Federal Register

Wednesday,
May 4, 2005

Book 2 of 2 Books
Pages 23305–23774

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 412, et al.

Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 412, 413, 415, 419, 422, and 485

[CMS–1500–P]

RIN 0938–AN57

Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates

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

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs to implement changes arising from our continuing experience with these systems. In addition, in the Addendum to this proposed rule, we describe the proposed changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for operating costs and capital-related costs. We also are setting forth proposed rate-of-increase limits as well as proposed policy changes for hospitals and hospital units excluded from the IPPS that are paid in full or in part on a reasonable cost basis subject to these limits. These proposed changes would be applicable to discharges occurring on or after October 1, 2005, with one exception: The proposed changes relating to submittal of hospital wage data by a campus or campuses of a multicampus hospital system (that is, the proposed changes to § 412.230(d)(2) of the regulations) would be effective upon publication of the final rule.

Among the policy changes that we are proposing to make are changes relating to: the classification of cases to the diagnosis-related groups (DRGs); the long-term care (LTC)–DRGs and relative weights; the wage data, including the occupational mix data, used to compute the wage index; rebasing and revision of the hospital market basket; applications for new technologies and medical services add-on payments; policies governing postacute care transfers, payments to hospitals for the direct and indirect costs of graduate medical education, submission of hospital quality data, payment adjustment for low-volume hospitals, changes in the requirements for provider-based facilities; and changes in the requirements for critical access hospitals (CAHs).

DATES: Comments will be considered if received at the appropriate address, as provided in the **ADDRESSES** section, no later than 5 p.m. on June 24, 2005.

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Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Security and Standards Group, Office of Regulations Development and Issuances, Room C4–24–02 7500 Security Boulevard, Baltimore, Maryland 21244–1850, Attn: James Wickliffe, CMS–1500–P; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3001, New Executive Office Building, Washington, DC 20503, Attn: Christopher Martin, CMS Desk Officer, CMS–1500–P, *Christopher_Martin@omb.eop.gov.* Fax (202) 395–6974.

FOR FURTHER INFORMATION CONTACT:

Marc Harstein, (410) 786–4539, Operating Prospective Payment, Diagnosis-Related Groups (DRGs), Wage Index, New Medical Services and Technology Add-On Payments, Hospital Geographic Reclassifications, Postacute Care Transfers, and Disproportionate Share Hospital Issues.

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

Steve Heffler, (410) 786–1211, Hospital Market Basket Revision and Rebasing.

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

Mary Collins, (410) 786–3189, Critical Access Hospitals (CAHs) Issues.

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

Martha Kuespert, (410) 786–4605 Specialty Hospitals Definition Issues.

SUPPLEMENTARY INFORMATION:

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Acronyms

AAOS American Association of Orthopedic Surgeons
ACGME Accreditation Council on Graduate Medical Education
AHIMA American Health Information Management Association
AHA American Hospital Association
AICD Automatic cardioverter defibrillator
AMI Acute myocardial infarction
AOA American Osteopathic Association
ASC Ambulatory Surgical Center
ASP Average sales price
AWP Average wholesale price
BBA Balanced Budget Act of 1997, Pub. L. 105–33
BES Business Expenses Survey
BIPA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
BLS Bureau of Labor Statistics
CAH Critical access hospital
CBSAs Core-Based Statistical Areas
CC Complication or comorbidity
CIPI Capital Input Price Index
CMS Centers for Medicare & Medicaid Services
CMSA Consolidated Metropolitan Statistical Area
COBRA Consolidated Omnibus Reconciliation Act of 1985, Pub. L. 99–272
CoP Condition of Participation
CPI Consumer Price Index
CRNA Certified registered nurse anesthetist
CRT Cardiac Resynchronization Therapy
DRG Diagnosis-related group
DSH Disproportionate share hospital
ECI Employment Cost Index
FDA Food and Drug Administration
FIPS Federal Information Processing Standards
FQHC Federally qualified health center
FTE Full-time equivalent
FY Federal fiscal year
GAAP Generally accepted accounting principles
GAF Geographic adjustment factor
HIC Health Insurance Card
HIS Health Information System
GME Graduate medical education
HCRIS Hospital Cost Report Information System
HIPC Health Information Policy Council
HIPAA Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191
HHA Home health agency
HHS Department of Health and Human Services
HPSA Health Professions Shortage Area
HQA Hospital Quality Alliance
ICD–9–CM International Classification of Diseases, Ninth Revision, Clinical Modification
ICD–10–PCS International Classification of Diseases, Tenth Edition, Procedure Coding System
ICF/MRs Intermediate care facilities for the mentally retarded
ICU Intensive Care Unit
IHS Indian Health Service
IME Indirect medical education
IPPS Acute care hospital inpatient prospective payment system
IPF Inpatient psychiatric facility
IRF Inpatient rehabilitation facility
IRP Initial residency period
JCAHO Joint Commission on Accreditation of Healthcare Organizations
LAMCs Large area metropolitan counties
LTC–DRG Long-term care diagnosis-related group
LTCH Long-term care hospital
MCE Medicare Code Editor
MCO Managed care organization
MDC Major diagnostic category
MDH Medicare-dependent small rural hospital
MedPAC Medicare Payment Advisory Commission
MedPAR Medicare Provider Analysis and Review File
MEI Medicare Economic Index
MGCRB Medicare Geographic Classification Review Board
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173
MRHFP Medicare Rural Hospital Flexibility Program
MSA Metropolitan Statistical Area
NAICS North American Industrial Classification System
NCD National coverage determination
NCHS National Center for Health Statistics
NCVHS National Committee on Vital and Health Statistics
NECMA New England County Metropolitan Areas
NICU Neonatal intensive care unit
NQF National Quality Forum
NTIS National Technical Information Service
NVHRI National Voluntary Hospital Reporting Initiative
OES Occupational Employment Statistics
OIG Office of the Inspector General
OMB Executive Office of Management and Budget
O.R. Operating room
OSCAR Online Survey Certification and Reporting (System)
OSHA Occupational Safety and Health Act
PRM Provider Reimbursement Manual
PPI Producer Price Index
PMS Performance Measurement System
PMSAs Primary Metropolitan Statistical Areas
PPS Prospective payment system
PRA Per resident amount
ProPAC Prospective Payment Assessment Commission
PRRB Provider Reimbursement Review Board
PS&R Provider Statistical and Reimbursement System
QIA Quality Improvement Organizations
RHC Rural health clinic
RHQDAPU Reporting Hospital Quality Data for Annual Payment Update
RNHCI Religious nonmedical health care institution
RRC Rural referral center
RUCAs Rural-Urban Commuting Area Codes
SCH Sole community hospital
SDP Single Drug Pricer
SIC Standard Industrial Codes
SNF Skilled nursing facility
SOCs Standard occupational classifications
SOM State Operations Manual
SSA Social Security Administration
SSI Supplemental Security Income
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, 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 or medical services that have been approved for special add-on payments. To qualify, a new technology or medical service must demonstrate that it is a substantial clinical improvement over technologies or services otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment.

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

Although payments to most hospitals under the IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid the higher of a hospital-specific rate based on their costs in a base year (the higher of FY 1982, FY 1987, or FY 1996) or the IPPS rate based on the standardized amount. For example, sole community hospitals (SCHs) are the sole source of care in their areas, and Medicare-dependent, small rural hospitals (MDHs) are a major source of care for Medicare beneficiaries in their areas. Both of these categories of hospitals are afforded this special payment protection in order to maintain access to services for beneficiaries. (An MDH receives only 50 percent of the difference between the IPPS rate and its hospital-specific rates if the hospital-specific rate is higher than the IPPS rate. In addition, an MDH does not have the option of using FY 1996 as the base year for its hospital-specific rate.)

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

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

2. Hospitals and Hospital Units Excluded From the IPPS

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

The existing regulations governing payments to excluded hospitals and hospital units are located in 42 CFR Parts 412 and 413.

a. IRFs

Under section 1886(j) of the Act, as amended, rehabilitation hospitals and units (IRFs) have been transitioned from payment based on a blend of reasonable cost reimbursement subject to a hospital-specific annual limit under section 1886(b) of the Act and the adjusted facility Federal prospective payment rate for cost reporting periods beginning January 1, 2002 through September 30, 2002, to payment at 100 percent of the Federal rate effective for cost reporting periods beginning on or after October 1, 2002 (66 FR 41316, August 7, 2001; 67 FR 49982, August 1, 2002; and 68 FR 45674, August 1, 2003). The existing regulations governing payments under the IRF PPS are located in 42 CFR Part 412, Subpart P.

b. LTCHs

Under the authority of sections 123(a) and (c) of Pub. L. 106–113 and section 307(b)(1) of Pub. L. 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 100 percent of the Federal rate 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 100 percent of the Federal rate (May 7, 2004 LTCH PPS final rule (69 FR 25674)). LTCHs may elect to be paid based on 100 percent of the Federal rate instead of a blended payment in any year during the 5-year transition period. The existing regulations governing payment under the LTCH PPS are located in 42 CFR Part 412, Subpart O.

c. IPFs

Under the authority of sections 124(a) and (c) of Pub. L. 106–113, inpatient psychiatric facilities (IPFs) (formerly psychiatric hospitals and psychiatric units of acute care hospitals) are paid under the new IPF PPS. Under the IPF PPS, some IPFs are transitioning from being paid for inpatient hospital services based on a blend of reasonable cost-based payment and a Federal per diem payment rate, effective for cost reporting periods beginning on or after January 1, 2005 (November 15, 2004 IPF PPS final rule (69 FR 66921)). For cost reporting periods beginning on or after July 1, 2008, IPFs will be paid 100 percent of the Federal per diem payment amount. The existing regulations governing payment under the IPF PPS are located in 42 CFR part 412, subpart N.

3. Critical Access Hospitals (CAHs)

Under sections 1814, 1820, and 1834(g) of the Act, payments are made to critical access hospitals (CAHs) (that is, rural hospitals or facilities that meet certain statutory requirements) for inpatient and outpatient services based

on 101 percent of reasonable cost. Reasonable cost is determined under the provisions of section 1861(v)(1)(A) of the Act and existing regulations under 42 CFR Parts 413 and 415.

4. Payments for Graduate Medical Education (GME)

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

On August 11, 2004, we published a final rule in the **Federal Register** (69 FR 48916) that implemented changes to the Medicare hospital inpatient prospective payment systems for both operating cost and capital-related costs, as well as changes addressing payments for excluded hospitals and payments for GME costs. Generally these changes were effective for discharges occurring on or after October 1, 2004. On October 7, 2004, we published a document in the **Federal Register** (69 FR 60242) that corrected technical errors made in the August 11, 2004 final rule. On December 30, 2004, we published another document in the **Federal Register** (69 FR 78525) that further corrected the August 11, 2004 final rule and the October 7, 2004 correction to that rule, effective January 1, 2005.

B. Major Contents of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare IPPS for operating costs and for capital-related costs in FY 2006. We also are setting forth proposed changes relating to payments for GME costs, payments to certain hospitals and units that continue to be excluded from the IPPS and paid on a reasonable cost basis, payments for DSHs, and requirements and payments for CAHs. The changes being proposed would be effective for discharges occurring on or after October 1, 2005, unless otherwise noted.

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

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

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

The major DRG classification changes we are proposing include:

- Reassigning procedure code 35.52 (Repair of atrial septal defect with prosthesis, closed technique) from DRG 108 to DRG 518 (Percutaneous Cardiovascular Procedure Without Coronary Artery Stent or AMI);
- Reassigning procedure code 37.26 (Cardiac electrophysiologic stimulation and recording studies) from DRGs 535 and 536 to DRGs 515 (Cardiac Defibrillator Implant Without Cardiac Catheterization);
- Splitting DRG 209 into two new DRGs based on the presence or absence of the procedure codes for major joint replacement or reattachment of lower extremity and revision of hip or knee replacement, DRG 545 (Revision of Hip or Knee Replacement) and DRG 544 (Major Joint Replacement or Reattachment of Lower Extremity);
- Reassigning procedure code 26.12 (Open biopsy of salivary gland or duct) from DRG 468 to DRG 477 (Nonextensive O.R. Procedure Unrelated To Principal Diagnosis);
- Reassigning the principal diagnosis codes for curvature of the spine or malignancy from DRGs 497 and 498 to proposed new DRG 546 (Spinal Fusion Except Cervical with PDX of Curvature of the Spine or Malignancy);
- Splitting DRGs 516 and 526 into four new DRGs based on the presence or absence of a CC;
- Reassigning procedure code 39.65 (Extracorporeal membrane oxygenation [ECMO]) from DRGs 104 and 105 to DRG 541 (ECMO or Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses With Major Operating Room Procedure).

We also are presenting our reevaluation of certain FY 2005 applicants for add-on payments for high-cost new medical services and technologies, and our analysis of FY 2006 applicants (including public input, as directed by Pub. L. 108–173, obtained in a town hall meeting).

We are proposing the annual update of the long-term care diagnosis-related group (LTC–DRG) classifications and relative weights for use under the LTCH PPS for FY 2006.

2. Proposed Changes to the Hospital Wage Index

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

- The FY 2006 wage index update, using wage data from cost reporting periods that began during FY 2002.
- The proposed occupational mix adjustment to the wage index that we began to apply effective October 1, 2004.
- The proposed revisions to the wage index based on hospital redesignations and reclassifications.
- The proposed adjustment to the wage index for FY 2006 based on commuting patterns of hospital employees who reside in a county and work in a different area with a higher wage index.
- The timetable for reviewing and verifying the wage data that will be in effect for the proposed FY 2006 wage index.

3. Proposed Revision and Rebasing of the Hospital Market Baskets

In section IV. of this proposed rule, we are proposing rebasing and revising the hospital operating and capital market baskets to be used in developing the FY 2006 update factor for the operating prospective payment rates and the excluded hospital market basket to be used in developing the FY 2006 update factor for the excluded hospital rate-of-increase limits. We are also setting forth the data sources used to determine the revised market basket relative weights and choice of price proxies.

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

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

- Solicitation of public comments on two options for possible expansion of the current postacute care transfer policy.
- The reporting of hospital quality data as a condition for receiving the full annual payment update increase.
- Proposed changes in the payment adjustment for low-volume hospitals.
- Proposed IME adjustment for TEFRA hospitals that are converting to IPPS hospitals, and IME FTE resident caps for urban hospitals that are granted

rural reclassification and then withdraw that rural classification.

- Proposed changes to implement section 951 of Pub. L. 108–173 relating to the provision of patient stay/SSI days data maintained by CMS to hospitals for the purpose of determining their DSH percentage.
- Proposed changes relating to hospitals' geographic classifications, including multicampus hospitals and urban group hospital reclassifications.
- Proposed changes and clarifications relating to GME, including GME initial residency period limitation, new teaching hospitals' participation in Medicare GME affiliated groups, and the GME FTE cap adjustment for rural hospitals;
- Solicitation of public comments on possible changes in requirements for provider-based entities relating to entities the location requirements for certain neonatal intensive care units as off-campus facilities;
- Discussion of the second year of implementation of the Rural Community Hospital Demonstration Program; and
- Clarification of the definition of a hospital as it relates to "specialty hospitals'' participating in the Medicare program.

5. PPS for Capital-Related Costs

In section VI. of this proposed rule, we are not proposing any policy changes to the capital-related prospective payment system. For the readers' benefit, we discuss the payment policy requirements for capital-related costs and capital payments to hospitals.

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

In section VII. of this proposed rule, we discuss the proposed revisions and clarifications concerning excluded hospitals and hospital units, proposed policy changes relating to continued participation by CAHs located in counties redesignated under section 1886(d)(8)(B) of the Act (Lugar counties), and proposed policy changes relating to designation of CAHs as necessary providers.

7. Proposed Changes in Payment for Blood Clotting Factor

In section VIII of this proposed rule, we discuss the proposed change in payment for blood clotting factor administered to inpatients with hemophilia for FY 2006.

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

In the Addendum to this proposed rule, we set forth proposed changes to the amounts and factors for determining the FY 2006 prospective payment rates for operating costs and capital-related costs. We also establish the proposed threshold amounts for outlier cases. In addition, we address the proposed update factors for determining the rate-of-increase limits for cost reporting periods beginning in FY 2006 for hospitals and hospital units excluded from the PPS.

9. Impact Analysis

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

10. Recommendation of Update Factor for Hospital Inpatient Operating Costs

In Appendix B of this proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we provided our recommendations of the appropriate percentage changes for FY 2006 for the following:

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

11. Discussion of Medicare Payment Advisory Commission Recommendations

Under section 1805(b) of the Act, the Medicare Payment Advisory Commission (MedPAC) is required to submit a report to Congress, no later than March 1 of each year, in which MedPAC reviews and makes recommendations on Medicare payment policies. MedPAC's March 2005 recommendation concerning hospital inpatient payment policies addressed only the update factor for inpatient hospital operating costs and capital-related costs under the IPPS and for hospitals and distinct part hospital units excluded from the IPPS. This recommendation is addressed in Appendix B of this proposed rule. MedPAC issued a second Report to Congress: Physician-Owned Specialty Hospitals, March 2005, which addressed other issues relating to Medicare payments to hospitals for inpatient services. The recommendations on these issues from this second report are addressed in section IX. of this preamble. For further information relating specifically to the MedPAC March 2005 reports or to obtain a copy of the reports, contact MedPAC at (202) 220–3700 or visit MedPAC's Web site at: *http://www.medpac.gov.*

II. Proposed Changes to DRG Classifications and Relative Weights

A. Background

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

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The proposed changes to the DRG classification system and the recalibration of the DRG weights for discharges occurring on or after October 1, 2005, are discussed below.

B. DRG Reclassifications

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

1. General

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

Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM).

The process of forming the DRGs was begun by dividing all possible principal diagnoses into mutually exclusive principal diagnosis areas referred to as Major Diagnostic Categories (MDCs). The MDCs were formed by physician panels as the first step toward ensuring that the DRGs would be clinically coherent. The diagnoses in each MDC correspond to a single organ system or etiology and, in general, are associated with a particular medical specialty. Thus, in order to maintain the requirement of clinical coherence, no final DRG could contain patients in different 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)). For FY 2005, cases are assigned to one of 519 DRGs in 25 MDCs. The table below lists the 25 MDCs.

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

In general, cases are assigned to an MDC based on the patient's principal diagnosis before assignment to a DRG. However, for FY 2005, there are nine DRGs to which cases are directly assigned on the basis of ICD–9–CM procedure codes. These DRGs are for heart transplant or implant of heart assist systems, liver and/or intestinal transplants, bone marrow, lung, simultaneous pancreas/kidney, and pancreas transplants and for tracheostomies. Cases are assigned to these DRGs before they are classified to an MDC. The table below lists the current nine pre-MDCs.

Pre-Major Diagnostic Categories (Pre-MDCs)	
DRG 103	Heart Transplant or Implant of Heart Assist System
DRG 480	Liver Transplant and/or Intestinal Transplant
DRG 481	Bone Marrow Transplant
DRG 482	Tracheostomy for Face, Mouth, and Neck Diagnoses
DRG 495	Lung Transplant
DRG 512	Simultaneous Pancreas/Kidney Transplant
DRG 513	Pancreas Transplant
DRG 541	Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except for Face, Mouth, and Neck Diagnosis with Major Operating Room Procedures
DRG 542	Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except for Face, Mouth, and Neck Diagnosis Without Major Operating Room Procedures

Once the MDCs were defined, each MDC was evaluated to identify those additional patient characteristics that would have a consistent effect on the consumption of hospital resources. Since the presence of a surgical procedure that required the use of the operating room would have a significant effect on the type of hospital resources used by a patient, most MDCs were initially divided into surgical DRGs and medical DRGs. Surgical DRGs are based on a hierarchy that orders operating room (O.R.) procedures or groups of O.R. procedures by resource intensity. Medical DRGs generally are differentiated on the basis of diagnosis and age (less than or greater than 17 years of age). Some surgical and medical DRGs are further differentiated based on the presence or absence of a complication or a comorbidity (CC).

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

Once the medical and surgical classes for an MDC were formed, each class of patients was evaluated to determine if complications, comorbidities, or the patient's age would consistently affect the consumption of hospital resources. Physician panels classified each diagnosis code based on whether the diagnosis, when present as a secondary condition, would be considered a substantial complication or comorbidity.

A substantial complication or comorbidity was defined as a condition, which because of its presence with a specific principal diagnosis, would cause an increase in the length of stay by at least one day in at least 75 percent of the patients. Each medical and surgical class within an MDC was tested to determine if the presence of any substantial comorbidities or complications would consistently affect the consumption of hospital resources.

The actual process of forming the DRGs was, and continues to be, highly iterative, involving a combination of statistical results from test data combined with clinical judgment. In deciding whether to create a separate DRG, we consider whether the resource consumption and clinical characteristics of the patients with a given set of conditions are significantly different than the remaining patients in the DRG. We evaluate patient care costs using average charges and length of stay as proxies for costs and rely on the judgment of our medical officers to decide whether patients are distinct or clinically similar to other patients in the DRG. In evaluating resource costs, we consider both the absolute and percentage differences in average charges between the cases we are selecting for review and the remainder of cases in the DRG. We also consider variation in charges within these groups; that is, whether observed average differences are consistent across patients or attributable to cases that are extreme in terms of charges or length of stay, or both. Further, we also consider the number of patients who will have a given set of characteristics and generally prefer not to create a new DRG unless it will include a substantial number of cases. As we explain in more detail in section IX. of this preamble, MedPAC has made a number of recommendations regarding the DRG system. As part of our review and analysis of MedPAC's recommendations, we will consider whether to establish guidelines for making DRG reclassification decisions.

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

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

After cases are screened through the MCE and assigned to a DRG by the GROUPER, the PRICER software calculates a base DRG payment. The PRICER calculates the payments for each case covered by the IPPS based on the DRG relative weight and additional factors associated with each hospital, such as IME and DSH adjustments. These additional factors increase the payment amount to hospitals above the base DRG payment.

The records for all Medicare hospital inpatient discharges are maintained in the Medicare Provider Analysis and

Review (MedPAR) file. The data in this file are used to evaluate possible DRG classification changes and to recalibrate the DRG weights. However, in the July 30, 1999 IPPS final rule (64 FR 41500), we discussed a process for considering non-MedPAR data in the recalibration process. In order for us to consider using particular non-MedPAR data, we must have sufficient time to evaluate and test the data. The time necessary to do so depends upon the nature and quality of the non-MedPAR data submitted. Generally, however, a significant sample of the non-MedPAR data should be submitted by mid-October for consideration in conjunction with the next year's proposed rule. This allows us time to test the data and make a preliminary assessment as to the feasibility of using the data. Subsequently, a complete database should be submitted by early December for consideration in conjunction with the next year's proposed rule.

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

The changes we are proposing to the DRG classification system for FY 2006 for the FY 2006 GROUPER, version 23.0 and to the methodology used to recalibrate the DRG weights are set forth below. Unless otherwise noted in this proposed rule, our DRG analysis is based on data from the December 2004 update of the FY 2004 MedPAR file, which contains hospital bills received through December 31, 2004 for discharges in FY 2004.

2. Pre-MDC: Intestinal Transplantation

In the FY 2005 IPPS final rule (69 FR 48976), we moved intestinal transplantation cases that were assigned to ICD–9–CM procedure code 46.97 (Transplant of intestine) out of DRG 148 (Major Small and Large Bowel Procedures with CC) and DRG 149 (Major Small and Large Bowel Procedures Without CC) and into DRG 480 (Liver Transplant). We also changed the title for DRG 480 to "Liver Transplant and/or Intestinal Transplant.'' We moved these cases out of DRGs 148 and 149 because our analysis demonstrated that the average charges for intestinal transplants are significantly higher than the average charges for other cases in these DRGs. We stated at that time that we would continue to monitor these cases.

Based on our review of the FY 2004 MedPAR data, we found 959 cases assigned to DRG 480 with overall average charges of approximately $165,622. There were only three cases involving an intestinal transplant alone and one case in which both an intestinal transplant and a liver transplant were performed. The average charges for the intestinal transplant cases ($138,922) were comparable to the average charges for the liver transplant cases ($165,314), while the remaining combination of an intestinal transplant and a liver transplant case had much higher charges ($539,841), and would be paid as an outlier case. Therefore, we are not proposing any DRG modification for intestinal transplantation cases at this time.

We note that an institution that performs intestinal transplantation, in correspondence to us written following the publication of the FY 2005 IPPS final rule, agreed with our decision to move cases assigned to code 46.97 to DRG 480.

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

a. Strokes

In 1996, the Food and Drug Administration (FDA) approved the use of tissue plasminogen activator (tPA), one type of thrombolytic agent that dissolves blood clots. In 1998, the ICD–9–CM Coordination and Maintenance Committee created code 99.10 (Injection or infusion of thrombolytic agent) in order to be able to uniquely identify the administration of thrombolytic agents. Studies have shown that tPA can be effective in reducing the amount of damage the brain sustains during an ischemic stroke, which is caused by blood clots that block blood flow to the brain. The use of tPA is approved for patients who have blood clots in the brain, but not for patients who have a bleeding or hemorrhagic stroke. Thrombolytic therapy has been shown to be most effective when used within the first 3 hours after the onset of a stroke, and it is contraindicated in hemorrhagic stroke. The presence or absence of code 99.10 does not currently influence DRG assignment. Since code 99.10 became effective, we have been monitoring the DRGs and cases in which this code can be found, particularly with respect to cardiac and stroke DRGs.

Last year, we met with representatives from several hospital stroke centers who recommended modification of the existing stroke DRGs 14 (Intracranial Hemorrhage or Cerebral Infarction) and 15 (Nonspecific CVA and Precerebral Occlusion Without Infarction) by using the administration of tPA as a proxy to identify patients who have severe strokes. The representatives stated that using tPA as a proxy for the more severely ill stroke patient would recognize the higher charges these cases generate because of their higher hospital resource utilization.

The stroke representatives made two suggestions concerning DRGs 14 and 15. First, they proposed modifying DRG 14 by renaming it "Ischemic Stroke Treatment with a Reperfusion Agent,'' and including only those cases containing code 99.10. The remainder of stroke cases where the patient was not treated with a reperfusion agent would be included in DRG 15, which would be renamed "Hemorrhagic Stroke or Ischemic Stroke without a Reperfusion Agent.'' Hemorrhagic stroke cases now found in DRG 14 that are not treated with a reperfusion agent would migrate to DRG 15.

The second suggestion was to leave DRGs 14 and 15 as they currently exist, and create a new DRG, with a recommended title "Ischemic Stroke Treatment with a Reperfusion Agent.'' This suggested DRG would only include strokes caused by clots, not by hemorrhages, and would include the administration of tPA, identified by procedure code 99.10.

We have examined the MedPAR data for the cases in DRGs 14 and 15, and have divided the cases based on the presence of a principal diagnosis of hemorrhage or occlusive ischemia, and the presence of procedure code 99.10. The following table displays the results:

DRG	Count	Average Length of Stay	Average Charges
14 - All Cases	221,879	5.67	$18,997
14 - Cases with intracranial hemorrhage	41,506	5.40	$19,193
14 - Cases with intracranial hemorrhage with code 99.10	61	7.4	$37,045
14 - Cases with intracranial hemorrhage without code 99.10	41,445	5.3	$19,167
14 - Cases without intracranial hemorrhage	180,373	5.74	$18,952
14 - Cases without intracranial hemorrhage with code 99.10	2,085	7.20	$35,128
14 - Cases without intracranial hemorrhage without code 99.10	178,288	5.72	$18,763
15 - All cases	71,335	4.53	$14,382
15 - Cases with intracranial hemorrhage	0	0	0
15 - Cases without intracranial hemorrhage	71,335	4.53	$14,382
15 - Cases without intracranial hemorrhage with code 99.10	302	5.10	$24,876
15 - Cases without intracranial hemorrhage without code 99.10	71,033	4.53	$14,337

The above table shows that the average standardized charges for cases treated with a reperfusion agent are more than $16,000 and $10,000 higher than all other cases in DRGs 14 and 15, respectively. While these data suggest that patients treated with a reperfusion agent are more expensive than all other stroke patients, this conclusion is based on a small number of cases. At this time, we are not proposing a change to the stroke DRGs because of this concern. However, we believe it is possible that more patients are being treated with a reperfusion agent than indicated by our data because the presence of code 99.10 does not affect DRG assignment and may be underreported.

We invite public comment on the changes to DRGs 14 and 15 suggested by the hospital representatives. In addition, we are interested in public comment on the number of patients currently being treated with a reperfusion agent as well as the potential costs of these patients relative to others with strokes that are also included in DRGs 14 and 15.

b. Unruptured Cerebral Aneurysms

In the FY 2004 IPPS final rule (68 FR 45353), we created DRG 528 (Intracranial Vascular Procedures With a Principal Diagnosis of Hemorrhage) in MDC 1. We received a comment at that time that suggested we create another DRG for intracranial vascular procedures for unruptured cerebral aneurysms. For the FY 2004 IPPS final rule (68 FR 45353) and the FY 2005 IPPS final rule (69 FR 48957), we evaluated the data for cases in the MedPAR file involving unruptured cerebral aneurysms assigned to DRG 1 (Craniotomy Age >17 With CC) and DRG 2 (Craniotomy Age >17 Without CC) and concluded that the average charges were consistent with those for other cases found in DRGs 1 and 2. Therefore, we did not propose a change to the DRG assignment for unruptured cerebral aneurysms.

We have reviewed the latest data for unruptured cerebral aneurysms cases. In our analysis of the FY 2004 MedPAR data, we found 1,136 unruptured cerebral aneurysm cases assigned to DRG 1 and 964 unruptured cerebral aneurysm cases assigned to DRG 2. Although the average charges for the unruptured cerebral aneurysm cases in DRG 1 ($53,455) and DRG 2 ($34,028) were slightly higher than the average charges for all cases in DRG 1 ($51,466) and DRG 2 ($30,346), we do not believe these differences are significant enough to warrant a change in these two DRGs at this time. Therefore, we are not proposing a change in the structure of these DRGs relating to unruptured cerebral aneurysm cases for FY 2006.

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

a. Automatic Implantable Cardioverter/Defibrillator

As part of our annual review of DRGs, for FY 2006, we performed a review of cases in the FY 2004 MedPAR file involving the implantation of a defibrillator in the following DRGs:

DRG 515 (Cardiac Defibrillator Implant Without Cardiac Catheterization).

DRG 535 (Cardiac Defibrillator Implant With Cardiac Catheterization With Acute Myocardial Infarction, Heart Failure, or Shock).

DRG 536 (Cardiac Defibrillator Implant With Cardiac Catheterization Without Acute Myocardial Infarction, Heart Failure, or Shock).

While conducting our review, we noted that there had been considerable comments from hospital coders on code 37.26 (Cardiac electrophysiologic stimulation and recording studies (EPS)), which is included in these DRGs. These comments from hospital coders were directed at both CMS and the American Hospital Association. The procedure codes for these three DRGs describe the procedures that are considered to be a cardiac catheterization. Code 37.26 is classified as a cardiac catheterization within these DRGs. Therefore, the submission of code

37.26 affects the DRG assignment for defibrillator cases and leads to the assignment of DRGs 535 or 536. When a cardiac catheterization is performed, the case is assigned to DRGs 535 or 536, depending on whether or not the patient also had an acute myocardial infarction, heart failure, or shock. The following chart shows the number of cases in each DRG, along with their average length of stay and average charges, found in the data:

DRG	Number of Cases	Average Length of Stay	Average Charges
515	25,236	4.32	$83,659.76
535	12,118	8.27	$113,175.43
536	18,305	5.39	$94,453.62

We have received a number of questions from hospital coders regarding the correct use of code 37.26. There is considerable confusion about whether or not code 37.26 should be reported when the procedure is performed as part of the defibrillator implantation. Currently, the ICD–9–CM instructs the coder not to report code 37.26 when a defibrillator is inserted. There is an inclusion term under the defibrillator code 37.94 (Implantation or replacement of automatic cardioverter/defibrillator, total system [AICD]) which states that EPS is included in code 37.94. We discussed modifying this instruction at the October 7–8, 2004 meeting of the ICD–9–CM Coordination and Maintenance Committee. We received a number of comments opposing a modification to the use of code 37.26 to also allow it to be reported with an AICD insertion. A report of this meeting can be found on the Web site: *http://www.cms.hhs.gov/paymentsystem/icd9.*

We performed an analysis of cases within DRGs 535 and 536 with cardiac catheterization and with and without code 37.26 and with code 37.26 only reported without cardiac catheterization and found the following:

DRG	Number of Cases	Average Length of Stay	Average Charges
535 - Cardiac Catheterization Without Code 37.26	5,060	10.63	$127,130.79
535 - With Code 37.26 Only Without Cardiac Catheterization	5,264	5.61	$98,900.13
535 - With Cardiac Catheterization and Code 37.26	1,794	9.44	$115,701.09
536 - Cardiac Catheterization Without Code 37.26	4,799	8.11	$110,493.86
536 - With Code 37.26 Only Without Cardiac Catheterization	10,829	3.85	$85,390.88
536 - With Cardiac Catheterization and Code 37.26	2,677	6.76	$102,359.21

The data show that when code 37.26 is the only procedure reported from the list of cardiac catheterizations, the average charges and the average length of stay are considerably lower. For example, the average standardized charges for a defibrillator implant with only an EPS are $85,390.88 in DRG 536, while the average standardized charges for DRG 536 with a cardiac catheterization, but not an EPS, are $110,493.86. The average standardized charges for all cases in DRG 536 are $94,453.62. The data show similar findings for DRG 535, with lower lengths of stay and average charges when the only code reported from the cardiac catheterization list is an EPS. When we also consider that there may be some coding problems in the use of code 37.26, we believe it is appropriate to propose a modification to these DRGs.

Data reflected in the chart above show that the average standardized charges for DRG 515 were $83,659.76. These average charges are closer to those in DRG 536 with code 37.26 and without any other cardiac catheterization code reported. While the cases in DRG 535 with code 37.26 and without a cardiac catheterization have higher average charges than the average charges for cases in DRG 515, these cases have much lower average charges than the average charges for overall cases in DRG 535. For these reasons, we are proposing to remove code 37.26 from the list of cardiac catheterizations for DRGs 535 and 536. If a defibrillator is implanted and an EPS is performed with no other type of cardiac catheterization, the case would be assigned to DRG 515.

CMS issued a National Coverage Determination for implantable cardioverter defibrillators, effective January 27, 2005, that expands coverage and requires, in certain cases, that patient data be reported when the defibrillator is implanted for the clinical indication of primary prevention of sudden cardiac death. The submission of data on patients receiving an implantable cardioverter defibrillator for primary prevention to a data collection system is needed for the determination that the implantable cardioverter

defibrillator is reasonable and necessary and for quality improvement. These data will be made available in some form to providers and practitioners to inform their decisions, monitor performance quality, and benchmark and identify best practices. We made a temporary registry available for use when the policy became effective and used the Quality Net Exchange for data submission because Medicare-participating hospitals already use the Exchange to report data.

We intend to transition from the temporary registry using the Quality Net Exchange to a more sophisticated follow-on registry that will have the ability to collect longitudinal data. Some providers have suggested that CMS increase reimbursement for implantable cardioverter defibrillators to compensate the provider for reporting data. ICD data reporting includes elements of patient demographics, clinical characteristics and indications, medications, provider information, and complications. Since these data elements are commonly found in patient medical records, it is CMS' expectation that these data are readily available to the individuals abstracting and reporting data. Therefore, we believe that increased reimbursement is not needed at this time.

b. Coronary Artery Stents

In the FY 2005 IPPS final rule (69 FR 48971 through 48974), we addressed two comments from industry representatives about the DRG assignments for coronary artery stents. These commenters had expressed concern about whether the reimbursement for stents is adequate, especially for insertion of multiple stents. They also expressed concern about whether the current DRG structure represents the most clinically coherent classification of stent cases.

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

- DRG 516 (Percutaneous Cardiovascular Procedures with AMI).
- DRG 517 (Percutaneous Cardiovascular Procedures with Nondrug-Eluting Stent without AMI).
- DRG 526 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent with AMI).
- DRG 527 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent without AMI).

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

In our response to comments in the FY 2005 IPPS final rule, we indicated that it was premature to act on this recommendation because the current coding structure for coronary artery stents cannot distinguish cases in which multiple stents are inserted from those in which only a single stent is inserted. Current codes are able to identify performance of PTCA in more than one vessel by use of code 36.05. However, while this code indicates that PTCA was performed in more than one vessel, its use does not reflect the exact number of procedures performed or the exact number of vessels treated. Similarly, when codes 36.06 and 36.07 are used, they document the insertion of at least one stent. However, these stenting codes do not identify how many stents were inserted in a procedure, nor distinguish insertion of a single stent from insertion of multiple stents. Even the use of one of the stenting codes in conjunction with multiple-PTCA code 36.05 does not distinguish insertion of a single stent from multiple stents. The use of code 36.05 in conjunction with code 36.06 or code 36.07 indicates only performance of PTCA in more than one vessel, along with insertion of at least one stent. The precise numbers of PTCA-treated vessels, the number of vessels into which stents were inserted, and the total number of stents inserted in all treated vessels cannot be determined. Therefore, the capabilities of the current coding structure do not permit the distinction between single and multiple vessel stenting that would be required under the recommended restructuring of the coronary stent DRGs.

We agree that the DRG classification of cases involving coronary stents must be clinically coherent and provide for adequate reimbursement, including those cases requiring multiple stents. For this reason, we created four new ICD–9–CM codes identifying multiple stent insertion (codes 00.45, 00.46, 00.47, and 00.48) and four new codes identifying multiple vessel treatment (codes 00.40, 00.41, 00.42, and 00.43) at the October 7, 2004 ICD–9–CM Coordination and Maintenance Committee Meeting. These eight new codes can be found in Table 6B of this proposed rule. We have worked closely with the coronary stent industry and the clinical community to identify the most logical code structure to identify new codes for both multiple vessel and multiple stent use. Effective October 1, 2005, code 36.05 will be deleted and the eight new codes will be used in its place. Coders are encouraged to use as many codes as necessary to describe each case, using one code to describe the angioplasty or atherectomy, and one code each for the number of vessels treated and the number of stents inserted. Coders are encouraged to record codes accurately, as these data will potentially be the basis for future DRG restructuring. While we agree that use of multiple vessel and stent codes will provide useful information in the future on hospital costs associated with percutaneous coronary procedures, we believe it remains premature to proceed with a restructuring of the current coronary stent DRGs on the basis of the number of vessels treated or the number of stents inserted, or both, in the absence of data reflecting use of this new coding structure.

The commenter's second recommendation was that we distinguish "complex'' from "noncomplex'' cases in the stent DRGs by expanding the higher weighted DRGs (516 and 526) to include conditions other than AMI. The commenter recommended recognizing certain comorbid and complicating conditions, including hypertensive renal failure, congestive heart failure, diabetes, arteriosclerotic cardiovascular disease, cerebrovascular disease, and certain procedures such as multiple vessel angioplasty or atherectomy (as evidenced by the presence of procedure code 36.05), as indicators of complex cases for this purpose. Specifically, the commenters recommended replacing the current structure with the following four DRGs:

- Recommended restructured DRG 516 (Complex percutaneous

cardiovascular procedures with non-drug-eluting stents).

• Recommended restructured DRG 517 (Noncomplex percutaneous cardiovascular procedures with non-drug-eluting stents).

• Recommended restructured DRG 526 (Complex percutaneous cardiovascular procedures with drug-eluting stents).

• Recommended restructured DRG 527 (Noncomplex percutaneous cardiovascular procedures with drug-eluting stents).

The commenter argued that this structure would provide an improvement in both clinical and resource coherence over the current structure that classifies cases according to the type of stent inserted and the presence or absence of AMI alone, without considering other complicating conditions. The commenter also presented an analysis, based on previous MedPAR data, that evaluated charges and lengths of stay for cases with expected high resource use and reclassified cases into its recommended new structure of paired "complex'' and "noncomplex'' DRGs. The commenter's analysis showed some evidence of clinical and resource coherence in the recommended DRG structure. However, we did not adopt the proposal in the FY 2005 IPPS final rule. First, the data presented by the commenter still represented preliminary experience under a relatively new DRG structure. Second, the analysis did not reveal significant gains in resource coherence compared to existing DRGs for stenting cases. Therefore, we were reluctant to adopt this approach because of comments and concern about whether the overall level of payment in the coronary stent DRGs was adequate. However, we indicated that this issue deserved further study and consideration, and that we would conduct an analysis of this recommendation and other approaches to restructuring these DRGs with updated data in the FY 2006 proposed rule.

This year, we have analyzed the MedPAR data to determine the impact of certain secondary diagnoses or complicating conditions on the four DRGs cited above. Specifically, we examined the data in DRGs 516, 517, 526, and 527, based on the presence of coronary stents (codes 36.06 and 36.07) and the following additional diagnoses:

• Congestive heart failure (represented by codes 398.91 (Rheumatic heart failure (congestive)), 402.01 (Hypertensive heart disease, malignant, with heart failure), 402.11, (Hypertensive heart disease, benign, with heart failure), 402.91 (Hypertensive heart disease, unspecified, with heart failure), 404.01 (Hypertensive heart and renal disease, malignant, with heart failure), 404.03 (Hypertensive heart and renal disease, malignant, with heart failure and renal failure), 404.11 (Hypertensive heart and renal disease, benign, with heart failure), 404.13 (Hypertensive heart and renal disease, benign, with heart failure and renal failure), 404.91 (Hypertensive heart and renal disease, unspecified, with heart failure), 404.93 (Hypertensive heart and renal disease, unspecified, with heart failure and renal failure), 428.0 (Congestive heart failure, unspecified), and 428.1 (Left heart failure)).

• Arteriosclerotic cardiovascular disease (represented by code 429.2 (Cardiovascular disease, unspecified)).

• Cerebrovascular disease (represented by codes 430.0 (Subarachnoid hemorrhage), 431.0 (Intracerebral hemorrhage), 432.0 (Nontraumatic extradural hemorrhage), 432.1, Subdural hemorrhage, 432.9, (Unspecified intracranial hemorrhage), 433.01 (Occlusion and stenosis of basilar artery, with cerebral infarction), 433.11 (Occlusion and stenosis of carotid artery, with cerebral infarction), 433.21 (Occlusion and stenosis of vertebral artery, with cerebral infarction), 433.31 (Occlusion and stenosis of multiple and bilateral precerebral arteries, with cerebral infarction), 433.81 (Occlusion and stenosis of other specified precerebral artery, with cerebral infarction), 434.01 (Cerebral thrombosis with cerebral infarction), 434.11 (Cerebral embolism with cerebral infarction), 434.91 (Cerebral artery occlusion with cerebral infarction, unspecified), 436.0 (Acute, but ill-defined, cerebrovascular disease)).

• Secondary diagnosis of acute myocardial infarction (represented by codes 410.01 (Acute myocardial infarction of anterolateral wall, initial episode of care), 410.11 (Acute myocardial infarction of other anterior wall, initial episode of care), 410.21 (Acute myocardial infarction of inferolateral wall, initial episode of care), 410.31 (Acute myocardial infarction of inferoposterior wall, initial episode of care), 410.41 (Acute myocardial infarction of other inferior wall, initial episode of care), 410.51 (Acute myocardial infarction of other lateral wall, initial episode of care), 410.61 (True posterior wall infarction, initial episode of care), 410.71 (Subendocardial infarction, initial episode of care), 410.81 (Acute myocardial infarction of other specified sites, initial episode of care), 410.91 (Acute myocardial infarction of unspecified site, initial episode of care)).

• Renal failure (represented by codes 403.01 (Hypertensive renal disease, malignant, with renal failure), 403.11 (Hypertensive renal disease, benign, with renal failure), 403.91 (Hypertensive renal disease, unspecified, with renal failure), 585.0 (Chronic renal failure), V42.0 (Organ or tissue replaced by transplant, kidney), V45.1 (Renal dialysis status), V56.0 (Extracorporeal dialysis), V56.1 (Fitting and adjustment of extracorporeal dialysis catheter), V56.2 (Fitting and adjustment of peritoneal dialysis catheter)). Any renal failure with congestive heart failure will be captured in the 404.xx codes listed above.

We reviewed the cases in the four coronary stent DRGs and found that most of the additional or "complicated'' cases did, in fact, have higher average charges in most instances. However, these results could potentially be duplicated for many DRGs, or sets of DRGs, within the PPS structure. That is, cases with selected complicating factors will tend to have higher average lengths of stay and average charges than cases without those complicating factors. Since cases with the selected complicating factors necessarily contain sicker patients, longer lengths of stay and higher average charges are to be expected. For example, cases in which patients with a cardiac condition also have renal failure are quite likely to consume higher resources than patients only with a cardiac condition. In addition, selectively recognizing the recommended secondary diagnoses or complicating conditions raises some issues related to the logic and structural integrity of the DRG system. Generally, we have taken into account the higher costs of cases with complications by maintaining a general list of comorbidities and complications (the CC) list), and, where appropriate, distinguishing pairs of DRGs by "with and without CCs.'' (This system also specifies exclusions from each pair, to account for cases where a condition on the CC list is an expected and normal constituent of the diagnoses reflected in the paired DRGs.) In order to maintain the basic DRG body-system structure, we have not employed special lists of procedures and diagnoses from one MDC to make determinations about the structure of DRGs in another MDC. The recommended restructuring of the coronary stent DRGs is inconsistent with this principle and may create a new precedent of selecting specific comorbidities and complications to restructure DRGs. For example, the

presence of code 403.11 (Hypertensive renal disease, malignant, with renal failure) may distinguish cases with higher average charges, but the same argument could be raised for many other procedures across other MDCs.

Rather than establishing such a precedent, we are proposing to restructure the coronary stent DRGs on the basis of the standard CC list to differentiate cases that require greater resources. We believe this list to be more inclusive of true comorbid or complicating conditions than selection of specific secondary diagnosis codes. Therefore, restructuring these DRGs on this basis would result in a logical arrangement of cases with regard to both clinical coherence and resource consumption. We have compared the existing CC list with the list of the codes recommended by the commenter as secondary diagnoses. All of the recommended codes already appear on the CC list except for codes 429.2, 432.9, V56.1, and V56.2. Code 429.2 represents a very vague diagnosis (arteriosclerotic cardiovascular disease (ASCVD)). Code 432.9 represents a nonspecific principal diagnosis that is rejected by the MCE when reported as the principal diagnosis. Codes V56.1 and V56.2 describe conditions relating to dialysis for renal failure. Therefore, we believe that our proposal to utilize the existing CC list would encompass most of the cases on the recommended list, as well as other cases with additional CCs requiring additional resources. We have examined the MedPAR data for the cases in the coronary stent DRGs, distinguishing cases that include CCs and those that do not. The following table displays the results:

DRG	Number of Cases	Average Length of Stay	Average Charges
DRG 516 - All Cases	37,325	4.79	$40,278
DRG 516 Cases With CC	25,806	5.5	$43,691
DRG 516 Cases Without CC	11,519	3.0	$32,631
DRG 517 - All Cases	64,022	2.58	$32,145
DRG 517 Cases With CC	50,960	2.8	$33,178
DRG 517 Cases Without CC	13,062	1.5	$28,113
DRG 526 - All Cases	51,431	4.36	$45,924
DRG 526 Cases With CC	32,904	5.2	$49,751
DRG 526 Cases Without CC	18,527	2.8	$39,126
DRG 527 - All Cases	176,956	2.23	$36,087
DRG 527 Cases With CC	137,641	2.4	$37,142
DRG 527 Cases Without CC	39,315	1.3	$32,392

The data show a clear differentiation in average charges between the cases in DRG 516 and 526 "with CC" and those "without CC." Therefore, the data suggest that a "with and without CC" split in DRG 516 and 526 is warranted. At the same time, the data do not show such a clear differentiation, in either average charges or lengths of stay, among the cases in DRGs 517 and 527.

Therefore, we are proposing to delete DRGs 516 and 526, and to substitute four new DRGs in their place. These new DRGs would be patterned after existing DRGs 516 and 526, except that they would be split based on the presence or absence of a secondary diagnosis on the existing CC list. Specifically, we are proposing to create DRG 547 (Percutaneous Cardiovascular Procedure with AMI with CC), DRG 548 (Percutaneous Cardiovascular Procedure with AMI without CC), DRG 549 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with AMI with CC), and DRG 550 (Percutaneous Cardiovascular Procedure with Drug-Eluting Stent with AMI without CC). As we noted above, the MedPAR data do not support restructuring DRGs 517 and 527 based on the presence or absence of a CC. Therefore, we are proposing to retain these two DRGs in their current forms. We believe this revised structure will result in a more inclusive and comprehensive array of cases within MDC 5 without selectively recognizing certain secondary diagnoses as "complex."

While we are proposing some restructuring of the coronary stent DRGs for FY 2006, it is important to note that we will continue to monitor and analyze clinical and resource trends in this area. For example, we have found indications in the current data that treatment may be moving toward use of drug-eluting stents, and away from use of bare metal stents. Specifically, cases in DRGs 516 and 517, which utilize bare metal stents, comprise only 44.4 percent, or less than half, of the cases in the four coronary stent DRGs in the MedPAR data we analyzed. As use of drug-eluting stents becomes the standard of treatment, we may consider over time whether to dispense with the distinction between these stents and the older bare metal stent technology in the structure of the coronary stent DRGs. In addition, we will continue to consider whether the structure of these DRGs ought to reflect differences in the number of vessels treated or the number of stents inserted, or both. As we discussed above, a new coding structure capable of identifying multiple vessel treatment and the insertion of multiple stents will go into effect on October 1, 2005. It remains premature to restructure the coronary stent DRGs on the basis of the number of vessels treated or the number of stents inserted, or both, until data reflecting the use of these new codes become available. However, we will analyze those data when they become available in order to determine whether a restructuring based on multiple vessel treatment or insertion of multiple stents, or both, is warranted. Our proposal to restructure two of the current coronary stent DRGs into paired "with and without CC" DRGs for FY 2006 does not preclude proposals in subsequent years to restructure the coronary stent DRGs in one or both of these ways.

c. Insertion of Left Atrial Appendage Device

Atrial fibrillation is a common heart rhythm disorder that can lead to a cardiovascular blood clot formation leading to increased risk of stroke. According to product literature, nearly all strokes are from embolic clots arising in the left atrial appendage of the heart: an appendage for which there is no useful function. Standard therapy uses anticoagulation drugs. However, these drugs may be contraindicated in certain patients and may cause complications such as bleeding. The underlying concept behind the left atrial appendage device is to block off the left atrial appendage, so that the blood clots formed therein cannot travel to other sites in the vascular system. The device is implanted using a percutaneous catheter procedure under fluoroscopy through the femoral vein. Implantation is performed in a hospital catheterization laboratory using standard transseptal technique, with the patient generally under local anesthesia. The procedure takes approximately 1 hour, and most patients stay overnight in the hospital.

In the FY 2005 IPPS final rule (69 FR 48978, August 11, 2004), we discussed the DRG assignment of new ICD–9–CM procedure code 37.90 (Insertion of left atrial appendage device) for clinical trials, effective for discharges occurring on or after October 1, 2004, to DRG 518 (Percutaneous Cardiovascular Procedure without Coronary Artery Stent or Acute Myocardial Infarction)). In that final rule, we addressed the DRG assignment of procedure code 37.90 in response to a comment from a manufacturer who suggested that placement of the code in DRG 108 (Other Cardiothoracic Procedures) was more representative of the complexity of the procedure than placement in DRG 518. The manufacturer indicated that the suggested placement of procedure code 37.90 in DRG 108 was justified because another percutaneous procedure, described by ICD–9-CM procedure code 35.52 (Repair of atrial septal defect with prosthesis, closed technique), was assigned to DRG 108. As we indicated in the FY 2005 final rule (69 FR 48978), this comment prompted us to examine data in the FY 2003 MedPAR file for cases of code 35.52 assigned to DRG 108 and DRG 518 in comparison to all cases assigned to DRG 108. We found the following:

DRG	Number of Cases	Average Length of Stay	Average Charges
DRG 108 With Code 35.52 Reported	423	2.69	$29,231
DRG 108 – All cases	5,293	10.1	$76,274
DRG 518 – All cases	39,553	4.3	$31,955

Therefore, we concluded that procedure code 35.52 showed a decided similarity to the cases found in DRG 518, not DRG 108. At that time, we determined that we would analyze the cases for both clinical coherence and charge data as part of the IPPS FY 2006 process of identifying the most appropriate DRG assignment for procedure code 35.52.

We have now examined data from the FY 2004 MedPAR file and found results for cases assigned to DRG 108 and DRG 518 that are similar to last year's findings as indicated in the chart below:

DRG	Number of Cases	Average Length of Stay	Average Charges
DRG 108 With Code 35.52 Reported	872	2.42	$29,579
DRG 108 – All cases	8,264	9.81	$81,323
DRG 518 – All cases	38,624	3.49	$27,591

From this comparison, we found that when an atrial septal defect is percutaneously repaired, and procedure code 35.52 is the only code reported in DRG 108, there is a significant discrepancy in both the average charges and the average length of stay between the cases with procedure code 35.52 reported in DRG 108 and the total cases in DRG 108. The total cases in DRG 108 have average charges of $51,744 greater than the 872 cases in DRG 108 reporting procedure code 35.52 as the only procedure. The total cases in DRG 108 also have an average length of stay of 7.39 days greater than the average length of stay for cases in DRG 108 with procedure code 35.52 reported. In comparison, the total cases in DRG 518 have average charges of only $1,988 lower than the cases in DRG 108 with only procedure code 35.52 reported. In addition, the length of stay in total cases in DRG 518 is more closely related to cases in DRG 108 with only procedure code 35.52 reported.

Based on our analysis of these data, we are proposing to move procedure code 35.52 out of DRG 108 and place it in DRG 518. We believe that this proposal would result in a more coherent group of cases in DRG 518 that reflect all percutaneous procedures.

d. External Heart Assist System Implant

In the August 1, 2002, final rule (67 FR 49989), we attempted to clinically and financially align ventricular assist device (VAD) procedures by creating DRG 525 (Heart Assist System Implant). We also noted that cases in which a heart transplant also occurred during the same hospitalization episode would continue to be assigned to DRG 103 (Heart Transplant).

After further data review during the next 2 years, we decided to realign the

DRGs containing VAD codes for FY 2005. In the August 11, 2004 final rule (69 FR 48927), we announced changes to DRG 103, DRG 104 (Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization), DRG 105 (Cardiac Valve and Other Major Cardiothoracic Procedures Without Cardiac Catheterization), and DRG 525.

In summary, these changes included—

- Moving code 37.66 (Insertion of implantable heart assist system) out of DRG 525 and into DRG 103.
- Renaming DRG 525 as "Other Heart Assist System Implant."
- Moving code 37.62 (Insertion of non-implantable heart assist system) out of DRGs 104 and 105 and back into DRG 525.

DRG 525 currently consists of any principal diagnosis in MDC 5, plus the following surgical procedure codes:

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

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

Since that decision, we have been encouraged by a manufacturer to reevaluate DRG 525 for FY 2006. The manufacturer requested that we again review the data surrounding cases reporting code 37.65 and has suggested moving these cases into DRG 103. The manufacturer pointed out the following: Code 37.65 describes the implantation of an external heart assist system and is currently approved by the FDA as a bridge-to-recovery device. From the standpoint of clinical status, the patients in DRG 103 and receiving an external heart assist system are similar because their native hearts cannot support circulation, and absent a heart transplant, a mechanical pump is needed for patient survival. The surgical procedures for implantation of both an internal VAD and an external VAD are very similar. However, the external heart assist system (code 37.65) is a less expensive device than the implantable heart assist system (code 37.66). The manufacturer suggested that the payment differential between DRGs 103 and 525 is an incentive to choose the higher paying device, and asserted that only a subset of patients receiving an implantable heart assist system are best served by this device. The manufacturer also suggested that the initial use of the least expensive therapeutically appropriate device yields both the best clinical outcomes and the lowest total system costs.

We note that, under the DRG system, our intent is to create payments that are reflective of the average resources required to treat a particular case. Our goal is that physicians and hospitals should make treatment decisions based on the clinical needs of the patient and not financial incentives.

When we reviewed the FY 2004 MedPAR data, we were able to demonstrate the following comparisons:

DRG	Number of Cases	Average Length of Stay	Average Charges
DRG 103 - All cases	633	37.5	$313,583
DRG 103 with code 37.65 reported	0	0	$0
DRG 103 without code 37.65 reported	0	0	$0
DRG 525 - All cases	291	13.66	$173,854
DRG 525 with code 37.65 reported	110	9.26	$206,497
DRG 525 without code 37.65 reported	181	16.34	$154,015

The above table shows that the 37.8 percent of cases in DRG 525 that reported code 37.65 have average charges that are nearly $33,000 higher than the average charges for all cases in the DRG. However, the average charges for the subset of cases with code 37.65 in DRG 525 ($206,497) are more than $107,086 lower than the average charges for all cases in DRG 103 ($313,583). Furthermore, the average length of stay for the subset of patients in DRG 525 receiving an external heart assist system was 9.26 days compared to 37.5 days for the 633 cases in DRG 103.

We note that the analysis above presents the difference in average charges, not costs. Because hospitals' charges are higher than costs, the difference in hospital costs will be less than the figures shown here. Moving cases containing code 37.65 from DRG 525 to DRG 103 would have two consequences. The cases in DRG 103 reporting code 37.65 would be appreciably overreimbursed, which would be inconsistent with our goal of coherent reimbursement structure within the DRGs. In addition, the relative weight of DRG 103 would decrease by moving the less resource-intensive external heart procedures into the same DRG with the more expensive heart transplant cases. The net effect would be an underpayment for heart transplant cases. Alternatively, we also reconsidered our position on moving the insertion of an implantable heart assist system (code 37.66) back into

DRG 525. However, as shown in the FY 2005 IPPS final rule (69 FR 48929), the resource costs associated with caring for a patient receiving an implantable heart assist system are far more similar to those cases receiving a heart transplant in DRG 103 than they are to cases in DRG 525. For these reasons, we are not proposing to make any changes to the structure of either DRG 103 or DRG 525 in this proposed rule.

e. Carotid Artery Stent

Stroke is the third leading cause of death in the United States and the leading cause of serious, long-term disability. Approximately 70 percent of all strokes occur in people age 65 and older. The carotid artery, located in the neck, is the principal artery supplying the head and neck with blood. Accumulation of plaque in the carotid artery can lead to stroke either by decreasing the blood flow to the brain or by having plaque break free and lodge in the brain or in other arteries to the head. The percutaneous transluminal angioplasty (PTA) procedure involves inflating a balloon-like device in the narrowed section of the carotid artery to reopen the vessel. A carotid stent is then deployed in the artery to prevent the vessel from closing or restenosing. A distal filter device (embolic protection device) may also be present, which is intended to prevent pieces of plaque from entering the bloodstream.

Effective July 1, 2001, Medicare covers PTA of the carotid artery concurrent with carotid stent placement when furnished in accordance with the FDA-approved protocols governing Category B Investigational Device Exemption (IDE) clinical trials. PTA of the carotid artery, when provided solely for the purpose of carotid artery dilation concurrent with carotid stent placement, is considered to be a reasonable and necessary service only when provided in the context of such clinical trials and, therefore, is considered a covered service for the purposes of these trials. Performance of PTA in the carotid artery when used to treat obstructive lesions outside of approved protocols governing Category B IDE clinical trials remains a noncovered service.

At the April 1, 2004 ICD–9–CM Coordination and Maintenance Committee meeting, we discussed creation of a new code or codes to identify carotid artery stenting, along with a concomitant percutaneous angioplasty or atherectomy (PTA) code for delivery of the stent(s). This subject was addressed in response to the need to identify carotid artery stenting for use in clinical trials in the upcoming fiscal year. Public comment confirmed the need for specific codes for this procedure. We established codes for carotid artery stenting procedures effective October 1, 2004, for patients who are enrolled in an FDA-approved clinical trial and are using on-label FDA approved stents and embolic protection devices.

New procedure codes 00.61 (Percutaneous angioplasty or atherectomy of precerebral (extracranial vessel(s)) and 00.63 (Percutaneous insertion of carotid artery stent(s)) were published in Table 6B, New Procedure Codes in the FY 2005 IPPS final rule (69 FR 49624).

Procedure code 00.61 was assigned to four MDCs and seven DRGs. The most likely scenario is that in which cases are assigned to MDC 1 (Diseases and Disorders of the Nervous System in DRGs 533 (Extracranial Procedures with CC) and 534 (Extracranial Procedures without CC). Cases may also be assigned to MDC 5 (Diseases and Disorders of the Circulatory System), MDC 21 (Injuries, Poisoning, and Toxic Effects of Drugs), and MDC 24 (Multiple Significant Trauma). Other less likely DRG assignments can be found in Table 6B in the Addendum to the FY 2005 IPPS final rule (69 FR 49624).

In the FY 2005 final rule, we indicated that we would continue to monitor DRGs 533 and 534 and procedure code 00.61 in combination with procedure code 00.63 in upcoming annual DRG reviews. For this proposed rule, we are using proxy codes to evaluate the costs and DRG assignments for carotid artery stenting because codes 00.61 and 00.63 were only approved for use beginning October 1, 2004, and because MedPAR data for this period are not yet available. We used procedure code 39.50 (Angioplasty or atherectomy of other noncoronary vessel(s)) in combination with procedure code 39.90 (Insertion of nondrug-eluting peripheral vessel stent(s)) in DRGs 533 and 534 as the proxy codes for coronary artery stenting. For this evaluation, we used principal diagnosis code 433.10 (Occlusion and stenosis of carotid artery, without mention of cerebral infarction) because this diagnosis most closely reflects the clinical trial criteria.

The following chart shows our findings:

DRG	Number of Cases	Average Length of Stay	Average Charges
DRG 533 - All cases	44,677	3.73	$24,464
DRG 533 with codes 39.50 and 39.90 reported	1,586	3.13	$29,737
DRG 534 - All cases	42,493	1.79	$15,873
DRG 534 with codes 39.50 and 39.90 reported	1,397	1.54	$22,002

The patients receiving a carotid stent (codes 39.50 and 39.90) represented 3.5 percent of all cases in DRG 534. On average, patients receiving a carotid stent had slightly shorter average lengths of stay than other patients in DRGs 533 and 534. While the average charges for patients receiving a carotid artery stent were higher than for other patients in DRG 534, in our view, the small number of cases and the magnitude of the difference in average charges are not sufficient to justify a change in the DRGs.

Because we have a paucity of data for the carotid stent device and its insertion, and no data utilizing procedure codes 00.61 and 00.63 in a clinical trial setting, we believe it is premature to revise the DRG structure at this time. We expect to revisit this analysis once data become available on the new codes for carotid artery stents.

f. Extracorporeal Membrane Oxygenation (ECMO)

Extracorporeal membrane oxygenation (ECMO) is a procedure to create a closed chest, heart-lung bypass system by insertion of vascular catheters. Patients receiving this procedure require mechanical ventilation. ECMO is performed for a small number of severely ill patients who are at high risk of dying without this procedure. Most often it is done for neonates with persistent pulmonary hypertension and respiratory failure for whom other treatments have failed, certain severely ill neonates receiving major cardiac procedures or diaphragmatic hernia repair, and certain older children and adults, most of whom are receiving major cardiac procedures.

We received several letters from institutions that perform ECMO. The commenters stated that, in the CMS GROUPER logic, this procedure has little or no impact on the DRG assignment in the newborn, pediatric, and adult population. According to these letters, patients receiving ECMO are highly resource intensive and should have a unique DRG that reflects the costs of these resources. The commenters recommended the creation of a new DRG for ECMO with a DRG weight equal to or greater than the DRG weight for tracheostomy.

ECMO is assigned to procedure code 39.65 (Extracorporeal membrane oxygenation). This code is classified as an O.R. procedure and is assigned to DRG 104 (Cardiac Valve and Other Major Cardiothoracic Procedure With Cardiac Catheterization) and DRG 105 (Cardiac Valve and Other Major Cardiothoracic Procedure Without Cardiac Catheterization). When ECMO is performed with other O.R. procedures, the case is assigned to the higher weighted DRG. For example, when ECMO and a tracheostomy are performed during the same admission, the case would be assigned to DRG 541 (Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses With Major O.R.).

We note that the primary focus of updates to the Medicare DRG classification system is changes relating to the Medicare patient population, not the pediatric patient population. Because ECMO is primarily a pediatric procedure and rarely performed in an adult population, we have few cases in our data to use to evaluate resource costs. We are aware that other insurers sometimes use Medicare's rates to make payments. We advise private insurers to make appropriate modifications to our payment system when it is being used for children or other patients who are not generally found in the Medicare population.

To evaluate the appropriateness of payment under the current DRG assignment, we have reviewed the FY 2004 MedPAR data and found 78 ECMO cases in 13 DRGs. The following table illustrates the results of our findings:

DRG With Code 39.65 Reported	Number of Cases	Average Length of Stay	Average Charges for ECMO Cases	Average Charges for All Cases in DRG
104	23	9	$147,766	$120,496
105	21	8	$131,700	$89,831
541	14	62.9	$561,210	$273,656
All Other DRGs	20	18.1	$308,341	NA

The average charges for all ECMO cases were approximately $258,821, and the average length of stay was approximately 20.7 days. The average charges for the ECMO cases are closer to the average charges for DRG 541 ($273,656) than to the average charges of DRG 104 ($147,766) and DRG 105 ($131,700). Of the 78 ECMO cases, 14 cases are already assigned to DRG 541. We believe that the data indicate that DRG 541 would be a more appropriate DRG assignment for cases where ECMO is performed. We further note that under the All Payer DRG System used in New York State, cases involving ECMO are assigned to the tracheostomy DRG. Thus, the assignment of ECMO cases to the tracheostomy DRG for Medicare would be similar to how these cases are grouped in another DRG system. For these reasons, we are proposing to reassign ECMO cases reporting code 39.65 to DRG 541. We are also proposing to change the title of DRG 541 to: "ECMO or Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses With Major O.R."

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

In the FY 2003 IPPS final rule (67 FR 50242), we created two new codes for procedures involving an artificial anal sphincter, effective for discharges occurring on or after October 1, 2002: code 49.75 (Implantation or revision of artificial anal sphincter) is used to identify cases involving implantation or revision of an artificial anal sphincter and code 49.76 (Removal of artificial anal sphincter) is used to identify cases involving the removal of the device. In Table 6B of that final rule, we assigned both codes to one of four MDCs, based on principal diagnosis, and one of six DRGs within those MDCs: MDC 6 (Diseases and Disorders of the Digestive System), DRGs 157 and 158 (Anal and Stomal Procedures With and Without CC, respectively); MDC 9 (Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast), DRG 267 (Perianal and Pilonidal Procedures); MDC 21 (Injuries, Poisonings, and Toxic Effects of Drugs), DRGs 442 and 443 (Other O.R. Procedures for Injuries With and without CC, respectively); and MDC 24 (Multiple Significant Trauma), DRG 486 (Other O.R. Procedures for Multiple Significant Trauma).

In the FY 2004 IPPS final rule (68 FR 45372), we discussed the assignment of these codes in response to a request we had received to consider reassignment of these two codes to different MDCs and DRGs. The requester believed that the average charges ($44,000) for these codes warranted reassignment. In the FY 2004 IPPS final rule, we stated that we did not have sufficient MedPAR data available on the reporting of codes 49.75 and 49.76 to make a determination on

DRG reassignment of these codes. We agreed that, if warranted, we would give further consideration to the DRG assignments of these codes because it is our customary practice to review DRG assignment(s) for newly created codes to determine clinical coherence and similar resource consumption after we have had the opportunity to collect MedPAR data on utilization, average lengths of stay, average charges, and distribution throughout the system. In the FY 2005 IPPS final rule, we reviewed the FY 2003 MedPAR data for the presence of codes 49.75 and 49.76 and determined that these procedures were not a clinical match with the other procedures in DRGs 157 and 158. Therefore, for FY 2005, we moved procedure codes 49.75 and 49.76 out of DRGs 157 and 158 and into DRGs 146 and 147 (Rectal Resection With and Without CC, respectively). This change had the effect of doubling the payment for the cases with procedure codes 49.75 and 49.76 assigned to DRGs 146 and 147 based on increases in the relative weights. One commenter had suggested that we create a new DRG for "Complex Anal/Rectal Procedure with Implant.'' However, we noted that the DRG structure is a system of averages and is based on groups of patients with similar characteristics. At that time, we indicated that we would continue to monitor procedure codes 49.75 and 49.76 and the DRGs to which they are assigned.

For this FY 2006 proposed rule, we reviewed the FY 2004 MedPAR data for the presence of codes 49.75 and 49.76. We found that these two procedures are still of low incidence. Among the six possible DRG assignments, we found a total of 18 cases reported with codes 49.75 and 49.76 for the implant, revision, or removal of the artificial anal sphincter. We found 13 of these cases in DRGs 146 and 147 (compared to 12,558 total cases in these DRGs), and the remaining 5 cases in DRGs 442 and 443 (compared to 19,701 total cases in these DRGs).

We believe the number of cases with codes 49.75 and 49.76 in these DRGs is too low to provide meaningful data of statistical significance. Therefore, we are not proposing any further changes to the DRGs for these procedures at this time. Neither are we proposing to change the structure of DRGs 146 or 147 at this time.

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

a. Hip and Knee Replacements

Orthopedic surgeons representing the American Association of Orthopaedic Surgeons (AAOS) requested that we subdivide DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity) in MDC 8 by creating a new DRG for revision of lower joint procedures. The AAOS made a presentation at the October 7–8, 2004 meeting of the ICD–9–CM Coordination and Maintenance Committee meeting. A summary report of this meeting can be found at the CMS Web site: *http://www.cms.hhs.gov/paymentsystems/icd9/*. We also received written comments on this request.

The AAOS surgeons stated that cases involving patients who require a revision of a prior replacement of a knee or hip require significantly more resources than cases in which patients receive an initial joint replacement. They pointed out that total joint replacement is one of the most commonly performed and successful operations in orthopedic surgery. The surgeons mentioned that, in 2002, over 300,000 hip replacement and 350,000 knee replacement procedures were performed in the United States. They also pointed out that these procedures are a frequent reason for Medicare hospitalization. The surgeons stated that total joint replacements have been shown to be highly cost-effective procedures, resulting in dramatic improvements in quality of life for patients suffering from disabling arthritic conditions involving the hip or knee. In addition, they reported that the medical literature indicates success rates of greater than 90 percent for implant survivorship, reduction in pain, and improvement in function at a 10-year to 15-year followup. However, despite these excellent results with primary total joint replacement, factors related to implant longevity and evolving patient demographics have led to an increase in the volume of revision total joint procedures performed in the United States over the past decade.

Total hip replacement is an operation that is intended to reduce pain and restore function in the hip joint by replacing the arthritic hip joint with a prosthetic ball and socket joint. The prosthetic hip joint consists of a metal alloy femoral component with a modular femoral head made of either metal or ceramic (the "ball'') that articulates with a metal acetabular component with a modular liner made of either metal, ceramic, or high-density polyethylene (the "socket'').

The AAOS surgeons stated that in a normal knee, four ligaments help hold the bones in place so that the joint works properly. When a knee becomes arthritic, these ligaments can become scarred or damaged. During knee replacement surgery, some of these ligaments, as well as the joint surfaces, are substituted or replaced by the new artificial prostheses. Two types of fixation are used to hold the prostheses in place. Cemented designs use polymethyl methacrylate to hold the prostheses in place. Cementless designs rely on bone growing into the surface of the implant for fixation.

The surgeons stated that all hip and knee replacements have an articular bearing surface that is subject to wear (the acetabular bearing surface in the hip and the tibial bearing surface in the knee). Traditionally, these bearing surfaces have been made of metal-on-metal or metal-on-polyethylene, although newer materials (both metals and ceramics) have been used more recently. Earlier hip and knee implant designs had nonmodular bearing surfaces, but later designs included modular articular bearing surfaces to reduce inventory and potentially simplify revision surgery. Wear of the articular bearing surface occurs over time and has been found to be related to many factors, including the age and activity level of the patient. In some cases, wear of the articular bearing surface can produce significant debris particles that can cause peri-prosthetic bone resorption (also known and osteolysis) and mechanical loosening of the prosthesis. Wear of the bearing surface can also lead to instability or prosthetic dislocation, or both, and is a common cause of revision hip or knee replacement surgery.

Depending on the cause of failure of the hip replacement, the type of implants used in the previous surgery, the amount and quality of the patient's remaining bone stock, and factors related to the patient's overall health and anatomy, revision hip replacement surgery can be relatively straightforward or extremely complex. Revision hip replacement can involve replacing any part or all of the implant, including the femoral or acetabular components, and the bearing surface (the femoral head and acetabular liner), and may involve major reconstruction of the bones and soft tissues around the hip. All of these procedures differ significantly in their clinical indications, outcomes, and resource intensity.

The AAOS surgeons provided the following summary of the types of

revision knee replacement procedures: Among revision knee replacement procedures, patients who underwent complete revision of all components had longer operative times, higher complication rates, longer lengths of stay, and significantly higher resource utilization, according to studies conducted by the AAOS. Revision of the isolated modular tibial insert component was the next most resource-intensive procedure, and primary total knee replacement was the least resource-intensive of all the procedures studied.

• *Isolated Modular Tibial Insert Exchange.* Isolated removal and exchange of the modular tibial bearing surface involves replacing the modular polyethylene bearing surface without removing the femoral, tibial, or patellar components of the prosthetic joint. Common indications for this procedure include wear of the polyethylene bearing surface or instability (for example, looseness) of the prosthetic knee joint. Patient recovery times are much shorter with this procedure than with removal and exchange of either the tibial, femoral, or patellar components.

• *Revision of the Tibial Component.* Revision of the tibial component involves removal and exchange of the entire tibial component, including both the metal base plate and the modular polyethylene bearing surface. Common indications for tibial component revision are wear of the modular bearing surface, aseptic loosening (often associated with osteolysis), or infection. Depending on the amount of associated bone loss and the integrity of the ligaments around the knee, tibial component revision may require the use of specialized implants with stems that extend into the tibial canal and/or the use of metal augments or bone graft to fill bony defects.

• *Revision of the Femoral Component.* Revision of the femoral component involves removal and exchange of the metal implant that covers the end of the thigh-bone (the distal femur). Common indications for femoral component revision are aseptic loosening with or without associated osteolysis/bone loss, or infection. Similar to tibial revision, femoral component revision that is associated with extensive bone loss often involves the use of specialized implants with stems that extend into the femoral canal and/or the use of metal augments or bone graft to fill bony defects.

• *Revision of the Patellar Component.* Complications related to the patella-femoral joint are one of the most common indications for revision knee replacement surgery. Early patellar implant designs had a metal backing covered by high-density polyethylene; these implants were associated with a high rate of failure due to fracture of the relatively thin polyethylene bearing surface. Other common reasons for isolated patellar component revision include poor tracking of the patella in the femoral groove leading to wear and breakage of the implant, fracture of the patella with or without loosening of the patellar implant, rupture of the quadriceps or patellar tendon, and infection.

• *Revision of All Components (Tibial, Femoral, and Patellar).* The most common type of revision knee replacement procedure is a complete total knee revision. A complete revision of all implants is more common in knee replacements than hip replacements because the components of an artificial knee are not compatible across vendors or types of prostheses. Therefore, even if only one of the implants is loose or broken, a complete revision of all components is often required in order to ensure that the implants are compatible. Complete total knee revision often involves extensive surgical approaches, including osteotomizing (for example, cutting) the tibia bone in order to adequately expose the knee joint and gain access to the implants. These procedures often involve extensive bone loss, requiring reconstruction with specialized implants with long stems and metal augments or bone graft to fill bony defects. Depending on the status of the ligaments in the knee, complete total knee revision at times requires implantation of a highly constrained or "hinged'' knee replacement in order to ensure stability of the knee joint.

• *Reimplantation from previous resection or cement spacer.* In cases of deep infection of a prosthetic knee, removal of the implants with implantation of an antibiotic-impregnated cement spacer, followed by 6 weeks of intravenous antibiotics is often required in order to clear the infection. Revision knee replacement from an antibiotic impregnated cement spacer often involves complex bony reconstruction due to extensive bone loss that occurs as a result of the infection and removal of the often well-fixed implants. As noted above, the clinical outcomes following revision from a spacer are often poor due to limited functional capacity while the spacer is in place, prolonged periods of protected weight bearing (following reconstruction of extensive bony defects), and the possibility of chronic infection.

The surgeons stated that the current ICD–9–CM codes did not adequately capture the complex nature of revisions of hip and knee replacements. Currently, code 81.53 (Revision of hip replacement) captures all "partial'' and "total'' revision hip replacement procedures. Code 81.55 (Revision of knee replacement) captures all revision knee replacement procedures. These two codes currently capture a wide variety of procedures that differ in their clinical indications, resource intensity, and clinical outcomes.

An AAOS representative made a presentation at the October 7–8, 2004 ICD–9–CM Coordination and Maintenance Committee. Based on the comments received at the October 7–8, 2004 meeting and subsequent written comments, new ICD–9–CM procedure codes were developed to better capture the variety of ways that revision of hip and knee replacements can be performed: codes 00.70 through 00.73 and code 81.53 for revisions of hip replacements and codes 00.80 through 00.84 and code 81.55 for revisions of knee replacements. These new and revised procedure codes, which will be effective on October 1, 2005, can be found in Table 6B and Table 6F of this proposed rule. The commenters stated that claims data using these new and specific codes should provide improved data on these procedures for future DRG modifications.

However, the commenters requested that CMS consider DRG modifications based on current data using the existing revision codes. The commenters reported on a recently completed study comparing detailed hospital resource utilization and clinical characteristics in over 10,000 primary and revision hip and knee replacement procedures at 3 high volume institutions: The Massachusetts General Hospital, the Mayo Clinic, and the University of California at San Francisco. The purpose of this study was to evaluate differences in clinical outcomes and resource utilization among patients who underwent different types of primary and revision hip or knee replacement procedures. The study found significant differences in operative time, complication rates, hospital length of stay, discharge disposition, and resource utilization among patients who underwent different types of revision hip or knee replacement procedures.

Among revision hip replacement procedures, patients who underwent both femoral and acetabular component revision had longer operative times, higher complication rates, longer lengths of stay, significantly higher resource utilization, and were more likely to be discharged to a subacute care facility. Isolated femoral

component revision was the next most resource-intensive procedure, followed by isolated acetabular revision. Primary hip replacement was the least resource intensive of all the procedures studied. Similarly, among revision knee replacement procedures, patients who underwent complete revision of all components had longer operative times, higher complication rates, longer lengths of stay, and significantly higher resource utilization. Revision of one component was the next most resource-intensive procedure. Primary total knee replacement was the least resource intensive of all the procedures studied.

In addition, the commenters indicated that the data showed that extensive bone loss around the implants and the presence of a peri-prosthetic fracture were the most significant predictors of higher resource utilization among all revision hip and knee replacement procedures, even when controlling for other significant patient and procedural characteristics.

For this proposed rule, we examined data in the FY 2004 MedPAR file on the current hip replacement procedures (codes 81.51, 81.52, 81.53) as well as the replacements and revisions of knee replacement procedures (codes 81.54 and 81.55) in DRG 209. We found that revisions were significantly more resource intensive than the original hip and knee replacements. We found average charges for revisions of hip and knee replacements were approximately $7,000 higher than average charges for the original joint replacements, as shown in the following charts. The average charges for revisions of hip replacements were 21 percent higher than the average charges for initial hip replacements. The average charges for revisions of knee replacements were 25 percent higher than for initial knee replacements.

DRG	Number of Cases	Average Length of Stay	Average Charges
209 - All cases	430,776	4.57	$30,695.41
209 With hip replacement codes 81.51 and 81.52 reported	181,460	5.21	$31,795.84
209 With hip revision code 81.53 reported	20,894	5.57	$38,432.04
209 With knee replacement code 81.54 reported	209,338	3.92	$28,525.66
209 With knee revision code 81.55 reported	18,590	4.64	$35,671.66

We note that there were no cases in DRG 209 for reattachment of the foot, lower leg, or thigh (codes 84.29, 84.27, and 84.28).

To address the higher resource costs associated with hip and knee revisions relative to the initial joint replacement procedure, we are proposing to delete DRG 209, create a proposed new DRG 544 (Major Joint Replacement or Reattachment of Lower Extremity), and create a proposed new DRG 545 (Revision of Hip or Knee Replacement).

We are proposing to assign the following codes to the new proposed DRG 544:

- 81.51, Total hip replacement.
- 81.52, Partial hip replacement.
- 81.54, Total knee replacement.
- 81.56, Total ankle replacement.
- 84.26, Foot reattachment.
- 84.27, Lower leg/ankle reattach.
- 84.28, Thigh reattachment.

We are proposing to assign the following codes to the proposed new DRG 545:

- 00.70, Revision of hip replacement, both acetabular and femoral components.
- 00.71, Revision of hip replacement, acetabular component.
- 00.72, Revision of hip replacement, femoral component.
- 00.73, Revision of hip replacement, acetabular liner and/or femoral head only.
- 00.80, Revision of knee replacement, total (all components).
- 00.81, Revision of knee replacement, tibial component.
- 00.82, Revision of knee replacement, femoral component.
- 00.83, Revision of knee replacement, patellar component.
- 00.84, Revision of knee replacement, tibial insert (liner).
- 81.53, Revision of hip replacement, not otherwise specified.
- 81.55, Revision of knee replacement, not otherwise specified.

We agree with the commenters and the AAOS that the creation of a new DRG for revisions of hip and knee replacements should resolve payment issues for hospitals that perform the more difficult revisions of joint replacements. In addition, as stated earlier, we have worked with the orthopedic community to develop new procedure codes that better capture data on the types of revisions of hip and knee replacements. These new codes will be implemented on October 1, 2005. Once we receive claims data using these new codes, we will review data to determine if additional DRG modifications are needed. This effort may include assigning some of the revision codes, such as 00.83 and 00.84 to a separate DRG. As stated earlier, the AAOS has found that some of the procedures may not be as resource intensive. Therefore, the AAOS has requested that CMS closely examine data from the use of the new codes and consider future revisions.

b. Kyphoplasty

In the FY 2005 IPPS final rule (69 FR 48938), we discussed the creation of new codes for vertebroplasty (81.65) and kyphoplasty (81.66), which went into effect on October 1, 2004. Prior to October 1, 2004, both of these surgical procedures were assigned to code 78.49 (Other repair or plastic operation on bone). For FY 2005, we assigned these codes to DRGs 233 and 234 (Other Musculoskeletal System and Connective Tissue O.R. Procedure With and Without CC, respectively) in MDC 8 (Table 6B of the FY 2005 final rule). (In the FY 2005 IPPS final rule (69 FR 48938), we indicated that new codes 81.65 and 81.66 were assigned to DRGs 223 and 234. We made a typographical error when indicating that these codes were assigned to DRG 223. Codes 81.65 and 81.66 have been assigned to DRGs

233 and 234.) Last year, we received comments opposing the assignment of code 81.66 to DRGs 233 and 234. The commenters supported the creation of the codes for kyphoplasty and vertebroplasty but recommended that code 81.66 be assigned to DRGs 497 and 498 (Spinal Fusion Except Cervical With and Without CC, respectively). The commenters stated that kyphoplasty requires special inflatable bone tamps and bone cement and is a significantly more resource intensive procedure than vertebroplasty. The commenters further stated that, while kyphoplasty involves internal fixation of the spinal fracture and restoration of vertebral heights, vertebroplasty involves only fixation. The commenters indicated that hospital costs for kyphoplasty procedures are more similar to resources used in a spinal fusion.

We stated in the FY 2005 IPPS final rule that we did not have data in the MedPAR file on kyphoplasty and vertebroplasty. Prior to October 1, 2004, both procedures were assigned in code 78.49, which was assigned to DRGs 233 and 234 in MDC 8. We stated that we would continue to review this area as part of our annual review of MedPAR data. While we do not have separate data for kyphoplasty because code 81.66 was not established until October 1, 2004, for this proposed rule, we did examine data on code 78.49, which includes both kyphoplasty and vertebroplasty procedures reported in DRGs 233 and 234. The following chart illustrates our findings:

DRG	Number of Cases	Average Length of Stay	Average Charges
233 - All cases	14,066	6.66	$28,967.78
233 With code 78.49 reported	8,702	5.91	$25,402.71
233 Without code 78.49 reported	5,364	7.88	$34,571.39
234 - All cases	7,106	2.79	$18,954.80
234 With code 78.49 reported	4,437	2.61	$18,426.11
234 Without code 78.94 reported	2,669	3.09	$19,833.71

We do not believe these data findings support moving cases represented by code 78.49 out of DRGs 233 and 234. While we cannot distinguish cases that are kyphoplasty from cases that are vertebroplasty, cases represented by code 78.49 have lower charges than do other cases within DRGs 233 and 234. Therefore, we are not proposing to change the DRG assignment of code 81.66 to DRGs 233 and 234 at this time. However, once specific charge data are available, we will consider whether further changes are warranted.

c. Multiple Level Spinal Fusion

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

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

Prior to the creation of these codes, we received a comment recommending the establishment of new DRGs that would be differentiated based on the number of vertebrae fused. In the FY 2005 IPPS final rule (69 FR 48936), we stated that we did not yet have any reported cases utilizing these multiple level spinal fusion codes. We stated that we would wait until sufficient data were available prior to making a final determination on whether to create separate DRGs based on the number of vertebrae fused. We also stated that spinal fusion surgery was an area undergoing rapid changes.

Effective October 1, 2004, we created a series of codes that describe a new type of spinal surgery, spinal disc replacement. Our medical advisors describe these procedures as a more conservative approach for back pain than the spinal fusion surgical procedure. These codes are as follows:

- 84.60, Insertion of spinal disc prosthesis, not otherwise specified.
- 84.61, Insertion of partial spinal disc prosthesis, cervical.
- 84.62, Insertion of total spinal disc prosthesis, cervical.
- 84.63, Insertion of spinal disc prosthesis, thoracic.
- 84.64, Insertion of partial spinal disc prosthesis, lumbosacral.
- 84.65, Insertion of total spinal disc prosthesis, lumbosacral.
- 84.66, Revision or replacement of artificial spinal disc prosthesis, cervical.
- 84.67, Revision or replacement of artificial spinal disc prosthesis, thoracic.
- 84.68, Revision or replacement of artificial spinal disc prosthesis, lumbosacral.
- 84.69, Revision or replacement of artificial spinal disc prosthesis, not otherwise specified.

We also created the following two codes effective October 1, 2004, for these new types of spinal surgery that are also a more conservative approach to back pain than is spinal fusion:

- 81.65 Vertebroplasty.
- 81.66 Kyphoplasty.

We do not yet have data in the MedPAR file on these new types of procedures. Therefore, we cannot yet determine what effect these new types of procedures will have on the frequency of spinal fusion procedures.

However, we do have data in the MedPAR file on multiple level spinal procedures for analysis for this year's proposed rule. We examined data in the FY 2004 MedPAR file on spinal fusion cases in the following DRGs:

- DRG 496 (Combined Anterior/Posterior Spinal Fusion).
- DRG 497 (Spinal Fusion Except Cervical With CC).
- DRG 498 (Spinal Fusion Except Cervical Without CC).
- DRG 519 (Cervical Spinal Fusion With CC).
- DRG 520 (Cervical Spinal Fusion Without CC).

Multiple level spinal fusion is captured by code 81.63 (Fusion or refusion of 4–8 vertebrae) and code 81.64 (Fusion or refusion of 9 or more vertebrae). Code 81.62 includes the fusion of 2–3 vertebrae and is not considered a multiple level spinal fusion. Orthopedic surgeons stated at the October 7–8, 2004 ICD–9–CM Coordination and Maintenance Committee meeting that the most simple and common type of spinal fusion involves fusing either 2 or 3 vertebrae. These surgeons stated that there was not

a significant difference in resource utilization for cases involving the fusion of 2 versus 3 vertebrae. For this reason, the orthopedic surgeons recommended that fusion of 2 and 3 vertebrae be grouped into one ICD–9–CM code.

We reviewed the Medicare charge data to determine whether the number of vertebrae fused or specific diagnoses have an effect on average length of stay and resource use for a patient. We found that, while fusing 4 or more levels of the spine results in a small increase in the average length of stay and a somewhat larger increase in average charges for spinal fusion patients, an even greater impact was made by the presence of a principal diagnosis of curvature of the spine or malignancy. The following list of diagnoses describes conditions that have a significant impact on resource use for spinal fusion patients:

- 170.2, Malignant neoplasm of vertebral column, excluding sacrum and coccyx.
- 198.5, Secondary malignant neoplasm of bone and bone marrow.
- 732.0, Juvenile osteochondrosis of spine.
- 733.13, Pathologic fracture of vertebrae.
- 737.0, Adolescent postural kyphosis.
- 737.10, Kyphosis (acquired) (postural).
- 737.11, Kyphosis due to radiation.
- 737.12, Kyphosis, postlaminectomy.
- 737.19, Kyphosis (acquired), other.
- 737.20, Lordosis (acquired) (postural).
- 737.21, Lordosis, postlaminectomy
- 737.22, Other postsurgical lordosis.
- 737.29, Lordosis (acquired), other.
- 737.30, Scoliosis [and kyphoscoliosis], idiopathic.
- 737.31, Resolving infantile idiopathic scoliosis.
- 737.32, Progressive infantile idiopathic scoliosis.
- 737.33, Scoliosis due to radiation.
- 737.34, Thoracogenic scoliosis.
- 737.39, Other kyphoscoliosis and scoliosis.
- 737.40, Curvature of spine, unspecified.
- 737.41, Curvature of spine associated with other conditions, kyphosis.
- 737.42, Curvature of spine associated with other conditions, lordosis.
- 737.43, Curvature of spine associated with other conditions, scoliosis.
- 737.8, Other curvatures of spine.
- 737.9, Unspecified curvature of spine.
- 754.2, Congenital scoliosis.
- 756.51, Osteogenesis imperfecta.

The majority of fusion patients with these diagnoses were in DRGs 497 and 498. The chart below reflects our findings. We also include in the chart statistics for cases in DRGs 497 and 498 with spinal fusion of 4 or more vertebrae and cases with a principal diagnosis of curvature of the spine or bone malignancy.

DRG	Number of Cases	Average Length of Stay	Average Charges
497	27,346	6.08	$64,471.82
498	17,943	3.80	$48,440.80
497 and 498 With spinal fusions of 4 or more vertebrae reported	7,881	6.3	$77,352.00
497 and 498 With principal diagnosis of curvature of the spine or bone malignancy	2,006	8.91	$95,315.00

Thus, these diagnoses result in a significant increase in resource use. While the fusing of 4 or more vertebrae resulted in average charges of $77,352, the impact of a principal diagnosis of curvature of the spine or bone malignancy was substantially greater with average charges of $95,315.

Based on this analysis, we are proposing to create a new DRG for noncervical spinal fusions with a principal diagnosis of curvature of the spine and malignancies. The proposed new DRG would be: proposed new DRG 546 (Spinal Fusions Except Cervical With Principal Diagnosis of Curvature of the Spine or Malignancy). Cases included in this proposed new DRG would include all noncervical spinal fusions previously assigned to DRGs 497 and 498 that have a principal diagnosis of curvature of the spine or malignancy and would include the following codes listed above: 170.2, 198.5, 732.0, 733.13, 737.0, 737.10, 737.11, 737.12, 737.19, 737.20, 737.21, 737.22, 737.29, 737.30, 737.31, 737.32, 737.33, 737.34, 737.39, 737.40, 737.41, 737.42, 737.43, 737.8, 737.9, 754.2, and 756.51. The proposed DRG 546 would not include cases currently assigned to DRGs 496, 519, or 520 that have a principal diagnosis of curvature of the spine or malignancy. The structure of DRGs 496, 519, and 520 would remain the same.

As part of our meeting with the AAOS on DRG 209 in February 2005 (discussed under section II.B.6.a. of this preamble), the AAOS offered to work with CMS to analyze clinical issues and make revisions to the spinal fusion DRGs (DRGs 496 through 498 and 519 and 520). At this time, we are limiting our proposed changes to the spinal fusion DRGs for FY 2006 to the creation of the proposed DRG 546 discussed above. However, we look forward to working with the AAOS to obtain its clinical recommendations concerning our proposed changes and potential additional modifications to the spinal fusion DRGs. We are also soliciting comments from the public on our proposed changes and how to incorporate new types of spinal procedures such as kyphoplasty and spinal disc prostheses into the spinal fusion DRGs.

7. MDC 18 (Infectious and Parasitic Diseases (Systemic or Unspecified Sites)): Severe Sepsis

As we did for FY 2005, we received a request to consider the creation of a separate DRG for the diagnosis of severe sepsis for FY 2006. Severe sepsis is described by ICD–9–CM code 995.92 (Systemic inflammatory response syndrome due to infection with organ dysfunction). Patients admitted with sepsis currently are assigned to DRG 416 (Septicemia Age > 17) and DRG 417

(Septicemia Age 0–17) in MDC 18 (Infectious and Parasitic Diseases, Systemic or Unspecified Sites). The commenter requested that all cases in which severe sepsis is present on admission, as well as those cases in which it develops after admission (which are currently classified elsewhere), be included in this new DRG. We addressed this issue in the FY 2005 IPPS final rule (69 FR 48975). As indicated last year, we do not feel the current clinical definition of severe sepsis is specific enough to identify a meaningful cohort of patients in terms of clinical coherence and resource utilization to warrant a separate DRG. Sepsis is found across hundreds of medical and surgical DRGs, and the term "organ dysfunction'' implicates numerous currently existing diagnosis codes. While we recognize that Medicare beneficiaries with severe sepsis are quite ill and require extensive hospital resources, we do not believe that they can be identified adequately to justify removing them from all of the other DRGs in which they appear. We are not proposing a new DRG for severe sepsis at this time.

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

In the FY 2005 IPPS final rule (69 FR 48939, August 11, 2004), we discussed a request that CMS modify DRGs 521 through 523 by removing the principal diagnosis code 292.82 (Drug-induced dementia) from these alcohol and drug abuse DRGs. These DRGs are as follows:

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

The commenter indicated that a patient who has a drug-induced dementia should not be classified to an alcohol/drug DRG. However, the commenter did not propose a new DRG assignment for code 292.82. Our medical advisors evaluated the request and determined that the most appropriate DRG classification for a patient with drug-induced dementia was within MDC 20. The medical advisors indicated that because the dementia is drug induced, it is appropriately classified to DRGs 521 through 523 in MDC 20. Therefore, we did not propose a new DRG classification for the principal diagnosis code 292.82.

In the FY 2005 IPPS final rule, we addressed a comment from an organization representing hospital coders that disagreed with our decision to keep code 292.82 in DRGs 521 through 523. The commenter stated that DRGs 521 through 523 are described as alcohol/drug abuse and dependence DRGs, and that drug-induced dementia can be caused by an adverse effect of a prescribed medication or a poisoning. The commenter did not believe that assignment to DRGs 521 through 523 was appropriate if the drug-induced dementia is due to one of these events and the patient is not alcohol or drug dependent. The commenter recommended that admissions for drug-induced dementia be classified to DRGs 521 through 523 only if there is a secondary diagnosis indicating alcohol/drug abuse or dependence.

The commenter recommended that drug-induced dementia that is due to the adverse effect of a drug or poisoning be classified to the same DRGs as other types of dementia, such as DRG 429 (Organic Disturbances and Mental Retardation). The commenter believed that when drug-induced dementia is caused by a poisoning, either accidental or intentional, the appropriate poisoning code would be sequenced as the principal diagnosis and, therefore, these cases would likely already be assigned to DRGs 449 and 450 (Poisoning and Toxic Effects of Drugs, Age Greater than 17, With and Without CC, respectively) and DRG 451 (Poisoning and Toxic Effects of Drugs, Age 0–17). The commenter stated that these would be the appropriate DRG assignments for drug-induced dementia due to a poisoning. We received a similar comment from a hospital organization.

In the FY 2005 IPPS final rule, we acknowledged that the commenters raised additional issues surrounding the DRG assignment for code 292.82 that should be considered. The commenters provided alternatives for DRG assignment based on sequencing of the principal diagnosis and reporting of additional secondary diagnoses. We recognized that patients may develop drug-induced dementia from drugs that are prescribed, as well as from drugs that are not prescribed. However, because dementia develops as a result of *use* of a drug, we believed the current DRG assignment to DRGs 521 through 523 remained appropriate. Some commenters have agreed with the current DRG assignment of code 292.82 since the dementia was caused by use of a drug. We agree that if either accidental or intentional poisoning caused the drug-induced dementia, the appropriate poisoning code should be sequenced as the principal diagnosis. As one commenter stated, these cases would be assigned to DRGs 449 through 451. We encouraged hospitals to examine the coding for these types of cases to determine if there were any coding or sequencing errors. As suggested by the commenter, if code 292.82 were reported as a secondary diagnosis and not a principal diagnosis in cases of poisoning or adverse drug reactions, the number of cases on DRGs 521 through 523 would decline.

In the FY 2005 IPPS final rule, we agreed to analyze this area for FY 2006 and to look at the alternative DRG assignments suggested by the commenters. For this proposed rule, we examined data from the FY 2004 MedPAR file on cases in DRGs 521 through 523 with a principal diagnosis of code 292.82. We found that there were only 134 cases reported with the principal diagnosis code 292.82 in DRGs 521 through 523 without a diagnosis of drug and alcohol abuse. The average standardized charges for cases with a principal diagnosis of code 292.82 that did not have a secondary diagnosis of drug/alcohol abuse or dependence were $12,244.35, compared to the average standardized charges for all cases in DRG 521, which were $10,543.69. There were no cases in DRG 522 with a principal diagnosis of code 292.82. We found only 24 cases in DRG 523 with a principal diagnosis of code 292.82. Given the small number of cases in DRG 522 and 523, and the similarity in average standardized charges between those cases in DRG 521 with a principal diagnosis of code 292.82 and without a secondary diagnosis of drug/alcohol abuse or dependence to the overall average for all cases in the DRG, we do not believe the data suggest that a modification to DRGs 521 through 523 is warranted. Therefore, we are not proposing changes to the current structure of DRGs 521 through 523 for FY 2006.

9. Medicare Code Editor (MCE) Changes

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

As explained under section II.B.1. of this preamble, the Medicare Code Editor (MCE) is a software program that detects and reports errors in the coding of Medicare claims data. Patient diagnoses, procedure(s), discharge status, and demographic information go into the Medicare claims processing systems and are subjected to a series of automated screens. The MCE screens are designed to identify cases that require further review before classification into a DRG.

a. Newborn Age Edit

In the past, we have discussed and received comments concerning revision of the pediatric portions of the Medicare IPPS DRG classification system, that is, MDC 15 (Newborns and Other Neonates With Conditions Originating in the Perinatal Period). Most recently, we addressed these comments in both the FY 2005 proposed rule (69 FR 28210) and the FY 2005 IPPS final rule (69 FR 48938). In those rules, we indicated that we would be responsive to specific requests for updating MDC 15 on a limited, case-by-case basis.

We have recently received a request through the Open Door Forum to revise the MCE "newborn age edit'' by removing over 100 codes located in Chapter 15 of ICD–9–CM that are identified as "newborn'' codes. This request was made because these codes usually cause an edit or denial to be triggered when they are used on children greater than 1 year of age. However, the underlying issue with these particular edits is that other payers have adopted the CMS Medicare Code Editor in a wholesale manner, instead of adapting it for use in their own patient populations.

We acknowledge that Medicare DRGs are sometimes used to classify other patient groups. However, CMS' primary focus of updates to the Medicare DRG classification system is on changes relating to the Medicare patient population, not the pediatric or neonatal patient populations.

There are practical considerations regarding the assumption of a larger role for the Medicare DRG in the pediatric or neonatal areas, given the difference between the Medicare population and that of newborns and children. There are also challenges surrounding the development of DRG classification systems and applications appropriate to children. We do not have the clinical expertise to make decisions about these patients, and must rely on outside clinicians for advice. In addition, because newborns and other children are generally not eligible for Medicare, we must rely on outside data to make decisions. We recognize that there are evolving alternative classification systems for children and encourage payers to use the CMS MCE as a template while making modifications appropriate for pediatric patients.

Therefore, we would encourage those non-Medicare systems needing a more comprehensive pediatric system of edits to update their systems by choosing from other existing systems or programs that are currently in use. Because of our reluctance to assume expertise in the pediatric arena, we are not proposing to make the commenter's suggested changes to the MCE "newborn age edit'' for FY 2006.

b. Newborn Diagnoses Edit

Last year, in our changes to the MCE, we inadvertently added code 796.6 (Abnormal findings on neonatal screening) to both the MCE edit for "Maternity Diagnoses—age 12 through 55'', and the MCE edit for "Diagnoses Allowed for Females Only''. We are proposing to remove code 796.6 from these two edits and add it to the "Newborn Diagnoses'' edit.

c. Diagnoses Allowed for "Males Only'' Edit

We have received a request to remove two codes from the "Diagnoses Allowed for Males Only'' edit, related to androgen insensitivity syndrome (AIS). AIS is a new term for testicular feminization. Code 257.8 (Other testicular dysfunction) is used to describe individuals who, despite having XY chromosomes, develop as females with normal female genitalia and mammary glands. Testicles are present in the same general area as the ovaries, but are undescended and are at risk for development of testicular cancer, so are generally surgically removed. These individuals have been raised as females, and would continue to be considered female, despite their XY chromosome makeup. Therefore, as AIS is coded to 257.8, and has posed a problem associated with the gender edit, we are proposing to remove this code from the "Males Only'' edit in the MCE.

A similar clinical scenario can occur with certain disorders that cause a defective biosynthesis of testicular androgen. This disorder is included in code 257.2 (Other testicular hypofunction). Therefore, we also are proposing to remove code 257.2 from the "Male Only'' gender edit in the MCE.

d. Tobacco Use Disorder Edit

We have become aware of the possible need to add code 305.1 (Tobacco use disorder) to the MCE in order to make admissions for tobacco use disorder a noncovered Medicare service when code 305.1 is reported as the principal diagnosis. On March 22, 2005, CMS published a final decision memorandum and related national coverage determination (NCD) on smoking cessation counseling services on its Web site: (*http://www.cms.hhs.gov/coverage/).* Among other things, this NCD provides that: "Inpatient hospital stays with the principal diagnosis of 305.1, Tobacco Use Disorder, are not reasonable and necessary for the effective delivery of tobacco cessation counseling services. Therefore, we will not cover tobacco cessation services if tobacco cessation is the primary reason for the patient's hospital stay.'' Therefore, in order to maintain internal consistency with CMS programs and decisions, we are proposing to add code 305.1 to the MCE edit "Questionable Admission-Principal Diagnosis Only'' in order to make tobacco use disorder a noncovered admission.

e. Noncovered Procedure Edit

Effective October 1, 2004, CMS adopted the use of code 00.61 (Percutaneous angioplasty or atherectomey of precerebral (extracranial) vessel(s) (PTA)) and code 00.63 (Percutaneous insertion of carotid artery stent(s). Both codes are to be recorded to indicate the insertion of a carotid artery stent or stents. At the time of the creation of the codes, the coverage indication for carotid artery stenting was only for patients in a clinical trial setting, and diagnostic code V70.7 (Examination of participation in a clinical trial) was required for payment of these cases. However, effective October 12, 2004, Medicare covers PTA of the carotid artery concurrent with the placement of an FDA-approved carotid stent for an FDA-approved indication when furnished in accordance with FDA-approved protocols governing post-approval studies. Therefore, as the coverage indication has changed, we are proposing to remove codes 00.61, 00.63, and V70.7 from the MCE noncovered procedure edit.

10. Surgical Hierarchies

(If you choose to comment on issues in this section, please include the caption "Surgical Hierarchy'' at the beginning of your comment.)

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

Because the relative resource intensity of surgical classes can shift as a function of DRG reclassification and recalibrations, we reviewed the surgical

hierarchy of each MDC, as we have for previous reclassifications and recalibrations, to determine if the ordering of classes coincides with the intensity of resource utilization.

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

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

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

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

Based on the preliminary recalibration of the DRGs, we are proposing to revise the surgical hierarchy for MDC 5 (Diseases and Disorders of the Circulatory System) and MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue) as follows:

In MDC 5, we are proposing to reorder—

- DRG 116 (Other Permanent Cardiac Pacemaker Implant) above DRG 549 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent With AMI With CC).
- DRG 549 above DRG 550 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent With AMI Without CC).
- DRG 550 above DRG 547 (Percutaneous Cardiovascular Procedure With AMI With CC).
- DRG 547 above DRG 548 (Percutaneous Cardiovascular Procedure With AMI Without CC).
- DRG 548 above DRG 527 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent Without AMI).
- DRG 527 above DRG 517 (Percutaneous Cardiovascular Procedure With Non-Drug Eluting Stent Without AMI).
- DRG 517 above DRG 518 (Percutaneous Cardiovascular Procedure Without Coronary Artery Stent or AMI).
- DRG 518 above DRGs 478 and 479 (Other Vascular Procedures With and Without CC, respectively).

In MDC 8, we are proposing to reorder—

- DRG 496 (Combined Anterior/Posterior Spinal Fusion) above DRG 546 (Spinal Fusion Except Cervical With Principal Diagnosis of Curvature of the Spine or Malignancy).
- DRG 546 above DRGs 497 and 498 (Spinal Fusion Except Cervical With and Without CC, respectively).
- DRG 217 (Wound Debridement and Skin Graft Except Hand, For Musculoskeletal and Connective Tissue Disease) above DRG 545 (Revision of Hip or Knee Replacement).
- DRG 545 above DRG 544 (Major Joint Replacement or Reattachment).
- DRG 544 above DRGs 519 and 520 (Cervical Spinal Fusion With and Without CC, respectively).

11. Refinement of Complications and Comorbidities (CC) List

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

a. Background

As indicated earlier in this preamble, under the IPPS DRG classification system, we have developed a standard list of diagnoses that are considered complications or comorbidities (CCs). Historically, we developed this list using physician panels that classified each diagnosis code based on whether the diagnosis, when present as a secondary condition, would be considered a substantial complication or comorbidity. A substantial complication or comorbidity was defined as a condition that, because of its presence with a specific principal diagnosis, would cause an increase in the length of stay by at least 1 day in at least 75 percent of the patients.

b. Comprehensive Review of the CC List

In previous years, we have made changes to the standard list of CCs, either by adding new CCs or deleting CCs already on the list, but we have never conducted a comprehensive review of the list. There are currently 3,285 diagnosis codes on the CC list. There are 121-paired DRGs that are split on the presence or absence of a CC.

We have reviewed these paired DRGs and found that the majority of cases that are assigned to DRGs that have a CC split fall into the DRG with CC. While this fact is not new, we have found that a much higher proportion of cases are being grouped to the DRG with a CC than had occurred in the past. In our review of the DRGs included in Table 7b of the September 1, 1987 **Federal Register** rule (52 FR 33125), we found the following percentages of cases assigned a CC in those DRGs that had a CC split (DRG Definitions Manual, GROUPER Version 5.0 (1986 data)):

- Cases with CC: 61.9 percent.
- Cases without CC: 38.1 percent.

When we compared the above DRG 1986 data to the DRG 2004 data that were included in the DRGs Definitions Manual, GROUPER Version 22.0, we found the following:

- Cases with CC: 79.9 percent.

• Cases without CC: 20.1 percent.

(We used DRGs Definitions Manual, GROUPER Version 5.0, for this analysis because prior versions of the DRGs Definitions Manual used age as a surrogate for a CC and the split was "CC and/or age greater than 69".)

The vast majority of patients being treated in inpatient settings have a CC as currently defined, and we believe that it is possible that the CC distinction has lost much of its ability to differentiate the resource needs of patients. The original definition used to develop the CC list (the presence of a CC would be expected to extend the length of stay of at least 75 percent of the patients who had the CC by at least one day) was used beginning in 1981 and has been part of the IPPS since its inception in 1983. There has been no substantive review of the CC list since its original development. In reviewing this issue, our clinical experts found several diseases that appear to be obvious candidates to be on the CC list, but currently are not:

Code	Code Description	2004 Count
041.7	Pseudomonas Infection in Conditions Classified Elsewhere and/or of Unspecified Site	47,350
253.6	Disorders of Neurohypophysis	23,613
414.12	Dissection of Coronary Artery	2,377
359.4	Toxic Myopathy	1,875
031.2	Disseminated Disease Due to Mycobacteria	1,428
451.83	Phlebitis and Thrombophlebitis of Deep Veins of Upper Extremeties	376

Conversely, our medical experts believe the following conditions are examples of common conditions that are on the CC list, but are not likely to lead to higher treatment costs when present as a secondary diagnosis:

Code	Code Description	2004 Count
424.0	Mitral Valve Disorder	401,359
305.00	Alcohol Abuse Unspecified Use	69,099
578.1	Blood in Stool	53,453
723.4	Brachial Neuritis/Radiculitis, Not Otherwise Specified	5,829
684	Impetigo	1,230
293.84	Anxiety Disorder in Conditions Classified Elsewhere	1,153

We note that the above conditions are examples only of why we believe the CC list needs a comprehensive review. In addition to this review, we note that these conditions may be treated differently under several DRG systems currently in use. For instance, ICD–9–CM code 414.12 (Dissection of coronary artery) is listed as a "Major CC" under the All Patient (AP) DRGs, GROUPER Version 21.0 and an "Extreme" CC under the All Patient Refined (APR) DRGs, GROUPER Version 20.0, but is not listed as a CC at all in GROUPER Version 22.0 of the DRGs Definitions Manual used by Medicare. Similarly, ICD–9–CM code 424.0 (Mitral valve disorder) is a CC under GROUPER Version 22.0 of the DRGs Definitions Manual for Medicare's DRG system, a minor CC under the GROUPER Version 20.0 of the APR–DRGs, and not a CC at all under GROUPER Version 21.0 of the AP–DRGs.

Given the long period of time that has elapsed since the original CC list was developed, the incremental nature of changes to it, and changes in the way inpatient care is delivered, we are planning a comprehensive and systematic review of the CC list for the IPPS rule for FY 2007. As part of this process, we plan to consider revising the standard for determining when a condition is a CC. For instance, we may use an alternative to classifying a condition as a CC based on how it affects the length of stay of a case. Similar to other aspects of the DRG system, we may consider the effect of a specific secondary diagnosis on the charges or costs of a case to evaluate whether to include the condition on the CC list. Using a statistical algorithm, we may classify each diagnosis based on its effect on hospital charges (or costs) relative to other cases when present as a secondary diagnosis to obtain better information on when a particular condition is likely to increase hospital costs. For example, Code 293.84 (Anxiety disorder in conditions classified elsewhere), which is currently listed as a CC, might be removed from the CC list if analysis of the data do not support the fact that it represents a significant increase in resource utilization, and a code such as 359.4 (Toxic myopathy), which is currently not listed as a CC, could be added to the CC list if the data support it. In addition to using hospital charge data as a basis for a review, we would expect to supplement the process with review by our medical experts. Further, we may also consider doing a comparison of the Medicare DRG CC list with other DRG systems such as the AP–DRGs and the APR–DRGs to determine how the same secondary diagnoses are treated under these systems.

By performing a comprehensive review of the CC list, we expect to revise the DRG classification system to better reflect resource utilization and remove conditions from the CC list that only have a marginal impact on a hospital's costs. We believe that a comprehensive review of the CC list would be consistent with MedPAC's recommendation that we improve the DRG system to better recognize severity. We will provide more detail about how we expect to undertake this analysis in the future, and any changes to the CC list will only be adopted after a notice and comment rulemaking that fully explains the methodology we plan to use in conducting this review. We encourage comment at this time regarding possible ways that more meaningful indicators of clinical severity and their implications for resource use can be incorporated into our comprehensive review and possible restructuring of the CC list.

c. CC Exclusions List for FY 2006

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. As we indicated above, we developed this list of diagnoses, using physician panels, to include those diagnoses that, when present as a secondary condition, would be considered a substantial complication or comorbidity. In previous years, we have made changes to the list of CCs, either by adding new CCs or deleting CCs already on the list. At this time, we are not proposing to delete any of the diagnosis codes on the CC list for FY 2006.

In the May 19, 1987 proposed notice (52 FR 18877) and the September 1, 1987 final notice (52 FR 33154), we explained that the excluded secondary diagnoses were established using the following five principles:

- Chronic and acute manifestations of the same condition should not be considered CCs for one another.
- Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for the same condition should not be considered CCs for one another.
- Codes for the same condition that cannot coexist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another.
- Codes for the same condition in anatomically proximal sites should not be considered CCs for one another.
- Closely related conditions should not be considered CCs for one another.

The creation of the CC Exclusions List was a major project involving hundreds of codes. We have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC.[1]

We are proposing a limited revision of the CC Exclusions List to take into account the proposed changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 2004. (See section II.B.13. of this preamble for a discussion of ICD–9–CM changes.) We are proposing these changes in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6G and 6H in the Addendum to this proposed rule contain the revisions to the CC Exclusions List that would be effective for discharges occurring on or after October 1, 2005. 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, 2005, the indented diagnoses would not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

CCs that are deleted from the list are in Table 6H—Deletions from the CC Exclusions List. Beginning with discharges on or after October 1, 2005, the indented diagnoses would be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

Copies of the original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for $152.50 plus shipping and handling. A request for the FY 1988 CC Exclusions List (which should include the identification accession number (PB) 88–133970) should be made to the following address: National Technical Information Service, United States Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161; or by calling (800) 553–6847.

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2001, 2002, 2003, 2004, and 2005) and those in Tables 6G and 6H of this proposed rule for FY 2006 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, 2005. (Note: There was no CC Exclusions List in FY 2000 because we did not make changes to the ICD–9–CM codes for FY 2000.)

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with CMS, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 22.0, is available for $225.00, which includes $15.00 for shipping and handling. Version 23.0 of this manual, which will include the final FY 2006 DRG changes, will be 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.

[1] *See* the FY 1989 final rule (53 FR 38485) [September 30, 1988] for the revision made for the discharges occurring in FY 1989; the FY 1990 final rule (54 FR 36552) [September 1, 1989] for the FY 1990 revision; the FY 1991 final rule (55 FR 36126) [September 4, 1990] for the FY 1991 revision; the FY 1992 final rule (56 FR 43209) [August 30, 1991] for the FY 1992 revision; the FY 1993 final rule (57 FR 39753) [September 1, 1992] for the FY 1993 revision; the FY 1994 final rule (58 FR 46278) [September 1, 1993] for the FY 1994 revisions; the FY 1995 final rule (59 FR 45334) [September 1, 1994] for the FY 1995 revisions; the FY 1996 final rule (60 FR 45782) [September 1, 1995] for the FY 1996 revisions; the FY 1997 final rule (61 FR 46171) [August 30, 1996] for the FY 1997 revisions; the FY 1998 final rule (62 FR 45966) [August 29, 1997] for the FY 1998 revisions; the FY 1999 final rule (63 FR 40954) [July 31, 1998] for the FY 1999 revisions; the FY 2001 final rule (65 FR 47064) [August 1, 2000] for the FY 2001 revisions; the FY 2002 final rule (66 FR 39851) [August 1, 2001] for the FY 2002 revisions; the FY 2003 final rule (67 FR 49998) [August 1, 2002] for the FY 2003 revisions; the FY 2004 final rule (68 FR 45364) [August 1, 2003] for the FY 2004 revisions; and the FY 2005 final rule (69 FR 49848) [August 11, 2004] for the FY 2005 revisions. In the FY 2000 final rule (64 FR 41490) [July 30, 1999], we did not modify the CC Exclusions List because we did not make any changes to the ICD–9–CM codes for FY 2000.

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

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

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

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

- 60.0, Incision of prostate.
- 60.12, Open biopsy of prostate.
- 60.15, Biopsy of periprostatic tissue.
- 60.18, Other diagnostic procedures on prostate and periprostatic tissue.
- 60.21, Transurethral prostatectomy.
- 60.29, Other transurethral prostatectomy.
- 60.61, Local excision of lesion of prostate.
- 60.69, Prostatectomy, not elsewhere classified.
- 60.81, Incision of periprostatic tissue.
- 60.82, Excision of periprostatic tissue.
- 60.93, Repair of prostate.
- 60.94, Control of (postoperative) hemorrhage of prostate.
- 60.95, Transurethral balloon dilation of the prostatic urethra.
- 60.96, Transurethral destruction of prostate tissue by microwave thermotherapy.
- 60.97, Other transurethral destruction of prostate tissue by other thermotherapy.
- 60.99, Other operations on prostate.

All remaining O.R. procedures are assigned to DRGs 468 and 477, with DRG 477 assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis.[2]

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

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

We identify those procedures occurring in conjunction with certain principal diagnoses with sufficient frequency to justify adding them to one of the surgical DRGs for the MDC in which the diagnosis falls. Based on this year's review, we did not identify any procedures in DRGs 468 or 477 that should be removed to one of the surgical DRGs. Therefore, in this proposed rule, we are not proposing any changes for FY 2006.

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.

It has come to our attention that procedure code 26.12 (Open biopsy of salivary gland or duct) is assigned to DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis). We believe this to be an error, as code 26.31 (Partial sialoadenectomy), which is a more extensive procedure than code 26.12, is assigned to DRG 477. Therefore, we are proposing to correct this error by moving code 26.12 out of DRG 468 and reassigning it to DRG 477.

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

c. Adding Diagnosis or Procedure Codes to MDCs

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

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 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 Official Version of the ICD–9-CM contains the list of valid diagnosis and procedure codes. (The Official Version of the ICD–9–CM is available from the Government Printing Office on CD–ROM for $25.00 by calling (202) 512–1800.) The Official Version of the ICD–9–CM is no longer available in printed manual form from the Federal Government; it is only available on CD–ROM. Users who need a paper version are referred to one of the many products available from publishing houses.

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

[2] 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 FY 1989 final rule (53 FR 38591). As part of the FY 1991 final rule (55 FR 36135), the FY 1992 final rule (56 FR 43212), the FY 1993 final rule (57 FR 23625), the FY 1994 final rule (58 FR 46279), the FY 1995 final rule (59 FR 45336), the FY 1996 final rule (60 FR 45783), the FY 1997 final rule (61 FR 46173), and the FY 1998 final rule (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 final rule (63 FR 40962); in FY 2000 (64 FR 41496); in FY 2001 (65 FR 47064); or in FY 2002 (66 FR 39852). In the FY 2003 final rule (67 FR 49999) we did not move any procedures from DRG 477. However, we did move procedure codes from DRG 468 and placed them in more clinically coherent DRGs. In the FY 2004 final rule (68 FR 45365), we moved several procedures from DRG 468 to DRGs 476 and 477 because the procedures are nonextensive. In the FY 2005 final rule (69 FR 48950), we moved one procedure from DRG 468 to 477. In addition, we added several existing procedures to DRGs 476 and 477.

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 2006 at a public meeting held on October 7–8, 2004, and finalized the coding changes after consideration of comments received at the meetings and in writing by January 12, 2005. Those coding changes are announced in Tables 6A through 6F of the Addendum to this proposed rule. The Committee held its 2005 meeting on March 31-April l, 2005. Proposed new codes for which there was a consensus of public support and for which complete tabular and indexing charges can be made by May 2005 will be included in the October 1, 2005 update to ICD–9–CM. These additional codes will be included in Tables 6A through 6F of the final rule.

Copies of the minutes of the procedure codes discussions at the Committee's October 7–8, 2004 meeting can be obtained from the CMS Web site: *http://www.cms.hhs.gov/paymentsystems/icd9/.* The minutes of the diagnoses codes discussions at the October 7–8, 2004 meeting 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. These Web sites also provide detailed information about the Committee, including information on requesting a new code, attending a Committee meeting, and timeline requirements and meeting dates.

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 2402, 3311 Toledo Road, Hyattsville, MD 20782. Comments may be sent by e-mail to: *dfp4@cdc.gov.*

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

The ICD–9–CM code changes that have been approved will become effective October 1, 2005. The new ICD–9–CM codes are listed, along with their DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in the Addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. In this proposed rule, we are only soliciting comments on the proposed classification of these new codes.

For codes that have been replaced by new or expanded codes, the corresponding new or expanded diagnosis codes are included in Table 6A. New procedure codes are shown in Table 6B. Diagnosis codes that have been replaced by expanded codes or other codes or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2005. Table 6D contains invalid procedure codes. These invalid procedure codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2005. 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 2006.

In the September 7, 2001 final rule implementing the IPPS new technology add-on payments (66 FR 46906), we indicated we would attempt to include proposals for procedure codes that would describe new technology discussed and approved at the April meeting as part of the code revisions effective the following October. As stated previously, ICD–9–CM codes discussed at the March 31-April 1, 2005 Committee meeting that receive consensus and that can be finalized by May 2005 will be included in Tables 6A through 6F of the final rule.

Section 503(a) of Pub. L. 108–173 included a requirement for updating ICD–9–CM codes twice a year instead of a single update on October 1 of each year. This requirement was included as part of the amendments to the Act relating to recognition of new technology under the IPPS. Section 503(a) amended section 1886(d)(5)(K) of the Act by adding a clause (vii) which states that the "Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) * * * until the fiscal year that begins after such date.'' This requirement improves the recognition of new technologies under the IPPS system by providing information on these new technologies at an earlier date. Data will be available 6 months earlier than would be possible with updates occurring only once a year on October 1.

While section 503(a) states that the addition of new diagnosis and procedure codes on April 1 of each year shall not require the Secretary to adjust the payment, or DRG classification under section 1886(d) of the Act until the fiscal year that begins after such date, we have to update the DRG software and other systems in order to recognize and accept the new codes. We also publicize the code changes and the need for a mid-year systems update by providers to capture the new codes. Hospitals also have to obtain the new code books and encoder updates, and make other system changes in order to capture and report the new codes.

The ICD–9–CM Coordination and Maintenance Committee holds its meetings in the Spring and Fall, usually in April and September, in order to update the codes and the applicable payment and reporting systems by October 1 of each year. Items are placed on the agenda for the ICD–9–CM Coordination and Maintenance Committee meeting if the request is received at least 2 months prior to the meeting. This requirement allows time for staff to review and research the coding issues and prepare material for discussion at the meeting. It also allows time for the topic to be publicized in meeting announcements in the **Federal Register** as well as on the CMS Web site. The public decides whether or not to attend the meeting based on the topics listed on the agenda. Final decisions on code title revisions are currently made by March 1 so that these titles can be included in the IPPS proposed rule. A

complete addendum describing details of all changes to ICD–9–CM, both tabular and index, are publicized on CMS and NCHS Web pages in May of each year. Publishers of coding books and software use this information to modify their products that are used by health care providers. This 5-month time period has proved to be necessary for hospitals and other providers to update their systems.

A discussion of this timeline and the need for changes are included in the December 4–5, 2003 ICD–9–CM Coordination and Maintenance Committee minutes. The public agreed that there was a need to hold the fall meetings earlier, in September or October, in order to meet the new implementation dates. The public provided comment that additional time would be needed to update hospital systems and obtain new code books and coding software. There was considerable concern expressed about the impact this new April update would have on providers.

In the FY 2005 IPPS final rule, we implemented section 503(a) by developing a mechanism for approving, in time for the April update, diagnoses and procedure code revisions needed to describe new technologies and medical services for purposes of the new technology add-on payment process. We also established the following process for making these determinations. Topics considered during the Fall ICD–9–CM Coordination and Maintenance Committee meeting are considered for an April 1 update if a strong and convincing case is made by the requester at the Committee's public meeting. The request must identify the reason why a new code is needed in April for purposes of the new technology process. The participants at the meeting and those reviewing the Committee meeting summary report are provided the opportunity to comment on this expedited request. All other topics are considered for the October 1 update. Participants at the Committee meeting are encouraged to comment on all such requests. There were no requests for an expedited April l, 2005 implementation of an ICD–9–CM code at the October 7–8, 2004 Committee meeting. Therefore, there were no new ICD–9–CM codes implemented on April 1, 2005.

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

Current addendum and code title information is published on the CMS Web page at: *http://www.cms.hhs.gov/paymentsystems/icd9.* Summary tables showing new, revised, and deleted code titles are also posted on the following CMS Web page: *http://www.cms.hhs.gov/medlearn/icd9code.asp.* Information on ICD–9–CM diagnosis codes, along with the Official ICD–9–CM Coding Guidelines, can be found on the Wep page at: *http://www.cdc.gov/nchs/icd9.htm.* Information on new, revised, and deleted ICD–9–CM codes is also provided to the AHA for publication in the *Coding Clinic for ICD–9–CM.* AHA also distributes information to publishers and software vendors.

CMS also sends copies of all ICD–9–CM coding changes to its contractors for use in updating their systems and providing education to providers.

These same means of disseminating information on new, revised, and deleted ICD–9–CM codes will be used to notify providers, publishers, software vendors, contractors, and others of any changes to the ICD–9–CM codes that are implemented in April. Currently, code titles are also published in the IPPS proposed and final rules. The code titles are adopted as part of the ICD–9–CM Coordination and Maintenance Committee process. The code titles are not subject to comment in the proposed or final rules. We will continue to publish the October code updates in this manner within the IPPS proposed and final rules. For codes that are implemented in April, we will assign the new procedure code to the same DRG in which its predecessor code was assigned so there will be no DRG impact as far as DRG assignment. This mapping was specified by Pub. L. 108–173. Any midyear coding updates will be available through the websites indicated above and through the *Coding Clinic for ICD–9–CM.* Publishers and software vendors currently obtain code changes through these sources in order to update their code books and software systems. We will strive to have the April 1 updates available through these websites 5 months prior to implementation (that is, early November of the previous year), as is the case for the October 1 updates. Codebook publishers are evaluating how they will provide any code updates to their subscribers. Some publishers may decide to publish mid-year book updates. Others may decide to sell an addendum that lists the changes to the October 1 code book. Coding personnel should contact publishers to determine how they will update their books. CMS and its contractors will also consider developing provider education articles concerning this change to the effective date of certain ICD–9–CM codes.

14. Other Issues: Acute Intermittent Porphyria

Acute intermittent porphyria is a rare metabolic disorder. The condition is described by code 277.1 (Disorders of porphyrin metabolism). Code 277.1 is assigned to DRG 299 (Inborn Errors of Metabolism) under MDC 10 (Endocrine, Nutritional, and Metabolic Diseases and Disorders).

In the FY 2005 final rule (69 FR 48981), we discussed the DRG assignment of acute intermittent porphyria. This discussion was a result of correspondence that we received during the comment period for the FY 2005 proposed rule in which the commenter suggested that Medicare hospitalization payments do not accurately reflect the cost of treatment. At that time, we indicated that we would take this comment into consideration when we analyzed the MedPAR data for this proposed rule for FY 2006.

Our review of the most recent MedPAR data shows a total of 1,370 cases overall in DRG 299, of which 471 had a principal diagnosis coded as 277.1. The average length of stay for all cases in DRG 299 was 5.17 days, while the average length of stay for porphyria cases with code 277.1 was 6.0 days. The average charges for all cases in DRG 299 were $15,891, while the average changes for porphyria cases with code 277.1 were $21,920. Based on our analysis of these data, we do not believe that there is a sufficient difference between the average charges and average length of stay for these cases to justify a change to the DRG assignment for treating this condition.

C. Proposed Recalibration of DRG Weights

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

We are proposing to use the same basic methodology for the FY 2006 recalibration as we did for FY 2005 (FY 2005 IPPS final rule (69 FR 48981)). That is, we have recalibrated the DRG weights based on charge data for

Medicare discharges using the most current charge information available (the FY 2004 MedPAR file).

The MedPAR file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills. The FY 2004 MedPAR data used in this final rule include discharges occurring between October 1, 2003 and September 30, 2004, based on bills received by CMS through December 31, 2004, from all hospitals subject to the IPPS and short-term acute care hospitals in Maryland (which are under a waiver from the IPPS under section 1814(b)(3) of the Act). The FY 2004 MedPAR file includes data for approximately 11,910,025 Medicare discharges. Discharges for Medicare beneficiaries enrolled in a Medicare+Choice managed care plan are excluded from this analysis. The data excludes CAHs, including hospitals that subsequently became CAHs after the period from which the data were taken.

The proposed methodology used to calculate the DRG relative weights from the FY 2004 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 2004 MedPAR file. (Medicare coverage for heart, heart-lung, liver, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)
- Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.
- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education and disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.
- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG. A transfer case is counted as a fraction of a case based on the ratio of its transfer payment under the per diem payment methodology to the full DRG payment for nontransfer cases. That is, a transfer case receiving payment under the transfer methodology equal to half of what the case would receive as a nontransfer would be counted as 0.5 of a total case.
- Statistical outliers were eliminated by removing all cases that are beyond 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG.
- The average charge for each DRG was then recomputed (excluding the statistical outliers) and divided by the national average standardized charge per case to determine the relative weight.

The proposed new weights are normalized by an adjustment factor of 1.47263 so that the average case weight after recalibration is equal to the average case weight before recalibration. This proposed adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We used that same case threshold in recalibrating the proposed DRG weights for FY 2006. Using the FY 2004 MedPAR data set, there are 41 DRGs that contain fewer than 10 cases. We are proposing to compute the weights for these low-volume DRGs by adjusting the FY 2005 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs.

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

D. Proposed LTC–DRG Reclassifications and Relative Weights for LTCHs for FY 2006

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

1. Background

In the June 6, 2003 LTCH PPS final rule (68 FR 34122), we changed the LTCH PPS annual payment rate update cycle to be effective July 1 through June 30 instead of October 1 through September 30. In addition, because 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 used under the IPPS. In that same final rule, we specified that we will continue to update the LTC–DRG classifications and relative weights to be effective for discharges occurring on or after October 1 through September 30 each year. Furthermore, we stated that we will publish the annual update of the LTC–DRGs in the proposed and final rules for the IPPS.

In the past, the annual update to the IPPS DRGs has been based on the annual revisions to the ICD–9–CM codes and was effective each October 1. As discussed in the FY 2005 IPPS final rule (69 FR 48954 through 48957) and in the February 3, 2005 LTCH PPS proposed rule (70 FR 5729 through 5733), with the implementation of section 503 (a) of Pub. L. 108–173, there is the possibility that one feature of the GROUPER software program may be updated twice during a Federal fiscal year (October 1 and April 1) as required by the statute for the IPPS. Specifically, ICD–9–CM diagnosis and procedure codes for new medical technology may be created and added to existing DRGs in the middle of the Federal fiscal year on April 1. This policy change will have no effect, however, on the LTC–DRG relative weights which will continue to be updated only once a year (October 1), nor will there be any impact on Medicare payments under the LTCH PPS. The use of the ICD–9–CM code set is also compliant with the current requirements of the Transactions and Code Sets Standards regulations at 45 CFR Parts 160 and 162, promulgated in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104–191.

In the health care industry, historically annual changes to the ICD–9–CM codes were effective for discharges occurring on or after October 1 each year. Thus, the manual and electronic versions of the GROUPER software, which are based on the ICD–9–CM codes, were also revised annually and effective for discharges occurring on or after October 1 each year. As noted above, the patient classification system used under the LTCH PPS (LTC–DRGs) is based on the patient classification system used under the IPPS (CMS–DRGs), which historically had been updated annually and effective for discharges occurring on or after October 1 through September 30 each year. As mentioned above, the ICD–9–CM coding update process has been revised, as discussed in greater detail in the FY 2005 IPPS final rule (69 FR 48954 through 48957). Specifically, section 503(a) of Pub. L. 108–173 includes a requirement for updating ICD–9–CM codes as often as twice a year instead of the current process of annual updates on October 1 of each year. This requirement is included as part of the amendments to the Act relating to recognition of new medical technology under the IPPS. Section 503(a) of Pub L. 108–173 amended section 1886(d)(5)(K) of the Act by adding a new clause (vii) which states that "the Secretary shall provide for the addition of new diagnosis and procedure codes in [sic] April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) * * * until the fiscal year that begins after such date.'' This requirement will improve the recognition of new technologies under the IPPS by accounting for those ICD–9–CM codes in the MedPAR claims data at an earlier date. Despite the fact that aspects of the GROUPER software may be updated to recognize any new technology ICD–9–CM codes, as discussed in the February 3, 2005 LTCH PPS proposed rule (70 FR 5730 through 5733), there will be no impact on either LTC–DRG assignments or payments under the LTCH PPS at that time. That is, changes to the LTC–DRGs (such as the creation or deletion of LTC–DRGs) and the relative weights will continue to be updated in the manner and timing (October 1) as they are now.

As noted above and as described in the February 3, 2005 LTCH PPS proposed rule (70 FR 5730), updates to the GROUPER for both the IPPS and the LTCH PPS (with respect to relative weights and the creation or deletion of DRGs) are made in the annual IPPS proposed and final rules and are effective each October 1. We explained in the FY 2005 IPPS final rule (69 FR 48955 and 48956), that since we do not publish a midyear IPPS rule, April 1 code updates discussed above will not be published in a midyear IPPS rule. Rather, we will assign any new diagnostic or procedure codes to the same DRG in which its predecessor code was assigned, so that there will be no impact on the DRG assignments. Any proposed coding updates will be available through the websites indicated in the same rule and provided above in section II.B. of this preamble and through the *Coding Clinic for ICD–9–CM.* Publishers and software vendors currently obtain code changes through these sources in order to update their code books and software system. If new codes are implemented on April 1, revised code books and software systems, including the GROUPER software program, will be necessary because we must use current ICD–9–CM codes. Therefore, for purposes of the LTCH PPS, since each ICD–9–CM code must be included in the GROUPER algorithm to classify each case into a LTC–DRG, the GROUPER software program used under the LTCH PPS would need to be revised to accommodate any new codes.

As we discussed in the FY 2005 IPPS final rule (69 FR 48956), in implementing section 503(a) of Pub. L. 108–173, there will only be an April 1 update if new technology codes are requested and approved. It should be noted that any new codes created for April 1 implementation will be limited to those diagnosis and procedure code revisions primarily needed to describe new technologies and medical services. However, we reiterate that the process of discussing updates to the ICD–9–CM has been an open process through the ICD–9–CM C&M Committee since 1995. Requestors will be given the opportunity to present the merits of their proposed new code and make a clear and convincing case for the need to update ICD–9–CM codes for purposes of the IPPS new technology add-on payment process through an April 1 update.

In addition, in the FY 2005 IPPS final rule (69 FR 48956), we stated that at the October 2004 ICD–9–CM Coordination and Maintenance Committee meeting, no new codes were proposed for an April 1, 2005 implementation, and the next update to the ICD–9–CM coding system would not occur until October 1, 2005 (FY 2006). Presently, as there were no coding changes suggested for an April 1, 2005 update, the ICD–9–CM coding set implemented on October 1, 2004 will continue through September 30, 2005 (FY 2005). The proposed update to the ICD–9–CM coding system for FY 2006 is discussed above in section II.B. of this preamble.

In this proposed rule, we are proposing revisions to the LTC–DRG classifications and relative weights and, to the extent that they are finalized, we will publish them in the corresponding IPPS final rule, to be effective October 1, 2005 through September 30, 2006 (FY 2006), using the latest available data. The proposed LTC–DRGs and relative weights for FY 2006 in this proposed rule are based on the proposed IPPS DRGs (GROUPER Version 23.0) discussed in section II. of this proposed rule.

2. Proposed 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, in this proposed rule, we are proposing to use the IPPS GROUPER Version 23.0 for FY 2006 to process LTCH PPS claims for LTCH occurring from October 1, 2005 through September 30, 2006. The proposed changes to the CMS DRG classification system used under the IPPS for FY 2006 (GROUPER Version 23.0) are discussed in section II.B. of the preamble to this proposed rule.

Under the LTCH PPS, we determine relative weights for each of the CMS DRGs to account for the difference in resource use by patients exhibiting the

case complexity and multiple medical problems characteristic of LTCH patients. In a departure from the IPPS, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55985), which implemented the LTCH PPS, and the FY 2004 IPPS final rule (68 FR 45374), we use low-volume quintiles in determining the LTC–DRG weights for LTC–DRGs with less than 25 LTCH cases, because LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. Specifically, we group those low-volume LTC–DRGs (LTC–DRGs with fewer than 25 cases) into 5 quintiles based on average charge per discharge. (A listing of the composition of low-volume quintiles for the FY 2005 LTC–DRGs (based on FY 2003 MedPAR data) appears in section II.D.3. of the FY 2005 IPPS final rule (69 FR 48985 through 48989).) We also adjust for cases in which the stay at the LTCH is less than or equal to five-sixths of the geometric average length of stay; that is, short-stay outlier cases (§ 412.529), as discussed below in section II.D.4. of this preamble.

b. Patient Classifications into DRGs

Generally, under the LTCH PPS, Medicare payment is made at a predetermined specific rate for each discharge; that is, payment varies by the LTC–DRG to which a beneficiary's stay is assigned. Similar to case classification for acute care hospitals under the IPPS (see section II.B. of this preamble), cases are classified into LTC–DRGs for payment under the LTCH PPS based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient. The diagnosis and procedure information is reported by the hospital using codes from the ICD–9–CM.

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

Because the assignment of a case to a particular LTC–DRG will help determine the amount that is paid for the case, it is important that the coding is accurate. As used under the IPPS, classifications and terminology used under the LTCH PPS are consistent with the ICD–9–CM and the Uniform Hospital Discharge Data Set (UHDDS), as recommended to the Secretary by the National Committee on Vital and Health Statistics ("Uniform Hospital Discharge Data: Minimum Data Set, National Center for Health Statistics, April 1980") and as revised in 1984 by the Health Information Policy Council (HIPC) of the U.S. Department of Health and Human Services. We 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 Transactions and Code Sets Standards under 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. Completed claim forms are to be submitted electronically to the LTCH's Medicare fiscal intermediary. Medicare fiscal intermediaries enter the clinical and demographic information into their claims processing systems and subject this information to a series of automated screening processes called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before assignment into an LTC–DRG can be made.

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

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

3. Development of the Proposed FY 2006 LTC–DRG Relative Weights

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

As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55981), one of the primary goals for the implementation of the LTCH PPS is to pay each LTCH an appropriate amount for the efficient delivery of care to Medicare patients. The system must be able to account adequately for each LTCH's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for those Medicare patients whose care is more costly. To accomplish these goals, we adjust the LTCH PPS standard Federal prospective payment system rate by the applicable LTC–DRG relative weight in determining payment to LTCHs for each case. Under the LTCH PPS, relative weights for each LTC–DRG are a primary element used to account for the variations in cost per discharge and resource utilization among the payment groups (§ 412.515). To ensure that Medicare patients classified to each LTC–DRG have access to an appropriate level of services and to encourage efficiency, we calculate a relative weight for each LTC–DRG that represents the resources needed by an average inpatient LTCH case in that LTC–DRG. For example, cases in an LTC–DRG with a relative weight of 2 will, on average, cost twice as much as cases in an LTC–DRG with a weight of 1.

b. Data

To calculate the proposed LTC–DRG relative weights for FY 2006 in this proposed rule, we obtained total Medicare allowable charges from FY 2004 Medicare hospital bill data from the December 2004 update of the MedPAR file, and we used the proposed Version 23.0 of the CMS GROUPER for IPPS (as discussed in section II.B. of this preamble) to classify cases. Consistent with the methodology under the IPPS, we are proposing to recalculate the FY 2006 LTC–DRG relative weights based on the best available data for this proposed rule.

As we discussed in the FY 2005 IPPS final rule (69 FR 48984), 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 proposed FY 2006 LTC–DRG relative weights, we have excluded the data of the 19 all-inclusive rate providers and the 3 LTCHs that are paid in accordance with demonstration projects that had claims in the FY 2003 MedPAR file.

In the FY 2005 IPPS final rule (6 FR 48984), we discussed coding inaccuracies that were found in the claims data for a large chain of LTCHs in the FY 2002 MedPAR file, which were used to determine the LTC–DRG relative weights for FY 2004. As we discussed in the same final rule, after notifying the large chain of LTCHs whose claims contained the coding inaccuracies to request that they resubmit those claims with the correct diagnosis, from an analysis of LTCH claims data from the December 2003 update of the FY 2003 MedPAR file, it appeared that such claims data no longer contain coding errors. Therefore, it was not necessary to correct the FY 2003 MedPAR data for the development of the FY 2005 LTC–DRGs and relative weights established in the same final rule.

As stated above, in this proposed rule, we are proposing to use the December 2004 update of the FY 2004 MedPAR file for the determination of the proposed FY 2006 LTC–DRG relative weights as these are the best available data. Based on an analysis of LTCH claims data from the December 2004 update of the FY 2004 MedPAR file, it appears that such claims data do not contain coding inaccuracies found previously in LTCH claims data. Therefore, it was not necessary to correct the FY 2004 MedPAR data for the development of the proposed FY 2006 LTC–DRGs and relative weights presented in this proposed rule.

c. Hospital-Specific Relative Value Methodology

By nature, LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. This 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. Proposed 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 established in the August 30, 2002 LTCH PPS final rule (67 FR 55984), we group those low-volume LTC–DRGs into one of five categories (quintiles) based on average charges, for the purposes of determining relative weights. For this proposed rule, using LTCH cases from the December 2004 update of the FY 2004 MedPAR file, we identified 172 LTC–DRGs that contained between 1 and 24 cases. This list of proposed LTC–DRGs was then divided into one of the 5 low-volume quintiles, each containing a minimum of 34 LTC–DRGs (172/5 = 34 with 2 LTC–DRGs as the remainder). For FY 2006, we are proposing to make an assignment to a specific low-volume quintile by sorting the low-volume proposed LTC–DRGs in ascending order by average charge. For this proposed rule, this results in an assignment to a specific low volume quintile of the sorted 172 low-volume proposed LTC–DRGs by ascending order by average charge. Because the number of LTC–DRGs with less than 25 LTCH cases is not evenly divisible by five, the average charge of the low-volume proposed LTC–DRG was used to determine which low-

volume quintile received the additional proposed LTC–DRG. After sorting the 172 low-volume LTC–DRGs in ascending order, we are proposing that the first fifth of low-volume LTC–DRGs with the lowest average charge would be grouped into Quintile 1. The highest average charge cases would be grouped into Quintile 5. Since the average charge of the proposed 35th LTC–DRG in the sorted list is closer to the proposed 34th LTC–DRG's average charge (assigned to Quintile 1) than to the average charge of the proposed 36th LTC–DRG in the sorted list (to be assigned to Quintile 2), we are proposing to place it into Quintile 1. This process was repeated through the remaining low-volume proposed LTC–DRGs so that 2 proposed low-volume quintiles contain 35 proposed LTC–DRGs and 3 proposed low-volume quintiles contain 34 proposed LTC–DRGs.

In order to determine the proposed relative weights for the proposed LTC–DRGs with low volume for FY 2006, in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55984), we are proposing to use the proposed five low-volume quintiles described above. The composition of each of the proposed five low-volume quintiles shown in the chart below would be used in determining the proposed LTC–DRG relative weights for FY 2006. We would determine a proposed relative weight and (geometric) average length of stay for each of the proposed five low-volume quintiles using the formula that we apply to the regular proposed LTC–DRGs (25 or more cases), as described below in section II.D.4. of this preamble. We are proposing to assign the same relative weight and average length of stay to each of the proposed LTC–DRGs that make up that proposed low-volume quintile. We note that, as this system is dynamic, it is possible that the number and specific type of LTC–DRGs with a low volume of LTCH cases will vary in the future. We use the best available claims data in the MedPAR file to identify low-volume LTC–DRGs and to calculate the relative weights based on our methodology.

Proposed Composition of Low-Volume Quintiles for FY 2006

LTC-DRG	Description
	QUINTILE 1
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC
25	SEIZURE & HEADACHE AGE >17 W/O CC
29	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC
65	DYSEQUILIBRIUM
69	OTITIS MEDIA & URI AGE >17 W/O CC
95	PNEUMOTHORAX W/O CC
102	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC
133	ATHEROSCLEROSIS W/O CC
140	ANGINA PECTORIS
142	SYNCOPE & COLLAPSE W/O CC
171	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC
175	G.I. HEMORRHAGE W/O CC
219	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC
237	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH
241	CONNECTIVE TISSUE DISORDERS W/O CC
246	NON-SPECIFIC ARTHROPATHIES
251	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC
254	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY
273	MAJOR SKIN DISORDERS W/O CC
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC
284	MINOR SKIN DISORDERS W/O CC
301	ENDOCRINE DISORDERS W/O CC
305	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC
312	URETHRAL PROCEDURES, AGE >17 W CC
319	KIDNEY & URINARY TRACT NEOPLASMS W/O CC
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC
328	URETHRAL STRICTURE AGE >17 W CC

LTC-DRG	Description
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL
431	CHILDHOOD MENTAL DISORDERS
441	HAND PROCEDURES FOR INJURIES
445	TRAUMATIC INJURY AGE >17 W/O CC
509	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA
511	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA
	QUINTILE 2
11	NERVOUS SYSTEM NEOPLASMS W/O CC
44	ACUTE MAJOR EYE INFECTIONS
46	OTHER DISORDERS OF THE EYE AGE >17 W CC
83	MAJOR CHEST TRAUMA W CC
86	PLEURAL EFFUSION W/O CC
93	INTERSTITIAL LUNG DISEASE W/O CC
97	BRONCHITIS & ASTHMA AGE >17 W/O CC
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE
128	DEEP VEIN THROMBOPHLEBITIS
136	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC
143	CHEST PAIN
151	PERITONEAL ADHESIOLYSIS W/O CC
173	DIGESTIVE MALIGNANCY W/O CC
206	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC
208	DISORDERS OF THE BILIARY TRACT W/O CC
250	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC
276	NON-MALIGANT BREAST DISORDERS
293	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC
306	PROSTATECTOMY W CC
325	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC
334	MAJOR MALE PELVIC PROCEDURES W CC
336	TRANSURETHRAL PROSTATECTOMY W CC
347	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC
348	BENIGN PROSTATIC HYPERTROPHY W CC
399	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC
404	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC
425	ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION
432	OTHER MENTAL DISORDER DIAGNOSES
433	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA
447	ALLERGIC REACTIONS AGE >17
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA
503	KNEE PROCEDURES W/O PDX OF INFECTION
	QUINTILE 3
8	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC
21	VIRAL MENINGITIS
31	CONCUSSION AGE >17 W CC
61	MYRINGOTOMY W TUBE INSERTION AGE >17

LTC-DRG	Description
67	EPIGLOTTITIS
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC
119	VEIN LIGATION & STRIPPING
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG
152	MINOR SMALL & LARGE BOWEL PROCEDURES W CC
177	UNCOMPLICATED PEPTIC ULCER W CC
178	UNCOMPLICATED PEPTIC ULCER W/O CC
181	G.I. OBSTRUCTION W/O 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
197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC
223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC
227	SOFT TISSUE PROCEDURES W/O CC
235	FRACTURES OF FEMUR
266	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC
270	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC
274	MALIGNANT BREAST DISORDERS W CC
295	DIABETES AGE 0-35
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS
419	FEVER OF UNKNOWN ORIGIN AGE >17 W CC
424	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS
443	OTHER O.R. PROCEDURES FOR INJURIES W/O CC
449	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC
454	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC
467	OTHER FACTORS INFLUENCING HEALTH STATUS
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES
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
531	SPINAL PROCEDURES WITH CC
532*	SPINAL PROCEDURES WITHOUT CC
	QUINTILE 4
22	HYPERTENSIVE ENCEPHALOPATHY
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17
63	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES
110	MAJOR CARDIOVASCULAR PROCEDURES W CC
116	OTH PERM CARD PACEMAK IMPL OR PTCA W CORONARY ARTERY STENT IMPLNT
118	CARDIAC PACEMAKER DEVICE REPLACEMENT
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG
150	PERITONEAL ADHESIOLYSIS W CC
157	ANAL & STOMAL PROCEDURES W CC
168	MOUTH PROCEDURES W CC
191	PANCREAS, LIVER & SHUNT PROCEDURES W CC

LTC-DRG	Description
195	CHOLECYSTECTOMY W C.D.E. W CC
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE
228	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC
288	O.R. PROCEDURES FOR OBESITY
299	INBORN ERRORS OF METABOLISM
303	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM
308	MINOR BLADDER PROCEDURES W CC
310	TRANSURETHRAL PROCEDURES W CC
323	URINARY STONES W CC, &/OR ESW LITHOTRIPSY
339	TESTES PROCEDURES, NON-MALIGNANCY AGE >17
341	PENIS PROCEDURES
360	VAGINA, CERVIX & VULVA PROCEDURES
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC
497	SPINAL FUSION W CC
500	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC
502	KNEE PROCEDURES W PDX OF INFECTION W/O CC
505	EXTENSIVE BURN OR FULL THICKNESS BURNS WITH MECH VENT 96+ HOURS WITHOUT SKIN GRAFT
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA
539	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITH CC
	QUINTILE 5
1	CRANIOTOMY AGE >17 W CC
75	MAJOR CHEST PROCEDURES
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC
115	PRM CARD PACEM IMPL W AMI,HRT FAIL OR SHK,OR AICD LEAD OR GNRTR P
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT
154	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC
200	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC
218	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR
268	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES
290	THYROID PROCEDURES
304	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY
364	D&C, CONIZATION EXCEPT FOR MALIGNANCY
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES
394	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA
488	HIV W EXTENSIVE O.R. PROCEDURE

LTC-DRG	Description
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY
499	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC
501	KNEE PROCEDURES W PDX OF INFECTION W CC
515	CARDIAC DEFIBRILATOR IMPLANT W/O CARDIAC CATH
517	PERCUTANEOUS CARDIVASCULAR PROC W NON-DRUG ELUTING STENT W/O AMI
519	CERVICAL SPINAL FUSION W CC
527	PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W/O AMI
529	VENTRICULAR SHUNT PROCEDURES W CC
533	EXTRACRANIAL VASCULAR PROCEDURES WITH CC
543	CRANIOTOMY W IMPLANT OF CHEMO AGENT OR ACUTE COMPLEX CNS PDX
544	MAJOR JOINT REPLACEMENT OR REATTACHMENT
545	REVISION OF HIP OR KNEE REPLACEMENT

*One of the original 172 low-volume proposed LTC-DRGs initially assigned to another proposed low-volume quintile and now assigned to this proposed low-volume quintile to address nonmonotonicity (see step 5 below).

4. Steps for Determining the Proposed FY 2006 LTC–DRG Relative Weights

As we noted previously, the proposed FY 2006 LTC–DRG relative weights are determined in accordance with the methodology established in the August 1, 2003 IPPS final rule (68 FR 45367). In summary, LTCH cases must be grouped in the appropriate LTC–DRG, while taking into account the low-volume proposed LTC–DRGs as described above, before the proposed FY 2006 LTC–DRG relative weights can be determined. After grouping the cases in the appropriate proposed LTC–DRG, we are proposing to calculate the proposed relative weights for FY 2006 in this proposed rule by first removing statistical outliers and cases with a length of stay of 7 days or less, as discussed in greater detail below. Next, we are proposing to adjust the number of cases in each proposed LTC–DRG for the effect of short-stay outlier cases under § 412.529, as also discussed in greater detail below. The short-stay adjusted discharges and corresponding charges are used to calculate "relative adjusted weights'' in each proposed LTC–DRG using the hospital-specific relative value method described above.

Below we discuss in detail the steps for calculating the proposed FY 2006 LTC–DRG relative weights.

Step 1—Remove statistical outliers.

The first step in the calculation of the proposed FY 2006 LTC–DRG relative weights is to remove statistical outlier cases. We define statistical outliers as cases that are outside of 3.0 standard deviations from the mean of the log distribution of both charges per case and the charges per day for each LTC–DRG. These statistical outliers are removed prior to calculating the proposed relative weights. We believe that they may represent aberrations in the data that distort the measure of average resource use. Including those LTCH cases in the calculation of the proposed relative weights could result in an inaccurate proposed relative weight that does not truly reflect relative resource use among the proposed LTC–DRGs.

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

The proposed FY 2006 LTC–DRG relative weights reflect the average of resources used on representative cases of a specific type. Generally, cases with a length of stay 7 days or less do not belong in a LTCH because these stays do not fully receive or benefit from treatment that is typical in a LTCH stay, and full resources are often not used in the earlier stages of admission to a LTCH. If we were to include stays of 7 days or less in the computation of the proposed FY 2006 LTC–DRG relative weights, the value of many proposed relative weights would decrease and, therefore, payments would decrease to a level that may no longer be appropriate.

We do not believe that it would be appropriate to compromise the integrity of the payment determination for those LTCH cases that actually benefit from and receive a full course of treatment at a LTCH, in order to include data from these very short-stays. Thus, in determining the proposed FY 2006 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.

After removing cases with a length of stay of 7 days or less, we are left with cases that have a length of stay of greater than or equal to 8 days. The next step in the calculation of the proposed FY 2006 LTC–DRG relative weights is to adjust each LTCH's charges per discharge for those remaining cases for the effects of short-stay outliers as defined in § 412.529(a). (However, we note that even if a case was removed in Step 2 (that is, cases with a length of stay of 7 days or less), it was paid as a short-stay outlier if its length of stay was less than or equal to five-sixths of the average length of stay of the LTC–DRG, in accordance with § 412.529.)

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

As we explained in the FY 2005 IPPS final rule (69 FR 48991), counting short-

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

Step 4—Calculate the Proposed FY 2006 LTC–DRG relative weights on an iterative basis.

The process of calculating the proposed LTC–DRG relative weights using the hospital specific relative value methodology is iterative. First, for each LTCH case, we calculate a hospital-specific relative charge value by dividing the short-stay outlier adjusted charge per discharge (see step 3) of the LTCH case (after removing the statistical outliers (see step 1)) and LTCH cases with a length of stay of 7 days or less (see step 2) by the average charge per discharge for the LTCH in which the case occurred. The resulting ratio is then multiplied by the LTCH's case-mix index to produce an adjusted hospital-specific relative charge value for the case. An initial case-mix index value of 1.0 is used for each LTCH.

For each proposed LTC–DRG, the proposed FY 2006 LTC–DRG relative weight is calculated by dividing the average of the adjusted hospital-specific relative charge values (from above) for the proposed LTC–DRG by the overall average hospital-specific relative charge value across all cases for all LTCHs. Using these recalculated proposed LTC–DRG relative weights, each proposed LTCH's average relative weight for all of its cases (case-mix) is calculated by dividing the sum of all the proposed 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 proposed LTC–DRG relative weights across all LTCHs. In this proposed rule, this iterative process is continued until there is convergence between the weights produced at adjacent steps, for example, when the maximum difference is less than 0.0001.

Step 5–Adjust the proposed FY 2006 LTC–DRG relative weights to account for nonmonotonically increasing relative weights.

As explained in section II.B. of this preamble, the proposed FY 2006 CMS DRGs, which the proposed FY 2006 LTC–DRGs are based, contain "pairs'' that are differentiated based on the presence or absence of CCs. The proposed LTC–DRGs with CCs are defined by certain secondary diagnoses not related to or inherently a part of the disease process identified by the principal diagnosis, but the presence of additional diagnoses does not automatically generate a CC. As we discussed in the FY 2005 IPPS final rule (69 FR 48991), the value of monotonically increasing relative weights rises as the resource use increases (for example, from uncomplicated to more complicated). The presence of CCs in a proposed LTC–DRG means that cases classified into a "without CC'' proposed LTC–DRG are expected to have lower resource use (and lower costs). In other words, resource use (and costs) are expected to decrease across "with CC''/"without CC'' pairs of proposed LTC–DRGs.

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

Thus, in developing the FY 2003 LTC–DRG relative weights for the LTCH PPS based on FY 2001 claims data, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55990), we found on occasion that the data suggested that cases classified to the LTC–DRG "with CCs'' of a "with CC''/"without CC'' pair had a lower average charge than the corresponding LTC–DRG "without CCs.'' Similarly, as discussed in the FY 2005 IPPS final rule (69 FR 48991 through 48992), based on FY 2003 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 the FY 2005 LTC–DRG relative weights.

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 because, in general, cases classified into a "with CC'' LTC–DRG are expected to have higher resource use (and higher cost) as discussed above. Therefore, previously when we determined the LTC–DRG relative weights in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55990), we grouped both the cases "with CCs'' and "without CCs'' together for the purpose of calculating the LTC–DRG relative weights for FYs 2003 through 2005. As we stated in that same final rule, we will continue to employ this methodology to account for nonmonotonically increasing relative weights until we have adequate data to calculate appropriate separate weights for these anomalous LTC–DRG pairs. We expect that, as was the case when we first implemented the IPPS, this problem will be self-correcting, as LTCHs submit more completely coded data in the future.

There are three types of "with CC'' and "without CC'' pairs that could be nonmonotonic; that is, where the "without CC'' proposed LTC–DRG would have a higher average charge than the "with CC'' proposed LTC–DRG. For this proposed rule, using the LTCH cases in the December 2004 update of the FY 2004 MedPAR file (the best available data at this time), we identified one of the three types of nonmonotonic LTC–DRG pairs.

The first category of nonmonotonically increasing proposed relative weights for FY 2006 proposed LTC–DRG pairs "with and without CCs'' contains zero pairs of proposed LTC–DRGs in which both the proposed LTC–DRG "with CCs'' and the proposed LTC–DRG "without CCs'' had 25 or more LTCH cases and, therefore, did not fall into one of the 5 low-volume quintiles. For those nonmonotonic proposed LTC–DRG pairs, we would combine the LTCH cases and compute a new proposed relative weight based on the case-weighted average of the combined LTCH cases of the proposed LTC–DRGs.

The case-weighted average charge is determined by dividing the total charges for all LTCH cases by the total number of LTCH cases for the combined proposed LTC–DRG. This new proposed relative weight would then be assigned to both of the proposed LTC–DRGs in the pair. In this proposed rule, for FY 2006, there are no proposed LTC–DRGs that fall into this category.

The second category of nonmonotonically increasing relative weights for proposed LTC–DRG pairs "with and without CCs'' consists of one pair of proposed LTC–DRGs that has fewer than 25 cases, and each proposed LTC–DRG would be grouped to different proposed low-volume quintiles in which the "without CC'' proposed LTC–DRG is in a higher-weighted proposed low-volume quintile than the "with CC'' proposed LTC–DRG. For those pairs, we would combine the LTCH cases and determine the case-weighted average charge for all LTCH cases. The case-weighted average charge is determined by dividing the total charges for all LTCH cases by the total number of LTCH cases for the combined proposed LTC–DRG. Based on the case-weighted average LTCH charge, we determine within which low-volume quintile the "combined LTC–DRG'' is grouped. Both proposed LTC–DRGs in the pair are then grouped into the same proposed low-volume quintile, and thus have the same proposed relative weight. In this proposed rule, for FY 2006, proposed LTC–DRGs 531 and 532 fall into this category.

The third category of nonmonotonically increasing relative weights for proposed LTC–DRG pairs "with and without CCs'' consists of zero pairs of proposed LTC–DRGs where one of the proposed LTC–DRGs has fewer than 25 LTCH cases and is grouped to a proposed low-volume quintile and the other proposed LTC–DRG has 25 or more LTCH cases and has its own proposed LTC–DRG relative weight, and the proposed LTC–DRG "without CCs'' has the higher proposed relative weight. We remove the proposed low-volume LTC–DRG from the proposed low-volume quintile and combine it with the other proposed LTC–DRG for the computation of a new proposed relative weight for each of these proposed LTC–DRGs. This new proposed relative weight is assigned to both proposed LTC–DRGs, so they each have the same proposed relative weight. In this proposed rule, for FY 2006, there are no proposed LTC–DRGs that fall into this category.

Step 6–Determine a proposed FY 2006 LTC–DRG relative weight for proposed LTC–DRGs with no LTCH cases.

As we stated above, we determine the proposed relative weight for each proposed LTC–DRG using charges reported in the December 2004 update of the FY 2004 MedPAR file. Of the 526 proposed LTC–DRGs for FY 2006, we identified 194 proposed LTC–DRGs for which there were no LTCH cases in the database. That is, based on data from the FY 2004 MedPAR file used in this proposed rule, no patients who would have been classified to those LTC–DRGs were treated in LTCHs during FY 2004 and, therefore, no charge data were reported for those proposed LTC–DRGs. Thus, in the process of determining the proposed LTC–DRG relative weights, we are unable to determine weights for these 194 proposed LTC–DRGs using the methodology described in steps 1 through 5 above. However, because patients with a number of the diagnoses under these proposed LTC–DRGs may be treated at LTCHs beginning in FY 2006, we assign proposed relative weights to each of the 194 "no volume'' proposed LTC–DRGs based on clinical similarity and relative costliness to one of the remaining 332 (156—194 = 332) proposed LTC–DRGs for which we are able to determine proposed relative weights, based on FY 2004 claims data.

As there are currently no LTCH cases in these "no volume'' proposed LTC–DRGs, we determine proposed relative weights for the 194 proposed LTC–DRGs with no LTCH cases in the FY 2004 MedPAR file used in this proposed rule by grouping them to the appropriate proposed low-volume quintile. This methodology is consistent with our methodology used in determining proposed relative weights to account for the proposed low-volume LTC–DRGs described above.

Our methodology for determining proposed relative weights for the proposed "no volume'' LTC–DRGs is as follows: We crosswalk the proposed no volume LTC–DRGs by matching them to other similar proposed LTC–DRGs for which there were LTCH cases in the FY 2004 MedPAR file based on clinical similarity and intensity of use of resources as determined by care provided during the period of time surrounding surgery, surgical approach (if applicable), length of time of surgical procedure, post-operative care, and length of stay. We assign the proposed relative weight for the applicable proposed low-volume quintile to the proposed no volume LTC–DRG if the proposed LTC–DRG to which it is crosswalked is grouped to one of the proposed low-volume quintiles. If the proposed LTC–DRG to which the proposed no volume LTC–DRG is crosswalked is not one of the proposed LTC–DRGs to be grouped to one of the proposed low-volume quintiles, we compare the proposed relative weight of the proposed LTC–DRG to which the proposed no volume LTC–DRG is crosswalked to the proposed relative weights of each of the five quintiles and we assign the proposed no volume LTC–DRG the proposed relative weight of the proposed low-volume quintile with the closest weight. For this proposed rule, a list of the proposed no volume FY 2006 LTC–DRGs and the proposed FY 2006 LTC–DRG to which it is crosswalked in order to determine the appropriate proposed low-volume quintile for the assignment of a relative weight for FY 2006 is shown in the chart below.

Proposed No Volume LTC-DRG Crosswalk and Quintile Assignment for FY 2006

LTC-DRG	DESCRIPTION	Proposed Cross-Walked LTC-DRG	Proposed Low-Volume Quintile Assignment
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 1
30	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	29	Quintile 1
32	CONCUSSION AGE >17 W/O CC	25	Quintile 1
33	CONCUSSION AGE 0-17	25	Quintile 1
36	RETINAL PROCEDURES	40	Quintile 4
37	ORBITAL PROCEDURES	40	Quintile 4
38	PRIMARY IRIS PROCEDURES	40	Quintile 4
39	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	40	Quintile 4
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	40	Quintile 4
42	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	40	Quintile 4
43	HYPHEMA	40	Quintile 4
45	NEUROLOGICAL EYE DISORDERS	40	Quintile 4
47	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	40	Quintile 4
48	OTHER DISORDERS OF THE EYE AGE 0-17	40	Quintile 4
49	MAJOR HEAD & NECK PROCEDURES	64	Quintile 4
50	SIALOADENECTOMY	63	Quintile 4
51	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	63	Quintile 4
52	CLEFT LIP & PALATE REPAIR	63	Quintile 4
53	SINUS & MASTOID PROCEDURES AGE >17	63	Quintile 4
54	SINUS & MASTOID PROCEDURES AGE 0-17	63	Quintile 4
55	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	63	Quintile 4
56	RHINOPLASTY	63	Quintile 4
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	69	Quintile 1
58	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	69	Quintile 1
59	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	69	Quintile 1
60	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	69	Quintile 1
62	MYRINGOTOMY W TUBE INSERTION AGE 0-17	69	Quintile 1
66	EPISTAXIS	69	Quintile 1
70	OTITIS MEDIA & URI AGE 0-17	69	Quintile 1
71	LARYNGOTRACHEITIS	97	Quintile 2
72	NASAL TRAUMA & DEFORMITY	73	Quintile 2
74	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	69	Quintile 1
81	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	69	Quintile 1
84	MAJOR CHEST TRAUMA W/O CC	93	Quintile 2
91	SIMPLE PNEUMONIA & PLEURISY AGE 0-17	90	Quintile 1
98	BRONCHITIS & ASTHMA AGE 0-17	97	Quintile 2
104	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH	110	Quintile 4
105	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH	110	Quintile 4
106	CORONARY BYPASS W PTCA	110	Quintile 4
107	CORONARY BYPASS W CARDIAC CATH	110	Quintile 4
108	OTHER CARDIOTHORACIC PROCEDURES	110	Quintile 4
109	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	110	Quintile 4
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	110	Quintile 4
129	CARDIAC ARREST, UNEXPLAINED	110	Quintile 4
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
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	176	Quintile 3
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	152	Quintile 3

LTC-DRG	DESCRIPTION	Proposed Cross-Walked LTC-DRG	Proposed Low-Volume Quintile Assignment
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	154	Quintile 5
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	154	Quintile 5
158	ANAL & STOMAL PROCEDURES W/O CC	157	Quintile 4
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	177	Quintile 3
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	177	Quintile 3
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	178	Quintile 3
163	HERNIA PROCEDURES AGE 0-17	178	Quintile 3
164	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	148	Quintile 5
165	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	148	Quintile 5
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	148	Quintile 5
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	148	Quintile 5
169	MOUTH PROCEDURES W/O CC	185	Quintile 3
184	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	183	Quintile 1
186	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	185	Quintile 3
187	DENTAL EXTRACTIONS & RESTORATIONS	185	Quintile 3
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	189	Quintile 1
192	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	191	Quintile 4
194	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	193	Quintile 3
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 5
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	210	Quintile 5
220	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	218	Quintile 5
224	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	227	Quintile 3
229	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	237	Quintile 1
232	ARTHROSCOPY	237	Quintile 1
234	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	237	Quintile 1
252	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	253	Quintile 3
255	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	253	Quintile 3
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC	274	Quintile 3
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	274	Quintile 3
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	274	Quintile 3
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	274	Quintile 3
267	PERIANAL & PILONIDAL PROCEDURES	271	Quintile 3
275	MALIGNANT BREAST DISORDERS W/O CC	274	Quintile 3
279	CELLULITIS AGE 0-17	273	Quintile 1
282	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	281	Quintile 1
286	ADRENAL & PITUITARY PROCEDURES	292	Quintile 5
289	PARATHYROID PROCEDURES	63	Quintile 4
291	THYROGLOSSAL PROCEDURES	63	Quintile 4

LTC-DRG	DESCRIPTION	Proposed Cross-Walked LTC-DRG	Proposed Low-Volume Quintile Assignment
298	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	297	Quintile 2
307	PROSTATECTOMY W/O CC	306	Quintile 2
309	MINOR BLADDER PROCEDURES W/O CC	308	Quintile 4
311	TRANSURETHRAL PROCEDURES W/O CC	310	Quintile 4
313	URETHRAL PROCEDURES, AGE >17 W/O CC	312	Quintile 1
314	URETHRAL PROCEDURES, AGE 0-17	305	Quintile 1
322	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	326	Quintile 1
324	URINARY STONES W/O CC	326	Quintile 1
327	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	326	Quintile 1
329	URETHRAL STRICTURE AGE >17 W/O CC	305	Quintile 1
330	URETHRAL STRICTURE AGE 0-17	305	Quintile 1
333	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	332	Quintile 3
335	MAJOR MALE PELVIC PROCEDURES W/O CC	345	Quintile 5
337	TRANSURETHRAL PROSTATECTOMY W/O CC	306	Quintile 2
338	TESTES PROCEDURES, FOR MALIGNANCY	336	Quintile 2
340	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	339	Quintile 4
342	CIRCUMCISION AGE >17	339	Quintile 4
343	CIRCUMCISION AGE 0-17	339	Quintile 4
349	BENIGN PROSTATIC HYPERTROPHY W/O CC	339	Quintile 4
351	STERILIZATION, MALE	339	Quintile 4
353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	339	Quintile 4
354	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	339	Quintile 4
355	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	339	Quintile 4
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	339	Quintile 4
357	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	339	Quintile 4
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	339	Quintile 4
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	339	Quintile 4
361	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	110	Quintile 4
362	ENDOSCOPIC TUBAL INTERRUPTION	110	Quintile 4
363	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	110	Quintile 4
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	110	Quintile 4
370	CESAREAN SECTION W CC	369	Quintile 3
371	CESAREAN SECTION W/O CC	368	Quintile 2
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	110	Quintile 4
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	110	Quintile 4
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C	110	Quintile 4
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	110	Quintile 4
376	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	110	Quintile 4
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	110	Quintile 4
378	ECTOPIC PREGNANCY	369	Quintile 3
379	THREATENED ABORTION	110	Quintile 4
380	ABORTION W/O D&C	110	Quintile 4

LTC-DRG	DESCRIPTION	Proposed Cross-Walked LTC-DRG	Proposed Low-Volume Quintile Assignment
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	110	Quintile 4
382	FALSE LABOR	110	Quintile 4
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	110	Quintile 4
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	110	Quintile 4
385	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	110	Quintile 4
386	EXTREME IMMATURITY	87	Quintile 4
387	PREMATURITY W MAJOR PROBLEMS	87	Quintile 4
388	PREMATURITY W/O MAJOR PROBLEMS	110	Quintile 4
389	FULL TERM NEONATE W MAJOR PROBLEMS	87	Quintile 4
390	NEONATE W OTHER SIGNIFICANT PROBLEMS	87	Quintile 4
391	NORMAL NEWBORN	110	Quintile 4
392	SPLENECTOMY AGE >17	197	Quintile 3
393	SPLENECTOMY AGE 0-17	197	Quintile 3
396	RED BLOOD CELL DISORDERS AGE 0-17	399	Quintile 2
402	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	395	Quintile 2
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 4
411	HISTORY OF MALIGNANCY W/O ENDOSCOPY	110	Quintile 4
412	HISTORY OF MALIGNANCY W ENDOSCOPY	110	Quintile 4
414	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	399	Quintile 2
417	SEPTICEMIA AGE 0-17	416	Quintile 3
420	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	419	Quintile 3
422	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	426	Quintile 1
446	TRAUMATIC INJURY AGE 0-17	445	Quintile 1
448	ALLERGIC REACTIONS AGE 0-17	447	Quintile 2
450	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	449	Quintile 3
451	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	449	Quintile 3
455	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	449	Quintile 3
479	OTHER VASCULAR PROCEDURES W/O CC	110	Quintile 4
481	BONE MARROW TRANSPLANT	394	Quintile 5
485	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR	487	Quintile 3
492	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	410	Quintile 5
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	493	Quintile 4
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	497	Quintile 4
498	SPINAL FUSION W/O CC	497	Quintile 4
504	EXTENSIVE BURN OR FULL THICKNESS BURNS WITH MECH VENT 96+ HOURS WITH SKIN GRAFT	468	Quintile 5
520	CERVICAL SPINAL FUSION W/O CC	497	Quintile 4
522	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC	521	Quintile 1
523	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC	521	Quintile 1
525	OTHER HEART ASSIST SYSTEM IMPLANT	468	Quintile 5
528	INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	1	Quintile 5

LTC-DRG	DESCRIPTION	Proposed Cross-Walked LTC-DRG	Proposed Low-Volume Quintile Assignment
530	VENTRICULAR SHUNT PROCEDURES W/O CC	529	Quintile 5
534	EXTRACRANIAL VASCULAR PROCEDURES WITHOUT CC	500	Quintile 4
535	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	517	Quintile 5
536	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	517	Quintile 5
538	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITHOUT CC	228	Quintile 4
540	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITHOUT CC	399	Quintile 2
546	SPINAL FUSION EXCEPT CERVICAL WITH PRINCIPAL DIAGNOSIS OF CURVATURE OF SPINE OR MALIGNANCY	499	Quintile 5
547	PERCUTANEOUS CARDIOVASCULAR PROCEDURE WITH AMI WITH CC	517	Quintile 5
548	PERCUTANEOUS CARDIOVASCULAR PROCEDURE WITH AMI WITHOUT CC	517	Quintile 5
549	PERCUTANEOUS CARDIOVASCULAR PROCEDURE WITH DRUG-ELUTING STENT WITH AMI WITH CC	517	Quintile 5
550	PERCUTANEOUS CARDIOVASCULAR PROCEDURE WITH DRUG-ELUTING STENT WITH AMI WITHOUT CC	517	Quintile 5

To illustrate this methodology for determining the proposed relative weights for the 194 proposed LTC–DRGs with no LTCH cases, we are providing the following examples, which refer to the proposed no volume LTC–DRGs crosswalk information for FY 2006 provided in the chart above.

Example 1:

There were no cases in the FY 2004 MedPAR file used for this proposed rule for proposed LTC–DRG 163 (Hernia Procedures Age 0–17). Since the procedure is similar in resource use and the length and complexity of the procedures and the length of stay are similar, we determined that proposed LTC–DRG 178 (Uncomplicated Peptic Ulcer Without CC), which is assigned to proposed low-volume Quintile 3 for the purpose of determining the proposed FY 2006 relative weights, would display similar clinical and resource use. Therefore, we assign the same proposed relative weight of proposed LTC–DRG 178 of 0.7586 (proposed Quintile 3) for FY 2006 (Table 11 in the Addendum to this proposed rule) to proposed LTC–DRG 163.

Example 2:

There were no LTCH cases in the FY 2004 MedPAR file used in this proposed rule for proposed LTC–DRG 91 (Simple Pneumonia and Pleurisy Age 0–17). Since the severity of illness in patients with bronchitis and asthma is similar in patients regardless of age, we determined that proposed LTC–DRG 90 (Simple Pneumonia and Pleurisy Age >17 Without CC) would display similar clinical and resource use characteristics and have a similar length of stay to proposed LTC–DRG 91. There were over 25 cases in proposed LTC–DRG 90. Therefore, it would not be assigned to a low-volume quintile for the purpose of determining the proposed LTC–DRG relative weights. However, under our established methodology, proposed LTC–DRG 91, with no LTCH cases, would need to be grouped to a proposed low-volume quintile. We determined that the proposed low-volume quintile with the closest weight to proposed LTC–DRG 90 (0.5004) (refer to Table 11 in the Addendum to this proposed rule) would be proposed low-volume Quintile 1 (0. 4502) (refer to Table 11 in the Addendum to this proposed rule). Therefore, we assign proposed LTC–DRG 91 a proposed relative weight of 0.4502 for FY 2006.

Furthermore, we are proposing LTC–DRG relative weights of 0.0000 for heart, kidney, liver, lung, pancreas, and simultaneous pancreas/kidney transplants (LTC–DRGs 103, 302, 480, 495, 512, and 513, respectively) for FY 2006 because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified.

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

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

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

Table 11 in the Addendum to this proposed rule lists the proposed LTC–DRGs and their respective proposed relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (to assist in the determination of short-stay outlier payments under § 412.529) for FY 2006.

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

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

1. Background

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

The regulations implementing this provision establish three criteria for new medical services and techniques to receive an additional payment. First, § 412.87(b)(2) defines when a specific medical service or technology will be considered new for purposes of new medical service or technology add-on payments. The statutory provision contemplated the special payment treatment for new medical services or technologies until such time as data are available to reflect the cost of the technology in the DRG weights through recalibration. There is a lag of 2 to 3 years from the point a new medical service or technology is first introduced on the market and when data reflecting the use of the medical service or technology are used to calculate the DRG weights. For example, data from discharges occurring during FY 2004 are used to calculate the proposed FY 2006 DRG weights in this proposed rule. Section 412.87(b)(2) provides that a "medical service or technology may be considered new within 2 or 3 years after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the new medical service or technology (depending on when a new code is assigned and data on the new medical service or technology become available for DRG recalibration). After CMS has recalibrated the DRGs, based on available data, to reflect the costs of an otherwise new medical service or technology, the medical service or technology will no longer be considered 'new' under the criterion for this section.''

The 2-year to 3-year period during which a technology or medical service can be considered new would ordinarily begin with FDA approval, unless there was some documented delay in bringing the product onto the market after that approval (for instance, component production or drug production had been postponed until FDA approval due to shelf life concerns or manufacturing issues). After the DRGs have been recalibrated to reflect the costs of an otherwise new medical service or technology, the special add-on payment for new medical services or technology ceases (§ 412.87(b)(2)). For example, an approved new technology that received FDA approval in October 2004 and entered the market at that time may be eligible to receive add-on payments as a new technology until FY 2007 (discharges occurring before October 1, 2006), when data reflecting the costs of the technology would be used to recalibrate the DRG weights. Because the FY 2007 DRG weights will be calculated using FY 2005 MedPAR data, the costs of such a new technology would likely be reflected in the FY 2007 DRG weights.

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

However, section 503(b)(1) of Pub. L. 108–173 amended section 1886(d)(5)(K)(ii)(I) of the Act to provide for "applying a threshold* * *that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of 1 standard deviation for the diagnosis-related group involved.'' The provisions of section 503(b)(1) apply to classification for fiscal years beginning with FY 2005. We updated Table 10 from the October 6, 2003 **Federal Register** correction document, which contains the thresholds that we used to evaluate applications for new service or technology add-on payments for FY 2005, using the section 503(b)(1) measures stated above, and posted these new thresholds on our Web site at: *http://www.cms.hhs.gov/providers/hipps/newtech.asp.* In the FY 2005 IPPS final rule (in Table 10 of the Addendum), we included the final thresholds that are being used to evaluate applicants for new technology add-on payments for FY 2006. (Refer to section IV.D. of the preamble to the FY 2005 IPPS final rule (69 FR 49084) for a discussion of a revision of the regulations to incorporate the change made by section 503(b)(1) of Pub. L. 108–173.)

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

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

The report language accompanying section 533 of Pub. L. 106–554 indicated Congressional intent that the Secretary implement the new mechanism on a budget neutral basis (H.R. Conf. Rep. No. 106–1033, 106th Cong., 2nd Sess. at 897 (2000)). Section 1886(d)(4)(C)(iii) of the Act requires that the adjustments to annual DRG classifications and relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. Therefore, in

the past, we accounted for projected payments under the new medical service and technology provision during the upcoming fiscal year at the same time we estimated the payment effect of changes to the DRG classifications and recalibration. The impact of additional payments under this provision was then included in the budget neutrality factor, which was applied to the standardized amounts and the hospital-specific amounts.

Section 503(d)(2) of Pub. L. 108–173 amended section 1886(d)(5)(K)(ii)(III) of the Act to provide that there shall be no reduction or adjustment in aggregate payments under the IPPS due to add-on payments for new medical services and technologies. Therefore, add-on payments for new medical services or technologies for FY 2005 and later years will not be budget neutral.

Applicants for add-on payments for new medical services or technologies for FY 2007 must submit a formal request, including a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement, along with a significant sample of data to demonstrate the medical service or technology meets the high-cost threshold, no later than October 15, 2005. Applicants must submit a complete database no later than December 30, 2005. Complete application information, along with final deadlines for submitting a full application, will be available after publication of the FY 2006 final rule at our Web site: *http://www.cms.hhs.gov/providers/hipps/default.asp.* To allow interested parties to identify the new medical services or technologies under review before the publication of the proposed rule for FY 2007, the website will also list the tracking forms completed by each applicant.

2. Public Input Before Publication of This Notice of Proposed Rulemaking on Add-On Payments

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

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

In order to provide an opportunity for public input regarding add-on payments for new medical services and technologies for FY 2006 before publication of this proposed rule, we published a notice in the **Federal Register** on December 30, 2004 (69 FR 78466) and held a town hall meeting at the CMS Headquarters Office in Baltimore, MD, on February 23, 2005. In the announcement notice for the meeting, we stated that the opinions and alternatives provided during the meeting would assist us in our evaluations of applications by allowing public discussions of the substantial clinical improvement criteria for each of the FY 2006 new medical service and technology add-on payment applications before the publication of this FY 2006 IPPS proposed rule.

Approximately 45 participants registered and attended in person, while additional participants listened over an open telephone line. The participants focused on presenting data on the substantial clinical improvement aspect of their products, as well as the need for additional payments to ensure access to Medicare beneficiaries. In addition, we received written comments regarding the substantial clinical improvement criterion for the applicants. We have considered these comments in our evaluation of each new application for FY 2006 in this proposed rule. We have summarized these comments or, if applicable, indicated that no comments were received, at the end of the discussion of the individual applications.

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

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

In this proposed rule, we evaluate whether new technology add-on payments will continue in FY 2006 for the three technologies that currently receive such payments. In addition, we present our evaluations of eight applications for add-on payments in FY 2006. The eight applications for FY 2006 include two applications for products that were denied new technology add-on payments for FY 2005.

3. FY 2006 Status of Technology Approved for FY 2005 Add-On Payments

a. INFUSE™ (Bone Morphogenetic Proteins (BMPs) for Spinal Fusions)

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

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

The FDA approved INFUSE™ for use on July 2, 2002. For FY 2005, INFUSE™ was still within the 2-year to 3-year period during which a technology can be considered new under the regulations. Therefore, in the FY 2005 IPPS final rule (69 FR 49007 through 49009), we continued add-on payments for FY 2005 for cases receiving INFUSE™ for spinal fusions in DRGs 497 (Spinal Fusion Except Cervical With CC) and 498 (Spinal Fusion Except Cervical Without CC).

As we discussed in the September 7, 2001 final rule (66 FR 46915), an approval of a new technology for special payment should extend to all technologies that are substantially similar. Otherwise, our payment policy would bestow an advantage to the first applicant to receive approval for a particular new technology. In last year's final rule (69 FR 49008), we discussed another product, called OP–1 Putty, manufactured by Stryker Biotech, that promotes natural bone growth by using a closely related bone morphogenetic protein called rhBMP–7. (INFUSE™ is rhBMP–2.) We also stated in last year's final rule that we had determined that the costs associated with the OP–1 Putty are similar to those associated with INFUSE™. Because the OP–1 Putty became available on the market in May 2004 (when it received FDA approval for spinal fusions) for similar spinal fusion procedures and because this product also eliminates the need for the autograft bone surgery, we extended new technology add-on payments to this technology as well for FY 2005.

As noted above, the period for which technologies are eligible to receive new technology add-on payments is 2 to 3 years after the product becomes available on the market and data reflecting the cost of the technology are reflected in the DRG weights. The FDA approved INFUSE™ bone graft on July 2, 2002. Therefore, data reflecting the cost of the technology are now reflected in the DRG weights. In addition, by the end of FY 2005, the add-on payment will have been made for 2 years. Therefore, we are proposing to discontinue new technology add-on payment for INFUSE™ for FY 2006. Because we apply the same policies in making new technology payment for OP–1 Putty as we do for INFUSE™, we are proposing to discontinue new technology add-on payment for OP–1 Putty as well for FY 2006.

b. InSync® Defibrillator System (Cardiac Resynchronization Therapy With Defibrillation (CRT–D))

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

In the FY 2005 IPPS final rule (69 FR 49016), we determined that cardiac resynchronization therapy with defibrillator (CRT–D) was eligible for add-on payments in FY 2005. Cases involving CRT–D that are eligible for new technology add-on payments are identified by either one of the following two ICD–9–CM procedure codes: 00.51 (Implantation of Cardiac Resynchronization Defibrillator, Total System (CRT–D)) or 00.54 (Implantation or Replacement of Pulse Generator Device Only (CRT–D)). InSync® Defibrillation System received FDA approval on June 26, 2002. However, another manufacturer, Guidant, received FDA approval for its CRT–D device on May 2, 2002. As we discussed in the September 7, 2001 final rule (66 FR 46915), an approval of a new technology for special payment should extend to all technologies that are substantially similar. Otherwise, our payment policy would bestow an advantage to the first applicant to receive approval for a particular new technology. We also noted that we would extend new technology add-on payments for the entire FY 2005 even though the 2–3 year period of newness ended in May 2005 for CRT–D since predictability is an important aspect of the prospective payment methodology and, therefore, we believe it is appropriate to apply a consistent payment methodology for new technologies throughout the fiscal year (69 FR 49016).

As noted in the FY 2005 IPPS final rule (69 FR 49014), because CRT–Ds were available upon the initial FDA approval in May 2002, we considered the technology to be new from this date. As a result, for FY 2006, the CRT–D will be beyond the 2–3 year period during which a technology can be considered new. Therefore, we are proposing to discontinue add-on payments for the CRT–D for FY 2006.

c. Kinetra® Implantable Neurostimulator for Deep Brain Stimulation

Medtronic, Inc. submitted an application for approval of the Kinetra® implantable neurostimulator device for new technology add-on payments for FY 2005. The Kinetra® device was approved by the FDA on December 16, 2003. The Kinetra® implantable neurostimulator is designed to deliver electrical stimulation to the subthalamic nucleus (STN) or internal globus pallidus (GPi) in order to ameliorate symptoms caused by abnormal neurotransmitter levels that lead to abnormal cell-to-cell electrical impulses in Parkinson's Disease and essential tremor. Before the development of Kinetra®, treating bilateral symptoms of patients with these disorders required the implantation of two neurostimulators (in the form of a product called Soletra™, also manufactured by Medtronic): one for the right side of the brain (to control symptoms on the left side of the body), the other for the left side of the brain (to control symptoms on the right side of the body). Additional procedures were required to create pockets in the chest cavity to place the two generators required to run the individual leads. The Kinetra® neurostimulator generator, implanted in the pectoral area, is designed to eliminate the need for two devices by accommodating two leads that are placed in both the left and right sides of the brain to deliver the necessary impulses. The manufacturer argued that the development of a single neurostimulator that treats bilateral symptoms provides a less invasive treatment option for patients, and simpler implantation, follow up, and programming procedures for physicians.

In December 2003, the FDA approved the device. Therefore, for FY 2006, Kinetra® qualifies under the newness criterion because FDA approval was within the statutory timeframe of 2 to 3 years and its costs are not yet reflected in the DRG weights. Because there were no data available to evaluate costs associated with Kinetra®, in the FY 2005 IPPS final rule, we conducted the cost analysis using Soletra™, the predecessor technology used to treat this condition, as a proxy for Kinetra®. The preexisting technology provided the closest means to track cases that have actually used similar technology and served to identify the need and use of the new device. The manufacturer informed us that the cost of the Kinetra® device is twice the price of a single Soletra™ device. Because most patients would receive two Soletra™ devices if the Kinetra® device is not implanted, we believed data regarding the cost of Soletra™ would give a good measure of the actual costs that would be incurred. Medtronic submitted data for 104 cases that involved the Soletra™ device (26 cases in DRG 1 (Craniotomy Age > 17

With CC), and 78 cases in DRG 2 (Craniotomy Age > 17 Without CC)). These cases were identified from the FY 2002 MedPAR file using procedure codes 02.93 (Implantation, intracranial neurostimulator) and 86.09 (Other incision of skin and subcutaneous tissue). In the analysis presented by the applicant, the mean standardized charges for cases involving Soletra™ in DRGs 1 and 2 were $69,018 and $44,779, respectively. The mean standardized charge for these Soletra™ cases according to Medtronic's data was $50,839.

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

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

The manufacturer claimed that Kinetra® provides a range of substantial improvements beyond previously available technology. These include a reduced rate of device-related complications and hospitalizations or physician visits and less surgical trauma because only one generator implantation procedure is required. Kinetra® has a reed switch disabling function that physicians can use to prevent inadvertent shutoff of the device, as occurs when accidentally tripped by electromagnetic inference (caused by common products such as metal detectors and garage door openers). Kinetra® also provides significant patient control, allowing patients to monitor whether the device is on or off, to monitor battery life, and to fine-tune the stimulation therapy within clinician-programmed parameters. While Kinetra® provides the ability for patients to better control their symptoms and reduce the complications associated with the existing technology, it does not eliminate the necessity for two surgeries. Because the patients who receive the device are often frail, the implantation generally occurs in two phases: the brain leads are implanted in one surgery, and the generator is implanted in another surgery, typically on another day. However, implanting Kinetra® does reduce the number of potential surgeries compared to its predecessor (which requires two surgeries to implant the two single-lead arrays to the brain and an additional surgery for implantation of the second generator). Therefore, the Kinetra® device reduces the number of surgeries from 3 to 2.

Last year, we solicited comments on (1) the issue of whether the device is sufficiently different from the previously used technology to qualify as a substantially improved treatment for the same patient symptoms; (2) the cost of the device; and (3) the approval of the device for add-on payment, given the uncertainty over the frequency with which the patients receiving the device have the generator implanted in a second hospital stay, and the frequency with which this implantation occurs in an outpatient setting. In the response, we received sufficient evidence to demonstrate that Kinetra® does represent a substantial clinical improvement over the previous Soletra™ device. Specifically, the increased patient control, reduced surgery, fewer complications, and elimination of environmental interference significantly improve patient outcomes. Therefore, we approved Kinetra® for new technology add-on payments for FY 2005.

Cases receiving Kinetra® for Parkinson's disease or essential tremor on or after October 1, 2004, are eligible to receive an add-on payment of up to $8,285, or half the cost of the device, which is approximately $16,570. These cases are identified by the presence of procedure codes 02.93 (Implantation or replacement of intracranial neurostimulator leads) and 86.95 (Insertion or replacement of dual array neurostimulator pulse generator). If a claim has only the procedure code identifying the implantation of the intracranial leads, or if the claim identifies only insertion of the generator, no add-on payment will be made.

This technology received FDA approval on December 16, 2003, and remains within the 2 to 3 year period during which it can be considered new. Therefore, we are proposing to continue add-on payments for Kinetra® Inplantable Neurostimulator for deep brain stimulation for FY 2006.

4. FY 2006 Applications for New Technology Add-On

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

Bone Morphogenetic Proteins (BMPs) have been shown to have the capacity to induce new bone formation and, therefore, to enhance the healing of fractures. Using recombinant techniques, some BMPs (also referred to as rhBMPs) can be produced in large quantities. This innovation has cleared the way for the potential use of BMPs in a variety of clinical applications such as in delayed union and nonunion of fractured bones and spinal fusions. One such product, rhBMP–2, is developed as an alternative to bone graft with spinal fusions.

Medtronic Sofamor Danek (Medtronic) resubmitted an application (previously submitted for consideration for FY 2005) for a new technology add-on payment in FY 2006 for the use of INFUSE™ Bone Graft in open tibia fractures. In cases of open tibia fractures, INFUSE™ is applied using an absorbable collagen sponge, which is then applied to the fractured bone to promote new bone formation and improved healing. The manufacturer contends that patient access to this technology is restricted due to the increased costs of treating these cases with INFUSE™. The FDA approved use of INFUSE™ for open tibia fractures on April 30, 2004.

Medtronic's first application for a new technology add-on payment for INFUSE™ Bone Graft in open tibia fractures was denied. As we discussed in the FY 2005 IPPS final rule (69 FR 49010), the FY 2005 application for INFUSE™ for open tibia fractures was denied because a similar product, OP–1, was approved in 2001 for the treatment of nonunion of tibia fractures.

Comment: In comments presented at the February 2005 new technology town hall meeting, Medtronic contended that there was no opportunity for public

comment on our decision regarding OP–1 Putty: "the public had no opportunity to comment on whether the follow-on products were 'substantially similar' to the primary technologies under consideration. The absence of such provisions led to unpredictability and confusion about the new-technology add-on program.''

Response: In the FY 2005 IPPS final rule, we noted that a commenter brought the existence of the Stryker Biotech OP–1 product to our attention during the comment period on the IPPS proposed rule for FY 2005. The commenter noted OP–1's clinical similarity to INFUSE™ and contended that the products should be treated the same with respect to new technology payments when the product is used for tibia fractures. At that time, we determined that, despite the differences in indications under the respective FDA approvals, the two products were in use for many of the same kinds of cases. Specifically, clinical studies on the safety of OP–1 included patients with complicated fractures of the tibia, and those cases were similar to the cases described in the clinical trials for INFUSE™ for open tibia fractures. In addition, cases involving the use of OP–1 for long bone union and open tibia fractures are assigned to the same DRGs (DRGs 218 and 219 (Lower Extremity Procedures With and Without CC, respectively)) as cases involving INFUSE™. Therefore, we denied new technology add-on payments for INFUSE™ for open tibia fractures for FY 2005 on the grounds that the technology involving the use of bone morphogenetic proteins to treat severe long bone fractures (including open tibia fractures) and recalcitrant long bone fractures had been in use for more than 3 years.

We note that Medtronic had ample opportunity, prior to the issuance of the FY 2005 IPPS final rule, to bring to our attention the fact that there was a similar product on the market that was being used in long bone fractures. We based our decision for FY 2005 on the record that was placed at our disposal by the applicant and by commenters during the comment period. Nevertheless, we have considered the issues raised by these two products again in the course of evaluating Medtronic's new application for approval of INFUSE™ for new technology add-on payments in FY 2006.

As part of its FY 2006 application, Medtronic advanced several arguments designed to demonstrate that OP–1 and INFUSE™ are substantially different. The application cites data from several studies as evidence of the clinical superiority of INFUSE™ over OP–1. Medtronic presented studies at the February 2005 new technology town hall meeting to provide evidence that INFUSE™ is superior to OP–1 in the time it takes for critical-sized defects to heal and in radiographic assessment, mechanical testing of the repaired bone, and histology of the union for trial subjects receiving INFUSE™ compared with OP–1. (Study subjects were canines whose ulnas had 2.5 cm each of bone removed and then equal amounts of OP–1 and INFUSE™ were put into the front legs in a head to head trial.) Medtronic has also argued that these studies demonstrate that OP–1 has been shown to be less effective than using the patient's own bone or the current standard of care (nail fixation with soft tissue medical management). Medtronic argued that the INFUSE™ product is not only superior to OP–1 for patients with open tibia fractures, but also that it is superior to any other treatment for these serious injuries.

Medtronic also pointed out that the FDA approved OP–1 for Humanitarian Device Exemption (HDE) status, whereas INFUSE™ received a Pre-Market Approval (PMA). To receive HDE approval, a product only needs to meet a safety standard, while standards of both safety and efficacy have to be met for a PMA approval. Medtronic argued that, because the only point the manufacturer of OP–1 was able to prove was that it did not harm those individuals that received it, the efficacy of OP–1 not only has not been demonstrated for the general population, but also more specifically, it has not been proven in the Medicare population. Medtronic presented arguments that INFUSE™ is a superior product to OP–1 because the INFUSE™ product has demonstrated safety and efficacy, while the OP–1 product has merely demonstrated that it is safe to use in humans. Medtronic pointed to the labeled indications and package inserts provided with the two products, stating that only INFUSE™ provides a substantial clinical improvement to patients receiving a BMP product.

We do not believe that the different types of FDA approvals for the two products are relevant to distinguish between the two products in determining whether either product should be considered for new technology add-on payments under the IPPS. Manufacturers seek different types of FDA approval for many different reasons, including timing, the availability of adequate studies, the availability of resources to pursue research studies, and the size of the patient population that may be affected. The FDA has stated that the HDE approval process was established to address cases involving devices used in the treatment or diagnosis of diseases affecting fewer than 4,000 individuals in the United States per year: "A device manufacturer's research and development costs could exceed its market returns for diseases or conditions affecting small patient populations. FDA, therefore, developed and published [the regulation establishing the HDE process] to provide an incentive for the development of devices for use in the treatment or diagnosis of diseases affecting these populations.'' (*http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfHDE/HDEInformation.cfm*). The fact that two products received different types of approval does not demonstrate either that they are substantially different for purposes of new technology add-on payments, or that one is new and the other is not. Nor do the different types of FDA approval imply that one product could meet our substantial clinical improvement criterion and the other could not. Neither type of FDA approval requires that products establish substantial clinical improvement, as is required for approval of new technology add-on payments. Theoretically, a product that receives an FDA HDE approval could subsequently meet our substantial clinical improvement criterion, while a product that receives an FDA PMA approval could fail to do so. We base our substantial clinical improvement determinations on the evidence presented in the course of the application process, and not on the type of FDA approval.

For purposes of determining whether the use of rhBMPs for open tibia fracture represents a new technology, the crucial consideration is whether the costs of this technology are represented in the weights of the relevant DRGs. Cases that involve treatment of non-healed and acute tibia fractures fall into the same DRGs. We have identified 10,047 cases involving the use of rhBMPs in the FY 2004 MedPAR data file. This use includes the approved indications for INFUSE™ in spinal fusions (6,712 cases) and tibia DRGs (77 cases). However, we note that an additional 3,258 cases involving the off-label use of rhBMPs were found in 47 DRGs in the FY 2004 MedPAR data. We also note that, in our analysis of the FY 2003 MedPAR data, an additional 890 cases of off-label use (identified by the presence of ICD–9–CM code 84.52) were found in 36 DRGs. Therefore, we note

that the use of rhBMPs, made by Medtronic or otherwise, has penetrated the cost data that were used to set the FY 2005 and FY 2006 DRG weights. Whether or not it is possible to differentiate between patient populations that would be eligible to receive the OP–1 Implant for nonunions or the INFUSE™ bone graft for open tibia fractures, the patient populations both fall into the same DRGs. In addition, we have determined that the costs associated with the two products are comparable (69 FR 49009). Therefore, because BMP products have been used in treating both types of fractures included in the same DRGs since 2001, we continue to believe that the hospital charge data used in developing the relative weights reflect the costs of these products.

Comment: In our **Federal Register** announcement of the February 23, 2005 new technology town hall meeting, held on February 23, 2005, we solicited comments on the issue of when products should be considered substantially similar. As a result, Medtronic recommended several criteria for determining whether two or more products are substantially similar and requested that we apply these criteria in determining whether OP–1 and INFUSE™ are similar for new technology add-on payment purposes. The three criteria recommended by Medtronic are:

- The technologies or services in question use the same, or a similar, mechanism of action to achieve the therapeutic outcome.
- The technologies or services are indicated for use in the same population for the same condition.
- The technologies or services achieve the same level of substantial improvement.

Medtronic has also argued that, according to its proposed criteria, OP–1 would fail on two of the three proposed tests for substantial similarity:

- According to Medtronic, the OP–1 implant "arguably" uses the same or a similar mechanism of action to achieve the therapeutic outcome.
- OP–1 and INFUSE™ are indicated for use in different population and different conditions. According to Medtronic, INFUSE™ Bone Graft has an indication for acute, open tibia fractures only, used within 14 days, and is to be used with an intramedullary (IM) nail as part of the primary procedure. There is no limitation on the number of patients that can receive the technology. OP–1 Implant is indicated only for recalcitrant long-bone non-unions that have failed to heal. The HDE approval also specifies that use of OP–1 is limited to secondary procedures (as would be expected with nonunions). The number of patients able to receive the device is limited to 4,000 patients per year and with oversight from an Institutional Review Board.
- Medtronic argues the products do not achieve the same level of substantial improvement (as discussed above).

Response: We agree with Medtronic that the first proposed criterion has some relevance in determining whether products are substantially similar. In evaluating the application for new technology add-on payments last year, we made the determination that, while these products are not identical chemically, the products do use the same mechanism of action to achieve the therapeutic outcome. However, we do not agree that the other two criteria recommended by Medtronic are relevant considerations for this purpose. As we have discussed above, we believe that whether cases involving different products are assigned to the same DRGs is a more relevant consideration than whether the products have the same specific indications. In addition, as we have already stated, we continue to believe that the hospital charge data used in developing the relative weights of the relevant DRGs reflect the costs of these products. Furthermore, we do not necessarily agree that considerations about the degrees of clinical improvements offered by different products should enter into decisions about whether products are new. We have always based our decisions about new technology add-on payments on a logical sequence of determinations, moving from the newness criterion to the cost criterion and finally to the substantial clinical improvement criterion. Specifically, we do not make determinations about substantial improvement unless a product has already been determined to be new and to meet the cost criterion. Therefore, we are reluctant to import substantial clinical improvement considerations into the logical prior decision about whether technologies are new. Furthermore, while we may sometimes need to make separate determinations about whether similar products meet the substantial clinical improvement criterion, we do not believe that it would be appropriate to make determinations about whether one product or another is clinically superior. However, we welcome comments while we continue to consider these issues.

Comment: Medtronic suggested revisions to the application process that are designed to assist in identifying substantially similar products and provide the public with opportunity for comment on specific instances in which substantial similarity is an issue. The suggested proposed revisions are:

- After receipt of all new applications for a fiscal year, CMS should publish a **Federal Register** notice specifically asking manufacturers to identify if they wish to receive consideration for products that may be substantially similar to applications received. Such notice would probably occur in January. Responses would be required by a date certain in advance of the new technology town hall meeting, and would include justification of how the products meet the "substantial similarity" criteria.
- The new technology town hall meeting should include a discussion of products identified by manufacturers as "substantially similar" to other approved products or pending applications.
- CMS should publish initial findings about "substantial similarity" in the proposed hospital inpatient rule, with opportunity for public comment.
- CMS should publish ultimate findings in the inpatient final rule.

Alternatively, Medtronic suggested that, if a manufacturer identifies a product that may be substantially similar to a technology with an approved add-on payment, the manufacturer may choose to submit an application under the normal deadlines for the add-on payment program.

Response: We appreciate Medtronic's suggestions for evaluating similar technologies for new technology add-on payment. We have stated on several occasions that we wish to avoid creating situations in which similar products receive different treatment because only one manufacturer has submitted an application for new technology add-on payments. As we discussed in the September 7, 2001 **Federal Register** (66 FR 46915), an approval of a new technology for special payment should extend to all technologies that are substantially similar. Otherwise, our payment policy would bestow an advantage to the first applicant to receive approval for a particular new technology.

In addition, we note that commenters on the FY 2005 proposed rule placed a great deal of emphasis on the fact that many manufacturers developing new technologies are not aware of the existence of the add-on payment provision or lack the resources to apply for add-on payment. Therefore, commenters on that proposed rule argued that the regulations we have established are already too stringent and cumbersome, especially for small manufacturers to access the new

technology add-on payment process. The proposal by Medtronic would place further burden on these small manufacturers, both to know that an application has been made for a similar product and to make representations on a product that may or may not be on the market. Therefore, we are reluctant to adopt a process that places the formal burden on a competitor to seek equal treatment. However, we welcome comments while we continue to consider these issues.

We note that Medtronic submitted data on 236 cases using INFUSE™ for open tibia fractures in the FY 2003 MedPAR data file, as identified by procedure code 79.36 (Reduction, fracture, open, internal fixation, tibia and fibula) and diagnosis codes of either 823.30 (Fracture of tibia alone, shaft, open) or 823.32 (Fracture of fibula and tibia, shaft, open). Medtronic also noted that the patients in clinical trials with malunion fractures (diagnosis code 733.81) or nonunion fractures (diagnosis code 733.82) would also be likely candidates to receive INFUSE™. Based on the data submitted by the applicant, INFUSE™ would be used primarily in two different DRGs: 218 and 219 (Lower Extremity and Humerus Procedures Except Hip, Foot, Femur Age > 17, With and Without CC, respectively). The analysis performed by the applicant resulted in a case-weighted cost threshold of $24,461 for these DRGs. The average case-weighted standardized charge for cases using INFUSE™ in these DRGs would be $39,537. Therefore, the applicant maintains that INFUSE™ for open tibia fractures meets the cost criterion.

However, because the costs of INFUSE™ and OP–1 are already reflected in the relevant DRGs, these products cannot be considered new. Therefore, we are proposing to deny new technology add-on payments for INFUSE™ bone graft for open tibia fractures for FY 2006.

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

CHF Solutions, Inc. resubmitted an application (previously submitted for consideration for FY 2005) for the approval of the System 100 for new technology add-on payments for FY 2006. The System 100 is designed to remove excess fluid (primarily excess water) from patients suffering from severe fluid overload through the process of ultrafiltration. Fluid retention, sometimes to an extreme degree, is a common problem for patients with chronic congestive heart failure. This technology removes excess fluid without causing hemodynamic instability. It also avoids the inherent nephrotoxicity and tachyphylaxis associated with aggressive diuretic therapy, the mainstay of current therapy for fluid overload in congestive heart failure.

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

On June 3, 2002, FDA approved the System 100 for use with peripheral venous access. On November 20, 2003, FDA approved the System 100 for expanded use with central venous access and catheter extension use for infusion or withdrawal circuit line with other commercially applicable venous catheters. According to the applicant, although the FDA first approved System 100 in June 2002, it was not used by hospitals until August 2002 because of the substantial amount of time necessary to market and sell the device to hospitals. The applicant presented data and evidence demonstrating that the System 100 was not marketed until August 2002.

We note the applicant submitted an application for FY 2005 and was denied new technology add-on payments. Our review indicated that the applicant did not present sufficient objective clinical evidence to determine that the System 100 meets the substantial clinical improvement criterion (such as a large prospective, randomized clinical trial) even though it is indicated for use in patients with congestive heart failure, a common condition in the Medicare population. However, for FY 2006, we are proposing to deny System 100 new technology add-on payments on the basis of our determination that it is no longer new. Technology is no longer considered new 2 to 3 years after data reflecting its costs begin to become available. Because data on the costs of the System 100 first became available in 2002, the costs are currently reflected in the DRG weights and the device is no longer new.

The applicant also submitted information for the cost and substantial clinical improvement criteria. As stated last year, it is important to note at the outset of the cost analysis that the console is reusable and is, therefore, a capital cost. Only the circuits and catheters are components that represent operating expenses. Section 1886(d)(5)(K)(i) of the Act requires that the Secretary establish a mechanism to recognize the costs of new medical services or technologies under the payment system established under subsection (d) of section 1886, which establishes the system for paying for the operating costs of inpatient hospital services. The system of payment for capital costs is established under section 1886(g) of the Act, which makes no mention of any add-on payments for a new medical service or technology. Therefore, it is not appropriate to include capital costs in the add-on payments for a new medical service or technology and these costs should also not be considered in evaluating whether a technology meets the cost criterion. The applicant has applied for add-on payments for only the circuits and catheter, which represent the operating expenses of the device. However, as stated in the FY 2005 IPPS final rule, we believe that the catheters cannot be considered new technology for this device. As a result, we considered only the UF 500 disposable blood circuit as relevant to the evaluation of the cost criterion.

The applicant submitted data from the FY 2003 MedPAR file in support of its application for new technology add-on payments for FY 2006. The applicant used a combination of diagnosis codes to determine which cases could potentially use the System 100. The applicant found 28,155 cases with the following combination of ICD–9-CM diagnosis codes: 428.0 through 428.9 (Heart Failure), 402.91 (Unspecified with Heart Failure), or 402.11 (Hypertensive Heart Disease with Heart Failure), in combination with 276.6 (Fluid Overload) and 782.3 (Edema). The 28,155 cases were found among 148 DRGs with 50.1 percent of cases mapped across DRGs 88, 89, 127, 277 and 316. The applicant eliminated those DRGs with less than 150 cases, which resulted in a total of 22,620 cases that could potentially use the System 100. The case-weighted average standardized charge across all DRGs was $13,619.32. The case-weighted threshold across all DRGs was $16,125.42. Although the case-weighted threshold is greater than the case-weighted standardized charge, it is necessary to include the standardized charge for the circuits used in each case. In order to establish the charge per circuit, the applicant submitted data regarding 76 actual cases that used the System 100. Based on these 76 cases, the standardized charge per circuit was $2,591. The applicant also stated that an average of two circuits are used per case. Therefore, adding $5,182 for the charge of the two

circuits to the case-weighted average standardized charge of $13,619.32 results in a total case-weighted standardized charge of $18,801.32. This amount is greater than the case-weighted threshold of $16,125.42.

The applicant contended that the System 100 represents a substantial clinical improvement for the following reasons: It removes excess fluid without the use of diuretics; it does not lead to electrolyte imbalance, hemodynamic instability or worsening renal function; it can restore diuretic responsiveness; it does not adversely affect the renin-angiotensin system; it reduces length of hospital stay for the treatment of congestive heart failure, and it requires only peripheral venous access. The applicant also noted that there are some clinical trials that have demonstrated the clinical safety and effectiveness as well as cost effectiveness of the System 100 in treating patients with fluid overload.

However, as stated above, we are proposing to deny new technology add-on payments for the System 100 because it does not meet the newness criterion.

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

c. CHARITE™ Artificial Disc (CHARITE™)

DePuy Spine™ submitted an application for new technology add-on payments for the CHARITE™ Artificial Disc for FY 2006. This device is a prosthetic intervertebral disc. DePuy Spine™ stated that the CHARITE™ Artificial Disc is the first artificial disc approved for use in the United States. It is a 3-piece articulating medical device consisting of a sliding core that is placed between two metal endplates. The sliding core is made from a medical grade plastic and the endplates are made from medical grade cobalt chromium alloy. The endplates support the core and have small teeth that are secured to the vertebrae above and below the disc space. The sliding core fits in between the endplates.

On October 26, 2004, the FDA approved the CHARITE™ Artificial Disc for single level spinal arthroplasty in skeletally mature patients with degenerative disc disease (DDD) between L4 and S1. The FDA further stated that DDD is defined as discogenic back pain with degeneration of the disc confirmed by patient history and radiographic studies. These DDD patients should have no more than 3 mm of spondylolisthesis at an involved level. Patients receiving the CHARITE™ Artificial Disc should have failed at least 6 months of conservative treatment prior to implantation of the CHARITE™ Artificial Disc. Because the device is within the statutory timeframe of 2 to 3 years and data is not yet reflected within the DRGs, we consider the CHARITE™ Artificial Disc to meet the newness criterion.

We note that an ICD–9–CM code was effective October 1, 2004, for IPPS tracking purposes. The code assigned to the CHARITE™ was 84.65 (Insertion of total spinal disc prosthesis, lumbosacral).

For analysis of the cost criterion, the applicant submitted two sets of data: one that used actual cases and one that used FY 2003 MedPAR cases. The applicant expects that cases using the CHARITE™ will map to DRGs 499 and 500. The applicant submitted 68 actual cases from 35 hospitals that used the CHARITE™. Of these 68 cases, only 3 were Medicare patients; the remaining cases were privately insured patients or patients for whom the payer was unknown. Using data from the 68 actual cases, the average standardized charge was $40,722. The applicant maintained that this figure is well in excess of the thresholds for DRGs 499 and 500 (regardless of a case weighted threshold) of $24,828 and $17,299 respectively. Based on this analysis, the applicant maintained that the CHARITE™ meets the cost criterion because the average standardized charge exceeds the charge thresholds for DRGs 499 and 500.

In addition, as stated above, the applicant submitted cases from the FY 2003 MedPAR file. The applicant searched the MedPAR file for ICD–9–CM procedure codes 81.06, 81.07, and 81.08 in combination with diagnosis codes 722.10, 722.2, 722.5, 722.52, 722.6, 722.7, 722.73 and 756.12, to identify a patient population that could be eligible for the CHARITE™ Artificial Disc and found a total of 12,680 cases. However, these cases are from the FY 2003 MedPAR file and precede the effective date of ICD–9–CM code 84.65 that is currently used to track the device. Of these 12,680 cases, 55.5 percent were reported in DRG 497, and 44.5 percent were reported in DRG 498. The applicant stated that cases using the CHARITE™ device group to the DRGs for back and neck procedures that exclude spinal fusions (DRGs 499 and 500). However, the applicant argues that the CHARITE™ could be a substitute for spinal fusion procedures found in DRGs 497 and 498 and, therefore, used cases from these DRGs to evaluate whether the CHARITE™ meets the cost criterion and to argue that procedures using the technology should be grouped to the spinal fusion DRGs. The average standardized charge per case was $50,098 for DRG 497 and $41,290 for DRG 498. Using revenue codes 272 and 278 from the MedPAR file, the applicant then subtracted the charges for surgical and medical supplies used in connection with spinal fusion procedures, which resulted in a standardized charge of all other charges of $24,333 for DRG 497 and $22,183 for DRG 498. Based on the actual cases above, the applicant then estimated the average standardized charge for surgical and medical supplies per case for the CHARITE™ was $20,033. The applicant estimated that charges have grown by 15 percent from FY 2003 to FY 2005 and, therefore, deflated the average standardized charge for surgical and medical supplies of the CHARITE™ by 15 percent to $17,420. The applicant then added the average standardized charge for surgical and medical supplies of the CHARITE™ to the standardized charge of all other charges for DRG 497 and 498 and also inflated the charges by 15 percent in order to update the data to FY 2005 charge levels. This amounted to a case-weighted average standardized charge of $46,256. Although the analysis was completed with DRGs 497 and 498, it is necessary to compare the average standardized charge to the thresholds of DRGs 499 and 500 because the GROUPER maps these cases to DRGs 499 and 500. As a result, the case-weighted threshold was $21,480. Similar to the analysis above, the applicant stated that the case-weighted average standardized charge is greater than the case-weighted threshold and, as a result, the applicant maintained that the CHARITE™ meets the cost criterion.

The applicant also contended that the CHARITE™ represents a substantial clinical improvement over existing technology. Use of the CHARITE™ may eliminate the need for spinal fusion and the use of autogenous bone, and the applicant stated that, based on the Investigational Device Exemption (IDE) study, "*A Prospective Randomized Multicenter Comparison of Artificial Disc vs. Fusion for Single Level Lumbar Degenerative Disc Disease*" (Blumenthal, S, *et al*, National American Spine Society 2004 Abstract) that patients who received the CHARITE™ Artificial Disc were discharged from the hospital after an average of 3.7 days compared to 4.2 days in the fusion group. Furthermore, the applicant stated that patients who received the CHARITE™ Artificial Disc had a statistically greater improvement in Oswetry Disability Index scores and Visual Analog Scale Pain scores compared to the fusion group at 6 weeks

and 3, 6 and 12 months. The study also showed greater improvement from baseline compared to the fusion group on the Physical Component Score at 3, 6, and 23 months. In addition, the applicant states that patients receiving the CHARITE™ Artificial Disc returned to normal activities in half the time, compared to patients who underwent fusion, and at the 2 year follow up, 15 percent of patients who underwent a fusion were dissatisfied with the postoperative improvements compared to 2 percent who received the CHARITE™ Artificial Disc. Also, patients who received the CHARITE™ Artificial Disc returned to work on average of 12.3 weeks after surgery compared to 16.3 weeks after circumferential fusion and 14.4 weeks with Bagby and Kuslich cages. The applicant finally stated that the motion preserving technology of the CHARITE™ Artificial Disc may reduce the risk of increase of degenerative disc disease (DDD). The applicant explained that degeneration of adjacent discs due to increased stress has been strongly associated with spinal fusion utilizing instrumentation. In a followup of 100 patients (minimum 10 years) who received the CHARITE™ Artificial Disc, the incidence of adjacent level DDD was 2 percent.

We are continuing to review the information on whether the CHARITE ™ Artificial Disc would appear to represent a substantial clinical improvement over existing technology for certain patient populations. Based on the studies submitted to the FDA and CMS, we remain concerned that the information presented may not definitively substantiate whether the CHARITE ™ Artificial Disc is a substantial clinical improvement over spinal fusion. In addition, we are concerned that the cited IDE study enrolled no patients over 60 years of age, which excludes much of the Medicare population, and we are concerned that the device is contraindicated in patients with "significant osteoporosis,'' which is quite common in the Medicare population. We invite comment on both of these points and on the more general question of whether the device satisfies the substantial clinical improvement criterion.

Despite the issues mentioned above, we are still considering whether it is appropriate to approve new technology add-on payment status for the CHARITE ™ Artificial Disc for FY 2006. If approved for add-on payments, the device would be reimbursed up to half of the costs for the device. Because the manufacturer has stated that the cost for the CHARITE ™ Artificial Disc would be $11,500, the maximum add-on payment for the device would be $5,750. In the final rule, we will make a final determination on whether the CHARITE ™ Artificial Disc should receive new technology add-on payments for FY 2006 based on public comments and our continuing analyses.

We finally note that the applicant requested a DRG reassignment for cases of the CHARITE ™ Artificial Disc from DRGs 499 (Back and Neck Procedures Except Spinal Fusion With CC) and 500 (Back and Neck Procedures Except Spinal Fusion Without CC) to DRGs 497 (Spinal Fusion Except Cervical With CC) and 498 (Spinal Fusion Except Cervical Without CC). The applicant argued that the costs associated with an artificial disc surgery are similar to spinal fusion and inclusion in DRGs 497 and 498 would obviate the need to make a new technology add-on payment. On October 1, 2004, we created new codes for the insertion of spinal disc prostheses (codes 84.60 through 84.69). In the FY 2005 IPPS proposed rule and the final rule, we described the new DRG assignments for these new codes in Table 6B of the Addendum to the rules. We received a number of comments recommending that we change the DRG assignments from DRGs 499 and 500 in MDC 8 to the DRGs for spinal fusion (DRGs 497 and 498). In the FY 2005 IPPS final rule (69 FR 48938), we indicated that DRGs 497 and 498 are limited to spinal fusion procedures. Because the surgery involving the CHARITE ™ is not a spinal fusion, we decided not to include this procedure in these DRGs. However, we will continue to analyze this issue and are interested in public comments on both the new technology application for the CHARITE ™ and the DRG assignment for spinal disc prostheses.

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

d. Endovascular Graft Repair of the Thoracic Aorta

Endovascular stent-grafting of the descending thoracic aorta (TA) provides a less invasive alternative to the traditional open surgical approach required for the management of descending thoracic aortic aneurysms. W.L. Gore & Associates, Inc. submitted an application for consideration of its Endovascular Graft Repair of the Thoracic Aorta (GORE TAG) for new technology add-on payments for FY 2006. The GORE TAG device is a tubular stent-graft mounted on a catheter-based delivery system, and it replaces the synthetic graft normally sutured in place during open surgery. The device is identified using ICD–9–CM procedure code 39.79 (Other endovascular repair (of aneurysm) of other vessels). The applicant has requested a unique ICD–9–CM procedure code.

At this point the time of the initial application, the FDA hads not yet approved this technology for general use. Subsequently, however, we were notified that FDA approval was granted on March 23, 2005. Although we discuss some of the data submitted with the application for new technology add-on payments below, we are unable to include a detailed analysis of cost data and substantial clinical improvement data in this proposed rule because FDA approval occurred too late for us to conduct a complete analysis.

The applicant submitted cost threshold information for the GORE TAG device. According to the manufacturer, cases using the GORE TAG device would fall into DRGs 110 and 111 (Major Cardiovascular Procedures With and Without CC, respectively). The applicant identified 185 cases in the FY 2003 MedPAR using procedure code 39.79 (Other endovascular repair (of aneurysm) of other vessels) and primary diagnosis codes 441.2 (Thoracic aneurysm, without mention of rupture), 441.1 (Thoracic aneurysm, ruptured), or 441.01 (Dissection of aorta, thoracic). The case-weighted standardized charge for 177 of these cases was $60,905. According to the manufacturer, the case-weighted cost threshold for these DRGs is $49,817. Based on this analysis, the manufacturer maintained that the technology meets our cost threshold.

The manufacturer argued that the GORE TAG represents a substantial clinical improvement over existing technology, primarily by avoiding the traditional open aneurysm repair procedure with its associated high morbidity and mortality. The applicant argued that a descending thoracic aorta aneurysm is a potentially life threatening condition that currently requires a major operative procedure for its treatment. The mortality and complication rates associated with this surgery are very high, and the surgery is frequently performed under urgent or emergent conditions. The applicant noted that such complications can increase the length of the hospital stay and can include neurological damage, paralysis, renal failure, pulmonary emboli, hemorrhage, and sepsis. The average time for patients undergoing surgical repair to return to normal activity is 3 to 4 months, but can be significantly longer.

In comparison, the applicant argued that endovascular stent-grafting done with the GORE TAG thoracic endoprosthesis is minimally invasive. The manufacturer noted that patients treated with the endovascular technique experience far less aneurysm-related mortality and morbidity, compared to those patients that receive the open procedure resulting in reduced overall length-of-stay, less intensive care unit days and less operative complications.

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

Comment: Several commenters expressed support for approval of new technology add-on payments for the GORE TAG device. These commenters noted that the data presented to the FDA advisory panel for consideration for FDA approval of the device clearly demonstrate the safety and efficacy of the GORE TAG device. They also noted that nearly 200 patients have been treated with the endografts, with a highly significant difference in both postoperative mortality and a reduction in the incidence of spinal cord ischemic complications, with some commenters noting the trial results, which showed a reduction in the rate of paraplegia from 14 percent to 3 percent, compared to open surgery. The commenters also stressed the rigorous nature of the open surgery, which requires a left lateral thoracotomy, resulting in significant morbidity. The commenters further argued that, since many of the patients with degenerative aneurysm of the thoracic aorta are elderly or present with significant comorbidities, or both, it is "a common circumstance in clinical practice to deny repair to such patients because of the magnitude of the conventional open surgery.'' Other commenters stated that the 5-year mortality in all patients diagnosed with thoracic aortic aneurysm is as high as 80 percent in some groups of patients. Therefore, the commenters argued, the GORE TAG device for thoracic aortic aneurysm satisfies the criteria for substantial clinical improvement.

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

Comment: A representative of another device manufacturer stated at the town hall meeting that the manufacturer has a similar product awaiting FDA approval.

Response: As we discussed in the September 7, 2001 **Federal Register** (66 FR 46915), an approval of a new technology for special payment should extend to all technologies that are substantially similar. Otherwise, our payment policy would bestow an advantage to the first applicant to receive approval for a particular new technology. In this case, we will determine whether the GORE TAG device qualifies for new technology add-on payments in the FY 2006 final rule. In the event that this technology satisfies all the criteria, we would extend new technology payments to any substantially similar technology that also receives FDA approval prior to publication of the FY 2006 final rule. We welcome comments regarding this technology in light of its recent FDA approval, particularly with regard to the cost threshold and the substantial clinical improvement criteria.

e. Restore® Rechargeable Implantable Neurostimulator

Medtronic Neurological submitted an application for new technology add-on payments for its Restore® Rechargeable Implantable Neurostimulator. The Restore® Rechargeable Implantable Neurostimulator is designed to deliver electrical stimulation to the spinal cord for treatment of chronic, intractable pain.

Neurostimulation is designed to deliver electrical stimulation to the spinal cord to block the sensation of pain. The current technology standard for neurostimulators utilizes internal sealed batteries as the power source to generate the electrical current. These internal batteries have finite lives, and require replacement when their power has been completely discharged. According to the manufacturer, the Restore® Rechargeable Implantable Neurostimulator "represents the next generation of neurostimulator technology, allowing the physician to set the voltage parameters in such a way that fully meets the patient's requirements to achieve adequate pain relief without fear of premature depletion of the battery.'' The applicant stated that the expected life of the Restore® rechargeable battery is 9 years, compared to an average life of 3 years for conventional neurostimulator batteries. The applicant stated that this represents a significant clinical improvement because patients can use any power settings that are necessary to achieve pain relief with less concern for battery depletion and subsequent battery replacement.

This device has not yet received approval for use by the FDA; however, another manufacturer has received approval for a similar device. (Advanced Bionics' Precision® Rechargeable Neurostimulator was approved by the FDA on April 27, 2004.)

Medtronic Neurological also provided data to determine whether the Restore® Rechargeable Implantable Neurostimulator meets the cost criterion. Medtronic Neurological stated that the cases involving use of the device would primarily fall into DRGs 499, 500, 531 and 532, which have a case-weighted threshold of $24,090. The manufacturer stated that the anticipated average standardized charge per case involving the Restore® technology is $59,265. This manufacturer derived this estimate by identifying cases in the FY 2003 MedPAR that reported procedure code 03.93 (Insertion or replacement of spinal neurostimulators). The manufacturer then added the total cost of the Restore® Rechargeable Implantable Neurostimulator to the average standardized charges for those cases. Of the applicable charges for the Restore® Rechargeable Implantable Neurostimulator, only the components that the applicant identified as new would be eligible for new technology add-on payments. Medtronic Neurological submitted information that distinguished the old and new components of the device and submitted data indicating that the neurostimulator itself is $17,995 and the patient recharger, antenna, and belt are $3,140. Thus, the total cost for new components would be $21,135, with a maximum add-on amount of $10,568 if the product were to be approved for new technology payments.

We note that we reviewed a technology for add-on payments for FY 2003 called Renew™ Radio Frequency Spinal Cord Stimulation (SCS) Therapy, made by Advanced Neuromodulation Systems (ANS). In the FY 2003 final rule, we discussed and subsequently denied an application for new technology add-on payment for Renew™ SCS because "Renew™ SCS was introduced in July 1999 as a device for the treatment of chronic intractable pain of the trunk and limbs.'' (67 FR 50019) We also noted, "[t]his system only requires one surgical placement and does not require additional surgeries to replace batteries as do other internal SCS systems.''

The applicant also stated in its application for Restore® that cases where it is used will be identified by ICD–9–CM procedure code 03.93 (Insertion or replacement of spinal neurostimulators). As we discussed in the FY 2003 final rule (67 FR 50019), the Renew™ SCS is identified by the same ICD–9–CM procedure code. The

applicant has also applied for a new ICD–9–CM code for rechargeable neurostimulator pulse generator (We refer readers to Tables 6A through 6H in the Addendum to this proposed rule for information regarding ICD–9–CM codes.) Because both technologies are similar, we asked Medtronic to provide information that would demonstrate how the products were substantially different. The applicant noted that the Renew™ SCS, while programmable and rechargeable, is not a good option for those patients who have high energy requirements because of chronic intractable pain that will result in more battery wear and subsequent surgery to replace the device. Both systems rely on rechargeable batteries, and in the case of Renew™ SCS the energy is transmitted through the skin from a radiofrequency source for the purpose of recharging. The manufacturer of the Restore® device contends that it is superior to the Renew™ device because Renew™ requires an external component that uses a skin adhesive that is uncomfortable and inconvenient (causes skin irritation, is affected by moisture that will come from bathing, sweating, swimming, etc.), leading to patient noncompliance.

Because FDA approval has not yet been received for this device, we are making no decision concerning the Restore® application at this time. We will make a formal determination if FDA approval occurs in sufficient time for full consideration in the final FY 2006 rule. However, we have reservations about whether this technology is new for purposes of the new technology add-on payments because of its similarity to other products that are also used to treat the same conditions. Although we recognize the benefits of a more easily rechargeable neurostimulator system, we believe that the Restore® device may not be sufficiently different from predecessor devices to meet the newness criterion for the new technology add-on payment. As we discussed above, similar products have been on the market since 1999. Therefore, these technologies are already represented in the DRG weights and are not considered new for the purposes of the new technology add-on payment provision. We welcome comments on this issue, specifically regarding how the Restore® device may or may not be significantly different from previous devices. We also seek comments on whether the product meets the cost and significant improvement criteria.

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

f. Safe-Cross® Radio Frequency Total Occlusion Crossing System (Safe-Cross®)

Intraluminal Therapeutics submitted an application for the Safe Cross® Radio Frequency (RF) Total Occlusion Crossing System. This device performs the function of a guidewire during percutaneous transluminal angioplasty of chronic total occlusions of peripheral and coronary arteries. Using fiberoptic guidance and radiofrequency ablation, it is able to cross lesions where a standard guidewire is unsuccessful. On November 21, 2003, the FDA approved the Safe Cross® for use in iliac and superficial femoral arteries. The device was approved by the FDA for all native peripheral arteries except carotids in August 2004. In January 2004, the FDA approved the Safe Cross® for coronary arteries as well. Because the device is within the statutory timeframe of 2 to 3 years for all approved uses and data regarding the cost of this device are not yet reflected within the DRG weights, we consider the Safe Cross® to meet the newness criterion.

We note that the applicant submitted an application for a distinctive ICD–9–CM code. The applicant noted in its application that the device is currently coded with ICD–9–CM procedure codes 36.09 (Other removal of coronary artery obstruction) and 39.50 (Angioplasty or atherectomy of other noncoronary vessels).

As we stated in last year's final rule, section 1886(d)(5)(K)(i) of the Act requires that the Secretary establish a mechanism to recognize the costs of new medical services or technologies under the payment system established under subsection (d) of section 1886, which establishes the system for paying for the operating costs of inpatient hospital services. The system of payment for capital costs is established under section 1886(g) of the Act, which makes no mention of any add-on payments for a new medical service or technology. Therefore, it is not appropriate to include capital costs in the add-on payments for a new medical service or technology, and these costs should not be considered in evaluating whether a technology meets the cost criterion. As a result, we consider only the Safe Cross® crossing wire, ground pad, and accessories to be operating equipment that is relevant to the evaluation of the cost criterion.

The applicant submitted the following two analyses on the cost criterion. The first analysis contained 27 actual cases from two hospitals. Of these 27 cases, 25.1 percent of the cases were reported in DRGs 24 (Seizure and Headache Age >17 With CC), 107 (Coronary Bypass With Cardiac Catheterization), 125 (Circulatory Disorders Except AMI, With Cardiac Catheterization and Without Complex Diagnosis), 518 (Percutaneous Cardiovascular Procedure Without Coronary Artery Stent or AMI), and 526 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent With AMI); and 74.9 percent were reported in DRG 527 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent Without AMI). This resulted in a case-weighted threshold of $35,956 and a case-weighted average standardized charge of $40,319. Because the case-weighted average standardized charge is greater than the case-weighted threshold, the applicant maintained that the Safe Cross® meets the cost criterion.

The applicant also submitted cases from the FY 2003 MedPAR. The applicant found a total of 1,274,535 cases that could be eligible for the Safe Cross® using diagnosis codes 411 through 411.89 (Other acute and subacute forms of ischemic heart disease) or 414 through 414.19 (Other forms of chronic ischemic heart disease) in combination with any of the following procedure codes: 36.01 (Single vessel percutaneous transluminal coronary angioplasty (PTCA) or coronary atherectomy without mention of thrombolytic agent), 36.02 (Single vessel PTCA or coronary atherectomy with mention of thrombolytic agent), 36.05 (Multiple vessel PTCA or coronary atherectomy performed during the same operation with or without mention of thrombolytic agent), 36.06 (Insertion of nondrug-eluting coronary artery stent(s)), 36.07 (Insertion of drug-eluting coronary artery stent(s)) and 36.09 (Other removal of coronary artery obstruction). A total of 59.40 percent of these cases fell into DRG 517 (Percutaneous Cardiovascular Procedure With Nondrug-Eluting Stent Without AMI), 16.4 percent of cases into DRG 516 (Percutaneous Cardiovascular Procedure With AMI), and 16.2 percent of cases into DRG 527, while the rest of the cases fell into the remaining DRGs 124, 518 and 526. The average case-weighted standardized charge per case was $40,318. This amount included an extra $6,000 for the charges related to the Safe Cross®. The case-weighed threshold across the DRGs mentioned above was $35,955. Similar to the analysis above, because the case-weighted average standardized charge is greater than the case-weighted

threshold, the applicant maintained that the Safe Cross® meets the cost criterion.

The applicant maintained that the device meets the substantial clinical improvement criterion. The applicant explained that many traditional guidewires fail to cross a total arterial occlusion due to difficulty in navigating the vessel and to the fibrotic nature of the obstructing plaque. By using fiberoptic guidance and radiofrequency ablation, the Safe Cross® succeeds where standard guidewires fail. The applicant further maintained that in clinical trials where traditional guidewires failed, the Safe Cross® succeeded in 54 percent of cases of coronary artery chronic total occlusions (CTOs), and in 76 percent of cases of peripheral artery CTOs.

However, we note that we use similar standards to evaluate substantial clinical improvement in the IPPS and OPPS. The IPPS regulations provide that technology may be approved for add-on payments when it "represents an advance in medical technology that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries'' (66 FR 46912). Under the OPPS, the standard for approval of new devices is "a substantial improvement in medical benefits for Medicare beneficiaries compared to the benefits obtained by devices in previously established (that is, existing or previously existing) categories or other available treatments'' (67 FR 66782). Furthermore, the OPPS and IPPS employ identical language (for IPPS, see 66 FR 46914, and for OPPS, see 67 FR 66782) to explain and elaborate on the kinds of considerations that are taken into account in determining whether a new technology represents substantial improvement. In both systems, we employ the following kinds of considerations in evaluating particular requests for special payment for new technology:

- The device offers a treatment option for a patient population unresponsive to, or ineligible for, currently available treatments.
- The device offers the ability to diagnose a medical condition in a patient population where that medical condition is currently undetectable or offers the ability to diagnose a medical condition earlier in a patient population than allowed by currently available methods. There must also be evidence that use of the device to make a diagnosis affects the management of the patient.
- Use of the device significantly improves clinical outcomes for a patient population as compared to currently available treatments. Some examples of outcomes that are frequently evaluated in studies of medical devices are the following:

—Reduced mortality rate with use of the device.
—Reduced rate of device-related complications.
—Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process).
—Decreased number of future hospitalizations or physician visits.
—More rapid beneficial resolution of the disease process treatment because of the use of the device.
—Decreased pain, bleeding, or other quantifiable symptom.
—Reduced recovery time.

In a letter to the applicant dated October 25, 2004, we denied approval of the Safe Cross® for pass-through payments for the OPPS on the basis that the technology did not meet the substantial clinical improvement criterion. In particular, we found that studies failed to show long-term or intermediate-term results, and the device had a relatively low rate of successfully opening occlusions. Since that initial determination, the applicant has requested reconsideration for pass-through payments under the IPPS. However, on the basis of the original findings under the OPPS, we do not now believe that the technology can qualify for new technology add-on payments under the IPPS. Therefore, we are proposing to deny new technology add-on payment for FY 2006 for Safe Cross® on the grounds that it does not appear to be a substantial clinical improvement over existing technologies. We welcome further information on whether this device meets the substantial clinical improvement criterion, and we will consider any further information prior to making our final determination in the final rule.

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

g. Trident® Ceramic Acetabular System

Stryker Orthopaedics submitted an application for new technology add-on payments for the Trident® Ceramic Acetabular System. This system is used to replace the "ball and socket'' joint of a hip when a total hip replacement is performed for patients suffering from arthritis or related conditions. The applicant stated that, unlike conventional hip replacement systems, the Trident® system utilizes alumina ceramic-on-ceramic bearing surfaces rather than metal-on-plastic or metal-on-metal. Alumina ceramic is the hardest material next to diamond. The Trident® System is a patented design that captures the ceramic insert in a titanium sleeve. This design increases the strength of the ceramic insert by 50 percent over other designs. The manufacturer stated that the alumina ceramic bearing of the device is a substantial clinical improvement because it is extremely hard and scratch resistant, has a low coefficient of friction and excellent wear resistance, has improved lubrication over metal or polyethylene, has no potential for metal ion release, and has less alumina particle debris. The manufacturer also stated that fewer hip revisions are needed when this product is used (2.7 percent of ceramic versus 7.5 percent for polyethylene). Stryker stated that the ceramic implant also causes less osteolysis (or bone loss from particulate debris). Due to these improvements over traditional hip implants, the manufacturer stated the Trident® Ceramic Acetabular System has demonstrated significantly lower wear versus the conventional plastic/metal system in the laboratory; therefore, it is anticipated that these improved wear characteristics will extend the life of the implant.

The Trident® Ceramic Acetabular System received FDA approval in February 3, 2003. However, this product was not available on the market until April 2003. The period that technologies are eligible to receive new technology add-on payment is no less than 2 years but not more than 3 years from the point the product comes on the market. At this point, we begin to collect charges reflecting the cost of the device in the MedPAR data. Because the device became available on the market in April 2003, charges reflecting the cost of the device may have been included in the data used to calculate the DRG weights in FY 2005 and the proposed DRG weights for FY 2006. Therefore, the technology may no longer be considered new for the purposes of new technology add-on payments. For this reason, we are proposing to deny add-on payments for the Trident® Ceramic Acetabular System for FY 2006.

Although we are proposing not to approve this application because the Trident® Ceramic Acetabular System does not meet the newness criterion, we note that the applicant submitted information on the cost and substantial clinical improvement criteria.

The applicant submitted cost threshold information for the Trident® Ceramic Acetabular System, stating that cases using the system would be

included in DRG 209 (Major Joint and Limb Reattachment Procedures of Lower Extremity). The manufacturer indicated that there is not an ICD–9–CM code specific to ceramic hip arthroplasty, but it is currently reported using code 81.51 (Total hip replacement). Of the applicable charges for the Trident® Ceramic Acetabular System, only the components that the applicant identified as new would be eligible for new technology add-on payments. The estimated cost of the new portions of the device, according to the information provided in the application, is $6,009. The charge threshold for DRG 209 is $34,195. The data submitted by Stryker Orthopaedics showed an average standardized charge, assuming a 28 percent implant markup, of $34,230.

Regarding the issue of substantial clinical improvement, we recognize that the Trident® Ceramic Acetabular System represents an incremental advance in prosthetic hip technology. However, we also recognize that there are a number of other new prostheses available that utilize a variety of bearing surface materials that also offer increased longevity and decreased wear. For this reason, we do not believe that the Trident® system has demonstrated itself to be a clearly superior new technology.

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

Comment: One commenter noted that clinical outcomes for the Trident® Ceramic Acetabular System are not a significant clinical improvement over similar devices on the market. A member of the orthopedic community noted at the new technology town hall meeting that this system is not the only new product that promises significantly improved results because of enhancements to materials and design. This commenter suggested that it may be inappropriate to recognize only one of these new hip replacement products for new technology add-on payments.

Response: We appreciate the commenter's input on this criterion. We will consider these comments regarding the substantial clinical improvement criterion. However, based on the observations provided at the town hall meeting, we are considering alternative methods of recognizing technological improvements in this area other than approving only one of these new technologies for add-on payments. For example, as discussed in section II.B.6.a. of the preamble to this proposed rule, we are proposing to split DRG 209 to create a new DRG for revisions of hip and knee replacements. We would leave all other replacements and attachment procedures in a separate, new DRG. We also stated that we will be reviewing these DRGs based on new procedure codes that will provide more detailed data on the specific nature of the revision procedures performed. In addition, we are creating new procedure codes that will identify the type of bearing surface of a hip replacement. As we obtain data from these new codes, we will consider additional DRG revisions to better capture the various types of joint procedures. We may consider a future restructuring of the joint replacement and revision DRGs that would better capture the higher costs of products that offer greater durability, extended life, and improved outcomes. In doing so, of course, we may need to create additional, more precise ICD–9–CM codes. We welcome comments on this issue, and generally on whether the Trident® Ceramic Acetabular System meets the criteria to qualify for new technology add-on payments.

h. Wingspan™ Stent System with Gateway™ PTA Balloon Catheter

Boston Scientific submitted an application for the Wingspan™ Stent System with Gateway™ PTA Balloon Catheter for new technology add-on payments. The device is designed for the treatment of patients with intracranial atherosclerotic disease who suffer from recurrent stroke despite medical management. The device consists of the following: a self-expanding nitinol stent, a multilumen over the wire delivery catheter, and a Gateway PTA Balloon Catheter. The device is used to treat stenoses that occur in the intracranial vessels. Prior to stent placement, the Gateway PTA Balloon is inflated to dilate the target lesion, and then the stent is deployed across the lesion to restore and maintain luminal patency. Effective October 1, 2004, two new ICD–9–CM procedure codes were created to code intracranial angioplasty and intracranial stenting procedures: procedure codes 00.62 (Percutaneous angioplasty or atherectomy of intracranial vessels) and 00.65 (Percutaneous insertion of intracranial vascular stents).

On January 9, 2004, the FDA designated the Wingspan™ as a Humanitarian Use Designation (HUD). The manufacturer has also applied for Humanitarian Device Exemption (HDE) status and expects approval from the FDA in July 2005. It is important to note that currently CMS has a noncoverage policy for percutaneous transluminal angioplasty to treat lesions of intracranial vessels. The applicant is working closely with CMS to review this decision upon FDA approval. Because the device is neither FDA-approved nor Medicare-covered, we do not believe it is appropriate to present our full analysis on whether the technology meets the individual criteria for the new technology add-on payment. However, we note that the applicant did submit the following information below on the cost criterion and substantial clinical improvement criterion.

The manufacturer submitted data from MedPAR and non-MedPAR databases. The non-MedPAR data was from the 2003 patient discharge data from California's Office of Statewide Health Planning and Development database for hospitals in California and from the 2003 patient data from Florida's Agency for Health Care Administration for hospitals in Florida. The applicant identified cases that had a diagnosis code of 437.0 (Cerebral atherosclerosis), 437.1 (Other generalized ischemic cerebrovascular disease) or 437.9 (Unspecified) or any diagnosis code that begins with the prefix of 434 (Occlusion of cerebral arteries) in combination with procedure code 39.50 (Angioplasty or atherectomy of noncoronary vessel) or procedure code 39.90 (Insertion of nondrug-eluting, noncoronary artery stents). The applicant used procedure codes 39.50 and 39.90 because procedure codes 00.62 and 00.65 were not available until FY 2005. The applicant found cases in DRG 5 (Extracranial Vascular Procedures) (which previously existed under the Medicare IPPS DRG system prior to a DRG split) and in DRGs 533 (Extracranial Procedure with CC) and 534 (Extracranial Procedure Without CC). Even though DRG 5 was split into DRGs 533 and 534 in FY 2003, some hospitals continued to use DRG 5 for non-Medicare cases. The applicant found 22 cases that had an intracranial PTA with a stent. The average (nonstandardized) charge per case was $78,363.

The applicant also submitted data from the FY 2002 and FY 2003 MedPAR files. Using the latest data from the FY 2003 MedPAR and the same combination of diagnosis and procedure codes mentioned above to identify cases of intracranial PTA with stenting, the applicant found 116 cases in DRG 533 and 20 cases in DRG 534. The case-weighted average standardized charge per case was $51,173. The average case-weighted threshold was $25,394. Based on this analysis, the applicant maintained that the technology meets the cost criteria since the average case-weighted standardized charge per case

is greater than the average case-weighted threshold.

The applicant also maintained that the technology meets the substantial clinical improvement criterion. Currently, there is no available surgical or medical treatment for recurrent stroke that occurs despite optimal medical management. The Wingspan™ is the first commercially available PTA/stent system designed specifically for the intracranial vasculature. However, because the Wingspan™ does not have FDA approval or Medicare coverage, as stated above, we are proposing to deny add-on payment for this new technology.

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

III. Proposed Changes to the Hospital Wage Index

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'' In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of statistical areas established by the Office of Management and Budget (OMB). A discussion of the proposed FY 2006 hospital wage index based on the statistical areas, including OMB's revised definitions of Metropolitan Areas, appears under section III.B. of this preamble.

Beginning October 1, 1993, section 1886(d)(3)(E) of the Act requires that we update the wage index annually. Furthermore, this section provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey should measure the earnings and paid hours of employment by occupational category, and must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. The proposed adjustment for FY 2006 is discussed in section II.B. of the Addendum to this proposed rule.

As discussed below in section III.G. of this preamble, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating the wage index. Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. The proposed budget neutrality adjustment for FY 2006 is discussed in section II.B. of the Addendum to this proposed rule.

Section 1886(d)(3)(E) of the Act also provides for the collection of data every 3 years on the occupational mix of employees for short-term, acute care hospitals participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. A discussion of the proposed occupational mix adjustment that we are proposing to apply beginning October 1, 2005 (the proposed FY 2006 wage index) appears under section III.C. of this preamble.

B. Core-Based Statistical Areas Used for the Proposed Hospital Wage Index

(If you choose to comment on issues in this section, please include the caption "CBSAs'' at the beginning of your comment.)

The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. In accordance with the broad discretion under section 1886(d)(3)(E) of the Act, beginning with FY 2005, we define hospital labor market areas based on the Core-Based Statistical Areas (CBSAs) established by OMB and announced in December 2003 (69 FR 49027). OMB defines a CBSA, beginning in 2003, as "a geographic entity associated with at least one core of 10,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties.'' The standards designate and define two categories of CBSAs: Metropolitan Statistical Areas (MSAs) and Micropolitan Statistical Areas (65 FR 82235).

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

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

The new CBSAs established by OMB comprised MSAs and the new Micropolitan Areas based on Census 2000 data. (A copy of the announcement may be obtained at the following Internet address: *http://www.whitehouse.gov/omb/bulletins/fy04/b04–03.html*.) The definitions recognize 49 new MSAs and 565 new Micropolitan Areas, and extensively revised the composition of many of the existing MSAs.

The new area designations resulted in a higher wage index for some areas and lower wage index for others. Further, some hospitals that were previously classified as urban are now in rural areas. Given the significant payment impacts upon some hospitals because of these changes, we provided a transition period to the new labor market areas in the FY 2005 IPPS final rule (69 FR 49027 through 49034). As part of that transition, we allowed urban hospitals that became rural under the new definitions to maintain their assignment to the Metropolitan Statistical Area (MSA) where they were previously located for the 3-year period of FY 2005, FY 2006, and FY 2007. Specifically, these hospitals were assigned the wage index of the urban area to which they previously belonged. (For purposes of wage index computation, the wage data of these hospitals remained assigned to the statewide rural area in which they are located.) The hospitals receiving this transition will not be considered urban hospitals; rather they will maintain their status as rural hospitals. Thus, the hospital would not be eligible, for example, for a large urban add-on payment under the capital PPS. In other words, it is the wage index, but not the urban or rural status, of these hospitals that is being affected by this transition. The higher wage indices that these hospitals are receiving are also being taken into consideration in determining

whether they qualify for the out-commuting adjustment discussed in section III.I. of this preamble and the amount of any adjustment.

FY 2006 will be the second year of this transition period. We will continue to assign the wage index for the urban area in which the hospital was previously located through FY 2007. In order to ensure this provision remains budget neutral, we will continue to adjust the standardized amount by a transition budget neutrality factor to account for these hospitals. Doing so is consistent with the requirement of section 1886(d)(3)(E) of the Act that any "adjustments or updates [to the adjustment for different area wage levels] * * * shall be made in a manner that assures that aggregate payments * * * are not greater or less than those that would have been made in the year without such adjustment.''

Beginning in FY 2008, these hospitals will receive their statewide rural wage index, although they will be eligible to apply for reclassification by the MGCRB, both during this transition period as well as in subsequent years.

In addition, in the FY 2005 IPPS final rule (69 FR 49032 through 49033), we provided a 1-year transition blend for hospitals that, due solely to the changes in the labor market definitions, experienced a decrease in their FY 2005 wage index compared to the wage index they would have received using the labor market areas included in calculating their FY 2004 wage index. Hospitals that experienced a decrease in their wage index as a result of adoption of the new labor market area changes received a wage index based on 50 percent of the CBSA labor market area definitions and 50 percent of the wage index that the provider would have received under the FY 2004 MSA boundaries (in both cases using the FY 2001 wage data). This blend applied to any provider experiencing a decrease due to the new definitions, including providers who were reclassifying under MGCRB requirements, section 1886(d)(8)(B) of the Act, or section 508 of Pub. L. 108–173. In the FY 2005 IPPS final rule (69 FR 49027 through 49033), we described the determination of this blend in detail. We noted that this blend would not prevent a decrease in wage index due to any reason other than adoption of CBSAs, nor did it apply to hospitals that benefited from a higher wage index due to the new labor market definitions.

Consistent with the FY 2005 IPPS final rule, we are proposing that hospitals receive 100 percent of their wage index based upon the new CBSA configurations beginning in FY 2006. Specifically, we will determine for each hospital a new wage index employing wage index data from FY 2002 hospital cost reports and using the CBSA labor market definitions.

C. Proposed Occupational Mix Adjustment to FY 2006 Index

(If you choose to comment on issues in this section, please include the caption "Occupational Mix Adjustment'' at the beginning of your comment.)

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

1. Development of Data for the Proposed Occupational Mix Adjustment

In the FY 2005 IPPS final rule (69 FR 49034), we discussed in detail the data we used to calculate the occupational mix adjustment to the FY 2005 wage index. For the FY 2006 wage index, we are proposing to use the same CMS Wage Index Occupational Mix Survey and Bureau of Labor Statistics (BLS) data that we used for the FY 2005 wage index, with two exceptions. The CMS survey requires hospitals to report the number of total paid hours for directly hired and contract employees in occupations that provide the following services: nursing, physical therapy, occupational therapy, respiratory therapy, medical and clinical laboratory, dietary, and pharmacy. These services each include several standard occupational classifications (SOCs), as defined by the BLS' Occupational Employment Statistics (OES) survey. For the proposed FY 2006 wage index, we used revised survey data for 20 hospitals that took advantage of the opportunity we afforded hospitals to submit changes to their occupational mix data during the FY 2006 wage index data collection process (see discussion of wage data corrections process under section III.J. of this preamble). We also excluded survey data for hospitals that became designated as CAHs since the original survey data were collected and hospitals for which there are no corresponding cost report data for the proposed FY 2006 wage index. The proposed FY 2006 wage index includes occupational mix data from 3,563 out of 3,765 hospitals (94.6 percent response rate). The results of the occupational mix survey are included in the chart below:

Medicare Occupational Mix Survey Results

General Service Categories	Number of Employee Hours	Percent of Service Category Hours	Percent of Total Employee Hours
Nursing Services and Medical Assistant Services			
Registered Nurses	1,417,185,853.99	70.53%	26.71%
Licensed Practical Nurses	149,668,932.85	7.45%	2.82%
Nursing Aides, Orderlies, & Attendants	370,250,786.25	18.43%	6.98%
Medical Assistants	72,325,777.65	3.60%	1.36%
Total	**2,009,431,350.74**	**100.00%**	**37.87%**
Physical Therapy Services			
Physical Therapists	44,614,573.23	61.07%	0.84%
Physical Therapist Assistants	16,904,089.98	23.14%	0.32%
Physical Therapist Aides	11,535,889.13	15.79%	0.22%
Total	**73,054,552.34**	**100.00%**	**1.38%**
Occupational Therapy Services			
Occupational Therapists	18,869,571.78	78.96%	0.36%
Occupational Therapist Assistants	4,053,698.81	16.96%	0.08%
Occupational Therapist Aides	973,231.36	4.07%	0.02%
Total	**23,896,501.96**	**100.00%**	**0.45%**
Respiratory Therapy Services			
Respiratory Therapists	83,808,882.33	80.22%	1.58%
Respiratory Therapy Technicians	20,660,821.20	19.78%	0.39%
Total	**104,469,703.52**	**100.00%**	**1.97%**
Pharmacy Services			
Pharmacists	54,803,606.95	48.02%	1.03%
Pharmacy Technicians	54,862,034.03	48.08%	1.03%
Pharmacy Assistants/Aides	4,450,140.38	3.90%	0.08%
Total	**114,115,781.37**	**100.00%**	**2.15%**
Dietary Services			
Dieticians	18,827,594.18	42.44%	0.35%
Dietetic Technicians	25,537,528.63	57.56%	0.48%
Total	**44,365,122.81**	**100.00%**	**0.84%**

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

2. Calculation of the Proposed FY 2006 Occupational Mix Adjustment Factor and the Proposed FY 2006 Occupational Mix Adjusted Wage Index

For the proposed FY 2006 wage index, we are proposing to use the same methodology that we used to calculate the occupational mix adjustment to the FY 2005 wage index (69 FR 49042). We are proposing to use the following steps for calculating the proposed FY 2006 occupational mix adjustment factor and the occupational mix adjusted wage index:

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

Step 2—For each hospital, the weighted average hourly rate for an SOC is determined by multiplying the percentage of the general service category (from Step 1) by the national average hourly rate for that SOC from the 2001 BLS OES survey, which was used in calculating the occupational mix adjustment for the FY 2005 wage index. The 2001 OES survey is BLS' latest available hospital-specific survey. (See Chart 4 in the FY 2005 IPPS final rule, 69 FR 49038.) Repeat this calculation for each of the 19 SOCs.

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

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

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

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

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

Step 8—To compute the national occupational mix adjusted average hourly wage, sum the total occupational mix adjusted salaries and wage-related costs for all hospitals in the nation, then sum the total hours for all hospitals in the nation. Next, divide the national occupational mix adjusted salaries and wage-related costs by the national hours. The proposed national occupational mix adjusted average hourly wage for FY 2006 is $27.9988.

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

Step 10—To compute the Puerto Rico specific occupational mix adjusted wage index, follow the Steps 1 through 9 above. The proposed Puerto Rico occupational mix adjusted average hourly wage for FY 2006 is $12.9875.

An example of the occupational mix adjustment was included in the FY 2005 IPPS final rule (69 FR 49043).

For the FY 2005 final wage index, we used the unadjusted wage data for hospitals that did not submit occupational mix survey data. For calculation purposes, this equates to applying the national SOC mix to the wage data for these hospitals, because hospitals having the same mix as the Nation would have an occupational mix adjustment factor equaling 1.0000. In the FY 2005 IPPS final rule (69 FF 49035), we noted that we would revisit this matter with subsequent collections of the occupational mix data. Because we are using essentially the same survey data for the proposed FY 2006 occupational mix adjustment that we used for FY 2005, with the only exceptions as stated in section III.C.1. of this preamble, we are proposing to treat the wage data for hospitals that did not respond to the survey in this same manner for the proposed FY 2006 wage index.

In implementing an occupational mix adjusted wage index based on the above calculation, the proposed wage index values for 14 rural areas (29.8 percent) and 206 urban areas (53.5 percent) would decrease as a result of the adjustment. Six (6) rural areas (12.8 percent) and 111 urban areas (28.8 percent) would experience a decrease of 1 percent or greater in their wage index values. The largest negative impact for a rural area would be 1.9 percent and for an urban area, 4.3 percent. Meanwhile, 33 rural areas (70.2 percent) and 179 urban areas (46.5 percent) would experience an increase in their wage index values. Although these results show that rural hospitals would gain the most from an occupational mix adjustment to the wage index, their gains may not be as great as might have been expected. Further, it might not have been anticipated that almost one-third of rural hospitals would actually fare worse under the adjustment. Overall, a fully implemented occupational mix adjusted wage index would have a redistributive effect on Medicare payments to hospitals.

In the FY 2005 IPPS, we indicated that, for future data collections, we would revise the occupational mix survey to allow hospitals to provide both salaries and hours data for each of the employment categories that are included on the survey. We also indicated that we would assess whether future occupational mix surveys should be based on the calendar year or if the data should be collected on a fiscal year basis as part of the Medicare cost report. (One logistical problem is that cost

report data are collected yearly, but occupational mix survey data are collected only every 3 years.) We are currently reviewing options for revising the occupational mix survey and improving the data collection process. We will publish any changes we make to the occupational mix survey in a **Federal Register** notice.

In our continuing efforts to meet the information needs of the public, we are providing three additional public use files for the proposed occupational mix adjusted wage index: (1) A file including each hospital's unadjusted and adjusted average hourly wage (FY 2006 Proposed Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage by Provider); (2) a file including each CBSA's adjusted and unadjusted average hourly wage (FY 2006 Proposed Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-Reclassified Wage Index by CBSA); and (3) a file including each hospital's occupational mix adjustment factors by occupational category (Provider Occupational Mix Adjustment Factors for Each Occupational Category). These additional files are being released concurrently with the publication of this proposed rule and are posted on the Internet, at *http://www.cms.hhs.gov/providers/hipps/ippswage.asp.* We will also post these files with future applications of the occupational mix adjustment.

D. Worksheet S–3 Wage Data for the Proposed FY 2006 Wage Index Update

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

The proposed FY 2006 wage index values (effective for hospital discharges occurring on or after October 1, 2005 and before October 1, 2006) in section VI. of the Addendum to this proposed rule are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2002 (the FY 2005 wage index was based on FY 2001 wage data).

The proposed FY 2006 wage index includes the following categories of data associated with costs paid under the IPPS (as well as outpatient costs):

- Salaries and hours from short-term, acute care hospitals (including paid lunch hours and hours associated with military leave and jury duty).
- Home office costs and hours.
- Certain contract labor costs and hours (which includes direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services).
- Wage-related costs, including pensions and other deferred compensation costs.

The September 1, 1994 **Federal Register** (59 FR 45356) included a list of core wage-related costs that are included in the wage index, and discussed criteria for including other wage-related costs. In that discussion, we instructed hospitals to use generally accepted accounting principles (GAAPs) in developing wage-related costs for the wage index for cost reporting periods beginning on or after October 1, 1994. We discussed our rationale that "the application of GAAPs for purposes of compiling data on wage-related costs used to construct the wage index will more accurately reflect relative labor costs, because certain wage-related costs (such as pension costs), as recorded under GAAPs, tend to be more static from year to year.''

Since publication of the September 1, 1994 rule, we have periodically received inquiries for more specific guidance on developing wage-related costs for the wage index. In response, we have provided clarifications in the IPPS rules (for example, health insurance costs (66 FR 39859)) and in the cost report instructions (Provider Reimbursement Manual (PRM), Part II, Section 3605.2). Due to recent questions and concerns we received regarding inconsistent reporting and overreporting of pension and other deferred compensation plan costs, as a result of an ongoing Office of Inspector General review, we are clarifying in this proposed rule that hospitals must comply with the PRM, Part I, sections 2140. 2141, and 2142 and related Medicare program instructions for developing pension and other deferred compensation plan costs as wage-related costs for the wage index. The Medicare instructions for pension costs and other deferred compensation costs combine GAAPs, Medicare payment principles, and other Federal labor requirements. We believe that the Medicare instructions allow for consistent reporting among hospitals and for the development of reasonable deferred compensation plan costs for purposes of the wage index.

Beginning with the FY 2007 wage index, hospitals and fiscal intermediaries must ensure that pension, post-retirement health benefits, and other deferred compensation plan costs for the wage index are developed according to the above terms.

Consistent with the wage index methodology for FY 2005, the proposed wage index for FY 2006 also excludes the direct and overhead salaries and hours for services not subject to IPPS payment, such as SNF services, home health services, costs related to GME (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs), and other subprovider components that are not paid under the IPPS. The proposed FY 2006 wage index also excludes the salaries, hours, and wage-related costs of hospital-based rural health clinics (RHCs), and Federally qualified health centers (FQHCs) because Medicare pays for these costs outside of the IPPS (68 FR 45395). In addition, salaries, hours and wage-related costs of CAHs are excluded from the wage index, for the reasons explained in the FY 2004 IPPS final rule (68 FR 45397).

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

In the August 11, 2004 final rule, we stated that a commenter had asked CMS to designate provider-based clinics as IPPS-excluded areas in order to remove the costs from the wage index (69 FR 49049). The commenter noted that provider-based clinics are like physician private offices, which are excluded from the wage index calculation, and that services provided in the provider-based clinics are paid for not through the IPPS, but rather under the hospital outpatient PPS. In response to the comment, we stated that we were not prepared to grant the commenter's request without first studying the issue, and that we would explore the matter of salaries related to provider-based clinics in a future rule.

Regulations at 42 CFR 413.65 describe the criteria and procedures for determining whether a facility or organization is provider-based. Historically, under the Medicare program, some providers, referred to as "main providers,'' have functioned as single entities while owning and operating multiple provider-based departments, locations, and facilities that are treated as part of the main provider for Medicare purposes. Section 413.65(a)(2) defines various types of provider-based facilities, including "department of a provider.'' A "department of a provider'' means a facility or organization that is either created by, or acquired by, a main provider for the purposes of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider * * * a department

of a provider may not itself be qualified to participate in Medicare as a provider under § 489.2 * * * the term 'department of a provider' does not include an RHC or * * * an FQHC.'' Thus, if a facility offers services that are similar to those provided in a freestanding physician's office, and the facility meets the criteria to become provider-based under § 413.65, the facility would be considered a "department of a provider.'' More specifically, the facility would be part of the main provider's outpatient department, since the facility offers health care services of the same type as those furnished by the main provider, and because a physician's office would not be subject to a provider agreement or receive a Medicare provider number under § 489.2. (We note that a provider-based RHC or FQHC may, by itself, be qualified to participate in Medicare as a provider under § 489.2 and, thus, would be classified not as a "department of a provider'' but as a "provider-based entity,'' as defined at § 413.65(a)(2)). This provider-based facility, or provider-based clinic, as the commenter referred to it, would be reported on the main provider's Medicare cost report as an outpatient service cost center, on Worksheet A, line 60. With the exception of RHC and FQHC salaries that have been excluded from the wage index beginning with FY 2004 (68 FR 45395, August 1, 2003), the salaries attributable to employees working in these outpatient service cost centers, including emergency departments, are included in the main provider's total salaries on Worksheet S–3, Part II, line 1, and accordingly, are included in the wage index calculation. We have historically included the salaries and wages of hospital employees working in the outpatient departments in the calculation of the hospital wage index since these employees often work in both the IPPS and in the outpatient areas of the hospital. Consistent with this longstanding treatment of outpatient salary costs in the wage index calculation, we believe it is appropriate to continue to include the salaries and wages of employees working in outpatient departments, including provider-based clinics, in the wage index calculation.

E. Verification of Worksheet S–3 Wage Data

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

The wage data for the proposed FY 2006 wage index were obtained from Worksheet S–3, Parts II and III of the FY 2002 Medicare cost reports. Instructions for completing the Worksheet S–3, Parts II and III are in the Provider Reimbursement Manual, Part I, sections 3605.2 and 3605.3. The data file used to construct the proposed wage index includes FY 2002 data submitted to us as of February 23, 2005. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries to revise or verify data elements that resulted in specific edit failures. Some unresolved data elements are included in the calculation of the proposed FY 2006 wage index, pending their resolution before calculation of the final FY 2006 index. We instructed the fiscal intermediaries to complete their data verification of questionable data elements and to transmit any changes to the wage data no later than April 15, 2005. We believe all unresolved data elements will be resolved by the date the final rule is issued. The revised data will be reflected in the final rule.

Also, as part of our editing process, we removed the data for 438 hospitals from our database: 402 hospitals became CAHs by the time we published the February public use file, and 28 hospitals were low Medicare utilization hospitals or failed edits that could not be corrected because the hospitals terminated the program or changed ownership. In addition, we removed the wage data for 8 hospitals with incomplete or inaccurate data resulting in zero or negative, or otherwise aberrant, average hourly wages. We have notified the fiscal intermediaries of these hospitals and will continue to work with the fiscal intermediaries to correct these data until we finalize our database to compute the final wage index. The data for these hospitals will be included in the final wage index if we receive corrected data that passes our edits. As a result, the proposed FY 2006 wage index is calculated based on FY 2002 wage data from 3,765 hospitals.

In constructing the proposed FY 2006 wage index, we include the wage data for facilities that were IPPS hospitals in FY 2002, even for those facilities that have since terminated their participation in the program as hospitals, as long as those data do not fail any of our edits for reasonableness. We believe that including the wage data for these hospitals is, in general, appropriate to reflect the economic conditions in the various labor market areas during the relevant past period. However, we exclude the wage data for CAHs (as discussed in 68 FR 45397). The proposed wage index in this proposed rule excludes hospitals that are designated as CAHs by February 1, 2005, the date of the latest available Medicare CAH listing at the time we released the proposed wage index public use file on February 25, 2005.

F. Computation of the Proposed FY 2006 Unadjusted Wage Index

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

The method used to compute the proposed FY 2006 wage index without an occupational mix adjustment follows:

Step 1—As noted above, we based the proposed FY 2006 wage index on wage data reported on the FY 2002 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, 2001 and before October 1, 2002. In addition, we included data from some hospitals that had cost reporting periods beginning before October 2001 and reported a cost reporting period covering all of FY 2002. These data were included because no other data from these hospitals would be available for the cost reporting period described above, and because particular labor market areas might be affected due to the omission of these hospitals. However, we generally describe these wage data as FY 2002 data. We note that, if a hospital had more than one cost reporting period beginning during FY 2002 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002), we included wage data from only one of the cost reporting periods, the longer, in the wage index calculation. If there was more than one cost reporting period and the periods were equal in length, we included the wage data from the later period in the wage index calculation.

Step 2—Salaries—The method used to compute a hospital's average hourly wage excludes certain costs that are not paid under the IPPS. In calculating a hospital's average salaries plus wage-related costs, we subtracted from Line 1 (total salaries) the GME and CRNA costs reported on Lines 2, 4.01, 6, and 6.01, the Part B salaries reported on Lines 3, 5 and 5.01, home office salaries reported on Line 7, and excluded salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to SNF services, home health services, and other subprovider components not

subject to the IPPS). We also subtracted from Line 1 the salaries for which no hours were reported. To determine total salaries plus wage-related costs, we added to the net hospital salaries the costs of contract labor for direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services (Lines 9 and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, and 18).

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

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

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocated overhead costs to areas of the hospital excluded from the wage index calculation. First, we determined the ratio of excluded area hours (sum of Lines 8 and 8.01 of Worksheet S–3, Part II) to revised total hours (Line 1 minus the sum of Part II, Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, and Part III, Line 13 of Worksheet S–3). We then computed the amounts of overhead salaries and hours to be allocated to excluded areas by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S–3, Part III. Next, we computed the amounts of overhead wage-related costs to be allocated to excluded areas using three steps: (1) We determined the ratio of overhead hours (Part III, Line 13) to revised hours (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7, 8, and 8.01); (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, 2001 through April 15, 2003 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
10/14/2001	11/15/2001	1.06469
11/14/2001	12/15/2001	1.06007
12/14/2001	1/15/2002	1.05566
01/14/2002	02/15/2002	1.05139
02/14/2002	03/15/2002	1.04725
03/14/2002	04/15/2002	1.04317
04/14/2002	05/15/2002	1.03907
05/14/2002	06/15/2002	1.03496
06/14/2002	07/15/2002	1.03083
07/14/2002	08/15/2002	1.02672
08/14/2002	09/15/2002	1.02261
09/14/2002	10/15/2002	1.01860
10/14/2002	11/15/2002	1.01478
11/14/2002	12/15/2002	1.01116
12/14/2002	01/15/2003	1.00757
01/14/2003	02/15/2003	1.00385
02/14/2003	03/15/2003	1.0000
03/14/2003	04/15/2003	0.99613

For example, the midpoint of a cost reporting period beginning January 1, 2002 and ending December 31, 2002 is June 30, 2002. An adjustment factor of 1.03083 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 2002 and covered a period of less than 360 days or more than 370 days, we annualized the data to reflect a 1-year cost report. Dividing the data by the number of days in the cost report and then multiplying the results by 365 accomplishes annualization.

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

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

Step 8—We added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the nation and then divided the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage. Using the data as described above, the proposed national average hourly wage is $27.9730.

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

Step 10—Following the process set forth above, we developed a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We added the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall proposed average hourly wage of $12.9957 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 Pub. L. 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 2006, this change affects 147 hospitals in 52 urban areas. The areas affected by this provision are identified by a footnote in Table 4A in the Addendum of this proposed rule.

G. Computation of the Proposed FY 2006 Blended Wage Index

(If you choose to comment on issues in this section, please include the caption "Blended Wage Index'' at the beginning of your comments.)

For the final FY 2005 wage index, we used a blend of the occupational mix adjusted wage index and the unadjusted wage index. Specifically, we adjusted 10 percent of the FY 2005 wage index adjustment factor by a factor reflecting occupational mix. Given that 2003–2004 was the first time for the administration of the occupational mix survey, hospitals had a short timeframe for collecting their occupational mix survey data and documentation, the wage data were not in all cases from a 1-year period, and there was no baseline data for purposes of developing a desk review program, we found it prudent not to adjust the entire wage index factor by the occupational mix. However, we did find the data sufficiently reliable for applying an adjustment to 10 percent of the wage index. We found the data reliable because hospitals were given an opportunity to review their survey data and submit changes in the Spring of 2004, hospitals were already familiar with the BLS OES survey categories, hospitals were required to be able to provide documentation that could be used by fiscal intermediaries to verify survey data, and the results of our survey were consistent with the findings of the 2001 BLS OES survey, especially for nursing and physical therapy categories. In addition, we noted that we were moving cautiously with implementing the occupational mix adjustment in recognition of changing trends in hiring nurses, the largest group in the survey. We noted that some States had recently established floors on the minimum level of registered nurse staffing in hospitals in order to maintain licensure. In addition, in some rural areas, we believed that hospitals might be accounting for shortages of physicians by hiring more registered nurses. (A complete discussion of the FY 2005 wage index adjustment factor can be found in section III.G. of the FY 2005 IPPS final rule (69 FR 49052)).

In the FY 2005 final rule, we noted that while the statute required us to collect occupational mix data every 3 years, the statute does not specify how the occupational mix adjustment is to be constructed or applied. We are clarifying in this proposed rule that the October 1, 2004 deadline for implementing an occupational mix adjustment is not codified in section 1886(d)(3)(E) of the Act, which requires only a collection and measurement of occupational mix data, but rather stems from the effective date provisions in section 304(c) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106–554 (BIPA). Although we believe that applying the occupational mix to 10 percent of the wage index factor fully implements the occupational mix adjustment, we also interpret BIPA as requiring only that we *begin* applying an adjustment by October 1, 2004. BIPA required the Secretary to complete, "by not later than September 30, 2003, for application beginning October 1, 2004,'' both the collection of occupational mix data and the measurement of such data. (BIPA, section 304(c)(3).) Thus, even if adjusting 10 percent of the wage index for occupational mix were not (as we believe it to be) considered to be full implementation of the BIPA effective date, we certainly began our application of the adjustment as of October 1, 2004.

In addition, section 1886(d)(3)(E) of the Act provides broad authority for us to establish the factor we use to adjust hospital costs to take into account area differences in wage levels. The statute is clear that the wage index factor is to be "established by the Secretary.'' The occupational mix is only one part of this wage index factor, which, for the most part, is calculated on the basis of average hourly wage data submitted by all hospitals in the United States. In exercising the Secretary's broad discretion to establish the factor that adjusts for geographic wage differences, in FY 2005 we adjusted 10 percent of such factor to account for occupational mix.

Indeed, we have often used percentage figures or blended amounts in exercising the Secretary's authority to establish the factor that adjusts for wage differences. For example, in the FY 2005 final rule, we implemented new mapping boundaries for assigning hospitals to the geographic labor market areas used for calculating the wage index. For hospitals that were harmed by the new geographic boundaries, we used a blended rate based on 50 percent of the wage index that would apply using the new geographic boundaries effective for FY 2005 and 50 percent of the wage index that would apply using the old geographic boundaries that were effective during FY 2004 (69 FR 49033). Similarly, beginning with FY 2000, we began phasing out costs related to GME and CRNAs from the wage index (64 FR 41505). Thus, for example, the FY 2001 wage index was based on a blend of 60 percent of an average hourly wage including these costs, and 40 percent of an average hourly wage excluding these costs (65 FR 47071).

For FY 2006, we are again proposing to adjust 10 percent of the wage index factor for occupational mix. In computing the occupational mix adjustment for the proposed FY 2006 wage index, we used the occupational mix survey data that we collected for the FY 2005 wage index, replacing the survey data for 20 hospitals that submitted revised data, and excluding the survey data for hospitals with no corresponding Worksheet S–3 wage data for FY 2006 wage index. While we considered adjusting 100 percent of the wage index by the occupational mix, we did not believe it was appropriate to use first-year survey data to make such a large adjustment. As hospitals gain additional experience with the occupational mix survey, and as we develop more information upon which to audit the data we receive, we expect to increase the portion of the wage index that is adjusted.

We also acknowledge the District Court opinion in *Bellevue Hospital Center* v. *Leavitt*, No. 04–8639 (S.D.N.Y, March 2005) finding that the statute requires full implementation of the occupational mix adjustment beginning October 1, 2004, and granting summary judgment to plaintiffs on the matter. At the time this proposed rule was written, an appeal had not yet been heard in the Circuit Court. Thus, because it was not yet clear whether the decision would be appealed, we determined that, for FY 2006, we would continue to propose the policy we believe to be most prudent in light of the survey data being used to adjust the wage index.

With 10 percent of the proposed FY 2006 wage index adjusted for occupational mix, the wage index values for 13 rural areas (27.7 percent) and 204 urban areas (53.0 percent) would decrease as a result of the adjustment. These decreases would be minimal; the largest negative impact for

a rural area would be 0.19 percent and for an urban area, 0.42 percent. Conversely, 34 rural areas (72.3 percent) and 181 urban areas (47.0 percent) would benefit from this adjustment, with 1 urban area increasing 2.1 percent and 1 rural area increasing 0.39 percent. As there are no significant differences between the FY 2005 and the FY 2006 occupational mix survey data and results, we believe it is appropriate to again apply the occupational mix to 10 percent of the proposed FY 2006 wage index. (See Appendix A to this proposed rule for further analysis of the impact of the occupational mix adjustment on the proposed FY 2006 wage index.)

The wage index values in Tables 4A, 4B, 4C, and 4F and the average hourly wages in Tables 2, 3A, and 3B in the Addendum to this proposed rule include the occupational mix adjustment.

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

(If you choose to comment on issues in this section, please include the caption "Hospital Redesignations and Reclassifications'' at the beginning of your comment.)

1. General

Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. Hospitals must apply to the MGCRB to reclassify by September 1 of the year preceding the year during which reclassification is sought. Generally, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. The MGCRB issues its decisions by the end of February for reclassifications that 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 requires the Secretary to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA to which the greatest number of workers in the county commute if: the rural county would otherwise be considered part of an urban area under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of *all* contiguous MSAs. In light of the new CBSA definitions and the Census 2000 data that we implemented for FY 2005 (69 FR 49027), we undertook to identify those counties meeting these criteria. The eligible counties are identified below under section III.H.5. of this preamble.

2. Effects of Reclassification

Section 1886(d)(8)(C) of the Act provides that the application of the wage index to redesignated hospitals is dependent on the hypothetical impact that the wage data from these hospitals would have on the wage index value for the area to which they have been redesignated. These requirements for determining the wage index values for redesignated hospitals is applicable both to the hospitals located in rural counties deemed urban under section 1886(d)(8)(B) of the Act and hospitals that were reclassified as a result of the MGCRB decisions under section 1886(d)(10) of the Act. Therefore, as provided in section 1886(d)(8)(C) of the Act,[3] the wage index values were determined by considering the following:

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

3. Proposed Application of Hold Harmless Protection for Certain Urban Hospitals Redesignated as Rural

Section 401(a) of Pub. L. 106–113 (the Balanced Budget Refinement Act of 1999) amended section 1886(d)(8) of the Act by adding paragraph (E). Section 401(a) created a mechanism that permits an urban hospital to apply to the Secretary to be treated, for purposes of subsection (d), as being located in the rural area of the State in which the hospital is located. A hospital that is granted redesignation under section 1886(d)(8)(E) of the Act, as added by section 401 of Pub. L. 106–113 is, therefore, treated as a rural hospital for

[3] 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 already below the wage index for rural areas in the State in which the urban area is located, the provision was effectively made moot by section 4410 of Pub. L. 105–33, which provides that the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. Also, section 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.

all purposes of payment under the Medicare IPPS, including the standardized amount, wage index, and disproportionate share calculations as of the effective date of the redesignation. Under current policy, as a result of an approved redesignation of an urban hospital as a rural hospital, the wage index data are excluded from the wage index calculation for the area where the urban hospital is geographically located and included in the rural hospital wage index calculation.

Last year, we became aware of an instance where the approved redesignation of an urban hospital as rural under section 1886(d)(8)(E) of the Act resulted in the hospital's data having an adverse impact on the rural wage index. We received a public comment noting that specific "hold harmless'' provisions apply to reclassifications that occur under section 1886(d)(8)(B) and section 1886(d)(10) of the Act. That is, if a hospital is granted geographic reclassification under section 1886(d)(8)(B) or section 1886(d)(10) of the Act, there are certain rules that apply when the inclusion of the hospital's data results in a reduction of the reclassification area's wage index, and these rules are slightly different for urban areas versus rural areas. These rules are more fully described in the FY 2005 IPPS final rule (69 FR 49053). Generally stated, these rules prevent a rural area from being adversely affected as a result of reclassification. That is, if excluding the reclassifying hospitals' wage data would decrease the wage index of the rural area, the reclassifying hospitals are included in the rural area's wage index. Otherwise, the reclassifying hospitals are excluded. For hospitals reclassifying out of urban areas, the rules provide that the wage data for the reclassified urban hospital is included in the wage index calculation of the urban area where the hospital is physically located.

The commenter recommended that we revise our regulations and apply similar hold harmless provisions and treat hospitals redesignated under 1886(d)(8)(E) of the Act in the same manner as reclassifications under section 1886(d)(8)(B) and section 1886(d)(10) of the Act. In our continued effort to promote consistency, equity and to simplify our rules with respect to how we construct the wage indexes of rural and urban areas, we are persuaded that there is a need to modify our policy when hospital redesignations occur under section 1886(d)(8)(E) of the Act. Therefore, for the FY 2006 wage index, we are proposing to apply the hold harmless rule that currently applies when rural hospitals are reclassifying out of the rural area (from rural to urban) to situations where hospitals are reclassifying into the rural area (from urban to rural under section 1886(d)(8)(E) of the Act). Thus, the rule would be that the wage data of the urban hospital reclassifying into the rural area is included in the rural area's wage index, if including the urban hospital's data increases the wage index of the rural area. Otherwise, the wage data is excluded. Similarly, we are proposing to apply to these cases the rule that currently applies when urban hospitals reclassify under the MGCRB process. Thus, the wage data for an urban hospital reclassifying under section 1886(d)(8)(E) of the Act is always included in the wage index of the urban area where the hospital is located, and can also be included in the wage index of the rural area to which it is reclassifying (if doing so increases the rural area's wage index). We believe this proposal provides uniformity in the way geographic areas are treated under all types of reclassifications. In addition, our proposal promotes predictability by alleviating fluctuations in the wage indexes due to a section 401 redesignation.

We are including in the Addendum to this proposed rule Table 9C, which shows hospitals redesignated under section 1886(d)(8)(E) of the Act.

4. FY 2006 MGCRB Reclassifications

At the time this proposed rule was constructed, the MGCRB had completed its review of FY 2006 reclassification requests. There were 295 hospitals approved for wage index reclassifications by the MGCRB for FY 2006. Because MGCRB wage index reclassifications are effective for 3 years, hospitals reclassified during FY 2004 or FY 2005 are eligible to continue to be reclassified based on prior reclassifications to current MSAs during FY 2006. There were 395 hospitals reclassified for wage index for FY 2005, and 94 hospitals reclassified for wage index in FY 2004. Some of the hospitals that reclassified in FY 2004 and FY 2005 have elected not to continue their reclassifications in FY 2006 because, under the new labor market area definitions, they are now physically located in the areas to which they previously reclassified. Of all of the hospitals approved for reclassification for FY 2004, FY 2005, and FY 2006, 672 hospitals will be in a reclassification status for FY 2006.

Prior to FY 2004, hospitals had been able to apply to be reclassified for purposes of either the wage index or the standardized amount. Section 401 of Pub. L. 108–173 established that all hospitals will be paid on the basis of the large urban standardized amount, beginning with FY 2004. Consequently, all hospitals are paid on the basis of the same standardized amount, which made such reclassifications moot. Although there could still be some benefit in terms of payments for some hospitals under the DSH payment adjustment for operating IPPS, section 402 of Pub. L. 108–173 equalized DSH payment adjustments for rural and urban hospitals, with the exception that the rural DSH adjustment is capped at 12 percent (except that RRCs have no cap). (A detailed discussion of this application appears in section IV.I. of the preamble of the FY 2005 IPPS final rule (69 FR 49085.)

5. Proposed FY 2006 Redesignations Under Section 1886(d)(8)(B) of the Act

Beginning October 1, 1988, section 1886(d)(8)(B) of the Act required us to treat a hospital located in a rural county adjacent to one or more urban areas as being located in the MSA if certain criteria were met. Prior to FY 2005, the rule was that a rural county adjacent to one or more urban areas would be treated as being located in the MSA to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area under the standards published in the **Federal Register** on January 3, 1980 (45 FR 956) for designating MSAs (and NECMAs), and if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of *all* contiguous MSAs (or NECMAs). Hospitals that met the criteria using the January 3, 1980 version of these OMB standards were deemed urban for purposes of the standardized amounts and for purposes of assigning the wage data index.

On June 6, 2003, OMB announced the new CBSAs based on Census 2000 data. For FY 2005, we used OMB's 2000 CBSA standards and the Census 2000 data to identify counties qualifying for redesignation under section 1886(d)(8)(B) for the purpose of assigning the wage index to the urban area. We presented this listing, effective for discharges occurring on or after October 1, 2004 (FY 2005), in Chart 6 of the FY 2005 final rule (69 FR 49057). However, Chart 6 in the FY 2005 final rule contained a printing error in which we misidentified rural counties that qualified for redesignation under

section 1886(d)(8)(B) of the Act. The list of rural counties qualifying to be urban in that Chart 6 incorrectly included Monroe, PA and Walworth, WI. This error was made only in the chart and not in the application of the rules; that is, we correctly applied the rules to the correct rural counties qualifying to be urban for FY 2005.

In addition, we discovered that, in the FY 2005 IPPS final rule, we had erroneously printed the names of the entire Metropolitan Statistical Areas rather than the Metropolitan Division names. Because we recognized Metropolitan Divisions as MSAs in the FY 2005 IPPS final rule (69 FR 49029), we should have printed the division names for the following counties: Henry, FL; Starke, IN; Henderson, TX; Fannin, TX; and Island, WA.

The chart below contains the corrected listing of the rural counties designated as urban under section 1886(d)(8)(B) of the Act that we are proposing to use for FY 2006. We are proposing that, for discharges occurring on or after October 1, 2005, hospitals located in the first column of this chart will be redesignated for purposes of using the wage index of the urban area listed in the second column.

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Rural Counties Redesignated as Urban under Section 1886(d)(8)(B) of the Act (Based on CBSAs and Census 2000 Data)

Rural County	CBSA
Cherokee, AL	Rome, GA
Macon, AL	Auburn-Opelika, AL
Talladega, AL	Anniston-Oxford, AL
Hot Springs, AR	Hot Springs, AR
Litchfield, CT	Hartford-West Hartford-East Hartford, CT
Windham, CT	Hartford-West Hartford-East Hartford, CT
Bradford, FL	Gainesville, FL
Flagler, FL	Deltona-Daytona Beach-Ormond Beach, FL
Hendry, FL	West Palm Beach-Boca Raton-Boynton, FL
Levy, FL	Gainesville, FL
Walton, FL	Fort Walton Beach-Crestview-Destin, FL
Banks, GA	Gainesville, GA
Chattooga, GA	Chattanooga, TN-GA
Jackson, GA	Atlanta-Sandy Springs-Marietta, GA
Lumpkin, GA	Atlanta-Sandy Springs-Marietta, GA
Morgan, GA	Atlanta-Sandy Springs-Marietta, GA
Peach, GA	Macon, GA
Polk, GA	Atlanta-Sandy Springs-Marietta, GA
Talbot, GA	Columbus, GA-AL
Bingham, ID	Idaho Falls, ID
Christian, IL	Springfield, IL
DeWitt, IL	Bloomington-Normal, IL
Iroquois, IL	Kankakee-Bradley, IL
Logan, IL	Springfield, IL
Mason, IL	Peoria, IL
Ogle, IL	Rockford, IL
Clinton, IN	Lafayette, IN
Henry, IN	Indianapolis, IN
Spencer, IN	Evansville, IN-KY
Starke, IN	Gary, IN
Warren, IN	Lafayette, IN
Boone, IA	Ames, IA
Buchanan, IA	Waterloo-Cedar Falls, IA
Cedar, IA	Iowa City, IA
Allen, KY	Bowling Green, KY
Assumption Parish, LA	Baton Rouge, LA
St. James Parish, LA	Baton Rouge, LA
Allegan, MI	Holland-Grand Haven, MI
Montcalm, MI	Grand Rapids-Wyoming, MI
Oceana, MI	Muskegon-Norton Shores, MI
Shiawassee, MI	Lansing-East Lansing, MI
Tuscola, MI	Saginaw-Saginaw Township North, MI
Fillmore, MN	Rochester, MN
Dade, MO	Springfield, MO
Pearl River, MS	Gulfport-Biloxi, MS

Rural County	CBSA
Caswell, NC	Burlington, NC
Granville, NC	Durham, NC
Harnett, NC	Raleigh-Cary, NC
Lincoln, NC	Charlotte-Gastonia-Concord, NC-SC
Polk, NC	Spartanburg, NC
Los Alamos, NM	Santa Fe, NM
Lyon, NV	Carson City, NV
Cayuga, NY	Syracuse, NY
Columbia, NY	Albany-Schenectady-Troy, NY
Genesee, NY	Rochester, NY
Greene, NY	Albany-Schenectady-Troy, NY
Schuyler, NY	Ithaca, NY
Sullivan, NY	Poughkeepsie-Newburgh-Middletown, NY
Wyoming, NY	Buffalo-Niagara Falls, NY
Ashtabula, OH	Cleveland-Elyria-Mentor, OH
Champaign, OH	Springfield, OH
Columbiana, OH	Youngstown-Warren-Boardman, OH-PA
Cotton, OK	Lawton, OK
Linn, OR	Corvallis, OR
Adams, PA	York-Hanover, PA
Clinton, PA	Williamsport, PA
Greene, PA	Pittsburgh, PA
Monroe, PA	Allentown-Bethlehem-Easton, PA-NJ
Schuylkill, PA	Reading, PA
Susquehanna, PA	Binghamton, NY
Clarendon, SC	Sumter, SC
Lee, SC	Sumter, SC
Oconee, SC	Greenville, SC
Union, SC	Spartanburg, SC
Meigs, TN	Cleveland, TN
Bosque, TX	Waco, TX
Falls, TX	Waco, TX
Fannin, TX	Dallas-Plano-Irving, TX
Grimes, TX	College Station-Bryan, TX
Harrison, TX	Longview, TX
Henderson, TX	Dallas-Plano-Irving, TX
Milam, TX	Austin-Round Rock, TX
Van Zandt, TX	Dallas-Plano-Irving, TX
Willacy, TX	Brownsville-Harlingen, TX
Buckingham, VA	Charlottesville, VA
Floyd, VA	Blacksburg-Christiansburg-Radford, VA

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Rural County	CBSA
Middlesex, VA	Virginia Beach-Norfolk-Newport News, VA
Page, VA	Harrisonburg, VA
Shenandoah, VA	Winchester, VA-WV
Island, WA	Seattle-Bellevue-Everett, WA
Mason, WA	Olympia, WA
Wahkiakum, WA	Longview, WA
Jackson, WV	Charleston, WV
Roane, WV	Charleston, WV
Green, WI	Madison, WI
Green Lake, WI	Fond du Lac, WI
Jefferson, WI	Milwaukee-Waukesha-West Allis, WI
Walworth, WI	Milwaukee-Waukesha-West Allis, WI

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

6. Reclassifications Under Section 508 of Pub. L. 108–173

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

We show the reclassifications effective under the one-time appeal process in Table 9B in the Addendum to this proposed rule.

I. Proposed FY 2006 Wage Index Adjustment Based on Commuting Patterns of Hospital Employees

(If you choose to comment on issues in this section, please include the caption "Out-Migration Adjustment'' at the beginning of your comment.)

In accordance with the broad discretion under section 1886(d)(13) of the Act, as added by section 505 of Pub. L. 108–173, beginning with FY 2005, we established a process to make adjustments to the hospital wage index based on commuting patterns of hospital employees. The process, outlined in the FY 2005 IPPS final rule (69 FR 49061), provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. Such adjustments to the wage index are effective for 3 years, unless a hospital requests to waive the application of the adjustment. A county will not lose its status as a qualifying county due to wage index changes during the 3-year period, and counties will receive the same wage index increase for those 3 years. However, a county that qualifies in any given year may no longer qualify after the 3-year period, or it may qualify but receive a different adjustment to the wage index level. Hospitals that receive this adjustment to their wage index are not eligible for reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act. Adjustments under this provision are not subject to the IPPS budget neutrality requirements at section 1886(d)(3)(E) or section 1886(d)(8)(D) of the Act.

Hospitals located in counties that qualify for the wage index adjustment are to receive an increase in the wage index that is equal to the average of the differences between the wage indexes of the labor market area(s) with higher wage indexes and the wage index of the resident county, weighted by the overall percentage of hospital workers residing in the qualifying county who are employed in any labor market area with a higher wage index. We have employed the prereclassified wage indexes in making these calculations.

We are proposing that hospitals located in the qualifying counties identified in Table 4J in the Addendum to this proposed rule that have not already reclassified through section 1886(d)(10) of the Act, redesignated through section 1886(d)(8) of the Act, received a section 508 reclassification, or requested to waive the application of the out-migration adjustment would receive the wage index adjustment listed in the table for FY 2006. We used the same formula described in the FY 2005 final rule (69 FR 49064) to calculate the out-migration adjustment. This proposed adjustment was calculated as follows:

Step 1. Subtract the wage index for the qualifying county from the wage index for the higher wage area(s).

Step 2. Divide the number of hospital employees residing in the qualifying county who are employed in such higher wage index area by the total number of hospital employees residing in the qualifying county who are employed in any higher wage index area. Multiply this result by the result obtaining in Step 1.

Step 3. Sum the products resulting from Step 2 (if the qualifying county has workers commuting to more than one higher wage area).

Step 4. Multiply the result from Step 3 by the percentage of hospital employees who are residing in the qualifying county and who are

employed in any higher wage index area.

The proposed adjustments calculated for qualifying hospitals are listed in Table 4J in the Addendum to this proposed rule. These proposed adjustments would be effective for each county for a period of 3 fiscal years. Hospitals that received the adjustment in FY 2005 will be eligible to retain that same adjustment for FY 2006 and FY 2007. For hospitals in newly qualified counties, adjustments to the wage index would be effective for 3 years, beginning with discharges occurring on or after October 1, 2005.

As previously noted, hospitals receiving the wage index adjustment under section 1886(d)(13)(F) of the Act are not eligible for reclassification under section 1886(d)(10) of the Act or reclassifications under section 508 of Pub. L. 108–173. Hospitals that wish to waive the application of this wage index adjustment must notify CMS within 45 days of the publication of this proposed rule. Waiver notification should be sent to the following address: Centers for Medicare and Medicaid Services, Center for Medicare Management, Attention: Wage Index Adjustment Waivers, Division of Acute Care, Room C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850. We will assume that hospitals that have been redesignated under section 1886(d)(8) of the Act or reclassified under section 886(d)(10) of the Act or under section 508 of Pub. L. 108–173 would prefer to keep their redesignation/reclassification unless they explicitly notify CMS that they would like to receive the out-migration adjustment instead. In addition, hospitals that wish to retain their redesignation/reclassification (instead of receiving the out-migration adjustment) for FY 2006 do not need to submit a formal request to CMS, and will automatically retain their redesignation/reclassification status for FY 2006. However, consistent with § 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of this proposed rule. Hospitals that have been reclassified by the MGCRB (including reclassifications under section 508 of Pub. L. 108–173) may terminate an existing 3-year reclassification within 45 days of the publication of this proposed rule in order to receive the wage index adjustment under this provision. Hospitals that are eligible to receive the wage index adjustment and that withdraw their application for reclassification will then automatically receive the wage index adjustment listed in Table 4J in the Addendum to this proposed rule. The request for withdrawal of an application for reclassification or termination of an existing 3-year reclassification that would be effective in FY 2006 must be received by the MGCRB within 45 days of the publication of this proposed rule. Hospitals should carefully review the wage index adjustment that they would receive under this provision (as listed in Table 2 in the Addendum to this proposed rule) in comparison to the wage index adjustment that they would receive under the MGCRB reclassification (Table 9 in the Addendum to this proposed rule).

J. Process for Requests for Wage Index Data Corrections

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

In the FY 2005 IPPS final rule (68 FR 27194), we revised the process and timetable for application for development of the wage index, beginning with the FY 2005 wage index. The preliminary and unaudited Worksheet S–3 wage data and occupational mix survey files were made available on October 8, 2004 through the Internet on the CMS Web site at: *http://cms.hhs.gov/providers/hipps/ippswage.asp.* In a memorandum dated October 6, 2004, we instructed all Medicare fiscal intermediaries to inform the IPPS hospitals they service of the availability of the wage index data files and the process and timeframe for requesting revisions (including the specific deadlines listed below). We also instructed the fiscal intermediaries to advise hospitals that these data are also made available directly through their representative hospital organizations.

If a hospital wished to request a change to its data as shown in the October 8, 2004 wage and occupational mix data files, the hospital was to submit corrections along with complete, detailed supporting documentation to its fiscal intermediary by November 29, 2004. 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 index data file on the Internet, through the October 6, 2004 memorandum referenced above.

In the October 6, 2004 memorandum, we also specified that a hospital could only request revisions to the occupational mix data for the reporting period that the hospital used in its original FY 2005 wage index occupational mix survey. That is, a hospital that submitted occupational mix data for the 12-month reporting period could not switch to submitting data for the 4-week reporting period and vice versa. Further, a hospital could not submit an occupational mix survey for the periods beginning before January 1, 2003, or after January 11, 2004. In addition, a hospital that did not submit an occupational mix survey for the FY 2005 wage index was not permitted to submit a survey for the FY 2006 wage index.

The fiscal intermediaries notified the hospitals by mid-February 2005 of any changes to the wage index data as a result of the desk reviews and the resolution of the hospitals' late November 2004 change requests. The fiscal intermediaries also submitted the revised data to CMS by mid-February 2005. CMS published the proposed wage index public use files that included hospitals' revised wage data on February 25, 2005. In a memorandum also dated February 25, 2005, we instructed fiscal intermediaries to notify all hospitals regarding the availability of the proposed wage index public use files and the criteria and process for requesting corrections and revisions to the wage index data. Hospitals had until March 14, 2005 to submit requests to the fiscal intermediaries for reconsideration of adjustments made by the fiscal intermediaries as a result of the desk review, and to correct errors due to CMS's or the fiscal intermediary's mishandling of the wage index data. Hospitals were also required to submit sufficient documentation to support their requests.

After reviewing requested changes submitted by hospitals, fiscal intermediaries are to submit any additional revisions resulting from the hospitals' reconsideration requests by April 15, 2005. The deadline for a hospital to request CMS intervention in cases where the hospital disagrees with the fiscal intermediary's policy interpretations is April 22, 2005.

Hospitals should also examine Table 2 in the Addendum to this proposed rule. Table 2 contains each hospital's adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 2002 data used to construct the FY 2006 wage index. We note that the hospital average hourly wages shown in Table 2 only reflect changes made to a hospital's data and transmitted to CMS by February 23, 2005.

We will release a final wage index data public use file in early May 2005 to hospital associations and the public on the Internet at *http://www.cms.hhs.gov/providers/hipps/*

ippswage.asp. The May 2005 public use file will be made available solely for the limited purpose of identifying any potential errors made by CMS or the fiscal intermediary in the entry of the final wage data that result from the correction process described above (revisions submitted to CMS by the fiscal intermediaries by April 15, 2005). If, after reviewing the May 2005 final file, a hospital believes 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 should send a letter to both its fiscal intermediary and CMS that outlines why the hospital believes an error exists and provide all supporting information, including relevant dates (for example, when it first became aware of the error). CMS and the fiscal intermediaries must receive these requests no later than June 10, 2005. Requests mailed to CMS should be sent to:

Centers for Medicare & Medicaid Services, Center for Medicare Management, Attention: Wage Index Team, Division of Acute Care, C4–08–06, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Each request also must be sent to the fiscal intermediary. The fiscal intermediary will review requests upon receipt and contact CMS immediately to discuss its findings.

At this point in the process, that is, after the release of the May 2005 wage index data file, changes to the hospital wage data will only be made in those very limited situations involving an error by the fiscal intermediary or CMS that the hospital could not have known about before its review of the final wage index data file. Specifically, neither the intermediary nor CMS will approve the following types of requests:

- Requests for wage data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries on or before April 15, 2005.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the February 25, 2005 wage index data file.
- Requests to revisit factual determinations or policy interpretations made by the fiscal intermediary or CMS during the wage index data correction process.

Verified corrections to the wage index received timely by CMS and the fiscal intermediaries (that is, by June 10, 2005) will be incorporated into the final wage index to be published by August 1, 2005, and to be effective October 1, 2005.

We created the processes described above to resolve all substantive wage index data correction disputes before we finalize the wage and occupational mix data for the FY 2006 payment rates. Accordingly, hospitals that do not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage index data corrections or to dispute the fiscal intermediary's decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth above will not be permitted to challenge later, before the Provider Reimbursement Review Board, the failure of CMS to make a requested data revision (*See W. A. Foote Memorial Hospital* v. *Shalala*, No. 99–CV–75202–DT (E.D. Mich. 2001), also *Palisades General Hospital* v. *Thompson*, No. 99–1230 (D.D.C. 2003)).

Again, we believe the wage index data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage index data to the fiscal intermediaries' attention. Moreover, because hospitals will have access to the final wage index data by early May 2005, they have the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or CMS before the development and publication of the final FY 2006 wage index by August 1, 2005, and the implementation of the FY 2006 wage index on October 1, 2005. If hospitals avail themselves of the opportunities afforded to provide and make corrections to the wage data, the wage index implemented on October 1 should be accurate. Nevertheless, in the event that errors are identified by hospitals and brought to our attention after June 10, 2005, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with § 412.64(k)(1) of our existing regulations, we make midyear corrections to the wage index for an area only if a hospital can show that: (1) The fiscal intermediary or CMS made an error in tabulating its data; and (2) the requesting hospital could not have known about the error or did not have an opportunity to correct the error, before the beginning of the fiscal year. For purposes of this provision, "before the beginning of the fiscal year'' means by the June deadline for making corrections to the wage data for the following fiscal year's wage index. 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 for the labor market area. As indicated earlier, since CMS makes the wage data available to a hospital on the CMS website prior to publishing both the proposed and final IPPS rules, and the fiscal intermediaries notify hospitals directly of any wage data changes after completing their desk reviews, we do not expect that midyear corrections would be necessary. However, under our current policy, 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 made.

We are proposing to revise § 412.64(k)(2) to specify that a change to the wage index can be made retroactive to the beginning of the Federal fiscal year only when: (1) The fiscal intermediary or CMS made an error in tabulating data used for the wage index calculation; (2) the hospital knew about the error and requested that the fiscal intermediary and CMS correct the error using the established process and within the established schedule for requesting corrections to the wage data, before the beginning of the fiscal year for the applicable IPPS update (that is, by the June 10, 2005 deadline for the FY 2006 wage index); and (3) CMS agreed that the fiscal intermediary or CMS made an error in tabulating the hospital's wage data and the wage index should be corrected. We are proposing this change because there may be instances in which a hospital identifies an error in its wage data and submits a correction request using all appropriate procedures and by the June deadline, CMS agrees that the fiscal intermediary or CMS caused the error in the hospital's wage data and that the wage index must be corrected, but CMS fails to publish or implement the corrected wage index value by the beginning of the Federal fiscal year. We believe that the above proposed revision to § 412.64(k)(2) is appropriate and fair. We also believe that unlike a generalized retroactive policy, the situations where this will occur will be minimal, thus minimizing the administrative burden associated with such retroactive corrections. In those circumstances where a hospital requests a correction to its wage data before CMS calculates the final wage index (that is, by the June deadline), and CMS acknowledges that the error in the hospital's wage data caused by CMS's or the fiscal intermediary's mishandling of the data, we believe that the hospital should not be penalized by our delay in publishing or implementing the correction. As with our current policy, this provision would not be available to a hospital seeking to revise another

hospital's data. In addition, the provision could not be used to correct prior years' wage data; it could only be used for the current Federal fiscal year. In other situations, we continue to believe that it is appropriate to make prospective corrections to the wage index in those circumstances where a hospital could not have known about or did not have the opportunity to correct the fiscal intermediary's or CMS's error before the beginning of the fiscal year (that is, by the June deadline).

We are proposing to make this change to § 412.64(k)(2) effective on October 1, 2005, that is, beginning with the FY 2006 wage index. We note that, as with prospective changes to the wage index, the proposed retroactive correction would be made irrespective of whether the change increases or decreases a hospital's payment rate. In addition, we note that the policy of retroactive adjustment would still apply in those instances where a judicial decision reverses a CMS denial of a hospital's wage data revision request.

In addition, we are proposing to correct the FY 2005 wage index retroactively (that is, from October 1, 2004) on a one-time only basis for a limited circumstance using the authority provided under section 903(a)(1) of Pub. L. 108–173. This provision authorizes the Secretary to make retroactive changes to items and services if failure to apply such changes would be contrary to the public interest. However, as indicated, our current regulations at § 412.64(k)(1) allow only for a prospective correction to the hospitals' area wage index values. We are proposing to correct the FY 2005 wage index retroactively in the limited circumstance where a hospital meets all of the following criteria: (1) The fiscal intermediary or CMS made an error in tabulating a hospital's FY 2005 wage index data; (2) the hospital informed the fiscal intermediary or CMS, or both, about the error, following the established schedule and process for requesting corrections to its FY 2005 wage index data; and (3) CMS agreed before October 1 that the fiscal intermediary or CMS made an error in tabulating the hospital's wage data and the wage index should be corrected by the beginning of the Federal fiscal year (that is, by October 1, 2004), but CMS was unable to publish the correction by the beginning of the fiscal year.

On December 30, 2004, we published in the **Federal Register** a correction notice to the FY 2005 IPPS final rule that included the corrected wage data for four hospitals that meet all of the three above stated criteria (69 FR 78526). These corrections were effective January 1, 2005. As noted, our current regulations allow only for a prospective correction to the hospitals' area wage index values. However, we believe that, in the limited circumstance mentioned above, a retroactive correction to the FY 2005 wage index is appropriate and meets the condition of section 903(a)(1) of Pub. L. 108–173 that "failure to apply the change retroactively would be contrary to the public interest.''

IV. Proposed Rebasing and Revision of the Hospital Market Baskets

(If you choose to comment on issues in this section, please include the caption "Hospital Market Basket'' at the beginning of your comment.)

A. Background

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

The terms "rebasing'' and "revising,'' while often used interchangeably, actually denote different activities. "Rebasing'' means moving the base year for the structure of costs of an input price index (for example, in this proposed rule, we are proposing to shift the base year cost structure for the IPPS hospital index from FY 1997 to FY 2002). "Revising'' means changing data sources, or price proxies, used in the input price index.

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

Since the inception of the IPPS, the projected change in the hospital market basket has been the integral component of the update factor by which the prospective payment rates are updated every year. An explanation of the hospital market basket used to develop the prospective payment rates was published in the **Federal Register** on September 1, 1983 (48 FR 39764). We also refer the reader to the August 1, 2002 **Federal Register** (67 FR 50032) in which we discussed the previous rebasing of the hospital input price index.

The hospital market basket is a fixed weight, Laspeyres-type price index that is constructed in three steps. First, a base period is selected (in this proposed rule, FY 2002) and total base period expenditures are estimated for a set of mutually exclusive and exhaustive spending categories based upon type of expenditure. Then the proportion of total operating costs that each category represents is determined. These proportions are called cost or expenditure weights. Second, each expenditure category is matched to an appropriate price or wage variable, referred to as a price proxy. In nearly every instance, these price proxies are price levels derived from publicly available statistical series that are published on a consistent schedule, preferably at least on a quarterly basis.

Finally, the expenditure weight for each cost category is multiplied by the level of its respective price proxy. The sum of these products (that is, the expenditure weights multiplied by their price levels) for all cost categories yields the composite index level of the market basket in a given period. Repeating this step for other periods produces a series of market basket levels over time. Dividing an index level for a given period by an index level for an earlier period produces a rate of growth in the input price index over that time period.

The market basket is described as a fixed-weight index because it describes the change in price over time of the same mix of goods and services purchased to provide hospital services in a base period. The effects on total expenditures resulting from changes in the quantity or mix of goods and services (intensity) purchased subsequent to the base period are not measured. For example, shifting a traditionally inpatient type of care to an outpatient setting might affect the volume of inpatient goods and services purchased by the hospital, but would not be factored into the price change measured by a fixed weight hospital market basket. In this manner, the market basket measures only the pure price change. Only when the index is rebased using a more recent base period would the quantity and intensity effects be captured in the cost weights. Therefore, we rebase the market basket periodically so the cost weights reflect changes in the mix of goods and services that hospitals purchase (hospital inputs) to furnish inpatient care between base periods. We last

rebased the hospital market basket cost weights effective for FY 2003 (67 FR 50032, August 1, 2002), with FY 1997 data used as the base period for the construction of the market basket cost weights.

B. Rebasing and Revising the Hospital Market Basket

1. Development of Cost Categories and Weights

a. Medicare Cost Reports

The major source of expenditure data for developing the proposed rebased and revised hospital market basket cost weights is the FY 2002 Medicare cost reports. These cost reports are from IPPS hospitals only. They do not reflect data from hospitals excluded from the IPPS or CAHs. The IPPS cost reports yield seven major expenditure or cost categories: wages and salaries, employee benefits, contract labor, pharmaceuticals, professional liability insurance (malpractice), blood and blood products, and a residual "all other."

Chart 1: Major Cost Categories found in Medicare Cost Reports

Major Cost Categories	FY 1997-Based Market Basket	Proposed FY 2002-Based Market Basket
Wages and salaries	48.965	45.590
Employee benefits	10.597	11.189
Contract labor	2.094	3.214
Professional Liability Insurance (Malpractice)	0.840	1.589
Pharmaceuticals	5.416	5.855
Blood and blood products	0.875	1.082
All other	31.213	31.481

b. Other Data Sources

In addition to the Medicare cost reports, other sources of data used in developing the market basket weights are the Benchmark Input-Output Tables (I–Os) created by the Bureau of Economic Analysis, U.S. Department of Commerce, and the Business Expenses Survey developed by the Bureau of the Census, U.S. Department of Commerce, from its Economic Census.

New data for these Census sources are scheduled for publication every 5 years, but often take up to 7 years after the reference year. Only an Annual I–O is produced each year, but the Annual I–O contains less industry detail than does the Benchmark I–O. When we rebased the market basket using FY 1997 data in the FY 2003 IPPS final rule, the 1997 Benchmark I–O was not yet available. Therefore, we did not incorporate data from that source into the FY 1997-based market basket (67 FR 50033). However, we did use a secondary source, the 1997 Annual Input-Output tables. The third source of data, the 1997 Business Expenditure Survey (now known as the Business Expenses Survey) was used to develop weights for the utilities and telephone services categories.

The 1997 Benchmark I–O data are a much more comprehensive and complete set of data than the 1997 Annual I–O estimates. The 1997 Annual I–O is an update of the 1992 I–O tables, while the 1997 Benchmark I–O is an entirely new set of numbers derived from the 1997 Economic Census. The 2002 Benchmark Input-Output tables are not yet available. Therefore, we are proposing to use the 1997 Benchmark I–O data in the proposed FY 2002-based market basket, to be effective for FY 2006. Instead of using the less detailed, less accurate Annual I–O data, we aged the 1997 Benchmark I–O data forward to FY 2002. The methodology we used to age the data involves applying the annual price changes from the price proxies to the appropriate cost categories. We repeat this practice for each year.

The "all other" cost category is further divided into other hospital expenditure category shares using the 1997 Benchmark Input-Output tables. Therefore, the "all other" cost category expenditure shares are proportional to their relationship to "all other" totals in the I–O tables. For instance, if the cost for telephone services were to represent 10 percent of the sum of the "all other" I–O (see below) hospital expenditures, then telephone services would represent 10 percent of the market basket's "all other" cost category.

2. PPS—Selection of Price Proxies

After computing the FY 2002 cost weights for the proposed rebased hospital market basket, it is necessary to select appropriate wage and price proxies to reflect the rate-of-price change for each expenditure category. With the exception of the Professional Liability proxy, all the indicators are based on Bureau of Labor Statistics (BLS) data and are grouped into one of the following BLS categories:

- Producer Price Indexes—Producer Price Indexes (PPIs) measure price changes for goods sold in other than retail markets. PPIs are preferable price proxies for goods that hospitals purchase as inputs in producing their outputs because the PPIs would better reflect the prices faced by hospitals. For example, we use a special PPI for prescription drugs, rather than the Consumer Price Index (CPI) for prescription drugs because hospitals generally purchase drugs directly from the wholesaler. The PPIs that we use measure price change at the final stage of production.
- Consumer Price Indexes—Consumer Price Indexes (CPIs) measure change in the prices of final goods and services bought by the typical consumer. Because they may not represent the price faced by a producer, we used CPIs only if an appropriate PPI

was not available, or if the expenditures were more similar to those of retail consumers in general rather than purchases at the wholesale level. For example, the CPI for food purchased away from home is used as a proxy for contracted food services.

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

We evaluated the price proxies using the criteria of reliability, timeliness, availability, and relevance. Reliability indicates that the index is based on valid statistical methods and has low sampling variability. Timeliness implies that the proxy is published regularly, at least once a quarter. Availability means that the proxy is publicly available. Finally, relevance means that the proxy is applicable and representative of the cost category weight to which it is applied. The CPIs, PPIs, and ECIs selected meet these criteria.

Chart 2 sets forth the complete proposed market basket including cost categories, weights, and price proxies. For comparison purposes, the corresponding FY 1997-based market basket is listed as well. A summary outlining the choice of the various proxies follows the chart.

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Chart 2: Proposed FY 2002-Based PPS Hospital Market Basket Cost Categories, Weights, and Proxies with FY 1997-Based Market Basket Used for Comparison

Expense Categories	FY 1997-Based Hospital Market Basket Weights	Proposed Rebased FY 2002-Based Hospital Market Basket Weights	Proposed Rebased FY 2002-Based Hospital Market Basket Price Proxies
1. Compensation	61.656	59.993	--
A. Wages and Salaries*	50.686	48.171	ECI-Wages and Salaries, Civilian Hospital Workers
B. Employee Benefits*	10.970	11.822	ECI-Benefits, Civilian Hospital Workers
2. Professional Fees*	5.401	5.510	ECI - Compensation for Professional, Specialty & Technical Workers
3. Utilities	1.353	1.251	--
A. Fuel, Oil, and Gasoline	0.284	0.206	PPI Refined Petroleum Products
B. Electricity	0.833	0.669	PPI Commercial Electric Power
C. Water and Sewerage	0.236	0.376	CPI-U Water & Sewerage Maintenance
4. Professional Liability Insurance	0.840	1.589	CMS Professional Liability Insurance Premium Index
5. All Other	30.749	31.657	--
A. All Other Products	19.537	20.336	--

Expense Categories	FY 1997-Based Hospital Market Basket Weights	Proposed Rebased FY 2002-Based Hospital Market Basket Weights	Proposed Rebased FY 2002-Based Hospital Market Basket Price Proxies
(1.) Pharmaceuticals	5.416	5.855	PPI Prescription Drugs
(2.) Direct Purchase Food	1.370	1.664	PPI Processed Foods & Feeds
(3.) Contract Service Food	1.274	1.180	CPI-U Food Away From Home
(4.) Chemicals	2.604	2.096	PPI Industrial Chemicals
(5.) Blood and Blood Products**	0.875	--	--
(6.) Medical Instruments	2.192	1.932	PPI Medical Instruments & Equipment
(7.) Photographic Supplies	0.204	0.183	PPI Photographic Supplies
(8.) Rubber and Plastics	1.668	2.004	PPI Rubber & Plastic Products
(9.) Paper Products	1.355	1.905	PPI Converted Paper & Paperboard Products
(10) Apparel	0.583	0.394	PPI Apparel
(11) Machinery and Equipment	1.040	0.565	PPI Machinery & Equipment
(12) Miscellaneous Products**	0.956	2.558	PPI Finished Goods less Food and Energy
B. All Other Services	11.212	11.321	--
(1.) Telephone Services	0.398	0.458	CPI-U Telephone Services
(2.) Postage	0.857	1.300	CPI-U Postage

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Expense Categories	FY 1997-Based Hospital Market Basket Weights	Proposed Rebased FY 2002-Based Hospital Market Basket Weights	Proposed Rebased FY 2002-Based Hospital Market Basket Price Proxies
(3.) All Other: Labor Intensive*	5.438	4.228	ECI - Compensation for Private Service Occupations
(4.) All Other: Non-Labor Intensive	4.519	5.335	CPI-U All Items
Total	100.000	100.000	--

*Labor-Related

** Blood and blood products, previously a separate cost category, is now contained within Miscellaneous Products in the proposed FY 2002-based market basket.

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a. Wages and Salaries

For measuring the price growth of wages in the proposed FY 2002-based market basket, we are proposing to use the ECI for wages and salaries for civilian hospital workers as the proxy for wages in the hospital market basket. This same proxy was used for the 1997-based market basket.

b. Employee Benefits

The proposed FY 2002-based hospital market basket uses the ECI for employee benefits for civilian hospital workers. This is the same proxy that was used in the FY 1997-based market basket.

c. Nonmedical Professional Fees

The ECI for compensation for professional and technical workers in private industry is applied to this category because it includes occupations such as management and consulting, legal, accounting and engineering services. The same proxy was used in the FY 1997-based market basket.

d. Fuel, Oil, and Gasoline

The percentage change in the price of gas fuels as measured by the PPI (Commodity Code #0552) is applied to this component. The same proxy was used in the FY 1997-based market basket.

e. Electricity

The percentage change in the price of commercial electric power as measured by the PPI (Commodity Code #0542) is applied to this component. The same proxy was used in the FY 1997-based market basket.

f. Water and Sewerage

The percentage change in the price of water and sewerage maintenance as measured by the CPI for all urban consumers (CPI Code #CUUR0000SEHG01) is applied to this component. The same proxy was used in the FY 1997-based market basket.

g. Professional Liability Insurance

The proposed FY 2002-based index uses the percentage change in the hospital professional liability insurance (PLI) premiums as estimated by the CMS Hospital Professional Liability Index, which we use as a proxy in the Medicare Economic Index (68 FR 63244), for the proxy of this category. Similar to the Physicians Professional Liability Index, we attempt to collect commercial insurance premiums for a fixed level of coverage, holding nonprice factors constant (such as a change in the level of coverage). In the FY 1997-based market basket, the same price proxy was used.

We continue to research options for improving our proxy for professional liability insurance. This research includes exploring various options for expanding our current survey, including the identification of another entity that would be willing to work with us to collect more complete and comprehensive data. We are also exploring other options such as third party or industry data that might assist us in creating a more precise measure of PLI premiums. At this time, we have not yet identified a preferred option. Therefore, we are not proposing to make any changes to the proxy in this proposed rule.

h. Pharmaceuticals

The percentage change in the price of prescription drugs as measured by the PPI (PPI Code #PPI283D#RX) is used as a proxy for this category. This is a special index produced by BLS and is the same proxy used in the 1997-based index.

i. Food: Direct Purchases

The percentage change in the price of processed foods and feeds as measured by the PPI (Commodity Code #02) is applied to this component. The same proxy was used in the FY 1997-based market basket.

j. Food: Contract Services

The percentage change in the price of food purchased away from home as measured by the CPI for all urban consumers (CPI Code #CUUR0000SEFV) is applied to this component. The same proxy was used in the FY 1997-based market basket.

k. Chemicals

The percentage change in the price of industrial chemical products as measured by the PPI (Commodity Code #061) is applied to this component. While the chemicals hospitals purchase include industrial as well as other types of chemicals, the industrial chemicals component constitutes the largest proportion by far. Thus, we believe that Commodity Code #061 is the appropriate proxy. The same proxy was used in the FY 1997-based market basket.

l. Medical Instruments

The percentage change in the price of medical and surgical instruments as

measured by the PPI (Commodity Code #1562) is applied to this component. The same proxy was used in the FY 1997-based market basket.

m. Photographic Supplies

The percentage change in the price of photographic supplies as measured by the PPI (Commodity Code #1542) is applied to this component. The same proxy was used in the FY 1997-based market basket.

n. Rubber and Plastics

The percentage change in the price of rubber and plastic products as measured by the PPI (Commodity Code #07) is applied to this component. The same proxy was used in the FY 1997-based market basket.

o. Paper Products

The percentage change in the price of converted paper and paperboard products as measured by the PPI (Commodity Code #0915) is used. The same proxy was used in the FY 1997-based market basket.

p. Apparel

The percentage change in the price of apparel as measured by the PPI (Commodity Code #381) is applied to this component. The same proxy was used in the FY 1997-based market basket.

q. Machinery and Equipment

The percentage change in the price of machinery and equipment as measured by the PPI (Commodity Code #11) is applied to this component. The same proxy was used in the FY 1997-based market basket.

r. Miscellaneous Products

The percentage change in the price of all finished goods less food and energy as measured by the PPI (Commodity Code #SOP3500) is applied to this component. Using this index removes the double-counting of food and energy prices, which are already captured elsewhere in the market basket. The same proxy was used in the FY 1997-based index. The weight for this cost category is higher than in the FY 1997-based index because the weight for blood and blood products (1.082) is added to it. In the FY 1997-based market basket, we included a separate cost category for blood and blood products, using the BLS PPI (Commodity Code #063711) for blood and derivatives as a price proxy. A review of recent trends in the PPI for blood and derivatives suggests that its movements may not be consistent with the trends in blood costs faced by hospitals. While this proxy did not match exactly with the product hospitals are buying, its trend over time appears to be reflective of the historical price changes of blood purchased by hospitals. However, an apparent divergence over recent periods led us to reevaluate whether the PPI for blood and derivatives was an appropriate measure of the changing price of blood. We ran test market baskets classifying blood in three separate cost categories: blood and blood products, contained within chemicals as was done for the FY 1992-based index, and within miscellaneous products. These categories use as proxies the following PPIs: The PPI for blood and blood products, the PPI for chemicals, and the PPI for finished goods less food and energy, respectively. Of these three proxies, the PPI for finished goods less food and energy moved most like the recent blood cost and price trends. In addition, the impact on the overall market basket by using different proxies for blood was negligible, mostly due to the relatively small weight for blood in the market basket. Therefore, we chose the PPI for finished goods less food and energy for the blood proxy because we believe it will best be able to proxy price changes (not quantities or required tests) associated with blood purchased by hospitals. We will continue to evaluate this proxy for its appropriateness and will explore the development of alternative price indexes to proxy the price changes associated with this cost.

s. Telephone

The percentage change in the price of telephone services as measured by the CPI for all urban consumers (CPI Code # CUUR0000SEED) is applied to this component. The same proxy was used in the FY 1997-based market basket.

t. Postage

The percentage change in the price of postage as measured by the CPI for all urban consumers (CPI Code # CUUR0000SEEC01) is applied to this component. The same proxy was used in the FY 1997-based market basket.

u. All Other Services: Labor Intensive

The percentage change in the ECI for compensation paid to service workers employed in private industry is applied to this component. The same proxy was used in the FY 1997-based market basket.

v. All Other Services: Nonlabor Intensive

The percentage change in the all-items component of the CPI for all urban consumers (CPI Code # CUUR0000SA0) is applied to this component. The same proxy was used in the FY 1997-based market basket.

For further discussion of the rationales for choosing many of the specific price proxies, we refer the reader to the August 1, 2002 final rule (67 FR 50037).

Chart 3: FY 1997-Based and Proposed FY 2002-Based Prospective Payment Hospital Operating Index Percent Change, FY 2000 through FY 2008

Fiscal Year (FY)	Proposed Rebased FY 2002-Based Hospital Market Basket	FY 1997-Based Market Basket
Historical data:		
FY 2000	3.2	3.3
FY 2001	4.1	4.3
FY 2002	3.7	3.8
FY 2003	4.0	3.9
FY 2004	3.9	3.8
Average FYs 2000-2004	3.8	3.8
Forecast:		
FY 2005	4.1	4.1
FY 2006	3.2	3.2
FY 2007	2.8	2.9
FY 2008	2.8	2.8
Average FYs 2005-2008	3.2	3.3

Source: Global Insight, Inc. 4th Qtr 2004, @USMACRO/CNTL1104 @CISSIM/TL1104.SIM

3. Labor-Related Share

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

Under section 1886(d)(3)(E) of the Act, the Secretary estimates from time to time the proportion of payments that are labor-related. "The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs of the DRG prospective payment rates. * * *" We refer to the proportion of hospitals' costs that are attributable to wages and wage-related costs as the "labor-related share."

The labor-related share is used to determine the proportion of the national PPS base payment rate to which the area wage index is applied. We are proposing to continue to use our current methodology of defining the labor-related share as the national average proportion of operating costs that are related to, influenced by, or vary with the local labor markets. We believe that the operating cost categories that are related to, influenced by, or vary with the local labor markets are wages and salaries, fringe benefits, professional fees, contract labor, and labor intensive services. Therefore, we are proposing to calculate the labor-related share by adding the relative weights for these operating cost categories. After we reviewed all cost categories in the proposed IPPS market basket using this definition of labor-related, we removed postage costs from the proposed FY 2002-based labor-related share because we no longer believe these costs are likely to vary with the local labor market. Using the cost category weights that we determined in section IV.B. of this preamble, we calculated a labor-related share of 69.731 percent, using the FY 2002-based PPS market basket. Accordingly, we are proposing to implement a labor-related share of 69.7 percent for discharges occurring on or after October 1, 2005. We note that section 403 of Pub. L. 108–173 amended sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act to provide that the Secretary must employ 62 percent as the labor-related share unless this employment "would result in lower payments than would otherwise be made."

We also are proposing an update to the labor-related share for Puerto Rico. Consistent with our methodology for determining the national labor-related share, we are proposing to add the Puerto Rico-specific relative weights for wages and salaries, fringe benefits, and contract labor. Because there are no Puerto Rico-specific relative weights for professional fees and labor intensive services, we are proposing to use the national weights. Alternatively, we could apply the national labor-related share to the Puerto Rico-specific rate. We note that we are still reviewing our data and have not yet calculated the updated Puerto Rico-specific labor-related share percentage. Therefore, the labor-related and nonlabor-related portions of the Puerto Rico-specific standardized amount listed in Table 1C of the Addendum to this proposed rule reflect the current (FY 2005) labor-related share for Puerto Rico of 71.3 percent. Once we have calculated the updated labor-related share for Puerto Rico, we will post it on the CMS website at *http://www.cms.hhs.gov/providers/hipps.* In addition, if we adopt this proposal, we would publish the updated Puerto Rico labor-related share in the IPPS final rule. We welcome comments on our proposal to update the labor-related share for Puerto Rico.

Unlike the 1997 Annual I–O which was based on Standard Industrial Codes (SIC), the 1997 Benchmark I–O is categorized using the North American Industrial Classification System (NAICS). This change required us to classify all cost categories under NAICS, including a reevaluation of labor-related costs on the NAICS definitions. Chart 4 compares the FY 1992-based labor-related share, the current measure, with the FY 2002-based labor-related share. When we rebased the market basket to

reflect FY 1997 data, we did not change the labor-related share (67 FR 50041). Therefore, the FY 1992-based labor-related share is the current measure.

Chart 4.--Labor-Related Share: FY 1992-Based and FY 2002-Based

Cost Category	FY 1992-Based Weight	Proposed FY 2002-Based Weight	Difference
Wages and salaries	50.244	48.171	-2.073
Fringe benefits	11.146	11.822	0.676
Nonmedical professional fees	2.127	5.510	3.383
Postal services*	0.272	--	-0.272
Other labor-intensive services**	7.277	4.228	-3.049
Total labor-related	71.066	69.731	-1.335
Total nonlabor-related	28.934	30.269	1.335

* No longer considered to be labor-related.

**Other labor-intensive services includes landscaping services, services to buildings, detective and protective services, repair services, laundry services, advertising, auto parking and repairs, physical fitness facilities, and other government enterprises.

Although we are proposing to continue to calculate the labor-related share by adding the relative weights of the labor-related operating cost categories, we continue to evaluate alternative methodologies. In the May 9, 2002 **Federal Register** (67 FR 31447), we discussed our research on the methodology for the labor-related share. This research involved analyzing the compensation share (the sum of wages and salaries and benefits) separately for urban and rural hospitals, using regression analysis to determine the proportion of costs influenced by the area wage index, and exploring alternative methodologies to determine whether all or only a portion of professional fees and nonlabor intensive services should be considered labor-related.

Our original analysis, which appeared in the May 9, 2002 **Federal Register** (67 FR 31447) and which focused mainly on edited FY 1997 hospital data, found that the compensation share of costs for hospitals in rural areas was higher on average than the compensation share for hospitals in urban areas. We also researched whether only a proportion of the costs in professional fees and labor-intensive services should be considered labor-related, not the entire cost categories. However, there was not enough information available to make this determination.

Our finding that the average compensation share of costs for rural hospitals was higher than the average compensation for urban hospitals was validated consistently through our regression analysis. Regression analysis is a statistical technique that determines the relationship between a dependent variable and one or more independent variables. We tried several regression specifications in an effort to determine the proportion of costs that are influenced by the area wage index. Furthermore, MedPAC raised the possibility that regression may be an alternative to the current market basket methodology. Our initial regression specification (in log form) was Medicare operating cost per Medicare discharge as the dependent variable and the independent variables being the area wage index, the case-mix index, the ratio of residents per bed (as proxy for IME status), and a dummy variable that equals one if the hospital is located in a metropolitan area with a population of 1 million or more. (A dummy variable represents the presence or absence of a particular characteristic.) This regression produced a coefficient for all hospitals for the area wage index of 0.638 (which is equivalent to the labor share and can be interpreted as an elasticity because of the log specification) with an adjusted R-squared of 64.3. (Adjusted R-squared is a measure of how well the regression model fits the data.) While, on the surface, this appeared to be a reasonable result, this same specification for urban hospitals had a coefficient of 0.532 (adjusted R-squared = 53.2) and a coefficient of 0.709 (adjusted R-squared = 36.4) for rural hospitals. This highlighted some apparent problems with the specification because the overall regression results appear to be masking underlying problems. It did not seem reasonable that urban hospitals would have a labor share below their actual compensation share or that the discrepancy between urban and rural hospitals would be this large. When we standardized the Medicare operating cost per Medicare discharge for case mix, the fit, as measured by adjusted R-squared, fell dramatically and the urban/rural discrepancy became even larger.

Based on this initial result, we tried two modifications to the FY 1997 regressions to correct for the underlying problems. First, we edited the data differently to determine if a few reports were causing the inconsistent results. We found when we tightened the edits, the wage index coefficient was lower and the fit was worse. When we loosened the edits, we found higher wage index coefficients and still a worse fit. Second, we added additional variables to the regression equation to attempt to explain some of the variation that was not being captured. We found the best fit occurred when the following variables were added: The occupancy rate, the number of hospital beds, a dummy variable that equals one if the hospital is privately owned and zero otherwise, a dummy variable that equals one if the hospital is government-controlled and zero otherwise, the Medicare length-of-stay, the number of FTEs per bed, and the age of fixed

assets. The result of this specification was a wage index coefficient of 0.620 (adjusted R-squared = 68.7), with the regression on rural hospitals having a coefficient of 0.772 (adjusted R-squared = 45.0) and the regression on urban hospitals having a coefficient of 0.474 (adjusted R-squared = 60.9). Neither of these alternatives seemed to help the underlying difficulties with the regression analysis.

Subsequent to the work described above, we have undertaken the research necessary to reevaluate the current assumptions used in determining the labor-related share. We ran regressions applying the previous specifications to more recent data (FY 2001 and FY 2002), and, as described below, we ran regressions using alternative specifications. Once again we encourage comments on this research and any information that is available to help determine the most appropriate measure.

The first step in our regression analysis to determine the proportion of hospitals' costs that varied with labor-related costs was to edit the data, which had significant outliers in some of the variables we used in the regressions. We originally began with an edit that excluded the top and bottom 5 percent of reports based on average Medicare cost per discharge and number of discharges. We also used edits to exclude reports that did not meet basic criteria for use, such as having costs greater than zero for total, operating, and capital for the overall facility and just the Medicare proportion. We also required that the hospital occupancy rate, length-of-stay, number of beds, FTEs, and overall and Medicare discharges be greater than zero. Finally, we excluded reports with occupancy rates greater than one.

Our regression specification (in log form) was Medicare operating cost per Medicare discharge as the dependent variable (the same dependent variable we used in the regression analysis described in the May 9, 2002 **Federal Register**) with the independent variables being the compensation per FTE, the ratio of interns and residents per bed (as proxy for IME status), the occupancy rate, the number of hospital beds, a dummy variable that equals one if the hospital is privately owned and is zero otherwise, a dummy variable that equals one if the hospital is government-controlled and is zero otherwise, the Medicare length-of-stay, the number of FTEs per bed, the age of fixed assets, and a dummy variable that equals one if the hospital is located in a metropolitan area with a population of 1 million or more. This is a similar model to the one described in the May 9, 2002 **Federal Register** (67 FR 31447) as having the best fit, with two notable exceptions. First, the area wage index is replaced by compensation per FTE, where compensation is the sum of hospital wages and salaries, contract labor costs, and benefits. The area wage index is a payment variable computed by averaging wages across all hospitals within each MSA, whereas compensation per FTE differs from one hospital to the next. Second, the case-mix index is no longer included as a regressor because it is correlated with other independent variables in the regression. In other words, the other independent variables are capturing part of the effect of the case-mix index. We made these two specification changes in an attempt to only use cost variables to explain the variation in Medicare operating costs per discharge. We believe this is appropriate in order to compare to the results we are getting from the market basket methodology, which is based solely on cost data. As we will show below, the use of payment variables on the right-hand side of the equation appears to be producing less reasonable results when cost data are used.

The revised specification for FY 2002 produced a coefficient for all hospitals for compensation per FTE of 0.673 (which is roughly equivalent to the labor share and can be interpreted as an elasticity because of the log specification) with an adjusted R-squared of 63.7. The coefficient result for FY 2001 is 64.5, with an adjusted R-squared of 65.2. (For comparison, a separate regression for FY 2002 with the log area wage index and log case-mix index included in the set of regressors displays a log area wage index coefficient of 75.6 (adjusted R-squared = 67.7).) For FY 2001, the coefficient for the log area wage index is 72.3 (adjusted R-squared = 67.9). On the surface, these seem to be reasonable results. However, a closer look reveals some problems. In FY 2001, the coefficient for urban hospitals was 59.6 (adjusted R-squared = 57.3), and the coefficient for rural hospitals was 61.3 (adjusted R-squared = 50.6). On the other hand, in FY 2002, the coefficient for urban hospitals increased to 69.2 (adjusted R-squared = 55.9), and the coefficient for rural hospitals decreased to 58.2 (adjusted R squared = 46.0). The results for FY 2001 seem reasonable, but not when compared with the results for FY 2002. Furthermore, for FY 2002 the compensation share of costs for hospitals in rural areas was higher on average than the compensation share for hospitals in urban areas. Rural areas had an average compensation share of 63.3 percent, while urban areas had a share of 60.5 percent. This compares to a share of 61.2 percent for all hospitals.

Due to these problems, we do not believe the regression analysis is producing sound enough evidence at this point for us to make the decision to change from the current method for calculating the labor-related share. We continue to analyze these data and work on alternative specifications, including working with MedPAC, who in the past have done similar analysis in their studies of payment adequacy. Comments on this approach would be welcomed, given the difficulties we have encountered.

We also continue to look into ways to refine our market basket approach to more accurately account for the proportion of costs influenced by the local labor market. Specifically, we are looking at the professional fees and labor-intensive cost categories to determine if only a proportion of the costs in these categories should be considered labor-related, not the entire cost category. Professional fees include management and consulting fees, legal services, accounting services, and engineering services. Labor-intensive services are mostly building services, but also include other maintenance and repair services.

We conducted preliminary research into whether the various types of professional fees are more or less likely to be purchased in local labor markets. Through contact with a handful of hospitals in only two States, we asked for the percentages of their advertising, legal, and management and consulting services that they purchased in either local, regional, or national labor markets. The results were quite consistent across all of the hospitals, indicating most advertising and legal services are purchased in local or regional markets and nearly all management and consulting services are purchased in national labor markets. This suggested we may be appropriately reflecting advertising and legal services in the labor-related share, but we plan to investigate further whether management and consulting services are appropriately reflected. We do not believe that this limited effort produced enough evidence for us to change our methodology. However, we do plan to expand our efforts in this area to ensure we appropriately determine the labor-related share. We are soliciting data or studies that would be helpful in this analysis. We are unsure if we will be able to finish this analysis in time for inclusion in the FY 2006 IPPS final rule.

As mentioned previously, we are proposing to continue to calculate the labor-related share by adding the relative weights of the operating cost categories that are related to, influenced by, or vary with the local labor markets. These categories include wages and salaries, fringe benefits, professional fees, contract labor and labor-intensive services. Since we no longer believe that postage costs meet our definition of labor-related, we are excluding them from the labor-related share. Using this methodology, we calculated a labor-related share of 69.731. Therefore, we are proposing a labor-related share of 69.731.

C. Separate Market Basket for Hospitals and Hospital Units Excluded from the IPPS

(If you choose to comment on issues in this section, please include the caption "Excluded Hospital Market Basket'' at the beginning of your comment.)

1. Hospitals Paid Based on Their Reasonable Costs

On August 7, 2001, we published a final rule in the **Federal Register** (66 FR 41316) establishing the PPS for IRFs, effective for cost reporting periods beginning on or after January 1, 2002. On August 30, 2002, we published a final rule in the **Federal Register** (67 FR 55954) establishing the PPS for LTCHs, effective for cost reporting periods beginning on or after October 1, 2002. On November 15, 2004, we published a final rule in the **Federal Register** (69 FR 66922) establishing the PPS for the IPFs, effective for cost reporting periods beginning on or after January 1, 2005.

Prior to being paid under a PPS, IRFs, LTCHs, and IPFs were reimbursed solely under the reasonable cost-based system under § 413.40 of the regulations, which impose rate-of-increase limits. Children's and cancer hospitals and religious nonmedical health care institutions (RNHCIs) are still reimbursed solely under the reasonable cost-based system, subject to the rate-of-increase limits. Under these limits, an annual target amount (expressed in terms of the inpatient operating cost per discharge) is set for each hospital based on the hospital's own historical cost experience trended forward by the applicable rate-of-increase percentages. To the extent a LTCH or IPF receives a blend of reasonable cost-based payment and the Federal prospective payment rate amount, the reasonable cost portion of the payment is also subject to the applicable rate-of-increase percentage. Section 1886(b)(3)(B)(ii) of the Act sets the percentage increase of the limits, which in certain years was based upon the market basket percentage increase. Beginning in FY 2003 and subsequent years, the applicable rate-of-increase is the market basket percentage increase. The market basket currently (and historically) used is the excluded hospital operating market basket, representing the cost structure of rehabilitation, long-term care, psychiatric, children's, and cancer hospitals (FY 2003 final rule, 67 FR 50042).

Because IRFs, LTCHs, and some IPFs are now paid under a PPS, we are considering developing a separate market basket for these hospitals that contains both operating and capital costs. We would publish any proposal to use a revised separate market basket for each of these types of hospitals when we propose the nest update of their respective PPS rates. Children's and cancer hospitals are two of the remaining three types of hospitals excluded from the IPPS that are still being paid based solely on their reasonable costs, subject to target amounts. (RNHCIs, the third type of IPPS-excluded entity still subject to target amounts, are reimbursed under § 403.752(a) of the regulations.) Because there are a small number of children's and cancer hospitals and RNHCIs, which receive in total less than 1 percent of all Medicare payments to hospitals and because these hospitals provide limited Medicare cost report data, we are not proposing to create a separate market basket specifically for these hospitals. Under the broad authority in sections 1886(b)(3)(A) and (B), 1886(b)(3)(E), and 1871 of the Act, we are proposing to use the proposed FY 2002 IPPS operating market basket percentage increase to update the target amounts for children's and cancer hospitals reimbursed under sections 1886(b)(3)(A) and (b)(3)(E) of the Act and the market basket for RNHCIs under § 403.752(a) of the regulations. This proposal reflects our belief that it is best to use an index that most closely represents the cost structure of children's and cancer hospitals and RNHCIs. The FY 2002 cost weights for wages and salaries, professional liability, and "all other'' for children's and cancer hospitals are noticeably closer to those in the IPPS operating market basket than those in the excluded hospital market basket, which is based on the cost structure of IRFs, LTCHs, IPFs, and children's and cancer hospitals and RNHCIs. Therefore, we believe it is more appropriate to use the IPPS operating market basket for children's and cancer hospitals and RNHCIs. However, when we compare the weights for LTCHs and IPFs to the weights for IPPS hospitals, we did not find them comparable. Therefore, we do not believe it is appropriate to use the IPPS market basket for LTCHs and IPFs.

For similar reasons, we are considering at some other date proposing a separate market basket to update the adjusted Federal payment amount for IRFs, LTCHs, and IPFs. We expect that these changes would be proposed in separate proposed rules for each of these three hospital types. We envision that these changes should apply to the adjusted Federal payment rate, and not the portion of the payment that is based on a facility-specific (or reasonable cost) payment to the extent such a hospital or unit is paid under a blend methodology. In other words, to the extent any of these hospitals are paid under a blend methodology whereby a percentage of the payment is based on reasonable cost principles, we would not propose to make changes to the existing methodology for developing the market basket for the reasonable cost portion of the payment because this portion of the payment is being phased out, if it is not already a nonexistent feature of the PPSs for IRFs, LTCHs, and IPFs. We do not believe that it makes sense to propose to create an entirely new methodology for creating the market basket index which updates the "reasonable cost'' portion of a blend methodology since the "reasonable cost portion'' will last at most for just 1 or 3 additional years (1 year for LTCHs paid under a blend methodology since LTCHs only have 1 year remaining in their transition, and 3 years for IPFs since IPFs paid under a blend methodology only have 3 years remaining under a blend methodology). However, the same cannot be said for the adjusted Federal payment amount. In the case of the IRF PPS, all IRFs are paid at 100 percent of the adjusted Federal payment amount and will continue to be paid based on 100 percent of this amount for perpetuity. In the LTCH PPS, most LTCHs (98 percent) are already paid at 100 percent of the adjusted Federal payment amount. In the case of the few LTCHs that are paid under a blend methodology for cost reporting periods beginning on or after October 1, 2006, payment will be based entirely on the adjusted Federal prospective payment rate. In the case of IPFs, new IPFs (as defined in § 412.426(c)) will be paid at 100 percent of the adjusted Federal prospective payment rate (the Federal per diem payment amount), while all others will

continue to transition to 100 percent of the Federal per diem payment amount. In any event, even those transitioning will be at 100 percent of the adjusted Federal prospective payment rate in 3 years.

Chart 5 compares the updates for the FY 2002-based IPPS operating market basket, our proposed index used to update the target amounts for children's and cancer hospitals, and RNHCIs, with a FY 2002-based excluded hospital market basket that is based on the current methodology (that is, based on the cost structure of IRFs, LTCHs, IPFs, and children's and cancer hospitals). Although the percent change in the IPPS operating market basket is typically lower than the percent change in the FY 2002-based excluded hospital market basket (see charts), we believe it is important to propose using the market basket that most closely reflects the cost structure of children's and cancer hospitals. We invite comments on our proposal to use the proposed FY 2002 IPPS operating market basket to update the target amounts for children's and cancer hospitals reimbursed under sections 1886(b)(3)(A) and (b)(3)(E) of the Act and the market basket for RNHCIs under § 403.752(a) of the regulations.

Chart 5 shows the historical and forecasted updates under both the proposed FY 2002-based IPPS operating market basket and the proposed FY 2002-based excluded hospital market basket. The forecasts are based on Global Insight, Inc. 4th quarter, 2004 forecast with historical data through the 3rd quarter of 2004. Global Insight, Inc. is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the market baskets.

Chart 5: Proposed FY 2002-Based IPPS and Proposed FY 2002-Based Excluded Hospital Operating Index Percent Change, FYs 2000 through 2007

Fiscal Year	Proposed Rebased FY 2002-Based IPPS Operating Market Basket	Proposed FY 2002-Based Excluded Hospital Market Basket
Historical Data		
FY 2000	3.2	3.3
FY 2001	4.1	4.3
FY 2002	3.7	4.2
FY 2003	4.0	4.1
FY 2004	3.9	4.0
Average FYs 2000-2004	3.8	4.0
Forecast		
FY 2005	4.1	4.0
FY 2006	3.2	3.4
FY 2007	2.8	3.1
Average FYs 2005-2007	3.4	3.5

Source: Global Insight, Inc, DRI-WEFA, 4th Qtr. 2004; @USMACRO/CONTROL1104 @CISSIM/TL1104.SIM

2. Excluded Hospitals Paid Under a Blend Methodology

As we discuss in greater detail in Appendix B to this proposed rule, in the past, hospitals and hospital units excluded from the IPPS have been paid based on their reasonable costs, subject to TEFRA limits. However, some of these categories of excluded hospitals and hospital units are now paid under their own PPSs. Specifically, some LTCHs and most IPFs are or will be transitioning from reasonable cost-based payments (subject to the TEFRA limits) to prospective payments under their respective PPSs. Under the respective transition period methodologies for the LTCH PPS and the IPF PPS, which are described below, payment is based, in part, on a decreasing percentage of the reasonable cost-based payment amount, which is subject to the TEFRA limits and an increasing percentage of the Federal prospective payment rate. For those LTCHs and IPFs whose PPS payment is comprised in part of a reasonable cost-based payment will have those reasonable cost-based payment amounts limited by the hospital's TEFRA ceiling.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs are paid under the LTCH PPS,

which was implemented with a 5-year transition period, transitioning existing LTCHs to a payment based on the fully Federal prospective payment rate (August 30, 2002; 67 FR 55954). However, a LTCH may elect to be paid at 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition period. A "new" LTCH, as defined in § 412.23(e)(4), are paid based on 100 percent of the standard Federal rate. Effective for cost reporting periods beginning on or after January 1, 2005, IPFs are paid under the IPF PPS under which they receive payment based on a prospectively determined Federal per diem rate that is based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality. During a 3-year transition period, existing IPFs are paid based on a blend of the reasonable cost-based payments and the Federal prospective per diem base rate. For cost reporting periods beginning on or after January 1, 2008, existing IPFs are to be paid based on 100 percent of the Federal per diem rate. A "new" IPF, as defined in § 412.426(c), are paid based on 100 percent of the Federal per diem payment amount. Any LTCHs or IPFs that receive a PPS payment that includes a reasonable cost-based payment during its respective transition period will have that portion of its payment subject to the TEFRA limits.

Under the broad authority of section 1886(b)(3)(A) and (b)(3)(B) of the Act, for LTCHs and IPFs that are transitioning to the fully Federal prospective payment rate, we are proposing to use the rebased FY 2002 based-excluded hospital market basket to update the reasonable cost-based portion of their payments. The proposed market basket update is described in detail below. We do not believe the IPPS operating market basket should be used for the proposed update to the reasonable cost-based portion of the payments to LTCHs or IPFs because this market basket does not reflect the cost structure of LTCHs and IPFs.

3. Development of Cost Categories and Weights for the Proposed FY 2002-Based Excluded Hospital Market Basket

a. Medicare Cost Reports

The major source of expenditure data for developing the proposed rebased and revised excluded hospital market basket cost weights is the FY 2002 Medicare cost reports. We choose FY 2002 as the base year because we believe this is the most recent, relatively complete year (with a 90-percent reporting rate) of Medicare cost report data. These cost reports are from rehabilitation, psychiatric, long-term care, children's, cancer, and religious nonmedical excluded hospitals. They do not reflect data from IPPS hospitals or CAHs. These are the same hospitals included in the FY 1997-based excluded hospital market basket, except for religious nonmedical hospitals. Due to insufficient Medicare cost report data for these excluded hospitals, their cost reports yield only four major expenditure or cost categories: Wages and salaries, pharmaceuticals, professional liability insurance (malpractice), and a residual "all other."

Since the cost weights for the FY 2002-based excluded hospital market basket are based on facility costs, we are proposing to use those cost reports for IRFs, LTCHs, and children's, cancer, and RNHCIs whose Medicare average length of stay is within 15 percent (that is, 15 percent higher or lower) of the total facility average length of stay for the hospital. We are proposing to use a less stringent edit for Medicare length of stay for IPFs, requiring the average length of stay to be within 30 or 50 percent (depending on the total facility average length of stay) of the total facility length of stay. This allows us to increase our sample size by over 150 reports and produce a cost weight more consistent with the overall facility. The edit we applied to IPFs when developing the FY 1997-based excluded hospital market basket was based on the best available data at the time.

We believe that limiting our sample to hospitals with a Medicare average length of stay within a comparable range of the total facility average length of stay provides a more accurate reflection of the structure of costs for Medicare treatments. Our method results in including in our data set hospitals with a share of Medicare patient days relative to total patient days that was approximately three times greater than for those hospitals excluded from our sample. Our goal is to measure cost shares that are reflective of case-mix and practice patterns associated with providing services to Medicare beneficiaries.

Cost weights for benefits, contract labor and blood and blood products were derived using the proposed FY 2002-based IPPS market basket. This is necessary because these data are poorly reported in the cost reports for non-IPPS hospitals. For example, the ratio of the benefit cost weight to the wages and salaries cost weight was applied to the proposed excluded hospital wages and salaries cost weight to derive a benefit cost weight for the proposed excluded hospital market basket.

Chart 6: Major Cost Categories Found in Excluded Hospital Medicare Cost Reports

Major Cost Categories	FY 1997-Based Excluded Hospital Market Basket	Proposed FY 2002-Based Excluded Hospital Market Basket
Wages and salaries	51.998	57.037
Professional Liability Insurance (Malpractice)	0.805	1.504
Pharmaceuticals	6.940	5.940
All other	40.257	35.519

b. Other Data Sources

In addition to the Medicare cost reports, the other source of data used in developing the excluded hospital market basket weights is the Benchmark Input-Output Tables (I–Os) created by the Bureau of Economic Analysis, U.S. Department of Commerce.

New data for this source are scheduled for publication every 5 years, but often take up to 7 years after the reference year. Only an Annual I–O is produced each year, but the Annual I–O contains less industry detail than does the Benchmark I–O. When we rebased the excluded hospital market basket using FY 1997 data in the FY 2003 IPPS final rule, the 1997 Benchmark I–O was not yet available. Therefore, we did not incorporate data from that source into the FY 1997-based excluded hospital market basket (67 FR 50033). However, we did use a secondary source the 1997 Annual Input-Output tables. The third source of data, the 1997 Business Expenditure Survey (now known as the Business Expenses Survey), was used to develop weights for the utilities and telephone services categories.

The 1997 Benchmark I–O data are a much more comprehensive and complete set of data than the 1997 Annual I–O estimates. The 1997 Annual I–O is an update of the 1992 I–O tables, while the 1997 Benchmark I–O is an entirely new set of numbers derived from the 1997 Economic Census. The 2002 Benchmark Input-Output tables are not yet available. Therefore, we are proposing to use the 1997 Benchmark I–O data in the proposed FY 2002-based excluded hospital market basket, to be effective for FY 2006. Instead of using the less detailed, less accurate Annual I–O data, we aged the 1997 Benchmark I–O data forward to FY 2002. The methodology we used to age the data involves applying the annual price changes from the price proxies to the appropriate cost categories. We repeat this practice for each year.

The "all other'' cost category is further divided into other hospital expenditure category shares using the 1997 Benchmark Input-Output tables. Therefore, the "all other'' cost category expenditure shares are proportional to their relationship to "all other'' totals in the I–O tables. For instance, if the cost for telephone services were to represent 10 percent of the sum of the "all other'' I–O (see below) hospital expenditures, then telephone services would represent 10 percent of the market basket's "all other'' cost category. The remaining detailed cost categories under the residual "all other'' cost category were derived using the 1997 Benchmark Input-Output Tables aged to FY 2002 using relative price changes.

4. Proposed 2002–Based Excluded Hospital Market Basket—Selection of Price Proxies

After computing the FY 2002 cost weights for the proposed rebased excluded hospital market basket, it is necessary to select appropriate wage and price proxies to reflect the rate-of-price change for each expenditure category. With the exception of the Professional Liability proxy, all the indicators are based on Bureau of Labor Statistics (BLS) data and are grouped into one of the following BLS categories:

• Producer Price Indexes—Producer Price Indexes (PPIs) measure price changes for goods sold in other than retail markets. PPIs are preferable price proxies for goods that hospitals purchase as inputs in producing their outputs because the PPIs would better reflect the prices faced by hospitals. For example, we use a special PPI for prescription drugs, rather than the Consumer Price Index (CPI) for prescription drugs because hospitals generally purchase drugs directly from the wholesaler. The PPIs that we use measure price change at the final stage of production.

• Consumer Price Indexes—Consumer Price Indexes (CPIs) measure change in the prices of final goods and services bought by the typical consumer. Because they may not represent the price faced by a producer, we used CPIs only if an appropriate PPI was not available, or if the expenditures were more similar to those of retail consumers in general rather than purchases at the wholesale level. For example, the CPI for food purchased away from home is used as a proxy for contracted food services.

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

We evaluated the price proxies using the criteria of reliability, timeliness, availability, and relevance. Reliability indicates that the index is based on valid statistical methods and has low sampling variability. Timeliness implies that the proxy is published regularly, at least once a quarter. Availability means that the proxy is publicly available. Finally, relevance means that the proxy is applicable and representative of the cost category weight to which it is applied. The CPIs, PPIs, and ECIs selected meet these criteria and, therefore, we believe they continue to be the best measure of price changes for the cost categories to which they are applied.

Chart 7 sets forth the complete proposed FY 2002-based excluded hospital market basket including cost categories, weights, and price proxies. For comparison purposes, the corresponding FY 1997-based excluded hospital market basket is listed as well. A summary outlining the choice of the various proxies follows the charts.

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Chart 7: Proposed FY 2002-Based Excluded Hospital Market Basket Cost Categories, Weights, and Proxies with FY 1997-Based Excluded Hospital Market Basket Used for Comparison

Expense Categories	FY 1997-Based Excluded Hospital Market Basket Weights	Proposed FY 2002-Based Excluded Hospital Market Basket Weights	Proposed FY 2002-Based Excluded Hospital Market Basket Price Proxies
1. Compensation	63.251	71.035	--
C. Wages and Salaries*	51.998	57.037	ECI-Wages and Salaries, Civilian Hospital Workers
D. Employee Benefits*	11.253	13.998	ECI-Benefits, Civilian Hospital Workers
2. Professional Fees*	4.859	3.543	ECI - Compensation for Professional, Specialty & Technical Workers
3. Utilities	1.296	0.804	--
A. Fuel, Oil, and Gasoline	0.272	0.132	PPI Refined Petroleum Products
B. Electricity	0.798	0.430	PPI Commercial Electric Power
C. Water and Sewerage	0.226	0.242	CPI-U Water & Sewerage Maintenance
4. Professional Liability Insurance	0.805	1.504	CMS Professional Liability Insurance Premium Index
5. All Other	29.790	23.114	--
B. All Other Products	19.680	15.836	--
(1.) Pharmaceuticals	6.940	5.940	PPI Prescription Drugs
(2.) Direct Purchase Food	1.233	1.070	PPI Processed Foods & Feeds
(3.) Contract Service Food	1.146	0.759	CPI-U Food Away From Home
(4.) Chemicals	2.343	1.347	PPI Industrial Chemicals
(5.) Blood and Blood Products**	0.821	--	--

Expense Categories	FY 1997-Based Excluded Hospital Market Basket Weights	Proposed FY 2002-Based Excluded Hospital Market Basket Weights	Proposed FY 2002-Based Excluded Hospital Market Basket Price Proxies
(6.) Medical Instruments	1.972	1.242	PPI Medical Instruments & Equipment
(7.) Photographic Supplies	0.184	0.118	PPI Photographic Supplies
(8.) Rubber and Plastics	1.501	1.289	PPI Rubber & Plastic Products
(9.) Paper Products	1.219	1.225	PPI Converted Paper & Paperboard Products
(10) Apparel	0.525	0.253	PPI Apparel
(11) Machinery and Equipment	0.936	0.364	PPI Machinery & Equipment
(12) Miscellaneous Products**	0.860	2.230	PPI Finished Goods less Food and Energy
B. All Other Services	10.110	7.279	--
(1.) Telephone Services	0.382	0.295	CPI-U Telephone Services
(2.) Postage	0.771	0.836	CPI-U Postage
(3.) All Other: Labor Intensive*	4.892	2.718	ECI - Compensation for Private Service Occupations
(4.) All Other: Non-Labor Intensive	4.065	3.430	CPI-U All Items
Total	100.000	100.000	--

*Labor-Related

** Blood and blood products, previously a separate cost category, is now contained within Miscellaneous Products in the proposed FY 2002-based excluded hospital market basket.

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a. Wages and Salaries

For measuring the price growth of wages in the proposed FY 2002-based excluded hospital market basket, we are proposing to use the ECI for wages and salaries for civilian hospital workers as the proxy for wages. This same proxy was used for the FY 1997-based excluded hospital market basket.

b. Employee Benefits

The proposed FY 2002-based excluded hospital market basket uses the ECI for employee benefits for civilian hospital workers. This is the same proxy that was used in the FY 1997-based excluded hospital market basket.

c. Nonmedical Professional Fees

The ECI for compensation for professional and technical workers in private industry is applied to this category because it includes occupations such as management and consulting, legal, accounting and engineering services. The same proxy was used in the FY 1997-based excluded hospital market basket.

d. Fuel, Oil, and Gasoline

The percentage change in the price of gas fuels as measured by the PPI (Commodity Code #0552) is applied to this component. The same proxy was used in the FY 1997-based excluded hospital market basket.

e. Electricity

The percentage change in the price of commercial electric power as measured by the PPI (Commodity Code #0542) is applied to this component. The same proxy was used in the FY 1997-based excluded hospital market basket.

f. Water and Sewerage

The percentage change in the price of water and sewerage maintenance as measured by the CPI for all urban consumers (CPI Code # CUUR0000SEHG01) is applied to this component. The same proxy was used in the FY 1997-based excluded hospital market basket.

g. Professional Liability Insurance

The proposed FY 2002-based excluded hospital market basket uses the percentage change in the hospital professional liability insurance (PLI) premiums as estimated by the CMS Hospital Professional Liability Index for the proxy of this category. Similar to the Physicians Professional Liability Index, we attempt to collect commercial insurance premiums for a fixed level of coverage, holding nonprice factors constant (such as a change in the level of coverage). In the FY 1997-based excluded hospital market basket, the same price proxy was used.

We continue to research options for improving our proxy for professional liability insurance. This research includes exploring various options for expanding our current survey, including the identification of another entity that would be willing to work with us to collect more complete and comprehensive data. We are also exploring other options such as third party or industry data that might assist us in creating a more precise measure of PLI premiums. At this time, we have not yet identified a preferred option. Therefore, we are not proposing to make any changes to the proxy in this proposed rule.

h. Pharmaceuticals

The percentage change in the price of prescription drugs as measured by the PPI (PPI Code #PPI283D#RX) is used as a proxy for this category. This is a special index produced by BLS and is the same proxy used in the FY 1997-based excluded hospital market basket.

i. Food: Direct Purchases

The percentage change in the price of processed foods and feeds as measured by the PPI (Commodity Code #02) is applied to this component. The same proxy was used in the FY 1997-based excluded hospital market basket.

j. Food: Contract Services

The percentage change in the price of food purchased away from home as measured by the CPI for all urban consumers (CPI Code # CUUR0000SEFV) is applied to this component. The same proxy was used in the FY 1997-based excluded hospital market basket.

k. Chemicals

The percentage change in the price of industrial chemical products as measured by the PPI (Commodity Code #061) is applied to this component. While the chemicals hospitals purchase include industrial as well as other types of chemicals, the industrial chemicals component constitutes the largest proportion by far. Thus, we believe that Commodity Code #061 is the appropriate proxy. The same proxy was used in the FY 1997-based excluded hospital market basket.

l. Medical Instruments

The percentage change in the price of medical and surgical instruments as measured by the PPI (Commodity Code #1562) is applied to this component. The same proxy was used in the FY 1997-based excluded hospital market basket.

m. Photographic Supplies

The percentage change in the price of photographic supplies as measured by the PPI (Commodity Code #1542) is applied to this component. The same proxy was used in the FY 1997-based excluded hospital market basket.

n. Rubber and Plastics

The percentage change in the price of rubber and plastic products as measured by the PPI (Commodity Code #07) is applied to this component. The same proxy was used in the FY 1997-based excluded hospital market basket.

o. Paper Products

The percentage change in the price of converted paper and paperboard products as measured by the PPI (Commodity Code #0915) is used. The same proxy was used in the FY 1997-based excluded hospital market basket.

p. Apparel

The percentage change in the price of apparel as measured by the PPI (Commodity Code #381) is applied to this component. The same proxy was used in the FY 1997-based excluded hospital market basket.

q. Machinery and Equipment

The percentage change in the price of machinery and equipment as measured by the PPI (Commodity Code #11) is applied to this component. The same proxy was used in the FY 1997-based excluded hospital market basket.

r. Miscellaneous Products

The percentage change in the price of all finished goods less food and energy as measured by the PPI (Commodity Code #SOP3500) is applied to this component. Using this index removes the double-counting of food and energy prices, which are already captured elsewhere in the market basket. The same proxy was used in the FY 1997-based excluded hospital market basket. The weight for this cost category is higher than in the FY 1997-based index because it also includes blood and blood products. In the FY 1997-based excluded hospital market basket, we included a separate cost category for blood and blood products, using the BLS PPI (Commodity Code #063711) for blood and derivatives as a price proxy. A review of recent trends in the PPI for blood and derivatives suggests that its movements may not be consistent with the trends in blood costs faced by hospitals. While this proxy did not match exactly with the product hospitals are buying, its trend over time appears to be reflective of the historical price changes of blood purchased by hospitals. However, an apparent divergence over recent periods led us to reevaluate whether the PPI for blood and derivatives was an appropriate measure of the changing price of blood. We ran test market baskets classifying blood in three separate cost categories: blood and blood products, contained within chemicals as was done for the FY 1992-based index, and within miscellaneous products. These categories use as proxies the following PPIs: the PPI for blood and blood products, the PPI for chemicals, and the PPI for finished goods less food and energy, respectively. Of these three proxies, the PPI for finished goods less food and energy moved most like the recent blood cost and price trends. In addition, the impact on the overall market basket by using different proxies for blood was negligible, mostly due to the relatively small weight for blood in the market basket. Therefore, we chose the PPI for finished goods less food and energy for the blood proxy because we believe it will best be able to proxy price

changes (not quantities or required tests) associated with blood purchased by hospitals. We will continue to evaluate this proxy for its appropriateness and will explore the development of alternative price indexes to proxy the price changes associated with this cost.

s. Telephone

The percentage change in the price of telephone services as measured by the CPI for all urban consumers (CPI Code #CUUR0000SEED) is applied to this component. The same proxy was used in the FY 1997-based excluded hospital market basket.

t. Postage

The percentage change in the price of postage as measured by the CPI for all urban consumers (CPI Code #CUUR0000SEEC01) is applied to this component. The same proxy was used in the FY 1997-based excluded hospital market basket.

u. All Other Services: Labor Intensive

The percentage change in the ECI for compensation paid to service workers employed in private industry is applied to this component. The same proxy was used in the FY 1997-based excluded hospital market basket.

v. All Other Services: Nonlabor Intensive

The percentage change in the all-items component of the CPI for all urban consumers (CPI Code #CUUR0000SA0) is applied to this component. The same proxy was used in the FY 1997-based excluded hospital market basket.

For further discussion of the rationale for choosing many of the specific price proxies, we refer the reader to the August 1, 2002 final rule (67 FR 50037).

Chart 8: FY 1997-Based and Proposed FY 2002-Based Excluded Hospital Operating Index Percent Change, FY 2000 through FY 2008

Fiscal Year (FY)	Proposed FY 2002-Based Excluded Hospital Market Basket	FY 1997-Based Excluded Hospital Market Basket
Historical data:		
FY 2000	3.3	3.3
FY 2001	4.3	4.3
FY 2002	4.2	3.9
FY 2003	4.1	4.0
FY 2004	4.0	3.9
Average FYs 2000-2004	3.9	3.9
Forecast:		
FY 2005	4.0	4.0
FY 2006	3.4	3.3
FY 2007	3.1	2.9
FY 2008	3.0	2.9
Average FYs 2005-2008	3.3	3.3

Source: Global Insight, Inc. 4th Qtr 2004, @USMACRO/CNTL1104 @CISSIM/TL1104.SIM

D. Frequency of Updates of Weights in IPPS Hospital Market Basket

Section 404 of Pub. L. 108–173 (MMA) requires CMS to report in this proposed rule the research that has been done to determine a new frequency for rebasing the hospital market basket. Specifically, section 404 states:

"(a) *More frequent updates in weights.* After revising the weights used in the hospital market basket under section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most current data available, the Secretary shall establish a frequency for revising such weights, including the labor share, in such market basket to reflect the most current data available more frequently than once every 5 years; and

"(b) *Incorporation of explanation in rulemaking.* The Secretary shall include in the publication of the final rule for payment for inpatient hospitals services under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for fiscal year 2006, an explanation of the reasons for, and options considered, in determining the frequency established under subsection (a).''

This section of the proposed rule discusses the research we have done to fulfill this requirement, and proposes a rebasing frequency that makes optimal use of available data.

Our past practice has been to monitor the appropriateness of the market basket on a consistent basis in order to rebase and revise the index when necessary. The decision to rebase and revise the index has been driven in large part by the availability of the data necessary to produce a complete index. In the past, we have supplemented the Medicare cost report data that are available on an annual basis with Bureau of the Census hospital expense data that are typically available only every 5 years (usually in years ending in 2 and 7). Because of this, we have generally rebased the index every 5 years. However, prior to the requirement associated with section 404 of Pub. L. 108–173, there was no legislative requirement regarding the timing of rebasing the hospital market basket nor was there a hard rule that we

used in determining this frequency. ProPAC, one of MedPAC's predecessor organizations, did a report to the Secretary on April 1, 1985, that supported periodic rebasing at least every 5 years.

The most recent rebasing of the hospital market basket was just 3 years ago, for the FY 2003 update. Since its inception with the hospital PPS in FY 1984, the hospital market basket has been rebased several times (FY 1987 update, FY 1991 update, FY 1997 update, FY 1998 update, and FY 2003 update). One of the reasons we believe it appropriate to rebase the index on a periodic basis is that rebasing (as opposed to revising, as explained in section IV.A. of this preamble) tends to have only a minor impact on the actual percentage increase applied to the PPS update. There are two major reasons for this: (1) The cost category weights tend to be relatively stable over shorter term periods (3 to 5 years); and (2) the update is based on a forecast, which means the individual price series tend not to grow as differently as they have in some historical periods.

We focused our research in two major areas. First, we reviewed the frequency and availability of the data needed to produce the market basket. Second, we analyzed the impact on the market basket of determining the market basket weights under various frequencies. We did this by developing market baskets that had base years for every year between 1997 and 2002, and then analyzed how different the market basket percent changes were over various periods. We used the results from these areas of research to assist in our determination of a new rebasing frequency. Based on this analysis, we are proposing to rebase the hospital market basket every 4 years. This would mean the next rebasing would occur for the FY 2010 update.

As we have described in numerous **Federal Register** documents over the past few decades, the hospital market basket weights are the compilation of data from more than one data source. When we are discussing rebasing the weights in the hospital market basket, there are two major data sources: (1) The Medicare cost reports; and (2) expense surveys from the Bureau of the Census (the Economic Census is used to develop data for the Bureau of Economic Analysis' input-output series). We will explore the future availability of each of these data sources.

Each Medicare-participating hospital submits a Medicare cost report to CMS on an annual basis. It takes roughly 2 years before "nearly complete'' Medicare cost report data are available. For example, approximately 90 percent of FY 2002 Medicare cost report data were available in October 2004 (only 50 percent of FY 2003 data was available), although only 20 percent of these reports were settled. We choose FY 2002 as the base year because we believe this is the most recent, relatively complete year (with a 90 percent reporting rate) of Medicare cost report data. In developing the hospital market basket weights, we have used the Medicare cost reports to determine the weights for six major cost categories (wages, benefits, contract labor, pharmaceuticals, professional liability, and blood). In FY 2002, these six categories accounted for 68.5 percent of the hospital market basket. Therefore, it is possible to develop a new set of market basket weights for these categories on an annual basis, but with a substantial lag (for the FY 2006 update, we consider the latest year of historical data to be FY 2002).

The second source of data is the U.S. Department of Commerce, Bureau of Economic Analysis' Benchmark Input-Output (I–O) table. These data are published every 5 years with a more significant lag than the Medicare cost reports. For example, the 1997 Benchmark I–O tables were not published until the beginning of 2003. We have sometimes used data from a third data source, the Bureau of the Census' Business Expenses Survey (BES), which is also published every 5 years. The BES data are used as an input into the I–O data, and thus are published a few months prior to the release of the I–O. However, the BES contains only a fraction of the detail contained in the I–O.

Chart 9 below takes into consideration the expected availability of these major data sources and summarizes how they could be incorporated into the development of future market basket weights.

Chart 9: Expected Future Data Availability for Major Data Sources used in the Hospital Market Basket

PPS FY Update	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Market Basket Base Year	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Medicare Cost Report Data Available	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
I-O Data Available	1997	1997	1997	1997	1997	2002
BES Data Available	1997	1997	1997	1997	1997	2002
Number of Years Data Must Be Aged	5	6	7	8	9	5

FPS FY Update	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Market Basket Base Year	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Medicare Cost Report Data Available	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
I-O Data Available	2002	2002	2002	2002	2007
BES Data Available	2002	2002	2002	2002	2007
Number of Years Data Must Be Aged	6	7	8	9	5

It would be necessary to age the I–O or BES data to the year for which cost report data are available using the price changes between those periods. While not a preferred method in developing the market basket weights, we have done this in the past when rebasing the index. We are proposing to age the 1997 Benchmark I–O data for this proposed rule.

As the table clearly indicates, the most optimal rebasing frequency from a data availability standpoint is every 5 years. That is, if we were to next rebase for the FY 2011 update, we could use the 2002 Benchmark I–O data that would recently be available. In order to match the Medicare cost report data that would be available at that time (FY 2007 data), we would have to age the I–O data to FY 2007. However, this would be aging the data only 5 years, whereas if the rebasing frequency was determined to be every 4 years, we would have to age 1997 I–O data to FY 2006. While aging data over 5 years is problematic (there can be significant utilization and intensity changes over that length period, as opposed to only a year or two), it would be significantly worse to age data over an 8-year or 9-year period. If we were on a 5-year rebasing frequency, for the FY 2016 update, we would use cost report data for FY 2012 and the newly available 2007 I–O data. Again, the I–O data would have to be aged only 5 years to match the cost report data.

We can look at the implications of determining a rebasing frequency of every 3 or 4 years. Considering a frequency of 3 years first, we would next rebase for the FY 2009 update using FY 2005 Medicare cost report data and 1997 I–O data (the same data currently being used in the proposed FY 2002-based market basket). This is problematic because the 1997 I–O data would need to be aged 8 years to match the cost report data. The next two rebasings would be for the FY 2012 update (using FY 2008 cost report data and 2002 I–O data) and FY 2015 (using FY 2011 cost report data and 2002 I–O data). This means that while we are making optimal use of the Medicare cost report data, we would be forced to use the same I–O data in consecutive rebasings and would have to age that data as much as 9 years to use the same year as the cost report data.

For a rebasing frequency of every 4 years, our next rebasing would be for the FY 2010 update using FY 2006 Medicare cost report data and 1997 I–O data. This is also problematic because the 1997 I–O data would need to be aged 9 years to match the cost report data. The next two rebasings would be for the FY 2014 update (using FY 2010 cost report data and 2002 I–O data) and FY 2018 (using FY 2014 cost report data and 2007 I–O data). Again, this frequency would make optimal use of the Medicare cost report data but would require aging of the I–O data between 7 and 9 years in order to match the cost report data.

It is clear from this analysis that neither the 3-year nor 4-year rebasing frequencies makes as good use of all the data as rebasing every 5 years. In addition, when comparing the 3-year and 4-year rebasing frequencies, no one method stands out as being significantly improved over another. Thus, this analysis does not lead us to draw any definitive conclusions as to a rebasing frequency more appropriate than every 5 years.

Our second area of research in determining a new rebasing frequency was to analyze the impact on the market basket of determining the market basket weights under various frequencies. We did this by using the current historical data that are available (both Medicare cost report and I–O) to develop market baskets with base year weights for each year between FY 1997 and FY 2002. We then analyzed how differently the market baskets moved over various historical periods.

Approaching the analysis this way allowed us to develop six hypothetical market baskets with different base years (FY 1997, FY 1998, FY 1999, FY 2000, FY 2001, and FY 2002). As we have done when developing the official market baskets, we used Medicare cost report data where available. Thus, cost report data were used to determine the weights for wages and salaries, benefits, contract labor, pharmaceuticals, blood and blood products, and all other costs. We used the 1997 Benchmark I–O data to fill out the remainder of the market basket weights (note that this produces a different index for FY 1997 than the official FY 1997-based hospital market basket that used the Annual 1997 I–O data), aging the data to the appropriate year to match the cost report data. This means the FY 2002-based index used in this analysis matches the FY 2002-based market basket we are proposing in this rule. Chart 10 shows the weights from these hypothetical market baskets:

Chart 10: Comparison Weights from Hypothetical Market Baskets, Base Years FY 1997 through FY 2002

Cost Category	FY 1997 (BMK I-O)	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002
Compensation	61.656	60.830	60.920	59.717	60.057	59.993
Wages	50.686	50.248	49.684	49.127	49.029	48.171
Benefits	10.970	10.582	11.236	10.590	11.028	11.822
Professional Fees	4.965	5.184	5.198	5.452	5.438	5.510
Utilities	1.219	1.242	1.208	1.258	1.329	1.251
Electricity	0.688	0.691	0.665	0.676	0.681	0.669
Fuel, Oil, Coal, etc.	0.181	0.183	0.175	0.203	0.277	0.206
Water & Sewerage	0.351	0.369	0.367	0.378	0.371	0.376
Malpractice	0.840	1.076	1.020	1.123	1.247	1.589
All Other	31.018	31.667	31.654	32.451	31.929	31.657
All Other Products	20.311	20.602	20.637	21.032	20.701	20.336
Drugs	5.416	5.560	5.890	5.954	5.938	5.855
Food-Direct	1.771	1.762	1.703	1.736	1.699	1.664
Food-Away	1.122	1.164	1.162	1.199	1.172	1.180
Chemicals	2.301	2.263	2.112	2.296	2.240	2.096
Medical Instruments	2.086	2.083	2.019	2.019	1.939	1.932
Photo Supplies	0.206	0.208	0.201	0.198	0.192	0.183
Rubber & Plastics	2.107	2.123	2.056	2.110	2.057	2.004
Paper Products	1.866	1.931	1.880	2.006	1.953	1.905
Apparel	0.425	0.433	0.423	0.428	0.406	0.394
Machinery & Equipment	0.625	0.628	0.608	0.610	0.580	0.565
Miscellaneous Products*	2.386	2.448	2.582	2.476	2.524	2.558
All Other Services	10.707	11.065	11.017	11.418	11.228	11.321
Telephone	0.497	0.504	0.489	0.488	0.464	0.458
Postage	1.269	1.284	1.277	1.298	1.269	1.300
All Other: Labor Intensive	3.800	3.991	4.004	4.176	4.136	4.228
All Other: Nonlabor Intensive	5.142	5.286	5.246	5.457	5.359	5.335
Total**	100.0	100.0	100.0	100.0	100.0	100.0

* Blood and blood products contained within Miscellaneous Products.
**May not add due to rounding.

Note that the weights remain relatively stable between periods. It is for this reason that we believe defining the market basket as a Laspeyres-type, fixed-weight index is appropriate. Because the weights in the market basket are generally for aggregated costs (for example, wages and salaries for all employees), there is not much volatility in the weights between periods, especially over shorter time spans. As the results of this analysis will show, it is for this reason that rebasing the market basket more frequently than every 5 years is expected to have little impact on the overall percent change in the hospital market basket.

Using these hypothetical market baskets, we can produce market basket percent changes over historical periods to determine what is the impact of using various base periods. In our analysis, we consider the hypothetical FY 1997-based index to be the benchmark measure and the other indexes to indicate the impact of rebasing over various frequencies. The hypothetical FY 2000-based index would reflect the impact of rebasing every 3 years, the hypothetical FY 2001-based index would reflect the impact of rebasing every 4 years, and the hypothetical FY 2002-based index would reflect the

impact of rebasing every 5 years. Chart 11 shows the results of these comparisons.

Chart 11: Comparison of Hypothetical Market Baskets, FY 1997 through FY 2002 Base Years, Percent Changes, FY 1998 through FY 2004

	Percent Change in Hypothetical Market Baskets					
Federal Fiscal Year	FY 1997-based	FY 1998-based	FY 1999-based	FY 2000-based	FY 2001-based	FY 2002-based
1998	2.7	2.6	2.7	2.6	2.6	2.6
1999	2.7	2.7	2.7	2.7	2.7	2.7
2000	3.2	3.2	3.2	3.2	3.2	3.2
2001	4.2	4.2	4.2	4.2	4.2	4.2
2002	3.8	3.8	3.7	3.7	3.7	3.7
2003	3.9	3.9	3.9	3.9	3.9	3.9
2004	3.8	3.7	3.8	3.8	3.8	3.8
Average:						
FY 1998-04	3.5	3.4	3.5	3.4	3.4	3.4

Source: Global Insight, Inc, 4th Qtr. 2004;@USMACRO/MODTREND @CISSIM/TL1104.SIM

It is clear from this comparison that there is little difference between the indexes, and, for some FYs, there would be no difference in the market basket update factor if we had rebased the market basket more frequently. In particular, there is no difference in the hypothetical indexes based between FY 2000 and FY 2002. This suggests that setting the rebasing frequency to 3, 4, or 5 years will have little or no impact on the resulting market basket. As we found when analyzing data availability, this portion of our research does not suggest that rebasing the market basket more frequently than every 5 years results in an improved market basket or that there is any noticeable difference between rebasing every 3 or 4 years.

Market basket rebasing is a 1-year to 2-year long process that includes data processing, analytical work, methodology reevaluation, and regulatory process. After developing a rebased and revised market basket, there are extensive internal review processes that a rule must undergo, both in proposed and final form. Once the proposed rule has been published, there is a 60-day comment period set aside for the public to respond to the proposed rule. After comments are received, we then need adequate time to research and reply to all comments submitted. The last part of the regulatory process is the 60-day requirement—the final rule must be published 60 days before the provisions of the rule can become effective.

We would like to rebase all of our indexes (PPS operating, PPS capital, excluded hospital with capital, SNFs, HHAs, and Medicare Economic Index) on a regular schedule. Therefore, if we were to choose a 3-year rebasing schedule, we would have to rebase more than one index at a time. This may potentially limit the amount of time we could devote to the market basket rebasing process. In addition, we recognize that, in the future, we may be required to develop additional market baskets that would require frequent rebasing.

Given the number of market baskets we are responsible for rebasing and revising, the regulatory process for each, and the availability of source data, we believe that while it is not necessary, rebasing and revising the hospital market baskets every 4 years is the most appropriate frequency to meet the legislative requirement.

E. Capital Input Price Index Section

The Capital Input Price Index (CIPI) was originally described in the September 1, 1992 **Federal Register** (57 FR 40016). There have been subsequent discussions of the CIPI presented in the May 26, 1993 (58 FR 30448), September 1, 1993 (58 FR 46490), May 27, 1994 (59 FR 27876), September 1, 1994 (59 FR 45517), June 2, 1995 (60 FR 29229), September 1, 1995 (60 FR 45815), May 31, 1996 (61 FR 27466), and August 30, 1996 (61 FR 46196) issues of the **Federal Register**. The August 1, 2002 (67 FR 50032) rule discussed the most recent revision and rebasing of the CIPI to a FY 1997 base year, which reflects the capital cost structure facing hospitals in that year.

We are proposing to revise and rebase the CIPI to a FY 2002 base year to reflect the more recent structure of capital costs in hospitals. Unlike the PPS operating market basket, we do not have FY 2002 Medicare cost report data available for the development of the capital cost weights, due to a change in the FY 2002 cost reporting requirements. Rather, we used hospital capital expenditure data for the capital cost categories of depreciation, interest, and other capital expenses for FY 2001 and aged these data to a FY 2002 base year using the relevant vintage-weighted price proxies. As with the FY 1997-based index, we have developed two sets of weights in order to calculate the proposed FY 2002-based CIPI. The first set of proposed weights identifies the proportion of hospital capital expenditures attributable to each expenditure category, while the second set of proposed weights is a set of relative vintage weights for depreciation

and interest. The set of vintage weights is used to identify the proportion of capital expenditures within a cost category that is attributable to each year over the useful life of the capital assets in that category. A more thorough discussion of vintage weights is provided later in this section.

Both sets of proposed weights are developed using the best data sources available. In reviewing source data, we determined that the Medicare cost reports provided accurate data for all capital expenditure cost categories. We are proposing to use the FY 2001 Medicare cost reports for PPS hospitals, aged to FY 2002, excluding expenses from hospital-based subproviders, to determine weights for all three cost categories: depreciation, interest, and other capital expenses. We compared the weights determined from the Medicare cost reports to the 2002 Bureau of the Census' Business Expenses Survey and found the weights to be similar to those developed from the Medicare cost reports.

Lease expenses are not broken out as a separate cost category in the CIPI, but are distributed among the cost categories of depreciation, interest, and other, reflecting the assumption that the underlying cost structure of leases is similar to capital costs in general. As was done in previous rebasings of the CIPI, we assumed 10 percent of lease expenses are overhead and assigned them to the other capital expenses cost category as overhead. The remaining lease expenses were distributed to the three cost categories based on the proportion of depreciation, interest, and other capital expenses to total capital costs excluding lease expenses.

Depreciation contains two subcategories: building and fixed equipment and movable equipment. The split between building and fixed equipment and movable equipment was determined using the Medicare cost reports. This methodology was also used to compute the FY 1997-based index.

Total interest expense cost category is split between government/nonprofit and profit interest. The FY 1997-based CIPI allocated 85 percent of the total interest cost weight to government/nonprofit interest, proxied by average yield on domestic municipal bonds, and 15 percent to for-profit interest, proxied by average yield on Moody's Aaa bonds (67 FR 50044). The methodology used to derive this split is explained in the June 2, 1995 issue of the **Federal Register** (60 FR 29233). We are proposing to derive the split using the relative FY 2001 Medicare cost report data on interest expenses for government/nonprofit and profit hospitals. Based on these data, we are proposing a 75/25 split between government/nonprofit and profit interest. We believe it is important that this split reflects the latest relative cost structure of interest expenses. The proposed split of 75/25 had little (less than 0.1 percent in any given year) or no effect on the annual capital market basket percent change in both the historical and forecasted periods.

Chart 12 presents a comparison of the proposed FY 2002-based CIPI capital cost weights and the FY 1997-based CIPI capital cost weights.

Chart 12: Comparison of FY 1997-Based and Proposed FY 2002-Based CIPI Cost Category Weights

Expense Categories	Proposed FY 2002 Weights	FY 1997 Weights	Price Proxy
Total	100.00	100.00	
Total depreciation	74.58	71.35	
Building and fixed equipment depreciation	36.23	34.22	Boeckh Institutional Construction Index--vintage weighted (23 years)
Movable equipment depreciation	38.35	37.13	PPI for machinery and equipment--vintage weighted (11 years)
Total interest	19.86	23.46	
Government/nonprofit interest	14.90	19.94	Average yield on domestic municipal bonds (Bond Buyer 20 bonds)--vintage weighted (23 years)
For-profit interest	4.97	3.52	Average yield on Moody's Aaa bonds--vintage weighted (23 years)
Other	5.55	5.19	CPI-U – Residential Rent

Because capital is acquired and paid for over time, capital expenses in any given year are determined by both past and present purchases of physical and financial capital. The vintage-weighted CIPI is intended to capture the long-term consumption of capital, using vintage weights for depreciation (physical capital) and interest (financial capital). These vintage weights reflect the proportion of capital purchases attributable to each year of the expected life of building and fixed equipment, movable equipment, and interest. We used the vintage weights to compute vintage-weighted price changes associated with depreciation and interest expense.

Vintage weights are an integral part of the CIPI. Capital costs are inherently complicated and are determined by complex capital purchasing decisions, over time, based on such factors as interest rates and debt financing. In addition, capital is depreciated over time instead of being consumed in the same period it is purchased. The CIPI accurately reflects the annual price changes associated with capital costs, and is a useful simplification of the actual capital investment process. By accounting for the vintage nature of capital, we are able to provide an accurate, stable annual measure of price changes. Annual nonvintage price changes for capital are unstable due to the volatility of interest rate changes and, therefore, do not reflect the actual annual price changes for Medicare capital-related costs. CMS' CIPI reflects the underlying stability of the capital acquisition process and provides hospitals with the ability to plan for changes in capital payments.

To calculate the vintage weights for depreciation and interest expenses, we needed a time series of capital purchases for building and fixed equipment and movable equipment. We found no single source that provides the best time series of capital purchases by hospitals for all of the above components of capital purchases. The early Medicare cost reports did not have sufficient capital data to meet this need. While the AHA Panel Survey provided a consistent database back to 1963, it did not provide annual capital purchases. The AHA Panel Survey provided a time series of depreciation expenses through 1997 which could be used to infer capital purchases over time. From 1998 to 2001, hospital depreciation expenses were calculated by multiplying the AHA Annual Survey total hospital expenses by the ratio of depreciation to total hospital expenses from the Medicare cost reports. Beginning in 2001, the AHA Annual Survey began collecting depreciation expenses. We hope to be able to use these data in future rebasings.

In order to estimate capital purchases from AHA data on depreciation expenses, the expected life for each cost category (building and fixed equipment, movable equipment, and interest) is needed to calculate vintage weights. We used FY 2001 Medicare cost reports to determine the expected life of building and fixed equipment and movable equipment. The expected life of any piece of equipment can be determined by dividing the value of the asset (excluding fully depreciated assets) by its current year depreciation amount. This calculation yields the estimated useful life of an asset if depreciation were to continue at current year levels, assuming straight-line depreciation. From the FY 2001 cost reports, the expected life of building and fixed equipment was determined to be 23 years, and the expected life of movable equipment was determined to be 11 years. The FY 1997-based CIPI showed the same expected life for the two categories of depreciation.

Although we are proposing to use this methodology for deriving the useful life of an asset, we intend to conduct a further review of the methodology between the publication of this proposed rule and the final rule. We plan to review alternate data sources, if available, and analyze in more detail the hospital's capital cost structure reported in the Medicare cost reports.

We are proposing to use the building and fixed equipment and movable equipment weights derived from FY 2001 Medicare cost reports to separate the depreciation expenses into annual amounts of building and fixed equipment depreciation and movable equipment depreciation. Year-end asset costs for building and fixed equipment and movable equipment were determined by multiplying the annual depreciation amounts by the expected life calculations from the FY 2001 Medicare cost reports. We then calculated a time series back to 1963 of annual capital purchases by subtracting the previous year asset costs from the current year asset costs. From this capital purchase time series, we were able to calculate the vintage weights for building and fixed equipment and movable equipment. Each of these sets of vintage weights is explained in detail below.

For building and fixed equipment vintage weights, the real annual capital purchase amounts for building and fixed equipment derived from the AHA Panel Survey were used. The real annual purchase amount was used to capture the actual amount of the physical acquisition, net of the effect of price inflation. This real annual purchase amount for building and fixed equipment was produced by deflating the nominal annual purchase amount by the building and fixed equipment price proxy, the Boeckh Institutional Construction Index. Because building and fixed equipment have an expected life of 23 years, the vintage weights for building and fixed equipment are deemed to represent the average purchase pattern of building and fixed equipment over 23-year periods. With real building and fixed equipment purchase estimates available back to 1963, we averaged sixteen 23-year periods to determine the average vintage weights for building and fixed equipment that are representative of average building and fixed equipment purchase patterns over time. Vintage weights for each 23-year period are calculated by dividing the real building and fixed capital purchase amount in any given year by the total amount of purchases in the 23-year period. This calculation is done for each year in the 23-year period, and for each of the sixteen 23-year periods. We are proposing to use the average of each year across the sixteen 23-year periods to determine the 2002 average building and fixed equipment vintage weights for the FY 2002-based CIPI.

For movable equipment vintage weights, the real annual capital purchase amounts for movable equipment derived from the AHA Panel Survey were used to capture the actual amount of the physical acquisition, net of price inflation. This real annual purchase amount for movable equipment was calculated by deflating the nominal annual purchase amount by the movable equipment price proxy, the PPI for Machinery and Equipment. Based on our determination that movable equipment has an expected life of 11 years, the vintage weights for movable equipment represent the average expenditure for movable equipment over an 11-year period. With real movable equipment purchase estimates available back to 1963, twenty-eight 11-year periods were averaged to determine the average vintage weights for movable equipment that are representative of average movable equipment purchase patterns over time. Vintage weights for each 11-year period are calculated by dividing the real movable capital purchase amount for any given year by the total amount of purchases in the 11-year period. This calculation was done for each year in the 11-year period, and for

each of the twenty-eight 11-year periods. We are proposing to use the average of each year across the twenty-eight 11-year periods to determine the average movable equipment vintage weights for the FY 2002-based CIPI.

For interest vintage weights, the nominal annual capital purchase amounts for total equipment (building and fixed, and movable) derived from the AHA Panel and Annual Surveys were used. Nominal annual purchase amounts were used to capture the value of the debt instrument. Because we have determined that hospital debt instruments have an expected life of 23 years, the vintage weights for interest are deemed to represent the average purchase pattern of total equipment over 23-year periods. With nominal total equipment purchase estimates available back to 1963, sixteen 23-year periods were averaged to determine the average vintage weights for interest that are representative of average capital purchase patterns over time. Vintage weights for each 23-year period are calculated by dividing the nominal total capital purchase amount for any given year by the total amount of purchases in the 23-year period. This calculation is done for each year in the 23-year period and for each of the sixteen 23-year periods. We are proposing to use the average of each year across the sixteen 23-year periods to determine the average interest vintage weights for the FY 2002-based CIPI. The vintage weights for the FY 1997 CIPI and the proposed FY 2002 CIPI are presented in Chart 13.

Chart 13: Current and Proposed Vintage Weights for Capital-Related Price Proxies

Year	Building and Fixed Equipment		Movable Equipment		Interest	
	FY 1997 23 years	Proposed FY 2002 23 years	FY 1997 11 years	Proposed FY 2002 11 years	FY 1997 23 years	Proposed FY 2002 23 years
1	0.018	0.021	0.063	0.065	0.007	0.010
2	0.021	0.022	0.068	0.071	0.009	0.012
3	0.023	0.025	0.074	0.077	0.011	0.014
4	0.025	0.027	0.080	0.082	0.012	0.016
5	0.026	0.029	0.085	0.086	0.014	0.019
6	0.028	0.031	0.091	0.091	0.016	0.023
7	0.030	0.033	0.096	0.095	0.019	0.026
8	0.032	0.035	0.101	0.100	0.022	0.029
9	0.035	0.038	0.108	0.106	0.026	0.033
10	0.039	0.040	0.114	0.112	0.030	0.036
11	0.042	0.042	0.119	0.117	0.035	0.039
12	0.044	0.045	--	--	0.039	0.043
13	0.047	0.047	--	--	0.045	0.048
14	0.049	0.049	--	--	0.049	0.053
15	0.051	0.051	--	--	0.053	0.056
16	0.053	0.053	--	--	0.059	0.059
17	0.057	0.056	--	--	0.065	0.062
18	0.060	0.057	--	--	0.072	0.064
19	0.062	0.058	--	--	0.077	0.066
20	0.063	0.060	--	--	0.081	0.070
21	0.065	0.060	--	--	0.085	0.071
22	0.064	0.061	--	--	0.087	0.074
23	0.065	0.061	--	--	0.090	0.076
Total	1.000	1.000	1.000	1.000	1.000	1.000

After the capital cost category weights were computed, it was necessary to select appropriate price proxies to reflect the rate of increase for each expenditure category. Our proposed price proxies for the FY 2002-based CIPI are the same as those used in the FY 1997-based CIPI. We still believe these are the most appropriate proxies for

hospital capital costs that meet our selection criteria of relevance, timeliness, availability, and reliability. We ran the proposed FY 2002-based index using the Moody's Aaa bonds average yield and then using the Moody's Baa bonds average yield as proxy for the for-profit interest cost category. There was no difference in the two sets of index percent changes either historically or forecasted. The rationale for selecting these price proxies is explained more fully in the August 30, 1996 final rule (61 FR 46196). The proposed proxies are presented in Chart 14.

Chart 14: Comparison of FY 1997-Based and Proposed FY 2002-Based Capital Input Price Index, Percent Change, FY 1998 through FY 2007

Federal Fiscal Year	CIPI, FY 1997-based	Proposed CIPI, FY 2002-based
1998	0.9	1.0
1999	0.9	0.9
2000	1.1	1.0
2001	0.9	0.9
2002	0.8	0.7
2003	0.6	0.5
2004	0.6	0.5
Forecast:		
2005	0.6	0.5
2006	0.8	0.7
2007	0.9	0.8
Average:		
FYs 1998-2004	0.8	0.8
FYs 2005-2007	0.8	0.7

Source: Global Insight, Inc, 4th Qtr. 2004; @USMACRO/CONTROL1104 @CISSIM/TL1104

Global Insight, Inc. forecasts a 0.7 percent increase in the FY 2002-based CIPI for 2006, as shown in Chart 15. This is the result of a 1.3 percent increase in projected depreciation prices (building and fixed equipment, and movable equipment) and a 2.7 percent increase in other capital expense prices, partially offset by a 2.3 percent decrease in vintage-weighted interest rates in FY 2006, as indicated in Chart 15. Accordingly, we are proposing a 0.7 percent increase in the CIPI.

Chart 15: CMS Proposed Capital Input Price Index Percent Changes, Total and Components, FYs 1995 through 2007

Fiscal Year	Total	Total Depreciation	Depreciation, building and fixed equipment	Depreciation, movable equipment	Interest	Other
Weights FY 2002	1.000	0.7458	0.3623	0.3835	0.1986	0.0556
Vintage-Weighted Price Changes						
1995	1.7	2.7	4.0	1.6	-1.2	2.5
1996	1.4	2.5	3.8	1.4	-1.8	2.6
1997	1.3	2.3	3.7	1.2	-2.0	2.8
1998	1.0	2.1	3.4	0.9	-2.6	3.2
1999	0.9	1.9	3.2	0.7	-2.6	3.2
2000	1.0	1.7	3.1	0.4	-1.7	3.4
2001	0.9	1.5	3.0	0.2	-2.2	4.3
2002	0.7	1.3	2.9	0.0	-2.4	4.3
2003	0.5	1.3	2.8	-0.2	-3.0	3.1
2004	0.5	1.3	2.8	-0.2	-3.3	2.7
Forecast:						
2005	0.5	1.3	2.8	-0.1	-3.4	2.9
2006	0.7	1.3	2.6	-0.1	-2.3	2.7
2007	0.8	1.3	2.5	-0.1	-2.0	2.1

Rebasing the CIPI from FY 1997 to FY 2002 decreased the percent change in the FY 2006 forecast by 0.1 percentage point, from 0.8 to 0.7, as shown in Chart 12. The difference is caused mostly by changes in the relationships between the cost category weights within depreciation and interest. The fixed depreciation cost weight relative to the movable depreciation cost weight and the nonprofit/government interest cost weight relative to the for-profit interest cost weight are both less in the FY 2002-based CIPI. The changes in these relationships have a small effect on the FY 2002-based CIPI percent changes. However, when added together, they are responsible for a negative one-tenth percentage point difference between the FY 2002-based CIPI and the FY 1997-based CIPI.

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

A. Postacute Care Transfer Payment Policy (§ 412.4)

(If you choose to comment on issues in this section, please include the caption "Postacute Care Transfers'' at the beginning of your comment.)

1. Background

Existing regulations at § 412.4(a) define discharges under the IPPS as situations in which a patient is formally released from an acute care hospital or dies in the hospital. Section 412.4(b) defines transfers from one acute care hospital to another, and § 412.4(c) defines transfers to certain postacute care providers. Our policy provides that, in transfer situations, full payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

The per diem rate paid to a transferring hospital is calculated by dividing the full DRG payment by the geometric mean length of stay for the DRG. Based on an analysis that showed that the first day of hospitalization is the most expensive (60 FR 45804), our policy provides for payment that is double the per diem amount for the first day (§ 412.4(f)(1)). Transfer cases are also eligible for outlier payments. The outlier threshold for transfer cases is equal to the fixed-loss outlier threshold for nontransfer cases, divided by the geometric mean length of stay for the DRG, multiplied by the length of stay for the case, plus one day. The purpose of the IPPS transfer payment policy is to avoid providing an incentive for a hospital to transfer patients to another hospital early in the patients' stay in order to minimize costs while still receiving the full DRG payment. The transfer policy adjusts the payments to approximate the reduced costs of transfer cases.

2. Changes to DRGs Subject to the Postacute Care Transfer Policy (§§ 412.4(c) and (d))

Section 1886(d)(5)(J) of the Act provides that, effective for discharges on or after October 1, 1998, a "qualified discharge'' from one of 10 DRGs selected by the Secretary to a postacute care provider would be treated as a transfer case. This section required the Secretary to define and pay as transfers all cases assigned to one of 10 DRGs selected by the Secretary, if the

individuals are discharged to one of the following postacute care settings:

- A hospital or hospital unit that is not a subsection 1886(d) hospital. (Section 1886(d)(1)(B) of the Act identifies the hospitals and hospital units that are excluded from the term "subsection (d) hospital'' as psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals.)
- A SNF (as defined at section 1819(a) of the Act).
- Home health services provided by a home health agency, if the services relate to the condition or diagnosis for which the individual received inpatient hospital services, and if the home health services are provided within an appropriate period (as determined by the Secretary).

In the July 31, 1998 IPPS final rule (63 FR 40975 through 40976), we specified that a patient discharged to home would be considered transferred to postacute care if the patient received home health services within 3 days after the date of discharge. In addition, in the July 31, 1998 final rule, we did not include patients transferred to a swing-bed for skilled nursing care in the definition of postacute care transfer cases (63 FR 40977).

Section 1886(d)(5)(J) of the Act directed the Secretary to select 10 DRGs based upon a high volume of discharges to postacute care and a disproportionate use of postacute care services. As discussed in the July 31, 1998 final rule, these 10 DRGs were selected in 1998 based on the MedPAR data from FY 1996. Using that information, we identified and selected the first 20 DRGs that had the largest proportion of discharges to postacute care (and at least 14,000 such transfer cases). In order to select 10 DRGs from the 20 DRGs on our list, we considered the volume and percentage of discharges to postacute care that occurred before the mean length of stay and whether the discharges occurring early in the stay were more likely to receive postacute care. We identified 10 DRGs to be subject to the postacute care transfer rule starting in FY 1999.

Section 1886(d)(5)(J)(iv) of the Act authorizes the Secretary to expand the postacute care transfer policy for FY 2001 or subsequent fiscal years to additional DRGs based on a high volume of discharges to postacute care facilities and a disproportionate use of postacute care services. In the FY 2004 IPPS final rule (68 FR 45412), we expanded the postacute care transfer policy to include additional DRGs. We established the following criteria that a DRG must meet, for both of the 2 most recent years for which data are available, in order to be included under the postacute care transfer policy:

- At least 14,000 postacute care transfer cases;
- At least 10 percent of its postacute care transfers occurring before the geometric mean length of stay;
- A geometric mean length of stay of at least 3 days; and
- If a DRG is not already included in the policy, a decline in its geometric mean length of stay during the most recent 5-year period of at least 7 percent.

In the FY 2004 IPPS final rule, we identified 21 new DRGs that met these criteria. We also determined that one DRG from the original group of 10 DRGs (DRG 263) no longer met the volume criterion of 14,000 transfer cases. Therefore, we removed DRGs 263 and 264 (DRG 264 is paired with DRG 263) from the policy and expanded the postacute care transfer policy to include payments for transfer cases in the new 21 DRGs, effective October 1, 2003. As a result, a total of 29 DRGs were subject to the postacute care transfer policy in FY 2004. In the FY 2004 IPPS final rule, we indicated that we would review and update this list periodically to assess whether additional DRGs should be added or existing DRGs should be removed (68 FR 45413).

For FY 2005, we analyzed the available data from the FY 2003 MedPAR file. For the 2 most recent years of available data (FY 2002 and FY 2003), we found that no additional DRGs qualified under the four criteria set forth in the IPPS final rule for FY 2004. We also analyzed the DRGs included under the policy for FY 2004 to determine if they still met the criteria to remain under the policy. In addition, we analyzed the special circumstances arising from a change to one of the DRGs included under the policy in FY 2004.

In the FY 2005 IPPS final rule (69 FR 48942), we deleted DRG 483 (Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnosis) and established the following new DRGs as replacements: DRG 541 (Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses With Major O.R. Procedure) and DRG 542 (Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses Without Major O.R. Procedure). Cases in the existing DRG 483 were assigned to the new DRGs 541 and 542 based on the presence or absence of a major O.R. procedure, in addition to the tracheostomy code that was previously required for assignment to DRG 483. Specifically, if the patient's case involves a major O.R. procedure (a procedure whose code is included on the list that is assigned to DRG 468 (Extensive O.R. Procedure Unrelated to Principal Diagnosis), except for tracheostomy codes 31.21 and 31.29), the case is assigned to the DRG 541. If the patient does not have an additional major O.R. procedure (that is, if there is only a tracheostomy code assigned to the case), the case is assigned to DRG 542.

Based on data analysis, we determined that neither DRG 541 nor DRG 542 would have enough cases to meet the existing threshold of 14,000 transfer cases for inclusion in the postacute care transfer policy. Nevertheless, we believed the cases that would be incorporated into these two DRGs remained appropriate candidates for application of the postacute care transfer policy and that the subdivision of DRG 483 should not change the original application of the postacute care transfer policy to the cases once included in that DRG. Therefore, for FY 2005, we proposed alternate criteria to be applied in cases where DRGs do not satisfy the existing criteria, for discharges occurring on or after October 1, 2004 (69 FR 28273 and 28374). The proposed new criteria were designed to address situations such as those posed by the split of DRG 483, where there remain substantial grounds for inclusion of cases within the postacute care transfer policy, although one or more of the original criteria may no longer apply. Under the proposed alternate criteria, DRGs 430, 541, and 542 would have qualified for inclusion in the postacute care transfer policy.

In the response to comments on our FY 2005 proposal, we decided not to adopt the proposed alternate criteria for including DRGs under the postacute care transfer policy in the FY 2005 IPPS final rule. Instead we adopted the policy of simply grandfathering, for a period of 2 years, any cases that were previously included within a DRG that has split, when the split DRG qualified for inclusion in the postacute care transfer policy for both of the previous 2 years. Under this policy, the cases that were previously assigned to DRG 483 and that now fall into DRGs 541 and 542 continue to be subject to the policy. Therefore, effective for discharges on or after October 1, 2004, 30 DRGs, including new DRGs 541 and 542, are subject to the postacute care transfer policy. We indicated that we would monitor the frequency with which these

cases are transferred to postacute care settings and the percentage of these cases that are short-stay transfer cases. Because we did not adopt the proposed alternate criteria for DRG inclusion in the postacute care transfer policy, DRG 430 (Psychoses) did not meet the criteria for inclusion and has not been subject to the postacute care transfer policy for FY 2005. We also invited comments on how to treat the cases formerly included in a split DRG after the grandfathering period.

We note that some commenters also suggested that, in place of the proposed alternate criteria, we should adopt a policy of permanently applying the postacute care transfer policy to a DRG once it has initially qualified for inclusion in the policy. These commenters noted that removing DRGs from the postacute care transfer policy makes the payment system less stable and results in inconsistent incentives over time. They also argued that "a drop in the number of transfers to postacute care settings is to be expected after the transfer policy is applied to a DRG, but the frequency of transfers may well rise again if the DRG is removed from the policy.'' We indicated that we would consider adopting this general policy once we had evaluated the experience with the specific cases that are subject to the grandfathering policy for FY 2005 and FY 2006.

In the May 18, 2004 proposed rule, we also called attention to the data concerning DRG 263, which was subject to the postacute care transfer policy until FY 2004. We removed DRG 263 from the postacute care transfer policy for FY 2004 because it did not have the minimum number of cases (14,000) transferred to postacute care (13,588 transfer cases in FY 2002, with more than 50 percent of transfer cases being short-stay transfers). The FY 2003 MedPAR data show that there were 15,602 transfer cases in the DRG in FY 2003, of which 46 percent were short-stay transfers. Because we removed the DRG from the postacute care transfer policy in FY 2004, it must meet all criteria to be included under the policy in subsequent fiscal years. Because the geometric mean length of stay for DRG 263 showed only a 6-percent decrease since 1999, DRG 263 did not qualify to be added to the policy for FY 2005 under the existing criteria that were included in last year's rule. DRG 263 would have qualified under the volume threshold and percent of short-stay transfer cases under the proposed new alternate criteria contained in the FY 2005 proposed rule. However, it still would not have met the proposed required decline in length of stay to qualify to be added to the policy for FY 2005. We indicated that we would continue to monitor the experience with DRG 263, especially in light of the comment that recommended a general policy of grandfathering cases that qualify under the criteria for inclusion in the postacute care transfer policy.

The table below displays the 30 DRGs that are included in the postacute care transfer policy, effective for discharges occurring on or after October 1, 2004.

DRG	DRG Title
12	Degenerative Nervous System Disorders
14	Intracranial Hemorrhage and Stroke with Infarction
24	Seizure and Headache Age >17 With CC
25	Seizure and Headache Age >17 Without CC
88	Chronic Obstructive Pulmonary Disease
89	Simple Pneumonia and Pleurisy Age > 17 With CC
90	Simple Pneumonia and Pleurisy Age >17 Without CC
113	Amputation for Circulatory System Disorders Except Upper Limb and Toe
121	Circulatory Disorders With AMI and Major Complication, Discharged Alive
122	Circulatory Disorders With AMI Without Major Complications Discharged Alive
127	Heart Failure & Shock
130	Peripheral Vascular Disorders With CC
131	Peripheral Vascular Disorders Without CC
209	Major Joint and Limb Reattachment Procedures of Lower Extremity
210	Hip and Femur Procedures Except Major Joint Age >17 With CC
211	Hip and Femur Procedures Except Major Joint Age >17 Without CC
236	Fractures of Hip and Pelvis
239	Pathological Fractures and Musculoskeletal and Connective Tissue Malignancy
277	Cellulitis Age >17 With CC
278	Cellulitis Age >17 Without CC
294	Diabetes Age>35
296	Nutritional and Miscellaneous Metabolic Disorders Age >17 With CC
297	Nutritional and Miscellaneous Metabolic Disorders Age >17 Without CC
320	Kidney and Urinary Tract Infections Age >17 With CC
321	Kidney and Urinary Tract Infections Age >17 Without CC
395	Red Blood Cell Disorders Age >17
429	Organic Disturbances and Mental Retardation
468	Extensive O.R. Procedure Unrelated to Principal Diagnosis
541 (formerly 483)	Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses With Major O.R. Procedure
542 (formerly 483)	Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses Without Major O.R. Procedure

For this year's proposed rule, we have conducted an extensive analysis of the FY 2003 and FY 2004 MedPAR data to monitor the effects of the postacute care transfer policy. We have also conducted an overall assessment of the postacute care transfer policy since its inception in FY 1999. Specifically, we have examined the relationship between rates of postacute care utilization and the geometric mean length of stay and the relationship between a high volume and a high proportion of postacute care transfers within a DRG in light of experience under the current policy. Specifically, we examined whether a decline in the geometric mean length of stay is associated with an increase in the volume and proportion of total cases in a DRG that are discharges to postacute care. We analyzed these data as part of determining whether to retain the criteria that a DRG must have a decline in the geometric mean length of stay of

at least 7 percent in the previous 5-year period to be included under the postacute care transfer policy.

Our current criteria for inclusion in the postacute care transfer policy include a requirement that, if a DRG is not already included in the policy, there must be a decline of at least 7 percent in the DRG's geometric mean length of stay during the most recent 5-year period. It has come to our attention that not all DRGs that experience an increase in postacute care utilization also experience a decrease in geometric mean length of stay. In fact, some DRGs with increases in postacute care utilization during the past several years have also experienced an increase in the geometric mean length of stay. The table below lists a number of DRGs that experienced increases in postacute care utilization and increases in the geometric mean length of stay from FY 2002 through FY 2004:

DRG	DRG Title	Percent Change in Geometric Mean Length of Stay	Percent Change in Postacute Care Utilization
1	Craniotomy Age >17 With CC	5.26	2.70
6	Carpal Tunnel Release	4.76	56.92
15	Nonspecific CVA and Precerebral Occlusion Without Infarction	30.00	27.75
40	Extraocular Procedures Except Orbit Age >17	12.50	15.47
42	Intraocular Procedures Except Retina, Iris, and Lens	12.75	6.71
51	Salivary Gland Procedures Except Sioloadenectomy	5.56	20.00
55	Miscellaneous Ear, Nose, Mouth, and Throat Procedures	11.11	22.22
113	Amputation for Circulatory System disorders Except Upper Limb and Toe	2.04	21.25
118	Cardiac Pacemaker Device Replacement	11.11	30.29
223	Major Shoulder/Elbow Procedure or Other Upper Extremity Procedure With CC	4.76	36.17
317	Admittance for Renal Dialysis	20.00	80.84
319	Kidney and Urinary Tract Neoplasms Without CC	4.76	24.49
345	Other Male Reproductive System O.R. Procedure Except for Malignancy	11.11	94.34
447	Allergic Reactions Age >17	5.56	16.81
494	Laparoscopic Cholecystectomy Without C.D.E. Without CC	5.26	26.39

Our current criteria also include a requirement that a DRG have at least 14,000 total postacute care transfer cases in order to be included in the policy. We have examined the data on the numbers of transfers and the percentage of postacute care transfer cases across DRGs. Among the 30 DRGs currently included within the postacute care transfer policy, the percentage of postacute care transfer cases ranges from a low of 15 percent to a high of 76 percent. Among DRGs that are not currently included within the policy, many have a relatively high percentage of postacute care transfer cases in proportion to the total volume of cases for the DRG or a relatively high volume of discharges to postacute care facilities, or both. For this reason, we reviewed the data for all DRGs before proposing a change to the postacute care transfer payment policy. As part of this review, we found that:

- Of 550 DRGs, 26 have been deactivated and 17 have no cases in the FY 2004 MedPAR files. We are not proposing any changes for these DRGs because application of the postacute care transfer policy to them would have no effect.
- Of the remaining 507 DRGs, 220 have geometric mean lengths of stay that are less than 3.0 days. Because the transfer payment policy provides 2 times the per diem rate for the first day of care (due to the large proportion of charges incurred on the first day of a patient's treatment), including these DRGs in the transfer policy would be relatively meaningless as they would all receive a full DRG payment. For this reason, we are not proposing any

changes to the postacute care transfer policy for these DRGs.

• Of the remaining 287 DRGs, 64 have fewer than 100 short-stay transfer cases. In addition, 39 of these 64 DRGs have fewer than 50 short-stay transfer cases. Consistent with the statutory guidance, we are not proposing any change to how we apply the postacute care transfer payment policy to these DRGs because we believe that these DRGs do not have a high volume of discharges to postacute care facilities or involve a disproportionate use of postacute care services.

Once we eliminated the DRGs cited above from consideration for the postacute care transfer policy, we examined the characteristics of the remaining 223 DRGs. We found that these DRGs had three common characteristics:

• The DRG had at least 2,000 total postacute care transfer cases.

• At least 20 percent of all cases in the DRG were discharged to postacute care settings.

• 10 percent of all discharges to postacute care were prior to the geometric mean length of stay for the DRG.

Consistent with the statutory guidance giving the Secretary the authority to make a DRG subject to the postacute care transfer policy based on a high volume of discharges to postacute care facilities and a disproportionate use of postacute care services, we believe these DRGs have characteristics that make them appropriate for inclusion in the postacute care transfer policy.

As a result of our analysis, we believe that it is appropriate to consider major revisions to the criteria for including a DRG within the postacute care transfer policy. First, our analysis calls into question the requirement that a DRG experience a decline in the geometric mean length of stay over the most recent 5-year period. Our findings that some DRGs with increases in postacute care utilization during the past several years have also experienced increases in geometric mean length of stay indicate that this criterion is no longer effective to identify those DRGs that should be subject to the postacute care transfer policy. In addition, our findings about the number of DRGs with relatively high volumes (at least 2,000 cases) and relatively high proportions (at least 20 percent) of postacute care utilization suggest that we should revise the requirement that a DRG have at least 14,000 total postacute care transfer cases to be included within the postacute care transfer policy.

Our analysis does confirm that it is appropriate to maintain the requirement that a DRG must have a geometric mean length of stay of at least 3.0 days in order to be included within the postacute care transfer policy. We believe that this policy should be retained because, under the transfer payment methodology, hospitals receive the entire payment for cases in these DRGs in the first 2 days of the stay. Lowering the limit below 3.0 days would, therefore, have no effect on payment for DRGs with geometric mean lengths-of-stay in this range. For the reasons discussed in the May 19, 2003 proposed rule (68 FR 27199) and because it is a common characteristic of DRGs with a large number of cases discharged to postacute care, we also continue to believe that it is appropriate to retain the criterion that at least 10 percent of all cases that are transferred to postacure care should be short-stay cases where the patient is transferred before the geometric mean length of stay for the DRG. We also continue to believe that both DRGs in a CC/non-CC pair should be subject to the postacute care transfer policy if one of the DRGs meets the criteria for inclusion. By including both DRGs in a CC/non-CC pair, our policy will preclude an incentive for hospitals to code cases in ways designed to avoid triggering the application of the policy, for example, by excluding codes that would identify a complicating or comorbid condition in order to assign a case to a non-CC DRG that is not subject to the policy.

Therefore, we are considering substantial revisions to the four criteria that are currently used to determine whether a DRG qualifies for inclusion in the postacute care transfer policy. The current criteria provide that, in order to be included within the policy, a DRG must have, for both of the 2 most recent years for which data are available:

• At least 14,000 total 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;

• 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; and

• If the DRG is one of a paired set of DRGs based on the presence or absence of a comorbidity or complication, both paired DRGs are included if either one meets the first three criteria above.

As a result of our analysis, we considered two options for revising the current criteria. Option 1 is to include all DRGs within the postacute care transfer policy. This option has the advantage of providing consistent treatment of all DRGs. However, as we discussed above, our analysis tends to indicate that, at a minimum, it may be appropriate to maintain the requirement that a DRG must have a geometric mean length of stay of at least 3.0 days because, under the transfer payment methodology, hospitals receive the entire payment for these DRGs in the first 2 days of the stay. Lowering the limit below 3.0 days, would therefore have little or no effect on payment for DRGs with geometric mean lengths of stay in this range.

Option 2 that we considered is to expand the application of the postacute care transfer policy by applying the policy to any DRG that meets the following criteria:

• The DRG has at least 2,000 postacute care transfer cases;

• At least 20 percent of the cases in the DRG are discharged to postacute care;

• Out of the cases discharged to postacute care, at least 10 percent occur before the geometric mean length of stay for the DRG;.

• The DRG has a geometric mean length of stay of at least 3.0 days;

• If the DRG is one of a paired set of DRGs based on the presence or absence of a comorbidity or complication, both paired DRGs are included if either one meets the first three criteria above.

Option 2 would expand the application of the postacute care transfer policy to 223 DRGs that have both a relatively high volume and a relatively high proportion of postacute care utilization. The proposed change would also avoid applying the postacute care transfer policy to DRGs with only a small number or proportion of cases transferred to postacute care. The table below shows the DRGs that would be included in the postacute care transfer policy under this option:

DRG	DRG Title
1	Craniotomy Age >17 With CC
2	Craniotomy Age >17 Without CC
7	Peripheral & Cranial Nerve & Other Nervous System Procedures With CC
8	Peripheral & Cranial Nerve & Other Nervous System Procedures Without CC
10	Nervous System Neoplasms With CC
11	Nervous System Neoplasms Without CC
12	Degenerative Nervous System Disorders
13	Multiple Sclerosis & Cerebellar Ataxia
14	Intracranial Hemorrhage or Cerebral Infarction
15	Nonspecific CVA & Precerebral Occlusion Without Infarction
16	Nonspecific Cerebrovascular Disorders With CC
17	Nonspecific Cerebrovascular Disorders Without CC
18	Cranial & Peripheral Nerve Disorders With CC
19	Cranial & Peripheral Nerve Disorders Without CC
20	Nervous System Infection Except Viral Meningitis
24	Seizure & Headache Age >17 With CC
25	Seizure & Headache Age >17 Without CC
28	Traumatic Stupor & Coma, Coma <1 Hour Age >17 With CC
29	Traumatic Stupor & Coma, Coma <1 Hour Age >17 Without CC
34	Other Disorders of the Nervous System With CC
35	Other Disorders of the Nervous System Without CC
68	Ottis Media & URI Age >17 With CC
69	Ottis Media & URI Age >17 Without CC
73	Other Ear, Nose, Mouth & Throat Diagnoses Age >17
75	Major Chest Procedures
76	Other Respiratory System O.R. Procedures With CC
77	Other Respiratory System O.R. Procedures Without CC

DRG	DRG Title
78	Pulmonary Embolism
79	Respiratory Infections & Inflammations Age >17 With CC
80	Respiratory Infections & Inflammations Age >17 Without CC
82	Respiratory Neoplasms
83	Major Chest Trauma With CC
84	Major Chest Trauma Without CC
85	Pleural Effusion With CC
86	Pleural Effusion Without CC
88	Chronic Obstructive Pulmonary Disease
89	Simple Pneumonia & Pleurisy Age >17 With CC
90	Simple Pneumonia & Pleurisy Age >17 Without CC
92	Interstitial Lung Disease With CC
93	Interstitial Lung Disease Without CC
94	Pneumothorax With CC
95	Pneumothorax Without CC
96	Bronchitis & Asthma Age >17 With CC
97	Bronchitis & Asthma Age >17 Without CC
101	Other Respiratory System Diagnoses With CC
102	Other Respiratory System Diagnoses Without CC
104	Cardiac Valve & Other Major Cardiothoracic Procedures With Cardiac Catheterization
105	Cardiac Valve & Other Major Cardiothoracic Procedures Without Cardiac Catheterization
107	Coronary Bypass With Cardiac Catheterization
108	Other Cardiothoracic Procedures
109	Coronary Bypass Without PTCA or Cardiac Catheterization
113	Amputation for Circulatory System Disorders Except Upper Limb & Toe
114	Upper Limb & Toe Amputation for Circulatory System Disorders
120	Other Circulatory System O.R. Procedures
121	Circulatory Disorders With AMI & Major Complications, Discharged Alive
126	Acute & Subacute Endocarditis
127	Heart Failure & Shock
130	Peripheral Vascular Disorders With CC
131	Peripheral Vascular Disorders Without CC
135	Cardiac Congenital & Valvular Disorders Age >17 With Cc
136	Cardiac Congenital & Valvular Disorders Age >17 Without CC
138	Cardiac Arrhythmia & Conduction Disorders With CC
139	Cardiac Arrhythmia & Conduction Disorders Without CC

DRG	DRG Title
144	Other Circulatory System Diagnoses With CC
145	Other Circulatory System Diagnoses Without CC
146	Rectal Resection With CC
147	Rectal Resection Without CC
148	Major Small & Large Bowel Procedures With CC
149	Major Small & Large Bowel Procedures Without CC
150	Peritoneal Adhesiolysis With CC
154	Stomach, Esophageal & Duodenal Procedures Age >17 With CC
155	Stomach, Esophageal & Duodenal Procedures Age >17 Without CC
157	Anal & Stomal Procedures With CC
158	Anal & Stomal Procedures Without CC
159	Hernia Procedures Except Inguinal & Femoral Age >17 With CC
160	Hernia Procedures Except Inguinal & Femoral Age >17 Without CC
161	Inguinal & Femoral Hernia Procedures Age >17 With CC
162	Inguinal & Femoral Hernia Procedures Age >17 Without CC
170	Other Digestive System O.R. Procedures With CC
171	Other Digestive System O.R. Procedures Without CC
172	Digestive Malignancy With CC
173	Digestive Malignancy Without CC
174	G.I. Hemorrhage With CC
175	G.I. Hemorrhage Without CC
176	Complicated Peptic Ulcer
180	G.I. Obstruction With CC
181	G.I. Obstruction Without CC
182	Esophagitis, Gastroenteritis & Miscellaneous Digestive Disorders Age >17 With CC
183	Esophagitis, Gastroenteritis & Miscellaneous Digestive Disorders Age >17 Without CC
188	Other Digestive System Diagnoses Age >17 With CC
189	Other Digestive System Diagnoses Age >17 Without CC
191	Pancreas, Liver & Shunt Procedures With CC
192	Pancreas, Liver & Shunt Procedures Without CC
197	Cholecystectomy Except By Laparoscope Without C.D.E. With CC
198	Cholecystectomy Except By Laparoscope Without C.D.E. Without CC
202	Cirrhosis & Alcoholic Hepatitis
203	Malignancy of Hepatobiliary System or Pancreas
205	Disorders of Liver Except Malignant, Cirrhosis, Alcohol Hepatobiliary With CC
206	Disorders of Liver Except Malignant, Cirrhosis, Alcohol Hepatobiliary Without CC

DRG	DRG Title
210	Hip & Femur Procedures Except Major Joint Age >17 With CC
211	Hip & Femur Procedures Except Major Joint Age >17 Without CC
213	Amputation for Musculoskeletal System & Connective Tissue Disorders
216	Biopsies of Musculoskeletal System & Connective Tissue
217	Wound Debridement & Skin Graft Except Hand, for Musculoskeletal & Connective Tissue Disorders
219	Lower Extremity & Humerous Procedures Except Hip, Foot, Femur Age >17 Without CC
225	Foot Procedures
226	Soft Tissue Procedures With CC
227	Soft Tissue Procedures Without CC
233	Other Musculoskeletal System & Connective Tissue O.R. Procedures With CC
234	Other Musculoskeletal System & Connective Tissue O.R. Procedures Without CC
235	Fractures of Femur
236	Fractures Of Hip & Pelvis
238	Osteomyelitis
239	Pathological Fractures & Musculoskeletal & Connective Tissue Malignancy
240	Connective Tissue Disorders With CC
241	Connective Tissue Disorders Without CC
243	Medical Back Problems
250	FX, Sprain, Strain & Dislocation of Forearm, Hand, Foot Age >17 With CC
251	FX, Sprain, Strain & Dislocation of Forearm, Hand, Foot Age >17 Without CC
253	FX, Sprain, Strain & Dislocation of Upper arm, Lower leg Except Foot Age >17 With CC
254	FX, Sprain, Strain & Dislocation of Upper arm, Lower leg Except Foot Age >17 Without CC
256	Other Musculoskeletal System & Connective Tissue Diagnoses
263	Skin Graft &/or Debridement for Skin Ulcer or Cellulitis With CC
264	Skin Graft &/or Debridement for Skin Ulcer or Cellulitis Without CC
265	Skin Graft &/or Debridement Except for Skin Ulcer or Cellulitis With CC
266	Skin Graft &/or Debridement Except for Skin Ulcer or Cellulitis Without CC
269	Other Skin, Subcutaneous Tissue & Breast Procedure With CC
270	Other Skin, Subcutaneous Tissue & Breast Procedure Without CC

DRG	DRG Title
271	Skin Ulcers
272	Major Skin Disorders With CC
273	Major Skin Disorders Without CC
277	Cellulitis Age >17 With CC
278	Cellulitis Age >17 Without CC
280	Trauma to the Skin, Subcutaneous Tissue & Breast Age >17 With CC
281	Trauma to the Skin, Subcutaneous Tissue & Breast Age >17 Without CC
283	Minor Skin Disorders With CC
284	Minor Skin Disorders Without CC
285	Amputation of Lower Limb for Endocrine, Nutrition, & Metabolism Disorders
287	Skin Grafts & Wound Debridement for Endocrine, Nutrition & Metabolism Disorders
292	Other Endocrine, Nutrition & Metabolism O.R. Procedure With CC
293	Other Endocrine, Nutrition & Metabolism O.R. Procedure Without CC
294	Diabetes Age >35
296	Nutritional & Miscellaneous Metabolic Disorders Age >17 With CC
300	Endocrine Disorders With CC
301	Endocrine Disorders Without CC
303	Kidney, Ureter & Major Bladder Procedures for Neoplasm
304	Kidney, Ureter & Major Bladder Procedures for Non-Neoplasm With CC
305	Kidney,Ureter & Major Bladder Procedures for Non-Neoplasm Without CC
308	Minor Bladder Procedures With CC
309	Minor Bladder Procedures Without CC
310	Transurethral Procedures With CC
311	Transurethral Procedures Without CC
316	Renal Failure
320	Kidney & Urinary Tract Infections Age >17 With CC
321	Kidney & Urinary Tract Infections Age >17 Without CC
331	Other Kidney & Urinary Tract Diagnoses Age >17 With CC
332	Other Kidney & Urinary Tract Diagnoses Age >17 Without CC
354	Uterine, Adnexa Procedures for Non-Ovarian/Adnexal Malignant With CC
355	Uterine, Adnexa Procedure for Non-Ovarian/Adnexal Malignant Without CC
395	Red Blood Cell Disorders Age >17
397	Coagulation Disorders
398	Reticuloendothelial & Immunity Disorders With CC

DRG	DRG Title
399	Reticuloendothelial & Immunity Disorders Without CC
401	Lymphoma & Non-Acute Leukemia With Other O.R. Procedures With CC
402	Lymphoma & Non-Acute Leukemia With Other O.R. Procedures Without CC
403	Lymphoma & Non-Acute Leukemia With CC
404	Lymphoma & Non-Acute Leukemia Without CC
415	O.R. Procedure for Infectious & Parasitic Diseases
416	Septicemia Age >17
418	Postoperative & Post-Traumatic Infections
419	Fever of Unknown Origin Age >17 With CC
420	Fever of Unknown Origin Age >17 Without CC
421	Viral Illness Age >17
423	Other Infectious & Parasitic Diseases Diagnoses
429	Organic Disturbances & Mental Retardation
440	Wound Debridements for Injuries
442	Other O.R. Procedures for Injuries With CC
443	Other O.R. Procedures for Injuries Without CC
444	Traumatic Injury Age >17 With CC
445	Traumatic Injury Age >17 Without CC
453	Complications of Treatment Without CC
462	Rehabilitation
463	Signs & Symptoms With CC
464	Signs & Symptoms Without CC
468	Extensive O.R. Procedure Unrelated to Principal Diagnosis
471	Bilateral or Multiple Major Joint Procedures of Lower Extremity
473	Acute Leukemia Without Major O.R. Procedure Age >17
475	Respiratory System Diagnosis With Ventilator Support
477	Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis
478	Other Vascular Procedures With CC
479	Other Vascular Procedures Without CC
482	Tracheostomy for Face, Mouth & Neck Diagnoses
485	Limb Reattachment, Hip and Femur Procedures for Multiple Significant Trauma
487	Other Multiple Significant Trauma
489	HIV With Major Related Condition
493	Laparoscopic Cholecystectomy Without C.D.E. With CC
494	Laparoscopic Cholecystectomy Without C.D.E. Without CC
497	Spinal Fusion Except Cervical With CC
498	Spinal Fusion Except Cervical Without CC

DRG	DRG Title
499	Back & Neck Procedures Except Spinal Fusion With CC
500	Back & Neck Procedures Except Spinal Fusion Without CC
501	Knee Procedures With PDX of Infection With CC
502	Knee Procedures With PDX of Infection Without CC
519	Cervical Spinal Fusion With CC
520	Cervical Spinal Fusion Without CC
521	Alcohol/Drug Abuse or Dependence With CC
522	Alcohol/Drug Abuse or Dependence With Rehabilitation Therapy Without CC
529	Ventricular Shunt Procedures With CC
530	Ventricular Shunt Procedures Without CC
531	Spinal Procedures With CC
532	Spinal Procedures Without CC
535	Cardiac Defibrillator Implant With Cardiac Catheter With AMI/HF/Shock
537	Local Excision & Removal of Internal Fixation Device Except Hip & Femur With CC
538	Local Excision & Removal of Internal Fixation Device Except Hip & Femur Without CC
541	Tracheostomy With Mechanical Ventilation 96+Hrs or PDX Except Face, Mouth, & Neck Diagnosis With Major O.R.
542	Tracheostomy With Mechanical Ventilation 96+Hrs or PDX Except Face, Mouth, & Neck Diagnosis Without Major O.R.
543	Craniotomy With Implant of Chemotherapy Agent or Acute Complex CNS Principal Diagnosis
544	Major Joint Replacement or Reattachment
545	Revision of Hip or Knee Replacement
547	Percutaneous Cardiovascular Procedure With Drug-Eluting Stent With AMI With CC
548	Percutaneous Cardiovascular Procedure With Drug-Eluting Stent With AMI Without CC
549	Percutaneous Cardiovascular Procedure With Drug-Eluting Stent Without AMI With CC
550	Percutaneous Cardiovascular Procedure With Drug-Eluting Stent Without AMI Without CC

We believe that the analysis that we have conducted suggest that substantial revisions to the criteria for including a DRG within the postacute care transfer policy are warranted. In this proposed rule, we are formally proposing Option 2 as presented above. However, we invite comments on both of these options and on the analysis that we have presented.

The impact section in Appendix A of this proposed rule discusses our findings on the effects of adopting Option 2. The proposed DRG relative weights included in Tables 5 and 7 of the Addendum to this proposed rule also include the effect of changing the postacute care transfer policy as described in Option 2 above. We note that if we adopt either option discussed above, or a variation based on comments submitted, we would follow procedures similar to those that are currently followed for treating cases identified as transfers in the DRG recalibration process. That is, as described in the discussion of DRG recalibration in section II.C. of the preamble to this proposed rule, additional transfer cases would be counted as a fraction of a case based on the ratio of a hospital's transfer payment under the per diem payment methodology to the full DRG payment for nontransfer cases.

Section 1886(d)(5)(J)(i) of the Act recognizes that, in some cases, a substantial portion of the cost of care is incurred in the early days of the inpatient stay. Similar to the policy for

transfers between two acute care hospitals, transferring hospitals receive twice the per diem rate for the first day of treatment and the per diem rate for each following day of the stay before the transfer, up to the full DRG payment, for cases discharged to postacute care. However, three of the DRGs subject to the postacute care transfer policy exhibit an even higher share of costs very early in the hospital stay in postacute care transfer situations. For these DRGs, hospitals receive 50 percent of the full DRG payment plus the single per diem (rather than double the per diem) for the first day of the stay and 50 percent of the per diem for the remaining days of the stay, up to the full DRG payment.

In previous years, we determined that DRGs 209 and 211 met this cost threshold and qualified to receive this special payment methodology. Because DRG 210 is paired with DRG 211, we include payment for cases in that DRG for the same reason we include paired DRGs in the postacute care transfer policy (to eliminate any incentive to code incorrectly in order to receive higher payment for those cases). The FY 2004 MedPAR data show that DRGs 209 and 211 continue to have charges on the first day of the stay that are higher than 50 percent of the average charges in the DRGs. In addition, several of the DRGs that may be added to the postacute care transfer policy under the options that we are considering may also meet the 50 percent threshold in their average charges. We have identified those additional DRGs that are subject to the special payment methodology in Tables 5 and 7 of the Addendum to this proposed rule.

B. Reporting of Hospital Quality Data for Annual Hospital Payment Update (§ 412.64(d)(2))

(If you choose to comment on issues in this section, please include the caption "Hospital Quality Data'' at the beginning of your document.)

1. Background

Section 1886(b)(3)(B)(vii) of the Act, as added by section 501(b) of Pub. L. 108–173 revised the mechanism used to update the standardized amount of payment for inpatient hospital operating costs. Specifically, the statute provides for a reduction of 0.4 percentage points to the update percentage increase (also known as the market basket update) for each of FYs 2005 through 2007 for any "subsection (d) hospital'' that does not submit data on a set of 10 quality indicators established by the Secretary as of November 1, 2003. The statute also provides that any reduction will apply only to the fiscal year involved, and will not be taken into account in computing the applicable percentage increase for a subsequent fiscal year. This measure establishes an incentive for IPPS hospitals to submit data on the quality measures established by the Secretary.

We initially implemented section 1886(b)(3)(B)(vii) of the Act in the FY 2005 IPPS final rule (August 11, 2004, 69 FR 49078) in continuity with the Department's Hospital Quality Initiative as described at the CMS Web site: *http://www.cms.hhs.gov/quality/hospitals*. At a press conference on December 12, 2002, the Secretary of the Department of Health and Human Services (HHS) announced a series of steps that HHS and its collaborators were taking to promote public reporting of hospital quality information. These collaborators include the American Hospital Association, the Federation of American Hospitals, the Association of American Medical Colleges, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Quality Forum, the American Medical Association, the Consumer-Purchaser Disclosure Project, the American Association of Retired Persons, the American Federation of Labor-Congress of Industrial Organizations, the Agency for Healthcare Research and Quality, as well as CMS, Quality Improvement Organizations (QIOs), and others.

In July 2003, CMS began the National Voluntary Hospital Reporting Initiative (NVHRI), now known as the Hospital Quality Alliance (HQA): Improving Care through Information. Data from this initiative have been used to populate a professional Web site providing data to healthcare professionals. This website will be followed by the development of a consumer Web site in an easy-to-use format. The consumer Web site is intended to be an important tool for individuals to use in making decisions about health care options. This information will assist beneficiaries by providing comparison information for consumers who need to select a hospital. It will also serve as a way to encourage accountability of hospitals for the care they provide to patients.

The 10 measures that were employed in this voluntary initiative as of November 1, 2003, are:

- Heart Attack (Acute Myocardial Infarction)
  - Was aspirin given to the patient upon arrival to the hospital?
  - Was aspirin prescribed when the patient was discharged?
  - Was a beta-blocker given to the patient upon arrival to the hospital?
  - Was a beta-blocker prescribed when the patient was discharged?
  - Was an ACE inhibitor given for the patient with heart failure?
- Heart failure
  - Did the patient get an assessment of his or her heart function?
  - Was an ACE inhibitor given to the patient?
- Pneumonia
  - Was an antibiotic given to the patient in a timely way?
  - Had a patient received a pneumococcal vaccination?
  - Was the patient's oxygen level assessed?

These measures have been endorsed by the National Quality Forum (NQF) and are a subset of the same measures currently collected for the JCAHO by its accredited hospitals. The Secretary adopted collection of data on these 10 quality measures in order to: (1) provide useful and valid information about hospital quality to the public; (2) provide hospitals with a sense of predictability about public reporting expectations; (3) begin to standardize data and data collection mechanisms; and (4) foster hospital quality improvement. Many hospitals are currently participating in the National Voluntary Hospital Reporting Initiative (NVHRI), and are submitting data to the QIO Clinical Warehouse for that purpose.

Over the next several years, hospitals are encouraged to take steps toward the adoption of electronic medical records (EMRs) that will allow for reporting of clinical quality data from the electronic record directly to a CMS data repository. CMS intends to begin working toward creating measures specifications and a system or mechanism, or both, that will accept the data directly without requiring the transfer of the raw data into an XML file as currently exists. The Department is presently working cooperatively with other Federal agencies in the development of Federal health architecture data standards. CMS encourages hospitals that are developing systems to conform them to both industry standards and the Federal health architecture data standards, and to ensure that they would capture the data necessary for quality measures. Ideally, such systems will also provide point-of-care decision support that enables high levels of performance on the measures. Hospitals using EMRs to produce data on quality measures will be held to the same performance expectations as hospitals not using EMRs. We are exploring requirements for the submission of electronically produced data and other options to encourage the submission of such data, and invite comments on this issue.

2. Requirements for Hospital Reporting of Quality Data

The procedures for participating in the Reporting Hospital Quality Data for the Annual Payment Update (RHQDAPU) program created in accordance with section 501(b) of Pub. L. 108–173 can be found on the QualityNet Exchange at the Web site: *http://www.qnetexchange.org* in the "Reporting Hospital Quality Data for Annual Payment Update Reference Checklist''. This checklist also contains all of the forms to be completed by hospitals participating in the program. In order to participate in the hospital reporting initiative, hospitals must follow these steps:

• The hospital must identify a QualityNet Exchange Administrator who follows the registration process and submits the information through the QIO. This must be done regardless of whether the hospital uses a vendor for transmission of data.

• All participants must first register with the QualityNet Exchange, regardless of the method used for data submission. If a hospital is currently participating in the voluntary reporting initiative, re-registration on QualityNet Exchange is unnecessary. However, the hospital must complete the Reporting Hospital Quality Data for Annual Payment Update Notice of Participation form. All hospitals must send this form to their QIOs.

• The hospital must collect data for all 10 measures and submit the data to the QIO Clinical Warehouse either using the CMS Abstraction & Reporting Tool (CART), the JCAHO Oryx Core Measures Performance Measurement System (PMS), or another third-party vendor that has met the measurement specification requirements for data transmission to QualityNet Exchange. The QIO Clinical Warehouse will submit the data to CMS on behalf of the hospitals. The submission will be done through QualityNet Exchange, which is a secure site that voluntarily meets or exceeds all current Health Insurance Portability and Accountability Act (HIPAA) requirements, while maintaining QIO confidentiality as required under the relevant regulations and statutes. The information in the Clinical Warehouse is considered QIO data and, therefore, is subject to the stringent QIO confidentiality regulations in 42 CFR Part 480.

For the first year of the program, FY 2005, hospitals were required to begin the submission of data by July 1, 2004, under the provisions of section 1886(b)(3)(B)(vii)(II) of the Act, as added by section 501(b) of Pub. L. 108–173. Because section 501(b) of Pub. L. 108–173 granted a 30-day grace period for submission of data for purposes of the FY 2005 update, hospitals were given until August 1, 2004, for completed submissions to be successfully accepted into the QIO Clinical Warehouse. Hospitals were required to submit data for the first calendar quarter of 2004. We received data from over 98 percent of the eligible hospitals.

For FY 2006, we are proposing that hospitals must continuously submit the required 10 measures each quarter according to the schedule found on the Web site at *http://www.qnetexchange.org*. New facilities must submit the data using the same schedule, as dictated by the quarter they begin discharging patients. We will expect that all hospitals will have submitted data to the QIO Clinical Warehouse for discharges through the fourth quarter of calendar year 2004 (October to December 2004). Hospitals have 4½ months from the end of the fourth quarter until the closing of the warehouse (from December 31, 2004, until May 15, 2005) to make sure there are no errors in the submitted data. The warehouse is closed at that time in order to draw the validation sample and to begin preparing the public file for Hospital Compare public reporting. Data from fourth quarter 2004 discharges (October through December 2004) will be the last quarter of data with a submission deadline (May 15, 2005) that precedes our deadline for certifying the hospitals eligible to receive the full update for FY 2006. As we required for FY 2005, the data for each quarter must be submitted on time and pass all of the edits and consistency checks required in the clinical warehouse. Hospitals that do not treat a condition or have very few discharges will not be penalized and will receive the full annual payment update if they submit all the data they do possess.

New hospitals should begin collecting and reporting data immediately and complete the registration requirements for the RHQDAPU. New hospitals will be held to the same standard as established facilities when determining the expected number of discharges for the calendar quarters covered for each fiscal year. The annual payment updates would be based on the successful submission of data to CMS via the QIO Clinical Warehouse by the established deadlines.

For FY 2005, hospitals could withdraw from RHQDAPU at any time up to August 1, 2004. Hospitals withdrawing from the program did not receive the full market basket update and, instead, received a reduction of 0.4 percentage points in their update. By law, a hospital's actions each year will not affect its update in a subsequent year. Therefore, a hospital must meet the requirements for RHQDAPU each year the program is in effect. Failure of a hospital to receive the full update in one year does not affect its update in a succeeding year.

For the first year, FY 2005, there were no chart-audit validation criteria in place. Based upon our experience from the FY 2005 submissions, and upon our requirement for reliable and valid data, we are proposing to place the following additional requirements on hospitals for the data for the FY 2006 payment update. These requirements, as well as additional information on validation requirements, will be placed on QualityNet Exchange.

• The hospital must have passed our validation requirement of a minimum of 80 percent reliability, based upon our chart-audit validation process, for the third quarter data of calendar year 2004 in order to receive the full market basket update in FY 2006. These data were due to the clinical warehouse by February 15, 2005. We will use appropriate confidence intervals to determine if a hospital has achieved an 80-percent reliability. The use of confidence intervals will allow us to establish an appropriate range below the 80-percent reliability threshold that will demonstrate a sufficient level of validity to allow the data to still be considered valid. We will estimate the percent reliability based upon a review of five charts and then calculate the upper 95 percent confidence limit for that estimate. If this upper limit is above the required 80 percent, the hospital data will be considered validated. We are proposing to use the design specific estimate of the variance for the confidence interval calculation, which, in this case, is a single stage cluster sample, with unequal cluster sizes. (For reference, see Cochran, William G. (1977) Sampling Techniques, John Wiley & Sons, New York, chapter 3, section 3.12.)

We will use a two-step process to determine if a hospital is submitting valid data. At the first step, we will calculate the percent agreement for all of the variables submitted in all of the charts, whether or not they are related to the 10 measures. If a hospital falls below the 80 percent cutoff, we will then restrict the comparison to those variables associated with the 10 measures required under section 501(b) of Pub. L. 108–173. We will recalculate the percent agreement and the estimated 95 percent confidence interval and again compare to the 80 percent cutoff

point. If a hospital passes under this restricted set of variables, the hospital will be considered to be submitting valid data for purposes of this proposed rule.

Under the standard appeal process, all hospitals are given the detailed results of the Clinical Data Abstraction Center (CDAC) reabstraction along with their estimated percent reliability and the upper bound of the 95 percent confidence interval. If a hospital disagrees with any of the abstraction results from the CDAC, the hospital has 10 days to appeal these results to their QIO. The QIO will review the appeal with the hospital and, if the QIO review agrees with the hospitals original abstraction, the QIO will forward the appeal to the CDAC for a final determination. If the QIO does not agree with the hospital's appeal, then the original results stand. When the CDAC has made its final determination, the new results will be provided to the hospital through the usual processes and the validation described previously will be repeated. This process is described in detail at the following Web site: *http://www.qnetexchange.org.* Hospitals that fail to receive the required 80-percent reliability after the standard appeals process may ask that CMS accept the fourth quarter of calendar year 2004 validation results as a final attempt to present evidence of reliability. However, in order to process the fourth quarter data in time to meet our internal deadlines, these hospitals will need to submit the charts requested for reabstraction as soon as possible, but no later than August 1, 2005, in order for us to guarantee consideration of this information. Hospitals that make the early submission of these data and pass the 80-percent reliability minimum level will satisfy this requirement. In reviewing the data for these hospitals, we plan to combine the 5 cases from the third quarter and the 5 cases from the fourth quarter into a single sample to determine whether the 80 percent reliability level is met. This gives us the greatest accuracy when estimating the reliability level. The confidence interval approach accounts for the variation in coding among the 5 charts pulled each quarter and for the entire year around the overall hospital mean score (on all individual data elements compared). The closer each case's reliability score is to the hospital mean score, the tighter the confidence interval established for that hospital. A hospital may code each chart equally inaccurately, achieve a tight confidence interval, and fail to pass even though its overall score is just below the passing threshold (75 percent, for example). A hospital with more variation among charts will achieve a broader confidence interval, which may allow it to pass even though some charts score very low and others very high. As we gain experience with this system, we will adjust it as appropriate over time as we build our sample of validated cases and learn more about hospital performance against the thresholds we establish.

We believe we have adopted the most suitable statistical tests for the hospital data we are trying to validate, but we invite public comments on this and any other approaches hospitals choose to comment on. We are particularly interested in comments from hospitals on the initial starting points for the passing threshold, the confidence interval established, and the sampling approach. Because we will be receiving data each quarter from hospitals, our information on the sampling methodology will improve with each quarter's submissions. We will analyze this information to determine if any changes in our methodology are required. We will make any necessary revisions to the sampling methodology and the statistical approach through manual issuances and other guidance to hospitals.

• The hospital must have two consecutive quarters of publishable data. The information collected by CMS through this rule will be displayed for public viewing on the Internet. Prior to this display, hospitals are permitted to preview their information as we have it recorded. In our previous experience, a number of hospitals requested that this information not be displayed due to errors in the submitted data that were not of the sort that could be detected by the normal edit and consistency checks. We acquiesced to these requests in the public interest and because of our own desire to present correct data. However, we still believe that the hospital bears the responsibility of submitting correct data that can serve as valid and reliable information. Therefore, in order to receive the full market basket update for IPPS, we are proposing to establish a requirement for two consecutive quarters of publishable data. We published the first quarter of calendar year 2004 data in November 2004. The first two quarters of calendar year 2004 data were published in March 2005. Our plans are to publish the first three quarters of calendar year 2004 in August 2005. For the FY 2006 update, we will expect that all hospitals receiving the full market basket update for FY 2006 to have published data for all of the required 10 measures for both the March and August 2005 publications. Allowances would be made for hospitals that do not treat a particular condition and for new hospitals that have not had the opportunity to provide the required data.

C. Sole Community Hospitals (SCHs) and Medicare Dependent Hospitals (MDHs) (§§ 412.73, 412.75, 412.77, 412.92 and 412.108)

(If you choose to comment on issues in this section, please include the caption "Sole Community Hospitals and Medicare Dependent Hospitals'' at the beginning of your comments.)

1. Background

Under the IPPS, special payment protections are provided to a sole community hospital (SCH). Section 1886(d)(5)(D)(iii) of the Act defines an SCH as a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, absence of other like hospitals (as determined by the Secretary), or historical designation by the Secretary as an essential access community hospital, is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries. The regulations that set forth the criteria that a hospital must meet to be classified as an SCH are located in § 412.92 of the regulations. Although SCHs and MDHs are paid under a special payment methodology, they are hospitals that are paid under section 1886(d) of the Act. Like all IPPS hospitals paid under section 1886(d) of the Act, SCHs and MDHs are paid for their discharges based on the DRG weights calculated under section 1886(d)(4) of the Act.

Effective with hospital cost reporting periods beginning on or after October 1, 2000, section 1886(d)(5)(D)(i) of the Act (as amended by section 6003(e) of Pub. L. 101–239) and section 1886(b)(3)(I) of the Act (as added by section 405 of Pub. L. 106–113 and further amended by section 213 of Pub. L. 106–554), provide that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment to the hospital for the cost reporting period:

• The Federal rate applicable to the hospital;

• 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.

For purposes of payment to SCHs for which the FY 1996 hospital-specific rate yields the greatest aggregate payment, payments for discharges during FYs 2001, 2002, and 2003 were based on a

blend of the FY 1996 hospital-specific rate and the greater of the Federal rate or the updated FY 1982 or FY 1987 hospital-specific rate. For discharges during FY 2004 and subsequent fiscal years, payments based on the FY 1996 hospital-specific rate are 100 percent of the updated FY 1996 hospital-specific rate.

For each cost reporting period, the fiscal intermediary determines which of the payment options will yield the highest rate of payment. Payments are automatically made at the highest rate using the best data available at the time the fiscal intermediary makes the determination. However, it may not be possible for the fiscal intermediary to determine in advance precisely which of the rates will yield the highest payment by year's end. In many instances, it is not possible to forecast the outlier payments, the amount of the DSH adjustment, or the IME adjustment, all of which are applicable only to payments based on the Federal rate. The fiscal intermediary makes a final adjustment at the close of the cost reporting period to determine precisely which of the payment rates would yield the highest payment to the hospital.

If a hospital disagrees with the fiscal intermediary's determination regarding the final amount of program payment to which it is entitled, it has the right to appeal the fiscal intermediary's decision in accordance with the procedures set forth in subpart R of part 400, which concern provider payment determinations and appeals.

Under section 1886(d)(5)(G) of the Act, Medicare dependent hospitals (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. The regulations that set forth the criteria that a hospital must meet to be classified as an MDH are located in § 412.108.

2. Budget Neutrality Adjustment to Hospital Payments Based on Hospital-Specific Rate

Under section 1886(d)(4)(C)(i) of the Act, beginning in FY 1988 and for each fiscal year thereafter, the Secretary is required to adjust the DRG classifications and weighting factors established under sections 1886(d)(4)(A) and (d)(4)(B) of the Act to reflect changes in treatment patterns, technology, and other factors that may change the use of hospital resources. For discharges beginning in FY 1991, section 1886(d)(4)(C)(iii) of the Act requires the Secretary to ensure that adjustments to DRG classifications and weighting factors result in aggregate DRG payments that are budget neutral (not greater or less than the aggregate payments without the adjustments). In addition, section 1886(d)(3)(E) of the Act requires the Secretary to update the hospital wage index annually in a manner that does not affect aggregate payments to hospitals under section 1886(d) of the Act.

As discussed in the May 9, 1990 IPPS proposed rule (55 FR 19466), we normalize the proposed 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. While this adjustment is intended to ensure that recalibration does not affect total payments to hospitals under section 1886(d) of the Act, our analysis has indicated that the normalization adjustment does not achieve budget neutrality with respect to aggregate payments to hospitals under section 1886(d) of the Act. In order to comply with the requirement of section 1886(d)(4)(C)(iii) of the Act that the DRG reclassification changes and recalibration of the relative weights be budget neutral and the requirement of section 1886(d)(3)(E) of the Act that the updated wage index be implemented in a budget neutral manner, we compare the estimated aggregate payments using the current year's relative weights and wage index factors to aggregate payments using the prior year's weights and factors. Based on this comparison, we compute a budget neutrality adjustment factor. This budget neutrality adjustment factor is then applied to the standardized per discharge payment amount. Beginning in FY 1994, in applying the current year's budget neutrality adjustment factor to both the standard Federal rate and hospital-specific rates, we do not remove the prior years' budget neutrality adjustment factors because estimated aggregate payments after the changes in the DRG relative weights and wage index factors must equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy this condition. (58 FR 30269)

We are bound by the Act to ensure that aggregate payments to hospitals under section 1886(d) of the Act are projected to neither increase nor decrease as a result of the annual updates to the DRG classifications and weighting factors and for the updated wage indices. However, we have broad authority under the statute to determine the method for implementing budget neutrality. We have maintained since 1991 that the budget neutrality adjustment is applied, as described above, to all hospitals paid under section 1886(d) of the Act, including those that are paid based on a hospital-specific rate. Thus, the budget neutrality factor applies to payments to SCHs and MDHs.

Hospitals that are paid under section 1886(d) of the Act based on a hospital-specific rate are subject to the DRG reclassification and recalibration factor component of the budget neutrality adjustment because, as IPPS hospitals, they are paid based on DRGs. As described above, changes in DRG relative weights from one year to the next affect aggregate SCH and MDH payments, which in turn affect total Medicare payments to hospitals under section 1886(d) of the Act. Because SCHs and MDHs are paid under section 1886(d) of the Act, we believe their DRG payments should be factored into the DRG reclassification and recalibration factor component of the budget neutrality adjustment to ensure that recalibration does not affect total payments to hospitals under section 1886(d) of the Act. Therefore, we continue to believe it is appropriate to apply the DRG reclassification and recalibration factor component of the budget neutrality adjustment to SCHs and MDHs. Furthermore, consistent with the requirement of section 1886(d)(4)(C)(iii) of the Act that DRG reclassification changes and recalibration of relative weights be budget neutral, we continue to believe it is appropriate to apply this adjustment without removing the previous year's adjustment factor.

In the May 9, 1990 proposed rule (55 FR 19466), we discussed the rationale behind our decision to apply the wage index portion of the budget neutrality adjustment factors to hospitals that are paid under section 1886(d) of the Act based on a hospital-specific rate. We described how, even though the wage index is only applicable to those hospitals that are paid based on the Federal rate, the changes in wage index can cause changes in the payment basis for some SCHs, and MDHs. That is, depending on the size of the increase in their wage index values, some hospitals that had been paid based on the hospital-specific rate could now be paid based on the Federal rate when the wage index-adjusted Federal rate exceeds the hospital-specific rate. In some instances, hospitals that had previously been paid based on the Federal rate may be paid based on the hospital-specific rate if the Federal rate is adjusted by a lower wage

index and the hospital-specific rate now exceeds the Federal rate. These shifts in the payment basis affect aggregate program payments and, therefore, are taken into account in the budget neutrality adjustment. In addition, we maintained that because we apply the adjustment to all hospitals paid based on the Federal rate under section 1886(d) of the Act, it would be fair to apply it to hospitals that are paid under section 1886(d) of the Act based on hospital-specific rates. We believed that if we did not apply the budget neutrality factor to hospitals paid based on their hospital-specific rate, hospitals that are paid on the Federal rate would be subject to larger reductions to make up for not adjusting payments to hospitals that are paid based on hospital-specific rates.

Concerns have been raised that hospitals under section 1886(d) of the Act whose reimbursement is based on a hospital-specific rate should not be subject to the wage index component of the budget neutrality adjustment. Hospital-specific rates reflect the effects of hospitals' area wage levels and, therefore, are not adjusted by an area wage index. Accordingly, the concern is that a budget neutrality factor for changes in the wage index should not be applied to hospitals that are paid based on a hospital-specific rate. In addition, it has been suggested that the budget neutrality adjustment that CMS applies to hospitals paid on a hospital-specific rate should be similar to the budget neutrality adjustment made to hospitals in Puerto Rico. Hospitals in Puerto Rico that are paid under the IPPS are paid based on a blend of the national prospective payment rate and the Puerto Rico-specific prospective payment rate (42 CFR 412.212). Beginning in FY 1991, the Puerto Rico-specific standardized amount became subject to a budget neutrality adjustment. This budget neutrality adjustment included both the DRG reclassification and recalibration factor component and the wage index component. However, beginning in FY 1998, the Puerto Rico-specific rate has been subject only to the DRG reclassification and recalibration factor component of the budget neutrality adjustment (62 FR 46038) and not to the wage index component of the budget neutrality adjustment. In other words, beginning in FY 1998, the budget neutrality adjustment for the Puerto Rico-specific rate reflects only the DRG reclassification and recalibration factor component. This adjustment is computed, as described above, for all hospitals paid under section 1886(d) of the Act, without removing the previous year's budget neutrality adjustment.

We have considered the concern that it is inappropriate to apply a budget neutrality factor that includes a component for changes in the wage index to a hospital with a payment rate that is not adjusted by a wage index adjustment. In cases in which a hospital's payments are ultimately based on a hospital-specific rate, that portion of the payment is not adjusted by a wage index. We believe that our current policy is valid, for the reasons indicated above and in previous rulemaking documents, but we recognize that there are also valid grounds to review the regulations and consider other approaches. Accordingly, we are revisiting this policy. After further consideration of these issues, we are proposing to remove the wage index component from the budget neutrality adjustment applied to the hospital-specific rate for hospitals paid under section 1886(d) of the Act. The DRG reclassification and recalibration factor component of the budget neutrality adjustment would still apply to these hospitals, as payments to SCHs and MDHs are based on DRGs and affect total Medicare payments to hospitals under section 1886(d) of the Act. In applying this budget neutrality adjustment factor, which would include only the DRG reclassification and recalibration factor component, to the hospital-specific rate, we would not remove the prior years' budget neutrality adjustment factors. This would satisfy the statutory requirement that estimated aggregate payments after the changes in the DRG relative weights equal estimated aggregate payments prior to the changes. We are proposing that the wage index portion of the budget neutrality adjustment would not be applied to hospital-specific amounts, as these amounts are not adjusted by an area wage index. While this may result in a slightly higher budget neutrality adjustment applied to all other IPPS hospitals, because these hospitals actually are paid based on the revised wage indices and are affected by wage index changes, we believe this is appropriate. In addition, we note that in FY 1990 when this policy was first discussed, we did not calculate a budget neutrality factor that reflected only the DRG changes. Because we now calculate such a budget neutrality factor for Puerto Rico hospitals, it would not be administratively burdensome to apply the same budget neutrality factor to SCHs and MDHs.

We are proposing to add a new paragraph (f) to § 412.73, a new paragraph (i) to § 412.75, and a new paragraph (j) to § 412.77 relating to the computation of the hospital-specific rate to clarify our longstanding policy that CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG reclassifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to hospitals under section 1886(d) of the Act are not affected, and that this adjustment is made without removing the budget neutrality adjustment for the prior year. These provisions are cross-referenced in § 412.92 for SCHs and § 412.108 for MDHs for purposes of computing the hospital-specific rates for these hospitals. This proposed regulatory text will reflect the proposed changes to the way CMS applies the budget neutrality adjustment to hospitals paid under section 1886(d) of the Act based on the hospital-specific rate. Specifically, it would indicate that the budget neutrality adjustment made to hospitals paid under section 1886(d) of the Act based on the hospital-specific rate will only account for the DRG reclassification and recallibration factor component. The budget neutrality adjustment would no longer include the wage index factor component.

3. Technical Change

In the September 4, 1990 IPPS final rule (55 FR 36056), we made changes to the regulations at § 412.92 to incorporate the provisions of section 6003(e) of Pub. L. 101–239. Section 6003(e) of Pub. L. 101–239 provided for a permanent payment methodology for SCHs that recognized distortions in operating costs in years subsequent to the implementation of the IPPS and provided for opportunity for payment based on a new base year. As a result of this legislation, we deleted from the regulations a special provision that we had included under § 412.92(g) that provided for a payment adjustment to compensate SCHs reasonably for the increased operating costs resulting from the addition of new services or facilities.

We have discovered that, in making the changes to § 412.92 in the September 4, 1990 final rule to remove paragraph (g), we inadvertently failed to make a conforming change to paragraph (d)(3) that references the provisions of paragraph (g) relating to a payment adjustment for significant increases in a SCH's operating costs. In this proposed rule, we are proposing to make this technical correction by revising paragraph (d)(3).

D. Rural Referral Centers (§ 412.96)

(If you choose to comment on issues in this section, please include the

caption "Rural Referral Centers'' at the beginning of your document.)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the IPPS as a rural referral center. For discharges occurring before October 1, 1994, rural referral centers received the benefit of payment based on the other urban standardized amount rather than the rural standardized amount. Although the other urban and rural standardized amounts are the same for discharges occurring on or after October 1, 1994, rural referral centers continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Section 402 of Pub. L. 108–173 raised the DSH adjustment for other rural hospitals with less than 500 beds and rural referral centers. Other rural hospitals with less than 500 beds are subject to a 12-percent cap on DSH payments. Rural referral centers are not subject to the 12.0 percent cap on DSH payments that is applicable to other rural hospitals (with the exception of rural hospitals with 500 or more beds). Rural referral centers are not subject to the proximity criteria when applying for geographic reclassification, and they do not have to meet the requirement that a hospital's average hourly wage must exceed 106 percent of the average hourly wage of the labor market area where the hospital is located.

Section 4202(b) of Pub. L. 105–33 states, in part, "[a]ny hospital classified as a rural referral center by the Secretary * * * for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent year.'' In the August 29, 1997 final rule with comment period (62 FR 45999), we also reinstated rural referral center status for all hospitals that lost the status due to triennial review or MGCRB reclassification, but not to hospitals that lost rural referral center status because they were now urban for all purposes because of the OMB designation of their geographic area as urban. However, subsequently, in the August 1, 2000 final rule (65 FR 47089), we indicated that we were revisiting that decision. Specifically, we stated that we would permit hospitals that previously qualified as a rural referral center and lost their status due to OMB redesignation of the county in which they are located from rural to urban to be reinstated as a rural referral center. Otherwise, a hospital seeking rural referral center status must satisfy the applicable criteria. For FYs 1984 through 2004, we used the definitions of "urban'' and "rural'' in § 412.63. For FY 2005 and subsequent years, the revised definitions of "urban'' and "rural'' in § 412.64 apply.

One of the criteria under which a hospital may qualify as a rural referral center is to have 275 or more beds available for use (§ 412.96(b)(1)(ii)). A rural hospital that does not meet the bed size requirement can qualify as a rural referral center if the hospital meets two mandatory prerequisites (a minimum case-mix index and a minimum number of discharges) and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume) (§ 412.96(c)(1) through (c)(5)). (See also the September 30, 1988 **Federal Register** (53 FR 38513)). With respect to the two mandatory prerequisites, a hospital may be classified as a rural referral center if—

- The hospital's case-mix index is at least equal to the lower of the median case-mix index for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median case-mix index for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year, as specified in section 1886(d)(5)(C)(i) of the Act.)

1. Case-Mix Index

Section 412.96(c)(1) provides that CMS will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the proposed national and regional case-mix index values is set forth in regulations at § 412.96(c)(1)(ii). The proposed national median case-mix index value for FY 2006 includes all urban hospitals nationwide, and the proposed regional values for FY 2006 are the median values of urban hospitals within each census region, excluding those hospitals with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105). These proposed values are based on discharges occurring during FY 2004 (October 1, 2003 through September 30, 2004) and include bills posted to CMS' records through December 2004.

We are proposing that, in addition to meeting other criteria, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2005, rural hospitals with fewer than 275 beds must have a case-mix index value for FY 2004 that is at least—

- 1.3659; or
- The median case-mix index value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by CMS for the census region in which the hospital is located.

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

Region	Case-Mix Index Value
1. New England (CT, ME, MA, NH, RI, VT)	1.2253
2. Middle Atlantic (PA, NJ, NY)	1.2427
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3276
4. East North Central (IL, IN, MI, OH, WI)	1.2768
5. East South Central (AL, KY, MS, TN)	1.2836
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2175
7. West South Central (AR, LA, OK, TX)	1.3406
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3603
9. Pacific (AK, CA, HI, OR, WA)	1.3151

The preceding numbers will be revised in the final rule to the extent required to reflect the updated FY 2004 MedPAR file, which will contain data from additional bills through March 31, 2005.

Hospitals seeking to qualify as rural referral centers or those wishing to know how their case-mix index value compares to the criteria should obtain hospital-specific case-mix index values (not transfer-adjusted) from their fiscal intermediaries. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. We are proposing to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2002 (that is, October 1, 2001 through September 30, 2002), which is the latest available cost report data we have at this time.

Therefore, we are proposing that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2005, 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, as indicated in the following table:

Region	Number of Discharges
1. New England (CT, ME, MA, NH, RI, VT)	5,607
2. Middle Atlantic (PA, NJ, NY)	8,010
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	6,765
4. East North Central (IL, IN, MI, OH, WI)	4,941
5. East South Central (AL, KY, MS, TN)	3,186
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1,876
7. West South Central (AR, LA, OK, TX)	2,774
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	3,384
9. Pacific (AK, CA, HI, OR, WA)	6,047

These numbers will be revised in the final rule based on the latest available cost report data.

We reiterate that if an osteopathic hospital is to qualify for rural referral center status for cost reporting periods beginning on or after October 1, 2005, the hospital would be required to have at least 3,000 discharges for its cost reporting period that began during FY 2002.

3. Technical Change

In the FY 1998 IPPS final rule (62 FR 46028), we removed paragraph (f) from § 412.96. Paragraph (f) was removed when the requirement for triennial reviews of rural referral centers was terminated (62 FR 45998 through 45600, 46028 through 46029). However, we inadvertently failed to address all of the related cross-references to paragraph (f) in the entire § 412.96. Therefore, we are proposing to revise § 412.96 to remove paragraphs (h)(4) and (i)(4), consistent with the removal of paragraph (f).

E. Payment Adjustment for Low-Volume Hospitals (§ 412.101)

(If you choose to comment on issues in this section, please include the caption "Low-Volume Hospital Payment Adjustment'' at the beginning of your comment.)

Section 1886(d)(12) of the Act, as added by section 406 of Pub. L. 108–173, provides for a payment adjustment to account for the higher costs per discharge of low-volume hospitals under the IPPS. Section 1886(d)(12)(C)(i) of the Act defines a low-volume hospital as a "subsection (d) hospital * * * that the Secretary determines is located more than 25 road miles from another subsection (d) hospital and that has less than 800 discharges during the fiscal year.'' Section 1886(d)(12)(C)(ii) of the Act further stipulates that the term "discharge'' refers to total discharges, and not merely to Medicare discharges. Specifically, the term refers to the "inpatient acute care discharge of an individual regardless of whether the individual is entitled to benefits under part A.'' Finally, the provision requires the Secretary to determine an applicable percentage increase for these low-volume hospitals based on the "empirical relationship'' between "the standardized cost-per-case for such hospitals and the total number of discharges of these hospitals and the amount of the additional incremental costs (if any) that are associated with such number of discharges.'' The statute thus mandates the Secretary to develop an empirically justifiable adjustment based on the relationship between costs and discharges for these low-volume hospitals. The statute also limits the adjustment to no more than 25 percent.

According to the analysis conducted for the FY 2005 IPPS final rule (69 FR 49099 through 49102), a 25 percent low-volume adjustment to all qualifying hospitals with less than 200 discharges was found to be most consistent with the statutory requirement to provide relief to low-volume hospitals where there is empirical evidence that higher incremental costs are associated with low numbers of total discharges. However, we acknowledged that the empirical evidence did not provide robust support for that conclusion and indicated that we would reexamine the empirical evidence for the FY 2006 IPPS final rule with the intention of modifying or even eliminating the adjustment if the empirical evidence indicates that it is appropriate to do so.

In the FY 2005 IPPS final rule (69 FR 49102), we indicated that our analysis showed that there are fewer than 100 hospitals with less than 200 total discharges. At that time, we were unable to determine how many of these hospitals also meet the requirement that a low-volume hospital be more than 25 road miles from the nearest IPPS hospital in order to qualify for the adjustment. Our data systems currently indicate that 10 hospitals are receiving the low-volume adjustment.

As indicated in the FY 2005 IPPS final rule, we have now conducted a more detailed multivariate analysis on the empirical basis for a low-volume adjustment for FY 2006. In order to further evaluate the need for a proposed change in the development of the low-volume adjustment, we replicated much of the analysis conducted for the FY 2005 IPPS final rule, using updated data. We again empirically modeled the relationship between hospital costs-per-case and total discharges in several ways. We used both regression analysis and straight-line statistics to examine this relationship.

We conducted three different regression analyses. For all of the analyses, we simulated the FY 2005 cost environment by inflating FY 2002 and FY 2003 hospital cost report data to FY 2005 using the full hospital market basket updates. We note that, at the time of this analysis, we only had cost report data from FY 2003 for approximately 57 percent of the IPPS hospitals. Therefore, we have placed a greater weight on the results from the simulated FY 2002 cost data, which are significantly more complete. We again simulated the FY 2005 payment environment because payments have undergone several changes between FY 2002 and FY 2003 and FY 2005, making the results of the earlier data less relevant. Furthermore, many of these policy changes may already have helped increase payments to low-volume hospitals. We were unable to simulate the FY 2006 environment because payment factors for FY 2006 were not available at the time of our analysis.

In the first regression analysis, we used a dummy variable approach to model the relationship between standardized costs and total discharges. Using FY 2002 cost data, we found some evidence for a low-volume payment adjustment for hospitals with up to 199 discharges, consistent with our current policy. Using FY 2003 cost data, the empirical evidence only supported an adjustment for hospitals with up to 99 total discharges.

We also used a descriptive analysis approach to understand empirically the relationship between costs and total discharges. We grouped all hospitals by their total discharges and compared the mean Medicare per discharge payment to Medicare per discharge cost ratios. Hospitals with less than 800 total discharges were split into 24 cohorts based on increments of 25 discharges. When using the FY 2002 cost report data, the mean payment-to-cost ratios were below one (implying that Medicare per discharge costs exceeded Medicare per discharge payments) for all cohorts of hospitals with less than 200 discharges, after which the ratio was consistently above one. When using the FY 2003 cost report data, the mean payment-to-cost ratios were below one for all but two cohorts up to those with less than 175 total discharges, after which the ratio was consistently above one. No obvious increasing trend in the ratios, from which it would be possible to infer a formula to generate adjustments for hospitals based upon the number of discharges, was evident. Because more than 70 percent of hospitals with less than 200 discharges had ratios below 0.80, this analysis supports applying the highest payment adjustment to all providers with less than 200 discharges that are eligible for the low-volume adjustment.

The second regression analysis modeled the Medicare per discharge cost to Medicare per discharge payment ratio as a function of total discharges. The cost-to-payment ratio model more explicitly accounts for the relative values of per discharge costs and per discharge payments. These models provided some evidence for a statistically significant negative relationship between the cost-to-payment ratio and total discharges. However, that result was limited to FY

2002 data. FY 2003 data displayed no significant relationship between the cost-to-payment ratio and total discharges.

The third regression analysis employed per discharge costs minus per discharge payments as the dependent variable and total discharges as an explanatory variable. The results of this analysis were similar to the other regression analyses: some evidence was provided for an adjustment with the FY 2002 data, but not with the FY 2003 data, simulated for FY 2005. In fact, the FY 2003 data results suggest (with a positive intercept and positive coefficient on total discharges) that payments are greater than costs for all hospitals, including the low-volume hospitals.

Based upon these multivariate analyses using the FY 2002 cost report data, a case can be made that hospitals with fewer than 200 total discharges have per discharge costs that are statistically significantly higher relative to their Medicare per discharge payments in comparison to hospitals with 200 or more total discharges. Therefore, we are proposing to extend the existing low-volume adjustment for FY 2006. That is, a low-volume adjustment would again be provided for qualifying hospitals with less than 200 discharges. As noted above, the descriptive data do not reveal any pattern that could provide a formula for calculating an adjustment in relation to the number of discharges. However, the descriptive analysis of the data does indicate that, for a large majority of the hospitals with less than 200 discharges, the maximum adjustment of 25 percent would be appropriate because, for example, the payment-to-cost ratios for more than 70 percent of these hospitals are 0.80 or less. The maximum adjustment of 25 percent would still leave most of these hospitals with payment-to-cost ratios below 1.00. Because a large majority of hospitals with less than 200 discharges have payment-to-cost ratios below 1.00, we are proposing to again provide hospitals with less than 200 total discharges in the most recent submitted cost report an adjustment of 25 percent on each Medicare discharge. This policy is consistent with the existing language in § 412.101(a) and (b).

However, the initial analysis of the FY 2003 data does not seem to provide strong empirical evidence for a relationship between Medicare per discharge costs and total discharges. Therefore, we will reevaluate the appropriateness of the low-volume adjustment in the FY 2007 proposed rule.

F. Indirect Medical Education (IME) Adjustment (§ 412.105)

(If you choose to comment on issues in this section, please include the caption "IME Adjustment'' at the beginning of your comment.)

1. Background

Section 1886(d)(5)(B) of the Act provides that prospective payment hospitals that have residents in an approved graduate medical education (GME) program receive an additional payment to reflect the higher indirect costs of teaching hospitals relative to nonteaching hospitals. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105. The IME adjustment to the DRG payment is based in part on the applicable IME adjustment factor. The IME adjustment factor is calculated using a hospital's ratio of residents to beds, which is represented as r, and a formula multiplier, which is represented as c, in the following equation: $c \times [\{1 + r\}^{.405} - 1]$. The formula is traditionally described in terms of a certain percentage increase in payment for every 10-percent increase in the resident-to-bed ratio.

2. IME Adjustment for TEFRA Hospitals Converting to IPPS Hospitals

The Balanced Budget Act of 1997 (Pub. L. 105–33) established a limit on the number of allopathic and osteopathic residents that a hospital may include in its full-time equivalent (FTE) count for direct GME and IME payment purposes. Under section 1886(h)(4)(F) of the Act, a hospital's unweighted FTE count of residents may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. Under section 1886(d)(5)(B)(v) of the Act, the limit on the FTE resident count for IME purposes is effective for discharges occurring on or after October 1, 1997. A similar limit is effective for direct GME purposes for cost reporting periods beginning on or after October 1, 1997.

When these provisions were enacted, hospitals reported their weighted FTE resident count for direct GME and their unweighted FTE resident count for IME on the Medicare cost report. The cost report was subsequently modified to require reporting of unweighted FTE resident counts for both direct GME and IME. However, for cost reporting periods ending on or before December 31, 1996 (the cost report on which the FTE limit is based), hospitals were not required to report unweighted FTE resident counts for direct GME purposes. Therefore, a separate data collection effort was required to obtain the unweighted FTE resident counts. The fiscal intermediaries worked with hospitals to determine the unweighted FTE resident counts for direct GME for cost reporting periods ending on or before December 31, 1996, for purposes of implementing the FTE cap.

During this process, the fiscal intermediaries did not determine IME FTE resident counts for hospitals that were excluded from the IPPS (that is, psychiatric hospitals, LTCHs, rehabilitation hospitals, children's hospitals, and cancer hospitals) because these hospitals were not paid under the IPPS and, therefore, did not receive any IME payment adjustments. Only the FTE resident data related to direct GME payments were relevant for these excluded hospitals and, therefore, only those data were collected. However, it has come to our attention that some hospitals that were excluded from the IPPS during the cost reporting period ending on or before December 31, 1996 (that is, the cost reporting period during which the hospital's FTE resident limit was established under section 1886(h)(4)(F) of the Act for purposes of direct GME payments) have either failed to continue to qualify for exclusion from the IPPS or deliberately changed their operations in a way to become subject to the IPPS and, as a result, have subsequently become subject to the IME payment adjustment provisions of the IPPS. For example, a provider that was a rehabilitation hospital during its cost reporting period ending on December 31, 1996, but no longer meets the regulatory criteria to qualify as a rehabilitation hospital would become subject to the IPPS and be able to receive IME payments. However, because no IME FTE resident count for the cost reporting period ending on or before December 31, 1996, was determined, such a hospital does not have an unweighted FTE resident limit for IME.

To address this situation, we are proposing to incorporate in the regulations (proposed § 412.105(f)(1)(xiii)) CMS' existing policy in such situations which provides for the establishment of an IME FTE cap for a hospital that was excluded from the IPPS during its base year and that subsequently became subject to the IPPS. We are clarifying and proposing to adopt into regulations our existing policy that, in such a situation, the fiscal intermediary would determine an IME FTE cap for the hospital, applicable beginning with the

hospital's payments under the IPPS, based on the FTE count of residents during the cost reporting period(s) used to determine the hospital's direct GME FTE cap in accordance with existing § 412.105(f) of the regulations. The new IPPS hospital's IME FTE cap would be subject to the same rules and adjustments as any IPPS hospital's IME FTE cap in accordance with § 412.105(f) of the regulations.

While calculation of the IME FTE cap for a TEFRA hospital that converts to an IPPS hospital may require that fiscal intermediaries obtain information from cost reporting periods that are closed, allowing a fiscal intermediary to obtain this information should not be understood as allowing a fiscal intermediary to reopen closed cost reports that are beyond the normal reopening period in order to carry out the provisions of this proposed regulation.

Finally, there may be situations where the data necessary to carry out this policy are not available. For example, under this proposal, if a children's hospital converts to an IPPS hospital on July 1, 2007, the fiscal intermediary may need to determine the count of FTE residents for IME purposes training at the hospital during the most recent cost reporting period ending on or before December 31, 1996, in order to establish an IME FTE cap for the hospital, effective for discharges occurring on or after October 1, 2007. However, the count of FTE residents for IME purposes from the cost reporting period ending on or before December 31, 1996, may no longer be available, as the minimum time that hospitals are required to retain records is 5 years from the date the hospital submits the cost report. We believe this problem may not occur with sufficient frequency to warrant specific regulatory action. We are specifically soliciting comments as to whether and how hospitals believe this is a problem that needs to be addressed.

In some cases, a hospital that was previously excluded from the IPPS may become subject to the IPPS as a result of a merger between two or more hospitals where the surviving hospital is subject to the IPPS (and not creating an IPPS hospital with an excluded unit). In such cases, CMS policy is that the FTE resident cap for the surviving hospital should reflect the combined FTE resident caps for the hospitals that merged. If two or more hospitals merge after the conclusion of each hospital's base year for purposes of calculating resident FTE caps, the surviving hospital's FTE resident cap is an aggregation of the FTE resident cap for each hospital participating in the merger. When a merger involves an IPPS-excluded hospital, the base year IME FTE count for the IPPS-excluded hospital has not been determined. We are clarifying and proposing to codify in regulations our existing policy that, in such cases, the fiscal intermediary would determine an IME FTE cap for the IPPS-excluded hospital for purposes of determining the merged hospital's IME FTE cap in accordance with § 412.105(f) of the regulations. Once this cap is determined, the aggregate IME FTE cap of the surviving entity may be calculated in accordance with existing CMS policy for mergers.

We note that we would compute an IME cap for an IPPS-excluded hospital only in cases of a merger between an IPPS-excluded hospital and an acute care IPPS hospital, where the entire surviving entity is subject to the IPPS. No such IME FTE cap would be computed for an IPPS-excluded hospital in instances where an IPPS-excluded hospital and an acute care IPPS hospital agree to form a Medicare GME affiliated group for purposes of aggregating FTE resident caps. In cases where an IPPS-excluded hospital enters into a Medicare GME affiliation agreement with other IPPS hospitals, the IPPS-excluded hospital can contribute only its direct GME FTE cap to the aggregate FTE cap for the group. This is because, as long as a hospital remains excluded from the IPPS, that hospital will not have an FTE resident cap established for purposes of IME. Under no circumstances may an IPPS-excluded hospital be considered to contribute any FTE residents to a Medicare GME affiliation group for purposes of the aggregate IME FTE resident cap. IPPS-excluded hospitals do not currently, and would not under this proposed policy, have an IME FTE resident cap.

3. Section 1886(d)(8)(E) Teaching Hospitals That Withdraw Rural Reclassification

In section V.I. of this preamble, we discuss situations in which an urban hospital may become rural under a reclassification request under section 1886(d)(8)(E) of the Act. Under section 1886(d)(8)(E) of the Act, an urban hospital may file an application to be treated as being located in a rural area. Becoming rural under this provision affects only payments under section 1886(d) of the Act. If the hospital is a teaching hospital, the hospital could not receive adjustments to its direct GME FTE cap because payments for direct GME are made under section 1886(h) of the Act and the section 1886(d)(8)(E) reclassifications affect only the payments that are made under section 1886(d) of the Act. Therefore, an urban hospital that reclassifies as rural under this provision may receive the 130-percent adjustment to its IME FTE resident cap. In addition, its IME FTE cap may be adjusted for any new programs (similar to a hospital that is actually located in an area designated as rural) under section 1886(d)(5)(B)(v) of the Act, as amended by section 407 of Pub. L. 106–113 (BBRA).

An urban hospital treated as rural under section 1886(d)(8)(E) of the Act may subsequently withdraw its election and return to its urban status under the regulations at § 412.103. We are proposing that, effective with discharges occurring on or after October 1, 2005, hospitals that rescind their section 1886(d)(8)(E) reclassifications and return to being urban would not be eligible for permanent increases in their IME caps. Rather, any adjustments the hospitals received to their IME caps due to their rural status would be forfeited upon returning to urban status. Although we read the relevant IME FTE cap provisions in section 1886(d)(5)(B) of the Act as effecting a permanent increase to the FTE cap, we believe we have the statutory authority under section 1886(d)(5)(I) of the Act to make necessary adjustments to these caps that we believe are appropriate. Section 1886(d)(5)(I)(i) of the Act grants the Secretary authority to provide by regulation for "such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.'' We believe it is appropriate that a section 1886(d)(8)(E) hospital forfeit the adjustments it received solely due to its reclassification to rural status when it returns to being urban. Otherwise, urban hospitals might reclassify to rural areas under section 1886(d)(8)(E) of the Act for a short period of time solely as a means of receiving an increase to their IME FTE caps. These hospitals could reclassify for as little as one year, simply in order to receive a permanent increase to their IME FTE caps. Because section 1886(d)(8)(E) hospitals have control over when they switch in and out of rural status, we believe any other policy would be subject to gaming and inappropriate usage of the section 1886(d)(8)(E) authority. In contrast, hospitals that become urban due to the OMB-revised labor area designations have no control in the matter, and therefore would not be subject to the same type of manipulation of payment rates we believe would exist with the section 1886(d)(8)(E) hospitals.

(We note that the above proposed policy would have no effect on rural track resident training programs.

Section 1886(h)(4)(H)(iv) of the Act, which governs direct GME, provides that an urban hospital may receive adjustments to its FTE caps for establishing "separately accredited approved medical residency training programs (or rural tracks) *in an [sic] rural area*.'' The provisions governing IME state that "Rules similar to the rules of subsection (h)(4)(H) shall apply for purposes of'' determining FTE resident caps (section 1886(d)(5)(B)(viii) of the Act). Since the requirement that the hospital be located in a rural area is found in the provisions governing direct GME (section 1886(h) of the Act), not the provision governing IME, and since hospitals cannot reclassify as rural for purposes of section 1886(h) of the Act, we believe that, as provided in section 1886(h) of the Act, the hospital with which the urban hospital establishes the rural track must be physically located in an area designated as rural. We do not believe we would be properly incorporating the rules of section 1886(h) of the Act or creating a rule similar to that used in section 1886(h) of the Act if we were to allow counting of such reclassified hospitals.)

For the reasons stated above, we are proposing to amend the regulations at § 412.105 by adding a new paragraph (f)(1)(xiv) to provide that a hospital that rescinds its section 1886(d)(8)(E) reclassification will forfeit any adjustments to its IME FTE cap it received due to its rural status. Thus, for example, a hospital that reclassified as rural under section 1886(d)(8)(e) of the Act with an IME FTE cap of 10 would have received a 130 percent adjustment to its IME cap (that is, 10 FTEs × 1.3). Furthermore, if this hospital, while reclassified as rural, started a new 3-year residency program with 2 residents in each program year, its FTE cap would have been increased by an additional 6 FTEs to 19 FTEs (that is, 13 FTEs + 6 FTEs). However, once this hospital rescinds its reclassification under section 1886(d)(8)(E) of the Act to become urban again, its IME FTE cap would return to 10 FTEs (its original pre-reclassification IME FTE cap).

G. Payment to Disproportionate Share Hospitals (DSHs) (§ 412.106)

(If you choose to comment on issues in this section, please include the caption "DSH Adjustment Data'' at the beginning of your comment.)

1. Background

Section 1886(d)(5)(F) of the Act provides for additional payments to subsection (d) hospitals that serve a disproportionate share of low-income patients. The Act specifies two methods for a hospital to qualify for the Medicare disproportionate share hospital (DSH) adjustment. Under the first method, hospitals that are located in an urban area and have 100 or more beds may receive a DSH payment adjustment if the hospital can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients. These hospitals are commonly known as "Pickle hospitals.'' The second method, which is also the most commonly used method for a hospital to qualify, is based on a complex statutory formula under which payment adjustments are based on the level of the hospital's DSH patient percentage, which is the sum of two fractions: the "Medicare fraction'' and the "Medicaid fraction.'' The Medicare fraction is computed by dividing the number of patient days that are furnished to patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits by the total number of patient days furnished to patients entitled to benefits under Medicare Part A. The Medicaid fraction is computed by dividing the number of patient days furnished to patients who, for those days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A by the number of total hospital patient days in the same period.

$$\text{DSH Patient Percentage} = \frac{\text{Medicare, SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Patient Days}}$$

2. Implementation of Section 951 of Pub. L. 108–173 (MMA)

Section 951 of Pub. L. 108–173 requires the Secretary to arrange to furnish the data necessary for hospitals to compute the number of patient days used in calculating the disproportionate patient percentages. The provision is not specific as to whether it applies to the patient day data used to determine the Medicare fraction or the Medicaid fraction. We are interpreting section 951 to require the Secretary to arrange to furnish to hospitals the data necessary to calculate both the Medicare and Medicaid fractions. With respect to both the Medicare and Medicaid fractions, we also are interpreting section 951 to require CMS to arrange to furnish the personally identifiable information that would enable a hospital to compare and verify its records, in the case of the Medicare fraction, against the CMS' records, and in the case of the Medicaid fraction, against the State Medicaid agency's records. Currently, as explained in more detail below, CMS provides the Medicare SSI days to certain hospitals that request these data. Hospitals are currently required under the regulation at § 412.106(b)(4)(iii) to provide the data adequate to prove eligibility for the Medicaid, non-Medicare days.

As indicated above, the numerator of the Medicare fraction includes the number of patient days furnished by the hospital to patients who were entitled to both Medicare Part A and SSI benefits. This number is divided by the hospital's total number of patient days furnished to patients entitled to benefits under Medicare Part A. In order to determine the numerator of this fraction for each hospital, CMS obtains a data file from the Social Security Administration (SSA). CMS matches personally identifiable information from the SSI file against its Medicare Part A entitlement information for the fiscal year to determine the number of Medicare SSI days for each hospital during each fiscal year. These data are maintained in the MedPAR Limited Data Set (LDS) as described in more detail below and discussed in a notice published on August 18, 2000 in the **Federal Register** (65 FR 50548). The number of patient days furnished by the hospital to Medicare beneficiaries entitled to SSI is divided by the hospital's total number of Medicare days (the denominator of the Medicare fraction). CMS determines this number from Medicare claims data; hospitals also have this information in their records. The Medicare fraction for each hospital is posted on the CMS Web site *(http://www.cms.hhs.gov)* under the SSI/Medicare Part A Disproportionate Share Percentage File. Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per

cost reporting period, and the hospital must accept the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year.

In accordance with section 951 of Pub. L. 108–173, we are proposing to change the process that we use to make Medicare data used in the DSH calculation available to hospitals. Currently, as stated above, CMS calculates the Medicare fraction for each section 1886(d) hospital using data from the MedPAR LDS (as established in a notice published in the August 18, 2000 **Federal Register** (65 FR 50548)). The MedPAR LDS contains a summary of all services furnished to a Medicare beneficiary, from the time of admission through discharge, for a stay in an inpatient hospital or skilled nursing facility, or both; SSI eligibility information; and enrollment data on Medicare beneficiaries. The MedPAR LDS is protected by the Privacy Act of 1974 (5 U.S.C. 552a) and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191). The Privacy Act allows us to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the purpose(s) for which the information was collected. Any such compatible use of data is known as a "routine use.'' In order to obtain this privacy-protected data, the hospital must qualify under the routine use that was described in the August 18, 2000 **Federal Register**. Currently, a hospital qualifies under the routine use if it has an appeal properly pending before the Provider Reimbursement Review Board (PRRB) or before an intermediary on the issue of whether it is entitled to DSH payments, or the amount of such payments. Once determined eligible to receive the data under the routine use, the hospital is then required to sign a data use agreement with CMS to ensure that the data are appropriately used and protected, and pay the requisite fee.

Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we are proposing to furnish MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. We are proposing to make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the months included in the two Federal fiscal years that encompass the hospital's cost reporting period. Under our proposal, the hospital could use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year. The data set made available to hospitals would be the same data set CMS uses to calculate the Medicare fractions for the Federal fiscal year.

Because we interpret section 951 to require the Secretary to arrange to furnish these data, we do not believe that it will continue to be appropriate to charge hospitals to access the data. These proposed changes would require CMS to modify the current routine use for the MedPAR LDS to reflect changes in the data provided and the circumstances under which they are made available to hospitals. In a future **Federal Register** document, we will publish the details of any necessary modifications to the current routine use to implement section 951 of Pub. L. 108–173. We welcome comments on all aspects of these proposed changes.

The numerator of the Medicaid fraction includes hospital inpatient days that are furnished to patients who, for those days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A. Under the regulation at § 412.106(b)(4)(iii), hospitals are responsible for proving Medicaid eligibility for each Medicaid patient day and verifying with the State that patients were eligible for Medicaid on the claimed days. The number of Medicaid, non-Medicare days is divided by the hospital's total number of inpatient days in the same period. Total inpatient days are reported on the Medicare cost report. (This number is also available in the hospital's own records.)

Much of the data used to calculate the Medicaid fraction of the DSH patient percentage are available to hospitals from their own records or from the States. We recognize that Medicaid State plans are only permitted to use and disclose information concerning applicants and recipients for "purposes directly connected with the administration of the [State] plan'' under section 1902(a)(7) of the Act. Regulations at 42 CFR 431.302 define these purposes to include establishing eligibility (§ 431.302(a)) and determining the amount of medical assistance (§ 431.302(b)). Thus, State plans are permitted under the currently applicable statutory and regulatory provisions governing the disclosure of individually identifiable data on Medicaid applicants and recipients to provide hospitals the data needed to meet their obligation under § 412.106(b)(4)(iii) in the context of either an "eligibility inquiry'' with the State plan or in order to assist the hospital, and thus the State plan, in determining the amount of medical assistance.

In the process of developing a plan for implementing section 951 with respect to the data necessary to calculate the Medicaid fraction, we asked our regional offices to report on the availability of this information to hospitals and on any problems that hospitals face in obtaining the information that they need. The information we received suggested that, in the vast majority of cases, there are established procedures for hospitals or their authorized representatives to obtain the information needed for hospitals to meet their obligation under § 412.106(b)(4)(iii) and to calculate their Medicaid fraction. There is no uniform national method for hospitals to verify Medicaid eligibility for a specific patient on a specific day. For instance, some States, such as Arizona, have secure online systems that providers may use to check eligibility information. However, in most States, providers send a list of patients to the State Medicaid office for verification. Other States, such as Hawaii, employ a third party private company to maintain the Medicaid database and run eligibility matches for providers. The information that providers submit to State plans (or third party contractors) differs among States as well. Most States require the patient's name, date of birth, gender, social security number, Medicaid identification, and admission and discharge dates. States or the third parties may respond with either "Yes/No'' or with more detailed Medicaid enrollment and eligibility information such as whether or not the patient is a dual-eligible, whether the patient is enrolled in a fee-for-service or HMO plan, and under which State assistance category the individual qualified for Medicaid.[4]

We note that we have been made aware of at least one instance in which a State is concerned about providing hospitals with the requisite eligibility data. We understand that the basis for the State's objections is section 1902(a)(7) of the Act. The State is concerned that section 1902(a)(7) of the Act prohibits the State from providing eligibility data for any purpose other than a purpose related to State plan

[4] Bear in mind that States and hospitals should, in keeping with the HIPAA Privacy Rule, limit the data exchanged in the context of these inquiries and responses to the minimum necessary to accomplish the task

administration. However, as described above, we believe that States are permitted to verify Medicaid eligibility for hospitals as a purpose directly related to State plan administration under § 431.302.

In addition, we believe it is reasonable to continue to place the burden of furnishing the data adequate to prove eligibility for each Medicaid patient day claimed for DSH percentage calculation purposes on hospitals because, since they have provided inpatient care to these patients for which they billed the relevant payors, including the State Medicaid plan, they will necessarily already be in possession of much of this information. We continue to believe hospitals are best situated to provide and verify Medicaid eligibility information. Although we believe the mechanisms are currently in place to enable hospitals to obtain the data necessary to calculate their Medicaid fraction of the DSH patient percentage, there is currently no mandatory requirement imposed upon State Medicaid agencies to verify eligibility for hospitals. At this point, we believe there is no need to modify the Medicaid State plan regulations to require that State plans verify Medicaid eligibility for hospitals. However, should we find that States are not voluntarily providing or verifying Medicaid eligibility information for hospitals, we will consider amending the State plan regulations to add a requirement that State plans provide certain eligibility information to hospitals.

H. Geographic Reclassifications (§§ 412.103 and 412.230)

(If you choose to comment on issues in this section, please include the caption "Geographic Reclassifications'' at the beginning of your comment.)

1. Background

With the creation of the MGCRB, beginning in FY 1991, under section 1886(d)(10) of the Act, hospitals could request reclassification from one geographic location to another for the purpose of using the other area's standardized amount for inpatient operating costs or the wage index value, or both (September 6, 1990 interim final rule with comment period (55 FR 36754), June 4, 1991 final rule with comment period (56 FR 25458), and June 4, 1992 proposed rule (57 FR 23631)). As a result of legislative changes under section 402(b) of Pub. L. 108–7, Pub. L. 108–89, and section 401 of Pub. L. 108–173, the standardized amount reclassification criterion for large urban and other areas is no longer necessary or appropriate and has been removed from our reclassification policy (69 FR 49103). We implemented this provision in the FY 2005 IPPS final rule (69 FR 49103). As a result, hospitals can request reclassification for the purposes of the wage index only and not the standardized amount. Implementing regulations in Subpart L of Part 412 (§§ 412.230 et seq.) set forth criteria and conditions for reclassifications for purposes of the wage index 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.

Under section 1886(d)(8)(E) of the Act, an urban hospital may file an application to be treated as being located in a rural area if certain conditions are met. The regulations implementing this provision are located under § 412.103.

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(d)(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 2006, the MGCRB used the 3-year average hourly wages published in Table 2 of the August 11, 2004 IPPS final rule (69 FR 49295). These average hourly wages are taken from data used to calculate the wage indexes for FY 2003, FY 2004, and FY 2005, based on cost reporting periods beginning during FY 1999, FY 2000, and FY 2001, respectively.

2. Multicampus Hospitals (§ 412.230)

As discussed in section III.B. of this preamble, on June 6, 2003, the OMB announced the new CBSAs, comprised of Metropolitan Statistical Areas (MSAs) and Micropolitan Statistical Areas, based on Census 2000 data. Effective October 1, 2004, for the IPPS, we implemented new labor market areas based on the CBSA definitions of MSAs. In some cases, the new CBSAs resulted in previously existing MSAs being divided into two or more separate labor market areas. In the FY 2005 IPPS final rule (69 FR 48916), we acknowledged that the implementation of the new MSAs would have a considerable impact on hospitals. Therefore, we made every effort to implement transitional provisions that would mitigate the negative effects of the new labor market areas on hospitals that request reclassification to another area for purposes of the wage index and on all hospitals.

Subsequent to the publication of the FY 2005 IPPS final rule, we became aware of a situation in which, as a result of the new labor market areas, a multicampus hospital previously located in a single MSA is now located in more than one CBSA. Under our current policy, a multicampus hospital with campuses located in the same labor market area receives a single wage index. However, if the campuses are located in more than one labor market area, payment for each discharge is determined using the wage index value for the MSA (or metropolitan division, where applicable) in which the campus of the hospital is located. In addition, the current provision set forth in section 2779F of the Medicare State Operations Manual provides that, in the case of a merger of hospitals, if the merged facilities operate as a single institution, the institution must submit a single cost report, which necessitates a single provider identification number. This provision does not differentiate between merged facilities in a single wage index area or in multiple wage index areas. As a result, the wage index data for the merged facility is reported for the entire entity on a single cost report.

The current criteria for a hospital being reclassified to another wage area by the MGCRB do not address the circumstances under which a single campus of a multicampus hospital may seek reclassification. That is, a hospital must provide data from the CMS hospital wage survey for the average hourly wage comparison that is used to support a request for reclassification. However, because a multicampus hospital is required to report data for the entire entity on a single cost report, there is no wage survey data for the individual hospital campus that can be used in a reclassification application. In an effort to remedy this situation, for FY 2007 and subsequent year reclassifications, we are proposing to allow a campus of a multicampus hospital system that wishes to seek geographic reclassification to another labor market area to report campus-specific wage data using a supplemental Form S–3 (CMS' manual version of Worksheet S–3) for purposes of the wage data comparison. These data would then constitute the appropriate wage data under § 412.232(d)(2) for purposes of comparing the hospital's wages to the wages of hospitals in the area to which it seeks reclassification as well as the area in which it is located. Before the data could be used in a reclassification application, the

hospital's fiscal intermediary would have to review the allocation of the entire hospital's wage data among the individual campuses.

For FY 2006 reclassification applications, we are proposing to allow a campus of a multicampus hospital system to use the average hourly wage data submitted for the entire multicampus hospital system as its appropriate wage data under § 412.232(d)(2). We are establishing this special rule for FY 2006 reclassifications because the deadline for submitting an application to the MGCRB was September 1, 2004, and there no longer is an opportunity to provide a Supplemental Form S–3 that allocates the wage data by individual hospital campus. This special rule will be applied only to an individual campus of a multicampus hospital system that made an application for reclassification for FY 2006 and that otherwise meets all of the reclassification criteria. We do not believe that the special rule is necessary for reclassifications for FY 2007 because the deadline for making those applications has not yet passed and a hospital seeking reclassification will be able to provide the Supplemental Form S–3 that allocates the wage data by individual hospital campus. We are proposing to apply these new criteria to geographic reclassification applications that were received by September 1, 2004, and that will take effect for FY 2006.

We are proposing to revise the regulations at § 412.230(d)(2) by redesignating paragraph (d)(2)(iii) as paragraph (d)(2)(v) and adding new paragraph (d)(2))(iii) and (d)(2)(iv) to incorporate the proposed new criteria for multicampus hospitals.

3. Urban Group Hospital Reclassifications

In FY 2005 IPPS final rule (69 FR 49104), we set forth, under § 412.234(a)(3)(ii), revised criteria for urban hospitals to be reclassified as a group. After the publication of the final rule, we became aware that portions of our policy discussion with respect to the implementing decision were inadvertently omitted. This policy was corrected in the October 7, 2004, correction to the final rule (69 FR 60248). The correction specified that "hospitals located in counties that are in the same Combined Statistical Area (under the MSA definitions announced by the OMB on June 6, 2003); or in the same Consolidated Metropolitan Statistical Area (CMSA) (under the standards published by the OMB on March 30, 1990) as the urban area to which they seek redesignation qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation.''

In making the determination to revise our urban group reclassification policy, we took into consideration the magnitude of the changes that would have resulted from our adoption of the new labor market areas. The resulting policy was intended to preserve the reclassification opportunities for urban county groups; in other words, an eligible urban county group would have to meet either the CSA or CMSA criteria, but not both to be eligible for consideration.

As a result of adopting the new labor market area definitions, we reexamined the appropriateness of the FY 2005 changes with emphasis on determining whether including "* * * or in the same Consolidated Metropolitan Statistical Area (CMSA) (under the standards published by the OMB on March 30, 1990)'' as a qualifying criterion, is necessary or consistent with our plans to fully implement the new labor area market definitions.

Based on our experiences now that the new labor market areas are in effect and since we revised the urban county group regulations, we no longer think it is necessary to retain use of a 1990-based standard as a criterion for determining whether an urban county group is eligible for reclassification. We believe it is reasonable to use the area definitions that are based on the most recent statistics; in other words, the CSA standard. Therefore, we are proposing to delete § 412.234(a)(3)(ii) to remove reference to the CMSA eligibility criterion. Beginning with FY 2006, we are proposing to require that hospitals must be located in counties that are in the same Combined Statistical Area (under the MSA definitions announced by the OMB on June 6, 2003) as the urban area to which they seek redesignation to qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation. We believe that this proposed change would improve the overall consistency of our policies by using a single labor market area definition for all aspects of the wage index and reclassification.

4. Clarification of Goldsmith Modification Criterion for Urban Hospitals Seeking Reclassification as Rural

Under section 1886(d)(8)(E) of the Act, certain urban hospitals may file an application for reclassification as rural if the hospital meets certain criteria. One of these criteria is that the hospital is located in a rural census tract of a CBSA, as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy. This provision is implemented in our regulations at § 412.103(a)(1).

The original Goldsmith Modification was developed using data from the 1980 census. In order to more accurately reflect current demographic and geographic characteristics of the Nation, the Office of Rural Health Policy, in partnership with the Department of Agriculture's Economic Research Service and the University of Washington, has developed the Rural-Urban Commuting Area codes (RUCAs) (69 FR 47518 through 47529, August 5, 2004). Rather than being limited to large area metropolitan counties (LAMCs), RUCAs use urbanization, population density, and daily commuting data to categorize every census tract in the country. RUCAs are the updated version of the Goldsmith Modification and are used to identify rural census tracts in all metropolitan counties.

We are proposing to update the Medicare regulations at § 412.103(a)(1) to incorporate this change in the identification of rural census tracts. We are also proposing to update the website and the agency location at which the RUCA codes are accessible.

5. Cross-Reference Changes

In the FY 2005 IPPS final rule, in conjunction with changes made by various sections of Pub. L. 108–173 and changes in the OMB standards for defining labor market areas, we established a new § 412.64 governing rules for establishing Federal rates for inpatient operating costs for FY 2005 and subsequent years. In this new section, we included definitions of "urban'' and "rural'' for the purpose of determining the geographic location or classification of hospitals under the IPPS. These definitions were previous located in § 412.63(b), applicable to FYs 1985 through 2004, and in § 412.62(f), applicable to FY 1984. References to the definitions under § 412.62(f) and § 412.63(b), appear throughout 42 CFR Chapter IV. However, when we finalized the provisions of § 412.64, we inadvertently omitted updating some of these cross-references to reflect the change in the location of the two definitions for FYs 2005 and subsequent years. We are proposing to change the cross-references to the definitions of "urban'' and "rural'' to reflect their current locations in Subpart D of Part 412, as applicable.

I. Payment for Direct Graduate Medical Education (§ 413.79)

(If you choose to comment on issues in this section, please include the caption "Graduate Medical Education'' at the beginning of your comment.)

1. Background

Section 1886(h) of the Act, as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272) and implemented in regulations at existing §§ 413.75 through 413.83, establishes a methodology for determining payments to hospitals for the costs of approved graduate medical education (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 beginning between October 1, 1983, through September 30, 1984). Medicare direct GME payments are calculated by multiplying the PRA times the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital (and nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days. In addition, as specified in section 1886(h)(2)(D)(ii) of the Act, for cost reporting periods beginning on or after October 1, 1993, through September 30, 1995, each hospital-specific PRA for the previous cost reporting period is not updated for inflation for any FTE residents who are not either a primary care or an obstetrics and gynecology resident. As a result, hospitals that train primary care and obstetrics and gynecology residents, as well as nonprimary care residents in FY 1994 or FY 1995, have two separate PRAs: One for primary care and obstetrics and gynecology residents and one for nonprimary care residents.

Pub. L. 106–113 amended section 1886(h)(2) of the Act to establish a methodology for the use of a national average PRA in computing direct GME payments for cost reporting periods beginning on or after October 1, 2000, and on or before September 30, 2005. Pub. L. 106–113 established a "floor'' for hospital-specific PRAs equal to 70 percent of the locality-adjusted national average PRA. In addition, the BBRA established a "ceiling'' that limited the annual adjustment to a hospital-specific PRA if the PRA exceeded 140 percent of the locality-adjusted national average PRA. Section 511 of the BIPA (Pub. L. 106–554) increased the floor established by the BBRA to equal 85 percent of the locality-adjusted national average PRA. Existing regulations at § 413.77(d)(2)(iii) specify that, for purposes of calculating direct GME payments, each hospital-specific PRA is compared to the floor and the ceiling to determine whether a hospital-specific PRA should be revised.

Section 1886(h)(4)(F) of the Act established limits on the number of allopathic and osteopathic residents that hospitals may count for purposes of calculating direct GME payments. For most hospitals, the limits were the number of allopathic and osteopathic FTE residents training in the hospital's most recent cost reporting period ending on or before December 31, 1996.

2. Direct GME Initial Residency Period (IRP) § 413.79(a)(10)

a. Background

As we have generally described above, the amount of direct GME payment to a hospital is based in part on the number of FTE residents the hospital is allowed to count for direct GME purposes during a year. The number of FTE residents, and thus the amount of direct GME payment to a hospital, is directly affected by CMS policy on how "initial residency periods'' are determined for residents. Section 1886(h)(4)(C)(ii) of the Act, implemented at § 413.79(b)(1), provides that while a resident is in the "initial residency period'' (IRP), the resident is weighted at 1.00. Section 1886(h)(4)(C)(iii) of the Act, implemented at § 413.79(b)(2), requires that if a resident is not in the resident's IRP, the resident is weighted at .50 FTE resident.

Section 1886(h)(5)(F) of the Act defines "initial residency period'' as the "period of board eligibility,'' and, subject to specific exceptions, limits the initial residency period to an "aggregate period of formal training'' of no more than 5 years for any individual. Section 1886(h)(5)(G) of the Act generally defines "period of board eligibility'' for a resident as "the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training.'' Existing § 413.79(a) of the regulations generally defines "initial residency period'' as the "minimum number of years required for board eligibility.'' Existing § 413.79(a)(5) provides that "time spent in residency programs that do not lead to certification in a specialty or subspecialty, but that otherwise meet the definition of approved programs * * * is counted toward the initial residency period limitation.'' Section 1886(h)(5)(F) of the Act further provides that "the initial residency period shall be determined, with respect to a resident, as of the time the resident enters the residency training program.''

The IRP is determined as of the time the resident enters the "initial'' or first residency training program and is based on the period of board eligibility associated with that medical specialty. Thus, these provisions limit the amount of FTE resident time that may be counted for a resident who, after entering a training program in one specialty, switches to a program in a specialty with a longer period of board eligibility or completes training in one specialty training program and then continues training in a subspecialty (for example, cardiology and gastroenterology are subspecialties of internal medicine).

b. Direct GME Initial Residency Period Limitation: Simultaneous Match

We understand that there are numerous programs, including anesthesiology, dermatology, psychiatry, and radiology, that require a year of generalized clinical training to be used as a prerequisite for the subsequent training in the particular specialty. For example, in order to become board eligible in anesthesiology, a resident must first complete a generalized training year and then complete 3 years of training in anesthesiology. This first year of generalized residency training is commonly known as the "clinical base year.'' Often, the clinical base year requirement is fulfilled by completing either a preliminary year in internal medicine (although the preliminary year can also be in other specialties such as general surgery or family practice), or a transitional year program (which is not associated with any particular medical specialty).

In many cases, during the final year of medical school, medical students apply for training in specialty residency training programs. Typically, a medical student who wants to train to become a specialist is "matched'' to both the clinical base year program and the specialty residency training program at the same time. For example, the medical student who wants to become an anesthesiologist will apply and "match'' simultaneously for a clinical base year in an internal medicine program for year 1 and for an anesthesiology training program beginning in year 2.

Prior to October 1, 2004, CMS' policy was that the IRP is determined for a

resident based on the program in which he or she participates in the resident's first year of training, without regard to the specialty in which the resident ultimately seeks board certification. Therefore, for example, a resident who chooses to fulfill the clinical base year requirement for an anesthesiology program with a preliminary year in an internal medicine program will be "labeled'' with the IRP associated with internal medicine, that is, 3 years (3 years of training are required to become board eligible in internal medicine), even though the resident may seek board certification in anesthesiology, which requires a minimum of 4 years of training to become board eligible. As a result, this resident would have an IRP of 3 years and, therefore, be weighted at 0.5 FTE in his or her fourth year of anesthesiology training for purposes of direct GME payment.

Effective with cost reporting periods beginning on or after October 1, 2004, to address programs that require a clinical base year, we revised our policy in the FY 2005 IPPS final rule (69 FR 49170 through 49174) concerning the IRP. Specifically, under the revised policy, if a hospital can document that a particular resident matches simultaneously for a first year of training in a clinical base year in one medical specialty, and for additional year(s) of training in a different specialty program, the resident's IRP will be based on the period of board eligibility associated with the specialty program in which the resident matches for the subsequent year(s) of training and not on the period of board eligibility associated with the clinical base year program. This change in policy is codified at § 413.79(a)(10) of the regulations.

This policy applies regardless of whether the resident completes the first year of training in a separately accredited transitional year program or in a preliminary (or first) year in another residency training program such as internal medicine.

In addition, because programs that require a clinical base year are nonprimary care specialties, we specified in § 413.79(a)(10) that the nonprimary care PRA would apply for the entire duration of the initial residency period. By treating the first year as part of a nonprimary care specialty program, the hospital will be paid at the lower nonprimary care PRA rather than the higher primary care PRA, even if the residents are training in a primary care program during the clinical base year.

In the FY 2005 IPPS final rule (69 FR 49170 and 49171), we also defined "residency match'' to mean, for purposes of direct GME, a national process by which applicants to approved medical residency programs are paired with programs on the basis of preferences expressed by both the applicants and the program directors.

These policy changes, which were effective October 1, 2004, are only applicable to residents that simultaneously match in both a clinical base year program and a longer specialty residency program. We have become aware of situations where residents, upon completion of medical school, only match for a program beginning in the second residency year in an advanced specialty training program but fail to match for a clinical base year of training. Residents that match into an advanced program but fail to match into a clinical base year program may independently pursue unfilled residency positions in preliminary year programs after the match process is complete. However, because these residents do not "simultaneously match'' into both a preliminary year and an advanced program, currently their IRP cannot be determined based on the period of board eligibility associated with the advanced program, as specified in § 413.79(a)(10). Rather, the IRP for such residents would continue to be determined based on the specialty associated with the preliminary year program. For example, a student in the final year of medical school may match into a radiology program that begins in the second residency year, but not match with any clinical base year program. Under our current policy, if subsequent to conclusion of the match process, this resident secured a preliminary year position in an internal medicine program, the resident would not have met the requirements at § 413.79(a)(10) for a simultaneous match and the IRP for this resident would be based on the length of time required to complete an internal medicine program (3 years) rather than the length of the radiology program (4 years).

The intent of the "simultaneous match'' provision of § 413.79(a)(10) is to identify in a verifiable manner the specialty associated with the program in which the resident will initially train and seek board certification. It is also the intent of § 413.79(a)(10) that a resident's IRP would not change if the resident, after initially entering a training program in one specialty, changes programs to train in another medical specialty. The "simultaneous match'' provisions of § 413.79(a)(10) allow CMS to *both* identify the specialty associated with the program in which the resident is ultimately expected to train and seek board certification and prevent inappropriate revision of the IRP in cases where a resident changes specialties subsequent to beginning residency training. However, we note that when a medical student in his or her final year of medical school matches into an advanced program (for example, anesthesiology) for the second program year, but fails to match in a clinical base year, and obtains a preliminary year position outside the match process, we can still identify the specialty associated with the program in which the resident is ultimately expected to train and seek board certification and prevent inappropriate changes to the IRP if the resident changes specialties subsequent to beginning residency training.

Therefore, we are proposing to revise § 413.79(a)(10) to state that, when a hospital can document that a resident matched in an advanced residency training program beginning in the second residency year prior to commencement of any residency training, the resident's IRP will be determined based on the period of board eligibility for the specialty associated with the advanced program, without regard to the fact that the resident had not matched for a clinical base year training program.

We note that this proposed policy change would not result in a policy to determine the IRP for all residents who must complete a clinical base year during the second residency training year based on the specialty associated with that second residency training year. That is, we *are not* proposing that, for any resident whose first year of training is completed in a program that provides a general clinical base year as required by the ACGME for certain specialties, an IRP should be assigned in the second year based on the specialty the resident enters in the second year of training. As we stated in the FY 2005 IPPS final rule (69 FR 49172), a "second year'' policy would not allow CMS to distinguish between those residents who, in their second year of training, match in a specialty program prior to their first year of training, those residents who participated in a clinical base year in a specialty and then continued training in that specialty, and those residents who simply switched specialties in their second year. Rather, we are proposing that, if a hospital can *document* that a particular resident had matched in an advanced specialty program that requires completion of a clinical base year prior to the resident's first year of training, the IRP would not be determined based on the period of board eligibility for the specialty associated with the clinical base year

program, for purposes of direct GME payment. Rather, under those circumstances, the IRP would be determined based upon the period of board eligibility associated with the specialty program in which the resident has matched and is expected to begin training in the second program year.

3. New Teaching Hospitals' Participation in Medicare GME Affiliated Groups (§ 413.79(e)(1))

In the August 29, 1997 final rule (62 FR 46005 through 46006) and the May 12, 1998 final rule (63 FR 26331 through 23336), we established rules for applying the FTE resident limit (or "FTE cap'') for calculating Medicare direct GME and IME payments to hospitals. We added regulations, currently at § 413.79(e), to provide for an adjustment to the FTE cap for certain hospitals that begin training residents in new medical residency training programs. For purposes of this provision, a new program is one that receives initial accreditation or begins training residents on or after January 1, 1995. Although we refer only to the direct GME provision throughout the remainder of this discussion, a similar cap adjustment is made under § 412.105(f) for IME purposes. Therefore, this proposal applies to both IME and direct GME.

A new teaching hospital is one that had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996. Under § 413.79(e)(1), if a new teaching hospital establishes one or more new medical residency training programs, the hospital's unweighted FTE caps for both direct GME and IME will be based on the product of the highest number of FTE residents in any program year in the third year of the hospital's first new program and the number of years in which residents are expected to complete the program(s), based on the minimum number of years of training that are accredited for the type of program(s).

The regulations at § 413.79(e)(1)(iv) specify that hospitals in urban areas that qualify for an FTE cap adjustment for residents in newly approved programs under § 413.79(e)(1) are not permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap. (A Medicare GME affiliated group is defined in the regulations at § 413.75(b).) We established this policy because of our concern that hospitals with existing medical residency training programs could otherwise, with the cooperation of new teaching hospitals, circumvent the statutory FTE resident caps by establishing new medical residency programs in the new teaching hospitals solely for the purpose of affiliating with the new teaching hospitals to receive an upward adjustment to their FTE cap under an affiliation agreement. This would effectively allow existing teaching hospitals to achieve an increase in their FTE resident caps beyond the number allowed by their statutory caps.

In contrast, hospitals in rural areas that qualify for an adjustment under § 413.79(e)(1)(v) are allowed to enter into a Medicare GME affiliation. Although we recognize that rural hospitals would not be immune from the kind of "gaming'' arrangement described above, we allow new rural teaching hospitals that begin training residents in new programs, and thereby increase their FTE cap, to affiliate because we understand that rural hospitals may not have a sufficient volume of patient care utilization at the rural hospital site to be able to support a training program that meets accreditation standards. Securing sufficient patient volumes to meet accreditation requirements may necessitate rotations of the residents to another hospital. Accordingly, the regulations allow new teaching hospitals in rural areas to enter into Medicare GME affiliation agreements. However, an affiliation is only permitted if the rural hospital provides training for at least one-third of the FTE residents participating in all of the joint programs of the affiliated hospitals because, as we stated in the May 12, 1998 **Federal Register** (63 FR 26333), we believe that requiring at least one-third of the training to take place in the rural area allows operation of programs that focus on, but are not exclusively limited to, training in rural areas.

Through comment and feedback from industry trade groups and hospitals, we understand that, while these rules were meant to prevent gaming on the part of existing teaching hospitals, they could also preclude affiliations that clearly are designed to facilitate additional training at the new teaching hospital.

For example, Hospital A had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996. As such, Hospital A's caps for direct GME and IME are both zero. Hospital A and Hospital B enter into a Medicare GME affiliation for the academic year beginning on July 1, 2003, and ending on June 30, 2004. On July 1, 2003, Hospital A begins training residents from an existing family medicine program located at Hospital B. This rotation will result in 5 FTE residents training at Hospital A. Through the affiliation agreement, Hospital A receives a positive adjustment of 5 FTE's for both its direct GME and IME caps. Hospital B receives a corresponding negative adjustment of 5 FTEs under the affiliation agreement. Hospital A's Board of Directors is interested in starting a new residency program in Internal Medicine that would begin training residents at Hospital A on July 1, 2005. If Hospital A establishes the new program, under existing Medicare regulations, Hospital A will have its direct GME and IME caps (which were both previously established at zero) permanently adjusted to reflect the additional residents training in the newly approved program in accordance with § 413.79(e)(1). However, under existing regulations, Hospital A may no longer enter into an affiliation with Hospital B after it receives the adjustment to its FTE caps under § 413.79(e)(1).

We are proposing to revise § 413.79(e)(1)(iv) so that new urban teaching hospitals that qualify for an adjustment under § 413.79(e)(1) may enter into a Medicare GME affiliation agreement under certain circumstances. Specifically, a new urban teaching hospital that qualifies for an adjustment to its FTE caps for a newly approved program may enter into a Medicare GME affiliation agreement, but only if the resulting adjustments to its direct GME and IME caps are "positive adjustments.'' "Positive adjustment'' means, for the purpose of this policy, that there is an *increase* in the new teaching hospital's caps as a result of the affiliation agreement. At no time would the caps of a hospital located in an urban area that qualifies for adjustment to its FTE caps for a new program under § 413.79(e)(1), be allowed to *decrease* as a result of a Medicare GME affiliation agreement. We believe this proposed policy change would allow new urban teaching hospitals flexibility to start new teaching programs without jeopardizing their ability to count additional FTE residents training at the hospital under an affiliation agreement.

We remain concerned that hospitals with existing medical residency training programs could cooperate with a new teaching hospital to circumvent the statutory FTE caps by establishing new programs at the new teaching hospital, and, through a Medicare GME affiliation agreement, moving most or all of the new residency program to its own hospital, thereby receiving an upward adjustment to its FTE caps. For this reason, we are proposing to revise

§ 413.79(e)(1)(iv) of the regulations to provide that a hospital that qualifies for an adjustment to its caps under § 413.79(e)(1) would not be permitted to enter into an affiliation agreement that would produce a negative adjustment to its FTE resident cap.

Continuing the example shown above, under the proposed change in policy, Hospital A and Hospital B would be able to continue the Medicare GME affiliation agreement under which Hospital A trained residents from Hospital B's family practice program because Hospital A would receive an increase in its direct GME or IME caps under an affiliation after qualifying for a new program adjustment under § 413.79(e)(1). However, Hospital B would not be able to receive an increase in its caps as a result of a Medicare GME affiliation agreement with Hospital A.

Thus, we are proposing the above policy change to provide some flexibility to hospitals that are currently prohibited from entering into a Medicare GME affiliation agreement, while continuing to protect the statutory FTE resident caps from being undermined by gaming. We solicit comments on the proposed change.

4. GME FTE Cap Adjustment for Rural Hospitals (§ 413.79(c) and (k))

As stated earlier under section V.I.1. of this preamble, Medicare makes both direct and indirect GME payments to hospitals for the training of residents. Direct GME payments are made in accordance with section 1886(h) of the Act, based generally on the hospital-specific PRA, the number of FTE residents a hospital trains, and the hospital's percentage of Medicare inpatient utilization. Indirect GME payments (referred to as IME) are made in accordance with section 1886(d)(5)(B) of the Act as an adjustment to DRG payment and are 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 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.

Effective October 1, 1997, Congress instituted caps on the number of allopathic and osteopathic residents a hospital is allowed to count for direct GME and IME purposes at sections 1886(h)(4)(F) (direct GME) and 1886(d)(5)(B)(v) (IME) of the Act. These caps were instituted in an attempt to end the implicit incentive for hospitals to increase the number of FTE residents. Dental and podiatric residents were not included in these statutorily mandated caps.

Congress provided certain exceptions for rural hospitals when establishing the 1996 caps "with the intent of encouraging physician training and practice in rural areas'' (65 FR 47032). For example, the statute states at section 1886(h)(4)(H)(i) that, in promulgating rules regarding application of the FTE caps to training programs established after January 1, 1995, "the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.'' Accordingly, in implementing this provision, we provided in the regulations under § 413.86(g)(6)(i)(C) (now § 413.79(e)(1)(iii)) that "except for rural hospitals, the cap will not be adjusted for new programs established more than 3 years after the first program begins training residents. In other words, only hospitals located in rural areas (that is, areas that are not designated as an MSA), receive adjustments to their unweighted FTE caps to reflect residents in new medical residency training programs past the third year after the first residency program began training in that hospital (62 FR 46006).

Section 413.79(e)(1) specifies the new program adjustment as the "product of the highest number of residents in any program year during the third year of the * * * program's existence * * * and the number of years in which residents are expected to complete the program based on the minimum accredited length for the type of program.'' The regulation applies only to new programs (as defined under § 413.79(1)) established by rural hospitals, not for expansion of previously existing programs. For example, if a rural hospital has an unweighted FTE cap for direct GME of 100 and begins training residents in a new 3-year residency program that has 10 residents in each of its first 3 program years (for a total of 30 residents in the entire program in the program's third year), the hospital's direct GME FTE cap of 100 would be permanently adjusted at the conclusion of the third program year by 30, and the hospital's new FTE cap would be 130. A similar adjustment would be made to the hospital's FTE cap for IME in accordance with the regulations at § 412.105(f)(1)(iv)(A). However, the rural hospital would not be able to receive adjustments to its FTE cap for any expansion of a preexisting program.

In 1999, Congress passed an additional provision under section 407 of Pub. L. 106–113 (BBRA) to promote physician training in rural areas. Section 407 of the Pub. L. 106–113 amended the FTE caps provision at sections 1886(h)(4)(F) and 1886(d)(5)(B)(v) of the Act to provide that "effective for cost reporting periods beginning on or after April 1, 2000, [a rural hospital's FTE cap] is 130 percent of the unweighted FTE count * * * for those residents for the most recent cost reporting period ending on or before December 31, 1996.'' In other words, the otherwise applicable FTE caps for rural hospitals were multiplied by 1.3 to encourage rural hospitals to expand preexisting residency programs. (As described above, even prior to the BBRA change, rural hospitals were able to receive FTE cap adjustments for new programs.) For example, a hospital that was rural as of April 1, 2000, and had a direct GME cap of 100 FTEs would receive a permanent cap adjustment of 30 FTEs (100 FTEs × 1.3 = 130 FTEs) and effective for cost reporting periods beginning on or after April 1, 2000, its FTE for direct GME would be 130. (A similar adjustment would be made to the FTE cap for IME for discharges occurring on or after April 1, 2000.)

We recently received questions regarding the application of the 130-percent FTE cap adjustment and the new program adjustment for rural hospitals in instances in which a rural teaching hospital is later redesignated as an urban hospital or reclassifies back to being an urban hospital after having been classified as rural. We are aware of two circumstances when a rural hospital may subsequently be reclassified as urban. The first circumstance involves labor market area changes, and the second involves urban hospitals, after having been reclassified as rural through section 1886(d)(8)(E) of the Act, that elect to be considered urban again. In both situations, if the hospital in question was a teaching hospital, its FTE caps would have been subject to the 130 percent and new program FTE cap adjustments while it was designated or classified as rural. The issue is whether the adjusted caps would continue to apply after the hospital becomes urban or returns to being treated as urban. Below we first address hospitals that lost their status as urban hospitals due to new labor market areas. We then address hospitals that rescinded their section 1886(d)(8)(E) reclassifications. (We note that reclassification by the MGCRB under section 1886(d)(10) of the Act, as well as reclassifications under section 1886(d)(8)(B) of the Act, are effective only for purposes of the wage index and would not affect the hospital's IME or direct GME payments).

a. Formerly Rural Hospitals That Became Urban Due to the New CBSA Labor Market Areas

In the FY 2005 IPPS final rule, we adopted the new CBSA-based labor market areas announced by OMB on June 6, 2003, and these areas became effective October 1, 2004. As a result of these new labor market areas, a number of hospitals that previously were located outside of an MSA and therefore considered rural are now located in a CBSA that is designated as urban and considered urban.

We believe that previously rural hospitals that received adjustments due to establishing new medical training programs should not now be required to forego such adjustments simply because they have now been redesignated as urban. Such hospitals added and received accreditation for new medical training programs under the assumption that such programs would effect a permanent increase in their FTE caps. Indeed, we believe it would be nonsensical to view the fact that these hospitals are now urban as causing them to lose the adjustments that stemmed directly from the permissible and encouraged establishment of new medical training programs. Such hospitals cannot reach back into the past and alter whether they added the new programs or not. Nor would it be reasonable to prohibit them from counting FTE residents training in new programs that they worked to accredit. (We note that the hospitals would not be required to close the programs. Rather, if they were not permitted to retain the adjustments to their FTE caps they received as a result of having established new programs, they would no longer be permitted to count FTE residents that exceeded their original, preadjustment FTE caps for purposes of direct GME and IME payments. The effect might be that the hospital would have to close the program(s) as a result of decreased Medicare funding, but the hospital would be free to continue to operate the programs(s).)

For these reasons, we believe the best reading of our regulation at § 413.79(e)(3), which states that if a hospital "is located in a rural area,'' it may adjust its FTE cap to reflect residents training in new programs, is that hospitals were permitted to receive a *permanent* adjustment to their FTE caps if, at the time of adding a new program, the hospitals were rural. A hospital's subsequent designation as urban or rural due to labor market area changes becomes irrelevant, because the central question is whether the hospital is rural at the time it adds the new programs. Therefore, we are clarifying in this proposed rule our policy that hospitals that became urban in FY 2005 due to the new labor market areas would nevertheless be permitted to retain the adjustments they received for new programs as long as they were rural at the time they received them. (Once such hospitals receive a designation as "urban,'' they may no longer seek FTE cap adjustments relating to new training programs; they may only retain the adjustments they received for the new programs they added when they were rural.)

Similarly, we believe that rural hospitals that received the statutorily mandated 130 percent adjustment to their FTE caps would be disadvantaged if we were to rescind this adjustment due to new urban designation. Such hospitals expanded their already existing training programs under the assumption that these expansions would cause a permanent increase in their FTE caps. Many of these hospitals expanded their programs only once the BBRA became effective (in 2000). Thus, they have had only a few years to expand their programs and receive the cap adjustment mandated by statute. For these reasons, we believe it is permissible to read sections 1886(h)(4)(F)(i) and 1886(d)(5)(B)(v) of the Act as permitting a *permanent* adjustment to the FTE caps at the time a rural hospital adds residents to its already existing program(s). The language states that the total number of FTE residents with respect to a "hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number (or, 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.'' As with the addition of new programs, we interpret the language "130 percent of such number in the case of a hospital located in a rural area,'' as meaning only that the hospital was required to be rural at the time it received the 30-percent increase. Once the hospital received such increase, the increase became a permanent increase in the FTE cap and should not be rescinded based on subsequent designation as an urban hospital.

We believe our interpretations are consistent with legislative intent. Congress provided for these FTE cap adjustments for rural hospitals with the intent of encouraging physician training and practice in rural areas. If rural hospitals had believed that new CBSAs would cause them to lose the adjustments, they would not have had the incentives Congress wished to increase the number of FTE residents training in their programs. These hospitals might have feared losing the adjustments as a result of new labor market areas, and therefore not carried out Congress' intent to expand their already existing residency training programs or add new residency training programs.

To provide an example of the how the above statutory interpretations would be applied, a hospital located in a rural area prior to October 1, 2004, with an unweighted direct GME FTE cap of 100 would have received a 30-percent increase in its FTE cap so that its adjusted cap was 130 FTEs. The rural hospital also could have received an adjustment for any new medical residency program. If this hospital, while rural, started a new 3-year residency program with 10 residents in each program year, its FTE cap would have been increased by an additional 30 FTEs to 160 FTEs (that is, (100 FTEs × 1.3) + 30 FTEs = 160 FTEs). Under our reading of the statute, if this hospital is now located in an urban area due to the new CBSAs, it would retain this cap of 160 FTEs.

We also believe that the statute should be interpreted as permitting urban hospitals with rural track training programs to retain the adjustment they received for such programs at § 413.79(k), even if the "rural'' tracks as of October 1, 2004, are now located in urban areas due to the new OMB labor market areas. As explained in the FY 2001 IPPS final rule (66 FR 47033), we provided that an urban hospital that establishes a separately accredited medical residency training program in a rural area (that is, a rural track) may receive an adjustment to reflect the number of residents in that program (existing § 413.79(k)). Section 1886(h)(4)(H)(iv) of the Act states: "In the case of a hospital that is not located in a rural area but establishes separately accredited approved medical residency training programs (or rural tracks) in an (sic) rural area or has an accredited training program with an integrated 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.''

Again, we believe that the reading that best carries out Congressional intent is one that allows the adjustment for rural tracks to remain permanent as long as the rural track training programs continue, even if the once-rural tracks

are now urban due to new labor market area boundaries. Congress clearly intended to encourage the training of physicians in the rural tracks identified by the statute. However, if the FTE cap adjustments were merely temporary, and hospitals could not rely on retaining the adjustments relating to the rural training programs in which they invested, then Congress' wishes to encourage rural training programs might not have been realized. Hospitals would always need to speculate as to whether the FTE cap adjustments relating to the rural track programs they established would be lost each time new labor market areas were adopted (which normally occurs once every 10 years). Thus, we believe the statutory language should be interpreted as allowing an urban hospital to retain its FTE cap adjustment for rural track programs as long as the tracks were actually located in rural areas at the time the urban hospital received its adjustment. However, if the urban hospital wants to receive a cap adjustment for a new rural track residency program, the rural track must involve rural hospitals that are located in rural areas based on the most recent OMB labor market designations as specified in the FY 2005 IPPS final rule. We are proposing to add a new paragraph (k)(7) to § 413.79 to incorporate this proposal.

b. Section 1886(d)(8)(E) Hospitals

As stated above, a second situation exists where a hospital that is treated as rural returns to being urban under section 1886(d)(8)(E) of the Act (§ 412.103 of the regulations). Under this provision, an urban hospital may file an application to be treated as being located in a rural area. A hospital's reclassification as located in a rural area under this provision affects only payments under section 1886(d) of the Act. Accordingly, a hospital that is treated as rural under this provision can receive the FTE cap adjustments that any other rural hospital receives, but only to the FTE cap that applies for purposes of IME payments, which are made under section 1886(d) of the Act. The hospital could not receive adjustments to its direct GME FTE cap because payments for direct GME are made under section 1886(h) of the Act and the section 1886(d)(8)(E) reclassifications affect only the payments that are made under that section 1886(d) of the Act. Therefore, a hospital that reclassifies as rural under section 1886(d)(8)(E) of the Act may receive the 130-percent adjustment to its IME FTE cap and its IME FTE cap may be adjusted for any new programs, similar to hospitals that are actually located in a rural location. A hospital treated as rural under section 1886(d)(8)(E) of the Act may subsequently withdraw its election and return to its urban status under the regulations at § 412.103. We are proposing that, effective with discharges occurring on or after October 1, 2005, a different policy should apply for hospitals that reclassify under section 1886(d)(8)(E) of the Act than the policy that applies to rural hospitals redesignated as urban due to changes in labor market areas, as discussed in section IV.F.3 of this preamble.

5. Technical Changes: Cross References

• In the FY 2005 IPPS final rule (69 FR 49234), we redesignated the contents of § 413.86 as §§ 413.75 through 413.83. We also updated cross-references to § 413.86 that were located in various sections under 42 CFR Parts 400 through 499. We inadvertently did not capture all of the needed cross-reference changes. In this proposed rule, we are proposing to correct the additional cross-references in 42 CFR Parts 405, 412, 413, 415, 419, and 422 that were not made in the August 11, 2004 final rule.

• When we redesignated § 413.86 as §§ 413.75 through 413.83 in the FY 2005 IPPS final rule, we also made a corresponding redesignation of § 413.80 as § 413.89. We are proposing to correct cross-references to § 413.80 in 42 CFR Parts 412, 413, 417, and 419 to reflect the redesignation of this section as § 413.89.

J. Provider-Based Status of Facilities and Organizations Under Medicare

(If you choose to comment on issues in this section, please include the caption "Provider-Based Entities'' at the beginning of your comment.)

1. Background

Since the beginning of the Medicare program, some providers, which we refer to as "main providers,'' have functioned as a single entity while owning and operating multiple provider-based departments, locations, and facilities that were treated as part of the main provider for Medicare purposes. Having clear criteria for provider-based status is important because this designation can result in additional Medicare payments for services furnished at the provider-based facility, and may also increase the coinsurance liability of Medicare beneficiaries for those services.

To set forth Medicare policies with regard to the provider-based status of facilities and organizations, we have published a number of **Federal Register** documents as follows:

• In a proposed rule published in the **Federal Register** on September 8, 1998 (63 FR 47552), we proposed specific and comprehensive criteria for determining whether a facility or organization is provider-based. In the preamble to the proposed rule, we explained why we believed meeting each criterion would be necessary to a finding that a facility or organization qualifies for provider-based status. After considering public comments on the September 8, 1998 proposed rule and making appropriate revisions, on April 7, 2000 (65 FR 18504), we published a final rule setting forth the provider-based regulations at 42 CFR 413.65.

• Before the regulations that were issued on April 7, 2000 could be implemented, Congress enacted the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Pub. L. 106–544. Section 404 of BIPA delayed implementation of the April 7, 2000 provider-based rules with respect to many providers, and mandated changes in the criteria at § 413.65 for determining provider-based status.

• In order to conform our regulations to the requirements of section 404 of BIPA and to codify certain clarifications of provider-based policy that had previously been posted on the CMS Web site, we published another proposed rule on August 24, 2001 (66 FR 44672). After considering public comments on the August 24, 2001 proposed rule and making appropriate revisions, we published a final rule on November 30, 2001 setting forth the provider-based regulations (66 FR 59909).

• On May 9, 2002, we proposed further significant revisions to the provider-based regulations at § 413.65 (67 FR 31480). After considering public comments on the May 9, 2002 proposed rule and making appropriate revisions, on August 1, 2002, we published a final rule specifying the criteria that must be met to qualify for provider-based status (67 FR 50078). These regulations remain in effect and continue to be codified at § 413.65.

Following is a discussion of the major provisions of the provider-based regulations: Section 413.65(a) of the regulations describes the scope of that section and provides definitions of key terms used in the regulations. Paragraph (b) describes the procedure for making provider-based determinations, and paragraph (c) imposes requirements for reporting material changes in relationships between main providers and provider-based facilities or organizations. In paragraph (d), we

specify the requirements that are applicable to all facilities or organizations seeking provider-based status, and in paragraph (e), we describe the additional requirements applicable to off-campus facilities or organizations (generally, those located more than 250 yards from the provider's main buildings). Paragraphs (f) through (o) set forth policies regarding joint ventures, obligations of provider-based facilities, facilities operated under management contracts or providing all services under arrangements, procedures in connection with certain provider-based determinations, and specific types of facilities such as Indian Health Service (IHS) and Tribal facilities and Federally qualified health centers (FQHCs).

2. Limits on the Scope of the Provider-Based Regulations—Facilities for Which Provider-Based Determinations Will Not Be Made

In § 413.65(a) (1)(ii), we list specific types of facilities and organizations for which determinations of provider-based status will not be made. We previously concluded that provider-based determinations should not be made for these facilities because the outcome of the determination (that is, whether a facility, unit, or department is found to be freestanding or provider-based) would not affect the methodology used to make Medicare or Medicaid payment, the scope of benefits available to a Medicare beneficiary in or at the facility, or the deductible or coinsurance liability of a Medicare beneficiary in or at the facility.

We have now concluded that, under the principle stated above, rural health clinics affiliated with hospitals having 50 or more beds should be added to the list of facilities for which provider-based status determinations are not made. Therefore, we are proposing to revise § 413.65(a)(1)(ii) to add rural health clinics with hospitals having 50 or more beds to the listing of the types of facilities for which a provider-based status determination will not be made. We believe this proposed revision to § 413.65(a)(1)(ii) is appropriate because all rural health clinics affiliated with hospitals having 50 or more beds are paid on the same basis as rural health clinics not affiliated with any hospital, and the scope of Medicare Part B benefits and beneficiary liability for Medicare Part B deductible and coinsurance amounts would be the same, regardless of whether the rural health clinic was found to be provider-based or freestanding.

In setting forth this proposal, we recognize that rural health clinics affiliated with hospitals report their costs using the hospital's cost report rather than by filing a separate rural health clinic cost report, and that whether or not a rural health clinic is hospital-affiliated will affect the selection of a fiscal intermediary for the clinic. However, we do not believe these administrative differences provide a sufficient reason to make provider-based determinations for such rural health clinics.

3. Location Requirement for Off-Campus Facilities: Application to Certain Neonatal Intensive Care Units

As we stated in the preamble to May 9, 2002 proposed rule for changes in the provider-based rules (67 FR 31485), we recognize that provider-based status is not limited to on-campus facilities or organizations and that facilities or organizations located off the main provider campus may also be sufficiently integrated with the main provider to justify a provider-based designation. However, the off-campus location of the facilities or organizations may make such integration harder to achieve, and such integration should not simply be presumed to exist. Therefore, to ensure that off-campus facilities or organizations seeking provider-based status are appropriately integrated, we have adopted certain requirements regarding the location of off-campus facilities or organizations. These requirements are set forth in § 413.65(e)(3). Section 413.65(e)(3) specifies that a facility or organization not located on the main campus of the potential main provider can qualify for provider-based status only if it is located within a 35-mile radius of the campus of the hospital or CAH that is the potential main provider, or meets any one of the following requirements.

- The facility or organization is owned and operated by a hospital or CAH that has a disproportionate share adjustment (as determined under § 412.106) greater than 11.75 percent or is described in § 412.106(c)(2) of the regulations which implement section 1886(e)(5)(F)(i)(II) of the Act and is—
  - —Owned or operated by a unit of State or local government;
  - —A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or
  - —A private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan).

  (§ 413.65(e)(3)(i))
- The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with CMS, and for each subsequent 12-month period—
  - —At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider (§ 413.65(e)(3)(ii)(A)); or
  - —At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of a rural health clinic seeking provider-based status received inpatient hospital services from the hospital that is the main provider (§ 413.65(e)(3)(ii)(B)).

Section 413.65(e)(3)(ii)(C) of the regulations allows new facilities or organizations to qualify as provider-based entities. Under this section, if a facility or organization is unable to meet the criteria in § 413.65(e)(3)(ii)(A) or (e)(3)(ii)(B) because it was not in operation during all of the 12-month period before the start of the period for which provider-based status is sought, the facility or organization may nevertheless meet the location requirement of paragraph (e)(3) of § 413.65 if it is located in a zip code area included among those that, during all of the 12-month period before the start of the period for which provider-based status is sought, accounted for at least 75 percent of the patients served by the main provider.

CMS has been advised that, in some cases, the location requirements in current regulations may inadvertently impede the delivery of intensive care services to newborn infants in areas where there is no nearby children's hospital with a neonatal intensive care unit (NICU). According to those who expressed this concern, hospitals participating in the Medicare program as children's hospitals establish off-site neonatal intensive care units (NICUs) which they operate and staff but which are located in space leased from other hospitals. The hospitals in which the offsite NICUs are housed typically are

short-term, acute care hospitals located in rural areas. According to comments that CMS has received, the nearest children's hospital in a rural area is usually located a considerable distance from individual rural communities, which prevents infants in these rural communities from having ready access to the specialized care offered by NICUs.

We have received a suggestion that this configuration (that of a hospital participating in the Medicare program as a hospital whose inpatients are predominantly individuals under 18 years of age under section 1886(d)(1)(B)(iii) of the Act, establishing an offsite NICU which it operates and staffs but which is located in space leased from another hospital) can be very helpful in making neonatal intensive care more quickly available in areas where community hospitals are located. In addition, this configuration can offer relief to families who otherwise would be required to travel long distances to obtain this care for their infants. However, offsite NICUs would not be able to qualify for provider-based status under the location criteria in our current regulations if they are located more than 35 miles from the children's hospital that would be the main provider, are not owned and operated by a hospital meeting the requirements of § 413.65(e)(3)(i), and cannot meet either of the "75 percent tests'' for service to the same patient population as the potential main provider that are specified in existing § 413.65(e)(3)(ii)(A) and § 413.65(e)(3)(ii)(B).

We understand the concern that requiring a patient to be transported to an NICU located on the campus of a distant children's hospital could create an unacceptable medical risk to the life of a newborn at a most critical time. To help us better understand this issue and determine what action, if any, CMS should take on it, we are soliciting specific public comment on the following question:

• Is the problem as described above actually occurring and, if so, in what locations? We are particularly interested in learning which areas of which States are experiencing such a problem, and in receiving specific information, such as the rates of transfer of newborns from community hospitals to children's hospital on-campus NICUs relative to adult or non-neonatal pediatric transfers for intensive care services, which describe the problem objectively. Such objective information will be much more useful than expressions of opinion or anecdotes.

We also wish to ask those who believe such a problem is currently occurring to comment on which of the following approaches would be most effective in resolving it. The proposed approaches on which we are soliciting specific comments are:

■ A change in the Medicare provider-based regulations to create an exception to the location requirements for NICUs located in community hospitals that are more than 35 miles from the children's hospital that is the potential main provider. The exception might take the form of a more generous mileage allowance (such as being within 50 miles of the potential main provider) or could require other criteria to be met. However, the exception would be available only if there is no other NICU within 35 miles of the community hospital.

■ A change in the national Medicaid regulations to allow off-campus NICUs that meet other provider-based requirements under § 413.65 to qualify as provider-based for purposes of payment under Medicaid, even though those facilities would not qualify as provider-based under Medicare. (We note that under 42 CFR 440.10(a)(3)(iii), services are considered to be "inpatient hospital services'' under the Medicaid program only if they are furnished in an institution that meets the requirements for participation in Medicare as a hospital. Because of the age of the patients they serve, NICUs typically have no Medicare utilization but a substantial proportion of their patients may be Medicaid patients.)

■ A change in individual State's Medicaid plans that would provide enhanced financial incentives for community hospitals to establish NICUs, possibly in collaboration with children's hospitals.

■ The establishment of children's hospitals that meet the requirements for being hospitals-within-hospitals under 42 CFR 412.22(e). (We note that this option, unlike the three above, would not require any revision of Medicare or Medicaid regulations or individual State Medicaid plans).

We also welcome suggestions for specific options other than those listed above.

4. Technical and Clarifying Changes to § 413.65

a. *Definitions.* In paragraph (a)(2) of § 413.65, we state that the term "Provider-based entity'' means a provider of health care services, or an RHC as defined in § 405.2401(b), that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership and administrative and financial control of the main provider, in accordance with the provisions of § 413.65. In recognition of the fact that provider-based entities, unlike departments of a provider, offer a type of services different from those of the main provider and participate separately in Medicare, we are proposing to revise this requirement by deleting the word "name'' from this definition. This change would simplify compliance with the provider-based criteria since entities that do not now operate under the potential main provider's name will not be obligated to change their names in order to be treated as provider-based.

b. *Provider-based determinations.* In paragraph (b)(3)(ii) of § 413.65, we state that, in the case of a facility not located on the campus of the potential main provider, the provider seeking a determination would be required to submit an attestation stating that the facility meets the criteria in paragraphs (d) and (e) of § 413.65, and if the facility is operated as a joint venture or under a management contract, the requirements of paragraph (f) or paragraph (h) of § 413.65, as applicable. However, paragraph (f), which sets forth rules regarding provider-based status for joint ventures, states clearly that a facility or organization operated as a joint venture may qualify for provider-based status only if it is located on the main campus of the potential main provider. To avoid any misunderstanding regarding the content of attestations for off-campus facilities, we are proposing to revise paragraph (b)(3)(ii) by removing the reference to compliance with requirements in paragraph (f) for joint ventures. We also are proposing to add a sentence to paragraph (b)(3)(i), regarding attestations for on-campus facilities, to state that if the facility is operated as a joint venture, the attestation by the potential main provider regarding that facility would also have to include a statement that the provider will comply with the requirements of paragraph (f) of § 413.65.

c. *Additional requirements applicable to off-campus facilities or organizations—Operation under the ownership and control of the main provider.* In paragraph (e)(1)(i), regarding 100 percent ownership by the main provider of the business enterprise that constitutes the facility or organization seeking provider-bases status, we are proposing to add the word "main'' before the word "provider'', to clarify that the main provider must own and control the facility or organization seeking provider-based status. We are also proposing, for purposes of

clarifying the requirements in paragraph (e)(1), to add the word "main'' before the word "provider'' in paragraphs (e)(1)(ii) and (e)(1)(iii).

d. *Additional requirements applicable to off-campus facilities or organizations—Location.* We are proposing several clarifying changes to this paragraph, as follows:

Currently, the opening sentence of § 413.65(e)(3) states that a facility or organization for which provider-based status is sought must be located within a 35-mile radius of the campus of the hospital or CAH that is the potential main provider, except when the requirements in paragraph (e)(3)(i), (e)(3)(ii), or (e)(3)(iii) of that section are met. However, the regulation text that follows does not contain a paragraph designation as paragraph (e)(3)(iii). We are proposing to correct this error by redesignating existing paragraph (e)(3)(ii)(C) as paragraph (e)(3)(iv). We are also proposing to revise this sentence to state that the facility or organization must meet the requirements in paragraph (e)(3)(i), (e)(3)(ii), (e)(3)(iii), (e)(3)(iv) or, in the case of an RHC, paragraph (e)(3)(v) of § 413.65 and the requirements in paragraph (e)(3)(vi) of § 413.65.

We are proposing to revise the opening sentence of § 413.65(e)(3) to reflect the changes in the coding of this paragraph as described above.

We are also proposing to redesignate paragraph (v) of § 413.65(e)(3) as paragraph (e)(3)(vi) and correct a drafting error by adding the word "that'' before "has fewer than 50 beds''. This proposed addition is a grammatical change that is intended only to clarify the size of the hospital with which a rural health clinic must have a provider-based relationship in order to qualify under the special location requirement in that paragraph.

e. *Paragraph (g)—Obligations of hospital outpatient departments and hospital-based entities.* We are proposing to revise the first sentence of paragraph (g)(7), regarding beneficiary notices of coinsurance liability, to clarify that notice must be given only if the service is one for which the beneficiary will incur a coinsurance liability for both an outpatient visit to the hospital and the physician service. This should help to make it clear that notice is not required for visits that do not result in additional coinsurance liability. In addition, we are proposing to reorganize the subsequent paragraphs of that section for clarity.

K. Rural Community Hospital Demonstration Program

(If you choose to comment on issues in this section, please include the caption "Rural Community Hospital Demonstration Program'' at the beginning of your comments.)

In accordance with the requirements of section 410A(a) of Pub. L. 108–173, the Secretary has established a 5-year demonstration (beginning with selected hospitals' first cost reporting period beginning on or after October 1, 2004) to test the feasibility and advisability of establishing "rural community hospitals'' for Medicare payment purposes for covered inpatient hospital services furnished to Medicare beneficiaries. A rural community hospital, as defined in section 410A(f)(1), is a hospital that—

- Is located in a rural area (as defined in section 1886(d)(2)(D) of the Act) or treated as being so located under section 1886(d)(8)(E) of the Act;
- Has fewer than 51 beds (excluding beds in a distinct part psychiatric or rehabilitation unit) as reported in its most recent cost report;
- Provides 24-hour emergency care services; and
- Is not designated or eligible for designation as a CAH.

As we indicated in the FY 2005 IPPS final rule (69 FR 49078), in accordance with sections 410A(a)(2) and (4) of Pub. L. 108–173 and using 2002 data from the U.S. Census Bureau, we identified 10 States with the lowest population density from which to select hospitals: Alaska, Idaho, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Utah, and Wyoming. (Source: U.S. Census Bureau Statistical Abstract of the United States: 2003) Thirteen rural community hospitals located within these States are participating in the demonstration.

Under the demonstration, participating hospitals are paid the reasonable costs of providing covered inpatient hospital services (other than services furnished by a psychiatric or rehabilitation unit of a hospital that is a distinct part), applicable for discharges occurring in the first cost reporting period beginning on or after the October 1, 2004 implementation date of the demonstration program. Payment will be the lesser amount of reasonable cost or a target amount in subsequent cost reporting periods. The target amount in the second cost reporting period is defined as the reasonable costs of providing covered inpatient hospital services in the first cost reporting period, increased by the inpatient prospective payment update factor (as defined in section 1886(b)(3)(B) of the Act) for that particular cost reporting period. The target amount in subsequent cost reporting periods is defined as the preceding cost reporting period's target amount, increased by the inpatient prospective payment update factor (as defined in section 1886(b)(3)(B) of the Act) for that particular cost reporting period.

Covered inpatient hospital services means inpatient hospital services (defined in section 1861(b) of the Act) and includes extended care services furnished under an agreement under section 1883 of the Act.

Section 410A of Pub. L. 108–173 requires that "in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' Generally, when CMS implements a demonstration on a budget neutral basis, the demonstration is budget neutral in its own terms; in other words, aggregate payments to the participating providers do not exceed the amount that would be paid to those same providers in the absence of the demonstration. This form of budget neutrality is viable when, by changing payments or aligning incentives to improve overall efficiency, or both, a demonstration may reduce the use of some services or eliminate the need for others, resulting in reduced expenditures for the demonstration participants. These reduced expenditures offset increased payments elsewhere under the demonstration, thus ensuring that the demonstration as a whole is budget neutral or yields savings. However, the small scale of this demonstration, in conjunction with the payment methodology, makes it extremely unlikely that this demonstration could be viable under the usual form of budget neutrality. Specifically, cost-based payments to 13 small rural hospitals are likely to increase Medicare outlays without producing any offsetting reduction in Medicare expenditures elsewhere. Therefore, a rural community hospital's participation in this demonstration is unlikely to yield benefits to the participant if budget neutrality were to be implemented by reducing other payments for these providers.

In order to achieve budget neutrality for this demonstration, we are proposing to adjust national inpatient PPS rates by an amount sufficient to account for the added costs of this demonstration. In other words, we apply budget neutrality

across the payment system as a whole rather than merely across the participants of this demonstration. As we discussed in the FY 2005 IPPS final rule (69 FR 49183), we believe that the language of the statutory budget neutrality requirements permits the agency to implement the budget neutrality provision in this manner. For FY 2006, using the most recent cost report data (that is, data for FY 2003), adjusted for increased estimated cost for the 13 participating hospitals, we are proposing that the estimated adjusted amount would be $12,706,334. This adjusted amount reflects the estimated difference between cost and IPPS payment based on data from hospitals' cost reports. We discuss the proposed payment rate adjustment that would be required to ensure the budget neutrality of the demonstration in section II.A.4. of the Addendum to this proposed rule.

The data collection instrument for the demonstration has been approved by OMB under the title "Medicare Waiver Demonstration Application,'' under OMB approval number 0938–0880, with a current expiration date of July 30, 2006.

L. Definition of a Hospital in Connection With Specialty Hospitals

(If you choose to comment on issues in this section, please include the caption "Specialty Hospitals'' at the beginning of your comment.)

Section 1861(e) of the Act provides a definition for a "hospital'' for purposes of participating in the Medicare program. In order to be a Medicare-participating hospital, an institution must, among other things, be primarily engaged in furnishing services to inpatients. This requirement is incorporated in our regulations on conditions of participation for hospitals at 42 CFR 482.1. An institution that applies for a Medicare provider agreement as a hospital but is unable to meet this requirement will have its application denied in accordance with our authority at 42 CFR 489.12. In addition, institutions that have a Medicare hospital provider agreement but are no longer primarily engaging in furnishing services to inpatients are subject to having their provider agreements terminated pursuant to 42 CFR 489.53. Although compliance with this requirement is not problematic for most hospitals, the issue of whether an institution is primarily engaged in providing care to inpatients has recently come to our attention in two arisen two contexts. First, an institution has applied to be certified as an "emergency hospital,'' yet the institution has 29 outpatient beds for emergency patients, including observation and post-anesthesia care, and only 2 inpatient beds. Emergency treatment by nature does not usually involve overnight stays. Second, the issue has also arisen in the area of "specialty hospitals.'' (For purposes of this discussion, "specialty hospitals'' are those hospitals specifically defined as such in section 507 of Pub. L. 108–173 (MMA), that is, those hospitals that are primarily or exclusively engaged in the care and treatment of:

(i) Patients with a cardiac condition; (ii) patients with an orthopedic condition; or (iii) patients receiving a surgical procedure.)

"Specialty hospitals'' are of interest partly because of section 507 of Pub. L. 108–173, which amended the hospital ownership exception to the physician self-referral prohibition statute, section 1877 of the Act. Prior to the enactment of Pub. L. 108–173, the "whole hospital'' exception contained in section 1877(d)(3) of the Act allowed a physician to refer Medicare patients to a hospital in which the physician (or an immediate family member of the physician) had an ownership or investment interest, if the physician was authorized to perform services at the hospital and the ownership or investment interest was in the entire hospital and not a subdivision of the hospital. Section 507 of Pub. L. 108–173 added an additional criterion to the whole hospital exception, specifying that for the 18-month period beginning on December 8, 2003 and ending on June 8, 2005, physician ownership and investment interests in "specialty hospitals'' would not qualify for the whole hospital exception. The term "specialty hospital'' does not include any hospital determined by the Secretary to be in operation or "under development'' as of November 18, 2003.

In our advisory opinions that we issue as to whether a requesting entity is subject to the 18-month moratorium described above, we inform the requesting entity that, among other things, it must meet the definition of a hospital that is contained in section 1861(e) of the Act. It has come to our attention that some institutions entities that describe themselves as surgical or orthopedic specialty hospitals may be primarily primarily engaged in furnishing services to outpatients, and thus would might not meet the definition of a hospital as contained in section 1861(e) of the Act. Therefore, although an institution entity may satisfy the "under development'' criteria for purposes of being excepted from the moratorium on physician-owner referrals to specialty hospitals, if we were to determine such entity is not primarily engaged in inpatient care at the time it seeks certification to participate in the Medicare program, its application for a provider agreement as a hospital would will be denied and it would not be eligible for the whole hospital exception to the prohibition on physician self-referrals. Further, if we were to determine that a specialty hospital that is operating under an existing Medicare provider agreement but is not, or is no longer, primarily engaged in treating inpatients, the hospital is subject to having its provider agreement terminated; in this event, it could no longer take advantage of and lose the protection of the whole hospital exception.

VI. PPS for Capital-Related Costs

(If you choose to comment on issues in this section, please include the caption "Capital-Related Costs'' at the beginning of your comment.)

In this proposed rule, we are not proposing 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, we are providing a summary of the statutory basis for the PPS for hospital capital-related costs and the methodology used to determine capital-related payments to hospitals. A discussion of the proposed rates and factors for FY 2006 (determined under our established methodology) can be found in section III. of the Addendum of this proposed rule.

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient acute hospital services "in accordance with a PPS established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the PPS for hospital inpatient capital-related costs. We initially implemented the PPS for capital-related costs in the August 30, 1991 IPPS final rule (56 FR 43358), in which we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

Federal fiscal year (FY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital inpatient capital-related costs. For cost reporting periods beginning in FY 2002, capital PPS payments are based solely on the Federal rate for most acute care hospitals (other than certain new hospitals and hospitals receiving certain exception payments). The basic

methodology for determining capital prospective payments using the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows:

(Standard Federal Rate) × (DRG Weight) × (Geographic Adjustment Factor (GAF)) × (Large Urban Add-on, if applicable) × (COLA Adjustment for hospitals located in Alaska and Hawaii) × (1 + Capital DSH Adjustment Factor + Capital IME Adjustment Factor, if applicable)

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year as specified in § 412.312(c) of the regulations.

The regulations at § 412.348(f) provide that a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control. This policy was originally established for hospitals during the 10-year transition period, but as we discussed in the August 1, 2002 IPPS final rule (67 FR 50102), we revised the regulations at § 412.312 to specify that payments for extraordinary circumstances are also made for cost reporting periods after the transition period (that is, cost reporting periods beginning on or after October 1, 2001). Additional information on the exceptions payment for extraordinary circumstances in § 412.348(f) can be found in the FY 2005 IPPS final rule (69 FR 49185 through 49186).

During the transition period, under §§ 412.348(b) through (e), eligible hospitals could receive regular exception payments. These exception payments guaranteed a hospital a minimum payment percentage of its Medicare allowable capital-related costs depending on the class of hospital (§ 412.348(c)), but were available only during the 10-year transition period. After the end of the transition period, eligible hospitals can no longer receive this exception payment. However, even after the transition period, eligible hospitals receive additional payments under the special exceptions provisions at § 412.348(g), which guarantees all eligible hospitals a minimum payment of 70 percent of its Medicare allowable capital-related costs provided that special exceptions payments do not exceed 10 percent of total capital IPPS payments. Special exceptions payments may be made only for the 10 years from the cost reporting year in which the hospital completes its qualifying project, and the hospital must have completed the project no later than the hospital's cost reporting period beginning before October 1, 2001. Thus, an eligible hospital may receive special exceptions payments for up to 10 years beyond the end of the capital PPS transition period. Hospitals eligible for special exceptions payments were required to submit documentation to the intermediary indicating the completion date of their project. (For more detailed information regarding the special exceptions policy under § 412.348(g), refer to the August 1, 2001 IPPS final rule (66 FR 39911 through 39914) and the August 1, 2002 IPPS final rule (67 FR 50102).)

Under the PPS for capital-related costs, § 412.300(b) of the regulations defines a new hospital as a hospital that has operated (under current or previous ownership) for less than 2 years. (For more detailed information see the August 30, 1991 final rule (56 FR 43418).) During the 10-year transition period, a new hospital was exempt from the capital PPS for its first 2 years of operation and was paid 85 percent of its reasonable costs during that period. Originally, this provision was effective only through the transition period and, therefore, ended with cost reporting periods beginning in FY 2002. Because we believe that special protection to new hospitals is also appropriate even after the transition period, as discussed in the August 1, 2002 IPPS final rule (67 FR 50101), we revised the regulations at § 412.304(c)(2) to provide that, for cost reporting periods beginning on or after October 1, 2002, a new hospital (defined under § 412.300(b)) is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its first 2 years of operation, unless the new hospital elects to receive fully-prospective payment based on 100 percent of the Federal rate. (Refer to the August 1, 2001 IPPS final rule (66 FR 39910) for a detailed discussion of the statutory basis for the system, the development and evolution of the system, the methodology used to determine capital-related payments to hospitals both during and after the transition period, and the policy for providing exception payments.)

Section 412.374 provides for the use of a blended payment amount for prospective payments for capital-related costs to hospitals located in Puerto Rico. Accordingly, under the capital PPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs. In general, hospitals located in Puerto Rico are paid a blend of the applicable capital PPS Puerto Rico rate and the applicable capital PPS Federal rate.

Prior to FY 1998, hospitals in Puerto Rico were paid a blended capital PPS rate that consisted of 75 percent of the applicable capital PPS Puerto Rico specific rate and 25 percent of the applicable capital PPS Federal rate. However, effective October 1, 1997 (FY 1998), in conjunction with the change to the operating PPS blend percentage for Puerto Rico hospitals required by section 4406 of Pub. L. 105–33, we revised the methodology for computing capital PPS payments to hospitals in Puerto Rico to be based on a blend of 50 percent of the Puerto Rico rate and 50 percent of the Federal rate. Similarly, effective beginning in FY 2005, in conjunction with the change in operating PPS payments to hospitals in Puerto Rico for FY 2005 required by section 504 of Pub. L. 108–173, we again revised the methodology for computing capital PPS payments to hospitals in Puerto Rico to be based on a blend of 25 percent of the Puerto Rico rate and 75 percent of the Federal rate for discharges occurring on or after October 1, 2004.

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

(If you choose to comment on issues in this section, please include the caption "Excluded Hospitals and Units'' at the beginning of your comment.)

A. Payments to Existing 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 cost reporting periods beginning on or after October 1, 1997 through September 30, 2002, for certain existing hospitals and hospital units excluded from the IPPS. Section 413.40(c)(4)(iii) of the implementing regulations states that "In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the target amount is the lower of amounts specified in paragraph (c)(4)(iii)(A) or (c)(4)(iii)(B) of this section.'' Accordingly, in general, for hospitals and units within these three classes of providers for the applicable 5-year period, the target amount is the lower of either: the hospital-specific target amount (§ 413.40(c)(4)(iii)(A)) or the 75th percentile cap (§ 413.40(c)(4)(iii)(B)). (We note that, in the case of LTCHs, for cost reporting periods beginning during

FY 2001, the hospital-specific target amount is the net allowable cost in a base period increased by the applicable update factors multiplied by 1.25.)

Questions have been raised as to whether § 413.40(c)(4)(iii) (specifically paragraph (c)(4)(iii)(A)) continues to apply beyond FY 2002. In order to clarify the policy for periods after FY 2002, we note that § 413.40(c)(4)(iii) applies only to cost reporting periods beginning on or after October 1, 1997 through September 30, 2002, for psychiatric hospitals and units, rehabilitation hospitals and units, and LTCHs. We discussed this applicable time period in the May 12, 1998 **Federal Register** (63 FR 26344) when we discussed implementing the caps. Specifically, we clarified our regulations to indicate that the target amount for FYs 1998 through 2002 is equal to the lower of the hospital-specific target amount or the 75th percentile of target amounts for hospitals in the same class for cost reporting periods ending during FY 1996, increased by the applicable market basket percentage for the subject period. We did not intend for the provisions of § 413.40(c)(4)(iii) to apply beyond FY 2002, as we specifically included an ending date; that is, we stated that the target amount calculation provisions were for FYs 1998 through 2002. More recently, in the FY 2003 IPPS final rule (67 FR 50103), we clarified again how the target amount for FY 2003 was to be determined by stating that: "* * * for cost reporting periods beginning in FY 2003, the hospital or unit should use its previous year's target amount, updated by the appropriate rate-of-increase percentage.'' Thus, the time-limited provision of § 413.40(c)(4)(iii) is neither a new policy nor a change in policy.

For cost reporting periods beginning on or after October 1, 2002, to the extent one of the above-mentioned excluded hospitals or units has all or a portion of its payment determined under reasonable cost principles, the target amounts for the reasonable cost-based portion of the payment are determined in accordance with section 1886(b)(3)(A)(ii) of the Act and the regulations at § 413.40(c)(4)(ii). Section 413.40(c)(4)(ii) states, "Subject to the provisions of [§ 413.40] paragraph (c)(4)(iii) of this section, for subsequent cost reporting periods, the target amount equals the hospital's target amount for the previous cost reporting period increased by the update factor for the subject cost reporting period unless the provisions of [§ 413.40] paragraph (c)(5)(ii) of this section apply.'' Thus, since § 413.40(c)(4)(ii) indicates that the provisions of that paragraph are subject to the provisions of § 413.40(c)(4)(iii), which are applicable only for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002, the target amount for FY 2003 is determined by updating the target amount for FY 2002 (the target amount from the previous period) by the applicable update factor. Accordingly, we are proposing to make a change to the language in § 413.40(c)(4)(iii) to clarify that the provisions of this paragraph relating to the caps on target amounts are for a specific period of time only, that is, cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002.

The inpatient operating costs of children's hospitals and cancer hospitals that are excluded from the IPPS are subject to the rate-of-increase limits established under the authority of section 1886(b) of the Act and implemented in the regulations at § 413.40. Under these limits, an annual target amount (expressed in terms of the inpatient operating cost per discharge) is set for each hospital, based on the hospital's own historical cost experience, trended forward by the applicable percentage increase. This target amount is applied as a ceiling on the allowable costs per discharge for the hospital's cost reporting period. (We note that, in accordance with § 403.752(a) of the regulations, RNHCIs are also subject to the rate-of-increase limits established under § 413.40 of the regulations.)

2. Updated Caps for New Excluded Hospitals and Units

Section 1886(b)(7) of the Act established the method for determining the payment amount for new rehabilitation hospitals and units, psychiatric hospitals and units, and LTCHs that first received payment as a hospital or unit excluded from the IPPS on or after October 1, 1997. However, effective for cost reporting periods beginning on or after October 1, 2002, this payment amount (or "new provider cap'') no longer applies to any new rehabilitation hospital or unit because they now are paid 100 percent of the Federal prospective rate under the IRF PPS.

In addition, LTCHs that meet the definition of a new LTCH under § 412.23(e)(4) are also paid 100 percent of the fully Federal prospective payment rate under the LTCH PPS. In contrast, those "new'' LTCHs that meet the criteria under § 413.40(f)(2)(ii) (that is, that were not paid as an excluded hospital prior to October 1, 1997), but were paid as a LTCH before October 1, 2002, may be paid under the LTCH PPS transition methodology with the reasonable cost portion of the payment subject to § 413.40(f)(2)(ii). Finally, LTCHs that existed prior to October 1, 1997, may also be paid under the LTCH PPS transition methodology with the reasonable cost portion of the payment subject to § 413.40(c)(4)(ii). (The last LTCHs that were subject to the payment amount limitation for "new'' LTCHs were new LTCHs that had their first cost reporting period beginning on September 30, 2002. In that case, the payment amount limitation remained applicable for the next 2 years—September 30, 2002 through September 29, 2003, and September 30, 2003 through September 29, 2004. This is because, under existing regulations at § 413.40(f)(2)(ii), a "new hospital'' would be subject to the same payment (target amount) in its second cost reporting period that was applicable to the LTCH in its first cost reporting period. Accordingly, for these hospitals, the updated payment amount limitation that we published in the FY 2003 IPPS final rule (67 FR 50103) applied through September 29, 2004. Consequently, there is no longer a need to publish updated payment amounts for new (§ 413.40(f)(2)(ii)) LTCHs. A discussion of how the payment limitations were 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).

A freestanding inpatient rehabilitation hospital, an inpatient rehabilitation unit of an acute care hospital, and an inpatient rehabilitation unit of a CAH are referred to as IRFs. Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is also no longer applicable to new rehabilitation hospitals and units because they are paid 100 percent of the Federal prospective rate under the IRF PPS. Therefore, it is also no longer necessary to update the payment limitation for new rehabilitation hospitals or units.

For psychiatric hospitals and units, under the IPF PPS, there is a 3-year transition period during which existing IPFs will receive a blended payment of the Federal per diem payment amount and the payment amount that IPFs would receive under the reasonable cost-based payment (TEFRA) methodology. However, new IPFs (those facilities that under present or previous ownership (or both) have their first cost reporting period as an IPF begin on or after January 1, 2005, are paid the fully Federal per diem payment amount rather than a blended payment amount.

(See section VII.A.5. of the preamble of this proposed rule for further discussion of the IPF PPS.) Thus, the payment limitations under the TEFRA payment system are not applicable for new IPFs that meet the definition in § 412.426(c).

However, "new'' IPFs that meet the criteria under § 413.40(f)(2)(ii) (that is, that were not paid as an excluded hospital prior to October 1, 1997), but were paid as an IPF before January 1, 2005, are paid under the IPF PPS transition methodology with the reasonable cost portion of the payment determined according to § 413.40(f)(2)(ii), that is, subject to the payment amount limitation. The last "new'' IPFs that were subject to the payment amount limitation were IPFs that had their first cost reporting period beginning on December 31, 2004. For these hospitals, the payment amount limitation that was published in the FY 2005 IPPS final rule (69 FR 49189) for cost reporting periods beginning on or after October 1, 2004, and before January 1, 2005, remains applicable for the IPF's first two cost reporting periods. IPFs with a first cost reporting period beginning on or after January 1, 2005, are paid 100 percent of the Federal rate and are not subject to the payment amount limitation. Therefore, since the last IPFs eligible for a blended payment have a cost reporting period beginning on December 31, 2004, the payment limitation published for FY 2005 remains applicable for these IPFs, and publication of the updated payment amount limitation is no longer needed. We note that IPFs that existed prior to October 1, 1997, may also be paid under the IPF transition methodology with the reasonable cost portion of the payment subject to § 413.40(c)(4)(ii).

The payment limitations for new hospitals under TEFRA do not apply to new LTCHs, IRFs, or IPFs, that is, these hospitals with their first cost reporting period beginning on or after the date that the particular class of hospitals implemented their respective PPS. Therefore, for the reasons noted above, we are proposing to discontinue publishing Tables 4G and 4H (Pre-Reclassified Wage Index for Urban and Rural Areas, respectively) in the annual proposed and final IPPS rules.

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 for the phase-in of a case-mix adjusted PPS for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation hospital unit (referred to in the statute as rehabilitation facilities) for cost reporting periods beginning on or after October 1, 2000, and before October 1, 2002, with payments based entirely on the adjusted Federal prospective payment 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. There was a transition period for cost reporting periods beginning on or after January 1, 2002 and ending before October 1, 2002. For cost reporting periods beginning on or after October 1, 2002, payments are based entirely on the Federal prospective payment rate determined under the IRF PPS.

4. Implementation of a PPS for LTCHs

In accordance with the requirements of section 123 of 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.

We published in the **Federal Register** on May 7, 2004, a final rule (69 FR 25673) that updated the payment rates for the upcoming rate year LTCH PPS and made policy changes effective as of July 1, 2004. The 5-year transition period to the fully Federal prospective rate will end with cost reporting periods beginning on or after October 1, 2005 and before October 1, 2006. For cost reporting periods beginning on or after October 1, 2006, payment is based entirely on the adjusted Federal prospective payment rate. However, existing hospitals can elect payment under 100 percent of the adjusted Federal prospective payment rate. Moreover, LTCHs as defined in § 412.23(e)(4) are paid under 100 percent of the adjusted Federal prospective payment rate.

5. Implementation of a PPS for IPFs

In accordance with section 124 of the BBRA and section 405(g)(2) of Pub. L. 108–173, we established a PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units of acute care hospitals and CAHs (inpatient psychiatric facilities (IPFs)). On November 15, 2004, we issued in the **Federal Register** a final rule (69 FR 66922) that established the IPF PPS, effective for IPF cost reporting periods beginning on or after January 1, 2005. Under the final rule, we compute a Federal per diem base rate to be paid to all IPFs for inpatient psychiatric services based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality. The Federal per diem base rate is adjusted to reflect certain patient characteristics, including age, specified DRGs, selected high-cost comorbidities, and day of the stay, and certain facility characteristics, including a wage index adjustment, rural location, indirect teaching costs, the presence of a full-service emergency department, and cost-of-living adjustments for IPFs located in Alaska and Hawaii. We have established a 3-year transition period during which IPFs will be paid based on a blend of reasonable cost-based payment and IPF PPS payments. For cost reporting periods beginning on or after January 1, 2008, IPFs will be paid 100 percent of the Federal per diem payment amount.

B. Critical Access Hospitals (CAHs)

(If you choose to comment on issues in this section, please include the caption "Critical Access Hospitals'' at the beginning of your comment.)

1. Background

Section 1820 of the Act provides for the establishment of Medicare Rural Hospital Flexibility Programs (MRHFPs), 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 (CoPs) under 42 CFR Part 485, Subpart F, will be certified as CAHs by CMS. Regulations governing payments to CAHs for services to Medicare beneficiaries are located in 42 CFR Part 413.

2. Proposed Policy Change Relating to Continued Participation by CAHs in Lugar Counties

Criteria for the designation of a CAH under the MRHFP at section 1820(c)(2)(b)(i) of the Act require that a hospital be located in a rural area as defined in section 1886(d)(2)(D) of the Act or be treated as being located in a rural area in accordance with section 1886(d)(8)(E) of the Act. The regulations at § 485.610 further define "rural area'' for purposes of being a CAH. Under § 485.610(b), a CAH must meet any one of the following three location requirements. First, a CAH must not be located in an MSA as defined by the Office of Management and Budget, not be deemed to be located in an urban area under 42 CFR 412.63(b), and not be reclassified by CMS or the MGCRB as urban for purposes of the standardized payment amount, nor be a member of a group of hospitals reclassified to an urban area under 42 CFR 412.232. Second, if a CAH does not meet the first criterion, if located in an MSA, a CAH will be treated as rural if it has reclassified under 42 CFR 412.103. Third, as we stated in the FY 2005 IPPS final rule, if the CAH cannot meet either of the first two requirements and is located in a revised labor market area (CBSA) under the standards announced by OMB on June 6, 2003 and adopted by CMS effective October 1, 2004, it has until September 30, 2006, to meet one of the other classification requirements without losing its CAH status.

Under section 1886(d)(8)(B) of the Act, hospitals that are located in a rural county that is adjacent to one or more urban counties are considered to be located in the urban MSA to which the greatest number of workers in the county commute, if certain conditions, specified in section 1886(d)(8)(B) of the Act, are met. Regulations implementing this provision are set forth in 42 CFR 412.62(f)(1) (for FY 1984), 42 CFR 412.63(b)(3) (for FYs 1985 through 2004), and at 42 CFR 412.64(b)(3) (for FY 2005 and subsequent fiscal years). The provision (section 1886(d)(8)(B) of the Act) is referred to as the "Lugar provision'' and the counties described by it are referred to as the "Lugar counties.''

As explained more fully in the FY 2005 IPPS final rule (69 FR 48916), certain counties that previously were not considered Lugar counties were, effective October 1, 2004, redesignated as Lugar counties as a result of the most recent census data and the new labor market area definitions announced by OMB on June 6, 2003. Some CAHs located in these newly designated Lugar counties are now unable to meet the rural location requirements described above, even though they were in full compliance with the location requirements in effect at the time they converted from short-term acute care hospital to CAH status.

We have received comments that suggest that it would be inappropriate for a facility to be required to terminate participation as a CAH and resume participating as a short-term acute care hospital because of a change in county classification that did not result from any change in functioning by the CAH. After consideration of these comments, we are clarifying our policy with respect to facilities located in Lugar counties. As we noted in the FY 2005 IPPS final rule, we believe it is appropriate to allow facilities located in counties that began to be considered part of MSAs effective October 1, 2004, as a result of data from the 2000 census and implementation of the new labor market area definitions announced by OMB on June 6, 2003, an opportunity to obtain rural designations under applicable State law or regulations from their State legislatures or regulatory agencies. Similarly, we believe that when a CAH's status as being located in a Lugar county occurs as a result of changes that the CAH did not originate and that were beyond its control, such as a change in the OMB standards for labor market area definitions, it is appropriate for the CAH to be allowed a reasonable opportunity to reclassify to rural status. Thus, we are clarifying our policy to note that CAHs in counties that were designated as Lugar counties effective October 1, 2004, because of implementation of the new labor market area definitions announced by OMB on June 6, 2003, are to be given the same reclassification opportunity. Of course, the opportunity to reclassify would not be available to a CAH if the CAH itself were to initiate some change, such as a redesignation as urban rather than rural under State law or regulations, which would invalidate a prior § 412.103 reclassification. As a result, we are proposing to make changes to § 485.610(b) of the regulations that would permit CAHs located in a county that, in FY 2004, was not part of a Lugar county, but as of FY 2005 was included in such a county as a result of the new labor market area definitions, to maintain their CAH status until September 30, 2006. These changes, if adopted in final form, would permit CAHs in newly designated Lugar counties to continue participating in Medicare as CAHs until September 30, 2006. We expect that this will provide these CAHs with sufficient time to seek reclassification as rural facilities under the current regulations at § 412.103. In other words, after October 1, 2006, these facilities must meet at least one of the criteria in § 412.103(a)(1) through (a)(3) to be eligible to reclassify from urban to rural status. Once the § 412.103 reclassification is approved, the facilities would meet the CAH rural location requirements in § 485.610(b)(2). In addition, consistent with the clarification of the policy, we are proposing to amend the regulations at § 412.103(a)(4) to reflect the proposed change in the text of the CAH location regulations at § 485.610(b)(3).

In addition, we are making a technical amendment to § 485.610(b)(1)(ii) by replacing the reference to 42 CFR 412.63(b) with 42 CFR 412.64(b). This proposed technical amendment would conform the regulations to reflect the rules governing geographic reclassification (found at § 412.64) that are already in place for fiscal years beginning on or after October 1, 2004 (69 FR 49242).

3. Proposed Policy Change Relating to Designation of CAHs as Necessary Providers

Section 405(h) of Pub. L. 108–173 amended section 1820(c)(2)(B)(i)(II) of the Act by adding language that terminated a State's authority to waive the location requirement for a CAH by designating the CAH as a necessary provider, effective January 1, 2006. Currently, a CAH is required to be located more than a 35-mile drive (or in the case of mountainous terrain or secondary roads, a 15-mile drive) from a hospital or another CAH, unless the CAH is certified by the State as a necessary provider of health care services to residents in the area. Under this provision, after January 1, 2006, States will no longer be able to designate a CAH based upon a determination that it is a necessary provider of health care. In addition, section 405(h) of Pub. L. 108–173 amended section 1820(h) of the Act to include a grandfathering provision for CAHs that are certified as necessary providers prior to January 1, 2006. In the FY 2005 IPPS final rule (69 FR 49220), we incorporated these amendments in our regulations at § 485.610 (c). Under that regulation, any CAH that is designated as a necessary provider in its State rural health plan prior to January 1, 2006, will be permitted to maintain its necessary provider designation. However, the regulations are limited to CAHs that were necessary providers as of January 1, 2006, and does not address the

situation where the CAH is no longer the same facility due to relocation, cessation of business, or a substitute facility. Currently, CMS Regional Offices make the decision for continued certification following relocation of a certified facility on a case-by-case basis.

The criteria used to qualify a CAH as a necessary provider were established by each State in its MRHFP. The State's MRHFP defined those CAHs that provide necessary services to a particular patient community in the event that the facility did not meet the required 35-mile (or 15-mile with stated exceptions) distance requirement from the nearest hospital or CAH. Each State's criteria are different, but the criteria share certain similarities and all define a necessary provider related to the facility location. Therefore, it becomes crucial to define whether the necessary provider designation remains pertinent in the event the certified CAH builds in a different location. Accordingly, the first step of this process is to determine whether building a new CAH facility in a different location is a replacement of an existing facility in essentially the same location, a relocation of the facility in a new location, or a cessation of business at one location and establishment of new business at another location.

a. Determination of the Relocation Status of a CAH

(1) *Replacement in the same location.* Under this approach, we are proposing that, if the CAH is constructing renovation of the same building in the same location, the renovation is considered to be a replacement of the same provider and not relocation. We would consider a construction of the CAH to be a replacement if construction was undertaken within 250 yards of the current building, as set by prior precedence in defining a hospital campus. In addition, if the replacement is constructed on land that is contiguous to the current CAH, and that land was owned by the CAH prior to enactment of Pub. L. 108–173, and the CAH is operating under a State-issued necessary provider waiver that is grandfathered by Pub. L. 108–173, we would consider that construction to be a replacement of the existing provider and the provisions of the grandfathered necessary provider designation would continue to apply regardless of when the construction or renovation work commenced and was completed.

(2) *Relocation of a CAH.* Under our proposed approach, if the CAH is constructing a new facility in a location that does not qualify the construction as replacement of an existing facility in the same location under the criteria in the preceding paragraph, we would need to determine if this building would be a relocation of the current provider or a cessation of business at one location and establishment of a new business at another location. In the event of relocation, the CAH must ensure that the provider is functioning as essentially the same provider in order to operate under the same provider agreement. A provider that is changing location is considered to have closed the old facility if the original community or service area can no longer be expected to be served at the new location. The distance of the moved CAH from its old location will be considered, but it will not be the sole determining factor in granting the relocation of a CAH under the same provider agreement. For example, a specialty hospital may move a considerable distance and still care for generally the same inpatient population, while the relocation of a CAH at a relatively short distance within a rural area may greatly affect the community served.

In the event that CMS determines the rebuilding of the CAH in a different location to be a relocation, the provider agreement would continue to apply to the CAH at the new location. In addition to the relocation being within the same service area, serving the same population, the CAH would need to be providing essentially the same services with the same staff; that is, at least 75 percent of the same staff and 75 percent of the range of services are maintained in the new location as the same provider of services. We are proposing the use of a 75-percent threshold because we believe it indicates that the CAH that is relocating demonstrates that it will maintain a high level of involvement, as opposed to just a majority involvement, in the current community. We note that CMS has also used a 75-percent threshold in other provider designation policies such as the provider-based policies at § 413.65(e)(3)(ii).

In all cases of relocation, the CAH must continue to meet all of the CoPs found at 42 CFR Part 485, Subpart F, including location in a rural area as provided for at § 485.610.

(3) *Cessation of business at one location.* Under existing CMS policy, if the CAH relocation results in the cessation of furnishing services to the same community, we would not consider this to be a relocation, but instead would consider such a scenario a cessation of business at one location and establishment of a new business at another location. Cessation of business is a basis for voluntary termination of the provider agreement under 42 CFR Part 489. If the proposed move constitutes a cessation of business, the CMS Regional Office may assist the provider in obtaining an agreement to participate under a new provider number. Furthermore, in such a situation, the regulations require the provider to give advanced notice to CMS and the public regarding its intent to stop providing medical services to the community. There is no appeals process for a voluntary termination. Under our current policies, the cessation of business by a CAH automatically terminates the CAH designation, regardless of whether the designation was obtained through a necessary provider determination.

b. Relocation of a CAH Using a Necessary Provider Designation To Meet the CoP for Distance

Once it has been determined that constructing a new facility will cause the CAH to relocate, the second step is to determine if the CAH that has a necessary provider designation can maintain this designation after relocating.

We recognize that § 485.610(c) relating to location relative to other facilities or necessary provider certification states that, after January 1, 2006, the "necessary provider'' designation will no longer be used to waive the mileage requirements. In addition, CMS policy regarding a change of size or location of a provider states that there may be situations where the facility relocation is so far removed from the originally approved site that we would conclude that this is a different provider or supplier, for example, it has different employees, services, and patients. Furthermore, the language of section 1820(c)(2)(i) of the Act allows a State to waive the mileage requirement and designate a facility as a necessary provider of health care services to residents in the area. We have interpreted "services to residents in the area'' to mean that the necessary provider designation does not automatically follow the provider if the facility relocates to a different location because it is no longer furnishing "services to patients'' in the area determined to need a necessary provider.

We do not intend to change this policy. Our proposal, noted below, is intended to establish a methodology to be used by all CMS Regional Offices in making such a decision consistent with the statutory provisions concerning necessary provider designation.

In this proposed rule, we are proposing to amend the regulations at § 485.610 to set forth the criteria by

which those relocated CAHs designated as necessary providers that embarked on a replacement facility project before the sunset provision was enacted on December 8, 2003, but find that they cannot be operational in the replacement facility by January 1, 2006, can retain their necessary provider status. As required by statute, no additional CAHs will be certified as a necessary provider on or after January 1, 2006. We recognize that the statute refers to a facility designated as a CAH while relocation of a facility may result in a different building. However, to provide flexibility for a facility designated as a CAH whose location may change, but is essentially the same facility in a different location, we are proposing to amend the regulations to account for this scenario. Essentially, we recognize that the necessary provider designation may need to be applied to certain relocated CAHs. To this end, we are proposing to use the specified relocation criteria as the initial step to determine continuing necessary provider status. Specifically, in this proposed rule, we are proposing that, when a CAH is determined to have relocated, it may nonetheless continue to operate under its necessary provider designation that exempts the distance from other providers only if the following conditions are met:

(1) The relocated CAH has submitted an application to the State agency for relocation prior to the January 1, 2006, sunset date. If the CAH is applying under a grandfathered status under section 1820(h)(3) of the Act, the following items would need to be included in the application:

- A demonstration that the CAH will meet the same State criteria for the necessary provider designation that were established when the waiver was originally issued. For example, if the location waiver was granted because the CAH was located in a health professional shortage area (HPSA), the CAH must remain in that HPSA.
- Assurance that, after the relocation, the CAH will be servicing the same community and will be operating essentially the same services with essentially the same staff (that is, a demonstration that it is serving at least 75 percent of the same service area, with 75 percent of the same services offered, and staffed by 75 percent of the same staff, including medical staff, contracted staff, and employees). This is essentially the same criteria used in determining whether the CAH has relocated.
- Assurance that the CAH will remain in compliance with all of the CoPs at 42 CFR Part 485 in the new location. Compliance will be established with a full survey in the new location to include the Life Safety Code and would include any off-site locations and rehabilitation or psychiatric distinct part units.
- A demonstration that construction plans were "under development'' prior to the effective date of Pub. L. 108–173 (December 8, 2003) in the application the CAH submits to continue using a necessary provider designation. Supporting documentation could include the drafting of architectural specifications, the letting of bids for construction, the purchase of land and building supplies, documented efforts to secure financing for construction, expenditure of funds for construction, and compliance with state requirements for construction such as zoning requirements, application for a certificate of need, and architectural review. However, we recognize that it may not have been feasible for a CAH to have completed all of these activities noted above as examples prior to December 8, 2003. Thus, we expect the CMS Regional Offices to consider all of the criteria and make case-by-case determinations of whether a relocated CAH continues to warrant necessary provider status. We note that we have also used the above documentation guidelines in Publication 100–20 for grandfathered specialty hospitals to determine if construction plans were "under development.''

In proposing these criteria, our intent in clarifying the sunset of the necessary provider designation provision is to allow CAHs to complete construction projects that were initiated prior to the enactment of Pub. L. 108–173, which we believe is consistent with the statutory language of section 405(h) of Pub. L. 108–173.

(2) In the application, the CAH demonstrates that the replacement will facilitate the access to care and improve the delivery of services to Medicare beneficiaries. We are soliciting comments on how a necessary provider CAH should demonstrate that the replacement will improve access to care.

These guidelines are meant to be applied to the relocated CAH that meets the CoP in the new location and wishes to maintain a necessary provider designation in order to meet the distance requirement at § 485.610(c). They are not meant to preclude a CAH from relocating at any time if the CAH does not seek to maintain the necessary provider designation. Any CAH may relocate at any time if the CAH meets the definition of relocation and can meet all the CoPs at 42 CFR part 485, subpart F, as determined by the CMS Regional Offices on a case-by-case basis.

Accordingly, we are proposing to revise § 485.610 of the regulations by adding a new paragraph (d) to incorporate this proposal. Specifically, the proposed new paragraph (d) would specify that a CAH may maintain its necessary provider certification provided for under § 485.610(c) if the new facility meets the requirements for either a replacement facility that is constructed within 250 yards of the current building or contiguous to the current CAH on land owned by the CAH prior to December 8, 2003; or as a relocated CAH if, at the relocated site, the CAH provides essentially (75 percent) the same services to the same service area with essentially the same staff. The CAH that plans to relocate must provide documentation demonstrating that its plans to rebuild in the relocated area were undertaken prior to December 8, 2003. We are also proposing that if a CAH that has a necessary provider certification from the State places a new facility in service on or after January 1, 2006, and does not meet either the requirements for a replacement facility or a relocated facility, as specified in the regulations, the action will be considered a cessation of business.

VIII. Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

(If you choose to comment on issues in this section, please include the caption "Blood Clotting Factor'' at the beginning of your comment.)

Section 1886(a)(4) of the Act excludes the costs of administering blood clotting factors to individuals with hemophilia from the definition of "operating costs of inpatient hospital services.'' Section 6011(b) of Pub. L. 101–239 (the Omnibus Budget Reconciliation Act of 1989) states that the Secretary of Health and Human Services shall determine the payment amount made to hospitals under Part A of Title XVIII of the Act for the costs of administering blood clotting factors to individuals with hemophilia by multiplying a predetermined price per unit of blood clotting factor by the number of units provided to the individual. The regulations governing payment for blood clotting factor furnished to hospital inpatients are located in §§ 412.2(f)(8) and 412.115(b).

Consistent with the rates paid under section 1842(o) of the Act for Medicare Part B drugs (including blood clotting factor furnished to individuals who are not inpatients), in FY 2005, we made payments for blood clotting factors furnished to inpatients at 95 percent of average wholesale price (AWP). Section 303 of Pub. L. 108–173 established

section 1847A of the Act which requires that almost all Medicare Part B drugs not paid on a cost or prospective basis be paid at 106 percent of average sales price (ASP) and provided for payment of a furnishing fee for blood clotting factor, effective January 1, 2005. On November 15, 2004, we issued regulations in the **Federal Register** (69 FR 66299) that implemented the provisions of section 1847A for payment for Medicare Part B drugs using the 106 percent of ASP payment methodology and for payment of the furnishing fee. These regulations are codified at 42 CFR 410.63 and subpart K of Part 414.

To ensure consistency in payment for Medicare Part A and Medicare Part B drugs, we are proposing to revise §§ 412.2(f)(8) and 412.115(b) of the regulations governing the IPPS to specify that, for discharges occurring on or after October 1, 2005, the additional payment for the blood clotting factor administered to hemophilia inpatients is made based on the average sales price methodology specified in subpart K of 42 CFR part 414 and the furnishing fee specified in § 410.63.

The proposed payment amount per unit and the unit payment for the furnishing fee for blood clotting factor administered to hospital inpatients who have hemophilia that we are proposing to apply under the IPPS for FY 2006 are specified in section V. of the Addendum to this proposed rule.

IX. MedPAC Recommendations

(If you choose to comment on issues in this section, please include the caption "MedPAC Recommendations'' at the beginning of your comment.)

We are required by section 1886(e)(4)(B) of the Act to respond to MedPAC's IPPS recommendations in our annual proposed IPPS rule. In March 2005, MedPAC released the following two reports to Congress, which included IPPS recommendations: "Report to Congress: Medicare Payment Policy'' and "Report to Congress: Physician-Owned Specialty Hospitals.'' We have reviewed each of these reports and have given them careful consideration in conjunction with the policies set forth in this document. These recommendations and our responses are set forth below. For further information relating specifically to the MedPAC reports or to obtain a copy of the reports, contact MedPAC at (202) 653–7220, or visit MedPAC's Web site at: *http://www.medpac.gov.*

A. Medicare Payment Policy

MedPAC's Recommendation 2A–1 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 proposed rule.

Recommendation 4A: The Congress should establish a quality incentive payment policy for hospitals in Medicare.

Response: We are exploring provider payment policies that link quality to Medicare reimbursement in a cost neutral manner under our demonstration authority. We currently have demonstrations underway that will identify and examine the components of such a policy.

B. Physician-Owned Specialty Hospitals

Recommendation 1: The Secretary should improve payment accuracy in the hospital inpatient PPS by:

- Refining the current DRGs to more fully capture differences in severity of illness among patients.
- Basing the DRG relative weights on the estimated cost of providing care rather than on charges.
- Basing the weights on the national average of hospitals' relative values in each DRG.

In making this recommendation, MedPAC recognized several implementation issues regarding potential low volume DRGs and potential changes in hospital coding and reporting behavior. In particular, MedPAC recommended that the Secretary project the likely effect of reporting improvements on total payments and make an offsetting adjustment to the standardized amounts.

Response: We expect to make changes to the DRGs to better reflect severity of illness. The following discussion briefly describes some of the options we are considering. As we discussed in section II.B. of this preamble, there is a standard list of diagnoses that are considered complications or comorbidities (CC). These conditions, when present as a secondary diagnosis, may result in payment using a higher weighted DRG. Currently, 3,285 diagnosis codes on this list, and 121-paired DRGs are differentiated based on the presence or absence of a CC. Our analysis indicates that the majority of cases assigned to these DRGs fall into the "with CC'' DRGs. We believe that it is possible that the CC distinction has lost much of its ability to differentiate the resource needs of patients, given the long period of time since the original CC list was developed and the incremental nature of subsequent changes in an environment of major changes in the way inpatient care is delivered.

We are planning a comprehensive and systematic review of the CC list for the IPPS rule for FY 2007. As part of this process, we will consider revising the standard for determining when a condition is a CC. For instance, we expect to use an alternative to the current method of classifying a condition as a CC based on how it affects the length of stay of a case. Similar to other aspects of the DRG system, we expect to consider the effect of a specific secondary diagnosis on the charges or costs of a case to evaluate whether to include the condition on the CC list.

Another option we are considering is a selective review of the specific DRGs, such as cardiac, orthopedic, and surgical DRGs, that are alleged to be overpaid and that create incentives for physicians to form specialty hospitals. We expect to selectively review particular DRGs based on statistical criteria such as the range or standard deviation among charges for cases included within the DRG. It is possible specific DRGs have high variation in resource costs and that a better recognition of severity would reduce incentives for hospitals to select the least costly and most profitable patients within these DRGs. Any analysis we perform would balance the goal of making payment based on an accurate coding system that recognizes severity of illness with the premise that the IPPS is a system of payment based on averages. We agree with MedPAC that, in refining the DRGs, we must continue to be mindful of issues such as the instability of small volume DRGs and the potential impact of changes in hospital coding and reporting behavior. As MedPAC noted, previous refinements to DRG definitions have led to unanticipated increases in payment because of more complete reporting of patients' diagnoses and procedures. As part of our analysis of possible refinements to the DRGs, we have concerns with our ability to account for the effect of changes in coding behavior on payment.

We are also considering the use of alternative DRG systems such as the all patient refined diagnosis related groups (APR–DRGs) in place of Medicare's current DRG system. The APR–DRGs have a greater number of DRGs that could relate payment rates more closely to patient resource needs, and thus reduce the advantages of selection of desirable patients within DRGs by specialty hospitals. However, any large change to the DRGs could have substantial effects across all hospitals. Therefore, we believe we must thoroughly analyze such options and

their impacts on the various types of hospitals before making any proposal. In addition, as noted above, we are concerned about our ability to account for the effect of changes in coding behavior on payment if we were to significantly expand the number of DRGs. Therefore, in light of the above, we must consider how to mitigate the risk of paying significantly more for the alternatives discussed above while measuring the benefit for Medicare beneficiaries.

In response to MedPAC's recommendation that we improve payment accuracy by basing the DRG relative weights on the estimated cost of providing care rather than on charges, we note that we do not have access to any information that would provide a direct measure of the costs of individual discharges. Claims filed by hospitals do provide information on the charges for individual cases. At present, we use this information to set the relative weights for the DRGs. We obtain information on costs from the hospital cost reports, but this information is at best at the department level; it does not include information about the costs of individual cases. Consequently, the most straightforward way to estimate costs of an individual case is to calculate a cost-to-charge ratio for some body of claims (for example, for a hospital's radiology department), and then apply this ratio to the charges for that department.

However, this procedure is not without disadvantages because assignment of costs to departments is not uniform from hospital to hospital, given the variability of hospital accounting systems, and because cost information is not available until a year or more after claims information. In addition, the application of a cost-to-charge ratio that is uniform across any body of claims may result in biased estimates of individual costs if hospital charging behavior is not uniform. Thus, it is alleged that hospitals mark up lower cost services less than higher cost services, and to the extent they do so, application of a uniform cost-to-charge ratio will result in underestimates of the costs of higher cost services and vice versa. We use estimated costs, based on hospital-specific, department-level cost-to-charge ratios, in the hospital outpatient prospective payment system. The accuracy of this procedure has generated some concern, and without further analysis, the extent to which accuracy of inpatient payments would be improved by adopting this method is not obvious.

We will closely analyze the impact of such a change from the current charge-based DRG weights to cost-based DRG weights. We note that such a change is complex and would require further analysis. With this in mind, CMS will consider the following issues in performing this analysis:

- The effect of using cost-to-charge ratio data, which is frequently older than the claims data we use to set the charge-based weights, and the impact on these data of any changes in hospitals' charging behavior that resulted from the recent modifications to the outlier payment methodology (68 FR 34494; June 9, 2003);
- Whether using this method has different effects on DRGs that have experienced substantial technological change compared to DRGs with more stable procedures for care;
- The effect of using a routine cost-to-charge ratio and department-level ancillary cost-to-charge data as compared to either an overall hospital cost-to-charge ratio or a routine cost-to-charge ratio and an overall ancillary cost-to-charge ratio, particularly in considering earlier studies performed for the Prospective Payment Assessment Commission, the predecessor to MedPAC, indicating that an overall ancillary cost-to-charge ratio led to more accurate estimates of case level costs; [5]
- Whether developing relative weights by estimating costs from charges multiplied by cost-to-charge ratios versus whether the sole use of charges improves payment accuracy; and
- How payments to hospitals would be affected by MedPAC's suggestion intended to simplify recalibration, to recalibrate weights based on costs every few years, and to calculate an adjustment to charge-based weights for the intervening periods.

In response to the recommendation that the Secretary should improve payment accuracy in the IPPS by basing the weights on the national average of hospitals' relative values in each DRG, we note that presently we set the relative weights using standardized charges (adjusted to remove the effects of differences in area wage costs and in IME and DSH payments). In contrast, MedPAC proposes that Medicare set the DRG relative weights using unstandardized, hospital-specific charges. Each hospital's unstandardized charges would become the basis for determining the relative weights for the DRGs for that hospital. These relative weights would be adjusted by the hospital's case-mix index when combining each hospital's relative weights to determine a national relative weight for all hospitals. This adjustment is designed to reduce the influence that a single hospital's charge structure could have on determining the relative weight when it provides a high proportion of the total, nationwide number of discharges in a particular DRG.

We will analyze the possibility of moving to hospital specific relative values while conducting the analysis outlined above in response to the recommendations regarding improved severity adjustment and using charges adjusted to estimated cost using cost-to-charge ratios to set the relative weights. We note that we use this method at present to set weights for the LTCH PPS. We use this method for LTCHs because of the small volume of providers and the possibility that only a few providers provide care for certain DRGs. The charges of one or a few hospitals could thus materially affect the relative weights for these DRGs. In this event, looking at relative values within hospitals first can smooth out the hospital-specific effects on DRG weights. A 1993 Rand Report on hospital specific relative values noted the possibility of DRG compression (or the undervaluing of high-cost cases and the overvaluing of low-cost cases) if we were to shift to a hospital-specific relative value method from the current method for determining DRG weights. We will need to consider whether the resultant level of compression is appropriate.

Recommendation 2: The Congress should amend the law to give the Secretary authority to adjust the DRG relative weights to account for differences in the prevalence of high-cost outlier cases.

Response: While MedPAC's language suggests that the law would need to be amended for us to adopt this suggestion, we believe the statute may give the Secretary broad discretion to consider all factors that change the relative use of hospital resources in calculating the DRG relative weights. We believe that MedPAC's recommendation springs from a concern that including high-charge outlier cases in the relative-weight calculation results in overvaluing DRGs that have a high prevalence of outlier cases. However, we believe that excluding outlier cases completely in calculating the relative weights would be inappropriate. Doing

[5] Cost Accounting for Health Care Organizations, Technical Report Series, 1–93–01, ProPAC, March 1993, page 6. Using a cost report package, the contractor simulated single and multiple ancillary cost-to-charge ratios and found that inpatient ancillary costs were 2.5 percent understated relative to what hospitals thought their costs were with the single cost-to-charge ratio, and 4.9 percent understated with the multiple cost-to-charge ratios.

so would undervalue the relative weight for a DRG with a high percentage of outliers by not including that portion of hospital charges that is above the median but below the outlier threshold. We believe it would be preferable to adjust the charges used for calculating the relative weights to exclude the portion of charges above the outlier threshold but to include the charges up to the outlier threshold. At this time, we expect to further analyze these ideas as we consider the other changes recommended by MedPAC and welcome public comments on this issue.

Finally, we believe that the recommendations made by MedPAC, or some variants of them, have significant promise in improving the accuracy of rates in the inpatient payment prospective payment system. We agree with MedPAC that they should be pursued even in the absence of concerns about the proliferation of specialty hospitals. However, until we have completed further analysis of these options and their effects, we cannot predict the extent to which they will provide payment equity between specialty and general hospitals. In fact, we must caution that any system that groups cases and provides a standard payment for cases in the group (that is, the IPPS among other Medicare payment systems) will always present some opportunities for providers to specialize in cases where they believe margins may be better. Improving payment accuracy should reduce these opportunities, and it may do so to the extent that Medicare payments no longer provide a significant impetus to further development of specialty hospitals.

Recommendation 3: The Congress and the Secretary should implement the case-mix measurement and outlier policies over a transitional period.

Response: Before proposing any changes to the DRGs, we would need to model the impact of any specific proposal and our authority under the statute to determine whether any changes should be implemented immediately or over a period of time. We do note that with regard to revising the existing DRG system with a new DRG system that fully captures differences in severity, there would likely be unique complexities in creating a transition from one DRG system to another. Our payment would be a blend of two different relative weights that would have to be determined using two different systems of DRGs. The systems and legal implications of such a transition or any other major change to the DRGs could be significant.

C. Other MedPAC Recommendations

MedPAC also made the following recommendations that we will address in our Report to Congress on Specialty Hospitals:

Recommendation 4: The Congress should extend the current [Pub. L. 108–173] moratorium on physician-owned single specialty hospitals until January 1, 2007.

Recommendation 5: The Congress should grant the Secretary the authority to allow gainsharing arrangements between physicians and hospitals and to regulate those arrangements to protect the quality of care and minimize financial incentives that could affect physician referrals.

X. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format; however, some files are available on diskette as well as on the Internet at *http://www.cms.hhs.gov/providers/hipps*. Data files and the cost for each file, if applicable, are listed below. Anyone wishing to purchase data tapes, cartridges, or diskettes should submit a written request along with a company check or money order (payable to CMS–PUF) to cover the cost to the following address: Centers for Medicare & Medicaid Services, Public Use Files, Accounting Division, P.O. Box 7520, Baltimore, MD 21207–0520, (410) 786–3691. Files on the Internet may be downloaded without charge.

1. CMS Wage Data

This file contains the hospital hours and salaries for FY 2002 used to create the FY 2006 prospective payment system wage index. The file will be available by the beginning of February for the NPRM and the beginning of May for the final rule.

Processing Year	Wage Data Year	PPS Fiscal Year
2005	2002	2006
2004	2001	2005
2003	2000	2004
2002	1999	2003
2001	1998	2002
2000	1997	2001
1999	1996	2000
1998	1995	1999
1997	1994	1998
1996	1993	1997
1995	1992	1996
1994	1991	1995
1993	1990	1994
1992	1989	1993
1991	1988	1992

These files support the following:

• NPRM published in the **Federal Register**.

• Final Rule published in the **Federal Register**.

Media: Diskette/most recent year on the Internet.

File Cost: $165.00 per year.

Periods Available: FY 2006 PPS Update.

2. CMS Hospital Wages Indices (Formerly: Urban and Rural Wage Index Values Only)

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

Media: Diskette/most recent year on the Internet.

File Cost: $165.00 per year.

Periods Available: FY 2006 PPS Update.

3. FY 2006 Proposed Rule Occupational Mix Adjusted and Unadjusted AHW by Provider

This file includes each hospital's adjusted and unadjusted average hourly wage.

Media: Internet.

Periods Available: FY 2006 PPS Update.

4. FY 2006 Proposed Rule Occupational Mix Adjusted and Unadjusted AHW and Pre-Reclassified Wage Index by CBSA

This file includes each CBSA's adjusted and unadjusted average hourly wage.

Media: Internet.

Periods Available: FY 2006 PPS Update.

5. Provider Occupational Mix Adjustment Factors for Each Occupational Category

This file contains each hospital's occupational mix adjustment factors by occupational category.

Media: Internet.

Periods Available: FY 2006 PPS Update.

6. PPS SSA/FIPS MSA State and County Crosswalk.

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

Media: Diskette/Internet.

File Cost: $165.00 per year.

Periods Available: FY 2006 PPS Update.

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

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

• NPRM published in the **Federal Register**.

• Final Rule published in the **Federal Register**.

Media: Diskette/Internet.

File Cost: $165.00 per year.

Periods Available: FY 2006 PPS Update.

8. PPS–IV to PPS–XII Minimum Data Set

The Minimum Data Set contains cost, statistical, financial, and other information from Medicare hospital cost reports. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare participating hospital by the Medicare fiscal intermediary to CMS. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Tape/Cartridge.

File Cost: $770.00 per year.

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

(**Note:** The PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, and PPS–XIX Minimum Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, PPS–XIX, and PPS–XX Hospital Data Set Files (refer to item 7 below).)

9. PPS–IX to PPS–XII Capital Data Set

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

Media: Tape/Cartridge.

Fine Cost: $770.00 per year.

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

(**Note:** The PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, and PPS–XIX Capital Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, PPS–XVIII, PPS–XIX, and PPS–XX Hospital Data Set Files (refer to item 7 below).)

10. PPS–XIII to PPS–XX Capital Data Set

The file contains costs, statistical, financial, and other data from the Medicare Hospital Cost Report. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for Medicare-certified hospital by the Medicare fiscal intermediary to CMS. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Diskette/Internet.

Fine Cost: $2,500.00.

	Periods beginning on or after	and before
PPS-XIII	10/01/95	10/01/96
PPS-XIV	10/01/96	10/01/97
PPS-XV	10/01/97	10/01/98
PPS-XVI	10/01/98	10/01/99
PPS-XVII	10/01/99	10/01/00
PPS-XVIII	10/01/00	10/01/01
PPS-XIX	10/01/01	10/01/02
PPS-XX	10/01/02	10/01/03

11. Provider-Specific File

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

Media: Diskette/Internet.

File Cost: $265.00.

Periods Available: FY 2006 PPS Update.

12. CMS Medicare Case-Mix Index File

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

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

Media: Diskette/most recent year on Internet.

Price: $165.00 per year/per file.

Periods Available: FY 1985 through FY 2006.

13. DRG Relative Weights (Formerly Table 5 DRG)

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

- NPRM.
- Final rule.

Media: Diskette/Internet.

File Cost: $165.00.

Periods Available: FY 2006 PPS Update.

14. PPS Payment Impact File

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

Media: Diskette/Internet.

File Cost: $165.00.

Periods Available: FY 2006 PPS Update.

15. AOR/BOR Tables

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

Two versions of this file are created each year. They support the following:

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

Media: Diskette/Internet.

File Cost: $165.00.

Periods Available: FY 2006 PPS Update.

16. Prospective Payment System (PPS) Standardizing File

This file contains information that standardizes the charges used to calculate relative weights to determine payments under the prospective payment system. Variables include wage index, cost-of-living adjustment (COLA), case-mix index, disproportionate share, and the Metropolitan Statistical Area (MSA). The file supports the following:

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

Media: Internet.

File Cost: No charge.

Periods Available: FY 2006 PPS Update.

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

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

B. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to evaluate fairly whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

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

The following information collection requirements included in this proposed rule and their associated burdens are subject to the PRA.

Section 412.64 Federal Rates for Inpatient Operating Costs for Federal Fiscal Year 2005 and Subsequent Fiscal Years

Section 412.64(d)(2) requires hospitals to submit quality data on a quarterly basis to CMS, as specified by CMS. In this document, we are setting out the specific requirements related to the data that must be submitted. The burden associated with this section is the time and effort associated with collecting, copying and submitting this data. We estimate that there will be approximately 4,000 respondents per year. Of this number, approximately 3,600 hospitals are JCAHO accredited and are currently collecting measures and submitting data to the JCAHO on a quarterly basis. Of the JCAHO accredited hospitals, approximately 3,300 are collecting the same measures CMS will be collecting for public reporting. Therefore, there will be no additional burden for these hospitals. Only approximately 300 of the JCAHO accredited hospitals will need to collect an additional topic in addition to the data already collected for maintaining JCAHO accreditation. In addition, there are approximately 400 hospitals that do not participate in the JCAHO accreditation process. These hospitals will have the additional burden of collecting data on all three topics.

For JCAHO accredited hospitals that are not already collecting all of the required measures, we estimate it will take 25 hours per month per topic for collection. We expect the burden for all of these hospitals to total 102,000 hours per year, including time allotted for overhead. For non-JCAHO accredited hospitals, we estimate the burden to be 136,000 hours per year. This estimate also includes overhead. The total number of burden hours for all hospitals combined is 238,000. The number of responders will vary according to the level of voluntary participation. One hundred percent of the data may be collected electronically.

In the preamble to this proposed rule, we are proposing additional validation criteria to ensure that the quality data being sent to CMS are accurate. Our validation process requires participating hospitals to submit five charts per quarter. The burden associated with this requirement is the time and effort associated with collecting, copying, and submitting these charts. It will take approximately 2 hours per hospital to submit the 5 charts per quarter. There will be a total of approximately 19,000 charts (3,800 hospitals × charts per hospital) submitted by the hospitals to CMS per quarter for a total burden of 7,600 hours per quarter and a total annual burden of 30,400 hours.

Section 413.65 Requirements for a Determination That a Facility or an Organization Has Provider-Based Status

Proposed § 413.65(b)(3)(i) requires potential main providers seeking a determination of provider-based status for a facility that is located on the campus of the potential main provider to submit an attestation stating that the facility meets the criteria in paragraph (d) of § 413.65 and, if it is a hospital, to also attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of § 413.65. We are also proposing to amend this paragraph to require that in the case of a facility that is operated as a joint venture, the potential main provider attest that it will comply with the requirements of paragraph (f) of § 413.65.

Proposed § 413.65(b)(3)(ii) provides that, if a facility is not located on the campus of the potential main provider, the potential main provider must submit an attestation stating that the facility meets the criteria in paragraph (d) and (e) of § 413.65 and, if it is a hospital, to also attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of § 413.65. If the facility is operated under a management contract, the potential main provider also attest that the facility meets the requirements of paragraph (h) of § 413.65.

Proposed § 413.65(e)(3) requires that a facility or organization for which provider-based status is sought that is not located on the campus of a potential main provider must (i) be located within a 35-mile radius of the campus of the hospital or CAH that is the potential main provider, or (ii) be owned and operated by a hospital or CAH that has a disproportionate share adjustment (as determined under § 412.106 of this chapter) greater than 11.75 percent and is described in § 412.106(c)(2) of this chapter implementing section 1886(e)(5)(F)(i)(II) of the Act and is (A) owned or operated by a unit of State or local government, (B) a public or nonprofit corporation formally granted governmental powers by a unit of State or local government; or (C) a private hospital having a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan), or (iii) demonstrate a high level of integration

with the main provider by showing that it meets all of the other provider-based criteria and demonstrate that it serves the same patient population as the main provider, by submitting certain records showing the information contained in paragraphs (e)(3)(iii)(A) and (e)(3)(iii)(B) of this section or (iv) if the facility or organization is unable to meet the criteria in paragraph (e)(3)(iii)(A) or paragraph (e)(3)(iii)(B) because it was not in operation during all of the 12-month period described in paragraph (e)(3)(iii), be located in a zip code area included among those that, during all of the 12-month period described in paragraph (e)(3)(iii), accounted for at least 75 percent of the patients served by the main provider, or (v) in the case of an RHC, (A) be an RHC that is otherwise qualified as a provider-based entity of a hospital that has fewer than 50 beds, and (B) the hospital with which the facility or organization has a provider-based relationship be located in a rural area, and (vi) be located in the same State as the main provider or, when consistent with the laws of both States, in adjacent States.

Section 413.65(g)(7) provides that when a Medicare beneficiary is treated in a hospital outpatient department that is not located on the main provider's campus, the treatment is not required to be provided by the antidumping rules of section 489.24, and the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital, as well as for the physician service the hospital must provide written notice to the beneficiary, before delivery of services of the amount of the beneficiary's potential financial liability. If the exact type and extent of care is not known, the hospital must provide written notice to the beneficiary that explains that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based, an estimate based on typical or average charges for visits to the facility, and a statement that the patient's actual liability will depend upon the actual services furnished by the hospital.

While the information collection requirements contained in this section are subject to the PRA, the burden associated with this requirement is currently approved under OMB approval no. 0938–0798.

Section 485.610 Condition of Participation: Status and Location

In order to be considered a relocation, we are proposing under § 485.610(d)(2)(ii) to require a CAH to provide documentation demonstrating that its plans to rebuild in a relocated area were undertaken prior to December 8, 2003. This requirement does impose an information collection requirement. However, because this burden would be imposed on less than 10 CAHs, under 5 CFR 1320.2(c), these requirements are exempt from the PRA.

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements described above.

If you have any comments on the information collection and recordkeeping requirements, please mail the copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Security and Standards Group, Regulations Development and Issuances Group, Room C4–24–02, 7500 Security Boulevard, Baltimore, MD 21244–1850, Attn.: James Wickliffe, CMS–1500–P.

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

Comments submitted to OMB may also be e-mailed to the following address: *Christopher_Martin@omb.eop.gov*; or faxed to OMB at (202) 395–6974 or (202) 395–5167. Attn.: CMS–1500–P.

C. Public Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments concerning the provisions of this proposed rule that we receive by the date and time specified in the **DATES** section of this preamble and respond to those comments in the preamble to that rule. We emphasize that section 1886(e)(5) of the Act requires the final rule for FY 2006 to be published by August 1, 2005, and we will consider only those comments that deal specifically with the matters discussed in this proposed rule.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements, Rural area, X-rays.

42 CFR Part 412

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

42 CFR Part 413

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

42 CFR Part 415

Health facilities, Health professions, Medicare, and reporting and recordkeeping requirements.

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 422

Health maintenance organizations (HMO), Medicare+Choice, Provider sponsored organizations (PSO).

42 CFR Part 485

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

For the reasons stated in the preamble of this proposed rule, the Centers for Medicare & Medicaid Services is proposing to amend 42 CFR chapter IV as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. Part 405 is amended as follows:

1. The authority citation for Part 405 continues to read as follows:

Authority: Secs. 1102, 1861, 1862(a), 1871, 1874, 1881, and 1886(k) of the Social Security Act (42 U.S.C. 1302, 1395x, 1395y(a), 1395hh, 1395kk, 1395rr, and 1395ww(k)), and sec. 353 of the Public Health Service Act (42 U.S.C. 263a).

§ 405.2468 [Amended]

2. In § 405.2468(f)(1), the reference "§ 413.86(b)'' is removed and the reference "§ 413.75(b)'' is added in its place.

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

B. Part 412 is amended as follows:

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

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

§ 412.1 [Amended]

2. In § 412.1(a)(1), the reference "§ 413.86'' is removed and the reference "§§ 413.75 through 413.83'' is added in its place.

§ 412.2 [Amended]

3. In § 412.2—

a. In paragraph (f)(7), remove the reference "§ 413.86'' and add in its place the reference "§§ 413.75 through 413.83''.

b. At the end of paragraph (f)(8), add the following sentence: "For discharges occurring on or after October 1, 2005, the additional payment is made based on the average sales price methodology specified in Subpart K, Part 414 of this subchapter and the furnishing fee specified in § 410.63 of this subchapter.''

4. Section 412.64 is amended by revising paragraph (k)(2) to read as follows:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

* * * * *

(k) *Midyear corrections to the wage index.*

* * * * *

(2)(i) Except as provided in paragraph (k)(2)(ii) of this section, a midyear correction to the wage index is effective prospectively from the date the change is made to the wage index.

(ii) Effective October 1, 2005, a change to the wage index may be made retroactively to the beginning of the Federal fiscal year, if, for the fiscal year in question, CMS determines all of the following—

(A) The fiscal intermediary or CMS made an error in tabulating data used for the wage index calculation;

(B) The hospital knew about the error in its wage data and requested the fiscal intermediary and CMS to correct the error both within the established schedule for requesting corrections to the wage data (which is at least before the beginning of the fiscal year for the applicable update to the hospital inpatient prospective payment system) and using the established process; and

(C) CMS agreed before October 1 that the fiscal intermediary or CMS made an error in tabulating the hospital's wage data and the wage index should be corrected.

* * * * *

5. Section 412.73 is amended by adding a new paragraph (f) to read as follows:

§ 412.73 Determination of the hospital-specific rate based on a Federal fiscal year 1982 base period.

* * * * *

(f) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to section 1886(d) hospitals are not affected.

6. Section 412.75 is amended by adding a new paragraph (i) to read as follows:

§ 412.75 Determination of the hospital-specific rate for inpatient operating costs based on a Federal fiscal year 1987 base period.

* * * * *

(i) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to section 1886(d) hospitals are not affected.

7. Section 412.77 is amended by—

a. Revising paragraph (a)(1).

b. Adding a new paragraph (j).

The revision and addition read as follows:

§ 412.77 Determination of the hospital-specific rate for inpatient operating costs for sole community hospitals based on a Federal fiscal year 1996 base period.

(a) *Applicability.* (1) This section applies to a hospital that has been designated as a sole community hospital, as described in § 412.92. If the 1996 hospital-specific rate exceeds the rate that would otherwise apply, that is, either the Federal rate under § 412.64 (or under § 412.63 for periods prior to FY 2005) or the hospital-specific rates for either FY 1982 under § 412.73 or FY 1987 under § 412.75, this 1996 rate will be used in the payment formula set forth in § 412.92(d)(1).

* * * * *

(j) *Maintaining budget neutrality.* CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to section 1886(d) hospitals are not affected.

8. Section 412.90 is amended by revising paragraph (e)(1) to read as follows:

§ 412.90 General rules.

* * * * *

(e) *Hospitals located in areas that are reclassified from urban to rural.* (1) CMS adjusts the rural Federal payment amounts for inpatient operating costs for hospitals located in geographic areas that are reclassified from urban to rural as defined in subpart D of this part. This adjustment is set forth in § 412.102.

* * * * *

9. Section 412.92 is amended by—

a. In paragraph (a) introductory text, removing the reference "§ 412.83(b)'' and adding in its place the reference "§ 412.64''.

b. Revising paragraph (d)(1)(i).

c. Revising paragraph (d)(3).

The revisions and addition read as follows:

§ 412.92 Special treatment: Sole community hospitals.

* * * * *

(d) *Determining prospective payment rates for inpatient operating costs for sole community hospitals.* (1) * * *

(i) The Federal payment rate applicable to the hospitals as determined under subpart D of this part.

* * * * *

(3) *Adjustment to payments.* A sole community hospital may receive an adjustment to its payments to take into account a significant decrease in the number of discharges, as described in paragraph (e) of this section.

* * * * *

10. Section 412.96 is amended by—

a. Revising paragraph (b)(1) introductory text.

b. Revising paragraph (c) introductory text.

c. In paragraph (c)(1) introductory text, removing the reference "paragraph (g)'' and adding in its place the reference "paragraph (h)''.

d. In paragraph (c)(2)(i), removing the reference "paragraph (h)'' and adding in its place the reference "paragraph (i)''.

e. Revising paragraph (g)(1).

f. In the introductory text of paragraph (h), removing the phrase "paragraphs (g)(1) through (g)(4)'' and adding in its place the phrase "paragraphs (h)(1) through (h)(4)''.

g. In paragraph (h)(2), removing the reference "(g)(1)'' and adding in its place the reference "(h)(1)''.

h. Removing paragraph (h)(4).

i. In paragraph (i)(2), removing the reference "(h)(1)'' and adding in its place the reference "(i)(1)''.

j. Removing paragraph (i)(4).

The revisions read as follows:

§ 412.96 Special treatment: Referral centers.

* * * * *

(b) *Criteria for cost reporting periods beginning on or after October 1, 1983.** * *

(1) The hospital is located in a rural area (as defined in subpart D of this part) and has the following number of beds, as determined under the provisions of § 412.105(b) available for use:

* * * * *

(c) *Alternative criteria.* For cost reporting periods beginning on or after October 1, 1985, a hospital that does not meet the criteria of paragraph (b) of this section is classified as a referral center if it is located in a rural area (as defined

in subpart D of this part) and meets the criteria specified in paragraphs (c)(1) and (c)(2) of this section and at least one of the three criteria specified in paragraphs (c)(3), (c)(4), and (c)(5) of this section.

* * * * *

(g) *Hospital cancellation of referral center status.* (1) A hospital may at any time request cancellation of its status as a referral center and be paid prospective payments per discharge based on the applicable rural rate, as determined in accordance with subpart D of this part.

* * * * *

11. Section 412.103 is amended by revising paragraphs (a)(1) and (a)(4) to read as follows:

§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.

(a) * * *

(1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural-Urban Commuting Area codes, as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration, which is available via the ORHP Web site at: *http://www.ruralhealth.hrsa.gov* or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9A–55, Rockville, MD 20857.

* * * * *

(4) For any period after September 30, 2004 and before October 1, 2006, a CAH in a county that, in FY 2004, was not part of an MSA as defined by the Office of Management and Budget and was not considered to be urban under § 412.64(b)(3) of this chapter, but as of FY 2005 was included as part of an MSA or was considered to be urban under § 412.64(b)(3) of this chapter as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003, may be reclassified as being located in a rural area for purposes of meeting the rural location requirement under § 485.610(b) of this chapter if it meets any of the requirements in paragraphs (a)(1), (a)(2), or (a)(3) of this section.

* * * * *

12. Section 412.105 is amended by—

a. Adding a new paragraph (f)(1)(iv)(D).

b. Adding a new paragraph (f)(1)(xiii).

c. Adding a new paragraph (f)(1)(xiv).

The additions read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.* (1) * * *

(iv) * * *

(D) A rural hospital redesignated as urban after September 30, 2004, as a result of the most recent census data and implementation of the new labor market area definitions announced by OMB on June 6, 2003, may retain the increases to its full-time equivalent resident cap that it received under paragraphs (f)(1)(iv)(A) and (f)(1)(vii) of this section while it was located in a rural area.

* * * * *

(xiii) For a hospital that was excluded from the hospital inpatient prospective payment system under Part 413 of this chapter and that subsequently changed to a hospital subject to the hospital inpatient prospective payment system for cost reporting periods ending on or before December 31, 1996, the total number of full-time equivalent residents for payment purposes is determined in accordance with the provisions of this paragraph (f). In the case of a merger of two or more hospitals, for purposes of this paragraph, the surviving hospital's number of full-time equivalent residents for payment purposes is equal to the aggregate number of the full-time equivalent resident count of each of the merged hospitals as determined in accordance with the provisions of this paragraph (f).

(xiv) Effective for discharges occurring on or after October 1, 2005, an urban hospital that reclassifies to a rural area under § 412.103 and then subsequently elects to revert back to urban classification will not be allowed to retain the adjustment to its IME FTE resident cap that it received as a result of being reclassified as rural.

* * * * *

13. Section 412.108 is amended by revising paragraph (c)(1) to read as follows:

§ 412.108 Special treatment: Medicare-dependent, small rural hospitals.

* * * * *

(c) *Payment methodology.* * * *

(1) The Federal payment rate applicable to the hospital, as determined under subpart D of this part, subject to the regional floor defined in § 412.70(c)(6).

* * * * *

14. Section 412.109 is amended by revising paragraph (b)(2) to read as follows:

§ 412.109 Special treatment: Essential access community hospitals (EACHs).

* * * * *

(b) *Location in a rural area.* * * *

(2) Is not deemed to be located in an urban area under subpart D of this part.

* * * * *

§ 412.113 [Amended]

15. In § 412.113—

a. In paragraph (b)(2), the reference "§ 413.86 of this chapter.'' is removed and the reference "§§ 413.75 through 413.83 of this subchapter.'' is added in its place.

b. In paragraph (b)(3), the reference "§ 413.86(c) of this chapter,'' is removed and the reference "§ 413.75(c) of this subchapter,'' is added in its place.

§ 412.115 [Amended]

16. In § 412.115—

a. In paragraph (a), the reference "§ 413.80'' is removed and the reference "§ 413.89'' is added in its place.

b. At the end of paragraph (b), add the following sentence: "For discharges occurring on or after October 1, 2005, the additional payment is made based on the average sales price methodology specified in subpart K, part 414 of this chapter and the furnishing fee specified in § 410.63 of this subchapter.''

17. Section 412.230 is amended by—

a. Redesignating paragraph (d)(2)(iii) as paragraph (d)(2)(v).

b. Adding new paragraphs (d)(2)(iii) and (d)(2)(iv).

The additions read as follows:

§ 412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.

* * * * *

(d) *Use of urban or other rural area's wage index.*—* * *

(2) *Appropriate wage data.* * * *

(iii) For applications submitted for reclassifications effective in FY 2006, a campus of a multicampus hospital system may seek reclassification to another CBSA. As part of its reclassification request, the requesting entity may submit the composite wage data for the entire multicampus hospital system as its hospital-specific data.

(iv) For applications submitted for reclassifications effective in FY 2007 and subsequent years, a campus of a multicampus hospital system may seek reclassification to another CBSA. As part of its reclassification request, the requesting entity must submit campus-specific wage data for purposes of the wage index comparison.

* * * * *

18. Section 412.234 is amended by—

a. In paragraph (a)(3)(ii), removing the phrase "fiscal years 2006 and thereafter''

and adding in its place the phrase "fiscal year 2006''.

b. Adding a new paragraph (a)(3)(iii).

c. In paragraph (b)(1), removing the phrase "or NECMA''.

The addition reads as follows:

§ 412.234 Criteria for all hospitals in an urban county seeking redesignation to another urban area.

(a) * * *

(3) * * *

(iii) For Federal fiscal year 2007 and thereafter, hospitals located in counties that are in the same Consolidated Statistical Area (CSA) (under the MSA definitions announced by the OMB on June 6, 2003) as the urban area to which they seek redesignation qualify as meeting the proximity requirement for reclassification to the urban area to which they seek redesignation.

* * * * *

§ 412.278 [Amended]

19. In § 412.278(b)(1), the phrase "Office of Payment Policy'' is removed and the phrase "Hospital and Ambulatory Policy Group'' is added in its place.

20. Section 412.304 is amended by revising paragraph (a) to read as follows:

§ 412.304 Implementation of the capital prospective payment system.

(a) *General rule.* As described in §§ 412.312 through 412.370, effective with cost reporting periods beginning on or after October 1, 1991, CMS pays an amount determined under the capital prospective payment system for each inpatient hospital discharge as defined in § 412.4. This amount is in addition to the amount payable under the prospective payment system for inpatient hospital operating costs as determined under subpart D of this part.

* * * * *

§ 412.521 [Amended]

21. In § 412.521—

a. Under paragraph (b)(2)(i), the reference "§§ 413.85, 413.86, and 413.87 of this subchapter.'' is removed and the reference "§§ 413.75 through 413.83, 413.85, and 413.87 of this subchapter.'' is added in its place.

b. Under paragraph (b)(2)(ii), the reference "§ 413.80'' is removed and the reference "§ 413.89'' is added in its place.

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

C. Part 413 is amended as follows:

1. The authority citation for Part 413 continued 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).

§ 413.13 [Amended]

2. In § 413.13 (d)(1), the reference "§ 413.80'' is removed and the reference "§ 413.89'' is added in its place.

3. Section 413.40 is amended by—

a. In paragraph(a)(3), under the definition of "Net inpatient operating costs'', removing the reference "§§ 413.85 and 413.86'' and adding in its place the reference "§§ 413.75 through 413.83 and 413.85''.

b. Revising paragraph (c)(4)(iii).

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

* * * * *

(c) *Costs subject to the ceiling*—* * *

(4) *Target amounts.* * * *

(iii) For cost reporting periods beginning on or after October 1, 1997 through September 30, 2002, in the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the target amount is the lower of the amounts specified in paragraph (c)(4)(iii)(A) or paragraph (c)(4)(iii)(B) of this section.

* * * * *

4. Section 413.65 is amended by—

a. Reprinting the introductory text of paragraph (a)(1)(ii) and adding a new paragraph (a)(1)(ii)(L).

b. Revising the definition of "Provider-based entity'' under paragraph (a)(2).

c. Revising paragraphs (b)(3)(i) and (b)(3)(ii).

d. Revising paragraphs (e)(1) introductory text and (e)(1)(i).

e. Revising paragraph (e)(3).

f. Revising paragraph (g)(7).

The addition and revision read as follows:

§ 413.65 Requirements for a determination that a facility or an organization has provider-based status.

(a) *Scope and definitions.* * * *

(1) * * *

(ii) The determinations of provider-based status for payment purposes described in this section are not made as to whether the following facilities are provider-based:

* * * * *

(L) Rural health clinics (RHCs) affiliated with hospitals having 50 or more beds.

* * * * *

(2) *Definitions.* * * *

Provider-based entity means a provider of health care services, or an RHC as defined in § 405.2401(b) of this chapter, that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the ownership and administrative and financial control of the main provider, in accordance with the provisions of this section. A provider-based entity comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. A provider-based entity may, by itself, be qualified to participate in Medicare as a provider under § 489.2 of this chapter, and the Medicare conditions of participation do apply to a provider-based entity as an independent entity.

* * * * *

(b) *Provider-based determinations.*—* * *

(3)(i) Except as specified in paragraphs (b)(2) and (b)(5) of this section, if a potential main provider seeks a determination of provider-based status for a facility that is located on the campus of the potential main provider, the provider would be required to submit an attestation stating that the facility meets the criteria in paragraph (d) of this section and, if it is a hospital, also attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of this section. The provider seeking such a determination would also be required to maintain documentation of the basis for its attestations and to make that documentation available to CMS and to CMS contractors upon request. If the facility is operated as a joint venture, the provider would also have to attest that it will comply with the requirements of paragraph (f) of this section.

(ii) If the facility is not located on the campus of the potential main provider, the provider seeking a determination would be required to submit an attestation stating that the facility meets the criteria in paragraphs (d) and (e) of this section, and if the facility is operated under a management contract, the requirements of paragraph (h) of this section. If the potential main provider is a hospital, the hospital also would be required to attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of this section. The provider would be required

to supply documentation of the basis for its attestations to CMS at the time it submits its attestations.

* * * * *

(e) * * *

(1) *Operation under the ownership and control of the main provider.* The facility or organization seeking provider-based status is operated under the ownership and control of the main provider, as evidenced by the following:

(i) The business enterprise that constitutes the facility or organization is 100 percent owned by the main provider.

* * * * *

(3) *Location.* The facility or organization meets the requirements in paragraph (e)(3)(i), (e)(3)(ii), (e)(3)(iii), (e)(3)(iv), or, in the case of an RHC, paragraph (e)(3)(v) of this section, and the requirements in paragraph (e)(3)(vi) of this section.

(i) The facility or organization is located within a 35-mile radius of the campus of the hospital or CAH that is the potential main provider.

(ii) The facility or organization is owned and operated by a hospital or CAH that has a disproportionate share adjustment (as determined under § 412.106 of this chapter) greater than 11.75 percent and is described in § 412.106(c)(2) of this chapter implementing section 1886(e)(5)(F)(i)(II) of the Act and is—

(A) Owned or operated by a unit of State or local government;

(B) A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or

(C) A private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan).

(iii) The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with CMS, and for each subsequent 12-month period—

(A) At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider; or

(B) At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider).

(iv) If the facility or organization is unable to meet the criteria in paragraph (e)(3)(iii)(A) or paragraph (e)(3)(iii)(B) of this section because it was not in operation during all of the 12-month period described in paragraph (e)(3)(iii) of this section, the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in paragraph (e)(3)(iii) of this section, accounted for at least 75 percent of the patients served by the main provider.

(v) Both of the following criteria are met:

(A) The facility or organization is an RHC that is otherwise qualified as a provider-based entity of a hospital that has fewer than 50 beds, as determined under § 412.105(b) of this chapter; and

(B) The hospital with which the facility or organization has a provider-based relationship is located in a rural area, as defined in Subpart D of Part 412 of this subchapter.

(vi) A facility or organization may qualify for provider-based status under this section only if the facility or organization and the main provider are located in the same State or, when consistent with the laws of both States, in adjacent States.

* * * * *

(g) *Obligations.* * * *

(7) When a Medicare beneficiary is treated in a hospital outpatient department that is not located on the main provider's campus, the treatment is not required to be provided by the antidumping rules in § 489.24 of this chapter, and the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, the following requirements must be met:

(i) The hospital must provide written notice to the beneficiary, before the delivery of services, of—

(A) The amount of the beneficiary's potential financial liability; or

(B) If the exact type and extent of care needed are not known, an explanation that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based, an estimate based on typical or average charges for visits to the facility, and a statement that the patient's actual liability will depend upon the actual services furnished by the hospital.

(ii) The notice must be one that the beneficiary can read and understand.

(iii) If the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, before the delivery of services, to the beneficiary's authorized representative.

(iv) In cases where a hospital outpatient department provides examination or treatment that is required to be provided by the antidumping rules of § 489.24 of this chapter, notice, as described in this paragraph (g)(7), must be given as soon as possible after the existence of an emergency has been ruled out or the emergency condition has been stabilized.

* * * * *

5. Section 413.75 is amended in paragraph (b) by revising paragraph (1) under the definition of "Medicare GME affiliated group'' to read as follows:

§ 413.75 Direct GME payments: General requirements.

* * * * *

(b) * * *

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 subpart D of part 412 of this subchapter.

* * * * *

§ 413.77 [Amended]

6. In § 413.77, under paragraph (e)(1)(iii), the reference "§ 412.62(f)(1)(i) of this chapter.'' is removed and the reference "subpart D of part 412 of this subchapter''. is added in its place.

7. Section 413.79 is amended by—

a. Revising paragraph (a)(10).

b. Revising the introductory text of paragraph (c)(2).

c. In paragraph (c)(3)(i), removing the reference "§ 412.62(f)(iii)'' and adding in its place the reference "subpart D of part 412 of this subchapter''.

d. Adding a new paragraph (c)(6).

e. Revising paragraph (e)(1)(iv).

f. In the introductory text of paragraph (k), removing the reference "(k)(6)'' and adding in its place the reference "(k)(7)''.

g. Adding a new paragraph (k)(7).

The revisions and additions read as follows:

§ 413.79 Direct GME payments: Determination of the weighted number of FTE residents.

* * * * *

(a) * * *

(10) Effective for portions of cost reporting periods beginning on or after October 1, 2004, if a hospital can document that a resident simultaneously matched for one year of training in a particular specialty program, and for a subsequent year(s) of training in a different specialty program, the resident's initial residency period will be determined based on the period of board eligibility for the specialty associated with the program for which the resident matched for the subsequent year(s) of training. Effective for cost reporting periods beginning on or after October 1, 2005, if a hospital can document that a particular resident, prior to beginning the first year of residency training, matched in a specialty program for which training would begin at the conclusion of the first year of training, that resident's initial residency period will be determined in the resident's first year of training based on the period of board eligibility associated with the specialty program for which the resident matched for subsequent training year(s).

* * * * *

(c) *Unweighted FTE counts.* * * *

(2) *Determination of the FTE resident cap.* Subject to the provisions of paragraphs (c)(3) through (c)(6) of this section and § 413.81, for purposes of determining direct GME payment—

* * * * *

(6) *FTE resident caps for rural hospitals that are reclassified as urban.* A rural hospital redesignated as urban after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003, may retain the increases to its FTE resident cap that it received under paragraphs (c)(2)(i), (e)(1)(iii), and (e)(3) of this section while it was located in a rural area.

* * * * *

(e) *New medical residency training programs.* * * *

(1) * * *

(iv) An urban hospital that qualifies for an adjustment to its FTE cap under paragraph (e)(1) of this section is permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap only if the adjustment that results from the affiliation is an increase to the urban hospital's FTE cap.

* * * * *

(k) *Residents training in rural track programs.* * * *

(7) If an urban hospital had established a rural track training program under the provisions of this paragraph (k) with a hospital located in a rural area and that rural area subsequently becomes an urban area due to the most recent census data and implementation of the new labor market area definitions announced by OMB on June 6, 2003, the urban hospital may continue to adjust its FTE resident limit in accordance with this paragraph (k) for the rural track programs established prior to the adoption of such new labor market area definitions. In order to receive an adjustment to its FTE resident cap for a new rural track residency program, the urban hospital must establish a rural track program with hospitals that are designated rural based on the most recent geographical location designations adopted by CMS.

* * * * *

§ 413.87 [Amended]

8. In § 413.87(d) introductory text, the reference "§ 413.86(d)(4)'' is removed and the reference "§ 413.76(d)(4)'' is added in its place.

§ 413.178 [Amended]

9. In § 413.178—

a. In paragraph (a), the reference "§ 413.80(b)'' is removed and the reference "§ 413.89(b)'' is added in its place.

b. In paragraph (b), the reference "§ 413.80'' is removed and the reference "§ 413.89'' is added in its place.

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

D. Part 415 is amended as follows:

1. The authority citation for part 415 continued to read as follows:

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

§ 415.55 [Amended]

2. In § 415.55(a)(5), the reference "§ 413.86'' is removed and the reference "§§ 413.75 through 413.83'' is added in its place.

§ 415.70 [Amended]

3. In § 415.70(a)(2), the reference "§ 413.86'' is removed and the reference "§§ 413.75 through 413.83'' is added in its place.

§ 415.102 [Amended]

4. In § 415.102(c)(1), the reference "§ 413.86'' is removed and the reference "§§ 413.75 through 413.83'' is added in its place.

§ 415.150 [Amended]

5. In § 415.150(b), the reference "§ 413.86'' is removed and the phrase "§§ 413.75 through 413.83'' is added in its place.

§ 415.152 [Amended]

6. In § 415.152—

a. In paragraph (2) of the definition of "Approved graduate medical education (GME) program'', the reference "§ 413.86(b)'' is removed and the reference "§ 413.75(b)'' is added in its place.

b. In the definition of "Teaching setting'', the reference "§ 413.86,'' is removed and the reference "§§ 413.75 through 413.83,'' is added in its place.

§ 415.160 [Amended]

7. In § 415.160—

a. In paragraph (c)(2), the reference "§ 413.86'' is removed and the reference "§ 413.78'' is added in its place.

b. In paragraph (d)(2), the reference "§ 413.86'' is removed and the reference "§§ 413.75 through 413.83'' is added in its place.

§ 415.174 [Amended]

8. In § 415.174(a)(1), the reference "§ 413.86.'' is removed and the phrase "§§ 413.75 through 413.83.'' is added in its place.

§ 415.200 [Amended]

9. In § 415.200(a), the reference "§ 413.86'' is removed and the reference "§§ 413.75 through 413.83'' is added in its place.

§ 415.204 [Amended]

10. In § 415.204(a)(2), the reference "§ 413.86'' is removed and the reference "§§ 413.75 through 413.83'' is added in its place.

§ 415.206 [Amended]

11. In § 415.206(a), the reference "§ 413.86(f)(1)(iii)'' is removed and the reference "§ 413.78'' is added in its place.

§ 415.208 [Amended]

12. In § 415.208—

a. In paragraph (b)(1), the reference "§ 413.86'' is removed and the reference "§§ 413.75 through 413.83'' is added in its place.

b. In paragraph (b)(4), the reference "§ 413.86'' is removed and the reference "§§ 413.75 through 413. 83'' is added in its place.

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR OUTPATIENT DEPARTMENT SERVICES

F. Part 419 is amended as follows:

1. The authority citation for part 419 continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

§ 419.2 [Amended]

2. In § 419.2—

a. In paragraph (c)(1), the reference "§ 413.86'' is removed and the reference "§§ 413.75 through 413.83'' is added in its place.

b. In paragraph (c)(6), the reference "§ 413.80(b)'' is removed and the reference "§ 413.89(b)'' is added in its place.

PART 422—SPECIAL RULES FOR SERVICES FURNISHED BY NONCONTRACT PROVIDERS

G. Part 422 is amended as follows:

1. The authority citation of part 422 continues to read as follows:

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

§ 422.214 [Amended]

2. In § 422.214—

a. In paragraph (b), the phrase "§§ 412.105(g) and 413.86(d))'' is removed and the phrase "§§ 412.105(g) and 413.76))'' is added in its place.

b. In paragraph (b), the phrase "Section 413.86 (d)'' is removed and the phrase "Section 413.76'' is added in its place.

§ 422.216 [Amended]

3. In § 422.216(a)(4), the reference "§§ 412.105(g) and 413.86(d)'' is removed and the reference "§§ 412.105(g) and 413.76'' is added in its place.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

G. Part 485 is amended as follows:

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

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

2. Section 485.610 is amended by—

a. In paragraph (b)(1)(i), removing the reference "§ 412.62(f)'' and adding in its place the reference "§ 412.64(b)''.

b. In paragraph (b)(1)(ii), removing the reference "§ 412.63(b)'' and adding in its place the reference "§ 412.64(b)''.

c. Revising paragraph (b)(3).

d. Adding a new paragraph (d).

The revisions and additions read as follows:

§ 485.610 Condition of participation: Status and location.

* * * * *

(b) * * *

(3) Effective only for October 1, 2004 through September 30, 2006, the CAH does not meet the location requirements in either paragraph (b)(1) or paragraph (b)(2) of this section and is located in a county that, in FY 2004, was not part of a Metropolitan Statistical Area as defined by the Office of Budget Management and was not considered to be urban under § 412.63(b)(3) of this chapter, but as of FY 2005 was included as part of such an MSA or was considered to be urban under § 412.64(b)(3) of this chapter, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

* * * * *

(d) *Standard: Relocation of CAHs with a necessary provider designation.* A CAH that has a necessary provider certification from the State and places a new facility in service after January 1, 2006, can continue to meet the location requirement of paragraph (c) of this section based on the necessary provider certification only if the new facility meets either the requirement for replacement in the same location in paragraph (d)(1) of this section or the requirement for a relocation of a CAH in paragraph (d)(2) of this section.

(1) A new construction of a CAH will be considered as a replacement facility if the construction is undertaken within 250 yards of the current building or contiguous to the current CAH on land owned by the CAH prior to December 8, 2003.

(2) A new facility CAH will be considered as a relocation of a CAH if, at the relocated site—

(i) The CAH serves at least 75 percent of the same service area that it served prior to its relocation, provides at least 75 percent of the same services that it provided prior to the relocation, and is staffed by 75 percent of the same staff (including medical staff, contracted staff, and employees); and

(ii) The CAH provides documentation demonstrating that its plans to rebuild in the relocated area were undertaken prior to December 8, 2003.

(3) If a CAH that has a necessary provider certification from the State places a new facility in service on or after January 1, 2006, and does not meet either the requirements in paragraph (d)(1) or paragraph (d)(2) of this section, the action will be considered a cessation of business as described in § 489.52(b)(3).

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

Dated: April 19, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: April 22, 2005.

Michael O. Leavitt,

Secretary.

[**Editorial Note:** The following Addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum—Proposed Schedule of Standardized Amount Effective With Discharges Occurring On or After October 1, 2005 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2005

(If you choose to comment on issues in this section, please include the caption "Operating Payment Rates'' at the beginning of your comment.)

I. Summary and Background

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

For discharges occurring on or after October 1, 2005, except for SCHs, MDHs, and hospitals located in Puerto Rico, each hospital's payment per discharge under the IPPS will be based on 100 percent of the Federal national rate, which will be based on the national adjusted standardized amount. This amount reflects the national average hospital costs per case from a base year, updated for inflation.

SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

Under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever is higher. MDHs do not have the option to use their FY 1996 hospital-specific rate.

For hospitals in Puerto Rico, the payment per discharge is based on the sum of 25 percent of a Puerto Rico rate that reflects base year average costs per case of Puerto Rico hospitals and 75 percent of the Federal national rate. (*See* section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are proposing to make changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2006. The proposed changes, to be applied

prospectively effective with discharges occurring on or after October 1, 2005, affect the calculation of the Federal rates. In section III. of this Addendum, we discuss our proposed changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2006. Section IV. of this Addendum sets forth our proposed changes for determining the rate-of-increase limits for hospitals excluded from the IPPS for FY 2006. Section V. of this Addendum sets forth policies on payment for blood clotting factors administered to hemophilia patients. The tables to which we refer in the preamble of this proposed rule are presented in section VI. of this Addendum.

II. Proposed Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for FY 2006

The basic methodology for determining prospective payment rates for hospital inpatient operating costs for FY 2005 and subsequent fiscal years is set forth at § 412.64. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for hospitals located in Puerto Rico for FY 2005 and subsequent fiscal years is set forth at §§ 412.211 and 412.212. Below we discuss the factors used for determining the prospective payment rates.

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

- Equalization of the standardized amounts for urban and other areas at the level computed for large urban hospitals during FY 2004 and onward, as provided for under section 1886(d)(3)(A)(iv) of the Act, updated by the applicable percentage increase required under sections 1886(b)(3)(B)(i)(XIX) and 1886(b)(3)(B)(vii) of the Act.
- The two labor-related shares that are applicable to the standardized amounts, depending on whether the hospital's payments would be higher with a lower (in the case of a wage index below 1.0000) or higher (in the case of a wage index above 1.0000) labor share, as provided for under sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act;
- Updates of 3.2 percent for all areas (that is, the full market basket percentage increase of 3.2 percent, as required by section 1886(b)(3)(B)(i)(XIX) of the Act, and reflecting the requirements of section 1886(b)(3)(B)(vii) of the Act to reduce the applicable percentage increase by 0.4 percentage points for hospitals that fail to submit data, in a form and manner specified by the Secretary, relating to the quality of inpatient care furnished by the hospital;
- An adjustment to ensure the proposed DRG recalibration and wage index update and changes are budget neutral, as provided for under sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act, by applying new budget neutrality adjustment factors to the standardized amount;
- An adjustment to ensure the effects of the special transition measures adopted in relation to the implementation of new labor market areas are budget neutral;
- 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 2005 budget neutrality factor and applying a revised factor;
- An adjustment to apply the new outlier offset by removing the FY 2005 outlier offset and applying a new offset;
- An adjustment to ensure the effects of the rural community hospital demonstration required under section 410A of Pub. L. 108–173 are budget neutral, as required under section 410A(c)(2) of Pub. L. 108–173.

A. Calculation of the Adjusted Standardized Amount

1. Standardization of Base-Year Costs or Target Amounts

The national standardized amount is based on per discharge averages of adjusted hospital costs from a base period (section 1886(d)(2)(A) of the Act) or, for Puerto Rico, adjusted target amounts from a base period (section 1886(d)(9)(B)(i) of the Act), updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. The 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 and 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 section 1886(d)(3)(E) of the Act, the Secretary estimates, from time-to-time, the proportion of hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the proportion considered the labor-related amount is adjusted by the wage index. Section 403 of Pub. L. 108–173 revises the proportion of the standardized amount that is considered labor-related. Specifically, section 1886(d)(3)(E) of the Act (as amended by section 403 of Pub. L. 108–173) requires that 62 percent of the standardized amount be adjusted by the wage index, unless doing so would result in lower payments to a hospital than would otherwise be made. (Section 403(b) of Pub. L. 108–173 extended this provision to the Puerto Rico standardized amounts.) We are proposing to update the labor-related share to 69.7 percent for FY 2006, as discussed in section IV.B.3. of the preamble to this proposed rule. We note that the revised labor-related share that we are proposing for FY 2006 was determined to be 69.731, as discussed in section IV of the preamble to this proposed rule. We are proposing to continue with our previous methodology and round the labor-related share to 69.7 percent for purposes of establishing the labor-related and nonlabor-related portions of the standardized amount. As discussed in section IV. of the preamble to this proposed rule, we are also proposing to rebase the current labor-related share for the Puerto Rico-specific amounts for FY 2006. Since the proposed rebased Puerto Rico labor-related share has not yet been calculated, the proposed standardized amounts that appear in Table 1C of this Addendum for providers with a wage index greater than 1.0000 reflect the current (FY 2005) labor-related share for the Puerto Rico-specific amounts of 71.3 percent for FY 2006. However, in the final rule, if we adopt our proposal to rebase the labor-related share for Puerto Rico, these amounts would reflect this revised labor-related share. We are proposing to adjust 62 percent of the national standardized amount and 62 percent of the Puerto Rico-specific amount by the wage index for all hospitals whose wage indexes are less than or equal to 1.0000. For all hospitals whose wage values are greater than 1.0000, we are proposing to adjust the national standardized amount by a labor-related share of 69.7 percent.

2. Computing the Average Standardized Amount

Sections 1886(d)(3)(A)(iv) of the Act previously required the Secretary to compute the following 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 accordance with section 1886(b)(3)(B)(i) of the Act, the large urban average standardized amount was 1.6 percent higher than the other area average standardized amount. In addition, under sections 1886(d)(9)(B)(iii) and 1886(d)(9)(C)(i) of the Act, the average standardized amounts per discharge were determined for hospitals located in urban and rural areas in Puerto Rico.

Section 402(b) of Pub. L. 108–7 required that, effective for discharges occurring on or after April 1, 2003, and before October 1, 2003, the Federal rate for all IPPS hospitals would be based on the large urban standardized amount. Subsequently, Pub. L. 108–89 extended section 402(b) of Pub. L. 108–7 beginning with discharges on or after October 1, 2003 and before March 31, 2004. Finally, section 401(a) of Pub. L. 108–173 amended section 1886(d)(3)(A)(iv) of the Act to require that, beginning with FY 2004 and thereafter, an equal standardized amount is to be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. This provision in effect makes permanent the equalization of the standardized amounts at the level of the previous standardized amount for large urban hospitals. Section 401(c) of Pub. L. 108–173 also amended section 1886(d)(9)(A) of the Act to equalize the Puerto Rico-specific urban and rural area rates. Accordingly, we are providing in this proposed rule for a single national standardized amount and a

single Puerto Rico standardized amount for FY 2006.

3. Updating the Average Standardized Amount

In accordance with section 1886(d)(3)(A)(iv)(II) of the Act, we are proposing to update the equalized standardized amount for FY 2006 by the full estimated market basket percentage increase for hospitals in all areas, as specified in section 1886(b)(3)(B)(i)(XIX) of the Act, as amended by section 501 of Pub. L. 108–173. The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital market basket increase for FY 2006 is 3.2 percent. Thus, for FY 2006, the proposed update to the average standardized amount is 3.2 percent for hospitals in all areas.

Section 1886(b)(3)(B) of the Act specifies the mechanism used to update the standardized amount for payment for inpatient hospital operating costs. Section 1886(b)(3)(B)(vii) of the Act, as amended by section 501(b) of Pub. L. 108–173, provides for a reduction of 0.4 percentage points to the update percentage increase (also known as the market basket update) for each of FYs 2005 through 2007 for any "subsection (d) hospital'' that does not submit data on a set of 10 quality indicators established by the Secretary as of November 1, 2003. The statute also provides that any reduction will apply only to the fiscal year involved, and will not be taken into account in computing the applicable percentage increase for a subsequent fiscal year. This measure establishes an incentive for hospitals to submit data on quality measures established by the Secretary. The proposed standardized amounts in Tables 1A through 1D of section VI. of this Addendum reflect these differential amounts.

Although the update factors for FY 2006 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 2006 for both IPPS hospitals and hospitals and hospital units excluded from the IPPS. Our recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth as Appendix B of this proposed rule.

4. Other Adjustments to the Average Standardized Amount

As in the past, we are proposing to adjust the FY 2006 standardized amount to remove the effects of the FY 2005 geographic reclassifications and outlier payments before applying the FY 2006 updates. We then apply the new offsets for outliers and geographic reclassifications to the standardized amount for FY 2006.

We do not remove the prior year's budget neutrality adjustments for reclassification and recalibration of the DRG weights and for updated wage data because, in accordance with section 1886(d)(4)(C)(iii) of the Act, estimated aggregate payments after the changes in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy this condition.

Budget neutrality is determined by comparing aggregate IPPS payments before and after making the changes that are required to be budget neutral (for example, reclassifying and recalibrating the DRGs, updating the wage data, and geographic reclassifications). We include outlier payments in the payment simulations because outliers may be affected by changes in these payment parameters.

We are also proposing to adjust the standardized amount this year by an amount estimated to ensure that aggregate IPPS payments do not exceed the amount of payments that would have been made in the absence of the rural community hospital demonstration required under section 410A of Pub. L. 108–173. This demonstration is required to be budget neutral under section 410A(c)(2) of Pub. L. 108–173.

a. Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment

Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II. of the preamble, we normalized the recalibrated DRG weights by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight prior to recalibration. However, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, we are proposing to make a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. For FY 2006, we are proposing to continue to adjust 10 percent of the wage index factor for occupational mix. We describe the proposed occupational mix adjustment in section III.C. of the preamble to this proposed rule. Because section 1886(d)(3)(E) of the Act requires us to update the wage index on a budget neutral basis, we are including the effects of this proposed occupational mix adjustment on the wage index in our budget neutrality calculations.

In FY 2005, those urban hospitals that became rural under the new labor market area definitions were assigned the wage index of the urban area in which they were located under the previous labor market definitions for a 3-year period of FY 2005, FY 2006, and FY 2007. Because we are in the second year of this 3-year transition, we are proposing to adjust the standardized amounts for FY 2006 to ensure budget neutrality for this policy. We discuss this adjustment in section III.B. of the preamble to this proposed rule.

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. As discussed in the FY 2005 IPPS final rule (69 FR 49110), we are in the second year of the 3-year provision that uses an imputed wage index floor for States that have no rural areas and States that have geographic rural areas, but that have no hospitals actually classified as rural. We are also adjusting for the effects of this provision in our calculation of the wage update budget neutrality factor.

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 2004 discharge data to simulate payments and compared aggregate payments using the FY 2005 relative weights and wage index to aggregate payments using the proposed FY 2006 relative weights and wage index. The same methodology was used for the FY 2005 budget neutrality adjustment.

Based on this comparison, we computed a proposed budget neutrality adjustment factor equal to 1.002494. We also are proposing to adjust the Puerto Rico-specific standardized amount for the effect of DRG reclassification and recalibration. We computed a proposed budget neutrality adjustment factor for the Puerto Rico-specific standardized amount equal to 0.999003. These proposed budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2005 budget neutrality adjustments. In addition, as discussed in section V.C.2. of the preamble to this proposed rule, we are proposing to apply the same DRG reclassification and recalibration budget neutrality factor of 0.999003 to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 2005.

Using the same data, we calculated a transition budget neutrality adjustment to account for the "hold harmless'' policy under which urban hospitals that became rural under the new labor market area definitions were assigned the wage index of the urban area in which they were located under the previous labor market area definitions for a 3-year period of FY 2005, FY 2006, and FY 2007 (*see* Table 2 in section VI. of this Addendum). Using the prereclassified wage index, we simulated payments under the new labor market area definitions and compared them to simulated payments under the "hold harmless'' policy. Based on this comparison, we computed a proposed transition budget neutrality adjustment of 0.999529.

b. Reclassified Hospitals—Budget Neutrality Adjustment

Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for

the reclassification of hospitals based on determinations by the MGCRB. Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the wage index.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amount to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. (We note that neither the wage index reclassifications provided under section 508 of Pub. L. 108–173 nor the wage index adjustments provided under section 505 of Pub. L. 108–173 are budget neutral. Section 508(b) of Pub. L. 108–173 provides that the wage index reclassifications approved under section 508(a) of Pub. L. 108–173 "shall not be effected in a budget neutral manner." Section 505(a) of Pub. L. 108–173 similarly provides that any increase in a wage index under that section shall not be taken into account "in applying any budget neutrality adjustment with respect to such index" under section 1886(d)(8)(D) of the Act.) To calculate this proposed budget neutrality factor, we used FY 2004 discharge data to simulate payments, and compared total IPPS payments prior to any reclassifications under sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act to total IPPS payments after such reclassifications. Based on these simulations, we are proposing to apply an adjustment factor of 0.992905 to ensure that the effects of this reclassification are budget neutral.

The proposed adjustment factor is applied to the standardized amount after removing the effects of the FY 2005 budget neutrality adjustment factor. We note that the proposed FY 2006 adjustment reflects FY 2006 wage index reclassifications approved by the MGCRB or the Administrator, and the effects of MGCRB reclassifications approved in FY 2004 and FY 2005 (section 1886(d)(10)(D)(v) of the Act makes wage index reclassifications effective for 3 years).

c. Outliers

Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments for "outlier" cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outlier payment). To determine whether the costs of a case exceed the fixed-loss threshold, a hospital's cost-to-charge ratio is applied to the total covered charges for the case to convert the charges to costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the costs above the threshold.

In accordance with section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year are projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amount by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized amounts applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases. More information on outlier payments may be found on the CMS Web site at *http://www.cms.hhs.gov/providers/hipps/ippsotlr.asp.*

i. Proposed FY 2006 outlier fixed-loss threshold. For FY 2006, we are proposing a new methodology to calculate the outlier fixed-loss threshold. For FY 2004, we simulated outlier payments by applying FY 2004 rates and policies using cases from the FY 2002 MedPAR file. In order to determine the FY 2004 outlier fixed-loss threshold, it was necessary to inflate the charges on the MedPAR claims by 2 years, from FY 2002 to FY 2004. In order to determine the FY 2004 threshold, we used the 2-year average annual rate-of-change in charges per case to inflate FY 2002 charges to approximate FY 2004 charges. (We refer the reader to the FY 2004 IPPS final rule (67 FR 45476) for a complete discussion of the FY 2004 methodology.) In the IPPS proposed rule for FY 2005 (69 FR 28376), we proposed to use the same methodology we used for determining the FY 2004 outlier fix-loss threshold to determine the FY 2005 outlier threshold. We further noted that the rate-of-increase in the 2-year average annual rate-of-change in charges derived from the period before the changes we made to the policy affecting the applicable cost-to-charge ratios (68 FR 34494) and, therefore, they may have represented rates-of-increase that could be higher than the rates-of-increase under our new policy. As a result, we welcomed comments on the data we were using to update charges for purposes of the threshold and specifically encouraged commenters to provide recommendations for data that might better reflect current trends in charge increases.

In response to the many comments we received on this proposed FY 2005 methodology, in the IPPS final rule for FY 2005 (69 FR 49275), we revised that proposed methodology and used the following methodology to calculate the final FY 2005 outlier fixed-loss threshold. Instead of using the 2-year average annual rate-of-change in charges per case from FY 2001 to FY 2002 and FY 2002 to FY 2003, we used more recent data to determine the annual rate-of-change in charges for the FY 2005 outlier threshold. Specifically, we compared the rate-of-increase in charges from the first half-year of FY 2003 to the first half-year of FY 2004. We stated that we believed this methodology would result in a more accurate determination of the rate-of-change in charges per case between FY 2003 and FY 2005. Although a full year of data was available for FY 2003, we did not have a full year of FY 2004 data at the time we set the FY 2005 outlier threshold. Therefore, we stated that we believed it was optimal to employ comparable periods in determining the rate-of-change from one year to the next. We also stated that we believed this methodology was the best methodology for determining the rate-of-change in charges per case because it used the most recent charge data available. Using this methodology, we established a fixed-loss cost outlier threshold for FY 2005 equal to the prospective payment rate for the DRG, plus any IME and DSH payment, and any add-on payment for new technology, plus $25,800.

For FY 2006, we are proposing to use a new methodology to calculate the outlier threshold that will take into account the lower inflation in hospital charges that is occurring as a result of the June 9, 2003 outlier final rule (68 FR 34505), which changed our methodology for determining outlier payments by implementing the use of more current and accurate cost-to-charge ratios when paying for outliers. As we have done in the past, to calculate the proposed FY 2006 outlier thresholds, we simulated payments by applying proposed FY 2006 rates and policies using cases from the FY 2004 MedPAR files. Therefore, in order to determine the appropriate proposed FY 2006 outlier threshold, it was necessary to inflate the charges on the MedPAR claims by 2 years, from FY 2004 to FY 2006.

However, we are not proposing to inflate charges using a 2-year average annual rate-of-change in charges per case from FY 2002 to FY 2003 and FY 2003 to FY 2004 because of the distortion in FY 2002 and FY 2003 charge data caused by the exceptionally high rate of hospital charge inflation during those years. Instead, we are proposing to use more recent data that reflect changes under the new outlier policy. However, we will continue to consider other methodologies in the future when calculating the outlier threshold once we have 2 complete years of charge data under the new outlier policy.

Specifically, we are proposing to establish the proposed FY 2006 outlier threshold as follows: Using the latest data available, the 1-year average annualized rate-of-change in charges per case from the last quarter of FY 2003 in combination with the first quarter of FY 2004 (July 1, 2003 through December 31, 2003) to the last quarter of FY 2004 in combination with the first quarter of FY 2005 (July 1, 2004 through December 31, 2004) was 8.65 percent (1.0865), or 18.04 percent (1.1804) over 2 years. As we have done in the past, we are proposing to use hospital cost-to-charge ratios from the most recent Provider Specific File, in this case the December 2004 update, in establishing the proposed FY 2006 outlier threshold. This file includes cost-to-charge ratios that reflect implementation of the changes to the policy for determining the applicable cost-to-charge ratios that became effective August 8, 2003 (68 FR 34494).

Using this methodology, we are proposing to establish a fixed-loss cost outlier threshold for FY 2006 equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $26,675. In addition, as stated in the June 9, 2003 outlier final rule (68 FR 34505), we believe the use of charge inflation is more appropriate than our previous methodology of cost inflation because charges tend to increase at a much faster rate than costs. Although charges have increased at a slower rate since the implementation of changes to our outlier payment methodology in 2003, we believe the use of charges is still appropriate because this trend is still evident.

As we did in establishing the FY 2005 outlier threshold (69 FR 49278), we are not including in the calculation of the outlier threshold the possibility that hospitals' cost-to-charge ratios and outlier payments may be reconciled upon cost report settlement. We believe that, due to the policy implemented in the June 9, 2003 outlier final rule, cost-to-charge ratios will no longer fluctuate significantly and, therefore, few hospitals, if any, will actually have these ratios reconciled upon cost report settlement. In addition, it is difficult to predict which specific hospitals will have cost-to-charge ratios and outlier payments reconciled in their cost reports in any given year. We also note that reconciliation occurs because hospitals' actual cost-to-charge ratios for the cost reporting period are different than the interim cost-to-charge ratios used to calculate outlier payments when a bill is processed. Our simulations assume cost-to-charge ratios accurately measure hospital costs and, therefore, are more reflective of post-reconciliation than pre-reconciliation outlier payments. As a result, we omitted any assumptions about the effects of reconciliation from the outlier threshold calculation.

ii. Other changes concerning outliers. As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a lower percentage of outlier payments for capital-related costs than for operating costs. We project that the proposed thresholds for FY 2006 will result in outlier payments equal to 5.1 percent of operating DRG payments and 5.03 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we reduced the proposed FY 2005 standardized amount by the same percentage to account for the projected proportion of payments paid to outliers.

The proposed outlier adjustment factors that would be applied to the standardized amount for FY 2006 are as follows:

	Operating Standardized Amounts	Capital Federal Rate
National	0.948994	0.949652
Puerto Rico	0.976257	0.975914

We are proposing to apply the outlier adjustment factors to the FY 2006 rates after removing the effects of the FY 2005 outlier adjustment factors on the standardized amount.

To determine whether a case qualifies for outlier payments, we apply hospital-specific cost-to-charge ratios to the total covered charges for the case. Operating and capital costs for the case are calculated separately by applying separate operating and capital cost-to-charge ratios. These costs are then combined and compared with the fixed-loss outlier threshold.

The June 9, 2003 outlier final rule (68 FR 34494) eliminated the application of the statewide average for hospitals whose cost-to-charge ratios fall below 3 standard deviations from the national mean cost-to-charge ratio. However, for those hospitals for which the fiscal intermediary computes operating cost-to-charge ratios greater than 1.220 or capital cost-to-charge ratios greater than 0.169, or hospitals for whom the fiscal intermediary is unable to calculate a cost-to-charge ratio (as described at § 412.84(i)(3) of our regulations), we are still using statewide average ratios to calculate costs to determine whether a hospital qualifies for outlier payments.[6] Table 8A in section VI. of this Addendum contains the proposed 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. Effective for discharges occurring on or after October 1, 2005, these proposed statewide average ratios would replace the ratios published in the IPPS final rule for FY 2005 (69 FR 49687). Table 8B in section VI. of this Addendum contains the proposed comparable statewide average capital cost-to-charge ratios. Again, the proposed cost-to-charge ratios in Tables 8A and 8B would be used during FY 2006 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 2004 and FY 2005 outlier payments. In the FY 2005 IPPS final rule, we stated that, based on available data, we estimated that actual FY 2004 outlier payments would be approximately 3.6 percent of actual total DRG payments (69 FR 49278, as corrected at 69 FR 60252). This estimate was computed based on simulations using the FY 2003 MedPAR file (discharge data for FY 2003 bills). That is, the estimate of actual outlier payments did not reflect actual FY 2004 bills, but instead reflected the application of FY 2004 rates and policies to available FY 2003 bills.

Our current estimate, using available FY 2004 bills, is that actual outlier payments for FY 2004 were approximately 3.5 percent of actual total DRG payments. Thus, the data indicate that, for FY 2004, the percentage of actual outlier payments relative to actual total payments is lower than we projected before FY 2004 (and, thus, is less than the percentage by which we reduced the standardized amounts for FY 2004). We note that, for FY 2005, the outlier threshold was lowered to $25,800 compared to $31,000 for FY 2004. The outlier threshold was lower in FY 2005 than FY 2004 as a result of slower growth in hospital charge inflation. We believe that this slower growth was due to changes in hospital charge practices following implementation of the outlier final rule published on June 9, 2003. Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not plan to make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2004 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2005 will be approximately 4.4 percent of actual total DRG payments, 0.7 percentage points lower than the 5.1 percent we projected in setting outlier policies for FY 2005. This estimate is based on simulations using the FY 2004 MedPAR file (discharge data for FY 2004 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2005 by applying FY 2005 rates and policies, including an outlier threshold of $25,800 to available FY 2004 bills.

d. Rural Community Hospital Demonstration Program Adjustment (Section 410A of Pub. L. 108–173)

Section 410A of Pub. L. 108–173 requires the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) of Pub. L. 108–173 requires that "in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' As discussed in section V.K. of the preamble to this proposed rule, we are proposing to satisfy this requirement by adjusting national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment that will be made to each participating hospital under the demonstration will be approximately $977,410. We based this estimate on the recent historical experience of the difference between inpatient cost and payment for hospitals that are participating in the demonstration. For 13 participating hospitals, the total annual impact of the demonstration program is estimated to be $12,706,334. The required adjustment to the Federal rate used in calculating Medicare inpatient prospective payments as a result of the demonstration is 0.999863.

[6] These figures represent 3.0 standard deviations from the mean of the log distribution of cost-to-charge ratios for all hospitals.

In order to achieve budget neutrality, we are proposing to adjust national IPPS rates by an amount sufficient to account for the added costs of this demonstration. In other words, we are proposing to apply budget neutrality across the payment system as a whole rather than merely across the participants of this demonstration. We believe that the language of the statutory budget neutrality requirement permits the agency to implement the budget neutrality provision in this manner. This is because the statutory language requires that "aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration * * * was not implemented,'' but does not identify the range across which aggregate payments must be held equal.

5. Proposed FY 2006 Standardized Amount

The adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B in section VI. of this Addendum contain the national standardized amount that we are proposing to apply to all hospitals, except hospitals in Puerto Rico. The amounts shown in the two tables differ only in that the labor-related share applied to the standardized amounts in Table 1A is 69.7 percent, and the labor-related share applied to the standardized amounts in Table 1B is 62 percent. In accordance with sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act, we are applying the labor-related share of 62 percent, unless the application of that percentage would result in lower payments to a hospital than would otherwise be made. The effect of this proposed application is that the labor-related share of the standardized amount is 62 percent for all hospitals whose wage indexes are less than or equal to 1.0000.

As discussed in section IV.B.3. of the preamble to this proposed rule (reflecting the Secretary's current estimate of the proportion of costs that are attributable to wages and wage-related costs), we are proposing to set the labor-related share of the standardized amount at 69.7 percent for hospitals whose wage indexes are greater than 1.0000. In addition, Tables 1A and 1B include proposed standardized amounts reflecting the full 3.2 percent update for FY 2006, and proposed standardized amounts reflecting the 0.4 percentage point reduction to the update applicable for hospitals that fail to submit quality data consistent with section 501(b) of Pub. L. 108–173. (Tables 1C and 1D show the proposed standardized amounts for Puerto Rico for FY 2006, reflecting the different labor-related shares that apply, that is, 71.3 percent or 62 percent.)

The following table illustrates the proposed changes from the FY 2005 national average standardized amount. The first column shows the proposed changes from the FY 2005 standardized amounts for hospitals that satisfy the quality data submission requirement for receiving the full update (3.2 percent). The second column shows the proposed changes for hospitals receiving the reduced update (2.8 percent). The first row of the table shows the proposed updated (through FY 2005) average standardized amount after restoring the FY 2005 offsets for outlier payments, demonstration budget neutrality, the wage index transition budget neutrality and geographic reclassification budget neutrality. The DRG reclassification and recalibration and wage index budget neutrality factor is cumulative. Therefore, the FY 2005 factor is not removed from the amount in the table. We have added separate rows to this table to reflect the different labor-related shares that apply to hospitals.

Comparison of FY 2005 Standardized Amounts to Proposed FY 2006 Single Standardized Amount with Full Update and Reduced Update

	Full Update (3.2 percent)	Reduced Update (2.8 percent)
FY 2005 Base Rate, after removing reclassification budget neutrality, demonstration budget neutrality, wage index transition budget neutrality factors and outlier offset (based on the proposed labor and nonlabor market share percentage for FY 2006)	Labor: $3,373.02 Nonlabor: $1,466.32	Labor: $3,373.02 Nonlabor: $1,466.32
Proposed FY 2006 Update Factor	1.032	1.028
Proposed FY 2006 DRG Recalibrations and Wage Index Budget Neutrality Factor	1.002494	1.002494
Proposed FY 2006 Reclassification Budget Neutrality Factor	0.992905	0.992905
Adjusted for Blend of FY 2005 DRG Recalibration and Wage Index Budget Neutrality Factors*	Labor: $3,464.88 Nonlabor: $1,506.25	Labor: $3,451.44 Nonlabor: $1,500.41
Proposed FY 2006 Outlier Factor	0.948994	0.948994
Proposed FY 2006 Labor Market Wage Index Transition Budget Neutrality Factor	0.999529	0.999529
Proposed Rural Demonstration Budget Neutrality Factor	0.999863	0.999863
Proposed Rate for FY 2006 (after multiplying FY 2005 base rate by above factors) where the wage index is less than or equal to 1.0000	Labor: $2,923.11 Nonlabor: $1,791.58	Labor: $2,911.78 Nonlabor: $1,784.63
Proposed Rate for FY 2006 (after multiplying FY 2005 base rate by above factors) where the wage index is greater than 1.0000	Labor: $3,286.14 Nonlabor: $1,428.55	Labor: $3,273.40 Nonlabor: $1,423.01

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount (as set forth in Table 1A). The labor-related and nonlabor-related 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-related share applied to the Puerto Rico standardized amount is 71.3 percent, or 62 percent, depending on which is more advantageous to the hospital. (Section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Pub. L. 108–173, provides that the labor-related share for hospitals in Puerto Rico will be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

B. Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1D, as set forth in section VI. of this Addendum, contain the labor-related and nonlabor-related shares that we are proposing to use to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico. This section addresses two types of adjustments to the standardized amounts that are made in determining the proposed prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of the preamble to this proposed rule, we discuss the data and methodology for the proposed FY 2006 wage index. The proposed FY 2006 wage indexes are 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 2006, we are proposing to adjust the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor-related portion of the standardized amount by the appropriate adjustment factor contained in the table below. If the Office of Personnel Management releases revised cost-of-living adjustment factors before July 1, 2005, we will publish them in the final rule and use them in determining FY 2006 payments.

Table of Cost-of-Living Adjustment Factors, Alaska and Hawaii Hospitals

Area	Cost of Living Adjustment Factor
Alaska-All areas	1.25
Hawaii:	
County of Honolulu	1.25
County of Hawaii	1.165
County of Kauai	1.2325
County of Maui	1.2375
County of Kalawao	1.2375

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

C. DRG Relative Weights

As discussed in section II. of the preamble, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section VI. of this Addendum contains the relative weights that we are proposing to use for discharges occurring in FY 2006. These factors have been recalibrated as explained in section II. of the preamble of this proposed rule.

D. Calculation of Proposed Prospective Payment Rates for FY 2006

General Formula for Calculation of Prospective Payment Rates for FY 2006

The proposed operating prospective payment rate for all hospitals paid under the IPPS located outside of Puerto Rico, except SCHs and MDHs, equals the Federal rate based on the corresponding amounts in Table 1A or Table 1B in section VI. of this Addendum.

The proposed prospective payment rate for SCHs equals the higher of the applicable Federal rate (from Table 1A or Table 1B) or the hospital-specific rate as described below. The proposed prospective payment rate for MDHs equals the higher of the Federal rate, or the Federal rate plus 50 percent of the difference between the Federal rate and the hospital-specific rate as described below. The proposed prospective payment rate for Puerto Rico equals 25 percent of the Puerto Rico rate plus 75 percent of the applicable national rate from Table 1C or Table 1D in section VI. of this Addendum.

1. Federal Rate

For discharges occurring on or after October 1, 2005 and before October 1, 2006, except for SCHs, MDHs, and hospitals in Puerto Rico, payment under the IPPS is based exclusively on the Federal rate.

The Federal rate is determined as follows:

Step 1—Select the appropriate average standardized amount considering the applicable wage index (Table 1A for wage indexes greater than 1.0000 and Table 1B for wage indexes less than or equal to 1.0000) and whether the hospital has submitted qualifying quality data (full update for qualifying hospitals, update minus 0.4 percentage points for nonqualifying hospitals).

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

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

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

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

The Federal rate as determined in Step 5 may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment.

2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

Section 1886(d)(5)(G) of the Act provides that MDHs are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal rate or the Federal rate plus 50 percent of the difference between the Federal rate and the greater of the updated hospital-specific rates based on either FY 1982 or FY 1987 costs per discharge. MDHs do not have the option to use their FY 1996 hospital-specific rate.

Hospital-specific rates have been determined for each of these hospitals based on the FY 1982 costs per discharge, the FY 1987 costs per discharge, or, for SCHs, the FY 1996 costs per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); the September 4, 1990 final rule (55 FR 35994); and the August 1, 2000 final rule (65 FR 47082). In addition, for both SCHs and MDHs, the hospital-specific rate is adjusted by the proposed budget neutrality adjustment factor (that is, by the recalibration budget neutrality factor of 0.999003) as discussed in section V.C.2. of the preamble to this proposed rule. The resulting rate would be used in determining the payment rate an SCH or MDH would receive for its discharges beginning on or after October 1, 2005.

b. Updating the FY 1982, FY 1987, and FY 1996 Hospital-Specific Rates for FY 2005

We are proposing to increase the hospital-specific rates by 3.2 percent (the hospital market basket percentage increase) for SCHs and MDHs for FY 2006. 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 2006, 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 2006, is the market basket rate-of-increase.

3. General Formula for Calculation of Proposed Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2005 and Before October 1, 2006

Under section 504 of Pub. L. 108–173, effective for discharges occurring on or after October 1, 2004, hospitals located in Puerto Rico are paid based on a blend of 75 percent of the national prospective payment rate and 25 percent of the Puerto Rico-specific rate.

a. Puerto Rico Rate

The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate average standardized amount considering the applicable wage index (*see* Table 1C).

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 amount from Step 3 by the appropriate DRG relative weight.

Step 5—Multiply the result in Step 4 by 25 percent (*see* Table 5 of section VI. of the Addendum).

b. National Rate

The national prospective payment rate is determined as follows:

Step 1—Select the appropriate average standardized amount considering the applicable wage index (*see* Table 1C).

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

Step 3—Multiply the amount from Step 2 by the appropriate DRG relative weight (*see* Table 5 of section VI. of the Addendum).

Step 4—Multiply the result in Step 3 by 75 percent.

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico. This rate may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment.

III. Proposed Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2006

(If you choose to comment on issues in this section, please include the caption "Capital Payment Rate'' at the beginning of your comment.)

The PPS for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period, hospitals were paid during a 10-year transition period (which extended through FY 2001) to change the payment methodology for Medicare acute care hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The basic methodology for determining Federal capital prospective rates is set forth in regulations at §§ 412.308 through 412.352. Below we discuss the factors that we are proposing to use to determine the capital Federal rate for FY 2006, which would be effective for discharges occurring on or after October 1, 2005. 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)) are paid based on 100 percent of the capital Federal rate. For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the capital standard Federal rate, as provided at § 412.308(c)(1), to account for capital input price increases and other factors. The regulations at § 412.308(c)(2) provide 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) exceptions under § 412.348. Section 412.308(c)(4)(ii) requires that the capital standard Federal rate be adjusted so that the effects of the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral.

For FYs 1992 through 1995, § 412.352 required that the capital Federal rate also be adjusted by a budget neutrality factor so that aggregate payments for inpatient hospital capital costs were projected to equal 90 percent of the payments that would have been made for capital-related costs on a reasonable cost basis during the fiscal year. That provision expired in FY 1996. Section 412.308(b)(2) describes the 7.4 percent reduction to the capital rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the capital rate made in FY 1996 as a result of the revised policy of paying for transfers. In FY 1998, we implemented section 4402 of Pub. L. 105–33, which required 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 FY 2003 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 FY 2002 IPPS final rule (66 FR 39911), beginning in FY 2002, an adjustment for regular exception payments is no longer necessary because regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001 (see § 412.348(b)). Because, effective with cost reporting periods beginning in FY 2002, payments are no longer being made under the regular exception policy, we no longer use the capital cost model. The capital cost model and its application during the transition period are described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099).

Section 412.374 provides for the use of a blended payment system for payments to Puerto Rico hospitals under the PPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs. 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 operating 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. Similarly, prior to FY 1998, hospitals in Puerto Rico were paid a blended capital rate that consisted of 75 percent of the applicable capital Puerto Rico specific rate and 25 percent of the applicable capital Federal rate. However, effective October 1, 1997, in accordance with section 4406 of Pub. L. 105–33, operating payments to hospitals in Puerto Rico were revised to be 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 occurring on or after October 1, 1997, we also revised the methodology for computing capital payments to hospitals in Puerto Rico to be based on a blend of 50 percent of the Puerto Rico capital rate and 50 percent of the capital Federal rate.

As we discussed in the FY 2005 IPPS final rule (69 FR 49185), section 504 of Pub. L. 108–173 increased the national portion of the operating IPPS payments for Puerto Rico hospitals from 50 percent to 62.5 percent and decreased the Puerto Rico portion of the operating IPPS payments from 50 percent to 37.5 percent for discharges occurring on or after April 1, 2004 through September 30, 2004 (see the March 26, 2004 One-Time Notification (Change Request 3158)). In addition, section 504 of Pub. L. 108–173 provided that the national portion of operating IPPS payments for Puerto Rico hospitals is equal to 75 percent and the Puerto Rico portion of operating IPPS payments is equal to 25 percent for discharges occurring on or after October 1, 2004. Consistent with that change in operating IPPS payments to hospitals in Puerto Rico, for FY 2005 (as we discussed in the FY 2005 IPPS final rule), we revised the methodology for computing capital payments to hospitals located in Puerto Rico to be based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate for discharges occurring on or after October 1, 2004.

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

In the FY 2005 IPPS final rule (69 FR 49283) and corrected in a December 30, 2004 correction notice (69 FR 78532), we established a capital Federal rate of $416.53 for FY 2005.

In the discussion that follows, we explain the factors that were used to determine the proposed FY 2006 capital Federal rate. In particular, we explain why the proposed FY 2006 capital Federal rate would increase 0.7 percent compared to the FY 2005 capital Federal rate. We also estimate aggregate capital payments would decrease by 0.1 percent during this same period. This decrease is due to several factors, including a projected decrease in the number of Medicare fee-for-service hospital admissions, and a decrease in the proposed geographic adjustment factor (GAF) values (which are based on the proposed wage index values). Our Office of the Actuary projects a decrease in Medicare fee-for-service Part A enrollment, in part, because of a projected increase in Medicare managed care enrollment as a result of the implementation of several provisions of Pub. L. 108–173. We are projecting a slight increase in the proposed GAF values (based on the proposed wage index) for some hospitals as a result of the completion of the transition to the CBSA-based labor market area definitions (as discussed in section III. of the preamble of this proposed rule). Thus, we are projecting that capital PPS payments would remain relatively unchanged from FY 2005 to FY 2006.

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 IPPS are estimated to decrease slightly in FY 2006 compared to FY 2005, as discussed above.

1. Projected Capital Standard Federal Rate Update

a. Description of the Update Framework

Under § 412.308(c)(1), the capital standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and several other policy adjustment factors. Specifically, we have adjusted the projected CIPI rate-of-increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. The proposed update factor for FY 2006 under that framework is 0.7 percent based on the best data available at this time. The proposed update factor is based on a projected 0.7 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a 0.0 percent adjustment for the FY 2004 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. As discussed below in section III.C. of this Addendum, we believe that the CIPI is the most appropriate input price index for capital costs to measure capital price changes in a given year. We also explain the basis for the FY 2006 CIPI projection in that same section of this Addendum. Below we describe the proposed policy adjustments that have been applied.

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

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

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

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher weighted DRGs but do not reflect higher resource requirements. The capital update framework includes the same case-mix index adjustment used in the former operating IPPS update framework (as discussed in the May 18, 2005 IPPS proposed rule for FY 2005 (69 FR 28816)). (We are no longer using an update framework in making a recommendation for updating the operating IPPS standardized amounts as discussed in section III. of Appendix B of this proposed rule.)

For FY 2006, we are projecting a 1.0 percent total increase in the case-mix index. We estimate that the real case-mix increase would also equal 1.0 percent in FY 2006. The net adjustment for change in case-mix is the difference between the projected increase in real case-mix and the projected total increase in real case-mix. Therefore, the net proposed adjustment for case-mix change in FY 2006 is 0.0 percentage points.

The capital update framework also contains an adjustment for the effects of DRG reclassification and recalibration. This adjustment is intended to 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 those due to patient severity. Due to the lag time in the availability of data, there is a 2-year lag in data used to determine the adjustment for the effects of DRG reclassification and recalibration. For example, we are adjusting for the effects of the FY 2004 DRG reclassification and recalibration as part of our proposed update for FY 2006. We estimate that FY 2004 DRG reclassification and recalibration would result in a 0.0 percent change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we are proposing to make a 0.0 percent adjustment for DRG reclassification and recalibration in the update for FY 2006 to maintain budget neutrality.

The capital update framework also 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 -0.1 percentage points was calculated for the FY 2004 update. That is, current historical data indicate that the forecasted FY 2004 CIPI used in calculating the FY 2004 update factor (0.7 percent) slightly overstated the actual realized price increases (0.6 percent) by 0.1 percentage points. This slight overprediction was mostly due to a prediction of the cuts in the interest rate by the Federal Reserve Board in 2004. However, the Federal Reserve Board did not cut interest rates during 2004, 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 proposing to make a 0.0 percent adjustment for forecast error in the update for FY 2006.

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

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

We have developed a Medicare-specific intensity measure based on a 5-year average. Past studies of case-mix change by the RAND Corporation (Has DRG Creep Crept Up? Decomposing the Case Mix Index Change Between 1987 and 1988 by G.M. Carter, J.P. Newhouse, and D.A. Relles, R–4098–HCFA/ ProPAC (1991)) suggest that real case-mix change was not dependent on total change, but was usually a fairly steady 1.0 to 1.4 percent per year. We use 1.4 percent as the upper bound because the RAND study did not take into account that hospitals may have induced doctors to document medical records more completely in order to improve payment.

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix. As we noted above, in accordance with § 412.308(c)(1)(ii), we began updating the capital standard Federal rate in FY 1996 using an update framework that takes into account, among other things, allowable changes in the intensity of hospital services. For FYs 1996 through 2001, we found that case-mix constant intensity was declining and we established a 0.0 percent adjustment for intensity in each of those years. For FYs 2002 and 2003, 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. For FYs 2004 and 2005, we found that the charge data appeared to be skewed (as discussed in greater detail below) and we established a 0.0 percent adjustment in each of those years. Furthermore, we stated that we would continue to apply a 0.0 percent adjustment for intensity until any increase in charges can be tied to intensity rather than attempts to maximize outlier payments.

Using the methodology described above, for FY 2006 we examined the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix for FYs 1999 through 2004. We found that, over this period and in particular the last 4 years of this period (FYs 2000 through 2003), the charge data appear to be skewed. More specifically, we found a dramatic increase in hospital charges for FYs 2000 through 2004 without a corresponding increase in the hospital case-mix index. These findings are similar to the considerable increase in hospitals' charges, which we found when we were determining the intensity factor in the FY 2004 and FY 2005 update recommendations as discussed in the FY 2004 IPPS final rule (68 FR 45482) and the FY 2005 IPPS final rule (69 FR 49285), respectively. If hospitals were treating new or different types of cases, which would result in an appropriate increase in charges per discharge, then we would expect hospitals' case-mix to increase proportionally.

As we discussed in the FY 2005 IPPS final rule (69 FR 49285), because our intensity calculation relies heavily upon charge data and we believe that these charge data may be inappropriately skewed, we established a 0.0 percent adjustment for intensity for FY 2005. We believed that it was appropriate to apply a zero intensity adjustment until we believe that any increase in charges can be tied to intensity rather than to attempts to maximize outlier payments. As discussed above, we believe that the most recently available charge data used to make this determination may still be inappropriately skewed. Therefore, we are proposing a 0.0 percent adjustment for intensity for FY 2006. In the past (FYs 1996 through 2001) when we found intensity to be declining, we believed a zero (rather than negative) intensity adjustment was appropriate. Similarly, we believe that it is appropriate to propose to apply a zero intensity adjustment for FY 2006 until any increase in charges can be tied to intensity rather than to attempts to maximize outlier payments.

Above we described the basis of the components used to develop the proposed 0.7 percent capital update factor for FY 2006 as shown in the table below.

CMS Proposed FY 2006 Update Factor to the Capital Federal Rate

Capital Input Price Index	0.7
Intensity:	0.0
Case-Mix Adjustment Factors:	
Real Across DRG Change	1.0
Projected Case-Mix Change	-1.0
Subtotal	0.0
Effect of FY 2004 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0
Total Proposed Update	0.7

b. Comparison of CMS and MedPAC Update Recommendation

In the past, MedPAC has included update recommendations for capital PPS in a Report to Congress. In its March 2005 Report to Congress, MedPAC did not make an update recommendation for capital PPS payments for FY 2006. However, in that same report, MedPAC made an update recommendation for hospital inpatient and outpatient services (page 40). MedPAC reviews inpatient and outpatient services together since they are so closely interrelated. MedPAC recommended an increase in the payment rate for the operating IPPS by the projected increase in the hospital market basket index, less 0.4 percent for FY 2006, based on their assessment of beneficiaries' access to care, volume of services, access to capital, quality of care, and the relationship of Medicare payments and costs. In addition, the Commission considered the efficient provision of services in making its FY 2006 update recommendations. (MedPAC's Report to the Congress: Medicare Payment Policy, March 2005, page 44.)

2. Proposed 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 FY 2005 IPPS final rule (69 FR 49286), we estimate that outlier payments for capital will equal 4.94 percent of inpatient capital-related payments based on the capital Federal rate in FY 2005. Based on the thresholds as set forth in section II.A.4.c. of this Addendum, we estimate that outlier payments for capital would equal 5.03 percent for inpatient capital-related payments based on the proposed Federal rate in FY 2006. Therefore, we are proposing to apply an outlier adjustment factor of 0.9497 to the capital Federal rate. Thus, the percentage of capital outlier payments to total capital standard payments for FY 2006 would be higher than the percentages for FY 2005.

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. The proposed FY 2006 outlier adjustment of 0.9497 is a −0.09 percent change from the FY 2005 outlier adjustment of 0.9506. The net change in the proposed outlier adjustment to the capital Federal rate for FY 2006 is 0.9991 (0.9497/0.9506). Thus, the proposed outlier adjustment decreases the FY 2006 capital Federal rate by 0.09 percent compared with the FY 2005 outlier adjustment.

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

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 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 GAF for Puerto Rico, we apply separate budget neutrality adjustments for the national GAF and the Puerto Rico GAF. 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 because the GAF for Puerto Rico was implemented in FY 1998.

In the past, we used the actuarial capital cost model (described in Appendix B of the FY 2002 IPPS final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of the capital Federal rate with and without changes in the DRG classifications and weights and in the GAF to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF. During the transition period, the capital cost model was also used to estimate the regular exception payment adjustment factor. As we explain in section III.A.4. of this Addendum, beginning in FY 2002, an adjustment for regular exception payments is no longer necessary. Therefore, we are no longer using the capital cost model. Instead, we are using historical data based on hospitals' actual cost experiences to determine the exceptions payment adjustment factor for special exceptions payments.

To determine the proposed factors for FY 2006, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2005 DRG relative weights and the average FY 2005 GAF (that is, the weighted average of the GAFs applied from October 2004 through December 2004 and the GAFs applied from January 2005 through September 2005) to estimated aggregate capital Federal rate payments based on the proposed FY 2006 relative weights and the proposed FY 2006 GAF. As we established in the FY 2005 IPPS final rule (69 FR 49287), the budget neutrality factors were 0.9914 for the national capital rate and 0.9895 for the Puerto Rico capital rate for discharges occurring on or after October 1, 2004 through December 31, 2004 (the first quarter of FY 2005). As a result of the corrections to the FY 2005 GAF values established in the December 30, 2004 correction notice (69 FR 78531), effective for January 1, 2005 through September 30, 2005 (the last three quarters of FY 2005), the budget neutrality factor for the national capital rate is 0.9912 and the budget neutrality factor for the Puerto Rico capital rate remained unchanged (0.9895). For FY 2005, the weighted average budget neutrality adjustment factors were 0.9912 ($0.9914 \times 1/4 + 0.9912 \times 3/4$) for the national capital rate (calculations were done on unrounded numbers) and 0.9895 for the Puerto Rico capital rate. In making the comparison, we set the regular and special exceptions reduction factors to 1.00. To achieve budget neutrality for the changes in the national GAF, based on calculations using updated data, we are proposing to apply an incremental budget neutrality adjustment of 1.0022 for FY 2006 to the weighted average of the previous cumulative FY 2005 adjustments of 0.9912 (yielding a proposed adjustment of 0.9934) through FY 2006 (calculations done on unrounded numbers). For the Puerto Rico GAF, we are proposing to apply an incremental budget neutrality adjustment of 1.0240 for FY 2006 to the previous cumulative FY 2005 adjustment of 0.9895, yielding a proposed cumulative adjustment of 1.0132 through FY 2006.

We then compared estimated aggregate capital Federal rate payments based on the FY 2005 DRG relative weights and the average FY 2005 GAF to estimated aggregate capital Federal rate payments based on the proposed FY 2006 DRG relative weights and the proposed FY 2006 GAF. The proposed incremental adjustment for DRG classifications and changes in relative weights is 0.9998 both nationally and for Puerto Rico. The proposed cumulative adjustments for DRG classifications and changes in relative weights and for changes in the GAF through FY 2005 are 0.9931 nationally and 1.013 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]	0.99771[3]	1.00009[3]	0.99780[3]	0.99922	1.00365[3]	1.00009[3]	1.00374[3]	1.00508
2002	0.99666[4]	0.99668[4]	0.99335[4]	0.99268	0.98991[4]	0.99668[4]	0.99662[4]	0.99164
2003[5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003[6]	0.99896[7]	0.99662[7]	0.99558[7]	0.98830	1.00809	0.99662	1.00468	0.99628
2004[8]	1.00175[9]	1.00081[9]	1.00256[9]	0.99083	1.00028	1.00081	1.00109	0.99736
2004[10]	1.00164[9]	1.00081[9]	1.00245[9]	0.99072	1.00028	1.00081	1.00109	0.99736
2005[11]	0.99967[12]	1.00094	1.00061[12]	0.99137	0.99115	1.00094	0.99208	0.98946
2005[13]	0.99946[12]	1.00094	1.00040[12]	0.99117	0.99115	1.00094	0.99208	0.98946
2006	1.00215[14]	0.99978	1.00192[14]	0.99313	1.02400	0.99978	1.02377	1.01298

[1]Factors effective for the first half of FY 2001 (October 2000 through March 2001).
[2]Factors effective for the second half of FY 2001 (April 2001 through September 2001).
[3]Incremental factors are applied to FY 2000 cumulative factors.
[4]Incremental factors are applied to the cumulative factors for the first half of FY 2001.
[5]Factors effective for the first half of FY 2003 (October 2002 through March 2003).
[6]Factors effective for the second half of FY 2003 (April 2003 through September 2003).
[7]Incremental factors are applied to FY 2002 cumulative factors.
[8]Factors effective for the first half of FY 2004 (October 2003 through March 2004).
[9]Incremental factors are applied to the cumulative factors for the second half of FY 2003.
[10]Factors effective for the second half of FY 2004 (April 2004 through September 2004).
[11]Factors effective for the first quarter of FY 2005 (September 2004 through December 2004).
[12]Incremental factors are applied to average of the cumulative factors for the first half (October 1, 2003 through March 31, 2004) and second half (April 1, 2004 through September 30, 2004) of FY 2004.
[13]Factors effective for the last three quarters of FY 2005 (January 2005 through September 2005).
[14]Incremental factors are applied to average of the cumulative factors for 2005.

The methodology used to determine the proposed recalibration and geographic (DRG/GAF) budget neutrality adjustment factor for FY 2006 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 FY 2005 IPPS final rule (69 FR 49288), we calculated a GAF/DRG budget neutrality factor of 1.0006 for FY 2005. As we noted above, as a result of the revisions to the GAF effective for discharges occurring on or after January 1, 2005 established in the December 30, 2004 correction notice (69 FR 78351), we calculated a GAF/DRG budget neutrality factor of 1.0004 for discharges occurring in the remainder of FY 2005. For FY 2006, we are proposing a GAF/DRG budget neutrality factor of 1.0019. The GAF/

DRG budget neutrality factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows from the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The proposed incremental change in the adjustment from the average from FY 2005 to FY 2006 is 1.0019. The proposed cumulative change in the capital Federal rate due to this adjustment is 0.9931 (the product of the incremental factors for FYs 1993 through 2005 and the proposed incremental factor of 1.0019 for FY 2006). (We note that averages of the incremental factors that were in effect during FYs 2004 and 2005, respectively, were used in the calculation of the proposed cumulative adjustment of 0.9931 for FY 2006.)

This proposed factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 2006 geographic reclassification decisions made by the MGCRB compared to FY 2005 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. Proposed 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 FY 2002 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 proposed FY 2006 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 FY 2002 IPPS final rule (66 FR 39949), in FY 2002 and subsequent fiscal years, no payments will be made under the regular exceptions provision. However, in accordance with § 412.308(c), we still need to compute a budget neutrality adjustment for special exception payments under § 412.348(g). We describe our methodology for determining the special exceptions adjustment used in calculating the proposed FY 2006 capital Federal rate below.

Under the special exceptions provision specified at § 412.348(g)(1), eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. An eligible hospital may receive special exceptions payments if it meets (1) a project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test as described at § 412.348(g)(4); (2) an age of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

Based on information compiled from our fiscal intermediaries, six hospitals have qualified for special exceptions payments under § 412.348(g). Since we have cost reports ending in FY 2004 for all of these hospitals, we calculated the proposed adjustment based on actual cost experience. Using data from cost reports ending in FY 2004 from the December 2004 update of the HCRIS data, we divided the capital special exceptions payment amounts for the six hospitals that qualified for special exceptions by the total capital PPS payment amounts (including special exception payments) for all hospitals. Based on the data from cost reports ending in FY 2004, this ratio is rounded to 0.0003. Because we have not received all cost reports ending in FY 2004, we also divided the FY 2004 special exceptions payments by the total capital PPS payment amounts for all hospitals with cost reports ending in FY 2003. This ratio also rounds to 0.0003. Because special exceptions are budget neutral, we are proposing to offset the capital Federal rate by 0.03 percent for special exceptions payments for FY 2006. Therefore, the proposed exceptions adjustment factor is equal to 0.9997 (1 − 0.0003) to account for special exceptions payments in FY 2006.

In the FY 2005 IPPS final rule (69 FR 49288), we estimated that total (special) exceptions payments for FY 2005 would equal 0.04 percent of aggregate payments based on the capital Federal rate. Therefore, we applied an exceptions adjustment factor of 0.9996 (1 − 0.0004) in determining the FY 2005 capital Federal rate. As we stated above, we estimate that exceptions payments in FY 2006 would equal 0.03 percent of aggregate payments based on the proposed FY 2006 capital Federal rate. Therefore, we are proposing to apply an exceptions payment adjustment factor of 0.9997 to the capital Federal rate for FY 2006. The proposed exceptions adjustment factor for FY 2006 is 0.01 percent higher than the factor for FY 2005 published in the FY 2005 IPPS final rule (69 FR 49288). The exceptions reduction factors are not built permanently into the capital rates; that is, the factors are not applied cumulatively in determining the capital Federal rate. Therefore, the proposed net change in the exceptions adjustment factor used in determining the proposed FY 2006 capital Federal rate is 1.0001 (0.9997/0.9996).

5. Proposed Capital Standard Federal Rate for FY 2006

In the FY 2005 IPPS final rule (69 FR 49283) and corrected in a December 30, 2004 correction notice (69 FR 78532), we established a capital Federal rate of $416.53 for FY 2005. In this proposed rule, we are proposing to establish a capital Federal rate of $419.90 for FY 2006. The proposed capital Federal rate for FY 2006 was calculated as follows:

- The proposed FY 2006 update factor is 1.0070; that is, the update is 0.7 percent.
- The proposed FY 2006 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 1.0019.
- The proposed FY 2006 outlier adjustment factor is 0.9497.
- The proposed FY 2006 (special) exceptions payment adjustment factor is 0.9997.

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

We are providing a chart that shows how each of the proposed factors and adjustments for FY 2006 affected the computation of the proposed FY 2006 capital Federal rate in comparison to the average FY 2005 capital Federal rate. The proposed FY 2006 update factor has the effect of increasing the capital Federal rate by 0.70 percent compared to the average FY 2005 Federal rate. The proposed GAF/DRG budget neutrality factor has the effect of increasing the capital Federal rate by 0.19 percent. The proposed FY 2006 outlier adjustment factor has the effect of decreasing the capital Federal rate by 0.09 percent compared to the average FY 2005 capital Federal rate, and the proposed FY 2006 exceptions payment adjustment factor has the effect of increasing the capital Federal rate by 0.01 percent compared to the exceptions payment adjustment factor for the FY 2005 capital Federal rate. The combined effect of all the proposed changes is to increase the capital Federal rate by 0.81 percent compared to the average FY 2005 capital Federal rate.

Comparison of Factors and Adjustments: FY 2005 Capital Federal Rate and Proposed FY 2006 Capital Federal Rate

	FY 2005	Proposed FY 2006	Proposed Change	Percent Change
Update factor[1]	1.0070	1.0070	1.0070	0.70
GAF/DRG Adjustment Factor[1]	1.0004	1.0019	1.0019	0.19
Outlier Adjustment Factor[2]	0.9506	0.9497	0.9991	-0.09
Exceptions Adjustment Factor[2]	0.9996	0.9997	0.0001	0.01
Capital Federal Rate	$416.53	$419.90	1.0081	0.81

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the proposed incremental change from FY 2005 to FY 2006 resulting from the application of the proposed 1.0019 GAF/DRG budget neutrality factor for FY 2006 is 1.0019.

[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 proposed net change resulting from the application of the proposed FY 2006 outlier adjustment factor is 0.9497/0.9506, or 0.9991.

6. Proposed Special Capital Rate for Puerto Rico Hospitals

Section 412.374 provides for the use of a blended payment system for payments to Puerto Rico hospitals under the PPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs. Under the broad authority of section 1886(g) of the Act, as discussed in section VI. of the preamble of this proposed rule, beginning with discharges occurring on or after October 1, 2004, capital payments to hospitals in Puerto Rico are based on a blend of 25 percent of the Puerto Rico capital rate and 75 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 IPPS (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 IPPS wage index and varies, depending on the labor market area or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended capital rate.

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. As we stated above in section III.A.4. of this Addendum, for Puerto Rico, the proposed GAF budget neutrality factor is 1.0240, while the proposed DRG adjustment is 0.9998, for a combined cumulative adjustment of 1.0130.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the capital rate (25 percent) is multiplied by the Puerto Rico-specific GAF for the labor market area in which the hospital is located, and the national portion of the capital rate (75 percent) is multiplied by the national GAF for the labor market area 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 2005, before application of the GAF, the special capital rate for Puerto Rico hospitals was $199.01 for discharges occurring on or after October 1, 2004 through September 30, 2005. With the changes we are proposing to the factors used to determine the capital rate, the proposed FY 2006 special capital rate for Puerto Rico is $205.64.

B. Calculation of Proposed Inpatient Capital-Related Prospective Payments for FY 2006

Because the 10-year capital PPS transition period ended in FY 2001, all hospitals (except "new" hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid based on 100 percent of the capital Federal rate in FY 2006. The applicable proposed capital Federal rate was determined by making adjustments as follows:

- For outliers, by dividing the proposed capital standard Federal rate by the proposed outlier reduction factor for that fiscal year; and
- For the payment adjustments applicable to the hospital, by multiplying the hospital's proposed GAF, disproportionate share adjustment factor, and IME adjustment factor, when appropriate.

For purposes of calculating payments for each discharge during FY 2006, the capital standard Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted capital Federal rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The proposed outlier thresholds for FY 2006 are in section II.A.4.c. of this Addendum. For FY 2006, 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 $26,675.

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 SCHs, 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 hospitals under the appropriate transition methodology. If the hold-harmless methodology were applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period. Under § 412.304(c)(2), for cost reporting periods beginning on or after October 1, 2002, we pay a new hospital 85 percent of its 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 FY 2003 IPPS final rule (67 FR 50044). (We note that we are proposing a rebasing to FY 2002 in section IV. of the preamble of this proposed rule.)

2. Forecast of the CIPI for FY 2006

Based on the latest forecast by Global Insight, Inc. (first quarter of 2005), we are forecasting the CIPI to increase 0.7 percent in FY 2006. This reflects a projected 1.3 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 2.7 percent increase in other capital expense prices in FY 2006, partially offset by a 2.3 percent decline in vintage-weighted interest expenses in FY 2006. The weighted average of these three factors produces the 0.7 percent increase for the CIPI as a whole in FY 2006.

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

(If you choose to comment on issues in this section, please include the caption "Excluded Hospitals Rate-of-Increase'' at the beginning of your comment.)

A. Payments to Existing Excluded Hospitals and Units

As discussed in section VII. of the preamble of this proposed rule, in accordance with section 1886(b)(3)(H)(i) of the Act and effective for cost reporting periods beginning on or after October 1, 2002, payments to existing psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals (LTCHs) excluded from the IPPS are no longer subject to a cap on a hospital-specific target amount (expressed in terms of the inpatient operating cost per discharge under TEFRA) that is set for each hospital, based on the hospital's own historical cost experience trended forward by the applicable percentage increase. However, the inpatient operating costs of children's hospitals and cancer hospitals that are excluded from the IPPS continue to be subject to the rate-of-increase limits established under the authority of section 1886(b) of the Act and § 413.40 of the regulations. This target amount is applied as a ceiling on the allowable costs per discharge for the hospital's cost reporting period.

Effective for cost reporting periods beginning on or after October 1, 2002, rehabilitation hospitals and units are paid 100 percent of the adjusted Federal prospective payment rate under the IRP PPS. 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. In implementing the LTCH PPS for existing LTCHs, we established a 5-year transition period from reasonable cost-based payments (subject to the TEFRA limit) to fully Federal prospective payment amounts during which a LTCH may receive a blended payment consisting of two payment components—one based on reasonable cost under the TEFRA payment system, and the other based on the standard Federal prospective payment rate. However, an existing LTCH may elect to be paid based on 100 percent of the standard Federal prospective payment rate during the transition period.

IPFs that have their first cost reporting period beginning on or after January 1, 2005, are not paid on a reasonable cost basis but paid under a prospective per diem payment system. As part of the PPS for existing IPFs, we have established a 3-year transition period during which IPFs will be paid based on a blend of reasonable cost-based payment (subject to the TEFRA limit) and the prospective per diem payment rate. For cost reporting periods beginning on or after January l, 2008, IPFs will be paid 100 percent of the Federal prospective per diem payment amount.

Excluded psychiatric hospitals and units as well as LTCHs that are paid under a blended methodology will have the reasonable cost-based portion of their payment subject to a hospital target amount and, if applicable, the payment amount limitation.

B. Updated Caps for New Excluded Hospitals and Units

Section 1886(b)(7) of the Act established the method for determining the payment amount for new rehabilitation hospitals and units, psychiatric hospitals and units, and LTCHs that first received payment as a hospital or unit excluded from the IPPS on or after October 1, 1997. However, due to the implementation of the IRF PPS, effective for cost reporting periods beginning on or after October 1, 2002, this payment amount (or "new provider cap'') no longer applies to any new rehabilitation hospital or unit because they now are paid 100 percent of the Federal prospective rate under the IRF PPS. In addition, LTCHs that meet the definition of a new LTCH under § 412.23(e)(4) are paid 100 percent of the fully Federal prospective payment rate. In contrast, those "new'' LTCHs that meet the criteria under § 413.40(f)(2)(ii) (that is, that were not paid as an excluded hospital prior to October 1, 1997, but were paid as a LTCH before October 1, 2002), may be paid under the LTCH PPS transition methodology, with the reasonable cost portion of the payment subject to § 413.40(f)(2)(ii). Finally, LTCHs that existed prior to October 1, 1997, may also be paid under the LTCH PPS transition methodology, with the reasonable cost portion subject to § 413.40(c)(4)(ii). (The last LTCHs that were subject to the payment amount limitation for "new'' LTCHs were new LTCHs that had their first cost reporting period beginning on September 30, 2002. In that case, the payment amount limitation remained applicable for the next 2 years—September 30, 2002 through September 29, 2003, and September 30, 2003 through September 29, 2004. This is because, under existing regulations at § 413.40(f)(2)(ii), the "new hospital'' would be subject to the same payment (target amount) in its second cost reporting period that was applicable to the LTCH in its first cost reporting period. Accordingly, for this hospital, the updated payment amount limitation that we published in the FY 2003 IPPS final rule (67 FR 50103) applied through September 29, 2004. Consequently, there is no longer a need to publish updated payment amounts for new (§ 413.40(f)(2)(ii)) LTCHs. A discussion of how the payment limitations were 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).

With the implementation of the LTCH PPS, payment limitations do not apply to any new LTCHs that meet the definition at § 412.23(e)(4) because they are paid 100 percent of the Federal prospective payment rate.

A freestanding inpatient rehabilitation hospital, an inpatient rehabilitation unit of an acute care hospital, and an inpatient rehabilitation unit of a CAH are referred to as IRFs. Effective for cost reporting periods beginning on or after October 1, 2002, this

payment limitation is also no longer applicable to new rehabilitation hospitals and units because they are paid 100 percent of the Federal prospective rate under the IRF PPS. Therefore, it is also no longer necessary to update the payment limitation for new rehabilitation hospitals or units.

Under the IPF PPS, there is a 3-year transition period during which existing IPFs will receive a blended payment of the Federal per diem payment amount and the payment amount that IPFs would receive under the reasonable cost-based payment (TEFRA) methodology. IPFs that were "new'' under § 413.40(f)(2)(ii) (that is, that were not paid as an excluded hospital prior to October 1, 1997, but were paid as an IPF prior to January 1, 2005), would have the reasonable cost portion of the transition period payment subject to the payment amount limitation as determined according to § 413.40(f)(2)(ii). The last "new'' IPFs that were subject to the payment amount limitation were IPFs that had their first cost reporting period beginning on December 31, 2004. For these hospitals, the payment amount limitation that was published in the FY 2005 IPPS final rule (69 FR 49189) for cost reporting periods beginning on or after October 1, 2004, and before January 1, 2005, remains applicable for the IPF's first two cost reporting periods. IPFs with a first cost reporting period beginning on or after January 1, 2005, are paid 100 percent of the Federal rate and are not subject to the payment amount limitation. Therefore, since the last IPFs eligible for a blended payment have a cost reporting period beginning on December 31, 2004, the payment limitation published for FY 2005 remains applicable for these IPFs, and publication of the updated payment amount limitation is no longer needed. We note that IPFs that existed prior to October 1, 1997, may also be paid under the IPF transition methodology with the reasonable cost portion of the payment subject to § 413.40(c)(4)(ii).

The payment limitations for new hospitals under TEFRA do not apply to new LTCHs, IRFs, or IPFs, that is, these hospitals with their first cost reporting period beginning on or after the date that the particular class of hospitals implemented the respective PPS. Therefore, for the reasons noted above, we are proposing to discontinue publishing Tables 4G and 4H (Pre-Reclassified Wage Index for Urban and Rural Areas, respectively) in the annual proposed and final IPPS rules.

V. Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

(If you choose to comment on issues in this section, please include the caption "Payment for Blood Clotting Factor'' at the beginning of your comments.)

As discussed in section VIII. of the preamble to this proposed rule, section 1886(a)(4) of the Act excludes the costs of administering blood clotting factors to individuals with hemophilia from the definition of "operating costs of inpatient hospital services.'' Section 6011(b) of Pub. L. 101–239 (the Omnibus Budget Reconciliation Act of 1989) provides that the Secretary shall determine the payment amount made to hospitals under Part A of Title XVIII of the Act for the costs of administering blood clotting factors to individuals with hemophilia by multiplying a predetermined price per unit of blood clotting factor by the number of units provided to the individual. Currently, we use the average wholesale price (AWP) methodology used to determine rates paid for Medicare Part B drugs to price blood clotting factors administered to inpatients who have hemophilia under Medicare Part A. Section 303 of Pub. L. 108–173 amended the Act by adding section 1847A, which changed the drug pricing system under Medicare Part B. Effective January 1, 2005, section 1847A of the Act established a payment methodology based on average sales price (ASP) under which almost all Medicare Part B drugs and biologicals not paid on a cost or prospective basis are paid at 106 percent of the ASP.

In the FY 2005 IPPS final rule (69 FR 49292), we had instructed the fiscal intermediaries for FY 2005 to continue to use the Single Drug Pricer (SDP) to establish the pricing limits for the blood clotting factor administered to hemophilia inpatients at 95 percent of the AWP. We did not use the new ASP pricing methodology for Part A blood clotting factor in FY 2005 because the IPPS final rule was published in advance of final regulations implementing the ASP payment methodology for Part B drugs and biologicals. Final regulations establishing the ASP methodology and the furnishing fee for blood clotting factor under Medicare Part B were published on November 15, 2004 (69 FR 66299). Therefore, we believe that a consistent methodology should be used to pay for blood clotting factor administered under both Medicare Part A and Part B. For this reason, we are proposing for FY 2006 that the fiscal intermediaries make payment for blood clotting factor using 106 percent of ASP and make payment for the furnishing fee at $0.14 per individual unit (I.U.) that is currently used for Medicare Part B drugs. The ASP will be updated quarterly. The furnishing fee will be updated annually based on the consumer price index.

VI. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this Addendum. Tables 1A, 1B, 1C, 1D, 2, 3A, 3B, 4A, 4B, 4C, 4F, 4J, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H, 7A, 7B, 8A, 8B, 9A, 9B, 9C, 10, and 11 are presented below. The tables presented below are as follows:

Table 1A—National Adjusted Operating Standardized Amounts, Labor/Nonlabor (69.7 Percent Labor Share/30.3 Percent Nonlabor Share If Wage Index Is Greater Than 1);
Table 1B—National Adjusted Operating Standardized Amounts, Labor/Nonlabor (62 Percent Labor Share/38 Percent Nonlabor Share If Wage Index Is Less Than or Equal To 1);
Table 1C—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor;
Table 1D—Capital Standard Federal Payment Rate;
Table 2—Hospital Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 2004; Hospital Average Hourly Wage for Federal Fiscal Years 2004 (2000 Wage Data), 2005 (2001 Wage Data), and 2006 (2002 Wage Data) Wage Indexes and 3-Year Average of Hospital Average Hourly Wages;
Table 3A—FY 2006 3-Year Average Hourly Wage for Urban Areas by CBSA;
Table 3B—FY 2006 and 3-Year Average Hourly Wage for Rural Areas by CBSA;
Table 4A—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas by CBSA;
Table 4B—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas by CBSA;
Table 4C—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified by CBSA;
Table 4F—Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF) by CBSA;
Table 4J—Out-Migration Adjustment—FY 2006;
Table 5—List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric and Arithmetic Mean Length of Stay;
Table 6A—New Diagnosis Codes;
Table 6B—New Procedure Codes;
Table 6C—Invalid Diagnosis Codes;
Table 6D—Invalid Procedure Codes;
Table 6E—Revised Diagnosis Code Titles;
Table 6F—Revised Procedure Code Titles;
Table 6G—Additions to the CC Exclusions List;
Table 6H—Deletions from the CC Exclusions List;
Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2004 MedPAR Update December 2004 GROUPER V22.0;
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2004 MedPAR Update December 2004 GROUPER V23.0;
Table 8A—Statewide Average Operating Cost-to-Charge Ratios—March 2005;
Table 8B—Statewide Average Capital Cost-to-Charge Ratios—March 2005;
Table 9A—Hospital Reclassifications and Redesignations by Individual Hospital and CBSA—FY 2006;
Table 9B—Hospital Reclassifications and Redesignations by Individual Hospital Under Section 508 of Pub. L. 108–173—FY 2006;
Table 9C—Hospitals Redesignated as Rural under Section 1886(s)(8)(E) of the Act—FY 2006;
Table 10—Geometric Mean Plus the Lesser of .75 of the National Adjusted Operating Standardized Payment Amount (Increased to Reflect the Difference Between Costs and Charges) or .75 of One Standard Deviation of Mean Charges by Diagnosis-Related Groups (DRGs)—March 2005;
Table 11—Proposed FY 2006 LTC-DRGs, Relative Weights, Geometric Average Length of Stay, and 5/6ths of the Geometric Average Length of Stay.

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

[69.7 Percent labor share/30.3 percent nonlabor share if wage index greater than 1]

Full update (3.2 Percent)		Reduced update (2.8 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,286.14	$1,428.55	$3,273.40	$1,423.01

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

[62 Percent labor share/38 percent nonlabor share if wage index less than or equal to 1]

Full update (3.2 Percent)		Reduced update (2.8 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$2,923.11	$1,791.58	$2,911.78	$1,784.63

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

			Rates if wage index less than or equal to 1	
Rates if wage index greater than 1	Labor	Nonlabor	Labor	Nonlabor
National	$3,286.14	$1,428.55	$2,923.11	$1,791.58
uerto Rico	$1,608.99	$647.66	$1,431.24	$812.25

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$419.90
Puerto Rico	$205.64

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
010001	1.4678	0.7743	19.4061	20.6563	21.3753	20.5001
010004	***	*	22.2674	22.7585	*	22.4801
010005 [h]	1.1407	0.8872	19.6063	20.4937	22.4906	20.9007
010006	1.4394	0.8305	19.0976	21.0241	23.4823	21.1655
010007	1.0619	0.7495	17.5462	16.8811	18.2430	17.5458
010008	0.9712	0.8276	19.6573	23.8333	20.4591	21.3782
010009	0.9770	0.8517	20.4309	21.6422	23.2229	21.7690
010010 [h]	1.0191	0.9124	19.2644	22.3021	22.3366	21.3489
010011	1.5689	0.8979	25.8231	24.8166	27.4850	26.0626
010012	1.2232	0.9099	20.0896	21.7622	22.7020	21.5233
010015	0.9785	0.7495	18.8890	20.4732	22.1736	20.6719
010016	1.3257	0.8979	21.7918	23.0414	25.1502	23.3217
010018	1.3369	0.8979	19.2071	20.5888	22.2990	20.6865
010019	1.2272	0.8305	18.9177	20.1336	22.0906	20.4039
010021 [h]	1.1869	0.7743	17.7596	20.7108	18.6785	19.0123
010022	0.9401	0.9414	22.2267	25.8797	24.5670	24.2502
010023	1.8430	0.8600	20.4901	23.7791	27.3303	23.6794
010024	1.5884	0.8600	18.5942	20.0067	20.7265	19.7702
010025	1.3235	0.8402	19.3649	19.8561	21.2674	20.1430
010027	0.7634	0.7495	14.0975	14.9585	15.3704	14.7992
010029	1.5415	0.8402	20.9868	21.6724	22.6976	21.8061
010031	***	*	21.0176	20.9463	*	20.9818
010032	0.8730	0.7495	16.4713	18.5073	19.1555	18.1219
010033	2.0553	0.8979	24.5088	25.5165	26.4666	25.5126
010034	0.9588	0.8600	14.9333	17.1625	16.9686	16.3417
010035	1.2540	0.8872	21.6182	23.1319	22.2870	22.3532
010036	1.1183	0.7495	19.2501	20.5125	22.9747	20.9446
010038	1.3277	0.7702	18.6578	20.3935	21.4509	20.2189

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
010039	1.6315	0.9124	23.0339	23.4151	25.8594	24.1509
010040	1.4605	0.7974	20.7779	21.6708	22.8851	21.7864
010043	1.0587	0.8979	19.9012	19.5422	22.5945	20.7320
010044	1.0475	0.8872	25.8560	23.0220	21.4036	23.2608
010045	1.0959	0.8872	22.7713	20.5658	20.0357	20.9382
010046	1.4626	0.7974	19.6754	20.8935	21.6965	20.8067
010047	0.8793	0.7495	16.1695	19.5937	21.0604	18.8438
010049	1.0828	0.7495	16.2973	17.7801	20.2413	18.1494
010050	1.0401	0.8979	20.7398	21.5625	22.1584	21.5077
010051	0.8969	0.8724	14.3006	14.7053	15.2208	14.7351
010052	0.8624	0.7495	11.9019	21.3673	16.4959	15.4174
010053	1.0098	0.7495	17.3238	17.4160	19.0108	17.9166
010054	1.0570	0.8517	20.6382	23.1894	22.5554	22.1149
010055	1.4983	0.7743	18.9664	19.1847	22.6828	20.2397
010056	1.5206	0.8979	21.1104	22.7183	23.7144	22.5773
010058	0.8800	0.8979	17.7800	20.3182	18.5537	18.9295
010059	1.0562	0.8517	20.5534	23.6963	21.3237	21.8874
010061	0.9666	0.7495	17.0447	20.5683	21.9374	19.8090
010062	1.0674	0.7743	17.1786	18.1323	18.3435	17.8796
010064	1.7183	0.8979	22.2280	25.4345	26.1110	24.2542
010065	1.4288	0.8276	17.2698	20.0108	21.2363	19.5522
010066	0.8327	0.7495	14.8696	17.0935	17.6152	16.5083
010068	1.2192	0.8979	18.3308	17.5690	19.0789	18.3440
010069	1.0478	0.7495	17.0957	19.6317	21.3608	19.4027
010072	1.1391	0.7702	18.8807	21.5419	21.8169	20.7331
010073	0.9330	0.7495	14.9826	16.4043	16.4168	15.9303
010078	1.3809	0.7702	20.1447	21.0633	21.5616	20.9141
010079	1.1647	0.9124	20.7401	20.4254	21.8199	21.0143
010083 [h]	1.2094	0.8089	19.8524	20.2166	22.3041	20.7945
010084	1.5531	0.8979	21.6522	22.5219	24.7127	22.9810
010085	1.2261	0.8517	22.5282	23.7007	24.4710	23.5499
010086	1.0771	0.7495	18.0122	19.4332	18.6081	18.6721
010087	1.9176	0.7902	19.7620	21.6226	22.5225	21.2536
010089	1.2348	0.8979	19.5783	22.2508	22.7508	21.4924
010090	1.6643	0.7902	20.0287	21.4322	23.6948	21.7237
010091	0.9178	0.7495	17.4672	19.4222	18.6912	18.5367
010092	1.5079	0.8724	19.9351	22.0709	24.6542	22.1991
010095	0.8622	0.8724	12.5243	13.4426	13.9326	13.3037
010097	0.7734	0.8600	15.1593	17.1735	16.7548	16.2912
010098	1.1131	0.7495	15.1629	19.6717	14.3076	16.0844
010099	0.9798	0.7495	16.3307	18.1849	18.7909	17.7973
010100 [h]	1.6637	0.8089	19.8146	20.0027	21.2915	20.4113
010101	1.1105	0.7702	19.0718	21.0085	21.6593	20.5878
010102	0.8953	0.7495	16.4637	19.9196	21.0903	19.1526
010103	1.8475	0.8979	22.5709	24.2201	26.1163	24.2529
010104	1.7281	0.8979	20.9391	24.1929	24.9226	23.2581
010108	1.0770	0.8600	20.7787	23.7803	28.4624	24.2639
010109	0.9471	0.7495	18.2235	21.7128	21.7997	20.5179
010110	0.7216	0.7495	16.0015	19.2706	18.6633	18.1283
010112	0.9699	0.7495	17.9243	17.2963	16.8902	17.3960
010113	1.6431	0.7902	19.4106	20.4181	21.4209	20.4385
010114	1.3235	0.8979	20.1763	21.5319	22.3431	21.3345
010115	0.8225	0.7495	15.7872	17.5985	29.1465	19.5466
010118	1.2436	0.8276	19.5302	18.8560	19.7673	19.4467
010119	***	*	20.5245	21.8215	*	21.1743
010120	0.9483	0.7902	19.4368	20.5855	20.9450	20.3424
010121	***	*	17.1640	17.0329	24.0867	18.5589
010125	1.0257	0.7495	16.8622	16.8419	18.4114	17.3762
010126	1.1015	0.8276	19.9647	23.1856	23.1381	22.1149
010128	0.8325	0.7495	14.7646	17.9354	21.4201	18.0579
010129 [h]	0.9813	0.7902	16.4905	18.7821	21.3555	19.1436
010130	0.9433	0.8979	18.7190	18.4944	23.2488	20.0658
010131	1.3281	0.9124	22.9969	24.2197	25.7837	24.4029
010134	***	0.7495	17.7717	*	*	17.7717
010138	0.6035	0.7495	14.2025	13.5082	13.8475	13.8713
010139	1.5206	0.8979	22.8390	24.9410	25.3014	24.4108
010143	1.1648	0.8872	20.5639	22.1312	22.0215	21.5734

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
010144	1.5626	0.7902	19.1497	20.6425	20.7433	20.2040
010145	1.2572	0.8724	22.1394	23.1976	25.1442	23.5267
010146	1.0392	0.7702	21.3083	19.9944	20.8917	20.7213
010148	0.8756	0.7495	17.6829	18.5309	20.5294	19.0227
010149	1.3179	0.8600	21.0086	23.1593	26.5854	23.4663
010150	1.0456	0.7495	21.2360	20.6738	21.6377	21.1783
010152	1.1957	0.7902	21.6038	22.1626	22.6202	22.1446
010157	1.1130	0.8305	19.6977	21.3574	24.3560	21.7462
010158	1.0822	0.8517	18.5464	22.4440	24.3531	21.6528
010161	***	*	*	27.5119	*	27.5119
020001	1.6973	1.2110	30.1452	31.6091	33.6407	31.9031
020004	1.1807	1.1977	27.3516	29.9926	32.0966	29.8229
020005	0.9509	1.1977	32.7936	*	*	32.7936
020008	1.2368	1.1977	33.4543	34.5856	35.9236	34.6652
020010	***	1.1977	20.7929	*	*	20.7929
020013	***	1.1977	30.6423	*	*	30.6423
020017	1.9426	1.2110	30.3017	32.9281	33.5852	32.3606
020024	1.1382	1.1977	28.0930	27.9799	33.0644	29.9221
030001	1.3278	1.0139	25.7513	27.7572	29.9840	27.8499
030002	2.0596	1.0139	25.6038	27.9628	29.0519	27.5075
030003	***	*	22.1436	*	*	22.1436
030007	1.3390	0.8991	26.1551	26.9442	29.6174	27.6578
030009	0.8821	0.9007	19.9131	21.4065	22.3992	21.1294
030010	1.3277	0.9007	20.7204	22.8647	24.8275	22.8055
030011	1.4456	0.9007	21.0028	22.8422	25.1361	23.0075
030012	1.2863	0.9884	24.2366	25.5205	26.3859	25.4550
030013	1.3235	0.9102	21.9766	23.5229	25.7050	23.8047
030014	1.4420	1.0139	23.3663	25.1189	25.6259	24.7232
030016	1.2336	1.0139	24.3380	27.1583	26.7003	26.0910
030017	1.9999	1.0139	21.8792	24.4055	26.2452	24.0378
030018	1.2176	1.0139	24.9216	24.4308	28.9476	25.9371
030019	1.3058	1.0139	23.2973	28.4917	27.3156	26.2053
030022	1.5630	1.0139	24.9941	25.1461	26.4404	25.5437
030023	1.6295	1.2094	28.6627	28.4112	33.8333	30.2808
030024	1.9347	1.0139	26.7641	28.3470	31.6658	28.9293
030027	0.9159	0.8991	19.4583	21.0527	20.4031	20.3074
030030	1.6344	1.0139	25.2425	24.6005	30.2712	26.5838
030033	1.1959	1.1713	26.3814	26.6009	26.6531	26.5511
030036	1.3185	1.0139	24.9432	26.5708	30.3521	27.3868
030037	2.1135	1.0139	23.0542	30.3907	28.6453	27.0409
030038	1.5694	1.0139	25.2632	26.5178	29.5509	27.6724
030040	0.9316	0.8991	21.2717	22.5130	24.8145	22.8703
030043	1.3135	0.8991	23.5172	26.0825	24.7932	24.8113
030044	0.8987	0.8991	21.9503	19.5714	*	20.6512
030055 [h]	1.3518	1.1416	22.8612	23.1837	24.5202	23.5684
030059	***	*	*	24.7676	*	24.7676
030060	1.1006	0.8991	21.7685	22.3551	24.3523	22.7950
030061	1.6076	1.0139	22.9706	23.4722	25.5529	24.0363
030062	1.1689	0.8991	21.1639	21.9849	23.8068	22.3433
030064	1.9175	0.9007	22.8009	24.6732	25.4922	24.2954
030065	1.5581	1.0139	24.6064	25.6738	27.1646	25.8836
030067	1.0095	0.8991	18.4003	19.1332	20.4376	19.2370
030068	1.0906	0.8991	19.7097	19.7030	20.8846	20.1346
030069 [h]	1.3425	1.1416	24.5432	25.6243	26.3518	25.5167
030080	1.5124	0.9007	22.8953	24.3573	25.2077	24.1500
030083	1.2683	1.0139	24.3273	24.9269	27.5353	25.6343
030085	1.5138	0.9007	21.8196	23.2070	24.5792	23.3008
030087	1.5725	1.0139	25.6351	26.3878	26.6594	26.2197
030088	1.3763	1.0139	23.5761	23.2478	26.6796	24.5472
030089	1.5398	1.0139	24.5055	26.2166	27.1835	26.0965
030092	1.3775	1.0139	24.0515	25.4127	27.3203	25.7452
030093	1.2260	1.0139	23.2485	23.5623	25.8955	24.3686
030094	1.3354	1.0139	24.5992	26.9985	29.5948	27.0516
030099	0.8991	0.8991	20.3310	26.7996	26.3236	24.0344
030100	1.9686	0.9007	27.6299	*	29.0691	28.4177
030101 [h]	1.3930	1.1416	23.7661	25.0077	26.1927	25.0150
030102	2.4590	1.0139	27.9419	*	29.0942	28.5553

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
030103	1.6379	1.0139	29.1105	28.2832	30.1994	29.2117
030104	***	*	34.6028	*	*	34.6028
030106	1.5145	1.0139	*	30.4791	34.7222	32.1177
040001	1.0582	0.8615	18.7141	23.1475	23.7718	21.8056
040002	1.1265	0.7478	18.0776	19.3429	20.1384	19.2037
040003	1.0545	0.7478	16.3918	18.5000	*	17.3854
040004	1.5197	0.8615	21.2335	23.3504	25.0286	23.2843
040007	1.6581	0.8768	23.3992	23.4565	25.7142	24.1728
040010	1.3488	0.8615	20.7114	22.0984	23.0274	21.9856
040011	1.0063	0.7478	18.8346	19.0319	17.9740	18.5849
040014	1.3420	0.8552	22.4970	24.0846	25.3451	23.9535
040015	1.0378	0.7478	18.8513	18.0793	19.2831	18.7435
040016	1.6546	0.8768	21.2198	22.7219	22.1228	22.0244
040017	1.0968	0.8251	17.7545	19.4365	21.9875	19.7066
040018	0.9839	0.8231	22.0408	23.8515	23.6044	23.2404
040019	1.1290	0.9108	21.1711	21.5316	23.7328	22.1722
040020	1.5076	0.9108	18.6419	20.9136	21.6603	20.4199
040021	1.2489	0.8768	23.5620	24.7771	25.6917	24.7363
040022	1.6031	0.8615	21.4194	23.7462	25.3039	23.4686
040024	1.0523	0.7478	17.5750	20.1101	*	18.8371
040026	1.4887	0.9066	22.7699	24.3053	25.4072	24.2169
040027	1.3418	0.8251	19.3388	19.9348	21.1412	20.1077
040029	1.5379	0.8768	22.1882	22.8770	24.0704	23.0869
040032	0.9581	0.7478	16.2781	18.5171	*	17.4291
040035	0.9080	0.7478	11.8237	13.4265	*	12.6475
040036	1.5682	0.8768	21.6742	24.2851	26.3226	24.0976
040039	1.3369	0.7793	15.9673	17.7976	19.5998	17.8170
040041	1.1827	0.8552	20.4646	22.0188	22.1531	21.5535
040042	1.3549	0.9346	16.2285	18.9550	19.9627	18.3286
040045	0.9321	0.7478	19.5572	18.7952	17.6742	18.6280
040047	1.0748	0.7793	21.6323	21.5334	21.9163	21.6924
040050	1.0797	0.7478	15.1428	15.4782	16.3930	15.6589
040051	0.9177	0.7478	17.6964	18.8943	19.1401	18.6103
040053	0.9720	0.7478	19.2586	20.8153	20.7824	20.2863
040054	1.0287	0.7478	16.5573	16.7370	18.2684	17.1740
040055	1.5474	0.8231	19.7336	22.2237	23.3156	21.7960
040062	1.5855	0.8231	21.9336	21.6403	23.1543	22.2707
040066	1.0396	0.7478	21.7766	23.4616	*	22.6592
040067	1.0244	0.7478	16.0516	15.1441	16.8799	16.0038
040069	1.0357	0.9108	20.5968	21.7607	24.4662	22.2668
040071	1.5128	0.8552	19.4324	22.9350	24.3824	22.1870
040072	1.0728	0.8552	19.3079	20.8269	19.9009	19.9951
040074	1.1860	0.8768	22.0800	22.6147	25.2423	23.2187
040075	0.9521	0.7478	15.7875	16.2583	18.3254	17.1733
040076	1.0208	0.8552	23.5947	21.0442	20.6272	21.3785
040077	0.9549	0.7478	16.7832	18.3261	17.1210	17.3842
040078	1.5395	0.8552	21.4854	24.4589	24.5378	23.4806
040080	0.9908	0.7793	18.4470	21.3483	22.3392	20.6867
040081	0.8047	0.7478	13.2797	13.7148	15.1081	14.0348
040084	1.0773	0.8768	20.1163	22.6441	24.7225	22.5619
040085	0.9955	0.7478	15.5811	18.0756	29.8444	19.6100
040088	1.3084	0.8767	20.0032	21.2974	22.6183	21.3215
040091	1.1599	0.8293	20.6688	23.0252	23.0080	22.2365
040100	1.3376	0.8552	17.8889	19.3560	20.0460	19.1639
040105	1.0117	0.7478	15.4697	15.8171	18.2182	16.4079
040107	0.7276	0.7478	17.6695	*	*	17.6695
040114	1.7030	0.8768	21.6849	23.5628	24.8992	23.4046
040118	1.4016	0.7968	21.7913	24.2547	24.7363	23.6447
040119	1.4402	0.8552	19.9013	20.1631	21.0103	20.3637
040126	0.8718	0.7478	13.3832	12.5944	14.0701	13.3074
040132	***	*	29.2343	36.5525	28.1390	31.3524
040134	2.4142	0.8768	24.4646	*	27.3412	25.9794
040137	1.1908	0.8768	24.7813	23.4672	25.2907	24.5263
040138	1.2572	0.8615	22.3523	23.3615	25.7513	23.9295
040140	***	*	*	25.1224	*	25.1224
040141	0.7691	0.8615	*	*	24.0901	24.0901
040142	1.2882	0.9066	*	*	27.9695	27.9695

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
050002	1.3621	1.5474	30.9729	31.9709	34.1948	32.4064
050006	1.6269	1.1909	25.4604	27.6176	30.5373	27.9248
050007	1.4885	1.4970	34.1406	37.5804	38.7033	36.8959
050008	1.3528	1.4970	32.4067	36.9371	39.1539	36.3445
050009	1.7971	1.3955	30.2740	35.5384	39.6393	35.2947
050013	2.0269	1.3955	29.8401	31.7637	31.9837	31.2570
050014	1.1326	1.2953	27.7646	29.5726	33.0373	30.2311
050015	1.2904	1.0848	27.5652	30.1398	30.7940	29.4852
050016	1.2223	1.1357	25.5508	25.5735	26.2162	25.7788
050017	1.9454	1.2953	28.4911	30.5863	36.8978	31.9726
050018	1.1521	1.1762	17.9621	20.3179	22.3472	20.1629
050022	1.5867	1.1297	28.1312	28.2773	29.8632	28.8610
050024	1.0894	1.1417	25.1425	26.9378	27.5587	26.6747
050025	1.8083	1.1417	29.8262	31.7242	36.1622	32.6605
050026	1.5241	1.1417	24.2564	26.6406	28.3027	26.5474
050028	1.2262	1.0848	18.7866	21.5448	26.6160	21.9931
050029	***	*	30.2538	34.3934	*	31.9320
050030	1.2312	1.0848	21.9251	22.9148	24.9707	23.2719
050032	***	*	28.8046	*	*	28.8046
050038	1.5479	1.5114	36.1619	35.0441	38.7527	36.6692
050039	1.6010	1.0848	26.8993	29.8179	31.6734	29.4369
050040	1.2018	1.1762	30.7426	31.8983	32.7413	31.8084
050042	1.3668	1.1909	27.6765	29.8062	33.9415	30.4516
050043	1.6285	1.5474	37.3217	39.6054	43.1589	40.0134
050045	1.2751	1.0848	22.1691	22.7051	23.8408	22.8906
050046	1.2116	1.1660	25.5490	25.2786	25.6875	25.5104
050047	1.7028	1.4970	34.4427	39.3993	40.9874	38.4201
050054	1.1776	1.1297	21.3495	27.1437	24.1262	24.0051
050055	1.2386	1.4970	36.1182	36.9386	37.5879	36.9364
050056	1.3348	1.1762	27.1458	29.4829	27.9330	28.1647
050057	1.6190	1.0848	24.2759	26.2099	29.4351	26.6650
050058	1.5358	1.1762	25.9389	27.3584	33.8215	29.0264
050060	1.4954	1.0848	22.9491	26.5515	27.3282	25.6824
050061	0.8559	1.1525	25.3042	*	32.2172	28.5425
050063	1.3227	1.1762	28.6093	32.0515	33.3039	31.3845
050065	1.7399	1.1660	28.8369	33.8223	34.0280	32.3405
050067	1.2228	1.1885	27.8867	29.6982	31.9597	29.7844
050068	***	*	21.9031	*	*	21.9031
050070	1.2848	1.4970	39.5178	40.5645	45.3382	41.9509
050071	1.3395	1.5474	40.1344	41.1036	45.3882	42.3609
050072	1.3403	1.5474	39.2529	40.8108	44.2651	41.6223
050073	1.3622	1.5474	38.6763	41.3430	45.9765	42.1975
050075	1.2439	1.5474	40.2265	43.7101	47.2356	44.0053
050076	2.0351	1.5474	40.8075	43.0845	46.4990	43.5903
050077	1.6700	1.1417	27.1234	29.6264	32.0245	29.6181
050078	1.2906	1.1762	24.1091	25.6814	27.9269	25.7615
050079	1.4307	1.5474	38.8981	42.7385	47.8597	43.4884
050082	1.6699	1.1660	27.5022	28.9139	37.7783	31.5037
050084	1.5479	1.1333	26.0607	28.2664	33.0179	29.0525
050088	***	1.1357	27.1103	26.4093	25.7385	26.4472
050089	1.3648	1.1660	24.7857	29.4884	33.5323	29.3416
050090	1.2969	1.4739	27.4193	31.1774	32.9584	30.4520
050091	1.1034	1.1762	29.2522	30.1534	30.8560	30.1209
050093	1.5128	1.0848	29.2642	31.1083	33.4119	31.3614
050096	1.3036	1.1762	23.0525	24.2277	24.6680	23.9648
050097	***	*	24.6726	26.6788	*	25.5991
050099	1.5210	1.1660	27.1282	28.7711	31.0437	29.0188
050100	1.7200	1.1417	25.6798	28.0303	29.6949	27.8627
050101	1.2944	1.4888	32.9866	35.4655	39.5330	36.1079
050102	1.3036	1.1297	25.5763	24.9381	29.1364	26.2832
050103	1.5463	1.1762	27.8079	28.7375	34.2529	30.2688
050104	1.4057	1.1762	26.1592	29.1240	29.7326	28.3301
050107	1.3890	1.1525	22.6900	27.6002	33.1358	27.7768
050108	1.9703	1.2953	28.5244	31.4271	35.5711	32.0693
050110	1.2602	1.1525	21.9297	20.0769	22.4428	21.4435
050111	1.2835	1.1762	23.7715	26.6345	28.1588	26.1803
050112	1.5361	1.1762	31.9797	34.0258	36.8026	34.4310

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
050113	1.2729	1.4970	32.6932	34.2851	33.8064	33.6092
050114	1.3830	1.1762	28.1938	29.2858	31.1294	29.5973
050115	1.4364	1.1417	24.1481	27.5207	30.9288	27.6106
050116	1.5151	1.1762	28.2924	28.8193	34.5110	30.5901
050117	1.2630	1.1123	24.7555	28.2227	32.4414	28.3268
050118	1.1710	1.1885	28.9358	33.0650	35.4044	32.6634
050121	1.3350	1.0848	25.0858	25.5962	27.9537	26.3210
050122	1.5372	1.1333	29.1534	29.7629	34.2416	31.1709
050124	1.2385	1.1762	23.0843	26.7065	28.0288	25.9680
050125	1.3685	1.5114	35.6573	40.9218	41.7020	39.5040
050126	1.3912	1.1762	27.7126	29.6203	26.4194	27.8473
050127	1.3401	1.2953	21.8719	23.6208	26.0500	23.7297
050128	1.5403	1.1417	28.7668	28.3278	31.0662	29.4553
050129	1.7571	1.1660	25.2780	27.8488	32.2680	28.7272
050131	1.2972	1.4970	37.7845	38.6834	40.5321	39.0707
050132	1.4262	1.1762	27.8805	29.4317	35.1544	30.7495
050133	1.4967	1.0951	25.1948	27.6030	31.3530	28.2112
050135	0.9765	1.1762	*	24.9415	24.3927	24.6796
050136	1.2106	1.4739	31.6146	35.2834	37.4560	34.8123
050137	1.2468	1.1762	35.0503	36.5409	38.4827	36.7225
050138	1.9167	1.1762	43.0858	43.8671	46.9557	44.6742
050139	1.2908	1.1762	33.8749	35.1013	37.6217	35.5604
050140	1.4660	1.1660	36.1708	37.5473	39.6269	37.8550
050144	1.4053	1.1762	30.3679	32.4042	33.5109	32.1636
050145	1.3142	1.4140	37.5722	39.5676	42.3134	39.8846
050148	1.1060	1.0848	17.3908	24.7063	27.3005	22.6027
050149	1.4351	1.1762	28.0500	30.1596	33.2270	30.4737
050150	1.1785	1.2953	26.7728	31.5333	31.7560	29.9321
050152	1.4009	1.4970	34.5694	40.3464	43.6487	39.6060
050153	1.5352	1.5114	34.5870	40.4446	43.3190	39.3912
050155	0.9838	1.1762	21.2068	21.8829	21.8550	21.6128
050158	1.2377	1.1762	30.6598	33.6400	35.1326	33.3121
050159	1.3232	1.1660	27.4051	30.8069	31.3199	29.8120
050167	1.3635	1.1333	23.2022	25.9850	28.5179	25.9911
050168	1.6244	1.1660	27.5313	30.8036	33.2506	30.5684
050169	1.4269	1.1762	25.6896	26.2864	27.4644	26.5104
050170	***	*	29.4075	*	*	29.4075
050173	1.2514	1.1660	27.7070	27.6097	30.3582	28.5541
050174	1.6425	1.4739	33.5204	36.3117	40.1747	36.7717
050175	1.2918	1.1762	26.9627	31.5615	30.5733	29.6977
050177	1.2491	1.1660	23.1575	24.7531	25.1442	24.3743
050179	1.2005	1.1885	23.0583	25.8072	27.1155	25.4092
050180	1.5845	1.5474	36.9905	40.8101	39.8123	39.2517
050186	***	*	27.6638	*	*	27.6638
050189	0.9939	1.4140	32.3513	20.0709	29.1280	26.2226
050191	1.4343	1.1762	28.1689	*	34.2091	31.2052
050192	0.9731	1.0848	19.5327	21.2448	27.0424	22.7189
050193	1.1968	1.1660	24.6307	30.7341	29.6421	28.4881
050194	1.3119	1.5159	28.1413	38.6750	40.9096	35.6972
050195	1.5170	1.5474	42.1735	43.9696	48.4358	44.9294
050196	1.0762	1.0848	20.7257	25.2168	32.1933	25.8088
050197	1.9645	1.4970	*	40.8832	48.9052	44.8389
050204	1.4068	1.1762	24.9458	25.2512	28.6423	26.2829
050205	1.2244	1.1762	25.2841	28.0504	27.8611	27.0700
050207	1.2714	1.0951	25.1863	27.0216	29.5215	27.2272
050211	1.2713	1.5474	34.3396	38.3319	41.2166	37.8840
050214	***	1.1762	22.4773	24.4785	23.9972	23.6229
050215	1.6351	1.5114	36.6063	41.6886	43.7985	40.7257
050217	1.1451	1.0848	22.2055	23.6286	24.9606	23.6369
050219	1.0993	1.1762	21.8649	22.9226	22.4065	22.4391
050222	1.6663	1.1417	25.2922	26.3882	29.1094	27.0242
050224	1.7203	1.1660	26.2108	26.7916	29.3143	27.4653
050225	1.5203	1.0848	25.0219	29.5184	29.9656	28.1785
050226	1.5875	1.1660	26.0826	29.2259	30.6541	28.6959
050228	1.3521	1.5474	38.6751	40.1362	42.4226	40.4482
050230	1.3593	1.1660	30.0380	34.1417	32.9555	32.4641
050231	1.6236	1.1762	27.8896	30.1298	30.9607	29.7082

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
050232	1.4386	1.1357	25.3439	24.4383	27.4099	25.6865
050234	1.1726	1.1417	24.0754	29.2421	29.6560	27.4243
050235	1.5578	1.1762	27.2838	27.8965	29.2979	28.1654
050236	1.3813	1.1660	27.0687	28.1969	32.1647	29.0012
050238	1.4440	1.1762	26.0312	29.1481	31.1764	28.8569
050239	1.5765	1.1762	27.0866	28.2327	31.0963	28.8857
050240	1.6442	1.1762	32.8542	35.2284	35.5735	34.6528
050242	1.3378	1.5159	34.4412	39.7629	44.3130	39.6054
050243	1.6214	1.1297	28.5626	31.8153	31.4883	30.6830
050245	1.3020	1.1660	25.7585	27.0949	28.6527	27.2127
050248	1.0286	1.4140	29.1192	31.6240	35.3864	32.0261
050251	1.0004	1.0848	24.4552	26.5021	27.2675	26.0899
050253	***	1.1564	23.9246	22.2450	24.0044	23.3808
050254	1.2166	1.2953	23.3358	24.1512	26.3150	24.6804
050256	1.5778	1.1762	26.8618	28.4728	29.8194	28.4077
050257	0.9814	1.0848	17.4909	20.8367	21.3216	19.7770
050261	1.3007	1.0848	21.4693	25.3005	27.3234	24.7145
050262	2.1232	1.1762	33.0425	36.1162	44.0256	37.8981
050264	1.3196	1.5474	37.4742	41.3478	41.1211	39.9496
050267	***	*	26.6558	26.7060	*	26.6806
050270	1.3272	1.1417	27.9871	30.0540	32.4812	30.2697
050272	1.3628	1.1660	24.0921	25.9103	27.1989	25.7666
050276	1.1883	1.5474	34.7422	41.2251	39.3778	38.5361
050277	1.0330	1.1762	35.6323	35.8246	32.5213	34.3014
050278	1.5907	1.1762	26.0331	28.0351	29.9244	28.0988
050279	1.2108	1.1660	23.5145	25.5299	27.6573	25.5685
050280	1.6443	1.2207	28.5504	30.6723	35.2030	31.5494
050281	1.4863	1.1762	25.7832	26.2623	27.3824	26.5030
050283	1.5233	1.5474	35.1831	38.5600	42.8618	39.0003
050286	***	*	19.7352	19.4973	*	19.6057
050289	1.5691	1.4970	34.9645	38.6875	41.1061	38.2220
050290	1.6177	1.1762	31.9510	32.6388	34.5482	33.0758
050291	1.8090	1.4739	28.3451	29.6162	35.3653	31.1027
050292	0.9624	1.1297	27.6114	27.0775	26.8879	27.1685
050295	1.5134	1.0848	25.4332	31.5960	36.1950	30.7774
050296	1.1551	1.5114	33.5948	34.9952	39.0061	36.0343
050298	1.1272	1.1660	26.1707	25.8232	27.7416	26.6026
050299	1.2244	1.1762	26.9870	27.7535	31.5435	28.9060
050300	1.5741	1.1660	26.3182	28.3862	30.7148	28.5022
050301	1.2254	1.0848	25.7167	28.5769	31.9995	28.7858
050305	1.4519	1.5474	38.7597	40.9978	44.8630	41.5654
050308	1.4919	1.5114	31.6790	38.0564	43.0691	37.5162
050309	1.3873	1.2953	25.5367	28.9181	34.4278	29.9079
050312	1.4865	1.2207	28.2557	32.6846	33.9022	31.7615
050313	1.2403	1.1333	25.3372	27.5321	31.4999	28.4222
050315	1.2710	1.0848	23.6638	26.1224	27.6037	25.8181
050320	1.2238	1.5474	31.4570	36.3252	40.2352	36.0082
050324	1.9289	1.1417	28.4931	30.9958	32.9792	30.9355
050325	1.1756	1.0848	26.6325	30.2280	30.6117	29.1581
050327	1.6847	1.1660	33.0549	29.8327	33.0087	31.8986
050329	1.2743	1.1297	26.6341	26.8021	26.2120	26.5339
050331	1.1721	1.4739	21.5193	20.9847	20.2692	20.9637
050333	1.0706	1.0848	15.6929	15.3119	23.4009	17.5306
050334	1.6937	1.4140	37.2336	38.7635	40.7467	38.9455
050335	1.4438	1.0848	24.9274	27.4046	26.2576	26.2253
050336	1.1664	1.1333	23.2687	25.3062	28.5659	25.7519
050342	1.2238	1.0848	23.0282	24.7654	26.8507	24.9581
050348	1.6959	1.1660	28.9864	33.2676	37.7898	33.4975
050349	0.9453	1.0848	15.6043	16.9251	17.4791	16.6299
050350	1.3661	1.1762	27.2573	29.4262	31.1833	29.2715
050351	1.5133	1.1762	27.4042	29.3082	30.8661	29.2314
050352	1.2358	1.2953	32.6572	24.2931	33.9362	30.0053
050353	1.5568	1.1762	25.4309	26.6332	29.1630	27.0686
050355	***	1.0848	*	11.2498	5.0506	7.4928
050357	1.4494	1.1525	25.2126	26.7265	32.3095	27.5322
050359	1.1442	1.0848	22.9175	23.6030	24.7311	23.7960
050360	1.4616	1.4970	35.9032	38.8658	37.0769	37.3332

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
050366	1.2256	1.0848	23.4696	25.7692	31.1854	26.8679
050367	1.4438	1.4888	32.6760	34.4959	38.7604	35.6778
050369	1.3974	1.1762	28.0909	27.1327	29.5697	28.2751
050373	1.4860	1.1762	30.7301	32.2315	32.2596	31.7447
050376	1.4575	1.1762	30.3530	30.7562	32.5870	31.2266
050377	***	*	14.3892	20.2484	*	16.9896
050378	0.9702	1.1762	30.4937	33.9087	34.2417	32.8674
050379	***	1.0848	27.5151	31.7645	32.9575	30.5157
050380	1.5471	1.5114	35.8014	39.1098	42.0782	38.9514
050382	1.4204	1.1762	26.8950	26.0927	27.4131	26.8049
050385	1.3521	1.4739	*	25.5735	34.5184	29.9098
050390	1.1788	1.1297	25.7881	28.7761	26.0066	26.7871
050391	1.3048	1.1762	20.2887	21.3012	18.1004	19.7304
050392	1.0187	1.0848	21.8139	22.7209	*	22.2790
050393	1.3163	1.1762	26.4918	28.2369	30.0661	28.2139
050394	1.4938	1.1660	25.1869	26.0074	27.2543	26.2043
050396	1.5902	1.1525	28.4161	30.5470	33.5699	30.9065
050397	0.8283	1.0848	24.7279	27.4716	28.1640	26.7356
050407	1.1949	1.4970	33.2894	35.6035	37.9066	35.6609
050410	0.9616	*	19.8436	19.4995	21.3814	20.2094
050411	1.4055	1.1762	35.5207	37.3817	37.8064	36.9551
050414	1.3026	1.2953	28.2381	28.8561	34.6532	30.6007
050417	1.2841	1.0848	24.5360	25.2930	29.5031	26.5285
050419	1.3330	1.1909	26.4357	28.4471	33.3125	29.3954
050420	1.1285	1.1762	26.7537	26.1838	24.9401	25.8686
050423	0.9475	1.1297	26.5188	28.5944	30.6416	28.6936
050424	1.9635	1.1417	27.5273	29.9133	31.0730	29.4697
050425	1.3899	1.2953	37.7347	38.5317	42.4177	39.7789
050426	1.3183	1.1660	30.9610	30.0077	30.6899	30.5313
050430	0.9585	1.0848	31.5170	24.6684	25.0607	26.4412
050432	1.5149	1.1762	28.1105	30.3547	30.8030	29.8170
050433	0.9214	1.0848	14.3846	20.7565	23.0806	19.1896
050434	1.1299	1.0848	*	25.9506	26.1621	26.0550
050435	1.0952	1.1417	22.6618	32.2183	28.0306	27.3138
050438	1.5305	1.1762	26.5535	26.4668	27.2662	26.7804
050441	1.9649	1.5114	36.6680	38.2823	42.9765	39.2937
050444	1.3319	1.1123	23.5299	27.6971	30.5504	27.3177
050447	0.8880	1.1417	25.7274	21.8552	25.2573	24.1974
050448	1.1326	1.0848	26.6967	25.0983	27.9759	26.6380
050454	1.8679	1.4970	34.4813	36.8383	43.3278	38.3744
050455	1.6861	1.0848	24.1694	24.5314	21.8846	23.4157
050456	1.2166	1.1762	23.7594	22.1675	22.5630	22.8117
050457	1.6122	1.4970	37.4570	40.2725	45.5829	41.0011
050464	1.6731	1.1885	31.4768	37.1342	37.3692	35.4838
050468	1.4533	1.1762	17.8128	29.4280	29.5448	24.3346
050469	1.0831	1.0848	25.7995	27.3281	28.9079	27.4122
050470	1.0907	1.0848	21.6981	18.4689	23.6649	21.2384
050471	1.7659	1.1762	32.3570	34.5484	34.5211	33.8184
050476	1.3587	1.0848	26.0482	30.9974	34.6585	30.3567
050477	1.4963	1.1762	32.1676	34.6400	34.6995	33.8960
050478	0.9760	1.1525	28.3894	30.9865	33.3998	30.9361
050481	1.4169	1.1762	30.3890	31.9177	33.7446	32.0928
050485	1.5976	1.1762	27.1437	28.8459	31.4233	29.1407
050488	1.3096	1.5474	37.2438	40.5313	42.9904	40.3037
050491	***	1.1564	29.2987	30.6461	32.1379	30.5664
050492	1.4025	1.0848	23.7384	27.4933	27.1540	26.2639
050494	1.3712	1.0848	30.8706	35.1457	34.8963	33.6068
050496	1.7798	1.5474	35.7115	38.2871	42.2672	38.6931
050497	***	*	14.4481	15.9501	*	15.1581
050498	1.2871	1.2953	28.2196	28.2667	32.7708	29.8260
050502	1.7452	1.1762	28.0102	28.7200	29.5615	28.8118
050503	1.4596	1.1417	26.7924	29.2001	31.6418	29.3049
050506	1.7058	1.1357	30.4731	32.4509	36.0164	33.1455
050510	1.2059	1.5474	39.6005	44.3883	47.5510	44.1129
050512	1.4016	1.5474	39.0767	41.8921	46.9233	42.8915
050515	1.3200	1.1417	36.3131	37.4251	38.9978	37.6365
050516	1.4489	1.2953	30.0985	29.4936	36.2618	31.8675

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
050517	1.0642	1.1660	23.4131	23.6034	23.9007	23.6377
050522	***	*	38.9157	*	*	38.9157
050526	1.2090	1.1660	29.0004	29.9495	31.3744	30.1287
050528	1.1389	1.0848	23.9177	28.6273	29.6838	27.7337
050531	1.0915	1.1762	22.7311	25.0157	26.9420	24.9597
050534	1.2648	1.1297	26.7941	29.7546	29.8603	28.8863
050535	1.3449	1.1660	29.7904	32.3646	32.3723	31.6438
050537	1.3781	1.2953	25.1291	27.4196	31.4527	28.1309
050539	1.2398	1.0848	25.3328	28.0586	29.6856	27.7611
050541	1.5362	1.5474	41.1980	43.7765	46.1121	43.8355
050542	1.0327	1.0848	21.2846	*	*	21.2846
050545	0.6959	1.1762	33.4322	42.9451	30.5554	35.4562
050546	0.7147	1.0848	42.8052	52.7180	30.2329	41.5266
050547	0.8260	1.4739	40.6483	45.1842	33.2205	39.9154
050548	0.7101	1.1660	32.3944	37.1314	*	34.6019
050549	1.5565	1.1604	31.8525	33.8288	34.9818	33.6342
050550	1.3762	1.1660	29.0938	31.1918	30.2302	30.2108
050551	1.2853	1.1660	28.6834	31.6782	31.6165	30.7425
050552	1.1118	1.1762	24.9755	26.8274	27.1744	26.5471
050557	1.5548	1.1885	25.8719	28.3111	31.1871	28.6462
050559	***	*	25.3299	26.9662	*	26.0948
050561	1.2178	1.1762	35.9611	37.5863	38.8651	37.5449
050567	1.5865	1.1660	27.8475	30.1167	32.9829	30.4114
050568	1.2251	1.0848	20.8324	22.5008	24.4061	22.5795
050569	1.3462	1.3480	27.7955	30.4874	33.0259	30.5066
050570	1.5162	1.1660	29.9470	32.6896	34.0171	32.2949
050571	1.2578	1.1762	29.1716	32.1656	33.6156	31.7338
050573	1.7100	1.1297	27.2328	30.5249	33.3268	30.3962
050575	1.2597	1.1762	23.1358	23.2447	25.2513	23.9658
050577	1.2157	1.1762	26.4806	28.7060	30.8841	28.7176
050578	1.7450	1.1762	30.4934	31.5953	33.8825	31.9512
050579	1.4291	1.1762	34.9794	40.2740	39.4976	38.3190
050580	1.2595	1.1660	27.2431	29.4337	31.6256	29.3950
050581	1.4452	1.1762	28.9696	32.0823	32.1801	31.1581
050583	1.5670	1.1417	30.0427	33.5209	33.3697	32.3610
050584	1.2914	1.1660	24.5544	24.5757	24.8180	24.6565
050585	1.1457	1.1660	26.0595	27.2982	22.7121	24.9986
050586	1.1583	1.1660	25.7172	25.3551	27.4173	26.0841
050588	1.3347	1.1762	30.5453	32.3603	32.8212	31.9715
050589	1.2362	1.1660	27.9845	30.6273	30.9547	29.9199
050590	1.2814	1.2953	27.0620	31.5987	32.1654	30.1866
050591	1.1623	1.1762	28.6151	28.5915	28.8549	28.6959
050592	1.1716	1.1660	25.9545	32.5000	24.4542	27.4073
050594	1.9876	1.1660	30.8028	34.6747	34.7946	33.5328
050597	1.2330	1.1762	24.5542	25.4868	27.5691	25.8776
050598	***	*	24.6875	*	*	24.6875
050601	1.5414	1.1762	32.3033	35.0325	34.7409	34.0841
050603	1.3839	1.1660	25.0996	28.6982	30.2464	28.0787
050604	1.2162	1.5114	42.0018	45.4433	49.9429	45.9484
050608	1.3821	1.0848	20.7955	22.1999	23.3630	22.1922
050609	1.3707	1.1660	37.4563	38.4561	41.1797	39.1280
050615	1.3061	1.1762	29.4323	32.8786	33.2909	31.8903
050616	1.3796	1.1660	23.1748	28.5636	36.9017	29.6253
050618	1.0245	1.0848	22.3481	25.4500	27.4539	25.0614
050623	***	1.1762	29.9553	29.6550	32.0627	30.4768
050624	1.2620	1.1762	23.3492	28.1941	32.2907	27.6796
050625	1.7422	1.1762	30.8013	33.5137	36.3631	33.6260
050630	***	*	27.7051	28.0726	30.9410	28.9666
050633	1.2315	1.1357	30.2883	33.4771	35.3734	33.1070
050636	1.3084	1.1417	23.2573	27.2360	30.5156	27.0926
050641	1.2243	1.1762	21.5030	20.4720	21.4612	21.1520
050644	0.8876	1.1762	28.4054	25.6614	27.6547	27.1915
050662	0.7678	1.5114	40.9242	47.5065	32.6362	40.4932
050663	1.0263	1.1762	22.9161	25.1493	25.7747	24.4728
050667	0.8884	1.3955	31.4906	25.9250	26.3937	27.9100
050668	0.9981	1.5474	55.9594	*	31.8065	41.1707
050674	1.2840	1.2953	36.8871	38.4454	42.6866	39.5960

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
050677	1.4811	1.1762	36.2702	37.3389	38.7984	37.5511
050678	1.2324	1.1660	27.1337	29.1159	30.7220	29.1295
050680	1.2133	1.4888	32.7065	35.6614	38.3946	35.9028
050682	0.8920	1.0848	23.0984	21.7264	21.7791	22.0865
050684	1.1341	1.1297	23.7443	25.2575	26.4234	25.2119
050686	1.2605	1.1297	37.3033	38.5595	40.9486	39.0574
050688	1.2096	1.5114	36.5555	41.3305	41.9325	39.9230
050689	1.5618	1.5474	37.5449	40.3815	42.2018	40.1932
050690	1.2343	1.4739	41.1385	43.9228	47.2769	44.3743
050693	1.2978	1.1660	32.6638	34.8040	35.0621	34.2547
050694	1.1914	1.1297	25.8298	26.7041	28.9544	27.1978
050695	1.1012	1.1333	27.8742	30.1226	35.6549	31.4872
050696	2.0751	1.1762	29.9410	36.9314	35.9220	34.4812
050697	1.0277	1.2207	18.6962	19.2603	25.1984	20.8006
050699	***	*	26.0909	25.6818	26.8210	26.1958
050701	1.2779	1.1297	28.4650	29.6896	29.6253	29.3536
050704	1.0120	1.1762	24.6072	24.6609	25.3488	24.8998
050707	1.3813	1.4970	27.7366	32.4877	34.0550	31.4563
050708	1.6591	1.0848	22.1606	21.2163	22.5034	21.9751
050709	1.2193	1.1660	22.7897	21.9079	25.6119	23.3937
050710	1.4396	1.0848	33.7204	34.8311	39.9858	36.4647
050713	1.2543	1.1762	19.0071	20.7448	20.2803	19.9969
050714	1.3580	1.5159	30.3263	32.4491	33.6676	32.2064
050717	1.0612	1.1762	33.0719	34.5519	38.0796	35.2375
050718	1.0152	1.1297	21.7835	15.4037	21.4996	18.9377
050719	***	*	22.0998	*	*	22.0998
050723	1.2353	1.1762	33.0797	34.9814	35.0119	34.4384
050724	2.1341	1.0848	23.7567	*	34.4267	28.5323
050725	0.9684	1.1762	20.6592	22.0946	21.7816	21.6358
050726	1.6664	1.1885	25.8742	27.0928	27.8433	27.0367
050727	1.2727	1.1762	*	23.7179	23.9437	23.8301
050728	1.3207	1.4739	*	31.4768	36.0820	33.6891
050729	1.4238	1.1762	*	*	34.2580	34.2580
050730	1.2649	1.1762	*	*	51.5425	51.5425
060001	1.5772	1.0517	23.1548	24.9410	26.8470	25.0779
060003	1.3962	1.0517	23.0807	24.7856	24.2224	24.0730
060004	1.1960	1.0710	25.0037	28.0656	29.9649	27.8289
060006	1.3423	0.9379	21.8609	22.7493	24.5704	23.0964
060007	1.0128	0.9379	21.4244	21.4792	*	21.4535
060008	1.1014	0.9379	19.8803	21.8037	23.3859	21.7601
060009	1.4646	1.0710	24.7920	27.0511	28.7645	26.9116
060010	1.7149	1.0146	25.8475	27.2290	28.9850	27.4402
060011	1.4232	1.0710	25.8919	26.1958	27.2833	0126.4630
060012	1.4557	0.9379	22.6374	24.1557	26.2469	24.3434
060013	1.3659	0.9379	23.3954	24.9708	24.5994	24.0758
060014	1.7846	1.0710	27.0326	29.6744	31.2588	29.2315
060015	1.7206	1.0710	27.6338	30.1158	30.4533	29.4109
060016	1.1655	0.9379	22.9300	23.9655	25.6527	24.2479
060018	1.2136	0.9379	21.0581	23.6620	25.7628	23.4747
060020	1.5388	0.9379	20.9025	22.2052	22.6748	21.9753
060022	1.5930	0.9457	24.7928	25.7832	26.5238	25.7483
060023	1.6438	0.9578	24.3749	26.7285	27.7644	26.3625
060024	1.7403	1.0710	25.2409	28.7231	29.0130	27.7028
060027	1.5666	1.0517	25.1480	26.6348	28.0909	26.7085
060028	1.3838	1.0710	27.1303	27.9686	30.0448	28.4352
060029	***	0.9379	19.7379	*	*	19.7379
060031	1.5393	0.9457	23.8781	25.6207	26.3650	25.3306
060032	1.5419	1.0710	27.1783	28.2234	30.4247	28.6396
060033	0.9865	0.9379	16.7266	*	*	16.7266
060036	1.1170	0.9379	19.4144	20.4635	20.7131	20.1878
060041	0.9219	0.9379	20.8746	22.7123	23.4978	22.3670
060043	0.9477	0.9379	19.1085	20.0939	18.7896	19.3418
060044	1.1417	1.0517	25.6112	25.2471	25.0360	25.3737
060049	1.2784	1.0146	25.3425	26.8089	29.0598	27.1748
060050	1.1981	0.9379	20.4386	21.9108	*	21.1679
060054	1.4335	0.9590	21.1281	23.5803	22.3490	22.3633
060057	1.0788	0.9379	24.3982	26.9891	*	25.7472

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
060064	1.4680	1.0710	29.1806	30.0963	31.3105	30.2470
060065	1.2936	1.0710	29.2377	28.5282	31.1987	29.6323
060070	***	0.9379	22.6894	*	*	22.6894
060075	1.2070	0.9379	27.7835	30.7835	32.7563	30.4907
060076	1.2848	0.9379	23.6266	25.5406	26.8236	25.4496
060096	1.5124	1.0517	26.4167	27.4085	30.0602	27.9908
060100	1.6735	1.0710	28.0561	29.7690	32.1537	30.0220
060103	1.1833	1.0517	26.6863	28.8063	30.3002	28.6961
060104	1.3558	1.0710	26.7683	30.8625	32.0889	29.9703
060107	1.4178	1.0710	*	26.8267	26.1883	26.4984
060108	***	*	19.0011	*	*	19.0011
060111	***	*	*	31.2571	*	31.2571
070001	1.6316	1.1790	29.9592	32.2718	34.0302	32.0467
070002	1.8165	1.1790	28.1101	29.0663	31.1530	29.4722
070003	1.0898	1.1790	29.8684	31.3716	32.7173	31.3528
070004	1.1896	1.1790	25.7207	27.3004	29.2292	27.3764
070005	1.3796	1.1790	29.8173	29.3265	32.1668	30.4848
070006 [2]	1.3118	1.2607	33.3814	33.9310	36.8469	34.7695
070007	1.2843	1.1790	29.0336	30.3648	31.7097	30.4054
070008	1.2463	1.1790	24.3907	24.9176	26.4806	25.2986
070009	1.1856	1.1790	25.6072	28.8649	30.2706	28.2076
070010	1.8269	1.2607	30.4192	33.1535	32.5798	32.0648
070011	1.3577	1.1790	24.9457	27.5391	29.9105	27.3901
070012	1.1771	1.1790	34.9099	40.3337	44.1424	39.6372
070015	1.4329	1.1790	30.0614	30.9728	33.4595	31.5141
070016	1.3424	1.1790	29.7505	29.6662	31.0903	30.2000
070017	1.3696	1.1790	29.2978	30.3951	31.7223	30.4949
070018 [2]	1.3351	1.2607	33.8654	35.7189	37.6081	35.8796
070019	1.2584	1.1790	27.9838	29.6290	31.8148	29.8448
070020	1.3392	1.1790	28.4084	29.9507	31.0935	29.8423
070021	1.2614	1.1790	30.3254	31.4397	33.2357	31.7179
070022	1.7784	1.1790	29.7376	32.3625	33.9804	32.0199
070024	1.3851	1.1790	28.3460	30.8308	32.0430	30.4352
070025	1.8564	1.1790	28.3017	29.2540	30.9938	29.5451
070027	1.2911	1.1790	36.9700	27.3487	31.8018	31.4568
070028	1.5983	1.2607	28.2078	29.5653	31.5036	29.7843
070029	1.2773	1.1790	25.8107	26.3871	27.7213	26.6692
070031	1.2393	1.1790	25.5880	27.2359	28.9190	27.3126
070033	1.2635	1.3191	34.3904	35.5355	37.1929	35.7524
070034 [2]	1.3877	1.2607	32.8074	35.6831	36.2719	34.9418
070035	1.2964	1.1790	26.1693	27.1816	27.5585	26.9760
070036	1.6654	1.1790	35.0701	34.0555	36.1610	35.1155
070038	1.1608	*	*	31.1133	25.7516	26.9407
070039	0.9382	1.1790	32.6059	35.0164	31.2269	32.9340
080001	1.6701	1.0652	28.0859	30.2463	30.0242	29.4815
080002	***	*	23.7309	26.4192	27.9670	26.0445
080003	1.5462	1.0652	24.8199	27.1131	29.2266	26.9651
080004	1.3741	1.0652	24.2251	26.0092	27.4735	25.9428
080006	1.2769	0.9606	23.6838	24.4204	25.6160	24.5955
080007	1.3900	1.0289	23.4964	24.6485	27.0074	25.0565
090001	1.7108	1.0935	29.5432	31.3552	35.0413	32.0128
090002	***	*	23.5158	29.6780	*	25.5760
090003	1.2607	1.0935	22.7014	27.0514	29.2660	26.1789
090004	1.9783	1.0935	28.7417	29.9785	32.0186	30.3834
090005	1.3818	1.0935	28.6142	30.2504	30.7728	29.9417
090006	1.3806	1.0935	23.7241	25.9086	29.5590	26.3083
090007	***	*	25.8430	30.1419	*	27.7359
090008	1.4284	1.0935	19.3212	29.6744	29.1059	25.7761
090011	2.0113	1.0935	31.7710	32.4412	34.0693	32.7262
100001	1.5628	0.9303	22.6150	25.2381	24.4060	24.0790
100002	1.3511	1.0061	22.5982	22.1269	25.3389	23.3729
100004	0.9314	0.8613	15.6306	16.2637	16.5974	16.2012
100006	1.6100	0.9446	23.3745	26.2372	26.2258	25.3340
100007	1.6285	0.9446	24.3305	25.4333	26.5612	25.5135
100008	1.6365	0.9757	22.7706	25.7377	27.4314	25.4374
100009	1.4157	0.9757	24.7811	24.4666	25.9381	25.0983
100010	***	*	25.5614	26.9486	*	26.2759

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
100012	1.6376	0.9333	24.2602	24.5762	26.3798	25.1067
100014	1.2930	0.9307	21.7566	22.3054	24.5862	22.8508
100015	1.3050	0.9292	22.1272	22.5781	24.6038	23.0946
100017	1.5188	0.9307	21.1905	22.9545	26.1580	23.5300
100018	1.6120	1.0115	24.1885	27.8582	28.1191	26.7581
100019	1.6412	0.9826	24.2888	25.5566	27.5435	25.8847
100020	1.3242	0.9757	23.5303	23.6106	23.8785	23.6811
100022	1.7131	1.0508	27.9072	29.0519	29.9345	29.0212
100023	1.4290	0.9446	21.8111	21.4015	23.0074	22.0889
100024	1.2486	0.9757	24.4070	27.6476	30.2395	27.3189
100025	1.6929	0.8613	21.2568	21.1174	22.1580	21.5429
100026	1.6114	0.8613	20.1602	21.3533	21.3651	20.9595
100027	1.2106	0.8613	23.8982	12.0314	16.1223	16.3797
100028	1.2795	0.9826	21.8879	23.7818	26.8661	24.1693
100029	1.1347	0.9757	24.6814	26.9307	27.5844	26.4439
100030	1.2887	0.9446	21.8567	22.4887	24.0943	22.9211
100032	1.6962	0.9292	21.6415	23.0174	25.2033	23.3437
100034	1.8227	0.9757	23.1111	24.4064	25.9415	24.5360
100035	1.5678	0.9554	22.6349	25.3590	26.9407	24.9239
100038	1.8717	1.0508	25.7948	27.4422	29.8583	27.7714
100039	1.3916	1.0508	23.8060	26.6016	28.4627	26.3398
100040	1.6805	0.9303	22.4679	23.5372	23.6443	23.2382
100043	1.2649	0.9292	21.7738	22.8963	25.2273	23.3549
100044	1.4156	1.0162	23.9952	26.3208	28.3596	26.2570
100045	1.3130	0.9446	25.2285	23.0520	26.9641	25.0756
100046	1.2283	0.9292	24.2746	26.6169	26.3673	25.8723
100047	1.6670	0.9274	24.3522	24.4212	25.0404	24.6186
100048	0.9388	0.8613	17.5533	18.3767	18.8771	18.2575
100049	1.1939	0.8934	21.8679	22.9532	22.9810	22.6230
100050	1.1699	0.9757	20.0405	20.6893	19.8713	20.2035
100051	1.3249	0.9446	20.0231	22.3311	23.2764	22.0397
100052	1.3546	0.8934	20.5916	20.9078	22.3920	21.3174
100053	1.2271	0.9757	23.7837	27.3383	27.3224	26.2170
100054	1.1950	0.8877	22.0352	25.7279	28.0512	25.3241
100055	1.3505	0.9292	19.6350	22.1051	23.5332	21.7040
100056	***	*	25.9245	25.7945	*	25.8574
100057	1.4813	0.9446	24.6417	22.6038	25.3897	24.1823
100061	1.5361	0.9757	26.1273	26.7673	29.2565	27.4077
100062	1.7092	0.8955	24.9807	24.1413	25.2340	24.7789
100063	1.2093	0.9292	21.5620	21.5566	24.7026	22.5862
100067	1.4142	0.9292	23.8892	23.9333	25.4597	24.4499
100068	1.7170	0.9307	23.7840	24.9025	25.9202	25.2289
100069	1.3251	0.9292	19.6037	22.4386	24.3111	22.1685
100070	1.6333	0.9554	23.5524	23.7746	24.9751	24.0912
100071	1.2241	0.9292	21.7675	23.4176	24.9682	23.4234
100072	1.3679	0.9307	23.5362	24.2934	26.0379	24.6995
100073	1.6820	1.0508	23.5843	25.3685	30.3358	26.4443
100075	1.4565	0.9292	22.3890	23.3503	25.1691	23.6907
100076	1.2340	0.9757	19.6444	21.0777	21.9483	20.8673
100077	1.4278	0.9274	22.3755	24.3478	26.0347	24.2410
100080	1.7259	1.0061	22.8704	26.3596	27.0126	25.4415
100081	1.0413	0.8672	16.8087	16.9168	15.6662	16.4022
100084	1.7911	0.9446	24.1122	25.4140	26.3475	25.2653
100086	1.2082	1.0508	25.2375	26.4817	28.2641	26.6950
100087	1.8721	0.9554	26.5915	25.9909	26.4999	26.3569
100088	1.6620	0.9303	23.6270	24.8729	25.9182	24.8465
100090	1.4618	0.9303	22.5894	24.0501	24.2422	23.6608
100092	1.5036	0.9826	25.4630	26.0856	28.4789	26.7319
100093	1.6987	0.8613	20.2949	21.1547	21.3524	20.9431
100098	1.0859	0.8613	20.0639	21.2505	*	20.6613
100099	1.0146	0.8934	18.5287	20.4328	21.3036	20.1035
100102	1.0412	0.8613	21.6772	22.8850	23.8596	22.8413
100103	0.9567	0.8613	20.3633	21.7494	22.9256	21.7001
100105	1.3654	0.9458	24.5464	24.9503	26.8091	25.4381
100106	0.9426	0.8613	20.3417	20.2882	24.0389	21.6406
100107	1.1491	0.9333	23.3789	24.4484	26.1337	24.6951
100108	0.7656	0.8613	14.8039	16.3757	22.0750	17.7359

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
100109	1.2500	0.9446	23.0779	23.8836	24.9951	24.0208
100110	1.5138	0.9446	24.4533	28.3699	29.1494	27.5406
100113	1.9521	0.9461	24.3614	25.0067	26.6479	25.3817
100114	1.3471	0.9757	25.3699	27.7413	29.2195	27.4364
100117	1.1856	0.9303	23.9134	26.0451	26.4536	25.5634
100118	1.3280	0.9303	24.1104	23.6669	28.0569	25.5448
100121	1.0708	0.8934	23.1100	24.0937	24.8579	24.0497
100122	1.2187	0.8877	24.1820	21.2597	23.4751	22.8811
100124	1.1623	0.8613	24.3048	21.6483	22.7023	22.7933
100125	1.1807	0.9757	22.4185	25.3532	26.7452	24.9756
100126	1.4012	0.9292	21.7977	23.2996	24.0192	23.0655
100127	1.6390	0.9292	21.0153	21.3223	23.8920	22.0931
100128	2.1468	0.9292	24.4104	25.6763	29.4979	26.6451
100130	1.1903	1.0061	20.2478	22.8324	24.2046	22.4252
100131	1.2656	0.9757	25.4811	25.8316	29.2462	26.9103
100132	1.2174	0.9292	21.1538	23.0428	24.3293	22.8670
100134	0.9426	0.8613	18.3391	19.5337	20.9244	19.6271
100135	1.5934	0.8712	20.4915	22.3071	24.0024	22.2526
100137	1.1612	0.8934	20.4007	23.3692	25.1974	23.1447
100139	0.8526	0.9461	18.2204	14.5046	17.5489	16.8211
100140	1.1665	0.9303	22.5124	24.8165	26.4720	24.7189
100142	1.2175	0.8613	20.0689	20.7219	22.9577	21.2432
100147	***	0.8613	17.1045	*	*	17.1045
100151	1.7655	0.9303	26.6470	26.1848	28.1322	27.0891
100154	1.5497	0.9757	23.0820	26.3703	27.6127	25.8181
100156	1.1022	0.8613	20.6928	22.2757	26.7092	23.2451
100157	1.5782	0.9292	23.1045	25.9133	27.3851	25.4671
100160	1.1887	0.8613	23.4877	27.2019	26.9851	25.9544
100161	1.5792	0.9446	24.6268	28.3607	28.8077	27.4143
100162	***	*	23.8001	*	*	23.8001
100167	1.2864	1.0508	26.4517	26.8584	30.3694	27.8827
100168	1.3732	1.0061	24.6276	26.0864	27.1292	25.9577
100169	***	*	23.4575	*	*	23.4575
100173	1.7343	0.9292	19.7190	22.4866	24.5390	22.2987
100175	0.9876	0.8613	21.0474	22.0666	23.5455	22.2224
100176	1.8792	1.0162	26.8740	29.8326	31.2694	29.3692
100177	1.3177	0.9826	24.5078	25.3973	26.6781	25.6089
100179	1.7603	0.9303	24.1801	26.6537	29.5619	26.9037
100180	1.3719	0.9292	24.9433	26.3299	27.1804	26.1924
100181	1.0880	0.9757	18.1320	19.5022	21.8540	19.8108
100183	1.1753	0.9757	24.4575	26.7893	27.4951	26.3276
100187	1.2686	0.9757	23.4760	26.1394	27.3653	25.7401
100189	1.3096	1.0508	26.6846	26.5763	28.4136	27.3048
100191	1.3075	0.9292	24.1911	24.3553	26.6340	25.0785
100200	1.3785	1.0508	24.8120	28.0926	29.8963	27.6635
100204	1.5254	0.9461	22.2613	24.4697	25.7537	24.2423
100206	1.2968	0.9292	22.8782	23.0340	25.2196	23.7228
100208	***	*	24.1482	24.9854	*	24.5807
100209	1.3575	0.9757	23.8502	25.0778	26.6246	25.2683
100210	1.5359	1.0508	26.0933	28.6449	28.9486	27.9114
100211	1.1787	0.9292	24.3243	*	24.7095	24.5352
100212	1.4636	0.8955	22.6584	24.2669	24.7566	23.9351
100213	1.5843	0.9554	24.4467	25.1893	27.1983	25.6153
100217	1.1771	1.0162	24.0291	25.2635	25.2907	24.8791
100220	1.6524	0.9333	24.9733	25.0154	26.0905	25.3692
100223	1.5843	0.8877	21.2434	23.4556	24.7015	23.2004
100224	1.2340	1.0508	23.0804	23.3593	24.8077	23.7932
100225	1.2707	1.0508	23.9971	27.9473	28.4316	26.8326
100226	1.2697	0.9303	23.8701	27.8003	29.3317	27.1288
100228	1.3187	1.0508	26.2593	27.2873	29.8952	28.0013
100229	***	*	21.0038	*	*	21.0038
100231	1.6878	0.8613	23.5418	24.6994	25.5175	24.6455
100232 [h]	1.2214	0.9303	21.8105	23.9405	24.9322	23.5285
100234	1.3110	1.0061	24.9141	25.2574	26.3601	25.5144
100236	1.3623	0.9274	23.9781	25.9282	26.6585	25.5663
100237	1.9568	1.0508	26.7664	25.6112	31.3543	27.7849
100238	1.5077	0.9292	24.6513	27.1748	28.4302	26.8154

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
100239	1.2789	0.9554	25.0509	26.9668	27.7592	26.6605
100240	0.9534	0.9757	23.0650	23.4830	25.3265	24.0024
100242	1.3586	0.8613	20.4681	21.5130	24.0990	22.0856
100243	1.5324	0.9292	23.2812	25.2987	26.1131	24.9766
100244	1.3330	0.9333	23.4876	24.1515	25.2584	24.3502
100246	1.6049	1.0162	26.7630	27.6382	28.9894	27.8151
100248	1.4986	0.9292	23.8742	25.9170	27.7797	25.9263
100249	1.2539	0.8955	21.3942	23.4021	23.2084	22.6697
100252	1.1974	1.0162	22.6475	24.9860	25.8540	24.5257
100253	1.3797	1.0061	23.6939	24.4051	25.7121	24.6472
100254	1.5814	0.8712	23.2794	25.0192	25.7338	24.6995
100255	1.1947	0.9292	22.9793	22.2341	24.1169	23.1055
100256	1.9673	0.9292	24.1969	26.0629	28.8856	26.4333
100258	1.4847	1.0061	24.5699	31.8772	31.2482	29.0443
100259	1.2244	0.9292	24.1148	24.9404	26.0175	25.0705
100260	1.3413	1.0162	23.5164	25.2630	27.5188	25.5518
100262	***	*	23.8006	26.3954	*	25.1412
100264	1.2531	0.9292	22.4800	25.0250	25.5489	24.4115
100265	1.2774	0.9292	21.0688	23.4758	23.6151	22.8276
100266	1.4031	0.8613	21.5258	22.6614	23.2340	22.5196
100267	1.2776	0.9554	23.3760	26.5059	27.3768	25.7444
100268	1.1529	1.0061	26.0297	29.8289	29.2898	28.4053
100269	1.3034	1.0061	24.9002	25.3228	26.7450	25.7303
100275	1.2616	1.0061	23.1419	24.3059	26.0361	24.5544
100276	1.2369	1.0508	25.4557	27.2589	30.0576	27.6322
100277	1.3339	0.9757	25.2985	47.3905	16.5427	24.0477
100279	1.2334	0.9333	24.8484	25.4909	26.8606	25.7747
100281	1.2641	1.0508	25.3382	27.0864	28.6660	27.1929
100284	1.0813	0.9757	22.3046	22.5927	23.8170	22.9628
100286	1.5579	1.0115	*	27.1051	29.4284	28.3288
100287	1.3676	1.0061	*	28.2229	28.3427	28.2858
100288	1.5140	1.0061	*	37.4785	33.8141	35.4781
100289	1.7415	1.0508	*	28.4504	29.2915	28.8970
100290	1.1280	0.8613	*	*	23.5080	23.5080
100292	1.2103	0.8672	*	*	25.9093	25.9093
110001	1.2172	0.9637	24.0561	25.1164	25.2695	24.8146
110002	1.2471	0.9637	20.4502	21.8616	25.3897	22.5380
110003	1.2762	0.9303	19.7061	20.0968	21.4002	20.4029
110004	1.2242	0.9099	21.8791	22.7929	23.9911	22.8563
110005	1.1543	0.9637	23.6146	22.3645	22.8082	22.9077
110006	1.4983	0.9813	23.8762	25.0719	28.6090	25.8225
110007	1.5952	0.8645	28.2025	30.7430	23.8785	27.0990
110008	1.3541	0.9637	22.6308	23.4662	27.0198	24.4256
110010	2.1112	0.9637	27.2029	28.7690	29.7142	28.5850
110011	1.1841	0.9637	23.2149	25.4620	26.0899	24.9213
110015	1.1253	0.9637	23.2280	25.5661	26.6610	25.2080
110016	1.1938	0.7684	18.8228	18.8376	21.7610	19.7802
110018	1.1764	0.9637	24.7007	25.6485	28.2431	26.2640
110020	1.2808	0.9637	23.3004	24.8735	26.8501	25.0177
110023	1.3725	0.9637	23.5673	25.3746	27.3029	25.5307
110024	1.3712	0.9483	22.1471	23.8091	25.7205	23.8901
110025	1.4319	0.9303	29.0965	31.5253	26.1311	28.6493
110026	1.1005	0.7684	19.3201	20.5740	21.2826	20.4005
110027	1.0627	0.7684	19.8351	19.2323	20.2175	19.7328
110028	1.7504	0.9567	25.9474	25.1836	27.9184	26.3393
110029	1.6515	0.9637	22.7981	25.2335	24.8893	24.3542
110030	1.1953	0.9637	22.2341	25.0842	26.4770	24.7162
110031	1.2600	0.9637	22.8695	24.1711	26.0384	24.4325
110032	1.1631	0.7684	18.0744	20.7211	21.9407	20.2437
110033	1.3973	0.9637	24.1447	25.2326	28.3210	25.8930
110034	1.6993	0.9567	24.0791	24.4141	27.0099	25.1876
110035	1.4949	0.9637	24.2581	25.7562	27.5532	25.9518
110036	1.7799	0.9483	24.4788	25.4854	26.8789	25.6507
110038	1.5400	0.8420	20.1710	20.5880	21.2138	20.6802
110039	1.4119	0.9567	17.0608	19.4032	19.7892	18.7582
110040	1.1097	0.9637	17.3095	18.8744	19.7509	18.6568
110041	1.2580	0.9684	20.8080	21.5402	23.4074	21.9417

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
110042	1.0979	0.9637	25.5588	26.8321	23.4645	25.2397
110043	1.7289	0.9483	22.7589	25.2788	26.7522	24.9357
110044	1.1609	0.7684	19.2562	19.6940	20.9654	19.9819
110045	1.1384	0.9637	19.7746	21.3922	24.9821	22.1119
110046	1.1501	0.9637	21.6201	24.0022	23.8292	23.2190
110049	0.9635	0.7684	18.9096	19.8706	*	19.4074
110050	1.0937	0.9033	*	25.6020	*	25.6020
110051	1.1347	0.7684	17.6816	19.0995	19.4276	18.7634
110054	1.4875	0.9637	20.5387	22.2250	25.7085	22.7254
110056	0.9430	0.7684	21.7608	23.0080	*	22.3710
110059	1.0697	0.7684	19.9802	18.7097	20.5565	19.6943
110061	***	0.8873	18.6696	*	*	18.6696
110064	1.4700	0.8570	21.7636	23.8739	24.2739	23.3486
110069	1.2734	0.9087	21.0518	22.3006	24.1669	22.5324
110071	0.9739	0.7684	15.2336	13.3731	18.0224	15.4555
110073	1.0759	0.7684	15.2711	16.3610	18.6336	16.6863
110074	1.4999	0.9813	24.4094	27.5836	27.0337	26.3402
110075	1.2670	0.9316	20.4634	20.9973	22.0935	21.2149
110076	1.4563	0.9637	23.8211	25.2424	26.3506	25.1774
110078	2.0424	0.9637	28.2149	27.8627	24.8746	26.9445
110079	1.3966	0.9637	22.8017	24.5255	23.1024	23.4646
110080	1.2439	0.9637	24.1958	21.5482	22.3213	22.5788
110082	1.9154	0.9637	27.2931	28.9731	29.8366	28.7072
110083	1.9070	0.9637	24.6460	26.2604	27.8245	26.3029
110086	1.3847	0.7684	18.8751	20.8557	21.1509	20.2673
110087	1.4065	0.9637	25.7908	26.2872	28.0471	26.7332
110089	1.1502	0.7684	20.6757	21.2013	21.9509	21.2887
110091	1.2996	0.9637	24.3354	26.3857	26.5523	25.8218
110092	1.0125	0.7684	16.9116	18.7397	18.5527	18.0853
110095	1.3953	0.8710	20.1024	21.8709	23.4846	21.8636
110096	0.9779	0.7684	18.5513	19.4498	*	19.0000
110100	0.9643	0.7684	15.1316	16.5833	16.5600	16.0845
110101	1.0706	0.7684	13.3943	14.4630	16.4270	14.7428
110104	1.0494	0.7684	17.9805	19.5575	18.7951	18.8040
110105	1.3229	0.7684	19.2156	20.6270	21.1077	20.3365
110107	1.8630	0.9485	21.8167	26.0763	26.2526	24.6977
110109	1.0104	0.7684	18.7397	20.4726	21.4280	20.2690
110111	1.1313	0.9567	20.9535	20.5577	29.2190	22.9282
110112	0.9374	0.7684	20.4565	21.0612	24.2463	21.7104
110113	1.0686	0.9567	18.0770	16.7641	19.1753	18.0155
110115	1.6816	0.9637	26.3274	29.8699	32.0197	29.3454
110118	***	0.7684	17.7344	*	*	17.7344
110121	1.0384	0.7684	19.5230	21.2534	21.6637	20.8173
110122	1.5295	0.8420	20.4184	22.0210	23.7589	22.1314
110124	1.0742	0.7684	19.7004	20.9334	22.7058	21.1178
110125	1.2373	0.9087	19.8695	22.1458	22.4238	21.5044
110128	1.2076	0.9316	28.4943	23.2576	24.4596	24.9779
110129	1.5230	0.8570	21.8204	22.4202	23.3631	22.5595
110130	0.9412	0.7684	17.5272	17.6529	18.7549	18.0115
110132	1.0349	0.7684	17.2924	18.9927	19.2307	18.5224
110135	1.2847	0.7684	18.5125	20.0057	20.4411	19.6750
110136	1.0675	0.7684	21.1235	22.7715	15.3030	19.7964
110142	0.9587	0.7684	16.3359	17.3328	18.1980	17.2921
110143	1.3701	0.9637	24.3898	25.4932	24.2240	24.6996
110146	1.0472	0.7684	17.2250	19.9221	23.9067	20.1122
110149	1.3335	0.9637	25.3619	24.7686	27.1477	25.8232
110150	1.2656	0.9087	22.7366	23.8157	22.6624	23.0726
110153	1.1467	0.9087	21.5300	22.8660	24.5368	22.9872
110155	***	*	16.1785	*	*	16.1785
110163	1.4114	0.8645	21.9411	25.5461	26.0764	24.4314
110164	1.5149	0.9485	23.7801	26.4450	27.0600	25.7931
110165	1.3808	0.9637	23.4071	24.3897	26.8378	24.9170
110166	***	0.9485	23.6665	25.2264	26.8070	25.1758
110168	1.8280	0.9637	23.3426	24.6321	27.0022	25.0628
110169	***	*	24.7083	*	*	24.7083
110172	1.1832	0.9637	25.2396	27.0240	29.1703	27.1002
110177	1.6699	0.9567	24.0700	25.0129	26.7504	25.3590

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
110179	***	*	26.0365	26.1173	26.0759	26.0760
110183	1.2345	0.9637	26.4248	27.6020	26.8591	26.9602
110184	1.2007	0.9637	24.3379	25.5420	23.3803	24.3763
110186	1.3771	0.8570	21.1176	23.2348	25.0299	23.1796
110187	1.2237	0.9637	23.2571	22.5730	24.2933	23.3967
110188	***	*	24.4785	*	*	24.4785
110190	1.0046	0.7684	21.9008	19.1054	14.2517	17.7557
110191	1.2930	0.9637	24.0572	25.8409	26.8277	25.5872
110192	1.3222	0.9637	24.3823	25.7406	26.7852	25.7103
110193	1.4229	0.9637	25.1779	27.8223	27.3341	26.8213
110194	0.9346	0.7684	16.8075	16.3148	18.4776	17.2529
110198	1.3834	0.9637	28.0634	30.8014	31.7748	30.3084
110200	1.8830	0.8570	20.1816	21.2177	22.3249	21.2486
110201	1.3894	0.9485	24.1171	27.0388	28.2232	26.3653
110203	0.9912	0.9637	30.2609	25.8951	26.8768	27.4232
110205	1.0674	0.9637	23.1969	20.6150	19.7409	21.0203
110209	0.5352	0.7684	17.4145	19.1000	19.0450	18.5793
110212	1.0406	0.8873	18.7651	20.9365	40.5120	27.9394
110215	1.2618	0.9637	22.5679	23.9657	25.7886	24.2458
110218	***	*	*	26.1073	*	26.1073
110219	1.3845	0.9637	*	27.1880	27.0362	27.1115
120001	1.7853	1.1206	30.0871	31.7108	34.6602	32.1463
120002	1.2134	1.0598	24.2715	26.9900	29.9913	27.2572
120004	1.2673	1.1206	26.8010	28.3569	28.6527	27.9367
120005	1.2757	1.0598	23.0113	26.9053	29.3405	26.3828
120006	1.2232	1.1206	28.1562	29.6751	31.1372	29.6846
120007	1.6776	1.1206	27.8497	28.7964	30.4247	29.0434
120010	1.6785	1.1206	25.4050	27.1265	30.1659	27.2823
120011	1.4508	1.1206	30.9308	31.7447	34.1643	32.3199
120014	1.2099	1.0598	25.3682	28.0786	28.6416	27.3772
120016	1.6705	*	39.1173	52.1034	19.6034	33.6763
120019	1.2043	1.0598	24.4036	28.9661	30.3809	27.8836
120022	1.8525	1.1206	22.4951	24.7875	26.6100	24.7024
120025	***	1.0598	40.2473	48.7148	30.2358	39.7283
120026	1.2887	1.1206	26.3653	28.5048	30.3293	28.4200
120027	1.2295	1.1206	24.9464	26.4630	28.4378	26.4965
120028	1.2577	1.1206	29.5070	31.3195	30.3794	30.4272
130002	1.3569	0.9048	20.1143	21.6626	23.6078	21.8876
130003	1.3696	1.0061	23.9403	25.4904	27.6345	25.7287
130005	***	*	24.4844	25.2550	25.7523	25.1326
130006	1.7884	0.9048	22.8567	24.3982	25.3221	24.2894
130007	1.7321	0.9048	22.8475	24.8764	24.9562	24.2827
130011	1.2145	0.8810	23.1120	22.9336	*	23.0196
130013	1.2894	0.9048	23.5316	26.3118	27.9209	25.9669
130014	1.1794	0.9048	21.6495	23.4789	24.3884	23.2115
130018	1.5937	0.8810	22.2249	23.9798	26.4125	24.2860
130021	***	0.8810	18.0006	18.9400	16.1658	17.7607
130022	1.1803	0.8810	21.5602	*	*	21.5602
130025	1.1842	0.8810	18.7814	19.7066	20.1452	19.5513
130026	1.1103	0.8810	24.4976	25.4020	*	24.9502
130028	1.3641	0.9348	21.1492	25.2938	26.3443	24.2492
130036	***	*	18.5921	16.7907	*	17.6689
130045	***	0.9183	19.0270	*	*	19.0270
130060	***	*	24.6773	26.7516	*	25.7861
130062	***	0.9409	24.0494	16.7951	20.6642	20.3051
130063	1.4243	0.9048	18.8782	20.9502	22.5904	20.7967
140001	1.0825	0.8285	20.0247	21.4779	22.3170	21.3141
140002	1.2711	0.8953	23.0207	24.4908	24.6954	24.0687
140003	1.0209	0.8285	19.2097	22.6230	*	20.9305
140005	***	0.8285	13.2365	*	*	13.2365
140008	1.4951	1.0846	26.3287	27.2211	28.5297	27.3790
140010	1.4434	1.0846	29.0224	31.5774	36.6365	32.6197
140011	1.1508	0.8285	19.0903	20.6338	22.4091	20.7429
140012	1.2283	1.0698	24.4070	24.3675	28.6564	25.7920
140013	1.4165	0.8844	19.9800	22.6022	23.3065	21.9604
140015	1.3843	0.8953	21.4328	22.2266	23.0600	22.2778
140016	1.0074	0.8285	16.3417	17.1372	18.1242	17.2195

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
140018	1.4161	1.0846	24.3285	27.3334	27.7548	26.4350
140019	0.9635	0.8285	17.4206	18.4554	18.9228	18.2432
140024	0.9981	0.8285	15.6616	16.9672	17.5249	16.7192
140026	1.1611	0.8285	20.4084	21.6847	23.0470	21.6994
140027	1.1589	0.8285	20.9855	22.6208	*	21.8225
140029	1.5505	1.0846	25.0485	27.7304	28.9717	27.3787
140030	1.6859	1.0846	26.5733	28.7623	29.3100	28.2629
140032	1.1817	0.8953	20.6273	22.8157	24.0574	22.5257
140033	1.2115	1.0444	23.4279	26.1553	25.6068	25.0497
140034	1.2308	0.8953	20.9635	22.1003	23.0034	21.9987
140037	0.8583	0.8285	15.5578	*	*	15.5578
140043	1.2327	0.9667	23.3751	26.0330	26.7996	25.3939
140045	1.0328	0.8285	18.9587	21.0042	20.6548	20.2345
140046	1.4582	0.8953	21.7969	22.5022	23.2127	22.5567
140048	1.2496	1.0846	25.9122	27.0874	28.2222	27.0819
140049	1.5568	1.0846	21.9546	26.6533	27.4009	25.3465
140051	1.5044	1.0846	24.2472	27.9935	27.7901	26.6740
140052	1.1992	0.8953	21.8161	22.2588	23.5662	22.5560
140053	1.8567	0.8879	22.6099	23.5477	24.8455	23.6468
140054	1.4302	1.0846	35.5659	31.7265	31.8564	32.8769
140058	1.2547	0.8953	20.5089	22.1269	22.8423	21.8133
140059	1.0783	0.8953	19.9777	22.7121	22.4651	21.7552
140061	0.9751	0.8953	22.7515	30.9925	20.8063	24.6734
140062	1.2085	1.0846	30.7005	31.2359	34.7113	32.2167
140063	1.3649	1.0846	30.5430	26.5584	27.8306	28.2367
140064	1.1568	0.8844	20.6505	21.7470	22.0407	21.4911
140065	1.3774	1.0846	26.3521	26.1904	34.6406	28.8914
140066	1.1153	0.8953	18.0915	20.4353	19.4775	19.2927
140067	1.8344	0.8844	21.9579	23.5906	25.3986	23.6801
140068	1.1769	1.0846	24.1316	25.8963	27.3956	25.8156
140070	***	*	25.2960	*	*	25.2960
140077	0.9555	0.8953	18.0487	19.0922	19.1363	18.7657
140079	***	*	25.7090	29.3040	*	27.5634
140080	1.4264	1.0846	24.4056	26.0109	23.2575	24.4826
140082	1.3940	1.0846	25.0474	26.8077	25.6645	25.8332
140083	1.0155	1.0846	23.2822	24.6491	26.5562	24.8886
140084	1.1998	1.0444	25.4818	27.6819	29.2515	27.5306
140088	1.8091	1.0846	28.4219	31.0364	32.4978	30.6729
140089	1.1918	0.8285	20.7632	22.1227	23.3401	22.0452
140090	***	*	35.0300	*	*	35.0300
140093	1.1539	0.9048	21.5376	22.1540	25.3127	22.9099
140094	1.0354	1.0846	24.2166	25.3678	27.0578	25.5410
140095	1.2149	1.0846	24.7706	29.9746	27.6799	27.5947
140100	1.2204	1.0444	27.1868	32.8743	37.0819	32.5610
140101	1.1371	1.0846	24.6106	25.4784	28.5365	26.3107
140102	1.0407	0.8285	19.8678	21.2278	*	20.5493
140103	1.2439	1.0846	21.2404	21.7512	23.3258	22.1297
140105	1.2336	1.0846	27.3323	26.3054	27.4531	27.0018
140109	1.1423	0.8285	16.4261	17.8103	19.5675	17.9602
140110	1.0533	1.0698	21.9880	25.6561	27.9844	25.2166
140113	1.5519	0.9591	25.6621	23.5337	26.7969	25.2477
140114	1.4645	1.0846	24.1926	25.7968	28.3014	26.1695
140115	1.1252	1.0846	25.3410	26.3677	25.1498	25.6313
140116	1.2744	1.0846	26.8924	30.5166	31.9902	29.9696
140117	1.5049	1.0846	23.3531	25.6314	26.8973	25.3122
140118	1.6963	1.0846	26.7350	27.7392	29.7570	28.1023
140119	1.7432	1.0846	31.3486	33.6302	36.1419	33.6518
140120	1.2478	0.8844	20.3237	22.5795	22.7375	21.8812
140121	1.6002	0.8844	17.6019	*	*	17.6019
140124	1.2606	1.0846	30.9648	35.2798	36.1327	34.0784
140125	1.2180	0.8953	19.5359	20.7189	20.4014	20.2151
140127	1.5733	0.9083	21.3102	22.8172	24.1658	22.7988
140129	***	0.8285	21.6495	*	*	21.6495
140132	***	*	23.0595	*	*	23.0595
140135	1.3954	0.8285	19.7919	21.2104	22.3264	21.1811
140137	1.0383	0.8953	21.6017	20.5053	21.4700	21.1955
140140	1.0049	0.8285	19.1636	21.4710	*	20.3063

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
140141	1.0111	0.8953	20.3706	23.0515	21.7871	21.7302
140143	1.1472	0.8844	22.0009	23.8255	26.2954	24.0154
140144	0.9464	1.0846	26.9258	27.8046	*	27.3474
140145	1.1245	0.8953	19.6429	21.6168	23.4608	21.6090
140147	1.1208	0.8285	18.2692	19.5896	19.8541	19.2467
140148	1.7042	0.8879	21.5777	23.0022	25.2030	23.2104
140150	1.5763	1.0846	32.9291	33.9013	35.2711	34.0702
140151	0.8471	1.0846	21.5167	22.4842	23.4879	22.5018
140152	1.1463	1.0846	28.5468	29.6882	27.6086	28.6011
140155 [2]	1.2537	1.0991	25.2034	27.6610	28.9724	27.2937
140158	1.3922	1.0846	22.5638	23.8542	28.6818	24.8001
140160	1.2262	0.9667	20.9986	22.7002	24.5373	22.7502
140161	1.1181	1.0698	22.2191	24.1071	23.1647	23.1691
140162	1.5842	0.9083	22.6426	26.0312	27.4472	25.4182
140164	1.7335	0.8953	19.7774	22.0424	23.7457	21.8696
140165	1.0648	0.8285	17.0666	15.9312	16.6304	16.5175
140166	1.1685	0.8285	20.7849	21.7776	23.1005	21.8859
140167	1.0308	0.8285	19.5959	19.7610	22.8911	20.7477
140168	1.1558	0.8953	18.7504	20.0225	*	19.4021
140170	0.9276	0.8285	17.0665	17.1608	*	17.1147
140171	***	0.8285	17.3214	*	*	17.3214
140174	1.4550	1.0846	23.6893	24.7011	27.8131	25.3970
140176	1.2096	1.0846	25.6824	28.9378	31.3490	28.8390
140177	0.8782	1.0846	20.8526	19.3328	22.5610	20.9656
140179	1.3651	1.0846	24.1539	26.3200	27.6376	26.0525
140180	1.2658	1.0846	25.4022	27.4366	28.3649	27.0717
140181	1.1677	1.0846	23.7308	23.6034	25.0100	24.1182
140182	1.4864	1.0846	32.1969	28.0337	28.2211	28.8901
140184	1.2150	0.8285	20.6499	20.1279	21.1802	20.6885
140185	1.4160	0.8953	20.0903	22.0222	23.8531	22.0093
140186 [2]	1.4842	1.0991	26.0970	28.1977	31.7593	28.8521
140187	1.4808	0.8953	20.5829	22.0674	23.2892	21.9710
140189	1.1406	0.9335	22.5875	25.6954	23.7198	24.0159
140190	1.0678	0.8285	17.9193	18.8530	19.8297	18.8585
140191	1.3038	1.0846	24.5446	25.2817	25.8813	25.2456
140193	0.9615	0.8285	20.5958	22.9443	*	21.7731
140197	1.2361	1.0846	19.2980	21.8060	23.0684	21.2577
140199	1.0379	0.8285	19.7888	21.3464	22.0315	21.0597
140200	1.4887	1.0846	24.1358	24.9217	26.6881	25.2459
140202	1.5458	1.0444	26.2460	27.4336	29.7870	27.9702
140203	1.0810	1.0846	26.5789	28.2212	*	27.4338
140205	0.5846	0.9975	25.1010	*	*	25.1010
140207	1.3693	1.0846	23.3197	25.7331	24.1048	24.4812
140208	1.6342	1.0846	27.4671	27.6586	29.4708	28.2131
140209	1.5435	0.8844	22.0813	23.3886	24.4266	23.3169
140210	1.0967	0.8285	15.5339	16.6729	19.2639	17.1406
140211	1.3023	1.0846	25.8556	29.5114	29.7054	28.4947
140213	1.1645	1.0846	27.4607	29.1649	30.2945	29.0178
140215	***	*	18.6962	22.3097	*	20.4262
140217	1.4239	1.0846	24.7146	29.3711	31.5324	28.5274
140223	1.4296	1.0846	27.4355	29.2540	30.4923	29.0769
140224	1.3921	1.0846	27.1725	29.0350	28.2177	28.1560
140228	1.5304	0.9975	22.9899	25.0074	25.6419	24.5738
140231	1.4741	1.0846	25.5536	28.3545	30.6410	28.2754
140233	1.5549	1.0698	24.7103	27.3379	28.6305	26.9841
140234	1.0501	0.8844	20.8676	23.2604	23.6928	22.6766
140239	1.5495	0.9975	23.9205	24.2112	29.0092	25.6976
140240	1.3929	1.0846	25.0325	27.2654	31.8945	27.8715
140242	1.4842	1.0846	28.8686	30.4005	32.0522	30.5576
140245	0.9866	0.8285	15.2537	16.0772	*	15.6642
140246	***	0.8285	16.1305	*	*	16.1305
140251	1.2806	1.0846	24.8256	26.7266	27.1870	26.2433
140252	1.3977	1.0846	28.3479	30.2656	33.3885	30.8286
140258	1.5252	1.0846	27.5741	27.9478	30.2639	28.6430
140271	0.8733	0.8285	17.5174	18.8535	*	18.2163
140275	1.2740	0.8716	23.1871	25.2824	26.1473	24.8583
140276	1.7772	1.0846	25.3222	27.5936	29.1983	27.3299

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
140280	1.4521	0.8716	21.7004	21.9302	23.4343	22.3632
140281	1.6920	1.0846	27.9115	29.2602	30.4849	29.2420
140285	***	0.8879	*	17.7824	20.7576	19.1679
140286	1.1088	1.0846	25.5805	28.4378	29.1543	27.7906
140288	1.5237	1.0846	26.3572	26.9581	29.3988	27.5648
140289	1.3248	0.8953	20.7506	22.3274	22.6211	21.9308
140290	1.3237	1.0846	29.9098	28.6926	31.7341	30.1371
140291	1.2597	1.0698	27.6675	28.2338	29.8958	28.6610
140292	1.1534	1.0846	26.4077	26.1781	27.6230	26.7673
140294	1.1263	0.8285	21.7473	22.6123	23.4504	22.6034
140300	1.1599	1.0846	30.5172	33.3983	34.8568	32.8808
140301	1.1555	1.0846	*	*	31.7073	31.7073
150001	1.1532	0.9922	25.4897	27.1021	29.6844	27.4774
150002	1.3813	1.0698	22.3327	23.3804	25.0063	23.5866
150003	1.6528	0.8730	21.0944	23.3196	25.3458	23.2610
150004	1.5181	1.0698	23.6169	24.8884	26.8458	25.1066
150005	1.1975	0.9922	23.8818	25.4443	27.2369	25.6152
150006	1.2943	0.9785	23.1779	24.8976	26.4061	24.8616
150007	1.2960	0.9555	22.1098	23.5841	26.6073	24.2353
150008	1.4015	1.0698	23.8916	23.6953	26.6928	24.7814
150009	1.3653	0.9264	19.4763	20.4993	22.2147	20.7473
150010	1.3255	0.9555	22.5445	23.9740	26.8524	24.4792
150011	1.1602	0.9776	22.1559	23.2249	24.3490	23.2593
150012	1.5342	0.9785	23.1644	22.9314	27.3031	24.2924
150013	0.9799	0.8632	19.8564	19.7689	21.8465	20.4949
150014	1.2880	0.9922	24.3754	26.5785	*	25.4309
150015	1.3161	1.0698	23.1616	24.3015	26.2434	24.6064
150017	1.8224	0.9797	22.7979	23.7180	25.2342	23.9446
150018	1.6280	0.9616	24.6138	24.7048	26.3289	25.2344
150019	1.0534	0.8632	17.3170	*	*	17.3170
150021	1.7262	0.9797	24.3658	27.8168	29.6967	27.2581
150022	1.0471	0.8632	22.2973	22.8035	22.6773	22.6089
150023	1.5248	0.8632	20.6926	23.1253	23.7159	22.4697
150024	1.3936	0.9922	21.7593	24.7879	27.1589	24.7582
150026	1.2781	0.9616	23.2169	23.7185	28.1127	25.1166
150027	0.9951	0.9922	21.5766	21.2855	17.4862	19.9164
150029	1.4269	0.9785	25.2067	23.4103	26.9680	25.0754
150030	1.2034	0.9776	23.0196	24.4361	26.9533	24.8565
150031	1.0678	0.8632	18.9180	*	*	18.9180
150034	1.4639	0.9366	22.8812	23.9388	26.0465	24.3610
150035	1.4585	0.9366	23.5468	26.0952	26.6620	25.4702
150037	1.2877	0.9922	24.4997	27.7009	28.5451	26.8949
150038	1.0995	0.9922	21.6608	24.4188	28.8054	24.9650
150042	1.3907	0.8632	23.7838	21.9917	23.0102	22.8781
150044	1.3121	0.9264	20.5156	23.1200	23.7065	22.4683
150045 [h]	1.0499	0.9797	23.0361	24.2899	25.2225	24.2205
150046	1.4135	0.8632	20.3453	21.0417	21.9369	21.1254
150047	1.7002	0.9797	24.8786	24.5455	25.8349	25.1035
150048	1.3259	0.9604	22.5181	24.5864	27.1817	24.7509
150049	1.1169	0.8632	18.4942	20.2178	22.3370	20.2342
150051	1.5540	0.8632	21.4009	22.6866	23.7061	22.5941
150052 [h]	1.0320	0.9264	19.1070	19.6073	20.6339	19.7871
150056	1.8253	0.9922	24.7841	27.6754	28.2842	26.9368
150057	2.0135	0.9922	28.0884	22.7804	24.8605	24.9551
150058	1.5550	0.9785	24.9479	26.9753	27.5341	26.5322
150059	1.5671	0.9922	25.6738	27.0792	28.5715	27.1975
150060	1.0728	0.8632	19.8990	23.2409	24.8544	22.6276
150061	1.1040	0.8632	19.2826	21.3640	22.2822	20.9919
150062	1.1136	0.8632	22.9214	23.5550	24.6088	23.7293
150063	***	*	24.4091	19.0377	*	21.8339
150064	1.1597	0.8632	21.2512	21.6370	23.7707	22.2400
150065	1.2439	0.9776	23.0636	24.4451	25.9461	24.5094
150067	1.0162	0.8632	21.4374	*	*	21.4374
150070	0.9415	0.8632	20.7413	22.6260	*	21.7117
150072	1.1999	0.8632	18.5447	20.3191	20.5111	19.8274
150073	***	*	14.8287	*	*	14.8287
150075	1.0759	0.9797	20.1119	24.2085	24.0745	22.8038

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
150076	1.2278	0.9785	25.4519	24.1434	28.1874	25.9085
150078	0.9426	0.8632	20.1259	21.2476	21.9771	21.1303
150079	1.0871	0.9264	19.3860	20.6486	21.4067	20.5165
150082	1.7137	0.8735	21.0651	22.2054	25.5860	22.9776
150084	1.7636	0.9922	27.8354	28.7722	29.3905	28.6939
150086	1.2074	0.9604	21.5815	22.4471	23.9404	22.7151
150088	1.2662	0.9776	22.2627	23.0998	23.6253	23.0168
150089	1.4706	0.8952	21.6806	22.6545	25.0449	23.0977
150090	1.4690	1.0698	24.9021	24.6758	26.2899	25.3163
150091 [h]	1.0853	0.9797	26.4248	27.8087	30.6209	28.2762
150096	0.9741	0.8632	19.7975	21.9091	23.8092	21.8206
150097	1.0577	0.9922	22.4564	24.4179	25.0367	24.0346
150100	1.6892	0.8735	21.2980	22.2687	24.3530	22.6387
150101	1.0267	0.9797	26.1271	27.9745	29.1657	27.6430
150102	1.0711	0.9366	21.3313	22.6870	24.5923	22.8112
150104	1.0414	0.9922	21.0799	21.8172	25.5871	22.8454
150106 [h]	1.0517	0.9797	19.1976	20.9955	20.9387	20.4063
150109	1.3698	0.8730	23.4642	24.3786	23.5865	23.8124
150112	1.4147	0.9776	23.5151	24.7455	26.5643	24.9478
150113	1.1907	0.9776	21.2412	23.0450	24.8760	23.1460
150115	1.3246	0.8632	20.3863	20.5215	19.3411	20.0486
150122	1.1182	0.8632	22.2752	24.2471	26.0173	24.2508
150123	***	0.8735	15.5997	15.3050	*	15.4580
150124	1.1187	0.8632	17.9063	18.8218	21.3933	19.4269
150125	1.4937	1.0698	23.1464	24.3872	26.7666	24.8140
150126	1.4161	1.0698	24.1917	25.5585	26.9887	25.6255
150128	1.3711	0.9922	20.9869	23.1660	26.4976	23.5710
150129	1.1881	0.9922	34.3166	35.4311	29.9099	32.9368
150130	1.0196	0.8735	18.5578	21.5678	21.7399	20.5294
150132	1.3880	1.0698	22.2707	24.2559	25.6257	24.1021
150133	1.2457	0.9797	21.8807	21.8839	22.7293	22.1682
150134	1.0951	0.9264	20.7680	22.1085	23.8526	22.2228
150136	***	0.9922	25.8467	25.7004	26.2703	25.9403
150146	1.0119	0.9797	25.1827	26.1168	29.3383	26.7878
150147	1.1985	1.0698	*	32.3336	22.8456	26.0420
150148	***	*	26.2188	27.2081	*	26.7661
150149	0.9756	0.8735	*	23.8554	23.6361	23.7419
150150	1.2639	0.9797	*	26.5138	25.5331	26.0172
150151	***	*	*	*	38.1446	38.1446
150152	***	0.9922	*	*	44.7143	44.7143
160001	1.1965	0.9231	22.8426	23.8657	25.1220	23.9155
160002	***	0.8563	19.9607	*	*	19.9607
160005	1.1819	0.8563	20.3313	21.1745	21.8950	21.1337
160008	1.0624	0.8563	17.9463	19.8066	20.7200	19.4883
160013	1.2044	0.8563	21.0541	23.0163	23.7163	22.5118
160014	0.9866	0.8563	18.3097	19.2447	20.9256	19.5050
160016	1.5746	0.9413	21.8400	21.2785	23.3031	22.1576
160020	1.0649	0.8563	16.6092	19.0043	19.5752	18.4226
160024	1.5772	0.9650	22.4256	24.2385	26.2392	24.3248
160026	0.9843	0.9231	22.8967	24.2045	24.7424	23.9779
160028	1.3058	0.9555	25.1998	26.0052	26.2948	25.8671
160029	1.6068	0.9751	23.7268	24.9493	27.9277	25.5651
160030	1.2629	0.9546	23.3687	24.9920	26.7068	25.0247
160031	0.9566	0.8563	17.8994	18.5281	19.7585	18.7487
160032	1.0533	0.8563	20.5024	22.3837	23.4727	22.1329
160033	1.7259	0.8716	22.2660	23.4148	24.6768	23.4865
160034	0.9398	0.8563	19.0684	19.4837	19.3503	19.3060
160039	0.9260	0.8563	19.8851	20.9623	22.1629	21.0029
160040	1.2162	0.8564	20.0567	21.8187	23.9053	21.9454
160043	***	0.8563	15.5765	*	*	15.5765
160045	1.6924	0.8605	22.1285	24.4957	25.4153	24.0445
160047	1.3599	0.9555	22.1550	24.5000	25.2072	23.9813
160048	1.0546	0.8563	18.1174	19.5701	19.6431	19.1317
160050	1.1022	0.8563	21.6247	23.8830	24.5403	23.3364
160057	1.2499	0.9574	20.8345	22.0472	23.2913	22.0638
160058	1.8388	0.9751	23.5663	25.5244	27.1646	25.4595
160064	1.5830	0.8563	23.8367	27.6301	28.6139	26.8350

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
160066	1.0921	0.8563	20.4609	21.4631	22.7453	21.6034
160067	1.3469	0.8564	19.9422	21.9418	23.4060	21.8952
160069	1.4317	0.9116	21.7197	22.7514	25.8067	23.4426
160072	***	0.8563	15.8236	*	*	15.8236
160076	0.9917	0.8563	20.1603	20.9749	*	20.5825
160079	1.4983	0.8605	21.6562	22.5299	22.4291	22.2178
160080	1.3105	0.9667	21.1713	23.5721	23.0138	22.5698
160081	1.1704	0.8563	20.4415	21.3614	23.1930	21.6437
160082	1.7449	0.9650	21.6230	23.8181	26.2453	23.8567
160083	1.6465	0.9650	23.4670	25.0617	28.2193	25.6738
160089	1.2795	0.9413	19.9688	21.5693	22.6551	21.4092
160090	0.9949	0.8563	19.6767	21.2753	*	20.4851
160091	0.9514	0.8563	16.1660	18.0630	17.9255	17.3725
160092	0.9582	0.8563	20.4731	22.0841	*	21.2805
160093	***	0.8605	22.8553	*	*	22.8553
160104	1.3676	0.8716	23.2832	24.0075	24.9134	24.0516
160106	1.1242	0.8563	19.8905	21.4912	*	20.6919
160107	1.0394	0.8563	19.5111	21.3754	*	20.4402
160110	1.6369	0.8564	21.9299	24.1762	24.9434	23.7256
160112	1.2659	0.8563	20.4038	21.8901	23.0673	21.8008
160113	0.9601	0.8563	16.7574	18.6599	*	17.7162
160114	0.9804	0.8563	19.1743	*	*	19.1743
160116	1.0412	0.8563	19.6923	22.2019	*	20.9445
160117	1.2747	0.9116	22.3228	23.4250	25.0278	23.6002
160118	1.0219	0.8563	16.9466	18.3322	19.7764	18.4025
160122	1.0854	0.8563	21.2843	22.9565	22.5810	22.2832
160124	1.1255	0.8563	21.2279	22.7223	23.1690	22.3848
160126	1.0455	0.8563	20.0149	20.3748	19.6296	20.0068
160131	0.9332	0.8563	18.0486	*	*	18.0486
160143	1.0569	0.8563	19.0623	*	*	19.0623
160147	1.2103	0.9231	22.7993	26.6577	25.1228	24.8830
160153	1.5766	0.9360	23.5212	26.3671	28.9881	26.3386
170001	1.1572	0.8032	19.8149	20.9837	21.9131	20.9143
170006	1.2459	0.8458	19.4488	20.6460	21.9019	20.7240
170008	***	0.8032	18.2352	*	*	18.2352
170010	1.2414	0.8313	20.6294	21.2131	24.0008	21.9435
170012	1.6156	0.8946	21.8587	22.6869	24.7392	23.0750
170013	1.5825	0.8946	21.4954	23.1159	24.9709	23.1630
170014	0.9823	0.9454	21.3416	22.9772	23.5960	22.6522
170015	1.0532	0.8032	18.0485	19.1902	20.2367	19.1620
170016	1.6153	0.8921	22.9479	24.2336	25.9482	24.4090
170017	1.1022	0.9156	21.6323	23.3030	24.7771	23.3226
170018	0.8898	0.8032	16.9169	17.9497	17.2199	17.3753
170019	1.2134	0.8032	18.7916	20.3243	22.0251	20.4068
170020	1.5747	0.8946	20.6658	22.2571	23.1800	22.0586
170022	1.0924	0.9454	21.1947	22.9313	22.2878	22.1486
170023	1.4742	0.8946	21.6273	23.2690	22.5551	22.4908
170024	***	0.8032	16.1196	*	*	16.1196
170026	***	0.8032	17.0836	*	*	17.0836
170033	1.3844	0.8946	20.0627	20.0801	20.5954	20.2325
170034	0.8698	0.8032	18.1074	*	*	18.1074
170040	1.8787	0.9454	24.5234	27.1771	28.2856	26.8014
170041	***	0.8032	13.9709	*	*	13.9709
170052	1.1985	0.8032	15.8809	17.3794	18.5291	17.3370
170054	0.9966	0.8032	18.5239	17.5500	*	18.0250
170056	***	0.8032	17.1872	*	*	17.1872
170068	1.1985	0.9165	20.5512	20.8771	22.6087	21.3531
170070	1.0679	0.8032	15.0539	16.4767	16.0162	15.8428
170074	1.1969	0.8032	18.5446	20.4936	21.0565	20.0516
170075	0.8302	0.8032	15.6809	16.2047	16.5444	16.1586
170077	***	0.8032	14.6377	*	*	14.6377
170082	***	0.8032	15.9973	*	*	15.9973
170086	1.5458	0.8921	22.1067	22.7737	24.0812	23.0117
170090	0.9249	0.8032	16.3550	15.9807	*	16.1812
170093	0.8184	0.8032	15.0307	16.8710	16.5553	16.1514
170094	0.9938	0.8032	20.1253	20.3678	21.3887	20.6420
170097	0.8884	0.8032	18.9865	20.3391	*	19.6594

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
170098	1.0009	0.8032	18.6676	20.0078	19.8881	19.5154
170099	0.8971	0.8032	15.8117	*	*	15.8117
170103	1.2452	0.9156	20.1263	21.4985	22.8707	21.5590
170104	1.5039	0.9454	23.6589	26.1866	26.6100	25.5135
170105	1.0723	0.8032	18.3824	19.6687	21.4422	19.8723
170109	0.9921	0.9454	20.7580	22.7166	23.2626	22.2703
170110	0.9659	0.8032	16.5883	21.8904	22.2650	20.1717
170113	1.0330	0.8032	19.9957	*	*	19.9957
170116	0.9958	0.8032	20.8800	23.1127	*	21.9980
170120	1.2748	0.8458	18.5895	19.8723	21.0499	19.8632
170122	1.6149	0.9156	22.2681	24.5826	25.3981	24.1100
170123	1.6579	0.9156	25.0073	26.4676	27.2239	26.2255
170133	1.0482	0.9454	20.0593	21.7748	22.9309	21.5574
170137	1.2299	0.8032	21.4394	22.7676	23.8863	22.7099
170142	1.3359	0.8785	19.8269	22.4095	22.5778	21.6027
170143	1.1294	0.8032	18.0308	19.7643	20.4459	19.4072
170144	***	*	23.9180	24.4259	24.6260	24.3634
170145	1.0646	0.8032	20.5143	21.4472	21.2071	21.0600
170146	1.5346	0.9454	27.0312	28.1965	28.8062	28.0903
170147	1.2185	0.9156	18.2480	23.1610	20.7436	20.6771
170148	***	*	26.3491	*	*	26.3491
170151	1.0014	0.8032	15.7242	*	*	15.7242
170171	***	*	14.7251	*	*	14.7251
170176	1.2996	0.9454	25.5404	24.2283	26.2366	25.2863
170180	***	*	25.0935	*	25.1366	25.1166
170182	1.4072	0.9454	23.2115	24.3820	25.7443	24.4497
170183	1.9491	0.9156	19.6919	22.8633	24.5539	22.4468
170185	1.2969	0.9454	26.8307	24.8478	26.7797	26.1506
170186	2.9412	0.9156	28.5602	30.5157	31.7896	30.4381
170187	1.1355	0.8032	20.8289	21.0780	23.3702	21.8354
170188	2.0008	0.9454	25.2504	27.2225	29.9751	27.6756
170189	***	*	28.1996	*	*	28.1996
170191	1.1514	0.8032	*	24.9599	21.3069	23.1771
170192	2.0555	0.9156	*	*	27.0380	27.0380
170193	1.2126	0.8032	*	*	24.7430	24.7430
170194	1.6735	0.9454	*	*	27.9904	27.9904
180001	1.2733	0.9604	22.2674	24.7647	25.4217	24.1342
180002	1.0456	0.7788	20.5135	21.6843	22.9727	21.7424
180004	1.0968	0.7788	19.8552	19.0834	19.5437	19.4871
180005	1.1514	0.9119	22.6704	22.8871	24.5561	23.3888
180006	0.8988	0.7788	14.4066	15.7136	14.8011	14.9439
180007	1.4096	0.9060	21.3545	21.8724	22.7606	21.9873
180009	1.6162	0.9482	22.4450	24.0971	25.3837	24.0052
180010	1.9470	0.9060	22.6846	16.6893	24.7256	20.7808
180011	1.3310	0.8830	18.8056	22.3183	22.7364	21.2726
180012	1.4989	0.9264	20.2758	22.9096	24.6642	22.6125
180013	1.4422	0.9492	21.0512	21.4728	22.9512	21.8902
180016	1.3138	0.9264	20.5203	22.2148	23.1832	22.0005
180017	1.2408	0.8286	18.0329	19.0694	20.8630	19.3296
180018	1.3264	0.8830	17.5670	18.3314	19.0992	18.3166
180019	1.1667	0.9604	20.8416	22.0379	24.1342	22.3292
180020	1.0301	0.7788	20.9964	22.3477	21.9494	21.7537
180021	1.0255	0.7788	17.6331	17.9346	18.5966	18.0522
180024	1.1362	0.9264	22.3922	23.6826	32.1824	25.9352
180025	1.0433	0.9264	18.3306	17.4781	19.1543	18.3232
180026	1.1055	0.7788	15.5354	15.8431	18.2120	16.5328
180027	1.2138	0.8092	20.5017	22.1072	23.8763	22.1722
180028	0.8828	0.9119	20.6324	21.4766	24.7968	22.1418
180029	1.2700	0.8095	20.4262	21.2110	23.0536	21.5776
180035	1.5412	0.9604	24.3874	26.7702	29.8438	27.1206
180036	1.1727	0.9482	22.2389	23.1636	25.1154	23.5250
180037	1.2780	0.9264	22.7893	24.4451	25.7361	24.4985
180038	1.3465	0.8806	20.6888	22.2750	24.6348	22.4970
180040	2.0835	0.9264	23.2341	24.5590	26.2125	24.7248
180041	1.0740	0.7788	19.1325	18.5483	*	18.8494
180043	1.1986	0.7788	20.6498	18.8436	19.0617	19.4791
180044	1.5046	0.9119	21.8163	21.6837	23.0971	22.1791

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
180045	1.3290	0.9604	22.1027	24.5856	25.8349	24.1325
180046	1.0500	0.9060	23.1139	24.7562	27.2244	25.0514
180047	0.8429	0.7788	17.8574	20.4768	21.8037	20.0588
180048	1.2624	0.9264	20.0114	22.3601	21.6571	21.3621
180049 [h]	1.3812	0.9060	18.5188	19.4488	23.3407	20.4067
180050	1.1118	0.7788	19.9082	21.7150	22.6473	21.3727
180051	1.3901	0.8272	18.8186	19.2100	21.3312	19.7863
180053	1.0384	0.7788	17.6239	18.6610	19.1578	18.5083
180054	0.9619	0.7788	19.1340	19.0657	*	19.0979
180055 [h]	1.0038	0.9060	17.8704	21.1989	20.7237	19.9661
180056	1.0631	0.8735	19.4072	21.4695	22.8910	21.2490
180063	1.1680	0.7788	15.5078	15.9185	17.9741	16.5674
180064	1.2463	0.7788	21.1067	15.3819	16.2638	17.3349
180066	1.0468	0.9492	21.1884	24.6359	24.9543	23.6588
180067	1.9180	0.9060	22.0056	24.0551	25.4080	23.7960
180069	1.0456	0.9119	20.3982	20.8797	22.3674	21.2166
180070	1.1131	0.7788	16.9892	17.4266	20.1308	18.1917
180072	***	*	17.5411	*	*	17.5411
180079	1.1252	0.7788	18.0472	19.5783	19.7791	19.1405
180080	1.3087	0.8470	18.9582	20.1651	21.7380	20.2813
180087	1.1742	0.7788	16.4726	17.7758	18.4331	17.6017
180088	1.5651	0.9264	23.7217	24.6053	27.5767	25.3642
180092	1.1282	0.9060	19.6790	22.4864	22.5679	21.6047
180093	1.4227	0.8508	18.8469	19.2748	20.5422	19.5520
180094	0.9602	0.7788	15.7640	*	*	15.7640
180099	***	0.7788	14.0115	*	*	14.0115
180102	1.5476	0.8092	20.1885	19.1136	18.4388	19.1595
180103	2.2069	0.9060	21.3867	25.1577	26.9407	24.4722
180104	1.6243	0.8092	21.3866	22.8911	24.9441	23.1113
180105	0.8484	0.7788	18.3521	19.5364	19.7615	19.2381
180106	0.9458	0.7788	15.4937	15.7851	17.8020	16.4485
180108	***	0.7788	16.7327	*	*	16.7327
180116	1.2066	0.8285	20.5453	21.8698	22.7353	21.7465
180117	0.9835	0.7788	17.7885	20.5952	21.1854	19.7909
180120	0.7761	0.7788	20.4507	*	*	20.4507
180124	1.3086	0.9492	20.5369	21.4270	23.1917	21.6877
180126	1.0372	0.7788	14.5644	15.1776	*	14.8844
180127	1.2754	0.9264	20.0059	21.4633	23.4765	21.6735
180128	0.9399	0.7788	19.8502	20.5575	20.8406	20.4307
180129	***	0.7788	14.1861	*	*	14.1861
180132	1.3264	0.8830	19.9358	22.2101	23.7652	21.9796
180134	1.0635	0.7788	*	17.3449	18.6779	18.0324
180138	1.2100	0.9264	23.0996	25.1789	27.3400	25.1767
180139	1.0372	0.8830	20.6287	21.3797	23.5363	21.8425
180141	1.7146	0.9264	22.6722	24.3140	25.3042	24.1450
180143	1.4820	0.9060	20.1309	14.2734	25.1613	19.0124
190001	1.0754	0.9003	20.4946	19.5680	19.7516	19.8963
190002	1.7155	0.8429	20.7172	21.7000	22.0056	21.4744
190003	1.4560	0.8429	20.7505	21.8156	23.4977	22.0368
190004	1.2890	0.7903	20.5272	22.1835	23.3290	21.9727
190005	1.4326	0.9003	20.0551	20.7987	22.3208	21.0635
190006	1.2504	0.8429	18.8115	19.4573	22.2467	20.1618
190007	1.1174	0.7445	17.9392	18.7854	19.7528	18.8587
190008	1.6429	0.7903	20.3278	21.4137	24.0111	21.9572
190009	1.2155	0.8048	17.5144	18.8295	19.8404	18.6932
190010	1.1212	0.7445	18.1797	19.9788	21.6889	19.9508
190011	1.0256	0.8044	15.4699	18.1525	19.7319	17.7235
190013	1.3334	0.7847	18.7538	19.6346	20.8626	19.7509
190014	1.1677	0.7445	17.0630	17.4740	22.4596	18.7727
190015	1.3076	0.9003	20.6167	22.1046	22.8875	21.9289
190017 [h]	1.3418	0.8429	18.3528	18.6962	21.5033	19.4006
190018	***	0.7445	19.2055	*	*	19.2055
190020	1.1401	0.8605	18.5659	19.8505	21.6136	19.9828
190025	1.2473	0.7445	19.9969	20.4651	20.8950	20.4776
190026	1.5166	0.8048	19.9229	21.3386	22.5087	0121.3125
190027	1.6352	0.7847	19.4057	21.2449	21.2526	20.6470
190034	1.1567	0.7445	16.8439	17.5002	19.6943	18.0127

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
190036	1.6456	0.9003	23.3903	23.7356	24.8359	24.0024
190037	0.9457	0.7847	15.6062	16.7629	18.6393	17.0499
190039	1.4625	0.9003	20.4900	23.3105	25.6665	23.2338
190040	1.3133	0.9003	22.9262	23.8076	26.7428	24.3506
190041	1.4459	0.8767	21.9983	23.9082	24.6734	23.4433
190043	1.0017	0.7445	15.7333	16.8944	17.3477	16.6784
190044 [h]	1.2058	0.8429	17.7460	19.5304	19.5567	18.9595
190045	1.5902	0.9003	22.8709	24.0490	25.3854	24.1220
190046	1.4233	0.9003	21.1019	22.2884	24.2128	22.4847
190048	1.0523	0.7445	18.1698	18.6148	19.6288	18.7855
190049	1.0149	0.7445	19.3768	20.1229	*	19.7625
190050	1.0741	0.7445	18.6663	18.5287	19.1076	18.7685
190053	1.1232	0.7445	13.8037	15.7258	16.4968	15.3819
190054	1.3671	0.7445	19.9370	20.3525	20.1108	20.1339
190059	0.8367	0.8605	18.3334	19.2396	*	18.7888
190060	1.5006	0.7847	20.2207	22.1499	23.6278	21.9859
190064	1.5577	0.8605	21.1262	21.5514	23.3617	22.0132
190065	1.4890	0.8605	20.3583	23.0523	23.7450	22.3992
190077	0.8526	0.8044	17.0480	18.4043	18.8409	18.0986
190078 [h]	1.0049	0.8429	19.8607	21.5782	21.3786	20.9721
190079	1.2488	0.9003	20.5000	21.8158	21.2546	21.1972
190081	0.8882	0.7445	11.4756	14.9141	15.6146	13.9838
190083	0.8728	0.7445	18.4954	19.2683	*	18.9013
190086	1.2357	0.8767	18.2005	18.8306	19.8823	18.9783
190088 [h]	1.0702	0.8767	18.6738	22.5045	22.3480	20.9939
190089	0.9609	0.7445	15.5151	16.2961	*	15.9103
190090	1.0843	0.7445	19.0519	20.0745	20.2045	19.8076
190095	***	*	16.9519	18.7302	18.0174	17.8930
190098	1.5840	0.8767	20.7537	23.0802	24.6353	22.7792
190099	1.0296	0.8470	23.1606	21.1657	20.4597	21.4552
190102	1.6258	0.8429	22.0190	23.4618	25.2267	23.6255
190106	1.2114	0.8048	20.3114	21.5643	21.7228	21.2163
190109	1.1376	0.7903	16.6515	17.4842	18.6524	17.5941
190110 [h]	0.8513	0.8429	16.5007	19.0611	*	17.8105
190111	1.5580	0.8767	24.4380	25.2370	24.4998	24.7275
190114	1.0513	0.7445	13.6101	14.6258	15.8031	14.6821
190115	1.1772	0.8767	25.4984	26.0272	26.6295	26.0395
190116	1.2394	0.7445	17.8297	18.6074	20.3844	18.9443
190118	0.9389	0.8767	17.5060	19.0200	19.7025	18.7558
190122	1.1878	0.8605	17.7811	19.3131	23.7082	20.0706
190124	1.5270	0.9003	23.3859	23.4862	24.6675	23.8477
190125	1.6350	0.8044	21.5692	22.3976	23.9649	22.6514
190128	1.0700	0.8605	23.8786	24.7842	27.9136	25.5637
190130	0.9482	0.7445	15.2678	16.6910	*	15.9880
190131	1.1718	0.9003	21.3154	22.5032	25.1917	22.9740
190133	0.8895	0.7445	13.4062	14.3089	13.6266	13.7628
190135	1.4454	0.9003	24.4908	26.9920	26.8238	26.1247
190140	0.9845	0.7445	15.4030	17.0371	17.6936	16.7104
190144 [h]	1.1367	0.8767	21.3838	21.1658	21.7547	21.4426
190145	0.9459	0.7445	17.4407	17.3361	18.9678	17.9319
190146	1.5445	0.9003	22.1502	23.7721	26.1792	24.0255
190147	***	0.7445	16.3596	*	*	16.3596
190149	0.9266	0.7445	18.4197	17.1671	18.8819	18.1219
190151	1.0072	0.7445	17.3402	17.8741	18.6293	17.9597
190152	1.3530	0.9003	25.1136	27.4708	27.6099	26.7879
190156	0.8717	0.7445	18.0528	18.3702	*	18.2089
190158	1.3600	0.9003	23.2361	26.2352	26.3042	25.4140
190160	1.4780	0.8044	19.8428	20.0025	21.6740	20.5204
190161	1.1157	0.7847	16.5322	17.8794	19.1022	17.8227
190162	***	0.9003	20.7350	22.1781	25.0328	22.6102
190164	1.1345	0.8048	20.2791	21.4247	22.8599	21.6241
190167	1.2264	0.7445	17.2643	17.8604	24.3185	19.7786
190175	1.3314	0.9003	22.7574	24.6790	27.1531	25.0038
190176	1.7308	0.9003	25.2536	25.8482	25.6997	25.6097
190177	1.5627	0.9003	22.3318	25.4769	27.4621	25.2171
190182	0.9036	0.9003	23.6016	25.0837	28.4799	25.6314
190183	1.1870	0.7903	17.1805	18.3151	19.8084	18.4205

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
190184	1.0174	0.7445	20.6096	21.3191	23.9609	21.8425
190185	1.3314	0.9003	29.7870	24.4176	24.7912	25.8807
190190	0.8693	0.7445	16.2819	14.0052	16.1195	15.4593
190191 [h]	1.3627	0.8470	21.9141	22.3755	23.5734	22.6642
190196	0.8706	0.8429	20.7601	21.9355	24.7135	22.5497
190197	1.3476	0.8044	21.6908	22.9631	24.3735	23.0241
190199	1.1533	0.8605	19.7776	18.5317	14.1410	17.3575
190200	1.5526	0.9003	24.1667	26.4258	27.5681	25.9873
190201	1.2736	0.7847	21.4335	22.5588	24.5877	22.9165
190202	1.2371	0.8605	22.4062	21.8900	24.7944	23.0825
190203	1.5000	0.9003	24.9518	26.9099	26.8795	26.2979
190204	1.4751	0.9003	26.1231	28.8777	28.3684	27.8932
190205	1.7106	0.8429	20.2374	21.7696	24.4540	22.1979
190206	1.6684	0.9003	24.2892	26.9117	26.0139	25.7960
190207	***	*	21.5325	*	*	21.5325
190218	1.1570	0.7445	21.6206	23.9182	25.0356	23.6192
190236	1.4154	0.8767	24.4661	23.8233	23.6824	23.9582
190240	0.9780	0.7445	15.4026	13.9888	*	14.7116
190241	1.2944	0.7903	24.2462	28.9620	23.9700	25.7012
190242	1.1208	0.8605	18.6672	20.5937	23.0072	20.7608
190243	***	*	*	30.6060	*	30.6060
190245	2.1960	0.8044	*	*	27.1786	27.1786
200001	1.2980	0.9985	21.6050	23.2210	25.1145	23.3710
200002	1.1625	0.9884	22.0700	24.1446	25.7478	23.9468
200007	1.0638	1.0382	21.0603	22.3920	*	21.7470
200008	1.2535	1.0382	25.1115	25.1741	27.4412	25.9041
200009	1.9724	1.0382	24.9041	28.1409	31.1056	28.0391
200012	1.1372	0.8840	21.8529	24.1243	25.7623	23.9787
200013	1.1001	0.8840	22.8909	23.9048	24.4131	23.7685
200018	1.1627	0.8840	21.1330	24.3294	23.6337	23.0851
200019	1.2839	1.0382	23.1114	24.0926	25.1367	24.1296
200020	1.2562	1.0503	27.0798	28.7351	31.7083	29.2990
200021	1.1892	1.0382	24.9925	25.1027	24.5519	24.8792
200024	1.5272	0.9884	22.9698	24.6484	26.0080	24.6372
200025	1.0696	1.0382	22.9023	24.3646	26.0573	24.4151
200026	1.0384	0.8840	19.7172	21.9997	*	20.8927
200027	1.2155	0.8840	21.0156	23.2912	26.3118	23.4478
200028	1.0270	0.8840	21.2180	24.3061	24.3271	23.3297
200031	1.3580	0.8840	18.8262	20.6202	21.9489	20.4626
200032	1.2155	0.8840	23.0487	24.2221	25.5227	24.3050
200033	1.8521	0.9985	25.1723	26.8727	28.6479	26.9328
200034	1.3802	0.9884	23.5415	26.1150	26.2926	25.3574
200037	1.1932	0.8840	22.6534	23.3490	23.2333	23.0870
200039	1.2758	0.9884	22.1333	24.0474	25.1196	23.8217
200040	1.2240	1.0382	21.8528	23.6791	25.5405	23.6763
200041	1.1389	0.8840	21.3816	23.6797	24.5532	23.3316
200050	1.2560	0.9985	23.4391	25.5233	26.4992	25.2144
200052	1.0527	0.8840	19.0535	22.7763	21.8726	21.2769
200063	1.1744	0.9884	23.0135	24.7235	25.0167	24.2686
200066	1.2279	0.8840	19.5890	21.6354	*	20.6005
210001	1.4095	0.9528	22.6614	26.3144	27.7561	25.5750
210002	1.9808	0.9892	25.6975	25.2859	26.4992	25.8584
210003	1.6574	1.0935	23.0790	32.3042	29.8684	28.0698
210004	1.4432	1.1471	29.4841	29.4300	34.2392	31.0347
210005	1.2836	1.1471	24.7185	27.1276	28.7557	26.8963
210006	1.0893	0.9892	24.7327	25.6396	25.4081	25.2468
210007	1.8793	0.9892	27.5104	28.4496	30.2548	28.7829
210008	1.3153	0.9892	24.6569	26.3008	25.2833	25.4086
210009	1.8013	0.9892	23.4889	24.6332	26.2360	24.8136
210010	***	0.9099	23.7761	24.5071	25.7850	24.6945
210011	1.4100	0.9892	22.3262	24.8373	27.5031	24.9589
210012	1.5973	0.9892	25.2892	25.7934	27.4103	26.2116
210013	1.2668	0.9892	23.0151	23.9875	25.1348	24.0450
210015	1.3230	0.9892	23.8419	25.8532	28.2029	25.9683
210016	1.8143	1.1471	27.2632	28.6992	32.2081	29.4293
210017	1.1663	0.9099	19.0248	21.3983	23.2168	21.2523
210018	1.2267	1.1471	25.3112	27.5431	29.2153	27.3955

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
210019	1.7403	0.9099	23.5259	24.9252	26.1824	24.9054
210022	1.4002	1.1471	27.6680	30.1470	33.8015	30.5481
210023	1.4502	0.9892	26.7837	29.0844	30.4656	28.8005
210024	1.6742	0.9892	24.8939	27.1756	29.5579	27.2560
210025	1.2278	0.9310	22.8882	23.8943	26.0771	24.3114
210027	1.4821	0.9310	19.3517	23.9255	26.0111	22.9283
210028	1.0800	0.9099	22.4054	24.1265	25.9221	24.1901
210029	1.2469	0.9892	26.2082	31.2888	27.9741	28.3176
210030	1.2604	0.9099	20.7802	27.5507	29.5702	25.7230
210032	1.1336	1.0652	20.3407	25.7138	26.1829	23.9925
210033	1.1618	0.9892	25.0301	26.6113	29.0420	26.9838
210034	1.2910	0.9892	22.8827	26.3896	28.4308	25.7800
210035	1.3279	1.0935	21.6973	24.5198	26.1082	24.1712
210037	1.1827	0.9099	23.5536	24.1913	24.8719	24.2175
210038	1.2100	0.9892	26.5696	28.3414	29.5979	28.1851
210039	1.1063	1.0935	24.0987	25.8415	27.6940	25.8514
210040	1.2556	0.9892	25.4729	28.3723	29.3514	27.8674
210043	1.3070	0.9892	22.2177	24.3070	27.5657	24.7038
210044	1.3455	0.9892	23.8101	24.8083	28.8700	25.7966
210045	1.0505	0.9099	11.8350	15.0867	15.6380	14.3653
210048	1.3334	0.9892	24.4328	25.0617	28.4638	26.0370
210049	1.2251	0.9892	24.7148	25.9342	26.9656	25.9278
210051	1.3202	1.0935	25.7103	27.3692	29.2998	27.5052
210054	1.3345	1.0935	27.3551	24.6658	26.2295	26.0806
210055	1.1840	1.0935	27.4218	28.0014	29.9708	28.5097
210056	1.3191	0.9892	23.5881	26.6884	28.6091	26.3638
210057	1.4185	1.1471	27.3520	29.2233	32.2883	29.7939
210058	1.0819	0.9892	22.0351	24.8576	29.7841	25.5191
210060	1.1664	1.0935	25.8377	28.7531	28.5087	27.8143
210061	1.2457	0.9099	22.5455	24.1369	23.6662	23.5086
220001	1.2068	1.1233	25.8030	27.3238	28.9854	27.3824
220002	1.3775	1.1233	26.3348	28.9722	30.3598	28.5921
220003	1.1465	1.1233	18.8150	20.5790	22.0549	20.5049
220006	1.5005	1.0525	27.1576	29.5946	30.7583	29.2881
220008	1.2473	1.0952	25.6647	27.1675	30.1043	27.7253
220010	1.2849	1.1233	24.5020	27.4161	29.7998	27.3015
220011	1.1320	1.1233	32.2266	32.6624	33.6258	32.9286
220012	1.4769	1.2518	32.0521	32.9791	36.2075	33.8319
220015	1.1789	1.0259	25.0272	25.5449	28.3397	26.3904
220016	1.1162	1.0259	25.7740	26.8798	28.0609	26.8986
220017	1.3302	1.1537	28.9024	28.8264	29.7108	29.1461
220019	1.1847	1.1233	21.6620	22.2294	23.2544	22.3943
220020	1.2561	1.0952	23.5737	24.2279	26.3475	24.7620
220024	1.2397	1.0259	24.1071	25.5837	27.3488	25.6784
220025	1.1085	1.1233	23.2374	24.5186	23.0637	23.5753
220028	1.4399	1.1233	31.4858	31.3592	32.0980	31.6438
220029	1.1188	1.1233	27.4792	28.1432	28.6970	28.1288
220030	1.1096	1.0259	20.0816	23.6257	24.4289	22.7602
220031	1.5358	1.1537	30.8324	32.2660	34.7388	32.5988
220033	1.1835	1.1233	25.4500	26.8049	28.1859	26.8967
220035	1.3734	1.1233	26.8486	27.5533	28.6238	27.6997
220036	1.4886	1.1537	28.2182	29.6296	31.5184	29.8330
220041	***	*	28.8184	29.7464	*	29.2230
220046	1.3512	1.0183	26.1955	27.7726	28.1396	27.3951
220049	1.1526	1.1233	26.7688	27.0464	27.7517	27.2011
220050	1.1149	1.0259	23.7326	24.9945	26.3768	25.0718
220051	1.2065	1.0183	22.2965	26.5575	29.8380	26.3369
220052	1.1597	1.1537	26.3043	28.0925	29.8577	28.1429
220058	1.0018	1.1233	22.4885	25.0598	24.9642	24.1665
220060	1.1851	1.2254	29.6960	30.8242	32.3362	31.0565
220062	0.5670	1.1233	22.6598	21.9489	24.2779	22.9699
220063	1.1890	1.1233	23.3704	25.5840	27.3967	25.3936
220065	1.2103	1.0259	22.4143	24.8737	26.5513	24.6535
220066	1.2809	1.0259	27.5575	26.2561	27.1317	26.9786
220067	1.1716	1.1537	22.4968	28.5220	29.8911	26.7470
220070	1.1474	1.1233	26.2697	28.9100	31.9283	28.7436
220071	1.8635	1.1537	27.7773	31.8322	32.2591	30.6680

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Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
220073	1.2181	1.0952	27.9309	29.2399	31.2591	29.4595
220074	1.2979	1.1537	25.7840	27.5763	28.4930	27.3187
220075	1.3687	1.1537	26.0527	27.9503	29.1588	27.7387
220076	***	1.1078	24.8040	27.2534	29.7507	27.1315
220077	1.7008	1.1085	27.0946	28.0935	30.2684	28.5352
220080	1.2093	1.1233	24.7399	27.1578	28.9101	27.0523
220082	1.2445	1.1233	23.9542	24.8060	26.9841	25.2609
220083	1.1182	1.1537	28.3533	29.9001	32.9143	30.3719
220084	1.2198	1.1233	26.8596	29.0505	32.5711	29.5958
220086	1.7240	1.1537	29.4911	31.7482	34.1236	31.7544
220088	1.8430	1.1537	26.5849	28.5711	28.5462	27.9606
220089	1.2383	1.1233	28.9252	32.4409	31.1708	30.8836
220090	1.2019	1.1233	26.5552	29.7945	30.8685	29.1558
220095	1.0909	1.1233	23.7629	24.9871	27.4273	25.3894
220098	1.1705	1.1233	26.2287	26.8538	28.8314	27.2888
220100	1.2709	1.1537	27.0265	28.4848	29.6912	28.4369
220101	1.3268	1.1233	26.9992	31.0834	33.1690	30.4912
220105	1.2174	1.1233	26.7570	30.0892	31.9421	29.7099
220108	1.2235	1.1537	26.0166	29.0804	30.6252	28.5516
220110	2.0895	1.1537	33.0445	35.4242	36.6043	35.0919
220111	1.1852	1.1537	27.7395	28.9092	31.1850	29.2950
220116	2.0126	1.1537	30.9871	32.2337	32.9988	32.0845
220119	1.1414	1.1537	25.9789	27.8372	28.2844	27.4417
220126	1.1438	1.1537	26.9853	26.7660	28.7805	27.5408
220133	***	*	33.0819	31.2981	33.6003	32.6683
220135	1.3023	1.2518	31.9159	31.3246	32.1205	31.7903
220153	1.0112	1.0259	*	18.9267	*	18.9267
220154	1.0325	1.1537	25.6069	30.9009	28.6462	28.0721
220163	1.6217	1.1233	29.9312	30.5056	33.6484	31.2574
220171	1.7280	1.1233	27.2647	28.9733	29.5666	28.6148
220174	1.1830	1.1233	*	30.3356	31.7572	31.0464
230001	1.1145	0.8923	22.0875	24.3660	*	23.2049
230002	1.2858	1.0453	23.7972	27.0305	28.7861	26.5792
230003	1.1978	0.9133	22.4322	25.2596	26.1278	24.6604
230004	1.6865	0.9677	23.0827	25.5573	26.7206	25.1973
230005 [h]	1.2420	1.0885	20.3750	22.1018	24.1902	22.4061
230006	1.1260	0.9786	22.0733	22.7656	23.8835	22.9495
230013	1.3537	0.9858	20.4633	22.7014	23.7822	22.3686
230015	1.0330	0.8923	21.7640	23.4512	24.6570	23.3267
230017	1.6186	1.0403	26.1609	27.3259	29.5178	27.7392
230019	1.5499	0.9858	24.7472	27.6563	28.4575	26.9496
230020	1.6718	1.0453	25.8267	26.8516	29.2869	27.3788
230021	1.5066	0.8923	22.0757	23.4663	24.9551	23.5352
230022	1.1968	1.0628	22.2179	22.2528	23.3000	22.6032
230024	1.5303	1.0453	24.7364	27.6555	30.0866	27.3402
230027	1.0785	0.9398	21.2223	22.5736	23.5511	22.4431
230029	1.6353	0.9858	26.7646	27.9012	29.0935	27.9121
230030	1.2551	0.9090	19.9853	20.9867	22.3174	21.1301
230031	1.3778	0.9858	22.1874	23.2910	25.4678	23.7275
230032	***	*	23.8366	*	*	23.8366
230035	1.2892	0.9398	18.0735	20.9197	21.2317	19.9973
230036	1.3478	0.8923	25.9801	26.5854	28.3622	26.9984
230037	1.1932	1.0628	24.4115	24.7875	26.0167	25.1030
230038	1.6544	0.9398	23.4685	25.2499	26.3480	25.2371
230040	1.1923	0.9398	21.8062	21.9813	24.2349	22.7262
230041	1.4739	0.9535	24.2297	25.2518	26.1760	25.1852
230042	1.1899	0.9133	21.8241	24.3640	26.2037	24.1687
230046	1.8546	1.0885	28.2320	29.2683	30.3591	29.3515
230047	1.3775	1.0453	24.3622	26.2447	28.1351	26.3210
230053	1.5876	1.0453	26.1415	28.3030	29.9871	28.0856
230054	2.0368	0.9439	23.0818	24.0137	24.9905	24.0601
230055	1.2813	0.8923	20.9350	23.7671	25.4143	23.4450
230058	1.1454	0.8923	22.4516	21.9308	24.0657	22.7966
230059	1.4370	0.9398	21.2743	23.1451	25.5350	23.3695
230060	1.2849	0.8923	22.3512	24.5073	25.5015	24.1280
230065	***	1.0453	26.3217	27.9179	28.4631	27.5421
230066	1.3075	0.9677	23.9696	25.8517	27.4928	25.8295

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
230069	1.1753	1.0654	26.0438	27.6815	29.5556	27.8051
230070	1.5701	0.9474	22.8588	25.1587	24.2342	24.0769
230071	0.8485	0.9858	23.6674	24.7707	26.3907	24.9681
230072	1.3590	0.9133	22.9626	24.1560	24.4933	23.9114
230075	1.3133	0.9492	22.6799	24.1482	27.6193	24.8869
230077	1.9292	1.0654	29.2041	27.3117	30.3431	28.9610
230078	1.0254	0.8923	20.5427	21.9200	23.9901	22.2077
230080	1.2619	0.9090	20.2405	21.2840	21.2314	20.9185
230081	1.1862	0.8923	20.4289	20.6777	23.0788	21.3975
230082	1.0168	0.8923	21.3100	23.1240	22.2165	22.1964
230085	1.2173	1.0403	24.2802	22.2569	22.7314	23.1872
230086	1.1453	0.8923	27.8923	20.8759	22.2965	23.4562
230087	***	*	22.2688	*	16.9168	19.0752
230089	1.3414	1.0453	23.3847	23.9486	28.7015	25.3973
230092	1.2758	0.9300	22.3122	24.3768	26.3584	24.3257
230093	1.1471	0.9398	25.1213	24.5055	26.4967	25.3702
230095	1.2485	0.8923	19.1810	19.2244	21.3915	19.9401
230096	1.1644	1.0403	26.7156	26.7578	28.7681	27.4077
230097	1.7922	0.8923	22.9902	25.2104	26.5773	24.9608
230099	1.2029	1.0628	23.5490	25.0390	26.4882	25.0486
230100	1.0901	0.8923	19.8016	20.4565	21.8895	20.6965
230101	1.0867	0.8923	22.3310	23.1349	24.3772	23.3147
230103	0.9926	0.9786	19.4434	18.4304	21.6609	19.7646
230104	1.5316	1.0453	27.4119	27.8864	30.5570	28.5801
230105	1.9274	0.9535	23.9851	24.6853	27.2705	25.3146
230106	1.1151	0.9398	23.1962	24.1128	24.3980	23.9236
230108	1.1539	0.8923	19.9842	22.4966	18.4063	20.1757
230110	1.2559	0.8923	21.5523	22.7621	28.7704	24.4693
230117	1.8428	1.0403	28.1220	29.6361	29.4775	29.0873
230118	1.0609	0.8923	22.2208	21.4886	22.3636	22.0278
230119	1.2750	1.0453	25.3562	29.2509	30.4910	28.0624
230120 [h]	1.1085	1.0885	22.7243	21.7894	24.1485	22.9095
230121	1.2547	0.9786	22.3708	23.4394	24.5220	23.4095
230124	1.3011	0.8923	22.0097	23.0508	*	22.5308
230130	1.7348	0.9858	23.7854	26.9907	26.6076	25.8001
230132	1.3708	1.0654	29.0292	29.9106	30.5074	29.8111
230133	1.4219	0.8923	20.4801	21.2273	22.7380	21.5235
230135	1.1067	1.0453	19.8290	23.9000	25.8406	23.1673
230141	1.6290	1.0654	23.9885	30.4643	28.6326	27.6090
230142	1.2390	1.0453	22.9036	25.6044	26.9433	25.2019
230143	1.2372	0.8923	19.5446	19.5387	21.4083	20.1494
230144	***	1.0885	23.6959	*	*	23.6959
230146	1.2340	1.0453	21.3539	24.3891	26.3432	24.1395
230149	0.9394	0.8923	20.8933	21.4753	*	21.1778
230151	1.3038	0.9858	23.8527	26.4669	27.1965	25.8699
230153	1.0978	0.9786	22.8584	22.3404	22.8644	22.6896
230155	1.0445	0.8923	18.0743	24.0404	*	20.6336
230156	1.5897	1.0885	27.7164	29.4855	31.1909	29.5181
230165	1.6979	1.0453	25.9534	27.3164	28.9636	27.4184
230167	1.6158	0.9786	24.7935	26.6828	27.3362	26.2749
230169	***	1.0453	24.9265	27.1172	31.8442	27.6798
230171	1.0700	0.8923	19.9097	22.0635	*	20.9931
230172	1.2263	1.0403	23.0023	24.0236	25.7402	24.2756
230174	1.3089	0.9133	24.4671	26.2770	27.6920	26.1839
230175	***	*	22.5964	*	*	22.5964
230180	1.0957	0.8923	20.9832	22.5454	24.7358	22.8206
230184	1.2135	0.9300	21.4031	21.9346	23.6707	22.3438
230186	***	*	21.6147	27.1126	26.2282	24.5338
230188	0.9259	0.8923	18.8076	*	*	18.8076
230190	1.0114	1.0403	27.3430	28.7365	29.9604	28.6717
230193	1.2672	0.9858	22.8916	24.3181	23.3565	23.5189
230195	1.4253	1.0453	25.3285	27.1266	28.2892	26.9865
230197	1.5717	1.0654	26.9840	28.3439	30.0367	28.4836
230204	1.2871	1.0453	24.4095	25.9871	29.1466	26.3875
230207	1.3574	0.9858	22.2848	22.2854	24.4641	22.9909
230208	1.1926	0.9398	20.3171	20.9420	21.9651	21.0908
230212	1.0168	1.0885	26.0656	27.3686	29.7980	27.6833

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
230216	1.5428	0.9858	23.4262	26.1468	27.5230	25.7787
230217	1.2812	0.9786	24.3650	26.7929	28.5002	26.7214
230222 [h]	1.3221	0.9474	24.6101	24.8925	26.3990	25.3118
230223	1.2599	0.9858	28.5549	27.1503	29.2853	28.3304
230227	1.5008	1.0453	27.7510	28.1105	29.6068	28.4994
230230	1.4934	0.9786	23.9568	25.4471	27.9607	25.8281
230235	1.0134	0.9090	19.9118	19.6046	21.8777	20.4653
230236	1.4098	0.9398	25.7463	26.3988	28.4754	26.9289
230239	1.2173	0.8923	19.8370	21.1643	22.1040	21.0930
230241	1.1712	0.9858	24.2063	25.8671	27.4890	25.8668
230244	1.3245	1.0453	23.9004	25.3817	26.4326	25.2154
230254	1.3405	0.9858	24.2594	26.4431	28.1216	26.2901
230257	1.0228	1.0453	24.8069	25.4086	27.8197	25.8794
230259	1.2092	1.0885	24.8598	24.3067	26.8677	25.3750
230264	2.1560	1.0453	17.4847	19.9992	19.2398	19.0176
230269	1.3453	0.9858	25.3367	27.4732	28.8187	27.2692
230270	1.2537	1.0453	22.8842	26.1113	27.8488	25.6802
230273	1.4149	1.0453	25.8466	30.2209	29.9307	28.6762
230275	0.4478	0.9474	29.4180	30.2244	23.1095	27.7059
230276	***	*	23.4928	*	*	23.4928
230279	0.5281	1.0654	21.2467	23.1636	24.7673	22.9663
230283	0.8624	1.0453	25.0038	24.9272	26.2622	25.3910
230288	***	*	30.3422	*	*	30.3422
230290	***	*	*	29.4792	*	29.4792
230291	***	*	*	*	30.9655	30.9655
230292	***	0.9474	*	*	31.8943	31.8943
240001	1.5054	1.1055	28.2239	29.9123	31.5753	29.9731
240002	1.8195	1.0224	24.7674	26.9608	28.9860	26.9851
240004	1.5291	1.1055	26.8197	27.8796	30.8072	28.5006
240006	1.0536	1.1128	29.5789	30.2330	30.1950	30.0237
240007	1.1446	0.9183	21.4367	23.7588	24.7344	23.3456
240010	2.0425	1.1128	29.0955	30.4139	31.3733	30.3196
240011	1.0425	0.9183	24.0364	22.9561	*	23.3835
240013	1.2687	1.0905	27.3855	28.7202	28.3860	28.1704
240014	1.0309	0.9183	26.5144	28.3788	29.8623	28.2985
240016	1.2584	0.9183	25.2629	24.9211	26.7814	25.7376
240017	1.2467	0.9183	21.6243	23.3314	24.4417	23.1535
240018	1.2293	1.0905	27.3634	27.9218	25.6484	26.6329
240019	1.1105	1.0224	25.1331	27.5441	28.6723	27.1439
240020	1.0806	1.1055	24.7516	28.1568	31.2443	28.0203
240021	0.8545	0.9183	23.9568	23.7096	27.1235	24.8433
240022	1.1064	0.9183	23.4702	23.7368	25.2066	24.1392
240025	1.0776	0.9183	21.2597	27.8656	*	24.3444
240027	0.9440	0.9183	18.3340	20.2531	18.2481	18.8765
240029	1.0819	0.9183	21.2342	24.3017	25.3568	23.3870
240030	1.3564	0.9785	22.0200	23.3753	24.7154	23.4178
240031	0.9494	1.0905	23.4389	26.7242	26.7778	25.6303
240036	1.6880	1.0905	23.4857	27.0821	28.0812	26.3323
240037	1.0359	0.9183	21.8392	24.3986	*	23.1115
240038	1.5291	1.1055	28.9676	29.8465	31.0779	30.0073
240040	1.0854	1.0224	21.3870	26.3177	27.4895	24.8843
240043	1.1301	0.9183	19.5532	20.7155	21.8685	20.7481
240044	1.1203	0.9183	22.7482	24.3009	22.5843	23.1864
240045	1.1212	1.0224	25.9223	26.1743	27.5013	26.5626
240047	1.5649	1.0224	29.6184	29.1211	28.8288	29.1562
240050	1.0196	1.1055	24.7589	26.6687	26.4854	26.0710
240052	1.1991	0.9183	23.5898	24.9870	26.4256	25.0236
240053	1.4186	1.1055	26.7122	28.4733	29.5315	28.3118
240056	1.2420	1.1055	28.5169	30.8619	31.6623	30.4153
240057	1.8473	1.1055	27.7600	29.4870	30.6258	29.3431
240059	1.0902	1.1055	27.0517	28.6340	29.7916	28.5358
240061	1.7485	1.1128	28.7372	30.0031	30.6383	29.8381
240063	1.5546	1.1055	26.7960	29.9603	32.3487	29.6692
240064	1.2568	1.0224	24.9928	26.6996	29.9662	27.5790
240066	1.3913	1.1055	27.4066	30.2716	33.4532	30.4657
240069	1.1378	1.1128	25.6943	27.4990	28.9496	27.4534
240071	1.1486	1.1128	24.8036	26.4780	28.0585	26.4808

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
240075	1.1988	0.9785	24.4084	26.6607	26.1956	25.7681
240076	1.1046	1.1055	26.7112	28.4519	29.8562	28.4067
240077	***	0.9183	18.9735	*	*	18.9735
240079	0.9411	1.1521	20.6644	20.9220	*	20.8010
240080	1.6892	1.1055	27.8807	29.6274	31.6484	29.7472
240083	1.2481	0.9183	24.4352	25.0214	26.6582	25.4096
240084	1.1252	1.0224	23.9942	24.7856	26.8142	25.2047
240087	1.0235	0.9183	20.1002	24.8479	24.9419	23.3753
240088	1.2698	0.9785	25.5587	27.6323	28.0825	27.1245
240089	***	0.9183	23.4028	*	*	23.4028
240094	1.0759	1.1055	24.4166	27.3974	28.3973	26.8076
240097	***	*	34.2810	*	*	34.2810
240101	1.1412	0.9183	24.3455	26.6078	25.5355	25.5132
240103	1.0495	0.9183	20.2324	22.5416	22.7078	21.8542
240104	1.1424	1.1055	27.4946	30.1392	31.4306	29.9577
240106	1.4870	1.1055	25.5890	27.5171	29.3455	27.5527
240107	0.9093	0.9183	24.5583	25.5199	26.1078	25.4514
240109	0.9472	0.9183	14.5892	15.2076	16.5051	15.4279
240115	1.6156	1.1055	27.0312	29.0261	31.3869	29.1786
240117	1.1377	0.9183	20.1436	22.0463	23.8076	22.0056
240121	0.9139	1.0224	24.5455	*	*	24.5455
240123	1.0528	0.9183	20.0721	20.5755	21.7500	20.8397
240124	0.9638	0.9183	23.5139	23.9297	*	23.7277
240127	***	*	19.3857	24.4824	*	21.5460
240128	1.0138	0.9183	20.1960	21.2638	21.5791	21.0226
240132	1.2654	1.1055	26.7063	29.5310	31.7139	29.3306
240133	1.1406	0.9183	23.6068	26.1836	27.7658	25.8348
240135	***	*	17.8573	16.1837	*	16.9824
240137	1.1919	0.9183	23.1752	23.8666	*	23.5315
240139	1.0798	0.9183	22.4473	23.7898	*	23.1612
240141	1.0222	1.1055	25.1597	26.7173	26.4016	26.1666
240143	0.8521	0.9183	18.9442	21.1180	21.7416	20.6376
240145	***	0.9183	22.6063	*	*	22.6063
240154	1.0199	0.9183	21.3809	23.9643	*	22.6453
240162	1.1601	0.9183	20.4807	22.3136	22.2721	21.7043
240166	1.1135	0.9183	21.5002	23.4265	25.7509	23.5628
240179	0.8255	0.9183	19.8249	20.8449	*	20.3419
240187	1.2137	1.0905	24.8879	26.5129	27.8811	26.4667
240196	0.8421	1.1055	27.2901	28.9380	30.7719	29.0287
240207	1.2007	1.1055	27.4330	29.2395	31.7414	29.5819
240210	1.2500	1.1055	26.6545	29.7227	32.1564	29.5372
240211	0.9023	1.0905	32.8801	44.4214	18.8503	27.6876
240213	1.3095	1.1055	27.5104	31.3974	32.7532	30.8794
250001	1.8170	0.8313	20.9338	21.9176	22.7827	21.9287
250002	0.8813	0.7685	21.6643	20.1310	23.3845	21.6434
250004	1.8313	0.9108	20.9295	20.6828	24.1065	21.8737
250006	1.0428	0.9108	20.3061	21.4038	24.0191	21.9290
250007	1.2343	0.8922	21.2226	23.6933	25.8710	23.5817
250009	1.2453	0.8799	19.7610	20.4329	22.2323	20.8522
250010	0.9833	0.7685	17.6204	19.4130	19.4403	18.8097
250012	0.9469	0.9346	15.6117	20.0493	20.2921	18.4571
250015	1.0268	0.7685	19.3794	20.6931	20.7555	20.2702
250017	1.0970	0.7685	19.0436	18.1013	21.3950	19.5260
250018	0.9215	0.7685	16.8783	17.0689	16.6294	16.8678
250019	1.5528	0.8922	22.9085	22.8358	23.9741	23.2493
250020	0.9918	0.7685	19.1877	19.3390	21.4019	19.9847
250021	***	*	15.8485	15.1242	20.3559	16.0142
250023	0.8443	0.8612	14.7355	16.1820	16.2418	15.7024
250025	1.0405	0.7685	21.2651	20.6892	20.5258	20.8816
250027	0.9794	0.7685	17.5937	17.3313	17.3481	17.4314
250030	***	0.7685	27.2140	*	*	27.2140
250034	1.5307	0.9108	20.3681	20.6752	24.3189	21.8100
250035	0.8545	0.7685	17.1071	14.6149	17.2045	16.2933
250036	1.0038	0.8164	17.0469	17.8313	19.1975	18.0476
250037	0.8638	0.7685	16.6347	17.4463	17.4012	17.1789
250038	0.9832	0.8313	16.8610	18.0209	18.9050	17.9032
250039	0.9125	0.8313	16.8729	15.2939	17.3155	16.4505

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
250040	1.4718	0.8612	20.8178	21.3451	23.2285	21.8161
250042	1.2038	0.9108	19.4367	21.4117	23.4135	21.3957
250043	1.0429	0.7685	17.7554	18.3322	19.8098	18.6971
250044	1.0199	0.7685	20.3711	21.1198	23.3862	21.6199
250045	1.0872	0.8922	25.3236	25.0863	26.3831	25.6144
250048	1.5843	0.8313	19.3635	21.6547	22.9765	21.3756
250049	0.8410	0.7685	13.4396	17.8154	17.7005	16.2411
250050	1.1957	0.7685	16.6723	18.3170	19.1467	18.0183
250051	0.8358	0.7685	10.5027	10.6908	10.6095	10.6008
250057	1.1292	0.7685	19.0571	19.6789	20.1900	19.6573
250058	1.2515	0.7685	16.5565	17.5160	18.1704	17.4280
250059	0.9814	0.7685	19.0733	17.7270	19.2977	18.6884
250060	0.7926	0.7685	14.0155	20.8115	16.8247	17.2475
250061	0.8412	0.7685	11.4573	15.2515	12.8174	12.9127
250065	0.8170	0.8313	16.2010	16.1984	*	16.1997
250066	0.7831	0.7685	16.1044	*	*	16.1044
250068	0.7547	0.7685	16.3759	16.9585	*	16.6506
250069	1.4860	0.8614	21.2224	21.6617	22.8162	21.9460
250071	0.8305	0.7685	13.7056	17.7149	*	15.4400
250072	1.4976	0.8313	20.7827	22.9316	24.6587	22.7773
250077	0.9403	0.7685	14.0318	14.2271	14.7632	14.3259
250078 [2]	1.5963	0.7685	17.5186	18.6563	20.9354	19.1036
250079	0.8383	0.8182	21.3506	27.2549	38.0031	29.5848
250081	1.2295	0.8182	20.4513	21.3830	24.7031	21.9463
250082	1.2744	0.8099	19.5962	20.5212	19.6966	19.9404
250083	0.9072	0.7685	19.5217	19.9484	*	19.7505
250084	1.1575	0.7685	22.4632	21.8001	18.5775	20.7280
250085	0.9532	0.7685	18.0473	18.7367	19.7007	18.8283
250089	1.0502	0.7685	16.0203	*	*	16.0203
250094	1.5886	0.8612	19.9619	22.3312	22.7312	21.7001
250095	0.9965	0.7685	18.6616	19.9553	21.3511	19.9748
250096	1.0784	0.8313	20.7246	22.7458	22.6298	22.0767
250097	1.3963	0.8470	18.8399	19.4534	20.1687	19.4858
250098	***	0.7685	17.9561	*	*	17.9561
250100	1.4464	0.8614	18.8877	22.0328	24.2209	21.7570
250101	***	*	*	21.2234	*	9.7147
250102	1.5446	0.8313	21.3213	22.5518	24.2868	22.7655
250104	1.4244	0.8182	20.5035	21.4431	22.6591	21.5782
250105	0.8995	0.7685	17.0136	17.9468	18.1196	17.6992
250107	0.9071	0.7685	16.7104	16.5369	17.8999	17.0742
250112	0.9521	0.7685	16.8696	19.6172	21.2824	19.4217
250117	1.0298	0.8612	18.8863	19.9774	23.3673	20.6608
250119	***	0.7685	17.1373	*	*	17.1373
250122	1.0617	0.7685	19.7966	23.7230	24.5854	22.7156
250123	1.2675	0.8922	22.2184	22.0486	24.5115	22.9495
250124	0.8390	0.8313	15.6866	15.4343	17.2181	16.1302
250125	1.2819	0.8922	25.3415	26.8379	27.7077	26.6997
250126	0.9380	0.9346	20.1118	20.4085	21.7111	20.7174
250128	0.8826	0.7685	15.8352	15.9344	17.6269	16.4363
250131	0.8879	0.7685	11.5396	*	*	11.5396
250136	0.9767	0.8313	21.9977	22.5832	23.0637	22.5479
250138	1.2637	0.8313	21.2490	22.7902	23.8861	22.6997
250141	1.5358	0.9346	22.5187	24.5772	27.6158	25.2301
250146	0.8784	0.7685	16.9341	17.2328	18.6486	17.5743
250149	0.8979	0.7685	16.4228	15.0367	15.0641	15.5315
250151	0.7214	0.7685	20.4581	21.8697	17.2205	18.4362
250152	1.6630	0.8313	*	*	25.7837	25.7837
250153	***	0.8313	*	*	29.0461	29.0461
260001	1.6129	0.8594	22.6646	25.3084	25.9250	24.6413
260002	***	0.8953	24.6812	27.2329	26.4879	26.0819
260003	1.0250	0.7927	16.5931	17.6339	*	17.1135
260004	0.9578	0.7927	16.4423	16.7742	16.9421	16.7356
260005	1.4759	0.8953	25.5927	24.6142	26.5773	25.6220
260006	1.4271	0.7927	24.1078	26.4948	26.7587	25.8174
260008	***	*	21.6256	17.6040	18.9522	19.2926
260009	1.1793	0.9454	20.1679	21.2729	22.1816	21.2122
260011	1.3859	0.8346	21.1625	21.4409	22.7061	21.7937

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
260012	1.0499	0.7927	17.7854	19.3389	20.3061	19.2632
260013	1.0044	0.8594	18.4857	19.2065	20.5007	19.3903
260015	1.0786	0.7927	21.7581	22.4450	22.5409	22.2644
260017	1.3014	0.8953	20.7837	21.1359	22.7022	21.5787
260018	1.0599	0.7927	14.3278	14.8425	17.0434	15.4340
260020	1.7361	0.8953	22.4709	25.7898	26.0407	24.8648
260021	1.3546	0.8953	27.2478	27.8332	27.6330	27.5756
260022	1.2242	0.8563	20.5417	21.7707	22.8085	21.6784
260023	1.2675	0.8953	19.6324	21.2519	21.2077	20.7002
260024	1.1370	0.7927	16.9968	17.5351	18.4829	17.6819
260025	1.2646	0.8953	19.3535	20.0901	22.4645	20.6596
260027	1.5961	0.9454	22.9973	24.7605	25.3348	24.3810
260029	1.0866	0.9454	22.0390	22.2892	23.1185	22.4857
260031	***	*	24.3626	24.2877	*	24.3260
260032	1.7985	0.8953	21.8830	23.1125	23.8459	22.9657
260034	0.9517	0.9454	21.6108	23.3034	24.1143	23.0518
260035	0.9459	0.7927	15.0468	16.8502	17.8741	16.5641
260036	0.9500	0.9454	19.4559	20.1324	22.1912	20.4830
260040	1.6194	0.8251	20.0422	21.9452	23.3566	21.8297
260044	0.9352	0.7927	18.2413	20.0686	22.4498	20.3210
260047	1.5009	0.8346	22.4585	22.6169	24.4185	23.1892
260048	1.2518	0.9454	26.6363	25.8089	24.3906	25.5119
260050	1.1354	0.7927	20.8510	20.6364	23.6849	21.9007
260052	1.3148	0.8953	21.1297	22.5809	24.5165	22.8077
260053	1.0393	0.8594	18.9606	20.0051	21.6607	20.2038
260057	1.0346	0.9454	15.8404	16.4875	19.3335	17.1879
260059	1.1931	0.7927	17.2807	18.6379	19.7243	18.6135
260061	1.0883	0.7927	18.7280	19.6674	21.5264	19.9180
260062	1.1811	0.9454	25.2958	26.0439	26.4539	25.9705
260063	0.9686	0.9454	21.1284	22.0826	*	21.6180
260064	1.3672	0.8346	17.5188	19.1587	19.0543	18.5908
260065	1.7230	0.8251	22.0058	23.6969	23.0015	22.9155
260067	0.8937	0.7927	14.9792	16.5364	17.6256	16.4270
260068	1.7577	0.8346	22.0951	23.9340	24.9504	23.7077
260070	0.9581	0.7927	11.2251	14.3881	18.4779	14.0836
260073	1.0189	0.7927	17.8185	19.2744	21.6214	19.6354
260074	1.1674	0.8346	18.7639	23.9301	24.8654	22.4254
260077	1.6385	0.8953	21.9947	23.5466	25.5782	23.7347
260078	1.1970	0.7927	16.9217	18.4017	19.0802	18.1811
260080	0.8933	0.7927	13.6815	11.2817	14.7774	13.2210
260081	1.4823	0.8953	22.6627	23.7447	26.3969	24.2793
260085	1.5874	0.9454	22.7394	24.6046	25.6302	24.3659
260086	0.8704	0.7927	17.2048	17.1202	19.1702	17.8711
260091	1.5058	0.8953	23.9975	26.1149	27.2407	25.8446
260094	1.6399	0.8251	20.1043	20.6805	23.2544	21.4540
260095	1.3081	0.9454	22.8156	23.8671	25.5668	24.0702
260096	1.4315	0.9454	23.5009	25.9932	27.5592	25.8492
260097	1.1515	0.7927	19.6203	21.5077	21.3957	20.9049
260102	0.8325	0.9454	24.1041	22.9283	24.2368	23.7509
260103	***	*	21.6192	23.3175	*	22.4894
260104	1.4636	0.8953	22.4769	24.0038	26.2867	24.3941
260105	1.7197	0.8953	24.6572	28.4652	28.8849	27.3498
260107	1.3072	0.9454	23.1564	24.2001	26.7782	24.6444
260108	1.8305	0.8953	22.7975	24.0936	25.0171	23.9907
260110	1.6192	0.8953	22.0026	22.2730	3.7978	22.7167
260113	1.0827	0.8285	16.3440	19.2467	20.9644	18.7740
260115	1.1542	0.8953	20.4880	21.7450	21.9859	21.4408
260116	1.1207	0.8285	16.9807	17.2698	18.5076	17.6168
260119	1.3355	0.7927	18.7959	22.1588	24.9937	22.8442
260120	***	*	18.7651	*	*	18.7651
260123	0.9970	0.7927	17.7996	16.1169	*	17.0002
260127	0.9648	0.7927	19.7946	22.5328	21.8534	21.3553
260134	1.1483	0.8953	18.4511	18.1531	*	18.2845
260137	1.6384	0.8594	20.7638	21.3426	22.7431	21.6630
260138	1.9066	0.9454	25.6579	27.8229	28.5610	27.3740
260141	1.9089	0.8346	21.0771	21.1511	22.4886	21.5378
260142	1.0487	0.7927	18.6412	19.6582	20.3993	19.6104

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
260147	0.9384	0.7927	16.1171	17.2291	18.5153	17.2858
260159	***	0.8953	23.1093	26.8924	23.7427	24.4817
260160	1.0773	0.7927	18.8723	19.4997	21.0544	19.7923
260162	1.3864	0.8953	22.5705	24.1246	25.1423	23.9984
260163	1.1422	0.7927	18.1310	19.2885	20.1949	19.2038
260164	1.0696	0.7927	16.9403	19.5539	19.7068	18.6878
260166	1.1854	0.9454	22.8409	25.5151	27.0237	25.1725
260172	0.9089	0.7927	17.1504	18.1438	*	17.6539
260175	1.1001	0.7927	19.7939	21.1257	22.6171	21.1462
260176	1.5811	0.8953	25.7802	29.2184	27.4244	27.5317
260177	1.2174	0.9454	24.0550	25.0724	26.1178	25.1274
260178	1.8186	0.8346	21.7704	21.4781	22.2251	21.8190
260179	1.5692	0.8953	23.2824	24.8541	26.1419	24.7933
260180	1.5399	0.8953	21.8585	21.9679	26.7461	23.4659
260183	1.6506	0.8953	24.2330	23.3924	26.0418	24.6030
260186	1.6276	0.8346	21.6620	23.4317	25.3148	23.5713
260190	1.1384	0.9454	24.5014	25.1653	26.4505	25.4095
260191	1.3158	0.8953	21.1331	22.4369	23.3856	22.3648
260193	1.2140	0.9454	22.9556	24.4705	26.2979	24.7042
260195	1.2803	0.8251	20.0889	20.1327	22.3958	20.9711
260198	1.1855	0.8953	25.3390	27.6116	27.5996	26.8633
260200	1.2198	0.8953	22.3913	25.1134	24.8624	24.2536
260207	1.0594	0.8251	18.5247	19.2467	19.7294	19.2332
260208	***	*	28.3158	*	*	28.3158
260210	1.2045	0.8953	*	*	25.3782	25.3782
260211	1.5796	0.9454	*	*	33.9109	33.9109
270002 [2]	1.2881	0.8822	19.7588	20.7620	22.7322	21.1317
270003	1.2770	0.9074	23.0396	24.2823	26.4843	24.5714
270004	1.6910	0.8855	21.5577	22.9081	23.5454	22.7035
270009	1.2674	0.8822	21.5655	*	*	21.5655
270012 [2]	1.4482	0.9074	21.7634	23.1697	25.2873	23.4084
270014	1.8188	0.9535	20.3456	25.0650	26.2025	23.6425
270017	1.2612	0.9535	23.2320	24.6186	27.5483	25.1665
270021	1.0085	0.8822	21.1624	21.6758	21.7056	21.5330
270023	1.5160	0.9535	23.7486	25.5525	26.7576	25.3555
270032	1.0500	0.8822	20.1801	18.2377	19.6212	19.3552
270036	0.7848	0.8822	18.8785	21.8255	20.4242	20.3944
270040	1.1798	0.8822	20.7240	*	*	20.7240
270050	1.0303	0.8822	21.0901	22.4195	*	21.7451
270051	1.5685	0.9535	22.2580	26.4457	26.6619	25.1119
270057	1.2222	0.8822	21.9997	22.6251	24.2980	23.0119
270060	0.8776	0.8822	*	16.6592	*	16.6592
270079	0.8473	0.8822	*	21.6382	*	21.6382
270081	1.0052	0.8822	15.6833	17.3174	17.4862	16.8348
270082	1.0621	0.8822	21.0150	19.6173	*	20.3610
270084 [2]	0.9843	0.8822	19.6104	22.2340	*	21.0235
280003	1.8332	1.0197	26.0937	27.2844	29.3921	27.8614
280005	***	*	23.9753	*	*	23.9753
280010	***	*	23.8325	22.6516	*	23.2571
280013	1.8041	0.9555	23.4920	24.5214	26.1908	24.7334
280020	1.7943	1.0197	23.4577	25.7522	26.5068	25.3300
280021	1.1390	0.8666	21.5215	22.2864	22.0489	21.9595
280023	1.4073	0.9666	19.6265	22.7207	22.3230	21.6126
280030	1.9343	0.9555	29.2221	32.5601	30.7481	30.8807
280032	1.3356	0.9666	21.5150	22.6510	23.6462	22.6240
280040	1.6685	0.9555	23.6597	25.2965	26.9827	25.3499
280047	0.7767	0.9555	19.5815	*	*	19.5815
280057	0.8190	0.9666	22.5481	23.6793	20.4830	22.0597
280060	1.6115	0.9555	23.1128	25.2288	26.2139	24.9273
280061	1.3565	0.9207	21.2901	23.9110	24.9482	23.4090
280065	1.2692	0.9597	23.8128	27.9937	26.0135	25.9591
280077	1.3308	0.9555	22.7244	24.0516	25.5624	24.1150
280081	1.6019	0.9555	24.3199	25.1973	26.0541	25.2026
280085	***	*	21.8473	*	*	21.8473
280108	1.0415	0.8666	20.9016	22.5584	23.2502	22.2006
280111	1.2083	0.8666	20.7398	22.1424	23.4770	22.1827
280117	1.0762	0.8666	20.5464	22.0611	24.1521	22.2744

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
280118	0.9146	0.8666	19.3466	*	*	19.3466
280125	1.5050	0.8666	20.0643	21.8385	21.7658	21.2295
280126	***	*	33.8918	*	*	33.8918
290002	0.8621	0.9786	16.8363	16.8433	18.3469	17.3909
290003	1.7448	1.1416	27.4732	27.1099	28.1625	27.5886
290005	1.3375	1.1416	24.6877	27.1531	27.6697	26.5417
290006	1.2159	1.0805	24.2211	26.3617	27.9502	26.1547
290007	1.5966	1.1416	35.1020	35.4193	37.5559	36.0546
290008	1.1726	1.1249	27.0115	26.4086	27.9714	27.1141
290009	1.8521	1.0984	26.9020	27.6011	29.8019	28.1837
290010	1.0895	1.1416	25.4598	23.8733	23.9654	24.4204
290012	1.3288	1.1416	25.8036	27.2675	31.0843	28.0502
290016	1.1453	0.9079	22.5111	25.1726	26.1925	24.6281
290019	1.3967	1.0805	25.1684	27.2484	28.6158	27.0192
290020 [h]	0.9611	1.1416	24.2373	21.3094	21.6993	22.1469
290021	1.7247	1.1416	26.2510	28.3837	33.2116	29.2014
290022	1.5056	1.1416	27.5364	29.8144	29.4422	28.9634
290027	0.9165	0.9079	13.5031	17.8850	15.1448	15.3083
290032	1.3609	1.0984	27.5425	29.4164	31.7105	29.6070
290039	1.5069	1.1416	28.7599	29.6801	31.2941	30.0435
290041	1.3172	1.1416	28.6294	30.1346	33.9878	31.0661
290045	1.5063	1.1416	26.5644	26.9319	30.9612	28.4883
300001	1.5520	1.0668	27.1312	29.4130	27.5032	28.0073
300003	2.0702	1.0668	26.7859	27.8059	33.3560	29.3633
300005	1.4218	1.0668	22.8163	25.1869	25.5583	24.5574
300006	1.1092	1.0668	22.0187	20.6787	23.3200	21.9532
300007	1.2560	1.0903	23.6919	25.3125	26.8347	25.3232
300010	1.2942	1.0668	24.6295	26.9346	27.5028	26.4641
300011	1.3026	1.0903	25.0979	27.3325	28.4044	26.9920
300012	1.3884	1.0903	26.3914	28.4234	30.5198	28.4955
300013	1.0657	1.0668	21.3397	23.1529	*	22.1888
300014	1.2155	1.0668	23.7144	25.5059	27.5151	25.6846
300015	1.0860	1.0668	24.4869	24.0620	*	24.2732
300016	***	1.0668	18.9756	24.5498	*	21.6922
300017	1.2121	1.0668	26.1104	28.3959	29.6957	28.0967
300018	1.3882	1.0668	25.7851	28.0308	29.7209	27.9654
300019	1.2223	1.0903	23.8076	25.3845	25.9656	25.1005
300020	1.1875	1.0903	24.8189	26.8402	28.6723	26.8622
300022	1.1118	1.0668	22.3918	23.5948	24.4048	23.4922
300023	1.4230	1.0668	24.9992	25.4873	28.6309	26.4774
300024	1.2139	1.0668	22.4883	23.9205	*	23.2005
300029	1.7645	1.0668	24.5772	26.9484	29.0806	26.9920
300034	2.0805	1.0903	26.9093	28.5375	29.7484	28.4471
310001	1.7701	1.3191	30.1786	33.9360	35.3612	33.2483
310002	1.8371	1.3191	33.9058	35.4567	37.3461	35.5944
310003	1.2057	1.3191	30.4234	31.1040	32.8935	31.5180
310005	1.3245	1.2192	26.0227	27.5690	29.0084	27.5943
310006	1.2346	1.3191	25.9000	27.0436	27.4545	26.7958
310008	1.3149	1.3191	28.0970	29.5857	31.2579	29.6725
310009	1.2458	1.3191	24.6353	29.7760	32.7384	29.0885
310010	1.2847	1.0837	26.7889	25.3139	28.5852	26.9172
310011	1.2662	1.1031	26.1586	28.5241	30.8612	28.5543
310012	1.6801	1.3191	31.1705	33.1622	34.6882	33.0545
310013	1.3585	1.3191	25.0951	28.5016	30.6248	28.1586
310014	1.8139	1.0607	29.1931	32.7222	29.7204	30.4762
310015	1.8694	1.3191	30.1767	32.4980	36.4776	33.0707
310016	1.3353	1.3191	25.7368	28.9788	33.9862	29.9150
310017	1.3378	1.2192	25.2636	28.0930	30.9233	28.1646
310018	1.1407	1.3191	25.9108	26.9399	30.3381	27.8107
310019	1.6282	1.3191	26.8663	31.0524	29.6592	29.1388
310020	1.5855	1.3191	25.0147	29.3392	30.6722	28.2107
310021	1.6207	1.0837	29.4003	29.6308	31.3410	30.1313
310022	1.2275	1.0607	26.7487	26.1914	28.2024	27.0808
310024	1.3520	1.2192	26.9499	27.5278	30.9171	28.3714
310025	1.2683	1.3191	26.8719	27.7960	31.1274	28.7415
310026	1.2192	1.3191	24.6697	25.3970	27.5171	25.9064
310027	1.2914	1.2192	22.1935	27.0982	53.3590	32.8604

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
310028	1.2218	1.2192	25.7246	29.1101	31.3849	28.7946
310029	1.8622	1.0607	25.9606	29.1439	30.7707	28.6905
310031	2.9677	1.1301	29.5581	30.2345	33.9685	31.2972
310032	1.2894	1.0652	25.7088	27.8754	27.5232	27.0476
310034	1.3320	1.1301	26.5224	27.8517	29.9162	28.1036
310037	1.3242	1.3191	30.1264	32.1471	35.0329	32.5209
310038	1.9813	1.3191	32.3865	32.1977	33.4822	32.7188
310039	1.2457	1.1301	24.6045	27.1054	28.8292	26.9337
310040	1.3638	1.3191	27.4041	28.0068	34.1113	29.8744
310041	1.2679	1.1301	26.8145	29.7335	32.8085	29.8863
310042	1.1514	1.3191	26.9695	29.0207	30.7358	28.9101
310044	1.3163	1.0837	25.1618	27.7752	31.3206	28.1678
310045	1.5833	1.3191	31.7376	32.6359	34.0151	32.8526
310047	1.3107	1.1618	26.1353	28.3415	32.8380	29.2921
310048	1.3562	1.2192	27.4050	28.4715	30.2025	28.7345
310049	***	*	26.5332	32.7666	27.8564	27.2897
310050	1.2751	1.2192	25.3772	27.2276	27.3033	26.7397
310051	1.3708	1.2192	29.2386	32.0113	33.7168	31.6981
310052	1.3032	1.1301	27.0324	28.1498	30.8036	28.6341
310054	1.2802	1.3191	28.1880	30.6905	34.1860	31.0476
310057	1.3058	1.0607	26.3903	26.4606	29.5221	27.5782
310058	1.0940	1.3191	28.1753	26.4816	28.0815	27.5746
310060	1.2669	1.0607	22.1914	23.2146	25.1575	23.5782
310061	1.2605	1.0607	24.9678	27.5400	28.2129	26.9521
310063	1.3317	1.2192	25.9868	28.3457	31.4884	28.5345
310064	1.5192	1.1618	27.8388	29.5979	33.4440	30.4173
310067	***	1.2192	26.3624	26.8068	*	26.5479
310069	1.2630	1.0652	25.7690	27.9656	28.1681	27.3281
310070	1.3475	1.3191	30.1917	32.1806	33.2310	31.9325
310072	***	*	25.3145	26.3520	*	25.8709
310073	1.7716	1.1301	28.8791	29.6611	32.0329	30.2191
310074	1.2859	1.3191	27.6789	28.4361	29.4834	28.5348
310075	1.2656	1.1301	25.7726	26.2479	31.6870	27.8786
310076	1.5940	1.3191	32.4533	34.9428	36.4280	34.6292
310077	1.6607	1.3191	28.7352	30.7465	32.6644	30.7450
310078	1.2963	1.3191	24.7753	26.9589	29.8014	27.2209
310081	1.2485	1.0607	24.6083	26.4259	26.6136	25.9041
310083	1.2961	1.3191	25.2465	24.6563	28.2392	25.9836
310084	1.2192	1.1301	27.3680	29.9437	32.9001	30.0920
310086	1.2110	1.0607	25.2751	27.3601	29.3058	27.3522
310088	1.1766	1.1618	23.7846	25.5274	26.4966	25.2810
310090	1.2599	1.2192	25.3640	27.1661	30.8941	27.8574
310091	1.1909	1.0652	25.6405	27.1115	27.7204	26.8559
310092	1.3547	1.0837	23.2226	25.7071	29.4999	26.1525
310093	1.1809	1.3191	24.6942	25.8727	28.0401	26.2654
310096	2.0766	1.3191	28.4705	30.3675	34.4275	31.1262
310105	1.2212	1.3191	28.7333	30.9968	31.9769	30.6308
310108	1.3809	1.1301	24.9090	29.1548	30.1002	28.0512
310110	1.2871	1.0837	26.4175	27.8707	31.2164	28.8347
310111	1.1936	1.1301	26.2496	28.8692	30.7475	28.7020
310112	1.2335	1.1301	27.8796	28.9928	30.4192	29.1502
310113	1.2365	1.1301	25.9143	27.5203	29.6079	27.7501
310115	1.2658	1.0607	24.5413	26.2803	29.6020	26.9083
310116	1.2404	1.3191	25.1189	26.6287	25.6976	25.7970
310118	1.2786	1.3191	28.0517	28.1238	28.8797	28.3510
310119	1.7690	1.3191	34.7468	35.6786	37.7876	36.1340
310120	1.1565	1.2192	24.7078	27.2010	31.4110	27.6263
320001	1.4765	0.9696	23.0290	26.1962	26.9434	25.3673
320002	1.3821	1.0908	26.7332	28.6963	30.5158	28.6521
320003	1.1105	0.8649	20.7939	22.3911	28.1402	23.4549
320004	1.2830	0.8649	19.4799	24.0362	24.9481	23.1709
320005	1.4230	0.9558	22.1677	21.2164	23.8264	22.4376
320006	1.3163	1.0163	21.1222	22.5615	24.2812	22.6734
320009	1.5090	0.9696	21.5870	24.4237	22.8293	22.9608
320011	1.1653	0.8649	20.7714	23.1539	24.2279	22.7686
320013	1.1462	1.0163	19.4487	27.8671	28.9276	24.8284
320014	1.1040	0.8649	19.7656	26.7112	24.5310	23.5594

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
320016	1.1520	0.8649	19.9326	21.7001	23.5040	21.7285
320017	1.2523	0.9696	22.5460	23.6861	25.0286	23.7296
320018	1.4565	0.8649	21.4650	23.0915	23.2360	22.6002
320019	1.5397	0.9696	26.6900	31.2250	31.5192	29.7045
320021	1.6254	0.9696	21.0913	28.5620	27.2357	25.1851
320022	1.0969	0.8649	20.7919	22.1492	23.7160	22.2284
320030	1.0284	0.8649	16.8696	18.0990	22.1971	18.9458
320033	1.1545	1.0163	24.2703	24.1185	27.6393	25.3263
320037	1.1552	0.9696	19.6466	21.6080	23.3999	21.6108
320038	1.1959	0.8649	19.2962	21.2181	20.1533	20.2270
320046	1.1718	0.8649	21.5915	22.9114	24.3534	22.9610
320063	1.2785	0.9593	20.7804	24.9141	24.4696	23.4155
320065	1.0973	0.9593	19.9012	21.6189	26.6603	22.8070
320067	0.8271	0.8649	13.9459	20.4431	23.7745	19.8406
320069	1.0924	0.8649	18.5375	19.7296	20.9167	19.7352
320074	1.1664	0.9696	28.3086	35.5980	22.2175	28.2084
320079	1.1142	0.9696	21.9090	23.8092	25.2105	23.6814
320083	2.5985	0.9696	20.6771	*	28.2114	23.7546
320084	1.0974	0.8649	*	*	17.2511	17.2511
320085	1.6090	0.8649	*	*	24.8752	24.8752
330001	***	1.3191	30.8509	31.3735	33.4718	31.9148
330002	1.4447	1.3191	28.0882	29.3459	31.1924	29.5603
330003	1.2641	0.8565	20.2744	21.6506	22.9945	21.6443
330004	1.2725	1.0576	24.3703	23.9959	26.0445	24.8414
330005	1.5973	0.8888	24.3578	25.9287	*	25.1198
330006	1.2917	1.3191	28.3904	29.7509	31.5370	29.8730
330008	1.1113	0.8888	20.6816	21.3269	21.8198	21.2850
330009	1.2845	1.3191	33.3605	35.8367	35.4986	34.8796
330010	***	*	19.8211	17.9178	19.6920	19.0804
330011	1.2998	0.8588	19.8035	20.3641	21.8008	20.6687
330013	2.1105	0.8565	21.2063	23.9070	24.3512	23.1632
330014	1.3351	1.3191	32.0824	35.4053	38.8123	35.4565
330016	0.9933	0.8220	18.1603	18.9388	28.4392	20.9735
330019	1.2932	1.3191	31.9042	32.3413	34.7814	33.0323
330023 [2]	1.5678	1.0767	29.4538	29.2669	29.8943	29.5534
330024	1.7206	1.3191	35.3598	36.5648	38.8643	36.8845
330025	1.0421	0.8888	18.7663	19.7561	20.2775	19.6152
330027	1.4553	1.3191	34.1281	35.1325	39.0717	36.0189
330028	1.3838	1.3191	31.8452	33.5312	34.2709	33.2330
330029	0.4208	0.8888	18.4354	18.6623	19.1589	18.7332
330030	1.2550	0.9117	22.0574	22.4368	22.9937	22.4866
330033	1.2667	0.8220	18.6316	21.3762	22.5681	20.8260
330036	1.1360	1.3191	27.0970	27.6813	28.9409	27.8674
330037	1.0926	0.9117	18.3557	19.6385	20.6904	19.5992
330041	1.1922	1.3191	34.5461	36.2481	36.0286	35.6239
330043	1.2957	1.2781	31.7873	34.1039	34.7480	33.5850
330044	1.2690	0.8313	22.0465	23.1450	23.8719	23.0325
330045	1.3308	1.2781	30.9046	34.4956	36.1749	33.9185
330046	1.4018	1.3191	41.6759	42.0900	44.8494	42.8629
330047 [h]	1.1968	0.8565	20.1646	21.1244	24.0678	21.8925
330049	1.3533	1.0767	24.7766	25.7022	29.2904	26.5366
330053	1.0847	0.9117	18.1728	19.6807	18.5290	18.7942
330055	1.6314	1.3191	34.9709	35.1393	38.4839	36.2207
330056	1.4539	1.3191	32.0982	32.9295	37.8444	34.2883
330057	1.6969	0.8565	20.9282	22.6519	24.4680	22.6890
330058	1.3165	0.9117	19.2916	19.5520	20.8234	19.9138
330059	1.5179	1.3191	36.4176	38.1019	39.7386	38.0767
330061	1.2264	1.3191	28.6725	32.7427	33.2848	31.6301
330062	1.1819	0.9204	20.0222	21.4270	21.0464	20.8258
330064	1.1415	1.3191	36.0976	38.5719	36.6153	37.0956
330065	1.0281	0.8888	20.5958	21.9192	23.9128	22.1517
330066	1.3120	0.8565	20.9990	23.0916	24.7941	23.0025
330067 [2]	1.4150	1.0767	24.8927	34.8416	26.4243	28.0084
330072	1.3818	1.3191	32.9665	32.7905	36.4336	34.0607
330073	1.1228	0.9117	18.4162	19.0781	20.1490	19.1772
330074	1.3126	0.9117	21.7299	20.2874	21.4274	21.1093
330075	1.1656	0.9595	19.9781	22.0240	22.4188	21.4854

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
330078	1.4256	0.8888	20.8379	22.7762	23.3786	22.3586
330079	1.3180	0.8220	21.1153	22.1064	22.5237	21.9214
330080	1.1477	1.3191	33.5537	36.1171	39.1724	36.3260
330084	1.0829	0.8220	19.2135	22.6365	21.5455	21.1058
330085	1.1913	0.9315	21.8271	23.2927	23.9568	23.0352
330086	1.3193	1.3191	27.1585	28.8425	29.1784	28.3884
330088	1.0442	1.2781	29.5181	31.2631	*	39.0244
330090	1.4373	0.8276	20.9327	22.7721	23.6174	22.4292
330091	1.3675	0.8888	22.9396	22.5796	23.1637	22.8973
330094	1.2532	0.8904	21.3659	22.1495	23.0001	22.1769
330095	***	*	28.9794	28.9914	31.9872	29.7944
330096	1.0690	0.8220	21.1648	22.4895	22.0337	21.9119
330097	1.1327	0.8220	18.6291	19.2233	20.2158	19.3250
330100	1.0066	1.3191	31.5775	32.8406	34.4621	32.9762
330101	1.8242	1.3191	38.4810	39.2601	38.7468	38.8311
330102	1.3460	0.8888	23.5254	23.6141	24.8184	23.9846
330103	1.0963	0.8220	17.9017	18.8763	21.1452	19.3116
330104	1.3563	1.3191	36.8451	33.7556	32.8818	34.4566
330106	1.7244	1.2781	38.7822	39.8558	41.2202	39.9816
330107	1.2325	1.2781	29.1958	31.8528	31.3888	30.7790
330108	1.1108	0.8276	20.2536	21.4680	22.2607	21.3131
330111	1.0397	0.8888	17.7020	17.6185	20.9387	18.7250
330114	***	*	19.2566	*	*	19.2566
330119	1.7468	1.3191	34.6591	36.5873	39.1114	36.7610
330121	0.9116	0.8220	17.9757	19.7388	23.9397	20.5934
330122	***	*	25.6500	26.3849	*	26.0090
330125	1.7658	0.9117	22.8078	24.6945	26.6379	24.8334
330126	1.2826	1.0767	27.7155	28.8299	31.6370	29.4715
330127	1.2655	1.3191	42.2836	43.7479	44.4667	43.5141
330128	1.1790	1.3191	32.7050	34.5289	*	33.6278
330132	1.0730	0.8220	16.0311	16.3088	17.4946	16.8474
330133	1.3118	1.3191	35.3136	44.0704	36.6962	38.2248
330135	1.2237	1.0767	25.6504	26.9969	29.0837	27.3649
330136	1.4654	0.9315	21.4225	22.5447	24.2010	22.7506
330140	1.7896	0.9595	21.1787	23.5774	25.7573	23.5011
330141	1.3034	1.2781	29.3283	30.6616	34.8902	31.6934
330144	1.0332	0.8220	17.3920	20.1805	20.9935	19.3948
330148	1.0266	0.8313	17.6560	18.5443	*	18.0744
330151	1.1030	0.8220	16.4028	17.6782	19.1841	17.7056
330152	1.3177	1.3191	32.3332	32.0616	36.5136	33.6447
330153	1.7022	0.8565	21.2843	21.9935	23.7172	22.3124
330157	1.3678	0.9315	23.5522	23.6939	24.9042	24.0644
330158	1.5489	1.3191	32.7159	33.0067	32.2990	32.6514
330159	1.3811	0.9595	22.5580	24.1916	28.8391	25.0788
330160	1.5392	1.3191	32.1266	34.0373	34.1960	33.4347
330162	1.2612	1.3191	29.6042	31.3812	32.1783	31.0913
330163	1.2015	0.8888	21.1517	22.4644	24.0200	22.5391
330164	1.4792	0.9117	23.5427	24.4306	28.8481	25.6753
330166 [h]	1.0593	0.8220	18.4262	18.8777	19.4360	18.9008
330167	1.7665	1.2781	30.9667	33.7365	34.4405	33.1152
330169	1.4095	1.3191	36.2725	38.3498	39.3361	37.9349
330171	1.1728	1.3191	25.9946	27.7810	30.0122	27.7871
330175	1.1137	0.8220	20.4628	21.1944	22.2067	21.3007
330177	0.9453	0.8220	19.0005	20.1850	19.6100	19.6031
330180	1.2265	0.8565	19.8951	21.9641	22.1920	21.3178
330181	1.3091	1.3191	37.1218	35.8846	38.5351	37.1836
330182	2.3204	1.3191	35.2416	36.3831	39.6038	37.1311
330184	1.4141	1.3191	30.7479	33.2843	34.4044	32.7893
330185	1.2671	1.2781	28.9787	31.0179	32.3466	30.8714
330188	1.2490	0.8888	21.1196	22.6803	23.9210	22.6030
330189	0.9765	0.8565	19.0726	19.2538	21.6229	19.9266
330191	1.2880	0.8565	20.9392	22.3719	24.0232	22.4577
330193	1.2567	1.3191	36.2427	36.9866	37.1807	36.8214
330194	1.7888	1.3191	38.5372	39.9177	43.9910	40.8421
330195	1.7407	1.3191	36.4249	38.6867	40.0206	38.4696
330196	1.2724	1.3191	31.1915	32.5883	33.2171	32.3484
330197	1.1300	0.8220	20.8386	22.3117	23.4291	22.2164

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
330198	1.3527	1.2781	25.3622	29.5359	30.5485	28.5487
330199	1.1121	1.3191	34.1354	32.7870	35.0059	33.9687
330201	1.6454	1.3191	29.3745	33.3215	39.3682	33.7813
330202	1.2540	1.3191	30.7990	34.3545	35.0804	33.5414
330203	1.4787	0.9595	24.7422	26.2459	26.5882	25.8191
330204	1.3191	1.3191	30.3699	30.3273	37.6849	32.8372
330205	1.2677	1.0767	29.0622	30.0101	32.1617	30.4707
330208	1.1879	1.3191	30.6158	28.2667	29.6282	29.4819
330209	1.1738	1.0767	27.7071	28.7213	29.7988	28.7477
330211	1.1533	0.8220	20.8224	21.1094	22.9966	21.6469
330212	***	1.3191	24.9434	27.0585	27.2232	26.1185
330213	1.1308	0.8220	20.7967	21.7208	22.5191	21.6931
330214	1.9065	1.3191	32.7647	33.7670	37.8500	34.8451
330215	1.3146	0.8313	19.9226	20.6343	22.5715	21.0552
330218	1.0371	0.9595	20.6012	21.4095	24.1106	22.0618
330219	1.6407	0.8888	28.7448	27.7400	29.3803	28.6143
330221	1.3773	1.3191	34.9345	34.7033	36.5539	35.4233
330222	1.2919	0.8565	23.5491	25.9825	23.9746	24.4778
330223	1.0310	0.8220	18.8253	18.4291	19.4229	18.9058
330224	1.2912	0.9260	22.7847	23.9379	25.7396	24.1533
330225	1.1790	1.2781	29.1744	28.9952	29.2719	29.1527
330226	1.3067	0.9117	23.5405	23.4783	21.8977	22.8832
330229 [h]	1.1699	0.8424	18.5590	19.5670	20.6095	19.5838
330230	0.9941	1.3191	32.5997	32.1101	33.3175	32.6586
330231	0.9977	1.3191	30.2184	33.9324	37.0175	33.7403
330232	1.1923	0.8565	21.1277	21.4765	24.2810	22.2924
330233	1.4170	1.3191	39.5133	41.9968	45.5132	42.4372
330234	2.2593	1.3191	37.7135	36.8500	40.6314	38.3961
330235	1.1320	0.9315	21.4643	22.1217	23.3866	22.3225
330236	1.4277	1.3191	31.8491	32.9391	35.6347	33.4921
330238	1.2507	0.9117	18.3846	19.2407	20.8639	19.5443
330239 [h]	1.2261	0.8424	19.7561	20.4936	21.5397	20.5927
330240	1.2179	1.3191	37.3866	40.7478	36.7910	38.3109
330241	1.8763	0.9595	26.7598	27.7213	29.0882	27.8974
330242	1.2925	1.3191	30.5172	32.2178	46.0013	35.2529
330245	1.9001	0.8313	20.2037	21.6857	22.7032	21.5626
330246	1.3295	1.2781	31.8857	31.6763	34.6329	32.7279
330247	1.0067	1.3191	25.6063	32.1733	32.2300	29.8298
330249	1.2019	0.9595	19.1469	21.4345	22.9834	21.2588
330250	1.2791	0.9306	22.1272	23.0641	25.1664	23.4900
330259	1.4142	1.2781	27.4131	30.0488	31.9495	29.9063
330261	1.2516	1.3191	30.4771	30.9356	30.7942	30.7386
330263	0.9776	0.8220	20.0831	20.8456	22.4675	21.1560
330264	1.2367	1.0767	26.3652	28.1501	30.0139	28.1122
330265	1.2729	0.9117	18.2547	19.9414	20.4635	19.5583
330267	1.4649	1.3191	29.0499	30.3709	31.5478	30.3522
330268	0.9506	0.8565	18.7991	18.9142	20.9720	19.5863
330270	2.0316	1.3191	36.5976	38.2605	52.4880	42.6074
330273	1.4020	1.3191	28.8548	29.5106	30.3976	29.6096
330276	1.1013	0.8220	20.7973	21.7826	22.2353	21.6210
330277	1.1667	0.9204	21.8866	25.1438	25.3582	24.1682
330279	1.4462	0.8888	23.8793	23.4816	24.9772	24.1439
330285	1.9363	0.9117	26.0446	27.1260	27.9018	27.0364
330286	1.3657	1.2781	31.1344	32.3244	33.3377	32.3174
330290	1.7357	1.3191	35.5617	36.3764	36.9981	36.3009
330293	***	*	17.6506	19.0290	*	18.3452
330304	1.2821	1.3191	31.1146	33.4431	34.5111	33.0739
330306	1.4608	1.3191	30.4426	30.7551	35.6640	32.2831
330307	1.2103	0.9855	23.8583	25.4128	27.5699	25.6624
330314	1.2270	1.2781	26.2954	26.0150	25.5597	25.9594
330316	1.2997	1.3191	33.7857	33.1512	34.8623	33.9322
330327	***	*	19.3465	*	*	19.3465
330332	1.2570	1.2781	30.5104	31.8389	33.0652	31.9293
330333	***	1.2781	29.7725	33.7637	26.1917	29.6723
330336	***	*	32.9548	*	*	32.9548
330339	0.8062	0.8565	20.8424	22.2812	22.6569	21.9390
330340	1.1756	1.2781	29.8140	31.4322	33.5504	31.6312

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
330350	1.4934	1.3191	35.5656	39.3541	36.6250	37.1672
330353	1.1504	1.3191	35.6821	38.6962	37.6549	37.3737
330357	1.2908	1.3191	36.5461	34.3965	35.5975	35.5017
330372	1.2505	1.2781	28.2490	30.1505	32.6721	30.3998
330385	1.1112	1.3191	44.3387	42.6671	34.7820	40.7280
330386	1.2069	1.0576	25.2064	25.9228	27.9943	26.4367
330389	1.9214	1.3191	32.2112	34.7552	34.7669	33.9210
330390	1.2676	1.3191	32.7450	33.2628	36.0573	33.8898
330393	1.7382	1.2781	33.0953	34.8213	34.8095	34.2742
330394	1.6408	0.8588	21.3678	23.3505	25.2229	23.3324
330395	1.3921	1.3191	32.1089	35.4619	39.6666	35.4994
330396	1.2486	1.3191	31.2429	32.5345	35.0297	32.9828
330397	1.3537	1.3191	40.0884	34.5110	38.4741	37.5361
330399	1.1709	1.3191	32.1248	33.6753	32.3688	32.7392
330401	1.3161	1.2781	33.8633	35.7435	40.5332	36.7926
330402	0.7916	0.9260	*	21.3302	*	21.3302
330403	***	0.9117	*	*	23.1887	23.1887
340001	1.4809	0.9717	21.6113	23.2436	25.0041	23.2441
340002	1.7358	0.9312	24.0145	25.1099	27.3349	25.5169
340003	1.0930	0.8570	20.8205	21.5562	23.3066	21.9251
340004	1.4023	0.9020	23.3756	24.2055	25.4474	24.3851
340005	0.9977	0.8570	20.8150	22.9830	22.3814	22.0177
340007	***	0.9133	19.5208	21.1519	*	20.3174
340008	1.0820	0.9585	22.7338	24.2089	26.6314	25.0622
340010	1.3214	0.9476	21.3024	23.1349	24.5666	23.0280
340011	1.0509	0.8570	18.1926	18.1843	19.9484	18.7756
340012	1.2823	0.8570	19.6350	22.0583	22.7189	21.4818
340013	1.2354	0.9585	21.0066	22.4787	23.0261	22.1688
340014	1.5332	0.9020	22.6757	24.4831	25.1872	24.1069
340015 [h]	1.3596	0.9717	24.3410	24.3870	26.2276	25.0387
340016	1.2110	0.8570	20.2859	22.7574	23.0359	22.0228
340017	1.2648	0.9312	21.7083	22.8879	23.8229	22.8228
340018	1.1294	0.9183	17.3480	20.3840	23.7243	20.2881
340019	0.9618	0.9020	16.7901	17.8768	*	17.3292
340020	1.1895	0.8570	21.3385	24.1955	23.7995	23.1233
340021	1.2956	0.9585	22.9208	23.6884	26.0995	24.2587
340022	***	0.8570	19.9078	*	*	19.9078
340024	1.1553	0.8570	20.4906	21.2671	22.2521	21.3515
340025	1.2401	0.9312	20.2864	20.9915	21.2276	20.8493
340027	1.1523	0.9414	21.0975	22.6107	23.6326	22.4564
340028	1.5451	0.9426	22.2028	24.6836	26.3298	24.3471
340030	2.0360	1.0260	26.7753	27.4664	29.3043	27.9060
340032	1.3877	0.9717	23.2204	24.8031	26.7475	25.0122
340035	1.0281	0.8570	16.4821	21.2407	23.5476	20.1377
340036	1.1712	0.9709	20.8313	22.2089	25.2077	22.9528
340037	1.0024	0.8570	21.9524	22.5089	21.6411	22.0344
340038	1.1871	0.8570	13.9936	14.0203	14.0713	14.0327
340039	1.2862	0.9585	24.8246	25.6605	27.1275	25.9204
340040	1.9063	0.9414	22.4777	24.1523	26.3325	24.3631
340041	1.2302	0.8931	17.6319	23.0497	23.4891	21.2362
340042	1.0903	0.8570	21.1107	22.1107	23.0236	22.0702
340044	0.9395	0.8570	18.2154	21.7089	22.8948	20.8194
340045	0.9726	0.8570	17.4066	14.5004	23.1918	18.0750
340047	1.8926	0.9020	22.5199	25.3727	25.0605	24.3496
340049	2.0329	1.0260	21.2734	22.3082	30.4827	24.7548
340050	1.0881	0.9193	20.3262	21.4511	24.2533	22.0481
340051	1.2288	0.8931	20.3057	21.9069	23.4091	21.9456
340053	1.5911	0.9717	24.9768	26.9361	27.7261	26.5947
340055	1.2318	0.8931	23.2990	24.3728	24.1057	23.9407
340060	1.0613	0.9133	20.8077	22.4303	22.8657	22.0570
340061	1.8009	1.0260	25.1081	26.6657	27.5594	26.4994
340064	1.0787	0.8570	19.4523	22.3631	22.9143	21.5916
340065	1.1887	0.8570	20.3296	20.8413	*	20.5941
340067	***	*	22.2565	*	*	22.2565
340069	1.8692	0.9993	24.4650	27.5045	27.4473	26.5163
340070	1.2588	0.8902	22.2605	23.6045	24.9033	23.6142
340071	1.1237	0.9476	19.9561	22.1854	25.4537	22.5747

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
340072	1.1835	0.8570	19.2773			
21.3320	22.6474	21.0148				
340073	1.3746	0.9993	26.6829	29.4189	30.2076	28.9147
340075	1.2112	0.8931	23.2904	24.1297	26.0225	24.4391
340084	1.1875	0.9717	20.8175	21.3227	21.2580	21.1447
340085 [h]	1.1572	0.9133	21.7112	23.0890	23.9793	22.8869
340087	1.1889	0.8570	17.8215	18.4202	22.0070	19.3351
340088	1.3425	0.8570	22.8687	24.3299	*	23.5994
340090	1.2312	0.9709	20.3261	21.7173	23.4542	21.9222
340091	1.5335	0.9020	23.1430	24.9411	25.8266	24.6682
340096 [h]	1.1818	0.9133	22.1174	23.6345	25.2169	23.6523
340097	1.1843	0.8570	20.8690	22.5775	24.2127	22.5886
340098	1.4546	0.9717	24.2262	25.4823	27.3308	25.7030
340099	1.1671	0.8570	17.5114	20.0178	20.3683	19.3181
340104	0.8280	0.8570	12.9949	14.3252	15.7521	14.3947
340106	1.0782	0.8570	20.1076	22.6979	22.4894	21.8047
340107	1.1794	0.8924	21.0960	22.5583	22.9698	22.2242
340109	1.3188	0.8841	20.4341	22.3826	23.4419	22.1467
340113	1.8523	0.9717	25.0729	26.0776	28.2546	26.5138
340114	1.6227	0.9993	19.9142	25.4533	26.6813	23.7911
340115	1.5773	0.9993	23.8284	25.1907	25.0212	24.7040
340116	1.7011	0.8931	23.9643	26.1641	25.3213	25.1777
340119	1.1252	0.9717	21.2239	22.4821	24.2287	22.6894
340120	1.0360	0.8570	19.9860	21.8548	23.0916	21.7078
340121	1.0374	0.9580	19.9409	20.3701	21.7576	20.7129
340123	1.1858	0.9133	22.3711	23.1879	26.1083	23.9306
340124	1.0791	0.9476	17.5691	18.3866	20.8018	18.8482
340126 [h]	1.2269	0.9709	21.4271	23.5405	25.0189	23.3764
340127	1.1717	0.9993	22.9672	24.6096	25.4786	24.4245
340129	1.2519	0.9585	22.3260	24.1356	25.4902	24.1365
340130	1.3631	0.9717	22.7687	23.0937	25.2941	23.7854
340131	1.5298	0.9414	24.1370	25.2989	27.9358	25.8415
340132	1.1782	0.8570	17.8771	20.4222	21.3521	19.8892
340133	0.9920	0.8570	23.1444	22.1588	22.5558	22.6188
340137	0.9669	0.8931	33.1751	29.9903	21.0642	28.4915
340138	0.8241	0.9993	29.5286	27.4767	*	28.5643
340141	1.6446	0.9580	24.2033	24.8132	27.3355	25.5266
340142	1.1805	0.8570	20.4320	22.1298	22.9907	21.8836
340143	1.4579	0.8931	23.0416	24.8904	25.3633	24.4002
340144	1.2329	0.9585	25.4598	25.6538	27.2686	26.1330
340145	1.2957	0.9585	21.8120	23.7028	23.7131	23.0768
340146	1.0505	0.8570	20.7252	18.8354	*	19.6880
340147	1.2003	0.9476	22.6057	23.9998	25.4534	24.0568
340148	1.3349	0.9020	20.8156	22.4205	23.5880	22.2985
340151	1.1033	0.8570	19.2593	22.2613	22.0052	21.1161
340153	1.9092	0.9717	23.7426	25.7078	26.4896	25.3204
340155	1.4341	1.0260	26.3663	28.8758	30.5006	28.6119
340158	1.1034	0.9580	21.7489	23.4724	26.4849	23.8953
340159	1.1424	1.0260	21.2983	22.1872	23.2991	22.2743
340160	1.2720	0.8570	18.7569	19.1330	20.7525	19.5589
340166	1.3649	0.9717	22.8349	25.7398	26.0557	24.9254
340168	***	0.9580	16.8278	16.8076	17.3249	17.0046
340171	1.1811	0.9717	25.9603	27.2074	28.2734	27.2246
340173	1.2448	0.9993	23.7037	26.6128	27.5072	26.0994
340176	***	*	26.5277	*	*	26.5277
340178	***	0.9426	*	*	28.7219	28.7219
350002	1.7334	0.7519	20.4398	20.6474	22.0283	21.0339
350003	1.1580	0.7278	21.0585	25.3076	21.8061	22.5764
350004	***	*	28.3773	27.5891	*	28.0246
350006	1.6770	0.7278	19.7577	19.5870	19.4985	19.5737
350009	1.0756	0.8778	20.2558	20.7014	23.0873	21.3437
350010	1.0942	0.7278	17.2489	18.5682	19.1965	18.3109
350011	1.9473	0.8778	21.9111	22.3896	23.1947	22.5594
350014	0.9131	0.7278	16.1718	18.5360	17.7565	17.4777
350015	1.6703	0.7519	18.5437	18.6381	19.7027	18.9716
350017	1.4352	0.7278	19.1952	20.1943	21.0243	20.1512
350019 [2]	1.6643	1.1521	21.3589	24.2382	32.2306	26.4362

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
350027	1.0413	0.7278	17.6731	14.2262	*	15.5713
350030	0.9514	0.7278	18.8822	19.2282	18.9978	19.0373
350043	***	*	18.8378	20.9732	*	19.9618
350058	0.9697	0.7278	15.0196	*	*	15.0196
350070	1.9138	0.8778	*	24.4464	25.2836	24.8833
360001	1.3315	0.9604	22.2387	23.7750	23.9101	23.2970
360002	1.1905	0.8788	20.7586	22.6923	24.5789	22.7274
360003	1.8081	0.9604	24.4144	26.3180	27.5029	26.0650
360006	1.9867	0.9848	24.0814	25.7041	27.9925	25.9633
360007	***	*	19.1315	*	*	19.1315
360009	1.5653	0.9263	22.4076	23.2659	23.1012	22.9250
360010	1.1890	0.8979	20.6290	22.0262	23.1178	21.9858
360011	1.3220	0.9848	21.4293	22.4482	25.5340	23.0257
360012	1.3639	0.9848	24.3618	25.5913	27.5470	25.9629
360013	1.0996	0.9263	24.4232	25.1588	26.8129	25.4875
360014	1.1458	0.9848	22.9372	23.8305	25.3861	24.0832
360016	1.4261	0.9604	22.8430	24.6587	26.1283	24.5377
360017	1.7197	0.9848	23.6181	25.4969	27.2910	25.5905
360018	***	*	29.9085	*	*	29.9085
360020	1.6198	0.9197	21.5085	22.3795	24.4343	22.8262
360024	***	*	22.5356	24.0612	23.5499	23.3173
360025	1.3926	0.9197	21.6676	23.6574	25.5633	23.7829
360026	1.2762	0.9069	20.8825	22.3303	23.5898	22.2676
360027	1.6543	0.9197	23.5907	24.7093	25.4894	24.6187
360029	1.0888	0.9573	20.4924	20.8778	22.7785	21.4073
360031	***	*	24.3482	24.4324	*	24.3900
360032 [h]	1.1314	0.9263	21.1743	22.9759	23.2638	22.4807
360034	1.1035	0.8788	21.5621	25.1366	*	23.3553
360035	1.7092	0.9848	24.2433	25.6895	27.5220	25.8774
360036	1.2117	0.9197	22.3567	25.0910	27.6094	25.0649
360037	1.3504	0.9197	32.6245	25.1615	24.3982	26.6839
360038	1.4244	0.9604	23.4855	24.8294	22.8009	23.7144
360039	1.4713	0.9848	23.4642	22.5921	24.0218	23.3755
360040	1.1396	0.8788	21.3307	22.8729	24.0942	22.7498
360041	1.4432	0.9197	22.1352	23.2625	24.1080	23.2048
360044	1.0612	0.8788	19.7212	20.4724	21.8411	20.6845
360046	1.1923	0.9604	22.8425	23.8918	25.0775	23.9800
360047	0.9522	0.8788	17.5885	17.1973	21.7248	18.9388
360048	1.7400	0.9573	24.7150	27.2274	28.8107	26.8831
360049	1.1298	0.9197	22.4939	24.2605	25.8367	24.2864
360051	1.6658	0.9069	23.0658	25.1785	25.7556	24.7297
360052	1.5398	0.9069	22.5005	23.3285	24.5405	23.5101
360054	1.2774	0.8788	19.2884	20.3176	22.6157	20.7734
360055	1.3753	0.8788	23.5586	25.1475	26.3112	24.9991
360056	1.5352	0.9604	22.4475	23.4638	23.1024	22.9631
360058	1.1220	0.8788	21.0768	22.7943	23.4434	22.4515
360059	1.4684	0.9197	23.0775	25.5222	25.3516	24.6433
360062	1.5341	0.9848	24.5746	26.8091	28.6518	26.7475
360064	1.5318	0.8788	21.3424	22.8729	22.2393	22.1811
360065	1.2012	0.9197	22.9727	24.0868	26.3036	24.5445
360066	1.5310	0.9263	24.6806	25.2316	27.3362	25.7779
360068	1.8254	0.9573	22.1110	23.7895	25.8414	23.9678
360069	1.1231	0.9573	20.5349	25.7032	24.2444	23.4234
360070	1.6302	0.8957	21.8228	23.1687	24.8863	23.3191
360071 [h]	1.2089	0.9263	21.4478	21.6176	22.0786	21.6950
360072	1.3941	0.9848	21.3736	23.0464	24.1825	22.9257
360074	1.2640	0.9573	22.2368	23.6172	24.9055	23.6214
360075	1.1808	0.9197	23.8492	24.7610	26.8453	25.2573
360076	1.3773	0.9604	22.5863	22.5943	25.9369	23.7285
360077	1.5368	0.9197	23.3686	24.7086	25.6505	24.5864
360078	1.2606	0.9197	23.3799	24.6821	26.1313	24.7447
360079	1.7689	0.9604	25.9623	25.8762	26.0935	25.9804
360080	1.0696	0.8788	18.7213	19.5436	20.8309	19.7267
360081	1.3058	0.9573	22.1973	25.1439	27.5695	24.8761
360082	1.3694	0.9197	25.2254	27.4264	27.1197	26.6255
360084	1.5327	0.8957	23.3257	25.2059	25.8415	24.8445
360085	2.0605	0.9848	24.6618	27.5792	29.0081	27.1579

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
360086	1.5132	0.9069	21.5983	22.3005	22.1859	22.0265
360087	1.4212	0.9197	23.9638	25.9131	25.4040	25.0901
360089	1.1144	0.8788	21.0229	21.0253	22.7951	21.6142
360090	1.4694	0.9573	22.6236	24.4291	26.7717	24.5859
360091	1.2086	0.9197	23.5759	26.0541	27.5067	25.7352
360092	1.2241	0.9848	21.9732	23.5100	25.6618	23.7647
360093	1.0308	0.8788	21.4623	24.1238	23.2648	22.9528
360094	***	*	22.6440	27.1864	26.6348	24.9723
360095	1.2895	0.8788	23.6518	24.6984	*	24.1867
360096	1.0859	0.8788	22.0673	22.2333	24.6317	22.9802
360098	1.4042	0.9197	22.7644	23.6413	24.8447	23.7933
360099	***	0.8788	20.8524	*	*	20.8524
360101	1.3585	0.9197	26.2875	27.7584	26.6208	26.9092
360106	1.0794	0.8788	19.8658	21.6450	24.1588	21.9428
360107	1.0416	0.9197	23.6880	24.5365	25.9697	24.7438
360109	1.0852	0.8788	23.0178	24.3236	25.4184	24.2613
360112	2.0143	1.0628	25.5910	26.7880	28.6784	26.9982
360113	1.2415	0.9604	22.3348	23.5138	25.6493	23.7408
360115	1.2494	0.9197	22.3926	24.0232	24.0052	23.4857
360116	1.2224	0.9604	21.3809	23.4049	18.0655	20.9510
360118	1.4861	*	23.0070	24.2526	*	23.6564
360121	1.2367	0.8788	23.2515	25.2037	*	24.2319
360123	1.4129	0.9197	23.1310	24.1761	22.6523	23.2730
360125	1.1792	0.9197	21.1408	22.6871	22.1096	21.9849
360126	***	*	22.2409	*	*	22.2409
360129	0.9317	0.8788	17.9151	19.5336	*	18.7493
360130	1.4471	0.9197	20.1257	21.7015	22.9762	21.5955
360131	1.2314	0.8957	21.7838	23.1730	24.0495	23.0299
360132	1.2426	0.9604	23.4179	25.7991	25.9453	25.1258
360133	1.6206	0.9069	22.0958	23.9457	24.6208	23.6001
360134	1.6811	0.9604	23.6817	25.3013	29.2975	26.0944
360137	1.6781	0.9197	23.8947	25.7647	26.9522	25.5442
360141	1.6446	0.8788	25.1442	31.0127	27.7085	27.9618
360142	0.9699	0.8788	20.6728	21.2084	22.1610	21.3780
360143	1.3211	0.9197	22.2275	23.8938	24.6306	23.6169
360144	1.3179	0.9197	24.7973	26.7160	24.0350	25.1500
360145	1.7297	0.9197	22.4813	23.4743	25.8268	23.9319
360147	1.3504	0.8788	20.0409	22.7172	24.1953	22.4020
360148	1.0603	0.8788	21.3211	24.4873	26.1946	24.0470
360150	1.1923	0.9197	24.8485	25.8703	24.7667	25.1568
360151	1.4859	0.8957	21.7215	22.2179	24.8629	22.8949
360152	1.4689	0.9848	22.9352	24.9894	27.9147	25.0211
360153	0.9512	0.8788	17.3367	19.0844	19.0226	18.4206
360154	0.9805	0.8788	16.2416	17.1274	*	16.6874
360155	1.4857	0.9197	23.0020	23.9466	25.3787	24.1428
360156	1.1333	0.8788	21.2853	22.6709	24.0510	22.6856
360159	1.2322	0.9848	23.3359	25.7108	33.1613	27.1828
360161	1.3645	0.8788	21.5114	22.6005	24.3792	22.8785
360163	1.8834	0.9604	23.1500	25.7966	26.9728	25.2619
360170	1.1824	0.9848	22.2815	22.9359	24.3620	23.3031
360172	1.3907	0.9197	22.7104	23.4727	26.3388	24.1922
360174	1.2111	0.9069	21.7129	22.8167	24.9990	23.2230
360175	1.1979	0.9848	22.7887	24.6152	26.5949	24.7311
360177	1.1457	0.8788	20.8194	23.4256	24.4712	22.9543
360178	***	0.8788	18.2393	*	*	18.2393
360180	2.2595	0.9197	25.1499	26.8720	26.1514	26.0861
360185	1.1807	0.8788	21.1245	21.8641	23.7173	22.2403
360187	1.5760	0.9069	21.9499	23.8362	24.8173	23.5639
360189	1.1222	0.9848	20.0275	24.2512	24.2136	22.8164
360192	1.3138	0.9197	24.9995	26.2976	26.7577	26.0512
360194 [h]	1.1529	*	20.3677	22.3297	*	21.3611
360195	1.0716	0.9197	23.1897	25.8043	26.1280	25.1222
360197	1.0908	0.9848	23.1378	24.7539	26.7508	24.9131
360203	1.1451	0.8788	19.3642	21.5564	22.1414	21.0862
360210	1.1668	0.9848	25.0811	26.5665	27.8415	26.5578
360211	1.5541	0.8840	22.4529	23.0884	22.5449	22.6945
360212	1.3654	0.9197	22.8041	24.5310	25.2756	24.2166

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
360218	1.1698	0.9848	22.8060	24.4720	27.4288	25.0106
360230	1.6048	0.9197	24.7681	26.6444	27.0223	26.1931
360234	1.3014	0.9604	22.1787	23.3325	24.2539	23.2304
360236	1.1515	0.9604	22.8821	21.3795	35.8144	24.3729
360239	1.3119	0.9069	23.5802	24.4398	25.2474	24.5362
360241	***	0.9197	23.4061	24.8089	24.7001	24.1133
360245	0.5232	0.9197	18.1015	18.7966	19.1885	18.7327
360247	0.3785	0.9848	*	25.1083	19.8892	22.3390
360253	2.2434	0.9069	31.3006	28.2555	30.4276	29.8452
360254	***	*	30.0792	*	*	30.0792
360257	1.0766	0.8788	*	17.9652	*	17.9652
360259	1.1777	0.9573	*	*	25.1338	25.1338
360260	***	0.8979	*	*	27.3903	27.3903
360261	1.7759	0.9482	*	*	22.5431	22.5431
360262	1.3387	0.9573	*	*	27.1680	27.1680
360263	1.6685	0.9263	*	*	20.8884	20.8884
370001	1.6782	0.8313	25.5838	26.2391	27.7549	26.5495
370002	1.1821	0.7615	18.9544	19.7718	20.1479	19.6308
370004	1.0932	0.8458	21.5041	24.7694	25.3919	23.7972
370006	1.2069	0.7615	15.6333	16.9469	20.1063	17.6384
370007	1.0399	0.7615	16.7598	17.2084	17.6547	17.2160
370008	1.3885	0.9043	22.1596	22.7419	24.2978	23.1423
370011	1.0810	0.9043	17.1458	19.2266	19.7821	18.6737
370013	1.5187	0.9043	21.1512	22.6451	24.9295	22.9792
370014	1.0403	0.8971	21.8473	24.8138	25.3576	24.0194
370015	0.9737	0.8313	20.3966	21.1833	23.6693	21.7009
370016 [h]	1.4747	0.8682	20.4407	24.2737	25.4062	23.3330
370018	1.4098	0.8313	20.8357	23.4286	23.5336	22.5984
370019	1.2184	0.7615	18.1260	19.6761	21.4474	19.7475
370020	1.2243	0.7615	16.8631	17.4835	18.5046	17.6368
370022	1.1976	0.7673	20.2432	18.4217	19.6495	19.4375
370023	1.2396	0.7615	19.3386	20.6002	21.5762	20.5441
370025	1.2545	0.8313	20.2845	22.0287	23.5659	21.9757
370026 [h]	1.5077	0.8682	21.9140	22.5734	23.0848	22.5236
370028	1.8453	0.9043	24.1009	24.8661	26.6153	25.1976
370029	1.0293	0.7615	19.5811	22.1163	23.9956	21.8559
370030	1.0428	0.7615	18.6541	20.3315	23.3037	20.7201
370032	1.4479	0.9043	20.0827	21.6029	23.4843	21.7536
370034	1.1924	0.7986	16.1540	17.6247	18.2341	17.3349
370036	1.0216	0.7615	16.5844	16.9222	17.7576	17.1504
370037	1.6563	0.9043	21.0719	23.1256	23.9685	22.7803
370039	1.0902	0.8313	20.3137	21.0793	21.8220	21.0783
370040	1.0053	0.8231	18.9981	21.1061	22.4048	20.8291
370041	0.8812	0.8313	19.0144	22.0082	22.3496	21.1267
370042	0.9473	0.7615	14.0899	15.3613	*	14.7180
370043	0.9286	0.7615	20.2929	21.5588	*	20.9707
370045	0.9116	0.7615	12.6613	14.6370	*	13.6711
370047	1.4244	0.8971	19.4856	19.7112	20.4657	19.9082
370048	1.0975	0.7615	15.4768	17.7273	19.2464	17.4431
370049	1.2985	0.9043	20.4826	21.6878	23.2171	21.8100
370051	1.0467	0.7615	12.0397	14.6254	17.2618	14.4702
370054	1.2568	0.7615	20.3788	21.5521	21.5043	21.1653
370056	1.6060	0.7916	20.4872	21.7647	22.0312	21.4507
370057	0.9425	0.8313	17.3020	18.0426	19.7284	18.3749
370060	0.9342	0.8313	23.1897	23.8007	18.7592	21.7395
370064	0.8954	0.7615	11.9044	14.1879	14.2053	13.4809
370065	1.0179	0.7615	18.3966	20.6537	20.0226	19.6691
370072	0.7985	0.7615	12.5765	14.6387	9.9616	11.8723
370076	***	*	19.0230	21.5461	*	20.2863
370078	1.6061	0.8313	22.2318	23.9507	25.4161	23.9078
370080	0.9012	0.7615	16.1444	17.4857	18.0665	17.2314
370082	***	0.7615	12.6060	*	*	12.6060
370084	0.9685	0.7615	16.1278	17.2735	16.6514	16.7384
370089	1.0714	0.7615	18.0505	19.9021	20.4699	19.4850
370091	1.6980	0.8313	24.2117	22.9893	20.8950	22.6316
370093	1.6152	0.9043	23.5685	25.7296	26.9774	25.3740
370094	1.3966	0.9043	20.6507	22.0591	23.1191	21.9907

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
370095	0.8800	0.7615	14.3563	16.5310	*	15.4277
370097	1.2850	0.7916	20.3218	21.7150	22.3267	21.5064
370099	1.0065	0.8313	20.2001	20.5217	20.5075	20.4227
370100	0.9736	0.7615	13.0681	14.1883	14.7712	14.0181
370103	0.9494	0.8038	15.6110	16.1408	17.8018	16.5505
370105	1.8469	0.9043	22.4493	22.1584	23.8978	22.8583
370106	1.3329	0.9043	24.1115	24.2393	26.5867	25.0105
370108	***	0.7615	13.8170	*	*	13.8170
370113	1.1317	0.8615	21.4267	23.3011	25.3565	23.3322
370114	1.5494	0.8313	19.4933	21.0603	21.7880	20.8230
370123	***	0.9043	20.5180	22.8174	25.4733	22.7986
370125	0.8500	0.7615	17.9240	17.2013	17.1361	17.4038
370138	1.0187	0.7615	19.0403	19.8308	18.3113	19.0435
370139	0.9394	0.7615	16.3224	17.8900	18.5225	17.5400
370141	***	*	24.7859	*	*	24.7859
370149 [h]	1.2033	0.9043	18.2260	21.0608	22.3537	20.7832
370153	1.0423	0.7615	17.9692	18.5417	19.8349	18.7951
370154	***	0.7615	17.4760	*	*	17.4760
370158	1.0192	0.9043	17.3412	17.3161	18.5578	17.7592
370166	0.9772	0.8313	21.3628	21.9070	23.1681	22.1327
370169	0.8969	0.7615	16.5607	15.7686	15.8002	16.0704
370176	1.1057	0.8313	22.1456	23.0324	25.0509	23.4362
370177	1.0170	0.7615	14.0279	15.6723	14.7193	14.7923
370178	0.8922	0.7615	12.9635	14.9767	14.6070	14.1857
370179	0.9231	0.8313	21.9673	22.8322	23.5794	22.6918
370183	1.0143	0.8313	17.9270	20.5025	21.8147	20.0076
370186	0.9064	0.7615	16.3879	*	*	16.3879
370192	1.7741	0.9043	24.3832	26.1338	31.4930	27.6466
370196	1.0758	0.9043	23.6334	29.4383	22.6824	25.4359
370199	0.9440	0.9043	20.7075	23.7340	26.0451	23.4652
370200	1.1666	0.7615	16.7164	18.1008	17.6317	17.5059
370201	1.7335	0.9043	18.9906	23.1240	23.3550	21.7730
370202	1.5326	0.8313	24.0239	24.4920	25.1181	24.5965
370203	1.3678	0.9043	19.8772	21.2426	23.5190	21.5182
370206	1.6351	0.9043	22.3471	27.4495	26.0912	25.5795
370207	***	*	26.3746	*	*	26.3746
370210	2.0839	0.8313	*	20.0360	21.2682	20.6946
370211	0.9454	0.9043	*	*	26.5344	26.5344
370212	1.5402	0.9043	*	*	21.0758	21.0758
370213	***	0.9043	*	*	29.3777	29.3777
370215	2.4364	0.9043	*	*	32.3589	32.3589
380001	1.1877	1.1229	20.9585	27.8554	29.7467	26.1275
380002	1.1956	1.0284	25.2629	26.3348	27.1861	26.3148
380003	***	1.0284	24.6377	*	*	24.6377
380005	1.3582	1.0284	26.3472	28.0682	30.2211	28.3075
380006	1.1408	1.0284	24.7492	26.0475	*	25.3948
380007	1.9556	1.1229	30.0497	31.5207	33.9969	31.9322
380008	1.1289	1.0328	24.6149	25.4494	25.8356	25.3227
380009	1.8990	1.1229	26.0012	30.4198	31.7042	29.4616
380010	0.9763	1.1229	25.5234	27.5291	30.2957	27.8451
380011	***	1.0284	21.9382	*	*	21.9382
380014	1.8048	1.0711	28.4536	27.7255	29.9648	28.7806
380017	1.7793	1.1229	29.2543	31.7440	32.2447	31.1318
380018	1.7996	1.0284	27.5171	27.8952	28.0701	27.8359
380020	1.3856	1.0810	23.7066	25.8320	28.3563	26.0268
380021	1.4351	1.1229	28.0334	29.3001	29.3295	28.9428
380022	1.2181	1.0328	26.4794	27.8683	29.2642	27.9316
380023	1.1682	1.0284	23.0079	23.7073	26.5439	24.4358
380025	1.2837	1.1229	28.8525	30.2628	33.2105	30.8181
380026	1.1324	1.0284	23.8666	26.5217	*	25.2072
380027	1.2867	1.0492	21.5822	23.8758	25.5161	23.7359
380029	1.2971	1.0445	24.2939	26.2070	26.9966	25.9075
380033	1.6592	1.0810	30.4783	29.7995	30.8767	30.3883
380035	1.0421	1.0284	26.2434	26.4784	*	26.3599
380037	1.2266	1.1229	25.0200	27.1884	30.5818	27.7342
380038	1.2591	1.1229	29.1804	30.5903	34.2303	31.3814
380039	0.9755	1.1229	27.5115	30.1544	32.3959	30.0601

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
380040	1.1950	1.0284	21.5958	28.4373	32.0103	27.1504
380047	1.8037	1.0492	26.5017	27.8385	29.8627	28.1638
380050	1.3931	1.0284	23.1332	24.2416	25.6190	24.3627
380051	1.5718	1.0445	26.2384	28.1305	29.7219	28.0410
380052	1.1643	1.0284	21.2567	22.6799	24.9476	22.9567
380056	0.9458	1.0445	22.3571	25.0068	25.1475	24.2275
380060	1.4020	1.1229	27.8551	30.2507	29.5370	29.2476
380061	1.6536	1.1229	27.3827	29.5145	29.8217	28.9273
380066	1.2243	1.0284	23.3581	27.5412	*	25.5211
380070	1.1747	1.1229	34.1039	*	*	34.1039
380072	0.8417	1.0284	21.9516	22.5275	*	22.2419
380075	1.3046	1.0284	25.1930	27.4795	29.0368	27.3082
380081	1.1379	1.0284	22.1822	21.0708	21.8850	21.7195
380082	1.2215	1.1229	28.0668	30.2721	32.4909	30.3569
380089	1.2717	1.1229	29.6989	30.8396	33.4214	31.3234
380090	1.2689	1.0284	31.8702	33.6822	34.4536	33.3615
380091	1.2950	1.1229	31.2807	35.7002	33.8950	33.5968
390001	1.6397	0.8530	21.5154	22.4407	22.5309	22.1581
390002	1.2571	0.8840	22.0646	23.0113	22.4388	22.5092
390003 [h]	1.1657	0.8530	19.1857	21.3182	21.6478	20.7084
390004	1.5540	0.9317	21.3475	23.4063	24.3249	23.1020
390005	0.9829	0.8746	19.0727	19.0318	*	19.0497
390006	1.8357	0.9145	23.0378	23.3960	25.1216	23.8687
390008 [h]	1.1582	0.8840	19.9417	21.0021	22.2680	21.0752
390009	1.7277	0.8746	21.9459	24.2789	25.5482	23.9471
390010	1.2001	0.8840	19.4377	21.6273	23.5390	21.5537
390011	1.3112	0.8348	18.6548	19.8602	21.9279	20.1129
390012	1.2176	1.1030	28.5114	*	28.5076	28.5093
390013	1.2121	0.9145	22.1679	23.3180	24.0044	23.1713
390016 [h]	1.1998	0.8446	18.1536	19.9899	21.9549	20.1569
390017 [h]	***	0.8840	19.1962	20.6575	*	19.8788
390018	***	*	19.9117	*	*	19.9117
390022	1.3090	1.1030	27.5504	31.0971	29.0710	29.1659
390023	1.2577	1.1030	25.3767	27.1600	31.7149	28.1614
390024	1.0501	1.1030	25.9806	37.4330	35.3959	29.4333
390025	0.5266	1.1030	14.8690	15.0282	17.2977	15.7085
390026	1.2353	1.1030	24.0326	27.0802	29.5157	26.9256
390027	1.5482	1.1030	33.2139	28.9159	35.6568	32.4911
390028	1.5912	0.8840	24.6796	23.6616	25.7246	24.7268
390029	***	*	*	24.4276	*	24.4276
390030	1.1837	0.9844	20.0598	20.9859	22.1581	21.0867
390031	1.2104	0.9500	20.3568	21.2949	22.6828	21.4388
390032	1.1735	0.8840	20.8450	20.9971	22.7205	21.5225
390035	1.2222	1.1030	23.2173	24.7281	26.2647	24.7742
390036	1.4446	0.8840	20.5751	23.3858	24.6032	22.8336
390037	1.3365	0.8840	20.1665	22.9008	24.7820	22.6385
390039 [h]	1.1565	0.8348	18.4580	17.8461	20.3787	18.9083
390040	***	*	20.5371	23.1807	*	21.7860
390041	1.3009	0.8840	21.0074	20.6789	21.5925	21.0799
390042	1.3204	0.8840	22.2351	23.9632	25.6328	23.9486
390043	1.1602	0.8300	19.8641	20.9835	22.2549	21.0509
390044	1.6591	0.9698	22.4235	24.2586	27.1505	24.6634
390045	1.5712	0.8368	20.2082	22.2582	23.0877	21.8830
390046	1.5379	0.9422	23.1271	25.0825	27.6367	25.3031
390048	1.0828	0.9145	20.3523	23.6622	24.7738	22.8564
390049	1.5860	0.9844	24.0933	25.4056	27.1366	25.5929
390050	2.0343	0.8840	22.6951	24.5424	26.6931	24.6339
390052	1.1848	0.8942	22.1380	21.6736	23.6105	22.4994
390054	1.1909	0.8530	19.8602	21.4983	22.8087	21.3801
390055	***	0.8840	23.5292	25.5675	25.6945	24.9860
390056	1.0653	0.8300	21.4239	*	19.5537	20.4834
390057	1.3195	1.1030	24.8235	25.1901	27.9583	26.0368
390058	1.2715	0.9317	22.0113	25.3415	27.4799	24.8349
390061	1.5355	0.9716	24.4550	25.5012	28.4538	26.1704
390062	1.1167	0.8942	17.6303	19.0692	21.4052	19.4592
390063	1.7404	0.8746	21.7120	23.5469	24.7614	23.4097
390065	1.2046	1.0813	23.1384	23.4021	25.9184	24.2223

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
390066	1.2713	0.9145	21.7717	23.0891	24.2087	23.0471
390067	1.8233	0.9317	23.5136	25.4576	26.3287	25.0668
390068	1.3022	0.9716	21.1177	25.9890	25.8291	24.3019
390070	1.3629	1.1030	24.4403	26.9235	30.9499	27.4435
390071	0.9895	0.8300	17.8117	20.9443	20.6652	19.7095
390072 [h]	1.0397	0.8530	20.0561	22.0155	24.9388	22.3043
390073	1.5559	0.8942	22.7073	24.8013	26.3698	24.6228
390074	1.1407	0.8840	21.8456	21.0941	22.8545	21.9412
390075	***	*	19.9775	22.6530	24.6359	22.3701
390076	1.3409	1.1030	21.2039	18.1276	27.9004	21.9007
390079	1.8970	0.8471	19.9169	21.4323	23.3053	21.5091
390080	1.2828	1.1030	23.3742	25.0921	27.2616	25.2851
390081	1.2236	1.0652	28.1056	28.7974	30.3840	29.1503
390084	1.2243	0.8300	18.3551	20.7799	19.8605	19.6630
390086	1.5445	0.8300	19.6488	20.7383	22.5317	20.9944
390090	1.7972	0.8840	22.4688	20.7474	25.2014	22.8601
390091	1.1421	0.8446	19.7361	20.8243	21.5586	20.7010
390093	1.1685	0.8446	19.9209	21.0427	21.4401	20.8186
390095	1.1908	0.8530	18.3939	21.0754	23.6240	20.9725
390096	1.4974	0.9698	22.9502	24.4145	27.0763	24.8874
390097	1.1901	1.1030	24.5304	25.3012	25.6660	25.2008
390100	1.6968	0.9716	23.4155	26.7267	27.7208	26.0717
390101	1.2400	0.9422	20.1271	20.1694	21.2641	20.5324
390102	1.3469	0.8840	20.9807	21.6629	24.8898	22.6239
390103	1.0080	0.8840	21.0637	18.6703	20.6775	20.1561
390104	1.0501	0.8300	16.5081	19.1803	19.6428	18.4897
390107	1.3679	0.8840	21.5852	23.1023	24.1386	23.0080
390108	1.2171	1.1030	23.7842	24.7486	27.2661	25.2833
390109	1.1229	0.8530	17.2667	18.7558	19.9156	18.6551
390110	1.5720	0.8840	22.3968	23.3355	23.9808	23.2737
390111	2.0139	1.1030	30.5814	30.6809	32.6510	31.3439
390112 [h]	1.1736	0.8348	15.6710	16.6113	19.2126	17.1537
390113	1.2850	0.8446	20.1160	21.7729	22.2591	21.3940
390114	1.3024	0.8840	23.6162	22.6630	24.0473	23.4341
390115	1.4409	1.1030	24.1951	26.4751	27.7333	26.1536
390116	1.2529	1.1030	24.9581	28.5563	29.7436	27.8303
390117	1.0952	0.8300	19.0983	20.0040	20.3946	19.8418
390118	1.1665	0.8300	17.8460	19.3332	21.5001	19.5328
390119	1.2920	0.8530	20.3034	21.2761	22.2746	21.3271
390121	1.6614	0.8942	20.8017	22.0556	23.1408	22.0024
390122	1.0973	0.8300	18.5130	21.6981	22.5785	20.8388
390123	1.1985	1.1030	23.2232	25.2209	28.6269	25.7365
390125	1.2705	0.8300	18.2411	19.4406	20.9456	19.5654
390127	1.3061	1.1030	25.0836	28.9238	30.9374	28.4999
390128	1.1865	0.8840	21.3668	21.8837	23.0255	22.1158
390130	1.2623	0.8348	19.4835	21.0694	24.0685	21.4556
390131	1.2940	0.8840	19.5296	21.2164	22.5177	21.1193
390132	1.3983	1.1030	24.6889	26.8153	27.7250	26.4427
390133	1.6988	1.1030	25.2110	26.1458	28.7162	26.7622
390135	***	1.1030	24.0445	*	24.4738	24.2670
390136	1.0748	0.8840	21.9531	24.8042	22.1415	22.9715
390137	1.4810	0.8530	19.5457	21.8830	23.4877	21.5609
390138	1.1787	1.0813	21.4705	22.7210	24.2769	22.8713
390139	1.3178	1.1030	26.3622	28.2089	30.4246	28.3708
390142	1.4621	1.1030	29.8874	32.0827	32.3517	31.4330
390145	1.4545	0.8840	20.6580	22.4255	23.8041	22.3138
390146	1.2491	0.8300	21.4580	22.3260	25.2460	23.0540
390147	1.2294	0.8840	22.3135	23.6380	25.0971	23.6939
390150	1.1557	0.8840	20.0261	24.5256	24.1855	22.9524
390151	1.2703	1.0813	24.7843	25.1422	27.1539	25.7127
390152	0.9999	0.8942	21.5474	11.7774	*	15.1275
390153	1.3749	1.1030	25.3391	27.5167	30.0586	27.7812
390154	1.2331	0.8300	19.1300	20.4408	20.6982	20.0794
390156	1.3484	1.0652	25.0801	27.8096	31.2571	28.0054
390157	1.2887	0.8840	20.6933	22.0222	22.7493	21.8431
390160	1.1601	0.8840	19.3598	19.5942	21.4877	20.1709
390162	1.4642	0.9844	24.0291	*	30.0900	26.8901

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
390163	1.2667	0.8840	18.8585	19.8863	22.1741	20.2736
390164	2.0562	0.8840	24.2334	25.1277	26.4971	25.3882
390166	1.1534	0.8840	19.8531	20.9510	24.9810	21.8402
390168	1.4369	0.8840	20.6777	21.9344	24.5820	22.5085
390169	1.4033	0.8530	22.7695	24.1682	27.2242	24.7030
390173	1.1624	0.8300	20.6958	21.6562	22.8220	21.7639
390174	1.7303	1.1030	28.4490	30.3725	32.6265	30.5109
390176	1.1510	0.8840	18.0752	17.1387	*	17.5532
390178	1.2958	0.8609	17.2384	19.2731	20.7270	19.1018
390179	1.3648	1.1030	24.0501	24.8350	27.2222	25.3975
390180	1.4462	1.0652	28.4842	30.4264	32.4375	30.5043
390181	1.0361	0.8300	*	25.7357	24.4573	25.1039
390183	1.0850	0.8300	21.6811	22.0117	25.6554	23.0449
390184	1.0849	0.8840	21.1962	21.3407	22.5519	21.7060
390185	1.2694	0.8530	20.4476	21.8871	23.0202	21.7597
390189	1.1071	0.8300	20.1365	21.2711	22.3722	21.3477
390191	1.0835	0.8300	18.5972	19.2308	20.8761	19.5306
390192	1.0157	0.8530	19.1883	20.0395	21.2620	20.1833
390193	***	0.8746	18.9764	18.5516	20.1024	19.2196
390194	1.1011	0.9844	21.5850	23.1814	25.4235	23.4479
390195	1.6321	1.1030	26.2024	28.3480	31.0019	28.5392
390197	1.3925	0.9844	22.8349	24.9234	25.7739	24.4854
390198	1.1641	0.8746	17.3937	16.8529	18.7222	17.6295
390199	1.2174	0.8300	18.9787	19.9653	21.3157	20.1079
390200	***	0.9716	19.4471	23.1486	23.7471	21.9484
390201	1.2961	0.8300	22.7849	24.8222	26.3658	24.6735
390203	1.6357	1.1030	26.9436	28.2741	28.9054	28.0870
390204	1.2498	1.1030	23.9673	25.6342	28.6829	26.1129
390211	1.2717	0.8609	21.0450	22.4472	23.1450	22.2313
390215	***	*	25.2617	26.4180	28.0402	26.4046
390217	1.1533	0.8840	21.4058	21.3281	24.3610	22.3261
390219	1.2908	0.8840	20.0594	22.8559	25.1705	22.7113
390220	1.0977	1.1030	23.4385	24.7553	41.6138	28.9098
390222	1.2483	1.0652	24.9345	27.0954	28.7488	26.9594
390223	1.9554	1.1030	22.8725	28.2538	27.6407	26.2383
390224	0.8462	0.8471	16.1289	18.1226	18.7624	17.7120
390225	1.1871	0.9716	20.9232	23.4945	24.9391	23.3545
390226	1.7312	1.1030	25.6917	27.0061	28.5890	27.1866
390228	1.3206	0.8840	21.0164	22.5999	23.3078	22.3536
390231	1.4382	1.1030	24.7757	27.0576	29.2653	27.1070
390233	1.3700	0.9422	21.8043	22.8667	24.8690	23.1907
390235	***	*	23.7068	*	*	23.7068
390237	1.5540	0.8530	23.2054	24.6316	26.9533	24.9348
390238	***	*	19.2171	26.4748	*	22.5836
390246	1.1671	0.8300	22.0687	23.3275	20.1581	21.8667
390249	0.8767	0.8471	14.7215	*	*	14.7215
390258	1.5307	1.1030	25.0634	27.2038	29.4626	27.3466
390262	***	*	21.3264	*	*	21.3264
390265	1.4456	0.8840	20.5948	21.6751	23.4836	21.9520
390266	1.1763	0.8609	18.2424	19.2836	20.3918	19.3171
390267	1.1835	0.8840	21.4801	22.5464	23.1051	22.3821
390268	1.3066	0.8368	23.1124	24.2050	25.0021	24.1351
390270	1.4615	0.8530	22.5258	24.0837	24.1496	23.6565
390278	0.5214	1.1030	21.1387	21.6893	23.6843	22.1694
390279	1.1519	0.8368	16.0510	15.3569	17.0012	16.1304
390285	1.5472	1.1030	30.6300	33.5347	35.0427	33.0866
390286	1.1613	1.1030	25.4499	27.4090	28.1761	27.0003
390287	1.4298	1.1030	32.9709	35.7147	37.6569	35.5140
390288	***	1.1030	28.0957	28.5267	29.7287	28.6956
390289	1.0920	1.1030	25.1658	28.4577	28.8826	27.4320
390290	1.9082	1.1030	31.0967	36.4991	37.9040	35.0787
390291	***	0.8840	21.0057	21.3015	*	21.1542
390294	***	*	33.3537	*	*	33.3537
390296	***	*	25.6981	*	*	25.6981
390298	***	*	*	26.8290	*	26.8290
390299	***	*	*	31.9423	*	31.9423
390300	***	*	*	40.4697	*	40.4697

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
390301	***	0.8530	*	*	30.9838	30.9838
400001	1.2643	0.4686	11.7572	16.1114	13.1847	13.4859
400002	1.7313	0.5178	11.6804	14.8607	16.7583	14.1458
400003	1.3456	0.5178	10.5963	13.0776	13.6751	12.3819
400004	1.1394	0.4686	11.4041	10.4716	14.3108	11.8780
400005	1.1205	0.4686	10.5356	10.2878	10.7207	10.5186
400006	1.1887	0.4686	9.2852	8.9919	9.2265	9.1710
400007	1.1804	0.4686	8.6022	8.7152	9.2463	8.8511
400009	1.0804	0.3186	9.4413	9.2007	9.3116	9.3159
400010	0.8250	0.4736	9.2799	10.9354	10.0962	10.0495
400011	1.0865	0.4686	8.9111	8.5868	8.5534	8.6726
400012	1.3545	0.4686	9.0740	8.3580	8.3802	8.5938
400013	1.2691	0.4686	9.9905	9.5584	10.3347	9.9727
400014	1.3193	0.4016	11.4580	11.7023	12.5363	11.8896
400015	1.3649	0.4686	*	15.6066	17.4086	16.6535
400016	1.3515	0.4686	14.6491	15.3497	14.7607	14.9193
400017	1.1959	0.4686	10.7475	10.1238	10.2734	10.3916
400018	1.1949	0.4686	10.8254	10.7948	11.6165	11.0939
400019	1.3212	0.4686	13.7007	14.9892	13.7754	14.1263
400021	1.3102	0.4646	13.5224	13.8643	14.1533	13.8469
400022	1.3444	0.5178	15.2904	16.0539	16.8806	16.0784
400024	0.8372	0.4016	9.8650	9.1316	12.4649	10.2156
400026	1.0673	0.3186	5.9206	5.2085	5.8200	5.6501
400028	1.2057	0.5178	9.5266	10.3354	10.9808	10.2872
400032	1.1946	0.4686	10.7100	10.7195	10.2652	10.5650
400044	1.2777	0.5178	9.0275	10.7890	13.7509	11.4819
400048	1.0975	0.4686	10.8618	14.0887	10.4266	11.8488
400061	1.7250	0.4686	16.5895	15.1639	20.3206	17.3616
400079	1.1310	0.4736	8.7218	9.4218	12.7825	10.1505
400087	1.1988	0.4686	10.7118	9.5860	10.6849	10.3421
400094	***	*	9.2871	8.8646	*	9.1244
400098	1.5719	0.4686	13.8036	13.7938	12.8230	13.4850
400102	1.1198	0.4686	10.9973	10.1795	10.2677	10.4779
400103	1.7425	0.4016	11.5797	12.8288	9.3859	10.9876
400104	1.1364	0.4686	7.1781	8.2758	8.3900	7.8760
400105	1.1274	0.4686	11.5608	12.7725	14.5339	12.8828
400106	1.1815	0.4686	10.1241	9.6902	11.4507	10.3951
400109	1.4714	0.4686	12.8921	14.2169	14.2111	13.7444
400110	1.0965	0.4413	12.0159	11.8458	12.3449	12.0750
400111	1.0774	0.4736	12.7701	13.4777	14.5029	13.5496
400112	1.1915	0.4686	12.2859	8.9469	19.3945	12.3541
400113	1.2040	0.5178	10.4416	10.0830	11.0072	10.4939
400114	1.0880	0.4686	9.7444	12.1920	11.5478	11.0784
400115	1.1179	0.4686	7.0411	9.1132	13.7392	9.2213
400117	1.1002	0.4686	9.7314	10.2911	12.7600	10.8102
400118	1.2310	0.4686	12.4590	11.9324	12.5743	12.3218
400120	1.2997	0.4686	11.8837	11.9714	12.7955	12.2196
400121	1.0671	0.4686	8.3575	8.6665	8.2197	8.4118
400122	1.9548	0.4686	9.6644	9.6463	8.3069	9.4955
400123	1.1994	0.4016	10.5643	11.8135	11.9825	11.4619
400124	2.8727	0.4686	14.3496	17.2258	16.1812	15.8787
400125	1.1319	0.4160	10.6642	10.7425	11.6386	11.0069
400126	1.2093	0.4646	*	13.3932	9.8008	11.0632
410001	1.3081	1.1233	24.0033	27.0309	28.0816	26.3767
410004	1.2319	1.1233	23.6409	25.4578	27.4209	25.5908
410005	1.2822	1.1233	24.6522	27.1171	30.1606	27.3044
410006	1.2503	1.1233	26.1372	27.1842	29.4395	27.6190
410007	1.7094	1.1233	27.7171	30.1360	31.8548	30.0135
410008	1.2098	1.1233	25.4183	28.4245	29.6092	27.8277
410009	1.2932	1.1233	26.9135	27.7337	29.4094	28.0697
410010	1.1636	1.0952	30.3860	30.7826	32.8599	31.3979
410011	1.2966	1.1233	29.7664	28.5875	29.9001	29.4052
410012	1.7532	1.1233	28.1791	32.1679	32.6009	31.1120
410013	1.2276	1.1233	28.9386	31.7482	35.4624	32.1157
420002	1.5184	0.9717	25.1067	27.9312	28.2848	27.1910
420004	1.9550	0.9433	23.4579	26.0279	28.4845	26.0443
420005	1.0179	0.8663	19.5521	19.8167	23.1943	20.8182

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
420006	1.0874	0.9433	22.7896	22.8920	24.0811	23.2220
420007	1.5636	0.9183	22.0228	25.0395	25.2650	24.2318
420009	1.3786	0.9807	18.6866	23.8668	25.5079	22.5621
420010	1.1844	0.8988	19.1746	21.6478	23.4562	21.5057
420011	1.1190	1.0138	17.7300	20.8895	21.4030	20.0081
420014	0.9635	0.9057	21.2045	21.5658	*	21.3876
420015	1.2398	1.0138	23.1274	24.7383	26.1298	24.6961
420016	0.9619	0.8663	17.0051	17.3837	17.1229	17.1752
420018	1.7534	0.9057	20.4649	23.6356	24.7324	22.8696
420019	1.1129	0.8663	19.6836	20.5472	22.5312	20.8812
420020	1.2595	0.9317	22.1616	24.6592	25.7225	24.3050
420023	1.6530	1.0138	23.2568	25.1035	26.7263	25.0152
420026	1.8566	0.9057	23.7406	29.2961	27.4814	26.8241
420027	1.5759	0.8887	21.0637	22.8322	24.8624	22.9488
420030	1.2331	0.9317	22.6766	24.2847	26.0079	24.3704
420033	1.1361	1.0138	26.2711	27.5740	31.8759	28.5975
420036	1.2525	0.9585	20.6649	21.9641	22.8294	21.8110
420037	1.2494	1.0138	25.5492	26.8750	29.4156	27.3838
420038	1.2524	1.0138	21.6133	22.6741	24.2259	22.8531
420039	1.0376	0.9183	21.9737	24.0637	25.1148	23.7048
420043 [h]	1.0680	0.9183	21.8816	22.9764	23.0555	22.6545
420048	1.2700	0.9057	21.9517	23.1515	24.1910	23.1357
420049	1.2080	0.8869	21.2604	23.2156	23.4769	22.6938
420051	1.4889	0.8988	20.6629	23.9455	24.8026	23.1828
420053	1.1415	0.8663	19.9013	21.1177	22.2825	21.1778
420054	1.0212	0.8663	20.8471	24.0653	24.8931	23.2676
420055	1.0684	0.8663	19.6817	20.3599	21.9764	20.6871
420056	1.4085	0.8663	20.0527	21.1640	21.6963	20.9682
420057	1.0376	0.8988	17.6727	19.7653	23.4311	20.1207
420059	1.0455	0.8663	20.2917	21.4260	*	20.8684
420061	1.1273	0.8663	19.9789	20.8684	*	20.4341
420062	1.0823	0.8663	17.4764	25.6683	25.8389	22.4958
420064	1.1956	0.8869	20.9057	22.1290	23.3610	22.2043
420065	1.3471	0.9433	22.0784	22.8674	24.5715	23.1699
420066	0.9655	0.8988	20.7782	20.5893	23.9048	21.7523
420067	1.2942	0.9316	22.8104	24.6038	25.0345	24.2301
420068	1.3390	0.9317	21.7257	22.2638	23.4248	22.4620
420069	1.0589	0.8663	17.6291	19.6959	20.5546	19.3217
420070	1.2778	0.9057	20.3664	22.4370	23.4355	22.1331
420071	1.3635	0.9807	21.8579	23.1727	24.9418	23.3888
420072	1.0926	0.8663	16.2578	17.5899	18.6742	17.5511
420073	1.3459	0.9057	21.4718	24.0274	24.5813	23.3018
420074	***	*	18.7010	*	*	18.7010
420078	1.8001	1.0138	24.3273	25.3032	29.4985	26.4127
420079	1.5104	0.9433	23.3992	25.2939	25.5354	24.7810
420080	1.3725	0.9316	26.7489	28.4569	28.4734	27.9158
420082	1.4774	0.9567	23.6936	26.1221	29.8528	26.5169
420083	1.3224	0.9183	24.8508	25.3043	27.1322	25.7973
420085	1.6210	0.9394	24.4040	25.3180	26.8692	25.5532
420086	1.3930	0.9057	24.5760	25.1372	25.7580	25.1689
420087	1.7766	0.9433	22.4526	23.2230	24.3609	23.3441
420088	***	*	23.5174	23.1273	*	23.4240
420089	1.3873	0.9433	23.3240	25.2729	26.0074	24.9015
420091	1.3034	0.8988	23.7936	23.4710	27.0189	24.8440
420093	0.9851	0.9183	21.4678	25.1457	27.4766	24.8258
420097	***	*	*	24.7809	*	24.7809
430005	1.2209	0.8475	18.2647	19.9454	21.8605	19.9621
430008 [2]	1.1152	0.8475	20.0124	20.9442	22.9340	21.2902
430011	1.2481	0.8475	19.9835	20.6597	*	20.3142
430012	1.2707	0.9616	21.2588	22.7530	24.0850	22.7129
430013 [2]	1.1784	0.8475	21.3389	22.9675	23.8572	22.7428
430014	1.2515	0.8778	22.0285	25.5387	26.4964	24.6896
430015	1.1338	0.8475	20.5849	23.2035	22.7947	22.1979
430016	1.5813	0.9616	24.2450	26.1495	27.8453	26.0153
430018	***	0.8475	17.9850	*	*	17.9850
430024	***	0.8475	18.8357	*	*	18.8357
430029	0.8995	0.8475	18.9464	20.2708	*	19.6526

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
430031 [2]	0.9339	0.8475	15.2321	15.6112	15.9156	15.5961
430033	***	0.8475	21.6254	*	*	21.6254
430047	0.9833	0.8475	18.2774	21.9116	18.8982	19.7432
430048	1.2364	0.8475	20.0607	21.1718	23.0783	21.5127
430054	0.9420	0.9616	17.8871	*	*	17.8871
430064	1.0393	0.8475	14.3407	16.4314	17.5376	16.1075
430077	1.6950	0.9027	21.6786	23.4835	25.1763	23.4802
430089	1.6248	0.9360	19.8572	21.1109	22.5625	21.3078
430090	1.4120	0.9616	25.6873	26.0851	25.7499	25.8502
430091	2.1791	0.9027	22.2824	23.8897	25.0828	23.8977
430092	1.7787	0.8475	19.7354	20.2570	23.8858	21.3414
430093	0.9141	0.9027	23.8820	23.1526	29.5244	25.7876
430094	1.8543	0.9207	20.8743	18.5429	19.0014	19.4190
430095	2.3163	0.9616	*	24.7074	28.1749	26.5823
430096	1.9499	0.8475	*	*	21.7103	21.7103
440001	1.1144	0.7958	18.9833	17.4802	19.3100	18.5533
440002	1.6911	0.8964	22.0178	23.2177	24.6664	23.3294
440003	1.2046	0.9757	21.6336	24.5168	25.9209	24.0777
440006	1.4022	0.9757	24.3173	26.7983	28.5951	26.6300
440007	0.9406	0.7915	14.8015	13.7042	25.8236	17.2437
440008	0.9974	0.8508	20.9237	22.1405	23.4301	22.0908
440009	1.1859	0.7915	19.6564	21.1274	21.5970	20.8327
440010	0.9389	0.7915	16.7270	16.9060	17.1803	16.9489
440011	1.3028	0.8470	20.5036	21.6861	22.5068	21.6145
440012	1.4390	0.8095	21.1213	21.4769	22.3029	21.6368
440015	1.8237	0.8470	23.4485	22.5583	23.7422	23.2495
440016	0.9690	0.7915	20.1504	20.0982	22.1646	20.8341
440017	1.7649	0.8095	21.8033	22.5313	22.9364	22.4333
440018	1.1326	0.7958	21.2242	21.7239	23.3444	22.1229
440019	1.7880	0.8470	21.8854	23.8802	25.2553	23.6676
440020	1.0554	0.9124	21.1075	23.1718	23.9475	22.7656
440023	0.9515	0.7915	15.5410	17.0335	18.2884	16.9816
440024	1.2316	0.8160	19.9751	20.3658	23.2478	21.1469
440025	1.1856	0.7915	19.1478	19.5995	20.6798	19.8282
440026	***	*	25.1655	26.9149	26.8986	26.2876
440029	1.3373	0.9757	24.1379	25.8538	28.0779	26.0679
440030	1.2498	0.8758	19.9056	20.0586	26.1060	22.0081
440031	1.0626	0.7915	17.0289	18.0944	19.6685	18.2797
440032	1.0136	0.8095	14.7683	16.0734	18.5277	16.4708
440033	1.0486	0.7915	17.2637	18.7749	20.7917	19.0076
440034	1.5293	0.8470	22.2478	23.1121	23.5403	22.9348
440035	1.3430	0.9492	21.4990	22.3230	24.3752	22.7486
440039	1.9897	0.9757	25.0874	26.4647	28.1729	26.6593
440040	0.9253	0.7915	16.9886	17.7647	17.8510	17.5455
440041	0.9316	0.8160	15.5784	17.4074	17.9409	17.0933
440046	1.1385	0.9757	22.3380	25.5329	26.1341	24.7333
440047	0.8547	0.7915	18.7962	20.4812	21.4280	20.2387
440048	1.8251	0.9346	23.1553	24.3283	27.7560	24.7999
440049	1.5582	0.9346	21.1930	22.9755	25.3043	23.1991
440050	1.2790	0.9312	21.1397	21.8972	23.1362	22.0679
440051	0.9362	0.7915	19.0165	20.7948	21.9108	20.5095
440052	0.9561	0.7915	18.1935	20.1875	21.1133	19.9032
440053	1.2082	0.9757	22.0345	23.9083	25.4345	23.8916
440054	1.1252	0.7915	15.4208	20.5992	21.4400	18.6411
440056	1.1345	0.8758	19.3108	20.4088	22.1068	20.7270
440057	1.0371	0.7915	14.1477	14.6242	16.4451	15.0915
440058	1.1730	0.9099	21.7512	22.6014	22.9263	22.4470
440059	1.5012	0.9492	22.4248	23.9301	26.3531	24.2538
440060	1.0098	0.8799	20.2189	22.7133	23.3014	22.1119
440061	1.0870	0.7915	19.5458	21.2085	21.8274	20.8215
440063	1.5962	0.7958	19.7468	21.8578	22.3256	21.2848
440064	0.9863	0.9099	19.4020	20.9742	22.0955	20.8374
440065	1.2170	0.9757	19.9099	21.4794	22.3247	21.2895
440067	1.1694	0.8470	19.5643	22.1410	23.1089	21.6500
440068	1.1443	0.9099	20.9188	23.1705	24.5971	22.9451
440070	0.9466	0.7915	18.3717	19.0240	19.4372	18.9540
440072	1.1880	0.9108	19.6579	20.9294	27.1443	22.1374

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
440073	1.3595	0.9492	20.7181	22.2959	23.9198	22.3108
440081 [h]	1.1378	0.8470	18.3141	19.0328	19.7918	19.0786
440082	2.1607	0.9757	26.1497	28.7828	27.9724	27.6484
440083	0.9067	0.7915	15.7015	16.0956	17.3329	16.4160
440084	1.1637	0.7915	15.0510	15.2825	16.3738	15.6128
440091	1.6254	0.9099	23.0296	26.1122	25.6797	24.9494
440102	1.1346	0.7915	16.6548	17.5140	17.5261	17.2560
440104	1.7607	0.9099	21.9870	23.3731	25.3739	23.6244
440105	1.0199	0.7958	19.2902	20.7821	22.3438	20.8223
440109	0.9843	0.7915	17.3578	18.2508	18.6720	18.1156
440110	1.1772	0.8470	19.9715	20.9039	21.3287	20.7233
440111	1.2422	0.9757	24.9883	25.8821	28.5705	26.5016
440114	0.9851	0.7915	20.1152	21.4271	24.0147	21.9369
440115	0.9888	0.7915	18.5389	20.0642	21.7830	20.1587
440120	1.5755	0.8470	22.4031	23.9003	25.7636	24.0777
440125	1.5716	0.8470	21.1018	21.9337	22.3888	21.8259
440130	1.1649	0.7915	20.6363	21.6480	23.4517	21.9020
440131	1.1987	0.9346	21.0640	22.4119	24.9598	22.8950
440132	1.2681	0.7915	18.9580	20.5716	21.5085	20.3655
440133	1.5674	0.9757	23.3600	27.5019	26.2422	25.6963
440135	1.0782	0.9757	23.9749	25.3928	26.6615	25.3742
440137	1.0485	0.7915	16.5529	18.2073	20.6663	18.4329
440141	0.9487	0.7915	19.2607	19.4528	21.3313	20.0578
440142	0.8702	0.9757	17.7587	*	*	17.7587
440144	1.1976	0.7915	19.7938	22.3671	23.3828	21.8222
440145	0.9916	0.7915	18.2019	20.9863	20.7875	19.9424
440147	***	*	25.0780	28.9038	31.2003	28.2394
440148	1.1199	0.9492	20.7693	23.0697	24.6412	22.8692
440149	1.0185	0.7915	18.1316	19.8020	20.4562	19.4498
440150	1.3517	0.9757	22.8733	25.4952	26.8308	25.0868
440151	1.0856	0.9492	21.1576	23.3037	23.9808	22.8559
440152	1.8738	0.9346	22.7498	25.9495	26.5513	25.0265
440153	1.0018	0.7915	19.9486	22.7744	22.2846	21.7049
440156	1.4931	0.9099	23.7799	25.6333	26.9689	25.5243
440159	1.4244	0.9346	20.5719	21.1073	22.8645	21.5659
440161	1.8202	0.9757	26.1354	28.6774	28.6854	27.8923
440162	***	*	20.3909	16.5305	21.1418	19.2406
440166	1.5235	0.9346	23.1692	27.1355	22.6509	24.5576
440168	0.9905	0.9346	21.2113	22.1764	22.8768	22.0809
440173	1.6407	0.8470	20.8442	20.8723	22.8692	21.5604
440174	0.8745	0.7915	19.2201	20.7960	22.0974	20.6472
440175	1.0488	0.9492	22.3331	24.0005	22.7299	23.0174
440176	1.2854	0.8095	20.4861	22.0079	23.6659	22.0556
440180	1.2061	0.8470	21.2398	21.9781	23.3808	22.2150
440181	0.9106	0.7915	19.6133	21.1406	22.7150	21.1984
440182	0.9022	0.7915	19.3928	20.2630	22.3612	20.6845
440183	1.5283	0.9346	24.9282	27.7769	27.1515	26.6633
440184	0.9990	0.7958	21.4484	20.8219	22.3475	21.5303
440185	1.1611	0.9099	22.1845	23.4172	23.9052	23.2612
440186	1.0310	0.9757	23.0193	24.6773	25.7445	24.4615
440187	1.0821	0.7915	19.9478	21.7637	21.3252	21.0131
440189	1.3728	0.8964	23.2866	24.7851	27.5435	25.2579
440192	1.0167	0.9492	21.3228	25.1119	25.7495	24.1386
440193	1.2566	0.9757	22.0345	24.3911	24.4299	23.6341
440194	1.3630	0.9757	24.4508	26.2498	26.6527	25.8291
440197	1.2605	0.9757	24.2660	26.4999	27.1534	25.9812
440200	0.9405	0.9757	16.7752	17.0633	17.7491	17.1850
440203	0.9753	0.7915	*	17.7639	19.3864	18.5423
440217	1.3463	0.9346	23.3544	25.9667	28.5968	26.1820
440218	0.8931	0.9757	20.1377	26.3741	24.6465	23.5719
440220	***	*	21.9117	*	*	21.9117
450002	1.4427	0.8954	24.0411	25.4975	25.7171	25.1126
450005	1.0651	0.8422	21.7110	23.4049	23.5576	22.9913
450007	1.2962	0.8987	18.3738	19.2875	20.7321	19.4904
450008	1.3133	0.8566	20.1816	22.0934	22.9669	21.7810
450010	1.5052	0.8327	20.3023	22.4133	23.7529	22.1525
450011	1.6756	0.8911	22.1472	24.0715	24.8831	23.7169

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
450014	1.0286	0.8148	20.6936	22.5001	*	21.5732
450015	1.5729	1.0226	23.9526	24.0730	27.4012	25.2046
450016	***	*	20.1232	22.1368	*	21.1548
450018	1.3942	1.0008	22.9019	24.6443	26.7999	24.7633
450020	0.9466	0.9451	19.1087	17.7148	18.3047	18.3252
450021	1.8194	1.0226	25.0769	28.5578	29.1350	27.5806
450023	1.3878	0.8148	19.1645	20.9278	22.0558	20.7053
450024	1.3228	0.8954	20.7727	20.5868	23.6211	21.6539
450028	1.5658	0.9853	22.7775	25.6030	26.8250	25.1270
450029	1.5162	0.8101	19.9198	23.9709	23.2995	22.4069
450031	1.4488	1.0226	21.7621	27.0328	27.9626	25.5466
450032	1.1987	0.8767	20.5217	20.8306	27.0748	22.7202
450033	1.6186	0.9853	26.5990	29.0541	28.5266	28.0983
450034	1.5259	0.8422	21.6097	23.4615	24.1589	23.0888
450035	1.5166	1.0008	24.1860	25.4580	26.2838	25.3196
450037	1.5141	0.8741	23.1179	23.1176	24.2684	23.5229
450039	1.3588	0.9955	22.0058	23.3034	24.7347	23.3847
450040	1.7455	0.8790	21.2990	23.8047	24.9590	23.3165
450042	1.6976	0.8532	21.8886	22.6936	24.1181	22.9317
450044	1.6507	1.0226	24.1127	25.8403	28.8098	26.9711
450046	1.5525	0.8557	20.9239	22.0695	23.4907	22.1959
450047	0.8562	0.9853	21.8840	22.7242	19.8221	21.4269
450050	0.9271	0.8038	19.5171	21.6933	23.3044	21.3893
450051	1.7617	1.0226	24.5533	27.2523	28.0411	26.6907
450052	0.9686	0.8038	17.6543	19.7185	19.7774	19.2138
450053	0.9574	0.8038	18.6556	19.4978	21.9082	20.0823
450054	1.6531	0.8566	23.2915	25.1229	24.2782	24.2283
450055	1.1284	0.8038	18.2235	20.5235	22.1979	20.3131
450056	1.7820	0.9451	24.4197	25.6685	27.0530	25.7808
450058	1.5325	0.8987	22.0158	24.7442	25.9653	24.1658
450059	1.3149	0.9451	22.8792	26.8209	26.6535	25.4407
450064	1.4037	0.9955	19.1271	24.2920	23.8748	22.4752
450068	2.0137	1.0008	24.0925	26.2864	27.9633	26.1666
450072	1.1350	1.0008	20.3683	22.5010	24.0166	22.2336
450073	0.9362	0.8038	19.2398	20.0464	21.7337	20.3411
450078	0.9261	0.8038	14.8285	17.2196	15.8968	15.9697
450079	1.5320	1.0226	24.0085	27.0443	28.1096	26.3674
450080	1.1799	0.8621	21.0353	21.2482	22.9835	21.7735
450081	1.0360	0.8038	19.2632	*	*	19.2632
450083	1.7207	0.9322	22.5063	24.9182	25.8214	24.4447
450085	1.0173	0.8038	18.1922	19.4524	22.0840	19.8958
450087	1.3393	0.9955	24.5976	26.4203	29.1587	26.8455
450090	1.1561	0.8038	17.1073	17.6506	19.4244	18.0792
450092	1.1362	0.8038	16.0199	20.4921	23.2071	19.7031
450094	1.0935	1.0226	25.8313	25.3618	25.2434	25.4570
450096	1.3677	0.8422	19.8012	22.8722	24.1619	22.3082
450097	1.4253	1.0008	22.2467	24.9380	26.4965	24.6105
450098	0.9223	0.8621	20.4795	22.9005	22.6626	21.9800
450099	1.1731	0.9165	21.4482	24.0293	26.6796	24.1168
450101	1.5502	0.8532	20.1473	20.6575	23.6905	21.4670
450102	1.7209	0.9322	20.9900	23.1773	24.5503	22.9587
450104	1.1697	0.8987	19.7126	22.5165	23.8469	22.0194
450107	1.4575	0.8954	23.2209	23.8770	25.9326	24.3252
450108	1.1001	0.8987	18.8084	19.3561	19.4935	19.2181
450109	***	0.8038	15.1459	*	*	15.1459
450113	***	0.8038	37.8944	*	54.6681	43.1390
450119	1.2979	0.8945	20.8840	24.1392	25.7008	23.6793
450121	1.4458	0.9955	24.6090	25.8826	25.7051	25.4063
450123	1.1207	0.8422	17.8629	19.5872	21.2154	19.5002
450124	1.8251	0.9451	24.2788	26.0280	27.4198	26.0262
450126	1.3283	1.0008	24.1961	27.3021	28.3033	26.6832
450128	1.2202	0.8945	*	21.4190	23.3633	22.3457
450130	1.1654	0.8987	19.6199	20.2777	21.5226	20.5273
450131	1.2121	0.8557	20.0434	23.2317	23.7098	22.3750
450132	1.5283	0.9893	22.4680	26.8476	28.6954	25.9595
450133	1.5415	0.9522	25.3928	25.0972	26.8344	25.8308
450135	1.6894	0.9955	22.5673	24.3858	26.0755	24.4084

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
450137	1.6059	0.9955	24.9732	27.0081	30.4254	27.6976
450140	0.8835	0.8038	18.3835	22.4695	*	20.3190
450143	1.0330	0.9451	18.4204	19.7487	21.8705	20.0996
450144	1.1455	0.9593	21.3896	20.9599	21.3289	21.2289
450146	***	0.8038	16.6808	*	*	16.6808
450148	1.1489	0.9955	22.1351	23.5037	25.3498	23.7382
450151	1.1987	0.8038	17.9127	20.1356	22.2915	20.0948
450152	1.1854	0.8566	20.0146	21.6351	22.7463	21.4376
450154	1.2665	0.8038	16.5204	18.6058	21.2021	18.7210
450155	1.0266	0.8038	18.4021	17.9306	18.0589	18.1275
450157	1.0057	0.8038	17.8764	17.8812	*	17.8788
450160	0.9248	0.8038	20.7736	21.9118	*	21.3607
450162	1.3639	0.8790	26.0570	31.0645	30.9903	29.3951
450163	0.9730	0.8038	19.8194	20.3280	23.1400	21.0903
450165	1.1177	0.8987	16.1632	20.2414	24.3242	20.2279
450176	1.3178	0.8945	19.1823	20.9392	20.9297	20.4107
450177	1.2130	0.8038	17.2637	19.7657	21.3322	19.4690
450178	0.9642	0.8038	19.1186	20.2992	24.7301	21.2492
450184	1.5254	1.0008	24.0596	25.3935	26.8458	25.4934
450185	0.9793	0.8038	14.3594	15.5838	*	14.9644
450187	1.1635	1.0008	22.6275	24.2400	25.6786	24.2306
450188	0.9262	0.8038	17.6158	18.9586	20.4070	19.0169
450191	1.1247	0.9451	23.2261	25.9078	26.0298	25.1584
450192	1.0805	0.9955	20.1718	22.5118	22.5880	21.7848
450193	2.0537	1.0008	26.6580	29.2751	32.2964	29.4595
450194	1.3506	0.9955	22.7310	22.3348	24.8972	23.2572
450196	1.4168	0.9955	20.1938	23.6170	24.7557	23.2376
450200	1.4482	0.8293	20.4656	22.0923	23.5344	22.0868
450201	0.9125	0.8038	19.5907	20.3350	20.9809	20.3028
450203	1.1655	0.9514	22.9226	23.3953	24.1675	23.5222
450209	1.8856	0.9165	23.4794	24.4977	26.0958	24.6956
450210	0.9537	0.8038	16.7851	19.6340	19.9832	18.8463
450211	1.3415	1.0008	20.0280	20.7982	23.8230	21.4806
450213	1.7482	0.8987	21.1280	21.7930	23.9676	22.3693
450214	1.1722	1.0008	22.4543	23.9112	25.9598	24.1177
450219	0.9721	0.8038	21.0691	20.8255	21.7934	21.2690
450221	1.1435	0.8038	19.6778	20.6887	20.3186	20.2506
450222	1.5561	1.0008	23.5033	26.2975	27.4426	25.8797
450224	1.4143	0.9164	20.4453	22.2250	24.1956	22.3315
450229	1.6333	0.8038	17.9811	19.8279	21.4459	19.7433
450231	1.6297	0.9165	21.3086	23.9532	25.2852	23.5313
450234	0.9831	0.8038	22.3954	23.6695	18.4451	21.2354
450235	0.9124	0.8038	18.7028	19.1453	21.5138	19.8415
450236	1.0405	0.8038	17.7373	19.2987	22.0788	19.5556
450237	1.6743	0.8987	22.4477	25.1504	24.8901	24.1935
450239	0.9310	0.8566	19.3655	21.8595	21.1945	20.7705
450241	0.9436	0.8038	17.4151	18.1155	18.7957	18.0879
450243	1.0022	0.8038	13.0790	14.0589	15.4636	14.1605
450249	0.9833	0.8038	13.1222	16.5616	*	14.7712
450250	***	0.8038	13.3731	*	*	13.3731
450264	0.9236	0.8038	13.5345	15.4111	*	14.4829
450269	1.0146	0.8038	12.6907	14.8204	*	13.7206
450270	1.0976	0.8038	13.9053	15.0879	14.4325	14.4468
450271	1.1532	0.9514	18.3659	19.4299	21.7719	19.9620
450272	1.2039	0.9451	21.4520	23.7933	25.9864	23.7631
450276	0.8990	0.8038	12.8895	16.0264	16.6319	15.2952
450280	1.5066	1.0226	23.1664	27.4523	28.7233	26.4522
450283	1.0602	0.9955	17.1013	20.0069	20.9680	19.5520
450289	1.3288	1.0008	23.7108	27.3864	28.5665	26.5635
450292	1.2940	1.0226	23.4257	23.5330	25.0411	24.0121
450293	0.8704	0.8038	17.7673	20.0898	21.3136	19.7647
450296	1.0400	1.0008	20.4483	29.2006	27.9690	25.4406
450299	1.5781	0.8911	22.9849	25.8183	26.4933	25.0990
450303	0.8372	0.8790	16.1330	*	*	16.1330
450315	***	1.0226	26.4677	27.9780	*	27.2229
450320	***	*	26.8089	*	*	26.8089
450327	***	0.8038	14.3848	*	*	14.3848

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
450340	1.3755	0.8287	20.0621	22.7826	24.0636	22.3350
450346	1.3855	0.8422	20.1921	21.9717	22.2469	21.4909
450347	1.1384	1.0008	21.7142	22.8133	27.2203	23.9176
450348	0.9886	0.8038	15.6324	17.0198	18.7675	17.1642
450351	1.2212	0.9514	22.2597	23.5895	25.6859	23.9245
450352	1.1057	1.0226	21.8138	23.4297	24.8012	23.3447
450353	1.2803	0.8038	19.5263	20.9271	24.4454	21.5974
450358	2.0076	1.0008	25.9105	29.3408	30.4280	28.6741
450362	0.9855	0.8038	20.6340	22.0223	25.4372	22.7898
450369	1.0166	0.8038	16.5636	17.5360	18.4848	17.6077
450370	1.1704	0.8038	19.0340	22.6815	20.0832	20.4877
450371	***	*	17.3415	*	*	17.3415
450373	0.9087	0.8038	17.7955	20.5789	22.2213	20.1017
450374	0.9164	0.8038	15.0670	17.4509	23.2285	18.2702
450378	1.3340	1.0008	25.8048	29.5108	30.7684	28.7797
450379	1.3574	1.0226	29.0865	31.1573	30.6072	30.3060
450381	0.9257	0.9451	19.0584	20.9200	22.0482	20.7572
450388	1.6460	0.8987	22.4441	24.1598	25.8674	24.3854
450389	1.1827	0.9955	20.7160	22.3803	23.8764	22.4221
450393	***	0.9518	23.8237	24.6872	18.4551	22.6427
450395	1.0142	0.8038	19.1938	23.9689	24.8656	22.6314
450399	0.9249	0.8038	19.1571	19.5928	18.2074	18.9826
450400	1.1916	0.8532	20.1376	22.0103	23.1739	21.7697
450403	1.2709	1.0226	24.6215	27.8138	29.3063	27.2736
450411	0.9558	0.8038	16.9558	17.6570	19.6086	18.1139
450417	0.8643	1.0008	16.1957	17.8078	20.0350	18.0319
450418	1.2488	1.0008	25.1306	27.0283	26.8434	26.3230
450419	1.1760	0.9955	26.7662	28.4122	31.0404	28.7694
450422	1.0462	1.0226	29.0032	29.5592	30.6659	29.7888
450424	1.2797	1.0008	22.0682	23.1253	28.3149	24.8057
450431	1.5343	0.9451	22.9545	24.7346	25.2477	24.3602
450438	1.1444	1.0008	19.2165	22.0476	21.9351	21.1413
450446	0.6161	1.0008	14.1684	14.9983	14.3132	14.4984
450447	1.1971	0.9955	21.0247	22.5602	23.5047	22.3940
450451	1.0873	0.9514	21.1046	22.3834	23.3042	22.3121
450460	0.9348	0.8038	17.9487	19.5709	20.5812	19.4136
450462	1.6600	1.0226	24.0081	25.6952	27.8923	25.9496
450464	***	0.8038	16.1987	*	*	16.1987
450469	1.4541	0.9518	24.0794	26.6781	28.7890	26.6238
450473	***	*	18.6002	*	*	18.6002
450484	1.3734	1.0008	23.2881	23.0604	25.3527	23.9206
450488	1.1123	0.8741	22.5650	22.3949	23.9144	22.9600
450489	1.0160	0.8038	18.5941	19.6884	21.4771	19.8409
450497	1.0329	0.8038	17.1327	17.6614	18.8344	17.8832
450498	0.8732	0.8038	19.2984	16.4358	17.7822	17.7509
450508	1.4085	0.9164	20.8183	23.5066	23.9572	22.7686
450514	1.1119	0.8422	21.0116	21.4034	22.6552	21.6987
450517	0.9088	0.8038	14.4246	15.2707	22.0440	17.2013
450518	1.6338	0.8422	21.1015	22.2587	24.1194	22.4755
450523	***	*	22.3034	28.6387	*	25.2834
450530	1.1553	1.0008	23.3005	26.1998	28.7451	26.1850
450534	0.8962	0.8038	22.5156	20.4715	*	21.4079
450535	***	*	23.7255	29.4427	*	26.5477
450537	1.3531	1.0226	22.5972	23.9256	27.5856	24.8361
450539	1.2112	0.8038	18.4299	20.0343	21.0442	19.8677
450545	***	*	21.7762	22.8130	*	22.2858
450547	0.9601	0.9955	22.6557	21.8106	21.6542	22.0062
450558	1.7596	0.8038	21.4201	25.0837	26.1551	24.1840
450563	1.3725	0.9955	27.5671	27.9427	28.7289	28.1251
450565	1.2388	0.8038	17.2171	22.1971	23.8847	20.9966
450571	1.4990	0.8287	21.5688	20.9651	22.7703	21.7784
450573	1.1238	0.8038	18.6233	21.6974	20.1479	20.0755
450578	0.9390	0.8038	17.3010	20.0454	20.2695	19.1233
450580	1.1057	0.8038	18.5225	20.4293	21.1574	20.0321
450584	1.0396	0.8038	16.9021	19.0373	21.0808	18.9453
450586	0.9605	0.8038	14.9061	14.6574	16.1003	15.2149
450587	1.1650	0.8038	19.0648	19.9712	20.4512	19.8609

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
450591	1.2007	1.0008	19.6229	22.4991	23.9992	22.0639
450596 [h]	1.0985	0.9514	24.3714	24.7477	25.3317	24.8345
450597	0.9702	0.8038	19.9596	22.9337	23.1711	22.1268
450603	***	0.8038	20.6138	*	*	20.6138
450605	1.1521	0.8557	22.0210	23.8820	22.2205	22.7037
450609	0.9809	0.8038	16.6870	18.3856	*	17.5807
450610	1.5974	1.0008	24.7706	22.5451	26.8710	24.6655
450614	***	*	18.5895	*	*	18.5895
450617	1.3959	1.0008	22.7514	25.2211	26.5026	24.9284
450620	0.9943	0.8038	17.1333	18.1819	17.7138	17.6710
450623	1.0833	0.9955	25.1400	28.3354	28.3552	27.2112
450626	0.9113	0.8038	17.7454	21.4445	26.8375	21.3925
450630	1.5237	1.0008	24.8096	27.8856	29.6796	27.5230
450631	***	*	22.8637	24.5409	*	23.7681
450634	1.5840	1.0226	24.8258	27.0412	28.1705	26.8022
450638	1.5909	1.0008	26.3653	29.5385	29.6184	28.6129
450639	1.5269	0.9955	24.2919	27.3593	29.2669	27.0735
450641	0.9690	0.8038	17.4072	17.0805	17.5845	17.3565
450643	1.3272	0.8101	20.2000	20.9674	21.1205	20.7972
450644	1.4121	1.0008	24.4574	27.2047	29.0186	27.0517
450646	1.3665	0.8954	21.8500	22.6541	23.8908	22.8626
450647	1.8080	1.0226	26.8276	28.8881	30.7334	28.8704
450648	0.9048	0.8038	17.3678	18.2826	*	17.7872
450649	0.9413	0.8038	17.5761	18.1118	*	17.8381
450651	1.6207	1.0226	26.9215	28.9829	32.4822	29.5833
450653	1.1208	0.9317	22.7236	21.8654	23.2603	22.6099
450654	0.9014	0.8038	16.3057	19.6054	19.9992	18.6631
450656	1.3925	0.9164	20.7824	22.7284	23.8280	22.4984
450658	0.9005	0.8038	19.6855	19.9597	20.5398	20.0788
450659	1.4288	1.0008	26.0224	28.8671	30.1727	28.5108
450661	1.1620	0.9893	20.0716	21.5537	23.2989	21.6941
450662	1.5437	0.9853	26.3794	24.5815	28.0913	26.3697
450665	0.8590	0.8038	15.8571	17.2566	18.6054	17.2495
450668	1.5024	0.8954	24.0081	26.4508	26.2375	25.5681
450669	1.2076	1.0226	25.0200	25.6411	27.4677	26.1106
450670	1.3351	1.0008	19.9621	22.0495	25.1575	22.3620
450672	1.6955	0.9955	25.3106	26.7785	27.6359	26.6135
450673	1.0764	0.8327	16.3319	19.4030	*	17.7858
450674	0.9403	1.0008	24.8137	26.8081	*	25.8948
450675	1.4122	0.9955	24.8661	26.1555	28.7765	26.7882
450677	1.3184	0.9955	22.9529	24.0218	28.4544	25.1326
450678	1.3836	1.0226	28.1917	30.1134	30.1500	29.5324
450683	1.1313	1.0226	24.5013	24.0080	24.6609	24.3870
450684	1.2141	1.0008	23.8945	26.2906	27.6789	25.9648
450686	1.6245	0.8790	17.9181	21.0565	23.2367	20.7924
450688	1.1771	1.0226	21.7922	23.7796	27.9057	24.4771
450690	1.4853	0.9322	33.1576	28.7529	28.0400	29.1149
450694	1.0990	1.0008	21.4784	22.3081	23.5790	22.4747
450697	1.3237	0.8987	20.8951	21.2662	23.7155	22.0489
450698	0.8758	0.8038	18.1764	18.5436	18.6494	18.4560
450700	0.9198	0.8038	17.3458	18.6373	18.4602	18.1609
450702	1.5061	0.8741	22.2953	24.8628	25.6147	24.3137
450709	1.2645	1.0008	23.4246	25.0932	25.4855	24.7135
450711	1.6067	0.8945	22.1489	24.8277	28.0104	25.1428
450712	***	*	18.4547	*	*	18.4547
450715	1.2343	1.0226	*	16.1897	28.0365	20.5948
450716	1.2179	1.0008	24.8614	28.8043	30.8440	28.2641
450718	1.1954	0.9451	24.9162	27.6672	27.3408	26.7229
450723	1.3817	1.0226	24.1618	27.0055	28.0812	26.5571
450724	***	*	21.9630	*	*	21.9630
450730	1.2563	1.0226	27.8476	30.7567	29.9430	29.5510
450733	***	*	23.8143	25.5624	26.4976	25.4115
450742	1.1492	1.0226	25.1295	26.3414	26.1190	25.8920
450743	1.4553	1.0226	23.7424	24.7397	27.3213	25.3404
450746	0.9449	0.8038	11.1672	16.9209	12.4748	13.1222
450747	1.1996	0.9955	21.5883	24.2674	22.2870	22.7471
450749	1.0081	0.8038	17.8696	18.4095	17.8227	18.0184

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
450751	1.2551	0.8293	23.3154	22.9070	19.3265	21.7472
450754	0.9215	0.8038	19.2827	21.3043	20.8968	20.5167
450755	0.9643	0.8790	19.2768	19.5168	18.0092	18.8178
450758	1.2430	1.0226	22.8713	24.0226	25.6548	24.1232
450760	1.1495	0.8954	23.2959	25.7453	24.6349	24.3909
450761	0.8380	0.8038	15.5151	16.2605	15.7483	15.8642
450763	1.1245	0.8038	19.8939	21.4171	22.4905	21.2790
450766	1.8603	1.0226	27.2499	28.8576	30.0441	28.7197
450770	1.1786	0.9451	19.9412	20.1763	20.3656	20.1550
450771	1.6492	1.0226	25.0490	26.0618	31.3924	27.9152
450774	1.7122	1.0008	21.7906	24.8562	24.9683	23.8170
450775	1.1967	1.0008	23.6621	25.3924	24.4006	24.5023
450776	0.9653	0.8038	14.6695	*	*	14.6695
450780	1.9234	0.8987	21.9046	22.8688	23.9516	22.9443
450788	1.5485	0.8557	21.4467	24.2643	25.4172	23.7014
450795	1.1361	1.0008	19.1371	28.1448	23.7510	23.4235
450796	2.1587	0.9165	22.4973	24.7564	27.9734	25.1133
450797	***	1.0008	18.6839	23.8708	20.5379	20.9547
450801	1.4873	0.8293	19.7790	22.2426	23.0373	21.7315
450803	1.2163	1.0008	23.8343	26.3054	30.6093	27.0662
450804	1.8040	1.0008	22.8275	26.0003	26.0980	25.0247
450808	1.6335	0.9451	18.6555	22.8247	23.8067	21.6597
450809	1.5600	0.9451	23.8758	24.7763	26.3659	25.0664
450811	1.8007	0.8945	22.7583	23.1022	25.8491	24.4306
450813	1.1082	0.8038	21.7208	22.1326	25.5949	23.1456
450817	***	*	28.4441	*	*	28.4441
450822	1.1421	1.0226	26.7821	29.7067	31.1431	29.3455
450824	2.3620	0.9451	24.5885	*	26.7803	25.7897
450825	1.4475	0.8945	18.8510	18.7069	20.2959	19.3490
450827	1.4188	0.8327	29.5838	21.1788	20.9704	23.0851
450828	1.1739	0.8038	20.9509	21.4128	22.3667	21.5956
450829	***	0.8987	14.4463	18.2860	19.5014	17.2726
450830	0.9282	0.9593	24.7834	26.9917	28.1617	26.6450
450831	1.6369	1.0008	*	20.0581	22.7885	21.7038
450832	1.1025	1.0008	24.8572	26.4725	26.6628	26.1075
450833	1.1371	1.0226	18.3196	26.1256	26.0044	23.5951
450834	1.3563	0.8911	21.7217	22.7691	21.2204	21.8968
450835	***	*	24.8374	*	*	24.8374
450838	1.1289	0.8038	*	15.0454	15.8026	15.4717
450839	0.9271	0.8767	*	21.1905	22.9711	22.0566
450840	0.9946	1.0226	*	29.5215	31.1914	30.4233
450841	1.6236	0.9853	*	17.6635	18.9468	18.3289
450842	***	*	*	23.0945	*	23.0945
450844	1.2573	1.0008	*	34.4235	28.7296	30.4450
450845	1.8144	0.8954	*	26.5040	27.7461	27.1743
450846	***	*	*	24.0791	*	24.0791
450847	1.1792	1.0008	*	26.8892	27.6854	27.3036
450848	1.1875	1.0008	*	26.5609	27.8100	27.1855
450850	1.4887	0.9522	*	*	22.1334	22.1334
450851	2.2455	1.0226	*	*	30.1213	30.1213
450852	***	1.0226	*	*	30.0191	30.0191
460001	1.8903	0.9578	24.8844	25.6932	27.0757	25.8934
460003	1.4892	0.9436	26.5141	24.3527	26.1372	25.6304
460004	1.6546	0.9436	24.3409	25.2191	26.4498	25.3907
460005	1.4234	0.9436	25.0063	22.6809	23.5633	23.6783
460006	1.2864	0.9436	23.4200	24.4350	25.4787	24.4752
460007	1.3119	0.9416	23.3603	24.2875	25.6686	24.4644
460008	1.3319	0.9436	24.8233	24.4453	26.5672	25.2587
460009	1.9172	0.9436	24.5865	25.0984	26.2833	25.3688
460010	2.0750	0.9436	25.1240	26.2331	27.4648	26.2912
460011	1.2723	0.9578	21.2634	22.3601	23.4023	22.3027
460013	1.3340	0.9578	23.1467	23.4765	25.2448	23.9897
460014	1.0825	0.9436	22.6125	23.9400	24.5384	23.7842
460015	1.2767	0.9183	23.1068	24.0939	25.6576	24.3035
460016	***	0.8134	18.7453	*	*	18.7453
460018 [h]	0.8785	1.2094	16.7143	18.8942	20.3755	18.6334
460019	1.0897	0.8134	18.1995	20.3625	19.9900	19.5496

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
460020	1.0465	0.8134	15.2162	19.4960	19.5669	17.9384
460021	1.6825	1.1249	23.8565	24.9725	26.3420	25.1139
460023	1.1620	0.9578	25.0874	25.0376	25.3094	25.1556
460025	0.9769	0.8134	22.3098	18.7978	*	20.4201
460026	0.9752	0.8134	21.9316	22.7589	24.1547	22.9505
460029	1.0584	0.8134	24.4379	*	*	24.4379
460032	0.9659	0.9578	21.2715	22.8987	*	22.1308
460033	0.9161	0.8134	21.7216	22.7816	22.0248	22.1909
460035	0.9171	0.8134	16.9657	16.9019	17.5723	17.1694
460036	1.2351	0.9578	23.9910	25.2647	27.2865	25.5949
460037	0.8624	0.8134	20.0323	19.8478	21.1035	20.3240
460039	1.0000	0.9048	26.3795	27.5912	28.5656	27.5288
460041	1.3167	0.9436	23.5132	24.0431	25.2744	24.2809
460042	1.3210	0.9436	22.0844	23.5819	22.9949	22.8865
460043	0.9066	0.9578	26.0277	26.6870	28.2089	27.0296
460044	1.2356	0.9436	24.7138	25.7342	26.6795	25.7463
460047	1.6135	0.9436	24.9214	25.1721	25.7920	25.3219
460049	1.9769	0.9436	21.9357	23.0683	24.5164	23.1856
460051	1.1333	0.9436	22.7540	23.4970	25.5881	24.0241
460052	1.4446	0.9578	23.1717	24.0797	25.3163	24.2177
460053	***	*	23.2274	*	*	23.2274
470001	1.2123	1.0668	23.5882	24.5499	27.7329	25.2768
470003	1.8981	1.0199	24.1739	24.6660	26.4919	25.1321
470005	1.3303	1.0199	24.9625	25.7288	29.8255	26.8311
470006	1.1851	1.0199	21.6036	26.0884	26.9651	24.9417
470008	1.1624	1.0199	20.7659	21.8951	*	21.3386
470010	1.1493	1.0199	23.2072	22.9777	26.1273	24.1019
470011	1.2027	1.0903	24.6034	25.9246	28.3911	26.3395
470012	1.2167	1.0199	20.5072	22.9159	24.3425	22.6924
470018	1.1669	1.0199	21.2904	25.9300	28.3419	25.0848
470023	1.2183	1.0199	24.1395	26.7486	*	25.4614
470024	1.1449	1.0199	22.4659	23.7745	25.8652	24.1048
490001	1.0907	0.8024	22.3622	21.7111	21.9953	22.0191
490002	1.0623	0.8024	17.5098	18.5220	19.5613	18.6066
490003	***	*	20.9783	23.8112	27.3456	23.8351
490004	1.2757	0.9806	22.7154	24.4580	25.4597	24.2345
490005	1.6453	1.0813	25.2213	27.6425	28.5744	27.1963
490006	1.1847	1.0214	13.4277	16.7679	*	15.2211
490007	2.2466	0.8841	22.2526	24.9533	26.2481	24.5292
490009	1.9263	1.0230	25.2181	27.5905	29.1962	27.2686
490011	1.4460	0.8841	20.0136	22.4410	24.5687	22.4266
490012	0.9964	0.8024	15.8346	18.3697	19.2275	17.8014
490013	1.2634	0.8596	19.5094	21.4838	22.2736	21.0913
490015	***	*	21.2557	22.5641	*	21.9516
490017	1.3989	0.8841	20.7691	22.9632	24.6845	22.9273
490018	1.2537	0.9806	22.0810	23.2215	24.5196	23.2792
490019 [h]	1.1521	1.0935	23.3077	24.4524	25.9761	24.6213
490020	1.2668	0.9319	21.2094	23.6611	24.8001	23.2943
490021	1.4407	0.8706	22.2537	23.5930	24.6440	23.5199
490022	1.4865	1.0935	24.4682	25.0277	28.0749	25.8811
490023	1.2256	1.0935	24.9734	28.8354	29.7774	27.9947
490024	1.6758	0.8450	21.2619	21.7268	23.0982	22.0522
490027	1.1416	0.8024	20.3644	19.8345	18.9409	19.7128
490031	1.1051	0.8024	18.4826	22.4300	22.0579	20.9706
490032	1.8812	0.9319	23.6489	22.8942	25.1381	23.9005
490033	1.0518	1.0935	24.4370	27.6355	30.0909	27.5418
490037	1.1577	0.8024	17.5104	19.0583	21.3035	19.2834
490038	1.1503	0.8024	18.1405	19.6427	22.1374	19.9691
490040	1.5115	1.0935	27.0513	30.1820	32.8738	30.0780
490041	1.4077	0.8841	19.9314	22.2955	24.5738	22.3542
490042	1.2563	0.8024	19.5127	20.5845	21.8749	20.7701
490043	1.1666	1.0935	25.4354	28.2969	30.8871	28.4640
490044	1.3756	0.8841	20.8739	22.1324	20.8351	21.2628
490045	1.3043	1.0935	24.7131	27.2132	28.8279	27.0743
490046	1.5526	0.8841	22.0040	24.6391	25.6328	24.1719
490047	1.0113	0.8998	19.8220	21.9156	22.5424	21.3597
490048	1.4287	0.8450	22.3138	24.1639	25.0097	23.8716

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
490050	1.5254	1.0935	26.1521	29.4660	30.5037	28.7334
490052	1.6709	0.8841	19.2480	21.4035	22.8889	21.2086
490053	1.2926	0.8095	18.6541	20.9367	21.8432	20.4783
490057	1.5826	0.8841	22.1612	25.1898	26.1128	24.5153
490059	1.5692	0.9319	23.3895	26.1518	28.7276	26.1974
490060	1.0283	0.8024	20.6028	21.0828	22.4200	21.3908
490063	1.8332	1.0935	31.0162	29.4216	30.3648	30.2236
490066	1.3174	0.8841	22.1034	23.3835	24.7146	23.4575
490067	1.1859	0.9319	20.4058	21.8730	22.9188	21.7183
490069	1.5306	0.9319	20.6957	24.4542	26.8791	24.1400
490071	1.2929	0.9319	25.4678	27.0374	28.4381	27.0687
490073	1.6276	1.0935	27.6711	25.2859	31.7743	27.8898
490075	1.4205	0.8514	22.3230	22.8303	23.8191	23.0000
490077	1.3109	1.0230	22.2643	24.8309	26.0800	24.4773
490079	1.2705	0.9020	19.2196	19.8100	23.4728	20.7435
490084	1.1954	0.8024	19.8598	22.7945	24.6045	22.3588
490088	1.0683	0.8706	19.7549	21.4818	22.4186	21.1984
490089	1.0461	0.8450	21.1522	21.2123	22.6461	21.7546
490090	1.1132	0.8024	20.3015	21.3410	22.2907	21.2854
490092	1.1103	0.9319	23.8364	21.6466	23.8656	23.0587
490093	1.4305	0.8841	20.7388	23.6779	25.0751	23.2941
490094	0.9993	0.9319	21.9886	26.0755	26.5726	25.0296
490097	1.0181	0.8024	18.1022	23.5366	23.8005	21.5573
490098	1.2311	0.8024	19.7116	20.9805	21.7231	20.8214
490101	1.2761	1.0935	28.5200	30.1800	30.4285	29.7644
490104	0.7943	0.9319	28.0286	33.1215	17.3295	24.4559
490105	0.7131	0.8095	40.6821	38.2813	24.7923	34.3492
490106	0.9458	0.9806	31.6541	30.1492	23.0199	28.3157
490107	1.2758	1.0935	26.5312	28.7296	29.7000	28.3786
490108	0.9611	0.8706	28.7277	27.9090	22.4345	26.3471
490109	0.9766	0.9319	28.0978	28.0548	21.9878	25.9914
490110	1.3198	0.8024	23.6080	21.3126	22.5974	22.4319
490111	1.2838	0.8024	19.4041	20.6373	22.0199	20.6805
490112	1.6692	0.9319	23.6028	25.8312	26.6453	25.4222
490113	1.2540	1.0935	28.0893	29.1786	29.5698	28.9669
490114	0.9717	0.8024	19.9725	20.0555	20.7017	20.2462
490115	1.1772	0.8024	19.9151	20.3615	21.4666	20.5969
490116	1.1327	0.8024	19.7007	21.3083	22.9017	21.2429
490117	1.1880	0.8024	15.6078	17.4111	18.0277	17.0302
490118	1.7046	0.9319	25.2230	26.8810	27.4050	26.6600
490119	1.3161	0.8841	21.3883	23.7813	25.2549	23.5234
490120	1.3813	0.8841	22.2389	23.1535	24.4434	23.3020
490122	1.4487	1.0935	27.3509	28.7020	31.0449	29.0227
490123	1.0953	0.8024	20.9506	22.9511	23.9233	22.6075
490124	***	*	21.3713	29.7939	*	25.7258
490126	1.2378	0.8024	20.4660	23.1423	22.2859	21.9403
490127	1.0786	0.8024	17.8070	19.4005	20.4289	19.2585
490130	1.3182	0.8841	18.6038	22.0769	22.8512	21.1640
490132	***	0.8024	19.5849	*	*	19.5849
500001	1.5872	1.1573	26.6420	26.7502	29.3707	27.5939
500002	1.4024	1.0459	24.0374	25.0665	25.3347	24.8482
500003	1.2634	1.1573	27.3435	28.4174	29.6341	28.5098
500005	1.8137	1.1573	28.9512	31.4415	32.0972	30.7955
500007	1.2933	1.0459	23.5774	26.1318	28.0476	25.9648
500008	1.9138	1.1573	28.9380	31.0128	31.8837	30.6288
500011	1.3458	1.1573	27.6762	28.3391	30.6508	28.9502
500012	1.5792	1.0459	26.2263	29.2045	30.6856	28.7227
500014	1.6444	1.1573	27.4248	30.1061	33.7536	30.6058
500015	1.3785	1.1573	27.3397	30.1596	32.0592	29.8941
500016	1.6460	1.1573	27.7863	29.3634	31.4221	29.6282
500019	1.2688	1.0459	25.7691	26.9702	28.6669	27.1697
500021	1.3005	1.0794	26.4648	28.5926	30.1690	28.5893
500023	1.1295	1.0459	23.9513	27.3823	*	25.6872
500024	1.6961	1.0794	27.2967	29.3946	30.7917	29.1683
500025	1.7523	1.1573	29.0400	31.7335	34.7252	31.7861
500026	1.4441	1.1573	28.7532	31.4152	33.2937	31.1325
500027	1.5647	1.1573	30.6901	29.5939	34.2175	31.5063

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
500030	1.5791	1.1705	29.0487	30.5926	32.7446	30.8324
500031	1.1888	1.0970	26.0740	28.5398	31.2186	28.5887
500033	1.2976	1.0459	25.4345	26.6704	29.4627	27.2338
500036	1.3747	1.0459	25.4753	26.0223	27.0072	26.1929
500037	1.0310	1.0459	23.5414	24.6548	26.9969	25.0377
500039	1.4511	1.1573	26.1409	27.9651	29.8809	28.0919
500041	1.2975	1.1229	24.9004	26.9101	26.5976	26.1814
500044	1.9843	1.0898	27.0880	26.9323	30.3164	28.1645
500049	1.3010	1.0459	26.6407	25.6104	27.1819	26.4960
500050	1.4422	1.1229	25.0907	26.8971	29.9791	27.4347
500051	1.7552	1.1573	26.9538	29.0100	31.9406	29.4441
500053	1.2441	1.0619	26.0112	26.8074	28.4130	27.1467
500054	2.0525	1.0898	27.1965	28.8062	30.8067	28.9786
500055	***	1.0459	25.3095	*	*	25.3095
500058	1.6605	1.0619	27.3411	28.4247	30.4699	28.8635
500060	1.2823	1.1573	31.7480	33.5169	34.1523	33.1768
500064	1.7416	1.1573	29.2539	31.1459	31.5371	30.6791
500065	1.2445	1.0459	26.5880	26.0960	*	26.3295
500071	1.1734	1.0459	23.2071	*	*	23.2071
500074	***	1.0459	21.9019	*	*	21.9019
500079	1.3420	1.0794	27.1775	28.4934	29.6623	28.4444
500084	1.3103	1.1573	26.5864	27.6306	29.3484	27.9397
500086	1.2807	1.0459	25.9705	*	*	25.9705
500092	0.8995	1.0459	20.8601	23.2466	*	22.0417
500104	1.0691	1.1573	26.8007	27.0034	*	26.9067
500108	1.6596	1.0794	27.4156	28.7206	29.4244	28.5667
500110	1.1857	1.0459	24.8448	25.4785	26.4560	25.6025
500118	1.1171	1.0459	26.1971	28.1074	*	27.1693
500119	1.3607	1.0898	25.1576	27.2335	30.9999	27.7928
500122	1.1916	1.0459	26.9006	27.4405	30.1396	28.2069
500124	1.4090	1.1573	24.8357	28.6598	31.5438	28.2647
500129	1.5325	1.0794	27.8351	30.0223	30.7536	29.5772
500134	0.4749	1.1573	21.3921	24.2990	26.8608	24.3808
500139	1.5310	1.0794	27.7281	29.2357	31.6591	29.5383
500141	1.2664	1.1573	28.2968	30.7478	30.5456	29.9289
500143	0.4570	1.0794	19.0982	20.7093	22.1419	20.7552
500147	0.8043	1.0459	*	16.3669	24.5807	16.9814
500148	1.1051	1.0459	*	18.2168	22.2161	20.0814
510001	1.9174	0.8840	21.4247	22.9351	23.4477	22.6536
510002	1.1623	0.8450	20.9822	22.4751	25.9597	23.1031
510006	1.2491	0.8840	21.0214	22.2947	23.5727	22.3142
510007	1.5458	0.9482	23.4411	24.3499	25.2835	24.3672
510008	1.1920	0.9528	22.7595	24.5293	24.6959	24.0287
510012	0.9435	0.7742	16.7710	18.5816	18.2845	17.8391
510013	1.1671	0.7742	19.7937	19.9710	20.8782	20.2065
510015	0.9561	0.8429	17.9040	*	*	17.9040
510022	1.8301	0.8429	22.7534	24.1481	24.2125	23.7112
510023	1.2510	0.7821	17.9267	19.4321	20.4908	19.2664
510024	1.7224	0.8840	21.3662	23.3115	24.0444	22.9061
510026	1.0110	0.7742	16.5389	18.0855	16.6192	17.0257
510028	0.9965	0.8274	24.6544	23.0518	21.7134	23.1596
510029	1.2527	0.8429	19.8202	21.7527	22.0060	21.2311
510030	1.1843	0.8332	19.8220	22.3658	21.5583	21.2766
510031	1.3895	0.8429	20.5743	21.6294	21.7637	21.3498
510033	1.3921	0.8303	19.6921	21.0707	23.0305	21.2329
510038	1.0245	0.7742	16.1016	16.8744	17.2832	16.7659
510039	1.2658	0.7742	17.6173	19.1280	19.5468	18.7692
510043	0.8986	0.7742	15.5857	16.0586	*	15.8328
510046	1.2834	0.8274	19.2802	21.2792	21.2540	20.5978
510047	1.1340	0.8840	22.1953	23.2093	24.0954	23.1668
510048	1.1071	0.7742	16.3761	17.6785	17.5096	17.1529
510050	1.5329	0.7742	18.9990	20.1943	19.9766	19.7250
510053	1.1350	0.7742	18.1054	20.7538	20.8609	19.9625
510055	1.4505	0.9482	27.7422	29.3962	30.7868	29.3287
510058	1.2970	0.8303	20.1104	21.9352	22.6976	21.6021
510059	0.6811	0.8429	18.1543	18.8712	21.9550	19.5138
510061	0.9818	0.9310	14.8848	15.3355	*	15.1074

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage ** (3 years)
510062	1.1655	0.7742	21.3405	21.1568	23.3216	21.9387
510067	1.1669	0.7742	18.0113	22.1582	21.2099	20.4433
510068	1.1126	1.0935	19.9056	20.0007	23.1011	21.0310
510070	1.1882	0.8274	20.0974	21.1895	23.2382	21.5724
510071	1.2853	0.8274	19.4029	21.5439	23.1685	21.4107
510072	1.0629	0.7742	18.4566	19.7990	20.1997	19.5568
510077	1.1621	0.9119	20.9153	22.8104	23.6585	22.4770
510082	1.1043	0.7742	17.2891	16.4742	19.1878	17.5963
510085	1.2020	0.8429	20.6364	22.6563	23.7173	22.3503
510086	1.0874	0.7742	16.3051	17.8234	17.5933	17.2267
510088	0.9820	0.7742	16.4373	18.3401	*	17.3534
510089	***	*	*	*	27.7062	27.7062
520002	1.2821	0.9964	22.0838	23.7316	24.9950	23.6544
520003	1.1724	0.9478	20.4234	21.8662	*	21.1608
520004	1.3395	0.9557	22.8530	24.4711	25.4639	24.2888
520008	1.5856	1.0111	26.0931	27.8127	29.8354	27.9737
520009	1.6869	0.9478	21.5169	23.4265	26.1503	23.6455
520010	1.1228	1.1055	26.3965	28.5569	29.2491	28.0349
520011	1.2647	0.9478	22.7880	23.7785	25.2747	23.9992
520013	1.3725	0.9478	23.1173	24.4766	26.6225	24.8211
520014	1.0762	1.0629	20.4281	22.1064	*	21.2683
520015	1.1411	.9478	22.8094	23.0403	*	22.9239
520017	1.1442	0.9478	21.7542	23.4044	24.6676	23.3009
520019	1.2709	0.9478	22.6895	24.9871	25.0377	24.2463
520021	1.3765	1.0698	24.1284	25.4872	26.6935	25.4468
520024	1.0697	0.9478	17.5368	18.5072	*	18.0423
520026	1.0913	1.1055	25.0504	26.1056	*	25.6168
520027	1.2710	1.0111	22.2089	26.2516	27.5490	25.5645
520028	1.2544	1.0416	24.3592	25.7778	25.4164	25.1844
520030	1.7713	0.9964	23.9474	25.3807	27.0185	25.5053
520032	1.1260	1.0629	22.7220	25.3059	25.3696	24.4819
520033	1.3031	0.9478	22.2650	23.9791	24.6125	23.6548
520034	1.1362	0.9478	22.6160	23.6563	23.9850	23.4634
520035	1.2757	0.9478	20.8563	23.2625	24.7767	23.0160
520037	1.7957	0.9964	25.0587	28.6984	29.7234	27.8508
520038	1.2023	1.0111	23.1036	24.6650	26.6470	24.8476
520040	1.3551	1.0111	21.5671	23.8501	25.1096	23.5636
520041	1.1069	1.0629	22.6216	22.8236	22.7596	22.7396
520042	1.0666	0.9478	21.9935	24.0788	23.6326	23.2471
520044	1.3206	0.9478	22.7627	24.9387	26.0191	24.5777
520045	1.4958	0.9478	24.1624	24.5844	26.0030	24.9427
520047	0.9463	0.9478	22.5686	25.5346	*	24.0011
520048	1.6494	0.9478	20.5069	23.1653	25.1724	22.8848
520049	2.1923	0.9478	22.7424	24.1083	25.9256	24.2130
520051	1.6606	1.0111	27.6695	28.8249	28.3040	28.2799
520057	1.1487	0.9478	21.2729	23.3205	25.3745	23.3399
520058	***	1.0224	23.2907	*	*	23.2907
520060	1.3001	0.9478	21.1271	22.0132	23.8817	22.3382
520062	1.2975	1.0111	23.7166	24.9988	28.2215	25.7059
520063	1.1228	1.0111	23.3037	25.3674	27.4101	25.4095
520064	1.4701	1.0111	24.3043	27.1120	28.6101	26.6968
520066	1.5188	1.0416	23.9212	25.8812	27.1657	25.6782
520068	0.8883	0.9478	21.4413	23.4746	24.8184	23.2981
520069	***	*	32.6484	*	*	32.6484
520071	1.2141	0.9957	23.4832	26.3154	27.6202	25.7950
520075	1.5364	0.9478	23.7322	26.0600	27.1699	25.6758
520076	1.1767	1.0416	22.2993	24.0879	26.1698	24.2625
520078	1.4830	1.0111	23.4414	25.7662	27.5989	25.6772
520083	1.7454	1.0629	25.7108	27.0012	28.8407	27.2481
520084	1.0616	1.0629	24.7909	25.5777	*	25.1765
520087	1.6953	0.9557	22.8974	24.5280	27.3374	24.8782
520088	1.3362	0.9957	23.8938	26.0882	26.9936	25.7252
520089	1.5475	1.0629	24.4435	26.6013	30.0448	27.0527
520091	1.2659	0.9478	22.8914	24.8269	24.6320	24.0764
520092	1.0263	0.9478	21.8662	23.4043	*	22.6433
520094	***	0.9957	22.3925	25.3166	25.7567	24.5483
520095	1.2045	1.0416	25.1402	28.6376	26.7863	26.8360

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2004 (2000 WAGE DATA), 2005 (2001 WAGE DATA), AND 2006 (2002 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider number	Case-mix index	Wage index FY 2006	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006	Average hourly wage** (3 years)
520096	1.3205	0.9957	21.1759	22.9929	24.5758	22.9775
520097	1.3919	0.9478	23.6512	25.1135	26.3321	25.1104
520098	2.0001	1.0629	25.8184	28.0730	30.6150	28.2679
520100	1.2767	0.9561	21.7072	24.5914	26.2161	24.1896
520102	1.0905	0.9957	23.7739	25.6146	26.8234	25.4621
520103	1.6066	1.0111	23.5984	25.5361	27.9147	25.8275
520107	1.2224	0.9478	25.7379	27.7413	28.3431	27.2253
520109	1.0371	0.9478	20.6357	22.4048	24.9379	22.6443
520111	***	*	26.9666	26.3095	*	26.6016
520112	1.1078	0.9478	19.1409	20.4034	*	19.7623
520113	1.2717	0.9478	24.0822	26.7926	27.4135	26.1479
520114	1.1620	0.9478	21.9847	22.0536	*	22.0194
520116	1.2099	0.9957	23.9066	26.3057	26.9902	25.8557
520117	1.0283	0.9478	21.9915	22.0023	*	21.9973
520123	1.0715	1.1055	21.2360	22.2430	*	21.7461
520130	***	0.9478	20.0277	*	*	20.0277
520134	***	0.9478	20.8502	*	*	20.8502
520136	1.6003	1.0111	23.2573	25.5145	27.7703	25.5032
520138	1.8350	1.0111	25.1434	26.9047	28.4394	26.8513
520139	1.2505	1.0111	23.7727	25.4424	26.5110	25.3279
520140	1.6615	1.0111	23.9176	26.1616	28.3001	26.0657
520145	***	*	25.0770	*	*	25.0770
520151	1.0251	0.9478	20.1995	22.9592	*	21.5728
520152	1.0564	0.9478	22.5440	23.2493	24.9392	23.6620
520154	1.1733	0.9478	23.2635	23.7160	*	23.4910
520156	1.0529	1.1055	23.7157	24.9258	*	24.3330
520160	1.8094	0.9478	22.9475	24.3528	25.7588	24.4208
520161	0.9206	0.9478	22.1857	24.0673	*	23.1340
520170	1.2905	1.0111	25.5470	25.6124	27.2221	26.1781
520173	1.0948	1.0224	24.4723	26.2224	28.0995	26.3133
520177	1.6337	1.0111	27.5560	28.4663	30.7317	29.0456
520178	0.9691	0.9478	22.3193	23.0419	20.2666	21.8785
520189	1.1063	1.0698	23.1658	26.3172	28.4720	26.3169
520192	***	*	22.5641	*	*	22.5641
520194	1.5971	*	*	*	24.9408	24.9408
520195	0.3562	1.0111	*	*	36.6973	36.6973
520196	1.5022	0.9478	*	*	35.1043	35.1043
530002	1.1527	0.9207	23.8852	25.2983	26.8356	25.4030
530004	***	*	19.7857	*	*	19.7857
530007	1.2447	0.9207	22.3309	19.3476	20.4391	20.6774
530008 [2]	1.2307	0.9207	21.8714	23.8271	23.8589	23.1777
530009	0.9699	0.9207	22.0450	24.2426	26.8316	24.1997
530010 [2]	1.2457	0.9207	21.4890	23.9255	25.8482	23.7290
530011	1.0112	0.9207	22.5720	24.1396	24.8245	23.8464
530012	1.6902	0.9207	22.4716	24.3454	25.2526	24.0014
530014	1.6077	0.9207	21.7314	23.6907	24.5947	23.3995
530015	1.2773	0.9207	25.3915	26.3107	27.6876	26.4934
530016	1.3351	0.9207	21.0666	21.6575	*	21.3685
530017	0.9556	0.9207	19.5630	23.5415	25.3362	22.8987
530023	1.1558	0.9207	22.5535	24.1493	21.3813	22.6451
530025	1.2781	1.0146	25.4693	27.7988	28.6938	27.3568
530026	***	0.9207	21.0732	*	*	21.0732
530031	0.9546	0.9207	16.8825	16.3472	*	16.6017
530032	1.0215	0.9207	19.4449	22.6584	22.9391	21.6640

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.C.2. of the preamble to this proposed rule.
[2] These hospitals are assigned a wage index value according to section III.H. of the preamble of this proposed rule.
[h] These hospitals are assigned a wage index value according to section III.G. of the preamble to this proposed rule.
*Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2004, 2005, and 2006.
***Denotes MedPAR data not available for the provider for FY 2004.

TABLE 3A.—FY 2006 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA

[*Based on the sum of the salaries and hours computed for Federal fiscal years 2004, 2005, and 2006]

CBSA code	Urban area	FY 2006 average hourly wage	3-Year average hourly wage
10180	Abilene, TX	22.1701	20.4985
10380	Aguadilla-Isabela-San Sebastín, PR	13.2502	11.5908
10420	Akron, OH	25.1189	23.9584
10500	Albany, GA	24.1844	26.6216
10580	Albany-Schenectady-Troy, NY	23.9528	22.6259
10740	Albuquerque, NM	27.1248	25.7999
10780	Alexandria, LA	22.5148	21.3129
10900	Allentown-Bethlehem-Easton, PA-NJ	27.5389	25.5680
11020	Altoona, PA	25.0167	22.9759
11100	Amarillo, TX	25.6410	24.0270
11180	Ames, IA	26.7068	25.0247
11260	Anchorage, AK	33.8779	32.1826
11300	Anderson, IN	24.1549	23.0714
11340	Anderson, SC	24.8624	22.9488
11460	Ann Arbor, MI	30.4505	29.2076
11500	Anniston-Oxford, AL	21.4718	20.7611
11540	Appleton, WI	25.9098	24.1044
11700	Asheville, NC	26.0511	24.5466
12020	Athens-Clarke County, GA	27.4532	26.1928
12060	Atlanta-Sandy Springs-Marietta, GA	26.9604	26.0983
12100	Atlantic City, NJ	32.5013	29.4922
12220	Auburn-Opelika, AL	22.6976	21.8061
12260	Augusta-Richmond County, GA-SC	26.7647	24.8652
12420	Austin-Round Rock, TX	26.4408	25.2181
12540	Bakersfield, CA	28.9777	26.6414
12580	Baltimore-Towson, MD	27.6740	26.1267
12620	Bangor, ME	27.9343	26.2399
12700	Barnstable Town, MA	35.0207	33.2353
12940	Baton Rouge, LA	24.0727	22.2239
12980	Battle Creek, MI	26.5543	24.8160
13020	Bay City, MI	26.1760	25.1852
13140	Beaumont-Port Arthur, TX	23.5603	22.3855
13380	Bellingham, WA	32.7446	30.8324
13460	Bend, OR	30.1666	28.0136
13644	Bethesda-Frederick-Gaithersburg, MD	32.0917	29.4434
13740	Billings, MT	24.7710	23.5742
13780	Binghamton, NY	24.0264	22.4051
13820	Birmingham-Hoover, AL	25.1185	23.9577
13900	Bismarck, ND	21.0353	20.1696
13980	Blacksburg-Christiansburg-Radford, VA	22.3143	21.3890
14020	Bloomington, IN	23.7061	22.5941
14060	Bloomington-Normal, IL	25.4101	23.7897
14260	Boise City-Nampa, ID	25.3133	24.3052
14484	Boston-Quincy, MA	32.2755	30.7174
14500	Boulder, CO	27.2574	26.2715
14540	Bowling Green, KY	23.0011	21.8437
14740	Bremerton-Silverdale, WA	29.8809	28.0919
14860	Bridgeport-Stamford-Norwalk, CT	35.2686	33.7851
15180	Brownsville-Harlingen, TX	27.5656	26.6683
15260	Brunswick, GA	26.1311	28.6493
15380	Buffalo-Niagara Falls, NY	24.8634	24.3177
15500	Burlington, NC	24.9033	23.6142
15540	Burlington-South Burlington, VT	26.4165	25.0134
15764	Cambridge-Newton-Framingham, MA	30.9921	29.2429
15804	Camden, NJ	29.4132	28.1192
15940	Canton-Massillon, OH	25.0564	23.6833
15980	Cape Coral-Fort Myers, FL	26.1095	25.0250
16180	Carson City, NV	28.6158	27.0192
16220	Casper, WY	25.2526	24.0014
16300	Cedar Rapids, IA	24.0727	23.2382
16580	Champaign-Urbana, IL	26.8325	25.4853
16620	Charleston, WV	23.5802	22.9895
16700	Charleston-North Charleston, SC	26.3883	24.7642
16740	Charlotte-Gastonia-Concord, NC-SC	27.1825	25.6465
16820	Charlottesville, VA	28.6200	26.8014
16860	Chattanooga, TN-GA	25.4537	24.0895
16940	Cheyenne, WY	24.5947	23.3995
16974	Chicago-Naperville-Joliet, IL	30.3410	28.6963
17020	Chico, CA	29.4447	27.4655

TABLE 3A.—FY 2006 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the sum of the salaries and hours computed for Federal fiscal years 2004, 2005, and 2006]

CBSA code	Urban area	FY 2006 average hourly wage	3-Year average hourly wage
17140	Cincinnati-Middletown, OH-KY-IN	26.8669	25.0229
17300	Clarksville, TN-KY	23.1419	21.5444
17420	Cleveland, TN	22.8278	21.2133
17460	Cleveland-Elyria-Mentor, OH	25.7303	25.0687
17660	Coeur d'Alene, ID	26.9749	25.1364
17780	College Station-Bryan, TX	24.9298	23.8550
17820	Colorado Springs, CO	26.4562	25.5825
17860	Columbia, MO	23.3470	22.3003
17900	Columbia, SC	25.3362	24.0049
17980	Columbus, GA-AL	23.9764	22.7919
18020	Columbus, IN	26.8458	25.0573
18140	Columbus, OH	27.5495	25.7193
18580	Corpus Christi, TX	23.9399	22.6210
18700	Corvallis, OR	29.9648	28.7806
19060	Cumberland, MD-WV	26.0448	22.8828
19124	Dallas-Plano-Irving, TX	28.6076	26.7125
19140	Dalton, GA	25.2695	24.8431
19180	Danville, IL	25.3127	22.9099
19260	Danville, VA	23.8191	23.0000
19340	Davenport-Moline-Rock Island, IA-IL	24.3842	23.2403
19380	Dayton, OH	25.3708	24.4405
19460	Decatur, AL	23.7138	22.9734
19500	Decatur, IL	22.5852	21.4281
19660	Deltona-Daytona Beach-Ormond Beach, FL	26.0379	24.0560
19740	Denver-Aurora, CO	29.9610	28.5110
19780	Des Moines, IA	26.9975	24.6647
19804	Detroit-Livonia-Dearborn, MI	29.2431	27.2952
20020	Dothan, AL	21.6602	20.2540
20100	Dover, DE	27.4735	25.9428
20220	Dubuque, IA	25.5030	23.5042
20260	Duluth, MN-WI	28.5299	27.0543
20500	Durham, NC	28.7033	27.3555
20740	Eau Claire, WI	25.7563	24.1573
20764	Edison, NJ	31.5082	29.5433
20940	El Centro, CA	25.1083	23.7136
21060	Elizabethtown, KY	24.6642	22.6125
21140	Elkhart-Goshen, IN	26.9005	25.1975
21300	Elmira, NY	23.1540	22.0419
21340	El Paso, TX	25.0500	23.9275
21500	Erie, PA	24.4677	22.8915
21604	Essex County, MA	29.4434	27.9641
21660	Eugene-Springfield, OR	30.2425	29.2693
21780	Evansville, IN-KY	24.4379	22.4627
21820	Fairbanks, AK	31.8995	29.8198
21940	Fajardo, PR	11.6386	10.6772
22020	Fargo, ND-MN	23.7360	23.9742
22140	Farmington, NM	23.8264	22.4376
22180	Fayetteville, NC	26.3708	24.3719
22220	Fayetteville-Springdale-Rogers, AR-MO	24.0127	22.5998
22380	Flagstaff, AZ	33.8333	30.2808
22420	Flint, MI	29.7989	28.6871
22500	Florence, SC	25.1444	23.2705
22520	Florence-Muscle Shoals, AL	23.2344	21.0532
22540	Fond du Lac, WI	26.9936	25.7252
22660	Fort Collins-Loveland, CO	28.2568	26.7964
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	29.1773	27.0873
22900	Fort Smith, AR-OK	23.0272	21.9069
23020	Fort Walton Beach-Crestview-Destin, FL	24.8333	23.4332
23060	Fort Wayne, IN	27.4082	25.7154
23104	Fort Worth-Arlington, TX	26.6167	24.9487
23420	Fresno, CA	29.6215	27.6921
23460	Gadsden, AL	22.3074	21.3197
23540	Gainesville, FL	26.4676	25.1553
23580	Gainesville, GA	24.8893	24.3542
23844	Gary, IN	26.2014	24.6755
24020	Glens Falls, NY	24.0232	22.4577
24140	Goldsboro, NC	24.5666	23.0280
24220	Grand Forks, ND-MN	32.2306	26.3170
24300	Grand Junction, CO	26.8293	25.6655

TABLE 3A.—FY 2006 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the sum of the salaries and hours computed for Federal fiscal years 2004, 2005, and 2006]

CBSA code	Urban area	FY 2006 average hourly wage	3-Year average hourly wage
24340	Grand Rapids-Wyoming, MI	26.2918	24.9274
24500	Great Falls, MT	25.2873	23.4084
24540	Greeley, CO	26.8470	25.0779
24580	Green Bay, WI	26.4060	25.1220
24660	Greensboro-High Point, NC	25.5495	24.2161
24780	Greenville, NC	26.3325	24.3631
24860	Greenville, SC	28.3616	25.8028
25020	Guayama, PR	08.9125	09.5939
25060	Gulfport-Biloxi, MS	24.9592	23.9056
25180	Hagerstown-Martinsburg, MD-WV	26.6548	25.0347
25260	Hanford-Corcoran, CA	28.1814	25.1270
25420	Harrisburg-Carlisle, PA	26.0656	24.4935
25500	Harrisonburg, VA	25.4597	24.2345
25540	Hartford-West Hartford-East Hartford, CT	31.0121	29.5959
25620	Hattiesburg, MS	21.3089	19.6542
25860	Hickory-Lenoir-Morganton, NC	24.9837	24.3032
25980	[1]Hinesville-Fort Stewart, GA	.-------	.-------
26100	Holland-Grand Haven, MI	25.4579	24.5609
26180	Honolulu, HI	31.3501	29.2509
26300	Hot Springs, AR	25.3627	24.1181
26380	Houma-Bayou Cane-Thibodaux, LA	22.1079	20.5356
26420	Houston-Baytown-Sugar Land, TX	27.9993	26.1356
26580	Huntington-Ashland, WV-KY-OH	26.5266	25.2510
26620	Huntsville, AL	25.5254	23.9276
26820	Idaho Falls, ID	26.3236	24.2135
26900	Indianapolis, IN	27.7571	26.3923
26980	Iowa City, IA	27.2791	25.4755
27060	Ithaca, NY	27.5699	25.6624
27100	Jackson, MI	26.0171	24.0809
27140	Jackson, MS	23.2553	21.9059
27180	Jackson, TN	25.0772	23.6035
27260	Jacksonville, FL	26.0254	24.9544
27340	Jacksonville, NC	23.0236	22.0702
27500	Janesville, WI	26.7462	25.0136
27620	Jefferson City, MO	23.4699	22.4350
27740	Johnson City, TN	22.2633	21.2152
27780	Johnstown, PA	23.3540	22.1239
27860	Jonesboro, AR	22.2913	21.0721
27900	Joplin, MO	24.0416	22.8597
28020	Kalamazoo-Portage, MI	29.1036	28.0902
28100	Kankakee-Bradley, IL	30.7469	28.2579
28140	Kansas City, MO-KS	26.4479	25.2795
28420	Kennewick-Richland-Pasco, WA	29.7070	27.8472
28660	Killeen-Temple-Fort Hood, TX	23.9626	23.6807
28700	Kingsport-Bristol-Bristol, TN-VA	22.5380	21.6656
28740	Kingston, NY	25.9063	24.4214
28940	Knoxville, TN	23.6960	22.7400
29020	Kokomo, IN	26.7312	24.3627
29100	La Crosse, WI-MN	26.7369	24.6616
29140	Lafayette, IN	24.4215	23.5470
29180	Lafayette, LA	23.5797	22.0745
29340	Lake Charles, LA	21.9512	20.7252
29404	Lake County-Kenosha County, IL-WI	29.2180	27.3940
29460	Lakeland, FL	24.9925	23.4702
29540	Lancaster, PA	27.1801	25.5025
29620	Lansing-East Lansing, MI	27.3767	25.6366
29700	Laredo, TX	22.6637	21.9619
29740	Las Cruces, NM	23.6548	22.8284
29820	Las Vegas-Paradise, NV	31.9355	30.3760
29940	Lawrence, KS	23.8863	22.7099
30020	Lawton, OK	22.1442	21.4717
30140	Lebanon, PA	24.2087	23.0471
30300	Lewiston, ID-WA	27.6345	24.9793
30340	Lewiston-Auburn, ME	26.1064	24.8965
30460	Lexington-Fayette, KY	25.3464	22.7343
30620	Lima, OH	25.7797	24.7454
30700	Lincoln, NE	28.5262	27.0530
30780	Little Rock-North Little Rock, AR	24.5286	23.3089
30860	Logan, UT-ID	25.6905	24.3475

TABLE 3A.—FY 2006 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the sum of the salaries and hours computed for Federal fiscal years 2004, 2005, and 2006]

CBSA code	Urban area	FY 2006 average hourly wage	3-Year average hourly wage
30980	Longview, TX	24.4521	23.4643
31020	Longview, WA	26.5976	26.1814
31084	Los Angeles-Long Beach-Glendale, CA	32.9050	31.0454
31140	Louisville, KY-IN	25.9154	24.2971
31180	Lubbock, TX	24.5905	22.7060
31340	Lynchburg, VA	24.3559	23.5846
31420	Macon, GA	26.5343	25.0025
31460	Madera, CA	24.4061	22.5247
31540	Madison, WI	29.7363	27.4059
31700	Manchester-Nashua, NH	28.8847	27.6772
31900	[1]Mansfield, OH	-------	-------
32420	Mayagüez, PR	11.2362	11.3917
32580	McAllen-Edinburg-Pharr, TX	25.0238	22.9932
32780	Medford, OR	28.6299	27.7062
32820	Memphis, TN-MS-AR	26.1471	24.2118
32900	Merced, CA	31.1184	27.6673
33124	Miami-Miami Beach-Kendall, FL	27.2942	25.9755
33140	Michigan City-La Porte, IN	26.3221	24.7313
33260	Midland, TX	26.6395	25.3824
33340	Milwaukee-Waukesha-West Allis, WI	28.2858	26.5793
33460	Minneapolis-St. Paul-Bloomington, MN-WI	30.9281	29.1156
33540	Missoula, MT	26.4227	24.2896
33660	Mobile, AL	22.1076	20.9624
33700	Modesto, CA	33.0964	31.0034
33740	Monroe, LA	22.5035	20.9918
33780	Monroe, MI	26.4882	25.0486
33860	Montgomery, AL	24.0586	21.7643
34060	Morgantown, WV	23.6097	22.7263
34100	Morristown, TN	24.5017	21.6486
34580	Mount Vernon-Anacortes, WA	29.2146	27.8316
34620	Muncie, IN	25.0449	23.0977
34740	Muskegon-Norton Shores, MI	27.0713	25.4822
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	24.8106	23.7419
34900	Napa, CA	35.3683	32.9923
34940	Naples-Marco Island, FL	28.2979	26.9037
34980	Nashville-Davidson—Murfreesboro, TN	27.2968	26.1014
35004	Nassau-Suffolk, NY	35.7543	34.1418
35084	Newark-Union, NJ-PA	34.1064	31.1564
35300	New Haven-Milford, CT	32.7989	31.1765
35380	New Orleans-Metairie-Kenner, LA	25.1852	23.9697
35644	New York-Wayne-White Plains, NY-NJ	36.9026	35.2542
35660	Niles-Benton Harbor, MI	24.8541	23.3997
35980	Norwich-New London, CT	31.8510	30.4182
36084	Oakland-Fremont-Hayward, CA	42.8742	40.0207
36100	Ocala, FL	25.0519	24.4578
36140	Ocean City, NJ	30.8612	28.5543
36220	Odessa, TX	27.6769	25.1761
36260	Ogden-Clearfield, UT	25.2772	24.5654
36420	Oklahoma City, OK	25.2975	23.7988
36500	Olympia, WA	30.5859	28.9079
36540	Omaha-Council Bluffs, NE-IA	26.7314	25.5410
36740	Orlando, FL	26.4250	25.3813
36780	Oshkosh-Neenah, WI	25.6249	23.9585
36980	Owensboro, KY	24.6348	22.4970
37100	Oxnard-Thousand Oaks-Ventura, CA	32.4624	29.7410
37340	Palm Bay-Melbourne-Titusville, FL	27.4887	25.7496
37460	Panama City-Lynn Haven, FL	22.3439	21.3568
37620	Parkersburg-Marietta, WV-OH	23.2293	21.7277
37700	Pascagoula, MS	22.8397	21.4591
37860	Pensacola-Ferry Pass-Brent, FL	22.6287	22.0289
37900	Peoria, IL	24.7421	23.2730
37964	Philadelphia, PA	30.8573	28.8565
38060	Phoenix-Mesa-Scottsdale, AZ	28.3642	26.6530
38220	Pine Bluff, AR	24.3824	22.1870
38300	Pittsburgh, PA	24.7296	23.2597
38340	Pittsfield, MA	28.4877	27.1701
38540	Pocatello, ID	26.1526	24.5528
38660	Ponce, PR	14.4851	13.0375
38860	Portland-South Portland-Biddeford, ME	29.0440	26.7442

TABLE 3A.—FY 2006 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the sum of the salaries and hours computed for Federal fiscal years 2004, 2005, and 2006]

CBSA code	Urban area	FY 2006 average hourly wage	3-Year average hourly wage
38900	Portland-Vancouver-Beaverton, OR-WA	31.4148	29.7614
38940	Port St. Lucie-Fort Pierce, FL	28.3669	26.5761
39100	Poughkeepsie-Newburgh-Middletown, NY	30.1207	29.3034
39140	Prescott, AZ	27.6508	26.3318
39300	Providence-New Bedford-Fall River, RI-MA	30.6398	28.8359
39340	Provo-Orem, UT	26.5574	25.4669
39380	Pueblo, CO	24.1431	23.0046
39460	Punta Gorda, FL	25.9442	24.8140
39540	Racine, WI	25.2201	23.6789
39580	Raleigh-Cary, NC	27.1623	25.4788
39660	Rapid City, SD	25.2538	23.5560
39740	Reading, PA	27.1301	24.7239
39820	Redding, CA	34.1503	31.2183
39900	Reno-Sparks, NV	30.7272	28.3079
40060	Richmond, VA	26.0695	24.6756
40140	Riverside-San Bernardino-Ontario, CA	30.8328	29.3251
40220	Roanoke, VA	23.4915	22.4289
40340	Rochester, MN	31.1302	30.1737
40380	Rochester, NY	25.5065	24.5493
40420	Rockford, IL	27.9047	25.7304
40484	Rockingham County-Strafford County, NH	29.0055	27.0997
40580	Rocky Mount, NC	24.9648	23.6953
40660	Rome, GA	26.3370	23.8100
40900	Sacramento--Arden-Arcade--Roseville, CA	36.2362	32.0754
40980	Saginaw-Saginaw Township North, MI	26.5050	25.8822
41060	St. Cloud, MN	28.0585	26.3196
41100	St. George, UT	26.3420	25.1139
41140	St. Joseph, MO-KS	26.7587	25.8174
41180	St. Louis, MO-IL	25.0452	23.7896
41420	Salem, OR	29.2207	27.6647
41500	Salinas, CA	39.5570	37.1828
41540	Salisbury, MD	25.3485	24.0517
41620	Salt Lake City, UT	26.3970	25.4439
41660	San Angelo, TX	23.1837	21.9567
41700	San Antonio, TX	25.1428	23.6255
41740	San Diego-Carlsbad-San Marcos, CA	31.9401	29.8191
41780	Sandusky, OH	25.2690	23.6568
41884	San Francisco-San Mateo-Redwood City, CA	41.8804	38.9640
41900	San Germán-Cabo Rojo, PR	12.9971	13.4135
41940	San Jose-Sunnyvale-Santa Clara, CA	42.2833	39.0995
41980	San Juan-Caguas-Guaynabo, PR	13.1085	12.3738
42020	San Luis Obispo-Paso Robles, CA	31.7731	29.7965
42044	Santa Ana-Anaheim-Irvine, CA	32.3515	30.4088
42060	Santa Barbara-Santa Maria-Goleta, CA	32.2413	28.8239
42100	Santa Cruz-Watsonville, CA	42.4095	37.7929
42140	Santa Fe, NM	30.5158	28.6521
42220	Santa Rosa-Petaluma, CA	37.7122	34.7294
42260	Sarasota-Bradenton-Venice, FL	26.6769	25.5601
42340	Savannah, GA	26.5289	24.9832
42540	Scranton—Wilkes-Barre, PA	23.8629	22.4039
42644	Seattle-Bellevue-Everett, WA	32.3774	30.4447
43100	Sheboygan, WI	24.9924	23.3301
43300	Sherman-Denison, TX	26.6281	25.3544
43340	Shreveport-Bossier City, LA	24.5258	23.6868
43580	Sioux City, IA-NE-SD	26.1843	24.0956
43620	Sioux Falls, SD	26.9025	25.0103
43780	South Bend-Mishawaka, IN-MI	27.3743	25.4781
43900	Spartanburg, SC	25.6900	24.5737
44060	Spokane, WA	30.4868	28.5450
44100	Springfield, IL	24.8405	23.3039
44140	Springfield, MA	28.7008	27.2255
44180	Springfield, MO	23.0819	22.2164
44220	Springfield, OH	23.4939	22.7752
44300	State College, PA	23.4099	22.4626
44700	Stockton, CA	31.7047	28.5078
44940	Sumter, SC	23.4355	22.1331
45060	Syracuse, NY	26.8425	25.0698
45104	Tacoma, WA	30.0701	28.9533
45220	Tallahassee, FL	24.3724	22.7559

TABLE 3A.—FY 2006 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on the sum of the salaries and hours computed for Federal fiscal years 2004, 2005, and 2006]

CBSA code	Urban area	FY 2006 average hourly wage	3-Year average hourly wage
45300	Tampa-St. Petersburg-Clearwater, FL	25.8608	24.1485
45460	Terre Haute, IN	23.2574	22.0638
45500	Texarkana, TX-Texarkana, AR	23.2000	21.8927
45780	Toledo, OH	26.7822	25.0440
45820	Topeka, KS	24.9561	23.6665
45940	Trenton-Ewing, NJ	30.3180	27.8778
46060	Tucson, AZ	25.1965	23.6781
46140	Tulsa, OK	23.2484	22.9280
46220	Tuscaloosa, AL	24.4051	22.1412
46340	Tyler, TX	26.0797	24.9826
46540	Utica-Rome, NY	23.2558	21.9605
46660	Valdosta, GA	24.8233	22.4638
46700	Vallejo-Fairfield, CA	41.6513	38.4022
46940	Vero Beach, FL	26.4579	25.3120
47020	Victoria, TX	22.7937	21.7127
47220	Vineland-Millville-Bridgeton, NJ	27.5232	27.0476
47260	Virginia Beach-Norfolk-Newport News, VA-NC	24.7332	23.2422
47300	Visalia-Porterville, CA	28.2676	26.4299
47380	Waco, TX	23.8678	22.0533
47580	Warner Robins, GA	24.2312	22.6117
47644	Warren-Farmington Hills-Troy, MI	27.5791	26.2703
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	30.5916	28.8815
47940	Waterloo-Cedar Falls, IA	23.9572	22.5445
48140	Wausau, WI	27.0185	25.5053
48260	Weirton-Steubenville, WV-OH	21.8793	21.4989
48300	Wenatchee, WA	28.1544	26.5892
48424	West Palm Beach-Boca Raton-Boynton Beach, FL	28.1452	26.6150
48540	Wheeling, WV-OH	20.0483	19.3905
48620	Wichita, KS	25.6152	24.4842
48660	Wichita Falls, TX	23.2954	21.9177
48700	Williamsport, PA	23.4090	21.9892
48864	Wilmington, DE-MD-NJ	29.4490	28.5184
48900	Wilmington, NC	26.7996	24.9839
49020	Winchester, VA-WV	28.5744	27.1963
49180	Winston-Salem, NC	25.0655	24.1158
49340	Worcester, MA	30.8969	29.3320
49420	Yakima, WA	28.4267	27.0960
49500	Yauco, PR	12.3449	12.0750
49620	York-Hanover, PA	26.3577	24.3575
49660	Youngstown-Warren-Boardman, OH-PA	24.0832	23.4935
49700	Yuba City, CA	30.6351	27.8070
49740	Yuma, AZ	25.7050	23.8047

[1]This area has no average hourly wage because there are no IPPS hospitals in the area.

TABLE 3B.—FY 2006 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS BY CBSA

[*Based on the sum of the salaries and hours computed for Federal fiscal years 2004, 2005, and 2006]

CBSA code	Nonurban area	FY 2006 average hourly wage	3-Year Average Hourly Wage
01	Alabama	20.9677	19.9301
02	Alaska	33.5065	31.4748
03	Arizona	24.5771	23.5781
04	Arkansas	20.9189	19.6660
05	California	30.3466	27.6453
06	Colorado	26.2370	24.6175
07	Connecticut	32.9843	31.5388
08	Delaware	26.8747	25.1962
10	Florida	24.0946	22.8362
11	Georgia	21.4961	20.5018
12	Hawaii	29.6476	27.4203
13	Idaho	22.5556	21.6678
14	Illinois	23.1784	21.8542
15	Indiana	24.1494	22.9960
16	Iowa	23.7869	22.2470
17	Kansas	22.3594	21.2491

TABLE 3B.—FY 2006 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS BY CBSA—Continued

[*Based on the sum of the salaries and hours computed for Federal fiscal years 2004, 2005, and 2006]

CBSA code	Nonurban area	FY 2006 average hourly wage	3-Year Average Hourly Wage
18	Kentucky	21.7864	20.6370
19	Louisiana	20.8290	19.5920
20	Maine	24.7292	23.4474
21	Maryland	25.4559	24.0971
22	Massachusetts [1]		
23	Michigan	24.8226	23.3712
24	Minnesota	25.6894	24.4485
25	Mississippi	21.5005	20.3551
26	Missouri	22.1717	20.6813
27	Montana	24.6808	23.0871
28	Nebraska	24.2446	23.3257
29	Nevada	25.3983	24.4345
30	New Hampshire	29.8455	26.8676
31	New Jersey [1]		
32	New Mexico	24.1961	22.4946
33	New York	22.8600	21.6353
34	North Carolina	23.9761	22.5825
35	North Dakota	20.3602	20.0510
36	Ohio	24.5857	23.0443
37	Oklahoma	21.2973	20.1660
38	Oregon	27.4748	25.9138
39	Pennsylvania	23.2205	21.9390
40	Puerto Rico [1]		
41	Rhode Island [1]		
42	South Carolina	24.2359	22.7771
43	South Dakota	23.7080	21.9887
44	Tennessee	22.1430	20.8103
45	Texas	22.4855	21.0274
46	Utah	22.7561	21.7771
47	Vermont	27.4761	24.9413
49	Virginia	22.4489	21.2273
50	Washington	29.2600	27.4343
51	West Virginia	21.6576	20.5854
52	Wisconsin	26.5156	24.7363
53	Wyoming	25.7561	24.1767

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

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
10180	[2] Abilene, TX	0.8038	0.8611
	Callahan County, TX.		
	Jones County, TX.		
	Taylor County, TX.		
10380	Aguadilla-Isabela-San Sebastián, PR	0.4736	0.5994
	Aguada Municipio, PR.		
	Aguadilla Municipio, PR.		
	Añasco Municipio, PR.		
	Isabela Municipio, PR.		
	Lares Municipio, PR.		
	Moca Municipio, PR.		
	Rincón Municipio, PR.		
	San Sebastián Municipio, PR.		
10420	Akron, OH	0.8979	0.9289
	Portage County, OH.		
	Summit County, OH.		
10500	Albany, GA	0.8645	0.9051
	Baker County, GA.		
	Dougherty County, GA.		
	Lee County, GA.		
	Terrell County, GA.		
	Worth County, GA.		
10580	Albany-Schenectady-Troy, NY	0.8565	0.8994
	Albany County, NY.		
	Rensselaer County, NY.		

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Saratoga County, NY.		
	Schenectady County, NY.		
	Schoharie County, NY.		
10740	Albuquerque, NM	0.9696	0.9791
	Bernalillo County, NM.		
	Sandoval County, NM.		
	Torrance County, NM.		
	Valencia County, NM.		
10780	Alexandria, LA	0.8048	0.8618
	Grant Parish, LA.		
	Rapides Parish, LA.		
10900	Allentown-Bethlehem-Easton, PA-NJ (PA Hospitals)	0.9844	0.9893
	Warren County, NJ.		
	Carbon County, PA.		
	Lehigh County, PA.		
	Northampton County, PA.		
10900	[2] Allentown-Bethlehem-Easton, PA-NJ (NJ Hospitals)	1.0607	1.0412
	Warren County, NJ.		
	Carbon County, PA.		
	Lehigh County, PA.		
	Northampton County, PA.		
11020	Altoona, PA	0.8942	0.9263
	Blair County, PA.		
11100	Amarillo, TX	0.9165	0.9420
	Armstrong County, TX.		
	Carson County, TX.		
	Potter County, TX.		
	Randall County, TX.		
11180	Ames, IA	0.9546	0.9687
	Story County, IA.		
11260	Anchorage, AK	1.2110	1.1401
	Anchorage Municipality, AK.		
	Matanuska-Susitna Borough, AK.		
11300	Anderson, IN	0.8634	0.9043
	Madison County, IN.		
11340	Anderson, SC	0.8887	0.9224
	Anderson County, SC.		
11460	Ann Arbor, MI	1.0885	1.0598
	Washtenaw County, MI.		
11500	Anniston-Oxford, AL	0.7702	0.8363
	Calhoun County, AL.		
11540	[2]Appleton, WI	0.9478	0.9640
	Calumet County, WI.		
	Outagamie County, WI.		
11700	Asheville, NC	0.9312	0.9524
	Buncombe County, NC.		
	Haywood County, NC.		
	Henderson County, NC.		
	Madison County, NC.		
12020	Athens-Clarke County, GA	0.9813	0.9872
	Clarke County, GA.		
	Madison County, GA.		
	Oconee County, GA.		
	Oglethorpe County, GA.		
12060	[1] Atlanta-Sandy Springs-Marietta, GA	0.9637	0.9750
	Barrow County, GA.		
	Bartow County, GA.		
	Butts County, GA.		
	Carroll County, GA.		
	Cherokee County, GA.		
	Clayton County, GA.		
	Cobb County, GA.		
	Coweta County, GA.		
	Dawson County, GA.		
	DeKalb County, GA.		
	Douglas County, GA.		
	Fayette County, GA.		
	Forsyth County, GA.		
	Fulton County, GA.		
	Gwinnett County, GA.		

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Haralson County, GA.		
	Heard County, GA.		
	Henry County, GA.		
	Jasper County, GA.		
	Lamar County, GA.		
	Meriwether County, GA.		
	Newton County, GA.		
	Paulding County, GA.		
	Pickens County, GA.		
	Pike County, GA.		
	Rockdale County, GA.		
	Spalding County, GA.		
	Walton County, GA.		
12100	Atlantic City, NJ	1.1618	1.1082
	Atlantic County, NJ.		
12220	Auburn-Opelika, AL	0.8113	0.8666
	Lee County, AL.		
12260	Augusta-Richmond County, GA-SC	0.9567	0.9701
	Burke County, GA.		
	Columbia County, GA.		
	McDuffie County, GA.		
	Richmond County, GA.		
	Aiken County, SC.		
	Edgefield County, SC.		
12420	[1]Austin-Round Rock, TX	0.9451	0.9621
	Bastrop County, TX.		
	Caldwell County, TX.		
	Hays County, TX.		
	Travis County, TX.		
	Williamson County, TX.		
12540	[2]Bakersfield, CA	1.0848	1.0573
	Kern County, CA.		
12580	[1]Baltimore-Towson, MD	0.9892	0.9926
	Anne Arundel County, MD.		
	Baltimore County, MD.		
	Carroll County, MD.		
	Harford County, MD.		
	Howard County, MD.		
	Queen Anne's County, MD.		
	Baltimore City, MD.		
12620	Bangor, ME	0.9985	0.9990
	Penobscot County, ME.		
12700	Barnstable Town, MA	1.2518	1.1663
	Barnstable County, MA.		
12940	Baton Rouge, LA	0.8605	0.9022
	Ascension Parish, LA.		
	East Baton Rouge Parish, LA.		
	East Feliciana Parish, LA.		
	Iberville Parish, LA.		
	Livingston Parish, LA.		
	Pointe Coupee Parish, LA.		
	St. Helena Parish, LA.		
	West Baton Rouge Parish, LA.		
	West Feliciana Parish, LA.		
12980	Battle Creek, MI	0.9492	0.9649
	Calhoun County, MI.		
13020	Bay City, MI	0.9535	0.9679
	Bay County, MI.		
13140	Beaumont-Port Arthur, TX	0.8422	0.8890
	Hardin County, TX.		
	Jefferson County, TX.		
	Orange County, TX.		
13380	Bellingham, WA	1.1705	1.1138
	Whatcom County, WA.		
13460	Bend, OR	1.0783	1.0530
	Deschutes County, OR.		
13644	[1]Bethesda-Frederick-Gaithersburg, MD	1.1471	1.0985
	Frederick County, MD.		
	Montgomery County, MD.		
13740	Billings, MT	0.8855	0.9201

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Carbon County, MT.		
	Yellowstone County, MT.		
13780	Binghamton, NY	0.8588	0.9010
	Broome County, NY.		
	Tioga County, NY.		
13820	[1] Birmingham-Hoover, AL	0.8979	0.9289
	Bibb County, AL.		
	Blount County, AL.		
	Chilton County, AL.		
	Jefferson County, AL.		
	St. Clair County, AL.		
	Shelby County, AL.		
	Walker County, AL.		
13900	Bismarck, ND	0.7519	0.8226
	Burleigh County, ND.		
	Morton County, ND.		
13980	[2] Blacksburg-Christiansburg-Radford, VA	0.8024	0.8601
	Giles County, VA.		
	Montgomery County, VA.		
	Pulaski County, VA.		
	Radford City, VA.		
14020	[2] Bloomington, IN	0.8632	0.9042
	Greene County, IN.		
	Monroe County, IN.		
	Owen County, IN.		
14060	Bloomington-Normal, IL	0.9083	0.9363
	McLean County, IL.		
14260	Boise City-Nampa, ID	0.9048	0.9338
	Ada County, ID.		
	Boise County, ID.		
	Canyon County, ID.		
	Gem County, ID.		
	Owyhee County, ID.		
14484	[1] Boston-Quincy, MA	1.1537	1.1029
	Norfolk County, MA.		
	Plymouth County, MA.		
	Suffolk County, MA.		
14500	Boulder, CO	0.9743	0.9823
	Boulder County, CO.		
14540	Bowling Green, KY	0.8222	0.8745
	Edmonson County, KY.		
	Warren County, KY.		
14740	Bremerton-Silverdale, WA	1.0681	1.0461
	Kitsap County, WA.		
14860	Bridgeport-Stamford-Norwalk, CT	1.2607	1.1719
	Fairfield County, CT.		
15180	Brownsville-Harlingen, TX	0.9853	0.9899
	Cameron County, TX.		
15260	Brunswick, GA	0.9341	0.9544
	Brantley County, GA.		
	Glynn County, GA.		
	McIntosh County, GA.		
15380	[1] Buffalo-Niagara Falls, NY	0.8888	0.9224
	Erie County, NY.		
	Niagara County, NY.		
15500	Burlington, NC	0.8902	0.9234
	Alamance County, NC.		
15540	[2] Burlington-South Burlington, VT	1.0199	1.0136
	Chittenden County, VT.		
	Franklin County, VT.		
	Grand Isle County, VT.		
15764	[1] Cambridge-Newton-Framingham, MA	1.1078	1.0726
	Middlesex County, MA.		
15804	[1 2] Camden, NJ	1.0607	1.0412
	Burlington County, NJ.		
	Camden County, NJ.		
	Gloucester County, NJ.		
15940	Canton-Massillon, OH	0.8957	0.9273
	Carroll County, OH.		
	Stark County, OH.		

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
15980	Cape Coral-Fort Myers, FL	0.9333	0.9538
	Lee County, FL.		
16180	Carson City, NV	1.0229	1.0156
	Carson City, NV.		
16220	[2] Casper, WY	0.9207	0.9450
	Natrona County, WY.		
16300	Cedar Rapids, IA	0.8605	0.9022
	Benton County, IA.		
	Jones County, IA.		
	Linn County, IA.		
16580	Champaign-Urbana, IL	0.9591	0.9718
	Champaign County, IL.		
	Ford County, IL.		
	Piatt County, IL.		
16620	Charleston, WV	0.8429	0.8896
	Boone County, WV.		
	Clay County, WV.		
	Kanawha County, WV.		
	Lincoln County, WV.		
	Putnam County, WV.		
16700	Charleston-North Charleston, SC	0.9433	0.9608
	Berkeley County, SC.		
	Charleston County, SC.		
	Dorchester County, SC.		
16740	[1] Charlotte-Gastonia-Concord, NC-SC	0.9717	0.9805
	Anson County, NC.		
	Cabarrus County, NC.		
	Gaston County, NC.		
	Mecklenburg County, NC.		
	Union County, NC.		
	York County, SC.		
16820	Charlottesville, VA	1.0230	1.0157
	Albemarle County, VA.		
	Fluvanna County, VA.		
	Greene County, VA.		
	Nelson County, VA.		
	Charlottesville City, VA.		
16860	Chattanooga, TN-GA	0.9099	0.9374
	Catoosa County, GA.		
	Dade County, GA.		
	Walker County, GA.		
	Hamilton County, TN.		
	Marion County, TN.		
	Sequatchie County, TN.		
16940	[2] Cheyenne, WY	0.9207	0.9450
	Laramie County, WY.		
16974	[1] Chicago-Naperville-Joliet, IL	1.0846	1.0572
	Cook County, IL.		
	DeKalb County, IL.		
	DuPage County, IL.		
	Grundy County, IL.		
	Kane County, IL.		
	Kendall County, IL.		
	McHenry County, IL.		
	Will County, IL.		
17020	[2] Chico, CA	1.0848	1.0573
	Butte County, CA.		
17140	[1] Cincinnati-Middletown, OH-KY-IN	0.9604	0.9727
	Dearborn County, IN.		
	Franklin County, IN.		
	Ohio County, IN.		
	Boone County, KY.		
	Bracken County, KY.		
	Campbell County, KY.		
	Gallatin County, KY.		
	Grant County, KY.		
	Kenton County, KY.		
	Pendleton County, KY.		
	Brown County, OH.		
	Butler County, OH.		

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Clermont County, OH.		
	Hamilton County, OH.		
	Warren County, OH.		
17300	Clarksville, TN-KY	0.8272	0.8782
	Christian County, KY.		
	Trigg County, KY.		
	Montgomery County, TN.		
	Stewart County, TN.		
17420	Cleveland, TN	0.8160	0.8700
	Bradley County, TN.		
	Polk County, TN.		
17460	[1] Cleveland-Elyria-Mentor, OH	0.9197	0.9443
	Cuyahoga County, OH.		
	Geauga County, OH.		
	Lake County, OH.		
	Lorain County, OH.		
	Medina County, OH.		
17660	Coeur d'Alene, ID	0.9642	0.9753
	Kootenai County, ID.		
17780	College Station-Bryan, TX	0.8911	0.9241
	Brazos County, TX.		
	Burleson County, TX.		
	Robertson County, TX.		
17820	Colorado Springs, CO	0.9457	0.9625
	El Paso County, CO.		
	Teller County, CO.		
17860	Columbia, MO	0.8346	0.8835
	Boone County, MO.		
	Howard County, MO.		
17900	Columbia, SC	0.9057	0.9344
	Calhoun County, SC.		
	Fairfield County, SC.		
	Kershaw County, SC.		
	Lexington County, SC.		
	Richland County, SC.		
	Saluda County, SC.		
17980	Columbus, GA-AL	0.8570	0.8997
	Russell County, AL.		
	Chattahoochee County, GA.		
	Harris County, GA.		
	Marion County, GA.		
	Muscogee County, GA.		
18020	Columbus, IN	0.9596	0.9722
	Bartholomew County, IN.		
18140	[1] Columbus, OH	0.9848	0.9896
	Delaware County, OH.		
	Fairfield County, OH.		
	Franklin County, OH.		
	Licking County, OH.		
	Madison County, OH.		
	Morrow County, OH.		
	Pickaway County, OH.		
	Union County, OH.		
18580	Corpus Christi, TX	0.8557	0.8988
	Aransas County, TX.		
	Nueces County, TX.		
	San Patricio County, TX.		
18700	Corvallis, OR	1.0711	1.0482
	Benton County, OR.		
19060	Cumberland, MD-WV	0.9310	0.9522
	Allegany County, MD.		
	Mineral County, WV.		
19124	[1] Dallas-Plano-Irving, TX	1.0226	1.0154
	Collin County, TX.		
	Dallas County, TX.		
	Delta County, TX.		
	Denton County, TX.		
	Ellis County, TX.		
	Hunt County, TX.		
	Kaufman County, TX.		

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Rockwall County, TX.		
19140	Dalton, GA	0.9033	0.9327
	Murray County, GA.		
	Whitfield County, GA.		
19180	Danville, IL	0.9048	0.9338
	Vermilion County, IL.		
19260	Danville, VA	0.8514	0.8957
	Pittsylvania County, VA.		
	Danville City, VA.		
19340	Davenport-Moline-Rock Island, IA-IL	0.8716	0.9102
	Henry County, IL.		
	Mercer County, IL.		
	Rock Island County, IL.		
	Scott County, IA.		
19380	Dayton, OH	0.9069	0.9353
	Greene County, OH.		
	Miami County, OH.		
	Montgomery County, OH.		
	Preble County, OH.		
19460	Decatur, AL	0.8517	0.8959
	Lawrence County, AL.		
	Morgan County, AL.		
19500	[2] Decatur, IL	0.8285	0.8791
	Macon County, IL.		
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.9307	0.9520
	Volusia County, FL.		
19740	[1] Denver-Aurora, CO	1.0710	1.0481
	Adams County, CO.		
	Arapahoe County, CO.		
	Broomfield County, CO.		
	Clear Creek County, CO.		
	Denver County, CO.		
	Douglas County, CO.		
	Elbert County, CO.		
	Gilpin County, CO.		
	Jefferson County, CO.		
	Park County, CO.		
19780	Des Moines, IA	0.9650	0.9759
	Dallas County, IA.		
	Guthrie County, IA.		
	Madison County, IA.		
	Polk County, IA.		
	Warren County, IA.		
19804	[1] Detroit-Livonia-Dearborn, MI	1.0453	1.0308
	Wayne County, MI.		
20020	Dothan, AL	0.7743	0.8393
	Geneva County, AL.		
	Henry County, AL.		
	Houston County, AL.		
20100	Dover, DE	0.9821	0.9877
	Kent County, DE.		
20220	Dubuque, IA	0.9116	0.9386
	Dubuque County, IA.		
20260	Duluth, MN-WI	1.0224	1.0153
	Carlton County, MN.		
	St. Louis County, MN.		
	Douglas County, WI.		
20500	Durham, NC	1.0260	1.0177
	Chatham County, NC.		
	Durham County, NC.		
	Orange County, NC.		
	Person County, NC.		
20740	[2] Eau Claire, WI	0.9478	0.9640
	Chippewa County, WI.		
	Eau Claire County, WI.		
20764	[1] Edison, NJ	1.1301	1.0874
	Middlesex County, NJ.		
	Monmouth County, NJ.		
	Ocean County, NJ.		
	Somerset County, NJ.		

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
20940	[2] El Centro, CA Imperial County, CA.	1.0848	1.0573
21060	Elizabethtown, KY Hardin County, KY. Larue County, KY.	0.8816	0.9173
21140	Elkhart-Goshen, IN Elkhart County, IN.	0.9616	0.9735
21300	Elmira, NY Chemung County, NY.	0.8276	0.8785
21340	El Paso, TX El Paso County, TX.	0.8954	0.9271
21500	Erie, PA Erie County, PA.	0.8746	0.9123
21604	Essex County, MA Essex County, MA.	1.0525	1.0357
21660	Eugene-Springfield, OR Lane County, OR.	1.0810	1.0548
21780	Evansville, IN-KY Gibson County, IN. Posey County, IN. Vanderburgh County, IN. Warrick County, IN. Henderson County, KY. Webster County, KY.	0.8735	0.9115
21820	[2] Fairbanks, AK Fairbanks North Star Borough, AK.	1.1977	1.1315
21940	Fajardo, PR Ceiba Municipio, PR. Fajardo Municipio, PR. Luquillo Municipio, PR.	0.4160	0.5485
22020	Fargo, ND-MN (ND Hospitals) Clay County, MN. Cass County, ND.	0.8778	0.9146
22020	[2] Fargo, ND-MN (MN Hospitals) Clay County, MN. Cass County, ND.	0.9183	0.9433
22140	[2] Farmington, NM San Juan County, NM.	0.8649	0.9054
22180	Fayetteville, NC Cumberland County, NC. Hoke County, NC.	0.9426	0.9603
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR. Madison County, AR. Washington County, AR. McDonald County, MO.	0.8615	0.9029
22380	Flagstaff, AZ Coconino County, AZ.	1.2094	1.1391
22420	Flint, MI Genesee County, MI.	1.0654	1.0443
22500	Florence, SC Darlington County, SC. Florence County, SC.	0.8988	0.9295
22520	Florence-Muscle Shoals, AL Colbert County, AL. Lauderdale County, AL.	0.8305	0.8806
22540	Fond du Lac, WI Fond du Lac County, WI.	0.9649	0.9758
22660	Fort Collins-Loveland, CO Larimer County, CO.	1.0146	1.0100
22744	[1] Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL.	1.0508	1.0345
22900	Fort Smith, AR-OK Crawford County, AR. Franklin County, AR. Sebastian County, AR. Le Flore County, OK. Sequoyah County, OK.	0.8231	0.8752
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL.	0.8877	0.9217

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
23060	Fort Wayne, IN	0.9797	0.9861
	Allen County, IN.		
	Wells County, IN.		
	Whitley County, IN.		
23104	[1] Fort Worth-Arlington, TX	0.9514	0.9665
	Johnson County, TX.		
	Parker County, TX.		
	Tarrant County, TX.		
	Wise County, TX.		
23420	[2] Fresno, CA	1.0848	1.0573
	Fresno County, CA.		
23460	Gadsden, AL	0.7974	0.8564
	Etowah County, AL.		
23540	Gainesville, FL	0.9461	0.9628
	Alachua County, FL.		
	Gilchrist County, FL.		
23580	Gainesville, GA	0.8897	0.9231
	Hall County, GA.		
23844	Gary, IN	0.9366	0.9561
	Jasper County, IN.		
	Lake County, IN.		
	Newton County, IN.		
	Porter County, IN.		
24020	Glens Falls, NY	0.8587	0.9009
	Warren County, NY.		
	Washington County, NY.		
24140	Goldsboro, NC	0.8781	0.9148
	Wayne County, NC.		
24220	Grand Forks, ND-MN	1.1521	1.1018
	Polk County, MN.		
	Grand Forks County, ND.		
24300	Grand Junction, CO	0.9590	0.9717
	Mesa County, CO.		
24340	Grand Rapids-Wyoming, MI	0.9398	0.9584
	Barry County, MI.		
	Ionia County, MI.		
	Kent County, MI.		
	Newaygo County, MI.		
24500	Great Falls, MT	0.9074	0.9356
	Cascade County, MT.		
24540	Greeley, CO	0.9597	0.9722
	Weld County, CO.		
24580	[2] Green Bay, WI	0.9478	0.9640
	Brown County, WI.		
	Kewaunee County, WI.		
	Oconto County, WI.		
24660	Greensboro-High Point, NC	0.9133	0.9398
	Guilford County, NC.		
	Randolph County, NC.		
	Rockingham County, NC.		
24780	Greenville, NC	0.9414	0.9595
	Greene County, NC.		
	Pitt County, NC.		
24860	Greenville, SC	1.0138	1.0094
	Greenville County, SC.		
	Laurens County, SC.		
	Pickens County, SC.		
25020	Guayama, PR	0.3186	0.4569
	Arroyo Municipio, PR.		
	Guayama Municipio, PR.		
	Patillas Municipio, PR.		
25060	Gulfport-Biloxi, MS	0.8922	0.9249
	Hancock County, MS.		
	Harrison County, MS.		
	Stone County, MS.		
25180	Hagerstown-Martinsburg, MD-WV	0.9528	0.9674
	Washington County, MD.		
	Berkeley County, WV.		
	Morgan County, WV.		
25260	[2] Hanford-Corcoran, CA	1.0848	1.0573

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Kings County, CA.		
25420	Harrisburg-Carlisle, PA	0.9317	0.9527
	Cumberland County, PA.		
	Dauphin County, PA.		
	Perry County, PA.		
25500	Harrisonburg, VA	0.9101	0.9375
	Rockingham County, VA.		
	Harrisonburg City, VA.		
25540	[1] [2] Hartford-West Hartford-East Hartford, CT	1.1790	1.1194
	Hartford County, CT.		
	Litchfield County, CT.		
	Middlesex County, CT.		
	Tolland County, CT.		
25620	[2] Hattiesburg, MS	0.7685	0.8350
	Forrest County, MS.		
	Lamar County, MS.		
	Perry County, MS.		
25860	Hickory-Lenoir-Morganton, NC	0.8931	0.9255
	Alexander County, NC.		
	Burke County, NC.		
	Caldwell County, NC.		
	Catawba County, NC.		
25980	Hinesville-Fort Stewart, GA	0.7684	0.8349
	Liberty County, GA.		
	Long County, GA.		
26100	Holland-Grand Haven, MI	0.9133	0.9398
	Ottawa County, MI.		
26180	Honolulu, HI	1.1206	1.0811
	Honolulu County, HI.		
26300	Hot Springs, AR	0.9066	0.9351
	Garland County, AR.		
26380	Houma-Bayou Cane-Thibodaux, LA	0.7903	0.8512
	Lafourche Parish, LA.		
	Terrebonne Parish, LA.		
26420	[1] Houston-Baytown-Sugar Land, TX	1.0008	1.0005
	Austin County, TX.		
	Brazoria County, TX.		
	Chambers County, TX.		
	Fort Bend County, TX.		
	Galveston County, TX.		
	Harris County, TX.		
	Liberty County, TX.		
	Montgomery County, TX.		
	San Jacinto County, TX.		
	Waller County, TX.		
26580	Huntington-Ashland, WV-KY-OH	0.9482	0.9642
	Boyd County, KY.		
	Greenup County, KY.		
	Lawrence County, OH.		
	Cabell County, WV.		
	Wayne County, WV.		
26620	Huntsville, AL	0.9124	0.9391
	Limestone County, AL.		
	Madison County, AL.		
26820	Idaho Falls, ID	0.9409	0.9591
	Bonneville County, ID.		
	Jefferson County, ID.		
26900	[1] Indianapolis, IN	0.9922	0.9947
	Boone County, IN.		
	Brown County, IN.		
	Hamilton County, IN.		
	Hancock County, IN.		
	Hendricks County, IN.		
	Johnson County, IN.		
	Marion County, IN.		
	Morgan County, IN.		
	Putnam County, IN.		
	Shelby County, IN.		
26980	Iowa City, IA	0.9751	0.9829
	Johnson County, IA.		

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Washington County, IA.		
27060	Ithaca, NY	0.9855	0.9900
	Tompkins County, NY.		
27100	Jackson, MI	0.9300	0.9515
	Jackson County, MI.		
27140	Jackson, MS	0.8313	0.8812
	Copiah County, MS.		
	Hinds County, MS.		
	Madison County, MS.		
	Rankin County, MS.		
	Simpson County, MS.		
27180	Jackson, TN	0.8964	0.9278
	Chester County, TN.		
	Madison County, TN.		
27260	[1] Jacksonville, FL	0.9303	0.9517
	Baker County, FL.		
	Clay County, FL.		
	Duval County, FL.		
	Nassau County, FL.		
	St. Johns County, FL.		
27340	[2] Jacksonville, NC	0.8570	0.8997
	Onslow County, NC.		
27500	Janesville, WI	0.9561	0.9697
	Rock County, WI.		
27620	Jefferson City, MO	0.8389	0.8867
	Callaway County, MO.		
	Cole County, MO.		
	Moniteau County, MO.		
	Osage County, MO.		
27740	Johnson City, TN	0.7958	0.8552
	Carter County, TN.		
	Unicoi County, TN.		
	Washington County, TN.		
27780	Johnstown, PA	0.8348	0.8837
	Cambria County, PA.		
27860	Jonesboro, AR	0.7968	0.8559
	Craighead County, AR.		
	Poinsett County, AR.		
27900	Joplin, MO	0.8594	0.9014
	Jasper County, MO.		
	Newton County, MO.		
28020	Kalamazoo-Portage, MI	1.0403	1.0274
	Kalamazoo County, MI.		
	Van Buren County, MI.		
28100	Kankakee-Bradley, IL	1.0991	1.0668
	Kankakee County, IL.		
28140	[1] Kansas City, MO-KS	0.9454	0.9623
	Franklin County, KS.		
	Johnson County, KS.		
	Leavenworth County, KS.		
	Linn County, KS.		
	Miami County, KS.		
	Wyandotte County, KS.		
	Bates County, MO.		
	Caldwell County, MO.		
	Cass County, MO.		
	Clay County, MO.		
	Clinton County, MO.		
	Jackson County, MO.		
	Lafayette County, MO.		
	Platte County, MO.		
	Ray County, MO.		
28420	Kennewick-Richland-Pasco, WA	1.0619	1.0420
	Benton County, WA.		
	Franklin County, WA.		
28660	Killeen-Temple-Fort Hood, TX	0.8566	0.8994
	Bell County, TX.		
	Coryell County, TX.		
	Lampasas County, TX.		
28700	Kingsport-Bristol-Bristol, TN-VA	0.8095	0.8653

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Hawkins County, TN.		
	Sullivan County, TN.		
	Bristol City, VA.		
	Scott County, VA.		
	Washington County, VA.		
28740	Kingston, NY	0.9260	0.9487
	Ulster County, NY.		
28940	Knoxville, TN	0.8470	0.8925
	Anderson County, TN.		
	Blount County, TN.		
	Knox County, TN.		
	Loudon County, TN.		
	Union County, TN.		
29020	Kokomo, IN	0.9555	0.9693
	Howard County, IN.		
	Tipton County, IN.		
29100	La Crosse, WI-MN	0.9557	0.9694
	Houston County, MN.		
	La Crosse County, WI.		
29140	Lafayette, IN	0.8730	0.9112
	Benton County, IN.		
	Carroll County, IN.		
	Tippecanoe County, IN.		
29180	Lafayette, LA	0.8429	0.8896
	Lafayette Parish, LA.		
	St. Martin Parish, LA.		
29340	Lake Charles, LA	0.7847	0.8470
	Calcasieu Parish, LA.		
	Cameron Parish, LA.		
29404	Lake County-Kenosha County, IL-WI	1.0444	1.0302
	Lake County, IL.		
	Kenosha County, WI.		
29460	Lakeland, FL	0.8934	0.9257
	Polk County, FL.		
29540	Lancaster, PA	0.9716	0.9805
	Lancaster County, PA.		
29620	Lansing-East Lansing, MI	0.9786	0.9853
	Clinton County, MI.		
	Eaton County, MI.		
	Ingham County, MI.		
29700	Laredo, TX	0.8101	0.8657
	Webb County, TX.		
29740	[2] Las Cruces, NM	0.8649	0.9054
	Dona Ana County, NM.		
29820	[1] Las Vegas-Paradise, NV	1.1416	1.0949
	Clark County, NV.		
29940	Lawrence, KS	0.8538	0.8974
	Douglas County, KS.		
30020	Lawton, OK	0.7916	0.8521
	Comanche County, OK.		
30140	Lebanon, PA	0.8654	0.9057
	Lebanon County, PA.		
30300	Lewiston, ID-WA (ID Hospitals)	0.9878	0.9916
	Nez Perce County, ID.		
	Asotin County, WA.		
30300	[2] Lewiston, ID-WA (WA Hospitals)	1.0459	1.0312
	Nez Perce County, ID.		
	Asotin County, WA.		
30340	Lewiston-Auburn, ME	0.9332	0.9538
	Androscoggin County, ME.		
30460	Lexington-Fayette, KY	0.9060	0.9346
	Bourbon County, KY.		
	Clark County, KY.		
	Fayette County, KY.		
	Jessamine County, KY.		
	Scott County, KY.		
	Woodford County, KY.		
30620	Lima, OH	0.9263	0.9489
	Allen County, OH.		
30700	Lincoln, NE	1.0197	1.0134

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Lancaster County, NE.		
	Seward County, NE.		
30780	Little Rock-North Little Rock, AR	0.8768	0.9139
	Faulkner County, AR.		
	Grant County, AR.		
	Lonoke County, AR.		
	Perry County, AR.		
	Pulaski County, AR.		
	Saline County, AR.		
30860	Logan, UT-ID	0.9183	0.9433
	Franklin County, ID.		
	Cache County, UT.		
30980	Longview, TX	0.8741	0.9120
	Gregg County, TX.		
	Rusk County, TX.		
	Upshur County, TX.		
31020	[2] Longview, WA	1.0459	1.0312
	Cowlitz County, WA.		
31084	[1] Los Angeles-Long Beach-Glendale, CA	1.1762	1.1175
	Los Angeles County, CA.		
31140	[1] Louisville, KY-IN	0.9264	0.9490
	Clark County, IN.		
	Floyd County, IN.		
	Harrison County, IN.		
	Washington County, IN.		
	Bullitt County, KY.		
	Henry County, KY.		
	Jefferson County, KY.		
	Meade County, KY.		
	Nelson County, KY.		
	Oldham County, KY.		
	Shelby County, KY.		
	Spencer County, KY.		
	Trimble County, KY.		
31180	Lubbock, TX	0.8790	0.9155
	Crosby County, TX.		
	Lubbock County, TX.		
31340	Lynchburg, VA	0.8706	0.9095
	Amherst County, VA.		
	Appomattox County, VA.		
	Bedford County, VA.		
	Campbell County, VA.		
	Bedford City, VA.		
	Lynchburg City, VA.		
31420	Macon, GA	0.9485	0.9644
	Bibb County, GA.		
	Crawford County, GA.		
	Jones County, GA.		
	Monroe County, GA.		
	Twiggs County, GA.		
31460	[2] Madera, CA	1.0848	1.0573
	Madera County, CA.		
31540	Madison, WI	1.0629	1.0427
	Columbia County, WI.		
	Dane County, WI.		
	Iowa County, WI.		
31700	[2] Manchester-Nashua, NH	1.0668	1.0453
	Hillsborough County, NH.		
	Merrimack County, NH.		
31900	Mansfield, OH	0.8788	0.9153
	Richland County, OH.		
32420	Mayagüez, PR	0.4016	0.5354
	Hormigueros Municipio, PR.		
	Mayagüez Municipio, PR.		
32580	McAllen-Edinburg-Pharr, TX	0.8945	0.9265
	Hidalgo County, TX.		
32780	[2] Medford, OR	1.0284	1.0194
	Jackson County, OR.		
32820	[1] Memphis, TN-MS-AR	0.9346	0.9547
	Crittenden County, AR.		

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	DeSoto County, MS.		
	Marshall County, MS.		
	Tate County, MS.		
	Tunica County, MS.		
	Fayette County, TN.		
	Shelby County, TN.		
	Tipton County, TN.		
32900	Merced, CA	1.1123	1.0756
	Merced County, CA.		
33124	[1] Miami-Miami Beach-Kendall, FL	0.9757	0.9833
	Miami-Dade County, FL.		
33140	Michigan City-La Porte, IN	0.9409	0.9591
	LaPorte County, IN.		
33260	Midland, TX	0.9522	0.9670
	Midland County, TX.		
33340	[1] Milwaukee-Waukesha-West Allis, WI	1.0111	1.0076
	Milwaukee County, WI.		
	Ozaukee County, WI.		
	Washington County, WI.		
	Waukesha County, WI.		
33460	[1] Minneapolis-St. Paul-Bloomington, MN-WI	1.1055	1.0711
	Anoka County, MN.		
	Carver County, MN.		
	Chisago County, MN.		
	Dakota County, MN.		
	Hennepin County, MN.		
	Isanti County, MN.		
	Ramsey County, MN.		
	Scott County, MN.		
	Sherburne County, MN.		
	Washington County, MN.		
	Wright County, MN.		
	Pierce County, WI.		
	St. Croix County, WI.		
33540	Missoula, MT	0.9535	0.9679
	Missoula County, MT.		
33660	Mobile, AL	0.7902	0.8511
	Mobile County, AL.		
33700	Modesto, CA	1.1885	1.1255
	Stanislaus County, CA.		
33740	Monroe, LA	0.8044	0.8615
	Ouachita Parish, LA.		
	Union Parish, LA.		
33780	Monroe, MI	0.9468	0.9633
	Monroe County, MI.		
33860	Montgomery, AL	0.8600	0.9019
	Autauga County, AL.		
	Elmore County, AL.		
	Lowndes County, AL.		
	Montgomery County, AL.		
34060	Morgantown, WV	0.8439	0.8903
	Monongalia County, WV.		
	Preston County, WV.		
34100	Morristown, TN	0.8758	0.9132
	Grainger County, TN.		
	Hamblen County, TN.		
	Jefferson County, TN.		
34580	[2] Mount Vernon-Anacortes, WA	1.0459	1.0312
	Skagit County, WA.		
34620	Muncie, IN	0.8952	0.9270
	Delaware County, IN.		
34740	Muskegon-Norton Shores, MI	0.9677	0.9778
	Muskegon County, MI.		
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	0.8869	0.9211
	Horry County, SC.		
34900	Napa, CA	1.2643	1.1742
	Napa County, CA.		
34940	Naples-Marco Island, FL	1.0115	1.0079
	Collier County, FL.		
34980	[1] Nashville-Davidson—Murfreesboro, TN	0.9757	0.9833

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Cannon County, TN.		
	Cheatham County, TN.		
	Davidson County, TN.		
	Dickson County, TN.		
	Hickman County, TN.		
	Macon County, TN.		
	Robertson County, TN.		
	Rutherford County, TN.		
	Smith County, TN.		
	Sumner County, TN.		
	Trousdale County, TN.		
	Williamson County, TN.		
	Wilson County, TN.		
35004	[1] Nassau-Suffolk, NY	1.2781	1.1830
	Nassau County, NY.		
	Suffolk County, NY.		
35084	[1] Newark-Union, NJ-PA	1.2192	1.1454
	Essex County, NJ.		
	Hunterdon County, NJ.		
	Morris County, NJ.		
	Sussex County, NJ.		
	Union County, NJ.		
	Pike County, PA.		
35300	[2] New Haven-Milford, CT	1.1790	1.1194
	New Haven County, CT.		
35380	[1] New Orleans-Metairie-Kenner, LA	0.9003	0.9306
	Jefferson Parish, LA.		
	Orleans Parish, LA.		
	Plaquemines Parish, LA.		
	St. Bernard Parish, LA.		
	St. Charles Parish, LA.		
	St. John the Baptist Parish, LA.		
	St. Tammany Parish, LA.		
35644	[1] New York-Wayne-White Plains, NY-NJ	1.3191	1.2088
	Bergen County, NJ.		
	Hudson County, NJ.		
	Passaic County, NJ.		
	Bronx County, NY.		
	Kings County, NY.		
	New York County, NY.		
	Putnam County, NY.		
	Queens County, NY.		
	Richmond County, NY.		
	Rockland County, NY.		
	Westchester County, NY.		
35660	[2] Niles-Benton Harbor, MI	0.8923	0.9249
	Berrien County, MI.		
35980	[2] Norwich-New London, CT	1.1790	1.1194
	New London County, CT.		
36084	[1] Oakland-Fremont-Hayward, CA	1.5474	1.3485
	Alameda County, CA.		
	Contra Costa County, CA.		
36100	Ocala, FL	0.8955	0.9272
	Marion County, FL.		
36140	Ocean City, NJ	1.1031	1.0695
	Cape May County, NJ.		
36220	Odessa, TX	0.9893	0.9927
	Ector County, TX.		
36260	Ogden-Clearfield, UT	0.9048	0.9338
	Davis County, UT.		
	Morgan County, UT.		
	Weber County, UT.		
36420	[1] Oklahoma City, OK	0.9043	0.9334
	Canadian County, OK.		
	Cleveland County, OK.		
	Grady County, OK.		
	Lincoln County, OK.		
	Logan County, OK.		
	McClain County, OK.		
	Oklahoma County, OK.		

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
36500	Olympia, WA	1.0970	1.0655
	Thurston County, WA.		
36540	Omaha-Council Bluffs, NE-IA	0.9555	0.9693
	Harrison County, IA.		
	Mills County, IA.		
	Pottawattamie County, IA.		
	Cass County, NE.		
	Douglas County, NE.		
	Sarpy County, NE.		
	Saunders County, NE.		
	Washington County, NE.		
36740	[1] Orlando, FL	0.9446	0.9617
	Lake County, FL.		
	Orange County, FL.		
	Osceola County, FL.		
	Seminole County, FL.		
36780	[2] Oshkosh-Neenah, WI	0.9478	0.9640
	Winnebago County, WI.		
36980	Owensboro, KY	0.8806	0.9166
	Daviess County, KY.		
	Hancock County, KY.		
	McLean County, KY.		
37100	Oxnard-Thousand Oaks-Ventura, CA	1.1604	1.1072
	Ventura County, CA.		
37340	Palm Bay-Melbourne-Titusville, FL	0.9826	0.9881
	Brevard County, FL.		
37460	[2] Panama City-Lynn Haven, FL	0.8613	0.9028
	Bay County, FL.		
37620	Parkersburg-Marietta, WV-OH (WV Hospitals)	0.8303	0.8804
	Washington County, OH.		
	Pleasants County, WV.		
	Wirt County, WV.		
	Wood County, WV.		
37620	[2] Parkersburg-Marietta, WV-OH (OH Hospitals)	0.8788	0.9153
	Washington County, OH.		
	Pleasants County, WV.		
	Wirt County, WV.		
	Wood County, WV.		
37700	Pascagoula, MS	0.8164	0.8703
	George County, MS.		
	Jackson County, MS.		
37860	[2] Pensacola-Ferry Pass-Brent, FL	0.8613	0.9028
	Escambia County, FL.		
	Santa Rosa County, FL.		
37900	Peoria, IL	0.8844	0.9193
	Marshall County, IL.		
	Peoria County, IL.		
	Stark County, IL.		
	Tazewell County, IL.		
	Woodford County, IL.		
37964	[1] Philadelphia, PA	1.1030	1.0694
	Bucks County, PA.		
	Chester County, PA.		
	Delaware County, PA.		
	Montgomery County, PA.		
	Philadelphia County, PA.		
38060	[1] Phoenix-Mesa-Scottsdale, AZ	1.0139	1.0095
	Maricopa County, AZ.		
	Pinal County, AZ.		
38220	Pine Bluff, AR	0.8716	0.9102
	Cleveland County, AR.		
	Jefferson County, AR.		
	Lincoln County, AR.		
38300	[1] Pittsburgh, PA	0.8840	0.9190
	Allegheny County, PA.		
	Armstrong County, PA.		
	Beaver County, PA.		
	Butler County, PA.		
	Fayette County, PA.		
	Washington County, PA.		

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Westmoreland County, PA.		
38340	Pittsfield, MA	1.0183	1.0125
	Berkshire County, MA.		
38540	Pocatello, ID	0.9348	0.9549
	Bannock County, ID.		
	Power County, ID.		
38660	Ponce, PR	0.5178	0.6372
	Juana Díaz Municipio, PR.		
	Ponce Municipio, PR.		
	Villalba Municipio, PR.		
38860	Portland-South Portland-Biddeford, ME	1.0382	1.0260
	Cumberland County, ME.		
	Sagadahoc County, ME.		
	York County, ME.		
38900	[1] Portland-Vancouver-Beaverton, OR-WA	1.1229	1.0826
	Clackamas County, OR.		
	Columbia County, OR.		
	Multnomah County, OR.		
	Washington County, OR.		
	Yamhill County, OR.		
	Clark County, WA.		
	Skamania County, WA.		
38940	Port St. Lucie-Fort Pierce, FL	1.0162	1.0111
	Martin County, FL.		
	St. Lucie County, FL.		
39100	Poughkeepsie-Newburgh-Middletown, NY	1.0767	1.0519
	Dutchess County, NY.		
	Orange County, NY.		
39140	Prescott, AZ	0.9884	0.9920
	Yavapai County, AZ.		
39300	[1] Providence-New Bedford-Fall River, RI-MA	1.0952	1.0643
	Bristol County, MA.		
	Bristol County, RI.		
	Kent County, RI.		
	Newport County, RI.		
	Providence County, RI.		
	Washington County, RI.		
39340	Provo-Orem, UT	0.9578	0.9709
	Juab County, UT.		
	Utah County, UT.		
39380	[2] Pueblo, CO	0.9379	0.9570
	Pueblo County, CO.		
39460	Punta Gorda, FL	0.9274	0.9497
	Charlotte County, FL.		
39540	[2] Racine, WI	0.9478	0.9640
	Racine County, WI.		
39580	Raleigh-Cary, NC	0.9709	0.9800
	Franklin County, NC.		
	Johnston County, NC.		
	Wake County, NC.		
39660	Rapid City, SD	0.9027	0.9323
	Meade County, SD.		
	Pennington County, SD.		
39740	Reading, PA	0.9698	0.9792
	Berks County, PA.		
39820	Redding, CA	1.2207	1.1463
	Shasta County, CA.		
39900	Reno-Sparks, NV	1.0984	1.0664
	Storey County, NV.		
	Washoe County, NV.		
40060	[1] Richmond, VA	0.9319	0.9528
	Amelia County, VA.		
	Caroline County, VA.		
	Charles City County, VA.		
	Chesterfield County, VA.		
	Cumberland County, VA.		
	Dinwiddie County, VA.		
	Goochland County, VA.		
	Hanover County, VA.		
	Henrico County, VA.		

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	King and Queen County, VA.		
	King William County, VA.		
	Louisa County, VA.		
	New Kent County, VA.		
	Powhatan County, VA.		
	Prince George County, VA.		
	Sussex County, VA.		
	Colonial Heights City, VA.		
	Hopewell City, VA.		
	Petersburg City, VA.		
	Richmond City, VA.		
40140	[1] Riverside-San Bernardino-Ontario, CA	1.1021	1.0688
	Riverside County, CA.		
	San Bernardino County, CA.		
40220	Roanoke, VA	0.8450	0.8911
	Botetourt County, VA.		
	Craig County, VA.		
	Franklin County, VA.		
	Roanoke County, VA.		
	Roanoke City, VA.		
	Salem City, VA.		
40340	Rochester, MN	1.1128	1.0759
	Dodge County, MN.		
	Olmsted County, MN.		
	Wabasha County, MN.		
40380	[1] Rochester, NY	0.9117	0.9387
	Livingston County, NY.		
	Monroe County, NY.		
	Ontario County, NY.		
	Orleans County, NY.		
	Wayne County, NY.		
40420	Rockford, IL	0.9975	0.9983
	Boone County, IL.		
	Winnebago County, IL.		
40484	[2] Rockingham County-Strafford County, NH	1.0668	1.0453
	Rockingham County, NH.		
	Strafford County, NH.		
40580	Rocky Mount, NC	0.8924	0.9250
	Edgecombe County, NC.		
	Nash County, NC.		
40660	Rome, GA	0.9414	0.9595
	Floyd County, GA.		
40900	[1] Sacramento—Arden-Arcade—Roseville, CA	1.2953	1.1939
	El Dorado County, CA.		
	Placer County, CA.		
	Sacramento County, CA.		
	Yolo County, CA.		
40980	Saginaw-Saginaw Township North, MI	0.9474	0.9637
	Saginaw County, MI.		
41060	St. Cloud, MN	1.0030	1.0021
	Benton County, MN.		
	Stearns County, MN.		
41100	St. George, UT	0.9416	0.9596
	Washington County, UT.		
41140	St. Joseph, MO-KS	0.9565	0.9700
	Doniphan County, KS.		
	Andrew County, MO.		
	Buchanan County, MO.		
	DeKalb County, MO.		
41180	St. Louis, MO-IL	0.8953	0.9271
	Bond County, IL.		
	Calhoun County, IL.		
	Clinton County, IL.		
	Jersey County, IL.		
	Macoupin County, IL.		
	Madison County, IL.		
	Monroe County, IL.		
	St. Clair County, IL.		
	Crawford County, MO.		
	Franklin County, MO.		

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Jefferson County, MO.		
	Lincoln County, MO.		
	St. Charles County, MO.		
	St. Louis County, MO.		
	Warren County, MO.		
	Washington County, MO.		
	St. Louis City, MO.		
41420	Salem, OR	1.0445	1.0303
	Marion County, OR.		
	Polk County, OR.		
41500	Salinas, CA	1.4140	1.2677
	Monterey County, CA.		
41540	[2] Salisbury, MD	0.9099	0.9374
	Somerset County, MD.		
	Wicomico County, MD.		
41620	Salt Lake City, UT	0.9436	0.9610
	Salt Lake County, UT.		
	Summit County, UT.		
	Tooele County, UT.		
41660	San Angelo, TX	0.8287	0.8793
	Irion County, TX.		
	Tom Green County, TX.		
41700	[1] San Antonio, TX	0.8987	0.9295
	Atascosa County, TX.		
	Bandera County, TX.		
	Bexar County, TX.		
	Comal County, TX.		
	Guadalupe County, TX.		
	Kendall County, TX.		
	Medina County, TX.		
	Wilson County, TX.		
41740	[1] San Diego-Carlsbad-San Marcos, CA	1.1417	1.0950
	San Diego County, CA.		
41780	Sandusky, OH	0.9033	0.9327
	Erie County, OH.		
41884	[1] San Francisco-San Mateo-Redwood City, CA	1.4970	1.3182
	Marin County, CA.		
	San Francisco County, CA.		
	San Mateo County, CA.		
41900	San Germán-Cabo Rojo, PR	0.4646	0.5916
	Cabo Rojo Municipio, PR.		
	Lajas Municipio, PR.		
	Sabana Grande Municipio, PR.		
	San Germán Municipio, PR.		
41940	[1] San Jose-Sunnyvale-Santa Clara, CA	1.5114	1.3269
	San Benito County, CA.		
	Santa Clara County, CA.		
41980	[1] San Juan-Caguas-Guaynabo, PR	0.4686	0.5951
	Aguas Buenas Municipio, PR.		
	Aibonito Municipio, PR.		
	Arecibo Municipio, PR.		
	Barceloneta Municipio, PR.		
	Barranquitas Municipio, PR.		
	Bayamón Municipio, PR.		
	Caguas Municipio, PR.		
	Camuy Municipio, PR.		
	Canóvanas Municipio, PR.		
	Carolina Municipio, PR.		
	Cataño Municipio, PR.		
	Cayey Municipio, PR.		
	Ciales Municipio, PR.		
	Cidra Municipio, PR.		
	Comerío Municipio, PR.		
	Corozal Municipio, PR.		
	Dorado Municipio, PR.		
	Florida Municipio, PR.		
	Guaynabo Municipio, PR.		
	Gurabo Municipio, PR.		
	Hatillo Municipio, PR.		
	Humacao Municipio, PR.		

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Juncos Municipio, PR.		
	Las Piedras Municipio, PR.		
	Loíza Municipio, PR.		
	Manatí Municipio, PR.		
	Maunabo Municipio, PR.		
	Morovis Municipio, PR.		
	Naguabo Municipio, PR.		
	Naranjito Municipio, PR.		
	Orocovis Municipio, PR.		
	Quebradillas Municipio, PR.		
	Río Grande Municipio, PR.		
	San Juan Municipio, PR.		
	San Lorenzo Municipio, PR.		
	Toa Alta Municipio, PR.		
	Toa Baja Municipio, PR.		
	Trujillo Alto Municipio, PR.		
	Vega Alta Municipio, PR.		
	Vega Baja Municipio, PR.		
	Yabucoa Municipio, PR.		
42020	San Luis Obispo-Paso Robles, CA	1.1357	1.0910
	San Luis Obispo County, CA.		
42044	[1] Santa Ana-Anaheim-Irvine, CA	1.1564	1.1046
	Orange County, CA.		
42060	Santa Barbara-Santa Maria-Goleta, CA	1.1525	1.1021
	Santa Barbara County, CA.		
42100	Santa Cruz-Watsonville, CA	1.5159	1.3296
	Santa Cruz County, CA.		
42140	Santa Fe, NM	1.0908	1.0613
	Santa Fe County, NM.		
42220	Santa Rosa-Petaluma, CA	1.3480	1.2269
	Sonoma County, CA.		
42260	Sarasota-Bradenton-Venice, FL	0.9554	0.9692
	Manatee County, FL.		
	Sarasota County, FL.		
42340	Savannah, GA	0.9483	0.9643
	Bryan County, GA.		
	Chatham County, GA.		
	Effingham County, GA.		
42540	Scranton—Wilkes-Barre, PA	0.8530	0.8968
	Lackawanna County, PA.		
	Luzerne County, PA.		
	Wyoming County, PA.		
42644	[1] Seattle-Bellevue-Everett, WA	1.1573	1.1052
	King County, WA.		
	Snohomish County, WA.		
43100	[2] Sheboygan, WI	0.9478	0.9640
	Sheboygan County, WI.		
43300	Sherman-Denison, TX	0.9518	0.9667
	Grayson County, TX.		
43340	Shreveport-Bossier City, LA	0.8767	0.9138
	Bossier Parish, LA.		
	Caddo Parish, LA.		
	De Soto Parish, LA.		
43580	Sioux City, IA-NE-SD	0.9360	0.9557
	Woodbury County, IA.		
	Dakota County, NE.		
	Dixon County, NE.		
	Union County, SD.		
43620	Sioux Falls, SD	0.9616	0.9735
	Lincoln County, SD.		
	McCook County, SD.		
	Minnehaha County, SD.		
	Turner County, SD.		
43780	South Bend-Mishawaka, IN-MI	0.9785	0.9852
	St. Joseph County, IN.		
	Cass County, MI.		
43900	Spartanburg, SC	0.9183	0.9433
	Spartanburg County, SC.		
44060	Spokane, WA	1.0898	1.0607
	Spokane County, WA.		

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
44100	Springfield, IL	0.8879	0.9218
	Menard County, IL.		
	Sangamon County, IL.		
44140	Springfield, MA	1.0259	1.0177
	Franklin County, MA.		
	Hampden County, MA.		
	Hampshire County, MA.		
44180	Springfield, MO	0.8251	0.8766
	Christian County, MO.		
	Dallas County, MO.		
	Greene County, MO.		
	Polk County, MO.		
	Webster County, MO.		
44220	[2] Springfield, OH	0.8788	0.9153
	Clark County, OH.		
44300	State College, PA	0.8368	0.8851
	Centre County, PA.		
44700	Stockton, CA	1.1333	1.0895
	San Joaquin County, CA.		
44940	[2] Sumter, SC	0.8663	0.9064
	Sumter County, SC.		
45060	Syracuse, NY	0.9595	0.9721
	Madison County, NY.		
	Onondaga County, NY.		
	Oswego County, NY.		
45104	Tacoma, WA	1.0794	1.0537
	Pierce County, WA.		
45220	Tallahassee, FL	0.8712	0.9099
	Gadsden County, FL.		
	Jefferson County, FL.		
	Leon County, FL.		
	Wakulla County, FL.		
45300	[1] Tampa-St. Petersburg-Clearwater, FL	0.9292	0.9510
	Hernando County, FL.		
	Hillsborough County, FL.		
	Pasco County, FL.		
	Pinellas County, FL.		
45460	[2] Terre Haute, IN	0.8632	0.9042
	Clay County, IN.		
	Sullivan County, IN.		
	Vermillion County, IN.		
	Vigo County, IN.		
45500	Texarkana, TX-Texarkana, AR	0.8293	0.8797
	Miller County, AR.		
	Bowie County, TX.		
45780	Toledo, OH	0.9573	0.9706
	Fulton County, OH.		
	Lucas County, OH.		
	Ottawa County, OH.		
	Wood County, OH.		
45820	Topeka, KS	0.8921	0.9248
	Jackson County, KS.		
	Jefferson County, KS.		
	Osage County, KS.		
	Shawnee County, KS.		
	Wabaunsee County, KS.		
45940	Trenton-Ewing, NJ	1.0837	1.0566
	Mercer County, NJ.		
46060	Tucson, AZ	0.9007	0.9309
	Pima County, AZ.		
46140	Tulsa, OK	0.8313	0.8812
	Creek County, OK.		
	Okmulgee County, OK.		
	Osage County, OK.		
	Pawnee County, OK.		
	Rogers County, OK.		
	Tulsa County, OK.		
	Wagoner County, OK.		
46220	Tuscaloosa, AL	0.8724	0.9108
	Greene County, AL.		

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Hale County, AL.		
	Tuscaloosa County, AL.		
46340	Tyler, TX	0.9322	0.9531
	Smith County, TX.		
46540	Utica-Rome, NY	0.8313	0.8812
	Herkimer County, NY.		
	Oneida County, NY.		
46660	Valdosta, GA	0.8873	0.9214
	Brooks County, GA.		
	Echols County, GA.		
	Lanier County, GA.		
	Lowndes County, GA.		
46700	Vallejo-Fairfield, CA	1.4888	1.3133
	Solano County, CA.		
46940	Vero Beach, FL	0.9458	0.9626
	Indian River County, FL.		
47020	Victoria, TX	0.8148	0.8691
	Calhoun County, TX.		
	Goliad County, TX.		
	Victoria County, TX.		
47220	[2] Vineland-Millville-Bridgeton, NJ	1.0607	1.0412
	Cumberland County, NJ.		
47260	[1] Virginia Beach-Norfolk-Newport News, VA-NC	0.8841	0.9191
	Currituck County, NC.		
	Gloucester County, VA.		
	Isle of Wight County, VA.		
	James City County, VA.		
	Mathews County, VA.		
	Surry County, VA.		
	York County, VA.		
	Chesapeake City, VA.		
	Hampton City, VA.		
	Newport News City, VA.		
	Norfolk City, VA.		
	Poquoson City, VA.		
	Portsmouth City, VA.		
	Suffolk City, VA.		
	Virginia Beach City, VA.		
	Williamsburg City, VA.		
47300	[2] Visalia-Porterville, CA	1.0848	1.0573
	Tulare County, CA.		
47380	Waco, TX	0.8532	0.8970
	McLennan County, TX.		
47580	Warner Robins, GA	0.8662	0.9063
	Houston County, GA.		
47644	[1] Warren-Farmington Hills-Troy, MI	0.9858	0.9903
	Lapeer County, MI.		
	Livingston County, MI.		
	Macomb County, MI.		
	Oakland County, MI.		
	St. Clair County, MI.		
47894	[1] Washington-Arlington-Alexandria, DC-VA-MD-WV	1.0935	1.0631
	District of Columbia, DC.		
	Calvert County, MD.		
	Charles County, MD.		
	Prince George's County, MD.		
	Arlington County, VA.		
	Clarke County, VA.		
	Fairfax County, VA.		
	Fauquier County, VA.		
	Loudoun County, VA.		
	Prince William County, VA.		
	Spotsylvania County, VA.		
	Stafford County, VA.		
	Warren County, VA.		
	Alexandria City, VA.		
	Fairfax City, VA.		
	Falls Church City, VA.		
	Fredericksburg City, VA.		
	Manassas City, VA.		

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Manassas Park City, VA.		
	Jefferson County, WV.		
47940	Waterloo-Cedar Falls, IA	0.8564	0.8993
	Black Hawk County, IA.		
	Bremer County, IA.		
	Grundy County, IA.		
48140	Wausau, WI	0.9964	0.9975
	Marathon County, WI.		
48260	Weirton-Steubenville, WV-OH (WV Hospitals)	0.7821	0.8451
	Jefferson County, OH.		
	Brooke County, WV.		
	Hancock County, WV.		
48260	[2] Weirton-Steubenville, WV-OH (OH Hospitals)	0.8788	0.9153
	Jefferson County, OH.		
	Brooke County, WV.		
	Hancock County, WV.		
48300	[2] Wenatchee, WA	1.0459	1.0312
	Chelan County, WA.		
	Douglas County, WA.		
48424	[1] West Palm Beach-Boca Raton-Boynton Beach, FL	1.0061	1.0042
	Palm Beach County, FL.		
48540	[2] Wheeling, WV-OH (WV Hospitals)	0.7742	0.8392
	Belmont County, OH.		
	Marshall County, WV.		
	Ohio County, WV.		
48540	[2] Wheeling, WV-OH (OH Hospitals)	0.8788	0.9153
	Belmont County, OH.		
	Marshall County, WV.		
	Ohio County, WV.		
48620	Wichita, KS	0.9156	0.9414
	Butler County, KS.		
	Harvey County, KS.		
	Sedgwick County, KS.		
	Sumner County, KS.		
48660	Wichita Falls, TX	0.8327	0.8822
	Archer County, TX.		
	Clay County, TX.		
	Wichita County, TX.		
48700	Williamsport, PA	0.8368	0.8851
	Lycoming County, PA.		
48864	Wilmington, DE-MD-NJ	1.0652	1.0442
	New Castle County, DE.		
	Cecil County, MD.		
	Salem County, NJ.		
48900	Wilmington, NC	0.9580	0.9710
	Brunswick County, NC.		
	New Hanover County, NC.		
	Pender County, NC.		
49020	Winchester, VA-WV	1.0214	1.0146
	Frederick County, VA.		
	Winchester City, VA.		
	Hampshire County, WV.		
49180	Winston-Salem, NC	0.9020	0.9318
	Davie County, NC.		
	Forsyth County, NC.		
	Stokes County, NC.		
	Yadkin County, NC.		
49340	Worcester, MA	1.1044	1.0704
	Worcester County, MA.		
49420	[2] Yakima, WA	1.0459	1.0312
	Yakima County, WA.		
49500	Yauco, PR	0.4413	0.5711
	Guánica Municipio, PR.		
	Guayanilla Municipio, PR.		
	Peñuelas Municipio, PR.		
	Yauco Municipio, PR.		
49620	York-Hanover, PA	0.9422	0.9600
	York County, PA.		
49660	[2] Youngstown-Warren-Boardman, OH-PA (OH Hospitals)	0.8788	0.9153
	Mahoning County, OH.		

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

CBSA code	Urban area (constituent counties)	Wage index	GAF
	Trumbull County, OH.		
	Mercer County, PA.		
49660	Youngstown-Warren-Boardman, OH-PA (PA Hospitals)	0.8609	0.9025
	Mahoning County, OH.		
	Trumbull County, OH.		
	Mercer County, PA.		
49700	Yuba City, CA	1.0951	1.0642
	Sutter County, CA.		
	Yuba County, CA.		
49740	Yuma, AZ	0.9188	0.9437
	Yuma County, AZ.		

[1] Large urban area.
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2006.

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

CBSA code	Nonurban area	Wage index	GAF
01	Alabama	0.7495	0.8208
02	Alaska	1.1977	1.1315
03	Arizona	0.8991	0.9298
04	Arkansas	0.7478	0.8195
05	California	1.0848	1.0573
06	Colorado	0.9379	0.9570
07	Connecticut	1.1790	1.1194
08	Delaware	0.9606	0.9728
10	Florida	0.8613	0.9028
11	Georgia	0.7684	0.8349
12	Hawaii	1.0598	1.0406
13	Idaho	0.8810	0.9169
14	Illinois	0.8285	0.8791
15	Indiana	0.8632	0.9042
16	Iowa	0.8563	0.8992
17	Kansas	0.8032	0.8606
18	Kentucky	0.7788	0.8427
19	Louisiana	0.7445	0.8171
20	Maine	0.8840	0.9190
21	Maryland	0.9099	0.9374
22	Massachusetts [1]	1.0066	1.0045
23	Michigan	0.8923	0.9249
24	Minnesota	0.9183	0.9433
25	Mississippi	0.7685	0.8350
26	Missouri	0.7927	0.8529
27	Montana	0.8822	0.9177
28	Nebraska	0.8666	0.9066
29	Nevada	0.9079	0.9360
30	New Hampshire	1.0668	1.0453
31	New Jersey [1]	1.0607	1.0412
32	New Mexico	0.8649	0.9054
33	New York	0.8220	0.8744
34	North Carolina	0.8570	0.8997
35	North Dakota	0.7278	0.8045
36	Ohio	0.8788	0.9153
37	Oklahoma	0.7615	0.8298
38	Oregon	1.0284	1.0194
39	Pennsylvania	0.8300	0.8802
40	Puerto Rico [1]	.....	.....
41	Rhode Island [1]	0.8807	0.9167
42	South Carolina	0.8663	0.9064
43	South Dakota	0.8475	0.8929
44	Tennessee	0.7915	0.8520
45	Texas	0.8038	0.8611
46	Utah	0.8134	0.8681
47	Vermont	1.0199	1.0136
49	Virginia	0.8024	0.8601
50	Washington	1.0459	1.0312
51	West Virginia	0.7742	0.8392
52	Wisconsin	0.9478	0.9640

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

CBSA code	Nonurban area	Wage index	GAF
53	Wyoming	0.9207	0.9450

[1] All counties within the State are classified as urban, with the exception of Massachusetts. Massachusetts has area(s) designated as rural, however, no short-term, acute care hospitals are located in the area(s) for FY 2006.

Massachusetts, New Jersey, and Rhode Island rural floors are imputed as discussed in section III. H. of the preamble of this proposed rule.

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

CBSA code	Area	Wage index	GAF
10180	Abilene, TX	0.8038	0.8611
10420	Akron, OH	0.8979	0.9289
10580	Albany-Schenectady-Troy, NY	0.8565	0.8994
10740	Albuquerque, NM	0.9558	0.9695
10780	Alexandria, LA	0.8048	0.8618
10900	Allentown-Bethlehem-Easton, PA-NJ	0.9844	0.9893
11020	Altoona, PA	0.8942	0.9263
11100	Amarillo, TX	0.9165	0.9420
11180	Ames, IA	0.9231	0.9467
11460	Ann Arbor, MI	1.0628	1.0426
11500	Anniston-Oxford, AL	0.7702	0.8363
11700	Asheville, NC	0.9312	0.9524
12020	Athens-Clarke County, GA	0.9684	0.9783
12060	Atlanta-Sandy Springs-Marietta, GA	0.9637	0.9750
12420	Austin-Round Rock, TX	0.9451	0.9621
12620	Bangor, ME	0.9985	0.9990
12700	Barnstable Town, MA	1.2254	1.1494
12940	Baton Rouge, LA	0.8470	0.8925
13020	Bay City, MI	0.9535	0.9679
13780	Binghamton, NY	0.8471	0.8926
13820	Birmingham-Hoover, AL	0.8872	0.9213
14260	Boise City-Nampa, ID	0.9048	0.9338
14484	Boston-Quincy, MA	1.1233	1.0829
14540	Bowling Green, KY	0.8222	0.8745
15380	Buffalo-Niagara Falls, NY	0.8888	0.9224
15540	Burlington-South Burlington, VT	0.9306	0.9519
15764	Cambridge-Newton-Framingham, MA	1.0903	1.0610
16180	Carson City, NV	0.9786	0.9853
16220	Casper, WY	0.9207	0.9450
16580	Champaign-Urbana, IL	0.9335	0.9540
16620	Charleston, WV (WV Hospitals)	0.8274	0.8783
16620	Charleston, WV(OH Hospitals)	0.8788	0.9153
16700	Charleston-North Charleston, SC	0.9317	0.9527
16740	Charlotte-Gastonia-Concord, NC-SC	0.9585	0.9714
16820	Charlottesville, VA	0.9806	0.9867
16860	Chattanooga, TN-GA	0.9099	0.9374
16974	Chicago-Naperville-Joliet, IL	1.0698	1.0473
17140	Cincinnati-Middletown, OH-KY-IN	0.9604	0.9727
17300	Clarksville, TN-KY	0.8092	0.8650
17460	Cleveland-Elyria-Mentor, OH	0.9197	0.9443
17780	College Station-Bryan, TX	0.8911	0.9241
17860	Columbia, MO	0.8346	0.8835
17900	Columbia, SC	0.9057	0.9344
17980	Columbus, GA-AL	0.8402	0.8876
18140	Columbus, OH	0.9848	0.9896
18700	Corvallis, OR	1.0328	1.0223
19124	Dallas-Plano-Irving, TX	0.9955	0.9969
19380	Dayton, OH	0.9069	0.9353
19460	Decatur, AL	0.8517	0.8959
19740	Denver-Aurora, CO	1.0517	1.0351
19780	Des Moines, IA	0.9413	0.9594
19804	Detroit-Livonia-Dearborn, MI	1.0453	1.0308
20260	Duluth, MN-WI	1.0224	1.0153
20500	Durham, NC	0.9993	0.9995
20764	Edison, NJ	1.1301	1.0874
20940	El Centro, CA	0.9102	0.9376
21060	Elizabethtown, KY	0.8286	0.8792
21500	Erie, PA	0.8424	0.8892

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

CBSA code	Area	Wage index	GAF
21604	Essex County, MA	1.0668	1.0453
21660	Eugene-Springfield, OR	1.0492	1.0334
21780	Evansville, IN-KY	0.8508	0.8953
22020	Fargo, ND-MN (ND, SD Hospitals)	0.8778	0.9146
22020	Fargo, ND-MN (MN Hospitals)	0.9183	0.9433
22180	Fayetteville, NC	0.9193	0.9440
22220	Fayetteville-Springdale-Rogers, AR-MO	0.8615	0.9029
22380	Flagstaff, AZ	1.1713	1.1144
22420	Flint, MI	1.0654	1.0443
22540	Fond du Lac, WI	0.9478	0.9640
22660	Fort Collins-Loveland, CO	1.0146	1.0100
22744	Ft Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0508	1.0345
22900	Fort Smith, AR-OK	0.7986	0.8573
23020	Fort Walton Beach-Crestview-Destin, FL	0.8672	0.9070
23060	Fort Wayne, IN	0.9797	0.9861
23104	Fort Worth-Arlington, TX	0.9514	0.9665
23540	Gainesville, FL	0.9461	0.9628
23844	Gary, IN	0.9366	0.9561
24340	Grand Rapids-Wyoming, MI	0.9398	0.9584
24500	Great Falls, MT	0.9074	0.9356
24540	Greeley, CO	0.9597	0.9722
24580	Green Bay, WI (MI Hospitals)	0.9439	0.9612
24580	Green Bay, WI (WI Hospitals)	0.9478	0.9640
24780	Greenville, NC	0.9414	0.9595
24860	Greenville, SC	0.9807	0.9867
25060	Gulfport-Biloxi, MS	0.8612	0.9027
25420	Harrisburg-Carlisle, PA	0.9145	0.9406
25500	Harrisonburg, VA	0.8998	0.9302
25540	Hartford-West Hartford-East Hartford, CT (MA Hospitals)	1.1085	1.0731
25540	Hartford-West Hartford-East Hartford, CT (CT Hospitals)	1.1790	1.1194
25860	Hickory-Lenoir-Morganton, NC	0.8931	0.9255
26100	Holland-Grand Haven, MI	0.9133	0.9398
26180	Honolulu, HI	1.1206	1.0811
26420	Houston-Baytown-Sugar Land, TX	1.0008	1.0005
26580	Huntington-Ashland, WV-KY-OH	0.9119	0.9388
26620	Huntsville, AL	0.9124	0.9391
26900	Indianapolis, IN	0.9776	0.9846
26980	Iowa City, IA	0.9574	0.9706
27060	Ithaca, NY	0.9204	0.9448
27140	Jackson, MS	0.8182	0.8716
27180	Jackson, TN	0.8799	0.9161
27260	Jacksonville, FL	0.9303	0.9517
27860	Jonesboro, AR	0.7793	0.8430
27900	Joplin, MO	0.8458	0.8916
28020	Kalamazoo-Portage, MI	1.0403	1.0274
28100	Kankakee-Bradley, IL	1.0991	1.0668
28140	Kansas City, MO-KS	0.9454	0.9623
28420	Kennewick-Richland-Pasco, WA	1.0459	1.0312
28700	Kingsport-Bristol-Bristol, TN-VA	0.8095	0.8653
28740	Kingston, NY	0.8904	0.9236
28940	Knoxville, TN	0.8470	0.8925
29180	Lafayette, LA	0.8429	0.8896
29404	Lake County-Kenosha County, IL-WI	1.0444	1.0302
29460	Lakeland, FL	0.8934	0.9257
29620	Lansing-East Lansing, MI	0.9786	0.9853
29740	Las Cruces, NM	0.8649	0.9054
29820	Las Vegas-Paradise, NV	1.1249	1.0839
30020	Lawton, OK	0.7673	0.8341
30460	Lexington-Fayette, KY	0.8830	0.9183
30620	Lima, OH	0.9263	0.9489
30700	Lincoln, NE	0.9666	0.9770
30780	Little Rock-North Little Rock, AR	0.8552	0.8984
30980	Longview, TX	0.8621	0.9034
31084	Los Angeles-Long Beach-Santa Ana, CA	1.1660	1.1109
31140	Louisville, KY-IN	0.9264	0.9490
31180	Lubbock, TX	0.8790	0.9155
31340	Lynchburg, VA	0.8596	0.9016
31420	Macon, GA	0.9087	0.9365
31540	Madison, WI	1.0416	1.0283
31700	Manchester-Nashua, NH	1.0668	1.0453

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

CBSA code	Area	Wage index	GAF
32780	Medford, OR	1.0284	1.0194
32820	Memphis, TN-MS-AR	0.9108	0.9380
33124	Miami-Miami Beach-Kendall, FL	0.9757	0.9833
33260	Midland, TX	0.9317	0.9527
33340	Milwaukee-Waukesha-West Allis, WI	0.9957	0.9971
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.0905	1.0611
33540	Missoula, MT	0.9535	0.9679
33660	Mobile, AL	0.7902	0.8511
33700	Modesto, CA	1.1885	1.1255
33860	Montgomery, AL	0.8276	0.8785
34060	Morgantown, WV	0.8332	0.8825
34980	Nashville-Davidson—Murfreesboro, TN	0.9492	0.9649
35084	Newark-Union, NJ-PA	1.2192	1.1454
35380	New Orleans-Metairie-Kenner, LA	0.9003	0.9306
35644	New York-Wayne-White Plains, NY-NJ	1.3191	1.2088
36084	Oakland-Fremont-Hayward, CA	1.5474	1.3485
36100	Ocala, FL	0.8955	0.9272
36140	Ocean City, NJ	1.0289	1.0197
36220	Odessa, TX	0.9593	0.9719
36260	Ogden-Clearfield, UT	0.9048	0.9338
36420	Oklahoma City, OK	0.9043	0.9334
36500	Olympia, WA	1.0970	1.0655
36540	Omaha-Council Bluffs, NE-IA	0.9555	0.9693
36740	Orlando, FL	0.9446	0.9617
37860	Pensacola-Ferry Pass-Brent, FL	0.8089	0.8648
37900	Peoria, IL	0.8844	0.9193
37964	Philadelphia, PA	1.1030	1.0694
38220	Pine Bluff, AR	0.8099	0.8656
38300	Pittsburgh, PA	0.8840	0.9190
38340	Pittsfield, MA	1.0199	1.0136
38860	Portland-South Portland-Biddeford, ME	0.9884	0.9920
38900	Portland-Vancouver-Beaverton, OR-WA	1.1229	1.0826
38940	Port St. Lucie-Fort Pierce, FL	1.0162	1.0111
39100	Poughkeepsie-Newburgh-Middletown, NY	1.0576	1.0391
39340	Provo-Orem, UT	0.9578	0.9709
39580	Raleigh-Cary, NC	0.9476	0.9638
39740	Reading, PA	0.9500	0.9655
39820	Redding, CA	1.1909	1.1271
39900	Reno-Sparks, NV (NV Hospitals)	1.0805	1.0545
39900	Reno-Sparks, NV (CA Hospitals)	1.0848	1.0573
40060	Richmond, VA	0.9319	0.9528
40220	Roanoke, VA	0.8450	0.8911
40340	Rochester, MN	1.1128	1.0759
40380	Rochester, NY	0.9117	0.9387
40420	Rockford, IL	0.9667	0.9771
40484	Rockingham County, NH	1.0503	1.0342
40660	Rome, GA	0.9414	0.9595
40900	Sacramento—Arden-Arcade—Roseville, CA	1.2953	1.1939
40980	Saginaw-Saginaw Township North, MI	0.9090	0.9368
41060	St. Cloud, MN	0.9785	0.9852
41100	St. George, UT	0.9416	0.9596
41180	St. Louis, MO-IL	0.8953	0.9271
41620	Salt Lake City, UT	0.9436	0.9610
41700	San Antonio, TX	0.8987	0.9295
41884	San Francisco-San Mateo-Redwood City,CA	1.4739	1.3043
41980	San Juan-Caguas-Guaynabo, PR	0.4686	0.5951
42044	Santa Ana-Anaheim-Irvine, CA	1.1297	1.0871
42140	Santa Fe, NM	1.0163	1.0111
42220	Santa Rosa-Petaluma, CA	1.3480	1.2269
42260	Sarasota-Bradenton-Venice, FL	0.9554	0.9692
42340	Savannah, GA	0.9316	0.9526
42644	Seattle-Bellevue-Everett, WA	1.1573	1.1052
43300	Sherman-Denison, TX	0.8971	0.9283
43340	Shreveport-Bossier City, LA	0.8767	0.9138
43620	Sioux Falls, SD	0.9616	0.9735
43780	South Bend-Mishawaka, IN-MI	0.9785	0.9852
43900	Spartanburg, SC	0.9183	0.9433
44060	Spokane, WA	1.0722	1.0489
44180	Springfield, MO	0.8251	0.8766
44300	State College, PA	0.8300	0.8802

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

CBSA code	Area	Wage index	GAF
44940	Sumter, SC	0.8663	0.9064
45060	Syracuse, NY	0.9315	0.9526
45104	Tacoma, WA	1.0794	1.0537
45220	Tallahassee, FL	0.8420	0.8889
45300	Tampa-St. Petersburg-Clearwater, FL	0.9292	0.9510
45500	Texarkana, TX-Texarkana, AR	0.8293	0.8797
45820	Topeka, KS	0.8785	0.9151
46140	Tulsa, OK	0.8313	0.8812
46220	Tuscaloosa, AL	0.8614	0.9029
46340	Tyler, TX	0.9164	0.9420
46660	Valdosta, GA	0.8710	0.9098
46700	Vallejo-Fairfield, CA	1.3955	1.2564
47260	Virginia Beach-Norfolk-Newport News, VA	0.8841	0.9191
47380	Waco, TX	0.8532	0.8970
47894	Washington-Arlington-Alexandria DC-VA	1.0813	1.0550
48140	Wausau, WI	0.9964	0.9975
48620	Wichita, KS	0.8946	0.9266
48700	Williamsport, PA	0.8300	0.8802
48864	Wilmington, DE-MD-NJ	1.0652	1.0442
48900	Wilmington, NC	0.9394	0.9581
49020	Winchester, VA-WV	1.0214	1.0146
49180	Winston-Salem, NC	0.9020	0.9318
49660	Youngstown-Warren-Boardman, OH-PA (PA Hospitals)	0.8446	0.8908
49660	Youngstown-Warren-Boardman, OH-PA (OH Hospitals)	0.8788	0.9153
03	Rural Arizona	0.8991	0.9298
04	Rural Arkansas	0.7478	0.8195
05	Rural California	1.0848	1.0573
07	Rural Connecticut	1.0448	1.0305
10	Rural Florida	0.8613	0.9028
13	Rural Idaho	0.8810	0.9169
14	Rural Illinois	0.8285	0.8791
15	Rural Indiana	0.8632	0.9042
16	Rural Iowa	0.8563	0.8992
17	Rural Kansas	0.8032	0.8606
19	Rural Louisiana	0.7445	0.8171
23	Rural Michigan	0.8923	0.9249
24	Rural Minnesota	0.9183	0.9433
26	Rural Missouri	0.7927	0.8529
30	Rural New Hampshire	1.0668	1.0453
37	Rural Oklahoma	0.7615	0.8298
38	Rural Oregon	1.0284	1.0194
45	Rural Texas	0.8038	0.8611
50	Rural Washington (ID Hospitals)	1.0061	1.0042
50	Rural Washington (WA Hospitals)	1.0459	1.0312
53	Rural Wyoming	0.9207	0.9450

TABLE 4F.—PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) BY CBSA

CBSA Code	Area	Wage Index	GAF	Wage Index -Reclassified Hospitals	GAF -Reclassified Hospitals
10380	Aguadilla-Isabela-San Sebastián, PR	1.0196	1.0134		
21940	Fajardo, PR	0.8956	0.9273		
25020	Guayama, PR	0.6858	0.7724		
32420	Mayagüez, PR	0.8647	0.9052		
38660	Ponce, PR	1.1147	1.0772		
41900	San Germán-Cabo Rojo, PR	1.0002	1.0001		
41980	San Juan-Caguas-Guaynabo, PR	1.0087	1.0059	1.0087	1.0059
49500	Yauco, PR	0.9500	0.9655		

The following list represents all hospitals that are eligible to have their wage index increased by the out-migration adjustment listed in this table. Hospitals cannot receive the out-migration adjustment if they are reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act. Hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section

1886(d)(8)(B) of the Act are designated with an asterisk. Hospitals have the opportunity to use the new additional 30-day period to review their individual situation to determine whether to submit a request to withdraw their reclassification/redesignation and receive the out-migration adjustment instead. We will automatically assume that hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act wish to retain their reclassification/redesignation status and waive the application of the out-migration adjustment. Hospitals are not required to provide CMS with any type of formal notification that they wish to remain reclassified/redesignated.

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006

Provider number	Out-migration adjustment	Qualifying county name
010005*	0.0259	MARSHALL
010008*	0.0212	CRENSHAW
010009	0.0092	MORGAN
010010	0.0259	MARSHALL
010012*	0.0205	DE KALB
010022*	0.0714	CHEROKEE
010025*	0.0225	CHAMBERS
010029*	0.0107	LEE
010035*	0.0375	CULLMAN
010038	0.0062	CALHOUN
010045*	0.0160	FAYETTE
010047	0.0155	BUTLER
010054	0.0092	MORGAN
010061	0.0506	JACKSON
010072*	0.0310	TALLADEGA
010078	0.0062	CALHOUN
010083*	0.0121	BALDWIN
010085	0.0092	MORGAN
010100*	0.0121	BALDWIN
010101*	0.0310	TALLADEGA
010109	0.0464	PICKENS
010115	0.0093	FRANKLIN
010129	0.0121	BALDWIN
010143*	0.0375	CULLMAN
010146	0.0062	CALHOUN
010150	0.0155	BUTLER
010158*	0.0093	FRANKLIN
040014*	0.0159	WHITE
040019*	0.0697	ST. FRANCIS
040047*	0.0090	RANDOLPH
040066	0.0382	CLARK
040069*	0.0140	MISSISSIPPI
040070	0.0140	MISSISSIPPI
040071*	0.0026	JEFFERSON
040076*	0.1075	HOT SPRING
040100*	0.0159	WHITE
040143	0.0026	JEFFERSON
050008	0.0028	SAN FRANCISCO
050009*	0.0478	NAPA
050013*	0.0478	NAPA
050014*	0.0131	AMADOR
050016	0.0087	SAN LUIS OBISPO
050042*	0.0219	TEHAMA
050046*	0.0156	VENTURA

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

Provider number	Out-migration adjustment	Qualifying county name
050047	0.0028	SAN FRANCISCO
050055	0.0028	SAN FRANCISCO
050065*	0.0029	ORANGE
050069*	0.0029	ORANGE
050073*	0.0269	SOLANO
050076*	0.0028	SAN FRANCISCO
050082*	0.0156	VENTURA
050084	0.0555	SAN JOAQUIN
050088	0.0087	SAN LUIS OBISPO
050089*	0.0152	SAN BERNARDINO
050090*	0.0308	SONOMA
050099*	0.0152	SAN BERNARDINO
050101	0.0269	SOLANO
050117	0.0463	MERCED
050118*	0.0555	SAN JOAQUIN
050122	0.0555	SAN JOAQUIN
050129*	0.0152	SAN BERNARDINO
050133	0.017	YUBA
050136*	0.0308	SONOMA
050140*	0.0152	SAN BERNARDINO
050150*	0.0316	NEVADA
050152	0.0028	SAN FRANCISCO
050159*	0.0156	VENTURA
050167	0.0555	SAN JOAQUIN
050168*	0.0029	ORANGE
050173*	0.0029	ORANGE
050174*	0.0308	SONOMA
050177*	0.0156	VENTURA
050193*	0.0029	ORANGE
050224*	0.0029	ORANGE
050226*	0.0029	ORANGE
050228*	0.0028	SAN FRANCISCO
050230*	0.0029	ORANGE
050232	0.0087	SAN LUIS OBISPO
050236*	0.0156	VENTURA
050245*	0.0152	SAN BERNARDINO
050253	0.0029	ORANGE
050272*	0.0152	SAN BERNARDINO
050279*	0.0152	SAN BERNARDINO
050291*	0.0308	SONOMA
050298*	0.0152	SAN BERNARDINO
050300*	0.0152	SAN BERNARDINO
050313	0.0555	SAN JOAQUIN
050325	0.0176	TUOLUMNE
050327*	0.0152	SAN BERNARDINO
050331*	0.0308	SONOMA
050335	0.0176	TUOLUMNE
050336	0.0555	SAN JOAQUIN
050348*	0.0029	ORANGE
050366	0.0096	CALAVERAS
050367	0.0269	SOLANO
050385*	0.0308	SONOMA

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

Provider number	Out-migration adjustment	Qualifying county name
050394*	0.0156	VENTURA
050407	0.0028	SAN FRANCISCO
050426*	0.0029	ORANGE
050444	0.0463	MERCED
050454	0.0028	SAN FRANCISCO
050457	0.0028	SAN FRANCISCO
050469*	0.0152	SAN BERNARDINO
050476	0.0257	LAKE
050491	0.0029	ORANGE
050494	0.0316	NEVADA
050506	0.0087	SAN LUIS OBISPO
050517*	0.0152	SAN BERNARDINO
050526*	0.0029	ORANGE
050528*	0.0463	MERCED
050535*	0.0029	ORANGE
050539	0.0257	LAKE
050543*	0.0029	ORANGE
050547*	0.0308	SONOMA
050548*	0.0029	ORANGE
050549	0.0156	VENTURA
050550*	0.0029	ORANGE
050551*	0.0029	ORANGE
050567*	0.0029	ORANGE
050568	0.0062	MADERA
050570*	0.0029	ORANGE
050580*	0.0029	ORANGE
050584*	0.0152	SAN BERNARDINO
050585*	0.0029	ORANGE
050586*	0.0152	SAN BERNARDINO
050589*	0.0029	ORANGE
050592*	0.0029	ORANGE
050594*	0.0029	ORANGE
050603*	0.0029	ORANGE
050609*	0.0029	ORANGE
050616*	0.0156	VENTURA
050618*	0.0152	SAN BERNARDINO
050633	0.0087	SAN LUIS OBISPO
050667*	0.0478	NAPA
050668*	0.0028	SAN FRANCISCO
050678*	0.0029	ORANGE
050680	0.0269	SOLANO
050690*	0.0308	SONOMA
050693	0.0029	ORANGE
050695	0.0555	SAN JOAQUIN
050720*	0.0029	ORANGE
050728*	0.0308	SONOMA
060001*	0.0294	WELD
060003*	0.0203	BOULDER
060027*	0.0203	BOULDER
060103*	0.0203	BOULDER
070003*	0.0009	WINDHAM
070006	0.0047	FAIRFIELD
070010	0.0047	FAIRFIELD
070018	0.0047	FAIRFIELD
070020	0.0073	MIDDLESEX
070021*	0.0009	WINDHAM
070028	0.0047	FAIRFIELD
070033*	0.0047	FAIRFIELD

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

Provider number	Out-migration adjustment	Qualifying county name
070034	0.0047	FAIRFIELD
080001	0.0059	NEW CASTLE
080003	0.0059	NEW CASTLE
100014	0.0118	VOLUSIA
100017	0.0118	VOLUSIA
100023* ...	0.0069	CITRUS
100045* ...	0.0118	VOLUSIA
100047	0.0021	CHARLOTTE
100062	0.0060	MARION
100068	0.0118	VOLUSIA
100072	0.0118	VOLUSIA
100077	0.0021	CHARLOTTE
100102	0.0133	COLUMBIA
100118* ...	0.0398	FLAGLER
100156	0.0133	COLUMBIA
100175	0.0231	DE SOTO
100212	0.0060	MARION
100232* ...	0.0347	PUTNAM
100236	0.0021	CHARLOTTE
100249* ...	0.0069	CITRUS
100252* ...	0.0233	OKEECHOBEE
110023* ...	0.0500	GORDON
110026	0.0220	ELBERT
110027	0.0387	FRANKLIN
110029* ...	0.0063	HALL
110041* ...	0.0777	HABERSHAM
110063	0.0290	LIBERTY
110069* ...	0.0474	HOUSTON
110120	0.0873	POLK
110124	0.0428	WAYNE
110136	0.0261	BALDWIN
110146	0.0642	CAMDEN
110150* ...	0.0261	BALDWIN
110153* ...	0.0474	HOUSTON
110187* ...	0.1172	LUMPKIN
110189* ...	0.0031	FANNIN
110190	0.0182	MACON
110205* ...	0.0779	GILMER
130003* ...	0.0095	NEZ PERCE
130011	0.0218	LATAH
130024	0.0275	BONNER
130049* ...	0.0349	KOOTENAI
140001	0.0199	FULTON
140012* ...	0.022	LEE
140026	0.0346	LA SALLE
140033	0.0147	LAKE
140043* ...	0.0046	WHITESIDE
140058* ...	0.0081	MORGAN
140084	0.0147	LAKE
140100	0.0147	LAKE
140110* ...	0.0346	LA SALLE
140129	0.0096	WABASH
140130	0.0147	LAKE
140155	0.0027	KANKAKEE
140160* ...	0.0286	STEPHENSON
140161* ...	0.0138	LIVINGSTON
140167* ...	0.0937	IROQUOIS
140173	0.0046	WHITESIDE
140186	0.0027	KANKAKEE
140199	0.0109	MONTGOMERY
140202	0.0147	LAKE
140205	0.0163	BOONE
140234* ...	0.0346	LA SALLE
140291* ...	0.0147	LAKE
150002* ...	0.0241	LAKE
150004* ...	0.0241	LAKE
150008* ...	0.0241	LAKE
150022	0.0249	MONTGOMERY
150030* ...	0.0201	HENRY

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

Provider number	Out-migration adjustment	Qualifying county name
150034	0.0241	LAKE
150035	0.0083	PORTER
150045	0.0416	DE KALB
150060	0.0052	VERMILLION
150062	0.0153	DECATUR
150065* ...	0.0139	JACKSON
150076* ...	0.0189	MARSHALL
150088* ...	0.0196	MADISON
150090* ...	0.0241	LAKE
150091	0.0573	HUNTINGTON
150102* ...	0.0160	STARKE
150113* ...	0.0196	MADISON
150122	0.0199	RIPLEY
150125* ...	0.0241	LAKE
150126* ...	0.0241	LAKE
150132* ...	0.0241	LAKE
150147* ...	0.0241	LAKE
150156	0.0241	LAKE
160013	0.0218	MUSCATINE
160026* ...	0.0496	BOONE
160030	0.0032	STORY
160032	0.0272	JASPER
160080* ...	0.0049	CLINTON
160140	0.0364	PLYMOUTH
170137* ...	0.0331	DOUGLAS
180012* ...	0.0083	HARDIN
180049	0.0532	MADISON
180055	0.0532	MADISON
180066* ...	0.0567	LOGAN
180127* ...	0.0352	FRANKLIN
180128	0.0282	LAWRENCE
190001* ...	0.0645	WASHINGTON
190003* ...	0.0107	IBERIA
190010	0.0401	TANGIPAHOA
190015* ...	0.0401	TANGIPAHOA
190017	0.0235	ST. LANDRY
190049	0.0645	WASHINGTON
190054	0.0107	IBERIA
190078	0.0235	ST. LANDRY
190086* ...	0.0129	LINCOLN
190088	0.0705	WEBSTER
190099* ...	0.039	AVOYELLES
190106* ...	0.0238	ALLEN
190116	0.0179	MOREHOUSE
190133	0.0238	ALLEN
190144	0.0705	WEBSTER
190147	0.0401	TANGIPAHOA
190148	0.039	AVOYELLES
190191* ...	0.0235	ST. LANDRY
200002* ...	0.0129	LINCOLN
200013	0.0186	WALDO
200019	0.0067	YORK
200020* ...	0.0067	YORK
200024* ...	0.0071	ANDROSCOGGIN
200032	0.046	OXFORD
200034* ...	0.0071	ANDROSCOGGIN
200040	0.0067	YORK
200050* ...	0.0140	HANCOCK
210001	0.0129	WASHINGTON
210004	0.0040	MONTGOMERY
210016	0.0040	MONTGOMERY
210018	0.0040	MONTGOMERY
210022	0.0040	MONTGOMERY
210023	0.0209	ANNE ARUNDEL
210028	0.0512	ST. MARYS
210043	0.0209	ANNE ARUNDEL
210048	0.0287	HOWARD

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

Provider number	Out-migration adjustment	Qualifying county name
210057	0.0040	MONTGOMERY
220001* ...	0.0056	WORCESTER
220002* ...	0.0249	MIDDLESEX
220003* ...	0.0056	WORCESTER
220006	0.0306	ESSEX
220010* ...	0.0306	ESSEX
220011* ...	0.0249	MIDDLESEX
220019* ...	0.0056	WORCESTER
220025* ...	0.0056	WORCESTER
220028* ...	0.0056	WORCESTER
220029* ...	0.0306	ESSEX
220033* ...	0.0306	ESSEX
220035* ...	0.0306	ESSEX
220049* ...	0.0249	MIDDLESEX
220058* ...	0.0056	WORCESTER
220062* ...	0.0056	WORCESTER
220063* ...	0.0249	MIDDLESEX
220070* ...	0.0249	MIDDLESEX
220076	0.0249	MIDDLESEX
220080* ...	0.0306	ESSEX
220082* ...	0.0249	MIDDLESEX
220084* ...	0.0249	MIDDLESEX
220089* ...	0.0249	MIDDLESEX
220090* ...	0.0056	WORCESTER
220095* ...	0.0056	WORCESTER
220098* ...	0.0249	MIDDLESEX
220101* ...	0.0249	MIDDLESEX
220105* ...	0.0249	MIDDLESEX
220163* ...	0.0056	WORCESTER
220171* ...	0.0249	MIDDLESEX
220174* ...	0.0306	ESSEX
230003	0.0035	OTTAWA
230005	0.0598	LENAWEE
230013	0.0091	OAKLAND
230015	0.0359	ST. JOSEPH
230019	0.0091	OAKLAND
230021	0.0136	BERRIEN
230022* ...	0.0113	BRANCH
230029	0.0091	OAKLAND
230037* ...	0.0178	HILLSDALE
230041	0.0099	BAY
230042* ...	0.0685	ALLEGAN
230047* ...	0.0082	MACOMB
230069* ...	0.0487	LIVINGSTON
230071	0.0091	OAKLAND
230072	0.0035	OTTAWA
230075	0.0145	CALHOUN
230078* ...	0.0136	BERRIEN
230092	0.0389	JACKSON
230093* ...	0.0079	MECOSTA
230096* ...	0.0359	ST. JOSEPH
230099* ...	0.0339	MONROE
230106	0.0030	NEWAYGO
230120	0.0598	LENAWEE
230121* ...	0.0691	SHIAWASSEE
230130	0.0091	OAKLAND
230151	0.0091	OAKLAND
230174	0.0035	OTTAWA
230184	0.0389	JACKSON
230195* ...	0.0082	MACOMB
230204* ...	0.0082	MACOMB
230207	0.0091	OAKLAND
230217* ...	0.0145	CALHOUN
230222	0.0228	MIDLAND
230223	0.0091	OAKLAND
230227* ...	0.0082	MACOMB
230254	0.0091	OAKLAND
230257* ...	0.0082	MACOMB
230264* ...	0.0082	MACOMB

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

Provider number	Out-migration adjustment	Qualifying county name
230269	0.0091	OAKLAND
230277	0.0091	OAKLAND
230279* ...	0.0487	LIVINGSTON
230295* ...	0.0685	ALLEGAN
240011	0.0506	MC LEOD
240013* ...	0.0226	MORRISON
240014	0.0454	RICE
240018* ...	0.1196	GOODHUE
240021	0.0897	LE SUEUR
240044	0.0868	WINONA
240064* ...	0.0138	ITASCA
240069* ...	0.0419	STEELE
240071* ...	0.0454	RICE
240089	0.1196	GOODHUE
240133	0.0319	MEEKER
240152* ...	0.0735	KANABEC
240154	0.0138	ITASCA
240187* ...	0.0506	MC LEOD
240205	0.0138	ITASCA
240211* ...	0.0705	PINE
250030	0.0318	LEAKE
250040* ...	0.0294	JACKSON
250045	0.0042	HANCOCK
250088	0.0122	WILKINSON
250154	0.0318	LEAKE
260011* ...	0.0007	COLE
260025* ...	0.0078	MARION
260047* ...	0.0007	COLE
260073	0.0197	BARTON
260074* ...	0.0158	RANDOLPH
260097	0.0425	JOHNSON
260127	0.0158	PIKE
280054	0.0137	GAGE
280077* ...	0.0089	DODGE
280123	0.0137	GAGE
290019* ...	0.0026	CARSON CITY
290020	0.1013	NYE
300007* ...	0.0080	HILLSBOROUGH
300011* ...	0.0080	HILLSBOROUGH
300012* ...	0.0080	HILLSBOROUGH
300017* ...	0.0361	ROCKINGHAM
300020* ...	0.0080	HILLSBOROUGH
300023* ...	0.0361	ROCKINGHAM
300029* ...	0.0361	ROCKINGHAM
300034* ...	0.0080	HILLSBOROUGH
310002* ...	0.0351	ESSEX
310009* ...	0.0351	ESSEX
310010	0.0180	MERCER
310011	0.0181	CAPE MAY
310013* ...	0.0351	ESSEX
310014	0.0156	CAMDEN
310018* ...	0.0351	ESSEX
310021	0.0180	MERCER
310022	0.0156	CAMDEN
310029	0.0156	CAMDEN
310031* ...	0.0137	BURLINGTON
310032* ...	0.0065	CUMBERLAND
310038* ...	0.0350	MIDDLESEX
310039	0.0350	MIDDLESEX
310044	0.0180	MERCER
310054* ...	0.0351	ESSEX
310057	0.0137	BURLINGTON
310061	0.0137	BURLINGTON
310070* ...	0.0350	MIDDLESEX
310076* ...	0.0351	ESSEX
310078* ...	0.0351	ESSEX
310083* ...	0.0351	ESSEX
310086	0.0156	CAMDEN
310092	0.0180	MERCER

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

Provider number	Out-migration adjustment	Qualifying county name
310093* ...	0.0351	ESSEX
310096* ...	0.0351	ESSEX
310108	0.0350	MIDDLESEX
310110	0.0180	MERCER
310119* ...	0.0351	ESSEX
320003	0.0630	SAN MIGUEL
320011	0.0442	RIO ARRIBA
320018	0.0063	DONA ANA
320085	0.0063	DONA ANA
330001* ...	0.0560	ORANGE
330004* ...	0.0959	ULSTER
330008* ...	0.0470	WYOMING
330027* ...	0.0137	NASSAU
330094* ...	0.0778	COLUMBIA
330106	0.0137	NASSAU
330126	0.0560	ORANGE
330135	0.0560	ORANGE
330167	0.0137	NASSAU
330175	0.0268	CORTLAND
330181* ...	0.0137	NASSAU
330182* ...	0.0137	NASSAU
330191* ...	0.0026	WARREN
330198	0.0137	NASSAU
330205	0.0560	ORANGE
330209	0.0560	ORANGE
330222	0.0003	SARATOGA
330224	0.0959	ULSTER
330225	0.0137	NASSAU
330235* ...	0.0270	CAYUGA
330259	0.0137	NASSAU
330264	0.0560	ORANGE
330276	0.0063	FULTON
330331	0.0137	NASSAU
330332	0.0137	NASSAU
330333	0.0137	NASSAU
330372	0.0137	NASSAU
330386* ...	0.1139	SULLIVAN
330402	0.0959	ULSTER
340003	0.0116	SURRY
340015	0.0267	ROWAN
340016	0.1312	JACKSON
340020	0.0207	LEE
340021* ...	0.0216	CLEVELAND
340027* ...	0.0126	LENOIR
340037	0.0216	CLEVELAND
340039* ...	0.0144	IREDELL
340069* ...	0.0053	WAKE
340070	0.0448	ALAMANCE
340073* ...	0.0053	WAKE
340085	0.0377	DAVIDSON
340088	0.0115	TRANSYLVANIA
340096	0.0377	DAVIDSON
340097	0.0116	SURRY
340104	0.0216	CLEVELAND
340114* ...	0.0053	WAKE
340126	0.0161	WILSON
340127* ...	0.0961	GRANVILLE
340129* ...	0.0144	IREDELL
340133	0.0302	MARTIN
340138* ...	0.0053	WAKE
340144* ...	0.0144	IREDELL
340145* ...	0.0563	LINCOLN
340173* ...	0.0053	WAKE
360013* ...	0.0166	SHELBY
360025* ...	0.0087	ERIE
360034	0.0263	WAYNE
360036* ...	0.0263	WAYNE
360040	0.0327	KNOX
360065* ...	0.0141	HURON

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

Provider number	Out-migration adjustment	Qualifying county name
360070	0.0028	STARK
360078* ...	0.0159	PORTAGE
360084	0.0028	STARK
360086* ...	0.0168	CLARK
360093	0.0120	DEFIANCE
360095	0.0087	HANCOCK
360096* ...	0.0031	COLUMBIANA
360099	0.0087	HANCOCK
360100	0.0028	STARK
360107* ...	0.0213	SANDUSKY
360131	0.0028	STARK
360151	0.0028	STARK
360156	0.0213	SANDUSKY
360175* ...	0.0159	CLINTON
360177	0.0212	FAYETTE
360185* ...	0.0031	COLUMBIANA
360187* ...	0.0168	CLARK
360197* ...	0.0092	LOGAN
370004* ...	0.0193	OTTAWA
370014* ...	0.0831	BRYAN
370015* ...	0.0463	MAYES
370023	0.0084	STEPHENS
370043	0.0294	MARSHALL
370065	0.0121	CRAIG
370113* ...	0.0205	DELAWARE
370138	0.0073	TEXAS
370149	0.0356	POTTAWATOMIE
370179* ...	0.0314	OKFUSKEE
380002	0.0130	JOSEPHINE
380008* ...	0.0201	LINN
380022* ...	0.0201	LINN
380029	0.0073	MARION
380051	0.0073	MARION
380056	0.0073	MARION
390011	0.0012	CAMBRIA
390030* ...	0.0274	SCHUYLKILL
390031* ...	0.0274	SCHUYLKILL
390044	0.0200	BERKS
390046	0.0098	YORK
390052* ...	0.0036	CLEARFIELD
390056	0.0042	HUNTINGDON
390065* ...	0.0501	ADAMS
390066* ...	0.0259	LEBANON
390086* ...	0.0036	CLEARFIELD
390096	0.0200	BERKS
390101	0.0098	YORK
390110* ...	0.0012	CAMBRIA
390130	0.0012	CAMBRIA
390138* ...	0.0325	FRANKLIN
390146	0.0053	WARREN
390150* ...	0.0206	GREENE
390151* ...	0.0325	FRANKLIN
390162	0.0149	NORTHAMPTON
390173	0.0074	INDIANA
390181* ...	0.0274	SCHUYLKILL
390183* ...	0.0274	SCHUYLKILL
390201* ...	0.1127	MONROE
390233	0.0098	YORK
420007	0.0001	SPARTANBURG
420009* ...	0.0162	OCONEE
420020* ...	0.0035	GEORGETOWN
420027	0.0210	ANDERSON
420030* ...	0.0103	COLLETON
420039* ...	0.0156	UNION
420043	0.0177	CHEROKEE
420062	0.0247	CHESTERFIELD
420068* ...	0.0097	ORANGEBURG
420070* ...	0.0101	SUMTER
420083	0.0001	SPARTANBURG

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

Provider number	Out-migration adjustment	Qualifying county name
420093	0.0001	SPARTANBURG
420098	0.0035	GEORGETOWN
430008	0.0504	BROOKINGS
430048	0.0088	LAWRENCE
430094* ...	0.0088	LAWRENCE
440008* ...	0.0663	HENDERSON
440016	0.0224	CARROLL
440024	0.0387	BRADLEY
440025	0.0037	GREENE
440033	0.0159	CAMPBELL
440035* ...	0.0441	MONTGOMERY
440047	0.0499	GIBSON
440050* ...	0.0037	GREENE
440051	0.0110	MC NAIRY
440056	0.0321	JEFFERSON
440060* ...	0.0499	GIBSON
440063	0.0011	WASHINGTON
440073* ...	0.0513	MAURY
440105	0.0011	WASHINGTON
440114	0.0523	LAUDERDALE
440115	0.0499	GIBSON
440143	0.0448	MARSHALL
440148* ...	0.0568	DE KALB
440153	0.0145	COCKE
440174	0.0372	HAYWOOD
440180* ...	0.0159	CAMPBELL
440181	0.0407	HARDEMAN
440182	0.0224	CARROLL
440184	0.0011	WASHINGTON
440185* ...	0.0387	BRADLEY
450032* ...	0.0416	HARRISON
450039* ...	0.0097	TARRANT
450050	0.0750	WARD
450059* ...	0.0073	COMAL
450064* ...	0.0097	TARRANT
450087* ...	0.0097	TARRANT
450099* ...	0.0180	GRAY
450113	0.0195	ANDERSON
450121* ...	0.0097	TARRANT
450135* ...	0.0097	TARRANT
450137* ...	0.0097	TARRANT

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

Provider number	Out-migration adjustment	Qualifying county name
450144* ...	0.0573	ANDREWS
450151	0.0210	FAYETTE
450163	0.0134	KLEBERG
450187* ...	0.0264	WASHINGTON
450194* ...	0.0328	CHEROKEE
450214* ...	0.0368	WHARTON
450224* ...	0.0411	WOOD
450347* ...	0.0427	WALKER
450362	0.0486	BURNET
450370	0.0258	COLORADO
450389* ...	0.0881	HENDERSON
450395	0.0484	POLK
450419* ...	0.0097	TARRANT
450438* ...	0.0258	COLORADO
450447* ...	0.0358	NAVARRO
450451* ...	0.0551	SOMERVELL
450465	0.0435	MATAGORDA
450547* ...	0.0411	WOOD
450563* ...	0.0097	TARRANT
450565	0.0492	PALO PINTO
450596	10.0808	HOOD
450597	0.0077	DE WITT
450623* ...	0.0492	FANNIN
450626	0.0294	JACKSON
450639* ...	0.0097	TARRANT
450672* ...	0.0097	TARRANT
450675* ...	0.0097	TARRANT
450677* ...	0.0097	TARRANT
450694* ...	0.0368	WHARTON
450747* ...	0.0195	ANDERSON
450755* ...	0.0484	HOCKLEY
450763	0.0236	HUTCHINSON
450779* ...	0.0097	TARRANT
450813	0.0195	ANDERSON
450858* ...	0.0097	TARRANT
460017	0.0392	BOX ELDER
460036* ...	0.0700	WASATCH
460039* ...	0.0392	BOX ELDER
470018	0.0287	WINDSOR
470023	0.0118	CALEDONIA
490019	0.1240	CULPEPER

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

Provider number	Out-migration adjustment	Qualifying county name
490038	0.0022	SMYTH
490047* ...	0.0198	PAGE
490084	0.0167	ESSEX
490105* ...	0.0022	SMYTH
490110	0.0082	MONTGOMERY
500003* ...	0.0208	SKAGIT
500007	0.0208	SKAGIT
500019	0.0213	LEWIS
500021	0.0055	PIERCE
500024* ...	0.0023	THURSTON
500039* ...	0.0174	KITSAP
500041* ...	0.0118	COWLITZ
500079	0.0055	PIERCE
500108	0.0055	PIERCE
500118	0.0548	MASON
500122* ...	0.0459	ISLAND
500129	0.0055	PIERCE
500139* ...	0.0023	THURSTON
500143* ...	0.0023	THURSTON
510018* ...	0.0209	JACKSON
510028* ...	0.0141	FAYETTE
510039	0.0112	OHIO
510047* ...	0.0275	MARION
510050	0.0112	OHIO
510077* ...	0.0021	MINGO
510088	0.0141	FAYETTE
520028* ...	0.0157	GREEN
520035	0.0077	SHEBOYGAN
520042	0.0118	SAUK
520044	0.0077	SHEBOYGAN
520057	0.0118	SAUK
520059* ...	0.0200	RACINE
520071* ...	0.0239	JEFFERSON
520076* ...	0.0181	DODGE
520094* ...	0.0200	RACINE
520095* ...	0.0118	SAUK
520096* ...	0.0200	RACINE
520102* ...	0.0298	WALWORTH
520116* ...	0.0239	JEFFERSON
520132	0.0077	SHEBOYGAN

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)

DRG	MDC	TYPE	DRG Title	Weights	Mean LOS	Mean LOS
1	01	SURG	CRANIOTOMY AGE >17 W CC	3.4276	7.6	10.1
2	01	SURG	CRANIOTOMY AGE >17 W/O CC	1.9544	3.5	4.6
3	01	SURG *	CRANIOTOMY AGE 0–17	1.9830	12.7	12.7
4	01	SURG	NO LONGER VALID	.0000	.0	.0
5	01	SURG	NO LONGER VALID	.0000	.0	0
6	01	SURG	CARPAL TUNNEL RELEASE	.7868	2.2	3.1
7	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.6679	6.6	9.5
8	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC.	1.5008	2.0	2.9
9	01	MED	SPINAL DISORDERS & INJURIES	1.3993	4.5	6.3
10	01	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2219	4.6	6.2
11	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	.8704	2.9	3.8
12	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	.8972	4.3	5.5
13	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	.8520	4.0	5.0
14	01	MED	INTRACRANIAL HEMORRHAGE OR STROKE WITH INFARCT	1.2533	4.5	5.8
15	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT.	.9402	3.7	4.6
16	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.3315	5.0	6.5
17	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	.7191	2.5	3.2
18	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	.9891	4.1	5.3
19	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	.7058	2.7	3.4

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	TYPE	DRG Title	Weights	Mean LOS	Mean LOS
20	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.7787	8.0	10.4
21	01	MED	VIRAL MENINGITIS	1.4424	4.9	6.4
22	01	MED	HYPERTENSIVE ENCEPHALOPATHY	1.1269	4.0	5.2
23	01	MED	NONTRAUMATIC STUPOR & COMA	.7695	3.0	3.9
24	01	MED	SEIZURE & HEADACHE AGE >17 W CC	.9954	3.6	4.8
25	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC	.6165	2.5	3.1
26	01	MED	SEIZURE & HEADACHE AGE 0–17	1.8098	3.4	6.3
27	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3455	3.2	5.1
28	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.3324	4.4	5.9
29	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	.7210	2.6	3.4
30	01	MED *	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	.3354	2.0	2.0
31	01	MED	CONCUSSION AGE >17 W CC	.9529	3.0	4.0
32	01	MED	CONCUSSION AGE >17 W/O CC	.6185	1.9	2.4
33	01	MED *	CONCUSSION AGE 0–17	.2106	1.6	1.6
34	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	1.0047	3.7	4.8
35	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	.6253	2.4	3.0
36	02	SURG	RETINAL PROCEDURES	.7238	1.3	1.6
37	02	SURG	ORBITAL PROCEDURES	1.1761	2.7	4.1
38	02	SURG	PRIMARY IRIS PROCEDURES	.6963	2.5	3.5
39	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	.7109	1.7	2.4
40	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	.9624	3.0	4.1
41	02	SURG *	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	.3414	1.6	1.6
42	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	.7865	2.0	2.8
43	02	MED	HYPHEMA	.6146	2.4	3.1
44	02	MED	ACUTE MAJOR EYE INFECTIONS	.6811	3.9	4.8
45	02	MED	NEUROLOGICAL EYE DISORDERS	.7462	2.5	3.1
46	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	.7471	3.2	4.2
47	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	.5189	2.3	2.9
48	02	MED *	OTHER DISORDERS OF THE EYE AGE 0–17	.3008	2.9	2.9
49	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.6375	3.2	4.4
50	03	SURG	SIALOADENECTOMY	.8661	1.5	1.8
51	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	.8829	1.9	2.8
52	03	SURG	CLEFT LIP & PALATE REPAIR	.8428	1.5	2.0
53	03	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.3302	2.5	4.0
54	03	SURG *	SINUS & MASTOID PROCEDURES AGE 0–17	.4874	3.2	3.2
55	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES.	.9577	2.1	3.1
56	03	SURG	RHINOPLASTY	.8623	1.9	2.6
57	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	1.1330	2.6	4.2
58	03	SURG *	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	.2768	1.5	1.5
59	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	.7950	1.8	2.5
60	03	SURG *	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	.2107	1.5	1.5
61	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.2804	3.3	5.4
62	03	SURG *	MYRINGOTOMY W TUBE INSERTION AGE 0–17	.2984	1.3	1.3
63	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.3908	3.0	4.5
64	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1606	4.1	6.1
65	03	MED	DYSEQUILIBRIUM	.5987	2.3	2.8
66	03	MED	EPISTAXIS	.5940	2.4	3.1
67	03	MED	EPIGLOTTITIS	.7724	2.9	3.7
68	03	MED	OTITIS MEDIA & URI AGE >17 W CC	.6646	3.2	4.0
69	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC	.4860	2.5	3.0
70	03	MED	OTITIS MEDIA & URI AGE 0–17	.4062	2.1	2.4
71	03	MED	LARYNGOTRACHEITIS	.7509	3.2	4.0
72	03	MED	NASAL TRAUMA & DEFORMITY	.7479	2.6	3.5
73	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	.8285	3.3	4.4
74	03	MED *	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17	.3393	2.1	2.1
75	04	SURG	MAJOR CHEST PROCEDURES	3.0699	7.6	9.9
76	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.8748	8.4	11.1
77	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.1897	3.4	4.7
78	04	MED	PULMONARY EMBOLISM	1.2411	5.4	6.4
79	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.6212	6.7	8.4
80	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC.	.8872	4.4	5.5
81	04	MED *	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	1.5360	6.1	6.1
82	04	MED	RESPIRATORY NEOPLASMS	1.3925	5.1	6.8
83	04	MED	MAJOR CHEST TRAUMA W CC	.9818	4.2	5.3
84	04	MED	MAJOR CHEST TRAUMA W/O CC	.5736	2.6	3.2
85	04	MED	PLEURAL EFFUSION W CC	1.2401	4.8	6.4

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	TYPE	DRG Title	Weights	Mean LOS	Mean LOS
86	04	MED	PLEURAL EFFUSION W/O CC	.6943	2.8	3.6
87	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3592	4.9	6.4
88	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	.8854	4.0	4.9
89	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0317	4.7	5.7
90	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	.6085	3.2	3.8
91	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	.8173	3.4	4.4
92	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.1859	4.9	6.1
93	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	.7022	3.1	3.8
94	04	MED	PNEUMOTHORAX W CC	1.1435	4.7	6.2
95	04	MED	PNEUMOTHORAX W/O CC	.6039	2.9	3.7
96	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC	.7356	3.6	4.4
97	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	.5340	2.8	3.4
98	04	MED *	BRONCHITIS & ASTHMA AGE 0–17	.5552	3.7	3.7
99	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	.7075	2.4	3.1
100	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	.5386	1.7	2.1
101	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	.8715	3.3	4.3
102	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	.5390	2.0	2.5
103	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	18.3069	23.5	37.5
104	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH.	8.2206	12.7	14.9
105	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH.	6.0149	8.5	10.2
106	05	SURG	CORONARY BYPASS W PTCA	7.0409	9.5	11.2
107	05	SURG	CORONARY BYPASS W CARDIAC CATH	5.4802	9.4	10.7
108	05	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.7861	8.6	10.9
109	05	SURG	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	4.0452	6.8	7.9
110	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	3.8908	5.8	8.4
111	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.4927	2.6	3.4
112	05	SURG	NO LONGER VALID	.0000	.0	.0
113	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	3.1547	10.8	13.7
114	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS.	1.7288	6.7	8.9
115	05	SURG	PRM CARD PACEM IMPL W AMI/HR/SHOCK OR AICD LEAD OR GNRTR.	3.5839	4.5	6.8
116	05	SURG	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	2.2975	3.0	4.3
117	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.	1.3232	2.6	4.2
118	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.6347	2.1	3.0
119	05	SURG	VEIN LIGATION & STRIPPING	1.3473	3.3	5.5
120	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.3814	5.9	9.2
121	05	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE.	1.6110	5.3	6.6
122	05	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.	.9818	2.8	3.5
123	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.5321	2.9	4.8
124	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.4417	3.3	4.4
125	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	1.0932	2.1	2.7
126	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.7261	9.4	11.9
127	05	MED	HEART FAILURE & SHOCK	1.0330	4.1	5.2
128	05	MED	DEEP VEIN THROMBOPHLEBITIS	.6919	4.4	5.2
129	05	MED	CARDIAC ARREST, UNEXPLAINED	1.0365	1.7	2.6
130	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	.9412	4.4	5.5
131	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	.5555	3.2	3.9
132	05	MED	ATHEROSCLEROSIS W CC	.6252	2.2	2.8
133	05	MED	ATHEROSCLEROSIS W/O CC	.5323	1.8	2.2
134	05	MED	HYPERTENSION	.6057	2.5	3.1
135	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC.	.8969	3.3	4.4
136	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.	.6228	2.2	2.8
137	05	MED *	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	.8275	3.3	3.3
138	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	.8313	3.1	3.9
139	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	.5222	2.0	2.4
140	05	MED	ANGINA PECTORIS	.5076	2.0	2.4
141	05	MED	SYNCOPE & COLLAPSE W CC	.7513	2.7	3.5
142	05	MED	SYNCOPE & COLLAPSE W/O CC	.5848	2.0	2.5
143	05	MED	CHEST PAIN	.5655	1.7	2.1

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	TYPE	DRG Title	Weights	Mean LOS	Mean LOS
144	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.2734	4.1	5.8
145	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	.5843	2.1	2.6
146	06	SURG	RECTAL RESECTION W CC	2.6565	8.6	10.0
147	06	SURG	RECTAL RESECTION W/O CC	1.4778	5.2	5.8
148	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.4400	10.0	12.3
149	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.4304	5.4	6.0
150	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.7986	8.9	11.0
151	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.2620	4.0	5.1
152	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.8768	6.7	8.0
153	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.0833	4.5	5.0
154	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	4.0333	9.9	13.2
155	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.2855	3.1	4.1
156	06	SURG *	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17.	.8522	6.0	6.0
157	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.3317	4.1	5.8
158	06	SURG	ANAL & STOMAL PROCEDURES W/O CC	.6634	2.1	2.6
159	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.4163	3.8	5.1
160	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	.8423	2.2	2.7
161	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.1998	3.1	4.4
162	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC.	.6763	1.7	2.1
163	06	SURG	HERNIA PROCEDURES AGE 0–17	.6711	2.2	2.9
164	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.2488	6.6	8.0
165	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.1833	3.6	4.2
166	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4517	3.3	4.5
167	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	.8918	1.9	2.2
168	03	SURG	MOUTH PROCEDURES W CC	1.2650	3.3	4.9
169	03	SURG	MOUTH PROCEDURES W/O CC	.7251	1.8	2.3
170	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.9522	7.8	11.0
171	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.1837	3.1	4.1
172	06	MED	DIGESTIVE MALIGNANCY W CC	1.4115	5.1	7.0
173	06	MED	DIGESTIVE MALIGNANCY W/O CC	.7442	2.7	3.6
174	06	MED	G.I. HEMORRHAGE W CC	1.0138	3.8	4.7
175	06	MED	G.I. HEMORRHAGE W/O CC	.5644	2.4	2.9
176	06	MED	COMPLICATED PEPTIC ULCER	1.1228	4.1	5.2
177	06	MED	UNCOMPLICATED PEPTIC ULCER W CC	.9158	3.6	4.4
178	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	.7014	2.6	3.1
179	06	MED	INFLAMMATORY BOWEL DISEASE	1.0877	4.5	5.9
180	06	MED	G.I. OBSTRUCTION W CC	.9769	4.2	5.4
181	06	MED	G.I. OBSTRUCTION W/O CC	.5609	2.8	3.3
182	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC.	.8463	3.4	4.5
183	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	.5846	2.3	2.9
184	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17.	.5700	2.5	3.3
185	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	.8689	3.3	4.5
186	03	MED *	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17.	.3248	2.9	2.9
187	03	MED	DENTAL EXTRACTIONS & RESTORATIONS	.8435	3.1	4.2
188	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.1257	4.2	5.6
189	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	.6052	2.4	3.1
190	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	.6258	3.2	4.4
191	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	3.9443	9.0	12.8
192	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.6802	4.3	5.7
193	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.2837	9.9	12.1
194	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.5786	5.6	6.7
195	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	3.0503	8.8	10.6
196	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6011	4.9	5.7
197	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	2.5397	7.5	9.2
198	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.1571	3.7	4.3

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	TYPE	DRG Title	Weights	Mean LOS	Mean LOS
199	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.4077	6.8	9.5
200	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.	2.7777	6.4	9.8
201	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.7156	9.9	13.8
202	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3463	4.7	6.3
203	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.3719	4.9	6.6
204	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.1216	4.2	5.6
205	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W CC	1.2026	4.4	6.0
206	07	MED	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC.	.7289	3.0	3.9
207	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.1730	4.1	5.3
208	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC	.6880	2.3	2.9
209	08	SURG	NO LONGER VALID	.0000	17.1	17.1
210	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	1.9035	6.1	6.9
211	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.2676	4.4	4.7
212	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17	1.2786	2.4	2.9
213	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	2.0393	7.2	9.7
214	08	SURG	NO LONGER VALID	.0000	.0	.0
215	08	SURG	NO LONGER VALID	.0000	.0	.0
216	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	1.9099	3.3	5.8
217	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS.	3.0414	9.3	13.2
218	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.	1.6068	4.3	5.5
219	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC.	1.0427	2.6	3.1
220	08	SURG *	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17.	.5904	5.3	5.3
221	08	SURG	NO LONGER VALID	.0000	.0	.0
222	08	SURG	NO LONGER VALID	.0000	.0	.0
223	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	1.1119	2.3	3.2
224	08	SURG	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC.	.8172	1.6	1.9
225	08	SURG	FOOT PROCEDURES	1.2189	3.7	5.2
226	08	SURG	SOFT TISSUE PROCEDURES W CC	1.5839	4.5	6.5
227	08	SURG	SOFT TISSUE PROCEDURES W/O CC	.8338	2.1	2.6
228	08	SURG	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC.	1.1414	2.8	4.1
229	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	.6957	1.9	2.5
230	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.3137	3.7	5.6
231	08	SURG	NO LONGER VALID	.0000	.0	.0
232	08	SURG	ARTHROSCOPY	.9699	1.8	2.8
233	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.9137	4.6	6.8
234	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC.	1.2204	2.0	2.8
235	08	MED	FRACTURES OF FEMUR	.7770	3.8	4.8
236	08	MED	FRACTURES OF HIP & PELVIS	.7393	3.8	4.6
237	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	.6084	3.0	3.7
238	08	MED	OSTEOMYELITIS	1.4237	6.7	8.6
239	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	1.0758	5.0	6.2
240	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.4024	5.0	6.7
241	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC	.6613	3.0	3.7
242	08	MED	SEPTIC ARTHRITIS	1.1452	5.1	6.7
243	08	MED	MEDICAL BACK PROBLEMS	.7752	3.6	4.6
244	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	.7098	3.6	4.5
245	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	.4555	2.5	3.1
246	08	MED	NON-SPECIFIC ARTHROPATHIES	.5910	2.8	3.6
247	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	.5787	2.6	3.3
248	08	MED	TENDONITIS, MYOSITIS & BURSITIS	.8556	3.8	4.8
249	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	.7025	2.7	3.8

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	TYPE	DRG Title	Weights	Mean LOS	Mean LOS
250	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	.6949	3.2	3.9
251	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	.4752	2.3	2.8
252	08	MED *	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	.2563	1.8	1.8
253	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W CC.	.7734	3.8	4.6
254	08	MED	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O CC.	.4588	2.6	3.1
255	08	MED *	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17.	.2985	2.9	2.9
256	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	.8459	3.9	5.1
257	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	.8958	2.0	2.6
258	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.7129	1.5	1.7
259	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	.9650	1.8	2.8
260	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	.7028	1.2	1.4
261	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	.9710	1.6	2.2
262	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	.9783	3.4	4.8
263	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC.	2.1033	8.5	11.4
264	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.0576	5.0	6.5
265	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.6577	4.4	6.7
266	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	.8664	2.3	3.2
267	09	SURG	PERIANAL & PILONIDAL PROCEDURES	.8946	2.8	4.2
268	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES.	1.1389	2.4	3.5
269	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.8291	6.2	8.6
270	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	.8270	2.7	3.8
271	09	MED	SKIN ULCERS	1.0072	5.5	7.0
272	09	MED	MAJOR SKIN DISORDERS W CC	.9814	4.5	5.9
273	09	MED	MAJOR SKIN DISORDERS W/O CC	.5536	2.9	3.7
274	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1223	4.7	6.3
275	09	MED	MALIGNANT BREAST DISORDERS W/O CC	.5302	2.4	3.2
276	09	MED	NON-MALIGANT BREAST DISORDERS	.6879	3.5	4.5
277	09	MED	CELLULITIS AGE >17 W CC	.8652	4.6	5.6
278	09	MED	CELLULITIS AGE >17 W/O CC	.5371	3.4	4.1
279	09	MED *	CELLULITIS AGE 0–17	.7810	4.2	4.2
280	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC.	.7309	3.2	4.1
281	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC.	.4897	2.3	2.9
282	09	MED *	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	.2596	2.2	2.2
283	09	MED	MINOR SKIN DISORDERS W CC	.7398	3.5	4.6
284	09	MED	MINOR SKIN DISORDERS W/O CC	.4563	2.4	3.0
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT,& METABOL DISORDERS.	2.1793	8.2	10.5
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	1.9353	4.0	5.5
287	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.9237	7.8	10.3
288	10	SURG	O.R. PROCEDURES FOR OBESITY	2.0358	3.2	4.1
289	10	SURG	PARATHYROID PROCEDURES	.9314	1.7	2.6
290	10	SURG	THYROID PROCEDURES	.8875	1.6	2.1
291	10	SURG	THYROGLOSSAL PROCEDURES	1.1155	1.5	2.8
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.6316	7.3	10.3
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.3434	3.2	4.5
294	10	MED	DIABETES AGE >35	.7642	3.3	4.3
295	10	MED	DIABETES AGE 0–35	.7250	2.9	3.7
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	.8175	3.7	4.8
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC.	.4845	2.5	3.1
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	.5246	2.5	4.0
299	10	MED	INBORN ERRORS OF METABOLISM	1.0293	3.7	5.2
300	10	MED	ENDOCRINE DISORDERS W CC	1.0918	4.6	6.0
301	10	MED	ENDOCRINE DISORDERS W/O CC	.6113	2.7	3.4
302	11	SURG	KIDNEY TRANSPLANT	3.1542	7.0	8.2

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	TYPE	DRG Title	Weights	Mean LOS	Mean LOS
303	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.2358	5.9	7.4
304	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.3647	6.1	8.6
305	11	SURG	KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1580	2.6	3.2
306	11	SURG	PROSTATECTOMY W CC	1.2674	3.6	5.5
307	11	SURG	PROSTATECTOMY W/O CC	.6192	1.7	2.1
308	11	SURG	MINOR BLADDER PROCEDURES W CC	1.6518	4.0	6.2
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	.9082	1.6	2.0
310	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.1948	3.1	4.5
311	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	.6425	1.5	1.9
312	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	1.1170	3.2	4.8
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	.6756	1.8	2.2
314	11	SURG *	URETHRAL PROCEDURES, AGE 0–17	.5004	2.3	2.3
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0801	3.6	6.8
316	11	MED	RENAL FAILURE	1.2673	4.9	6.4
317	11	MED	ADMIT FOR RENAL DIALYSIS	.7965	2.4	3.5
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1535	4.2	5.8
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	.6388	2.1	2.8
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	.8644	4.2	5.2
321	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	.5644	3.0	3.6
322	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	.5569	2.9	3.5
323	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	.8200	2.3	3.1
324	11	MED	URINARY STONES W/O CC	.5045	1.6	1.9
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC.	.6417	2.9	3.7
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC.	.4385	2.1	2.6
327	11	MED *	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	.3742	3.1	3.1
328	11	MED	URETHRAL STRICTURE AGE >17 W CC	.7085	2.6	3.5
329	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	.4712	1.5	1.8
330	11	MED *	URETHRAL STRICTURE AGE 0–17	.3222	1.6	1.6
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC.	1.0606	4.1	5.5
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC.	.6119	2.4	3.1
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	.9788	3.6	5.4
334	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.4366	3.5	4.3
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.0980	2.4	2.7
336	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	.8409	2.5	3.3
337	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	.5737	1.7	1.9
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.3738	3.9	6.2
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.1809	3.2	5.1
340	12	SURG *	TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	.2864	2.4	2.4
341	12	SURG	PENIS PROCEDURES	1.2585	1.9	3.2
342	12	SURG	CIRCUMCISION AGE >17	.8721	2.5	3.4
343	12	SURG *	CIRCUMCISION AGE 0–17	.1557	1.7	1.7
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	1.2458	1.7	2.7
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	1.1474	3.1	4.8
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	1.0439	4.2	5.7
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	.6080	2.2	3.0
348	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	.7191	3.2	4.1
349	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	.4223	1.9	2.4
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	.7274	3.5	4.5
351	12	MED *	STERILIZATION, MALE	.2389	1.3	1.3
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	.7388	2.9	4.0
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.8474	4.7	6.3
354	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC.	1.5238	4.6	5.7
355	13	SURG	UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC.	.8834	2.8	3.1
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	.7429	1.7	1.9
357	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.2212	6.5	8.1
358	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1428	3.2	4.0

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	TYPE	DRG Title	Weights	Mean LOS	Mean LOS
359	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	.7936	2.2	2.4
360	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	.8559	2.0	2.6
361	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.0844	2.2	3.0
362	13	SURG *	ENDOSCOPIC TUBAL INTERRUPTION	.3053	1.4	1.4
363	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	.9742	2.7	3.8
364	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	.8710	3.0	4.2
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	2.0317	5.3	7.7
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.2296	4.8	6.5
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	.5734	2.3	3.0
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.1668	5.2	6.7
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	.6297	2.4	3.2
370	14	SURG	CESAREAN SECTION W CC	.8956	4.1	5.2
371	14	SURG	CESAREAN SECTION W/O CC	.6037	3.1	3.4
372	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	.5047	2.6	3.2
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	.3562	2.0	2.2
374	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	.6762	2.4	2.7
375	14	SURG *	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	.5829	4.4	4.4
376	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	.5215	2.6	3.4
377	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	1.6547	2.9	4.5
378	14	MED	ECTOPIC PREGNANCY	.7508	1.9	2.3
379	14	MED	THREATENED ABORTION	.3590	2.0	2.8
380	14	MED	ABORTION W/O D&C	.3913	1.6	2.1
381	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY.	.6059	1.7	2.3
382	14	MED	FALSE LABOR	.2071	1.3	1.4
383	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS.	.5053	2.6	3.7
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	.3187	1.8	2.6
385	15	MED *	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.3909	1.8	1.8
386	15	MED *	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	4.5865	17.9	17.9
387	15	MED *	PREMATURITY W MAJOR PROBLEMS	3.1325	13.3	13.3
388	15	MED *	PREMATURITY W/O MAJOR PROBLEMS	1.8900	8.6	8.6
389	15	MED *	FULL TERM NEONATE W MAJOR PROBLEMS	3.2177	4.7	4.7
390	15	MED *	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1388	3.4	3.4
391	15	MED *	NORMAL NEWBORN	.1542	3.1	3.1
392	16	SURG	SPLENECTOMY AGE >17	3.0278	6.5	9.2
393	16	SURG *	SPLENECTOMY AGE 0–17	1.3624	9.1	9.1
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.9019	4.5	7.4
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	.8303	3.2	4.3
396	16	MED *	RED BLOOD CELL DISORDERS AGE 0–17	2.5374	4.1	4.1
397	16	MED	COAGULATION DISORDERS	1.3113	3.8	5.2
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.2212	4.5	5.8
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	.6665	2.7	3.3
400	17	SURG	NO LONGER VALID	.0000	.0	.0
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC.	2.9643	8.0	11.3
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	1.1793	2.8	4.1
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.8406	5.8	8.1
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	.9244	3.0	4.2
405	17	MED *	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17	1.9316	4.9	4.9
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.	2.7989	7.0	9.9
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC.	1.2325	3.0	3.8
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC.	2.2303	4.8	8.2
409	17	MED	RADIOTHERAPY	1.2066	4.3	5.8
410	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	1.1022	3.0	3.8
411	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY	.3645	2.5	3.3
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	.8442	1.8	2.8

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	TYPE	DRG Title	Weights	Mean LOS	Mean LOS
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC.	1.3035	5.0	6.8
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC.	.7784	3.0	4.0
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.9753	11.0	14.8
416	18	MED	SEPTICEMIA AGE >17	1.6705	5.6	7.5
417	18	MED	SEPTICEMIA AGE 0–17	1.2962	3.6	5.3
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.1035	4.9	6.4
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	.8526	3.4	4.4
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	.6088	2.7	3.4
421	18	MED	VIRAL ILLNESS AGE >17	.7680	3.1	4.1
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	.6185	2.6	3.7
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.9163	6.0	8.4
424	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS.	2.2400	7.3	11.7
425	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION.	.6187	2.6	3.5
426	19	MED	DEPRESSIVE NEUROSES	.4655	3.0	4.1
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	.5159	3.2	4.7
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	.6944	4.6	7.2
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	.7893	4.3	5.6
430	19	MED	PSYCHOSES	.6306	5.6	7.7
431	19	MED	CHILDHOOD MENTAL DISORDERS	.5194	4.0	5.9
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES	.6322	2.9	4.3
433	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	.2774	2.2	3.0
434	20	MED	NO LONGER VALID	.0000	.0	.0
435	20	MED	NO LONGER VALID	.0000	.0	.0
436	20	MED	NO LONGER VALID	.0000	.0	.0
437	20	MED	NO LONGER VALID	.0000	.0	.0
438	20		NO LONGER VALID	.0000	.0	.0
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.9204	5.4	8.8
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.9346	5.9	9.2
441	21	SURG	HAND PROCEDURES FOR INJURIES	.9334	2.3	3.4
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.5647	6.0	8.9
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.9911	2.6	3.4
444	21	MED	TRAUMATIC INJURY AGE >17 W CC	.7540	3.2	4.1
445	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	.5016	2.3	2.8
446	21	MED *	TRAUMATIC INJURY AGE 0–17	.2995	2.4	2.4
447	21	MED	ALLERGIC REACTIONS AGE >17	.5572	1.9	2.6
448	21	MED *	ALLERGIC REACTIONS AGE 0–17	.0985	2.9	2.9
449	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	.8509	2.6	3.7
450	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	.4288	1.6	2.0
451	21	MED *	POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	.2658	2.1	2.1
452	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0388	3.5	4.9
453	21	MED	COMPLICATIONS OF TREATMENT W/O CC	.5278	2.2	2.8
454	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	.8128	2.9	4.1
455	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	.4700	1.7	2.2
456	22		NO LONGER VALID	.0000	.0	.0
457	22	MED	NO LONGER VALID	.0000	.0	.0
458	22	SURG	NO LONGER VALID	.0000	.0	.0
459	22	SURG	NO LONGER VALID	.0000	.0	.0
460	22	MED	NO LONGER VALID	.0000	.0	.0
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	1.3957	3.0	5.1
462	23	MED	REHABILITATION	.8496	8.8	10.7
463	23	MED	SIGNS & SYMPTOMS W CC	.6946	3.1	3.9
464	23	MED	SIGNS & SYMPTOMS W/O CC	.5057	2.4	2.9
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.6015	2.4	3.6
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.6922	2.7	4.7
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.4789	2.0	2.7
468			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.9877	9.7	13.2
469		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.0000	.0	.0
470		**	UNGROUPABLE	.0000	.0	.0
471	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.	3.1328	4.5	5.1
472	22	SURG	NO LONGER VALID	.0000	.0	.0
473	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.4949	7.6	12.9

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	TYPE	DRG Title	Weights	Mean LOS	Mean LOS
474	04	SURG	NO LONGER VALID	.0000	.0	.0
475	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT.	3.5930	8.1	11.3
476		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.1792	7.4	10.5
477		SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.0539	5.8	8.7
478	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.4118	4.7	7.2
479	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4433	2.1	2.8
480	PRE	SURG	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT	8.9426	13.7	17.9
481	PRE	SURG	BONE MARROW TRANSPLANT	6.2341	18.3	21.8
482	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	3.3281	9.7	12.1
483	PRE	SURG	NO LONGER VALID	.0000	.0	.0
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.1050	9.3	12.8
485	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA.	3.4619	8.3	10.2
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.	4.7225	8.5	12.4
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.9309	5.3	7.3
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.4100	11.7	16.4
489	25	MED	HIV W MAJOR RELATED CONDITION	1.8294	6.0	8.5
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0638	3.9	5.4
491	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.6734	2.6	3.1
492	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT.	3.5856	8.8	13.6
493	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8413	4.6	6.1
494	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.0275	2.1	2.7
495	PRE	SURG	LUNG TRANSPLANT	8.5766	13.9	17.3
496	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	6.2260	6.6	9.0
497	08	SURG	SPINAL FUSION EXCEPT CERVICAL W CC	3.6385	5.0	5.9
498	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O CC	2.7792	3.4	3.8
499	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.3903	3.1	4.3
500	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	.9033	1.8	2.2
501	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.6488	8.5	10.4
502	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.4419	4.9	5.8
503	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2014	2.9	3.8
504	22	SURG	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/SKIN GFT.	11.6990	21.6	27.3
505	22	MED	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/O SKIN GFT.	2.3035	2.4	4.7
506	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	4.1098	11.2	15.9
507	22	SURG	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	1.7419	5.9	8.5
508	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	1.2672	5.1	7.3
509	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	.8233	3.6	5.2
510	22	MED	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.1808	4.4	6.5
511	22	MED	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	.7452	2.7	4.1
512	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.3328	10.7	12.8
513	PRE	SURG	PANCREAS TRANSPLANT	5.9670	8.9	10.0
514	05	SURG	NO LONGER VALID	.0000	.0	.0
515	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	5.5196	2.6	4.3
516	05	SURG	NO LONGER VALID	.0000	.0	.0
517	05	SURG	PERC CARDIO PROC W NON-DRUG ELUTING STENT W/O AMI	2.0601	1.8	2.6
518	05	SURG	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	1.7772	2.3	3.5
519	08	SURG	CERVICAL SPINAL FUSION W CC	2.4826	3.0	4.8
520	08	SURG	CERVICAL SPINAL FUSION W/O CC	1.6774	1.6	2.0
521	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	.6935	4.2	5.6
522	20	MED	ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC.	.4767	7.7	9.6
523	20	MED	ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC.	.3785	3.2	3.9
524	01	MED	TRANSIENT ISCHEMIA	.7274	2.6	3.2
525	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT	11.5451	7.3	13.9
526	05	SURG	NO LONGER VALID	.0000	.0	.0
527	05	SURG	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W/O AMI.	2.3161	1.6	2.2

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	TYPE	DRG Title	Weights	Mean LOS	Mean LOS
528	01	SURG	INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	7.0396	13.8	17.2
529	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	2.3118	5.3	8.3
530	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC	1.2020	2.4	3.1
531	01	SURG	SPINAL PROCEDURES W CC	3.1221	6.5	9.6
532	01	SURG	SPINAL PROCEDURES W/O CC	1.4172	2.8	3.7
533	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.5728	2.4	3.7
534	01	SURG	EXTRACRANIAL PROCEDURES W/O CC	1.0198	1.5	1.8
535	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	8.0777	8.0	10.4
536	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK.	6.9110	5.9	7.7
537	08	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W CC.	1.8333	4.8	6.9
538	08	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC.	.9815	2.1	2.8
539	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC	3.2371	7.0	10.8
540	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC	1.1892	2.6	3.6
541	PRE	SURG	ECMO OR TRACH W MV 96+HRS OR PDX EXC FACE, MTH, FACE&NECK DX W/MAJ OR.	19.6693	38.0	45.4
542	PRE	SURG	TRACH W MV 96+HRS OR PDX EXC FACE, MTH, FACE&NECK DX W/O MJ OR.	12.7797	29.0	34.9
543	01	SURG	CRANIOTOMY W/IMPLANT OF CHEMO AGENT OR ACUTE COMPLX CNS PDX.	4.4062	8.5	12.2
544	08	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY.	1.9612	4.1	4.6
545	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT	2.4781	4.5	5.2
546	08	SURG	SPINAL FUSION EXC CERV WITH PDX OF CURVATURE OF THE SPINE OR MALIG.	5.0779	7.2	9.1
547	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W AMI W CC	2.8246	4.4	5.6
548	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W AMI W/O CC	2.0984	2.7	3.0
549	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG ELUTING STENT W AMI W CC.	3.2154	4.1	5.2
550	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG ELUTING STENT W AMI W/O CC.	2.5116	2.5	2.9

*Medicare data has been supplemented by data from 19 States for low-volume DRGs.
**DRGs 469 and 470 contain cases which could not be assigned to valid DRGs.
Note: Geometric mean is used only to determine payment for transfer cases.
Note: Arithmetic means are presented for informational purposes only.
Note: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
259.5	Androgen insensitivity syndrome	N	10	300, 301
276.50	Volume depletion, unspecified	Y	10	296, 297, 298
			15	387,[1] 3891
			[2]25	490
276.51	Dehydration	Y	10	296, 297, 298
			15	387,[1] 389[1]
			[2]52	490
276.52	Hypovolemia	Y	10	296, 297, 298
			15	387,[1] 389[1]
			[2]52	490
278.02	Overweight	N	10	296, 297, 298
287.30	Primary thrombocytopenia, unspecified	Y	16	397
287.31	Immune thrombocytopenic purpura	Y	16	397
287.32	Evans' syndrome	Y	16	397
287.33	Congenital and hereditary thrombocytopenic purpura	Y	16	397
287.39	Other primary thrombocytopenia	Y	16	397
291.82	Alcohol induced sleep disorders	N	20	521, 522, 523
292.85	Drug induced sleep disorders	N	20	521, 522, 523
327.00	Organic insomnia, unspecified	N	19	432
327.01	Insomnia due to medical condition classified elsewhere	N	19	432
327.02	Insomnia due to mental disorder	N	19	432
327.09	Other organic insomnia	N	19	432
327.10	Organic hypersomnia, unspecified	N	19	432
327.11	Idiopathic hypersomnia with long sleep time	N	19	432
327.12	Idiopathic hypersomnia without long sleep time	N	19	432

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
327.13	Recurrent hypersomnia	N	19	432
327.14	Hypersomnia due to medical condition	N	19	432
327.15	Hypersomnia due to mental disorder	N	19	432
327.19	Other organic hypersomnia	N	19	432
327.20	Organic sleep apnea, unspecified	N	PRE	482
			3	73, 74
327.21	Primary central sleep apnea	N	PRE	482
			1	34, 35
327.22	High altitude periodic breathing	N	PRE	482
			4	99, 100
327.23	Obstructive sleep apnea (adult) (pediatric)	N	PRE	482
			3	73, 74
327.24	Idiopathic sleep related non-obstructive alveolar hypoventilation	N	PRE	482
			3	73, 74
327.26	Sleep related hypoventilation/hypoxemia in conditions classifiable elsewhere	N	PRE	482
			3	73, 74
327.27	Central sleep apnea in conditions classified elsewhere	N	PRE	482
			1	34, 35
327.29	Other organic sleep apnea	N	PRE	482
			3	73, 74
362.03	Nonproliferative diabetic retinopathy NOS	N	2	46, 47, 48
362.04	Mild nonproliferative diabetic retinopathy	N	2	46, 47, 48
362.05	Moderate nonproliferative diabetic retinopathy	N	2	46, 47, 48
362.06	Severe nonproliferative diabetic retinopathy	N	2	46, 47, 48
362.07	Diabetic macular edema	N	2	46, 47, 48
426.82	Long QT syndrome	N	5	138, 139
443.82	Erythromelalgia	N	5	130, 131
525.40	Complete edentulism, unspecified	N	PRE	482
			3	185, 186, 187
525.41	Complete edentulism, class I	N	PRE	482
			3	185, 186, 187
525.42	Complete edentulism, class II	N	PRE	482
			3	185, 186, 187
525.43	Complete edentulism, class III	N	PRE	482
			3	185, 186, 187
525.44	Complete edentulism, class IV	N	PRE	482
			3	185, 186, 187
525.50	Partial edentulism, unspecified	N	PRE	482
			3	185, 186, 187
525.51	Partial edentulism, class I	N	PRE	482
			3	185, 186, 187
525.52	Partial edentulism, class II	N	PRE	482
			3	185, 186, 187
525.53	Partial edentulism, class III	N	PRE	482
			3	185, 186, 187
525.54	Partial edentulism, class IV	N	PRE	482
			3	185, 186, 187
567.21	Peritonitis (acute) generalized	Y	6	188, 189, 190
			15	387,[1] 389[1]
567.22	Peritoneal abscess	Y	6	188, 189, 190
			15	387,[1] 389[1]
567.23	Spontaneous bacterial peritonitis	Y	6	188, 189, 190
			15	387,[1] 389[1]
567.29	Other suppurative peritonitis	Y	6	188, 189, 190
			15	387,[1] 389[1]
567.38	Other retroperitoneal abscess	Y	6	188, 189, 190
			15	387,[1] 389[1]
567.39	Other retroperitoneal infections	Y	6	188, 189, 190
			15	387,[1] 389[1]
567.81	Choleperitonitis	Y	6	188, 189, 190
			15	387,[1] 389[1]
567.82	Sclerosing mesenteritis	Y	6	188, 189, 190
			15	387,[1] 389[1]
567.89	Other specified peritonitis	Y	6	188, 189, 190
			15	387,[1] 389[1]
585.1	Chronic kidney disease, Stage I	Y	PRE	512, 513
			11	315, 316
585.2	Chronic kidney disease, Stage II (mild)	Y	PRE	512, 513
			11	315, 316
585.3	Chronic kidney disease, Stage III (moderate)	Y	PRE	512, 513
			11	315, 316

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
585.4	Chronic kidney disease, Stage IV (severe)	Y	PRE 11	512, 513 315, 316
585.5	Chronic kidney disease, Stage V	Y	PRE 11	512, 513 315, 316
585.6	End stage renal disease	Y	PRE 11	512, 513 315, 316
585.9	Chronic kidney disease, unspecified	Y	PRE 11	512, 513 315, 316
599.60	Urinary obstruction, unspecified	Y 11	15	331, 332, 333 387,[1] 389[1]
599.69	Urinary obstruction, not elsewhere classified	Y	11 15	331, 332, 333 387,[1] 389[1]
651.70	Multiple gestation following (elective) fetal reduction, unspecified as to episode of care or not applicable.	N	14	469
651.71	Multiple gestation following (elective) fetal reduction, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
651.73	Multiple gestation following (elective) fetal reduction, antepartum condition or complication	N	14	383, 384
760.77	Anticonvulsants	N	15	390
760.78	Antimetabolic agents	N	15	390
763.84	Meconium passage during delivery	N	15	390
770.10	Fetal and newborn aspiration, unspecified	N	15	387,[3] 389[3]
770.11	Meconium aspiration without respiratory symptoms	N	15	387,[3] 389[3]
770.12	Meconium aspiration with respiratory symptoms	Y	15	387,[3] 389[3]
770.17	Other fetal and newborn aspiration without respiratory symptoms	N	15	387,[3] 389[3]
770.18	Other fetal and newborn aspiration with respiratory symptoms	Y	15	387,[3] 389[3]
779.84	Meconium staining	N	15	390
780.95	Other excessive crying	N	23	463, 464
799.01	Asphyxia	Y	4	101, 102
799.02	Hypoxemia	Y	4	101, 102
996.40	Unspecified mechanical complication of internal orthopedic device, implant, and graft	Y	8	249
996.41	Mechanical loosening of prosthetic joint	Y	8	249
996.42	Dislocation of prosthetic joint	Y	8	249
996.43	Prosthetic joint implant failure	Y	8	249
996.44	Peri-prosthetic fracture around prosthetic joint	Y	8	249
996.45	Peri-prosthetic osteolysis	Y	8	249
996.46	Articular bearing surface wear of prosthetic joint	Y	8	249
996.47	Other mechanical complication of prosthetic joint implant	Y	8	249
996.49	Other mechanical complication of other internal orthopedic device, implant, and graft	Y	8	249
V12.42	Person history, Infections of the central nervous system	N	23	467
V12.60	Person history, Unspecified disease of respiratory system	N	23	467
V12.61	Person history, Pneumonia (recurrent)	N	23	467
V12.69	Person history, Other diseases of respiratory system	N	23	467
V13.02	Person history, Urinary (tract) infection	N	23	467
V13.03	Person history, Nephrotic syndrome	N	23	467
V15.88	History of fall	N	23	467
V17.81	Family history, Osteoporosis	N	23	467
V17.89	Family history, Other musculoskeletal diseases	N	23	467
V18.9	Family history, Genetic disease carrier	N	23	467
V26.31	Testing for genetic disease carrier status	N	23	467
V26.32	Other genetic testing	N	23	467
V26.33	Genetic counseling	N	23	467
V46.13	Encounter for weaning from respirator [ventilator]	Y	23	467
V46.14	Mechanical complication of respirator [ventilator]	Y	23	467
V49.84	Bed confinement status	N	23	467
V59.70	Egg (oocyte) (ovum) donor, unspecified	N	23	467
V59.71	Egg (oocyte) (ovum) donor, under age 35,anonymous recipient	N	23	467
V59.72	Egg (oocyte) (ovum) donor, under age 35, designated recipient	N	23	467
V59.73	Egg (oocyte) (ovum) donor, age 35 and over,anonymous recipient	N	23	467
V59.74	Egg (oocyte) (ovum) donor, age 35 and over, designated recipient	N	23	467
V62.84	Suicidal ideation	N	19	425
V64.00	Vaccination not carried out, unspecified reason	N	23	467
V64.01	Vaccination not carried out because of acute illness	N	23	467
V64.02	Vaccination not carried out because of chronic illness or condition	N	23	467
V64.03	Vaccination not carried out because of immune compromised state	N	23	467
V64.04	Vaccination not carried out because of allergy to vaccine or component	N	23	467
V64.05	Vaccination not carried out because of caregiver refusal	N	23	467
V64.06	Vaccination not carried out because of patient refusal	N	23	467
V64.07	Vaccination not carried out for religious reasons	N	23	467
V64.08	Vaccination not carried out because patient had disease being vaccinated against	N	23	467
V64.09	Vaccination not carried out for other reason	N	23	467
V69.5	Behavioral insomnia of childhood	N	23	467

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
V72.86	Encounter for blood typing	N	23	467
V85.0	Body Mass Index less than 19, adult	N	23	467
V85.1	Body Mass Index between 19–24, adult	N	23	467
V85.21	Body Mass Index 25.0–25.9, adult	N	23	467
V85.22	Body Mass Index 26.0–26.9, adult	N	23	467
V85.23	Body Mass Index 27.0–27.9, adult	N	23	467
V85.24	Body Mass Index 28.0–28.9, adult	N	23	467
V85.25	Body Mass Index 29.0–29.9, adult	N	23	467
V85.30	Body Mass Index 30.0–30.9, adult	N	23	467
V85.31	Body Mass Index 31.0–31.9, adult	N	23	467
V85.32	Body Mass Index 32.0–32.9, adult	N	23	467
V85.33	Body Mass Index 33.0–33.9, adult	N	23	467
V85.34	Body Mass Index 34.0–34.9, adult	N	23	467
V85.35	Body Mass Index 35.0–35.9, adult	N	23	467
V85.36	Body Mass Index 36.0–36.9, adult	N	23	467
V85.37	Body Mass Index 37.0–37.9, adult	N	23	467
V85.38	Body Mass Index 38.0–38.9, adult	N	23	467
V85.39	Body Mass Index 39.0–39.9, adult	N	23	467
V85.4	Body Mass Index 40 and over, adult	N	10	296, 297, 298

[1] Secondary diagnosis of major problem in DRGs 387 and 389.
[2] Principal diagnosis of significant HIV-related condition.
[3] Principal or secondary diagnosis of major problem.

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
00.40	Procedure on single vessel	N		
00.41	Procedure on two vessels	N		
00.42	Procedure on three vessels	N		
00.43	Procedure on four or more vessels	N		
00.45	Insertion of one vascular stent	N		
00.46	Insertion of two vascular stents	N		
00.47	Insertion of three vascular stents	N		
00.48	Insertion of four or more vascular stents	N		
00.70	Revision of hip replacement, both acetabular and femoral components	Y	8	471, 545
			10	292, 293
			21	442, 443
			24	485
00.71	Revision of hip replacement, acetabular component	Y	8	471, 545
			10	292, 293
			21 2	442, 443
			4	485
00.72	Revision of hip replacement, femoral component	Y	8	471, 545
			10	292, 293
			21	442, 443
			24	485
00.73	Revision of hip replacement, acetabular liner and/or femoral head only	Y	8	471, 545
			10	292, 293
			21	442, 443
			24	485
00.80	Revision of knee replacement, total (all components)	Y	8	471, 545
			21	442, 443
			24	486
00.81	Revision of knee replacement, tibial component	Y	8	471, 545
			21	442, 443
			24	486
00.82	Revision of knee replacement, femoral component	Y	8	471, 545
			21	442, 443
			24	486
00.83	Revision of knee replacement, patellar component	Y	8	471, 545
			21	442, 443
			24	486
00.84	Revision of total knee replacement, tibial insert (liner)	Y	8	471, 545
			21	442, 443
			24	486
37.41	Implantation of prosthetic cardiac support device around the heart	Y	5	110, 111

TABLE 6B.—NEW PROCEDURE CODES—Continued

Procedure code	Description	OR	MDC	DRG
37.49	Other repair of heart and pericardium	Y	5	110, 111
			21	442, 443
			24	486
84.56	Insertion of (cement) spacer	N		
84.57	Removal of (cement) spacer	N		
86.97	Insertion or replacement of single array rechargeable neurostimulator pulse generator	Y	1	7, 8
86.98	Insertion or replacement of dual array rechargeable neurostimulator pulse generator	Y	1	7, 8

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
276.5	Volume depletion	Y	10	296, 297, 298
			15	387,[1] 3891
			[2] 25	490
287.3	Primary thrombocytopenia	Y	16	397
567.2	Other suppurative peritonitis	Y	6	188, 189, 190
			15	387,[1] 389 [1]
67.8	Other specified peritonitis	Y	6	188, 189, 190
			15	387,[1] 389 [1]
585	Chronic renal failure	Y	PRE	512, 513
			11	315,316
599.6	Urinary obstruction, unspecified	Y	11	331, 332, 333
			15	387,[1] 389 [1]
770.1	Meconium aspiration syndrome	Y	15	387,[3] 389 [3]
799.0	Asphyxia	N	4	101, 102
996.4	Mechanical complication of internal orthopedic device, implant, and graft	Y	8	249
V12.6	Diseases of the respiratory system	N	23	467
V17.8	Other musculoskeletal diseases	N	23	467
V26.3	Genetic counseling and testing	N	23	467
V64.0	Vaccination not carried out because of contradiction	N	23	467

[1] Secondary Diagnosis of Major Problem
[2] Principal diagnosis of Significant HIV Related Condition
[3] Principal or Secondary Diagnosis of Major Problem

TABLE 6D.—INVALID PROCEDURE CODES

Procedure Code	Description	OR	MDC	DRG
36.02	Single vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy with mention of thrombolytic agent.	Y	5	106, 516, 517, 518, 526, 527
36.05	Multiple vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy performed during the same operation, with or without mention of thrombolytic agent.	Y	5	106, 516, 517, 518, 526, 527
37.4	Repair of heart and pericardium	Y	5	110, 111
			21	442, 443
			24	486

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis Code	Description	CC	MDC	DRG
403.00	Hypertensive kidney disease, malignant, without chronic kidney disease	Y	11	331, 332, 333
403.01	Hypertensive kidney disease, malignant, with chronic kidney disease	Y	11	315, 316
403.10	Hypertensive kidney disease, benign, without chronic kidney disease	N	11	331, 332, 333
403.11	Hypertensive kidney disease, benign, with chronic kidney disease	Y	11	315, 316
403.90	Hypertensive kidney disease, unspecified, without chronic kidney disease	N	11	331, 332, 333
403.91	Hypertensive kidney disease, unspecified, with chronic kidney disease	Y	11	315, 316
404.00	Hypertensive heart and kidney disease, malignant, without heart failure or chronic kidney disease.	Y	5	134
404.01	Hypertensive heart and kidney disease, malignant, with heart failure	Y	5	115, 121, 124, 127, 535
			15	1387, 389 [1]
404.02	Hypertensive heart and kidney disease, malignant, with chronic kidney disease	Y	11	315, 316

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES—Continued

Diagnosis Code	Description	CC	MDC	DRG
404.03	Hypertensive heart and kidney disease, malignant, with heart failure and chronic kidney disease.	Y	5	115, 121, 124, 127, 535
			15	387, 389 [1]
404.10	Hypertensive heart and kidney disease, benign, without heart failure or chronic kidney disease	N	5	134
404.11	Hypertensive heart and kidney disease, benign, with heart failure	Y	5	115, 121, 124, 127, 535
			15	387, 389 [1]
404.12	Hypertensive heart and kidney disease, benign, with chronic kidney disease	Y	11	315, 316
404.13	Hypertensive heart and kidney disease, benign, with heart failure and chronic kidney disease	Y	5	115, 121, 124, 127, 535
			15	387, 3891
404.90	Hypertensive heart and kidney disease, unspecified, without heart failure or chronic kidney disease.	N	5	34
404.91	Hypertensive heart and kidney disease, unspecified, with heart failure	Y	5	115, 121, 124, 127, 535
			15	387, 389 [1]
404.92	Hypertensive heart and kidney disease, unspecified, with chronic kidney disease	Y	11	315, 316
404.93	Hypertensive heart and kidney disease, unspecified, with heart failure and chronic kidney disease.	Y	5	115, 121, 124, 127, 535
			15	387, 389 [1]
728.87	Muscle weakness (generalized)	N	8	247
780.51	Insomnia with sleep apnea, unspecified	N	PRE	482
			3	73, 74
780.52	Insomnia, unspecified	N	19	432
780.53	Hypersomnia with sleep apnea, unspecified	N	PRE	482
			3	73, 74
780.54	Hypersomnia, unspecified	N	19	432
780.57	Unspecified sleep apnea	N	PRE	482
			3	73, 74

[1] Major problem in DRGs 387 and 389.

TABLE 6F.—REVISED PROCEDURE CODE TITLES

Procedure Code	Description	OR	MDC	DRG
36.01	Percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy	Y	5	106, 516, 517, 518, 526, 527
37.79	Revision or relocation of cardiac device pocket	Y	1	7, 8
			5	117
			9	269, 270
			21	442, 443
			24	486
81.53	Revision of hip replacement, not otherwise specified	Y	8	471, 545
			10	292, 293
			21	442, 443
			24	485
81.55	Revision of knee replacement, not otherwise specified	Y	8	471, 545
			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.]

*185
59960
59969
*1880
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*1881
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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

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*1882
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*1883
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*1884

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

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*1885
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*1886
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59969

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

*1887
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*1889
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*1892
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*1893
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*1898
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*1899
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*25040
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*25041
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*25042
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*25043
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*25080
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*25081
5851

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

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*25082
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*25083
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*25090
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*25091
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*25092
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*25093
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*2595
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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

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*27411
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*27419
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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

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*2767
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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

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*2870
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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

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*2899
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*29182
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29211
29212
2922
29281
29282
29283
29284
29289
2929
29381
29382
29383
29384
30300
30301
30302

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

30390
30391
30392
30400
30401
30402
30410
30411
30412
30420
30421
30422
30440
30441
30442
30450
30451
30452
30460
30461
30462
30470
30471
30472
30480
30481
30482
30490
30491
30492
30500
30501
30502
30530
30531
30532
30540
30541
30542
30550
30551
30552
30560
30561
30562
30570
30571
30572
30590
30591
30592
*29285
2910
2911
2912
2913
2914
29181
29189
2919
2920
29211
29212
2922
29281
29282

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

29283
29284
29289
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29381
29382
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30300
30301
30302
30390
30391
30392
30400
30401
30402
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30421
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30440
30441
30442
30450
30451
30452
30460
30461
30462
30470
30471
30472
30480
30481
30482
30490
30491
30492
30500
30501
30502
30530
30531
30532
30540
30541
30542
30550
30551
30552
30560
30561
30562
30570
30571
30572
30590
30591
30592
7105
*34461
59960
59969

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

*42682
4260
42612
42613
42653
42654
4266
4267
42681
42689
4269
4270
4271
4272
42731
42732
42741
42742
*51881
79901
79902
*51882
79901
79902
*51883
79901
79902
*51884
79901
79902
*5670
56721
56722
56723
56729
56733
56739
56781
56782
56789
*5671
56721
56722
56723
56729
56733
56739
56781
56782
56789
*56721
5670
5671
56721
56722
56723
56729
56733
56739
56781
56782
56789
5679
*56722
5670
5671

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

56721
56722
56723
56729
56733
56739
56781
56782
56789
5679
*56723
5670
5671
56721
56722
56723
56729
56733
56739
56781
56782
56789
5679
*56729
5670
5671
56721
56722
56723
56729
56733
56739
56781
56782
56789
5679
*56733
5670
5671
56721
56722
56723
56729
56733
56739
56781
56782
56789
5679
*56739
5670
5671
56721
56722
56723
56729
56733
56739
56781
56782
56789
5679
*56781
5670
5671
56721

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

56722
56723
56729
56733
56739
56781
56782
56789
5679
*56782
5670
5671
56721
56722
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56729
56733
56739
56781
56782
56789
5679
*56789
5670
5671
56721
56722
56723
56729
56733
56739
56781
56782
56789
5679
*5679
56721
56722
56723
56729
56733
56739
56781
56782
56789
*56989
56721
56722
56723
56729
56733
56739
56781
56782
56789
*5699
56721
56722
56723
56729
56733
56739
56781
56782
56789
*5800

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

5851
5852
5853
5854
5855
5856
5859
*5804
5851
5852
5853
5854
5855
5856
5859
*58081
5851
5852
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5854
5855
5856
5859
*58089
5851
5852
5853
5854
5855
5856
5859
*5809
5851
5852
5853
5854
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5856
5859
*5810
5851
5852
5853
5854
5855
5856
5859
*5811
5851
5852
5853
5854
5855
5856
5859
*5812
5851
5852
5853
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5856
5859
*5813
5851
5852

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

5853
5854
5855
5856
5859
*58181
5851
5852
5853
5854
5855
5856
5859
*58189
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5852
5853
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5855
5856
5859
*5819
5851
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5853
5854
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5856
5859
*5820
5851
5852
5853
5854
5855
5856
5859
*5821
5851
5852
5853
5854
5855
5856
5859
*5822
5851
5852
5853
5854
5855
5856
5859
*5824
5851
5852
5853
5854
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5856
5859
*58281
5851
5852
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5854

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

5855
5856
5859
*58289
5851
5852
5853
5854
5855
5856
5859
*5829
5851
5852
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5856
5859
*5830
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5853
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5856
5859
*5831
5851
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5854
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5856
5859
*5832
5851
5852
5853
5854
5855
5856
5859
*5834
5851
5852
5853
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5856
5859
*5836
5851
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5853
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5856
5859
*5837
5851
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5856

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

5859
*58381
5851
5852
5853
5854
5855
5856
5859
*58389
5851
5852
5853
5854
5855
5856
5859
*5839
5851
5852
5853
5854
5855
5856
5859
*5845
5851
5852
5853
5854
5855
5856
5859
*5846
5851
5852
5853
5854
5855
5856
5859
*5847
5851
5852
5853
5854
5855
5856
5859
*5848
5851
5852
5853
5854
5855
5856
5859
*5849
5851
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5855
5856
5859
*5851

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

5800
5804
58081
58089
5809
5810
5811
5812
5813
58181
58189
5819
5834
5845
5846
5847
5848
5849
5851
5852
5853
5854
5855
5856
5859
59010
59011
5902
5903
59080
59081
5909
591
*5852
5800
5804
58081
58089
5809
5810
5811
5812
5813
58181
58189
5819
5834
5845
5846
5847
5848
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5851
5852
5853
5854
5855
5856
5859
59010
59011
5902
5903
59080
59081
5909

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

591
*5853
5800
5804
58081
58089
5809
5810
5811
5812
5813
58181
58189
5819
5834
5845
5846
5847
5848
5849
5851
5852
5853
5854
5855
5856
5859
59010
59011
5902
5903
59080
59081
5909
591
*5854
5800
5804
58081
58089
5809
5810
5811
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5813
58181
58189
5819
5834
5845
5846
5847
5848
5849
5851
5852
5853
5854
5855
5856
5859
59010
59011
5902
5903
59080

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

59081
5909
591
*5855
5800
5804
58081
58089
5809
5810
5811
5812
5813
58181
58189
5819
5834
5845
5846
5847
5848
5849
5851
5852
5853
5854
5855
5856
5859
59010
59011
5902
5903
59080
59081
5909
591
*5856
5800
5804
58081
58089
5809
5810
5811
5812
5813
58181
58189
5819
5834
5845
5846
5847
5848
5849
5851
5852
5853
5854
5855
5856
5859
59010
59011
5902

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

5903
59080
59081
5909
591
*5859
5800
5804
58081
58089
5809
5810
5811
5812
5813
58181
58189
5819
5834
5845
5846
5847
5848
5849
5851
5852
5853
5854
5855
5856
5859
59010
59011
5902
5903
59080
59081
5909
591
*586
5851
5852
5853
5854
5855
5856
5859
*587
5851
5852
5853
5854
5855
5856
5859
*5880
5851
5852
5853
5854
5855
5856
5859
*5881
5851
5852

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

5853
5854
5855
5856
5859
*58881
5851
5852
5853
5854
5855
5856
5859
*58889
5851
5852
5853
5854
5855
5856
5859
*5889
5851
5852
5853
5854
5855
5856
5859
*5890
5851
5852
5853
5854
5855
5856
5859
*5891
5851
5852
5853
5854
5855
5856
5859
*5899
5851
5852
5853
5854
5855
5856
5859
*59000
5851
5852
5853
5854
5855
5856
5859
*59001
5851
5852
5853
5854

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

5855
5856
5859
*59010
5851
5852
5853
5854
5855
5856
5859
*59011
5851
5852
5853
5854
5855
5856
5859
*5902
5851
5852
5853
5854
5855
5856
5859
*5903
5851
5852
5853
5854
5855
5856
5859
*59080
5851
5852
5853
5854
5855
5856
5859
*59081
5851
5852
5853
5854
5855
5856
5859
*5909
5851
5852
5853
5854
5855
5856
5859
*591
5851
5852
5853
5854
5855
5856

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

5859
*5921
59960
59969
*5929
59960
59969
*5930
5851
5852
5853
5854
5855
5856
5859
*5931
5851
5852
5853
5854
5855
5856
5859
*5932
5851
5852
5853
5854
5855
5856
5859
*5933
59960
59969
*5934
59960
59969
*5935
59960
59969
*59389
5851
5852
5853
5854
5855
5856
5859
59960
59969
*5939
5851
5852
5853
5854
5855
5856
5859
59960
59969
*5940
59960
59969
*5941
59960
59969

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

*5942
59960
59969
*5948
59960
59969
*5949
59960
59969
*5950
59960
59969
*5951
59960
59969
*5952
59960
59969
*5953
59960
59969
*5954
59960
59969
*59581
59960
59969
*59582
59960
59969
*59589
59960
59969
*5959
59960
59969
*5960
59960
59969
*59651
59960
59969
*59652
59960
59969
*59653
59960
59969
*59654
59960
59969
*59655
59960
59969
*59659
59960
59969
*5968
59960
59969
*5969
59960
59969
*5970
59960
59969

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

*59780
59960
59969
*59781
59960
59969
*59789
59960
59969
*59800
59960
59969
*59801
59960
59969
*5981
59960
59969
*5982
59960
59969
*5988
59960
59969
*5989
59960
59969
*5990
59960
59969
*5991
59960
59969
*5992
59960
59969
*5993
59960
59969
*5994
59960
59969
*5995
59960
59969
*59960
5921
5935
5950
5951
5952
5954
59581
59582
59589
5959
5970
5981
5982
5990
5994
59960
59969
78820
78829
*59969

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

5921
5935
5950
5951
5952
5954
59581
59582
59589
5959
5970
5981
5982
5990
5994
59960
59969
78820
78829
*5997
5851
5852
5853
5854
5855
5856
5859
59960
59969
*59981
5851
5852
5853
5854
5855
5856
5859
59960
59969
*59982
5851
5852
5853
5854
5855
5856
5859
59960
59969
*59983
5851
5852
5853
5854
5855
5856
5859
59960
59969
*59984
5851
5852
5853
5854
5855
5856

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

5859
59960
59969
*59989
5851
5852
5853
5854
5855
5856
5859
59960
59969
*5999
5851
5852
5853
5854
5855
5856
5859
59960
59969
*60000
59960
59969
*60001
59960
59969
*60010
59960
59969
*60011
59960
59969
*60020
59960
59969
*60021
59960
59969
*6003
59960
59969
*60090
59960
59969
*60091
59960
59969
*6010
59960
59969
*6011
59960
59969
*6012
59960
59969
*6013
59960
59969
*6014
59960
59969
*6018

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

59960
59969
*6019
59960
59969
*6020
59960
59969
*6021
59960
59969
*6022
59960
59969
*6023
59960
59969
*6028
59960
59969
*6029
59960
59969
*7530
5851
5852
5853
5854
5855
5856
5859
59960
59969
*75310
5851
5852
5853
5854
5855
5856
5859
59960
59969
*75311
5851
5852
5853
5854
5855
5856
5859
59960
59969
*75312
5851
5852
5853
5854
5855
5856
5859
59960
59969
*75313
5851
5852

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

5853
5854
5855
5856
5859
59960
59969
*75314
5851
5852
5853
5854
5855
5856
5859
59960
59969
*75315
5851
5852
5853
5854
5855
5856
5859
59960
59969
*75316
5851
5852
5853
5854
5855
5856
5859
59960
59969
*75317
5851
5852
5853
5854
5855
5856
5859
59960
59969
*75319
5851
5852
5853
5854
5855
5856
5859
59960
59969
*75320
5851
5852
5853
5854
5855
5856
5859
59960

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

59969
*75321
5851
5852
5853
5854
5855
5856
5859
59960
59969
*75322
5851
5852
5853
5854
5855
5856
5859
59960
59969
*75323
5851
5852
5853
5854
5855
5856
5859
59960
59969
*75329
5851
5852
5853
5854
5855
5856
5859
59960
59969
*7533
5851
5852
5853
5854
5855
5856
5859
59960
59969
*7534
59960
59969
*7535
59960
59969
*7536
59960
59969
*7537
59960
59969
*7538
59960
59969

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

*7539
5851
5852
5853
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5856
5859
59960
59969
*7685
77012
77018
*7686
77012
77018
*7689
77012
77018
*769
77012
77018
*7700
77012
77018
*77010
7685
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7700
77012
77018
7702
7703
7704
7705
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77084
*77011
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77012
77018
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77084
*77012
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7700
77012
77018
7702
7703
7704
7705
7707
77084
*77017
7685
769
7700
77012

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

77018
7702
7703
7704
7705
7707
77084
*77018
7685
769
7700
77012
77018
7702
7703
7704
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77084
*7702
77012
77018
*7703
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77018
*7704
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77018
*7705
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77018
*7706
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*7707
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*77081
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*77082
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*77083
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*77084
77012
77018
*77089
77012
77018
*7709
77012
77018
*77981
77012
77018
*77982
77012
77018
*77983
77012
77018
*77984
76501

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

76502
76503
76504
76505
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76507
76508
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76711
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7700
77012
77018
7702
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77084
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77181
77183
77210
77211
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77214
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TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

*77989
77012
77018
*78091
79901
79902
*78092
79901
79902
*78093
79901
79902
*78094
79901
79902
*78095
04082
44024
78001
78003
7801
78031
78039
7817
7854
78550
78551
78552
78559
7863
78820
78829
7895
7907
7911
7913
79901
79902
7991
7994
*78099
79901
79902
*7881
59960
59969
*7980
79901
79902
*79901
79901
79902
7991
*79902
79901
79902
7991
*7991
79901
79902
*79981
79901
79902
*79989
79901
79902

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

*99640
99640
99641
99642
99643
99644
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99647
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99657
99660
99666
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99670
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*99641
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*99642
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*99643
99640
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99642
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99644
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99646
99647

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

99649
99657
99660
99666
99667
99669
99670
99677
99678
99679
*99644
99640
99641
99642
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99670
99677
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*99645
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*99646
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99649
99657
99660
99666
99667
99669
99670
99677
99678

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

99679
*99647
99640
99641
99642
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99644
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99649
99657
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99666
99667
99669
99670
99677
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99679
*99649
99640
99641
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99657
99660
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99677
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99679
*99666
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*99667
99640
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99644
99645
99646
99647
99649
*99677
99640
99641
99642
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99644
99645

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

99646
99647
99649
*99678
99640
99641
99642
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99649
*99791
99640
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*99799
99640
99641
99642
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99646
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99649
*99881
99640
99641
99642
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99649
*99883
99640
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99642
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99644
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99649
*99889
99640
99641
99642
99643
99644
99645
99646
99647
99649
*9989
99640
99641

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[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.]

99642
99643
99644
99645
99646
99647
99649
*V460
V4613
V4614
*V4611
V4613
V4614
*V4612
V4613
V4614
*V4613
V4611
V4612
V4613
V4614
*V4614
V4611
V4612
V4613
V4614
*V462
V4613
V4614
*V468
V4613
V4614
*V469
V4613
V4614

TABLE 6H.—DELETIONS TO THE CC EXCLUSIONS LIST

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

*185
5996
*1880
5996
*1881
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*1882
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*1883
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*1884
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*1885
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*1886
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*1887
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*1888
5996

TABLE 6H.—DELETIONS TO THE CC EXCLUSIONS LIST—Continued

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

*1889
5996
*1892
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*1893
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*1894
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*1898
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*1899
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*25040
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*25041
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*25042
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*25043
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*25080
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*25081
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*25082
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*25083
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*25090
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*25091
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*25092
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*25093
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*27410
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*27411
5996
*27419
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*2760
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*2765
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*2766
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*2767
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TABLE 6H.—DELETIONS TO THE CC EXCLUSIONS LIST—Continued

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

*2768
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*2769
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*2860
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*2861
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*2862
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*2863
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*2864
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*2875
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*2878
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*2879
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*28981
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*28982
2873
*28989
2873
*2899
2873
*34461
5996
*5670
5672

TABLE 6H.—DELETIONS TO THE CC EXCLUSIONS LIST—Continued

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

5678
*5671
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*5672
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*5678
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*5679
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*56989
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*5699
5672
5678
*5800
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*5804
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*58081
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*58089
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*5809
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*5810
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*5811
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*5812
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*5813
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*58181
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*58189
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*5819
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*5820
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*5821
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*5822
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*5824
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*58281
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*58289
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*5829
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*5830
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*5831

TABLE 6H.—DELETIONS TO THE CC EXCLUSIONS LIST—Continued

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

585
*5832
585
*5834
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*5836
585
*5837
585
*58381
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*58389
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*5839
585
*5845
585
*5846
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*5847
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*5848
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*5849
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*585
5800
5804
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58089
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58181
58189
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59010
59011
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*587
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*5880
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*5881
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*58881
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*58889
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*5889

TABLE 6H.—DELETIONS TO THE CC EXCLUSIONS LIST—Continued

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

585
*5890
585
*5891
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*5899
585
*59000
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*59001
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*59010
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*59011
585
*5902
585
*5903
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*59080
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*59081
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*5909
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*59389
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*5941
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*5942
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*5948
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*5949
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*5950
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*5951
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*5952
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*5953

TABLE 6H.—DELETIONS TO THE CC EXCLUSIONS LIST—Continued

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

5996
*5954
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*59581
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*59582
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*59589
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*5959
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*5960
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*59651
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*59652
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*59653
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*5992
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*5993
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*5994
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*5995
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*5996
5921
5935
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5951

TABLE 6H.—DELETIONS TO THE CC EXCLUSIONS LIST—Continued

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

5952
5954
59581
59582
59589
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5970
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5982
5990
5994
5996
78820
78829
*5997
585
5996
*59981
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*59982
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*59983
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*59984
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*59989
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*60020
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*60021
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*6003
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*60090
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*60091
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*6010
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*6011
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*6012
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*6013
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*6014
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*6018
5996
*6019

TABLE 6H.—DELETIONS TO THE CC EXCLUSIONS LIST—Continued

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

5996
*6020
5996
*6021
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*6022
5996
*6023
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*6028
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*6029
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*7530
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*75310
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*75311
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*75312
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*75321
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*75322
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5996
*75323
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5996
*75329
585
5996
*7533
585
5996
*7534
5996
*7535
5996
*7536

TABLE 6H.—DELETIONS TO THE CC EXCLUSIONS LIST—Continued

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

5996
*7537
5996
*7538
5996
*7539
585
5996
*7685
7701
*7686
7701
*7689
7701
*769
7701
*7700
7701
*7701
7685
769
7700
7701
7702
7703
7704
7705
7707
77084
*7702
7701
*7703

TABLE 6H.—DELETIONS TO THE CC EXCLUSIONS LIST—Continued

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

7701
*7704
7701
*7705
7701
*7706
7701
*7707
7701
*77081
7701
*77082
7701
*77083
7701
*77084
7701
*77089
7701
*7709
7701
*77981
7701
*77982
7701
*77983
7701
*77989
7701
*7881
5996
*7990

TABLE 6H.—DELETIONS TO THE CC EXCLUSIONS LIST—Continued

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

7991
*9964
9964
99657
99660
99666
99667
99669
99670
99677
99678
99679
*99666
9964
*99667
9964
*99677
9964
*99678
9964
*99791
9964
*99799
9964
*99881
9964
*99883
9964
*99889
9964
*9989
9964

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

[FY 2004 MedPAR Update December 2004 GROUPER V22.0]

DRG	Number of discharges	Arithmetic means LOS	10th percentile	25th percentile	50th percentile	75 percentile	90th percentile
1	23,272	9.8371	3	5	8	13	19
2	10,351	4.5604	1	2	4	6	9
3	4	9.5000	1	1	8	14	15
6	410	3.0512	1	1	2	4	7
7	15,592	9.2952	2	4	7	12	19
8	3,701	2.8652	1	1	2	4	7
9	1,945	6.1594	1	3	5	7	12
10	19,511	6.0234	2	3	5	8	12
11	3,279	3.7600	1	2	3	5	7
12	54,431	5.3747	2	3	4	6	10
13	7,337	4.9162	2	3	4	6	8
14	236,958	5.6626	2	3	4	7	11
15	76,129	4.5225	1	2	4	6	8
16	16,264	6.3451	2	3	5	8	12
17	3,008	3.2114	1	2	2	4	6
18	33,082	5.2590	2	3	4	7	10
19	8,568	3.4383	1	2	3	4	6
20	6,532	9.8403	3	5	8	12	19
21	2,197	6.3245	2	3	5	8	13
22	3,316	5.2223	2	2	4	7	10
23	10,732	3.8906	1	2	3	5	7
24	63,863	4.7303	1	2	4	6	9
25	28,153	3.1246	1	2	3	4	6
26	18	6.2778	1	2	3	4	8
27	5,387	5.1142	1	1	3	6	11
28	17,558	5.7440	1	3	4	7	12
29	6,274	3.3202	1	1	3	4	6

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

[FY 2004 MedPAR Update December 2004 GROUPER V22.0]

DRG	Number of discharges	Arithmetic means LOS	10th percentile	25th percentile	50th percentile	75 percentile	90th percentile
30	1	19.0000	19	19	19	19	19
31	5,090	3.9800	1	2	3	5	8
32	1,982	2.4001	1	1	2	3	5
34	27,872	4.7722	1	2	4	6	9
35	7,895	3.0011	1	1	3	4	6
36	1,472	1.6019	1	1	1	1	3
37	1,241	4.1281	1	1	3	5	9
38	56	3.5179	1	1	2	4	6
39	448	2.3772	1	1	1	2	5
40	1,383	4.1063	1	1	4	5	8
42	1,145	2.7721	1	1	2	4	6
43	125	3.1440	1	1	2	4	6
44	1,160	4.7836	2	3	4	6	8
45	2,803	3.0756	1	2	2	4	6
46	3,819	4.1712	1	2	3	5	8
47	1,335	2.8854	1	1	2	4	5
49	2,478	4.3906	1	2	3	5	8
50	2,170	1.8143	1	1	1	2	3
51	190	2.7632	1	1	1	3	6
52	165	1.9818	1	1	1	2	4
53	2,225	3.9542	1	1	2	5	9
54	1	7.0000	7	7	7	7	7
55	1,354	3.1300	1	1	2	4	7
56	435	2.5724	1	1	1	3	6
57	698	4.1547	1	1	2	5	9
59	102	2.5392	1	1	1	2	6
60	8	3.2500	1	1	2	4	4
61	219	5.4064	1	1	3	7	12
63	2,842	4.4838	1	2	3	5	9
64	3,343	6.0464	1	2	4	8	13
65	41,424	2.7728	1	1	2	3	5
66	8,007	3.1309	1	1	2	4	6
67	419	3.6826	1	2	3	4	7
68	17,328	3.9720	1	2	3	5	7
69	4,816	3.0328	1	2	3	4	5
70	25	2.3600	1	1	2	3	4
71	68	4.0000	1	2	3	5	7
72	1,066	3.4531	1	2	3	4	7
73	7,935	4.3806	1	2	3	6	9
74	4	2.5000	2	2	2	3	3
75	45,034	9.8129	3	5	7	12	20
76	47,341	10.8198	3	5	8	13	21
77	2,153	4.6716	1	2	4	6	9
78	45,631	6.2559	2	4	6	8	10
79	170,684	8.1939	3	4	7	10	15
80	7,724	5.3718	2	3	4	7	10
81	4	11.5000	8	8	11	13	14
82	65,161	6.6908	2	3	5	9	13
83	6,950	5.2373	2	3	4	7	10
84	1,472	3.1454	1	2	3	4	6
85	21,878	6.2321	2	3	5	8	12
86	1,861	3.6239	1	2	3	5	7
87	82,727	6.4131	2	3	5	8	12
88	413,844	4.9009	2	3	4	6	9
89	550,707	5.6477	2	3	5	7	10
90	45,868	3.8123	2	2	3	5	7
91	45	4.3556	1	2	3	5	9
92	16,495	5.9978	2	3	5	8	11
93	1,598	3.8273	1	2	3	5	7
94	13,338	6.1223	2	3	5	8	12
95	1,612	3.6340	1	2	3	5	7
96	59,134	4.3754	2	2	4	5	8
97	27,017	3.3864	1	2	3	4	6
98	8	2.5000	1	2	2	3	3
99	21,547	3.1101	1	1	2	4	6
100	6,953	2.1151	1	1	2	3	4
101	23,105	4.2502	1	2	3	5	8
102	5,237	2.4921	1	1	2	3	5
103	724	37.3798	8	12	23	48	79
104	20,953	14.4988	6	8	12	18	25

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

[FY 2004 MedPAR Update December 2004 GROUPER V22.0]

DRG	Number of discharges	Arithmetic means LOS	10th percentile	25th percentile	50th percentile	75 percentile	90th percentile
105	31,568	9.9544	4	6	8	12	18
106	3,499	11.2138	5	7	9	13	19
107	70,111	10.5005	5	7	9	12	17
108	8,878	9.8314	1	5	8	12	19
109	50,742	7.7661	4	5	6	9	13
110	57,167	8.3880	1	3	7	11	17
111	10,077	3.4273	1	1	3	5	7
113	37,263	12.5945	4	6	10	16	24
114	8,514	8.4514	2	4	7	11	16
115	22,137	6.8327	1	2	5	9	14
116	118,685	4.2655	1	1	3	6	9
117	5,151	4.2386	1	1	2	5	10
118	7,605	3.0473	1	1	2	4	7
119	993	5.4945	1	1	3	7	13
120	36,309	9.0439	1	3	6	12	20
121	159,575	6.2485	2	3	5	8	12
122	61,768	3.3855	1	2	3	4	6
123	33,656	4.7990	1	1	3	6	11
124	130,770	4.3991	1	2	3	6	9
125	95,808	2.7249	1	1	2	3	5
126	5,823	11.2705	3	6	9	14	21
127	695,800	5.1260	2	3	4	6	10
128	5,181	5.1662	2	3	5	6	9
129	3,762	2.5944	1	1	1	3	6
130	89,126	5.4275	1	3	5	7	10
131	23,839	3.8048	1	2	4	5	7
132	117,297	2.8049	1	1	2	3	5
133	7,287	2.1806	1	1	2	3	4
134	42,414	3.1069	1	2	2	4	6
135	7,439	4.2879	1	2	3	5	8
136	1,133	2.7643	1	1	2	3	5
138	207,068	3.9126	1	2	3	5	7
139	78,609	2.4367	1	1	2	3	5
140	38,178	2.4370	1	1	2	3	5
141	121,892	3.4612	1	2	3	4	6
142	52,279	2.4785	1	1	2	3	5
143	249,312	2.0936	1	1	2	3	4
144	99,715	5.6964	1	2	4	7	12
145	6,187	2.6198	1	1	2	3	5
146	10,769	9.8862	5	6	8	12	17
147	2,634	5.8193	3	4	6	7	9
148	135,681	12.0864	5	7	9	15	22
149	19,915	5.9490	3	4	6	7	9
150	22,708	10.8769	4	6	9	14	20
151	5,353	5.1362	1	2	5	7	10
152	5,007	8.0429	3	5	7	9	14
153	2,092	4.9809	2	3	5	6	8
154	28,497	13.0520	3	6	10	16	25
155	6,161	4.1344	1	2	3	6	8
156	6	24.1667	1	5	9	27	27
157	8,260	5.7196	1	2	4	7	12
158	4,106	2.6086	1	1	2	3	5
159	19,174	5.1209	1	2	4	7	10
160	11,988	2.6625	1	1	2	3	5
161	10,428	4.3945	1	2	3	6	9
162	5,497	2.0806	1	1	1	3	4
163	10	2.9000	1	1	2	3	6
164	5,945	7.9862	3	5	7	10	14
165	2,523	4.2089	2	3	4	5	7
166	4,933	4.5046	1	2	3	5	9
167	4,634	2.2169	1	1	2	3	4
168	1,544	4.9087	1	2	3	6	10
169	756	2.2844	1	1	2	3	5
170	17,471	10.7718	2	5	8	14	22
171	1,484	4.0964	1	2	3	5	8
172	32,879	6.8401	2	3	5	9	14
173	2,392	3.5920	1	1	3	5	7
174	267,905	4.7020	2	3	4	6	9
175	32,657	2.8910	1	2	2	4	5
176	14,560	5.1422	2	3	4	6	10

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

[FY 2004 MedPAR Update December 2004 GROUPER V22.0]

DRG	Number of discharges	Arithmetic means LOS	10th percentile	25th percentile	50th percentile	75 percentile	90th percentile
177	8,554	4.4329	2	2	4	5	8
178	2,909	3.1158	1	2	3	4	5
179	14,429	5.8559	2	3	5	7	11
180	92,193	5.3215	2	3	4	7	10
181	25,897	3.3265	1	2	3	4	6
182	292,198	4.4293	1	2	3	5	8
183	86,576	2.8664	1	1	2	4	5
184	78	3.2821	1	2	2	4	6
185	5,680	4.4905	1	2	3	5	9
186	4	2.0000	1	1	1	3	3
187	621	4.1723	1	2	3	5	8
188	90,968	5.5332	1	2	4	7	11
189	13,182	3.0882	1	1	2	4	6
190	69	4.3768	1	2	3	5	8
191	10,411	12.6933	3	6	9	16	26
192	1,322	5.6899	1	3	5	7	10
193	4,514	12.0549	5	7	10	15	22
194	521	6.6756	3	4	6	8	11
195	3,249	10.6190	4	6	9	13	19
196	701	5.7275	2	4	5	7	9
197	17,317	9.0988	3	5	7	11	17
198	4,645	4.3208	2	3	4	6	7
199	1,425	9.5298	2	4	7	13	19
200	936	9.6976	1	4	7	12	20
201	2,665	13.7471	3	6	10	18	28
202	27,281	6.1787	2	3	5	8	12
203	31,656	6.4850	2	3	5	8	13
204	72,845	5.5246	2	3	4	7	11
205	31,474	5.8950	2	3	4	7	12
206	2,081	3.8847	1	2	3	5	8
207	35,754	5.2393	1	2	4	7	10
208	9,758	2.9364	1	1	2	4	6
209	461,222	4.5677	3	3	4	5	7
210	128,455	6.6967	3	4	6	8	11
211	26,708	4.6708	3	3	4	5	7
212	10	2.9000	1	1	3	4	4
213	10,257	9.1059	2	4	7	12	18
216	17,656	5.7608	1	1	3	8	14
217	17,622	12.4479	3	5	9	15	26
218	28,708	5.4480	2	3	4	7	10
219	21,361	3.1063	1	2	3	4	5
220	4	2.7500	2	2	3	3	3
223	13,425	3.2055	1	1	2	4	6
224	10,889	1.8875	1	1	1	2	3
225	6,514	5.1650	1	2	4	7	11
226	6,660	6.3380	1	2	4	8	13
227	5,074	2.6139	1	1	2	3	5
228	2,640	4.1258	1	1	3	5	9
229	1,201	2.5129	1	1	2	3	5
230	2,565	5.5922	1	2	4	7	12
232	729	2.8230	1	1	1	3	6
233	15,118	6.6726	1	2	5	9	14
234	7,676	2.7952	1	1	2	4	6
235	4,970	4.6463	1	2	4	6	9
236	42,408	4.4748	1	3	4	5	8
237	2,022	3.6682	1	2	3	4	7
238	9,869	8.2633	3	4	6	10	15
239	42,943	6.0632	2	3	5	7	11
240	12,653	6.6177	2	3	5	8	13
241	2,696	3.7066	1	2	3	5	7
242	2,742	6.5864	2	3	5	8	12
243	101,477	4.5166	1	2	4	6	8
244	15,792	4.4924	1	2	4	6	8
245	5,840	3.1334	1	1	3	4	6
246	1,430	3.5664	1	2	3	4	7
247	21,671	3.3172	1	2	3	4	6
248	15,118	4.8397	1	3	4	6	9
249	14,026	3.8285	1	1	3	5	8
250	4,155	3.8876	1	2	3	5	7
251	2,148	2.7514	1	1	3	3	5

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

[FY 2004 MedPAR Update December 2004 GROUPER V22.0]

DRG	Number of discharges	Arithmetic means LOS	10th percentile	25th percentile	50th percentile	75 percentile	90th percentile
252	1	1.0000	1	1	1	1	1
253	24,857	4.5324	2	3	4	5	8
254	10,420	3.0461	1	2	3	4	5
255	1	7.0000	7	7	7	7	7
256	7,152	5.0301	1	2	4	6	10
257	13,512	2.6104	1	1	2	3	5
258	12,042	1.7498	1	1	1	2	3
259	2,903	2.7689	1	1	1	3	7
260	2,991	1.4055	1	1	1	1	2
261	1,603	2.2052	1	1	1	2	4
262	636	4.8428	1	2	4	7	10
263	23,809	10.7403	3	5	8	13	21
264	3,922	6.2358	2	3	5	8	12
265	4,307	6.5677	1	2	4	8	14
266	2,304	3.1788	1	1	2	4	7
267	272	4.1838	1	1	3	5	10
268	1,004	3.5508	1	1	2	4	7
269	10,686	8.3273	2	4	6	11	16
270	2,639	3.8151	1	1	3	5	8
271	21,054	6.7875	2	3	5	8	12
272	5,942	5.8009	2	3	4	7	11
273	1,349	3.6449	1	2	3	5	7
274	2,288	6.2592	2	3	5	8	12
275	228	3.2456	1	1	2	4	7
276	1,447	4.4630	1	2	4	6	8
277	112,318	5.5013	2	3	5	7	10
278	33,865	4.0567	2	2	3	5	7
279	6	4.6667	1	3	5	6	6
280	19,272	4.0080	1	2	3	5	7
281	7,093	2.8429	1	1	2	4	5
283	6,274	4.5695	1	2	3	6	9
284	1,833	3.0295	1	1	2	4	6
285	7,623	10.0454	3	5	8	12	19
286	2,703	5.4802	2	2	4	6	10
287	6,114	9.8368	3	5	7	12	19
288	10,450	4.1090	2	2	3	4	7
289	6,894	2.5582	1	1	1	2	5
290	10,859	2.1325	1	1	1	2	4
291	64	2.7969	1	1	1	2	5
292	7,331	10.0308	2	4	8	13	20
293	368	4.4674	1	2	3	6	9
294	98,963	4.2920	1	2	3	5	8
295	4,102	3.6675	1	2	3	4	7
296	254,706	4.7202	1	2	4	6	9
297	45,347	3.0710	1	2	3	4	6
298	81	3.9383	1	1	2	4	7
299	1,478	5.1604	1	2	4	6	10
300	21,343	5.8673	2	3	5	7	11
301	3,901	3.4107	1	2	3	4	6
302	9,649	8.1898	4	5	6	9	14
303	23,760	7.3943	3	4	6	9	14
304	13,826	8.4735	2	3	6	11	18
305	3,087	3.2096	1	2	3	4	6
306	6,350	5.4737	1	2	3	8	12
307	2,066	2.0736	1	1	2	2	3
308	7,093	6.1095	1	2	4	8	14
309	3,559	2.0014	1	1	1	2	4
310	26,035	4.5265	1	2	3	6	10
311	6,480	1.8782	1	1	1	2	3
312	1,456	4.8365	1	1	3	6	11
313	508	2.2165	1	1	2	3	4
314	1	2.0000	2	2	2	2	2
315	36,565	6.7584	1	1	4	9	16
316	180,999	6.2874	2	3	5	8	12
317	2,766	3.4678	1	1	2	4	7
318	5,927	5.7441	1	2	4	7	11
319	383	2.7546	1	1	2	3	6
320	218,684	5.0953	2	3	4	6	9
321	31,401	3.5963	1	2	3	4	6
322	61	3.4918	2	2	3	4	6

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

[FY 2004 MedPAR Update December 2004 GROUPER V22.0]

DRG	Number of discharges	Arithmetic means LOS	10th percentile	25th percentile	50th percentile	75 percentile	90th percentile
323	20,482	3.0937	1	1	2	4	6
324	5,421	1.8843	1	1	1	2	3
325	9,615	3.6813	1	2	3	5	7
326	2,584	2.6207	1	1	2	3	5
327	5	2.6000	1	1	2	3	5
328	606	3.4719	1	1	3	5	7
329	72	1.8333	1	1	1	2	3
331	54,798	5.4332	1	2	4	7	11
332	4,389	3.1246	1	1	2	4	6
333	252	5.4921	1	2	3	7	13
334	9,810	4.3009	2	2	3	5	7
335	11,931	2.6866	1	2	3	3	4
336	31,264	3.2999	1	2	2	4	7
337	25,156	1.9182	1	1	2	2	3
338	652	6.1748	1	2	3	9	14
339	1,253	5.1173	1	1	3	7	11
340	2	5.0000	4	4	6	6	6
341	3,185	3.1586	1	1	2	3	7
342	565	3.4248	1	2	2	4	8
344	2,693	2.7037	1	1	1	2	6
345	1,461	4.8077	1	1	3	6	11
346	3,966	5.7307	1	3	4	7	11
347	247	3.0202	1	1	2	4	7
348	4,171	4.0897	1	2	3	5	8
349	575	2.3583	1	1	2	3	4
350	7,137	4.4541	2	2	4	5	8
352	975	4.0133	1	2	3	5	8
353	2,735	6.3192	2	3	4	7	12
354	7,612	5.6967	2	3	4	6	10
355	4,937	3.0614	2	2	3	4	4
356	23,993	1.9281	1	1	2	2	3
357	5,570	8.1269	3	4	6	10	15
358	20,798	3.9629	2	2	3	4	7
359	28,741	2.4058	1	2	2	3	4
360	14,764	2.5880	1	1	2	3	4
361	272	3.0184	1	1	2	3	7
362	2	1.0000	1	1	1	1	1
363	2,128	3.7810	1	2	2	4	8
364	1,451	4.1909	1	2	3	5	9
365	1,622	7.7404	2	3	5	9	17
366	4,789	6.4792	2	3	5	8	13
367	456	2.9934	1	1	2	4	6
368	3,924	6.6351	2	3	5	8	13
369	3,613	3.2419	1	1	2	4	6
370	1,843	5.1557	2	3	4	5	8
371	2,244	3.3944	2	3	3	4	5
372	1,164	3.1847	2	2	2	3	5
373	4,871	2.2373	1	2	2	3	3
374	156	2.7436	2	2	2	3	4
375	6	4.0000	1	2	2	6	6
376	388	3.3711	1	2	2	4	6
377	77	4.4805	1	1	3	4	8
378	196	2.3163	1	1	2	3	4
379	508	2.8130	1	1	2	3	6
380	91	2.1099	1	1	1	2	4
381	212	2.2642	1	1	1	2	4
382	43	1.4419	1	1	1	2	2
383	2,473	3.6526	1	1	2	4	7
384	132	2.5606	1	1	1	3	5
385	1	1.0000	1	1	1	1	1
389	1	21.0000	21	21	21	21	21
390	1	1.0000	1	1	1	1	1
392	2,203	9.1770	2	4	6	11	19
393	1	4.0000	4	4	4	4	4
394	2,820	7.3553	1	2	5	9	16
395	116,129	4.2575	1	2	3	5	8
396	9	4.4444	1	1	2	3	6
397	18,482	5.1407	1	2	4	6	10
398	18,288	5.7016	2	3	4	7	11
399	1,640	3.3250	1	2	3	4	6

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

[FY 2004 MedPAR Update December 2004 GROUPER V22.0]

DRG	Number of discharges	Arithmetic means LOS	10th percentile	25th percentile	50th percentile	75 percentile	90th percentile
401	6,328	11.0390	2	5	9	14	22
402	1,401	4.0293	1	1	3	5	9
403	31,865	7.9367	2	3	6	10	16
404	3,802	4.1528	1	2	3	5	8
406	2,224	9.9150	2	4	7	12	21
407	584	3.8253	1	2	3	5	7
408	2,170	8.1949	1	2	5	10	19
409	1,808	5.7954	1	3	4	6	12
410	28,417	3.8214	1	2	3	5	6
411	12	3.2500	1	2	2	4	4
412	12	2.7500	1	1	1	3	4
413	5,198	6.7563	2	3	5	9	13
414	573	4.0244	1	2	3	5	8
415	50,827	14.0035	4	6	11	18	28
416	239,006	7.3769	2	3	6	9	14
417	23	5.2174	1	2	3	5	10
418	28,508	6.1657	2	3	5	8	12
419	16,282	4.3857	1	2	3	5	8
420	2,941	3.3747	1	2	3	4	6
421	11,882	4.0613	1	2	3	5	7
422	52	3.7115	1	1	2	4	7
423	8,637	8.2173	2	3	6	10	17
424	1,071	11.7274	2	4	8	14	22
425	14,779	3.4569	1	1	3	4	7
426	4,313	4.1203	1	2	3	5	8
427	1,505	4.7375	1	2	3	5	9
428	773	7.2549	1	2	5	8	15
429	25,479	5.4228	2	3	4	6	10
430	71,439	7.6737	2	3	6	9	15
431	304	5.8947	1	2	4	7	12
432	420	4.2548	1	2	3	5	8
433	5,191	2.9626	1	1	2	3	6
439	1,739	8.7993	1	3	5	10	19
440	5,613	8.7825	2	3	6	10	18
441	779	3.3813	1	1	2	4	7
442	18,017	8.6810	2	3	6	11	18
443	3,385	3.4003	1	1	3	4	7
444	5,892	4.0324	1	2	3	5	8
445	2,346	2.8372	1	1	2	4	5
447	6,264	2.5686	1	1	2	3	5
448	1	2.0000	2	2	2	2	2
449	38,802	3.6742	1	1	3	4	7
450	7,805	1.9867	1	1	1	2	4
451	3	1.6667	1	1	1	3	3
452	27,634	4.8762	1	2	3	6	10
453	5,437	2.7993	1	1	2	3	5
454	3,837	4.1058	1	2	3	5	8
455	846	2.2222	1	1	2	3	4
461	2,722	5.1267	1	1	3	6	12
462	7,761	10.1584	4	6	8	13	18
463	31,045	3.8939	1	2	3	5	7
464	7,661	2.9141	1	1	2	4	5
465	219	3.6347	1	1	2	4	7
466	1,377	4.7117	1	1	2	5	9
467	1,015	2.6788	1	1	2	3	5
468	50,481	12.8082	3	6	10	16	25
471	15,614	5.0496	3	3	4	5	8
473	8,778	12.4026	2	3	7	18	32
475	116,534	11.0157	2	5	9	14	21
476	3,025	10.4998	2	4	9	14	21
477	29,407	8.5221	1	3	6	11	18
478	113,660	7.1046	1	2	5	9	15
479	24,603	2.7884	1	1	2	4	6
480	802	17.9102	7	9	13	22	36
481	1,066	21.8208	10	16	20	25	35
482	5,076	11.4967	4	6	9	14	21
484	449	12.7506	2	6	10	17	25
485	3,420	9.6038	4	5	7	11	18
486	2,562	12.3478	2	6	10	16	25
487	4,644	7.0540	1	3	5	9	14

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

[FY 2004 MedPAR Update December 2004 GROUPER V22.0]

DRG	Number of discharges	Arithmetic means LOS	10th percentile	25th percentile	50th percentile	75 percentile	90th percentile
488	786	16.3422	4	7	13	22	35
489	13,461	8.3538	2	3	6	10	17
490	5,204	5.3918	1	2	4	7	11
491	19,789	3.1423	1	2	3	3	5
492	4,012	13.6269	3	5	6	23	31
493	61,628	6.0515	1	3	5	8	12
494	25,626	2.6772	1	1	2	4	5
495	307	17.4072	8	9	13	19	31
496	3,261	8.9877	3	4	6	11	18
497	29,453	6.0617	3	4	5	7	10
498	19,400	3.7954	2	3	3	5	6
499	35,676	4.3236	1	2	3	5	9
500	48,323	2.2420	1	1	2	3	4
501	3,122	9.9308	4	5	8	13	18
502	717	5.6987	2	3	5	7	9
503	5,909	3.8284	1	2	3	5	7
504	187	27.1818	8	16	23	36	49
505	179	4.6704	1	1	1	6	11
506	1,004	15.9273	3	7	13	21	33
507	307	8.4919	1	3	7	11	18
508	641	7.2044	1	3	5	9	15
509	168	5.1607	1	2	3	6	11
510	1,755	6.4160	1	2	4	8	14
511	635	4.0787	1	1	2	5	8
512	513	12.7719	7	8	10	14	23
513	227	9.9824	5	7	8	12	16
515	27,312	4.2899	1	1	2	6	11
516	38,732	4.7893	2	2	4	6	9
517	66,287	2.5801	1	1	1	3	6
518	41,113	3.4800	1	1	2	4	8
519	11,506	4.8233	1	1	3	6	11
520	15,266	2.0074	1	1	1	2	4
521	32,148	5.4742	2	3	4	7	11
522	5,646	9.3666	3	4	7	12	19
523	15,866	3.8769	1	2	3	5	7
524	118,949	3.1907	1	2	3	4	6
525	315	13.4222	1	3	8	16	32
526	55,877	4.3572	1	2	3	5	8
527	192,230	2.2326	1	1	1	2	5
528	1,770	17.1090	6	10	15	22	30
529	4,032	7.9923	1	2	5	10	18
530	2,363	3.1240	1	1	2	4	6
531	4,799	9.4049	2	4	7	12	20
532	2,622	3.7227	1	1	3	5	8
533	47,609	3.7364	1	1	2	4	9
534	45,285	1.7909	1	1	1	2	3
535	13,002	8.2678	1	3	7	11	17
536	19,606	5.4113	1	2	4	7	12
537	8,641	6.7775	1	3	5	8	14
538	5,604	2.8164	1	1	2	4	6
539	5,020	10.7639	2	4	7	14	23
540	1,510	3.5808	1	1	3	4	7
541	22,369	42.8902	17	25	35	52	76
542	24,376	32.5434	12	18	27	40	58
543	5,415	11.9830	2	5	10	16	24
	12,140,152						

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

[FY 2004 MedPAR Update December 2004 GROUPER V23.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	23,271	9.8373	3	5	8	13	19
2	10,351	4.5604	1	2	4	6	9
3	4	9.5000	1	1	8	14	15
6	410	3.0512	1	1	2	4	7
7	15,592	9.2952	2	4	7	12	19

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

[FY 2004 MedPAR Update December 2004 GROUPER V23.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
8	3,701	2.8652	1	1	2	4	7
9	1,945	6.1594	1	3	5	7	12
10	19,511	6.0234	2	3	5	8	12
11	3,279	3.7600	1	2	3	5	7
12	54,431	5.3747	2	3	4	6	10
13	7,337	4.9162	2	3	4	6	8
14	236,958	5.6626	2	3	4	7	11
15	76,129	4.5225	1	2	4	6	8
16	16,264	6.3451	2	3	5	8	12
17	3,008	3.2114	1	2	2	4	6
18	33,082	5.2590	2	3	4	7	10
19	8,568	3.4383	1	2	3	4	6
20	6,532	9.8403	3	5	8	12	19
21	2,197	6.3245	2	3	5	8	13
22	3,316	5.2223	2	2	4	7	10
23	10,732	3.8906	1	2	3	5	7
24	63,863	4.7303	1	2	4	6	9
25	28,153	3.1246	1	2	3	4	6
26	18	6.2778	1	2	3	4	8
27	5,387	5.1142	1	1	3	6	11
28	17,558	5.7440	1	3	4	7	12
29	6,274	3.3202	1	1	3	4	6
30	1	19.0000	19	19	19	19	19
31	5,090	3.9800	1	2	3	5	8
32	1,982	2.4001	1	1	2	3	5
34	27,872	4.7722	1	2	4	6	9
35	17,895	3.0011	1	1	3	4	6
36	1,472	1.6019	1	1	1	1	3
37	1,241	4.1281	1	1	3	5	9
38	56	3.5179	1	1	2	4	6
39	448	2.3772	1	1	1	2	5
40	1,383	4.1063	1	1	4	5	8
42	1,145	2.7721	1	1	2	4	6
43	125	3.1440	1	1	2	4	6
44	1,160	4.7836	2	3	4	6	8
45	2,803	3.0756	1	2	2	4	6
46	3,819	4.1712	1	2	3	5	8
47	1,335	2.8854	1	1	2	4	5
49	2,478	4.3906	1	2	3	5	8
50	2,170	1.8143	1	1	1	2	3
51	190	2.7632	1	1	1	3	6
52	165	1.9818	1	1	1	2	4
53	2,225	3.9542	1	1	2	5	9
54	1	7.0000	7	7	7	7	7
55	1,354	3.1300	1	1	2	4	7
56	435	2.5724	1	1	1	3	6
57	698	4.1547	1	1	2	5	9
59	102	2.5392	1	1	1	2	6
60	8	3.2500	1	1	2	4	4
61	219	5.4064	1	1	3	7	12
63	2,842	4.4838	1	2	3	5	9
64	3,343	6.0464	1	2	4	8	13
65	41,424	2.7728	1	1	2	3	5
66	8,007	3.1309	1	1	2	4	6
67	419	3.6826	1	2	3	4	7
68	17,328	3.9720	1	2	3	5	7
69	4,816	3.0328	1	2	3	4	5
70	25	2.3600	1	1	2	3	4
71	68	4.0000	1	2	3	5	7
72	1,066	3.4531	1	2	3	4	7
73	7,935	4.3806	1	2	3	6	9
74	4	2.5000	2	2	2	3	3
75	45,031	9.8127	3	5	7	12	20
76	47,341	10.8198	3	5	8	13	21
77	2,153	4.6716	1	2	4	6	9
78	45,631	6.2559	2	4	6	8	10
79	170,684	8.1939	3	4	7	10	15
80	7,724	5.3718	2	3	4	7	10
81	4	11.5000	8	8	11	13	14
82	65,161	6.6908	2	3	5	9	13

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

[FY 2004 MedPAR Update December 2004 GROUPER V23.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
83	6,950	5.2373	2	3	4	7	10
84	1,472	3.1454	1	2	3	4	6
85	21,878	6.2321	2	3	5	8	12
86	1,861	3.6239	1	2	3	5	7
87	82,727	6.4131	2	3	5	8	12
88	413,844	4.9009	2	3	4	6	9
89	550,707	5.6477	2	3	5	7	10
90	45,868	3.8123	2	2	3	5	7
91	45	4.3556	1	2	3	5	9
92	16,495	5.9978	2	3	5	8	11
93	1,598	3.8273	1	2	3	5	7
94	13,338	6.1223	2	3	5	8	12
95	1,612	3.6340	1	2	3	5	7
96	59,134	4.3754	2	2	4	5	8
97	27,017	3.3864	1	2	3	4	6
98	8	2.5000	1	2	2	3	3
99	21,547	3.1101	1	1	2	4	6
100	6,953	2.1151	1	1	2	3	4
101	23,105	4.2502	1	2	3	5	8
102	5,237	2.4921	1	1	2	3	5
103	724	37.3798	8	12	23	48	79
104	20,929	14.5053	6	8	12	18	25
105	31,544	9.9561	4	6	8	12	18
106	3,499	11.2138	5	7	9	13	19
107	70,111	10.5005	5	7	9	12	17
108	7,947	10.6922	4	6	9	13	19
109	50,742	7.7661	4	5	6	9	13
110	57,167	8.3880	1	3	7	11	17
111	10,077	3.4273	1	1	3	5	7
113	37,263	12.5945	4	6	10	16	24
114	8,514	8.4514	2	4	7	11	16
115	22,137	6.8327	1	2	5	9	14
116	118,685	4.2655	1	1	3	6	9
117	5,151	4.2386	1	1	2	5	10
118	7,605	3.0473	1	1	2	4	7
119	993	5.4945	1	1	3	7	13
120	36,309	9.0439	1	3	6	12	20
121	159,575	6.2485	2	3	5	8	12
122	61,768	3.3855	1	2	3	4	6
123	33,656	4.7990	1	1	3	6	11
124	130,770	4.3991	1	2	3	6	9
125	95,808	2.7249	1	1	2	3	5
126	5,823	11.2705	3	6	9	14	21
127	695,800	5.1260	2	3	4	6	10
128	5,181	5.1662	2	3	5	6	9
129	3,762	2.5944	1	1	1	3	6
130	89,126	5.4275	1	3	5	7	10
131	23,839	3.8048	1	2	4	5	7
132	117,297	2.8049	1	1	2	3	5
133	7,287	2.1806	1	1	2	3	4
134	42,414	3.1069	1	2	2	4	6
135	7,439	4.2879	1	2	3	5	8
136	1,133	2.7643	1	1	2	3	5
138	207,068	3.9126	1	2	3	5	7
139	78,609	2.4367	1	1	2	3	5
140	38,178	2.4370	1	1	2	3	5
141	121,892	3.4612	1	2	3	4	6
142	52,279	2.4785	1	1	2	3	5
143	249,312	2.0936	1	1	2	3	4
144	99,715	5.6964	1	2	4	7	12
145	6,187	2.6198	1	1	2	3	5
146	10,769	9.8862	5	6	8	12	17
147	2,634	5.8193	3	4	6	7	9
148	135,681	12.0864	5	7	9	15	22
149	19,915	5.9490	3	4	6	7	9
150	22,708	10.8769	4	6	9	14	20
151	5,353	5.1362	1	2	5	7	10
152	5,007	8.0429	3	5	7	9	14
153	2,092	4.9809	2	3	5	6	8
154	28,496	13.0519	3	6	10	16	25

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

[FY 2004 MedPAR Update December 2004 GROUPER V23.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
155	6,161	4.1344	1	2	3	6	8
156	6	24.1667	1	5	9	27	27
157	8,260	5.7196	1	2	4	7	12
158	4,106	2.6086	1	1	2	3	5
159	19,174	5.1209	1	2	4	7	10
160	11,988	2.6625	1	1	2	3	5
161	10,428	4.3945	1	2	3	6	9
162	5,497	2.0806	1	1	1	3	4
163	10	2.9000	1	1	2	3	6
164	5,945	7.9862	3	5	7	10	14
165	2,523	4.2089	2	3	4	5	7
166	4,933	4.5046	1	2	3	5	9
167	4,634	2.2169	1	1	2	3	4
168	1,544	4.9087	1	2	3	6	10
169	756	2.2844	1	1	2	3	5
170	17,471	10.7718	2	5	8	14	22
171	1,484	4.0964	1	2	3	5	8
172	32,879	6.8401	2	3	5	9	14
173	2,392	3.5920	1	1	3	5	7
174	267,905	4.7020	2	3	4	6	9
175	32,657	2.8910	1	2	2	4	5
176	14,560	5.1422	2	3	4	6	10
177	8,554	4.4329	2	2	4	5	8
178	2,909	3.1158	1	2	3	4	5
179	14,429	5.8559	2	3	5	7	11
180	92,193	5.3215	2	3	4	7	10
181	25,897	3.3265	1	2	3	4	6
182	292,198	4.4293	1	2	3	5	8
183	86,576	2.8664	1	1	2	4	5
184	78	3.2821	1	2	2	4	6
185	5,680	4.4905	1	2	3	5	9
186	4	2.0000	1	1	1	3	3
187	621	4.1723	1	2	3	5	8
188	90,968	5.5332	1	2	4	7	11
189	13,182	3.0882	1	1	2	4	6
190	69	4.3768	1	2	3	5	8
191	10,411	12.6933	3	6	9	16	26
192	1,322	5.6899	1	3	5	7	10
193	4,514	12.0549	5	7	10	15	22
194	521	6.6756	3	4	6	8	11
195	3,249	10.6190	4	6	9	13	19
196	701	5.7275	2	4	5	7	9
197	17,316	9.0988	3	5	7	11	17
198	4,645	4.3208	2	3	4	6	7
199	1,425	9.5298	2	4	7	13	19
200	936	9.6976	1	4	7	12	20
201	2,665	13.7471	3	6	10	18	28
202	27,281	6.1787	2	3	5	8	12
203	31,656	6.4850	2	3	5	8	13
204	72,845	5.5246	2	3	4	7	11
205	31,474	5.8950	2	3	4	7	12
206	2,081	3.8847	1	2	3	5	8
207	35,754	5.2393	1	2	4	7	10
208	9,758	2.9364	1	1	2	4	6
210	128,455	6.6967	3	4	6	8	11
211	26,708	4.6708	3	3	4	5	7
212	10	2.9000	1	1	3	4	4
213	10,257	9.1059	2	4	7	12	18
216	17,656	5.7608	1	1	3	8	14
217	17,622	12.4479	3	5	9	15	26
218	28,708	5.4480	2	3	4	7	10
219	21,361	3.1063	1	2	3	4	5
220	4	2.7500	2	2	3	3	3
223	13,425	3.2055	1	1	2	4	6
224	10,889	1.8875	1	1	1	2	3
225	6,514	5.1650	1	2	4	7	11
226	6,660	6.3380	1	2	4	8	13
227	5,074	2.6139	1	1	2	3	5
228	2,640	4.1258	1	1	3	5	9
229	1,201	2.5129	1	1	2	3	5

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

[FY 2004 MedPAR Update December 2004 GROUPER V23.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
230	2,565	5.5922	1	2	4	7	12
232	729	2.8230	1	1	1	3	6
233	15,118	6.6726	1	2	5	9	14
234	7,676	2.7952	1	1	2	4	6
235	4,970	4.6463	1	2	4	6	9
236	42,408	4.4748	1	3	4	5	8
237	2,022	3.6682	1	2	3	4	7
238	9,869	8.2633	3	4	6	10	15
239	42,943	6.0632	2	3	5	7	11
240	12,653	6.6177	2	3	5	8	13
241	2,696	3.7066	1	2	3	5	7
242	2,742	6.5864	2	3	5	8	12
243	101,477	4.5166	1	2	4	6	8
244	15,792	4.4924	1	2	4	6	8
245	5,840	3.1334	1	1	3	4	6
246	1,430	3.5664	1	2	3	4	7
247	21,671	3.3172	1	2	3	4	6
248	15,118	4.8397	1	3	4	6	9
249	14,026	3.8285	1	1	3	5	8
250	4,155	3.8876	1	2	3	5	7
251	2,148	2.7514	1	1	3	3	5
252	1	1.0000	1	1	1	1	1
253	24,857	4.5324	2	3	4	5	8
254	10,420	3.0461	1	2	3	4	5
255	1	7.0000	7	7	7	7	7
256	7,152	5.0301	1	2	4	6	10
257	13,512	2.6104	1	1	2	3	5
258	12,042	1.7498	1	1	1	2	3
259	2,903	2.7689	1	1	1	3	7
260	2,991	1.4055	1	1	1	1	2
261	1,603	2.2052	1	1	1	2	4
262	636	4.8428	1	2	4	7	10
263	23,809	10.7403	3	5	8	13	21
264	3,922	6.2358	2	3	5	8	12
265	4,307	6.5677	1	2	4	8	14
266	2,304	3.1788	1	1	2	4	7
267	272	4.1838	1	1	3	5	10
268	1,004	3.5508	1	1	2	4	7
269	10,686	8.3273	2	4	6	11	16
270	2,639	3.8151	1	1	3	5	8
271	21,054	6.7875	2	3	5	8	12
272	5,942	5.8009	2	3	4	7	11
273	1,349	3.6449	1	2	3	5	7
274	2,288	6.2592	2	3	5	8	12
275	228	3.2456	1	1	2	4	7
276	1,447	4.4630	1	2	4	6	8
277	112,318	5.5013	2	3	5	7	10
278	33,865	4.0567	2	2	3	5	7
279	6	4.6667	1	3	5	6	6
280	19,272	4.0080	1	2	3	5	7
281	7,093	2.8429	1	1	2	4	5
283	6,274	4.5695	1	2	3	6	9
284	1,833	3.0295	1	1	2	4	6
285	7,623	10.0454	3	5	8	12	19
286	2,703	5.4802	2	2	4	6	10
287	6,114	9.8368	3	5	7	12	19
288	10,450	4.1090	2	2	3	4	7
289	6,894	2.5582	1	1	1	2	5
290	10,859	2.1325	1	1	1	2	4
291	64	2.7969	1	1	1	2	5
292	7,331	10.0308	2	4	8	13	20
293	368	4.4674	1	2	3	6	9
294	98,963	4.2920	1	2	3	5	8
295	4,102	3.6675	1	2	3	4	7
296	254,706	4.7202	1	2	4	6	9
297	45,347	3.0710	1	2	3	4	6
298	81	3.9383	1	1	2	4	7
299	1,478	5.1604	1	2	4	6	10
300	21,343	5.8673	2	3	5	7	11
301	3,901	3.4107	1	2	3	4	6

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

[FY 2004 MedPAR Update December 2004 GROUPER V23.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
302	9,649	8.1898	4	5	6	9	14
303	23,760	7.3943	3	4	6	9	14
304	13,826	8.4735	2	3	6	11	18
305	3,087	3.2096	1	2	3	4	6
306	6,350	5.4737	1	2	3	8	12
307	2,066	2.0736	1	1	2	2	3
308	7,093	6.1095	1	2	4	8	14
309	3,559	2.0014	1	1	1	2	4
310	26,035	4.5265	1	2	3	6	10
311	6,480	1.8782	1	1	1	2	3
312	1,456	4.8365	1	1	3	6	11
313	508	2.2165	1	1	2	3	4
314	1	2.0000	2	2	2	2	2
315	36,565	6.7584	1	1	4	9	16
316	180,999	6.2874	2	3	5	8	12
317	2,766	3.4678	1	1	2	4	7
318	5,927	5.7441	1	2	4	7	11
319	383	2.7546	1	1	2	3	6
320	218,684	5.0953	2	3	4	6	9
321	31,401	3.5963	1	2	3	4	6
322	61	3.4918	2	2	3	4	6
323	20,482	3.0937	1	1	2	4	6
324	5,421	1.8843	1	1	1	2	3
325	9,615	3.6813	1	2	3	5	7
326	2,584	2.6207	1	1	2	3	5
327	5	2.6000	1	1	2	3	5
328	606	3.4719	1	1	3	5	7
329	72	1.8333	1	1	1	2	3
331	54,798	5.4332	1	2	4	7	11
332	4,389	3.1246	1	1	2	4	6
333	252	5.4921	1	2	3	7	13
334	9,810	4.3009	2	2	3	5	7
335	11,931	2.6866	1	2	3	3	4
336	31,264	3.2999	1	2	2	4	7
337	25,156	1.9182	1	1	2	2	3
338	652	6.1748	1	2	3	9	14
339	1,253	5.1173	1	1	3	7	11
340	2	5.0000	4	4	6	6	6
341	3,185	3.1586	1	1	2	3	7
342	565	3.4248	1	2	2	4	8
344	2,693	2.7037	1	1	1	2	6
345	1,461	4.8077	1	1	3	6	11
346	3,966	5.7307	1	3	4	7	11
347	247	3.0202	1	1	2	4	7
348	4,171	4.0897	1	2	3	5	8
349	575	2.3583	1	1	2	3	4
350	7,137	4.4541	2	2	4	5	8
352	975	4.0133	1	2	3	5	8
353	2,735	6.3192	2	3	4	7	12
354	7,612	5.6967	2	3	4	6	10
355	4,937	3.0614	2	2	3	4	4
356	23,993	1.9281	1	1	2	2	3
357	5,570	8.1269	3	4	6	10	15
358	20,798	3.9629	2	2	3	4	7
359	28,741	2.4058	1	2	2	3	4
360	14,764	2.5880	1	1	2	3	4
361	272	3.0184	1	1	2	3	7
362	2	1.0000	1	1	1	1	1
363	2,128	3.7810	1	2	2	4	8
364	1,451	4.1909	1	2	3	5	9
365	1,622	7.7404	2	3	5	9	17
366	4,789	6.4792	2	3	5	8	13
367	456	2.9934	1	1	2	4	6
368	3,924	6.6351	2	3	5	8	13
369	3,613	3.2419	1	1	2	4	6
370	1,843	5.1557	2	3	4	5	8
371	2,244	3.3944	2	3	3	4	5
372	1,164	3.1847	2	2	2	3	5
373	4,871	2.2373	1	2	2	3	3
374	156	2.7436	2	2	2	3	4

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

[FY 2004 MedPAR Update December 2004 GROUPER V23.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
375	6	4.0000	1	2	2	6	6
376	388	3.3711	1	2	2	4	6
377	77	4.4805	1	1	3	4	8
378	196	2.3163	1	1	2	3	4
379	508	2.8130	1	1	2	3	6
380	91	2.1099	1	1	1	2	4
381	212	2.2642	1	1	1	2	4
382	43	1.4419	1	1	1	2	2
383	2,473	3.6526	1	1	2	4	7
384	132	2.5606	1	1	1	3	5
385	1	1.0000	1	1	1	1	1
389	1	21.0000	21	21	21	21	21
390	1	1.0000	1	1	1	1	1
392	2,203	9.1770	2	4	6	11	19
393	1	4.0000	4	4	4	4	4
394	2,820	7.3553	1	2	5	9	16
395	116,129	4.2575	1	2	3	5	8
396	9	4.4444	1	1	2	3	6
397	18,482	5.1407	1	2	4	6	10
398	18,288	5.7016	2	3	4	7	11
399	1,640	3.3250	1	2	3	4	6
401	6,328	11.0390	2	5	9	14	22
402	1,401	4.0293	1	1	3	5	9
403	31,865	7.9367	2	3	6	10	16
404	3,802	4.1528	1	2	3	5	8
406	2,224	9.9150	2	4	7	12	21
407	584	3.8253	1	2	3	5	7
408	2,170	8.1949	1	2	5	10	19
409	1,808	5.7954	1	3	4	6	12
410	28,417	3.8214	1	2	3	5	6
411	12	3.2500	1	2	2	4	4
412	12	2.7500	1	1	1	3	4
413	5,198	6.7563	2	3	5	9	13
414	573	4.0244	1	2	3	5	8
415	50,826	14.0037	4	6	11	18	28
416	239,006	7.3769	2	3	6	9	14
417	23	5.2174	1	2	3	5	10
418	28,508	6.1657	2	3	5	8	12
419	16,282	4.3857	1	2	3	5	8
420	2,941	3.3747	1	2	3	4	6
421	11,882	4.0613	1	2	3	5	7
422	52	3.7115	1	1	2	4	7
423	8,637	8.2173	2	3	6	10	17
424	1,071	11.7274	2	4	8	14	22
425	14,779	3.4569	1	1	3	4	7
426	4,313	4.1203	1	2	3	5	8
427	1,505	4.7375	1	2	3	5	9
428	773	7.2549	1	2	5	8	15
429	25,479	5.4228	2	3	4	6	10
430	71,439	7.6737	2	3	6	9	15
431	304	5.8947	1	2	4	7	12
432	420	4.2548	1	2	3	5	8
433	5,191	2.9626	1	1	2	3	6
439	1,739	8.7993	1	3	5	10	19
440	5,613	8.7825	2	3	6	10	18
441	779	3.3813	1	1	2	4	7
442	18,017	8.6810	2	3	6	11	18
443	3,384	3.3992	1	1	3	4	7
444	5,892	4.0324	1	2	3	5	8
445	2,346	2.8372	1	1	2	4	5
447	6,264	2.5686	1	1	2	3	5
448	1	2.0000	2	2	2	2	2
449	38,802	3.6742	1	1	3	4	7
450	7,805	1.9867	1	1	1	2	4
451	3	1.6667	1	1	1	3	3
452	27,634	4.8762	1	2	3	6	10
453	5,437	2.7993	1	1	2	3	5
454	3,837	4.1058	1	2	3	5	8
455	846	2.2222	1	1	2	3	4
461	2,722	5.1267	1	1	3	6	12

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

[FY 2004 MedPAR Update December 2004 GROUPER V23.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
462	7,761	10.1584	4	6	8	13	18
463	31,045	3.8939	1	2	3	5	7
464	7,661	2.9141	1	1	2	4	5
465	219	3.6347	1	1	2	4	7
466	1,377	4.7117	1	1	2	5	9
467	1,015	2.6788	1	1	2	3	5
468	50,458	12.8082	3	6	10	16	25
471	15,614	5.0496	3	3	4	5	8
473	8,778	12.4026	2	3	7	18	32
475	116,534	11.0157	2	5	9	14	21
476	3,025	10.4998	2	4	9	14	21
477	29,425	8.5246	1	3	6	11	18
478	113,660	7.1046	1	2	5	9	15
479	24,603	2.7884	1	1	2	4	6
480	802	17.9102	7	9	13	22	36
481	1,066	21.8208	10	16	20	25	35
482	5,076	11.4967	4	6	9	14	21
484	449	12.7506	2	6	10	17	25
485	3,420	9.6038	4	5	7	11	18
486	2,562	12.3478	2	6	10	16	25
487	4,644	7.0540	1	3	5	9	14
488	786	16.3422	4	7	13	22	35
489	13,461	8.3538	2	3	6	10	17
490	5,204	5.3918	1	2	4	7	11
491	19,789	3.1423	1	2	3	3	5
492	4,012	13.6269	3	5	6	23	31
493	61,628	6.0515	1	3	5	8	12
494	25,626	2.6772	1	1	2	4	5
495	304	17.3092	8	9	13	19	31
496	3,261	8.9877	3	4	6	11	18
497	27,838	5.8368	3	3	5	7	10
498	19,057	3.7703	2	3	3	5	6
499	35,676	4.3236	1	2	3	5	9
500	48,323	2.2420	1	1	2	3	4
501	3,122	9.9308	4	5	8	13	18
502	717	5.6987	2	3	5	7	9
503	5,909	3.8284	1	2	3	5	7
504	187	27.1818	8	16	23	36	49
505	179	4.6704	1	1	1	6	11
506	1,004	15.9273	3	7	13	21	33
507	307	8.4919	1	3	7	11	18
508	641	7.2044	1	3	5	9	15
509	168	5.1607	1	2	3	6	11
510	1,755	6.4160	1	2	4	8	14
511	635	4.0787	1	1	2	5	8
512	513	12.7719	7	8	10	14	23
513	227	9.9824	5	7	8	12	16
515	44,478	4.3401	1	1	2	6	10
517	66,287	2.5801	1	1	1	3	6
518	42,044	3.4580	1	1	2	4	8
519	11,506	4.8233	1	1	3	6	11
520	15,266	2.0074	1	1	1	2	4
521	32,148	5.4742	2	3	4	7	11
522	5,646	9.3666	3	4	7	12	19
523	15,866	3.8769	1	2	3	5	7
524	118,949	3.1907	1	2	3	4	6
525	313	13.4952	1	3	8	16	32
527	192,230	2.2326	1	1	1	2	5
528	1,770	17.1090	6	10	15	22	30
529	4,032	7.9923	1	2	5	10	18
530	2,363	3.1240	1	1	2	4	6
531	4,799	9.4049	2	4	7	12	20
532	2,622	3.7227	1	1	3	5	8
533	47,609	3.7364	1	1	2	4	9
534	45,285	1.7909	1	1	1	2	3
535	7,387	10.3013	3	5	8	13	20
536	8,055	7.6500	2	4	6	9	14
537	8,641	6.7775	1	3	5	8	14
538	5,604	2.8164	1	1	2	4	6
539	5,020	10.7639	2	4	7	14	23

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

[FY 2004 MedPAR Update December 2004 GROUPER V23.0]

DRG	Number of discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
540	1,510	3.5808	1	1	3	4	7
541	22,435	42.7921	17	24	35	52	76
542	24,376	32.5434	12	18	27	40	58
543	5,415	11.9830	2	5	10	16	24
544	418,885	4.5100	3	3	4	5	7
545	42,337	5.1387	3	3	4	6	8
546	1,958	9.1062	3	5	7	11	18
547	26,797	5.5682	2	3	4	7	10
548	11,935	3.0404	1	2	3	4	5
549	35,690	5.2044	2	3	4	6	10
550	20,187	2.8595	1	2	3	4	5
	12,140,152						

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS—MARCH 2005

State	Urban	Rural
Alabama	0.279	0.348
Alaska	0.454	0.784
Arizona	0.295	0.392
Arkansas	0.359	0.383
California	0.251	0.354
Colorado	0.328	0.483
Connecticut	0.458	0.522
Delaware	0.546	0.548
District of Columbia	0.386	.....
Florida	0.257	0.304
Georgia	0.373	0.426
Hawaii	0.404	0.479
Idaho	0.487	0.577
Illinois	0.337	0.442
Indiana	0.439	0.47
Iowa	0.407	0.505
Kansas	0.313	0.471
Kentucky	0.401	0.404
Louisiana	0.306	0.369
Maine	0.504	0.489
Maryland	0.762	0.827
Massachusetts	0.485	.....
Michigan	0.396	0.496
Minnesota	0.404	0.531
Mississippi	0.354	0.391
Missouri	0.346	0.408
Montana	0.437	0.481
Nebraska	0.371	0.503
Nevada	0.245	0.558
New Hampshire	0.467	0.508
New Jersey	0.196	.....
New Mexico	0.428	0.414
New York	0.372	0.526
North Carolina	0.454	0.439
North Dakota	0.418	0.467
Ohio	0.389	0.543
Oklahoma	0.332	0.423
Oregon	0.499	0.481

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS—MARCH 2005—Continued

State	Urban	Rural
Pennsylvania	0.299	0.472
Puerto Rico	0.443	.....
Rhode Island	0.439	.....
South Carolina	0.313	0.34
South Dakota	0.385	0.498
Tennessee	0.337	0.402
Texas	0.309	0.38
Utah	0.428	0.598
Vermont	0.577	0.635
Virginia	0.386	0.398
Washington	0.454	0.497
West Virginia	0.492	0.472
Wisconsin	0.458	0.497
Wyoming	0.442	0.614

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS—MARCH 2005

State	Ratio
Alabama	0.027
Alaska	0.044
Arizona	0.029
Arkansas	0.03
California	0.019
Colorado	0.03
Connecticut	0.035
Delaware	0.047
District of Columbia	0.029
Florida	0.026
Georgia	0.035
Hawaii	0.034
Idaho	0.041
Illinois	0.03
Indiana	0.041
Iowa	0.033

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS—MARCH 2005—Continued

State	Ratio
Kansas	0.033
Kentucky	0.033
Louisiana	0.032
Maine	0.036
Maryland	0.016
Massachusetts	0.036
Michigan	0.037
Minnesota	0.034
Mississippi	0.032
Missouri	0.029
Montana	0.039
Nebraska	0.039
Nevada	0.019
New Hampshire	0.037
New Jersey	0.015
New Mexico	0.036
New York	0.033
North Carolina	0.039
North Dakota	0.041
Ohio	0.032
Oklahoma	0.031
Oregon	0.038
Pennsylvania	0.026
Puerto Rico	0.033
Rhode Island	0.022
South Carolina	0.03
South Dakota	0.04
Tennessee	0.034
Texas	0.03
Utah	0.039
Vermont	0.045
Virginia	0.039
Washington	0.037
West Virginia	0.033
Wisconsin	0.038
Wyoming	0.046

TABLE 9A.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2006

Provider number	Geographic CBSA	Reclassified CBSA	Lugar
010005	01	13820	
010008	01	33860	
010012	01	16860	
010022	01	40660	LUGAR

TABLE 9A.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2006—Continued

Provider number	Geographic CBSA	Reclassified CBSA	Lugar
010025	01	17980	
010029	12220	17980	
010035	01	13820	
010044	01	13820	
010045	01	13820	
010065	01	33860	
010072	01	11500	LUGAR
010083	01	37860	
010100	01	37860	
010101	01	11500	LUGAR
010118	01	33860	
010120	01	33660	
010126	01	33860	
010143	01	13820	
010158	01	19460	
030013	49740	20940	
030033	03	22380	
040014	04	30780	
040017	04	44180	
040019	04	32820	
040020	27860	32820	
040027	04	44180	
040039	04	27860	
040041	04	30780	
040047	04	27860	
040069	04	32820	
040071	38220	30780	
040072	04	30780	
040076	04	30780	
040078	26300	30780	
040080	04	27860	
040088	04	43340	
040091	04	45500	
040100	04	30780	
040119	04	30780	
050006	05	39820	
050009	34900	46700	
050013	34900	46700	
050014	05	40900	
050022	40140	42044	
050042	05	39820	
050046	37100	31084	
050054	40140	42044	
050065	42044	31084	
050069	42044	31084	
050071	41940	36084	
050073	46700	36084	
050076	41884	36084	
050082	37100	31084	
050089	40140	31084	
050090	42220	41884	
050099	40140	31084	
050102	40140	42044	
050118	44700	33700	
050129	40140	31084	
050136	42220	41884	
050140	40140	31084	
050150	05	40900	
050159	37100	31084	
050168	42044	31084	
050173	42044	31084	
050174	42220	41884	
050177	37100	31084	
050193	42044	31084	
050224	42044	31084	
050226	42044	31084	
050228	41884	36084	
050230	42044	31084	
050236	37100	31084	
050243	40140	42044	

TABLE 9A.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2006—Continued

Provider number	Geographic CBSA	Reclassified CBSA	Lugar
050245	40140	31084	
050251	05	39900	
050272	40140	31084	
050279	40140	31084	
050291	42220	41884	
050292	40140	42044	
050298	40140	31084	
050300	40140	31084	
050327	40140	31084	
050329	40140	42044	
050331	42220	41884	
050348	42044	31084	
050385	42220	41884	
050390	40140	42044	
050394	37100	31084	
050419	05	39820	
050423	40140	42044	
050426	42044	31084	
050430	05	39900	
050510	41884	36084	
050517	40140	31084	
050526	42044	31084	
050534	40140	42044	
050535	42044	31084	
050541	41884	36084	
050543	42044	31084	
050547	42220	41884	
050548	42044	31084	
050550	42044	31084	
050551	42044	31084	
050567	42044	31084	
050569	05	42220	
050570	42044	31084	
050573	40140	42044	
050580	42044	31084	
050584	40140	31084	
050585	42044	31084	
050586	40140	31084	
050589	42044	31084	
050592	42044	31084	
050594	42044	31084	
050603	42044	31084	
050609	42044	31084	
050616	37100	31084	
050667	34900	46700	
050668	41884	36084	
050678	42044	31084	
050684	40140	42044	
050686	40140	42044	
050690	42220	41884	
050693	42044	31084	
050694	40140	42044	
050701	40140	42044	
050709	40140	31084	
050718	40140	42044	
050720	42044	31084	
050728	42220	41884	
060001	24540	19740	
060003	14500	19740	
060023	24300	39340	
060027	14500	19740	
060044	06	19740	
060049	06	22660	
060096	06	19740	
060103	14500	19740	
070003	07	25540	LUGAR
070021	07	25540	LUGAR
070033	14860	35644	
080004	20100	48864	
080007	08	36140	

TABLE 9A.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2006—Continued

Provider number	Geographic CBSA	Reclassified CBSA	Lugar
100022	33124	22744	
100023	10	36740	
100024	10	33124	
100045	19660	36740	
100049	10	29460	
100081	10	23020	LUGAR
100109	10	36740	
100118	10	27260	
100139	10	23540	LUGAR
100150	10	33124	
100157	29460	45300	
100176	48424	38940	
100217	46940	38940	
100232	10	27260	
100239	45300	42260	
100249	10	36100	
100252	10	38940	
100292	10	23020	LUGAR
110001	19140	12060	
110002	11	12060	
110003	11	27260	
110023	11	12060	
110025	15260	27260	
110029	23580	12060	
110038	11	45220	
110040	11	12060	LUGAR
110041	11	12020	
110052	11	16860	LUGAR
110054	40660	12060	
110069	47580	31420	
110075	11	42340	
110088	11	12060	LUGAR
110095	11	46660	
110117	11	12060	LUGAR
110122	46660	45220	
110125	11	31420	
110128	11	42340	
110150	11	31420	
110153	47580	31420	
110168	40660	12060	
110187	11	12060	LUGAR
110189	11	12060	
110205	11	12060	
120028	12	26180	
130002	13	14260	
130003	30300	50	
130049	17660	44060	
140012	14	16974	
140015	14	41180	
140032	14	41180	
140034	14	41180	
140040	14	37900	
140043	14	40420	
140046	14	41180	
140058	14	41180	
140061	14	41180	
140064	14	37900	
140110	14	16974	
140143	14	37900	
140160	14	40420	
140161	14	16974	
140164	14	41180	
140189	14	16580	
140233	40420	16974	
140234	14	37900	
140236	14	28100	LUGAR
140291	29404	16974	
150002	23844	16974	
150004	23844	16974	
150006	33140	43780	

TABLE 9A.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2006—Continued

Provider number	Geographic CBSA	Reclassified CBSA	Lugar
150008	23844	16974	
150011	15	26900	
150015	33140	16974	
150030	15	26900	LUGAR
150048	15	17140	
150065	15	26900	
150069	15	17140	
150076	15	43780	
150088	11300	26900	
150090	23844	16974	
150102	15	23844	LUGAR
150112	18020	26900	
150113	11300	26900	
150125	23844	16974	
150126	23844	16974	
150132	23844	16974	
150133	15	23060	
150146	15	23060	
150147	23844	16974	
160001	16	11180	
160016	16	19780	
160026	16	11180	LUGAR
160057	16	26980	
160080	16	40420	
160089	16	19780	
160147	16	11180	
170006	17	27900	
170010	17	46140	
170012	17	48620	
170013	17	48620	
170020	17	48620	
170022	17	28140	
170023	17	48620	
170033	17	48620	
170058	17	28140	
170068	17	11100	
170120	17	27900	
170142	17	45820	
170175	17	48620	
180005	18	26580	
180011	18	30460	
180012	21060	31140	
180013	14540	34980	
180017	18	21060	
180018	18	30460	
180019	18	17140	
180024	18	31140	
180027	18	17300	
180028	18	26580	
180029	18	28700	
180044	18	26580	
180048	18	31140	
180066	18	34980	
180069	18	26580	
180075	18	14540	LUGAR
180078	18	26580	
180080	18	28940	
180093	18	21780	
180102	18	17300	
180104	18	17300	
180116	18	14	
180124	14540	34980	
180127	18	31140	
180132	18	30460	
180139	18	30460	
190001	19	35380	
190003	19	29180	
190015	19	35380	
190086	19	43340	
190099	19	12940	

TABLE 9A.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2006—Continued

Provider number	Geographic CBSA	Reclassified CBSA	Lugar
190106	19	10780	
190131	12940	35380	
190155	19	12940	LUGAR
190164	19	10780	
190191	19	12940	
190223	19	12940	LUGAR
200002	20	38860	
200020	38860	40484	
200024	30340	38860	
200034	30340	38860	
200039	20	38860	
200050	20	12620	
200063	20	38860	
220001	49340	14484	
220002	15764	14484	
220003	49340	14484	
220010	21604	14484	
220011	15764	14484	
220019	49340	14484	
220025	49340	14484	
220028	49340	14484	
220029	21604	14484	
220033	21604	14484	
220035	21604	14484	
220049	15764	14484	
220058	49340	14484	
220060	14484	12700	
220062	49340	14484	
220063	15764	14484	
220070	15764	14484	
220077	44140	25540	
220080	21604	14484	
220082	15764	14484	
220084	15764	14484	
220089	15764	14484	
220090	49340	14484	
220095	49340	14484	
220098	15764	14484	
220101	15764	14484	
220105	15764	14484	
220133	15764	14484	
220163	49340	14484	
220171	15764	14484	
220174	21604	14484	
230022	23	11460	
230030	23	40980	
230035	23	24340	LUGAR
230037	23	11460	
230042	23	26100	LUGAR
230047	47644	19804	
230054	23	24580	
230069	47644	22420	
230077	40980	22420	
230080	23	40980	
230093	23	24340	
230096	23	28020	
230099	33780	11460	
230105	23	13020	
230121	23	29620	LUGAR
230134	23	26100	LUGAR
230195	47644	19804	
230204	47644	19804	
230208	23	24340	LUGAR
230217	12980	29620	
230227	47644	19804	
230235	23	40980	LUGAR
230257	47644	19804	
230264	47644	19804	
230279	47644	22420	
230295	23	26100	LUGAR

TABLE 9A.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2006—Continued

Provider number	Geographic CBSA	Reclassified CBSA	Lugar
240013	24	33460	
240018	24	33460	
240030	24	41060	
240031	41060	33460	
240036	41060	33460	
240052	24	22020	
240064	24	20260	
240069	24	40340	
240071	24	40340	
240075	24	41060	
240088	24	41060	
240093	24	33460	
240105	24	40340	LUGAR
240150	24	40340	LUGAR
240152	24	33460	
240187	24	33460	
240211	24	33460	
250004	25	32820	
250006	25	32820	
250009	25	27180	
250023	25	25060	LUGAR
250031	25	27140	
250034	25	32820	
250040	37700	25060	
250042	25	32820	
250069	25	46220	
250079	25	27140	
250081	25	27140	
250082	25	38220	
250094	25620	25060	
250097	25	12940	
250099	25	27140	
250100	25	46220	
250104	25	27140	
250117	25	25060	LUGAR
260009	26	28140	
260011	27620	17860	
260017	26	41180	
260022	26	16	
260025	26	41180	
260047	27620	17860	
260049	26	44180	LUGAR
260064	26	17860	
260074	126	17860	
260094	26	44180	
260110	26	41180	
260113	26	14	
260116	26	14	
260183	26	41180	
260186	26	17860	
270003	27	24500	
270011	27	24500	
270017	27	33540	
270051	27	33540	
280009	28	30700	
280023	28	30700	
280032	28	30700	
280057	28	30700	
280061	28	53	
280065	28	24540	
280077	28	36540	
290002	29	16180	LUGAR
290006	29	39900	
290008	29	29820	
290019	16180	39900	
300003	30	31700	
300005	30	31700	
300007	31700	15764	
300011	31700	15764	
300012	31700	15764	

TABLE 9A.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2006—Continued

Provider number	Geographic CBSA	Reclassified CBSA	Lugar
300014	40484	31700	
300017	40484	21604	
300018	40484	31700	
300019	30	15764	
300020	31700	15764	
300023	40484	21604	
300029	40484	21604	
300034	31700	15764	
310002	35084	35644	
310009	35084	35644	
310013	35084	35644	
310015	35084	35644	
310018	35084	35644	
310031	15804	20764	
310032	47220	48864	
310038	20764	35644	
310048	20764	35084	
310054	35084	35644	
310070	20764	35644	
310076	35084	35644	
310078	35084	35644	
310083	35084	35644	
310093	35084	35644	
310096	35084	35644	
310119	35084	35644	
320005	22140	10740	
320006	32	42140	
320013	32	42140	
320014	32	29740	
320033	32	42140	LUGAR
320063	32	36220	
320065	32	36220	
330001	39100	35644	
330004	28740	39100	
330008	33	15380	LUGAR
330027	35004	35644	
330038	33	40380	LUGAR
330062	33	27060	LUGAR
330073	33	40380	LUGAR
330085	33	45060	
330094	33	28740	
330136	33	45060	
330157	33	45060	
330181	35004	35644	
330182	35004	35644	
330191	24020	10580	
330229	27460	21500	
330235	33	45060	LUGAR
330239	27460	21500	
330250	33	15540	
330277	33	27060	
330359	33	39100	LUGAR
330386	33	39100	LUGAR
340004	24660	49180	
340008	34	16740	
340010	24140	39580	
340013	34	16740	
340018	34	43900	LUGAR
340021	34	16740	
340023	11700	24860	
340027	34	24780	
340039	34	16740	
340050	34	22180	
340051	34	25860	
340068	34	48900	
340069	39580	20500	
340071	34	39580	LUGAR
340073	39580	20500	
340091	24660	49180	
340109	34	47260	

TABLE 9A.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2006—Continued

Provider number	Geographic CBSA	Reclassified CBSA	Lugar
340114	39580	20500	
340115	34	20500	
340124	34	39580	LUGAR
340127	34	20500	LUGAR
340129	34	16740	
340131	34	24780	
340136	34	20500	LUGAR
340138	39580	20500	
340144	34	16740	
340145	34	16740	LUGAR
340147	40580	39580	
340173	39580	20500	
350009	35	22020	
360008	36	26580	
360010	36	10420	
360011	36	18140	
360013	36	30620	
360014	36	18140	
360019	10420	17460	
360020	10420	17460	
360025	41780	17460	
360027	10420	17460	
360036	36	17460	
360039	36	18140	
360054	36	16620	
360065	36	17460	
360078	10420	17460	
360079	19380	17140	
360086	44220	19380	
360096	36	49660	LUGAR
360107	36	17460	
360112	45780	11460	
360125	36	17460	LUGAR
360150	10420	17460	
360159	36	18140	
360175	36	18140	
360185	36	49660	LUGAR
360187	44220	19380	
360197	36	18140	
360211	48260	38300	
360238	36	49660	LUGAR
360241	10420	17460	
360245	36	17460	LUGAR
370004	37	27900	
370014	37	43300	
370015	37	46140	
370018	37	46140	
370022	37	30020	
370025	37	46140	
370034	37	22900	
370047	37	43300	
370049	37	36420	
370099	37	46140	
370103	37	45	
370113	37	22220	
370179	37	46140	
380001	38	38900	
380008	38	18700	LUGAR
380022	38	18700	LUGAR
380027	38	21660	
380047	13460	21660	
380050	38	32780	
380070	38	38900	
390006	39	25420	
390013	39	25420	
390016	39	49660	
390030	39	10900	
390031	39	39740	LUGAR
390048	39	25420	
390052	39	11020	

TABLE 9A.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2006—Continued

Provider number	Geographic CBSA	Reclassified CBSA	Lugar
390065	39	47894	
390066	30140	25420	
390071	39	48700	LUGAR
390079	39	13780	
390081	37964	48864	
390086	39	44300	
390091	39	49660	
390093	39	49660	
390110	27780	38300	
390113	39	49660	
390133	10900	37964	
390138	39	47894	
390150	39	38300	LUGAR
390151	39	47894	
390156	37964	48864	
390180	37964	48864	
390222	37964	48864	
390224	39	13780	LUGAR
390244	39	48700	LUGAR
390246	39	48700	
390249	39	13780	LUGAR
400048	25020	41980	
410001	39300	14484	
410004	39300	14484	
410005	39300	14484	
410006	39300	14484	
410007	39300	14484	
410008	39300	14484	
410009	39300	14484	
410011	39300	14484	
410012	39300	14484	
410013	39300	14484	
420009	42	24860	LUGAR
420020	42	16700	
420028	42	44940	LUGAR
420030	42	16700	
420036	42	16740	
420039	42	43900	LUGAR
420067	42	42340	
420068	42	16700	
420069	42	44940	LUGAR
420070	44940	17900	
420071	42	24860	
420080	42	42340	
420085	34820	48900	
430012	43	43620	
430014	43	22020	
430094	43	53	
440008	44	21780	
440020	44	26620	
440035	17300	34980	
440050	44	11700	
440058	44	16860	
440059	44	34980	
440060	44	27180	
440067	34100	28940	
440068	44	16860	
440072	44	32820	
440073	44	34980	
440148	44	34980	
440151	44	34980	
440175	44	34980	
440180	44	28940	
440185	17420	16860	
440192	44	34980	
450007	45	41700	
450032	45	43340	
450039	23104	19124	
450059	41700	12420	
450064	23104	19124	

TABLE 9A.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2006—Continued

Provider number	Geographic CBSA	Reclassified CBSA	Lugar
450073	45	10180	
450080	45	30980	
450087	23104	19124	
450098	45	30980	
450099	45	11100	
450121	23104	19124	
450135	23104	19124	
450137	23104	19124	
450144	45	36220	
450148	23104	19124	
450187	45	26420	
450192	45	19124	
450194	45	19124	
450196	45	19124	
450211	45	26420	
450214	45	26420	
450224	45	46340	
450283	45	19124	LUGAR
450286	45	17780	LUGAR
450347	45	26420	
450351	45	23104	
450389	45	19124	LUGAR
450400	45	47380	
450419	23104	19124	
450438	45	26420	
450447	45	19124	
450451	45	23104	
450484	45	26420	
450508	45	46340	
450547	45	19124	
450563	23104	19124	
450623	45	19124	LUGAR
450639	23104	19124	
450653	45	33260	
450656	45	46340	
450672	23104	19124	
450675	23104	19124	
450677	23104	19124	
450694	45	26420	
450747	45	19124	
450755	45	31180	
450770	45	12420	LUGAR
450779	23104	19124	
450830	45	36220	
450839	45	43340	
450858	23104	19124	
450872	23104	19124	
450880	23104	19124	
460004	36260	41620	
460005	36260	41620	
460007	46	41100	
460011	46	39340	
460021	41100	29820	
460036	46	39340	
460039	46	36260	
460041	36260	41620	
460042	36260	41620	
470001	47	30	
470011	47	15764	
470012	47	38340	
490004	25500	16820	
490005	49020	47894	
490006	49	49020	LUGAR
490013	49	31340	
490018	49	16820	
490047	49	25500	LUGAR
490079	49	49180	
490092	49	40060	
490105	49	28700	
490106	49	16820	

TABLE 9A.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—FY 2006—Continued

Provider number	Geographic CBSA	Reclassified CBSA	Lugar
490109	47260	40060	
500002	50	28420	
500003	34580	42644	
500016	48300	42644	
500024	36500	45104	
500031	50	36500	
500039	14740	42644	
500041	31020	38900	
500072	50	42644	
500139	36500	45104	
500143	36500	45104	
510001	34060	38300	
510002	51	40220	
510006	51	38300	
510018	51	16620	LUGAR
510024	34060	38300	
510028	51	16620	
510030	51	34060	
510046	51	16620	
510047	51	38300	
510070	51	16620	
510071	51	16620	
510077	51	26580	
520002	52	48140	
520021	29404	16974	
520028	52	31540	LUGAR
520037	52	48140	
520059	39540	29404	
520060	52	22540	LUGAR
520066	27500	31540	
520071	52	33340	LUGAR
520076	52	31540	
520088	22540	33340	
520094	39540	33340	
520095	52	31540	
520096	39540	33340	
520102	52	33340	LUGAR
520107	52	24580	
520113	52	24580	
520116	52	33340	LUGAR
520152	52	24580	
520173	52	20260	
520189	29404	16974	
530002	53	16220	
530025	53	22660	

TABLE 9B.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUB. L. 108–173

Provider number	Geographic CBSA	Wage index CBSA 508 reclassification	Own wage index
010150	01	17980	
020008	02		1.2841
050494	05	42220	
050549	37100	42220	
060057	06	19740	
060075	06		1.1709
070001	35300	35004	
070005	35300	35004	
070010	14860	35644	
070016	35300	35004	
070017	35300	35004	
070019	35300	35004	
070022	35300	35004	
070028	14860	35644	
070031	35300	35004	
070036	25540		1.2926

TABLE 9B.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUB. L. 108–173—Continued

Provider number	Geographic CBSA	Wage index CBSA 508 reclassification	Own wage index
070039	35300	35004	
120025	12	26180	
150034	23844	16974	
160040	47940	16300	
160064	16		1.0228
160067	47940	16300	
160110	47940	16300	
190218	19	43340	
220046	38340	14484	
230003	26100	28020	
230004	34740	28020	
230013	47644	22420	
230019	47644	22420	
230020	19804	11460	
230024	19804	11460	
230029	47644	22420	
230036	23	22420	
230038	24340	28020	
230053	19804	11460	
230059	24340	28020	
230066	34740	28020	
230071	47644	22420	
230072	26100	28020	
230089	19804	11460	
230092	27100	24340	
230097	23	28020	
230104	19804	11460	
230106	24340	28020	
230119	19804	11460	
230130	47644	22420	
230135	19804	11460	
230146	19804	11460	
230151	47644	22420	
230165	19804	11460	
230174	26100	28020	
230176	19804	11460	
230207	47644	22420	
230223	47644	22420	
230236	24340	28020	
230254	47644	22420	
230269	47644	22420	
230270	19804	11460	
230273	19804	11460	
230277	47644	22420	
250002	25	25060	
250122	25	25060	
270021	27	13740	
270023	33540	13740	
270032	27	13740	
270050	27	13740	
270057	27	13740	
310021	45940	35644	
310028	35084	35644	
310050	35084	35644	
310051	35084	35644	
310060	10900	35644	
310115	10900	35644	
310120	35084	35644	
330049	39100	35644	
330067	39100	35300	
330106	35004		1.4734
330126	39100	35644	
330135	39100	35644	
330205	39100	35644	
330264	39100	35004	
340002	11700	16740	
350002	13900	22020	
350003	35	22020	
350006	35	22020	

TABLE 9B.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUB. L. 108–173—Continued

Provider number	Geographic CBSA	Wage index CBSA 508 reclassification	Own wage index
350010	35	22020	
350014	35	22020	
350015	13900	22020	
350017	35	22020	
350030	35	22020	
350061	35	22020	
380090	38		1.2316
390001	42540	10900	
390003	39	10900	
390054	42540	29540	
390072	39	10900	
390095	42540	10900	
390109	42540	10900	
390119	42540	10900	
390137	42540	10900	
390169	42540	10900	
390185	42540	29540	
390192	42540	10900	
390237	42540	10900	
390270	42540	29540	
410010	39300		1.1746
430005	43	39660	
430015	43	43620	
430048	43	43620	
430060	43	43620	
430064	43	43620	
430077	39660	43620	
430091	39660	43620	
450010	48660	32580	
450072	26420	26420	
450591	26420	26420	
470003	15540	14484	
490001	49	31340	
490024	40220	19260	
530015	53		0.9897
070006*	14860	35644	
070018*	14860	35644	
070034*	14860	35644	
140155*	28100	16974	
140186*	28100	16974	
250078*	25620	25060	
270002*	27	33540	
270012*	24500	33540	
270084*	27	33540	
330023*	39100	35644	
330067*	39100	35644	
350019*	24220	22020	
430008*	43	43620	
430013*	43	43620	
430031*	43	43620	
530008*	53	16220	
530010*	53	16220	

TABLE 9C.—HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(D)(8)(E) OF THE ACT

Provider number	Geographic CBSA	Redesignated rural area
030007	39140	03
040075	22220	04
050192	23420	05
050469	40140	05
050528	32900	05
050618	40140	05
070004	25540	07
100048	37860	10
100134	27260	10
130018	26820	13

TABLE 9C.—HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(D)(8)(E) OF THE ACT—Continued

Provider number	Geographic CBSA	Redesignated rural area
140167	14	14
150051	14020	15
150078	23844	15
170137	29940	17
190048	26380	19
230078	35660	23
240037	33460	24
260006	41140	26
300009	31700	30
370054	36420	37
380040	13460	38
380084	41420	38
390181	39	39
390183	39	39
390201	39	39
450052	45	45
450078	10180	45
450243	10180	45
450276	48660	45
450348	45	45
500023	28420	50
500037	49420	50
500122	50	50
500147	42644	50
500148	48300	50

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG)—MARCH 2005 [1]

DRG	Cases	Threshold
1	23,252	$53,083
2	10,344	$37,759
3	4	$48,426
6	410	$15,918
7	15,583	$41,465
8	3,699	$30,770
9	1,942	$26,987
10	19,496	$24,514
11	3,278	$17,942
12	54,365	$17,418
13	7,327	$16,737
14	236,739	$24,767
15	76,007	$18,842
16	16,254	$26,229
17	3,005	$14,673
18	33,048	$19,757
19	8,553	$14,440
20	6,528	$41,346
21	2,195	$28,454
22	3,315	$23,057
23	10,714	$15,561
24	63,800	$19,706
25	28,130	$12,635
26	18	$25,170
27	5,385	$26,078
28	17,543	$26,266
29	6,262	$14,651
31	5,087	$19,123
32	1,981	$12,778

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG)—MARCH 2005 [1]—Continued

DRG	Cases	Threshold
34	27,853	$19,761
35	7,887	$12,867
36	1,469	$14,560
37	1,237	$23,489
38	56	$14,212
39	447	$14,248
40	1,382	$19,777
42	1,144	$16,384
43	125	$11,950
44	1,159	$13,657
45	2,798	$15,147
46	3,816	$15,156
47	1,334	$10,768
49	2,474	$32,109
50	2,161	$17,332
51	190	$18,236
52	165	$17,220
53	2,223	$26,424
55	1,353	$18,794
56	435	$17,620
57	697	$22,175
59	102	$15,452
60	8	$16,595
61	219	$25,804
63	2,841	$27,928
64	3,339	$23,367
65	41,395	$12,285
66	8,002	$11,762
67	418	$15,509

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG)—MARCH 2005 [1]—Continued

DRG	Cases	Threshold
68	17,310	$13,327
69	4,810	$9,913
70	25	$8,304
71	68	$15,084
72	1,065	$15,307
73	7,925	$16,547
74	4	$7,279
75	45,004	$47,996
76	47,304	$43,717
77	2,153	$24,202
78	45,589	$24,850
79	170,543	$30,457
80	7,717	$17,767
81	4	$37,091
82	65,088	$27,672
83	6,944	$19,629
84	1,470	$11,706
85	21,855	$24,898
86	1,859	$14,235
87	82,642	$27,783
88	413,274	$17,776
89	550,119	$20,636
90	45,801	$12,316
91	45	$16,785
92	16,483	$23,911
93	1,596	$14,444
94	13,330	$23,013
95	1,609	$12,307
96	59,079	$14,840

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG)—MARCH 2005 [1]—Continued

DRG	Cases	Threshold
97	26,996	$10,870
98	8	$8,495
99	21,531	$14,399
100	6,934	$11,081
101	23,083	$17,487
102	5,236	$11,147
103	724	$214,160
104	20,904	$117,844
105	31,499	$89,729
106	3,492	$108,656
107	69,982	$85,171
108	7,942	$85,326
109	50,600	$65,918
110	57,121	$59,055
111	10,070	$44,900
113	37,225	$44,754
114	8,509	$31,122
115	22,119	$58,803
116	118,448	$43,379
117	5,146	$26,461
118	7,591	$33,464
119	993	$26,580
120	36,272	$36,812
121	159,450	$30,813
122	61,715	$19,625
123	33,617	$27,218
124	130,598	$28,749
125	95,641	$22,067
126	5,822	$42,108
127	695,047	$20,505
128	5,170	$13,906
129	3,751	$20,637
130	89,029	$18,640
131	23,806	$11,216
132	117,219	$12,597
133	7,276	$10,986
134	42,382	$12,400
135	7,433	$17,747
136	1,133	$12,797
138	206,854	$16,622
139	78,506	$10,671
140	38,098	$10,335
141	121,790	$15,337
142	52,218	$12,040
143	249,138	$11,604
144	99,593	$25,098
145	6,178	$11,899
146	10,762	$44,908
147	2,627	$29,912
148	135,543	$51,340
149	19,884	$28,508
150	22,692	$45,073
151	5,351	$25,703
152	5,006	$34,651
153	2,089	$21,823
154	28,473	$55,952
155	6,159	$25,835
156	6	$52,265
157	8,254	$26,362
158	4,104	$13,493
159	19,160	$28,111
160	11,968	$17,182
161	10,417	$23,781
162	5,486	$13,865
163	10	$14,004
164	5,941	$39,874
165	2,518	$23,716
166	4,928	$28,877
167	4,623	$17,916
168	1,544	$25,383
169	754	$14,788
170	17,464	$44,402
171	1,483	$24,371
172	32,853	$27,512
173	2,388	$15,475
174	267,618	$20,328
175	32,616	$11,567
176	14,542	$22,357
177	8,545	$18,625
178	2,903	$14,386
179	14,417	$21,872
180	92,094	$19,340
181	25,878	$11,462
182	291,824	$16,956
183	86,469	$12,060
184	78	$10,539
185	5,678	$17,264
186	4	$6,213
187	621	$17,068
188	90,890	$22,183
189	13,170	$12,414
190	69	$12,679
191	10,395	$54,119
192	1,322	$33,415
193	4,505	$50,334
194	520	$32,038
195	3,247	$49,676
196	699	$32,386
197	17,294	$41,808
198	4,629	$24,029
199	1,422	$38,851
200	936	$39,812
201	2,664	$51,676
202	27,245	$26,568
203	31,633	$27,380
204	72,764	$22,089
205	31,436	$23,369
206	2,075	$14,944
207	35,719	$23,543
208	9,747	$14,208
210	128,257	$35,917
211	26,620	$24,559
212	10	$26,686
213	10,256	$34,143
216	17,645	$36,166
217	17,611	$42,611
218	28,683	$32,278
219	21,323	$20,929
220	4	$31,838
223	13,414	$22,467
224	10,864	$16,561
225	6,508	$24,064
226	6,656	$29,923
227	5,068	$16,786
228	2,639	$23,112
229	1,198	$14,205
230	2,564	$26,523
232	721	$19,464
233	15,107	$35,245
234	7,659	$25,357
235	4,964	$14,917
236	42,358	$14,238
237	2,019	$12,305
238	9,863	$27,442
239	42,910	$21,095
240	12,638	$25,924
241	2,693	$13,360
242	2,742	$22,347
243	101,378	$15,581
244	15,777	$14,369
245	5,832	$9,431
246	1,429	$12,106
247	21,645	$11,781
248	15,098	$17,268
249	14,017	$13,881
250	4,149	$13,866
251	2,146	$9,765
253	24,829	$15,141
254	10,404	$9,271
256	7,144	$16,671
257	13,494	$17,881
258	12,014	$14,270
259	2,898	$19,381
260	2,981	$14,202
261	1,603	$19,576
262	636	$19,862
263	23,791	$33,555
264	3,921	$20,803
265	4,304	$29,777
266	2,303	$17,605
267	272	$18,035
268	1,003	$23,142
269	10,670	$31,752
270	2,635	$16,856
271	21,019	$19,407
272	5,931	$19,148
273	1,348	$11,532
274	2,287	$23,181
275	228	$11,152
276	1,445	$13,974
277	112,171	$17,127
278	33,823	$10,861
279	6	$17,172
280	19,255	$14,562
281	7,092	$9,993
283	6,268	$14,563
284	1,829	$9,200
285	7,615	$35,872
286	2,702	$35,486
287	6,107	$32,104
288	10,432	$37,872
289	6,881	$18,298
290	10,827	$17,619

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG)—MARCH 2005 [1]—Continued

DRG	Cases	Threshold
291	64	$18,543
292	7,321	$41,142
293	367	$27,840
294	98,864	$15,044
295	4,096	$14,601
296	254,455	$16,168
297	45,318	$9,887
298	81	$9,998
299	1,478	$20,010
300	21,321	$21,770
301	3,896	$12,544
302	9,646	$52,723
303	23,740	$39,286
304	13,816	$38,375
305	3,084	$23,623
306	6,341	$25,247
307	2,061	$12,398
308	7,089	$30,158
309	3,555	$18,659
310	26,019	$23,711
311	6,468	$13,013
312	1,454	$22,529
313	507	$14,119
315	36,526	$35,138
316	180,759	$25,061
317	2,756	$16,124
318	5,923	$23,425
319	382	$13,277
320	218,425	$17,103
321	31,366	$11,424
322	61	$11,164
323	20,454	$16,793
324	5,414	$10,413
325	9,600	$13,014
326	2,574	$9,069
327	5	$5,743
328	606	$14,673
329	71	$10,155
331	54,748	$20,954
332	4,387	$12,467
333	251	$18,573
334	9,802	$28,443
335	11,919	$21,877
336	31,235	$16,658
337	25,130	$11,427
338	652	$27,712
339	1,253	$23,286
340	2	$18,734
341	3,183	$25,976
342	563	$17,354
344	2,691	$25,572
345	1,461	$22,328
346	3,962	$21,235
347	247	$12,515
348	4,171	$14,696
349	575	$8,797
350	7,134	$14,636
352	973	$14,967
353	2,725	$32,476
354	7,603	$29,914
355	4,922	$17,549

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG)—MARCH 2005 [1]—Continued

DRG	Cases	Threshold
356	23,932	$14,960
357	5,563	$38,097
358	20,763	$22,658
359	28,654	$15,907
360	14,748	$17,209
361	272	$22,454
362	2	$11,608
363	2,127	$19,999
364	1,449	$17,758
365	1,620	$32,955
366	4,786	$24,830
367	455	$12,018
368	3,920	$23,343
369	3,610	$12,832
370	1,838	$17,389
371	2,236	$11,866
372	1,162	$9,834
373	4,860	$7,061
374	156	$13,290
375	6	$33,543
376	388	$10,147
377	77	$25,958
378	195	$15,828
379	507	$7,202
380	91	$7,834
381	212	$12,620
382	43	$4,126
383	2,472	$9,812
384	132	$6,300
392	2,202	$45,471
394	2,818	$31,480
395	115,973	$16,480
396	9	$15,832
397	18,425	$24,257
398	18,256	$24,100
399	1,634	$13,682
401	6,325	$43,589
402	1,401	$24,076
403	31,827	$30,787
404	3,799	$18,943
406	2,222	$42,772
407	583	$24,742
408	2,170	$33,802
409	1,807	$24,850
410	28,395	$22,712
411	12	$7,141
412	12	$16,545
413	5,193	$26,451
414	572	$16,081
415	50,799	$51,864
416	238,848	$29,646
417	23	$20,595
418	28,478	$21,320
419	16,269	$17,124
420	2,939	$12,324
421	11,866	$14,876
422	52	$10,935
423	8,631	$29,978
424	1,071	$36,011
425	14,758	$12,572
426	4,309	$9,562

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG)—MARCH 2005 [1]—Continued

DRG	Cases	Threshold
427	1,504	$10,543
428	769	$13,558
429	25,454	$15,545
430	71,402	$12,774
431	304	$10,532
432	420	$12,850
433	5,189	$5,613
439	1,738	$30,816
440	5,606	$30,736
441	779	$18,744
442	18,000	$37,969
443	3,382	$20,255
444	5,891	$14,879
445	2,345	$10,336
447	6,258	$10,696
449	38,766	$16,579
450	7,787	$8,697
451	3	$5,847
452	27,610	$20,394
453	5,431	$10,730
454	3,835	$15,920
455	846	$9,717
461	2,722	$27,440
462	7,751	$16,591
463	31,026	$13,855
464	7,651	$10,292
465	219	$12,019
466	1,377	$12,550
467	1,013	$9,726
468	50,411	$55,817
470	32	$13,204
471	15,474	$55,297
473	8,761	$39,707
475	116,437	$51,182
476	3,018	$36,994
477	29,401	$33,866
478	113,571	$40,296
479	24,583	$29,518
480	800	$120,367
481	1,065	$86,015
482	5,070	$49,484
484	449	$74,694
485	3,412	$50,963
486	2,562	$66,540
487	4,640	$32,711
488	786	$58,001
489	13,453	$29,620
490	5,203	$21,034
491	19,730	$32,883
492	4,005	$44,873
493	61,564	$35,020
494	25,546	$20,780
495	303	$109,115
496	3,255	$92,679
497	27,777	$59,046
498	19,008	$49,170
499	35,640	$27,782
500	48,213	$18,126
501	3,120	$43,064
502	717	$28,008
503	5,905	$24,316

TABLE 10.—GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG)—MARCH 2005 [1]—Continued

DRG	Cases	Threshold
504	187	$136,123
505	179	$27,684
506	1,004	$51,873
507	307	$32,100
508	641	$24,619
509	168	$14,897
510	1,755	$21,890
511	633	$12,748
512	513	$81,413
513	227	$97,844
515	44,389	$88,758
517	66,155	$40,225
518	42,015	$35,092
519	11,497	$43,638
520	15,218	$33,659
521	32,138	$13,596
522	5,642	$9,515
523	15,863	$7,639
524	118,842	$14,823
525	313	$139,715
527	191,680	$44,147
528	1,767	$102,318
529	4,030	$37,957
530	2,362	$24,232
531	4,796	$45,158
532	2,622	$29,368
533	47,549	$31,277
534	45,166	$20,426
535	7,384	$123,742
536	8,047	$108,821
537	8,640	$33,393
538	5,598	$20,028
539	5,014	$44,863
540	1,509	$23,964
541	22,410	$242,891
542	24,343	$155,852
543	5,403	$62,826
544	417,780	$37,604
545	42,280	$44,313
546	1,954	$77,955
547	26,756	$49,899
548	11,898	$41,613
549	35,640	$55,680
550	20,130	$47,573

[1] Cases are taken from the FY 2004 MedPAR file; DRGs are from GROUPER Version 23.0.

TABLE 11.—PROPOSED FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
1	[5] CRANIOTOMY AGE >17 W CC	1.6862	38.0	31.7
2	[7] CRANIOTOMY AGE >17 W/O CC	1.6862	38.0	31.7
3	[7] CRANIOTOMY AGE 0–17	1.6862	38.0	31.7
6	[7] CARPAL TUNNEL RELEASE	0.4502	18.8	15.7
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	1.3854	37.5	31.3
8	[3] PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	0.7586	24.5	20.4
9	SPINAL DISORDERS & INJURIES	0.9617	33.2	27.7
10	NERVOUS SYSTEM NEOPLASMS W CC	0.7441	24.2	20.2
11	[2] NERVOUS SYSTEM NEOPLASMS W/O CC	0.5834	21.0	17.5
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.6903	25.5	21.3
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.6625	23.0	19.2
14	INTERCRANIAL HEMORRHAGE OR STROKE WITH INFARCT	0.7758	25.9	21.6
15	NONSPECIFIC CVA & PRECEREBRAL OCCULUSION WITHOUT INFARCT	0.7398	27.0	22.5
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.7507	23.5	19.6
17	[1] NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.4502	18.8	15.7
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.7242	23.6	19.7
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.4809	21.2	17.7
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.0284	27.1	22.6
21	[3] VIRAL MENINGITIS	0.7586	24.5	20.4
22	[4] HYPERTENSIVE ENCEPHALOPATHY	1.1679	29.6	24.7
23	NONTRAUMATIC STUPOR & COMA	0.8101	25.4	21.2
24	SEIZURE & HEADACHE AGE >17 W CC	0.6262	22.4	18.7
25	[1] SEIZURE & HEADACHE AGE >17 W/O CC	0.4502	18.8	15.7
26	[7] SEIZURE & HEADACHE AGE 0–17	0.4502	18.8	15.7
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	0.9658	27.7	23.1
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	0.9042	30.2	25.2
29	[1] TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.4502	18.8	15.7
30	[7] TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	0.4502	18.8	15.7
31	[3] CONCUSSION AGE >17 W CC	0.7586	24.5	20.4
32	[7] CONCUSSION AGE >17 W/O CC	0.4502	18.8	15.7
33	[7] CONCUSSION AGE 0–17	0.4502	18.8	15.7
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.8056	25.2	21
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.5758	24.0	20
36	[7] RETINAL PROCEDURES	1.1679	29.6	24.7
37	[7] ORBITAL PROCEDURES	1.1679	29.6	24.7

TABLE 11.—PROPOSED FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
38	[7] PRIMARY IRIS PROCEDURES	1.1679	29.6	24.7
39	[7] LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	1.1679	29.6	24.7
40	[4] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	1.1679	29.6	24.7
41	[7] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	1.1679	29.6	24.7
42	[7] INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	1.1679	29.6	24.7
43	[7] HYPHEMA	1.1679	29.6	24.7
44	[2] ACUTE MAJOR EYE INFECTIONS	0.5834	21.0	17.5
45	[7] NEUROLOGICAL EYE DISORDERS	1.1679	29.6	24.7
46	[2] OTHER DISORDERS OF THE EYE AGE >17 W CC	0.5834	21.0	17.5
47	[7] OTHER DISORDERS OF THE EYE AGE >17 W/O CC	1.1679	29.6	24.7
48	[7] OTHER DISORDERS OF THE EYE AGE 0–17	1.1679	29.6	24.7
49	[7] MAJOR HEAD & NECK PROCEDURES	1.1679	29.6	24.7
50	[7] SIALOADENECTOMY	1.1679	29.6	24.7
51	[7] SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	1.1679	29.6	24.7
52	[7] CLEFT LIP & PALATE REPAIR	1.1679	29.6	24.7
53	[7] SINUS & MASTOID PROCEDURES AGE >17	1.1679	29.6	24.7
54	[7] SINUS & MASTOID PROCEDURES AGE 0–17	1.1679	29.6	24.7
55	[7] MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	1.1679	29.6	24.7
56	[7] RHINOPLASTY	1.1679	29.6	24.7
57	[7] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.4502	18.8	15.7
58	[7] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	0.4502	18.8	15.7
59	[7] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.4502	18.8	15.7
60	[7] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	0.4502	18.8	15.7
61	[3] MYRINGOTOMY W TUBE INSERTION AGE >17	0.7586	24.5	20.4
62	[7] MYRINGOTOMY W TUBE INSERTION AGE 0–17	0.4502	18.8	15.7
63	[4] OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.1679	29.6	24.7
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1477	26.2	21.8
65	[1] DYSEQUILIBRIUM	0.4502	18.8	15.7
66	[7] EPISTAXIS	0.4502	18.8	15.7
67	[3] EPIGLOTTITIS	0.7586	24.5	20.4
68	OTITIS MEDIA & URI AGE >17 W CC	0.5134	18.0	15
69	[1] OTITIS MEDIA & URI AGE >17 W/O CC	0.4502	18.8	15.7
70	[7] OTITIS MEDIA & URI AGE 0–17	0.4502	18.8	15.7
71	[7] LARYNGOTRACHEITIS	0.5834	21.0	17.5
72	[7] NASAL TRAUMA & DEFORMITY	0.5834	21.0	17.5
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.6360	20.4	17
74	[7] OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17	0.4502	18.8	15.7
75	[5] MAJOR CHEST PROCEDURES	1.6862	38.0	31.7
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.5324	43.6	36.3
77	[5] OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.6862	38.0	31.7
78	PULMONARY EMBOLISM	0.6955	21.9	18.3
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	0.8252	22.8	19
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.5993	21.5	17.9
81	[7] RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	0.4502	18.8	15.7
82	RESPIRATORY NEOPLASMS	0.7138	20.1	16.8
83	[2] MAJOR CHEST TRAUMA W CC	0.5834	21.0	17.5
84	[7] MAJOR CHEST TRAUMA W/O CC	0.5834	21.0	17.5
85	PLEURAL EFFUSION W CC	0.7308	21.2	17.7
86	[2] PLEURAL EFFUSION W/O CC	0.5834	21.0	17.5
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.0797	25.3	21.1
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.6620	19.6	16.3
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.7027	20.8	17.3
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.5004	17.8	14.8
91	[7] SIMPLE PNEUMONIA & PLEURISY AGE 0–17	0.4502	18.8	15.7
92	INTERSTITIAL LUNG DISEASE W CC	0.6764	20.2	16.8
93	[2] INTERSTITIAL LUNG DISEASE W/O CC	0.5834	21.0	17.5
94	PNEUMOTHORAX W CC	0.5913	17.0	14.2
95	[1] PNEUMOTHORAX W/O CC	0.4502	18.8	15.7
96	BRONCHITIS & ASTHMA AGE >17 W CC	0.6436	19.4	16.2
97	[2] BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5834	21.0	17.5
98	[7] BRONCHITIS & ASTHMA AGE 0–17	0.5834	21.0	17.5
99	RESPIRATORY SIGNS & SYMPTOMS W CC	0.9262	23.3	19.4
100	[3] RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.7586	24.5	20.4
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8143	21.1	17.6
102	[1] OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.4502	18.8	15.7
103	[6] HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	0.0000	1.0	0.8

TABLE 11.—PROPOSED FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
104	[7] CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	1.1679	29.6	24.7
105	[7] CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	1.1679	29.6	24.7
106	[7] CORONARY BYPASS W PTCA	1.1679	29.6	24.7
107	[7] CORONARY BYPASS W CARDIAC CATH	1.1679	29.6	24.7
108	[7] OTHER CARDIOTHORACIC PROCEDURES	1.1679	29.6	24.7
109	[7] CORONARY BYPASS W/O PTCA OR CARDIAC CATH	1.1679	29.6	24.7
110	[4] MAJOR CARDIOVASCULAR PROCEDURES W CC	1.1679	29.6	24.7
111	[7] MAJOR CARDIOVASCULAR PROCEDURES W/O CC	1.1679	29.6	24.7
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	1.4877	39.2	32.7
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.2453	33.2	27.7
115	[5] PRM CARD PACEM IMPL W AMI,HRT FAIL OR SHK,OR AICD LEAD OR GNRTR P.	1.6862	38.0	31.7
116	[4] OTH PERM CARD PACEMAK IMPL OR PTCA W CORONARY ARTERY STENT IMPLNT.	1.1679	29.6	24.7
117	5CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.6862	38.0	31.7
118	[4] CARDIAC PACEMAKER DEVICE REPLACEMENT	1.1679	29.6	24.7
119	[3] VEIN LIGATION & STRIPPING	0.7586	24.5	20.4
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.1050	31.8	26.5
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	0.8200	22.6	18.8
122	[2] CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	0.5834	21.0	17.5
123	CIRCULATORY DISORDERS W AMI, EXPIRED	0.8678	18.7	15.6
124	[4] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.1679	29.6	24.7
125	[3] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	0.7586	24.5	20.4
126	ACUTE & SUBACUTE ENDOCARDITIS	0.8467	25.3	21.1
127	HEART FAILURE & SHOCK	0.6890	21.1	17.6
128	[2] DEEP VEIN THROMBOPHLEBITIS	0.5834	21.0	17.5
129	[7] CARDIAC ARREST, UNEXPLAINED	1.1679	29.6	24.7
130	PERIPHERAL VASCULAR DISORDERS W CC	0.6755	23.1	19.3
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.4698	20.4	17
132	ATHEROSCLEROSIS W CC	0.6639	21.8	18.2
133	[1] ATHEROSCLEROSIS W/O CC	0.4502	18.8	15.7
134	HYPERTENSION	0.6388	24.7	20.6
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.7272	23.7	19.8
136	[2] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.5834	21.0	17.5
137	[7] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	0.5834	21.0	17.5
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.6183	20.4	17
139	[2] CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5834	21.0	17.5
140	[1] ANGINA PECTORIS	0.4502	18.8	15.7
141	SYNCOPE & COLLAPSE W CC	0.4356	18.3	15.3
142	[1] SYNCOPE & COLLAPSE W/O CC	0.4502	18.8	15.7
143	[2] CHEST PAIN	0.5834	21.0	17.5
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.7364	21.6	18
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.4544	18.0	15
146	[7] RECTAL RESECTION W CC	1.6862	38.0	31.7
147	[7] RECTAL RESECTION W/O CC	1.6862	38.0	31.7
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	1.8800	40.8	34
149	[7] MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	0.7586	24.5	20.4
150	[4] PERITONEAL ADHESIOLYSIS W CC	1.1679	29.6	24.7
151	[2] PERITONEAL ADHESIOLYSIS W/O CC	0.5834	21.0	17.5
152	[3] MINOR SMALL & LARGE BOWEL PROCEDURES W CC	0.7586	24.5	20.4
153	[7] MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	0.7586	24.5	20.4
154	[5] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	1.6862	38.0	31.7
155	[7] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.6862	38.0	31.7
156	[7] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17	1.6862	38.0	31.7
157	[4] ANAL & STOMAL PROCEDURES W CC	1.1679	29.6	24.7
158	[7] ANAL & STOMAL PROCEDURES W/O CC	1.1679	29.6	24.7
159	[7] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	0.7586	24.5	20.4
160	[7] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	0.7586	24.5	20.4
161	[5] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.6862	38.0	31.7
162	[7] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.7586	24.5	20.4
163	[7] HERNIA PROCEDURES AGE 0–17	0.7586	24.5	20.4
164	[7] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.6862	38.0	31.7
165	[7] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.6862	38.0	31.7
166	[7] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.6862	38.0	31.7
167	[7] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	1.6862	38.0	31.7
168	[4] MOUTH PROCEDURES W CC	1.1679	29.6	24.7
169	[7] MOUTH PROCEDURES W/O CC	0.7586	24.5	20.4

TABLE 11.—PROPOSED FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	1.6319	35.9	29.9
171	[1] OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	0.4502	18.8	15.7
172	DIGESTIVE MALIGNANCY W CC	0.8568	21.8	18.2
173	[2] DIGESTIVE MALIGNANCY W/O CC	0.5834	21.0	17.5
174	G.I. HEMORRHAGE W CC	0.6984	22.0	18.3
175	[1] G.I. HEMORRHAGE W/O CC	0.4502	18.8	15.7
176	COMPLICATED PEPTIC ULCER	0.8510	21.5	17.9
177	[3] UNCOMPLICATED PEPTIC ULCER W CC	0.7586	24.5	20.4
178	[3] UNCOMPLICATED PEPTIC ULCER W/O CC	0.7586	24.5	20.4
179	INFLAMMATORY BOWEL DISEASE	0.9834	24.1	20.1
180	G.I. OBSTRUCTION W CC	0.9417	23.5	19.6
181	[3] G.I. OBSTRUCTION W/O CC	0.7586	24.5	20.4
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.7753	22.6	18.8
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.3959	17.2	14.3
184	[7] ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17	0.4502	18.8	15.7
185	[3] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.7586	24.5	20.4
186	[7] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17	0.7586	24.5	20.4
187	[7] DENTAL EXTRACTIONS & RESTORATIONS	0.7586	24.5	20.4
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0009	24.0	20
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.4730	18.2	15.2
190	[7] OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	0.4502	18.8	15.7
191	[4] PANCREAS, LIVER & SHUNT PROCEDURES W CC	1.1679	29.6	24.7
192	[7] PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.1679	29.6	24.7
193	[3] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	0.7586	24.5	20.4
194	[7] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	0.7586	24.5	20.4
195	[4] CHOLECYSTECTOMY W C.D.E. W CC	1.1679	29.6	24.7
196	[7] CHOLECYSTECTOMY W C.D.E. W/O CC	0.7586	24.5	20.4
197	[3] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	0.7586	24.5	20.4
198	[7] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	0.7586	24.5	20.4
199	[7] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	1.6862	38.0	31.7
200	[5] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	1.6862	38.0	31.7
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	2.0391	36.1	30.1
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	0.6636	20.5	17.1
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	0.7939	19.5	16.3
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	0.9564	22.9	19.1
205	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.6709	20.6	17.2
206	[2] DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	0.5834	21.0	17.5
207	DISORDERS OF THE BILIARY TRACT W CC	0.7600	21.5	17.9
208	[2] DISORDERS OF THE BILIARY TRACT W/O CC	0.5834	21.0	17.5
210	[5] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.6862	38.0	31.7
211	[4] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.1679	29.6	24.7
212	[7] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17	1.6862	38.0	31.7
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.2016	33.9	28.3
216	[4] BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.1679	29.6	24.7
217	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	1.2917	38.0	31.7
218	[5] LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC	1.6862	38.0	31.7
219	[1] LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	0.4502	18.8	15.7
220	[7] LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0–17	1.6862	38.0	31.7
223	[3] MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	0.7586	24.5	20.4
224	[7] SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	0.7586	24.5	20.4
225	FOOT PROCEDURES	0.9996	28.9	24.1
226	SOFT TISSUE PROCEDURES W CC	0.9487	30.0	25
227	[3] SOFT TISSUE PROCEDURES W/O CC	0.7586	24.5	20.4
228	[4] MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	1.1679	29.6	24.7
229	[7] HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.4502	18.8	15.7
230	[5] LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.6862	38.0	31.7
232	[7] ARTHROSCOPY	0.4502	18.8	15.7
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.2832	33.9	28.3
234	[7] OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	0.4502	18.8	15.7
235	[3] FRACTURES OF FEMUR	0.7586	24.5	20.4
236	FRACTURES OF HIP & PELVIS	0.6553	25.2	21
237	[1] SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.4502	18.8	15.7
238	OSTEOMYELITIS	0.8271	28.2	23.5
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	0.6923	23.6	19.7
240	CONNECTIVE TISSUE DISORDERS W CC	0.7320	24.5	20.4

TABLE 11.—PROPOSED FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
241	[1] CONNECTIVE TISSUE DISORDERS W/O CC	0.4502	18.8	15.7
242	SEPTIC ARTHRITIS	0.7931	26.6	22.2
243	MEDICAL BACK PROBLEMS	0.6107	23.4	19.5
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.5280	22.2	18.5
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4651	20.4	17
246	[1] NON-SPECIFIC ARTHROPATHIES	0.4502	18.8	15.7
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5269	21.4	17.8
248	TENDONITIS, MYOSITIS & BURSITIS	0.6627	22.6	18.8
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.6614	24.7	20.6
250	[2] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.5834	21.0	17.5
251	[1] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.4502	18.8	15.7
252	[7] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	0.7586	24.5	20.4
253	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	0.6838	26.3	21.9
254	[1] FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	0.4502	18.8	15.7
255	[7] FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0–17	0.7586	24.5	20.4
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.7953	25.3	21.1
257	[7] TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.7586	24.5	20.4
258	[7] TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7586	24.5	20.4
259	[2] SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.5834	21.0	17.5
260	[7] SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7586	24.5	20.4
261	[7] BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	0.7586	24.5	20.4
262	[1] BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.4502	18.8	15.7
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.3245	39.4	32.8
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	0.9555	31.9	26.6
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.0426	33.1	27.6
266	[3] SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	0.7586	24.5	20.4
267	[7] PERIANAL & PILONIDAL PROCEDURES	0.7586	24.5	20.4
268	[5] SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.6862	38.0	31.7
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.2945	35.9	29.9
270	[3] OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.7586	24.5	20.4
271	SKIN ULCERS	0.8707	27.6	23
272	MAJOR SKIN DISORDERS W CC	0.7490	22.5	18.8
273	[1] MAJOR SKIN DISORDERS W/O CC	0.4502	18.8	15.7
274	[3] MALIGNANT BREAST DISORDERS W CC	0.7586	24.5	20.4
275	[7] MALIGNANT BREAST DISORDERS W/O CC	0.7586	24.5	20.4
276	[2] NON-MALIGANT BREAST DISORDERS	0.5834	21.0	17.5
277	CELLULITIS AGE >17 W CC	0.6281	20.9	17.4
278	CELLULITIS AGE >17 W/O CC	0.4440	17.8	14.8
279	[7] CELLULITIS AGE 0–17	0.4502	18.8	15.7
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.6728	24.3	20.3
281	[1] TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.4502	18.8	15.7
282	[7] TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	0.4502	18.8	15.7
283	MINOR SKIN DISORDERS W CC	0.6968	23.9	19.9
284	[1] MINOR SKIN DISORDERS W/O CC	0.4502	18.8	15.7
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	1.3552	35.6	29.7
286	[7] ADRENAL & PITUITARY PROCEDURES	1.6862	38.0	31.7
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.1270	33.6	28
288	[4] O.R. PROCEDURES FOR OBESITY	1.1679	29.6	24.7
289	[7] PARATHYROID PROCEDURES	1.1679	29.6	24.7
290	[5] THYROID PROCEDURES	1.6862	38.0	31.7
291	[7] THYROGLOSSAL PROCEDURES	1.1679	29.6	24.7
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	1.3437	31.7	26.4
293	[2] OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	0.5834	21.0	17.5
294	DIABETES AGE >35	0.7330	24.8	20.7
295	[3] DIABETES AGE 0–35	0.7586	24.5	20.4
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.7232	23.1	19.3
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.5262	18.4	15.3
298	[7] NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	0.5834	21.0	17.5
299	[4] INBORN ERRORS OF METABOLISM	1.1679	29.6	24.7
300	ENDOCRINE DISORDERS W CC	0.6413	21.2	17.7
301	[1] ENDOCRINE DISORDERS W/O CC	0.4502	18.8	15.7
302	[6] KIDNEY TRANSPLANT	0.0000	1.0	0.8
303	[4] KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	1.1679	29.6	24.7
304	[5] KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	1.6862	38.0	31.7
305	[1] KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	0.4502	18.8	15.7
306	[2] PROSTATECTOMY W CC	0.5834	21.0	17.5
307	[7] PROSTATECTOMY W/O CC	0.5834	21.0	17.5

TABLE 11.—PROPOSED FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
308	[4] MINOR BLADDER PROCEDURES W CC	1.1679	29.6	24.7
309	[7] MINOR BLADDER PROCEDURES W/O CC	1.1679	29.6	24.7
310	[4] TRANSURETHRAL PROCEDURES W CC	1.1679	29.6	24.7
311	[7] TRANSURETHRAL PROCEDURES W/O CC	1.1679	29.6	24.7
312	[1] URETHRAL PROCEDURES, AGE >17 W CC	0.4502	18.8	15.7
313	[7] URETHRAL PROCEDURES, AGE >17 W/O CC	0.4502	18.8	15.7
314	[7] URETHRAL PROCEDURES, AGE 0–17	0.4502	18.8	15.7
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	1.4005	31.5	26.3
316	RENAL FAILURE	0.8208	22.6	18.8
317	ADMIT FOR RENAL DIALYSIS	1.0001	25.5	21.3
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	0.7648	20.2	16.8
319	[1] KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.4502	18.8	15.7
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.6185	22.1	18.4
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.4813	19.0	15.8
322	[7] KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	0.4502	18.8	15.7
323	[4] URINARY STONES W CC, &/OR ESW LITHOTRIPSY	1.1679	29.6	24.7
324	[7] URINARY STONES W/O CC	0.4502	18.8	15.7
325	[2] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.5834	21.0	17.5
326	[1] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4502	18.8	15.7
327	[7] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	0.4502	18.8	15.7
328	[1] URETHRAL STRICTURE AGE >17 W CC	0.4502	18.8	15.7
329	[7] URETHRAL STRICTURE AGE >17 W/O CC	0.4502	18.8	15.7
330	[7] URETHRAL STRICTURE AGE 0–17	0.4502	18.8	15.7
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	0.8033	23.0	19.2
332	[3] OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.7586	24.5	20.4
333	[7] OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	0.7586	24.5	20.4
334	[2] MAJOR MALE PELVIC PROCEDURES W CC	0.5834	21.0	17.5
335	[7] MAJOR MALE PELVIC PROCEDURES W/O CC	1.6862	38.0	31.7
336	[2] TRANSURETHRAL PROSTATECTOMY W CC	0.5834	21.0	17.5
337	[7] TRANSURETHRAL PROSTATECTOMY W/O CC	0.5834	21.0	17.5
338	[7] TESTES PROCEDURES, FOR MALIGNANCY	0.5834	21.0	17.5
339	[4] TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.1679	29.6	24.7
340	[7] TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	1.1679	29.6	24.7
341	[4] PENIS PROCEDURES	1.1679	29.6	24.7
342	[7] CIRCUMCISION AGE >17	1.1679	29.6	24.7
343	[7] CIRCUMCISION AGE 0–17	1.1679	29.6	24.7
344	[1] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	0.4502	18.8	15.7
345	[5] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	1.6862	38.0	31.7
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	0.6105	20.6	17.2
347	[2] MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.5834	21.0	17.5
348	[2] BENIGN PROSTATIC HYPERTROPHY W CC	0.5834	21.0	17.5
349	[7] BENIGN PROSTATIC HYPERTROPHY W/O CC	1.1679	29.6	24.7
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.6562	21.6	18
351	[7] STERILIZATION, MALE	1.1679	29.6	24.7
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.6360	23.4	19.5
353	[7] PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.1679	29.6	24.7
354	[7] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.1679	29.6	24.7
355	[7] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	1.1679	29.6	24.7
356	[7] FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.1679	29.6	24.7
357	[7] UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	1.1679	29.6	24.7
358	[7] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1679	29.6	24.7
359	[7] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	1.1679	29.6	24.7
360	[4] VAGINA, CERVIX & VULVA PROCEDURES	1.1679	29.6	24.7
361	[7] LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.1679	29.6	24.7
362	[7] ENDOSCOPIC TUBAL INTERRUPTION	1.1679	29.6	24.7
363	[7] D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	1.1679	29.6	24.7
364	[5] D&C, CONIZATION EXCEPT FOR MALIGNANCY	1.6862	38.0	31.7
365	[5] OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.6862	38.0	31.7
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	0.7126	20.3	16.9
367	[7] MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	1.1679	29.6	24.7
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.6455	20.7	17.3
369	[3] MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.7586	24.5	20.4
370	[7] CESAREAN SECTION W CC	0.7586	24.5	20.4
371	[7] CESAREAN SECTION W/O CC	0.5834	21.0	17.5
372	[7] VAGINAL DELIVERY W COMPLICATING DIAGNOSES	1.1679	29.6	24.7
373	[7] VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	1.1679	29.6	24.7

TABLE 11.—PROPOSED FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
374	[7] VAGINAL DELIVERY W STERILIZATION &/OR D&C	1.1679	29.6	24.7
375	[7] VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	1.1679	29.6	24.7
376	[7] POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	1.1679	29.6	24.7
377	[7] POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.1679	29.6	24.7
378	[7] ECTOPIC PREGNANCY	0.7586	24.5	20.4
379	[7] THREATENED ABORTION	1.1679	29.6	24.7
380	[7] ABORTION W/O D&C	1.1679	29.6	24.7
381	[7] ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	1.1679	29.6	24.7
382	[7] FALSE LABOR	1.1679	29.6	24.7
383	[7] OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	1.1679	29.6	24.7
384	[7] OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	1.1679	29.6	24.7
385	[7] NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.1679	29.6	24.7
386	[7] EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	1.1679	29.6	24.7
387	[7] PREMATURITY W MAJOR PROBLEMS	1.1679	29.6	24.7
388	[7] PREMATURITY W/O MAJOR PROBLEMS	1.1679	29.6	24.7
389	[7] FULL TERM NEONATE W MAJOR PROBLEMS	1.1679	29.6	24.7
390	[7] NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1679	29.6	24.7
391	[7] NORMAL NEWBORN	1.1679	29.6	24.7
392	[7] SPLENECTOMY AGE >17	0.7586	24.5	20.4
393	[7] SPLENECTOMY AGE 0–17	0.7586	24.5	20.4
394	[5] OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.6862	38.0	31.7
395	RED BLOOD CELL DISORDERS AGE >17	0.6611	21.8	18.2
396	[7] RED BLOOD CELL DISORDERS AGE 0–17	0.5834	21.0	17.5
397	COAGULATION DISORDERS	0.8665	22.5	18.8
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.8193	23.5	19.6
399	[2] RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.5834	21.0	17.5
401	[5] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	1.6862	38.0	31.7
402	[7] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	0.5834	21.0	17.5
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	0.8844	21.3	17.8
404	[2] LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.5834	21.0	17.5
405	[7] ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17	0.5834	21.0	17.5
406	[4] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	1.1679	29.6	24.7
407	[7] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.1679	29.6	24.7
408	[4] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	1.1679	29.6	24.7
409	RADIOTHERAPY	0.8567	23.4	19.5
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1.1719	26.4	22
411	[7] HISTORY OF MALIGNANCY W/O ENDOSCOPY	1.1679	29.6	24.7
412	[7] HISTORY OF MALIGNANCY W ENDOSCOPY	1.1679	29.6	24.7
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	0.8990	20.5	17.1
414	[7] OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.5834	21.0	17.5
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	1.4237	35.5	29.6
416	SEPTICEMIA AGE >17	0.8255	23.4	19.5
417	[7] SEPTICEMIA AGE 0–17	0.7586	24.5	20.4
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	0.8296	24.7	20.6
419	[3] FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.7586	24.5	20.4
420	[7] FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.7586	24.5	20.4
421	VIRAL ILLNESS AGE >17	0.9474	27.3	22.8
422	[7] VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	0.4502	18.8	15.7
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	0.9403	21.7	18.1
424	[3] O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	0.7586	24.5	20.4
425	[2] ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION	0.5834	21.0	17.5
426	DEPRESSIVE NEUROSES	0.4131	20.7	17.3
427	NEUROSES EXCEPT DEPRESSIVE	0.4713	23.8	19.8
428	[1] DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.4502	18.8	15.7
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.5831	26.5	22.1
430	PSYCHOSES	0.4350	24.1	20.1
431	[1] CHILDHOOD MENTAL DISORDERS	0.4502	18.8	15.7
432	[2] OTHER MENTAL DISORDER DIAGNOSES	0.5834	21.0	17.5
433	[2] ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.5834	21.0	17.5
439	SKIN GRAFTS FOR INJURIES	1.3758	35.6	29.7
440	WOUND DEBRIDEMENTS FOR INJURIES	1.3261	35.9	29.9
441	[1] HAND PROCEDURES FOR INJURIES	0.4502	18.8	15.7
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.4028	33.4	27.8
443	[3] OTHER O.R. PROCEDURES FOR INJURIES W/O CC	0.7586	24.5	20.4
444	TRAUMATIC INJURY AGE >17 W CC	0.7551	25.9	21.6
445	[1] TRAUMATIC INJURY AGE >17 W/O CC	0.4502	18.8	15.7
446	[7] TRAUMATIC INJURY AGE 0–17	0.4502	18.8	15.7

TABLE 11.—PROPOSED FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
447	[2] ALLERGIC REACTIONS AGE >17	0.5834	21.0	17.5
448	[7] ALLERGIC REACTIONS AGE 0–17	0.5834	21.0	17.5
449	[3] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.7586	24.5	20.4
450	[7] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.7586	24.5	20.4
451	[7] POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	0.7586	24.5	20.4
452	COMPLICATIONS OF TREATMENT W CC	0.9139	25.2	21
453	COMPLICATIONS OF TREATMENT W/O CC	0.5449	23.2	19.3
454	[3] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.7586	24.5	20.4
455	[7] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.7586	24.5	20.4
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.2315	34.0	28.3
462	REHABILITATION	0.5815	22.4	18.7
463	SIGNS & SYMPTOMS W CC	0.6234	23.7	19.8
464	SIGNS & SYMPTOMS W/O CC	0.5565	24.1	20.1
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6959	21.8	18.2
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6713	21.9	18.3
467	[3] OTHER FACTORS INFLUENCING HEALTH STATUS	0.7586	24.5	20.4
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.1439	40.0	33.3
469	[6] PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	1.0	0.8
470	[6] UNGROUPABLE	0.0000	1.0	0.8
471	[5] BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	1.6862	38.0	31.7
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	0.8580	20.0	16.7
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	2.0848	34.5	28.8
476	[4] PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.1679	29.6	24.7
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.5867	35.2	29.3
478	OTHER VASCULAR PROCEDURES W CC	1.3338	30.7	25.6
479	[7] OTHER VASCULAR PROCEDURES W/O CC	1.1679	29.6	24.7
480	[6] LIVER TRANSPLANT	0.0000	1.0	0.8
481	[7] BONE MARROW TRANSPLANT	1.6862	38.0	31.7
482	[3] TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	0.7586	24.5	20.4
484	[2] CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	0.5834	21.0	17.5
485	[7] LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR.	0.7586	24.5	20.4
486	[5] OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	1.6862	38.0	31.7
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	0.9046	26.0	21.7
488	[5] HIV W EXTENSIVE O.R. PROCEDURE	1.6862	38.0	31.7
489	HIV W MAJOR RELATED CONDITION	0.8348	21.1	17.6
490	HIV W OR W/O OTHER RELATED CONDITION	0.5012	16.4	13.7
491	[5] MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.6862	38.0	31.7
492	[7] CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT	1.6862	38.0	31.7
493	[4] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.1679	29.6	24.7
494	[7] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.1679	29.6	24.7
495	[6] LUNG TRANSPLANT	0.0000	1.0	0.8
496	[7] COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	1.1679	29.6	24.7
497	[4] SPINAL FUSION W CC	1.1679	29.6	24.7
498	[7] SPINAL FUSION EXCEPT CERVICAL W/O CC	1.1679	29.6	24.7
499	[5] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.6862	38.0	31.7
500	[4] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	1.1679	29.6	24.7
501	[5] KNEE PROCEDURES W PDX OF INFECTION W CC	1.6862	38.0	31.7
502	[4] KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.1679	29.6	24.7
503	[2] KNEE PROCEDURES W/O PDX OF INFECTION	0.5834	21.0	17.5
504	[7] EXTENSIVE BURNS OF FULL THICKNESS BURNS WITH MECH VENT 96+HRS WITH SKIN GRAFT.	1.6862	38.0	31.7
505	[4] EXTENSIVE BURN OR FULL THICKNESS BURNS WITH MECH VENT 96+ HOURS WITHOUT SKIN GRAFT.	1.1679	29.6	24.7
506	[4] FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	1.1679	29.6	24.7
507	[3] FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	0.7586	24.5	20.4
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	0.8403	29.4	24.5
509	[1] FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	0.4502	18.8	15.7
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	0.7737	24.6	20.5
511	[1] NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.4502	18.8	15.7
512	[6] SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	0.0000	1.0	0.8
513	[6] PANCREAS TRANSPLANT	0.0000	1.0	0.8
515	[5] CARDIAC DEFIBRILATOR IMPLANT W/O CARDIAC CATH	1.6862	38.0	31.7
517	[5] PERCUTANEOUS CARDIVASCULAR PROC W NON-DRUG ELUTING STENT W/O AMI.	1.6862	38.0	31.7
518	[3] PERCUTANEOUS CARDIVASCULAR PROC W/O CORONARY ARTERY STENT OR AMI.	0.7586	24.5	20.4

TABLE 11.—PROPOSED FY 2006 LTC–DRGS, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY—Continued

LTC–DRG	Description	Relative weight	Geometric average length of stay	5/6ths of the geometric average length of stay
519	[5] CERVICAL SPINAL FUSION W CC	1.6862	38.0	31.7
520	[7] CERVICAL SPINAL FUSION W/O CC	1.1679	29.6	24.7
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.4533	19.8	16.5
522	[7] ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC.	0.4502	18.8	15.7
523	[7] ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC.	0.4502	18.8	15.7
524	TRANSIENT ISCHEMIA	0.5069	21.1	17.6
525	[7] OTHER HEART ASSIST SYSTEM IMPLANT	1.6862	38.0	31.7
527	[5] PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W/O AMI	1.6862	38.0	31.7
528	[7] INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	1.6862	38.0	31.7
529	[5] VENTRICULAR SHUNT PROCEDURES W CC	1.6862	38.0	31.7
530	[7] VENTRICULAR SHUNT PROCEDURES W/O CC	1.6862	38.0	31.7
531	[3] SPINAL PROCEDURES WITH CC	0.7586	24.5	20.4
532	[8] SPINAL PROCEDURES WITHOUT CC	0.7586	24.5	20.4
533	[5] EXTRACRANIAL VASCULAR PROCEDURES WITH CC	1.6862	38.0	31.7
534	[7] EXTRACRANIAL PROCEDURES W/O CC	1.1679	29.6	24.7
535	[7] CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	1.6862	38.0	31.7
536	[7] CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	1.6862	38.0	31.7
537	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITH CC.	1.1670	34.6	28.8
538	[7] LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITHOUT CC.	1.1679	29.6	24.7
539	[4] LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITH CC	1.1679	29.6	24.7
540	[7] LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC	0.5834	21.0	17.5
541	ECMO OR TRACH W MECH VENT 96+ HRS OR PDX EXCEPT FACE, MOUTH & NECK DIAG WITH MAJOR OR.	4.2566	65.6	54.7
542	TRACH W MECH VENT 96+ HRS OR PDX EXCEPT FACE, MOUTH & NECK DIAG WITHOUT MAJOR OR.	3.1821	47.9	39.9
543	[5] CRANIOTOMY W IMPLANT OF CHEMO AGENT OR ACUTE COMPLEX CNS PDX	1.6862	38.0	31.7
544	[5] MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	1.6862	38.0	31.7
545	[5] REVISION OF HIP OR KNEE REPLACEMENT	1.6862	38.0	31.7
546	[7] SPINAL FUSION EXCEPT CERVICAL WITH PRINCIPAL DIAGNOSIS OF CURVATURE OF SPINE OR MALIGNANCY.	1.6862	38.0	31.7
547	[7] PERCUTANEOUS CARDIOVASCULAR PROCEDURE WITH AMI WITH CC	1.6862	38.0	31.7
548	[7] PERCUTANEOUS CARDIOVASCULAR PROCEDURE WITH AMI WITHOUT CC	1.6862	38.0	31.7
549	[7] PERCUTANEOUS CARDIOVASCULAR PROCEDURE WITH DRUG-ELUTING STENT WITH AMI WITH CC.	1.6862	38.0	31.7
550	[7] PERCUTANEOUS CARDIOVASCULAR PROCEDURE WITH DRUG-ELUTING STENT WITH AMI WITHOUT CC.	1.6862	38.0	31.7

[1] Proposed relative weights for these proposed LTC–DRGs were determined by assigning these cases to proposed low-volume quintile 1.
[2] Proposed relative weights for these proposed LTC–DRGs were determined by assigning these cases to proposed low-volume quintile 2.
[3] Proposed relative weights for these proposed LTC–DRGs were determined by assigning these cases to proposed low-volume quintile quintile 3.
[4] Proposed relative weights for these proposed LTC–DRGs were determined by assigning these cases to proposed low-volume quintile 4.
[5] Proposed relative weights for these proposed LTC–DRGs were determined by assigning these cases to proposed low-volume quintile quintile 5.
[6] Proposed relative weights for these proposed LTC–DRGs were assigned a value of 0.0000.
[7] Proposed relative weights for these proposed LTC–DRGs were determined by assigning these cases to the appropriate proposed low volume quintile because there are no LTCH cases in the FY 2004 MedPAR file.
[8] Proposed relative weights for these proposed LTC–DRGs were determined after adjusting to account for nonmonotonicity (see step 5 above).

Appendix A—Regulatory Analysis of Impacts

(If you choose to comment on issues in this section, please include the caption "Impact Analyses'' at the beginning of your comment.)

I. Background and Summary

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined that this proposed rule is a major rule as defined in 5 U.S.C. 804(2). We estimate that the total impact of these proposed changes for FY 2006 payments compared to FY 2005 payments to be approximately a $2.40 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 proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). However, under the new labor market definitions, we no longer employ NECMAs to define urban areas in New England. Therefore, we now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the IPPS, we continue to classify these hospitals as urban hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any proposed rule (or a final rule that has been preceded by a proposed rule) that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This proposed 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 proposed rule in light of Executive Order 13132 and have determined that it would not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

The following analysis, in conjunction with the remainder of this document, demonstrates that this proposed rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The proposed rule 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 proposed changes in this proposed 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 proposed 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 proposed policy changes, as well as statutory changes effective for FY 2006, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. As we have done in the previous proposed rules, we are soliciting comments and information about the anticipated effects of these proposed changes on hospitals and our methodology for estimating them. Any comments that we receive in response to this proposed rule will be addressed in the final rule.

IV. Hospitals Included In and Excluded From the IPPS

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general short-term, acute care hospitals that participate in the Medicare program. There were 35 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 46 such hospitals in Maryland remain excluded from the IPPS under the waiver at section 1814(b)(3) of the Act.

As of March 2005, there are 3,693 IPPS hospitals to be included in our analysis. This represents about 63 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals. There are also approximately 974 critical access hospitals (CAHs). These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. There are also 1,138 specialty hospitals and units that are excluded from the IPPS. These specialty hospitals include psychiatric hospitals and units, rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals. The impacts of our proposed policy changes on these hospitals are discussed below.

V. Impact on Excluded Hospitals and Hospital Units

As of March 2005, there were 1,138 specialty hospitals excluded from the IPPS. Of these 1,138 specialty hospitals, 467 psychiatric hospitals, 80 children's, 11 cancer hospitals, and 21 LTCHs that are paid under the LTCH PPS blend methodology are being paid, in whole or in part, on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. The remaining providers—218 IRFs and 361 LTCHs are paid 100 percent of the Federal prospective rate under the IRF PPS and the LTCH PPS, respectively. In addition, there were 1,342 psychiatric units (paid on a blend of the IPF PPS per diem payment and the TEFRA reasonable cost-based payment) and 1,006 rehabilitation units (paid under the IRF PPS) in hospitals otherwise subject to the IPPS. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 46 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 2006. For these hospitals, the proposed update is the percentage increase in the excluded hospital market basket, currently estimated at 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 2005, 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 proposed rule.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs are paid under a LTCH PPS, based on a Federal prospective payment amount that is updated annually. LTCHs will receive a blended payment that consists of the Federal prospective payment rate and a reasonable cost-based payment rate 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 estimate of the excluded hospital market basket (or 3.4 percent).

Section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) required the development of a per diem prospective payment system (PPS) for payment of inpatient hospital services furnished in psychiatric hospitals and psychiatric units of acute care hospitals and

CAHs (inpatient psychiatric facilities (IPFs)). We published a final rule to implement the IPF PPS on November 15, 2004 (69 FR 66922). The final rule established a 3-year transition to the IPF PPS during which some providers will receive a blend of the IPF PPS per diem payment and the TEFRA reasonable cost-based payment. For purposes of determining what the TEFRA payment to the IPF would be, we are proposing that the IPF's TEFRA limit will be updated by the estimate of 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. However, at the same time, 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 proposed rule, we are announcing policy changes and payment rate updates for the IPPS for operating costs. Changes to the capital payments are discussed in section VIII. of this Appendix. Based on the overall percentage change in payments per case estimated using our payment simulation model (a 2.5 percent increase), we estimate the total impact of these proposed changes for FY 2006 operating payments compared to FY 2005 operating payments to be approximately a $2.41 billion increase. This amount does not reflect changes in hospital admissions or case-mix intensity, which would also affect overall payment changes.

We have prepared separate impact analyses of the proposed changes to each system. This section deals with proposed changes to the operating prospective payment system. Our payment simulation model relies on the most recent available data to enable us to estimate the impacts on payments per case of certain changes we are proposing in this rule. However, there are other changes we are proposing for which we do not have data available that would allow us to estimate the payment impacts using this model. For those proposed changes, we have attempted to predict the payment impacts of those proposed changes based upon our experience and other more limited data.

The data used in developing the quantitative analyses of changes in payments per case presented below are taken from the FY 2004 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Although the analyses of the changes to the operating PPS do not incorporate cost data, data from the most recently available hospital cost report were used to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to the proposed policy changes, and we do not adjust for future changes in such variables as admissions, lengths of stay, or case-mix. Second, due to the interdependent nature of the IPPS payment components, it is very difficult to precisely quantify the impact associated with each proposed change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. However, for individual hospitals, some miscategorizations are possible.

Using cases in the FY 2004 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 IPPS (Indian Health Service hospitals and hospitals in Maryland) were excluded from the simulations. The impact of payments under the capital IPPS, or the impact of payments for costs other than inpatient operating costs, are not analyzed in this section. Estimated payment impacts of proposed FY 2006 changes to the capital IPPS are discussed in section VIII of this Appendix.

The proposed changes discussed separately below are the following:

- The effects of the 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 proposed changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 2002, compared to the FY 2001 wage data.
- The effect of the proposed change in the way we use the wage data for hospitals that reclassify as rural under section 401 of the BBRA to compute wage indexes.
- The effect of the proposed wage and recalibration budget neutrality factors.
- The effect of the remaining labor market area transition for those hospitals that were urban under the old labor market area designations and are now considered rural hospitals.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2006.
- The effects of section 505 of Pub. L. 108–173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.
- The total change in payments based on proposed FY 2006 policies and MMA-imposed changes relative to payments based on FY 2005 policies.

To illustrate the impacts of the proposed FY 2006 changes, our analysis begins with a FY 2006 baseline simulation model using: the proposed update of 3.2 percent; the FY 2005 DRG GROUPER (version 22.0); the CBSA designations for hospitals based on OMB's June 2003 MSA definitions; the FY 2005 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total operating DRG and outlier payments.

Section 1886(b)(3)(B)(vii) of the Act, as added by section 501(b) of Pub. L. 108–173, provides that, for FYs 2005 through 2007, the update factors will be reduced by 0.4 percentage points for any hospital that does not submit quality data. For purposes of the FY 2006 simulations in this proposed impact analysis, we are assuming all hospitals will qualify for the full update.

Each proposed and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2006 model incorporating all of the proposed changes. This allows us to isolate the effects of each proposed change.

Our final comparison illustrates the percent change in payments per case from FY 2005 to FY 2006. Three factors not discussed separately have significant impacts here. The first is the update to the standardized amount. In accordance with section 1886(b)(3)(B)(i) of the Act, we have updated standardized amounts for FY 2006 using the most recently forecasted hospital market basket increase for FY 2006 of 3.2 percent. (Hospitals that fail to comply with the quality data submission requirement to receive the full update will receive an update reduced by 0.4 percentage points to 2.8 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 3.2 percent.

A second significant factor that impacts changes in hospitals' payments per case from FY 2005 to FY 2006 is the change in MGCRB status from one year to the next. That is, hospitals reclassified in FY 2005 that are no longer reclassified in FY 2006 may have a negative payment impact going from FY 2005 to FY 2006; conversely, hospitals not reclassified in FY 2005 that are reclassified in FY 2006 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 2005 will be 4.4 percent of total DRG payments. When the FY 2005 final rule was published, we projected FY 2005 outlier payments would be 5.1 percent of total DRG plus outlier payments; the average standardized amounts were offset correspondingly. The effects of the lower than expected outlier payments during FY 2005 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 2005 payments per case to estimated FY 2006 payments per case (with outlier payments projected to equal 5.1 percent of total DRG payments).

B. Analysis of Table I

Table I displays the results of our analysis of proposed changes for FY 2006. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 3,693 hospitals included in the analysis. This number is 204 fewer hospitals than were included in the impact analysis in the FY 2005 final rule (69 FR 49758).

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 2,537 hospitals located in urban areas included in our analysis. Among these, there are 1,399 hospitals located in large urban areas (populations over 1 million), and 1,138 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 1,156 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 2006 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 2,575, 1,410, 1,165, and 1,118, respectively.

The next three groupings examine the impacts of the proposed 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 2,615 nonteaching hospitals in our analysis, 841 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 for DSH purposes. The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the proposed changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and Medicare dependant hospitals (MDHs)), as well as rural hospitals not receiving a special payment designation. There were 134 RRCs, 405 SCHs, 158 MDHs, and 73 hospitals that are both SCH and RRC.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 2002 Medicare cost report files, if available (otherwise FY 2001 data are used).

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 2006. The next two groupings separate the hospitals in the first group by urban and rural status. The final two rows in Table I contain hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act and hospitals located in urban counties, but deemed to be rural under section 1886(d)(8)(E) of the Act.

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TABLE I. IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2006

	No. of Hospitals[1] (1)	Postacute Transfer Policy Proposal[2] (2)	DRG Recalibration[3] (3)	New Wage Data[4] (4)	Change to Treatment of section 1886(d)(8)(E) Wage Data[5] (5)	DRG and Wage Index Changes[6] (6)	Transition for Hospitals Moving from Urban to Rural[7] (7)	MGCRB Reclassifications[8] (8)	Out-Migration Data[9] (9)	All FY 2006 Changes[10] (10)
By Geographic Location:										
All hospitals	3,693	-1.1	0.1	-0.4	0.0	0.0	0.0	0.0	0.1	**2.5**
Urban hospitals	2,537	-1.1	0.2	-0.4	0.0	0.1	0.0	-0.3	0.1	**2.5**
Large urban areas (populations over 1 million)	1,399	-1.2	0.1	-0.4	0.0	0.0	0.0	-0.4	0.0	**2.4**
Other urban areas (populations of 1 million of fewer)	1,138	-1.1	0.3	-0.4	0.0	0.1	0.0	-0.2	0.1	**2.7**
Rural hospitals	1,156	-0.7	-0.1	-0.3	0.0	-0.3	0.3	2.0	0.1	**2.6**
Bed Size (Urban):										
0-99 beds	611	-1.1	0.0	-0.2	0.0	0.0	0.0	-0.4	0.0	**2.5**
100-199 beds	877	-1.1	0.2	-0.3	0.0	0.2	0.0	-0.2	0.1	**2.6**
200-299 beds	479	-1.1	0.1	-0.3	0.0	0.2	0.0	-0.2	0.1	**2.7**
300-499 beds	408	-1.1	0.2	-0.5	0.0	0.0	0.0	-0.3	0.1	**2.5**
500 or more beds	162	-1.1	0.2	-0.5	0.0	0.0	0.0	-0.4	0.0	**2.5**
Bed Size (Rural):										
0-49 beds	473	-0.6	-0.3	-0.2	0.0	-0.4	0.1	0.6	0.2	**2.3**
50-99 beds	387	-0.7	-0.2	-0.3	0.0	-0.3	0.3	1.1	0.2	**2.7**
100-149 beds	188	-0.8	-0.1	-0.5	0.0	-0.4	0.5	2.5	0.1	**2.6**
150-199 beds	61	-0.7	-0.1	-0.6	0.0	-0.5	0.6	3.1	0.1	**2.8**
200 or more beds	47	-0.7	0.1	0.0	0.0	0.2	0.1	2.9	0.0	**2.7**
Urban by Region:										
New England	129	-1.9	0.4	-1.1	0.2	-0.1	0.0	-0.1	0.1	**1.0**
Middle Atlantic	356	-1.2	0.2	-0.6	0.0	0.0	0.0	-0.2	0.2	**1.9**
South Atlantic	386	-1.0	0.2	-0.7	0.0	-0.2	0.0	-0.4	0.0	**2.6**
East North Central	400	-1.2	0.2	-0.5	0.0	-0.1	0.0	-0.3	0.0	**2.1**

	No. of Hospitals[1] (1)	Postacute Transfer Policy Proposal[2] (2)	DRG Recalibration[3] (3)	New Wage Data[4] (4)	Change to Treatment of section 1886(d)(8)(E) Wage Data[5] (5)	DRG and Wage Index Changes[6] (6)	Transition for Hospitals Moving from Urban to Rural[7] (7)	MGCRB Reclassifications[8] (8)	Out-Migration Data[9] (9)	All FY 2006 Changes[10] (10)
East South Central	165	-0.9	0.2	-0.2	0.0	0.2	0.0	-0.4	0.1	**3.0**
West North Central	155	-1.1	0.1	-0.6	0.0	-0.3	0.0	-0.5	0.0	**2.3**
West South Central	344	-0.8	0.1	-0.3	0.0	-0.1	0.0	-0.4	0.0	**3.1**
Mountain	138	-1.0	0.2	-0.3	0.1	0.2	0.0	-0.3	0.0	**2.7**
Pacific	412	-1.2	0.1	0.5	0.0	1.1	0.0	-0.2	0.1	**4.0**
Puerto Rico	52	-0.1	0.1	-0.6	0.0	-0.4	0.0	-0.5	0.0	**2.9**
Rural by Region:										
New England	29	-1.1	0.0	1.0	0.1	1.3	0.0	0.5	0.1	**2.3**
Middle Atlantic	76	-0.8	-0.1	-0.4	0.0	-0.4	0.1	2.0	0.0	**3.2**
South Atlantic	183	-0.7	0.0	-0.7	0.0	-0.6	0.3	2.1	0.2	**2.5**
East North Central	151	-0.8	-0.1	-0.2	0.0	-0.1	0.2	1.6	0.1	**2.6**
East South Central	194	-0.8	-0.1	-0.2	0.0	-0.1	0.2	3.0	0.1	**2.9**
West North Central	167	-0.5	-0.2	-0.3	-0.2	-0.5	0.0	1.5	0.1	**2.3**
West South Central	217	-0.7	-0.2	-0.5	0.1	-0.4	0.5	2.5	0.2	**2.2**
Mountain	87	-0.4	-0.2	-0.9	-0.3	-1.2	2.1	0.5	0.1	**2.7**
Pacific	52	-0.6	-0.1	0.3	0.2	0.5	0.0	1.2	0.1	**3.3**
By Payment Classification: Urban hospitals	2,575	-1.1	0.2	-0.4	0.0	0.1	0.0	-0.3	0.1	**2.5**
Large urban areas (populations over 1 million)	1,410	-1.2	0.1	-0.4	0.0	0.0	0.0	-0.4	0.0	**2.4**
Other urban areas (populations of 1 million of fewer)	1,165	-1.1	0.3	-0.4	0.0	0.1	0.0	-0.1	0.1	**2.7**
Rural areas	1,118	-0.7	-0.1	-0.3	0.0	-0.2	0.3	1.8	0.1	**2.6**
Teaching Status: Nonteaching	2,615	-1.0	0.1	-0.3	0.0	0.0	0.0	0.3	0.1	**2.8**
Fewer than 100 Residents	841	-1.1	0.2	-0.4	0.0	0.0	0.0	-0.2	0.1	**2.6**

	No. of Hospitals[1]	Postacute Transfer Policy Proposal[2]	DRG Recalibration[3]	New Wage Data[4]	Change to Treatment of section 1886(d)(8)(E) Wage Data[5]	DRG and Wage Index Changes[6]	Transition for Hospitals Moving from Urban to Rural[7]	MGCRB Reclassifications[8]	Out-Migration Data[9]	All FY 2006 Changes[10]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
100 or more Residents	237	-1.2	0.2	-0.6	0.0	0.0	0.0	-0.3	0.0	**2.1**
Urban DSH: Non-DSH	981	-1.1	0.1	-0.4	0.0	0.0	0.0	-0.1	0.1	**2.4**
100 or more beds	1,484	-1.1	0.2	-0.4	0.0	0.1	0.0	-0.3	0.1	**2.6**
Less than 100 beds	349	-1.1	0.0	0.0	0.0	0.3	0.0	0.0	0.1	**2.8**
Rural DSH: Sole Community (SCH)	422	-0.4	-0.2	-0.2	0.0	-0.4	0.2	0.4	0.1	**2.7**
Referral Center (RRC)	179	-0.8	0.0	-0.2	0.0	-0.1	0.2	3.4	0.0	**2.7**
Other Rural: 100 or more beds	62	-0.9	0.0	-1.1	0.1	-0.9	1.7	1.0	0.3	**2.4**
Less than 100 Beds	216	-1.1	-0.3	-0.6	0.0	-0.5	0.5	1.0	0.5	**2.3**
Urban teaching and DSH: DSH	797	-1.1	0.2	-0.5	0.0	0.0	0.0	-0.3	0.0	**2.4**
Teaching and no DSH	217	-1.2	0.2	-0.6	0.0	-0.1	0.0	-0.3	0.1	**2.1**
No teaching and DSH	1,036	-1.0	0.1	-0.2	0.0	0.2	0.0	-0.1	0.1	**2.9**
No teaching and no DSH	525	-1.2	0.1	-0.3	0.0	0.1	0.0	-0.3	0.0	**2.6**
Rural Hospital Types: Non special status Hospitals	341	-1.0	-0.2	-0.7	0.1	-0.6	0.9	1.0	0.4	**2.4**
RRC	134	-1.1	0.0	-0.2	0.0	0.0	0.3	4.5	0.0	**2.6**
SCH	405	-0.3	-0.2	-0.2	0.0	-0.3	0.2	0.2	0.0	**2.8**
Medicare-dependent hospitals (MDH)	158	-0.9	-0.3	-0.3	0.0	-0.4	0.0	1.1	0.2	**2.4**
SCH and RRC	73	-0.4	0.0	-0.2	0.1	-0.1	0.0	1.3	0.0	**2.7**
Type of Ownership: Voluntary	2,205	-1.1	0.2	-0.5	0.0	0.0	0.0	0.0	0.1	**2.4**
Proprietary	800	-0.9	0.0	-0.4	0.0	-0.1	0.1	0.0	0.0	**2.8**

	No. of Hospitals[1]	Postacute Transfer Policy Proposal[2]	DRG Recalibration[3]	New Wage Data[4]	Change to Treatment of section 1886(d)(8)(E) Wage Data[5]	DRG and Wage Index Changes[6]	Transition for Hospitals Moving from Urban to Rural[7]	MGCRB Reclassifications[8]	Out-Migration Data[9]	All FY 2006 Changes[10]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Government	688	-0.9	0.1	-0.1	0.0	0.3	0.0	0.1	0.1	**2.9**
Medicare Utilization as a Percent of Inpatient Days:										
0-25	289	-1.0	0.1	-0.3	0.0	0.1	0.0	-0.2	0.0	**2.8**
25-50	1,441	-1.2	0.2	-0.4	0.0	0.1	0.0	-0.3	0.0	**2.5**
50-65	1,551	-1.0	0.2	-0.5	0.0	0.0	0.0	0.3	0.1	**2.6**
Over 65	412	-1.0	0.0	-0.6	0.0	-0.3	0.1	0.4	0.1	**2.3**
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2005 Reclassifications:										
All Reclassified Urban Hospitals	299	-1.2	0.1	-0.3	0.0	0.1	0.0	2.3	0.0	**3.0**
Urban Nonreclassified Hospitals	2,211	-1.1	0.2	-0.4	0.0	0.1	0.0	-0.6	0.1	**2.5**
All Reclassified Rural Hospitals	360	-0.8	-0.1	-0.2	0.0	-0.1	0.1	3.7	0.0	**2.8**
Rural Nonreclassified Hospitals	726	-0.6	-0.2	-0.5	0.0	-0.6	0.6	-0.3	0.3	**2.5**
Other Reclassified Hospitals (Section 1886(d)(8)(B))	32	-0.4	-0.1	-0.1	0.7	0.6	0.0	-0.7	0.0	**2.0**
Other Reclassified Hospitals (Section 1886(d)(8)(E))	65	-1.0	0.1	-1.1	0.2	-0.6	0.0	3.9	0.0	**1.4**

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2003, and hospital cost report data are from reporting periods beginning in FY 2002 and FY 2001.

[2] This column displays the payment impact of the proposed change to the post acute care transfer policy.

[3] This column displays the payment impact of the recalibration of the DRG weights based on FY 2003 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

[4] This column displays the impact of updating the wage index with wage data from hospitals' FY 2002 cost reports. It also displays the impact of moving into the second year of the transition from MSA to CBSA. For FY 2005, the wage index was a 50/50 blend of the MSA and CBSA based wage index in areas where the CBSA wage index was lower than the MSA; For FY 2006 the blend percentage is 100 percent CBSA wage index.

[5] This column displays the impact of changing the way wage data from section 1886(d)(8)(E) redesignations is treated in determining pre-reclassified wage index values.

[6] 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 3, 4 and 5, and the proposed FY 2006 budget neutrality factor of 1.002494 (the change to the postacute transfer policy shown in Column 2 is not included in the budget neutrality calculation). The effects of adopting an imputed floor for all-urban States are included in this column.

[7] Shown here are the effects of providing rural hospitals formerly located in urban areas with urban wage index values in FY 2006. The effects reflected here are budget neutral: this column therefore includes the effect of the 0.999529 adjustment that we have applied to the rates to ensure budget neutrality.

[8] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2006 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2006. Reclassification for prior years has no bearing on the payment impacts shown here. This column reflects the geographic budget neutrality factor of 0.992905.

[9] This column displays the impact of the FY 2006 proposed implementation of section 505 of Pub. L. 108-173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.

[10] This column shows changes in payments from FY 2005 to FY 2006. It incorporates all of the changes displayed in Columns 2, 5, 7, 8, and 9 (the changes displayed in Columns 3, 4 and 5 are included in Column 6). It also reflects the impact of the FY 2006 update, changes in hospitals' reclassification status in FY 2006 compared to FY 2005, and the changes in payments as a result of continuing the reclassifications under section 508 of Pub. L. 108-173. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effect.

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C. Impact of the Proposed Changes to the Postacute Care Transfer Policy (Column 2)

In Column 2 of Table I, we present the effects of Option 2 for the proposed expansion of the postacute care transfer policy, as discussed in section V.A. of the preamble to this proposed rule. We compared aggregate payments using the FY 2005 DRG relative weights (GROUPER version 22.0) and Option 2 for the proposed expansion of the postacute care transfer policy to aggregate payments using the FY 2005 DRG relative weights (GROUPER version 22.0) and the FY 2005 postacute care transfer policy. The changes we are proposing are estimated to result in a 1.1 percent decrease in payments to hospitals overall. We estimate the total savings at approximately $880 million.

To simulate the impact of this proposed policy, we calculated two sets of transfer-adjusted discharges and case-mix index values for hospitals. The first set was based on the FY 2005 transfer policy rules and the second was based on Option 2 for the proposed expanded transfer policy discussed in the preamble to this proposed rule. Estimated payments were computed for both sets of data and were then compared. The transfer-adjusted discharge fraction is calculated in one of two ways, depending on the transfer payment methodology. Under the transfer payment methodology in place in FY 2005, 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. There are 88 DRGs (including 210, 211) that would qualify to receive the special payment consideration. DRG 209 which formerly received the special payment has been split into two new DRGs 544 and 545. Both DRG 544 and DRG 545 are included in the 88 special payment DRGs as they continue to 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 proposed change to the transfer policy.

This proposed expansion of the policy, which represents a significant change from our prior policy, has a negative 1.1 percent payment impact overall among both urban and rural hospitals. There is only small variation among all of the hospital categories from this negative 1.1 percent impact. The areas that are most dramatically impacted are urban areas, with urban New England experiencing a 1.9 percent decline in payments and the Middle Atlantic experiencing a 1.2 percent decline. Although rural New England hospitals are losing 1.1 percent, most of the other rural regions lose less than 1 percent from this policy change. Urban areas tend to have a greater concentration of postacute care facilities to which to discharge patients than do rural areas and are, therefore, more likely to be impacted by this policy proposal.

D. Impact of the Proposed Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 3)

In Column 3 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II. of the preamble to this proposed rule. Section 1886(d)(4)(C)(i) of the Act requires us annually to make appropriate classification changes and to recalibrate the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

We compared aggregate payments using the FY 2005 DRG relative weights (GROUPER version 22.0) to aggregate payments using the proposed FY 2006 DRG relative weights (GROUPER version 23.0). We note that, consistent with section 1886(d)(4)(C)(iii) of the Act, we have applied a budget neutrality factor to ensure that the overall payment impact of the DRG changes (combined with the wage index changes) is budget neutral. This proposed budget neutrality factor of 1.002494 is applied to payments in Column 6. Because this is a combined DRG reclassification and recalibration and wage index budget neutrality factor, it is not applied to payments in Column 3.

The major DRG classification changes we are proposing include: reassigning procedure code 35.52 (Repair of atrial septal defect with prosthesis, closed technique) from DRG 108 to DRG 518 (Percutaneous Cardiovascular Procedure Without Coronary Artery Stent or AMI); reassigning procedure code 37.26 (Cardiac electrophysiologic stimulation and recording studies) from DRGs 535 and 536 to DRGs 515 (Cardiac Defibrillator Implant Without Cardiac Catheterization); splitting DRG 209 into two new DRGs based on the presence or absence of the procedure codes for major joint replacement or reattachment of lower extremity and revision of hip or knee replacement, DRG 545 (Revision of Hip or Knee Replacement) and DRG 544 (Major Joint Replacement or Reattachment of Lower Extremity); reassigning procedure code 26.12 (Open biopsy of salivary gland or duct) from DRG 468 to DRG 477 (Non-Extensive O.R. Procedure Unrelated To Principal Diagnosis); reassigning the principal diagnosis codes for curvature of the spine or malignancy from DRGs 497 and 498 to new DRG 546 (Spinal Fusion Except Cervical with PDX of Curvature of the Spine or Malignancy); splitting DRGs 516 and 526 into four new DRGs based on the presence or absence of a CC, DRG 547 (Percutaneous Cardiovascular Procedure With AMI With CC), DRG 548 (Percutaneous Cardiovascular Procedure With AMI Without CC), DRG 549 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent With AMI With CC), DRG 550 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent With AMI Without CC); reassigning procedure code 39.65 (Extracorporeal membrane oxygenation [ECMO]) from DRGs 104 and 105 to DRG 541 (ECMO or Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses With Major Operating Room Procedure).

In the aggregate, these proposed changes would result in a 0.1 percent increase in overall payments to hospitals. On average, the impacts of these changes on any particular hospital group are very small, with urban hospitals experiencing a 0.2 percent increase and rural hospitals experiencing a 0.1 percent decrease. The largest impact is a 0.4 percent increase among urban hospitals in New England. This is in part due to the residual effects of the proposed change to the postacute care transfer policy on the relative weights. Including a DRG in the postacute care transfer group reduces the number of cases in the DRG (cases that qualify as transfers are only counted as a fraction of a case) which in turn increases the average charge for the DRG and the weight.

E. Impact of Proposed Wage Index Changes (Column 4)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the proposed wage index for FY 2006 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002. 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 2005 wage index, based on FY 2001 wage data, to a model using the FY 2006 pre-reclassification wage index, based on FY 2002 wage data. The FY 2005 wage index baseline incorporated a blended wage index of 50 percent of the MSA wage index and 50 percent of the CBSA wage index in areas where the CBSA wage index was lower than the MSA wage index to reflect the transition policy that was in effect in FY 2005. The wage data collected on the FY 2002 cost report is the same as the FY 2001 wage data that were used to calculate the FY 2005 wage index.

Column 4 shows the impacts of updating the wage data using FY 2002 cost reports. Overall, the new wage data will lead to a 0.4 percent decrease for all hospitals and for hospitals in urban areas. This decrease is due to both fluctuations in the wage data itself and the fact that the transition blended wage index, which benefited areas that were negatively impacted by the labor market

transition is no longer in effect for FY 2006. Among regions, the largest increase is in the rural New England which is experiencing a 1.0 percent increase. The largest decline from updating the wage data is seen in the urban New England region (a 1.1 percent decrease).

In looking at the wage data itself, the national average hourly wage increased 6.1 percent compared to FY 2005. Therefore, the only manner in which to maintain or exceed the previous year's wage index was to match the national 6.1 increase in average hourly wage. Of the 3,617 hospitals with wage index values in both FYs 2005 and 2006, 1,642, or 45.4 percent, also experienced an average hourly wage increase of 6.1 percent or more.

The following chart compares the shifts in wage index values for hospitals for FY 2006 relative to FY 2005. Among urban hospitals, 58 will experience an increase of between 5 percent and 10 percent and 24 will experience an increase of more than 10 percent. A total of 14 rural hospitals would experience increases greater than 5 percent, but none will experience increases of greater than 10 percent. On the negative side, 56 urban hospitals will experience decreases in their wage index values of at least 5 percent, but less than 10 percent. Fourteen urban hospitals will experience decreases in their wage index values greater than 10 percent.

The following chart shows the projected impact for urban and rural hospitals.

Percentage Change in Area Wage Index Values	Number of Hospitals	
	Urban	Rural
Increase more than 10 percent	24	0
Increase more than 5 percent and less than 10 percent	58	14
Increase or decrease less than 5 percent	2,584	1,141
Decrease more than 5 percent and less than 10 percent	56	12
Decrease more than 10 percent	14	0

F. Impact of Proposed Change in Treatment of Section 1886(d)(8)(E) Wage Data (Column 5)

For the FY 2006 wage index, we are proposing to leave the wage data for a hospital redesignated as rural under section 1886(d)(8)(E) of the Act in the urban area in which the hospital is geographically located for purposes of calculating the wage index of those areas. We are proposing to move the wage data for these hospitals into the rural wage index only if it increases the wage index in the rural area. In this way, the rural floor is only affected by the wage data for these redesignated hospitals if it would increase the rural wage index and thus reset the rural floor at a higher value. Previously, the wage data for these redesignated hospitals was moved into the rural area wage index calculations regardless of whether it increased or decreased the rural wage index, and this caused the rural floor for several States to be lower than it would have been had the redesignated providers' data not been included.

Column 5 shows the impact of adopting this policy. In aggregate, this policy proposal has no effect on payments to providers. Hospitals in the urban New England region experience an increase in payments of 0.2 percent, which indicates that CBSAs in that region that receive the rural floor are now receiving a higher wage index. Hospitals in West North Central are shown to experience a 0.2 decline. However, when the redesignated data are added to the rural wage index, their rural floor increases and they do not actually experience a loss from this policy. Hospitals reclassified as rural under section 1886(d)(8)(E) of the Act will experience a 0.2 percent increase.

G. Combined Impact of Proposed DRG and Wage Index Changes, Including Budget Neutrality Adjustment (Column 6)

The impact of the DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this proposed rule compared simulated aggregate payments using the FY 2005 DRG relative weights and wage index to simulated aggregate payments using the proposed FY 2006 DRG relative weights and blended wage index.

We computed a proposed wage and recalibration budget neutrality factor of 1.002494. 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 6. The changes in this column are the sum of the proposed changes in Columns 3, 4, and 5, 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.

Among urban regions, the largest impacts are in the West North Central region and Puerto Rico, with 0.3 and 0.4 percent declines, respectively. The Pacific region experiences the largest increase of 1.1 percent. Among rural regions, the New England region benefits the most with a 1.3 percent increase, while the Mountain region experiences the largest decline (1.2 percent).

H. Impact of Allowing Urban Hospitals That Were Converted to Rural as a Result of the CBSA Designations To Maintain the Wage Index of the MSA Where They Are Located (Column 7)

To help alleviate the decreased payments for urban hospitals that became rural under the new labor market area definitions, for purposes of the wage index, we adopted a policy in FY 2005 to allow them to maintain the wage index assignment of the MSA where they were located for the 3-year period FY 2005, FY 2006, and FY 2007. Column 7 shows the impact of the remaining labor market area transition, for those hospitals that were urban under the old labor market area designations and are now considered rural hospitals. Section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. Therefore, we applied an adjustment of 0.999529 to ensure that the effects of reclassification are budget neutral as indicated by the zero effect on payments to hospitals overall. The rural hospital row shows a 0.3 percent benefit from this provision as these hold harmless hospitals are now considered geographically rural.

I. Impact of MGCRB Reclassifications (Column 8)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in Column 8 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2006. These decisions affect hospitals' standardized amount and wage index area assignments.

By February 28 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. The MGCRB may approve a hospital's reclassification request for the purpose of using another area's wage index value. The proposed FY 2006 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2006. The wage index values also reflect any decisions made by the CMS Administrator through the appeals and review process through February 28, 2005. Additional changes that result from the Administrator's review of MGCRB decisions or a request by a hospital to withdraw its application will be reflected in the final rule for FY 2006.

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 0.992905 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this proposed rule.)

As a group, rural hospitals benefit from geographic reclassification. We estimate that their payments will rise 2.0 percent in Column 8. Payments to urban hospitals will decline by 0.3 percent. Hospitals in other urban areas will experience an overall decrease in payments of 0.2 percent, while large urban hospitals will 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 all of the rural hospital groups. The smallest increase among the rural census divisions is 0.5 for the Mountain and New England regions. The largest increases are in the rural East South Central region, with an increase of 3.0 percent and in the West South Central region, which would experience an increase of 2.5 percent.

Urban hospitals reclassified for FY 2006 are expected to receive an increase of 2.3 percent, while rural reclassified hospitals are expected to benefit from the MGCRB changes with a 3.7 percent increase in payments. Payments to urban and rural hospitals that did not reclassify are expected to decrease slightly due to the MGCRB changes, decreasing by 0.6 percent for urban hospitals and 0.3 percent for rural hospitals.

J. Impacts of the Proposed Wage Index Adjustment for Out-Migration (Column 9)

Section 1886(d)(13) of the Act, as added by section 505 of Pub. L. 108–173, provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county, but work in a different area with a higher wage index. Hospitals located in counties that qualify for the payment adjustment are to receive an increase in the wage index that is equal to a weighted average of the difference between the wage index of the resident county and the higher wage index work area(s), weighted by the overall percentage of workers who are employed in an area with a higher wage index. Using our established criteria, 345 counties and 688 hospitals qualify to receive a commuting adjustment in FY 2006.

Due to the statutory formula to calculate the adjustment and the small number of counties that qualify, the impact on hospitals is minimal, with an overall impact on all hospitals of 0.1 percent.

K. All Changes (Column 10)

Column 10 compares our estimate of payments per case, incorporating all changes reflected in this proposed rule for FY 2006 (including statutory changes), to our estimate of payments per case in FY 2005. This column includes all of the proposed policy changes. Because the reclassifications shown in Column 8 do not reflect FY 2005 reclassifications, the impacts of FY 2006 reclassifications only affect the impacts from FY 2005 to FY 2006 if the reclassification impacts for any group of hospitals are different in FY 2006 compared to FY 2005.

• Column 10 reflects all FY 2006 changes relative to FY 2005, shown in Columns 2 through 9 and those not applied until the final rates are calculated. The average increase for all hospitals is approximately 2.5 percent. This increase includes the effects of the proposed 3.2 percent market basket update. It also reflects the 0.7 percentage point difference between the projected outlier payments in FY 2005 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2005 (4.4 percent), as described in the introduction to this Appendix and the Addendum to this proposed rule. As a result, payments are projected to be 0.7 percentage point lower in FY 2005 than originally estimated, resulting in a 0.7 percentage point greater increase for FY 2006 than would otherwise occur. In addition, the impact of section 505 adjustments accounted for a 0.1 percent increase. Payment decreases of 1.5 percent are primarily attributable to the impact of expanding the postacute care transfer policy (−1.1 percent). Indirect medical education formula changes for teaching hospitals under section 502 of Pub. L. 108–173, changes in payments due to the difference between the FY 2005 and FY 2006 wage index values assigned to providers reclassified under section 508 of Pub. L. 108–173, and changes in the incremental increase in payments from section 505 of Pub. L. 108–173 out migration adjustments account for the remaining −0.4 percent.

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 2006, eligible SCHs receive 100 percent of their 1996 hospital-specific rate. In addition, in this proposed rule we are proposing to revise the budget neutrality adjustment applied to the hospital-specific rates to reflect only the payment changes resulting from DRG recalibration. Previously, we had also adjusted the hospital-specific rates to reflect payment changes based on area wage levels. The impact of this provision is modeled in Column 10 as well. In addition, section 402 of Pub. L. 108–173 increases the DSH adjustment for hospitals that serve a disproportionate share of low-income Medicare and Medicaid patients, which include rural hospitals and urban hospitals with fewer than 100 beds, SCHs, rural referral centers, and rural hospitals with less than 500 beds. The increase in DSH payments became effective for discharges occurring on or after April 1, 2004. As provided in the new Medicare law, the cap on DSH payment adjustments increased from 5.25 percent to 12 percent for urban hospitals with fewer than 100 beds, SCHs, and rural hospitals with less than 500 beds. There is no cap on rural referral centers, large urban hospitals over 100 beds, or rural hospitals over 500 beds.

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 2006 would increase by 2.5 percent. Hospitals in urban areas would experience a 2.5 percent increase in payments per case compared to FY 2005. Hospitals in rural areas, meanwhile, would experience a 2.6 percent payment increase. Hospitals in large urban areas would experience a 2.4 percent increase in payments and hospitals in other urban areas would experience a 2.7 percent increase in payments.

Among urban census divisions, the largest payment increase would be 4.0 percent in the Pacific region. Hospitals in the urban East South Central and West South Central regions would experience the next largest overall increases of 3.0 percent and 3.1 percent, respectively. The smallest urban increase would occur in the New England region, with an increase of 1.0 percent.

Among rural regions in Column 10, no hospital category will experience overall payment decreases. The Pacific and Middle Atlantic regions will benefit the most, with 3.3 and 3.2 percent increases, respectively. The smallest increase will occur in the West South Central region, with 2.2 percent increases in payments.

Among special categories of rural hospitals in Column 10, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) would experience payment increases of 2.8 percent, 2.4 percent, and 2.7 percent, respectively. This outcome is primarily related to the fact that, for hospitals receiving payments under the hospital-specific methodology, there were several increases to payments made in relation to implementation of the Pub. L. 108–173.

Urban hospitals reclassified for FY 2006 are anticipated to receive an increase of 3.0 percent, while rural reclassified hospitals are expected to benefit from reclassification with a 2.8 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 1.4 percent.

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TABLE II. IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2006 OPERATING PROSPECTIVE PAYMENT SYSTEM (PAYMENTS PER CASE)

	Number of Hospitals (1)	Average FY 2005 Payment Per Case[1] (2)	Average FY 2006 Payment Per Case[1] (3)	All FY 2006 Changes (4)
By Geographic Location:				
All hospitals	3,693	8,266	8,476	**2.5**
Urban hospitals	2,537	8,595	8,812	**2.5**
Large urban areas (populations over 1 million)	1,399	8,970	9,188	**2.4**
Other urban areas (populations of 1 million of fewer)	1,138	8,142	8,360	**2.7**
Rural hospitals	1,156	6,542	6,713	**2.6**
Bed Size (Urban):				
0-99 beds	611	6,437	6,595	**2.5**
100-199 beds	877	7,194	7,378	**2.6**
200-299 beds	479	8,144	8,361	**2.7**
300-499 beds	408	9,109	9,332	**2.5**
500 or more beds	162	10,865	11,137	**2.5**
Bed Size (Rural):				
0-49 beds	473	5,602	5,733	**2.3**
50-99 beds	387	6,020	6,181	**2.7**
100-149 beds	188	6,583	6,751	**2.6**
150-199 beds	61	7,688	7,899	**2.8**
200 or more beds	47	7,783	7,997	**2.7**
Urban by Region:				
New England	129	9,258	9,350	**1.0**
Middle Atlantic	356	9,317	9,498	**1.9**
South Atlantic	386	8,164	8,372	**2.6**
East North Central	400	8,262	8,437	**2.1**
East South Central	165	7,866	8,106	**3.0**
West North Central	155	8,677	8,878	**2.3**
West South Central	344	8,124	8,373	**3.1**
Mountain	138	8,488	8,721	**2.7**

	Number of Hospitals (1)	Average FY 2005 Payment Per Case[1] (2)	Average FY 2006 Payment Per Case[1] (3)	All FY 2006 Changes (4)
Pacific	412	10,126	10,530	**4.0**
Puerto Rico	52	4,011	4,128	**2.9**
Rural by Region:				
New England	29	8,339	8,527	**2.3**
Middle Atlantic	76	6,188	6,385	**3.2**
South Atlantic	183	6,430	6,590	**2.5**
East North Central	151	6,438	6,603	**2.6**
East South Central	194	5,805	5,975	**2.9**
West North Central	167	6,985	7,147	**2.3**
West South Central	217	6,145	6,283	**2.2**
Mountain	87	7,388	7,591	**2.7**
Pacific	52	9,863	10,189	**3.3**
By Payment Classification:				
Urban hospitals	2,575	8,555	8,771	**2.5**
Large urban areas (populations over 1 million)	1,410	8,947	9,164	**2.4**
Other urban areas (populations of 1 million of fewer)	1,165	8,084	8,301	**2.7**
Rural areas	1,118	6,689	6,866	**2.6**
Teaching Status:				
Non-teaching	2,615	6,970	7,163	**2.8**
Fewer than 100 Residents	841	8,389	8,606	**2.6**
100 or more Residents	237	12,193	12,445	**2.1**
Urban DSH:				
Non-DSH	981	7,459	7,637	**2.4**
100 or more beds	1,484	9,060	9,293	**2.6**
Less than 100 beds	349	5,917	6,081	**2.8**
Rural DSH:				
Sole Community (SCH)	422	7,128	7,324	**2.7**
Referral Center (RRC)	179	7,293	7,488	**2.7**
Other Rural: 100 or more beds	62	5,588	5,723	**2.4**
Less than 100 beds	216	4,927	5,038	**2.3**
Urban teaching and DSH:				
Both teaching and DSH	797	10,005	10,248	**2.4**
Teaching and no DSH	217	8,421	8,597	**2.1**

	Number of Hospitals (1)	Average FY 2005 Payment Per Case[1] (2)	Average FY 2006 Payment Per Case[1] (3)	All FY 2006 Changes (4)
No teaching and DSH	1,036	7,278	7,490	**2.9**
No teaching and no DSH	525	6,923	7,104	**2.6**
Rural Hospital Types:				
Non special status hospitals	341	5,152	5,274	**2.4**
RRC	134	6,725	6,900	**2.6**
SCH	405	7,770	7,986	**2.8**
Medicare-dependent hospitals (MDH)	158	4,820	4,938	**2.4**
SCH and RRC	73	8,384	8,614	**2.7**
Type of Ownership:				
Voluntary	2,205	8,386	8,591	**2.4**
Proprietary	800	7,548	7,755	**2.8**
Government	688	8,473	8,720	**2.9**
Medicare Utilization as a Percent of Inpatient Days:				
0-25	289	11,200	11,516	**2.8**
25-50	1,441	9,281	9,516	**2.5**
50-65	1,551	7,333	7,521	**2.6**
Over 65	412	6,573	6,724	**2.3**
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2005 Reclassifications:				
All Urban Reclassified Hospitals	299	8,498	8,753	**3.0**
Urban Nonreclassified Hospitals	2,211	8,596	8,809	**2.5**
All Reclassified Rural Hospitals	360	7,123	7,323	**2.8**
Rural Nonreclassified Hospitals	726	6,004	6,154	**2.5**
Other Reclassified Hospitals (Section 1886(d)(8)(E))	32	10,216	10,422	**2.0**
Other Reclassified Hospitals (Section 1886(d)(8)(B))	65	5,687	5,766	**1.4**

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

Table II presents the projected impact of the proposed changes for FY 2006 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 2005 with the average estimated per case payments for FY 2006, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from Column 10 of Table I.

VII. Impact of Other Proposed Policy Changes

In addition to those proposed changes discussed above that we are able to model using our IPPS payment simulation model, we are proposing various other changes in this proposed rule. Generally, we have limited or no specific data available with which to estimate the impacts of these changes. Our estimates of the likely impacts associated with these other proposed changes are discussed below.

A. Impact of Proposed LTC-DRG Reclassifications and Relative Weights for LTCHs

In section II.D. of the preamble of this proposed rule, we discuss the proposed changes in the LTC-DRG relative weights for FY 2006 based on the proposed version 23.0 of the CMS GROUPER (including the

proposed changes in the classifications, relative weights and geometric mean length of stay for each LTC-DRG). Based on LTCH cases in the FY 2004 MedPAR file, we estimate that the proposed changes would result in an aggregate decrease in LTCH payments of approximately 4.7 percent. When we compared the version 22 (FY 2005) LTC-DRG relative weights to the proposed version 23 (FY 2006) LTC-DRG relative weights, we found that approximately 72 percent of the LTC-DRGs had higher relative weights under version 22 in comparison to the proposed version 23. We also found that the version 22 LTC-DRG relative weights were, on average, approximately 16 percent higher than the proposed version 23 LTC-DRG relative weights.

In addition, based on an analysis of the most recent available LTCH claims data from the FY 2004 MedPAR file, we continue to observe that the proposed average LTC-DRG relative weight decreases due to an increase of relatively lower charge cases being assigned to LTC-DRGs with higher relative weights in the prior year. Contributing to this increase in these relatively lower charge cases being assigned to LTC-DRGs with higher relative weights in the prior year are improvements in coding practices, which are typically found when moving from a reasonable cost-based payment system to a PPS. The impact of including cases with relatively lower charges into LTC-DRGs that had a relatively higher relative weight in the version 22.0 (FY 2005) GROUPER is a decrease in the average relative weight for those LTC-DRGs in the proposed GROUPER version 23.0. We also found that there is over a 15 percent increase in the average LTCH charge across all LTC-DRGs from FY 2003 to FY 2004. For some LTC-DRGs in which the average charge within the LTC-DRG increase is less than 15 percent, the relative weights for those LTC-DRGs will decrease because the average charge for each of those LTC-DRGs is being divided by a larger number (that is, the average charge across all LTC-DRGs). For the reasons discussed above, we believe that the proposed changes in the LTC-DRG relative weights, which include a number of proposed LTC-DRGs with lower proposed relative weights, would result in approximately a 4.6 percent decrease in aggregate LTCH PPS payments.

B. Impact of Proposed New Technology Add-On Payments

We are no longer required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral (see section II.E. of the preamble to this proposed rule). However, we are still providing an estimate of the payment increases here, as they will have a significant impact on total payments made in FY 2006. New technology add-on payments are limited to the lesser of 50 percent of the costs of the technology, or 50 percent of the costs in excess of the DRG payment for the case. Because it is difficult to predict the actual new technology add-on payment for each case, we are estimating the increase in payment for FY 2006 as if every claim with these add-on payments will receive the maximum add-on payment. As discussed in section II.E. of the preamble of this proposed rule, we are not proposing to approve any of the new technology applications that were filed for FY 2006. However, we are proposing to continue to make add-on payments in FY 2006 for an FY 2005 new technology: Kinetra$_{TM}$ implants. We estimate this approval would increase overall payments by $12.8 million. The increase in payments for this new technology is not reflected in the tables.

C. Impact of Requirements for Hospital Reporting of Quality Data for Annual Hospital Payment Update

In section V.B. of the preamble to this proposed rule, we discuss our implementation of section 1886(b)(3)(B)(vii) of the Act, as added by section 501(b) of Pub. L. 108–173, which revised the mechanism used to update the standardized amount of payment for inpatient hospital operating costs. Specifically, section 1886(b)(3)(B)(vii) of the Act provides for a reduction of 0.4 percentage points to the update percentage increase (also known as the market basket update) for each of FYs 2005 through 2007 for any subsection (d) hospital that does not submit data on a set of 10 quality indicators established by the Secretary as of November 1, 2003. The statute also provides that any reduction will apply only to the year involved, and will not be taken into account in computing the applicable percentage increase for a subsequent fiscal year. We are unable to precisely estimate the effect of this provision because, while receiving the full update for those years is conditional upon the submission of quality data by a hospital, the submitted data must also be validated, as described in section V.B. above. The final date for submission of quality data for purposes of receiving the full adjustment in FY 2006 is May 15, 2005. Preliminary results indicate that over 98 percent of IPPS hospitals have submitted quality data. The QIOs are still in the process of validating that data and certifying those hospitals eligible to receive the full update for FY 2006. We have continued our efforts to ensure that QIOs provide assistance to all hospitals that wish to submit data. In the preamble to this proposed rule, we are proposing additional validation criteria to ensure that the quality data being sent to CMS are accurate. Our validation process requires participating hospitals to submit five charts per quarter. We reimburse each hospital for the cost of sending charts to the Clinical Data Abstraction Center at the rate of 12 cents per page for copying and approximately $4.00 per chart for postage. Based on our experience, the average size of a chart is 140 pages. Therefore, we estimate our expenditures for chart collection at $380,000 per quarter. Because we provide reimbursement to hospitals for the costs of chart submission, we believe that this requirement represents a minimal burden to participating hospitals. Based on test applications of these validation criteria to quality data that have been submitted thus far, we currently estimate that approximately 5 percent of hospitals will fail the edits and receive the reduced market basket update to the standardized amount. Based on this reduced payment to some hospitals, we estimate savings to the Medicare program of approximately $20 million for FY 2006.

D. Impact of Proposed Policy on Payment Adjustments for Low-Volume Hospitals

In section V.E. of the preamble to this proposed rule, we discussed our proposed FY 2006 implementation of section 1886(d)(12) of the Act, as added by section 406 of Pub. L. 108–173, which provides for a payment adjustment to account for the higher costs per discharge of low-volume hospitals under the IPPS. For FY 2006, we are proposing to continue to apply the low-volume adjustment criteria that we specified in the FY 2005 IPPS final rule (69 FR 49099). Currently, our fiscal intermediaries have identified 10 providers that are eligible for the low-volume adjustment. We estimate that the impact of these providers receiving the additional 25 percent payment increase to be approximately $1.5 million.

E. Impact of Proposed Policies on Payment for Indirect Costs of Graduate Medical Education

1. IME Adjustment for TEFRA Hospitals Converting to IPPS Hospitals

In section V.F.2. of the preamble of this proposed rule, we discuss our proposal to incorporate into regulations our existing policy regarding the IME adjustment for TEFRA hospitals converting to IPPS hospitals. We establish an FTE resident cap for TEFRA hospitals converting to an IPPS hospital for IME payment purposes as if the hospital had been an IPPS hospital during the base year used to compute the hospital's direct GME FTE resident cap. We are only aware of four hospitals where this issue has arisen. The proposed addition to the regulations clarifies the established policy for computing an IME FTE resident cap for these hospitals. Because this is a proposal to clarify existing policy and codify it in regulations, there is no financial impact for FY 2006.

2. Section 1886(d)(8)(E) Teaching Hospitals That Withdraw Rural Reclasssification

In section V.F.3. of the preamble to this proposed rule, we present our proposal to adjust the IME FTE resident caps of hospitals that rescind their section 1886(d)(8)(E) rural reclassifications so that they do not continue to receive the increase in the FTE resident cap that is applied for rural teaching hositals. The purpose of this policy is to prevent urban hospitals from reclassifying to rural areas under section 1886(d)(8)(E) of the Act for a short period of time, solely as a means of receiving a permanent increase to their IME FTE caps. The impact of this policy is that section 1886(d)(8)(E) hospitals may receive decreased IME payments if they return to urban status. This impact cannot be quantified because we are unable to determine the number of hospitals that would otherwise game the system in the absence of this proposal and we are not aware of any teaching hospitals that became rural under the provision of section 1886(d)(8)(E) of the Act that have subsequently reverted to urban status.

F. Impact of Proposed Policy Relating to Geographic Reclassifications of Multicampus Hospitals

In section V.H. of the preamble of this proposed rule, we discuss the impact of our implementation of the new labor market areas on multicampus hospital systems. Under our current policy, a multicampus hospital with campuses located in the same labor market area receives a single wage index. However, if the campuses are located in more than one labor market area, payment for each discharge is determined using the wage index value for the labor market area in which the campus of the hospital is located. In addition, current provisions provide that, in the case of a merger of hospitals, if the merged facilities operate as a single institution, the institution must submit a single cost report, which necessitates a single provider identification number. This provision also does not differentiate between merged facilities in a single wage index area or in multiple wage index areas. As a result, the wage index data for the merged facility is reported for the entire entity on a single cost report.

The current criteria for a hospital being reclassified to another wage area by the MGCRB do not address the circumstances under which a single campus of a multicampus hospital may seek reclassification.

Specifically, we are proposing that for reclassification applications submitted for FY 2006 (that is, applications received by September 1, 2004), we would allow a campus or campuses of a multicampus hospital system to seek geographic reclassification on the basis of the average hourly wage data submitted for the entire hospital system. For reclassification applications that would take effect for FY 2007 (that is, applications received by September 1, 2005) and thereafter, a campus of a multihospital system could not use the wage data of the entire hospital system, but rather, would have the opportunity to separate out campus-specific wage data for purposes of seeking reclassification for such campus. We estimate that this proposal will apply to fewer than 12 multicampus hospital systems nationwide and, therefore, will not lead to additional program expenditures because hospital geographic reclassifications are budget neutral under section 1886(d)(8)(D) of the Act.

G. Impact of Proposed Policy on Payment for Direct Costs of Graduate Medical Education

1. GME Initial Residency—Match for Second Year

In section V.I.2. of the preamble to this proposed rule, we discuss our proposed changes related to the initial residency period for residents that match into an advanced residency program, but fail to match into a clinical base year of training. We are proposing that, in instances where a hospital can document that, prior to commencement of any residency training, a resident matched into an advanced program that begins in the second residency year, that resident's initial residency period will be determined based on the period of board eligibility for the advanced program, without regard to the fact that the resident had not matched for a clinical base year training program. For purposes of this proposed rule, we have estimated the impact of this proposed rule change for FY 2006, using assumptions about the national average per resident amount, the number of affected residents, and the national average Medicare utilization rate. We estimate that this provision will affect approximately 600 residents. Using a national average per resident amount of $92,000, and an average Medicare utilization rate of 35 percent, we estimate that, for FY 2006, the impact of treating those residents as a full FTE rather than .50 FTE, Medicare payments for direct GME will increase by approximately $9.7 million.

2. New Teaching Hospitals' Participation in Medicare GME Affiliated Groups

In section V.I.3. of the preamble to this proposed rule, we discuss our proposed changes related to new teaching hospitals' participation in Medicare GME affiliated groups. Under current regulations, a new teaching hospital located in an urban area that establishes an FTE resident cap under § 413.79(e) may not participate in a Medicare GME affiliated group. We are proposing to revise the regulations to allow a new teaching hospital located in an urban area to participate in a Medicare GME affiliated group, but only if any adjustments made by the Medicare GME affiliation agreement result in an increase to the new teaching hospital's adjusted resident FTE resident caps for purposes of IME and direct GME payment. There is no estimated increase in program payments related to this proposed change because any additional residents that would be counted at the new teaching hospitals as a result of this change could have been counted prior to the affiliation for Medicare GME payment purposes at the hospital that is losing slots under the affiliation agreement.

H. Impact of Policy on Rural Community Hospital Demonstration Program

In section V.K. of the preamble to this proposed rule, we discuss our implementation of section 410A of Pub.L. 108–173 that required the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) requires that "in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' As discussed in section V.K. of the preamble to this proposed rule, we are satisfying this requirement by adjusting national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment for FY 2006 that will be made to each participating hospital under the demonstration will be approximately $977,410. We based this estimate on the recent historical experience of the difference between inpatient cost and payment for hospitals that have applied for the demonstration. For 13 participating hospitals, the total annual impact of the demonstration program is estimated to be $12,706,334. We describe the budget neutrality adjustment required for this purpose in the Addendum to this proposed rule.

I. Impact of Proposed Policy on CAH Relocation Provisions

In section VII.B.3. of the preamble to this proposed rule, we discuss the proposed change to the necessary provider provision as it applies to CAHs. As required by statute, no additional CAHs will be certified as a necessary provider on or after January 1, 2006. We are proposing to revise the regulations to allow some flexibility for those CAHs previously designated as necessary providers that embarked on a replacement facility project before the sunset provision was enacted on December 8, 2003, but find that they cannot be operational in the replacement facility by January 1, 2006. We are proposing that, when a CAH is determined to have relocated, it may continue to operate under its existing necessary provider designation that exempts CAHs from the distance from another provider requirement only if certain conditions are met. The proposed clarification to the sunset of the necessary provider provision is intended to allow CAHs to complete construction projects that were initiated prior to the enactment of Pub. L. 108–173. The Health Resources Services Administration (HRSA) estimates that this proposal will apply to fewer than six CAHs nationwide. The average cost of construction of a new 25 bed CAH is approximately $25 million. Given a depreciation schedule based on a 25 useful life and Medicare utilization of approximately 50 percent, the additional capital costs for six CAHs would be $3 million. However, the actual cost to the program would be further reduced since those 6 CAH are currently being reimbursed for their existing capital costs and also the increased operating costs that are associated with operating an aged facility. Accordingly, the budgetary impact for the proposed change on the affected CAHs is estimated at between $1 million and $2 million. Expressed on a per-facility basis, the budgetary impact of this proposed change is estimated at between $167,000 and $333,000 per CAH.

VIII. Impact of Proposed Changes in the Capital PPS

A. General Considerations

Fiscal year (FY) 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 VI. of the preamble of this proposed rule, with the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), beginning in FY 2002 capital prospective payment system payments for most hospitals are based solely on the capital Federal rate. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

In accordance with § 412.312, the basic methodology for determining a capital PPS 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 +3 Disproportionate Share (DSH) Adjustment Factor + Indirect Medical Education (IME) Adjustment Factor, if applicable).

In addition, hospitals may also receive outlier payments for those cases that qualify under the threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the December 2004 update of the FY 2004 MedPAR file and the December 2004 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 2004 update of the most recently available hospital cost report data (FY 2003) 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 IPPS, it is very difficult to precisely quantify the impact associated with each change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases (for instance, the number of beds), there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available sources overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the December 2004 update of the FY 2004 MedPAR file, we simulated payments under the capital PPS for FY 2005 and FY 2006 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general IPPS (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations.

As we explain in section III.A.4. of the Addendum of this proposed rule, payments are no longer made under the regular exceptions provision under §§ 412.348(b) through (e). Therefore, we no longer use the actuarial capital cost model (described in Appendix B of the August 1, 2001 proposed rule (66 FR 40099)). We modeled payments for each hospital by multiplying the capital Federal rate by the GAF and the hospital's case-mix. We then added estimated payments for indirect medical education, disproportionate share, large urban add-on, and outliers, if applicable. For purposes of this impact analysis, the model includes the following assumptions:

- We estimate that the Medicare case-mix index would increase by 1.0 percent in both FYs 2005 and 2006.
- We estimate that the Medicare discharges will be 13.5 million in FY 2005 and 13.3 million in FY 2006 for a 1.5 percent decrease from FY 2005 to FY 2006.
- The capital Federal rate was updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The proposed FY 2006 update is 0.7 percent (see section III.A.1.a. of the Addendum to this proposed rule).
- In addition to the proposed FY 2006 update factor, the proposed FY 2006 capital Federal rate was calculated based on a proposed GAF/DRG budget neutrality factor of 1.0019, a proposed outlier adjustment factor of 0.9497, and a proposed (special) exceptions adjustment factor of 0.9997.

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 PPS transition period payment methodology. We are no longer including this information because all hospitals (except new hospitals under § 412.324(b) and under § 412.304(c)(2)) will be paid 100 percent of the capital Federal rate in FY 2006.

We used the actuarial model described above to estimate the potential impact of our changes for FY 2006 on total capital payments per case, using a universe of 3,693 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the December 2004 update of the FY 2004 MedPAR file, the December 2004 update to the Provider-Specific File, and the most recent cost report data from the December 2004 update of HCRIS. In Table III, we present a comparison of total payments per case for FY 2005 compared to FY 2006 based on the proposed FY 2006 payment policies. Column 2 shows estimates of payments per case under our model for FY 2005. Column 3 shows estimates of payments per case under our model for FY 2006. Column 4 shows the total percentage change in payments from FY 2005 to FY 2006. The change represented in Column 4 includes the 0.7 percent update to the capital Federal rate, a 1.0 percent increase in case-mix, changes in the adjustments to the capital Federal rate (for example, the effect of the new hospital wage index on the GAF), and reclassifications by the MGCRB, as well as changes in special exception payments. The comparisons are provided by: (1) Geographic location; (2) region; and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 1.7 percent in FY 2006. In addition to the 0.7 percent increase due to the capital market basket update, this projected increase in capital payments per case is largely attributable to an estimated increase in outlier payments in FY 2006. Our comparison by geographic location shows that urban hospitals are expected to experience a 1.8 percent increase in IPPS capital payments per case, while rural hospitals are only expected to experience a 1.2 percent increase in capital payments per case. This difference is mostly due to a projection that urban hospitals would experience a larger increase in estimated outlier payments from FY 2005 to FY 2006 compared to rural hospitals.

All regions are estimated to receive an increase in total capital payments per case from FY 2005 to FY 2006. Changes by region vary from a minimum increase of 0.1 percent (Middle Atlantic rural region) to a maximum increase of 3.3 percent (Pacific urban region). The relatively small increase in projected capital payments per discharge for hospitals located in the Middle Atlantic rural region is largely attributable to the proposed changes in the GAF values (that is, the proposed GAFs for most of these hospitals for FY 2006 are lower than the weighted average of the GAFs for FY 2005) . The relatively large increase in capital payments per discharge for hospitals located in the Pacific urban region is largely due to the proposed changes in the GAF values (that is, the proposed GAFs for most of these hospitals for FY 2006 are higher than the average of the GAFs for FY 2005) and a larger than average increase in estimated outlier payments for FY 2006.

Hospitals located in Puerto Rico are expected to experience an increase in total capital payments per case of 1.0 percent. This slightly lower than average increase in payment per case for hospitals located in Puerto Rico is largely due to the proposed changes in the proposed GAF values (that is, the proposed GAFs for most of these hospitals for FY 2006 are higher than the average of the GAFs for FY 2005).

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 and proprietary hospitals are expected to increase 1.6 percent and 1.8 percent, respectively. As noted above, this slightly larger projected increase in capital payments per case for government hospitals is mostly due to the larger than average increase in projected outlier payments for FY 2006 and a smaller than average decrease in the proposed GAF values.

Section 1886(d)(10) of the Act established the MGCRB. Previously, hospitals could apply for reclassification for purposes of the standardized amount, wage index, or both. Section 401(c) of Pub. L. 108–173 equalized the standardized amounts under the operating IPPS. Therefore, beginning in FY 2005, there is no longer reclassification for the purposes of the standardized amounts; hospitals may apply for reclassification for purposes of the wage index in FY 2006. Reclassification for wage index purposes also

affects the GAF because that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2006 compared to the effects of reclassification for FY 2005, 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 2006 as a whole are projected to experience a 2.0 percent increase in payments. Payments to nonreclassified hospitals in FY 2006 are expected to increase 1.7 percent. Hospitals reclassified during both FY 2005 and FY 2006 are projected to experience an increase in payments of 1.3 percent. Hospitals reclassified during FY 2006 only are projected to receive an increase in payments of 3.2 percent. This relatively large increase is primarily due to the proposed changes in the GAF values (that is, the proposed GAFs for most of these hospitals for FY 2006 are higher than the average of the GAFs for FY 2005).

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TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE
[FY 2005 Payments Compared To Proposed FY 2006 Payments]

	Number of hospitals	Average FY 2005 payments/ case	Average FY 2006 payments/ case	Change
By Geographic Location:				
All hospitals	3,693	727	739	1.7
Large urban areas (populations over 1 million)	1,399	810	825	1.8
Other urban areas (populations of 1 million of fewer)	1,138	720	733	1.8
Rural areas	1,156	501	507	1.2
Urban hospitals	2,537	769	783	1.8
0-99 beds	611	581	589	1.4
100-199 beds	877	650	660	1.6
200-299 beds	479	726	739	1.7
300-499 beds	408	810	823	1.6
500 or more beds	162	974	997	2.3
Rural hospitals	1,156	501	507	1.2
0-49 beds	473	415	419	1.0
50-99 beds	387	461	467	1.2
100-149 beds	188	510	516	1.4
150-199 beds	61	560	565	0.9
200 or more beds	47	627	635	1.4
By Region:				
Urban by Region	2,537	769	783	1.8
New England	129	834	843	1.1
Middle Atlantic	356	834	847	1.5
South Atlantic	386	736	748	1.5
East North Central	400	761	771	1.4
East South Central	165	696	709	1.9
West North Central	155	763	774	1.4
West South Central	344	723	738	2.1
Mountain	138	771	786	1.9
Pacific	412	874	903	3.3
Puerto Rico	52	339	342	1.0
Rural by Region	1,156	501	507	1.2
New England	29	635	647	1.9
Middle Atlantic	76	513	513	0.1
South Atlantic	183	492	498	1.2
East North Central	151	530	536	1.1
East South Central	194	461	469	1.7
West North Central	167	524	528	0.7
West South Central	217	453	458	1.0
Mountain	87	522	532	1.8
Pacific	52	592	608	2.8
By Payment Classification:				
All hospitals	3,693	727	739	1.7
Large urban areas (populations over 1 million)	1,410	809	824	1.8
Other urban areas (populations of 1 million of fewer)	1,165	718	730	1.8
Rural areas	1,118	502	508	1.2
Teaching Status:				
Non-teaching	2,615	607	616	1.6
Fewer than 100 Residents	841	746	758	1.6

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE
[FY 2005 Payments Compared To Proposed FY 2006 Payments]

	Number of hospitals	Average FY 2005 payments/ case	Average FY 2006 payments/ case	Change
100 or more Residents	237	1,072	1,095	2.1
Urban DSH:				
100 or more beds	1,484	797	812	1.9
Less than 100 beds	349	517	526	1.7
Rural DSH:				
Sole Community (SCH/EACH)	422	451	455	0.9
Referral Center (RRC/EACH)	179	563	571	1.5
Other Rural:				
100 or more beds	62	472	478	1.3
Less than 100 beds	216	417	421	0.9
Urban teaching and DSH:				
Both teaching and DSH	797	877	895	2.0
Teaching and no DSH	217	794	803	1.2
No teaching and DSH	1,036	644	656	1.8
No teaching and no DSH	525	666	677	1.6
Rural Hospital Types:				
Non special status hospitals	341	442	447	1.1
RRC/EACH	134	571	579	1.4
SCH/EACH	405	472	476	1.0
Medicare-dependent hospitals (MDH)	158	417	421	1.0
SCH, RRC and EACH	73	574	580	0.9
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
Reclassification Status During FY 2005 and FY 2006:				
Reclassified During Both FY 2005 and FY 2006	427	639	647	1.3
Reclassified During FY 2006 Only	232	711	733	3.2
Reclassified During FY 2005 Only	32	551	541	-1.9
FY2006 Reclassifications:				
All Reclassified Hospitals	659	664	678	2.0
All Nonreclassified Hospitals	2,937	743	756	1.7
All Urban Reclassified Hospitals	299	759	776	2.2
Urban Nonreclassified Hospitals	2,211	772	785	1.7
All Reclassified Rural Hospitals	360	550	560	1.7
Rural Nonreclassified Hospitals	726	446	450	0.7
Other Reclassified Hospitals (Section 1886(D)(8)(B))	73	511	507	-0.7
Type of Ownership:				
Voluntary	2,205	745	758	1.6
Proprietary	800	662	674	1.8
Government	688	699	713	2.0
Medicare Utilization as a Percent of Inpatient Days:				
0-25	289	928	950	2.4
25-50	1,441	817	834	2.0
50-65	1,551	645	654	1.4
Over 65	412	587	594	1.1

Appendix B: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

(If you choose to comment on issues in this section, please include the caption "Update Factors'' at the beginning of your comment.)

I. Background

Section 1886(e)(4)(A) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), recommend update factors for inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish update factors recommended by the Secretary in the proposed and final rule. Accordingly, this Appendix provides the recommendations of appropriate update factors for the IPPS standardized amount, the hospital-specific rates for SCHs and MDHs, and the rate-of-increase limits and Federal prospective payment amounts 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 Recommendations

Section 1886(b)(3)(B)(i)(XIX) of the Act sets the FY 2006 percentage increase in the operating cost standardized amount equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas subject to the hospital submitting quality information under rules established by the Secretary under section 1886(b)(3)(B)(vii) of the Act. For hospitals that do not provide these data, the update is equal to the market

basket percentage increase less 0.4 percentage points. Based on the Office of the Actuary's fourth quarter 2004 forecast of the FY 2006 market basket increase, we are proposing an update to the standardized amount of 3.2 percent (that is, the market basket rate-of-increase) for hospitals in all areas, provided the hospital submits quality data in accordance with our rules.

Section 1886(b)(3)(B)(iv) of the Act sets the FY 2006 percentage increase in the hospital-specific rates applicable to SCHs and MDHs equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act (that is, the same update factor as for all other hospitals subject to the IPPS, or the rate-of-increase in the market basket). Therefore, the proposed update to the hospital-specific rate applicable to SCHs and MDHs is also 3.2 percent.

Section 1886(b)(3)(B)(ii) of the Act sets the FY 2006 percentage increase in the rate-of-increase limits for various hospitals and hospital units excluded from the IPPS, that is, certain psychiatric hospitals and units (now referred to as inpatient psychiatric facilities (IPFs)), certain LTCHs, cancer hospitals, and children's hospitals, equal to the market basket percentage increase. In the past, hospitals and hospital units excluded from the IPPS have been paid based on their reasonable costs subject to TEFRA limits. However, some of these categories of excluded hospitals and units are currently, or soon will be, paid under their own prospective payment systems. Currently, children's and cancer hospitals and RNHCIs are the remaining three types of hospitals still reimbursed fully under reasonable costs. Those psychiatric hospitals and units of hospitals not yet paid under a PPS are still reimbursed fully on a reasonable cost basis subject to TEFRA limits. In addition, those LTCHs and IPFs paid under a blend methodology have the TEFRA portion of that payment subject to the TEFRA limits. Hospitals and units that receive any reasonable cost-based payments will have those payments determined subject to the TEFRA limits for FY 2006.

As we discuss in section IV. of the preamble and in section IV. of the Addendum to this proposed rule, we are proposing to use the estimated FY 2006 IPPS operating market basket percentage increase (3.2 percent) to update the target limits for children's hospitals, cancer hospitals, and religious nonmedical institutions.

As described in greater detail below, under their respective PPSs, LTCHs and IPFs are in a transition period during which some LTCHs and IPFs are paid a blend of reasonable cost-based payments (subject to the TEFRA limits) and a Federal prospective payment amount. Under the respective transition period methodologies for the LTCH PPS and IPF PPS, which are described below, payment is based, in part, on a decreasing percentage of the reasonable cost-based payment amount. As we discuss in section IV. of the preamble of this proposed rule, we are proposing to rebase the market basket used to determine the reasonable cost-based payment amount for LTCHs and IPFs. We are proposing that the portion of payments to LTCHs and IPFs that are reasonable cost-based will be determined using the FY 2002-based excluded hospital market basket (currently estimated at 3.4 percent).

Effective for cost reporting periods beginning FY 2003, LTCHs are paid under the LTCH PPS, which was implemented with a 5-year transition period. (Refer to the August 30, 2002 final rule (67 FR 55954).) A LTCH may elect to be paid on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition period. For purposes of the update factor for inpatient operating services for FY 2006, the portion of the LTCH PPS transition blend payment that is based on reasonable costs would be determined by updating the LTCH's TEFRA limit by the current estimate of the FY 2002-based excluded hospital market basket (or 3.4 percent).

Effective for cost reporting periods beginning on or after January 1, 2005, IPFs are paid under the IPF PPS under which they receive payment based on a Federal per diem rate that is based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF, adjusted for budget neutrality. During a transition period between January 1, 2005 and January 1, 2008, some IPFs are paid based on a blend of the reasonable cost-based payments, subject to the TEFRA limit, and the Federal per diem base rate. For cost reporting periods beginning on or after January 1, 2008, IPFs will be paid based on 100 percent of the Federal per diem rate. For purposes of the update factor for FY 2006, the portion of the IPF PPS transitional blend payment based on reasonable costs would be determined by updating the IPF's TEFRA limit by the current estimate of the FY 2002-based excluded hospital market basket (or 3.4 percent).

IRFs are paid under the IRF PPS for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2004, and thereafter, the Federal prospective payments to IRFs are based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually. (Refer to the July 30, 2004 final rule (69 FR 45721).)

III. Update Framework

Consistent with the current law, for FY 2006, for IPPS hospitals, we are recommending an update of 3.2 percent, which reflects the CMS Office of the Actuary's most recent (fourth quarter) 2004 forecast of the FY 2006 market basket increase. In previous years, in making a recommendation, we included an update framework that analyzed hospital productivity, scientific and technological advances, practice pattern changes, changes in case mix, the effects of reclassification on recalibration and forecast error correction. Although we have used this framework in past years, we are no longer including this analysis in our recommendation for the update. We are not discussing the framework because the productivity measure cannot be adequately computed for FY 2006 because of the anticipated effects on admissions due to the expected increases in enrollment in Medicare Advantage plans. The increased enrollment in Medicare Advantage plans has the effect of causing admissions to decline. However, we do not have information on how hospital employment will be affected for our methodology. Thus, in the absence of data to predict the effect of a decline in hospital admissions on hospital employment, we cannot appropriately reflect productivity in our framework. As a result, based on the discussion above, we believe it is appropriate to recommend an update of 3.2 percent, based on the Office of the Actuary's fourth quarter 2004 forecast of the FY 2006 market basket percentage increase.

We note that, although we are not using the framework for our recommendation to update the operating standardized amounts due to the reasons above, we continue to use the framework to calculate the capital standardized amounts as discussed in section III.A.1.a. of the Addendum to this proposed rule. This is due to the fact that the framework for the capital standardized amounts is calculated without a productivity factor and, therefore, the reasons discussed above do not apply to the update framework of the capital standardized amounts.

We also note that section 1886(e)(3) of the Act directs the Secretary to report to Congress an initial estimate of the recommendation of an appropriate payment inflation update for inpatient hospital services for the upcoming fiscal year. Earlier this year, the Secretary reported to Congress that the initial estimate of the recommendation of an update factor was 3.3 percent, which was the market basket update for the IPPS standardized amount in the President's FY 2006 budget. The difference between the Secretary's initial estimate and the update we are recommending in this proposed rule (3.2 percent) is due to the availability and use of more recent data for the market basket than were available at the time the Secretary's initial estimate was developed. In addition, the Secretary's initial estimate was based on the FY 1997-based hospital market basket, while the proposed update in this proposed rule (the current update recommendation) is based on the proposed FY 2002-based hospital market basket.

Aside from making a recommendation for IPPS hospitals, in accordance with section 1886(e)(4)(A) of the Act, it is necessary to make a recommendation of the update factor for all other types of hospitals. Consistent with current law, for FY 2006, for SCHs and MDHs, we are recommending an update of 3.2 percent, which reflects the CMS Office of the Actuary's most recent (fourth quarter) 2004 forecast of the FY 2006 market basket percentage increase.

Consistent with our proposal in section IV. of the preamble of this proposed rule, for FY 2006, for cancer hospitals, religious nonmedical health care institutions, and children's hospitals, we are recommending an update of 3.2 percent to the target limits. Consistent with our proposal in the February 3, 2005 LTCH PPS proposed rule (70 FR 5735), we are recommending an update factor of 3.1 percent for rate year (RY) 2006. For LTCHs that currently may be paid during a transition period a blend of reasonable cost-based payments (subject to the TEFRA limits) and Federal prospective payment amounts,

we are recommending an update factor of 3.4 percent for the portion of the payment that is based on reasonable costs, subject to the TEFRA limits, consistent with our proposal in section IV. of the preamble of this proposed rule. For the Federal portion of this same blended payment amount, we are recommending an update of 3.1 percent. Because the IPF PPS was effective for cost reporting periods beginning on or after January 1, 2005, and the base rates are effective until July 1, 2006, we are recommending an update of zero for IPFs (69 FR 66922). Finally, for the IRF PPS, we have not published a proposed rule proposing an update for FY 2006. As a result, we are recommending an update of 3.1 percent to IRF PPS for FY 2006, the same update used for FY 2005.

IV. MedPAC Recommendation for Assessing Payment Adequacy and Updating Payments in Traditional Medicare

In the past, MedPAC has suggested specific adjustments to its update recommendation for each of the factors discussed under section III. of this Appendix. In its March 2005 Report to Congress, MedPAC assessed the adequacy of current payments and costs and the relationship between payments and an appropriate cost base, utilizing an established methodology used by the Commission in the past several years. MedPAC stressed that the issue at hand was whether payments were too high or too low, and not how they became either too high or too low.

In the first portion of MedPAC's analysis on the assessment of payment adequacy, the Commission reviewed the relationship between costs and payments. MedPAC's indicator of the relationship between payments and costs is the overall Medicare margin. The overall Medicare margin is calculated as the difference between payments and costs divided by payments. Based on the latest cost report data available, MedPAC estimated an inpatient hospital Medicare operating margin for FY 2003 of 1.3 percent (down from 5.9 percent and 9.8 percent for FY 2002 and FY 2001, respectively).

MedPAC also projected margins for FY 2005, making certain assumptions about changes in payments and costs. On the payment side, MedPAC applied the annual payment updates (as specified by law for FYs 2001 through 2005), and then modeled the effects of other policy changes that have affected the level of payments. On the cost side, MedPAC estimated the increases in cost per unit of output over the same time period at the rate of inflation as measured by the applicable market basket index generated by CMS.

In addition to considering the relationship between estimated payments and costs, MedPAC also considered the following three factors to assess whether current payments are adequate:

- Changes in access to or quality of care;
- Changes in the volume of services or number of providers; and
- Change in providers' access to capital.

MedPAC's recommendation was to increase payments under the IPPS by the projected increase in the hospital market basket index, less 0.4 percent, for FY 2006. MedPAC noted that the indicators of payment adequacy present a mixed picture. MedPAC was concerned about the trend of falling hospital margins, which may result in hospitals having a limited financial cushion for dealing with pressures that may arise in the coming year. On the other hand, MedPAC stated that the current cost trend was unsustainable and may have been driven by a lack of cost containment. Therefore, MedPAC concluded that an update of the hospital market basket index minus 0.4 percent is appropriate.

Response: As described above, we are recommending a full market basket update for FY 2006 consistent with current law. We believe this will appropriately balance incentives for hospitals to operate efficiently with the need to provide sufficient payments to maintain access to quality care for Medicare beneficiaries.

In addition, because the operating and capital prospective payment systems remain separate, we are proposing to continue to use separate updates for operating and capital payments. The proposed update to the capital payment rate is discussed in section III. of the Addendum to this proposed rule.

[FR Doc. 05–8507 Filed 4–25–05; 4:12 pm]

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