transfer once a decision has been made by the patient or the patient's family to leave the hospital.

We recognize that, in some cases, a hospital cannot know the patient will go to another hospital. However, we note the claims processing system can identify cases coded as discharges where the date of discharge matches the admission date at another hospital. In these cases, the fiscal intermediary will notify the hospital of the need to submit an adjustment claim. However, if the hospital can present documentation showing that the patient's care associated with the admission to the hospital was completed before discharge, consistent with our current policy, the transfer policy will not be applied.

Comment: Commenters opposed the proposed expansion of the transfer policy to include all patients who are admitted to another IPPS hospital on the same day that the patient is discharged from an IPPS hospital. They argued that situations in which a limited number of hospitals are abusing the payment rules should be handled by review of those hospitals' claims, and not through a policy change that will place additional burdens on all hospitals.

Response: We disagree that this policy expansion would create an additional burden on all hospitals. We note that it is our current policy to consider patients discharged from one IPPS hospital and admitted to another IPPS hospital on the same day as a transfer in all situations except LAMA situations, unless the original discharging hospital can document that the discharge was appropriate and unrelated to the subsequent same-day admission. We understand from the OIG that these situations are extremely rare, and in the vast majority of cases, same-day readmissions to another hospital are, in fact, transfers.

Our proposal would merely extend this current policy to LAMA situations. As is the case under our present policy, we believe it will be exceedingly rare that a patient leaves one hospital in LAMA status, and is readmitted to a second hospital on the same day for an unrelated purpose. Because the need for a hospital to supply documentation would only arise in these rare situations, we do not believe this policy change creates an additional burden for hospitals.

In relation to the appropriateness of a general policy expansion as opposed to a review and adjustment of individual hospital's claims, we believe a general policy expansion is necessary in this circumstance. As described in the proposed rule and above in this final rule, we considered proposing a policy that would be based on whether the hospital actively participated in the transfer and that would exempt from the transfer definition cases in which the hospital had absolutely no knowledge that the patient intended to go to another hospital. However, we did not propose such a policy because it would require a determination as to whether the hospital or the physician had

knowledge of the patient's intentions. We believed that if we adopted such a policy, we would be creating a financial disincentive to hospitals for ensuring an efficient and cooperative transfer once a decision has been made by the patient or the patient's family to leave the hospital.

Comment: Several commenters wrote that CMS was overreacting to anecdotal examples and that the proposed policy was ''not sustainable under any application of reasonableness.'' They suggested that, rather than put the burden on all hospitals due to the abuse from these isolated incidents, hospitals should be evaluated from the frequency of LAMA discharges. Those that fall outside of the ''norm'' could be investigated, similar to the outlier studies.

Response: We agree that the problems uncovered in the OIG's report on transfers reported as LAMAs are relatively small within the overall scope of the IPPS. In fact, we made the point to OIG in our comments on a draft of its report that their findings equated with one inappropriate LAMA discharge per hospital per year. However, the OIG found this problem was not spread equally across all hospitals, but occurred disproportionately in a small number of hospitals.

We believe we are establishing clear and unequivocal policies for handling those situations that do occur and that this policy change will have a minimal impact on the majority of hospitals nationwide. Consequently, we are finalizing the change to our regulations to expand 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, effective for discharges occurring on or after October 1, 2003.

Comment: Commenters stated that the proposed expanded definition of a transfer provides no guidance to hospitals as to what would be acceptable documentation that the patient's treatment was completed at the time of discharge. Some commenters asked whether an exact match of the principal diagnoses codes for the two admissions would be used to determine that the same-day readmission was related to the prior discharge. One commenter suggested that it would be more appropriate for the fiscal intermediary to request medical documentation from both hospitals involved in the transfer in order to determine whether a transfer payment should be made to the transferring hospital, rather than solely requesting documentation from the transferring hospital.

Another commenter asserted that CMS is placing the burden of correcting this situation on all hospitals rather than directing fiscal intermediaries to develop screens to identify these cases. In addition, they noted possible conflicts of sharing information between hospitals regarding patient care due to new HIPAA requirements.

Response: We anticipate the documentation necessary to establish that the readmission was unrelated to the prior, same-day discharge would be similar to the type of documentation relied upon by fiscal intermediaries and Quality Improvement Organizations (QIOs) to evaluate whether patients were discharged prematurely. (For example, section 4135 of the Peer Review Manual discusses discharge review.) That is, there are existing practices for determining that patients were medically unstable at discharge or the discharge was inconsistent with the patient's need for continued acute inpatient hospitalization. Therefore, there should be no breach in HIPAA disclosure requirements.

We are developing claims processing systems edits to more accurately identify transfers that are inappropriately coded as discharges. These edits identify claims that are entered with inappropriate discharge codes and will prevent payment to the second hospital if there is already a discharge from another hospital in the system for the same beneficiary on the same day. If this situation occurs, the claim from the first hospital is sent back to the hospital for correction, and the second claim is paid. We expect a similar edit that identifies same-day readmissions following a LAMA discharge would be added to the claims processing system edits.

Comment: One commenter requested clarification as to the appropriate discharge destination code in those situations when a patient left the first hospital against medical advice and the fiscal intermediary notifies this hospital of a subsequent same-day admission to another hospital.

Response: This situation is similar to those situations in which a hospital believes and intends to discharge a patient to home, but is subsequently notified that the discharge qualifies under the postacute care transfer policy because the patient received qualifying postacute care. The hospital would submit an amended bill coded to reflect the fact that the hospital now has information that the patient received subsequent care.

2. Technical Correction

Section 412.4(b)(2) defines a discharge from one inpatient area of the hospital to another area of the hospital as a transfer. Although this situation may be viewed as an intrahospital transfer, it does not implicate the transfer policy under the IPPS. In the May 19, 2003 proposed rule, to avoid confusion and to be consistent with the changes to § 412.4(b) described at section IV.A.3. of this preamble, we proposed to delete existing § 412.4(b)(2) from the definition of a transfer. We did not receive any comments on this proposal. Therefore, we are deleting existing § 412.4(b)(2) from the definition of a transfer.

3. Expanding the Postacute Care Transfer Policy to Additional DRGs (§§ 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 requires 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. Also, 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 the following DRGs to be subject to the special 10 DRG transfer rule:

- DRG 14 (Intracranial Hemorrhage and Stroke with Infarction (formerly ''Specific Cerebrovascular Disorders Except Transient Ischemic Attack''));
- DRG 113 (Amputation for Circulatory System Disorders Except Upper Limb and Toe);
- DRG 209 (Major Joint Limb Reattachment Procedures of Lower Extremity);
- DRG 210 (Hip and Femur Procedures Except Major Joint Procedures Age ≤17 With CC);
- DRG 211 (Hip and Femur Procedures Except Major Joint Procedures Age ≤17 Without CC);
- DRG 236 (Fractures of Hip and Pelvis);
- DRG 263 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis With CC);
- DRG 264 (Skin Graft and/or Debridement for Skin Ulcer or Cellulitis Without CC);
- DRG 429 (Organic Disturbances and Mental Retardation); and
- DRG 483 (Tracheostomy With Mechanical Ventiliation 96 + Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses (formerly ''Tracheostomy Except for Face, Mouth, and Neck Diagnoses'')).

Similar to the policy for transfers between two acute care hospitals, the transferring hospital in a postacute care transfer for 7 of the 10 DRGs receives twice the per diem rate the first day and the per diem rate for each following day of the stay before the transfer, up to the full DRG payment. However, 3 of the 10 DRGs exhibit a disproportionate share of costs very early in the hospital stay in postacute care transfer situations. For these 3 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. This is consistent with section 1886(d)(5)(J)(i) of the Act, which recognizes that in some cases ''a substantial portion of the costs of care are incurred in the early days of the inpatient stay.''

Section 1886(d)(5)(J)(iv) of the Act authorizes the Secretary to expand the postacute care transfer policy beyond 10 DRGs. In the May 9, 2002 IPPS proposed rule, we discussed the possibility of expanding this policy to either all DRGs or a subset of additional DRGs (we identified 13 additional DRGs in that proposed rule) (67 FR 31455). However, as discussed further in the August 1, 2002 final rule (65 FR 50048), we did not expand the postacute care transfer provision to additional DRGs for FY 2003. The commenters on the options in the May 9, 2002 proposed rule raised many issues regarding the impact of expanding this policy that we needed to consider further before proceeding. In particular, due to the limited time between the close of the comment period and the required publication date of August 1, we were unable to completely analyze and respond to all of the points that were raised. We indicated that we would continue to conduct research to assess whether further expansion of this policy may be warranted and, if so, how to design any such refinements.

Many commenters on the May 9, 2002 proposed rule argued that, in a system based on averages, expansion of the postacute care transfer policy negatively influences, and in fact penalizes, hospitals for efficient care. They claimed that this policy indiscriminately penalizes hospitals for efficient treatment and for ensuring that patients receive the right care at the right time in the right place. They believed that the postacute care transfer provision creates an inappropriate incentive for hospitals to keep patients longer.

Commenters also expressed concern that the expansion of the transfer provision violates the fundamental principle of the IPPS. The DRG system is based on payments that will, on average, be adequate. These commenters argued that expansion of the postacute care transfer policy would give the IPPS a per-diem focus and would mean that hospitals would be paid less for shorter than average lengths of stay, although they would not be paid more for the cases that are longer than average (except for outlier cases).

We agree that the transfer policy should not hamper the provision of effective patient care. We also agree that any future expansion must consider both the need to reduce payments to reflect cost-shifting out of the acute care setting due to reductions in length of stay attributable to early transfers to postacute care and the need to ensure that payments, on average, remain adequate to ensure effective patient care. Therefore, we have assessed the extent to which the current postacute care transfer policy balances these objectives.

The table below displays the results of our analysis. We first examined whether the 10 DRGs included in the policy continue to exhibit a relatively high percentage of cases transferred to postacute care settings, particularly among cases with lengths of stay shorter than the geometric mean for the DRG (these cases would be affected by the reduced payments for transfers). The table shows that these DRGs continue to contain high percentages of cases transferred to postacute care settings similar to those we reported in the FY 1999 final rule (63 FR 40975). These results would appear to demonstrate that the postacute care transfer policy has not greatly altered hospitals' treatment patterns for these cases.

This similarity in treatment patterns is further evidenced by the fact that, for 6 of the 10 DRGs, the geometric mean length of stay has continued to decline in the 5 years since the policy was implemented. Accordingly, hospitals have continued to transfer many patients in these DRGs before the mean length of stay, despite the transfer policy. As we stated in the July 31, 1998 final rule, the transfer provision adjusts payments to hospitals to reflect the reduced lengths of stay arising from the shift of patient care from the acute care setting to the postacute care setting (63 FR 40977). This policy does not require a change in physician clinical decisionmaking nor in the manner in which physicians and hospitals practice medicine: It simply addresses the appropriate level of payments once those decisions have been made.

With respect to whether this policy alters the fundamental averaging principles of the IPPS, we believe the current policy, which targets specific DRGs where evidence shows hospitals have aggressively moved care to postacute care settings, does not alter the averaging principles of the system. In fact, it could be said to enhance those principles because a transfer case is counted as only a fraction of a case toward DRG recalibration based on the ratio of its transfer payment to the full DRG payment for nontransfer cases. This methodology ensures the DRG

weight calculation is consistent with the payment policy for transfer cases. The last column of the table below indicates that all but three of these DRGs have experienced increases in DRG weights since the policy was implemented. By reducing the contribution of transfer cases to the calculation of the DRG average charge, the relative weights (the result of dividing the DRG average charge by the national average charge per case) are higher than they would otherwise be. This is because transfers, particularly short-stay transfers, have lower total charges, on average.

DRG	DRG title	All transfer cases	Percent of all cases transferred to postacute care setting	Percent of all cases transferred prior to mean length of stay	Percent change in mean length of stay FYs 1992–1998	Percent change in mean length of stay FYs 1998–2003	Percent change in DRG relative weight FYs 1998–2003
14	Intracranial Hemorrhage and Stroke with Infarction.	143,649	48.88	11.74	−29.17	−5.88	8.53
113	Amputation for Circulatory System Disorders Except Upper Limb and Toe.	24,470	66.57	30.12	−32.17	7.22	9.21
209	Major Joint and Limb Reattachment Procedures of Lower Extremity.	244,969	66.66	19.76	−47.52	−15.09	−8.09
210	Hip and Femur Procedures Except Major Joint Age >17 With CC.	87,253	76.26	35.67	−42.98	−6.15	0.1
211	Hip and Femur Procedures Except Major Joint Age >17 Without CC.	20,239	72.38	15.89	−44.44	−8.00	1.39
236	Fractures of Hip and Pelvis	26,583	69.86	11.20	−34.85	−6.98	−1.43
263	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC.	13,158	62.00	31.35	−41.45	4.49	9.36
264	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis Without CC.	1,759	49.97	18.81	−37.21	1.85	5.36
429	Organic Disturbances and Mental Retardation.	30,349	53.25	15.22	−28.95	−12.96	−5.27
483	Tracheostomy With Mechanical Ventilation 96 + Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses.	21,818	52.93	27.34	−15.29	2.37	1.38

We indicated in the proposed rule that we believe the current 10 DRG postacute care transfer policy appears to be appropriately balancing the objectives to reduce payments to reflect cost-shifting due to reductions in length of stay attributable to early postacute care transfers and to ensure that payments, on average, remain adequate to ensure effective patient care. Therefore, we once again undertook the analysis to identify additional DRGs to which the policy might be expanded.

However, we did not propose to expand the policy to all DRGs. Although we indicated that expanding the postacute care transfer policy to all DRGs might be the most equitable approach because a policy that is limited to certain DRGs may result in disparate payment treatment across hospitals, at this time, we believe an incremental expansion is appropriate. That is, we believe further analysis is necessary to assess whether it would be appropriate to apply a reduced payment for postacute care transfers across all DRGs. In particular, it is important to attempt to distinguish between DRGs where the care is increasingly being shifted to postacute care sites versus DRGs where some patients have always been discharged to postacute care early in the stay. It may not be appropriate to reduce payment for these latter DRGs if the base payment already reflects a similar postacute care utilization rate (for example, in these cases there would be no cost shifting).

As described below, we proposed an additional 19 DRGs, based on declining mean lengths of stay and high percentages of postacute transfers, for which an expansion of the current policy appeared warranted.

We also noted that MedPAC has conducted analysis on the current postacute care transfer policy. Most recently, in its March 2003 Report to Congress, MedPAC recommended adding 13 additional DRGs to the 10 DRGs covered under the current policy (page 46). The 13 DRGs were the same DRGs included in one of our proposals to expand the postacute care transfer policy in last year's IPPS proposed rule. MedPAC did not recommend expanding the policy to include all DRGs at this time, noting that this expansion might reduce payments to some hospitals by as much as 4 percent. Rather, it suggested evaluating the impact of a limited expansion before extending the policy to more DRGs.

MedPAC's report cites several reasons for expanding the postacute care transfer policy beyond the current 10 DRGs. First, it notes the continuing shifts in services from the acute care setting to the postacute care setting. Second, the report points to different postacute care utilization for different hospitals, particularly based on geographic location. Third, the report states: ''the expanded transfer policy provides a better set of incentives to protect beneficiaries from potential premature discharge to postacute care.'' Fourth, MedPAC notes that the policy improves payment equity across hospitals by: reducing payments to hospitals that transfer patients to postacute care while making full payments to hospitals that provide all of the acute inpatient services in an acute care setting; and maintaining more accurate DRG weights that reflect the

true resource utilization required to provide the full course of acute inpatient care, as distinguished from the partial services provided to patients who are transferred to postacute care.

Since the publication of last year's rule, we have conducted an extensive analysis to identify the best method by which to expand the postacute care transfer policy. Similar to the analysis used to identify the current 10 DRGs, in the May 19, 2003 proposed rule, we proposed to identify DRGs with high postacute care transfer rates and at least 14,000 transfer cases. However, rather than ranking DRGs on the basis of the percentage of all postacute care transfers, we proposed to rank DRGs on the basis of the percentage of postacute care transfers occurring before the DRG geometric mean length of stay. This is because only transfers that occur before the geometric mean length of stay, minus one day due to the policy that hospitals receive double the per diem for the first day, are impacted by the transfer policy. In order to focus on those DRGs where this policy would have the most impact, we proposed to include only DRGs where at least 10 percent of all cases were transferred to postacute care before the geometric mean length of stay. (We note that preceding sentence was stated incorrectly in the proposed rule. The criterion should have read ''at least 10 percent of all cases that were transferred to postacute care were transferred before the geometric mean length of stay.'') The next proposed criterion is to identify DRGs with at least a 7-percent decline in length of stay over the past 5 years (from FY 1998 to FY 2003). This criterion would focus on those DRGs for which hospitals have been most aggressively discharging patients sooner into postacute care settings. Finally, we proposed to include only DRGs with a geometric mean length of stay of at least 3 days because the full payment is reached on the second day for a DRG with a 3-day length of stay.

Using these criteria, we proposed 19 additional DRGs to include in the postacute care transfer policy. However, some of the 13 DRGs proposed last year (and included in MedPAC's proposed expansion) were not included in the May 19, 2003 proposed rule. For example, DRGs 79 and 80 (Respiratory Infections and Inflammations Age >17 With and Without CC, respectively) were included in last year's proposed expansion but were not included in the proposed rule for FY 2004. DRGs 79 and 80 were excluded from the proposed rule because they did not exhibit a decline in length of stay of at least 7 percent over the past 5 years.

We noted that 7 of the proposed 19 DRGs are paired DRGs (that is, they contain a CC and no-CC split). Because these DRGs are paired DRGs (that is, the only difference in the cases assigned to DRG 130, for example, as opposed to DRG 131 is that the patient has a complicating or comorbid condition), we proposed to include both DRGs under this expanded policy. If we were to include only DRG 130 in the transfer policy, we believed there would be an incentive for hospitals not to include any code that would identify a complicating or comorbid condition, so that a transfer case would be assigned to DRG 131 instead of DRG 130.

Using the selection criteria described above, we proposed the following 19 DRGs to include under the postacute care transfer policy (in addition to the 10 DRGs already subject to the policy).

DRG	DRG title	All transfer cases	Percent of all cases transferred to postacute care setting	Percent of all cases transferred prior to mean length of stay	Percent change in mean length of stay FYs 1992–1998	Percent change in mean length of stay FYs 1998–2003
12	Degenerative Nervous System Disorders	39,034	54.13	13.10	−21.74	−12.00
24	Seizure and Headache Age >17 With CC	19,239	35.67	11.63	−20.75	−7.69
25	Seizure and Headache Age >17 Without CC	4,738	19.15	2.15	−14.29	−10.71
89	Simple Pneumonia and Pleurisy Age > 17 With CC.	175,441	34.86	11.37	−18.31	−11.11
90	Simple Pneumonia and Pleurisy Age >17 Without CC.	9,544	20.86	2.82	−20.37	−15.00
121	Circulatory Disorders With AMI and Major Complication, Discharged Alive.	79,242	52.52	20.46	−21.95	−11.67
122	Circulatory Disorders With AMI Without Major Complications Discharged Alive.	33,028	48.91	24.09	−26.67	−23.08
130	Peripheral Vascular Disorders With CC	31,106	37.78	14.27	−13.11	−11.76
131	Peripheral Vascular Disorders Without CC	5,723	23.08	5.42	−4.44	−19.51
239	Pathological Fractures and Musculoskeletal and Connective Tissue Malignancy.	23,188	53.54	21.96	−22.67	−7.55
243	Medical Back Problems	36,772	41.49	13.61	−14.00	−7.50
277	Cellulitis Age >17 With CC	35,015	37.77	14.03	−21.43	−7.84
278	Cellulitis Age >17 Without CC	6,526	22.05	3.11	−18.87	−10.00
296	Nutritional and Miscellaneous Metabolic Disorders Age >17 With CC.	104,216	40.05	11.88	−21.67	−9.30
297	Nutritional and Miscellaneous Metabolic Disorders Age >17 Without CC.	12,649	28.03	2.17	−17.50	−10.00
320	Kidney and Urinary Tract Infectious Age >17 With CC.	77,669	44.64	12.40	−23.88	−8.51
321	Kidney and Urinary Tract Infections Age >17 Without CC.	8,610	29.90	5.67	−20.41	−13.89
462	Rehabilitation	147,211	56.59	22.69	−22.54	−11.43
468	Extensive O.R. Procedure Unrelated to Principal Diagnosis.	24,783	44.51	18.53	−20.30	−7.07

We proposed to revise § 412.4(d) to incorporate these additional 19 DRGs as qualifying DRGs for transfer payments and to make a conforming change to § 412.4(c).

We also examined whether any of these DRGs would qualify for the alternative payment methodology of 50

percent of the full DRG payment plus 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 specified in existing regulations under § 412.4(f). To identify the DRGs that might qualify, we compared the average charges for all cases with a length of stay of 1 day to the average charges of all cases in a particular DRG. To qualify for the alternative methodology, we indicated that the average charges of 1-day discharge cases must be at least 50 percent of the average charges for all cases in the DRG.

Based on this analysis, we determined that 5 out of the proposed 19 DRGs would qualify for this payment method (DRGs 25, 122, 131, 297, and 321). However, the fact that the average charges of 1-day stays equal at least 50 percent of the average charges for all cases in these DRGs is due to the very short lengths of stay for these DRGs. Therefore, we did not propose to include them in the alternative payment methodology. For example, for a DRG with a 3-day geometric mean length of stay, full DRG payment will be made on the second day of the stay, regardless of which payment methodology is used. Therefore, in the May 19, 2003 proposed rule, we proposed that none of the 19 additional DRGs that we were proposing to add to the postacute care transfer policy would be paid under the alternative payment methodology.

We also analyzed the 10 DRGs that are currently subject to the postacute care transfer policy. Of the three DRGs that are receiving payments under the special payment (transfers after 1 day incur charges equal to at least 50 percent of the average charges for all cases). Unlike the five DRGs that would otherwise meet this criterion, the geometric mean length of stay of both DRG 209 and 211 is over 4 days. In addition, DRG 210 is currently paid under the special payment methodology, but our current analysis indicates average charges for 1-day stays are less than 50 percent of the average charges for all cases in the DRG. Nonetheless, DRG 210 is paired with DRG 211, which meets the criteria. Therefore, we proposed that DRG 210 would continue to be paid under the special payment methodology. Similar to our rationale for including both paired DRGs when one qualifies for inclusion in the postacute care transfer policy, we proposed to include both DRGs in this pair under the special payment methodology. Accordingly, we proposed that only DRGs 209, 210, and 211 that are currently paid under the alternative transfer payment methodology would continue to be paid under this methodology.

Finally, we noted that the OIG has prepared several reports that examined hospitals' compliance with proper coding of patients' discharge status as transferred under our guidelines, and has found substantial noncompliance leading to excessive payments.[6] Specifically, the OIG found hospitals submitting claims indicating the patient had been discharged when, in fact, the patient was transferred to a postacute care setting. As we indicated in the May 8, 1998 **Federal Register** (63 FR 25593), hospitals found to be intentionally engaging in such practices may be investigated for fraudulent or abusive billing practices. We intend to work with the OIG to develop the most appropriate response to ensure all hospitals are compliant with our guidelines.

Comment: Many commenters argued that any expansion of the postacute care transfer policy, and even the policy itself, undermines clinical decisionmaking and penalizes hospitals for providing the right care at the right time and in the right setting. Commenters further argued that the policy itself violates the original premise of the IPPS, because it makes it difficult or impossible for hospitals to break-even on patients who receive postacute care after discharge. One commenter argued that hospitals lose if patients are discharged prior to the mean length of stay, and they lose if patients are discharged after the mean length of stay.

Commenters also argued the postacute care transfer policy is not good policy because it may create a perverse incentive for hospitals to increase patients' lengths of stay. One commenter expressed concern that longer lengths of stay would result from a shift in focus from per-case cost control to per-day cost control. The commenter suggested that this policy sends a conflicting message to hospital administrators who have taken steps recently to reduce their hospitals' average lengths of stay.

Some commenters pointed out that the postacute care transfer policy fails to acknowledge or recognize that, for many patients, postacute care is already reflected in the IPPS base payment rate for many DRGs. In particular, hospitals in certain regions of the country have historically had lower average lengths of stay, and therefore, these hospitals are disproportionately impacted by this policy.

Other commenters suggested the DRG relative weights are self-adjusting, and as patients spend less time in the acute care setting and costs decrease, the DRG relative weights will begin to fall. Therefore, there is no need for a postacute care transfer policy.

Commenters also noted the increasing costs of dealing with these higher cost cases, and that transfer payments do not adequately cover the costs of the newer and better treatment that is resulting in shorter lengths of stay. Commenters objected to the expansion of the policy due to the current financial pressure that many hospitals are currently under because of nursing shortages, inadequate Medicare payment for services they provide, and increasing costs associated with malpractice and insurance costs and increasing costs of pharmaceuticals and equipment. They also noted the financial burden in preparing to treat the aging ''baby boomer'' generation and costs associated with emergency management preparation.

Commenters argued that many hospitals are suffering as a result of not receiving the full market basket update (accounting for inflation each year), and further expansion of the postacute care transfer policy will further limit their resources. In addition, they argued, Congress already addresses the issues of shorter lengths of stay when it determines the market basket update each year. In effect, they claimed, hospitals whose lengths of stay decline significantly are not praised, but penalized—twice—for their efforts to provide better care. One commenter wrote to ''respectfully submit that to deal with fraudulent providers in this sweeping manner is inconsistent and inappropriate.''

Response: We disagree that the postacute care transfer policy is contrary to the fundamental theory of the IPPS. Concern that hospitals would shift a portion of the acute care services to other providers in response to the incentives of the IPPS has been an ongoing concern. In fact, in response to a comment during the first year of the IPPS on the hospital-to-hospital transfer policy, we stated that ''(t)he rationale for per diem payments as part of our transfer policy is that the transferring hospital generally provides only a limited amount of treatment. Therefore, payment of the full prospective payment rate would be unwarranted'' (49 FR 244). We also note that in its earliest update recommendations, the Prospective Payment Assessment Commission (a predecessor to MedPAC)

[6] The OIG report identification numbers are: A–04–00–02162, A–04–00–01210, A–04–0122, and A–04–02–07005.

included what it called a site-of-service substitution adjustment to account for the shifting of portions of inpatient care to other settings.

We disagree that the postacute care transfer policy creates a perverse incentive to keep patients in the hospital longer than necessary. Our view is the policy simply responds to changing medical practice and addresses the appropriate level of payment once clinical decisions about the most appropriate care in the most appropriate setting have been made. The validity of this position is substantiated by the finding that the geometric mean length of stay for 6 of the 10 DRGs currently included in the policy have continued to fall since the policy was implemented.

In regard to the comment that the policy fails to recognize that the DRG base payments reflect some degree of postacute care, we note that the policy is intended to recognize that, since the implementation of the IPPS, the use of postacute care has generally increased. For many DRGs, the use of postacute care continues to increase at a high rate. However, an increase in the frequency of the use of postacute care does not, by itself, necessitate a policy response. If patients continue to receive the full course of acute care in the IPPS setting prior to transfer, a full DRG payment is warranted. However, if patients begin to be transferred to postacute care settings to receive care that, during the IPPS base period, was provided in the IPPS setting, paying a full DRG would not be appropriate because some of the care on which the full DRG payment is based is now being provided in the postacute care setting.

This shift in the setting where care is provided is not accounted for through DRG recalibration. During recalibration, reductions in the relative weights of certain DRGs result in increases in the weights of other DRGs. Therefore, there is no net reduction in the IPPS payments to hospitals, even though some of the care that used to be provided in the acute inpatient setting is now provided elsewhere.

Comment: Commenters took issue with our evaluation of the impact of the postacute care transfer policy on the averaging aspects of the IPPS if the policy were expanded. Pointing to our statement in the August 1, 2002 **Federal Register** that we intended to undertake a more comprehensive analysis of this issue, some commenters stated that we did not provide such a comprehensive analysis or include a discussion of the topic in the proposed rule.

However, other commenters expressed appreciation for our analysis of the impacts of the existing policy in the proposed rule. One commenter noted that we had made some interesting and potentially valid points that an expanded transfer policy would eliminate or reduce some of the problems caused by making national average payments to all hospitals, regardless of treatment patterns and patient-mix within specific DRGs (although this commenter suggested that we address the payment inequities caused by expensive short-stay cases, or ''inliers'').

Several commenters noted that the recalculation of weights in the affected DRGs is unfair because, in the system of averages, transfers are accounted for as only partial cases but the remaining cases are not adjusted upward. The commenter wrote: ''[i]f a DRG's length of stay is declining, doesn't that suggest recalibration of the relative weight?'' The commenter believed inclusion of reduction in length of stay criteria ''begs the question of what is the true average length of stay for these particular DRGs. If these DRGs are experiencing a large percentage of cases transferred prior to the average length of stay, it logically follows that the average length of stay would be less.''

Response: We regret that commenters perceived that we neglected to address this important issue. Our point in evaluating the DRG relative weights for the 10 DRGs that are currently included in the policy was to make the point that reducing the contribution of transfer cases in the DRG relative weight recalibration enhances the averaging mechanism for these DRGs. By treating transfer cases as less than a full discharge (reducing the denominator), we effectively inflate the charges (the numerator) to reflect the higher charges that would have occurred if the patient had been transferred. This increases, rather than decreases, the average charges (and thus the relative weights) for the affected DRGs.

For example, the DRG weights for each of these 10 DRGs declined over the 5-year period (FYs 1993 through 1998) immediately preceding the implementation of this policy. However, as shown in the table above, the DRG weights for all but three of these DRGs have increased during the 5-years since implementation of this policy. Payments for all cases in these DRGs were declining as the number of cases being transferred to postacute care increased and the average length of the inpatient acute stay decreased. However, since implementation of the policy, payments for the cases that are not implicated under this policy are rising in most of the 10 DRGs. In those DRGs where the relative weight has declined in over the 5-year period since implementation of this policy, the geometric mean length of stay has continued to decline.

As discussed above, the premise of the postacute care transfer policy is that hospitals have shifted some of the acute care formerly provided in the hospital into the postacute care setting. This distorts the averaging principle of the IPPS because the average case is now less expensive without a corresponding adjustment to the base rate. However, a high percentage of postacute care utilization by cases in a particular DRG does not, by itself, create a distortion, if the high postacute care utilization was also reflected in the calculation of the base rate.

Therefore, to ensure that any proposed expansion of the postacute care transfer policy did not improperly distort the averaging principles of the IPPS, we evaluated the change in the mean lengths of stay for the DRGs we proposed to add to the policy to identify those in which the high postacute care utilization is resulting in shorter lengths of stay and lower costs. These shorter stays represent a shift in the site (and costs) of care relative to the base period, and, thus, a distortion in the averaging principle of the IPPS.

Comment: Several commenters argued that the postacute care transfer policy is no longer necessary, as lengths of stay have stabilized and Medicare spending on postacute care has slowed. In particular, commenters pointed to the transition of postacute care provider types to prospective payment systems, which reduces the incentives for postacute care providers to agree to admit very sick patients from an acute care hospital. One commenter argued that the concept of duplicate payment for the same care is a misconception when both the acute and the postacute care providers are paid under a prospective payment system.

Commenters claimed the policy puts an undue burden on them to be required to track patients after they are discharged to another setting. They claimed this creates an ''unworkable'' situation for them by making hospitals track patients and requiring frequent payment and claim readjustments. They noted the relatively small payment impact for all hospitals (only 0.2 percent) compared to the administrative burden hospitals will incur to administer the expansion of the policy.

Response: We agree that postacute care providers are likely to be less willing to admit very sick patients under prospective payment systems than they were under cost reimbursement payment methodologies.

However, the incentives for acute care hospitals to reduce costs by transferring patients to a postacute care setting remain as strong as ever. Furthermore, duplicate payments would still exist if the acute care hospital is shifting costs for which it is paid under the IPPS to a postacute care provider; that is, receiving payment for the care under a prospective payment system (potentially at a rate even higher than its costs). Therefore, we believe there is still a need for the postacute care transfer policy, despite the adoption of prospective payment systems for most postacute care providers under Medicare. Similarly, it is appropriate to evaluate the need to expand the policy.

Comment: Commenters suggested that, under our proposed criterion for selecting additional DRGs to cover under the policy, we should apply the same criteria to the existing postacute care transfer DRGs as to the new proposed DRGs. These commenters pointed out that 7 of the 10 DRGs would not qualify under these criteria, and should no longer be included in the policy.

One commenter argued that DRG 209 should be removed from the current list of DRGs subject to the postacute care transfer policy because the rate of decline in the average length of stay for this DRG had fallen dramatically since its inclusion in the postacute care transfer policy.

In addition, one commenter applied the proposed criteria to more recent data and determined some of the DRGs proposed to be included in the policy no longer met all the criteria. Specifically, the commenter found that 11 of the 19 DRGs proposed to be included in the transfer policy fail to meet the criterion that at least 10 percent of the postacute care transfer cases occur prior to the geometric mean length of stay.

Several commenters also noted that it appears our analysis identifying the 19 DRGs that were proposed to be added to the list included transfers from IPPS-exempt units. The commenters added that these units are not subject to the postacute care transfer policy and should not have been included in the analysis. The commenters pointed out that DRG 462 (Rehabilitation) only qualifies as a result of the inclusion of transfers from IPPS-exempt units in the analysis.

Response: We do not believe it is necessary to evaluate whether the lengths of stay for the DRGs currently included in the policy are declining. One would expect that, to the extent patients were being transferred early in the episode of care to a postacute care setting in order to minimize costs to the acute care hospital (as opposed to a general shift in the clinical care for particular cases, which is more likely to result in a continued drop in the length of stay despite the inclusion of the DRG in the transfer policy), inclusion of a particular DRG in the postacute care transfer policy would be likely to stabilize the mean length of stay for the DRG. Therefore, we did not evaluate the current DRGs included in the policy to the 7-percent decline in the length of stay criterion.

We also note that included in the commenter's list of 11 DRGs that it claim did not meet the new criteria, 6 of these DRGs are paired DRGs and were not selected based on meeting the criteria, but rather were included due to the paired nature of the DRG.

We have analyzed the remaining 5 DRGs the commenter identified as having not met the criteria that at least 10 percent of all postacute care transfer cases occur before the geometric mean length of stay. However, it appears the commenter divided the total number of transfer cases by the total number of cases in the DRG, rather than dividing by the number of postacute care transfer cases. Using the data the commenter provided to us, we found that all but l DRG met the 10 percent short-stay transfer definition we had proposed, with one DRG being a pair to another DRG that does meet the criterion.

However, we do agree with the notion that, to be included in the postacute care transfer policy, DRGs currently included in the policy should continue to meet all of the other applicable criteria. In addition, concerns from the commenters encouraged us evaluate whether the variation from year to year might also needs to be accounted for in our new criteria. Therefore, in order to improve the year-to-year stability of all the DRGs included in the policy, in this final rule, we are adding the requirement that the criteria must be met during both of the 2 most recent years for which data are available. That is, to be included in the policy, a DRG must have, for both of the 2 most recent years for which data are available:

- At least 14,000 cases 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.

Applying these criteria, we determined that DRG 263 no longer qualifies (there were only 13,588 postacute care transfer cases in this DRG during FY 2002). In addition, this is a paired DRG with DRG 264. Therefore, for FY 2004, we are no longer including DRGs 263 and 264 in the postacute care transfer policy.

We also corrected the programming error noted by the commenters that allowed IPPS-exempt units to be included in the analysis. Removing these units from the analysis resulted in the exclusion of some DRGs that were proposed to be included in the policy, and the inclusion of some new DRGs. The table below displays all the DRGs that met the criteria during both of the 2 most recent years available (FYs 2001 and 2002), as well as their paired-DRG if one of the DRGs meeting the criteria includes a CC/no-CC split.

DRG	DRG title	DRG title care transfer cases	Percent of all cases transferred prior to mean length of stay	Percent change in mean length of stay FYs 1998–2003
12	Degenerative Nervous System Disorders	28,103	31.42	−12.00
14	Intracranial Hemorrhage and Stroke with Infarction	138,636	22.84	−5.88
24	Seizure and Headache Age >17 With CC	19,306	15.85	−7.69
25	Seizure and Headache Age >17 Without CC	4,695	10.46	−10.71
88	Chronic Obstructive Pulmonary Disease	95,249	24.88	−10.87
89	Simple Pneumonia nad Pleurisy Age >17 With CC	175,526	31.83	−11.11
90	Simple Pneumonia and Pleurisy Age >17 Without CC	47,987	12.51	−15.00
113	Amputation for Circulatory System Disorders Except Upper Limb and Toe	24,810	45.31	7.22
121	Circulatory Disorders With AMI and Major Complication, Discharged Alive	55,629	22.42	−11.67
122	Circulatory Disorders With AMI Without Major Complications Discharged Alive.	71,838	10.53	−23.08

DRG	DRG title	DRG title care transfer cases	Percent of all cases transferred prior to mean length of stay	Percent change in mean length of stay FYs 1998–2003
127	Heart Failure & Shock	196,581	24.18	−8.89
130	Peripheral Vascular Disorders With CC	29,859	21.92	−11.76
131	Peripheral Vascular Disorders Without CC	26,455	20.16	−19.51
209	Major Joint and Limb Reattachment Procedures of Lower Extremity	247,513	29.20	−15.09
210	Hip and Femur Procedures Except Major Joint Age >17 With CC	89,612	46.77	−6.15
211	Hip and Femur Procedures Except Major Joint Age >17 Without CC	20,584	21.89	−8.00
236	Fractures of Hip and Pelvis	24,633	11.26	−6.98
239	Pathological Fractures and Musculoskeletal and Connective Tissue Malignancy.	23,184	40.44	−7.55
277	Cellulitis Age >17 With CC	35,873	36.56	−7.84
278	Cellulitis Age >17 Without CC	31,857	13.24	−10.00
294	Diabetes Age >35	29,608	17.65	−15.00
296	Nutritional and Miscellaneous Metabolic Disorders Age >17 With CC	106,923	29.26	−9.30
297	Nutritional and Miscellaneous Metabolic Disorders Age >17 Without CC	48,116	7.25	−10.00
320	Kidney and Urinary Tract Infections Age >17 With CC	80,717	27.38	−8.51
321	Kidney and Urinary Tract Infections Age >17 Without CC	30,934	18.34	−13.89
395	Red Blood Cell Disorders Age >17	23,053	25.27	−11.11
429	Organic Disturbances and Mental Retardation	14,731	46.30	−12.96
468	Extensive O.R. Procedure Unrelated to Principal Diagnosis	25,114	41.26	7.07
483	Tracheotomy With Mechanical Ventilation 96 + Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses.	20,034	49.56	2.37

Transfers to postacute care from the DRGs listed in the above table will be included under this policy, effective for discharges occurring on or after October 1, 2003. As a result of our analysis in which we applied the new qualifying criteria, we removed DRG 263 and DRG 264 from the current list of 10 DRGs, and we removed DRG 243 and DRG 462 from the proposed list of additional 19 DRGs. However, we added four new DRGs (that were not included in our proposal) to the policy based on this analysis: DRG 88 (Chronic Obstructive Pulmonary Disease); DRG 127 (Heart Failure and Shock); DRG 294 (Diabetes Age >35); and DRG 395 (Red Blood Cell Disorders, Age >17). We will review and update this list periodically to assess whether additional DRGs should be added or existing DRGs should be removed.

Comment: One commenter contested the automatic inclusion of both DRGs in a paired-DRG combination. The commenter believed any incentive for hospitals not to include a code that would identify a complicating or comorbid condition would be very limited and would have negligible effect on hospital behavior. However, the commenter asserted that if CMS is going to include both DRGs in a paired-DRG combination, CMS must combine the data for the two DRGs when applying the selection criteria.

Response: We include both DRGs from a paired-DRG combination because if we were to include only the ''with CC'' DRG from a ''with/without CC'' DRG combination in the transfer policy, there would be an incentive for hospitals not to include any code that would identify a complicating or comorbid condition. We believe our approach of identifying either DRG from a paired-DRG combination individually for inclusion in the policy is appropriate.

Comment: One commenter argued that DRG 468 should not be included in the policy because of the variation in the types of cases included in this DRG. The commenter pointed out that the cases in the DRG are, by definition, atypical, and the average lengths of stay for procedures included in this DRG vary widely. The commenter noted that ''every year CMS makes changes to the list of procedures that are assigned to this DRG. Therefore, a comparison of length of stay over time is not valid because the types of cases in the DRG change every year. The criterion that length of stay must have decreased by 7 percent compared to 1998 cannot be applied to DRG 468.'' The commenter added that application of a per diem payment based on a mean length of stay to a DRG that contains such a wide variety of different types of cases will result in extreme inequities.

One commenter argued for the exclusion of DRG 483 from the policy. The commenter argued that due to the large variation of lengths of stay for treatments in this DRG, the transfer policy has a very significant impact on payment for these cases that is unrelated to the use of postacute care.

Response: We disagree that DRG 468 should be excluded from the policy because of the variation in the types of cases within this DRG. Over 40 percent of transfers to postacute care within this DRG occurred before the geometric mean length of stay. Although it is true the nature of this DRG makes it difficult to assess whether there is a trend to shift care out of the acute care setting into the postacute care setting or there is just a different mix of cases being assigned to this DRG, we believe it is equitable to adjust payments for short-stay cases transferred to postacute care within this DRG. As noted above, application of this policy in the DRG recalibration process results in an overall increase in the payments for other cases in the DRG. Given the heterogeneous nature of this DRG, we believe this is appropriate.

We have addressed similar concerns in the past with respect to the inclusion of DRG 483 in this policy.

Comment: One comment noted that DRGs 121 and 122 should be included in the special payment provision due to the fact that ''these cases receive the most resource intensive services within the first day of the stay due to the acute nature of a myocardial infarction * * * [including care in] intensive care units, costly IV drug infusions, and multiple tests and monitoring.''

Response: Based on the revised list of DRGs that meet the criteria as described above, we analyzed which of these DRGs qualified for the special payment methodology. The only DRGs that had charges for short-stay transfer cases on the first day of stay that were greater than 50 percent of the average charges of all cases across the DRG were DRGs 209 and 211 (71 percent and 57 percent, respectively). Because DRG 211 is paired with DRG 210, we included DRG 210 in the payment policy as well (our analysis showed that short-stay transfer cases had 40 percent of costs on the first

day of the stay compared to costs for all cases across the DRG). However, DRGs 121 and 122 did not meet the 50 percent threshold.

Comment: Commenters again noted their objection to the expansion of the policy to all DRGs, even though we did not propose to expand the policy to all DRGs at this time. They refer to the language in section 1886(d)(J) of the Act that states that only those DRGs that have a ''high volume of discharges'' and ''disproportionate use of post discharge services'' could be included in an expanded postacute care transfer policy. Since this language would not apply to many DRGs, it makes this possibility ''implausible.''

Commenters also argue that, since we admit we need to do further analysis before expanding the policy to all DRGs, it is unclear why we do not need to conduct further analysis to make an incremental expansion.

Response: As noted previously, we did not propose to expand this policy to all DRGs because, for some DRGs, it may not be appropriate to reduce payment for these DRGs if the base payment already reflects a similar postacute care utilization rate. For the 29 DRGs included in the policy effective October 1, 2003, we have determined the data indicate there is substantial utilization of postacute care early in the stay, leading to decreasing lengths of stay.

Comment: Other commenters noted that, if we were focusing our efforts on analyzing lengths of stay in this manner, we should redirect our focus instead on a more thorough analysis of length of stay in particular regions to determine if changes are being adequately reflected in the yearly updates.

Response: We recognize that lengths of stay have tended to vary by region, and that regions with shorter lengths of stay tend to also have lower average costs due to the fewer number of days that patient spend in the hospitals. One of the reasons for the variation is the greater reliance on postacute care earlier in the stay in those areas with lower average lengths of stay.

We do not believe it would be appropriate to base the transfer payment methodology on regional average lengths of stay. The national standardized amounts, which apply across all regions, reflect costs and lengths of stay across all regions. To the extent hospitals in one area of the country are transferring patients early in the course of their treatment while hospitals in another part of the country are providing the entire treatment in the acute care hospital, adjusting payments for those hospitals transferring patients early in the stay and reflecting this in the process of recalibration maintains full DRG payments for hospitals in areas of the country providing the full course of treatment in the acute care hospital.

B. Rural Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria 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 amount rather than the rural standardized amount. Although the other urban and rural standardized amounts are the same for discharges beginning with that date, rural referral centers continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Rural referral centers with a disproportionate share percentage of at least 30 percent are not subject to the 5.25 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 mean case-mix index value for FY 2004 in the May 19, 2003 proposed rule included all urban hospitals nationwide, and the proposed regional values for FY 2004 were 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 were based on discharges occurring during FY 2002 (October 1, 2001 through September 30, 2002) and included bills posted to CMS' records through December 2002.

In the May 19, 2003 proposed rule, we proposed 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, 2003, rural hospitals with fewer than 275 beds must have a case-mix index value for FY 2002 that is at least—

- 1.3374; 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. (See the table set forth in the May 19, 2003 proposed rule at 68 FR 27201.)

Based on the latest data available (FY 2002 bills received through March 2003), in addition to meeting other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2003, must have a case-mix index value for FY 2003 that is at least—

- 1.3373; 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 final 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)	1.2245
2. Middle Atlantic (PA, NJ, NY)	1.2262
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3146
4. East North Central (IL, IN, MI, OH, WI)	1.2489
5. East South Central (AL, KY, MS, TN)	1.2511
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1841
7. West South Central (AR, LA, OK, TX)	1.2705
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3482
9. Pacific (AK, CA, HI, OR, WA)	1.2845

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. In the May 19, 2003 proposed rule, we proposed to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2002 (that is, October 1, 2001 through September 30, 2002).

Therefore, in the May 19, 2003 proposed rule, we proposed 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, 2003, must have as the number of discharges for its cost reporting period that began during FY 2002 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. (See the table set forth in the May 19, 2003 proposed rule at 68 FR 27201.)

Based on the latest discharge data available for FY 2002, the final median number of discharges for urban hospitals by census region area are as follows:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	7,476
2. Middle Atlantic (PA, NJ, NY)	8,906
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	9,497
4. East North Central (IL, IN, MI, OH, WI)	8,439
5. East South Central (AL, KY, MS, TN)	6,894
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	3,991
7. West South Central (AR, LA, OK, TX)	7,629
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8,908
9. Pacific (AK, CA, HI, OR, WA)	7,021

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, 2003, the hospital must have at least 3,000 discharges for its cost reporting period that began during FY 2002.

We did not receive any comments on the criteria for rural referral centers.

C. Indirect Medical Education (IME) Adjustment (§ 412.105) and Disproportionate Share Hospital (DSH) Adjustment (§ 412.105)

1. Available Beds and Patient Days: Background (§ 412.105(b) and § 412.106(a)(1)(ii))

Section 1886(d)(5)(B) of the Act provides that subsection (d) hospitals that have residents in approved graduate medical education (GME) programs receive an additional payment for each discharge of Medicare beneficiaries to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The existing regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105. The additional payment is based on the IME adjustment factor, calculated using hospitals' ratios of residents to beds. The determination of the number of beds, based on available bed days, is specified at § 412.105(b). This determination of the number of available beds is also applicable for other purposes, including the level of the disproportionate share hospital (DSH) adjustment payments under § 412.106(a)(1)(i).

Section 1886(d)(5)(F) of the Act specifies two methods for a hospital to qualify for the Medicare DSH adjustment. The primary method, which is a subject of this final rule, is for a hospital to qualify based on a complex statutory formula under which payment adjustments are based on the level of the DSH patient percentage. 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 adjustments for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, hospitals that qualify as rural referral centers or SCHs, and other hospitals.

As described in the May 19, 2003 proposed rule, we are combining in this final rule our discussion of changes to the policies for counting beds and patient days, in relation to the calculations at §§ 412.105(b) and 412.106(a)(1) because the underlying concepts are similar, and we believe they should generally be interpreted in a consistent manner for both purposes. Specifically, we proposed to clarify that

beds and patient days that are counted for these purposes should be limited to beds or patient days in hospital units or wards that would be directly included in determining the allowable costs of inpatient hospital care payable under the IPPS on the Medicare cost reports. As a preliminary matter, beds, and patient days associated with these beds, that are located in units or wards that are excluded from the IPPS (for example, psychiatric or rehabilitation units), and thus from the determination of allowable costs of inpatient hospital care under the IPPS on the Medicare cost report, are not to be counted for purposes of §§ 412.105(b) and 412.106(a)(1).

The remainder of this discussion pertains to beds and patient days in units or wards that are not excluded from the IPPS and for which costs are included in determining the allowable costs of inpatient hospital care under the IPPS on the Medicare cost report. For example, neonatal intensive care unit beds are included in the determination of available beds because the costs and patient days associated with these beds are directly included in the determination of the allowable costs of inpatient hospital care under the IPPS. In contrast, beds, and patient days associated with the beds, that are located in excluded distinct-part psychiatric or rehabilitation units would not be counted for purposes of §§ 412.105(b) and 412.106(a)(1) under any circumstances, because the costs associated with those units or wards are excluded from the determination of the costs of allowable inpatient care under IPPS.

This policy has been upheld in the past by various courts. (*See,* for example, *Little Co. of Mary Hospital and Health Care Centers* v. *Shalala*, 165 F.3d 1162 (7th Cir. 1999; *Grant Medical Center* v. *Shalala*, 905 F. Supp. 460 (S.D. Ohio 1995); *Sioux Valley Hospital* v. *Shalala*, No. 93–3741SD, 1994 U.S. App. LEXIS 17759 (8th Cir. July 20, 1996) (unpublished table decision); *Amisub* v. *Shalala*, No. 94–1883 (TFH) (D.D.C. December 4, 1995) (mem.).) In these cases, the courts agreed with the Secretary's position distinguishing between the treatment of neonatal intensive care unit beds and well-baby nursery beds based on the longstanding policy of CMS that neonatal intensive care unit days are considered intensive care days (part of inpatient routine care) rather than nursery days.

Our policies on counting beds are applied consistently for both IME and DSH although the incentives for hospitals can be different for IME and DSH. For purposes of IME, teaching hospitals have an incentive to minimize their number of available beds in order to increase the resident-to-bed ratio and maximize the IME adjustment. On the other hand, for DSH purposes, urban hospitals with under 100 beds and rural hospitals with under 500 beds may have an incentive to increase their bed count in order to qualify for the higher DSH payments for urban hospitals with over 100 beds or rural hospitals with over 500 beds.

However, some courts have applied our current rules in a manner that is inconsistent with our current policy and that would result in inconsistent treatment of beds, patient days, and costs. For example, in *Clark Regional Medical Center* v. *United States Department of Health & Human Services*, 314 F.3d 241 (6th Cir. 2002), the court upheld the district court's ruling that all bed types not specifically excluded from the definition of available bed days in the regulations must be included in the count of available bed days. Similarly, in a recent decision in the Ninth Circuit Court of Appeals (*Alhambra* v. *Thompson*, 259 F.3d 1071 (Ninth Cir. 2001), the court ruled that days attributable to groups of beds that are not separately certified as distinct part beds (that is, nonacute care beds in which care provided is at a level below the level of routine inpatient acute care) but are adjacent to or in an acute care ''area'' are included in the ''areas of the hospital that are subject to the prospective payment system'' and should be counted in calculating the Medicare DSH patient percentage.

These courts considered subregulatory guidance (program instructions) in formulating their decisions. Although this final rule clarifies the underlying principles for our bed and patient days counting policies and amends the relevant regulations to be consistent with these clarifications, we recognize the need to revise some of our program instructions to make them fully consistent with these clarifications and will act to do so as soon as possible.

While some of the topics discussed below pertain only to counting available beds (unoccupied beds) and some only to counting patient days (section 1115 waiver days, dual-eligible days, and Medicare+Choice days), several important topics are applicable to both bed-counting and day-counting policies (nonacute care beds and days, observation beds and days, and swing-beds and days). Therefore, for ease of discussion, we have combined all topics pertaining to counting available beds and patient days together in the following discussion.

Comment: One commenter expressed concern about our policy to use the same definition of beds for IME and DSH. The commenter argued that Congress used different terminology to define the types of beds that should be used for these two payment adjustments. Section 1886(d)(5)(B)(vi)(I) of the Act indicates the IME adjustment is to be based on ''the hospital's available beds (as defined by the Secretary).'' For purposes of the DSH adjustment, section 1886(d)(5)(F)(v) of the Act simply refers to the number of ''beds'' in the hospital. The commenter believed that, because the Act does not narrow the bed count for DSH purposes to those that are available, it is unlawful and inappropriate for CMS to use the available bed definition for DSH purposes.

Response: We believe both statutory references cited by the commenter provide the Secretary with administrative discretion to define beds, one explicitly and one implicitly. In light of this discretion, we strongly believe it is important to apply a consistent definition for purposes of both IME and DSH adjustments, particularly because many hospitals receive both types of adjustments. We note that we have used available beds for purposes of determining whether hospitals qualify for DSH payments Congress directed us to make this adjustment in 1988. Since that time, Congress has amended the DSH provisions in the Act on numerous occasions, and certainly could have made clear its intention that we not use available beds for DSH purposes if that was its intent. Therefore, we disagree with this comment.

2. Unoccupied Beds

We are still reviewing the large number of comments on our proposal on unoccupied beds in the May 19, 2003 proposed rule. Due to the number and nature of the comments we received on our proposed policy, we are addressing the public comments in a separate document. We refer individuals who are interested in reviewing the background information and discussion of the proposed policy to the May 19, 2003 proposed rule (68 FR 37202 through 37204).

3. Nonacute Care Beds and Days

As noted above, our policies for counting beds are generally consistent with the method of reporting patient days for the purpose of calculating the costs of hospital inpatient care in individual cost centers on the Medicare cost report. Furthermore, since the IME and DSH adjustments are part of the

IPPS, we read the statutory references to beds and days to apply only to inpatient beds and days.

Under the existing provisions of § 412.105(b), the regulations specifically exclude beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units as types of beds excluded from the count of available beds.

Existing regulations at § 412.106(a)(1)(ii) state that the number of patient days used in the DSH percentage calculation includes only those days attributable to areas of the hospital that are subject to the IPPS and excludes all others. This regulation was added after being proposed in the March 22, 1988 **Federal Register** (53 FR 9339), and made final in the September 30, 1988 **Federal Register** (53 FR 38479). At that time, we indicated that, ''based on a reading of the language in section 1886(d)(5)(F) of the Act, which implements the disproportionate share provision, we are in fact required to consider only those inpatient days to which the prospective payment system applies in determining a prospective payment hospital's eligibility for a disproportionate share adjustment.'' Using this reasoning, we stated that the DSH patient percentage calculation should only include patient days associated with the types of services paid under the IPPS.

As noted previously, a recent decision in the Ninth Circuit Court of Appeals (*Alhambra* v. *Thompson*) ruled that days attributable to groups of beds that are not separately certified as distinct part beds (that is, nonacute care beds in which care provided is generally at a level below the level of routine inpatient acute care), but are adjacent to or in an acute care ''area,'' are included in the ''areas of the hospital that are subject to the prospective payment system'' and should be counted in calculating the Medicare DSH patient percentage.

In light of the Ninth Circuit decision that our rules were not sufficiently clear to permit exclusion of bed days based on the area where the care is provided, in the May 19, 2003 proposed rule, we proposed to revise our regulations to be more specific. Therefore, we proposed to clarify that beds and patient days are excluded from the calculations at § 412.105(b) and § 412.106(a)(1)(ii) if the nature of the care provided in the unit or ward is inconsistent with what is typically furnished to acute care patients, regardless of whether these units or wards are separately certified or are located in the same general area of the hospital as a unit or ward used to provide an acute level of care. Although the intensity of care may vary within a particular unit, such that some patients may be acute patients while others are nonacute, believe that a patient-by-patient, day-by-day review of whether the care received would be paid under the IPPS would be unduly burdensome. Therefore, we believe it is more practical to apply this principle (that is, that we should consider only the inpatient days to which the IPPS applies) by using a proxy measure that is based upon the location at which the services were furnished.

In particular, we proposed to revise our regulations to clarify that the beds and patient days attributable to a nonacute care unit or ward should not be included in the calculations at § 412.105(b) and § 412.106(a)(1)(ii), even if the unit is not separately certified by Medicare as a distinct-part unit and even if the unit or ward is within the same general location of the hospital as areas that are subject to the IPPS (that is, a unit that provides an IPPS level of care is on the same floor of the hospital as a subacute care unit that does not provide an IPPS level of care).

Exceptions to this policy to use the level of care generally provided in a unit or ward as proxy for the level of care provided to a particular patient on a particular day are outpatient observation bed days and swing-bed days, which are excluded from the count of available bed days even if the care is provided in an acute care unit. Our policies pertaining to these beds and days are discussed further below. Another exception is healthy newborn nursery days. The costs, days, and beds associated with a healthy newborn nursery are excluded from inpatient calculations for Medicare purposes. Meanwhile, for the purpose of computing the Medicaid patient share computation of the DSH patient percentages, these days are included both as Medicaid patient days and as total patient days. Newborn nursery costs, days, and beds are treated this way because the costs are not directly included in calculating Medicare hospital inpatient care costs because Medicare does not generally cover services for infants. However, Medicaid does offer extensive coverage to infants, and nursery costs would be directly included in calculating Medicaid hospital inpatient care costs. Therefore, these costs, days, and beds are excluded for Medicare purposes, but included for determining the Medicaid DSH percentage. (This policy was previously communicated through a memorandum to CMS Regional Offices on February 27, 1997.)

Generally, as discussed previously, if the nature of the care provided in the unit or ward is consistent with what is typically furnished to acute care patients, and, therefore, would be characteristic of services paid under the IPPS, the patient days, beds, and costs of that unit or ward would be classified as inpatient acute care (except for observation bed days and swing bed days, as discussed later in this preamble). Conversely, if the intensity and type of care provided in the unit or ward are not typical of a service that would be paid under the IPPS (for example, nonacute care), we proposed that the beds and patient days attributable to a nonacute care unit or ward should not be included in the calculations of beds and patient days at § 412.105(b) and § 412.106(a)(1)(ii).

The proposed policy is not intended to focus on the level or type of care provided to individual patients in a unit, but rather on the level and type of care provided in the unit as a whole. For example, the bed days for a patient participating in an experimental procedure that is not covered under the IPPS should be counted as long as the patient is treated in a unit of the hospital that generally provides acute inpatient care normally payable under the IPPS. The expectation is that a patient located in an acute care unit or ward of the hospital is receiving a level of care that is consistent with what would be payable under the IPPS.

There are instances where services that are provided in units excluded from the IPPS (such as rehabilitation and psychiatric distinct-part units) are also consistent with the level of care that would qualify for payment under the IPPS. However, §§ 412.105(b) and 412.106(a)(1)(ii) specifically exclude the beds and patient days associated with these excluded units. That exclusion is because the costs of care provided in these units are paid outside the IPPS, even though some of the care provided may be of a type that would be payable under the IPPS if the care was provided in an IPPS unit.

We proposed to revise § 412.105(b) to clarify that beds in units or wards established or used to provide a level of care that is not consistent with care that would be payable under the IPPS cannot be counted. We also proposed to revise the DSH regulations at § 412.106(a)(1)(ii) to clarify that the number of patient days includes only those attributable to patients that receive care in units or wards that generally furnish a level of care that would generally be payable under the IPPS.

We note the proposed revisions were clarifications of our regulations to

reflect our longstanding interpretation of the statutory intent, especially relating to the calculation of the Medicare DSH patient percentage.

Comment: Several commenters objected to our proposal and indicated that we were attempting to codify the Secretary's litigation position in *Alhambra* and administratively overrule the Ninth Circuit's decision in that case. Commenters asserted that the flaw in the proposal is that it is inconsistent with the Act to base the Medicaid days calculation of the DSH patient percentage on whether or not Medicare pays for the services that are generally provided within a unit. Specifically, commenters believed the proposal would restrict the definition of patient days in a way that is not authorized by the Act.

Response: We disagree that our proposed clarification is inconsistent with the statute. First, the clarification is merely a codification of the Secretary's longstanding policy. In addition, we believe that interpreting the statute as we have historically done is reasonable and permissible. Section 1886(d)(5)(F)(vi)(II) of the Act governs the portion of the disproportionate share percentage made up of the percentage of patient days used by patients eligible for medical assistance under a title XIX State plan. Specifically, section 1886(d)(5)(F)(vi)(II) of the Act states that the numerator of such fraction equals the ''number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, but who were not entitled to benefits under part A of this title.'' The statute does not define the term ''hospital's patient days.'' Thus, the statute is ambiguous, and the Secretary has the authority to reasonably interpret that term.

We note that although the calculation performed under section 1886(d)(5)(F)(vi)(II) of the Act includes a count of patient days used by Medicaid-eligible individuals, the calculation actually is used to determine how much additional payment the hospital should receive under Medicare for the higher Medicare costs associated with treating a disproportionate share of low-income individuals. This point is demonstrated in the rationale for establishing the DSH adjustment as described in the Committee Report accompanying Pub. L. 99–272: ''Hospitals that serve a disproportionate share of low-income patients have higher Medicare costs per case'' (H. Rept. No. 99–242(I), 99th Cong., 2d Sess., (1985), p. 16).

Furthermore, we view section 1886(d)(5)(F)(vi)(II) of the Act as purely a Medicare, inpatient hospital provision, given that there already exists a distinct formula for computing DSH payments under title XIX—the Medicaid title. Because the DSH formula in title XVIII of the Act is intended to provide an add-on payment to inpatient hospitals for additional amounts they incur in treating low-income, Medicare patients, we believe it is reasonable to count only those days spent in wards or units that would generally provide an acute level of care.

We believe it is reasonable to interpret the phrase, ''hospital's patient days,'' to mean only the hospital's inpatient days at a level of care that would be covered under the IPPS as a means to determine an IPPS payment adjustment. Further, we believe that it is administratively inefficient and impracticable to calculate a hospital's inpatient days based on a determination, on a day-by-day basis, of whether a particular patient in a particular inpatient bed is receiving a level of care that would be covered under the IPPS. Therefore, we proposed to use, as a proxy, the level of care that is generally provided in particular units or wards, and to exclude patient days attributable to units or wards in which care delivered is not generally of a type that would be covered under the IPPS.

We also do not believe that by placing our longstanding interpretation of our rules in regulations we are unlawfully overruling or nullifying the decision by the Ninth Circuit in *Alhambra Hospital* v. *Thompson*, 259 F.3d 1071 (9th Cir. 2001). The Ninth Circuit decision focused on an interpretation of CMS' previous regulation at § 412.106(a)(1)(ii)—not on an interpretation of the statute. (For example, when the court stated the ''Standard of Review'' it would use to decide the case, it referred only to ''[o]ur review of an agency's interpretation of its own regulations.'' *Alhambra* at 1074). Although we respectfully disagree with the Ninth Circuits interpretation of the existing regulations, we are nonetheless amending them, through notice and comment rulemaking to ensure that going forward the regulations clearly reflect our longstanding position. Therefore, we do not agree with the commenter's assertion that our proposed policy is an illegal attempt to administratively overrule the Ninth Circuit's decision in *Alhambra.* Therefore, going forward, we plan to apply the clarified regulation to hospitals in all U.S. jurisdictions, including hospitals in the Ninth Circuit.

4. Observation Beds and Swing-Beds

Observation services are those services furnished by a hospital on the hospital's premises that include use of a bed and periodic monitoring by a hospital's nursing or other staff in order to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient. When a hospital places a patient under observation but has not formally admitted him or her as an inpatient, the patient initially is treated as an outpatient. Consequently, the observation bed days are not recognized under the IPPS as part of the inpatient operating costs of the hospital.

Observation services may be provided in a distinct observation bed area, but they may also be provided in a routine inpatient care unit or ward. In either case, our policy is the bed days attributable to beds used for observation services are excluded from the counts of available bed days and patient days at §§ 412.105(b) and 412.106(a)(1)(ii). This policy was clarified in a memorandum that was sent to all CMS Regional Offices (for distribution to fiscal intermediaries) dated February 27, 1997, which stated that if a hospital provides observation services in beds that are generally used to provide hospital inpatient services, the days that those beds are used for observation services should be excluded from the available bed day count (even if the patient is ultimately admitted as an acute inpatient).

A swing-bed is a bed that is otherwise available for use to provide acute inpatient care and is also occasionally used to provide SNF-level care. The criteria for a hospital to meet the requirements to be granted an approval from CMS to provide posthospital extended care services are located under § 482.66, and for a swing-bed CAH under § 485.645. Under § 413.114(a)(1), payment for posthospital SNF care furnished in swing-beds is in accordance with the provisions of the prospective payment system for SNF care (effective for services furnished in cost reporting periods beginning on and after July 1, 2002). Similar to observation beds and patient days, swing-beds and patient days are excluded from the counts of available bed days and patient days at §§ 412.105(b) and 412.106(a)(1)(ii) when the swing-bed is used to furnish SNF care.[7]

Observation beds and swing-beds are both special, frequently temporary, alternative uses of acute inpatient care

[7] Ibid.

beds. That is, only the days an acute inpatient care unit or ward bed is used to provide outpatient observation services are to be deducted from the available bed count under § 412.105(b). Otherwise, the bed is considered available for acute care services (as long as it otherwise meets the criteria to be considered available). This same policy applies for swing-beds. The policies to exclude observation bed days and swing-bed days as described above stem from the fact that these days are not payable under the IPPS.

Some hospitals have contested our policy excluding swing-beds and patient days and observation beds and patient days under existing §§ 412.105(b) and 412.106(a)(1)(ii). For example, in *Clark Regional Medical Center* v. *United States Department of Health & Human Services,* 314 F.3d 241 (6th Cir. 2002), the court upheld the district court's ruling that all bed types not specifically excluded from the definition of available bed days in the regulations must be included in the count of available bed days. The hospitals involved in this decision wanted to include observation and swing-bed days in their bed count calculation in order to qualify for higher DSH payments as available to hospitals with more than 100 beds. The Court found that ''the listing of beds to be excluded from the count restricts the class of excluded beds only to those specifically listed.'' Because observation beds and swing-beds are not currently specifically mentioned in § 412.105(b) as being excluded from the bed count, the Court ruled that these beds must be included in the count.

The list of the types of beds excluded from the count under existing § 412.105(b) was never intended to be an exhaustive list of all of the types of beds to be excluded from the bed count under this provision. In fact, over the years, specific bed types have been added to the list as clarifications of the types of beds to be excluded, not as new exclusions (see the September 1, 1994 **Federal Register** (59 FR 45373) and September 1, 1995 **Federal Register** (60 FR 45810), where we clarified exclusions under our policy that were not previously separately identified in the regulation text).

Although the Court in *Clark* found that Congress had not explicitly ''addressed the question of whether swing and observation beds should be included in the count of beds in determining whether a hospital qualifies for the DSH adjustment,'' Clark, 314 F.3d at 245, the Court found that observation and swing-bed days were included under the ''plain meaning'' of the regulation text at § 412.106(a)(1)(ii), which reads: ''The number of patient days includes only those days attributable to areas of the hospital that are subject to the prospective payment system and excludes all others.'' However, the preamble language of the rule that promulgated the regulatory provision at § 412.106(a)(1)(ii) clarified its meaning (53 FR 38480, September 30, 1988):

''Although previously the Medicare regulations did not specifically define the inpatient days for use in the computation of a hospital's disproportionate share patient percentage, we believe that, based on a reading of the language in section 1886(d)(5)(F) of the Act, which implements the disproportionate share provision, we are in fact required to consider only those inpatient days to which the prospective payment system applies in determining a prospective payment hospital's eligibility for a disproportionate share adjustment.''

Our policy excluding outpatient observation and swing-bed days is consistent with this regulatory interpretation of days to be counted under § 412.106(a)(1)(ii). That is, the services provided in these beds are not payable under the IPPS (unless the patient is admitted, in the case of observation bed days).

As outlined previously, our consistent and longstanding policy, which has been reviewed and upheld previously by several courts, including the United States District Court for the District of Columbia in *Amisub* v. *Shalala,* is based on the principle of counting beds in generally the same manner as the patient days and costs are counted. Our policy to exclude observation and swing-bed days under the regulations at § 412.105(b) and § 412.106(a)(1) stems from this policy.

In the May 19, 2003 proposed rule, although we reiterated our longstanding policy that observation beds and swing bed days generally are excluded, we proposed to amend our policy with respect to observation bed days of patients who ultimately are admitted. We are still in the process of reviewing the comments and defer action until a later rule with respect this issue—for example, patients in observation beds who are ultimately admitted to the hospital.

Comment: Some commenters objected to the exclusion of observation bed days from the available bed days count on the grounds that it is a flawed premise that the size of a hospital's bed complement should be impacted by the payment policy classification of the services provided to the patient. That is, a bed should not be excluded from the available bed day count because it is used to provide services not payable under the IPPS on a particular day.

Response: When the application of IPPS payment policy is dependent on a determination of a hospital's number of beds, it seems reasonable to base that determination on the portion of the hospital that generates the costs that relate to those IPPS payments. As stated above, our bed counting policies start with the premise that the treatment of beds should be consistent with the treatment of the patient days and the costs of those days on the Medicare cost report. Therefore, we continue to believe it is appropriate to exclude outpatient observation bed days, even when the beds used to provide that service is located in a routine inpatient care unit or ward.

5. Labor, Delivery, and Postpartum Beds and Days

Prior to December 1991, Medicare's policy on counting days for maternity patients was to count an inpatient day for an admitted maternity patient in the labor/delivery room at the census taking hour. This is consistent with Medicare policy for counting days for admitted patients in any other ancillary department at the census-taking hour. However, based on decisions adverse to the government regarding this policy in a number of Federal courts of appeal, including the United States Court of Appeals for the District of Columbia Circuit, the policy regarding the counting of inpatient days for maternity patients was revised to reflect our current policy.

Our current policy regarding the treatment of labor and delivery bed days is described in Section 2205.2 of the PRM, which states that a maternity inpatient in the labor/delivery room at midnight is not included in the census of inpatient routine care if the patient has not occupied an inpatient routine bed at some time since admission. For example, if a Medicaid patient is in the labor room at the census and has not yet occupied a routine inpatient bed, the bed day is not counted as a routine bed day of care in Medicaid or total days and, therefore, is not included in the counts under existing §§ 412.105(b) and 412.106(a)(1)(ii). If the patient is in the labor room at the census but had first occupied a routine bed, a routine inpatient bed day is counted, in Medicaid and total days, for DSH purposes and for apportioning the cost of routine care on the cost report (consistent with our longstanding policy to treat days, costs, and beds similarly).

Increasingly, hospitals are redesigning their maternity areas from separate labor and delivery rooms, and postpartum rooms, to single multipurpose labor, delivery, and postpartum (LDP) rooms. In order to appropriately track the days and costs associated with LDP rooms, it is necessary to apportion them between the labor and delivery cost center, which is an ancillary cost center and the routine adults and pediatrics cost center. This is done under our policy by determining the proportion of the patient's stay in the LDP room that the patient was receiving ancillary services (labor and delivery) as opposed to routine adult and pediatric services (postpartum).

An example of this would be if 25 percent of the patient's time in the LDP room was for labor/delivery services and 75 percent for routine care, over the course of a 4-day stay in the LDP room. In that case, 75 percent of the time the patient spent in the LDP room is applied to the routine inpatient bed days and costs (resulting in 3 routine adults and pediatrics bed days for this patient, 75 percent of 4 total days). For purposes of determining the hospital bed count, the time that the beds are unoccupied should be counted as available bed days using an average percentage (for example, 75 percent adults and pediatrics and 25 percent ancillary) based on all patients. In other words, in this example, 75 percent of the days the bed is unoccupied would be counted in the available bed count.

We realize that it may be burdensome for a hospital to determine for each patient in this type of room the amount of time spent in labor/delivery and the amount of time spent receiving routine care. Alternatively, the hospital could calculate an average percentage of time patients receive ancillary services, as opposed to routine inpatient care in the LDP room(s) during a typical month, and apply that percentage through the rest of the year.

Comment: Some commenters stated that the LDP days that patients spend in routine inpatient wards of hospitals prior to the day those patients give birth are in areas of the hospital where routine inpatient beds are located, and they are not excluded from the IPPS. Therefore, the commenters asserted that these days should be counted in the patient days and available bed days counts. Commenters also pointed out the LDP days are in licensed beds, and argued that these days should be counted in their entirety.

Other commenters supported our proposal to allow calculation of an average percentage of time LDP patients spend in labor/delivery compared to postpartum to be used to apportion LDP days. Commenters commended CMS for recognizing the cumbersome recordkeeping and reporting that would otherwise be required.

One commenter suggested that it is not necessary for our policy applicable to counting patient days for purposes of the DSH computation to comply with other Medicare cost reporting policies, such as the need to separately allocate the ancillary costs associated with LDP rooms. The commenter cited prior PRRB appeals in which CMS took this position.

Response: As we previously stated above and in the proposed rule, initially, Medicare's policy did count an inpatient day for an admitted maternity patient even if the patient was in the labor/delivery room at the census-taking hour. However, based on adverse court decisions, the policy was revised to state that the patient must first occupy an inpatient routine bed before being counted as an inpatient. With the development of LDP rooms, we found it necessary to apply this policy consistently in those settings, in order to appropriately apportion the costs between labor and delivery ancillary services and routine inpatient care.

Although we have not previously formally specified in guidance or regulations the methodology for applying this policy to LDP rooms, this is not a new policy. However, as suggested by the commenters, we believe this policy may not have been applied consistently. Therefore, we believe it is important to clarify the policy as part of our discussion of our policies pertaining to counting patient bed days.

We continue to believe the LDP apportionment described above is an appropriate policy and does not, in fact, impose a significant additional burden because hospitals are already required to allocate cost on the cost report between ancillary and routine costs. In addition, this allocation is already required to be consistent with our treatment of costs, days, and beds and is consistent with our other patient bed day policies. Therefore, this policy will be applied to all currently open and future cost reports. However, it is not necessary to reopen previously settled cost reports to apply this policy.

6. Days Associated With Demonstration Projects Under Section 1115 of the Act

Some States extend medical benefits to a given population that could not have been made eligible for Medicaid under a State plan amendment under section 1902(r)(2) or section 1931(b) of the Act under a section 1115(a)(2) demonstration project (also referred to as a section 1115 waiver). These populations are specific, finite populations identifiable in the award letters and special terms and conditions apply to the demonstrations.

On January 20, 2000, we issued an interim final rule with comment period (65 FR 3136), followed by a final rule issued on August 1, 2000 (65 FR 47086 through 47087), to allow hospitals to include the patient days of all populations that receive benefits under a section 1115 demonstration project in calculating the Medicare DSH adjustment. Previously, hospitals were to include only those days for populations under the section 1115 demonstration project who were, or could have been made, eligible under a State plan. Patient days of those expansion waiver groups who could not be made eligible for medical assistance under the State plan were not to be included for determining Medicaid patient days in calculating the Medicare DSH patient percentage. Under the January 20, 2000 interim final rule with comment period (65 FR 3137), hospitals could include in the numerator of the Medicaid fraction those patient days for individuals who receive benefits under a section 1115 expansion waiver demonstration project (effective with discharges occurring on or after January 20, 2000).

In the January 20, 2000 interim final rule with comment period, we explained that including the section 1115 expansion populations ''in the Medicare DSH calculation is fully consistent with the Congressional goals of the Medicare DSH adjustment to recognize the higher costs to hospitals of treating low-income individuals covered under Medicaid.''

Since that revision, we have become aware that there are certain section 1115 demonstration projects that serve expansion populations with benefit packages so limited that the benefits are not similar to the medical assistance available under a Medicaid State plan. These section 1115 demonstration projects extend coverage only for specific services and do not include inpatient care in the hospital. Because of the limited nature of the coverage offered, the population involved may have a significantly higher income than traditional Medicaid beneficiaries.

In allowing hospitals to include patient days related to section 1115 expansion waiver populations, our intention was to include patient days of section 1115 expansion waiver populations who receive benefits under the demonstration project that are similar to those available to traditional

Medicaid beneficiaries, including inpatient benefits. Because of the differences between expansion populations in these limited benefit demonstrations and traditional Medicaid beneficiaries, in the May 19, 2003 proposed rule, we proposed that the Medicare DSH calculation should exclude from treatment as Medicaid patient days those patient days attributable to limited benefit section 1115 expansion waiver populations (proposed § 412.106(b)(4)(i)).

For example, a State may extend a family planning benefit to an individual for 2 years after she has received the 60-day postpartum benefit under Medicaid, or a State may choose to provide a family planning benefit to all individuals below a certain income level, regardless of having previously received the Medicaid postpartum benefit. This is a limited, temporary benefit that is generally administered in a clinic setting (see section 1905(a)(4)(C) of the Act). Also, a number of States are developing demonstrations that are limited to providing beneficiaries an outpatient prescription drug benefit. Generally, these limited benefits under a demonstration project do not include inpatient benefits. If a hospital were to include the days attributable to patients receiving benefits under such a limited benefit, the hospital would be able to receive higher DSH payments, perhaps substantially, for patients who may otherwise be insured for inpatient care. For example, these limited demonstrations provide benefits that may be needed to supplement private insurance coverage for individuals who do not have incomes low enough to qualify for Medicaid under the State plan. We do not believe such patients should be counted in the DSH patient percentage as eligible for title XIX.

As we have noted previously, at the time the Congress enacted the Medicare DSH adjustment provision (which was added to the law by section 9105 of COBRA and was effective for discharges occurring on or after May 1, 1986), there were no approved section 1115 demonstration projects involving expansion populations and the statute does not address the treatment of these days. Although we did not initially include patient days for individuals who receive extended benefits only under a section 1115 demonstration project, we nevertheless expanded our policy in the January 20, 2000 revision to these rules to include such patient days. We now believe that this reading is warranted only to the extent that those individuals receive inpatient benefits under the section 1115 demonstration project.

Therefore, we proposed to revise § 412.106(b)(4)(i) to clarify that patients must be eligible for medical assistance inpatient hospital benefits under an approved State Medicaid plan (or similar benefits, including inpatient hospital benefits, under a section 1115 demonstration project) in order for their hospital inpatient days to be counted as Medicaid days in the calculation of a hospital's DSH patient percentage. Under the proposed clarification, hospital inpatient days attributed to patients who do not receive coverage for inpatient hospital benefits either under the approved State plan or through a section 1115 demonstration would not be counted in the calculation of Medicaid days for purposes of determining a hospital's DSH patient percentage.

Under this reading, in the examples given above, the days associated with a hospital inpatient who receives coverage of prescription drugs or family planning services on an outpatient basis, but no inpatient hospital coverage, through either a Medicaid State plan or a section 1115 demonstration, would not be counted as Medicaid days for purposes of determining the DSH patient percentage.

The proposed revision addressed an unintended potential consequence of our interpretation that hospitals may include in the DSH calculation patient days associated with section 1115 demonstration populations (65 FR 3136). As discussed above, that interpretation was based on our finding that individuals receiving a comprehensive benefit package under a section 1115 demonstration project could appropriately be included in the numerator of the Medicaid fraction (even though the statute does not require such an inclusion), but did not address individuals who were receiving limited benefit packages under a section 1115 demonstration project.

Comment: Some commenters questioned our authority to require a patient obtain to covered inpatient benefits under either a Medicaid State plan or a section 1115 demonstration, in order to be included in the numerator of the Medicaid ratio for the DSH computation. One commenter pointed out that there are many circumstances under which an individual may have income low enough to qualify for Medicaid but still not qualify due to other qualifying criteria, and requested that all patient days of such individuals be counted as Medicaid-eligible.

Response: As stated above and in the proposed rule, we do not believe patients covered under limited-benefit section 1115 demonstration projects that are so limited that they are not similar to the medical assistance available under a Medicaid State plan should not be included in the count of Medicaid-eligible patients.

Under a traditional State Medicaid program, States are required to offer inpatient benefits to all eligible beneficiaries (see section 1902(a)(10)(A) of the Act). However, under the 1115 demonstration authority, the Secretary has permitted coverage for a limited set of services, such as pharmaceuticals or family planning services, and thus inpatient hospital services may be excluded for expansion populations under some of the section 1115 demonstration programs.

Our intention in allowing hospitals to include patient days related to section 1115 expansion waiver populations was to include patient days of demonstration populations who receive benefits under the demonstration project that are similar to traditional Medicaid beneficiaries, including inpatient benefits.

Comment: One commenter requested that the effective date of the proposed change be delayed until January 1, 2004, to allow fiscal intermediaries to contact States and identify specific coverage for their various section 1115 waiver populations.

Response: Because the DSH adjustment is reconciled when hospitals' cost reports are settled, we do not believe it is necessary to delay the implementation of this policy until January 1, 2004. Furthermore, although we believe it would have been reasonable for hospitals or fiscal intermediaries to have applied this interpretation of our policy regarding the inclusion of section 1115 waiver days prior to this clarification, we recognize that there may be situations in which this policy was not already applied. Therefore, we are making this change and the regulation at § 412.106(b)(4)(i) will be effective for discharges occurring on or after October 1, 2003.

7. Dual-Eligible Patient Days

We are still reviewing the large number of comments received on the proposed provision relating to dual-eligible patient days in the May 19, 2003. Due to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document. We refer individuals who are interested in reviewing the background information and discussions regarding this policy to the May 19, 2003 proposed rule (68 FR 27207–27208).

8. Medicare+Choice (M+C) Days

We are still reviewing the large number of comments we received on the proposed provision relating to the counting of Medicare+Choice days for purposes of the IME and DSH adjustments. Due to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document. We refer individuals interested in reviewing the background information and the discussion regarding these policies to the May 19, 2003 proposed rule (68 FR 27208).

D. Medicare Geographic Classification Review Board (MGCRB) Reclassification Process (§ 412.230)

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 2004, the MGCRB used the 3-year average hourly wages published in Table 2 of the August 1, 2002 IPPS final rule (67 FR 50135). These average hourly wages are taken from data used to calculate the wage indexes for FY 2001, FY 2002, and FY 2003, based on cost reporting periods beginning during FY 1997, FY 1998, and FY 1999, respectively.

Last year, we received a comment suggesting that we allow for the correction of inaccurate data from prior years as part of a hospital's bid for geographic reclassification (67 FR 50027). The commenter suggested that not to allow corrections to the data results in inequities in the calculation in the average hourly wage for purposes of reclassification. In the August 1, 2002 IPPS final rule, we responded:

''Hospitals have ample opportunity to verify the accuracy of the wage data used to calculate their wage index and to request revisions, but must do so within the prescribed timelines. We consistently instruct hospitals that they are responsible for reviewing their data and availing themselves to the opportunity to correct their wage data within the prescribed timeframes. Once the data are finalized and the wage indexes published in the final rule, they may not be revised, except through the mid-year correction process set forth in the regulations at § 412.63(x)(2). Accordingly, it has been our consistent policy that if a hospital does not request corrections within the prescribed timeframes for the development of the wage index, the hospital may not later seek to revise its data in an attempt to qualify for MGCRB reclassification.

''Allowing hospitals the opportunity to revise their data beyond the timelines required to finalize the data used to calculate the wage index each year would lessen the importance of complying with those deadlines. The likely result would be that the data used to compute the wage index would not be as carefully scrutinized because hospitals would know they may change it later, leading to inaccuracy in the data and less stability in the wage indexes from year to year.''

Since responding to this comment in the FY 2003 IPPS final rule, we have become aware of a situation in which a hospital does not meet the criteria to reclassify because its wage data were erroneous in prior years, and these data are now being used to evaluate its reclassification application. In addition, in this situation, the hospital's wage index was subject to the rural floor because the hospital was located in an urban area with an actual wage index below the statewide rural wage index for the State, and it was for a time period preceding the requirement for using 3 years of data. Therefore, the hospital contends, it had no incentive to ensure its wage data were completely accurate. (However, we would point out that hospitals are required to certify that their cost reports submitted to CMS are complete and accurate. Furthermore, inaccurate or incomplete reporting may have other payment implications beyond the wage index.)

We now more fully understand this particular hospital's situation and we have the administrative authority to establish a policy allowing corrections for this particular set of circumstances, in the proposed rule, we solicited comments on whether it may be appropriate to establish a policy whereby, for the limited purpose of qualifying for reclassification based on data from years preceding the establishment of the 3-year requirement (that is, cost reporting years beginning before FY 2000), a hospital in an urban area that was subject to the rural floor for the period during which the wage data the hospital wishes to revise were used to calculate the wage index, a hospital may request that its wage data be revised.

Comment: One commenter supported the proposed establishment of the exception. However, the commenter recommended that CMS consider allowing all hospitals to make corrections to the data that is used in reclassification determinations.

Response: We continue to believe that requiring wage data corrections by specified deadlines is essential to ensuring that wage data is finalized in an efficient manner. We also continue to believe that final wage data published in the annual IPPS final rules should be as complete and accurate as possible. However, we believe that, in the limited circumstances raised in our proposed rule where the hospital could not have foreseen that its wage data would later be used in a 3-year average, and the hospital was subject to the rural floor, it is feasible to permit a limited exception. Therefore, in this final rule, we are amending § 412.230(e)(2)(ii)(A) to allow, for the limited purpose of qualifying for geographic reclassification, hospitals demonstrating that they meet the limited circumstances described in the amended regulation be considered for reclassification after taking into account revisions subsequent to its use to construct the wage index for IPPS payment purposes. We are not adopting a broader exception, because we continue to believe it is important to ensure that final wage data published in the annual IPPS final rule are complete and accurate. Creating a broad exception to allow for corrections of prior years' data would affect the accuracy and stability in the wage indices from year to year. Therefore, we will continue to require hospitals—other than hospitals meeting the limited exception described in § 412.230(e)(2)(ii)(A)—to ensure that their wage data are correct by applicable deadlines and will not allow for wage data corrections after such deadlines.

Comment: Several hospitals who were interested in reclassifying, as a group, for purposes of the wage index, commented that their efforts to reclassify as an urban group have been unsuccessful primarily because they fail to meet the established requirement set forth in § 412.234(c)(2) that the requesting hospitals must demonstrate that their costs exceed their current payments by 75 percent of the additional payments they would receive through reclassification. The commenters submitted several recommendations for our consideration to clarify or improve our policies and regulations. They recommended that we consider:

- Allowing hospital groups to seek geographic reclassification for purposes of the wage index or standardized amount;
- Allowing hospital groups seeking geographic reclassification to areas where the reclassification would not result in a different standardized amount to seek reclassification for purposes of the wage index without having to satisfy the criteria applicable to hospitals seeking reclassification for purposes of the standardized amount;
- Allowing hospitals in NECMAs to seek reclassification to another MSA under the alternative criteria at § 412.236(c);
- Lowering the cost-to-payment threshold used to evaluate group reclassification applications; or
- In order to evaluate the interrelationship between the area where the hospitals are located and the target area in which they are seeking to reclassify, replacing the cost comparison criteria used to evaluate reclassification eligibility for purposes of the standardized amount with a better indicator of the connection such as, census commuting patterns.

Response: We appreciate the comments and recommendations presented by the hospitals and the importance of this issue. We note that, in developing the proposed rule, we did consider including a proposal to allow urban hospitals to reclassify as a group either for wage index or the standardized amount, or both. However, we did not go forward with the proposal because, upon further review, the criterion that hospitals demonstrate that their costs are in excess of their payments seemed appropriate. We will consider the commenters' recommendations in the future.

Comment: One commenter recommended that CMS consider lowering the applicable qualifying thresholds at § 412.230(c)(1)(iii) and (iv) for urban hospitals seeking reclassification for purposes of the wage index. The commenter specifically suggested that the threshold be lowered from 108 percent of the average hourly wage of hospitals in the area in which the hospital is located, and 84 percent of the average hourly wage of hospitals in the area to which the hospital seeks reclassification, to 106 percent and 82 percent, respectively, for urban hospitals. The commenter further recommended that, if the lower thresholds cannot be reduced for all urban hospitals, CMS consider implementing the lower thresholds for urban hospitals in areas where they are paid as if they are rural.

Response: As pointed out by the commenter, this issue was discussed, in detail, in the August 1, 2000 **Federal Register** (65 FR 47089 through 47090). While we will consider the recommendations for possible inclusion in a future proposed rule, we did not propose any changes or clarifications to the existing policy. Therefore, we are not adopting this comment.

E. Costs of Approved Nursing and Allied Health Education Activities (§ 413.85)

1. Background

Medicare has historically paid providers for the program's share of the costs that providers incur in connection with approved educational activities. The activities may be divided into the following three general categories to which different payment policies apply:

- Approved graduate medical education (GME) programs in medicine, osteopathy, dentistry, and podiatry. Medicare makes direct and indirect medical education payments to hospitals for residents training in these programs. Existing policy on direct GME payment is found at 42 CFR 413.86, and for indirect GME payment at 42 CFR 412.105.
- Approved nursing and allied health education programs operated by the provider. The costs of these programs are excluded from the definition of inpatient hospital operating costs and are not included in the calculation of payment rates for hospitals paid under the IPPS or in the calculation of payments to hospitals and hospital units excluded from the IPPS that are subject to the rate-of-increase ceiling. These costs are separately identified and ''passed through'' (that is, paid separately on a reasonable cost basis). Existing regulations on nursing and allied health education program costs are located at 42 CFR 413.85.
- All other costs that can be categorized as educational programs and activities are considered to be part of normal operating costs and are included in the per discharge amount for hospitals subject to the IPPS, or are included as reasonable costs that are subject to the rate-of-increase limits for hospitals and hospital units excluded from the IPPS.

In the May 19, 2003 proposed rule, we proposed to clarify our policy governing payments to hospitals for provider-operated nursing and allied health education programs. Under the regulations at § 413.85 (''Cost of approved nursing and allied health educational activities''), Medicare makes reasonable cost payment to hospitals for provider-operated nursing and allied health education programs. A program is considered to be provider-operated if the hospital meets the criteria specified in § 413.85(f), which means the hospital directly incurs the training costs, controls the curriculum and the administration of the program, employs the teaching staff, and provides and controls both clinical training and classroom instruction (where applicable) of a nursing or allied health education program.

In the January 12, 2001 **Federal Register** (66 FR 3358), we published a final rule that clarified the policy for payments for approved nursing and allied health education activities in response to section 6205(b)(2) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239) and sections 4004(b)(1) and (2) of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508).

Section 6205(b)(2) of Pub. L. 101–239 directed the Secretary to publish regulations clarifying the rules governing allowable costs of approved educational activities. The Secretary was directed to publish regulations to specify the conditions under which those costs are eligible for pass-through, including the requirement that there be a relationship between the approved nursing or allied health education program and the hospital. Section 4004(b)(1) of Pub. L. 101–508 provides an exception to the requirement that programs be provider-operated to receive pass-through payments. The section provides that, effective for cost reporting periods beginning on or after October 1, 1990, if certain conditions are met, the costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) for clinical training (as defined by the Secretary) conducted on the premises of the hospital under an approved nursing or allied health education program that is *not* operated by the hospital are treated as pass-through costs and paid on the basis of

reasonable cost. Section 4004(b)(2) of Pub. L. 101–508 sets forth the conditions that a hospital must meet to receive payment on a reasonable cost basis under section 4004(b)(1).

2. Continuing Education Issue for Nursing and Allied Health Education

Since publication of the January 12, 2001 final rule on nursing and allied health education, we have encountered questions concerning the substantive difference between provider-operated *continuing education* programs for nursing and allied health education (which would *not* be reimbursable under Medicare on a reasonable cost basis) and provider-operated approved programs that are eligible to receive Medicare reasonable cost payment. In that final rule, we stated that Medicare would generally provide reasonable cost payment for ''programs of long duration designed to develop trained practitioners in a nursing or allied health discipline, such as professional nursing or occupational therapy. This is contrasted with a continuing education program of a month to a year in duration in which a practitioner, such as a registered nurse, receives training in a specialized skill such as enterostomal therapy. While such training is undoubtedly valuable in enabling the nurse to treat patients with special needs and in improving the level of patient care in a provider, the nurse, upon completion of the program, continues to function as a registered nurse, albeit one with special skills. Further distinction can be drawn between this situation and one in which a registered nurse undergoes years of training to become a CRNA. For these reasons, the costs of continuing education training programs are not classified as costs of approved educational activities that are passed-through and paid on a reasonable cost basis. Rather, they are classified as normal operating costs covered by the prospective payment rate or, for providers excluded from the IPPS, as costs subject to the target rate-of-increase limits'' (66 FR 3370).

Accordingly, upon publication of the final rule, we revised § 413.85(h)(3) to include continuing education programs in the same category as ''educational seminars and workshops that increase the quality of medical care or operating efficiency of the provider.'' Costs associated with continuing education programs, as stated above, are recognized as normal operating costs and are paid in accordance with applicable principles.

Prior to the issuance of the May 19, 2003 proposed rule, we received an inquiry requesting further clarification on what is meant by continuing education. It is our belief that provider-operated programs that do not lead to any specific certification in a specialty would be classified as continuing education. In the proposed rule (68 FR 27210), we stated that our use of the term ''certification'' does not mean certification in a specific skill, such as when an individual is certified to use a specific piece of machinery or perform a specific procedure. Rather, we stated that we believe certification means the ability to perform in the specialty as a whole.

Although, in the past, we believe we have allowed hospitals to be paid for operating a pharmacy ''residency'' program, in the May 19, 2003 proposed rule, we stated that it has come to our attention that those programs do not meet the criteria for approval as a certified program. Once individuals have finished their undergraduate degree in pharmacy, there are *some* individuals who go on to participate in 1-year hospital-operated postundergraduate programs. It is our understanding that many individuals complete the 1-year postundergraduate program practice pharmacy inside the hospital setting. However, we also understand that there are pharmacists who *do not* complete the 1-year postundergraduate program, but have received the undergraduate degree in pharmacy, who also practice pharmacy inside the hospital setting. Because pharmacy students need not complete the 1-year residency program to be eligible to practice pharmacy in the hospital setting, the 1-year programs that presently are operated by hospitals would be considered continuing education, and therefore, would be ineligible for pass-through reasonable cost payment.

We stated that we understood that *all* individuals who wish to be nurses practicing in a hospital must either complete a 4-year degree program in a university setting, a 2-year associate degree in a community or junior college setting, or a diploma program traditionally offered in a hospital setting. Since participants that complete a provider-operated diploma nursing program could not practice as nurses without that training, the diploma nursing programs are *not* continuing education programs and, therefore, may be eligible for pass-through treatment.

Because of the apparent confusion concerning the distinction between continuing education programs and approved education programs in the context of reasonable cost pass-through payments for nursing and allied health education activities, in the May 19, 2003 proposed rule, we proposed to revise § 413.85(h)(3) to state that educational seminars, workshops, and continuing education programs in which the employees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to certification required to practice or begin employment in a nursing or allied health specialty, would be treated as educational activities that are part of normal operating costs. We also proposed to add a conforming definition of ''certification'' for purposes of nursing and allied health education under § 413.85(c) to mean ''the ability to practice or begin employment in a specialty as a whole.''

Comment: A large number of commenters responded to our proposal to clarify that, effective October 1, 2003, activities that do not lead to certification required to practice or begin employment in a nursing or allied health specialty would be treated as educational activities (continuing education) that are part of normal operating costs, and not as approved programs that are eligible for reasonable cost reimbursement. Many commenters strongly disagreed with the section of the proposed rule that included clinical pastoral education (CPE) as continuing education and stated that CMS must have been badly misinformed when writing the proposed rule. The commenters argued that CPE is a rigorous and structured education program accredited by the Association for Clinical Pastoral Education, Inc. (ACPE). The commenters stressed that, in varying amounts, CPE is a requirement for graduation for the master of divinity degree and for professional certification by the Association of Professional Chaplains (APC) as a health care chaplain, or as a CPE supervisor. Many commenters also noted prior Provider Reimbursement Review Board (PRRB) rulings that recognized chaplaincy as an allied health discipline, and asserted that hospitals that receive Medicare reasonable cost pass-through payment for CPE do so for the purpose of their professional CPE programs, not as continuing education for individuals already qualified to practice in hospital chaplaincy. Many commenters mentioned that the Joint Commission on Accreditation of Healthcare Organizations also recognizes chaplains as allied health professionals and considers them ''primary care providers.'' Similarly, commenters referred to various studies that have

shown the positive spiritual and therapeutic benefits of pastoral care. The commenters warned that removal of funding for CPE would represent a huge step backward for American health care. The commenters urged CMS to ensure continuing pass-through payments for CPE.

Response: In the May 19, 2003 proposed rule (68 FR 27210), we stated that we received an inquiry requesting further clarification of what is meant by continuing education. We proceeded to explain what constitutes ''continuing education'' for the purpose of determining whether a nursing or allied health education activity would or would not qualify for Medicare reasonable cost pass-through payments. We acknowledge that the definition of ''continuing education'' for Medicare payment purposes may differ from the academic view of what, in general, constitutes such activities. In the proposed rule, we stated that we believed that provider-operated programs that do not lead to any specific certification or the ability to perform in the specialty would be classified as ''continuing education.''

Our intent is to ensure that Medicare pass-through payments are only provided for programs that enable an individual to be employed in a capacity that he or she could not have been employed without having first completed a particular education program. We believe that, *for Medicare purposes,* training that enhances an individual's competencies, but does not permit that individual to be employed in a new capacity in which he or she could not have been employed without completing the additional training, would not qualify for Medicare reasonable cost pass-through payment. Medicare provides payments for such educational activities, but only under the methodology applicable to payment of normal operating costs. Our intent was simply to provide clarification for the purpose of distinguishing between those educational programs that qualify for reasonable cost pass-through payment (that is, programs that enable an individual to begin employment in a specialty as a whole) and those programs that should be paid as normal operating costs (that is, activities that are intended to enhance the current skill set of an individual's profession or advance an individual's professional career).

Since publication of the proposed rule, we have learned from information provided by the ACPE and the APC that there are several levels of CPE. Specifically, the ACPE accredits three different levels of CPE. The first level of CPE is generally geared to interns and beginning residents. The second level of CPE is generally geared to residents doing specialization and preparation for chaplaincy certification. The third level is supervisory training, which is geared toward preparation for certification by the ACPE as a CPE supervisor.

We understand that, as a part of the requirements for a master of divinity degree, many theological schools and seminaries require or strongly recommend completion of an internship, or 1 unit of CPE for graduation. A unit of CPE is 400+ hours of supervised CPE in a health care or institutional setting. Students taking either 1 or 2 units of CPE are generally referred to as interns. In addition, many faith groups require, at their national or regional levels, that individuals complete at least 1 unit of CPE in order for them to be ordained into professional ministry. Theological schools that offer doctoral degrees (for example, a doctor of philosophy, a doctor of ministry, or a doctor of theology) with specialties in pastoral counseling and related fields also generally require some amount of CPE as a part of those degree programs. Upon completion of a CPE internship, the health care institution typically reports to the theological school in which the student is enrolled that the student has successfully completed the internship, and the theological school subsequently awards credit for the training. Based upon information received from the commenters, we understand that completion of only an internship, or 400+ hours of CPE, would not qualify an individual for employment as a chaplain in a hospital setting.

In contrast to CPE internships, CPE residents generally participate in a 1-year, or occasionally a 2-year, full-time CPE program. A 1-year residency typically consists of 4 units of postgraduate CPE (that is, 1,600+ hours of supervised CPE), in a health care or institutional setting. Generally, individuals who undertake 1,600 hours of CPE do so in order to become a board-certified chaplain. The ACPE has established 4 units, or 1,600 hours of supervised CPE, as the national minimum amount of CPE that is required to become a board-certified chaplain. However, some certifying boards or particular programs may require some additional hours of CPE for board certification. We note that, in instances where academic credit is granted for completion of 1 unit, or 400 hours, of CPE prior to receipt of a degree, an individual seeking to become a board-certified chaplain generally must complete an additional 1,600 hours of CPE training.

The board certification of chaplains is carried out by nationally recognized organizations that are part of the Commission on Ministry in Specialized Settings (COMISS), an umbrella network for pastoral care organizations that share the same standards of educational preparation and clinical training. These organizations include the Association of Professional Chaplains (APC), the National Association of Catholic Chaplains (NACC), the National Association of Jewish Chaplains (NAJC), and the Canadian Association for Pastoral Practice and Education (CAPPE). The ACPE accredits CPE training for all of these certifying organizations.

Based on information received from the commenters, we understand that most health care organizations that are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) advertise for and recruit only board-certified chaplains, which means that qualified applicants for employment as hospital chaplains will usually have completed at least 1,600 hours of CPE.

Individuals who seek to develop a health care chaplaincy specialization (for example, hospice, pediatrics, cardiology, rehabilitation, neurology) may undertake a second year of CPE residency. A second year of residency consists of an additional 4 units of CPE (or 1,600+ hours of supervised CPE). However, there is currently no established board certification process for residents completing a second year of CPE residency training.

To be eligible to apply for supervisory CPE training, an individual must have completed at least 4 units (1 year) of CPE training. Upon completion of supervisory training, an individual becomes certified by the ACPE as a CPE supervisor and is qualified to develop and conduct CPE training for all ACPE-accredited programs.

Based on information submitted by the commenters on the different levels of CPE training, two important points relative to Medicare reimbursement have become clear to us. First, in instances where internship training is completed as a prerequisite for a degree granted by an educational institution other than a hospital, such training is *not* provider-operated, and, therefore, does *not* qualify for Medicare reasonable cost pass-through payment under § 413.85. Under § 413.85(f), a program is considered to be provider-operated only if the hospital directly incurs the training costs, directly controls the curriculum and the administration of

the program, employs the teaching staff, and provides and controls both clinical training and classroom instruction (where applicable). While a hospital may serve as the site for a CPE internship, such training is provided to satisfy curriculum requirements of a theological school, which grants the master degree upon completion of the internship. While the hospital might incur training costs and employ the supervising faculty, it would not ordinarily meet the other ''provider-operated'' criteria concerning controlling the curriculum and providing both the didactic and clinical training necessary for the degree. Thus, a CPE internship, or any other CPE training that is a requirement for a degree, whether it is undergraduate, graduate, or doctoral, is not eligible for Medicare reasonable cost pass-through payment.

Secondly, a CPE residency consisting of 1,600 hours of training could be a provider-operated program and could also lead to certification and the ability to be employed in a new or different capacity. Specifically, a CPE residency consisting of approximately 1,600 hours of training leads to board certification in chaplaincy, and, as we understand it, most JCAHO-accredited hospitals generally only employ board-certified chaplains. In consideration of these facts, the costs of CPE training programs that meet the requirements under § 413.85, including accreditation by a nationally recognized accrediting body, direct operation by a provider, and lead to certification that is generally a requirement for employment in a particular specialty, may be eligible for Medicare reasonable cost pass-through payment.

In the May 19, 2003 proposed rule (68 FR 27210), we proposed to revise the regulations at § 413.85(h)(3) to state that activities treated as normal operating costs include ''Educational seminars, workshops, and continuing education programs in which the employees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to certification required to practice or begin employment in a nursing or allied health specialty.'' We proposed to add a conforming definition of ''certification'' for purposes of nursing and allied health education under § 413.85(c) to mean ''the ability to practice or begin employment in a specialty as a whole.'' However, it is apparent from the comments we received that our proposed definition of ''certification'' was not clear. Some commenters believed we intended, through the proposed definition, to allow pass-through payments for the costs of a program that would only enhance an individual's set of skills. However, that was not our intent. We believe it would have been more appropriate to use the word ''and'' instead of the word ''or'', to further emphasize that pass-through payment would only apply to activities that enable an individual to practice *and* begin employment in a specialty, but would *not* apply to activities that serve to add to or to enhance an individual's current skill set.

In addition, based on the comments received, we understand that there may be several distinct levels of training in a given health profession, and each level of training may be a requirement in order for an individual to work in a new capacity or ''specialty'' in that profession, but *not* a requirement to practice or begin employment in the specialty ''as a whole.'' Since a second level of training is not required to begin practicing in a profession, under the proposed definition, we would not have been able to allow for pass-through payments for a second (or potentially a third) level of training. Therefore, we understand that inclusion of the words ''as a whole'' in the proposed definition of ''certification'' was misleading. Consequently, where a subsequent level of training is a requirement to practice in a new specialty in a given profession, pass-through payment may be made for the subsequent level of training.

Finally, we have concluded that it is not necessary to include a specific definition of ''certification'' at § 413.85. In this final rule, we are deleting the proposed definition of ''certification'' from § 413.85(c), and amending § 413.85(h)(3) by removing the words ''certification required'' and inserting the words ''the ability.'' We are also changing the word ''or'' to ''and''. Specifically, we are amending the proposed regulations at § 413.85(h)(3) to state that activities treated as normal operating costs include ''Educational seminars, workshops, and continuing education programs in which the employees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to the ability to practice and begin employment in a nursing or allied health specialty.''

Our view of a ''specialty'' in the nursing and allied health education context is based on what the industry views as the standard of practice in a specific area within a profession. The training required to allow a person to serve in the ''specialty'' is tailored to the skill level and context that an individual is expected to use in that ''specialty.''

Consistent with what we stated in the proposed rule, Medicare reasonable cost pass-through payments are only provided for programs that, according to industry norms, qualify an individual to be employed in a specialty in which the individual could not have been employed before completing a particular education program. Given the confusion expressed by commenters, we recognize the need to specify how we will determine whether completion of a particular education program enables an individual to be employed in a specialty. We will use ''industry norms'' as the standard to determine whether participation in a specialty enables an individual to be employed in a capacity that he or she could not have been employed without having first completed a particular education program. We are defining ''industry norm'' to mean that more than 50 percent of hospitals in a random, statistically valid sample require the completion of a particular training program before an individual may be employed in a specialty. (We understand that, in some instances, due to the unique staffing circumstances faced by many smaller hospitals, inclusion of small hospitals in the sample would introduce factors that are not typically representative of the industry as a whole and would skew the results inappropriately. In such a case, if appropriate, we would consider excluding hospitals with less than 100 beds, which would still retain over 75 percent of all hospitals in the universe).

Based on comments received, we believe that it is the ''industry norm'' to require a CPE residency and board certification for employment as a hospital chaplain. Since it is currently the ''industry norm'' for hospitals to employ only board-certified chaplains, and since completion of approximately 1,600 hours of CPE training is a requirement to practice and begin employment in hospital chaplaincy, we view hospital chaplaincy as a ''specialty'' of pastoral counseling. Consequently, a hospital that operates a CPE residency may be eligible for reasonable cost pass-through payment.

Specifically, assuming all requirements under § 413.85 are met, Medicare reasonable cost pass-through payments may only be made to hospitals for CPE hours that are *not* prerequisites for *any* academic degree, *and* are provided to students in order to obtain board certification in hospital chaplaincy. A hospital may not receive reasonable cost payment for any costs

incurred in connection with providing CPE that is undertaken to meet the requirements of an academic degree. In addition, since generally a minimum of approximately 1,600 hours of CPE is required to become a board-certified chaplain, any costs incurred for an individual participating in CPE training that exceeds the minimum number of hours required to obtain board certification would not be eligible to be paid on a reasonable cost basis.

However, we note that we do not completely defer to the information provided by industry representatives in order to determine the ''industry norm.'' Rather, if at any time we obtain information that calls our view of industry norms into question, we may make our own determination based on a random sample of hospitals. Therefore, assuming all other requirements under § 413.85 are met, a hospital may receive reasonable cost pass-through payment for the hours of CPE for which academic credit is *not* granted (since *those* CPE hours are not generally provider-operated), and for the hours of CPE that may be used to satisfy training requirements for board certification. We will continue to allow reasonable cost payment for CPE that leads to board certification as long as we do *not* have evidence indicating that, based on a statistically valid, random sample, the ''industry norm'' is *not* to require board certification for chaplains that are employed by hospitals.

We also recognize that industry norms are susceptible to change over time. Therefore, although it may not currently be the ''industry norm'' to require completion of a particular nursing or allied health education program in order to practice and begin employment in a particular specialty, it may become the ''industry norm'' in the future. If we find that it has become the ''industry norm,'' we may allow the hospitals operating those programs (and meeting the requirements at § 413.85) to be paid for the costs of those programs on a reasonable cost basis.

In relation to the commenters' recommendation that reasonable cost reimbursement should be provided for CPE supervisory training, we understand that, essentially, the purpose of the supervisory training is to prepare a chaplain to develop CPE programs and to teach interns and residents. We believe that CPE supervisors are practicing in the teaching profession, not within a nursing or allied health discipline. Furthermore, we do not believe that Congress intended to provide for reasonable cost pass-through payments for programs that are intended to produce instructors or teachers. While we recognize that CPE supervisors are necessary to train and prepare individuals for hospital chaplaincy, we believe that it is appropriate for the costs of supervisory programs in general to be treated as normal operating costs and paid accordingly.

Comment: One commenter stated that our proposed definition of provider-operated programs intended to exclude programs ''that do not lead to certification required to practice or begin employment in a nursing or allied health specialty * * *'' is not appropriate in light of the growing number of skills that require intensive clinical experiences. Another commenter stated that this proposal will seriously hinder reversal of the nursing shortage across the nation and, as a result, will have an adverse impact on the quality and safety of care provided in hospitals. The commenters used the example of nurse residencies, which a number of hospitals across the country are hosting for registered nurses. The commenters explained that these residencies, which are postgraduate and typically last 1 year, are designed to equip the newly licensed nurse with the skills to care for patients who require the most complex and sophisticated diagnostic and therapeutic services, and to prepare the nurses for leadership roles earlier in their careers and give them the tools to improve the quality of care and reduce medical errors. The commenters claimed that the Federal Government has thus far provided minimal funding to help ameliorate the nursing shortage and, therefore, the proposed rule is particularly distressing. They urged CMS to include criteria in the final rule for pass-through payment of nurse residencies.

Response: First, we do not believe that nurse residencies, which are intended to help integrate newly licensed nurses into complex acute care environments by enhancing their competencies and skills, are programs that qualify these nurses to be employed in a new specialty. Accordingly, it is more appropriate to treat such activities as normal operating costs. As we stated above, Medicare reasonable cost pass-through payment will only be provided for programs that, according to industry norms, qualify an individual to be employed in a specialty in which the individual could not have been employed prior to completing a particular education program. Second, we note that nurse residencies do not qualify for reasonable cost payment because they also do not meet the requirement for accreditation by a national approving body under § 413.85(d)(1)(i)(A). Therefore, while we are sympathetic to the commenters' concerns, we do not believe that it is appropriate at the present time to allow for pass-through payment to be made under the Medicare program for nurse residencies.

Comment: Some commenters stated that CMS was ''entirely correct'' in identifying CPE as continuing education and concurred with our proposal to discontinue pass-through payments for CPE. One commenter contended that ACPE-accredited training is not primarily used to prepare students to be health care chaplains. Rather, CPE is primarily ministry training, and there are various ways that one can choose to use CPE. One commenter added that very few individuals who train in CPE, including those individuals in 1-year residencies, become employed as health care chaplains. The commenter further stated that CPE is ''properly a funding responsibility of the church rather than the government''. The commenters argued that Medicare should not be supporting continuing education for religious care providers whose primary base and certifying group is their denomination or faith group.

Another commenter presented a similar argument concerning pharmacy residencies and questioned why Medicare (that is, taxpayers) should subsidize these residency programs. The commenter claimed that hospitals ''use government monies in order to hire these 'residents,' utilize them in 'clinical' positions under the guise of postgraduate training, thereby bypassing having to use FTEs in the hospital pharmacy budget.'' The commentator believed that if hospitals and pharmacists were truly concerned with improving patient care, hospital pharmacy departments would train their own staff pharmacists to perform the clinical aspects themselves, rather than having taxpayers provide the funding.

Response: We are sympathetic to the commenters' concerns. However, we understand that many CPE programs do occur in hospitals, and that, while there may be various kinds of CPE training, generally, completion of approximately 1,600 hours of CPE training is required for board certification and employment by a hospital. Therefore, we believe that CPE residencies that lead to board certification generally would not be considered continuing education.

In response to the commenters' concerns about the taxpayers, through the Medicare program, providing support for CPE and pharmacy residencies, we note Medicare payment for these and other similar programs are made in accordance with the Medicare

statute. Under section 1861(v) of the Act, Congress provides for Medicare payments to be made in support of certain medical education activities. Currently, if a program meets the regulatory requirements under § 413.85, which were specified earlier in this preamble, a hospital operating that program may qualify for Medicare reasonable cost pass-through payment.

Comment: One commenter explained that a dietetic internship is a post-baccalaureate program that is one of the requirements for practicing as a registered dietitian. The commenter pointed out that the Commission on Accreditation of Dietetic Education (CADE) of the American Dietetic Association accredits these internships and the interns contribute directly to patient care in a hospital. The commenter urged us to continue to pay health care organizations for dietetic internships.

Response: We appreciate the comment and note that, as long as a dietetic internship meets the requirements under § 413.85 (and we do not find that it is not the industry norm to require this training to be employed as a registered dietitian), the hospital operating the internship may qualify for Medicare reasonable cost pass-through payment.

Comment: A large number of commenters responded to our proposal to clarify that, effective October 1, 2003, training that does not lead to certification required to practice or begin employment in a nursing or allied health specialty would be treated as educational activities (continuing education) that are part of normal operating costs, and not as approved programs that are eligible for reasonable cost pass-through payments. Many commenters strongly disagreed with our proposal that included pharmacy residencies in the type of training that is considered continuing education and claimed that the proposed rule reflected a fundamental misunderstanding of pharmacy education. The commenters stated that educational seminars, workshops, and continuing education programs are generally performed outside the provider setting, and in most instances do not exceed 40 hours per year, whereas a pharmacy residency is a full-time commitment that lasts for 1 year. The commenters emphasized that the pharmacy residencies are structured, intensive programs that incorporate direct patient care experience where residents work as part of a clinical team and are required to complete a comprehensive project. The commenters contended that residency experience provides focused, invaluable training that yields proven positive clinical and financial outcomes. The commenters also noted that, while residencies are not a requirement for all hospital pharmacy positions, they are a requirement for most clinical specialist positions. The commenters maintained that residencies would be a more universal hiring requirement were it not for the current shortage of pharmacists and residency programs. The commenters stressed the benefits of clinical pharmacist involvement in patient care and cautioned that CMS' attempt at short-term cost savings will result in significant long-term cost of care increases. The commenters urged CMS to ensure continuing reasonable cost pass-through payments for pharmacy residencies.

Response: As we stated above in response to the comments received from the clinical pastoral counseling community, in the May 19, 2003 proposed rule (68 FR 27210), we explained what constitutes ''continuing education'' for the purpose of determining whether a nursing or allied health education activity would or would not qualify for Medicare reasonable cost pass-through payments. We acknowledge that the definition of ''continuing education'' for Medicare payment purposes may differ from the academic view of what, in general, constitutes such activities. As we stated earlier, we believe that provider-operated programs that do not lead to any specific certification, or the ability to perform in the specialty, would be classified as ''continuing education.''

Our intent is to ensure that Medicare reasonable cost pass-through payments are only provided for programs that enable an individual to be employed in a capacity that he or she could not have been employed without having first completed a particular education program. We believe that, *for Medicare purposes,* training that enhances an individual's competencies, but does not permit that individual to be employed in a new specialty in which he or she could not have been employed without completing the additional training, would not qualify for Medicare reasonable cost pass-through payment. Medicare provides payment for such educational activities, but only under the methodology applicable to payments for normal operating costs. Our intent was to provide clarification for the purpose of distinguishing between those educational programs that qualify for reasonable cost pass-through payment (that is, programs that enable an individual to begin employment in a specialty), and those programs that should be paid as normal operating costs (that is, activities that are intended to enhance the current skill set of an individual for a profession or advance an individual's professional career).

Since publication of the proposed rule, we have learned from information provided by the commenters that there are two categories of pharmacy residencies—pharmacy practice residencies and specialized pharmacy residencies, both of which are accredited by the American Society of Health-System Pharmacists (ASHP). If a pharmacist chooses to participate in residency training, he or she would generally do so after completion of an undergraduate bachelor of science degree or a doctor of pharmacy degree. (In some cases, residencies are offered as a part of a postgraduate degree (a master of science or a doctor of pharmacy). However, these programs would *not* meet our provider-operated criteria.) A pharmacy practice residency is typically a 1-year, organized, directed, postgraduate training program in a defined area of pharmacy practice that may take place in a variety of settings, including hospitals. For those seeking additional skills in a focused area of pharmacy practice (for example, oncology), an individual may choose to complete a second year of specialized pharmacy residency. Currently, ASHP, in partnerships with other professional organizations, accredits 17 second-year pharmacy residencies, in areas such as cardiology, geriatrics, infectious diseases, and oncology.

Of the 17 second-year pharmacy residencies, only 5 of these residencies currently lead to board certification. The Board of Pharmaceutical Specialties (BPS) is the organization that administers the certifying examinations after completion of each of these five residencies. Upon completion of a residency in 1 of the other 12 second-year residencies, the hospital in which the resident has trained issues a certificate to the pharmacist.

We understand that many employers, including hospitals, increasingly are requiring completion of an ASHP-accredited first year pharmacy practice residency as a condition for employment as a clinical (''on the floor'') or direct patient care pharmacist. While a licensed pharmacist who has not completed a pharmacy practice residency might be hired by a hospital as a staff or distribution pharmacist, a hospital typically would only hire an individual who has completed at least a 1-year pharmacy practice residency to fill a position that requires direct work with hospital patients. Some hospitals may even require their pharmacists to have completed a second-year

specialized residency before allowing those pharmacists to specialize on a particular group or type of patients. For example, before a pharmacist may work exclusively to design, implement, and monitor a course of treatment for oncology patients, some hospitals require that the pharmacist complete a residency in oncology pharmacy. However, many hospitals may employ pharmacists who have only completed a pharmacy practice residency to treat these groups or types of patients, including oncology patients.

As we explained above in response to the comments on CPE, in the May 19, 2003 proposed rule (68 FR 27210), we proposed to revise the regulations at § 413.85(h)(3) to state that activities treated as normal operating costs include ''Educational seminars, workshops, and continuing education programs in which the employees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to certification required to practice or begin employment in a nursing or allied health specialty.'' We proposed to add a conforming definition of ''certification'' for purposes of nursing and allied health education under § 413.85(c) to mean ''the ability to practice or begin employment in a specialty as a whole.'' However, it is apparent from the comments we received that our proposed definition of ''certification'' was not clear. Some commenters believed we intended, through the proposed definition, to allow pass-through payments for the costs of a program that would only enhance an individual's set of skills. However, that was not our intent. We believe it would have been more appropriate to use the word ''and'' instead of the word ''or'' to further emphasize that pass-through payment would only apply to activities that enable an individual to practice *and* begin employment in a specialty, but would *not* apply to activities that serve to add to or to enhance an individual's current skill set.

In addition, based on the comments received, we understand that there may be several distinct levels of training in a given health profession, and each level of training may be a requirement in order for an individual to work in a new capacity or ''specialty'' in that profession, but *not* a requirement to practice or begin employment in the specialty ''as a whole.'' Since a second level of training is not required to begin practicing in a profession, under the proposed definition, we would not have been able to allow for pass-through payments for a second (or potentially a third) level of training. Therefore, we understand that inclusion of the words ''as a whole'' in the proposed definition of ''certification'' was misleading. Consequently, where a subsequent level of training is a requirement to practice in a new specialty in a given profession, pass-through payment may be made for the subsequent level of training.

Finally, we have concluded that it is not necessary to include a specific definition of ''certification'' in the regulations at § 413.85. In this final rule, we are deleting the proposed definition of ''certification'' from § 413.85(c), and amending § 413.85(h)(3) by removing the words ''certification required'' and inserting the words ''the ability.'' We are also changing the word ''or'' to ''and''. Specifically, we are amending the proposed § 413.85(h)(3) to state that activities treated as normal operating costs include ''Educational seminars, workshops, and continuing education programs in which the employees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to the ability to practice and begin employment in a nursing or allied health specialty.''

As we stated above in response to the comments concerning CPE, our view of a ''specialty'' in the nursing and allied health education context is based on what the health care industry views as the standard of practice in a specific area within a profession. We are defining ''industry norm'' to mean that more than 50 percent of hospitals in a random, statistically valid sample require the completion of a particular training program before an individual may be employed in a specialty. (We understand that, in some instances, due to the unique staffing circumstances faced by many smaller hospitals, inclusion of small hospitals in the sample would introduce factors that are not typically representative of the industry as a whole and would skew the results inappropriately. In such cases, we would consider excluding hospitals with less than 100 beds, which would still retain over 75 percent of all hospitals in the sample universe.)

Based on comments received, we believe that it is currently the ''industry norm'' for hospitals to generally hire only pharmacists who have completed a pharmacy practice residency to work directly in patient care. Specifically, without having completed a pharmacy practice residency, a pharmacist would typically be employed by a hospital as a staff or distribution pharmacist, but not as a clinical pharmacist who works directly with patients to develop treatment plans. Since completion of a pharmacy practice residency has become a requirement by hospitals to practice or begin employment in a position that involves direct patient care, we would view ''hospital pharmacy'' as a ''specialty'' of the pharmacy profession. Accordingly, pharmacy practice residency training programs that meet the requirements under § 413.85, including accreditation by a nationally recognized accrediting body, direct operation by a provider, and lead to certification that is a requirement for employment, may be eligible for Medicare reasonable cost pass-through payment.

However, it is apparent from the comments that it is *not* unusual for a hospital to employ a pharmacist that has only completed a pharmacy practice residency in an area in which an accredited second-year program exists (that is, geriatrics, cardiology, or oncology), without requiring the pharmacist to first complete that second-year residency program. For example, we would view further training in oncology pharmacy or cardiology pharmacy as specializations within the pharmacy field under the policy in this final rule. However, these second-year residencies would *not* qualify for reasonable cost pass-through payment because, based on information received from commenters, it is not currently the ''industry norm'' to require completion of these programs before beginning work in these specialties. If we find in the future that it has become the ''industry norm'' for hospitals to require second-year pharmacy residencies, we may allow the hospitals operating those programs to be reimbursed for the costs of those programs on a reasonable cost basis.

3. Programs Operated by Wholly-Owned Subsidiary Educational Institutions of Hospitals

Another matter that has come to our attention since publication of the January 12, 2001 final rule (66 FR 3363) on nursing and allied health education concerns the preamble language of the rule, which states:

''Concerning those hospitals that have established their own educational institution to meet accrediting standards, we believe that, in some cases, these providers can be eligible to receive payment for the classroom and clinical training of students in approved programs. If the provider demonstrates that the educational institution it has established is wholly within the provider's control and ownership and that the provider continues to incur the costs of both the classroom and clinical

training portions of the program, the costs would continue to be paid on a reasonable cost basis. An independent college would not meet these criteria.

''An example of a program that could be considered provider-operated would be one in which the hospital is the sole corporate member of the college, elects the board of trustees, has board members in common, employs the faculty and pays the salaries, controls the administration of the program and the curriculum, and provides the site for the clinical and classroom training on the premises of the hospital. We believe that, in these situations, the community has not undertaken to finance the training of health professionals; the provider has merely restructured its provider-operated program to meet certain State or accrediting requirements. In most cases, providers have aligned themselves with already established educational institutions. We note that a program operated by an educational institution that is related to the provider through common ownership or control would not be considered to meet the criteria for provider operated.'' (66 FR 3363)

We have received a question from a hospital that pertains to the cited preamble language in the narrow circumstance where the hospital previously received Medicare reasonable cost payment for direct operation of nursing or allied health education programs and then established its own wholly owned subsidiary college to operate the programs, in order to meet accreditation standards. The hospital has continued to receive Medicare payments after the hospital moved operation of the programs to the wholly owned subsidiary college. The hospital believes that, based on the cited preamble language regarding wholly owned subsidiary colleges and the lack of prior specific guidance on this particular organizational structure (as well as its continued receipt of pass-through payments) and because the hospital continues to pay all of the costs of the nursing and allied health education programs, the hospital is still the direct operator of the programs and should continue to receive pass-through treatment. However, we believe that once the hospital moved the direct operation of its nursing and allied health education programs to the college, the programs no longer met our provider-operated criteria at § 413.85(f). At the very least, it appears that the hospital did not hire the faculty for the program(s) and did not have direct control of the curriculum of the program(s) after operation was transferred to the wholly owned subsidiary college. As we stated in the preamble language quoted above: ''a program operated by an educational institution that is related to the provider through common ownership or control would not be considered to meet the criteria for provider operated'' (66 FR 3363).

However, we understand that some hospitals, including this hospital, may have interpreted the preamble language that stated, ''if the provider demonstrates that the educational institution it has established is wholly within the provider's control and ownership and that the provider continues to incur the costs of both the classroom and clinical training portions of the program, the costs would continue to be paid on a reasonable cost basis'' (*Ibid.*), to mean that hospitals that establish wholly owned subsidiary colleges or educational institutions would continue to receive Medicare reasonable cost payment if the hospitals incur the costs of the classroom instruction and clinical training. In the May 19, 2003 proposed rule, we proposed to clarify that transferring operation of previously provider-operated programs to educational institutions, even if the institutions are wholly owned by the hospital, does *not* necessarily mean that the programs continue to meet our provider-operated criteria under § 413.85(f). In order to remain provider operated, the hospital must have *direct control* of the program; the hospital itself must employ the teaching staff, have direct control of the program curriculum, and meet other requirements, as stated at § 413.85(f).

While we proposed to clarify that merely operating programs through a wholly owned subsidiary college does not constitute direct operation of nursing or allied health education programs unless the hospital itself meets the requirements of the regulations at § 413.85(f), we believe it would be unfair to recoup Medicare payments that have already been made to hospitals that meet this very narrow fact pattern. Therefore, we proposed that Medicare would not recoup reasonable cost payment from hospitals that have received pass-through payments for portions of cost reporting periods occurring before October 1, 2003 for the nursing or allied health education program(s) where the program(s) had originally been operated by the hospital, and then operation of the program(s) had been transferred by the hospital to a wholly owned subsidiary educational institution in order to meet accreditation standards prior to October 1, 2003, and where the hospital had continuously incurred the costs of both the classroom and clinical training portions of the programs at the educational institution.

In addition, we proposed that, for portions of cost reporting periods occurring on or after October 1, 2003, such a hospital would continue to receive reasonable cost payments for the clinical training costs incurred by the hospital for the program(s) described above that were previously provider operated. However, we further proposed that, with respect to classroom costs, only those classroom costs incurred by the hospital for the courses that were paid by Medicare on a reasonable cost basis and included in the hospital's provider-operated program(s) could continue to be reimbursed on a reasonable cost basis. That is, Medicare would pay on a reasonable cost basis for the classroom costs associated with the courses provided as part of the nursing and allied health education programs (for example, the courses relating to the theory and practice of the particular nursing and allied health discipline(s)) that were offered by the hospital when the hospital was the direct operator of the program(s).

We believe the proposed policy is appropriate since continued pass-through payment will allow these hospitals to maintain equal footing with other hospitals that receive pass-through payments and have maintained their provider-operated programs. In addition, it would not be equitable to discontinue longstanding Medicare pass-through payment to these hospitals (in fact, reasonable cost payment to at least one of these hospitals for nonprovider-operated programs preceded the publication of the January 12, 2001 final rule on nursing and allied health education payments by many years) that restructured operation of their nursing and allied health education program(s) as wholly owned subsidiaries in order to meet accreditation standards while relying on their understanding of CMS' prior expressions of provider-operated requirements and the recent preamble language. If these providers were now forced to restructure in order to meet the requirements of § 413.85(f), they would not be able to maintain their accreditation.

We note that Congress has specifically expressed its intent that providers that have restructured their programs to be operated by a wholly owned subsidiary educational institution in order to meet accreditation standards should continue to receive Medicare reasonable cost payment. In the conference report accompanying the Consolidated

Appropriations Resolution for FY 2003, Congress stated:

''The conferees are particularly concerned about nursing and allied health educational programs that cannot meet the regulations set forth at 42 CFR 413.85(f) solely as a result of regional educational accrediting criteria. Given the shortage of nursing and allied health professionals, the conferees support the payment of costs on a reasonable cost basis for a hospital that has historically been the operator of nursing and allied health education programs(s) that qualified for Medicare payments under 42 CFR 413.85, but, solely in order to meet educational standards, subsequently relinquishes some control over the program(s) to an educational institution, which meets regional accrediting standards; is wholly owned by the provider; and is supported by the hospital, that is, the hospital is incurring the costs of both the classroom and clinical training of the program.'' (H.R. Rep. No. 108–10, 108th Cong., 1st Sess., 1115 (2003).)

However, we note that the proposed policy would not allow these hospitals to be paid for additional classroom costs for courses that were not paid on a reasonable cost basis to the hospitals in conjunction with their provider-operated programs (for example, additional classes needed to meet degree requirements). We believe that to allow pass-through payment for those additional costs would provide these hospitals with an unfair advantage over other hospitals with provider-operated programs.

We note that any hospital that chooses to restructure its programs to be operated by a wholly-owned subsidiary educational institution on or after the effective date of this proposal when finalized (October 1, 2003) would not be eligible for pass-through payments under the proposed provision unless the hospital continues to meet the requirements of § 413.85(f). We believe it is appropriate to limit the proposed payments to hospitals that restructured before October 1, 2003 because our policy with respect to programs by a wholly-owned subsidiary of a hospital will have been clarified by that date (the date that this final rule is effective).

We proposed to revise § 413.85 by adding new paragraphs (d)(1)(iii) and (g)(3) to reflect the proposed payment policy.

Comment: Several comments supported our proposal. Specifically, the commenters believed that the proposed rule is consistent with the recent expressions of Congressional intent reflected in the conference report to the 2003 Consolidated Appropriations Resolution, which recognize that there is a shortage of nursing and allied health professionals, and that payments made for programs that are operated by wholly-owned subsidiary educational institutions of hospitals should not be retrospectively recouped and may continue in the future.

However, several commenters disagreed with the proposal under proposed § 413.85(g)(3)(iii) that, effective for portions of cost reporting periods occurring on or after October 1, 2003, eligible hospitals could receive payment for the clinical training costs and for the classroom costs, but only those classroom costs incurred by the hospital for the courses that were included in the program(s) that had originally been provider-operated before transfer of operation of the program(s) to a wholly owned subsidiary educational institution. One commenter stated that such criteria regarding reimbursement of classroom costs appears to presume that while a hospital was operating its own program before transferring the operation of the program to a wholly-owned subsidiary, the hospital must have offered fewer or different programs. The commenter believed that our example in the preamble of the proposed rule seems to suggest that ''noncore'' or nonnursing related classes would be excluded from reasonable cost reimbursement, effective October 1, 2003. The commenter contended that we have incorrectly assumed that diploma programs include only nursing courses because, in fact, such diploma programs typically included general courses for English, basic science, math, and similar subjects. The commenter asked that we revise the preamble to clarify that courses for which costs were historically reimbursed would continue to qualify for reasonable cost payment without regard to whether they are ''core'' or ''noncore'' nursing courses.

Other commenters argued that restricting reimbursement to courses originally offered by the provider-operated program would discourage providers from ensuring that training of health care professionals is kept up to date and would not allow providers to meet evolving requirements of accrediting organizations. One commenter noted that the conference report accompanying the Consolidated Appropriations Resolution for FY 2003 states that ''* * * the conferees support the payment of costs on a reasonable cost basis for a *hospital* that has historically been the operator of nursing and allied health education program(s) * * *'' (Emphasis added) (H.R. Rept. No. 108–10, 108th Cong., 1st Sess., 1115 (2003)). The commenter believed this language indicates that Congress intended that schools should be reimbursed, not particular courses.

In addition, commenters expressed concern that capping reimbursement for educational programs effective October 1, 2003, would further aggravate the existing shortage of appropriately trained healthcare workers. Finally, commenters suggested that the October 1, 2003 effective date be postponed because this date will cause hardship for institutions currently in the process of creating educational organizations for the purpose of transitioning their programs to those educational organizations.

Response: We acknowledge the commenters' general support of the proposed changes. In response to the commenters who disagreed with our proposal for limiting payment to certain classroom costs, as we stated in the preamble to the proposed rule (68 FR 27210), this proposed exception to the reasonable cost payment policy for programs operated by wholly-owned subsidiary educational institutions was based on a question that we received from a hospital pertaining to the language in the January 12, 2001 **Federal Register** (66 FR 3363) concerning hospitals that established their own educational institutions to meet accreditation standards. Specifically, the hospital that raised the issue previously received Medicare reasonable cost payment for the direct operation of nursing and allied health education programs and then established its own wholly-owned subsidiary college to operate the programs, in order to meet accreditation standards. The hospital in question has continued to receive Medicare payments after the hospital moved operation of the programs to the wholly-owned subsidiary college. The hospital believed that, based on the cited preamble language in the January 12, 2001 **Federal Register** regarding wholly owned subsidiary colleges and the lack of prior specific guidance on this particular organizational structure (as well as its continued receipt of pass-through payments) and because the hospital continues to pay all of the costs of the nursing and allied health education programs, that it is still the direct operator of the programs and should continue to receive pass-through treatment.

As we stated in the proposed rule, we believe that once the hospital moved the direct operation of its nursing and allied health education programs to the college, the programs no longer met our provider-operated criteria at § 413.85(f).

As we stated in the preamble language quoted above: ''a program operated by an educational institution that is related to the provider through common ownership or control would not be considered to meet the criteria for provider operated'' (66 FR 3363).

We explained that we understood that some hospitals may have interpreted the preamble language that stated, ''if the provider demonstrates that the educational institution it has established is wholly within the provider's control and ownership and that the provider continues to incur the costs of both the classroom and clinical training portions of the program, the costs would continue to be paid on a reasonable cost basis' (*Ibid.*), to mean that hospitals that establish wholly owned subsidiary colleges or educational institutions would continue to receive Medicare reasonable cost payment if the hospitals incur the costs of the classroom instruction and clinical training. Accordingly, although we proposed to clarify in the proposed rule that, in general transferring operation of previously provider-operated programs to educational institutions, even if the institutions are wholly owned by the hospital, does not necessarily mean that the programs continue to meet our provider-operated criteria under § 413.85(f), we believed it would be unfair to recoup Medicare payments that have already been made to such a hospital that meets *this very narrow fact pattern.* Therefore, we proposed to add a *limited* exception to § 413.85 to reflect the unique circumstances of such a hospital.

First, we proposed that, for portions of cost reporting periods occurring on or before October 1, 2003, Medicare would not recoup reasonable cost payment from such a hospital that has received pass-through payments for the nursing or allied health education program(s) where the program(s) had originally been operated by the hospital, and then operation of the program(s) had been transferred by the hospital to a wholly owned subsidiary educational institution in order to meet accreditation standards prior to October 1, 2003, and where the hospital had continuously incurred the costs of both the classroom and clinical training portions of the programs at the educational institution.

Second, since we believed that such a hospital's programs were no longer provider-operated, and therefore, should not continue in the future to receive *full* reasonable cost payments for the clinical and classroom costs of programs that are now operated by the wholly owned subsidiary educational institution, we proposed that, for portions of cost reporting periods occurring on or after October 1, 2003, such a hospital would continue to receive reasonable cost payments for the clinical training costs incurred by the hospital for the program(s) described above that were previously provider operated. However, we further proposed that, with respect to classroom costs, only those classroom costs incurred by the hospital for the courses that were paid by Medicare on a reasonable cost basis and were included in the hospital's provider-operated program(s) could continue to be reimbursed on a reasonable cost basis. That is, we proposed that Medicare would pay on a reasonable cost basis for the classroom costs associated with the courses provided as part of the nursing and allied health education programs (for example, the courses relating to the theory and practice of the particular nursing and allied health discipline(s)) that were offered by the hospital when the hospital was the direct operator of the program(s).

In proposing that, effective for portions of cost reporting periods occurring on or after October 1, 2003, we would only continue to pay on a reasonable cost basis for classroom costs associated with the courses that relate to the theory and practice of the particular nursing or allied health discipline(s) that were offered by the hospital when the hospital was the direct operator of the program(s), and *not* for additional classes needed to meet degree requirements provided as part of the nursing or allied health education programs, we did assume, as a commenter suggested, that diploma nursing programs typically only include courses related to the theory and practice of nursing. However, regardless of whether diploma programs include additional general courses other than ''core'' nursing courses, we continue to believe it is more appropriate to pay a hospital that meets the limited exception that allows continued payment for only those costs associated with courses included in the program(s) when the hospital was still the direct operator of the program(s). If, in fact, a hospital that meets the limited exception currently offers the same courses that it had offered when it was still the direct operator of the programs, we would continue to pay for the classroom costs associated with those courses, even if those courses do not relate directly to the theory and practice of the nursing or allied health program(s). However, if new courses, whether or not they are nursing-related or allied health-related course, have been added after the operation of the program(s) was transferred to a wholly owned subsidiary educational institution, we would not pay on a reasonable cost basis for the classroom costs associated with those new courses, effective October 1, 2003. If the courses offered currently are the same as the courses offered prior to transfer of the programs to the wholly owned subsidiary, but, for example, the names of the courses have changed, or there have been course substitutions, we would evaluate each course on an individual basis to determine whether we would continue to allow reasonable cost payment for those courses. All other things being equal (that is, after adjusting for inflation and changes in enrollment), our intent is not to pay more on a reasonable cost basis as of October 1, 2003, for classroom costs to such a hospital than we had paid to the hospital when the hospital was still the direct operator of the program(s).

In response to the comments we received that urged us not to restrict the number of courses for which we would provide reasonable cost reimbursement due to concerns about evolving accreditation requirements and the existing nursing shortage, we emphasize again that this proposal is not at all broad in scope. Rather, based on the information we currently have available to us, we believe this provision would have a limited application.. Therefore, we do not believe that our proposal will aggravate the nursing shortage or adversely affect hospitals that otherwise meet the requirements for reasonable cost payment under § 413.85 but add courses to their programs. Similarly, we do not believe that the effective date of October 1, 2003, will cause hardship to other providers that are currently in the process of transitioning their programs to educational organizations, since the proposed changes would only apply to a provider that had *already* created its own educational institution. We also note that, as indicated above, programs that transition in some respect to educational institutions created by providers could possibly be considered ''provider-operated'' under § 413.85(f) and, if all other requirements are met, could qualify to receive reasonable cost reimbursement.

Comment: One commenter disagreed with our statement in the proposed rule (68 FR 27211) that ''* * * transferring operation of previously provider-operated programs to educational institutions, even if the institutions are wholly owned by the hospital, does not necessarily mean that the programs continue to meet our provider-operated

criteria under § 413.85(f).'' Rather, the commenter believed that programs that are wholly owned or wholly controlled by a hospital are provider-operated programs. The commenter asserted that CMS'' distinction between provider-operated programs and wholly owned programs conflicts with CMS'' regulations at § 413.17(c)(2) which state that ''If the provider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the provider, in effect the items are obtained from itself.'' The commenter also referenced § 412.2(c)(5)(i) concerning the DRG 3-day payment window that applies to services provided by a hospital or by an entity wholly owned or operated by the hospital, and asserted that there is ''no rational basis'' for treating wholly owned or wholly controlled affiliates differently for purposes of pass-through payment.

Response: The commenter is incorrect in stating that, in the proposed rule, we indicated that wholly owned (or wholly controlled) programs by definition cannot meet the provider-operated criteria and, therefore, would not qualify for reasonable cost pass-through payments. In fact, as we have stated in the January 12, 2001 final rule (66 FR 3363), and reiterated in the preamble to the proposed rule, if the hospital that wholly owns the educational institution meets the provider-operated criteria, the hospital would qualify to receive reasonable cost pass-through payment. Specifically, we stated in the proposed rule (68 FR 27210) that ''Concerning those hospitals that have established their own educational institution to meet accrediting standards, we believe that, in some cases, these providers can be eligible to receive payment for the classroom and clinical training of students in approved programs. * * * An example of a program that *could be considered provider-operated* would be one in which the hospital is the sole corporate member of the college, elects the board of trustees, has board members in common, employs the faculty and pays the salaries, controls the administration of the program and the curriculum, and provides the site for the premises of the hospital (emphasis added). Thus, while we still believe that transferring operation of previously provider-operated programs to educational institutions, even if the institutions are wholly owned by the hospital, does not necessarily mean that the programs continue to meet our provider-operated criteria under § 413.85(f) (68 FR 27211), we reiterate that only in instances where the hospital continues to meet the provider-operated criteria under § 413.85(f) would the hospital continue to qualify for reasonable cost pass-through payments, as it did prior to transferring operation of a provider-operated program(s) to a wholly owned educational institution.

The commenter also mentioned the generally applicable ''related-entity'' rules, and suggested that a wholly owned school would be a related entity that should be treated as if it is the provider. Thus, a wholly owned educational institution would remain provider-operated. However, we note that, for purposes of nursing or allied health education payment under § 413.85, it is not sufficient for a program to be operated by a related entity. Rather, the ''related entity'' principles do not apply under the agency's nursing and allied health education payment policy because, as indicated in previous rulemakings, that policy requires that a program be directly operated by the provider itself. Requiring direct operation of a program by the provider ensures that, under § 413.85(c), costs borne by related organizations (that is, the community) are not redistributed to the hospital and claimed as a pass-through under the Medicare program.

Comment: Commenters requested clarification on whether the proposed change regarding providers that created wholly owned subsidiary educational institutions to meet accreditation requirements would have any effect on provider-operated nursing or allied health programs that have entered into written contracts with colleges or universities to award their degrees.

Response: As we have explained in response to a previous comment, the proposed change was extremely limited in scope and only relates to hospitals with a unique set of circumstances surrounding operation of their programs by a wholly owned subsidiary educational institution. Therefore, the proposed changes do not have any impact on existing policy related to hospitals that enter into contracts with academic institutions to award their degrees. However, we stress that, in the instance where an academic institution other than the hospital grants the final certificate or degree upon completion of the program, the burden of proof is on the hospital to demonstrate that it, in fact, meets the ''provider-operated'' criteria under § 413.85(f) before reasonable cost payment may be made to that hospital.

Comment: One commenter believed that it is inappropriate to use the term ''wholly owned'' in reference to entities that, in many cases, are nonprofit institutions because, technically, nonprofit organizations are public trusts. The commenter suggested that it would be more accurate to refer to ''wholly owned'' or ''wholly controlled'' educational institutions.

Response: We believe that, for purposes of payment under § 413.85, it is appropriate to use the term ''wholly owned.'' Although we recognize that nonprofit entities would not technically be ''wholly owned'' since they do not issue stock, we do not agree with the commenter that ''wholly controlled'' is an appropriate alternative because of the potential for confusion over issues relating to ''control'' and ''provider operation.'' Further, we believe that the term ''wholly owned'' is commonly used in the context of nonprofit entities, and implies the kind of relationship we intend—where there is a single founder or member. Therefore, we will continue to use the term ''wholly owned subsidiary'' in the context of payment under § 413.85.

We are finalizing the two proposals associated with programs operated by wholly owned subsidiary educational institutions of hospitals. Specifically, we are finalizing the proposal under new § 413.85(g)(3) that, effective for portions of cost reporting periods occurring on or after October 1, 2003, a provider that incurs costs for a nursing or allied health education program(s) where those program(s) had originally been provider-operated, and then operation of the programs) was transferred to a wholly owned subsidiary educational institution in order to meet accreditation standards prior to October 1, 2003, and where the provider has continuously incurred the costs of both the classroom and clinical training portions of the program(s) at the educational institution, may receive reasonable cost payment for such a program(s). Further, reasonable cost payment will be made if a provider received reasonable cost payment for those nursing and allied health education program(s) both prior and subsequent to the date the provider transferred operation of the program(s) to this wholly owned subsidiary educational institution (and ceased to be provider-operated program(s)). Such a provider would receive reasonable cost payments for: (a) The clinical training costs incurred for the program(s), and (b) classroom costs, but only those classroom costs incurred by the provider for the courses that were included in the programs that were

originally provider-operated prior to the transfer to a wholly owned subsidiary educational institution. That is, Medicare would pay on a reasonable cost basis for the classroom costs associated with the courses provided as part of the nursing or allied health education programs that were offered by the hospital when the hospital was the direct operator of the program(s). We would not allow such a hospital to be paid for additional classroom costs for courses that were not paid on a reasonable cost basis to the hospital in conjunction with its provider-operated programs.

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

1. Background

Under section 1886(h) of the Act, Medicare pays hospitals for the direct costs of graduate medical education (GME). The payments are based in part on the number of residents trained by the hospital. Section 1886(h)(4)(F) of the Act caps the number of allopathic and osteopathic residents that hospitals may count for direct GME.

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 § 413.86(e), 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 complex (or nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days to determine Medicare's direct GME payments.

Existing regulations at § 413.86(e)(4) specify the methodology for calculating each hospital's weighted average PRA and the steps for determining whether a hospital's PRA will be revised.

2. Prohibition Against Counting Residents Where Other Entities First Incur the Training Costs

a. General Background on Methodology for Determining FTE Resident Count

As we explain earlier in this preamble, Medicare makes both direct and indirect GME payments to hospitals for the training of residents. Direct GME payments are reimbursed 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. The indirect costs of GME are reimbursed 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. It is well-established that 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) (direct GME) and section 1886(d)(5)(B)(v) (IME) of the Act. Dental and podiatric residents were not included in this statutorily mandated cap.

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 separate reimbursement of direct GME costs ''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 on 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 non-hospital 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 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. Inappropriate Counting of FTE Residents

As we stated above, dental residents, along with podiatric residents, are excepted from the statutory cap on the count of FTE residents for both direct GME and IME payment purposes. We have become aware of a practice pertaining to the counting of FTE residents at a nonhospital site, particularly dental residents, that we see as inappropriate under Medicare policy. Most often, the situation involves dental schools that, for a number of years, have been training dental residents in programs at the dental schools of universities affiliated with teaching hospitals, and the schools have been directly incurring the costs of the dental residents training at the dental schools (for example, the teaching faculty costs, the resident salary costs, the office space costs, and any overhead expenses of the programs). We also understand that there are dental clinics at these dental schools that treat patients (that is, are involved in ''patient care activities'').

As a result of the provisions that Congress added to allow hospitals to count FTE residents and receive IME payment, as well as direct GME payment, if the hospital incurs ''all or substantially all'' the costs of training residents in nonhospital settings, a significant number of dental schools are shifting the resident training costs of the dental programs from the schools to the hospital, and thus to the Medicare program, when the hospitals count the FTE dental residents training in these dental schools (that is, ''nonhospital sites'') under the regulations at § 413.86(f)(4). Furthermore, in the case of training dentists at dental school clinics, as a result of this cost-shifting and because dental residents are excepted from the cap, hospitals are receiving significant amounts of Medicare direct GME and IME payments when they have incurred relatively small costs of the residents training in a dental school.

The following actual situations are illustrative of the inappropriate application of Medicare direct GME and IME policy that we have found:

• An academic medical center hospital associated with a university has been training allopathic residents for at least 20 years. Prior to 1999, the university's affiliated dental school had always incurred the costs of dental residency programs at the dental school. Beginning with the hospital's cost report for its fiscal year ending in 1999, for the first time ever, the hospital has requested direct GME and IME payment for an additional 67 FTE residents because the hospital claims it has begun to incur ''all or substantially all'' of the costs of the dental residents training in the university's affiliated dental school, in accordance with the regulations at § 413.86(f)(4).

• A university dental school in one State has been incurring the costs of dental residency programs at its dental school for several years. Beginning in FY 1999, a teaching hospital in a neighboring State decided to begin incurring all or substantially all of the costs of the dental residents training in the dental clinics in the program (which is located in a different State from the hospital) in order to receive Medicare direct GME and IME payment for an additional 60 FTE residents.

• In another situation, a teaching hospital on the East Coast of the United States has requested direct GME and IME payment for an additional 60 FTE dental residents, some of whom are training in dental programs at nonhospital sites located in Hawaii, New Mexico, and the Netherlands, because it has begun to incur ''all or substantially all'' of the costs of dental residents training in those remote ''nonhospital sites''. Prior to 1999, the costs for these dental programs were funded by nonhospital sources.

We note that such inappropriate cost-shifting practices are by no means limited to the dental school context. Indeed, we understand that there are some hospitals with resident counts below their direct GME and IME FTE resident caps that have recently (as of October 1, 1997, when it became possible to receive significant IME payments under the amendment made by Pub. L. 105–33) started to incur ''all or substantially all'' of the costs of residents who had been training at sites outside of the hospital without any financial assistance from the hospital, in order for the hospital to count those FTE residents and receive Medicare direct GME and IME payments for the additional residents. The actual costs of the programs that are being shifted from nonhospital entities to hospitals are relatively small, compared to the direct GME and IME payments that hospitals receive as a result of incurring ''all or substantially all'' of the training costs.

• In another example, an academic medical center hospital in one State asked Medicare to allow it to count an additional 10 FTEs for both direct GME and IME payment, beginning with its fiscal year ending 1999 cost report, because the hospital claims it is incurring all or substantially all of the costs of training osteopathic family practice residents in a walk-in clinic. The osteopathic family practice residency program had previously been sponsored by this clinic for several years and the residents do not participate in any training at the hospital.

c. Congressional Intent

Congress has delegated broad authority to the Secretary to implement a policy on the count of FTE residents for purposes of calculating direct GME and IME payments. For IME payment, section 1886(d)(5)(B) of the Act simply states that ''the Secretary shall provide for an additional payment amount'' which includes ''the ratio of the hospital's full-time equivalent interns and residents to beds.'' The methodology to compute the count of FTE residents for IME is not established in the statute. Similarly, for direct GME, section 1886(h)(4)(A) of the Act states that ''the Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time equivalent residents in an approved medical residency training program.''

Although not in the context of the general rules for counting FTE residents, Congress similarly acknowledged its intent to defer to the Secretary with respect to the rules for implementing ''limits'' or caps on the number of FTE residents hospitals may count for purposes of direct GME and IME payment. The conference agreement that accompanied Pub. L. 105–33, which established a cap on the number of allopathic and osteopathic residents a hospital may count, states—

''[T]he Conferees recognize that such limits raise complex issues, and provide for specific authority for the Secretary to promulgate regulations to address the implementation of this provision. The Conferees believe that rulemaking by the Secretary would allow careful but timely consideration of this matter, and that the record of the Secretary's rulemaking would be valuable when Congress revisits this provision.'' (H.R. Conf. Rep. No. 105–217, 105th Cong., 1st Sess., 821 (1997).

The absence of statutory specificity on determining FTE counts in these situations and the declared Congressional delegations of authority to the Secretary on the subject are clear indications that Congress has given the Secretary broad discretion to promulgate reasonable regulations in order to implement the policy on the

counting of residents for direct GME and IME payments.

When Congress enacted the nonhospital site provisions for both direct GME and IME, Congress intended to address application of the FTE count policy to situations where the training site had been the hospital. The intent was to create incentives for hospitals to move resident training from the hospital to nonhospital settings. We believe that Congress did not intend for hospitals to be able to add to their FTE counts residents that had historically trained outside the hospital in other settings. Training in those nonhospital settings had historically occurred without Congress offering any financial incentive to hospitals to move the training out of the hospital.

This Congressional intent is evident in the legislative history of both the direct GME and the IME provisions on nonhospital settings. First, legislative history associated with passage of the direct GME provision (as part of Pub. L. 99–509) indicates that Congress intended to broaden the scope of settings in which a hospital could train its residents and still receive separate direct GME cost reimbursement, and to provide incentives to hospitals for training residents in primary care programs. The Conference committee report indicates that ''[s]ince it is difficult to find sufficient other sources of funding [than hospitals and Medicare] for the costs of such training, [that is, training in freestanding primary care settings such as family practice clinics or ambulatory surgery centers] *assignments to these settings* are discouraged. It is the Committee's view that training in these settings is desirable, because of the growing trend to treat more patients *out of the inpatient hospital setting* and because of the encouragement it gives to primary care.'' (Emphasis added.) (H.R. Rep. No. 99–727, 99th Cong., 1st Sess., 70 (1986).)

Thus, from the start of the policy allowing payment for training in nonprovider sites, we believe Congress intended to create a monetary incentive for hospitals to rotate residents from the hospital to the nonhospital settings. We believe Congress did not intend for hospitals to be paid for residents who had previously been training at nonhospital sites without hospital funding.

Further, in the Conference committee report accompanying the provision of Pub. L. 105–33 on IME payment for training in nonhospital settings, Congress stated that ''[t]he conference agreement includes new permission for *hospitals to rotate residents through nonhospital settings,* without reduction in indirect medical education funds.'' (Emphasis added.) (H.R. Conf. Rep. No. 105–217, 105th Cong., 1st Sess., 817 (1997).)

We note that, prior to enactment of Pub. L. 105–33, if a hospital rotated a resident to train at a nonhospital site, the hospital could not count the time the resident spent at the nonhospital site for purposes of Medicare IME payments. As a result, the lack of IME payments acted as a disincentive and discouraged hospitals from rotating residents out of the hospital. Therefore, Congress authorized hospitals to count residents in nonhospital sites for IME purposes as a specific incentive to encourage hospitals to rotate their residents to nonhospital sites (and not to encourage hospitals to incur the costs of a program at a nonhospital site that had already been funded by other sources). This legislative intent becomes more apparent when the nature of the Medicare IME payment is considered. The Medicare IME payment is inherently a payment that reflects the increased operating costs of treating inpatients as a result of the hospital having a residency program. For example, as explained in the September 29, 1989 final rule (54 FR 40286), the indirect costs of medical education might include added costs resulting from an increased number of tests ordered by residents as compared to the number of tests normally ordered by more experienced physicians.

The IME payment is an adjustment that is made for each Medicare discharge from the areas subject to the IPPS in a teaching hospital. The authorization by Congress for IME payments relating to nonhospital services while residents are training at nonhospital sites would be absurd if not viewed as an incentive to transfer existing residency training from the hospital to the nonhospital setting. We do not believe Congress intended to permit such IME payments to be allowable to the hospital that is incurring ''all or substantially all the costs'' of residents training in nonhospital sites except in the situation where the hospital rotated residents from the hospital to the nonhospital settings. The illustrative situations described above in which nonhospital sites, such as dental schools, are shifting the costs of existing programs to the hospitals are not consistent with the intent of Congress to encourage hospitals to rotate residents from the hospital setting to nonhospital sites.

Thus, we believe Congress intended both cited provisions of the Act on counting residents in nonhospital sites for purposes of direct GME and IME payments to be limited to situations in which hospitals rotate residents from the hospital to the nonhospital settings, and not situations in which nonhospital sites transfer the costs of an existing program at a nonhospital site to the hospital.

d. Medicare Principles on Redistribution of Costs and Community Support

It is longstanding Medicare policy that if the community has undertaken to bear the costs of medical education, these costs are not to be assumed by the Medicare program. In addition, medical education costs that have been incurred by an educational institution may not be redistributed to the Medicare program. Indeed, these concepts, community support and redistribution of costs, have been a part of Medicare GME payment policy since the inception of the Medicare program. Both the House and Senate Committee reports accompanying Pub. L. 89–97 (the authorizing Medicare statute) indicate that Congress intended Medicare to share in the costs of medical education only in situations in which the community has not stepped in to incur them:

''Many hospitals engage in substantial education activities, including the training of medical students, internship and residency programs, the training of nurses and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution and it is intended, *until the community undertakes to bear such education costs in some other away,* that a part of the net cost of such activities * * * should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program. (Emphasis added.) (S. Rep. No. 404, 89th Cong., 1st Sess., 36 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess., 32 (1965).)

The principle behind the congressional committee report language for Pub. L. 89–97 that Medicare would share in the costs of educational activities until communities bore them in some other way has guided Medicare policy on educational activities from the inception of the Medicare program. The principles of community support and redistribution of costs associated with payment for GME have been continually reiterated in various regulations, manual provisions, and implementing instructions to fiscal intermediaries. As recently as the final rule published in the **Federal Register** on January 12, 2001, we stated:

''We note that the proposed revisions in the proposed rule inadvertently did not include community support as the basis for an offset from the allowed cost of a GME or nursing and allied health program. In this final rule, we restate our longstanding policy that Medicare will share in the costs of educational activities of providers where communities have not assumed responsibility for financing these programs. Medicare's policy is to offset from otherwise allowable education costs, community funding for these activities.'' (66 FR 3368)

We note the instructions that CMS (then HCFA) gave to its Regional Offices in the 1990 audit instructions for purposes of calculating the direct GME base period PRA specifically addressed redistribution of costs and community support in the GME context:

''Where costs for services related to medical education activities have historically been borne by the university, it is assumed the community has undertaken to support these activities, and subsequent allocation of these costs to a hospital constitutes a redistribution of costs from an educational institution to a patient care institution. In such a situation, these costs are not allowable under the Medicare program. (See 42 CFR 413.85(c) and HCFA Pub. 15–1, § 406). For example, if in the past the hospital did not identify and claim costs attributable to the time teaching physicians spent supervising I&Rs [interns and residents] working at the hospital, it is assumed that these costs were borne by the university. Therefore, the hospital may not claim these costs in subsequent cost reports.'' (Instructions for Implementing Program Payments for Graduate Medical Education to ARAs for Medicare, Director of Office of Financial Operations of the Health Care Financing Administration, BPO–F12, February 12, 1990.)

Furthermore, the regulation at § 413.85(c) that was originally issued in the **Federal Register** on September 30, 1986 (51 FR 34793) (which was further refined, but conceptually left unchanged, as of March 12, 2001) addressed the Congressional intent not to increase program costs, as well. That paragraph (c) stated:

Educational Activities. Many providers engage in education activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties.* * * Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

The Secretary of Health and Human Services interpreted this provision to deny reimbursement of educational costs that were borne in prior years by a hospital's affiliated medical school. The U.S. Supreme Court affirmed the Secretary's interpretation of the redistribution of costs regulation in *Thomas Jefferson University* v. *Shalala (''Thomas Jefferson''*), 512 U.S. 504 (1994). The Court found of § 413.85(c) that:

''The regulation provides, *in unambiguous terms,* that the 'costs' of these educational activities will not be reimbursed when they are the result of a 'redistribution,' or shift, of costs of an 'educational' facility to a 'patient care' facility.'' (Emphasis added.) (Thomas Jefferson, 512 U.S. at 514). Thus, the Supreme Court in *Thomas Jefferson* held that it is well within the Secretary's discretion to interpret the language at § 413.85(c), which was specifically derived from the legislative history of the original enacting Medicare legislation quoted above, to impose a substantive limitation on medical education payment.

The Supreme Court's opinion in *Thomas Jefferson* lends substantial support and credibility to CMS'' longstanding policy on community support and redistribution of costs in the GME context.

e. Application of Redistribution of Costs and Community Support Principles.

As we have described above, we have discovered an inappropriate application of Medicare direct GME and IME payment policies relating to the counting of FTE residents in nonhospital settings. As stated previously, we believe that: (1) Congress has given the Secretary broad discretion to implement policy on FTE resident counts; (2) Congress intended that the nonhospital site policy for both direct GME and IME would encourage hospitals to move resident training from the hospital to nonhospital settings, not to enable nonhospital sites to shift the costs of already established residency programs in the nonhospital site to the hospital; and (3) since the inception of the Medicare program, CMS'' policy has been consistent with the intent of Congress that Medicare would only share in the costs of medical education until the community assumes the costs. The Supreme Court has specifically found that CMS'' implementation of the redistribution of costs and community support principles is ''reasonable.'' (*Thomas Jefferson,* 512 U.S. at 514.)

Accordingly, in the May 19, 2003 proposed rule, we proposed that residents training at nonhospital sites may be counted in a hospital's FTE resident count only where the principles of redistribution of costs and community support are not violated. We proposed this policy to address the inappropriate practice of nonhospital sites shifting costs to hospitals solely to allow the hospitals to count residents training in the nonhospital sites. However, we believe the concepts of redistribution of costs and community support are equally relevant to the counting of FTEs residents by a hospital in general.

We note again that the Medicare program has a long tradition of applying redistribution of costs and community support principles to medical education payments. As we have stated above, both the House and Senate Committee reports accompanying Pub. L. 89–97 (the 1965 authorizing Medicare statute) indicate that Congress intended Medicare to share in the costs of medical education only where the community has not stepped in to incur them.

We believe it is appropriate to employ the principles of redistribution of costs and community support to specifically address the inappropriate scenarios described above whereby hospitals attempt to inflate their FTE resident counts by assuming payment of training costs for residents in nonhospital sites that were previously funded by a nonhospital entity. Therefore, we proposed to specify the application of the redistribution of costs and community support principles by adopting the definitions (with some modification to reflect the methodology for counting FTE residents applicable to GME) of ''community support'' and ''redistribution of costs'' at § 413.85(c), which relate to nursing and health education program costs, for use at § 413.86(b), which relates to GME. In addition, we proposed a general rule at proposed § 413.86(i) on the application of community support and redistribution of costs principles to the counting of FTE residents for GME. We proposed to (1) make the provisions under § 413.86(f) relating to determining the number of FTE residents subject to the provisions of the proposed § 413.86(i); (2) add a proposed § 413.86(f)(4) in order to clarify that the principles of redistribution of costs and community support are applicable to the counting of FTE residents, including when the residents are training in nonhospital settings; and (3) making the

provisions of the proposed § 413.86(i) specifically applicable to determining the number of FTE residents under § 413.86(g)(4) through (6) and (g)(12).

The general rule at proposed § 413.86(i) contained two provisions. Proposed § 413.86(i)(1) stated the principles of community support and redistribution of costs: In relation to community support, we proposed that if the community has undertaken to bear the costs of medical education through community support, the training costs of residents that are paid through community support are not considered GME costs to the hospital for purposes of Medicare payment. In relation to redistribution of costs, we are proposing that 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.

In applying the redistribution of costs and community support principles, we proposed under § 413.86(i)(2) to state that a hospital must continuously incur direct GME costs of residents training in a particular program at a training site since the date the residents first began training in that site in order for the hospital to count the FTE residents in accordance with the provisions of paragraphs (f) and (g)(4) through (g)(6), and (g)(12) of § 413.86.

We note that our reasons for specifically referencing the applicability of the principles of community support and redistribution of costs at § 413.86(f)(4), the paragraph concerning counting residents training in nonhospital settings for direct GME purposes, are twofold. First, although we already proposed to make the proposed § 413.86(i) applicable to § 413.86(f), which would make the principles applicable to each paragraph under § 413.86(f), in consideration of the inappropriate applications we have identified of the GME FTE-counting policy with respect to counting residents in nonhospital sites, we believe it is appropriate to also specifically address the applicability of the redistribution of costs and community support principles to § 413.86(f)(4). In addition, we note that the proposed reference at § 413.86(f)(4) has implications for IME payment as well, as explained below.

Under existing § 412.105(f)(1)(ii)(C), the rule for the counting of FTE residents training in nonhospital settings for IME payment, there is a specific reference indicating that the criteria set forth in § 413.86(f)(4) must be met in order for a hospital to count the FTE residents training in nonhospital settings for purposes of IME payments. Thus, if under proposed § 413.86(f)(4)(iv) (the paragraph making redistribution of costs and community support principles applicable) a hospital is not permitted to count the FTE residents training in a nonhospital site because of redistribution of costs or community support, the hospital would not be permitted to count the FTE residents for purposes of IME payment as well, because the IME regulation at § 412.105(f)(1)(ii)(C) requires the criteria under § 413.86(f)(4) to be met.

As we have stated above, payment for IME is based on the concept that, as a direct result of the hospital's resident training program, the costs the hospital incurs for patient care are increased. When Congress included section 1886(d)(5)(B)(iv) of the Act as part of Pub. L. 105–33, the statute expanded the circumstances under which IME payments to a hospital could be made by allowing the hospital to count the number of residents training outside the hospital setting under certain conditions. Even though it is clear that those residents training outside the hospital cannot have any impact on patient care costs to the hospital, Congress nevertheless allowed the hospital to receive IME payments when the hospital counts FTE residents training in a nonhospital setting in accordance with section 1886(d)(5)(B)(iv) of the Act, where those residents would otherwise have trained in the hospital setting. As we have stated, Congress created an incentive (or removed a disincentive) with the provisions of Pub. L. 105–33 for hospitals to rotate residents to nonhospital settings by allowing hospitals to continue to receive IME payment as if the residents continued to train in the hospital setting. If there is a redistribution of costs or community support, we believe IME payment to the hospital would be contrary to Congressional intent to encourage the hospital to rotate residents from the hospital to the nonhospital site.

In addition, when Congress included section 1886(d)(5)(B)(iv) of the Act as part of Pub. L. 105–33, the statutory authority for IME payment was premised on the hospital incurring the direct GME costs of the residents: ''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.'' (Emphasis added.) (Section 4621(b)(2) of Pub. L. 105–33; section 1886(d)(5)(B)(iv) of the Act.) We believe Congress intended the hospital to incur direct GME costs of the program in the nonhospital site in order to count the FTE residents training in nonhospital settings for purposes of IME payment. Thus, in the situation where a hospital incurred direct GME costs but there was redistribution of costs or community support, a disallowance of direct GME payments as well as a disallowance of IME payments is appropriate.

Although we are stating generally that the principles of community support and redistribution of cost have applied since the inception of Medicare to graduate medical education payment, as we have stated above, we have identified relatively recent inappropriate application of the nonhospital site policy for counting FTE residents. Therefore, we believed it was appropriate to propose to identify January 1, 1999 as the date our fiscal intermediaries should use to determine whether a hospital or another entity has been incurring the costs of training in a particular program at a training setting for purposes of determining whether there has been a redistribution of costs or community support. We proposed that January 1, 1999 be used as the date the fiscal intermediaries should use for determinations, since it may be difficult for our fiscal intermediaries to obtain from hospitals contemporaneous documentation that the hospitals have appropriately been incurring the direct GME costs in earlier fiscal years. We believe the January 1, 1999 date should simplify confirmation by our fiscal intermediaries and hospitals of whether the hospital or another entity had been incurring the costs of the program in particular training settings and whether redistribution of costs or community support had occurred. We have chosen the January 1, 1999 date because of administrative convenience and feasibility, so that necessary data are both valid and available, and in recognition of the fact that our fiscal intermediaries must prioritize their limited audit resources. While we are not requiring our fiscal intermediaries to determine whether a hospital had been incurring the training costs of a program prior to the January 1, 1999 date, if the fiscal intermediaries determine that there is a redistribution of costs or community support exists with respect to certain residents prior to January 1, 1999, a disallowance of direct GME and IME payments with respect to those FTE residents would certainly be required.

Since calculation of a hospital's FTE resident count is dependent upon whether the hospital incurred the training costs, we proposed to require

each teaching hospital and its fiscal intermediary to determine which entity had been incurring the training costs at least since January 1, 1999. For example, if a nonhospital entity, such as a school of medicine or dentistry, had incurred the costs of training the residents anytime on or after January 1, 1999, and a hospital subsequently begins to incur direct GME costs of training those FTE residents, the hospital would not qualify to count those FTE residents for purposes of direct GME and IME payments.

We note that the proposal stated that a hospital must have been *continuously* incurring the costs of the training since the date the residents first began training in that program. Accordingly, if a hospital had at one time incurred the costs of training residents in a particular program, whether at the hospital or in a nonhospital setting, but a nonhospital institution later assumed the costs of training in that setting, even if the hospital assumed payment for the training costs again, the hospital could not then count those residents for purposes of direct GME and IME payments.

We note that if a hospital incurs the direct GME costs, whether training takes place inside the hospital or in a nonhospital setting, in a new residency program, the hospital may be eligible to count the FTE residents as specified by the regulations under § 413.86(g)(6).

Consistent with the policy on redistribution of costs and community support discussed above, if a hospital incurs the direct GME costs of *additional* FTE residents training in an existing program in a hospital setting where the costs of the existing program had been incurred by a nonhospital entity and the hospital has continuously funded the *additional* residents in the existing program in the hospital setting since the date the residents first began training there, the redistribution of costs or community support principles would not prohibit the hospital from counting the additional FTE residents for purposes of direct GME and IME payments.

We note that, under existing policy, to count residents in a nonhospital setting, a hospital is required to incur for ''all or substantially all of the costs of the *program*'' in that setting. In other words, a hospital is required to assume financial responsibility for the *full* complement of residents training in a nonhospital site in a particular program in order to count any FTE residents training there for purposes of IME payment. A hospital cannot count any FTE residents if it incurs ''all or substantially all of the costs'' for only a portion of the FTE residents in that program training setting. This policy is derived from the language of the IME and direct GME provisions of the statute on counting residents in nonhospital settings; both sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act state that the hospital must incur ''all, or substantially all, of the costs for the training *program* in that setting.'' (Emphasis added.) In contrast, as explained earlier, it is permissible under the proposed policy on the application of the redistribution of costs and community support principles for the hospital to count FTE residents where the hospital incurs direct GME costs of FTE residents that are *added* to an existing program, even though the hospital may not count the existing FTE residents due to the application of the redistribution of costs or community support rules. In the nonhospital setting, as a result of the interaction of these two separate FTE counting requirements—(1) that the hospital must not violate the redistribution of costs and the community support principles in order to count the resident FTEs in the nonhospital settings, and (2) that the hospital must incur ''all or substantially all'' of the costs for the training program in that setting—a hospital would be prohibited from counting FTE residents added to an existing program at a nonhospital site unless the hospital incurs all or substantially all of the costs of training *all* of the residents in that program at that setting. That is, even if the hospital incurs all or substantially all of the costs for all of the training program at the nonhospital site, the hospital would only be able to count the additional FTE residents who were not excluded by application of the redistribution of costs or community support principles.

For example, training in a general dentistry program with 10 FTE residents has taken place at a school of dentistry for 20 years. The school of dentistry has been incurring the training costs of the general dentistry residents since the inception of the program. Beginning in 2003, the school of dentistry has decided to add an additional 5 FTE residents to the program, and Hospital A decides to incur ''all or substantially all'' the costs of those 5 additional FTE residents only. Applying the policy concerning redistribution of costs and community support in combination with the policy on incurring all or substantially all of the costs, the hospital could not count the additional 5 FTE residents in the dental school since it is not paying for all or substantially all of the costs of the program. Even if the hospital were to incur all or substantially all of the costs for the training program for all 15 FTE residents, the hospital could not count the 10 FTEs that were part of the existing general dentistry program because of the redistribution of costs and community support principles; it would be a redistribution of costs for the hospital to begin to incur direct GME costs of the 10 FTE residents when the dental school had previously been incurring those costs.

We note that such a result does not occur when a *new program* is established in the nonhospital site. If, from the outset of the program, the hospital incurs direct GME costs and also incurs ''all or substantially all'' of the costs for the training program for all the new residents training at the site, there would be no redistribution of costs or community support, and the hospital could count all of those residents in the new program in its FTE count (subject, of course, to the hospital's 1996 FTE resident cap).

We also note that the interaction of the two provisions discussed above—redistribution of costs and community support, and ''all or substantially all''—does not occur when counting FTE residents training inside the hospital, since a hospital is not required to incur ''all or substantially all'' of the costs for the training program inside the hospital.

Furthermore, if one hospital had incurred the direct GME costs of training residents in a particular program in a nonhospital site from one point in time, for example, 1995 through 1999, and then another hospital consecutively incurs the costs from 2000 and thereafter, the second hospital may be eligible to receive direct GME and IME payments for training the FTE residents from the point in time where the second hospital incurred the direct GME costs, and the redistribution and community support exclusions would not apply. The second hospital may be eligible to receive Medicare direct GME and IME payments because the costs were incurred previously by a hospital, and not either the community or the university. Therefore, there was neither community support nor redistribution of costs.

The following are some examples to clarify how the proposed policies would be implemented:

Example 1

Since 1995, 10 FTE residents in an internal medicine program have been training in the Community Clinic. In accordance with the current provisions of § 413.86(f), Hospital A has incurred all or substantially all of the costs of

training the 10 FTE residents since 1995. Assuming the current provisions of the regulations at §§ 412.105(f)(1)(ii)(C) and 413.86(f)(3) and (f)(4) are met, Hospital A may continue to receive IME and direct GME payments for 10 FTE residents because Hospital A had incurred direct GME costs continuously (as evidenced by contemporaneous documentation since January 1, 1999), as specified in our proposed regulation.

Beginning July 1, 2004, in addition to continuing to incur all or substantially all of the costs of the first 10 FTE internal medicine residents training in the nonhospital site, Hospital A also incurs all or substantially all of the costs of training an additional 3 FTE internal medicine residents at that site. Accordingly, beginning July 1, 2004, Hospital A may count all 13 FTE residents training in the Community Clinic for purposes of direct GME and IME payments, assuming Hospital A does not exceed its FTE cap for IME and direct GME.

Example 2

Since 1995, 2.25 dental FTE residents in a dental school program were training in a dental clinic at the dental school. While the 2.25 FTEs were training at the clinic, the dental school paid for all of the costs of the dental program. Prior to July 1, 2000, Hospital A signed a written agreement with the clinic to incur all or substantially all of the costs of training the 2.25 FTE residents, from July 1, 2000 and onward. Thus, beginning with July 1, 2000, the dental school no longer incurred the costs of the program at this nonhospital site. In this scenario (even if Hospital A inappropriately received direct GME and IME payments for the 2.25 FTEs since July 1, 2000), Hospital A may not receive direct GME or IME payment for the 2.25 FTE residents training in the clinic because there would have been a redistribution of costs associated with training these 2.25 FTE residents from the dental school to the hospital.

Example 3

Since 1995, 2.25 FTE residents in a family practice program were training in a physicians' group practice. While the 2.25 FTEs were training at the physicians' practice, a school of medicine paid for the costs of the family practice residency program. Prior to July 1, 2000, Hospital A signed a written agreement with the physicians' practice to send 1 additional family practice FTE resident to the physicians' practice and to incur all or substantially all of the costs of training the original 2.25 FTE residents *and* the 1 additional FTE, from July 1, 2000 and onward. Thus, beginning with July 1, 2000, the school of medicine no longer incurred the costs of the program at this nonhospital site. Hospital A may not count the 2.25 FTE residents that had been training since 1995 in that physicians' practice for purposes of direct GME and IME payments because the training costs were shifted from the school of medicine to the hospital. However, Hospital A may count the 1 FTE resident the hospital began to rotate for training in the physicians' practice because there was no cost-shifting for that resident and Hospital A incurred ''all or substantially all'' of the costs of the entire family practice program in the physicians' office setting.

Example 4

Residents in a surgery program have been rotating from a hospital to two nonhospital clinics, Clinic A and Clinic B, since 1996. The training of the surgery residents in Clinic A has been supported by a nonhospital institution since 1996, while the hospital has incurred all or substantially all of the costs of the surgery residents in Clinic B since 1996. The hospital cannot count the surgery FTE residents training in Clinic A, even if it begins to pay for all of the costs of the program at that site, since a nonhospital institution had supported the training in Clinic A since 1996 (in other words, the redistribution of costs and community support principles would prohibit the hospital from counting these FTE residents). However, if the hospital continues to incur all or substantially all of the costs of the surgery residents in Clinic B, the hospital may count the FTE residents training in Clinic B for purposes of direct GME and IME payments because there would be no cost-shifting to the hospital for these residents and the hospital would incur all or substantially all of the costs for the training program in that setting.

We received a large number of comments from the public on this proposal. Following is a summary of these comments and our responses:

Comment: Some commenters supported our proposed application of redistribution of cost and community support to direct GME. One commenter stated: ''We believe that the proposed changes * * * will result in more accurate and consistent reimbursement to providers. The changes provide more definitive guidance to providers and to intermediaries in applying the regulations. In addition, the changes will more closely match Medicare reimbursement with actual IPPS-type services. This is especially true in the case of dental residents, who typically spend little or no time caring for patients receiving IPPS type services.''

Response: We agree with the commenters' assertions and appreciate the commenters' support of our proposals on redistribution of costs and community support.

Comment: Many commenters disagreed with our proposed application of redistribution of cost and community support to direct GME. In general, they believed they did not receive proper notice of the application of the principles. One commenter stated: ''[t]he proposed change to the rules midstream, and only with respect to subsequent payment years, distorts the balance on which the established payment formula depends.'' Other commenters believed that, in the past, CMS has never suggested that incurring the costs of offsite training in the then-current year would be a condition to hospitals' claiming those costs in future years. The commenters contended that nowhere in the regulations promulgated has CMS stated that, in order to receive GME and IME payments, a hospital must meet an additional requirement of incurring the training costs since the inception of the training program. The commenters believed it is inequitable to impose such a ''retroactive requirement.''

The commenters stated that many hospitals that were contemplating whether to initiate a training program in a nonhospital setting, notified CMS in advance of establishing such a program, and requested CMS's approval. One commenter stated that, in numerous cases, ''including some of the cases discussed in the regulatory preamble, CMS issued a written approval of the proposed training program. In such approval letters, CMS never mentioned the redistribution of costs and community support principles.''

Finally, another commenter stated that there is nothing in the direct GME and IME statutes that supports CMS' decision to apply redistribution of costs and community support principles.

Response: The principles of redistribution of cost and community support associated with Medicare's payments for GME have been in existence for over 35 years, that is, since the inception of the Medicare program in 1965. The principles have been continually reiterated in various regulations, manual provisions, and implementing instructions to fiscal intermediaries. We do not believe we have given the public any reason to conclude that the principles would not continue to be applicable. Several examples of our views on the principles

of redistribution of cost and community support were mentioned in the proposed rule. These included:

Both the House and Senate Committee reports accompanying Pub. L. 89–97 (the authorizing Medicare statute) indicate that Congress intended Medicare to share in the costs of medical education *only* in situations in which the community has not stepped in to incur them:

''Many hospitals engage in substantial education activities, including the training of medical students, internship and residency programs, the training of nurses and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution and it is intended, *until the community undertakes to bear such education costs in some other away,* that a part of the net cost of such activities * * * should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.'' (Emphasis added.) (S. Rept. No. 404, 89th Cong., 1st Sess., 36 (1965); H.R. Rept. No. 213, 89th Cong., 1st Sess., 32 (1965).)

The principle behind the congressional committee report language for Pub. L. 89–97 that Medicare would share in the costs of educational activities until communities bore them in some other way has guided Medicare policy on educational activities from the inception of the Medicare program.

The regulations that evolved from the authorizing legislation, first published on November 22, 1966 (31 FR 14814), as well as Chapter 4 of the Provider Reimbursement Manual in 1971, echoed the congressional committee report language from 1965 that Medicare would share in the costs of educational activities until communities bore them in some other way.

As recently as the final rule published in the **Federal Register** on January 12, 2001, we stated:

''We note that the proposed revisions in the proposed rule inadvertently did not include community support as the basis for an offset from the allowed cost of a GME or nursing and allied health program. In this final rule, we restate our longstanding policy that Medicare will share in the costs of educational activities of providers where communities have not assumed responsibility for financing these programs. Medicare's policy is to offset from otherwise allowable education costs, community funding for these activities.'' (66 FR 3368)

Although the above language was written in the context of a regulation that clarified Medicare policy for provider (hospital) operated nursing and allied health education programs, we note that GME and nursing and allied health education programs were historically paid under the same regulations (the latest of which was codified at § 413.85) and the same cost principles. The quoted language is indicative of this relationship and the Agency's mindset that, while direct GME may have changed in the method of payment to a prospective payment, some principles, such as redistribution of cost and community support, continue to apply as they do with nursing and allied health education at § 413.85(c). Further evidence of continued application is at existing § 413.85(c) in the definition of ''redistribution of cost'': ''* * * costs for a school of nursing or allied health education or a medical school that were incurred by an educational institution and were not allowable to the provider [hospital] in its prospective payment or a rate-of-increase limit base year cost report, or graduate medical education per resident amount calculated under § 413.86, *are not allowable costs in subsequent fiscal years.*'' (Emphasis added.) Therefore, even codified in regulations now is a policy that applies the principle of redistribution of cost to direct GME payments *in subsequent years.*

Furthermore, § 413.85(c), which was a codification of longstanding Medicare policy, was originally issued in the **Federal Register** on September 30, 1986 (51 FR 34793) and was further refined, but conceptually left unchanged, as of March 12, 2001 (*see* 66 FR 3358). Section 413.85(c) addressed the Congressional intent not to increase program costs resulting from redistribution of costs, as well. That paragraph (c) stated:

''*Educational Activities.* Many providers engage in education activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. * * * Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.''

We note that the guidance that CMS (then HCFA) gave to its Regional Offices in the 1990 audit instructions for purposes of calculating the direct GME base period PRA specifically addressed redistribution of costs and community support in the GME context:

''Where costs for services related to medical education activities have historically been borne by the university, it is assumed the community has undertaken to support these activities, and subsequent allocation of these costs to a hospital constitutes a redistribution of costs from an educational institution to a patient care institution. In such a situation, these costs are not allowable under the Medicare program. (*See* 42 CFR 413.85(c) and HCFA Pub. 15–1, section 406). For example, if in the past the hospital did not identify and claim costs attributable to the time teaching physicians spent supervising I&Rs [interns and residents] working at the hospital, it is assumed that these costs were borne by the university. Therefore, the hospital may not claim these costs in subsequent cost reports.'' (Instructions for Implementing Program Payments for Graduate Medical Education to ARAs for Medicare, Director of Office of Financial Operations of the Health Care Financing Administration, BPO–F12, February 12, 1990.)

We believe we have continually put the public on notice that the Medicare program has applied and continues to apply the principles of redistribution of costs and community support to payments for education costs, including direct GME payments to hospitals. Therefore, we *do not* believe that we have proposed changes to the rules ''in midstream'' as one commenter suggested. Nor do we believe, as the commenters suggested, that we have proposed a ''retroactive requirement.'' We have never disavowed the principles of redistribution of cost and community support. Rather, we have continually promulgated rules and program guidance on the application of the principles since the inception of the Medicare program.

We again point to the Supreme Court case, *Thomas Jefferson,* to demonstrate CMS' *longstanding* policy on community support and redistribution of costs in the GME context. In *Thomas Jefferson,* the Secretary of Health and Human Services interpreted the regulation at § 413.85(c) to deny reimbursement of educational costs that were borne in prior years by a hospital's affiliated medical school for purposes of calculating the direct GME base year allowable cost for the PRA. The U.S. Supreme Court affirmed the Secretary's interpretation of the redistribution of costs regulation. The Court found that:

''The regulation [at § 413.85(c)] provides, *in unambiguous terms,* that the 'costs' of these educational activities will not be reimbursed when they are

the result of a 'redistribution,' or shift, of costs of an 'educational' facility to a 'patient care' facility.'' (Emphasis added.) (*Thomas Jefferson,* 512 U.S. at 514).

In addition, in response to the argument by the provider that CMS (then HCFA) had been silent in internal operating instructions in a 1978 operating memorandum on the policies of redistribution and community support, as well as in another exchange of memoranda in 1982 and other agency documentation, the Court stated that the omission in these documents of discussion of redistribution and community support is not indicative of a contrary policy on GME reimbursement: ''* * * the mere failure to address [the redistribution principle in an intermediary letter] hardly establishes an inconsistent policy on the part of the Secretary.'' *Thomas Jefferson,* 512 U.S. at 516.

Thus, the Supreme Court in *Thomas Jefferson* held that it is well within the Secretary's discretion to interpret the language at § 413.85(c), which was specifically derived from the legislative history of the original legislation that enacted Medicare, to impose a substantive limitation on medical education payment, even in the arguably novel context of calculating a hospital's GME costs for purposes of the base year PRA.

To address the commenters' point that CMS ''never mentioned the redistribution of costs and community support principles'' in CMS ''approval letters'' to hospitals that requested ''approval'' from CMS in advance of establishing a relationship with a nonhospital site in order to count the residents training in that setting, we note that when the letters were written to CMS in fiscal year end 1999–2002, it was not clear at all from the incoming correspondence that hospitals were not, in fact, rotating the hospital-based residents to the nonhospital setting in accordance with statutory intent. In other words, it was not clear from the incoming correspondence that a redistribution of costs was being contemplated by the hospitals. In addition, the letters did not explicitly mention that the costs of the program were currently being borne by the community in the contemplated arrangements. In the last 2 or 3 years, when hospitals met with or wrote to CMS for guidance on the nonhospital site policy under § 413.86(f)(4), we provided responses that were limited to the scope of the inquiries. We answered questions about the requirements of § 413.86(f)(4). It did not seem necessary to bring up the issue of ''redistribution'' or ''community support'' because it was not apparent that the community had previously incurred the direct GME costs. It was not until the relatively recent audits by our fiscal intermediaries of the fiscal year ending 1998 and 1999 cost reports of certain hospitals that CMS became aware that cost shifting was occurring. With this awareness came the necessity to explicitly reassert and explain the application of the longstanding Medicare principles of redistribution of costs and community support.

Comment: Several commenters have stated that the principles of redistribution of cost and community support do not apply in determination of a hospital's FTE resident count for direct GME. One commenter argued, in part relying on a Federal district court case, *Episcopal Hospital* v. *Shalala*, 1997 U.S. Dist. Lexis 8701 (E.Da.Pa. 1997), to state: ''* * * CMS has argued, and the courts have agreed, that Medicare cost principles have no effect with respect to the direct GME payment method prescribed by section 1886(h) of the Act * * * these principles implement the statutory provision in section 1861(v) of the [Social Security] Act for payment of reasonable cost.'' This commenter also quoted extensively from the September 29, 1989 final rule to argue that the GME regulation ''construes the GME statute so as to preclude consideration of allowable costs incurred in connection with a resident's training.''

Similarly, another commenter believed that Congress ''replaced the old reasonable cost payment system'' with a prospective payment methodology, and that those principles that formed the basis for reasonable cost payments for GME were no longer relevant. The commenter believed the redistribution of costs and community support principles have no application to the current payment methodology, which relies on FTEs and PRAs.

Several commenters also disputed our citation to the *Thomas Jefferson* case for application of the principles to FTE counts. The commenters believed that CMS should not use this case in support of our policy because the case did not discuss applying the principles to the counting of residents. In addition, they believe the case was ''very limited'' and ''only discussed the establishment of base year resident costs, which were used in developing base payment rates.''

Response: We disagree with the commenters that the principles of redistribution of costs and community support do not apply in determination of a hospital's FTE resident count for direct GME. When Congress enacted section 1886(h) of the Act as part of section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272) on April 7, 1986, it did not altogether ''preclude'' consideration of allowable costs in connection with a resident's training, as the first commenter suggests. Upon enactment of the new legislation, CMS (then HCFA) considered a hospital's allowable reasonable costs, and applied reasonable cost principles (*including* redistribution of costs and community support, as we have explained) to calculate a hospital's direct GME costs and FTE resident count in order to determine hospital-specific PRAs in the base year. Although in cost reporting years after the PRA base year, the applicable PRAs are largely determined by the statute, we believe that *costs* continue to be a factor in determining the number of FTE residents that may be counted by a hospital. For example, a hospital may only count FTE residents training *at the hospital* for which, as repeatedly described in the September 29, 1989 final rule, the hospital almost necessarily incurs *some* direct GME costs. Hospitals may also count FTE residents training in nonhospital sites *only if* the hospital incurs all or substantially all the training *costs* of the program at that site (and meets other regulatory requirements.) Thus, it cannot be said that our view of the statute ''precludes'' consideration of allowable costs associated with training residents.

Although Congress did implement a prospective payment system for direct GME costs by enacting section 902 of COBRA 1985, we do not believe this means that all reasonable cost principles are no longer applicable under the revised system. Section 1886(h)(1) of the Act provides that: ''[n]ot withstanding section 1861(v) [defining reasonable cost], instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection.'' The statute literally provides that the reasonable cost payment method in section 1861(v) of the Act does not apply to section 1886(h)(3) of the Act (but those principles do apply to the remainder of section 1886(h) of the Act), which is the paragraph that specifies the general prospective payment formula for direct GME (the direct GME PRA). Thus, section 1886(h)(1) of the Act does not, as the commenter suggested, preclude

any consideration of reasonable costs associated with the training of residents. Indeed, section 1886(h)(1) of the Act provides that, instead of payment under section 1861(v) of the Act, ''the Secretary shall provide for payment for *such* costs'', which refers back to ''the reasonable costs of hospitals for direct graduate medical education costs.'' Thus, the statutory provisions governing direct GME payments continue to contemplate that Medicare payments to hospitals will be made for reasonable costs even under the prospective payment that is based on direct GME PRAs and FTE residents. Therefore, we do not believe the statute precludes application of reasonable cost principles, including the principles of redistribution of costs and community support.

Although we do recognize that certain reasonable cost principles are inherently contrary to a prospective payment system, others are compatible and may continue to be relevant, even upon implementation of the prospective payment. For example, in the case cited by the commenter, the Secretary and the court acknowledged that the principle of ''cross-subsidization'' found in section 1861(v)(1)(A) of the Act does not apply under a prospective payment context. The cross-subsidization provision requires that, in determining the reasonable costs of services, the Medicare program must ensure that it bears fully, but exclusively, ''the necessary costs of efficiently delivering covered services'' to Medicare beneficiaries. Simply put, the provision requires the Medicare program to pay for all the costs associated with care for its beneficiaries, and no more, so that other parties are not subsidizing care provided to Medicare beneficiaries, and Medicare is not subsidizing care provided to non-Medicare beneficiaries. However, when Medicare payments are determined prospectively, the Medicare program necessarily ceases to be concerned about whether cross-subsidization occurs—in other words, it is expected that a particular provider's costs may be higher or lower than the prospectively-determined payment (hence, the underlying premise that prospective payment systems create incentives for providers to control costs and operate efficiently).

In contrast, the principles of redistribution of costs and community support are completely congruent with the prospective payment system under section 1886(h) of the Act. Redistribution of costs and community support principles derive from legislative intent that was expressed at the enactment of the Medicare program, that the program should not assume payment for education costs that were previously funded by other sources. There is no reason to conclude that this intent changed with the enactment of the prospective payment methodology in section 1886(h) of the Act, with the addition of the FTE caps specified in section 1886(h)(4)(e) of the Act, or with the amendments that allow hospitals to count residents training in nonhospital sites for purposes of direct GME and IME payments. We do not believe that Congress intended by any of these enactments to enable an expansion in Medicare direct (or indirect) GME payments that result from cost shifting to hospitals. Rather, we believe section 1886(h) of the Act and later amendments were primarily directed toward limiting expansion of Medicare direct GME and IME payments. Therefore, we believe that the principles of redistribution of costs and community support are consistent with, and continue to be applicable under, the current direct GME payment system.

We also believe it is appropriate to cite the Supreme Court in the *Thomas Jefferson* case. The commenters believed that the scope of the Supreme Court's opinion that supported the agency's application of the principles of redistribution of costs and community support is limited to the calculation of hospitals' reasonable costs of GME for the purpose of determining the base period PRA. However, as we stated above, the statutory provisions governing direct GME payments continue to contemplate that Medicare payments to hospitals will be made for ''such costs'' even under the prospective payment methodology specified in section 1886(h) of the Act. In calculating the base year PRAs, the Agency allowed hospitals to count FTE residents where the hospitals were incurring direct GME costs associated with training those residents. This policy was clearly consistent with the principles of redistribution of costs and community support because the calculation of base year PRAs was dependent on the proper counting of FTE residents. Any opinion from the Court on the application of the principles to the base year costs would equally apply to FTE resident counts. Therefore, we believe the relevance of the *Thomas Jefferson* case is not limited to the establishment of base year costs, as the commenters suggested. Rather, the Court's opinion recognized that the principles of redistribution of costs and community support legitimately continue to apply under section 1886(h) of the Act. The Supreme Court's opinion is entirely relevant to the calculation of direct GME payments to hospitals in cost reporting periods on or after the PRA base year.

Finally, to address the commenters' reference to the 1989 final rule to support the argument that CMS interpreted the statute to preclude consideration of costs in connection with counting FTE residents, we note that the cited rule is *replete* with suggestions that CMS expected hospitals to continue to incur some level of direct GME costs for training residents, even under the direct GME PRA-based payment methodology. For example, the final rule at 54 FR 40298 states:

''Nothing in section 1886(h) of the Act indicates that the bearing of costs in connection with particular residents is a factor in determining who should be counted. The law simply requires the Secretary to determine the average amount incurred to train residents during the specified base period and to make GME payments for the residents in the hospital's programs thereafter on that basis. There was no authorization to establish a two-tiered system to account both for residents whom the hospital incurs full training costs and for residents whom hospitals incur only supervisory and overhead costs because the residents' salaries are paid by another entity.'' (*Ibid.*)

We believe the language quoted above from the 1989 rule is exemplary of the Agency's mindset (as well as of the mindset of the commenter in that rule) that the question of whether costs were incurred by the hospital was, and would continue to be, a consideration for purposes of direct GME payment.

Comment: One commenter appeared to agree with what we stated in the proposed preamble at 68 FR 27216 that because IME regulations on counting residents at nonhospital sites cross-reference the direct GME nonhospital provisions, the provisions on redistribution of costs and community support would equally apply to IME FTE counts, as well as direct GME FTE counts, when counting residents in nonhospital settings. However, the commenter requested clarification on the issue of whether IME FTE residents counts in hospital settings would be subject to the community support and redistribution of costs provisions.

Another commenter argued that the redistribution of costs and community support principles do not apply to FTE counts for purposes of IME payment. This commenter argues that there is no evidence indicating that a teaching hospital's operating costs bear any relation to past or present sources of funding for residents' training.

Response: In response to the commenters' concerns regarding the application of the redistribution of costs principles and community support to counting residents for purposes of determining payments for IME for training in hospital settings, we agree with the commenters; the redistribution of costs and community support principles do not apply to FTE counts for residents training in *hospital settings* for purposes of IME payment. As we have explained in several regulations, the object of IME payments associated with resident training in hospital settings is to address the additional indirect operating costs that teaching hospitals incur in furnishing patient care (see 66 FR 39896 or 54 FR 40286). Even if the redistribution of costs and community support principles could theoretically apply to training inside the hospital, we do not know how *all* of these additional indirect operating costs incurred by a hospital could be ''redistributed'' to a nonhospital entity or could be borne by the community. As long as the hospital had consistently incurred at least some of those indirect costs, there could be no violation of redistribution of costs and community support principles, and no resulting disallowance of FTEs in calculating the hospital's IME adjustment. In any event, as stated above, we agree with the commenters because we believe the legislative history that gave rise to the principles of redistribution of costs and community support was focused on Medicare payments for direct GME.

However, we note that, for training that occurs in nonhospital settings, the application of the principles of redistribution of costs and community support to direct GME FTE counts does have implications for IME payment for residency training in nonhospital settings. Under existing § 412.105(f)(1)(ii)(C), which is the rule for the counting of FTE residents training in nonhospital settings for IME payment, there is a specific reference indicating that the criteria set forth in § 413.86(f)(4) must be met in order for a hospital to count the FTE residents training in nonhospital settings for purposes of IME payments. Thus, if under § 413.86(f)(4)(iv) (the paragraph that specifically applies redistribution of costs and community support principles to FTE counts for purposes of direct GME) a hospital is not permitted to count the FTE residents training in a nonhospital site because of redistribution of costs or community support, the hospital would not be permitted to count the FTE residents for purposes of IME payment as well, because the IME regulation at § 412.105(f)(1)(ii)(C) requires the criteria under § 413.86(f)(4) to be met.

As we have stated above, IME payments are based on the concept that, as a direct result of the hospital's resident training program, the hospital incurs increased indirect costs for patient care. When Congress added section 1886(d)(5)(B)(iv) of the Act as part of Pub. L. 105–33, the circumstances under which IME payments to a hospital could be made were broadened to allow the hospital to count the number of residents training outside the hospital setting under certain conditions, even though it is clear residents training outside the hospital cannot have any impact on the hospital's indirect patient care costs. Nevertheless, Congress authorized hospitals to receive IME payments by allowing hospitals to count FTE residents training in a nonhospital setting in accordance with section 1886(d)(5)(B)(iv) of the Act. As we have stated, we believe Congress intended the provisions of Pub. L. 105–33 to create an incentive (or remove a disincentive), for hospitals to rotate residents to nonhospital settings by allowing hospitals to continue to receive IME payment as if the residents continued to train in the hospital setting. However, we believe IME payment to the hospital would be contrary to Congressional intent if there is a redistribution of costs or community support associated with residents training in a nonhospital site. We also believe the IME payment to the hospital was only intended by Congress to encourage the hospital to rotate residents from the hospital to the nonhospital site, not to encourage (or enable) existing training programs to transfer their costs to the hospital and thereby expand the hospitals Medicare IME payments.

In addition, when Congress added section 1886(d)(5)(B)(iv) to the Act as part of Pub. L. 105–33, the statutory authority for IME payment for residents training at a nonhospital site was premised on the hospital incurring the direct GME costs of the residents: ''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.'' (Emphasis added.) (Section 4621(b)(2) of Pub. L. 105–33; section 1886(d)(5)(B)(iv) of the Act.) The statute requires a hospital to incur ''all or substantially all of the costs for the training program'' in the nonhospital setting in order to count FTE residents training there for purposes of both direct GME and IME payment. The link between the IME regulation at existing § 412.105(f)(1)(ii)(c) and direct GME regulations at § 413.86(f)(4) implement this shared statutory requirement. As we have stated, we believe Congress intended hospitals to facilitate training in nonhospital sites that would not have occurred without the hospital's sponsorship, and for the hospital also to incur direct GME costs of the program in the nonhospital site as a precondition to counting the FTE residents training in nonhospital settings for purposes of IME payment. Thus, in the situation where a hospital currently is incurring direct GME costs at the nonhospital site but there has been a redistribution of costs or community support, a disallowance of direct GME payments, as well as a disallowance of IME payments, is appropriate.

Comment: One commenter noted that proposed § 413.86(i) (redistribution of costs and community support provision) applies not only to subparagraph (f)(4), the nonhospital site provision, but also to the remaining provisions of paragraph (f) and also to paragraphs (g)(4) through (g)(6). The commenter requested that CMS specify that the principles affect only the counting of residents in nonhospital sites and not the count of residents being trained in hospitals, both the inpatient and outpatient settings. In addition, this commenter believes such a clarification would also be consistent with other Medicare policy on counting FTE residents, such as the policy detailed in the August 1, 2002 final rule (67 FR 50077) concerning when residents rotate to other hospitals: ''which entity may count the residents for IME and Direct GME payments is based on where the actual training occurs, not which hospital is incurring the costs.''

Response: While the primary reason we proposed to make the principles of redistribution of costs and community support explicit in the direct GME regulations was to specifically address the inappropriate scenarios described in the proposed rule whereby hospitals increase their FTE resident counts by assuming payment of training costs for residents in nonhospital sites that were previously funded by a nonhospital entity, we do not believe the principles are applicable in only this circumstance. In other words, the principles of community support and redistribution of costs apply generally to direct GME FTE counts, as we have explained. This holds true whether the counts relate to residents training in nonhospital sites (where we have seen the most

inappropriate counting), or to residents training *inside* the hospital—inpatient or outpatient. Thus, it *is* technically possible to have a redistribution of direct GME costs for the training of residents inside the hospital setting (as well as in the nonhospital setting). Therefore, we are not adopting the commenter's suggestion to limit application of the principles to § 413.86(f)(4) (the nonhospital site provision). However, we note that we believe a redistribution of *all* of the direct GME costs for training that occurs in a hospital setting would be rare. *All* of the direct costs of the program—resident salaries, teaching physician salaries, overhead expenses, etc., would need to be redistributed to an outside entity in order for there to be a disallowance of direct GME FTE residents for training inside the hospital due to redistribution of costs or community support.

We contrast this application of the principles of redistribution of costs and community support in the current prospective payment system that depends upon PRA and FTE resident counts to application of the principles in the previous reasonable cost payment methodology that was based on cost finding and cost allocations. Under the former reasonable cost methodology, a hospital was eligible to receive direct GME payment for those direct GME costs that it incurred; however, any direct GME costs that were redistributed to the hospital were not allowable. We note that the instructions that CMS (then HCFA) gave to its Regional Offices in the 1990 audit instructions for purposes of calculating the direct GME base period PRA specifically addressed redistribution of costs and community support in the GME context:

> Where costs for services related to medical education activities have historically been borne by the university, it is assumed the community has undertaken to support these activities, and subsequent allocation of these costs to a hospital constitutes a redistribution of costs from an educational institution to a patient care institution. In such a situation, these costs are not allowable under the Medicare program. (See 42 CFR 413.85(c) and HCFA Pub. 15–1, § 406). For example, if in the past the hospital did not identify and claim costs attributable to the time teaching physicians spent supervising I&Rs [interns and residents] working at the hospital, it is assumed that these costs were borne by the university. Therefore, the hospital may not claim these costs in subsequent cost reports. (Instructions for Implementing Program Payments for Graduate Medical Education to ARAs for Medicare, Director of Office of Financial Operations of the Health Care Financing Administration, BPO–F12, February 12, 1990.)

Thus, under the previous cost payment scheme, the principles of redistribution of costs and community support were applied to direct GME reasonable cost payment using a cost finding methodology. In contrast, in the current context where payment is no longer based solely on reasonable costs incurred, but on PRA and FTE resident counts, if the hospital can demonstrate that it has continuously incurred *some* of the direct GME costs of training the residents since the inception of the residency program at a training site, then no redistribution of costs or community support has taken place. As noted, current direct GME payments are no longer based on detailed cost finding of allowable costs of hospitals. Therefore, we believe it is appropriate to require that a hospital demonstrate that there has been no redistribution of costs or community support by proving that the hospital has incurred *some* of the direct GME costs of the program continuously since the inception of the program. Finally, contrary to the commenter's assertion, we believe we have been consistent with the other Medicare policies on counting residents, including the policy cited by the commenter concerning the prohibition on counting residents training at other hospitals. (See the August 1, 2002 final rule (67 FR 60077). As stated above, there would be no redistribution of costs or community support if a hospital counts a resident when another hospital incurs the resident's salary, as long as the first hospital still incurs other direct GME costs associated with the training of that resident. In any case, as we explained above and also in the proposed rule, the principles of redistribution of costs and community support are not applicable to cost shifted between the hospitals, only costs shifted between a hospital and educational institutions or other organizations that are not Medicare providers.

Comment: One commenter stated that a hospital was ''required'' to include in the calculation of its average per resident amount, time spent in the hospital by residents who were paid by ''other entities.'' This commenter quoted the September 29, 1989 final rule: ''the 1989 GME rule was modified after publication of the proposed rule in order 'to *require* Medicare hospitals to count residents who are working in their facility even if the residents' salaries are fully paid by other entities, either Federal or non-Federal. This revised policy will *apply to both GME base period and cost reporting periods subject to the new payment methodology.*' 54 FR 40299 (emphasis added).''

Response: We believe the language quoted above by the commenter from the 1989 final rule has been taken out of context. In essence, the commenter has generalized from the language selectively quoted above to support an argument that Medicare would have required a hospital to count resident time when the residents were ''paid by other entities,'' thereby supporting the commenter's argument that Medicare not only condones redistribution of costs but, in fact, would seem to ''require'' them. However, we believe the language quoted by the commenter from a particular comment and response in the 1989 rule, if quoted in its full context, actually supports the CMS policy on the application of the principles of redistribution of costs and community support that as long as the hospital has continuously incurred at least some of the direct GME cost of the residency program since the inception of the program, there has been no redistribution of costs or community support and the hospital may count the FTE residents. Specifically, the commenters in that rule at 54 FR 40298 asked in relevant part: ''A particular problem referred to was the treatment of residents who are paid by medical schools, faculty practice plans, and others rather than by hospitals that participate in Medicare. It was pointed out that teaching hospitals incur other costs such as teaching physicians' salaries and overhead costs in connection with these residents, and it would be unfair not to count these residents for payment purposes.'' In our response to this comment, we stated, also in relevant part on 54 FR 40299: ''we note that some of the comments have led us to believe that, in addition to Federally-employed residents (for example, residents in Veterans Administration or Department of Defense programs), a significant number of residents are paid a salary by non-Federal, nonprovider entities (for example, medical schools or philanthropic agencies). As noted by the commenters, although no hospital participating in Medicare incurs salary costs for these residents, *hospitals do incur other substantial GME costs associated with these residents.* Therefore, we are modifying our proposed rule to require Medicare hospitals to count residents who are working in their facility even if the residents' salaries are fully paid by other entities, either Federal or nonfederal.'' (Emphasis added). It becomes apparent when the language quoted by the

commenter on this final rule is read in context that, even as far as back as the 1989 final rule, we acknowledged that hospitals may count the FTE residents where other entities may have incurred the residents' salaries, but where the hospitals still ''incur other substantial GME costs associated with these residents.'' This view is entirely consistent with the CMS application of redistribution of costs and community support. In a scenario where a nonhospital entity, such as a medical school, incurs the residents' salaries, we continue to believe that the hospital may count the FTE residents if the hospital can demonstrate that it has incurred other direct GME costs, such as the supervisory physician salaries, since the inception of the program.

Comment: One commenter argued that when we explained our policy in the July 31, 1998 **Federal Register** (63 FR 40954) to require a written agreement indicating that the hospital must provide reasonable compensation for physicians' supervision of residents' training in the nonhospital setting, ''nothing was said about an additional requirement that a hospital must have continuously incurred this additional cost, as well as the residents' compensation required under the prior regulations, since the inception of the training program.'' This commenter further makes the point that in the final rule at 63 FR 40986, in response to a comment that hospitals did not compensate nonhospital sites for supervisory teaching physician costs and it would not be fair to shift these costs to teaching hospitals, CMS responded:

> Hospitals and nonhospital sites will have 5 months following publication of this final rule to negotiate agreements that will allow hospitals to continue counting residents training in nonhospital sites for indirect and direct GME. These arrangements are related solely to financial arrangements for training in nonhospital sites. We do not believe that the agreements regarding these financial transactions will necessitate changes in the placement and training of residents.
>
> In response to the comment that it is unfair to shift costs to the hospital, we believe that it is appropriate to include supervisory costs in the nonhospital site as part of ''all or substantially all'' of the costs that hospitals must incur to count the resident. Currently, the hospital is able to count the resident even though the costs for that resident may be lower during the time when the resident trains outside the hospital. At the same time, the nonhospital site may have incurred costs for which it received no compensation. We believe that requiring the hospital to incur the costs associated with training in the nonhospital site is equitable to both the hospital and the nonhospital site and is consistent with the statutory requirement that the hospital must incur ''all or substantially all'' of the costs.

(63 FR 40995 (emphasis added by commenter).)

The commenter believed that this explanation of the changes to the GME and IME rules, effective January 1, 1999, ''belies CMS' current assertion of a longstanding policy of applying the redistribution of costs and community support principles in the determination of the resident counts used to compute payment for GME and IME.''

Response: The commenter has used the language quoted above from the 1998 final rule to argue that when CMS (then HCFA) described the policy on counting residents in nonhospital sites for IME, ''nothing was said about an additional requirement that a hospital must have continuously incurred this additional cost * * * since the inception of the training program.'' The commenter has inferred from the language quoted above that CMS has *not* had a longstanding policy of applying the redistribution of costs and community support principles. However, we believe the language actually *supports* the longstanding existence of our policy in two ways. First, the quoted language demonstrates the agency's view that the nonhospital site policy was written from the standpoint of addressing the counting of residents when hospitals *rotate* residents from the hospital to the nonhospital site. Second, the quoted language is also indicative of the Agency's policy that as long as the hospital has continuously incurred at least some of the direct GME cost of the residency program since the inception of the program, there has been no redistribution of costs or community support and the hospital may count the FTE residents (assuming that other requirements are met).

Specifically, the comment relating to the portion of the 1998 final rule quoted above stated at 63 FR 40994, in relevant part: ''One commenter noted that some arrangements between hospitals and nonhospital settings for the training of residents predate the GME base year. This commenter stated that hospitals did not compensate nonhospital sites for supervisory teaching physician costs and it would not be fair to shift these costs to teaching hospitals. *The commenter also stated that teaching hospitals have already entered into written agreements with nonhospital sites under the existing rules.*'' (Emphasis added.) In addition, as quoted above in the comment, we responded, in relevant part at 63 FR 40995 (with different emphasis):

> * * * hospitals and nonhospital sites will have 5 months following publication of this final rule to negotiate agreements that will allow hospitals to *continue counting residents* training in nonhospital sites for indirect and direct GME. These arrangements are related solely to financial arrangements for training in nonhospital sites. We do not believe that the agreements regarding these financial transactions will necessitate changes in the placement and training of residents.
>
> In response to the comment that it is unfair to shift costs to the hospital, we believe that it is appropriate to include supervisory costs in the nonhospital site as part of ''all or substantially all'' of the costs that hospitals must incur to count the resident. Currently, the hospital is able to count the resident even though the costs for that resident may be lower *during the time when the resident trains outside the hospital.* At the same time, the nonhospital site may have incurred costs for which it received no compensation. We believe that requiring the hospital to incur the costs associated with training in the nonhospital site is equitable to both the hospital and the nonhospital site and is consistent with the statutory requirement that the hospital must incur ''all or substantially all'' of the costs. *Ibid.*

We believe the quoted comment and response from the 1998 rule paint a picture of a hospital that has had a pre-existing relationship with a nonhospital site involving *rotation of residents from the hospital to the nonhospital site for a period of time* during the residency program. The language we emphasized in the response—that the hospital may ''*continue to count* residents'' when they train in the nonhospital sites, and that the hospital ''may count the resident even though the costs for the resident may be lower *during the time* when the resident trains outside the hospital''—clearly refers to a rotational arrangement between the hospital and the nonhospital site. In addition, according to the circumstances described by the commenter in the 1998 rule, the hospitals had been incurring the residents' salaries, a direct GME cost, because they had formerly complied with the earlier regulation requiring that hospitals incur residents' salaries for purposes of meeting ''all or substantially all of the costs'' under § 413.86(f)(3). We had no reason to believe that the hospitals had not incurred at least the residents' salaries since the inception of the training program (the commenters state that the arrangements ''predate the GME base year''). In that event, the counting of residents in the nonhospital sites would not result in a redistribution of costs if, as of January 1, 1999, the hospital was required to incur the additional direct GME cost for supervisory physician costs while the residents rotate to the

nonhospital site. We believe that the commenter in the 1998 rule simply did not agree with the additional regulatory requirement finalized in the 1998 final rule that the hospital must also incur the supervisory physician costs for purposes of incurring ''all or substantially all of the costs,'' and hoped to label this new regulatory requirement as a ''cost shift'' in order to avoid it. As we have explained, it appears that there has been no redistribution in the case described by the 1998 final rule commenter because it can be inferred that the hospital had incurred at least some of the direct GME costs (the residents' salaries) since the inception of the program.

Therefore, we believe the language the commenter quotes from the 1998 rule is consistent with our clarifications in this final rule on redistribution of costs and community support. In addition, the language cited by the commenter supports our interpretation of the policy on counting residents in nonhospital sites that it was intended to address the situation when hospitals rotate residents from the hospital to the nonhospital site.

Comment: Some commenters disputed the CMS interpretation of Congressional intent as discussed in the preamble of the proposed rule (see 68 FR 27213). One commenter stated: ''there is no support in the legislative history of the non-provider setting amendments [the 1986 and 1997 amendments of the Act] for the Secretary's view that these changes were not intended to shift new costs to hospitals in support of on-going training in non-provider settings * * * it can be reasonably inferred that Congress was aware, and even intended, that some costs of existing residency training programs in non-provider settings would be shifted to hospitals in order for the hospitals to qualify for direct GME and IME funding under the 1986 and 1997 amendments of the Act.'' Similarly, another commenter stated that the Secretary ''must look elsewhere to the statute [other than section 1886(h)(4) of the Act] for support for his proposed rule; he cannot simply create out of whole cloth an interpretation that is inconsistent with the amendment's other provisions.''

Response: The commenters would have us interpret and implement policy in a statutory vacuum. We believe we have reasonably discerned Congressional intent by interpreting the plain language of the statute at sections 1886(d)(5)(B) and 1886(h) of the Act *in conjunction with* the accompanying legislative history of these sections.

As we stated in the preamble to the proposed rule, Congress has delegated broad authority to the Secretary to implement a policy on the count of FTE residents for purposes of calculating direct GME and IME payments. In section 1886(d)(5)(B) of the Act (IME), the statute does not specify at all how FTE counts should be determined, and the plain language in the statute under section 1886 (h)(4) of the Act (direct GME) indicates that the Secretary ''shall establish rules'' for direct GME consistent with the statute. We also considered the deference expressed in the conference agreement that accompanied Pub. L. 105–33, which established a cap on the number of allopathic and osteopathic residents a hospital may count—''[T]he Conferees recognize that such limits raise complex issues, and provide for specific authority for the Secretary to promulgate regulations to address the implementation of this provision.''(H.R. Conf. Rep. No. 105–217, 105th Cong., 1st Sess., 821 (1997).

Thus, in the absence of statutory specificity on determining FTE counts and the declared Congressional delegation of authority to the Secretary on the subject are *clear* indications that Congress has given the Secretary broad discretion to promulgate reasonable regulations in order to implement the policy on the counting of residents for direct GME and IME payments.

In addition, we have *not*, as the second commenter suggests, ''created out of whole cloth'' an interpretation of the policy concerning counting residents in nonhospital settings that is ''inconsistent with the amendment's other provisions,'' nor do we at all believe that ''it can be reasonably inferred that Congress was aware, and even intended, that some costs of existing residency training programs in non-provider settings would be shifted to hospitals in order for the hospitals to qualify for direct GME and IME funding under the 1986 and 1997 amendments of the Act,'' as the first commenter suggests. Rather, as we have stated, we believe that when Congress created the provisions on counting resident FTEs in nonhospital settings, it was creating a monetary incentive for hospitals to rotate residents *from* the hospital *to* nonhospital settings. We have drawn this conclusion, as we explained, from the legislative history of both the direct GME and IME provisions authorizing payments to hospitals for training in nonhospital settings. First, legislative history associated with passage of the direct GME provision (as part of Pub. L. 99–509) indicates that Congress intended to broaden the scope of settings in which a hospital could train its residents and still receive separate direct GME cost reimbursement, and to provide incentives to hospitals for training residents in primary care programs. The Conference committee report indicates that ''[s]ince it is difficult to find sufficient other sources of funding [than hospitals and Medicare] for the costs of such training, [that is, training in freestanding primary care settings such as family practice clinics or ambulatory surgery centers] *assignments to these settings* are discouraged. It is the Committee's view that training in these settings is desirable, because of the growing trend to treat more patients *out of the inpatient hospital setting* and because of the encouragement it gives to primary care.'' (Emphasis added.) (H.R. Rep. No. 99–727, 99th Cong., 1st Sess., 70 (1986).)

Thus, from the inception of the policy allowing payment for training in nonprovider sites, we believe Congress intended to create a monetary incentive for hospitals to rotate residents from the hospital to the nonhospital settings. We do not believe Congress intended for hospitals to be paid for residents who had previously been training at nonhospital sites without hospital funding.

Further, in the Conference committee report accompanying the provision of Pub. L. 105–33 that authorizes IME payment for training in nonhospital settings, Congress stated that ''[t]he conference agreement includes new permission for *hospitals to rotate residents through nonhospital settings*, without reduction in indirect medical education funds.'' (Emphasis added.) (H.R. Conf. Rep. No. 105–217, 105th Cong., 1st Sess., 817 (1997).)

We note that, prior to enactment of Pub. L. 105–33, if a hospital rotated a resident from the hospital to train at a nonhospital site, the hospital could not count the time the resident spent at the nonhospital site for purposes of Medicare IME payments. As a result, the ''loss'' of IME payments acted as a disincentive and discouraged hospitals from rotating residents out of the hospital. It appears from the legislative history that Congress authorized hospitals to count residents in nonhospital sites for IME purposes as a specific incentive to encourage hospitals to rotate their residents to nonhospital sites (and not to encourage hospitals to incur the costs of a program at a nonhospital site that had already been funded by other sources). This legislative intent becomes more apparent when the nature of the Medicare IME payment is considered.

The Medicare IME payment is inherently a payment that reflects the increased operating costs of treating inpatients as a result of the hospital having a residency program. For example, as explained in the September 29, 1989 final rule (54 FR 40286), the indirect costs of medical education might include added costs resulting from an increased number of tests ordered by residents as compared to the number of tests normally ordered by more experienced physicians.

The IME payment is an ''add-on'' adjustment that is made for each Medicare discharge from the areas subject to the IPPS in a teaching hospital. The authorization by Congress for IME payments relating to nonhospital services while residents are training at nonhospital sites would be absurd if not viewed as an incentive to transfer existing residency training from the hospital to the nonhospital setting. We do not believe Congress intended to permit IME payments to be allowable to the hospital that is incurring ''all or substantially all the costs'' of residents training in nonhospital sites except in the situations where either the hospital rotated residents from the hospital to the nonhospital settings or where the hospital started new programs in the nonhospital settings (and incurred the direct GME costs from the programs' inception). The illustrative situations described above and in the proposed rule in which nonhospital sites, such as dental schools, are shifting the costs of existing programs to the hospitals are not consistent with the intent of Congress to encourage hospitals to rotate residents from the hospital setting to nonhospital sites.

Thus, we believe Congress intended both cited provisions of the Act on counting residents in nonhospital sites for purposes of direct GME and IME payments to be limited to situations in which hospitals rotate residents from the hospital to the nonhospital settings, and *not* situations in which nonhospital sites transfer the costs of an existing program at a nonhospital site to the hospital.

Comment: One commenter cited section 1886(h)(5)(J) of the Act to support the general argument that CMS lacks the authority under the statute to ''impose additional conditions'' on counting FTE residents training in nonhospital sites—that is, the principles of redistribution of costs and community support. The commenter stated:

This conclusion is further supported by Congress' treatment of family practice residency programs. In 42 U.S.C. § 1395ww(h)(5)(J), Congress provided a special payment provision for family practice residency programs. Specifically, Congress authorized hospitals to claim costs related to such programs even if, during the GME prospective payment base year—a year reimbursed under the reasonable cost system and a year to which the community support principle applied—the cost of such programs had been paid by the United States, a State, a political subdivision of the State, or an instrumentality of the State or political subdivision. Congress also provided that, in the event that such program payments were part of the PRA calculation during the GME base year, the payment in future years would be reduced ''in an amount equal to the proportion of such program funds received during the cost reporting period involved * * *.'' Thus, Congress has spoken to the issue of whether hospitals may claim costs in the current year if those costs have been paid in the past by third parties, and it has allowed reduction in current-year payments only if: (1) During the GME PPS base year, a third party had paid for the cost of the hospital's family practice residency program; and (2) as a result, the hospital had received a PRA that included an ''estimate of the amount that would have been recognized as reasonable * * * if the hospital had not received such funds.'' 42 U.S.C. § 1395ww(h)(5)(J)(i). In all other situations, I submit, Congress does not permit the Secretary to reduce payments in the current year simply because, in the past, some third party may have paid the cost.

Response: We disagree with the commenter that section 1886(h)(5)(J) of the Act supports the assertion that ''Congress has spoken to the issue'' of whether a hospital may claim third party costs and has allowed reductions in direct GME reimbursement resulting from redistribution of costs or community support in only the very limited circumstance of that exception in the Act. Generally, section 1886(h)(5)(J) of the Act did two things: first, in subparagraph (J)(i)(1), Congress specifically allowed a hospital that *only* has an approved training program in family medicine and received a PRA in the base year of less than $10,000 for its family practice program, to receive a revised PRA that reflects the inclusion of ''funds from the United States, a State, or a political subdivision of a State * * *'' for the hospital's family practice program. Thus, the provision recognizes that ordinarily such funds would not be included in the hospital's base year per resident amount (because they were not incurred by the hospital in the base year). However, Congress explicitly created a narrow exception to the ''cost finding'' principles to allow such a hospital to include Federal, State, or local government grants to be included in the hospital's PRA base year calculation. Second, subparagraph (J)(i)(2) requires that direct GME payment to such a hospital that received a revised PRA amount under subparagraph (J)(i)(1) must also be reduced in subsequent cost reporting periods by the proportionate amount of funding the hospital receives from Federal, State, or local government payments. In other words, what subparagraph (J)(i)(2) does is to prohibit this hospital from receiving duplicative payments for the same GME program—both through the adjusted PRA and through continued Federal, State, and local government funding.

The commenter argues that subparagraph (J)(i)(2) is the ''only'' situation where Congress has ''spoken'' about reductions in current year payment because of third party reimbursement. However, as we stated above, we believe the effect of subparagraph (J)(i)(2) is to prevent of duplicative payments for the same program that could otherwise occur in the narrow circumstances of the exception provided by section 1886(h)(5)(J), and has nothing to do with the continued applicability of the principles of redistribution of costs and community support. To the contrary, as we have stated, we believe that subparagraph (J)(i)(1) addresses a limited theoretical ''retroactive redistribution'' of costs and community support to allow a very narrow *exception* of allowing costs to be included in direct GME payment. Thus, we believe section 1886(h)(5)(J) of the Act would support our assertion that Congress intends application of redistribution of costs and community support to direct GME payment (except in the narrow circumstance of the type of hospital described in that section), rather than support the commenter's contrary assertion that the section is inconsistent with our proposal on application of the principles.

Comment: One commenter suggested that the redistribution of costs and community support principles at nonhospital sites should apply on a ''year-by-year basis,'' such that if another entity funds a training program during a particular fiscal year, the hospital would not be allowed to include the residents in its count for that fiscal year.

Response: We believe the commenter's suggestion of a ''year-by-year basis'' policy is, in effect, already in place under existing Medicare policy without reference to the redistribution of costs or community support principles. Under the existing policy, where another entity funds a training program in a particular year while the residents are training at a nonhospital site—that is, incurs the residents' salaries and fringes, and the supervisory

physician costs (''all or substantially all of the costs''), the hospital may not include the residents in its FTE count for that fiscal year. This requirement, of course, is independent of the redistribution of costs and community support policy. It is based on the statutory requirement that allows a hospital to count residents training at nonhospital sites only if the hospital has incurred for all or substantially all of the costs of the program at that site during the hospital's fiscal year.

Comment: One commenter stated that the 1989 final rule made clear that a hospital's resident count may also include residents for whom ''community support was received'' through a State or local grant. Similarly, another commenter stated ''certain family medicine training programs that may have received outside funds, for example, State dollars, at any time in the past will be prohibited [by the hospital we proposed] from receiving GME reimbursement.''

Similarly, another commenter stated that ''it is axiomatic'' that State-supported and public teaching hospitals receive State appropriations to support their residency programs. The commenter urged CMS to clarify that the application of the redistribution of costs and community support principles would not apply to State or local appropriations to public hospitals, with respect to the counting of FTE residents in either the hospital or the nonhospital setting.

Response: As we explained in the 1989 final rule (54 FR 40302), grants that were restricted (those grants that were designated by the donor to pay for certain specified provider costs) or unrestricted were considered allowable costs of the hospital (including direct GME costs) when Medicare paid hospitals on a reasonable cost basis. The policy allowing payment to hospitals for costs that had been funded by grants was authorized by section 901 of the Omnibus Budget Reconciliation Act (OBRA) of 1980 (Pub. L. 96–499), which added section 1134 of the Act. Section 1134 of the Act applies to ''the reasonable costs of services provided by nonprofit hospitals or critical access hospitals.'' Section 1134(1) of the Act specifies that a ''grant, gift or endowment or income therefrom which is to or for such a hospital * * *'' may not be deducted from the operating costs of such hospitals that are paid on a reasonable cost basis. Therefore, when hospitals were paid on a reasonable cost basis for direct GME costs, the ''community support'' that came from ''grants, gifts, or endowments'' was allowable under Medicare. We are clarifying in this final rule, that under the direct GME prospective payment methodology under section 1886(h) of the Act, if a hospital had received a grant, gift or endowment to subsidize its residency programs at the hospital, and the hospital requested direct GME payment for training the residents, it would not be considered community support. Under section 1134 of the Act, it is as if the hospital had itself incurred the cost for which it had received the grant subsidy. For example, if in 2003 a hospital received a State grant to fund its family practice program at the hospital, the grant would not be considered community support under our regulation. This is because we would treat the hospital as if itself incurred the costs for the family practice program, instead of the State grant.

However, we note that this policy would *not* include ordinary State and local appropriations. As we mentioned in the January 12, 2001 final rule at 66 FR 3367, ''In administrative, legal and policy matters, we have consistently maintained that State appropriations for the cost of medical education activities constitute community support that is to be offset from a provider's allowable costs.'' Therefore, if a program were entirely funded by State or local appropriations, an inappropriate redistribution of costs would occur if the hospital subsequently begin to incur the costs of the residency program—for training inside or outside the hospital. Although, for most hospitals that receive State and local appropriations for their residency programs, the hospitals continuously incur (since the inception of the programs) some direct GME costs, there would be no disallowance of FTEs due to community support.

We contrast the situation of a grant to a hospital with the situation of a grant to a nonhospital site. If, hypothetically, nonhospital sites were reimbursed by Medicare on a reasonable cost basis, and the nonhospital site had received grants to subsidize all of the direct GME costs for the residency program there, under section 1134 of the Act, we would treat the costs the grant subsidized as if they were costs of the nonhospital site. If a hospital then tried to incur the direct GME costs, this *could* be a redistribution of costs or community support issue, since the hospital would be claiming FTE residents who had historically trained at the nonhospital site for whom the community had assumed the cost of that training, as described in the scenarios at 68 FR 27213.

Comment: Several commenters objected to the sentence in the preamble to the proposed rule that stated: ''* * * a hospital is required to assume financial responsibility for the full complement of residents training in a nonhospital site in a particular program in order to count any FTE residents training there for purposes of IME.'' One commenter explained that there are a number of situations where a hospital is truly incurring the cost of having a resident at a site, but the hospital is not incurring the cost of the entire complement of residents. ''For example, if two different hospital programs each elect to send residents to the same clinic, under the interpretation in the [proposed rule], neither of the two hospitals would be able to count any of the residents because neither of the two programs would incur the cost of the full complement of residents.'' Another commenter believed that ''this change'' runs contrary to other current Medicare policies that focus on the resident rather than the program. The commenter believed that both the direct GME and IME regulations ''are replete with references to 'resident' rather than 'program'.'' The commenter believed that ''residency program'' is referenced only in the context of the requirement that, for residents to be counted for direct GME and IME payments, they must be part of an ''approved program'' (§ 413.86(f)(1)).

Response: We understand the concerns of the commenters about the requirement for a hospital to incur ''all or substantially all of the cost'' of training residents in a training *program* at a nonhospital site. However, we *do not* believe this is a *change* in policy. We believe that the policy that requires a hospital to incur the cost of ''the program'' in the nonhospital site has existed since the passage of the direct GME provisions, section 9314 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509), and the passage of the IME provision, section 4621(b)(2) of the Balanced Budget Act of 1997 (Pub. L. 105–33), that permitted hospitals to continue to count residents in nonhospital sites, for purposes of direct GME and IME payment, if the hospital incurred ''all or substantially all of the cost'' of residents training in the program.

As we explained in the proposed rule, this policy is derived from the language of the IME and direct GME provisions of the statute on counting residents in nonhospital settings; *both* sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act state that the hospital must incur ''all, or substantially all, of the costs for the training *program* in that setting.'' (Emphasis added.) Therefore, we believe a better reading of this language is that hospitals must incur all

or substantially all of the cost for the full complement of residents in the training program at the nonhospital site.

We note that the policy that requires the hospital to incur the cost of the *program does* appear to be somewhat of a departure from other current Medicare policies on graduate medical education that focus on the resident rather than the program, as the commenter suggests. However, we believe the statutory provisions cited above require hospitals to assume the cost of the full complement of residents training in the program at the nonhospital sites in order to count any FTE residents training at that site.

In addition, as we noted at 68 FR 27217 of the proposed rule, and also above, under policy on the application of the redistribution of costs and community support principles, it is permissible for the hospital to count FTE residents where the hospital incurs direct GME costs of FTE residents that are *added* to an existing program, even though the hospital is not permitted to count the existing FTE residents due to the application of the redistribution of costs or community support rules. In the nonhospital setting, as a result of the interaction of these two separate FTE-counting requirements—(1) that the hospital must not violate the redistribution of costs and the community support principles in order to count the resident FTEs in the nonhospital settings; and (2) that the hospital must incur ''all or substantially all'' of the costs for the training program in that setting—a hospital would be prohibited from counting FTE residents added to an existing program at a nonhospital site unless the hospital incurs all or substantially all of the costs of training *all* of the residents in that program at that setting. That is, even if the hospital incurs all or substantially of the costs for all of the training program at the nonhospital site, the hospital would only be able to count the additional FTE residents who were not excluded by application of the redistribution of costs or community support principles.

Comment: Several comments cited a letter from CMS (then the Health Care Finance Administration, or ''HCFA'') dated March 30, 1999 to C. Scott Litch of the American Association of Dental Schools (now the American Dental Education Association). Specifically, these commenters cited a sentence in the letter to Mr. Litch which stated: ''If a hospital establishes a new relationship with a dental clinic and meets the conditions for counting residents training outside the hospital, the hospital may count more residents currently for indirect and direct graduate medical education than were counted in 1996 if those residents are dental residents.'' One commenter stated that the ''new relationship'' referred to in the letter from CMS presupposes the existence of an ongoing program whose costs presumably had been met by means other than the hospital before the affiliation with a nonhospital dental clinic began. This commenter believed that this letter provided assurance to many hospitals that new affiliations with preexisting dental programs were permissible.

Response: We do not agree with the commenter that the sentence in the letter to Mr. Litch ''presupposes the existence of an ongoing program'' where the costs of such a program ''had been met by means other than the hospital''. Rather, we believe the ''new relationship'' between the hospital and the dental clinic could be reconciled with application of the principles of redistribution of costs and community support and characterized by two possible interpretations, both of which would allow for the counting of residents in nonhospital sites—(1) where the hospital would rotate residents from the hospital to the nonhospital site; or (2) where the hospital would fund new training slots at the nonhospital site (the dental clinic referred to in the Mr. Litch's letter). Such assignments from the hospital to the dental clinic, or new residency training slots, would be the ''new relationship,'' but in either case, no redistribution would occur. Therefore, we do not believe the letter from 1999 is necessarily inconsistent with the principles of redistribution of costs and community support described in the proposed rule.

Comment: Many commenters, while remaining generally opposed to application of redistribution of costs and community support principles, requested that if CMS were to finalize the proposed rule, CMS apply the principles prospectively. One commenter, a dental school, explained that it had just admitted a new class of residents, many of whom will not complete their programs until 2006. The commenter believed that, in the application of the principles, CMS seeks to remove all Medicare funding for these residents retroactively. Along a similar vein, another commenter pointed out in support of the suggestion to apply the principles only prospectively, that the implementation of the proposed regulation would result in ''substantial dislocation and hardship to hospitals, dental and other schools, and the residents themselves.'' Therefore, the commenter believed CMS should indicate specifically in the final rule that such changes will only be applied to a provider's cost reporting period beginning on or after October 1, 2003, and CMS should not apply its final GME policy on redistribution of costs and community support to any prior cost reporting periods that remain open or unsettled, or are settled but potentially subject to reopening under the Medicare rules.

In addition, several commenters requested clarification regarding the effective date for the proposed application of the principles of redistribution of costs and community support to FTE counts. Specifically, the commenters point to the following language in the proposed rule:

- ''A hospital must continuously incur direct GME costs of residents training in a particular program at a training site since the date the residents first began training in that site in order for the hospital to count the FTE residents.'' (68 FR 27215)
- ''We propose * * * to identify January 1, 1999, as the date our fiscal intermediaries should use to determine whether a hospital or another entity has been incurring the costs of training in a particular program at a training setting.'' (68 FR 27216)
- ''[i]f the fiscal intermediaries determine that there is a redistribution of costs or community support exists with respect to certain residents prior to January 1, 1999, a disallowance of direct GME and IME payment with respect to those FTE residents would certainly be required.'' (68 FR 27216)
- ''We are proposing that, effective October 1, 2003, in order for a hospital to receive IME and direct GME payment, the hospital must have been continuously incurring the direct GME cost of residents training in a particular program since the date the residents first began training in the program in order for the hospital to count the FTE residents.'' (68 FR 27417)

Response: We have stated that we believe the principles of redistribution of costs and community support are *longstanding* Medicare policy. While we have reminded the public of the continuing application of the principles in various regulations and program guidance, we also recognize that CMS has not had occasion to invoke them in Agency policy expressions relating specifically to direct GME payments since the direct GME PRA base year.

As we have stated, we believe redistributions would occur only in rare circumstances for residency training inside the hospital. Between 1987 and 1997 when hospitals could count FTE

residents training in nonhospital sites for purposes of direct GME payments, but not IME payments, we did not observe the kinds of inappropriate counting of FTE residents we described in our proposed rule. It is only since hospitals have been allowed to count FTE residents training in nonhospital sites for purposes of IME payment, that CMS has become aware that cost shifting has become prevalent in the hospital industry, which has implicated the principles of redistribution of costs and community support. Therefore, in general, we are implementing a prospective effective date of October 1, 2003, for purposes of payment. That is, for direct GME, effective for portions of cost reporting periods beginning with October 1, 2003, and for IME, effective for discharges occurring on or after October 1, 2003, a hospital must have been continuously incurring direct GME costs of residents training in a particular program since the date the residents first began training in the program in order for the hospital to count the FTE residents. We note that the effective dates apply only as they relate to disallowances of FTEs and bear no relation to determinations of redistributions or community support. Therefore, in general, a fiscal intermediary that determines that a redistribution of costs has taken place for a particular hospital prior to October 1, 2003, may disallow FTEs based on that determination beginning with October 1, 2003. For example, if a fiscal intermediary determines that a redistribution of costs has occurred that affected 10 FTEs for direct GME and IME during the hospital's cost report ending in fiscal year ending in 1999, the fiscal intermediary would take disallowances for those 10 FTEs, but not until October 1, 2003, for purposes of direct GME and IME payment.

In addition, because we have received a large number of public comments expressing surprise and confusion regarding our policy on these principles, we are grandfathering residents who began training in a program on or before October 1, 2003. That is, an FTE resident who began training in a residency program on or before October 1, 2003 (the effective date of this final rule), and with respect to whom there has been a redistribution or community support, may continue to be counted by a hospital for purposes of direct GME and IME payments after October 1, 2003, 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. We believe continued direct GME and IME payments to the hospital while the ''redistributed'' residents finish their training for up to 3 years is appropriate to address many situations in which nonhospital sites have made arrangements with hospitals to shift the costs of training those residents. We understand that, in nonhospital sites, virtually all dental residency programs are of a duration of 3 years in length or less. This policy addresses the situation pointed out by the dental school commenter and other commenters that a school may have just admitted a new class of residents, many of whom will not complete 3-year programs until 2006.

We note that this prospective ''grandfather'' policy *does not* apply to resident FTEs with respect to whom there has been a redistribution of costs or community support, and who begin training after October 1, 2003. In addition, those residents described above who began training in a program on or before October 1, 2003, may be counted until those particular residents finish their training in that program (or 3 years, whichever comes first). In order to count such residents, we are requiring that hospitals identify those residents (by social security number) to their fiscal intermediary and specify the length of time the hospital will be counting these FTE residents for direct GME and IME payment purposes.

We note that the policy described above that effectively ''grandfathers'' residents who began their training on or before October 1, 2003, applies only as it relates to payments to hospitals for those specified FTE residents, and bears no relation to determinations of whether a redistribution of costs or community support has taken place. Therefore, if a fiscal intermediary determines that a redistribution of costs has taken place with respect to residents counted by a particular hospital even prior to October 1, 2003, the intermediary will disallow any FTEs based on that determination, beginning October 1, 2003, except for the ''grandfathered'' residents. Hospitals that continue to count grandfathered FTE residents (where the costs of whom had been redistributed) may only do so until those residents finish their training in the specific program they were training in on or before or to October 1, 2003 (which would be no later than September 30, 2006, 3 years after October 1, 2003).

For example, a fiscal intermediary determines for a hospital's FYE December 31, 2003 cost report that a redistribution of costs has taken place with respect to certain FTEs the hospital counted for direct GME and IME (that is, the costs of training residents at a nonhospital site were incurred by a university from 1990 through 1999). Assume that 5 FTEs began training in a 2-year orthodontics program in a dental school on July 1, 2003, and another 5 residents begin their training in the same program on July 1, 2004. The 5 FTEs who began training on July 1, 2003, are ''grandfathered,'' and, therefore, the fiscal intermediary would not disallow these 5 FTEs as of October 1, 2003. The hospital may continue to count these 5 FTEs that began training on July 1, 2003 through June 30, 2005, when they finish the 2-year orthodontics program. We note that subsequent to completion of the 2-year orthodontics program on June 30, 2005, if any of these 5 FTEs participate in additional GME training programs, the fiscal intermediary would disallow these FTEs because disallowances for redistribution of costs and community support relate to FTE slots and not specific residents.

However, the 5 FTEs that began training in the 2-year orthodontics program on July 1, 2004 are not ''grandfathered,'' and, therefore, beginning July 1, 2004 of the hospital's December 31, 2004 cost report, the fiscal intermediary will disallow IME and direct GME payment associated with these 5 FTE slots.

Comment: Commenters disputed the situations we cited in the preamble to the proposed rule that were supposed to be illustrative of what we believe to be inappropriate application of Medicare direct GME and IME policy at 68 FR 27213. One commenter, in particular, requested information on the identity of programs cited in the examples.

Response: We do not believe it is appropriate to disclose the identities of those cited in the examples. Therefore, we are unable to respond to the commenters' points on the matter, except to state that the situations in the examples represent what we believed are the more ''egregious'' scenarios involving redistribution of costs and community support principles and inappropriate counting of FTE residents, we note that the same issues arise, and the same principles apply, whether the counting of residents relates to training that is taking place in another country, another State, or on the same hospital campus, as the hospital.

Comment: One commenter believed that CMS's policy on the application of the redistribution of costs and community support will lead to considerable, ''but needless,'' litigation over what it means to ''incur'' the costs of off-site training.

Response: We disagree with the commenter and see no reason to be

concerned that these clarifications would result in any more litigation than other Medicare payment policies that are conditioned on whether a provider incurs costs. For example, for several decades, Medicare policy required that hospitals ''incur'' costs in order to receive payment from Medicare. The Medicare statute and regulations currently require that a hospital incur certain costs in order to count FTE residents training in nonhospital sites for purposes of direct GME and IME payments. We are unsure why the requirement under the policy on redistribution of costs and community support that a hospital ''incur'' the direct GME cost continuously for a residency program at a training site is any more complex than other cost requirements under Medicare.

Comment: One commenter suggested that we craft a narrower solution to the issue of inappropriate counting of FTE residents in nonhospital sites by focusing the language on salary and benefits for residents. The commenter believed that CMS could state that, unless the hospital in 1999 had incurred the costs of salary and benefits for FTE residents who were training in offsite locations, the hospital may not receive direct GME and IME payment for training those FTE residents at the nonhospital sites today.

Response: We do not believe a policy such as the one the commenter suggested—determining redistribution of costs based upon whether a hospital continuously incurs the residents' salaries and benefits during training in the nonhospital site— is necessary or appropriate. This is because, under the policy on redistribution of costs and community support we describe in the proposed rule and in this final rule, a hospital that continuously incurs the residents' salaries and benefits (from 1999 or before) while the residents train in the nonhospital site, or even inside the hospital, would *not* be redistributing costs if the nonhospital site later incurs the other direct GME costs (such as supervisory physician salaries) in the nonhospital site. There would be no redistribution of costs because the hospital would have continuously incurred at least some of the direct GME costs (the residents' salaries and benefits) since the inception of the program. However, we note that even if there has not been a redistribution of costs or community support with FTE residents training in a nonhospital site in such a scenario, the hospital would still need to meet the requirements in the existing regulations (at § 413.86(f) and § 412.105(1)(ii)(c)) in order to count those FTE residents for purposes of direct GME and IME payment.

For example, Hospital A has had a family practice program with 10 FTE residents for about 20 years, for which the hospital has incurred the residents' salaries and fringes and some other (but not all) direct GME costs for the program. For the first time, in fiscal year ending 2003, Hospital A rotates 2 FTE residents to an ambulatory clinic (a nonhospital site), and fulfills the requirements at § 413.86(f)(4), including incurring ''all or substantially all of the costs'' of the training program in the nonhospital site. There is no redistribution of costs with respect to these 2 FTE residents because Hospital A has continuously incurred some of the direct GME costs of the program—the residents' salaries—and therefore it may count the 2 FTE residents training at the clinic (up to the hospital's FTE cap), since it also has complied with the requirements at § 413.86(f)(4).

Comment: Some commenters suggested that the application of redistribution of costs and community support principles would impose large administrative burdens on hospitals to demonstrate which entity has been ''continuously incurring'' the costs of the residency training. One commenter stated: ''[t]his burden would be additive to a policy that already is fraught with excessive administrative requirements.''

One commenter asked if hospitals would be required to document responsibility for the costs of training residents prior to January 1, 1999.

Response: If the hospital has continuously been incurring at least some of the direct GME costs (for example, resident salaries or supervisory physician salaries) since the inception of the residency program, we do not believe any additional documentation is necessary beyond which hospitals are already required to maintain. If resident or supervisory physician salaries, for instance, are paid through the hospital payroll, the hospital will have kept documentation of such costs for Federal tax purposes.

In response to the second comment, we stated in the proposed rule that January 1, 1999 should be used by our fiscal intermediaries as the date for determinations of whether a hospital or another entity has been incurring the costs of a training in a particular program at a training site for purposes of determining whether there has been a redistribution of costs or community support. This date was chosen as an administrative convenience because we believe it could otherwise be difficult for our fiscal intermediaries to obtain contemporaneous documentation that the hospitals have appropriately been incurring costs in earlier years. Therefore, we believe that, for purposes of determining redistribution of costs or community support, most hospitals would only be required to maintain appropriate documentation to demonstrate that they have continuously been incurring the direct GME costs from January 1, 1999 forward. However, as we mentioned in the proposed rule, if the fiscal intermediaries determine that there was a redistribution of costs or community support for a fiscal year ending for a cost report for a particular hospital prior to January 1, 1999, the hospital would be required to show contemporaneous documentation to prove otherwise.

Comment: One commenter stated that it may be difficult to track residents that have been funded by some type of community support. The commenter described a scenario where a program at a hospital has four internal medicine residents and one is covered by some type of community support for a 3-year period. The commenter stated that it may be difficult to track that slot over the next 5, 10, or 20 years to avoid submitting it for future direct GME or IME payments.

Response: As we stated above, we understand there may be administrative issues that hospitals must confront in their efforts to comply with the principles of redistribution of costs and community support. However, we do not believe it would very difficult to track the FTEs in a program that receives community support. Once the FTE residents for which community support is received have been identified, the hospital will know the number of FTE residents to remove from the count that is submitted in future cost reports (all of which will be subject to audit by our fiscal intermediaries). Using the commenter's example, if direct GME costs for one out of four FTEs in an internal medicine program is identified as being entirely subsidized by community support for three years (the duration of an internal medicine program), the hospital would know to refrain from counting one FTE in future cost reports, even after the 3 years of training for a particular resident has passed. This is because, as the commenter seemed to understand, the redistribution of costs and community support principles are applied to the FTE resident training slots of a hospital; the principles are not associated with a particular resident, to which the principles could apply differently from year to year.

Comment: One commenter disagreed with the choice of words used in the

proposed definition of ''redistribution of costs'' at proposed § 413.86(b). As proposed, the definition states: ''*Redistribution of costs* means an attempt by a hospital to increase the amount it is allowed to receive from Medicare under this section by counting FTE residents who were in medical residency programs where the costs of the programs had previously been incurred by the educational institution.'' In particular, the commenter objected to the first part of the definition: ''an *attempt* by a hospital to increase the amount it is allowed to receive from Medicare.'' The commenter believed that the phrase was unnecessary to the definition and should be deleted.

Response: We understand the concern of the commenter. However, we have used ''the attempt'' language at § 413.86(b) for the proposed definition of ''redistribution of costs'' primarily because we have adopted the language of the existing regulation at § 413.85(c) that defines ''redistribution of costs'' (now applicable to costs of approved nursing and allied health education activities). The language was not intended to be offensive. Rather, we meant it to be descriptive of a possible motive for a redistribution of costs. In light of the commenter's suggestion, we are revising the language to be purely descriptive of the scenario of the redistribution and not reflect a possible motive. Accordingly, we are revising the language at § 413.86(b) to state: ''Redistribution of costs'' occurs when a hospital counts FTE residents in medical residency programs and the costs of the programs had previously been incurred by an educational institution. In the future, we will consider conforming changes to the definition of ''redistribution of costs'' at § 413.85(c) as well.

Comment: Some commenters believed that, through the enactment of the 1996 cap on the count of allopathic and osteopathic residents, Congress has already dealt with the problem that CMS is attempting to revisit with the proposed rule. The commenters believed that when Congress exempted the dental residents from the caps, it intended to create hospital incentives for dental training. The commenters believed that the CMS redistribution of costs and community support policy contradicts this Congressional intent.

Response: We do not believe that when Congress instituted the caps on the count of residents with the Balanced Budget Act of 1997, it was aware that inappropriate counting of FTE residents could occur through redistribution of costs. CMS, itself, did not become aware that many hospitals were engaging in these cost shifting arrangements, very often involving dental residents since at least October 1, 1997, when hospitals were authorized to count FTE residents for purposes of IME payments, as well as direct GME payments, for training in nonhospital sites. As we stated above, it is only since the audits by our fiscal intermediaries of the fiscal year ending 1998 and 1998 cost reports that have occurred within the last 2 years that CMS became aware that significant cost shifting was taking place. Therefore, we do not believe Congress would have been in a position to consider whether to authorize cost shifting in its 1997 legislation. Thus, we do not believe, as the commenters do, that Congress expected, or tacitly condone, cost shifting to dental residents as a result of exempting the dental residents from the 1996 caps. Rather, we believe that when Congress exempted dental residents from the 1996 caps, it intended to allow more dental training to occur in the hospital, not to authorize cost shifting from dental schools to hospitals and to the Medicare program.

Comment: One commenter asked what types of costs the hospital is required to incur for training in nonhospital sites in order for there to be no redistribution of costs or community support. Specifically, the commenter described a scenario under which a teaching hospital and a medical school are related parties and asked whether the teaching hospital is required to pay for the teaching physician services relating to offsite rotations at a medical school clinic before the FTE residents participating in the rotation can be counted for purposes of IME or direct GME payment.

Response: We understand from the scenario described by the commenter that hospital-based residents are being rotated to the medical school clinic. As such, we assume that the hospital is already incurring at least the residents' salary and fringe benefits. Therefore, when rotating the residents to the clinic, the hospital is incurring at least some of the direct GME costs of training the residents. Under these circumstances, a redistribution of costs has not taken place. However, according to the requirements for counting FTE residents in nonhospital settings under § 413.86(f)(4), among other requirements, the hospital is required to incur the portion of the teaching physicians' salaries and fringe benefits attributable to direct GME (by the term ''related party,'' we are assuming that the medical school clinic is not provider-based as specified under § 413.65, and therefore, is not considered part of the hospital). Thus, under the commenter's scenario, the hospital may be prohibited from counting the FTE residents, not because of redistribution of costs but because of failure to incur ''all or substantially all of the cost'' under § 413.86(f)(4) if the hospital is not incurring the supervisory physician's salary attributable to direct GME.

Comment: A number of commenters argued that the proposed application of the redistribution of costs and community support principles is bad public policy from the perspective of access, quality and cost-effectiveness of oral health care.

Response: We understand that dental training programs provide much needed oral health care to the American public and did not intentionally target them with our policy on redistribution of costs and community support. However, we believe much of the inappropriate cost sifting to hospitals and to the Medicare program is related to dental residency programs—which is probably due to the fact that dental residents are exempted from the statutory 1996 FTE caps. Although we regret that publication of this rule may upset some newly formed relationships between hospitals and dental schools, we continue to believe that the Medicare program should not pay for nonhospital dental residency training that had previously been funded by other sources, without any sponsorship by hospitals or the Medicare program.

Comment: One commenter stated that by establishing a PRA floor equal to 85 percent of the locality-adjusted national average PRA, Congress created an exception to the principles of community support and redistribution of costs. The commenter noted that this floor increased reimbursement to a number of teaching hospitals around the country whose own PRAs were low ''precisely'' because the community or another educational institution had been bearing the training costs in the GME PRA base year. Therefore, the commenter argued, the PRA floor ''picked up'' some of those disallowed costs, and that Medicare is, in effect, currently paying for those costs in the PRAs that were raised to the floor.

Response: The commenter is referring to section 311 of the Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113), which, for FY 2001, established a floor PRA at 70 percent of the locality-adjusted national average PRA, and to section 511 of the Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554), which, for FY 2002, established a floor PRA at 85 percent of the locality-adjusted national average PRA. Regulations concerning

these provisions are implemented at § 413.86(e)(4). These provisions were intended, in part, to narrow the disparities (both high and low) in direct GME payments to teaching hospitals across the country. One of the reasons a number of hospitals had low base year PRAs is because a significant amount of their GME costs in the PRA base year was incurred by another entity (that is, the ''community''). (Variations in base year PRAs were otherwise due to differences in hospital-specific accounting practices and differences in reimbursement methods for supervising physician and resident salaries.) By providing for increased GME payments to certain hospitals with low PRAs, we do not believe Congress implicitly condoned, or made an exception to, the redistribution of costs and community support principles. We note that Congress provided for an increase to the floor PRA for *all* hospitals that had PRAs below the floor, *not* just to hospitals that, in the base year, did not incur certain GME costs. Rather, we believe Congress intended to provide increased GME payments to hospitals with low PRAs, regardless of the reasons those particular hospitals may have had low PRAs, in an attempt to even out some of the disparity in PRAs, nationally.

Comment: A commenter noted that the among the examples cited in the proposed rule at 68 FR 27213 as illustrative of inappropriate application of Medicare IME and direct GME policy, we described a situation where a hospital on the East Coast of the United States is counting dental residents training in nonhospital sites in Hawaii. The commenter believed that we have incorrect information regarding this program, and that there is, in fact, no redistribution of costs from the community to the Medicare program with respect to the program in Hawaii. Specifically, the commenter explained that in August 2002, a hospital in New York placed one dental resident in a clinic located in Honolulu. The New York hospital pays the costs of the resident's stipend and the supervising faculty's salary, and there is a written agreement between the hospital and the clinic. The commenter stated that in the future, the program anticipates placing additional residents at other nonhospital sites in Hawaii.

Response: As we stated in the preambles to the proposed rule and this final rule, there would be no redistribution of costs or community support if, from the outset of the program, a hospital incurs direct GME costs. Therefore, if, in fact, a hospital in New York has been incurring direct GME costs for a training program located in a clinic in Hawaii since the program's inception, then there would be no redistribution of costs or community support. The hospital in New York could count FTE residents training in the nonhospital site as long as the applicable requirements are met.

Comment: One commenter that described a scenario in which a university funded a family practice program for many years. However, in 2000, a Federally Qualified Health Center (FQHC) entered into a written agreement with the university and began reimbursing the university for ''all or substantially all'' of the costs of the program. The FQHC has been receiving Medicare direct GME payments since that time. The commenter stated that under the terms of the proposed rule, this FQHC would be ineligible for receipt of GME payments, since, prior to 2000, the program was funded exclusively by the university.

Response: The commenter raised the point that the redistribution of costs and community support principles are applicable to providers other than hospitals that may receive Medicare payments for residency training. Specifically, FQHCs and RHCs under § 405.2468, CAHs under § 413.70, and Medicare+Choice organizations (MCO) under § 422.270 may qualify to receive payments for direct GME costs. We note that the existing regulations at § 405.2468(f)(6) for FQHCs and RHCs, and at § 422.270(c) for MCOs, already clearly state that the allowable direct GME costs of these entities are subject to the redistribution of costs and community support principles in § 413.85(c). We agree with the commenter and are also clarifying the regulations at § 413.86(i) to clearly state that the principles of redistribution of costs and community support apply equally to hospitals, FQHCs, RHCs, CAHs, and MCOs. Therefore, we agree that, in the situation described by the commenter the FQHC would *not* be eligible for Medicare direct GME payments since the family practice program represents a redistribution of costs from the community (that is, the university) to the Medicare program (that is, the FQHC through direct GME payments).

3. Rural Track FTE Limitation for Purposes of Direct GME and IME for Urban Hospitals That Establish Separately Accredited Approved Medical Programs in a Rural Area (§§ 412.105(f)(1)(x) and 413.86(g)(12))

a. Change in the Amount of Rural Training Time Required for an Urban Hospital To Qualify for an Increase in the Rural Track FTE Limitation

To encourage the training of physicians in rural areas, section 407(c) of Pub. L. 106–113 amended sections 1886(d)(5)(B) and 1886(h)(4)(H) of the Act to add a provision that, in the case of an urban hospital that establishes separately accredited approved medical residency training programs (or rural tracks) in a rural area or has an accredited training program with an integrated rural track, an adjustment shall be made to the urban hospital's cap on the number of residents. For direct GME, the amendment applies to payments to hospitals for cost reporting periods beginning on or after April 1, 2000; for IME, the amendment applies to discharges occurring on or after April 1, 2000.

Section 407(c) of Pub. L. 106–113 did not define a ''rural track'' or an ''integrated rural track,'' nor are these terms defined elsewhere in the Act or in any applicable regulations.

Currently, there are a number of accredited 3-year primary care residency programs in which residents train for 1 year of the program at an urban hospital and are then rotated for training for the other 2 years of the 3-year program to a rural facility(ies). These separately accredited ''rural track'' programs are recognized by the Accreditation Council of Graduate Medical Education (ACGME) as ''1–2'' rural track programs. As far as CMS is able to determine, ACGME is the only accrediting body to ''separately accredit'' rural track residency programs, a requirement specified in Pub. L. 106–113.

We implemented the rural track program provisions of section 1886(d)(5)(B) and 1886(h)(4)(H) of the Act to address these ''1–2'' programs and to account for other programs that are not specifically ''1–2'' programs but that include rural training components. As stated above, since there is no existing definition of ''rural track'' or ''integrated rural track,'' we define at § 413.86(b) a ''rural track'' and an ''integrated rural track'' as 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 to a rural nonhospital site(s). We have previously noted that the terms ''rural track'' and ''integrated rural track,'' for purposes of this definition, are synonymous.

To implement these provisions, we revised § 413.86 to add paragraph (g)(11) (since redesignated as (g)(12)), and § 412.105 to add paragraph (f)(1)(x) to specify that, for direct GME, for cost reporting periods beginning on or after April 1, 2000, or, for IME, for discharges occurring on or after April 1, 2000, 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, under certain circumstances, include in its FTE count residents in those rural tracks, in addition to the residents subject to the FTE cap at § 413.86(g)(4). (See the August 1, 2000 interim final rule with comment period (65 FR 47033) and the August 1, 2001 IPPS final rule (66 FR 39902)). These regulations specify that an urban hospital may count the residents in the rural track in excess of the hospital's FTE cap up to a ''rural track FTE limitation'' for that hospital. We defined this rural track FTE limitation at § 413.86(b) as the maximum number of residents (as specified in § 413.86(g)(12)) training in a rural track residency program that an urban hospital may include in its FTE count, in addition to the number of FTE residents already included in the hospital's FTE cap.

Generally, the rural track policy is divided into two categories: Rural track programs in which residents are rotated to a rural area for at least two-thirds of the duration of the program; and rural track programs in which residents are rotated to a rural area for less than two-thirds of the duration of the program. Currently, family practice is the only specialty that has separately accredited rural track programs. As previously noted, to account for other specialties that have program lengths greater than or less than 3 years, or that are not ''1–2'' programs, but may establish separately accredited rural track residency programs that are longer than 3 years, our regulations specify that residents must train in the rural area for ''two-thirds of the duration of the program,'' rather than ''2 out of 3 program years,'' in order for the urban hospital to count FTEs in the rural track (up to the rural track FTE limitation) in addition to the residents included in the hospital's FTE limitation. Thus, for example, under current policy, if a surgery program, which is a 5-year program, were to establish a separately accredited rural track, the urban hospital must rotate the surgery residents to the rural area for at least two-thirds of the duration of the 5-year program in order to qualify to count those FTEs in excess of the hospital's FTE cap, as provided in § 413.86(g)(12) and § 412.105(f)(1)(x).

Accordingly, our policy for determining whether an urban hospital qualifies for an adjustment to the FTE cap for training residents in rural areas is dependent upon the proportion of time the residents spend training in the rural areas. If the time spent training in rural areas (either at a rural hospital or a rural nonhospital site) constitutes *at least two-thirds* of the duration of the program, then the urban hospital may include the time the residents train *at that urban hospital* in determining GME payments. However, if the urban hospital rotates residents to rural areas for a period of time that is *less than two-thirds* of the duration of the program, although the rural hospital may count the time the residents train at the rural hospital if the program is new, the urban hospital may not include the time the residents train at the urban hospital for GME payment purposes (unless it can do so within the hospital's FTE cap).

When we first implemented this policy on rural tracks, it was consistent with our understanding of how the ACGME accredits rural track ''1–2'' programs, in which residents train for 1 year of the program at an urban hospital and are then rotated for training years 2 and 3 to a rural facility. We believed that the ACGME did not separately accredit an approved program as a rural track program unless it met this ''1–2'' condition; that is, the residents were spending one-third of program training in the urban area and two-thirds of the program training in the rural area. However, we have recently learned that there are a few rural track programs that are separately accredited by the ACGME as ''1–2'' rural track programs, but the residents in these programs are not training in rural areas for at least two-thirds of the duration of the program. We understand that in certain instances in which the case-mix of the rural facilities might not be sufficiently broad to provide the residents with an acceptable range of training opportunities, the ACGME allows the residents in program years 2 and 3 to return to the urban hospital for some training in both years. However, because the training in years 2 and 3 is predominantly occurring at the rural locations, the ACGME still separately accredits the urban and rural portions as a ''1–2'' program.

The existing regulations at §§ 412.105(f)(1)(x) and 413.86(g)(12) specify two main criteria for an urban hospital to count the time spent by residents training in a rural track while at the urban hospital in excess of the hospital's FTE limitation: (1) the program must be separately accredited by the ACGME; *and* (2) the time spent training in rural areas (either at a rural hospital or a rural nonhospital site) must constitute *at least two-thirds* of the duration of the program.

We believe that an urban hospital that operates a program that is separately accredited by the ACGME as a ''1–2'' program, but in which residents train in rural areas for more than half but less than two-thirds of the duration of the program, should still be allowed to count those FTE residents for GME payment purposes. Therefore, to be consistent with the ACGME accreditation practices, in the May 19, 2003 proposed rule, we proposed to revise our regulations. Proposed § 413.86(g)(12) still addressed our policy that an urban hospital qualifies for an adjustment to the FTE cap for training in rural areas based upon the proportion of time the residents spend training in the rural areas. However, instead of using ''two-thirds'' as the criterion to specify the amount of time residents training in the rural areas under regulations at §§ 413.86(g)(12)(i) through (iv) and 412.105(f)(1)(x), as under current policy, the proposal would use ''one-half'' as the criterion. This proposal addressed the limited cases where ACGME separately accredits programs as ''1–2'' rural tracks but residents in those programs train in the rural areas less than two-thirds of the time, although greater than one-half of the time. Specifically, we proposed at § 413.86(g)(12) to state:

- If an urban hospital rotates residents to a separately accredited rural track program at a 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, 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.
- If an urban hospital rotates residents to a separately accredited rural track program at 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, the urban hospital may include those residents in its FTE count, subject to the requirements under § 413.86(f)(4).

• 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, 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, the rural hospital may not include those residents in its FTE count (if the rural track is not a new program under § 413.86(g)(6)(iii), 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.

• If an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for a period of time 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, the urban hospital may include those residents in its FTE count, subject to the requirements under § 413.86(f)(4).

We also proposed to make a conforming change to § 412.105(f)(1)(x) to make these proposed provisions applicable to IME payments for discharges occurring on or after October 1, 2003.

We believe the proposal produces a more equitable result than the existing policy; the proposal encompasses what we believe to be all situations in which the ACGME separately accredits rural track programs and in which residents in the programs spend a majority of the time training in rural settings, fulfilling the intent of Congress for Medicare to provide GME payments for significant rural residency training.

Comment: Several commenters supported our proposal that, effective for cost reporting periods beginning on or after October 1, 2003, an urban hospital would be allowed to include residents in its FTE count above its FTE cap for the time that the residents train at the urban hospital, if the residents rotate to a separately accredited rural track program in a rural area for more than one-half of the duration of the program. The commenters believed that this proposed policy better reflects Congressional intent to encourage training in rural areas, while allowing residency programs the flexibility to rotate residents back to urban areas for needed clinical experiences that are not available in the rural setting.

One commenter recommended that the proposal should reduce the required rural training time even further, since research suggests that more than 50 percent of family practice residents who spend as little as 3 months training in rural areas end up practicing in rural settings.

Response: We agree with the commenters that an urban hospital that operates a program that is separately accredited by the ACGME as a ''1–2'' program, but in which residents train in rural areas for more than half but less than two-thirds of the duration of the program, should still be allowed to count those FTE residents for GME payment purposes. However, we do not agree that urban hospitals should be allowed to receive an increase in their FTE caps to include residents in its FTE count for the time that the residents train at the urban hospital, if the residents rotate to a rural area for one-half or less than one-half of the duration of the program. As we stated in the August 1, 2001 **Federal Register** (66 FR 39904–39905), we interpret section 1886(h)(4)(H)(iv) of the Act as only allowing for an urban hospital to receive an adjustment under the rural track provision if the rural track program is ''*separately accredited.*'' In order to be separately accredited as a rural track, the program must meet the ACGME's ''1–2'' criteria; that is, the residents are typically spending approximately two-thirds of the duration of the program in the rural area. We also explained that while we agree that post-residency retention in rural areas is important, we also believe it is important to prevent hospitals from receiving adjustments to their FTE caps in situations when only a nominal amount of training occurs in the rural area. Therefore, we are not adopting the commenter's request to allow an urban hospital to receive an increase in its FTE caps to include residents in its FTE count for the time that the residents train at the urban hospital, if the residents rotate to a rural area for one-half or less than one-half of the duration of the program.

Comment: One commenter that works for a community health center (CHC) that treats a high percentage of patients below the poverty line expressed concern about the detrimental effects that shrinking hospital revenues are having on the training of family practice residents at the CHC and at other rural and community-based settings. The commenter noted that doubling the number of CHCs is a goal of the President, and urged that, if there should be further ''restraint'' on teaching programs, programs that expand into CHCs should be exempt from such restrictions.

Response: We appreciate the comment. However, we note that since we did not specifically make any proposals related to residency training in community health centers, this comment is outside the scope of this final rule. Therefore, we are not responding to it at this time.

b. Inclusion of Rural Track FTE Residents in the Rolling Average Calculation

Section 1886(h)(4)(G) of the Act, as added by section 4623 of Pub. L. 105–33, provides that, for a hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's FTE resident count for direct GME payment purposes equals the average of the actual FTE resident count for that cost reporting period and the preceding cost reporting period. Section 1886(h)(4)(G) of the Act requires that, for cost reporting periods beginning on or after October 1, 1998, a hospital's FTE resident count for direct GME payment purposes equals the average of the actual FTE resident count for the cost reporting period and the preceding two cost reporting periods (that is, a 3-year rolling average). This provision phases in over a 3-year period any reduction in direct GME payments to hospitals that results from a reduction in the number of FTE residents below the number allowed by the FTE cap. We first implemented this provision in the August 29, 1997 final rule with comment period (62 FR 46004) and revised § 413.86(g)(5) accordingly. Because hospitals may have two PRAs, one for residents in primary care and obstetrics and gynecology (the ''primary care PRA''), and a lower PRA for nonprimary care residents, we revised our policy for computing the rolling average for direct GME payment purposes (*not* for IME) in the August 1, 2001 final rule (66 FR 39893) to create two separate rolling averages, one for primary care and obstetrics and gynecology residents (the ''primary care rolling average''), and one for nonprimary care residents. Effective for cost reporting periods beginning on or after October 1, 2001, direct GME payments are calculated based on the sum of: (1) the product of the primary care PRA and the primary care rolling average; and (2) the product of the nonprimary care PRA and the nonprimary care FTE rolling average. (This sum is then multiplied by the

Medicare patient load to determine Medicare direct GME payments).

Section 407(c) of Pub. L. 106–113, which amended sections 1886(d)(5)(B) and 1886(h)(4)(H) of the Act to create the rural track provision, provided that, in the case of an urban hospital that establishes a separately accredited rural track, ''* * * the Secretary shall *adjust the limitation under subparagraph (F)* in an appropriate manner insofar as it applies to such programs in such rural areas in order to encourage the training of physicians in rural areas'' (emphasis added). Subparagraph (F) of the Act is the provision that establishes a cap on the number of allopathic and osteopathic FTE residents that may be counted at each hospital for Medicare direct GME payment purposes. Thus, the provision authorizes the Secretary to allow for an increase to an urban hospital's FTE cap on allopathic and osteopathic residents in certain instances when an urban hospital establishes a rural track program. Although the rural track provision effectively allows an increase to the urban hospital's FTE cap by adjusting the FTE limitation under subparagraph (F), the statute makes no reference to subparagraph (G), the provision concerning the rolling average count of residents. That is, the statute does not provide for an exclusion from the rolling average for the urban hospital for those FTE residents training in a rural track.

Since we implemented this rural track provision in the August 1, 2000 interim final rule with comment period (65 FR 47033), we have interpreted this provision to mean that, except for new rural track programs begun by urban teaching hospitals that are establishing an FTE cap for the first time under § 413.86(g)(6)(i), when an urban hospital establishes a new rural track program or expands an existing rural track program, FTE residents in the rural track that are counted by the urban hospital are included in the hospital's rolling average calculation immediately. Although we have not specified in the regulations that rural track FTE residents counted by an urban hospital are included in the hospital's rolling average FTE resident count, this has been our policy. The Medicare cost report, Form CMS–2552–96 (line 3.05 on Worksheet E, Part A, for IME payments, and on line 3.02 on Worksheet E–3, Part IV, for direct GME payments), reflects this policy. Accordingly, FTE residents in a rural track program are to be included in the urban hospital's rolling average count for IME and direct GME for cost reporting periods beginning on or after April 1, 2000.

In the May 19, 2003 proposed rule, we proposed to revise the regulations at § 413.86(g)(5) to add a new paragraph (vii) to clarify that, subject to regulations at § 413.86(g)(12), except for new rural track programs begun by urban hospitals that are first establishing an FTE cap under § 413.86(g)(6)(i), when an urban hospital with an existing FTE cap establishes a new program with a rural track (or an integrated rural track), or expands an existing rural track (or an integrated rural track) program, the FTE residents in that program that are counted by the urban hospital are included in the urban hospital's rolling average FTE resident count immediately. We also proposed to revise §§ 413.86(g)(12)(i)(A), (g)(12)(ii)(B), and (g)(12)(iv)(A) to indicate that 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, training in the rural track at the urban hospital.

Comment: Commenters supported our proposal to revise § 413.86(g)(5) to clarify that the FTE residents in that program that are counted by the urban hospital are included in the urban hospital's rolling average FTE resident count immediately. The commenters stated that allowing immediate inclusion of rural track resident counts will serve to assist urban hospitals in their development of educational partnerships with rural hospitals.

Response: We appreciate the commenters support and, as explained below, are adopting revisions to the regulations concerning inclusion of rural track residents in the rolling average count of urban hospitals as final.

Except for new rural track programs begun by urban hospitals that are first establishing an FTE cap under § 413.86(g)(6)(i), or for rural hospitals that are establishing new rural track programs under § 413.86(g)(6)(iii), we are implementing sections 1886(d)(5)(B) and 1886(h)(4)(H) of the Act to require that FTE residents that are counted by an urban hospital based on the residents' participation in a rural track are included in the rolling average calculation. Accordingly, for IME and direct GME purposes, unless the rural track program is a new program under § 413.86(g)(13) and qualifies for a cap adjustment under § 413.86(g)(6)(i) or (g)(6)(iii), in instances where an urban hospital increases the number of residents it trains due to the establishment of a new or an expansion of an existing rural track program, the additional FTE residents in the rural track program are only gradually included (over a 3-year period) in the urban hospital's FTE count, since they are immediately included in the rolling average calculation of the urban hospital.

The following is an example of how residents in a rural track would be included in the rolling average calculation:

Assume that urban Hospital A, with a fiscal year end (FYE) date of June 30, had 10 unweighted FTE residents training in its cost reporting period ending June 30, 1996, thereby establishing an FTE cap of 10. Hospital A only trains primary care residents. In its cost reporting periods ending on June 30, 2002, and June 30, 2001, Hospital A again trained 10 FTE residents. However, in July 2002, Hospital A starts a rural training track program, adding 2 FTE residents. Since the additional rural track residents are included immediately in the rolling average, in FYE June 30, 2003, Hospital A's FTE residents for payment purposes equal 10.67 FTEs (12 + 10 + 10 / 3) and not 12 FTEs [(10 + 10 + 10 / 3) + 2], which would be the FTE count if FTEs in a rural track program were not subject to the rolling average calculation.

We are finalizing our proposed revision of § 413.86(g)(5) to add a new paragraph (vii) as explained above. In addition, we are finalizing our revision of §§ 413.86(g)(12)(i)(A), (g)(12)(ii)(B), and (g)(12)(iv)(A) to indicate that 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, training in the rural track at the urban hospital.

4. Technical Change Relating to Affiliated Groups and Affiliation Agreements

Section 1886(h)(4)(H)(ii) of the Act permits, but does not require, the Secretary to prescribe rules that allow institutions that are members of the same affiliated group (as defined by the Secretary) to elect to apply the FTE resident limit on an aggregate basis. This provision allows the Secretary to give hospitals flexibility in structuring rotations within a combined cap when they share a resident's time. Consistent with the broad authority conferred by the statute, we established criteria for defining an ''affiliated group'' and an ''affiliation agreement'' in both the August 29, 1997 final rule (62 FR 45965) and the May 12, 1998 final rule (63 FR 26317). We further clarified our policy concerning affiliation agreements in the August 1, 2002 final rule (67 FR 50069).

We are aware that there has been some confusion at times among members of the provider community when using the term ''affiliation agreement,'' since the term is used in contexts other than for Medicare GME payment purposes. For example, an ''affiliation agreement'' is a term historically used in the academic community that generally relates to agreements made between hospitals and medical schools or among sponsors of medical residency education programs. To help prevent further confusion, in the May 19, 2003 proposed rule, we proposed to change the term in the regulations to ''Medicare GME affiliation agreement.'' We believe this will help to distinguish these agreements used for purposes of GME payments from agreements used for other purposes in the provider community. We proposed to revise the regulations at § 413.86(b) to state ''Medicare GME affiliated group,'' and ''Medicare GME affiliation agreement''. We proposed to make similar revisions to § 413.86(g)(4)(iv), (g)(7)(i) through (v), and § 412.105(f)(1)(vi) for IME payment purposes.

Comment: Commenters supported our proposal to change the terms ''affiliated group'' and ''affiliation agreement'', as defined in § 413.86(b), to ''Medicare GME affiliated group'' and ''Medicare GME affiliation agreement'', respectively. The commenters believed that the changes in terminology will help distinguish these terms from other affiliation agreements that are entered into by hospitals, medical schools, and other institutions that sponsor residency training.

Response: We agree with the commenters and are adopting as final the proposed changes throughout § 412.105 for IME and § 413.86 for direct GME.

Out of Scope Comments Relating to GME

Comment: Several comments addressed miscellaneous IME and direct GME issues, including the initial residency period (IRP) and volunteer physicians.

Response: Because we did not propose any changes in policy concerning these issues, we are unable to respond to these comments at this time. We will consider them for purposes of future rulemaking.

G. Updates to the Reasonable Compensation Equivalent (RCE) Limits (§ 415.70)

1. Background

Under the Medicare program, payment for services furnished by a physician is made under either the Hospital Insurance Program (Part A) or the Supplementary Medical Insurance Program (Part B), depending on the type of services furnished. In accordance with section 1848 of the Act, physicians' charges for medical or surgical services to individual Medicare patients generally are covered under Part B on a fee-for-service basis under the Medicare physician fee schedule. The compensation that physicians receive from or through a provider for services that benefit patients generally (for example, administrative services, committee work, teaching, and supervision) can be covered under Part A or Part B, depending on the provider's setting.

As required by section 1887(a)(2)(B) of the Act, allowable compensation for services furnished by physicians to providers that are paid by Medicare on a reasonable cost basis is subject to reasonable compensation equivalent (RCE) limits. Under these limits, payment is determined based on the lower of the actual cost of the services to the provider (that is, any form of compensation to the physician) or a reasonable compensation equivalent. For purposes of applying the RCE limits, physician compensation costs means monetary payments, fringe benefits, deferred compensation and any other items of value (excluding office space or billing and collection services) that a provider or other organization furnishes a physician in return for the physician's services.

The RCE limits do not apply to the costs of physician compensation that are attributable to furnishing inpatient hospital services paid under the IPPS or as GME costs. In addition, RCE limits do not apply to the costs CAHs incur in compensating physicians for services. Furthermore, compensation that a physician receives for activities that may not be paid under either Part A or Part B is not considered in applying the RCE limits.

The limits apply equally to all physician services to providers that are payable on a reasonable cost basis under Medicare. If a physician receives any compensation from a provider for his or her physician services to the provider (that is, those services that benefit patients generally), payment to those affected providers for the costs of such compensation is subject to the RCE limits. The RCE limits are not applied to payment for services that are identifiable medical or surgical services to individual patients and paid under the physician fee schedule, even if the physician agrees to accept compensation (for example, from a hospital) for those services. (However, payments to teaching hospitals that have elected to be paid for these services on a reasonable cost basis in accordance with section 1861(b)(7) of the Act are subject to the limits.)

Section 415.70(b) of the regulations specifies the methodology for determining annual RCE limits, considering average physician incomes by specialty and type of location, to the extent possible using the best available data. On October 31, 1997, the revised RCE limits update methodology was published in the **Federal Register** (62 FR 59075). For cost reporting periods beginning on or after January 1, 1998, updates to the RCE limits are calculated using the Medicare Economic Index (MEI). The inflation factor used to develop the initial RCE limits and, subsequently, to update those limits to reflect increases in net physician compensation was the Consumer Price Index for All Urban Consumers (CPI–U). In 1998, we revised the update methodology for the RCE limits by replacing the CPI–U with the inflation factor for the physician fee schedule (the MEI) to achieve a measure of consistency in the methodologies employed to determine reasonable payments to physicians for direct medical and surgical services furnished to individual patients and reasonable compensation levels for physicians' services that benefit provider patients generally.

2. Updated RCE Limits

In the May 19, 2003 proposed rule, we indicated our intent to publish updated payment limits on the amount of allowable compensation for services furnished by physicians to providers in this FY 2004 IPPS final rule. These revised RCE limits are based on updated economic index data and replace the limits that were published in the **Federal Register** on May 5, 1997 (62 FR 24483). We calculated the revised RCE limits by using the methodology published in the **Federal Register** on October 31, 1997 (62 FR 59075). These limits are specified in the chart below and are effective for cost reporting periods beginning on or after January 1, 2004.

The revised RCE limits are mere updates that have been calculated by applying the most recent economic index data. In the proposed rule, we did

not propose to change the methodology used to determine the limits. We indicated that, in accordance with § 415.70(f), we are allowed to publish the revised RCE limits in a final rule without prior publication of a proposed rule for public comment. Furthermore, indicated our belief that publication of the revised RCE limits in a proposed rule with opportunity for public comment was unnecessary, and that we found good cause to waive the procedure.

Comment: One commenter was encouraged to learn of our proposal to publish updated RCE limits and suggested that these updates occur on an annual basis.

Response: We will continue to review the RCE limits on a regular basis by applying the most recent economic index data and publish updates as necessary.

3. Application of RCE Limits

This section, as well as the two following sections, is not describing new policy, but rather is simply a discussion of a continuation of the existing policies with respect to the application of and exceptions to the RCE limits and the geographic area classifications used for purposes of establishing the RCE limits. We will continue to use the RCE limits to compute Medicare payments when a physician is compensated by a provider that is subject to the RCE limits in some or all of its areas. We also will use these limits when the physician is compensated by any other related organization for physician administrative, supervisory, and other provider services paid under Medicare. In applying the RCE limits, the intermediary will assign each compensated physician to the most appropriate specialty category. If no specialty category is appropriate (for example, in determining the reasonable cost for an emergency room physician), the fiscal intermediary will use the RCE level for the ''Total'' category, which is based on income data for all physicians. The fiscal intermediary will determine the appropriate geographic area classification given in Table 9 of the addendum of this final rule.

If the physician's contractual compensation covers all duties, activities, and services furnished to the provider and to its patients and the physician is employed full-time, the appropriate specialty compensation limit will be used and adjusted by the physician's allocation agreement to arrive at the program's share of allowable costs as physician compensation costs. In the absence of an allocation agreement, we generally will assume that 100 percent of the compensation was related to services paid under the physician fee schedule and that there are no allowable costs for the physician's services to the provider.

If a physician's compensation from the provider represents payment only for services that benefit patients generally (that is, the physician bills fees for all services furnished to individual patients), the appropriate specialty compensation limit will be used. If a physician is employed by a provider to furnish services of general benefit to patients on other than a full-time basis, the RCE amount will be adjusted upward or downward to reflect the percentage of time his or her actual hours related to a full work year of 2,080 hours.

4. Exceptions to the RCE Limits

Some providers, particularly but not exclusively small or rural hospitals, may be unable to recruit or maintain an adequate number of physicians at a compensation level within the prescribed limits. In accordance with section 1887(a)(2)(C) of the Act, if a provider is able to demonstrate to the intermediary its inability to recruit or maintain physicians at a compensation level allowable under the RCE limits (as documented, for example, by unsuccessful advertising through national medical or health care publications), the intermediary may grant an exception to the RCE limits established under these rules.

5. Geographic Area Classifications for RCE Limits

We adjust the RCE limits to account for differences in salary levels by location as well as by specialty. Under our methodology for establishing limits, and in the limits set forth below, we have classified geographic areas into three types: nonmetropolitan areas, metropolitan areas less than 1 million, and metropolitan areas greater than 1 million.

As we do for purposes of the IPPS and the physician fee schedule, we use the most current MSA designations for purposes of establishing the RCE limits. In New England, we use the NECMAs for this purpose. Tables 4A and 4B of the Addendum to this final rule includes information that identifies, by type of location (urban and rural), the geographic areas affected; that is, they list all MSAs and their constituent counties and identifies whether their population are classified as large urban. Any county not listed in the tables and all other affected U.S. possessions and territories not part of a State are considered rural areas. This information will enable providers, physicians, Medicare fiscal intermediaries, and other members of the public to determine which RCE limit level will apply in specific areas.

ESTIMATES OF FTE ANNUAL AVERAGE NET COMPENSATION LEVELS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JANUARY 1, 2004 *

Specialty	Nonmetropolitan areas	Metropolitan areas less than one million	Metropolitan areas greater than one million
Total	159,800	171,400	177,200
General/Family Practice	142,500	136,700	138,700
Internal Medicine	150,200	154,100	165,600
Surgery	182,900	204,100	208,000
Pediatrics	130,900	152,100	140,600
OB/GYN	200,300	194,500	196,400
Radiology	217,600	231,100	225,300
Psychiatry	138,700	142,500	154,100
Anesthesiology	167,500	200,300	200,300
Pathology	208,000	219,500	215,700

*All figures are rounded to the nearest $100.

V. PPS for Capital-Related Costs

In the May 19, 2003 proposed rule, we did not propose any changes in the policies governing the determination of the payment rates for capital-related costs for short-term acute care hospitals under the IPPS. However, for the readers' benefit, in this section of this final rule, we are providing a summary of the statutory basis for the PPS for hospital capital-related costs, the methodology used to determine capital-related payments to hospitals, and a brief description of the payment policies under the PPS for capital-related costs for new hospitals, extraordinary circumstances, and exception (regular and special) payments. (Refer to the August 1, 2001 IPPS final rule (66 FR 39910) for a more 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 regular and special exceptions payments.)

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient 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 capital PPS 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. Beginning in FY 2002, capital PPS payments are based solely on the Federal rate for the vast majority of hospitals. The basic methodology for determining capital prospective payments based on the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG Weight) × (Geographic Adjustment Factor (GAF)) × (Large Urban Add-on, if applicable) × (COLA Adjustment for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME Adjustment Factor, if applicable) Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year that are specified in § 412.312(c) of existing regulations.

During the 10-year transition period, a new hospital (as defined at 412.300(b)) 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. As we discussed in the August 1, 2002 final rule (67 FR 50101), this payment provision was implemented to provide special protection to new hospitals during the transition period in response to concerns that prospective payments under a DRG system may not be adequate initially to cover the capital costs of newly built hospitals. Therefore, we believe that the rationale for this policy applies to new hospitals after the transition period as well, and in that same final rule, we established regulations under § 412.304(c)(2) that provide the same special payment to new hospitals for cost reporting periods beginning on or after October 1, 2002. Therefore, 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. (For more detailed information regarding this policy, see the August 1, 2002 IPPS final rule (67 FR 50101).)

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 established for hospitals during the 10-year transition period, but we established regulations at § 412.312(e) 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). (For more detailed information regarding this policy, refer to the August 1, 2002 **Federal Register** (67 FR 50102).)

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 of a percentage of its Medicare allowable capital-related costs depending on the class of hospital (§ 412.348(c)). However, after the end of the transition period, eligible hospitals can receive additional payments under the special exceptions provisions at § 412.348(g), which guarantees an eligible hospital a minimum payment of 70 percent of its Medicare allowable capital-related costs. Special exceptions payments may be made only for the 10 years after the cost reporting year in which the hospital completes its qualifying project, which can be 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).)

VI. Changes for Hospitals and Hospital Units Excluded From the IPPS

A. Payments to Excluded Hospitals and Hospital Units (§§ 413.40(c), (d), and (f))

1. Payments to Existing Excluded Hospitals and Hospital Units

Section 1886(b)(3)(H) of the Act (as amended by section 4414 of Pub. L. 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 apply 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. The ceiling would be 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 100 percent of the 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 DRG-based PPS. As part of the PPS for LTCHs, we established a 5-year transition period from reasonable cost-based reimbursement to a fully Federal PPS. However, a LTCH, subject to the blend methodology, may elect to be paid based on a 100 percent of the Federal prospective rate. (Sections VI.A.3. and 4. of this preamble contain a more detailed discussion of the IRF PPS and the LTCH PPS.)

2. Updated Caps for New Excluded Hospitals and Units

Section 1886(b)(7) of the Act establishes a payment limitation for new psychiatric hospitals and units, new rehabilitation hospitals and units, and new LTCHs. 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 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 third period, updated by the applicable hospital market basket increase percentage.

The amounts included in the following table reflect the updated 110 percent of the national median target amounts of new excluded psychiatric hospitals and units for cost reporting periods beginning during FY 2004. These figures are updated with the most recent data available to reflect the projected market basket increase percentage of 3.4 percent. This 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	FY 2004 labor-related share	FY 2004 nonlabor-related share
Psychiatric	$7,294	$2,899

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new LTCHs because they are paid 100 percent of the Federal rate. Under the LTCH PPS, a new LTCH is defined as a provider of inpatient hospital services that meets the qualifying criteria for LTCHs specified under § 412.23(e)(1) and (e)(2) and whose first cost reporting period as a LTCH begins on or after October 1, 2002 (§ 412.23(e)(4)). (We note that this definition of new LTCHs should not be confused with those LTCHs first paid under the TEFRA payment system for discharges occurring on or after October 1, 1997, and before October 1, 2002.) New LTCHs are paid 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. 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). Under § 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, because 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 for new LTCHs.

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is 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 Pub. L. 105–33, provided 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 Pub. L. 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 Pub. L. 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. Under the IRF PPS, for cost reporting periods beginning on or after January 1, 2002, and before October 1, 2002, payment consisted of 33⅓ percent of the facility-specific payment amount (based on the reasonable cost-based reimbursement methodology) and 66⅔ percent of the adjusted Federal prospective payment. 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. We plan to issue in the **Federal Register** by

August 1, 2003 a final rule that will update the payment rates under the IRF PPS for FY 2004, to be effective for discharges occurring on or after October 1, 2003 and before October 1, 2004.

4. Development of a PPS for Inpatient Psychiatric Facilities

We are in the process of developing a proposed rule that would establish a per diem PPS for inpatient psychiatric facilities (IPFs) (previously referred to as psychiatric hospitals and units) that is required under the provisions of section 124 of Pub. L. 106.113.

5. Implementation of a PPS for LTCHs

In accordance with the requirements of section 123 of Pub. L. 106–113, as modified by section 307(b) of Pub. L. 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.

As part of the implementation of the system, we established a 5-year transition period from reasonable cost-based reimbursement to the fully Federal prospective rate. A blend of the reasonable cost-based reimbursement percentage and the prospective payment Federal rate percentage would be used to determine a LTCH's total payment under the LTCH PPS during the transition period. Certain LTCHs may elect to be paid based on 100 percent of the Federal prospective rate. All LTCHs will be paid under the fully Federal prospective rate for cost reporting periods beginning on or after October 1, 2006.

We published in the **Federal Register** on June 6, 2003 a final rule (68 FR 34122) that updated the payment rates for the LTCH PPS and made policy changes effective for a new LTCH PPS rate year of July l, 2003 through June 30, 2004.

6. Report of Adjustment (Exception) Payments

Section 4419(b) of Pub. L. 105–33 requires the Secretary to publish annually in the **Federal Register** a report describing the total amount of adjustment (exception) payments made to excluded hospitals and units, by reason of section 1886(b)(4) of the Act, during the previous fiscal year. However, the data on adjustment payments made during the previous fiscal year are not available in time to publish a report describing the total amount of adjustment payments made to all excluded hospitals and units.

The process of requesting, adjudicating, and awarding an adjustment payment is likely to occur over a 2-year period or longer. First, an excluded hospital or unit must file its cost report for a fiscal year with its intermediary within 5 months after the close of its cost reporting period. The fiscal intermediary then reviews the cost report and issues a Notice of Program Reimbursement (NPR) within approximately 2 months after the filing of the cost report. If the hospital's operating costs are in excess of the ceiling, the hospital may file a request for an adjustment payment within 6 months from the date of the NPR. The intermediary, or CMS, depending on the type of adjustment requested, then reviews the request and determines if an adjustment payment is warranted. This determination is often not made until more than 6 months after the date the request is filed. Therefore, it is not possible to provide data in this final rule. However, in an attempt to provide interested parties with data on the most recent adjustments for which we do have data, we are publishing data on adjustments that were processed by the fiscal intermediary or CMS during FY 2002.

The table below includes the most recent data available from the fiscal intermediaries and CMS on adjustment payments that were adjudicated during FY 2002. As indicated above, the adjustments made during FY 2002 only pertain to cost reporting periods ending in years prior to FY 2001. Total adjustment payments awarded to excluded hospitals and units during FY 2002 are $8,541,349. The table depicts for each class of hospital, in the aggregate, the number of adjustment requests adjudicated, the excess operating cost over ceiling, and the amount of the adjustment payment.

Class of hospital	Number	Excess cost over ceiling	Adjustment payments
Rehabilitation	14	$6,330,380	$1,058,646
Psychiatric	7	7,524,434	3,717,465
Long-Term Care	2	23,462,335	1,713,364
Children's	4	3,336,306	997,269
Cancer	1	70,078,995	1,018,919
Christian Science	2	113,304	35,686

B. Payment for Services Furnished at Hospitals-Within-Hospitals and Satellite Facilities

Existing regulations at § 412.22(e) define a hospital-within-a-hospital as a hospital that occupies space in the same building as another hospital, or in one or more entire 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.

Sections 412.22(h) and 412.25(e), relating to satellites of hospitals and hospital units, respectively, excluded from the IPPS, define a satellite facility as a part of a hospital or unit that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital. Sections 412.22(h)(3) and 412.25(e)(3) provide for the grandfathering of excluded hospitals and units that were structured as satellite facilities on September 30, 1999, to the extent they operate under the same terms and conditions in effect on that date.

In providing for the grandfathering of satellite facilities of hospitals and hospital units, we believed it was appropriate to require that the satellite facilities operate under the same terms and conditions that were in effect on September 30, 1999. There are similarities between the definition of satellite facilities and the definition of hospitals-within-hospitals (that is, hospitals-within-hospitals and satellite facilities are both physically located in acute care hospitals that are paid for their inpatient services on a prospective

payment basis). Also, satellite facilities of both excluded hospitals and hospital units and hospitals-within-hospitals provide inpatient hospital services that are paid at a higher rate than would apply if the facilities were treated by Medicare as part of an acute care hospital.

In the May 19, 2003 proposed rule, we proposed to revise § 412.22(f) to specify that, effective with cost reporting periods beginning on or after October 1, 2003, a hospital operating as a hospital-within-a-hospital on or before September 30, 1995, is exempt from the criteria in § 412.22(e)(1) through (e)(5) only if the hospital-within-a-hospital continues to operate under the same terms and conditions in effect as of September 30, 1995. The intent of the grandfathering provision was to ensure that hospitals that had been in existence prior to the effective date of our hospital-within-hospital requirements should not be adversely affected by those requirements. To the extent hospitals were already operating as hospitals-within-hospitals without meeting those requirements, we believe it is appropriate to limit the grandfathering provision to those hospitals that continue to operate in the same manner as they had operated prior to the effective date of those rules. However, if a hospital changes the way it operates (for example, adds more beds) subsequent to the effective date of the new rules, it should no longer receive the benefit of the grandfathering provision.

Under § 412.22(e), we specify the criteria that a hospital-within-a-hospital is required to meet in order to be excluded from the IPPS. One of these criteria, under § 412.22(e)(5)(i), requires that a hospital-within-a-hospital is able to perform basic hospital functions (for example, medical record services and nursing services) that are presently included in the Medicare hospital conditions of participation under Part 482 of the Medicare regulations. These requirements were first included in Part 412 in response to hospitals organizing themselves as what is referred to as the hospital-within-a-hospital model. Thus, to avoid recognizing nominal hospitals, while allowing hospitals adequate flexibility and opportunity for legitimate networking and sharing of services, we included, by reference, certain hospital conditions of participation as additional criteria in Part 412 for hospitals-within-hospitals that request exclusion from the IPPS. (Further discussion can be found in a final rule published in the **Federal Register** on September 1, 1994 (59 FR 45389).) Modifications to the conditions of participation have been made since the publication of that September 1, 1994 final rule. Thus, we need to update the references to the conditions of participation in § 412.22(e)(5)(i) to make them consistent with existing provisions under the basic hospital conditions of participation. Therefore, we also proposed to amend § 412.22(e)(5)(i) to add references to § 482.43 (discharge planning) and § 482.45 (organ, tissue, and eye procurement) as basic hospital functions that a hospital-within-a-hospital would also be required to meet.

Comment: Several commenters disagreed with our proposal to require grandfathered hospitals-within-hospitals to continue to operate under the same terms and conditions that were in place on September 30, 1995 (for example, adding beds). These commenters believed that the adoption of this proposal could result in a decertification of a number of LTCHs, thus depriving Medicare beneficiaries of specialized services and unique programs. They asserted that CMS is requiring these grandfathered hospitals-within-hospitals to either reverse their previously approved changes or lose their certification, which would retroactively reverse prior governmental approvals of LTCH changes. The commenters further asserted that there is no good reason to treat these hospitals any differently from other providers participating in the Medicare program, a practice that the commenters believed would result in inequitable treatment of patients as well as employees. Furthermore, the commenters expressed concern that the proposed effective date timeframe for implementation (that is, 60 days) is too short for purposes of implementing this proposed change because it would not allow adequate time for providers to undo previous changes.

Response: We have reviewed the commenters' concerns with regard to our proposal to require ''grandfathered'' hospitals-within-hospitals to continue to operate under the same terms and conditions that were in place on September 30, 1995. We understand the commenters' concern that adoption of this change as proposed could adversely impact some grandfathered hospitals-within-hospitals that, over the years, have made changes to the terms and conditions under which they operate.

After careful consideration of the comments, we have decided to revise § 412.22(f) to state that if a hospital-within-a-hospital was excluded from the IPPS under the provisions of § 412.22(f) on or before September 30, 1995, and at that time occupied space in a building also used by another hospital or in one or more buildings located on the same campus as buildings used by another hospital, the provisions of § 412.22(e) do not apply to the hospital as long as the hospital meets either of two conditions: First, under § 412.22(f)(1), the hospital continues to operate under the same terms and conditions, including the number of beds and square footage considered to be part of the hospital for purposes of Medicare participation and payment, in effect on September 30, 1995. Second, under § 412.22(f)(2) a hospital that changed the terms and conditions under which it operates after September 30, 1995 but before October 1, 2003, may continue in its grandfathered status if it continues to operate under the same terms and conditions, including the number of beds and square footage considered to be part of the hospital for purposes of Medicare participation and payment, in effect on September 30, 2003. The second condition was added in recognition of commenters who suggested that hospitals be held harmless for past changes in their terms and conditions of operation. We note that any changes occurring on or after October 1, 2003, including changes in number of beds or square footage, could lead to a loss of grandfathered status.

We want to reiterate that, in establishing grandfathering provisions, our general intent has been to protect existing hospitals from the potentially adverse impact of recent, more specific regulations that we now believe to be essential to the goals of the Medicare program. However, a hospital that continues to be excluded from the IPPS through grandfathered status may wish to alter the terms and conditions that were in effect either on September 30, 1995, or after October 1, 2003, as provided in revised § 412.22(h). In that circumstance, in order to continue being paid as a hospital excluded from the IPPS, the hospital would need to comply with the general hospital-within-a-hospital requirements set forth in § 412.22(e).

We plan to review the issue of whether further revisions to this regulation should be made to allow more changes in operation by grandfathered hospital-within-hospitals, and welcome specific suggestions on this issue.

C. Clarification of Classification Requirements for LTCHs

Under § 412.23(e)(2), to qualify to be excluded from the IPPS as a LTCH and to be paid under the LTCH PPS, a hospital must have an average Medicare length of stay of greater than 25 days (which includes all covered and

noncovered days of stay for Medicare patients) as calculated under the criteria of § 412.23(e)(3). In calculating this average Medicare inpatient length of stay, data from the hospital's most recently filed cost report are used to make this determination. However, if the hospital has not yet filed a cost report or if there is an indication that the most recently filed cost report does not accurately reflect the hospital's current Medicare average length of stay, data from the most recent 6-month period are used.

Our interpretation of § 412.23(e)(3)(ii) and (e)(3)(iii) was to allow hospitals that submit data for purposes of exclusion from the IPPS to use a period of at least 5 months of the most recent data from the preceding 6-month period. This longstanding policy interpretation was necessary in order to comply with the time requirement in § 412.22(d) that specifies that, for purposes of the IPPS, status is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Therefore, in the May 19, 2003 proposed rule, we proposed to revise §§ 412.23(e)(3)(ii) and (iii) to reflect our longstanding interpretation of the regulations.

Comment: One commenter suggested that we clarify the source of our data for computing the average length of stay for purposes of designation as a LTCH.

Response: Although we did not propose any policy change regarding the average length of stay calculation, we did describe the data source for this calculation, which is set forth at § 412.23(e)(3). Therefore, we will take this opportunity to correct an inadvertent misstatement of the data source for this calculation and clarify present data collection procedures. In the proposed rule, we stated that we relied on data from a ''. . . hospital's most recently filed cost report . . .'' for determining whether it qualified as a LTCH. However, the regulation does not specify or require that the hospital's cost report (Hospital and Hospital Health Care Complex Cost Report, CMS Form 2552–96) be the source of these data used in the determination for LTCH classification. Specifically, the regulation only notes that the calculation requires dividing the total Medicare inpatient days by the total number of Medicare discharges occurring for the *hospital's most recent complete cost reporting period* (§ 412.23(e)(3)). (A detailed description of the designation process is included in the August 30, 2002 IPPS final rule (67 FR 55970 through 55974).)

Prior to the October 1, 2002 implementation of the LTCH prospective payment system, we did rely on data from the most recently *submitted* cost report for this purpose. In addition, the calculation, for purposes of qualifying as a LTCH, was based on total days and discharges for all LTCH inpatients. However, with the implementation of the LTCH PPS, we revised § 412.23(e)(3)(i) to only count total days and discharges for Medicare inpatients (67 FR 55970, August 30, 2002). Presently, we are unable to capture these data on our present cost reporting forms. Therefore, until the cost reporting form is revised, for purposes of the average length of stay calculation, we will be relying upon patient census data extracted from MedPAR files that reflect each LTCH's cost reporting period. Fiscal intermediaries and LTCHs have been informed of this course of action through official agency transmittals, but we want to emphasize that this temporary shift in data sources should have no effect on the evaluation policy set forth in regulations at §§ 412.22(d) and 412.23(e)(3) and the procedures described in the August 30, 2002 final rule.

D. Criteria for Payment on a Reasonable Cost Basis for Clinical Diagnostic Laboratory Services Performed by CAHs

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. Section 1834(g) of the Act states that the amount of payment for outpatient services furnished by a CAH will be the reasonable costs of the CAH in providing these services.

Regulations implementing section 1834(g) of the Act are set forth at § 413.70. These regulations state, in paragraph (b)(2)(iii), that payment to a CAH for outpatient clinical diagnostic laboratory tests will be made on a reasonable cost basis only if the individuals for whom the tests are performed are outpatients of the CAH, as defined in § 410.2, at the time the specimens are collected. The regulations also state that clinical diagnostic laboratory tests for persons who are not patients of the CAH at the time the specimens are collected will be paid for in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Act. These provisions, which also are the basis for payment for clinical diagnostic laboratory tests performed by independent laboratories and by hospitals on specimens drawn at other locations, set payment at the least of: (1) charges determined under the fee schedule as set forth in section 1833(h)(1) or section 1834(d)(1) of the Act; (2) the limitation amount for that test determined under section 1833(h)(4)(B) of the Act; or (3) a negotiated rate established under section 1833(h)(6) of the Act. Payments determined under this methodology are typically referred to as ''fee schedule payments,'' and are so described here both for ease of reference and to differentiate them from payments determined on a reasonable cost basis.

The definition of an ''outpatient'' in § 410.2 states that an outpatient means a person who has not been admitted as an inpatient but who is registered on hospital or CAH records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

Recently, we have received numerous questions about how Medicare pays for laboratory services that a CAH may furnish to Medicare beneficiaries in various settings other than the CAH. Specifically, the questioners have asked whether a CAH may obtain reasonable cost payment for such services to individuals in other locations by sending a CAH employee into the setting and registering the individual as a CAH patient while the blood is drawn or other specimen collection is accomplished. The settings that have been referred to most frequently are: (1) a rural health clinic (RHC), especially one that is provider-based with respect to the CAH; (2) the individual's home; and (3) an SNF.

We have considered these suggestions and understand the position taken by those who believe that nominal compliance with the requirements for outpatient status should be enough to warrant reasonable cost payment for clinical diagnostic laboratory tests for individuals at locations outside the CAH. However, we do not agree that providing reasonable cost payment under these circumstances would be appropriate. On the contrary, we believe that extending reasonable cost payment for services furnished to individuals who are not at the CAH when the specimen is drawn would duplicate existing coverage, create confusion for beneficiaries and others by blurring the distinction between CAHs and other providers, such as SNFs and HHAs, and increase the costs of care to Medicare patients without enhancing either the quality or the availability of that care.

To clarify our policies in this area and avoid possible misunderstandings about the scope of the CAH benefit, in the May

19, 2003 proposed rule, we proposed to revise § 413.70(b)(2)(iii) to state that payment to a CAH for outpatient clinical diagnostic laboratory tests will be made on a reasonable cost basis only if the individuals for whom the tests are performed are outpatients of the CAH, as defined in § 410.2, ''and are physically present in the CAH'' at the time the specimens are collected. (We note that, in some cases, the CAH outpatients from whom specimens are collected at the CAH may include individuals referred to the CAH from RHCs or other facilities to receive the tests.) We proposed to further revise this paragraph to state that clinical diagnostic laboratory tests for individuals who do not meet these criteria but meet other applicable requirements will be paid for only in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Act, that is, payment will be made only on a fee schedule basis. We emphasize that the second proposal does not mean that no payment would be made for clinical diagnostic laboratory tests performed by CAHs that do not meet the revised criteria. On the contrary, such tests would be paid, but on a fee schedule basis. We believe these clarifications are appropriate, as the CAH is not providing CAH services but is acting as an independent laboratory in providing these clinical diagnostic laboratory tests.

Comment: Some commenters stated that a major goal of the Medicare Rural Hospital Flexibility Program, under which reasonable cost payment to CAHs is authorized, is to ensure that isolated rural hospitals have access to critical health care services. The commenters believed that our proposal would undermine that goal by paying less than reasonable cost amounts for certain services. These commenters stated that, in some rural communities, there may be few, or no, reasonable alternatives to having laboratory tests performed by a CAH. Because of this, the commenters believed reasonable cost payment for CAH-performed laboratory tests is warranted, even when specimens are collected in settings other than the CAH from patients who are being registered as CAH patients for the sole purpose of generating higher Medicare payment for the tests.

Response: We agree that an important goal of the CAH legislation is to pay on a reasonable cost basis for services that CAHs provide in their facilities to their inpatients and outpatients. However, we do not believe that legislation can or should be read so broadly as to authorize payment on a reasonable cost basis for laboratory services to patients who do not come to the CAH for those services, but receive them in other settings, including settings in which coverage for the services is available. We also do not agree that because the CAH may be one of only a few sources of laboratory services that the CAH should therefore be paid a higher amount for those services than would otherwise be the case. Therefore, we are not making any change to our proposal based on this comment.

Comment: Several commenters stated that even when a sample is collected outside a CAH, the cost of processing in a CAH laboratory is incurred by the CAH. Because of this circumstance, the commenters recommended that payment be based on the payment method applicable to the site where the processing is done, so that payment for laboratory tests processed at a CAH would be paid on a reasonable cost basis, not under the fee schedule.

Response: We believe the approach recommended by these commenters could create an inappropriate incentive to CAHs to expand their testing activities far beyond their normal service areas, in order to gain cost reimbursement for patients who have no other connection with the CAH other than having a specimen processed by the CAH. In some cases, this could result in payment being made on a cost basis for laboratory services to patients residing in suburban or even urban areas where there is no shortage of qualified laboratories. Such a result would only inappropriately increase payment to CAHs and create market distortions, because non-CAH laboratories performing exactly the same services may be paid substantially less for them. Therefore, we are not adopting this recommendation.

Comment: One commenter agreed with our proposal as it applies to laboratory specimens drawn in health care providers or suppliers other than CAHs, such as SNFs or RHCs, but recommended that we allow reasonable cost payment for clinical diagnostic laboratory tests on specimens drawn in physician clinics that are located in close proximity to the CAH, if the CAH owns the clinic and supplies the personnel who collect the specimens.

Response: While we considered this suggestion, we are not adopting it. A clinic of the type described by the commenter is not a part of the CAH, but is a physician office. We see no basis for treating such a non-CAH setting differently from other non-CAH facilities (such as RHCs) that are similarly owned and located. In the case of an ambulatory patient being seen in a physician office located in close proximity to the CAH, we do not believe it is unreasonable to expect the patient to go to the CAH for the laboratory service as he or she would for therapy or any other CAH outpatient service. Alternatively, the specimen may be collected during the physician visit and payment could be made to the CAH under the laboratory benefit, generally on a fee schedule basis.

Comment: Some commenters stated that the proposed revision is not a clarification but a change from past policy.

Response: We disagree with the commenter, but we do recognize from the questions raised on the issue that there has been some confusion about the policy among rural facilities. To clarify the agency policy in this area and ensure that all relevant issues are publicly noted, we set forth the clarification through notice and comment rulemaking procedures rather than through other processes, such as a program memorandum, a set of responses to ''frequently asked questions,'' or other document.

Comment: One commenter stated that it is inappropriate for proposed changes to CAH payment to be published in the proposed IPPS regulation. The commenter recommended that if changes are to be made to the payment methodology for those facilities excluded from the IPPS rule, they should be published separately in the **Federal Register**, not in a proposed rule that would not normally be reviewed by officials associated with CAHs.

Response: The IPPS proposed and final rules are published on an established and regular annual cycle and have been read for many years by a large health care population, including national, State, and local hospital associations as well as individual hospitals, including hospitals paid under the reasonable cost payment system as well as those paid under the IPPS. Because we recognize this as an important tool for disseminating information, we have used the IPPS publication in order to implement several major payment issues relating to CAHs. For example, changes in the CAH payment rules in § 413.70 were included in the IPPS final rule published on August 1, 2002 (67 FR 49982) and the IPPS final rule published on August 1, 2001 (66 FR 39828). We believe this is an appropriate vehicle in providing the information necessary to allow the CAHs access to the information they need to continue to participate knowledgeably in the Medicare program. In fact, we received over 40 comments on the provision alone.

Comment: Some commenters recommended that we withdraw our proposal because reasonable cost payment for clinical diagnostic laboratory tests on specimens collected in non-CAH settings can be an important revenue source for CAHs and yet would generate only a small amount of additional cost to the Medicare program.

Response: For the reasons stated above and in the preamble to the proposed rule, we do not believe it is appropriate to pay on a reasonable cost basis for these laboratory tests. Moreover, doing so might create an unintended incentive for laboratories processing a substantial volume of tests to affiliate with CAHs, in order to obtain the higher level of payment for tests on individuals who are only nominally patients of the CAH. Therefore, we are not adopting this recommendation.

Comment: Some commenters stated that beneficiaries, particularly frail, elderly individuals residing in remote rural areas, could be inconvenienced by our proposed clarification because they would now be required to travel to the CAH to obtain laboratory services payable on a reasonable cost basis. These commenters expressed concern that frail, elderly patients confined to nursing homes could be required by this policy to travel to CAHs to obtain needed laboratory tests.

Response: Under our proposed clarification, Medicare would not deny payment for medically necessary clinical diagnostic laboratory tests that the CAH performs on specimens collected from patients in non-CAH locations. On the contrary, clinical diagnostic laboratory tests performed by CAHs on such specimens would be paid under the same conditions as would apply to such tests furnished by an independent laboratory. In such a case, a CAH would be providing independent laboratory services and generally would be paid under the laboratory fee schedule.

Regarding the concern about the difficulty of travel for some beneficiaries, we believe it is an incorrect assumption that beneficiaries in rural areas will not have specimens collected in their homes or other locations if the CAH is not paid on a cost basis for the collection and travel. If it is medically necessary for the specimen to be collected in the patient's home, the laboratory benefit under Medicare Part B will pay the specimen collection fee (currently $3 per specimen), plus a separate travel allowance (currently at least 75 cents per mile where the average round trip is more than 20 miles) for employees of independent, mobile or hospital-based laboratories to travel to the beneficiary's home. These payments are in addition to payment for performing the tests. (For further details on how specimen collection and travel fees are calculated, see CMS Transmittal AB–98–33, Change Request #526, dated July 1998; this transmittal is available on the CMS Web site at *www.cms.hhs.gov.*) In many cases, the laboratories collect blood specimens in batches or groups of beneficiaries residing in neighboring areas. This can make the technicians' trips to beneficiaries' residences more cost-effective.

In addition to laboratories, home health agencies that have laboratory provider numbers can perform blood draws at a beneficiary's residence and bill Medicare under the laboratory benefit, using the appropriate codes for specimen collection and travel. Agencies would be reimbursed the $3 specimen collection fee, plus travel costs determined by the Medicare contractor.

It is also important to note that home health agencies with laboratory provider numbers may conduct some of the less complex blood tests themselves, receive the collection and travel fee, and receive a fee through the laboratory benefit for performing the tests. These are called the Clinical Laboratory Improvement Amendments (CLIA)-waived tests, and, among others, include: glucose (blood sugar levels for diabetic patients), fructosamine (also checks blood sugar levels but over longer period of time), hemoglobin (tests hemoglobin levels for patients with anemia), urine dip stick (tests urine for a variety of diseases/infections), and cholesterol/triglyceride (checks for lipid levels for patients with cardiovascular disease) tests.

A variety of other providers can draw blood at a beneficiary's home, often in conjunction with other services necessitating the laboratory tests. For example, while a physician conducts a home visit for evaluation and management, the physician may also draw a blood specimen. If the physician meets applicable requirements under the laboratory benefit, he or she may receive an additional payment for the specimen collection.

The physician also can arrange for a nurse practitioner, physician assistant, or clinical nurse specialist to conduct a home visit and draw blood when they examine the beneficiary. These clinicians are reimbursed at a rate equal to 85 percent of the physician fee schedule for a home visit, and if all applicable billing requirements are met, they are also paid specimen collection and travel fees.

Regarding tests for nursing home patients, we note that if a CAH furnishes laboratory services to a beneficiary in an SNF stay covered by Part A, nonemergency diagnostic laboratory tests—regardless of whether furnished by the SNF directly or under an arrangement with the CAH—would be included within the SNF's bundled PPS per diem payment for the covered stay itself. If a CAH furnishes laboratory services to a beneficiary in an SNF stay not covered by Part A (for example, Part A benefits exhausted; no prior qualifying hospital stay; SNF level of care requirements not met), the SNF consolidated billing restrictions do not apply. However, if the SNF nonetheless elects to bill for such a beneficiary's laboratory services, section 1888(e)(9) of the Act provides that an SNF's Part B bills are to be paid in accordance with the fee schedule that applies to the particular item or service being billed.

In the case of beneficiaries in nursing homes, patients are already under the care of an institution staffed with registered nurses, licensed practical nurses, and nursing assistants, and other health care workers who are presumably well-trained in collecting specimens for analysis, and the nursing homes are already being paid, by Medicare, Medicaid, private insurers, or other means for caring for the patient. Under these circumstances, it would not seem unreasonable to expect the nursing home to take responsibility for collecting the specimens.

Because of the many ways in which specimen collection and travel are payable under Medicare, we do not expect beneficiaries to face reduced access to services under this proposal. We specifically reject the claims made by several commenters that beneficiaries would be able to obtain needed laboratory services only by traveling to the CAH to obtain them.

Comment: Some commenters took exception to the preamble statements that allowing cost reimbursement for laboratory tests on specimens obtained by CAH personnel in non-CAH settings would duplicate existing coverage, create confusion for beneficiaries, and add to the costs of care furnished to Medicare patients. Regarding the costs of care, the commenters stated that because clinical diagnostic laboratory tests are not subject to deductible or coinsurance liability under Medicare, there would be no increase in out-of-pocket costs for beneficiaries.

Response: Regarding duplication of coverage, we have explained in a response to an earlier comment the many ways in which Medicare now pays for specimen collection fees and

travel costs. Given this payment provision, adding another, more expensive payment option for the services would duplicate existing coverage without providing any benefit to anyone other than the operators of the CAHs. Despite the commenters' claims to the contrary, we continue to believe patients under the care of one provider (such as a SNF or RHC) might have questions as to why personnel from another provider are coming in to perform functions that could be performed by staff of the facility in which they are being treated. Finally, while there is no deductible or coinsurance liability associated with laboratory services, paying for services on a reasonable cost basis rather than on a fee schedule basis will ultimately drive up the cost of laboratory care provided under Medicare, increasing costs for taxpayers and contributing to general health care cost increases. To the extent Medicare Part B premiums will increase in the future because of current spending rises, we believe adopting the policy recommended by commenters would increase out-of-pocket costs for beneficiaries as well as for all other taxpayers.

Comment: One commenter asked whether the proposed clarification of our policy on payment for clinical diagnostic laboratory tests would be applied prospectively only, or also retroactively.

Response: Although this proposal represents a clarification of policy, we recognize that this policy has not been well understood in all areas. Therefore, we do not plan to direct Medicare contractors to routinely reopen and review past claims for compliance.

After full consideration of public comments on these issues as summarized above, we are adopting our proposed changes to § 413.70 as final without change.

E. Technical Change

On July 30, 1999, we published in the **Federal Register** a final rule (64 FR 41532) that set forth criteria for a satellite facility of a hospital or hospital unit to be excluded from the IPPS under § 412.25. Section 412.25(e)(3) of the regulations specifies that any unit structured as a satellite facility on September 30, 1999, and excluded from the IPPS on that date, is grandfathered as an excluded hospital to the extent that the unit continues operating under the same terms and conditions, including the number of beds and square footage considered to be part of the unit, in effect on September 30, 1999, except as we specified in § 412.25(e)(4). When we specified the exception for the number of beds and square footage requirement under § 412.25(e)(4), we inadvertently referred to paragraph (e)(4) as being an exception to paragraph (h)(3). We should have specified that it was an exception to paragraph (e)(3). We proposed to correct this reference.

We did not receive any comments on this proposal and, therefore, are adopting the proposed technical change as final.

VII. MedPAC Recommendations

We are required by section 1886(e)(4)(B) of the Act to respond to MedPAC's IPPS recommendations in our annual IPPS rules. We have reviewed MedPAC's March 1, 2003 ''Report to the Congress: Medicare Payment Policy'' and have given it careful consideration in conjunction with the policies 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: *http://www.medpac.gov.*

MedPAC's Recommendation 2A–6 concerning the update factor for inpatient hospital operating costs and for hospitals and distinct-part hospital units excluded from the IPPS is discussed in Appendix B to this final rule. MedPAC's other recommendations relating to payments for Medicare inpatient hospital services focused mainly on the expansion of DRGs subject to the postacute care transfer policy, a reevaluation of the labor-related share of the market basket used in determining the hospital wage index, an increase in the DSH adjustment, and payments to rural hospitals. These recommendations and our responses are set forth below:

Recommendation 2A–1: The Secretary should add 13 DRGs to the postacute transfer policy in FY 2004 and then evaluate the effects on hospitals and beneficiaries before proposing further expansions.

Response: After reevaluation of this recommendation, in this final rule we are expanding the postacute care transfer policy to include 21 additional DRGs for FY 2004, although we are removing 2 DRGs from the current list. A thorough discussion of this provision, including a summary of MedPAC's analysis, can be found at section IV.A.3. of this preamble.

Recommendation 2A–2: The Congress should enact a low-volume adjustment to the rates used in the inpatient PPS. This adjustment should apply only to hospitals that are more than 15 miles from another facility offering acute inpatient care.

Response: MedPAC's analysis ''revealed that hospitals with a small volume of total discharges have higher costs per discharge than larger facilities, after controlling for the other cost-related factors recognized in the payment system.'' Although there are special payment protections for some rural hospitals such as CAHs, SCHs, and MDHs, MedPAC believes these provisions do not sufficiently target hospitals with low discharge volume.

This recommendation, which MedPAC estimates would increase Medicare payments to hospitals by less than $50 million in FY 2004, and others requiring Congressional action, should be considered in the context of larger discussions within Congress and between Congress and the Administration regarding Medicare reform and payment refinements. Therefore, we are not responding specifically to MedPAC's recommendation regarding a low-volume adjustment to the IPPS payments at this time.

Recommendation 2A–3: The Secretary should reevaluate the labor share used in the wage index system that geographically adjusts rates in the inpatient PPS, with any resulting change phased in over 2 years.

Response: We define the labor-related share to include costs that are likely related to, influenced by, or vary with local labor markets, even if they could be purchased in a national market. Since the implementation of the IPPS, the labor-related share has been determined by adding together the cost weights from categories in the hospital market basket that are influenced by local labor markets. When the hospital market basket weights are updated or rebased, the labor-related share is updated. The estimate of the labor-related share using the most recently revised and rebased hospital market basket (1997-based) is 72.495 percent.

In the August 1, 2002 IPPS final rule, we elected to continue to use 71.066 percent as the labor-related share applicable to the standardized amounts (67 FR 50041). At that time, we indicated that we would conduct further analysis to determine the most appropriate methodology for the labor-related share. Again, in the May 19, 2003 proposed rule, we did not propose to use the updated labor-related share for FY 2004 because we have not yet completed our research into the appropriateness of this updated measure. Specifically, we continue to review the labor-related share in two ways. First, we are performing

regression analysis with the expectation that it would help give an alternative indication of the labor-related share. Second, we continue to reevaluate the methodology we currently use for determining the labor-related share using the hospital market basket.

Our regression analysis is an attempt to explain the variation in operating cost per case for a given year using many different explanatory variables, such as case-mix, DSH status, and ownership type. We described this methodology and some of our initial results in the May 9, 2002 **Federal Register** (67 FR 31447–31479). However, the findings from the regressions continue to be both difficult to explain and inconsistent with the underlying cost data. Thus, we believe at this point that the regression results are not robust enough to support changing the current labor-related share measurement.

We also continue to explore all options for alternative data or methodology for determining the labor-related share using the hospital market basket. We have researched various alternative data sources for use in further breaking down the cost categories in the market basket and have evaluated alternative methodologies to determine the feasibility of separating the labor-related portion or the portion that varies with local labor markets from the portion that does not vary. While each of these alternatives has strengths and weaknesses, it is not clear at this point that any one alternative data source or methodology is superior to the current methodology. We will continue to research these alternatives.

Comment: Several commenters suggested the labor share should only be adjusted by those costs (wages and salaries and benefits) that are reflected in the wage index survey. Commenters suggested that CMS should consider reducing the labor-related share for rural hospitals or having different labor shares by geographic location.

Response: We define the labor-related share to include all costs that are likely related to, influenced by, or vary with local labor markets, even if they could be purchased in a national market. This differs from the hospital wage index survey, which only collects direct labor and patient-related contract costs. Using only those direct labor costs reflected in the wage index survey would mean redefining the term labor-related share and would likely leave out many of the other costs that do vary with the local labor market.

As indicated in prior rules, we continue to research alternative methodologies for determining the labor-related share, including reexamining the labor portion of each of the individual market basket categories. However, due to a lack of one definitive data source, our analysis is still preliminary and, therefore, we will continue to use 71.066 percent as the labor-related share applicable to the standardized amounts while we conduct further analysis to determine the most appropriate methodology for determining the labor-related share.

It is currently our policy to use a national labor-related share to apply to the national PPS standardized amounts. This policy has been in effect since the implementation of the IPPS in 1983. We will consider the commenters' recommended alternative approaches, such as different labor shares for urban and rural hospitals or labor shares that vary by more detailed geographic area, as part of our ongoing research efforts. However, until we have completed our research, we will continue to use only a national labor-related share, which is currently 71.066 percent and was calculated from the 1992-based market basket.

Comment: One commenter believed that we should examine each of the categories currently included in the labor share and determine which portion of that category was actually labor-related or varied with the local labor market.

Response: We agree with the commenter that it is important that the labor-related portion of the market basket include only those categories that are actually labor-related or vary with the local labor market. As we indicated in the May 19, 2003 rule, we are continuing to explore all options for accounting for the labor-related share, including reexamining each of the categories included in the current labor share (particularly professional fees, postage, and other labor-intensive services) to make sure the labor share represents only those costs that do vary with the local labor market. However, our preliminary research has indicated that much of the data needed to break out details from each of the current market basket categories into labor and nonlabor-related components are not readily available on a national basis. We will continue to research various data sources for this information and will update the labor share as needed once our research is complete.

Recommendation 2A–4: The Congress should raise the inpatient base rate for hospitals in rural and other urban areas to the level of the rate for those in large urban areas, phased in over 2 years.

Response: This recommendation, which MedPAC estimates would increase Medicare payments to hospitals by between $200 and $600 million in FY 2004, and others requiring Congressional action, should be considered in the context of larger discussions within Congress and between Congress and the Administration regarding Medicare reform and payment refinements. Therefore, we are not responding specifically to MedPAC's recommendation regarding raising the base rate for hospitals in rural and other urban areas at this time.

Recommendation 2A–5: The Congress should raise the cap on the disproportionate share add-on a hospital can receive in the inpatient PPS from 5.25 percent to 10 percent, phased in over 2 years.

Response: This recommendation, which MedPAC estimates would increase Medicare payments to hospitals by between $50 and $200 million in FY 2004, and others requiring Congressional action, should be considered in the context of larger discussions within Congress and between Congress and the Administration regarding Medicare reform and payment refinements. Therefore, we are not responding specifically to MedPAC's recommendation regarding raising the maximum DSH adjustments at this time.

VIII. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have 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.* In the May 19, 2003 proposed rule, we published a list of data files that are available for purchase from CMS or that may be downloaded from the Internet free of charge (68 FR 27226 through 27228).

B. Collection of Information Requirements

This final rule directly does not impose any collection and recordkeeping requirements. Consequently, it does not need to be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare,

Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

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

■ For the reasons stated in the preamble of this final rule, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV 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 412.4 is amended by—

■ A. Revising paragraphs (b), (c), and (d).

■ B. In paragraph (f)(1), revising the reference ''paragraph (b)(1) or (c)'' to read ''paragraph (b) or (c)''.

The revisions read as follows:

§ 412.4 Discharges and transfers.

* * * * *

(b) *Acute care transfers.* A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this part if the patient is readmitted the same day (unless the readmission is unrelated to the initial discharge) to another hospital that is—

(1) Paid under the prospective payment system described in subparts A through M of this part; or

(2) Excluded from being paid under the prospective payment system described in subparts A through M of this part because of participation in an approved statewide cost control program as described in subpart C of part 403 of this chapter.

(c) *Postacute care transfers.* A discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in § 412.60(c), to one of the qualifying diagnosis-related groups (DRGs) listed in paragraph (d) of this section and the discharge is made under any of the following circumstances:

(1) To a hospital or distinct part hospital unit excluded from the prospective payment system described in subparts A through M of this part under subpart B of this part.

(2) To a skilled nursing facility.

(3) To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge.

(d) *Qualifying DRGs.* For purposes of paragraph (c) 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:

(1) The DRG must have a geometric mean length of stay of at least 3 days;

(2) The DRG must have at least 14,000 cases identified as postacute care transfer cases.

(3) The DRG must have at least 10 percent of the postacute care transfers occurring before the geometric mean length of stay for the DRG.

(4) 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 under specified paragraphs (d)(1) through (d)(3) of this section.

(5) To initially qualify, the DRG meet the criteria specified in paragraphs (d)(1) through (d)(4) 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) through (d)(4) of this section for each subsequent fiscal year.

* * * * *

■ 3. Section 412.22 is amended by:

■ A. Republishing the introductory text of paragraph (e)(5) and revising the first sentence of paragraph (e)(5)(i).

■ B. Revising paragraph (f).

The revisions read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(e) * * *

(5) *Performance of basic hospital functions.* The hospital meets one of the following criteria:

(i) 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. * * *

(f) *Application for certain hospitals.* If a hospital was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital, the criteria in paragraph (e) of this section do not apply to the hospital as long as the hospital either—

(1) Continues to operate under the same terms and conditions, including the number of beds and square footage considered to be part of the hospital for purposes of Medicare participation and payment in effect on September 30, 1995; or

(2) In the case of a hospital that changes the terms and conditions under which it operates after September 30, 1995, but before October 1, 2003, continues to operate under the same terms and conditions, including the number of beds and square footage considered to be part of the hospital for purposes of Medicare participation and payment in effect on September 30, 2003.

* * * * *

■ 4. Section 412.23 is amended by revising paragraphs (e)(3)(ii) and (e)(3)(iii) to read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(e) *Long-term care hospitals.* * * *

(3) *Calculation of average length of stay.* * * *

(ii) If a change in the hospital's Medicare average length of stay is indicated, the calculation is made by the same method for the period of at least 5 months of the immediately preceding 6-month period.

(iii) If a hospital has undergone a change of ownership (as described in § 489.18 of this chapter) at the start of a cost reporting period or at any time within the period of at least 5 months of the preceding 6-month period, the hospital may be excluded from the prospective payment system as a long-term care hospital for a cost reporting period if, for the period of at least 5 months of the 6 months immediately preceding the start of the period (including time before the change of ownership), the hospital has the required Medicare average length of stay, continuously operated as a hospital, and continuously participated as a hospital in Medicare.

* * * * *

§ 412.25 [Amended]

■ 5. In § 412.25(e)(4), introductory text, the reference ''paragraph (h)(3) of this section'' is revised to read ''paragraph (e)(3) of this section''.

■ 6. 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.

* * * * *

(a) *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 set at 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.

■ 7. Section 412.105 is amended by—

■ A. In paragraph (a)(1), introductory text, revising the phrase ''paragraph (f) of this section'' to read ''paragraphs (f) and (h) of this section''.

■ B. In paragraph (a)(1)(i), revising the phrase ''affiliated groups'' to read ''Medicare GME affiliated groups''.

■ C. Revising paragraph (b).

■ D. Adding a sentence at the end of paragraph (f)(1)(v).

■ E. In paragraph (f)(1)(vi), revising the phrase ''affiliated group'' to read ''Medicare GME affiliated group''.

■ F. Revising paragraph (f)(1)(x).

The revisions and additions read as follows:

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

* * * * *

(b) *Determination of number of beds.* For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period. This count of available bed days excludes bed days associated with—

(1) Beds in any other units or wards where the level of care provided would not be payable under the acute care hospital inpatient prospective payment system;

(2) Beds in excluded distinct part hospital units;

(3) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing-bed services, or ancillary labor/delivery services;

(4) Beds or bassinets in the healthy newborn nursery; and

(5) Custodial care beds;

* * * * *

(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.* (1) * * *

(v) * * * Subject to the provisions of paragraph (f)(1)(x) of this section, effective for cost reporting periods beginning on or after April 1, 2000, FTE residents at an urban hospital in a rural track program are included in the urban hospital's rolling average calculation described in this paragraph (f)(1)(v).

* * * * *

(x) An urban hospital that establishes a new residency program (as defined in § 413.86(g)(13) of this subchapter), 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 accordance with the applicable provisions of § 413.86(g)(12) of this subchapter.

* * * * *

■ 7. Section 412.106 is amended by revising paragraphs (a)(1)(ii) and (b)(4)(i) to read as follows:

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

(a) General considerations. (1) * * *

(ii) For purposes of this section, the number of patient days in a hospital includes only those days attributable to units or wards of the hospital providing acute care services generally payable under the prospective payment system and excludes patient days associated with—

(A) Beds in excluded distinct part hospital units;

(B) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing-bed services, or ancillary labor/delivery services; and

(C) Beds in any other units or wards where the level of care provided would not be payable under the acute care hospital inpatient prospective payment system.

* * * * *

(b) *Determination of a hospital's disproportionate payment percentage.* * * *

(4) *Second computation.* * * *

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

* * * * *

■ 8. In § 412.112, the introductory text is republished and a new paragraph (d) is added to read as follows:

§ 412.112 Payments determined on a per case basis.

A hospital is paid the following amounts on a per case basis.

* * * * *

(d) Additional payments for new medical services and technologies determined under subpart F of this part.

■ 9. Section 412.116 is amended by revising paragraph (e) to read as follows:

§ 412.116 Method of payment.

* * * * *

(e) *Outlier payment and additional payments for new medical services and technologies.* Payments for outlier cases and additional payments for new medical services and technologies (described in subpart F of this part) are not made on an interim basis. These payments are made based on submitted bills and represent final payment.

* * * * *

■ 10. Section 412.230 is amended by—

■ A. Republishing paragraph (e)(2) introductory text.

■ B. Revising paragraph (e)(2)(ii)(A).

The revisions read as follows:

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

* * * * *

(e) *Use of urban or other rural area's wage index.* * * *

(2) *Appropriate wage data.* For a wage index change, the hospital must submit appropriate wage data as follows:

* * * * *

(ii) * * *

(A) For hospital-specific data, the hospital must provide a weighted 3-year average of its average hourly wages using data from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes. However, for the limited purpose of qualifying for geographic reclassification based on wage data from cost reporting periods beginning prior to FY 2000, a hospital may request that its wage data be revised if the hospital is in an urban area that was subject to the rural floor for the period during which the wage data the hospital wishes to revise were used to calculate its wage index.

* * * * *

■ 11. Section 412.278 is amended by revising paragraph (f)(2)(i) to read as follows:

§ 412.278 Administrator's review.

* * * * *

(f) * * *

(2) The Administrator issues a decision in writing to the party with a copy to CMS—

(i) Not later than 90 days following receipt of the party's request for review, except the Administrator may, at his or her discretion, for good cause shown, toll such 90 days; or

* * * * *

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 413.70 is amended by revising paragraph (b)(2)(iii), introductory text, to read as follows:

§ 413.70 Payment for services of a CAH.

* * * * *

(b) *Payment for outpatient services furnished by CAH.* * * *

(2) *Reasonable costs for facility services.* * * *

(iii) Payment for outpatient clinical diagnostic laboratory tests is not subject to the Medicare Part B deductible and coinsurance amounts. Payment to a CAH for clinical diagnostic laboratory tests will be made on a reasonable cost basis under this section only if the individuals are outpatients of the CAH, as defined in § 410.2 of this chapter, and are physically present in the CAH, at the time the specimens are collected. Clinical diagnostic laboratory tests performed for persons who are not physically present in the CAH when the specimens are collected will be made in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Social Security Act.

* * * * *

■ 3. Section 413.85 is amended by—

■ A. Republishing the introductory text of paragraph (d)(1) and adding a new paragraph (d)(1)(iii).

■ B. Adding a new paragraph (g)(3).

■ C. Republishing the introductory text of paragraph (h) and revising paragraph (h)(3).

The addition and revision read as follows.

§ 413.85 Cost of approved nursing and allied health education activities.

* * * * *

(d) *General payment rules.* (1) Payment for a provider's net cost of nursing and allied health education activities is determined on a reasonable cost basis, subject to the following conditions and limitations:

* * * * *

(iii) The costs of certain nonprovider-operated programs at wholly owned subsidiary educational institutions are reimbursable on a reasonable cost basis if the provisions of paragraph (g)(3) of this section are met.

* * * * *

(g) *Payments for certain nonprovider-operated programs.* * * *

(3) *Special rule: Payment for certain nonprovider-operated programs at wholly owned subsidiary educational institutions.*

(i) Effective for portions of cost reporting periods occurring on or after October 1, 2003, a provider that incurs costs for a nursing or allied health education program(s) where those program(s) had originally been provider-operated according to the criteria at paragraph (f) of this section, and then operation of the program(s) was transferred to a wholly owned subsidiary educational institution in order to meet accreditation standards prior to October 1, 2003, and where the provider has continuously incurred the costs of both the classroom and clinical training portions of the program(s) at the educational institution, may receive reasonable cost payment for such a program(s) according to the specifications under paragraphs (g)(3)(ii) and (g)(3)(iii) of this section.

(ii) Payment for the incurred costs of educational activities identified in paragraph (g)(3)(i) of this section will be made on a reasonable cost basis if a provider, as described in paragraph (g)(3)(i) of this section, received Medicare reasonable cost payment for those nursing and allied health education program(s) both prior and subsequent to the date the provider transferred operation of the program(s) to its wholly owned subsidiary educational institution (and ceased to be a provider-operated program(s) according to the criteria under paragraph (f) of this section).

(iii) The provider that meets the requirements in paragraphs (g)(3)(i) and (g)(3)(ii) of this section will be eligible to receive payment under this paragraph for: (A) the clinical training costs incurred for the program(s) as described in paragraph (g)(3)(i) of this section; and (B) classroom costs, but only those costs incurred by the provider for the courses that were included in the programs.

(h) *Activities treated as normal operating costs.* The costs of the following educational activities incurred by a provider but not operated by that provider are recognized only as normal operating costs and paid in accordance with the reimbursement principles specified in part 412 of this subchapter. They include:

* * * * *

(3) Educational seminars, workshops, and continuing education programs in which the employees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to the ability to practice and begin employment in a nursing or allied health specialty.

* * * * *

■ 4. Section 413.86 is amended by—

■ A. Under paragraph (b)—

■ (1) Removing the definitions of ''Affiliated group'' and ''Affiliation agreement''.

■ (2) Adding definitions of ''Community support'', ''Medicare GME affiliated agreement'', ''Medicare GME affiliated group'', and ''Redistribution of costs'' in alphabetical order.

■ (3) Under the definition of ''Rural track FTE limitation'', revising the phrase ''paragraph (g)(11)'' to read ''paragraph (g)(12)''.

■ B. Revising the introductory text of paragraph (f).

■ C. Adding a new paragraph (f)(4)(iv).

■ D. In paragraph (g)(1)(i), revising the reference ''paragraphs (g)(1)(ii) and (g)(1)(iii)'' to read ''paragraphs (g)(1)(ii) through (g)(1)(iv)''.

■ E. Revising the introductory text of paragraph (g)(4).

■ F. Revising paragraph (g)(4)(iv).

■ G. Revising the introductory text of paragraph (g)(5).

■ H. Adding a new paragraph (g)(5)(vii).

■ I. Revising paragraphs (g)(6)(i)(D) and (g)(6)(i)(E).

■ J. Revising paragraph (g)(7).

■ K. Revising the introductory text of paragraph (g)(12).

■ L. Revising paragraph (g)(12)(i).

■ M. Revising paragraph (g)(12)(ii), introductory text.

■ N. Revising paragraph (g)(12)(ii)(A).

■ O. Revising paragraph (g)(12)(ii)(B)(*1*)(i).

■ P. Revising paragraph (g)(12)(iii).

■ Q. Revising paragraph (g)(12)(iv), introductory text.

■ R. Revising paragraph (g)(12)(iv)(A).
■ S. Revising paragraph (g)(12)(iv)(B)(*1*).
■ T. Redesignating paragraphs (i) and (j) as paragraphs (j) and (k), respectively, and adding a new paragraph (i).

The additions and revisions read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(b) *Definitions.* * * *

''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.

* * * * *

''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 paragraph (g)(7)(ii) of this section.

(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 paragraph (g)(7)(ii) of this section, 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 paragraph (g)(7)(ii) of this section.

''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 one 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.

* * * * *

''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.

* * * * *

(f) *Determining the total number of FTE residents.* Subject to the weighting factors in paragraphs (g) and (h) of this section, and subject to the provisions of paragraph (i) of this section, the count of FTE residents is determined as follows:

* * * * *

(4) * * *

(iv) The hospital is subject to the principles of community support and redistribution of costs as specified in the provisions of paragraph (i) of this section.

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

(4) Subject to the provisions of paragraph (i) of this section, for purposes of determining direct graduate medical education payment—

* * * * *

(iv) Hospitals that are part of the same Medicare GME affiliated group (as described under paragraph (b) of this section) may elect to apply the limit on an aggregate basis as described under paragraph (g)(7) of this section.

* * * * *

(5) Subject to the provisions of paragraph (i) of this section, for purposes of determining direct graduate medical education payment—

* * * * *

(vii) Subject to the provisions under paragraph (g)(12) 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 paragraph (g)(5) of this section.

* * * * *

(6) * * *

(i) * * *

(D) An urban hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is not permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap.

(E) A rural hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap.

* * * * *

(7) A hospital may receive a temporary adjustment to its FTE cap, which is subject to the averaging rules under paragraph (g)(5)(iii) of this section, to reflect residents added or subtracted because the hospital is participating in a Medicare GME affiliated group (as defined under paragraph (b) of this section). Under this provision—

(i) Each hospital in the Medicare GME affiliated group must submit the Medicare GME affiliation agreement, as defined under paragraph (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.

(ii) Each hospital in the Medicare GME affiliated group must have a shared rotational arrangement, as defined in paragraph (b) of this section, 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.

(iii) During the shared rotational arrangements under a Medicare GME affiliation agreement, as defined in paragraph (b) of this section, 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.

(iv) 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.

(v) 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 (g)(4) of this section.

* * * * *

(12) Subject to the provisions of (i) of this section, 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 (g)(4) 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 (g)(12)(i) through (g)(12)(vi) of this section.

(i) 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:

(A) 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 (g)(5)(vii) of this section, training in the rural track at the urban hospital.

(B) 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.

(ii) 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 paragraph (f)(4) of this section. 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:

(A) 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 (g)(5)(vii) of this section, training in the rural track at the urban hospital and the rural nonhospital site(s).

(B) * * *

(*1*) * * *

(*i*) 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

* * * * *

(iii) 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 (g)(6)(iii) 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.

(iv) 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 paragraph (f)(4) of this section. 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:

(A) 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 (g)(5)(vii) of this section, training in the rural track at the rural nonhospital site(s).

(B) * * *

(*1*) 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

* * * * *

(i) *Application of community support and redistribution of costs in determining FTE resident counts.*

(1) For purposes of determining direct graduate medical education payments, the following principles apply:

(i) *Community support.* If the community has undertaken to bear the costs of medical education through community support, the costs are not considered graduate medical education costs to the hospital for purposes of Medicare payment.

(ii) *Redistribution of costs.* The costs of training residents that constitute a redistribution of costs from an educational institution to the hospital are not considered graduate medical education costs to the hospital for purposes of Medicare payment.

(2) *Application.* A hospital must continuously incur costs of direct graduate medical education 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 paragraphs (f) and (g)(4) through (g)(6) and (g)(12) of this section. 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.

(3)(i) *Effective date.* Subject to the provisions of paragraph (i)(3)(ii) of this section, payments made in accordance with determinations made under the provisions of paragraphs (i)(1) and (i)(2) of this section will be effective for portions of cost reporting periods occurring on or after October 1, 2003.

(ii) *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 (i)(1) and (i)(2) 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.

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

Dated: July 23, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Dated: July 24, 2003.

Tommy G. Thompson,

Secretary.

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

Addendum—Schedule of Standardized Amounts Effective With Discharges Occurring on or After October 1, 2003 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning on or After October 1, 2003

I. Summary and Background

In this Addendum, we are setting forth the 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 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, 2003, 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 50 percent of a Puerto Rico rate that reflects base year average costs per case of Puerto Rico hospitals and 50 percent of a blended Federal national rate (a discharge-weighted average of the national large urban and other areas standardized amounts). (See section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are making changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2004. The changes, to be applied prospectively effective with discharges occurring on or after October 1, 2003, affect the calculation of the Federal rates. In section III. of this Addendum, we discuss our changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2004. Section IV. of this Addendum sets forth our 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 final rule are presented in section VI. of this Addendum.

II. Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for FY 2004

The basic methodology for determining prospective payment rates for hospital inpatient operating costs is set forth at § 412.63. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below, we discuss the factors used for determining the prospective payment rates.

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

- Updates of 3.4 percent for all areas (that is, the full market basket percentage increase of 3.4 percent);
- An adjustment to ensure the proposed DRG recalibration and wage index update and changes, as well as the add-on payments for new technology, 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 large urban and other standardized amounts;
- 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 2003 budget neutrality factor and applying a revised factor;
- An adjustment to apply the new outlier offset by removing the FY 2003 outlier offsets and applying a new offset.

A. Calculation of Adjusted Standardized Amounts

1. Standardization of Base-Year Costs or Target Amounts

The national standardized amounts are 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, in determining payments under the IPPS, the Secretary estimates from time to time the proportion of costs that are wages and wage-related costs. Based on the estimated labor-related share, the standardized amounts are divided into labor-related and nonlabor-related amounts. As discussed in section IV. of the preamble to the August 1, 2002 IPPS final rule, when we revised the market basket in FY 2003, we did not revise the labor share of the standardized amount (the proportion adjusted by the wage index). We consider 71.1 percent of costs to be labor-related for purposes of the IPPS. The average labor share in Puerto Rico is 71.3 percent.

2. Computing Large Urban and Other Area Average Standardized Amounts

Sections 1886(d)(2)(D) and (d)(3) of the Act require the Secretary to compute two average standardized amounts for discharges occurring in a fiscal year: one for hospitals located in large urban areas and one for hospitals located in other areas. In addition, under sections 1886(d)(9)(B)(iii) and (d)(9)(C)(i) of the Act, the average standardized amount per discharge must be determined for hospitals located in 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 is 1.6 percent higher than the other area average standardized amount.

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. However, for discharges occurring on or after October 1, 2003, the Federal rate will again be calculated based on separate average standardized amounts for hospitals in large urban areas and for hospitals in other areas.

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

As discussed previously, on June 6, 2003, OMB announced revised definitions of MSAs and new definitions of Micropolitan Statistical Areas and Combined Statistical Areas. In order to implement these changes for the IPPS, it is necessary to identify the new area designation for each county and hospital in the country. Because this process will have to be extensively reviewed and verified, we were unable to undertake it before publication of this final rule. Therefore, we are continuing to use MSAs based on OMB's definitions of MSAs prior to June 6, 2003. Based on those definitions, 63 areas meet the criteria to be defined as large urban areas for FY 2004. These areas are identified in Table 4A of section VI. of this Addendum.

3. Updating the Average Standardized Amounts

In accordance with section 1886(d)(3)(A)(iv) of the Act, we are updating the arge urban areas' and the other areas' average standardized amounts for FY 2004 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. 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 2004 is 3.4 percent. Thus, for FY 2004, the update to the average standardized amounts equals 3.4 percent for hospitals in all areas.

Although the update factors for FY 2004 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 2004 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 final rule.

Comment: One commenter recommended an increase to the market basket that would account for large increases in the costs of malpractice, pensions, health benefits, pharmaceuticals, and new technology that hospitals are facing.

Response: The hospital market basket is structured to measure the change in prices for an exhaustive list of inputs used by hospitals in providing services. The index measures the ''pure'' price change of those inputs and appropriately does not measure changes in quantity or intensity. These nonprice factors include shifts in the skill mix of employees, increased amounts of labor purchased, increased malpractice coverage, the increased use of pharmaceuticals and technology in providing care, and movements toward more or less intensive pharmaceuticals and technology. Nonprice factors such as these may be contributing to the increases in cost that hospitals are currently facing.

In addition, the most recent data available are used to forecast the market basket price changes and are intended to reflect conditions that hospitals will face in the upcoming fiscal year. As it is intended, the hospital market basket measures the national average price increase and will not reflect geographic differences from one geographic area to another. In other words, while one area may see a large surge in the prices of inputs, another area may actually be experiencing much smaller increases in the prices of these inputs. This may also be contributing to the increased costs to which the commenter referred. Therefore, we believe that the market basket is an accurate representation of the national average price increase facing hospitals in providing services, and the 3.4 percent increase for FY 2004 provides an adequate update to hospitals to account for the inflationary increase in costs.

4. Other Adjustments to the Average Standardized Amounts

As in the past, we adjust the FY 2004 standardized amounts to remove the effects of the FY 2003 geographic reclassifications and outlier payments before applying the FY 2004 updates. We then apply the new offsets to the standardized amounts for outliers and geographic reclassifications for FY 2004.

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. Because the changes to the postacute care transfer policy discussed in section IV.A. of the preamble of this final rule are not budget neutral, we included the effects of expanding this policy to additional DRGs prior to estimating the payment effects of the DRG and wage data changes.

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 making 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.

Section 4410 of Pub. L. 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 Pub. L. 105–33 to be budget neutral. Therefore, we include the effects of this provision in our calculation of the wage update budget neutrality factor.

In addition, we are required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. As discussed in section II.E. of this final rule, we are approving two new technologies for add-on payments in FY 2004. We estimate that the total add-on payments for these new technologies will be $14.4 million for FY 2004.

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 2002 discharge data to simulate payments and compared aggregate payments using the FY 2003

relative weights, wage index, and new technology add-on payments to aggregate payments using the FY 2004 relative weights and wage index, plus the add-on payments for new technology. The same methodology was used for the FY 2003 budget neutrality adjustment.

Based on this comparison, we computed a budget neutrality adjustment factor equal to 1.005522. We also adjust the Puerto Rico-specific standardized amounts for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor for Puerto Rico-specific standardized amounts equal to 1.001661. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2003 budget neutrality adjustments.

In addition, we are applying these same adjustment factors to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 2003. (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 standardized amount or the wage index, or both.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the 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. To calculate this budget neutrality factor, we used FY 2002 discharge data to simulate payments, and compared total IPPS payments prior to any reclassifications to total IPPS payments after reclassifications. Based on these simulations, we are applying an adjustment factor of 0.992026 to ensure that the effects of reclassification are budget neutral.

The adjustment factor is applied to the standardized amounts after removing the effects of the FY 2003 budget neutrality adjustment factor. We note that the FY 2004 adjustment reflects FY 2004 wage index and standardized amount reclassifications approved by the MGCRB or the Administrator, and the effects of section 1886(d)(10)(D)(v) of the Act to extend wage index reclassifications 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 amounts 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. FY 2004 outlier fixed-loss cost threshold. In the August 1, 2002 IPPS final rule (67 FR 50124), we established a threshold for FY 2003 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 $33,560. The marginal cost factor (the percent of costs paid after costs for the case exceed the threshold) was 80 percent.

In the May 19, 2003 proposed rule, we proposed 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 $50,645. However, we also stated that the final FY 2004 threshold was likely to be different from that proposed threshold, as a result of any changes to outlier policy subsequent to a proposed rule published on March 5, 2003. Subsequently, we published three central changes to our outlier policy in a final rule on June 9, 2003.

The first of the changes was that fiscal intermediaries will use more up-to-date data when determining the cost-to-charge ratio for each hospital. Currently, fiscal intermediaries use the hospital's most recent settled cost report. We revised our regulations to specify that fiscal intermediaries will use either the most recent settled or the most recent tentative settled cost report, whichever is from the latest reporting period.

The second change removed the requirement in our regulations specifying that a fiscal intermediary will assign a hospital the statewide average cost-to-charge ratio when the hospital has a cost-to-charge ratio that falls below an established threshold (3 standard deviations below the national geometric mean cost-to-charge ratio). We specified that hospitals will receive their actual cost-to-charge ratios no matter how low their ratios actually fall.

The third change added a provision to our regulations to provide that the outlier payments for some hospitals will become subject to reconciliation when the hospitals' cost reports are settled. In addition, outlier payments will be subject to an adjustment to account for the time value of any outlier overpayments or underpayments that are ultimately reconciled.

To calculate the FY 2004 outlier thresholds, we simulated payments by applying FY 2004 rates and policies using cases from the FY 2002 MedPAR file. Therefore, in order to determine the appropriate FY 2004 threshold, it was necessary to inflate the charges on the MedPAR claims by 2 years, from FY 2002 to FY 2004.

As discussed in the August 1, 2002 IPPS final rule (67 FR 50124), rather than use the rate-of-cost increase from hospitals' FY 1998 and FY 1999 cost reports to project the rate-of-increase from FY 2001 to FY 2003, as had been done in prior years, we used a 2-year average annual rate of change in charges per case to calculate the FY 2003 outlier threshold.

We are continuing to use the 2-year average annual rate of change in charges per case to establish the FY 2004 threshold. 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.

In the past, we used cost-to-charge ratios from the Provider Specific File, and multiplied these ratios by the charges for each case to estimate costs. After the changes in policy enacted by the final outlier rule this year, it is necessary to calculate more recent cost-to-charge ratios because fiscal intermediaries will now use the latest tentatively settled cost report instead of the latest settled cost report to determine a hospital's cost-to-charge ratio. Therefore, to approximate using the latest tentative settled cost reports in our estimate of the FY 2004 outlier threshold, we calculated updated cost-to-charge ratios using the following three steps: for each hospital, we matched charges-per-case to costs-per-case from the most recent cost reporting year; we then divided each hospital's costs by its charges to calculate the cost-to-charge ratio for each hospital; and we multiplied charges from each case in the FY 2002 MedPAR (inflated to FY 2004) by this cost-to-charge ratio to calculate the cost per case. The final outlier rule also established the policy that fiscal intermediaries are to reconcile outlier payments at the time of cost report final settlement if a hospital's actual operating or capital cost-to-charge ratios are found to be substantially different from the cost-to-charge ratios used during that time period to make outlier payments.

However, it is difficult to project which hospitals will be subject to reconciliation of their outlier payments using available data. For example, for most hospitals, the latest available cost data are from FY 2000. In addition, the amount of fiscal intermediary resources necessary to undertake reconciliation will ultimately influence the number of hospitals reconciled. Without actual experience with the reconciliation process, it is difficult to predict the number of hospitals that will be reconciled. However, as later data become available, particularly data reflecting hospital's latest tentative settled cost-to-charge ratios, we will be better able to assess the appropriate number of hospitals to be reconciled.

Based on our analysis of hospitals that have been consistently overpaid recently for outliers, we have identified approximately 50 hospitals we believe will be reconciled. Therefore, for these hospitals, to account for the fact that the reconciliation will result in

different outlier payments than predicted using the cost-to-charge ratios calculated as described above, we attempted to project each hospital's cost-to-charge ratio based on its rate of increase in charges per case based on FY 2002 charges, compared to costs (inflated to FY 2002 using actual market basket increases).

Using this methodology, we are establishing 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 $31,000.

This single threshold will be applicable to qualify for both operating and capital outlier payments. We also are maintaining the marginal cost factor for cost outliers at 80 percent.

Comment: One commenter supported our changes to the outlier payment methodology but asked that we reconsider and revise the outlier threshold to at least a level of increase consistent with prior years. Other commenters asked that we lower the threshold to reflect the financial impact of the new outlier policies, to allow deserving hospitals to qualify for outlier payments and to ensure that hospitals receive the statutory mandated level of 5 to 6 percent of total DRG payments set aside for outliers. Another commenter reasoned that hospitals that have had their outlier payments dwindle to record low amounts will have no incentive to treat high-cost cases; therefore, the outlier threshold must be lowered. Another commenter noted that the current proposed threshold makes it almost impossible for hospitals to qualify for outlier payments and will cause hospitals to lose an extraordinary amount of money before additional outlier payments become available.

Other commenters indicated that they had conducted research, using the 2001 MedPAR file, which showed that the threshold required to spend 5.1 percent of total DRG payments decreased by 45 percent when the cost-to-charge ratios used to estimate costs were updated from the latest final settled to the latest tentatively settled cost report. Based on this finding, the commenters recommended a 45-percent reduction to the proposed outlier threshold, which would yield a threshold less than $28,000.

Some commenters believed that, in light of the changes adopted this year, it is appropriate that CMS revert to using changes in hospital costs to set the charge inflation factor rather than changes in hospital charges. The commenters explained that the combination of the changes made to the outlier policy and a return to using a cost inflation factor would lead to a more accurate and lower threshold. Another commenter noted the previous problems using changes in costs and recommended that CMS use a blend of the rates-of-increases for costs and charges to establish the charge inflation factor.

One commenter recommended that CMS keep the outlier threshold at $33,560 until CMS can determine the impact of using the most current cost-to-charge ratio during a full fiscal year. Other commenters also recommended that CMS eliminate any increase in the outlier threshold because the new outlier regulations will have a significant impact on Medicare outlier payments for FY 2004.

One commenter requested that CMS factor in the calculation of the threshold the fact that certain hospitals have distorted their charges significantly.

One commenter submitted a model of the outlier threshold for FY 2004 that incorporated the changes from the June 9, 2003 final rule. The commenter estimated the fixed-loss threshold to be $25,375 under these assumptions. The commenter also noted that the reconciliation process will reduce outlier payments and, accordingly, CMS should model a reduction in the outlier threshold to account for reconciliation, which would further lower the outlier threshold.

One commenter suggested that CMS lower the outlier threshold because independent studies strongly suggest that final FY 2003 outlier payments will fall short of the legislative mandate of 5 to 6 percent. Another commenter suggested that the outlier threshold remain at its current level because outlier payments for the first 3 months of FY 2003 represent 5.5 percent of total payments and, as a result, there does not seem to be any justification for such an increase. Another commenter explained that the transfer policy already reduces the payment to hospitals for short-stay cases and any increase in the outlier threshold will further penalize hospitals for treating high cost, medically complex cases.

Response: As described above, we are reflecting the changes made to outliers from the June 9, 2003 final rule. These changes have resulted in a substantial reduction in the outlier threshold from the proposed level. We estimate the outlier threshold would be approximately $50,200 without accounting for the effects of these changes. Therefore, the final threshold is 37 percent lower due to the changes described above. This reduction in the outlier threshold will allow hospitals that have been negatively impacted by the increase in the FY 2003 threshold due to those hospitals that maximized their outlier payments by dramatically increasing charges to qualify for higher outlier payments due to the lower threshold.

We are concerned that the outlier policy maintains its original intent to ensure hospitals are not significantly disadvantaged by unpredictable extraordinarily costly cases, and, therefore, we acted to close the loopholes in our prior policy through the final outlier rule. As a result of those changes, the threshold has fallen significantly from the proposed threshold.

Comment: Another commenter asked that any final outlier threshold included in the final rule be subject to a 60-day review and comment period.

Response: In the proposed rule, we noted that we would incorporate any final outlier policy changes in this final rule. We received many comments in response to the proposed rule, and we have considered them thoroughly in undertaking our analysis. Therefore, we do not believe there is any need for an additional public comment period on the changes. Accordingly, a fixed-loss threshold of $31,000 will be applied to calculate outlier payments for discharges occurring on or after October 1, 2003.

Comment: One commenter asked that CMS implement a transition period to protect those hospitals harmed by the significant changes in the June 9, 2003 final outlier rule. The commenter explained that a transition period is justified and would be consistent with previous transition methodologies employed for CMS changes, such as those proposed.

One commenter stated that any reconciliation would be inconsistent with the prospective nature of the IPPS.

Response: We responded to similar comments in the June 9, 2003 final rule on outliers (68 FR 34494). Therefore, we refer the commenters to that final rule.

Comment: Two commenters stated that the criterion in the final rule on outliers that specifically addressed our policy on reconciliation (that if a hospital's cost-to-charge ratio changed by 10 or more percentage points, a hospital would be subject to reconciliation) is flawed. The commenters believed that the criterion would tolerate vastly different rates of charge growth among hospitals, and hospitals with the lowest charges in relation to cost would be inappropriately subject to the greatest restriction in charge growth. The commenters provided an example where a hospital with a cost-to-charge ratio of .30 could mark up its charges by 50 percent in a 2-year period without triggering reconciliation, while another hospital with a cost-to-charge ratio of .80 would trigger reconciliation if charges grew by only 14 percent. The commenters recommended that, because of this inequity in this criterion, CMS modify the trigger for outlier reconciliation by promulgating a scale of cost-to-charge ratios rather than a constant amount. The scale could be based upon a rate of tolerable charge growth, which CMS would choose.

Response: We appreciate the suggestion by the commenters and will carefully evaluate the information provided by them. We note that fiscal intermediaries have discretion under the reconciliation policy to reconcile additional hospitals' cost reports based on analysis that indicates the outlier payments made to those hospitals are significantly inaccurate.

Comment: One commenter explained that one health care system agreed to accept reduced outlier payments during FY 2003. The commenter asked that this reduction be accounted for in the calculation of the threshold.

Response: Our calculation of the outlier threshold reflects the application of the outlier policies implemented by the June 9, 2003 final rule. The agreement referred to by the commenter was based upon the application of policies prior to that final rule. Therefore, it has no bearing on the calculation of the FY 2004 threshold described in this final rule.

Comment: One commenter noted that outlier payments are increasing because DRG payments are not keeping pace with the high cost of treatment. The commenter added that adjusting the outlier threshold will only add to the problem of underfunded health care and, because health care is not a priority,

there will always be a struggle to pay for it. The commenter noted that there needs to be a determination of what care will be paid for, and then hospitals need to decide if they will provide the noncovered services.

Another commenter believed that the final rule on outliers would affect hospitals that have applied outlier payments appropriately. The commenter also believed that Medicare beneficiaries would be impacted as community hospitals shift care to more costly tertiary care facilities due to concerns about underpayment for potentially complex patient cases. The commenter explained that it is concerned that claims processing errors in the application of the outlier provision may result in underreporting of services provided, which will perpetuate underpayments to hospitals and lead to long-term ramifications on the integrity of the data generated by the IPPS.

Response: As discussed above, we lowered the outlier threshold in response to the new provisions on outliers. We anticipate that, as a result of the changes implemented by our June 5, 2003 final rule, outlier payments will be better targeted to truly high-cost cases. This will help alleviate the commenters' concerns.

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 higher percentage of outlier payments for capital-related costs than for operating costs. We project that the thresholds for FY 2004 will result in outlier payments equal to 5.1 percent of operating DRG payments and 4.8 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B), we reduced the FY 2004 standardized amounts by the same percentage to account for the projected proportion of payments paid to outliers. The outlier adjustment factors to be applied to the standardized amounts for FY 2004 are as follows:

	Operating standard-ized amounts	Capital fed-eral rate
National	0.949236	0.952050
Puerto Rico	0.976658	0.993231

We apply the outlier adjustment factors after removing the effects of the FY 2003 outlier adjustment factors on the standardized amounts.

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 final rule 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 1.203 or capital cost-to-charge ratios greater than 0.163, 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.[8] 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, 2002 IPPS final rule (67 FR 50263). Table 8B in section VI. of this Addendum contains the comparable statewide average capital cost-to-charge ratios. Again, the cost-to-charge ratios in Tables 8A and 8B will be used during FY 2004 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 2002 and FY 2003 outlier payments.

In the August 1, 2002 IPPS final rule (67 FR 50125), we stated that, based on available data, we estimated that actual FY 2002 outlier payments would be approximately 6.9 percent of actual total DRG payments. This estimate was computed based on simulations using the FY 2001 MedPAR file (discharge data for FY 2001 bills). That is, the estimate of actual outlier payments did not reflect actual FY 2002 bills but instead reflected the application of FY 2002 rates and policies to available FY 2001 bills.

Our current estimate, using available FY 2002 bills, is that actual outlier payments for FY 2002 were approximately 7.8 percent of actual total DRG payments. Thus, the data indicate that, for FY 2002, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 2002 (and thus exceeds the percentage by which we reduced the standardized amounts for FY 2002). 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 2002 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2003 will be approximately 6.5 percent of actual total DRG payments, 1.4 percentage points higher than the 5.1 percent we projected in setting outlier policies for FY 2003. This estimate is based on simulations using the FY 2002 MedPAR file (discharge data for FY 2002 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2003 by applying FY 2003 rates and policies including an outlier threshold of $33,560 to available FY 2002 bills. This estimate does not reflect the outlier policy changes implemented in the June 9, 2003 final rule that will become effective on August 8, 2003. Due to the limited time remaining in FY 2003 during which these changes will be effective, we do not anticipate that these changes will substantially affect our estimate.

5. FY 2004 Standardized Amounts

The adjusted standardized amounts are divided into labor and nonlabor portions. Table 1A in section VI. of this Addendum contains the two national standardized amounts that we will be applying to all hospitals, except hospitals in Puerto Rico. As described in section II.A.1. of this Addendum, we are not revising the labor share of the national standardized amount from 71.1 percent.

The following table illustrates the changes from the FY 2003 national average standardized amounts. The first row in the table shows the updated (through FY 2003) average standardized amounts after restoring the FY 2003 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 2003 factor is not removed from the amounts in the table.

	Large urban	Other areas
FY 2003 Base Rate (after removing reclassification budget neutrality and outlier offset).	Labor: $3,213.66 Nonlabor: $1,306.26	Labor: $2,974.75 Nonlabor: $1,209.15
FY 2004 Update Factor	1.034	1.034
FY 2004 DRG Recalibrations and Wage Index Budget Neutrality Factor	1.005522	1.005522
FY 2004 Reclassification Budget Neutrality Factor	0.992026	0.992026
Adjusted for Blend of FY 2003 DRG Recalibration and Wage Index Budget Neutrality Factors (factor of 0.993209 effective October 1, 2002; factor of 0.993012 effective April 1, 2003).	Labor: $3,314.31 Nonlabor: $1,347.17	Labor: $3,261.83 Nonlabor: $1,325.84
FY 2004 Outlier Factor	0.949236	0.949236

[8] These figures represent 3.0 standard deviations from the mean of the log distribution of cost-to-charge ratios for all hospitals.

	Large urban	Other areas
Rate for FY 2004 (after multiplying FY 2003 base rate by above factors)	Labor: $3,146.06 Nonlabor: $1,278.780	Labor: $3,096.25 Nonlabor: $1,258.54

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount and the national other standardized amount (as set forth in Table 1A). The labor and nonlabor portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C 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.

B. Adjustments for Area Wage Levels and Cost-of-Living

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

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the 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 final rule, we discuss the data and methodology for the FY 2004 wage index. The FY 2004 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 2004, we are adjusting the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below.

Area	Cost of living adjustment factor
Alaska: All areas	1.25
Hawaii:	
County of Honolulu	1.25
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 using for discharges occurring in FY 2004. These factors have been recalibrated as explained in section II. of the preamble of this final rule.

D. Calculation of Prospective Payment Rates for FY 2004

General Formula for Calculation of Prospective Payment Rates for FY 2004

The 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 amounts in Table 1A in section VI. of this Addendum.

The prospective payment rate for SCHs equals the higher of the applicable Federal rate from Table 1A or the hospital-specific rate as described below. The 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 prospective payment rate for Puerto Rico equals 50 percent of the Puerto Rico rate plus 50 percent of the national rate from Table 1C in section VI. of this Addendum.

1. Federal Rate

For discharges occurring on or after October 1, 2003 and before October 1, 2004, 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 location of the hospital (large urban or other) (see Table 1A in section VI. of this Addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located 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 budget neutrality adjustment factor (that is, by 1.005522) as discussed in section II.A.4.a. of this Addendum. The resulting rate was used in determining the payment rate an SCH or MDH will receive for its discharges beginning on or after October 1, 2003.

b. Updating the FY 1982, FY 1987, and FY 1996 Hospital-Specific Rates for FY 2004

We are increasing the hospital-specific rates by 3.4 percent (the hospital market basket percentage) for SCHs and MDHs for FY 2004. 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 2004, 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 2004, is the market basket rate.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning on or After October 1, 2003 and Before October 1, 2004

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

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

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

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

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

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

b. National Rate

The national prospective payment rate is determined as follows:

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

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

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

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

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico. This rate may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment.

III. Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2004

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 and during a 10-year transition period extending through FY 2001, acute care hospital inpatient capital-related costs were paid on the basis of an increasing proportion of the capital PPS Federal rate and a decreasing proportion of a hospital's historical costs for capital.

The basic methodology for determining Federal capital prospective rates is set forth in regulations at §§ 412.308 through 412.352. Below we discuss the factors that we used to determine the capital Federal rate for FY 2004, which will be effective for discharges occurring on or after October 1, 2003. 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 in § 412.308(c)(1), to account for capital input price increases and other factors. Section 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 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 Pub. L. 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)). Since payments are no longer being made under the regular exception policy in FY 2003 and after, 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, as a result of section 4406 of Pub. L. 105–33, operating payments to hospitals in Puerto Rico are based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges on or after October 1, 1997, we compute capital payments to hospitals in Puerto Rico based on a blend of 50 percent of the Puerto Rico capital rate and 50 percent of the capital Federal rate.

Section 412.374 provides for the use of this blended payment system for payments to Puerto Rico hospitals under the PPS for acute care hospital inpatient capital-related costs. Accordingly, for capital-related costs, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital.

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

In the final IPPS rule published in the **Federal Register** on August 1, 2002 (67 FR 50127), we established a capital Federal rate of $407.01 for FY 2003. Section 402(b) of Pub. L. 108–7 requires that, effective for discharges occurring on or after April 1, 2003, and before October 1, 2003, the capital Federal rate for operating costs for all IPPS hospitals is based on the large urban standardized amount. However, under current law for discharges occurring on or after October 1, 2003, the capital Federal rate will again be calculated based on separate average standardized amounts for hospitals in large urban areas and for hospitals in other areas. In addition, a correction notice to the FY 2003 final IPPS rule issued in the **Federal Register** on April 25, 2003 (68 FR 22272) contains corrections and revisions to the wage index and geographic adjustment factor (GAF). In conjunction with the change to the operating PPS standardized amounts made by Pub. L. 108–7 and the wage index and GAF corrections, we have established a capital PPS standard Federal rate of $406.93

effective for discharges occurring on or after April 1, 2003 through September 30, 2003. As we discussed in the May 19, 2003 proposed rule (68 FR 27238), the capital rates effective for discharges occurring on or after April 1, 2003 through September 30, 2003, were used in determining the final FY 2004 capital rates. As a result of the changes to the factors used to establish the capital Federal rate that are explained in this Addendum, the FY 2004 capital standard Federal rate is $415.47.

In the discussion that follows, we explain the factors that were used to determine the FY 2004 capital Federal rate. In particular, we explain why the FY 2004 capital Federal rate has increased 2.10 percent compared to the FY 2003 capital Federal rate (effective for discharges occurring on or after April 1, 2003 through September 30, 2003). We also estimate aggregate capital payments will increase by 1.4 percent during this same period. This increase is primarily due to the increase in the number of hospital admissions and the increase in case-mix. This increase in capital payments is slightly less than last year (5.81 percent), mostly due to the restoration of the 2.1 percent reduction to the capital Federal rate in FY 2003 (§ 412.308(b)(6)) and the projected decrease in outlier payments as a result of the IPPS outlier policy established in the June 9, 2003 high-cost outlier final rule (68 FR 34494).

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 2004 compared to FY 2003.

1. 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. In the May 19, 2003 proposed rule (68 FR 27239), we proposed an update factor of 0.7 for FY 2004 under that framework based on the best data available at that time. Under that same update framework based on more recent data, the final update factor for FY 2004 is 0.7 percent. This final update factor is based on a 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 2002 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. We explain the basis for the FY 2004 CIPI projection in section III.C. of this Addendum. Below we describe the policy adjustments that have been applied.

The case-mix index is the measure of the average DRG weight for cases paid under the 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 2002 DRG reclassification and recalibration as part of our update for FY 2004.) We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 2004, we are projecting a 1.0 percent total increase in the case-mix index. We estimate that real case-mix increase will equal 1.0 percent in FY 2004. Therefore, the net adjustment for case-mix change in FY 2004 is 0.0 percentage points.

We estimate that FY 2002 DRG reclassification and recalibration will result in a 0.0 percent change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we are making a 0.0 percent adjustment for DRG reclassification and recalibration in the update for FY 2004 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 0.2 percentage points was calculated for the FY 2002 update. That is, current historical data indicate that the forecasted FY 2002 CIPI used in calculating the FY 2002 update factor (0.7 percent) overstated the actual realized price increases (0.5 percent) by 0.2 percentage points. This slight overprediction was mostly due to an underestimation of the interest rate cuts by the Federal Reserve Board in 2002, 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 2004.

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.

As we discussed in the May 19, 2003 proposed rule (68 FR 27239), 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, as we discussed in the May 19, 2003 proposed rule (68 FR 27239), for FY 2004 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 1998 though 2002. We found that, over this period and in particular the last 3 years of this period (FYs 2000 through 2002), the charge data appear to be skewed. More specifically, we found a dramatic increase in hospital charges for FYs 2000 through 2002 without a corresponding increase in hospital case-mix index. 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.

The timing of this increase in charge growth is consistent with the dramatic increase in charges that we discussed in the June 9, 2003 high-cost outlier final rule (68 FR 34494). As we discussed in that final rule, because hospitals have the ability to increase their outlier payments through dramatic charge increases, we have made several changes in our high-cost outlier policy at §§ 412.84(i) and (m) in order to prevent hospitals from taking advantage of our current outlier policy.

As discussed above, our intensity calculation relies heavily upon charge data and we believe that this charge data may be inappropriately skewed. Therefore, in the May 19, 2003 proposed rule (68 FR 22739), we proposed a 0.0 percent adjustment for intensity for FY 2004. As we explained in that same proposed rule, 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 apply a zero intensity adjustment for FY 2004 until we believe that any increase in charges can be tied to intensity rather then to attempts to maximize outlier payments. We received no comments on our proposed 0.0 percent adjustment for intensity. Therefore, in this final rule, we are making a 0.0 percent adjustment for intensity in the update for FY 2004.

Above we described the basis of the components used to develop the 0.7 percent final capital update factor for FY 2004 as shown in the table below.

CMS'S FY 2004 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 2002 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0
Total 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. As we discussed in the May 19, 2003 proposed rule (68 FR 27240), in its March 2003 Report to Congress, MedPAC did not make an update recommendation for capital PPS payments. However, in that same report, MedPAC made an update recommendation for hospital inpatient and outpatient services (page 4). MedPAC stated that hospital inpatient and outpatient services should be considered together because they are so closely interrelated. Their recommendation is based on an assessment of whether payments are adequate to cover the costs of efficient providers, an estimate of input price inflation (measured by the market basket index), and an adjustment for technological charges, which is offset by reasonable expectations in productivity gains.

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, 2002 IPPS final rule (67 FR 50129), we estimated that outlier payments for capital in FY 2003 would equal 5.31 percent of inpatient capital-related payments based on the FY 2003 capital Federal rate. Accordingly, we applied an outlier adjustment factor of 0.9469 to the FY 2003 capital Federal rate. Based on the thresholds as set forth in section II.A.4.c. of this Addendum, we estimate that outlier payments for capital will equal 4.79 percent of inpatient capital-related payments based on the capital Federal rate in FY 2004. Therefore, we are establishing an outlier adjustment factor of 0.9521 to the capital Federal rate. Thus, the percentage of capital outlier payments to total capital standard payments for FY 2004 is lower than the percentage for FY 2003. This projected decrease in capital outlier payments is mostly due to the changes in the IPPS outlier policy established in the June 9, 2003 high-cost outlier final rule (68 FR 34494).

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. Therefore, the net change in the outlier adjustment to the capital Federal rate for FY 2004 is 1.0055 (0.9521/0.9469). The outlier adjustment increases the FY 2004 capital Federal rate by 0.55 percent compared with the FY 2003 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 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 2003 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 factors for FY 2004, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2003 DRG relative weights and the FY 2003 GAF to estimated aggregate capital Federal rate payments based on the FY 2004 relative weights and the FY 2004 GAF. In the August 1, 2002 IPPS final rule (67 FR 50129) for FY 2003, the budget neutrality adjustment factors were 0.9885 for the national capital rate and 0.9963 for the Puerto Rico capital rate. As a result of the revisions to the GAF effective for discharges occurring on or after April 1, 2003 through September 30, 2003, the budget neutrality adjustment factor is 0.9983 for the national capital rate for discharges occurring on or before April 1, 2003 through September 30, 2003. The budget neutrality adjustment factor for the Puerto Rico capital rate remained

unchanged (0.9963). As we noted above, the capital rates effective for discharges occurring on or after April 1, 2003 through September 30, 2003 were used in determining the FY 2004 capital rates. 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 applying an incremental budget neutrality adjustment of 1.0051 for FY 2004 to the previous cumulative FY 2003 adjustment (0.9883), yielding a cumulative adjustment of 0.9933 through FY 2004. For the Puerto Rico GAF, we are applying an incremental budget neutrality adjustment of 1.0002 for FY 2004 to the previous cumulative FY 2003 adjustment (0.9963), yielding a cumulative adjustment of 0.9965 through FY 2004.

We then compared estimated aggregate capital Federal rate payments based on the FY 2003 DRG relative weights and the FY 2003 GAF to estimated aggregate capital Federal rate payments based on the FY 2004 DRG relative weights and the FY 2004 GAF. The incremental adjustment for DRG classifications and changes in relative weights is 1.0008 both nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the GAF through FY 2004 are 0.9941 nationally and 0.9973 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal year	National				Puerto Rico			
	Incremental adjustment			Cumulative	Incremental adjustment			Cumulative
	Geographic adjustment factor	DRG reclassifications and recalibration	Combined		Geographic adjustment factor	DRG Reclassifications and Recalibration	Combined	
1992	—	—	1.00000	—	—	—	—	—
1993	—	—	0.99800	0.99800	—	—	—	—
1994	—	—	1.00531	1.00330	—	—	—	—
1995	—	—	0.99980	1.00310	—	—	—	—
1996	—	—	0.99940	1.00250	—	—	—	
1997	—	—	0.99873	1.00123	—	—	—	—
1998	—	—	0.99892	1.00015	—	—	—	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001 [1]	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508
2001 [2]	[3] 0.99771	[3] 1.00009	[3] 0.99780	0.99922	[3] 1.00365	[3] 1.00009	[3] 1.00374	1.00508
2002	[4] 0.99666	[4] 0.99668	[4] 0.99335	0.99268	[4] 0.98991	[4] 0.99668	[4] 0.99662	0.99164
2003 [5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003 [6]	[7] 0.99896	[7] 0.99662	[7] 0.99558	0.98830	[7] 1.00809	[7] 0.99662	[7] 1.00468	[7] 0.99628
2004	[8] 1.00510	1.00081	[8] 1.00591	0.99414	[8] 1.00023	[8] 1.00081	[8] 1.00104	0.99731

[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] Incremental factors are applied to the cumulative factors for the second half of FY 2003.

The methodology used to determine the recalibration and geographic (DRG/GAF) budget neutrality adjustment factor for FY 2004 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, 2002 IPPS final rule (67 FR 50129), we calculated a GAF/DRG budget neutrality factor of 0.9957 for FY 2003. As we noted above, as a result of the revisions to the GAF effective for discharges occurring on or after April 1, 2003 through September 30, 2003 published in the **Federal Register** on April 25, 2003 (68 FR 22272), we calculated a GAF/DRG budget neutrality factor of 0.9956 for discharges occurring on or after April 1, 2003 through September 30, 2003. Furthermore, as noted above, the capital rates effective for discharges occurring on or after April 1, 2003 through September 30, 2003 were used in determining the FY 2004 capital rates.

In the May 19, 2003 proposed rule (68 FR 27241), for FY 2004 we calculated a GAF/DRG budget neutrality factor of 1.0038. For this final rule, based on updated data, we are establishing a GAF/DRG budget neutrality factor of 1.0059 for FY 2004. 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 incremental change in the adjustment from FY 2003 to FY 2004 is 1.0059. The cumulative change in the capital Federal rate due to this adjustment is 0.9941 (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, and the incremental factor for FY 2004: $0.9980 \times 1.0053 \times 0.9998 \times 0.9994 \times 0.9987 \times 0.9989 \times 1.0028 \times 0.9985 \times 0.9979 \times 0.9934 \times 0.9956 \times 1.0059 = 0.9941$).

This factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 2004 geographic reclassification decisions made by the MGCRB compared to FY 2003 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 2004 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 2003 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 2004 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).

As we explained in the August 1, 2001 IPPS final rule (66 FR 39912–39914), in order to determine the estimated proportion of special exceptions payments to total capital payments, we attempted to identify the universe of eligible hospitals that may potentially qualify for special exceptions payments. First, we identified hospitals that met the eligibility requirements at § 412.348(g)(1). Then we determined each hospital's average fixed asset age in the earliest available cost report starting in FY 1992 and subsequent fiscal years. For each of those hospitals, we calculated the average fixed asset age by dividing the accumulated depreciation by the current year's depreciation. In accordance with § 412.348(g)(3), a hospital must have an average age of buildings and fixed assets above the 75th percentile of all hospitals in the first year of the capital PPS. In the September 1, 1994 final rule (59 FR 45385), we stated that, based on the June 1994 update of the cost report files in HCRIS, the 75th percentile for buildings and fixed assets for FY 1992 was 16.4 years. However, we noted that we would make a final determination of that value on the basis of more complete cost report information at a later date. In the August 29, 1997 final rule (62 FR 46012), based on the December 1996 update of HCRIS and the removal of outliers, we finalized the 75th percentile for buildings and fixed assets for FY 1992 as 15.4 years. Thus, we eliminated any hospitals from the potential universe of hospitals that may qualify for special exception payments if its average age of fixed assets did not exceed 15.4 years.

For the hospitals remaining in the potential universe, we estimated project-size by using the fixed capital acquisitions shown on Worksheet A7 from the following HCRIS cost reports updated through March 2003.

PPS year	Cost reporting periods beginning in—
IX	FY 1992
X	FY 1993
XI	FY 1994
XII	FY 1995
XIII	FY 1996
XIV	FY 1997
XV	FY 1998
XVI	FY 1999
XVII	FY 2000
XVIII	FY 2001

Because the project phase-in may overlap 2 cost reporting years, we added together the fixed acquisitions from sequential pairs of cost reports to determine project size. Under § 412.348(g)(5), the hospital's project cost must be at least $200 million or 100 percent of its operating cost during the first 12-month cost reporting period beginning on or after October 1, 1991. We calculated the operating costs from the earliest available cost report starting in FY 1992 and later by subtracting inpatient capital costs from inpatient costs (for all payers). We did not subtract the direct medical education costs as those costs are not available on every update of the HCRIS minimum data set. If the hospital met the project size requirement, we assumed that it also met the project need requirements at § 412.348(g)(2) and the excess capacity test for urban hospitals at § 412.348(g)(4).

Because we estimate that so few hospitals will qualify for special exceptions, projecting costs, payments, and margins would result in high statistical variance. Consequently, we decided to model the effects of special exceptions using historical data based on hospitals' actual cost experiences. If we determined that a hospital may qualify for special exceptions, we modeled special exceptions payments from the project start date through the last available cost report (FY 2001). While we have not yet received all of the FY 2001 cost reports, we do have a sufficient number of FY 2001 cost reports to model a preliminary estimate of special exception payments for FY 2004. For purposes of modeling, we used the cost and payment data on the cost reports from HCRIS assuming that special exceptions would begin at the start of the qualifying project. In other words, when modeling costs and payment data, we ignored any regular exception payments that these hospitals may otherwise have received as if there had not been regular exception provision during the transition period. In projecting an eligible hospital's special exception payment, we applied the 70-percent minimum payment level, the cumulative comparison of current year capital PPS payments and costs, and the cumulative operating margin offset (excluding 75 percent of operating DSH payments).

Our modeling of special exception payments for FY 2004 produced the following results:

Cost report	Number of hospitals eligible for special exceptions	Special exceptions as a fraction of capital payments to all hospitals
PPS IX	—	—
PPS X	—	—
PPS XI	2	—
PPS XII	5	—
PPS XIII	7	—
PPS XIV	13	0.0001
PPS XV	17	0.0001
PPS XVI	24	0.0001
PPS XVII	26	0.0001
PPS XVIII	29	*0.0004

*Preliminary estimate based on submission of cost reports available as of March 2003.

We note that hospitals must complete their projects by the end of PPS XVIII in order to be eligible for special exceptions payments. With complete submission of the PPS XVIII (FY 2001) cost reports, we estimate that about 30 hospitals may qualify for special exceptions payments. Thus, we project that special exception payments as a fraction of capital payments to all hospitals to be approximately 0.0005.

Because special exceptions are budget neutral, in the May 19, 2003 proposed rule, we proposed to offset the capital Federal rate by 0.05 percent for special exceptions payments for FY 2004. For this final rule, based on updated data, we are offsetting the capital Federal rate by 0.05 percent for special exceptions payments for FY 2004. Therefore, the exceptions adjustment factor is equal to 0.9995 (1 − 0.0005) to account for special exceptions payments in FY 2004.

In the August 1, 2002 IPPS final rule (67 FR 50131) for FY 2003, we estimated that total (special) exceptions payments would equal 0.30 percent of aggregate payments based on the capital Federal rate. Therefore, we applied an exceptions reduction factor of 0.9970 (1 − 0.0030) in determining the FY 2003 capital Federal rate. As we stated above, we estimate that exceptions payments in FY 2004 will equal 0.05 percent of aggregate payments based on the FY 2004 capital Federal rate. Therefore, we are applying an exceptions payment adjustment factor of 0.9995 (1 − 0.0005) to the capital Federal rate for FY 2004. The exceptions adjustment factor for FY 2004 is 0.25 percent higher than the factor for FY 2003 published in the

August 1, 2002 IPPS final rule (67 FR 50131). This increase is primarily due to a refined analysis of more recent data.

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 net change in the exceptions adjustment factor used in determining the FY 2004 capital Federal rate is 0.9995/0.9970, or 1.0025.

5. Capital Standard Federal Rate for FY 2004

In the August 1, 2002 IPPS final rule (67 FR 50131) we established a capital Federal rate of $407.01 for FY 2003. As we noted above, as a result of the revisions to the GAF effective for discharges occurring on or after April 1, 2003 through September 30, 2003 published August 25, 2003 in the **Federal Register** (68 FR 22272), we have established a capital Federal rate of $406.93 for discharges occurring on or after April 1, 2003 through September 30, 2003. The capital rates effective for discharges occurring on or after April 1, 2003 through September 30, 2003, were used in determining the FY 2004 capital rates. In this final rule, we are establishing a capital Federal rate of $415.47 for FY 2004. The capital Federal rate for FY 2004 was calculated as follows:

- The FY 2004 update factor is 1.0070; that is, the update is 0.70 percent.
- The FY 2004 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 1.0059.
- The FY 2004 outlier adjustment factor is 0.9521.
- The FY 2004 (special) exceptions payment adjustment factor is 0.9995.

Since the 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 making 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 factors and adjustments for FY 2004 affected the computation of the FY 2004 capital Federal rate in comparison to the FY 2003 capital Federal rate. The FY 2004 update factor has the effect of increasing the capital Federal rate by 0.70 percent compared to the FY 2003 capital Federal rate, while the GAF/DRG budget neutrality factor has the effect of increasing the capital Federal rate by 0.59 percent. The FY 2004 outlier adjustment factor has the effect of increasing the capital Federal rate by 0.55 percent compared to the FY 2003 capital Federal rate. The FY 2004 exceptions payment adjustment factor has the effect of increasing the capital Federal rate by 0.25 percent compared to the exceptions payment adjustment factor for capital FY 2003. The combined effect of all the changes is to increase the capital Federal rate by 2.10 percent compared to the FY 2003 capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2003 CAPITAL FEDERAL RATE AND FY 2004 CAPITAL FEDERAL RATE

	FY 2003	FY 2004	Change	Percent change
Update factor[1]	1.0110	1.0070	1.0070	0.70
GAF/DRG Adjustment Factor[1]	0.9957	1.0059	1.0059	0.59
Outlier Adjustment Factor[2]	0.9469	0.9521	1.0055	0.55
Exceptions Adjustment Factor[2]	0.9970	0.9995	1.0025	0.25
Capital Federal Rate	$406.93	$415.47	[3] 1.0210	[3] 2.10

[1] 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 2003 to FY 2004 resulting from the application of the 1.0059 GAF/DRG budget neutrality factor for FY 2004 is 1.0059.

[2] 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 FY 2004 outlier adjustment factor is 0.9521/0.9469, or 1.0055.

[3] The percent change in factors and adjustments may not sum due to rounding.

We are also providing a chart that shows how the final FY 2004 capital Federal rate differs from the proposed FY 2004 capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2004 PROPOSED CAPITAL FEDERAL RATE AND FY 2004 FINAL CAPITAL FEDERAL RATE

	Proposed FY 2004	Final FY 2004	Change	Percent change
Update factor	1.0070	1.0070	1.0000	0.00
GAF/DRG Adjustment Factor	1.0038	1.0059	1.0021	0.21
Outlier Adjustment Factor	0.9455	0.9521	1.0070	0.70
Exceptions Adjustment Factor	0.9995	0.9995	1.0000	0.00
Capital Federal Rate	$411.72	$415.47	1.0091	0.91

6. Special Capital Rate for Puerto Rico Hospitals

As explained at the beginning of section II.D. of this Addendum, hospitals in Puerto Rico are 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). 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 in section III.A.4. of this Addendum, for Puerto Rico the GAF budget neutrality factor is 1.0002, while the DRG adjustment is 1.0008, for a combined cumulative adjustment of 0.9973.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the capital rate (50 percent) is multiplied by the Puerto Rico-specific GAF for the MSA in which the hospital is located, and the national portion of the capital rate (50 percent) is multiplied by the national GAF for the MSA in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto

Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico capital rate as a result of Pub. L. 105–33. In FY 2003, a small part of that reduction was restored.

For FY 2003, before application of the GAF, the special capital rate for Puerto Rico hospitals was $198.29. With the changes we proposed to the factors used to determine the capital rate, the proposed FY 2004 special capital rate for Puerto Rico was $201.26. For this final rule, based on the final factors, the FY 2004 capital rate for Puerto Rico is $203.15.

B. Calculation of Inpatient Capital-Related Prospective Payments for FY 2004

With the end of the capital PPS transition period 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 2004. The applicable capital Federal rate was determined by making adjustments as follows:

- For outliers, by dividing the capital standard Federal rate by the outlier reduction factor for that fiscal year; and
- For the payment adjustments applicable to the hospital, by multiplying the hospital's GAF, disproportionate share adjustment factor, and IME adjustment factor, when appropriate.

For purposes of calculating payments for each discharge during FY 2004, 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 outlier thresholds for FY 2004 are in section II.A.4.c. of this Addendum. For FY 2004, 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 $31,000.

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 was 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 final 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 2004

Based on historical data available through the second quarter of 2003, we forecast the CIPI to increase 0.7 percent in FY 2004. This reflects a projected 1.2 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.8 percent increase in other capital expense prices in FY 2004, partially offset by a 2.6 percent decline in vintage-weighted interest expenses in FY 2004. The weighted average of these three factors produces the 0.7 percent increase for the CIPI as a whole in FY 2004.

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

As discussed in section VI. of the preamble of this final 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 no longer paid on a reasonable cost basis but are paid under the 100 percent of 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 that is subject to the blend methodology may elect to be paid based on a 100 percent of the Federal prospective rate.

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 (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 hospitals and units excluded from the IPPS. While both rehabilitation hospitals and units and LTCHs are now paid under a PPS, psychiatric hospitals and units continue to be subject to the payment limitation. 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 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 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 updated 110 percent of the national median target amounts of new excluded psychiatric hospitals and units for cost reporting periods beginning during FY 2004. These figures are updated with the most recent data available to reflect the market basket increase percentage of 3.4 percent. This 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	FY 2004 labor-related share	FY 2004 nonlabor-related share
Psychiatric	$7,294	$2,899

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new LTCHs since they will be paid 100 percent of the Federal rate. A new LTCH is a provider of inpatient hospital services that meets the qualifying criteria for LTCHs specified under § 412.23(e)(1) and (e)(2) and whose first cost reporting period as a LTCH begins on or after October 1, 2002 (§ 412.23(e)(4)). Under the LTCH PPS, new LTCHs are paid 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. 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). 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.

We are in the process of developing a proposed rule that would establish a per diem PPS for inpatient psychiatric facilities (IPFs) (previously referred to as psychiatric hospitals and units) that is required under the provisions of section 124 of Pub. L. 106–113.

V. Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

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 final rule and in this Addendum. For purposes of this final rule, and to avoid confusion, we have retained the designations of Tables 1 through 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1A, 1C, 1D, 2, 3A, 3B, 4A, 4B, 4C, 4F, 4G, 4H, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H, 7A, 7B, 8A, 8B, 9, 10, and 11 are presented below. The tables presented below are as follows:

Table 1A—National Adjusted Operating Standardized Amounts, Labor/Nonlabor
Table 1C.—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1D.—Capital Standard Federal Payment Rate
Table 2.—Hospital Average Hourly Wage for Federal Fiscal Years 2002 (1998 Wage Data), 2003 (1999 Wage Data), and 2004 (2000 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
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TABLE 1A.—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,145.06	$1,278.78	$3,095.27	$1,258.54

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

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National	$3,119.61	$1,268.03	$3,119.61	$1,268.03
Puerto Rico	1,510.12	607.86	1,486.22	598.24

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$415.47
Puerto Rico	203.15

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
010001	17.4467	17.9841	19.4061	18.2955
010004	19.0010	20.1613	22.2673	20.4948
010005	18.6554	19.9733	19.6063	19.4156
010006	17.6115	18.3931	19.0976	18.4162
010007	15.6788	16.0781	17.5462	16.4299
010008	17.4728	19.0182	19.6573	18.7416
010009	18.4979	19.7272	20.4309	19.5485
010010	16.4664	17.7348	19.2644	17.7722
010011	22.4292	24.8922	25.8231	24.3180
010012	15.8686	20.3376	20.0896	18.5710
010015	19.1178	19.8205	18.8890	19.2826
010016	20.2198	20.3175	21.7918	20.8284
010018	18.9388	19.5519	19.2071	19.2353
010019	17.0856	17.6414	18.9177	17.8535
010021	15.1241	25.3335	17.7595	18.4456
010022	17.6435	22.1250	22.2266	20.3667
010023	16.3209	18.4567	20.4900	18.3307
010024	15.9034	17.3746	18.5942	17.2467
010025	15.1548	17.4702	19.3649	17.3268
010027	16.8595	16.5157	14.0974	15.7259
010029	18.3605	19.3393	20.9868	19.6276
010031	18.6402	19.2612	21.0176	19.6504
010032	15.3590	16.3967	16.4712	16.0937
010033	21.2986	21.9828	24.5088	22.5487
010034	15.3639	14.9379	14.9333	15.0828
010035	15.9439	20.7808	21.6182	19.2869
010036	17.7166	18.7158	19.2501	18.5418
010038	19.6098	19.6887	18.6578	19.2855
010039	20.3406	21.3550	23.0339	21.6158
010040	20.0983	20.4486	20.7779	20.4475
010043	18.6640	17.3567	19.9012	18.6528
010044	24.0265	23.4575	25.8561	24.4502
010045	17.0417	18.7569	22.7713	19.2947
010046	18.9737	18.8741	19.6754	19.1973
010047	15.4190	13.4130	16.1695	14.9341
010049	15.5246	16.3349	16.2973	16.0600
010050	17.9830	20.3028	20.7398	19.6262
010051	11.8108	12.3280	14.3007	12.8040

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
010052	18.0653	19.8289	11.9019	15.6329
010053	15.5649	15.4156	17.3238	16.1023
010054	19.4955	20.9656	20.6382	20.3799
010055	18.8590	19.5667	18.9664	19.1295
010056	19.6577	20.5645	21.1104	20.4208
010058	16.9715	16.1265	17.7800	16.9302
010059	18.8020	19.1270	20.5534	19.4928
010061	14.5003	18.5320	17.0447	16.6905
010062	12.3259	16.9721	17.1786	15.3820
010064	19.5256	20.5650	22.2280	20.6930
010065	16.8752	17.0557	17.2698	17.0733
010066	13.1559	14.8904	14.8696	14.3351
010068	18.6925	23.4322	18.3308	20.2712
010069	14.7211	15.4497	17.0957	15.7416
010072	16.2339	16.5652	18.8807	17.1920
010073	14.1273	13.5594	14.9826	14.2068
010078	18.1363	18.5127	20.1447	18.9315
010079	17.0648	17.1612	20.7401	18.2252
010081	17.2996	*	*	17.2996
010083	18.0312	18.4282	19.8525	18.7454
010084	18.7769	19.8773	21.6522	20.1274
010085	19.9023	21.5860	22.5282	21.3942
010086	16.5711	16.8886	18.0122	17.1417
010087	18.0567	18.7915	19.7620	18.8065
010089	17.7800	19.5241	19.5783	18.9652
010090	18.9445	19.5635	20.0287	19.5086
010091	17.0799	17.1775	17.4672	17.2432
010092	17.8144	18.5478	19.9351	18.7658
010095	12.2597	12.3064	12.5243	12.3676
010097	12.7286	14.2675	15.1593	14.0568
010098	14.0300	15.5763	15.1629	14.9158
010099	15.5619	15.9232	16.3307	15.9423
010100	17.9430	18.3755	19.8146	18.7658
010101	14.4625	18.9525	19.0718	17.2612
010102	13.8136	15.7777	16.4636	15.3148
010103	17.7242	22.0802	22.5709	20.6405
010104	16.8457	21.9457	20.9391	19.7211
010108	19.4617	19.1596	20.7787	19.7956
010109	14.6752	15.9627	18.2235	16.2157
010110	15.8283	15.5817	16.0015	15.8256
010112	16.8271	15.6041	17.9243	16.7545
010113	16.8936	18.2774	19.4106	18.1836
010114	17.0760	19.3772	20.1763	18.8237
010115	14.2261	15.3510	15.7873	15.0923
010118	17.0834	17.4620	19.5302	17.9294
010119	19.3942	19.5163	20.5245	19.8190
010120	18.2567	18.9975	19.4369	18.8719
010121	14.5262	15.2345	17.1640	15.7079
010123	19.2140	*	*	19.2141
010124	16.7465	*	*	16.7465
010125	16.0136	16.5117	16.8622	16.4618
010126	19.1065	19.5933	19.9647	19.5751
010127	18.2786	*	*	18.2786
010128	14.4322	16.6899	14.7646	15.2637
010129	16.1733	16.7609	16.4904	16.4644
010130	19.5573	17.4614	18.7190	18.5367
010131	20.1883	19.0492	22.9969	20.8110
010134	19.9856	18.5179	17.7717	18.7919
010137	20.5828	21.3573	28.9402	23.2122
010138	14.5254	14.1369	14.2024	14.2898
010139	20.4331	20.5708	22.8390	21.2553
010143	17.6212	18.9084	20.5639	19.0433
010144	18.2040	18.8272	19.1497	18.7345
010145	20.5895	20.8157	22.1394	21.2084

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
010146	19.1415	18.3666	21.3083	19.5948
010148	15.8349	18.4591	17.6830	17.3825
010149	18.0156	19.0199	21.0086	19.3661
010150	18.9359	19.4819	21.2360	19.9132
010152	18.7677	19.8990	21.6038	20.0519
010155	15.0689	13.6136	*	14.4394
010157	*	17.7372	19.6977	18.7304
010158	18.3957	18.6052	18.5464	18.5206
010159	*	19.3950	*	19.3950
020001	28.0394	28.6530	30.1452	28.9867
020002	25.1987	28.2759	*	26.6688
020004	25.4679	29.2351	27.3516	27.2833
020005	29.2378	35.0860	32.7936	32.3866
020006	28.1417	33.0843	31.2673	30.7745
020007	32.3852	27.7269	*	29.7080
020008	30.8691	31.8878	33.4543	32.1364
020009	18.4660	18.5594	*	18.5119
020010	22.7559	23.7275	20.7928	22.3051
020011	28.0658	27.5062	*	27.7745
020012	25.5320	26.7586	27.9955	26.7886
020013	28.1557	29.5646	30.6424	29.4993
020014	24.5875	27.7870	29.6806	27.4656
020017	28.0572	28.8752	30.3017	29.1234
020024	25.3205	25.5933	28.0930	26.3977
020025	20.2583	29.4375	*	24.0587
030001	21.7869	22.8996	25.7513	23.3305
030002	21.8375	23.1450	25.6038	23.5516
030003	22.6804	23.9849	22.1436	22.9249
030004	15.5478	13.8452	*	14.6087
030006	20.0273	20.5019	23.2881	21.1483
030007	21.5169	22.2473	26.1551	23.4298
030008	22.2190	*	*	22.2190
030009	18.7557	19.1258	19.9131	19.2261
030010	19.5123	19.8496	20.7204	20.0003
030011	19.4310	19.8141	21.0028	20.0690
030012	20.6585	21.1099	24.2366	22.1509
030013	20.0535	19.9517	21.9766	20.7166
030014	19.7966	20.3017	23.3663	21.1589
030016	19.4785	22.2526	24.3380	22.1886
030017	21.7938	23.1702	21.8792	22.2509
030018	20.8980	21.8067	24.9216	22.5811
030019	21.2540	22.0341	23.2973	22.2278
030022	19.5794	22.3351	24.9941	22.3479
030023	24.1678	25.4626	28.6628	26.2700
030024	23.6009	23.7663	26.7641	24.7020
030025	11.9894	20.2690	*	15.6341
030027	17.6555	18.5500	19.4583	18.5927
030030	21.6932	23.1280	25.2425	23.1970
030033	20.2820	20.3034	26.3814	22.2735
030034	20.8689	19.5578	*	20.1515
030035	20.0226	20.5339	*	20.2741
030036	21.6371	22.2690	24.9432	23.0233
030037	23.7615	23.7325	23.0542	23.5162
030038	22.9822	23.4477	25.2632	23.9087
030040	19.7636	19.3706	21.2717	20.1331
030041	18.8717	18.4750	*	18.6831
030043	20.5598	20.5653	23.5172	21.6042
030044	17.6575	18.6781	21.9503	19.2464
030047	21.4412	22.7385	*	22.1035
030049	19.3580	19.7315	*	19.5288
030054	15.0657	15.7973	*	15.4443
030055	20.2991	20.8373	22.8612	21.3919
030059	22.6279	27.3929	*	24.8227
030060	18.6313	19.5021	21.7685	19.9508

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
030061	19.9047	21.1013	22.9706	21.3676
030062	18.7172	19.2670	21.1639	19.7478
030064	20.3837	21.6435	22.8009	21.6120
030065	20.7838	22.2846	24.6064	22.6068
030067	17.2778	17.6414	18.4004	17.7581
030068	17.7208	18.9718	19.7097	18.8803
030069	21.0936	23.4902	24.5432	23.0752
030080	20.6581	21.2299	22.8953	21.6643
030083	23.5229	23.5049	24.3273	23.8162
030085	20.8690	21.6542	21.8196	21.4875
030087	21.9465	23.1339	25.6351	23.5333
030088	20.5340	21.4491	23.5761	21.9185
030089	20.9516	22.0850	24.5055	22.5911
030092	21.8308	19.6625	24.0515	21.9130
030093	20.4314	21.7195	23.2485	21.9062
030094	22.8123	21.8049	24.5992	23.0301
030095	13.7664	20.5222	*	16.1313
030099	18.2263	19.8092	20.3310	19.5882
030100	23.7609	23.5868	27.6299	25.3037
030101	19.2547	21.1029	23.7661	21.3217
030102	18.2413	21.5405	27.9419	22.5589
030103	*	28.9308	29.1105	29.0254
030104	*	32.8668	34.6026	33.8315
040001	16.9178	16.3882	18.7141	17.4255
040002	15.1107	16.1353	18.0776	16.4361
040003	15.5740	15.5186	16.3918	15.8349
040004	17.9034	19.0105	21.2335	19.4115
040005	11.1318	16.5465	*	13.6054
040007	18.6998	22.5319	23.3992	21.2518
040008	14.7985	20.2121	*	17.4031
040010	19.4913	19.8251	20.7114	20.0272
040011	16.0995	17.1337	18.8346	17.5256
040014	18.1434	19.3996	22.4970	19.9652
040015	15.5207	17.9602	18.8513	17.4824
040016	20.2321	19.8087	21.2198	20.4114
040017	15.4736	16.5648	17.7545	16.6023
040018	18.7463	18.8203	22.0408	19.7570
040019	23.4163	21.0465	21.1711	21.7572
040020	18.9844	17.6056	18.6419	18.3851
040021	19.6835	21.3321	23.5620	21.5681
040022	20.8281	19.2393	21.4194	20.3876
040024	17.6607	17.1507	17.5750	17.4623
040025	13.4705	14.8071	*	14.1228
040026	19.7924	21.0143	22.7699	21.2074
040027	17.4431	17.7161	19.3388	18.1973
040028	13.9946	15.2850	*	14.6625
040029	21.1370	22.5094	22.1882	21.9489
040030	11.2402	16.5488	*	13.2353
040032	13.2872	13.8013	16.2781	14.3506
040035	10.9569	11.0611	11.8237	11.2698
040036	20.2012	21.1066	21.6742	21.0202
040037	14.0941	15.4984	*	14.7246
040039	14.7177	15.2811	15.9673	15.3471
040040	19.1984	19.6704	*	19.4380
040041	16.4624	17.7783	20.4646	18.2091
040042	15.2057	16.6875	16.2285	16.0552
040044	13.3501	17.1869	*	15.1931
040045	16.2469	16.6648	19.5573	17.3603
040047	17.5336	18.6295	21.6323	19.2840
040050	14.0036	14.2087	15.1428	14.4627
040051	16.6039	18.2152	17.6964	17.5006
040053	15.0219	14.1508	19.2586	15.8377
040054	14.2577	16.5217	16.5573	15.7676
040055	18.0414	17.4236	19.7335	18.3506

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
040058	16.4278	19.3124	*	17.6419
040060	17.9805	15.4220	*	16.5871
040062	17.8902	19.4255	21.9336	19.7228
040064	11.5029	13.3479	*	12.3898
040066	19.7144	19.5619	21.7766	20.3116
040067	14.4741	15.0081	16.0516	15.1736
040069	17.0026	18.9754	20.5968	18.8667
040070	16.9700	18.6066	*	17.8568
040071	17.6144	18.4956	19.4324	18.4911
040072	17.4960	21.3320	19.3079	19.3210
040074	18.7542	20.8465	22.0800	20.5126
040075	14.0975	14.6681	15.7875	14.8313
040076	20.5840	21.8010	23.5948	21.9901
040077	13.9114	14.7230	16.7832	15.1038
040078	18.5821	19.6363	21.4854	19.9519
040080	19.3707	22.8153	18.4470	20.0143
040081	11.1332	12.4796	13.2797	12.2892
040082	15.1331	16.4840	*	15.7978
040084	17.7295	18.3410	20.1163	18.7753
040085	16.5216	14.1782	15.5811	15.3778
040088	17.1624	18.3159	20.0032	18.4492
040090	19.0824	16.6619	*	17.8591
040091	20.1378	20.2904	20.6688	20.3813
040093	13.9741	14.7132	*	14.3380
040100	15.6833	17.0271	17.8889	16.9700
040105	14.3896	14.8936	15.4697	14.9508
040106	18.1341	19.0936	*	18.6698
040107	17.8628	20.6852	17.6695	18.7676
040109	16.6278	16.2496	17.1706	16.6926
040114	21.1231	21.3826	21.6849	21.4003
040118	18.2123	19.6248	21.7913	19.9047
040119	16.9407	18.6028	19.9013	18.5380
040124	19.2889	*	*	19.2889
040126	11.6517	16.3391	13.3832	13.6732
040132	10.3875	24.6941	29.2337	17.5163
040134	19.0185	22.1291	24.4646	22.0021
040135	23.0084	*	*	23.0082
040136	*	21.4139	*	21.4138
040137	*	*	24.7813	24.7813
040138	*	*	22.3523	22.3523
050002	36.9630	30.2629	30.9729	32.2632
050006	18.2061	22.4890	25.4604	22.0357
050007	30.8676	31.6270	34.1406	32.1656
050008	26.3682	28.2021	32.4067	28.7024
050009	28.4734	28.3021	30.2740	29.0378
050013	28.0569	27.2552	29.8401	28.3575
050014	23.6745	25.1664	27.7646	25.5586
050015	27.7731	28.2204	27.5652	27.8552
050016	21.2045	22.7014	25.5508	23.2128
050017	25.6178	25.7403	28.4911	26.6066
050018	15.2903	16.5909	17.9621	16.7254
050022	24.5254	26.2574	28.1312	26.3930
050024	22.4274	21.5230	25.1425	23.0352
050025	24.8245	26.0161	29.8262	26.8932
050026	23.1904	23.4651	24.2564	23.6605
050028	17.6138	17.9421	18.7866	18.1131
050029	24.6839	26.6783	30.2538	27.1782
050030	21.5621	21.8639	21.9251	21.7896
050032	24.3598	24.4176	28.8046	25.7369
050033	32.0179	31.1768	*	31.6954
050036	21.8239	24.8017	25.3885	24.0459
050038	29.9698	32.1757	36.1619	32.5954
050039	22.8288	23.8478	26.8993	24.5711
050040	30.2607	30.1153	30.7426	30.3810

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
050042	24.5260	25.4903	27.6765	25.9508
050043	33.8255	38.8988	37.3217	36.6008
050045	21.1474	21.0356	22.1691	21.4359
050046	25.2005	25.3067	25.5490	25.3505
050047	29.9580	31.6959	34.4427	32.0849
050051	18.7809	17.9266	*	18.3161
050054	22.0982	19.2395	21.3495	20.8463
050055	29.2730	32.0923	36.1182	32.3322
050056	23.8396	24.7994	27.1458	25.3250
050057	20.7420	22.2584	24.2758	22.4840
050058	23.3009	24.8366	25.9389	24.7179
050060	20.5450	21.9971	22.9491	22.0213
050061	24.5488	23.9906	25.3042	24.6040
050063	25.7593	25.5798	28.6093	26.6450
050065	24.6290	27.6677	28.8369	27.0472
050066	16.1649	26.3920	*	19.8363
050067	25.8857	22.1250	27.8867	24.8006
050068	19.3615	19.2325	21.9031	19.5920
050069	24.6153	25.8560	27.2744	25.8994
050070	34.0721	36.4136	39.5178	36.7625
050071	34.4367	36.4834	40.1344	37.0182
050072	39.7321	36.1146	39.2529	38.3306
050073	32.8555	36.1054	38.6763	35.9238
050075	33.7160	37.8104	40.2265	37.4233
050076	33.9752	37.0415	40.8075	37.1398
050077	24.1404	25.3481	27.1234	25.5664
050078	24.3150	23.0613	24.1091	23.8126
050079	30.0167	36.5455	38.8981	35.1106
050082	23.7617	23.7718	27.5022	24.9190
050084	25.4517	25.1155	26.0607	25.5652
050088	24.9641	25.2282	27.1103	25.7384
050089	22.8450	23.4120	24.7857	23.6599
050090	24.6070	25.4545	27.4193	25.8348
050091	23.7713	26.6463	29.2522	26.4442
050092	17.1211	17.1883	*	17.1549
050093	25.6647	27.2048	29.2642	27.4393
050095	30.4847	29.2226	*	29.7245
050096	22.7394	22.5034	23.0526	22.7555
050097	22.5991	24.2548	24.6726	23.8591
050099	25.3722	26.2363	27.1282	26.2763
050100	25.2031	23.9877	25.6798	24.9469
050101	31.8957	33.1232	32.9866	32.6718
050102	24.0014	22.6741	25.5763	24.0204
050103	25.4133	23.5946	27.8079	25.5235
050104	26.9726	27.3260	26.1592	26.8000
050107	22.2019	22.2746	22.6900	22.4227
050108	25.1758	25.6983	28.5244	26.4357
050110	19.9589	21.3399	21.9296	21.1132
050111	20.7897	21.0813	23.7715	21.9292
050112	26.8182	29.1268	31.9797	29.3043
050113	28.5224	32.4493	32.6932	31.3678
050114	26.6757	27.6486	28.1938	27.5328
050115	23.0182	24.3748	24.1481	23.8529
050116	24.9196	27.0331	28.2924	26.6320
050117	22.2123	23.0697	24.7555	23.3917
050118	23.7129	24.9094	28.9358	25.8815
050121	18.7272	18.8430	25.0858	20.5240
050122	26.9546	26.9048	29.1534	27.6723
050124	24.5069	23.9379	23.0843	23.8087
050125	32.0230	33.3290	35.6572	33.6339
050126	24.6752	26.9718	27.7126	26.4996
050127	20.9027	20.5928	21.8719	21.1212
050128	26.6132	26.2519	28.7668	27.1805
050129	24.0108	23.7432	25.2780	24.3452

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
050131	32.5462	33.0980	37.7844	34.4656
050132	24.0173	24.1583	27.8805	25.3842
050133	23.2093	23.9479	25.1948	24.1576
050135	24.7157	23.2750	*	23.9658
050136	24.7280	28.0754	31.6146	27.9406
050137	32.9192	33.7489	35.0503	33.8818
050138	38.1584	40.8912	43.0858	40.6538
050139	31.4984	35.1492	33.8749	33.3407
050140	32.7609	36.7096	36.1708	35.1295
050144	27.4069	29.8983	30.3678	29.2851
050145	34.5185	37.5003	37.5722	36.5610
050148	20.0971	21.1622	17.3908	19.5271
050149	26.8674	25.8880	28.0501	26.8823
050150	24.6596	25.9494	26.7728	25.8255
050152	33.3305	34.5096	34.5694	34.1486
050153	32.3389	33.3333	34.5870	33.4428
050155	25.3354	23.2118	21.2069	23.1002
050158	28.6071	28.9764	30.6598	29.4328
050159	22.5313	26.6139	27.4051	24.9053
050167	21.8796	21.9596	23.2022	22.3516
050168	25.1937	27.1971	27.5313	26.5678
050169	24.8407	24.7737	25.6896	25.1108
050170	24.3654	27.7693	29.4075	26.9505
050172	19.6120	22.0400	24.5849	22.0737
050173	24.8694	*	27.7070	26.3141
050174	30.2775	31.6888	33.5204	31.9008
050175	24.7548	26.0146	26.9627	25.9076
050177	21.1396	22.5039	23.1575	22.2317
050179	23.8868	22.8941	23.0583	23.2574
050180	33.3257	34.0900	36.9905	34.8613
050186	23.6288	25.0791	27.6638	25.5202
050188	28.2364	30.6007	34.1503	31.0517
050189	27.4071	28.3295	32.3514	29.2097
050191	25.3516	29.4162	28.1689	27.6587
050192	14.1996	19.0400	19.5327	17.3659
050193	24.9444	25.5294	24.6307	25.0325
050194	29.5678	28.5389	28.1413	28.7132
050195	36.9068	39.1617	42.1735	39.4471
050196	18.2411	19.4304	20.7257	19.5002
050197	32.4030	34.6878	*	33.4489
050204	22.7099	23.0192	24.9458	23.5600
050205	24.1691	24.1275	25.2841	24.5169
050207	22.9941	23.7774	25.1863	23.9991
050211	31.7280	33.2481	34.3396	33.0898
050213	21.4951	*	*	21.4951
050214	24.0276	21.1480	22.4773	22.4934
050215	35.0459	31.6895	36.6063	34.4197
050217	20.2042	21.3026	22.2055	21.2565
050219	21.2458	21.7637	21.8649	21.6598
050222	23.3563	23.0670	25.2922	23.9448
050224	23.5101	24.8431	26.2108	24.9081
050225	21.6820	22.0981	25.0218	22.9304
050226	24.4443	26.1959	26.0826	25.7144
050228	34.2596	36.0632	38.6751	36.2629
050230	26.6291	26.7963	30.0380	27.8217
050231	26.7321	27.4697	27.8896	27.3721
050232	24.5245	25.8640	25.3439	25.2423
050234	24.6126	25.0104	24.0754	24.5126
050235	27.0922	26.0323	27.2838	26.7962
050236	25.9458	27.7406	27.0687	26.9151
050238	24.5823	25.1796	26.0312	25.2541
050239	23.2711	24.9469	27.0866	25.1260
050240	26.7620	28.8910	32.8542	29.7204
050241	29.8345	*	*	29.8345

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
050242	32.0829	33.5646	34.4412	33.3749
050243	26.4627	26.0256	28.5626	27.0708
050245	23.2716	24.6092	25.7585	24.5579
050248	27.6457	28.4413	29.1192	28.4523
050251	23.6360	27.9531	24.4552	25.2214
050253	16.7540	21.0399	23.9247	20.2377
050254	20.1176	22.3414	23.3358	21.9420
050256	23.4835	25.1104	26.8618	25.3035
050257	17.2596	15.6379	17.4909	16.8191
050260	27.4234	30.1623	*	28.8055
050261	20.1040	19.4649	21.4693	20.3613
050262	29.5550	30.8866	33.0425	31.0973
050264	36.0331	33.2270	37.4741	35.5250
050267	26.0401	27.8393	26.6558	26.7955
050270	25.3757	26.4092	27.9871	26.6878
050272	23.0587	23.3443	24.0921	23.5076
050276	33.3302	34.0633	34.7422	34.0318
050277	26.0822	23.6065	35.6323	28.8604
050278	23.9289	24.9699	26.0331	24.9976
050279	21.8949	22.2776	23.5145	22.5756
050280	25.6651	26.3392	28.5504	26.8526
050281	24.2251	25.2699	25.7832	25.1246
050282	25.4428	26.4698	*	25.9126
050283	31.7669	32.3270	35.1831	33.1816
050286	19.4241	20.6191	19.7351	19.9268
050289	30.4750	32.2125	34.9646	32.5479
050290	29.6796	31.5000	31.9510	31.0288
050291	29.4029	30.9334	28.3451	29.5051
050292	20.8410	21.4357	27.6114	23.1188
050293	24.1875	17.1935	*	20.0134
050295	21.7883	25.4405	25.4332	24.2106
050296	28.3906	30.0984	33.5948	30.6658
050298	23.2006	22.4000	26.1707	23.8598
050299	25.5035	24.6751	26.9870	25.7710
050300	25.9228	26.0298	26.3182	26.1028
050301	21.1403	24.7987	25.7167	23.8557
050305	36.7908	36.6981	38.7597	37.4248
050308	28.9284	30.3887	31.6790	30.3648
050309	25.3515	25.5221	25.5367	25.4704
050312	26.0015	26.0172	28.2557	26.8194
050313	25.6827	28.9126	25.3372	26.5450
050315	22.7359	22.5906	23.6638	23.0139
050320	32.4809	31.6571	31.4570	31.8291
050324	25.3694	26.8313	28.4931	27.0063
050325	23.6327	22.6353	26.6326	24.1679
050327	25.6450	31.1527	33.0549	29.6283
050329	21.6984	24.2134	26.6341	24.1720
050331	25.0230	25.2110	21.5193	23.7909
050333	19.1449	14.1808	15.6929	16.0637
050334	34.2557	34.3956	37.2336	35.3386
050335	22.9926	22.9335	24.9274	23.6376
050336	21.3402	22.0203	23.2687	22.1975
050342	20.8255	22.4510	23.0282	22.0864
050348	25.1085	29.3364	28.9864	27.7954
050349	15.0667	15.4536	15.6042	15.3828
050350	26.4161	27.2368	27.2573	26.9829
050351	24.8121	25.2436	27.4042	25.8956
050352	26.4262	27.7489	32.6572	28.8606
050353	23.2699	24.1009	25.4309	24.2678
050355	21.0969	41.4710	*	27.5904
050357	24.5345	24.3540	25.2126	24.7119
050359	21.7548	19.7653	22.9175	21.4664
050360	31.7583	33.3592	35.9032	33.7039
050366	19.6823	22.0442	23.4696	21.8093

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
050367	30.7328	31.7487	32.6760	31.7233
050369	26.2234	26.6627	28.0909	27.0127
050373	27.8275	29.9749	30.7301	29.4528
050376	28.0990	28.4026	30.3530	28.9347
050377	17.0012	11.6463	14.3889	14.7469
050378	26.9101	27.8389	30.4937	28.3969
050379	18.4278	24.2408	27.5150	22.7721
050380	31.9578	31.5962	35.8014	33.0886
050382	25.9244	26.3968	26.8949	26.4027
050385	*	27.1692	*	27.1692
050388	22.0122	17.6762	*	19.7924
050390	24.2700	25.8556	25.7881	25.2656
050391	20.0615	19.0832	20.2887	19.7798
050392	22.9430	24.9003	21.8139	23.1475
050393	24.1981	25.4028	26.4918	25.4171
050394	23.1526	23.1641	25.1869	23.8865
050396	25.3729	25.7580	28.4161	26.5200
050397	20.6397	23.3212	24.7280	22.8187
050401	18.4593	*	*	18.4593
050404	15.9839	16.4845	*	16.2457
050406	17.8596	21.5282	*	19.5336
050407	30.8346	32.0753	33.2894	32.0587
050410	19.8508	17.1718	19.8436	18.9151
050411	33.1943	33.1718	35.5207	33.9577
050414	25.9723	24.5471	28.2381	26.2718
050417	23.3005	23.3862	24.5360	23.7554
050419	23.4936	25.1449	26.4357	25.0021
050420	23.5438	26.4201	26.7537	25.5652
050423	21.3552	24.8113	26.5188	24.3189
050424	24.0727	25.9378	27.5273	25.9000
050425	35.3712	33.7276	37.7347	35.6925
050426	29.0120	26.7941	30.9610	28.8680
050427	16.4330	31.4154	*	23.2879
050430	21.2275	25.2322	31.5171	24.6961
050432	24.5630	26.0686	28.1105	26.3124
050433	18.9021	17.7980	14.3846	17.2267
050434	*	24.0017	*	24.0017
050435	23.3426	22.5428	22.6618	22.8189
050438	23.2583	25.3763	26.5535	25.0490
050440	22.5400	25.4767	*	23.9820
050441	31.8774	33.4696	36.6680	33.8900
050443	17.2875	16.8897	*	17.0772
050444	22.4530	22.6469	23.5299	22.8500
050446	22.3422	20.3611	*	21.2838
050447	18.9851	24.4339	25.7274	23.3050
050448	21.7718	22.6612	26.6967	23.5469
050449	23.4614	*	*	23.4614
050454	30.0792	30.3063	34.4813	31.6390
050455	19.8577	20.5575	24.1694	21.4327
050456	18.1585	17.5846	23.7594	19.3948
050457	32.1910	34.2116	37.4570	34.4455
050464	25.7710	25.8092	31.4768	27.7900
050468	22.2926	22.9771	17.8128	20.5312
050469	24.5205	*	25.7995	25.2381
050470	16.0805	15.7765	21.6981	17.5845
050471	27.1597	29.4705	32.3570	29.6121
050476	24.0253	25.9458	26.0482	25.3722
050477	27.5819	30.8781	32.1676	30.2255
050478	26.3306	28.1829	28.3893	27.6685
050481	27.7973	28.5320	30.3890	28.9165
050482	16.0114	21.6091	*	18.2916
050485	24.6906	25.2723	27.1437	25.6725
050488	31.7481	33.8291	37.2438	34.4285
050491	27.4600	27.7412	29.2987	28.1988

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
050492	20.5030	23.4977	23.7383	22.6518
050494	29.1296	30.2875	30.8706	30.1345
050496	34.9704	32.7474	35.7115	34.4409
050497	15.4115	*	14.4481	14.9306
050498	26.1716	27.6099	28.2196	27.3481
050502	25.3701	27.2724	28.0102	26.8843
050503	23.3745	25.7668	26.7924	25.3905
050506	25.0333	27.1555	30.4731	27.5747
050510	33.7481	36.2548	39.6005	36.5514
050512	34.4368	36.0785	39.0767	36.6044
050515	33.7321	37.3440	36.3131	35.7452
050516	26.1969	25.3450	30.0985	27.0287
050517	22.0985	23.6067	23.4131	22.9981
050522	36.2127	37.0295	38.9158	36.9675
050523	31.2522	32.1272	33.8053	32.4311
050526	26.4014	26.8814	29.0004	27.4593
050528	18.9155	21.1741	23.9177	21.3604
050531	21.3948	*	22.7311	22.0660
050534	24.0001	24.4038	26.7941	25.0949
050535	26.8511	27.7626	29.7904	28.1965
050537	24.0354	26.2342	25.1292	25.1574
050539	23.3846	23.7778	25.3328	24.1813
050541	36.6149	37.0551	41.1980	38.3379
050542	17.7737	21.8129	21.2846	19.9901
050543	21.6795	22.4134	24.0333	22.7542
050545	31.7280	33.6302	33.4322	32.9305
050546	38.8087	39.4266	42.8053	40.3552
050547	37.7681	37.7633	40.6483	38.6518
050548	29.8516	30.3336	32.3944	30.8485
050549	28.9615	30.0948	31.8525	30.3559
050550	25.6588	26.5515	29.0938	27.1362
050551	24.8084	26.1042	28.6834	26.5676
050552	20.3239	20.6068	24.9755	21.7907
050557	22.2562	23.8340	25.8719	24.0562
050559	24.7866	26.3799	25.3299	25.4887
050561	33.4423	34.2065	35.9611	34.5098
050564	24.2091	*	*	24.2090
050565	20.8349	*	*	20.8349
050566	22.3448	21.7712	*	22.0475
050567	25.0787	26.2588	27.8475	26.4308
050568	20.5376	21.9313	20.8324	21.0880
050569	27.3429	27.3294	27.7955	27.4880
050570	25.8619	26.8965	29.9470	27.6972
050571	24.0154	26.2226	29.1716	26.5115
050573	25.6589	25.9380	27.2328	26.2959
050575	20.7090	27.8579	23.1358	23.6994
050577	23.5487	25.2861	26.4806	25.0050
050578	28.9009	32.0554	30.4934	30.4285
050579	29.9348	32.0245	34.9794	32.4397
050580	24.6962	22.7522	27.2431	24.7685
050581	24.9807	26.0580	28.9696	26.6705
050583	25.8800	26.2664	30.0427	27.5806
050584	19.5805	24.5294	24.5544	22.7601
050585	24.2824	26.4446	26.0595	25.5822
050586	23.1850	*	25.7172	24.5880
050588	24.5472	27.0506	30.5453	27.6351
050589	23.8880	23.7918	27.9845	25.1893
050590	24.4797	25.1100	27.0620	25.5289
050591	25.0209	26.7662	28.6151	26.8393
050592	22.1174	23.8267	25.9545	23.8223
050594	27.7002	28.7415	30.8029	29.1185
050597	23.3280	23.1209	24.5542	23.6763
050598	23.9202	25.1622	24.6875	24.6305
050599	26.0892	26.3782	27.7684	26.7559

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
050601	29.7417	29.7734	32.3033	30.6813
050603	21.7031	24.9032	25.0996	23.8892
050604	35.4034	36.4669	42.0018	37.9795
050608	18.1664	20.9171	20.7954	19.9529
050609	33.5028	34.8949	37.4563	35.1739
050613	30.2413	34.9768	*	32.5464
050615	27.5682	25.8698	29.4322	27.6985
050616	24.9843	25.0016	23.1748	24.3242
050618	21.4895	22.3548	22.3481	22.1206
050623	27.5832	28.6475	29.9553	28.6716
050624	26.4659	22.4030	23.3492	23.8718
050625	27.5816	29.3665	30.8013	29.3364
050630	24.2120	25.2915	27.7052	25.7731
050633	25.4283	27.8165	30.2883	27.9289
050636	23.5257	25.0214	23.2573	23.9123
050638	18.2159	15.6375	*	16.7440
050641	17.1258	17.9379	21.5030	19.2373
050644	22.1489	*	28.4054	25.2877
050662	35.0989	38.9592	40.9243	38.2885
050663	24.9110	22.7770	22.9161	23.2174
050667	27.5045	26.9236	31.4906	28.5908
050668	61.7751	57.8627	55.9594	58.7058
050670	24.6101	24.1626	*	24.3757
050674	32.4807	33.7845	36.8871	34.4747
050676	20.2087	16.3948	*	18.1923
050677	33.6070	34.0936	36.2702	34.6349
050678	22.7756	25.2143	27.1337	25.0885
050680	31.4839	31.9166	32.7065	32.0475
050682	17.3566	19.8107	23.0983	19.8665
050684	23.3697	24.2792	23.7443	23.7986
050685	35.1307	30.4194	*	32.6498
050686	33.4420	34.8278	37.3032	35.1892
050688	31.0648	34.9936	36.5555	34.8315
050689	30.9399	34.0571	37.5449	34.4378
050690	34.8112	36.7516	41.1385	37.6299
050693	25.5662	29.1213	32.6638	29.3244
050694	23.5572	25.1964	25.8299	24.8850
050695	24.4301	26.2838	27.8742	26.2576
050696	28.3291	29.6685	29.9410	29.3284
050697	18.2338	24.1116	18.6962	20.0478
050698	*	24.9559	*	24.9559
050699	17.5296	23.4611	26.0909	21.8689
050701	24.3055	26.4901	28.4650	26.3518
050704	22.7618	25.6565	24.6072	24.3668
050707	27.8958	28.2637	27.7366	27.9699
050708	24.8647	24.5606	22.1605	23.8703
050709	19.4977	21.8770	22.7897	21.4220
050710	27.5828	30.5918	33.7204	30.7878
050713	16.8538	18.2822	19.0071	18.0075
050714	30.1925	30.3290	30.3262	30.2901
050717	28.7973	31.5021	33.0719	31.0905
050718	18.0940	22.5989	21.7835	21.3483
050719	23.0833	*	22.0997	22.4754
050720	25.8677	*	26.1941	26.0295
050723	*	32.0291	33.0797	32.5951
050724	*	*	23.7567	23.7567
050725	*	*	20.6592	20.6592
050726	*	*	25.8742	25.8742
060001	21.1819	21.4562	23.1548	21.9595
060003	20.4682	21.9043	23.0807	21.8505
060004	21.4496	22.9265	25.0037	23.2681
060006	20.0213	21.0003	21.8609	21.0085
060007	18.2977	19.3071	21.4244	19.6205
060008	18.4590	18.7097	19.8803	19.0217

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
060009	22.7164	23.9272	24.7920	23.8281
060010	23.6827	24.2735	25.8475	24.6131
060011	22.3458	22.2058	25.8919	23.4930
060012	19.4932	21.2980	22.6374	21.1159
060013	19.1256	23.5248	23.3954	22.3367
060014	24.3210	25.7701	27.0326	25.7458
060015	23.2469	23.6015	27.6338	24.8106
060016	20.2408	20.2361	22.9300	21.1421
060018	21.5083	21.8478	21.0581	21.4599
060020	18.8985	19.7348	20.9025	19.8893
060022	21.0830	22.8059	24.7928	22.9453
060023	21.5475	22.4731	24.3749	22.8346
060024	22.9185	24.3658	25.2409	24.2358
060027	22.0713	22.1717	25.1480	23.2185
060028	23.1792	24.2985	27.1303	24.8437
060029	18.2938	19.8498	19.7379	19.2937
060030	20.3452	21.2612	22.8309	21.5553
060031	22.5067	23.3995	23.8781	23.2637
060032	22.8123	24.7678	27.1783	24.9890
060033	16.0760	17.8514	16.7266	16.8791
060034	23.2816	24.3652	26.1602	24.6636
060036	18.5988	18.6521	19.4144	18.9130
060037	15.4513	15.7495	*	15.6040
060038	14.3249	16.6525	*	15.6518
060041	19.1263	19.5872	20.8745	19.8909
060042	20.8597	19.3967	*	19.9173
060043	13.4443	15.4073	19.1085	15.9780
060044	20.8673	21.3102	25.6112	23.4887
060046	22.2699	22.6819	*	22.4792
060047	17.1534	17.9173	*	17.5379
060049	23.0613	25.9592	25.3425	24.9252
060050	19.0832	*	20.4386	19.8467
060052	14.8729	16.0543	*	15.4475
060053	18.0232	19.4746	*	18.7228
060054	20.4160	19.7753	21.1281	20.4312
060056	18.1263	21.9586	*	20.1887
060057	25.4185	24.6599	24.3982	24.8074
060058	13.8539	16.4504	*	15.1564
060060	15.6018	19.4418	*	17.3849
060062	16.8640	17.1032	*	16.9796
060064	22.7797	28.8746	29.1806	26.8320
060065	24.5572	24.4554	29.2377	26.0841
060066	17.2537	17.5556	*	17.3996
060070	18.8960	19.2220	22.6894	20.3042
060071	17.4068	17.6452	20.1385	18.3916
060073	17.0846	18.4971	*	17.7673
060075	23.8724	25.0552	27.7835	25.5595
060076	20.3265	22.9426	23.6266	22.3373
060085	14.3409	10.9724	*	12.5324
060088	13.7174	20.7211	*	16.8131
060090	16.3760	16.5321	*	16.4540
060096	20.8937	21.9951	26.4167	23.1494
060100	23.9305	24.8116	28.0561	25.6542
060103	23.5083	24.4962	26.6863	24.9275
060104	21.1820	24.4248	26.7682	23.9805
060107	21.9221	*	*	21.9222
060108	*	19.1327	19.0011	19.0448
060109	*	27.3180	*	27.3180
060110	*	*	29.8561	29.8561
070001	26.3596	27.7441	29.9592	27.9941
070002	26.1768	26.6881	28.1101	26.9593
070003	27.5200	28.1721	29.8684	28.5356
070004	24.2567	25.4310	25.7207	25.1218
070005	26.9151	27.6733	29.8173	28.0976

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
070006	28.6413	33.6291	33.3814	32.0737
070007	26.3313	28.0875	29.0336	27.8511
070008	24.2971	25.1362	24.3907	24.6106
070009	24.1871	24.9408	25.6072	24.9173
070010	29.2194	28.3168	30.4192	29.3329
070011	23.0883	24.8206	24.9457	24.2870
070012	28.8067	37.5917	34.9099	33.4527
070015	28.1204	29.2693	30.0614	29.1548
070016	24.4633	28.4833	29.7505	27.3887
070017	26.0424	27.5515	29.2978	27.4590
070018	30.6864	32.6301	33.8654	32.4296
070019	24.9249	26.2348	27.9838	26.4038
070020	25.9964	26.6203	28.4084	27.0418
070021	26.3043	29.4596	30.3254	28.7921
070022	26.9111	27.2423	29.7376	27.9567
070024	24.8948	26.3544	28.3460	26.5801
070025	25.4345	27.3592	28.3017	27.0096
070027	26.8450	25.9279	36.9699	29.0675
070028	25.7492	26.7286	28.2078	26.9036
070029	23.9682	23.8427	25.8107	24.5347
070030	22.1578	*	*	22.1578
070031	24.1198	25.6347	25.5880	25.0884
070033	31.4736	34.1591	34.3904	33.3381
070034	29.4916	30.0744	32.8074	30.7406
070035	24.1423	24.5996	26.1693	24.9143
070036	29.9470	31.2961	35.0701	32.0463
070038	*	26.3126	*	26.3126
070039	22.3356	*	32.6059	29.3416
080001	24.8833	26.8887	28.0859	26.6310
080002	20.1965	20.9385	23.7309	21.6786
080003	23.1275	24.8200	24.8199	24.2173
080004	22.9706	21.7344	24.2251	22.9785
080006	22.6671	20.9399	23.6838	22.4133
080007	21.3746	21.5415	23.4964	22.1696
090001	21.5751	23.0365	29.5432	24.4308
090002	21.5726	20.6550	23.5159	21.8418
090003	23.1268	27.1087	22.7014	24.0752
090004	25.5054	25.9717	28.7417	26.8011
090005	26.3074	26.8690	28.6142	27.2997
090006	22.0957	22.9658	23.7241	22.9485
090007	29.2840	24.6668	25.8430	26.6042
090008	25.2708	*	19.3212	22.1162
090010	23.6616	25.9373	*	24.7397
090011	26.6349	27.6038	31.7710	28.7553
100001	20.2157	22.0101	22.6150	21.6357
100002	21.0222	21.5772	22.5982	21.7602
100004	15.4149	16.1638	15.6306	15.7493
100006	21.2293	21.6922	23.3745	22.1765
100007	22.1590	22.5317	24.3305	23.0600
100008	20.8381	21.6416	22.7706	21.7804
100009	22.1741	22.6370	24.7811	23.2097
100010	23.0637	23.9582	25.5614	24.1330
100012	20.4659	22.0244	24.2602	22.3053
100014	19.5770	21.9875	21.7566	21.0988
100015	18.0654	18.9383	22.1272	19.7135
100017	19.8655	20.1417	21.1905	20.4341
100018	21.6388	22.6587	24.1885	22.8575
100019	23.5462	25.8297	24.2888	24.5531
100020	20.7816	21.7421	23.5303	22.0615
100022	26.5695	27.4235	27.9072	27.2953
100023	19.1787	20.2034	21.8111	20.3897
100024	22.1332	22.9872	24.4070	23.2018
100025	19.4529	20.1360	21.2568	20.2991
100026	20.9461	21.3742	20.1603	20.7988

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
100027	14.7916	20.5889	23.8982	18.2776
100028	19.3371	20.3751	21.8879	20.5632
100029	20.8950	22.2553	24.6814	22.4835
100030	20.5952	19.5604	21.8567	20.7315
100032	19.7451	20.6543	21.6415	20.6364
100034	19.5282	20.0099	23.1111	20.8438
100035	23.8117	21.3519	22.6349	22.5792
100038	24.5864	24.9548	25.7948	25.1579
100039	21.7861	23.3111	23.8060	22.9806
100040	18.6321	19.5154	22.4679	20.1990
100043	18.8206	20.7688	21.7738	20.4584
100044	22.7236	22.9474	23.9952	23.2248
100045	21.0228	22.8096	25.2285	22.9374
100046	21.3028	23.2027	24.2746	22.8753
100047	20.6068	21.4971	24.3522	22.2329
100048	15.7790	17.3663	17.5533	16.9309
100049	19.1025	20.9490	21.8679	20.6413
100050	17.9039	17.8960	20.0405	18.6106
100051	17.9453	19.3258	20.0231	19.1698
100052	18.1780	19.6620	20.5916	19.4656
100053	19.6800	21.6634	23.7837	21.6611
100054	21.1518	20.9612	22.0352	21.4046
100055	18.8760	19.1324	19.6350	19.2002
100056	21.8506	23.1737	25.9245	23.6383
100057	19.5319	22.3406	24.6417	22.0507
100060	23.5997	*	*	23.5997
100061	22.9176	24.5277	26.1273	24.5205
100062	21.4424	21.9054	24.9807	22.7317
100063	18.4642	19.2510	21.5620	19.9030
100067	18.4851	19.2168	23.8892	20.4263
100068	19.8308	19.9648	23.7840	21.3340
100069	17.3666	18.5789	19.6037	18.6041
100070	20.0381	20.9592	23.5524	21.5325
100071	17.7234	20.7461	21.7675	20.3419
100072	20.5968	22.0317	23.5362	22.1454
100073	22.2812	22.2425	23.5843	22.7262
100075	19.4480	20.4604	22.3890	20.7468
100076	17.8612	18.4815	19.6444	18.6617
100077	19.0640	20.9482	22.3755	20.8572
100078	19.2891	16.6003	*	17.8844
100080	22.7153	22.9720	22.8704	22.8570
100081	15.4253	16.5149	16.8087	16.2486
100084	22.7009	24.5682	24.1122	23.8713
100086	23.3718	24.3067	25.2375	24.3294
100087	23.6562	22.1764	26.5915	24.1164
100088	20.5566	20.6667	23.6270	21.6062
100090	19.7695	21.0431	22.5894	21.1520
100092	20.1760	21.4601	25.4630	22.1148
100093	16.8422	18.7153	20.2949	18.6499
100098	20.8315	21.1723	20.0639	20.7185
100099	15.7591	16.5271	18.5287	16.8485
100102	19.7673	19.0193	21.6772	20.1082
100103	18.7844	19.1222	20.3633	19.4145
100105	21.8268	22.7793	24.5464	23.0784
100106	17.4958	21.4342	20.3417	19.7704
100107	20.0719	21.7553	23.3789	21.7356
100108	20.1125	18.4127	14.8039	17.4685
100109	20.8370	20.6007	23.0779	21.5126
100110	20.1853	22.8127	24.4533	22.5939
100112	15.2128	16.2109	*	15.7583
100113	21.3489	23.3380	24.3614	22.9690
100114	22.8178	22.5326	25.3699	23.4863
100117	20.6962	21.3085	23.9133	21.9869
100118	20.7323	21.7067	24.1105	22.1068

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
100121	18.5842	19.9033	23.1100	20.5301
100122	19.2643	24.9765	24.1820	22.6871
100124	20.4022	20.0867	24.3048	21.5323
100125	19.6097	20.3232	22.4185	20.8356
100126	19.3103	21.4349	21.7977	20.8062
100127	19.2122	20.5153	21.0153	20.2670
100128	22.8826	23.5835	24.4104	23.6230
100130	20.0947	21.0023	20.2478	20.4482
100131	23.1622	24.6184	25.4811	24.4722
100132	18.7863	19.5259	21.1538	19.8114
100134	15.9733	16.9302	18.3392	17.1001
100135	19.1865	19.7675	20.4915	19.8235
100137	19.5562	20.9015	20.4007	20.3128
100138	14.9539	14.9760	*	14.9656
100139	15.2532	15.7378	18.2204	16.3584
100140	19.0584	20.2288	22.5124	20.6430
100142	18.4113	17.7250	20.0689	18.7079
100146	21.3359	20.8381	*	21.0641
100147	15.2348	17.1566	17.1045	16.4924
100150	21.5057	25.4269	22.9193	23.1341
100151	23.8489	26.6143	26.6470	25.8202
100154	20.4068	21.6715	23.0820	21.7335
100156	18.4779	20.0348	20.6929	19.7809
100157	22.6195	24.2188	23.1045	23.3126
100159	10.7818	15.0633	*	12.9868
100160	23.3121	22.6942	23.4877	23.1680
100161	22.3053	23.3612	24.6268	23.4502
100162	20.3110	24.2950	23.8001	22.8069
100165	22.6622	*	*	22.6623
100166	21.2309	22.2419	23.7419	22.3795
100167	23.2969	25.7676	26.4517	25.1920
100168	20.3167	23.0121	24.6276	22.6616
100169	20.3017	21.6397	23.4575	21.8200
100170	19.3005	21.2469	*	20.1922
100172	14.8826	15.7827	17.6051	16.0261
100173	17.1337	18.3828	19.7190	18.4365
100174	21.9807	*	*	21.9807
100175	20.5442	21.2532	21.0474	20.9357
100176	24.3089	24.6595	26.8740	25.2920
100177	24.4284	25.1037	24.5078	24.6849
100179	23.0849	23.9633	24.1801	23.7691
100180	21.5388	22.7781	24.9433	23.1701
100181	18.9510	17.9048	18.1320	18.3165
100183	23.0654	22.2063	24.4575	23.2115
100187	20.8535	21.4988	23.4760	21.9203
100189	26.5962	27.1295	26.6846	26.8004
100191	21.0647	22.0526	24.1911	22.4941
100200	23.8729	24.8878	24.8120	24.5400
100204	20.2193	21.1922	22.2613	21.2482
100206	20.1171	20.3436	22.8782	21.0874
100208	20.7029	20.4678	24.1482	21.8277
100209	23.3903	22.8236	23.8502	23.3700
100210	21.8545	23.0431	26.0933	23.6634
100211	20.7516	21.6367	24.3243	22.2366
100212	21.1263	21.7239	22.6584	21.8516
100213	21.1818	22.0176	24.4467	22.6180
100217	22.7335	22.7116	24.0291	23.1695
100220	21.8246	24.6233	24.9733	23.7248
100221	21.2321	23.2263	*	22.1854
100223	20.2233	21.8962	21.2434	21.1576
100224	21.8628	22.3567	23.0804	22.4588
100225	21.5059	22.4619	23.9971	22.6579
100226	21.8808	22.7301	23.8701	22.8717
100228	20.8810	24.9691	26.2593	24.0864

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
100229	18.2350	19.7259	21.0039	19.5689
100230	22.5650	23.4169	25.0518	23.8929
100231	18.7526	21.5712	23.5418	21.0310
100232	19.8002	20.1459	21.8105	20.6232
100234	21.6360	24.3355	24.9141	23.6582
100236	20.6942	21.7886	23.9781	22.1000
100237	23.2408	23.2712	26.7664	24.3476
100238	20.8252	23.3747	24.6513	22.9237
100239	19.4481	23.2242	25.0509	22.4527
100240	21.0606	21.3495	23.0650	21.8213
100241	17.1063	14.1059	*	15.6623
100242	18.6938	19.1097	20.4681	19.4815
100243	20.8041	22.4495	23.2812	22.2413
100244	20.5352	21.4386	23.4876	21.8968
100246	21.9247	23.5614	26.7630	24.0120
100248	21.2988	22.1553	23.8742	22.4825
100249	18.1397	18.4932	21.3942	19.2694
100252	19.8079	22.0976	22.6475	21.5855
100253	22.4778	22.6517	23.6939	22.9719
100254	19.5523	20.4410	23.2794	21.2417
100255	21.0284	20.7228	22.9793	21.5458
100256	21.2786	22.4844	24.1969	22.6427
100258	20.0300	22.0790	24.5699	22.2126
100259	21.1160	21.4991	24.1148	22.2915
100260	24.9183	21.2413	23.5164	23.1305
100262	21.0927	22.7137	23.8006	22.3809
100264	19.9491	21.7410	22.4800	21.4196
100265	18.2291	20.2664	21.0688	19.9095
100266	19.3623	20.2821	21.5258	20.4415
100267	21.7430	22.8054	23.3760	22.6752
100268	24.0538	23.5414	26.0297	24.5763
100269	22.5114	26.0271	24.9002	24.4895
100270	16.7148	20.8217	*	18.7430
100271	20.8695	21.9823	*	21.4488
100275	21.4904	23.2920	23.1419	22.6892
100276	24.1022	24.8251	25.4557	24.8136
100277	19.7241	14.9157	25.2985	18.4223
100279	22.5879	23.1776	24.8484	23.4843
100280	18.1972	19.0157	*	18.6075
100281	23.0142	23.4729	25.3382	24.0569
100282	18.4884	20.9256	*	19.7594
100284	18.9448	18.5716	22.3046	19.9187
110001	20.1150	22.4535	24.0561	22.2069
110002	19.5158	20.2149	20.4502	20.0753
110003	17.1450	18.2792	19.7061	18.4215
110004	19.7733	20.6096	21.8791	20.7777
110005	22.4568	21.8105	23.6147	22.7129
110006	21.0601	22.0325	23.8762	22.3201
110007	25.2523	25.9135	28.2025	26.4671
110008	18.5265	20.4972	22.6308	20.7088
110009	17.4306	16.6452	*	17.0362
110010	23.9104	25.1930	27.2029	25.4211
110011	18.9823	20.4028	23.2149	20.8820
110013	18.9160	16.7833	*	17.8487
110014	18.1787	18.4463	*	18.3068
110015	20.9926	21.2600	23.2279	21.9187
110016	14.2398	14.7571	18.8228	15.7864
110017	22.2537	21.2970	*	21.7842
110018	22.1480	23.0577	24.7007	23.3525
110020	19.4617	20.9687	23.3004	21.1787
110023	22.0546	21.6512	23.5673	22.4650
110024	20.7345	21.3945	22.1471	21.4330
110025	20.4232	20.2493	29.0965	22.6398
110026	16.2484	16.9161	19.3200	17.4907

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
110027	14.7081	19.8976	19.8351	18.0251
110028	29.1670	28.1695	25.9474	27.6479
110029	21.2150	21.3694	22.7981	21.8333
110030	19.6412	20.4656	22.2341	20.7841
110031	20.0553	20.9219	22.8695	21.3219
110032	18.2014	19.2685	18.0744	18.4929
110033	25.6335	23.1939	24.1447	24.2752
110034	19.5554	23.0724	24.0791	22.0313
110035	22.7950	21.8646	24.2581	22.9820
110036	24.9234	22.5481	24.4788	23.9524
110038	17.7396	18.4508	20.1710	18.7818
110039	20.4998	18.9817	17.0608	18.7776
110040	16.8083	17.7798	17.3095	17.2984
110041	20.2755	20.1398	20.8080	20.4113
110042	25.2331	25.0535	25.5588	25.2869
110043	20.6150	21.2714	22.7589	21.5611
110044	17.2087	17.5905	19.2562	17.9982
110045	21.3049	22.2424	19.7747	21.0415
110046	21.4905	22.8820	21.6201	22.0167
110048	15.6113	18.8751	*	17.1524
110049	16.8639	17.1396	18.9096	17.6498
110050	19.2291	18.9048	*	19.0644
110051	17.2292	17.2050	17.6816	17.3795
110054	20.0549	20.7825	20.5387	20.4734
110056	17.7959	17.9037	21.7607	19.3353
110059	16.7990	17.8076	19.9802	18.2059
110061	16.3557	17.4601	18.6696	17.5523
110062	17.0053	17.9421	*	17.4730
110063	18.5071	18.0256	25.0270	24.4605
110064	19.1203	18.8742	21.7636	19.8777
110065	16.3546	16.9829	*	16.6570
110066	22.4189	23.4554	*	22.9140
110069	20.9575	21.1513	21.0518	21.0559
110070	17.3438	19.6361	*	18.6196
110071	18.8321	21.5042	15.2336	18.3234
110072	12.7625	13.6626	*	13.1941
110073	16.4658	17.9372	15.2711	16.4347
110074	22.3769	24.4924	24.4094	23.8133
110075	20.1757	20.1604	20.4634	20.2673
110076	21.9798	23.6127	23.8211	23.1622
110078	24.0893	25.7416	28.2149	26.0373
110079	22.1070	22.3641	22.8017	22.4150
110080	19.1839	19.4635	24.1958	20.7509
110082	24.3140	22.7015	27.2931	24.6475
110083	23.1463	22.2609	24.6460	23.3708
110086	16.6374	19.0164	18.8751	18.1588
110087	22.7069	24.0994	25.7908	24.2653
110089	19.3855	19.0453	20.6757	19.7052
110091	21.5328	23.7110	24.3354	23.1945
110092	16.9725	15.9178	16.9116	16.5923
110093	16.9827	*	*	16.9827
110094	16.9503	16.8890	*	16.9211
110095	17.1195	18.9904	20.1024	18.8017
110096	17.4157	18.0418	18.5513	18.0235
110097	17.4558	17.8454	*	17.6373
110098	16.0597	16.7800	*	16.4502
110100	19.0764	18.6822	15.1316	17.6555
110101	18.8491	13.8787	13.3943	14.8763
110103	21.1837	21.5683	*	21.4221
110104	15.9431	16.6322	17.9805	16.8523
110105	16.7775	18.1306	19.2156	18.0663
110107	19.3897	21.2267	21.8167	20.8132
110108	25.2161	20.1140	*	22.2083
110109	16.4031	16.5977	18.7397	17.2348

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
110111	18.3951	18.4274	20.9536	19.3428
110112	19.8986	18.9574	20.4565	19.7953
110113	15.9532	16.0942	18.0770	16.7135
110114	16.4812	16.8297	*	16.6546
110115	22.5049	26.5759	26.3274	24.9969
110118	19.7509	17.5714	17.7344	18.2780
110120	17.7452	18.4738	20.3099	18.8660
110121	19.3643	18.8744	19.5230	19.2555
110122	21.1469	20.6070	20.4184	20.7024
110124	18.3366	19.4093	19.7005	19.1562
110125	18.0090	19.5666	19.8695	19.1558
110127	20.3765	16.1107	*	18.2840
110128	18.0835	20.3046	28.4942	21.9309
110129	19.0001	20.9442	21.8204	20.6124
110130	14.6011	16.6915	17.5272	16.2937
110132	16.3943	17.1820	17.2924	16.9658
110134	19.8639	19.0305	*	19.4185
110135	17.3504	15.6668	18.5125	17.0191
110136	16.9629	20.7827	21.1235	19.3927
110140	17.7915	*	*	17.7915
110141	14.4935	13.2710	*	13.8938
110142	13.9525	14.1203	16.3359	14.8326
110143	22.5926	22.4254	24.3898	23.1388
110144	17.5112	17.5678	*	17.5388
110146	17.1835	17.8499	17.2250	17.4052
110149	32.1975	25.2525	25.3618	27.1829
110150	21.2909	22.8322	22.7366	22.3193
110152	15.1324	16.3837	*	15.7696
110153	20.5068	20.6972	21.5300	20.9068
110154	17.3761	16.5286	*	16.9482
110155	16.5146	16.4756	16.1785	16.4073
110156	16.3876	16.0759	*	16.2355
110161	22.2861	24.5776	26.4200	24.5439
110163	18.6637	20.1183	21.9411	20.2136
110164	21.2160	22.6605	23.7801	22.5540
110165	20.8030	22.5604	23.4071	22.3021
110166	20.5049	22.3822	23.6665	22.0307
110168	21.8058	22.3181	23.3426	22.5338
110169	22.6648	23.3750	24.7083	23.5314
110171	25.5296	24.5313	32.6386	27.7697
110172	23.6803	24.7005	25.2396	24.5635
110174	14.6199	*	*	14.6199
110177	21.2796	22.7831	24.0700	22.7532
110179	22.0767	24.3673	26.0365	24.0945
110181	12.9798	13.9591	*	13.4445
110183	22.5148	24.2899	26.4248	24.4133
110184	22.1920	22.2761	24.3379	22.9563
110185	17.7925	17.3330	*	17.5916
110186	18.3178	19.7172	21.1176	19.7561
110187	19.8419	22.8248	23.2571	21.8964
110188	23.7032	22.0258	24.4785	23.4118
110189	20.8786	19.8454	21.4255	20.7155
110190	18.3649	20.7292	21.9009	20.2241
110191	21.4033	21.3404	24.0572	22.3044
110192	21.0486	22.9684	24.3823	22.8864
110193	20.7867	22.1477	25.1779	22.7067
110194	14.8115	15.8129	16.8075	15.8165
110195	12.7261	10.9444	*	11.8061
110198	24.8646	24.8275	28.0634	25.9885
110200	17.7744	17.9631	20.1816	18.6638
110201	20.9497	21.9313	24.1171	22.2994
110203	22.7453	24.2062	30.2609	25.5883
110204	30.7342	35.3699	*	32.7584
110205	21.3617	20.1405	23.1969	21.5575

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
110207	14.7154	14.6045	*	14.6569
110208	15.6161	15.0350	*	15.3251
110209	18.6404	20.0629	17.4145	18.6822
110211	26.9151	20.1024	*	22.9486
110212	14.3790	15.8420	18.7651	16.2466
110215	18.1539	21.0263	22.5679	20.7523
110216	27.1878	*	*	27.1877
120001	29.0427	29.4126	30.0871	29.5170
120002	25.2021	23.5667	24.2715	24.3269
120003	23.9115	24.6238	*	24.2718
120004	24.8632	26.1398	26.8010	25.9297
120005	24.1662	22.3213	23.0113	23.1311
120006	25.8943	26.6302	28.1562	26.8635
120007	22.8772	22.7179	27.8497	24.2388
120009	16.4485	16.7630	*	16.6019
120010	24.1923	24.9089	25.4050	24.8421
120011	37.2759	35.2051	30.9308	34.0921
120012	21.8507	22.0371	*	21.9472
120014	24.1208	25.3557	25.3682	24.9359
120015	42.6465	*	*	42.6472
120016	45.1899	43.5083	39.1160	42.7373
120018	31.1879	*	*	31.1877
120019	25.5659	23.8535	24.4036	24.5914
120021	23.1839	36.8286	*	27.8298
120022	19.2614	22.2781	22.4951	21.2033
120024	32.2514	21.9657	*	26.7529
120025	50.6376	40.1332	40.2485	43.1574
120026	25.1314	25.7023	26.3653	25.7684
120027	24.4535	23.1434	24.9464	24.1547
120028	27.0897	27.5365	29.5070	28.0817
130001	17.6306	19.6328	*	18.6568
130002	16.9867	18.5746	20.1143	18.6076
130003	22.3430	23.0994	23.9403	23.1432
130005	21.2386	22.6364	24.4844	22.7104
130006	20.4614	21.4640	22.8567	21.6494
130007	21.8107	22.0894	22.8475	22.2657
130008	13.6018	19.3392	*	16.1567
130009	15.9701	20.8748	*	18.2398
130010	17.5119	17.7826	*	17.6552
130011	20.1147	22.1125	23.1120	21.7785
130012	24.9976	24.2451	*	24.6140
130013	15.1129	22.6624	23.5316	20.2820
130014	19.2107	19.8240	21.6495	20.2756
130015	18.5913	16.4136	*	17.4135
130016	19.0516	20.1220	*	19.6075
130017	19.6875	19.9511	*	19.8231
130018	19.8425	20.0563	22.2249	20.7344
130019	19.1711	19.5147	*	19.3390
130021	15.6155	14.4430	18.0007	15.8914
130022	18.9127	19.7814	21.5602	20.1253
130024	19.0703	19.9934	22.1611	20.4440
130025	16.4627	17.5989	18.7814	17.6827
130026	21.8106	23.2093	24.4976	23.1615
130027	20.5344	20.6641	*	20.5964
130028	20.9674	21.2217	21.1492	21.1146
130029	18.7694	22.9243	*	20.4335
130030	17.5759	18.5827	*	18.0583
130031	16.7766	20.4146	*	18.2292
130034	18.9483	20.5802	*	19.7427
130035	20.7770	17.2864	*	19.1660
130036	13.6362	15.1590	18.5921	15.7605
130037	18.6856	19.2108	*	18.9656
130043	16.7904	17.6920	*	17.2343
130044	13.4513	18.7067	*	15.9723

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
130045	19.0208	17.5152	19.0271	18.5109
130048	16.7900	*	*	16.7900
130049	22.4440	22.0520	23.7212	22.7595
130054	17.7085	16.4675	*	17.0330
130056	20.9476	28.8008	*	24.4940
130060	22.7399	23.2512	24.6773	23.5532
130061	14.7394	*	*	14.7393
130062	19.8157	19.8264	24.0494	21.3157
130063	18.8024	18.4797	18.8782	18.7287
140001	17.7990	18.1511	20.0247	18.6600
140002	19.9284	20.9959	23.0207	21.2902
140003	17.8595	18.0163	19.2097	18.3647
140004	17.4574	18.9713	*	18.2174
140005	12.3002	12.4144	13.2365	12.6493
140007	23.8585	24.9847	25.1836	24.6934
140008	22.1111	24.2634	26.3287	24.2035
140010	28.5635	28.0863	29.0224	28.6047
140011	18.6164	18.4052	19.0903	18.7086
140012	21.4374	22.5885	24.4070	22.8406
140013	19.6722	20.3147	19.9800	19.9935
140014	21.4042	22.2944	*	21.8387
140015	17.6805	20.3540	21.4328	19.8233
140016	14.4938	15.4454	16.3417	15.3940
140018	22.4132	23.4062	24.3285	23.3864
140019	16.4254	16.1180	17.4206	16.6387
140024	15.3782	16.1032	15.6616	15.7091
140025	18.5135	21.7775	*	20.0183
140026	18.3220	19.7839	20.4084	19.5156
140027	19.2149	20.5980	20.9855	20.2413
140029	26.0833	28.5670	25.0485	26.4725
140030	23.1760	25.3715	26.5733	25.0959
140031	17.6067	16.9650	*	17.2985
140032	19.0383	19.8033	20.6273	19.8411
140033	25.1639	22.8705	23.4279	23.7474
140034	19.8792	19.7711	20.9635	20.1903
140035	15.5040	17.4514	*	16.4777
140036	19.1076	21.2366	*	20.1966
140037	14.1083	14.3082	15.5578	14.6732
140038	18.4948	19.8197	*	19.1560
140040	16.7450	18.0342	19.2160	18.0347
140041	18.5952	18.8042	*	18.7014
140042	15.8892	16.1157	*	16.0034
140043	20.1176	21.7356	23.3751	21.8035
140045	17.7799	17.4261	18.9587	18.0683
140046	18.6371	20.0859	21.7969	20.2134
140047	13.3610	16.6672	*	14.8654
140048	23.9545	23.8652	25.9122	24.5813
140049	26.9483	26.7160	21.9546	25.3052
140051	24.0796	24.7180	24.2472	24.3525
140052	17.9571	21.0450	21.8161	20.1407
140053	19.9620	20.9768	22.6099	21.1760
140054	23.1576	23.9459	35.5659	27.3968
140055	14.3603	15.8756	*	15.1297
140058	18.6861	19.1199	20.5089	19.4559
140059	*	18.2593	19.9777	19.0797
140061	18.2039	18.4264	22.7515	19.6171
140062	28.5304	28.6390	30.7005	29.3149
140063	29.1453	29.6998	30.5430	29.8595
140064	18.9379	19.6954	20.6505	19.7669
140065	25.3336	25.5939	26.3521	25.7796
140066	13.6491	15.4818	18.0915	15.5544
140067	19.5292	20.7511	21.9579	20.7435
140068	21.6188	22.3622	24.1316	22.6861
140069	17.3879	17.7785	*	17.5876

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
140070	22.7153	25.2646	25.2960	24.2944
140074	21.6052	22.2563	*	21.9232
140075	21.6434	21.8472	26.5350	22.9476
140077	17.3647	17.3236	18.0487	17.5877
140079	23.6928	22.7046	25.7090	24.0330
140080	22.1968	22.0682	24.4056	22.8890
140081	16.9808	18.1746	*	17.5725
140082	29.7262	26.5960	25.0474	26.9608
140083	21.0330	20.7704	23.2822	21.6156
140084	22.3467	23.0263	25.4818	23.6135
140086	19.1613	19.1815	*	19.1714
140087	17.1147	21.4593	*	19.1145
140088	25.4176	26.5258	28.4219	26.7393
140089	18.3157	19.3230	20.7632	19.4616
140090	26.9364	28.0530	35.0300	29.4280
140091	21.9322	23.5559	23.7560	23.1453
140093	20.1528	20.7564	21.5376	20.7969
140094	21.9383	22.8892	24.2166	23.0115
140095	24.2859	25.5716	24.7706	24.8985
140097	21.1719	21.8418	*	21.5268
140100	23.1399	23.8226	27.1868	24.8138
140101	21.4211	23.1418	24.6106	23.0966
140102	17.5729	18.6328	19.8678	18.6663
140103	18.1303	19.1834	21.2404	19.5117
140105	22.8944	23.8258	27.3323	24.5505
140107	11.8383	11.5827	*	11.7127
140108	26.9971	27.9140	*	27.4761
140109	14.5498	15.9178	16.4262	15.6166
140110	19.2888	20.9631	21.9880	20.7795
140112	17.6974	18.1119	*	17.9053
140113	19.5584	26.2393	25.6621	23.5275
140114	21.0976	23.0383	24.1926	22.8235
140115	21.0433	20.4587	25.3410	22.2094
140116	23.8993	25.5980	26.8924	25.5257
140117	21.4876	22.0889	23.3531	22.3481
140118	24.3260	25.3249	26.7350	25.4595
140119	27.9145	30.6468	31.3486	29.9292
140120	17.9716	17.7667	20.3237	18.6579
140121	16.6993	16.2607	17.6019	16.8238
140122	26.1270	26.7882	26.8595	26.5933
140124	27.9813	30.6820	30.9648	29.8366
140125	16.9516	17.8190	19.5359	18.0996
140127	20.0489	20.8397	21.3102	20.7463
140128	23.1327	23.5481	*	23.3351
140129	20.2868	21.6252	21.6495	21.1744
140130	23.4298	26.0464	25.7324	25.1138
140132	23.3054	23.7046	23.0595	23.3426
140133	21.4166	20.1740	24.0458	21.8049
140135	17.3985	18.2479	19.7919	18.5332
140137	18.6330	20.4807	21.6017	20.2583
140138	17.1968	14.5771	*	15.8048
140139	11.0397	*	*	11.0397
140140	17.6845	18.8185	19.1636	18.5459
140141	19.1097	20.2606	20.3707	19.9234
140143	19.0810	19.9885	22.0009	20.2373
140144	22.2864	24.8854	26.9259	24.6726
140145	18.1788	19.4509	19.6429	19.1056
140146	19.9704	19.4272	*	19.6862
140147	18.8049	17.1013	18.2691	18.0420
140148	18.7730	19.7630	21.5777	20.0626
140150	24.7976	28.9853	32.9291	28.5851
140151	20.0310	20.8820	21.5167	20.8051
140152	25.6011	28.3946	28.5468	27.5188
140155	20.2778	24.2907	25.2034	23.1447

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
140158	22.7988	23.7428	22.5638	23.0543
140160	17.7921	19.8825	20.9986	19.6014
140161	20.3799	21.2045	22.2191	21.3060
140162	20.3452	21.6901	22.6426	21.5722
140164	18.6589	19.8246	19.7774	19.4344
140165	14.7223	16.3700	17.0665	16.0112
140166	18.3833	19.3672	20.7849	19.4761
140167	17.6525	18.8532	19.5959	18.7351
140168	17.7453	18.2896	18.7503	18.2528
140170	16.4107	17.6901	17.0666	17.0536
140171	15.0237	15.2617	17.3214	15.8617
140172	23.6262	24.8587	27.3373	25.2144
140173	16.3924	16.0030	*	16.1514
140174	35.9320	22.0418	23.6893	25.2341
140176	24.5338	26.3468	25.6824	25.5437
140177	15.0827	20.3142	20.8526	18.2773
140179	21.9859	22.7345	24.1539	22.9472
140180	22.7996	22.7508	25.4022	23.6250
140181	21.9864	22.6643	23.7308	22.8340
140182	28.9515	25.1302	32.1969	28.8546
140184	17.2401	17.9169	20.6499	18.6226
140185	18.2867	18.8573	20.0903	19.0816
140186	23.5034	25.6807	26.0970	25.1056
140187	18.3331	19.4049	20.5829	19.4291
140188	16.1907	*	*	16.1907
140189	20.6627	21.1515	22.5875	21.4411
140190	17.5263	16.6673	17.9194	17.3611
140191	25.2628	27.4166	24.5446	25.6579
140193	17.4057	18.5651	20.5958	18.8417
140197	19.3774	19.9406	19.2979	19.5430
140199	18.0450	18.5409	19.7888	18.7992
140200	21.7680	22.4626	24.1358	22.8115
140202	23.7955	25.2777	26.2460	25.1620
140203	21.0848	24.8870	26.5789	24.2582
140205	20.0784	*	25.1010	22.9703
140206	22.5109	22.8223	24.7616	23.3613
140207	22.3905	25.4539	23.3197	23.6919
140208	26.2527	28.3112	27.4671	27.3501
140209	20.1557	20.2433	22.0813	20.8567
140210	14.8248	15.5345	15.5339	15.3158
140211	22.6265	22.8852	25.8556	23.8141
140213	24.9892	25.6839	27.4607	26.0827
140215	15.2893	18.5502	18.6962	17.4895
140217	25.7329	25.9030	24.7146	25.4260
140218	14.9851	17.4171	*	16.1590
140220	17.8450	19.3915	*	18.6260
140223	24.9017	26.2168	27.4355	26.1911
140224	32.8292	25.6766	27.1725	28.2184
140228	20.1688	21.8627	22.9899	21.6593
140230	18.2983	12.3494	*	14.8541
140231	24.5019	26.0208	25.5536	25.3988
140233	21.2333	24.4419	24.7103	23.5150
140234	*	19.7266	20.8676	20.3084
140236	12.9253	*	*	12.9252
140239	20.3745	21.6074	23.9205	21.9718
140240	24.6949	25.1418	25.0325	24.9609
140242	25.2317	26.1850	28.8686	26.8470
140245	14.2481	15.1320	15.2537	14.8687
140246	11.6267	15.0650	16.1305	14.1116
140250	23.6449	25.3410	25.5501	24.8622
140251	21.9435	23.5128	24.8256	23.4339
140252	25.0220	26.4715	28.3479	26.6235
140253	19.5858	18.4567	*	19.0172
140258	25.3622	25.0743	27.5741	26.0514

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
140271	12.0079	16.0350	17.5175	14.8913
140275	23.8171	22.9656	23.1871	23.2884
140276	25.3134	26.1713	25.3222	25.5791
140280	18.8300	20.0763	21.7004	20.2210
140281	25.2719	26.5197	27.9115	26.6261
140285	18.5916	15.7435	*	17.0403
140286	26.1290	24.0368	25.5805	25.1984
140288	24.4331	25.8717	26.3572	25.5938
140289	18.1747	17.7886	20.7506	18.9533
140290	22.8590	26.5055	29.9098	26.4896
140291	24.9537	26.8628	27.6675	26.5471
140292	21.9950	26.8610	26.4077	25.1307
140294	17.7301	19.4218	21.7473	19.5616
140300	27.8436	28.9830	30.5172	29.1412
150001	24.0620	22.6875	25.4897	24.1367
150002	20.7651	20.7353	22.3327	21.2734
150003	20.8636	21.4649	21.0944	21.1408
150004	21.2449	22.8060	23.6169	22.5090
150005	21.6806	22.8149	23.8818	22.8498
150006	20.6523	21.8435	23.1779	21.9153
150007	20.6635	21.2811	22.1098	21.3541
150008	21.8457	23.0208	23.8916	22.9022
150009	19.0030	19.5869	19.4763	19.3625
150010	20.5570	21.2466	22.5445	21.4807
150011	18.3275	19.9096	22.1559	20.1096
150012	22.1402	21.7903	23.1644	22.3790
150013	16.9327	17.5531	19.8564	18.1751
150014	21.5168	22.8402	24.3754	22.8817
150015	21.9037	24.2370	23.1616	23.0637
150017	19.5339	20.6758	22.7979	21.0370
150018	21.0496	22.8922	24.6138	22.9251
150019	17.8585	19.8341	17.3170	18.2548
150020	16.6600	15.9405	18.4688	17.0524
150021	21.5944	23.3800	24.3658	23.1607
150022	17.9222	18.7751	22.2973	19.8109
150023	19.3412	20.3015	20.6926	20.0896
150024	19.2295	19.8368	21.7593	20.1808
150025	20.2750	*	*	20.2750
150026	22.4978	21.9448	23.2169	22.5611
150027	18.0335	19.4238	21.5766	19.7256
150029	23.2454	24.8939	25.2067	24.4325
150030	19.2406	20.7256	23.0196	21.0229
150031	18.3463	21.3494	18.9179	19.4671
150033	22.6741	23.0756	24.1701	23.2959
150034	23.1533	23.3718	22.8812	23.1378
150035	21.2374	22.3779	23.5468	22.3841
150036	21.4567	22.1464	*	21.8009
150037	24.4611	22.3699	24.4997	23.7287
150038	22.0572	20.3454	21.6608	21.3217
150039	19.6215	16.0227	*	17.5902
150042	20.2221	18.0185	23.7838	20.4589
150043	20.1741	20.6301	*	20.4010
150044	19.1309	19.8951	20.5156	19.8505
150045	18.1670	20.6406	23.0361	20.5780
150046	18.2543	19.4146	20.3453	19.3721
150047	22.0145	21.9824	24.8786	22.8897
150048	19.1648	21.1441	22.5181	20.9965
150049	18.6451	21.6309	18.4942	19.5768
150050	17.7354	18.0411	*	17.8858
150051	19.7257	20.6895	21.4009	20.6516
150052	17.3750	18.8345	19.1070	18.4211
150053	18.8632	18.3493	*	18.6061
150054	18.3916	19.3424	*	18.8632
150056	21.5774	23.0603	24.7841	23.1287

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
150057	16.9736	17.4044	28.0884	20.1891
150058	22.1409	23.0273	24.9479	23.3727
150059	22.7360	23.1398	25.6737	23.8406
150060	18.6159	19.5011	19.8990	19.3356
150061	19.7968	19.4014	19.2826	19.4675
150062	20.8274	21.2608	22.9214	21.6432
150063	22.6525	24.8587	24.4091	23.9888
150064	20.3865	20.6232	21.2512	20.7527
150065	21.2153	21.4572	23.0636	21.9337
150066	19.5313	19.6845	*	19.6122
150067	18.8862	20.5000	21.4374	20.3431
150069	23.3969	23.5510	23.8353	23.5678
150070	18.0827	18.9332	20.7413	19.2893
150071	13.5111	16.4179	*	15.0051
150072	15.0765	18.5813	18.5447	17.3134
150073	*	19.8034	14.8287	16.6860
150074	20.2305	21.3500	22.9598	21.5274
150075	16.7532	17.2267	20.1119	17.8912
150076	22.6424	23.3724	25.4519	23.8726
150078	19.9668	20.2068	20.1260	20.1068
150079	18.2051	18.3668	19.3860	18.6860
150082	17.8381	19.6881	21.0651	19.5469
150084	24.3107	24.9529	27.8354	25.7663
150086	18.3838	19.7763	21.5815	19.9584
150088	20.3366	22.3055	22.2627	21.6628
150089	22.1725	21.5664	21.6806	21.8078
150090	21.0945	21.9803	24.9021	22.5584
150091	22.4640	26.5235	26.4248	25.0867
150092	16.9179	18.2592	*	17.6063
150094	17.5244	16.8351	*	17.1591
150095	19.2749	22.3214	*	20.8258
150096	20.8204	*	19.7975	20.2623
150097	19.7751	21.1462	22.4565	21.2367
150098	15.2829	16.4763	*	15.8733
150100	19.8066	18.7289	21.2980	19.8754
150101	20.6209	21.2025	26.1272	22.4675
150102	23.7180	20.8818	21.3313	21.8627
150103	18.7036	19.3653	*	19.0657
150104	20.0765	21.3141	21.0799	20.8409
150105	22.4412	21.6975	*	22.0619
150106	16.8714	18.7088	19.1976	18.3084
150109	19.9066	21.7870	21.3123	21.0077
150110	21.9336	*	*	21.9336
150111	19.2355	24.1559	*	21.5147
150112	20.5253	22.1939	23.5151	22.0747
150113	19.6603	20.5871	21.2412	20.5276
150114	17.9877	18.3097	*	18.1462
150115	18.4844	18.1308	20.3863	19.0118
150122	17.7867	20.7540	22.2752	20.2587
150123	14.0508	16.2898	15.5997	15.3438
150124	15.9487	16.2104	17.9062	16.6729
150125	21.3311	22.0299	23.1464	22.1849
150126	20.6857	24.0000	24.1917	22.8979
150127	17.0052	18.0532	*	17.5279
150128	19.5576	20.4742	20.9869	20.3528
150129	28.6211	29.9888	34.3166	30.8814
150130	18.4846	18.3852	18.5578	18.4750
150132	20.9443	21.2747	22.2707	21.4967
150133	18.4250	20.0320	21.8807	20.1148
150134	19.3632	20.2764	20.7680	20.1127
150136	21.8097	22.9091	25.8467	23.5584
150146	19.0204	*	25.1827	22.2199
150148	*	*	26.2190	26.2188
160001	19.0085	20.1699	22.8425	20.6574

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
160002	16.6003	17.6600	19.9607	18.0502
160003	16.2208	17.5429	17.5050	17.1062
160005	17.9405	19.3348	20.3313	19.1990
160007	15.1738	14.9137	*	15.0384
160008	16.6193	16.7863	17.9463	17.1044
160009	17.9886	19.0664	*	18.5265
160012	16.7112	17.9236	*	17.3007
160013	18.6304	20.3023	21.0541	20.0165
160014	16.7146	18.7253	18.3097	17.9036
160016	19.9747	21.6050	21.8400	21.1711
160018	15.6141	16.0793	*	15.8463
160020	15.5384	15.7960	16.6092	15.9961
160021	16.7617	16.7920	*	16.7772
160023	15.0099	15.3854	*	15.1953
160024	19.4764	20.5622	22.4256	20.7981
160026	19.5260	20.4567	22.8967	20.9474
160027	16.9417	18.2081	*	17.5712
160028	21.0000	22.9000	25.1998	22.9593
160029	21.3457	22.2106	23.7268	22.4567
160030	19.6182	21.6899	23.3687	21.5386
160031	16.1267	16.8957	17.8994	16.9687
160032	18.3168	19.2464	20.5024	19.3173
160033	18.8859	20.1916	22.2660	20.4096
160034	16.5957	17.3644	19.0684	17.6441
160035	16.3991	17.0165	*	16.6797
160036	17.4558	20.2598	*	18.9565
160037	19.5045	19.5067	*	19.5056
160039	17.8647	19.1998	19.8851	19.0101
160040	18.0667	19.6339	20.0567	19.2064
160041	17.4435	18.7943	*	18.1971
160043	14.8564	16.7841	15.5765	15.7233
160044	17.8323	19.5552	19.0956	18.8738
160045	20.0611	21.4757	22.1285	21.2575
160046	16.2737	16.8665	*	16.5694
160047	19.0787	20.4259	22.1550	20.6216
160048	15.6856	17.2709	18.1174	16.9461
160049	15.5673	15.3233	*	15.4375
160050	17.7878	21.1184	21.6247	20.1164
160051	16.4261	15.8213	*	16.1223
160052	21.7647	22.1933	*	21.9810
160054	16.1981	16.5258	*	16.3650
160055	15.1674	17.6177	*	16.3808
160056	17.0172	17.9534	*	17.4726
160057	19.1378	19.6802	20.8345	19.9113
160058	22.1061	22.2812	23.5663	22.6513
160060	17.2825	17.7489	*	17.5106
160061	17.0938	17.2064	*	17.1526
160062	17.4388	18.8163	*	18.1382
160063	16.3583	17.3771	*	16.8751
160064	22.2131	25.2962	23.8367	23.7172
160065	17.1043	17.0609	*	17.0808
160066	17.9971	19.3202	20.4609	19.2300
160067	16.7833	17.6602	19.9422	17.9572
160068	19.0572	20.5995	*	19.8512
160069	19.1640	20.5989	21.7197	20.4818
160070	18.4588	17.7855	*	18.1126
160072	14.4141	15.3384	15.8236	15.1936
160073	11.4997	15.5946	*	13.3036
160074	17.9513	18.4624	22.2989	19.4707
160075	18.4613	20.7842	*	19.5562
160076	17.8824	19.1590	20.1603	19.0456
160077	13.6658	15.0468	*	14.3610
160079	18.6333	20.5010	21.6562	20.2670
160080	19.4925	19.6680	21.1713	20.1081

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
160081	17.4466	19.1442	20.4415	18.9934
160082	19.5322	20.7306	21.6230	20.6308
160083	19.7542	21.3221	23.4670	21.4372
160085	21.2557	19.1929	*	20.1491
160086	17.5308	19.0477	*	18.2672
160088	22.3655	23.8098	*	23.1166
160089	17.3449	18.3526	19.9688	18.5909
160090	17.9614	18.4210	19.6767	18.6779
160091	14.2573	14.8904	16.1660	15.1176
160092	17.0633	17.9251	20.4731	18.4608
160093	18.5675	19.5732	22.8552	20.0542
160094	17.6094	18.7835	*	18.1925
160095	15.2722	16.4927	*	15.8700
160097	16.6790	17.7860	*	17.2349
160098	16.8670	16.8997	*	16.8833
160099	15.0880	16.0710	*	15.5905
160101	18.9788	19.6314	22.1741	20.2613
160102	20.1161	14.4837	*	17.0012
160103	18.2741	19.6168	*	18.9247
160104	17.4829	21.0060	23.2832	20.6810
160106	17.3474	19.4385	19.8906	18.8668
160107	18.0097	18.8936	19.5110	18.7905
160108	16.7779	17.7577	*	17.2637
160109	17.9873	18.2938	*	18.1453
160110	20.6215	20.9959	21.9299	21.2145
160111	14.9965	15.1104	*	15.0564
160112	17.2450	19.6950	20.4038	19.1223
160113	15.4834	14.9449	16.7574	15.7259
160114	16.5006	18.0532	19.1743	17.9155
160115	16.5654	16.9991	17.6815	17.0701
160116	16.6993	18.4261	19.6923	18.2708
160117	18.7615	20.1682	22.3228	20.3906
160118	19.4472	17.1480	16.9466	17.7185
160120	15.6789	15.0577	*	15.3496
160122	18.1469	18.8469	21.2843	19.4799
160124	19.1600	19.9144	21.2279	20.1448
160126	19.4903	17.8643	20.0149	19.0751
160129	17.2112	18.0113	*	17.6110
160130	15.6666	16.2628	*	15.9651
160131	16.0424	16.5397	18.0485	16.8699
160134	15.3012	14.6396	*	14.9483
160135	18.7711	18.3973	*	18.6129
160138	17.1491	18.3957	*	17.7222
160140	18.5630	19.6155	22.1666	20.1522
160142	18.1467	17.2792	*	17.6980
160143	17.4497	18.1287	19.0623	18.2106
160145	16.9092	17.8887	*	17.3945
160146	17.7010	19.0576	20.6638	19.0955
160147	19.4041	21.6062	22.7993	21.2446
160151	17.2177	18.3398	*	17.7679
160152	15.9500	17.0750	*	16.5042
160153	21.2085	22.7004	23.5212	22.4610
170001	17.9218	18.5120	19.8150	18.7852
170004	16.1442	17.2262	*	16.6775
170006	17.5982	19.1982	19.4488	18.7531
170008	16.8412	17.7061	18.2351	17.6303
170009	23.1349	25.0508	25.8246	24.6993
170010	19.4584	19.5990	20.6294	19.9051
170012	18.4432	20.2412	21.8587	20.2179
170013	19.4667	20.1852	21.4954	20.4080
170014	18.4931	19.6044	21.3416	19.7473
170015	17.1302	17.2443	18.0485	17.4844
170016	20.0675	22.1023	22.9479	21.7131
170017	19.5994	19.7908	21.6323	20.3473

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
170018	15.3237	14.8794	16.9170	15.7229
170019	16.9362	17.4699	18.7916	17.7083
170020	18.1325	19.1418	20.6658	9.3514
170022	19.1888	20.3269	21.1947	20.2097
170023	19.2441	19.6533	21.6273	20.2090
170024	14.3604	15.0081	16.1196	15.1666
170025	18.7182	19.1720	19.2124	19.0231
170026	14.8974	16.9094	17.0837	16.3226
170027	17.8690	18.4466	20.7776	19.0432
170030	15.9282	12.9413	*	14.2743
170031	14.2151	16.4660	*	15.2706
170032	16.3449	15.2207	*	15.7798
170033	19.1952	20.4533	20.0627	19.9270
170034	16.9586	17.8239	18.1073	17.6353
170035	17.0945	19.8334	*	18.4676
170038	13.8582	15.2505	*	14.5672
170039	17.0774	18.5780	18.4473	18.0348
170040	21.0617	23.1014	24.5234	22.7728
170041	12.4488	9.9263	13.9710	11.9108
170044	17.3254	*	*	17.3256
170045	25.8331	20.5454	*	22.7910
170049	20.7921	21.2917	22.9404	21.7361
170051	16.4851	16.9003	*	16.6903
170052	15.2283	16.0948	15.8809	15.7508
170053	14.6133	14.3628	*	14.4847
170054	14.6354	15.2814	18.5239	16.1318
170055	18.2607	18.1783	*	18.2208
170056	18.3550	19.7369	17.1872	18.5237
170058	19.5415	20.1090	23.0649	20.9522
170060	18.9853	17.5290	*	18.2470
170061	15.0258	15.6412	*	15.3202
170063	14.1185	13.7611	*	13.9331
170066	16.2891	16.8009	*	16.5466
170067	14.9921	20.7945	*	17.6559
170068	17.0022	19.2629	20.5512	18.8725
170070	14.0627	14.8348	15.0540	14.6220
170072	12.7709	*	*	12.7710
170073	17.7056	17.7586	*	17.7331
170074	17.3699	17.6543	18.5446	17.8791
170075	13.6816	14.4939	15.6809	14.6514
170076	14.6109	14.9392	*	14.7742
170077	13.9104	14.1376	14.6378	14.2439
170079	11.5902	16.7227	*	13.7740
170080	14.8293	13.6794	15.0079	14.4977
170081	14.6823	15.0840	*	14.8705
170082	13.7462	14.8154	15.9973	14.8264
170084	13.0519	13.6517	*	13.3503
170085	17.5422	21.8907	17.2585	18.9901
170086	19.7182	20.7298	22.1067	20.8528
170088	13.4860	*	*	13.4860
170089	15.4860	20.2263	*	18.1131
170090	10.9444	23.6837	16.3550	15.3916
170093	14.0276	14.7803	15.0308	14.6148
170094	21.2035	21.2484	20.1253	20.9151
170095	15.3532	16.1078	*	15.7358
170097	17.7540	18.6023	18.9865	18.4524
170098	16.6210	17.3480	18.6676	17.5026
170099	14.3370	16.5247	15.8118	15.5495
170101	18.0143	17.3381	17.9291	17.7556
170102	14.2447	14.4499	*	14.3487
170103	17.9530	18.6172	20.1264	18.9371
170104	21.0049	22.0671	23.6589	22.2552
170105	16.7403	18.2788	18.3824	17.8166
170106	17.7467	*	*	17.7468

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
170109	16.9782	18.3483	20.7581	18.8210
170110	18.5731	21.0637	16.5883	18.8196
170112	15.4049	15.8097	*	15.6012
170113	14.6486	16.4938	19.9957	16.7158
170114	16.2645	13.9726	17.4687	15.7793
170115	12.9216	13.0253	*	12.9743
170116	18.1830	19.4278	20.8800	19.4962
170117	16.8237	16.8301	*	16.8270
170119	15.2708	15.1982	*	15.2357
170120	17.4917	18.2832	18.5895	18.1013
170122	21.1769	21.4588	22.2681	21.6171
170123	23.6534	25.2122	25.0073	24.6043
170124	15.0596	16.3925	*	15.7353
170126	13.5736	14.5527	*	14.0496
170128	14.1676	17.6259	*	15.6677
170133	18.8119	19.9778	20.0593	19.6138
170134	14.6799	15.1932	*	14.9285
170137	19.3118	19.3344	21.4394	20.0379
170139	14.3001	14.8157	*	14.5522
170142	17.7134	19.0547	19.8269	18.8721
170143	16.0415	16.3258	18.0308	16.8248
170144	20.4392	20.8488	23.9179	21.2803
170145	19.0142	20.1494	20.5143	19.9005
170146	21.7919	25.2520	27.0312	24.7198
170147	17.6717	18.4634	18.2480	18.1292
170148	19.1942	24.4828	26.3491	22.6386
170150	15.9072	14.9718	16.3723	15.7462
170151	14.3668	14.5002	15.7242	14.8570
170152	15.6423	16.0930	*	15.8733
170160	14.4732	17.0629	*	15.6980
170164	17.4072	17.0791	*	17.2470
170166	12.7507	16.5113	17.8131	15.5313
170171	13.1792	14.7051	14.7251	14.2074
170175	20.1907	20.8671	22.5605	21.1305
170176	23.5043	23.5743	25.5404	24.2059
170180	8.6352	*	25.0933	14.1579
170182	21.3454	21.9797	23.2115	22.1999
170183	19.5182	16.6577	19.6919	18.5350
170185	*	26.8136	26.8307	26.8217
170186	*	33.2457	28.5602	30.5574
170187	*	*	20.8289	20.8289
170188	*	*	25.2504	25.2504
170189	*	*	28.1999	28.1996
180001	20.4885	20.8169	22.2674	21.1866
180002	17.5798	19.8195	20.5135	19.2747
180004	17.7149	18.0494	19.8552	18.5287
180005	22.4634	23.4941	22.6704	22.8061
180006	10.3400	11.2872	14.4066	11.8905
180007	17.9491	18.6823	21.3545	19.3281
180009	21.0608	21.7746	22.4450	21.7873
180010	19.6311	19.4210	22.6846	20.6134
180011	19.0526	22.6798	18.8056	20.1971
180012	19.0646	19.6614	20.2758	19.6759
180013	19.7418	20.0950	21.0512	20.3043
180014	21.3361	23.0067	*	22.1047
180016	21.1458	19.7242	20.5203	20.4674
180017	15.6583	16.7649	18.0329	16.8060
180018	15.4892	18.1529	17.5670	17.0578
180019	17.8285	19.5953	20.8416	19.3979
180020	18.0111	19.4391	20.9964	19.4334
180021	17.0618	16.5376	17.6330	17.0802
180023	17.4717	19.0574	*	18.2571
180024	16.5040	19.6313	22.3922	19.4653
180025	15.4180	17.1875	18.3306	16.9977

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
180026	15.0118	13.9959	15.5354	14.8403
180027	17.5286	19.6928	20.5017	19.2757
180028	15.7005	26.2220	20.6324	19.9445
180029	17.7248	20.0841	20.4262	19.4335
180030	17.9543	17.5043	*	17.7176
180031	13.1848	17.1003	*	14.6814
180032	17.2784	17.2362	*	17.2589
180033	15.4131	17.0498	*	16.2281
180034	16.3991	17.0349	*	16.7087
180035	21.3666	22.4651	24.3874	22.7541
180036	20.1860	20.6951	22.2389	21.0630
180037	21.2184	21.0177	22.7893	21.7251
180038	18.5923	19.3837	20.6888	19.5760
180040	21.2229	22.2270	23.2341	22.2487
180041	16.3699	17.5950	19.1325	17.6429
180042	17.1519	15.5660	*	16.2972
180043	14.6526	17.2414	20.6499	17.2898
180044	19.4984	21.1057	21.8163	20.8254
180045	20.8455	20.7498	22.1027	21.2441
180046	21.2080	21.6955	23.1139	22.0204
180047	18.6938	17.8625	17.8574	18.1198
180048	17.7816	18.3151	20.0114	18.6877
180049	16.5459	17.8418	18.5188	17.6210
180050	17.1493	19.4992	19.9082	18.8700
180051	17.5441	18.3028	18.8186	18.2489
180053	15.8994	17.3167	17.6239	16.9255
180054	20.0946	17.4354	19.1340	18.8876
180055	15.8422	16.6072	17.8704	16.7352
180056	17.5881	18.7038	19.4072	18.5962
180058	14.5355	14.8840	*	14.7232
180059	14.7032	17.2542	*	15.8589
180063	12.4448	14.7338	15.5077	14.2770
180064	15.5066	16.3894	21.1067	17.5598
180065	11.1934	11.0966	*	11.1508
180066	19.8956	20.7907	21.1883	20.6121
180067	20.1712	20.2762	22.0056	20.7541
180069	16.2916	19.0836	20.3982	18.5550
180070	15.9362	15.4643	16.9892	16.1274
180072	17.2347	17.0576	17.5411	17.2563
180078	21.7116	23.7765	23.4616	23.0019
180079	15.9048	18.1683	18.0472	17.3416
180080	16.6428	17.6735	18.9582	17.7773
180087	15.6089	16.2378	16.4726	16.1124
180088	22.1774	22.8908	23.7217	23.0858
180092	18.3597	18.8964	19.6790	18.9885
180093	17.8492	17.7592	18.8469	18.1473
180094	13.6233	14.3306	15.7641	14.5357
180095	13.9050	15.4478	15.9881	15.0485
180099	13.2991	14.0464	14.0115	13.7738
180101	*	21.0704	22.4094	21.7406
180102	18.5240	18.8169	20.1885	19.1448
180103	20.3490	20.9598	21.3867	20.8948
180104	19.3922	20.2731	21.3866	20.3724
180105	16.6997	18.2976	18.3521	17.7554
180106	15.2895	15.5278	15.4937	15.4371
180108	14.4740	14.8720	16.7327	15.3846
180115	16.9096	18.0951	19.2396	18.0795
180116	18.6077	19.2389	20.5453	19.4231
180117	23.0192	20.7961	17.7885	20.4030
180118	16.9250	17.9017	*	17.4046
180120	15.3115	16.4226	20.4507	17.0636
180121	20.0494	16.9570	16.9881	17.9386
180122	18.1930	18.7549	*	18.4837
180123	21.1067	21.5962	*	21.3452

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
180124	18.8487	19.7138	20.5369	19.6944
180125	14.9314	22.6609	*	17.5824
180126	14.3551	14.8501	14.5644	14.5905
180127	17.6365	18.0498	20.0059	18.6352
180128	18.2817	18.7194	19.8502	18.9725
180129	22.3536	15.6637	14.1861	16.9914
180130	20.6450	21.9413	23.4982	22.0567
180132	19.5884	19.8393	19.9358	19.7903
180133	21.7800	23.2679	*	22.4729
180134	14.5387	16.5901	*	15.5000
180138	20.2102	19.8524	23.0996	21.0830
180139	20.5350	20.3816	20.6287	20.5179
180140	15.2719	14.6466	*	14.9413
180141	23.8930	20.3404	22.6722	22.1534
180142	20.7510	*	*	20.7510
180143	*	21.3197	20.1309	20.7446
190001	18.1514	18.8583	20.4946	19.2128
190002	19.8834	20.6057	20.7172	20.4121
190003	19.9121	19.5115	20.7504	20.0615
190004	18.3620	19.6755	20.5272	19.5326
190005	17.5161	19.0994	20.0551	18.8486
190006	17.5911	17.7333	18.8115	18.0279
190007	14.4720	16.3633	17.9392	16.3508
190008	19.2456	22.4797	20.3278	20.6463
190009	15.9731	16.0395	17.5144	16.4753
190010	16.5020	17.7616	18.1797	17.4941
190011	15.6351	15.7319	15.4699	15.6120
190013	15.5019	16.7770	18.7538	16.9778
190014	17.8015	18.6929	17.0630	17.8584
190015	18.9896	19.7673	20.6167	19.7967
190017	17.5381	19.8449	18.3528	18.5693
190018	11.1898	13.1355	19.2055	14.0443
190019	18.3788	18.7344	20.8193	19.3423
190020	17.6840	18.7252	18.5659	18.3279
190025	16.8686	18.1892	19.9968	18.3102
190026	18.5015	19.0130	19.9229	19.1670
190027	17.4761	18.4070	19.4057	18.4089
190029	19.1967	18.7344	*	18.9666
190034	18.0754	19.2007	16.8439	18.0233
190036	20.0300	21.2960	23.3903	21.5497
190037	19.9878	14.1323	15.6062	16.9453
190039	19.0376	18.7625	20.4900	19.4221
190040	21.7376	23.1819	22.9262	22.6065
190041	17.9535	19.5511	21.9983	19.8665
190043	15.5618	15.5645	15.7333	15.6215
190044	17.4471	17.6788	17.7460	17.6341
190045	21.2853	22.0065	22.8709	22.1191
190046	20.4458	20.2414	21.1019	20.5823
190048	16.8136	16.6848	18.1698	17.2383
190049	17.7417	18.5902	19.3768	18.5593
190050	16.2854	16.9053	18.6663	17.3158
190053	13.0080	13.4768	13.8037	13.4554
190054	18.9059	17.7269	19.9370	18.8703
190059	15.8373	17.8651	18.3334	17.3742
190060	17.8443	19.9121	20.2207	19.3688
190064	18.2466	19.7215	21.1262	19.7488
190065	18.3091	18.3280	20.3583	19.0184
190071	16.4138	16.3822	*	16.3974
190077	16.5536	16.8829	17.0480	16.8252
190078	16.9383	19.5879	19.8607	18.8295
190079	17.9403	18.8187	20.5000	19.0592
190081	14.9707	14.7919	11.4756	13.7796
190083	18.4951	16.2970	18.4954	17.7997
190086	16.5074	17.6237	18.2005	17.4309

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
190088	19.9362	20.4725	18.6738	19.7186
190089	15.0395	15.2055	15.5151	15.2626
190090	16.2351	19.8201	19.0519	18.4143
190095	17.3258	17.3637	16.9519	17.2138
190098	21.0847	21.4328	20.7537	21.0874
190099	19.0635	19.0545	23.1606	20.4338
190102	20.7870	21.1614	22.0190	21.3440
190103	14.4158	15.6415	*	15.0851
190106	18.5908	19.9117	20.3114	19.6058
190109	15.8187	16.3641	16.6515	16.2945
190110	15.7313	15.2652	16.5007	15.8208
190111	20.6508	21.3622	24.4380	22.2154
190112	22.0741	24.2806	*	23.0835
190113	*	19.0411	*	19.0411
190114	13.9209	13.5044	13.6101	13.6758
190115	22.7583	24.0098	25.4984	24.0286
190116	17.3757	18.3223	17.8297	17.8503
190118	16.3776	17.8543	17.5060	17.2223
190120	17.2309	17.6708	*	17.4476
190122	15.3742	16.7189	17.7811	16.6133
190124	20.1206	22.8245	23.3859	22.1043
190125	19.8298	20.1401	21.5692	20.4994
190128	20.8770	21.5869	23.8786	22.1716
190130	14.0379	14.5586	15.2678	14.6311
190131	18.8958	19.7483	21.3154	20.0242
190133	15.1393	15.7834	13.4062	14.7514
190134	12.4507	*	*	12.4507
190135	21.3454	23.0213	24.4908	22.9222
190136	15.1662	15.6286	*	15.3892
190140	14.6829	14.8738	15.4029	14.9883
190142	16.2280	19.0464	*	17.6182
190144	18.4405	18.3513	21.3838	19.3822
190145	16.2505	16.4402	17.4407	16.7345
190146	21.9607	20.9312	22.1502	21.6747
190147	14.7202	15.2732	16.3596	15.4387
190148	15.5338	19.4518	19.3245	17.9652
190149	16.4722	16.5153	18.4197	17.1004
190151	15.5210	16.2783	17.3402	16.3739
190152	22.0319	22.7142	25.1136	23.3179
190156	16.0442	17.6573	18.0528	17.2654
190158	20.4078	21.6307	23.2361	21.7367
190160	18.4662	19.3139	19.8428	19.2603
190161	15.9280	15.7807	16.5322	16.0786
190162	20.1962	20.9645	20.7350	20.6423
190164	18.2379	19.0473	20.2791	19.2845
190167	17.7611	15.5795	17.2643	16.7861
190170	14.5222	16.2045	*	15.4153
190173	23.0934	*	*	23.0934
190175	20.4580	23.0144	22.7574	22.0818
190176	22.2316	21.7051	25.2536	23.0962
190177	19.7794	20.3679	22.3318	20.8422
190178	12.0372	*	*	12.0373
190182	20.7102	23.1997	23.6016	22.4491
190183	16.0752	16.7402	17.1805	16.6637
190184	19.8436	18.6583	20.6096	19.6762
190185	20.5852	20.7351	29.7870	23.2575
190186	17.4078	16.7272	*	17.0775
190190	15.8985	13.7951	16.2819	15.2413
190191	19.6911	19.7218	21.9141	20.4097
190196	18.6138	19.1961	20.7601	19.5709
190197	20.2082	20.9871	21.6908	21.0235
190199	15.3522	17.8288	19.7776	17.7558
190200	21.6852	22.3510	24.1667	22.7347
190201	19.7421	21.7185	21.4335	20.9991

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
190202	*	22.4701	22.4062	22.4391
190203	21.7931	23.0636	24.9518	23.3496
190204	20.5784	22.9134	26.1231	23.1780
190205	19.3737	18.8750	20.2374	19.4986
190206	21.3307	21.7867	24.2892	22.5212
190207	19.0216	20.7024	21.5325	20.4305
190208	16.9641	17.6834	23.0838	18.5667
190218	19.2992	20.7290	21.6207	20.5593
190231	17.7247	*	*	17.7247
190236	21.1982	22.5796	24.4661	22.8193
190238	20.6799	*	*	20.6799
190239	19.7601	*	*	19.7601
190240	14.3579	16.0658	15.4026	15.3226
190241	*	*	24.2462	24.2462
190242	*	*	18.6672	18.6672
200001	18.2513	19.7903	21.6050	19.8942
200002	22.3035	22.3145	22.0701	22.2222
200003	18.4141	18.5779	*	18.4971
200006	21.0922	18.9818	*	20.0361
200007	18.1681	19.0387	21.0603	19.3368
200008	21.5556	23.2883	25.1116	23.3957
200009	21.4763	23.3090	24.9041	23.2536
200012	19.1047	20.5141	21.8529	20.5012
200013	17.9378	20.3793	22.8909	20.4397
200016	17.1187	16.2939	*	16.7047
200018	17.8675	19.8848	21.1330	19.6434
200019	19.9245	21.1893	23.1114	21.4018
200020	22.3355	24.7433	27.0798	24.8624
200021	20.7361	22.0144	24.9925	22.6569
200023	20.2063	*	*	20.2063
200024	20.8336	21.0633	22.9698	21.5997
200025	20.4165	21.4247	22.9023	21.6004
200026	17.9021	18.1459	19.7172	18.5708
200027	19.4220	20.2100	21.0156	20.2414
200028	18.8763	19.8886	21.2180	20.0108
200031	16.1641	17.7875	18.8262	17.5634
200032	19.4613	20.9148	23.0487	21.1916
200033	22.4685	23.6298	25.1723	23.7287
200034	20.4941	21.8266	23.5414	22.0096
200037	20.3015	19.5004	22.6534	20.7355
200038	21.2632	22.9220	*	22.0751
200039	20.1508	21.5695	22.1333	21.2851
200040	18.9580	20.7744	21.8528	20.5334
200041	18.8131	20.2986	21.3816	20.1961
200043	19.4295	20.0280	*	19.7244
200050	20.2014	23.0314	23.4391	22.2180
200051	22.0712	*	*	22.0712
200052	17.6271	18.9290	19.0536	18.5591
200055	18.5983	19.4998	*	19.0402
200062	18.4279	18.0949	*	18.2587
200063	21.2121	22.5265	23.0135	22.2678
200066	17.0570	18.4281	19.5890	18.3751
210001	18.6617	21.5280	22.6614	20.9120
210002	23.5132	26.5907	25.6975	24.9889
210003	26.0447	22.3090	23.0790	23.7255
210004	24.9760	27.2278	29.4841	27.2832
210005	21.3829	22.5304	24.7185	22.9229
210006	19.3682	20.8607	24.7327	21.6597
210007	23.8840	23.4582	27.5104	24.9372
210008	21.2895	21.0767	24.6569	22.4641
210009	20.7479	20.8476	23.4889	21.7419
210010	19.5908	20.4097	23.7761	21.2714
210011	21.4043	20.4017	22.3262	21.3567
210012	21.3977	24.8430	25.2892	23.7249

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
210013	19.4505	23.1649	23.0151	21.9197
210015	18.7448	23.9651	23.8419	22.0261
210016	26.5193	24.7441	27.2632	26.1662
210017	18.5079	18.2963	19.0248	18.6083
210018	22.8553	23.6442	25.3112	23.9214
210019	20.6025	21.5429	23.5259	21.9407
210022	24.5744	25.6728	27.6680	25.9838
210023	22.9989	24.4815	26.7837	24.7914
210024	24.4280	24.7858	24.8939	24.7076
210025	21.2769	21.4910	22.8882	21.8653
210026	13.8668	20.7986	*	16.5220
210027	17.1060	16.2219	19.3517	17.5295
210028	19.4157	20.4027	22.4054	20.7783
210029	25.4939	24.7605	26.2082	25.5405
210030	20.9574	21.9547	20.7801	21.2193
210032	20.1955	20.0825	20.3407	20.2132
210033	23.7588	22.8303	25.0300	23.8986
210034	19.4144	22.6812	22.8827	21.5075
210035	20.8317	21.6662	21.6973	21.4040
210037	20.5528	21.1659	23.5536	21.8146
210038	24.9762	25.9701	26.5696	25.8902
210039	21.3559	23.3583	24.0987	22.9560
210040	23.4252	23.7067	25.4729	24.1964
210043	22.4000	22.9504	22.2177	22.5015
210044	23.0917	22.9540	23.8101	23.2851
210045	12.1467	13.5654	11.8350	12.5334
210048	24.6921	24.9381	24.4328	24.6715
210049	19.3022	21.1056	24.7148	21.8854
210051	23.6476	24.8949	25.7103	24.7772
210054	23.2730	25.1694	27.3551	25.2404
210055	26.5272	23.8025	27.4218	25.8633
210056	22.9593	22.6958	23.5881	23.1051
210057	26.0076	25.6142	27.3520	26.3322
210058	16.3191	17.4250	22.0351	18.6822
210059	25.6052	*	*	25.6053
210060	26.5846	26.4566	25.8377	26.3021
210061	16.1931	20.8975	22.5454	20.0819
220001	22.9064	23.4091	25.8030	24.0472
220002	24.5840	25.4158	26.3348	25.4205
220003	17.9319	17.6069	18.8150	18.0852
220006	22.6337	23.8920	27.1576	24.5485
220008	22.0796	24.2393	25.6647	24.0447
220010	22.0067	23.4009	24.5021	23.3133
220011	29.5290	20.6390	32.2266	26.8387
220012	31.2303	31.1041	32.0521	31.4899
220015	23.1893	24.1348	25.0272	24.1474
220016	23.0951	24.6149	25.7740	24.4672
220017	25.1568	25.9000	28.9024	26.5392
220019	19.8551	19.9268	21.6620	20.5000
220020	22.4295	22.5375	23.5737	22.8711
220024	21.9316	23.8620	24.1071	23.3004
220025	22.8593	22.0003	23.2374	22.6994
220028	21.0630	24.1251	31.4858	25.0402
220029	25.6560	25.7660	27.4792	26.3128
220030	18.7429	18.9012	20.0816	19.2486
220031	29.3091	28.3832	30.8324	29.5603
220033	20.3609	21.8156	25.4500	22.4846
220035	23.1892	25.7456	26.8486	25.2168
220036	24.4091	25.5771	28.2182	25.9570
220038	22.3162	22.9821	*	22.6423
220041	27.5034	28.6790	28.8184	28.3414
220042	26.0473	28.4675	*	27.2387
220046	23.3149	24.1931	26.1955	24.5514
220049	27.2689	25.4358	26.7688	26.4669

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
220050	22.5265	23.3330	23.7326	23.2036
220051	21.7357	22.4826	22.2965	22.1608
220052	23.5225	25.4091	26.3043	25.1274
220057	25.8064	26.2945	*	26.0375
220058	26.8345	21.6814	22.4885	23.6768
220060	28.0794	28.3950	29.6960	28.7409
220062	20.2254	22.5567	22.6598	21.8448
220063	20.8079	21.8365	23.3704	22.0573
220064	22.7497	24.0982	*	23.3816
220065	20.1424	21.5657	22.4143	21.3853
220066	23.4477	24.5463	27.5575	25.2252
220067	27.5405	28.2685	22.4968	25.8119
220070	20.9128	23.9850	26.2697	24.8446
220071	27.4151	27.7679	27.7773	27.6608
220073	26.1328	27.4778	27.9309	27.1753
220074	24.3057	25.3331	25.7840	25.1801
220075	22.5329	24.6982	26.0527	24.4363
220076	23.2795	24.1224	24.8040	24.0785
220077	26.1545	27.1503	26.7020	26.6704
220079	22.0769	25.7305	*	23.1834
220080	22.1971	22.9911	24.7399	23.3385
220081	29.6682	31.1326	*	30.4202
220082	22.1453	23.2818	23.9542	23.1292
220083	22.5815	27.2605	28.3533	25.8389
220084	25.3761	26.0395	26.8596	26.1410
220086	26.7778	28.7324	29.4911	28.2821
220088	23.4258	25.0671	26.5849	25.0216
220089	25.4106	25.3521	28.9252	26.5987
220090	23.3049	26.0265	26.5552	25.3702
220092	24.7905	29.4173	*	26.0747
220095	21.7851	22.6828	23.7629	22.7845
220098	23.1547	24.7180	26.2287	24.7066
220100	27.5841	26.8001	27.0265	27.1375
220101	27.0711	28.0856	26.9992	27.3742
220104	28.7258	*	*	28.7258
220105	21.9185	25.5692	26.7570	24.9300
220106	25.9277	27.6812	*	26.8476
220108	23.4975	24.5939	26.0166	24.7052
220110	29.1648	30.6173	33.0445	30.9588
220111	24.7510	26.7573	27.7395	26.3905
220116	32.0049	28.5716	30.9871	30.4812
220119	23.8785	24.6344	25.9789	24.8166
220123	32.4678	29.6084	*	31.0767
220126	23.6045	23.8123	26.9853	24.8811
220133	29.3911	29.8366	33.0819	30.7739
220135	28.3648	29.6837	31.9159	30.1085
220154	21.1563	23.3590	25.6070	23.4930
220163	29.2299	29.3552	29.9312	29.6034
220171	24.9261	27.3487	27.2647	26.5898
230001	20.0438	23.3051	22.0875	21.7854
230002	23.0439	24.3115	23.7972	23.6903
230003	21.2215	21.6493	22.4322	21.7672
230004	20.5005	22.4538	23.0827	21.9931
230005	17.0943	20.5596	20.3750	19.2300
230006	20.4978	20.6985	22.0733	21.1112
230013	22.2211	20.0954	20.4633	20.9362
230015	20.6464	21.9499	21.7640	21.4230
230017	22.9755	25.7900	26.1609	24.9780
230019	23.6674	23.8779	24.7472	24.1266
230020	21.8526	28.8869	25.8267	25.0794
230021	19.8256	20.9145	22.0757	20.9148
230022	21.9129	21.8808	22.2179	22.0038
230024	24.9664	26.2155	24.7364	25.2298
230027	19.6393	22.5114	21.2223	21.0886

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
230029	22.1782	24.9754	26.7646	24.5358
230030	18.6406	19.2441	19.9853	19.3164
230031	19.9465	19.4676	22.1874	20.5558
230032	24.8930	22.8436	23.8366	23.8513
230034	19.4366	17.9276	18.5767	18.6094
230035	17.7490	20.5906	18.0735	18.7098
230036	23.8398	25.1507	25.9801	25.0254
230037	23.2751	22.7382	24.4115	23.4697
230038	21.9692	20.9389	23.4685	22.1152
230040	20.7841	20.2451	21.8062	20.9418
230041	21.7364	23.2870	24.2297	23.0470
230042	21.3870	20.7745	21.8240	21.3299
230046	25.3206	26.1787	28.2320	26.5218
230047	22.3595	23.7178	24.3622	23.4689
230053	26.8917	23.5702	26.1415	25.5713
230054	20.8014	22.2105	23.0818	21.9613
230055	20.8492	20.8930	20.9350	20.8938
230056	17.8091	17.3516	*	17.5708
230058	21.0303	21.6619	22.4516	21.7265
230059	20.7092	20.6540	21.2743	20.8742
230060	19.8987	20.5120	22.3513	20.9455
230062	18.8039	18.2283	*	18.4950
230065	22.7416	23.3414	26.3217	24.0577
230066	23.0475	23.2790	23.9696	23.4290
230069	24.2470	25.0212	26.0438	25.1015
230070	21.5666	21.2476	22.8588	21.8801
230071	23.1337	23.6398	23.6674	23.4732
230072	20.4456	22.6533	22.9626	22.0164
230075	22.5866	22.3632	22.6799	22.5400
230076	24.7010	26.9662	*	25.7305
230077	20.2823	22.6781	29.2041	23.7945
230078	17.9868	19.1638	20.5427	19.2537
230080	20.2104	19.1810	20.2405	19.8736
230081	19.0199	20.0464	20.4289	19.7958
230082	19.0419	18.2165	21.3101	19.3810
230085	23.4996	24.5765	24.2802	24.1339
230086	20.1730	20.1461	27.8923	22.4120
230087	19.9700	20.6619	22.2688	20.9389
230089	22.6994	23.1023	23.3847	23.0660
230092	20.7738	22.3437	22.3122	21.8236
230093	20.6314	21.0274	25.1213	22.3453
230095	17.6444	18.0582	19.1810	18.3175
230096	22.7785	24.3004	26.7156	24.6007
230097	21.1254	22.5006	22.9902	22.2246
230099	21.7513	22.3422	23.5490	22.5510
230100	17.3842	18.2477	19.8016	18.4668
230101	20.5315	22.5159	22.3310	21.7559
230103	11.3429	18.5254	19.4434	16.3738
230104	24.1238	25.5606	27.4119	25.7958
230105	22.6098	23.0086	23.9851	23.2114
230106	21.6825	22.9909	23.1961	22.6494
230107	17.1386	18.9985	*	18.1307
230108	20.3437	21.4592	19.9843	20.6199
230110	19.7262	21.0925	21.5523	20.7782
230115	19.6281	21.0361	*	20.3009
230116	14.5692	15.6064	*	15.0755
230117	25.6797	25.5154	28.1220	26.4781
230118	20.6797	20.2770	22.2209	21.0377
230119	22.6555	23.9898	25.3562	24.0351
230120	20.3306	20.6105	22.7243	21.0521
230121	21.3342	21.4615	22.3708	21.7224
230124	18.9981	20.9641	22.0096	20.6756
230128	24.0724	24.4952	*	24.2953
230130	22.1775	23.5123	23.7854	23.1764

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
230132	26.1946	27.3637	29.0292	27.5003
230133	17.1058	19.0770	20.4801	18.9081
230135	20.5637	18.4193	19.8290	19.6840
230141	22.4570	24.4560	23.9885	23.6151
230142	23.5621	25.0282	22.9036	23.7956
230143	16.7948	18.2700	19.5446	18.1583
230144	23.4237	23.3295	23.6959	23.4486
230145	19.2638	17.9811	15.8192	17.6120
230146	21.2260	22.3838	21.3539	21.6475
230147	23.2755	26.5260	*	24.7445
230149	18.8005	19.9577	20.8933	19.8319
230151	23.3967	24.3705	23.8527	23.8745
230153	18.7403	20.0098	22.8584	20.5717
230154	15.4362	16.7152	*	16.0814
230155	20.5409	20.7546	18.0743	19.8594
230156	25.6228	27.2254	27.7164	26.8324
230157	17.3571	*	*	17.3571
230162	21.7148	22.7984	*	22.2573
230165	23.8881	24.7959	25.9534	24.8621
230167	22.9745	24.1344	24.7935	23.9629
230169	24.3874	28.1039	24.9264	25.7012
230171	17.1282	16.1129	19.9097	17.6776
230172	21.4675	22.1709	23.0023	22.2346
230174	22.7304	23.5025	24.4671	23.5848
230175	*	14.4932	22.5965	17.8784
230176	23.8204	24.9032	24.6675	24.4504
230178	17.3030	17.3428	*	17.3243
230180	18.5744	19.6062	20.9832	19.7598
230184	19.7717	20.6406	21.4031	20.6108
230186	15.7837	19.1289	21.6148	18.4668
230188	16.2975	16.8687	18.8076	17.2358
230189	17.9218	19.1990	22.7783	19.9127
230190	26.4687	24.4643	27.3430	26.0988
230191	18.4861	20.6633	*	19.5216
230193	19.8287	21.5358	22.8917	21.3669
230195	22.9228	23.4647	25.3285	23.9218
230197	24.0854	25.5312	26.9840	25.4785
230199	20.6580	22.4592	*	21.5622
230201	18.0787	18.2486	*	18.1632
230204	23.4966	24.5127	24.4095	24.1113
230205	15.9314	18.1551	*	17.0325
230207	21.2483	20.9059	22.2848	21.4738
230208	16.7454	17.8118	20.3171	18.1693
230211	21.8581	21.1245	*	21.4701
230212	24.2611	24.6420	26.0656	24.9839
230213	15.5469	17.1062	*	16.3453
230216	21.0710	22.2137	23.4262	22.2338
230217	22.2698	24.1455	24.3649	23.6068
230219	20.0442	18.1277	*	19.1295
230222	21.9711	23.2545	24.6101	23.2761
230223	22.6887	25.2666	28.5549	25.4631
230227	22.3155	25.8826	27.7510	25.3402
230230	22.3097	22.1703	23.9568	22.8400
230235	17.7197	17.5940	19.9118	18.3853
230236	25.9676	25.3251	25.7463	25.6755
230239	17.8168	18.9790	19.8370	18.8918
230241	20.7297	21.8472	24.2063	22.3226
230244	22.2697	23.1175	23.9004	23.0804
230253	21.0433	22.7706	*	21.8858
230254	22.6335	23.3714	24.2594	23.4070
230257	21.3880	23.1794	24.8070	22.9716
230259	22.3969	23.1768	24.8598	23.5220
230264	17.4864	18.6598	17.4847	17.8541
230269	24.0992	24.3772	25.3368	24.6276

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
230270	22.5985	25.2665	22.8842	23.5619
230273	22.8715	24.1278	25.8466	24.2438
230275	20.8985	32.0037	29.4179	26.3638
230276	25.8709	22.3313	23.4929	23.8465
230277	23.9771	24.3351	25.3378	24.5551
230279	17.8074	18.3256	21.2467	19.1913
230280	18.3497	*	*	18.3498
230283	22.5082	*	25.0038	23.8515
230286	*	47.5925	*	47.5929
230287	*	22.5420	*	22.5420
230288	*	*	30.3423	30.3422
240001	25.6936	26.6372	28.2239	26.9164
240002	23.2307	24.2214	24.7674	24.0905
240004	24.4030	25.6238	26.8197	25.6037
240005	20.3193	20.2389	*	20.2771
240006	23.0715	25.7288	29.5789	26.1049
240007	19.0850	20.7189	21.4367	20.4240
240008	23.3783	22.7437	*	23.0360
240009	17.1187	17.4518	*	17.2880
240010	25.4752	28.3796	29.0955	27.6985
240011	21.5875	22.5188	24.0365	22.7468
240013	21.7544	25.1560	27.3855	24.7029
240014	24.2610	25.2306	26.5144	25.3969
240016	22.2011	23.3772	25.2629	23.6323
240017	18.9272	19.3431	21.6243	19.9559
240018	18.4268	23.6092	27.3634	22.7452
240019	23.1477	24.0613	25.1331	24.1004
240020	20.8849	20.6819	24.7516	21.9956
240021	20.1457	19.0469	23.9570	20.9424
240022	21.3234	23.0394	23.4702	22.5966
240023	22.8224	22.3002	*	22.5542
240025	20.0308	20.7672	21.2597	20.6915
240027	16.7758	18.3837	18.3340	17.8317
240028	25.1934	*	*	25.1933
240029	20.0164	23.0440	21.2343	21.3892
240030	20.1653	20.9799	22.0200	21.0838
240031	19.3983	21.7620	23.4390	21.5566
240036	22.1721	22.5436	23.4857	22.7589
240037	20.1195	21.4275	21.8392	21.1496
240038	24.3957	26.4513	28.9676	26.5881
240040	23.1352	22.8191	21.3870	22.2562
240041	21.8655	21.9054	*	21.8860
240043	16.9859	18.0186	19.5532	18.2400
240044	20.3339	22.5750	22.7482	21.8790
240045	24.1557	24.2936	25.9223	24.7977
240047	23.8098	25.3233	29.6184	26.0294
240050	21.6499	23.1109	24.7589	23.1788
240051	22.5855	23.2612	*	22.9217
240052	*	22.3485	23.5899	22.9828
240053	23.8693	24.4191	26.7122	25.0197
240056	23.7139	24.8549	28.5169	25.8728
240057	24.8686	25.3984	27.7600	26.0195
240058	18.4009	19.0506	*	18.6980
240059	23.7808	25.3847	27.0517	25.4242
240061	25.9951	27.9151	28.7372	27.5834
240063	24.4031	25.8594	26.7960	25.7034
240064	22.8578	24.6785	24.9928	24.2158
240065	14.8734	14.4623	*	14.6647
240066	24.1143	25.5163	27.4066	25.7241
240069	21.7991	23.3373	25.6943	23.6461
240071	21.2463	22.6332	24.8036	22.9056
240072	20.9529	21.5455	*	21.2512
240073	17.3559	17.9013	*	17.6278
240075	21.3357	21.9160	24.4084	22.5903

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
240076	22.3280	23.6159	26.7112	24.3211
240077	20.3445	22.1509	18.9735	20.4406
240078	25.1082	26.2576	27.5066	26.3275
240079	18.8345	18.2929	20.6644	19.2023
240080	25.5619	26.3071	27.8807	26.6115
240082	18.7995	20.2018	*	19.5072
240083	21.0317	22.3484	24.4352	22.5864
240084	21.7421	23.1951	23.9942	22.9738
240085	20.9778	20.7535	*	20.8640
240086	18.1401	18.1497	*	18.1450
240087	21.3323	21.2116	20.1003	20.8883
240088	23.1056	24.6260	25.5587	24.4549
240089	21.1989	21.3949	23.4029	21.9959
240090	19.2166	21.0856	*	20.2006
240093	20.2400	20.7138	22.3968	21.1802
240094	22.0247	22.5923	24.4166	23.1169
240096	21.0417	20.2992	*	20.6594
240097	27.9496	29.7597	34.2812	30.8115
240098	24.2296	23.9626	*	24.0891
240099	15.4964	18.8139	*	17.0132
240100	20.8325	24.1875	24.7500	23.2514
240101	19.9837	22.1329	24.3455	22.2487
240102	16.3659	15.5114	*	15.9578
240103	18.7510	21.0182	20.2325	19.9774
240104	23.5351	25.1139	27.4947	25.4150
240106	23.5005	23.9677	25.5890	24.4099
240107	20.9004	21.2163	24.5581	22.1688
240108	18.2427	17.6500	*	17.9383
240109	16.3216	15.1369	14.5891	15.2649
240110	21.0277	21.7340	*	21.3899
240111	17.8617	19.9712	*	18.9100
240112	16.6244	17.2437	*	16.9303
240114	17.3682	18.3415	*	17.8558
240115	23.8675	24.6529	27.0312	25.2010
240116	18.3520	17.3460	*	17.8140
240117	17.9941	18.6677	20.1436	18.9763
240119	21.8289	23.0230	*	22.4209
240121	22.2266	22.4858	24.5455	23.1566
240122	21.2876	20.7795	23.5331	21.8695
240123	18.3941	18.9494	20.0721	19.1239
240124	20.4728	21.2023	23.5138	21.7551
240125	14.9708	17.3846	*	16.1716
240127	17.9724	16.4294	19.3859	17.7982
240128	16.3608	17.5611	20.1960	17.9593
240129	16.5209	17.7242	*	17.1253
240130	16.4271	17.7634	*	17.0885
240132	23.1452	24.5633	26.7063	24.8516
240133	19.5293	20.8958	23.6068	21.3584
240135	15.7015	15.6298	17.8575	16.3349
240137	21.5073	21.6644	23.1752	22.1872
240138	16.7332	19.1676	*	17.8651
240139	20.5496	21.0163	22.4472	21.2707
240141	23.1009	23.6498	25.1597	24.0447
240142	29.2238	24.0719	*	26.3951
240143	20.4266	20.7307	18.9442	20.0050
240144	21.4469	23.1661	*	22.2972
240145	19.0689	17.6747	22.6062	19.4589
240146	16.5412	17.3275	*	16.9537
240148	19.5204	19.5372	*	19.5281
240150	20.8331	23.3857	*	21.8697
240152	22.4744	24.1818	25.4031	24.1733
240153	19.3336	18.6556	*	18.9785
240154	21.5052	21.5859	21.3809	21.4857
240155	20.9385	23.6944	*	22.3046

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
240157	13.7309	20.0571	*	16.8744
240160	15.9014	16.4990	*	16.1985
240161	16.8809	18.0542	*	17.5023
240162	19.1542	19.3296	20.4807	19.6719
240163	20.4760	22.2009	*	21.3326
240166	19.4131	19.4496	21.5002	20.1541
240169	16.3958	*	*	16.3959
240170	20.3779	21.5994	*	20.9960
240171	18.5172	19.6732	*	19.0959
240172	20.8606	20.3699	*	20.6109
240173	18.5187	18.3183	*	18.4146
240179	20.4004	17.7557	19.8250	19.2836
240184	16.8917	17.6979	*	17.2977
240187	21.2736	23.2471	24.8879	23.1462
240193	18.4664	26.6381	*	22.8029
240196	25.3479	26.2793	27.2901	26.3467
240200	14.9076	18.7517	*	16.6495
240207	25.2814	26.0927	27.4330	26.3128
240210	24.5664	25.6060	26.6545	25.6507
240211	30.6260	34.7849	32.8805	32.7909
240213	*	*	27.5104	27.5104
250001	19.2756	20.2019	20.9338	20.1232
250002	18.6938	19.6081	21.6643	20.0536
250003	16.7570	18.7331	*	17.7556
250004	18.3860	19.2913	20.9295	19.5583
250005	12.5834	13.7341	*	13.1962
250006	17.5192	19.4531	20.3061	19.0833
250007	19.7562	20.9757	21.2226	20.6508
250008	15.8506	15.8096	*	15.8287
250009	17.7283	18.0463	19.7610	18.4932
250010	14.6101	16.0233	17.6204	16.0381
250012	16.7579	17.4032	15.6117	16.4987
250015	11.7249	16.6522	19.3794	15.3452
250017	20.5976	18.8850	19.0435	19.5747
250018	13.1687	14.7291	16.8783	14.8458
250019	18.0956	19.9070	22.9085	20.3396
250020	16.2698	19.6575	19.1877	18.3910
250021	10.5844	12.7242	15.8485	12.9174
250023	12.3434	13.8210	14.7354	13.5480
250024	12.9899	14.8394	*	13.8135
250025	20.3625	21.9075	21.2651	21.1983
250027	14.5445	15.1790	17.5936	15.6987
250029	16.0682	14.8216	*	15.4307
250030	26.6173	25.5089	27.2140	26.4270
250031	18.3825	19.8779	21.0894	20.1840
250032	17.5957	*	*	17.5957
250033	15.0941	16.9132	*	15.9970
250034	17.0399	18.8231	20.3681	18.7749
250035	16.8349	18.3861	17.1071	17.4370
250036	16.1913	17.6247	17.0469	16.9644
250037	12.7156	14.3994	16.6348	14.4707
250038	17.7019	18.8434	16.8610	17.7868
250039	15.1409	16.4502	16.8729	16.1389
250040	18.3364	19.6513	20.8178	19.5733
250042	17.6531	18.3858	19.4367	18.4780
250043	16.6500	18.4025	17.7554	17.5544
250044	16.7321	19.0321	20.3711	18.6909
250045	21.8988	22.7225	25.3236	23.3569
250047	14.7461	16.0109	*	15.2694
250048	17.6649	19.4976	19.3636	18.8723
250049	12.1635	12.8275	13.4396	12.7838
250050	15.1159	16.0234	16.6723	15.9407
250051	10.4900	10.1212	10.5027	10.3736
250057	16.1838	16.6316	19.0571	17.2494

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
250058	15.7197	16.2623	16.5565	16.1875
250059	16.6494	17.9507	19.0733	17.8262
250060	16.1804	12.6893	14.0155	14.2269
250061	11.5108	12.0186	11.4573	11.6591
250063	13.3092	15.0894	*	14.1572
250065	13.6904	15.0507	16.2010	14.9097
250066	16.1742	17.2711	16.1044	16.5014
250067	16.8522	18.3773	20.0430	18.4322
250068	13.4127	13.2644	16.3759	14.2410
250069	16.8980	18.5782	21.2224	18.7343
250071	12.3488	13.1934	13.7056	13.0670
250072	18.9487	21.0602	20.7827	20.1324
250077	13.7404	13.9479	14.0318	13.8984
250078	15.9739	17.4118	17.5186	17.0110
250079	16.5835	16.1483	21.3505	18.0112
250081	19.0358	18.1848	20.4513	19.1805
250082	17.1427	17.3096	19.5962	18.0482
250083	16.6065	16.3054	19.5217	17.6288
250084	20.6429	21.0870	22.4632	21.3407
250085	15.4477	16.7377	18.0473	16.7196
250088	18.2736	19.3976	*	18.8261
250089	14.3027	15.0238	16.0202	15.0666
250093	16.1506	16.8647	17.4413	16.7983
250094	18.5063	18.9681	19.9619	19.1031
250095	17.4217	18.4944	18.6616	18.1868
250096	19.0584	19.3630	20.7246	19.7069
250097	15.5741	16.3328	18.8398	16.9174
250098	18.3874	18.8163	17.9562	18.4324
250099	15.1265	15.9867	18.2504	16.5120
250100	17.8688	19.7559	18.8877	18.8640
250101	17.7194	17.6704	*	17.6984
250102	18.9348	19.8487	21.3213	20.0396
250104	18.7651	19.0165	20.5035	19.4465
250105	15.5133	16.1480	17.0135	16.2367
250107	15.0737	16.5635	16.7104	16.0939
250109	21.3867	24.5760	*	22.9646
250112	16.3640	16.6447	16.8696	16.6208
250117	16.9787	15.9335	18.8863	17.1858
250119	16.1218	16.5700	17.1373	16.5802
250120	16.7182	18.1428	22.9071	18.9423
250122	19.2990	19.8033	19.7966	19.6361
250123	18.7863	22.1376	22.2184	21.1030
250124	13.2490	14.4008	15.6866	14.4505
250125	21.2660	21.9366	25.3415	22.8644
250126	21.9101	19.0168	20.1117	20.3133
250128	16.1418	15.9958	15.8352	15.9898
250131	12.4557	11.2470	11.5396	11.7049
250134	18.5142	21.4489	22.0310	20.5243
250136	21.3497	20.0333	21.9977	21.1329
250138	20.4550	19.3446	21.2490	20.3584
250141	19.6692	21.6835	22.5187	21.4042
250145	11.2120	11.2021	*	11.2080
250146	14.7781	15.4061	16.9341	15.6577
250148	19.4233	23.1459	*	21.1903
250149	15.2318	15.7537	16.4228	15.8106
250150	21.8599	*	*	21.8600
250151	*	*	20.4581	20.4581
260001	20.1560	20.9620	22.6646	21.2406
260002	21.6597	23.4259	24.6812	23.4142
260003	15.4482	16.2023	16.5931	16.0798
260004	13.7035	15.2735	16.4424	15.0947
260005	23.9681	22.5860	25.5927	24.0655
260006	20.0994	22.1692	24.1078	22.0536
260008	16.8893	18.2114	21.6256	18.7442

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
260009	18.2863	19.0654	20.1679	19.1754
260011	19.5059	20.3279	21.1624	20.3470
260012	17.1662	17.3810	17.7853	17.4521
260013	16.1825	17.3772	18.4857	17.3402
260015	17.8817	18.3849	21.7581	19.2237
260017	16.9914	17.9796	20.7837	18.6298
260018	12.5301	13.6120	14.3278	13.5417
260019	*	18.3629	*	18.3629
260020	20.2241	21.0314	22.4709	21.2482
260021	21.6237	23.3527	27.2478	23.9117
260022	17.7772	18.7707	20.5417	18.9739
260023	17.8649	18.5665	19.6324	18.6837
260024	15.7815	15.6095	16.9968	16.1784
260025	17.0965	18.2804	19.3535	18.2493
260027	22.0362	23.1505	22.9973	22.7247
260029	21.1858	20.1832	22.0390	21.1257
260030	11.9215	12.8349	*	12.3857
260031	19.7249	22.5379	24.3626	22.0014
260032	19.6728	20.3847	21.8830	20.6295
260034	20.4902	20.5439	21.6108	20.9281
260035	13.0071	15.1611	15.0468	14.4184
260036	18.8104	20.1242	19.4559	19.4803
260039	14.6644	15.9689	*	15.3281
260040	18.0140	18.5132	20.0422	18.9525
260042	18.7514	20.8821	*	19.9434
260044	15.9206	16.7879	18.2413	17.0028
260047	19.2247	20.2724	22.4585	20.5821
260048	21.0602	22.4800	26.6363	23.4107
260050	16.8520	17.8142	20.8510	18.4171
260052	18.0914	19.1044	21.1297	19.4548
260053	16.5166	17.4110	18.9606	17.6806
260054	20.6242	23.0188	*	21.7799
260055	15.4214	17.9547	*	16.6421
260057	19.7144	16.5704	15.8404	17.4526
260059	17.0546	16.2074	17.2807	16.8654
260061	15.7112	17.1343	18.7280	17.2320
260062	21.3138	22.0091	25.2958	22.8789
260063	18.8973	19.7231	21.1284	19.8962
260064	17.8033	18.3749	17.5188	17.8922
260065	20.0975	20.6671	22.0058	20.9509
260066	15.3460	15.3139	*	15.3302
260067	15.1837	14.5499	14.9791	14.8944
260068	19.4240	20.7947	22.0951	20.7923
260070	13.9510	18.7384	11.2251	14.4396
260073	15.9182	16.9496	17.8184	16.9459
260074	19.8915	20.4033	18.7639	19.6422
260077	19.4482	20.5830	21.9947	20.6796
260078	14.9463	16.0586	16.9217	15.9818
260079	16.1453	16.4816	*	16.3135
260080	14.6832	13.1617	13.6815	13.7659
260081	20.3053	20.2471	22.6627	21.1095
260082	15.9858	18.2853	*	17.1198
260085	20.7051	21.5137	22.7394	21.6591
260086	15.2927	16.7579	17.2049	16.4038
260091	21.5464	22.0772	23.9975	22.5709
260094	18.5395	19.7308	20.1043	19.4945
260095	20.7292	21.6999	22.8156	21.7294
260096	22.5972	22.8259	23.5009	22.9961
260097	19.0632	18.6965	19.6203	19.1454
260100	16.6523	16.5439	*	16.5979
260102	20.6361	21.2133	24.1041	22.0613
260103	19.7146	19.9144	21.6192	20.4243
260104	20.3176	21.6624	22.4769	21.5601
260105	24.8181	22.8005	24.6572	24.0540

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
260107	20.4269	22.5214	23.1564	21.9109
260108	20.0034	20.9029	22.7975	21.3006
260109	14.8181	15.9724	*	15.3919
260110	18.3227	19.5633	22.0026	19.9361
260113	16.2223	16.1346	16.3440	16.2356
260115	17.4698	19.3873	20.4880	19.0630
260116	14.9812	16.0187	16.9807	15.9921
260119	17.2942	18.0725	18.7958	18.0259
260120	16.4904	17.6811	18.7651	17.6553
260122	16.0931	16.3700	16.1637	16.2077
260123	14.6822	15.2926	17.7996	15.9122
260127	18.4026	18.1342	19.7946	18.7879
260128	12.6414	13.2942	*	12.9660
260131	18.4154	18.0395	*	18.2242
260134	17.5127	17.1341	18.4511	17.6303
260137	19.4697	19.5976	20.7638	19.9765
260138	23.2364	23.6502	25.6579	24.1474
260141	19.1893	19.0444	21.0771	19.7195
260142	17.3084	18.2023	18.6412	18.0732
260143	13.9040	15.4688	*	14.6858
260147	14.7769	15.8522	16.1172	15.5706
260148	11.3524	12.6651	*	11.9781
260158	12.7699	13.9790	*	13.3959
260159	19.7951	20.9636	23.1093	21.1490
260160	16.5792	18.4007	18.8723	17.9546
260162	21.4099	20.7331	22.5705	21.6084
260163	15.8593	16.8300	18.1311	16.9540
260164	15.1211	16.3874	16.9403	16.1072
260166	21.1224	22.4071	22.8409	22.1650
260172	16.0772	16.4854	17.1504	16.5822
260173	14.2090	15.5733	*	14.9505
260175	17.5625	18.3632	19.7939	18.5994
260176	21.6044	23.2414	25.7802	23.6435
260177	21.9014	22.9112	24.0550	23.0148
260178	20.2796	20.8189	21.7704	20.9701
260179	22.7185	21.4470	23.2824	22.4725
260180	18.9881	19.5983	21.8585	20.1342
260183	21.3175	23.7057	24.2330	23.0675
260186	19.6026	21.0675	21.6620	20.8448
260188	22.5060	23.7475	*	23.0915
260189	16.4233	*	*	16.4232
260190	19.3419	21.6994	24.5014	21.8167
260191	18.1604	19.6784	21.1331	19.7205
260193	20.2577	22.2030	22.9556	21.8741
260195	19.7068	*	20.0889	19.9145
260197	20.5453	*	*	20.5453
260198	19.7552	21.7926	25.3390	22.1557
260200	20.6888	21.7031	22.3912	21.7042
260207	*	*	18.5247	18.5247
260208	*	*	28.3159	28.3158
270002	19.2387	19.0221	19.7588	19.3381
270003	22.5019	20.7277	23.0396	22.0300
270004	19.4834	20.1821	21.5577	20.5193
270006	17.0715	15.1006	*	15.8776
270007	13.8824	15.5780	*	14.6202
270009	20.8238	20.7031	21.5655	21.0425
270011	21.1653	21.8086	21.4031	21.4583
270012	19.7878	20.7913	21.7634	20.7748
270014	19.9859	20.4321	20.3456	20.2664
270016	18.6149	17.9984	*	18.3149
270017	20.0152	22.1046	23.2320	21.7798
270019	15.4128	18.5111	*	16.8388
270021	16.9457	18.0515	21.1624	18.5631
270023	22.7181	22.7162	23.7486	23.1141

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
270026	18.0568	20.1673	*	19.1571
270027	17.2091	17.2005	*	17.2045
270028	19.1177	19.6212	*	19.3643
270029	17.3710	18.2097	*	17.8047
270032	18.7811	19.3937	20.1801	19.4478
270033	18.4876	20.7060	*	19.5715
270035	16.4302	17.9822	*	17.2166
270036	16.8552	16.1031	18.8787	17.3089
270039	19.6796	20.3800	*	20.0267
270040	20.1242	20.1887	20.7239	20.3415
270041	25.8153	*	*	25.8151
270044	17.5137	19.2939	*	18.3206
270048	18.0666	17.4506	*	17.7260
270049	22.2540	22.0263	22.9524	22.4171
270050	19.9356	19.6317	21.0901	20.2259
270051	20.1950	20.0386	22.2580	20.8285
270052	14.7009	17.1932	*	15.8725
270057	20.6714	20.1507	21.9997	20.9799
270058	16.1412	18.4780	*	17.1845
270059	19.1808	16.9303	*	17.9228
270060	20.4148	21.3776	*	20.7622
270063	15.1049	16.4553	*	15.7723
270073	16.1937	16.6083	*	16.4041
270079	16.7048	19.5493	*	18.0578
270080	15.0705	16.6010	*	15.8020
270081	16.7389	18.0543	15.6834	16.8629
270082	23.1245	23.3209	21.0150	22.5579
270083	17.8554	16.8420	*	17.3363
270084	16.2958	15.7062	19.6105	17.1115
280001	18.1831	18.7137	*	18.4397
280003	23.0213	23.6058	26.0937	24.2580
280005	23.6949	22.8981	23.9753	23.5311
280009	20.9643	23.2300	23.8046	22.6996
280010	20.0462	22.0137	23.8324	22.0012
280011	15.9614	16.2281	*	16.0965
280013	22.5163	24.0852	23.4920	23.3630
280014	16.8368	16.7109	*	16.7707
280015	16.6939	18.0207	*	17.3362
280017	13.9939	16.9884	*	15.5624
280018	15.4496	16.6439	*	16.0417
280020	21.2467	21.9587	23.4577	22.2709
280021	17.6345	19.1263	21.5215	19.4605
280022	16.8184	15.3785	*	16.0620
280023	22.3433	21.5761	19.6265	21.1633
280024	15.0380	15.8747	*	15.4523
280025	21.4764	22.2214	*	21.8488
280026	16.5851	18.7258	*	17.6496
280028	18.0793	19.1080	*	18.5723
280029	24.4359	17.1351	*	20.5379
280030	24.7723	26.3542	29.2221	26.6821
280031	9.6321	9.6951	*	9.6643
280032	19.1191	20.5246	21.5150	20.4101
280033	17.4745	17.9841	*	17.7291
280035	16.6872	18.6089	*	17.5717
280037	17.1064	14.8049	*	15.9325
280038	18.2503	18.9305	*	18.5950
280039	16.1587	17.0153	*	16.5923
280040	20.9896	21.5426	23.6597	22.1127
280041	16.5503	16.6889	*	16.6228
280042	16.6239	16.4684	*	16.5457
280043	17.5937	16.8186	*	17.2004
280045	15.7630	17.7408	*	16.6924
280046	17.3214	17.9752	*	17.6376
280047	17.4735	21.3143	19.5815	19.4044

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
280048	15.8100	17.9319	*	16.9007
280049	18.4365	19.4589	*	18.9514
280050	20.0379	*	*	20.0378
280051	17.1942	19.6206	*	18.3037
280052	14.1201	14.9903	*	14.5662
280054	18.7575	19.4049	23.1191	20.4732
280055	13.8129	14.2046	*	14.0093
280056	15.6135	15.6442	*	15.6285
280057	20.0686	21.4754	22.5480	21.4261
280058	21.4868	22.8105	*	22.1817
280060	20.7022	22.4677	23.1128	22.1022
280061	18.6370	20.2066	21.2901	20.0793
280062	15.6018	16.1708	*	15.8878
280064	16.8330	18.2196	*	17.5260
280065	20.7370	21.6999	23.8128	22.1199
280066	11.7207	12.2225	*	11.9695
280068	10.5987	10.5103	*	10.5519
280070	22.6201	18.7211	*	20.3601
280073	17.7698	18.3496	*	18.0596
280074	17.3143	13.6025	*	15.0619
280075	13.2230	13.3154	*	13.2730
280076	16.7488	16.1939	*	16.4635
280077	20.0148	21.1883	22.7244	21.3192
280079	16.6117	17.1519	*	16.8816
280080	16.9487	16.1902	*	16.5447
280081	20.9606	23.3805	24.3199	22.8549
280082	14.6173	15.4420	*	15.0337
280083	21.5336	20.8995	*	21.2308
280084	13.6536	13.2158	*	13.4147
280085	20.4825	20.8532	21.8473	21.1233
280089	18.9567	19.9003	*	19.4122
280090	15.1274	*	*	15.1274
280091	16.1866	16.3456	*	16.2669
280092	14.7912	13.3032	*	14.0640
280094	16.3474	16.9180	*	16.6358
280097	13.8223	14.1870	*	14.0071
280098	12.5875	12.4995	*	12.5457
280101	16.9973	10.5153	*	12.9714
280104	16.2167	15.5949	*	15.8820
280105	21.0735	23.7103	25.1401	23.2737
280106	16.0679	16.3564	*	16.2080
280107	14.4679	*	*	14.4678
280108	17.1961	18.5134	20.9016	18.8959
280109	12.4408	*	*	12.4408
280110	14.2136	13.0278	*	13.5867
280111	19.6283	19.7688	20.7398	20.0680
280114	17.3076	17.1154	*	17.2096
280115	18.1480	18.3464	*	18.2483
280117	18.8279	20.3819	20.5464	19.9214
280118	18.6524	17.8891	19.3465	18.6584
280123	11.8582	23.6682	24.3539	18.1396
280125	16.3944	17.2718	20.0643	17.8221
280126	*	*	33.8917	33.8918
290001	22.7450	24.3681	25.9590	24.4242
290002	16.5419	16.7948	16.8363	16.7281
290003	24.2175	25.4303	27.4732	25.7436
290005	21.9814	22.7804	24.6877	23.2224
290006	22.4063	22.4832	24.2211	23.1190
290007	30.9075	34.9911	35.1020	33.7290
290008	24.1255	26.9216	27.0115	25.8955
290009	23.9373	24.8816	26.9020	25.2711
290010	16.4476	20.8387	25.4598	20.8166
290011	21.1234	19.7410	*	20.4163
290012	25.0430	25.5647	25.8036	25.4802

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
290013	15.7932	20.2914	*	17.6683
290014	18.7829	20.2762	*	19.5633
290015	19.4504	20.2336	*	19.8204
290016	23.8656	21.8030	22.5111	22.7099
290019	22.2045	22.5584	25.1684	23.3359
290020	21.2380	19.5039	24.2374	21.4763
290021	22.9488	24.1397	26.2510	24.4455
290022	25.5011	25.3914	27.5364	26.1224
290027	13.3769	13.1463	13.5030	13.3422
290032	23.9504	26.9846	27.5425	26.3410
290036	12.9074	*	*	12.9073
290038	27.7030	26.0836	*	26.8185
290039	25.5024	26.6283	28.7598	27.0508
290041	25.9905	27.7740	28.6294	27.7224
290042	18.7527	18.7669	*	18.7611
290043	27.9053	*	*	27.9053
290045	*	*	26.5644	26.5644
300001	23.8567	25.7142	27.1312	25.6218
300003	24.1297	25.3252	26.7859	25.4284
300005	22.2858	22.3258	22.8163	22.4895
300006	18.9745	22.2642	22.0188	21.0625
300007	20.6325	21.3633	23.6919	21.9920
300008	19.6149	20.9207	*	20.2733
300009	20.0938	20.1486	*	20.1242
300010	20.2130	21.0316	24.6296	21.8421
300011	23.0279	23.8390	25.0979	24.0124
300012	24.5619	25.8581	26.3914	25.6783
300013	20.1669	20.0269	21.3396	20.4889
300014	20.1774	21.6705	23.7144	21.9343
300015	19.6627	22.8966	24.4870	22.4848
300016	17.8148	15.1311	18.9756	17.3711
300017	22.7191	23.9651	26.1105	24.3969
300018	21.6385	22.8379	25.7851	23.5726
300019	19.6728	20.5801	23.8076	21.3279
300020	22.6627	23.0806	24.8189	23.5472
300021	19.3101	20.2585	*	19.7842
300022	19.1875	20.1209	22.3918	20.6206
300023	22.7649	22.1896	24.9992	23.3536
300024	21.5842	22.2235	22.4882	22.1265
300028	20.0778	21.4207	*	20.7175
300029	22.6013	23.8415	24.5772	23.7645
300033	17.1632	17.4836	*	17.3175
300034	24.4975	25.2355	26.9093	25.5558
310001	27.4730	31.1568	30.1786	29.6321
310002	27.9728	28.7786	33.9058	30.2896
310003	27.5624	29.3522	30.4234	29.1284
310005	22.9712	23.9477	26.0227	24.3007
310006	22.0894	24.1538	25.9000	24.0238
310008	24.7618	26.4989	28.0970	26.4414
310009	21.7094	23.2420	24.6353	23.1866
310010	23.1060	24.5471	26.7889	24.8998
310011	24.2885	25.4900	26.1586	25.3131
310012	26.6772	28.1367	31.1705	28.7006
310013	22.5603	23.2424	25.0951	23.6575
310014	23.1956	31.0834	29.1931	27.3029
310015	27.9684	29.1340	30.1767	29.1087
310016	24.5206	26.0738	25.7368	25.3848
310017	24.5976	25.1634	25.2636	25.0211
310018	22.4779	24.1428	25.9108	24.1664
310019	24.9914	28.5952	26.8663	26.7986
310020	24.4152	25.0803	25.0147	24.8332
310021	25.4393	27.8958	29.4003	27.4884
310022	20.8258	23.3412	26.7487	23.5627
310024	24.9521	27.0459	26.9499	26.3252

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
310025	24.1812	25.5227	26.8719	25.4915
310026	22.1997	23.2895	24.6697	23.2693
310027	22.5696	24.4437	22.1935	23.0737
310028	23.9428	26.1931	25.7246	25.2908
310029	23.6610	24.4290	25.9606	24.6455
310031	26.6831	26.7174	29.5581	27.5915
310032	24.7404	24.9133	25.7088	25.2148
310034	24.1150	24.8567	26.5224	25.1396
310036	21.7187	23.0320	*	22.3716
310037	28.1289	28.7738	30.1264	29.0191
310038	28.4893	28.1756	32.3865	29.6794
310039	22.7317	23.6605	24.6045	23.6772
310040	26.3573	26.5769	27.4041	26.7680
310041	23.5559	23.8857	26.8145	24.8018
310042	24.7678	24.9702	26.9695	25.5501
310043	21.6128	24.0238	*	22.6515
310044	23.1549	23.1489	25.1618	23.8298
310045	28.9274	29.4877	31.7376	30.0182
310047	26.1921	25.9777	26.1353	26.1004
310048	25.2870	23.4189	27.4050	25.3502
310049	27.0842	25.6732	26.5332	26.4118
310050	24.7988	23.7735	25.3772	24.6345
310051	27.5378	28.6248	29.2386	28.4543
310052	23.3973	24.9773	27.0324	25.0131
310054	27.7376	27.6290	28.1880	27.8584
310057	22.2572	22.2630	26.3903	23.6641
310058	26.3765	25.3983	28.1753	26.6605
310060	20.0997	21.4455	22.1914	21.1757
310061	33.9582	23.4283	24.9678	26.7631
310063	22.1080	21.2619	25.9868	22.9697
310064	25.4822	25.9350	27.8388	26.4138
310067	23.9278	24.1943	26.3624	24.7328
310069	24.2329	25.3464	25.7690	25.1083
310070	28.2220	29.5101	30.1917	29.3042
310072	22.5611	24.4480	25.3145	24.0886
310073	26.2937	26.7954	28.8791	27.3211
310074	22.3588	24.2009	27.6789	24.7835
310075	24.4788	23.9771	25.7726	24.7214
310076	27.9918	29.6667	32.4533	30.0527
310077	26.1251	26.7092	28.7352	27.1831
310078	24.0587	24.5862	24.7753	24.4599
310081	22.4086	23.3310	24.6082	23.4635
310083	24.8204	25.0191	25.2465	25.0205
310084	24.6049	25.4946	27.3680	25.8446
310086	23.1719	23.4966	25.2751	23.9606
310087	21.1215	20.6847	*	20.9048
310088	23.1722	23.0610	23.7846	23.3408
310090	24.8986	23.6661	25.3640	24.6461
310091	23.2969	24.5357	25.6405	24.4610
310092	21.6964	22.9721	23.2226	22.6239
310093	23.7251	23.9404	24.6942	24.1032
310096	24.5759	26.6588	28.4705	26.4515
310105	26.2537	28.1317	28.7333	27.6263
310108	23.8308	25.1368	24.9090	24.6281
310110	23.2146	23.3461	26.4175	24.4668
310111	22.1151	23.3646	26.2496	23.9377
310112	24.7914	24.2999	27.8796	25.6804
310113	23.1961	24.2708	25.9143	24.5219
310115	21.1645	23.5148	24.5413	23.0976
310116	23.6366	24.2696	25.1189	24.3065
310118	26.1315	26.8760	28.0517	26.9540
310119	32.7858	29.1045	34.7468	32.0732
310120	23.3200	22.6526	24.7079	23.4981
320001	20.6225	21.5564	23.0290	21.8122

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
320002	23.0983	25.5144	26.7332	25.2033
320003	16.4642	16.4961	20.7939	17.8265
320004	19.6642	21.3681	19.4799	20.2196
320005	21.0411	22.4178	22.1677	21.9174
320006	20.3863	19.8672	21.1222	20.4529
320009	19.3500	20.3783	21.5870	20.3252
320011	18.5222	19.1476	20.7713	19.4939
320012	17.1764	17.1317	*	17.1558
320013	24.5543	25.5403	19.4487	22.2842
320014	16.8412	22.9026	19.7656	19.7876
320016	18.8519	18.8763	19.9326	19.2629
320017	19.4498	20.4390	22.5460	20.8081
320018	19.2336	20.3141	21.4650	20.3556
320019	26.9637	25.1210	26.6900	26.3394
320021	19.1265	20.0089	21.0913	20.0920
320022	18.0606	20.9797	20.7919	20.0415
320023	17.8419	*	*	17.8418
320030	18.6859	18.1556	16.8696	17.8853
320031	25.1715	18.2244	*	21.3628
320032	20.6871	21.4815	*	21.0803
320033	21.0621	21.9804	24.2703	22.4984
320035	15.0612	17.8058	*	16.5303
320037	17.8280	17.6724	19.6466	18.4044
320038	22.2664	23.1987	19.2962	21.6253
320046	18.9607	19.4732	21.5914	20.0169
320048	16.8769	*	*	16.8769
320063	17.9089	18.5600	20.7804	18.9108
320065	18.6525	22.5428	19.9012	20.1608
320067	15.3228	16.8015	13.9459	15.7173
320068	18.5103	15.6864	*	17.0317
320069	14.4212	15.7350	18.5375	16.2248
320074	20.2290	22.3403	28.3085	22.7142
320079	19.8555	20.2473	21.9090	20.6661
320083	*	*	20.6771	20.6771
330001	27.3996	28.6214	30.8509	29.0053
330002	26.9341	27.1811	28.0882	27.3842
330003	18.9211	19.3972	20.2744	19.5052
330004	20.9501	22.5082	24.3703	22.6203
330005	22.1957	22.6137	24.3578	23.0431
330006	25.8006	26.2970	28.3904	26.7950
330008	19.2341	19.6770	20.6816	19.8702
330009	31.3435	30.9087	33.3605	31.8514
330010	16.6508	17.8935	19.8211	18.0647
330011	18.6748	18.7995	19.8035	19.0860
330013	19.6269	19.0995	21.2063	19.9545
330014	36.8669	32.4496	32.0824	33.6237
330016	16.8016	18.7194	18.1603	17.8636
330019	33.5369	31.5927	31.9042	32.2626
330020	15.1142	16.6952	*	15.9156
330023	25.6512	26.6997	29.4538	27.3398
330024	37.3316	35.7485	35.3598	36.0893
330025	16.8687	17.6169	18.7663	17.7638
330027	35.5255	35.1046	34.1281	34.9304
330028	29.5294	31.7699	31.8452	31.1533
330029	17.0016	19.4377	18.4354	18.2976
330030	19.1085	18.0866	22.0574	20.0482
330033	17.4444	19.5836	18.6316	18.5329
330034	27.7738	38.2451	*	31.2246
330036	25.2820	25.5888	27.0970	25.9905
330037	16.4866	18.3260	18.3557	17.7256
330038	17.3429	16.2997	*	16.8497
330041	31.4871	29.5305	34.5461	31.7315
330043	27.4661	28.9622	31.7873	29.4079
330044	19.5219	19.9808	22.0465	20.8006

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
330045	27.9919	28.5267	30.9046	29.1458
330046	35.2703	38.1184	41.6759	38.2919
330047	18.5536	19.5561	20.1646	19.4202
330048	19.1093	19.6129	*	19.3678
330049	20.5731	22.1523	24.7766	22.4977
330053	17.8082	17.9161	18.1728	17.9636
330055	32.8910	34.2159	34.9709	34.0397
330056	30.0945	29.8377	32.0982	30.6226
330057	19.3643	20.0995	20.9282	20.1517
330058	17.7672	18.1007	19.2916	18.3759
330059	34.2426	35.0121	36.4176	35.2563
330061	25.4082	26.8580	28.6725	26.9280
330062	18.1318	18.4662	20.0222	18.7978
330064	33.6447	35.1422	36.0976	34.9476
330065	19.9305	20.1615	20.5958	20.2322
330066	18.8707	19.3644	20.9990	19.7359
330067	22.1065	23.6836	24.8927	23.5465
330072	30.4171	30.3737	32.9665	31.2232
330073	16.4518	16.5166	18.4162	17.3766
330074	17.7308	18.9326	21.7299	19.4328
330075	17.6385	19.2938	19.9781	18.9556
330078	18.7884	18.0362	20.8379	19.1917
330079	18.7622	18.9398	21.1153	19.6188
330080	31.4424	34.6880	33.5537	33.2193
330084	19.3216	19.0261	19.2135	19.1805
330085	20.6203	20.9332	21.8271	21.1349
330086	23.6496	26.2979	27.1585	25.5888
330088	25.7940	26.7583	29.5181	27.3384
330090	19.2112	20.1344	20.9327	20.1124
330091	19.7776	21.6004	22.9396	21.4093
330092	13.3723	17.2083	*	15.2706
330094	18.1582	18.8941	21.3659	19.4211
330095	21.1096	21.1809	28.9794	22.2151
330096	18.5149	20.0370	21.1648	19.9256
330097	16.4433	16.1945	18.6291	17.0573
330100	29.0916	28.9956	31.5775	29.8728
330101	31.5914	35.3618	38.4810	34.9116
330102	19.0058	21.0057	23.5253	21.0029
330103	16.8110	17.3511	17.9017	17.3639
330104	31.2074	31.9746	36.8451	33.4319
330106	35.3775	36.2526	38.7822	36.7882
330107	27.7797	28.9225	29.7378	29.5391
330108	18.0786	18.5849	20.2536	18.9350
330111	15.9321	13.3352	17.7020	15.4904
330114	17.0581	19.1162	19.2566	18.4674
330115	17.4684	18.5911	18.5544	18.2257
330116	14.9610	16.8567	*	15.8888
330119	33.1179	33.5653	34.6591	33.7652
330121	16.3385	17.1869	17.9757	17.1336
330122	20.2417	23.0384	25.6500	22.9753
330125	19.7638	20.5922	22.8078	20.9861
330126	23.8957	25.1175	27.7155	25.5857
330127	30.7356	40.0112	42.2836	37.9337
330128	30.8242	34.3468	32.7050	32.6252
330132	14.3673	14.8704	16.0311	15.1074
330133	35.3576	37.5192	35.9692	35.9945
330135	22.2670	23.5662	25.6504	23.7351
330136	20.1043	20.4124	21.4225	20.6554
330140	19.3615	21.1841	21.1787	20.5922
330141	26.7096	27.5960	29.3283	27.9225
330144	16.2517	17.1513	17.3920	16.9610
330148	16.2782	16.7251	17.6560	16.8727
330151	15.7594	15.2233	16.4028	15.7871
330152	30.8314	33.5587	32.9336	32.8160

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
330153	18.1776	19.4417	21.2843	19.6379
330157	22.3804	23.1743	23.5522	23.0369
330158	27.1228	29.3163	32.7159	29.6159
330159	19.4998	20.2753	22.5580	20.7593
330160	29.5885	30.7893	32.1266	30.7976
330162	27.6010	27.9705	29.6042	28.3718
330163	20.7456	21.4143	21.1517	21.0818
330164	20.9003	22.0699	23.5427	22.1914
330166	15.4420	17.0637	18.4262	17.0093
330167	30.2346	32.0541	30.9667	31.0372
330169	35.4794	36.3690	36.2725	36.0426
330171	24.8035	25.1567	25.9946	25.3030
330175	18.3116	18.8701	20.4628	19.1836
330177	16.3704	16.6059	19.0005	17.2818
330179	13.8953	16.0113	*	14.8822
330180	17.9877	19.2670	19.8951	19.0453
330181	33.0908	34.6065	37.1218	34.9071
330182	33.6531	33.3363	35.2415	34.0997
330183	20.6164	20.3520	*	20.4865
330184	31.3706	28.4726	30.7479	30.2392
330185	26.8612	27.8894	28.9787	27.9279
330188	18.8000	20.2849	21.1196	20.1045
330189	18.4498	23.5589	19.0726	20.2279
330191	19.0348	19.5623	20.9392	19.8520
330193	30.2260	32.5496	36.2427	32.8255
330194	35.2036	35.6486	38.5372	36.5109
330195	34.8966	34.4689	36.4249	35.2744
330196	30.5799	28.9488	31.1915	30.2340
330197	18.3527	19.2237	20.8386	19.4333
330198	24.8590	25.6669	25.3622	25.3000
330199	30.5409	28.0374	34.1354	30.7601
330201	28.7861	30.0524	29.3745	29.3679
330202	31.2575	35.4943	30.7990	32.6310
330203	25.0345	25.9211	24.7422	25.2170
330204	32.2005	31.1366	30.3699	31.2607
330205	22.3490	24.9040	29.0622	25.3829
330208	26.6682	27.3170	30.6158	28.1551
330209	25.1281	27.0257	27.7071	26.6630
330211	19.5405	20.0006	20.8224	20.1312
330212	24.7681	24.8554	24.9434	24.8488
330213	19.6796	20.1166	20.7967	20.2015
330214	32.4292	32.3130	32.7647	32.5110
330215	17.9863	19.0726	19.9226	18.9889
330218	21.1890	21.4747	20.6012	21.0785
330219	23.4310	25.1792	28.7448	25.6786
330221	33.3796	32.5044	34.9345	33.6092
330222	18.5571	19.3148	23.5491	20.4196
330223	17.8306	19.1604	18.8253	18.6087
330224	20.4309	20.5881	22.7847	21.2721
330225	27.0379	28.0523	29.1744	28.0410
330226	23.1859	21.6368	23.5405	22.8458
330229	17.5326	18.2554	18.5590	18.1157
330230	29.6283	30.6937	32.5997	30.9389
330231	32.7200	32.4163	30.2184	31.7719
330232	19.1787	20.0924	21.1277	20.1536
330233	44.1265	43.1186	39.5133	42.2764
330234	35.0720	35.8327	37.7135	36.1847
330235	19.5880	20.1255	21.4643	20.3704
330236	31.3463	32.1246	31.8491	31.7633
330238	17.3976	17.8867	18.3846	17.8977
330239	18.5079	18.9953	19.7561	19.0658
330240	30.7321	35.6576	37.3866	34.3729
330241	23.8638	24.7545	26.7598	25.1593
330242	27.6384	28.3561	30.5172	28.8163

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
330245	18.5161	20.7605	20.2037	19.8717
330246	28.1205	29.8777	31.8857	29.8369
330247	27.3937	32.5858	25.6063	28.6111
330249	17.1320	17.6846	19.1469	18.0226
330250	19.9619	20.8742	22.1272	21.0158
330254	15.9123	15.7864	*	15.8547
330258	31.8910	32.6745	*	32.2903
330259	25.9994	26.3620	27.4131	26.5822
330261	27.9766	30.0489	30.4771	29.5060
330263	18.7378	19.5057	20.0831	19.4473
330264	22.8099	24.9714	26.3652	24.7466
330265	17.6301	21.1215	18.2547	19.0141
330267	24.5939	27.8255	29.0499	27.1989
330268	15.9060	16.8358	18.7991	17.2148
330270	36.0824	33.0375	36.5976	35.2587
330273	26.0565	27.0454	28.8548	27.3093
330275	18.7268	*	*	18.7268
330276	19.0228	19.6572	20.7973	19.8310
330277	19.1761	20.7851	21.8865	20.6281
330279	20.7107	21.7827	23.8793	22.1432
330285	24.0491	24.5388	26.0446	24.8963
330286	27.7762	28.0994	31.1344	29.0184
330290	30.4706	34.3439	35.5617	33.3907
330293	16.9238	17.3180	17.6507	17.2993
330304	27.3562	29.2207	31.1146	29.2299
330306	29.5937	29.6641	30.4426	29.9146
330307	21.7257	23.2838	23.8583	22.9902
330314	25.9937	25.5405	26.2954	25.9412
330316	27.9543	27.9277	33.7857	29.8270
330327	20.3874	20.1705	19.3465	20.0015
330331	33.1276	32.3249	34.6302	33.3443
330332	25.3689	27.6955	30.5104	28.0245
330333	*	28.8819	29.7725	29.3003
330336	29.8294	27.9163	32.9548	30.2195
330338	21.2670	23.6142	25.4319	23.4256
330339	20.1028	20.2382	20.8423	20.3907
330340	28.4129	28.2732	29.8140	28.8238
330350	30.9763	33.5493	35.5656	33.4000
330353	34.2431	34.2260	35.6821	34.7146
330357	34.1846	36.8598	36.5461	35.8671
330372	33.3771	23.5381	28.2490	27.9598
330381	31.8602	*	*	31.8602
330385	33.2246	37.5523	44.3387	38.5414
330386	20.4231	21.4363	25.2063	22.3343
330389	37.3749	33.1192	32.2112	34.0979
330390	30.8744	31.7344	32.7450	31.7461
330393	27.8352	31.9272	33.0953	30.9212
330394	18.9343	19.6892	21.3678	19.9899
330395	32.7494	33.2318	32.1089	32.8033
330396	30.7961	32.8517	31.2429	31.6152
330397	32.6068	34.6435	40.0884	35.3787
330398	29.2872	*	*	29.2871
330399	33.3012	32.7149	32.1248	32.6847
330400	16.2707	16.8168	*	16.5566
330401	*	*	33.8633	33.8633
340001	19.7093	22.0257	21.6113	21.1407
340002	20.5253	22.9425	24.0145	22.6770
340003	19.5145	19.6545	20.8205	19.9936
340004	20.9863	23.0890	23.3756	22.5010
340005	16.7176	16.6909	20.8149	18.1113
340006	16.5709	16.1379	*	16.3589
340007	18.3399	18.3760	19.5208	18.7399
340008	20.4157	22.6570	22.7338	21.9732
340009	20.9178	20.6155	*	20.8194

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
340010	19.4302	20.6547	21.3024	20.4707
340011	14.4798	17.4534	18.1926	16.7010
340012	17.5112	19.3651	19.6350	18.7911
340013	19.4613	21.5130	21.0066	20.6934
340014	27.7888	21.9804	22.6757	23.7385
340015	19.4676	20.3493	24.3410	21.2831
340016	18.8958	19.4160	20.2859	19.5502
340017	20.2775	20.6263	21.7083	20.8968
340018	18.1751	16.4611	17.3480	17.2851
340019	15.2887	15.9037	16.7901	15.9850
340020	18.0897	19.2392	21.3385	19.6156
340021	20.5813	22.0220	22.9208	21.8064
340022	18.7714	20.6484	19.9078	19.7763
340023	19.3146	19.9023	22.3591	20.5625
340024	17.9130	19.1430	20.4906	19.1924
340025	18.4628	19.1770	20.2864	19.3249
340027	19.4548	19.4907	21.0975	19.9909
340028	19.9403	20.6496	22.2028	21.0172
340030	22.4709	23.9505	26.7753	24.2706
340031	14.6370	15.4935	*	15.0325
340032	20.7444	22.0245	23.2204	21.9802
340035	18.9930	18.5883	16.4821	17.7616
340036	17.7619	18.4203	20.8313	18.9871
340037	17.5829	18.3655	21.9524	19.3820
340038	18.1493	20.3091	13.9936	16.9604
340039	21.3711	22.4020	24.8246	22.8823
340040	20.7237	21.1397	22.4777	21.4396
340041	15.5873	16.3200	17.6319	16.5216
340042	17.0034	19.1386	21.1107	19.0690
340044	18.0863	18.9562	18.2154	18.4256
340045	13.6182	20.2641	17.4067	16.7851
340047	20.0744	21.5178	22.5199	21.3642
340049	19.5127	17.2986	21.2734	19.3901
340050	19.6726	20.6831	20.3262	20.2425
340051	19.3627	19.0282	20.3057	19.5812
340052	23.2134	26.2243	*	24.4619
340053	19.9915	23.2410	24.9768	22.5255
340054	15.5090	16.6208	*	15.9979
340055	19.4035	20.8253	23.2990	21.1986
340060	19.3410	20.8570	20.8076	20.3431
340061	22.1175	23.7173	25.1081	23.6221
340063	16.7377	26.4132	*	21.1044
340064	18.5069	17.6106	19.4523	18.4891
340065	17.3530	23.2606	20.3296	20.0017
340067	19.7187	22.4054	22.2565	21.2710
340068	17.8065	18.8758	19.4487	18.7043
340069	21.6728	22.5995	24.4650	22.9542
340070	20.6829	21.3511	22.2605	21.4483
340071	18.0767	19.3679	19.9561	19.1824
340072	17.7129	18.7920	19.2773	18.5813
340073	23.5832	24.0794	26.6829	24.9327
340075	20.0081	19.7450	23.2904	21.0501
340080	18.2061	*	*	18.2061
340084	19.0103	19.6087	20.8175	19.7922
340085	18.3179	20.3684	21.7112	20.1771
340087	18.2255	20.2445	17.8215	18.7854
340088	22.2322	22.6462	22.8687	22.5844
340089	15.4760	16.1321	*	15.8015
340090	18.5287	18.7701	20.3261	19.2336
340091	20.3861	21.2665	23.1430	21.6613
340093	16.8903	16.5452	*	16.7319
340094	*	21.0091	*	21.0091
340096	19.4696	20.9686	22.1174	20.8605
340097	18.2399	20.0302	20.8690	19.7362

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
340098	21.9578	23.4949	24.2262	23.3005
340099	15.3752	16.9979	17.5114	16.5762
340101	15.6509	20.7841	*	17.9177
340104	11.5169	12.1845	12.9949	12.2095
340106	18.1211	19.1147	20.1076	19.1527
340107	19.3197	20.7601	21.0960	20.4083
340109	19.0532	19.3357	20.4341	19.6192
340111	16.5976	17.2127	*	16.9155
340112	15.5142	16.9592	*	16.2328
340113	21.9883	24.4222	25.0729	23.8451
340114	20.7261	21.7750	19.9142	20.7205
340115	21.7586	24.7924	23.8284	23.3620
340116	20.6800	21.6744	23.9643	22.1286
340119	19.5827	20.5394	21.2239	20.4881
340120	15.8240	16.9847	19.9860	17.6157
340121	17.8771	19.0420	19.9409	18.9829
340123	18.9078	21.5041	22.3711	20.9859
340124	17.4185	17.5411	17.5691	17.5084
340125	20.2748	*	*	20.2748
340126	19.3734	21.2045	21.4271	20.6156
340127	19.3842	21.4797	22.9672	21.3229
340129	20.6521	21.0773	22.3260	21.4712
340130	19.8707	20.5851	22.7687	21.1316
340131	21.3849	23.2478	24.1370	22.9644
340132	17.5711	17.7110	17.8771	17.7237
340133	17.2138	17.5170	23.1444	19.0209
340137	31.7702	39.9826	33.1750	34.5096
340138	*	*	29.5285	29.5286
340141	21.4986	23.2961	24.2033	23.0468
340142	18.0766	18.1824	20.4320	18.9192
340143	24.4098	21.9304	23.0416	23.0758
340144	22.9183	22.8634	25.4597	23.8048
340145	19.9233	21.5958	21.8120	21.1598
340146	17.3051	19.1306	20.7252	19.1365
340147	20.5520	21.5912	22.6057	21.5761
340148	18.9912	20.6790	20.8156	20.1791
340151	18.4733	19.0779	19.2593	18.9459
340153	20.7533	21.7375	23.7426	22.0619
340155	23.1021	25.0965	26.3663	24.8240
340158	19.0843	20.0921	21.7489	20.4390
340159	19.0338	19.4992	21.2983	19.9832
340160	16.7170	17.1963	18.7569	17.6323
340164	21.5769	*	*	21.5769
340166	20.8270	22.0519	22.8349	21.9930
340168	15.6071	15.4250	16.8277	15.9431
340171	22.4779	22.7304	25.9603	23.8162
340173	21.0898	23.3690	23.7037	22.7805
340176	*	*	26.5277	26.5277
350001	16.6551	15.6193	*	16.1279
350002	18.3459	19.1931	20.4398	19.3340
350003	19.2840	20.0663	21.0585	20.1107
350004	23.7016	25.1976	28.3773	25.5370
350005	19.9156	20.7467	*	20.3296
350006	19.0343	19.1257	19.7577	19.2916
350007	13.8824	13.9966	*	13.9397
350008	22.3783	23.4052	*	22.8911
350009	18.3688	19.3668	20.2558	19.3312
350010	16.6272	16.7774	17.2489	16.8799
350011	19.1944	20.6809	21.9111	20.4046
350012	18.2524	16.0990	*	17.4568
350013	17.2596	17.8145	*	17.5341
350014	18.0999	18.6786	16.1719	17.7037
350015	17.1071	17.5658	18.5437	17.7151
350017	17.5124	18.0840	19.1952	18.2584

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
350018	16.4939	16.3210	*	16.4077
350019	20.1608	20.6743	21.3589	20.7389
350021	17.7123	16.3394	*	16.9912
350023	17.4983	18.3253	*	17.9246
350024	15.4788	15.7510	*	15.6148
350025	15.0469	14.6099	*	14.8289
350027	15.5178	17.5882	17.6730	16.8430
350029	14.6173	*	*	14.6173
350030	18.1131	18.7993	18.8822	18.5954
350033	16.0870	16.0903	*	16.0886
350034	19.6445	*	*	19.6446
350035	11.7675	12.6496	*	12.2147
350038	19.6854	19.5497	*	19.6189
350039	16.6278	14.8599	*	15.7361
350041	19.1341	23.1150	*	21.1445
350042	19.3309	19.3370	*	19.3339
350043	16.7433	17.6722	18.8378	17.7606
350044	11.0601	10.9690	*	11.0158
350047	18.0094	19.9749	*	18.9594
350049	18.1993	16.8322	*	17.5040
350050	12.2183	25.2747	*	15.7885
350051	17.0653	16.9201	*	16.9927
350053	15.9160	16.7456	*	16.3628
350055	15.7916	16.1691	*	15.9782
350056	15.0995	15.7752	*	15.4239
350058	16.7034	16.1013	15.0197	15.9830
350060	10.3076	10.5325	*	10.4159
350061	18.8790	19.6460	18.8494	19.1278
360001	19.6655	20.3515	22.2387	20.7565
360002	18.2613	19.6145	20.7586	19.4748
360003	22.7521	23.2905	24.4144	23.4719
360006	22.4436	22.6333	24.0814	23.0671
360007	14.8213	15.3656	19.1316	16.2099
360008	18.7961	19.8034	21.3795	20.0267
360009	18.9935	19.6277	22.4076	20.3429
360010	19.1852	20.5934	20.6291	20.1715
360011	21.3659	19.5383	21.4293	20.6951
360012	20.0525	23.0125	24.3618	22.5334
360013	21.3690	22.3407	24.4232	22.7482
360014	20.7419	22.9930	22.9372	22.2320
360016	21.2505	21.3967	22.8430	21.8319
360017	22.2740	22.7446	23.6181	22.8938
360018	24.6686	24.6694	29.9085	26.0220
360019	20.6480	21.4708	23.3006	21.7875
360020	22.1751	21.6607	21.5085	21.7901
360024	20.1352	20.9408	22.5356	21.2300
360025	20.2531	20.9266	21.6676	20.9599
360026	17.9523	18.6739	20.8825	19.1730
360027	21.7650	22.8098	23.5907	22.7203
360028	18.7174	*	*	18.7174
360029	19.2928	19.7466	20.4925	19.8555
360030	17.6058	19.0551	*	18.3339
360031	21.0687	21.0481	24.3482	22.0734
360032	19.8020	19.8367	21.1743	20.2841
360034	17.9594	19.4982	21.5621	19.7369
360035	21.0674	22.6982	24.2433	22.6934
360036	20.9916	21.4486	22.3567	21.6200
360037	23.1674	23.7504	32.6245	25.9190
360038	19.9415	21.4804	23.4855	21.6060
360039	19.0013	19.3703	23.4642	20.4568
360040	18.7425	19.9750	21.3307	20.0479
360041	19.7968	21.9093	22.1352	21.3781
360042	17.1952	19.3774	*	18.2267
360044	17.6882	17.8417	19.7212	18.4151

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
360045	22.4018	22.8112	*	22.5916
360046	20.4607	21.4292	22.8425	21.5814
360047	15.2922	15.8279	17.5885	16.2546
360048	22.4890	25.6259	24.7150	24.1596
360049	20.8393	*	22.4938	21.5834
360050	15.0568	15.6847	*	15.3748
360051	20.8757	21.2225	23.0658	21.7279
360052	18.7931	19.8037	22.5005	20.3830
360054	17.4911	17.5714	19.2884	18.1334
360055	21.4112	22.8755	23.5586	22.6117
360056	20.6968	23.4405	22.4475	22.2067
360057	15.8569	16.0395	*	15.9541
360058	19.3306	19.0440	21.0768	19.7927
360059	19.9304	23.2129	23.0775	22.0496
360062	21.9195	24.4898	24.5746	23.8212
360063	17.5108	20.2671	*	18.8180
360064	20.0615	20.7659	21.3424	20.7273
360065	19.6199	22.3443	22.9727	21.6463
360066	22.8175	24.1295	24.6806	23.9204
360067	14.2745	17.3734	*	15.7627
360068	22.6227	22.6027	22.1110	22.4481
360069	14.6597	18.5382	20.5349	17.7132
360070	18.8406	19.4700	21.8228	20.0184
360071	19.0302	19.6873	21.4478	20.0864
360072	19.0166	20.8819	21.3736	20.4643
360074	18.5889	19.9947	22.2368	20.2638
360075	26.0663	27.6992	23.8492	26.5296
360076	20.3317	21.0402	22.5863	21.3489
360077	21.5517	22.2964	23.3686	22.4049
360078	22.6490	22.7743	23.3799	22.9416
360079	21.6644	23.9491	25.9623	23.8072
360080	17.6369	18.0392	18.7213	18.1448
360081	20.4614	20.7477	22.1973	21.1275
360082	20.7610	22.9390	25.2254	23.0000
360084	22.0492	22.1699	23.3257	22.5390
360085	21.5151	24.8010	24.6618	23.5397
360086	19.3701	20.5858	21.5983	20.5220
360087	20.7969	21.1621	23.9638	22.0097
360088	24.0822	20.5703	*	22.1866
360089	18.1941	19.5260	21.0229	19.5818
360090	20.8971	21.2072	22.6236	21.6097
360091	21.8447	22.6510	23.5759	22.6962
360092	21.5073	20.9588	21.9732	21.4976
360093	19.0261	21.0134	21.4623	20.5059
360094	20.1227	21.1952	22.6440	21.2292
360095	19.8521	21.3505	23.6518	21.6069
360096	19.6726	20.9838	22.0673	20.9264
360098	19.8178	20.8049	22.7645	21.0895
360099	19.6241	20.8801	20.8524	20.4553
360100	18.0442	19.9768	21.5911	19.8051
360101	20.2635	24.1551	26.2875	23.5545
360102	18.5367	*	*	18.5367
360106	19.1778	18.9779	19.8658	19.3346
360107	22.1359	21.9939	23.6880	22.6413
360108	20.0681	19.0649	*	19.5523
360109	19.9237	17.3564	23.0178	19.9966
360112	24.6335	25.7920	25.5910	25.3189
360113	20.8154	22.8088	22.3348	21.9843
360114	18.7509	19.4212	*	19.0907
360115	20.7652	21.0104	22.3926	21.3952
360116	18.8319	20.1408	21.3809	20.0857
360118	19.9141	21.0235	*	20.4951
360121	22.2175	21.9111	23.2515	22.4617
360123	20.9792	21.9985	23.1310	22.1195

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
360125	20.5508	21.6675	21.1408	21.0968
360126	24.5387	*	22.2409	23.5396
360127	16.5559	18.2150	*	17.4089
360128	17.0515	17.5557	18.0355	17.5624
360129	16.6114	17.2309	17.9151	17.2650
360130	18.4539	19.8906	20.1257	19.4067
360131	18.4688	20.4123	21.7838	20.2068
360132	21.3493	21.0162	23.4179	21.9298
360133	20.2857	22.1957	22.0958	21.4858
360134	20.9564	21.6081	23.6817	22.0689
360136	18.2194	18.5687	*	18.3942
360137	22.3648	23.1867	23.8947	23.1248
360140	21.2881	18.3463	*	19.7842
360141	23.5343	23.5980	25.1442	24.0943
360142	18.3188	19.6189	20.6728	19.5866
360143	21.0336	20.9158	22.2275	21.3979
360144	20.9033	20.9386	24.7973	22.2165
360145	20.0513	21.2931	22.4813	21.2645
360147	17.6779	18.7258	20.0409	18.8813
360148	19.1393	20.3120	21.3211	20.2546
360150	22.3620	23.1858	24.8485	23.4439
360151	19.2788	20.5594	21.7215	20.4860
360152	21.6005	20.9704	22.9352	21.8108
360153	16.7399	16.1021	17.3367	16.7252
360154	14.3593	14.9606	16.2416	15.1371
360155	22.2112	22.3347	23.0020	22.5355
360156	18.9095	19.9382	21.2853	20.0637
360159	21.5695	22.7992	23.3359	22.5729
360161	20.6160	19.6266	21.5114	20.5834
360163	21.2689	22.1012	23.1500	22.1757
360165	18.2417	19.6205	*	18.9117
360170	20.4407	19.7980	22.2815	20.8462
360172	19.8909	22.3294	22.7104	21.5807
360174	20.5399	20.5874	21.7129	20.9378
360175	21.5450	22.0274	22.7887	22.1417
360176	16.6228	17.6743	*	17.1399
360177	18.9576	19.6992	20.8194	19.8306
360178	16.7962	18.0773	18.2393	17.6939
360179	20.7069	21.3520	23.0678	21.6241
360180	21.0146	22.9260	25.1499	22.9741
360185	19.4858	20.0848	21.1245	20.2540
360186	20.7572	18.1254	*	19.4292
360187	19.6535	20.8423	21.9499	20.7934
360188	18.3057	16.4329	*	17.4338
360189	18.5940	19.0481	20.0275	19.2171
360192	22.7846	23.9969	24.9995	23.9111
360194	17.6140	19.3901	20.3677	19.1372
360195	20.5828	21.2801	23.1897	21.7230
360197	20.5062	21.6110	23.1378	21.7597
360200	17.9623	19.5866	*	18.6858
360203	15.9609	17.9698	19.3642	17.7421
360210	21.8629	21.5961	25.0811	22.8213
360211	20.6081	22.0011	22.4529	21.6965
360212	20.6987	21.0632	22.8041	21.5064
360213	19.0584	20.5448	*	19.7786
360218	18.8204	20.7709	22.8059	20.8145
360230	20.8042	21.2417	24.7681	22.2381
360231	14.4168	12.7388	*	13.4906
360234	20.6131	21.0473	22.1787	21.3387
360236	21.4628	20.5683	22.8821	21.6382
360239	19.2375	20.9440	23.5802	21.2633
360241	25.3741	23.7679	23.4061	24.1565
360245	15.9782	16.7956	18.1015	16.9965
360247	17.0776	*	*	17.0775

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
360249	25.4331	*	*	25.4330
360250	*	50.5106	*	50.5105
360253	*	*	31.3006	31.3006
360254	*	*	30.0791	30.0792
360255	*	*	15.0964	15.0963
370001	24.1929	22.0586	25.5838	23.8868
370002	15.4333	16.1853	18.9544	16.8753
370004	18.5233	22.5027	21.5041	20.8266
370005	15.3881	*	*	15.3881
370006	16.4995	15.7367	15.6334	15.9348
370007	15.8312	14.4961	16.7597	15.6795
370008	17.5553	18.5253	22.1596	19.3861
370011	15.6178	16.1757	17.1458	16.3495
370012	12.4942	13.3824	*	12.9251
370013	18.9584	19.3237	21.1513	19.8462
370014	20.2858	22.7976	21.8473	21.6639
370015	20.8765	18.9169	20.3965	20.0611
370016	19.1613	20.0888	20.4407	19.8819
370017	13.6531	*	*	13.6531
370018	17.7054	18.7928	20.8357	19.1122
370019	14.6216	16.1367	18.1260	16.2132
370020	15.1035	15.6057	16.8631	15.8317
370021	12.9030	*	*	12.9030
370022	17.3724	18.2109	20.2432	18.6171
370023	17.5148	18.1255	19.3386	18.3281
370025	18.4815	19.1013	20.2845	19.2928
370026	18.0412	18.6982	21.9141	19.5712
370028	21.1292	22.1765	24.1009	22.4973
370029	18.2580	19.3285	19.5811	19.0934
370030	16.5803	18.4568	18.6541	17.9169
370032	18.1538	18.9050	20.0827	19.0803
370033	11.3210	15.3857	*	13.1697
370034	15.6288	16.2204	16.1541	15.9959
370036	12.4070	11.7667	16.5843	13.2363
370037	18.9556	20.6493	21.0719	20.2262
370038	13.0210	15.4551	*	14.1589
370039	19.4498	22.7015	20.3137	20.7707
370040	15.5109	16.8127	18.9981	17.0372
370041	16.2316	14.7346	19.0145	16.6419
370042	15.2764	15.9005	14.0899	15.1360
370043	17.0892	20.0991	20.2929	18.9889
370045	11.3560	11.6163	12.6613	11.8767
370047	17.8769	18.4743	19.4856	18.6175
370048	15.6803	17.0785	15.4768	16.0450
370049	19.4868	20.3405	20.4826	20.0887
370051	12.5171	11.4943	12.0397	11.9839
370054	18.0787	19.2294	20.3788	19.2048
370056	18.1432	19.2867	20.4872	19.2536
370057	15.1228	16.0301	17.3020	16.1401
370059	18.3314	21.3103	*	19.7652
370060	19.3051	17.9469	23.1897	20.1750
370063	16.7342	*	*	16.7342
370064	11.9954	11.6347	11.9044	11.8446
370065	18.1349	18.2406	18.3966	18.2581
370071	16.4567	*	*	16.4568
370072	13.6519	12.5765	12.5766	12.8934
370076	14.3555	15.4067	19.0231	16.2477
370078	19.2412	15.2513	22.2318	18.5140
370079	16.9201	17.5915	*	17.2356
370080	14.7323	14.3546	16.1445	15.0543
370082	15.0669	16.9715	12.6060	14.8254
370083	13.1810	15.6824	18.5669	15.6441
370084	13.1197	15.6184	16.1277	15.0212
370085	48.1271	13.7216	*	19.0856

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
370086	11.1900	*	*	11.1900
370089	17.2638	17.9243	18.0505	17.7472
370091	20.1822	20.8536	24.2117	21.6700
370092	15.7678	16.8432	*	16.3152
370093	19.7008	22.1966	23.5685	21.8046
370094	19.5462	19.5565	20.6507	19.9482
370095	13.4202	14.5909	14.3563	14.1246
370097	23.2056	19.3793	20.3218	20.7266
370099	19.4646	18.1467	20.2001	19.2453
370100	18.8274	12.9784	13.0682	14.6358
370103	18.2685	23.1347	15.6109	19.0349
370105	20.7890	25.1252	22.4493	22.5846
370106	20.3651	21.8937	24.1115	22.1312
370108	12.7470	14.0190	13.8170	13.5126
370112	15.3039	14.3384	16.5964	15.3556
370113	17.6107	20.3439	21.4267	19.8197
370114	17.8941	17.9757	19.4933	18.4780
370121	21.3099	20.5488	*	20.9192
370122	15.4375	*	*	15.4374
370123	19.0313	19.7958	20.5180	19.7729
370125	13.9436	14.4664	17.9240	15.3291
370126	15.8020	*	*	15.8021
370131	15.7261	*	*	15.7262
370133	12.9545	16.1855	*	14.6252
370138	17.5551	17.4574	19.0403	18.0470
370139	14.9964	16.0898	16.3223	15.8016
370140	17.1393	17.4950	*	17.3218
370141	20.7798	19.8606	24.7859	21.7383
370146	13.0399	13.9900	*	13.5128
370148	20.6612	22.6237	22.8526	22.0700
370149	17.0929	18.0699	18.2260	17.8047
370153	16.4669	16.5267	17.9692	16.9732
370154	15.6093	16.6687	17.4760	16.6039
370156	14.5696	15.4303	15.9647	15.3521
370158	15.6994	16.3637	17.3412	16.4535
370159	21.1267	25.5592	*	22.6485
370163	20.4217	*	*	20.4216
370165	13.0375	12.9569	*	12.9979
370166	21.0797	19.4219	21.3628	20.6200
370169	12.7138	14.8384	16.5607	14.5408
370176	18.9951	19.6537	22.1455	20.2849
370177	14.6481	14.1304	14.0279	14.2494
370178	11.6200	9.8655	12.9636	11.3085
370179	21.3002	23.8404	21.9673	22.2749
370183	16.9318	16.6061	17.9270	17.1700
370186	15.4533	16.3671	16.3879	16.0737
370190	19.3570	20.6398	22.3326	20.7903
370192	19.6967	21.8343	24.3832	21.9053
370196	*	*	23.6334	23.6334
370199	*	*	20.7075	20.7075
370200	22.5299	18.3941	16.7164	18.9908
370201	*	18.2548	18.9906	18.6571
370202	*	16.5384	24.0239	20.2030
370203	*	23.5454	19.8772	21.4569
370206	*	*	22.3471	22.3471
370207	*	*	26.3745	26.3746
380001	26.4822	25.1542	20.9585	23.8121
380002	21.9185	23.2479	25.2629	23.4657
380003	20.9007	23.8074	24.6377	23.1951
380004	23.3609	24.5418	27.5184	25.2584
380005	25.0750	24.7476	26.3472	25.4394
380006	21.3520	20.5914	24.7492	22.3626
380007	32.2678	25.9239	30.0497	29.1804
380008	22.3004	21.6133	24.6149	22.8464

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
380009	24.3851	25.1040	26.0012	25.1913
380010	22.7276	24.1931	25.5234	24.1293
380011	20.3357	20.6759	21.9382	20.9633
380013	19.8180	19.9606	24.1491	21.3157
380014	25.9828	26.6038	28.4536	27.0598
380017	25.3954	21.9236	29.2543	25.5247
380018	22.9822	24.8661	27.5171	25.1199
380019	20.8176	21.1743	*	20.9950
380020	22.9568	23.9978	23.7066	23.5720
380021	23.8499	24.4365	28.0334	25.5509
380022	24.5974	25.6255	26.4793	25.6210
380023	21.3831	23.4328	23.0079	22.7334
380025	26.9346	26.9398	28.8525	27.6239
380026	20.6972	22.7561	23.8666	22.4738
380027	21.5490	22.2573	21.5822	21.7906
380029	20.1471	22.0371	24.2939	22.3500
380031	20.3396	23.7634	*	22.1387
380033	27.1343	26.6899	30.4783	28.1499
380035	23.9719	25.6016	26.2434	25.3543
380036	27.2157	*	*	27.2157
380037	22.1774	23.4798	25.0199	23.6781
380038	26.7759	28.1436	29.1804	28.0609
380039	22.8048	25.7614	27.5115	25.2376
380040	22.5477	22.6412	21.5958	22.2243
380042	24.4172	21.6793	*	22.9706
380047	24.2524	25.2591	26.5017	25.3895
380048	18.3005	18.2773	*	18.2867
380050	20.3205	22.1089	23.1332	21.8624
380051	22.3207	24.4081	26.2384	24.3019
380052	18.6299	20.7431	21.2567	20.2520
380056	18.4961	20.7895	22.3571	20.6518
380060	24.2059	23.0106	27.8551	25.0526
380061	22.8781	24.1121	27.3827	24.9756
380062	18.2148	26.1370	*	22.4060
380064	22.9160	27.0627	*	25.0195
380065	22.9608	23.3146	*	23.1416
380066	23.2794	23.1175	23.3581	23.2487
380069	20.4882	21.2057	*	20.8487
380070	27.7790	29.9706	34.1038	30.4794
380071	25.1808	25.9113	27.9055	26.3468
380072	19.4346	20.6568	21.9516	20.7086
380075	22.4139	23.1910	25.1930	23.7443
380078	21.0903	22.6996	*	21.9036
380081	20.4082	22.9805	22.1822	21.8754
380082	22.9606	23.7927	28.0668	25.0482
380083	21.7431	22.4058	*	22.0627
380084	27.1689	31.0111	*	28.8040
380087	17.0380	21.3119	*	19.2714
380088	19.5346	24.8158	*	22.0237
380089	25.2908	26.1967	29.6989	27.0928
380090	24.9351	30.4223	31.8702	28.9771
380091	25.3062	28.7846	31.2807	28.6166
390001	19.6732	20.3350	21.5154	20.5284
390002	19.7833	20.8831	22.0646	20.9201
390003	18.1025	18.0436	19.1857	18.4384
390004	20.3204	20.0557	21.3475	20.5889
390005	16.9472	19.0218	19.0727	18.2821
390006	21.1786	21.7867	23.0378	22.0092
390007	21.3839	*	*	21.3839
390008	18.2743	19.5439	19.9417	19.2572
390009	20.6241	22.5580	21.9459	21.7141
390010	17.3335	18.1275	19.4377	18.3086
390011	18.3257	18.2751	18.6548	18.4184
390012	21.0610	22.2060	28.5114	23.7778

* Denotes wage data not available for the provider for that year.
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TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
390013	19.6562	20.2186	22.1679	20.7339
390015	13.7352	14.3138	*	14.0190
390016	17.1133	17.4931	18.1536	17.5840
390017	18.6113	18.5869	19.1962	18.7750
390018	19.0279	20.0672	19.9117	19.6570
390019	17.7258	18.7609	21.2807	19.2350
390022	24.8468	25.2980	27.5504	25.9222
390023	22.1044	23.9246	25.3767	23.8310
390024	25.4606	27.7643	25.9806	26.4580
390025	15.5523	14.0077	14.8690	14.8024
390026	22.9718	23.6317	24.0326	23.5437
390027	29.5940	29.4334	33.2139	30.7948
390028	23.6571	22.7820	24.6796	23.7138
390029	21.2661	24.4753	*	22.6697
390030	18.6887	18.9121	20.0598	19.2297
390031	18.8162	19.2040	20.3568	19.4469
390032	21.5105	18.5545	20.8450	20.3351
390035	22.3591	21.9325	23.2173	22.4923
390036	19.7671	20.2103	20.5751	20.1842
390037	20.4263	19.9175	20.1665	20.1659
390039	17.5300	17.6181	18.4580	17.8792
390040	16.6876	17.4451	20.5371	18.2001
390041	20.4397	19.6159	21.0074	20.3638
390042	22.5775	22.0668	22.2351	22.2889
390043	17.4764	17.6739	19.8641	18.3598
390044	20.9831	21.3382	22.4235	21.5908
390045	19.4677	20.2107	20.2082	19.9676
390046	21.7445	21.3960	23.1271	22.1125
390047	26.9709	*	*	26.9709
390048	19.7992	18.9776	20.3523	19.7014
390049	22.1586	22.8196	24.0933	23.0206
390050	22.2639	24.9156	22.6951	23.1957
390051	28.1385	*	*	28.1385
390052	20.1195	21.2729	22.1380	21.1379
390054	18.4975	19.4686	19.8602	19.2479
390055	23.4017	25.7327	23.5292	24.2129
390056	19.3901	21.4121	21.4239	20.7360
390057	20.2395	21.6693	24.8235	22.2695
390058	20.3520	20.7930	22.0113	21.0507
390061	23.8722	22.8728	24.4550	23.7184
390062	17.3750	17.4710	17.6303	17.4968
390063	19.4965	20.1696	21.7120	20.4817
390065	20.0473	20.2930	23.1384	21.2152
390066	18.9296	19.0132	21.7717	19.8676
390067	20.8162	21.9885	23.5136	22.0765
390068	19.1109	21.6408	21.1177	20.4766
390070	21.8549	22.7909	24.4403	23.0308
390071	16.0100	18.9416	17.8117	17.5040
390072	16.9232	16.9445	20.0561	17.9031
390073	21.2623	22.2703	22.7073	22.0769
390074	18.3093	19.7446	21.8456	19.9484
390075	18.7695	19.5840	19.9774	19.3988
390076	21.3290	19.7719	21.2039	20.7327
390078	19.0156	20.6483	*	19.7928
390079	18.9269	19.5982	19.9169	19.5006
390080	21.4707	22.2449	23.3742	22.3584
390081	24.7461	25.6575	28.1056	26.2492
390083	*	26.1660	*	26.1660
390084	20.2529	17.0197	18.3551	18.4310
390086	18.3563	19.7645	19.6488	19.2797
390088	23.9506	*	*	23.9506
390090	21.3759	20.5433	22.4688	21.4690
390091	18.3770	19.0355	19.7361	19.0422
390093	18.4442	20.0135	19.9209	19.4590

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
390095	16.6930	17.9697	18.3939	17.6811
390096	22.4382	22.2974	22.9502	22.5646
390097	25.2845	24.7853	24.5304	24.8507
390100	20.9263	21.1186	23.4155	21.8409
390101	18.5039	19.0180	20.1271	19.2316
390102	21.5496	19.3111	20.9807	20.6410
390103	18.8667	20.4422	21.0637	20.0228
390104	16.3255	16.2440	16.5081	16.3661
390106	16.8439	17.4747	*	17.1489
390107	20.9841	20.6024	21.5852	21.0626
390108	21.3142	22.0444	23.7842	22.3277
390109	16.5299	17.4540	17.2667	17.0836
390110	21.6464	21.6005	22.3968	21.8598
390111	33.3971	27.1429	30.5814	30.4618
390112	15.0065	14.8634	15.6710	15.1640
390113	19.3634	19.9496	20.1160	19.8009
390114	20.9533	19.8004	23.6162	21.4379
390115	21.4287	22.3545	24.1951	22.7320
390116	21.3671	22.6783	24.9581	22.9637
390117	18.0769	18.9764	19.0983	18.7219
390118	18.9507	17.2668	17.8460	18.0300
390119	18.8815	19.3946	20.3034	19.5629
390121	19.1315	20.6253	20.8017	20.2031
390122	17.7734	15.5438	18.5130	17.2135
390123	21.3974	21.8897	23.2232	22.1599
390125	17.5446	17.0975	18.2411	17.6363
390127	22.4555	22.8787	25.0836	23.5152
390128	19.3165	19.9764	21.3668	20.1918
390130	18.3695	18.5519	19.4835	18.7830
390131	19.2096	19.1931	19.5296	19.3184
390132	22.8414	24.1878	24.6889	23.9106
390133	24.7561	24.1590	25.2110	24.7109
390135	22.1905	22.2501	24.0445	22.8305
390136	20.6286	16.8505	21.9531	19.6672
390137	18.5397	19.4769	19.5457	19.1463
390138	20.6936	20.7726	21.4705	20.9891
390139	23.9757	24.8347	26.3622	25.0742
390142	28.8877	28.4680	29.8874	29.0890
390145	20.4228	20.4964	20.6580	20.5260
390146	18.6505	20.1788	21.4580	20.0672
390147	21.2492	21.7600	22.3135	21.7727
390150	20.3155	20.8970	20.0261	20.3992
390151	22.5206	23.6072	24.7843	23.6769
390152	19.4017	20.2581	21.5474	20.4133
390153	22.9707	23.9039	25.3391	24.1056
390154	16.7052	17.8774	19.1300	17.9859
390156	22.6398	24.0034	25.0801	23.9044
390157	19.1783	20.2647	20.6933	20.0398
390160	19.4463	19.4793	19.3598	19.4262
390162	21.9188	21.3379	24.0291	22.4183
390163	17.7564	18.1831	18.8585	18.2862
390164	24.9750	26.1698	24.2334	25.0898
390166	19.7978	19.8899	19.8531	19.8460
390168	18.8863	19.6875	20.6777	19.7568
390169	22.0547	22.7920	22.7695	22.5431
390170	24.7973	*	*	24.7973
390173	18.6613	18.8265	20.6958	19.3949
390174	25.3307	26.3891	28.4490	26.7187
390176	20.8368	21.7650	18.0752	20.3817
390178	17.0534	17.1142	17.2384	17.1362
390179	21.8593	21.5792	24.0501	22.5243
390180	26.5541	26.7743	28.4842	27.3230
390181	19.3832	18.8681	*	19.1299
390183	17.9848	17.4535	21.6811	18.9628

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
390184	20.9349	21.1941	21.1962	21.1056
390185	20.3877	20.3301	20.4476	20.3876
390189	20.3338	19.6186	20.1365	20.0174
390191	17.2270	17.1919	18.5972	17.6639
390192	17.6597	16.6469	19.1883	17.8533
390193	18.1209	17.3804	18.9764	18.1140
390194	21.2689	21.0549	21.5850	21.3104
390195	24.1793	24.2891	26.2024	24.9040
390197	20.7998	22.1974	22.8349	21.9546
390198	15.8833	16.6803	17.3937	16.6375
390199	17.3865	17.7782	18.9787	18.0590
390200	15.4012	18.2456	19.4471	17.7454
390201	20.3533	21.3291	22.7849	21.5155
390203	21.4989	22.4685	26.9436	23.7942
390204	22.9616	22.7282	23.9673	23.2268
390209	18.7059	16.8200	*	17.7119
390211	18.4213	19.4552	21.0450	19.6873
390213	19.1553	20.1152	*	19.6103
390215	21.2032	23.5953	25.2617	23.2887
390217	19.9837	19.7578	21.4058	20.3609
390219	19.6226	20.1311	20.0594	19.9347
390220	17.7916	22.7617	23.4385	21.1834
390222	22.1548	22.7491	24.9345	23.2935
390223	22.1775	18.9493	22.8725	21.2902
390224	13.7518	17.2173	16.1289	15.4447
390225	18.7290	19.0364	20.9232	19.6059
390226	21.8481	22.8588	25.6917	23.3415
390228	19.8180	19.6212	21.0164	20.1594
390231	19.4798	21.0757	24.7757	21.7340
390233	20.2309	20.5800	21.8043	20.8925
390235	21.4200	19.9925	23.7068	21.4467
390236	17.8735	19.1427	19.8687	18.9492
390237	22.3011	21.7847	23.2054	22.4279
390238	17.1055	18.1956	19.2170	18.1264
390244	15.6402	14.2136	*	14.8974
390245	24.5076	*	*	24.5076
390246	25.0556	22.3892	22.0687	23.0374
390247	21.2151	*	*	21.2151
390249	13.1657	14.1062	14.7215	14.0139
390256	22.2773	22.3540	22.6146	22.4202
390258	22.6852	23.8318	25.0634	23.8724
390260	21.5982	*	*	21.5982
390262	*	18.8942	21.3264	20.1664
390263	20.3796	20.6348	22.0008	21.0295
390265	20.4950	20.4760	20.5948	20.5230
390266	17.1966	17.6223	18.2424	17.6964
390267	19.2665	20.2424	21.4801	20.3933
390268	22.0909	22.2046	23.1124	22.4784
390270	19.2074	20.7957	22.5258	20.8233
390278	17.7176	18.5776	21.1387	19.0743
390279	14.8655	15.8080	16.0509	15.5561
390283	22.5490	*	*	22.5489
390284	34.3904	*	*	34.3902
390285	*	29.1270	30.6300	29.8499
390286	*	22.9746	25.4499	24.2027
390287	*	30.3252	32.9709	31.6159
390288	*	26.9662	28.0958	27.3905
390289	*	22.8963	25.1658	23.9733
390290	*	30.5037	31.0967	30.8194
390291	*	20.0272	21.0057	20.4818
390293	*	23.5285	*	23.5284
390294	*	*	33.3535	33.3537
390295	*	*	26.8863	26.8862
390296	*	*	25.6979	25.6981

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
390297	*	*	25.7318	25.7318
400001	10.5757	10.7531	11.7572	11.0430
400002	13.0494	13.3684	11.6804	12.6379
400003	12.4078	11.2726	10.5963	11.4141
400004	8.5648	9.0781	11.4041	9.6304
400005	7.7432	9.7802	10.5356	9.1053
400006	10.1048	10.4988	9.2852	9.9205
400007	8.0174	8.1974	8.6022	8.2631
400009	8.8650	8.7341	9.4413	9.0138
400010	10.8011	9.1359	9.2799	9.7479
400011	8.5426	8.6252	8.9111	8.6956
400012	8.4728	8.6538	9.0740	8.7216
400013	9.2624	9.8197	9.9905	9.7250
400014	9.4798	10.2712	11.4580	10.3309
400015	14.4076	15.5827	*	14.8835
400016	13.3922	13.7001	14.6491	13.9317
400017	9.2577	9.9167	10.7476	9.9817
400018	10.6208	10.5583	10.8254	10.6669
400019	10.8940	12.1251	13.6516	12.2168
400021	12.1434	12.7462	13.5224	12.8271
400022	12.2199	13.0915	15.2904	13.4548
400024	9.2409	9.0826	9.8650	9.4011
400026	5.8335	7.4280	5.9206	6.3365
400028	9.1794	8.9567	9.5266	9.2275
400032	10.0448	10.1898	10.7100	10.3326
400044	11.9486	12.8671	9.0275	11.6261
400048	15.1405	11.5104	10.8618	12.2444
400061	13.0988	10.3664	16.5895	12.9754
400079	9.7203	8.7218	8.7218	8.9772
400087	9.8534	8.6480	10.7118	9.8615
400094	7.9187	9.4600	9.2871	8.8796
400098	9.7791	10.4312	13.5901	11.0612
400102	9.9903	8.5290	10.9973	9.8471
400103	11.5359	11.8454	11.5797	11.6448
400104	10.7292	7.9552	7.1781	8.8476
400105	9.0556	10.6028	11.5608	10.1248
400106	9.2187	9.8694	10.1240	9.7589
400109	11.8760	12.2080	12.8886	12.3304
400110	10.5277	10.7228	12.0159	11.1009
400111	10.9665	12.3311	12.7701	12.0404
400112	10.8694	11.0634	12.2859	11.4080
400113	8.3168	9.3000	10.4416	9.6011
400114	7.0510	9.9477	9.7444	8.8440
400115	8.5487	7.2203	7.0411	7.5166
400117	10.8756	11.3351	9.7314	10.6287
400118	11.4051	11.4317	12.4590	11.7860
400120	10.6584	10.9315	11.8837	11.1482
400121	9.8322	8.7584	8.3575	8.9176
400122	7.6413	9.1638	9.6644	8.8133
400123	10.2367	10.9047	10.5643	10.5707
400124	12.2452	12.7323	14.1627	13.0714
400125	10.2056	10.5997	10.5811	10.4664
410001	23.1738	22.4972	24.0033	23.2235
410004	21.0638	23.5408	23.6409	22.7712
410005	22.7170	24.0086	24.6521	23.7686
410006	23.8700	22.8959	26.1372	24.3270
410007	23.1325	24.9846	27.7171	25.1159
410008	24.9726	24.4792	25.4183	24.9582
410009	24.3895	24.3760	26.9135	25.2049
410010	28.4589	29.7315	30.3860	29.5220
410011	26.1183	27.4880	29.7664	27.7381
410012	24.1695	26.4570	28.1791	26.2184
410013	24.8800	25.3688	28.9386	26.3621
420002	20.7804	22.6182	25.1067	22.8141

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
420004	20.9588	22.4680	23.4579	22.2290
420005	17.9694	17.8202	19.5521	18.4820
420006	19.1760	18.7153	22.7896	19.8079
420007	18.6456	19.0199	22.0228	19.8823
420009	19.9586	21.2566	18.6866	19.8536
420010	18.0252	19.3267	19.1746	18.8763
420011	18.0970	16.7523	17.7299	17.5010
420014	18.0519	19.0455	21.2046	19.4445
420015	20.1164	20.8736	23.1274	21.4737
420016	15.5485	16.6448	17.0051	16.4309
420018	21.8775	20.7779	20.4649	20.9903
420019	17.1726	19.0199	19.6836	18.6013
420020	20.3193	20.5801	22.1616	21.0728
420023	20.4053	20.8600	23.2568	21.5753
420026	21.8749	23.3072	23.7406	23.0011
420027	19.2594	19.7322	21.0637	20.0499
420030	20.6448	22.5159	22.6766	21.9685
420031	8.2516	15.3605	*	10.6827
420033	23.1303	23.7974	26.2710	24.4383
420036	21.3222	19.8285	20.6649	20.5448
420037	22.7099	23.5244	25.5492	24.0161
420038	18.6568	19.9829	21.6132	20.0798
420039	18.3017	18.0055	21.9737	19.2483
420043	19.7570	19.6834	21.8816	20.4303
420048	18.8070	20.5531	21.9517	20.4950
420049	19.4049	20.1765	21.2604	20.3295
420051	19.1555	19.8549	20.6629	19.9007
420053	18.1657	19.0780	19.9013	19.0557
420054	20.2574	20.2275	20.8471	20.4420
420055	16.8717	18.6782	19.6817	18.3873
420056	15.1835	16.5491	20.0527	17.2450
420057	20.5266	22.1312	17.6727	20.1808
420059	17.1483	18.2093	20.2917	18.4487
420061	17.3543	17.7047	19.9789	18.3969
420062	21.7469	20.9032	17.4764	19.8282
420064	16.0794	19.7067	20.9057	19.0582
420065	19.9435	19.2150	22.0784	20.4983
420066	18.0042	19.5366	20.7782	19.3987
420067	19.7824	20.8524	22.8104	21.1856
420068	18.5481	20.2580	21.7257	20.1957
420069	18.1298	18.9017	17.6291	18.2134
420070	17.3876	19.2186	20.3664	19.0084
420071	20.3902	20.1897	21.8579	20.8383
420072	15.0158	18.2531	16.2578	16.5142
420073	19.9986	20.2697	21.4718	20.6373
420074	18.0967	18.1839	18.7011	18.3051
420075	12.8158	15.0132	15.9890	14.6306
420078	21.9082	22.7156	24.3273	22.9650
420079	21.0874	21.3177	23.3992	21.9864
420080	21.9968	23.2871	26.7489	24.1988
420082	21.7210	22.8516	23.6936	22.7569
420083	22.6376	24.4499	24.8508	24.0155
420085	21.6791	22.0071	24.4040	22.7952
420086	20.2878	23.5303	24.5760	22.8222
420087	19.8388	20.8217	22.4526	21.0450
420088	19.9919	21.8979	23.5174	21.7712
420089	20.5360	21.3954	23.3240	21.8074
420091	20.3092	21.8367	23.7936	21.9046
420093	18.3902	19.1299	21.4678	19.5913
420095	*	33.4632	*	33.4634
420096	*	26.4863	*	26.4864
430004	19.6344	19.2737	*	19.4433
430005	16.4560	17.3400	18.2647	17.3726
430007	14.6331	15.1494	*	14.8985

* Denotes wage data not available for the provider for that year.
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TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
430008	18.1323	18.5234	20.0124	18.8898
430010	19.8191	16.5750	*	17.9984
430011	17.4750	18.3648	19.9835	18.5721
430012	17.6997	19.2921	21.2588	19.3790
430013	18.4817	18.8978	21.3388	19.5495
430014	20.2387	20.9118	22.0285	21.0694
430015	18.2875	18.8998	20.5848	19.2456
430016	20.8850	22.7585	24.2450	22.6451
430018	16.2244	15.9424	17.9850	16.6387
430022	14.5118	14.0661	*	14.2905
430023	16.2164	16.7850	18.8816	17.1465
430024	16.1801	17.4816	18.8359	17.4068
430027	20.2591	20.8666	22.1807	21.1128
430028	17.1577	18.2829	*	17.7353
430029	17.6986	17.4932	18.9463	18.0331
430031	12.4660	13.2105	15.2322	13.5804
430033	17.3652	18.3978	21.6255	19.2950
430034	14.2491	13.8535	*	14.0594
430036	15.6258	16.7827	*	16.1636
430037	18.1293	18.7009	*	18.4202
430038	18.4078	*	*	18.4078
430040	14.4509	14.7860	*	14.6153
430041	14.8816	*	*	14.8815
430043	14.9949	17.0193	17.9673	16.5225
430044	21.0823	*	*	21.0824
430047	17.9823	17.5377	18.2773	17.9221
430048	18.7602	19.0261	20.0608	19.3158
430049	15.2237	14.9025	*	15.0665
430051	18.8070	18.8697	*	18.8400
430054	14.8003	15.0101	17.8870	15.8667
430056	10.3697	14.1914	*	12.0169
430057	17.2805	18.8777	*	18.0992
430060	10.0176	9.7678	10.6493	10.1353
430064	14.2184	13.8666	14.3407	14.1427
430066	15.6660	14.5957	*	15.1085
430073	15.3776	16.5112	*	15.9305
430076	13.9883	15.2453	*	14.6206
430077	19.8558	20.4361	21.6786	20.6834
430079	14.1815	14.4154	*	14.2974
430089	17.9790	17.5100	19.8572	18.4672
430090	21.5974	23.5180	25.6873	23.7486
430091	18.1567	21.6239	22.2824	21.1724
430092	21.3807	19.7644	19.7354	20.2342
430093	19.5013	23.3009	23.8820	22.1340
430094	*	*	20.8742	20.8743
440001	15.5897	17.2282	18.9833	17.1918
440002	20.3740	21.4299	22.0178	21.2905
440003	19.3042	20.3756	21.6336	20.4509
440006	21.4055	23.1483	24.3173	22.9919
440007	14.8959	14.0612	14.8015	14.5822
440008	18.8994	20.3303	20.9238	20.0515
440009	17.4831	18.4068	19.6564	18.5235
440010	16.3283	13.3692	16.7270	15.2992
440011	18.3375	19.3165	20.5036	19.4558
440012	19.5739	19.8949	21.1213	20.1775
440014	16.1143	15.0656	*	15.5948
440015	22.0659	21.6106	23.4485	22.3272
440016	16.2964	14.6142	20.1504	16.8295
440017	20.4563	20.4705	21.8033	20.8965
440018	17.4995	18.1620	21.2242	19.0126
440019	21.5402	22.8463	21.8854	22.0914
440020	17.8879	20.2189	21.1075	19.7440
440023	16.7837	15.6603	15.5410	15.9556
440024	18.4046	18.4276	19.9751	18.8456

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
440025	16.3140	17.0997	19.1478	17.5703
440026	23.2566	25.6490	25.1655	24.7161
440029	20.7050	22.2889	24.1379	22.4401
440030	16.9925	17.6297	19.9056	18.2332
440031	17.0211	17.2555	17.0289	17.1002
440032	13.8140	13.9784	14.7683	14.1838
440033	13.7328	16.4679	17.2637	15.8189
440034	20.0309	21.1672	22.2478	21.1521
440035	19.3034	20.4168	21.4990	20.4205
440039	21.6536	22.4158	25.0874	23.1050
440040	16.9275	17.6781	16.9886	17.1928
440041	14.9545	14.6684	15.5784	15.0621
440046	19.3229	20.5562	22.3380	20.6463
440047	17.8092	18.7469	18.7962	18.4413
440048	21.4993	21.6132	23.1553	22.1163
440049	18.7967	19.6920	21.1931	19.8880
440050	18.2511	19.7915	21.1397	19.7737
440051	16.0421	17.7067	19.0165	17.5455
440052	19.8075	18.6589	18.1935	18.8415
440053	19.6494	21.5253	22.0345	21.0746
440054	13.3967	15.2154	15.4208	14.7050
440056	16.2742	20.4903	19.3108	18.5997
440057	13.7257	14.4363	14.1477	14.1083
440058	19.1878	20.7722	21.7512	20.5453
440059	19.6018	20.8882	22.4248	21.0016
440060	19.7916	20.7628	20.2188	20.2562
440061	22.5525	16.9234	19.5458	19.4254
440063	19.8371	18.8072	19.7468	19.4529
440064	18.9809	18.2678	19.4020	18.8736
440065	18.8296	19.2282	19.9099	19.3487
440067	17.2397	18.2973	19.5643	18.4105
440068	19.3668	19.5428	20.9188	19.9728
440070	14.0437	18.0064	18.3717	16.8031
440071	19.7836	*	*	19.7836
440072	19.1522	20.0691	19.6579	19.6208
440073	19.5554	19.6290	20.7181	19.9917
440078	16.0188	17.1645	*	16.5456
440081	19.3454	17.2905	18.3142	18.2349
440082	22.6855	22.5590	26.1497	23.7116
440083	13.7423	13.7630	15.7015	14.3937
440084	13.7731	13.8085	15.0510	14.2295
440091	20.1065	20.1359	23.0296	21.0909
440100	14.7113	15.9969	*	15.3629
440102	14.5500	16.0783	16.6548	15.7421
440103	18.6990	*	*	18.6990
440104	22.6754	21.7135	21.9870	22.0956
440105	17.1172	18.1375	19.2902	18.1888
440109	17.7443	17.6399	17.3578	17.5716
440110	17.4816	18.4998	19.9715	18.7259
440111	23.2254	23.2111	24.9883	23.8046
440114	15.0036	18.5327	20.1152	17.9248
440115	18.5457	18.7054	18.5389	18.5956
440120	16.3115	19.8997	22.4031	19.5197
440125	19.4115	20.0599	21.1018	20.2091
440130	17.4857	19.0905	20.6364	19.0816
440131	16.1214	19.9883	21.0641	18.9957
440132	16.8871	17.9186	18.9580	17.9377
440133	23.0891	22.2257	23.3600	22.8900
440135	22.2005	22.5452	23.9749	22.9815
440137	15.0070	15.3530	16.5529	15.6758
440141	15.9429	17.6819	19.2607	17.4468
440142	16.8855	17.1483	17.7587	17.2159
440143	18.2061	18.6844	19.2978	18.7274
440144	18.3859	18.8127	19.7938	19.0189

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
440145	18.3948	18.3850	18.2020	18.3221
440147	26.1464	25.3766	25.0779	25.5115
440148	19.4598	19.3769	20.7693	19.8862
440149	18.4281	19.8304	18.1316	18.8060
440150	20.3006	21.2942	22.8733	21.5258
440151	18.3928	19.8977	21.1576	19.7369
440152	22.7664	21.7382	22.7498	22.4243
440153	16.5716	18.1781	19.9486	18.2431
440156	21.7577	21.9374	23.7799	22.5299
440157	18.4249	15.5316	*	17.0805
440159	20.9371	21.4914	20.5719	20.9737
440161	22.8816	23.6805	26.1354	24.2908
440162	15.5534	19.8075	20.3909	18.5104
440166	19.2159	19.6632	23.1692	20.6397
440168	19.1509	21.1947	21.2114	20.4537
440173	19.1812	21.0284	20.8442	20.3754
440174	18.0865	19.3966	19.2201	18.8962
440175	18.5186	19.9022	22.3331	20.2599
440176	19.2208	19.8448	20.4861	19.8829
440180	20.2184	20.2057	21.2398	20.5594
440181	17.7709	19.0915	19.6133	18.8053
440182	19.7094	18.1953	19.3928	19.0713
440183	21.3465	22.2401	24.9282	22.9040
440184	16.8880	18.6890	21.4484	18.5678
440185	21.2188	21.1226	22.1845	21.5612
440186	19.7983	20.8600	23.0193	21.1673
440187	17.5872	18.3729	19.9478	18.6211
440189	18.5252	22.2555	23.2866	21.3831
440192	19.1705	19.1976	21.3228	19.9395
440193	18.6999	19.9078	22.0345	20.2055
440194	22.4562	21.9609	24.4508	23.0024
440197	21.8503	22.5282	24.2660	22.9060
440200	19.8078	18.7302	16.7752	18.4446
440203	16.2861	16.9819	*	16.6264
440210	11.9815	12.7622	*	12.3704
440214	28.0285	*	*	28.0287
440215	22.2928	*	*	22.2928
440217	*	19.2834	23.3544	21.1703
440218	*	*	20.1377	20.1377
440220	*	*	21.9117	21.9117
450002	21.4836	21.5141	24.0411	22.4013
450004	16.7850	15.9452	*	16.4042
450005	16.6396	16.6354	21.7110	18.0529
450007	19.1910	18.0269	18.3737	18.5024
450008	17.6582	19.3745	20.1817	19.0466
450010	17.6677	19.8998	20.3023	19.2481
450011	20.8102	20.2963	22.1472	21.0609
450014	17.5815	19.8846	20.6936	19.3710
450015	21.6773	22.9820	23.9526	22.8711
450016	18.3456	19.1522	20.1232	19.2132
450018	23.2293	21.9921	22.9019	22.6021
450020	19.1153	18.4642	19.1087	18.9021
450021	23.3630	23.7663	25.0769	24.0893
450023	17.6360	19.2808	19.1645	18.7230
450024	18.5985	19.5584	20.7727	19.7057
450028	19.1658	19.5905	22.7775	20.4223
450029	17.7425	19.9505	19.9198	19.2371
450031	29.6945	29.6772	21.7621	26.1343
450032	14.6530	20.8525	20.5217	18.3019
450033	21.0222	21.3766	26.5990	22.8755
450034	18.8823	19.5233	21.6097	19.9960
450035	20.3599	20.3146	24.1860	21.4818
450037	19.9140	19.6532	23.1179	20.8871
450039	19.7176	20.4660	22.0058	20.7406

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
450040	19.6370	24.8621	21.2990	22.1496
450042	18.8357	20.6041	21.8886	20.4547
450044	21.0909	23.4476	24.1127	22.8038
450046	17.3631	20.2917	20.9239	20.0838
450047	16.9028	15.9525	21.8840	18.0090
450050	17.7209	19.1390	19.5171	18.7476
450051	21.1008	23.0010	24.5533	22.8745
450052	15.5890	20.3702	17.6543	17.8920
450053	17.2781	19.3347	18.6557	18.3562
450054	19.2431	25.3285	23.2915	22.8358
450055	15.8526	16.4789	18.2235	16.8274
450056	21.8605	22.5341	24.4197	22.9813
450058	18.6172	20.0424	22.0158	20.1655
450059	19.8240	21.4873	22.8792	21.4779
450063	12.7211	15.1779	*	13.6764
450064	19.7682	21.3929	19.1271	20.0460
450065	23.3797	23.8471	*	23.6194
450068	23.3495	22.5626	24.0925	23.3338
450072	18.0307	20.0134	20.3683	19.5324
450073	16.5942	23.7700	19.2398	20.0099
450078	13.2820	13.9324	14.8285	13.9373
450079	20.6483	22.0609	24.0085	22.2224
450080	18.6212	19.8414	21.0353	19.7911
450081	17.5737	19.0276	19.2632	18.6116
450082	16.8677	18.0688	16.6566	17.1967
450083	23.3754	20.7446	22.5063	22.1900
450085	20.0085	17.5001	18.1922	18.5095
450087	21.9320	23.4141	24.5976	23.4136
450090	15.5796	15.6090	17.1073	16.1114
450092	17.9520	17.2058	16.0199	17.0396
450094	23.2863	25.2158	25.8313	24.8017
450096	18.6802	19.4430	19.8012	19.3176
450097	19.7187	20.7653	22.2467	21.0001
450098	19.0454	19.8469	20.4795	19.8538
450099	20.4181	19.3493	21.4482	20.3831
450101	17.7928	17.6368	20.1473	18.5186
450102	19.8793	21.4361	20.9900	20.7697
450104	17.0821	17.8219	19.7126	18.2038
450107	24.1094	24.5034	23.2209	23.9133
450108	15.2797	17.9596	18.8084	17.4498
450109	10.5973	18.1085	15.1459	13.9232
450111	21.4908	*	*	21.4908
450112	18.1026	17.9624	20.2627	18.7413
450113	20.8306	20.7782	37.8953	21.1550
450119	20.2030	20.1436	20.8840	20.4169
450121	21.9198	22.0485	24.6090	22.7993
450123	14.1755	17.5051	17.8629	16.2415
450124	22.5208	22.9853	24.2788	23.3063
450126	21.4789	22.9423	24.1961	22.8519
450128	18.1446	18.7067	*	18.4296
450130	18.9211	20.2613	19.6199	19.6368
450131	17.4168	18.1401	20.0434	18.5074
450132	21.8089	20.8908	22.4680	21.7157
450133	26.0763	24.5319	25.3928	25.3029
450135	20.4068	21.7038	22.5673	21.5916
450137	23.4346	22.8653	24.9732	23.6854
450140	17.3370	19.6205	18.3835	18.4738
450143	15.0871	17.8206	18.4204	17.0420
450144	17.4309	21.9135	21.3896	20.1692
450145	16.1895	18.0437	*	17.1256
450146	15.5030	17.4391	16.6809	16.5128
450147	19.0477	20.3019	21.7248	20.3699
450148	20.4923	21.4982	22.1352	21.3649
450149	21.7219	22.6138	*	22.1667

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
450150	17.8612	17.8804	*	17.8714
450151	16.4209	16.3279	17.9127	16.8202
450152	17.7265	19.6105	20.0146	19.2384
450153	18.6514	20.9651	*	19.6822
450154	13.9119	16.8748	16.5204	15.7956
450155	13.3456	20.2582	18.4020	17.1145
450157	15.3083	16.8569	17.8764	16.7446
450160	10.6852	18.7780	20.7736	15.2692
450162	21.9218	20.5032	26.0570	22.6007
450163	17.8028	19.7675	19.8194	19.0677
450164	17.7180	18.7103	*	18.2191
450165	17.3283	16.1010	16.1632	16.4885
450166	11.0541	12.6627	*	11.8721
450170	14.3234	15.8525	*	15.0719
450176	17.2576	19.2397	19.1823	18.5579
450177	15.2419	16.4503	17.2637	16.3229
450178	16.0280	15.8597	19.1186	16.9564
450181	18.6936	18.3600	*	18.5293
450184	20.0821	22.7744	24.0596	22.3298
450185	11.5228	13.2015	14.3593	12.9076
450187	18.5053	20.8105	22.6275	20.5632
450188	15.1954	16.9800	17.6158	16.6235
450191	20.9512	20.5883	23.2261	21.6512
450192	21.2497	20.8315	20.1718	20.7147
450193	23.1639	25.1215	26.6580	25.0322
450194	20.7745	20.7152	22.7310	21.4587
450196	17.8993	21.1226	20.1938	19.6870
450200	19.2228	19.6496	20.4656	19.7649
450201	17.1463	18.0646	19.5908	18.2573
450203	19.3978	19.7978	22.9226	20.7388
450209	20.0140	21.3218	23.4794	21.6108
450210	16.3470	16.8532	16.7851	16.6843
450211	18.8114	18.7305	20.0280	19.2048
450213	19.0651	19.3440	21.1280	19.7979
450214	20.5070	21.3448	22.4543	21.4482
450217	12.7647	13.1840	*	12.9705
450219	17.6884	18.5534	21.0691	18.7782
450221	15.2120	16.2308	19.6778	16.9127
450222	19.8967	23.2779	23.5033	22.2859
450224	20.1579	20.1723	20.4453	20.2606
450229	16.7853	17.0346	17.9811	17.2535
450231	19.1746	20.7709	21.3086	20.4242
450234	16.3003	17.9478	22.3954	18.6856
450235	16.3115	17.0143	18.7028	17.2571
450236	16.4957	18.4551	17.7372	17.5626
450237	19.0325	21.6497	22.4477	21.0610
450239	17.8401	18.8416	19.3655	18.6917
450241	16.4240	16.6046	17.4151	16.8266
450243	13.6416	11.2035	13.0790	12.6321
450246	16.7959	22.7940	*	19.5014
450249	11.7658	10.6467	13.1223	11.8062
450250	13.6787	18.3361	13.3732	15.0054
450253	13.2177	14.5492	16.6523	14.6986
450258	16.7337	17.0724	*	16.8994
450264	14.5956	17.2825	13.5346	14.9127
450269	12.7717	12.2970	12.6907	12.5661
450270	14.4792	13.8881	13.9053	14.0814
450271	16.7831	17.9570	18.3659	17.7341
450272	18.4344	20.5888	21.4520	20.2033
450276	14.0745	14.0779	12.8895	13.6150
450278	15.2950	14.3931	*	14.7982
450280	22.2936	22.2648	23.1664	22.5953
450283	15.1950	15.8224	17.1014	16.1659
450288	18.8935	17.4817	*	18.1670

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
450289	20.3460	22.4656	23.7108	22.1634
450292	20.5335	21.1511	23.4257	21.6168
450293	16.2721	16.4077	17.7673	16.8504
450296	22.3430	21.5998	20.4483	21.4253
450299	*	21.2754	22.9849	22.1397
450303	12.8996	14.3353	16.1330	14.3646
450306	14.2047	13.6333	17.6820	14.6856
450307	17.0691	17.6757	*	17.3739
450309	13.3771	16.0363	*	14.6950
450315	21.4684	23.8151	26.4677	23.7712
450320	20.6596	24.8602	26.8089	24.0198
450321	14.7344	17.2289	*	15.8859
450322	29.1884	28.9834	*	29.0897
450324	19.1692	20.9081	23.8523	21.3049
450327	13.3639	11.0983	14.3848	12.7752
450330	19.8066	21.0921	22.9948	21.3142
450334	13.8392	13.9812	*	13.9103
450337	25.5708	*	*	25.5709
450340	*	19.2611	20.0622	19.6678
450341	*	20.8814	*	20.8814
450346	18.9475	19.2769	20.1921	19.5923
450347	19.3475	20.1899	21.7142	20.4550
450348	13.3585	15.0069	15.6324	14.6025
450351	19.3159	21.2842	22.2596	20.9600
450352	20.1871	21.2035	21.8138	21.1211
450353	16.0003	17.3274	19.5263	17.5681
450355	11.8933	12.8876	*	12.3798
450358	23.0206	25.5767	25.9105	24.7573
450362	18.1983	18.7687	20.6340	19.2155
450369	15.3122	16.0667	16.5636	15.9500
450370	16.1369	18.7539	19.0340	18.0704
450371	16.0236	17.7591	17.3415	16.8971
450372	22.0746	21.4050	22.9079	22.0659
450373	17.9554	18.5716	17.7955	18.1170
450374	15.1750	15.0146	15.0670	15.0810
450378	23.4599	24.4143	25.8048	24.6304
450379	22.8756	25.1931	29.0865	25.7747
450381	16.7112	16.7237	19.0584	17.6325
450388	19.7408	20.7989	22.4441	21.1047
450389	18.8448	19.3156	20.7160	19.6532
450393	22.4992	21.4405	23.8236	22.5782
450395	18.0024	17.5236	19.1938	18.2716
450399	15.3491	16.3333	19.1571	16.9654
450400	18.6668	19.1345	20.1376	19.3717
450403	22.8430	24.7657	24.6215	24.1271
450411	15.1121	15.9165	16.9559	15.9781
450417	15.3591	15.2713	16.1956	15.6177
450418	21.9690	22.2511	25.1306	23.1136
450419	23.2551	22.9522	26.7662	24.2202
450422	28.0257	28.0395	29.0032	28.3661
450424	18.7895	20.7634	22.0682	20.6438
450431	22.0361	22.6766	22.9545	22.5599
450438	15.4553	21.0474	19.2165	18.2799
450446	20.7592	13.8011	14.1684	15.5340
450447	18.0377	19.7532	21.0247	19.5725
450451	18.2988	18.9519	21.1046	19.4672
450457	19.6569	*	*	19.6569
450460	14.6523	15.9446	17.9487	16.1581
450462	22.1144	22.5413	24.0081	22.8970
450464	15.5908	15.8121	16.1987	15.8774
450465	15.4731	19.3928	19.4486	17.6468
450467	17.0004	18.9388	*	17.8588
450469	22.1930	22.0389	24.0794	22.8914
450473	19.7148	18.3813	18.6003	18.8420

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
450475	16.9269	19.0010	20.9443	18.9625
450484	18.9825	19.5505	23.2881	20.6738
450488	19.2173	22.0927	22.5650	21.2542
450489	16.3584	17.8779	18.5941	17.5105
450497	16.2997	15.9654	17.1327	16.4523
450498	14.4713	15.9479	19.2985	16.4927
450508	19.0991	19.3274	20.8183	19.8005
450514	20.0144	20.7064	21.0116	20.6064
450517	14.3191	17.6011	14.4247	15.4999
450518	21.4873	20.7355	21.1015	21.1171
450523	21.0393	23.8270	22.3034	22.4026
450530	21.1634	21.8988	23.3005	22.1616
450534	20.1520	19.7410	22.5156	20.7023
450535	21.0513	21.5449	23.7255	22.0993
450537	20.1161	20.8849	22.5972	21.2300
450539	18.7559	19.3681	18.4299	18.8532
450544	23.6652	22.7282	*	23.2148
450545	20.2823	21.0792	21.7762	21.0259
450547	18.1524	20.5049	22.6558	20.1983
450551	16.6237	16.1437	*	16.3738
450558	20.7404	21.3116	21.4201	21.1518
450563	22.0708	21.9935	27.5671	23.9083
450565	17.3803	17.8058	17.2171	17.4667
450570	19.0336	*	*	19.0336
450571	18.2784	19.5325	21.5688	19.7274
450573	17.3518	17.6157	18.6233	17.8792
450574	14.6128	14.8549	*	14.7345
450575	22.5621	24.0386	*	23.3408
450578	18.0925	17.2863	17.3010	17.5480
450580	16.7374	17.8224	18.5226	17.6863
450583	14.4411	15.9430	*	15.2044
450584	14.6735	14.9237	16.9020	15.4896
450586	13.8248	14.7433	14.9061	14.4503
450587	18.0219	18.0014	19.0648	18.3640
450591	17.7795	18.6714	19.6229	18.7114
450596	21.6729	21.9445	24.3714	22.6695
450597	17.6179	19.0641	19.9596	18.8329
450603	23.5572	23.4924	20.6138	22.5917
450604	17.6582	18.7465	19.5288	18.6690
450605	19.4580	19.7400	22.0210	20.3694
450609	17.0986	14.1776	16.6870	15.9595
450610	21.5191	23.5626	24.7706	23.4743
450614	16.5754	*	18.5895	17.6527
450615	15.2956	15.0621	17.2717	15.8832
450617	20.8919	21.5004	22.7514	21.7690
450620	16.0987	16.4330	17.1333	16.5680
450623	23.1270	25.1122	25.1400	24.4887
450626	18.4349	20.5225	17.7454	18.8435
450628	18.6093	20.0411	*	19.3786
450630	20.9605	23.1840	24.8096	23.0353
450631	21.6736	21.8940	22.8637	22.1659
450632	13.9147	15.1416	*	14.5084
450633	19.4949	*	*	19.4949
450634	22.9877	23.0470	24.8258	23.7101
450638	22.1704	23.8335	26.3653	24.1319
450639	21.6421	23.0496	24.2919	23.0328
450641	15.7578	15.3652	17.4072	16.1535
450643	16.8152	18.9088	20.2000	18.7134
450644	22.7721	24.5834	24.4574	24.0080
450646	19.1433	23.1240	21.8500	21.2678
450647	24.2763	25.0549	26.8276	25.4018
450648	15.0305	14.4884	17.3678	15.6152
450649	16.6577	16.8505	17.5760	17.0475
450651	22.7112	25.4679	26.9215	25.1260

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
450652	17.2445	*	*	17.2446
450653	19.2349	20.2436	22.7236	20.7352
450654	14.5423	15.5858	16.3057	15.4780
450656	18.2606	18.5874	20.7824	19.2080
450658	17.2630	19.4139	19.6855	18.7689
450659	23.0108	22.9344	26.0224	24.0406
450661	18.9071	19.5504	20.0716	19.5103
450662	19.3152	20.7973	26.3794	22.0858
450665	16.1319	14.5158	15.8571	15.5177
450666	20.2549	*	*	20.2549
450668	21.0972	21.2002	24.0081	22.0964
450669	21.6746	22.5150	25.0200	23.1112
450670	20.2632	19.7696	19.9621	19.9838
450672	21.4927	23.2623	25.3106	23.3562
450673	13.7005	14.9115	16.3319	15.0676
450674	22.2426	21.9624	24.8137	23.0636
450675	21.4479	23.3954	24.8661	23.3355
450677	20.6556	21.7366	22.9529	21.8092
450678	24.1301	25.1841	28.1917	25.8918
450683	22.8699	22.1965	24.5013	23.1739
450684	21.9962	22.2380	23.8945	22.7570
450686	16.4632	17.4746	17.9181	17.2988
450688	20.1831	21.7691	21.7922	21.3124
450690	22.4707	27.2399	33.1576	27.0095
450694	18.1872	18.5520	21.4785	19.2847
450697	19.4949	19.4424	20.8952	19.9640
450698	15.4750	16.5111	18.1764	16.7102
450700	15.9050	14.2055	17.3457	15.8451
450702	21.3739	19.8094	22.2953	21.1028
450704	20.7987	18.1835	*	19.2723
450705	22.1809	18.7138	*	20.2752
450706	22.0884	22.4329	*	22.2641
450709	22.1490	22.0123	23.4246	22.5690
450711	19.8581	20.8047	22.1489	20.9512
450712	15.9298	11.1086	18.4546	14.6487
450713	22.6986	23.6189	24.4002	23.6310
450715	22.5988	24.8068	*	23.7226
450716	20.9074	20.8913	24.8614	22.2839
450717	20.6551	22.0243	*	21.3435
450718	22.1765	23.0051	24.9162	23.5065
450723	20.8213	22.0633	24.1618	22.4391
450724	20.3706	23.3799	21.9630	21.8831
450727	17.9172	24.6125	16.0843	19.3135
450728	19.8879	14.9265	*	17.2495
450730	23.0054	24.5952	27.8476	25.3002
450733	20.2199	21.9921	23.8143	22.0738
45042	21.8392	22.8135	25.1295	23.3180
450743	19.6015	20.5017	23.7424	21.3472
450746	30.2657	14.6683	11.1672	15.8134
450747	20.3914	20.3870	21.5883	20.8604
450749	19.1678	18.7138	17.8696	18.5551
450750	13.8098	*	*	13.8098
450751	19.9995	19.8170	23.3152	20.7533
450754	16.7145	17.8497	19.2827	17.9575
450755	19.8743	20.0667	19.2768	19.7781
450757	14.9434	15.6425	*	15.2936
450758	19.0221	22.6196	22.8713	21.5676
450760	19.2225	20.4209	23.2959	20.7991
450761	15.7681	14.6511	15.5151	15.2848
450763	18.6092	18.9713	19.8939	19.1937
450766	23.3879	25.4057	27.2499	25.3311
450769	18.4163	17.9879	*	18.2056
450770	19.0183	20.0632	19.9412	19.7010
450771	21.8268	21.6946	25.0490	22.9471

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
450774	16.2948	*	21.7906	18.6936
450775	21.3504	22.6526	23.6621	22.5576
450776	14.1720	13.4263	14.6695	14.0866
450777	19.0380	18.3119	*	18.6460
450779	21.6642	22.6216	23.8882	22.7424
450780	19.0914	20.0824	21.9046	20.4076
450788	19.6469	19.9817	21.4467	20.3179
450795	22.5753	27.0250	19.1371	22.4874
450796	19.2059	26.8539	22.4973	23.7266
450797	16.4923	20.2356	18.6839	18.3681
450801	17.9548	18.0598	19.7790	18.5904
450802	17.1435	18.2460	*	17.6977
450803	21.6653	37.0925	23.8343	26.2012
450804	19.0893	20.5225	22.8275	20.8633
450806	*	20.7906	*	20.7906
450807	13.4306	18.4410	*	15.3677
450808	17.4917	18.1728	18.6555	18.1215
450809	19.7899	21.9845	23.8758	21.8428
450811	19.9168	21.6115	22.7583	21.5237
450813	14.5392	15.3780	21.7208	16.6296
450815	21.2741	*	*	21.2742
450817	*	*	28.4441	28.4441
450819	16.5521	*	*	16.5521
450820	26.8348	24.6542	26.9120	26.1797
450822	22.8556	24.8702	26.7821	24.9818
450823	*	17.9756	*	17.9757
450824	*	25.7488	24.5885	25.1472
450825	*	16.0793	18.8510	17.6091
450827	*	20.1310	29.5838	24.8201
450828	*	19.2902	20.9509	20.1462
450829	*	14.7121	14.4463	14.5541
450830	*	*	24.7835	24.7834
450832	*	*	24.8572	24.8572
450833	*	*	18.3195	18.3196
450834	*	*	21.7217	21.7217
450835	*	*	24.8374	24.8374
450837	*	*	24.2965	24.2964
460001	22.2735	23.5485	24.8844	23.5856
460003	22.6289	22.9549	26.5141	23.9755
460004	21.7234	23.1289	24.3409	23.0686
460005	22.5252	23.0189	25.0063	23.5075
460006	21.0700	22.1648	23.4200	22.2290
460007	21.1922	22.0409	23.3603	22.2561
460008	19.1153	22.6808	24.8233	22.3133
460009	22.5295	23.1933	24.5865	23.4290
460010	22.4948	24.0907	25.1240	23.9360
460011	19.7674	25.3818	21.2634	21.8917
460013	20.1936	21.2360	23.1467	21.5125
460014	18.5370	*	22.6125	20.9837
460015	21.0470	22.4872	23.1068	22.2481
460016	21.9105	19.0910	18.7453	19.8107
460017	18.9929	19.0724	20.7789	19.6010
460018	17.0063	17.0385	16.7143	16.9128
460019	17.8690	19.3442	18.1995	18.4514
460020	17.2663	18.1542	15.2162	16.7463
460021	21.5174	23.1368	23.8565	22.9024
460022	21.3614	20.7539	*	21.0221
460023	22.9265	24.1825	25.0874	24.0957
460025	17.3494	17.4070	22.3100	18.8099
460026	20.2576	21.1759	21.9316	21.1444
460027	22.2955	21.4833	*	21.8486
460029	20.8366	23.7148	24.4379	23.0146
460030	17.1383	18.7655	21.2546	18.9564
460032	21.4832	21.0286	21.2715	21.2538

* Denotes wage data not available for the provider for that year.
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TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
460033	19.2664	20.2389	21.7215	20.4433
460035	16.1685	15.6979	16.9657	16.2272
460036	23.4573	24.2651	23.9909	23.9286
460037	17.7399	19.0115	20.0323	18.9515
460039	24.4808	24.5134	26.3795	25.1512
460041	20.2035	21.6676	23.5132	21.8727
460042	19.5662	19.7531	22.0844	20.5371
460043	23.2819	25.1366	26.0277	24.8166
460044	21.8485	23.6604	24.7139	23.4328
460047	22.7524	23.5447	24.9214	23.7640
460049	20.8283	21.5241	21.9358	21.5104
460051	22.1758	21.8950	22.7540	22.2835
460052	19.8961	20.1989	23.1718	21.0691
460053	*	*	23.2273	23.2274
470001	21.3817	21.7774	23.5882	22.3065
470003	22.0563	23.3612	24.1739	23.1995
470004	18.1879	17.3576	*	17.7382
470005	23.1808	22.6589	24.9625	23.6347
470006	20.2829	21.0835	21.6036	21.0098
470008	20.1969	20.3833	20.7659	20.4458
470010	21.0616	22.3913	23.2072	22.2567
470011	22.2415	24.1306	24.6034	23.6561
470012	18.9444	19.8831	20.5072	19.7941
470015	20.2125	21.8204	*	21.0240
470018	21.2406	24.8493	21.2904	22.3634
470020	21.5688	21.9911	*	21.7766
470023	21.7139	22.5334	24.1395	22.7760
470024	21.9807	23.2738	22.4659	22.5822
490001	20.0570	21.4952	22.3622	21.3461
490002	15.7365	16.5198	17.5098	16.5736
490003	20.3237	20.7688	20.9782	20.6753
490004	19.7074	20.7616	22.7154	21.0565
490005	21.3318	23.1708	25.2213	23.2687
490006	12.3253	19.8977	13.4277	15.2731
490007	19.8938	20.7896	22.2526	20.9740
490009	23.7659	24.7602	25.2181	24.6030
490011	19.8042	19.8179	20.0136	19.8803
490012	15.2965	16.0994	15.8346	15.7118
490013	18.2396	18.3901	19.5094	18.7096
490014	23.5266	27.8907	*	25.5759
490015	20.0667	21.4500	21.2557	20.9648
490017	19.3854	19.6594	20.7691	19.9104
490018	18.5508	19.8955	22.0810	20.2089
490019	21.0124	21.6790	23.3077	22.0282
490020	19.3424	20.9212	21.2094	20.4866
490021	20.0496	21.2263	22.2537	21.2008
490022	22.3380	24.3008	24.4682	23.7523
490023	21.5683	22.8400	24.9733	23.1948
490024	18.4314	19.7491	21.2619	19.8335
490027	16.7556	17.5178	20.3644	18.2452
490030	8.6446	*	*	8.6446
490031	16.0003	17.4262	18.4826	17.3314
490032	21.4037	22.2041	23.6489	22.3775
490033	19.2908	23.2088	24.4370	22.3633
490037	17.0113	17.2117	17.5103	17.2485
490038	17.6324	18.6012	18.1405	18.1142
490040	24.1266	25.5461	27.0513	25.6394
490041	18.7987	17.9942	19.9314	18.8986
490042	17.0972	18.1864	19.5127	18.3230
490043	22.1068	23.5367	25.4354	23.6479
490044	19.7842	18.4845	20.8739	19.7388
490045	20.5558	22.5238	24.7131	22.7244
490046	19.9102	19.8518	22.0040	20.5969
490047	18.7614	20.1660	19.8220	19.5730

* Denotes wage data not available for the provider for that year.
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TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
490048	19.5417	20.9110	22.3138	20.9455
490050	23.3668	23.8519	26.1521	24.5290
490052	16.4787	18.5693	19.2480	18.1097
490053	16.8410	17.7363	18.6541	17.7531
490054	19.5780	22.5136	*	21.2010
490057	20.3160	21.1871	22.1612	21.2650
490059	21.4801	24.1516	23.3895	22.9645
490060	18.5917	19.3525	20.6028	19.5408
490063	26.1930	28.0906	31.0162	28.4308
490066	19.8352	21.5920	22.1034	21.2122
490067	17.8487	18.6469	20.4058	18.9938
490069	20.7582	18.8335	20.6957	20.1008
490071	23.3511	24.1882	25.4677	24.4329
490073	26.0957	*	27.6711	26.9865
490075	19.2156	20.5801	22.3229	20.7337
490077	22.6504	21.9175	22.2643	22.2859
490079	17.7016	17.5839	19.2196	18.1709
490084	18.0555	18.9679	19.8598	18.9692
490085	17.6158	19.4261	*	18.5291
490088	17.9141	19.1924	19.7549	18.9853
490089	18.2290	19.7936	21.1522	19.7626
490090	17.5799	19.2094	20.3015	19.0319
490091	25.0272	23.7493	*	24.4545
490092	16.4360	27.1805	23.8364	21.5391
490093	17.8275	19.1131	20.7388	19.2083
490094	22.3033	20.2020	21.9886	21.4787
490097	16.9518	16.6563	18.1022	17.2610
490098	16.0488	18.5133	19.7116	18.0649
490099	18.3985	19.2604	*	18.8235
490101	23.5553	25.7804	28.5200	26.0299
490104	40.2529	17.1683	28.0286	24.6486
490105	21.4428	28.7831	40.6822	26.6520
490106	26.3821	31.8566	31.6541	29.5471
490107	22.9283	23.9962	26.5312	24.6073
490108	24.1232	24.8596	28.7277	25.7440
490109	25.9475	23.0609	28.0978	25.5419
490110	18.1561	18.8042	23.6080	20.0833
490111	17.8510	19.9552	19.4041	19.0697
490112	22.1162	23.2843	23.6028	23.0255
490113	23.9043	26.1840	28.0893	26.0992
490114	18.0359	18.8920	19.9725	18.9850
490115	16.8537	18.4499	19.9150	18.4166
490116	17.2040	18.2935	19.7007	18.4196
490117	14.7944	17.1723	15.6078	15.8681
490118	23.2022	24.2668	25.2230	24.2345
490119	18.6046	18.9535	21.3883	19.5991
490120	20.5777	20.6828	22.2389	21.1886
490122	23.8198	26.6681	27.3509	25.9831
490123	19.3056	20.0920	20.9506	20.1282
490124	21.3818	23.6526	21.3713	22.1870
490126	20.4294	19.0782	20.4660	19.9498
490127	16.5993	17.6437	17.8070	17.3281
490129	28.6868	*	*	28.6863
490130	17.6943	18.6406	18.6038	18.3141
490132	18.4671	19.1742	19.5850	19.0428
500001	24.4829	25.3478	26.6420	25.5079
500002	19.8476	22.9942	24.0374	22.2651
500003	24.4333	25.1200	27.3435	25.6803
500005	24.3870	26.2066	28.9512	26.5073
500007	21.9911	24.7889	23.5774	23.3350
500008	26.1737	27.2852	28.9380	27.5261
500011	24.6554	25.7263	27.6762	26.0196
500012	24.2799	24.5450	26.2263	25.0463
500014	24.0990	25.0490	27.4248	25.5566

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
500015	24.9923	25.9465	27.3397	26.1168
500016	24.9439	25.1227	27.7863	25.9574
500019	23.2054	23.5730	25.7691	24.2429
500021	27.6490	25.9403	26.4648	26.6119
500023	27.1025	32.3079	23.9513	27.3082
500024	26.6452	26.2113	27.2967	26.7293
500025	24.4825	27.3697	29.0400	26.8639
500026	26.9884	26.6108	28.7532	27.4597
500027	25.1125	27.7429	30.6901	27.9493
500028	18.9556	19.0261	*	18.9904
500029	18.5042	19.3130	*	18.9280
500030	26.3828	28.5297	29.0487	28.0239
500031	23.6099	25.8542	26.0740	25.1801
500033	22.5462	23.8994	25.4345	23.9873
500036	23.6333	25.1255	25.4753	24.7809
500037	21.4059	22.1774	23.5414	22.3769
500039	24.0007	25.4225	26.1409	25.2258
500041	25.4376	24.7070	24.9005	25.0014
500043	22.0466	24.1745	*	23.1775
500044	24.2212	24.7816	27.0880	25.3901
500045	24.0526	24.6265	*	24.3304
500048	20.3207	20.6333	*	20.4821
500049	24.5997	26.5857	26.6407	25.8996
500050	22.6563	23.0804	25.0907	23.6590
500051	25.9447	26.7628	26.9538	26.5713
500053	22.8399	24.2492	26.0112	24.3887
500054	23.8089	25.7815	27.1965	25.6339
500055	23.8622	23.7988	25.3095	24.3502
500057	19.0479	20.5812	21.0357	20.2825
500058	24.1106	26.5679	27.3411	26.0709
500059	26.6270	25.3528	*	25.9254
500060	28.3655	29.6030	31.7480	29.9426
500061	20.8624	24.5908	*	22.7197
500062	19.0557	19.1685	*	19.1136
500064	26.7000	27.5791	29.2539	27.8671
500065	23.5671	24.0966	26.5881	24.7506
500068	19.2638	20.9278	*	20.1095
500069	21.4542	22.4158	*	21.9517
500071	19.1428	22.3253	23.2071	21.4408
500072	25.2001	25.7734	27.5706	26.2080
500073	21.7698	22.5222	*	22.1712
500074	19.5981	20.6120	21.9018	20.7646
500077	23.9410	24.5695	26.5692	25.0435
500079	23.1041	24.7946	27.1775	25.0691
500080	18.3883	18.8188	*	18.6306
500084	24.4044	25.0556	26.5864	25.4001
500085	20.4517	20.7422	*	20.5981
500086	22.8829	24.2556	25.9705	24.3779
500088	25.2478	26.4212	30.1689	27.0767
500089	19.7166	20.3478	*	20.0210
500090	20.4429	21.7716	*	21.0547
500092	19.2028	20.3058	20.8601	20.1437
500094	15.7866	17.6625	*	16.7064
500096	23.3564	25.1135	*	24.2745
500097	20.8774	21.4423	*	21.1473
500098	15.2040	17.8453	*	16.5267
500101	15.8000	19.8614	*	17.6277
500102	21.8963	23.1307	*	22.5307
500104	24.9389	24.7875	26.8007	25.5111
500106	19.1465	17.1066	*	18.1033
500107	17.9489	17.4641	*	17.7015
500108	28.6229	26.1609	27.4156	27.3893
500110	22.9775	23.5941	24.8448	23.8174
500118	24.8034	24.7875	26.1971	25.2739

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
500119	22.1192	23.9939	25.1576	23.7715
500122	23.5264	24.4462	26.9006	25.0168
500123	19.6646	21.7133	*	20.9232
500124	23.7742	24.6591	24.8357	24.4790
500125	14.7910	15.6304	*	15.2302
500129	25.4685	25.2082	27.8351	26.2009
500132	23.1822	21.9915	*	22.6185
500134	17.2430	15.9791	21.3919	17.5320
500139	22.3053	23.7993	27.7281	24.5780
500141	29.9695	28.1014	28.2968	28.7009
500143	18.2570	18.7523	19.0982	18.7216
510001	20.0429	20.2514	21.4247	20.5803
510002	17.6392	19.1517	20.9822	19.2895
510005	13.8621	13.8641	*	13.8631
510006	19.9609	19.9760	21.0214	20.3316
510007	21.6761	22.9326	23.4411	22.6998
510008	19.0513	19.9176	22.7595	20.6320
510012	15.6089	15.8596	16.7710	16.1127
510013	19.5798	18.3486	19.7937	19.2416
510015	16.7311	17.1595	17.9040	17.2636
510018	18.5358	18.3023	19.9490	18.9487
510020	14.1211	15.7512	*	14.9242
510022	21.5770	21.4336	22.7534	21.9321
510023	16.7777	17.6516	17.9267	17.4783
510024	18.7461	19.6521	21.3662	19.9294
510026	13.7952	14.8785	16.5389	14.9496
510027	18.5945	20.5222	*	19.5739
510028	19.9208	22.4826	24.6543	22.2359
510029	18.4668	18.9000	19.8202	19.0740
510030	17.7603	19.2558	19.8220	18.9626
510031	18.6341	19.3049	20.5742	19.5716
510033	18.4718	19.6900	19.6921	19.3132
510035	18.3164	21.8290	*	20.0924
510036	13.8786	15.0266	*	14.4439
510038	15.5576	15.9821	16.1016	15.8882
510039	17.1461	17.4002	17.6173	17.3850
510043	13.1308	14.4202	15.5857	14.3831
510046	18.5896	18.7424	19.2802	18.8707
510047	20.8101	21.2885	22.1953	21.4251
510048	17.1647	15.2886	16.3761	16.2789
510050	18.4036	18.3964	18.9990	18.5986
510053	17.5798	18.1046	18.1054	17.9357
510055	24.2133	25.6333	27.7422	25.8187
510058	18.4501	18.6025	20.1104	19.0814
510059	16.1044	17.3844	18.1544	17.1696
510061	14.1968	14.6774	14.8848	14.5883
510062	18.1588	19.7202	21.3404	19.7139
510067	17.3067	17.8816	18.0113	17.7501
510068	23.0452	19.4299	19.9056	20.6790
510070	18.7091	18.6226	20.0974	19.1353
510071	18.0278	18.8766	19.4029	18.7564
510072	15.9257	16.5279	18.4566	16.9820
510077	18.2947	20.4521	20.9153	19.8338
510080	16.3453	19.7131	*	17.8253
510081	11.9701	10.4972	*	11.2092
510082	13.5946	16.0014	17.2891	15.5840
510084	13.5339	14.9683	*	14.2476
510085	18.6227	19.0175	20.6364	19.4471
510086	14.2241	16.3413	16.3051	15.6167
510088	14.8854	16.2850	16.4373	15.8902
520002	19.6755	20.2691	22.0838	20.7249
520003	18.7956	18.7507	20.4234	19.3853
520004	20.4591	21.1549	22.8530	21.4781
520006	21.4884	22.4099	*	21.9357

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
520007	18.4629	18.3959	*	18.4330
520008	24.9395	24.4927	26.0931	25.2072
520009	21.4638	19.8142	21.5169	20.8888
520010	22.3311	25.5623	26.3964	24.7924
520011	21.5223	21.6945	22.7880	22.0154
520013	20.5944	22.1009	23.1173	21.9777
520014	18.0841	19.2760	20.4282	19.2712
520015	19.7672	21.0428	22.8094	21.2438
520016	18.4320	19.5656	*	18.9788
520017	19.4780	21.1409	21.7542	20.8166
520018	21.5279	22.1929	*	21.8799
520019	20.9164	21.8870	22.6895	21.8682
520021	21.9531	22.8484	24.1284	23.0293
520024	14.4750	16.4879	17.5368	16.1948
520025	20.3838	21.9529	*	21.1922
520026	20.8546	22.4779	25.0504	22.8714
520027	21.5868	22.1450	22.2089	21.9932
520028	22.5941	22.0333	24.3592	23.0143
520029	21.4197	21.5561	*	21.4863
520030	21.6311	22.7239	23.9474	22.8336
520031	20.9875	21.2809	*	21.1290
520032	21.1069	24.1092	22.7220	22.6429
520033	20.2520	21.0088	22.2650	21.1839
520034	20.4307	21.5275	22.6160	21.7180
520035	18.7135	19.8917	20.8563	19.8607
520037	21.6017	23.0801	25.0587	23.2977
520038	20.6130	21.4208	23.1036	21.7099
520039	23.3687	21.1719	*	22.1557
520040	21.2023	23.0710	21.5671	21.9307
520041	18.4117	18.2997	22.6216	19.7373
520042	19.5466	20.6354	21.9935	20.7535
520044	19.1877	21.4913	22.7626	21.1506
520045	21.2427	21.9812	24.1624	22.4304
520047	20.3487	21.0370	22.5686	21.3314
520048	19.8926	20.3488	20.5069	20.2455
520049	20.1667	21.8271	22.7424	21.6003
520051	24.0460	23.4366	27.6695	25.0213
520053	18.0851	18.9512	*	18.5170
520054	16.8363	16.6278	*	16.7267
520057	19.8492	20.6959	21.2729	20.6322
520058	21.2500	23.6794	23.2907	22.7126
520059	21.5796	22.1618	24.1863	22.6609
520060	18.8232	20.3357	21.1271	20.1183
520062	19.7038	21.2865	23.7166	21.6639
520063	20.5262	21.2774	23.3037	21.7486
520064	22.0917	23.8181	24.3043	23.3833
520066	24.0087	25.4528	23.9212	24.4126
520068	19.6855	20.6112	21.4413	20.5790
520069	20.1770	21.7233	32.6484	21.3815
520070	19.4261	20.0096	22.0590	20.5199
520071	19.9866	22.0066	23.4832	21.8338
520074	20.9007	21.6636	*	21.2683
520075	20.7301	22.1894	23.7322	22.2613
520076	19.5878	20.6155	22.2993	20.8518
520077	18.7119	18.1077	*	18.3984
520078	21.7545	21.7414	23.4414	22.2794
520083	23.5787	24.2401	25.7108	24.5108
520084	23.5446	21.8102	24.7909	23.3951
520087	20.7821	22.2579	22.8974	22.0182
520088	21.8931	22.3921	23.8938	22.6992
520089	22.1055	23.2335	24.4435	23.2707
520090	20.3645	20.9069	*	20.6378
520091	20.9440	22.2218	22.8914	22.0430
520092	18.6248	19.7181	21.8662	20.1341

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
520094	20.6179	21.3082	22.3925	21.4517
520095	18.6425	21.9177	25.1402	21.7601
520096	20.6668	21.6803	21.1759	21.1819
520097	20.8016	22.2375	23.6512	22.2609
520098	23.4707	25.0055	25.8184	24.7756
520100	19.4788	20.5366	21.7072	20.6024
520101	19.9875	20.0164	*	20.0019
520102	21.0138	22.3640	23.7739	22.4092
520103	20.1092	22.2765	23.5984	22.0082
520107	21.7907	23.8421	25.7379	23.7522
520109	19.7609	20.3208	20.6356	20.2580
520110	21.0055	22.3923	*	21.7201
520111	17.7673	18.2744	26.9667	20.3598
520112	18.9577	17.6226	19.1409	18.5293
520113	21.8852	23.1852	24.0822	23.0750
520114	17.8476	18.5767	21.9848	19.3865
520115	19.2248	21.4279	*	20.3524
520116	20.6922	22.2741	23.9066	22.2707
520117	18.3963	19.3653	*	19.9396
520118	14.8626	13.9920	*	14.4086
520121	20.8492	20.9422	*	20.8956
520122	16.9335	16.9905	*	16.9629
520123	17.7986	19.8134	21.2360	19.6609
520124	17.9205	19.2621	*	18.5941
520130	16.6873	18.8845	20.0277	18.5254
520131	20.2591	21.0400	*	20.6634
520132	18.1630	18.2634	19.5140	18.6382
520134	18.8150	19.6881	20.8502	19.7907
520135	17.3476	18.1026	18.8254	18.0936
520136	20.9050	21.3966	23.2573	21.8325
520138	22.5599	23.1498	25.1434	23.6620
520139	21.4042	22.8070	23.7727	22.6778
520140	22.3671	22.5459	23.9176	22.9362
520142	21.9432	21.4120	*	21.6717
520144	19.9120	20.5864	*	20.2475
520145	18.7958	20.3461	25.0771	20.8014
520146	18.2370	18.6337	*	18.4453
520148	19.1502	20.5075	22.4299	20.7682
520149	12.8928	13.8614	*	13.3481
520151	18.7070	19.3362	20.1995	19.4436
520152	22.5980	26.2402	22.5440	23.5479
520153	17.0863	18.5986	*	17.8517
520154	19.5994	21.0486	23.2635	21.3043
520156	20.9638	20.7808	23.7157	21.8343
520157	19.6008	21.6821	*	20.6349
520159	17.7649	21.8783	*	19.8043
520160	20.5154	21.5871	22.9475	21.7239
520161	20.1102	21.4038	22.1857	21.2456
520170	21.9857	23.0867	25.5470	23.5499
520171	18.0785	18.1844	*	18.1321
520173	20.9209	23.2955	24.4722	22.8643
520177	24.0139	25.0908	27.5560	25.5340
520178	20.9010	23.1509	22.3193	22.0890
520189	*	22.0889	23.1658	22.6212
520192	*	*	22.5643	22.5641
530002	21.0560	23.0582	23.8852	22.6216
530003	15.9523	17.1646	*	16.5866
530004	13.3788	17.4672	19.7857	16.7474
530005	15.3255	18.4391	*	16.9756
530006	19.1305	20.7661	21.3429	20.4783
530007	17.7897	18.5286	22.3309	19.6133
530008	19.0113	19.5386	21.8714	20.1106
530009	21.7795	23.5839	22.0451	22.4288
530010	13.9536	17.8687	21.4890	17.2328

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (1999 WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly wage** (3yrs)
530011	19.4606	19.9212	22.5720	20.6678
530012	21.1854	22.5084	22.4716	22.0976
530014	18.4900	20.0422	21.7314	20.1695
530015	23.4040	24.6527	25.3915	24.5334
530016	19.3205	20.3647	21.0666	20.2058
530017	17.7736	20.9408	19.5631	19.3707
530018	19.5986	20.1226	*	19.8663
530019	20.1097	18.1492	*	19.0248
530022	19.6136	19.7902	*	19.7065
530023	20.0677	21.6352	22.5534	21.5200
530025	22.0300	22.4816	25.4693	23.3672
530026	19.8969	20.9919	21.0733	20.6804
530027	25.5067	*	*	25.5069
530029	19.3361	20.3046	19.9692	19.8988
530031	20.1734	23.2766	16.8825	20.2555
530032	20.0132	20.9856	19.4450	20.0811

*Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 3A.—FY 2004 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS

[*Based on the Sum of the Salaries and Hours Computed for Federal Fiscal Years 2002, 2003, and 2004]

Urban area	FY 2004 average hourly wage	3-Year average hourly wage
Abilene, TX	18.8450	18.2266
Aguadilla, PR	10.6399	10.5889
Akron, OH	22.8434	22.3877
Albany, GA	26.8394	25.0646
Albany-Schenectady-Troy, NY	20.9741	19.8010
Albuquerque, NM	22.9788	22.1382
Alexandria, LA	19.8135	18.6733
Allentown-Bethlehem-Easton, PA	24.0178	23.0413
Altoona, PA	21.7576	21.1859
Amarillo, TX	22.2017	20.8641
Anchorage, AK	30.1827	29.0196
Ann Arbor, MI	27.3610	25.9303
Anniston, AL	19.9890	19.0540
Appleton-Oshkosh-Neenah, WI	22.3237	21.2583
Arecibo, PR	10.2650	10.2305
Asheville, NC	24.0145	22.6770
Athens, GA	24.2576	23.3576
Atlanta, GA	25.0274	23.5635
Atlantic-Cape May, NJ	26.6718	25.8172
Auburn-Opelika, AL	20.9868	19.6276
Augusta-Aiken, GA-SC	23.7818	23.2814
Austin-San Marcos, TX	23.7418	22.5676
Bakersfield, CA	24.2375	22.8607
Baltimore, MD	24.5068	23.1821
Bangor, ME	24.4712	22.6991
Barnstable-Yarmouth, MA	32.0118	31.0786
Baton Rouge, LA	20.7683	19.4439

TABLE 3A.—FY 2004 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the Sum of the Salaries and Hours Computed for Federal Fiscal Years 2002, 2003, and 2004]

Urban area	FY 2004 average hourly wage	3-Year average hourly wage
Beaumont-Port Arthur, TX	20.8140	19.6576
Bellingham, WA	29.0487	28.0239
Benton Harbor, MI	22.0757	20.9454
Bergen-Passaic, NJ	28.8869	27.7302
Billings, MT	22.1402	21.3587
Biloxi-Gulfport-Pascagoula, MS	22.3087	20.4967
Binghamton, NY	20.8245	19.6736
Birmingham, AL	22.7610	21.2316
Bismarck, ND	19.6799	18.6613
Bloomington,IN	21.4009	20.6516
Bloomington-Normal, IL	21.8206	21.0629
Boise City, ID	22.7531	21.5699
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	27.7541	26.4283
Boulder-Longmont, CO	24.8276	23.1313
Brazoria, TX	20.1054	19.4362
Bremerton, WA	26.1409	25.2258
Brownsville-Harlingen-San Benito, TX	25.4556	21.9472
Bryan-College Station, TX	22.2836	21.2298
Buffalo-Niagara Falls, NY	23.7287	22.1616
Burlington, VT	23.9756	23.1273
Caguas, PR	10.2735	10.3098
Canton-Massillon, OH	22.4122	21.0501
Casper, WY	22.4716	22.0976
Cedar Rapids, IA	21.9242	20.8155
Champaign-Urbana, IL	24.4767	23.3108

TABLE 3A.—FY 2004 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the Sum of the Salaries and Hours Computed for Federal Fiscal Years 2002, 2003, and 2004]

Urban area	FY 2004 average hourly wage	3-Year average hourly wage
Charleston-North Charleston, SC	23.0562	21.6706
Charleston, WV	21.9412	21.1056
Charlotte-Gastonia-Rock Hill, NC-SC	24.0412	22.5876
Charlottesville, VA	24.7694	24.2141
Chattanooga, TN-GA	22.4487	21.4283
Cheyenne, WY	21.7314	20.1695
Chicago, IL	26.9106	25.7471
Chico-Paradise, CA	25.1840	23.2716
Cincinnati, OH-KY-IN	23.2565	22.0537
Clarksville-Hopkinsville, TN-KY	20.3697	19.5203
Cleveland-Lorain-Elyria, OH	23.8949	22.4359
Colorado Springs, CO	24.2952	23.0525
Columbia, MO	21.4825	20.1775
Columbia, SC	21.9947	21.6170
Columbus, GA-AL	21.4813	19.9213
Columbus, OH	23.8368	22.6103
Corpus Christi, TX	21.0529	20.0005
Corvallis, OR	28.4536	27.0598
Cumberland, MD-WV	20.2591	18.9863
Dallas, TX	24.6430	23.3642
Danville, VA	22.3229	20.7337
Davenport-Moline-Rock Island, IA-IL	22.2001	20.6175
Dayton-Springfield, OH	23.5163	21.8747
Daytona Beach, FL	22.3855	21.1832
Decatur, AL	21.8128	20.7814
Decatur, IL	20.1642	18.9150
Denver, CO	26.7753	24.8304
Des Moines, IA	22.4988	20.7693
Detroit, MI	24.9570	24.1824
Dothan, AL	19.1266	18.5999

TABLE 3A.—FY 2004 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the Sum of the Salaries and Hours Computed for Federal Fiscal Years 2002, 2003, and 2004]

Urban area	FY 2004 average hourly wage	3-Year average hourly wage
Dover, DE	24.2251	22.9785
Dubuque, IA	21.9559	20.4460
Duluth-Superior, MN-WI	25.1306	24.0503
Dutchess County, NY	27.0153	25.1274
Eau Claire, WI	22.3936	21.0371
El Paso, TX	22.7218	21.6306
Elkhart-Goshen, IN	24.1721	22.8091
Elmira, NY	20.6973	19.6769
Enid, OK	21.1469	19.7375
Erie, PA	21.2504	20.4729
Eugene-Springfield, OR	28.3045	26.4658
Evansville, Henderson, IN-KY	20.8266	19.5719
Fargo-Moorhead, ND-MN	24.2066	22.2472
Fayetteville, NC	22.2028	21.0390
Fayetteville-Springdale-Rogers, AR	20.7450	19.4920
Flagstaff, AZ-UT	28.0003	25.5509
Flint, MI	26.8272	25.6484
Florence, AL	19.1407	18.2496
Florence, SC	21.5166	20.4519
Fort Collins-Loveland, CO	24.9739	23.6020
Fort Lauderdale, FL	25.1107	24.0387
Fort Myers-Cape Coral, FL	24.2518	22.5750
Fort Pierce-Port St. Lucie, FL	24.7279	23.4505
Fort Smith, AR-OK	20.8140	18.9811
Fort Walton Beach, FL	22.1527	21.6155
Fort Wayne, IN	23.6812	22.0804
Fort Worth-Arlington, TX	23.1224	22.0190
Fresno, CA	25.0577	23.7002
Gadsden, AL	20.2758	19.8948
Gainesville, FL	23.9479	22.6475
Galveston-Texas City, TX	22.9264	22.5715
Gary, IN	23.2496	22.2496
Glens Falls, NY	20.9392	19.5463
Goldsboro, NC	21.3024	20.4707
Grand Forks, ND-MN	21.3373	20.7295
Grand Junction, CO	23.8003	22.4013
Grand Rapids-Muskegon-Holland, MI	23.3944	22.6455
Great Falls, MT	21.7634	20.7748
Greeley, CO	23.1548	21.9595
Green Bay, WI	23.3746	22.0316
Greensboro-Winston-Salem-High Point, NC	22.6468	21.8467
Greenville, NC	22.4777	21.4396
Greenville-Spartanburg-Anderson, SC	23.0642	21.6183
Hagerstown, MD	22.6614	20.9120
Hamilton-Middletown, OH	22.7644	21.8133
Harrisburg-Lebanon-Carlisle, PA	22.6413	21.7012
Hartford, CT	28.5484	26.9960
Hattiesburg, MS	18.0540	17.5271
Hickory-Morganton-Lenoir, NC	22.8342	21.5753
Honolulu, HI	27.4202	26.5871
Houma, LA	19.2012	18.8317
Houston, TX	24.2970	22.9364
Huntington-Ashland, WV-KY-OH	23.7059	22.5222
Huntsville, AL	22.8430	21.1034
Indianapolis, IN	24.4986	22.9037
Iowa City, IA	23.5910	22.6224
Jackson, MI	22.2026	21.6786
Jackson, MS	20.6489	19.8519
Jackson, TN	22.1981	21.3037
Jacksonville, FL	23.5433	21.9817
Jacksonville, NC	21.1107	19.0690
Jamestown, NY	19.1768	18.5426
Janesville-Beloit, WI	22.9321	22.5285
Jersey City, NJ	27.4614	26.1004
Johnson City-Kingsport-Bristol, TN-VA	20.3906	19.6130
Johnstown, PA	20.1558	19.6398
Jonesboro, AR	19.2565	18.7034
Joplin, MO	21.4481	20.3222
Kalamazoo-Battlecreek, MI	25.9432	24.7762
Kankakee, IL	25.7423	24.2639
Kansas City, KS-MO	24.0023	22.6223
Kenosha, WI	24.1159	22.6827
Killeen-Temple, TX	22.6286	22.0631
Knoxville, TN	21.7911	20.8323
Kokomo, IN	22.3466	21.1444
La Crosse, WI-MN	22.8473	21.8008
Lafayette, LA	20.2761	19.6888
Lafayette, IN	21.2081	21.0348
Lake Charles, LA	19.3730	18.3946
Lakeland-Winter Haven, FL	21.7693	21.2439
Lancaster, PA	22.9333	21.5961
Lansing-East Lansing, MI	24.0008	22.7120
Laredo, TX	19.9917	19.1033
Las Cruces, NM	21.4650	20.3556
Las Vegas, NV-AZ	28.4828	26.7950
[1] Lawrence, KS	.....	.....
Lawton, OK	20.4263	19.7110
Lewiston-Auburn, ME	23.1828	21.7433
Lexington, KY	21.4595	20.3189
Lima, OH	23.5255	22.2651
Lincoln, NE	24.7884	23.5189
Little Rock-North Little Rock, AR	22.0469	21.0421
Longview-Marshall, TX	22.5155	20.5262
Los Angeles-Long Beach, CA	29.1430	27.8976
Louisville, KY-IN	22.8350	21.8979
Lubbock, TX	20.4375	20.4762
Lynchburg, VA	22.5683	21.4474
Macon, GA	22.1194	21.1586
Madison, WI	25.3588	24.2523
Mansfield, OH	20.3677	20.0909
Mayaguez, PR	11.8482	11.3512
McAllen-Edinburg-Mission, TX	20.7063	19.5970
Medford-Ashland, OR	26.6156	24.7374
Melbourne-Titusville-Palm Bay, FL	24.1528	23.3952
Memphis, TN-AR-MS	22.2594	21.0284
Merced, CA	23.9460	22.9922
Miami, FL	24.4448	23.1253
Middlesex-Somerset-Hunterdon, NJ	28.0828	26.5600
Milwaukee-Waukesha, WI	24.6768	23.3099
Minneapolis-St. Paul, MN-WI	27.1814	25.6666
Missoula, MT	21.5392	21.2648
Mobile, AL	19.7516	18.8646
Modesto, CA	27.8581	25.5375
Monmouth-Ocean, NJ	27.0700	25.3662
Monroe, LA	19.5724	18.9404
Montgomery, AL	19.5356	17.8815
Muncie, IN	21.6806	21.8078
Myrtle Beach, SC	22.5122	21.0737
Naples, FL	24.1885	22.8575
Nashville, TN	24.3495	22.8046
Nassau-Suffolk, NY	32.0836	31.2325
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	30.6008	28.8874
New London-Norwich, CT	28.7359	27.3016
New Orleans, LA	22.6662	21.2642
New York, NY	34.5159	33.4648
Newark, NJ	28.4574	26.9201
Newburgh, NY-PA	28.4349	26.5830
Norfolk-Virginia Beach-Newport News, VA-NC	21.2953	20.1214
Oakland, CA	36.8654	35.3917
Ocala, FL	24.0353	22.3921
Odessa-Midland, TX	23.0451	22.4675
Oklahoma City, OK	22.1973	20.7818
Olympia, WA	27.0877	25.9904
Omaha, NE-IA	24.0761	22.9780
Orange County, CA	28.0961	26.5056
Orlando, FL	23.8528	22.6357
Owensboro, KY	20.6888	19.5760
Panama City, FL	20.2643	20.3561
Parkersburg-Marietta, WV-OH	19.8623	19.0009
Pensacola, FL	21.6272	20.1029
Peoria-Pekin, IL	21.5796	20.4881
Philadelphia, PA-NJ	26.8898	25.3667
Phoenix-Mesa, AZ	25.0252	23.1478
Pine Bluff, AR	19.4324	18.4911
Pittsburgh, PA	21.9917	21.6912
Pittsfield, MA	25.3885	23.9758
Pocatello, ID	22.3412	21.7279
Ponce, PR	11.6330	11.7569
Portland, ME	24.5806	22.8110
Portland-Vancouver, OR-WA	27.7033	25.8270
Providence-Warwick, RI	27.1208	25.4419

TABLE 3A.—FY 2004 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the Sum of the Salaries and Hours Computed for Federal Fiscal Years 2002, 2003, and 2004]

Urban area	FY 2004 average hourly wage	3-Year average hourly wage
Provo-Orem, UT	24.6487	23.2777
Pueblo, CO	21.6891	20.4756
Punta Gorda, FL	23.4973	21.6974
Racine, WI	21.7768	21.4720
Raleigh-Durham-Chapel Hill, NC	24.6061	23.2373
Rapid City, SD	21.7579	20.7364
Reading, PA	22.5640	21.8521
Redding, CA	28.0470	26.2716
Reno, NV	26.3924	24.8500
Richland-Kennewick-Pasco, WA	26.2126	25.7613
Richmond-Petersburg, VA	23.0989	22.2365
Riverside-San Bernardino, CA	28.0369	26.3968
Roanoke, VA	21.4945	20.0801
Rochester, MN	29.0034	27.6344
Rochester, NY	23.2999	21.7673
Rockford, IL	23.8812	22.2379
Rocky Mount, NC	22.4234	21.4021
Sacramento, CA	29.2650	27.4594
Saginaw-Bay City-Midland, MI	24.7875	22.8302
St. Cloud, MN	23.4868	22.6816
[1] St. Joseph, MO	.....	.....
St. Louis, MO-IL	22.3172	20.9395
Salem, OR	25.8986	24.0695
Salinas, CA	35.4282	34.0968
Salt Lake City-Ogden, UT	24.4924	23.2233
San Angelo, TX	21.0874	19.7140
San Antonio, TX	21.9156	20.4598
San Diego, CA	27.5405	26.1970
San Francisco, CA	35.8606	33.3285
San Jose, CA	36.1362	33.5095
San Juan-Bayamon, PR	12.1065	11.2275
San Luis Obispo-Atascadero-Paso Robles, CA	28.2381	26.3416
Santa Barbara-Santa Maria-Lompoc, CA	25.7977	24.7645
Santa Cruz-Watsonville, CA	31.9761	31.6254
Santa Fe, NM	26.3197	24.7347
Santa Rosa, CA	31.8165	30.4128
Sarasota-Bradenton, FL	24.6181	23.0141
Savannah, GA	23.4019	22.5251
Scranton-Wilkes Barre-Hazleton, PA	20.7846	20.0327
Seattle-Bellevue-Everett, WA	28.5675	26.8843
Sharon, PA	19.1498	18.3866
Sheboygan, WI	21.3074	20.1274
Sherman-Denison, TX	23.9656	22.2184
Shreveport-Bossier City, LA	22.4424	21.1518
Sioux City, IA-NE	22.2184	20.9019
Sioux Falls, SD	22.9990	21.6460
South Bend, IN	24.2656	23.1221
Spokane, WA	26.9328	25.3371

TABLE 3A.—FY 2004 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the Sum of the Salaries and Hours Computed for Federal Fiscal Years 2002, 2003, and 2004]

Urban area	FY 2004 average hourly wage	3-Year average hourly wage
Springfield, IL	22.0988	20.5053
Springfield, MO	20.8945	19.9103
Springfield, MA	25.8461	25.1765
State College, PA	21.5944	20.9171
Steubenville-Weirton, OH-WV	20.7491	20.1726
Stockton-Lodi, CA	25.7060	24.7659
Sumter, SC	20.3664	19.0084
Syracuse, NY	23.2541	22.4437
Tacoma, WA	27.4633	26.2816
Tallahassee, FL	21.0498	19.9557
Tampa-St. Petersburg-Clearwater, FL	22.4909	21.1327
Terre Haute, IN	20.5698	19.8370
Texarkana, AR-Texarkana, TX	20.1353	19.1483
Toledo, OH	23.1784	22.6054
Topeka, KS	22.5038	21.2556
Trenton, NJ	25.9846	24.5060
Tucson, AZ	22.1900	20.9404
Tulsa, OK	22.6934	20.5926
Tuscaloosa, AL	20.2900	19.1399
Tyler, TX	23.2339	22.2980
Utica-Rome, NY	20.7625	19.6938
Vallejo-Fairfield-Napa, CA	33.0511	31.4566
Ventura, CA	27.3366	25.8578
Victoria, TX	20.2203	19.7139
Vineland-Millville-Bridgeton, NJ	25.7088	24.0750
Visalia-Tulare-Portersville, CA	24.3519	22.5730
Waco, TX	20.7383	19.2135
Washington, DC-MD-VA-WV	26.9401	25.5595
Waterloo-Cedar Falls, IA	20.6706	19.0431
Wausau, WI	23.9474	22.8336
West Palm Beach-Boca Raton, FL	24.2086	23.0506
Wheeling, OH-WV	18.5167	18.0478
Wichita, KS	22.8238	22.1166
Wichita Falls, TX	20.6081	19.2867
Williamsport, PA	20.1552	19.7395
Wilmington-Newark, DE-MD	26.8874	25.7166
Wilmington, NC	23.6270	22.3947
Yakima, WA	25.6274	24.6154
Yolo, CA	22.7407	22.1146
York, PA	22.5293	21.5429
Youngstown-Warren, OH	22.7645	21.9498
Yuba City, CA	25.1911	24.0864
Yuma, AZ	21.9766	20.7166

[1] The MSA is empty for FY 2004. The hospital(s) in the MSA received rural status under Section 401 of the Balanced Budget Refinement Act of 1999 (P.L. 106–113). The MSA is assigned the statewide rural wage index (*see* Table 4B).

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	18.5095	17.5501
Alaska	29.3667	28.1193
Arizona	22.9036	20.6368
Arkansas	19.1097	17.8462
California	24.6268	22.9807
Colorado	23.0480	21.2325
Connecticut	30.1004	28.6608
Delaware	23.6122	22.0986
Florida	21.8790	20.6381
Georgia	21.2360	19.6529
Hawaii	24.6034	24.3938
Idaho	22.1711	20.5606
Illinois	20.3932	19.0845
Indiana	21.8020	20.4901
Iowa	20.7936	19.3045
Kansas	19.9482	18.5189
Kentucky	19.6987	18.7214
Louisiana	18.4100	17.6401
Maine	21.7717	20.5721
Maryland	22.5448	21.0794
Massachusetts	25.7740	25.8569
Michigan	21.9324	20.9463
Minnesota	23.0526	21.4147
Mississippi	19.2177	17.9189
Missouri	19.9049	18.6897
Montana	21.7432	20.0906
Nebraska	21.7975	19.3637
Nevada	24.2285	22.6578
New Hampshire	24.7802	23.0565
New Jersey[1]	.....	.....
New Mexico	20.4327	20.1351
New York	21.0650	19.9857
North Carolina	20.8923	20.0240
North Dakota	19.2168	18.1538
Ohio	21.7920	20.3411
Oklahoma	18.6216	17.6885
Oregon	24.6914	23.6590
Pennsylvania	20.6996	19.8537
Puerto Rico	9.9286	10.2348
Rhode Island[1]	.....	.....
South Carolina	20.9969	20.0185
South Dakota	20.2488	18.5076
Tennessee	19.4835	18.4938
Texas	19.2213	18.1708
Utah	22.1713	21.3599
Vermont	22.9948	21.9226
Virginia	20.9960	19.7068
Washington	25.6670	23.9261
West Virginia	19.8114	18.7534
Wisconsin	22.9879	21.4434
Wyoming	22.5088	20.9256

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

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

Urban area (constituent counties)	Wage index	GAF
0040 [2] Abilene, TX Taylor, TX	0.7748	0.8397

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

Urban area (constituent counties)	Wage index	GAF
0060 Aguadilla, PR	0.4289	0.5601
Aguada, PR		
Aguadilla, PR		
Moca, PR		
0080 Akron, OH	0.9443	0.9615
Portage, OH		
Summit, OH		
0120 Albany, GA	1.0819	1.0554
Dougherty, GA		
Lee, GA		
0160 [2] Albany-Schenectady-Troy, NY	0.8491	0.8940
Albany, NY		
Montgomery, NY		
Rensselaer, NY		
Saratoga, NY		
Schenectady, NY		
Schoharie, NY		
0200 Albuquerque, NM	0.9263	0.9489
Bernalillo, NM		
Sandoval, NM		
Valencia, NM		
0220 Alexandria, LA	0.8004	0.8586
Rapides, LA		
0240 Allentown-Bethlehem-Easton, PA	0.9682	0.9781
Carbon, PA		
Lehigh, PA		
Northampton, PA		
0280 Altoona, PA	0.8792	0.9156
Blair, PA		
0320 Amarillo, TX	0.8950	0.9268
Potter, TX		
Randall, TX		
0380 Anchorage, AK	1.2301	1.1524
Anchorage, AK		
0440 Ann Arbor, MI	1.1029	1.0694
Lenawee, MI		
Livingston, MI		
Washtenaw, MI		
0450 Anniston, AL	0.8058	0.8626
Calhoun, AL		
0460 [2] Appleton-Oshkosh-Neenah, WI	0.9266	0.9491
Calumet, WI		
Outagamie, WI		
Winnebago, WI		
0470 Arecibo, PR	0.4138	0.5465
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
0480 Asheville, NC	0.9680	0.9780
Buncombe, NC		
Madison, NC		
0500 Athens, GA	0.9778	0.9847
Clarke, GA		
Madison, GA		
Oconee, GA		
0520 [1] Atlanta, GA	1.0089	1.0061
Barrow, GA		
Bartow, GA		
Carroll, GA		
Cherokee, GA		
Clayton, GA		
Cobb, GA		
Coweta, GA		
DeKalb, GA		
Douglas, GA		
Fayette, GA		
Forsyth, GA		
Fulton, GA		
Gwinnett, GA		
Henry, GA		
Newton, GA		
Paulding, GA		
Pickens, GA		
Rockdale, GA		
Spalding, GA		
Walton, GA		
0560 Atlantic-Cape May, NJ	1.0751	1.0508
Atlantic, NJ		
Cape May, NJ		
0580 Auburn-Opelika, AL	0.8460	0.8918
Lee, AL		
0600 Augusta-Aiken, GA-SC	0.9587	0.9715
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Edgefield, SC		
0640 [1] Austin-San Marcos, TX	0.9570	0.9704
Bastrop, TX		
Caldwell, TX		
Hays, TX		
Travis, TX		
Williamson, TX		
0680 [2] Bakersfield, CA	0.9927	0.9950
Kern, CA		
0720 [1] Baltimore, MD	0.9879	0.9917
Anne Arundel, MD		
Baltimore, MD		
Baltimore City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Anne's, MD		
0733 Bangor, ME	0.9864	0.9907
Penobscot, ME		
0743 Barnstable-Yarmouth, MA	1.2904	1.1908
Barnstable, MA		
0760 Baton Rouge, LA	0.8372	0.8854
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
0840 Beaumont-Port Arthur, TX	0.8390	0.8867
Hardin, TX		
Jefferson, TX		
Orange, TX		
0860 Bellingham, WA	1.1710	1.1142
Whatcom, WA		
0870 Benton Harbor, MI	0.8899	0.9232
Berrien, MI		
0875 [1] Bergen-Passaic, NJ	1.1683	1.1124
Bergen, NJ		
Passaic, NJ		
0880 Billings, MT	0.8925	0.9251
Yellowstone, MT		
0920 Biloxi-Gulfport-Pascagoula, MS	0.8993	0.9299
Hancock, MS		
Harrison, MS		
Jackson, MS		
0960 [2] Binghamton, NY	0.8491	0.8940
Broome, NY		
Tioga, NY		
1000 Birmingham, AL	0.9175	0.9427
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
1010 Bismarck, ND	0.8001	0.8584
Burleigh, ND		
Morton, ND		
1020 [2] Bloomington, IN	0.8788	0.9153
Monroe, IN		
1040 Bloomington-Normal, IL	0.8796	0.9159
McLean, IL		
1080 Boise City, ID	0.9195	0.9441
Ada, ID		
Canyon, ID		
1123 [1] Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1188	1.0799
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		
1125 Boulder-Longmont, CO	1.0008	1.0005
Boulder, CO		
1145 Brazoria, TX	0.8105	0.8660
Brazoria, TX		
1150 Bremerton, WA	1.0537	1.0365
Kitsap, WA		
1240 Brownsville-Harlingen-San Benito, TX	1.0261	1.0178
Cameron, TX		
1260 Bryan-College Station, TX	0.8983	0.9292
Brazos, TX		
1280 [1] Buffalo-Niagara Falls, NY	0.9565	0.9700
Erie, NY		
Niagara, NY		
1303 Burlington, VT	0.9665	0.9769
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
1310 Caguas, PR	0.4184	0.5506

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

Urban area (constituent counties)	Wage index	GAF
Caguas, PR		
Cayey, PR		
Cidra, PR		
Gurabo, PR		
San Lorenzo, PR		
1320 Canton-Massillon, OH	0.9034	0.9328
Carroll, OH		
Stark, OH		
1350 Casper, WY	0.9171	0.9425
Natrona, WY		
1360 Cedar Rapids, IA	0.8838	0.9189
Linn, IA		
1400 Champaign-Urbana, IL	0.9867	0.9909
Champaign, IL		
1440 Charleston-North Charleston, SC	0.9294	0.9511
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
1480 Charleston, WV	0.8845	0.9194
Kanawha, WV		
Putnam, WV		
1520 [1] Charlotte-Gastonia-Rock Hill, NC-SC	0.9691	0.9787
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		
Mecklenburg, NC		
Rowan, NC		
Stanly, NC		
Union, NC		
York, SC		
1540 Charlottesville, VA	0.9985	0.9990
Albemarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
1560 Chattanooga, TN-GA	0.9049	0.9339
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
1580 [2] Cheyenne, WY	0.9073	0.9356
Laramie, WY		
1600 [1] Chicago, IL	1.0848	1.0573
Cook, IL		
DeKalb, IL		
DuPage, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		
Will, IL		
1620 Chico-Paradise, CA	1.0152	1.0104
Butte, CA		
1640 [1] Cincinnati, OH-KY-IN	0.9380	0.9571
Dearborn, IN		
Ohio, IN		
Boone, KY		
Campbell, KY		
Gallatin, KY		
Grant, KY		
Kenton, KY		
Pendleton, KY		
Brown, OH		
Clermont, OH		
Hamilton, OH		
Warren, OH		
1660 Clarksville-Hopkinsville, TN-KY	0.8320	0.8817
Christian, KY		
Montgomery, TN		
1680 [1] Cleveland-Lorain-Elyria, OH	0.9632	0.9747
Ashtabula, OH		
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Lorain, OH		
Medina, OH		
1720 Colorado Springs, CO	0.9793	0.9858
El Paso, CO		
1740 Columbia, MO	0.8660	0.9062
Boone, MO		
1760 Columbia, SC	0.8866	0.9209
Lexington, SC		
Richland, SC		
1800 Columbus, GA-AL	0.8659	0.9061
Russell, AL		
Chattahoochee, GA		
Harris, GA		
Muscogee, GA		
1840 [1] Columbus, OH	0.9609	0.9731
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
1880 Corpus Christi, TX	0.8486	0.8937
Nueces, TX		
San Patricio, TX		
1890 Corvallis, OR	1.1470	1.0985
Benton, OR		
1900 [2] Cumberland, MD-WV (MD Hospitals)	0.9088	0.9366
Allegany, MD		
Mineral, WV		
1900 Cumberland, MD-WV (WV Hospitals)	0.8166	0.8705
Allegany, MD		
Mineral, WV		
1920 [1] Dallas, TX	0.9934	0.9955
Collin, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Henderson, TX		
Hunt, TX		
Kaufman, TX		
Rockwall, TX		
1950 Danville, VA	0.8998	0.9302
Danville City, VA		
Pittsylvania, VA		
1960 Davenport-Moline-Rock Island, IA-IL	0.8949	0.9268
Scott, IA		
Henry, IL		
Rock Island, IL		
2000 Dayton-Springfield, OH	0.9490	0.9648
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
2020 Daytona Beach, FL	0.9024	0.9321
Flagler, FL		
Volusia, FL		
2030 Decatur, AL	0.8793	0.9157
Lawrence, AL		
Morgan, AL		
2040 [2] Decatur, IL	0.8221	0.8745
Macon, IL		
2080 [1] Denver, CO	1.0793	1.0536
Adams, CO		
Arapahoe, CO		
Broomfield, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
2120 Des Moines, IA	0.9069	0.9353
Dallas, IA		
Polk, IA		
Warren, IA		
2160 [1] Detroit, MI	1.0060	1.0041
Lapeer, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
St. Clair, MI		
Wayne, MI		
2180 Dothan, AL	0.7734	0.8386
Dale, AL		
Houston, AL		
2190 Dover, DE	0.9765	0.9838
Kent, DE		
2200 Dubuque, IA	0.8850	0.9197
Dubuque, IA		
2240 Duluth-Superior, MN-WI	1.0130	1.0089
St. Louis, MN		
Douglas, WI		
2281 Dutchess County, NY	1.0890	1.0601
Dutchess, NY		
2290 [2] Eau Claire, WI	0.9266	0.9491
Chippewa, WI		
Eau Claire, WI		
2320 El Paso, TX	0.9159	0.9416
El Paso, TX		
2330 Elkhart-Goshen, IN	0.9744	0.9824
Elkhart, IN		
2335 [2] Elmira, NY	0.8491	0.8940
Chemung, NY		

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

Urban area (constituent counties)	Wage index	GAF
2340 Enid, OK	0.8524	0.8964
Garfield, OK		
2360 Erie, PA	0.8566	0.8994
Erie, PA		
2400 Eugene-Springfield, OR	1.1410	1.0945
Lane, OR		
2440 [2] Evansville-Henderson, IN-KY (IN Hospitals)	0.8788	0.9153
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2440 Evansville-Henderson, IN-KY (KY Hospitals)	0.8395	0.8871
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2520 Fargo-Moorhead, ND-MN	0.9758	0.9834
Clay, MN		
Cass, ND		
2560 Fayetteville, NC	0.8950	0.9268
Cumberland, NC		
2580 Fayetteville-Springdale-Rogers, AR	0.8362	0.8847
Benton, AR		
Washington, AR		
2620 Flagstaff, AZ-UT	1.1287	1.0864
Coconino, AZ		
Kane, UT		
2640 Flint, MI	1.0814	1.0551
Genesee, MI		
2650 Florence, AL	0.7766	0.8410
Colbert, AL		
Lauderdale, AL		
2655 Florence, SC	0.8673	0.9071
Florence, SC		
2670 Fort Collins-Loveland, CO	1.0096	1.0066
Larimer, CO		
2680 [1] Ft. Lauderdale, FL	1.0436	1.0297
Broward, FL		
2700 Fort Myers-Cape Coral, FL	0.9776	0.9846
Lee, FL		
2710 Fort Pierce-Port St. Lucie, FL	1.0083	1.0057
Martin, FL		
St. Lucie, FL		
2720 Fort Smith, AR-OK	0.8390	0.8867
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
2750 Fort Walton Beach, FL	0.8930	0.9254
Okaloosa, FL		
2760 Fort Wayne, IN	0.9546	0.9687
Adams, IN		
Allen, IN		
De Kalb, IN		
Huntington, IN		
Wells, IN		
Whitley, IN		
2800 [1] Forth Worth-Arlington, TX	0.9321	0.9530
Hood, TX		
Johnson, TX		
Parker, TX		
Tarrant, TX		
2840 Fresno, CA	1.0101	1.0069
Fresno, CA		
Madera, CA		
2880 Gadsden, AL	0.8195	0.8726
Etowah, AL		
2900 Gainesville, FL	0.9653	0.9761
Alachua, FL		
2920 Galveston-Texas City, TX	0.9242	0.9475
Galveston, TX		
2960 Gary, IN	0.9372	0.9566
Lake, IN		
Porter, IN		
2975 [2] Glens Falls, NY	0.8491	0.8940
Warren, NY		
Washington, NY		
2980 Goldsboro, NC	0.8587	0.9009
Wayne, NC		
2985 Grand Forks, ND-MN (ND Hospitals)	0.8601	0.9019
Polk, MN		
Grand Forks, ND		
2985 [2] Grand Forks, ND-MN (MN Hospitals)	0.9307	0.9520
Polk, MN		
Grand Forks, ND		
2995 Grand Junction, CO	0.9881	0.9918
Mesa, CO		
3000 [1] Grand Rapids-Muskegon-Holland, MI	0.9430	0.9606
Allegan, MI		
Kent, MI		
Muskegon, MI		
Ottawa, MI		
3040 Great Falls, MT	0.8882	0.9220
Cascade, MT		
3060 Greeley, CO	0.9415	0.9596
Weld, CO		
3080 Green Bay, WI	0.9479	0.9640
Brown, WI		
3120 [1] Greensboro-Winston-Salem-High Point, NC	0.9129	0.9395
Alamance, NC		
Davidson, NC		
Davie, NC		
Forsyth, NC		
Guilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
3150 Greenville, NC	0.9129	0.9395
Pitt, NC		
3160 Greenville-Spartanburg-Anderson, SC	0.9297	0.9513
Anderson, SC		
Cherokee, SC		
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
3180 Hagerstown, MD	0.9135	0.9399
Washington, MD		
3200 Hamilton-Middletown, OH	0.9176	0.9428
Butler, OH		
3240 Harrisburg-Lebanon-Carlisle, PA	0.9127	0.9394
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
3283 [1, 2] Hartford, CT	1.2134	1.1416
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
3285 [2] Hattiesburg, MS	0.7762	0.8407
Forrest, MS		
Lamar, MS		
3290 Hickory-Morganton-Lenoir, NC	0.9205	0.9449
Alexander, NC		
Burke, NC		
Caldwell, NC		
Catawba, NC		
3320 Honolulu, HI	1.1071	1.0722
Honolulu, HI		
3350 Houma, LA	0.7740	0.8391
Lafourche, LA		
Terrebonne, LA		
3360 [1] Houston, TX	0.9794	0.9858
Chambers, TX		
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
3400 Huntington-Ashland, WV-KY-OH	0.9556	0.9694
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
3440 Huntsville, AL	0.9208	0.9451
Limestone, AL		
Madison, AL		
3480 [1] Indianapolis, IN	0.9875	0.9914
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Madison, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		

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

Urban area (constituent counties)	Wage index	GAF
3500 Iowa City, IA	0.9510	0.9662
Johnson, IA		
3520 Jackson, MI	0.8950	0.9268
Jackson, MI		
3560 Jackson, MS	0.8355	0.8842
Hinds, MS		
Madison, MS		
Rankin, MS		
3580 Jackson, TN	0.8948	0.9267
Madison, TN		
Chester, TN		
3600 [1] Jacksonville, FL	0.9490	0.9648
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
3605 Jacksonville, NC	0.8510	0.8954
Onslow, NC		
3610 [2] Jamestown, NY	0.8491	0.8940
Chautauqua, NY		
3620 [2] Janesville-Beloit, WI	0.9266	0.9491
Rock, WI		
3640 Jersey City, NJ	1.1070	1.0721
Hudson, NJ		
3660 Johnson City-Kingsport-Bristol, TN-VA (TN Hospitals)	0.8223	0.8746
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3660 [2] Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals)	0.8464	0.8921
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3680 [2] Johnstown, PA	0.8344	0.8834
Cambria, PA		
Somerset, PA		
3700 Jonesboro, AR	0.7777	0.8418
Craighead, AR		
3710 Joplin, MO	0.8646	0.9052
Jasper, MO		
Newton, MO		
3720 Kalamazoo-Battlecreek, MI	1.0458	1.0311
Calhoun, MI		
Kalamazoo, MI		
Van Buren, MI		
3740 Kankakee, IL	1.0377	1.0257
Kankakee, IL		
3760 [1] Kansas City, KS-MO	0.9675	0.9776
Johnson, KS		
Leavenworth, KS		
Miami, KS		
Wyandotte, KS		
Cass, MO		
Clay, MO		
Clinton, MO		
Jackson, MO		
Lafayette, MO		
Platte, MO		
Ray, MO		
3800 Kenosha, WI	0.9721	0.9808
Kenosha, WI		
3810 Killeen-Temple, TX	0.9122	0.9390
Bell, TX		
Coryell, TX		
3840 Knoxville, TN	0.8784	0.9150
Anderson, TN		
Blount, TN		
Knox, TN		
Loudon, TN		
Sevier, TN		
Union, TN		
3850 Kokomo, IN	0.9008	0.9310
Howard, IN		
Tipton, IN		
3870 [2] La Crosse, WI-MN	0.9266	0.9491
Houston, MN		
La Crosse, WI		
3880 Lafayette, LA	0.8191	0.8723
Acadia, LA		
Lafayette, LA		
St. Landry, LA		
St. Martin, LA		
3920 [2] Lafayette, IN	0.8788	0.9153
Clinton, IN		
Tippecanoe, IN		
3960 Lake Charles, LA	0.7809	0.8442
Calcasieu, LA		
3980 Lakeland-Winter Haven, FL	0.8823	0.9178
Polk, FL		
4000 Lancaster, PA	0.9244	0.9476
Lancaster, PA		
4040 Lansing-East Lansing, MI	0.9675	0.9776
Clinton, MI		
Eaton, MI		
Ingham, MI		
4080 Laredo, TX	0.8059	0.8626
Webb, TX		
4100 Las Cruces, NM	0.8653	0.9057
Dona Ana, NM		
4120 [1] Las Vegas, NV-AZ	1.1481	1.0992
Mohave, AZ		
Clark, NV		
Nye, NV		
4150 [2] Lawrence, KS	0.8041	0.8613
Douglas, KS		
4200 Lawton, OK	0.8234	0.8754
Comanche, OK		
4243 Lewiston-Auburn, ME	0.9345	0.9547
Androscoggin, ME		
4280 Lexington, KY	0.8650	0.9055
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Madison, KY		
Scott, KY		
Woodford, KY		
4320 Lima, OH	0.9483	0.9643
Allen, OH		
Auglaize, OH		
4360 Lincoln, NE	0.9992	0.9995
Lancaster, NE		
4400 Little Rock-North Little Rock, AR	0.8887	0.9224
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
4420 Longview-Marshall, TX	0.9076	0.9358
Gregg, TX		
Harrison, TX		
Upshur, TX		
4480 [1] Los Angeles-Long Beach, CA	1.1790	1.1194
Los Angeles, CA		
4520 [1] Louisville, KY-IN	0.9205	0.9449
Clark, IN		
Floyd, IN		
Harrison, IN		
Scott, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
4600 Lubbock, TX	0.8238	0.8757
Lubbock, TX		
4640 Lynchburg, VA	0.9097	0.9372
Amherst, VA		
Bedford, VA		
Bedford City, VA		
Campbell, VA		
Lynchburg City, VA		
4680 Macon, GA	0.8939	0.9261
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Twiggs, GA		
4720 Madison, WI	1.0222	1.0151
Dane, WI		
4800 [2] Mansfield, OH	0.8784	0.9150
Crawford, OH		
Richland, OH		
4840 Mayaguez, PR	0.4776	0.6029
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
Sabana Grande, PR		
San German, PR		
4880 McAllen-Edinburg-Mission, TX	0.8347	0.8836
Hidalgo, TX		
4890 Medford-Ashland, OR	1.0729	1.0494
Jackson, OR		

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

Urban area (constituent counties)	Wage index	GAF
4900 Melbourne-Titusville-Palm Bay, FL	0.9736	0.9818
Brevard, Fl		
4920 [1] Memphis, TN-AR-MS	0.8973	0.9285
Crittenden, AR		
DeSoto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4940 [2] Merced, CA	0.9927	0.9950
Merced, CA		
5000 [1] Miami, FL	0.9854	0.9900
Dade, FL		
5015 [1] Middlesex-Somerset-Hunterdon, NJ	1.1320	1.0886
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
5080 [1] Milwaukee-Waukesha, WI	0.9947	0.9964
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		
Waukesha, WI		
5120 [1] Minneapolis-St. Paul, MN-WI	1.0957	1.0646
Anoka, MN		
Carver, MN		
Chisago, MN		
Dakota, MN		
Hennepin, MN		
Isanti, MN		
Ramsey, MN		
Scott, MN		
Sherburne, MN		
Washington, MN		
Wright, MN		
Pierce, WI		
St. Croix, WI		
5140 Missoula, MT	0.8848	0.9196
Missoula, MT		
5160 Mobile, AL	0.7962	0.8555
Baldwin, AL		
Mobile, AL		
5170 Modesto, CA	1.1230	1.0827
Stanislaus, CA		
5190 [1] Monmouth-Ocean, NJ	1.1038	1.0700
Monmouth, NJ		
Ocean, NJ		
5200 Monroe, LA	0.7890	0.8502
Ouachita, LA		
5240 Montgomery, AL	0.7875	0.8491
Autauga, AL		
Elmore, AL		
Montgomery, AL		
5280 [2] Muncie, IN	0.8788	0.9153
Delaware, IN		
5330 Myrtle Beach, SC	0.9075	0.9357
Horry, SC		
5345 Naples, FL	0.9750	0.9828
Collier, FL		
5360 [1] Nashville, TN	0.9815	0.9873
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
5380 [1] Nassau-Suffolk, NY	1.2933	1.1926
Nassau, NY		
Suffolk, NY		
5483 [1] New Haven-Bridgeport-Stamford-Waterbury-	1.2418	1.1599
Danbury, CT		
Fairfield, CT		
New Haven, CT		
5523 [2] New London-Norwich, CT	1.2134	1.1416
New London, CT		
5560 [1] New Orleans, LA	0.9137	0.9401
Jefferson, LA		
Orleans, LA		
Plaquemines, LA		
St. Bernard, LA		
St. Charles, LA		
St. James, LA		
St. John The Baptist, LA		
St. Tammany, LA		
5600 [1] New York, NY	1.3913	1.2538
Bronx, NY		
Kings, NY		
New York, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
5640 [1] Newark, NJ	1.1471	1.0985
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Warren, NJ		
5660 Newburgh, NY-PA	1.1462	1.0979
Orange, NY		
Pike, PA		
5720 [1] Norfolk-Virginia Beach-Newport News, VA-NC	0.8584	0.9007
Currituck, NC		
Chesapeake City, VA		
Gloucester, VA		
Hampton City, VA		
Isle of Wight, VA		
James City, VA		
Mathews, VA		
Newport News City, VA		
Norfolk City, VA		
Poquoson City, VA		
Portsmouth City, VA		
Suffolk City, VA		
Virginia Beach City VA		
Williamsburg City, VA		
York, VA		
5775 [1] Oakland, CA	1.5058	1.3235
Alameda, CA		
Contra Costa, CA		
5790 Ocala, FL	0.9689	0.9786
Marion, FL		
5800 Odessa-Midland, TX	0.9290	0.9508
Ector, TX		
Midland, TX		
5880 [1] Oklahoma City, OK	0.8948	0.9267
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
5910 Olympia, WA	1.0919	1.0621
Thurston, WA		
5920 Omaha, NE-IA	0.9705	0.9797
Pottawattamie, IA		
Cass, NE		
Douglas, NE		
Sarpy, NE		
Washington, NE		
5945 [1] Orange County, CA	1.1445	1.0968
Orange, CA		
5960 [1] Orlando, FL	0.9615	0.9735
Lake, FL		
Orange, FL		
Osceola, FL		
Seminole, FL		
5990 Owensboro, KY	0.8340	0.8831
Daviess, KY		
6015 [2] Panama City, FL	0.8819	0.9175
Bay, FL		
6020 Parkersburg-Marietta, WV-OH (WV Hospitals)	0.8007	0.8588
Washington, OH		
Wood, WV		
6020 [2] Parkersburg-Marietta, WV-OH (OH Hospitals)	0.8784	0.9150
Washington, OH		
Wood, WV		
6080 [2] Pensacola, FL	0.8819	0.9175
Escambia, FL		
Santa Rosa, FL		
6120 Peoria-Pekin, IL	0.8699	0.9090
Peoria, IL		
Tazewell, IL		
Woodford, IL		
6160 [1] Philadelphia, PA-NJ	1.0839	1.0567
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Salem, NJ		

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

Urban area (constituent counties)	Wage index	GAF
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
6200 [1] Phoenix-Mesa, AZ	1.0088	1.0060
Maricopa, AZ		
Pinal, AZ		
6240 Pine Bluff, AR	0.7855	0.8476
Jefferson, AR		
6280 [1] Pittsburgh, PA	0.8865	0.9208
Allegheny, PA		
Beaver, PA		
Butler, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
6323 [2] Pittsfield, MA	1.0390	1.0265
Berkshire, MA		
6340 Pocatello, ID	0.9212	0.9453
Bannock, ID		
6360 Ponce, PR	0.4689	0.5953
Guayanilla, PR		
Juana Diaz, PR		
Penuelas, PR		
Ponce, PR		
Villalba, PR		
Yauco, PR		
6403 Portland, ME	0.9909	0.9938
Cumberland, ME		
Sagadahoc, ME		
York, ME		
6440 [1] Portland-Vancouver, OR-WA	1.1167	1.0785
Clackamas, OR		
Columbia, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Clark, WA		
6483 [1] Providence-Warwick-Pawtucket, RI	1.0932	1.0629
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
6520 Provo-Orem, UT	0.9936	0.9956
Utah, UT		
6560 [2] Pueblo, CO	0.9291	0.9509
Pueblo, CO		
6580 Punta Gorda, FL	0.9472	0.9635
Charlotte, FL		
66004[2] Racine, WI	0.9266	0.9491
Racine, WI		
6640 [1] Raleigh-Durham-Chapel Hill, NC	0.9919	0.9944
Chatham, NC		
Durham, NC		
Franklin, NC		
Johnston, NC		
Orange, NC		
Wake, NC		
6660 Rapid City, SD	0.8771	0.9141
Pennington, SD		

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

Urban area (constituent counties)	Wage index	GAF
6680 Reading, PA	0.9096	0.9372
Berks, PA		
6690 Redding, CA	1.1306	1.0877
Shasta, CA		
6720 Reno, NV	1.0639	1.0433
Washoe, NV		
6740 Richland-Kennewick-Pasco, WA	1.0566	1.0384
Benton, WA		
Franklin, WA		
6760 Richmond-Petersburg, VA	0.9311	0.9523
Charles City County, VA		
Chesterfield, VA		
Colonial Heights City, VA		
Dinwiddie, VA		
Goochland, VA		
Hanover, VA		
Henrico, VA		
Hopewell City, VA		
New Kent, VA		
Petersburg City, VA		
Powhatan, VA		
Prince George, VA		
Richmond City, VA		
6780 [1] Riverside-San Bernardino, CA	1.1302	1.0874
Riverside, CA		
San Bernardino, CA		
6800 Roanoke, VA	0.8664	0.9065
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
6820 Rochester, MN	1.1691	1.1129
Olmsted, MN		
6840 [1] Rochester, NY	0.9392	0.9580
Genesee, NY		
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
6880 Rockford, IL	0.9627	0.9743
Boone, IL		
Ogle, IL		
Winnebago, IL		
6895 Rocky Mount, NC	0.9039	0.9331
Edgecombe, NC		
Nash, NC		
6920 [1] Sacramento, CA	1.1797	1.1198
El Dorado, CA		
Placer, CA		
Sacramento, CA		
6960 Saginaw-Bay City-Midland, MI	0.9992	0.9995
Bay, MI		
Midland, MI		
Saginaw, MI		
6980 St. Cloud, MN	0.9640	0.9752
Benton, MN		
Stearns, MN		

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

Urban area (constituent counties)	Wage index	GAF
7000 [2] St. Joseph, MO	0.8024	0.8601
Andrew, MO		
Buchanan, MO		
7040 [1] St. Louis, MO-IL	0.8996	0.9301
Clinton, IL		
Jersey, IL		
Madison, IL		
Monroe, IL		
St. Clair, IL		
Franklin, MO		
Jefferson, MO		
Lincoln, MO		
St. Charles, MO		
St. Louis, MO		
St. Louis City, MO		
Warren, MO		
7080 Salem, OR	1.0440	1.0299
Marion, OR		
Polk, OR		
7120 Salinas, CA	1.4281	1.2764
Monterey, CA		
7160 [1] Salt Lake City-Ogden, UT	0.9873	0.9913
Davis, UT		
Salt Lake, UT		
Weber, UT		
7200 San Angelo, TX	0.8500	0.8947
Tom Green, TX		
7240 [1] San Antonio, TX	0.8834	0.9186
Bexar, TX		
Comal, TX		
Guadalupe, TX		
Wilson, TX		
7320 [1] San Diego, CA	1.1102	1.0742
San Diego, CA		
7360 [1] San Francisco, CA	1.4455	1.2870
Marin, CA		
San Francisco, CA		
San Mateo, CA		
7400 [1] San Jose, CA	1.4567	1.2938
Santa Clara, CA		
7440 [1] San Juan-Bayamon, PR	0.4880	0.6118
Aguas Buenas, PR		
Barceloneta, PR		
Bayamon, PR		
Canovanas, PR		
Carolina, PR		
Catano, PR		
Ceiba, PR		
Comerio, PR		
Corozal, PR		
Dorado, PR		
Fajardo, PR		
Florida, PR		
Guaynabo, PR		
Humacao, PR		
Juncos, PR		
Los Piedras, PR		
Loiza, PR		
Luguillo, PR		
Manati, PR		
Morovis, PR		
Naguabo, PR		

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

Urban area (constituent counties)	Wage index	GAF
Naranjito, PR		
Rio Grande, PR		
San Juan, PR		
Toa Alta, PR		
Toa Baja, PR		
Trujillo Alto, PR		
Vega Alta, PR		
Vega Baja, PR		
Yabucoa, PR		
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.1383	1.0928
San Luis Obispo, CA		
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0399	1.0272
Santa Barbara, CA		
7485 Santa Cruz-Watsonville, CA	1.2890	1.1899
Santa Cruz, CA		
7490 Santa Fe, NM	1.0610	1.0414
Los Alamos, NM		
Santa Fe, NM		
7500 Santa Rosa, CA	1.2825	1.1858
Sonoma, CA		
7510 Sarasota-Bradenton, FL	0.9931	0.9953
Manatee, FL		
Sarasota, FL		
7520 Savannah, GA	0.9450	0.9620
Bryan, GA		
Chatham, GA		
Effingham, GA		
7560 Scranton—Wilkes-Barre—Hazleton, PA	0.8378	0.8859
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Wyoming, PA		
7600 [1] Seattle-Bellevue-Everett, WA	1.1516	1.1015
Island, WA		
King, WA		
Snohomish, WA		
7610 [2] Sharon, PA	0.8344	0.8834
Mercer, PA		
7620 [2] Sheboygan, WI	0.9266	0.9491
Sheboygan, WI		
7640 Sherman-Denison, TX	0.9661	0.9767
Grayson, TX		
7680 Shreveport-Bossier City, LA	0.9047	0.9337
Bossier, LA		
Caddo, LA		
Webster, LA		
7720 Sioux City, IA-NE	0.8956	0.9273
Woodbury, IA		
Dakota, NE		
7760 Sioux Falls, SD	0.9271	0.9495
Lincoln, SD		
Minnehaha, SD		
7800 South Bend, IN	0.9782	0.9850
St. Joseph, IN		
7840 Spokane, WA	1.0857	1.0579
Spokane, WA		
7880 Springfield, IL	0.8908	0.9239
Menard, IL		
Sangamon, IL		
7920 Springfield, MO	0.8423	0.8891
Christian, MO		
Greene, MO		
Webster, MO		
8003 Springfield, MA	1.0419	1.0285
Hampden, MA		
Hampshire, MA		
8050 State College, PA	0.8705	0.9094
Centre, PA		
8080 [2] Steubenville-Weirton, OH-WV (OH Hospitals)	0.8784	0.9150
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8080 Steubenville-Weirton, OH-WV (WV Hospitals)	0.8364	0.8848
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8120 Stockton-Lodi, CA	1.0921	1.0622
San Joaquin, CA		
8140 [2] Sumter, SC	0.8464	0.8921
Sumter, SC		
8160 Syracuse, NY	0.9374	0.9567
Cayuga, NY		
Madison, NY		
Onondaga, NY		
Oswego, NY		
8200 Tacoma, WA	1.1071	1.0722
Pierce, WA		
8240 [2] Tallahassee, FL	0.8819	0.9175
Gadsden, FL		
Leon, FL		
8280 [1] Tampa-St. Petersburg-Clearwater, FL	0.9066	0.9351
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
8320 [2] Terre Haute, IN	0.8788	0.9153
Clay, IN		
Vermillion, IN		
Vigo, IN		
8360 Texarkana,AR-Texarkana, TX	0.8117	0.8669
Miller, AR		
Bowie, TX		
8400 Toledo, OH	0.9359	0.9556
Fulton, OH		
Lucas, OH		
Wood, OH		
8440 Topeka, KS	0.9071	0.9354
Shawnee, KS		
8480 Trenton, NJ	1.0474	1.0322
Mercer, NJ		
8520 [2] Tucson, AZ	0.9233	0.9468
Pima, AZ		
8560 Tulsa, OK	0.9148	0.9408
Creek, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
8600 Tuscaloosa, AL	0.8179	0.8714
Tuscaloosa, AL		
8640 Tyler, TX	0.9366	0.9561
Smith, TX		
8680 [2] Utica-Rome, NY	0.8491	0.8940
Herkimer, NY		
Oneida, NY		
8720 Vallejo-Fairfield-Napa, CA	1.3371	1.2201
Napa, CA		
Solano, CA		
8735 Ventura, CA	1.1019	1.0687
Ventura, CA		
8750 Victoria, TX	0.8151	0.8694
Victoria, TX		
8760 Vineland-Millville-Bridgeton, NJ	1.0363	1.0247
Cumberland, NJ		
8780 [2] Visalia-Tulare-Porterville, CA	0.9927	0.9950
Tulare, CA		
8800 Waco, TX	0.8360	0.8846
McLennan, TX		
8840 [1] Washington, DC-MD-VA-WV	1.0860	1.0581
District of Columbia, DC		
Calvert, MD		
Charles, MD		
Frederick, MD		
Montgomery, MD		
Prince Georges, MD		
Alexandria City, VA		
Arlington, VA		
Clarke, VA		
Culpeper, VA		
Fairfax, VA		
Fairfax City, VA		
Falls Church City, VA		
Fauquier, VA		
Fredericksburg City, VA		
King George, VA		
Loudoun, VA		
Manassas City, VA		
Manassas Park City, VA		
Prince William, VA		
Spotsylvania, VA		
Stafford, VA		
Warren, VA		
Berkeley, WV		
Jefferson, WV		
8920 [2] Waterloo-Cedar Falls, IA	0.8382	0.8862
Black Hawk, IA		
8940 Wausau, WI	0.9744	0.9824
Marathon, WI		

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

Urban area (constituent counties)	Wage index	GAF
8960 [1] West Palm Beach-Boca Raton, FL	0.9759	0.9834
Palm Beach, FL		
9000 [2] Wheeling, WV-OH (WV Hospitals)	0.7986	0.8573
Belmont, OH		
Marshall, WV		
Ohio, WV		
9000 [2] Wheeling, WV-OH (OH Hospitals)	0.8784	0.9150
Belmont, OH		
Marshall, WV		
Ohio, WV		
9040 Wichita, KS	0.9200	0.9445
Butler, KS		
Harvey, KS		
Sedgwick, KS		
9080 Wichita Falls, TX	0.8307	0.8807
Archer, TX		
Wichita, TX		
9140 [2] Williamsport, PA	0.8344	0.8834
Lycoming, PA		
9160 Wilmington-Newark, DE-MD	1.0838	1.0567
New Castle, DE		
Cecil, MD		
9200 Wilmington, NC	0.9524	0.9672
New Hanover, NC		
Brunswick, NC		
9260 [2] Yakima, WA	1.0346	1.0236
Yakima, WA		
9270 [2] Yolo, CA	0.9927	0.9950
Yolo, CA		
9280 York, PA	0.9106	0.9379
York, PA		
9320 Youngstown-Warren, OH	0.9176	0.9428
Columbiana, OH		
Mahoning, OH		
Trumbull, OH		
9340 Yuba City, CA	1.0155	1.0106
Sutter, CA		
Yuba, CA		
9360 [2] Yuma, AZ	0.9233	0.9468
Yuma, AZ		

[1] Large Urban Area
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2004.

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

Nonurban area	Wage index	GAF
Alabama	0.7461	0.8183
Alaska	1.1838	1.1225
Arizona	0.9233	0.9468
Arkansas	0.7703	0.8363
California	0.9927	0.9950
Colorado	0.9291	0.9509
Connecticut	1.2134	1.1416

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

Nonurban area	Wage index	GAF
Delaware	0.9557	0.9694
Florida	0.8819	0.9175
Georgia	0.8586	0.9009
Hawaii	0.9918	0.9944
Idaho	0.8937	0.9259
Illinois	0.8221	0.8745
Indiana	0.8788	0.9153
Iowa	0.8382	0.8862
Kansas	0.8041	0.8613
Kentucky	0.7942	0.8540
Louisiana	0.7494	0.8207
Maine	0.8776	0.9145
Maryland	0.9088	0.9366
Massachusetts	1.0390	1.0265
Michigan	0.8851	0.9198
Minnesota	0.9307	0.9520
Mississippi	0.7762	0.8407
Missouri	0.8024	0.8601
Montana	0.8765	0.9137
Nebraska	0.8787	0.9153
Nevada	0.9767	0.9840
New Hampshire	0.9989	0.9992
New Jersey [1]	.....	.....
New Mexico	0.8236	0.8756
New York	0.8491	0.8940
North Carolina	0.8422	0.8890
North Dakota	0.7746	0.8395
Ohio	0.8784	0.9150
Oklahoma	0.7506	0.8216
Oregon	0.9953	0.9968
Pennsylvania	0.8344	0.8834
Puerto Rico	0.4002	0.5341
Rhode Island [1]	.....	.....
South Carolina	0.8464	0.8921
South Dakota	0.8162	0.8702
Tennessee	0.7854	0.8475
Texas	0.7748	0.8397
Utah	0.8937	0.9259
Vermont	0.9496	0.9652
Virginia	0.8464	0.8921
Washington	1.0346	1.0236
West Virginia	0.7986	0.8573
Wisconsin	0.9266	0.9491
Wyoming	0.9073	0.9356

[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
Akron, OH	0.9443	0.9615
Albany, GA	1.0621	1.0421
Albuquerque, NM (NM hospitals)	0.9263	0.9489
Albuquerque, NM (CO hospitals)	0.9291	0.9509
Alexandria, LA	0.8004	0.8586
Allentown-Bethlehem-Easton, PA	0.9682	0.9781
Altoona, PA	0.8792	0.9156
Amarillo, TX	0.8822	0.9177

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

Area	Wage index	GAF
Anchorage, AK	1.2301	1.1524
Ann Arbor, MI	1.0802	1.0543
Anniston, AL	0.7943	0.8541
Asheville, NC	0.9439	0.9612
Athens, GA	0.9525	0.9672
Atlanta, GA	0.9955	0.9969
Atlantic-Cape May, NJ	1.0489	1.0332
Augusta-Aiken, GA–SC	0.9395	0.9582
Austin-San Marcos, TX	0.9570	0.9704
Bangor, ME	0.9864	0.9907
Barnstable-Yarmouth, MA	1.2669	1.1759
Baton Rouge, LA	0.8372	0.8854
Bellingham, WA	1.1358	1.0911
Benton Harbor, MI	0.8899	0.9232
Bergen-Passaic, NJ	1.1683	1.1124
Billings, MT	0.8925	0.9251
Biloxi-Gulfport-Pascagoula, MS	0.8373	0.8855
Binghamton, NY	0.8394	0.8870
Birmingham, AL	0.9175	0.9427
Bismarck, ND	0.8001	0.8584
Bloomington-Normal, IL	0.8796	0.9159
Boise City, ID	0.9195	0.9441
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1188	1.0799
Burlington, VT	0.9294	0.9511
Caguas, PR	0.4184	0.5506
Casper, WY	0.9171	0.9425
Champaign-Urbana, IL	0.9422	0.9600
Charleston-North Charleston, SC	0.9294	0.9511
Charleston, WV (WV Hospitals)	0.8533	0.8971
Charleston, WV (OH Hospitals)	0.8784	0.9150
Charlotte-Gastonia-Rock Hill, NC–SC	0.9578	0.9709
Charlottesville, VA	0.9837	0.9888
Chattanooga, TN–GA	0.9049	0.9339
Chicago, IL	1.0719	1.0487
Cincinnati, OH–KY–IN	0.9380	0.9571
Clarksville-Hopkinsville, TN–KY	0.8320	0.8817
Cleveland-Lorain-Elyria, OH	0.9632	0.9747
Columbia, MO	0.8522	0.8963
Columbia, SC	0.8866	0.9209
Columbus, GA–AL (GA Hospitals)	0.8586	0.9009
Columbus, GA–AL (AL Hospitals)	0.8446	0.8908
Columbus, OH	0.9609	0.9731
Corpus Christi, TX	0.8486	0.8937
Corvallis, OR	1.1196	1.0804
Dallas, TX	0.9934	0.9955
Davenport-Moline-Rock Island, IA–IL	0.8949	0.9268
Dayton-Springfield, OH	0.9490	0.9648
Decatur, AL	0.8545	0.8979
Denver, CO	1.0617	1.0419
Des Moines, IA	0.9069	0.9353
Detroit, MI	1.0060	1.0041
Dothan, AL	0.7734	0.8386
Duluth-Superior, MN–WI	1.0130	1.0089
Dutchess County, NY	1.0687	1.0466

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

Area	Wage index	GAF
Elkhart-Goshen, IN	0.9515	0.9665
Erie, PA	0.8491	0.8940
Eugene-Springfield, OR	1.0932	1.0629
Fargo-Moorhead, ND–MN	0.9463	0.9629
Fayetteville, NC	0.8782	0.9149
Flagstaff, AZ–UT	1.1035	1.0698
Flint, MI	1.0659	1.0447
Florence, AL	0.7766	0.8410
Fort Collins-Loveland, CO	1.0096	1.0066
Ft. Lauderdale, FL	1.0436	1.0297
Fort Pierce-Port St. Lucie, FL	1.0083	1.0057
Fort Smith, AR–OK	0.8044	0.8615
Fort Walton Beach, FL	0.8768	0.9139
Forth Worth-Arlington, TX	0.9321	0.9530
Gadsden, AL	0.8195	0.8726
Grand Forks, ND–MN	0.8601	0.9019
Grand Junction, CO	0.9881	0.9918
Grand Rapids-Muskegon-Holland, MI	0.9430	0.9606
Great Falls, MT	0.8882	0.9220
Greeley, CO	0.9415	0.9596
Green Bay, WI	0.9479	0.9640
Greensboro-Winston-Salem-High Point, NC	0.9022	0.9319
Greenville, NC	0.9129	0.9395
Hamilton-Middletown, OH	0.9176	0.9428
Harrisburg-Lebanon-Carlisle, PA	0.9127	0.9394
Hartford, CT	1.1279	1.0859
Hickory-Morganton-Lenoir, NC	0.9076	0.9358
Honolulu, HI	1.1071	1.0722
Houston, TX	0.9794	0.9858
Huntington-Ashland, WV–KY–OH	0.9039	0.9331
Huntsville, AL	0.8979	0.9289
Indianapolis, IN	0.9875	0.9914
Iowa City, IA	0.9366	0.9561
Jackson, MS	0.8355	0.8842
Jackson, TN	0.8784	0.9150
Jacksonville, FL	0.9490	0.9648
Johnson City-Kingsport-Bristol, TN–VA (VA Hospitals)	0.8464	0.8921
Johnson City-Kingsport-Bristol, TN–VA (KY Hospitals)	0.8223	0.8746
Jonesboro, AR (AR Hospitals)	0.7777	0.8418
Jonesboro, AR (MO Hospitals)	0.8024	0.8601
Joplin, MO	0.8523	0.8963
Kalamazoo-Battlecreek, MI	1.0458	1.0311
Kansas City, KS–MO	0.9675	0.9776
Knoxville, TN	0.8784	0.9150
Kokomo, IN	0.9008	0.9310
Lafayette, LA	0.8191	0.8723
Lakeland-Winter Haven, FL	0.8823	0.9178
Las Vegas, NV–AZ	1.1355	1.0909
Lawton, OK	0.8107	0.8661
Lexington, KY	0.8441	0.8904
Lima, OH	0.9483	0.9643
Lincoln, NE	0.9559	0.9696
Little Rock-North Little Rock, AR	0.8887	0.9224
Longview-Marshall, TX	0.8906	0.9237
Los Angeles-Long Beach, CA	1.1790	1.1194
Louisville, KY–IN	0.9081	0.9361
Lubbock, TX	0.8238	0.8757
Lynchburg, VA	0.8905	0.9237
Macon, GA	0.8939	0.9261
Madison, WI	1.0076	1.0052
Medford-Ashland, OR	1.0383	1.0261
Memphis, TN–AR–MS	0.8751	0.9127
Miami, FL	0.9854	0.9900
Milwaukee-Waukesha, WI	0.9789	0.9855
Minneapolis-St. Paul, MN–WI	1.0957	1.0646
Missoula, MT	0.8848	0.9196
Mobile, AL	0.7962	0.8555
Modesto, CA	1.1103	1.0743
Monmouth-Ocean, NJ	1.1038	1.0700
Monroe, LA	0.7890	0.8502
Montgomery, AL	0.7875	0.8491
Nashville, TN	0.9552	0.9691
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2418	1.1599
New Orleans, LA	0.9137	0.9401
New York, NY	1.3913	1.2538
Newark, NJ	1.1471	1.0985
Newburgh, NY–PA	1.1298	1.0872
Oakland, CA	1.5058	1.3235
Ocala, FL	0.9541	0.9683
Odessa-Midland, TX	0.9039	0.9331
Oklahoma City, OK	0.8948	0.9267
Olympia, WA	1.0919	1.0621
Omaha, NE–IA	0.9705	0.9797
Orange County, CA	1.1445	1.0968
Orlando, FL	0.9615	0.9735
Peoria-Pekin, IL	0.8699	0.9090
Philadelphia, PA–NJ	1.0839	1.0567
Phoenix-Mesa, AZ	1.0088	1.0060
Pine Bluff, AR	0.7855	0.8476
Pittsburgh, PA	0.8865	0.9208
Pittsfield, MA	0.9756	0.9832
Pocatello, ID	0.9212	0.9453
Portland, ME	0.9619	0.9737
Portland-Vancouver, OR–WA	1.1167	1.0785
Provo-Orem, UT	0.9811	0.9870
Raleigh-Durham-Chapel Hill, NC	0.9691	0.9787
Rapid City, SD	0.8771	0.9141
Reading, PA	0.8962	0.9277
Redding, CA	1.1306	1.0877
Reno, NV	1.0639	1.0433
Richland-Kennewick-Pasco, WA	1.0358	1.0244
Richmond-Petersburg, VA	0.9311	0.9523
Roanoke, VA	0.8664	0.9065
Rochester, MN	1.1691	1.1129
Rockford, IL	0.9402	0.9587
Sacramento, CA	1.1797	1.1198
Saginaw-Bay City-Midland, MI	0.9712	0.9802
St. Cloud, MN	0.9640	0.9752
St. Joseph, MO	0.8544	0.8978
St. Louis, MO–IL	0.8996	0.9301
Salinas, CA	1.4281	1.2764
Salt Lake City-Ogden, UT	0.9873	0.9913
San Antonio, TX	0.8834	0.9186
Santa Fe, NM	0.9486	0.9645
Santa Rosa, CA	1.2825	1.1858
Sarasota-Bradenton, FL	0.9931	0.9953
Savannah, GA	0.9450	0.9620
Seattle-Bellevue-Everett, WA	1.1516	1.1015
Sherman-Denison, TX	0.9166	0.9421
Shreveport-Bossier City, LA	0.9047	0.9337
Sioux City, IA–NE (NE Hospitals)	0.8787	0.9153
Sioux City, IA–NE (SD Hospitals)	0.8750	0.9126
Sioux Falls, SD	0.9147	0.9408
South Bend, IN	0.9676	0.9777
Spokane, WA	1.0673	1.0456
Springfield, IL	0.8908	0.9239
Springfield, MO	0.8225	0.8748
Stockton-Lodi, CA	1.0921	1.0622
Syracuse, NY	0.9374	0.9567
Tampa-St. Petersburg-Clearwater, FL	0.9066	0.9351
Texarkana, AR-Texarkana, TX	0.7937	0.8537
Toledo, OH	0.9359	0.9556
Topeka, KS	0.8869	0.9211
Tucson, AZ	0.9233	0.9468
Tulsa, OK	0.8902	0.9234
Tuscaloosa, AL	0.8068	0.8633
Tyler, TX	0.9118	0.9387
Vallejo-Fairfield-Napa, CA	1.3371	1.2201
Victoria, TX	0.8151	0.8694
Waco, TX	0.8360	0.8846
Washington, DC–MD–VA–WV	1.0860	1.0581
Waterloo-Cedar Falls, IA	0.8382	0.8862
Wausau, WI	0.9744	0.9824
West Palm Beach-Boca Raton, FL	0.9759	0.9834
Wichita, KS	0.8967	0.9281
Wichita Falls, TX	0.8307	0.8807
Wilmington-Newark, DE–MD	1.0667	1.0452
Wilmington, NC	0.9386	0.9575
York, PA	0.9106	0.9379
Youngstown-Warren, OH	0.9176	0.9428
Rural Florida	0.8663	0.9064
Rural Illinois (IA Hospitals)	0.8382	0.8862
Rural Illinois (MO Hospitals)	0.8221	0.8745
Rural Kentucky	0.7942	0.8540
Rural Louisiana	0.7494	0.8207
Rural Michigan	0.8851	0.9198
Rural Minnesota	0.9307	0.9520
Rural Mississippi	0.7762	0.8407
Rural Missouri	0.8024	0.8601
Rural Nebraska	0.8787	0.9153
Rural Nevada	0.9238	0.9472
Rural New Hampshire	0.9989	0.9992
Rural Texas	0.7748	0.8397
Rural Washington	1.0346	1.0236
Rural Wyoming	0.8947	0.9266

TABLE 4F.—PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF)

Area	Wage index	GAF	Wage index—reclass. hospitals	GAF—reclass. hospitals
Aguadilla, PR	0.9180	0.9431		
Arecibo, PR	0.8856	0.9202		
Caguas, PR	0.8956	0.9273	0.8956	0.9273
Mayaguez, PR	1.0222	1.0151		
Ponce, PR	1.0037	1.0025		
San Juan-Bayamon, PR	1.0445	1.0303		
Rural Puerto Rico	0.8566	0.8994		

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties)	Wage index
0040 Abilene, TX	0.7748
Taylor, TX	
0060 Aguadilla, PR	0.4289
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9208
Portage, OH	
Summit, OH	
0120 Albany, GA	1.0819
Dougherty, GA	
Lee, GA	
0160 Albany-Schenectady-Troy, NY	0.8491
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9263
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.7987
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	0.9682
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.8771
Blair, PA	
0320 Amarillo, TX	0.8950
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.2167
Anchorage, AK	
0440 Ann Arbor, MI	1.1029
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8058
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI	0.9266
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR	0.4138
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9680
Buncombe, NC	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Madison, NC	
0500 Athens, GA	0.9778
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 Atlanta, GA	1.0089
Barrow, GA	
Bartow, GA	
Carroll, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
DeKalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Pickens, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
0560 Atlantic-Cape May, NJ	1.0751
Atlantic, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.8460
Lee, AL	
0600 Augusta-Aiken, GA-SC	0.9587
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 Austin-San Marcos, TX	0.9570
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 Bakersfield, CA	0.9927
Kern, CA	
0720 Baltimore, MD	0.9879
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne's, MD	
0733 Bangor, ME	0.9864
Penobscot, ME	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
0743 Barnstable-Yarmouth, MA	1.2904
Barnstable, MA	
0760 Baton Rouge, LA	0.8372
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8390
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.1710
Whatcom, WA	
0870 Benton Harbor, MI	0.8899
Berrien, MI	
0875 Bergen-Passaic, NJ	1.1644
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.8925
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.8993
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 Binghamton, NY	0.8491
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.9175
Blount, AL	
Jefferson, AL	
St. Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.7933
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.8788
Monroe, IN	
1040 Bloomington-Normal, IL	0.8796
McLean, IL	
1080 Boise City, ID	0.9172
Ada, ID	
Canyon, ID	
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (NH Hospitals)	1.1188
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Rockingham, NH	
Strafford, NH	
1125 Boulder-Longmont, CO	1.0008
Boulder, CO	
1145 Brazoria, TX	0.8105
Brazoria, TX	
1150 Bremerton, WA	1.0537
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	1.0261
Cameron, TX	
1260 Bryan-College Station, TX	0.8983
Brazos, TX	
1280 Buffalo-Niagara Falls, NY	0.9565
Erie, NY	
Niagara, NY	
1303 Burlington, VT	0.9665
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4141
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.9034
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9073
Natrona, WY	
1360 Cedar Rapids, IA	0.8838
Linn, IA	
1400 Champaign-Urbana, IL	0.9867
Champaign, IL	
1440 Charleston-North Charleston, SC	0.9294
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.8845
Kanawha, WV	
Putnam, WV	
1520 Charlotte-Gastonia-Rock Hill, NC-SC	0.9691
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	0.9985
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN-GA	0.9049
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 Cheyenne, WY	0.9073
Laramie, WY	
1600 Chicago, IL	1.0848
Cook, IL	
DeKalb, IL	
DuPage, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	1.0152
Butte, CA	
1640 Cincinnati, OH-KY-IN	0.9375
Dearborn, IN	
Ohio, IN	
Boone, KY	
Campbell, KY	
Gallatin, KY	
Grant, KY	
Kenton, KY	
Pendleton, KY	
Brown, OH	
Clermont, OH	
Hamilton, OH	
Warren, OH	
1660 Clarksville-Hopkinsville, TN-KY	0.8211
Christian, KY	
Montgomery, TN	
1680 Cleveland-Lorain-Elyria, OH	0.9632
Ashtabula, OH	
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9793
El Paso, CO	
1740 Columbia, MO	0.8660
Boone, MO	
1760 Columbia, SC	0.8866
Lexington, SC	
Richland, SC	
1800 Columbus, GA-AL	0.8659
Russell, AL	
Chattahoochee, GA	
Harris, GA	
Muscogee, GA	
1840 Columbus, OH	0.9609
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8486
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1470
Benton, OR	
1900 Cumberland, MD-WV (WV Hospital)	0.8166
Allegany, MD	
Mineral, WV	
1920 Dallas, TX	0.9934
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.8998
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA-IL	0.8949
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9479
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.9024
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8793
Lawrence, AL	
Morgan, AL	
2040 Decatur, IL	0.8221
Macon, IL	
2080 Denver, CO	1.0793
Adams, CO	
Arapahoe, CO	
Broomfield, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.9069
Dallas, IA	
Polk, IA	
Warren, IA	
2160 Detroit, MI	1.0060
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.7710
Dale, AL	
Houston, AL	
2190 Dover, DE	0.9765
Kent, DE	
2200 Dubuque, IA	0.8850
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0130
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0890
Dutchess, NY	
2290 Eau Claire, WI	0.9266
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.9159
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9744
Elkhart, IN	
2335 Elmira, NY	0.8491
Chemung, NY	
2340 Enid, OK	0.8524
Garfield, OK	
2360 Erie, PA	0.8566
Erie, PA	
2400 Eugene-Springfield, OR	1.1410
Lane, OR	
2440 Evansville-Henderson, IN-KY (IN Hospitals)	0.8788
Posey, IN	
Vanderburgh, IN	
Warrick, IN	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Henderson, KY	
2520 Fargo-Moorhead, ND-MN	0.9758
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8950
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8362
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	1.1287
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.0814
Genesee, MI	
2650 Florence, AL	0.7716
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8673
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0067
Larimer, CO	
2680 Ft. Lauderdale, FL	1.0122
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9776
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	0.9968
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.8390
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.8930
Okaloosa, FL	
2760 Fort Wayne, IN	0.9546
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 Forth Worth-Arlington, TX	0.9321
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0101
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8173
Etowah, AL	0.9653
2900 Gainesville, FL.	
Alachua, FL	
2920 Galveston-Texas City, TX	0.9242
Galveston, TX	
2960 Gary, IN	0.9372
Lake, IN	
Porter, IN	
2975 Glens Falls, NY	0.8491
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8587
Wayne, NC	
2985 Grand Forks, ND-MN	0.8601
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9594
Mesa, CO	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
3000 Grand Rapids-Muskegon-Holland, MI	0.9430
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.8773
Cascade, MT	
3060 Greeley, CO	0.9334
Weld, CO	
3080 Green Bay, WI	0.9422
Brown, WI	
3120 Greensboro-Winston-Salem-High Point, NC	0.9129
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9061
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9297
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.9135
Washington, MD	
3200 Hamilton-Middletown, OH	0.9176
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9127
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 Hartford, CT	1.2134
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 Hattiesburg, MS	0.7747
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.9205
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1053
Honolulu, HI	
3350 Houma, LA	0.7740
Lafourche, LA	
Terrebonne, LA	
3360 Houston, TX	0.9794
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV-KY-OH	0.9556
Boyd, KY	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.9208
Limestone, AL	
Madison, AL	
3480 Indianapolis, IN	0.9875
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9510
Johnson, IA	
3520 Jackson, MI	0.8950
Jackson, MI	
3560 Jackson, MS	0.8324
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.8948
Madison, TN	
Chester, TN	
3600 Jacksonville, FL	0.9490
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 Jacksonville, NC	0.8510
Onslow, NC	
3610 Jamestown, NY	0.8491
Chautauqua, NY	
3620 Janesville-Beloit, WI	0.9266
Rock, WI	
3640 Jersey City, NJ	1.1070
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA	0.8220
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA	0.8344
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.7762
Craighead, AR	
3710 Joplin, MO	0.8646
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.0458
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	1.0377
Kankakee, IL	
3760 Kansas City, KS-MO	0.9675
Johnson, KS	
Leavenworth, KS	
Miami, KS	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Wyandotte, KS	
Cass, MO	
Clay, MO	
Clinton, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
3800 Kenosha, WI	0.9721
Kenosha, WI	
3810 Killeen-Temple, TX	0.9122
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.8784
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.9008
Howard, IN	
Tipton, IN	
3870 La Crosse, WI-MN	0.9266
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8173
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.8788
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.7809
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.8819
Polk, FL	
4000 Lancaster, PA	0.9244
Lancaster, PA	
4040 Lansing-East Lansing, MI	0.9675
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.8059
Webb, TX	
4100 Las Cruces, NM	0.8653
Dona Ana, NM	
4120 Las Vegas, NV-AZ	1.1481
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.8041
Douglas, KS	
4200 Lawton, OK	0.8234
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9345
Androscoggin, ME	
4280 Lexington, KY	0.8650
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.9483
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	0.9992

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.8887
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.9076
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 Los Angeles-Long Beach, CA	1.1748
Los Angeles, CA	
4520 Louisville, KY-IN	0.9205
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.8238
Lubbock, TX	
4640 Lynchburg, VA	0.9097
Amherst, VA	
Bedford, VA	
Bedford City, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.8916
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0222
Dane, WI	
4800 Mansfield, OH	0.8784
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4776
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.8347
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0729
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	0.9736
Brevard, Fl	
4920 Memphis, TN-AR-MS	0.8973
Crittenden, AR	
DeSoto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA	0.9927
Merced, CA	
5000 Miami, FL	0.9854
Dade, FL	
5015 Middlesex-Somerset-Hunterdon, NJ	1.1320
Hunterdon, NJ	
Middlesex, NJ	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Somerset, NJ	
5080 Milwaukee-Waukesha, WI	0.9947
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 Minneapolis-St. Paul, MN-WI	1.0957
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Sherburne, MN	
Washington, MN	
Wright, MN	
Pierce, WI	
St. Croix, WI	
5140 Missoula, MT	0.8765
Missoula, MT	
5160 Mobile, AL	0.7962
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.1230
Stanislaus, CA	
5190 Monmouth-Ocean, NJ	1.0912
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.7890
Ouachita, LA	
5240 Montgomery, AL	0.7875
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	0.8788
Delaware, IN	
5330 Myrtle Beach, SC	0.9075
Horry, SC	
5345 Naples, FL	0.9750
Collier, FL	
5360 Nashville, TN	0.9815
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 Nassau-Suffolk, NY	1.2933
Nassau, NY	
Suffolk, NY	
5483 New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2335
Fairfield, CT	
New Haven, CT	
5523 New London-Norwich, CT	1.2134
New London, CT	
5560 New Orleans, LA	0.9137
Jefferson, LA	
Orleans, LA	
Plaquemines, LA	
St. Bernard, LA	
St. Charles, LA	
St. James, LA	
St. John The Baptist, LA	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
St. Tammany, LA	
5600 New York, NY	1.3913
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 Newark, NJ	1.1471
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY-PA	1.1462
Orange, NY	
Pike, PA	
5720 Norfolk-Virginia Beach-Newport News, VA-NC	0.8584
Currituck, NC	
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
Isle of Wight, VA	
James City, VA	
Mathews, VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson City, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City VA	
Williamsburg City, VA	
York, VA	
5775 Oakland, CA	1.4860
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9689
Marion, FL	
5800 Odessa-Midland, TX	0.9290
Ector, TX	
Midland, TX	
5880 Oklahoma City, OK	0.8948
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.0919
Thurston, WA	
5920 Omaha, NE-IA	0.9705
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 Orange County, CA	1.1326
Orange, CA	
5960 Orlando, FL	0.9615
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.8340
Daviess, KY	
6015 Panama City, FL	0.8819
Bay, FL	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
6020 Parkersburg-Marietta, WV-OH	0.8007
Washington, OH	
Wood, WV	
6080 Pensacola, FL	0.8819
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8699
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 Philadelphia, PA-NJ	1.0839
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 Phoenix-Mesa, AZ	1.0088
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7833
Jefferson, AR	
6280 Pittsburgh, PA	0.8865
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 Pittsfield, MA	1.0390
Berkshire, MA	
6340 Pocatello, ID	0.9006
Bannock, ID	
6360 Ponce, PR	0.4689
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9909
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 Portland-Vancouver, OR-WA	1.1167
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 Providence-Warwick-Pawtucket, RI	1.0932
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	0.9936
Utah, UT	
6560 Pueblo, CO	0.9291
Pueblo, CO	
6580 Punta Gorda, FL	0.9472
Charlotte, FL	
6600 Racine, WI	0.9266

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Racine, WI	
6640 Raleigh-Durham-Chapel Hill, NC	0.9919
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8771
Pennington, SD	
6680 Reading, PA	0.9096
Berks, PA	
6690 Redding, CA	1.1306
Shasta, CA	
6720 Reno, NV	1.0639
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.0566
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9311
Charles City County, VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
6780 Riverside-San Bernardino, CA	1.1302
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8664
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.1691
Olmsted, MN	
6840 Rochester, NY	0.9392
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9627
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9039
Edgecombe, NC	
Nash, NC	
6920 Sacramento, CA	1.1797
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9992
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St. Cloud, MN	0.9468

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Benton, MN	
Stearns, MN	
7000 St. Joseph, MO	0.8024
Andrew, MO	
Buchanan, MO	
7040 St. Louis, MO-IL	0.8996
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
Lincoln, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Warren, MO	
7080 Salem, OR	1.0440
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4281
Monterey, CA	
7160 Salt Lake City-Ogden, UT	0.9873
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.8500
Tom Green, TX	
7240 San Antonio, TX	0.8834
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 San Diego, CA	1.1102
San Diego, CA	
7360 San Francisco, CA	1.4455
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 San Jose, CA	1.4567
Santa Clara, CA	
7440 San Juan-Bayamon, PR	0.4880
Aguas Buenas, PR	
Barceloneta, PR	
Bayamon, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Ceiba, PR	
Comerio, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Morovis, PR	
Naguabo, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trujillo Alto, PR	
Vega Alta, PR	
Vega Baja, PR	
Yabucoa, PR	
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.1383
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0399
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.2890
Santa Cruz, CA	
7490 Santa Fe, NM	1.0610
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.2825
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9924
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9433
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton—Wilkes-Barre—Hazleton, PA	0.8378
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 Seattle-Bellevue-Everett, WA	1.1516
Island, WA	
King, WA	
Snohomish, WA	
7610 Sharon, PA	0.8344
Mercer, PA	
7620 Sheboygan, WI	0.9266
Sheboygan, WI	
7640 Sherman-Denison, TX	0.9661
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.9047
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.8956
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.9271
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9782
St. Joseph, IN	
7840 Spokane, WA	1.0857
Spokane, WA	
7880 Springfield, IL	0.8908
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8423
Christian, MO	
Greene, MO	
Webster, MO	
8003 Springfield, MA	1.0419
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.8705
Centre, PA	
8080 Steubenville-Weirton, OH-WV (WV Hospitals)	0.8364
Jefferson, OH	
Brooke, WV	
Hancock, WV	
8120 Stockton-Lodi, CA	1.0362
San Joaquin, CA	
8140 Sumter, SC	0.8464
Sumter, SC	
8160 Syracuse, NY	0.9374
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.1071
Pierce, WA	
8240 Tallahassee, FL	0.8819
Gadsden, FL	
Leon, FL	
8280 Tampa-St. Petersburg-Clearwater, FL	0.9066
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 Terre Haute, IN	0.8788
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana, AR-Texarkana, TX	0.8117
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9343
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.9071
Shawnee, KS	
8480 Trenton, NJ	1.0474
Mercer, NJ	
8520 Tucson, AZ	0.9233
Pima, AZ	
8560 Tulsa, OK	0.9148
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8179
Tuscaloosa, AL	
8640 Tyler, TX	0.9366
Smith, TX	
8680 Utica-Rome, NY	0.8491
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3323
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.1019
Ventura, CA	
8750 Victoria, TX	0.8151
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0363
Cumberland, NJ	
8780 Visalia-Tulare-Porterville, CA	0.9927
Tulare, CA	
8800 Waco, TX	0.8360
McLennan, TX	
8840 Washington, DC-MD-VA-WV	1.0860
District of Columbia, DC	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Clarke, VA	
Culpepper, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Fauquier, VA	
Fredericksburg City, VA	
King George, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Spotsylvania, VA	
Stafford, VA	
Warren, VA	
Berkeley, WV	
Jefferson, WV	
8920 Waterloo-Cedar Falls, IA	0.8382
Black Hawk, IA	
8940 Wausau, WI	0.9653
Marathon, WI	
8960 West Palm Beach-Boca Raton, FL	0.9759
Palm Beach, FL	
9000 Wheeling, WV-OH	0.7986
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9200
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.8307
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8344

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	1.0838
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9524
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	1.0346
Yakima, WA	
9270 Yolo, CA	0.9927
Yolo, CA	
9280 York, PA	0.9082
York, PA	
9320 Youngstown-Warren, OH	0.9176
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0155
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	0.9233
Yuma, AZ	

TABLE 4H.—PRE-RECLASSIFIED WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.7461
Alaska	1.1838
Arizona	0.9233
Arkansas	0.7703
California	0.9927
Colorado	0.9291
Connecticut	1.2134
Delaware	0.9518
Florida	0.8819
Georgia	0.8560
Hawaii	0.9918
Idaho	0.8937

TABLE 4H.—PRE-RECLASSIFIED WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
Illinois	0.8221
Indiana	0.8788
Iowa	0.8382
Kansas	0.8041
Kentucky	0.7941
Louisiana	0.7421
Maine	0.8776
Maryland	0.9088
Massachusetts	1.0390
Michigan	0.8841
Minnesota	0.9293
Mississippi	0.7747
Missouri	0.8024
Montana	0.8765
Nebraska	0.8787
Nevada	0.9767
New Hampshire	0.9989
New Jersey [1]	.....
New Mexico	0.8236
New York	0.8491
North Carolina	0.8422
North Dakota	0.7746
Ohio	0.8784
Oklahoma	0.7506
Oregon	0.9953
Pennsylvania	0.8344
Puerto Rico	0.4002
Rhode Island [1]	.....
South Carolina	0.8464
South Dakota	0.8162
Tennessee	0.7854
Texas	0.7748
Utah	0.8937
Vermont	0.9269
Virginia	0.8464
Washington	1.0346
West Virginia	0.7986
Wisconsin	0.9266
Wyoming	0.9073

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

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARTHIMETIC MEAN LENGTH OF STAY (LOS)

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
1	01	SURG	CRANIOTOMY AGE >17 W CC	3.6186	8.00	10.90
2	01	SURG	CRANIOTOMY AGE >17 W/O CC	2.0850	4.10	5.30
3	01	SURG*	CRANIOTOMY AGE 0-17	1.9753	12.70	12.70
4	01	SURG	NO LONGER VALID	0.0000	0.00	0.00
5	01	SURG	NO LONGER VALID	0.0000	0.00	0.00
6	01	SURG	CARPAL TUNNEL RELEASE	0.8092	2.20	3.10
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.6519	6.60	9.80
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	1.5453	1.90	2.80
9	01	MED	SPINAL DISORDERS & INJURIES	1.4214	4.70	6.90
10	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2448	4.80	6.50
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	0.8571	3.00	4.10
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.9259	4.50	5.90
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.8176	4.00	5.00
14	01	MED	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	1.2682	4.70	6.10
15	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	0.9677	3.90	4.90

* Medicare data have been supplemented by data from 19 States for low volume DRGs.
** DRGs 469 and 470 contian cases that could 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.

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARTHIMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.2618	4.80	6.40
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.6991	2.50	3.20
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	1.0026	4.20	5.50
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.7041	2.80	3.50
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.7394	8.00	10.50
21	01	MED	VIRAL MENINGITIS	1.5138	5.00	6.60
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	1.0737	3.90	5.10
23	01	MED	NONTRAUMATIC STUPOR & COMA	0.8239	3.20	4.30
24	01	MED	SEIZURE & HEADACHE AGE >17 W CC	1.0121	3.70	5.00
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	0.6109	2.50	3.20
26	01	MED	SEIZURE & HEADACHE AGE 0-17	1.3730	2.20	4.10
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3370	3.20	5.20
28	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR AGE <17 W CC	1.3386	4.40	6.10
29	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR AGE <17 W/O CC	0.7087	2.70	3.50
30	01	MED*	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.3341	2.00	2.00
31	01	MED	CONCUSSION AGE >17 W CC	0.9117	3.10	4.10
32	01	MED	CONCUSSION AGE >17 W/O CC	0.5684	2.00	2.50
33	01	MED*	CONCUSSION AGE 0-17	0.2098	1.60	1.60
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9931	3.70	5.00
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.6355	2.50	3.10
36	02	SURG	RETINAL PROCEDURES	0.6298	1.20	1.50
37	02	SURG	ORBITAL PROCEDURES	1.0575	2.50	3.80
38	02	SURG	PRIMARY IRIS PROCEDURES	0.4669	1.90	2.80
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.6285	1.50	2.10
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.8937	2.70	3.80
41	02	SURG*	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.3401	1.60	1.60
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.7064	1.90	2.70
43	02	MED	HYPHEMA	0.5382	2.40	3.40
44	02	MED	ACUTE MAJOR EYE INFECTIONS	0.6597	4.00	5.00
45	02	MED	NEUROLOGICAL EYE DISORDERS	0.7250	2.50	3.10
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	0.7936	3.40	4.50
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.5317	2.40	3.10
48	02	MED*	OTHER DISORDERS OF THE EYE AGE 0-17	0.2996	2.90	2.90
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.7277	3.20	4.50
50	03	SURG	SIALOADENECTOMY	0.8317	1.50	1.90
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	0.8410	1.90	2.80
52	03	SURG	CLEFT LIP & PALATE REPAIR	0.8018	1.40	1.80
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.2520	2.20	3.60
54	03	SURG*	SINUS & MASTOID PROCEDURES AGE 0-17	0.4856	3.20	3.20
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	0.9247	2.00	3.00
56	03	SURG	RHINOPLASTY	0.9233	1.90	2.90
57	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	1.1029	2.40	3.70
58	03	SURG*	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17.	0.2757	1.50	1.50
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.9557	1.90	2.70
60	03	SURG*	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.2099	1.50	1.50
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.2334	3.10	5.20
62	03	SURG*	MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.2973	1.30	1.30
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.3759	3.00	4.40
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.3089	4.30	6.50
65	03	MED	DYSEQUILIBRIUM	0.5748	2.30	2.80
66	03	MED	EPISTAXIS	0.5811	2.40	3.10
67	03	MED	EPIGLOTTITIS	0.7780	2.90	3.70
68	03	MED	OTITIS MEDIA & URI AGE >17 W CC	0.6531	3.10	3.90
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	0.4987	2.50	3.00
70	03	MED	OTITIS MEDIA & URI AGE 0-17	0.3188	2.00	2.40
71	03	MED	LARYNGOTRACHEITIS	0.7065	2.50	3.40
72	03	MED	NASAL TRAUMA & DEFORMITY	0.6954	2.60	3.40
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.8184	3.30	4.50
74	03	MED*	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.3380	2.10	2.10
75	04	SURG	MAJOR CHEST PROCEDURES	3.0437	7.70	10.00
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.8184	8.40	11.10
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.2378	3.50	4.80
78	04	MED	PULMONARY EMBOLISM	1.2731	5.60	6.60
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.5974	6.70	8.50

* Medicare data have been supplemented by data from 19 States for low volume DRGs.
** DRGs 469 and 470 contian cases that could be assigned to valid DRGs.
Note 1: Geometric mean is used only to determine payment for transfer cases.
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Note 3: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARTHIMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.8400	4.30	5.40
81	04	MED*	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	1.5300	6.10	6.10
82	04	MED	RESPIRATORY NEOPLASMS	1.3724	5.10	6.90
83	04	MED	MAJOR CHEST TRAUMA W CC	0.9620	4.30	5.40
84	04	MED	MAJOR CHEST TRAUMA W/O CC	0.5371	2.60	3.30
85	04	MED	PLEURAL EFFUSION W CC	1.1927	4.80	6.30
86	04	MED	PLEURAL EFFUSION W/O CC	0.6864	2.80	3.60
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3430	4.80	6.40
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.9031	4.10	5.10
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0463	4.90	5.90
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.6147	3.40	4.00
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.7408	3.10	5.10
92	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.2024	5.00	6.30
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	0.7176	3.30	4.00
94	04	MED	PNEUMOTHORAX W CC	1.1340	4.70	6.30
95	04	MED	PNEUMOTHORAX W/O CC	0.6166	3.00	3.80
96	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	0.7464	3.70	4.60
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5505	2.90	3.50
98	04	MED*	BRONCHITIS & ASTHMA AGE 0-17	0.9662	3.70	3.70
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	0.7032	2.40	3.20
100	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.5222	1.80	2.10
101	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8654	3.30	4.40
102	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.5437	2.10	2.60
103	PRE	SURG	HEART TRANSPLANT	18.6081	26.10	42.40
104	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH.	7.9351	12.20	14.40
105	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH.	5.7088	8.20	9.90
106	05	SURG	CORONARY BYPASS W PTCA	7.2936	9.60	11.40
107	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.3751	9.20	10.40
108	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.3656	7.30	9.80
109	05	SURG	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	3.9401	6.70	7.70
110	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.0492	6.20	8.90
111	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.4797	3.20	4.10
112	05	SURG	NO LONGER VALID	0.0000	0.00	0.00
113	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	3.0106	10.40	13.30
114	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.6436	6.30	8.70
115	05	SURG	PRM CARD PACEM IMPL W AMI/HR/SHOCK OR AICD LEAD OR GNRTR.	3.5465	5.00	7.40
116	05	SURG	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	2.3590	3.10	4.40
117	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.3951	2.60	4.30
118	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.6089	2.00	2.90
119	05	SURG	VEIN LIGATION & STRIPPING	1.3739	3.20	5.30
120	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.3164	5.60	9.00
121	05	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE.	1.6169	5.30	6.60
122	05	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.	1.0297	2.90	3.70
123	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.5645	2.90	4.80
124	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.4367	3.30	4.40
125	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	1.0947	2.20	2.80
126	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.5418	9.20	11.80
127	05	MED	HEART FAILURE & SHOCK	1.0265	4.20	5.30
128	05	MED	DEEP VEIN THROMBOPHLEBITIS	0.7285	4.60	5.50
129	05	MED	CARDIAC ARREST, UNEXPLAINED	1.0229	1.70	2.60
130	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	0.9505	4.50	5.70
131	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	0.5676	3.30	4.10
132	05	MED	ATHEROSCLEROSIS W CC	0.6422	2.30	2.90
133	05	MED	ATHEROSCLEROSIS W/O CC	0.5559	1.80	2.30
134	05	MED	HYPERTENSION	0.5954	2.50	3.20
135	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.9282	3.40	4.50
136	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.	0.5740	2.20	2.70

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** DRGs 469 and 470 contian cases that could be assigned to valid DRGs.
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TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARTHIMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
137	05	MED*	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.8243	3.30	3.30
138	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.8355	3.10	4.00
139	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5160	2.00	2.50
140	05	MED	ANGINA PECTORIS	0.5305	2.00	2.50
141	05	MED	SYNCOPE & COLLAPSE W CC	0.7473	2.80	3.60
142	05	MED	SYNCOPE & COLLAPSE W/O CC	0.5761	2.10	2.60
143	05	MED	CHEST PAIN	0.5480	1.70	2.10
144	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.2260	3.90	5.60
145	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.5787	2.00	2.60
146	06	SURG	RECTAL RESECTION W CC	2.7376	8.80	10.20
147	06	SURG	RECTAL RESECTION W/O CC	1.5375	5.60	6.20
148	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.4025	10.10	12.30
149	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.4590	5.80	6.30
150	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.8711	9.20	11.30
151	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.3061	4.40	5.60
152	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9134	6.90	8.40
153	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.1310	4.70	5.30
154	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	4.0212	9.90	13.30
155	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.3043	3.00	4.10
156	06	SURG*	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	0.8489	6.00	6.00
157	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.3152	4.00	5.80
158	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	0.6517	2.00	2.60
159	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.3744	3.80	5.10
160	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	0.8219	2.20	2.70
161	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.1676	3.00	4.30
162	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.6446	1.60	1.90
163	06	SURG*	HERNIA PROCEDURES AGE 0-17	0.6965	2.10	2.10
164	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.3306	7.00	8.40
165	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2302	3.90	4.50
166	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4317	3.60	4.70
167	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	0.8889	2.00	2.40
168	03	SURG	MOUTH PROCEDURES W CC	1.3158	3.30	4.90
169	03	SURG	MOUTH PROCEDURES W/O CC	0.7525	1.80	2.40
170	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.8245	7.50	10.90
171	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.1912	3.30	4.30
172	06	MED	DIGESTIVE MALIGNANCY W CC	1.3670	5.20	7.00
173	06	MED	DIGESTIVE MALIGNANCY W/O CC	0.7528	2.80	3.80
174	06	MED	G.I. HEMORRHAGE W CC	1.0025	3.90	4.80
175	06	MED	G.I. HEMORRHAGE W/O CC	0.5587	2.50	2.90
176	06	MED	COMPLICATED PEPTIC ULCER	1.0998	4.10	5.20
177	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	0.9259	3.70	4.60
178	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	0.6940	2.60	3.10
179	06	MED	INFLAMMATORY BOWEL DISEASE	1.0885	4.60	6.00
180	06	MED	G.I. OBSTRUCTION W CC	0.9642	4.20	5.50
181	06	MED	G.I. OBSTRUCTION W/O CC	0.5376	2.80	3.40
182	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC.	0.8223	3.40	4.40
183	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	0.5759	2.30	2.90
184	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.4813	2.40	3.30
185	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	0.8685	3.30	4.70
186	03	MED*	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17.	0.3236	2.90	2.90
187	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	0.7778	3.00	4.00
188	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.1088	4.10	5.60
189	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.5987	2.40	3.10
190	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.8104	3.70	5.20
191	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.2787	9.80	13.80
192	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.8025	4.70	6.20
193	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.4211	10.40	12.80

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DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
194	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.6030	5.70	6.70
195	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	3.0613	8.70	10.60
196	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6117	4.80	5.60
197	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	2.5547	7.50	9.20
198	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.1831	3.80	4.40
199	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3953	7.00	9.80
200	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.	3.0415	6.70	10.50
201	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.6841	10.20	14.20
202	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3120	4.80	6.40
203	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.3482	5.00	6.70
204	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.1675	4.40	5.80
205	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W CC	1.2095	4.60	6.20
206	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC	0.7071	2.90	3.80
207	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.1539	4.00	5.30
208	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	0.6601	2.30	2.90
209	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.	2.0327	4.40	4.90
210	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	1.8477	6.10	7.00
211	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.2544	4.50	4.90
212	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.4152	3.20	6.40
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.8904	6.70	9.20
214	08	SURG	NO LONGER VALID	0.0000	0.00	0.00
215	08	SURG	NO LONGER VALID	0.0000	0.00	0.00
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	2.1107	5.00	8.00
217	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS.	3.0020	9.00	13.40
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.	1.5750	4.30	5.50
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC.	1.0258	2.70	3.20
220	08	SURG*	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17.	0.5881	5.30	5.30
221	08	SURG	NO LONGER VALID	0.0000	0.00	0.00
222	08	SURG	NO LONGER VALID	0.0000	0.00	0.00
223	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	1.0573	2.20	3.00
224	08	SURG	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC.	0.7898	1.60	1.90
225	08	SURG	FOOT PROCEDURES	1.1704	3.60	5.30
226	08	SURG	SOFT TISSUE PROCEDURES W CC	1.5529	4.50	6.60
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC	0.8190	2.10	2.60
228	08	SURG	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC.	1.1639	2.70	4.20
229	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.7064	1.80	2.30
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.3147	3.60	5.60
231	08	SURG	NO LONGER VALID	0.0000	0.00	0.00
232	08	SURG	ARTHROSCOPY	0.9674	1.80	2.70
233	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	2.0024	5.00	7.40
234	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	1.1977	2.20	3.10
235	08	MED	FRACTURES OF FEMUR	0.7580	3.80	4.90
236	08	MED	FRACTURES OF HIP & PELVIS	0.7358	3.90	4.80
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.5983	2.90	3.70
238	08	MED	OSTEOMYELITIS	1.3564	6.50	8.70
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	1.0614	5.10	6.40
240	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.3153	4.90	6.70
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	0.6358	3.00	3.80

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TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARTHIMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
242	08	MED	SEPTIC ARTHRITIS	1.1695	5.30	6.90
243	08	MED	MEDICAL BACK PROBLEMS	0.7525	3.70	4.70
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.7155	3.70	4.70
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4786	2.60	3.30
246	08	MED	NON-SPECIFIC ARTHROPATHIES	0.6063	3.00	3.80
247	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	0.5724	2.60	3.30
248	08	MED	TENDONITIS, MYOSITIS & BURSITIS	0.8585	3.80	4.90
249	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	0.6744	2.50	3.60
250	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	0.7091	3.20	4.10
251	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	0.4578	2.30	2.80
252	08	MED*	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.2553	1.80	1.80
253	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W CC.	0.7581	3.70	4.70
254	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC.	0.4464	2.60	3.20
255	08	MED*	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0-17	0.2974	2.90	2.90
256	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	0.8190	3.80	5.10
257	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.8913	2.10	2.60
258	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7018	1.60	1.80
259	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9420	1.80	2.70
260	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.6854	1.20	1.40
261	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	0.8944	1.60	2.10
262	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.9533	2.90	4.30
263	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	2.0556	8.30	11.50
264	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.0605	5.00	6.60
265	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.5984	4.20	6.60
266	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	0.8791	2.30	3.20
267	09	SURG	PERIANAL & PILONIDAL PROCEDURES	0.9574	2.90	4.50
268	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.1513	2.40	3.80
269	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.7747	6.00	8.50
270	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.8129	2.50	3.60
271	09	MED	SKIN ULCERS	1.0280	5.60	7.20
272	09	MED	MAJOR SKIN DISORDERS W CC	1.0185	4.60	6.00
273	09	MED	MAJOR SKIN DISORDERS W/O CC	0.6192	3.00	3.90
274	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1574	4.70	6.50
275	09	MED	MALIGNANT BREAST DISORDERS W/O CC	0.5729	2.40	3.40
276	09	MED	NON-MALIGANT BREAST DISORDERS	0.6471	3.50	4.50
277	09	MED	CELLULITIS AGE >17 W CC	0.8805	4.70	5.80
278	09	MED	CELLULITIS AGE >17 W/O CC	0.5432	3.50	4.20
279	09	MED	CELLULITIS AGE 0-17	0.7779	4.00	5.30
280	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.7109	3.20	4.10
281	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.4866	2.30	2.90
282	09	MED*	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.2586	2.20	2.20
283	09	MED	MINOR SKIN DISORDERS W CC	0.7322	3.50	4.70
284	09	MED	MINOR SKIN DISORDERS W/O CC	0.4215	2.30	2.90
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT,& METABOL DISORDERS.	2.0825	7.90	10.60
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.0342	4.40	5.90
287	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.8899	7.70	10.30
288	10	SURG	O.R. PROCEDURES FOR OBESITY	2.1498	3.90	5.00
289	10	SURG	PARATHYROID PROCEDURES	0.9441	1.80	2.70
290	10	SURG	THYROID PROCEDURES	0.8938	1.70	2.20
291	10	SURG	THYROGLOSSAL PROCEDURES	0.6468	1.40	1.60
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.7336	7.30	10.60
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.3896	3.20	4.70
294	10	MED	DIABETES AGE >35	0.7800	3.50	4.60

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TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARTHIMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
295	10	MED	DIABETES AGE 0-35	0.7975	3.00	4.00
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.8639	4.00	5.10
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.5085	2.70	3.30
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.4537	2.40	3.10
299	10	MED	INBORN ERRORS OF METABOLISM	0.9466	3.80	5.50
300	10	MED	ENDOCRINE DISORDERS W CC	1.1001	4.70	6.20
301	10	MED	ENDOCRINE DISORDERS W/O CC	0.6158	2.80	3.60
302	11	SURG	KIDNEY TRANSPLANT	3.2343	7.20	8.50
303	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.3659	6.40	8.00
304	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.3856	6.20	8.90
305	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1854	2.80	3.60
306	11	SURG	PROSTATECTOMY W CC	1.2257	3.50	5.40
307	11	SURG	PROSTATECTOMY W/O CC	0.6145	1.70	2.10
308	11	SURG	MINOR BLADDER PROCEDURES W CC	1.5993	4.00	6.20
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	0.8991	1.70	2.10
310	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.1502	2.90	4.40
311	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	0.6258	1.50	1.80
312	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	1.0841	3.00	4.50
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	0.6814	1.70	2.20
314	11	SURG*	URETHRAL PROCEDURES, AGE 0-17	0.4984	2.30	2.30
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0796	3.70	7.00
316	11	MED	RENAL FAILURE	1.2987	4.90	6.60
317	11	MED	ADMIT FOR RENAL DIALYSIS	0.8503	2.40	3.60
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1871	4.40	6.10
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.6771	2.20	2.90
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.8853	4.30	5.40
321	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.5685	3.10	3.70
322	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.4625	2.80	3.30
323	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.8088	2.40	3.20
324	11	MED	URINARY STONES W/O CC	0.4797	1.60	1.90
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.6553	2.90	3.80
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4206	2.10	2.60
327	11	MED*	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.3727	3.10	3.10
328	11	MED	URETHRAL STRICTURE AGE >17 W CC	0.7613	2.70	3.80
329	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	0.5296	1.70	2.10
330	11	MED*	URETHRAL STRICTURE AGE 0-17	0.3210	1.60	1.60
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0618	4.20	5.60
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.5982	2.40	3.20
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.9483	3.70	5.70
334	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.4810	3.90	4.60
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.0835	2.80	3.00
336	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	0.8595	2.60	3.40
337	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	0.5869	1.80	2.00
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.2316	3.50	5.50
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.1345	2.90	4.80
340	12	SURG*	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.2853	2.40	2.40
341	12	SURG	PENIS PROCEDURES	1.2739	1.90	3.20
342	12	SURG	CIRCUMCISION AGE >17	0.7800	2.40	3.20
343	12	SURG*	CIRCUMCISION AGE 0-17	0.1551	1.70	1.70
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	1.3306	1.60	2.50
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	1.1671	3.00	4.90
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	1.0213	4.50	5.90
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.5417	2.20	3.00
348	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	0.7472	3.30	4.40
349	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	0.4608	2.00	2.50
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.7370	3.60	4.50
351	12	MED*	STERILIZATION, MALE	0.2379	1.30	1.30
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.7097	2.90	4.00
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.8390	4.90	6.50

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DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
354	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC.	1.4808	4.70	5.70
355	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC.	0.8912	3.00	3.20
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	0.7556	1.80	2.10
357	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.2737	6.70	8.40
358	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1807	3.40	4.20
359	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	0.8099	2.30	2.60
360	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	0.8661	2.20	2.80
361	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.0793	2.20	3.20
362	13	SURG*	ENDOSCOPIC TUBAL INTERRUPTION	0.3041	1.40	1.40
363	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.9374	2.60	3.60
364	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.9098	2.90	4.10
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	2.1284	5.30	8.20
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.2826	4.80	6.80
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.5588	2.30	3.10
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.1657	5.10	6.70
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	0.6065	2.40	3.30
370	14	SURG	CESAREAN SECTION W CC	1.0119	4.20	5.70
371	14	SURG	CESAREAN SECTION W/O CC	0.6317	3.20	3.50
372	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.5520	2.70	3.50
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.3856	2.00	2.30
374	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.7402	2.50	3.00
375	14	SURG*	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.5806	4.40	4.40
376	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	0.5693	2.50	3.40
377	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	1.0321	3.10	4.10
378	14	MED	ECTOPIC PREGNANCY	0.7950	2.00	2.60
379	14	MED	THREATENED ABORTION	0.3626	2.00	3.00
380	14	MED	ABORTION W/O D&C	0.4323	1.60	2.00
381	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.5257	1.50	1.90
382	14	MED	FALSE LABOR	0.2190	1.30	1.70
383	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.5123	2.70	3.80
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	0.3485	1.90	2.60
385	15	MED*	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.3855	1.80	1.80
386	15	MED*	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	4.5687	17.90	17.90
387	15	MED*	PREMATURITY W MAJOR PROBLEMS	3.1203	13.30	13.30
388	15	MED*	PREMATURITY W/O MAJOR PROBLEMS	1.8827	8.60	8.60
389	15	MED*	FULL TERM NEONATE W MAJOR PROBLEMS	3.2052	4.70	4.70
390	15	MED*	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1344	3.40	3.40
391	15	MED*	NORMAL NEWBORN	0.1536	3.10	3.10
392	16	SURG	SPLENECTOMY AGE >17	3.3164	7.10	9.70
393	16	SURG*	SPLENECTOMY AGE 0-17	1.3571	9.10	9.10
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.9338	4.70	7.60
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	0.8307	3.20	4.40
396	16	MED	RED BLOOD CELL DISORDERS AGE 0-17	0.6986	2.90	4.20
397	16	MED	COAGULATION DISORDERS	1.2648	3.70	5.20
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.2360	4.50	5.90
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.6651	2.70	3.50
400	17	SURG	NO LONGER VALID	0.0000	0.00	0.00
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.8946	8.10	11.60
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	1.1430	2.70	4.00
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.8197	5.80	8.20
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.8658	3.00	4.10
405	17	MED*	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.9241	4.90	4.90
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.	2.7055	6.90	9.70

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407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC.	1.2410	3.20	4.10
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC.	2.1984	4.80	8.20
409	17	MED	RADIOTHERAPY	1.2439	4.60	6.10
410	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	1.0833	3.20	4.10
411	17	MED*	HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.3948	4.70	4.70
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	0.5679	2.50	3.60
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.3224	5.20	7.10
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.7370	3.20	4.20
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.6276	10.40	14.40
416	18	MED	SEPTICEMIA AGE >17	1.5918	5.60	7.50
417	18	MED	SEPTICEMIA AGE 0-17	0.9612	4.40	5.70
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.0672	4.80	6.30
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.8476	3.60	4.60
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.6107	2.80	3.40
421	18	MED	VIRAL ILLNESS AGE >17	0.7464	3.10	4.10
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.7248	2.50	3.70
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.8155	5.90	8.40
424	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.4074	8.00	13.10
425	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION.	0.6781	2.80	3.80
426	19	MED	DEPRESSIVE NEUROSES	0.5087	3.20	4.50
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.5012	3.10	4.40
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.7291	4.50	7.10
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.8291	4.50	6.10
430	19	MED	PSYCHOSES	0.6801	5.60	7.90
431	19	MED	CHILDHOOD MENTAL DISORDERS	0.6620	4.40	6.90
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES	0.6513	2.90	4.00
433	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.2904	2.20	3.10
434	20	MED	NO LONGER VALID	0.0000	0.00	0.00
435	20	MED	NO LONGER VALID	0.0000	0.00	0.00
436	20	MED	NO LONGER VALID	0.0000	0.00	0.00
437	20	MED	NO LONGER VALID	0.0000	0.00	0.00
438	20		NO LONGER VALID	0.0000	0.00	0.00
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.7547	5.20	8.20
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.8878	5.80	9.10
441	21	SURG	HAND PROCEDURES FOR INJURIES	0.9662	2.10	3.10
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.4200	5.60	8.60
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	0.9787	2.50	3.40
444	21	MED	TRAUMATIC INJURY AGE >17 W CC	0.7475	3.20	4.20
445	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	0.5015	2.30	2.90
446	21	MED*	TRAUMATIC INJURY AGE 0-17	0.2983	2.40	2.40
447	21	MED	ALLERGIC REACTIONS AGE >17	0.5238	1.90	2.50
448	21	MED*	ALLERGIC REACTIONS AGE 0-17	0.0981	2.90	2.90
449	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.8352	2.60	3.70
450	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.4246	1.60	2.00
451	21	MED*	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.2648	2.10	2.10
452	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0455	3.50	4.90
453	21	MED	COMPLICATIONS OF TREATMENT W/O CC	0.5113	2.10	2.80
454	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.8153	3.00	4.20
455	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.4773	1.80	2.40
456	22		NO LONGER VALID	0.0000	0.00	0.00
457	22	MED	NO LONGER VALID	0.0000	0.00	0.00
458	22	SURG	NO LONGER VALID	0.0000	0.00	0.00
459	22	SURG	NO LONGER VALID	0.0000	0.00	0.00
460	22	MED	NO LONGER VALID	0.0000	0.00	0.00
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	1.1692	2.20	3.60
462	23	MED	REHABILITATION	0.9747	9.00	11.00
463	23	MED	SIGNS & SYMPTOMS W CC	0.6856	3.10	4.10
464	23	MED	SIGNS & SYMPTOMS W/O CC	0.4982	2.40	3.00
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	0.8881	2.00	3.90

* Medicare data have been supplemented by data from 19 States for low volume DRGs.
** DRGs 469 and 470 contian cases that could 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.

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARTHIMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	0.8088	2.20	3.90
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.5274	1.90	3.70
468			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.8454	9.40	13.10
469		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.00	0.00
470		**	UNGROUPABLE	0.0000	0.00	0.00
471	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.	3.0576	4.70	5.40
472	22	SURG	NO LONGER VALID	0.0000	0.00	0.00
473	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.4885	7.40	12.70
474	04	SURG	NO LONGER VALID	0.0000	0.00	0.00
475	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	3.6000	8.00	11.30
476		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2477	8.00	11.10
477		SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.8873	5.40	8.30
478	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.3743	4.90	7.30
479	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4300	2.40	3.20
480	PRE	SURG	LIVER TRANSPLANT	9.7823	14.00	21.10
481	PRE	SURG	BONE MARROW TRANSPLANT	6.1074		
1	9.20	21.80				
482	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	3.4803	9.60	12.50
483	PRE	SURG	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE, MOUTH & NECK DX OSES.	16.7762	34.20	41.60
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.4179	9.70	14.50
485	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA.	3.2121	7.90	10.00
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	4.8793	8.70	12.90
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	2.0057	5.30	7.30
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.8118	11.70	17.00
489	25	MED	HIV W MAJOR RELATED CONDITION	1.8603	6.00	8.60
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0512	3.90	5.50
491	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.7139	2.80	3.40
492	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT.	3.8371	9.30	14.90
493	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8302	4.40	6.00
494	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.0034	2.00	2.50
495	PRE	SURG	LUNG TRANSPLANT	8.5551	13.40	16.20
496	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	5.6839	6.80	8.90
497	08	SURG	SPINAL FUSION EXCEPT CERVICAL W CC	3.4056	5.20	6.30
498	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O CC	2.5319	3.60	4.00
499	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.4244	3.30	4.50
500	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	0.9369	2.00	2.40
501	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.6393	8.30	10.70
502	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.4192	5.10	6.20
503	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2233	3.00	3.90
504	22	SURG	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	11.6215	0.30	8.00
505	22	MED	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT	2.0006	2.30	5.60
506	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	4.1070	12.10	16.90
507	22	SURG	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	1.8154	6.50	9.20
508	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	1.3775	5.60	8.00
509	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	0.6426	3.10	4.40
510	22	MED	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.1812	4.60	6.80
511	22	MED	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.6753	3.20	4.70
512	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.3405	11.10	13.20
513	PRE	SURG	PANCREAS TRANSPLANT	6.1594	8.70	10.00
514	05	SURG	NO LONGER VALID	0.0000	0.00	0.00
515	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	5.3366	3.00	5.20
516	05	SURG	PERCUTANEOUS CARDIOVASC PROC W AMI	2.6911	3.80	4.80
517	05	SURG	PERC CARDIO PROC W NON-DRUG ELUTING STENT W/O AMI	2.1598	1.80	2.50

* Medicare data have been supplemented by data from 19 States for low volume DRGs.
** DRGs 469 and 470 contian cases that could 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.

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARTHIMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
518	05	SURG	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	1.7494	2.30	3.40
519	08	SURG	CERVICAL SPINAL FUSION W CC	2.4266	3.20	5.10
520	08	SURG	CERVICAL SPINAL FUSION W/O CC	1.5780	1.70	2.10
521	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.7115	4.30	5.80
522	20	MED	ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC.	0.5226	7.70	9.70
523	20	MED	ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC.	0.3956	3.30	4.10
524	01	MED	TRANSIENT ISCHEMIA	0.7320	2.70	3.40
525	05	SURG	HEART ASSIST SYSTEM IMPLANT	11.4372	8.90	17.00
526	05	SURG	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W AMI.	2.9891	3.60	4.50
527	05	SURG	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W/O AMI.	2.4483	1.80	2.50
528	01	SURG	INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	7.2205	14.20	17.50
529	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	2.2529	5.30	8.20
530	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC	1.2017	2.80	3.60
531	01	SURG	SPINAL PROCEDURES W CC	3.0552	6.80	9.90
532	01	SURG	SPINAL PROCEDURES W/O CC	1.4482	2.90	4.00
533	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.6678	2.70	4.10
534	01	SURG	EXTRACRANIAL PROCEDURES W/O CC	1.0748	1.60	2.00
535	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	8.1560	8.10	11.00
536	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	6.2775	3.90	5.80
537	08	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W CC.	1.8185	4.70	7.00
538	08	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC.	0.9919	2.10	2.90
539	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC	3.3846	7.40	11.20
540	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC	1.2891	2.90	4.00

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**DRGs 469 and 470 contian cases that could 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.

TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
[1] 079.82	SARS-associated coronavirus	Y	15	390
			18	421, 422
255.10	Primary aldosteronism	N	10	300, 301
255.11	Glucocorticoid-remediable aldosteronism	N	10	300, 301
255.12	Conn's syndrome	N	10	300, 301
255.13	Bartter's syndrome	N	10	300, 301
255.14	Other secondary aldosteronism	N	10	300, 301
277.81	Primary carnitine deficiency	N	10	299
277.82	Carnitine deficiency due to inborn errors of metabolism	N	10	299
277.83	Iatrogenic carnitine deficiency	N	10	299
277.84	Other secondary carnitine deficiency	N	10	299
277.89	Other specified disorders of metabolism	N	10	299
282.41	Sickle-cell thalassemia without crisis	Y	15	387,[2] 389 [2]
			16	395, 396
282.42	Sickle-cell thalassemia with crisis	Y	15	387,[2] 389 [2]
			16	395, 396
282.49	Other thalassemia	Y	15	387,[2] 389 [2]
			16	395, 396
282.64	Sickle-cell/Hb-C disease with crisis	Y	16	395, 396
282.68	Other sickle-cell disease without crisis	Y	16	395, 396
289.52	Splenic sequestration	N	16	398, 399
289.81	Primary hypercoagulable state	Y	16	398, 399
289.82	Secondary hypercoagulable state	Y	16	398, 399
289.89	Other specified diseases of blood and blood-forming organs	N	16	398, 399
331.11	Pick's disease	N	1	12
331.19	Other frontotemporal dementia	N	1	12
331.82	Dementia with Lewy bodies	N	1	12

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
348.30	Encephalopathy, unspecified	N	1	16, 17
			25	489 [3]
348.31	Metabolic encephalopathy	N	1	16, 17
			25	489 [3]
348.39	Other encephalopathy	N	1	16, 17
			25	489 [3]
358.00	Myasthenia gravis without (acute) exacerbation	Y	1	12
358.01	Myasthenia gravis with (acute) exacerbation	Y	1	12
414.07	Coronary atherosclerosis, of bypass graft (artery) (vein) of transplanted heart	N	5	132,133
458.21	Hypotension of hemodialysis	N	5	141, 142
458.29	Other iatrogenic hypotension	N	5	141,142
480.31	Pneumonia due to SARS-associated coronavirus	Y	4	89, 90, 91
			15	390
			25	489
493.81	Exercise induced bronchospasm	N	4	96, 97, 98
493.82	Cough variant asthma	N	4	96, 97, 98
[1] 517.3	Acute chest syndrome	N	4	92, 93
530.20	Ulcer of esophagus without bleeding	N	6	176
530.21	Ulcer of esophagus with bleeding	Y	6	176
530.85	Barrett's esophagus	N	6	176
600.00	Hypertrophy (benign) of prostate without urinary obstruction	N	12	348, 349
600.01	Hypertrophy (benign) of prostate with urinary obstruction	N	12	348, 349
600.10	Nodular prostate without urinary obstruction	N	12	348, 349
600.11	Nodular prostate with urinary obstruction	N	12	348, 349
600.20	Benign localized hyperplasia of prostate without urinary obstruction	N	12	348, 349
600.21	Benign localized hyperplasia of prostate with urinary obstruction	N	12	348, 349
600.90	Hyperplasia of prostate, unspecified, without urinary obstruction	N	12	348, 349
600.91	Hyperplasia of prostate, unspecified, with urinary obstruction	N	12	348, 349
607.85	Peyronie's disease	N	12	352
674.50	Peripartum cardiomyopathy, unspecified as to episode of care or not applicable.	Y	14	469
674.51	Peripartum cardiomyopathy, delivered, with or without mention of antepartum condition.	Y	14	370, 371, 372, 374, 375
674.52	Peripartum cardiomyopathy, delivered, with mention of postpartum condition	Y	14	370, 371, 372, 374, 375
674.53	Peripartum cardiomyopathy, antepartum condition or complication	Y	14	383, 384
674.54	Peripartum cardiomyopathy, postpartum condition or complication	Y	14	376, 377
719.7	Difficulty in walking	N	8	247
728.87	Muscle weakness	N	8	247
728.88	Rhabdomyolysis	Y	8	248
752.81	Scrotal transposition	N	12	352
752.89	Other specified anomalies of genital organs	N	12	352
			13	358, 359, 369
766.21	Post-term infant	N	15	391
766.22	Prolonged gestation of infant	N	15	391
767.11	Epicranial subaponeurotic hemorrhage (massive)	Y	15	389
767.19	Other injuries to scalp	N	15	391
779.83	Delayed separation of umbilical cord	N	15	391
780.93	Memory loss	N	23	463, 464
780.94	Early satiety	N	23	463, 464
781.94	Facial weakness	N	1	34, 35
785.52	Septic shock	Y	18	416, 417
788.63	Urgency of urination	N	11	325, 326, 327
790.21	Impaired fasting glucose	N	10	296, 297, 298
790.22	Impaired glucose tolerance test (oral)	N	10	296, 297, 298
790.29	Other abnormal glucose	N	10	296, 297, 298
799.81	Decreased libido	N	23	467
799.89	Other ill-defined conditions	N	23	467
850.11	Concussion, with loss of consciousness of 30 minutes or less	Y	1	31, 32, 33
			24	487
850.12	Concussion, with loss of consciousness from 31 to 59 minutes	Y	1	31, 32, 33
			24	487
959.11	Other injury of chest wall	N	21	444, 445, 446
			24	487

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
959.12	Other injury of abdomen	N	21 24	444, 445, 446 487
959.13	Fracture of corpus cavernosum penis	N	21 24	444, 445, 446 487
959.14	Other injury of external genitals	N	21 24	444, 445, 446 487
959.19	Other injury of other sites of trunk	N	21 24	444, 445, 446 487
996.57	Complication, Due to insulin pump	Y	21	452, 453
[1] V01.82	Exposure to SARS-associated coronavirus	N	15 23	390 467
V04.81	Need for prophylactic vaccination and inoculation, Influenza	N	23	467
V04.82	Need for prophylactic vaccination and inoculation, Respiratory synctial virus (RSV).	N	23	467
V04.89	Need for prophylactic vaccination and inoculation, Other viral diseases	N	23	467
V15.87	History of Extracorporeal Membrane Oxygenation (ECMO)	N	23	467
V25.03	Encounter for emergency contraceptive counseling and prescription	N	23	467
V43.21	Organ or tissue replaced by other means, Heart assist device	Y	5	144, 145
V43.22	Organ or tissue replaced by other means, Fully implantable artificial heart	Y	5	144, 145
V45.85	Insulin pump status	N	23	467
V53.90	Fitting and adjustment, Unspecified device	N	23	467
V53.91	Fitting and adjustment of insulin pump	N	23	467
V53.99	Fitting and adjustment, Other device	N	23	467
V54.01	Encounter for removal of internal fixation device	N	8	249
V54.02	Encounter for lengthening/adjustment of growth rod	N	8	249
V54.09	Other aftercare involving internal fixation device	N	8	249
V58.63	Long-term (current) use of antiplatelet/antithrombotic	N	23	465, 466
V58.64	Long-term (current) use of non-steroidal anti-inflammatories	N	23	465, 466
V58.65	Long-term (current) use of steroids	N	23	465, 466
V64.41	Laparoscopic surgical procedure converted to open procedure	N	23	467
V64.42	Thoracoscopic surgical procedure converted to open procedure	N	23	467
V64.43	Arthroscopic surgical procedure converted to open procedure	N	23	467
V65.11	Pediatric pre-birth visit for expectant mother	N	23	467
V65.19	Other person consulting on behalf of another person	N	23	467
V65.46	Encounter for insulin pump training	N	23	467

[1] The SARS-related codes were created after publication of the May 19, 2003 proposed rule.
[2] Classified as a Major Problem.
[3] Classified as a Major Related Condition.

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
00.15	High-dose infusion interleukin-2 (IL–2)	N*	17	492
37.51	Heart transplantation	Y	PRE	103
37.52	Implantation of total replacement heart system	5	525	
37.53	Replacement or repair of thoracic unit of total replacement heart system	Y	5	525
37.54	Replacement or repair of other implantable component of total replacement heart system.	Y	5	525
68.31	Laparoscopic supracervical hysterectomy (LSH)	Y	13 14	354, 355, 357, 358, 359 375
68.39	Other subtotal abdominal hysterectomy, NOS	Y	13 14	354, 355, 357, 358, 359 375
81.62	Fusion or refusion of 2–3 vertebrae	N[1]		
81.63	Fusion or refusion of 4–8 vertebrae	N[1]		
81.64	Fusion or refusion of 9 or more vertebrae	N[1]		

* Nonoperating room procedure, but affects DRG.
[1] Nonoperating room procedure code. The DRG assignment is made based on the specific fusion or refusion (81.00–81.08, 81.30–81.39, 81.61).

TABLE 6C.—INVALID PROCEDURE CODES

Diagnosis code	Description	CC	MDC	DRG
255.1	Hyperaldosteronism	N	10	300, 301
277.8	Other specified disorders of metabolism	N	10	299

TABLE 6C.—INVALID PROCEDURE CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
282.4	Thalassemias	Y	15	387,[1] 389[1]
			16	395, 396
289.8	Other specified diseases of blood and blood-forming organs	N	16	398, 399
331.1	Pick's disease	N	1	12
348.3	Encephalopathy, unspecified	N	1	16, 17
			25	489[2]
358.0	Myasthenia gravis	Y	1	12
458.2	Iatrogenic hypotension	N	5	141, 142
530.2	Ulcer of esophagus	N	6	176
600.0	Hypertrophy (benign) of prostate	N	12	348, 349
600.1	Nodular prostate	N	12	348, 349
600.2	Benign localized hyperplasia of prostate	N	12	348, 349
600.9	Hyperplasia of prostate, unspecified	N	12	348, 349
719.70	Difficulty in walking, site unspecified	N	8	247
719.75	Difficulty in walking, pelvic region and thigh	N	8	247
719.76	Difficulty in walking, lower leg	N	8	247
719.77	Difficulty in walking, ankle and foot	N	8	247
719.78	Difficulty in walking, other specified sites	N	8	247
719.79	Difficulty in walking, multiple sites	N	8	247
752.8	Other specified anomalies of genital organs	N	12	352
			13	358, 359, 369
766.2	Post term infant, not ≧heavy for dates≧	N	15	391
767.1	Injuries to scalp	N	15	391
790.2	Abnormal glucose tolerance test	N	10	296, 297, 298
799.8	Other ill-defined conditions	N	23	467
850.1	Concussion, with brief loss of consciousness	Y	1	31, 32, 33
			24	487
959.1	Injury, trunk	N	21	444, 445, 446
			24	487
V04.8	Need for prophylactic vaccination and inoculation against certain viral disease, Influenza.	N	23	467
V43.2	Organ or tissue replaced by other means, Heart	Y	5	144, 145
V53.9	Fitting and adjustment of other device, Other and unspecified device	N	23	467
V54.0	Aftercare involving removal of fracture plate or other internal fixation device	N	8	249
V64.4	Laparoscopic surgical procedure converted to open procedure	N	23	467
V65.1	Person consulting on behalf of another person	N	23	467

[1] Classified as a Major Problem.
[2] Classified as a Major Related Condition.

TABLE 6D.—INVALID PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
37.5	Heart transplantation	Y	PRE	103
68.3	Subtotal abdominal hysterectomy	Y	13	354, 355, 357, 358, 359
			14	375

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
282.60	Sickle-cell disease, unspecified	Y	16	395, 396
282.61	Hb-SS disease without crisis	Y	16	395, 396
282.62	Hb-SS disease with crisis	Y	16	395, 396
282.63	Sickle-cell/Hb-C disease without crisis	Y	16	395, 396
282.69	Other sickle-cell disease with crisis	Y	16	395, 396
414.06	Of native coronary artery of transplanted heart	N	5	132, 133
491.20	Obstructive chronic bronchitis, without exacerbation	Y	4	88
491.21	Obstructive chronic bronchitis, with (acute) exacerbation	Y	4	88
493.00	Extrinsic asthma, unspecified	N	4	96, 97, 98
493.02	Extrinsic asthma, with (acute) exacerbation	Y	4	96, 97, 98
493.10	Intrinsic asthma, unspecified	N	4	96, 97, 98
493.12	Intrinsic asthma, with (acute) exacerbation	Y	4	96, 97, 98
493.20	Chronic obstructive asthma, unspecified	Y	4	88
493.22	Chronic obstructive asthma, with (acute) exacerbation	Y	4	88
493.90	Asthma, unspecified	N	4	96, 97, 98
493.92	Asthma, unspecified, with (acute) exacerbation	Y	4	96, 97, 98

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES—Continued

Diagnosis code	Description	CC	MDC	DRG
V06.1	Diphtheria-tetanus-pertussis, combined [DTP] [DtaP]	N	23	467
V06.5	Tetanus-diphtheria [Td][DT]	N	23	467

TABLE 6F.—REVISED PROCEDURE CODE TITLES

Procedure code	Description	OR	MDC	DRG
37.33	Excision or destruction of other lesion or tissue of heart, open approach	Y	5	108
37.34	Excision or destruction of other lesion or tissue of heart, other approach	Y	5	516, 517, 518
39.79	Other endovascular repair (of aneurysm) of other vessels	Y	1	1, 2, 3
			5	110, 111
			11	315
			21	442, 443
			24	486

TABLE 6G.--ADDITIONS TO THE CC EXCLUSIONS LIST

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

*01100	07982	4803	*01170	07982	4803
07982	4803	*01145	07982	4803	*01215
4803	*01123	07982	4803	*01193	07982
*01101	07982	4803	*01171	07982	4803
07982	4803	*01146	07982	4803	*01216
4803	*01124	07982	4803	*01194	07982
*01102	07982	4803	*01172	07982	4803
07982	4803	*01150	07982	4803	*01280
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*01103	07982	4803	*01173	07982	4803
07982	4803	*01151	07982	4803	*01281
4803	*01126	07982	4803	*01196	07982
*01104	07982	4803	*01174	07982	4803
07982	4803	*01152	07982	4803	*01282
4803	*01130	07982	4803	*01200	07982
*01105	07982	4803	*01175	07982	4803
07982	4803	*01153	07982	4803	*01283
4803	*01131	07982	4803	*01201	07982
*01106	07982	4803	*01176	07982	4803
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*01114	07982	4803	*01184	07982	4803
07982	4803	*01162	07982	4803	*01792
4803	*01140	07982	4803	*01210	07982
*01115	07982	4803	*01185	07982	4803
07982	4803	*01163	07982	4803	*01793
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85011	85011	85011	80005	80076	80149
85012	85012	85012	80006	80079	80150
*80435	*80460	*80483	80009	80080	80151
85011	85011	85011	80010	80081	80152
85012	85012	85012	80011	80082	80153
*80436	*80461	*80484	80012	80083	80154
85011	85011	85011	80013	80084	80155
85012	85012	85012	80014	80085	80156
*80439	*80462	*80485	80015	80086	80159
85011	85011	85011	80016	80089	80160
85012	85012	85012	80019	80090	80161
*80440	*80463	*80486	80020	80091	80162
85011	85011	85011	80021	80092	80163
85012	85012	85012	80022	80093	80164
*80441	*80464	*80489	80023	80094	80165
85011	85011	85011	80024	80095	80166
85012	85012	85012	80025	80096	80169
*80442	*80465	*80490	80026	80099	80170
85011	85011	85011	80029	80100	80171
85012	85012	85012	80030	80101	80172
*80443	*80466	*80491	80031	80102	80173
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85012	85012	85012	80033	80104	80175
*80444	*80469	*80492	80034	80105	80176
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85012	85012	85012	80036	80109	80180
*80445	*80470	*80493	80039	80110	80181
85011	85011	85011	80040	80111	80182
85012	85012	85012	80041	80112	80183
*80446	*80471	*80494	80042	80113	80184
85011	85011	85011	80043	80114	80185

80186	80324	80395	80466	85129	85200
80189	80325	80396	80469	85130	85201
80190	80326	80399	80470	85131	85202
80191	80329	80400	80471	85132	85203
80192	80330	80401	80472	85133	85204
80193	80331	80402	80473	85134	85205
80194	80332	80403	80474	85135	85206
80195	80333	80404	80475	85136	85209
80196	80334	80405	80476	85139	85210
80199	80335	80406	80479	85140	85211
8021	80336	80409	80480	85141	85212
80220	80339	80410	80481	85142	85213
80221	80340	80411	80482	85143	85214
80222	80341	80412	80483	85144	85215
80223	80342	80413	80484	85145	85216
80224	80343	80414	80485	85146	85219
80225	80344	80415	80486	85149	85220
80226	80345	80416	80489	85150	85221
80227	80346	80419	80490	85151	85222
80228	80349	80420	80491	85152	85223
80229	80350	80421	80492	85153	85224
80230	80351	80422	80493	85154	85225
80231	80352	80423	80494	85155	85226
80232	80353	80424	80495	85156	85229
80233	80354	80425	80496	85159	85230
80234	80355	80426	80499	85160	85231
80235	80356	80429	8500	85161	85232
80236	80359	80430	85011	85162	85233
80237	80360	80431	85012	85163	85234
80238	80361	80432	8502	85164	85235
80239	80362	80433	8503	85165	85236
8024	80363	80434	8504	85166	85239
8025	80364	80435	8505	85169	85240
8026	80365	80436	8509	85170	85241
8027	80366	80439	85100	85171	85242
8028	80369	80440	85101	85172	85243
8029	80370	80441	85102	85173	85244
80300	80371	80442	85103	85174	85245
80301	80372	80443	85104	85175	85246
80302	80373	80444	85105	85176	85249
80303	80374	80445	85106	85179	85250
80304	80375	80446	85109	85180	85251
80305	80376	80449	85110	85181	85252
80306	80379	80450	85111	85182	85253
80309	80380	80451	85112	85183	85254
80310	80381	80452	85113	85184	85255
80311	80382	80453	85114	85185	85256
80312	80383	80454	85115	85186	85259
80313	80384	80455	85116	85189	85300
80314	80385	80456	85119	85190	85301
80315	80386	80459	85120	85191	85302
80316	80389	80460	85121	85192	85303
80319	80390	80461	85122	85193	85304
80320	80391	80462	85123	85194	85305
80321	80392	80463	85124	85195	85306
80322	80393	80464	85125	85196	85309
80323	80394	80465	85126	85199	85310

85311	80032	80103	80174	80312	80383
85312	80033	80104	80175	80313	80384
85313	80034	80105	80176	80314	80385
85314	80035	80106	80179	80315	80386
85315	80036	80109	80180	80316	80389
85316	80039	80110	80181	80319	80390
85319	80040	80111	80182	80320	80391
85400	80041	80112	80183	80321	80392
85401	80042	80113	80184	80322	80393
85402	80043	80114	80185	80323	80394
85403	80044	80115	80186	80324	80395
85404	80045	80116	80189	80325	80396
85405	80046	80119	80190	80326	80399
85406	80049	80120	80191	80329	80400
85409	80050	80121	80192	80330	80401
85410	80051	80122	80193	80331	80402
85411	80052	80123	80194	80332	80403
85412	80053	80124	80195	80333	80404
85413	80054	80125	80196	80334	80405
85414	80055	80126	80199	80335	80406
85415	80056	80129	8021	80336	80409
85416	80059	80130	80220	80339	80410
85419	80060	80131	80221	80340	80411
*85012	80061	80132	80222	80341	80412
430	80062	80133	80223	80342	80413
431	80063	80134	80224	80343	80414
4320	80064	80135	80225	80344	80415
4321	80065	80136	80226	80345	80416
436	80066	80139	80227	80346	80419
78001	80069	80140	80228	80349	80420
78003	80070	80141	80229	80350	80421
80000	80071	80142	80230	80351	80422
80001	80072	80143	80231	80352	80423
80002	80073	80144	80232	80353	80424
80003	80074	80145	80233	80354	80425
80004	80075	80146	80234	80355	80426
80005	80076	80149	80235	80356	80429
80006	80079	80150	80236	80359	80430
80009	80080	80151	80237	80360	80431
80010	80081	80152	80238	80361	80432
80011	80082	80153	80239	80362	80433
80012	80083	80154	8024	80363	80434
80013	80084	80155	8025	80364	80435
80014	80085	80156	8026	80365	80436
80015	80086	80159	8027	80366	80439
80016	80089	80160	8028	80369	80440
80019	80090	80161	8029	80370	80441
80020	80091	80162	80300	80371	80442
80021	80092	80163	80301	80372	80443
80022	80093	80164	80302	80373	80444
80023	80094	80165	80303	80374	80445
80024	80095	80166	80304	80375	80446
80025	80096	80169	80305	80376	80449
80026	80099	80170	80306	80379	80450
80029	80100	80171	80309	80380	80451
80030	80101	80172	80310	80381	80452
80031	80102	80173	80311	80382	80453

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80455	85116	85189	85300	85011	85011
80456	85119	85190	85301	85012	85012
80459	85120	85191	85302	*85104	*85129
80460	85121	85192	85303	85011	85011
80461	85122	85193	85304	85012	85012
80462	85123	85194	85305	*85105	*85130
80463	85124	85195	85306	85011	85011
80464	85125	85196	85309	85012	85012
80465	85126	85199	85310	*85106	*85131
80466	85129	85200	85311	85011	85011
80469	85130	85201	85312	85012	85012
80470	85131	85202	85313	*85109	*85132
80471	85132	85203	85314	85011	85011
80472	85133	85204	85315	85012	85012
80473	85134	85205	85316	*85110	*85133
80474	85135	85206	85319	85011	85011
80475	85136	85209	85400	85012	85012
80476	85139	85210	85401	*85111	*85134
80479	85140	85211	85402	85011	85011
80480	85141	85212	85403	85012	85012
80481	85142	85213	85404	*85112	*85135
80482	85143	85214	85405	85011	85011
80483	85144	85215	85406	85012	85012
80484	85145	85216	85409	*85113	*85136
80485	85146	85219	85410	85011	85011
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80489	85150	85221	85412	*85114	*85139
80490	85151	85222	85413	85011	85011
80491	85152	85223	85414	85012	85012
80492	85153	85224	85415	*85115	*85140
80493	85154	85225	85416	85011	85011
80494	85155	85226	85419	85012	85012
80495	85156	85229	*8502	*85116	*85141
80496	85159	85230	85011	85011	85011
80499	85160	85231	85012	85012	85012
8500	85161	85232	*8503	*85119	*85142
85011	85162	85233	85011	85011	85011
85012	85163	85234	85012	85012	85012
8502	85164	85235	*8504	*85120	*85143
8503	85165	85236	85011	85011	85011
8504	85166	85239	85012	85012	85012
8505	85169	85240	*8505	*85121	*85144
8509	85170	85241	85011	85011	85011
85100	85171	85242	85012	85012	85012
85101	85172	85243	*8509	*85122	*85145
85102	85173	85244	85011	85011	85011
85103	85174	85245	85012	85012	85012
85104	85175	85246	*85100	*85123	*85146
85105	85176	85249	85011	85011	85011
85106	85179	85250	85012	85012	85012
85109	85180	85251	*85101	*85124	*85149
85110	85181	85252	85011	85011	85011
85111	85182	85253	85012	85012	85012
85112	85183	85254	*85102	*85125	*85150
85113	85184	85255	85011	85011	85011
85114	85185	85256	85012	85012	85012

*85151	*85174	*85199	*85223	*85246	*85311
85011	85011	85011	85011	85011	85011
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*85152	*85175	*85200	*85224	*85249	*85312
85011	85011	85011	85011	85011	85011
85012	85012	85012	85012	85012	85012
*85153	*85176	*85201	*85225	*85250	*85313
85011	85011	85011	85011	85011	85011
85012	85012	85012	85012	85012	85012
*85154	*85179	*85202	*85226	*85251	*85314
85011	85011	85011	85011	85011	85011
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*85155	*85180	*85203	*85229	*85252	*85315
85011	85011	85011	85011	85011	85011
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*85156	*85181	*85204	*85230	*85253	*85316
85011	85011	85011	85011	85011	85011
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*85159	*85182	*85205	*85231	*85254	*85319
85011	85011	85011	85011	85011	85011
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*85161	*85184	*85209	*85233	*85256	*85401
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*85162	*85185	*85210	*85234	*85259	*85402
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*85163	*85186	*85211	*85235	*85300	*85403
85011	85011	85011	85011	85011	85011
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*85164	*85189	*85212	*85236	*85301	*85404
85011	85011	85011	85011	85011	85011
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*85165	*85190	*85213	*85239	*85302	*85405
85011	85011	85011	85011	85011	85011
85012	85012	85012	85012	85012	85012
*85166	*85191	*85214	*85240	*85303	*85406
85011	85011	85011	85011	85011	85011
85012	85012	85012	85012	85012	85012
*85169	*85192	*85215	*85241	*85304	*85409
85011	85011	85011	85011	85011	85011
85012	85012	85012	85012	85012	85012
*85170	*85193	*85216	*85242	*85305	*85410
85011	85011	85011	85011	85011	85011
85012	85012	85012	85012	85012	85012
*85171	*85194	*85219	*85243	*85306	*85411
85011	85011	85011	85011	85011	85011
85012	85012	85012	85012	85012	85012
*85172	*85195	*85221	*85244	*85309	*85412
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85012	85012	85012	85012	85012	85012
*85173	*85196	*85222	*85245	*85310	*85413
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95207	80612	95217	80622	85012	99674
95208	80613	95218	80623	*9599	99675
95209	80614	95219	80624	85011	99676
95210	80615	9522	80625	85012	99677
95211	80616	9523	80626	*99600	99678
95212	80617	9524	80627	99657	99679
95213	80618	9528	80628	*99601	*99659
95214	80619	9529	80629	99657	99657
95215	80620	*95919	80630	*99602	*99660
95216	80621	80500	80631	99657	99657
95217	80622	80501	80632	*99603	*99661
95218	80623	80502	80633	99657	99657
95219	80624	80503	80634	*99604	*99662
9522	80625	80504	80635	99657	99657
9523	80626	80505	80636	*99609	*99663
9524	80627	80506	80637	99657	99657
9528	80628	80507	80638	*9961	*99664
9529	80629	80508	80639	99657	99657
*95914	80630	80510	8064	*9962	*99665
80500	80631	80511	8065	99657	99657
80501	80632	80512	80660	*99630	*99666
80502	80633	80513	80661	99657	99657
80503	80634	80514	80662	*99639	*99667
80504	80635	80515	80669	99657	99657
80505	80636	80516	80670	*9964	*99668
80506	80637	80517	80671	99657	99657
80507	80638	80518	80672	*99651	*99669
80508	80639	8052	80679	99657	99657
80510	8064	8053	8068	*99652	*99670
80511	8065	8054	8069	99657	99657
80512	80660	8055	95200	*99653	*99671
80513	80661	8056	95201	99657	99657
80514	80662	8057	95202	*99654	*99672
80515	80669	8058	95203	99657	99657
80516	80670	8059	95204	*99655	*99673
80517	80671	80600	95205	99657	99657
80518	80672	80601	95206	*99656	*99674
8052	80679	80602	95207	99657	99657
8053	8068	80603	95208	*99657	*99675
8054	8069	80604	95209	99655	99657
8055	95200	80605	95210	99656	*99676
8056	95201	80606	95211	99657	99657
8057	95202	80607	95212	99659	*99677
8058	95203	80608	95213	99660	99657
8059	95204	80609	95214	99661	*99678
80600	95205	80610	95215	99662	99657
80601	95206	80611	95216	99663	*99679
80602	95207	80612	95217	99664	99657
80603	95208	80613	95218	99665	*99680
80604	95209	80614	95219	99666	V4321
80605	95210	80615	9522	99667	V4322
80606	95211	80616	9523	99668	*99683
80607	95212	80617	9524	99669	V4321
80608	95213	80618	9528	99670	V4322
80609	95214	80619	9529	99671	*99687
80610	95215	80620	*9598	99672	V4321
80611	95216	80621	85011	99673	V4322

*99791	*99881	*99889	*V421	V4321	V4322
99657	99657	99657	V4321	V4322	
*99799	*99883	*9989	V4322	*V4322	
99657	99657	99657	*V4321	V4321	

TABLE 6H.--DELETIONS TO THE CC EXCLUSIONS LIST

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

*25060	2824	2824	2840	53141	53461
3580	*2819	*2830	2848	53150	53471
*25061	2824	2824	2849	53151	53491
3580	*2820	*28310	2850	53160	53501
*25062	2824	2824	2851	53161	53511
3580	*2821	*28311	2860	53171	53521
*25063	2824	2824	2861	53191	53531
3580	*2822	*28319	2862	53200	53541
*25080	2824	2824	2863	53201	53551
3580	*2823	*2832	2864	53210	53561
*25081	2824	2824	2865	53211	53783
3580	*2824	*2839	2866	53220	53784
*25082	2800	2824	2867	53221	56202
3580	2814	*2840	2869	53231	56203
*25083	2818	2824	2870	53240	56212
3580	2824	*2848	2871	53241	56213
*25090	28260	2824	2872	53250	5693
3580	28261	*2849	2873	53251	56985
*25091	28262	2824	2874	53260	56986
3580	28263	*2850	2875	53261	5780
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*80125	8501	*80196	8501	*80369	8501
8501	*80162	8501	*80333	8501	*80404
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*80132	8501	*80303	8501	*80374	8501
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8501	*80461	8501	80052	80123	80194
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80324	80395	80466	85130	85201	85312
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80330	80401	80472	85134	85205	85316
80331	80402	80473	85135	85206	85319
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80333	80404	80475	85139	85210	85401
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80369	80440	85102	85173	85244	8501
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TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY

[FY 2002 Medpar Update March 2003 Grouper V20.0]

DRG	Number of discharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	29,410	10.9	3	5	8	14	22
2	14,837	5.1	1	2	4	7	10
3	3	6.0	1	1	4	13	13
4	6,793	7.3	1	2	5	9	16
5	95,905	3.0	1	1	2	3	7
6	360	3.0	1	1	2	4	7
7	14,744	9.9	2	4	7	12	20
8	4,140	2.8	1	1	1	3	7
9	1,741	6.7	1	3	5	8	12
10	18,736	6.4	2	3	5	8	13
11	3,312	4.0	1	2	3	5	8
12	52,693	5.8	2	3	4	7	11
13	7,144	5.0	2	3	4	6	9
14	237,827	5.9	2	3	5	7	11
15	94,552	4.9	2	3	4	6	9
16	9,982	6.3	2	3	5	8	12
17	2,757	3.2	1	1	2	4	6
18	29,858	5.5	2	3	4	7	10
19	8,583	3.5	1	2	3	5	7
20	6,244	10.2	3	5	8	13	20
21	1,894	6.6	2	3	5	8	13
22	2,794	5.1	2	2	4	6	10
23	12,654	4.2	1	2	3	5	8
24	59,420	4.9	1	2	4	6	10
25	27,639	3.2	1	2	3	4	6
26	20	4.1	1	1	2	3	4
27	4,470	5.2	1	1	3	7	11
28	14,063	6.0	1	3	5	8	12
29	5,344	3.5	1	2	3	4	7
30	3	5.7	2	2	4	11	11
31	3,976	4.0	1	2	3	5	8
32	1,932	2.5	1	1	2	3	5
34	23,918	4.9	1	2	4	6	9
35	7,483	3.1	1	1	3	4	6
36	2,125	1.5	1	1	1	1	2
37	1,392	3.8	1	1	2	5	8
38	98	2.8	1	1	1	4	5
39	563	2.1	1	1	1	2	4
40	1,555	3.8	1	1	3	5	7
42	1,592	2.7	1	1	1	3	6
43	95	3.4	1	1	3	4	6
44	1,231	5.0	2	3	4	6	9
45	2,690	3.1	1	2	3	4	6
46	3,495	4.5	1	2	3	6	8
47	1,415	3.1	1	1	2	4	6
49	2,392	4.5	1	2	3	6	9
50	2,439	1.9	1	1	1	2	3
51	243	2.8	1	1	1	3	8
52	224	1.8	1	1	1	2	3
53	2,485	3.6	1	1	2	4	8
55	1,489	2.9	1	1	1	3	7
56	476	2.9	1	1	1	3	6
57	715	3.7	1	1	2	4	8
58	1	2.0	2	2	2	2	2
59	117	2.7	1	1	1	3	6
60	1	3.0	3	3	3	3	3
61	255	5.2	1	1	3	7	11
62	2	7.0	1	1	13	13	13
63	3,038	4.4	1	2	3	5	9
64	3,149	6.5	1	2	4	8	13
65	40,527	2.8	1	1	2	4	5
66	7,876	3.1	1	1	2	4	6
67	387	3.6	1	2	3	5	7
68	11,695	3.9	1	2	3	5	7
69	3,782	3.0	1	2	3	4	5
70	32	2.4	1	1	2	3	4
71	80	3.4	1	1	2	4	6
72	972	3.4	1	1	3	4	6
73	7,740	4.4	1	2	3	6	9

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

[FY 2002 Medpar Update March 2003 Grouper V20.0]

DRG	Number of discharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
75	43,515	10.0	3	5	7	12	20
76	44,651	11.1	3	5	9	14	21
77	2,484	4.8	1	2	4	7	10
78	39,668	6.6	3	4	6	8	11
79	169,669	8.5	3	4	7	11	16
80	8,115	5.3	2	3	4	7	10
81	5	4.4	1	1	3	8	8
82	64,585	6.9	2	3	5	9	14
83	6,788	5.4	2	3	4	7	10
84	1,616	3.2	1	2	3	4	6
85	22,461	6.2	2	3	5	8	12
86	2,262	3.5	1	2	3	4	7
87	61,337	6.3	1	3	5	8	12
88	405,367	5.0	2	3	4	6	9
89	536,888	5.8	2	3	5	7	11
90	49,023	4.0	2	2	3	5	7
91	45	5.0	1	2	3	5	13
92	15,881	6.3	2	3	5	8	12
93	1,782	4.0	1	2	3	5	7
94	12,922	6.2	2	3	5	8	12
95	1,672	3.8	1	2	3	5	7
96	57,107	4.6	2	2	4	6	8
97	28,950	3.5	1	2	3	4	6
98	9	3.7	1	1	2	2	5
99	21,531	3.2	1	1	2	4	6
100	8,350	2.1	1	1	2	3	4
101	22,498	4.4	1	2	3	6	9
102	5,699	2.6	1	1	2	3	5
103	495	42.4	9	12	23	54	96
104	20,732	14.3	6	8	12	17	25
105	29,353	9.9	4	6	8	11	18
106	3,515	11.4	5	7	10	14	20
107	83,704	10.4	5	7	9	12	17
108	6,543	9.8	2	5	8	12	18
109	57,705	7.7	4	5	6	9	13
110	55,056	8.8	2	4	7	11	18
111	9,618	4.1	1	2	4	6	7
113	39,897	12.5	4	6	9	15	24
114	8,369	8.6	2	4	7	11	17
115	19,879	7.4	1	3	6	10	15
116	116,607	4.4	1	2	3	6	9
117	4,751	4.3	1	1	2	5	10
118	8,319	2.9	1	1	1	4	7
119	1,257	5.3	1	1	3	7	13
120	38,350	9.0	1	3	6	12	20
121	164,602	6.3	2	3	5	8	12
122	77,383	3.5	1	2	3	5	7
123	38,786	4.8	1	1	3	6	11
124	135,861	4.4	1	2	3	6	9
125	92,387	2.8	1	1	2	4	5
126	5,422	11.5	3	6	9	15	22
127	678,154	5.2	2	3	4	7	10
128	7,226	5.4	2	3	5	7	9
129	3,884	2.6	1	1	1	3	6
130	89,220	5.6	2	3	5	7	10
131	27,255	4.0	1	2	4	5	7
132	142,959	2.9	1	1	2	4	5
133	8,743	2.3	1	1	2	3	4
134	41,755	3.2	1	2	2	4	6
135	7,825	4.5	1	2	3	5	8
136	1,191	2.7	1	1	2	3	5
138	209,417	4.0	1	2	3	5	8
139	88,233	2.5	1	1	2	3	5
140	56,027	2.5	1	1	2	3	5
141	109,260	3.6	1	2	3	4	7
142	52,906	2.6	1	1	2	3	5
143	251,335	2.1	1	1	2	3	4
144	95,251	5.5	1	2	4	7	11
145	7,414	2.6	1	1	2	3	5

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

[FY 2002 Medpar Update March 2003 Grouper V20.0]

DRG	Number of discharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
146	10,813	10.2	5	6	8	12	17
147	2,649	6.2	3	5	6	8	9
148	134,602	12.3	5	7	10	15	22
149	20,279	6.3	4	5	6	7	9
150	21,258	11.3	4	6	9	14	20
151	5,171	5.6	2	3	5	7	10
152	4,594	8.4	3	5	7	10	15
153	2,069	5.2	3	4	5	7	8
154	28,481	13.2	3	7	10	17	26
155	6,654	4.1	1	2	3	6	8
156	4	2.5	1	1	1	3	5
157	8,336	5.7	1	2	4	7	12
158	4,379	2.6	1	1	2	3	5
159	18,211	5.1	1	2	4	7	10
160	12,263	2.7	1	1	2	3	5
161	10,838	4.3	1	1	3	6	9
162	6,447	1.9	1	1	1	2	4
163	8	3.3	1	1	2	3	6
164	5,432	8.4	3	5	7	10	15
165	2,351	4.5	2	3	4	6	7
166	4,228	4.7	1	2	4	6	9
167	4,121	2.4	1	1	2	3	4
168	1,437	4.8	1	2	3	6	10
169	811	2.4	1	1	2	3	5
170	15,746	10.8	2	4	8	14	22
171	1,535	4.3	1	2	4	6	9
172	31,608	7.0	2	3	5	9	14
173	2,503	3.8	1	2	3	5	8
174	253,175	4.8	2	3	4	6	9
175	35,116	2.9	1	2	3	4	5
176	13,542	5.2	2	3	4	6	10
177	9,121	4.6	2	2	4	6	8
178	3,396	3.1	1	2	3	4	6
179	13,263	5.9	2	3	5	7	11
180	91,043	5.4	2	3	4	7	10
181	27,384	3.4	1	2	3	4	6
182	274,383	4.4	1	2	3	5	8
183	91,766	2.9	1	1	2	4	5
184	75	3.3	1	1	2	4	7
185	5,415	4.7	1	2	3	6	10
186	6	6.7	2	3	3	10	10
187	637	4.1	1	2	3	6	8
188	84,442	5.6	1	2	4	7	11
189	13,179	3.1	1	1	2	4	6
190	76	5.1	1	2	4	6	10
191	9,576	13.8	3	6	10	17	28
192	1,322	6.2	1	3	6	8	11
193	4,844	12.7	5	7	10	16	23
194	651	6.7	2	4	6	8	12
195	4,041	10.5	4	6	9	13	19
196	1,007	5.6	2	3	5	7	10
197	18,401	9.2	3	5	7	11	17
198	5,446	4.4	2	3	4	6	7
199	1,644	9.8	2	4	7	13	21
200	1,082	10.5	2	3	7	14	23
201	2,146	14.2	4	6	10	18	29
202	26,905	6.4	2	3	5	8	13
203	30,167	6.7	2	3	5	9	13
204	65,940	5.7	2	3	4	7	11
205	27,684	6.2	2	3	5	8	12
206	2,079	3.8	1	2	3	5	8
207	33,045	5.2	1	2	4	7	10
208	10,244	2.9	1	1	2	4	5
209	401,363	4.9	3	3	4	5	7
210	123,436	6.9	3	4	6	8	11
211	30,259	4.8	3	4	4	6	7
212	10	6.4	1	1	3	5	7
213	10,018	9.2	2	4	7	12	18
216	8,808	8.0	1	2	6	11	17

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

[FY 2002 Medpar Update March 2003 Grouper V20.0]

DRG	Number of discharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
217	17,420	13.4	3	5	9	16	28
218	24,033	5.5	2	3	4	7	10
219	20,076	3.2	1	2	3	4	6
220	1	1.0	1	1	1	1	1
223	13,406	3.0	1	1	2	4	6
224	11,846	1.9	1	1	1	2	3
225	6,539	5.3	1	2	4	7	11
226	5,895	6.5	1	2	4	8	14
227	4,883	2.6	1	1	2	3	5
228	2,553	4.1	1	1	3	5	9
229	1,274	2.3	1	1	2	3	5
230	2,474	5.6	1	2	3	7	12
231	13,405	5.0	1	1	3	6	11
232	825	2.7	1	1	1	2	6
233	10,014	7.4	1	3	6	10	15
234	5,408	3.1	1	1	2	4	7
235	5,150	4.9	1	2	4	6	9
236	40,417	4.6	1	3	4	6	8
237	1,790	3.7	1	2	3	5	7
238	9,003	8.6	3	4	7	10	17
239	46,422	6.3	2	3	5	8	12
240	12,147	6.6	2	3	5	8	13
241	3,197	3.8	1	2	3	5	7
242	2,621	6.9	2	3	5	9	14
243	97,186	4.7	1	2	4	6	9
244	14,757	4.7	1	2	4	6	9
245	5,890	3.3	1	2	3	4	6
246	1,501	3.8	1	2	3	5	7
247	20,607	3.3	1	1	3	4	7
248	14,008	4.9	1	3	4	6	9
249	13,006	3.6	1	1	2	4	7
250	3,835	4.1	1	2	3	5	8
251	2,403	2.8	1	1	3	3	5
253	22,265	4.7	2	3	4	6	8
254	10,865	3.2	1	2	3	4	5
256	6,755	5.1	1	2	4	6	10
257	15,803	2.6	1	1	2	3	5
258	15,399	1.8	1	1	2	2	3
259	3,531	2.7	1	1	1	3	6
260	4,255	1.4	1	1	1	1	2
261	1,801	2.1	1	1	1	2	4
262	674	4.3	1	1	3	6	9
263	23,297	11.5	3	5	8	14	22
264	3,898	6.6	2	3	5	8	13
265	4,132	6.6	1	2	4	8	14
266	2,567	3.2	1	1	2	4	7
267	242	4.4	1	1	3	6	10
268	931	3.8	1	1	2	4	8
269	9,911	8.5	2	3	7	11	17
270	2,824	3.6	1	1	2	5	7
271	19,513	7.2	2	4	6	9	14
272	5,770	6.0	2	3	5	7	12
273	1,351	4.0	1	2	3	5	8
274	2,328	6.5	1	3	5	8	13
275	232	3.6	1	1	2	4	7
276	1,333	4.5	1	2	4	6	8
277	101,243	5.7	2	3	5	7	10
278	32,701	4.2	2	2	4	5	7
279	10	5.3	2	2	3	7	7
280	18,038	4.1	1	2	3	5	8
281	7,650	2.9	1	1	2	4	5
283	6,106	4.7	1	2	4	6	9
284	2,039	2.9	1	1	2	4	6
285	7,012	10.5	3	5	8	13	20
286	2,511	5.9	2	3	4	7	12
287	6,330	10.3	3	5	8	13	20
288	5,684	5.0	2	3	4	5	8
289	6,977	2.7	1	1	1	2	6
290	10,000	2.2	1	1	1	2	4

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

[FY 2002 Medpar Update March 2003 Grouper V20.0]

DRG	Number of discharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
291	60	1.6	1	1	1	2	3
292	6,576	10.5	2	4	8	14	21
293	368	4.7	1	1	3	6	9
294	99,279	4.5	1	2	3	6	9
295	3,603	4.0	1	2	3	5	7
296	281,526	5.1	1	2	4	6	10
297	48,952	3.3	1	2	3	4	6
298	117	3.1	1	1	2	4	6
299	1,291	5.5	1	2	4	7	11
300	18,877	6.1	2	3	5	8	12
301	3,649	3.6	1	2	3	4	7
302	8,941	8.5	4	5	6	9	15
303	21,890	8.0	3	4	6	9	15
304	12,646	8.9	2	4	6	11	18
305	3,058	3.5	1	2	3	4	7
306	7,087	5.4	1	2	3	7	12
307	2,041	2.1	1	1	2	2	3
308	7,321	6.2	1	2	4	8	14
309	4,198	2.1	1	1	1	2	4
310	24,966	4.4	1	1	3	6	10
311	7,518	1.8	1	1	1	2	3
312	1,532	4.6	1	1	3	6	10
313	558	2.3	1	1	1	3	5
314	2	40.5	1	1	80	80	80
315	34,371	7.0	1	1	4	9	16
316	120,183	6.5	2	3	5	8	13
317	2,045	3.6	1	1	2	4	7
318	5,811	6.1	1	3	5	8	12
319	416	2.9	1	1	2	4	6
320	188,879	5.3	2	3	4	6	10
321	31,494	3.7	1	2	3	5	7
322	55	3.3	1	2	3	4	5
323	20,049	3.2	1	1	2	4	6
324	7,086	1.9	1	1	1	2	4
325	9,360	3.8	1	2	3	5	7
326	2,755	2.6	1	1	2	3	5
327	7	2.6	1	1	2	3	4
328	748	3.7	1	1	3	5	8
329	92	2.1	1	1	1	3	5
331	51,750	5.6	1	3	4	7	11
332	5,046	3.2	1	1	2	4	6
333	269	5.7	1	2	3	7	11
334	10,565	4.6	2	3	4	5	8
335	12,782	3.0	2	2	3	4	5
336	36,048	3.4	1	2	2	4	7
337	29,654	2.0	1	1	2	2	3
338	941	5.5	1	2	3	7	13
339	1,491	4.8	1	1	3	6	11
340	1	2.0	2	2	2	2	2
341	3,599	3.2	1	1	2	3	7
342	694	3.2	1	1	2	4	7
344	3,598	2.5	1	1	1	2	5
345	1,376	4.9	1	1	3	6	11
346	4,919	5.9	2	3	5	8	12
347	318	3.0	1	1	2	4	6
348	3,416	4.3	1	2	3	5	8
349	619	2.5	1	1	2	3	5
350	6,778	4.5	2	2	4	6	8
352	968	4.0	1	2	3	5	8
353	2,585	6.5	2	3	5	7	12
354	7,455	5.7	3	3	4	6	10
355	5,602	3.2	2	2	3	4	5
356	26,093	2.1	1	1	2	3	3
357	5,648	8.4	3	4	6	10	16
358	21,749	4.2	2	2	3	5	7
359	32,221	2.6	1	2	2	3	4
360	15,906	2.8	1	1	2	3	4
361	348	3.2	1	1	2	3	7
362	5	1.4	1	1	1	2	2

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

[FY 2002 Medpar Update March 2003 Grouper V20.0]

DRG	Number of discharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
363	2,529	3.6	1	2	2	4	8
364	1,643	4.1	1	1	3	5	8
365	1,842	8.2	1	3	5	10	17
366	4,601	6.7	1	3	5	8	14
367	489	3.1	1	1	2	4	7
368	3,592	6.6	2	3	5	8	13
369	3,510	3.3	1	1	2	4	7
370	1,390	5.8	2	3	4	5	9
371	1,764	3.5	2	3	3	4	5
372	979	3.5	2	2	2	3	5
373	4,246	2.3	1	2	2	3	3
374	100	3.0	2	2	2	3	6
376	332	3.5	1	2	2	4	7
377	53	4.1	1	2	3	5	8
378	175	2.6	1	1	2	3	5
379	365	3.0	1	1	2	3	5
380	98	2.0	1	1	1	2	3
381	194	1.9	1	1	1	2	4
382	49	1.7	1	1	1	2	3
383	2,031	3.8	1	2	3	4	7
384	133	2.6	1	1	2	3	5
385	3	2.0	1	1	2	3	3
387	1	55.0	55	55	55	55	55
389	12	6.3	2	3	5	9	10
390	20	4.3	1	2	3	5	7
392	2,292	9.7	3	4	7	12	21
393	1	4.0	4	4	4	4	4
394	2,614	7.6	1	2	5	9	17
395	108,545	4.3	1	2	3	5	9
396	19	4.2	1	1	2	5	9
397	19,105	5.2	1	2	4	6	10
398	18,238	5.9	2	3	5	7	11
399	1,698	3.5	1	2	3	4	6
400	6,366	9.0	1	3	6	12	21
401	5,876	11.5	2	5	9	15	23
402	1,480	4.0	1	1	3	5	9
403	32,056	8.1	2	3	6	10	17
404	4,368	4.1	1	2	3	5	8
405	1	31.0	31	31	31	31	31
406	2,435	9.7	2	4	7	12	20
407	645	4.1	1	2	3	5	7
408	2,131	8.2	1	2	5	10	20
409	2,166	6.2	2	3	4	6	12
410	28,518	4.1	1	2	4	5	6
411	7	2.3	1	1	2	2	4
412	17	3.6	1	1	3	6	7
413	5,371	7.0	2	3	5	9	14
414	638	4.2	1	2	3	5	8
415	43,615	14.4	4	6	11	18	28
416	193,642	7.4	2	4	6	9	14
417	41	5.7	2	2	5	7	12
418	26,059	6.3	2	3	5	8	12
419	16,513	4.6	1	2	4	6	9
420	3,233	3.4	1	2	3	4	6
421	10,805	4.1	1	2	3	5	8
422	68	3.7	1	2	2	3	6
423	8,149	8.3	2	3	6	10	17
424	1,249	13.1	2	4	9	15	26
425	16,274	3.8	1	2	3	5	8
426	4,619	4.5	1	2	3	6	9
427	1,614	4.4	1	2	3	5	9
428	800	7.1	1	2	5	8	14
429	26,027	6.0	2	3	4	7	11
430	65,641	7.8	2	3	6	10	16
431	319	6.8	1	2	4	7	12
432	454	4.0	1	2	3	5	8
433	5,603	3.1	1	1	2	4	6
439	1,532	8.2	1	3	5	9	17
440	5,838	9.1	2	3	6	11	19

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

[FY 2002 Medpar Update March 2003 Grouper V20.0]

DRG	Number of discharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
441	690	3.1	1	1	2	4	6
442	17,683	8.5	1	3	6	10	18
443	3,949	3.4	1	1	3	4	7
444	5,831	4.2	1	2	3	5	8
445	2,592	2.9	1	1	2	4	5
447	6,551	2.5	1	1	2	3	5
448	1	1.0	1	1	1	1	1
449	33,429	3.7	1	1	3	4	7
450	7,534	2.0	1	1	1	2	4
451	1	1.0	1	1	1	1	1
452	25,827	4.9	1	2	3	6	10
453	5,733	2.8	1	1	2	3	5
454	4,822	4.2	1	2	3	5	8
455	1,086	2.4	1	1	2	3	5
461	5,281	3.6	1	1	2	4	8
462	9,763	10.9	4	6	9	14	19
463	27,225	4.0	1	2	3	5	8
464	7,273	3.0	1	1	2	4	6
465	203	3.9	1	1	1	3	6
466	1,761	4.0	1	1	2	4	7
467	1,167	3.6	1	1	2	3	6
468	52,616	12.8	3	6	10	16	25
471	13,425	5.4	3	3	4	6	8
473	8,123	12.4	2	3	7	17	32
475	110,111	11.2	2	5	9	15	22
476	3,675	11.1	2	5	10	15	21
477	25,578	8.2	1	3	6	11	17
478	108,616	7.3	1	3	5	9	16
479	24,164	3.2	1	1	2	4	7
480	627	21.1	6	8	12	22	47
481	867	21.8	13	17	20	24	33
482	5,312	12.5	4	6	9	15	24
483	45,887	39.5	15	22	33	49	70
484	346	14.5	2	6	11	21	30
485	3,279	9.9	4	5	7	12	19
486	2,225	12.8	1	6	10	17	26
487	3,908	7.2	1	3	6	9	15
488	777	17.0	4	7	13	22	36
489	13,457	8.6	2	3	6	10	18
490	5,499	5.5	1	2	4	7	11
491	15,451	3.4	1	2	3	4	6
492	3,115	14.9	3	5	7	25	33
493	59,856	6.0	1	3	5	8	11
494	29,005	2.5	1	1	2	3	5
495	200	16.1	7	9	12	19	30
496	2,506	8.9	3	4	6	11	18
497	22,601	6.4	3	4	5	7	11
498	16,204	4.0	2	3	4	5	6
499	34,803	4.5	1	2	3	6	9
500	50,192	2.4	1	1	2	3	4
501	2,615	10.6	4	5	8	13	20
502	784	6.2	3	4	5	7	11
503	6,020	3.9	1	2	3	5	7
504	128	28.0	7	13	21	38	55
505	136	5.6	1	1	1	4	10
506	926	16.9	4	7	13	21	35
507	346	9.1	2	4	7	13	19
508	634	7.8	2	3	5	10	17
509	161	4.3	1	2	3	5	9
510	1,660	6.7	1	3	5	8	15
511	592	4.7	1	1	3	6	10
512	505	13.2	6	8	10	15	23
513	215	10.0	5	6	8	10	16
514	26,940	6.9	1	2	5	9	15
515	8,312	5.2	1	1	3	7	12
516	52,442	4.6	2	2	4	5	9
517	119,770	2.5	1	1	1	3	5
518	49,376	3.4	1	1	2	4	7
519	8,549	4.9	1	1	3	6	11

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

[FY 2002 Medpar Update March 2003 Grouper V20.0]

DRG	Number of discharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
520	12,798	2.1	1	1	1	2	4
521	30,971	5.7	2	3	4	7	11
522	6,047	9.6	3	5	8	12	20
523	15,530	4.0	1	2	3	5	7
524	133,080	3.4	1	2	3	4	6
525	584	16.8	1	4	9	18	37
526	32,121	NA	NA	NA	NA	NA	NA
527	84,729	NA	NA	NA	NA	NA	NA
	11,761,542						

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

[FY 2002 Medpar Update March 2003 Grouper V21.0]

DRG	Number of disharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	24,378	10.8	3	5	8	14	21
2	11,909	5.3	1	3	4	7	10
3	3	6.0	1	1	4	13	13
6	360	3.0	1	1	2	4	7
7	14,886	9.8	2	4	7	12	20
8	4,213	2.8	1	1	1	3	7
9	1,741	6.7	1	3	5	8	12
10	18,736	6.4	2	3	5	8	13
11	3,312	4.0	1	2	3	5	8
12	52,693	5.8	2	3	4	7	11
13	7,144	5.0	2	3	4	6	9
14	237,827	5.9	2	3	5	7	11
15	94,552	4.9	2	3	4	6	9
16	9,982	6.3	2	3	5	8	12
17	2,757	3.2	1	1	2	4	6
18	29,858	5.5	2	3	4	7	10
19	8,583	3.5	1	2	3	5	7
20	6,244	10.2	3	5	8	13	20
21	1,894	6.6	2	3	5	8	13
22	2,794	5.1	2	2	4	6	10
23	11,327	4.3	1	2	3	5	8
24	59,420	4.9	1	2	4	6	10
25	27,639	3.2	1	2	3	4	6
26	20	4.1	1	1	2	3	4
27	4,470	5.2	1	1	3	7	11
28	14,063	6.0	1	3	5	8	12
29	5,344	3.5	1	2	3	4	7
30	3	5.7	2	2	4	11	11
31	3,976	4.0	1	2	3	5	8
32	1,932	2.5	1	1	2	3	5
34	23,938	4.9	1	2	4	6	9
35	7,506	3.1	1	1	3	4	6
36	2,125	1.5	1	1	1	1	2
37	1,392	3.8	1	1	2	5	8
38	98	2.8	1	1	1	4	5
39	563	2.1	1	1	1	2	4
40	1,555	3.8	1	1	3	5	7
42	1,592	2.7	1	1	1	3	6
43	95	3.4	1	1	3	4	6
44	1,231	5.0	2	3	4	6	9
45	2,690	3.1	1	2	3	4	6
46	3,495	4.5	1	2	3	6	8
47	1,415	3.1	1	1	2	4	6
49	2,392	4.5	1	2	3	6	9
50	2,439	1.9	1	1	1	2	3
51	243	2.8	1	1	1	3	8
52	224	1.8	1	1	1	2	3
53	2,485	3.6	1	1	2	4	8
55	1,489	2.9	1	1	1	3	7
56	476	2.9	1	1	1	3	6
57	715	3.7	1	1	2	4	8

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

[FY 2002 Medpar Update March 2003 Grouper V21.0]

DRG	Number of disharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
58	1	2.0	2	2	2	2	2
59	117	2.7	1	1	1	3	6
60	1	3.0	3	3	3	3	3
61	255	5.2	1	1	3	7	11
62	2	7.0	1	1	13	13	13
63	3,038	4.4	1	2	3	5	9
64	3,149	6.5	1	2	4	8	13
65	40,527	2.8	1	1	2	4	5
66	7,876	3.1	1	1	2	4	6
67	387	3.6	1	2	3	5	7
68	11,695	3.9	1	2	3	5	7
69	3,782	3.0	1	2	3	4	5
70	32	2.4	1	1	2	3	4
71	80	3.4	1	1	2	4	6
72	972	3.4	1	1	3	4	6
73	7,740	4.4	1	2	3	6	9
75	43,515	10.0	3	5	7	12	20
76	44,651	11.1	3	5	9	14	21
77	2,484	4.8	1	2	4	7	10
78	39,668	6.6	3	4	6	8	11
79	169,669	8.5	3	4	7	11	16
80	8,115	5.3	2	3	4	7	10
81	5	4.4	1	1	3	8	8
82	64,585	6.9	2	3	5	9	14
83	6,788	5.4	2	3	4	7	10
84	1,616	3.2	1	2	3	4	6
85	22,461	6.2	2	3	5	8	12
86	2,262	3.5	1	2	3	4	7
87	61,337	6.3	1	3	5	8	12
88	405,367	5.0	2	3	4	6	9
89	536,888	5.8	2	3	5	7	11
90	49,023	4.0	2	2	3	5	7
91	45	5.0	1	2	3	5	13
92	15,881	6.3	2	3	5	8	12
93	1,782	4.0	1	2	3	5	7
94	12,922	6.2	2	3	5	8	12
95	1,672	3.8	1	2	3	5	7
96	57,107	4.6	2	2	4	6	8
97	28,950	3.5	1	2	3	4	6
98	9	3.7	1	1	2	2	5
99	21,531	3.2	1	1	2	4	6
100	8,350	2.1	1	1	2	3	4
101	22,498	4.4	1	2	3	6	9
102	5,699	2.6	1	1	2	3	5
103	495	42.4	9	12	23	54	96
104	20,732	14.3	6	8	12	17	25
105	29,353	9.9	4	6	8	11	18
106	3,515	11.4	5	7	10	14	20
107	83,704	10.4	5	7	9	12	17
108	6,543	9.8	2	5	8	12	18
109	57,705	7.7	4	5	6	9	13
110	55,100	8.8	2	4	7	11	18
111	9,622	4.1	1	2	4	6	7
113	39,897	12.5	4	6	9	15	24
114	8,369	8.6	2	4	7	11	17
115	19,878	7.4	1	3	6	10	15
116	116,606	4.4	1	2	3	6	9
117	4,751	4.3	1	1	2	5	10
118	8,319	2.9	1	1	1	4	7
119	1,257	5.3	1	1	3	7	13
120	38,350	9.0	1	3	6	12	20
121	164,602	6.3	2	3	5	8	12
122	77,383	3.5	1	2	3	5	7
123	38,786	4.8	1	1	3	6	11
124	135,861	4.4	1	2	3	6	9
125	92,387	2.8	1	1	2	4	5
126	5,422	11.5	3	6	9	15	22
127	678,154	5.2	2	3	4	7	10
128	7,226	5.4	2	3	5	7	9
129	3,884	2.6	1	1	1	3	6

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

[FY 2002 Medpar Update March 2003 Grouper V21.0]

DRG	Number of disharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
130	89,220	5.6	2	3	5	7	10
131	27,255	4.0	1	2	4	5	7
132	142,959	2.9	1	1	2	4	5
133	8,743	2.3	1	1	2	3	4
134	41,755	3.2	1	2	2	4	6
135	7,825	4.5	1	2	3	5	8
136	1,191	2.7	1	1	2	3	5
138	209,417	4.0	1	2	3	5	8
139	88,233	2.5	1	1	2	3	5
140	56,027	2.5	1	1	2	3	5
141	109,260	3.6	1	2	3	4	7
142	52,906	2.6	1	1	2	3	5
143	251,335	2.1	1	1	2	3	4
144	95,251	5.5	1	2	4	7	11
145	7,414	2.6	1	1	2	3	5
146	10,813	10.2	5	6	8	12	17
147	2,649	6.2	3	5	6	8	9
148	134,602	12.3	5	7	10	15	22
149	20,279	6.3	4	5	6	7	9
150	21,258	11.3	4	6	9	14	20
151	5,171	5.6	2	3	5	7	10
152	4,594	8.4	3	5	7	10	15
153	2,069	5.2	3	4	5	7	8
154	28,481	13.2	3	7	10	17	26
155	6,654	4.1	1	2	3	6	8
156	4	2.5	1	1	1	3	5
157	8,336	5.7	1	2	4	7	12
158	4,379	2.6	1	1	2	3	5
159	18,211	5.1	1	2	4	7	10
160	12,263	2.7	1	1	2	3	5
161	10,838	4.3	1	1	3	6	9
162	6,447	1.9	1	1	1	2	4
163	8	3.3	1	1	2	3	6
164	5,432	8.4	3	5	7	10	15
165	2,351	4.5	2	3	4	6	7
166	4,228	4.7	1	2	4	6	9
167	4,121	2.4	1	1	2	3	4
168	1,437	4.8	1	2	3	6	10
169	811	2.4	1	1	2	3	5
170	15,751	10.8	2	4	8	14	22
171	1,538	4.3	1	2	4	6	9
172	31,608	7.0	2	3	5	9	14
173	2,503	3.8	1	2	3	5	8
174	253,175	4.8	2	3	4	6	9
175	35,116	2.9	1	2	3	4	5
176	13,542	5.2	2	3	4	6	10
177	9,121	4.6	2	2	4	6	8
178	3,396	3.1	1	2	3	4	6
179	13,263	5.9	2	3	5	7	11
180	91,043	5.4	2	3	4	7	10
181	27,384	3.4	1	2	3	4	6
182	274,383	4.4	1	2	3	5	8
183	91,766	2.9	1	1	2	4	5
184	75	3.3	1	1	2	4	7
185	5,415	4.7	1	2	3	6	10
186	6	6.7	2	3	3	10	10
187	637	4.1	1	2	3	6	8
188	84,442	5.6	1	2	4	7	11
189	13,179	3.1	1	1	2	4	6
190	76	5.1	1	2	4	6	10
191	9,576	13.8	3	6	10	17	28
192	1,322	6.2	1	3	6	8	11
193	4,844	12.7	5	7	10	16	23
194	651	6.7	2	4	6	8	12
195	4,041	10.5	4	6	9	13	19
196	1,007	5.6	2	3	5	7	10
197	18,401	9.2	3	5	7	11	17
198	5,446	4.4	2	3	4	6	7
199	1,644	9.8	2	4	7	13	21
200	1,082	10.5	2	3	7	14	23

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

[FY 2002 Medpar Update March 2003 Grouper V21.0]

DRG	Number of disharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
201	2,146	14.2	4	6	10	18	29
202	26,905	6.4	2	3	5	8	13
203	30,167	6.7	2	3	5	9	13
204	65,940	5.7	2	3	4	7	11
205	27,684	6.2	2	3	5	8	12
206	2,079	3.8	1	2	3	5	8
207	33,045	5.2	1	2	4	7	10
208	10,244	2.9	1	1	2	4	5
209	401,363	4.9	3	3	4	5	7
210	123,436	6.9	3	4	6	8	11
211	30,259	4.8	3	4	4	6	7
212	10	6.4	1	1	3	5	7
213	10,018	9.2	2	4	7	12	18
216	8,808	8.0	1	2	6	11	17
217	17,420	13.4	3	5	9	16	28
218	24,033	5.5	2	3	4	7	10
219	20,076	3.2	1	2	3	4	6
220	1	1.0	1	1	1	1	1
223	13,406	3.0	1	1	2	4	6
224	11,846	1.9	1	1	1	2	3
225	6,539	5.3	1	2	4	7	11
226	5,895	6.5	1	2	4	8	14
227	4,883	2.6	1	1	2	3	5
228	2,553	4.1	1	1	3	5	9
229	1,274	2.3	1	1	2	3	5
230	2,474	5.6	1	2	3	7	12
232	825	2.7	1	1	1	2	6
233	10,014	7.4	1	3	6	10	15
234	5,408	3.1	1	1	2	4	7
235	5,150	4.9	1	2	4	6	9
236	40,417	4.6	1	3	4	6	8
237	1,790	3.7	1	2	3	5	7
238	9,003	8.6	3	4	7	10	17
239	46,422	6.3	2	3	5	8	12
240	12,147	6.6	2	3	5	8	13
241	3,197	3.8	1	2	3	5	7
242	2,621	6.9	2	3	5	9	14
243	97,186	4.7	1	2	4	6	9
244	14,757	4.7	1	2	4	6	9
245	5,890	3.3	1	2	3	4	6
246	1,501	3.8	1	2	3	5	7
247	20,607	3.3	1	1	3	4	7
248	14,008	4.9	1	3	4	6	9
249	13,006	3.6	1	1	2	4	7
250	3,835	4.1	1	2	3	5	8
251	2,403	2.8	1	1	3	3	5
253	22,265	4.7	2	3	4	6	8
254	10,865	3.2	1	2	3	4	5
256	6,774	5.1	1	2	4	6	10
257	15,803	2.6	1	1	2	3	5
258	15,399	1.8	1	1	2	2	3
259	3,531	2.7	1	1	1	3	6
260	4,255	1.4	1	1	1	1	2
261	1,801	2.1	1	1	1	2	4
262	674	4.3	1	1	3	6	9
263	23,297	11.5	3	5	8	14	22
264	3,898	6.6	2	3	5	8	13
265	4,132	6.6	1	2	4	8	14
266	2,567	3.2	1	1	2	4	7
267	242	4.4	1	1	3	6	10
268	931	3.8	1	1	2	4	8
269	9,911	8.5	2	3	7	11	17
270	2,824	3.6	1	1	2	5	7
271	19,513	7.2	2	4	6	9	14
272	5,770	6.0	2	3	5	7	12
273	1,351	4.0	1	2	3	5	8
274	2,328	6.5	1	3	5	8	13
275	232	3.6	1	1	2	4	7
276	1,333	4.5	1	2	4	6	8
277	101,243	5.7	2	3	5	7	10

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

[FY 2002 Medpar Update March 2003 Grouper V21.0]

DRG	Number of disharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
278	32,701	4.2	2	2	4	5	7
279	10	5.3	2	2	3	7	7
280	18,038	4.1	1	2	3	5	8
281	7,650	2.9	1	1	2	4	5
283	6,106	4.7	1	2	4	6	9
284	2,039	2.9	1	1	2	4	6
285	7,012	10.5	3	5	8	13	20
286	2,511	5.9	2	3	4	7	12
287	6,330	10.3	3	5	8	13	20
288	5,684	5.0	2	3	4	5	8
289	6,977	2.7	1	1	1	2	6
290	10,000	2.2	1	1	1	2	4
291	60	1.6	1	1	1	2	3
292	6,576	10.5	2	4	8	14	21
293	368	4.7	1	1	3	6	9
294	99,279	4.5	1	2	3	6	9
295	3,603	4.0	1	2	3	5	7
296	281,526	5.1	1	2	4	6	10
297	48,952	3.3	1	2	3	4	6
298	117	3.1	1	1	2	4	6
299	1,291	5.5	1	2	4	7	11
300	18,877	6.1	2	3	5	8	12
301	3,649	3.6	1	2	3	4	7
302	8,941	8.5	4	5	6	9	15
303	21,890	8.0	3	4	6	9	15
304	12,646	8.9	2	4	6	11	18
305	3,058	3.5	1	2	3	4	7
306	7,087	5.4	1	2	3	7	12
307	2,041	2.1	1	1	2	2	3
308	7,321	6.2	1	2	4	8	14
309	4,198	2.1	1	1	1	2	4
310	24,966	4.4	1	1	3	6	10
311	7,518	1.8	1	1	1	2	3
312	1,532	4.6	1	1	3	6	10
313	558	2.3	1	1	1	3	5
314	2	40.5	1	1	80	80	80
315	34,371	7.0	1	1	4	9	16
316	120,183	6.5	2	3	5	8	13
317	2,045	3.6	1	1	2	4	7
318	5,811	6.1	1	3	5	8	12
319	416	2.9	1	1	2	4	6
320	188,879	5.3	2	3	4	6	10
321	31,494	3.7	1	2	3	5	7
322	55	3.3	1	2	3	4	5
323	20,049	3.2	1	1	2	4	6
324	7,086	1.9	1	1	1	2	4
325	9,360	3.8	1	2	3	5	7
326	2,755	2.6	1	1	2	3	5
327	7	2.6	1	1	2	3	4
328	748	3.7	1	1	3	5	8
329	92	2.1	1	1	1	3	5
331	51,750	5.6	1	3	4	7	11
332	5,046	3.2	1	1	2	4	6
333	269	5.7	1	2	3	7	11
334	10,565	4.6	2	3	4	5	8
335	12,782	3.0	2	2	3	4	5
336	36,048	3.4	1	2	2	4	7
337	29,654	2.0	1	1	2	2	3
338	941	5.5	1	2	3	7	13
339	1,491	4.8	1	1	3	6	11
340	1	2.0	2	2	2	2	2
341	3,599	3.2	1	1	2	3	7
342	694	3.2	1	1	2	4	7
344	3,598	2.5	1	1	1	2	5
345	1,376	4.9	1	1	3	6	11
346	4,919	5.9	2	3	5	8	12
347	318	3.0	1	1	2	4	6
348	3,416	4.3	1	2	3	5	8
349	619	2.5	1	1	2	3	5
350	6,778	4.5	2	2	4	6	8

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

[FY 2002 Medpar Update March 2003 Grouper V21.0]

DRG	Number of disharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
352	968	4.0	1	2	3	5	8
353	2,585	6.5	2	3	5	7	12
354	7,455	5.7	3	3	4	6	10
355	5,602	3.2	2	2	3	4	5
356	26,093	2.1	1	1	2	3	3
357	5,648	8.4	3	4	6	10	16
358	21,749	4.2	2	2	3	5	7
359	32,221	2.6	1	2	2	3	4
360	15,906	2.8	1	1	2	3	4
361	348	3.2	1	1	2	3	7
362	5	1.4	1	1	1	2	2
363	2,529	3.6	1	2	2	4	8
364	1,643	4.1	1	1	3	5	8
365	1,842	8.2	1	3	5	10	17
366	4,601	6.7	1	3	5	8	14
367	489	3.1	1	1	2	4	7
368	3,592	6.6	2	3	5	8	13
369	3,510	3.3	1	1	2	4	7
370	1,390	5.8	2	3	4	5	9
371	1,764	3.5	2	3	3	4	5
372	979	3.5	2	2	2	3	5
373	4,246	2.3	1	2	2	3	3
374	100	3.0	2	2	2	3	6
376	332	3.5	1	2	2	4	7
377	53	4.1	1	2	3	5	8
378	175	2.6	1	1	2	3	5
379	365	3.0	1	1	2	3	5
380	98	2.0	1	1	1	2	3
381	194	1.9	1	1	1	2	4
382	49	1.7	1	1	1	2	3
383	2,031	3.8	1	2	3	4	7
384	133	2.6	1	1	2	3	5
385	2	1.5	1	1	2	2	2
387	1	55.0	55	55	55	55	55
392	2,292	9.7	3	4	7	12	21
393	1	4.0	4	4	4	4	4
394	2,614	7.6	1	2	5	9	17
395	108,545	4.3	1	2	3	5	9
396	19	4.2	1	1	2	5	9
397	19,105	5.2	1	2	4	6	10
398	18,238	5.9	2	3	5	7	11
399	1,698	3.5	1	2	3	4	6
401	5,876	11.5	2	5	9	15	23
402	1,480	4.0	1	1	3	5	9
403	32,056	8.1	2	3	6	10	17
404	4,368	4.1	1	2	3	5	8
405	1	31.0	31	31	31	31	31
406	2,435	9.7	2	4	7	12	20
407	645	4.1	1	2	3	5	7
408	2,131	8.2	1	2	5	10	20
409	2,166	6.2	2	3	4	6	12
410	28,518	4.1	1	2	4	5	6
411	7	2.3	1	1	2	2	4
412	17	3.6	1	1	3	6	7
413	5,371	7.0	2	3	5	9	14
414	638	4.2	1	2	3	5	8
415	43,615	14.4	4	6	11	18	28
416	193,642	7.4	2	4	6	9	14
417	41	5.7	2	2	5	7	12
418	26,059	6.3	2	3	5	8	12
419	16,513	4.6	1	2	4	6	9
420	3,233	3.4	1	2	3	4	6
421	10,805	4.1	1	2	3	5	8
422	68	3.7	1	2	2	3	6
423	8,149	8.3	2	3	6	10	17
424	1,264	13.1	2	4	9	15	26
425	16,274	3.8	1	2	3	5	8
426	4,619	4.5	1	2	3	6	9
427	1,614	4.4	1	2	3	5	9
428	800	7.1	1	2	5	8	14

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

[FY 2002 Medpar Update March 2003 Grouper V21.0]

DRG	Number of disharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
429	27,358	5.9	2	3	4	7	11
430	65,641	7.8	2	3	6	10	16
431	319	6.8	1	2	4	7	12
432	454	4.0	1	2	3	5	8
433	5,603	3.1	1	1	2	4	6
439	1,532	8.2	1	3	5	9	17
440	5,838	9.1	2	3	6	11	19
441	690	3.1	1	1	2	4	6
442	17,683	8.5	1	3	6	10	18
443	3,949	3.4	1	1	3	4	7
444	5,831	4.2	1	2	3	5	8
445	2,592	2.9	1	1	2	4	5
447	6,551	2.5	1	1	2	3	5
448	1	1.0	1	1	1	1	1
449	33,429	3.7	1	1	3	4	7
450	7,534	2.0	1	1	1	2	4
451	1	1.0	1	1	1	1	1
452	25,827	4.9	1	2	3	6	10
453	5,733	2.8	1	1	2	3	5
454	4,822	4.2	1	2	3	5	8
455	1,086	2.4	1	1	2	3	5
461	5,012	3.7	1	1	2	4	8
462	9,763	10.9	4	6	9	14	19
463	27,225	4.0	1	2	3	5	8
464	7,273	3.0	1	1	2	4	6
465	203	3.9	1	1	1	3	6
466	1,761	4.0	1	1	2	4	7
467	1,126	3.6	1	1	2	3	6
468	51,697	12.8	3	6	10	16	25
471	13,425	5.4	3	3	4	6	8
473	8,123	12.4	2	3	7	17	32
475	110,111	11.2	2	5	9	15	22
476	3,674	11.1	2	5	10	15	21
477	26,494	8.3	1	3	6	11	17
478	108,594	7.3	1	3	5	9	15
479	24,163	3.2	1	1	2	4	7
480	627	21.1	6	8	12	22	47
481	867	21.8	13	17	20	24	33
482	5,312	12.5	4	6	9	15	24
483	45,887	39.5	15	22	33	49	70
484	346	14.5	2	6	11	21	30
485	3,279	9.9	4	5	7	12	19
486	2,225	12.8	1	6	10	17	26
487	3,908	7.2	1	3	6	9	15
488	756	17.0	4	7	13	22	36
489	13,475	8.6	2	3	6	10	18
490	5,502	5.5	1	2	4	7	11
491	15,451	3.4	1	2	3	4	6
492	3,115	14.9	3	5	7	25	33
493	59,856	6.0	1	3	5	8	11
494	29,005	2.5	1	1	2	3	5
495	200	16.1	7	9	12	19	30
496	2,506	8.9	3	4	6	11	18
497	22,093	6.3	3	4	5	7	11
498	15,887	4.0	2	3	4	5	6
499	34,803	4.5	1	2	3	6	9
500	50,192	2.4	1	1	2	3	4
501	2,615	10.6	4	5	8	13	20
502	784	6.2	3	4	5	7	11
503	6,020	3.9	1	2	3	5	7
504	128	28.0	7	13	21	38	55
505	136	5.6	1	1	1	4	10
506	926	16.9	4	7	13	21	35
507	346	9.1	2	4	7	13	19
508	634	7.8	2	3	5	10	17
509	161	4.3	1	2	3	5	9
510	1,660	6.7	1	3	5	8	15
511	592	4.7	1	1	3	6	10
512	505	13.2	6	8	10	15	23
513	215	10.0	5	6	8	10	16

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

[FY 2002 Medpar Update March 2003 Grouper V21.0]

DRG	Number of disharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
515	8,312	5.2	1	1	3	7	12
516	33,015	4.6	2	2	4	5	9
517	68,536	2.5	1	1	1	3	5
518	49,374	3.4	1	1	2	4	7
519	9,057	5.1	1	1	3	6	12
520	13,115	2.1	1	1	1	2	4
521	30,971	5.7	2	3	4	7	11
522	6,047	9.6	4	5	8	12	20
523	15,530	4.1	1	2	3	5	7
524	133,080	3.4	1	2	3	4	6
525	584	16.8	1	4	9	18	37
526	51,533	NA	NA	NA	NA	NA	NA
527	135,957	NA	NA	NA	NA	NA	NA
528	1,596	17.3	6	10	15	22	32
529	3,671	8.2	1	3	5	11	19
530	2,698	3.6	1	2	3	4	7
531	3,859	9.9	2	4	7	13	20
532	2,973	3.9	1	1	3	5	8
533	43,392	4.1	1	1	2	5	9
534	52,512	2.0	1	1	1	2	4
535	6,099	10.9	2	6	9	14	21
536	20,841	5.8	1	2	4	8	12
537	6,921	7.0	1	3	5	9	14
538	6,484	2.9	1	1	2	4	6
539	4,472	11.2	2	4	8	15	24
540	1,894	4.0	1	1	3	5	8
	11,761,542						

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS—JULY 2003

State	Urban	Rural
Alabama	0.327	0.397
Alaska	0.402	0.662
Arizona	0.34	0.449
Arkansas	0.425	0.413
California	0.322	0.408
Colorado	0.394	0.532
Connecticut	0.504	0.542
Delaware	0.56	0.483
District of Columbia	0.38	.....
Florida	0.33	0.345
Georgia	0.449	0.444
Hawaii	0.402	0.447
Idaho	0.541	0.513
Illinois	0.383	0.475
Indiana	0.484	0.514
Iowa	0.456	0.583
Kansas	0.367	0.549
Kentucky	0.451	0.461
Louisiana	0.377	0.459
Maine	0.542	0.503
Maryland	0.76	0.82
Massachusetts	0.499	0.523
Michigan	0.437	0.534
Minnesota	0.461	0.614
Mississippi	0.432	0.418
Missouri	0.389	0.454
Montana	0.51	0.512
Nebraska	0.415	0.525
Nevada	0.284	0.461
New Hampshire	0.523	0.586
New Jersey	0.335	.....
New Mexico	0.474	0.477
New York	0.469	0.583

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS—JULY 2003—Continued

State	Urban	Rural
North Carolina	0.503	0.468
North Dakota	0.64	0.619
Ohio	0.475	0.567
Oklahoma	0.371	0.467
Oregon	0.525	0.578
Pennsylvania	0.368	0.497
Puerto Rico	0.479	0.569
Rhode Island	0.484	.....
South Carolina	0.435	0.451
South Dakota	0.484	0.535
Tennessee	0.407	0.436
Texas	0.372	0.475
Utah	0.481	0.581
Vermont	0.522	0.596
Virginia	0.427	0.495
Washington	0.532	0.581
West Virginia	0.562	0.527
Wisconsin	0.505	0.581
Wyoming	0.442	0.618

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS—JULY 2003

State	Ratio
Alabama	0.040
Alaska	0.053
Arizona	0.034
Arkansas	0.042
California	0.031
Colorado	0.045

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS—JULY 2003—Continued

State	Ratio
Connecticut	0.036
Delaware	0.048
District of Columbia	0.027
Florida	0.038
Georgia	0.047
Hawaii	0.041
Idaho	0.046
Illinois	0.037
Indiana	0.050
Iowa	0.046
Kansas	0.045
Kentucky	0.045
Louisiana	0.043
Maine	0.036
Maryland	0.013
Massachusetts	0.049
Michigan	0.044
Minnesota	0.042
Mississippi	0.041
Missouri	0.040
Montana	0.049
Nebraska	0.047
Nevada	0.032
New Hampshire	0.058
New Jersey	0.030
New Mexico	0.044
New York	0.046
North Carolina	0.046
North Dakota	0.065
Ohio	0.044
Oklahoma	0.040
Oregon	0.043
Pennsylvania	0.035

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS—JULY 2003—Continued

State	Ratio
Puerto Rico	0.046
Rhode Island	0.029
South Carolina	0.046
South Dakota	0.051
Tennessee	0.046
Texas	0.043
Utah	0.045
Vermont	0.046
Virginia	0.048
Washington	0.052
West Virginia	0.044
Wisconsin	0.049
Wyoming	0.050

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
010005	01	3440	3440
010010	01	3440	3440
010012	01	2880	
010022	01	2880	
010035	01	1000	
010036	01	2750	
010043	01	1000	1000
010044	01	25	
010072	01	0450	0450
010089	01	1000	
010101	01	0450	0450
010118	01	5240	
010120	01	5160	
010121	01	5240	
010126	01	2180	
010150	01	5240	
010158	01	2030	
020008	02	0380	
030007	03	2620	
030012	03	6200	
030033	03	2620	
030043	03	8520	
040014	04	4400	
040017	04	26	
040019	04	4920	
040020	3700	4920	
040026	04	4400	
040027	04	7920	
040041	04	4400	
040066	04	4400	
040069	04	4920	
040072	04	4400	
040076	04	4400	
040078	04	4400	
040080	04	3700	
040088	04	7680	
040091	04	8360	
040107	04	8360	
040119	04	4400	
050042	05	6690	
050045	05		7320
050071	7400	5775	
050073	8720	5775	
050101	8720	5775	
050150	05	6920	
050174	7500	8720	
050228	7360	5775	
050230	5945	4480	
050236	8735	4480	4480
050251	05	6720	
050296	05	7120	
050325	05	5170	
050335	05	5170	
050419	05	6690	
050457	7360	5775	
050494	05	6920	
050510	7360	5775	
050541	7360	5775	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
050549	8735	4480	
050569	05	7500	
050594	5945	4480	
050609	5945	4480	
050668	7360	5775	
050686	6780	5945	
060001	3060	2080	2080
060003	1125	2080	2080
060013	06	0200	
060023	2995	6520	
060027	1125	2080	2080
060049	06	2080	
060057	06	2995	
060075	06	2995	
060076	06	3060	
060096	06	2080	
060103	1125	2080	2080
070006	5483	5600	
070018	5483	5600	
070033	5483	5600	
070034	5483	5600	
080002	08		0720
080004	2190	9160	
080007	08	0560	
100022	5000	2680	
100023	10	5960	
100024	10	5000	
100045	2020		5960
100049	10	3980	
100098	10	8960	8960
100103	10	3600	3600
100105	10	2710	2710
100109	10	5960	
100150	10	5000	
100176	8960	2710	
100211	8280	3980	
100217	10	2710	2710
100232	10	5790	2900
100239	8280	7510	
100249	10	8280	
100268	8960	2680	
110001	11	0520	0520
110002	11	0520	
110003	11	3600	
110016	11	1800	
110023	11	0520	
110025	11	3600	3600
110029	11	0520	
110038	11	10	
110040	11	0500	0500
110041	11	0500	
110050	11	0520	
110054	11	0520	
110074	0500		0520
110075	11	7520	
110118	11	0120	
110122	11	10	
110150	11	4680	
110168	11	0520	
110187	11	0520	
110188	11	0520	
110189	11	0520	
110205	11	0520	
120028	12	3320	
130002	13	29	
130003	13	50	
130011	13	50	
130018	13	6340	
130026	13	6340	
130028	6340	7160	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
130049	13	7840	
130060	13	1080	
140014	6120	1040	
140015	14	7040	
140027	14	1960	
140031	14	1400	
140032	14	7040	
140034	14	7040	7040
140040	14	6120	
140043	14	6880	
140046	14	7040	
140058	14	7880	
140064	14	1960	
140086	14	7040	7040
140093	14	1400	
140102	14	7880	7880
140110	14	6120	
140112	14	6120	6120
140141	14	7040	7040
140143	14	6120	
140160	14	6880	
140161	14	1600	
140164	14	7040	
140189	14	1400	
140230	14	1400	1400
140234	14	6120	
140245	14		7040
140271	14	7800	7800
150002	2960	1600	1600
150004	2960	1600	1600
150006	15	7800	
150008	2960	1600	1600
150011	15	3480	3480
150015	15	1600	1600
150027	15		3480
150030	15	3480	3480
150034	2960	1600	1600
150036	15	3850	
150048	15	3200	
150051	1020		3480
150062	15	3480	3480
150065	15	3480	
150067	15		3480
150069	15	1640	1640
150076	15	7800	
150090	2960	1600	1600
150096	15	2330	
150102	15	7800	
150105	15	3480	
150112	15	3480	3480
150125	2960	1600	1600
150126	2960	1600	1600
150132	2960	1600	1600
150133	15	2330	
150146	15	2330	
150147	2960	1600	1600
160001	16	2120	
160016	16	2120	
160026	16	2120	
160030	16	2120	
160037	16	24	
160057	16	3500	
160064	16	24	
160080	16	6880	
160088	16	2120	
160089	16	2120	
160094	16	8920	
160122	16	14	
170001	17	9040	
170006	17	3710	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
170010	17	8560	
170012	17	9040	
170013	17	9040	
170014	17	3760	
170020	17	9040	
170022	17	7000	
170023	17	9040	
170025	17	9040	
170033	17	9040	
170045	17	8440	
170058	17	3710	
170060	17	28	
170089	17	0320	
170094	17	8440	
170120	17	3710	
170131	17	8440	8440
170145	17	8560	
170166	17	0320	
170175	17	9040	
180005	18	3400	
180011	18	4280	
180012	18	4520	
180013	18	5360	
180016	18	4520	
180018	18	4280	
180027	18	1660	
180028	18	3400	
180029	18	3660	
180044	18	3400	
180048	18	4280	
180054	18	1660	
180066	18	5360	
180069	18	3400	
180078	18	3400	
180102	18	1660	
180104	18	1660	
180116	18	1660	
180124	18	5360	
180125	18	3400	
180127	18	4520	
180132	18	4280	
180139	18	4280	
190001	19		5560
190003	19	3880	
190015	19	5560	
190025	19	3880	
190049	19		5560
190054	19	3880	
190083	19	5200	
190086	19	5200	
190099	19	3880	
190106	19	3880	
190131	19	5560	
190218	19	0220	
200002	20	6403	
200020	6403	1123	1123
200024	4243	6403	
200034	4243	6403	
200039	20	6403	
200040	6403		1123
200050	20	0733	
200063	20	6403	
220060	1123	0743	
220077	8003	3283	
220123	22	0743	
230022	23	0440	
230027	23	3000	3000
230030	23	6960	
230036	23	6960	
230037	23	0440	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
230040	23	3720	3000
230054	23	3080	
230080	23	6960	
230096	23	3720	
230097	23	3000	
230105	23	6960	
230106	23	3000	
230121	23	2640	2640
230188	23	6960	6960
230199	23	0870	0870
230235	23	6960	6960
230253	23	2160	
240011	24	5120	5120
240013	24	5120	
240014	24	5120	
240016	24	2520	
240018	24		5120
240023	24	5120	
240045	24	2240	
240052	24	2520	
240064	24	2240	
240069	24	6820	
240071	24		5120
240072	24	2240	
240075	24	6980	
240088	24	6980	
240089	24	5120	
240119	24	2240	
240121	24	2240	
240139	24	5120	
240142	24	6980	
240152	24	5120	
240187	24	5120	
250002	25	2650	
250004	25	4920	
250009	25	3580	
250030	25	3560	
250031	25	3560	
250034	25	4920	
250042	25	4920	
250069	25	3560	
250078	3285	0920	
250081	25	3560	
250082	25	6420	
250088	25	0760	
250094	3285	0920	
250097	25	0760	
250100	25	8600	
250101	25	3560	
250104	25	3560	
250122	25	19	
250126	25	4920	
260009	26	3760	
260011	26	1740	
260015	26	3700	
260017	26	7040	
260022	26	1740	
260025	26	7040	
260034	26	3760	
260047	26	1740	
260064	26	1740	
260074	26	1740	
260078	26	7920	
260094	26	7920	
260110	26	7040	7040
260113	26	14	
260116	26	7040	
260119	26	3700	
260120	26	3700	
260127	26	7040	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
260131	26	1740	
260164	26		7040
260183	26	7040	
260186	26	1740	
270002	27	0880	
270003	27	3040	
270011	27	3040	
270017	27	5140	
270051	27	5140	
270057	27	0880	
270082	27	3040	
280009	28	4360	
280023	28	4360	
280032	28	4360	
280054	28	4360	
280058	28	4360	
280061	28	53	
280065	28	3060	
280077	28	5920	
280111	28	5920	
280125	28	7720	
290006	29	6720	
290008	29	4120	
300003	30	1123	
300005	30	1123	
300019	30	1123	1123
300024	30		1123
310001	0875	5600	
310002	5640	5600	
310003	3640	5600	
310015	5640	0875	
310021	8480	5190	
310031	6160	5190	
310032	8760	6160	6160
310038	5015	5600	
310045	0875	5600	
310047	0560	6160	
310048	5015	5640	
310064	0560	6160	
310070	5015	5600	
310076	5640	5600	
310087	8760	6160	
310088	0560	6160	
310119	5640	5600	
320005	32	0200	
320006	32	7490	
320011	32	7490	
320013	32	7490	
320063	32	5800	
320065	32	5800	
330001	5660	0875	0875
330004	33	5660	
330023	2281	5660	5600
330027	5380	5600	
330084	33	1303	
330085	33	8160	
330103	33		1280
330106	5380	5600	
330126	5660	0875	0875
330135	5660	0875	0875
330136	33	8160	
330157	33	8160	
330181	5380	5600	
330182	5380	5600	
330205	5660	0875	0875
330209	5660	0875	0875
330224	33	3283	
330235	8160		6840
330239	3610	2360	
330250	33	1303	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
330264	5660	0875	0875
330307	33	8160	
330386	33	5660	
340003	34	3120	
340008	34	2560	
340010	2980	6640	
340013	34	1520	
340017	34	0480	
340021	34	1520	
340023	34	0480	
340027	34	3150	
340039	34		1520
340050	34	2560	
340051	34	3290	
340052	3120	1520	
340064	34	3120	
340068	34	9200	
340071	34	6640	6640
340088	34	0480	
340109	34		5720
340115	34	6640	6640
340124	34	6640	6640
340126	34	6640	6640
340143	3290	1520	
340147	6895	6640	
350003	35	1010	
350005	35	2985	
350006	35	1010	
350009	35	2520	
360002	36		1680
360008	36	3400	
360010	36	0080	
360011	36	1840	1840
360013	36	2000	
360014	36	1840	
360024	36	1680	1680
360025	36	1680	1680
360036	36	0080	
360039	36	1840	1840
360046	3200		1640
360054	36	1480	
360065	36	1680	1680
360071	36	4320	4320
360076	3200		1640
360078	0080	1680	1680
360081	8400		2160
360084	1320	0080	
360088	36	1840	
360090	8400		2160
360092	36	1840	1840
360095	36	8400	
360107	36	8400	
360108	36	4800	4800
360109	36	1840	1840
360112	8400	0440	
360121	36	0440	
360132	3200		1640
360142	36		1640
360150	0080		1680
360159	36	1840	
360175	36	1840	
360197	36	1840	1840
360211	8080		6280
370004	37	3710	
370006	37	8560	
370014	37	7640	
370015	37	8560	
370018	37	8560	
370022	37	4200	
370023	37	4200	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
370025	37	8560	
370034	37	2720	
370047	37	7640	
370048	37	8360	
370049	37	5880	
370054	37	5880	
370084	37	2720	
370103	37	45	
370153	37	4200	
370200	37	5880	
380001	38	6440	
380002	38	4890	
380006	38		6440
380022	38	1890	
380027	38	2400	
380040	38	2400	
380047	38	2400	
380050	38	4890	
380051	7080		6440
380065	38	2400	
380070	38	6440	
380084	7080	6440	
380090	38	2400	
390006	39	3240	
390008	39	6280	6280
390013	39	3240	
390016	39	6280	6280
390017	39	6280	6280
390030	39	0240	6680
390031	39	6680	6680
390048	39	3240	
390052	39	0280	
390065	39	8840	9280
390079	39	0960	
390091	39	6280	
390093	39	6280	
390110	3680	6280	
390113	39	9320	
390133	0240	6160	
390138	39	8840	
390150	39	6280	
390151	39	8840	
390163	39	6280	
390181	39	6680	6680
390183	39	6680	6680
390189	39	3240	
390197	0240	6160	
390201	39	5660	5640
390263	0240	6160	
400018	40	1310	
410001	6483	1123	1123
410004	6483	1123	1123
410005	6483	1123	1123
410006	6483	1123	1123
410007	6483	1123	1123
410008	6483	1123	1123
410009	6483	1123	1123
410010	6483	1123	1123
410011	6483	1123	1123
410012	6483	1123	1123
410013	6483	1123	1123
420020	42	1440	
420030	42	1440	
420036	42	1520	
420068	42	0600	
420070	8140	1760	
420071	42	0600	
420080	42	7520	
420085	5330	9200	
430004	43	6660	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
430008	43	24	
430012	43	7760	
430013	43	7760	
430014	43	2520	
430015	43	6660	
430047	43	28	
430048	43	53	
430089	43	7720	
440008	44	3580	
440020	44	3440	
440024	44	1560	
440050	44	0480	
440058	44	1560	
440059	44	5360	
440060	44	3580	
440067	44	3840	
440068	44	3840	
440072	44	4920	
440073	44	5360	
440148	44	5360	
440175	44	3440	
440180	44	3840	
440185	44	1560	
440186	44	5360	
440187	44	18	
440192	44	5360	
440200	44	5360	
440203	44	1560	
450007	45	7240	
450014	45	8750	
450080	45	4420	
450085	45	9080	
450098	45	4420	
450099	45	0320	
450140	45	5800	
450144	45	5800	
450146	45	0320	
450163	45	1880	
450178	45	5800	
450187	45	3360	
450192	45	1920	
450194	45	1920	
450196	45	1920	
450211	45	3360	
450214	45	3360	
450224	45	8640	
450347	45	3360	
450351	45	2800	
450353	45	1880	
450373	45	4420	
450395	45	3360	
450400	45	8800	
450438	45	0640	
450447	45	1920	
450451	45	2800	
450484	45	3360	
450508	45	8640	
450534	45	0320	
450623	45	1920	
450626	45	8750	
450653	45	5800	
450656	45	8640	
450694	45	3360	
450747	45	1920	
450755	45	4600	
450763	45	0320	
450770	45	0640	
460011	46	6520	
460021	46	4120	
460027	46	6520	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
460032	46	6520	
460036	46	6520	
460039	46	7160	
470001	47	30	
470011	47	1123	1123
470012	47	6323	
470018	47	1123	1123
490001	49	3660	
490004	49	1540	
490005	49	8840	
490013	49	4640	
490018	49	4640	
490038	49	3660	
490047	49	8840	
490066	5720	6760	
490079	49	3120	3120
490126	49	6800	
500002	50	6740	
500003	50	0860	
500007	50	0860	
500016	50	7600	
500031	50	5910	
500041	50	6440	
500059	50	7600	
500072	50	7600	
500079	8200		7600
510001	51	6280	
510002	51	6800	
510006	51	6280	
510024	51	6280	6280
510028	51	1480	
510046	51	1480	
510047	51	6280	
510048	51	3400	
510062	51	1480	
510070	51	1480	
510071	51	1480	
520002	52	8940	
520006	52	8940	
520018	52	5120	
520021	3800	1600	1600
520028	52	4720	
520032	52	4720	
520037	52	8940	
520059	6600	5080	5080
520066	3620	4720	
520071	52	5080	5080
520076	52	4720	
520084	52	4720	
520088	52	5080	
520094	6600	5080	5080
520096	6600	5080	5080
520102	52	5080	5080
520107	52	3080	
520113	52	3080	
520116	52	5080	5080
520152	52	3080	
520173	52	2240	
520189	3800	1600	1600
530002	53	1350	
530009	53	1350	
530015	53	6340	
530025	53	2670	
530032	53	7160	

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003

DRG	Cases	Mean + .75 standard deviation
1	23,157	$71,862
2	11,535	$41,916
3	3	$57,168
6	350	$15,743
7	14,489	$55,309
8	4,031	$33,403
9	1,677	$27,210
10	18,339	$25,124
11	3,244	$17,654
12	51,660	$17,776
13	6,919	$16,312
14	233,816	$24,738
15	92,167	$19,059
16	9,810	$25,016
17	2,700	$13,796
18	29,250	$20,071
19	8,385	$14,298
20	6,112	$57,114
21	1,869	$30,726
22	2,746	$21,754
23	11,062	$16,410
24	58,122	$19,963
25	26,945	$12,212
26	18	$22,836
27	4,348	$27,026
28	13,770	$26,999
29	5,226	$14,276
30	2	$19,365
31	3,834	$18,092
32	1,866	$11,256
34	23,474	$19,760
35	7,325	$12,760
36	2,079	$11,821
37	1,351	$21,123
38	94	$9,781
39	547	$12,494
40	1,508	$17,526
42	1,553	$14,008
43	93	$11,353
44	1,185	$13,306
45	2,622	$14,326
46	3,418	$16,038
47	1,373	$10,908
49	2,341	$34,744
50	2,385	$15,810
51	241	$16,991
52	216	$15,789
53	2,435	$23,943
55	1,458	$18,384
56	458	$16,976
57	700	$21,430
59	113	$16,063
61	249	$24,772
62	2	$20,652
63	2,964	$28,015
64	3,064	$27,189
65	39,700	$11,389
66	7,690	$11,535
67	379	$15,758
68	11,373	$12,869
69	3,665	$9,805
70	29	$6,582
71	79	$13,057
72	949	$13,674
73	7,561	$16,376
75	42,731	$60,129
76	43,909	$56,525
77	2,427	$23,987

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003—Continued

DRG	Cases	Mean + .75 standard deviation
78	38,870	$24,907
79	165,957	$32,680
80	7,866	$16,846
81	5	$20,229
82	63,317	$28,781
83	6,565	$19,177
84	1,552	$10,644
85	21,981	$24,242
86	2,201	$13,781
87	60,101	$27,456
88	396,200	$17,702
89	523,048	$20,511
90	47,344	$11,871
91	44	$14,737
92	15,549	$24,280
93	1,738	$14,448
94	12,597	$22,970
95	1,622	$12,263
96	55,628	$14,761
97	28,174	$10,803
98	9	$14,090
99	20,984	$13,983
100	8,129	$10,369
101	21,861	$17,290
102	5,503	$10,797
103	484	$378,244
104	20,223	$150,559
105	28,716	$108,046
106	3,432	$136,812
107	81,816	$99,133
108	6,341	$109,106
109	56,282	$73,253
110	53,777	$81,343
111	9,323	$49,746
113	39,244	$56,405
114	8,198	$33,220
115	19,499	$69,161
116	114,338	$44,903
117	4,622	$27,878
118	8,168	$31,457
119	1,211	$27,147
120	37,745	$46,550
121	161,616	$30,683
122	75,737	$19,715
123	38,021	$32,143
124	133,344	$27,371
125	90,371	$20,832
126	5,309	$51,405
127	663,251	$20,085
128	7,042	$14,239
129	3,774	$20,775
130	87,289	$18,660
131	26,583	$11,113
132	140,158	$12,462
133	8,475	$10,723
134	40,649	$11,970
135	7,697	$17,958
136	1,166	$11,432
138	204,872	$16,521
139	86,072	$10,173
140	54,193	$10,288
141	107,180	$14,813
142	51,782	$11,382
143	245,795	$10,741
144	93,108	$24,851
145	7,201	$11,714
146	10,627	$52,920

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003—Continued

DRG	Cases	Mean + .75 standard deviation
147	2,602	$29,373
148	132,078	$67,116
149	19,892	$27,061
150	20,888	$57,096
151	5,067	$25,243
152	4,490	$37,305
153	2,025	$21,509
154	27,969	$82,200
155	6,498	$25,001
156	4	$16,997
157	8,150	$25,875
158	4,273	$12,709
159	17,842	$26,972
160	11,973	$15,839
161	10,620	$22,659
162	6,290	$12,519
163	8	$9,397
164	5,322	$45,313
165	2,297	$22,967
166	4,142	$27,527
167	4,013	$16,618
168	1,406	$26,010
169	802	$14,782
170	15,473	$57,315
171	1,495	$23,568
172	30,878	$28,013
173	2,414	$15,971
174	247,933	$19,856
175	34,337	$11,032
176	13,301	$21,548
177	8,939	$18,108
178	3,315	$13,584
179	12,973	$21,773
180	88,999	$19,227
181	26,699	$10,651
182	268,140	$16,395
183	89,558	$11,492
184	69	$9,542
185	5,256	$17,532
186	6	$17,504
187	609	$15,462
188	82,829	$22,197
189	12,856	$12,176
190	75	$16,578
191	9,340	$88,382
192	1,299	$36,558
193	4,733	$68,254
194	638	$31,775
195	3,957	$59,356
196	969	$30,122
197	17,996	$50,435
198	5,289	$23,379
199	1,609	$48,963
200	1,069	$62,346
201	2,100	$75,551
202	26,307	$26,667
203	29,543	$28,095
204	64,510	$22,991
205	27,001	$24,271
206	2,015	$14,280
207	32,214	$22,980
208	9,967	$13,150
209	394,702	$35,979
210	121,348	$33,587
211	29,657	$22,493
212	9	$31,925
213	9,818	$37,689

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003—Continued

DRG	Cases	Mean + .75 standard deviation
216	8,691	$41,935
217	17,092	$61,011
218	23,524	$30,313
219	19,672	$19,359
223	13,125	$20,384
224	11,574	$14,926
225	6,390	$22,849
226	5,793	$30,350
227	4,783	$15,628
228	2,495	$22,908
229	1,245	$13,667
230	2,430	$25,765
232	809	$18,306
233	9,829	$40,036
234	5,300	$24,173
235	5,032	$14,695
236	39,468	$13,922
237	1,748	$11,857
238	8,729	$27,480
239	45,525	$20,661
240	11,846	$26,301
241	3,110	$12,646
242	2,542	$23,380
243	94,969	$15,031
244	14,423	$14,330
245	5,746	$9,757
246	1,473	$11,896
247	20,113	$11,410
248	13,674	$17,154
249	12,784	$13,336
250	3,727	$14,018
251	2,332	$9,097
253	21,753	$14,893
254	10,593	$8,759
256	6,586	$16,469
257	15,517	$16,712
258	15,055	$13,056
259	3,486	$17,996
260	4,160	$12,825
261	1,747	$17,565
262	653	$18,615
263	22,868	$41,675
264	3,819	$21,268
265	4,031	$31,156
266	2,516	$17,172
267	238	$20,021
268	895	$23,309
269	9,688	$35,630
270	2,743	$16,079
271	18,989	$20,610
272	5,658	$20,167
273	1,313	$12,601
274	2,264	$24,353
275	223	$12,616
276	1,304	$13,267
277	98,858	$17,235
278	31,750	$10,661
279	10	$15,979
280	17,551	$13,991
281	7,377	$9,589
283	5,976	$14,555
284	1,992	$8,504
285	6,869	$41,732
286	2,477	$39,318
287	6,166	$37,798
288	5,471	$41,746
289	6,830	$18,048

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003—Continued

DRG	Cases	Mean + .75 standard deviation
290	9,803	$16,847
291	58	$13,308
292	6,420	$55,995
293	356	$28,741
294	96,631	$15,356
295	3,475	$16,050
296	275,298	$17,000
297	47,552	$9,995
298	109	$9,503
299	1,253	$18,904
300	18,462	$22,372
301	3,554	$12,547
302	8,653	$61,825
303	21,521	$46,383
304	12,430	$47,807
305	3,009	$23,106
306	6,967	$24,014
307	1,983	$11,422
308	7,203	$31,717
309	4,094	$17,613
310	24,593	$22,507
311	7,407	$11,963
312	1,502	$21,429
313	547	$13,534
314	2	$815,660
315	33,535	$41,732
316	117,415	$26,424
317	1,994	$16,978
318	5,685	$24,541
319	403	$14,083
320	184,548	$17,149
321	30,606	$11,011
322	49	$9,127
323	19,641	$16,239
324	6,874	$9,611
325	9,136	$13,204
326	2,696	$8,569
327	7	$7,111
328	732	$15,295
329	93	$10,358
331	50,553	$21,469
332	4,905	$12,274
333	254	$19,142
334	10,300	$27,789
335	12,490	$19,981
336	35,495	$16,280
337	29,140	$10,776
338	929	$23,997
339	1,460	$22,362
341	3,545	$25,849
342	686	$14,916
344	3,549	$26,710
345	1,354	$22,352
346	4,775	$21,343
347	308	$11,845
348	3,361	$15,104
349	604	$9,831
350	6,602	$14,657
352	945	$14,499
353	2,491	$35,744
354	7,324	$28,230
355	5,481	$16,312
356	25,562	$14,230
357	5,570	$44,892
358	21,321	$22,339
359	31,420	$14,957
360	15,538	$16,445

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003—Continued

DRG	Cases	Mean + .75 standard deviation
361	339	$21,352
362	5	$16,578
363	2,471	$18,875
364	1,610	$18,054
365	1,815	$42,185
366	4,504	$25,764
367	477	$11,799
368	3,503	$23,599
369	3,419	$12,532
370	1,327	$18,299
371	1,662	$11,458
372	927	$10,237
373	4,076	$6,914
374	89	$13,913
376	316	$11,055
377	47	$21,747
378	171	$14,743
379	349	$7,238
380	98	$8,554
381	188	$10,611
382	48	$4,333
383	1,956	$10,030
384	129	$7,214
385	3	$34,210
389	12	$23,975
392	2,248	$66,268
394	2,567	$38,588
395	105,976	$16,486
396	17	$16,006
397	18,727	$25,519
398	17,860	$24,884
399	1,671	$13,548
401	5,768	$59,903
402	1,454	$22,863
403	31,365	$37,680
404	4,277	$18,437
406	2,391	$53,929
407	634	$24,003
408	2,081	$44,985
409	2,127	$25,574
410	28,001	$21,908
411	7	$7,483
412	15	$11,456
413	5,253	$27,415
414	622	$15,291
415	42,746	$75,112
416	189,451	$32,070
417	38	$22,076
418	25,456	$21,447
419	16,128	$17,016
420	3,139	$12,214
421	10,563	$14,503
422	66	$12,891
423	7,972	$36,726
424	1,224	$49,024
425	15,914	$13,506
426	4,462	$10,410
427	1,557	$10,483
428	782	$14,266
429	26,797	$15,953
430	64,123	$13,703
431	310	$12,670
432	443	$12,980
433	5,479	$5,805
439	1,493	$34,068
440	5,673	$36,892
441	668	$18,081

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003—Continued

DRG	Cases	Mean + .75 standard deviation
442	17,291	$48,763
443	3,848	$19,622
444	5,629	$14,813
445	2,485	$9,965
447	6,390	$10,119
449	32,589	$16,465
450	7,304	$8,328
452	25,308	$20,911
453	5,591	$10,522
454	4,691	$16,299
455	1,043	$9,576
461	5,133	$24,128
462	9,531	$19,503
463	26,512	$13,669
464	7,075	$9,864
465	192	$13,169
466	1,684	$14,122
467	1,106	$10,115
468	51,680	$77,692
470	52	$504,684
471	13,167	$54,184
473	7,976	$72,650
475	108,084	$75,747
476	3,608	$46,392
477	25,103	$37,665
478	106,238	$48,149
479	23,387	$27,938
480	610	$193,008
481	819	$122,102
482	5,175	$70,600

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003—Continued

DRG	Cases	Mean + .75 standard deviation
483	44,784	$328,441
484	334	$110,056
485	3,178	$61,849
486	2,077	$99,908
487	3,701	$40,225
488	760	$99,624
489	13,168	$37,620
490	5,356	$21,486
491	15,098	$31,213
492	3,052	$82,667
493	58,870	$35,610
494	28,431	$18,981
495	191	$165,379
496	2,444	$112,012
497	21,734	$66,414
498	15,556	$49,426
499	34,350	$27,633
500	49,302	$17,736
501	2,580	$51,260
502	761	$27,677
503	5,883	$24,011
504	125	$257,167
505	134	$36,044
506	916	$87,492
507	337	$37,309
508	612	$27,746
509	155	$13,241
510	1,625	$23,313
511	571	$13,248
512	481	$101,931

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003—Continued

DRG	Cases	Mean + .75 standard deviation
513	206	$107,611
515	8,028	$105,722
516	33,015	$45,394
517	68,536	$35,730
518	55,225	$36,574
519	8,892	$47,738
520	12,823	$29,760
521	30,454	$14,130
522	6,008	$10,049
523	15,103	$7,817
524	130,318	$14,293
525	562	$247,370
526	51,533	$42,080
527	135,957	$33,802
528	1,343	$140,528
529	4,633	$63,385
530	2,807	$24,282
531	3,766	$64,237
532	2,888	$30,290
533	42,601	$32,675
534	51,346	$20,340
535	5,896	$156,207
536	20,103	$118,567
537	6,765	$36,526
538	6,350	$19,355
539	4,388	$69,606
540	1,866	$25,633

TABLE 11.—FY 2004 LTC-DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
1	[5] CRANIOTOMY AGE >17 W CC	2.0841	40.0	33.3
2	[8] CRANIOTOMY AGE > 17 W/O CC	2.0841	40.0	33.3
3	[8] CRANIOTOMY AGE 0-17	2.0841	40.0	33.3
6	[8] CARPAL TUNNEL RELEASE	0.4964	18.5	15.4
7	[7] PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	1.5754	41.0	34.1
8	[7] PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	1.5754	41.0	34.1
9	SPINAL DISORDERS & INJURIES	1.5025	32.9	27.4
10	NERVOUS SYSTEM NEOPLASMS W CC	0.7549	23.4	19.5
11	NERVOUS SYSTEM NEOPLASMS W/O CC	0.7281	22.0	18.3
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.7485	25.8	21.5
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.7530	25.9	21.5
14	INTERCRANIAL HEMORRHAGE & STROKE W INFARCT	0.9196	27.4	22.8
15	NONSPECIFIC CVA & PRECEREBRAL OCCULUSION W/O INFARCT	0.8714	28.8	24.0
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.9125	23.9	19.9
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.5262	20.4	17.0
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.8225	23.9	19.9
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.6236	22.7	18.9
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.0097	24.8	20.6
21	[2] VIRAL MENINGITIS	0.7372	23.5	19.5
22	[2] HYPERTENSIVE ENCEPHALOPATHY	0.7372	23.5	19.5
23	NONTRAUMATIC STUPOR & COMA	0.9033	28.8	24.0
24	SEIZURE & HEADACHE AGE >17 W CC	0.8527	26.2	21.8
25	SEIZURE & HEADACHE AGE >17 W/O CC	0.7727	24.1	20.0
26	[8] SEIZURE & HEADACHE AGE 0-17	0.7372	23.5	19.5
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.1929	30.4	25.3
28	TRAUMATIC STUPOR & COMA, COMA >1 HR AGE ≤17 W CC	1.0211	29.0	24.1
29	TRAUMATIC STUPOR & COMA, COMA >1 HR AGE ≤17 W/O CC	0.9056	26.6	22.1
30	[8] TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.9562	26.1	21.7
31	[7] CONCUSSION AGE >17 W CC	0.9562	26.1	21.7

TABLE 11.—FY 2004 LTC-DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
32	[7] CONCUSSION AGE >17 W/O CC	0.9562	26.1	21.7
33	[8] CONCUSSION AGE 0-17	0.7372	23.5	19.5
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9140	27.8	23.1
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.6651	24.5	20.4
36	[8] RETINAL PROCEDURES	0.4964	18.5	15.4
37	[8] ORBITAL PROCEDURES	0.4964	18.5	15.4
38	[8] PRIMARY IRIS PROCEDURES	0.4964	18.5	15.4
39	[8] LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.4964	18.5	15.4
40	[5] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	2.0841	40.0	33.3
41	[8] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.4964	18.5	15.4
42	[8] INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.4964	18.5	15.4
43	[8] HYPHEMA	0.4964	18.5	15.4
44	[1] ACUTE MAJOR EYE INFECTIONS	0.4964	18.5	15.4
45	[8] NEUROLOGICAL EYE DISORDERS	0.4964	18.5	15.4
46	[1] OTHER DISORDERS OF THE EYE AGE >17 W CC	0.4964	18.5	15.4
47	[1] OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.4964	18.5	15.4
48	[8] OTHER DISORDERS OF THE EYE AGE 0-17	0.4964	18.5	15.4
49	[8] MAJOR HEAD & NECK PROCEDURES	1.3569	32.5	27.0
50	[8] SIALOADENECTOMY	0.9562	26.1	21.7
51	[8] SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	0.9562	26.1	21.7
52	[8] CLEFT LIP & PALATE REPAIR	0.9562	26.1	21.7
53	[2] SINUS & MASTOID PROCEDURES AGE >17	0.7372	23.5	19.5
54	[8] SINUS & MASTOID PROCEDURES AGE 0-17	0.9562	26.1	21.7
55	[8] MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	0.9562	26.1	21.7
56	[8] RHINOPLASTY	0.7372	23.5	19.5
57	[8] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	0.9562	26.1	21.7
58	[8] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17.	0.9562	26.1	21.7
59	[8] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.9562	26.1	21.7
60	[8] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.9562	26.1	21.7
61	[2] MYRINGOTOMY W TUBE INSERTION AGE >17	0.7372	23.5	19.5
62	[8] MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.9562	26.1	21.7
63	[3] OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	0.9562	26.1	21.7
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.2540	27.5	22.9
65	[1] DYSEQUILIBRIUM	0.4964	18.5	15.4
66	[1] EPISTAXIS	0.4964	18.5	15.4
67	[8] EPIGLOTTITIS	0.9562	26.1	21.7
68	OTITIS MEDIA & URI AGE >17 W CC	0.8243	21.9	18.2
69	[1] OTITIS MEDIA & URI AGE >17 W/O CC	0.4964	18.5	15.4
70	[8] OTITIS MEDIA & URI AGE 0-17	0.4964	18.5	15.4
71	[8] LARYNGOTRACHEITIS	0.4964	18.5	15.4
72	[2] NASAL TRAUMA & DEFORMITY	0.7372	23.5	19.5
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.7215	20.3	16.9
74	[8] OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.4964	18.5	15.4
75	[5] MAJOR CHEST PROCEDURES	2.0841	40.0	33.3
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.4382	43.9	36.5
77	[5] OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	2.0841	40.0	33.3
78	PULMONARY EMBOLISM	0.8896	24.2	20.1
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	0.8985	22.6	18.8
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.7645	22.3	18.5
81	[8] RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	0.4964	18.5	15.4
82	RESPIRATORY NEOPLASMS	0.7480	20.3	16.9
83	[3] MAJOR CHEST TRAUMA W CC	0.9562	26.1	21.7
84	[2] MAJOR CHEST TRAUMA W/O CC	0.7372	23.5	19.5
85	PLEURAL EFFUSION W CC	0.8514	23.5	19.5
86	PLEURAL EFFUSION W/O CC	0.6540	22.4	18.6
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.6513	31.9	26.5
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.7653	20.7	17.2
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.8428	23.1	19.2
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.7318	21.7	18.0
91	[8] SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.7372	23.5	19.5
92	INTERSTITIAL LUNG DISEASE W CC	0.7702	20.4	17.0
93	[1] INTERSTITIAL LUNG DISEASE W/O CC	0.4964	18.5	15.4
94	PNEUMOTHORAX W CC	0.6571	18.9	15.7
95	[1] PNEUMOTHORAX W/O CC	0.4964	18.5	15.4
96	BRONCHITIS & ASTHMA AGE >17 W CC	0.7381	20.5	17.0
97	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5296	18.7	15.5
98	[8] BRONCHITIS & ASTHMA AGE 0-17	0.4964	18.5	15.4

TABLE 11.—FY 2004 LTC-DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
99	RESPIRATORY SIGNS & SYMPTOMS W CC	1.0622	26.6	22.1
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC	1.0579	26.1	21.7
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.9009	22.6	18.8
102	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.7011	21.0	17.5
103	[6] HEART TRANSPLANT	0.0000	0.0	0.0
104	[8] CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH.	2.0841	40.0	33.3
105	[8] CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH.	2.0841	40.0	33.3
106	[8] CORONARY BYPASS W PTCA	2.0841	40.0	33.3
107	[8] CORONARY BYPASS W CARDIAC CATH	2.0841	40.0	33.3
108	[5] OTHER CARDIOTHORACIC PROCEDURES	2.0841	40.0	33.3
109	[8] CORONARY BYPASS W/O PTCA OR CARDIAC CATH	2.0841	40.0	33.3
110	[5] MAJOR CARDIOVASCULAR PROCEDURES W CC	2.0841	40.0	33.3
111	[8] MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.0841	40.0	33.3
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	1.5629	38.7	32.2
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.3604	38.3	31.9
115	[5] PRM CARD PACEM IMPL W AMI,HRT FAIL OR SHK,OR AICD LEAD OR GNRTR P.	2.0841	40.0	33.3
116	[5] OTH PERM CARD PACEMAK IMPL OR PTCA W CORONARY ARTERY STENT IMPLNT.	2.0841	40.0	33.3
117	[3] CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	0.9562	26.1	21.7
118	[5] CARDIAC PACEMAKER DEVICE REPLACEMENT	2.0841	40.0	33.3
119	[4] VEIN LIGATION & STRIPPING	1.3569	32.5	27.0
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.2435	34.4	28.6
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	0.7467	22.1	18.4
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	0.6440	18.8	15.6
123	CIRCULATORY DISORDERS W AMI, EXPIRED	0.8527	18.8	15.6
124	[4] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.3569	32.5	27.0
125	[4] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	1.3569	32.5	27.0
126	ACUTE & SUBACUTE ENDOCARDITIS	0.8706	25.6	21.3
127	HEART FAILURE & SHOCK	0.7719	22.1	18.4
128	[2] DEEP VEIN THROMBOPHLEBITIS	0.7372	23.5	19.5
129	[3] CARDIAC ARREST, UNEXPLAINED	0.9562	26.1	21.7
130	PERIPHERAL VASCULAR DISORDERS W CC	0.7712	24.4	20.3
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.6398	23.1	19.2
132	ATHEROSCLEROSIS W CC	0.8092	22.4	18.6
133	ATHEROSCLEROSIS W/O CC	0.7044	21.9	18.2
134	HYPERTENSION	0.9154	27.9	23.2
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.9039	23.1	19.2
136	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.7186	22.4	18.6
137	[8] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.7372	23.5	19.5
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.7430	22.7	18.9
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.6032	20.3	16.9
140	ANGINA PECTORIS	0.6094	19.3	16.0
141	SYNCOPE & COLLAPSE W CC	0.6453	22.9	19.0
142	SYNCOPE & COLLAPSE W/O CC	0.5041	20.3	16.9
143	CHEST PAIN	0.7314	21.8	18.1
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.7921	22.2	18.5
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.6983	20.7	17.2
146	[8] RECTAL RESECTION W CC	2.0841	40.0	33.3
147	[8] RECTAL RESECTION W/O CC	2.0841	40.0	33.3
148	[5] MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.0841	40.0	33.3
149	[1] MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	0.4964	18.5	15.4
150	[4] PERITONEAL ADHESIOLYSIS W CC	1.3569	32.5	27.0
151	[8] PERITONEAL ADHESIOLYSIS W/O CC	1.3569	32.5	27.0
152	[4] MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.3569	32.5	27.0
153	[8] MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.3569	32.5	27.0
154	[5] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	2.0841	40.0	33.3
155	[8] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.3569	32.5	27.0
156	[8] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	1.3569	32.5	27.0
157	[4] ANAL & STOMAL PROCEDURES W CC	1.3569	32.5	27.0
158	[3] ANAL & STOMAL PROCEDURES W/O CC	0.9562	26.1	21.7
159	[8] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	1.3569	32.5	27.0
160	[8] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	1.3569	32.5	27.0
161	[4] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.3569	32.5	27.0
162	[8] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.4964	18.5	15.4
163	[8] HERNIA PROCEDURES AGE 0-17	0.4964	18.5	15.4

TABLE 11.—FY 2004 LTC-DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
164	[8] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.0841	40.0	33.3
165	[8] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	0.4964	18.5	15.4
166	[8] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	2.0841	40.0	33.3
167	[8] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	0.4964	18.5	15.4
168	[5] MOUTH PROCEDURES W CC	2.0841	40.0	33.3
169	[8] MOUTH PROCEDURES W/O CC	0.7372	23.5	19.5
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	1.7006	40.3	33.5
171	[4] OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.3569	32.5	27.0
172	DIGESTIVE MALIGNANCY W CC	0.8702	22.5	18.7
173	DIGESTIVE MALIGNANCY W/O CC	0.7092	20.2	16.8
174	G.I. HEMORRHAGE W CC	0.7874	23.7	19.7
175	G.I. HEMORRHAGE W/O CC	0.6345	21.1	17.5
176	COMPLICATED PEPTIC ULCER	0.7728	21.2	17.6
177	[2] UNCOMPLICATED PEPTIC ULCER W CC	0.7372	23.5	19.5
178	[1] UNCOMPLICATED PEPTIC ULCER W/O CC	0.4964	18.5	15.4
179	INFLAMMATORY BOWEL DISEASE	1.0023	25.2	21.0
180	[7] G.I. OBSTRUCTION W CC	0.8222	22.9	19.0
181	[7] G.I. OBSTRUCTION W/O CC	0.8222	22.9	19.0
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.8449	23.5	19.5
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.6362	20.3	16.9
184	[8] ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.7372	23.5	19.5
185	[2] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.7372	23.5	19.5
186	[8] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	0.7372	23.5	19.5
187	[8] DENTAL EXTRACTIONS & RESTORATIONS	0.7372	23.5	19.5
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0308	25.3	21.0
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.7826	21.8	18.1
190	[8] OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.7372	23.5	19.5
191	[4] PANCREAS, LIVER & SHUNT PROCEDURES W CC	1.3569	32.5	27.0
192	[1] PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	0.4964	18.5	15.4
193	[2] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	0.7372	23.5	19.5
194	[3] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	0.7372	23.5	19.5
195	[4] CHOLECYSTECTOMY W C.D.E. W CC	1.3569	32.5	27.0
196	[8] CHOLECYSTECTOMY W C.D.E. W/O CC	0.9562	26.1	21.7
197	[3] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	0.9562	26.1	21.7
198	[8] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	0.9562	26.1	21.7
199	[8] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	0.7372	23.5	19.5
200	[2] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	0.7372	23.5	19.5
201	[5] OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	2.0841	40.0	33.3
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	0.7254	22.3	18.5
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	0.6758	18.9	15.7
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	0.9986	23.4	19.5
205	[7] DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.7029	22.1	18.4
206	[7] DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	0.7029	22.1	18.4
207	[7] DISORDERS OF THE BILIARY TRACT W CC	0.6671	20.5	17.0
208	[7] DISORDERS OF THE BILIARY TRACT W/O CC	0.6671	20.5	17.0
209	[4] MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.	1.3569	32.5	27.0
210	[4] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.3569	32.5	27.0
211	[2] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	0.7372	23.5	19.5
212	[8] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	0.7372	23.5	19.5
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.3851	33.8	28.1
216	[4] BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.3569	32.5	27.0
217	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS.	1.4038	39.3	32.7
218	[3] LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC.	0.9562	26.1	21.7
219	[8] LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC.	0.9562	26.1	21.7
220	[8] LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	0.9562	26.1	21.7
223	[3] MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	0.9562	26.1	21.7
224	[8] SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	0.9562	26.1	21.7
225	[3] FOOT PROCEDURES	0.9562	26.1	21.7
226	[7] SOFT TISSUE PROCEDURES W CC	1.3569	32.5	27.0
227	[7] SOFT TISSUE PROCEDURES W/O CC	1.3569	32.5	27.0
228	[4] MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	1.3569	32.5	27.0
229	[8] HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.9562	26.1	21.7

TABLE 11.—FY 2004 LTC-DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
230	[4] LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.3569	32.5	27.0
232	[2] ARTHROSCOPY	0.7372	23.5	19.5
233	[3] OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	0.9562	26.1	21.7
234	[3] OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	0.9562	26.1	21.7
235	FRACTURES OF FEMUR	0.8396	29.6	24.6
236	FRACTURES OF HIP & PELVIS	0.7368	27.1	22.5
237	[2] SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.7372	23.5	19.5
238	OSTEOMYELITIS	0.8432	27.9	23.2
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	0.6610	22.0	18.3
240	CONNECTIVE TISSUE DISORDERS W CC	0.6685	21.2	17.6
241	CONNECTIVE TISSUE DISORDERS W/O CC	0.4538	18.7	15.5
242	SEPTIC ARTHRITIS	0.7721	26.4	22.0
243	MEDICAL BACK PROBLEMS	0.6616	23.2	19.3
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.5563	20.0	16.6
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4721	18.5	15.4
246	NON-SPECIFIC ARTHROPATHIES	0.5128	22.2	18.5
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5536	20.2	16.8
248	TENDONITIS, MYOSITIS & BURSITIS	0.7274	24.5	20.4
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.7829	27.0	22.5
250	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.8206	29.9	24.9
251	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.6009	27.3	22.7
252	[8] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.9562	26.1	21.7
253	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	0.8176	27.6	23.0
254	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	0.6691	25.1	20.9
255	[8] FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	0.9562	26.1	21.7
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.8294	25.9	21.5
257	[3] TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9562	26.1	21.7
258	[8] TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.9562	26.1	21.7
259	[8] SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9562	26.1	21.7
260	[8] SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.9562	26.1	21.7
261	[5] BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	2.0841	40.0	33.3
262	[3] BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.9562	26.1	21.7
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.4522	42.4	35.3
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.2892	44.1	36.7
265	[7] SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.2215	34.8	29.0
266	[7] SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	1.2215	34.8	29.0
267	[8] PERIANAL & PILONIDAL PROCEDURES	0.9562	26.1	21.7
268	[5] SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	2.0841	40.0	33.3
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.4466	43.0	35.8
270	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.9916	33.9	28.2
271	SKIN ULCERS	0.9620	30.4	25.3
272	MAJOR SKIN DISORDERS W CC	0.7121	22.8	19.0
273	[1] MAJOR SKIN DISORDERS W/O CC	0.4964	18.5	15.4
274	MALIGNANT BREAST DISORDERS W CC	0.9072	24.9	20.7
275	[2] MALIGNANT BREAST DISORDERS W/O CC	0.7372	23.5	19.5
276	[1] NON-MALIGANT BREAST DISORDERS	0.4964	18.5	15.4
277	CELLULITIS AGE >17 W CC	0.7409	23.6	19.6
278	CELLULITIS AGE >17 W/O CC	0.5982	20.7	17.2
279	[8] CELLULITIS AGE 0-17	0.9562	26.1	21.7
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.9724	29.5	24.5
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.7386	26.4	22.0
282	[8] TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.7372	23.5	19.5
283	MINOR SKIN DISORDERS W CC	0.6508	19.3	16.0
284	[1] MINOR SKIN DISORDERS W/O CC	0.4964	18.5	15.4
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS.	1.5176	37.4	31.1
286	[8] ADRENAL & PITUITARY PROCEDURES	0.7372	23.5	19.5
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.3982	39.7	33.0
288	[5] O.R. PROCEDURES FOR OBESITY	2.0841	40.0	33.3
289	[8] PARATHYROID PROCEDURES	0.7372	23.5	19.5
290	[8] THYROID PROCEDURES	0.7372	23.5	19.5
291	[8] THYROGLOSSAL PROCEDURES	0.7372	23.5	19.5
292	[4] OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	1.3569	32.5	27.0
293	[8] OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	0.9562	26.1	21.7
294	DIABETES AGE >35	0.8061	25.9	21.5

TABLE 11.—FY 2004 LTC-DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
295	[3] DIABETES AGE 0-35	0.9562	26.1	21.7
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.8207	24.1	20.0
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.6524	24.5	20.4
298	[8] NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.7372	23.5	19.5
299	[3] UNBORN ERRORS OF METABOLISM	0.9562	26.1	21.7
300	ENDOCRINE DISORDERS W CC	0.7704	22.3	18.5
301	[2] ENDOCRINE DISORDERS W/O CC	0.7372	23.5	19.5
302	[6] KIDNEY TRANSPLANT	0.0000	0.0	0.0
303	[8] KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	2.0841	40.0	33.3
304	[5] KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	2.0841	40.0	33.3
305	[1] KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	0.4964	18.5	15.4
306	[8] PROSTATECTOMY W CC	1.3569	32.5	27.0
307	[8] PROSTATECTOMY W/O CC	1.3569	32.5	27.0
308	[4] MINOR BLADDER PROCEDURES W CC	1.3569	32.5	27.0
309	[2] MINOR BLADDER PROCEDURES W/O CC	0.7372	23.5	19.5
310	[4] TRANSURETHRAL PROCEDURES W CC	1.3569	32.5	27.0
311	[1] TRANSURETHRAL PROCEDURES W/O CC	0.4964	18.5	15.4
312	[4] URETHRAL PROCEDURES, AGE >17 W CC	1.3569	32.5	27.0
313	[8] URETHRAL PROCEDURES, AGE >17 W/O CC	0.4964	18.5	15.4
314	[8] URETHRAL PROCEDURES, AGE 0-17	0.4964	18.5	15.4
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	1.5070	36.8	30.6
316	RENAL FAILURE	0.9214	23.8	19.8
317	[3] ADMIT FOR RENAL DIALYSIS	0.9562	26.1	21.7
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	0.7048	21.1	17.5
319	[1] KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.4964	18.5	15.4
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.7223	23.0	19.1
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.6260	23.2	19.3
322	[8] KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.4964	18.5	15.4
323	[2] URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.7372	23.5	19.5
324	[2] URINARY STONES W/O CC	0.7372	23.5	19.5
325	[3] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.9562	26.1	21.7
326	[1] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4964	18.5	15.4
327	[8] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.4964	18.5	15.4
328	[8] URETHRAL STRICTURE AGE >17 W CC	0.4964	18.5	15.4
329	[8] URETHRAL STRICTURE AGE >17 W/O CC	0.4964	18.5	15.4
330	[8] URETHRAL STRICTURE AGE 0-17	0.4964	18.5	15.4
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	0.8473	23.2	19.3
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.5722	21.1	17.5
333	[8] OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.4964	18.5	15.4
334	[8] MAJOR MALE PELVIC PROCEDURES W CC	2.0841	40.0	33.3
335	[8] MAJOR MALE PELVIC PROCEDURES W/O CC	2.0841	40.0	33.3
336	[8] TRANSURETHRAL PROSTATECTOMY W CC	0.7372	23.5	19.5
337	[8] TRANSURETHRAL PROSTATECTOMY W/O CC	0.7372	23.5	19.5
338	[8] TESTES PROCEDURES, FOR MALIGNANCY	0.7372	23.5	19.5
339	[2] TESTES PROCEDURES, NON-MALIGNANCY AGE >17	0.7372	23.5	19.5
340	[8] TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.7372	23.5	19.5
341	[2] PENIS PROCEDURES	0.7372	23.5	19.5
342	[1] CIRCUMCISION AGE >17	0.4964	18.5	15.4
343	[8] CIRCUMCISION AGE 0-17	0.7372	23.5	19.5
344	[1] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	0.4964	18.5	15.4
345	[5] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	2.0841	40.0	33.3
346	[7] MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	0.7150	22.3	18.5
347	[7] MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.7150	22.3	18.5
348	[1] BENIGN PROSTATIC HYPERTROPHY W CC	0.4964	18.5	15.4
349	[1] BENIGN PROSTATIC HYPERTROPHY W/O CC	0.4964	18.5	15.4
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	1.1820	26.6	22.1
351	[8] STERILIZATION, MALE	0.7372	23.5	19.5
352	[3] OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.9562	26.1	21.7
353	[8] PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	2.0841	40.0	33.3
354	[8] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	2.0841	40.0	33.3
355	[8] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	2.0841	40.0	33.3
356	[8] FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.3569	32.5	27.0
357	[8] UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	1.3569	32.5	27.0
358	[8] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.3569	32.5	27.0
359	[8] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	1.3569	32.5	27.0
360	[4] VAGINA, CERVIX & VULVA PROCEDURES	1.3569	32.5	27.0

TABLE 11.—FY 2004 LTC-DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
361	[8] LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	0.4964	18.5	15.4
362	[8] ENDOSCOPIC TUBAL INTERRUPTION	0.4964	18.5	15.4
363	[8] D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.4964	18.5	15.4
364	[8] D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.4964	18.5	15.4
365	[5] OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	2.0841	40.0	33.3
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	0.8139	23.1	19.2
367	[1] MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.4964	18.5	15.4
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.6963	19.3	16.0
369	[3] MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.9562	26.1	21.7
370	[8] CESAREAN SECTION W CC	0.9562	26.1	21.7
371	[8] CESAREAN SECTION W/O CC	0.4964	18.5	15.4
372	[8] VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.4964	18.5	15.4
373	[8] VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.4964	18.5	15.4
374	[8] VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.4964	18.5	15.4
375	[8] VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.4964	18.5	15.4
376	[1] POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.4964	18.5	15.4
377	[8] POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	0.4964	18.5	15.4
378	[8] ECTOPIC PREGNANCY	0.9562	26.1	21.7
379	[8] THREATENED ABORTION	0.4964	18.5	15.4
380	[8] ABORTION W/O D&C	0.4964	18.5	15.4
381	[8] ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.4964	18.5	15.4
382	[8] FALSE LABOR	0.4964	18.5	15.4
383	[8] OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.4964	18.5	15.4
384	[8] OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.4964	18.5	15.4
385	[8] NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0.4964	18.5	15.4
386	[8] EXTREME IMMATURITY	0.4964	18.5	15.4
387	[8] PREMATURITY W MAJOR PROBLEMS	0.4964	18.5	15.4
388	[8] PREMATURITY W/O MAJOR PROBLEMS	0.4964	18.5	15.4
389	[8] FULL TERM NEONATE W MAJOR PROBLEMS	0.4964	18.5	15.4
390	[8] NEONATE W OTHER SIGNIFICANT PROBLEMS	0.4964	18.5	15.4
391	[8] NORMAL NEWBORN	0.4964	18.5	15.4
392	[8] SPLENECTOMY AGE >17	0.7372	23.5	19.5
393	[8] SPLENECTOMY AGE 0-17	0.7372	23.5	19.5
394	[3] OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	0.9562	26.1	21.7
395	RED BLOOD CELL DISORDERS AGE >17	0.7782	24.0	20.0
396	[8] RED BLOOD CELL DISORDERS AGE 0-17	0.4964	18.5	15.4
397	COAGULATION DISORDERS	0.9454	23.5	19.5
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.8372	22.0	18.3
399	[1] RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.4964	18.5	15.4
401	[5] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.0841	40.0	33.3
402	[3] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	0.9562	26.1	21.7
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	0.8941	22.4	18.6
404	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.7394	18.0	15.0
405	[8] ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	0.7372	23.5	19.5
406	[5] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	2.0841	40.0	33.3
407	[8] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	0.9562	26.1	21.7
408	[3] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	0.9562	26.1	21.7
409	RADIOTHERAPY	0.8871	25.1	20.9
410	[3] CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	0.9562	26.1	21.7
411	[8] HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.4964	18.5	15.4
412	[8] HISTORY OF MALIGNANCY W ENDOSCOPY	0.4964	18.5	15.4
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	0.9541	25.5	21.2
414	[1] OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.4964	18.5	15.4
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	1.6849	40.1	33.4
416	SEPTICEMIA AGE >17	0.9191	24.9	20.7
417	[8] SEPTICEMIA AGE 0-17	0.9562	26.1	21.7
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	0.8304	25.2	21.0
419	[3] FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.9562	26.1	21.7
420	[2] FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.7372	23.5	19.5
421	[2] VIRAL ILLNESS AGE >17	0.7372	23.5	19.5
422	[8] VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.7372	23.5	19.5
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	0.9024	23.1	19.2
424	[4] O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	1.3569	32.5	27.0
425	ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION	0.5981	27.5	22.9
426	DEPRESSIVE NEUROSES	0.4660	22.3	18.5
427	[4] NEUROSES EXCEPT DEPRESSIVE	1.3569	32.5	27.0
428	[1] DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.4964	18.5	15.4
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.6438	27.4	22.8

TABLE 11.—FY 2004 LTC-DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
430	PSYCHOSES	0.4689	22.7	18.9
431	[1] CHILDHOOD MENTAL DISORDERS	0.4964	18.5	15.4
432	[1] OTHER MENTAL DISORDER DIAGNOSES	0.4964	18.5	15.4
433	[1] ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.4964	18.5	15.4
439	SKIN GRAFTS FOR INJURIES	1.3663	40.5	33.7
440	WOUND DEBRIDEMENTS FOR INJURIES	1.5854	40.0	33.3
441	[5] HAND PROCEDURES FOR INJURIES	2.0841	40.0	33.3
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.4971	44.6	37.1
443	[4] OTHER O.R. PROCEDURES FOR INJURIES W/O CC	1.3569	32.5	27.0
444	TRAUMATIC INJURY AGE >17 W CC	0.9609	30.6	25.5
445	TRAUMATIC INJURY AGE >17 W/O CC	0.7552	26.6	22.1
446	[8] TRAUMATIC INJURY AGE 0-17	0.7372	23.5	19.5
447	[3] ALLERGIC REACTIONS AGE >17	0.9562	26.1	21.7
448	[8] ALLERGIC REACTIONS AGE 0-17	0.7372	23.5	19.5
449	[7] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.9562	26.1	21.7
450	[7] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.9562	26.1	21.7
451	[8] POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.7372	23.5	19.5
452	COMPLICATIONS OF TREATMENT W CC	0.9692	24.9	20.7
453	COMPLICATIONS OF TREATMENT W/O CC	0.8633	24.2	20.1
454	[2] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.7372	23.5	19.5
455	[2] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.7372	23.5	19.5
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.3216	36.5	30.4
462	REHABILITATION	0.6471	23.2	19.3
463	SIGNS & SYMPTOMS W CC	0.7541	26.8	22.3
464	SIGNS & SYMPTOMS W/O CC	0.6170	25.5	21.2
465	[2] AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.7372	23.5	19.5
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.7365	22.0	18.3
467	[1] OTHER FACTORS INFLUENCING HEALTH STATUS	0.4964	18.5	15.4
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.0686	42.5	35.4
469	[6] PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
470	[6] UNGROUPABLE	0.0000	0.0	0.0
471	[5] BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	2.0841	40.0	33.3
473	[3] ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	0.9562	26.1	21.7
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	2.1358	35.2	29.3
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.0032	31.9	26.5
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.8998	40.0	33.3
478	[7] OTHER VASCULAR PROCEDURES W CC	1.2567	34.2	28.5
479	[7] OTHER VASCULAR PROCEDURES W/O CC	1.2567	34.2	28.5
480	[6] LIVER TRANSPLANT	0.0000	0.0	0.0
481	[8] BONE MARROW TRANSPLANT	0.9562	26.1	21.7
482	[5] TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	2.0841	40.0	33.3
483	TRACH W MECH VENT 96+ HRS OR PDX EXCEPT FACE,MOUTH & NECK DIAG.	3.2131	55.7	46.4
484	[8] CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	2.0841	40.0	33.3
485	[8] LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR.	1.3569	32.5	27.0
486	[4] OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	1.3569	32.5	27.0
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.2484	32.7	27.2
488	[5] HIV W EXTENSIVE O.R. PROCEDURE	2.0841	40.0	33.3
489	HIV W MAJOR RELATED CONDITION	0.9254	21.3	17.7
490	HIV W OR W/O OTHER RELATED CONDITION	0.7361	19.6	16.3
491	[8] MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.3569	32.5	27.0
492	[8] CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS OR W USE HIGH DOSE CHEMOTHERAPY AGENT.	0.9562	26.1	21.7
493	[7] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.3569	32.5	27.0
494	[7] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	2.0841	40.0	33.3
495	[6] LUNG TRANSPLANT	0.0000	0.0	0.0
496	[8] COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	1.3569	32.5	27.0
497	[7] SPINAL FUSION W CC	0.9562	26.1	21.7
498	[7] SPINAL FUSION W/O CC4	0.9562	26.1	21.7
499	[5] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	2.0841	40.0	33.3
500	[4] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	1.3569	32.5	27.0
501	[5] KNEE PROCEDURES W PDX OF INFECTION W CC	2.0841	40.0	33.3
502	[2] KNEE PROCEDURES W PDX OF INFECTION W/O CC	0.7372	23.5	19.5
503	[3] KNEE PROCEDURES W/O PDX OF INFECTION	0.9562	26.1	21.7
504	[8] EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	2.0841	40.0	33.3
505	[4] EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT	1.3569	32.5	27.0

TABLE 11.—FY 2004 LTC-DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
506	[7] FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	0.7372	23.5	19.5
507	[7] FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	0.7372	23.5	19.5
508	[2] FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	0.7372	23.5	19.5
509	[2] FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	0.7372	23.5	19.5
510	[2] NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	0.7372	23.5	19.5
511	[1] NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.4964	18.5	15.4
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 DEFIBRILATOR IMPLANT W/O CARDIAC CATH	2.0841	40.0	33.3
516	[8] PERCUTANEOUS CARDIVASCULAR PROCEDURE W AMI	0.9562	26.1	21.7
517	[4] PERCUTANEOUS CARDIVASCULAR PROC W NON-DRUG ELUTING STENT W/O AMI.	1.3569	32.5	27.0
518	[3] PERCUTANEOUS CARDIVASCULAR PROC W/O CORONARY ARTERY STENT OR AMI.	0.9562	26.1	21.7
519	[4] CERVICAL SPINAL FUSION W CC	1.3569	32.5	27.0
520	[8] CERVICAL SPINAL FUSION W/O CC	0.9562	26.1	21.7
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.4753	20.5	17.0
522	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC.	0.4061	20.4	17.0
523	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC.	0.4214	19.8	16.5
524	TRANSIENT ISCHEMIA	0.5885	22.9	19.0
525	[8] HEART ASSIST SYSTEM IMPLANT	2.0841	40.0	33.3
526	[8] PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W AMI.	1.3569	32.5	27.0
527	[8] PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W/O AMI.	1.3569	32.5	27.0
528	[8] INTRACRANIAL VASCLUAR PROCEDURES WITH PDX HEMORRHAGE	2.0841	40.0	33.3
529	[2] VENTRICULAR SHUNT PROCEDURES WITH CC	0.7372	23.5	19.5
530	[8] VENTRICULAR SHUNT PROCEDURES WITHOUT CC	0.7372	23.5	19.5
531	[4] SPINAL PROCEDURES WITH CC	1.3569	32.5	27.0
532	[3] SPINAL PROCEDURES WITHOUT CC	0.9562	26.1	21.7
533	[5] EXTRACRANIAL VASCULAR PROCEDURES WITH CC	2.0841	40.0	33.3
534	[8] EXTRACRANIAL VASCULAR PROCEDURES WITHOUT CC	1.3569	32.5	27.0
535	[8] CARDIAC DEFIB IMPLANT WITH CARDIAC CATH WITH AMI/HF/SHOCK	2.0841	40.0	33.3
536	[5] CARDIAC DEFIB IMPLANT WITH CARDIAC CATH WITHOUT AMI/HF/SHOCK	2.0841	40.0	33.3
537	[4] LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITH CC.	1.3569	32.5	27.0
538	[1] LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITHOUT CC.	0.4964	18.5	15.4
539	[8] LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITH CC	2.0841	40.0	33.3
540	[1] LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITHOUT CC	0.4964	18.5	15.4

[1] Relative weights for these LTC-DRGs were determined by assigning these cases to low volume quintile 1.
[2] Relative weights for these LTC-DRGs were determined by assigning these cases to low volume quintile 2.
[3] Relative weights for these LTC-DRGs were determined by assigning these cases to low volume quintile 3.
[4] Relative weights for these LTC-DRGs were determined by assigning these cases to low volume quintile 4.
[5] Relative weights for these LTC-DRGs were determined by assigning these cases to low volume quintile 5.
[6] Relative weights for these LTC-DRGs were assigned a value of 0.0000.
[7] Relative weights for these LTC-DRGs were determined after adjusting to account for nonmonotonicity (see step 5 above).
[8] Relative weights for these LTC-DRGs were determined by assigning these cases to the appropriate low volume quintile because they had no LTCH cases in the FY 2002 MedPAR.

Appendix A—Regulatory Analysis of Impacts

I. Background and Summary

We have examined the impacts of this final 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 final 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 1.8 percent increase), we estimate that the total impact of these proposed changes for FY 2004 payments compared to FY 2003 payments to be approximately a $1.8 billion increase. 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 final 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 define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the IPPS, we 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 a final rule that has been preceded by a proposed rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule will 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 final rule in light of Executive Order 13132 and have determined that it will 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 final rule was reviewed by the Office of Management and Budget.

The following analysis, in conjunction with the remainder of this document, demonstrates that this final rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The final rule will 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 final rule will 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 changes will 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 policy changes, as well as statutory changes effective for FY 2004, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. In the May 19, 2003 proposed rule, we solicited comments and information about the anticipated effects of the changes on hospitals that we had proposed and our methodology for estimating them. Any comments that we received in response to the proposed rule are addressed in the appropriate sections throughout this 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 42 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.

There are approximately 768 critical access hospitals (CAHs). These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. The remaining 20 percent are specialty hospitals 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 policy changes on these hospitals are discussed below.

Thus, as of April 2003, we have included 4,049 hospitals in our analysis. This represents about 80 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

V. Impact on Excluded Hospitals and Hospital Units

As of July 2003, there were 1,086 specialty hospitals excluded from the IPPS that were paid instead on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. Broken down by specialty, there were 478 psychiatric, 216 rehabilitation, 300 long-term care, 81 children's, and 11 cancer hospitals. In addition, there were 1,405 psychiatric units and 985 rehabilitation units 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 2004. For these hospitals, the update is the percentage increase in the excluded hospital market basket, 3.4 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 2004, the IRF PPS is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually. Therefore, these hospitals are not impacted by this final rule.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs are paid under a 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, a 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 excluded hospital market basket (or 3.4 percent).

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 Policy Changes Under the IPPS for Operating Costs

A. Basis and Methodology of Estimates

In this final 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 1.8 percent increase), we estimate the total impact of these changes for FY 2004 payments compared to FY 2003 payments to be approximately a $1.8 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 changes to each system. This section deals with changes to the operating prospective payment system. Our payment simulation model relies on available data to enable us to estimate the impacts on payments per case of certain changes we are making in this final rule. However, there are other changes we have made, but for which we do not have data available that would allow us to estimate the payment impacts using this model. For those changes, we have attempted to predict the payment impacts of those 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 2002 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 these final 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 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 2002 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 final FY 2004 changes to the capital IPPS are discussed in section VIII. of this Appendix.

The final changes discussed separately below are the following:

- The effects of expanding the postacute care transfer policy to 21 additional DRGs.
- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of the final changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 2000, compared to the FY 1999 wage data, including the effects of removing wage data for Part B costs of RCHs and FQHCs.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2004.
- The effects on FY 2004 outlier payments of the policy changes implemented in the June 9, 2003 final rule on high-cost outlier payments.
- The total change in payments based on final FY 2004 policies relative to payments based on FY 2003 policies.

To illustrate the impacts of the final FY 2004 changes, our analysis begins with a FY 2004 baseline simulation model using: the FY 2003 DRG GROUPER (version 20.0); the current postacute care transfer policy for 10 DRGs; the FY 2003 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total operating DRG and outlier payments.

Each final and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2004 model incorporating all of the final changes. This allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 2003 to FY 2004. Five factors have significant impacts here. The first is the update to the standardized amounts. In accordance with section 1886(b)(3)(B)(i) of the Act, we have updated the large urban and the other areas average standardized amounts for FY 2004 using the most recently forecasted hospital market basket increase for FY 2004 of 3.4 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 3.4 percent.

A second significant factor that impacts changes in hospitals' payments per case from FY 2003 to FY 2004 is the change in MGCRB status from one year to the next. That is, hospitals reclassified in FY 2003 that are no longer reclassified in FY 2004 may have a negative payment impact going from FY 2003 to FY 2004; conversely, hospitals not reclassified in FY 2003 that are reclassified in FY 2004 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 2003 will be 6.5 percent of total DRG payments. When the FY 2003 final rule was published, we projected FY 2003 outlier payments would be 5.1 percent of total DRG plus outlier payments; the average standardized amounts were offset correspondingly. The effects of the higher than expected outlier payments during FY 2003 (as discussed in the Addendum to this final rule) are reflected in the analyses below comparing our current estimates of FY 2003 payments per case to estimated FY 2004 payments per case.

Fourth, we have expanded the postacute care transfer policy to 21 additional DRGs and dropped 2 DRGs from the original policy. This makes a total of 29 DRGs that will be subject to the postacute care transfer policy. This expansion is estimated to result in Medicare savings of $205 million because we will no longer pay a full DRG payment for these cases. As a result, there will be a lower total increase in Medicare spending for FY 2004.

Fifth, section 402(b) of Pub. L. 108–7 provided that the large urban standardized amount of the Federal rate is applicable for all IPPS hospitals for discharges occurring on or after April 1, 2003, and before October 1, 2003. For discharges occurring on or after October 1, 2003, the Federal rate will again be based on separate average standardized amounts for hospitals in large urban areas and for hospitals in other areas. The effect is to reduce the percent increase in FY 2004 payments compared to those made in FY 2003.

B. Analysis of Table I

Table I demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 4,049 hospitals included in the analysis. This number is 181 fewer hospitals than were included in the impact analysis in the FY 2003 final rule (67 FR 50279). There are 98 new CAHs that were excluded from last year's analysis.

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. There are 2,564 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,488 hospitals located in large urban areas (populations over 1 million), and 1,076 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 1,485 hospitals in rural areas. The next two groupings are by bed-size categories, shown

separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2004 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 2,605, 1,582, 1,023, and 1,444, 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 2,932 nonteaching hospitals in our analysis, 880 teaching hospitals with fewer than 100 residents, and 237 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural after MGCRB reclassifications. Therefore, hospitals in the rural DSH categories represent hospitals that were not reclassified for purposes of the standardized amount or for purposes of the DSH adjustment. (However, they may have been reclassified for purposes of the wage index.)

The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the final changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and MDHs), as well as rural hospitals not receiving a special payment designation. The RRCs (148), SCHs (497), MDHs (250), and hospitals that are both SCH and RRC (75) shown here were not reclassified for purposes of the standardized amount.

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 2000 Medicare cost report files, if available (otherwise FY 1999 data are used). Data needed to determine ownership status were unavailable for 122 hospitals. Similarly, the data needed to determine Medicare utilization were unavailable for 106 hospitals.

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 2004. 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 FINAL CHANGES FOR FY 2004 OPERATING PROSPECTIVE PAYMENT SYSTEM [PERCENT CHANGES IN PAYMENTS PER CASE]

	Number of hosps.[1] (1)	Revised outlier policy[2] (2)	Transfer changes[3] (3)	New wage data[4] (4)	New wage index without CAHS[5] (5)	New wage index without CAHS & NPHYS. part B[6] (6)	DRG Recal[7] (7)	DRG & Wage index changes[8] (8)	MCGRB reclassification[9] (9)	All FY 2004 changes[10] (10)	All FY 2004 changes w/o FY 2003 outliers[11] (11)
By Geographic Location:											
All hospitals	4,049	0.0	−0.2	−0.3	−0.2	0.0	0.0	0.0	0.0	1.8	3.2
Urban hospitals	2,564	−0.1	−0.3	−0.3	−0.2	0.0	0.0	0.0	−0.3	1.2	2.9
Large urban areas (populations over 1 million)	1,488	−0.4	−0.3	−0.3	−0.2	0.0	0.0	0.0	−0.4	1.1	3.2
Other urban areas (populations of 1 million or fewer)	1,076	0.3	−0.2	−0.3	−0.2	0.0	0.0	0.0	−0.3	1.4	2.4
Rural hospitals	1,485	0.7	−0.2	−0.3	0.2	0.1	0.0	0.5	2.2	5.8	5.5
Bed Size (Urban):											
0–99 beds	614	−0.1	−0.4	0.0	−0.2	0.0	−0.1	0.5	−0.6	2.1	3.1
100–199 beds	914	−0.6	−0.5	−0.3	−0.2	0.0	0.0	0.1	−0.4	1.2	2.9
200–299 beds	508	0.0	−0.4	−0.3	−0.2	0.0	0.0	0.0	−0.3	1.4	2.9
300–499 beds	372	−0.5	−0.2	−0.1	−0.2	0.0	−0.1	0.2	−0.3	0.8	3.1
500 or more beds	156	0.5	0.0	−0.7	−0.2	0.0	0.1	−0.4	−0.4	1.4	2.6
Bed Size (Rural):											
0–49 beds	671	0.2	−0.3	−0.4	0.2	0.1	0.0	0.7	0.5	6.0	5.9
50–99 beds	474	0.4	−0.2	−0.3	0.1	0.0	0.0	0.4	0.9	6.2	6.1
100–149 beds	203	0.8	−0.2	−0.4	0.2	0.1	0.0	0.3	2.8	6.0	5.6
150–199 beds	70	1.1	0.0	−0.2	0.3	0.0	−0.1	0.6	4.2	4.4	3.9
200 or more beds	67	1.1	0.0	−0.1	0.1	0.0	−0.1	0.4	3.5	5.7	5.1
Urban by Region:											
New England	132	1.2	−0.4	−0.3	−0.6	0.0	0.0	0.5	0.1	2.8	2.5
Middle Atlantic	395	−3.1	−0.3	−0.9	−0.2	0.0	0.0	−0.6	0.2	−2.8	2.3
South Atlantic	370	1.1	−0.3	−0.1	−0.2	0.0	0.0	0.2	−0.5	2.7	3.0
East North Central	422	1.3	0.0	−0.6	−0.2	0.0	0.0	−0.3	−0.3	2.7	2.6
East South Central	154	1.0	0.0	0.1	−0.2	0.0	−0.1	0.3	−0.6	2.9	3.1
West North Central	175	1.6	−0.5	0.0	−0.2	0.0	−0.1	0.2	−0.7	3.1	2.9
West South Central	327	−0.1	−0.2	−0.1	−0.2	0.0	0.0	0.2	−0.6	1.6	3.2
Mountain	130	1.5	−0.2	0.5	0.0	0.0	−0.1	0.8	−0.5	4.4	4.1
Pacific	413	−2.0	−0.5	−0.1	−0.2	0.0	0.0	0.2	−0.4	−0.6	3.3
Puerto Rico	46	0.3	0.1	−0.3	−0.1	0.0	−0.2	−0.1	−0.7	2.8	2.9
Rural by Region:											
New England	37	0.7	−0.1	−0.2	0.1	0.0	−0.1	0.3	2.6	6.8	6.6
Middle Atlantic	66	0.7	−0.2	−0.4	0.0	0.0	0.0	0.1	2.6	4.1	3.6
South Atlantic	222	1.0	−0.2	−0.1	0.1	0.0	−0.1	0.5	2.3	5.3	4.8
East North Central	193	0.7	−0.2	0.1	0.2	0.0	−0.1	0.7	1.5	4.5	4.1
East South Central	231	0.7	−0.2	−0.4	0.0	0.0	0.0	0.2	2.6	4.7	4.4
West North Central	247	0.4	−0.1	−0.1	0.6	0.1	−0.1	0.9	1.3	7.9	7.8
West South Central	273	0.6	−0.2	−0.6	0.0	0.2	0.0	0.3	3.6	5.8	5.5
Mountain	121	0.3	0.0	−0.3	0.2	0.0	0.0	0.2	1.5	7.1	6.9
Pacific	90	0.7	−0.1	−0.6	0.3	0.1	0.0	0.2	2.3	8.7	8.4
Puerto Rico	5	0.1	−0.1	−4.2	−0.1	0.0	−0.1	−4.1	0.4	−0.3	−0.5
By Payment Classification:											
Urban hospitals	2,605	−0.1	−0.3	−0.3	−0.2	0.0	0.0	0.0	−0.3	1.2	2.9
Large urban areas (populations over 1 million)	1,582	−0.3	−0.3	−0.3	−0.2	0.0	0.0	0.0	−0.2	1.2	3.1
Other urban areas (populations of 1 million or fewer)	1,023	0.2	−0.2	−0.3	−0.2	0.0	0.0	0.0	−0.4	1.3	2.4
Rural areas	1,444	0.6	−0.2	−0.3	0.2	0.1	0.0	0.4	2.1	5.9	5.7
Teaching Status:											
Non-teaching	2,932	−0.1	−0.3	−0.2	−0.1	0.0	0.0	0.3	0.3	2.6	3.7
Fewer than 100 Residents	880	−0.2	−0.1	−0.2	−0.2	0.0	0.0	0.2	−0.2	1.3	3.1
100 or more Residents	237	0.4	−0.2	−0.7	−0.2	0.0	0.0	−0.4	−0.1	1.2	2.4
Urban DSH:											
Non-DSH	1,349	0.5	−0.2	−0.2	−0.1	0.0	0.0	0.2	0.0	2.5	3.3
100 or more beds	1,399	−0.3	−0.3	−0.4	−0.2	0.0	0.0	0.0	−0.3	0.9	2.8

TABLE I.—IMPACT ANALYSIS OF FINAL CHANGES FOR FY 2004 OPERATING PROSPECTIVE PAYMENT SYSTEM [PERCENT CHANGES IN PAYMENTS PER CASE]—Continued

	Number of hosps.[1]	Revised outlier policy[2]	Transfer changes[3]	New wage data[4]	New wage index without CAHS[5]	New wage index without CAHS & NPHYS. part B[6]	DRG Recal[7]	DRG & Wage index changes[8]	MCGRB reclassification[9]	All FY 2004 changes[10]	All FY 2004 changes w/o FY 2003 outliers[11]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Less than 100 beds	282	−1.1	−0.5	−0.1	−0.2	0.0	−0.1	0.4	−0.5	0.9	3.1
Rural DSH:											
Sole Community (SCH)	493	0.2	−0.1	−0.2	0.1	0.0	0.0	0.5	0.3	10.0	9.9
Referral Center (RRC)	156	1.1	−0.1	−0.3	0.2	0.1	−0.1	0.4	4.5	4.5	4.0
Other Rural: 100 or more beds	71	0.9	−0.3	−0.7	0.0	0.1	0.0	0.0	1.3	2.5	2.0
Less than 100 beds	299	0.5	−0.4	−0.6	0.0	0.1	0.0	0.3	1.2	2.8	2.6
Urban teaching and DSH:											
DSH	775	−0.3	−0.2	−0.4	−0.2	0.0	0.0	−0.1	−0.3	0.9	2.8
Teaching and no DSH	274	0.8	−0.1	−0.3	−0.2	0.0	0.0	0.0	−0.2	2.1	2.9
No teaching and DSH	906	−0.6	−0.5	−0.3	−0.2	0.0	0.0	0.1	−0.3	1.0	2.8
No teaching and no DSH	650	0.2	−0.3	−0.1	−0.2	0.0	0.0	0.3	−0.3	1.8	3.1
Rural Hospital Types:											
Non special status hospitals	474	0.7	−0.4	−0.5	0.1	0.1	0.0	0.3	1.3	2.7	2.4
RRC	148	1.5	−0.2	−0.2	0.3	0.1	−0.1	0.6	5.8	3.5	2.9
SCH	497	0.1	−0.1	−0.1	0.1	0.0	0.0	0.5	0.2	10.8	10.8
Medicare-dependent hospitals (MDH)	250	0.3	−0.3	−0.5	0.3	0.1	−0.1	0.7	0.8	3.3	3.2
SCH and RRC	75	0.2	0.0	−0.2	0.1	0.0	0.0	0.2	1.2	7.4	7.3
Type of Ownership:											
Voluntary	2,411	0.4	−0.1	−0.3	−0.2	0.0	0.0	0.0	0.0	2.2	3.1
Proprietary	698	−3.7	−1.0	0.0	−0.2	0.0	−0.1	0.4	−0.1	−2.1	3.6
Government	818	1.2	−0.3	−0.4	−0.1	0.0	0.0	0.0	0.2	4.0	3.8
Unknown	122	2.4	0.0	−1.0	−0.1	0.0	0.1	−0.6	−0.4	3.5	2.2
Medicare Utilization as a Percent of Inpatient Days:											
0–25	303	0.5	0.0	0.1	−0.2	0.0	−0.1	0.3	−0.2	2.5	3.4
25–50	1,533	−0.2	−0.3	−0.4	−0.2	0.0	0.0	0.0	−0.2	1.2	3.0
50–65	1,651	0.4	−0.2	−0.3	−0.1	0.0	0.0	0.1	0.3	2.8	3.4
Over 65	456	−1.2	−0.2	−0.2	−0.1	0.0	0.0	0.4	0.7	1.1	3.6
Unknown	106	−0.6	−0.1	0.1	−0.2	0.0	−0.1	0.4	−0.6	1.7	3.4
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2004 Reclassifications:											
All Reclassified Hospitals	616	−0.7	−0.1	−0.3	0.0	0.0	0.0	0.3	4.3	2.6	4.3
Standardized Amount Only	22	0.9	0.0	−0.8	0.0	0.1	0.0	−0.1	3.4	5.4	5.6
Wage Index Only	554	−1.0	−0.1	−0.3	0.0	0.0	0.0	0.3	4.2	1.9	3.7
Both	33	1.7	0.1	−0.3	0.0	0.0	0.0	0.2	4.1	4.1	3.3
Nonreclassified Hospitals	3,407	0.1	−0.3	−0.3	−0.2	0.0	0.0	0.1	−0.6	1.8	3.2
All Reclassified Urban Hospitals	125	−3.3	−0.2	−0.3	−0.3	0.0	0.0	0.1	4.6	−1.8	3.0
Standardized Amount Only	15	2.5	−1.3	−0.9	−0.1	0.0	0.0	−0.6	0.8	−4.6	3.2
Wage Index Only	71	−5.4	0.0	−0.3	−0.4	0.0	0.0	0.0	5.1	−4.1	2.9
Both	39	1.8	−0.3	0.1	−0.2	0.0	−0.1	0.4	4.6	4.1	3.3
Urban Nonreclassified Hospitals	2,408	0.1	−0.3	−0.3	−0.2	0.0	0.0	0.0	−0.6	1.4	2.9
All Reclassified Rural Hospitals	491	0.9	−0.1	−0.2	0.2	0.1	−0.1	0.4	4.0	5.5	5.1
Standardized Amount Only	27	1.6	0.0	−0.1	0.2	0.0	−0.1	0.6	3.1	2.3	1.3
Wage Index Only	451	0.8	−0.1	−0.3	0.2	0.1	−0.1	0.4	4.0	5.7	5.4
Both	13	1.8	0.0	0.0	0.2	0.0	−0.1	0.8	7.1	5.4	4.6
Rural Nonreclassified Hospitals	992	0.3	−0.2	−0.3	0.1	0.1	0.0	0.5	−0.4	6.2	6.1
Other Reclassified Hospitals (Section 1886(D)(8)(B))	33	0.6	−0.2	0.0	−0.2	0.0	0.0	0.5	−1.5	3.0	2.8

[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 2002, and hospital cost report data are from reporting periods beginning in FY 2000 and FY 1999.
[2] This column displays the payment impact of the outlier policy that were published in the June 9, 2003 **Federal Register**.
[3] This column displays the payment impact of the expanded postacute care transfer policy.
[4] This column displays the impact of updating the wage index with wage data from hospitals' FY 2000 cost reports.
[5] This column displays the impact of removing CAHs from the wage index.
[6] This column displays the impact of the revised wage data used to calculate the wage index from removal of nonphysician Part B costs and hours from cost report data (Worksheet S–3, Part II, Line 5.01).
[7] This column displays the payment impact of the recalibration of the DRG weights based on FY 2002 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.
[8] 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 4, 5, 6 and 7, and the final FY 2004 budget neutrality factor of 1.005522.
[9] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2004 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2004. Reclassification for prior years has no bearing on the payment impacts shown here.
[10] This column shows changes in payments from FY 2003 to FY 2004. It incorporates all of the changes displayed in columns 2, 3, and 8 (the changes displayed in columns 4, 5, and 6 are included in column 8). It also reflects the impact of the FY 2004 update, changes in hospitals' reclassification status in FY 2004 compared to FY 2003, and the difference in outlier payments from FY 2003 to FY 2004. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effect.
[11] This column shows changes in payments from FY 2003 to FY 2004, similar to column 10. However, this simulation assumes FY 2003 outlier payments will be at the same percentage level as FY 2004. This effectively reduces FY 2003 outlier payments from 6.5 percent of total DRG payments to 5.1 percent of total DRG payments, thereby reducing FY 2003 payments and increasing the percent changes from FY 2003 to FY 2004.

C. Impact of the Changes to the Outlier Policy (Column 2)

In the proposed rule, we estimated the FY 2004 outlier threshold to be $50,645. We also noted that the final outlier threshold was likely to be different from the proposed threshold after taking into account changes implemented by the final outlier rule. Since the publication of the proposed IPPS rule, we published a final outlier rule on June 9, 2003 (68 FR 34494).

We published three central changes to our outlier policy in the June 9, 2003 final rule. First, fiscal intermediaries will use either the most recent settled or the most recent tentative settled cost report, whichever is from the latest reporting period when determining the cost-to-charge ratio for each hospital. Second, we removed the requirement in our regulations that specified that a fiscal intermediary will assign a hospital the statewide average cost-to-charge ratio when the hospital has a cost-to-charge ratio that falls below established thresholds. Third, outlier payments for some hospitals will become subject to reconciliation when the hospitals' cost reports are settled.

Column 2 shows the effects of these changes. This column displays the effects of moving from our policy prior to the changes in the June 9 final rule, that hospitals' cost-to-charge ratios are based on their latest settled cost reports, and if the ratio falls below 3 standard deviations from the mean, the statewide average is assigned, to the new

policy where the cost-to-charge ratio is based on the latest tentatively settled cost report, there is no minimum ratio, and outlier payments may be subject to reconciliation when the cost report is settled. As a result of these changes, the outlier threshold falls from $50,200 (this represents what the FY 2004 threshold would be absent the policy changes to $31,000).

The top row in this column indicates these changes have no impact on overall spending. However, the changes among specific categories of hospitals are quite dramatic. Hospital categories negatively impacted in this column are those groups expected to have dramatic reduction in their cost-to-charge ratios as a result of the new policies. On the other hand, hospitals that are not expected to experience dramatic changes in their cost-to-charge ratios benefit from the decline in the threshold.

Rural hospitals overall experience a 0.7 percent increase in their outlier payments as a result of this change. On the other hand, urban hospitals in the Middle Atlantic census division experience a 3.1 percent decrease. The largest negative impacts are among proprietary hospitals, with a 3.7 percent decrease and among urban hospitals that reclassified for the purposes of wage index only, with a decrease of 5.4 percent.

D. Impact of the Changes to the Postacute Care Transfer Policy (Column 3)

In column 3 of Table I, we present the effects of the postacute care transfer policy expansion, as discussed in section IV.A. of the preamble to this final rule. We compared aggregate payments using the FY 2003 DRG relative weights (GROUPER version 21.0) with the expanded postacute care transfer policy to aggregate payments using the expanded postacute care transfer policy (with the additional 21 DRGs). The changes we are making are estimated to result in 0.2 percent lower payments to hospitals overall. We estimate the total savings at approximately $205 million.

To simulate the impact of this final policy, we calculated hospitals' transfer-adjusted discharges and case-mix index values, including the additional 21 DRGs, minus 2 of the current 10 DRGs. The transfer-adjusted discharge fraction is calculated in one of two ways, depending on the transfer payment methodology. Under our previous transfer payment methodology, for all but the three DRGs receiving special payment consideration (DRGs 209, 210, and 211), this adjustment is made by adding 1 to the length of stay and dividing that amount by the geometric mean length of stay for the DRG (with the resulting fraction not to exceed 1.0). For example, a transfer after 3 days from a DRG with a geometric mean length of stay of 6 days would have a transfer-adjusted discharge fraction of 0.667 ((3+1)/6).

For transfers from any one of the three DRGs receiving the alternative payment methodology, the transfer-adjusted discharge fraction is 0.5 (to reflect that these cases receive half the full DRG amount the first day), plus one half of the result of dividing 1 plus the length of stay prior to transfer by the geometric mean length of stay for the DRG. None of the 21 additional DRGs qualify to receive the alternative payment methodology. As with the above adjustment, the result is equal to the lesser of the transfer-adjusted discharge fraction or 1.

The transfer-adjusted case-mix index values are calculated by summing the transfer-adjusted DRG weights and dividing by the transfer-adjusted discharges. The transfer-adjusted DRG weights are calculated by multiplying the DRG weight by the lesser of 1 or the transfer-adjusted discharge fraction for the case, divided by the geometric mean length of stay for the DRG. In this way, simulated payments per case can be compared before and after the change to the transfer policy.

This expansion of the policy has a negative 0.2 percent payment impact overall among both urban and rural hospitals. There is very small variation among all of the hospital categories from this negative 0.2 percent impact. This outcome is different than the impacts exhibited when we implemented the postacute care transfer policy for the original 10 DRGs in the July 31, 1998 **Federal Register** (63 FR 41108). At that time, the impact of going from no postacute transfer policy to a postacute care transfer policy applicable to 10 DRGs was a 0.6 decrease in payments per case. In addition, at that time, the impact was greatest among urban hospitals (0.7 percent payment decrease, compared to 0.4 percent among rural hospitals).

The less dramatic impact observed for this proposed expansion to additional DRGs is not surprising. The movement to transfer more and more patients for postacute care sooner appears to have abated in recent years. While it does appear that many patients continue to be transferred for postacute care early in the course of their acute care treatment, the rapid expansion of this trend that was apparent during the mid-1990s appears to have subsided. To a large extent, this decline probably stems from the decreased payment incentives to transfer patients to postacute care settings as a result of the implementation of prospective payment systems for IRFs, SNFs, LTCHs, and HHAs.

E. Impact of Wage Index Changes (Columns 4, 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 final wage index for FY 2004 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000. The impact of the new data on hospital payments 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 FY 2003 wage index, based on FY 1999 wage data, to a model using the FY 2004 pre-reclassification wage index, based on FY 2000 wage data).

The wage data collected on the FY 2000 cost reports are similar to the data used in the calculation of the FY 2003 wage index. Also, as described in section III.B of the preamble of this final rule, the final FY 2004 wage index is calculated by removing CAHs, shown in column 5, and the removal of nonphysician Part B costs and hours of RHCs and FQHCs, shown in column 6.

Column 4 shows the impacts of updating the wage data using FY 2000 cost reports. Overall, the new wage data would lead to a 0.3 percent reduction, but this reduction is offset by the budget neutrality factor. Urban hospitals' wage indexes would decline by 0.3 percent, and rural hospitals' wage indexes would decline by 0.3 percent. Among regions, the largest impact of updating the wage data is seen in rural Puerto Rico (a 4.2 percent decrease). Rural hospitals in the West South Central and Pacific regions would experience the next largest impact, with a 0.6 percent decrease for each. The rural East North Central region would experience an increase of 0.1.

The national average hourly wage increased 6.79 percent compared to last year. Therefore, the only manner in which to maintain or exceed the previous year's wage index was to match the national 6.79 increase in average hourly wage. Of the 4,018 hospitals with wage index values in both FYs 2003 and 2004, 1,753, or 43.6 percent, also experienced an average hourly wage increase of 6.79 percent or more.

In order to confirm the −0.3 percent, we compared FY 2003 prereclassified wage indexes to those of FY 2004, which yielded a percent change of −0.62 percent per MSA. We weighted this value based on the frequency of hospitals in each MSA, which produced an overall reduction of 0.4 percent. When we multiplied this value by the 71.1 percent labor share representing the proportion of IPPS payments affected by the wage index, we found that the overall wage index values dropped 0.29 percent, essentially equaling the overall change in column 4.

Among urban hospitals, the Middle Atlantic and East North Central regions would experience 0.9 and 0.6 percent decreases, respectively. These impacts result, respectively from a 4.9 percent fall in the FY 2004 final wage index for Pittsburgh, Pennsylvania, and a 5.7 percent decrease in Janesville-Beloit, Wisconsin, as well as a 5.4 percent decrease in the Muncie and Lafayette, Indiana wage indexes. The Mountain and East South Central regions would experience increases of 0.5 percent and 0.1 percent, respectively.

The next column (5) shows the impacts on the calculation of the FY 2004 wage index of removing CAHs. The effects of this change are relatively small with the exception of urban New England, which would experience a 0.6 percent decrease, due primarily to the Pittsfield, Springfield, and rural Massachusetts wage indexes, each falling 7.5 percent. The rural West North Central region would experience an increase of 0.6 percent.

Column 6 shows the impacts of removing nonphysician Part B costs for RHCs and FQHCs. The effects of this change are relatively small.

The following chart compares the shifts in wage index values for labor market areas for FY 2004 relative to FY 2003. This chart demonstrates the impact of the changes for

the final FY 2004 wage index, including updating to FY 2000 wage data. The majority of labor market areas (336) would experience less than a 5-percent change. A total of 9 labor market areas would experience an increase of more than 5 percent and less than 10 percent. One area would experience an increase greater than 10 percent. A total of 25 areas would experience decreases of more than 5 percent and less than 10 percent. Finally, 2 areas would experience declines of 10 percent or more.

Percentage change in area wage index values	Number of labor market areas	
	FY 2003	FY 2004
Increase more than 10 percent	3	1
Increase more than 5 percent and less than 10 percent	11	9
Increase or decrease less than 5 percent	343	336
Decrease more than 5 percent and less than 10 percent	15	25
Decrease more than 10 percent	1	2

Among urban hospitals, 35 would experience an increase of between 5 and 10 percent and 5 more than 10 percent. A total of 37 rural hospitals would experience increases greater than 5 percent, but none would experience increases of greater than 10 percent. On the negative side, 107 urban hospitals would experience decreases in their wage index values of at least 5 percent but less than 10 percent. Seven urban hospitals would experience decreases in their wage index values greater than 10 percent. There are 27 rural hospitals that would experience decreases in their wage index values of greater than 5 percent but less than 10 percent. The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	5	0
Increase more than 5 percent and less than 10 percent	35	37
Increase or decrease less than 5 percent	2,443	1,754
Decrease more than 5 percent and less than 10 percent	107	27
Decrease more than 10 percent	7	0

F. Impact of the Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 7)

In column 7 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II. of the preamble to this final 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 2003 DRG relative weights (GROUPER version 20.0) to aggregate payments using the final FY 2004 DRG relative weights (GROUPER version 21.0). Both simulations reflected the expansion of the postacute care transfer policy. 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 budget neutrality factor of 1.005522 is applied to payments in Column 8. 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 are: creating additional DRGs that are split based on the presence or absence of CCs; creating a new DRG for cases with ruptured brain aneurysms; and creating a new DRG for cases involving the implantation of a cardiac defibrillator where the patient experiences acute myocardial infarction, heart failure, or shock. In the aggregate, these changes will result in 0.0 percent change in overall payments to hospitals. The impacts of these changes on any particular hospital group are very small.

G. Combined Impact of DRG and Wage Index Changes, Including Budget Neutrality Adjustment (Column 8)

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 final rule, we compared simulated aggregate payments using the FY 2003 DRG relative weights and wage index to simulated aggregate payments using the FY 2004 DRG relative weights and blended wage index. In addition, we are required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. As discussed in section II.E. of the preamble of this final rule, we have maintained the new technology status of the drug Xigris® for the treatment of severe sepsis (approved in last year's final rule at 67 FR 50013). We estimate the total add-on payments for this new technology for FY 2004 will be $10 million.

We also approved a second new technology for add-on payments. For FY 2004, the InFUSE™ Bone Graft/LT–CAGE™ Lumbar Tapered Fusion Device for spinal fusions will be eligible to receive add-on payments. We estimate the total add-on payments associated with cases involving this new device for FY 2004 will be $4.4 million.

We computed a final wage and recalibration budget neutrality factor of 1.005522. The 0.0 percent impact for all hospitals demonstrates that these 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 8. The changes in this column are the sum of the final changes in columns 4, 5, 6, and 7, 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. There also may be some variation of plus or minus 0.1 percentage point due to rounding.

H. Impact of MGCRB Reclassifications (Column 9)

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 9 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2004. 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 standardized amount, wage index value, or both. The final FY 2004 wage index values incorporate all of the MGCRB's

reclassification decisions for FY 2004. The wage index values also reflect any decisions made by the CMS Administrator through the appeals and review process.

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 0.992026 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this final rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments would rise 2.2 percent in column 9. Payments to urban hospitals would decline 0.3 percent. Hospitals in other urban areas would experience an overall decrease in payments of 0.3 percent, while large urban hospitals would 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 0.4 for Puerto Rico and 1.3 percent for the West North Central region. The largest increases are in the rural Middle Atlantic, New England, and East South Central with increases of 2.6 percent and in the West South Central region which would experience an increase of 3.6 percent.

Among all the hospitals that were reclassified for FY 2004 (including hospitals that received wage index reclassifications in FY 2002 or FY 2003 that extend for 3 years), the MGCRB changes are estimated to provide a 4.3 percent increase in payments. Urban hospitals reclassified for FY 2004 are expected to receive an increase of 4.6 percent, while rural reclassified hospitals are expected to benefit from the MGCRB changes with a 4.0 percent increase in payments. Overall, among hospitals that were reclassified for purposes of the standardized amount only, a payment increase of 3.4 percent is expected, while those reclassified for purposes of the wage index only show a 4.2 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 0.6 percent for urban hospitals and 0.4 percent for rural hospitals.

I. All Changes (Columns 10 and 11)

Column 10 compares our estimate of payments per case, incorporating all changes reflected in this proposed rule for FY 2004 (including statutory changes), to our estimate of payments per case in FY 2003. This column includes all of the final policy changes. Because the reclassifications shown in column 9 do not reflect FY 2003 reclassifications, the impacts of FY 2004 reclassifications only affect the impacts from FY 2003 to FY 2004 if the reclassification impacts for any group of hospitals are different in FY 2004 compared to FY 2003.

Column 10 includes the effects of the 3.4 percent update to the standardized amounts and the hospital-specific rates for MDHs and SCHs. It also reflects the 1.4 percentage point difference between the projected outlier payments in FY 2003 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2003 (6.5 percent), as described in the introduction to this Appendix and the Addendum to this final rule. As a result, payments are projected to be 1.4 percent higher in FY 2003 than originally estimated, resulting in a 1.4 percent smaller increase than would otherwise occur. (Column 11, as discussed below, displays the changes from FY 2003 to 2004 after adjusting for the higher than expected FY 2003 outlier payments.)

Section 213 of Pub. L. 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 2004, eligible SCHs receive 100 percent of their 1996 hospital-specific rate. The impact of this provision is modeled in column 10 as well.

The expansion of the postacute care transfer policy also reduces payments by paying for discharges to postacute care in 21 additional DRGs as transfers and dropping 2 DRGs from the original list of affected DRGs. Because FY 2003 payments reflect full DRG payments for all cases in these 29 DRGs, there is a negative impact due to the expansion of this policy compared to FY 2003. The net effect of this expanded policy, as displayed in column 3, is also seen in the lower overall percent change shown in column 10 comparing FY 2004 simulated payments per case to FY 2003 payments.

Another influence on the overall change reflected in this column is the requirement of section 402(b) of Pub. L. 108–7 that all hospitals receive the large urban standardized amount for all discharges occurring on or after April 1, 2003, and before October 1, 2003. For discharges occurring on or after October 1, 2003, the Federal rate will again be calculated based on separate average standardized amounts for hospitals in large urban areas and for hospitals in other areas. The effect is to reduce the percent increase reflected in the ''all changes'' column.

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 2004 would increase by 1.8 percent. Hospitals in urban areas would experience a 1.2 percent increase in payments per case compared to FY 2003. Hospitals in rural areas, meanwhile, would experience a 5.8 percent payment increase. Hospitals in large urban areas would experience a 1.1 percent increase in payments.

Among urban census divisions, the largest payment increase was 4.4 percent in the Mountain region. Hospitals in the urban East South Central region and in Puerto Rico would experience an overall increase of 2.9 percent and 2.8 percent, respectively. The smallest increase would occur in the West South Central region, with an increase of 1.6 percent. These below average increases are primarily due to the inflated outlier payments for some of these hospitals during FY 2003 compared to FY 2004.

The effect of outlier payments is illustrated in column 11, which sets each hospital's outlier percentage equal to their projected percentage for FY 2004. In this way, we are able to model FY 2003 payments as if outlier payments were on a par with projected FY 2004 outlier payments. The results illustrate the dampening effect the high FY 2003 outliers have on column 10. After removing this effect, the impact for all hospitals in FY 2004 is a 3.2 percent increase, equal to the 3.4 percent update minus 0.2 percent for the impact of the expanded postacute transfer policy. For the most part (except for the 0.5 percent decrease in the rural Puerto Rico category), this reverses any negative overall impacts observed in column 10.

Among rural regions in column 10, the only hospital category that would experience overall payment decreases is Puerto Rico, where payments would decrease by 0.3 percent, largely due to the updated wage data. The West North Central and Pacific regions would benefit the most, with 7.9 and 8.7 percent increases, respectively.

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 10.8 percent, 3.3 percent, and 7.4 percent, respectively. This outcome is primarily related to the fact that, for hospitals receiving payments under the hospital-specific methodology, there are no outlier payments. Therefore, these hospitals would not experience negative payment impacts from the decline in outlier payments from FY 2003 to FY 2004 as would hospitals paid based on the national standardized amounts. The 10.8 percent increase for SCHs is due to the increase in percentage of the 1996 hospital-specific rate percentage from 75 percent in FY 3003 to 100 percent in FY 2004.

Hospitals that were reclassified for FY 2004 are estimated to receive a 2.6 percent increase in payments. Urban hospitals reclassified for FY 2004 are anticipated to receive a decrease of 1.8 percent, while rural reclassified hospitals are expected to benefit from reclassification with a 5.5 percent increase in payments. Overall, among hospitals reclassified for purposes of the standardized amount, a payment increase of 5.4 percent is expected, while those hospitals reclassified for purposes of the wage index only would show an expected 1.9 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 3.0 percent.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2004 OPERATING PROSPECTIVE PAYMENT SYSTEM (PAYMENTS PER CASE)

	Number of hospitals	Average FY 2003 payment per case[1]	Average FY 2004 payment per case[1]	All FY 2004 changes
	(1)	(2)	(3)	(4)
By Geographic Location:				
All hospitals	4,049	7,512	7,651	1.8
Urban hospitals	2,564	7,976	8,073	1.2
Large urban areas (populations over 1 million)	1,488	8,466	8,557	1.1
Other urban areas (populations of 1 million or fewer)	1,076	7,324	7,429	1.4
Rural hospitals	1,485	5,506	5,825	5.8
Bed Size (Urban):				
0–99 beds	614	5,539	5,654	2.1
100–199 beds	914	6,691	6,772	1.2
200–299 beds	508	7,653	7,763	1.4
300–499 beds	372	8,568	8,635	0.8
500 or more beds	156	10,199	10,339	1.4
Bed Size (Rural):				
0–49 beds	671	4,526	4,796	6.0
50–99 beds	474	5,113	5,431	6.2
100–149 beds	203	5,519	5,851	6.0
150–199 beds	70	5,845	6,101	4.4
200 or more beds	67	7,051	7,453	5.7
Urban by Region:				
New England	132	8,390	8,623	2.8
Middle Atlantic	395	9,010	8,757	−2.8
South Atlantic	370	7,538	7,739	2.7
East North Central	422	7,509	7,708	2.7
East South Central	154	7,201	7,407	2.9
West North Central	175	7,639	7,877	3.1
West South Central	327	7,432	7,549	1.6
Mountain	130	7,770	8,110	4.4
Pacific	413	9,774	9,718	−0.6
Puerto Rico	46	3,346	3,438	2.8
Rural by Region:				
New England	37	6,932	7,404	6.8
Middle Atlantic	66	5,581	5,809	4.1
South Atlantic	222	5,596	5,890	5.3
East North Central	193	5,479	5,726	4.5
East South Central	231	4,957	5,191	4.7
West North Central	247	5,728	6,183	7.9
West South Central	273	4,733	5,005	5.8
Mountain	121	6,266	6,710	7.1
Pacific	90	7,231	7,861	8.7
Puerto Rico	5	2,621	2,613	−0.3
By Payment Classification:				
Urban hospitals	2,605	7,953	8,052	1.2
Large urban areas (populations over 1 million)	1,582	8,362	8,463	1.2
Other urban areas (populations of 1 million or fewer)	1,023	7,350	7,445	1.3
Rural areas	1,444	5,483	5,809	5.9
Teaching Status:				
Non-teaching	2,932	6,189	6,351	2.6
Fewer than 100 Residents	880	7,768	7,871	1.3
100 or more Residents	237	11,499	11,642	1.2
Urban DSH:				
Non-DSH	1,349	6,736	6,902	2.5
100 or more beds	1,399	8,575	8,656	0.9
Less than 100 beds	282	5,425	5,472	0.9
Rural DSH:				
Sole Community (SCH)	493	5,589	6,146	10.0
Referral Center (RRC)	156	6,053	6,326	4.5
Other Rural: 100 or more beds	71	4,647	4,762	2.5
Less than 100 beds	299	4,286	4,404	2.8
Urban teaching and DSH:				
Both teaching and DSH	775	9,435	9,523	0.9
Teaching and no DSH	274	7,704	7,865	2.1
No teaching and DSH	906	6,814	6,881	1.0
No teaching and no DSH	650	6,265	6,380	1.8
Rural Hospital Types:				
Non special status hospitals	474	4,441	4,559	2.7
RRC	148	5,868	6,072	3.5
SCH	497	6,022	6,673	10.8

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2004 OPERATING PROSPECTIVE PAYMENT SYSTEM (PAYMENTS PER CASE)—Continued

	Number of hospitals (1)	Average FY 2003 payment per case[1] (2)	Average FY 2004 payment per case[1] (3)	All FY 2004 changes (4)
Medicare-dependent hospitals (MDH)	250	4,162	4,301	3.3
SCH and RRC	75	6,805	7,312	7.4
Type of Ownership:				
Voluntary	2,411	7,617	7,784	2.2
Proprietary	698	7,189	7,035	−2.1
Government	818	7,264	7,557	4.0
Unknown	122	7,528	7,794	3.5
Medicare Utilization as a Percent of Inpatient Days:				
0–25	303	10,131	10,383	2.5
25–50	1,533	8,568	8,669	1.2
50–65	1,651	6,505	6,686	2.8
Over 65	456	5,824	5,891	1.1
Unknown	106	6,766	6,884	1.7
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2004 Reclassifications:				
All Reclassified Hospitals	616	6,892	7,071	2.6
Standardized Amount Only	22	5,672	5,980	5.4
Wage Index Only	554	6,952	7,082	1.9
Both	33	6,146	6,398	4.1
All Nonreclassified Hospitals	3,407	7,639	7,777	1.8
All Urban Reclassified Hospitals	125	8,779	8,619	−1.8
Urban Nonreclassified Hospitals	15	6,352	6,646	4.6
Standardized Amount Only	71	9,881	9,471	−4.1
Wage Index Only	39	7,018	7,304	4.1
Both	2,408	7,946	8,059	1.4
All Reclassified Rural Hospitals	491	6,040	6,372	5.5
Standardized Amount Only	27	6,218	6,363	2.3
Wage Index Only	451	6,047	6,393	5.7
Both	13	5,345	5,632	5.4
Rural Nonreclassified Hospitals	992	4,863	5,166	6.2
Other Reclassified Hospitals (Section 1886(d)(8)(B))	33	5,087	5,241	3.0

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

Table II presents the projected impact of the final changes for FY 2004 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 2003 with the average estimated per case payments for FY 2004, 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 Policy Changes

In addition to those changes discussed above that we are able to model using our IPPS payment simulation model, we are implementing various other changes in this final rule. Generally, we have limited or no specific data available with which to estimate the impacts of these changes. Our estimates of the likely impacts associated with these other changes are discussed below.

A. Changes to Bed and Patient Day Counting Policies

1. Background

Under IPPS, both the IME and the DSH adjustments utilize statistics regarding the number of beds and patient days of a hospital to determine the level of the respective payment adjustment. For IME, hospitals receiving this adjustment want to minimize their numbers of beds in order to maximize their resident-to-bed ratio. For DSH, urban hospitals with 100 or more beds qualify for a higher payment adjustment, so some hospitals have an incentive to maximize their bed count to qualify for higher payments. Existing regulations specify that the number of beds is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period.

2. Nonacute Care Beds and Days

The rule clarifies that days attributable to a nonacute care unit or ward, regardless of whether the unit or ward is separately certified by Medicare or is adjacent to a unit or ward used to provide an acute level of care, would not be included in the count of bed or patient days. In a recent decision by the Ninth Circuit Court of Appeals (*Alhambra Hosp.* v. *Thompson*, 259 F.3d 1017 (9th Cir. 2001)), the court found that our policy for counting patient days did not preclude a hospital from counting the patient days attributable to a nonacute care unit adjacent to an area of the hospital subject to the IPPS. Under this ruling, hospitals within the jurisdiction of the Ninth Circuit would be able to count those patient days.

Because the *Alhambra* decision was based on a regulatory interpretation, this final rule would supersede the *Alhambra* decision in the Ninth Circuit. We estimate that if all hospitals in the Ninth Circuit that could take advantage of this ruling were currently doing so, the impact of this provision would be $184 million in reduced Medicare program payments to the affected hospitals in FY 2004 for DSH. This estimate reflects the impact of adding all days of non-Medicare certified nursing facilities to the count of inpatient days for hospitals in the nine States under the jurisdiction of the Ninth Circuit. For example, in Alaska, nursing facility days constitute 11 percent of total Medicaid inpatient days. If all of these nursing facility days are currently included in the Medicaid inpatient days count, we estimate this provision would reduce Medicare DSH payments to Alaska's hospitals by $662,097.

We are unable to estimate the effect of this provision on specific hospitals because we are not aware of specific hospitals that are presently including those inpatient days in their calculation of Medicaid days for purposes of determining their Medicare DSH percentage. However, we expect the impact on any particular hospital would be minimal (with no impact on the level of beneficiary

services), because the days attributable to patients receiving these limited benefit programs should be only a small portion of the overall Medicaid days at any particular hospital. No other provider types would be affected. However, because our policy is to count patient days and beds consistently, inclusion of the days of postacute care units in the DSH calculation would lead to an offsetting negative payment impact for teaching hospitals. The inclusion of additional beds decreases the resident-to-bed ratios used to calculate the IME adjustments.

Therefore, the actual potential impact on hospitals of this policy clarification is likely to be significantly less than $184 million.

3. Observation and Swing-Beds

We are revising our regulations to clarify that swing-bed and observation bed days are to be excluded from the count of bed and patient days. Because this clarification reflects our current policy, despite the fact that there has been some confusion and we have had adverse court decisions, we do not anticipate this clarification would have a significant impact on payments. We do not have data available that would enable us to identify those hospitals that have not been applying this policy and, therefore, would be required to change their policy. Consequently, we are unable to quantify the impacts of this clarification.

4. Labor, Delivery, and Postpartum Beds and Days

Similarly, in the case of labor, delivery, and postpartum rooms, we are clarifying that it is necessary to apportion the days and costs of a patient stay between the labor/delivery ancillary cost centers and the routine adults and pediatrics cost center on the basis of the percentage of time during the entire stay associated with these various services. Because this is a clarification of existing policy, we do not anticipate this change will have a significant payment impact. However, we do not have data available to enable us to identify those hospitals that have not been applying this policy and, therefore, will be required to change their policy. Consequently, we are unable to quantify the impacts of this clarification.

5. Days Associated With Demonstration Projects Under Section 1115 of the Act

Some States have demonstration projects that provide family planning or outpatient drug benefits that are limited benefits that do not include Medicaid coverage for inpatient services. In this final rule, we also clarify that any hospital inpatient days attributed to a patient who is not eligible for Medicaid inpatient hospital benefits either under the approved State plan or through a section 1115 waiver must not be counted in the calculation of Medicaid days for purposes of determining a hospital's DSH percentage.

We estimated the potential impact of the clarification to our policy of excluding days associated with inpatients who are eligible only for Medicaid outpatient benefits. We identified the percentage of individuals receiving only outpatient family planning benefits under Medicaid compared to all Medicaid-eligible beneficiaries (this is currently the only outpatient-only category for which we have numbers of eligible beneficiaries). These percentages were calculated on a statewide basis for each State with a family planning benefit. Based on these percentages, assuming family planning beneficiaries use inpatient services at the same rate as all other Medicaid beneficiaries, we estimated the amount of total Medicare DSH payments for each State that may be attributable to family planning beneficiaries' use of inpatient services.

For example, in Alabama, total Medicare DSH payments in 1999 (the latest year for which a complete database of cost reports from all hospitals is available) were $97.1 million. Because the percentage of family planning beneficiaries to total Medicaid eligible beneficiaries is 11.24 percent, we estimated 11.24 percent of $97.1 million in Medicare DSH payments, or $10.9 million, is the maximum amount of Medicare DSH that may currently be attributable to the inclusion of inpatient days for individuals who are only eligible for outpatient family planning Medicaid benefits. Based on this analysis, we have identified the potential impact upon hospitals to be as much as $290 million in reduced DSH payments from the Medicare program to those hospitals in FY 2004. Of this amount, $170 million is attributable to California. This amount is not an impact on State programs nor does it require States to spend any additional money. We also note that we are not aware of any specific hospitals that are including inpatient days attributable to individuals with no inpatient Medicaid benefits. Therefore, this estimate reflects the maximum potential impact, but the actual impact is very likely to be much less.

We are unable to estimate the effect of this clarification on specific hospitals because we are not aware of specific hospitals that are presently including those inpatient days in their calculation of Medicaid days for purposes of determining their Medicare DSH percentage. However, we expect the impact on any particular hospital would be minimal (with no impact on the level of beneficiary services), because the days attributable to patients receiving these limited benefit programs should be only a small portion of the overall Medicaid days at any particular hospital. No other provider types would be affected.

B. Costs of Approved Nursing and Allied Health Education Activities

1. Continuing Education

In section IV.E. of the preamble of this final rule, we are clarifying further the distinction between continuing education, which is not eligible for pass-through payment, and approved educational programs, which are eligible for pass-through payment. An approved program that qualifies for pass-through payment is generally a program of long duration designed to develop trained practitioners in a nursing or allied health discipline, such as professional nursing, in which the individual learns ''value-added'' skills that enable him or her to work in a particular capacity upon completion of the program. Such a program is in contrast to a continuing education program in which a practitioner, such as a registered nurse, receives training in a specialized skill or a new technology. While such training is undoubtedly valuable in enabling the nurse to treat patients with special needs, the nurse, upon completion of the program, continues to function as a registered nurse, albeit one with an additional skill. Effective October 1, 2003, we are clarifying our policy concerning not allowing pass-through payment for continuing education because it has come to our attention that certain programs, which in our view constitute continuing education are inappropriately receiving pass-through payment.

To the extent that Medicare would no longer pay for such programs, Medicare payments would be reduced. We believe that these programs comprise a small fraction of the approximately $230 million that are paid for all nursing and allied health education programs under Medicare.

2. Nonprovider-Operated Nursing and Allied Health Education Programs With Wholly Owned Subsidiary Educational Institutions

As discussed in section IV.E.3. of this final rule, we are finalizing the proposal that Medicare would not recoup reasonable cost payment from hospitals that have received pass-through payment for portions of cost reporting periods occurring on or before October 1, 2003 for costs of nursing or allied health education program(s) where the program(s) had originally been operated by the hospital, and then operation of program(s) had been transferred by the hospital to a wholly owned subsidiary educational institution in order to meet accreditation standards prior to October 1, 2003, and where the hospital had continued to incur the costs of both the classroom and clinical training portions of the programs while the program(s) were operated by the educational institution. We estimate that the costs to the Medicare program of this proposal will be approximately $10 to $20 million. We do not believe many hospitals fit the criteria described above of previously receiving Medicare payment for direct operation of nursing or allied health education program(s) and then transferring operation of the program(s) to a wholly owned subsidiary educational institution, all the while incurring the classroom and clinical training costs of the program(s).

In addition, we are finalizing the proposal that, for portions of cost reporting periods beginning on or after October 1, 2003, a hospital that meets the criteria described above may continue to receive reasonable cost payments for clinical training costs incurred by the hospital for the nursing and allied health education program(s) that were operated by the hospital prior to the date the hospital transferred operation of the program(s) to its wholly owned subsidiary educational institution (and ceased to be a provider-operated program). We are also finalizing that, with respect to classroom costs, only those classroom costs incurred by the hospital for the courses that were paid by Medicare on a reasonable cost basis and included in the hospital's provider-operated program(s) could continue to be reimbursed on a reasonable cost basis. We estimate the

costs to the Medicare program for this provision will be $1 to $2 million per year.

C. Prohibition Against Counting Residents Where Other Entities Have Previously Incurred the Training Costs

As we explain in section IV.F.2. of the preamble of this final rule, under section 1886(h) of the Act, hospitals may count the time that residents spend training in nonhospital sites if they meet certain conditions, including incurring ''all or substantially all'' of the costs of training at the nonhospital site. Legislative history indicates that the purpose of this provision is to encourage hospitals to provide more training outside the traditional hospital environment.

It has come to our attention that hospitals have been incurring the costs of and receiving direct GME and IME payment for residency training that had previously been occurring in nonhospital settings, without the financial support of the hospitals. We believe that where no new or additional training is provided in these nonhospital settings, the receipt of Medicare payment in such cases is contrary to Congressional intent and is, therefore, inappropriate. In addition, it violates Medicare's redistribution of costs and community support principles, which state that Medicare will not share in the costs of educational activities of a hospital that represent a redistribution of costs from a university or the community to the hospital. Accordingly, we are revising our policy concerning counting residents to ensure that, effective for portions of cost reporting periods occurring on or after October 1, 2003, Medicare GME payments are not made to hospitals for training that had already been in place in the absence of the hospital's financial support. However, we also are providing that, for an FTE resident who began 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, the resident may continue to be counted by a hospital as an 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.

By prohibiting payment for residency training that had been previously supported by nonhospital institutions, this change will reduce the amount of direct GME and IME payments received by hospitals. Although we cannot estimate the impact on programs nationally, we are aware that two hospitals in New York were receiving over $10 million annually for payments for dental residents training in nonhospital sites. Another hospital in Boston was receiving over $2 million annually for dental residents training at a dental school.

D. Rural Track GME Training Programs

1. Reduction in the Time Required for Training Residents in a Rural Area

As explained in section IV.F.3. of the preamble of this final rule, under existing regulations, if an urban hospital rotates residents to a separately accredited rural track program in a rural area for two-thirds of the duration of the training program, the urban hospital may receive an increase in its FTE cap to reflect the time those residents train at the urban hospital. When we first implemented these regulations, we did so based on our understanding that the Accreditation Council for Graduate Medical Education (ACGME) requires that at least two-thirds of the duration of the program be spent in a rural area. However, it has come to our attention that, while the ACGME generally follows a one-third/two-thirds model for accreditation, the rural training requirement is actually somewhat less than two-thirds of the duration of the program. Therefore, we are revising the regulations to state that if an urban hospital rotates residents to a separately accredited rural track program in a rural area for more than 50 percent of the duration of the training program, the urban hospital may receive an increase in its FTE cap to reflect the time those residents train at the urban hospital. We estimate that this provision will only slightly increase Medicare payments for IME and direct GME costs.

2. Inclusion of Rural Track FTE Residents in the Rolling Average Calculation

As explained in section IV.F.4. of the preamble of this final rule, when we first issued the regulations concerning residents training in a rural track program, we inadvertently did not specify in regulations that these residents would be included in the hospital's rolling average count of FTE residents used for computing GME payment. We are making this technical clarification to the regulations. We believe that this provision will not have a budget impact because it is a clarification of existing policy.

D. Impact of Application of RCE Limits

As discussed in section IV.G. of this final rule, we are updating the RCE limits by applying the most recent economic index. In this final rule, we are announcing an update of the limits, as required by § 415.70(f)(3) and does not alter any regulations or policy. The RCE limits apply only to providers paid on a reasonable cost basis and to compensation a physician receives from a provider for services that benefit patients generally or otherwise but that are not eligible for payment under the physician fee schedule. Also, the limits do not apply to costs of physician compensation that are attributable to furnishing inpatient hospital services paid under the IPPS or that are attributable to GME costs. In addition, RCE limits do not apply to the costs CAHs incur in compensating physicians for services. As a result of the application of the RCE limits, we estimate the costs associated with the updated limits for calendar year 2004 to be approximately $11 million.

VIII. Impact of 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 final 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 2004 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 March 2003 update of the FY 2002 MedPAR file and the March 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 2002 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 prospective payment system, 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 March 2003 update of the FY 2002 MedPAR file, we simulated payments under the capital prospective payment system for FY 2003 and FY 2004 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general hospital inpatient prospective payment systems (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 final 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 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 1.01 percent in both FY 2003 and FY 2004.
- We estimate that the Medicare discharges will be 14.3 million in FY 2003 and 14.5 million in FY 2004 for a 1.5 percent increase from FY 2003 to FY 2004.
- 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 FY 2004 update is 0.7 percent (see section III.A.1.a. of the Addendum to this final rule).
- In addition to the FY 2004 update factor, the FY 2004 capital Federal rate was calculated based on a GAF/DRG budget neutrality factor of 1.0059, an outlier adjustment factor of 0.9522, and a (special) exceptions adjustment factor of 0.9995.

2. 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 prospective payment system transition period payment methodology. We are no longer including this information since 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 2004.

We used the actuarial model described above to estimate the potential impact of our changes for FY 2004 on total capital payments per case, using a universe of 3,929 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the March 2003 update of the FY 2002 MedPAR file, the March 2003 update to the Provider-Specific File, and the most recent cost report data from the March 2003 update of HCRIS. In Table III, we present a comparison of total payments per case for FY 2003 compared to FY 2004 based on the FY 2004 payment policies. Column 2 shows estimates of payments per case under our model for FY 2003. Column 3 shows estimates of payments per case under our model for FY 2004. Column 4 shows the total percentage change in payments from FY 2003 to FY 2004. The change represented in Column 4 includes the 0.7 percent update to the capital Federal rate, a 1.01 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 decrease slightly −0.2 percent) in FY 2004. This projected decrease in capital payments per case is mostly due to the estimated decrease in outlier payments in FY 2004 as a result of the changes to the outlier policy established in the June 9, 2003 high-cost outlier final rule (68 FR 34494). Our comparison by geographic location shows that urban hospitals are expected to experience a slight decrease in capital payments per case (−0.6 percent), while rural hospitals are expected to experience an increase in capital payments per case (2.5 percent). This difference is mostly due to a projection that urban hospitals will experience a larger decrease in outlier payments from FY 2003 to FY 2004 due to the changes in the outlier policy established in the June 9, 2003 high-cost outlier final rule compared to rural hospitals.

Most regions are estimated to receive an increase in total capital payments per case. Changes by region vary from a maximum decrease of 4.1 percent (Middle Atlantic urban region) to a maximum increase of 3.3 percent (West North Central rural region). Hospitals located in Puerto Rico are expected to experience an increase in total capital payments per case of 0.4 percent.

By type of ownership, government hospitals are projected to have the largest rate of increase of total payment changes (2.0 percent). Similarly, payments to voluntary hospitals are expected to increase 0.7 percent, while payments to proprietary hospitals are expected to decrease 6.9 percent. As noted above, this projected decrease in capital payments per case for proprietary hospitals is mostly due to the estimated decrease in outlier payments in FY 2004 as a result of the changes to the outlier policy established in the June 9, 2003 high-cost outlier final rule.

Section 1886(d)(10) of the Act established the MGCRB. Hospitals may apply for reclassification for purposes of the standardized amount, wage index, or both. Although the capital Federal rate is not affected, a hospital's geographic classification for purposes of the operating standardized amount does affect a hospital's capital payments as a result of the large urban adjustment factor and the disproportionate share adjustment for urban hospitals with 100 or more beds. Reclassification for wage index purposes also affects the geographic adjustment factor, since that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2004 compared to the effects of reclassification for FY 2003, 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 2004 as a whole are projected to experience a 0.3 percent increase in payments. Payments to nonreclassified hospitals in FY 2004 are expected to decrease 0.3 percent. Hospitals reclassified during both FY 2003 and FY 2004 are projected to experience a slight decrease in payments of 0.2 percent. Hospitals reclassified during FY 2004 only are projected to receive an increase in payments of 5.7 percent. This increase is primarily due to changes in the GAF (wage index).

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE (FY 2003 PAYMENTS COMPARED TO FY 2004 PAYMENTS)

	Number of hospitals	Average FY 2003 payments/case	Average FY 2004 payments/case	Change
By Geographic Location:				
All hospitals	3,929	715	714	−0.2
Large urban areas (populations over 1 million)	1,436	820	813	−0.8
Other urban areas (populations of 1 million of fewer)	1,035	703	701	−0.3
Rural areas	1,458	479	491	2.5
Urban hospitals	2,471	770	765	−0.6
0–99 beds	549	545	545	−0.1
100–199 beds	895	647	646	−0.1
200–299 beds	503	738	734	−0.6
300–499 beds	369	823	814	−1.0
500 or more beds	155	980	976	−0.5
Rural hospitals	1,458	479	491	2.5
0–49 beds	650	391	402	2.9
50–99 beds	468	442	453	2.5

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE (FY 2003 PAYMENTS COMPARED TO FY 2004 PAYMENTS)—Continued

	Number of hospitals	Average FY 2003 payments/case	Average FY 2004 payments/case	Change
100–149 beds	203	484	496	2.5
150–199 beds	70	526	538	2.3
200 or more beds	67	599	612	2.2
By Region:				
Urban by Region	2,471	770	765	−0.6
New England	129	816	827	1.4
Middle Atlantic	389	865	830	−4.1
South Atlantic	359	733	734	0.1
East North Central	403	736	748	1.6
East South Central	151	691	698	1.0
West North Central	168	754	761	0.9
West South Central	307	721	710	−1.5
Mountain	121	746	768	2.9
Pacific	400	907	886	−2.3
Puerto Rico	44	320	321	0.4
Rural by Region	1,458	479	491	2.5
New England	37	597	593	−0.6
Middle Atlantic	65	503	514	2.2
South Atlantic	220	492	504	2.4
East North Central	191	492	504	2.3
East South Central	228	437	448	2.5
West North Central	242	478	493	3.3
West South Central	268	426	439	3.1
Mountain	116	508	519	2.1
Pacific	86	566	580	2.5
By Payment Classification:				
All hospitals	3,929	715	714	−0.2
Large urban areas (populations over 1 million)	1,529	809	804	−0.6
Other urban areas (populations of 1 million of fewer)	983	705	702	−0.5
Rural areas	1,417	476	487	2.5
Teaching Status:				
Non-teaching	2,821	585	586	0.1
Fewer than 100 Residents	872	742	742	0.1
100 or more Residents	236	1,097	1,085	−1.1
Urban DSH:				
100 or more beds	1,383	809	804	−0.7
Less than 100 beds	269	530	518	−2.4
Rural DSH:				
Sole Community (SCH/EACH)	491	419	431	2.7
Referral Center (RRC/EACH)	156	544	557	2.4
Other Rural:				
100 or more beds	71	440	448	1.9
Less than 100 beds	291	407	417	2.4
Urban teaching and DSH:				
Both teaching and DSH	769	890	885	−0.6
Teaching and no DSH	271	774	775	0.1
No teaching and DSH	883	645	638	−1.1
No teaching and no DSH	589	639	637	−0.3
Rural Hospital Types:				
Non special status hospitals	453	425	435	2.3
RRC/EACH	148	556	570	2.4
SCH/EACH	492	441	453	2.6
Medicare-dependent hospitals (MDH)	249	395	406	2.9
SCH, RRC and EACH	75	542	555	2.5
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
Reclassification Status During FY2003 and FY2004:				
Reclassified During Both FY2003 and FY2004	556	628	626	−0.2
Reclassified During FY2004 Only	58	618	654	5.7
Reclassified During FY2003 Only	55	580	557	−4.1
FY2004 Reclassifications:				
All Reclassified Hospitals	614	627	629	0.3
All Nonreclassified Hospitals	3,283	732	730	−0.3
All Urban Reclassified Hospitals	124	835	811	−3.0
Urban Nonreclassified Hospitals	2,317	768	764	−0.4
All Reclassified Rural Hospitals	490	532	546	2.6
Rural Nonreclassified Hospitals	966	413	423	2.3
Other Reclassified Hospitals (Section 1886(D)(8)(B))	32	490	502	2.5
Type of Ownership:				
Voluntary	2,399	728	733	0.7

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE (FY 2003 PAYMENTS COMPARED TO FY 2004 PAYMENTS)—Continued

	Number of hospitals	Average FY 2003 payments/case	Average FY 2004 payments/case	Change
Proprietary	685	704	656	−6.9
Government	811	651	665	2.0
Medicare Utilization as a Percent of Inpatient Days:				
0–25	298	917	925	0.8
25–50	1,523	817	810	−0.9
50–65	1,641	619	624	0.8
Over 65	451	566	560	−1.1

Appendix B: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

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 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 amounts, the hospital-specific rates for SCHs and MDHs, and the rate-of-increase limits for hospitals and hospitals units excluded from the IPPS. We also discuss our update framework and respond to MedPAC's recommendations concerning the update factors.

II. Secretary's Final Recommendations for Updating the Prospective Payment System Standardized Amounts

In recommending an update, the Secretary takes into account the factors in the update framework, as well as other factors, such as the recommendations of MedPAC, the long-term solvency of the Medicare Trust Funds, and the capacity of the hospital industry to continually provide access to high quality care to Medicare beneficiaries through adequate payment to health care providers.

Comment: One commenter noted that overall Medicare payments are less than the costs associated with providing care to Medicare beneficiaries. The commenter indicated its organization will continue to urge Congress to provide adequate Medicare reimbursement to hospitals.

Response: As noted above, the Secretary's update recommendation for FY 2004 is consistent with current law. Therefore, Congress is the appropriate body to address the issue of adequate Medicare reimbursement that was raised by the commenter.

III. Secretary's Final Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals and Hospital Units

We did not receive any comments concerning our proposed recommendation for updating the rate-of-increase for excluded hospitals and hospital units. Our final recommendation does not differ from the proposed recommendation. However, the second quarter forecast of the market basket percentage increase is 3.4 for excluded hospitals and hospital units (compared to the 3.5 percent estimated in the proposed rule). Thus, the policy finalized in this final rule is that the update for the remaining hospitals and hospital units excluded from the IPPS is 3.4 percent.

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