AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

Federal Register

Friday,
August 12, 2005

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 412, 413, 415, et al.

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Final 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–F]

RIN 0938–AN57

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

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

ACTION: Final rule.

SUMMARY: We are revising the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs to implement changes arising from our continuing experience with these systems. In addition, in the Addendum to this final rule, we describe the 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 rate-of-increase limits as well as 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 changes are applicable to discharges occurring on or after October 1, 2005, with one exception: The changes relating to submittal of hospital wage data by a campus or campuses of a multicampus hospital system (that is, the changes to § 412.230(d)(2) of the regulations) are effective on August 12, 2005.

Among the policy changes that we are making 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: *Effective Dates:* The provisions of this final rule, except the provisions of § 412.230(d)(2), are effective on October 1, 2005. The provisions of § 412.230(d)(2) are effective on August 12, 2005. This rule is a major rule as defined in 5 U.S.C. 804(2). Pursuant to 5 U.S.C. 801(a)(1)(A), we are submitting a report to Congress on this rule on August 1, 2005.

FOR FURTHER INFORMATION CONTACT:

Marc Hartstein, (410) 786–4548, 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.

Debbra Hattery, (410) 786–1855, Quality Data for Annual Payment Update Issues.

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

SUPPLEMENTARY INFORMATION:

Electronic Access

This **Federal Register** document is also available from the **Federal Register** online database through *GPO Access*, a service of the U.S. Government Printing Office. Free public access is available on a Wide Area Information Server (WAIS) through the Internet and via asynchronous dial-in. Internet users can access the database by using the World Wide Web; the Superintendent of Documents home page address is *http://www.access.gpo.gov/nara_docs/*, by using local WAIS client software, or by telnet to *swais.access.gpo.gov*, then login as guest (no password required). Dial-in users should use communications software and modem to call (202) 512–1661; type swais, then login as guest (no password required).

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 implantable 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
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)
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

Table of Contents

I. Background
A. Summary
1. Acute Care Hospital Inpatient Prospective Payment System (IPPS)
2. Hospitals and Hospital Units Excluded from the IPPS
a. IRFs
b. LTCH
c. IPFs
3. Critical Access Hospitals (CAHs)
4. Payments for Graduate Medical Education (GME)
B. Summary of Provisions of the FY 2006 IPPS Proposed Rule
1. Changes to the DRG Reclassifications and Recalibrations of Relative Weights
2. Changes to the Hospital Wage Index
3. Revision and Rebasing of the Hospital Market Basket
4. Other Decisions and Changes to the PPS for Inpatient Operating and GME Costs
5. PPS for Capital-Related Costs
6. Changes for Hospitals and Hospital Units Excluded From the IPPS
7. Payment for Blood Clotting Factors for Inpatients With Hemophilia
8. Determining Prospective Payment Operating and Capital Rates and Rate-of-Increase Limits
9. Impact Analysis
10. Recommendation of Update Factor for Hospital Inpatient Operating Costs
11. Discussion of Medicare Payment Advisory Commission Recommendations
C. Public Comments Received in Response to the FY 2006 IPPS Proposed Rule
II. Changes to DRG Classifications and Relative Weights
A. Background
B. DRG Reclassifications
1. General
2. Yearly Review for Making DRG Changes; Request for Public Comment
3. Pre-MDC: Intestinal Transplantation
4. MDC 1 (Diseases and Disorders of the Nervous System)
a. Strokes
b. Unruptured Cerebral Aneurysms
5. MDC 5 (Diseases and Disorders of the Circulatory System)
a. Severity Adjusted Cardiovascular Procedures
b. Automatic Implantable Cardioverter/Defibrillator
c. Coronary Artery Stents
d. Insertion of Left Atrial Appendage Device
e. External Heart Assist System Implant
f. Carotid Artery Stent
g. Extracorporeal Membrane Oxygenation (ECMO)
6. MDC 6 (Diseases and Disorders of the Digestive System): Artificial Anal Sphincter
7. MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue)
a. Hip and Knee Replacements
b. Kyphoplasty
c. Multiple Level Spinal Fusion
d. Charite(tm) Spinal Disc Replacement Device
8. MDC 18 (Infectious and Parasitic Diseases (Systemic or Unspecified Sites)): Severe Sepsis
9. MDC 20 (Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders): Drug-Induced Dementia
10. Medicare Code Editor (MCE) Changes
a. Newborn Age Edit
b. Newborn Diagnoses Edit
c. Diagnoses Allowed for ''Males Only'' Edit
d. Tobacco Use Disorder Edit
e. Noncovered Procedure Edit
11. Surgical Hierarchies
12. Refinement of Complications and Comorbidities (CC) List
a. Background
b. Comprehensive Review of the CC List
c. CC Exclusion List for FY 2006
13. Review of Procedure Codes in DRGs 468, 476, and 477
a. Moving Procedure Codes from DRG 468 or DRG 477 to MDCs
b. Reassignment of Procedures among DRGs 468, 476, and 477
c. Adding Diagnosis or Procedure Codes to MDCs
14. Changes to the ICD–9–CM Coding System
15. Other Issues
a. Acute Intermittent Porphyria
b. Prosthetic Cardiac Support Device (Code 37.41)
c. Coronary Intravascular Ultrasound (IVUS) (Procedure Code 00.24)
d. Islet Cell Transplantation
C. Recalibration of DRG Weights
D. LTC–DRG Reclassifications and Relative Weights for LTCHs for FY 2006
1. Background
2. Changes in the LTC–DRG Classifications
a. Background
b. Patient Classifications into DRGs
3. Development of the Proposed FY 2006 LTC–DRG Relative Weights
a. General Overview of Development of the LTC–DRG Relative Weights
b. Data
c. Hospital-Specific Relative Value Methodology
d. Low-Volume LTC–DRGs
4. Steps for Determining the FY 2006 LTC–DRG Relative Weights
5. Other Public Comments Relating to the LTCH PPS Payment Policies
E. Add-On Payments for New Services and Technologies
1. Background
2. FY 2006 Status of Technology Approved for FY 2005 Add-On Payments
3. Reevaluation of FY 2005 Applications That Were Not Approved
4. FY 2006 Applicants for New Technology Add-On Payments
III. Changes to the Hospital Wage Index
A. Background
B. Core-Based Statistical Areas for the Hospital Wage Index
C. Occupational Mix Adjustment to FY 2006 Index
1. Development of Data for the Occupational Mix Adjustment
2. Calculation of the Occupational Mix Adjustment Factor and the Occupational Mix Adjusted Wage Index
D. Worksheet S–3 Wage Data for the FY 2006 Wage Index Update
E. Verification of Worksheet S–3 Wage Data
F. Computation of the FY 2006 Unadjusted Wage Index
G. Computation of the FY 2006 Blended Wage Index
H. Revisions to the Wage Index Based on Hospital Redesignation

1. General
2. Effects of Reclassification
3. Application of Hold Harmless Protection for Certain Urban Hospitals Redesignated as Rural
4. FY 2006 MGCRB Reclassifications
5. FY 2006 Redesignations under Section 1886(d)(8)(B) of the Act
6. Reclassifications under Section 508 of Pub. L. 108–173
I. FY 2006 Wage Index Adjustment Based on Commuting Patterns of Hospital Employees
J. Requests for Wage Index Data Corrections
IV. Rebasing and Revision of the Hospital Market Baskets
A. Background
B. Rebasing and Revising the Hospital Market Basket
1. Development of Cost Categories and Weights
2. PPS—Selection of Price Proxies
3. Labor-Related Share
C. Separate Market Basket for Hospitals and Hospital Units Excluded from the IPPS
1. Hospitals Paid Based on Their Reasonable Costs
2. Excluded Hospitals Paid Under Blend Methodology
3. Development of Cost Categories and Weights for the 2002-Based Excluded Hospital Market Basket
D. Frequency of Updates of Weights in IPPS Hospital Market Basket
E. Capital Input Price Index Section
V. Other Decisions and Changes to the IPPS for Operating Costs and GME Costs
A. Postacute Care Transfer Payment Policy
1. Background
2. Changes to DRGs Subject to the Postacute Care Transfer Policy
B. Reporting of Hospital Quality Data for Annual Hospital Payment Update
1. Background
2. Requirements for Hospital Reporting of Quality Data
C. Sole Community Hospitals and Medicare Dependent Hospitals
1. Background
2. Budget Neutrality Adjustment to Hospital Payments Based on Hospital-Specific Rate
3. Technical Change
D. Rural Referral Centers
1. Case-Mix Index
2. Discharges
3. Technical Change
E. Payment Adjustment for Low-Volume Hospitals
F. Indirect Medical Education (IME) Adjustment
1. Background
2. IME Adjustment for IPPS-Excluded Hospitals Converting to IPPS Hospitals
3. Section 1886(d)(3)(E) Teaching Hospitals That Withdraw Rural Reclassification
G. Payment to Disproportionate Share Hospitals (DSHs)
1. Background
2. Implementation of Section 951 of Pub. L. 108–173
3. Calculation of the Medicare Fraction
4. Calculation of the Medicaid Fraction
H. Geographic Reclassifications
1. Background
2. Multicampus Hospitals
3. Urban Group Hospital Reclassifications
4. Clarification of Goldsmith Modification Criterion for Urban Hospitals Seeking Reclassification as Rural
I. Payment for Direct Graduate Medical Education
1. Background
2. Direct GME Initial Residency Period
a. Background
b. Direct GME Initial Residency Period Limitation: Simultaneous Match
3. New Teaching Hospitals' Participation in Medicare GME Affiliated Groups
4. GME FTE Cap Adjustments for Rural Hospitals
5. Technical Changes: Cross-References
J. Provider-Based Status of Facilities under Medicare
1. Background
2. Limits on Scope of Provider-Based Regulations—Facilities for Which Provider-Based Determinations Will Not Be Made
3. Location Requirement for Off-Campus Facilities: Application to Certain Neonatal Intensive Care Units
4. Technical and Clarifying Changes
K. Rural Community Hospital Demonstration Program
L. Definition of a Hospital in Connection with Specialty Hospitals
VI. PPS for Capital-Related Costs
VII. Changes for Hospitals and Hospital Units Excluded From the IPPS
A. Payments to Excluded Hospitals and Hospital Units
1. Payments to Existing Excluded Hospitals and Hospital Units
2. Updated Caps for New Excluded Hospitals and Units
3. Implementation of a PPS for IRFs
4. Implementation of a PPS for LTCHs
5. Implementation of a PPS for IPFs
6. Report of Adjustment (Exception) Payments
B. Critical Access Hospitals (CAHs)
1. Background
2. Policy Change Relating to Continued Participation by CAHs in Lugar Counties
3. Policy Change Relating to Designation of CAHs as Necessary Providers
a. Determination of the Relocation Status of a CAH
b. Relocation of a CAH Using a Waiver To Meet the CoP for Distance
VIII. Payment for Blood Clotting Factor Administered to Hemophilia Inpatients
IX. MedPAC Recommendations
A. Medicare Payment Policy
1. Update Factor
2. Quality Incentive Payment Policy
3. Refinement of DRGs Based on Severity of Illness
4. APR–DRGs
5. DRG Relative Weights
6. High-Cost Outliers
B. Other MedPAC Recommendations
X. Other Required Information
A. Requests for Data From the Public
B. Collection of Information Requirements

Regulation Text

Addendum—Schedule of Standardized Amounts 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
I. Summary and Background
II. Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for FY 2006
A. Calculation of the Adjusted Standardized Amount
1. Standardization of Base-Year Costs or Target Amounts
2. Computing the Average Standardized Amount
3. Updating the Average Standardized Amount
4. Other Adjustments to the Average Standardized Amount
a. Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment
b. Reclassified Hospitals—Budget Neutrality Adjustment
c. Outliers
d. Rural Community Hospital Demonstration Program Adjustment (Section 410A of Pub. L. 108–173)
5. FY 2006 Standardized Amount
B. Adjustments for Area Wage Levels and Cost-of-Living
1. Adjustment for Area Wage Levels
2. Adjustment for Cost-of-Living in Alaska and Hawaii
C. DRG Relative Weights
D. Calculation of Prospective Payment Rates for FY 2006
1. Federal Rate
2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)
a. Calculation of Hospital-Specific Rate
b. Updating the FY 1982, FY 1987, and FY 1996 Hospital-Specific Rates for FY 2006
3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2005 and Before October 1, 2006
a. Puerto Rico Rate
b. National Rate
III. Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2006
A. Determination of Federal Hospital Inpatient Capital-Related Prospective Payment Rate Update
1. Capital Standard Federal Rate Update
a. Description of the Update Framework
b. Comparison of CMS and MedPAC Update Recommendation
2. Outlier Payment Adjustment Factor
3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the Geographic Adjustment Factor
4. Exceptions Payment Adjustment Factor
5. Capital Standard Federal Rate for FY 2006
6. Special Capital Rate for Puerto Rico Hospitals
B. Calculation of Inpatient Capital-Related Prospective Payments for FY 2006
C. Capital Input Price Index
1. Background

2. Forecast of the CIPI for FY 2006
IV. Changes to Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages
A. Payments to Existing Excluded Hospitals and Units
B. Updated Caps for New Excluded Hospitals and Units
V. Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

Tables

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 Wage Indexes for Federal Fiscal Year 2006; 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 and 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 Wage Adjustment—FY 2006
Table 5—List of Diagnosis-Related Groups (DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay (LOS)
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 March 2005 GROUPER V22.0]
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay: [FY 2004 MedPAR Update March 2005 GROUPER V23.0]
Table 8A—Statewide Average Operating Cost-to-Charge Ratios-July 2005
Table 8B—Statewide Average Capital Cost-to-Charge Ratios-July 2005
Table 9A—Hospital Reclassifications and Redesignations by Individual Hospital and CBSA—FY 2006
Table 9B—Hospital Reclassifications and Redesignation by Individual Hospital Under Section 508 of Pub. L. 108–173—FY 2006
Table 9C—Hospitals Redesignated as Rural under Section 1886(d)(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)—July 2005
Table 11—FY 2006 LTC-DRGs, Relative Weights, Geometric Average Length of Stay, and 5/6ths of the Geometric Average Length of Stay
Appendix A—Regulatory Impact Analysis
Appendix B—Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

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 patient. 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 on or after 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; 68 FR 45674, August 1, 2003, and 69 FR 45721, July 30, 2004). 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 (LTCH PPS final rule (70 FR 24168)). LTCHs not meeting the definition in § 412.23(e)(4) of the regulations 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. LTCHs meeting the definition in § 412.23(e)(4) will be paid based on 100 percent of the standard Federal rate. 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 January 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 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.

B. Summary of the Provisions of the FY 2006 IPPS Proposed Rule

In the FY 2006 IPPS proposed rule (70 FR 23306), we set forth proposed changes to the Medicare IPPS for operating costs and for capital-related costs in FY 2006. We also set 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 were proposed to 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 proposed and the issues we addressed in the FY 2006 IPPS proposed rule.

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

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

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

We proposed 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. Changes to the Hospital Wage Index

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

• The FY 2006 wage index update, using wage data from cost reporting periods that began during FY 2002.
• The occupational mix adjustment to the wage index that we began to apply effective October 1, 2004.
• The revisions to the wage index based on hospital redesignations and reclassifications.
• The 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 were in effect for the FY 2006 wage index.

3. Revision and Rebasing of the Hospital Market Baskets

We proposed 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 also set forth the data sources used to determine the proposed revised market basket relative weights and choice of price proxies.

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

In the proposed rule, we discussed 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.
• Changes in the application of the budget neutrality adjustment to MDHs and SCHs for computing the hospital-specific rate.
• Updated national and regional case-mix values and discharges for purposes of determining rural referral center status.
• The payment adjustment for low-volume hospitals.
• The 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.
• Changes to implement section 951 of Pub. L. 108–173 relating to the provision of patient stay days/SSI data maintained by CMS to hospitals for the purpose of determining their DSH percentage.
• Changes relating to hospitals' geographic classifications, including multicampus hospitals and urban group hospital reclassifications.
• 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 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 the proposed rule, we did not propose any policy changes to the capital-related prospective payment system. For the readers' benefit, we discussed the payment policy requirements for capital-related costs and capital payments to hospitals.

6. Changes for Hospitals and Hospital Units Excluded from the IPPS

In the proposed rule, we discussed 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. Changes in Payment for Blood Clotting Factor

In the proposed rule, we discussed 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 the 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 established the proposed threshold amounts for outlier cases. In addition, we addressed 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 the proposed rule, we set forth an analysis of the impact that the proposed changes would have on affected hospitals.

10. Recommendation of Update Factor for Hospital Inpatient Operating Costs

In Appendix B of the proposed rule, as required by sections 1886(e)(4) and (e)(5) of the Act, we provided our recommendations of the appropriate percentage changes for FY 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 the 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 were addressed in section IX. of the preamble of the proposed rule. 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.*

C. Public Comments Received in Response to the FY 2006 IPPS Proposed Rule

We received over 2,000 timely items of correspondence containing multiple comments on the FY 2006 IPPS proposed rule. Summaries of the public comments and our responses to those comments are set forth below under the appropriate heading.

II. Changes to DRG Classifications and Relative Weights

A. Background

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

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

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 520 DRGs in 25 MDCs. (We note that, in the FY 2006 proposed rule (70 FR 23313), we inadvertently stated that there were 519 DRGs.) 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.

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.

In the FY 2006 IPPS proposed rule (70 FR 23312), we proposed numerous changes to the DRG classification system for FY 2006 and to the methodology used to recalibrate the DRG weights. The changes we proposed to the DRG classification system, the public comments we received concerning the proposed changes, the final DRG changes, and the methodology used to recalibrate the DRG weights are set forth below. The changes we are implementing in this final rule will be reflected in the FY 2006 GROUPER, version 23.0, and are effective for discharges occurring on or after October 1, 2005. Unless otherwise noted in this final rule, our DRG analysis is based on data from the September 2004 update of the FY 2004 MedPAR file, which contains hospital bills received through September 30, 2004 for discharges in FY 2004.

2. Yearly Review for Making DRG Changes; Request for Public Comment

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 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 lengths 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.

To date, we have not used specific statistical standards as part of our guidelines for determining when DRG changes are warranted. However, we could potentially establish objective guidelines that are used in the DRG development process. For instance, such standards could include a minimum percentage or absolute difference in average charges or length of stay and number of cases in order for us to create a DRG or change the DRG assignment of a particular code or service. As part of our review and analysis of MedPAC's recommendations, we will consider whether to establish such guidelines for making DRG reclassification decisions. We welcome public comments on this issue.

3. 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 did not propose any DRG modification for intestinal transplantation cases for FY 2006.

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.

Comment: Several commenters, including an institute that performs intestinal transplantation, supported our decision to reassign intestinal transplantation cases to DRG 480. One commenter commended CMS for its progress, but urged us to continue to evaluate a separate DRG for intestinal transplantation. While payment has improved, the commenter stated that it is still inadequate, and insufficient reimbursement could ultimately hinder beneficiary access to care.

Response: As indicated in the FY 2006 IPPS proposed rule (70 FR 23315), we found only three cases in the Medicare data that included an intestinal transplant. We found that the average charges were less for intestinal transplant cases ($138,922) than liver transplant cases ($165,314). Thus, even though we have a very low number of cases to make these comparisons, the data do not suggest that intestinal transplants are underpaid in DRG 480. We remain committed to assigning procedures to the most appropriate DRG based on clinical coherence and utilization of resources using the most recently available data. As we stated in the FY 2005 IPPS final rule (69 FR 48977), when we receive sufficient additional Medicare data on intestinal transplantation cases, we will again consider the DRG assignment for intestinal transplants.

Comment: One commenter concurred with the decision to assign intestinal transplant cases to DRG 480 but recommended that CMS create separate DRGs for liver-intestinal and liver-kidney transplants. The commenter requested that CMS report average charges for these cases in the final rule. The commenter noted that DRGs have been created for double organ transplants such as DRG 512 (Simultaneous Pancreas/Kidney Transplant).

Response: While the focus of our review in the proposed rule was limited to whether we should reassign intestinal transplants to DRG 480, we reviewed all cases in this DRG. Based on our review of the FY 2004 MedPAR data, the following table illustrates our findings:

DRG	Number of cases	Average length of stay	Average charges
DRG 480	959	16.65	$165,622
Liver Transplantation	876	16.5	165,314
Intestinal Transplantation	3	26.0	138,922
Liver-Intestinal Transplantation	1	72.0	539,841
Liver-Kidney Transplantation	79	21.3	237,759

As we stated in the proposed rule (70 FR 23315), while the average charges and length of stay were much higher for the one liver-intestinal transplantation case, for which we had data, than the other cases in DRG 480, the case would likely be paid as an outlier. One case is insufficient to create a new DRG. Similarly, we are reluctant to create a

new DRG for such a small number of liver-kidney transplant cases, even though average charges and length of stay are higher for liver-kidney transplants than other cases in DRG 480. As discussed, in section IX.A. of this final rule, we plan in the next year to undertake a comprehensive review of the existing Medicare DRG system and expect to make changes to the DRGs to better reflect the severity of illness. As we study this issue, we will further analyze hospital costs for patients needing multiple organ transplants. At this time, we are not making any further modifications to the DRGs for multiple transplants in FY 2006.

4. 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. 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, CMS has been monitoring the DRGs and cases in which this code can be found, particularly with respect to cardiac and stroke DRGs.

Last year, CMS 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 would help to identify patients who have strokes that are more severely and costly and would recognize the higher charges that these cases generate because of their higher hospital resource utilization. At that time, the presenters provided evidence that strokes where tPA was used were both more severe and more resource intensive. Specifically, they showed that patients who were given tPA for strokes had higher stroke severity scores at presentation, and that they were more expensive to care for because of increased intensive care unit monitoring requirements, increased diagnostic imaging costs, and increased laboratory and pharmacy costs. They also demonstrated that these patients had markedly better clinical outcomes. The stroke representatives made two suggestions concerning the stroke DRGs.

The first proposal suggested 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, 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 include only cases where patients with strokes caused by arterial occlusion (or clot(s)) are also treated with tPA thrombolytic therapy.

We have examined the MedPAR data for the cases in DRGs 14 and 15. We 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. In the FY 2006 IPPS proposed rule, we did not propose a change to the stroke DRGs because of the small number of reperfusion cases reported. However, we stated that 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.

In the FY 2006 IPPS proposed rule, we invited public comment on the changes to DRGs 14 and 15 suggested by the hospital representatives. In addition, we solicited 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.

Comment: Forty commenters supported the creation of a new DRG to recognize the group of patients who presented with stroke and who also received thrombolytic therapy. The commenters cited the following reasons for supporting this proposal: Increased costs of caring for these patients, specifically in intensive care unit, more

diagnostic imaging studies, and laboratory and pharmacy resources. In addition, the commenters noted that the proposal is also supported by evidence that patients receiving thrombolytic therapy have strokes of increased severity. The commenters also stated that the proposal demonstrates the need for hospitals to have an incentive to establish the infrastructure necessary to provide stroke patients with aggressive evaluation and management services, such as thrombolytic therapy, which have become the standard of care.

Response: We appreciate the commenters' responses in reply to our solicitation for public comment on the changes to DRGs 14 and 15 as suggested in the proposed rule. The level of detail provide in the responses helped us to formulate a change to the medical stroke DRGs. We agree with the commenters that there is an increased cost in caring for these patients including increased use of the intensive care unit, more diagnostic imaging studies, and laboratory and pharmacy resources. We also agree that—(1) the data indicate that patients receiving thrombolytic therapy have increased severity; and (2) reperfusion therapy is a good means to segregate these patients into a separate DRG.

Comment: One commenter encouraged CMS to modify DRGs 14 and 15 using one of two options. The first option would be to create DRG ''A'' where hemorrhagic and ischemic strokes were combined, but only supportive care was given, while DRG ''B'' would contain those hemorrhagic and ischemic stroke cases in which reperfusion or hemostatic agents were administered.

Alternatively, the commenter suggested that DRGs 14 and 15 could be modified by creating four new DRGs. DRG ''A'' would contain cases of hemorrhagic stroke and supportive care, DRG ''B'' would contain cases of hemorrhagic stroke treated with hemostatic agents, DRG ''C'' would contain cases of ischemic stroke and supportive care, and DRG ''D'' would contain cases of ischemic stroke treated with reperfusion agents.

Response: This commenter is suggesting that the DRG system recognize treatment of hemorrhage strokes with hemostatic agents as well as ischemic strokes with reperfusion agents. While we anticipate great industry strides in the treatment of stroke, currently no approved hemostatic agent is on the market. According to the manufacturer(s) of hemostatic agents, it is unlikely that these agents will be available for use during FY 2006. Therefore, we do not have any Medicare charge information that supports creating separate DRGs for hemorrhagic stroke patients treated with hemostatic agents as we do for ischemic stroke patients treated with thrombolytic therapy. When hemostatic agents are available on the market, we will reevaluate this issue.

Comment: One commenter believed that the two potential changes to the stroke DRGs as set forth in the proposed rule are too limited as written. The commenter believed that the descriptor, ''reperfusion agent'', is not broad enough to encompass other promising pharmacotherapies for stroke that are in late stages of clinical development. The commenter pointed out that these therapies include treatment for both ischemic stroke and hemorrhagic stroke. The commenter further noted that it is unlikely that any of the potential therapies will be approved for use during FY 2006. The commenter recommended that CMS broaden the title for the proposed new DRG to include a wider range of any newly approved therapies.

Response: While we look forward to improved therapies for treating patients with strokes, we are unable to create DRGs that recognize as yet unapproved treatment modalities. When the FDA has approved additional pharmaceuticals for the treatment of either ischemic or hemorrhagic stroke, we will evaluate the data and make DRG changes as appropriate. We point out that the DRG titles cannot possibly acknowledge all the codes located therein. The important part of the DRG is the structure of the logic; that is, what codes are assigned to the DRG.

Comment: One commenter recommended that CMS commit to creating a surgical DRG for ischemic stroke patients who are treated with surgical interventions. The commenter included several scenarios of possible diagnosis and procedure coding combinations that CMS could use to identify stroke cases and increase the scope of our analysis.

Response: Our goal was not to review all stroke cases within the MedPAR database, but to identify those cases in medical DRG 14, and possibly DRG 15, that might have included the administration of tPA as identified by procedure code 99.10. DRGs that identify a precise surgical procedure already exist; all of the combinations of procedure codes suggested by the commenter already appropriately group to DRGs within MDC 1.

Comment: One commenter stated that because code 99.10 was not reimbursable [did not have an impact on DRG assignment], hospital coders often did not use it. Some hospitals in which reperfusion therapy was commonplace never used this code.

Response: We would like to take this opportunity to reiterate that all cases should be accurately and completely coded, irrespective of the DRG implications of a specific code or codes. By coding accurately and completely, we will have more information on patient care costs for different services and treatments that better enable us to research further changes to the DRG system.

Comment: One commenter noted that, because only a single type of reperfusion agent is presently approved for stroke treatment, the proposed change would create a DRG that is, *de facto,* product specific. In addition, the commenter stated that the DRG change on which CMS requested comment would improve access to therapy for only a small fraction of all stroke patients. The commenter added that implementation of a narrowly-defined change [by creating a specific stroke-plus-tPA DRG] may necessitate further changes to the stroke DRGs in the near future to ensure patient access to emerging drug therapies once approved.

Response: While we did not propose a specific change to the stroke DRGs in the proposed notice, we have decided to modify the DRGs to distinguish those cases in which tPA is used as a treatment modality based on the strong support for this change voiced by commenters. When we reviewed the data represented in the above table, we noted that the average standardized charges for all cases in DRG 14 were $18,997, but that the subset of 2,085 cases in which tPA was used had average standardized charges of $35,128. We noted that the cases in DRG 14 without hemorrhage that did not report the use of tPA had average standardized charges of $18,763, which was comparable with the figures for all cases in the DRG. Given that these cases are easily identifiable through the use of procedure code 99.10, and that the average standardized charges are $16,131 higher for the cases using tPA, we decided to carve these cases out of the existing DRGs 14 and 15, and represent them in a new DRG. We are changing the structure of stroke DRGs not to award higher payment for a specific drug but to recognize the need for better overall care for this group of patients. Even though a tPA is indicated only for a small proportion of stroke patients (only those experiencing ischemic strokes treated within 3 hours of the onset of symptoms), our data suggest that there are enough patients to support the DRG change. While our goal

is to make payment relate more closely to resource use, we also note that use of a tPA in a carefully selected patient population will lead to better outcomes and overall care and may lessen the need for postacute care. With regard to the potential need to modify stroke DRGs in the future, we note that we perform an update to the DRGs and modify DRGs every year. We reiterate that should additional types of therapy be approved, we will evaluate them, and after judicious study, will make appropriate DRG title and/or logic changes as required.

In this final rule, after consideration of public comments received and based on our analysis of MedPAR data that supports the creation of a DRG that identifies embolic stroke combined with tPA treatment, we are creating new DRG 559 (Acute Ischemic Stroke with Use of Thrombolytic Agent). From a data consistency standpoint, we believe that adding a new DRG identifying these cases will be less disruptive to our stakeholders than creating three new DRGs, two of which would mimic existing DRGs 14 and 15. The GROUPER logic for DRGs 14 and 15 will not be affected by this change; that is, the GROUPER content of DRGs 14 and 15 will be the same in FY 2006 as it was in FY 2005. The structure of the new DRG 559 includes the following codes:

Principal Diagnosis

- 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 arteries, with cerebral infarction
- 433.81, Occlusion and stenosis of other specified precerebral artery, with cerebral infarction
- 433.91, Occlusion and stenosis of unspecified precerebral artery, with cerebral infarction
- 434.01, Cerebral thrombosis, with cerebral infarction
- 434.11, Cerebral embolism, with cerebral infarction
- 434.91, Cerebral artery occlusion, unspecified, with cerebral infarction

and

Nonoperating Room Procedure

- 99.10, Injection or infusion of thrombolytic agent

We will continue to monitor stroke DRGs in the future. As noted above, should treatment modalities change, we will be open to making changes to the DRG structure that will recognize improvements in treatment and technology.

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 data for unruptured cerebral aneurysms cases in DRGs 1 and 2. In our analysis of these 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 did not propose a change in the structure of these DRGs relating to unruptured cerebral aneurysm cases for FY 2006.

Comment: Several commenters agreed that the minimal differences in charges for unruptured cerebral aneurysms cases compared to all cases assigned to DRGs 1 and 2 do not justify a change in the DRG assignment for these cases. One commenter stated that unruptured cerebral aneurysm cases should be reclassified into a new DRG. The commenter stated that a new DRG is warranted to understand the true weight of these procedures and to establish reimbursement that recognizes the cost of medical devices used to treat unruptured cerebral aneurysms.

Response: Our analysis is based on the most recent charge information available reflecting the overall resources used to treat unruptured cerebral aneurysms in Medicare patients. We concur with the commenters that there are minimal differences in the charges for the unruptured cerebral aneurysm cases compared to all cases assigned to DRGs 1 and 2 and that the results of the data do not justify creation of a new DRG. We believe that unruptured cerebral aneurysms are appropriately assigned to DRGs 1 and 2. Therefore, we are not making any modifications to the DRG assignment for unruptured cerebral aneurysms.

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

a. Severity Adjusted Cardiovascular Procedures

In response to the FY 2006 IPPS proposed rule, one commenter noted that section 507(c) of Pub. L. 108–173 required MedPAC to conduct a study to determine how the DRG system should be updated to better reflect the cost of delivering care in a hospital setting. The commenter noted that MedPAC reported that the ''cardiac surgery DRGs had high relative profitability ratios.'' While the commenter noted that it may take time to conduct and complete a thorough evaluation of the MedPAC payment recommendations for all DRGs, the commenter strongly encouraged CMS to revise the cardiac DRGs through patient severity refinements as part of the final rule to be effective for FY 2006. In section IX.A. of the preamble to this final rule, we are responding in detail to this comment by making significant revisions to a number of cardiovascular DRGs that currently contain patients with a wide range of severity and resource consumption in order to reflect more accurately the resources required to care for different kinds of cardiovascular patients. Accordingly, in response to the issues raised by the commenter and as an interim step until we can complete a comprehensive review of MedPAC's recommendations, we are deleting current DRGs 107, 109, 111, 116, 478, 516, 517, 526, and 527, and creating new DRGs 547 through 558 in their place.

We received several comments on the FY 2006 IPPS proposed rule that recommended that we split additional cardiovascular DRGs based on the presence or absence of heart failure, acute myocardial infarction, and shock. As indicated in section IX.A. of this final rule, we conducted a focused review of a number of different cardiovascular DRGs and are making revisions to them based on a newly designated list of ''major cardiovascular conditions.''

We believe these new DRGs will help to address a number of the concerns raised by these commenters. We intend to monitor these DRGs carefully in upcoming years and welcome input regarding the success of these DRGs in

reflecting patient severity and resource use.

b. 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 to 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 that would 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 the acknowledged coding problems in the use of code 37.26, we believe it is inappropriate to base a defibrillator DRG assignment on the EPS code. Cases identified with this code capture patients who require less resource use than patients who have a cardiac catheterization.

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 proposed 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.

Comment: One commenter stated that there has been considerable confusion surrounding the use of code 37.26. The commenter indicated that coders are unclear whether code 37.26 should be reported when an electrophysiologic study (EPS) is performed as part of a defibrillator implantation or only when defibrillator device checks are performed. The commenter pointed out that the continuing efforts of the Editorial Advisory Board for Coding Clinic to clarify the use of this code have led to changes in coding advice published in *Coding Clinic for ICD–9–CM* by the American Hospital Association. However, the commenter stated, while the change in coding advice was intended to clarify use of code 37.26, coders continue to have questions about it. The commenter supported our proposal to remove code 37.26 from the list of cardiac catheterizations for DRGs 535 and 536 and agreed with CMS' plans to continue working to clarify use of this code or modify the code through the ICD–9–CM Coordination and Maintenance Committee. The commenter suggested that, once the coding issues are resolved and consistent data are collected, CMS should reexamine the DRG assignment(s) for code 37.26.

Other commenters opposed our proposal to remove code 37.26 from DRGs 535 and 536. These commenters stated that code 37.26 is used to capture a variety of disparate procedures with varying purposes, sites of service, and intensity, and that the resultant data are not representative of any one of these. Other commenters stated that the code contains three separate procedures of varying intensity: Electrophysiology study, intraoperative device interrogation, and noninvasive programmed stimulation. Several commenters believed that the payment change would have a severe financial impact on their hospitals. They believed it is inappropriate to make the change without the data to justify the change. Several commenters stated that the change would have a significant impact on the use of CRT–D implants because the devices are more costly. The commenters suggested that, before considering a revision to DRGs 535 and 536 for code 37.26, CMS should resolve the coding confusion. The commenters asked that the code be discussed at the September 29, 2005 ICD–9–CM Coordination and Maintenance Committee meeting and suggested that separate codes be created for the different procedures currently captured by code 37.26. According to the commenters, the new codes that are created could go into effect on October 1, 2006. The commenters suggested that, once data are available, CMS should consider a revision to DRGs 535 and 536 for EPS procedures.

Response: We agree with the commenter that there is considerable confusion regarding the use of code 37.26. It is possible that code 37.26 is being used for a variety of electrophysiologic procedures such as EPS, noninvasive programmed electrical stimulation, and programmed electrical stimulation. However, as indicated in the proposed rule and above in this final rule, our data show that the cases coded with 37.26 that were not separately coded with a cardiac catheterization had average charges of $98,900.13 in DRG 535 and $85,390.88 in DRG 536 compared to $127,130.79 and $110,493.86, respectively, for all other cases in these DRGs. For this reason, we believe it is appropriate to include code 37.26 in DRG 515 and no longer assign it to DRGs 535 and 536 that are for patients who receive a cardiac catheterization.

As we discussed earlier in this section of the preamble, Medicare significantly expanded coverage of implantable defibrillators on January 27, 2005 (Pub. No. 100–3, section 20.4) to patients who have a prior history of heart disease but are not in acute heart failure. These prophylactic defibrillator implants are expected to significantly increase the number of patients in DRGs 515, 535, and 536. It is our experience that most of these patients will not be receiving a cardiac catheterization and will be less resource-intensive than the acute heart failure patients receiving an implantable defibrillator. We note that the Bernstein Research Call publication of April 27, 2005 stated that this DRG change could ''dampen the elective implantation of de-novo CRT–D or dual chamber devices into relatively stable patients.'' The article further states that CMS ''realizes that the new prophylactic ICD [implantable cardioverter defibrillators] eligibility requirements do not require an EP test, and that EP tests *per se* do not consume sufficient resources to justify the reimbursement differentials seen between DRGs 515 versus 535 and 536.'' We believe it is particularly important to make the change to DRGs 515, 535, and 536 at this time, given the expansion of Medicare coverage of implantable defibrillators and the evidence that suggests that patients who receive an EP test, but not a cardiac catheterization, are less expensive than other patients receiving these devices.

We will address code 37.26 at our September 29–30, 2005 meeting of the ICD–9–CM Coordination and Maintenance Committee meeting. The public is encouraged to participate in this meeting and offer suggestions for code modifications. Information on this meeting can be found at: *http://www.cms.hhs.gov/paymentsystems/icd9.*

Comment: Five commenters stated that CMS' data show that the average charges for cases with code 37.26 are significantly higher than those in DRG 515. The commenters suggested that the volume of cases is significant enough to create a new DRG for cases with cardiac defibrillator implant without cardiac catheterization, but with code 37.26.

Response: Given the extensive comments concerning coding problems with code 37.26, we do not believe it is appropriate to create a new DRG that would specifically capture defibrillator implants with this code. Therefore, we are not creating the suggested new DRG at this time. As stated earlier, we will continue to work with the coding and health care community to modify code 37.26 so that it will lead to more consistent reporting. Once we have better data, we will evaluate additional DRG modifications.

After consideration of the public comments received on the proposed rule, in this final rule, we are implementing the modification of DRGs 535 and 536 as proposed for FY 2006. We are removing code 37.26 from the list of cardiac catheterizations for DRGs

535 and 536 and adding the code in DRG 515.

c. 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. In the FY 2006 proposed rule (70 FR 23318 through 23319), we included the following discussion regarding the commenter's concerns:

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.''

In response to those comments, we analyzed the MedPAR data to determine the impact of certain secondary diagnoses or complicating conditions on the four stent DRGs. 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 (Subarachnoid hemorrhage), 431 (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 (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 (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. Because 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. 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.

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.)

Thus, we proposed to restructure the coronary stent DRGs on the basis of the standard CC list to differentiate cases that require greater resources. We believed this list to be more inclusive of true comorbid or complicating conditions than selection of specific secondary diagnosis codes. Therefore, we anticipated that restructuring these DRGs on this basis would result in a logical arrangement of cases with regard to both clinical coherence and resource consumption. We 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 encompassed most of the cases on the recommended list, as well as other cases with additional CCs requiring additional resources. We 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 suggested that a ''with and without CC'' split in DRG 516 and 526 was warranted. At the same time, the data did not show such a clear differentiation, in either average charges or lengths of stay, among the cases in DRGs 517 and 527.

As a result of this analysis, in the proposed rule, we had originally proposed to delete DRGs 516 and 526, and to substitute four new DRGs in their place. These new DRGs were to have been 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 intended 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 did not support restructuring DRGs 517 and 527 based on the presence or absence of a CC. Therefore, we proposed to retain these two DRGs in their current forms. We believed this revised structure would result in a more inclusive and comprehensive array of cases within MDC 5 without selectively recognizing certain secondary diagnoses as ''complex.''

We received a number of comments on the proposed restructuring of DRGs 516, 517, 526, and 527 in the FY 2006 IPPS proposed rule.

Comment: All of the commenters approved of the proposed restructuring of these DRGs, especially with regard to dividing DRGs 516 and 526 on the basis of the presence or absence of complicating secondary diagnoses.

Response: We appreciate the comments submitted in support of this proposal.

Comment: One commenter noted that the average patient receives 1.5 stents, and expressed the desire for CMS to begin ''appropriate reimbursement'' in FY 2006, consistent with the additional expense involved when multiple stents are inserted. One commenter remained concerned that the DRG weights significantly underestimate the true costs of performing drug-eluting stent procedures, especially for multiple vessel, multiple stent procedures, and expressed concern that the proposed relative weights could result in financial losses for hospitals, with the result that access to stent procedures is discouraged.

Response: We created new ICD–9–CM procedure codes effective for discharges on or after October 1, 2005, to capture both the number of stents inserted and the number of vessels treated. Absent accurate charge data, we cannot predict the correct relative weight for a DRG containing more than one stent. We reiterate that we will continue to monitor the MedPAR data, and will make future evidence-based changes to the DRG structure and logic as warranted.

Comment: Several commenters supported the maintenance of separate reimbursement structures for drug-eluting stents and recommended that we continue to separate drug-eluting and bare metal stents in different DRGs until such time as the bare metal stents represent an insignificant proportion of the total coronary stent discharges.

Response: We recognize that the resources surrounding bare metal stents and drug-eluting stents differ appreciably and will continue to keep these cases separate from each other until such time as it is appropriate, according to the evidence provided in our MedPAR data, that these cases can be combined.

Comment: Several commenters supported CMS' proposal to create eight new procedure codes; four codes describing the number of vessels treated and four codes describing the number of stents inserted. In addition, two commenters suggested that CMS should issue a separate communication reiterating the correct use of these codes.

Response: We take this opportunity to clear up a misconception. The codes published in Tables 6A through 6F are not proposed codes. They are final codes, and as such, are not subject to comment. Absent any typographical errors or late changes to the codes, they may be considered available for use on October 1 of the following fiscal year. This year, because of the changes made by the March 31, 2005 and April 1, 2005 ICD–9–CM Coordination and Maintenance Committee, the codes in the proposed rule were not as complete as those codes published in this final rule. The codes contained in Tables 6A through 6F of this final rule include all new codes for FY 2006, which will go into effect on October 1, 2005.

CMS partners with the American Hospital Association with regard to correct coding advice published in the *Coding Clinic for ICD–9–CM.* AHA's fourth edition of the year always includes the new codes for the upcoming year and includes examples on their proper use. In addition, CMS' MedLearn site at *http://www.cms.hhs.gov/medlearn/icd9code.asp#top* contains coding information.

Comment: One commenter recommended that the use of the eight new codes describing number of vessels and number of stents be used on both coronary and peripheral vessels.

Response: The note that will appear at the top of the 00.4 (Adjunct Vascular System Procedures) section of Tabular section of the ICD–9–CM Procedure Coding Book will read as follows: ''These codes can apply to both coronary and peripheral vessels. These codes are to be used in conjunction with other therapeutic procedure codes to provide additional information on the number of vessels upon which a procedure was performed or the number of stents inserted, or both. As appropriate, hospitals should code both the number of vessels operated on (00.40 through 00.43) and the number of stents inserted (00.45 through 00.48).

Comment: One commenter stated that by the time CMS gets data on the eight new codes, it will be FY 2008, and hospitals will have had inadequate reimbursement for multiple stents until then. The commenter suggested that CMS incorporated additional payment for multiple stents and multiple vessels treated into the FY 2007 weights.

Response: We will follow the use of these codes, but may not be prepared to make any DRG changes based on their use with only one year's worth of data.

Comment: One commenter stated that DRGs should not be restructured for multiple stent insertion without adequate data to support our decisionmaking process.

Response: We agree and intend to closely follow the use of these eight new codes in the MedPAR data.

Comment: One commenter was not convinced that the proposed new structure of DRGs 516 and 526, with and without comorbidities and complications should be the permanent solution for all coronary stent DRGs. This commenter agreed that the new structure of these DRGs should not preclude subsequent restructuring of the stent DRGs.

Response: We agree that restructuring DRGs 516 and 526 in the proposed manner might not be a permanent solution for classifying all stent DRGs. However, we have now decided not to adopt the proposed restructuring of DRGs 516 and 526 that was described in the proposed rule. We have now determined that it is appropriate to restructure nine DRGs in MDC 5, including DRGs 516, 517, 526, and 527,

on the basis of the presence or absence of a major cardiovascular condition. We are making this change in the DRG structure in response to public comments concerning our response to MedPAC's recommendations to better recognize severity in the DRG system. The full text of the changes we are making to the cardiovascular DRG, including the coronary artery stent DRGs, can be found in section IX.A. of this final rule.

Comment: One commenter requested that CMS adopt an ICD–9–CM code that was discussed at the October 7, 2004 ICD–9–CM Coordination and Maintenance Committee. That code, had it been adopted, would have been 00.44 (Procedure on bifurcated vessels) in the new series of codes describing the number of vessels treated. The commenter stated that the creation of this code is critical to understanding the contemporary approaches to treatment of coronary artery disease. The commenter further stated that treatment of stenosis [of a blood vessel] at a bifurcation represents 25 to 30 percent of percutaneous coronary interventions and recommended that coders use one code for number of vessels, one code for number of stents, and an additional code to note that a bifurcated vessel was treated. According to the commenter, a new code for the treatment of a bifurcated vessel is necessary because the existing codes that describe the number of vessels treated (codes 00.40 through 00.43) will only be used by coders for the counting of uninterrupted, straight vessels.

Response: We did not choose to create a new code for procedure on a bifurcated vessel for two reasons. First, we do not believe that level of granularity is needed in order to accurately code stent insertion for bifurcated vessels. We believe that the codes for multiple stents and vessels will provide the necessary information about resource use for the procedure. Second, we are concerned that coders will not have sufficient information documented in the medical record to identify procedures on bifurcated vessels as opposed to a specific number of procedures on a specific number of vessels. Because procedures on bifurcated vessels are so prevalent (25 to 30 percent, according to the commenter), they should be considered technical variants rather than distinct entities to be coded separately. We solicited input from the industry when creating the new coronary stent codes, and we believe that the new codes as they exist adequately capture resource utilization. We also note that this level of detail is not present in the Current Procedural Terminology (CPT) coding structure, which is the basis upon which physicians are paid.

Accordingly, in this final rule, for FY 2006, we are deleting DRGs 516, 517, 526, and 527 for percutaneous placement of both drug-eluting and nondrug-eluting stents. We are creating four new DRGs in their places. Rather than divide these DRG pairs based on whether the patient had an acute myocardial (AMI), we are splitting each pair of DRGs based on the presence or absence of a major cardiovascular condition. Although, as discussed in the proposed rule, in the past we have expressed concerns regarding selectively recognizing secondary diagnoses or complicating conditions, particularly conditions from other MDCs, in making DRG assignments, we believe these concerns are not relevant to the new cardiovascular DRGs. While we are adopting an approach for distinguishing patients with complex conditions, with a few exceptions, our approach uses complex cardiovascular conditions (or diagnoses within the MDC) to decide whether a patient should be assigned to the higher weighted DRG. In those cases where we have used a diagnosis from another MDC in assigning a patient to the MCV DRG, the condition is generally a closely related vascular condition that is linked to the patient's cardiovascular illness. We believe that this revised structure identifies subgroups of significantly more severe patients who use greater hospital resources more accurately than was possible under the previous DRGs. The new DRG titles are:

- DRG 555 (Percutaneous Cardiovascular Procedure With Major Cardiovascular Diagnosis (formerly DRG 516)
- DRG 556 (Percutaneous Cardiovascular Procedure With Non-Drug-Eluting Stent Without Major Cardiovascular Diagnosis (formerly DRG 517)
- DRG 557 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent With Major Cardiovascular Diagnosis (formerly DRG 526)
- DRG 558 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent Without Major Cardiovascular Diagnosis (formerly DRG 527)

We refer the reader to section IX.A. of the preamble to this final rule for a full presentation of the changes to the DRGs for coronary artery stents for FY 2006.

Although we are adopting some restructuring of the coronary stent DRGs for FY 2006, it is important to note that this change does not preclude proposals in subsequent years to further restructure the coronary stent DRGs based on the number of vessels treated. 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. After we have pertinent data in our historical MedPAR database, we will analyze those data in order to determine whether a restructuring of the DRGs based on multiple vessel treatment or insertion of multiple stents, or both, is warranted.

We refer the reader to Table 6B of this final rule for the descriptions of 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). Coders are encouraged to use as many codes as necessary to describe each case, using new code 00.66 (Percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy) and one code each for the number of vessels treated and the number of stents inserted. Coders are encouraged to record codes accurately, irrespective of whether the code has an impact on the DRG assignment, as these data will potentially be the basis for future DRG restructuring.

d. 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	523	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 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 this analysis, we proposed to move procedure code 35.52 out of DRG 108 and place it in DRG 518.

Comment: One commenter agreed that the left atrial appendage device procedure code should be moved out of DRG 108 and into DRG 518 based on significantly lower average charges and length of stay as compared to the majority of cases within the current classification.

Response: Even though this comment did not exactly reflect our proposal regarding the left atrial appendage device, we are interpreting the commenter's statement to mean that it agreed that code 35.52 should be removed from DRG 108.

Comment: One commenter addressed the proposed removal of code 35.52 from DRG 108. The commenter acknowledged that the resource intensity for patients undergoing percutaneous atrial septal defect repair is less than that of open repair, but did not believe that the costs are akin to procedures presently assigned to DRG 518 because of the cost of the closure device and additional testing, such as electrocardiography. The commenter recommended that CMS not move code 35.52 out of DRG 108 until better data can be gathered and a more appropriate reimbursement calculation can be developed.

Response: This year, CMS undertook an extensive review of MDC 5 after issuance of the FY 2006 IPPS proposed rule in response to MedPAC's recommendations regarding restructuring the Medicare DRG system to improve payment accuracy under the IPPS. A discussion of the results of that review and our subsequent decision in response to a comment on the proposed rule to make changes to nine cardiovascular DRGs, can be found in section IX.A. of this preamble. During that review, we evaluated each surgical DRG within MDC 5. In addition, within each DRG, we evaluated each procedure code to determine the number of cases,

the average length of stay, and the average standardized charges. In DRG 108, the results were the same as in the table shown above in this section, and published in the FY 2006 IPPS proposed rule. Code 35.52 had an average length of stay of approximately one fourth of the rest of the cases in that DRG, and had average charges that were greater than $51,700 less than the remainder of the cases in DRG 108. In addition, code 35.52 represents a closed technique approach, unlike the other cases in DRG 108. We believe this is compelling evidence that this procedure is not most appropriately assigned to DRG 108. Therefore, we are finalizing our proposal to move code 35.52 out of DRG 108 and into DRG 518 with cases that resemble it in average length of stay, average charges, and clinical coherence. We believe that this move will result in a more coherent group of cases in DRG 518 that reflect all percutaneous procedures.

Comment: Three commenters did not believe that the left atrial appendage device, represented by new code 37.90, should be placed in DRG 518. They believed that DRG 518 does not cover the costs for the procedure and device, and suggested placement in another DRG that would include similar procedures and a better reimbursement. Two commenters suggested that a more appropriate DRG would be either DRG 108 or DRG 111 (Major Cardiovascular Procedures Without CC).

Response: Based on our data review and discussion above, we do not believe that placement of code 37.90 is appropriate in DRG 108. Code 37.90 is a percutaneously placed device utilizing local anesthesia, and with an expected length of stay of one day.

We reviewed cases in the MedPAR file assigned to both DRG 110 (Major Cardiovascular Procedures With CC) and DRG 111. The results of the review show that both open and percutaneous procedures are grouped in these paired DRGs. A comparison of the MedPAR data in DRGs 110, 111, and 518 is shown in the following table:

DRG	Number of cases	Average length of stay	Average standardized charges
DRG 110	53,527	[1] 8.4	$66,475
DRG 111	9,438	[1] 3.43	26,941
DRG 518—All cases	38,624	3.49	27,591
DRG 518 with code 37.90	0	0	0

[1] Days.

As shown in the table, code 37.90 in DRG 518 has not been reported in the database yet. It is a new code; therefore, it has no payment history. We note that the cases in DRG 518 closely match those in DRG 111 in terms of both average length of stay and average charges. However, we also note that DRGs 110 and 111 are paired DRGs with significantly different average charges and lengths of stay. Even with a CC, we believe it is unlikely that an endovascular placement of a left atrial appendage device will approximate the costs of cases to be assigned to DRG 110. Therefore, in our view, there is the potential for significant overpayment if we were to assign the left atrial appendage device to DRG pairs 110 and 111. We continue to believe that placement of the left atrial appendage device in DRG 518 is appropriate absent any evidence that would convince us otherwise. Therefore, we are not making any changes in our proposal in this final rule. We will continue to monitor its data in our annual review of DRGs and the IPPS.

As we proposed, in this final rule we are moving procedure code 35.52 out of DRG 108 and placing it in DRG 518. We believe that this move will result in a more coherent group of cases in DRG 518 that reflect all percutaneous procedures.

e. 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 subsequent 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 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 the patients 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).

Further, the Medicare charge data show that patients in DRG 525 receiving the external heart assist system had an average length of stay that was more than 28 days less than all patients in DRG 103.

The manufacturer suggested that the payment differential between DRGs 103 and 525 provides 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 (code 37.66). 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	9	81.3	625,065
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

Note: This table does not contain the same data that appear in the table in the proposed rule (70 FR 23322). The row containing "DRG 103 without code 37.65" had values of "0" in all fields. These entries were confusing and therefore deleted.

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 all 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 overpaid, which would be inconsistent with our goal of coherent reimbursement structure within the DRGs. In addition, the relative weight of DRG 103 would ultimately 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 did not propose to make any changes to the structure of either DRG 103 or DRG 525.

Comment: Six commenters mentioned the high cost of the external heart assist device and for treatment for implantation of the device, and requested that CMS increase payment to cover the cost of caring for the patients that can benefit from this technology.

Two commenters agreed with CMS' assessment that the cost associated with implantation of an external heart assist system are considerably less than a heart transplant or insertion of an implantable heart assist system. One commenter echoed CMS' concerns that movement of code 37.65 to DRG 103 would result in overpayment for that service and would result in a decrease of the relative weight of the heart transplant DRG, ultimately resulting in underpayment of heart transplant cases. Both commenters agreed with CMS' decision not to include the implantation of external heart assist systems in DRG 103.

Several commenters noted that significant achievements in the areas of patient selection, implantation technique, and post-implant management have been made surrounding this technology. They added that improvements in the external heart assist device itself have been reported to make the newer devices safer and more durable. One commenter noted that observations from personal experience and research demonstrate that recent improvements to the device have resulted in increased survival rates from 35 percent (the national average) to nearly 50 percent. Several commenters mentioned that, with experience, they have discovered that a longer period of support is required than was originally anticipated for the patient's native heart to recover. The commenters stated that, originally, patients were supported an average of 5 to 7 days, but it has been found that patient outcomes were better with a longer support period, perhaps as long as 30 to 60 days. These commenters cited the increased expenses related to supporting the patient and the major financial commitment on the part of the hospitals choosing to treat this severely ill group of patients as reasons for requesting increased payment for this population of cases.

One commenter offered the following four proposals to address the payment differences between the external heart assist device and an implantable device:

- Create a new DRG for patients requiring heart assist devices who also sustained an Acute Myocardial Infarction (AMI) because these patients have higher resource consumption than patients with other diagnoses in MDC 5.
- Assign all cases with AMI and a procedure code of 37.65 to DRG 103.
- Increase the overall weight of DRG 525 to better align it with "true hospital charges."
- Allow a second DRG payment or an add-on payment for heart transplantations if recovery of the patient's native heart is first attempted.

Response: We appreciate the commenters' thorough understanding of the IPPS DRG grouping and payment process. We are aware that the external heart assist device cases represent a very resource-intensive group of patients. For this reason, we carefully reviewed the suggestions from the commenter about potential DRG payment policy changes that we could make to address the issue. We reviewed the MedPAR data in DRG 525, using ICD–9–CM codes 410.01 through 410.91 to identify AMIs. In

addition, we reviewed all cases of patients who received the external heart assist device procedure represented by ICD–9–CM code 37.65. The results are summarized in the following table:

	Number of cases	Average length of stay (days)	Average charges
DRG 525—Cases with Any Diagnosis of AMI	46	8.5	$195,758
DRG 525—Cases of Principal Diagnosis of AMI	31	8.9	210,369
DRG 525—Cases with Secondary Diagnosis of AMI	15	7.7	165,562
DRG 525—Cases with No Diagnosis of AMI	71	9.2	204,472
DRG 525—All Cases	291	13.66	206,497

We do not believe that these data demonstrate that the presence of an AMI has significant impact on either the length of stay or the average standardized charges. All cases with AMI have lower lengths of stay than both the average of all cases in DRG 525 (13.66 days) and the 71 cases in which no AMI was documented (9.2 days). Likewise, only those cases with a principal diagnosis of AMI have slightly higher charges than either the group without AMI, or the total of all cases. Because the data do not justify it, we are rejecting the suggestion of creating a new DRG for patients receiving an external heart assist device, as identified by procedure code 37.65, with any diagnosis of AMI.

With respect to the commenter's second suggestion, our data clearly demonstrate in the above table that patients with an AMI and procedure code 37.65 have average standardized charges of $210,369. The first table in this section that was included in the proposed rule shows that cases in DRG 103 have average standardized charges of $313,583. We believe that the relative weight of DRG 103 would eventually decrease by moving all of the less resource-intensive external heart procedures into the same DRG with the more expensive heart transplant cases. For these reasons, we are rejecting the commenter's proposal to assign cases with AMI and code 37.65 to DRG 103.

With regard to the suggestion (received many times) to selectively increase the relative weight of specific DRGs, the DRG relative weights are annually recalibrated based on Medicare hospital discharges using the most current charge information available (FY 2004 MedPAR file for the FY 2006 relative weights). We use a complex mathematical algorithm to determine the relative weights that is fully explained in section II. of this preamble. The DRG relative weights are neither arbitrarily nor capriciously assigned. However, if we adopted the suggestion to select a relative weight for a specific DRG outside of this process, we are concerned that the relative weight determination would be viewed as arbitrary and capricious, and we would lose the advantage of having an objective methodology that bases the relative weight on average hospital charges. For this reason, we are not adopting the commenter's suggestion to select a relative weight for external heart assist device cases outside of our traditional process.

The commenter's fourth suggestion was to make two payments for a single inpatient stay when the patient receives the external heart assist system, recovery of the patient's native heart is attempted and fails, and the patient receives a heart transplant. In cases where the patient received the external heart assist system and later receives a heart transplant, the case is already paid using DRG 103. In this situation, the relative weight for DRG 103 will reflect the average charges for all patients in the DRG, including those described in the scenario presented by the commenter. Thus, to the extent that hospital charges for these patients are already reflected in the relative weight for the DRG, we do not believe that it is necessary for Medicare to make a second payment. To arbitrarily select one DRG, or a group of DRGs, and add an additional DRG payment to those cases is contrary to our stated goal of having a system in which all cases are fairly considered by the same recalibration formula. Therefore, we do not intend to either determine an additional DRG payment or an add-on payment for this category of patients.

We reiterate that our data do not support the argument that patients receiving the external heart assist device have longer lengths of stay than other patients in DRG 525, even though the data show that their average charges are higher, as noted in the above table. In determining the possible reasons for higher average charges and lower lengths of stay, we further examined the Medicare billing data. We found that almost 76 percent of the Medicare beneficiaries receiving the external heart device expired during the hospital stay. Thus, the shorter length of stay and the higher average charges for these patients compared to other patients in DRG 525 are likely explained by the high cost of the device and the fact that these patients are severely ill and frequently expire.

Upon further analysis of the data, we did find that there was a single subgroup of patients who are comparable in resource usage and length of stay to those included in DRG 103. These patients received both the external heart assist device and later had it removed after a lengthy period of rest and recovery. We note that commenters provided information indicating that survival rates are improving for patients receiving more advanced versions of these devices. In addition, commenters provided information indicating that longer periods of support with the external heart assist device are improving patients' survival chances and opportunity to be discharged with their native heart. According to information included with the comments, the data show a 50-percent survival rate with an average total length of stay of 43 days for all AMI heart recovery patients. On average, a surviving patient will receive 31 days of average support time followed by an additional 38 days in the hospital after the device is removed. Based on the commenter's information from a later year than our MedPAR data, it is clear that patients weaned from the external heart assist system have longer lengths of stay and are very different from the average patients having this procedure that are in our FY 2004 data. Given the newness of this procedure, the Medicare charge data included a limited number of patients having the device implanted and removed. However, the Medicare charge data did support that patients receiving both an implant and removal of an external heart assist system in a single hospital stay had an average length of stay exceeding 50 days and average charges of $378,000 that are more comparable to

patients in DRG 103 than DRG 525. While we did not suggest a change to DRG 103 in the proposed rule, we believe that consideration of the comments is best served by recognizing this unique subset of patients and making a DRG change which acknowledges the increased resources required for improvements in their care.

The commenter has provided us with data showing that with superior patient selection, and increased duration of treatment with an improved device, the patients are more likely to be discharged from the hospital with the native heart intact. While we have limited Medicare data and the data are from a different year than the commenter's data, our data do support that patients having an external heart assist device implanted and removed during the same admission are comparable to in costs and average length of stay to heart transplant and implantable heart assist system patients in DRG 103. While we did not suggest a change to DRG 103 in the proposed rule, we believe that consideration of the comments is best served by recognizing this unique subset of patients, and making a DRG change that acknowledges the increased resources required for improvement in their care. Because we believe that this therapy offers a treatment option to patients who have limited alternatives, we are making a change to the DRG using the limited Medicare data we have available rather than waiting a year to receive more supporting data.

For the reasons stated above, for FY 2006, we are reconfiguring DRG 103 in the following manner: Those patients who have both the implantation of the external VAD (code 37.65) and the explantation of that VAD (code 37.64) prior to the hospital discharge will be assigned to DRG 103. The revised DRG 103 contains the following codes:

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

Or

- 37.65, Implant of external heart assist system

And

- 37.64, Removal of heart assist system.

By making this change, Medicare will be making higher payments for patients who receive both an implant and an explant of an external heart assist system during a single hospital stay. Our intent in establishing this policy is to recognize the higher costs of patients who have a longer length of stay and are discharged alive with their native heart. Cases in which a heart transplant also occurs during the same hospitalization episode would continue to be assigned to DRG 103.

In order to accurately monitor these patients and obtain more information on patients with these conditions, we intend to have the Quality Improvement Organizations (QIOs, formerly the PROs) review all cases in DRG 103 under the auspices of their eighth scope of work to determine whether implantation and care during the admission were reasonable and necessary to promote the recovery of the injured myocardium and lead to improvement of the patient's condition. For medical review under this contract, the QIOs determine whether items and services are reasonable and medically necessary and whether the quality of such services meets professionally recognized standards of health care. In addition, in hospitals subject to the IPPS, the QIOs review the validity of diagnostic information, the completeness, adequacy, and quality of care provided, and the appropriateness of admissions and discharges. We will continue to examine the claims data in upcoming years to determine if CMS' consideration surrounding the unique circumstances of these patients and this treatment modality were in the best interest of both the patients and the Medicare program.

f. 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 its April 1, 2004 meeting, the ICD–9–CM Coordination and Maintenance Committee 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). We established codes for carotid artery stenting procedures for use with discharges occurring on or after October 1, 2004 inpatients who are enrolled in an FDA-approved clinical trial and are using on-label FDA-approved stents and embolic protection devices. These codes are as follows:

- 00.61 (Percutaneous angioplasty or atherectomy of precerebral (extracranial vessel(s)); and
- 00.63 (Percutaneous insertion of carotid artery stent(s)).

We assigned procedure code 00.61 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). Other DRG assignments can be found in Table 6B of the Addendum to the FY 2005 IPPS final rule (69 FR 49624).

In the FY 2005 IPPS 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 the FY 2006 IPPS proposed rule and this final rule, we used 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 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 carotid artery stenting. For this evaluation, we used principal diagnosis code 433.10 (Occlusion and stenosis of carotid artery, without mention of cerebral

infarction) to reflect 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, 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.

We received 11 comments on our presentation of the carotid stent device issue in the FY 2006 IPPS proposed rule.

Comment: One commenter recommended that CMS include carotid stenting in the DRG for carotid endarterectomy in FY 2006 and ensure that the data it is collecting for setting payment rates in FY 2007 appropriately accounts for the cost of the device.

Response: Code 38.12 (Endarterectomy, other vessels of head and neck) describes the open endarterectomy procedure, and is assigned to DRGs 533 and 534 which is the same DRG assignment as the endovascular endarterectomy. Therefore, both the open endarterectomy and the placement of carotid stent result in assignment to the same DRG, which reflects CMS' policy of placing new codes in predecessor DRGs. We point out that codes 00.61 and 00.63 must be used together to allow payment for carotid stenting. Code 00.63 is not recognized by the GROUPER program as a stand-alone O.R. procedure and, as such, has no impact on DRG assignment. Therefore, we anticipate that the cost of the device will be reflected in the hospital charges.

Comment: One commenter agreed with our presentation in the proposed rule and suggested that we should make no change to the DRG assignment for carotid artery stenting.

Response: We agree and will not be making a change to the DRG assignment for carotid artery stenting.

Comment: Nine commenters encouraged CMS to create two new DRGs for carotid stent procedures and split these new DRGs on the basis of the presence or absence of comorbidities or complications. They believed that, even though the current volume of carotid artery stenting cases appears small, the recent availability of FDA-approved devices, new and ongoing clinical trials, multiple post-market registries, as well as expanded Medicare coverage, will result in a large increase in the number of cases. They also expressed concern that the potential increase in patient volume and their perceived inadequate payment for carotid artery stent cases will create a financial hardship on facilities providing this technology, potentially resulting in decreased Medicare beneficiary access to this beneficial therapy.

Response: We continue to believe that the most appropriate changes to the IPPS and the structure of the DRGs are based on evidence of a significant difference in average costs between technology itself and the DRG where its code is assigned. Because the ICD–9–CM procedure codes are new, we do not have data showing that carotid artery stents are more costly than other cases in DRGs 533 and 534. Further, using codes 39.50 and 39.90 as proxies for carotid artery stenting, we did not observe a substantial difference in average charges between cases using these codes and other cases in the DRGs. For this reason, we do not have sufficient evidence to warrant a DRG change at this time.

In this final rule, we are retaining code 00.61 in DRGs 533 and 534 for FY 2006. We will continue to monitor the Medicare charge data in our annual review of DRGs and the IPPS.

g. 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.

Prior to the proposed rule, 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 the DRG
4	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 proposed to reassign ECMO cases reporting code 39.65 to DRG 541. We also proposed 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. Procedure''.

Comment: Several commenters supported the proposed modification to ECMO cases reporting code 39.65 to DRG 541.

Response: We appreciate the commenters' support.

Accordingly, in this final rule, we are adopting as final the proposed change to ECMO cases reporting code 39.65 to DRG 541 with minor modification. To further clarify the change, we are changing the title of DRG 541 to ''ECMO or Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck With Major O.R.'' This title has been modified since the proposed rule (70 FR 23324) to delete the term ''Diagnoses'' from the title. For consistency purposes, we are also changing the DRG title for DRG 542 from ''Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses Without Major O.R. Procedure'' to ''Tracheostomy With Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth, and Neck Without Major O.R.''

6. 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 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 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 the 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 did not propose any further changes to the DRGs for these procedures at this time. Neither did we propose to change the structure of DRGs 146 or 147 at this time.

Comment: One commenter agreed that we should maintain the current DRG assignment for codes 49.75 and 49.76. The commenter recommended that CMS continue to monitor the use of these codes and their DRG assignment.

Response: We acknowledge the support of the commenter and will continue to monitor utilization of the services with codes 49.75 and 49.76.

For FY 2006, we are retaining codes 49.75 and 49.76 within DRGs 146 and 147, as proposed.

7. 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 prior to the issuance of the FY 2006 IPPS proposed rule.

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- 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 as 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 final 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 the FY 2006 IPPS 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 (days)	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 proposed 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 proposed to assign the following codes to the new proposed DRG 544: 81.51, 81.52, 81.54, 81.56, 84.26, 84.27, and 84.28.

We proposed to assign the following codes to the proposed new DRG 545: 00.70, 00.71, 00.72, 00.73, 00.80, 00.81, 00.82, 00.83, 00.84, 81.53, and 81.55.

In response to the FY 2006 IPPS proposed rule, we received the following public comments:

Comment. Four commenters supported our proposal to delete DRG 209 and to create proposed new DRGs 544 and DRG 545. One commenter stated that the proposed rule reveals that the average joint revision charges are $7,000 higher than original joint replacements, which supports the point that joint revision procedures are more resource-intensive than initial replacements.

Another commenter commended CMS for its efforts to provide appropriate payment for revision hip and knee arthroplasty by proposing to split DRG 209 into DRG 544 and 545, and to expand the scope of the relevant ICD–9–CM procedure codes included in these DRGs. The commenter stated that the new codes, in particular, are an important component in aligning hospital reimbursement with hospital costs and patient benefits of total joint arthroplasty. The commenter encouraged CMS to continue its dialogue with industry and providers regarding further DRG changes to primary joint arthroplasty procedures, which represent approximately 90 percent of total hip and knee arthroplasty procedures.

One commenter recommended that CMS consider the number of individual components used in the joint replacement when future DRG revisions are made. The commenter stated the hospital's costs will vary based on the number of parts replaced during the procedure. According to the commenter, we may be overpaying simple head and/or liner exchanges in hips, and patellar/insert exchanges in knees relative to primary hip and knee procedures. The commenter indicated that, with the more specific ICD–9–CM codes, CMS will be able to evaluate further changes in the joint replacement and revision DRGs.

We did not receive any comments that opposed the proposed DRG revisions for hip and knee replacements.

Response: We appreciate the support of the commenters. We will use the data obtained from use of the new codes to consider future DRG revisions for joint replacement and revision procedures.

In this final rule, for FY 2006, we are adopting the DRG revisions relating to hip and knee replacements as proposed. We are deleting DRG 209 and creating new DRG 544 (Major Joint Replacement or Reattachment of Lower Extremity) and new DRG 545 (Revision of Hip or Knee Replacement). The new DRG 544 includes the following code assignments:

- 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

The new DRG 545 includes the following code assignments:

- 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 believe that the creation of the new DRGs 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 the FY 2006 IPPS 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 (days)	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, in the FY 2006 IPPS proposed rule, we did not propose to change the DRG assignment of code 81.66 to DRGs 233 and 234.

Comment: Two commenters supported our proposal not to change the DRG assignment of code 81.66 (Kyphoplasty). Both commenters agreed with our proposal to keep code 81.66 in DRGs 233 and 234. They also agreed that we should wait for bill data using the new kyphoplasty code prior to considering any DRG modification.

Response: We appreciate the commenters' support for our proposal.

In this final rule, for FY 2006, we are retaining the assignment of code 81.66 in DRGs 233 and 234. As we proposed, we will consider whether further changes are warranted once additional hospital charge data are available using the new code.

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 IPPS 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 remain 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 (days)	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 proposed to create a new DRG 546 for noncervical spinal fusions with a principal diagnosis of curvature of the spine and malignancies: proposed new DRG 546 (Spinal Fusions Except Cervical With Principal Diagnosis of Curvature of the Spine or Malignancy). We proposed to include in the proposed new DRG cases all noncervical spinal fusions cases previously assigned to DRGs 497 and 498 that have a principal diagnosis of curvature of the spine or malignancy and with 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. We proposed that 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 and that 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). Therefore, we limited our proposed changes to the spinal fusion DRGs for FY 2006 to the creation of the proposed DRG 546 discussed above. However, we indicated that 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 also solicited 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.

Comment: A number of commenters supported our proposal to create new DRG 546 (Spinal Fusions Except Cervical With Principal Diagnosis of Curvature of the Spine or Malignancy) to include all noncervical spinal fusions previously assigned to DRGs 497 and 498 that have a principal diagnosis of curvature of the spine or malignancy. One commenter stated that the addition of new DRG 546, with its higher weight, would help reimburse hospitals more adequately for the resources used in treating patients with significant spinal deformities and other problems. One commenter stated that the cost associated with a multilevel spine fusion when the patient has a diagnosis of curvature of the spine or malignancy exceeds the current Medicare reimbursement.

Several commenters noted that the following four ICD–9–CM diagnosis

codes are manifestation codes that cannot be reported as a principal diagnosis:

- 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

The commenter pointed out that these codes can only be reported as a secondary diagnosis. Therefore, the commenters stated that our proposed DRG logic for DRG 546 would not work with these four codes.

Response: We appreciate the support of the commenters for the creation of the new DRG 546. We agree that this new DRG would better align Medicare payment with hospital costs for treating these more severe orthopedic cases. We also agree that codes 737.40, 737.41, 737.42, and 737.43 are not to be reported as a principal diagnosis because they are manifestation codes. We inadvertently included them among the list of principal diagnoses that would be assigned to DRG 546. In this final rule, we are removing codes 737.40, 737.41, 737.42, and 737.43 from the list of principal diagnosis codes that would lead to an assignment of DRG 546. However, we will retain these codes as a secondary diagnosis that will result in an assignment to DRG 546 because they describe curvature of the spine. Therefore, patients admitted with an orthopedic diagnosis who receive a spinal fusion will be assigned to DRG 546 if codes 737.40, 737.41, 737.42, and 737.43 are present as a secondary diagnosis. Consistent with this change in the GROUPER logic, we will also remove the term ''principal diagnosis'' from the proposed title so that DRG 546 will be titled ''Spinal Fusions Except Cervical With Curvature of the Spine or Malignancy.''

Comment: One commenter suggested that CMS consider adding the following diagnoses to the list of codes that would be assigned to the new DRG 546:

- 213.2, Benign neoplasm of bone and articular cartilage; vertebral column, excluding sacrum and coccyx
- 238.0, Neoplasm of uncertain behavior of other and unspecified sites and tissues; Bone and articular cartilage
- 239.2, Neoplasms of unspecified nature; Bone, soft tissue, and skin
- 721.7, Spondylosis and allied disorders; Traumatic spondylopathy
- 724.3, Other and unspecified disorders of back; Sciatica
- 732.8, Other specified forms of osteochondropathy
- 756.19, Anomalies of spine; Other

Response: We discussed these additional diagnosis codes recommended by the commenter with our medical advisors and they agree that the first three listed codes (213.2, 238.0, and 239.2) should be added because they are neoplasm codes. Therefore, they are clinically similar to the other neoplasm codes on our proposed list. Our medical advisors did not support the addition on the latter four codes because they are vague codes that do not necessarily represent significant conditions. Therefore, in this final rule, we are adding codes 213.2, 238.0, 239.2 to our list of conditions in DRG 546. We are not adding codes 721.7, 724.3, 732.8, or 756.19.

After careful consideration of the public comments received, in this final rule, we are establishing a new DRG 546 (Spinal Fusions Except Cervical with Curvature of the Spine or Malignancy). New DRG 546 will be composed of all noncervical spinal fusions previously assigned to DRGs 497 and 498 that have a principal or secondary diagnosis of curvature of the spine or a principal diagnosis of a malignancy. The principal diagnosis codes that will lead to this DRG assignment are the following:

- 170.2, Malignant neoplasm of vertebral column, excluding sacrum and coccyx
- 198.5, Secondary malignant neoplasm of bone and bone marrow
- 213.2, Benign neoplasm of bone and articular cartilage; vertebral column, excluding sacrum and coccyx
- 238.0, Neoplasm of uncertain behavior of other and unspecified sites and tissues; Bone and articular cartilage
- 239.2, Neoplasms of unspecified nature; bone, soft tissue, and skin
- 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
- 737.8, Other curvatures of spine
- 737.9, Unspecified curvature of spine
- 754.2, Congenital scoliosis
- 756.51, Osteogenesis imperfecta

The secondary diagnoses that will lead to the new DRG 546 assignment are:

- 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

d. CHARITE™ Spinal Disc Replacement Device

As we noted in our discussion of applications for new technology add-on payments for FY 2006 in section II.E. of the IPPS proposed rule (70 FR 23362), the applicant for new technology for CHARITE™ requested a DRG reassignment for cases involving implantation of the CHARITE™ Artificial Disc. CHARITE™ is a prosthetic intervertebral disc. On October 26, 2004, the FDA approved the CHARITE™ Artificial Disc for single level spinal arthroplasty in skeletally mature patients with degenerative disc disease between L4 and S1. The applicant requested a DRG assignment for these cases from DRG 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 of an inpatient stay to implant an artificial disc prosthesis are similar to spinal fusion and inclusion in DRGs 497 and 498 should be made consistent with section 1886(d)(5)(K) of the Act that indicates a clear preference for assigning a new technology to a DRG based on similar clinical or anatomical characteristics and costs. As indicated in section II.E. of this final rule, we did not find that CHARITE™ meets the substantial clinical improvement criterion and are not considering a DRG reassignment under the new technology provisions. However, we did evaluate whether to reassign CHARITE™ to a different DRG using the Secretary's authority under section 1886(d)(4) of the Act.

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 and final rules, we described the new DRG assignments for these new codes in Table 6B of the Addendum to those rules. We received a number of comments on the FY 2005 IPPS proposed rule recommending that we change the assignments for these codes from DRG DRGs 499 and 500 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 stated that we would continue to analyze this issue and solicited further public comments on the DRG assignment for spinal disc prostheses.

We received a number of public comments in response to the FY 2006 proposed rule. A summary of the comments and our responses follow.

Comment: One commenter supported our recommendation to keep the CHARITE™ spinal disc procedure code in DRGs 499 and 500. The commenter took no position on CMS' decision on whether to grant add-on payment for new technology for the CHARITE™ spinal disc procedure. However, the commenter stated that until further data becomes publicly available, it would be premature to reassign spinal disc prostheses to DRGs 497 and 498. The commenter stated that waiting for Medicare data would be consistent with the approach CMS used in considering changes to DRGs 497 and 498 for account for multilevel spinal fusion. (We did not propose a change for FY 2006 to account for multilevel spinal fusions because sufficient data were not available in MedPAR under the new multilevel spine fusion procedure codes.) The commenter also stated that the spinal fusion DRGs were well-established based on several years of utilization and accrual of cost experience. Without a fuller understanding of the expected resource use of cases with spinal disc prostheses, the commenter was concerned that reassignment of these procedures to DRGs 497 and 498 may have the potential to cause an inappropriate reduction in future weights for spinal fusion. Therefore, the commenter recommended that spinal disc replacements be kept in DRGs 499 and 500 until data are available to evaluate this change.

Response: We agree with the commenter that our policy is to assign a new procedure code to a DRG based on the assignment of its predecessor code until we have Medicare charge data to evaluate a DRG modification. We also agree that the spinal fusion cases are well-established based on several years of utilization and cost experience. Without Medicare data that shows Medicare charges for CHARITE™ artificial discs in DRGs 499 and 500 and until we receive Medicare charge data using the new procedure codes, it is difficult to evaluate a request for a DRG modification.

Comment: Eight commenters opposed our proposal of keeping CHARITE™ artificial discs in DRGs 499 and 500 until we received Medicare charge data. These commenters recommended that the CHARITE™ spinal disc procedure (code 84.65) be moved out of DRGs 499 and 500 and into the spinal fusion DRGs (DRG 497 and 498). According to the commenters, the current DRG assignment to DRGs 499 and 500 provides a very significant economic disincentive for hospitals to use CHARITE™ in the Medicare population. Based on information submitted with its new technology application, these commenters argued that hospital resources for patients receiving CHARITE™ artificial discs are most closely comparable to patients in DRGs 497 and 498 (the data provided to support the new technology application are discussed in detail in section II.E. of this final rule). The commenters also stated that the Health Service Cost Review Commission (HSCRC) of Maryland developed new artificial disc DRGs for its DRG system.

Response: With respect to the commenter's point regarding the HSCRC, we acknowledge that they recently decided to create new DRGs for artificial disc patients. We understand that the HSCRC established these new DRGs with relative weights that are higher than DRGs 499 and 500 and less than the spinal fusion DRGs (DRGs 497 and 498). We are unaware of the criteria that the HSCRC uses for creating separate DRGs. Currently, we do not have a basis for creating a separate DRG for spinal disc protheses because we have no FY 2004 Medicare charge data that could be used to set the FY 2006 relative weight. Therefore, we are unable to adopt an option similar to that of the HSCRC at this time.

For its new technology application, we note that the applicant supplied cost data for 376 total cases where CHARITE™ was actually used, including 12 cases involving Medicare patients. The data for the 12 Medicare patients did not come from the MedPAR data systems because that information is not yet available due to the fact that give that FDA approval and the code used to identify these patients was not effective until October 2004. Thus, as with all new technology applications, the data supporting whether the technology meets the cost criterion came directly from the applicant and not from Medicare's data systems. While the applicant also supplied data from the FY 2003 MedPAR file, we note that these cases did not actually involve the CHARITE™ artificial disc. Rather the applicant modified the claims data for spinal fusion cases by removing the medical and surgical costs associated with the spinal fusions. The applicant then replaced these costs with costs represented to be those of a typical CHARITE™ artificial disc. These data are acceptable to evaluate whether a new technology meets the cost criterion in a new technology application because, by definition, there is limited or no Medicare data upon which to evaluate a new technology's costs. However, these data do not meet the standards that we apply for making a change to a DRG. That is, we use the predecessor code for a new technology until we have evidence from Medicare's data systems that suggest a change to the DRG assignment is warranted.

As stated previously, we do not have Medicare charge information to evaluate a DRG change at this time. For this reason, we are not making a change to the DRG assignment for CHARITE™. However, we will consider whether a DRG reassignment for CHARITÉ™ is warranted for FY 2007, once we have information from Medicare's data system that will assist us in evaluating the cost of these patients.

8. 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 as a principal diagnosis 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 again addressed this issue in the FY 2006 IPPS proposed rule

(70 FR 23329) as we had in the FY 2005 IPPS final rule (69 FR 48975). In both instances, we did not believe 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. For this reason, we did not propose a new DRG for severe sepsis for FY 2006.

Comment: Two commenters expressed concerns about the sequencing instructions for severe sepsis. They pointed out that current ICD–9–CM coding guidelines mandate that a code from category 038.x be sequenced as the principal diagnosis followed by code 995.92 for patients admitted in respiratory failure who also have severe sepsis. The commenters expressed concerns that this sequencing instruction results in lower hospital reimbursement for patients with severe sepsis placed on mechanical ventilation. These commenters did not recommend that CMS create a new DRG for patients with severe sepsis. Instead, they suggested that the codes or guidelines, or both, be modified so that other conditions can be sequenced as the principal diagnosis.

Response: We share the concern of the commenters about sequencing guidelines for patients with severe sepsis and respiratory failure. The current ICD–9–CM codes for systemic inflammatory response syndrome (SIRS), codes 995.91 through 995.94, that include severe sepsis mandate these sequencing guidelines. However, the National Center for Health Statistics (NCHS) discussed modifications to these codes at the April 1, 2005 ICD–9–CM Coordination and Maintenance Committee meeting. NCHS has scheduled this topic for further discussion at the September 29–30, 2005 Committee meeting. Suggestions for revising these codes and any resulting guidelines should be sent to Donna Pickett, NCHS, 3311 Toledo Road, Room 2402, Hyattsville, MD 2082, or to the e-mail address *dfp4@cdc.gov*.

Comment: One commenter expressed disappointment that CMS did not create a new DRG for severe sepsis. The commenter disagreed with our statement that these patients could not be easily identified within our Medicare data. The commenter stated that severe sepsis is a systemic inflammatory syndrome in response to infection that is associated with acute organ dysfunction. The commenter suggested that CMS use the SIRS ICD–9–CM codes for infection plus organ dysfunction along with an ICD–9–CM procedure code for organ support such as ventilation management (code 96.7x), acute renal replacement (codes 39.95 and 54.98), or vasopressor support (code 00.17), to identify these patients. The commenter recommended that CMS create two new DRGs, one for medical severe sepsis patients with organ support and another for surgical severe sepsis patients with organ support. The commenter recommended that these two DRGs be assigned as pre-MDCs.

Response: There were extensive discussions about the problems in using the current SIRS codes at the March 31–April 1, 2005 ICD–9–CM Coordination and Maintenance Committee meeting. A summary report of this meeting can be found at the Web site: *http://www.cdc.gov/nchs/icd9cm*. As stated earlier, NCHS has scheduled further discussions on this topic for the September 29–30 Committee meeting.

Given the considerable confusion among the coding community regarding the use of these codes, we believe it would be premature to consider new DRGs for severe sepsis patients at this time. Therefore, we are not making revisions to the DRG for severe sepsis patients at this time. We will continue to work with NCHS to improve the codes so that our data on these patients improve. We will continue to examine data on these patients as we consider future modifications.

9. 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. As indicated in the FY 2006 IPPS 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 did not propose changes to the current structure of DRGs 521 through 523 for FY 2006.

Comment: One commenter expressed concern that CMS did not propose any DRG change to code 292.82, drug-induced dementia. The commenter stated that a patient admitted with dementia due to an adverse effect of a drug would result in code 292.82, followed by the appropriate E code as a secondary diagnosis, grouping to one of the alcohol and drug abuse DRGs (521 through 523). The commenter indicated an adverse effect of a drug should not be confused with alcohol or drug abuse and recommended that CMS examine the potential impact of not reassigning code 292.82 into a new DRG from both a quality of care and a financial perspective.

Response: We appreciate the commenter's recommendation. However, as we indicated above and in the FY 2006 IPPS proposed rule, drug-induced dementia develops as a result of *use* of a drug. Therefore, it is appropriate to assign the code to DRGs 521, 522, or 523. As we indicated in the FY 2006 proposed rule (70 FR 23330), we did receive suggestions that drug-induced dementia due to the adverse effects of a drug or poisoning be assigned to DRGs 429, 449, 450, or 451. However, we believe these DRGs should only be assigned when the hospital uses the appropriate poisoning or other codes sequenced as the principal diagnosis. In addition, the data analyzed from the FY 2004 MedPAR file did not support a modification to DRGs 521 through 523. Our data show that hospital charges for patients assigned to DRGs 521 through 523 with a principal diagnosis of code 292.82 and no drug abuse secondary diagnosis were similar to other patients in these DRGs. Given that no other secondary diagnosis codes were used, it is not possible to know whether these patients were more clinically similar to patients in DRGs 426, 449, 450, 451, or 521 through 523. Absent any other diagnoses other than code 292.82, we have no evidence that these patients were clinically different than other patients in DRGs 521 through 523.

After consideration of the comments received, as we proposed, in this final rule we are not changing the DRG assignment for drug-induced dementia (code 292.82) for FY 2006.

10. Medicare Code Editor (MCE) Changes

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 DRGs 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, as we proposed we are not making the commenter's suggested changes to the MCE ''newborn age edit'' for FY 2006.

Comment: One commenter requested that CMS reconsider making the necessary revisions to the ''newborn age edit'' and other pediatric data. The commenter suggested that if CMS continues its current stance regarding the internal level of expertise to develop newborn and pediatric edits, then these edit should be removed from the MCE.

Response: We believe the commenter's recommendation to remove the newborn and pediatric edits from the MCE has merits and will consider it for FY 2007. However, we believe it is important that we have an opportunity to analyze this issue further and consider any comments from interested parties before eliminating these edits.

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''. In the FY 2006 IPPS proposed rule, we proposed to remove code 796.6 from these two edits and add it to the ''Newborn Diagnoses'' edit.

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

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, in the FY 2006 IPPS proposed rule, we proposed 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 proposed to remove code 257.2 from the ''Male Only'' gender edit in the MCE.

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

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 proposed to add code 305.1 to the MCE edit ''Questionable Admission-Principal Diagnosis Only'' in order to make tobacco use disorder a noncovered admission.

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

e. Noncovered Procedure Edit

Effective October 1, 2004, CMS adopted the use of code 00.61 (Percutaneous angioplasty or atherectomy 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 proposed to remove codes 00.61, 00.63, and V70.7 from the MCE noncovered procedure edit.

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

f. Error in Non-Covered Procedure Edit—code 36.32

It has come to our attention that an entry in the Non-Covered Procedures section of the MCE was made in error. Procedure code 36.32 (Other transmyocardial revascularization) is covered as a late or last resort for patients with severe (Canadian Cardiovascular Society classification Classes III or IV) angina (stable or unstable). The angina symptoms must be caused by areas of the heart not amenable to surgical therapies. Therefore, as code 36.32 is erroneously in the Non-Covered Procedure edit in the MCE, we are removing it from the edits for FY 2006.

11. Surgical Hierarchies

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

Because the relative resource intensity of surgical classes can shift as a function of DRG reclassification and recalibrations, we reviewed the surgical hierarchy of each MDC, as we have for previous reclassifications and recalibrations, to determine if the ordering of classes coincides with the intensity of resource utilization.

A surgical class can be composed of one or more DRGs. For example, in MDC 11, the surgical class ''kidney transplant'' consists of a single DRG (DRG 302) and the class ''kidney, ureter and major bladder procedures'' consists of three DRGs (DRGs 303, 304, and 305). Consequently, in many cases, the surgical hierarchy has an impact on more than one DRG. The methodology for determining the most resource-intensive surgical class involves

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

This methodology may occasionally result in assignment of a case involving multiple procedures to the lower-weighted DRG (in the highest, most resource-intensive surgical class) of the available alternatives. However, given that the logic underlying the surgical hierarchy provides that the GROUPER search for the procedure in the most resource-intensive surgical class, 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, in the FY 2006 IPPS proposed rule (70 FR 23332), we proposed 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 proposed reordering—

- 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).

Comment: Several commenters agreed with the proposed changes in the surgical hierarchy for MDC 5.

Response: We appreciate the commenters' support. However, because in this final rule we are deleting 9 DRGS and creating 12 new DRGs in MDC 5, as discussed under ''MedPAC Recommendations'' in section IX.A of this preamble, we are reordering the following DRGs in MDC 5:

- DRG 106 (Coronary Bypass With PTCA) above DRGs 547 and 548 (Coronary Bypass With Cardiac Catheterization With and Without Major CV Diagnosis, respectively);
- DRGs 547–548 above DRGs 549 and 550 (Coronary Bypass Without Cardiac Catheterization With and Without Major CV Diagnosis, respectively);
- DRG 113 (Amputation For Circulatory System Disorders Except Upper Limb or Toe) above DRG 551 (Permanent Cardiac Pacemaker Implant With Major CV Diagnosis or AICD Lead or Generator);
- DRG 551 above DRG 552 (Other Permanent Cardiac Pacemaker Implant Without Major CV Diagnosis);
- DRG 552 above DRG 557 (Percutaneous Cardiovascular Procedure With Drug Eluting Stent With Major CV Diagnosis);
- DRG 557 above DRG 555 (Percutaneous Cardiovascular Procedure With Major CV Diagnosis);
- DRG 555 above DRG 558 (Percutaneous Cardiovascular Procedure With Drug Eluting Stent Without Major CV Diagnosis);
- DRG 558 above DRG 556 (Percutaneous Cardiovascular Procedure Without Major CV Diagnosis);
- DRG 556 above DRG 518 (Percutaneous Cardiovascular Procedure Without Coronary Artery Stent Or AMI);
- DRG 518 above DRG 553 (Other Vascular Procedures With CC With Major CV Diagnosis);
- DRG 553 above DRG 554 (Other Vascular Procedures With CC Without Major CV Diagnosis);
- DRG 554 above DRG 479 (Other Vascular Procedures Without CC).

In MDC 8, we proposed to reorder—

- DRG 496 (Combined Anterior/Posterior Spinal Fusion) above DRG 546 (Spinal Fusions Except Cervical With Curvature of the Spine or Malignancy).
- DRG 546 above DRGs 497 and 498 (Spinal Fusions 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).

Comment: Several commenters agreed with the proposed changes in the surgical hierarchy for MDC 8.

Response: We appreciate the commenters' support. Based on a test of the proposed revisions using the March 2005 update of the FY 2004 MedPAR file and the revised GROUPER software, we found that the revisions to MDC 8 are still supported by the data.

Accordingly, in this final rule, we are adopting the proposed change in the surgical hierarchy for MDC 8 as final, without modification.

12. Refinement of Complications and Comorbidities (CC) List

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 1986 DRG data to the 2004 DRG 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 Extremities	376

Conversely, our medical experts believe the following conditions are examples of common conditions that are on the CC list, but are not likely 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, as indicated in the FY 2006 IPPS proposed rule, 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 indicates that 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 significant structural 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. In the FY 2006 IPPS proposed rule, we encouraged comment 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.

Comment: Several commenters agreed with CMS that changes in resource utilization and in inpatient hospital care, particularly the focus on decreasing length of stay, may be resulting in the CC distinction not being able to differentiate resource utilization and patient severity as well as it has in the past. Several commenters agreed that it may be valuable to conduct a substantial and comprehensive review of the CC list for the future. While some commenters applauded CMS' efforts to keep refining the DRG system, the commenters believed that review of the CC list can only be taken as an interim step and a more refined DRG system can only be accomplished with more specific clinical classification systems capable of providing more complete information about a patient's condition and the services provided to treat those conditions—namely, ICD–10–CM and ICD–10–PCS. Some commenters suggested waiting to adopt the MedPAC recommendations until these new coding classification systems are implemented.

MedPAC stated that a comprehensive review and revision of the CC list might lead to a desirable improvement in the extent to which payment rates reflect patient severity of illness. However, MedPAC does not expect that even a major revision of the list would greatly improve the extent to which the IPPS payment rates recognize the effects of differences in patient severity of illness. MedPAC noted that the CC distinction is based entirely on the presence or absence of any CC, implicitly assuming that all CCs have equal effects on severity of illness and costs. Even if the CC review process were to correctly identify all secondary diagnoses that significantly affect hospitals' costs, MedPAC's research and CMS' earlier work have shown that simply distinguishing between patients with and without CCs fails to capture large, predictable differences in costs among patients. MedPAC stated that further differentiation is necessary to make the most effective use of information about patients' secondary diagnoses and to help minimize opportunities for hospitals to benefit financially from patient selection.

Response: There has not been a comprehensive review of the CC list in over 20 years. Such a review may indicate that a more focused list will better distinguish the effects of CCs on severity of illness than earlier analysis. Until this comprehensive review and analysis are complete, we will not know whether there is merit in adopting a modification of the CC list or whether it will be necessary to adopt a more comprehensive change to the DRG system such as APR–DRGs. We currently plan to continue with our comprehensive review of the CC list. In addition, we expect shortly to engage a contractor highly experienced with DRG development to study the APR–DRGs over the next year. We appreciate the commenters' suggestions about waiting to adopt MedPAC's recommendations until ICD–10–CM and ICD–10–PCS have been implemented. While we do not have a proposal in place at this time to implement ICD–10–CM and ICD–10–PCS, before adopting any major changes to the DRG system, we will consider the implications of potential future changes to our coding systems as part of our analysis of MedPAC's recommendation.

Comment: Commenters gave numerous suggestions for performing the analysis of the CC list. The suggestions include:

- Analyze all diagnosis and procedures codes reported on the claim, not just nine diagnosis codes and six procedure codes.
- Examine the impact of multiple CCs on hospital resource consumption and length of stay.
- Examine further differentiation beyond simply distinguishing between patients with and without CCs to make the most effective use of information about patients' secondary diagnoses and minimize opportunities for hospitals to benefit financially from patient selection.
- Study the need for a general/standard list of CCs that addresses patient conditions across all body systems and a list of special severity conditions that are unique to specific population/diseases.
- Consider abandoning length of stay as an indicator for severity because, in today's clinical environment, length of stay is determined more by postacute care referral dynamics than patient need.
- Consider differentiating comorbidities from complications. The former are predictable and can be used to easily affect admission selection.
- Compare the existing CC list with those used with other DRG systems.
- Conduct the comprehensive review and analysis cautiously, systemically, and thoroughly, using external expertise and maintaining transparency and stakeholder involvement throughout the process, and do not rush the analysis simply to meet the deadline for the FY 2007 IPPS rule.
- Use open door forums to inform the public of progress.
- Consider combining the cases from each DRG pair in one homogenous DRG. Under such a change, hospitals would still receive the same total reimbursement for the same patients but would have more financial incentive to improve the quality and efficiency of care.
- Before inclusion as a CC condition, a diagnosis should meet the following four criteria: (1) The patient group represents a higher cost in that DRG than those without the comorbid condition; (2) the condition cannot be prevented, in any possible way, by superior care in the hospital; (3) the condition is not related to the principal diagnosis; and (4) there is at least some indication that the patient would face inadequate options for finding appropriate medical care without a more appropriate payment.

Response: We appreciate these many suggestions. As we indicated above, we will continue to conduct a thorough review of the CC list. We also will be engaging a contractor shortly to assist us with evaluating APR–DRGs and other mechanisms to better recognize severity in our payment systems.

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 a 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. We did not receive any comments specific to the diagnosis codes on the FY 2006 CC list. Therefore, as we proposed in the FY 2006 IPPS proposed rule, we are not deleting 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]

As proposed, we are making a limited revision of the CC Exclusions List to take into account the changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 2005. (See section II.B.14. of this preamble for a discussion of ICD–9–CM changes.) We are making these changes in accordance with the principles established when we created the CC Exclusions List in 1987.

We receive one comment that agreed with the revised CC Exclusion List based on the information provided.

Tables 6G and 6H in the Addendum to this final rule contain the revisions to the CC Exclusions List that will 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 will not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

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

Copies of the original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for $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 final 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 in hard copy for $250.00. Version 23.0 of the manual is also available on a CD for $200.00; a combination hard copy and CD is available for $400.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, CT 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

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

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:

[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.

- 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. We did not receive any comments on this provision. Therefore, in this final rule, we are not making 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 proposed to correct this error by moving code 26.12 out of DRG 468 and reassigning it to DRG 477. We received one comment in support of our proposal to move code 26.12 out of DRG 468 and reassign it to DRG 477. Therefore, we are adopting as final our proposal to move procedure code 26.12 out of DRG 468 and reassigning it to DRG 477. We received no comments opposing our plan of not moving any procedure codes from DRG 476 to DRGs 468 or 477 or from DRG 477 to DRG 468. Therefore, as we proposed, we are not moving 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, as we proposed, we are not adding any diagnosis codes to MDCs. We did not receive any comments on our proposal and are therefore not adding any diagnosis codes to any MDCs.

14. 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), the Centers for Disease Control and Prevention, 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 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

[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.

as the American Health Information Management Association (AHIMA), the American Hospital Association (AHA), and various physician specialty groups, as well as individual physicians, 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 final rule. The Committee held its 2005 meeting on March 31–April l, 2005. New codes for which there was a consensus of public support and for which complete tabular and indexing changes were made by May 2005 are included in the October 1, 2005 update to ICD–9–CM. Code revisions that were discussed at the March 31–April 1, 2005 Committee meeting were not finalized in time to include them in the FY 2006 IPPS proposed rule. These additional codes are included in Tables 6A through 6F of this final rule and are marked with an asterisk (*).

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 final rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. In the FY 2006 IPPS proposed rule, we only solicited 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 received consensus and that were finalized are included in Tables 6A through 6F of this 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 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 March 31–April 1, 2005 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 Web 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 section 503(a) of Pub. L. 108–173. Any midyear coding updates will be available through the Web sites 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 Web sites 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.

Comment: Five commenters recommended that CMS modify its DRG GROUPER and instruct fiscal intermediaries to expand the number of diagnoses processed from 9 to 25 and the number of procedures processed from 6 to 25. The commenters were concerned that CMS was not evaluating all reported diagnoses and procedures that could possibly affect a patient's severity of illness or the resources used, or both. The commenters pointed out that the current DRG GROUPER only considers 9 diagnoses and up to 6 procedures; that hospitals submit claims to CMS in electronic format, and that the HIPAA compliant electronic transaction standard, HIPAA 837i, allows up to 25 diagnoses and 25 procedures. The commenters stated that fiscal intermediaries are currently ignoring or omitting the additional codes (beyond 9 diagnoses and 6 procedures) submitted by hospital providers, since these additional diagnoses and procedures are not needed by the GROUPER to assign a DRG. Several commenters stated that, while it is important for inpatient acute hospitals, it is even more crucial for LTCHs whose patients are medically complex and have multiple illnesses beyond the nine diagnoses allowed by CMS. Several commenters further stated that a list of CCs qualifying for comorbidity adjustments for inpatient psychiatric facility services was only recently introduced under the new IRP PPS. Thus, the commenter added, these hospitals have not historically used the software available to sort and rearrange secondary diagnosis cods so that all CCs possibly affecting the DRG grouping are prioritized. One commenter stated that the continued use of more limited diagnosis and procedure codes acts as a disincentive for the reporting of additional codes, and will result in less precise assignment of DRGs.

Response: The commenters are correct that the current Medicare GROUPER does not process codes submitted electronically on the 837i electronic format beyond the first 9 diagnoses and the first 6 procedures. This limitation is not being imposed by the GROUPER. CMS made the decision to process only the first 9 diagnosis codes and first 6 procedure codes. While HIPAA requires CMS to accept up to 25 ICD–9–CM diagnosis and procedure codes on the HIPAA 837i electronic format, it does not require that CMS process that many diagnosis and procedure codes.

As suggested by the commenters, there is value in retaining additional data on patient conditions that would

result from expanding Medicare's data system so it can accommodate additional diagnosis and procedure codes. We will consider this issue further as we contemplate further refinements to our DRG system to better recognize patient severity. However, while it would be a simple matter to modify our GROUPER software to accept and evaluate 25 diagnosis and 25 procedure codes, extensive lead time to allow for modifications to our internal and contractors' electronic systems would be necessary before we could process and store this additional information. We are unable to move forward with this recommendation without carefully evaluating implementation issues. Nevertheless, we plan to proceed with this evaluation as we consider further changes to our DRG systems.

Comment: Many commenters recommended that CMS act immediately to adopt coordinated implementation of ICD–10–CM and ICD–10–PCS in the United States. Some of these commenters noted that Pub. L. 108–173 (MMA) included report language urging the Secretary to move forward with the implementation of ICD–10 as quickly as possible. The commenters noted that the National Committee on Vital and Health Statistics (NCVHS) raised concerns about the viability of ICD–9–CM in 2003 and stated it was ''increasingly unable to address the needs for accurate data for health care billing, quality assurance, public health reporting, and health services research.'' The commenter further noted that the NCVHS recommended in 2003 that DHHS act expeditiously to initiate the regulatory process for adoption of ICD–10–CM and ICD–10–PCS. The commenter stated that, as of 2005, ''we are still awaiting a process from HHS to begin this important transition.'' While some of the commenters acknowledged the complexities involved with the transition from ICD–9–CM to ICD–10, the commenters still recommended that we act quickly to begin adoption of ICD–10. Other commenters also indicated that the 4-digit structure of ICD–9–CM is limiting the ability of the procedure coding system to identify new procedures and new technologies and it is becoming increasingly outdated. According to these commenters, it is becoming more difficult each year to make changes to the ICD–9–CM coding system because of the availability of new codes. One commenter noted that several participants at the March 31–April 1, 2005 ICD–9–CM Coordination and Maintenance Committee ''appeared to be advocating a higher threshold for the award of new codes based on the ever decreasing number of available codes under ICD–9–CM.'' Many of the commenters indicated that the coding system's limitations are making it difficult to compare outcomes and efficacy between older and newer technologies, identify costs associated with the new technology, or revise reimbursement policies to appropriately reflect the cost of patient care when new technology is used. One commenter indicated that failure to recognize the looming problems with the ICD–9–CM coding system will impede efforts to meet the President's goal of adopting electronic health records by 2013.

Many of the commenters referred to ICD–10–PCS as the next generation of coding systems. They stated that ICD–10–PCS would modernize and expand CMS' capacity to keep pace with changes in medical practice and technology. In addition, these commenters stated that the structure of ICD–10–PCS would incorporate all new procedures as unique codes that would explicitly identify the technology used to perform the procedure.

Response: We agree that it is becoming increasingly difficult to update ICD–9–CM. However, we are continuing to make revisions to ICD–9–CM and create codes that recognize new medical technology. We continue to update ICD–10–PCS on an annual basis to keep it up to date with changing technology. We agree that it is important to have an accurate and precise coding system for this purpose. However, as noted by many of the commenters, the transition from one coding system to another raises many complex operational issues. The Department will continue to study this matter as we consider whether to adopt ICD–10.

15. Other Issues

a. 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 did not believe that there is a sufficient difference between the average charges and average length of stay for these cases to justify proposing a change to the DRG assignment for treating this condition.

Comment: One commenter agreed with our proposal not to modify the DRG assignment for acute intermittent porphyria, code 277.1, to DRG 229 due to the minor variance in average charges and length of stay between porphyria cases and other cases in this DRG.

Response: We appreciate the commenter's support of our proposal. Review of the MedPAR data did not demonstrate a significant disparity in the average charges compared to average length of stay.

For FY 2006, as we proposed, we are not modifying the DRG assignment for code 277.1 (Acute intermittent porphyria) to DRG 229.

b. Prosthetic Cardiac Support Device (Code 37.41)

Code 37.41 (Implantation of prosthetic cardiac support device around the heart) was addressed in the FY 2006 IPPS proposed rule only as a notification in Table 6B that the new code was being created to describe a prosthetic cardiac support device (70 FR 23594). Code 37.41 was deemed to be an O.R. procedure and was assigned to MDC 5 (Diseases and Disorders of the Circulatory System), DRGs 110 and 111 (Major Cardiovascular Procedures With and Without CC, respectively). This device is being marketed as the CorCap™ Cardiac Support Device and is intended to prevent and reverse heart failure by improving the heart's structure and function.

This topic was discussed at the ICD–9–CM Coordination and Maintenance Meeting on October 7, 2004. At that time, there was no specific ICD–9–CM code that more precisely identified this procedure, so coders were advised to use code 37.99 (Other operations on

heart and pericardium) to describe the operation. Code 37.99 is currently assigned to DRGs 110 and 111.

As is our established pattern, we assign a new code to its predecessor code's DRG until we obtain a pattern of use of the code in the MedPAR data file. After we have evidence-based justification for reassignment of codes within DRGs, we are better able to make decisions about the most appropriate placement of those new codes.

We received 11 comments on this topic as part of the comments on the FY 2006 IPPS proposed rule.

Comment: Most of the commenters responding were cardiovascular surgeons who were principal investigators participating in the United States' CorCap™ clinical trials. All of the commenters requested that we reconsider the assignment of the prosthetic cardiac support device from DRGs 110 and 111 to DRG 108, where the resources [in DRG 108] more closely approximate those associated with implantation of the device. The commenters stated that procedures in DRG 108 are more clinically similar to the implantation of the prosthetic cardiac support device, being exclusively performed on the internal or external structures of the heart and generally requiring access through a sternotomy.

One commenter likened this procedure to the maze procedure, described by code 37.33 (Excision or destruction of other lesion or tissue of heart, open approach). Another commenter compared it to transmyocardial revascularization, described by code 36.31 (Open chest transmyocardial revascularization). Both of these procedure codes are assigned to DRG 108. Commenters also stated that classification of this procedure to DRGs 110 and 111 would establish a financial disincentive for hospitals to adopt this potentially life-saving and cost-reducing treatment for Medicare beneficiaries suffering from a problem that may otherwise require implantation of a ventricular assist device or heart transplant.

Response: As noted above, we have classified procedure 37.41 to the same DRG as its predecessor code, in accordance with our established policy. Until we have Medicare billing data that will allow us to assess whether the new procedure code has been correctly assigned, our default position is to assign a new procedure code to the same DRG as its predecessor code. Of major concern to CMS is the late June 2005 decision by an FDA advisory panel urging FDA to reject approval of the CorCap™ device on the basis that the panel had not seen sufficient evidence of benefit for patients with heart failure. The FDA's concerns included the efficacy of the device in achieving a longer lifespan for patients, and the possibility that the device's benefits did not outweigh the risks of surgery. In addition, the FDA advisory panel had other concerns, including whether the application of this device around the ventricles of the heart might make future heart surgeries more difficult.

Code 37.41 is too new to be included in the MedPAR data. Therefore, we will continue to monitor this prosthetic cardiac support device in future IPPS updates. As noted above, should FDA approve this device and should there be an evidence-based justification for reassignment of codes within these DRGs, we will be open to making changes to the DRG structure.

c. Coronary Intravascular Ultrasound (IVUS) (Procedure Code 00.24)

Procedure code 00.24 (Coronary intravascular ultrasound) was addressed in the FY 2005 IPPS proposed rule only as a notification in Table 6B that for FY 2005 a new code had been created to describe this imaging technique (69 FR 49624). Code 00.24 describes ultrasonic imaging within the coronary vessels. It was not assigned ''O.R.'' status within the GROUPER program; that is, the presence or absence of this code does not affect a claim's DRG assignment or payment.

We received one comment on this procedure code as part of the public comments on the FY 2006 IPPS proposed rule.

Comment: One commenter noted that IVUS is an added cost to hospitals. The commenter stated that it has conducted an analysis of coronary IVUS resource use in calendar year 2004 hospital data to determine possible impact. The commenter reported its findings that, in DRGs 516, 517, 526, and 527, cases utilizing IVUS had higher total charges and higher total costs. The commenter requested that CMS perform an analysis of FY 2005 coronary IVUS cases and consider reassigning ICD–9–CM procedure code 00.24 to DRGs where the average resource use most closely approximates the resource use of cases in which an IVUS technique has been employed.

Response: We will perform the requested data analysis using FY 2005 MedPAR data for the FY 2007 annual IPPS update.

d. Islet Cell Transplantation

Islet cell transplantation was not a topic addressed in the FY 2006 IPPS proposed rule. The issue of payment for pancreatic islet cell transplantation in clinical trials was addressed in detail in the FY 2005 IPPS final rule (69 FR 48950). At that time, we discussed section 733(b) of Pub. L. 108–173, which provides that Medicare payments, beginning no earlier than October 1, 2004, for the routine costs as well as the costs of the transplantation and appropriate related items and services will be allowed for Medicare beneficiaries who are participating in clinical trials as if such transplantations were covered under Medicare Part A or Part B. In addition, the DRG payment will be supplemented by an add-on payment that includes pre-transplant tests and services, pancreas procurement, and islet isolation services. Cases were assigned to DRG 315 (Other Kidney and Urinary Tract Procedures).

We received one comment on this topic as part of the public comments on the FY 2006 IPPS proposed rule.

Comment: One commenter was concerned that the proposed relative weight for DRG 315 published in the FY 2006 IPPS proposed rule represented a decrease of almost 33 percent. The commenter also indicated that it continues to believe that this procedure is inappropriately classified, and suggested that these cases be reassigned into pre-MDC DRG 513 (Pancreas Transplant). The commenter believed the suggested DRG change is justified because islet cell and pancreas transplants involve substantially similar patient populations. The commenter further pointed out that the transplants both serve the same clinical function—that of freeing the patient from insulin dependence. The commenter requested that CMS identify those admissions in DRG 315 that involve islet cell transplantation and determine the actual costs involved to decide whether islet cell transplant cases should be reclassified to DRG 513.

Response: We do not understand why the commenter believes that the relative weight for DRG 315 decreased by 33 percent. The FY 2006 proposed relative weight (2.0801 (see Table 5 of the FY 2006 proposed rule, 70 FR 23587)) is approximately 0.3 percent less than the FY 2005 relative weight (2.0861 (see Table 5 of the FY 2005 final rule, 69 FR 49603)). We have reviewed the MedPAR data for the first quarter of FY 2005, and have found no cases of islet cell transplantation in DRG 315. Therefore, we do not have a basis for comparison of islet cell transplantation cases to the remainder of the cases in DRG 315. We also take this opportunity to clarify that the DRGs are groupings of cases that are similar both from a clinical perspective

as well as a resource-intensity perspective. While the commenter's position is that the same clinical endpoint is attempted with both islet cell transplantation and pancreas transplant, the result or endpoint of treatment results is not one of the axis upon which the DRGs are structured. In addtion, the pancreas transplant involves an open abdominal procedure in which one pancreas is surgically removed and a cadaveric pancreas is transplanted. Conversely, islet cells are infused via catheter. Therefore, from the standpoint of clinical similarity, we do not believe that the cases are comparable enough to consider putting the islet cell transplantation into DRG 513.

Comment: The same commenter was concerned about payment for islet cell transplants under a National Institutes of Health (NIH) clinical trial. The commenter believed that the $18,848 islet cell isolation add-on amount is insufficient. This commenter also believed that the data used to calculate the add-on amount were inadequate to form the basis for establishing payment.

Response: The $18,848 isolation add-on amount was based on the best data available, and we remain convinced that it is an appropriate payment for isolating the islet cells from one pancreas. However, we have learned that it typically requires two isolations to acquire enough cells for one infusion. Therefore, while we will maintain the current rate of $18,848 per isolation, we will pay up to two islet isolations per discharge. If only one islet isolation is necessary, Medicare will make an add-on payment of $18,848; if two are necessary, Medicare will make an add-on payment of $37,696. In cases that require two islet isolations, CMS will pay for two pancreata. Pancreata will continue to be paid as a cost pass-through.

We will review the MedPAR data as requested using more complete FY 2005 MedPAR data during our next annual IPPS update for FY 2007.

C. Recalibration of DRG Weights

We are using 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 March 31, 2005, 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 12,006,022 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 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/or intestinal, 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/or intestinal, and lung transplants is limited to those facilities that have received approval from CMS as transplant centers.)
- Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.
- Charges were standardized to remove the effects of differences in area wage levels, indirect medical education and disproportionate share payments, and, for hospitals in Alaska and Hawaii, the applicable cost-of-living adjustment.
- The average standardized charge per DRG was calculated by summing the standardized charges for all cases in the DRG and dividing that amount by the number of cases classified in the DRG. A transfer case is counted as a fraction of a case based on the ratio of its transfer payment under the per diem payment methodology to the full DRG payment for nontransfer cases. That is, a transfer case receiving payment under the transfer methodology equal to half of what the case would receive as a nontransfer would be counted as 0.5 of a total case.
- Statistical outliers were eliminated by removing all cases that are beyond 3.0 standard deviations from the mean of the log distribution of both the charges per case and the charges per day for each DRG.
- The average charge for each DRG was then recomputed (excluding the statistical outliers) and divided by the national average standardized charge per case to determine the relative weight.

The new weights are normalized by an adjustment factor of 1.47462 so that the average case weight after recalibration is equal to the average case weight before recalibration. This adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS.

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 DRG weights for FY 2006. Using the FY 2004 MedPAR data set, there are 41 DRGs that contain fewer than 10 cases. We 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 final rule, we are making a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Comment: One commenter noted that there is a reduction in the proposed weights for DRG 103 (Heart Transplant or Implant of Heart Assist System) and DRG 512 (Simultaneous Pancreas/Kidney Transplant). According to the commenter, the proposed weights represent a 6-percent reduction in DRG 103 and an 11-percent reduction in DRG 512. The commenter inquired as to whether these reductions may have

resulted from a methodological change in the way organ acquisition costs are addressed in the DRG weighting process.

Response: There is no change in the calculation of the DRG relative weight. 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.

As described above, the relative weight for each DRG is calculated by comparing the average charge for cases within each DRG (after removing statistical outliers) with the national average charge per case. Therefore, there are several factors that can cause a shift in the relative weight of a DRG from one fiscal year to the next. For example, even though the average charges of cases within DRG 103 increased from $278,096 in the FY 2005 final rule to $285,317 in the proposed rule, it did not increase by an equal or greater percentage than the national average. As a result, the DRG weight for DRG 103 declined. For DRG 512, the average charges decreased from $85,630 in the FY 2005 final rule to $83,113 in the proposed rule which accounts for the decline in the weight.

Comment: One commenter pointed out three typographical errors in DRG titles in Table 5 (List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric and Arithmetic Mean Length of Stay) in the Addendum to the FY 2006 IPPS proposed rule. The commenter indicated that the title for DRG 14 should read ''Intracranial Hemorrhage or Cerebral Infarction'' based on the change in FY 2005 IPPS final rule (69 FR 48927) and the title for DRG 315 should read ''Other Kidney & Urinary Tract Procedures'' based on the change in the FY 2003 IPPS final rule (67 FR 49993). The commenter also pointed out a misspelling of the word ''Malignant'' in the title for DRG 276.

Response: The commenter is correct. We have made these corrections in Table 5 in the Addendum to this final rule.

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

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 Rate Year (RY) 2006 LTCH PPS final rule (70 FR 24173 through 24175), 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. However, this policy change will have no effect 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.

As we explained in the FY 2006 IPPS proposed rule (70 FR 23338 through 23339), 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) and in section II.B. 14. of this final rule. 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 RY 2006 LTCH PPS final rule (70 FR 24173 through 24175) and the FY 2006 IPPS proposed rule (70 FR 23338 through 23339), 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 both the RY 2006 LTCH PPS final rule (70 FR 24174) and the FY 2006 IPPS proposed rule (70 FR 23339), 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), and in section II.B.13. of this preamble, 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 diagnosis 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 coding updates will be available through the Web sites 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, because 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) and in section II.B.14. of this preamble, 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. We note 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 Coordination and Maintenance Committee since 1995. Requestors will be given the opportunity to present the merits for a 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.

However, as we explained in the FY 2006 IPPS proposed rule (70 FR 23339), at the October 2004 ICD–9–CM Coordination and Maintenance Committee meeting, there were no requests for an April 1, 2005 implementation of ICD–9–CM codes, 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 update to the ICD–9–CM coding system for FY 2006 is discussed above in section II.B.14. of this preamble.

As we proposed in the FY 2006 IPPS proposed rule (70 FR 23339), in this final rule we are making revisions to the LTC–DRG classifications and relative weights, effective October 1, 2005 through September 30, 2006 (FY 2006), using the latest available data. As we proposed in that same IPPS proposed rule, the final LTC–DRGs and relative weights for FY 2006 in this final rule are based on the final IPPS DRGs (GROUPER Version 23.0) discussed in section II. of the preamble to this final rule.

2. Changes in the LTC–DRG Classifications

a. Background

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

In accordance with section 307(b)(1) of Pub. L. 106–554 and § 412.515 of our existing regulations, the LTCH PPS uses information from LTCH patient records to classify patient cases into distinct LTC–DRGs based on clinical characteristics and expected resource needs. The LTC–DRGs used as the patient classification component of the LTCH PPS correspond to the DRGs under the IPPS for acute care hospitals. Thus, as we proposed in the FY 2006 IPPS proposed rule (70 FR 23339), in this final rule, we are establishing the use of the IPPS GROUPER Version 23.0 for FY 2006 to process LTCH PPS claims for LTCH discharges occurring from October 1, 2005 through September 30, 2006. The final 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 final rule.

Under the LTCH PPS, we determine relative weights for each of the DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristics 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 2006 IPPS proposed rule (70 FR 23340), 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. 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. Just as cases are classified 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 the ICD–9–CM codes.

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 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 time of discharge of the patient. Therefore, it is mandatory that the coders continue to report the same principal diagnosis on all claims and include all diagnosis 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 and is 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 and payment rates. 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 LTCH 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 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

In the FY 2006 IPPS proposed rule (70 FR 23341), we proposed to calculate the proposed LTC–DRG relative weights for FY 2006 using total Medicare allowable charges from FY 2004 Medicare hospital bill data from the December 2004 update of the MedPAR file, which were the best available data at that time, and we proposed to use the proposed Version 23.0 of the CMS GROUPER used under the IPPS (as discussed in that same proposed rule) to classify cases. To calculate the LTC–DRG relative weights for FY 2006 in this final rule, we obtained total Medicare allowable charges from FY 2004 Medicare hospital bill data from the March 2005 update of the MedPAR file, which are the most recent available data, and we used the Version 23.0 of the CMS GROUPER used under the IPPS (as discussed in section II.B. of this preamble) to classify cases. In the FY 2006 IPPS proposed rule (70 FR 23341), we stated that ''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 final rule, we are using the best available data, that is, the March 2005 update of the MedPAR file.

As we discussed in the FY 2006 IPPS proposed rule (70 FR 23341), 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 final 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 2004 MedPAR file.

In the FY 2005 IPPS final rule (69 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 noted above, in the FY 2006 IPPS proposed rule, we proposed to calculate the proposed LTC–DRG relative weights for FY 2006 using the December 2004

update of the MedPAR file, which were the most recent available data at that time. As stated above, in this final rule, we are using the March 2005 update of the FY 2004 MedPAR file for the determination of the FY 2006 LTC–DRG relative weights as these are the best available data. As we discussed in the FY 2006 IPPS proposed rule (70 FR 23341), based on an analysis of LTCH claims data from 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 FY 2006 LTC–DRGs and relative weights presented in that proposed rule or in this final rule.

Comment: Several commenters cited a study that concluded that the claims data used to develop the proposed LTC–DRG relative weights (that is, the December 2004 update of the FY 2004 MedPAR file) contain irregularities or errors. The commenters' concern was based on a comparison, by a private research group that was commissioned by one of the commenters, of the LTCH FY 2004 MedPAR data to the internal records of one LTCH. The commenters were specifically concerned that the MedPAR data may underrepresent interrupted stay cases and cases during which the beneficiary exhausted Medicare Part A benefits. In addition to the possible underrepresentation of interrupted stay and exhausted benefit cases, these commenters indicated that they had reviewed the FY 2004 MedPAR data used to develop the proposed FY 2006 LTC–DRG relative weights and asserted that there are some cases in the FY 2004 MedPAR file that include overstated or understated charges. They also indicated that there were ''missing'' LTCH cases that they believe should be included in the MedPAR file. The commenters further believed that the missing LTCH cases may be the consequence of ''a high level of suspended claims which were occurring due to the transition [to a different billing system during FY 2004].'' Specifically, the commenters stated that because payment for these suspended claims was received by April 2004, their claims and associated charges for these cases should have been reflected in the December 2004 update of the FY 2004 MedPAR file that was used to compute the proposed FY 2006 LTC–DRG relative weights.

The commenters believed that such errors or irregularities may be the source of the observed decrease in the average charges of many LTC–DRGs. Therefore, they urged CMS to reexamine the MedPAR data to ensure that the charges for all cases are fully accounted for in computing the final FY 2006 LTC–DRG relative weights.

The commenter who commissioned the study gave a number of examples of the alleged irregularities/errors in LTCH claims in the FY 2004 MedPAR file. The commenter's findings from a comparison of one provider's internal records and data reported in the December 2004 update of the FY 2004 MedPAR file, which were used in setting the proposed LTC–DRG relative weights, were extrapolated to all LTCHs and then the proposed FY 2006 LTC–DRG relative weights were recalculated ''to correct for these errors.'' The commenter challenged the integrity of the proposed LTC–DRG relative weights, as well as the final relative weights, which would be based on a more recent update (March 2005) of the FY 2004 MedPAR file, in keeping with our historical practice that uses the best available data for computing payment adjustments for all Medicare PPSs.

Response: After an extensive analysis of the data submitted by one of the commenters, we do not agree with the commenters' assertion that the proposed FY 2006 LTC–DRG relative weights are based on faulty claims data in the FY 2004 MedPAR file. We believe that the use of highly case-specific and interim data drawn from the claims records of one LTCH to challenge the integrity of the LTCH claims in the entire FY 2004 MedPAR file is inappropriate. Our analysis did not reveal systemic problems that would have undermined the data upon which we based the proposed FY 2006 LTC–DRG relative weights or the data upon which we are basing our final FY 2006 LTC–DRG relative weights in this final rule (as discussed above). As indicated by our analysis of the issues presented by the commenter, detailed below, we continue to believe that the March 2005 update of the FY 2004 MedPAR file is the best available data for setting the FY 2006 LTC–DRG relative weights and it accurately reflects LTCH charges per discharge.

The comments were based on the commenters' analysis of one LTCH's data and the results of that analysis were extrapolated to the universe of LTCHs. We reviewed the LTCH data used by the commenter and compared that data to the data in both the December 2004 update of the FY 2004 MedPAR file that were used to determine the proposed FY 2006 LTC–DRG relative weights and in the March 2005 update of the FY 2004 MedPAR file that are being used to determine the final FY 2006 LTC–DRG relative weights in this final rule. The commenter raised four categories of alleged problems: missing discharges related to the exhaustion of Medicare Part A benefits; inaccurate representation of interrupted stay cases; cases not reported in the MedPAR file due to ''an atypical level of suspension of LTCH claims''; and cases with incorrectly reported charges (overstated or understated). Our analysis revealed that rather than being distinct problems, three of the concerns raised by the commenters—the benefits-exhausted cases, the interrupted stay cases, and missing hospital claims—are caused by the same basic problems. That is, the December 2003 update of the FY 2004 MedPAR file did not include some patient claims from the records of the one LTCH in question. Because the MedPAR file represents a total beneficiary stay (total single episode of care) in an inpatient hospital once a beneficiary has been physically discharged from the inpatient hospital, as described below, we evaluated the reasons why such a situation could occur under normal claims processing procedures.

The MedPAR file is a discharge file for inpatient claims and, therefore, during the creation of the MedPAR file, inpatient hospital data without a discharge date would not be included. When a claim is processed for payment calculation, the data from the fiscal intermediary are included in the Medicare Common Working File (CWF), at which time payment authorization or denial will be made and, if authorized, a remittance will be generated to the provider. After the remittance is generated, the National Claims History (NCH) is updated to reflect all of the claims submitted for an entire stay, which may include one claim or multiple claims. The NCH inpatient hospital data are used in the creation of the MedPAR file and all adjustments are resolved prior to the creation of a stay record in the MedPAR file. The creation of the MedPAR file takes all claims submitted for a beneficiary at the same facility and collapses all the data so that one record is created that represents a single record of the entire stay at the facility.

A claim that is correctly coded and submitted timely by the provider will be captured by the specific update of the NCH files, the data source for the MedPAR file. However, if there are issues with the claim, the claim may be suspended. Therefore, even though the hospital will have a record of the stay, until the issue with the claim is resolved, it will not process into the NCH and, therefore, will not be recorded in the MedPAR file. Issues leading to claim suspension may

include submission-systems failures by the provider, including the absence of crucial information or incorrect coding of patient status by the provider. Alternatively, issues may arise during the fiscal intermediary processing of the claim, as a result of data processing problems or broader standard systems issues. The fiscal intermediary may also delay processing the claim pending resolution of policy issues in specific situations. A fiscal intermediary may need to contact a subject-matter specialist at Medicare, for example, for assistance in determining whether a particular atypical patient discharge, treatment, and readmittance scenario would be governed by the payment rules established under either of the interrupted stay policies at § 412.531.

Therefore, there are several reasons why claims could be held in suspension and hence not be ''resolved'' either for payment purposes or for inclusion in the MedPAR file. We understand that, at any one time, there may be as many as 25 percent of a hospital's claims in suspension pending resolution of one or more of the above issues. This statistic is not reflective of any unique problems in the processing procedure but rather is a standard feature of a dynamic claims payment process. In recognition of this fact, and in order to enable a cash flow to a provider where there may be a disproportionate number of unresolved claims in suspension, our regulations at § 412.541(f) provide for accelerated payments, which are reconciled with actual remittances at a future date.

The commenter's first concern was that a substantial number of benefits-exhaust claims from the one LTCH were not included in the March 2004 update of the FY 2004 MedPAR file. Our case-level analysis revealed several reasons for this, which are discussed below. Primarily, we believe that there has been some degree of confusion on by that LTCH as to the policy distinction established under the LTCH PPS between a discharge for payment purposes and a patient's physical discharge. In the August 30, 2002 final rule for the LTCH PPS, we established regulations at § 412.503 specifying that a Medicare patient is considered ''discharged'' for payment purposes when the patient no longer has any Medicare covered days (that is, when Medicare Part A benefits are exhausted). At that point, a LTCH may submit a ''discharge'' claim to its fiscal intermediary and Medicare will issue a payment for covered care (CMS Pub. 100–4 Chapter 1, Section 50.2) delivered until the benefits were exhausted. The patient may continue to receive care at the LTCH, but Medicare Part A will no longer be financially responsible for that treatment. In that same final rule, we also established that we would include data for all inpatient days that a Medicare beneficiary was physically in the LTCH for purposes of meeting the length of stay requirements to qualify as a LTCH as set forth under § 412.23(e) (67 FR 55974) and for developing LTC–DRG relative weights (67 FR 55984). Therefore, for purposes of these two policies, data from the fiscal year during which the patient is physically discharged from the LTCH will include the total day count for the patient's entire stay as well as the total charges for the entire length of stay, including data from noncovered days, even where the Medicare payment to the LTCH was made in a prior fiscal year, based on the earlier bill submitted by the LTCH when the patient's benefits exhausted.

In response to the commenter's allegation that the data from the December 2004 update of the FY 2004 MedPAR file did not capture 16 of 35 benefits-exhaust claims for one specific LTCH, CMS' analysis revealed that 5 of these 16 cases noted by the commenter are, in fact, included in the more recent March 2005 update of the FY 2004 MedPAR file. This indicates that if the bill did not appear on the earlier December update due to a processing suspension, these 5 cases appear in the March 2005 update of the MedPAR file because the issue for which the bill was suspended has been resolved by that time. Furthermore, an additional 7 of the 16 claims that the hospital identified as ''discharged'' represented beneficiaries who were still in the hospital at the end of FY 2004 (September 30, 2004), even though Medicare was no longer making payments for their care (and they had been ''discharged for payment purposes'' under § 412.503). As noted above, only at physical discharge will data be included in the corresponding MedPAR file. Once those 7 patients are discharged physically from the LTCH in question, their data will appear in the MedPAR file for the fiscal year of their discharge. Accordingly, we do not believe that the absence from the March 2005 update of the FY 2004 MedPAR file of the four discharges for this one LTCH represents a systematic and serious underrepresentation of benefits-exhaust cases in the LTCH FY 2004 MedPAR file.

The commenter also claimed that the MedPAR file had inaccurately reported interrupted stay cases, that is, a LTCH stay that has an intervening stay at an acute care hospital for 9 days or less, an IRF for 27 days or less, or a SNF for 45 days or less during the LTCH stay (§ 412.531). The one LTCH upon which the commenter bases his concerns had records of 102 interrupted stay cases discharged during FY 2004. Of these, it is claimed that 44 were reported correctly in the December 2004 update of the FY 2004 MedPAR file upon which the proposed LTC–DRG relative weights were based. If an episode of care is governed by the greater than 3 days interruption of stay policy, both segments of the stay at the LTCH are paid as one. The commenter claimed that, in such cases, only one-half of particular interrupted stay cases in that LTCH that were reported were included in the December 2004 update of the FY 2004 MedPAR file. The commenter also claimed that in other interrupted stay cases, the entire stay was absent from the December 2004 update of the FY 2004 MedPAR file. We reviewed the commenter's claims and concluded that most of these cases are included in the recent March 2005 update of the FY 2004 MedPAR file. We believe that these cases were not included in the December 2004 update of the FY 2004 MedPAR file because the provider's final bill was in suspension.

It is likely that the cases appear in the March 2005 update of the FY 2004 MedPAR file because the patient was finally physically discharged or issues relating to the claim were otherwise settled and the claims were no longer in suspension. Other claims reported by the LTCH but still not included in the March 2005 update of the FY 2004 MedPAR file are appropriately not in the MedPAR file because they are still in suspension for various reasons (as noted above and discussed in greater detail below).

As stated above, there may be one or even several valid and appropriate reasons why the interrupted stay cases are suspended. We understand that the initial implementation of certain LTCH PPS system changes resulted in problems, including the mechanics of claim submission. Specifically, for many fiscal intermediaries, the implementation of the 3-day or less interruption of stay policy at § 412.531(a) (69 FR 25690) initially led to submission of overlapping claims, inappropriate payments, recoupment of payments, and subsequent withdrawal and resubmission of claims, and required considerable provider education and resulted in initial suspension of the claims during FY 2004. However, this is no longer a significant problem for fiscal intermediaries. In fact, the fiscal intermediary that services the LTCH cited by the commenter noted that several of its providers worked

aggressively and in a timely manner to ensure that their claims governed by this policy were being submitted according to CMS instructions, and paid and reported accurately. However, other LTCHs were still working to rectify their claims submission procedures under the new policies or their internal records. Among those LTCHs that apparently had data submission and payment problems, the fiscal intermediary identified the LTCH that was the subject of the commenter's original data collection. Therefore, while we acknowledge that there were initial claims processing difficulties with interrupted stay cases, based on our conversations with the fiscal intermediary that services approximately two-thirds of all LTCHs, as well as with the fiscal intermediary that services the LTCH in question and 10 other LTCHs, we do not believe that there continues to be a significant issue. Furthermore, we believe that, currently, for the vast majority of LTCHs, internal records are consistent with the actual payment adjustments made by their fiscal intermediaries that are reported in the MedPAR file. However, the few LTCHs that experience an inconsistency between their internal records and the data reported in the MedPAR file do so as a result of provider specific billing issues which are in no way indicative of a widespread or even a significant problem with the integrity of the FY 2003 MedPAR data.

As noted above, the commenter believes that ''an atypical level of suspension of LTCH claims'' results from dealing with the FY 2004 conversion from the Arkansas Part A Standard System (APASS) billing system to the Fiscal Intermediary Share System (FISS) billing system. The commenter believed this transition resulted in inaccurate and underreported claims in the FY 2004 MedPAR data. While there were some initial difficulties with the system transition, our analysis of the MedPAR data again indicates that those difficulties have been addressed and, in fact, the MedPAR data accurately reflect provider billings and are reliable.

Based on discussions with the fiscal intermediaries that process the vast majority of LTCH bills, we conclude that, although initially there were some problems with the system's processing of a limited number of claims that were impacted by either the 3-day or less interrupted stay policy (§ 412.531(a)) or cases of exhaustion of Medicare benefits, the problems were typically resolved in a timely manner and the claims are reflected in the March 2005 update of the FY 2004 MedPAR file. Furthermore, the fiscal intermediary that serves the LTCH in question also noted experiencing some difficulties with its conversion to the FISS billing system originally, but presently, it is no longer experiencing a significant number of suspended claims as a result of those issues.

We also analyzed the commenter's assertions that, for a number of the LTCH bills in question, the LTCH's internal records of charges included either additional or fewer charges than the amount reported as the charges in the December 2004 update of the FY 2004 MedPAR file. The commenter believed that, because the FY 2004 MedPAR file does not reflect all of the bill's charges for this LTCH, there is a systemic problem that affects the calculations of the FY 2006 LTC–DRG relative weights. We believe the FY 2004 MedPAR file is providing cases with accurate charge data for that fiscal year. Because all Medicare charges that are reported in the MedPAR file are taken directly from claims submitted by providers, in order to further evaluate the commenter's assertion, we requested that the fiscal intermediary serving this LTCH review claims that the commenter alleged exemplified the ''discrepancy'' between the LTCH charges identified in its records and those that appear in the FY 2004 MedPAR file. A comparison of the electronic claims submitted by the LTCH to the fiscal intermediary did not reveal any inconsistencies. That is, the charges on the electronic claims for those cases matched those charges that appeared in the most recent update (March 2005) of the MedPAR file. Therefore, the MedPAR data are consistent with charge data submitted by the LTCH to CMS. Furthermore, as we analyzed each of the commenter's specific allegations of systemic flaws in the FY 2004 MedPAR data, we have concluded that the only way that the actual charges could be higher or lower on the hospital's own records than those charges that appear on the claim in the NCH (upon which the MedPAR file is derived) would be if the provider did not include those charges on the bill submitted to the fiscal intermediary for processing. We note that this issue of a discrepancy between billed charges and the MedPAR data is not an issue for other providers. Therefore, we believe that any inconsistencies between charges for a few cases as listed in the internal records of one LTCH and those reported for those same cases in the FY 2004 MedPAR file are due to internal data reporting practices of a specific LTCH and are not indicative of a widespread problem with the reporting of charges for LTCHs throughout the country in the FY 2004 MedPAR data that affects the final LTC–DRG relative weights.

Based upon our detailed analysis of the commenter's assertions, we believe that there are no systematic errors in the LTCH FY 2004 MedPAR data and we continue to believe it is appropriate to base the FY 2006 LTC–DRG relative weights on the March 2005 update of the FY 2004 MedPAR file. We believe that the December 2004 update of the FY 2004 MedPAR file that we used to determine the proposed LTC–DRG relative weights for FY 2006 in the FY 2006 IPPS proposed rule reflected the best available data at that time. Moreover, we maintain that calculating the final LTC–DRG payment weights set forth in this final rule using the March 2005 update of the FY 2004 MedPAR file eliminates most of the issues raised by the commenter, even with the specific claims submitted by the one LTCH cited by the commenter. Furthermore, based on our analysis, we conclude that many of the issues experienced by that LTCH were unique to that hospital and were not systemic issues.

In summary, as explained above, we do not believe there is evidence to support the contention that there is a systemic flaw in the LTCH FY 2004 MedPAR data or the integrity of the FY 2006 final LTC–DRG relative weights. Rather, we believe that extrapolation to the entire universe of LTCHs of the issues of one particular LTCH with its own submission and reporting history as proof of the unreliability of our FY 2004 MedPAR data is both misleading and inaccurate. Therefore, in this final rule, we are using the LTCH claims data from the March 2005 update of the FY 2004 MedPAR file to determine the FY 2006 LTC–DRG relative weights using the methodology described below.

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 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, as implemented in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991), we standardize charges for each case by first dividing the adjusted charge for the case (adjusted for short-stay outliers under § 412.529 as described in section II.D.4. (step 3) of this preamble) by the average adjusted charge for all cases at the LTCH in which the case was treated. Short-stay outliers under § 412.529 are cases with a length of stay that is less than or equal to five-sixths the average length of stay of the LTC–DRG. The average adjusted charge reflects the average intensity of the health care services delivered by a particular LTCH and the average cost level of that LTCH. The resulting ratio is multiplied by that LTCH's case-mix index to determine the standardized charge for the case.

Multiplying by the LTCH's case-mix index accounts for the fact that the same relative charges are given greater weight in a LTCH with higher average costs than they would at a LTCH with low average costs which is needed to adjust each LTCH's relative charge value to reflect its case-mix relative to the average case-mix for all LTCHs. Because we standardize charges in this manner, we count charges for a Medicare patient at a LTCH with high average charges as less resource intensive than they would be at a LTCH with low average charges. For example, a $10,000 charge for a case in a LTCH with an average adjusted charge of $17,500 reflects a higher level of relative resource use than a $10,000 charge for a case in a LTCH with the same case-mix, but an average adjusted charge of $35,000. We believe that the adjusted charge of an individual case more accurately reflects actual resource use for an individual LTCH because the variation in charges due to systematic differences in the markup of charges among LTCHs is taken into account.

d. Low-Volume LTC–DRGs

In order to account for LTC–DRGs with low-volume (that is, with fewer than 25 LTCH cases), in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55984), we group those ''low-volume LTC–DRGs'' (that is, DRGs that contained between 1 and 24 cases annually) into one of five categories (quintiles) based on average charges, for the purposes of determining relative weights. In the FY 2006 IPPS proposed rule (70 FR 23341), we stated that we would continue to employ this treatment of low volume LTC–DRGs in determining the FY 2006 LTC–DRG relative weights using the best available LTCH data. In that same 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. For this final rule, using LTCH cases from the March 2005 update of the FY 2004 MedPAR file, we identified 171 LTC–DRGs that contained between 1 and 24 cases. This list of LTC–DRGs was then divided into one of the 5 low-volume quintiles, each containing a minimum of 34 LTC–DRGs (171/5 = 34 with 1 LTC–DRG as the remainder). In accordance with our established methodology, we then make an assignment to a specific low-volume quintile by sorting the low-volume LTC–DRGs in ascending order by average charge. For this final rule, this results in an assignment to a specific low volume quintile of the sorted 171 low-volume 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 LTC–DRG was used to determine which low-volume quintile received the additional LTC–DRG. After sorting the 171 low-volume LTC–DRGs in ascending order, we group the first fifth of low-volume LTC–DRGs with the lowest average charge into Quintile 1. The highest average charge cases are grouped into Quintile 5. Since the average charge of the 69th LTC–DRG in the sorted list is closer to the 68th LTC–DRG's average charge (assigned to Quintile 2) than to the average charge of the 70th LTC–DRG in the sorted list (to be assigned to Quintile 3), we placed it into Quintile 2. This process was repeated through the remaining low-volume LTC–DRGs so that 1 low-volume quintile contains 35 LTC–DRGs and 4 low-volume quintiles contain 34 LTC–DRGs.

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

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.

COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2006—Continued

LTC–DRG	Description
65	DYSEQUILIBRIUM.
69	OTITIS MEDIA & URI AGE >17 W/O CC.
86	PLEURAL EFFUSION 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.
143	CHEST PAIN.
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.
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.
328	URETHRAL STRICTURE AGE >17 W CC.
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.
29	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC.
44	ACUTE MAJOR EYE INFECTIONS.
46	OTHER DISORDERS OF THE EYE AGE >17 W CC.
83	MAJOR CHEST TRAUMA W 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.
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.
254	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE >17 W/O 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.
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O 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.

COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2006—Continued

LTC–DRG	Description
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.
67	EPIGLOTTITIS.
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC.
110	MAJOR CARDIOVASCULAR PROCEDURES W 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.
195	CHOLECYSTECTOMY W 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.
308	MINOR BLADDER PROCEDURES W CC.
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.
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.
507	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.
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.
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.
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.
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.
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.
419	FEVER OF UNKNOWN ORIGIN AGE >17 W CC.
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.
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.
551	PERMANENT CARDIAC PACEMAKER IMPLANT WITH MAJOR CV DIAGNOSIS OR AICD LEAD OR GNRTR.
552	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT WITHOUT MAJOR CV DIAGNOSIS.

COMPOSITION OF LOW-VOLUME QUINTILES FOR FY 2006—Continued

LTC–DRG	Description
555	PERCUTANEOUS CARDIOVASCULAR PROC WITH MAJOR CV DIAGNOSIS.
556*	PERCUTANEOUS CARDIOVASCULAR PROC WITH NON-DRUG-ELUTING STENT WITHOUT MAJOR CV DIAGNOSIS.
557*	PERCUTANEOUS CARDIOVASCULAR PROC WITH DRUG-ELUTING STENT WITH MAJOR CV DIAGNOSIS.
QUINTILE 5	
1	CRANIOTOMY AGE >17 W CC.
75	MAJOR CHEST PROCEDURES.
77	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC.
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.
482	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES.
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.
488	HIV W EXTENSIVE O.R. PROCEDURE.
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC.
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.
519	CERVICAL SPINAL FUSION W CC.
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 OF LOWER EXTREMITY.
545	REVISION OF HIP OR KNEE REPLACEMENT.
556**	PERCUTANEOUS CARDIOVASCULAR PROC WITH NON-DRUG-ELUTING STENT WITHOUT MAJOR CV DIAGNOSIS.
557**	PERCUTANEOUS CARDIOVASCULAR PROC WITH DRUG-ELUTING STENT WITH MAJOR CV DIAGNOSIS.

*One of the original 171 low-volume LTC–DRGs initially assigned to a different low-volume quintile; reassigned to this low-volume quintile in addressing nonmonotonicity (see step 4 below).

**One of the original 171 low-volume LTC–DRGs initially assigned to this low-volume quintile; reassigned to a different low-volume quintile in addressing nonmonotonicity (see step 4 below).

***One of the original 171 low-volume LTC–DRGs initially assigned to this low-volume quintile; removed from this low-volume quintile in addressing nonmonotonicity (see step 4 below).

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

As we noted in the FY 2006 IPPS proposed rule (70 FR 23346), the FY 2006 LTC–DRG relative weights are determined in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989 through 55991). In summary, LTCH cases must be grouped in the appropriate LTC–DRG, while taking into account the low-volume LTC–DRGs as described above, before the FY 2006 LTC–DRG relative weights can be determined. After grouping the cases in the appropriate LTC–DRG, we calculated the relative weights for FY 2006 in this final 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 adjusted the number of cases in each 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 LTC–DRG using the hospital-specific relative value method described above.

Comment: A few commenters expressed concern regarding what they believed to be a proposed change in the methodology to compute the LTC–DRG relative weights. Specifically, they asserted that removing statistical outlier cases and cases with a length of stay of 7 days or less may inappropriately remove too many cases from the relative weight calculations. The commenters believed that, by narrowing the universe of cases used to compute the LTC–DRG relative weights, the principle of averaging that is a fundamental feature of a PPS would be eroded or distorted.

Response: We did not propose any policy change in the methodology for determining the LTC–DRG relative weights for FY 2006 in the FY 2006 IPPS proposed rule. The commenters are mistaken in their belief that we did. Rather, the six steps for determining the proposed FY 2006 LTC–DRG relative weights presented in the FY 2006 IPPS proposed rule (70 FR 23346 through 23353) are the same steps that we have used to determine the LTC–DRG relative weights since the implementation of the LTCH PPS in FY 2003 (August 30, 2002 LTCH IPPS final rule (67 FR 55989 through 55991)). In every final rule in which we have updated the LTC–DRG

relative weights since the October 1, 2002 implementation of the LTCH PPS (68 FR 45375 through 45385, and 69 FR 48989 through 49000), we reiterated the same steps of our established methodology to determine the annual update to the LTC–DRG relative weights. We continue to believe that this methodology continues to be valid, and we do not find any reason at this time to revise it.

As we explained in the FY 2006 IPPS proposed rule (70 FR 23346), we believe it is appropriate to remove statistical outlier cases and cases with a length of stay of 7 days or less because including those LTCH cases in the calculation of the relative weights could result in an inaccurate relative weight, and therefore an inappropriate payment amount, that does not truly reflect relative resource use among the LTC–DRGs. Specifically, we continue to believe that statistical outlier cases may represent aberrations in the data that distort the measure of average resource use and that, as we explained above, including them in the calculation of the relative weights could result in an inappropriate payment amount.

In the RY 2006 LTCH PPS final rule (70 FR 23346) and as we discussed in greater detail in the FY 2005 IPPS final rule (69 FR 48990), we also explained that, generally, cases with a length of stay 7 days or less are not representative of either typical or perhaps even appropriate LTCH patients. Furthermore, in general, in a hospital established solely to treat very long-stay patients, and with a payment system calibrated to reflect the costs incurred in treating such patients, stays of 7 days or less would not fully receive or benefit from treatment or the range of resource use that is typical in a LTCH stay, and full resources are often not used in the earlier stages of admission to a LTCH. We continue to believe that, if we were to include stays of 7 days or less in the computation of the LTC–DRG relative weights, the value of many relative weights would decrease and, therefore, payments would decrease to a level that may no longer be appropriate. Specifically, because LTCH cases with very short lengths of stay (that is, 7 days or less) do not use the same amount or type of resources as typical LTCH inlier cases (that is, cases in which Medicare covered days exceed five-sixths of the geometric average length of stay for the LTC–DRG) and the patient is discharged prior to receiving a LTCH PPS high-cost outlier payment, our simulations indicate that including these cases would significantly bias payments against LTCH inlier cases to a point where LTCH inlier cases would be underpaid (69 FR 48990). Thus, 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. Consequently, we disagree with the commenters that removing aberrant LTCH cases (that is, statistical outlier cases and cases with a length of stay of 7 days or less) undermines the averaging principle upon which PPSs are developed.

Although we did not propose any change in the methodology for determining the LTC–DRG relative weights for FY 2006, we disagree with the assertions that removing statistical outlier cases and cases with a length of stay of 7 days or less inappropriately narrows the universe of cases used to compute the LTC–DRG relative weights, resulting in a distortion of the principle of averaging. Rather, because each LTC–DRG relative weight represents the average resources required to treat cases in that particular LTC–DRG, relative to the average resources used to treat cases in all LTC–DRGs, we believe that, by removing cases that do not represent the ''average resource use'' of the mix of LTCH cases within a DRG (that is, statistical outlier cases and cases with a length of stay of 7 days or less), for the reasons explained above, we are preserving the integrity of a system that is based on averages. Therefore, in establishing the FY 2006 LTC–DRG relative weights in this final rule, we have continued to remove statistical outlier cases and cases with a length of stay of 7 days or less from the MedPAR data used to compute the FY 2006 LTC–DRG relative weights.

Comment: Four commenters believed the estimated decrease in LTCH PPS payments resulting from the proposed changes to the LTC–DRG relative weights is inconsistent with the statutory mandate that the LTCH PPS be maintained in a budget neutral manner. These commenters recommended that we apply a budget neutrality adjustment to the LTC–DRG relative weights in order to mitigate the estimated LTCH PPS payment reductions that we estimated would result from the proposed changes to the LTC–DRG relative weights for FY 2006. Two of those commenters cited the statutory language authorizing the establishment of the LTCH PPS and argued that the language requires that the LTCH PPS continue to operate under ''budget neutrality.'' They further asserted that, although we did not interpret this language as mandating budget neutrality beyond the initial year of the LTCH PPS, the Secretary should use his or her broad discretionary authority to assure ''the same level of payments projected in the FY 2006 LTCH update regulation'' by making a budget neutrality adjustment in developing the FY 2006 LTC–DRG relative weights.

Response: We understand that these commenters are concerned about the estimated decrease in payments under LTCH PPS based upon changes in the LTC–DRG relative weights for FY 2006. However, we believe that this issue is distinct from the Secretary's budget neutrality obligation under the statute for the first year of implementation of the LTCH PPS. After the first year of the LTCH PPS, the statute gives the Secretary broad authority to determine the appropriateness of system updates and matters such as annual updates and policy changes. As we discussed in the FY 2005 IPPS final rule (69 FR 48999), with respect to budget neutrality, we interpreted section 123(a)(1) of Pub. L. 106–113 to require that total payments under the LTCH PPS during FY 2003 will be projected to equal estimated payments that would have been made for LTCHs' operating and capital-related inpatient hospital costs had the LTCH PPS not have been implemented. Thus we believe the statute's mandate for budget neutrality applies only to the first year of implementation of the LTCH PPS (that is, FY 2003). Consistent with the broad discretional authority conferred upon the Secretary under section 123(a)(1) of Pub. L. 103–116, as amended by section 307 of Pub. L. 106–554, the Secretary is exercising his broad authority to make updates the LTCH PPS in a nonbudget neutral manner after FY 2003 for various components of the LTCH PPS, including the annual update of the LTC–DRG classifications and relative weights.

Consistent with this budget neutrality requirement for the first year of implementation of the LTCH PPS, under § 412.523(d)(2) of the regulations, an adjustment is made in determining the standard Federal rate for FY 2003 so that aggregate payments under the LTCH PPS are estimated to equal the amount that would have been paid to LTCHs under the reasonable cost-based (TEFRA) payment system if the LTCH PPS were not implemented. Therefore, in the August 30, 2002 LTCH PPS final rule (67 FR 56027 through 56037), which implemented the LTCH PPS, in order to maintain budget neutrality, we adjusted the LTCH PPS Federal rate for FY 2003 so that aggregate payments under the LTCH PPS are estimated to equal the amount that would have been paid to LTCHs under the reasonable cost-based (TEFRA) payment system

had the LTCH PPS not been implemented.

As we stated in the FY 2005 IPPS final rule (70 FR 48999 through 49000), we continue to believe that section 123 of the Pub. L. 106–113 does not require that the annual update to the LTC–DRG classifications and relative weights maintain budget neutrality. We believe we have satisfied the budget neutrality requirement of section 123 of the Pub. L. 106–113 by establishing the LTCH PPS Federal rate for FY 2003 under § 412.523(d)(2) so that aggregate payment under the LTCH PPS are projected equal to estimated aggregate payments under the reasonable cost-based payment system if the LTCH PPS were not implemented. Therefore, we disagree with the commenters that a budget neutrality adjustment to the LTC–DRG relative weights or to the LTCH PPS Federal rate is required by statute or as a result of the annual update to the LTC–DRGs under § 412.517 for FY 2006.

We agree with the commenters that, under section 123 of the BBRA and section 307 of the BIPA, the Secretary generally has broad authority in developing the LTCH PPS, including whether and how to make adjustments to the LTCH PPS. As we discussed in the RY 2006 LTCH PPS final rule (70 FR 24188), we will consider whether it is appropriate for us to propose a budget neutrality adjustment in the annual update of some aspects of the LTCH PPS under our broad discretionary authority under the statute to provide ''appropriate adjustments'' to the LTCH PPS. As several commenters noted, LTCHs are still transitioning to a PPS and, while coding practices continue to improve, the FY 2004 claims data may ''not yet fully reflect the nature and types of services, staff, and other resources'' that LTCH provide to their patients. In the RY 2005 LTCH PPS final rule, we indicated that, until the 5-year transition from reasonable cost-based reimbursement to prospective payment is complete, we believe it may not be appropriate to update any aspects of the LTCH PPS in a budget neutral manner. As noted above, the most recent available LTCH PPS claims data are from discharges occurring during FY 2004. These LTCH claims data are from the second year of the LTCH PPS (FY 2004), which is the only first full year since the LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002 (FY 2003). Because it is still early in the 5-year LTCH PPS transition period, we continue to believe that it is inappropriate to update any aspects of the LTCH PPS in a budget neutral manner. A primary reason for waiting until after the transition is complete before evaluating aspects of the LTCH PPS, including the budget neutrality issue, is that the data available to analyze such issues are very limited because the LTCH PPS is still relatively new and there is a lag time in data availability. As several commenters pointed out, the FY 2004 MedPAR data are the first full year of LTCH PPS data since the LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002 (FY 2003). In addition, the fact that a number of LTCHs were and some are still transitioning to 100 percent of the Federal prospective payment rate may make the available data on which to base a budget neutrality adjustment even less appropriate because LTCHs may still be modifying their behavior based on their transition to prospective payment and, therefore, our data may not yet fully reflect any operational changes LTCHs may have made in response to prospective payment. We continue to believe that, once we have progressed further through the 5-year transition period, we will have a better opportunity to evaluate the impacts of the implementation of this new payment system based on a number of years of LTCH PPS data, which will most appropriately reflect LTCHs' experience under a PPS.

For the reasons stated above, we do not believe that a budget neutrality adjustment to the FY 2006 LTC–DRG relative weights or to the LTCH PPS Federal rate is necessary or appropriate. Accordingly, in developing the FY 2006 LTC–DRGs and relative weights shown in Table 11 of the Addendum of this final rule, we have not applied an adjustment for budget neutrality nor are we adjusting the 2006 LTCH PPS rate year Federal rate established in the 2006 LTCH PPS final rule (70 FR 24180) to account for the estimated change in LTCH PPS payments that will result from the annual update to the LTC–DRG classifications and relative weights for FY 2006.

Comment: Several commenters recommended implementing a ''dampening policy,'' similar to that which was implemented for the Ambulatory Payment Classification (APC) changes under the Hospital Outpatient PPS (OPPS) in CY 2003, which would reduce the decrease in any relative weight in excess of a threshold (for example, 15 percent) by half, to mitigate instability in LTCH PPS payments because of the ''significant/substantial'' decrease in many of the relative weights.

Response: A ''dampening policy,'' as recommended by the commenters, would limit the decrease in any of the LTC–DRG relative weights to a maximum amount, which would reduce the estimated decrease in LTCH PPS payments that we projected in the FY 2006 IPPS proposed rule as a result of the proposed changes to the LTC–DRG relative weights for FY 2006 (70 FR 23667). The commenters believed that the estimated decrease in the LTCH PPS payments resulting from the proposed changes to the LTC–DRGs for FY 2006 would create a ''destabilizing effect'' on LTCH PPS payments. For the reasons discussed below, we do not believe the estimated decrease in LTCH PPS payments resulting from the changes we are making to the LTC–DRG relative weights for FY 2006 in this final rule will lead to instability in LTCH PPS payments, and therefore, we are not implementing a ''dampening policy,'' as recommended by the commenters.

As discussed in the November 1, 2002 OPPS final rule (67 FR 66749 through 66750), we believed it was appropriate to implement the ''dampening policy'' under the OPPS referenced by the commenters because many of the decreases in payment rates for some of the APCs appeared to be linked to ''changes in the methodology for those drugs and devices that will no longer be eligible for pass-through payments; miscoding; restructuring of APCs (in which movement of a single code from one APC to another may change the median cost of both APCs), or use of data from the period following the implementation of the OPPS.'' Although Medicare payment for both hospital outpatient services and inpatient LTCH services are reimbursed under a PPS (respectively), there are significant distinctions between the two payment systems. For instance, under the LTCH PPS, a single per LTC–DRG payment is made for all inpatient hospital services provided to a patient for each stay, where in contrast, under the OPPS, payments based on APCs may include distinct payment methodologies for certain drugs and devices that are eligible for pass-through payments. Thus, there are significant distinctions between the two payment systems that warrant different considerations when evaluating the need for a ''dampening policy.'' Below we discuss the reasons we believe that a ''dampening policy'' to mitigate the effects of the changes in the LTC–DRG relative weights for FY 2006 on LTCH PPS payments are not necessary or appropriate.

As noted by the commenters, many of the proposed FY 2006 LTC–DRG relative weights decreased in

comparison to the FY 2005 LTC–DRG relative weights, which would result in an aggregate estimated decrease in FY 2006 LTCH PPS payments. As we explained in the FY 2006 IPPS proposed rule (70 FR 23667), we continue to observe an increase of relatively lower charge cases being assigned to LTC–DRGs with higher relative weights in the prior year. The addition of these lower charge cases results in a decrease in the many of the LTC–DRG relative weights from FY 2005 to FY 2006. This decrease in many of the LTC–DRG relative weights, in turn, will result in an estimated decrease in LTCH PPS payments. As we explained in that same proposed rule, contributing to this increased number of 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. A further analysis of the LTCH claims in the March 2005 update of the FY 2004 MedPAR data, which we used to determine the FY 2006 LTC–DRG relative weights in this final rule, continue to show an increase of relatively lower charge cases being assigned to LTC–DRGs with higher relative weights in the prior year. As we explained the FY 2006 IPPS proposed rule (70 FR 23667), 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, which, in turn, results in an estimated aggregate decrease in LTCH PPS payments.

A few commenters acknowledged that with the move from cost-based reimbursement to a PPS, LTCHs' coding practices are still undergoing refinement. Specifically, two commenters stated that ''the LTCH PPS, in its third year of implementation, is still in transition; the initial 5-year phase-in will end September 2006. During this time of transition, LTCH coding and data are still undergoing improvement.'' Therefore, it is not unreasonable to observe relatively significant changes (either higher or lower) in the average charge for many LTC–DRGs as LTCHs' behavior coding continues to change in response to the implementation of a PPS. As the transition progresses, we expect that LTCH's behavior will result in fewer nonuniform changes in the average charge of many LTC–DRGs, which may impact the LTC–DRG relative weights from year to year.

As we discussed above, we believe that there are no systemic errors in the LTCH FY 2004 MedPAR data, and we believe that the increase of relatively lower charge cases being assigned to LTC–DRGs with higher relative weights that we observed in the FY 2004 LTCH claims data (which results in a decrease in the many of the LTC–DRG relative weights) accurately represents current LTCH costs. Specifically, an analysis of a comparison of the FY 2003 LTCH claims data (used to develop the FY 2005 LTC–DRG relative weights) and the FY 2004 LTCH claims data (used to develop the FY 2006 LTC–DRG relative weights) shows that, of the 155 LTC–DRGs that are used on a ''regular basis'' (that is, nationally, LTCHs discharge, in total, 25 or more of these cases annually), about 30 percent of those LTC–DRGs have experienced a decrease in the average charge per case, which generally results in a lower relative weight. In addition, about 45 percent of those LTC–DRGs have experienced an increase in the average charge that is *less* than the increase (16 percent) in the overall average charge across all LTC–DRGs. In general, the LTC–DRG relative weights are determined by dividing the average charge for each LTC–DRG by the average charge across all LTC–DRGs. Accordingly, those LTC–DRGs with an increase in average charge of less than 16 percent (that is, the increase in average charge across all LTC–DRGs) will also experience a reduction in their relative weight because the average charge for each of those LTC–DRGs is being divided by a bigger number (that is, the average charge across all LTC–DRGs). Therefore, because we believe the FY 2004 LTCH claims data used to determine the FY 2006 LTC–DRG relative weights accurately reflect the resources used by LTCHs to treat their patients, and these data show either a decrease in the average charge of the LTC–DRG or an increase in the average charge of the LTC–DRG that is less than the overall increase in the average charge across all LTC–DRGs, we believe that the decrease in many of the LTC–DRG relative weights is appropriate.

The LTC–DRG relative weights are designed to reflect the average of resources used to treat representative cases of the discharges within each LTC–DRG. As we discussed in greater detail above, after our extensive analysis of the FY 2004 MedPAR data, which we used to determine the FY 2006 LTC–DRG relative weights, we concluded that there are no systematic errors in that data. Therefore, we continue to believe it is appropriate to base the FY 2006 LTC–DRG relative weights on LTCH claims data in the FY 2004 MedPAR file. Furthermore, we believe that the decrease in many of the LTC–DRG relative weights is appropriate and is reflective of the changing behaviors of LTCHs' response to a PPS environment. As we discussed above, we believe that the LTCH claims data in the FY 2004 MedPAR file accurately reflects the resources that are expended to treat LTCH patients in each LTC–DRG. Although many of the LTC–DRG relative weights (and consequently aggregate LTCH PPS payments, excluding the update to the LTCH PPS Federal rate effective July 1, 2005 (70 FR 24217) will be lower in FY 2006 as compared to FY 2005, we do not believe that the payment rates for those LTC–DRGs are inappropriate based on the LTCH claims data in the FY 2004 MedPAR files. Rather, we believe that the lower LTC–DRG relative weights (and consequently a reduction in aggregate LTCH PPS payments) are appropriate, given that the average resources used to treat a LTCH patient in a particular LTC–DRG are less than the average resources used to treat a LTCH patient in a particular LTC–DRG based on FY 2003 LTCH claims data. Therefore, we do not agree with the commenters' assertion that the changes to the LTC–DRG relative weights for FY 2006 will result in instability in LTCH PPS payments. Rather, we believe that the changes to the LTC–DRG relative weights for FY 2006 will result in appropriate payments for the resources used to treat LTCH patients in a particular LTC–DRG. Accordingly, for the reasons discussed above, we are not implementing a ''dampening policy'' in determining the FY 2006 LTC–DRG relative weights in this final rule. We also note that the 4.2 percent decrease in LTCH PPS payments estimated as a result of the changes we are making to the LTC–DRGs and relative weights in this final rule for FY 2006 (see section VII. of the Addendum to this final rule) is partially offset by the projected 5.7 percent increase in LTCH PPS payments estimated based on the updated rates and factors effective for discharges occurring on or after July 1, 2005 established in the FY 2006 LTCH PPS final rule (70 FR 24217).

Below we discuss in detail the steps for calculating the FY 2006 LTC–DRG relative weights as presented in the FY 2006 IPPS proposed rule (70 FR 23346 through 23353). We note that, as we stated above in section II.D.3.b. of this preamble, as we proposed, we have excluded the data of all-inclusive rate LTCHs and LTCHs that are paid in accordance with demonstration projects

that had claims in the FY 2004 MedPAR file.

Step 1—Remove statistical outliers.

The first step in the calculation of the 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 relative weights. As noted above, we believe that they may represent aberrations in the data that distort the measure of average resource use. Including those LTCH cases in the calculation of the relative weights could result in an inaccurate relative weight that does not truly reflect relative resource use among the LTC–DRGs.

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

The FY 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. As explained above, if we were to include stays of 7 days or less in the computation of the FY 2006 LTC–DRG relative weights, the value of many relative weights would decrease and, therefore, payments would decrease to a level that may no longer be appropriate.

We do not believe that it would be appropriate to compromise the integrity of the payment determination for those LTCH cases that actually benefit from and receive a full course of treatment at a LTCH, in order to include data from these very short-stays. Thus, as explained above, in determining the 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 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 LTC–DRG for nonshort-stay outlier cases. This has the effect of proportionately reducing the impact of the lower charges for the short-stay outlier cases in calculating the average charge for the LTC–DRG. This process produces the same result as if the actual charges per discharge of a short-stay outlier case were adjusted to what they would have been had the patient's length of stay been equal to the average length of stay of the LTC–DRG.

As we explained in the FY 2006 IPPS proposed rule (70 FR 23346 through 23347), counting short-stay outlier cases as full discharges with no adjustment in determining the LTC–DRG relative weights would lower the LTC–DRG relative weight for affected LTC–DRGs because the relatively lower charges of the short-stay outlier cases would bring down the average charge for all cases within a LTC–DRG. This would result in an ''underpayment'' to nonshort-stay outlier cases and an ''overpayment'' to short-stay outlier cases. Therefore, in this final rule, we adjust for short-stay outlier cases under § 412.529 in this manner because it results in more appropriate payments for all LTCH cases.

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

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

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

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

As explained in section II.B. of this preamble, the FY 2006 CMS DRGs, on which the FY 2006 LTC–DRGs are based, contain ''pairs'' that are differentiated based on the presence or absence of CCs. The LTC–DRGs with CCs are defined by certain secondary diagnoses not related to or inherently a part of the disease process identified by the principal diagnosis, but the presence of additional diagnoses does not automatically generate a CC. As we discussed in the 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 LTC–DRG means that cases classified into a ''without CC'' LTC–DRG are expected to have lower resource use (and lower costs). In other words, resource use (and costs) are expected to decrease across ''with CC/without CC'' pairs of LTC–DRGs.

For a case to be assigned to a LTC–DRG with CCs, more coded information is called for (that is, at least one relevant secondary diagnosis), than for a case to be assigned to a LTC–DRG ''without CCs'' (which is based on only one principal diagnosis and no relevant secondary diagnoses). Currently, the LTCH claims data include both accurately coded cases without complications and cases that have complications (and cost more), but were not coded completely. Both types of cases are grouped to a LTC–DRG ''without CCs'' when only the 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 since the implementation of the LTCH PPS in FY 2003. 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'' LTC–DRG would have a higher average charge than the ''with CC'' LTC–DRG. For this final rule, using the LTCH cases in the March 2005 update of the FY 2004 MedPAR file (the best available data at this time), we identified three types of nonmonotonic LTC–DRG pairs. As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55990), we believe this anomaly may be due to coding inaccuracies and expect that, as was the case when we first implemented the acute care hospital IPPS, this problem will be self-correcting, as LTCHs submit more completely coded data in the future.

The first category of nonmonotonically increasing relative weights for FY 2006 LTC–DRG pairs ''with and without CCs'' contains one pair of LTC–DRGs in which both the LTC–DRG ''with CCs'' and the LTC–DRG ''without CCs'' had 25 or more LTCH cases and, therefore, did not fall into one of the 5 low-volume quintiles. For those nonmonotonic LTC–DRG pairs, we combine the LTCH cases and compute a new relative weight based on the case-weighted average of the combined LTCH cases of the LTC–DRGs. The case-weighted average charge is determined by dividing the total charges for all LTCH cases by the total number of LTCH cases for the combined LTC–DRG. This new relative weight is then assigned to both of the LTC–DRGs in the pair. In this final rule, for FY 2006, LTC–DRGs 553 and 554 fall into this category.

The second category of nonmonotonically increasing relative weights for LTC–DRG pairs ''with and without CCs'' consists of one pair of LTC–DRGs that has fewer than 25 cases, and each LTC–DRG is grouped to different low-volume quintiles in which the ''without CC'' LTC–DRG is in a higher-weighted low-volume quintile than the ''with CC'' LTC–DRG. For those pairs, we combine the LTCH cases and determine the case-weighted average charge for all LTCH cases. The case-weighted average charge is determined by dividing the total charges for all LTCH cases by the total number of LTCH cases for the combined LTC–DRG. Based on the case-weighted average LTCH charge, we determine within which low-volume quintile the ''combined LTC–DRG'' is grouped. Both LTC–DRGs in the pair are then grouped into the same low-volume quintile, and thus have the same relative weight. In this final rule, for FY 2006, LTC–DRGs 555, 556 and 557 fall into this category. (We note, 3 LTC–DRGs make up this non-monotonic ''pair'' of LTC–DRGs because these percutaneous cardiovascular procedure DRGs are further split depending on the presence or absence of a drug eluting stint and the presence or absence of a major ''CV'' (cardiovascular) diagnosis, which is similar to the adjustment for non-monotonicity for DRGs 521, 522 and 523 in the development of the FY 2005 LTC–DRG relative weights (69 FR 78922).

The third category of nonmonotonically increasing relative weights for LTC–DRG pairs ''with and without CCs'' consists of one pair of LTC–DRGs where one of the LTC–DRGs has fewer than 25 LTCH cases and is grouped to a low-volume quintile and the other LTC–DRG has 25 or more LTCH cases and has its own LTC–DRG relative weight, and the LTC–DRG ''without CCs'' has the higher relative weight. We removed the low-volume LTC–DRG from the low-volume quintile and combined it with the other LTC–DRG for the computation of a new relative weight for each of these LTC–DRGs. This new relative weight is assigned to both LTC–DRGs, so they each have the same relative weight. In this final rule, for FY 2006, LTC–DRGs 142 and 143 fall into this category.

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

As we stated above, we determine the relative weight for each LTC–DRG using charges reported in the March 2005 update of the FY 2004 MedPAR file. Of the 526 LTC–DRGs for FY 2006, we identified 196 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 final 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 LTC–DRGs. Thus, in the process of determining the LTC–DRG relative weights, we are unable to determine weights for these 196 LTC–DRGs using the methodology described in steps 1 through 5 above. However, because patients with a number of the diagnoses under these LTC–DRGs may be treated at LTCHs beginning in FY 2006, we assign relative weights to each of the 196 ''no volume'' LTC–DRGs based on clinical similarity and relative costliness to one of the remaining 330 (526 − 196 = 330) LTC–DRGs for which we are able to determine relative weights, based on FY 2004 claims data.

As there are currently no LTCH cases in these ''no volume'' LTC–DRGs, we determined relative weights for the 196 LTC–DRGs with no LTCH cases in the FY 2004 MedPAR file used in this final rule by grouping them to the appropriate low-volume quintile. This methodology is consistent with our methodology used in determining relative weights to account for the low-volume LTC–DRGs described above.

Our methodology for determining relative weights for the ''no volume'' LTC–DRGs is as follows: We crosswalk

the no volume LTC–DRGs by matching them to other similar 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 relative weight for the applicable low-volume quintile to the no volume LTC–DRG if the LTC–DRG to which it is crosswalked is grouped to one of the low-volume quintiles. If the LTC–DRG to which the no volume LTC–DRG is crosswalked is not one of the LTC–DRGs to be grouped to one of the low-volume quintiles, we compare the relative weight of the LTC–DRG to which the no volume LTC–DRG is crosswalked to the relative weights of each of the five quintiles and we assign the no volume LTC–DRG the relative weight of the low-volume quintile with the closest weight. For this final rule, a list of the no volume FY 2006 LTC–DRGs and the FY 2006 LTC–DRG to which it is crosswalked in order to determine the appropriate low-volume quintile for the assignment of a relative weight for FY 2006 is shown in the chart below.

NO VOLUME LTC–DRG CROSSWALK AND QUINTILE ASSIGNMENT FOR FY 2006

LTC–DRG	Description	Cross-walked LTC–DRG	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 2.
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	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17	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	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	73	Quintile 3.
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	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC	90	Quintile 1.
98	BRONCHITIS & ASTHMA AGE 0–17	97	Quintile 2.
104	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH	110	Quintile 3.
105	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH	110	Quintile 3.
106	CORONARY BYPASS W PTCA	110	Quintile 3.
107	CORONARY BYPASS W CARDIAC CATH	110	Quintile 3.
108	OTHER CARDIOTHORACIC PROCEDURES	110	Quintile 3.
109	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	110	Quintile 3.
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	110	Quintile 3.
129	CARDIAC ARREST, UNEXPLAINED	110	Quintile 3.
137	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	136	Quintile 2.
146	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC	148	Quintile 5.
147	NASAL TRAUMA & DEFORMITY	148	Quintile 5.
149	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	176	Quintile 3.
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	152	Quintile 3.
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.

NO VOLUME LTC–DRG CROSSWALK AND QUINTILE ASSIGNMENT FOR FY 2006—Continued

LTC–DRG	Description	Cross-walked LTC–DRG	Low-volume quintile assignment
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	178	Quintile 3.
163	HERNIA PROCEDURES AGE 0–17	178	Quintile 3.
164	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	148	Quintile 5.
165	CESAREAN SECTION W/O CC	148	Quintile 5.
166	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	148	Quintile 5.
167	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	148	Quintile 5.
169	MOUTH PROCEDURES W/O CC	185	Quintile 3.
184	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT 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	PERIANAL & PILONIDAL PROCEDURES	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	SEPTICEMIA AGE 0–17	253	Quintile 3.
255	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR	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	MAJOR HEAD & NECK 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	EXTREME IMMATURITY	292	Quintile 5.
289	PARATHYROID PROCEDURES	63	Quintile 4.
291	THYROGLOSSAL PROCEDURES	63	Quintile 4.
298	PREMATURITY W MAJOR PROBLEMS	297	Quintile 2.
307	PROSTATECTOMY W/O CC	306	Quintile 2.
309	MINOR BLADDER PROCEDURES W/O CC	308	Quintile 3.
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	FULL TERM NEONATE W MAJOR PROBLEMS	321	Quintile 1.
324	NEONATE W OTHER SIGNIFICANT PROBLEMS	321	Quintile 1.
326	RECTAL RESECTION W/O CC	321	Quintile 1.
327	RECTAL RESECTION W CC	321	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 2.
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 3.
362	ENDOSCOPIC TUBAL INTERRUPTION	110	Quintile 3.
363	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	110	Quintile 3.
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	110	Quintile 3.
370	CESAREAN SECTION W CC	369	Quintile 3.
371	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	368	Quintile 2.
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	110	Quintile 3.

NO VOLUME LTC–DRG CROSSWALK AND QUINTILE ASSIGNMENT FOR FY 2006—Continued

LTC–DRG	Description	Cross-walked LTC–DRG	Low-volume quintile assignment
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	110	Quintile 3.
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C	110	Quintile 3.
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	110	Quintile 3.
376	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	110	Quintile 3.
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	110	Quintile 3.
378	ECTOPIC PREGNANCY	369	Quintile 3.
379	THREATENED ABORTION	110	Quintile 3.
380	ABORTION W/O D&C	110	Quintile 3.
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	110	Quintile 3.
382	FALSE LABOR	110	Quintile 3.
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	110	Quintile 3.
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	110	Quintile 3.
385	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	110	Quintile 3.
386	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	87	Quintile 4.
387	URINARY STONES W/O CC	87	Quintile 4.
388	PREMATURITY W/O MAJOR PROBLEMS	110	Quintile 3.
389	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	87	Quintile 4.
390	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	87	Quintile 4.
391	NORMAL NEWBORN	110	Quintile 3.
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	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG 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 3.
412	HISTORY OF MALIGNANCY W ENDOSCOPY	110	Quintile 3.
414	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	399	Quintile 2.
417	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	416	Quintile 3.
420	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	419	Quintile 4.
422	ADRENAL & PITUITARY PROCEDURES	419	Quintile 4.
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.
478	OTHER VASCULAR PROCEDURES W CC	110	Quintile 3.
479	OTHER VASCULAR PROCEDURES W/O CC	110	Quintile 3.
481	BONE MARROW TRANSPLANT	394	Quintile 5.
485	OTHER HEART ASSIST SYSTEM IMPLANT	487	Quintile 4.
492	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	410	Quintile 4.
494	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	493	Quintile 5.
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	497	Quintile 4.
498	SPINAL FUSION W/O CC	497	Quintile 4.
504	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	468	Quintile 5.
518	PERCUTANEOUS CARDIVASCULAR PROC W/O CORONARY ARTERY STENT OR AMI	125	Quintile 3.
520	CERVICAL SPINAL FUSION W/O CC	497	Quintile 4.
522	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	521	Quintile 1.
523	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	521	Quintile 1.
525	EXTENSIVE BURN OR FULL THICKNESS BURNS WITH MECH VENT 96+ HOURS WITH SKIN GRAFT.	468	Quintile 5.
528	INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	1	Quintile 5.
530	VENTRICULAR SHUNT PROCEDURES W/O CC	529	Quintile 5.
534	EXTRACRANIAL VASCULAR PROCEDURES WITHOUT CC	500	Quintile 4.
535	ACUTE ISCHEMIC STROKE WITH USE OF THROMBOLYTIC AGENT	515	Quintile 5.
536	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	515	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 CURVATURE OF SPINE OR MALIGNANCY	499	Quintile 5.

To illustrate this methodology for determining the relative weights for the 201 LTC–DRGs with no LTCH cases, we are providing the following examples, which refer to the 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 final rule for LTC–DRG 163 (Hernia Procedures Age 0–17). Since the procedure is similar in resource use and the length and complexity of the procedures and the length of stay are similar, we determined that LTC–DRG 178 (Uncomplicated Peptic Ulcer Without CC), which is assigned to low-

volume Quintile 3 for the purpose of determining the FY 2006 relative weights, would display similar clinical and resource use. Therefore, we assign the same relative weight of LTC–DRG 178 of 0.7637 (Quintile 3) for FY 2006 (Table 11 in the Addendum to this final rule) to LTC–DRG 163.

Example 2: There were no LTCH cases in the FY 2004 MedPAR file used in this final rule for LTC–DRG 91 (Simple Pneumonia and Pleurisy Age 0–17). Since the severity of illness in patients with bronchitis and asthma is similar in patients regardless of age, we determined that LTC–DRG 90 (Simple Pneumonia and Pleurisy Age >17 Without CC) would display similar clinical and resource use characteristics and have a similar length of stay to LTC–DRG 91. There were over 25 cases in LTC–DRG 90. Therefore, it would not be assigned to a low-volume quintile for the purpose of determining the LTC–DRG relative weights. However, under our established methodology, LTC–DRG 91, with no LTCH cases, would need to be grouped to a low-volume quintile. We determined that the low-volume quintile with the closest weight to LTC–DRG 90 (0.4970) (refer to Table 11 in the Addendum to this final rule) would be low-volume Quintile 1 (0.4499) (refer to Table 11 in the Addendum to this final rule). Therefore, we assign LTC–DRG 91 a relative weight of 0.4499 for FY 2006.

Furthermore, we are establishing 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 LTC–DRGs with a zero volume of LTCH cases based on the system will vary in the future. We used the best most recent available claims data in the MedPAR file to identify zero volume LTC–DRGs and to determine the relative weights in this final rule.

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

5. Other Public Comments Relating to the LTCH PPS Payment Policies

Comment: One commenter submitted comments that addressed aspects of the existing LTCH PPS, including the hospital-within-hospital policy, which was discussed in the FY 2005 IPPS final rule (69 FR 49191), and the June 2004 MedPAC recommendations concerning the definition of LTCHs, which was discussed in the RY 2006 LTCH PPS final rule (70 FR 5757), for which we did not propose LTCH policy changes in the FY 2006 IPPS proposed rule.

Response: Because those comments pertain to specific aspects of the existing LTCH PPS that were not specific proposed changes to the LTCH PPS presented in the FY 2006 IPPS proposed rule, we are not responding to them at this time. Rather, we believe it is more appropriate to address the issues in the annual LTCH PPS proposed and final rules. We will consider the issues raised in those comments in the context of future rulemaking for the LTCH PPS.

E. Add-On Payments for New Services and Technologies

1. Background

Sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and ensuring adequate payment for new medical services and technologies under the IPPS. Section 1886(d)(5)(K)(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 FY 2006 DRG weights in this final 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, August 1, 2003), 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 **Federal Register** document that corrects the FY 2004 final rule (68 FR 57753, October 6, 2003), 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, August 11, 2004) 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 1886(d)(5)(K)(ii)(III) of the Act, as amended by section 503(d)(2) of Pub. L. 108–173, provides 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 this 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 Web site will also list the tracking forms completed by each applicant.

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

Section 1886(d)(5)(K)(viii) of the Act, as amended by section 503(b)(2) of Pub. L. 108–173, provides 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 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 the FY 2006 IPPS 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 the 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 considered these comments in our evaluation of each new application for FY 2006 in the proposed rule and in this final 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 1886(d)(5)(K)(ix) of the Act, as added by section 503(c) of Pub. L. 108–173, requires 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 DRG assignment is necessary or a new technology add-on payment is appropriate when the reimbursement under these currently assigned 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 final rule.

In this final 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.

Comment: Commenters argued that CMS' interpretation of the newness criterion is inconsistent with the statute and that, as a result, CMS is prematurely denying eligibility for many technologies. Commenters believed that instead of basing the newness criterion on FDA approval or market availability, CMS should start the 2–3 year period that a technology can be considered new from the later of the date that the technology is assigned an ICD–9–CM code or is approved by the FDA. Commenters argued that neither the statutory language nor the regulatory language refers to the date of FDA approval in determining whether a technology is new. One commenter further argued that CMS should ensure a maximum period of eligibility for new technology add-on payments that takes into account a ''host of 'newness' factors'' such as production and distribution, negotiation with hospitals, and physician education programs. The commenter proposed that CMS determine newness, based on the latest of the following dates:

• Date of ICD–9–CM code assignment;

• Date of FDA approval plus six months; or

• The time/date at which 50 percent of the Fiscal Intermediaries are processing claims that include the technology in question.

The commenter further recommended that, given the numerous challenges of bringing a device to market, CMS should extend the period that a product is considered new from two to three years to four or five years.

Response: Section 1886(d)(5)(K)(vi) of the Act provides the Secretary with broad discretion to define a ''new medical service or technology.'' As we have indicated in prior rules (for example, see 66 FR 46914, September 7, 2001), we believe that a product should be considered new 2 to 3 years from the date a product becomes available on the market (generally from the date of FDA approval unless an applicant can demonstrate that there was a delay in making the product available on the market). Once a product becomes available on the market, hospitals that use the new technology will begin including charges for the product on their bills under either an existing or new ICD–9–CM code. These charges will be used to set the DRG relative weights two years later (that is, FY 2004 charge data are being used to set the FY 2006 DRG relative weights). Therefore, 2 to 3 years after the technology is available on the market, there will be a full year of Medicare charge data used to set the relative weights that will reflect the cost of the device. We note that a manufacturer can reasonably predict when a product will become available on the market and, if warranted, could request a new ICD–9–CM code in order to distinctly identify the new technology in our data. In the FY 2005 final rule (69 FR 49002), we provided a detailed explanation for why using the date on which a specific ICD–9–CM code is assigned to a technology is not an appropriate test of newness. In that rule, we noted that, in many instances, a technology may have been in use for several years, or even several decades, prior to the assignment of a new code (69 FR 49003). Thus, we believe it is appropriate to continue to determine newness based on the date on which a product becomes available for use in the Medicare population and the date when hospitals can begin to use either an existing or new ICD–9–CM code to bill for the new service or technology.

Comment: One commenter indicated that, because Medicare does not pay for devices during clinical trials, ''little or no internal Medicare claims data exist upon which to base an initial DRG assignment for new technologies.'' To address this issue, commenters suggested that CMS should accept external data while maintaining confidentiality for proprietary data. Other commenters indicated that CMS decisions regarding substantial clinical improvement have been largely subjective and made without stakeholder input. Commenters requested that CMS include ''a consistent and reasonable set of requirements for manufacturers of novel technologies to meet'' in order to be eligible for new technology add-on

payments. Several commenters indicated the process for applying for new technology add-on payments is particularly burdensome for smaller companies. Commenters urged CMS to provide a preliminary assessment of substantial clinical improvement for each technology in the proposed rule, in order for the public to respond CMS' findings during the public comment period.

Response: With respect to the comment about the lack of Medicare claims data for making a DRG assignment for a new medical product, we believe that the new technology process is intended to address precisely this issue. In our evaluation of a new technology application, we consider any external data provided by the applicant to make judgments as to whether a product meets the three criteria we have established either to assign a new technology to a different DRG or to approve a new technology for add-on payments. In addition, while we generally do not pay for an experimental device itself when used as part of a clinical trial, a hospital is not precluded from including an existing or a newly assigned ICD–9–CM code or V-Codes on its bill for Medicare covered services. Thus, we have been able to successfully track devices that are (or were) in clinical trials in our MedPAR data, and have used these data to determine whether several new technologies have met the cost threshold for new technology payment. We addressed the concerns over submissions of external data and proprietary information in the FY 2005 final rule (69 FR 49004, August 11, 2004). As indicated in that rule, we are continuing to consider this issue, but we are not making any changes to our policy on the submission of external data and proprietary information at this time.

We disagree that determinations regarding applications for add-on payments are made without stakeholder input. There is ample opportunity for applicants and other interested parties to make their views known to us throughout the application process, at the public meeting, as well as during the comment period on the proposed rule. We have had numerous meetings with applicants where they have addressed our concerns and/or brought further information to our attention on the merits of their technology. Our initial new technology final rule (66 FR 46914, September 7, 2001) provides the specific guidelines we consider to determine whether a technology is a substantial clinical improvement. In that final rule, we indicated that, in order to meet the substantial clinical improvement criteria, a new technology must be able to offer a new treatment option for a patient population unresponsive to, or ineligible for, currently available treatments; diagnose a previously undetectable condition or allow for earlier diagnosis; or significantly improve clinical outcomes. We provided seven potential measures to evaluate this third standard. While our regulations provide specific criteria for evaluating substantial clinical improvement, by its very nature, this process involves judgment. Before making a final judgment about substantial clinical improvement, we carefully consider all of the information that is provided to us in a new technology application, as well as the viewpoints expressed through the public meeting, during the comment period, and in meetings with individual applicants.

We do not believe that our criteria present an inordinately cumbersome burden for smaller companies that want to apply for new technology add-on payments. Several small companies have already approached us seeking advice on how to apply for new technology add-on payments FY 2007 and later years. We encourage potential applicants to contact us before their technology is available on the market to become familiar with the new technology application process.

With respect to providing preliminary determinations of substantial clinical improvement in the proposed rule, we addressed this issue in the FY 2006 proposed rule (70 FR 23359). We indicated that our decision about new technology add-on payments follows a logical sequence of determinations, moving from the newness criterion, to the cost criterion and finally to the substantial clinical improvement criterion. Therefore, we are reluctant to import substantial clinical improvement considerations into the logically prior decisions about whether technologies satisfy the newness and cost criteria. We acknowledge that an applicant seeking new technology payment for a product expected to receive FDA approval between the proposed and final rule has an interest in knowing CMS' findings about substantial clinical improvement. Nevertheless, we believe that FDA approval of a product is a logical prior determination because substantial clinical improvement is a higher standard to meet than either of the FDA standards for allowing a product on the market. If a product does not meet the FDA standards for a pre-market (''safe and effective'') or humanitarian device exemption (''safe'') approval, it cannot be a substantial clinical improvement. While we do not believe a determination about substantial clinical improvement should be made prior to FDA approval, two applicants have received FDA approval for their products since the publication of the proposed rule. We met with these two applicants during the public comment period to discuss our concerns about substantial clinical improvement. As indicated below, we are approving both of these technologies for new technology add-on payments beginning in FY 2006.

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 new technology final rule (66 FR 46915), September 7, 2001 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, as we proposed, we are discontinuing 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 also discontinuing new technology add-on payment for OP–1 Putty for FY 2006.

Comment: Several commenters agreed with our proposal to terminate add-on payment for INFUSE® bone graft for spinal fusions.

Response: We are finalizing our proposal to terminate new technology add-on payments for INFUSE® bone graft for spinal fusions in this final rule.

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 new technology final rule (66 FR 46915, September 7, 2001), 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 the FY 2005 final rule, we also noted that we would extend new technology add-on payments for CRT–D for the entire FY 2005 even though the 2–3 year period of newness ended in May 2005 for CRT–D. 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, as we proposed, we are discontinuing add-on payments for the CRT–D for FY 2006.

Comment: One commenter thanked CMS for approving add-on payments for the CRT–D. The commenter also indicated that add-on payment for this device had contributed significantly to patient access and broader physician adoption of this new treatment. Another commenter requested that CMS continue to make add-on payment for CRT–D to avoid financial problems that hospitals will experience if payment is ceased.

Response: We appreciate the commenter's support of our decision to approve add-on payments for CRT–D. Consistent with section 1886(d)(5)(K)(ii) of the Act, the regulations do not permit us to extend payment for CRT–D beyond the 2–3 year period during which a technology can be considered new. Therefore, we are finalizing our proposal to discontinue add on payments for the CRT–D in 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, followup, and programming procedures for physicians.

The FDA approved the device in December 2003. 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 charges for cases that included implantation of the Soletra™ device were $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 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 does not separately identify cases with the Kinetra® device and is only 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 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, as we proposed, we are continuing add-on payments for Kinetra® Implantable Neurostimulator for deep brain stimulation for FY 2006.

Comment: Several commenters supported our decision to continue add-on payments for Kinetra® Implantable Neurostimulator for deep brain stimulation for FY 2006.

Response: In this final rule, we are finalizing our proposal to continue add-on payments for the Kinetra® Implantable 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 that INFUSE® for open tibia fractures was substantially similar to OP–1 Implant for recalcitrant long bone non-unions. Medtronic stated that ''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 technology using 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 and to explain why this product should not affect our consideration of the application for new technology add-on payments for INFUSE®. 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 open tibia fractures 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: in radiographic assessment and mechanical testing of the repaired bone; and in 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 over existing technologies, 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. Even if it were possible to differentiate between patients who 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, as we stated in last year's final rule in connection with our decision to make add-on payments for both products when used for spinal fusions, 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 of the relevant DRGs reflect the costs of these products.

Prior to the publication of the FY 2006 IPPS proposed rule, we received the following public comments on the application for add-on payments for FY 2006.

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 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 populations 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 there is 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 its first proposed criterion has some relevance in determining whether products are substantially similar. In evaluating the application for new technology add-on payments for INFUSE® for open tibia fractures 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 should be controlling 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 both 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 logically 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.

Comment: In response to our request for comments on the issue of substantial similarity in the **Federal Register** announcement of the new technology town hall meeting, Medtronic also 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 new technology 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 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, in the FY 2006 IPPS proposed rule, we solicited comments on the use of substantial similarity to determine whether products qualify for new technology add-on payments while we continued to consider these issues. The comments we received in response to this request are addressed below in our discussion of substantial similarity.

We note that, in support of its application for add-on payments for FY 2006, 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, in the FY 2006 IPPS proposed rule we proposed to deny new technology add-on payments for INFUSE® bone graft for open tibia fractures for FY 2006.

During the 60-day comment period on the FY 2006 IPPS proposed rule, we received the following comments on this application:

Comment: Several commenters wrote to support the application for INFUSE® bone graft for open tibia fractures for new technology add-on payments. These commenters disagreed with our assertion that the costs for this technology are adequately reflected in the DRG weights. The commenters argued that the data include few claims for OP–1 and do not justify denying add-on payments to INFUSE®. Further, commenters argued that the different types of FDA approval are relevant to the discussion of newness and substantial clinical improvement of the BMP products. Commenters pointed to the limited number of cases that would have been eligible to receive OP–1 due to its limited FDA humanitarian device exemption (HDE) approval. Commenters noted that an HDE approval limits the number of patients that can receive the product to 4,000 patients, and therefore the costs of the cases are not adequately reflected in the DRG weights. According to the commenters, CMS' own analysis supports this point because there were only 77 cases in the FY 2004 MedPAR data, indicating that a patient received a BMP product with no mention as to whether there were any cases in the relevant DRGs for FY 2003. Therefore, commenters argued, the technology is not used frequently enough to be adequately reflected in the DRG weights. In addition, commenters argued that OP–1 is only indicated for non-union fractures while INFUSE® is for open tibia fractures.

Response: We appreciate the commenters' input on this technology. However, we continue to believe that INFUSE® is not a new product because of its substantial similarity to OP–1. These products are both designed to promote healing of broken bones even though they are FDA approved for somewhat different indications. Furthermore, treatment of open tibia fractures and non-unions of tibia fractures will be paid using the same DRGs. Because the OP–1 Implant received FDA approval in 2001 and INFUSE® is a similar product that will be included in the same DRG, we do not believe that the product can be considered new for the purposes of new technology add-on payments. While the commenters argue that the MedPAR data do not include a sufficient number of cases for CMS to argue that payment for BMP products are included in the DRG weights, we do not believe that case volume is a relevant consideration for making the determination as to whether a product is new. Consistent with the statute, a technology no longer qualifies as new once it is more than 2 to 3 years old irrespective of how frequently it has been used in the Medicare population. Thus, if a product is more than 2 to 3 years old, we consider its costs to be included in the DRG relative weights whether its use in the Medicare population has been frequent or infrequent. We also recognize that, without financial incentive to code BMPs, it is possible that hospitals may not have included procedure code 84.52 on hospital bills for all instances when a BMP product was used. Therefore, the incidence of actual use of BMPs for this period may be higher than shown in the Medicare data. Nevertheless, even though hospitals may not have coded all uses of procedure code 84.52, hospital bills would still include charges for all items and services furnished to a Medicare patient including use of a BMP product. Therefore, even though we may be not be able to identify all uses of a BMP product in the Medicare charge data, hospital charges for the DRG would continue to reflect use of these products. In addition, we note that open tibia fractures are not common among the elderly population, and we would therefore not expect to find a high incidence of these cases in the MedPAR data. Also, given the penetration that BMPs have made in DRGs 219 and 220, in addition to many other DRGs, we believe that the BMP technology is adequately reflected in our MedPAR data that were used to recalibrate the DRG weights for FY 2006. Therefore, the

technology can no longer be considered new for the purposes of new technology add-on payments. In this final rule, we are finalizing our proposal to deny add-on payments for INFUSE® bone graft for tibia fractures.

Comment: As discussed above, prior to publication of the FY 2006 IPPS proposed rule, we received a comment offering suggestions for how to define when products are ''substantially similar.'' We responded to this comment in the proposed rule (70 FR 23359), and indicated that we welcomed further comments on this issue. Several commenters raised concerns about CMS' responses to this comment.

One commenter indicated that CMS ''is using the determination of 'substantial similarity' as a basis to support a preliminary determination that these technologies are 'not new' * * * when no such criter[ion] exists in the threshold criteria.'' Another commenter indicated that the discussion of substantial similarity creates confusion between the issue of substantial similarity and the three add-on payment criteria. This commenter indicated that the discussion of this issue in the proposed rule implies that substantial similarity is a subfactor of the newness criterion, while prior rules have implied that it is a subfactor of the substantial clinical improvement criterion or a replacement for all three criteria. To support this point, the commenter stated that the new technology final rule (66 FR 46915) indicates that a substantially similar technology would still be required to submit data showing that the technology was inadequately paid and meets the criterion for being new, thus implying that substantial similarity is a subfactor of the substantial clinical improvement criterion. The commenter referenced the discussion in the FY 2005 IPPS final rule (69 FR 49008–49009) indicating that new technology add-on payments would be extended to OP–1 putty without the submission of an application for add-on payments as evidence that substantial similarity has replaced all three criteria. Commenters further expressed concern over the detrimental effects that this standard could have, denying patient access to therapies ''merely because the therapy has the same mechanism of action as an existing treatment.'' These commenters recommended that CMS eliminate substantial similarity from our new technology add-on payment deliberations, and grant add-on payments based solely on whether a product satisfies the newness, cost, and substantial clinical improvement criteria specified in the regulations.

Other commenters noted that CMS has no way to distinguish between manufacturers when similar products use the same ICD–9–CM codes. Therefore, the commenters argued, there is no need for competitors to apply for their own new technology add-on payment if a product has already been approved for add-on payments, despite the language contained in the new technology final rule stating that the manufacturers of substantially similar products would be required to file a separate application for add-on payment (66 FR 46915).

Response: With respect to the discussion of substantial similarity in the new technology final rule, we did indicate that a manufacturer of a substantially similar product would have to submit an application to be awarded add-on payments. However, we note that this statement was made without any actual experience with the implementation of section 1886(d)(5)(K) of the Act. After reviewing and approving technologies for add-on payment for several years, we have found that our original policy did not adequately reflect the fact that substantially similar products will use the same ICD–9–CM codes and that it would be impractical to create manufacturer-specific codes and also require each manufacturer to submit separate applications for products that are essentially the same. Moreover, given that we cannot distinguish one manufacturer from another when substantially similar technologies use the same ICD–9–CM code, there is no practical purpose for manufacturers of substantially similar products to apply separately for new technology add-on payments. Therefore, we have not required that an application for add-on payments be submitted for a substantially similar product that uses the same ICD–9–CM code as a product that has previously been approved for add-on payments. In addition, we have made an effort to identify competitors that might be eligible to receive new technology add-on payments for their devices. In fact, we note that we have discussed several such technologies in this year's and previous years' rules and have allowed for add-on payments for particular, new classes of technologies that fall within the same ICD–9–CM code (for example, CRT–D).

We believe that these commenters raise interesting and complex policy issues regarding the application of the new technology add-on payment policy to products that are substantially similar. While the commenters generally appear to agree with our policy when we have extended new technology add-on payments to substantially similar products, they appear to disagree with our application of the concept of substantial similarity when we have denied add-on payments. (We note that one commenter disagreed with both the decision to extend new technology add-on payments to OP–1 for spinal fusions and the decision to deny them to INFUSE® for tibia fractures on the basis of substantial similarity. Nevertheless, this same commenter has also asked us to use the concept of substantial similarity to extend new technology add-on payments to the Talent Endovascular Stent Graft.

This apparent policy contradiction is illustrated with the example of INFUSE® and OP–1. We extended new technology add-on payments to OP–1 for spinal fusions without a separate application because of its substantial similarity to INFUSE® and without specifically finding that the product met all three criteria for add-on payments. We determined that OP–1 putty was substantially similar to another product that had been approved for new technology add-on payments. OP–1 putty was clearly new given the date it was approved by the FDA and was substantially similar to another new product that had been approved for new technology add-on payments. However, because the technology of using BMPs for spinal fusions had already been found to meet the newness, cost and substantial clinical improvement criteria, we did not separately address these criteria. Rather, after determining that the two products were substantially similar, we extended the approval of add-on payments to OP–1. The commenters appear to agree with this decision and the concept of extending new technology add-on payments to substantially similar products so that our payment policy does not bestow an advantage to the first applicant representing a particular new technology to receive approval. However, the commenters appear to disagree with our denial of new technology add-on payments to INFUSE® for tibia fractures on the basis of its substantial similarity to OP–1. Because OP–1 Implant for recalcitrant long bone unions had been in use for 3 years and the costs for this technology had been included in the weights for the DRGs where cases involving INFUSE® for tibia fractures are assigned, in the final rule for FY 2005, we determined that INFUSE® could not longer be considered ''new.'' (69 FR 49012).

We believe that the concept of substantial similarity needs to be applied consistently both in the context of extending and denying new

technology add-on payments. Thus, we believe it is important to clarify whether a finding of substantial similarity among products constitutes only a decision about the newness criterion or about all three criteria. One commenter indicated that our decision to extend new technology add-on payments to OP–1 for spinal fusions because of its similarity to INFUSE® implies that our determination on substantial similarity replaced consideration of the three criteria. This commenter and others believed, however, that our determination on substantial similarity between OP–1 and INFUSE® for tibia fractures implies that we are applying the concept as a subfactor of newness.

In both cases, we only made a determination about the similarity of the products and did not specifically make a finding as to whether all three criteria for add-on payments were met. When we denied new technology add-on payments to INFUSE® for open tibia fractures, we effectively made a logical prior determination about newness based on our finding of substantial similarity and, as a result, we did not need to evaluate either the cost or substantial clinical improvement criteria. Similarly, when we extended new technology add-on payments to OP–1 for spinal fusions on the grounds that it is substantially similar to INFUSE®, we effectively indicated that both products were new but did not make a specific finding about cost and substantial clinical improvement with respect to OP–1. Rather, we extended the existing approval of add-on payments for the new technology of using BMPs in spinal fusions to a substantially similar product in order to avoid bestowing an advantage to the first product to receive an approval of add-on payments for this particular new technology.

We see two policy options to address this issue. Under the first option, we continue our current practice. That is, if we make a finding of substantial similarity among two products, we will extend new technology add-on payment without a further application from the manufacturer of the competing product or a specific finding on cost and clinical improvement. Also, we will deny new technology add-on payments to substantially similar products if one of the products no longer qualifies as a new medical technology without a specific finding on the remaining two criteria. Under the second option, we would depart from our current practice and only extend new technology add-on payment to an applicant's product after making a determination that it meets the newness, cost, and substantial clinical improvement criteria. As we have indicated in the past, we believe that continuing our current practice is the better policy because we avoid:

- Creating manufacturer-specific codes for substantially similar products.
- Requiring different manufacturers of substantially similar products from having to submit separate new technology applications.
- Having to compare the merits of competing technologies on the basis of substantial clinical improvement.
- Bestowing an advantage to the first applicant representing a particular new technology to receive approval.

The commenters also argued that the concept of substantial similarity is being applied without having been defined in the regulations. We do not believe that it would be appropriate at this time to adopt rigid criteria to define substantial similarity. Such criteria would restrict unduly our ability to make appropriate determinations regarding whether a product should qualify for new technology add-on payments. For example, if we were to use the Medtronic definition of substantial similarity described above, each manufacturer of a competing technology would have to submit a separate application for an add-on payment and, potentially, we would have to create separate codes for each manufacturer's product if we found that one product met all of the criteria for an add-on payment while the other did not. For instance, Medtronic supported the application of W. L. Gore & Associates, Inc. for its Endovascular Graft Repair of the Thoracic Aorta (GORE TAG). If this device were to be approved for new technology add-on payments, Medtronic recommended that we extend these payments to its Talent Endovascular Stent Graft once it is approved by the FDA. As indicated below, we are approving for the GORE TAG device for new technology add-on payments. If we were to use Medtronic's criteria for defining substantial similarity, for us to extend new technology add-on payments to its device for an endovascular thoracic aortic aneurysm repair, we would have to make a determination that the products: (1) Use the same or a similar mechanism of action to achieve the therapeutic outcome; (2) are indicated for use in the same population for the same condition; and (3) achieve the same level of substantial clinical improvement. While it may be possible to make a determination on the first of these two criteria based on a description of the products and their FDA approved indications, we believe it would not be possible to make a decision on the third criterion without a new technology application and specific review in order to determine whether the two products achieve the same level of substantial clinical improvement. Applying Medtronic's criteria, we do not believe that new technology add-on payments could be extended to a substantially similar product in the middle of a fiscal year. Thus, for example, add-on payments for Medtronic's Talent Endovascular Stent Graft, which has not yet received FDA approval, could not begin until at least FY 2007. Further, in the absence of a finding that the products achieve the same level of substantial clinical improvement, we would need to establish a specific code for the GORE TAG device that other manufacturers of similar products could not use unless they also made a new technology application and we made a finding on the three criteria for determining substantial similarity suggested by Medtronic. Thus, in this circumstance, application of Medtronic's suggested criteria for defining substantial similarity would bestow an advantage to GORE TAG until we could make a specific finding on the Talent Endovascular Stent Graft.

In the proposed rule, we indicated that whether a product uses the same or a similar mechanism of action to achieve the therapeutic outcome has some relevance for determining substantial similarity. We also indicated that the whether the products are assigned to the same or a different DRG is also relevant for determining substantial similarity and assessing if the hospital charge data used in developing the relative weights of the relevant DRGs reflects the costs of these products. In making a determination of substantial similarity, we believe both of these criteria should be met. If only one of the criteria is met, we do not believe the products should be considered substantially similar and new technology add-on payments should not be extended or denied on this basis. In the case of OP–1 and INFUSE®, both are bone morphogenetic products that are used to induce bone growth (''use the same or similar mechanism of action to achieve the therapeutic outcome'') assigned to the same DRGs (DRGs 497 and 498 for spinal fusions and DRGs 218 and 219 for tibia fractures). Furthermore, both of these products can be described by the same ICD–9–CM code (code 84.52, Insertion of recombinant bone morphogenetic protein). Thus, our decisions to extend new technology add-on payments to OP–1 for spinal fusions and deny them to INFUSE® for tibia fractures on the

basis of substantial similarity, applied, the two above described criteria consistently.

We believe the above discussion indicates that these are complex issues. While the application of the above two criteria worked well in the context of OP–1 and INFUSE® (as well as the GORE TAG and Talent Endovascular Stent Graft), it is possible that we should have the flexibility to consider these or other factors in some contexts but not in others. For these reasons, we will continue to analyze the question of substantial similarity, and welcome further public input on this issue.

In this final rule, we are finalizing our proposal to deny add-on payments for INFUSE® bone graft for open tibia fractures for the reasons discussed above. 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 proposed 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 is 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-weighed 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 hospital length of 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 proposed 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 prior to publication of the FY 2006 IPPS proposed rule. During the 60-

day comment period for the FY 2006 IPPS proposed rule, we also received no comments. Therefore, we are finalizing our proposal to deny new technology add-on payments for the System 100 because it does not meet the newness criterion.

c. CHARITÉ™ Artificial Disc (CHARITÉ™)

DePuy Spine™ submitted an application for new technology add-on payments for the CHARITÉ™ Artificial Disc for FY 2006. This device is a prosthetic intervertebral disc. DePuy Spine™ stated that the CHARITÉ™ 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 CHARITÉ™ 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 CHARITÉ™ Artificial Disc should have failed at least 6 months of conservative treatment prior to implantation of the CHARITÉ™ 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 CHARITÉ™ 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 CHARITÉ™ 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 cases using CHARITÉ™ map to DRGs 499 and 500. The applicant submitted 68 actual cases from 35 hospitals that used the CHARITÉ™. 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 CHARITÉ™ 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 CHARITÉ™ 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. As noted above, cases using the CHARITÉ™ device group to the DRGs for back and neck procedures that exclude spinal fusions (DRGs 499 and 500). However, the applicant argues that the CHARITÉ™ 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 CHARITÉ™ 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 CHARITÉ™ 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 CHARITÉ™ by 15 percent to $17,420. The applicant then added the average standardized charge for surgical and medical supplies of the CHARITÉ™ to the standardized charge of the remaining 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 computation resulted in 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 where these cases are grouped. 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 CHARITÉ™ meets the cost criterion.

Comment: The applicant commissioned two independent consultants to conduct separate data analyses demonstrating with actual cases of CHARITÉ™ that the device meets the cost criterion. The consultants found 308 cases using CHARITÉ™ including 9 Medicare cases. One consultant found 94 cases with average standardized charges of $43,065, and the other consultant found 214 cases with average standardized charges of $45,791. As in the proposed rule, the commenter noted that the average standardized charges per case are well in excess of the threshold for DRG 499.

Response: We appreciate the commenter's submission of additional data in support of its application. Based on these data, it appears that the technology meets the cost criterion.

The applicant also contended that the CHARITÉ™ represents a substantial clinical improvement over existing technology. Use of the CHARITÉ™ 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 CHARITÉ™ 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 CHARITÉ™ 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 CHARITÉ™ 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 CHARITÉ™ Artificial Disc. Also, patients who received the CHARITÉ™ 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 CHARITÉ™ 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 follow up of 100 patients (minimum 10 years) who received the CHARITÉ™ Artificial Disc, the incidence of adjacent level DDD was 2 percent.

In the FY 2006 IPPS proposed rule, we indicated that we were continuing to review the information on whether the CHARITÉ™ 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 CHARITÉ™ 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. We also are concerned about the prevalence of osteoporosis within the Medicare population, because it is a contraindication for this device. In the FY 2006 IPPS proposed rule, we invited 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 noted in the FY 2006 IPPS proposed rule that we were still considering whether it is appropriate to approve new technology add-on payment status for the CHARITÉ™ Artificial Disc for FY 2006. If approved for add-on payments, hospitals would be reimbursed for up to half of the costs for the device. Because the manufacturer has stated that the cost for the CHARITÉ™ Artificial Disc would be $11,500, the maximum add-on payment for the device would be $5,750.

We finally noted that the applicant requested a DRG reassignment for cases of the CHARITÉ™ 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 CHARITÉ™ is not a spinal fusion, we decided not to include this procedure in these DRGs. However, in the FY 2006 IPPS proposed rule, we indicated that we would continue to analyze this issue and solicited public comments on both the new technology application for the CHARITÉ™ and the DRG assignment for spinal disc prostheses.

We received no public comments regarding this application for new technology add-on payments prior to the publication of the FY 2005 IPPS proposed rule. However, we received the following comments during the 60-day comment period on the proposed rule.

Comment: The applicant noted that on July 15, 2005, two new articles were published in the journal ''Spine.'' [3] The applicant maintained that the studies demonstrate the following conclusions:

- The CHARITÉ™ obviates the iliac crest bone graft donor site morbidity.
- The CHARITÉ™ preserves segmental motion in flexion/extension through 24 months post implantation.
- The CHARITÉ™ provided maintenance of post operative disc height through 24 months compared to anterior interbody fusion; disc space height was maintained in greater than 99 percent of CHARITÉ™ subjects through 24 month followup.
- The CHARITÉ™ has the potential to reduce second surgical procedures for adjacent disc disease by maintaining motion (the manufacturer intends to investigate this).
- The CHARITÉ™ provides early improvement in pain and function as measured by the Oswestry Disability Index compared to anterior interbody fusion at 6 weeks, 3 months, 6 months, and 12 months.
- The CHARITÉ™ provides improvement in pain reduction as measured by the Visual Analog Scale compared to anterior interbody fusion at 6 weeks, 3 months, 6 months, and 12 months.
- The CHARITÉ™ provides improvement in quality of life on the physical component score of the SF–36 outcomes tool at 3 months, 6 months, and 24 months.

CMS requested comments on whether or not the results from the IDE study can be generalized to the Medicare population. The commenter commissioned a consultant to conduct a survey to capture clinical information for the Medicare population 65 years or older and the Medicare population that had been implanted with the CHARITÉ™, noting that the under 65 Medicare disabled population represents 14 percent of all Medicare beneficiaries or approximately 5 million people. The consultant found data for 18 Medicare beneficiaries and submitted the following results: Surgeons reported that 94.4 percent of the patients demonstrated improvement in overall outcome, pain, and function after the CHARITÉ™ had been implanted. Surgeons also noted the following: 100 percent of the patients reported an improved level of activity; 50 percent of the patients achieved full recovery, the other 50 percent had an improved level of activity compared to their preoperative status; and 100 percent of the surgeons recommended the CHARITÉ™ for other Medicare patients who meet the clinical indications. The commenter believed that the above studies and the IDE trial demonstrate that CHARITÉ™ offers a substantial clinical improvement over fusion for Medicare beneficiaries.

The commenter also stated that Medicare beneficiaries with disabilities make up 21.8 percent of all discharges in DRGs 496, 497, and 498. It is likely that a significant number of these

[3] A. Blumenthal et al., ''A Prospective, Randomized, Multi Center FDA IDE Study of Lumbar Total Disc Replacement with the CHARITÉ™ Artificial Disc vs. Lumbar Fusion: Part I—Evaluation of Clinical Outcomes.''

B. McAfee et al., ''A Prospective, Randomized, Multi Center FDA IDE Study of Lumbar Total Disc Replacement with the CHARITÉ™ Artificial Disc vs. Lumbar Fusion: Part II—Evaluation of Radiographic Outcomes and Correlation of Surgical Technique Accuracy with Clinical Outcomes.''

patients could benefit from the CHARITÉ™. In response to CMS' concern that CHARITÉ™ is contraindicated in patients with osteoporosis, the commenter noted that spinal fusion surgery is also not indicated in this patient population. Nevertheless, the commenter noted that the Medicare charge data included nearly 98,000 spinal fusions in FY 2004.

The commenter further stated that, although many patients above the age of 65 do have osteoporosis, implanting surgeons report seeing many patients over the age of 65 who are extremely active and do not have signs of osteoporosis, as validated by a Dexascan.

The commenter also requested that CMS apply the substantial clinical improvement criteria consistently to CHARITÉ™ and INFUSE® bone graft for spinal fusions. The commenter noted that in the FY 2004 IPPS final rule (68 FR 45388, August 1, 2003), CMS approved INFUSE® for new technology add-on payment even though evidence was submitted for a small number of Medicare aged patients treated with the product. CMS acknowledged that there was some positive, though limited, evidence for generalized application for the Medicare population, leading CMS to conclude that based on ''[t]hese results, combined with the benefits of the elimination of the need to harvest bone graft from the iliac crest (and associated complications), INFUSE® does meet the substantial clinical improvement criteri[on].'' The commenter added that, in addition to eliminating the need for harvesting bone from the iliac crest, the CHARITÉ™ provides other significant clinical improvements, including maintaining a more normal range of motion, restoration of disc height, potential to reduce adjacent level disc disease, earlier and sustained improvement in pain and function and earlier return to normal activity and improvement in qualify of life.

Based on the comments above, the commenter noted that the CHARITÉ™ meets all the criteria and should be approved for new technology add-on payments.

Response: There have been a number of clinical studies conducted on the CHARITÉ™ (some of the studies referenced below were also submitted by the applicant). One study showed unsatisfactory long term results. Three studies [4 5 6] demonstrated excellent or good results, but did not explicitly compare the surgery to spinal fusion. One study [7] showed promising short-term results, but had no long-term data and indicated the need for further study. After reviewing all the information supplied by the applicant and in these clinical studies discussed above, CMS acknowledges that the CHARITÉ™ may have potential benefit for certain carefully selected Medicare beneficiaries. However, our medical officers could not find sufficient evidence to support a finding that this device meets the criteria for being a substantial clinical improvement. Specifically, we are concerned about the lack of comparative data beyond 24 months in the materials that were submitted for review. While the clinical studies above cited by the manufacturer suggest positive outcomes with the device for up to 24 months, other studies cast doubt on both its short-term and long-term performance, and raise troubling questions regarding longer term adverse outcomes. Specifically, as mentioned above, one study [8] included 27 patients who received the device between 1989 and 2001. Of these patients, 12 reported some short-term benefit, while 14 others reported no benefit at all. The study found that patients in this study had ''recurrent or persistent back and leg pain [that] was caused mainly by disc degeneration on neighboring levels, hyperlordosis of the operated segment, subsidence and migration.'' In addition, the study indicated that removal of the prosthesis is dangerous, and posterior fusion without removing the prosthesis will give suboptimal results. The study further suggested that the CHARITÉ™ should be considered experimental until long term results by unbiased observers can indicate to the orthopedic community if the device is an acceptable orthopedic procedure. We also are concerned about the very low number of Medicare beneficiaries who have received the device (18). In addition, aside from a lack of long-term clinical evidence that demonstrates the effectiveness of the device, we also note significant controversy within the orthopedic and spine surgery community regarding the overall effectiveness and safety of this device regardless of a patient's age, primarily based on the lack of long term data to support its use. Therefore, due to the lack of good evidence of long-term clinical benefit and safety, and because of the degree of controversy surrounding the device within the orthopedic and spine surgery community, we do not believe it meets the criterion for substantial clinical improvement and we are denying the application for new technology add-on payments for FY 2006.

We finally note that we believe we have applied a consistent standard of evidence. While the applicant stated there may be similarities between this device and INFUSE®, as noted above, we believe there are still many unanswered questions regarding CHARITÉ™, including the lack of long-term clinical evidence and the overall effectiveness of the device, which preclude us from determining that it meets the substantial clinical improvement criterion.

Comment: One commenter who had the CHARITÉ™ implanted supported approving the CHARITÉ™ for new technology add-on payments. The commenter explained that the device has offered clinical benefits, such as pain relief, that other procedures or surgeries were unable to achieve. Other commenters also supported approval of the CHARITÉ™, indicating that the FDA prospective study showed a reduction in length of stay of a half day and patients also returned to normal activities in half of the time of spinal fusion patients.

Response: As noted above, we acknowledge that the CHARITÉ™ may have potential benefit for certain carefully selected Medicare beneficiaries. However, we do not believe that one patient's experience is sufficient to show the substantial clinical improvement criterion has been met. Further, while the patient's experience indicates that there may be short-term benefits from receiving treatment with CHARITÉ™, we remain

[4] David TJ. ''Lumbar disc prosthesis; Five years follow-up study on 96 patients [abstract]'' Presented at the 15th Annual Meeting of the North American Spine Society (NASS), New Orleans, LA, 2000.

[5] Lemaire JP., ''SB Charite III intervertebral disc prosthesis: Biomechanical, clinical, and radiological correlations with a series of 100 cases over a follow-up of more than 10 years'', Rachis [Fr]. 2002;14:271–285, *cited in* DePuy Spine, Inc. Charité Artificial Disc. Technical Monograph. SA01–030–000. JC/AG. Raynham, MA: DePuy; November 2004.

[6] Caspi I, Levinkopf M, Nerubay J., ''Results of lumbar disk prosthesis after a follow-up period of 48 months'', *Israel Medical Association Journal.* Volume 5, Issue 1, Pages 9–11, 2003.

[7] A. Geisler FH, Blumenthal SL, Guyer Rd, et al., ''Neurological complications of lumbar artificial disc replacement and comparison of clinical results with those related to lumbar arthrodesis in the literature: Results of a multicenter, prospective, randomized investigational device exemption study of Charité intervertebral disc'', Journal of Neurosurgery (Spine 2) Volume 1 Number 2, Pages 143–154, 2004.

[8] Van Ooij, Oner, ''Complications of Artificial Disc Replacement.'', *Verbout Journal of Spinal Disorders and Techniques,* Vol. 16 No. 4, p. 369–383, 2003.

concerned that the data supplied by the applicant did not demonstrate substantial clinical improvement long term, despite the product being available on the European market since 1987. We are also concerned about the degree of controversy surrounding the device within the orthopedic and spine surgery community. Therefore, we are denying this application for new technology add-on payments because we did not find enough evidence that the product meets the substantial clinical improvement criterion.

Comment: One commenter noted that CMS did not acknowledge that section 1886(d)(5)(K) of the Act states:

''Before establishing any add-on payment * * * with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology.''

The commenter explained that, in the proposed rule, CMS solicited comment on whether to reassign ICD–9–CM code 84.65 and on the new technology application for the CHARITÉ™. The commenter added that, instead of considering these as two distinct issues, CMS should consider a DRG change within the new technology application as mandated by the statute.

Another commenter indicated that the purpose of the new technology add-on program is to provide a cost-based bridge to compensate hospitals for additional costs related to new technology. Consistent with CMS' position not to consider DRG changes until sufficient data became available in MedPAR to support it, the commenter believed it would be premature to reassign spinal disc prostheses to DRGs 497 and 498 until further data become publicly available. The commenter added that DRGs 497 and 498 are well established and any changes to these DRGs, such as including cases of disc prosthesis in these DRGs without more complete data could result in an inappropriate reduction to the weight of these DRGs.

Response: We agree with the comments regarding section 1886(d)(5)(K) of the Act. If a product meets all of the criteria for Medicare to pay for a product as a new technology, there is a clear preference expressed in the statute for us to assign the technology to a DRG based on similar clinical or anatomical characteristics and costs. However, as stated above, we are denying new technology add on payments for CHARITÉ™ because we could not establish that it meets the substantial clinical improvement criterion. Nevertheless, we did evaluate whether to make a DRG change for CHARITÉ™ outside of the context of the new technology process. We are providing a full analysis of this issue in section II.B.6.d. of the preamble to this final rule.

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. (We refer readers to Tables 6A through 6H in the Addendum to this final rule for information regarding ICD–9–CM codes.)

At the time of the initial application, the FDA had not yet approved this technology for general use. Subsequently, however, we were notified that FDA approval was granted on March 23, 2005. Therefore, GORE TAG meets the newness criterion. Although we discussed some of the data submitted with the application for new technology add-on payments, we were unable to include a detailed analysis of cost data and substantial clinical improvement data in the FY 2006 IPPS 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 prior to publication of the FY 2006 IPPS proposed rule.

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. In the FY 2006 proposed rule, we indicated that we would consider these comments regarding the substantial clinical improvement criterion in the final rule if we determined 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: In the proposed rule, we responded that as we discussed in the new technology 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 this case, we will determine whether the GORE TAG device qualifies for new technology add-on payments in this final rule. In the event that this technology satisfies all the criteria, as we indicated in the FY 2006 IPPS proposed rule, 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. In the FY 2006 IPPS proposed rule, we solicited comments regarding this technology in light of its recent FDA approval, particularly with regard to the cost threshold and the substantial clinical improvement criteria.

During the 60-day comment period for the FY 2006 IPPS proposed rule, we received the following comments:

Comment: The applicant submitted an additional validation sample of cases to confirm the costs associated with this technology. In this sample, charges for the device ranged from approximately $7,000.00 to $11,000.00 per device.

Response: We have reviewed the evidence presented above and have determined that the manufacturer has demonstrated that this device meets the cost threshold for the DRGs to which these cases will be assigned. However, we note that we would expect there to be significantly fewer hospital resources required to care for a patient undergoing the endovascular procedure compared to an open thoracotomy. Thus we are concerned that the cost of cases using this device is unnecessarily high. We will continue to monitor the data associated with the endovascular repair of a thoracic aortic aneurysm in the future to obtain further information about this issue.

Comment: Several commenters encouraged CMS to approve the GORE TAG device for new technology add-on payment approval. These commenters indicated that this device is a significant advance in the treatment of thoracic aortic aneurysms, particularly for elderly, frail patients who are not candidates for the open procedure to correct life-threatening aneurysms. They added that physicians pointed to the mortality and comorbidity rates associated with the open procedure, stating ''even in centers of excellence, the risk of either mortality or paraplegia complicating surgery runs up to the 10 percent range.''

Response: We appreciate the commenters' input on the substantial clinical improvement criterion, and we have determined that the GORE TAG device meets the substantial clinical improvement criterion. In our view, the GORE TAG device meets a number of the standards that we use to evaluate whether a new technology is a substantial clinical improvement. For instance, GORE TAG offers a treatment option for patients with thoracic aortic aneurysms that are not candidates for open surgery. Prior to endovascular treatment with this device, there were no treatment options available for patients who were not candidates for open repair of a thoracic aortic aneurysm. We also believe that, relative to the open repair procedure, endovascular aneurysm repair improves clinical outcomes through lower mortality and complication rates, reduced overall length-of-stay, less intensive care unit days and less operative complications. For the reasons stated above, we find that the GORE TAG device meets the substantial clinical improvement criterion.

As indicated earlier, GORE TAG meets both the newness and cost criteria. Therefore, in this final rule, we are approving the GORE TAG device for new technology add-on payment for FY 2006. These cases generally are in DRGs 110 and 111. Cases involving the device should code for the device using the newly created ICD–9–CM procedure code 39.73 (Endovascular implantation of graft in thoracic aorta). The cost of a single device is $12,798. Because the average patient receives 1.8 endovascular prostheses, we estimate the cost of the device to be $21,198 per patient. Therefore, beginning October 1, 2005, cases that include code 39.73 will be eligible to receive new technology add-on payments up to $10,599, or half the cost of the device.

Comment: In the proposed rule, we stated that ''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.'' Commenters argued that, CMS should not require, FDA approval to be granted to substantially similar devices prior to the publication of the final rule for CMS to extend new technology payments to these products.

Response: We agree with the commenters. Any substantially similar device that is FDA-approved after the publication of the final rule that uses the same ICD–9–CM procedure code as GORE TAG and falls into the same DRGs as those approved for new technology add-on payments should also receive the new technology add-on payment associated with this technology in FY 2006. The discussion of this issue in the preamble to the proposed rule was intended to communicate that we would extend new technology payments to any substantially similar product that is assigned to the same ICD–9–CM code, as long as the applicant's product received FDA approval prior to the final rule. For the reason stated above, we have changed our position on this issue and will extend add-on payment to any substantially similar products that are assigned to the same ICD–9–CM code and that receive FDA approval either before or during FY 2006.

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.

At the time of the FY 2006 proposed rule, this device had not yet received approval for use by the FDA; however, another manufacturer had 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. The manufacturer derived this estimate by identifying cases in the FY 2003 MedPAR that reported procedure code 03.93 (Insertion or replacement of spinal nerostimulators). 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'' and could no longer be considered a new product (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), and this code was also used to identify the predecessor technology in order to perform the cost threshold analysis. 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. As discussed in the proposed rule, the applicant applied for and was assigned a new ICD–9–CM code for rechargeable neurostimulator pulse generator. (We refer readers to Tables 6A through 6H in the Addendum to this final rule for information regarding ICD–9–CM codes.) Because the Renew™ SCS and Restore® technologies appear 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. Medtronic contends that the Restore® device 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 had not yet been received for this device, in the proposed rule, we indicated that we were making no decision concerning the Restore® application. We indicated that we would make a formal determination if FDA approval occurs in sufficient time for full consideration in this final FY 2006 rule. However, we noted that we had 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 recognized the benefits of a more easily rechargeable neurostimulator system, we believed that the Restore® device might 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 received no public comments regarding this application for add-on payments prior to the publication of the FY 2006 IPPS proposed rule. In the proposed rule, we solicited comments on this application for add-on payments, specifically regarding how the Restore® device may or may not be significantly different from previous devices. We also sought comments on whether the product meets the cost and significant improvement criteria.

During the 60-day comment period for the proposed rule, we received the following comments:

Comment: Several commenters supported the application for the rechargeable implantable neurostimulator for add-on payment. Commenters noted that there is a large difference between the radio frequency (RF) devices and the rechargeable implantable neurostimulators. They argued that there is little relief with the RF systems, because once the transmitter/power source is removed, the therapy immediately ends. Further, commenters argued that due to these restrictions and the difficulty of ensuring patient compliance with this device, the pain relief the RF system is intended to provide is not possible. As such, the commenters argued that the rechargeable implantable device is a much better option for many patients with high power needs than previously available neurostimulators.

Commenters argued that the new, rechargeable, implantable neurostimulators meet the substantial clinical improvement criterion by eliminating surgeries to replace the

batteries, reducing the infection rate associated with greater frequency of replacement surgeries, and providing more treatment options for those patients that require high energy stimulation. In addition, commenters noted the clinical improvement associated with the ability to use two 16-electrode leads instead of the 8-channel leads that are used in older neurostimulators. They pointed out that, by using leads with more electrodes, the physician can place the leads so that more coverage is provided to the spinal nerves, and the physician is provided an option to reprogram the neurostimulator without further invasive surgery if a lead migrates after the unit is installed. Further, commenters argued that, by paying the higher up-front expenses associated with these technologies, CMS will ultimately save money on reduced surgical and physician encounters, while improving the care that Medicare beneficiaries receive. Finally, the manufacturer submitted an updated price for the Restore® rechargeable implantable neurostimulator that reflects a decrease in total costs for the new components associated with the device. Based on this change, the manufacturer calculated the new maximum add-on payment amount to be $9,320 if the application is approved.

Response: We appreciate these commenters' input regarding this device. While the comments were submitted in support of a finding that this device meets the substantial clinical improvement criterion, they have also convinced us that the device is significantly different from predecessor devices. Therefore, we are reversing our preliminary determination that the Restore® Rechargeable Implantable Neurostimulator is likely not new, and we have determined that it can be considered new for the purposes of the new technology add-on payment for this reason. The manufacturer also provided data from its device registry demonstrating that nearly 34 percent of patients aged 65 and older, who receive non-rechargeable devices, require a replacement surgery within the first 10 years of implantation. In addition, of those patients that require replacement surgeries, more than half of those patients have high energy needs that deplete the battery within the first 3 years. By avoiding the need for a battery replacement surgery, we believe these data demonstrate that this device is a substantial clinical improvement for a large proportion of the patients who receive implantable neurostimulators. In addition, we agree that the patient compliance issues with the predecessor devices that use of RF as the recharging source are significant. The applicant has demonstrated that there will not be the same patient compliance issues with its product. Because of the elimination of the need for serial battery replacement surgeries and in light of the information provided by the manufacturer and commenters further clarifying the distinctions and improvements of the Restore® technology when compared to other devices, we believe that the device is a substantial clinical improvement over prior technologies.

As stated in the proposed rule, we had previously determined that Restore® in combination with the other devices that already received FDA approval in 2004 and 2005, meets the newness and cost threshold criteria. Therefore, we are approving new technology add-on payments for rechargeable, implantable neurostimulators for FY 2006. Cases involving these devices will be identified by the presence of newly created ICD–9–CM code 86.98 (Insertion or replacement of dual array rechargeable neurostimulator pulse generator). These cases are generally included in the following DRGs: 7, 8, 499, 500, 531, or 532. In the proposed rule, we stated that the maximum add-on payment for the new components of the device would be $10,568, or half of $21,135. The applicant reported a reduction in the price to $18,640 after publication of the proposed rule, making the maximum add-on payment for the device $9,320. Therefore, we are finalizing a maximum add-on payment of $9,320 for cases that involve this technology.

f. Safe-Cross(r) 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. In January 2004, the FDA approved the Safe Cross® for coronary arteries. The device was also approved by the FDA for all native peripheral arteries except carotids in August 2004. 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 $37,304 and a case-weighted average standardized charge of $40,705. (We have updated the case weighted threshold and case weighted average standardized charge from the proposed rule due to an inadvertent clerical error in reporting these figures in the proposed rule.) 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, in the FY 2006 IPPS proposed rule, we noted 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, in the FY 2006 IPPS proposed rule, we proposed 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 sought further information on whether this device meets the substantial clinical improvement criterion, and indicated that we would consider any further information prior to making our final determination in this final rule.

We received no public comments regarding this application for add-on payments prior to the publication of the FY 2006 IPPS proposed rule. During the 60-day comment period on the FY 2006 IPPS proposed rule, we received the following comment:

Comment: One commenter expressed support for the Safe Cross®, explaining that the increased chance of crossing a CTO enables the placement of drug-eluting stents and represents a substantial clinical improvement for treating the most challenging clinical subgroup with these conditions. Using the device also raises the cost per case and, therefore, the commenter recommended that CMS pay new technology add-on payments for this device.

Response: In a letter dated June 3, 2003 to the applicant, CMS denied pass-through payments under the OPPS for the Safe Cross® because it did not demonstrate a substantial clinical improvement. The letter explained that the company has not yet provided intermediate to long-term results regarding reocclusion of previously occluded vessels after angioplasty with substantially improved patient outcomes, which could demonstrate that the Safe Cross® technology leads to significant clinical improvement for patients in comparison with other available treatments. Given the similar criteria for making pass-through payments under the OPPS and new technology add-on payments under the IPPS, a finding that Safe Cross® does not

meet the OPPS criteria means that, in the absence of relevant new information, it cannot qualify for new technology add-on payments under the IPPS. Therefore, we are finalizing our proposal to deny new technology add-on payments for the Safe Cross® in FY 2006 because it does not meet the substantial clinical improvement criterion.

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.

In addition, we note that 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 final 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, in the FY 2006 IPPS proposed rule, we proposed to deny add-on payments for the Trident® Ceramic Acetabular System for FY 2006.

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 prior to publication of the FY 2006 IPPS proposed rule.

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. In the proposed rule, we indicated that we would consider these comments regarding the substantial clinical improvement criterion. However, based on the observations provided at the town hall meeting, we noted that 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 the proposed rule, we proposed 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 would review 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 stated that we would consider additional DRG revisions to better capture the various types of joint procedures. We also stated that 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. In the FY 2006 IPPS proposed rule, we sought comments on this issue, and generally on whether the Trident® Ceramic Acetabular System meets the criteria to qualify for new technology add-on payments and received the following comments during the 60-day comment period.

During the 60-day comment period on the FY 2006 proposed rule, we received the following comments:

Comment: Several commenters supported new technology add-on payments for the Trident® ceramic on ceramic hip. Many of these comments reiterated the comment from the device manufacturer, disagreeing with our assertion that the technology represents only an incremental improvement over other technologies. The commenters emphasized that the Trident® Ceramic Acetabular System had been evaluated in an extensive prospective, randomized, controlled clinical study, and that the FDA Panel reviewing the

study commended it for its design, statistical report, and patient followup. Therefore, the commenters argued, the product had shown clinical superiority where other devices and improved designs had not shown clinical superiority to the metal on polyethelene hip implants. The commenter also cited a post-market study of a subset of the original study patients that demonstrates continued good patient outcomes at a mean of 5.2 years followup, as presented at the 2005 American Academy of Orthopedic Surgeons Annual Meeting.

Response: The Trident® Ceramic Acetabular 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. Prosthetic hip joints have been used to treat these conditions for many years. The Trident® Ceramic Acetabular System differs from its predecessor prosthetic hips only in the materials that are used in the joint. Thus, the Trident® Ceramic Acetabular System uses the same or a similar mechanism of action to achieve a therapeutic outcome (that is, it replaces the joint to address pain and related conditions for patients suffering from arthritis or related conditions). Further, we note that the cases using the Trident® Ceramic Acetabular System will go into new DRGs 544 or 545 (Major Joint Replacement, Revision of Hip or Knee Replacement), the same DRGs as the patients that receive the older prosthetic hip replacements. Therefore, because the Trident product appears to offer only an incremental advance in the treatment of patients requiring a total hip replacement, we find that it does not meet the substantial clinical improvement criterion. We also note that in this final rule, as proposed, CMS is splitting DRG 209 into two separate DRGs (544 and 545) in order to better reflect the higher costs of revising hip and knee replacements.

Comment: Several commenters objected to our interpretation of the period of new with regard to this technology. Several commenters noted that there appeared to be inconsistency in the method CMS has used to determine the period of ''newness'' for each technology, noting in particular that both the CRT–D device and INFUSE® bone graft for spinal fusion received new technology add-on payment beyond the 2–3 year period that the devices could be considered new. As noted in the proposed rule, commenters argued that, by CMS' own rationale, payment beyond this period was designed to provide payment predictability and consistency for the entire fiscal year, rather than terminating payments part way through the year. Commenters urged us to reconsider whether this technology meets the newness criterion because it will not be 3 years old until more than 6 months into FY 2006.

Response: We believe the commenters make a good point about application of the newness criteria to the Trident® product. The commenters are correct that we have generally followed a guideline that uses a 6-month window before and after the start of the fiscal year to determine whether to extend the add-on payment for an additional year. In general, we extend add-on payments for an additional year if the 3 year anniversary date of the product's entry on the market occurs in the latter half of the fiscal year.

In the case of the Trident® ceramic acetabular system, the device was not available on the market until April, 2003. Thus, the product will not have been available on the market for 3 years until the second half of FY 2006. Thus, under policy, the Trident® ceramic acetabular system could potentially qualify as new for FY 2006. However, the device is very similar to existing products, only differing in the composite material used in manufacturing. It is also used in the same DRGs as these other similar technologies, and we question whether it would be appropriate to deem this technology new and substantially different from previous hip prosthetics. Thus, as noted above, we continue to find that the device does not meet our substantial clinical improvement criterion. Therefore, in this final rule, we are finalizing our decision to deny new technology add-on payments for this device for FY 2006.

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 did not believe it was appropriate to present our full analysis on whether the technology meets the individual criteria for the new technology add-on payment in the proposed rule. 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, in the FY 2006 IPPS proposed rule, we proposed to deny add-on payment for this new technology.

We received no public comments regarding this application for add-on payments prior to the publication of the FY 2006 IPPS proposed rule.

During the 60-day comment period for the FY 2006 IPPS proposed rule, we received the following comment:

Comment: One commenter, the applicant, commented that the Wingspan™ represents a substantial clinical improvement over what is currently available to treat patients with intracranial atherosclerotic disease, and who suffer from recurring stroke and recommended that, upon FDA approval of the Wingspan™, CMS determine the most appropriate payment for this new therapy.

Response: We thank the commenter for its comments and upon FDA approval we encourage the applicant to reapply for new technology add-on payments. However, because the Wingspan™ does not have FDA approval or Medicare coverage, we are finalizing our proposal to deny add-on payment for this new technology.

III. Changes to the Hospital Wage Index

A. Background

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

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

Section 1886(d)(3)(E) of the Act also provides for the collection of data every 3 years on the occupational mix of employees for 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 occupational mix adjustment that we are applying beginning October 1, 2005 (the FY 2006 wage index) appears under section III.C. of this preamble.

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

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. These hospitals will be considered rural for reclassification purposes.

In addition, in the FY 2005 IPPS final rule (69 FR 49032 and 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 adoption of 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 does not prevent a decrease in wage index due to any reason other than adoption of CBSAs, nor does 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, beginning in FY 2006, we are providing that hospitals receive 100 percent of their wage index based upon the new CBSA configurations. Specifically, we have determined for each hospital a new wage index for FY 2006 employing wage index data from FY 2002 hospital cost reports and using the CBSA labor market definitions.

Comment: Commenters asked CMS to defer 100 percent adoption of the new labor market area definitions to allow hospitals more time to adjust to the significant reimbursement impact. Most commenters urged CMS to maintain the current 50 percent CBSA/50 percent MSA blend. One commenter proposed using a 75 percent CBSA/25 percent MSA blend.

Response: We have decided not to provide for a longer transition because we have already, in effect, provided 1 year at a higher wage index for hospitals by delaying full implementation of the new Census designations. Given that the new designations are based on the most recent Census data, whereas the prior labor market areas are based on 1990 Census data, we believe it is both reasonable and appropriate to adopt the new designations for FY 2006.

Comment: One commenter noted that, while CMS provided urban hospitals that became rural under the new definitions hold harmless protection for 3 years, urban hospitals that remained in MSAs that experienced large wage index reductions did not receive that same protection. The commenter stated that, although all hospitals that experienced a decrease in their wage index from the effects of the labor market area changes received a 1-year blended transition, this transition expires on September 30, 2005. The commenter urged CMS to provide hold harmless protection to all hospitals that experienced a wage index decrease of more than 10 percent as a result of the new labor market areas, regardless of whether the hospital remained urban or rural.

Response: We refer readers to the FY 2005 IPPS final rule for a full discussion of our rationale for limiting hold harmless protection to a particular group of hospitals (69 FR 49032).

Comment: A few commenters addressed the use of Micropolitan Areas as geographic areas. They stated that because CMS assigns Micropolitan Areas to the statewide rural area for purposes of the IPPS, several hospitals, by virtue of now being in a Micropolitan county, are reclassified as rural despite their previous designation as an urban hospital. They noted that, although CMS provided a 3-year transition period to help alleviate the decreased wage index payments for hospitals that were previously classified as urban and are now in rural areas based on the new definitions, this transition did not ameliorate any reductions in DSH payments, because the transition did not affect a hospital's urban/rural status. They emphasized that, while urban hospitals of 100 or more beds have no cap on DSH payments, rural hospitals of all sizes are capped at 12 percent for DSH payments. Commenters offered various recommendations about how to protect these hospitals from the changes in the labor market area definitions. Most commenters advocated allowing counties that are reclassified as Micropolitan Areas despite their previous urban designation to be grandfathered into their previously urban MSA. Other commenters recommended that CMS provide an exception to these hospitals under section 1886(d)(5)(I)(i) of the Act. Further, commenters suggested that CMS adopt OMB's new standards for use in defining labor market areas, but lower the commuting threshold used by OMB to define CBSAs.

Response: We disagree with the commenters that hospitals that changed status from urban to rural received no amelioration with respect to DSH. As stated in the FY 2005 IPPS final rule (69 FR 49033), the provisions of § 412.102 provide special protections for hospitals against abrupt reductions in DSH payments resulting from transitions from urban to rural status. Specifically, as described in § 412.102, in the first year after a hospital loses urban status, the hospital will receive an additional payment that equals two-thirds of the difference between the urban disproportionate share payments applicable to the hospital before its redesignation from urban to rural and the rural disproportionate share payments applicable to its redesignation from urban to rural. In the second year after the hospital loses urban status, the hospital will receive an additional payment that equals one-third of the difference between the urban disproportionate share payments applicable to the hospital before its redesignation from urban to rural and the rural disproportionate share payments applicable to its redesignation from urban to rural. Because hospitals are already receiving adequate relief with respect to DSH payments, we do not believe it is necessary to address the commenters' recommendations regarding grandfathering, exceptions, or use of lower commuting thresholds. We refer readers to the explanation in the FY 2005 IPPS final rule for our adoption of the new Census designations as well as the treatment of Micropolitan areas as rural (69 FR 49027).

C. Occupational Mix Adjustment to FY 2006 Index

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

1. Development of Data for the Occupational Mix Adjustment

In the 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 final FY 2006 wage index, as proposed, we are using 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 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 FY 2006 wage index. The FY 2006 wage index includes occupational mix data from 3,541 out of 3,742 hospitals (94.6 percent response rate). The results of the occupational mix survey are included in the chart below.

BILLING CODE 4120–01–P

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	1,415,561,858.21	70.53%	26.72%
Licensed Practical Nurses	149,394,275.50	7.44%	2.82%
Nursing Aides, Orderlies, & Attendants	369,917,515.38	18.43%	6.98%
Medical Assistants	72,098,872.45	3.59%	1.36%
Total	**2,006,972,521.54**	**100.00%**	**37.89%**
Physical Therapy Services			
Physical Therapists	44,514,502.82	61.07%	0.84%
Physical Therapist Assistants	16,876,198.25	23.15%	0.32%
Physical Therapist Aides	11,500,524.12	15.78%	0.22%
Total	**72,891,225.19**	**100.00%**	**1.38%**
Occupational Therapy Services			
Occupational Therapists	18,813,718.13	78.97%	0.36%
Occupational Therapist Assistants	4,038,942.16	16.95%	0.08%
Occupational Therapist Aides	970,862.86	4.08%	0.02%
Total	**23,823,523.16**	**100.00%**	**0.45%**
Respiratory Therapy Services			
Respiratory Therapists	83,657,724.62	80.22%	1.58%
Respiratory Therapy Technicians	20,630,320.54	19.78%	0.39%
Total	**104,288,045.15**	**100.00%**	**1.97%**
Pharmacy Services			
Pharmacists	54,749,976.18	48.02%	1.03%
Pharmacy Technicians	54,819,713.65	48.08%	1.03%
Pharmacy Assistants/Aides	4,440,425.08	3.89%	0.08%
Total	**114,010,114.92**	**100.00%**	**2.15%**
Dietary Services			
Dieticians	18,789,967.67	42.38%	0.35%
Dietetic Technicians	25,546,217.97	57.62%	0.48%

General Service Categories	Number of Employee Hours	Percent of Service Category Hours	Percent of Total Employee Hours
Total	**44,336,185.64**	**100.00%**	**0.84%**
Medical & Clinical Lab Services			
Medical & Clinical Lab Technologists	114,525,613.70	58.71%	2.16%
Medical & Clinical Lab Technicians	80,542,453.02	41.29%	1.52%
Total	**195,068,066.72**	**100.00%**	**3.68%**
Total Nursing, Therapy, Pharmacy, Dietary, and Medical & Clinical Occupations	**2,561,390,134.80**		**48.35%**
All Other Occupations	**2,717,890,445.56**		**51.31%**
Total Hospital Employees	**5,297,280,580.11**		**100.00%**

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

BILLING CODE 4120–01–C

Comment: Two commenters noted that the ''Medicare Occupational Mix Survey Results'' table in the FY 2006 proposed rule (70 FR 23369) did not include data pertaining to medical and clinical laboratory services, all other occupations, and total hospital employees. The commenters requested that CMS publish the complete table in the final rule.

Response: We apologize for any inconveniences caused by the misprint of the table in the proposed rule. The above table includes the complete set of occupational mix survey results for the final FY 2006 wage index.

Comment: As a mechanism to achieve a higher response rate, one commenter recommended that CMS reward hospitals that submit occupational mix survey data. The commenter suggested that, for hospitals that submit occupational mix data, CMS should apply a higher percentage of the occupational mix adjustment if the adjustment results in a positive impact, and a lower percentage if the adjustment results in a negative impact.

Response: Although the commenter's suggestion pertaining to a procedural mechanism by which CMS conducts the occupational mix survey is not a subject of the final policies included in this final rule, we note that we disagree with the suggestion. We do not believe that hospitals should receive a special reward for completing and submitting the occupational mix survey. Rather, a hospital should deem the submission of occupational mix data as a necessary part of its responsibility to provide complete and accurate data for the wage index. We also note that implementing an occupational mix adjustment so that it applies to reporting hospitals only when it is beneficial to such hospitals would defeat the purpose of the occupational mix adjustment.

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

For the final FY 2006 wage index, we used the same methodology that we used to calculate the occupational mix adjustment to the FY 2005 wage index (69 FR 49042). We used the following steps for calculating the 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 seven 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 seven 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 are calculated by multiplying the hospital's total salaries and wage-related costs (from Step 5 of the unadjusted wage index calculation in section III.F. of this preamble) 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 seven 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 seven 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 III.F. of this preamble).

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 national occupational mix adjusted average hourly wage for FY 2006 is $28.0272.

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 Steps 1 through 9 above. The Puerto Rico occupational mix adjusted average hourly wage for FY 2006 is $12.7985.

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 FR 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 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 treating the wage data for hospitals that did not respond to the survey in this same manner for the FY 2006 wage index.

In implementing an occupational mix adjusted wage index based on the above calculation, the wage index values for 14 rural areas (29.8 percent) and 206 urban areas (53.4 percent) would decrease as a result of the adjustment. Seven (7) rural areas (14.9 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, 4.2 percent. Meanwhile, 32 rural areas (68.1 percent) and 179 urban areas (46.4 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 proposed rule, 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.

Comment: Several commenters provided recommendations for the design and release of a revised occupational mix survey.

Response: We plan to release a revised occupational mix survey in an upcoming **Federal Register** notice. We will address the design and data collection issues, including the commenters' recommendations, as part of that notice.

In our continuing efforts to meet the information needs of the public, we provided via the Internet three additional public use files for the proposed occupational mix adjusted wage index concurrently with the publication of the FY 2006 IPPS proposed rule: (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). We also plan to post these files via the Internet with future applications of the occupational mix adjustment.

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

The 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 final 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 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 final rule that hospitals must comply with the requirements in 42 CFR 413.100, 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 Department of Labor and Internal Revenue Service requirements. We believe that the Medicare instructions allow for both consistent reporting among hospitals and for the development of reasonable deferred compensation plan costs for purposes of the wage index.

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.

Comment: A few commenters addressed our discussion regarding the treatment of pension, post-retirement health benefits, and other deferred compensation costs for purposes of the wage index. Two commenters expressed concern that the instructions are a significant change from our original instructions published September 1, 1994. The commenters asserted that CMS provided no rationale for moving away from using GAAP for developing these costs for the wage index, and requested an additional opportunity for public comment. One commenter suggested that using GAAP provides a more consistent methodology for capturing these costs than Medicare reasonable cost principles. A fourth commenter requested a more specific description of the treatment of pension, post-retirement health benefits, and other deferred compensation costs if there are other ''related Medicare program instructions'' as we stated above.

Response: For cost reporting periods beginning prior to October 1, 1994, hospitals were required to include in the wage index only the amount of actual payments that the hospital made to retirees in the reporting year. For periods beginning on or after October 1, 1994, CMS instructed hospitals to use GAAPs, an accrual method of accounting, for developing pension, deferred compensation, and other wage-related costs for wage index purposes. All other wage costs on Worksheet S–3 must reflect costs that are actually expended by the hospital during the cost reporting period. We believed then and continue to believe that the use of accrual accounting allows hospitals to be more inconsistent in their reporting of wage-related costs from year to year so that the wage index could be more static.

Section 413.24 of the regulations also provides for the accrual basis of accounting for developing costs under Medicare's cost finding principles. However, a major difference between GAAP and Medicare principles for recognizable pension and other deferred compensation plan costs is an issue of funding. In § 413.100 (and as discussed in 60 FR 33126, June 27, 2005), we clarified and codified CMS' longstanding requirement that, for purposes of program payment, providers must timely liquidate their liabilities. GAAP does not specify a time requirement for recognizing accrued costs.

In 2003, we updated the cost report instructions in section 3605.2 of the PRM, Part II, to also clarify the September 1, 1994 instructions for the wage index. At the instructions for wage-related costs, lines 13 through 20, we noted that, ''Although hospitals must use GAAP in developing wage-related costs, the amount reported for wage index purposes must meet the reasonable cost provisions of Medicare.'' The clarification was to ensure that a hospital includes in the wage index only those pension and other deferred compensation plan costs that meet the timely liquidation requirements for Medicare reasonable cost principles. When CMS issued the September 1, 1994 instructions, CMS did not anticipate nor intend for hospitals to include costs in the wage index that have not been funded and may never be funded. Including unfunded deferred compensation costs in the wage index can significantly misrepresent an area's average hourly wage, especially if the plan is never funded. In a May 4, 2005 Early Alert to CMS's Administrator, the OIG stated that ''While some hospitals include millions of dollars in unfunded pension and other postretirement benefit costs in the annual wage data shown on their Medicare cost reports, others include only funded amounts. As a result, the wage indexes for the hospitals that include unfunded amounts are inflated, which leads to an inadequate distribution of Medicare payments among hospitals.'' In addition, the OIG warned that ''* * * the hospitals' inclusion of costs related to unfunded liabilities could compromise the reliability of the wage data that CMS uses to develop the market basket * * *. Thus, the inclusion of costs related to unfunded liabilities in hospitals' wage data could produce an inaccurate market basket index for use in updating payments to hospitals.''

Regarding the comment requesting a specific description of the treatment of pension, post-retirement health benefits, and other deferred compensation costs if there are other ''related Medicare program instructions,'' we included this phrase to set forth that hospitals must also comply with any future instructions related to these costs that may be initially issued through rulemaking or a one-time notice before being included in the above PRM sections.

We believe that our discussion in the proposed rule was sufficient notification for this policy clarification. Therefore, we do not agree that CMS should provide another comment period for this matter. In addition, we believe that hospitals and intermediaries should be able to ensure that pension and other deferred compensation costs are developed according to the above terms by the FY 2007 wage index, as hospitals have been required, since cost reporting periods beginning during FY 1995, to complete Form 339, a reconciliation worksheet between GAAP and Medicare principles.

Consistent with the wage index methodology for FY 2005, the 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 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).

Comment: Two commenters recommended that CAHs be included in the wage index. One commenter suggested that CMS should exclude the wage data for a CAH only if it is designated a CAH during the base year for the wage index calculation. MedPAC suggested that CMS should include the wage data for all CAHs, even if the hospital is a CAH in the base year that is used for calculating the wage index. In addition, MedPAC stated the following:

- The wage index should ideally reflect the data for all providers that are similar in services and occupations to hospitals receiving payment under Medicare's IPPS and OPPS. CAHs are similar to other small rural hospitals and in many cases are located close enough to IPPS hospitals to compete for the same workers.
- About 500 hospitals converted to CAH status over the past 3 years. Since CAHs now dominate the rural areas for some states, the data for CAHs may become critical for an accurate representation of rural area wage levels. It is important to note that this representation affects payment for not only the IPPS hospitals but also for other providers that are paid under a Medicare prospective payment system, such as SNFs, HHAs, and LTCHs.

MedPAC recommended that CMS begin collecting wage data from CAHs this year.

Response: In the FY 2004 final rule (68 FR 45397), we provided a complete discussion, rationale, and analysis of our policy for excluding CAHs from the wage index. In that rule, we stated that CAHs are not paid under the IPPS, and, like other non-IPPS providers such as SNFs, HHAs, LTCHs, and children's hospitals, we have always excluded non-IPPS providers from the wage index calculation. We also stated that, due to their remote location and more limited services, CAHs ''are unique compared to other short-term acute care hospitals.'' Using data collected from cost reporting periods beginning during FY 2000, we further noted that, in most labor market areas with hospitals that converted to CAH status some time after FY 2000, the average hourly wage for CAHs was significantly lower than the average hourly wage for other short-term hospitals in the area. As a result, with the FY 2004 wage index, we began excluding the data for any CAH, even if it was an IPPS provider during the wage index base year.

We agree with MedPAC that CAHs have recently become more similar in composition, services, and proximity to other rural hospitals, largely due to the Pub. L. 108–173 (MMA). Section 405 of Pub. L. 108–173 allows for more hospitals to now qualify and more seamlessly convert to CAH status. However, because Pub. L. 108–173 was enacted in calendar year 2003, it would not affect the FY 2002 base year for the FY 2006 IPPS wage index. In addition, our analysis of the FY 2006 wage index shows that rural areas are not harmed by the exclusion of CAHs. For FY 2006, we removed the wage data for 162 hospitals in 39 rural areas because they became CAHs after they filed their FY 2002 cost reports as IPPS hospitals. In all 39 rural areas, the average hourly wages for FY 2006 increased over those for FY 2005. For 76.9 percent of the rural areas, the average hourly wage increase is 5 percent or greater.

Therefore, we continue to believe that it is prudent policy to remove the data from CAHs from the wage index. As such, we have excluded from the FY 2006 wage index in this final rule the wages and hours for all hospitals that are currently designated as a CAH, even if the hospital was paid under the IPPS during FY 2002, the cost reporting period used in calculating the FY 2006 wage index. We will reconsider our policy when we can collect and analyze wage data for a base year that could be impacted by Pub. L. 108–173 changes for CAHs.

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. We note that in the IPPS rules, we do not address comments pertaining to the wage indices for non-PPS providers. Such comments should be made in response to separate proposed rules for those providers.

In the FY 2005 IPPS 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 hospital would integrate the facility into the main provider's outpatient department, since the facility offers health care services of the same type as those furnished by the main provider. In addition, because a physician's office would not receive its own provider agreement or receive a Medicare provider number under § 489.2 unlike an FQHC or an RHC, it cannot be considered a ''provider-based entity,'' rather it would be considered a department of a provider. (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), 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.

Comment: Two commenters objected to our clarification of historical policy that the salaries of employees working in provider-based clinics should continue to be included in the wage index calculation. The commenters referred to these facilities as ''hospital-owned provider-based physician practices'' that may be qualified to participate in Medicare as providers under § 489.2 of the regulations, and therefore, by definition, are not ''departments of a provider.'' They argued that CMS should exclude ''hospital-owned provider-based physician practices'' from the wage index because, similar to RHCs and FQHCs, the services provided by these facilities are also not paid for under the IPPS. The commenters alluded to the OIG 2004 Red Book (October 22, 2004), which proposed that CMS should eliminate provider-based designations for ''hospital-owned physician practices,'' since hospitals treat these facilities as provider-based without CMS' approval. The commenters questioned whether it would be ''more accurate and practical'' to exclude all ''hospital-owned provider-based physician practices'' from the wage index, in light of the OIG's proposal. Lastly, the commenters asserted that CMS' statement that the salaries and wages of hospital employees working in the outpatient areas of the hospital have historically been included in the wage index since those employees often work both in the inpatient and outpatient areas of the hospital, is inaccurate with respect to ''hospital-owned provider-based physician practices'' because the facilities do not provide services to IPPS areas of the hospital.

Response: In the FY 2006 IPPS proposed rule (70 FR 23371), we discussed whether to include the costs of provider-based clinics in the wage index because we stated in a response to a comment in the FY 2005 IPPS final rule (69 FR 49049) that we would explore the matter in a future rule. Thus, we considered the issue and concluded that it is appropriate to include the salaries and hours of employees working in provider-based clinics in the wage index calculation. We came to this conclusion because provider-based clinics cannot qualify by themselves to participate in Medicare as a provider under § 489.2 of the regulations and are, therefore, categorized as ''departments of a provider'' under the provider-based regulations at § 413.65. Accordingly, they would be reported as part of the main provider's outpatient department on line 60 of Worksheet C of the Medicare cost report. In making this conclusion, we distinguished provider-based clinics that are part of the hospital outpatient department and included in the IPPS wage index from ''provider-based entities'' (such as SNFs, RHCs, and FQHCs) that are excluded from the IPPS wage index because, under the regulations at § 413.65, they participate in Medicare under their own provider agreements. Commenters are incorrect when they asserted that RHCs and FQHCs would be included in the wage index except for the fact that these entities are not paid under the IPPS. Rather, wage data from RHCs and FQHCs are also not included in the wage index because, although they may be provider-based, these entities are providers in their own right and may, by themselves, qualify to participate in Medicare as a provider under § 489.2. As a general rule, we do not include the wage data of facilities that are providers in their own right in the IPPS wage index. Thus, the commenters are also incorrect that ''hospital-owned provider-based physician practices'' may, by themselves, be qualified to participate in Medicare as a provider under § 489.2 of the regulations, and therefore, by definition, are not ''departments of a provider.'' We note that § 489.2 does not list ''hospital-owned provider-based physician practice'' as one of the facilities that may participate in Medicare as a *provider*. Further, while § 489.2 does list ''clinics'' as a type of facility that can participate in Medicare as a provider, § 489.2(c) specifies that only clinics that furnish outpatient physical therapy and speech pathology services may qualify as providers. Therefore, if a hospital wishes that a physician practice be considered provider-based, the physician practice, by definition, must be categorized as part of hospital outpatient departments. As such, the services provided in these provider-based clinics are paid for by Medicare under the OPPS. Accordingly, it is appropriate that the salaries and hours attributable to the provider-based clinics are included in the IPPS wage index.

In response to the commenters' speculation as to whether it would be ''more accurate and practical'' to exclude all ''hospital-owned provider-based physician practices'' from the wage index, in light of the OIG's proposal in the OIG 2004 Red Book (October 22, 2004), we believe the commenter is confusing the policies regarding (a) who should be considered provider-based and (b) whether salaries and hours associated with provider-based clinics should be included in the wage index. These are two different policy matters. On the first policy, we agree that firm oversight and consistent audit procedures for determining and monitoring provider-based status are necessary, since our existing payment systems provide for more generous payment to hospital outpatient departments than similar freestanding facilities. However, the proposed rule discussed the second matter, not the first. The purpose of the discussion in the proposed rule was *not* to debate

whether physician practices should ever be considered for provider-based status. Certainly, we agree that freestanding physician offices, or facilities that have been denied provider-based status by the CMS Regional Office, should not be included in the wage index. Rather, the purpose of the discussion in the proposed rule was to *clarify* our longstanding policy that as long as a hospital reports, and the CMS Regional Office approves, that a facility which might formerly have been a freestanding physician office is provider-based, the proper categorization of such a facility is *as an outpatient department* and the wages and hours attributable to that outpatient department are included in the IPPS wage index. Thus, we believe the commenters' reference to the OIG Red Book is misplaced.

Further, the commenters' provide no support for their assertion that workers in ''hospital-owned provider-based physician practices'' do not provide services to IPPS areas of the hospital. We have not seen any evidence suggesting that the employees working in provider-based clinics work exclusively there, or in other outpatient areas of the hospital. Furthermore, we believe it would be extremely complicated and unnecessary to attempt to distinguish between the salaries and hours of employees that work in the various outpatient areas of hospitals, for purposes of computing the IPPS wage index. Hospitals often maintain provider-based facilities since the Medicare payment for services provided in a hospital (provider-based) setting is typically more than the payment would be for the same service provided in a freestanding setting. Hospitals should not be permitted to treat these facilities as part of the hospital for one purpose, and separate from the hospital for purposes of the wage index. If hospitals wish to exclude certain facilities from the wage index, they have the option to do so by converting them to freestanding facilities. Therefore, as stated in the FY 2006 proposed rule, consistent with our longstanding policy, we continue to believe that it is appropriate to include the salaries and hours of employees working in the outpatient departments, including provider-based clinics, in the wage index calculation.

Comment: Two commenters expressed concern that the data used in calculating the wage index are developed inconsistently across the Nation. One of the commenters stressed the need for consistent interpretation and application of all wage index policies by all fiscal intermediaries. The commenters did not provide any specific examples of cases where wage index data is developed inconsistently, or where intermediaries are interpreting wage index policies inconsistently.

Response: We are equally concerned about consistent interpretation and application of wage index policies by both intermediaries and hospitals, as the wage index is a *relative* measure of area wage differences. Throughout the years, we have revised and refined our policy statements and cost reporting instructions in order to achieve more accurate reporting of wage and hours data among hospitals and intermediaries. In addition, we seek to close any loopholes in our policies that may result in varied applications among hospitals. Our work to ensure accuracy and consistency in the wage index is a continuous effort. We encourage hospitals and intermediaries to bring to our attention any instances of perceived inconsistencies. Also, we remind hospitals that the wage data correction process is another mechanism that is available for hospitals that require CMS' intervention to settle disputes with intermediaries over wage index policy interpretations (see section III.J. of this preamble).

E. Verification of Worksheet S–3 Wage Data

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 wage index includes FY 2002 data as of June 30, 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. While most of the edit failures were resolved, we did remove the wage data of some hospitals from the final FY 2006 wage index. For the final FY 2006 wage index in this final rule, we removed the data for 235 hospitals from our database: 201 hospitals became CAHs between February 20, 2004, the cutoff date for exclusion of CAHs from the FY 2005 wage index, and February 18, 2005, this year's cutoff date for the exclusion of CAHS from the FY 2006 wage index, and 27 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 7 hospitals with incomplete or inaccurate data resulting in zero or negative, or otherwise aberrant, average hourly wages. As a result, the final FY 2006 wage index is calculated based on FY 2002 wage data from 3,742 hospitals.

In constructing the 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 wage index in this final 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 (PUF) on February 25, 2005.

Comment: Two commenters expressed concern that the wage data for two CAHs would not be removed from the final FY 2006 wage index. The commenters explained that the effective date for conversion to CAH status for both providers was in December 2004, but because of the timing of the notification of the CAH status, the providers' wage data was included in the February 25, 2005 PUF, and in Tables 2 and 4A that accompanied publication of the proposed rule. The commenters noted that, although CMS subsequently removed these providers' wage data from the May 6, 2005 PUF, their wage data continued to be included in the revised Table 2 that was posted June 1, 2005 on the CMS Web site. The commenters asked for assurance that the wage data for these two CAHs would not be included in the final FY 2006 wage index.

Response: As stated in the FY 2004 IPPS final rule (68 FR 45398), we exclude providers from the wage index that were designated as CAHs by 7 or more days prior to the posting of the preliminary PUF. This year, since the preliminary PUF was posted on February 25, 2005, we excluded providers that were designated as CAHs by February 18, 2005. These hospitals were both designated as CAHs prior to February 18, 2005, and should not be included in the FY 2006 wage index calculations. The commenters are correct that, initially, we did not receive notification of the providers' CAH status in time to remove their wage data from the February 25, 2005 PUF. We did not

include their wage data in the May 6, 2005 PUF. However, these hospitals continued to be included in the updated Table 2 posted on the CMS Web site on June 1, 2005 because these revisions to the wage data were based on the February 25, 2005 PUF. However, the data for these two CAHs are not included in the FY 2006 final wage index calculations. We note that these two providers will continue to appear on Table 2 published along with the FY 2006 final rule because, although no average hourly wage will be listed next to these providers for FY 2006, they did have wage data that contributed to the wage index for their CBSA in FY 2004 and FY 2005.

F. Computation of the FY 2006 Unadjusted Wage Index

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

Step 1—As noted above, we based the 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	1.00000
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 national average hourly wage is $28.0011.

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

Step 10—Following the process set forth above, we developed a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We added the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage of $12.8063 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. (For all-urban States, we established an imputed floor (69 FR 49109). 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 174 hospitals in 63 urban areas. The areas affected by this provision are identified by a footnote in Table 4A in the Addendum of this final rule.

Comment: Numerous commenters were concerned with the proposed change in step 4 of the wage index calculation in the FY 2006 IPPS proposed rule (70 FR 23373). In order to allocate overhead wage-related costs to areas of a hospital that are excluded from the IPPS, CMS uses three steps: (1) Determine the ratio of overhead hours to revised (that is, allowable) hours; (2) compute overhead wage-related costs by multiplying the overhead hours ratio from Step 1 by wage-related costs; and (3) multiply the overhead wage-related costs from Step 2 by the excluded hours ratio (see Step 4 for more detail). The commenters noted that, for FY 2006, the calculation of the overhead hours ratio in Step 1 will be modified to subtract hours attributable to excluded areas (from line 8 for SNFs and line 8.01 for excluded areas of Worksheet S–3, Part II of the Medicare cost report). The commenters observed that this change results in a higher overhead hours ratio, which, in turn, results in a greater amount of overhead cost being allocated to excluded areas. The commenters believed that, because more costs are being allocated to excluded areas, a hospital's average hourly wage would decrease as a result of the proposal. One commenter added that the proposed methodology is flawed, but did not indicate why. Other commenters stated that the excluded area overhead hours ratio computed with CMS' proposed methodology is ''dramatically high'' and does not accurately reflect the hospital's overhead costs attributable to its employee benefit amounts, but they did not offer an explanation or an alternative for accurately identifying excluded overhead costs.

In general, the commenters, including the national hospital association, were concerned that the proposed rule did not discuss the impact of the change, and did not include a lengthy discussion of the changes. These commenters believed that CMS should postpone the change until a lengthy discussion of the proposal can be included in a future proposed rule. The commenters further recommended that, because the change in the wage index calculation caused confusion among hospitals as to the correct average hourly wages, hospitals should be given an opportunity to withdraw or reinstate their requests for geographic reclassification within 30 days of the publication of the final rule.

Response: We have carefully considered the comments we received regarding the proposed change in the FY 2006 IPPS proposed rule to the methodology for removing overhead wage-related costs attributable to areas of the hospital excluded from the IPPS. Overall, commenters seemed to be more concerned that the proposed rule did not contain a detailed discussion of the modification, rather than disagreeing in principle with our modification. Therefore, we are adopting our proposal without modifications because we believe the proposal most accurately calculates the overhead wage-related costs that are attributable to excluded areas. Historically, the wage index used to adjust a hospital's payment under the IPPS has only reflected costs of services that are provided in areas of the hospital that are covered under the IPPS. That is, because certain areas of a hospital are specifically excluded from the IPPS, such as hospital-based SNFs, or distinct part rehabilitation and psychiatric units, the proportion of the salaries paid to and the hours worked by employees in areas of the hospital excluded from the IPPS are identified and removed from the hospital's total salaries and hours. The remaining allowable salaries and hours are used to compute the hospital's average hourly wage, which, in turn, is used to calculate the wage index for the labor market area in which the hospital is located.

In addition to removing salaries and hours that are directly attributable to employees working in excluded areas, for each hospital reporting both total overhead salaries and total overhead hours greater than zero, we also remove any overhead (administrative and general) costs and hours attributable to excluded areas by allocating overhead costs and hours between the IPPS areas of the hospital and the areas of the hospital excluded from the IPPS. We do this by determining the ''excluded rate'' for each hospital, which is the ratio of excluded area hours to total hours (see Step 4 of the wage index calculation). The ''excluded rate'' reflects the percentage of hours worked by hospital employees in areas of the hospital excluded from the IPPS. For example, an ''excluded rate'' of 0.15 means that approximately 15 percent of total employee hours was spent in excluded areas (and therefore, about 85 percent of the employees' time worked was spent in the IPPS areas of the hospital). We then determine the amount of overhead salaries and hours to be allocated to the excluded areas by taking the ''excluded rate'' and multiplying it by the

hospital's total salaries and hours attributable to overhead.

Next, because wage-related costs are separate from salaries, we perform a similar calculation to determine the percentage of wage-related costs attributable to overhead that should be allocated to the excluded areas of the hospital. We do this by computing the ''overhead rate,'' which is the percentage of allowable (that is, does not include excluded area) overhead hours to total hours. The ''overhead rate'' is multiplied by total wage-related costs to determine the amount of wage-related cost attributable to overhead. Finally, the amount of wage-related costs attributable to overhead is multiplied by the ''excluded rate'' to determine the amount of overhead wage-related costs that are associated with excluded areas, and, therefore, should be *subtracted* from the total allowable wages used in the wage index. Obviously, the larger the ''overhead rate,'' the greater the amount of overhead wage-related costs to be allocated across the hospital, and the greater the excluded area, the greater the amount of overhead wage-related cost that is identified as being associated with excluded areas and that should be subtracted from allowable wages.

Through FY 2005, in determining the ''overhead rate,'' we divided the allowable overhead hours by the hospital's total hours, including hours attributable to excluded areas, even though the latter hours are excluded from the wage index. Last year, after publication of the FY 2005 IPPS final rule, we became aware of the mismatch between the numerator and the denominator in the ''overhead rate'' calculation. Specifically, because the numerator in the ''overhead rate'' calculation does not include excluded area overhead hours, and the denominator in the ''overhead rate'' calculation does include the hours attributable to excluded areas, this results in an understatement of the amount of wage-related costs attributable to overhead that should be allocated to the excluded areas. That is, because we had not completely removed the amount of wage-related cost attributable to excluded areas from the denominator, the ''overhead rate'' was lower than it should be. A lower ''overhead rate'' has the unintended effect of artificially raising a hospital's average hourly wage because a lower amount of overhead attributable to excluded areas is removed from total allowable salaries. To the extent that a hospital has a higher ''excluded rate'' (that is, they provide a significant amount of services that are not covered under the IPPS, and therefore, have a high percentage of employee hours related to the excluded areas), this issue is more significant. For example, in the case of one hospital with an ''excluded rate'' of 96 percent, under the FY 2005 calculation, we identified (and removed) only 40 percent of the overhead wage-related costs as being attributable to excluded areas, whereas under the FY 2006 calculation, 93 percent of the hospital's overhead wage-related costs has been identified as being attributable to excluded areas, and therefore, are being removed for the FY 2006 wage index. Clearly, in the case of this hospital which predominantly provides services that are excluded from the IPPS, it is logical that the vast majority of its overhead costs are attributable to excluded areas of the hospital as well, and, therefore, these overhead costs should be removed from the hospital's average hourly wage used to determine the IPPS wage index.

Accordingly, in order to correct the discrepancy between the numerator and the denominator in the overhead rate calculation, and to correct the understatement of the excluded overhead wage-related costs, we believe that it is more appropriate to determine the amount of overhead wage-related costs associated with excluded areas that should be excluded from the wage index based on the ratio of allowable costs to *allowable hours* (that is, only hours related to IPPS areas of the hospital). Specifically, we are not including the hours associated with excluded areas in the denominator of the ''overhead rate'' calculation. While hospitals with small excluded areas relative to their IPPS areas should be minimally affected by the removal of the excluded area hours from the calculation, this change will serve to lower the average hourly wages of hospitals with relatively large excluded areas, more closely aligning them with costs allowed under the IPPS.

We believe that, despite the absence of a lengthy discussion of the policy in the proposed rule, the change in the overhead wage-related cost allocation noted in the FY 2006 IPPS proposed rule (70 FR 23373) provided hospitals with adequate notice of the change. Hospitals are sufficiently sophisticated to understand the implications of a proposal to exclude certain lines on the cost report from its calculations. In addition, the Average Hourly Wage Calculator, which included the revised overhead wage-related cost allocation, has been available on our Web site: *http://www.cms.hhs.gov/providers/hipps/ippswage.asp* since shortly after the proposed rule went on public display on April 24, 2005. The tables included with the FY 2006 proposed rule also showed the average hourly wages and the wage indices resulting from the proposed modification. Finally, clearly the fact that a hospital association and other commenters provided comments on the proposal demonstrates that hospitals had actual notice of the change. Some commenters even computed the effect of the change on the calculation of their wage indices for FY 2006. In addition, even if some hospitals might object that they did not understand the change included in the FY 2006 proposed rule, we believe that the detailed steps used in calculating the wage index are interpretive rules that are not subject to the notice and comment rulemaking procedures of the Administrative Procedure Act. Clearly, we do not include each of the detailed steps and lines from the cost report in our regulations at § 412.64(h), the section of the regulations requiring CMS to adjust the ''proportion of the Federal rate for inpatient operating costs that are attributable to wages and labor-related costs for area differences in hospital wage levels by a [wage index] factor.'' For these reasons, we believe that we have provided sufficient notice of the change in the ''overhead rate'' calculation.

Commenters are correct that some hospitals that wish to reclassify for FY 2007 could also be affected by decreased average hourly wages. However, we have analyzed our data, and have found that the impact of the change is limited. Specifically, approximately 42 hospitals in 11 labor market areas are receiving a decrease of 1.0 to 5.5 percent in their FY 2006 wage index as a result of this change in the calculation. These labor market areas are primarily in the New England and East North Central census regions. In addition, 10 rural hospitals and 18 urban hospitals are experiencing a decrease in their average hourly wages of between 10 percent and 45 percent. However, the ''excluded rates'' for these hospitals range between 74 percent up to and including 100 percent. While we note that CMS did provide a 30-day period after publication of the FY 2005 IPPS final rule (69 FR 49066) allowing hospitals to reconsider their geographic reclassification decisions, we provided this opportunity because of the number of changes between the proposed and final rules and the apparent confusion regarding application of the section 505 out-migration adjustment. We do not believe a similar extension is warranted in this case. Further, we do not agree that a 30-day window after publication of the final rule is necessary in order to

allow cancellations or reinstatements of reclassifications. The FY 2006 proposed rule change was clearly reflected in the wage index tables accompanying the proposed rule. Thus, hospitals were well aware of their proposed average hourly wages and proposed wage indices for FY 2006. Hospitals could review these wage tables, find the proposed average hourly wage and wage index listed for the hospital and wage area, and on the basis of such information, determine whether they wished to withdraw or retain a certain reclassification. Because of such notice, there is no need to provide a subsequent 30-day period for withdrawal or reinstatement. Further, we note that hospitals could use the Average Hourly Wage Calculator on the CMS Web site to determine exactly how the revised methodology affected the wage index. For the reasons stated above, we are finalizing our proposed decision to remove the excluded area hours on lines 8 and 8.01 from the overhead wage-related cost allocation.

G. Computation of the FY 2006 Blended Wage Index

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 final 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).

As we proposed in the FY 2006 IPPS proposed rule, for FY 2006, we are again adjusting 10 percent of the wage index factor for the occupational mix. In computing the occupational mix adjustment for the final 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.

As we did in the proposed rule, we also acknowledge the finding of the District Court opinion in *Bellevue Hospital Center* v. *Leavitt*, No. 04–8639 (S.D.N.Y, March 2005). Given that the Government has appealed the occupational mix portion of that decision, we believe it is appropriate to continue with our policy of adopting the policy we believe to be most prudent for occupational mix.

With 10 percent of the FY 2006 wage index adjusted for occupational mix, the national average hourly wage is $28.0037 and the Puerto Rico specific average hourly wage is $12.8055. The wage index values for 13 rural areas (27.7 percent) and 201 urban areas (52.1 percent) would decrease as a result of

the adjustment. These decreases would be minimal; the largest negative impact for a rural area would be 0.18 percent and for an urban area, 0.43 percent. Conversely, 31 rural areas (66.0 percent) and 176 urban areas (45.6 percent) would benefit from this adjustment, with 1 urban area increasing 2.2 percent and 1 rural area increasing 0.37 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 final FY 2006 wage index. (See Appendix A to this final rule for further analysis of the impact of the occupational mix adjustment on the final FY 2006 wage index.)

Comment: Most commenters supported our proposal to adjust only 10 percent of the FY 2006 wage index for occupational mix. However, one commenter requested CMS to implement the occupational mix adjustment in a way that ensures that the adjustment does not negatively impact his hospital and other similar hospitals, providing no further elaboration for his suggestion, while two other commenters opposed applying any occupational mix adjustment at all until CMS performs a new survey. In contrast, a few commenters representing hospitals that would benefit from a 100 percent occupational mix adjustment to the wage index recommended the policy that would most behoove them (that is, a full implementation of the adjustment for the FY 2006 wage index). These commenters supported their proposal by noting that: (1) For FY 2006, hospitals were given an opportunity to revise or correct data originally submitted; (2) occupational mix data from FY 2005 were consistent with registered nurse and licensed practical nurse data from a AHA annual survey of hospitals; and (3) Congress intended for 100 percent of the wage index to be adjusted for occupational mix beginning October 1, 2004.

Response: We do not agree with the commenters recommending elimination of the occupational mix adjustment. As we stated in the proposed rule, given the FY 2005 and FY 2006 wage indices were based on the first year of survey data, as well as other stated considerations (see 70 FR 23375), we found survey results sufficiently robust to support an adjustment to 10 percent of the wage index, but did not believe it prudent to adjust the entire wage index by occupational mix. We refer readers to the proposed rule for a full discussion of our rationale. We continue to believe that the data are sufficient to support applying the occupational mix to 10 percent of the wage index. Moreover, we believe that by implementing the wage index in this manner, we are carrying out the Congressional requirement to begin applying an occupational mix to the wage index by October 1, 2004.

We do not agree with commenters that stated that the correction of data permitted for FY 2006 is sufficient to allow for a 100 percent adjustment in FY 2006. While hospitals were permitted to correct their data for FY 2006, only 20 out of the 3,541 hospitals did so. Further, the fact that hospitals were permitted to submit corrected data does not alleviate concerns that (a) the data continued to be derived from the first year of an occupational mix survey; or (b) that CMS had no historical baseline data for developing a robust audit program for such data. Given such concerns, we also believe it would be neither equitable nor appropriate to adjust 100 percent of the wage index when the occupational mix benefits hospitals, but 10 percent of the wage index when it does not. Instead, we continue to believe that the proposed, more moderate occupational mix adjustment is the most equitable and appropriate approach. As such, the FY 2006 wage index in this final rule is a blend of 10 percent of a wage index adjusted for occupational mix and 90 percent of an unadjusted wage index.

Comment: One commenter expressed concern regarding CMS' statement in the proposed rule that ''hospitals might be accounting for shortages of physicians by hiring more registered nurses'' (70 FR 23375). The commenter suggested that the statement is unsupported and implies a ''practice of downgrading care, especially since it uses 'registered nurses', not even nurse practitioners.'' The commenter requested that we delete the statement from the final rule.

Response: We did not intend to imply that hospitals that have increased their reliance on registered nurses provide downgraded care. Nursing schools and nursing associations acknowledge a significant increase in the number of registered nurses who are pursuing or have achieved advanced practice degrees as nurse practitioners, clinical nurse specialists, nurse midwives, and certified registered nurse anesthetists. Our statement merely acknowledged that hiring advanced practice registered nurses helps to mitigate problems with physician shortages by increasing the number of staff who are available to provide primary care, and that such hiring practices may have contributed to the higher than expected occupational mix reported by many rural hospitals.

The wage index values for FY 2006 (except those for hospitals receiving wage index adjustments under section 505 of Pub. L. 108–173) are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this final rule.

Tables 3A and 3B in the Addendum to this final rule list the 3-year average hourly wage for each labor market area before the redesignation of hospitals, based on FYs 2004, 2005, 2006 cost reporting periods. Table 3A lists these data for urban areas and Table 3B lists these data for rural areas. In addition, Table 2 in the Addendum to this final rule includes the adjusted average hourly wage for each hospital from the FY 2000 and FY 2001 cost reporting periods, as well as the FY 2002 period used to calculate the FY 2006 wage index. The 3-year averages are calculated by dividing the sum of the dollars (adjusted to a common reporting period using the method described previously) across all 3 years, by the sum of the hours. If a hospital is missing data for any of the previous years, its average hourly wage for the 3-year period is calculated based on the data available during that period.

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 final rule include the occupational mix adjustment.

Other Public Comments

Comment: One commenter stated that an ongoing concern is that the hospital wage index is applied to many provider types for which wage data are excluded from the wage index calculation. The commenter recommended that CMS separate wage indices for SNFs, IRFs, and IPFs by modifying the way the wage index data are reported on the Medicare cost report.

Response: We appreciate the comment, but note that the subject-matter of this final rule is the IPPS system and not the PPSs governing non-IPPS entities such as SNFs, IRFs, and IPFs. Therefore, we are not responding to this comment at this time. We suggest that the commenter raise his or her concerns as part of the rulemaking process for updating the respective facility's PPS.

H. Revisions to the Wage Index Based on Hospital Redesignation

1. General

Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. Hospitals 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 and 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 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,[9] 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. 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 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'

[9] 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. For all-urban States, CMS established an imputed floor (69 FR 49109). 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.

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 are 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 section 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, in the FY 2006 IPPS proposed rule, we proposed 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 are included in the rural area's wage index, if including the urban hospital's data increase the wage index of the rural area. Otherwise, the wage data are excluded. Similarly, we proposed 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 are 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). In the FY 2006 IPPS proposed rule, we stated that we believe this proposal provides uniformity in the way geographic areas are treated under all types of reclassifications. In addition, we further stated that our proposal promotes predictability by alleviating fluctuations in the wage indexes due to a section 401 redesignation.

No commenters objected to extending hold harmless protection to urban hospitals that are redesignated as rural under section 401. Therefore, in this final rule, we are finalizing the policy to extend hold harmless protection to urban hospitals that are redesignated as rural under section 401.

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

4. FY 2006 MGCRB Reclassifications

The MGCRB's review of FY 2006 reclassification requests resulted in 299 hospitals approved for wage index reclassifications 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, 631 hospitals are 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).

Under § 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of a proposed rule. The request for withdrawal of an application for reclassification or termination of an existing 3-year reclassification that would be effective in FY 2005 must be received by the MGCRB within 45 days of the publication of the proposed rule. If a hospital elects to withdraw its wage index application after the MGCRB has issued its decision, but prior to the above date, it may later cancel its withdrawal in a subsequent year and request the MGCRB to reinstate its wage index reclassification for the remaining fiscal year(s) of the 3-year period (§ 412.273(b)(2)(i)). The request to cancel a prior withdrawal must be in writing to the MGCRB no later than the deadline for submitting reclassification applications for the following fiscal year (§ 412.273(d)). For further information about withdrawing, terminating, or canceling a previous withdrawal or termination of a 3-year reclassification for wage index purposes, we refer the reader to § 412.273, as well as the August 1, 2002, IPPS final rule (67 FR 50065) and the August 1, 2001 IPPS final rule (66 FR 39887).

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

Applications for FY 2007 reclassifications are due to the MGCRB by September 1, 2005. We note that this is also the deadline for canceling a previous wage index reclassification withdrawal or termination under § 412.273(d). Applications and other information about MGCRB reclassifications may be obtained, beginning in Mid-July 2005, via the CMS Internet Web site at: *http://cms.hhs.gov/providers/prrb/mgcinfo.asp*, or by calling the MGCRB at (410) 786–1174. The mailing address of the MGCRB is: 2520 Lord Baltimore Drive, Suite L, Baltimore, MD 21244–2670.

5. 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 the redesignation areas for two 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 listed the redesignation CBSAs for 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 using for FY 2006. 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.

Comment: Several commenters urged CMS to permit hospitals located in counties redesignated under section 1886(d)(8)(B) of the Act to waive or reject the redesignation if the redesignation proves to be detrimental or otherwise undesirable to the qualifying hospital. They cited examples in which hospitals with special designations, such as rural referral centers, SCHs, MDHs, and CAHs, where their status is dependent on being located in a rural area, lost their special designation when they were reclassified to an urban area under section 1886(d)(8)(B) of the Act.

Response: We considered this comment and are responding to it only insofar as it relates to section 1886(d) hospitals, such as rural referral centers, SCHs, and MDHs, located in Lugar counties. We refer readers to the section on CAHs in this final rule for information on how CMS treats CAHs in Lugar counties. The statute specifically states that ''(f)or purposes of this subsection, the Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in (a) urban metropolitan statistical area * * *.'' Therefore, all section 1886(d) hospitals located in Lugar counties are deemed urban and such classification cannot be waived, except if a hospital is eligible for an out-migration adjustment. In order for a section 1886(d) hospital to retain its special designation when the area in which it is located is redesignated from rural to urban, a hospital must apply for reclassification under § 412.103(a). We encourage a hospital seeking reclassification under this section to submit a complete application in writing to its CMS Regional Office.

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.
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.

RURAL COUNTIES REDESIGNATED AS URBAN UNDER SECTION 1886(d)(8)(B) OF THE ACT—Continued

[Based on CBSAs and Census 2000 Data]

Rural county	CBSA
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.
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.
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 were permitted to compare the reclassified wage index for the labor market area in Table 4C in the Addendum of the May 4, 2005 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 were provided the opportunity to withdraw from an MGCRB reclassification within 45 days of the publication of the FY 2006 IPPS proposed rule (May 4, 2005).

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.

Comment: Some commenters indicated that hospitals currently receiving a section 508 reclassification are eligible to reclassify to that same area under the standard reclassification process as a result of the new labor market definitions that we adopted for FY 2005. The commenters pointed out that the governing regulations indicate that ''if a hospital is already reclassified to a given geographic area for wage index purposes for a 3-year period, and submits an application to the same area for either the second or third year of the 3-year period, that application will not be approved.'' These commenters expressed concern that the MGCRB will deny these hospitals reclassification for FY 2007 if there is no change in the regulations to address this issue.

Response: We appreciate the commenters' interest in this matter. Hospitals that indicate in their MGCRB applications that they agree to waive their section 508 reclassification for the first 6 months of FY 2007 if they are granted a 3-year reclassification under the traditional MGCRB process will not be subject to the regulation cited above. Thus, in applying for a 3-year MGCRB reclassification beginning in FY 2007, hospitals that are already reclassified to the same area under section 508 should indicate in their MGCRB reclassification requests that if they receive the MGCRB reclassification, they will forfeit the section 508 reclassification for the first 6 months of FY 2007.

Comment: Many commenters expressed concern regarding the timing overlaps between section 508 of Pub. L. 108–173 and the FY 2007 reclassifications. The commenters pointed out that section 508 of Pub. L. 108–173 required the Secretary to develop a one-time special reclassification procedure that allowed hospitals meeting specified criteria to be reclassified from April 1, 2004, through March 31, 2007. They further stated that some hospitals that qualified for reclassification under section 508 may qualify for geographic reclassification under one of the opportunities available under the regulations in 42 CFR part 412, subpart L. Because pending reclassifications will expire in the middle of a Federal fiscal year, the commenters requested that CMS clarify when the hospitals should apply for reclassification under an opportunity under subpart L. Commenters stated that, unless CMS establishes an accommodation for section 508 hospitals, hospitals will be confronted with a difficult dilemma: Forfeiting 6 months of section 508 reclassification to be able to reclassify for FY 2007; or postponing reclassification until FY 2008 and being without reclassification for the 6 months between April 1 and September 30, 2007. The commenters believed that both of these options would carry significant financial consequences for hospitals. The commenters urged CMS to implement a solution that does not require hospitals to make such a difficult choice, and would provide them with the full benefits of the section 508 reclassification.

Response: We appreciate the commenters' suggestions and their interest in this matter. Under 1886(d)(10)(D)(v) of the Act, CMS has the authority to ''establish procedures'' under which a hospital may elect to terminate a reclassification before the end of a 3-year period. Based on comments and on a careful review of the statute, we have decided to exercise this authority to establish a procedural rule for section 508 hospitals to retain their section 508 reclassification through its expiration on March 31, 2007 and reclassify under a subpart L opportunity for the second half of FY 2007. The following procedural rules will apply for section 508 hospitals that wish to reclassify for the second half of FY 2007:

For section 508 hospitals applying for individual reclassification under 42 CFR 412.230—

(1) Hospitals must apply for reclassification through the MGCRB by the September 1, 2005 deadline.

(2) Section 508 hospitals that are approved by the MGCRB for reclassification will have 45 days from the date the FY 2007 IPPS proposed rule is published to cancel their section 1886(d)(10) reclassifications for either the first 6 months of FY 2007 or for the entire fiscal year. Hospitals should note that if they fail to cancel their section 1886(d)(10) reclassification by the deadline, they will not receive their section 508 wage adjustment in FY 2007. To further clarify—

- Hospitals that cancel their section 1886(d)(10) reclassification for the first 6 months receive their section 508 reclassifications for October 2006 through March 2007 and their section 1886(d)(10) reclassifications for April through September 2007.
- Hospitals that cancel their section 1886(d)(10) reclassification for the entire year will receive their section 508 reclassification for October 2006 through March 2007 and their home area wage index for April through September 2007.
- Hospitals that do not cancel their section 1886(d)(10) reclassifications will receive their section 1886(d)(10) reclassification, not their section 508 reclassification, for the entire fiscal year.

Hospital groups that include a section 508 hospital would also be permitted to submit section 1886(d)(10) reclassification applications by the September 1, 2005 deadline. However, in order for a group reclassification to be approved, either of the following conditions would need to be met:

(1) The section 508 hospital that is part of the group must waive its section 508 reclassification for the first half of FY 2007. This is necessary because the regulations at §§ 412.232 and 412.234 state that all hospitals in a county must apply for reclassification as a group. The hospitals either agree to receive the same reclassification or they fail to qualify as a group. The Administrator upheld this policy in an MGCRB appeal for FY 2006.

(2) Each member of the group agrees in writing, at the time the application is submitted September 1, 2005, that they cancel the group reclassification if granted for the first 6 months of FY 2007. The section 1886(d)(10) reclassification will be effective only

April through September 2007. Under this scenario, the section 508 hospital receives its section 508 reclassification from October 2006 through March 2007 and the remainder of the group receives the home wage index for that time period. For April through September 2007, the section 508 hospital and the remainder of the group receive the group reclassification. The group will have the opportunity to cancel the April through September 2007 group reclassification within 45 days of publication of the proposed rule.

We would apply a similar rule for purposes of the out-migration adjustment. The statute states that a hospital cannot receive an out-migration adjustment if it is simultaneously reclassified under section 1886(d)(10) of the Act. Therefore, hospitals that are not reclassified during any part of FY 2007 will, by default, receive an out-migration adjustment during that time period.

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

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

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 under section 1886(d)(3)(E) or section 1886(d)(8)(D) of the Act.

Comment: One commenter proposed that CMS allow hospitals that reclassify and receive a diluted wage index to receive the out-migration adjustment provided it does not exceed the actual wage index for the area to which they are reclassified.

Response: The statute specifically states that hospitals that receive an out-migration adjustment are ineligible for reclassification under section 1886(d)(8) or section 1886(d)(10) of the Act.

Hospitals located in counties that qualify for the wage index adjustment will receive an increase in the wage index that is equal to the average of the differences between the wage indices of the labor market area(s) with higher wage indices 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 indices in making these calculations.

Hospitals located in the qualifying counties identified in Table 4J in the Addendum to this final 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 will 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 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 adjustments calculated for qualifying hospitals are listed in Table 4J in the Addendum to this final rule. These adjustments are 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 are 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 sections 1886(d)(8) or (d)(10) of the Act, or under section 508 of Pub. L. 108–173, unless they waive such out-migration adjustment. As announced in the FY 2005 final rule as well as the proposed rule for FY 2006, hospitals redesignated under section 1886(d)(8) of the Act or reclassified under section 1886(d)(10) of the Act or under section 508 of Pub. L. 108–173 were deemed to have chosen to retain their redesignation or reclassification, unless they explicitly notified CMS that they elected to receive the out-migration adjustment instead within 45 days from the publication of the FY 2006 IPPS proposed rule (May 4, 2005). Under § 412.273, hospitals that have been reclassified by the MGCRB were permitted to terminate existing 3-year reclassifications within 45 days of the May 4, 2005 proposed rule. Hospitals that are eligible to receive the out-migration wage index adjustment and that withdraw their application for reclassification automatically receive the wage index adjustment listed in Table 4J in the Addendum to this final rule. Requests for withdrawal of an application for reclassification or termination of an existing 3-year reclassification will be effective in FY 2006 and had to have been received by the MGCRB within 45 days of the publication of the FY 2006 IPPS proposed rule. Requests to waive section 1886(d)(8) redesignations for FY 2006 had to have been received by CMS within 45 days of the publication of the FY 2006 IPPS proposed rule. In addition, hospitals that wished to retain their redesignation/reclassification under section 1886(d)(8), section 1886(d)(10), or section 508 (instead of receiving the out-migration adjustment) for FY 2006 did not need to submit a formal request to CMS; they automatically retain their redesignation/reclassification status for FY 2006.

Comment: Commenters expressed opposition to and support of CMS' interpretation of the law that hospitals will receive the same out-migration adjustment in each of the 3 years of eligibility for the adjustment. One

commenter recommended that CMS maintain its policy to keep the out-migration adjustment unchanged to minimize uncertainties and instability in Medicare reimbursement to hospitals. Other commenters recommended that CMS revise its policy so that the out-migration adjustment will be recalculated each year based on updated wage data and the new wage indices.

Response: We appreciate the comments we received regarding this issue. The governing statute specifically states that the wage index increase ''shall be effective for a period of 3 fiscal years.'' We have interpreted this to mean that the adjustment shall be identical for 3 years. If we were to recalculate the out-migration adjustment each year based on updated wage data as suggested, counties could potentially be deemed ineligible for the wage index adjustment if the average hourly wage for all hospitals in the labor market area exceeded the average hourly wages for all hospitals in the county. Therefore, we have elected to maintain our policy to keep the out-migration adjustment associated with a particular county unchanged.

Comment: One commenter requested that we clarify the removal of several providers from Table 4J between the May 4, 2005 **Federal Register** publication and the revised table posted on the CMS Web site on June 1, 2005.

Response: There were some errors for CBSAs and imputed rural floors and these errors had an effect on the out-migration calculations shown in Table 4J of the proposed rule. We posted the corrected adjustments on the CMS Web site on June 1, 2005. Hospitals were also notified of the corrected out-migration adjustments via the Listserv and a Hospital Open Door Forum on June 2, 2005.

Comment: Commenters requested that CMS make available the hospital commuting data used to compute the out-migration adjustment.

Response: We plan to make the data used for determining the qualifying counties and the out-migration adjustment available after the publication of this final rule on the CMS Web site at: *http://www.cms.gov.*

Comment: Commenters requested that CMS implement a policy similar to the policy established for FY 2005 that allows hospitals to withdraw or reinstate their geographic applications within 30 days of the date that the final rule is published. Several commenters believed there is still a likelihood that revisions made between the proposed and final rules may affect a hospital's choice of whether to accept the out-migration or a reclassification.

Response: First, we note that cancellation and reinstatement rules for geographic reclassifications are procedural rules that are not subject to notice and comment rulemaking. Second, we note that it has been our longstanding policy that our procedural rules on withdrawals or terminations of reclassifications require such terminations and withdrawals be made within 45 days of the proposed rule (§ 412.273). However, FY 2005 was an exceptional circumstance due to the extensive changes to the wage index as a result of our adoption of the new labor market areas. We noted that this was a limited circumstance, and we did not expect to extend the withdrawal date beyond 45 days after the proposed rule in future years. We do not believe the exceptional circumstance that existed for FY 2005 exists for FY 2006, given the changes to the labor market areas have been adopted. Therefore, we are continuing with our longstanding policy that terminations of reclassifications are required to be made within 45 days of the proposed rule. As we have explained in previous preamble discussions (see, for example, 56 FR 43241, August 30, 1991), the 45-day deadline provides a reasonable time to take withdrawals or terminations into account in developing the final wage index and prospective payment rates.

J. Requests for Wage Index Data Corrections

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 transmitted 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 disagreed with the fiscal intermediary's policy interpretations was April 22, 2005.

Hospitals were also instructed to examine Table 2 in the Addendum to

the proposed rule. Table 2 of the proposed rule contained 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 noted that the hospital average hourly wages shown in Table 2 only reflected changes made to a hospital's data and transmitted to CMS by February 23, 2005.

The final wage data public use file was released 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 was made available solely for the limited purpose of identifying any potential errors made by CMS or the fiscal intermediary in the entry of the final wage data that result from the correction process described above (revisions submitted to CMS by the fiscal intermediaries by April 15, 2005). If, after reviewing the May 2005 final file, a hospital believed that its wage data were incorrect due to a fiscal intermediary or CMS error in the entry or tabulation of the final wage data, it was provided the opportunity to send a letter to both its fiscal intermediary and CMS that outlined why the hospital believed an error exists and to provide all supporting information, including relevant dates (for example, when it first became aware of the error). These requests had to be received by CMS and the fiscal intermediaries by no later than June 10, 2005. The fiscal intermediary reviewed requests upon receipt and contacted CMS immediately to discuss its findings.

After the release of the May 2005 wage index data file, changes to the hospital wage data were only 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 accepted the following types of requests:

- Requests for wage data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries on or before April 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) have been incorporated into the final wage index of this final rule and are 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 did 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) and *Palisades General Hospital* v. *Thompson,* No. 99–1230 (D.D.C. 2003.) We refer the reader also to the FY 2000 final rule (64 FR 41513) for a discussion of the parameters for appealing to the PRRB for wage index data corrections.

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 had access to the final wage index data by early May 2005, they had the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or CMS before the development and publication of the final FY 2006 wage index in this final rule, and the implementation of the FY 2006 wage index on October 1, 2005. If hospitals availed 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 Web site 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.

In the FY 2006 IPPS proposed rule, we proposed 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 proposed 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 made this proposed revision to § 412.64(k)(2) because we believe that it 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, we indicated that the proposed 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 making 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 final retroactive correction will 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 will still apply in those instances where a judicial decision reverses a CMS denial of a hospital's wage data revision request.

In addition, in the FY 2006 IPPS proposed rule, we proposed 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 proposed 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.''

Comment: Several commenters supported CMS' proposal to correct the FY 2005 wage index retroactive to October 1, 2004, using the authority provided under section 903(a)(1) of Pub. L. 108–173 on a one-time only basis for the limited circumstance where a hospital meets the first two criteria specified in the proposal. However, the commenters requested that CMS amend the proposed policy to delete the third criterion that CMS must have agreed before October 1 that the fiscal intermediary or CMS made an error in tabulating the hospital's wage data. The commenters were concerned that if CMS could not notify hospitals before October 1 that the wage data would be corrected, the hospital would not be eligible for the retroactive correction to the FY 2005 wage index.

Response: We believe it is important to retain the requirement that CMS must have notified the hospital before October 1 that an error was made in calculating the wage index for an area for the correction to be made retroactively to October 1. The October 1 date is relevant because it is the first day of the new fiscal year. Once the fiscal year begins, we believe it is important to only make changes to the wage index prospectively, as has been CMS' longstanding policy as stated in the FY 1984 IPPS final rule (49 FR 258, January 3, 1984), unless it is clear that CMS determined that either it or the fiscal intermediary made an error prior to the beginning of the fiscal year and intended to pay hospitals using a different wage index. With respect to the specific requirements for making FY 2005 wage index corrections retroactive to October 1, 2004, we will accept letters, e-mails, and other written evidence from hospitals demonstrating that, prior to October 1, 2004, CMS agreed that an error was made to the wage index and intended to pay the hospital at the corrected wage index effective October 1, 2004.

Comment: Two commenters urged CMS to retroactively apply the policy that we are finalizing in this final rule to extend hold harmless protections to urban hospitals that are redesignated as rural under section 401 to the FY 2005 IPPS wage index.

Response: Retroactive wage corrections are intended to correct errors made in a previous year. In this case, we made a change to the regulations prospectively. Because the regulation change is unrelated to errors that were not corrected, we do not believe a retroactive wage index correction is warranted.

Comment: One commenter, a group of hospitals within a single CBSA, believed that the proposed retroactive wage index corrections should be expanded to include geographic classification errors. The commenter indicated that CMS made an error in tabulating the FY 2005 wage index data for the CBSA when it incorrectly categorized one provider as belonging to another CBSA. The commenter added that the geographic classification error had the effect of lowering the wage index of the CBSA and inflating the wage index for the other CBSA. The commenter indicated that CMS was given notice of the error prior to October 1, 2004, but the correction was changed prospectively effective January 1, 2005, rather than retrospectively.

Response: We agree that both geographic classification and reclassification technical errors should be corrected retroactive to the beginning of the fiscal year and that the special rule for FY 2005 should apply if the circumstances are the same as those that we are applying to the wage index. This would apply in cases where the wage index of an area has been miscalculated because of the improper assignment of a particular hospital to a labor market area.

Beginning with FY 2006, a hospital could receive a retroactive adjustment to its wage index for a geographic classification or reclassification error if the circumstances included in § 412.64(k)(2) exist. Generally stated, the following circumstances must be present.

For classification/reclassification errors made during the proposed rule:

(1) CMS made a technical error in assigning the hospital to a geographic labor market area. (The error made must be truly technical in nature and could not include any disputes about policy or cases where a hospital disagrees with

the MGCRB or CMS' reclassification decisions.)

(2) The hospital notifies CMS of the technical error using the formal comment process and during the comment period on the proposed rule. (This period is different from the period for requesting wage index corrections, as wage index data are posted on the CMS Web site and must follow a certain schedule set by CMS—for example, for FY 2006, tabulation errors were required to have been identified by June 10, 2005.)

(3) The error was not corrected in the final rule.

(4) The hospital again notifies CMS of the geographic assignment error, via written correspondence or e-mail following the publication of the final rule, and CMS agrees prior to October 1 that an error was made.

For classification/reclassification errors made for the first time during the final rule:

(1) CMS made a technical error in the final rule in assigning the hospital to a geographic labor market area; and

(2) The hospital notifies CMS of the error via written correspondence or e-mail, following the publication of the final rule, and CMS agrees prior to October 1 that an error was made.

In addition, we also agree that geographic classification or reclassification errors that resulted in an incorrect wage index for FY 2005 should also be corrected 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. Again, we believe it would not be in the public interest for us to pay hospitals using an incorrect wage index when the geographic classification/reclassification error was brought to our attention and we agreed prior to the beginning of FY 2005 that the error should be corrected. For FY 2005, we will make corrections to the wage index for geographic classification errors retroactive to October 1, 2004 in the following circumstances:

For classification/reclassification errors made during the FY 2005 IPPS proposed rule:

(1) CMS made a technical error in the tables of the FY 2005 proposed rule (69 FR 28752, May 18, 2004) in assigning a hospital to a geographic labor market area;

(2) The hospital notified CMS of the error, via written correspondence or e-mail during the comment period on the proposed rule and using the procedures for submitting formal comments;

(3) The error was not corrected in the tables accompanying the FY 2005 final rule (69 FR 49690); and

(4) The hospital notified CMS of the error via written correspondence or e-mail following the publication of the final rule, CMS agreed prior to October 1, 2004, that an error was made, CMS agreed that the error 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 such fiscal year.

For geographic assignment errors made for the first time during the FY 2005 final rule:

(1) CMS made a technical error in the tables of the FY 2005 final rule (69 FR 49690) in assigning a hospital to a geographic labor market area; and

(2) The hospital notified CMS of the error via written correspondence or e-mail following the publication of the final rule, CMS agreed prior to October 1, 2004, that an error was made, CMS agreed that the error 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 such fiscal year.

IV. Rebasing and Revision of the Hospital Market Baskets

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 final rule, we are shifting 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 final 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 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	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 sources are scheduled for publication every 5 years, but may 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, as we proposed in the FY 2006 IPPS proposed rule, we use the 1997 Benchmark I–O data in the 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 rebased hospital market basket, it was 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 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.

CHART 2.—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	Rebased FY 2002-based hospital market basket weights	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	
(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.
(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 FY 2002-based market basket. See discussion in section IV.B.2.r., miscellaneous products, as well as comment and response on blood and blood products that follow this section.

a. Wages and Salaries

For measuring the price growth of wages in the FY 2002-based market basket, as we proposed, we used 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 FY 1997-based market basket.

b. Employee Benefits

The 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 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. We have not yet identified a preferred option. Therefore, we did not make any changes to the proxy in this rule.

h. Pharmaceuticals

The percentage change in the price of prescription drugs as measured by the PPI (PPI Code #PPI32541DRX) 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 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 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 market basket. The weight for this cost category is higher than in the FY 1997-based market basket 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 market basket, and within miscellaneous products. These categories use as proxies the following PPIs: the PPI for blood and blood derivatives, the PPI for chemicals, and the PPI for finished goods less food and energy, respectively. Of these three market baskets, the market basket with blood in miscellaneous products and its associated proxy, the PPI for finished goods less food and energy, moved very similar to the market basket with blood as a separate category. 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.

Comment: Some commenters questioned the CMS proposal to remove blood and blood products as a separate cost category and add its weight to the miscellaneous products cost category of

the hospital market basket. A few commenters supported this move only as a temporary measure until a more appropriate blood and blood products PPI can be developed by the BLS.

Response: We studied different cost categories that might be used until we have had the opportunity to evaluate whether the BLS' PPI for Blood and Organ Banks (NAICS 621991), which is still in development, may be an appropriate price proxy that could be proposed for blood and blood products. The alternative cost categories we considered were Blood and Blood Products, Chemicals, and Miscellaneous Products. We considered placing blood and blood products in the ''other products'' subcategory because blood is a product purchased by hospitals. From 2001 to 2003 the percent changes in the price proxies for these respective cost categories were:

CHART 3.—ANNUAL GROWTH RATES FOR THREE POSSIBLE PRICE PROXIES

Cost category	Proxy	2001–2002	2002–2003
Chemicals	Industrial Chemicals	−0.9	11.3
Blood	Blood and Derivatives	−7.2	−11.4
Miscellaneous Products	Finished Goods less Food and Energy	0.1	0.2

In discussions with the blood banking industry we were presented data that the cost of blood had been increasing over the 2001–2003 period. In addition, an analysis of Medicare Cost Report data indicated that the cost weight for blood was increasing had increased from 1.023 in 2001 to 1.082 in 2002. Neither of these data sources supported the trends in the PPI for blood and derivatives over this period. In addition, we had previously determined that the PPI for Industrial Chemicals was not an appropriate price proxies for the change in blood prices (67 FR 50035). We believed the PPI for finished goods less food and energy was an appropriate proxy because it has a more stable measure than the others considered, and had not exhibited negative price movements in recent periods and currently serves as a proxy for all product costs that are small or without a specific price proxy.

We ran test market baskets using the most recent forecast (2005q2, with history through 2005q1). The three market baskets were identical, except that the blood weight was in its own cost category, in chemicals, or in miscellaneous products, respectively. As shown in Chart 4, the annual increases in the market baskets were similar, regardless of which cost category contained the market basket weight for blood and blood products. Therefore, even if blood and blood products were its own cost category, it would have little effect on the market basket update factor.

CHART 4.—MARKET BASKET INCREASE WITH BLOOD AND BLOOD PRODUCTS LOCATED IN:

	Blood and blood products	Chemicals	Miscellaneous products
2000	3.2	3.3	3.2
2001	4.2	4.2	4.1
2002	3.7	3.6	3.7
2003	3.9	4.2	4.0
2004	3.9	4.0	3.9
Average: 2000–2004	3.8	4.0	3.8

We are adopting the PPI for finished goods less food and energy as the price proxy for blood and blood products because our analysis shows that this price proxy most accurately reflects changes in costs of blood products. We note that the BLS is developing a Producer Price Index for Blood and Organ Banks. We look forward to evaluating this index when it is ready for use.

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 5.—FY 1997-BASED AND FY 2002-BASED PROSPECTIVE PAYMENT HOSPITAL OPERATING INDEX PERCENT CHANGE, FY 2000 THROUGH FY 2008

Fiscal year (FY)	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	3.9
Average FYs 2000–2004	3.8	3.8
Forecast:		
FY 2005	4.2	4.2
FY 2006	3.7	3.7
FY 2007	3.1	3.2
FY 2008	2.9	3.0
Average FYs 2005–2008	3.5	3.5

Source: Global Insight, Inc. 2nd Qtr 2005, @USMACRO/CNTL0605 @CISSIM/TL0505.SIM

Prior to the publication of the FY 2006 IPPS proposed rule, we had been actively working with our forecasting firm, Global Insight, Inc. (GII), to improve the forecasting accuracy of the market baskets. GII is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the market baskets. Among other services GII provides to CMS, GII calculates projected inflation factors for price proxies using models that take into account national and global economic trends.

Over the last several years, dramatic fluctuations in the price of certain costs have made it difficult to forecast price proxy inflation. This uncertainty has resulted in market basket forecast error greater than 0.25 percentage points in FY 2001, FY 2003, and FY 2004. The driving force behind much of this uncertainty has been the instability of energy costs, which, in a global economy, have an indirect effect on wages and other costs as well as a direct effect on utility prices. With our input and consultation, GII recently evaluated and modified their forecasting models to help improve their accuracy. Using these improved forecasting models, GII calculated updated inflation factors for the major cost categories in Chart 6.

CHART 6.—COMPARISON OF THE 4 QUARTER MOVING AVERAGE PERCENT CHANGES FOR SEVERAL COST CATEGORY WEIGHTS BETWEEN THE FY 2006 IPPS PROPOSED AND FINAL RULES

Expense category	FY 2002-based cost weights	GII 2004q4 forecast of FY 2006 (Proposed Rule)	GII 2005q2 forecast of FY 2006 (Final Rule)
Total—PPS02	100.000	3.2	3.7
Compensation	59.993	3.5	3.9
Utilities	1.251	0.8	3.6
Professional Fees	5.510	3.6	4.3
Professional liability insurance	1.589	8.4	7.8
All Other	31.657	2.4	3.0
All Other Products	20.336	2.3	3.2
All Other Services	11.321	2.4	2.6

In the FY 2006 IPPS proposed rule, we forecasted a market basket update of 3.2 percent. Based on our updated forecasting model, we are forecasting a market basket update of 3.7 percent for FY 2006.

Comment: Several commenters requested that CMS review and revise the methodology used to determine the projected FY 2006 market basket. They are concerned that the previously proposed FY 2006 update of 3.2 percent is a dramatic underestimation. They emphasized the importance of a reliable projection methodology in order to ensure equitable payments.

Response: We recognize the importance of a reliable forecasting methodology. As discussed above, we have worked with our forecasting firm, GII, to modify and improve GII's forecasting models to help improve their accuracy. The final FY 2006 update of 3.7 percent reflects these modifications.

Comment: Several commenters requested that CMS make the calculation of the projected FY 2006 available to the public.

Response: We have summarized our calculation of the market basket update in Chart 6 above.

3. Labor-Related Share

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. As we proposed in the FY 2006 IPPS proposed rule, we are continuing to use our current methodology of defining the labor-related share as the national average proportion of operating costs that are attributable to wages and salaries, fringe benefits, professional fees, contract labor, and labor intensive services. Therefore, we calculate the labor-related share by adding the relative weights for these operating cost categories. We continue to believe, as we have stated in the past, that these operating cost categories likely are related to, are influenced by, or vary with the local markets. Our definition of the labor-related share therefore continues to be consistent with section 1886(d)(3) of the Act. As we proposed, we are removing postage costs from the FY 2002-based labor-related share.

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, in this final rule, we are implementing 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.''

Comment: One commenter suggested that we decrease the labor-related share from 62 percent to 50 percent for those hospitals with wage indices under 1.0.

Response: As stated above, the 62 percent labor-related share provision was established by section 403 of Pub. L. 108–173. This provision was mandated by Congress and, therefore, CMS has no authority to modify it.

As we proposed, we also are updating the labor-related share for Puerto Rico. Consistent with our methodology for determining the national labor-related share, we 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 use the national weights. In the proposed rule, we observed that, rather than using a Puerto Rico-specific labor-related share, another option would be to apply the national labor-related share to the Puerto Rico-specific rate. In the proposed rule, we also noted that we were still reviewing our data and had not yet calculated the updated Puerto Rico-specific labor-related share percentage. Therefore, in the proposed rule, the labor-related and nonlabor-related portions of the Puerto Rico-specific standardized amount listed in Table 1C of the Addendum to the proposed rule reflected the current FY 2005 labor-related share for Puerto Rico of 71.3 percent. We solicited comments on our proposal to update the labor-related share for Puerto Rico.

After publication of the proposed rule, we calculated an updated labor-related share of 58.7 percent for Puerto Rico and posted it on the CMS Web site at *http://www.cms.hhs.gov/providers/hipps.* We did not receive any public comments on the proposed updated labor-share for Puerto Rico. Accordingly, we are adopting an updated Puerto Rico labor-related share of 58.7 percent, which is reflected in the Table 1C of the Addendum of this final rule.

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 7 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 7.—LABOR-RELATED SHARE: FY 1992-BASED AND FY 2002-BASED

Cost category	FY 1992-based weight	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 continuing 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 sufficient 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. In our initial regression specification (in log form), Medicare operating cost per Medicare discharge was the dependent variable and the independent variables were the area wage index, the case-mix index, the ratio of residents per bed (as proxy for IME status), and a dummy variable that equaled one if the hospital was 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 appeared 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 whether 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. In the FY 2006 IPPS proposed rule, we solicited 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 used an edit that 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. In the FY 2006 IPPS proposed rule, we solicited comments on this approach, 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 locally. 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 locally, regionally, or nationally. The results were quite consistent across all of the hospitals, indicating most advertising and legal services are purchased locally or regionally and nearly all management and consulting services are purchased nationally. Although the results of our research are instructive, as we have stated in the past, we believe that items should not be excluded from the labor-related share merely because they could be purchased nationally (68 FR 45467). We do plan to expand our efforts in this area to determine whether it would be appropriate in the future to modify our methodology for calculating the labor-related share. In the FY 2006 IPPS proposed rule, we solicited data or studies that would be helpful in this analysis. However, we indicated that we were unsure if we would be able to finish this analysis in time for inclusion in this FY 2006 IPPS final rule.

Comment: Several commenters objected to our proposal to change the labor-related share to 69.7 percent and requested that CMS maintain a labor-related share of 71.1 percent. The commenters provided similar reasons for rejecting this provision of the proposed rule. Generally, the commenters were concerned that the new lower labor share would negatively impact urban hospitals and several commenters stated that CMS should postpone changing the labor share until the agency has finished researching they are finished researching different labor-related share methodologies. In addition, commenters noted that the budget neutral manner in which CMS proposed to implement this labor share change would increase the standardized amount for all hospitals. They believed this is unfair as the increased amount would provide an additional benefit to rural hospitals that are already advantaged by many provisions of Pub. L. 108–173, including section 403 which sets the labor share at 62 percent for hospitals with a wage index less than or equal to 1.0.

Response: Section 404 of Pub. L. 108–173 requires the Secretary to update the weights used in the IPPS operating and capital market baskets, *including the labor-related share,* to reflect the most current available data. Therefore, we are directed by statute to update the labor share and cannot maintain the labor share at the outdated percentage of 71.1. Since the FY 2003 IPPS final rule was issued, CMS has continued to evaluate alternative labor-related share methodologies. Given this research, we believe our existing methodology of calculating the labor-related share is the most appropriate methodology at this time. Our alternative methodologies did not produce the sound evidence needed to justify changing our existing methodology. Specifically, our regression results were inconsistent and highlighted underlying data problems that were not evident in our market basket labor-related share methodology. We are confident that our current model is the best method presently available to appropriately capture the changing cost structures hospitals have faced over the last ten year period (1992 to 2002). Therefore, we are establishing the labor share at 69.7 percent.

In addition, we are implementing this revised and rebased labor share in a budget neutral manner, but consistent with section 1886(d)(3)(E) of the Act, we are not taking into account the additional payments that will be made as a result of hospitals with a wage index less than or equal to 1.0 being paid using a labor-related share lower than the labor-related share of hospitals with a wage index greater than 1.0. Section 1886(d)(3)(E) of the Act directs us to determine a labor related share that reflects the ''proportion * * * of hospitals'' costs which are attributable to wages and wage-related costs.'' In addition, section 1886(d)(3)(E) of the Act requires that we implement the wage index adjustment in a budget neutral manner. However, section 403 of Pub. L. 108–173, which sets the labor-related share at 62 percent for hospitals with a wage index less than or equal to 1.0, also provides that the Secretary shall calculate the budget neutrality adjustment for the wage index as if the Pub. L. 108–173 had not been enacted. Therefore, for purposes of the budget neutrality adjustment, section 403 of Pub. L. 108–173 prohibits us from taking into account the additional payments that will be made as a result of hospitals with a wage index less than or equal to 1.0 being paid using a labor-related share of 62 percent. While we recognize that this does have the effect of increasing the standardized amount applicable to all hospitals, the statute requires this implementation methodology.

As mentioned previously in the proposed rule, we proposed 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. Using this methodology, we calculated a labor-related share of 69.731, which we are using for FY 2006.

Comment: One commenter requested that CMS continue to include postage in the labor-related share.

Response: We do not believe that we should continue to include postage costs in the labor-related share as postage fees are set at nationally uniform rates and are not affected by local purchasing power of hospitals. The cost of postage is primarily

influenced by weight of the package and the distance the package is traveling (National Zone Chart Program Technical Guide 2003–2004, *http://www.ribbs.usps.gov/files/Zone_Charts/ZCTECHNICAL_GUIDE.PDF*, page 2). For example, the cost of mailing a package from Boston, MA to Baltimore, MD (approximately 450 miles) is the same price as mailing a package from Long Beach, NC to Baltimore, MD (approximately 450 miles) (*http://postcalc.usps.gov/*).

Comment: One commenter argued that geographical differences in costs of goods and services such as food, energy, telephone services, pharmaceuticals, and supplies are attributable to local differences in wages and hence should be included in the labor-related share.

Response: We believe that the commenter may have misunderstood a statement in the notice of proposed rulemaking. Previously, we stated that our current methodology is to define the labor-related share as the national average proportion of operating costs that are related to, influenced by, or vary with local labor markets. As we have stated in previous rules and clarified in this final rule, it is more accurate to say that we define the labor-related share as the national average proportion of operating costs that are attributable to wages and salaries, fringe benefits, professional fees, contract labor, and labor intensive services. These costs are included in the labor-related share because they are labor intensive, and therefore, are ''hospitals'' costs that are attributable to wages and wage-related costs.'' As was stated previously, we believe that, with the exclusion of postage, the costs included in the labor-related share are, in fact, related to, influenced by, or vary with local labor markets. However, hospital costs are not necessarily ''attributable to wages and wage-related costs ''merely because they may be related to, may be influenced by, or may vary with local labor markets. Therefore, it would be incorrect to say that all costs that are related to, influenced by, or vary with the local labor market must be included in the labor-related share merely because they are related to, influenced by, or vary with the local labor market.

We include only labor-intensive inputs in the labor-related share (55 FR 36046). Although the costs of goods and services such as food, pharmaceuticals, energy, telephone services, and supplies may vary by geographic area, these items are not labor-intensive inputs. Thus, we disagree with the commenter's argument that these items should be included in the labor-related share.

Comment: Several commenters suggested that we include professional liability insurance (PLI) in the labor-related share since these costs are included in the wage index. The commenters also claimed that professional liability insurance costs are wage related.

Response: The wage index includes, as a fringe benefit cost, PLI for those policies that list actual names or specific titles of covered employees (59 FR 45358). The benefit cost weight in the market basket, included in the labor-related share, is also based on the same wage index benefit data. Therefore, the labor-related share includes these PLI costs. General PLI coverage maintained by hospitals is not recognized as a wage-related cost for purposes of the wage index or labor-related share.

Although general PLI costs do vary by geographic region, they are not labor-intensive inputs. The variance in general PLI costs is primarily influenced by state legislation and risk level, not by local wage rates. In fact, areas with high wage indices may have low relative PLI costs. For example, the malpractice geographic price indices, used in the Medicare physician payment system, for San Francisco, Los Angeles, and Boston regions are below 1, while their hospital wage indices for comparable areas are much greater than 1.

Comment: Several commenters requested that CMS explain why the labor-related share is fluctuating between FYs 1992, 1997, and 2002-based market baskets. They stated these changes raise questions about the (1) veracity of the data, (2) the change in base cost data, (3) effect of proxy changes on the trending, (4) consistency of CMS' methodology, and (5) other factors. They specifically requested that CMS explain in more detail the change in the other labor-intensive services cost weight.

Response: In addition to the official market basket weights published in the **Federal Register**, CMS also analyzed the weights based on different trimming methodologies and on a matched sample of hospitals over time. These weights exhibited the same trends as our published weights. Specifically, the compensation cost weight, the largest component in the labor-related share, from 1997 to 2002 steadily declined in all instances.

The decline in the nonmedical professional fees from 1992 to 1997 reflects hospital purchasing patterns' and a change in the data source used to derive this weight. The FY 1992-based market basket used the American Hospital Association Survey data while the FY 1997-based market basket used the 1997 Bureau of Economic Analysis' Annual I–O Tables. As stated in the FY 2003 IPPS final rule (67 FR 50034), if CMS had used the Annual I–O Tables to calculate the FY 1992 nonmedical professional fees component, the proportion would have been similar to the FY 1997 share. The FY 2002 nonmedical professional fees cost category is based on 1997-Benchmark I–O data trended forward using the ECI for Compensation for Private Service Occupations.

The decline in the other labor intensive cost category from 1997 to 2002 is a result of hospitals purchasing patterns and substituting the 1997 Benchmark I–O data for the 1997 Annual I–O data. 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 1997-Benchmark I–O is also based on the 1997 North American Industrial Classification System while the 1997 Annual I–O is based on the 1987 Standard Industrial Classification System.

CMS has maintained a relatively consistent methodology for calculating the hospital market basket cost weights. However, the methodology is periodically modified to include more comprehensive data sources and/or price proxies. These methodological changes, as well as their impacts, are published in the **Federal Register**. In most instances, the modifications have a small effect on the total market basket update.

Finally, approximately 85 percent of the labor-related shares (FY 1992, FY 1997, and FY 2002) are based on Medicare Cost Report data submitted by hospitals.

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

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 an 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 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).

In the FY 2006 IPPS proposed rule, we indicated that because IRFs, LTCHs, and some IPFs are now paid under a PPS, we were considering developing a separate market basket for these hospitals that contains both operating and capital costs. (The IPF PPS was implemented recently for cost reporting periods beginning on or after January 1, 2005; therefore, all IPFs will soon be paid under the IPF PPS.) We indicated that we would publish any proposal to use a revised separate market basket for each of these types of hospitals when we propose the next 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, in the FY 2006 IPPS proposed rule, we did not propose 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 proposed to use the FY 2002 IPPS operating market basket percentage increase to update the target amounts for children's and cancer hospitals and the market basket for RNHCIs under § 403.752(a) of the regulations. This proposal reflected 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, as proposed, for this final rule we are using the IPPS operating market basket to update the target amounts for children's and cancer hospitals and the market basket for RNHCIs under § 403.752(a) of the regulations. However, when we compare the weights for LTCHs and IPFs to the weights for IPPS hospitals, we did not find them comparable. Therefore, we did not believe it was appropriate to use the IPPS market basket for LTCHs and IPFs to update the portion of their payment that is based on reasonable cost.

For similar reasons, we indicated in the proposed rule that 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. As indicated in the proposed rule, 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 1 or 3 additional years (1 year for LTCHs paid under a blend methodology since some LTCHs only have 1 year remaining in their transition, and 3 years for IPFs since existing 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 under current law. 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.

Comment: One commenter supported CMS evaluation of a potential new market basket for LTCHs and other post-acute care providers. However, they cautioned CMS to look at the distinct attributes and price inputs of various providers, claiming the price inputs of LTCHs are linked more closely to those of acute care hospitals than other types of providers. They also recommended that CMS use FY 2002 hospital data to calculate the excluded hospital with capital market basket in the 2007 LTCH rate year payment update.

Response: In the RY 2007 LTCH proposed rule, we plan to propose a new market basket for updating the LTCH prospective payments which may be based on 2002 data. The proposed methodology used to create this market basket will be described in detail and is likely going to be similar to the market basket described in the IRF FY 2006 proposed rule. We will also present any additional analysis we have conducted on the differing cost structures of LTCHs

and other types of providers. This proposed rule will be subject to comments.

Comment: Several commenters disagreed with CMS proposal to use the FY 2002 IPPS operating market basket to update the target amounts for children's and cancer hospitals. One commenter recommended CMS implement a separate market basket for cancer hospitals that would recognize the actual cost increases experienced by these institutions. The commenters contended that the existing excluded market basket falls short of reflecting the annual cost increases actually experienced by cancer hospitals. They have determined this shortfall to be specific cost weights and relative price proxies of pharmaceuticals and compensation. Another commenter recommended using the excluded hospital market basket until new market baskets are implemented for IRFs, IPFs, and LTCHs.

Response: Due to the small number of children's and cancer hospitals and RNCHIs (less than 80 in 2002) and limited reporting, we believe we are unable to create a representative market basket for those hospitals still being paid based solely on their reasonable costs, subject to target amounts. Therefore, we proposed to use the FY 2002 IPPS operating market basket percentage increase to update the target amounts for children's and cancer hospitals and the market basket for RNHCIs under § 403.752(a) of the regulations because this market basket most closely represented the cost structure of children's and cancer hospitals and RNHCIs.

Chart 8 compares the limited data available on median salary, median pharmaceutical, and median professional liability insurance (PLI) cost weights (as a percent of operating costs) for cancer and children's hospitals and RNCHTs; IPPS hospitals; and IRFs, LTCHs, and IPFs. As indicated, the cost structure for cancer and children's hospitals and RNCHIs is more like the cost structure for IPPS hospitals than that for IRFs, LTCHs, and IPFs. Because both the excluded and IPPS market baskets use the same price proxies, a difference in update would be due to the base cost structure. Therefore, by choosing a market basket that most closely represents the cost structures of cancer and children's hospitals and RNCHIs, we are reflecting the annual cost increases experienced by these hospitals.

CHART 8.—COMPARISON OF 2002 MEDIAN COST WEIGHTS FROM THE MEDICARE COST REPORTS

	Cancer and children's hospitals and RNCHIs	IPPS hospitals	IRFs, LTCHs, and IPFs
Salary Cost Weight	49.486	46.278	55.263
(Number of providers)	(68)	(3889)	(591)
Pharmaceutical Cost Weight	6.053	5.453	4.992
(Number of providers)	(56)	(3891)	(585)
PLI Cost Weight	1.050	1.099	0.922
(Number of Providers)	(75)	(2341)	(279)

[1] Costs were included if they were greater than zero and less than operating costs.
[2] Salary cost weights exclude contract labor costs.
[3] The cost weights presented here are medians, which is different than the market basket cost weights which are means (they are calculated by dividing total expenditures for all hospitals by total operating costs for all hospitals).

We will continue to monitor the cost structures of children's and cancer hospitals and RNHCIs to ensure the IPPS hospital market basket adequately reflects these hospitals purchasing patterns. We do not believe it is necessary to postpone the implementation of the IPPS market basket to update the target limits for children's and cancer hospitals and RNCHIs until a new market basket has been implemented to update IRFs, LTCHs, and IPFs payments. The latter group of hospitals are, or soon will be, reimbursed under a PPS that will not affect the reimbursement of children's and cancer hospitals and RNCHIs.

Chart 9 compares the updates for the FY 2002-based IPPS operating market basket, the index we proposed to use 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 use the market basket that most closely reflects the cost structure of children's and cancer hospitals and RNCHIs. In the FY 2006 IPPS proposed rule, we invited 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. The forecasts are based on the GII 2nd quarter, 2005 forecast with historical data through the 1st quarter of 2005, incorporating two more quarters of historical data than published in the FY 2006 IPPS proposed rule. (As we indicated earlier, GII is a nationally recognized economic and financial forecasting firm that contracts with CMS to forecast the components of the market baskets.)

CHART 9.—FY 2002-BASED IPPS AND FY 2002-BASED EXCLUDED HOSPITAL OPERATING INDEX PERCENT CHANGE, FYS 2000 THROUGH 2007

Fiscal year	Rebased FY 2002-based IPPS operating market basket	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	4.2	4.2
FY 2006	3.7	3.8
FY 2007	3.1	3.4
Average FYs 2005–2007	3.7	3.8

Source: Global Insight, Inc, 2nd Qtr. 2005; @USMACRO/CONTROL0605 @CISSIM/TL0505.SIM.

2. Excluded Hospitals Paid Under a Blend Methodology

As we discuss in greater detail in Appendix B to this final 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, existing LTCHs and existing 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. In general, 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, an existing 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 is paid based on 100 percent of the standard Federal rate. Effective for cost reporting periods beginning on or after January 1, 2005, IPFs, as defined in § 412.426(c), 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), is 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 sections 1886(b)(3)(A) and (b)(3)(B) of the Act, as was proposed, for LTCHs and IPFs that are transitioning to the fully Federal prospective payment rate, we are using the rebased FY 2002-based excluded hospital market basket to update the reasonable cost-based portion of their payments. The market basket update is described in detail below. We do not believe the IPPS operating market basket should be used for the 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. Chart 8 compares the median salary, median pharmaceutical, and median professional liability insurance cost weights for IPPS hospitals and IRFs, LTCHs, and IPFs.

Comment: One commenter endorsed the CMS proposal to rebase the excluded hospital market basket, stating that rebasing the excluded hospital market basket improves accuracy and predictability of the LTCH PPS. The commenter also hoped that the forecast for the final rule for FY 2006 will be higher than the proposed rule's forecast of 3.2 percent.

Response: We agree that the market baskets should be periodically rebased to ensure they adequately reflect the purchasing patterns of hospitals and the price increases associated with providing hospital services. The 2002-based excluded hospital's FY 2006 forecast was run on the GII second quarter forecast for 2005, with historical data through the first quarter of 2005, incorporating two more quarters of historical data than published in the FY 2006 IPPS proposed rule. The forecast for FY 2006 for the FY 2002-based excluded hospital market basket is 3.8 percent.

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

a. Medicare Cost Reports

In this final rule, as was proposed, the major source of expenditure data for developing the rebased and revised excluded hospital market basket cost weights is the FY 2002 Medicare cost reports. We chose 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 RNHCIs. 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 RNHCIs. 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, as we proposed, in this final rule, we are using 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 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.

As was proposed, cost weights for benefits, contract labor, and blood and blood products were derived using the 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 excluded hospital wages and salaries cost weight to derive a benefit cost weight for the excluded hospital market basket.

CHART 10.—MAJOR COST CATEGORIES FOUND IN EXCLUDED HOSPITAL MEDICARE COST REPORTS

Major cost categories	FY 1997-based excluded hospital market basket	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 may 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, as was proposed, for this final rule, 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 used the 1997 Benchmark I–O data in the 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. As was proposed, the methodology we used to age the data for this final rule 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. FY 2002-Based Excluded Hospital Market Basket—Selection of Price Proxies

After computing the FY 2002 cost weights for the 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, as was proposed, 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 made no changes to the proposed price proxies in this final rule. 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 11 sets forth the complete 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.

CHART 11.—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	FY 2002-based excluded hospital market basket weights	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		
(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 FY 2002-based excluded hospital market basket.

a. Wages and Salaries

For measuring the price growth of wages in the FY 2002-based excluded hospital market basket, we used 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 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 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 making any changes to the proxy in this final rule.

h. Pharmaceuticals

The percentage change in the price of prescription drugs as measured by the PPI (PPI Code #PPI32541DRX) 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. These three market

baskets moved similarly. 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.

We received several comments on including blood and blood products costs in miscellaneous products cost weight. These comments were addressed in section IV.B.1.b.2 of this final rule and are applicable to the FY 2002-based excluded hospital market basket as well because our rationale for how we treat blood and blood products in the IPPS market basket is the same as in the FY 2002-based excluded hospital market basket.

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 12 compares the updates for the FY 2002-based excluded hospital market basket (based on the cost structures of IRFs, LTCHs, IPFs, children's and cancer hospitals, and RNCHIs), the index we proposed to use to update the reasonable cost-based portion of IPF and LTCH payments and which we are adopting in this final rule, with a FY 1997-based excluded hospital market basket (based on the cost structure of IRFs, LTCHs, IPFs, and children's and cancer hospitals).

CHART 12.—FY 1997-BASED AND FY 2002-BASED EXCLUDED HOSPITAL OPERATING INDEX PERCENT CHANGE, FY 2000 THROUGH FY 2008

Fiscal Year (FY)	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	4.0	3.9
Forecast:		
FY 2005	4.2	4.2
FY 2006	3.8	3.8
FY 2007	3.4	3.2
FY 2008	3.2	3.0
Average FYs 2005–2008	3.7	3.6

Source: Global Insight, Inc. 2nd Qtr 2005, @USMACRO/CNTL0605 @CISSIM/TL0505.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 final 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 final rule discusses the research we have done to fulfill this requirement, and sets forth 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, submitted 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, as we proposed in the FY 2006 IPPS proposed rule, we would 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).

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 and blood products). 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 13 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 13.—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. For instance, we have aged the 1997 Benchmark I–O data for this final 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 one or two years), 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 systematically examined 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 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 optimize the timeliness of the data relative to 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 using in this final rule. Chart 14 shows the weights from these hypothetical market baskets:

BILLING CODE 4120–01–P

Chart 14: 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.

BILLING CODE 4120–01–C

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, 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 15 shows the results of these comparisons.

CHART 15.—COMPARISON OF HYPOTHETICAL MARKET BASKETS, FY 1997 THROUGH FY 2002 BASE YEARS, PERCENT CHANGES, FY 1998 THROUGH FY 2004

Federal Fiscal Year	Percent Change in Hypothetical Market Baskets					
	FY 1997-based	FY 1998-based	FY 1999-based	FY 2000-based	FY 2001-based	FY 2002-based
1998	2.7	2.6	2.6	2.6	2.6	2.6
1999	2.7	2.5	2.5	2.5	2.5	2.5
2000	3.2	3.3	3.3	3.3	3.3	3.2
2001	4.2	4.2	4.2	4.2	4.2	4.1
2002	3.8	3.8	3.8	3.7	3.7	3.7
2003	3.9	4.0	4.0	4.0	4.0	4.0
2004	3.9	3.8	3.9	3.8	3.9	3.9
Average: FY 1998–2004	3.5	3.5	3.5	3.4	3.5	3.4

Source: Global Insight, Inc, 2nd Qtr. 2005;@USMACRO/CNTL0605 @CISSIM/TL0505.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 require adequate time to research and reply to all comments submitted. The last part of the regulatory process is the 60-day requirement that is, 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 and resources 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.

Comment: A few commenters stated there is no compelling reason to rebase the market basket for the FY 2006 update. They requested that CMS begin its 4-year rebasing schedule, beginning with the FY 2007 update (4 years after the last rebasing of the hospital market for the FY 2003 update).

Response: Section 404(a) of Pub. L. 108–173 directs the Secretary to establish a frequency for rebasing the market basket after updating the weights used in the IPPS operating and capital market baskets to reflect the most current available data. Section 404(b) of the Pub. L. 108–173 provides that the Secretary shall include his explanation of the reasons for the frequency of market basket updates in the FY 2006 IPPS final rule. We believe that section 404 of Pub. L. 108–173 requires that we rebase the market basket in the FY 2006 IPPS final rule because we are required to establish a schedule for rebasing the market basket in the FY 2006 IPPS final rule, but may not establish the schedule until after we have rebased the market basket to reflect the most current data available.

Comment: MedPAC urged the Secretary to propose legislation to repeal section 404 of Pub. L. 108–173 requiring the more frequent updating of the market basket. CMS' analysis shows that updating the weights more frequently then every 5 years would make only small differences in its market basket forecasts. In addition, some of the data used in developing the market basket is only available every 5 years, thus a 4-year rebasing schedule could make the market basket weights even more out of date due to the timing of these data sources. Therefore, MedPAC concluded that updating the weights more often than once every 5 years is unnecessary and potentially counterproductive. Other commenters also requested that CMS continue with a 5-year rebasing schedule.

Response: As described in this rule, we agree with the commenters that rebasing the hospital market basket more frequently than every 5 years is unnecessary. However, section 404 of Pub. L. 108–173 requires a shorter frequency, which CMS has set at every 4 years.

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.

In this final rule, we are revising and rebasing 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 FY 2002-based CIPI. The first set of weights identifies the proportion of hospital capital expenditures attributable to each expenditure category, while the second set of 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 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 used 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 derived 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 applied 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 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 16 presents a comparison of the FY 2002-based CIPI capital cost weights and the FY 1997-based CIPI capital cost weights.

CHART 16.—COMPARISON OF FY 1997-BASED AND FY 2002-BASED CIPI COST CATEGORY WEIGHTS

Expense categories	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 expect 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.

Between the publication of the FY 2006 IPPS proposed rule and this final rule, we conducted a further review of the methodology used to derive the useful life of an asset. Based on this brief analysis into the capital cost structures of hospitals, we are not changing the expected life of fixed and moveable assets for the final rule.

As proposed, we used 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 used 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 used 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 used 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 FY 2002 CIPI are presented in Chart 17.

CHART 17.—FY 1997 AND FY 2002 VINTAGE WEIGHTS FOR CAPITAL-RELATED PRICE PROXIES

Year	Building and fixed equipment		Movable equipment		Interest	
	FY 1997 23 years	FY 2002 23 years	FY 1997 11 years	FY 2002 11 years	FY 1997 23 years	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 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 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 proxies are presented in Chart 18.

CHART 18.—COMPARISON OF FY 1997-BASED AND FY 2002-BASED CAPITAL INPUT PRICE INDEX, PERCENT CHANGE, FY 1998 THROUGH FY 2007

Federal fiscal year	CIPI, FY 1997-based	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	1.0	0.8
2007	1.0	0.9
Average:		
FYs 1998–2004	0.8	0.8
FYs 2005–2007	0.9	0.7

Source: Global Insight, Inc, 2nd Qtr. 2005; @USMACRO/CONTROL0605 @CISSIM/TL0505.

Global Insight, Inc. forecasts a 0.8 percent increase in the FY 2002-based CIPI for 2006, as shown in Chart 17. This is the result of a 1.4 percent increase in projected depreciation prices (building and fixed equipment, and movable equipment) and a 3.3 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 19. Accordingly, for FY 2006, we have adopted a 0.8 percent increase in the CIPI.

CHART 19.—CMS 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	−3.7	3.0
2006	0.8	1.4	2.7	0.0	−2.3	3.3
2007	0.9	1.3	2.6	0.0	−2.0	3.2

Rebasing the CIPI from FY 1997 to FY 2002 decreased the percent change in the FY 2006 forecast by 0.2 percentage point, from 1.0 to 0.8, as shown in Chart 14. 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 two-tenths of a percentage point difference between the FY 2002-based CIPI and the FY 1997-based CIPI.

We did not receive any public comments on the CIPI.

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

A. Postacute Care Transfer Payment Policy (§ 412.4)

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 FY 1999 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 FY 1999 IPPS 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 FY 1999 IPPS 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 noted 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 FY 2005 IPPS 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 was required to meet all of the criteria to be included under the policy in subsequent fiscal years. The geometric mean length of stay for DRG 263 showed only a 6-percent decrease since 1999. As a result, DRG 263 did not qualify to be included in the policy for FY 2005 under the criteria that were applied in last year's final 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 the FY 2006 IPPS proposed rule, we conducted an extensive analysis of the FY 2003 and FY 2004 MedPAR data to monitor the effects of the postacute care transfer policy. We also conducted an overall assessment of the postacute care transfer policy since its inception in FY 1999. Specifically, we 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 considering our experience under the current policy. We also 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, we found that 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 had 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 we proposed a change to the postacute care transfer payment policy in the FY 2006 proposed rule. 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 did not propose 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 did not propose any changes to the postacute care transfer policy for these DRGs for FY 2006.
- 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 did not propose any change to how we would 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 231 DRGs. In the proposed rule, we stated that 223 DRGs were included in this analysis, but subsequently posted a change to the number of eligible DRGs on our Web site. This change reflected that we had inadvertently excluded 8 DRGs. Of these 231 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, in the FY 2006 proposed rule, we indicated that we believed these DRGs have characteristics that make them appropriate for inclusion in the postacute care transfer policy. We also indicated that we believed it is appropriate to consider major revisions to the criteria for including a DRG within the postacute care transfer policy. First, our analysis called 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 indicated 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 suggested 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 did 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 FY 2004 IPPS 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 indicated that we would retain the criterion that at least 10 percent of all cases that are transferred to postacute 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 precludes 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, for the FY 2006 IPPS proposed rule, we considered 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 we indicated in the FY 2006 IPPS proposed rule, as a result of our analysis, we considered two options for revising the current criteria. Option 1 was 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 in the proposed rule and above in this final rule, 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. Therefore, lowering the limit below 3.0 days would have little or no effect on payment for DRGs with geometric mean lengths of stay in this range.

The second option that we considered in the FY 2006 IPPS proposed rule was 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.

As explained above, option 2 would expand the application of the postacute care transfer policy to 231 DRGs (rather than 223 DRGs as stated in the proposed rule) that have both a relatively high volume and a relatively high proportion of postacute care utilization. We proposed this change to avoid applying the postacute care transfer policy to DRGs with only a small number or proportion of cases transferred to postacute care. We believe that the analysis that we conducted suggests that substantial revisions to the criteria for including a DRG within the postacute care transfer policy are warranted. Therefore, in the FY 2006 IPPS proposed rule, we formally proposed Option 2 as presented above. However, we invited comments on both of the options and on the analysis that we had presented.

Comment: Many commenters expressed opposition to the postacute care transfer policy in general. Some of these commenters argued that the policy is contrary to the premise of the DRG system, which is to pay the average of all cases in a DRG, regardless of cost and length of stay. Some commenters also contended that the transfer policy is based on a false assumption of gaming by providers, and that it punishes providers for providing the appropriate level of care in the most appropriate setting. Other commenters argued that the rationale for the policy no longer exists because most of the providers of postacute care services in question have transitioned from cost-based reimbursement to PPSs themselves (SNFs as of October 1, 1998; HHAs as of October 1, 2000; IRFs as of January 1, 2002; LTCHs as of October 1, 2002; and IPFs as of January 1, 2005). Further, commenters noted that each of these postacute care payment systems have admission criteria to ensure that patients are not discharged prematurely to a lower level of care.

Other commenters contended that the policy creates a geographic bias against regions that have access to greater capital resources and postacute care facilities and that traditionally have had shorter lengths of stay for their patients than other regions of the country. Some commenters argued that the provision creates a perverse incentive for hospitals to keep their patients longer and to deny them the appropriate care in postacute care facilities when it is needed. Commenters continued to argue that this policy undermines the incentive for hospitals to reduce lengths of stay. Several commenters pointed to the tremendous administrative burden placed on hospitals with the expansion of the policy, particularly with regard to transfers to HHAs. Other commenters noted the administrative burdens of time, resource utilization, and delay of payments already associated with these types of transfers and subsequent claims corrections and reprocessing with the existing 30 DRGs.

Response: We do not agree that the postacute care transfer policy is inappropriate or contrary to the principles of prospective payment. The policy is fully consistent with the principles of prospective payment because the operative averaging principle in such systems assumes that the full extent of care is consistently provided in an acute care hospital. The averaging principle would be undermined if the system did not provide for adjustments in cases where a large proportion of the patient's care is provided by another entity. Thus, the statute appropriately provides for treating discharges to postacute care from certain DRGs as transfer cases. The statute also gives the Secretary the discretion to select appropriate DRGs to which this policy should be applied on the basis of a high volume of discharges to postacute care and a disproportionate use of post discharge services. Although it is true that many postacute settings to which the policy applies are now subject to a prospective payment methodology, this fact in no way undermines the appropriateness of a postacute transfer policy. Rather, such a policy serves to ensure that Medicare does not make full payments under two different payment systems when a patient's full course of treatment is divided between two facilities. It is just as inappropriate for Medicare to pay for the treatment of patients in these cases, at the full DRG amount at the IPPS hospital and under either a per discharge or per diem prospective payment in the postacute care setting as it is to pay the full DRG payment twice

when a patient is transferred from one acute care hospital to another. Therefore, because the majority of short-stay transfer cases receive the majority of their care at postacute care facilities (except for those DRGs that we have identified as having high costs on the first day and that are paid under a special payment methodology), we continue to believe that full payment to those facilities and reduced payment to acute facilities for these cases are merited. Numerous studies of the postacute care transfer policy by MedPAC, the Office of Inspector General, and other health-related entities continue to support the need for the policy, and some studies have supported expansion of the policy to additional DRGs where appropriate.

Comment: Most commenters objected to the proposed alternate criteria for DRGs to be included in the postacute care transfer policy. Some commenters objected to our proposing changes in the qualifying criteria for the postacute care transfer policy for the third consecutive year. These commenters argued that such frequent changes in policy gives the appearance of a contrived policy to suit CMS' desires and makes the regulatory process unpredictable and unfair. Many commenters asserted that there was little analytical support for changing the criteria, and in particular that CMS had presented little analytical support for the proposed thresholds of 2,000 and 20 percent of cases transferred to postacute care. Some commenters also contended that the proposed criteria appeared contrived to ensure that the proposal would meet specific budgetary goals. Many commenters expressed dismay that CMS would lower the limit so drastically from 14,000 postacute care transfer cases to 2,000, a ''dramatic drop of 86 percent.'' Many commenters also believed that the proposed alternate criteria did not meet the standards established in the statute. Specifically, these commenters indicated that the proposed threshold of 2,000 transfer cases does not constitute a ''high volume of discharges'' under the statute. Similarly, many commenters stated that a threshold of 20 percent of postacute transfer cases does not constitute a ''disproportionate use of post-discharge services.'' These commenters argued that, by definition, disproportionate use of postacute care should be well above the norm. One commenter added that it ''is a statistical impossibility for half of the universe of DRGs to have 'disproportionate use of post-discharge services.' '' Some commenters suggested that CMS consider using alternatives to the newly proposed criteria. One commenter proposed that CMS establish thresholds at least one standard deviation above the average to determine when DRGs meet a disproportionate use of postacute care. Another commenter noted that thresholds of one standard deviation are employed elsewhere in Medicare policy. One commenter noted that, under the original implementation of the policy, the 10 DRGs that were included had a postacute care utilization rate of at least 45.3 percent (not including pairs) and when the policy was expanded to 30 DRGs, the lowest percentage of postacute care utilization (not including pairs) was 34.86. Therefore, this commenter contended that a reasonable figure that might represent a disproportionate use of postacute care utilization would be no less than 34.0 percent.

Response: We do not agree that the proposed thresholds were inappropriate or without analytical support. In particular, we do not agree that the threshold of 2,000 discharges to postacute care falls short of the statutory standard that DRGs included within the policy must have a ''high volume of discharges.'' In analyzing the total number of discharges to postacute care in each DRG, we found that the median DRG had approximately 1,600 discharges to postacute care. Thus, our proposed criteria of 2,000 discharges to postacute care is well above the median DRG's number of discharges to postacute care and can easily be argued to meet the statutory criteria of a ''high volume of discharges.'' Nevertheless, in response to the many comments on the proposed new thresholds, we have reexamined the data concerning the volume and the proportions of discharges to postacute care across DRGs. Our goal was to select thresholds that are appropriate to the purposes of the postacute care transfer policy and that clearly meet the statutory standards cited by the commenters.

We began by considering the suggestion of several commenters that it might be appropriate to establish thresholds at levels of one standard deviation above the average to determine high volume and disproportionate use of postacute care services. As one commenter pointed out, we have used such a standard for similar purposes in other areas of the Medicare program. However, our examination of the DRG data indicated that the average, or mean, is not the most appropriate measure of central tendency in these cases. The distributions of discharge volume and postacute care usage across DRGs are positively skewed. As a result, a relatively small number of DRGs with very high volume and rates of postacute care utilization have a disproportionate impact on the average or mean. Therefore, a better measure of central tendency in these cases is the median, or 50th percentile in the rankings of discharges and rates of postacute care utilization from highest to lowest. However, employing the median rather than the mean makes it impossible to employ the standard deviation in setting an appropriate threshold. In lieu of using the mean and standard deviation as suggested by the commenter, it is possible to select a percentile ranking in each array as an appropriate measure of ''high volume'' and ''disproportionate use.'' By definition, any volume of discharges above the 50th percentile can be considered a high volume in the context of the ranking from highest to lowest. Similarly, any rate of postacute care utilization above the 50th percentile can also be considered disproportionate use of such services. However, we agree with those commenters who recommended thresholds based on standard deviations above the mean, that it is appropriate to establish levels somewhat above the measures of central tendency as thresholds for high volume and disproportionate use. Therefore, we have determined that the 55th percentile is an appropriate level at which to establish these thresholds.

In the course of examining the relevant data, we also considered several alternatives to the ratio of postacute care discharges to total discharges as the most appropriate measure of the rate of postacute care utilization across DRGs. We came to the conclusion that a more appropriate measure of postacute care utilization is the proportion of discharges to postacute care that occur prior to the geometric mean length of stay for a DRG. We believe that the proportion of such short-stay discharges is a more appropriate measure in this context than the overall proportion of discharges to postacute care because only these discharges are affected by the postacute care transfer policy. Specifically, under the formula employed to determine payments for transfer cases, discharges that occur at or after the mean length of stay receive payments that equal the full DRG payment. Furthermore, we believe a focus on short-stay discharges to postacute care is more consistent with the statutory criteria of ''disproportionate use of post-discharge services.'' These short-stay cases are atypical in that they are discharged

before the geometric mean length of stay and result in the majority of care being provided at postacute care facilities.

Therefore, we examined the percentile rankings of DRGs inVersion 23.0 of the DRG Definitions Manual (FY 2006) in relation to the volume of discharges to postacute care, and the ratio of short-stay discharges to postacute care. We employed the March 2005 update of FY 2004 MedPAR data, the most recent data available to us. We determined that the median number of discharges to postacute care across all DRGs was 1,619, and the 55th percentile was 2,050. The median proportion of short-stay discharges to postacute care was 4.8 percent, and the 55th percentile was 5.5 percent. Therefore, in place of the first two criteria that we proposed in the FY 2006 IPPS proposed rule, we are establishing the following two criteria in this final rule, effective October 1, 2005:

- The DRG has at least 2,050 postacute care transfer cases;
- At least 5.5 percent of the cases in the DRG are discharged to postacute care prior to the geometric mean length of stay for the DRG.

In response to the comments suggesting that we provided little data or analytic support for our proposal, we provided detailed analysis of our findings on these issues in both the FY 2006 IPPS proposed rule and this final rule. The data underlying our analysis are publicly available through the CMS Web site at: *http://www.cms.hhs.gov/data/order/default.asp.*

Comment: Many commenters also objected to our proposal to eliminate the requirement that a DRG experience a decline in length of stay. These commenters contended that there was no evidence provided that hospitals are changing their behavior, transferring patients earlier, or taking advantage of the payment system. Another commenter argued that removal of the requirement that DRGs experience a decline in length of stay was contrary to the intent of the statute. This commenter argued that the objective of the policy was ''to adjust inpatient PPS payments to account for reduced hospital lengths of stay due to a discharge to another setting.'' Therefore, the commenter argued, if the MedPAR data demonstrates that postacute care utilization for a DRG does not contribute to a significant decrease in the geometric mean length of stay, the DRG should not be subject to the policy. In general, commenters recommend a different approach to further expansions of the postacute care transfer policy that they assert would more accurately reflect the costs of patient care provided in acute care hospitals.

Response: The statute does not establish any requirement that we consider declining length of stay as a standard in selecting appropriate DRGs for inclusion under the postacute care transfer policy. We originally adopted such a standard because we found a relationship between declining lengths of stay and increasing use of postacute care services. As we discussed in the proposed rule, and again above, our more recent analysis has called into question the basis for the requirement that a DRG experience a decline in the geometric mean length of stay over the most recent 5-year period. Our finding that some DRGs with increases in postacute care utilization during the past several years have also experienced increases in geometric mean length of stay indicates that this criterion is no longer effective to identify those DRGs that should be subject to the postacute care transfer policy. Therefore, we are finalizing our proposal to discontinue the current criterion for inclusion in the policy that requires a DRG to experience a decline of at least 7 percent over the last 5 years in the geometric mean length of stay.

Comment: Some commenters objected to our current criterion that 10 percent of the postacute care transfer cases within a DRG must be short-stay cases in order for the DRG to be included in the policy. Some of these commenters argued that this would effectively mean that up to 90 percent of all discharges within a DRG are not short-stay discharges, and therefore, these DRGs would not meet the disproportionate use requirement as provided in the statute.

Response: We do not agree with the commenters that inclusion of this criterion in the policy was inappropriate. To the contrary, for the reasons we have discussed above and in previous rules, we believe that some consideration of the proportion of short-stay discharges to postacute care—the discharges actually affected by the application of the policy—is an appropriate component of the criteria employed to determine the scope of the policy. However, we have decided not to retain that specific criterion under the revised policy that we are adopting in this final rule. This criterion is unnecessary because we decided to adopt the criterion that at least 5.5 percent of cases in the DRG must be discharged to postacute care prior to the geometric mean length of stay for the DRG. By including this criterion as a measure of disproportionate use of postacute care services, we believe that it becomes redundant to retain another measure that uses short-stay transfer cases.

Comment: Many commenters also did not support the criterion of including paired DRGs in the policy, citing that most hospitals have switched to a coding system that interfaces with the coder electronically, thereby reducing the probability that a coder would remove a CC code in order to change the payment for a case that was transferred to postacute care. Further, some commenters noted that it might be inappropriate to include paired DRGs in the special payment methodology, as the transfer payment for the first day for many of the CC DRGs in the CC/non-CC pair is typically higher than the full DRG payment for the non-CC pair. As a result, these commenters contended that coders would not have any incentive to exclude a CC from the hospital's bill. Therefore, these commenters suggested that CMS consider adopting a policy that excludes ''the non-CC of a paired DRG when the transfer weight of the CC DRG would be greater than the full DRG payment of the non-CC DRG.'' They noted that, by following this recommendation, the policy would agree with CMS' rationale for the inclusion of paired DRGs and also exclude those DRGs that do not meet the qualifying criteria.

Response: It has been our practice to include paired DRGs since the inception of the policy in 1998. This practice is in compliance with § 412.4(d)(1)(iv) of the regulations. While it is possible that technical advances have resulted in electronic systems and more automated coding, the selection of codes to include on the bill remain within the responsibility and authority of the hospital and its staff. Thus, we believe the coder will have the ability to select whether to include or exclude a CC secondary diagnosis code on the hospital's bill when a patient is transferred to postacute care. We include both DRGs from a paired-DRG combination because if we were to include only the more complex DRG (that is, the ''with CC'' DRG from a ''with/without CC'' DRG combination) in the transfer policy, there might be an incentive for hospitals not to include any code that would identify a complicating or cormorbid condition. In our analysis of the included pairs in our data, we have not found support for the commenter's assertion that, in some instances, the transfer adjusted payment for a ''CC'' DRG is greater than the full payment for the non-transfer adjusted ''without CC'' DRG. In cases where a ''CC:'' DRG is transferred after a one day length of stay, the estimated transfer adjusted payments for the ''CC'' DRGs

are less than the full payments for the ''without CC'' DRGs. As this could introduce improper coding incentives, we continue to believe our approach of identifying either DRG from a paired-DRG combination individually for inclusion in the policy is appropriate.

Comment: Some commenters argued that including a transfer-adjusted case weight in the DRG relative weight calculation has the effect of maintaining the DRG weight at an artificially high level. Other commenters indicated that, in the absence of this adjustment, the lower costs of short-stay postacute care transfers will be reflected in lower DRG case weights, making a postacute care transfer payment policy unnecessary. Another commenter stated that the cost savings realized through shorter lengths of stay, including those from transfer cases, have already been considered and accounted for by Congress each year when it sets the market basket update.

Response: We agree with the commenters that a high proportion of short-stay to total cases in DRGs that are not subject to the postacute care transfer policy will likely result in lower weights for these DRGs. However, we believe these commenters actually support our argument for expanding the postacute care transfer policy to more DRGs where there is disproportionate use of postacute care services. While including all cases in the relative weight calculation without any adjustment would likely result in a lower DRG weight and payment for a short-stay transfer case, it would also result in lower payments for all of the remaining cases in the DRG where the hospital used more resources to care for the patient. To the extent that there is disproportionate use of postacute care services, hospitals would be disadvantaged in the relative weight calculation and their payments when the patient is not discharged early if we were to make no adjustment for a transfer case when setting the DRG relative weight. By reducing the impact that short-stay cases have on the DRG relative weight, we believe our payment will more accurately reflect all of the resources provided by a hospital during a typical stay. Thus, the payment will better reflect all of the costs a hospital expends for the stay when a full course of treatment is provided and our postacute care transfer policy will appropriately provide less payment for a transfer case in recognition of the lower cost of an abbreviated hospital stay.

Comment: Some commenters objected to the method by which CMS proposed the change in the criteria for DRGs to qualify to be included in the postacute care transfer policy. They argued that CMS should have proposed the criteria, accepted comment on the alternate criteria, and made appropriate changes based on those comments before applying them to any additional DRGs. Instead, commenters contended that CMS seemingly arbitrarily created the alternate set of criteria and applied them to new DRGs in the same rule.

Response: We are making the change to our postacute care transfer policy through a notice and comment rulemaking procedure before applying the new policy to any DRGs. The implication in these comments that we have already expanded the policy to additional DRGs is incorrect. We will be applying the revised postacute care transfer policy for discharges occurring on or after October 1, 2006, after having provided notice of our proposal to revise the policy in the proposed rule; allowing for a 60-day public comment period; and making changes to the policy in response to public comment.

Comment: Some commenters objected to the implication that early discharges to postacute care are done for economic reasons instead of patient need. Other commenters believed hospitals may keep patients in the hospital longer to avoid the reduced IPPS payment. These commenters indicated that the policy would increase, not reduce, Medicare spending to treat the same patients. Other commenters encouraged CMS to complete its analysis of the MedPAC recommendation to adopt severity DRGs before expanding the postacute care transfer policy. These commenters argued that CMS should apply the postacute care transfer policy to DRGs consistent with the goal of ''aligning patient severity with payment.'' These commenters argued that, if severity DRGs were implemented, there would be no need for a postacute care transfer policy because the system would recognize higher payment for more resource intensive patients.

Response: Our proposal to expand the postacute care transfer policy was not intended to imply that hospitals will prematurely discharge patients early to postacute care for financial reasons. Rather, our policy recognizes that hospitals expend fewer resources for patients who are discharged prior to the geometric mean length of stay and Medicare's payment should be less. We do note that some of the commenters themselves imply that hospitals will react to the financial incentives of the revised postacute care transfer policy by keeping patients in the hospital longer to avoid payment reductions that will occur if patients are discharged early to postacute care. If true, it is hard to understand what the hospitals would accomplish because even though they would receive the full DRG payment, they would also have costs associated with retaining patients who would be more appropriately discharged to another setting in the hospital.

It is not clear to us why an analysis of MedPAC's recommendation that we adopt severity DRGs is relevant to the postacute care transfer policy. To our knowledge, such a change to the DRG system would be intended to result in better recognition of severity levels in making DRG assignments, but would not involve any direct consideration of whether a hospital provides the full course of treatment to a patient. We are unaware that a severity DRG system, such as the APR–DRGs, would use length of stay and early discharge to postacute care as a basis for making a DRG assignment. Nevertheless, we will consider this issue as we study the MedPAC recommendation.

Comment: Commenters argued that we should not further expand the postacute care transfer payment policy until a full analysis of last year's changes to the policy is completed. According to the commenters, we should analyze whether the postacute care transfer policy has led to unnecessarily extended hospital stays in order to avoid the adjustment and affected quality of care. Commenters also noted that studies show that the majority of patients who use postacute care have longer (7.51 days), not shorter (4.93 days), hospital stays. These commenters argued that CMS should focus its efforts on improving quality of care, not on further expanding the postacute care transfer provision.

Response: In the FY 2005 IPPS final rule (69 FR 49073), we established a policy for how to apply the criteria for the postacute care transfer policy to cases that were previously assigned to a DRG that has split, when the split DRG qualified for inclusion in the postacute care transfer policy. This policy was a rather limited change to our postacute care transfer policy that has little bearing on the changes that we are making for FY 2006. Thus, we do not believe further analysis of this change is necessary before undertaking the changes we are adopting in this final rule.

We believe the point made by the commenter provides further grounds to expand the postacute care transfer policy. The policy only applies to patients that are discharged from the hospital at least one day before the geometric mean length of stay. The policy does not apply to the longer stay patients that are, according to the

commenter, more resource intensive. Thus, we make a reduced payment only for those short-stay patients transferred to postacute care that are, following the logic of the comment, less costly to the hospital.

Comment: Some commenters argued that studies have shown that many rural areas now have the same types of postacute care facilities as urban hospitals and expanding the postacute care transfer policy will harm rural areas by reducing payments to rural hospitals. Many commenters suggested that, if CMS is determined to make an expansion to the policy without providing analysis supporting the changes, any changes should be made in a budget neutral manner. Other commenters suggested that we should implement the policy expansion over 3 years to lessen the financial impact in the first year. Commenters also disputed our savings estimates indicating that once the effects of IME, disproportionate share, capital and outlier payments are taken into consideration, the total annual reduction would be closer to $894 million. They argued that hospitals can ill-afford this kind of reduction in payments at a time when they are already experiencing nursing shortages, incurring losses for treating Medicare beneficiaries, and expecting tremendous increases in costs associated with the aging baby boom generation.

Commenters also indicated that the policy should not apply in situations where a patient is living in a SNF. In these cases, the commenters argued that an early discharge of the patient to a SNF is really a discharge to the patient's home and the policy should not be applied.

Response: We do not believe that the law permits us to distinguish between urban and rural areas when applying this policy. Furthermore, we do not believe there is a policy basis for such a distinction because the principle of making lower payments to the acute care hospital based on the majority of care being provided in a postacute care setting would apply equally to urban and rural hospitals. The law does not require or authorize us to make these changes over a transitional period or in a budget neutral manner as suggested by the commenters. For this reason, we are implementing the policy as we have described. We note that our savings estimates have been updated to reflect the policies we are adopting in this final rule. With respect to a discharge to a SNF, we note that section 1886(d)(5)(J)(ii)(II) of the Act makes clear that the postacute care transfer policy must apply in this situation.

The impact section in Appendix A of this final rule discusses our findings on the effects of adopting our final rule policy. The DRG relative weights in Tables 5 and 7 of the Addendum to this final rule also include the effect of changing the postacute care transfer policy. We note that we will 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 final rule, additional transfer cases will 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.

In summary, after consideration of the comments received, in this final rule, we have revised the criteria that we proposed for determining which DRGs qualify for postacute care transfer payments. The final policy, which we are incorporating into the regulations at § 412.4, specifies that, effective October 1, 2005, we are making a DRG subject to the postacute care transfer policy if, based on the Version 23.0 GROUPER (FY 2006), using data from FY 2004, the DRG meets the following criteria:

- The DRG must have a geometric mean length of stay of at least 3 days;
- The DRG must have at least 2,050 postacute care transfer cases;
- At least 5.5 percent of the cases in the DRG are discharged to postacute care prior to the geometric mean length of stay for the DRG; 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 three criteria above.

If a DRG meets the above criteria based on the Version 23.0 GROUPER and FY 2004 MedPAR data, we are making the DRG subject to the postacute care transfer policy. We will not revise the list of DRGs subject to the postacute care transfer policy annually unless we are making a change to a specific DRG. Using the version of the Medicare GROUPER for the year when a new or revised DRG first becomes effective, we will make the DRG subject to the postacute care transfer policy if its total number of discharges and proportion of short-stay discharges to postacute care exceed the 55th percentile for all DRGs. We are establishing this policy to promote certainty and stability in the postacute care transfer payment policy. Annual reviews of the list of DRGs subject to the policy would likely lead to great volatility in the payment methodology with certain DRGs qualifying for the policy in one year, deleted the next year, only to be readded the following year. However, over time, as treatment practices change it is possible that some DRGs that currently qualify for the policy will no longer exhibit a disproportionate use of postacute care. Similarly, there may be other DRGs that currently have a low rate of discharges to postacute care, but which will have very high rates in the future. For these reasons, we expect to periodically review the criteria that are used to make a DRG subject to the postacute transfer policy. At this time, we have not decided on how frequently to perform this review but are considering undertaking this analysis every 5 years. We welcome public comments on this issue.

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, in the past, three of the DRGs subject to the postacute care transfer policy have exhibited 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.

Comment: Commenters indicated there was not a clear explanation for when a DRG would be subject to the special payment methodology. For example, commenters indicated that DRGs 107 (Coronary Bypass with PTCA), 108 (Coronary Bypass with Cardiac Catheterization) and 109 (Coronary Bypass without PTCA or Cardiac Catheterization) are all related, but only DRG 109 is paid using the special payment methodology. The commenters argued that resource utilization for all three of these surgical DRGs would be similar, and therefore, all three DRGs should be paid using the special payment methodology.

Response: To identify DRGs that are subject to the special payment methodology, we compare the average charges for all cases with a length of stay of 1 day to the average charges of all cases in a particular DRG. To qualify for the alternative methodology, the average charges of the 1-day discharge

cases must be at least 50 percent of the average charges for all cases in the DRG. We only apply this methodology to those DRGs that have a mean length of stay that is greater than 4 days because cases with a shorter average length of stay will receive the full DRG payment for the case on the second day of the stay regardless of the payment methodology used. In addition, if a DRG in a paired set of DRGs based on the presence or absence of a comorbidity or complication meets the criteria for being included in the postacute care transfer policy and qualifies for the special payment methodology, we include both DRGs in the special payment methodology in order to eliminate any incentive to code incorrectly to receive a higher payment for a case. We have identified those additional DRGs that are subject to the special payment methodology in Table 5 of the Addendum to this final rule.

B. Reporting of Hospital Quality Data for Annual Hospital Payment Update (§ 412.64(d)(2))

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: *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. The Hospital Compare Web site has also been developed to provide information appropriate for Medicare beneficiaries. The consumer Web site is intended to be an important tool for individuals to use in making decisions about health care options. The information in this Web site assists beneficiaries by providing comparison information for consumers who need to select a hospital. It also serves as a way to encourage accountability of hospitals for the care they provide to patients.

The 10 measures that are 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 chose these 10 quality measures in order to collect data 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 have participated in the National Voluntary Hospital Reporting Initiative (NVHRI), and are continuing to submit 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 is currently done. 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, when developed, the Federal health architecture data standards, and to ensure that the data necessary for quality measures are captured. 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. In the FY 2006 IPPS proposed rule, we indicated that we were exploring requirements and other options to encourage the submission of electronically produced data, and invited comments on such requirements and options.

Comment: One commenter expressed support for the creation of a system to move information from electronic health records to a CMS data repository.

Response: We agree, and this is one of the reasons why we proposed the question in the preamble of the Notice. We appreciate this commenter's support and will strive to minimize data burdens while improving hospital quality by moving to an industry-accepted system of electronic health records.

Comment: One commenter supported the use of a single national database of quality measures that could be used by all stakeholders. However, this commenter believed that the business case for the investment in electronic medical records is not clear.

Response: CMS strives to minimize data reporting burdens, while working with providers to improve hospital

quality. We will study and assess cost, burden, and benefits of moving to an industry-accepted system of electronic health records.

Comment: Several commenters suggested that CMS should provide financial support and appropriate technical assistance to hospitals prior to, or in conjunction with any requirements for hospitals to implement electronic medical records and submit the data directly to the CMS data warehouse. The commenter added that, eventually, using electronic medical records to submit data would add additional burdens to the hospital, such as cost and the need for additional resources.

Response: We do not currently have the authority to pay for electronic data submission. However, we do appreciate the challenges and work that lie ahead to achieve the vision of using electronic medical records to submit data. We will keep these issues in mind as we move forward pursuing electronic data submission.

This method of collecting data, if well designed, should expedite the submission of quality data. We found in the Surgical Care Improvement Project (SCIP) that hospitals with electronic records were able to abstract SCIP data in as little as 10 minutes. It may require designing a report specifically for the Medicare measures, but after that work is complete, we would expect no increase in resources in hospitals with electronic records. At worst, hospitals with EMRs should only have the additional expense of printing the patient record. After that is done, the abstraction cost would be no greater burden on the hospital.

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'' section of the Web site. 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 participated 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 QIO.
- 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 tool 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 information 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, to begin submissions 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.

We proposed in the FY 2006 IPPS proposed rule, and are adopting as final policy in this rule, that, for FY 2006, 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 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 had 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 were no errors in the submitted data. The warehouse was closed at that time in order to draw the validation sample and to begin preparing the public file for the Hospital Compare public reporting Web site. Data from fourth quarter 2004 discharges (October through December 2004) are the last quarter of data with a submission deadline (May 15, 2005) preceding 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 on the 10 measures.

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 full annual payment updates will be based on the successful submission of data to CMS via the QIO Clinical Warehouse by the established deadlines.

For FY 2005, hospitals could have withdrawn 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 to qualify for the full update each 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 proposed to place the following additional requirements on hospitals for the data for the FY 2006 payment update. We are finalizing the proposed additional requirements in this rule. These requirements, as well as additional information on validation requirements, are being placed on QualityNet Exchange.

- The hospital must pass 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. These data were due to the clinical warehouse by February 15, 2005. We use appropriate confidence intervals as explained in the proposed rule to determine if a hospital has achieved an 80-percent reliability. The use of confidence intervals allows us to establish an appropriate range below the 80-percent reliability threshold that demonstrates a sufficient level of validity to allow the data to still be considered valid. We 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 reliability, the hospital data are considered validated. As proposed, we are using 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 use a two-step process to determine if a hospital is submitting valid data. In the first step, we calculate the percent agreement for all of the variables submitted in all of the charts. If a hospital falls below the 80 percent cutoff, we then restrict the comparison to those variables associated with the 10 measures required under section 501(b) of Pub. L. 108–173. We 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 is considered to be submitting valid data for purposes of the RHQDAPU.

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 does not meet the required 80 percent threshold, the hospital has 10 days to appeal these results to their QIO. The QIO will review the appeal with the hospital and make a final determination on the appeal. If the QIO does not agree with the hospital's appeal, then the original results stand. 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 needed to submit the charts requested for reabstraction by 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 not 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 score very high.

We believe we have adopted the most suitable statistical tests for the hospital data we are trying to validate. However, in the FY 2006 IPPS proposed rule, we invited public comments on this and any other approaches. We expressed particular interest 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 have indicated that 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.

Comment: Several commenters requested that we provide additional time for the hospitals to appeal their validation determinations. Many commenters stated that the current timeframe of 10 days is not sufficient time to decide to appeal the results. Commenters also asked CMS to specify if the 10-day time period is measured in calendar days or business days.

Response: The 10 days are business days. This timeframe is designed to provide sufficient time for hospitals to gather relevant information. Hospital will not need to produce more information in deciding whether or not to appeal the results of the abstraction. Hospitals are required only to submit their request for appeal form within the 10-day time period. We believe 10 business days is sufficient time for a hospital to decide whether or not it wants the contractor to review its original abstraction. However, it does expedite the final determination and minimizes data lag for public reporting and payment determination.

Comment: Four commenters requested that CMS allow more time for the hospital to produce the medical record and submit the record for the validation review.

Response: We believe the timeframe provides sufficient time for hospitals to gather the medical record and copy and forward it to the contractor. After the warehouse closes for quarterly submissions, a sample of five charts is selected for validation. The CDAC requests the charts from the hospital. Hospitals are provided 30 days, as stated in the Hospital Validation Flow Chart which can be found on QNet Exchange Web site. Upon completion of validation, the hospital receives a submission report that states whether the five charts meet the validation criteria. If the hospital fails validation, the hospital is provided 10 business days to notify the QIO that it wishes to appeal the validation decision. This timeframe helps expedite the final determination and minimizes data lag for public reporting and payment determination.

Comment: Four commenters requested that CMS delay hospital reporting until we have aligned our definitions and abstraction guidelines with JCAHO.

Response: The third quarter 2004 definitions and abstraction guidelines are better aligned to JCAHO than previous quarters, and with these third quarter 2004 definitions and abstraction guidelines, we believe we have made great strides in the long-term alignment process with JCAHO. Although CMS and JCAHO will not be fully aligned with third quarter and fourth quarter discharges, validation results for these periods are calculated from only those

aligned data elements. We anticipate full alignment with first quarter 2005 discharges.

Comment: Many of the comments requested requiring only submission of hospital reporting data in order to be eligible for the full annual payment update, and separating the process of validation from eligibility for the market basket update. Commenters frequently cited difficulties with the data infrastructure, specifically the communication of validation results to the hospital that was causing confusion for the hospitals. The commenters also cited technical difficulties with data submission to the warehouse.

Response: A production problem occurred while releasing the first set of third quarter 2004 validation results. A CMS contractor had forwarded individual validation results with the wrong data to a small number of hospitals. The run was discontinued immediately upon discovery. All hospitals involved were notified of the error and have verified the destruction of the files. In addition, hospitals also encountered abstraction and processing issues in this process. CMS and its contractors readily resolved these issues and there has not been a negative impact on hospitals or their patients. Ninety-eight percent of the hospitals that submitted data for the third quarter of 2004 that are eligible for the market basket update will receive the full update based on validation results. The production problem did not contribute to the 2 percent of the hospitals whose data did not validate. We believe that it is important for the data in the clinical warehouse on which full payment is determined to be reliable and valid.

Comment: Three commenters stated that five charts per hospital for validation is not a sufficient number to judge the quality of the care delivered in the hospital.

Response: CMS factored cost, burden, and precision of the validation results when deciding to implement the current validation sampling methodology. The goal of the chart audit validation process is to ensure that the hospital is abstracting and submitting accurate data. In order to calculate quality measures, which are used to determine the standard of care, we need to have complete and accurate data. Errors of omission and transcription errors contribute to the overall errors in calculating quality measures. We agree that it is important to differentiate between these errors in order to provide feedback to hospitals. The process we have in place to provide this feedback gives each hospital the detailed abstraction results from the CDAC reabstraction so that hospital staff may determine the types of errors and take appropriate action.

The five sampled charts usually yield 100 data elements that are used to determine the validation rate. This sample of data elements is sufficient to produce reliable validation rate estimates. Analysis of previous quarters' submitted data indicates that the clustering effect caused by the five chart sample boosts sampling variability by a relatively small proportion. Despite this increase in sampling variability, the sample still produces reliable validation rate estimates. The relative sampling variability is largely determined by the number of data elements abstracted, while incorporating the increased variability caused by the number of records. Analysis of previous quarters' submitted data indicates that the sampling variability is increased by a relatively small proportion.

Comment: Seven commenters requested that we use a test process for our data submission and our validation parameters.

Response: We agree that there should be a test process. In order to address this concern, we encourage hospitals to submit data continuously throughout the quarter; thereby data submission problems can be addressed and corrected early. Also, CMS, JCAHO, and the Hospital Reporting QIOSC conduct National calls once a month with vendors to provide further assistance. The calls give vendors the opportunity to ask questions and get timely feedback to make necessary changes to the data file prior to submission.

Hospitals have continued access to view and change their own data in the warehouse up to the time the warehouse is closed. The hospitals can pull the validation sample and begin preparing the file used for public reporting on the Hospital Compare Web site at *http://www.HospitalCompare.hhs.gov*. CMS encourages hospitals to test their data submission processing during this time by submitting quality data into the QIO clinical warehouse before the deadline and reviewing their submission reports to ensure that all data were successfully submitted into the warehouse.

The validation parameters for the CART software are extensively tested through internal quality assurance and independent validation and verification. The CMS contractor uses an internal quality control process to verify that all applications and data processes produce the results outlined in the specifications. CMS provides further quality assurance in some areas using an Independent Validation & Verification (IV&V) process by another contractor. CMS will extend IV&V to all areas involving the annual payment update. In addition, a pre production check has been implemented and will be enhanced to review any output prior to production release. Finally, CMS has a QualityNet Help Desk that can assist providers with questions or concerns.

Comment: One commenter suggested that CMS resolve all of the vendor upload issues prior to increasing the reimbursement for pay-for-performance programs.

Response: The hospital-to-vendor relationship is external to CMS. Therefore, hospitals are responsible for selecting and ensuring that vendors submit valid data into the QIO clinical warehouse. CMS does not have contractual agreements with vendors. Communication with vendors is the hospitals' responsibility. CMS holds hospitals responsible for submitting accurate data. Therefore, hospitals that have a contractual agreement with a vendor must collaborate with the vendor to ensure the data file is submitted accurately. When the data are uploaded to the QIO Clinical Warehouse, we encourage providers to access their Data Submission report. To access this report, log in to QNet Exchange and click on the QIO Clinical Warehouse Feedback Reports. The Data Submission report will give the provider a detailed summary of the cases that entered the clinical warehouse.

Comment: Sixteen commenters recommended that CMS state submission and validation parameters clearly and document them. They also recommended that CMS provide 120-day notice prior to any changes to the parameters. The commenters added that there should be less frequent changes to the requirements.

Response: CMS and its contractors strive to give providers sufficient time to incorporate changes to submission and validation parameters. However, processing and logistical issues sometimes require more expedited implementation of these changes, because measure and policy changes frequently occur. To address this issue, CMS and JCAHO released an aligned manual on January 1, 2005. This release occurred 108 days prior to implementation of any of the provisions in the manual. Since that time, CMS and JCAHO have agreed to release documents at a minimum of 120 days prior to implementation. All manuals contain data file submission requirements and programming formats for each quarter.

Comment: Eight commenters requested that CMS be consistent when releasing any communications related to

hospital reporting, and that there should be one central point for all of these communications.

Response: Hospitals are required to establish relationships with the Quality Improvement Organizations for their States and, furthermore, must establish a formal relationship with the QIO Clinical Data Warehouse and its Web site, *http://www.QNetexchange.org*. All policies and procedures concerning hospital reporting are communicated to the hospital community through these two channels. CMS communicates information about hospital reporting directly to the QIOs through the QIO Hospital Public Reporting contact for each State, using a formal system of memoranda (''SDPS memos'') which can be viewed at *http://qionet.sdps.org*. The QIOs are then responsible for dissemination of the information to the appropriate hospital staff in each State. Responses to specific questions are addressed through the Quest system; CMS monitors responses and clarifications that are published on Quest. QIOs are expected to provide technical assistance, as well as provide e-mail blasts to all hospitals on any important topics and developments pertinent to reporting hospitals. Hospitals also receive direct communication or can seek assistance from the QIO Clinical Data Warehouse, by Internet (through QNet Exchange).

CMS and the JCAHO have formally agreed to work together to maintain common performance measures and to ensure that any communication concerning these measures is coordinated and consistent.

In addition to this formal system of communication, hospitals can obtain information or seek answers to specific questions on the monthly Hospital Open Door Forum (see *http://www.cms.hhs.gov/opendoor/schedule.asp* for schedule) on the hospital quality initiative. Hospitals can also monitor CMS's activities to promote quality of care in hospitals by checking *http://www.cms.hhs.gov/quality/hospital/*. This site includes information about CMS's involvement in the Hospital Quality Alliance, a public-private partnership to promote hospital public reporting (see *http://www.hospitalcompare.hhs.gov*).

Comment: A few commenters suggested that the only requirement to receive the full market basket update should be submission of data to the warehouse. These commenters stated the intent of the law was to limit the requirement to data submission, and not require validation. In addition, there were comments that the validation process is flawed and any link to payment should be delayed until data infrastructure and processes are improved.

Response: We disagree with the comments indicating that section 501(b) of Pub. L. 108–173 only requires the submission of data. The commenters stated that additional requirements were not contemplated by Congress. However, the validation process does not contradict Pub. L. 108–173. Section 501 (b) also states the submission of the data is to be in the ''form and manner specified by the Secretary''. We believe that validation requirements fall under this broad authority. This requirement does not appear to be to stringent based on validation results showing 98 percent of providers that submitted data for the third quarter 2004 are eligible for the full market basket update. While hospitals did encounter abstraction and processing issues, these problems were immediately resolved. CMS' policy on validation requirements are very lenient, and offer hospitals several opportunities to validate their data in order to receive the full update.

Comment: Two commenters recommended using the first quarter 2005 as the first quarter in which the validation process is used for calculating the full payment to occur in 2007.

Response: We appreciate the comment and will incorporate this comment into the decisionmaking process for the FY 2007 payment determination. It has been our intention to use continuous quarters of data, but CMS and JCAHO measures differed in several substantial areas (pre-alignment) prior to the third quarter 2004 calendar year. Based largely on these differences in measures, we chose to use validation results from third and fourth quarter 2004 calendar year discharges only using aligned measures to provide the highest possibility for validation for hospitals. The CMS and JCAHO measures were approximately 95 percent aligned for the third quarter 2004 calendar year discharges. Our validation results for this period were calculated from only those aligned data elements.

Comment: Two commenters stated that misalignment with the JCAHO measures caused many issues with the initial submission of the 10 starter measures.

Response: As of July 1, 2004 discharges, all data elements within the 10 starter set were aligned. CMS and its contractors worked diligently to ensure that alignment issues did not impact eligibility for receiving the market basket update. All providers can review their quality data in the clinical warehouse after submitting their data. Hospitals also have the opportunity to appeal their validation results if their validation rate is below 80 percent. Therefore, hospitals are provided the opportunity to appeal if it appears validation was denied due to an alignment issue. CMS and JCAHO continue to work collaboratively to accomplish full alignment across all of the quality measures. We anticipate full alignment with first quarter 2005 discharges.

Comment: One commenter suggested that there be better communication between the abstractors and providers. Providers do not know appropriate standards for abstraction.

Response: CMS contracts with the QIO in each State to provide technical assistance and to work with providers on the abstraction process. We believe this State-level conduit provides local, accurate, and accessible communication to providers about the abstraction process. In addition to the QIO assistance, guidelines for abstraction prior to discharges January 1, 2005 were available on the QNet Exchange Web site under the CART Content link under Related Resources. These guidelines were in a downloadable PDF format. These Topic Specific Resources were designed to assist abstractors in determining how a question should be answered. The abstractor should first refer to the specific notes and guidelines under each data element. All of the allowable values for a given question were outlined, and notes and guidelines were often included which provided the necessary direction for abstracting a data element. Beginning with discharges January 1, 2005, the guidelines all abstractors use are published in the *Specifications Manual for National Hospital Quality Measures*. These guidelines are available to all providers in a PDF format and can be downloaded from the QNet Exchange Web site at *https://qnetexchange.org/public/hdc.do?hdcPage=rltd-rsrcs*. CMS also has an online questions and answers database that provides a centralized and standard solution for the management of questions and answers submitted by the user community. This database may be accessed on the QNet Exchange Web site mentioned above by selecting the ''Resources'' heading at *https://qnetexchange.org/public/home.do*. CMS welcomes comments from the provider and QIO communities on additional ways to improve communication.

Comment: Seven commenters stated that the validation process should only incorporate data associated with the 10 specified measures.

Response: Although hospitals are urged to submit more than the starter set of measures, hospitals submitting quality data will only be denied the full market basket update in the validation process if the 10 specified measures do not meet the 80 percent upper bound of a 95 percent confidence interval. The current process allows CMS to incorporate the reliability of both the 22 HQA measures as a whole, and exclusively the 10 specific measures.

Comment: Five commenters stated that we have to be careful not to withhold the full update from hospitals due to errors on the part of abstractors or CMS.

Response: We agree that it is important not to withhold the full update from hospitals due to such errors. With this in mind, in the chart audit validation process, the CDAC reabstracts the medical records and compares it to the original abstraction submitted. The abstraction is compared at the element level and a percent agreement is calculated. The chart audit validation process determines a hospital's reliability score. The score is the number on which an appeal is based. If a provider does not meet the 80-percent reliability threshold, it can appeal. Beginning with third quarter 2004 validation results, the final appeal decision will be made by the QIOs. This allows for an independent review and it is designed to find coding errors on the part of abstractors. In this process, the QIO can either uphold or reverse the CDAC validation decision. The QIO receives from the hospital the element or elements that are to be evaluated during the appeal process, along with the hospital rationale for the difference between the hospital's abstraction and the CDAC's abstraction. The QIO has available to it the hospital's answer and the CDAC decision when it reviews the hospital rationale and a copy of the medical record sent to it by the CDAC. The QIO then makes a final decision on the response to the element or elements. This final decision is whether the element(s) response will remain as the CDAC indicated or whether the QIO will reverse the CDAC's decision and agree with the hospital's response. QIOs are obligated to make appeal decisions based on the data that was submitted to the clinical warehouse from the hospitals. In addition, the abstraction guidelines are clear and straight forward. The information requested by each question in the abstraction tool is either there, as stated, or it is not. We have devoted a great deal of resources to ensuring that the CDAC abstraction process is consistent and accurate through our training and internal quality assurance. We consistently achieve inter-rater reliability rates approaching 100 percent in the CDAC.

Comment: Two commenters stated that hospitals should not fail validation based on the parent element not validating, and therefore the child element not validating.

Response: Parent/child relationships are defined in the analytic flows. The responses to the parent element, and possibly the child element, determine the measure category assignment. The response to this ''parent'' element also determines whether the ''child'' questions are then answered or not. Validation follows this same relationship. In validation, if the parent response causes a ''stop abstraction,'' then no further elements are answered. Only the elements answered (parent only) are included in the validation score. If the parent response causes the child element(s) to be answered, then both the parent and child elements are validated and count in the validation score. For example, the parent is Working Diagnosis of Pneumonia and the response is no, the measure category assignment is ''B'' (not in the measure population), this record would not need to be processed through the individual measure algorithms. In another example, the parent is Working Diagnosis of Pneumonia and the response is ''yes.'' Per the algorithm, if the ''child'' element is Comfort Measures Only and if the response is ''no,'' continue to the ''child'' element Transfer From another ED and if that response is no, continue to the next ''child'' element Admission Source and continue through the algorithm based on the response to each ''child'' question.

Comment: One commenter stated that the current validation process does not match the intended outcome. The commenter believed that the intended outcome is to validate that the publicly reported numbers are accurate. The commenter indicated that, currently, it is only an element by element validation of data abstraction.

Response: The purpose of the validation of these data is to determine the hospital's ability to correctly abstract and report clinical data as evidenced by the consistency between what the hospital reports, and reabstraction by the CDAC. Because these data are used for quality improvement, public reporting, and also for determining eligibility for the APU, it is important for CMS to assess the reliability of this information. It is not a validation of the quality of the care exhibited by the measures. All of the elements used for determining data validation are used to calculate the quality measures. The brief history of hospital submission and validation indicates that hospitals are improving the element level rate of validation. We expect this improvement to continue over time. As this rate increases, we believe that the overall accuracy of the measures will also improve over time. In the near future, CMS and its contractors will assess the accuracy of these hospital submitted measures, relative to surveillance sample data abstracted by CDAC. This process is necessary to eventually improve quality of care for patients.

Comment: One commenter stated that an additional component of variability that is attributable to CMS ratings should be factored into the computation of the confidence interval for the agreement statistic.

Response: The validation rates are based on the reliability of hospital submitted data, relative to an independent abstraction of the sampled charts by the CDAC. The CDAC abstraction is considered to be a gold standard, relative to the hospital abstracted data. We believe that the percentage agreement between the hospital's submitted elements and CDAC-abstracted elements is a valid estimator of a hospital's submitted data.

Comment: One commenter requested that there be accommodation for exceptions to be included in the design of measurement requirements.

Response: The fundamental reason for standardized reporting is to identify a means for hospitals, consumers and others to compare hospital performance using a common metric. The measures are defined to a very detailed level (''microspecifications''), which include flow diagrams that portray acceptable documentation. In the current microspecifications of the measures, the ''accommodation for exceptions'' is built into the measures through identification of exclusionary factors and excluded populations. Hospitals and readers can view the technical descriptions of the measures in the Specifications Manual for National Hospital Quality Measures at *http://qnetexchange.org/public/hdc.do?hdcPage=rltd-rsrcs* for the most definitive description of the inclusion and exclusion criteria for each reported measure.

Comment: Three commenters requested that CMS clarify the validation process and clearly state the parameters.

Response: We appreciate the comment and will strive to clarify the existing documentation about the validation process on the QualityNet

Exchange internet site. CMS also contracts with QIOs to work with hospitals in explaining the validation process and its parameters. Since the publication of the proposed rule, we have added additional information to the Qnet exchange Web site explaining the application of the confidence interval to the overall validation results. The data are being validated at several levels. There are consistency and internal edit checks to ensure the integrity of the submitted data; there are external edit checks to verify expectations about the volume of the data received. Beginning with data for the fourth quarter of 2002 (October through December), there will be chart level audits to ensure the reliability of the submitted data.

Web sites where additional information related to Hospital Data Validation can be found:

Quality Net Exchange: *https://qnetexchange.org/public/hdc.do*

CMS Hospital Quality Initiative: *https://qnetexchange.org/public/hdc.do*

The purpose of patient level record validation is to verify that the data abstracted by the hospitals is consistent and reproducible. CMS will identify the universe of abstracted data submitted by the hospital, draw a small, simple random sample, obtain access to the identified charts, and have the CDAC reabstract the clinical measures. The CDAC reabstractions will be compared to the original hospital abstractions and the results shared with the QIO and the affected hospital. The hospitals will be deemed certified as submitting valid data based upon the percent agreement between the hospital and CDAC abstractions. The QIO will be responsible for making all final appeal decisions and for providing assistance to improve hospital abstractions.

All data that has been successfully submitted and is in the QIO Clinical Warehouse is subject to the hospital data validation process. An overview of the processes that make up the entire hospital data validation process is described below:

- For each calendar quarter, all hospitals submitting abstracted data will be identified.
- For each hospital, all abstracted charts will be enumerated.
- A simple random sample of five charts per quarter will be identified from all hospitals with a minimum of six discharges in the QIO Clinical Warehouse. The sample is selected from all the cases submitted and is not topic-specific.
- The CMS CDAC will request the paper medical records for each of the sampled charts.
- The CDAC will reabstract the chart using the CMS CART. The relevant differences will be identified and the CDAC will assign a reason code to each difference noted.
- The results of the reabstraction will be stored in the QIO Clinical Warehouse and made available to the QIO to provide feedback to each hospital.
- Hospitals will receive educational feedback including an overall reliability rate and case details on each abstraction.
- Based upon the CDAC reabstraction, the percent agreement at the element level will be calculated. Hospitals that reach or exceed the 80 percent threshold will be considered to be supplying valid data for that quarter.
- Measures for which there are found to be significant errors may not be posted on the Web site.

Comment: Two commenters requested that the optional elements validated by the CDAC not be included in determining validation and reimbursement.

Response: All of the elements used for determining data validation are used to calculate the quality measures. It is the responsibility of each vendor (and ultimately, of the hospital) to adhere to skip logic as defined in the CMS measures. For third quarter 2004, the ten CMS measures used for market basket update were largely aligned with JCAHO. CMS is currently working with the JCAHO to completely align exclusion criteria and missing data treatment that covers skip logic with the JCAHO. CMS policy is if a measure is submitted to the warehouse, that data is subject to validation. For example, AMI test measures are optional only in the sense that you had the choice of whether to include those test measures in your abstraction, or not to include them in your abstraction. The *Specifications for Calculating Hospital Data Validation* document that was updated June 21, 2005, on QNet Exchange states ''The CDAC will abstract elements for all measures (indicators) based on the measure sent in the original (hospital) xml file.'' If the indicator for T1a (LDL Cholesterol Assessment) is included, then the corresponding data elements should be included.

Hospitals submitting quality data will be considered not eligible for full market basket update in the validation process only if the ten specified measures do not meet the 80 percent upper bound of a 95 percent confidence interval. The current process allows CMS to incorporate the reliability of both the 22 HQA measures as a whole, and exclusively the 10 specific measures. To protect the integrity of the data in the QIO Clinical Warehouse, we believe if a measure is submitted to the warehouse that data is subject to validation.

Comment: One commenter expressed concern over a lack of an independent review process outside of the CDAC review system for a hospital's appeal.

Response: Beginning with third quarter 2004 validation results, the final appeal decision will be made by the QIOs. This allows for an independent review, since the QIOs and CDACs are not connected with each other. In this process, the QIO can either uphold or reverse the CDAC validation decision. QIOs are obligated to make appeal decisions based on the data that was submitted to the clinical warehouse by the hospital. The abstraction guidelines are clear and straight forward. The information requested by each question in the abstraction tool is either there, as stated, or it is not.

Comment: One commenter suggested that CMS continue to improve communications with hospitals and vendors. We should also improve the quality of the phone calls so that participants can hear CMS and JCAHO officials.

Response: We welcome suggestions on how to improve our processes and communications. CMS and its contractors currently conduct monthly calls with vendors, and separate monthly calls with QIOs. We also encourage hospitals to participate in the quality section of the Hospital Open Door Forums (ODF) that are held once a month. Information on these ODF can be found at *http://www.cms.hhs.gov/opendoor/hospitals.asp*. We will strive to improve the quality of these phone calls. We recommend that callers press the ''mute'' button to minimize outside noise during these calls.

Comment: One commenter stated that data validation should be directed more at care, and not just at abstraction.

Response: It is the hospitals' performance on the measures that reflect the quality of care a hospital provides to patients with any of these clinical conditions, not the abstraction process itself. Validation of these data is to determine the hospitals' ability to correctly abstract and report clinical data. All of the elements used for determining data validation are used to calculate the quality measures. These quality measures are designed to estimate the quality of care.

Comment: One commenter expressed concern over incorrect abstraction by the CDACs due to the fact that hospitals keep charts differently. The commenter is concerned that this inconsistency is

resulting in an erroneously high rate of non-validation.

Response: It is every hospital's responsibility to abstract valid data and provide, upon request, a complete medical record for validation. The same abstraction guidelines are used by the CDAC and the hospital. Therefore, the results of the abstraction should be the same regardless of how the hospital maintains its records. It is every hospital's responsibility to abstract valid data. The measures and exclusion criteria are created by expert panels of medical and technical professionals. The CDAC abstraction guidelines are designed to minimize these ambiguities encountered by the CDAC abstractors.

Comment: One commenter suggested the only validation criteria should be submission of four consecutive quarters of data, or 12 months' worth of data. If the hospital submits 4 consecutive quarters of data, and the data passes the warehouse edits, the hospital should be given credit for the submission.

Response: It is CMS' goal for FY 2007 to use the four consecutive quarters' validation results as the validation criteria.

Comment: One commenter stated that vendors working with the hospital should employ the same skip logic in their software that is used by the CDAC.

Response: The hospital-to-vendor relationship is external to CMS. Therefore, hospitals are responsible for selecting and ensuring that vendors submit valid data into the QIO clinical warehouse. We suggest that hospitals exercise due diligence in selecting vendors to abstract and submit quality data. It is the responsibility of each vendor (and ultimately, of the hospital) to adhere to skip logic as defined in the CMS measures.

Comment: One commenter stated that hospitals should be able to submit documentation to us to prove that care took place. This followup documentation should be accepted after the hospital validation results have been published.

Response: The medical chart is the basis of information for conducting CDAC abstractions. Using supplementary information that differs greatly by hospital would create greater ambiguity in the abstraction process. The abstraction guidelines are written to use the medical chart to objectively abstract the necessary information. Hospitals are given 30 days to submit the medical records to the CDAC for validation abstractions. The request for the medical records happens approximately 5 months after the close of the quarter that is being validated. We believe this provide sufficient time for hospitals to collate all necessary documents for the medical record. It is important for the hospitals to submit all necessary documentation for validation as part of the medical records upon the request of the CDAC.

Comment: One commenter stated that we should add outcome measures to the hospital reporting initiatives to align our efforts with those of private purchases to financially reward high quality providers for improving outcomes of care.

Response: We are engaged in a number of activities to develop meaningful, actionable measures of the outcomes of care, including various research and demonstration projects. In addition, CMS is participating in the Hospital Quality Alliance (HQA), a pubic-private collaboration to promote public reporting on hospital quality. The HQA is currently considering the feasibility of adding outcome measures that would complement the current set of 20 process measures that are reported publicly. However, there are no definite plans to add outcome measures at this time.

Comment: One commenter stated that hospitals should be able to appeal mismatches even if their data reached the 80 percent validation mark. The commenter added that all appeals should be reviewed by a clinician.

Response: Hospitals are reviewed by QIO staff. This staff is made up of health care professionals. We have determined that providers with a reliability score of 80 percent and above have met the chart audit validation requirement and therefore no appeal is necessary. The appeals process is designed to provide feedback to those hospitals that did not meet the 80 percent validation rate. Workload and other issues prevent CMS from implementing this process for all providers. The goal is to have reliable data in the warehouse at the 80 percent element level.

Comment: One commenter recommended that CMS describe the credentials of the staff the agency uses for chart abstraction, describe the training of those staff, and facilitate the development of materials that hospitals could use to hire and train their own personnel. The commenter also recommended that CMS should have clinical staff study the inter-rater reliability of its own abstractor's determinations.

Response: The CDAC staff are professional abstractors specifically trained to abstract these data as described in the measures and validation criteria. The measures and exclusion criteria are created by expert panels of medical and technical professionals. CDAC abstractors must have at least 2 years of experience in work involving hospital medical record review. Once hired, the abstractors undergo a rigorous training program. The multiphase CDAC training program consists of knowledge transfer, simulation, evaluation and feedback. Employees must demonstrate a high level of proficiency before ''graduating'' to live production abstraction. During production, inter-rater reliability and data accuracy are monitored continuously through the CDAC quality control process. We consistently achieve inter-rater reliability rates approaching 100 percent in the CDAC. CMS and its contractors monitor the performance of the CDAC abstractions, and perform quality assurance to ensure that their abstraction is of the highest quality.

Comment: One commenter stated that there are many data elements that are subject to interpretation.

Response: It is every hospital's responsibility to abstract valid data. The measures and exclusion criteria are created by expert panels of medical and technical professionals. A Data Dictionary is posted for abstractors to utilize in the abstraction of each element for the measures. As questions are received, the data elements are reviewed to determine if additional clarification would improve the reliability of the abstraction. Revisions are made in conjunction with the JCAHO and released with each new version of the Specifications Manual.

Comment: One commenter suggested that we should automatically compute the match rate confidence interval for the entire submitted data set and for the 10 starter measures only. We should then automatically assign the higher score to the hospital, even if both are passing rates.

Response: The sequential rate calculation process is designed to provide hospitals with the opportunity to be eligible to receive the full market basket update. Hospitals are eligible if the 95 percent upper bound of either CI rate is 80 percent or greater. CMS uses this rate for the sole purpose of determining payment eligibility.

- 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, as we proposed, we are establishing a requirement for 2 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 3 quarters of calendar 2004 in September 2005. For the FY 2006 update, we 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 September 2005 publications. Allowances will 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. The fiscal intermediaries will provide information on new hospitals to the QIO in the State in which the hospital has opened for operations as a Medicare provider as soon as possible so that the QIO can enter the provider information into its Program Resource System (PRS) and follow through with ensuring provider participation with the requirements for quality data reporting under this rule.

Comment: Two commenters expressed support for the validation of the hospital reporting data.

Response: We appreciate the commenters' support. The Hospital Quality Data for Annual Payment Update initiative has been an evolving process that we are dedicated to improving. We want to acknowledge our appreciation to QIOs, hospitals and stakeholders. We strive to provide hospitals and the public with valid quality data for quality improvement, and better consumer information about hospital quality.

Comment: Three commenters stated that the reports resulting from the reporting do not provide clear information to determine the numerator and the denominator and percent of agreement.

Response: Hospital Validation Reports are available on QualityNet Exchange. These reports have been modified with third quarter 2004 validation results. They now reflect all elements that count toward the numerator and the denominator and the percent of agreement. The Hospital Validation Case Detail report provides administrative, demographic, and clinical information at the element level; it will only include a mismatch reason and educational information if the elements are a true mismatch affecting the numerator and denominator calculation from the CDAC abstracted records.

Comment: Three commenters expressed support for the Hospital Reporting initiative and the subsequent quality improvement that will result from this effort.

Response: We agree and appreciate these commenters' support. We will strive to provide hospitals and the public with valid quality data for quality improvement, as well as better consumer information about hospital quality.

Comment: One commenter expressed concern over access to individual hospital data. The commenter noted that employees of the hospital system may not have access to data necessary to do their jobs.

Response: Privacy restrictions to patient-level data must be strictly enforced. It is each hospital's responsibility to ensure that only appropriate parties within their management structure are able to access the quality data as well as make available the results of the quality data for quality improvement activities as appropriate throughout the hospital. We refer readers to the HIPAA regulations at 45 CFR Parts 160 and 164 or the individual institution's Privacy or HIPAA Specialist. We believe there should be no reason for an employee not to have the necessary data to do their jobs.

Comment: One commenter stated that the proposed rule change would add to the significant adverse reimbursement actions that are threatening the viability of hospitals that bear the brunt of caring for the uninsured and underinsured.

Response: All hospitals eligible for Medicare reimbursement are responsible for keeping sufficient records and documentation about the quality of care. The purpose of this change is to help hospitals improve the quality of care that they provide to all patients.

C. Sole Community Hospitals (SCHs) and Medicare Dependent Hospitals (MDHs) (§§ 412.73, 412.75, 412.77, 412.92 and 412.108)

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 405, 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 FY 2001 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 FY 1991 IPPS 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 a 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 a 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 paid 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 (§ 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, in the FY 2006 IPPS proposed rule, we revisited this policy. After further consideration of these issues, as we proposed, we are removing the wage index component from the budget neutrality adjustment applied to the hospital-specific rates for hospitals paid under section 1886(d) of the Act. The DRG reclassification and recalibration factor component of the budget neutrality adjustment will 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 will not remove the prior years' budget neutrality adjustment factors. This will satisfy the statutory requirement that estimated aggregate payments after the changes in the DRG relative weights equal estimated aggregate payments prior to the changes. As we proposed, the wage index portion of the budget neutrality adjustment will not be applied to hospital-specific amounts, as these amounts are not adjusted by an area wage index. While this may result in the application of a slightly higher budget neutrality adjustment 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.

Comment: Several commenters requested that CMS provide more detailed information regarding the impact of the proposed change on FY 2006 payments as well as the impact of the proposed change if it were imposed retroactively.

Response: The impact of this provision can be found in column 10 of the impact section (Appendix A) of both the FY 2006 proposed rule and this final rule. Our analysis shows that the impact on FY 2006 payments will be minimal.

With respect to applying this policy retroactively, section 903 of Pub. L. 108–173 prohibits us from issuing retroactive rulemaking unless it is necessary to comply with statutory requirements or failure to apply the change retroactively would be contrary to public interest. We do not believe this policy meets either of the conditions for making the policy retroactive. Therefore, we have not assessed the fiscal impact of this policy if it were to be imposed retroactively.

After consideration of the public comments received, as we proposed, we are adding 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. The text of these new provisions reflects changes to the way CMS applies the budget neutrality adjustment to hospitals paid under section 1886(d) of the Act based on a hospital-specific rate. Specifically, it indicates that the budget neutrality adjustment made to hospitals paid under section 1886(d) of the Act based on a hospital-specific rate will only account for the DRG reclassification and recalibration factor component. The budget neutrality adjustment will no longer include the wage index factor component.

3. Technical Change

In the FY 1991 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.

In the FY 2006 IPPS proposed rule, we indicated that we had discovered that, in making the changes to § 412.92 in the FY 1991 IPPS 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. We proposed to make a technical correction by revising paragraph (d)(3). We did not receive any

comments on this proposed correction. Therefore, in this final rule, we are adopting the proposed technical correction as final.

D. Rural Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the IPPS as a rural referral center. For discharges occurring before October 1, 1994, rural referral centers received the benefit of payment based on the other urban 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 national and regional case-mix index values is set forth in regulations at § 412.96(c)(1)(ii). The national median case-mix index value for FY 2006 includes all urban hospitals nationwide, and the 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 values are based on discharges occurring during FY 2004 (October 1, 2003 through September 30, 2004) and include bills posted to CMS' records through March 2005.

In the FY 2006 IPPS proposed rule, (70 FR 23428) [May 4, 2005] we proposed that, in addition to meeting other criteria, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 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. (See the table set forth in the FY 2006 IPPS proposed rule at 70 FR 23430.)

Based on the latest data available (FY 2004 bills received through March 2005), in addition to meeting other criteria, hospitals with fewer than 275 beds, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2005, must have a case-mix index value for FY 2004 that is at least—

- 1.3721; or
- The median case-mix index value (not transfer-adjusted) for urban hospitals (excluding teaching programs as identified in § 412.105) calculated by CMS for the census region in which the hospital is located.

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

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2300
2. Middle Atlantic (PA, NJ, NY)	1.2469
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3277
4. East North Central (IL, IN, MI, OH, WI)	1.2762
5. East South Central (AL, KY, MS, TN)	1.2911
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.2252
7. West South Central (AR, LA, OK, TX)	1.3532
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3620
9. Pacific (AK, CA, HI, OR, WA)	1.3241

Hospitals seeking to qualify as rural referral centers or those wishing to know how their case-mix index value compares to the criteria should obtain hospital-specific case-mix index values (not transfer-adjusted) from their fiscal intermediaries. Data are available on the Provider Statistical and Reimbursement

(PS&R) System. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. In the FY 2006 IPPS proposed rule (70 FR 23428), we proposed to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2002 (that is, October 1, 2001 through September 30, 2002), which is the latest available cost report data we had at that time.

Therefore, in the FY 2006 IPPS proposed rule, we proposed that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 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. (See the table set forth in the FY 2006 IPPS proposed rule at 70 FR 23430.)

Based on the latest discharge data available at this time, that is, for cost reporting periods that begin during FY 2003, the final median number of discharges for urban hospitals by census region area are as follows:

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	7,494
2. Middle Atlantic (PA, NJ, NY)	9,332
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,001
4. East North Central (IL, IN, MI, OH, WI)	8,261
5. East South Central (AL, KY, MS, TN)	7,812
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	7,084
7. West South Central (AR, LA, OK, TX)	7,093
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	9,288
9. Pacific (AK, CA, HI, OR, WA)	6,885

We note that the median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, 5,000 discharges is the minimum criterion for all hospitals.

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, as we proposed in the FY 2006 IPPS proposed rule (70 FR 23428), we are revising § 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)

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 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, as we proposed in the FY 2006 IPPS proposed rule, in this final rule we are extending 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 believe that it is appropriate 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).

Comment: One commenter supported a continuous adjustment rather than the application of the same percentage adjustment to all qualifying low-volume hospitals. The commenter indicated that the continuous adjustment should use an empirically-based formula to lower the adjustment for hospitals as their volume increase. By extending the adjustment to hospitals with slightly more than 200 discharges and by phasing out the adjustment through the use of a declining continuous adjustment, the commenter added, hospitals may be less likely to experience significant year-to-year variation in payments; especially if a hospital has slightly less than 200 discharges one year and slightly more than 200 discharges the next. The commenter indicated that such an adjustment might also alleviate any possible payment inequities for hospitals with just over 200 discharges in comparison to those with less than 200 discharges within any given year.

Response: Our analysis for the low-volume adjustment included an investigation of the use of a continuous formula. Neither the payment-to-cost ratios nor the regressions models of standardized costs per discharge and total discharges revealed any pattern that could be used to model a continuous formula given the constraints on the maximum adjustment. As mentioned above, the descriptive analysis of the data indicates 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. When looking at the FY 2002 data, the mean payment-to-cost ratio for hospitals with between 175 and 199 total discharges was 0.79. Therefore, there is some empirical evidence that the maximum adjustment of 25 percent is appropriate even for hospitals with slightly less the 200 hospitals. In addition, as indicated above, our analysis, including both the regressions and payment-to-cost ratios, did not support adjustments for hospitals with 200 or more discharges. Thus, the evidence does not suggest that there would be an inequity in our policy for hospitals with more than 200 discharges. We also do not have any evidence from hospitals of significant year-to-year variation in payments due to the low-volume adjustment. Therefore, the most empirically justifiable adjustment that we found was to give the maximum percentage adjustment to all low-volume hospitals with less than 200 discharges.

Comment: Commenters suggested that it is not necessary to update the analysis and adjustment for the low-volume adjustment every year. The rationale

behind this comment is that the adjustment should reflect the long-term relationship between volume and costs, which should not change significantly from year to year.

Response: Because the IPPS policy environment can significantly change from year to year, we do believe that is important to regularly investigate the relationship between hospitals' standardized costs per discharge and volume of discharges for purposes of the low-volume adjustment. In addition, 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)

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 IPPS-Excluded 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) resident 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, in the FY 2006 IPPS proposed rule (70 FR 23432), we proposed 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 the FTE cap base year and that subsequently became subject to the IPPS. We clarified and proposed 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 formerly IPPS-excluded 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 regulation.

Finally, there may be situations where the data necessary to carry out this policy are not available. For example, under our 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. In the FY 2006 IPPS proposed rule, we specifically solicited comments as to whether and how hospitals believe this is a problem that needs to be addressed.

Comment: Commenters pointed out that the proposed rule applies to an IPPS excluded hospital that is subsequently certified as an acute hospital and is subject to IPPS. However, the commenters added, the proposed rule is silent on the applicability of the proposed methodology to adjust the IME resident cap of an acute hospital that had an excluded unit and the unit subsequently becomes subject to the IPPS. Some commenters believed CMS should apply the same methodology and treat these formerly IPPS-excluded units in the same way as the freestanding IPPS-excluded hospitals that are subsequently certified as acute care hospitals subject to the IPPS. One commenter maintained that the situations are comparable because, if a teaching hospital in 1996 had residents training in a rehabilitation department that was not an excluded unit, those residents would have been included in the hospital's IME cap. However, the commenter added that if the rehabilitation unit was excluded from the IPPS during the FTE cap base year, the hospital was not permitted to include the resident counts from the excluded unit in its IME cap calculation. Therefore, the commenter contended that an acute care hospital that no longer has a separately certified IPPS-excluded unit should be able to add the resident count of the formerly excluded unit to the hospital's IME cap. The commenter noted that adding the FTE count from the formerly excluded unit to the acute care hospital's existing IME cap avoids a discrepancy between the direct GME and IME resident caps.

Response: In the case where a psychiatric or rehabilitation unit within the hospital is no longer separately certified from the acute care hospital, we do not believe it is appropriate to recalculate the acute care hospital's IME cap to include the IME FTE resident count from the base year for which the hospital's FTE limits were previously established. Section 1886(d)(5)(B)(v) of the Act has already established the methodology for determining an acute care hospital's IME cap. We note that if the hospital creates a new rehabilitation or psychiatric unit within the acute care IPPS hospital, the hospital's IME cap is not adjusted, because the cap is established for the hospital based on the number of residents it was training in 1996. In the case of an acute care hospital that ''closes'' its IPPS-excluded unit, at best it is only adding beds to the existing acute care IPPS hospital. In instances where an acute care hospital adds or removes beds, the previously established IME cap remains unaffected. We note further that the hospital's direct GME cap is unaffected by the closure of the unit because the direct GME limit was established based on the FTE residents training in the hospital complex, including the IPPS-excluded unit. Furthermore, such units are nonetheless provider-based as defined in 42 CFR 413.65 and, therefore, have always been integrally related to the hospital. While commenters have argued that the transition of IPPS-excluded units into acute care hospitals is comparable to the transition of freestanding IPPS-excluded hospitals to the IPPS, we believe the more accurate comparison is the one we have presented above. That is, when a former IPPS-excluded unit is subsumed within an acute care hospital and, thereby, becomes subject to the IPPS, it is equivalent to an expansion in the bed size of the acute care hospital. Therefore, we believe the acute care hospital's established IME FTE resident cap should remain unaffected as consistent with bed size expansions under other circumstances.

Regarding the possibility of a discrepancy between the IME and direct GME FTE resident caps, we note that, by virtue of the statute and our regulations, the rules differ for counting of FTE residents for purposes of IME and GME, and many hospitals currently have different FTE resident caps for IME and direct GME payments.

Comment: In response to our expression of concern about the potential that FTE resident information may no longer be available to establish an IME FTE cap for a 1996 base year, and our solicitation of comments on that issue, some commenters recommended that CMS make IME cap determinations based on more current data than the cost reports ending on or before December 31, 1996. The commenters supported using either or both of the following cost reporting periods: (1) The most recent cost report period prior to November 15, 2004, which CMS used in the policy to establish the adjustments to the PPS payments due to ''teaching status'' for the IPF PPS; and (2) the most recent cost report period prior to November 15, 2003, which CMS proposed for the IRF PPS.

One commenter pointed out that teaching hospitals have changed significantly since 1996, the year on which caps are based. Therefore, the commenter believed it would be unfair to establish new IME caps on hospitals' situations from 10 years ago.

Some commenters supported our proposal to base the IME cap on the data from cost reports ending on or before December 31, 1996.

Response: We agree with the commenters that using data from 1996 to establish the IME cap for IPPS-excluded hospitals converting to the IPPS many years after 1996 could be problematic. However, section 1886(d)(5)(B)(v) of the Act explicitly requires that ''the total number of full-time equivalent interns and residents * * * may not exceed the number * * * of such full-time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.'' Therefore, the statute requires that the IME cap be based on the 1996 data. However, because FTE residents are counted differently for purposes of IME and direct GME payments (for example, in 1996, FTE residents were not counted in an IPPS-excluded unit for IME and, therefore, would not have been included in determining the IME cap) even where the hospital has an existing direct GME FTE cap that was determined for the IPPS-excluded hospital based on data from the hospital's 1996 cost report, an appropriate IME FTE resident count must be determined based on data from the hospital's most recent cost reporting period ending on or before December 31, 1996. In some instances, the necessary data from 1996 to determine the IME cap may no longer be available. Accordingly, where 1996 documentation is no longer available, we will use the following methodology. In order to be consistent with the statute that requires IPPS IME FTE caps to be determined based on the 1996 cost reporting period data, we will use the hospital's direct GME cap, which is from the 1996 cost reporting period, be used as a starting point for determining the IME cap. However, because the rules for counting FTEs for direct GME differ somewhat from the rules for counting FTEs for IME, particularly prior to the BBA of 1997, IME data from the hospital's most recent cost reporting period ending on or before December 31, 2004, will be used to adjust the 1996 direct GME cap in order to establish the hospital's 1996 IME cap. For example, since in 1996, residents training in nonhospital sites could be counted for direct GME but not for IME, if the data from the hospital's most recent cost reporting period ending on or before December 31, 2004, showed that residents spent 10 percent of their time training at nonhospital sites, then the 1996 direct GME cap would be reduced by 10 percent to reflect that in 1996, residents training in nonhospital sites

would not have been included in the IME count.

Comment: One commenter requested that CMS make it clear that any new IME cap for a hospital that was excluded from the IPPS will be based on the count of FTEs rotating both within the hospital and in qualifying nonhospital sites.

Response: We disagree with the commenter and clarify that the IME cap for formerly IPPS-excluded hospitals will not include FTE counts of residents training at nonhospital sites. The IME cap will be established for the base year in accordance with the IME regulations that were in effect in 1996. Those regulations did not allow residents training at nonhospital sites to be included in the IME FTE count. Accordingly, only residents training in the inpatient (the portion of the hospital subject to IPPS) and outpatient departments of the hospital can be counted to establish the IME FTE cap for 1996. The BBA revised the statute to allow residents training at nonhospital sites to be counted for purposes of IME payments only effective October 1, 1997. Therefore, the hospitals' FTE count in 1996, the base year for establishing the IME cap, may not include any residents training at nonhospital sites.

Comment: One commenter interpreted our proposal in the proposed rule to mean the hospital's IME cap would equal the resident count that was used to establish the direct GME cap.

Response: We believe the commenter misunderstood our proposal. Under the proposed rule, we would have determined the IME cap based on the FTE resident data in the most recent cost reporting period ending on or before December 31, 1996. Because FTE residents are counted differently for purposes of IME and direct GME payments (for example, FTE residents are not counted in an IPPS-excluded unit for IME), we note that the FTE resident data for computing the IME cap would have come from the same cost reporting period used to establish the direct GME cap, but not necessarily be the direct GME cap itself.

Comment: Some commenters opposed the reduction in the FY 2006 IME formula and urged CMS to maintain the formula at its current percentage.

Response: We did not propose any changes in policy concerning this issue.

In summary, we are changing the policy in response to comments regarding the base year to use to establish the IME cap for a hospital that was excluded from the IPPS and that subsequently becomes subject to the IPPS. In order to be consistent with the statute at section 1886(d)(5)(B)(v), which requires the limit on the total number of FTE residents for payment purposes to be based on the 1996 cost reporting period, we believe it is appropriate to determine the IME cap based on the hospital's data from 1996 when the data are available. However, in instances where IME-specific 1996 data are unavailable, the IME data for the most recent cost reporting period ending on or before December 31, 2004, must be used to determine the 1996 IME cap. 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 (which we distinguish from a merger that results in an IPPS hospital with an excluded unit). In such cases, CMS policy is that the FTE resident cap for the surviving IPPS 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 FTE resident 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 resident count for the IPPS-excluded hospital would not have been determined previously. As we proposed, we are clarifying and codifying in regulations our existing policy that, in such cases, the fiscal intermediary would determine an IME FTE resident 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 resident 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 IME FTE resident 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 resident cap to the aggregate FTE resident 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 policy, have an IME FTE resident cap.

In this final rule, we are incorporating in the regulations at §§ 412.105(f)(1)(xiii) and (f)(1)(xiv) (proposed § 412.105(f)(1)(xiii) in the proposed rule) CMS' existing policy in situations that provide 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 providing that, in such a situation, the fiscal intermediary will 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 will 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. We note that, while we are finalizing the policy under which the fiscal intermediary will determine an IPPS IME FTE cap for an IPPS-excluded hospital that merges with an IPPS hospital if no IPPS-excluded unit is created, we will be vigilant to ensure that this policy is not inappropriately manipulated. For example, in a merger between an IPPS hospital and an IPPS-excluded hospital where no IPPS-excluded unit is created initially, and the surviving IPPS hospital benefits from the determination of an IPPS IME FTE cap relating to the formerly IPPS-excluded hospital, we would continue to monitor whether the hospital ultimately creates an IPPS-excluded unit. If the hospital did create an IPPS-excluded unit, we would closely examine the facts to determine whether the unit was created ''as a result of the merger'' and, therefore, the determination and application of an IPPS IME FTE cap was not appropriate.

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 any adjustments to its direct GME FTE cap that are available only to rural hospitals 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 (as can 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. In the FY 2006 IPPS proposed rule, we proposed that, effective with discharges occurring on or after October 1, 2005, hospitals that rescind their section 1886(d)(8)(E) rural reclassifications and return to being urban could not retain permanently the 30-percent increases in their IME caps. Rather, any adjustments the hospitals received to their IME FTE resident 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.[10]

Comment: Several commenters commended CMS and supported our proposal to revise the current regulations that would allow a rural hospital redesignated as urban as a result of the changes to CBSA that were effective October 1, 2004, to retain any cap adjustments that it received as a rural hospital. However, some commenters recommended that, under certain circumstances, an urban teaching hospital that reclassifies under section 1886(d)(8)(E) of the Act to become rural and then subsequently withdraws its election to return to urban status should be allowed to retain any IME FTE cap adjustments it might have received while rural, if that hospital has been reclassified as rural for a significant period of time (for example, 5 or 10 years). The commenter believed that, in such a scenario, the urban hospital obviously did not reclassify merely as a means of receiving an increase to its IME FTE caps and, therefore, should be allowed to keep any increase to its FTE caps.

Response: We appreciate the commenters' concerns. We agree with the commenters that, if an urban hospital were reclassified as rural for a significant amount of time, the urban hospital should be allowed to retain any adjustments to its IME FTE cap. However, we believe 10 years is a more appropriate time period than 5 years. A 10-year time period is most similar to the period in which the OMB reassesses its urban and rural designations, and we have historically reviewed our geographic designations. Thus, hospitals generally maintain their urban or rural status (absent any action on their part to reclassify) for 10 years. In other words, because the census is taken every 10 years, and revisions to the labor market areas are based on such census data, hospitals generally will maintain urban or rural status for a period of 10 years, and changes would occur only once new census figures have been issued. Any shorter time period would treat hospitals that voluntarily obtain rural status through section 1886(d)(8)(E) of the Act differently from hospitals assigned rural status solely due to our implementation of revisions to the OMB labor market areas. Thus, we believe it is most equitable to utilize a 10-year period, and we are providing in this final rule that, effective October 1, 2005, 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 if that hospital were reclassified as rural for fewer than 10 years. We are amending the regulations at § 412.105 by adding a new paragraph (f)(1)(xv) to provide that a hospital that maintained a section 1886(d)(8)(E) reclassification for fewer than 10 years and that rescinds such 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 for fewer than 10 years 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 x 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 (due to the cap adjustment under § 413.79(e)(1)(iii) or (e)(3), which is only applicable to rural hospitals) 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).

[10] We note that the 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 payments 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.

Comment: One commenter requested clarification regarding whether the urban hospital that rescinded its section 1886(d)(8)(E) rural reclassification under our proposal would also forfeit new program IME FTE cap adjustments that it received while reclassified as rural.

Response: In the proposed rule, we stated that an urban hospital that reclassifies under section 1886(d)(8)(E) of the Act is treated as rural for payment purposes under section 1886(d) of the Act and, as such, can receive a 130-percent IME FTE cap adjustment and can also receive IME FTE resident cap adjustments based on new programs. We proposed that an urban hospital that rescinds its section 1886(d)(8)(E) reclassification would forfeit any increases to its IME cap that it received as a result of being reclassified as rural.

As mentioned above in this final rule, we are modifying our proposal to state that only an urban hospital that had reclassified as rural for fewer than 10 years will forfeit the cap adjustments that it received as a result of being reclassified as rural. Therefore, in response to the commenter, where the hospital had been reclassified as rural under section 1886(d)(8)(E) of the Act for fewer than 10 years and then rescinds its rural reclassification, the hospital's IME FTE resident cap would be adjusted to eliminate any adjustment for training residents in a new program. Only rural hospitals may receive a cap adjustment at any time for starting new programs. Unless the urban hospital qualifies for a cap adjustment for new programs under § 413.79(e)(1), an urban hospital that begins training residents in a new program cannot receive an adjustment to their IME FTE resident caps.

For the reasons stated above, in this final rule we are amending the regulations at § 412.105 by adding a new paragraph (f)(1)(xv) (changed from proposed paragraph (f)(1)(xiv) in the proposed rule) to provide that a hospital that rescinds its section 1886(d)(8)(E) reclassification and that has been reclassified under such section for fewer than 10 years will forfeit any adjustments to its IME FTE resident cap it received due to its rural status. Thus, as stated in the example given above, 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 FTE 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 IME FTE resident cap would have been increased by an additional 6 FTEs to 19 FTEs (that is, 13 FTEs + 6 FTEs). However, if the hospital maintains its rural status for a period of fewer than 10 continuous years, once the hospital rescinds its reclassification under section 1886(d)(8)(E) of the Act to become urban again, its IME FTE resident cap would return to 10 FTEs (its original pre-reclassification IME FTE cap).

G. Payment to Disproportionate Share Hospitals (DSHs) (§ 412.106)

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.

$$\text{DHS Patient Percentage} = \frac{\text{Medicare, SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Patient Days}}$$

2. Implementation of Section 951 of Pub. L. 108–173 (MMA)

In the FY 2006 IPPS proposed rule (69 FR 23434), we proposed to implement a mechanism for implementing section 951 of Pub. L. 108–173, which 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 interpret 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 interpret 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.

3. Calculation of the Medicare Fraction

The first component of the Medicare DSH patient percentage calculation is the Medicare fraction. 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, as we proposed in the FY 2006 IPPS proposed rule, we are changing 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 will arrange to furnish, consistent with the Privacy Act, 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 will 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 2 Federal fiscal years that encompass the hospital's cost reporting period. Under this provision, the hospital will be able to 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 will 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 changes will 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.

Comment: Several commenters supported our proposal to release information from the MedPAR LDS to hospitals so that they can verify their Medicare DSH calculation. The commenters also supported our proposal to allow hospitals to choose whether they prefer to have their calculations performed using data from the Federal fiscal year or the hospital's cost reporting period. In addition, most commenters agreed with our proposal to eliminate the need for a pending appeal in order to receive the data and to eliminate the corresponding fee.

Several commenters requested that CMS expedite the publication of the updated routine use for the MedPAR system of records, which will reflect the changes necessary to implement section 951 of Pub. L. 108–173. One commenter urged CMS to eliminate the fee associated with data requests for all years and not just years that span December 8, 2004. In addition, the commenter recommended the elimination of the appeals requirement for all years, including those that occur before the cost reporting period that includes December 8, 2004.

One commenter recommended that CMS clarify how hospitals will receive the SSI/Medicare data for both the Federal fiscal year and the hospital's cost reporting period. The commenter also asked whether CMS expected or would require hospitals to elect the same time period from year to year. Another commenter requested that CMS provide specific guidance to hospitals and fiscal intermediaries on how to use this information to support the Medicare DSH calculation. One commenter requested that CMS clarify whether the data provided to the hospitals will be patient-specific and whether the data will include the date of discharge.

Response: We appreciate the commenters' support for our proposed policies and kept their views in mind in developing the final regulations set forth below. We understand hospitals' need for more information on the updated routine use and data use agreement and are working to release these documents as soon as possible. As we stated in the FY 2006 IPPS proposed rule, the new routine use and data use agreement will require neither a fee nor a properly pending appeal before the fiscal intermediary or the PRRB for us to furnish information from the MedPAR LDS to hospitals. Hospitals must submit a written request to CMS through the fiscal intermediary to receive this information. With respect to applying this policy retroactively, section 903 of Pub. L. 108–173 prohibits us from issuing retroactive rulemaking unless it is necessary to comply with statutory requirements, or failure to apply the change retroactively would be contrary to public interest. We do not believe this policy meets either of the conditions for making the policy retroactive to cost reporting periods prior to those that span December 8, 2004.

We expect that hospitals will use these data to calculate and verify their DSH Medicare fraction, and to decide

whether they prefer to have the fraction determined on the basis of their cost reporting period rather than a Federal fiscal year. The information from the MedPAR LDS released to hospitals will contain the matched patient-specific Medicare Part A inpatient days/SSI eligibility data on a month-to-month basis for the 2 Federal fiscal years that comprise a hospital's cost reporting period. At this time, we are not requiring hospitals to select either the Federal fiscal year or their cost reporting period and use that selection for each subsequent year. A hospital may opt to use the data from either time period each year. Regardless, a hospital will continue to be required under the regulations at § 412.106(b)(3) to submit a written request to CMS, through its fiscal intermediary, if it prefers to use its cost reporting period data instead of the Federal fiscal year data in determining the DSH Medicare fraction. The resulting fraction will become the hospital's official DSH Medicare fraction for that period and will be binding for that cost reporting period.

Comment: One commenter cautioned that, while access to the data could reduce the number of appeals to the PRRB on the DSH calculation, CMS must respond in a timely manner to hospital requests for the SSI/Medicare data for this policy to be effective.

Response: We understand that it is imperative that we release information from the MedPAR LDS to hospitals in a timely manner to ensure that they can calculate their Medicare DSH fraction. When we publish the updated routine use, we will indicate the timeframes within which we expect to make these data available to hospitals. Currently, we publish the prior Federal fiscal year's DSH Medicare fractions (also called ''SSI ratios'') for all providers in August of each year.

Comment: Several commenters suggested that we release the data file of SSI eligibility information provided to CMS by SSA. The commenters indicated that hospitals need access to the SSI eligibility file in order to compute their own Medicare DSH adjustment. One commenter suggested that CMS modify the routine use to allow SSI eligibility information to be provided directly to hospitals.

Response: In accordance with the published routine use for the SSI system of records maintained by the SSA, CMS signs a data use agreement with SSA to receive the SSI data file for the sole purpose of administering the Medicare and Medicaid programs. While we understand the commenters' concern, CMS is strictly prohibited from disclosing SSI eligibility information. In addition, SSA is prohibited from disclosing this information by Federal law and regulations. While we cannot release the SSI eligibility information provided by SSA, we are permitted to disclose the results of the data match of SSI eligibility information with the Medicare inpatient hospital billing data as a routine use for the MedPAR LDS system of records. The routine use allows us to release the information to hospitals that sign a data use agreement that limits the uses and protects the privacy of the SSI/MedPAR LDS match information.

Comment: One commenter stated that SSA has expressed a willingness to provide CMS with updated SSI eligibility information that may include retroactive grants or denials of eligibility, which would then be used by CMS to revise calculations of hospitals' DSH Medicare fractions.

Response: We understand that many hospitals are concerned that later data matches may produce a different Medicare fraction. However, we believe that there needs to be administrative finality to the calculation of a hospital's Medicare fraction. CMS has previously stated that its goal is to obtain reasonably accurate but not perfect calculations (51 FR 16777). Additionally, our data have shown that 98 to 99 percent of SSI eligibility determinations are made and remain unchanged 6 months after the end of the Federal fiscal year. There will be a minimum of 6 months between the end of the hospital's cost reporting period and the April 1 date that we receive SSI eligibility information. The time lag between the close of a hospital's cost reporting period and the April 1 date that we obtain the eligibility information could actually be much longer for many hospitals. For a hospital with an October 1 to September 30 cost reporting period, we will use SSI eligibility information from 6 months after its year ends. However, we will be using SSI eligibility 17 months after a hospital's year ends with a November 1 to October 31 cost reporting period. Given the time between the end of hospital cost reporting periods and when we are furnished with SSI eligibility information for that period, we believe it is highly unlikely that a subsequent data run will produce data that is significantly different than one completed 6 months after the end of the Federal fiscal year.

Therefore, we will use the SSI eligibility information provided to CMS by SSA 6 months after the end of the Federal fiscal year (or April 1) to calculate the DSH Medicare fraction. We will match these data to the MedPAR system once and conduct no further matches after that time. For cost reporting periods that span 2 Federal fiscal years, a hospital will receive the data for the 2 Federal fiscal years once the data from the second year have been matched against the SSI data available to CMS 6 months after the end of that year. Although it is possible that these data will be available up to 17 months after the cost reporting period has ended, hospitals will continue to be permitted to use the data to determine whether they prefer to base their calculation on data from the Federal fiscal year or their cost reporting period. The calculation from the requested time period will be used in the final settlement for the cost reporting period. This policy will be reflected in the updated routine use and in the data use agreement, which hospitals will sign with CMS to obtain the privacy protected MedPAR LDS data match. As previously mentioned, we will publish the updated notice of routine use for the MedPAR system of records in a future **Federal Register** document.

Comment: One commenter requested that CMS allow hospitals to choose the data field CMS would use to conduct the SSI eligibility/MedPAR LDS data match. The commenter suggested that hospitals be allowed to request that the data match be made by social security number, health insurance claim account number (HICAN), name, gender, date of birth, or Title II identifier, or a combination of these factors.

Response: We do not use social security numbers to conduct the SSI/MedPAR data match because social security numbers are used on a ''wage earner'' basis that is not necessarily specific to an individual Medicare beneficiary (or hospital patient). The HICANs are unique to each beneficiary. Because of this, we do not have social security numbers for every Medicare beneficiary in the MedPAR data.

In addition, we do not agree that individual hospitals should be given the choice to run the SSI/MedPAR data match by alternative criteria. Such variation between providers would result in an inconsistent matching methodology, and inconsistent DSH Medicare fraction calculations, among providers.

Comment: One commenter suggested that, in place of using the MedPAR system, CMS use the Provider Statistical and Reimbursement (PS&R) data file to determine the denominator of the Medicare fraction.

Response: We believe it is appropriate to continue to use the MedPAR for Medicare DSH calculations. Principally, as documented in the **Federal Register**,

the MedPAR system has been the Medicare Part A data source for the Medicare DSH calculation since the implementation of the DSH adjustment. More importantly, the MedPAR system and the PS&R do not necessarily contain the same data. The MedPAR system contains utilized days and the PS&R contains days paid to the provider by Medicare. The PS&R does not contain certain types of days that should be included in the denominator of the Medicare fraction, such as covered days that were paid by a Medicare managed care organization (''MCO''). For these reasons, we are not proceeding with the commenter's recommendation at this time.

Comment: Several commenters suggested that CMS allow a hospital to submit additional days that it believes were omitted in error from the SSI/MedPAR system data match. One commenter acknowledged that the hospital would bear the burden of proving SSI/Medicare entitlement for each patient day claimed.

Response: If a hospital disagrees with the fiscal intermediary's determination regarding the final amount of Medicare DSH payment to which it is entitled, the hospital has the right to appeal the fiscal intermediary's decision in accordance with the procedures set forth in the regulations at 42 CFR Part 405, Subpart R, which concern provider payment determinations and appeals. Generally, during the first stage of the appeals process, a fiscal intermediary will consider any documentation a hospital has submitted for review. The fiscal intermediary will assess whether the information provided is sufficient to warrant a reconsideration of the DSH Medicare fraction at that point in the appeals process.

Comment: One commenter requested that CMS clarify ''Medicare days'' included in the Medicare fraction and explain how the MedPAR system captures all of the days that should be included, especially if Medicare did not pay the claim. The commenter specifically requested that CMS address the treatment of MCO or ''Medicare Advantage'' days, dual-eligible with exhausted Medicare Part A benefits, dual-eligible without SSI, and third party payer patient days.

Response: Although we believe that this comment is generally out of the scope of the FY 2006 IPPS proposed rule regarding the implementation of section 951 of the MMA, we understand the commenter's concern regarding the possible exclusion of certain days from the Medicare DSH calculation. Due to this concern, we are currently examining our system to ensure that all appropriate days are included in the DSH Medicare fraction.

In addition, on several occasions we have stated our policies concerning the treatment of MCO, dual-eligible with exhausted Medicare Part A benefits, dual-eligible without entitlement to SSI, and third party payer patient days in the Medicare DSH calculation. We suggest that the commenter refer to the FY 2005 IPPS final rule for our policy on dual-eligible patient days, including those with exhausted Medicare Part A hospital coverage and MCO days (69 FR 49098 and 49099). Commenters may also review the IPPS final rule for FY 1991 regarding when the MedPAR was updated to include MCO days (55 FR 35994, September 4, 1990). Regarding third party payer days, we refer commenters to the IPPS final rule for FY 1987, which states our policy prior to our FY 2005 policy change (51 FR 31460, September 3, 1986). For FY 2005 and subsequent fiscal years, we have updated the regulations at § 412.106(b) to reflect the inclusion of days for which Medicare was not the primary payer.

4. Calculation of the Medicaid Fraction

The second component of the Medicare DSH patient percentage calculation is the Medicaid fraction. 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.[11]

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

[11] 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.

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 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 payers, 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 continue to 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.

Comment: Several commenters encouraged CMS to amend the Medicaid State plan requirements to require States to furnish Medicare eligibility data to requesting hospitals. Several commenters believed that variability in how State Medicaid agencies collect and manage Medicaid data make the process to convert and match hospital records to State Medicaid records extremely time-consuming and complex. The commenter believed that requiring every State to report Medicaid eligibility data in the same manner would decrease hospitals' administrative work. Several other commenters suggested that CMS not make any change to the States' requirements at this time, but continue to consider this idea as an option for the future. Another commenter suggested that CMS amend the State plan requirements to include a requirement that the States must make Medicaid eligibility information available in a timely manner, such as 90 days after receipt of a hospital's request. This commenter believed that States should be prohibited from charging hospitals a fee for accessing the data. Several commenters suggested that CMS modify the Medicaid State plan requirements to require that any contract between the State Medicaid agency and an MCO specify that the MCO would be required to submit reliable utilization data to the State to verify managed care days/patients.

Response: We are dedicated to working with the State Medicaid agencies to ensure that hospitals have access to data to verify Medicaid eligibility. While the commenters expressed concern that some hospitals find it burdensome to adapt the Medicaid eligibility data available from the States to their records, we do not believe these types of data processing concerns are significant enough to warrant changes to the State plan requirements. We are also aware that not all State agencies have the resources available to modify their systems in a standardized way. We note that the Center for Medicaid and State Operations in CMS has communicated CMS' expectation of compliance with hospitals' requests for Medicaid eligibility information to the State Medicaid agencies. If the State Medicaid agencies refuse to provide data to enable hospitals to calculate their DSH Medicaid fraction and meet their obligations under our regulations at § 412.106(b)(4)(iii), we will consider amending the Medicaid State plan requirements to require the State agency to release the information to the requesting hospitals.

We also do not believe that we have the authority to require State Medicaid agencies to provide the Medicaid eligibility information free-of-charge. However, we do note that the State Medicaid Manual already requires that States not impose unreasonable fees on hospitals seeking eligibility information.

With respect to Medicaid MCO utilization, State Medicaid agencies must maintain Medicaid eligibility information on beneficiaries enrolled in MCOs in order to make payments to those MCOs. Because hospitals are seeking Medicaid eligibility information and not inpatient hospital utilization information, we do not believe that it is appropriate for CMS to oblige the State Medicaid agencies to record and make available to hospitals MCO utilization data.

Comment: Several commenters argued that Congress intended that CMS provide the Medicaid eligibility data to aid hospitals in calculating their own Medicare DSH patient percentage.

Response: While we are aware that section 951 requires that CMS provide the data necessary for hospitals to calculate their Medicare DSH patient percentage, we stand by our belief that hospitals are in a better position to verify Medicaid eligibility with the State Medicaid agencies through their established mechanisms. Therefore, we believe hospitals have available to them the data necessary to calculate the Medicaid fraction for their Medicare DSH patient percentage. CMS will continue to work with State Medicaid agencies to ensure that Medicaid eligibility information is made available to hospitals.

Comment: Several commenters indicated that some State Medicaid agencies are refusing to provide hospitals with Medicaid eligibility information.

Response: We are not aware of any State Medicaid agency that is refusing to provide hospitals with current Medicaid eligibility information, and the commenters did not cite any such circumstances. However, we are aware that several State Medicaid agencies have previously expressed concern regarding hospital requests for historic Medicaid eligibility information. We note that section 2080.18 of the State Medicaid Manual limits the timeframe within which the State Medicaid agencies may provide eligibility information to requesting hospitals. Section 2018.18 clearly specifies that State Medicaid agencies may only provide eligibility information for dates within 12 months of the date of the request. Therefore, many States have expressed concern that responding to requests for eligibility data outside of that 12-month window would be in violation of CMS' policy. In light of past and pending appeals and litigation, we are working with the States to make sure historic information is available to requesting hospitals. The Center for Medicaid and State Operations released a memo to the CMS Regional Offices to be shared with the Medicaid State agencies. This memo, dated September 9, 2003, requested the full cooperation of the State Medicaid agencies in responding to hospital requests for historic Medicaid eligibility information. The States were specifically encouraged to retain Medicaid eligibility records in order to be able to comply with hospital requests for historic data, even if their normal record retention schedule would have allowed the destruction of such records. CMS' request to Medicaid State Agencies to provide hospitals with

historical Medicaid eligibility data represents an exception to the general rule as stated in section 2080.18 of the State Medicaid Manual intended to assist hospitals to respond to the past and pending appeals and litigation.

Comment: Several commenters stated that the data provided to hospitals from the Medicaid State agencies are often inaccurate. They noted that several fiscal intermediaries have refused to accept data from hospitals, which was obtained from the State Medicaid agencies.

Response: The Medicaid State agencies maintain eligibility information on Medicaid recipients. To date, we have been made aware of accuracy problems insofar as the data requested are historic and the complete records may no longer be available. As previously noted, we have requested that the State Medicaid agencies comply with hospital requests for historic data and modify their record retention schedules appropriately. We suggest that hospitals experiencing problems with the quality of current Medicaid eligibility data work with their fiscal intermediaries and State Medicaid agency to address the specific problems the hospital is encountering.

Comment: One commenter suggested that CMS establish a formal process for hospitals to report States that are not complying with hospital requests for Medicaid eligibility information. The commenter proposed that CMS dedicate an area on the CMS Web site for hospitals to report problems encountered with State Medicaid agencies.

Response: We are interested in the commenter's proposals and will consider this for future modification of the CMS Web site. Although we are not adopting the proposal at this time, we ask that hospitals that experience difficulty obtaining Medicaid eligibility information from a State Medicaid agency contact the appropriate CMS Regional Office. We will continue to work with the individual State agencies to ensure that hospitals have access to such information.

Comment: One commenter suggested that the fiscal intermediaries process hospital requests for Medicaid eligibility data and work with the State Medicaid agencies to obtain such data.

Response: Under the regulations at § 412.106(b)(4)(iii), hospitals bear the burden of furnishing data adequate to provide eligibility for each Medicaid patient day claimed in the Medicare DSH calculation. This includes verifying with the State that a patient was eligible for Medicaid on each of the claimed days. As stated above, the information provided to CMS by the Regional Offices indicated that 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. In light of this, we do not believe that fiscal intermediaries should be made responsible for verifying Medicaid eligibility with the State Medicaid agencies.

Comment: One commenter suggested that CMS issue explicit instructions to fiscal intermediaries indicating that hospitals may submit their own data to support the days included in the Medicaid fraction.

Response: While hospitals do bear the burden of verifying Medicaid eligibility for the patient days they submit to be included in calculation of their DSH Medicaid fraction, the State Medicaid agency must verify that, for those days, the particular patient was eligible for inpatient hospital benefits under an approved Medicaid State plan or section 1115 waiver program. If a hospital believes that the State Medicaid agency did not correctly determine the Medicaid eligibility of a patient on a specific day for which the hospital has additional and distinct evidence to indicate that the patient was in fact eligible for Medicaid on that day, the hospital may submit this information for review by the fiscal intermediary. The fiscal intermediary retains the right to determine whether the documentation is sufficient to warrant the inclusion of the days in the Medicaid fraction. While we currently have no plans to issue instructions to fiscal intermediaries on the verification of Medicaid eligibility, we will consider addressing this concern in future communication with fiscal intermediaries.

Comment: One commenter stated that certain Medicaid eligibility information must be made available to hospitals through the State Medicaid agencies. The commenter indicated that solely providing whether a patient is eligible for Medicaid is not sufficient to determine whether the hospital days associated with that patient should be included in the DSH Medicaid fraction calculation. Specifically, this commenter indicated that the State must also provide: the dates of eligibility for Medicaid or whether the patient was eligible for Medicaid during an inpatient stay, whether the recipient has met spend down requirements (if applicable), and the type of Medicaid benefits the recipient received. The commenter indicated that this information is critical in determining the days that should be included in the DSH Medicaid fraction calculation.

Response: We encourage hospitals to continue working with individual State Medicaid agencies to ensure that they have access to the information needed to determine Medicaid eligibility for purposes of the DSH Medicaid fraction. If hospitals are unable to obtain from the Medicaid State agencies data needed to calculate their DSH Medicaid fraction, we encourage them to notify their CMS Regional Office for assistance.

Comment: One commenter suggested that CMS establish a more efficient method for hospitals to verify dual eligibility using the Common Working File (CWF).

Response: We encourage hospitals to continue working with individual State Medicaid agencies and fiscal intermediaries to ensure that they have access to the information needed to determine Medicaid eligibility for purposes of the DSH Medicaid fraction. If hospitals are unable to obtain data from the Medicaid State agencies needed to calculate their DSH Medicaid fraction, we encourage them to notify their CMS Regional Office for assistance.

H. Geographic Reclassifications (§§ 412.103, 412.230, and 412.234)

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.

Comment: One commenter sought clarification as to whether a hospital can apply for and be granted MGCRB reclassification for a future year if the hospital is currently designated rural under section 1886(d)(8)(E) of the Act but also received an approved notice canceling its rural designation from the CMS Regional Office.

Response: Section 412.230(a)(5)(iii) of the regulations specifies that ''an urban hospital that has been granted redesignation as rural under § 412.103 cannot receive an additional reclassification by the MGCRB based on the acquired rural status as long as such redesignation is in effect.'' If a hospital, at the time of applying to the MGCRB, has written notice from the CMS Regional Office demonstrating that its rural redesignation will cancel prior to the effective date of the MGCRB decision, the MGCRB should approve the hospital for reclassification, assuming all other criteria have been satisfied. For purposes of subpart L of Part 412 of the regulations, the hospital will be considered urban because it is physically located in an urban area and will longer be in rural status upon the effective date of the MGCRB decision. Thus, the hospital will be subject to reclassification rules that apply to urban hospitals for individual hospital reclassification applications under § 412.230 and countywide group reclassification applications under § 412.234. We note that § 412.230(a)(5)(iv) may imply that a hospital cannot receive a reclassification by the MGCRB while it has acquired rural status under § 412.103. We are modifying § 412.230(a)(5)(iv) to indicate that a hospital may not be granted reclassification by the MGCRB for a year in which ''such designation'' is in effect.

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, in the FY 2006 IPPS proposed rule, we proposed 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 § 412.230(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 proposed 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 § 412.230(d)(2). We proposed to establish 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 proposed 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 proposed 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.

Comment: Many commenters supported our proposal to allow reporting of campus-specific wage data using a supplemental Worksheet S–3 for campuses of multicampus hospitals that are located in a wage area that is different from the wage area in which the main provider is located. The commenters stated that the proposal would provide equitable treatment for these hospitals under the reclassification rules. However, one commenter expressed concern that the proposal may encourage an individual hospital that is part of a multicampus hospital to seek reclassification to different labor market areas. The commenter believed that this option should only be available in cases where an individual campus is requesting reclassification for purposes of reclassifying to an area where another one of the campuses is located.

Another commenter recommended that CMS modify its policy and include only salaries and hours of the workforce attributable to the campus or campuses located in the area in order to calculate an area wage index. The commenter recommended that CMS require that all multicampus hospitals with campuses in more than one wage area complete the manual Worksheet S–3 by area. If reporting wage data by campus proves to be administratively burdensome, the commenter suggested that all of the multicampus hospital's wage data be included in the area in which the majority of the multicampus hospital's employees work.

Other commenters questioned how the manual Worksheet S–3s would be reviewed and when and how often (that is, once a year or every 3 years) the hospitals would be required to submit the manual Worksheet S–3s.

Response: We appreciate the commenters' suggestions and their interest in this matter. We are finalizing our proposal for FY 2006 reclassifications to allow a campus of a multicampus hospital to use the average hourly wage data submitted for the entire multicampus hospital as its wage data under § 412.230(d)(2), if that campus applied for reclassification for FY 2006 and it otherwise meets all of the reclassification criteria. For FY 2007 and subsequent year reclassifications, we proposed that a campus of a multicampus hospital that seeks geographic reclassification to another labor market area must submit a manual version of Worksheet S–3 of the Medicare cost report that allocates the wage data by individual campus. We also stated that before the data could be used for a reclassification, the hospital's fiscal intermediary would have to review the allocation of the entire hospital's wage data among the individual campuses. Based on the public comments, we have further considered the potential burden to hospitals and fiscal intermediaries that the use of a manual Worksheet S–3 would entail. We have realized that the proposal concerning the manual Worksheet S–3 presents certain difficulties, particularly when considering that the MGCRB's deadline for informing hospitals of whether their reclassification applications are approved is February 1. In particular, because the information on the Worksheet S–3 flows from and is linked to other worksheets in the Medicare cost report, it would not be sufficient for campuses to submit only the Worksheet S–3; other worksheets would need to be submitted manually as well. In addition, since beginning with FY 2005, hospitals' wage data include an occupational mix adjustment, reporting of campus-specific occupational mix data would also be necessary. Because hospitals currently do not report their wage or occupational mix data by individual campus, we believe it could be difficult for hospitals to prepare and submit the appropriate information between the time that this final rule is published and the September 1, 2005 deadline for FY 2007 reclassifications. Furthermore, the submission of manual cost report data would require a lengthy and tedious manual audit process for fiscal intermediaries, making it extremely difficult for them to complete these supplemental reviews and for CMS to calculate the average hourly wages of these campuses in time for the MGCRB to make its decisions by February 1, 2006.

We also note that our process for collecting wage index data precludes us from adopting changes to the cost report for FY 2008 reclassifications. The wage data that will be used for an FY 2008 reclassification will be data from a hospital's FY 2003 cost report, which is used to determine the FY 2007 wage index. Hospitals have already submitted their FY 2003 cost reports to their fiscal intermediaries and the CMS data reporting systems. The process for reviewing and auditing these data will begin in October 2005. Thus, the cost report changes that would be necessary to report wage index data by individual campus would have needed to be in place for campus-specific wage data to be subject to the same reporting and audit requirements that apply generally to hospitals' wage data. While making formal changes to the Medicare cost report to allow multicampus hospitals to electronically report their wage data by individual campus is a possibility for future years, it is certainly not a feasible option for the FY 2007 or FY 2008 reclassification applications.

In addition to burden that would be associated with requiring a manual cost report, we also considered several other issues when deciding on a final policy. We believe that it is appropriate to have the campus use the average hourly wage data submitted on the cost report for the entire multicampus hospital for several reasons.

First, under the criteria for geographic reclassification, a hospital must already demonstrate a close proximity to the area to which it seeks reclassification. When the campus meets such proximity requirements, it is reasonable to speculate that the average hourly wages for an individual campus and the whole hospital are similar because the two (or more) campuses are operating as a single entity under one Medicare provider number, are under common ownership and control, and are clinically and financially integrated. Accordingly, when the facilities are in close proximity to each other (and share a common labor market area and are within normal commuting distance), we believe there may not be a wide range of salaries for the same occupational categories within the same institution. (In contrast, if, when, using the wage data of the entire hospital, the campus cannot meet either the proximity criteria of § 412.230(b) or the wage comparison criteria of § 412.230(d), the campus cannot be reclassified. The failure to meet either of these criteria indicates that either (a) the campus is not sufficiently proximate to assume similar wage data, or (b) the data of the entire hospital is either not sufficiently comparable to the reclassification area or is not sufficiently different from the area in which the campus is already located, to warrant a reclassification. It would be inappropriate to assign a campus the wage index of an area that the entire hospital would not qualify to receive, if not for the fact that one campus of that hospital happens to be located within the boundaries of a geographic area with a higher wage index.)

Second, the use of the entire hospital's wage data is practical and administratively feasible for hospitals, CMS, and the fiscal intermediaries because wage data for all campuses are reported together on a single cost report under a single Medicare provider number.

Third, we note that use of the wage data for the entire multicampus hospital is consistent with our treatment of multicampus hospitals for calculating area wage index values, GME, DSH, and provider-based purposes, under which multicampus hospitals operating under a single Medicare provider number are treated as a single hospital for payment purposes.

For the reasons described above, we have decided not to finalize our proposed policy to require a campus of a multicampus hospital to submit manual Worksheet S–3s with campus-specific wage data to support a reclassification application at this time. Rather, we are extending the policy that we had proposed for FY 2006 reclassifications to FY 2007 and FY 2008. That is, for FY 2006, FY 2007, or FY 2008, for a campus of a multicampus hospital that wishes to seek reclassification to a geographic wage area where another campus(es) is located, we are requiring that a campus of a multicampus hospital use the average hourly wage data submitted on the cost report for the entire multicampus hospital as its wage data under § 412.230(d)(2). We are modifying the regulations at § 412.230(d)(2)(iv) accordingly. We will continue to explore options that will allow individual campuses of multicampus hospitals to submit wage data necessary for geographic reclassification without undue administrative burden. We will also monitor the number of multicampus hospitals affected by this provision.

The proposal to allow campuses of multicampus hospitals to reclassify was intended to mitigate the negative effects the new labor market areas had on multicampus hospitals that were previously located in a single MSA and are now located in more than one CBSA. Although this proposal was an outgrowth of the change to the new labor market areas, we have decided to apply this provision to any multicampus hospitals with campuses in more than one labor market area. We believe the same opportunity to reclassify should be available to all multicampus hospitals in this situation, even those that were located in different wage areas prior to the change in the OMB definitions. Further, we will only allow a campus of a multicampus hospital to use the average hourly wage for the entire hospital to reclassify to the labor market area where the other campus(es) is located. We believe this limitation is warranted because, currently, the data available for which the campus to base a reclassification on are the wage data reported for the entire hospital on the Medicare cost report. We will consider further the comments that recommend that we modify our policy to include only salaries and hours of the employees actually working in a particular labor market area when determining the wage index for that area. We believe this recommendation presents certain logistical challenges that we would like to consider in the context of possible permanent cost report changes to accommodate the electronic reporting of separate wage data by individual campus. We anticipate having a full discussion of these issues as part of a future rulemaking.

3. Urban Group Hospital Reclassifications

Section 412.234(a)(3)(ii) of the regulations sets forth criteria for urban hospitals to be reclassified as a group for FY 2006 and thereafter. Under such criteria, ''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.''

As a result of adopting the new labor market area definitions, we reexamined in the proposed rule whether to retain old standards that allowed proximity to be determined on the basis of being included in the same CMSA (under the standards published by the OMB on March 30, 1990). Based on our experiences now that the new labor market areas have been in effect for one year, we no longer believe it is necessary to use 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, in the FY 2006 IPPS proposed rule, we proposed to delete § 412.234(a)(3)(ii) to remove reference to the CMSA eligibility criterion. For reclassifications beginning FY 2007, we proposed 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 believed 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. We also proposed to make a conforming change by eliminating the term ''NECMA'' from the regulations at § 412.234(b)(1).

Comment: Many commenters opposed CMS' proposal to eliminate the CMSA criterion for urban county group reclassifications. They were concerned that eliminating the CMSA criterion would result in a reduction in the number of hospitals eligible for reclassification. Some commenters suggested that CMS postpone eliminating this criterion until at least FY 2008, which would coincide with the expiration of a 3-year transition period for hospitals that changed status from urban to rural as a result of the redefined labor market areas.

Response: We continue to believe that it is reasonable to use the area definitions that are based on the most recent definitions. The new designations were released on June 6, 2003. In essence, we have already delayed the implementation of the new Census information. Consistent with our proposal to use the area definitions announced by OMB on June 3, 2003, we are also further modifying § 412.234(b)(1) to eliminate ''or NECMA'' for purposes of the wage data comparison. Because New England County Metropolitan Areas (NECMAs) are no longer used in our area wage definitions, we believe this term should be deleted from the regulations.

We note that the ''3-year transition'' to which commenters refer was not in any way related to MGCRB reclassifications and was solely directed toward the wage index that would be received by hospitals that changed status from urban to rural as a result of the redefined labor market areas—a limited group of hospitals that is not representative of the broader hospital community. Therefore, we are finalizing the proposed policy in this final rule.

Comment: A group of hospitals in New England protested an MGCRB decision under which they were denied reclassification. The hospitals believed they were unfairly denied an opportunity to reclassify for Medicare

wage purposes for FY 2006 because of a narrow interpretation of the urban county group reclassification regulations by the MGCRB. The hospital group applied for reclassification for FY 2006, but was subsequently denied by the MGCRB, and the decision was later upheld by the Administrator on the basis that the applying county did not meet the regulatory requirements in § 412.234(a)(3)(ii). The county was neither part of the same CMSA (1990 Standard) or CSA as the requested area (2000 Standard). The hospital group argued that the county would have been included in the same CMSA as Boston if the CMSA standards had been applied at the county-level rather than at the township level in New England. The hospital group requested that CMS grant their reclassification request for FY 2006 through FY 2008.

Response: We are not granting the hospital group's request. The hospital has asked us to reverse an Administrator decision. However, Administrator decisions are considered to be the final decision of the Department (§ 412.278(f)(3)) and are subject to reopening only in very limited circumstances which are not present in this case. In addition, we note that Administrator decisions are not subject to judicial review (§ 412.278(f)(4)). As the Administrator has already found, the hospitals did not meet the regulatory requirements of § 412.234 to be reclassified to the Boston-Worcester-Lawrence CMSA. A Boston-Worcester-Lawrence CMSA existed under the 1990 township-based MSA system in New England. However, approximately one-half of the townships in the applicant county fall outside of the CMSA boundaries (including at least two of the three townships where the applicant hospitals are located). Therefore, as the Administrator has already held, the applicant county is not within the Boston CMSA, and there is no provision in the regulations that will allow us to reclassify the Bristol County hospital to the Boston-Worcester-Lawrence CMSA.

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.

In the FY 2006 IPPS proposed rule, we proposed to update the Medicare regulations at § 412.103(a)(1) to incorporate this change in the identification of rural census tracts. We also proposed to update the Web site and the agency location at which the RUCA codes are accessible.

Comment: Two commenters indicated that the use of RUCA codes results in an inaccurate classification of their rural communities as urban. They urged CMS to work with the Office of Rural Health Policy to address problems in the methodology and to ensure that rural areas are not inadvertently classified as urban.

Response: We appreciate the comments regarding use of the RUCA codes. CMS will continue to work closely with the ORHP to ensure the adequacy of rural health policy issues.

Comment: Commenters stated that they had difficulty locating the Rural-Urban Commuting Area codes on the Web site identified in the proposed rule. They requested a more detailed Web site reference as a link to the codes.

Response: The Rural-Urban Commuting Area codes are maintained by the Office of Rural Health Policy (ORHP). Since Web site links are subject to change, we encourage commenters to contact the ORHP directly for information regarding the RUCA codes. Commenters may also request copies of the RUCA codes from the 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.

Comment: Commenters urged CMS to provide grandfather status to protect hospitals that were redesignated as rural based on the old Goldsmith Modification criteria and no longer qualify under the new RUCAs. They indicated that a loss of rural status would be devastating for many hospitals, particularly CAHs.

Response: Currently § 412.103(a)(1) requires that hospitals be located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification. The RUCAs are the most recent of the Goldsmith Modification. Therefore, hospitals must qualify on the basis of the new RUCAs. CMS will continue to monitor how the new standards affect hospitals' rural status.

In this final rule, we are adopting as final, without modification, our proposal to update the regulations at § 412.103(a)(1) to incorporate the change in the identification of rural census tracts and to update the Web site 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 changing the cross-references to the definitions of ''urban'' and ''rural'' to reflect their current locations in Subpart D of Part 412, as applicable.

Other Comments

Comment: We received a number of suggestions for revising the geographic reclassification rules that were independent from the policies we proposed. Some commenters recommended that CMS develop criteria that would allow areas within CBSAs to qualify as core urban areas and for all providers located in those areas to receive their own wage indices. In

addition, they suggested that CMS develop MGCRB criteria through which hospitals not located in the core urban area, but within the same CBSA, could apply for reclassification into the core urban area. Other commenters requested that CMS expand the urban group reclassification eligibility criteria to allow hospitals in counties that are in the same CBSA as the urban area to which they seek redesignation to qualify as meeting the proximity requirement. One commenter proposed alternative reclassification criteria by which a hospital in a single hospital Metropolitan Statistical Area could apply for reclassification to a noncontiguous urban area for wage index purposes.

Response: In the FY 2006 IPPS proposed rule, we did not propose any changes that are specific to these comments. Because these proposals would have a negative effect on some hospitals or might appear inequitable to similarly situated hospitals, we do not believe it would be prudent to adopt any of them in this final rule without first opening them up for public comment.

Comment: One commenter stated that a Pennsylvania hospital in a single hospital MSA surrounded by rural counties is at a competitive disadvantage because the rural hospitals that surround the hospital have been reclassified to higher wage index areas or have been designated as rural referral centers, SCHs, MDHs, or CAHs. The urban hospital is ineligible for reclassification to a higher wage area either as an individual hospital or as a group under current regulations. The commenter advocated a change to the urban county group reclassification regulations whereby a hospital in a single hospital MSA surrounded by rural counties would be able to reclassify to the closest urban area which is part of a Combined Statistical Area (CSA) located in the same state as the hospital.

Response: As we indicated above, we did not propose any changes that are specific to these comments in the FY 2006 IPPS proposed rule and do not believe it would be prudent to adopt any of them in this final rule without first opening them up for public comment and being able to fully consider the effect on other hospitals that are similarly situated. For this reason, we are unable to address this issue at this time without further study. We note that the comment raises a point about the hospital competing with other rural hospitals that are able to reclassify under special access rules that apply to RRCs and SCHs. Rural referral centers and SCHs are eligible for special access rules under section 1886(d)(10)(D)(i)(III) of the Act. Under these provisions, where a hospital is the sole source of inpatient hospital care or is the only provider of needed tertiary services in rural areas—as, by definition, RRCs and SCHs are—special proximity rules apply in cases of reclassification, in order to ensure access to care. These rules were implemented in a 1992 rulemaking and are specific to RRCs and SCHs. (See the June 4, 1992 proposed rule (57 FR 23618 and 23634) and the September 1, 1992 final rule (57 FR 39746 and 39769).)

We will consider this issue further and whether future rulemaking is warranted to address this situation.

I. Payment for Direct Graduate Medical Education (§ 413.79)

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 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 a 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 portions of 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, in the FY 2006 IPPS proposed rule, we proposed 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 or transitional year training program.

We noted 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 did not propose 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 proposed 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.

Comment: Several commenters commended and supported our proposal to revise the current regulations to state that a resident who initially matches only to an advanced program without simultaneously matching to a clinical base year program will have his or her IRP determined based on the number of years required for the advanced program. A number of commenters suggested that we implement a standard second-year policy in which the resident's IRP would always be based on the specialty that a resident enters in his or her second year of training, regardless of what occurred during the residents first year of GME training. These commenters suggested that a ''second year'' policy would be less complicated, less administratively burdensome, and could be applied more universally, as many residents enter an advanced program in their second year of training without being involved in the match process. The commenters also added that this seems more consistent with legislative intent as stated in the Conference report language accompanying section 712 of Pub. L. 108–173. That language states that ''the initial residency period for any residency for which the ACGME requires a preliminary or general clinical year of training is to be determined the resident's second year of training.''

Response: We appreciate the commenters' support for our proposal. However, we do not agree with the comment that we should revise the regulations and establish a ''second year'' policy for determining the IRP for residents. As we indicated in the FY 2005 IPPS final rule (69 FR 49171), we considered proposing a change in policy to determine the IRP for a resident who participates in a clinical base year program based on the specialty associated with the resident's second year of training as suggested by the Conference Committee language. We ultimately rejected this policy because we believe that, if we were to establish a ''second year'' policy, there would be no way to distinguish between those residents who matched to a specialty program for a second year of training prior to beginning their first year of training, and those residents who simply switched specialties in their second year. Because section 1886(h)(5)(F) of the Act provides that the IRP must be determined ''as of the time the resident enters the residency training program,'' we believe the IRP needs to be determined based on the ''initial'' or first program in which a resident trains. Thus, we are not adopting the commenters' suggestion that we ignore the specifics of the first year of training and wait to establish the ''initial'' residency period based solely on the program in which the resident is training during his or her second year. The policy advocated by the commenter would lead us to establish the IRP based on the period of board eligibility for a specialty training program the resident entered in the second year even where the resident had clearly switched specialties in the second year. We do not believe this would be consistent with legislative intent.

Comment: Some commenters stated that a resident who enters into a transitional year program or a preliminary training year program in an internal medicine residency should be assigned an IRP based on the program that the resident enters in his or her second year of training, since such a resident could never receive certification from his or her clinical base year of training.

Response: In the FY 2005 rule, we finalized an IRP policy stating that for a resident that matches in a clinical base year program and simultaneously matches in a specialty training program, Medicare will use the period of board eligibility of the specialty training program to determine the resident's IRP. In this final rule, we are revising our policy to state that the IRP for a resident who initially matches, prior to beginning any residency training, only to an advanced program without simultaneously matching to a clinical base year or transitional year program, will have his or her IRP determined based on the period of board eligibility for the advanced program.

In the limited circumstance where a resident trains in the transitional year program without matching in a specialty

program for the second year, we would, in fact, establish the IRP in the second year of the resident's training because there is no specialty associated with transitional year programs, and even though the resident would have ''entered'' a residency training program, we would be unable to identify any specialty with the transitional year program for purposes of determining the IRP. Because training in a transitional year program cannot lead by itself to certification in any specialty, the earliest that Medicare is able to determine such a resident's IRP is when the resident ''enters'' a specialty program in the resident's second year of training. Thus, in the limited circumstance of a resident that trains in a transitional year program without having matched into a specialty program that begins in the second year, we believe it is necessary, and therefore appropriate, to look to the resident's second year of training to identify the specialty that should be used for the purpose of determining the IRP.

We note that the situation of the resident in the transitional year program is substantially different from the situation where the resident begins training in other preliminary year programs, such as internal medicine. In the case of preliminary year programs, there is a specialty associated with the training, and we could, therefore, establish an IRP based on the period of board eligibility for that program. Therefore, it would not be necessary for us to wait until the second year to establish the resident's IRP. Under the policy revision we proposed, the IRP for a resident that enters a preliminary year in internal medicine and continues training in an advanced specialty is established based on the period of board eligibility for the advanced specialty if the hospital documents that the resident had matched to the advanced specialty program *prior* to commencement of any residency training. Without such documentation, as mentioned before, CMS would have no way to distinguish between those residents who matched or planned to train in a particular advanced specialty program prior to entering their first year of training in an internal medicine or other ''preliminary year,'' and those residents who simply switched specialties in their second year.

Comment: One commenter noted that we indicated in the proposed rule that this proposal best reflects our original intent in revising the IRP rule effective October 1, 2004, and recommended that we clarify our current proposal to also be effective October 1, 2004.

Response: As stated in the proposed rule, we were ''proposing to revise § 413.79(a)(10)'' and that this is a ''policy change.'' While this policy change is similar to the policy change we made last year regarding simultaneous matches, nevertheless it is a change in policy. Accordingly, the change will not be effective October 1, 2004, but rather the effective date for the final policy change in this final rule is for portions of cost reporting periods occurring on or after October 1, 2005.

Comment: One commenter requested clarification as to what type of documentation would be needed to demonstrate that a resident matched to the advanced residency prior to beginning any training program. The commenter was concerned that there may be confusion during audits if no documentation standard was established. In particular, the commenter mentioned that, although it is fairly easy to acquire such documentation from the National Resident Matching Program (NRMP), it is harder to acquire such documentation from the San Francisco Matching Program. This commenter requested that we identify documentation from the San Francisco Matching Program that would be consistent with the NRMP documentation.

Response: As we understand it, the San Francisco Matching Program sends letters to providers indicating which residents matched into which specialty programs. This letter would be sufficient documentation to show that, prior to beginning any residency training program, a resident matched into an advanced program for the second residency year.

Comment: Two commenters requested clarification and provided recommendations on issues relating to residency training programs that were not addressed in the proposed rule.

Response: Because we did not propose any changes in policy concerning the issues addressed by the commenters in the FY 2006 IPPS proposed rule, we are not responding to those issues in this final rule.

Comment: One commenter noted that CMS did not mention which PRA would be applied to a resident training in his or her clinical base year versus which PRA would be applied once that resident enters his or her second year of training.

Response: We believe it is appropriate to finalize a policy that treats residents consistently in terms of the specialty program in which they are considered to be training. For this reason, we are finalizing our proposal from the FY 2006 proposed rule that for a resident who initially matches only to a specialty program, to begin in the resident's second year of training, without simultaneously matching to a clinical base year or transitional year program, the IRP is established in the resident's first year of training based on the period of board eligibility associated with the specialty program, that is, the program in which the resident will seek certification. Because those specialties that require a clinical base year are not primary care specialties, the specialty that the IRP is based on in the first year of training would be a non-primary care specialty. We believe it is only consistent to apply the non-primary care PRA during the first clinical base year of training as well.

Comment: One commenter suggested that residents training in their clinical base year should be assigned a Med School number of 8888 for IRIS diskette purposes. The commenter indicated that this would be similar to foreign residents who are currently identified with a 9999 Med School number on the IRIS diskette.

Response: In implementing this policy change, we will consider within CMS the need for and possibility of implementing such a change to the IRIS diskette.

Comment: One commenter requested clarification on how the IRP would be determined for a resident who, at the end of his or her clinical base year, decides to enter a different subspecialty that does not require a clinical base year.

Response: Medicare establishes the IRP based on the specialty associated with the program that the resident ''enters'' in his or her first year of training (unless, prior to beginning any training program, the resident matches to an advanced specialty program for the second year of training, in which case the IRP is based on the specialty program). The resident retains this IRP for the remainder of his or her residency training, even if the resident decides later to train in a different specialty training program. Therefore, consider, for example, a resident who matched prior to beginning any residency training to a radiology program that would begin in the second residency year. The resident then completes training in an internal medicine clinical base year program, and decides that instead of continuing into the radiology program, he or she will continue training in the internal medicine program. Under our policy, the IRP for this resident would have already been established in the first year of training at 5 years, based on the period of board eligibility for radiology. Thus, even after

the resident decides to continue training in internal medicine, the resident would maintain the IRP that was established in the first year of training.

After consideration of the comments received, we are adopting as final, without modification, our proposal to revise § 413.79(a)(10) to indicate that, when a hospital can document that a resident matched prior to commencement of any residency training in an advanced residency training program beginning in the second residency year, 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.

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 26336), 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 discussion 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).

In the FY 2006 IPPS proposed rule, we proposed 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 the 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 proposed 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 proposed 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 specifically solicited comments on the proposed change.

We would like to clarify a statement made at 70 FR 23440 of the FY 2006 IPPS proposed rule in which we state, ''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)'' (emphasis added). The sentence could be read to mistakenly imply that the new teaching Hospital A is not permitted to affiliate only once its cap becomes effective beginning with the fourth program year of the new program. In fact, the new teaching Hospital A cannot affiliate from the time it begins training residents in the newly accredited program(s).

Comment: Numerous commenters agreed with the proposed policy change to allow new urban teaching hospitals to enter into a Medicare GME affiliation agreement if the adjustment results in an increase in their direct GME and IME caps. Some of the commenters stated that the proposal allows new urban teaching hospitals the flexibility to start new teaching programs without ''jeopardizing their ability to count additional FTE residents training at the hospital under an affiliation agreement.'' These commenters stated that an increase in Medicare payments received by the new urban teaching hospital when residents from existing teaching hospitals rotate to the new urban teaching hospital is necessary to cover both direct and indirect costs incurred ''to train the 'in rotating' residents from other hospital teaching programs.''

Response: We appreciate the comments in support of our proposal to allow for new urban teaching hospitals to join a Medicare GME affiliated group if, under the agreement, there is a positive increase to the FTE cap of the new teaching hospital. We agree that our proposal will allow new urban teaching hospitals greater flexibility in starting new teaching programs without endangering their ability to train other FTE residents from existing programs under an affiliation agreement.

Comment: One commenter urged CMS to consider ''replacing the permanent exclusion of negative adjustments for new urban teaching facilities with a temporary exclusion for the first 3 to 5 years.'' The commenter believed that such a replacement would permit new urban teaching facilities flexibility similar to that allowed for new rural teaching facilities and allow for adjustments due to ''unforeseen future circumstances.''

Response: We disagree with the commenter's suggestion. We continue to be concerned that hospitals with existing medical residency training programs could affiliate with a new teaching hospital to circumvent the statutory FTE caps by establishing new programs at the new teaching hospital, and move the additional FTE slots to its own hospital, thus receiving an upward adjustment to its FTE caps. For this reason, we limited our proposal 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 cap.

Comment: One commenter believed CMS's proposal to permit an affiliation agreement as long as it results in an increase in the new teaching hospital's resident cap is a ''positive'' change but stated that the proposal does not address the issue that ''all teaching programs must meet specific teaching requirements'' and often need to rotate residents to other facilities in order to meet those requirements. The commenter believed that, because the ''used'' portion of the teaching hospitals' direct GME and IME FTE resident caps were reduced by 75 percent in accordance with section 422 of Pub. L. 108–173, new teaching facilities may have difficulty finding a hospital that will accept their residents for the necessary rotations without an affiliation agreement. The commenter believed that, unless it could aggregate its FTE resident limit with other hospital(s) through a Medicare GME affiliation agreement, it may become necessary for the new teaching hospital to pay for training the residents in the new program at another hospital in order for another hospital to agree to provide a training site for the residents. The commenter suggested CMS revise the regulations to allow new teaching hospitals to join an affiliated group and allow for a cap decrease as long as the new teaching facility can document that, at a minimum, 75 percent of the total training hours for each resident was completed at the new teaching facility, and no more than 25 percent of training was done at another hospital site during the cost report period.

Response: We disagree with the commenter's suggestions. We continue to be 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 some of the new residency program to its own hospital, thereby receiving an upward adjustment to its FTE caps. For this reason, we limited our proposal 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 a Medicare GME affiliation agreement that would produce a negative adjustment to its FTE cap,

Comment: Several commenters requested that CMS consider ''broadening its proposed changes to the affiliation agreement requirement.'' The commenters believed that CMS' concerns regarding possible gaming are unnecessary and therefore the policy is ''too restrictive.'' The commenters indicated that hospitals do not decide to become teaching hospitals and become involved with the accreditation process with the intention of ''gaming'' the system. The commenters stated that CMS has not provided any evidence ''that this type of gaming has ever

occurred.'' The commenters further asserted that, in imposing restrictions on affiliation agreements for new urban teaching hospitals to prevent gaming, CMS has not considered the safeguards that are already in place to avert gaming. They added that the ''intensive process'' of accreditation by an appropriate accrediting body is one of the several existing safeguards against gaming. The commenters believed that an additional safeguard against gaming is the requirement that a hospital ''must maintain its new program for a period of three years before it qualifies to receive a permanent FTE cap.'' Referring to the previous sentence, the commenters believed that ''establishing a program requires concerted action by staff throughout a facility, which actions must be sustained for a subsequent period of time. It is unlikely that many institutions would undertake such action merely to help another hospital to obtain a purported improper gain in its GME payment.'' The commenters stated that additional protection against gaming is provided through changes CMS has made over time to affiliation agreement requirements. They gave as an example of such changes to affiliation agreement requirements the requirement that there be ''a bona fide shared rotational arrangement between two hospitals as a pre-condition to entry into an affiliation agreement.''

The commenters asserted that CMS' affiliation agreement policy could have a negative impact on medical education. The commenters stated that, due to circumstances that are unforeseen, a hospital may need to shift a group of residents to another hospital in its affiliated group. The commenters believed that CMS would penalize the receiving hospital for circumstances beyond its control by disallowing the receiving hospital to increase its FTE cap ''through a shift of a portion of the new teaching hospital's FTE cap.'' The commenters believed that this lack of flexibility will ''discourage parties from entering into affiliation agreements with new teaching hospitals because of the fear of adverse financial implications arising from unforeseen circumstances.'' The commenters requested that CMS reconsider the policy to allow a new teaching hospital to enter into affiliation agreements only when they result in an increase in the new hospital's FTE cap.

Response: We appreciate, but disagree with, the commenter's views. Despite the commenters' examples of safeguards against gaming, we continue to be 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 FTE slots to its own hospital, thus receiving an upward adjustment to its FTE caps. In order to prevent the artificial expansion of the aggregate FTE limits for all teaching hospitals that could otherwise result, we proposed a limited revision to § 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 a Medicare GME affiliation agreement that would produce a negative adjustment to its FTE resident cap.

We would also like to clarify, from an operational perspective, what a Medicare GME affiliation agreement would look like between an existing urban teaching hospital with a 1996 cap and a new urban teaching hospital that is receiving a permanent cap adjustment for a newly approved program. Because, under § 413.79(e)(1)(ii), the new teaching hospital does not have permanent FTE caps within the first 3 years of the new program's existence, the new teaching hospital would affiliate with its FTE caps of zero. That is, the affiliation agreement between the new teaching hospital and the existing teaching hospital would show a positive adjustment to the new teaching hospital's 1996 FTE cap of zero. However, once the FTE caps have been permanently established beginning with the fourth program year of the new program's existence, the affiliation agreement between the new teaching hospital and the existing teaching hospital would show a positive adjustment to the new teaching hospital's adjusted cap resulting from the new program(s).

Comment: One commenter urged CMS to make the provision allowing new urban teaching hospitals to enter into affiliation agreements only if there is an increase in direct GME and IME cap(s) ''effective for affiliation agreements entered into on or after October 1, 2005, and be noted in the final rule.''

Response: Although this final rule generally takes effect on October 1, 2005, because hospitals must affiliate by July 1 of a given year, as a practical matter, the new policy will be effective for affiliation agreements entered into on or after July 1, 2006, which is the first academic year that new teaching hospitals could affiliate under these new rules.

Comment: Two commenters requested clarification and provided recommendations on topics not addressed in the proposed rule. One commenter requested guidance on how the increases in FTE resident limits under section 422 of Pub. L. 108–173 would be applied. On a different subject-matter, the commenter recommended that we perform an analysis to determine the validity of the Council on Graduate Medical Education's recommendations that CMS gradually increases its resident caps in the face of a possible physician shortage in the future. Another commenter requested clarification on how CMS would treat two affiliation agreements for payment purposes where Hospital A, Hospital B, Hospital C, and Hospital D agree to affiliate and then Hospital D and Hospital E enter into a separate affiliation agreement that specifically states the agreement's intent not to include Hospital E as part of the agreement between Hospitals A, B, C, and D.

Response: In the FY 2006 IPPS proposed rule, we did not propose any changes that are specific to these comments. Therefore, we are not responding to them at this time.

In this final rule, we are adopting as final, without modification, our proposal 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. This provision is effective for affiliation agreements entered into on or after October 1, 2005.

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 affect 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, as we proposed in the FY 2006 IPPS proposed rule, we are clarifying in this final rule our policy that hospitals that became urban in FY 2005 due to the new labor market areas will 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. As we proposed in the FY 2006 IPPS proposed rule, we are adding a new paragraph (k)(7) to § 413.79 to incorporate this policy.

Comment: Several commenters commended CMS and supported our proposal to revise the current regulations that would allow a rural hospital redesignated as urban as a result of the changes to CBSAs that were effective on October 1, 2004, to retain any adjustment that it received as a rural hospital.

Response: We appreciate the commenters' support of our proposal.

Accordingly, in this final rule, we are adopting the proposal as final without modification.

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. As we proposed in the FY 2006 IPPS proposed rule, we are providing that, effective with discharges occurring on or after October 1, 2005, a different policy applies 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 final rule, we are correcting 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. In this final rule, we are correcting 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

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, in the FY 2006 IPPS proposed rule, we proposed 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 policy, 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.

Comment: Two commenters supported the proposed change but did not comment in further detail on it.

Response: We appreciate the commenters' views and have taken them into consideration in developing the final rule.

Comment: One commenter recommended that the final rule be revised to state that the inclusion of rural health clinics affiliated with hospitals having 50 or more beds in § 413.65(a)(1)(ii) is effective for cost reporting periods beginning on or after October 1, 2005.

Response: Although rural health clinics affiliated with hospitals having 50 or more beds were not previously specifically listed in § 413.65(a)(1)(ii), it has been CMS' general policy that determinations under § 413.65 are not made for facilities or organizations if the outcome of the determination would not have any effect on the amount of Medicare payment or on the scope of benefits or liability of Medicare beneficiaries. Under this general policy, we believe that such determinations have historically not been made for such clinics, and, therefore, we view this revision to § 413.65 (a)(1)(ii) as a clarification of existing policy and not as the announcement of a new policy for which an effective date must be specified. Therefore we have not made any changes to § 413.65 (a)(1)(ii) based on this comment. The general effective date for this final rule is October 1, 2005.

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 a 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, in the FY 2006 IPPS proposed rule, we solicited specific public comment on the following question:

• Is the problem as described above actually occurring and, if so, in what locations? We were 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.

Comment: One commenter stated that it is aware of only one hospital in its State that is in the situation described above. Another commenter echoed the same comment and stated that it is not aware of any other children's hospital with off-campus NICU services in host hospitals more than 35 miles from the main campus of the children's hospital. Another commenter indicated that it is aware of only one hospital in the country that is in the situation described above.

Response: We appreciate the information provided by these commenters and have taken it into account in developing the final rule set forth below.

We also asked those who believed 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 solicited specific comments were:

• 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.

Comment: Two commenters stated that this option, that of providing a more generous mileage allowance for NICUs for which provider-based status is sought, would not fully account for the appropriate provision of crucial services in underserved areas. Two other commenters noted that a mileage allowance of 50 miles would not accommodate both current and proposed off-campus NICUs. Thus, these commenters recommended that this option not be adopted.

Response: We understand and have considered the concerns of these commenters. However, for the reasons set forth below, we are adopting as final an approach under which a NICU seeking provider-based status that is unable to meet existing location criteria can be located up to 100 miles from the main provider, as long as it meets certain other requirements described in detail below.

• 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.)

Comment: Several commenters supported this option, stating that it would be the most effective in ensuring access to crucial services in underserved areas.

Response: We understand and have considered the views of these commenters. However, we believe this final rule is not the appropriate vehicle for such a change to the national Medicaid regulations. As stated earlier and for the reasons set forth below, we are adopting as final the approach proposed for public comment as Option 1, with some modification.

• A change in an individual State's Medicaid plans that would provide enhanced financial incentives for community hospitals to establish NICUs, possibly in collaboration with children's hospitals.

Comment: Two commenters expressed disapproval of this option, stating that a change in State Medicaid plans would be too difficult for individual hospitals to achieve. Two other commenters noted that discussions with State Medicaid officials have indicated that changing the State Medicaid plan is not a feasible option in that State.

Response: We understand the concerns of these commenters and, after further review of this option, have decided not to adopt it in this final rule.

• 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.)

Comment: Two commenters expressed disapproval of this option, stating that it would be unrealistic to expect 6 to 8 bed facilities to operate as separate hospitals because they would then not have the support of a full-service children's hospital. Two other commenters noted that operating these NICUs as separately certified hospitals located within the community hospitals would result in a reduced level of Medicaid DSH funding to the main

hospital under Medicaid rules in that State.

Response: We understand the concerns of these commenters and, after further review of this option, have decided not to adopt it in this final rule.

We also solicited suggestions for specific options other than those listed above but did not receive any specific recommendations regarding alternative approaches to the NICU issue.

After consideration of the comments received on the four options we offered for comment, we have decided to adopt Option 1, but to modify it by specifically requiring a NICU that is seeking provider-based status but is unable to meet existing location criteria to qualify for provider-based status only if the facility or organization meets all of the following requirements:

• The facility or organization meets the criteria for identifying intensive care type units as set forth in the Medicare reasonable cost reimbursement regulations at § 413.53(d), and as further explained in section 2202.7 II.A. of the Medicare Provider Reimbursement Manual (CMS Pub. 15–1). Generally, these criteria state that an intensive care type unit must—

—Be located in a hospital;
—Be physically and identifiably separate from general routine patient care areas;
—Have specific written policies that include criteria for admission to, and discharge from, the unit;
—Have registered nursing care available on a continuous 24-hour basis with at least one registered nurse present in the unit at all times;
—Maintain a minimum nurse-patient ratio of one nurse to two patients per patient day; and
—Be equipped with, or have available for immediate use, life-saving equipment needed to treat the critically ill patients for which the unit is designed.

• The facility or organization accepts only patients who are newborn infants who require intensive care on an inpatient basis.

• The hospital that is the potential main provider meets the criteria in § 412.23(d) for reimbursement under Medicare as a children's hospital.

• The hospital in which the facility or organization is physically located is in a rural area as defined in § 412.64(b)(1)(ii)(C).

• The facility or organization is located within a 100-mile radius of the children's hospital that is the potential main provider.

• The facility or organization is located at least 35 miles from the nearest other NICU.

• The facility or organization meets all other requirements for provider-based status under § 413.65.

We took several factors into account in adopting these final rules. By requiring compliance with existing Medicare requirements for intensive care-type units, we can ensure that only qualified NICUs are considered under this new provision, while at the same time not imposing any added burden on existing NICUs. The rural location requirement is consistent with the description of these facilities as being located in rural areas. The enhanced mileage allowance (100 miles) takes into account the comments of those who stated that a 50-mile standard would be overly restrictive, but nevertheless establishes a clear location standard for the NICUs to meet. We believe the 100-mile criterion will sufficiently address the two currently operating remote NICUs that commenters identified. The complementary requirement for a minimum separation of at least 35 miles should help to ensure that hospitals in which the remote NICUs are located are not currently adequately served by another NICU. The requirement that the facility or organization accept only patients who are newborn infants who require intensive care on an inpatient basis will ensure that facilities or organizations are able to take advantage of the more generous mileage allowance only if they are dedicated to the care of neonates.

These criteria are set forth in new § 413.65(e)(3)(v) of this final rule.

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 proposed 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.

Comment: One commenter suggested that the text of paragraph (a)(2) be revised to state that the change described above is effective with respect to determinations made on or after October 1, 2005.

Response: The general effective date for this final rule is October 1, 2005. Therefore, the commenter is correct in understanding that this change will apply to determinations made on or after that date, and this policy will be communicated to all CMS staff involved in provider-based determinations. However, we believe it could be confusing to readers if we were to specifically revise the definition of ''provider-based entity'' in § 413.65(a)(2) to specify an effective date for this change since the word ''name'' will no longer appear in the definition. Therefore, we are not making any changes in the final rule based on this comment.

We received no other comments on this proposed technical revision, and after consideration of the comment summarized above, we are adopting the revision as final without change in this final rule.

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 proposed to revise paragraph (b)(3)(ii) by removing the reference to compliance with requirements in paragraph (f) for joint ventures. We also proposed 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.

We did not receive any comments on this proposed revision and are adopting it without change in this final rule.

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 proposed 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 also proposed, 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).

We did not receive any comments on this proposed revision and are adopting it without change in this final rule.

d. *Additional requirements applicable to off-campus facilities or organizations—Location.* We proposed 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 proposed to correct this error by redesignating existing paragraph (e)(3)(ii)(C) as paragraph (e)(3)(iv). We also proposed 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 proposed to revise the opening sentence of § 413.65(e)(3) to reflect the changes in the coding of this paragraph as described above.

We also proposed 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.

Comment: Regarding our proposal to revise the opening sentence of paragraph (e)(3) of § 413.65 for clarity, one commenter stated that our proposed language did not clarify whether a facility or organization not located on the campus of the prospective main provider is required to meet all of 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 as well as the requirements in paragraph (e)(3)(vi) of § 413.65 or only any one of the requirements in paragraphs (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 as well as the requirements in paragraph (e)(3)(vi). The commenter requested that we clarify that a facility or organization that is located within a 35-mile radius of the campus of the prospective main provider is not also required to meet the requirement in proposed paragraphs (e)(3)(ii), (e)(3)(iii), (e)(3)(iv), or, in the case of an RHC, paragraph (e)(3)(v).

Response: The commenter's understanding of this requirement is correct: a facility or organization that meets the 35-mile requirement in proposed paragraph (e)(3)(i) would not also be required to meet the criteria in proposed paragraphs (e)(3)(ii), (e)(3)(iii), (e)(3)(iv), or, in the case of an RHC, paragraph (e)(3)(v). Because we did not receive other comments expressing concern about the meaning of this paragraph, we have not included any further revision of it in this final rule. However, we understand the commenter's concern and will issue clarifying instructions or educational materials in the future if there is evidence of misunderstanding of this paragraph.

After consideration of all of the comments received on these proposed revisions, we are adopting them with only two changes in this final rule. Because we are adding a new paragraph (e)(3)(v) to § 413.65 (see section V.J.3. of this preamble) that sets forth new provider-based requirements for NICUs located in rural areas, we are redesignating certain provisions of paragraph (e)(3) and are making appropriate changes in the references to proposed paragraphs (e)(3)(v), (e)(3)(vi), and (e)(3)(vii) to accommodate this addition. In addition, to provide a reference to the definition of ''rural'' applicable to Federal fiscal years 2005 and subsequent fiscal year for purposes of paragraph (e)(3), in § 413.65(e)(3)(v) (redesignated by this final rule as section 413.65(e)(3)(vi)), we are removing the reference to § 412.62(f)(1)(iii) and replacing it with a reference to § 412.64(b)(1)(ii)(C). We are also making a technical, clarifying change to paragraph (e)(3)(i) of § 413.65 by replacing the reference to section 1886(e)(5)(F)(i)(II) of the Act with section 1886(d)(5)(F)(i)(II) of the Act, which is the statutory basis for § 412.106(c)(2). Additionally, for consistency with the language of section 404(b)(2)(B) of Pub. L. 106–554, we are making a clarifying change in paragraph (e)(3)(ii) by revising the phrase ''and is described in § 412.106(c)(2) of this chapter'' to read ''or is described in § 412.106(c)(2) of this chapter''.

e. *Paragraph (g)—Obligations of hospital outpatient departments and hospital-based entities.* We proposed 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 proposed to reorganize the subsequent paragraphs of that section for clarity.

Comment: Two commenters expressed approval of this proposal, stating that it would improve general understanding of the provider-based requirements for off-campus facilities and organizations.

Response: We appreciate the support of the commenters and have taken it into account in developing this final rule.

After consideration of all comments received on this proposed revision, we are adopting it without change in this final rule.

K. Rural Community Hospital Demonstration Program

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, as we proposed in the FY 2006 IPPS proposed rule, we are adjusting 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, the estimated adjusted amount is $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 payment rate adjustment that will be required to ensure the budget neutrality of the demonstration in section II.A.4. of the Addendum to this final 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.

We did not receive any public comments on the Rural Community Hospital Demonstration Program discussed in the proposed rule.

L. Definition of a Hospital in Connection With Specialty Hospitals

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 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, it has come to our attention that some entities that describe themselves as surgical or orthopedic specialty hospitals may be primarily engaged in furnishing services to outpatients, and thus might not meet the definition of a hospital as contained in section 1861(e) of the Act. Therefore, if we were to determine that a facility is not primarily engaged in inpatient care at the time it seeks certification to participate in the Medicare program as a hospital, its application for a provider agreement would be denied. Further, if we were to determine that a specialty hospital operating under an existing Medicare provider agreement 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 the whole hospital exception.

We received several comments concerning our observation in the FY 2006 IPPS proposed rule that some specialty hospitals may not meet the definition of a ''hospital'' contained in section 1861(e) of the Act. As we stated earlier, an institution must be ''primarily engaged'' in furnishing services to inpatients in order to be a ''hospital'' for purposes of participating in Medicare. We noted in the proposed rule that some specialty hospitals may be primarily engaged in furnishing care to outpatients. At least one commenter was under the impression that we were proposing to make changes in the regulations in the FY 2006 IPPS proposed rule to address the ''primarily engaged'' requirement of the statute. In fact, that was not our intention. Over the next several months, we plan to review our procedures for enrolling specialty hospitals in Medicare. During this review, we will examine whether specialty hospitals meet the definition of a ''hospital'' contained in section 1861(e) of the Act. Following such review, we may issue proposed rulemaking for comment concerning the definition of a ''hospital'' or other conditions of participation.

VI. PPS for Capital-Related Costs

In the FY 2006 IPPS proposed rule, we did not propose any changes in the policies governing the determination of the payment rates for inpatient 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 inpatient capital-related costs and the methodology used to determine capital-related payments to hospitals. A discussion of the rates and factors for FY 2006 (determined under our established methodology) can be found in section III. of the Addendum of this final 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 threshold 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 exception payment for extraordinary circumstances in § 412.348(f) can be found in the FY 2005 IPPS final rule (69 FR 49185 and 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 capital PPS Puerto Rico specific rate and 25 percent of the 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 capital PPS Puerto Rico rate and 50 percent of the capital PPS 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 capital PPS Puerto Rico rate and 75 percent of the capital PPS Federal rate for discharges occurring on or after October 1, 2004.

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

A. Payments to Existing Hospitals and Hospital Units (§§ 413.40(c), (d), and (f))

1. Payments to Existing Excluded Hospitals and Hospital Units

Historically, hospitals and units excluded from the PPS received payment for inpatient hospital services they furnished on the basis of reasonable costs, subject to a rate-of-increase ceiling. An annual per discharge limit (the target amount as defined in § 413.40(a)) was set for each hospital or hospital unit based on the hospital's own cost experience in its base year. The target amount was multiplied by the Medicare discharges and applied as an aggregate upper limit (the ceiling as defined in § 413.40(a)) on total inpatient operating costs for a hospital's cost reporting period. Prior to October 1, 1997, these payment provisions applied consistently to all categories of excluded providers (rehabilitation hospitals and units, psychiatric hospitals and units, long term care hospitals, children's hospitals, and cancer hospitals excluded from the IPPS). Payment for children's hospitals and cancer hospitals that are excluded from the IPPS continues to be subject to the rate-of-increase limits based on the hospital's own historical cost experience. (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.)

For the other three classes of excluded providers, rehabilitation hospitals and units, psychiatric hospitals and units, and LTCHs, payment provisions changed significantly for cost reporting periods beginning on or after October 1, 1997.

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 factor multiplied by 1.25.)

In addition, a new method of determining the payment amount for ''new'' excluded providers was established at § 1886(b)(7) of the Act. The law was applicable for three classes of excluded providers, rehabilitation hospitals and units, psychiatric hospitals and units, and LTCHs, with a first cost reporting period beginning on or after October 1, 1997. These ''new'' excluded providers would be paid the lesser of their net inpatient operating costs per case or 110 percent of the national median of target amounts for providers in its class, as adjusted for differences in wage levels and updated to the first cost reporting period in which the hospital receives payment, as implemented in the regulations at § 413.40(f)(2)(ii). For providers in one of the aforementioned classes of excluded providers that were not paid as such prior to October 1, 1997, a hospital specific target amount based on the hospital's own cost experience was no longer involved in the payment process.

We have received questions regarding the determination of a target amount for FY 2003 for certain existing hospitals and hospital units excluded from the IPPS, and 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, as we proposed in the May 4, 2005 proposed rule, we are making 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.

Comment: Two commenters submitted a comment regarding the proposed clarification of policy concerning the determination of a hospital's target amount as described in § 413.(c)(4)(iii) for the cost reporting period beginning on or after October 1, 2002. One of the commenters, in submitting two scenarios, asked CMS to affirm his understanding of the proposed clarification regarding the calculation of the target amount for cost reporting periods beginning on or after October 1, 2002. The first scenario involved a psychiatric unit that existed prior to FY 1998 (the first year of the 75th percentile limitation), and therefore, was subject to the provisions in § 413.40(c)(4)(iii) where the target amount is limited by the 75th percentile cap. The provider was paid the capped amount in FY 2002, and the fiscal intermediary used this capped amount, increasing it by the update factor to arrive at the provider's target amount for FY 2003. However, the commenter believed that the correct target amount for FY 2003 should be the hospital specific target amount, as determined in the base year and updated.

The second scenario involved a psychiatric unit that was established in FY 1999. In this case, as stated in the comment, the fiscal intermediary used the ''capped rate trended forward with the update factors as specified by CMS'' as the target amount for each year, including years subsequent to FY 2002. Based on the proposed clarification, the commenter believes that the higher hospital-specific target rate should be used for those cost reporting periods beginning in FY 2003 instead of the capped amount.

The second commenter stated that while there was a clarification of policy regarding the effective period for the 75th percentile cap on target amounts, CMS should also clarify that if a provider's target amount was limited to the capped amount in FY 2002, it is that capped amount that is updated for FY 2003.

Response: In order for us to clarify the applicability of the provisions of § 413.40(c)(4)(iii), we noted in the proposed rule that this subsection applied only for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002, for psychiatric hospitals and units, rehabilitation hospitals and units, and long term hospitals. During this time period, payment to existing (in operation prior to FY 1998) providers was limited by the 75th percentile cap, i.e., the provider would be paid 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, updated by the applicable market basket percentage. As we pointed out in the proposed rule, we had previously clarified how the target amount for FY 2003 was to be determined. In the FY 2003 final rule (67 FR 50103), we stated 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.'' The provisions of § 413.40(c)(4)(iii) are for a specific period of time and the provider's target amount for FY 2003 is determined by updating the target amount for FY 2002 (the target amount from the previous period).

The intent of our proposal to clarify the language in § 413.40(c)(4(iii) was to emphasize that because § 413.40(c)(4)(iii) was no longer applicable for cost reporting periods beginning on or after October 1, 2002, the target amount for FY 2003 is determined according to § 413.40(c)(4)(ii) which states that ''Subject to the provisions of paragraph (c)(4)(iii), 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 paragraph (c)(5)(ii) of this section apply.'' Therefore, if a provider was paid the cap amount in FY 2002, the target amount for FY 2003 would be the cap amount paid in FY 2002, updated to FY 2003 (that is, the target amount from the previous year increased by the applicable update factor).

The commenter who submitted the two examples showing how the target amount for FY 2003 should be determined misinterpreted the point of our proposed clarification. That is, in the first example, the commenter believed that because the 75th percentile cap provision had expired with FY 2002, that the FY 2003 target amount should be the hospital specific target amount (as determined in its base year), updated. This is incorrect. Once the 75th percentile cap provision in paragraph (c)(4)(iii) of § 413.40 expired, the target amount is then determined based on § 413.40(c)(4)(ii) which states that, ''* * * Subject to the provisions of 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 * * *'' Thus, under the requirements of § 413.40(c)(4)(ii), in this instance, the previous cost reporting period's target amount would be the capped amount increased by the applicable update factor to arrive at the target amount for FY 2003.

In the commenter's second example, the provider was established in FY 1999, thus, making it a ''new'' provider and therefore, subject to payment in accordance with § 413.40(f)(2)(ii) and not § 413.40(c)(4)(iii), which is the subject of our clarification. Section 413.40(f)(2)(ii) of the regulations state that, ''For cost reporting periods beginning on or after October 1, 1997, the amount of payment for a new psychiatric hospital or unit, a new rehabilitation hospital or unit, or a new LTCH that was not paid as an excluded hospital prior to October 1, 1997, is the lower of the hospital's net inpatient operating costs per case or 110 percent of the national median of the target amounts for the class of excluded hospitals and units (psychiatric, rehabilitation, or long-term care), as adjusted for differences in wage levels and updated to the first cost reporting period in which the hospital receives payment.'' This provision further states that the second cost reporting period for such providers is subject to the same target amount as in the first cost reporting period, that is, the first year payment amount is not updated for purposes of determining the payment amount for the second cost reporting period. With respect to the third 12-month cost reporting period for these new providers, the regulations at § 413.40(c)(4)(v) specify that the target amount is the payment amount from the second cost reporting period (the payment amount determined under § 413.40(f)(2)(ii)(A)), updated to the third cost reporting period. Thus, the commenter is incorrect that a hospital-specific target amount in a base year

should be used for cost reporting periods beginning in FY 2003 instead of the ''capped amount.''

We point out that, with the implementation of a payment limit for ''new providers,'' a hospital-specific target amount (base year cost per discharge updated) is not calculated. This is because, under the new provider limit, the amount of payment for the first two cost reporting periods (if less than a new provider's inpatient operating costs) is based on the 110 percent of the national median provision in § 413.40(f)(2)(ii). The second cost reporting period is subject to the same target amount as the first cost reporting period. For a new provider's third 12-month cost reporting period, the payment amount in the second cost reporting period is updated. We also note that, unlike § 413.40(c)(4)(iii) with the 75th percentile cap provision, the regulation for new providers at § 413.40(f)(2)(ii) is not time limited. While it has the same effective date as the 75th percentile cap provision (cost reporting periods beginning on or after October 1, 1997), it remains effective for cost reporting periods beyond FY 2002 to the extent a provider's payment or part of the payment is based on reasonable cost.

As we stated in the proposed rule, ''* * * 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.'' We believe that this more than adequately responds to the second commenter's concerns with regard to the determination of the target amount for FY 2003 and thereafter.

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, not paid as excluded hospitals prior to October 1, 1997), but were paid as LTCHs 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 under § 413.40(f)(2)(ii) 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 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 had the IPF PPS not been implemented. However, under § 412.426(c), 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 final 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 of new inpatient psychiatric facilities 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) and had their first cost reporting period beginning 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 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. As stated above, IPFs with a first cost reporting period beginning on or after January 1, 2005, are paid 100 percent of the Federal per diem payment amount; they are not subject to the payment amount limitation in accordance with § 412.426(c). 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, are 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 (§ 413.40(f)(2)(ii)) do not apply to those LTCHs or IPFs that have their first cost reporting period beginning on or after the date that the particular class of hospitals implemented their respective PPS, or for new IRFs that are paid under the IRF PPS. Therefore, for the reasons noted above, we are discontinuing the publication of 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 unit (referred to in the statute as rehabilitation facilities (IRFs)) 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 IRFs 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 inpatient 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 IRFs, 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 adjusted 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 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 whose first cost reporting periods began before January 1, 2005, 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, all IPFs will be paid 100 percent of the Federal per diem payment amount.

6. Report of Adjustment (Exceptions) Payments

Section 4419(b) of Pub. L. 105–33 requires the Secretary to publish annually in the **Federal Register** a report describing the total amount of adjustment payments made to excluded hospitals and units, by reason of section 1886(b)(4) of the Act, during the previous fiscal year.

The process of requesting, adjudicating, and awarding an adjustment payment is likely to occur over a 2-year period or longer. First, generally, an excluded hospital or excluded unit of a hospital must file its cost report for a fiscal year with its fiscal intermediary within 5 months after the close of its cost reporting period in accordance with § 413.24(f)(2). The fiscal intermediary then reviews the cost report and issues a Notice of Program Reimbursement (NPR) within approximately 2 months after the filing of the cost report. If the hospital's operating costs are in excess of the ceiling, the hospital may file a request for an adjustment payment within 180 days from the date of the NPR. The fiscal intermediary, or CMS, depending on the type of adjustment requested, then reviews the request and determines if an adjustment payment is warranted. This determination is often not made until more than 6 months after the date the request is filed. However, in an attempt to provide interested parties with data on the most recent adjustments for which we do have data, we are publishing data on adjustment payments that were processed by the fiscal intermediary or CMS during FY 2004.

The table below includes the most recent data available from the fiscal intermediaries and CMS on adjustment payments that were adjudicated during FY 2004. As indicated above, the adjustments made during FY 2004 only pertain to cost reporting periods ending in years prior to FY 2003. Total adjustment payments awarded to excluded hospitals and units during FY 2004 are $5,896,215. The table depicts for each class of hospitals, in the aggregate, the number of adjustment requests adjudicated, the excess operating cost over ceiling, and the amount of the adjustment payments.

Class of hospital	Number	Excess cost over ceiling	Adjustment payments
Rehabilitation	3	$825,008	$129,529
Psychiatric	11	7,491,268	2,628,817

Class of hospital	Number	Excess cost over ceiling	Adjustment payments
Long-Term Care	3	3,348,078	2,570,034
Children's	1	99,942	58,825
Cancer	.....	.....	.....
Religious Nonmedical Health Care Institution	13	1,317,098	509,010

B. Critical Access Hospitals (CAHs)

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 currently at § 485.610 further define ''rural area'' for purposes of being a CAH. Under the current regulations at § 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 § 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 § 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 § 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.

Prior to the issuance of the FY 2006 IPPS proposed rule, we received comments that suggested 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, as we discussed in the proposed rule, we proposed to clarify our policy with respect to facilities located in Lugar counties. The FY 2005 IPPS final rule already contained provisions allowing 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, in the proposed rule we stated our belief 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, it is appropriate for the CAH to be allowed a reasonable opportunity to reclassify to rural status. Thus, in the proposed rule, we stated that we would clarify our policy 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, were to be given the same reclassification opportunity under § 412.103. In other words, we proposed to revise § 485.610(b)(3) to allow CAHs in counties that were designated as Lugar counties effective October 1, 2004, to remain in compliance with the conditions of participation at § 485.610(b)(2) through a reclassification under § 412.103. In addition, consistent with the clarification of the policy, we proposed 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).

Comment: Several commenters supported our proposal to permit CAHs in newly designated Lugar counties to reclassify to be considered ''rural'' under the regulations at § 412.103.

Response: We appreciate the commenters' support and kept their views in mind in finalizing the proposed policy change in this final rule.

Comment: Several commenters disagreed with our proposed policy because they believed that the rules under which a facility can reclassify under § 412.103 do not sufficiently protect all facilities. They stated, for instance, that while rural referral centers, SCHs, and CAHs receive special consideration for purposes of reclassification, MDHs do not.

Response: We believe that addressing the reclassification regulations at § 412.103 in the context of the commenter's statements is outside of the scope of our proposed rule change. This is especially true for section 1886(d) hospitals, such as MDHs, which are subject to the statutory provisions for Lugar status under section 1886(d)(8)(B) of the Act. Our proposal dealt only with CAHs and did not include any proposal

to change the way in which other facilities, such as subsection 1886(d) hospitals, are treated. Consequently, we are not making any change to the final rule based on this comment.

Comment: Several commenters believed that the process to reclassify under § 412.103 is burdensome and unnecessary because, in their view, the Secretary has the authority to allow a facility to opt out of the reclassification under section 1886(d)(5)(I)(i) of the Act.

As an alternative to our proposal, the commenters suggested that CMS allow hospitals that are disadvantaged by the Lugar reclassification to waive or reject the reclassification. One of the commenters suggested that waiver of Lugar status be allowed during a limited time period. In support of their recommendation, the commenters stated that CMS currently allows hospitals to waive other geographic reclassifications during a defined period. Several commenters pointed out that the Lugar provision was intended to help many rural hospitals and not disadvantage the few facilities that were more benefited by participating in a rural facility program.

Response: While we understand that Lugar designation affects hospitals as well as CAHs, we do not believe it is within the scope of our proposed rule to address changes in the way CMS treats hospitals in Lugar counties. Therefore, we considered this comment and are responding to it only insofar as it relates to CAHs in Lugar counties.

We considered the commenters' concerns that reclassification under § 412.103 is unnecessarily burdensome. In light of the stated concerns, we revisited the statutory requirements under sections 1820(c)(2)(B)(i) and 1886(d)(8)(B) of the Act and the regulatory requirements of § 485.610. Section 1886(d)(8)(B) of the Act defines the conditions under which a county is considered ''Lugar.'' The statute specifically states that ''(f)or purposes of this subsection, the Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in (a) urban metropolitan statistical area. * * *'' CAHs do not fall under subsection 1886(d) of the Act. In addition, section 1820(c)(2)(B)(i) of the Act permits a facility to qualify for designation as a CAH only if it is located in a rural area as defined in section 1886(d)(2)(D) of the Act or in an area being treated as rural under section 1886(d)(8)(E) of the Act. Because section 1820(c)(2)(B)(i) of the Act does not include any reference to the Lugar provision (section 1886(d)(8)(B) of the Act), we do not believe that the statute requires CMS to treat a facility as being in an urban area for purposes of CAH participation because it is in a Lugar county.

While CAHs are not subsection 1886(d) hospitals, they are subject to the regulations at § 485.610, which reference the definitions of ''rural'' and ''urban'' at § 412.63(b) (for FYs 1985 through 2004). (For FYs 2005 and subsequent fiscal years, the implementing regulations are at § 412.64(b).) The regulations at § 412.63(b)(3) and § 412.64(b)(3) specify that a hospital in a Lugar county is urban in accordance with section 1886(d)(8)(B) of the Act. Accordingly, under the current regulations at § 485.610, CAHs in a Lugar county are considered under such regulations to be in an urban area. We believe these regulations maintained consistency throughout the program, and that it was permissible and appropriate to apply Lugar status (and, hence, urban status) to all facilities in those counties, including CAHs.

However, in light of the major revisions caused by the new OMB areas, our review of the statute, and in consideration of the commenters' concerns that the process for reclassification may create an unnecessary burden, we have concluded that it is appropriate in this final rule to amend the regulations at § 485.610(b)(1)(i) to remove all references to a facility being recognized as urban under the regulations implementing the Lugar provision (§ 412.63(b)(3) for FYs 1984 through 2004 and § 412.64(b)(3) for FY 2005 and subsequent fiscal years). The effect of this change is that, beginning in FY 2006, facilities in Lugar counties will be considered, for purposes of CAH participation, to be located in rural areas. In other words, the Lugar reclassifications under section 1886(d)(8)(B) of the Act will not be considered in determining whether a hospital is rural for purposes of section 1820 of the Act. As a result, CAHs will not need to submit an application for reclassification under § 412.103 to remain in compliance with the conditions of participation at § 485.610. We believe this change will achieve the result of our original proposal without increasing the administrative burden for CAHs or the Medicare program. We emphasize that this change will be effective only for purposes of CAH participation and will not otherwise affect the status of hospitals or CAHs in Lugar counties. In addition, section 1886(d) hospitals in Lugar counties will be considered to be in a rural area for purposes of applying for CAH status.

Accordingly, in light of the above, in this final rule, we are not adopting the proposed revisions to § 412.103(a)(4) and § 485.610(b)(1)(ii) that were included in the proposed rule. Instead, we are amending the regulations at § 485.610(b)(1) to remove paragraph (b)(1)(ii), which references a facility being recognized as urban under the regulations implementing the Lugar provision (§ 412.63(b)(3) for FYs 1984 through 2004. (As noted earlier, implementing regulations for the Lugar provisions are set forth at § 412.64(b)(3) for FY 2005 and subsequent fiscal years.)

In addition, as a technical conforming change, we are revising paragraph (b)(1)(i) of § 485.610 by removing the reference to § 412.62(f), which relates to FYs 1984 through 2004, and replacing it with a reference to § 412.64(b), excluding paragraph (b)(3), which relates to FY 2005 and subsequent fiscal years.

3. 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, in the FY 2006 IPPS proposed rule, we proposed 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 proposed that 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 indicated that 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 proposed 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, as noted previously, the language of section 1820(c)(2)(i) of the Act allowed a State to exempt the mileage requirement and designate such 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, was 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 the FY 2006 IPPS proposed rule, we proposed 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 proposed 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 proposed to use the specified relocation criteria as the initial step to determine continuing necessary provider status. Specifically, in the proposed rule, we proposed 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 offsite 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 was 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 solicited 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 proposed to revise § 485.610 of the regulations by adding a new paragraph (d) to incorporate this proposal. Specifically, under the proposed new paragraph (d) we specified 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. We proposed that a 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 also proposed 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.

We received approximately 150 timely pieces of correspondence commenting on the proposed policy change regarding CAHs with a necessary provider designation being able to relocate and maintain their necessary provider designation.

Comment: Most commenters opposed the proposed date restrictions that would require a CAH to have initiated relocation plans prior to December 8, 2003, and to notify the CMS Regional Office by January 1, 2006 of plans to relocate their facility.

Response: We have carefully considered the commenters' concerns regarding the proposed date requirement. Many commenters stated that the proposed date restrictions would force CAHs to continue to operate in outdated, inefficient facilities which could potentially put patients' safety at risk or to lose their necessary provider designation. As a result of our review and in light of the compelling argument presented by the commenters, we have decided not to adopt as final the date requirement as proposed. Under this final rule, we are allowing a necessary provider CAH to replace its facility at any time and maintain its necessary provider designation, provided it complies with the 75-percent criteria specified at § 485.610(d)(1).

Comment: Many commenters opposed the proposed distance restriction of 250 yards to qualify as a replacement facility. They stated that the 250 yards is arbitrary and will impede the progress

of health care. The commenters suggested that CMS should consider distances that ranged from 500 yards to 5 miles that would qualify a new CAH facility as a replacement facility and, therefore, be considered to be serving the same service area.

Many commenters agreed with the proposed 75-percent criteria (75 percent of the same service area, same services, and same staff) as a way to ensure that a necessary provider CAH will continue to provide access to care in its community. However, one commenter opposed the 75-percent criteria, stating that it is not reasonable and that necessary provider CAHs should be allowed to relocate based on the needs of the community.

Others commenters suggested that if a CAH moves further than 5 miles, then an approach similar to the 75-percent test could be used to ensure that a facility is serving the same population. One commenter suggested that a necessary provider CAH be allowed to relocate within 2 miles of the current location or within 5 miles of the current location, provided that the nearest hospital is more than 15 miles away.

Several CAHs cited issues of being land-locked and poor beneficiary access as examples of why it is not feasible to replace their facility on or adjacent to their current location. Several commenters highlighted the fact that being able to modernize their facilities in a new location will allow them to expand their services and gain a competitive edge with larger full service hospitals.

Response: After carefully considering the comments received, we have decided to modify proposed paragraph (d)(1) to state that a necessary provider CAH can relocate its facility and begin providing services at a new location, provided the necessary provider will be essentially the same facility in its new location. To help ensure that the facility is the same, we will require the relocated necessary provider CAH to provide at least 75 percent of its current services to 75 percent of the same service area with 75 percent of its current staff in its new location. This change effectively replaces the need to distinguish between replacement and relocated necessary provider CAHs. All new necessary provider CAH facilities that will be constructed after January 1, 2006, will be considered relocated facilities.

Based on our review of comments, we have determined that a mileage requirement would not effectively ensure access to care. Therefore, in this final rule, we are modifying paragraph (d)(1) as proposed to delete all distance restrictions to state that a necessary provider CAH can relocate its facility and provide services at a new location if the necessary provider is essentially the same facility in the new location.

Comment: A few commenters asked CMS to explain how the necessary provider CAH would demonstrate that it meets the 75-percent criteria.

Response: We will develop guidelines for the CMS Regional Offices and State agencies to utilize when evaluating compliance with the 75-percent criteria. One example could be to have the CAHs self attest that they meet the 75-percent criteria in all areas. CMS could follow up the attestation with an audit based on claims data. These data would identify the services that the CAH provides and their service area. CMS could conduct an audit at the end of the year when CMS settles the cost report (which also identifies the service area and services provided). To address the employee criterion, the CAH can provide a list of employees before and after the move. These are some examples of how CMS may evaluate compliance with the criteria and do not represent a final decision as to how the 75-percent criteria will be administered.

Currently, the CMS Regional Offices make the decision for continued certification following relocation of a certified facility on a case-by-case basis. We have not changed this policy. The criteria used to qualify a CAH as a necessary provider were established by each State in its MRHFP. The State, in its MRHFP, defined those CAHs that provide necessary services to a particular patient community. The State agencies and Regional Offices will closely monitor each necessary provider CAH that relocates to ensure that it will continue to provide services based on the criteria that qualified the CAH to be designated as a necessary provider.

The intent of the CAH program is to keep hospital-level services in rural communities, thereby ensuring access to care. We are revising the regulation to allow a necessary provider CAH to relocate its facility and to continue to ensure access to care in the community for which it was designated as a necessary provider. The intent of this policy change is not to improve the competitive edge of necessary provider CAHs with full service hospitals. CMS will monitor closely the effectiveness of this policy change on the CAHs and full service hospitals and, if necessary, will revisit this issue through future rulemaking.

Comment: A few commenters suggested that a CAH should be considered as a relocated facility if it constructs a new facility within the city or town limits.

Response: We do not believe that the use of city or town limits should be a criterion for determining if a necessary provider CAH has relocated its facility. We have heard from several CAHs that have special circumstances (landlocked, adjacent to a mountain, etc.) and, thus, would find it difficult to relocate within the town or city limits. We believe that the 75-percent criteria set forth in proposed paragraphs (d)(1) will better help to ensure that CAHs appropriately relocate their facilities.

Comment: A few commenters stated that flexibility in measuring demographics for a CAH should be allowed due to expected changes in the needs of the community.

Response: We believe that the three 75-percent criteria requirements will assist in ensuring continued access to care in the community for which the CAH was originally designated as a necessary provider. We also believe that it is not the responsibility of CMS to project future changes in demographics for a necessary provider CAH. We do believe that we are responsible for ensuring access to care under the current conditions for which necessary provider CAHs were granted their designations.

Comment: Several commenters suggested requiring a CAH to satisfy only three of five criteria for relocating. The commenters stated that, in addition to the staff, services and population measures, CMS should consider adding a needs assessment and cost comparison. The commenters further stated that if a CAH can show through a needs assessment that a change in services provided would be appropriate, the CAH should not have to comply with the requirement to provide 75 percent of the same services.

Response: We do not believe that it is necessary to add other requirements such as a needs assessment and a cost comparison to the criteria. We would expect a CAH, as part of its normal business practice, to compare the cost of building a new facility with renovating its current facility before making the decision to relocate. We continue to believe that the 75-percent rule for the services provided, staff, and service area allows sufficient flexibility to ensure continued access to care in the communities that are served by the necessary provider CAHs.

Comment: Several commenters suggested that we rescind the proposal and allow necessary provider CAHs to relocate as needed to meet the needs of their communities.

Response: We believe the revised policy does not interfere with any CAH's ability to serve the needs of its community. We further believe that it is prudent to establish consistent guidelines whereby necessary provider CAHs can continue to provide care to their service area and not violate the intent of the CAH program. We also believe that, by maintaining the percentage criteria, CAHs will be able to relocate appropriately and continue to serve their communities.

Comment: Several commenters chose to raise issues that are beyond the scope of the proposed rule concerning the CAH necessary provider policy.

Response: In this final rule, we are not summarizing or responding to those comments. However, we will review the comments and consider whether to take other actions, such as revising or clarifying CMS program operating instructions or procedures.

In this final rule, we are adopting the proposed new § 485.610(d), with modifications. We are removing the proposed distinction between a replacement and relocation of a necessary provider CAH. We are also eliminating the proposed distance requirement for replacing a facility. As a result, all CAHs that construct a new facility will be considered to have relocated and may be able to maintain the necessary provider designation if they meet the requirements of § 485.610(d)(l). In addition, we are eliminating the proposed date restriction.

VIII. Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

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 certain Medicare Part B drugs, 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. In accordance with the current regulations at Subpart K of Part 414, effective January 1, 2005, blood clotting factor under Medicare Part B is paid based on the lesser of 106 percent of ASP (that is, ASP+ 6 percent) or the actual charge.

To ensure consistency in payment for Medicare Part A and Medicare Part B drugs, in the FY 2006 IPPS proposed rule we proposed 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 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 proposed to apply under the IPPS for FY 2006 are specified in section V. of the Addendum to this final rule.

Comment: One commenter supported the proposal to pay for blood clotting factors consistently under Medicare Part A and Part B in FY 2006. The commenter pointed out that clotting factors are described in terms of International Units (IUs), and that one of the blood clotting factors is dosed in micrograms rather than IUs. The commenter stated that, under Medicare Part B, for the purpose of providing the $0.14 per unit furnishing fee, a single unit is equal to one microgram. In order to ensure consistency in payments for blood clotting factors, the commenter requested that CMS designate one microgram as one unit for the purpose of payment under the ASP methodology and for providing the furnishing fee to hospital inpatient providers.

Response: In the Medicare Claims Processing Manual (Pub. 100–4), Chapter 3, section 20.7.3, we instruct the fiscal intermediaries to report HCPCS code Q0187 (Factors viia recombinant) which is dosed 1.2 micrograms, based on one billing unit per 1.2 mg; that is, one billing unit per single dose.

In this final rule, we are adopting as final for FY 2006 that fiscal intermediaries make payment for blood clotting factor using ASP+ 6 percent and make payment for the furnishing at $0.14 per individual unit (I.U.) that is currently used for Medicare Part B drugs. This furnishing fee will be updated each calendar year in accordance with § 410.63.

IX. MedPAC Recommendations

We are required by section 1886(e)(4)(B) of the Act to respond to MedPAC's IPPS recommendations in our annual IPPS rules. 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 in MedPAC March 2005 Reports to Congress

1. Update Factor

MedPAC's Recommendation 2A–1 in the Report to Congress on Medicare Payment Policy concerning the update factor for inpatient hospital operating costs and for hospitals and distinct-part hospital units excluded from the IPPS is discussed in Appendix B to this final rule.

2. Quality Incentive Payment Policy

Recommendation 4A in the Report to Congress on Medicare Payment Policy: The Congress should establish a quality incentive payment policy for hospitals in Medicare.

In the FY 2006 IPPS proposed rule, we indicated that 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.

We did not receive any public comments on this recommendation.

3. Refinement of DRGs Based on Severity of Illness

Section 2A of the Report to Congress on Medicare Payment Policy (page 64) and Recommendation 1 in the Report to Congress on Physician-Owned Specialty Hospitals: 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 the FY 2006 IPPS proposed rule (70 FR 23454), we stated that we expected to make changes to the DRGs to better reflect severity of illness. We indicated that it was our plan to conduct a comprehensive review of the complications and comorbidities (CC) list as well as of the possibility of using the All Patient Refined (APR) DRGs for Medicare for FY 2007. The comprehensive review of the CC list is discussed in section II.B.12.b. of this preamble. We did not propose to adopt APR–DRGs for FY 2006 because it would represent a significant undertaking that could have a substantial effect on all hospitals. There was insufficient time to adopt a change of this magnitude through notice and comment rulemaking between the release of the MedPAC reports in March 2005 and the publication of the FY 2006 IPPS proposed rule for us to analyze fully a change of this magnitude. Nevertheless, we indicated that we planned to further consider all of MedPAC's recommendations.

As we indicated in section II.B.5.a. of this preamble, in response to the proposed rule, we received a comment noting that section 507(c) of Pub. L. 108–173 required MedPAC to conduct a study to determine how the DRG system should be updated to better reflect the cost of delivering care in a hospital setting. The commenter noted that MedPAC reported that the ''cardiac surgery DRGs have high relative profitability ratios.'' While the commenter noted that it may take time to conduct and complete a thorough evaluation of the MedPAC payment recommendations for all DRGs, the commenter strongly encouraged CMS to revise the cardiac DRGs through patient severity refinement as part of the IPPS final rule effective for FY 2006.

As a result of this comment, we performed an extensive review of the cardiovascular DRGs in MDC 5 (Diseases and Disorders of the Circulatory System), particularly those DRGs that are commonly billed by specialty hospitals. To begin our analysis, we considered whether the approach that is currently used for paired DRGs 121 and 122 (Circulatory Disorders With AMI With and Without Major Complication Discharged Alive, respectively) and paired DRGs 124 and 125 (Circulatory Disorders Except AMI With Cardiac Catheterization With and Without Complex Diagnosis, respectively) would have applicability to other DRGs in MDC 5. Currently, DRGs 121 and 122 are split based on whether the patient is diagnosed with a ''cardiovascular complication.'' DRGs 124 and 125 are split based on whether the patient has a ''complex diagnosis.'' There is some overlap between the lists of cardiovascular complications and complex diagnoses. The lists are used to segregate patients into DRGs that use greater resources. Because the hospital industry is familiar with the major complication and complex diagnosis lists used within the cardiovascular DRGs, we began our analysis with these two overlapping lists.

These two lists were originally developed for the current DRG system because they contained conditions that could have an impact on the resources needed to treat a cardiovascular patient. Many of them are cardiovascular diagnoses and, therefore, would be classified to MDC 5. However, we have determined that some of the diagnoses are not cardiovascular, but would still have an impact on a cardiovascular patient. The conditions that are not cardiovascular diagnoses would not be assigned to MDC 5 if they were the principal diagnosis. An example would be code 430 (Subarachnoid hemorrhage). If code 430 were the principal diagnosis, the condition would be assigned to MDC 1 (Diseases and Disorders of the Nervous System). However, we have determined that this condition, if present as a secondary diagnosis, would be a major complication for a patient with a principal diagnosis of AMI included in DRG 121. For a case to be assigned to either DRG 121 or DRG 124, the cardiovascular complication or complex diagnosis can be present as either a principal diagnosis or a secondary diagnosis. We retained this logic for our approach to identifying more severe cases in our focused review of the cardiovascular DRGs.

Our clinical advisors reviewed the conditions on the two overlapping lists and identified conditions that they believed would lead to a more complicated patient stay requiring greater resource use. We are referring to these conditions as ''major cardiovascular conditions (MCVs).'' They could be present as either a principal diagnosis or a secondary diagnosis and, as shown below, lead to greater resource consumption. The complete list of MCVs is shown below.

Most of the conditions on the MCV list are cardiovascular diagnoses assigned to MDC 5 when present as a principal diagnosis. In the chart below, a code that is labeled ''PS'' could be present as either a principal diagnosis or a secondary diagnosis to be assigned to an MCV DRG (new DRGs 547, 549, 551, 553, 555, and 557 identified later in this discussion). If only a ''P'' is shown, the diagnosis would only assign the patient to an MCV DRG when present as a principal diagnosis. Similarly, if only an ''S'' is shown, the diagnosis would only assign a patient to an MCV DRG when present as a secondary diagnosis. Diagnosis codes with only an ''S'' shown are noncardiovascular conditions that, if present as a principal diagnosis, would assign a patient to a noncardiovascular DRG. For example, code 415.19 (Pulmonary embolism and infarction) is shown with only an ''S'' on the chart because if it were present as the principal diagnosis, the case would not be assigned to a cardiovascular DRG in MDC 5. Therefore, code 415.19 could only be considered an MCV if it were listed as a secondary diagnosis. The principal diagnosis must be a cardiovascular condition that assigns the case to one of the new MCV or non-MCV DRGs (547 through 558). The case would be classified to an MCV DRG if code 415.19 was present as a secondary diagnosis.

Using the MCV list, we tested our assumption that these conditions described a more severe set of cardiovascular surgery patients. We grouped all the cardiovascular surgery patients within MDC 5 based on the presence or absence of an MCV condition. We found that this split was predictive of significantly increased resource use for nine surgical cardiovascular DRGs. By splitting these surgical DRGs based on the presence or absence of an MCV condition, we identified subgroups of patients with average charges that were 28 to 45 percent higher than average charges for those cases without an MCV condition. We did not find that the MCV approach could explain patient severity and resource use among the cardiovascular medical DRGs or surgical DRGs other than the nine shown below. The other surgical DRGs within MDC 5 did not clearly identify more severe cases using this methodology. Applying the MCV

list to the other surgical cardiovascular DRGs did not provide a sufficient difference in average charges or the distribution of cases between the MCV and non-MCV patients to justify adopting this approach. The chart below illustrates our findings.

We made one minor revision to this overall approach. Our clinical advisors identified five diagnoses on the MCV list which they believe would be the reason for admission for the surgical procedure. Therefore, these five diagnoses should not be counted as an MCV for specific surgical DRGs. For instance, a complete atrioventricular block (code 426.0) would be the reason a patient would receive a pacemaker. This patient is currently assigned to DRG 115 (Permanent Cardiac Pacemaker Implant With AMI/HF/Shock or AICD Lead or Generator Procedure) or DRG 116 (Other Permanent Cardiac Pacemaker Implant). Because the patient's heart block is the reason for the pacemaker insertion, our clinical advisors advised that code 426.0 should not count as an MCV for our analysis of the pacemaker implant DRGs. Therefore, code 426.0 will not count as an MCV for current DRGs 115 and 116.

The complete list of conditions that will not count as an MCV for current DRGs 115 and 116 because they are the reason for the pacemaker implant are:

- 426.0, Atrioventricular block, complete
- 426.53, Bilateral bundle branch block
- 426.54, Trifascicular block

Our clinical advisors identified two codes on the MCV condition list that would be the reason for the cardiovascular surgery for cases currently assigned to DRGs 107 (Coronary Bypass with Cardiac Catheterization), 109 Coronary Bypass Without Cardiac Catheterization), 516 (Percutaneous Cardiovascular Procedures With AMI), 526 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent With AMI), and 527 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent Without AMI). These two conditions are:

- 411.1, Intermediate coronary syndrome (unstable angina)
- 411.81, Coronary occlusion without myocardical infarction

Making this minor revision to the MCV list greatly increased the predictive value of this methodology for the relevant cardiovascular DRGs. The following chart illustrates the current DRGs that are being revised and the new DRGs being created based on the presence or absence of an MCV.

Current DRGs 107, 109, and 478 are being split based on the presence or absence of an MCV. For instance, cases currently assigned to DRG 107 that have an MCV diagnosis will be assigned to new DRG 547 (Coronary Bypass With Cardiac Catheterization With MCV Diagnosis). Cases in current DRG 107 that do not have an MCV will be assigned to new DRG 548 (Coronary Bypass With Cardiac Catheterization Without MCV Diagnosis). We are deleting DRG 107. Similarly, we are deleting DRGs 109 and 478 and assigning their cases to new DRG pairs 549 (Coronary Bypass Without Cardiac Catheterization With MCV Diagnosis) and 550 (Coronary Bypass Without Cardiac Catheterization Without MCV Diagnosis) and 553 (Other Vascular Procedures With CC With MCV Diagnosis) and 554 (Other Vascular Procedures With CC Without MCV Diagnosis), respectively.

The following three DRG pairs are already divided based on the presence of specific diagnoses such as AMI, heart failure, or shock that are on the MCV list: DRG 115 (Permanent Cardiac Pacemaker Implant With AMI, Heart Failure, and Shock) and 116 (Other Permanent Cardiac Pacemaker Implant), DRGs 516 (Percutaneous Cardiovascular Procedures With AMI) and 517 (Percutaneous Cardiovascular Procedures With Non-Drug-Eluting Stent Without AMI), and DRGs 526 (Percutaneous Cardiovascular Procedures With Drug-Eluting Stent With AMI) and 527 (Percutaneous Cardiovascular Procedures With Drug-Eluting Stent Without AMI). Rather than further subdivide these DRGs, we are expanding the DRGs that include AMI, heart failure, and shock to encompass all of the other conditions on the MCV list. Thus, DRGs 115 and 116 are being replaced by new DRGs 551 (Permanent Cardiac Pacemaker Implant With MCV Diagnosis or AICD Lead or Generator) and 552 (Other Permanent Cardiac Pacemaker Implant Without MCV Diagnosis). DRGs 516 and 517 are being replaced by new DRGs 555 (Percutaneous Cardiovascular Procedures With MCV Diagnosis) and 556 (Percutaneous Cardiovascular Procedures With Nondrug-Eluting Stent Without MCV Diagnosis). DRGs 526 and 527 are being replaced by new DRGs 557 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent With MCV Diagnosis) and 558 (Percutaneous Cardiovascular Procedure With Drug-Eluting Stent Without MCV Diagnosis). The left side of the chart shows the 9 existing DRGs and their relevant statistics. These 9 DRGs are being deleted and replaced by the 12 new DRGs on the right side.

BILLING CODE 4120–01–P

Current Version 23.0					New Version 23.0 DRG Modifications							
Current FY 2005 DRG		Cases	Average Length of Stay	Average Std. Charges	New FY 2006 DRG		Cases	Average Length of Stay	Average Std. Charges	Perc Cases	Difference in Average Std. Charges	Percent Difference in Average Std. Charges
107	CORONARY BYPASS W CARDIAC CATH	65,673	10.5	$82,398	547	CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX	33,389	12.1	$92,542	50.8%	$20,635	28.7%
					548	CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX	32,284	8.9	$71,906	49.2%		
109	CORONARY BYPASS W/O CARDIAC CATH	47,554	7.8	$61,478	549	CORONARY BYPASS W/O CARDIAC CATH W MAJOR CV DX	13,633	10.1	$76,483	28.7%	$21,035	37.9%
					550	CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX	33,921	6.8	$55,447	71.3%		
115	PRM CARD PACEM IMPL W AMI/HR/SHOCK OR AICD LEAD OR GNRTR	20,815	6.9	$55,837	551	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR	53,259	6.4	$48,212	40.3%	$15,562	47.7%
116	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	111,414	4.3	$35,757	552	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX	78,970	3.5	$32,649	59.7%		
478	OTHER VASCULAR PROCEDURES W CC	106,278	7.1	$36,854	553	OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX	35,967	9.5	$46,459	33.8%	$14,518	45.5%
					554	OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX	70,311	5.9	$31,941	66.2%		
516	PERCUTANEOUS CARDIOVASC PROC W AMI	37,325	4.8	$40,278	555	PERCUTANEOUS CARDIOVASCULAR PROC W MAJOR CV DX	53,489	4.6	$39,908	52.8%	$10,097	33.9%
517	PERC CARDIO PROC W NON-DRUG ELUTING STENT W/O AMI	64,022	2.6	$32,145	556	PERCUTANEOUS CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX	47,858	2.1	$29,811	47.2%		
526	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W AMI	51,431	4.4	$45,924	557	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX	87,207	4.1	$44,681	38.2%	$10,319	30.0%
527	PERCUTANEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W/O AMI	176,956	2.2	$36,087	558	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX	141,180	1.9	$34,362	61.8%		

As can be seen from this chart, 6 of these 12 new DRGs better identify subgroups of significantly more severely ill patients who use greater hospital resources than was possible under the previous DRGs, while the remaining 6 DRGs better account for the less severely ill patients who use fewer hospital resources. For instance, current DRG

107 has average standardized charges of $82,398. DRG 107 has been replaced by new DRGs 547 and 548 with average standardized charges of $92,542 and $71,906, respectively. These two new DRGs have a difference of $20,635, or 28.7 percent, in average standardized charges. The chart illustrates that other pairs of new DRGs show differences in average standardized charges of 30.0 to 47.7 percent. Thus, we believe these new DRGs are an improvement over the existing DRG structure because they better recognize a patient's severity of illness and, accordingly, permit us to make higher payments for more severely ill patients who require more resources while lowering our payments for less severely ill and less resource-intensive patients.

The complete list of MCVs is shown below:

MCV code number	MCV code titles P-Principal, S-Secondary diagnosis	DRGs 551 and 552	DRGs 547, 548, 549, 550, 553, 554, 555, 556, 557, and 558
398.91	Rheumatic Heart Failure (Congestive)	PS	PS
402.01	Hypertensive Heart Disease, Malignant, With Congestive Heart Failure	PS	PS
402.11	Hypertensive Heart Disease, Benign, With Congestive Heart Failure	PS	PS
402.91	Hypertensive Heart Disease, With Congestive Heart Failure, Unspecified Benign or Malignant.	PS	PS
404.01	Malignant Hypertensive Heart and Renal Disease, With Congestive Heart Failure	PS	PS
404.03	Malignant Hypertensive Heart and Renal Disease, With Congestive Heart Failure and Renal Failure.	PS	PS
404.11	Benign Hypertensive Heart and Renal Disease, With Congestive Heart Failure	PS	PS
404.13	Benign Hypertensive Heart and Renal Disease, With Congestive Heart Failure and Renal Failure.	PS	PS
404.91	Hypertensive Heart and Renal Disease, Unspecified Benign or Malignant, With Congestive Heart Failure.	PS	PS
404.93	Hypertensive Heart & Renal Disease, Unspecified Benign or Malignant, W/ Congestive Heart Failure & Renal Failure.	PS	PS
410.01	Acute Myocardial Infarction, Anterolateral Wall, Initial Episode of Care	PS	PS
410.11	Acute Myocardial Infarction, Anterior Wall, Initial Episode of Care	PS	PS
410.21	Acute Myocardial Infarction, Inferolateral Wall, Initial Episode of Care	PS	PS
410.31	Acute Myocardial Infarction, Inferoposterior Wall, Initial Episode of Care	PS	PS
410.41	Acute Myocardial Infarction, Inferior Wall, Initial Episode of Care	PS	PS
410.51	Acute Myocardial Infarction, Lateral Wall, Initial Episode of Care	PS	PS
410.61	True Posterior Wall Infarction, Initial Episode of Care	PS	PS
410.71	Subendocardial Infarction, Initial Episode of Care	PS	PS
410.81	Acute Myocardial Infarction, Other Specified Site, Initial Episode of Care	PS	PS
410.91	Acute Myocardial Infarction, Unspecified Site, Initial Episode of Care	PS	PS
411.0	Postmyocardial Infarction Syndrome	PS	PS
411.1	Intermediate Coronary Syndrome (Unstable Angina)	PS	Code does not count.
411.81	Coronary Occlusion Without Myocardial Infarction	PS	Code does not count.
414.10	Heart (Wall) Aneurysm	PS	PS
414.11	Aneurysm of Coronary Vessel	PS	PS
414.12	Dissection of Coronary Artery	PS	PS
414.19	Aneurysm of Heart	PS	PS
415.0	Acute Cor Pulmonale	PS	PS
415.11	Iatrogenic Pulmonary Embolism and Infarction	S	S
415.19	Pulmonary Embolism and Infarction	S	S
420.0	Acute Pericarditis In Diseases Classified Elsewhere	PS	PS
420.90	Acute Pericarditis, Unspecified	PS	PS
420.91	Acute Idiopathic Pericarditis	PS	PS
420.99	Acute Pericarditis	PS	PS
421.0	Acute/Subacute Bacterial Endocarditis	PS	PS
421.1	Acute/Subacute Infective Endocarditis In Diseases Classified Elsewhere	PS	PS
421.9	Acute Endocarditis, Unspecified	PS	PS
422.92	Septic Myocarditis	PS	PS
423.0	Hemopericardium	PS	PS
424.90	Endocarditis, Valve Unspecified, Unspecified Cause	PS	PS
426.0	Atrioventricular Block, Complete	Code does not count	PS
426.53	Bilateral Bundle Branch Block	Code does not count	PS
426.54	Trifascicular Block	Code does not count	PS
427.1	Paroxysmal Ventricular Tachycardia	PS	PS
427.41	Ventricular Fibrillation	PS	PS
427.5	Cardiac Arrest	PS	PS
428.0	Congestive Heart Failure	PS	PS
428.1	Left Heart Failure	PS	PS
428.20	Unspecified Systolic Heart Failure	PS	PS
428.21	Acute Systolic Heart Failure	PS	PS
428.22	Chronic Systolic Heart Failure	PS	PS
428.23	Acute on Chronic Systolic Heart Failure	PS	PS

MCV code number	MCV code titles P-Principal, S-Secondary diagnosis	DRGs 551 and 552	DRGs 547, 548, 549, 550, 553, 554, 555, 556, 557, and 558
428.30	Unspecified Diastolic Heart Failure	PS	PS
428.31	Acute Diastolic Heart Failure	PS	PS
428.32	Chronic Diastolic Heart Failure	PS	PS
428.33	Acute on Chronic Diastolic Heart Failure	PS	PS
428.40	Unspecified Combined Systolic and Diastolic Heart Failure	PS	PS
428.41	Acute Combined Systolic and Diastolic Heart Failure	PS	PS
428.42	Chronic Combined Systolic and Diastolic Heart Failure	PS	PS
428.43	Acute on Chronic Combined Systolic and Diastolic Heart Failure	PS	PS
428.9	Heart Failure, Unspecified	PS	PS
429.5	Chordae Tendineae Rupture	PS	PS
429.6	Papillary Muscle Rupture	PS	PS
429.71	Acquired Cardiac Septal Defect	PS	PS
429.79	Other Certain Sequelae of Myocardial Infarction, Not Elsewhere Classified	PS	PS
429.81	Papillary Muscle Disorder	PS	PS
430	Subarachnoid Hemorrhage	S	S
431	Intracerebral Hemorrhage	S	S
432.0	Nontraumatic Extradural Hemorrhage	S	S
432.1	Subdural Hemorrhage	S	S
432.9	Unspecified Intracranial Hemorrhage	S	S
433.01	Occlusion and Stenosis of Basilar Artery With Cerebral Infarction	S	S
433.11	Occlusion and Stenosis of Carotid Artery With Cerebral Infarction	S	S
433.21	Occlusion and Stenosis of Vertebral Artery With Cerebral Infarction	S	S
433.31	Occlusion and Stenosis of Multiple and Bilateral Precerebral Arteries With Cerebral Infarction.	S	S
433.81	Occlusion and Stenosis of Precerebral Artery With Cerebral Infarction	S	S
433.91	Occlusion and Stenosis of Unspecified Precerebral Artery With Cerebral Infarction	S	S
434.00	Cerebral Thrombosis Without Cerebral Infarction	S	S
434.01	Cerebral Thrombosis With Cerebral Infarction	S	S
434.10	Cerebral Embolism Without Cerebral Infarction	S	S
434.11	Cerebral Embolism With Cerebral Infarction	S	S
434.90	Unspecified Cerebral Artery Occlusion Without Cerebral Infarction	S	S
434.91	Unspecified Cerebral Artery Occlusion With Cerebral Infarction	S	S
436	Acute, But Ill-Defined, Cerebrovascular Disease	S	S
441.00	Dissection of Aorta, Unspecified Site	PS	PS
441.01	Dissection of Aorta, Thoracic	PS	PS
441.02	Dissection of Aorta, Abdominal	PS	PS
441.03	Dissection of Aorta, Thoracoabdominal	PS	PS
441.1	Thoracic Aneurysm, Ruptured	PS	PS
441.3	Abdominal Aneurysm, Ruptured	PS	PS
441.5	Aortic Aneurysm of Unspecified Site, Ruptured	PS	PS
441.6	Thoracoabdominal Aneurysm, Ruptured	PS	PS
443.22	Dissection of Iliac Artery	PS	PS
443.29	Dissection of Other Artery	PS	PS
444.0	Embolism or Thrombosis of Abdominal Aorta	PS	PS
444.1	Embolism or Thrombosis of Thoracic Aorta	PS	PS
445.81	Atheroembolism of Kidney	S	S
453.2	Embolism and Thrombosis of Vena Cava	PS	PS
785.50	Shock, Unspecified	PS	PS
785.51	Cardiogenic Shock	PS	PS
861.02	Laceration of Heart Without Penetration of Heart Chambers or Open Wound Into Thorax	PS	PS
861.03	Laceration of Heart With Penetration of Heart Chambers, Without Open Wound Into Thorax	PS	PS
861.10	Unspecified Injury of Heart With Open Wound Into Thorax	PS	PS
861.11	Contusion of Heart With Open Wound Into Thorax	PS	PS
861.12	Laceration of Heart Without Penetration of Heart Chambers With Open Wound Into Thorax	PS	PS
861.13	Laceration of Heart With Penetration of Heart Chambers, and Open Wound Into Thorax	PS	PS
862.9	Multiple/Unspecified Intrathoracic Organ Injury With Open Wound Into Cavity	S	S
996.61	Infection and Inflammatory Reaction Due To Cardiac Device/Implant/Graft	PS	PS
996.62	Infection and Inflammatory Reaction Due To Other Vascular Device/Implant/Graft	PS	PS
996.72	Complication Due To Other Cardiac Device/Implant/Graft	PS	PS
996.83	Complications of Transplanted Heart	PS	PS

In this final rule, we are implementing new DRGs 547 through 558 as described above for FY 2006. However, we emphasize that the refinements to the DRGs described above are being taken as an interim step to better recognize severity in the DRG system for FY 2006 until we can complete a more comprehensive analysis of the APR–DRG system and the CC list as part of a complete analysis of the MedPAC recommendations that we plan to perform over the next year.

4. APR–DRGs

In the FY 2006 IPPS proposed rule, we indicated that we were 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, such a far-reaching structural change to the current DRG system could have substantial effects across all hospitals. Therefore, we believe we must thoroughly analyze the options and their impacts on the various types of hospitals before making any proposal to replace the current DRG system. In addition, as noted above, we indicated our concern 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, before making a change of this magnitude, we must consider how to mitigate the risk of paying significantly more under an alternative DRG system, while measuring the benefit for Medicare beneficiaries.

We received the following comments in response to the FY 2006 IPPS proposed rule:

Comment: A number of commenters supported our proposal to consider the APR–DRGs as an alternate DRG system in response to the MedPAC recommendation. Seventeen commenters also agreed with the concerns we identified in the proposed rule regarding the potential impact and unpredictable effect a change of this magnitude could have upon a hospital's reimbursement. One commenter recommended that CMS not implement any of the MedPAC recommendations administratively and that CMS discourage Congress from requiring such implementation in statute. This commenter indicated that if CMS and Congress are interested in pursuing these ideas, they should first conduct a full-scale fiscal impact analysis. The commenter stated that its own internal analysis, completed using data from the FY 2002 MedPAR file and the Hospital Cost Reporting Information System (HCRIS), of the APR–DRGs and hospital-specific relative values showed that these changes alone would redistribute $1 billion in Medicare payments. According to the commenter, hospitals that would experience a disproportionate share of the losses from these changes would be rural hospitals, public hospitals, and major teaching hospitals.

Response: We appreciate the commenters' support of our proposal. We agree that the process to determine whether an APR–DRG system would be an improvement over our current DRG system will require a thorough and extensive evaluation. As discussed in the proposed rule, we will thoroughly study MedPAC's recommendations over the course of the next year and consider proposing changes for FY 2007 if our analysis suggests that adopting MedPAC's recommendations would lead to improvements in the DRG system. We are currently in the process of engaging a contractor experienced in Medicare payment issues to conduct a comprehensive review of the MedPAC recommendations. We note that any fundamental changes to our DRG classification system in order to better recognize severity; to use cost-based weights; or to adopt hospital-specific relative weights could have implications for other payment adjustments that are part of the IPPS (for example, the indirect medical education and disproportionate share adjustments). The contract we expect to award shortly will include tasks to study both the MedPAC recommendations and their implications for these other payment adjustments.

Comment: MedPAC responded to our concern that adopting an alternative payment system might improve payment accuracy but could also substantially alter the distribution of payments among hospitals. MedPAC indicated that the potential redistribution of payments among hospitals provides strong evidence that the current payment system is distorted. Therefore, MedPAC believes its payment recommendations should be adopted quickly. In addition, MedPAC indicated that our concern about the impact of their suggested changes upon the current payment system should not prevent us from taking steps toward improving the DRG system.

Response: MedPAC believes that the potential redistribution of payments resulting from improvements to the DRG system should not deter us from making changes that are designed to increase the accuracy of the DRG system. We agree. Given the potential for significant redistribution in payments, our discussion of the MedPAC recommendations in the proposed rule was simply intended to indicate that the changes MedPAC is recommending are significant and should be extensively studied before we make any broad, fundamental changes to the current Medicare DRG system. As shown above, we are replacing 9 cardiovascular DRGs with 12 new DRGs that account for nearly 700,000 cases as an interim step to better recognize severity of illness in the DRG system until we can complete a comprehensive analysis of MedPAC's recommendations.

Comment: MedPAC also addressed our concern that significantly expanding the number of DRGs could lead to changes in hospitals' case-mix reporting that may cause inappropriate increases in Medicare payments. According to MedPAC's comment, the Secretary has authority to make a prospective adjustment to the national base payment amounts to offset expected increases in payments resulting from changes in hospitals' case-mix reporting. MedPAC suggested that CMS use reabstracted medical records collected from Medicare's quality assurance program to carry out this policy. It also suggested that CMS exclude nonspecific secondary diagnoses from more highly valued severity DRGs; issue guidance to hospitals about appropriate coding practices; monitor case-mix changes for individual hospitals; and select hospitals for review and audit of medical records and claims.

Response: We agree that the law provides the Secretary with authority to make a prospective adjustment to the national base payment rate to offset expected increases in payments resulting from changes in hospital case-mix. We also appreciate MedPAC's suggestions for using reabstracted data from Medicare's quality data reporting process and are interested in learning more from MedPAC about how the data can be used for this purpose.

5. DRG Relative Weights

In the FY 2006 proposed rule, 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 noted 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 single, uniform cost-to-charge ratio 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 overestimates 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 the accuracy of inpatient payments would be improved by adopting this method is not obvious.

In the proposed rule, we indicated that we would closely analyze the impact of a change from the current charge-based DRG weights to cost-based DRG weights. We noted that such a change is complex and would require further analysis. With this in mind, we indicated that we would consider the following issues in performing this analysis:

- The effect of using cost-to-charge ratio data, which are 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; [12]
- Whether developing relative weights by estimating costs from charges multiplied by cost-to-charge ratios versus the 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 of a DRG when the hospital is responsible for 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 adoption of an improved severity adjustment and the use of charges adjusted to estimated cost through the application of 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. Therefore, the charges of one or a few hospitals could 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.

Comment: MedPAC responded that cost-based weights would better track the true relative costliness of DRGs than charge-based weights. MedPAC explained that hospital charge markups are highly varied both among and within hospitals. These differences will result in varying amounts of distortion in charge-based relative weights. While MedPAC agreed that there would be some level of distortion in cost-based weights because they are based in part on hospital charges, it indicated that the substantial difference in markups across departments are removed when cost-based weights are calculated while in charge-based weights they are included.

MedPAC noted that CMS had correctly observed that cost data are not as timely as charge data and, therefore, cost-based weights may trail changes in costliness compared to charge-based weights. In response, MedPAC commented that under its methodology, CMS would recalibrate the weights using cost estimates only periodically and would calculate the relationship between cost-based and charge-based weights and adjust the weights to account for the relationship between cost-based and charge-based weights in intervening years, which would mitigate the timeliness problem of using cost-based weights.

With respect to hospital-specific relative weights, MedPAC commented on our point that data from a 1993 RAND study showed that this method could undervalue high-cost DRGs and overvalue low-cost DRGs, a phenomenon known as ''compression.'' MedPAC indicated that the conclusions from the RAND study may no longer apply today. It indicated that the compression may not have resulted from the methodology itself but instead from the pattern of cross-subsidies in charge markups by hospitals that performed the majority of cardiac surgeries. MedPAC indicated that charge markups were much smaller 15 years ago than they are today and cardiac surgeries are currently performed by more hospitals than they were at the time of the RAND study. Thus, MedPAC believed the hospital-specific relative value method is a more effective way of removing the effects on the weights of the differences in the level of costs or charges among hospitals. MedPAC also stated that CMS' method of standardizing hospital

[12] Cost Accounting for Health Care Organizations, Technical Report Series, I–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.

charges could also be causing distortions in the relative weights, in particular because MedPAC believes that the IME and DSH adjustments are poorly related to the cost impact on hospitals of providing medical education and treating low-income patients.

Response: We will consider these comments in our analysis of cost-based weights and hospital-specific DRGs. As we have indicated above, these issues are among those that we have engaged a contractor to assist us in analyzing.

6. High-Cost Outliers

Recommendation 2 in the Report to Congress on Physician-Owned Specialty Hospitals: 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.

In the FY 2006 IPPS proposed rule, we noted that, 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 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. In the proposed rule, we indicated that we expect to further analyze these ideas as we consider the other changes recommended by MedPAC and solicited public comments on this issue.

We received the following comments in response to the FY 2006 IPPS proposed rule.

Comment: One commenter disagreed with MedPAC's proposal to exclude outliers from the computation of the DRG weights because this would exacerbate the problem of overestimating the outlier threshold, resulting in underpayments of outliers in a given fiscal year.

Response: We appreciate these comments and will take them into consideration as we conduct further analysis of MedPAC's recommendations.

Comment: MedPAC clarified its earlier recommendation in its comments on the proposed rule. MedPAC explained that, rather than finance outlier payments through a single 5.1 percent adjustment to the standardized amount that is required under current law, it meant to recommend that outlier payments in each DRG be financed out of aggregate payments in the DRG. MedPAC believes that the current policy makes DRGs with a high prevalence of outliers more profitable for two reasons: (1) These DRGs receive more in outlier payments than the 5.1 percent that is removed from the national standardized amount; and (2) the relative weights for these DRGs are overvalued because their values are influenced by the high standardized charges for outlier cases included in the relative weight calculation. MedPAC's recommendation would require a change in law because the current law requires that the Secretary reduce the standardized amount by 5 to 6 percent for cases paid as cost outliers. MedPAC further noted that, under its recommendation, outlier payments in each DRG would be financed out of the aggregate payments in the DRG which would reduce the distortion in the relative weights that comes from including the outlier cases in the calculation of the weight and would correct the differences in profitability that stem from using a uniform outlier offset for all cases. MedPAC added that its recommendation would help make relative profitability more uniform across all DRGs.

Response: We appreciate MedPAC clarifying and providing more detail on its outlier recommendation. Now that we better understand the recommendation, it is clear that the part of MedPAC's proposal that would replace the 5.1 percent offset to the standardized amount would require a change in the law. While CMS does have broad authority to determine how the DRG relative weights are calculated, we are required by law to reduce the standardized amount by not less than 5 percent or more than 6 percent to account for the additional payments made to outlier cases. However, as explained above, MedPAC found DRGs with a high prevalence of outliers are overvalued both because they receive more in outlier payments than is removed from the national standardized amount and the relative weights of these DRGs are influenced by the high standardized charges that are included in the relative weight calculation. We believe this latter factor can be addressed without a change in law. As we indicated in the proposed rule, the law provides broad discretion to the Secretary to consider all factors that change the relative use of hospital resources in calculating the DRG relative weights. Thus, even in the absence of a change in law, we expect to consider changes that would reduce or eliminate the effect of high-cost outliers on the DRG relative weights for FY 2007.

Finally, we believe that the recommendations made by MedPAC, or some variants of them, have significant promise to improve the accuracy of rates in the IPPS. We agree with MedPAC that these possible refinements to our payment methodology should be explored, 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 all 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 such an extent that Medicare payments no longer provide a significant impetus for the further development of specialty hospitals.

Recommendation 3 of the Report to Congress on Physician-Owned Specialty Hospitals: The Congress and the Secretary should implement the case-mix measurement and outlier policies over a transitional period.

In the FY 2006 IPPS proposed rule, we stated that, before proposing any fundamental changes to the DRGs system, 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 did note that, in the event we replace 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.

We received the following comments in response to the FY 2006 IPPS proposed rule.

Comment: One commenter supported refinements to the DRGs that better capture cost variations among Medicare patients but expressed concern about the redistributive impact such a change would have on Medicare reimbursement to hospitals. The commenter recommended that CMS evaluate DRG case-mix severity outside of budget neutrality. The commenter also recommended that CMS make these changes over a transition period of at least 6 years. Many other commenters suggested that CMS implement any changes over a transition period in order to mitigate the financial impact on hospitals. Other commenters also urged CMS to proceed slowly and deliberately with extensive research as a foundation for any proposed changes. MedPAC noted it would continue to work with CMS to develop ways to mitigate the complexity and burden of a transition methodology.

Response: Section 1886(d)(4) of the Act gives the Secretary broad discretion to develop DRG classifications and weighting factors. However, it also requires that adjustments to the classification or weighting factors cannot change aggregate payments under the IPPS. Thus, while the Secretary has authority to adopt DRGs that better recognize severity of illness under current law, the law does not allow us to adopt these changes outside of budget neutrality. As noted above, before proposing any changes to the DRGs, we would need to model the impact of any specific proposal and assess our authority under the statute to determine whether any changes should be implemented immediately or over a period of time. We appreciate MedPAC's efforts in working with CMS and note that we will take all of the comments into consideration as we conduct further analysis of MedPAC's recommendations.

Comment: MedPAC commented that it was pleased that CMS shares its views on improving payment accuracy within the IPPS. However, MedPAC was concerned that CMS may not be doing enough to address the distortions within the IPPS pointed out by MedPAC. The commission explained that the list of analyses CMS included in response to MedPAC's recommendation is long and broad, raising the risk that some analysis may not be complete by FY 2007.

Response: We are currently engaging a contractor experienced in Medicare payment issues to assist in CMS's comprehensive review of the MedPAC recommendations. We also have made significant progress in our review of the CC list. As a result, we are optimistic that these analyses will be completed during the next year.

B. Other MedPAC Recommendations

MedPAC also made the following recommendations that we addressed in the Secretary's Report to Congress on Specialty Hospitals. This report is available on our Web site at: *http://www.cms.hhs.gov/media/press/files/052005/RTC-StudyofPhysOwnedSpecHosp.pdf.*

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.

We received no comments in response to our discussion of these recommendations in the FY 2006 proposed rule. We note, however, that in section V.L. of the preamble to this final rule, we address comments relating to the definition of a hospital in connection with specialty hospitals.

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*. In the FY 2006 IPPS proposed rule, we published a list of data files that are available for purchase from CMS or that may be downloaded from the internet without charge (70 FR 23456 through 23459).

B. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 30-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.

In the FY 2006 IPPS proposed rule (70 FR 23459), we solicited public comments on each of these issues for the information collection requirements discussed below. A summary of any public comments we received and our responses follow each requirement.

The following information collection requirements included in this 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, in order to qualify for the full annual market basket update, 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 these 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 the FY 2006 IPPS proposed rule, we proposed additional validation criteria to ensure that the quality data being sent to CMS are accurate (70 FR 23424 through 23426). These validation criteria are finalized in this final rule. 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 × 5 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.

A summary of the public comments that we received and our responses on the quality data submission requirement are included under section V.B. of this preamble.

Section 413.65 Requirements for a Determination That a Facility or an Organization Has Provider-Based Status

We proposed under § 413.65(b)(3)(i) to require 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 § 413.65(d) 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 § 413.65(g). We also proposed 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 § 413.65(f).

We proposed under § 413.65(b)(3)(ii) to provide 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 paragraphs (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 § 413.65(g). If the facility is operated under a management contract, the potential main provider must also attest that the facility meets the requirements of § 413.65(h).

We proposed to clarify the regulations under § 413.65(e)(3) which require 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) greater than 11.75 percent and is described in § 412.106(c)(2) 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 § 413.65(e)(3)(iii)(A) or (e)(3)(iii)(B); or (iv) if the facility or organization is unable to meet the criteria in § 413.65(e)(3)(iii)(A) or § 413.65(e)(3)(iii)(B) because it was not in operation during all of the 12-month period described in § 413.65(e)(3)(iii), be located in a zip code area included among those that, during all of the 12-month period described in § 413.65(e)(3)(iii), accounted for at least 75 percent of the patients served by the main provider; or (v) the facility or organization meets the requirements applicable to neonatal intensive care units in § 413(e)(3)(v); or (vi) in the case of an RHC (A) the hospital is 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 is located in a rural area; and (vii) the hospital is 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 § 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 the FY 2006 IPPS proposed rule, we proposed under proposed § 485.610(d)(2)(ii) that, in order to be considered a relocation, a CAH would be required to provide documentation demonstrating that its plans to rebuild in a relocated area were undertaken prior to December 8, 2003. This requirement would have imposed an information collection requirement if it were finalized. However, after consideration of the public comments received, we have deleted this provision, and hence the information collection requirement, from the final regulation in this final rule.

We have submitted a copy of this rule to OMB for its review of the information collection requirements described above. The information collection and recording requirement of § 412.64(d)(2) are not effective until they are approved by OMB. If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development and

Issuances Group, Attn: Jim Wickliffe, CMS–1500–F Room C5–13–28, 7500 Security Boulevard, Baltimore, MD 21244–1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Christopher Martin, CMS Desk Officer, CMS–1500–F, *Christopher_Martin@omb.eop.gov.* Fax (202) 395–6974.

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 final rule, the Centers for Medicare & Medicaid Services is amending 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 412.4 is amended by—

■ a. Revising the introductory text of paragraph (d)(1).

■ b. Revising paragraph (d)(1)(v).

■ c. Adding a new paragraph (d)(3).

■ d. Revising the introductory text of paragraph (f)(2).

■ e. Adding a new paragraph (f)(5).

The revision and additions read as follows:

§ 412.4 Discharges and transfers.

* * * * *

(d) *Qualifying DRGs.* (1) For a fiscal year prior to FY 2006, for purposes of paragraph (c) of this section, and subject to the provisions of paragraph (d)(2) of this section, the qualifying DRGs must meet the following criteria for both of the 2 most recent years for which data are available:

* * * * *

(v) To initially qualify, the DRG must meet the criteria specified in paragraphs (d)(1)(i) through (d)(1)(iv) of this section and must have a decline in the geometric mean length of stay for the DRG during the most recent 5 years of at least 7 percent. Once a DRG initially qualifies, the DRG is subject to the criteria specified in paragraphs (d)(1)(i) through (d)(1)(iv) of this section for each subsequent fiscal year.

* * * * *

(3) For fiscal years beginning with FY 2006, for purposes of paragraph (c) of this section—

(i) The qualifying DRGs must meet the following criteria using data from the March 2005 update of the FY 2004 MedPAR file and Version 23.0 of the DRG Definitions Manual (FY 2006):

(A) The DRG has at least 2,050 total postacute care transfer cases;

(B) At least 5.5 percent of the cases in the DRG are discharged to postacute care prior to the geometric mean length of stay for the DRG;

(C) The DRG must have a geometric mean length of stay greater than 3 days;

(D) The DRG is paired with a DRG based on the presence or absence of a comorbidity or complication or major cardiovascular condition that, it meets the criteria specified in paragraphs (d)(3)(i)(A) and (d)(3)(ii)(B) of this section.

(ii) If a DRG did not exist in Version 23.0 of the DRG Definitions Manual or a DRG included in Version 23.0 of the DRG Definitions Manual is revised, the DRG will be a qualifying DRG if it meets the following criteria based on the version of the DRG Definitions Manual in use when the new or revised DRG first becomes effective, using the most recent complete year of MedPAR data:

(A) The total number of discharges to postacute care in the DRG must equal or exceed the 55th percentile for all DRGs;

(B) The proportion of short-stay discharges to postacute care to total discharges in the DRG exceeds the 55th percentile for all DRGs; and

(C) The DRG is paired with a DRG based on the presence or absence of a comorbidity or a complication or major cardiovascular condition that meets the criteria specified under paragraph (d)(3)(ii)(A) and (d)(3)(ii)(B) of this section.

* * * * *

(f) *Payment for transfers.*

* * * * *

(2) *Special rule for DRGs 209, 210, and 211 for fiscal years prior to FY 2006.* For fiscal years prior to FY 2006, a hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section and the transfer is assigned to DRGs 209, 210, or 211 is paid as follows:

* * * * *

(5) *Special rule for DRGs meeting specific criteria.* For discharges occurring on or after October 1, 2005, a hospital that transfers an inpatient under the circumstances described in paragraph (c) of this section is paid

using the provisions of paragraph (f)(2)(i) and (f)(2)(ii) of this section if the transfer case is assigned to one of the DRGs meeting the following criteria:

(i) The DRG meets the criteria specified in paragraph (d)(3)(i) or (d)(3)(iii) of this section;

(ii) The average charges of the 1-day discharge cases in the DRG must be at least 50 percent of the average charges for all cases in the DRG; and

(iii) The geometric mean length of stay for the DRG is greater than 4 days; and

(iv) If a DRG is a paired with a DRG based on the presence or absence of a comorbidity or complication or a major cardiovascular complication that meets the criteria specified in paragraph (f)(5)(i) through (f)(5)(iii) of this section, that DRG will also be paid under the provisions of paragraph (f)(2)(i) and (f)(2)(ii) of this section.

■ 5. Section 412.64 is amended by—

■ a. Adding a new paragraph (b)(5).

■ b. Revising paragraph (i)(3)(iv).

■ c. Revising paragraph (k)(2).

The addition and revision reads as follows:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

* * * * *

(b) *Geographic classifications.* * * *

(5) For hospitals that consist of two or more separately located inpatient hospital facilities, the national adjusted prospective payment rate is based on the geographic location of the hospital facility at which the discharge occurred.

* * * * *

(i) *Adjusting the wage index to account for commuting patterns of hospital employees.* * * *

(3) *Process for determining the adjustment.*

* * * * *

(iv) A hospital in a qualifying county that receives a wage index adjustment under this paragraph (i) is not eligible for reclassification under subpart L of this part or section 1886(d)(8) of the Act.

* * * * *

(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.

* * * * *

■ 6. 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.

■ 7. 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.

■ 8. 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.

■ 9. 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.

* * * * *

■ 10. 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.

* * * * *

■ 11. 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.

* * * * *

■ 12. Section 412.103 is amended by revising paragraph (a)(1) 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.

* * * * *

■ 13. 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).
■ d. Adding a new paragraph (f)(1)(xv).
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 paid under Part 413 of this chapter as a hospital excluded from the hospital inpatient prospective payment system and that subsequently becomes subject to the hospital inpatient prospective payment system, the limit on the total number of FTE residents for payment purposes is determined based on the data from the hospital's most recent cost reporting period ending on or before December 31, 1996.

(xiv) In the case of a merger of a hospital that is excluded from the hospital inpatient prospective payment system and an acute care hospital subject to the hospital inpatient prospective payment system, if the surviving hospital is a hospital subject to the hospital inpatient prospective payment system and no hospital unit that is excluded from the hospital inpatient prospective payment system is created as a result of the merger, the surviving hospital's number of FTE residents for payment purposes is equal to the sum of the FTE resident count of the hospital that is subject to the hospital inpatient prospective payment system as determined under paragraph (f)(1)(ii)(B) of this section and the limit on the total number of FTE residents for the excluded hospital as determined under paragraph (f)(1)(xiii) of this section.

(xv) Effective for discharges occurring on or after October 1, 2005, an urban hospital that reclassifies to a rural area under § 412.103 for fewer than 10 continuous years 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.

* * * * *

■ 14. 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).

* * * * *

■ 15. 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]

■ 16. 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]

■ 17. 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.''

■ 18. Section 412.230 is amended by—
■ a. Revising paragraph (a)(5)(iv)
■ b. Redesignating paragraph (d)(2)(iii) as paragraph (d)(2)(iv).

■ c. Adding new paragraph (d)(2)(iii).

The revision and additions read as follows:

§ 412.230 Criteria for an individual hospital seeking redesignation to another rural area or an urban area.

(a) *General.* * * *

(5) *Limitations on redesignations.* * * *

(iv) An urban hospital that has been granted redesignation as rural under § 412.103 cannot receive an additional reclassification by the MGCRB based on this acquired rural status for a year in which such redesignation is in effect.

* * * * *

(d) *Use of urban or other rural area's wage index.*— * * *

(2) *Appropriate wage data.* * * *

(iii) For applications submitted for reclassifications effective in FYs 2006 through 2008, a campus of a multicampus hospital may seek reclassification to a CBSA in which another campus(es) is located. If the campus is seeking reclassification to a CBSA in which another campus(es) is located, as part of its reclassification request, the requesting entity may submit the composite wage data for the entire multicampus hospital as its hospital-specific data.

* * * * *

■ 19. Section 412.234 is amended by—

■ a. Revising paragraph (a)(3)(ii).

■ 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) * * *

(ii) For fiscal year 2006, hospitals located in counties that are in the same Combined Statistical Area (CSA) (under the MSA definitions announced by the OMB on June 6, 2003) as the urban area to which they seek redesignation; 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 designation qualify as meeting the proximity requirements for reclassification to the urban area to which they seek redesignation.

(iii) For Federal fiscal year 2007 and thereafter, hospitals located in counties that are in the same Combined 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]

■ 20. 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.

■ 21. 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]

■ 22. 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 paragraph (e)(1) introductory text, (e)(1)(i), (e)(1)(ii), and (e)(1)(iii).

■ 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.

(ii) The main provider and the facility or organization seeking status as a department of the main provider, a remote location of a hospital, or a satellite facility have the same governing body.

(iii) The facility or organization is operated under the same organizational documents as the main provider. For example, the facility or organization seeking provider-based status must be subject to common bylaws and operating decisions of the governing body of the main provider where it is based.

* * * * *

(3) *Location.* The facility or organization meets the requirements in paragraph (e)(3)(i), (e)(3)(ii), (e)(3)(iii), (e)(3)(iv), (e)(3)(v), or, in the case of an RHC, paragraph (e)(3)(vi) of this section, and the requirements in paragraph (e)(3)(vii) 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 or is described in § 412.106(c)(2) of this chapter implementing section 1886(d)(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) The facility or organization meets all of the following criteria:

(A) The facility or organization is seeking provider-based status with respect to a hospital that meets the criteria in § 412.23(d) for reimbursement under Medicare as a children's hospital;

(B) The facility or organization meets the criteria for identifying intensive care type units set forth in the Medicare reasonable cost reimbursement regulations under § 413.53(d).

(C) The facility or organization accepts only patients who are newborn infants who require intensive care on an inpatient basis.

(D) The hospital in which the facility or organization is physically located is in a rural area as defined in § 412.64(b)(1)(ii)(C) of this chapter.

(E) The facility or organization is located within a 100-mile radius of the children's hospital that is the potential main provider.

(F) The facility or organization is located at least 35 miles from the nearest other neonatal intensive care unit.

(G) The facility or organization meets all other requirements for provider-based status under this section.

(vi) 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 § 412.64(b)(1)(ii)(C) of this subchapter.

(vii) 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 portions of 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 redesignated 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 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 1395hh.

■ 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), excluding paragraph (b)(3).''
■ b. Removing paragraph (b)(1)(ii) and redesignating paragraph (b)(1)(iii) as paragraph (b)(1)(ii).
■ c. Adding a new paragraph (d).

The revisions and additions read as follows:

§ 485.610 Condition of participation: Status and location.

* * * * *

(d) *Standard: Relocation of CAHs with a necessary provider designation.* A CAH that has a necessary provider designation from the State that was in effect prior to January 1, 2006, and relocates its facility after January 1, 2006, can continue to meet the location requirement of paragraph (c) of this section based on the necessary provider designation only if the relocated facility meets the requirements as specified in paragraph (d)(1) of this section.

(1) If a necessary provider CAH relocates its facility and begins providing services in a new location, the CAH can continue to meet the location requirement of paragraph (c) of this section based on the necessary provider designation only if the CAH in its new location—

(i) Serves at least 75 percent of the same service area that it served prior to its relocation;

(ii) Provides at least 75 percent of the same services that it provided prior to the relocation; and

(iii) Is staffed by 75 percent of the same staff (including medical staff, contracted staff, and employees) that were on staff at the original location.

(2) If a CAH that has been designated as a necessary provider by the State begins providing services at another location after January 1, 2006, and does not meet the requirements in paragraph (d)(1) 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: July 26, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: July 27, 2005.

Michael O. Leavitt,

Secretary.

[Editorial Note: The following Addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum—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

I. Summary and Background

In this Addendum, we are setting forth the amounts and factors for determining prospective payment rates for Medicare hospital inpatient operating costs and Medicare hospital inpatient capital-related costs. We are also setting forth the 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 making changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2006. The 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 changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2006. Section IV. of this Addendum sets forth our 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 final rule are presented in section VI. of this Addendum.

II. 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 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 3.7 percent for all areas (that is, the full market basket percentage increase of 3.7 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 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 updating the labor-related share to 69.7 percent for FY 2006, as discussed in section IV.B.3. of the preamble to this final rule. We note that the revised labor-related share for FY 2006 was determined to be 69.731 (the same amount that we proposed in the FY 2006 IPPS proposed rule), as discussed in section IV of the preamble to this final rule. We used our

previous methodology and rounded 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 final rule, we are also rebasing the current labor-related share for the Puerto Rico-specific amounts for FY 2006. At the time we issued the proposed rule, we had not calculated a rebased Puerto Rico labor-related share. Therefore, the proposed standardized amounts that appeared in Table 1C of the Addendum of the proposed rule for providers with a wage index greater than 1.0000 reflected the FY 2005 labor-related share for the Puerto Rico-specific amounts of 71.3 percent for FY 2006. However, we subsequently calculated a rebased labor-related share for Puerto Rico for FY 2006 of 58.7 percent which was posted on the CMS Web site the week of May 29, 2005. We are adopting this Puerto Rico specific labor share of 58.7 in this final rule.

We are adjusting 62 percent of the national standardized amount 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 adjusting the national standardized amount by a labor-related share of 69.7 percent. For hospitals in Puerto Rico, we are adjusting 58.7 percent of the Puerto Rico specific standardized amount for all hospitals whose wage indexes are less than or equal to 1.0000 and 62 percent of the Puerto Rico specific standardized amount for hospitals whose wage values are greater than 1.0000.

2. Computing the Average Standardized Amount

Section 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 final 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 updating 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 3.7 percent (compared to the proposed estimated forecast of 3.2 percent). Thus, for FY 2006, the update to the average standardized amount is 3.7 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 standardized amounts in Tables 1A through 1C 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)(4) of the Act to report to the Congress our 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 final rule.

4. Other Adjustments to the Average Standardized Amount

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

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. For FY 2006, we are continuing to adjust 10 percent of the wage index factor for occupational mix. We describe the occupational mix adjustment in section III.C. of the preamble to this final 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 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 adjusting 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 final 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 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 budget neutrality adjustment factor equal to 1.002271. We also are adjusting the Puerto Rico-specific standardized amount for the effect of DRG reclassification and recalibration. We computed a budget neutrality adjustment factor for the Puerto Rico-specific standardized amount equal to 0.998993. These 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 final rule, we are applying the same DRG reclassification and recalibration budget neutrality factor of 0.998993 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 pre-reclassified 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 transition budget neutrality adjustment of 0.998859.

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 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 applying an adjustment factor of 0.992521 to ensure that the effects of this reclassification are budget neutral.

The adjustment factor is applied to the standardized amount after removing the effects of the FY 2005 budget neutrality adjustment factor. We note that the 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 greater than the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the ''outlier threshold'' or ''fixed loss'' amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outlier payment). We refer to the sum of the prospective payment rate for the DRG, any IME and DSH payments, any new technology add-on payments, and the outlier threshold as the outlier ''fixed-loss cost threshold.'' To determine whether the costs of a case exceed the fixed-loss cost 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 fixed-loss cost threshold. The marginal cost factor for FY 2006 is 80 percent—the same marginal cost factor we have used since FY 1995 (59 FR 45367).

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 amount 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. FY 2006 outlier fixed-loss cost threshold. For FY 2006, as we proposed, we are using a refined methodology to calculate the outlier 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 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 outlier 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 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 proposing to use 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 the IPPS final rule for FY2005 (69 FR 49275), in response to the many comments we received on the proposed FY 2005 methodology, we revised 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 used this 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 an outlier fixed-loss cost 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.

In the FY 2006 IPPS proposed rule, we proposed to use a refined methodology to calculate the outlier threshold that would take into account the lower inflation in hospital charges that is occurring as a result of the outlier final rule (68 FR 34505, June 9, 2003), 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 FY 2006 outlier threshold, we proposed to simulate payments by applying FY 2006 rates and policies using cases from the FY 2004 MedPAR files. Therefore, in order to determine the FY 2006 outlier threshold, we proposed to inflate the charges on the MedPAR claims by 2 years, from FY 2004 to FY 2006.

However, we did not propose 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 atypically high rate of hospital charge inflation during FYs 2002 and 2003. Instead, we proposed to use more recent data that reflected the rate-of-change in hospital charges under the new outlier policy. However, we stated we would continue to consider other methodologies in the future when calculating the outlier threshold once we had 2 complete years of charge data under the new outlier policy.

Specifically, we proposed to establish the FY 2006 outlier threshold as follows: Using the latest data available, we proposed to calculate 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). This rate-of-change was 8.65 percent (1.0865) or 18.04 percent (1.1804) over 2 years. As we have done in the past, in establishing the FY 2006 outlier threshold, we proposed to use, hospital cost-to-charge ratios from the most recent Provider-Specific File, which, at the time of the proposed rule was the December 2004 update, in establishing the 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 proposed an outlier fixed-loss cost 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.

For this final rule, we determined the FY 2006 outlier threshold using the methodology proposed in the proposed rule, but using updated data. We determined a charge inflation factor based on the first six months of FY 2005 relative to same period for FY 2004. The new outlier policy was in effect for this entire period, so we believe these charge inflation data will project charge inflation more accurately than the data that were available when we established the outlier thresholds for FYs 2004 and 2005. For this final rule, we had hospital charge information for two full 6-month periods (October 1, 2003 through March 31, 2004 and October 1, 2004 through March 31, 2005) that span only two fiscal years (FY 2004 and FY 2005) and fully incorporate implementation of the new outlier policy. Using data from this period, we determined a charge inflation factor of 14.94 percent, which is substantially lower than the charge inflation factor of 18.04 percent in the proposed rule. We used updated cost-to-charge ratios from the March 2005 update of the Provider Specific File. This file includes cost-to-charge ratios taken from the most recent tentatively settled cost reports of hospitals.

Using this methodology, for FY 2006, we are establishing an outlier fixed-loss cost threshold equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add on payment for new technology, plus $23,600.

Comment: A number of commenters opposed the proposed increase in the outlier threshold because outlier payments over the last several years have been less than the 5.1 percent removed from the standardized amounts. These commenters requested an explanation of why CMS proposed to increase the outlier threshold for FY 2006 when actual outlier payments are projected to be below 5.1 percent for FY 2004 and FY 2005 and result in a savings to Medicare of $1.4 billion and $600 million for each of these respective years.

Several commenters suggested an alternative to the methodology we proposed using. These commenters indicated that in addition to inflating charges from FY 2004 to FY 2006, CMS similarly should adjust cost-to-charge ratios that will be used to calculate the FY 2006 outlier threshold. Using cost report data from the March 31, 2005 update to HCRIS, the commenters calculated an aggregate annual rate of increase in cost per discharge from 2001–2003 of 6.57 percent. Taken together with the 8.65 percent increase in charges calculated by CMS in the proposed rule, the commenter projected a decline in cost-to-charge ratios and estimated an outlier threshold of $24,050 for FY 2006.

These commenters indicated that, if CMS had applied the commenters' methodology to calculate the outlier thresholds for FY 2004 and FY 2005 outlier payments would have been much closer to 5.1 percent of total IPPS payments. These and other commenters also estimated what the outlier threshold for the past three fiscal years would have been if CMS had used a methodology of inflating costs instead charges. The commenters argued that using a cost inflation methodology would have resulted in total outlier payment being much closer to 5.1 percent of total IPPS payments. These commenters noted that CMS set the outlier threshold using cost inflation from FY 1994 to FY 2002. Using data from the March 31, 2005 HCRIS update and using a cost inflation methodology, the commenter projected an outlier threshold of $22,250. The commenters recommended that CMS either return to using cost inflation or adopt a methodology that takes into account the decline in cost-to-charge ratios as well as increases in charges when calculating the outlier threshold. According to the commenters these methodologies have proven to be more accurate in predicting outlier payments than the ones used by CMS.

Some commenters recommended that CMS consider making mid-year adjustments to the outlier threshold if it appears that outlier payments are going to be less than 95 or more than 105 percent of the 5.1 percent of total IPPS payments. One commenter recommended that CMS analyze the practicality and effects of making change to the outlier threshold similar to the market basket update forecast error adjustment. Another commenter suggested that CMS recalculate the outlier threshold that would have been necessary in FY 2005 for outlier payments to be 5.1 percent of total IPPS payments and use that amount as the outlier threshold for FY 2006.

Response: We appreciate the alternative methodologies suggested by the commenters and have considered them carefully. However, as explained above, we determined the FY 2006 outlier threshold using the methodology we had proposed in the proposed rule.

While our current estimates are that actual outlier payments were less than 5.1 percent of total IPPS payments for both FYs 2004 and 2005, we believe that there are special circumstances that applied in these years that made it especially difficult to project the increase in Medicare charges when calculating the outlier threshold. To calculate the outlier threshold for FY 2004 we used an inflation factor of 26.8 percent based on a 2-year average of the rate-of-change in charges from FY 2000 to FY 2002. This high rate of charge inflation coincided with a period when Medicare payments for outliers were substantially in excess of the outlier thresholds for those years (7.7 percent for FY 2001 and 7.8 percent for FY 2002). The actual rate of charge inflation subsided significantly in FY 2004 after we made significant changes to our outlier policy (68 FR 34494, June 9, 2003). We believe that hospitals changed their charging practices as a result of the changes. Thus, the projected rate of charge inflation used to set the outlier threshold in the IPPS rule for FY 2004 was substantially in excess of the actual rate of charge inflation during FY 2004

Similarly, it was also difficult to project charge inflation in setting the FY 2005 outlier

threshold using FY 2003 MedPAR data. The effective date of the outlier final rule was August 8, 2003, almost 2 months before the end of FY 2003. Thus, most of the FY 2003 MedPAR data reflected charges from discharges occurring prior to the effective date of the changes to our outlier policy and other data reflected charges from after the effective date of the changes. In addition, we used data from the first half of FY 2003 to measure the rate of charge inflation, so all of these data reflected charges from discharges that occurred prior to the effective date of the changes in our outlier policy.

Therefore, we believe that the charge inflation used for setting both the FY 2004 and FY 2005 cost thresholds was atypical because of the significant growth in hospital charges in the years preceding the change to our outlier policy as well as the instability in hospital charging practices that followed the adoption of our new outlier policy.

We also carefully analyzed the comments suggesting that we also adjust the cost-to-charge ratios that are used in setting the outlier thresholds. We believe it is necessary to inflate the charges from the FY 2004 MedPAR file to project charge levels for FY 2006, but we do not believe it is also necessary to adjust the cost-to-charge ratios from the March 2005 Provider-Specific File. The FY 2004 MedPAR charge data include charges for dates of service through August 31, 2003. Although these data are the most recent case-specific charge information we have available for a complete fiscal year, the FY 2004 MedPAR charge data are over 2 years old. We likely would greatly underestimate FY 2006 outlier payments if we did not inflate the MedPAR charge data.

On the other hand, the cost-to-charge ratios from the March 2005 Provider-Specific File reflect much more recent hospital-specific data than the case-specific data in the FY 2005 MedPAR file. The March 2005 Provider-Specific File includes the cost-to-charge ratios from hospitals' most recent tentatively-settled cost report. In many cases, for part of FY 2006, fiscal intermediaries will determine actual outlier payment amounts using the same cost-to-charge ratios that are in the March 2005 Provider-Specific File. Fiscal intermediaries will begin using an updated cost-to-charge ratio to calculate the outlier payments for a hospital only after a more recent cost report of the hospital has been tentatively settled. We note that the cost-to-charge ratios that we are using from the March 2005 Provider-Specific File are approximately 3 percent lower on average than the cost-to-charge ratios from the December 2004 Provider-Specific File that we used in setting the proposed rule outlier threshold.

In addition, we continue to believe that using charge inflation, rather than cost inflation, will more likely result in an outlier threshold that leads to outlier payments equaling 5.1 percent of total IPPS payments. Our current methodology of estimating outlier payments more closely captures how actual outlier payment amounts are calculated. Fiscal intermediaries approximate the costs of a case by applying the hospital's cost-to-charge ratio to the total covered charges for the case. Similarly, under the charge inflation methodology we used to simulate FY 2006 outlier payments, we applied the most recent provider-specific cost-to-charge ratios we had available (which, as explained above, in some cases will be the same cost-to-charge ratios fiscal intermediaries will use to calculate actual outlier payments during FY 2006) to case-specific FY 2004 MedPAR charge data that had been inflated to approximate current hospital charge levels.

If we estimated FY 2006 outlier payments using the cost inflation methodology we employed from FY 1994 to FY 2002, we would apply historical cost-to-charge ratios from FY 2004 to FY 2004 MedPAR data and then inflate the simulated FY 2004 costs using a cost inflation factor. As a commenter pointed out, this methodology would not include an adjustment for the time lag between the historical FY 2004 cost-to-charge ratios and the cost-to-charge ratios fiscal intermediaries will use to calculate actual outlier payments in FY 2006. Because our charge inflation methodology simulates outlier payments using much more recent cost-to-charge ratios, we believe that our charge inflation methodology is preferable to the cost inflation methodology suggested by the commenters. We note that, as hospital charging practices stabilize and we gain more experience forecasting charge inflation, we expect it will become easier to forecast outlier payments.

As we did in establishing the FY 2005 outlier threshold (69 FR 49278), in our projection of FY 2006 outlier payments we did not make an adjustment for 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 that cost-to-charge ratios accurately measure hospital costs and, therefore, are more indicative 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.

We also do not believe that a mid-year adjustment is consistent with the goals of the IPPS. We have responded to similar comments a number of times, including the final rules for FY 1993 (57 FR 39784), FY 1994 (58 FR 46347), FY 1995 (59 FR 45408), FY 1996 (60 FR 45856), and FY 1997 (61 FR 46299).

The mid-year adjustments contemplated by the commenters would be extremely difficult or impracticable (if not impossible) to administer. Hospital bill data with respect to a given fiscal year continue to be added to the MedPAR file some time after the end of the fiscal year. (We update the MedPAR file for 2 full years after the end of the respective fiscal year.) Therefore, precise figures on actual outlier payments for a given fiscal year cannot be determined until well after that fiscal year ends. As a result, we do not believe we would have sufficient data in time to make a meaningful mid-year adjustment to the outlier threshold. We do publish estimates of ''actual'' outlier payments for recent fiscal years, but those estimates are based on available bills (and sometimes based on simulations using bills for a previous year, adjusted for estimates of inflation).

With respect to the commenter's suggestion that we analyze the practicality and effects of a forecast error adjustment, it is not clear how a forecast error adjustment would function in the outlier context. However, we note that our outlier policy is intended to reimburse hospitals for treating extraordinarily costly cases and, under the statute, outlier payments are intended to approximate the marginal cost of providing care above the outlier fixed-loss cost threshold. Any adjustment to the outlier threshold or standardized amount in a given year to account for ''overpayments'' or ''underpayments'' of outliers in other years would result in us making outlier payments that were not directly related to the actual cost of furnishing care in extraordinarily costly cases.

In addition, consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not make retroactive adjustments to outlier payments to ensure that total outlier payments in a past year are equal to 5.1 percent of total DRG payments. In short, we believe our outlier policies are consistent with the statute and the goals of the prospective payment system.

We finally note that CMS plans on issuing instructions to fiscal intermediaries in the near future that update the policies in the July 3, 2003 program memorandum (A–03–058) and detail the specifics of reconciling outlier payments and other policies related to outliers.

ii. Other changes concerning outliers. As stated in the FY 1994 final rule (58 FR 46348, September 1, 1993), 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 thresholds for FY 2006 will result in outlier payments equal to 5.1 percent of operating DRG payments and 4.85 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B) of the Act, we reduced the FY 2006 standardized amount by the same percentage to account for the projected proportion of payments paid to outliers.

The outlier adjustment factors that will be applied to the standardized amount for FY 2006 are as follows:

	Operating standardized amounts	Capital Federal rate
National	0.948990	0.951511
Puerto Rico	0.974897	0.973755

We are applying 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 outlier fixed-loss cost threshold.

The outlier final rule (68 FR 34494, June 9, 2003) eliminated the application of the statewide average cost-to-charge ratios 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 1.254 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 cost-to-charge ratios to determine whether a hospital qualifies for outlier payments.[13] Table 8A in section VI. of this Addendum contains the statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals for which the fiscal intermediary is unable to compute a hospital-specific cost-to-charge ratio within the above range. Effective for discharges occurring on or after October 1, 2005, these statewide average ratios will 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 comparable statewide average capital cost-to-charge ratios. Again, the cost-to-charge ratios in Tables 8A and 8B will 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 3.52 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 that went into effect on August 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 4.1 percent of actual total DRG payments, 1 percentage point lower than the 5.1 percent we projected in setting the 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 final 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 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 0.999865.

In order to achieve budget neutrality, we are adjusting national IPPS rates by an amount sufficient to account for the added costs of this demonstration. In other words, we are applying 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. 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 applying 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 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. For hospitals in Puerto Rico the labor-related share of the standardized amount is 58.7 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 final rule (reflecting the Secretary's current estimate of the proportion of costs that are attributable to wages and wage-related costs), we are setting the labor-related share of the standardized amount at 69.7 percent for hospitals whose wage indexes are greater than 1.0000. For hospitals in Puerto Rico the labor-related share of the standardized amount is 62 percent for all hospitals whose wage indexes are greater than 1.0000. In addition, Tables 1A and 1B include standardized amounts reflecting the full 3.7 percent update for FY 2006, and standardized amounts reflecting the 0.4 percentage point reduction to the update applicable for hospitals that fail to submit quality data consistent with section 501(b) of Pub. L. 108–173. (Tables 1C and 1D show the standardized amounts for Puerto Rico for FY 2006, reflecting the different labor-related shares that apply, that is, 58.7 percent or 62 percent.)

The following table illustrates the changes from the FY 2005 national average standardized amount. The first column shows the changes from the FY 2005

[13] These figures represent 3.0 standard deviations from the mean of the log distribution of cost-to-charge ratios for all hospitals.

standardized amounts for hospitals that satisfy the quality data submission requirement for receiving the full update (3.7 percent). The second column shows the changes for hospitals receiving the reduced update (3.3 percent). The first row of the table shows the 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 FY 2006 SINGLE STANDARDIZED AMOUNT WITH FULL UPDATE AND REDUCED UPDATE

	Full update (3.7 percent)	Reduced update (3.3 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 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
FY 2006 Update Factor	1.037	1.033
FY 2006 DRG Recalibrations and Wage Index Budget Neutrality Factor	1.002271	1.002271
FY 2006 Reclassification Budget Neutrality Factor	0.992521	0.992521
Adjusted for Blend of FY 2005 DRG Recalibration and Wage Index Budget Neutrality Factors.	Labor: $3,479.54 Nonlabor: $1,512.63	Labor: $3,466.12 Nonlabor: $1,506.79
FY 2006 Outlier Factor	0.94899	0.94899
FY 2006 Labor Market Wage Index Transition Budget Neutrality Factor	0.998859	0.998859
Rural Demonstration Budget Neutrality Factor	0.999865	0.999865
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: $2,933.52 Nonlabor: $1,797.95	Labor: $2,922.20 Nonlabor: $1,791.02
Rate for FY 2006 (after multiplying FY 2005 base rate by above factors) where the wage index is greater than 1.0000.	Labor: $3,297.84 Nonlabor: $1,433.63	Labor: $3,285.12 Nonlabor: $1,482.10

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 specific standardized amount is 58.7 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 1C, as set forth in section VI. of this Addendum, contain the labor-related and nonlabor-related shares that we are using to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of the preamble to this final rule, we discuss the data and methodology for the FY 2006 wage index. The 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 adjusting 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.

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 of this final rule, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section VI. of this Addendum contains the relative weights that we are using for discharges occurring in FY 2006. These factors have been recalibrated as explained in section II. of the preamble of this final rule.

D. Calculation of Prospective Payment Rates for FY 2006

General Formula for Calculation of Prospective Payment Rates for FY 2006

The operating prospective payment rate for all hospitals paid under the IPPS located outside of Puerto Rico, except SCHs and MDHs, equals the Federal rate based on the corresponding amounts in Table 1A or Table 1B in section VI. of this Addendum.

The 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 prospective payment rate for MDHs equals the higher of the Federal rate, or the Federal rate plus 50 percent of the difference between the Federal rate and the hospital-specific rate as described below. The prospective payment rate for Puerto Rico equals 25 percent of the Puerto Rico rate from Table 1C in section VI. Of this addendum plus 75 percent of the applicable national rate from Table 1A or Table 1B 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 FY 1984 IPPS interim final rule (September 1, 1983, 48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); the FY 1991 IPPS final rule (September 4, 1990, 55 FR 35994); and the FY 2001 IPPS final rule (August 1, 2000, 65 FR 47082). In addition, for both SCHs and MDHs, the hospital-specific rate is adjusted by the budget neutrality adjustment factor (that is, by the recalibration budget neutrality factor of 0.998993) as discussed in section V.C.2. of the preamble to this final rule. The resulting rate is used in determining the payment rate an SCH or MDH will 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 increasing the hospital-specific rates by 3.7 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 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. Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2006

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 using to determine the capital Federal rate for FY 2006, which will 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 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 FY 2006 capital Federal rate. In particular, we explain why the FY 2006 capital Federal rate will increase approximately 1.0 percent compared to the FY 2005 capital Federal rate. We also estimate aggregate capital payments will increase by 0.6 percent during this same period. This increase is due to several factors, including the update to the capital Federal rate (discussed in section III.A.1.a. of this Addendum) and a projected increase in outlier payments. We are projecting a slight increase in capital outlier payments as a result of the decrease in the outlier thresholds (as discussed in section II.A.4.c. this Addendum). Thus, we are projecting that capital PPS payments will increase slightly 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 increase 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 update factor for FY 2006 under that framework is 0.8 percent based on the best data available at this time. The update factor is based on a projected 0.8 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 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 final 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 will also equal 1.0 percent in FY 2006. The net adjustment for change in case-mix is the difference between the projected increase in case-mix and the projected total increase in case-mix. Therefore, the net 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 update for FY 2006. We estimate that FY 2004 DRG reclassification and recalibration will result in a 0.0 percent change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we are making a 0.0 percent adjustment for DRG reclassification and recalibration in the update for FY 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 making a 0.0 percent adjustment for forecast error in the update for FY 2006.

Under the capital IPPS update framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data that were used in the framework used in the past under the operating IPPS. 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. Accordingly, in the FY 2006 IPPS proposed rule (70 FR 23476), we proposed a 0.0 percent adjustment for intensity for FY 2006. As we explained in that same proposed rule, 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 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. Therefore, in this final rule, we are establishing a 0.0 percent adjustment for intensity for FY 2006.

Above we described the basis of the components used to develop the 0.8 percent capital update factor for FY 2006 as shown in the table below.

CMS FY 2006 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE

Capital Input Price Index	0.8
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 Update	0.8

b. Comparison of CMS and MedPAC Update Recommendation

As we discussed in the FY 2006 IPPS proposed rule (70 FR 23477), 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. 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 will equal 4.85 percent for inpatient capital-related payments based on the Federal rate in FY 2006. Therefore, we are applying an outlier adjustment factor of 0.9515 to the capital Federal rate. Thus, the percentage of capital outlier payments to total capital standard payments for FY 2006 will be lower 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 FY 2006 outlier adjustment of 0.9515 is a 0.09 percent change from the FY 2005 outlier adjustment of 0.9506. The net change in the outlier adjustment to the capital Federal rate for FY 2006 is 1.0009 (0.9515/0.9506). Thus, the outlier adjustment increases the FY 2006 capital Federal rate by 0.09 percent compared with the FY 2005 outlier adjustment.

3. 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 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 FY 2006 relative weights and the 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 applying an incremental budget neutrality adjustment of 1.0019 for FY 2006 to the weighted average of the previous cumulative FY 2005 adjustments of 0.9912 (yielding an adjustment of 0.9931) through FY 2006 (calculations done on unrounded numbers). For the Puerto Rico GAF, we are applying an incremental budget neutrality adjustment of 1.0076 for FY 2006 to the previous cumulative FY 2005 adjustment of 0.9895, yielding a cumulative adjustment of 0.9970 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 FY 2006 DRG relative weights and the FY 2006 GAF. The incremental adjustment for DRG classifications and changes in relative weights is 0.9989 both nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the GAF through FY 2005 are 0.9920 nationally and 9.9959 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

BILLING CODE 4120–01–P

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	1.00185[14]	0.99892	1.00076[14]	0.99198	1.00762	0.99892	1.00653	0.99592

[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 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 establishing a GAF/DRG budget neutrality factor of 1.0008. The GAF/DRG budget neutrality factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows from the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The incremental change in the adjustment from the average from FY 2005 to FY 2006 is 1.0008. The cumulative change in the capital Federal rate due to this adjustment is 0.9920 (the product of the incremental factors for FYs 1993 though 2005 and the incremental factor of 1.0008 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 cumulative adjustment of 0.9920 for FY 2006.)

This 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. 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 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 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 adjustment based on actual cost experience. Using data from cost reports ending in FY 2004 from the March 2005 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 offsetting the capital Federal rate by 0.03 percent for special exceptions payments for FY 2006. Therefore, the 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 will equal 0.03 percent of aggregate payments based on the FY 2006 capital Federal rate. Therefore, we are applying an exceptions payment adjustment factor of 0.9997 to the capital Federal rate for FY 2006. The 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 net change in the exceptions adjustment factor used in determining the FY 2006 capital Federal rate is 1.0001 (0.9997/0.9996).

5. 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 final rule, we are establishing a capital Federal rate of $420.65 for FY 2006. The capital Federal rate for FY 2006 was calculated as follows:

- The FY 2006 update factor is 1.0080; that is, the update is 0.8 percent.
- The 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 1.0008.
- The FY 2006 outlier adjustment factor is 0.95150.
- The FY 2006 (special) exceptions payment adjustment factor is 0.9997.

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

We are providing a chart that shows how each of the factors and adjustments for FY 2006 affected the computation of the FY 2006 capital Federal rate in comparison to the average FY 2005 capital Federal rate. The FY 2006 update factor has the effect of increasing the capital Federal rate by 0.80 percent compared to the average FY 2005 Federal rate. The GAF/DRG budget neutrality factor has the effect of increasing the capital Federal rate by 0.8 percent. The FY 2006 outlier adjustment factor has the effect of increasing the capital Federal rate by 0.09 percent compared to the average FY 2005 capital Federal rate, and the 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 changes is to increase the capital Federal rate by 0.99 percent compared to the average FY 2005 capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2005 CAPITAL FEDERAL RATE AND FY 2006 CAPITAL FEDERAL RATE

	FY 2005	FY 2006	Change	Percent change
Update factor[1]	1.0070	1.0080	1.0080	0.80
GAF/DRG Adjustment Factor[1]	1.0004	1.0008	1.0008	0.08
Outlier Adjustment Factor[2]	0.9506	0.9515	1.0009	0.09

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2005 CAPITAL FEDERAL RATE AND FY 2006 CAPITAL FEDERAL RATE—Continued

	FY 2005	FY 2006	Change	Percent change
Exceptions Adjustment Factor[2]	0.9996	0.9997	0.0001	0.01
Capital Federal Rate[3]	$416.53	$420.65	1.0099	0.99

[1]The update factor and the GAF/DRG budget neutrality factors are built permanently into the capital rates. Thus, for example, the incremental change from FY 2005 to FY 2006 resulting from the application of the 1.0008 GAF/DRG budget neutrality factor for FY 2006 is 1.0008. [2]The outlier reduction factor and the exceptions adjustment factor are not built permanently into the capital rates; that is, these factors are not applied cumulatively in determining the capital rates. Thus, for example, the net change resulting from the application of the FY 2006 outlier adjustment factor is 0.9515/0.9506, or 1.0009. [3]The percent change in factors may not sum due to rounding.

We are also providing a chart that shows how the final FY 2006 capital Federal rate differs from the proposed FY 2006 capital Federal rate presented in the FY 2006 IPPS proposed rule (70 FR 23480).

COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 2006 CAPITAL FEDERAL RATE AND FINAL FY 2006 CAPITAL FEDERAL RATE

	Proposed FY 2006	Final FY 2006	Change	Percent Change
Update factor	1.0070	1.0080	1.0010	0.10
GAF/DRG Adjustment Factor	1.0019	1.0008	0.9989	−0.11
Outlier Adjustment Factor	0.9497	0.9515	1.0019	0.19
Exceptions Adjustment Factor	0.9997	0.9997	0.0000	0.00
Capital Federal Rate	$419.90	$420.65	1.0018	0.18

6. 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 final 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 GAF budget neutrality factor is 1.0076, while the DRG adjustment is 0.9989, for a combined cumulative adjustment of 0.9959.

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 making to the factors used to determine the capital rate, the FY 2006 special capital rate for Puerto Rico is $201.93.

B. Calculation of 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 capital Federal rate was determined by making adjustments as follows:

- For outliers, by dividing the capital standard Federal rate by the outlier reduction factor for that fiscal year; and
- For the payment adjustments applicable to the hospital, by multiplying the hospital's GAF, disproportionate share adjustment factor, and IME adjustment factor, when appropriate.

For purposes of calculating payments for each discharge during FY 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 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 $23,600.

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 rebasing to FY 2002 in section IV. of the preamble of this final rule.)

2. Forecast of the CIPI for FY 2006

Based on the latest forecast by Global Insight, Inc. (second quarter of 2005), we are forecasting the CIPI to increase 0.8 percent in FY 2006. This reflects a projected 1.4 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.3 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 0.8 percent increase for the CIPI as a whole in FY 2006.

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

A. Payments to Existing Excluded Hospitals and Units

As discussed in section VII. of the preamble of this final rule, in accordance with section 1886(b)(3)(H)(i) of the Act and effective for cost reporting periods beginning on or after October 1, 2002, payments to existing psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals (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 was set for each hospital. 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. LTCHs and IPFs that have part of their payments based on reasonable costs also have the reasonable cost portion subject to the rate of increase limits in § 413.40.

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 existing 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. New IPFs are paid based on 100 percent of the Federal per diem payment amount (§ 412.426). 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.

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 adjusted 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 under § 413.40(f)(2)(ii)

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 adjusted 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 reasonable cost-based payment amount TEFRA. 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 discontinuing the publication of 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

As discussed in section VIII. of the preamble to this final 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, as we proposed in the FY 2006 IPPS proposed rule, we are providing that, for FY 2006, the fiscal intermediaries make payment for blood clotting factor using 106 percent of ASP (that is ASP+ 6 percent) 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 final 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 Labore 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 Wage Indexes for Federal Fiscal Year 2006; 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 and 3-Year Average Hourly Wage for Urban 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, and Geometric and Arithmetic Mean Length of Stay (LOS)
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 March 2005 GROUPER V22.0]
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay [FY 2004 MedPAR Update March 2005 GROUPER V23.0]
Table 8A—Statewide Average Operating Cost-to-Charge Ratios—July 2005
Table 8B—Statewide Average Capital Cost-to-Charge Ratios—July 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(d)(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)—July 2005
Table 11—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 (3.7 percent)		Reduced update (3.3 percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,297.84	$1,433.63	$3,285.12	$1,428.10

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 (3.7 percent)		Reduced update (3.3 percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$2,933.52	$1,797.95	$2,922.20	$1,791.02

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

	Rates if wage index greater than 1		Rates if wage index less than or equal to 1	
	Labor	Nonlabor	Labor	Nonlabor
National	$3,297.84	$1,433.63	$2,933.52	$1,797.95
Puerto Rico	$1,402.46	$859.57	$1,327.81	$934.22

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$420.65
Puerto Rico	$201.93

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
010001	1.4738	0.7757	$19.4061	$20.6563	$21.6546	$20.5970
010004	***	*	$22.2674	$22.7585	*	$22.4801
010005 [h]	1.1467	0.9379	$19.6063	$20.4937	$22.4906	$20.9007
010006	1.4559	0.8297	$19.0976	$21.0241	$23.4823	$21.1655
010007	1.0885	0.7463	$17.5462	$16.8811	$18.2430	$17.5458
010008	1.0025	0.8300	$19.6573	$23.8333	$20.4591	$21.3782
010009	0.9852	0.8601	$20.4309	$21.6422	$23.2229	$21.7690
010010 [h]	1.0269	0.9379	$19.2644	$22.3021	$21.4974	$21.0618
010011	1.5830	0.8959	$25.8231	$24.8166	$27.4850	$26.0626
010012	1.2324	0.9089	$20.0896	$21.7622	$22.7020	$21.5233
010015	0.9730	0.7463	$18.8890	$20.4732	$21.5111	$20.4315
010016	1.3312	0.8959	$21.7918	$23.0414	$25.1502	$23.3217
010018	1.2538	0.8959	$19.2071	$20.5888	$22.2990	$20.6865
010019	1.2330	0.8297	$18.9177	$20.1336	$22.0906	$20.4039
010021 [h]	1.2024	0.7757	$17.7596	$20.7108	$18.6785	$19.0123
010022	0.9447	0.9405	$22.2267	$25.8797	$24.5670	$24.2502
010023	1.8563	0.8630	$20.4901	$23.7791	$27.6174	$23.7666
010024	1.6214	0.8630	$18.5942	$20.0067	$20.7265	$19.7702
010025	1.3289	0.8394	$19.3649	$19.8561	$21.2674	$20.1430
010027	0.7679	0.7463	$14.0975	$14.9585	$15.3704	$14.7992
010029	1.5563	0.8394	$20.9868	$21.6724	$22.6976	$21.8061
010031	***	*	$21.0176	$20.9463	*	$20.9818
010032	0.8874	0.7463	$16.4713	$18.5073	$19.1555	$18.1219
010033	2.0404	0.8959	$24.5088	$25.5165	$26.3784	$25.4860
010034	0.9689	0.8630	$14.9333	$17.1625	$16.9686	$16.3417
010035	1.2590	0.8959	$21.6182	$23.1319	$22.2870	$22.3532
010036	1.1539	0.7463	$19.2501	$20.5125	$22.9747	$20.9446
010038	1.3348	0.7779	$18.6578	$20.3935	$21.4509	$20.2189
010039	1.6434	0.9120	$23.0339	$23.4151	$25.8820	$24.1525
010040	1.4704	0.7966	$20.7779	$21.6708	$22.8851	$21.7864
010043	1.0652	0.8959	$19.9012	$19.5422	$22.5945	$20.7320
010044	1.0535	0.8959	$25.8560	$23.0220	$21.4036	$23.2608
010045	1.0943	0.8959	$22.7713	$20.5658	$19.8803	$20.8779
010046	1.4623	0.7966	$19.6754	$20.8935	$21.6965	$20.8067
010047	0.8851	0.7618	$16.1695	$19.5937	$21.0604	$18.8438
010049	1.0914	0.7463	$16.2973	$17.7801	$20.2413	$18.1494
010050	1.0423	0.8959	$20.7398	$21.5625	$22.1584	$21.5077
010051	0.9034	0.8648	$14.3006	$14.7053	$15.2208	$14.7351
010052	0.8752	0.7463	$11.9019	$21.3673	$16.4959	$15.4174
010053	1.0186	0.7463	$17.3238	$17.4160	$19.0108	$17.9166
010054	1.0675	0.8601	$20.6382	$23.1894	$22.5554	$22.1149
010055	1.5040	0.7757	$18.9664	$19.1847	$22.3800	$20.1389
010056	1.5304	0.8959	$21.1104	$22.7183	$23.7144	$22.5773
010058	0.8812	0.8959	$17.7800	$20.3182	$18.5537	$18.9295
010059	1.0579	0.8509	$20.5534	$23.6963	$21.3237	$21.8874
010061	0.9745	0.7969	$17.0447	$20.5683	$21.9370	$19.8088
010062	1.0751	0.7757	$17.1786	$18.1323	$18.3435	$17.8796
010064	1.7028	0.8959	$22.2280	$25.4345	$26.1110	$24.2542
010065	1.4305	0.8300	$17.2698	$20.0108	$21.3785	$19.6007
010066	0.8403	0.7463	$14.8696	$17.0935	$17.6152	$16.5083
010068	1.2166	0.8959	$18.3308	$17.5690	$19.0789	$18.3440
010069	1.0532	0.7463	$17.0957	$19.6317	$21.3608	$19.4027
010072	1.1497	0.7717	$18.8807	$21.5419	$21.8169	$20.7331
010073	0.9378	0.7463	$14.9826	$16.4043	$16.4168	$15.9303
010078	1.3765	0.7779	$20.1447	$21.0633	$21.6857	$20.9549
010079	1.1745	0.9120	$20.7401	$20.4254	$21.8199	$21.0143
010083 [h]	1.2054	0.8081	$19.8524	$20.2166	$22.3041	$20.7945
010084	1.5407	0.8959	$21.6522	$22.5219	$24.7127	$22.9810
010085	1.2286	0.8601	$22.5282	$23.7007	$24.4710	$23.5499
010086	1.0940	0.7463	$18.0122	$19.4332	$18.6081	$18.6721
010087	1.9263	0.7898	$19.7620	$21.6226	$22.5225	$21.2536
010089	1.2383	0.8959	$19.5783	$22.2508	$22.8448	$21.5236
010090	1.6654	0.7898	$20.0287	$21.4322	$23.6948	$21.7237
010091	0.9268	0.7463	$17.4672	$19.4222	$18.6912	$18.5367
010092	1.5091	0.8648	$19.9351	$22.0709	$24.4592	$22.1357
010095	0.8679	0.8648	$12.5243	$13.4426	$13.9326	$13.3037
010097	0.7797	0.8630	$15.1593	$17.1735	$16.7548	$16.2912

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
010098	1.1057	0.7463	$15.1629	$19.6717	$14.3076	$16.0844
010099	0.9928	0.7463	$16.3307	$18.1849	$18.7909	$17.7973
010100 [h]	1.6620	0.8081	$19.8146	$20.0027	$21.2915	$20.4113
010101	1.1183	0.7717	$19.0718	$21.0085	$21.6593	$20.5878
010102	0.9035	0.7463	$16.4637	$19.9196	$21.0903	$19.1526
010103	1.8583	0.8959	$22.5709	$24.2201	$26.1163	$24.2529
010104	1.7367	0.8959	$20.9391	$24.1929	$24.7394	$23.1972
010108	1.0869	0.8630	$20.7787	$23.7803	$28.4624	$24.2639
010109	0.9573	0.7914	$18.2235	$21.7128	$21.6194	$20.4648
010110	0.7413	0.7463	$16.0015	$19.2706	$17.5957	$17.7893
010112	0.9711	0.7463	$17.9243	$17.2963	$16.8902	$17.3960
010113	1.6497	0.7898	$19.4106	$20.4181	$21.4121	$20.4357
010114	1.3236	0.8959	$20.1763	$21.5319	$22.3752	$21.3396
010115	0.8303	0.7556	$15.7872	$17.5985	$21.7478	$17.8278
010118	1.2532	0.8300	$19.5302	$18.8560	$19.7673	$19.4467
010119	***	*	$20.5245	$21.8215	*	$21.1743
010120	0.9549	0.7898	$19.4368	$20.5855	$20.9450	$20.3424
010121	***	*	$17.1640	$17.0329	$24.0867	$18.5589
010125	1.0390	0.7463	$16.8622	$16.8419	$18.4114	$17.3762
010126	1.1100	0.8300	$19.9647	$23.1856	$23.1381	$22.1149
010128	0.8402	0.7463	$14.7646	$17.9354	$21.4201	$18.0579
010129 [h]	0.9911	0.8019	$16.4905	$18.7821	$21.3555	$19.1436
010130	0.9505	0.8959	$18.7190	$18.4944	$23.2488	$20.0658
010131	1.3400	0.9120	$22.9969	$24.2197	$25.7837	$24.4029
010134	***	*	$17.7717	*	*	$17.7717
010137	1.2752	0.8959	$28.9402	$29.7665	$24.7366	$27.6545
010138	0.6239	0.7463	$14.2025	$13.5082	$13.8475	$13.8713
010139	1.5213	0.8959	$22.8390	$24.9410	$25.3014	$24.4108
010143	1.1690	0.8959	$20.5639	$22.1312	$22.0215	$21.5734
010144	1.5618	0.7898	$19.1497	$20.6425	$20.8209	$20.2306
010145	1.2807	0.8648	$22.1394	$23.1976	$24.9531	$23.4608
010146	1.0363	0.7779	$21.3083	$19.9944	$20.8917	$20.7213
010148	0.8816	0.7463	$17.6829	$18.5309	$20.5589	$19.0324
010149	1.3313	0.8630	$21.0086	$3.1593	$26.5854	$23.4663
010150	1.0526	0.8394	$21.2360	$20.6738	$21.6377	$21.1783
010152	1.2065	0.7898	$21.6038	$22.1626	$22.6202	$22.1446
010157	1.1281	0.8297	$19.6977	$21.3574	$24.3560	$21.7462
010158	1.0829	0.8509	$18.5464	$22.4440	$24.3531	$21.6528
010161	***	*	*	$27.5119	*	$27.5119
010162	1.8283	0.8959	*	*	*	*
010163	1.2761	0.7757	*	*	*	*
010164	1.0870	0.7717	*	*	*	*
010165	1.7531	0.9120	*	*	*	*
020001	1.6984	1.1965	$30.1452	$31.6091	$32.8120	$31.6051
020004	1.1704	1.1965	$27.3516	$29.9926	$32.0966	$29.8229
020005	0.9519	*	$32.7936	*	*	$32.7936
020006	1.2203	1.1965	$31.2673	$33.4210	$36.0540	$33.6428
020008	1.2317	1.2828	$33.4543	$34.5856	$35.9236	$34.6652
020010	***	*	$20.7929	*	*	$20.7929
020012	1.3442	1.1965	$27.9955	$29.3419	$31.8995	$29.8198
020013	***	*	$30.6423	*	*	$30.6423
020014	1.0326	1.1965	$29.6805	$32.1233	$32.0893	$31.3377
020017	1.9353	1.1965	$30.3017	$32.9281	$33.5852	$32.3606
020018	0.9338	1.1965	*	*	*	*
020019	0.8198	1.9343	*	*	*	*
020020	0.8449	*	*	*	*	*
020021	0.9569	*	*	*	*	*
020024	1.1394	1.1965	$28.0930	$27.9799	$33.0644	$29.9221
020026	1.5552	1.9343	*	*	*	*
020027	0.9166	1.9343	*	*	*	*
030001	1.3883	1.0129	$25.7513	$27.7572	$29.9840	$27.8499
030002	2.0946	1.0129	$25.6038	$27.9628	$29.0519	$27.5075
030003	***	*	$22.1436	*	*	$22.1436
030004	0.8735	*	*	*	*	*
030006	1.6926	0.9027	$23.2881	$24.0169	$25.8872	$24.4719
030007	1.3598	1.1382	$26.1551	$26.9442	$29.6174	$27.6578
030009	0.8941	0.9027	$19.9131	$21.4065	$22.3992	$21.1294

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
030010	1.3563	0.9027	$20.7204	$22.8647	$24.8275	$22.8055
030011	1.4714	0.9027	$21.0028	$22.8422	$25.1361	$23.0075
030012	1.3007	0.9422	$24.2366	$25.5205	$26.3859	$25.4550
030013	1.3461	0.9179	$21.9766	$23.5229	$25.7050	$23.8047
030014	1.4729	1.0129	$23.3663	$25.1189	$25.6259	$24.7232
030016	1.2676	1.0129	$24.3380	$27.1583	$26.7003	$26.0910
030017	2.0460	1.0129	$21.8792	$24.4055	$26.2452	$24.0378
030018	1.2271	1.0129	$24.9216	$24.4308	$28.9476	$25.9371
030019	1.3599	1.0129	$23.2973	$28.4917	$27.3156	$26.2053
030022	1.5548	1.0129	$24.9941	$25.1461	$26.4404	$25.5437
030023	1.6260	1.2082	$28.6627	$28.4112	$33.8333	$30.2808
030024	2.0251	1.0129	$26.7641	$28.3470	$31.6658	$28.9293
030027	0.9336	0.9007	$19.4583	$21.0527	$20.4031	$20.3074
030030	1.6760	1.0129	$25.2425	$24.6005	$30.2712	$26.5838
030033	1.2098	1.1382	$26.3814	$26.6009	$26.6531	$26.5511
030036	1.3281	1.0129	$24.9432	$26.5708	$30.3521	$27.3868
030037	2.2386	1.0129	$23.0542	$30.3907	$28.6453	$27.0409
030038	1.6056	1.0129	$25.2632	$26.5178	$29.5509	$27.6724
030040	0.9548	0.9007	$21.2717	$22.5130	$24.8145	$22.8703
030043	1.3515	0.9007	$23.5172	$26.0825	$24.7932	$24.8113
030044	0.9107	*	$21.9503	$19.5714	*	$20.6512
030055 [h]	1.3655	1.1404	$22.8612	$23.1837	$24.5202	$23.5684
030059	***	*	*	$24.7676	*	$24.7676
030060	1.1098	0.9007	$21.7685	$22.3551	$24.3523	$22.7950
030061	1.6175	1.0129	$22.9706	$23.4722	$25.5529	$24.0363
030062	1.1767	0.9007	$21.1639	$21.9849	$23.8068	$22.3433
030064	1.9148	0.9027	$22.8009	$24.6732	$25.4922	$24.2954
030065	1.5739	1.0129	$24.6064	$25.6738	$27.1646	$25.8836
030067	1.0119	0.9007	$18.4003	$19.1332	$20.4376	$19.2370
030068	1.1175	0.9007	$19.7097	$19.7030	$20.8846	$20.1346
030069 [h]	1.3479	1.1404	$24.5432	$25.6243	$26.3518	$25.5167
030071	0.9121	1.4448	*	*	*	*
030073	1.0619	1.4448	*	*	*	*
030074	1.3283	1.4448	*	*	*	*
030077	0.8892	1.4448	*	*	*	*
030078	1.2973	1.4448	*	*	*	*
030080	1.5280	0.9027	$22.8953	$24.3573	$25.2077	$24.1500
030083	1.3085	1.0129	$24.3273	$24.9269	$27.5353	$25.6343
030084	0.9817	1.4448	*	*	*	*
030085	1.5277	0.9027	$21.8196	$23.2070	$24.5792	$23.3008
030087	1.5910	1.0129	$25.6351	$26.3878	$26.6594	$26.2197
030088	1.3843	1.0129	$23.5761	$23.2478	$26.6796	$24.5472
030089	1.5441	1.0129	$24.5055	$26.2166	$27.1835	$26.0965
030092	1.3900	1.0129	$24.0515	$25.4127	$27.3203	$25.7452
030093	1.2317	1.0129	$23.2485	$23.5623	$25.8955	$24.3686
030094	1.3602	1.0129	$24.5992	$26.9985	$29.5948	$27.0516
030099	0.9027	0.9007	$20.3310	$26.7996	$26.3236	$24.0344
030100	2.0028	0.9027	$27.6299	*	$29.0691	$28.4177
030101 [h]	1.4076	1.1404	$23.7661	$25.0077	$26.1927	$25.0150
030102	2.5592	1.0129	$27.9419	*	$29.0942	$28.5553
030103	1.6685	1.0129	$29.1105	$28.2832	$30.1994	$29.2117
030104	***	*	$34.6028	*	*	$34.6028
030105	2.4472	1.0129	*	$27.6900	$31.3094	$29.8084
030106	1.5550	1.0129	*	$30.4791	$34.7222	$32.1177
030107	2.2261	1.0129	*	*	*	*
030108	1.9023	1.0129	*	*	*	*
030109	2.1680	1.0129	*	*	*	*
030110	1.0957	1.0129	*	*	*	*
030111	0.8225	0.9027	*	*	*	*
030112	1.8096	1.0129	*	*	*	*
040001	1.0611	0.8707	$18.7141	$23.1475	$23.7718	$21.8056
040002	1.1352	0.7493	$18.0776	$19.3429	$20.1384	$19.2037
040003	1.0582	*	$16.3918	$18.5000	*	$17.3854
040004	1.5440	0.8707	$21.2335	$23.3504	$25.0286	$23.2843
040007	1.6746	0.8759	$23.3992	$23.4565	$25.7142	$24.1728
040010	1.3668	0.8707	$20.7114	$22.0984	$23.0274	$21.9856
040011	1.0105	0.7493	$18.8346	$19.0319	$20.3970	$19.4802

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
040014	1.3837	0.8558	$22.4970	$24.0846	$25.3451	$23.9535
040015	1.0508	0.7493	$18.8513	$18.0793	$19.2831	$18.7435
040016	1.7065	0.8759	$21.2198	$22.7219	$22.1228	$22.0244
040017	1.0997	0.8242	$17.7545	$19.4365	$21.9875	$19.7066
040018	0.9918	0.8247	$22.0408	$23.8515	$23.6044	$23.2404
040019	1.1532	0.9148	$21.1711	$21.5316	$23.7328	$22.1722
040020	1.5108	0.9148	$18.6419	$20.9136	$21.6603	$20.4199
040021	1.2519	0.8759	$23.5620	$24.7771	$25.6917	$24.7363
040022	1.6253	0.8707	$21.4194	$23.7462	$25.4052	$23.5017
040024	1.0583	*	$17.5750	$20.1101	*	$18.8371
040026	1.5143	0.9020	$22.7699	$24.3053	$25.4072	$24.2169
040027	1.3588	0.8242	$19.3388	$19.9348	$21.1412	$20.1077
040029	1.5605	0.8759	$22.1882	$22.8770	$24.0704	$23.0869
040032	0.9574	*	$16.2781	$18.5171	*	$17.4291
040035	0.9191	*	$11.8237	$13.4265	*	$12.6475
040036	1.5893	0.8759	$21.6742	$24.2851	$26.3226	$24.0976
040039	1.3470	0.7784	$15.9673	$17.7976	$19.5998	$17.8170
040041	1.1930	0.8558	$20.4646	$22.0188	$22.1531	$21.5535
040042	1.3638	0.9402	$16.2285	$18.9550	$19.9627	$18.3286
040045	0.9454	0.7493	$19.5572	$18.7952	$17.2280	$18.4644
040047	1.0852	0.7919	$21.6323	$21.5334	$21.9163	$21.6924
040050	1.0870	0.7493	$15.1428	$15.4782	$16.3930	$15.6589
040051	0.9253	0.7493	$17.6964	$18.8943	$19.1401	$18.6103
040053	1.0125	0.7493	$19.2586	$20.8153	$20.7824	$20.2863
040054	1.0370	0.7493	$16.5573	$16.7370	$18.2684	$17.1740
040055	1.5720	0.8247	$19.7336	$22.2237	$23.3156	$21.7960
040062	1.5986	0.8247	$21.9336	$21.6403	$23.3083	$22.3231
040066	1.0416	*	$21.7766	$23.4616	*	$22.6592
040067	1.0257	0.7493	$16.0516	$15.1441	$16.8799	$16.0038
040069	1.0526	0.9148	$20.5968	$21.7607	$24.4662	$22.2668
040071	1.5315	0.8733	$19.4324	$22.9350	$24.3824	$22.1870
040072	1.0802	0.8558	$19.3079	$20.8269	$19.9009	$19.9951
040074	1.2035	0.8759	$22.0800	$22.6147	$25.2423	$23.2187
040075	0.9612	0.7493	$15.7875	$16.2583	$18.3254	$16.7901
040076	1.0330	0.8842	$23.5947	$21.0442	$20.6272	$21.6458
040077	0.9696	0.7493	$16.7832	$18.3261	$18.2082	$17.7537
040078	1.5651	0.9020	$21.4854	$24.4589	$24.5378	$23.4806
040080	0.9900	0.7784	$18.4470	$21.3483	$22.3392	$20.6867
040081	0.8227	0.7493	$13.2797	$13.7148	$15.1081	$14.0348
040084	1.0802	0.8759	$20.1163	$22.6441	$24.7225	$22.5619
040085	1.0020	0.7493	$15.5811	$18.0756	$29.8444	$19.6100
040088	1.3134	0.8758	$20.0032	$21.2974	$22.6183	$21.3215
040091	1.1579	0.8285	$20.6688	$23.0252	$23.1320	$22.2743
040100	1.3499	0.8558	$17.8889	$19.3560	$20.0460	$19.1639
040105	1.0187	0.7493	$15.4697	$15.8171	$18.2182	$16.4079
040107	0.7355	*	$17.6695	*	*	$17.6695
040109	1.0950	0.7493	$17.1706	$18.8624	$22.8801	$19.5134
040114	1.7269	0.8759	$21.6849	$23.5628	$24.8992	$23.4046
040118	1.4172	0.7960	$21.7913	$24.2547	$24.7363	$23.6447
040119	1.4440	0.8558	$19.9013	$20.1631	$21.0103	$20.3637
040126	0.8734	0.7493	$13.3832	$12.5944	$14.0701	$13.3074
040132	***	*	$29.2343	$36.5525	$28.1390	$31.3524
040134	2.4871	0.8759	$24.4646	*	$27.3412	$25.9794
040137	1.2240	0.8759	$24.7813	$23.4672	$25.2907	$24.5263
040138	1.2558	0.8707	$22.3523	$23.3615	$25.7513	$23.9295
040140	***	*	*	$25.1224	*	$25.1224
040141	0.7865	0.8707	*	*	$24.0901	$24.0901
040142	1.2881	0.9020	*	*	$27.9695	$27.9695
040144	1.8281	0.8247	*	*	*	*
040145	1.6490	0.7960	*	*	*	*
040146	1.5160	0.8707	*	*	*	*
050002	1.3838	1.5463	$30.9729	$31.9709	$34.1948	$32.4064
050006	1.6406	1.1897	$25.4604	$27.6176	$30.5373	$27.9248
050007	1.4970	1.4974	$34.1406	$37.5804	$38.7033	$36.8959
050008	1.3604	1.5000	$32.4067	$36.9371	$39.1539	$36.3445
050009	1.8013	1.3972	$30.2740	$35.5384	$39.6393	$35.2947
050013	2.0861	1.3972	$29.8401	$31.7637	$31.9837	$31.2570

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
050014	1.1355	1.2949	$27.7646	$29.5726	$33.0373	$30.2311
050015	1.2876	1.1042	$27.5652	$30.1398	$30.7940	$29.4852
050016	1.2303	1.1449	$25.5508	$25.5735	$26.2162	$25.7788
050017	1.9469	1.2949	$28.4911	$30.5863	$36.6593	$31.9215
050018	1.1836	1.1793	$17.9621	$20.3179	$22.3472	$20.1629
050022	1.5996	1.1296	$28.1312	$28.2773	$29.8632	$28.8610
050024	1.1356	1.1406	$25.1425	$26.9378	$27.5587	$26.6747
050025	1.8361	1.1406	$29.8262	$31.7242	$36.1622	$32.6605
050026	1.5525	1.1406	$24.2564	$26.6406	$28.3027	$26.5474
050028	1.2414	1.1042	$18.7866	$21.5448	$26.6160	$21.9931
050029	***	*	$30.2538	$34.3934	*	$31.9320
050030	1.2356	1.1042	$21.9251	$22.9148	$24.9707	$23.2719
050032	***	*	$28.8046	*	*	$28.8046
050036	1.6046	1.1042	$25.3885	$27.4915	$32.7929	$28.6943
050038	1.4838	1.5088	$36.1619	$35.0441	$38.7527	$36.6692
050039	1.6104	1.1042	$26.8993	$29.8179	$31.6734	$29.4369
050040	1.2146	1.1793	$30.7426	$31.8983	$34.3279	$32.3366
050042	1.3842	1.1897	$27.6765	$29.8062	$33.9415	$30.4516
050043	1.6433	1.5463	$37.3217	$39.6054	$43.1589	$40.0134
050045	1.2820	1.1042	$22.1691	$22.7051	$23.8408	$22.8906
050046	1.2229	1.1769	$25.5490	$25.2786	$25.6875	$25.5104
050047	1.7071	1.5000	$34.4427	$39.3993	$40.9874	$38.4201
050054	1.1951	1.1296	$21.3495	$27.1437	$24.1262	$24.0051
050055	1.2558	1.5000	$36.1182	$36.9386	$37.5879	$36.9364
050056	1.3730	1.1793	$27.1458	$29.4829	$27.9330	$28.1647
050057	1.6271	1.1042	$24.2759	$26.2099	$29.4351	$26.6650
050058	1.5543	1.1793	$25.9389	$27.3584	$33.8215	$29.0264
050060	1.5154	1.1042	$22.9491	$26.5515	$27.3282	$25.6824
050061	0.8661	1.1681	$25.3042	*	$32.2172	$28.5425
050063	1.3437	1.1793	$28.6093	$32.0515	$33.3039	$31.3845
050065	1.7814	1.1687	$28.8369	$33.8223	$34.0280	$32.3405
050067	1.2547	1.1960	$27.8867	$29.6982	$31.9597	$29.7844
050068	***	*	$21.9031	*	*	$21.9031
050069	1.6333	1.1687	$27.2744	$28.6752	$31.2172	$29.0770
050070	1.3101	1.4974	$39.5178	$40.5645	$45.3382	$41.9509
050071	1.3143	1.5463	$40.1344	$41.1036	$44.9464	$42.2000
050072	1.3841	1.5463	$39.2529	$40.8108	$44.2651	$41.6223
050073	1.3621	1.5463	$38.6763	$41.3430	$45.9765	$42.1975
050075	1.2741	1.5463	$40.2265	$43.7101	$47.2356	$44.0053
050076	2.0222	1.5463	$40.8075	$43.0845	$46.4990	$43.5903
050077	1.6862	1.1406	$27.1234	$29.6264	$32.0245	$29.6181
050078	1.3018	1.1793	$24.1091	$25.6814	$31.1425	$26.6955
050079	1.4490	1.5463	$38.8981	$42.7385	$47.8597	$43.4884
050082	1.6915	1.1769	$27.5022	$28.9139	$37.7783	$31.5037
050084	1.5652	1.1884	$26.0607	$28.2664	$33.0179	$29.0525
050088	***	*	$27.1103	$26.4093	$25.7385	$26.4472
050089	1.4042	1.1687	$24.7857	$29.4884	$33.5323	$29.3416
050090	1.2979	1.4740	$27.4193	$31.1774	$32.9584	$30.4520
050091	1.1111	1.1793	$29.2522	$30.1534	$30.8560	$30.1209
050093	1.5182	1.1042	$29.2642	$31.1083	$33.4119	$31.3614
050095	1.9620	1.5463	*	*	*	*
050096	1.3470	1.1793	$23.0525	$24.2277	$24.6680	$23.9648
050097	***	*	$24.6726	$26.6788	*	$25.5991
050099	1.5364	1.1687	$27.1282	$28.7711	$31.0437	$29.0188
050100	1.7257	1.1406	$25.6798	$28.0303	$29.6949	$27.8627
050101	1.3034	1.5194	$32.9866	$35.4655	$40.3195	$36.3932
050102	1.3335	1.1296	$25.5763	$24.9381	$29.1364	$26.2832
050103	1.5518	1.1793	$27.8079	$28.7375	$34.2529	$30.2688
050104	1.4289	1.1793	$26.1592	$29.1240	$29.7326	$28.3301
050107	1.3995	1.1681	$22.6900	$27.6002	$33.1358	$27.7768
050108	1.9705	1.2949	$28.5244	$31.4271	$35.5711	$32.0693
050110	1.2808	1.1681	$21.9297	$20.0769	$26.1453	$22.5312
050111	1.2956	1.1793	$23.7715	$26.6345	$28.1588	$26.1803
050112	1.5575	1.1793	$31.9797	$34.0258	$36.8026	$34.4310
050113	1.2863	1.4974	$32.6932	$34.2851	$33.8064	$33.6092
050114	1.4206	1.1793	$28.1938	$29.2858	$31.1294	$29.5973
050115	1.4425	1.1406	$24.1481	$27.5207	$30.9288	$27.6106

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
050116	1.5310	1.1793	$28.2924	$28.8193	$34.5110	$30.5901
050117	1.2695	1.1575	$24.7555	$28.2227	$32.4414	$28.3268
050118	1.1749	1.1960	$28.9358	$33.0650	$35.4044	$32.6634
050121	1.3421	1.1042	$25.0858	$25.5962	$27.9537	$26.3210
050122	1.5329	1.1884	$29.1534	$29.7629	$34.2416	$31.1709
050124	1.2574	1.1793	$23.0843	$26.7065	$28.0288	$25.9680
050125	1.3697	1.5088	$35.6573	$40.9218	$41.7020	$39.5040
050126	1.4092	1.1793	$27.7126	$29.6203	$29.3360	$28.8881
050127	1.3547	1.2949	$21.8719	$23.6208	$26.1222	$23.7516
050128	1.5401	1.1406	$28.7668	$28.3278	$31.0662	$29.4553
050129	1.7891	1.1687	$25.2780	$27.8488	$32.2680	$28.7272
050131	1.3037	1.4974	$37.7845	$38.6834	$40.5321	$39.0707
050132	1.4510	1.1793	$27.8805	$29.4317	$35.1544	$30.7495
050133	1.5036	1.1212	$25.1948	$27.6030	$31.3530	$28.2112
050135	1.0272	1.1793	*	$24.9415	$24.3927	$24.6796
050136	1.2278	1.4740	$31.6146	$35.2834	$37.4560	$34.8123
050137	1.3314	1.1793	$35.0503	$36.5409	$38.4827	$36.7225
050138	1.9543	1.1793	$43.0858	$43.8671	$46.9557	$44.6742
050139	1.3297	1.1793	$33.8749	$35.1013	$37.6217	$35.5604
050140	1.3938	1.1687	$36.1708	$37.5473	$39.6269	$37.8550
050144	1.4278	1.1793	$30.3679	$32.4042	$33.5109	$32.1636
050145	1.3157	1.4126	$37.5722	$39.5676	$42.3134	$39.8846
050146	1.6530	*	*	*	*	*
050148	1.1183	1.1042	$17.3908	$24.7063	$27.3005	$22.6027
050149	1.4274	1.1793	$28.0500	$30.1596	$33.2270	$30.4737
050150	1.1828	1.2949	$26.7728	$31.5333	$31.7560	$29.9321
050152	1.4073	1.5000	$34.5694	$40.3464	$43.6487	$39.6060
050153	1.5356	1.5088	$34.5870	$40.4446	$43.3190	$39.3912
050155	0.9853	1.1793	$21.2068	$21.8829	$21.8550	$21.6128
050158	1.2548	1.1793	$30.6598	$33.6400	$35.1326	$33.3121
050159	1.3195	1.1769	$27.4051	$30.8069	$31.3199	$29.8120
050167	1.3716	1.1884	$23.2022	$25.9850	$28.5179	$25.9911
050168	1.6387	1.1687	$27.5313	$30.8036	$33.2506	$30.5684
050169	1.4440	1.1793	$25.6896	$26.2864	$27.4644	$26.5104
050170	***	*	$29.4075	*	*	$29.4075
050172	1.2976	1.1042	$24.5849	$27.1497	$28.5604	$26.7638
050173	1.2683	1.1687	$27.7070	$27.6097	$30.3582	$28.5541
050174	1.6685	1.4740	$33.5204	$36.3117	$40.1747	$36.7717
050175	1.3257	1.1793	$26.9627	$31.5615	$30.5733	$29.6977
050177	1.2560	1.1769	$23.1575	$24.7531	$25.1442	$24.3743
050179	1.2062	1.1960	$23.0583	$25.8072	$27.1155	$25.4092
050180	1.5936	1.5463	$36.9905	$40.8101	$40.2504	$39.4196
050186	***	*	$27.6638	*	*	$27.6638
050188	1.3728	1.5088	$34.1503	$39.3507	$39.5110	$37.7827
050189	0.9950	1.4126	$32.3513	$20.0709	$29.1280	$26.2226
050191	1.4576	1.1793	$28.1689	*	$34.2091	$31.2052
050192	0.9922	1.1042	$19.5327	$21.2448	$27.0424	$22.7189
050193	1.2105	1.1687	$24.6307	$30.7341	$29.6421	$28.4881
050194	1.3143	1.5144	$28.1413	$38.6750	$40.9096	$35.6972
050195	1.5288	1.5463	$42.1735	$43.9696	$48.4358	$44.9294
050196	1.0813	1.1042	$20.7257	$25.2168	$32.1933	$25.8088
050197	1.9485	1.4974	*	$40.8832	$48.9052	$44.8389
050204	1.4278	1.1793	$24.9458	$25.2512	$28.6423	$26.2829
050205	1.2423	1.1793	$25.2841	$28.0504	$27.8611	$27.0700
050207	1.2722	1.1042	$25.1863	$27.0216	$29.5215	$27.2272
050211	1.2769	1.5463	$34.3396	$38.3319	$41.2166	$37.8840
050214	***	*	$22.4773	$24.4785	$23.9972	$23.6229
050215	1.6360	1.5088	$36.6063	$41.6886	$43.7985	$40.7257
050217	1.1523	*	$22.2055	$23.6286	*	$22.9187
050219	1.1203	1.1793	$21.8649	$22.9226	$22.4065	$22.4391
050222	1.6451	1.1406	$25.2922	$26.3882	$29.1094	$27.0242
050224	1.7382	1.1687	$26.2108	$26.7916	$29.3143	$27.4653
050225	1.5374	1.1042	$25.0219	$29.5184	$29.9656	$28.1785
050226	1.6099	1.1687	$26.0826	$29.2259	$30.5867	$28.6690
050228	1.3576	1.5463	$38.6751	$40.1362	$42.4226	$40.4482
050230	1.3869	1.1687	$30.0380	$34.1417	$32.9555	$32.4641
050231	1.6526	1.1793	$27.8896	$30.1298	$30.9607	$29.7082

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
050232	1.4450	1.1449	$25.3439	$24.4383	$27.4099	$25.6865
050234	1.1731	1.1406	$24.0754	$29.2421	$29.6560	$27.4243
050235	1.5444	1.1793	$27.2838	$27.8965	$29.2979	$28.1654
050236	1.3994	1.1769	$27.0687	$28.1969	$32.1647	$29.0012
050238	1.4564	1.1793	$26.0312	$29.1481	$31.1764	$28.8569
050239	1.5849	1.1793	$27.0866	$28.2327	$31.0963	$28.8857
050240	1.6565	1.1793	$32.8542	$35.2284	$35.5735	$34.6528
050242	1.3410	1.5144	$34.4412	$39.7629	$44.3130	$39.6054
050243	1.6534	1.1296	$28.5626	$31.8153	$31.4883	$30.6830
050245	1.3548	1.1687	$25.7585	$27.0949	$28.6527	$27.2127
050248	1.0461	1.4126	$29.1192	$31.6240	$35.3864	$32.0261
050251	1.0047	1.1042	$24.4552	$26.5021	$27.2675	$26.0899
050253	***	*	$23.9246	$22.2450	$24.0044	$23.3808
050254	1.2205	1.2949	$23.3358	$24.1512	$27.0041	$24.9056
050256	1.5793	1.1793	$26.8618	$28.4728	$29.8194	$28.4077
050257	1.0004	1.1042	$17.4909	$20.8367	$21.3216	$19.7770
050261	1.3301	1.1042	$21.4693	$25.3005	$27.3234	$24.7145
050262	2.1454	1.1793	$33.0425	$36.1162	$44.0256	$37.8981
050264	1.3258	1.5463	$37.4742	$41.3478	$41.1211	$39.9496
050267	***	*	$26.6558	$26.7060	*	$26.6806
050270	1.3557	1.1406	$27.9871	$30.0540	$32.4812	$30.2697
050272	1.3855	1.1687	$24.0921	$25.9103	$27.1989	$25.7666
050276	1.1976	1.5463	$34.7422	$41.2251	$39.3778	$38.5361
050277	1.0670	1.1793	$35.6323	$35.8246	$32.5213	$34.3014
050278	1.5957	1.1793	$26.0331	$28.0351	$29.9244	$28.0988
050279	1.2401	1.1687	$23.5145	$25.5299	$27.6573	$25.5685
050280	1.6713	1.2195	$28.5504	$30.6723	$35.2030	$31.5494
050281	1.5109	1.1793	$25.7832	$26.2623	$27.3824	$26.5030
050283	1.5342	1.5463	$35.1831	$38.5600	$43.0638	$39.0754
050286	***	*	$19.7352	$19.4973	*	$19.6057
050289	1.5684	1.4974	$34.9645	$38.6875	$41.1774	$38.2497
050290	1.6298	1.1793	$31.9510	$32.6388	$34.5482	$33.0758
050291	1.8266	1.4740	$28.3451	$29.6162	$35.3653	$31.1027
050292	1.0060	1.1296	$27.6114	$27.0775	$26.8879	$27.1685
050295	1.5315	1.1042	$25.4332	$31.5960	$36.1950	$30.7774
050296	1.1543	1.5088	$33.5948	$34.9952	$39.0061	$36.0343
050298	1.1432	1.1687	$26.1707	$25.8232	$27.7416	$26.6026
050299	1.2359	1.1793	$26.9870	$27.7535	$31.5435	$28.9060
050300	1.5896	1.1687	$26.3182	$28.3862	$30.7148	$28.5022
050301	1.2259	1.1042	$25.7167	$28.5769	$31.9995	$28.7858
050305	1.4554	1.5463	$38.7597	$40.9978	$44.8630	$41.5654
050308	1.4708	1.5088	$31.6790	$38.0564	$43.0691	$37.5162
050309	1.3967	1.2949	$25.5367	$28.9181	$34.4145	$29.9035
050312	1.4897	1.2195	$28.2557	$32.6846	$33.9022	$31.7615
050313	1.2490	1.1884	$25.3372	$27.5321	$31.8003	$28.5358
050315	1.3108	1.1042	$23.6638	$26.1224	$28.5933	$26.1591
050320	1.2329	1.5463	$31.4570	$36.3252	$40.2352	$36.0082
050324	1.9659	1.1406	$28.4931	$30.9958	$32.9792	$30.9355
050325	1.1941	1.1218	$26.6325	$30.2280	$30.6117	$29.1581
050327	1.6830	1.1687	$33.0549	$29.8327	$33.0087	$31.8986
050329	1.2877	1.1296	$26.6341	$26.8021	$26.2120	$26.5339
050331	1.1730	1.4740	$21.5193	$20.9847	$20.2692	$20.9637
050333	1.0827	1.1042	$15.6929	$15.3119	$23.4009	$17.5306
050334	1.7039	1.4126	$37.2336	$38.7635	$40.7467	$38.9455
050335	1.4400	1.1218	$24.9274	$27.4046	$28.9403	$27.1683
050336	1.1812	1.1884	$23.2687	$25.3062	$28.5659	$25.7519
050342	1.2397	1.1042	$23.0282	$24.7654	$26.8507	$24.9581
050348	1.7148	1.1687	$28.9864	$33.2676	$37.7898	$33.4975
050349	0.9544	1.1042	$15.6043	$16.9251	$17.4791	$16.6299
050350	1.3733	1.1793	$27.2573	$29.4262	$31.1833	$29.2715
050351	1.5221	1.1793	$27.4042	$29.3082	$30.8661	$29.2314
050352	1.2426	1.2949	$32.6572	$24.2931	$33.9362	$30.0053
050353	1.5760	1.1793	$25.4309	$26.6332	$31.8291	$27.9376
050355	***	*	*	$11.2498	*	$11.2498
050357	1.4534	1.1681	$25.2126	$26.7265	$32.3095	$27.5322
050359	1.1458	1.1042	$22.9175	$23.6030	$25.7739	$24.1671
050360	1.4790	1.4974	$35.9032	$38.8658	$37.0769	$37.3332

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
050366	1.2339	1.1042	$23.4696	$25.7692	$31.1854	$26.8679
050367	1.4231	1.5194	$32.6760	$34.4959	$38.7727	$35.6827
050369	1.4460	1.1793	$28.0909	$27.1327	$29.5697	$28.2751
050373	1.5312	1.1793	$30.7301	$32.2315	$31.9271	$31.6344
050376	1.4749	1.1793	$30.3530	$30.7562	$32.9393	$31.3430
050377	***	*	$14.3892	$20.2484	*	$16.9896
050378	1.0130	1.1793	$30.4937	$33.9087	$34.2417	$32.8674
050379	***	*	$27.5151	$31.7645	$32.9575	$30.5157
050380	1.5551	1.5088	$35.8014	$39.1098	$42.0782	$38.9514
050382	1.4416	1.1793	$26.8950	$26.0927	$29.4323	$27.5053
050385	1.3604	1.4740	*	$25.5735	$34.5184	$29.9098
050390	1.2081	1.1296	$25.7881	$28.7761	$26.0066	$26.7871
050391	1.3574	1.1793	$20.2887	$21.3012	$18.1004	$19.7304
050392	1.0336	*	$21.8139	$22.7209	*	$22.2790
050393	1.3444	1.1793	$26.4918	$28.2369	$30.0661	$28.2139
050394	1.5114	1.1769	$25.1869	$26.0074	$27.5061	$26.2967
050396	1.5986	1.1681	$28.4161	$30.5470	$33.5699	$30.9065
050397	0.8430	1.1042	$24.7279	$27.4716	$28.1640	$26.7356
050407	1.2038	1.5000	$33.2894	$35.6035	$37.9066	$35.6609
050410	0.9582	1.1042	$19.8436	$19.4995	$21.3814	$20.2094
050411	1.4367	1.1793	$35.5207	$37.3817	$37.8064	$36.9551
050414	1.3118	1.2949	$28.2381	$28.8561	$34.6672	$30.6054
050417	1.3035	1.1042	$24.5360	$25.2930	$29.5031	$26.5285
050419	1.3417	1.1897	$26.4357	$28.4471	$33.3125	$29.3954
050420	1.1580	1.1793	$26.7537	$26.1838	$24.9401	$25.8686
050423	0.9647	1.1296	$26.5188	$28.5944	$30.6416	$28.6936
050424	1.9964	1.1406	$27.5273	$29.9133	$31.0730	$29.4697
050425	1.3918	1.2949	$37.7347	$38.5317	$42.4177	$39.7789
050426	1.3428	1.1687	$30.9610	$30.0077	$30.6899	$30.5313
050430	0.9530	1.1042	$31.5170	$24.6684	$25.0607	$26.4412
050432	1.5243	1.1793	$28.1105	$30.3547	$30.8030	$29.8170
050433	0.9295	1.1042	$14.3846	$20.7565	$23.0806	$19.1896
050434	1.1531	1.1042	*	$25.9506	$26.1621	$26.0550
050435	1.1069	1.1406	$22.6618	$32.2183	$28.0306	$27.3138
050438	1.5308	1.1793	$26.5535	$26.4668	$27.2662	$26.7804
050441	1.9818	1.5088	$36.6680	$38.2823	$42.9765	$39.2937
050444	1.3397	1.1575	$23.5299	$27.6971	$30.5504	$27.3177
050447	0.9222	1.1406	$25.7274	$21.8552	$25.2573	$24.1974
050448	1.1545	1.1042	$26.6967	$25.0983	$27.9759	$26.6380
050454	1.8872	1.5000	$34.4813	$36.8383	$43.5311	$38.4458
050455	1.6960	1.1042	$24.1694	$24.5314	$22.7235	$23.7347
050456	1.2406	1.1793	$23.7594	$22.1675	$22.5630	$22.8117
050457	1.6228	1.5000	$37.4570	$40.2725	$45.5829	$41.0011
050464	1.6633	1.1960	$31.4768	$37.1342	$37.3692	$35.4838
050468	1.4897	1.1793	$17.8128	$29.4280	$29.5448	$24.3346
050469	1.1011	1.1042	$25.7995	$27.3281	$28.9079	$27.4122
050470	1.1024	1.1042	$21.6981	$18.4689	$24.6755	$21.6205
050471	1.7973	1.1793	$32.3570	$34.5484	$34.5211	$33.8184
050476	1.3677	1.1299	$26.0482	$30.9974	$34.6585	$30.3567
050477	1.5014	1.1793	$32.1676	$34.6400	$34.6995	$33.8960
050478	0.9911	1.1681	$28.3894	$30.9865	$33.3998	$30.9361
050481	1.4449	1.1793	$30.3890	$31.9177	$33.7446	$32.0928
050485	1.6093	1.1793	$27.1437	$28.8459	$31.4233	$29.1407
050488	1.3372	1.5463	$37.2438	$40.5313	$42.9904	$40.3037
050491	***	*	$29.2987	$30.6461	$32.1379	$30.5664
050492	1.4155	1.1042	$23.7384	$27.4933	$27.1540	$26.2639
050494	1.3645	1.3467	$30.8706	$35.1457	$35.9909	$33.9880
050496	1.7942	1.5463	$35.7115	$38.2871	$42.2672	$38.6931
050497	***	*	$14.4481	$15.9501	*	$15.1581
050498	1.2896	1.2949	$28.2196	$28.2667	$33.0298	$29.9964
050502	1.7506	1.1793	$28.0102	$28.7200	$29.5615	$28.8118
050503	1.4553	1.1406	$26.7924	$29.2001	$31.6418	$29.3049
050506	1.7275	1.1449	$30.4731	$32.4509	$36.0164	$33.1455
050510	1.2221	1.5463	$39.6005	$44.3883	$47.5510	$44.1129
050512	1.3790	1.5463	$39.0767	$41.8921	$46.9233	$42.8915
050515	1.3588	1.1406	$36.3131	$37.4251	$38.9978	$37.6365
050516	1.4661	1.2949	$30.0985	$29.4936	$36.2772	$31.8725

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
050517	1.0856	1.1687	$23.4131	$23.6034	$23.9007	$23.6377
050522	***	*	$38.9157	*	*	$38.9157
050523	1.2555	1.5463	$33.8053	$34.7491	$35.5452	$34.7574
050526	1.2399	1.1687	$29.0004	$29.9495	$31.3744	$30.1287
050528	1.1417	1.1042	$23.9177	$28.6273	$29.6838	$27.7337
050531	1.1058	1.1793	$22.7311	$25.0157	$26.9420	$24.9597
050534	1.2857	1.1296	$26.7941	$29.7546	$29.8603	$28.8863
050535	1.3768	1.1687	$29.7904	$32.3646	$32.3723	$31.6438
050537	1.3916	1.2949	$25.1291	$27.4196	$31.3844	$28.1091
050539	1.2510	*	$25.3328	$28.0586	$29.8242	$27.8112
050541	1.6070	1.5463	$41.1980	$43.7765	$46.1121	$43.8355
050542	1.1241	*	$21.2846	*	*	$21.2846
050543	0.7293	1.1687	$24.0334	$25.7161	$26.1103	$25.3298
050545	0.7134	1.1793	$33.4322	$42.9451	$30.5554	$35.4562
050546	0.7307	1.1042	$42.8052	$52.7180	$30.2329	$41.5266
050547	0.8543	1.4740	$40.6483	$45.1842	$33.2205	$39.9154
050548	0.7266	1.1687	$32.3944	$37.1314	$30.3775	$33.5849
050549	1.5502	1.3467	$31.8525	$33.8288	$34.9818	$33.6342
050550	1.4030	1.1687	$29.0938	$31.1918	$30.2302	$30.2108
050551	1.3078	1.1687	$28.6834	$31.6782	$31.6165	$30.7425
050552	1.1266	1.1793	$24.9755	$26.8274	$27.1744	$26.5471
050557	1.5569	1.1960	$25.8719	$28.3111	$31.8048	$28.8575
050559	***	*	$25.3299	$26.9662	*	$26.0948
050561	1.2622	1.1793	$35.9611	$37.5863	$38.8651	$37.5449
050567	1.5993	1.1687	$27.8475	$30.1167	$32.9829	$30.4114
050568	1.2479	1.1104	$20.8324	$22.5008	$24.4061	$22.5795
050569	1.3416	1.3467	$27.7955	$30.4874	$33.0259	$30.5066
050570	1.5225	1.1687	$29.9470	$32.6896	$34.0171	$32.2949
050571	1.3109	1.1793	$29.1716	$32.1656	$33.6156	$31.7338
050573	1.7313	1.1296	$27.2328	$30.5249	$34.1991	$30.6886
050575	1.2700	1.1793	$23.1358	$23.2447	$25.2513	$23.9658
050577	1.2292	1.1793	$26.4806	$28.7060	$30.8841	$28.7176
050578	1.7728	1.1793	$30.4934	$31.5953	$33.8825	$31.9512
050579	1.4467	1.1793	$34.9794	$40.2740	$39.4976	$38.3190
050580	1.2914	1.1687	$27.2431	$29.4337	$31.6256	$29.3950
050581	1.4899	1.1793	$28.9696	$32.0823	$32.1801	$31.1581
050583	1.5944	1.1406	$30.0427	$33.5209	$33.3697	$32.3610
050584	1.3233	1.1687	$24.5544	$24.5757	$24.8180	$24.6565
050585	1.1560	1.1687	$26.0595	$27.2982	$22.7121	$24.9986
050586	1.1733	1.1687	$25.7172	$25.3551	$27.4173	$26.0841
050588	1.3510	1.1793	$30.5453	$32.3603	$32.8212	$31.9715
050589	1.2707	1.1687	$27.9845	$30.6273	$30.9547	$29.9199
050590	1.2858	1.2949	$27.0620	$31.5987	$32.2142	$30.2046
050591	1.1589	1.1793	$28.6151	$28.5915	$28.8549	$28.6959
050592	1.1853	1.1687	$25.9545	$32.5000	$24.4542	$27.4073
050594	2.0368	1.1687	$30.8028	$34.6747	$34.7946	$33.5328
050597	1.2589	1.1793	$24.5542	$25.4868	$27.5691	$25.8776
050598	***	*	$24.6875	*	*	$24.6875
050599	1.8974	1.2949	$27.7684	$30.8420	$38.1975	$32.3121
050601	1.5294	1.1793	$32.3033	$35.0325	$34.7409	$34.0841
050603	1.4068	1.1687	$25.0996	$28.6982	$30.2464	$28.0787
050604	1.2727	1.5088	$42.0018	$45.4433	$49.9429	$45.9484
050608	1.4179	1.1042	$20.7955	$22.1999	$23.3630	$22.1922
050609	1.3791	1.1687	$37.4563	$38.4561	$41.1797	$39.1280
050613	0.8939	1.4974	*	*	*	*
050615	1.3236	1.1793	$29.4323	$32.8786	$33.2909	$31.8903
050616	1.3870	1.1769	$23.1748	$28.5636	$36.9017	$29.6253
050618	1.0253	1.1042	$22.3481	$25.4500	$27.4539	$25.0614
050623	***	*	$29.9553	$29.6550	$32.0627	$30.4768
050624	1.2788	1.1793	$23.3492	$28.1941	$32.2907	$27.6796
050625	1.7550	1.1793	$30.8013	$33.5137	$36.3631	$33.6260
050630	***	*	$27.7051	$28.0726	$30.9410	$28.9666
050633	1.2323	1.1449	$30.2883	$33.4771	$35.3734	$33.1070
050636	1.3270	1.1406	$23.2573	$27.2360	$30.5156	$27.0926
050641	1.2310	1.1793	$21.5030	$20.4720	$21.4612	$21.1520
050644	0.9036	1.1793	$28.4054	$25.6614	$27.6547	$27.1915
050660	1.4561	*	*	*	*	*

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
050662	0.7908	1.5088	$40.9242	$47.5065	$32.6362	$40.4932
050663	1.0382	1.1793	$22.9161	$25.1493	$25.7747	$24.4728
050667	0.9090	1.3972	$31.4906	$25.9250	$26.3937	$27.9100
050668	1.0144	1.5463	$55.9594	*	$31.8065	$41.1707
050674	1.3172	1.2949	$36.8871	$38.4454	$42.6866	$39.5960
050677	1.4866	1.1793	$36.2702	$37.3389	$38.7984	$37.5511
050678	1.2681	1.1687	$27.1337	$29.1159	$30.7220	$29.1295
050680	1.2141	1.5194	$32.7065	$35.6614	$38.3946	$35.9028
050681	1.5453	1.1793	*	*	*	*
050682	0.8883	1.1042	$23.0984	$21.7264	$21.7791	$22.0865
050684	1.1340	1.1296	$23.7443	$25.2575	$26.4234	$25.2119
050686	1.3399	1.1296	$37.3033	$38.5595	$40.9486	$39.0574
050688	1.2165	1.5088	$36.5555	$41.3305	$41.9325	$39.9230
050689	1.5667	1.5463	$37.5449	$40.3815	$42.2018	$40.1932
050690	1.2618	1.4740	$41.1385	$43.9228	$47.2769	$44.3743
050693	1.2877	1.1687	$32.6638	$34.8040	$35.0621	$34.2547
050694	1.2058	1.1296	$25.8298	$26.7041	$28.9544	$27.1978
050695	1.1260	1.1884	$27.8742	$30.1226	$35.6549	$31.4872
050696	2.0831	1.1793	$29.9410	$36.9314	$35.9220	$34.4812
050697	1.0591	1.2195	$18.6962	$19.2603	$25.1984	$20.8006
050699	***	*	$26.0909	$25.6818	$26.8210	$26.1958
050701	1.2963	1.1296	$28.4650	$29.6896	$29.6253	$29.3536
050704	1.0586	1.1793	$24.6072	$24.6609	$25.3488	$24.8998
050707	1.3365	1.4974	$27.7366	$32.4877	$34.0550	$31.4563
050708	1.6893	1.1042	$22.1606	$21.2163	$22.5034	$21.9751
050709	1.2235	1.1687	$22.7897	$21.9079	$25.6119	$23.3937
050710	1.3958	1.1042	$33.7204	$34.8311	$39.9858	$36.4647
050713	1.1982	1.1793	$19.0071	$20.7448	$20.2803	$19.9969
050714	1.3705	1.5144	$30.3263	$32.4491	$33.6676	$32.2064
050717	1.0677	1.1793	$33.0719	$34.5519	$38.0796	$35.2375
050718	1.0244	1.1296	$21.7835	$15.4037	$21.4996	$18.9377
050719	***	*	$22.0998	*	*	$22.0998
050720	0.9271	1.1687	$26.1941	$24.8117	$30.0812	$27.1452
050722	0.9675	1.1406	*	*	*	*
050723	1.2891	1.1793	$33.0797	$34.9814	$35.0119	$34.4384
050724	2.1500	1.1042	$23.7567	*	$34.4267	$28.5323
050725	1.0001	1.1793	$20.6592	$22.0946	$21.7816	$21.6358
050726	1.6871	1.1960	$25.8742	$27.0928	$27.8433	$27.0367
050727	1.3105	1.1793	*	$23.7179	$24.3026	$24.0102
050728	1.3521	1.4740	*	$31.4768	$36.0820	$33.6891
050729	1.4726	1.1793	*	*	$34.2580	$34.2580
050730	1.2831	1.1793	*	*	$51.5425	$51.5425
050731	1.7945	1.1194	*	*	*	*
050732	2.6180	1.1042	*	*	*	*
050733	1.4289	1.2195	*	*	*	*
050734	1.5908	1.1793	*	*	*	*
060001	1.5846	1.0507	$23.1548	$24.9410	$26.8470	$25.0779
060003	1.4167	1.0507	$23.0807	$24.7856	$24.2224	$24.0730
060004	1.2436	1.0699	$25.0037	$28.0656	$29.9649	$27.8289
060006	1.3607	0.9369	$21.8609	$22.7493	$24.5704	$23.0964
060007	1.0268	*	$21.4244	$21.4792	*	$21.4535
060008	1.1218	0.9369	$19.8803	$21.8037	$23.3859	$21.7601
060009	1.4811	1.0699	$24.7920	$27.0511	$28.7645	$26.9116
060010	1.7203	1.0136	$25.8475	$27.2290	$28.9850	$27.4402
060011	1.4799	1.0699	$25.8919	$26.1958	$27.2833	$26.4630
060012	1.5002	0.9369	$22.6374	$24.1557	$26.2469	$24.3434
060013	1.3908	0.9369	$23.3954	$24.9708	$24.5994	$24.0758
060014	1.7944	1.0699	$27.0326	$29.6744	$31.2588	$29.2315
060015	1.7610	1.0699	$27.6338	$30.1158	$30.4533	$29.4109
060016	1.1757	0.9369	$22.9300	$23.9655	$25.6527	$24.2479
060018	1.2207	0.9369	$21.0581	$23.6620	$25.7628	$23.4747
060020	1.6221	0.9369	$20.9025	$22.2052	$22.6748	$21.9753
060022	1.6261	0.9447	$24.7928	$25.7832	$26.5238	$25.7483
060023	1.6527	0.9581	$24.3749	$26.7285	$27.7644	$26.3625
060024	1.7646	1.0699	$25.2409	$28.7231	$29.0130	$27.7028
060027	1.5906	1.0507	$25.1480	$26.6348	$28.0909	$26.7085
060028	1.4101	1.0699	$27.1303	$27.9686	$30.0448	$28.4352

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
060029	***	*	$19.7379	*	*	$19.7379
060030	1.3890	1.0136	$22.8309	$26.0011	$26.6251	$25.3046
060031	1.5600	0.9447	$23.8781	$25.6207	$26.3650	$25.3306
060032	1.5456	1.0699	$27.1783	$28.2234	$30.4247	$28.6396
060033	0.9940	*	$16.7266	*	*	$16.7266
060034	1.6440	1.0699	$26.1602	$28.4604	$29.8445	$28.2231
060036	1.1229	0.9369	$19.4144	$20.4635	$20.7131	$20.1878
060041	0.9282	0.9369	$20.8746	$22.7123	$23.4978	$22.3670
060043	0.9500	0.9369	$19.1085	$20.0939	$18.7896	$19.3418
060044	1.1611	1.0507	$25.6112	$25.2471	$25.0360	$25.3737
060049	1.2730	1.0136	$25.3425	$26.8089	$29.0598	$27.1748
060050	1.1992	*	$20.4386	$21.9108	*	$21.1679
060054	1.4317	0.9581	$21.1281	$23.5803	$22.3490	$22.3633
060057	1.0678	*	$24.3982	$26.9891	*	$25.7472
060064	1.4920	1.0699	$29.1806	$30.0963	$31.3105	$30.2470
060065	1.3196	1.0699	$29.2377	$28.5282	$31.1987	$29.6323
060070	***	*	$22.6894	*	*	$22.6894
060071	1.1349	0.9369	$20.1385	$20.2706	$25.7248	$22.1931
060075	1.2191	1.1697	$27.7835	$30.7835	$32.7563	$30.4907
060076	1.2865	0.9369	$23.6266	$25.5406	$26.8236	$25.4496
060096	1.4740	1.0507	$26.4167	$27.4085	$30.0602	$27.9908
060100	1.7163	1.0699	$28.0561	$29.7690	$32.1537	$30.0220
060103	1.1819	1.0507	$26.6863	$28.8063	$30.3002	$28.6961
060104	1.3833	1.0699	$26.7683	$30.8625	$32.0889	$29.9703
060107	1.3856	1.0699	*	$26.8267	$26.1883	$26.4984
060108	***	*	$19.0011	*	*	$19.0011
060110	***	*	$29.8561	*	*	$29.8561
060111	***	*	*	$31.2571	*	$31.2571
060112	1.5129	1.0699	*	*	*	*
060113	1.2985	1.0699	*	*	*	*
060114	1.1972	1.0699	*	*	*	*
070001	1.6462	1.2739	$29.9592	$32.2718	$34.0302	$32.0467
070002	1.8219	1.1726	$28.1101	$29.0663	$31.1530	$29.4722
070003	1.0941	1.1726	$29.8684	$31.3716	$32.4197	$31.2543
070004	1.1910	1.1726	$25.7207	$27.3004	$29.2544	$27.3780
070005	1.3868	1.2739	$29.8173	$29.3265	$32.1668	$30.4848
070006 [2]	1.3201	1.3194	$33.3814	$33.9310	$36.8469	$34.7695
070007	1.2960	1.1726	$29.0336	$30.3648	$31.7125	$30.4064
070008	1.2616	1.1726	$24.3907	$24.9176	$26.4806	$25.2986
070009	1.2064	1.1726	$25.6072	$28.8649	$30.2706	$28.2076
070010	1.8394	1.3194	$30.4192	$33.1535	$32.5798	$32.0648
070011	1.3775	1.1726	$24.9457	$27.5391	$29.9105	$27.3901
070012	1.1898	1.1726	$34.9099	$40.3337	$44.1424	$39.6372
070015	1.4436	1.3194	$30.0614	$30.9728	$33.4595	$31.5141
070016	1.3613	1.2739	$29.7505	$29.6662	$31.0903	$30.2000
070017	1.3930	1.2739	$29.2978	$30.3951	$31.7223	$30.4949
070018 [2]	1.3416	1.3194	$33.8654	$35.7189	$37.6081	$35.8796
070019	1.2639	1.2739	$27.9838	$29.6290	$31.8148	$29.8448
070020	1.3495	1.1799	$28.4084	$29.9507	$31.0935	$29.8423
070021	1.2785	1.1726	$30.3254	$31.4397	$33.2357	$31.7179
070022	1.7912	1.2739	$29.7376	$32.3625	$35.4120	$32.5068
070024	1.3856	1.1726	$28.3460	$31.0243	$32.0430	$30.5001
070025	1.8602	1.1726	$28.3017	$29.2540	$30.9938	$29.5451
070027	1.3063	1.1726	$36.9700	$27.3487	$31.8018	$31.4568
070028	1.6215	1.3194	$28.2078	$29.5653	$31.5036	$29.7843
070029	1.2918	1.1726	$25.8107	$26.3871	$27.7213	$26.6692
070031	1.2501	1.2739	$25.5880	$27.2359	$28.9190	$27.3126
070033	1.2736	1.3194	$34.3904	$35.5355	$37.1929	$35.7524
070034 [2]	1.3886	1.3194	$32.8074	$35.6831	$36.3899	$34.9826
070035	1.3067	1.1726	$26.1693	$27.1816	$27.5585	$26.9760
070036	1.6645	1.2913	$35.0701	$34.0555	$36.1610	$35.1155
070038	1.1829	1.1910	*	$31.1133	$25.7516	$26.9407
070039	0.9507	1.2739	$32.6059	$35.0164	$31.2269	$32.9340
080001	1.6806	1.0579	$28.0859	$30.2463	$30.0242	$29.4815
080002	***	*	$23.7309	$26.4192	$27.7932	$25.9827
080003	1.5960	1.0579	$24.8199	$27.1131	$29.2266	$26.9651
080004	1.3844	1.0325	$24.2251	$26.0092	$27.4921	$25.9420

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
080006	1.2825	0.9579	$23.6838	$24.4204	$25.6160	$24.5955
080007	1.4048	1.0279	$23.4964	$24.6485	$27.0074	$25.0565
090001	1.7144	1.0928	$29.5432	$31.3552	$35.0413	$32.0128
090002	***	*	$23.5158	$29.6780	*	$25.5760
090003	1.2860	1.0928	$22.7014	$27.0514	$29.2660	$26.1789
090004	1.9621	1.0928	$28.7417	$29.9785	$32.2021	$30.4513
090005	1.3773	1.0928	$28.6142	$30.2504	$30.7728	$29.9417
090006	1.4103	1.0928	$23.7241	$25.9086	$29.5590	$26.3083
090007	***	*	$25.8430	$30.1419	*	$27.7359
090008	1.4931	1.0928	$19.3212	$29.6744	$29.1059	$25.7761
090011	2.0232	1.0928	$31.7710	$32.4412	$34.0693	$32.7262
100001	1.6183	0.9294	$22.6150	$25.2381	$24.4060	$24.0790
100002	1.3562	1.0051	$22.5982	$22.1269	$25.3389	$23.3729
100004	0.9452	0.8584	$15.6306	$16.2637	$16.5974	$16.2012
100006	1.6269	0.9450	$23.3745	$26.2372	$26.3789	$25.3884
100007	1.6462	0.9450	$24.3305	$25.4333	$26.5378	$25.5049
100008	1.6518	0.9747	$22.7706	$25.7377	$27.4314	$25.4374
100009	1.4445	0.9747	$24.7811	$24.4666	$25.9381	$25.0983
100010	***	*	$25.5614	$26.9486	*	$26.2759
100012	1.6553	0.9323	$24.2602	$24.5762	$26.3788	$25.1063
100014	1.3001	0.9416	$21.7566	$22.3054	$24.5862	$22.8508
100015	1.3184	0.9328	$22.1272	$22.5781	$24.6038	$23.0946
100017	1.5242	0.9416	$21.1905	$22.9545	$26.1580	$23.5300
100018	1.6293	1.0114	$24.1885	$27.8582	$28.1481	$26.7680
100019	1.6455	0.9830	$24.2888	$25.5566	$27.6179	$25.9118
100020	1.3148	0.9747	$23.5303	$23.6106	$23.9414	$23.7036
100022	1.7585	1.0497	$27.9072	$29.0519	$29.9345	$29.0212
100023	1.4527	0.9450	$21.8111	$21.4015	$23.0074	$22.0889
100024	1.2489	0.9747	$24.4070	$27.6476	$30.2395	$27.3189
100025	1.6924	0.8584	$21.2568	$21.1174	$22.1580	$21.5429
100026	1.6201	0.8584	$20.1602	$21.3533	$21.4703	$20.9953
100027	1.1975	0.8584	$23.8982	$12.0314	$16.1223	$16.3797
100028	1.3007	0.9830	$21.8879	$23.7818	$26.8661	$24.1693
100029	1.1782	0.9747	$24.6814	$26.9307	$27.5844	$26.4439
100030	1.2924	0.9450	$21.8567	$22.4887	$24.0943	$22.9211
100032	1.7231	0.9328	$21.6415	$23.0174	$25.2450	$23.3565
100034	1.8273	0.9747	$23.1111	$24.4064	$25.9415	$24.5360
100035	1.5876	0.9634	$22.6349	$25.3590	$26.9407	$24.9239
100038	1.8898	1.0497	$25.7948	$27.4422	$29.8583	$27.7714
100039	1.4212	1.0497	$23.8060	$26.6016	$28.4627	$26.3398
100040	1.6882	0.9294	$22.4679	$23.5372	$23.6443	$23.2382
100043	1.2798	0.9328	$21.7738	$22.8963	$25.2273	$23.3549
100044	1.4261	1.0151	$23.9952	$26.3208	$28.3596	$26.2570
100045	1.3178	0.9450	$25.2285	$23.0520	$26.9641	$25.0756
100046	1.2409	0.9328	$24.2746	$26.6169	$26.3673	$25.8723
100047	1.7017	0.9286	$24.3522	$24.4212	$25.0404	$24.6186
100048	0.9446	0.8584	$17.5533	$18.3767	$18.8771	$18.2575
100049	1.2006	0.8925	$21.8679	$22.9532	$22.9810	$22.6230
100050	1.1817	0.9747	$20.0405	$20.6893	$19.8713	$20.2035
100051	1.3167	0.9450	$20.0231	$22.3311	$23.1940	$22.0077
100052	1.3612	0.8925	$20.5916	$20.9078	$22.3920	$21.3174
100053	1.2414	0.9747	$23.7837	$27.3383	$27.3224	$26.2170
100054	1.2242	0.8868	$22.0352	$25.7279	$28.0512	$25.3241
100055	1.3567	0.9328	$19.6350	$22.1051	$23.5332	$21.7040
100056	***	*	$25.9245	$25.7945	*	$25.8574
100057	1.4902	0.9450	$24.6417	$22.6038	$25.3897	$24.1823
100061	1.5568	0.9747	$26.1273	$26.7673	$29.2565	$27.4077
100062	1.7188	0.9006	$24.9807	$24.1413	$25.2340	$24.7789
100063	1.2226	0.9328	$21.5620	$21.5566	$24.7026	$22.5862
100067	1.4372	0.9328	$23.8892	$23.9333	$26.1213	$24.6500
100068	1.7322	0.9416	$23.7840	$24.9025	$25.9202	$25.2289
100069	1.3222	0.9328	$19.6037	$22.4386	$24.7442	$22.2985
100070	1.6777	0.9634	$23.5524	$23.7746	$24.8883	$24.0603
100071	1.2323	0.9328	$21.7675	$23.4176	$24.9682	$23.4234
100072	1.3707	0.9416	$23.5362	$24.2934	$26.0459	$24.7023
100073	1.6999	1.0497	$23.5843	$25.3685	$30.3358	$26.4443
100075	1.4873	0.9328	$22.3890	$23.3503	$25.1691	$23.6907

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
100076	1.2488	0.9747	$19.6444	$21.0777	$21.9483	$20.8673
100077	1.4270	0.9286	$22.3755	$24.3478	$26.0347	$24.2410
100079	1.6927	*	*	*	*	*
100080	1.7700	1.0051	$22.8704	$26.3596	$27.0126	$25.4415
100081	1.0416	0.8584	$16.8087	$16.9168	$15.6662	$16.4022
100084	1.8066	0.9450	$24.1122	$25.4140	$26.3393	$25.2629
100086	1.2304	1.0497	$25.2375	$26.4817	$28.2641	$26.6950
100087	1.8903	0.9634	$26.5915	$25.9909	$27.1531	$26.5891
100088	1.6794	0.9294	$23.6270	$24.8729	$25.9182	$24.8465
100090	1.4786	0.9294	$22.5894	$24.0501	$24.2422	$23.6608
100092	1.5155	0.9830	$25.4630	$26.0856	$28.4789	$26.7319
100093	1.7097	0.8584	$20.2949	$21.1547	$21.3524	$20.9431
100098	1.1058	*	$20.0639	$21.2505	*	$20.6613
100099	1.0234	0.8925	$18.5287	$20.4328	$21.3036	$20.1035
100102	1.0598	0.8709	$21.6772	$22.8850	$23.8596	$22.8413
100103	0.9719	*	$20.3633	$21.7494	*	$21.0705
100105	1.3731	0.9448	$24.5464	$24.9503	$26.8091	$25.4381
100106	0.9559	0.8584	$20.3417	$20.2882	$24.0389	$21.6406
100107	1.1536	0.9323	$23.3789	$24.4484	$26.1337	$24.6951
100108	0.7740	0.8584	$14.8039	$16.3757	$22.0750	$17.7359
100109	1.2577	0.9450	$23.0779	$23.8836	$24.9951	$24.0208
100110	1.5362	0.9450	$24.4533	$28.3699	$29.1494	$27.5406
100113	1.9395	0.9375	$24.3614	$25.0067	$26.3806	$25.2830
100114	1.3730	0.9747	$25.3699	$27.7413	$29.2195	$27.4364
100117	1.2013	0.9294	$23.9134	$26.0451	$26.4536	$25.5634
100118	1.3382	0.9294	$24.1104	$23.6669	$28.0569	$25.5448
100121	1.0774	0.8925	$23.1100	$24.0937	$24.8579	$24.0497
100122	1.2284	0.8868	$24.1820	$21.2597	$23.4751	$22.8811
100124	1.1728	0.8584	$24.3048	$21.6483	$22.7023	$22.7933
100125	1.1907	0.9747	$22.4185	$25.3532	$26.7452	$24.9756
100126	1.4150	0.9328	$21.7977	$23.2996	$24.4515	$23.2342
100127	1.6611	0.9328	$21.0153	$21.3223	$24.4485	$22.2652
100128	2.1526	0.9328	$24.4104	$25.6763	$29.4979	$26.6451
100130	1.2025	1.0051	$20.2478	$22.8324	$24.2046	$22.4252
100131	1.2751	0.9747	$25.4811	$25.8316	$29.2462	$26.9103
100132	1.2231	0.9328	$21.1538	$23.0428	$24.3293	$22.8670
100134	0.9566	0.8584	$18.3391	$19.5337	$20.9244	$19.6271
100135	1.6045	0.8703	$20.4915	$22.3071	$24.0024	$22.2526
100137	1.1709	0.8925	$20.4007	$23.3692	$25.1974	$23.1447
100139	0.8583	0.9375	$18.2204	$14.5046	$17.5489	$16.8211
100140	1.1864	0.9294	$22.5124	$24.8165	$26.4720	$24.7189
100142	1.2277	0.8584	$20.0689	$20.7219	$22.9577	$21.2432
100147	***	*	$17.1045	*	*	$17.1045
100150	1.4017	0.9747	$22.9194	$25.7122	$26.1990	$24.9706
100151	1.7883	0.9294	$26.6470	$26.1848	$28.1322	$27.0891
100154	1.5421	0.9747	$23.0820	$26.3703	$27.6127	$25.8181
100156	1.1045	0.8709	$20.6928	$22.2757	$26.7092	$23.2451
100157	1.5973	0.9328	$23.1045	$25.9133	$27.3851	$25.4671
100160	1.1995	0.8584	$23.4877	$27.2019	$26.9851	$25.9544
100161	1.5798	0.9450	$24.6268	$28.3607	$28.8077	$27.4143
100162	***	*	$23.8001	*	*	$23.8001
100166	1.4927	0.9634	$23.7419	$24.4251	$27.9618	$25.2885
100167	1.3172	1.0497	$26.4517	$26.8584	$30.3694	$27.8827
100168	1.3915	1.0051	$24.6276	$26.0864	$27.1292	$25.9577
100169	***	*	$23.4575	*	*	$23.4575
100172	1.2906	0.9747	$17.6051	$18.4651	$18.2735	$18.1344
100173	1.7474	0.9328	$19.7190	$22.4866	$24.8721	$22.4023
100175	1.0032	0.8815	$21.0474	$22.0666	$23.5455	$22.2224
100176	1.9043	1.0151	$26.8740	$29.8326	$31.2694	$29.3692
100177	1.3333	0.9830	$24.5078	$25.3973	$26.6781	$25.6089
100179	1.7758	0.9294	$24.1801	$26.6537	$29.5619	$26.9037
100180	1.3821	0.9328	$24.9433	$26.3299	$27.1804	$26.1924
100181	1.1077	0.9747	$18.1320	$19.5022	$21.8540	$19.8108
100183	1.1819	0.9747	$24.4575	$26.7893	$27.4951	$26.3276
100187	1.2915	0.9747	$23.4760	$26.1394	$27.3653	$25.7401
100189	1.3226	1.0497	$26.6846	$26.5763	$28.4136	$27.3048
100191	1.3178	0.9328	$24.1911	$24.3553	$26.6340	$25.0785

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
100200	1.3861	1.0497	$24.8120	$28.0926	$29.8963	$27.6635
100204	1.5308	0.9375	$22.2613	$24.4697	$25.7537	$24.2423
100206	1.3026	0.9328	$22.8782	$23.0340	$25.2196	$23.7228
100208	***	*	$24.1482	$24.9854	*	$24.5807
100209	1.3649	0.9747	$23.8502	$25.0778	$26.6246	$25.2683
100210	1.5495	1.0497	$26.0933	$28.6449	$28.9486	$27.9114
100211	1.1990	0.9328	$24.3243	*	$24.7095	$24.5352
100212	1.4656	0.9006	$22.6584	$24.2669	$24.7566	$23.9351
100213	1.6219	0.9634	$24.4467	$25.1893	$27.1936	$25.6138
100217	1.1882	1.0151	$24.0291	$25.2635	$25.2907	$24.8791
100220	1.6567	0.9323	$24.9733	$25.0154	$26.0905	$25.3692
100223	1.5971	0.8868	$21.2434	$23.4556	$24.7015	$23.2004
100224	1.2332	1.0497	$23.0804	$23.3593	$24.8077	$23.7932
100225	1.2993	1.0497	$23.9971	$27.9473	$28.4316	$26.8326
100226	1.2785	0.9294	$23.8701	$27.8003	$29.3317	$27.1288
100228	1.3238	1.0497	$26.2593	$27.2873	$29.8952	$28.0013
100229	***	*	$21.0038	*	*	$21.0038
100230	1.3172	1.0497	$25.0518	$26.3690	$28.1703	$26.6050
100231	1.6896	0.8584	$23.5418	$24.6994	$25.5175	$24.6455
100232 [h]	1.2414	0.9722	$21.8105	$23.9405	$24.9322	$23.5285
100234	1.3194	1.0051	$24.9141	$25.2574	$26.3601	$25.5144
100236	1.3721	0.9286	$23.9781	$25.9282	$26.6585	$25.5663
100237	1.9760	1.0497	$26.7664	$25.6112	$31.3543	$27.7849
100238	1.5274	0.9328	$24.6513	$27.1748	$28.4302	$26.8154
100239	1.2798	0.9634	$25.0509	$26.9668	$27.7592	$26.6605
100240	0.8844	0.9747	$23.0650	$23.4830	$25.3265	$24.0024
100242	1.3721	0.8584	$20.4681	$21.5130	$24.0990	$22.0856
100243	1.5526	0.9328	$23.2812	$25.2987	$26.1131	$24.9766
100244	1.3600	0.9323	$23.4876	$24.1515	$25.2584	$24.3502
100246	1.6200	1.0151	$26.7630	$27.6382	$28.9894	$27.8151
100248	1.5168	0.9328	$23.8742	$25.9170	$27.7797	$25.9263
100249	1.2673	0.8946	$21.3942	$23.4021	$23.2084	$22.6697
100252	1.2047	1.0151	$22.6475	$24.9860	$25.8540	$24.5257
100253	1.3828	1.0051	$23.6939	$24.4051	$25.7121	$24.6472
100254	1.5903	0.8703	$23.2794	$25.0192	$25.7338	$24.6995
100255	1.2022	0.9328	$22.9793	$22.2341	$24.4808	$23.2508
100256	2.0016	0.9328	$24.1969	$26.0629	$28.8856	$26.4333
100258	1.4996	1.0051	$24.5699	$31.8772	$31.2482	$29.0443
100259	1.2301	0.9328	$24.1148	$24.9404	$26.0175	$25.0705
100260	1.3611	1.0151	$23.5164	$25.2630	$27.5188	$25.5518
100262	***	*	$23.8006	$26.3954	*	$25.1412
100264	1.2614	0.9328	$22.4800	$25.0250	$25.5489	$24.4115
100265	1.2982	0.9328	$21.0688	$23.4758	$24.1454	$23.0219
100266	1.4044	0.8584	$21.5258	$22.6614	$23.2340	$22.5196
100267	1.2892	0.9634	$23.3760	$26.5059	$27.3768	$25.7444
100268	1.1552	1.0051	$26.0297	$29.8289	$29.2898	$28.4053
100269	1.3013	1.0051	$24.9002	$25.3228	$26.7450	$25.7303
100271	2.2234	*	*	*	*	*
100275	1.2960	1.0051	$23.1419	$24.3059	$26.0361	$24.5544
100276	1.2393	1.0497	$25.4557	$27.2589	$30.0576	$27.6322
100277	1.3788	0.9747	$25.2985	$47.3905	$16.5427	$24.0477
100279	1.2480	0.9323	$24.8484	$25.4909	$26.8606	$25.7747
100281	1.2803	1.0497	$25.3382	$27.0864	$28.6660	$27.1929
100284	1.0961	0.9747	$22.3046	$22.5927	$23.8170	$22.9628
100286	1.5763	1.0114	*	$27.1051	$29.4284	$28.3288
100287	1.3767	1.0051	*	$28.2229	$28.3427	$28.2858
100288	1.5086	1.0051	*	$37.4785	$33.8141	$35.4781
100289	1.8008	1.0497	*	$28.4504	$29.2915	$28.8970
100290	1.1344	0.9166	*	*	$23.5080	$23.5080
100291	1.2572	0.9830	*	*	*	*
100292	1.2330	0.8584	*	*	*	*
100294	2.6620	0.9450	*	*	*	*
100295	2.0078	0.9747	*	*	*	*
100296	1.3342	0.9747	*	*	*	*
100297	1.9333	0.8584	*	*	*	*
100298	0.6963	0.8703	*	*	*	*
100299	1.3082	0.9634	*	*	*	*

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
110001	1.2397	0.9782	$24.0561	$25.1164	$25.3102	$24.8284
110002	1.2464	0.9782	$20.4502	$21.8616	$25.3897	$22.5380
110003	1.3086	0.9294	$19.7061	$20.0968	$21.4002	$20.4029
110004	1.2230	0.9089	$21.8791	$22.7929	$23.9911	$22.8563
110005	1.1638	0.9782	$23.6146	$22.3645	$22.9000	$22.9401
110006	1.4890	0.9826	$23.8762	$25.0719	$28.6090	$25.8225
110007	1.6071	0.8634	$28.2025	$30.7430	$23.8729	$27.0966
110008	1.3988	0.9782	$22.6308	$23.4662	$27.1711	$24.4777
110010	2.1369	0.9782	$27.2029	$28.7690	$29.7142	$28.5850
110011	1.1924	0.9782	$23.2149	$25.4620	$26.0899	$24.9213
110015	1.1494	0.9782	$23.2280	$25.5661	$26.6610	$25.2080
110016	1.1984	0.7679	$18.8228	$18.8376	$21.7610	$19.7802
110018	1.1923	0.9782	$24.7007	$25.6485	$28.2431	$26.2640
110020	1.2822	0.9782	$23.3004	$24.8735	$26.8501	$25.0177
110023	1.3719	0.9782	$23.5673	$25.3746	$27.3029	$25.5307
110024	1.3944	0.9464	$22.1471	$23.8091	$25.7205	$23.8901
110025	1.4489	0.9294	$29.0965	$31.5253	$26.1311	$28.6493
110026	1.1044	0.7679	$19.3201	$20.5740	$21.2826	$20.4005
110027	1.0675	0.8066	$19.8351	$19.2323	$20.2175	$19.7328
110028	1.7446	0.9751	$25.9474	$25.1836	$28.1619	$26.4128
110029	1.6684	0.9782	$22.7981	$25.2335	$24.8893	$24.3542
110030	1.2123	0.9782	$22.2341	$25.0842	$26.4770	$24.7162
110031	1.2695	0.9782	$22.8695	$24.1711	$24.7874	$23.9912
110032	1.1708	0.7679	$18.0744	$20.7211	$21.9407	$20.2437
110033	1.4050	0.9782	$24.1447	$25.2326	$28.3210	$25.8930
110034	1.7124	0.9751	$24.0791	$24.4141	$26.9986	$25.1766
110035	1.5056	0.9782	$24.2581	$25.7562	$27.4583	$25.9197
110036	1.8079	0.9464	$24.4788	$25.4854	$26.8789	$25.6507
110038	1.5737	0.8385	$20.1710	$20.5880	$21.2138	$20.6802
110039	1.4151	0.9751	$17.0608	$19.4032	$24.7248	$20.0879
110040	1.1196	0.9782	$17.3095	$18.8744	$19.7509	$18.6568
110041	1.2605	0.9694	$20.8080	$21.5402	$23.4074	$21.9417
110042	1.1045	0.9782	$25.5588	$26.8321	$28.6873	$27.1121
110043	1.7587	0.9464	$22.7589	$25.2788	$26.6323	$24.8956
110044	1.1685	0.7679	$19.2562	$19.6940	$20.9654	$19.9819
110045	1.1544	0.9782	$19.7746	$21.3922	$24.9821	$22.1119
110046	1.1621	0.9782	$21.6201	$24.0022	$23.8292	$23.2190
110049	0.9856	*	$18.9096	$19.8706	*	$19.4074
110050	1.1084	0.9067	*	$25.6020	$26.1320	$25.8647
110051	1.1338	0.7679	$17.6816	$19.0995	$19.4276	$18.7634
110054	1.4998	0.9782	$20.5387	$22.2250	$25.7085	$22.7254
110056	0.9527	*	$21.7608	$23.0080	*	$22.3710
110059	1.0870	0.7679	$19.9802	$18.7097	$20.5565	$19.6943
110061	***	*	$18.6696	*	*	$18.6696
110063	1.1145	*	$19.4401	$20.3760	*	$19.9198
110064	1.5138	0.8562	$21.7636	$23.8739	$24.2739	$23.3486
110069	1.2779	0.9078	$21.0518	$22.3006	$24.1669	$22.5324
110071	0.9789	0.7679	$15.2336	$13.3731	$18.0224	$15.4555
110073	1.0915	0.7679	$15.2711	$16.3610	$18.6336	$16.6863
110074	1.5001	0.9826	$24.4094	$27.5836	$27.1207	$26.3724
110075	1.2651	0.9300	$20.4634	$20.9973	$22.0935	$21.2149
110076	1.4712	0.9782	$23.8211	$25.2424	$26.3506	$25.1774
110078	2.0531	0.9782	$28.2149	$27.8627	$29.5779	$28.5704
110079	1.4257	0.9782	$22.8017	$24.5255	$23.1024	$23.4646
110080	1.2797	0.9782	$24.1958	$21.5482	$22.3213	$22.5788
110082	1.9279	0.9782	$27.2931	$28.9731	$29.8366	$28.7072
110083	1.9347	0.9782	$24.6460	$26.2604	$27.8245	$26.3029
110086	1.4411	0.7679	$18.8751	$20.8557	$21.1509	$20.2673
110087	1.4167	0.9782	$25.7908	$26.2872	$28.0471	$26.7332
110089	1.1500	0.7679	$20.6757	$21.2013	$21.9509	$21.2887
110091	1.2959	0.9782	$24.3354	$26.3857	$26.5523	$25.8218
110092	1.0183	0.7679	$16.9116	$18.7397	$18.5527	$18.0853
110095	1.4222	0.8701	$20.1024	$21.8709	$23.4846	$21.8636
110096	0.9833	*	$18.5513	$19.4498	*	$19.0000
110100	0.9748	0.7679	$15.1316	$16.5833	$16.5600	$16.0845
110101	1.0811	0.7679	$13.3943	$14.4630	$16.4270	$14.7428
110104	1.0702	0.7679	$17.9805	$19.5575	$18.7951	$18.8040

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
110105	1.3296	0.7679	$19.2156	$20.6270	$21.1077	$20.3365
110107	1.8825	0.9475	$21.8167	$26.0763	$26.2526	$24.6977
110109	1.0145	0.7679	$18.7397	$20.4726	$21.4280	$20.2690
110111	1.1472	0.9751	$20.9535	$20.5577	$29.2190	$22.9282
110112	0.9453	0.7679	$20.4565	$21.0612	$24.2463	$21.7104
110113	1.0690	0.9751	$18.0770	$16.7641	$19.1753	$18.0155
110115	1.7318	0.9782	$26.3274	$29.8699	$32.0197	$29.3454
110118	***	*	$17.7344	*	*	$17.7344
110120	***	*	$20.3098	*	*	$20.3098
110121	1.0471	0.7679	$19.5230	$21.2534	$21.6637	$20.8173
110122	1.5383	0.8864	$20.4184	$22.0210	$23.7589	$22.1314
110124	1.0894	0.8107	$19.7004	$20.9334	$22.7058	$21.1178
110125	1.2347	0.9078	$19.8695	$22.1458	$22.4238	$21.5044
110128	1.2275	0.9300	$28.4943	$23.2576	$24.4596	$24.9779
110129	1.5326	0.8562	$21.8204	$22.4202	$23.3631	$22.5595
110130	0.9572	0.7679	$17.5272	$17.6529	$18.7549	$18.0115
110132	1.0434	0.7679	$17.2924	$18.9927	$19.2307	$18.5224
110135	1.2819	0.7679	$18.5125	$20.0057	$20.4411	$19.6750
110136	1.0906	0.7940	$21.1235	$22.7715	$15.8573	$19.9782
110142	0.9682	0.7679	$16.3359	$17.3328	$18.1980	$17.2921
110143	1.3817	0.9782	$24.3898	$25.4932	$27.7055	$25.9154
110146	1.0617	0.7679	$17.2250	$19.9221	$23.9067	$20.1122
110149	1.3423	0.9782	$25.3619	$24.7686	$27.1477	$25.8232
110150	1.2819	0.9078	$22.7366	$23.8157	$22.6624	$23.0726
110153	1.1438	0.9078	$21.5300	$22.8660	$24.5368	$22.9872
110155	***	*	$16.1785	*	*	$16.1785
110161	1.5043	0.9782	$26.4200	$27.4435	$29.3201	$27.7967
110163	1.4067	0.8634	$21.9411	$25.5461	$26.0764	$24.4314
110164	1.5286	0.9475	$23.7801	$26.4450	$27.0600	$25.7931
110165	1.4137	0.9782	$23.4071	$24.3897	$26.8378	$24.9170
110166	***	*	$23.6665	$25.2264	$26.8070	$25.1758
110168	1.8519	0.9782	$23.3426	$24.6321	$27.0022	$25.0628
110169	***	*	$24.7083	*	*	$24.7083
110171	***	*	$32.6386	*	*	$32.6386
110172	1.2169	0.9782	$25.2396	$27.0240	$29.1703	$27.1002
110177	1.6728	0.9751	$24.0700	$25.0129	$26.7504	$25.3590
110179	***	*	$26.0365	$26.1173	$26.0759	$26.0760
110183	1.2387	0.9782	$26.4248	$27.6020	$29.6133	$28.0105
110184	1.2066	0.9782	$24.3379	$25.5420	$26.5240	$25.5354
110186	1.3917	0.8562	$21.1176	$23.2348	$25.0299	$23.1796
110187	1.2286	0.9782	$23.2571	$22.5730	$24.2933	$23.3967
110188	***	*	$24.4785	*	*	$24.4785
110189	1.0968	0.9782	$21.4255	$23.9404	$26.7653	$24.1143
110190	1.0217	0.7861	$21.9008	$19.1054	$14.2517	$17.7557
110191	1.3090	0.9782	$24.0572	$25.8409	$26.8277	$25.5872
110192	1.3254	0.9782	$24.3823	$25.7406	$26.7852	$25.7103
110193	1.4091	0.9782	$25.1779	$27.8223	$27.3341	$26.8213
110194	0.9413	0.7679	$16.8075	$16.3148	$18.4776	$17.2529
110198	1.4037	0.9782	$28.0634	$30.8014	$31.7748	$30.3084
110200	1.8513	0.8562	$20.1816	$21.2177	$22.3249	$21.2486
110201	1.4094	0.9475	$24.1171	$27.0388	$28.2232	$26.3653
110203	0.9953	0.9782	$30.2609	$25.8951	$26.8768	$27.4232
110205	1.0813	0.9782	$23.1969	$20.6150	$19.7409	$21.0203
110209	0.5664	0.7679	$17.4145	$19.1000	$19.0450	$18.5793
110212	1.0529	0.8864	$18.7651	$20.9365	$40.5120	$27.9394
110215	1.2763	0.9782	$22.5679	$23.9657	$25.7886	$24.2458
110218	***	*	*	$26.1073	*	$26.1073
110219	1.4347	0.9782	*	$27.1880	$27.0362	$27.1115
110220	1.3633	0.8562	*	*	*	*
110221	2.1187	0.9782	*	*	*	*
110222	2.6522	0.9751	*	*	*	*
110223	1.2880	0.9782	*	*	*	*
110224	1.3977	0.9475	*	*	*	*
110225	1.1917	0.9782	*	*	*	*
120001	1.7844	1.1213	$30.0871	$31.7108	$34.7715	$32.1848
120002	1.2199	1.0587	$24.2715	$26.9900	$29.9913	$27.2572
120004	1.2647	1.1213	$26.8010	$28.3569	$28.6527	$27.9367

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
120005	1.3002	1.0587	$23.0113	$26.9053	$29.3405	$26.3828
120006	1.2367	1.1213	$28.1562	$29.6751	$31.2285	$29.7168
120007	1.6704	1.1213	$27.8497	$28.7964	$30.4247	$29.0434
120010	1.6900	1.1213	$25.4050	$27.1265	$30.1659	$27.2823
120011	1.4781	1.1213	$30.9308	$31.7447	$34.1643	$32.3199
120014	1.2116	1.0587	$25.3682	$28.0786	$28.6416	$27.3772
120016	1.5918	1.0587	$39.1173	$52.1034	$19.6034	$33.6763
120019	1.1922	1.0587	$24.4036	$28.9661	$30.3809	$27.8836
120022	1.8675	1.1213	$22.4951	$24.7875	$26.6100	$24.7024
120024	0.8789	1.0587	*	*	*	*
120025	***	*	$40.2473	$48.7148	$30.2358	$39.7283
120026	1.2789	1.1213	$26.3653	$28.5048	$30.3293	$28.4200
120027	1.2385	1.1213	$24.9464	$26.4630	$28.6717	$26.5704
120028	1.2824	1.1213	$29.5070	$31.3195	$30.3794	$30.4272
120029	1.9790	1.1213	*	*	*	*
130002	1.3652	0.9039	$20.1143	$21.6626	$23.6078	$21.8876
130003	1.3678	1.0095	$23.9403	$25.4904	$27.6345	$25.7287
130005	***	*	$24.4844	$25.2550	$25.7523	$25.1326
130006	1.7997	0.9039	$22.8567	$24.3982	$25.3221	$24.2894
130007	1.7373	0.9039	$22.8475	$24.8764	$24.9562	$24.2827
130011	1.2278	*	$23.1120	$22.9336	*	$23.0196
130013	1.2951	0.9039	$23.5316	$26.3118	$27.9209	$25.9669
130014	1.1868	0.9039	$21.6495	$23.4789	$24.3884	$23.2115
130018	1.5966	0.9394	$22.2249	$23.9798	$26.4125	$24.2860
130021	***	*	$18.0006	$18.9400	$16.1658	$17.7607
130022	1.1928	*	$21.5602	*	*	$21.5602
130024	1.1376	0.8964	$22.1610	$21.7853	$23.3347	$22.4344
130025	1.2091	0.8689	$18.7814	$19.7066	$20.1452	$19.5513
130026	1.1154	*	$24.4976	$25.4020	*	$24.9502
130028	1.3724	0.9394	$21.1492	$25.2938	$26.3443	$24.2492
130036	***	*	$18.5921	$16.7907	*	$17.6689
130045	***	*	$19.0270	*	*	$19.0270
130049	1.4577	1.0711	$23.7212	$24.5841	$26.9749	$25.1364
130060	***	*	$24.6773	$26.7516	*	$25.7861
130062	***	*	$24.0494	$16.7951	$20.6642	$20.3051
130063	1.4722	0.9039	$18.8782	$20.9502	$22.5904	$20.7967
130065	1.8387	0.8689	*	*	*	*
130066	1.9247	0.9982	*	*	*	*
130067	0.6317	0.8689	*	*	*	*
140001	1.0975	0.8279	$20.0247	$21.4779	$22.3170	$21.3141
140002	1.2742	0.8958	$23.0207	$24.4908	$24.6954	$24.0687
140003	1.0219	*	$19.2097	$22.6230	*	$20.9305
140005	***	*	$13.2365	*	*	$13.2365
140007	1.3190	1.0787	$25.1836	$26.7943	$28.3482	$26.7800
140008	1.5155	1.0787	$26.3287	$27.2211	$28.5297	$27.3790
140010	1.4537	1.0787	$29.0224	$31.5774	$35.1024	$32.1200
140011	1.1584	0.8279	$19.0903	$20.6338	$22.4091	$20.7429
140012	1.2419	1.0646	$24.4070	$24.3675	$28.6564	$25.7920
140013	1.4287	0.8845	$19.9800	$22.6022	$23.3065	$21.9604
140015	1.3914	0.8958	$21.4328	$22.2266	$23.0600	$22.2778
140016	1.0254	0.8279	$16.3417	$17.1372	$18.1242	$17.2195
140018	1.4356	1.0787	$24.3285	$27.3334	$27.7548	$26.4350
140019	0.9686	0.8279	$17.4206	$18.4554	$18.9228	$18.2432
140024	1.0049	*	$15.6616	$16.9672	$17.5249	$16.7192
140026	1.1678	0.8625	$20.4084	$21.6847	$23.0470	$21.6994
140027	1.1697	*	$20.9855	$22.6208	*	$21.8225
140029	1.5538	1.0787	$25.0485	$27.7304	$28.6565	$27.2604
140030	1.7218	1.0787	$26.5733	$28.7623	$29.7771	$28.4275
140032	1.1810	0.8958	$20.6273	$22.8157	$24.0574	$22.5257
140033	1.2358	1.0581	$23.4279	$26.1553	$25.6068	$25.0497
140034	1.2428	0.8958	$20.9635	$22.1003	$23.0034	$21.9987
140037	0.8642	*	$15.5578	*	*	$15.5578
140040	1.2197	0.8743	$19.2160	$20.0269	$22.2969	$20.4819
140043	1.2416	0.9664	$23.3751	$26.0330	$26.7996	$25.3939
140045	1.0450	*	$18.9587	$21.0042	$20.6548	$20.2345
140046	1.4795	0.8958	$21.7969	$22.5022	$23.2127	$22.5567
140048	1.2945	1.0787	$25.9122	$27.0874	$28.2222	$27.0819

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
140049	1.5948	1.0787	$21.9546	$26.6533	$27.4009	$25.3465
140051	1.5185	1.0787	$24.2472	$27.9935	$27.7901	$26.6740
140052	1.2078	0.8958	$21.8161	$22.2588	$23.5662	$22.5560
140053	1.8710	0.8787	$22.6099	$23.5477	$24.8455	$23.6468
140054	1.4602	1.0787	$35.5659	$31.7265	$31.8564	$32.8769
140058	1.2598	0.8958	$20.5089	$22.1269	$22.8423	$21.8133
140059	1.0851	0.8958	$19.9777	$22.7121	$22.4651	$21.7552
140061	0.9901	0.8958	$22.7515	$30.9925	$20.8063	$24.6734
140062	1.2163	1.0787	$30.7005	$31.2359	$34.7704	$32.2360
140063	1.3737	1.0787	$30.5430	$26.5584	$27.8306	$28.2367
140064	1.1693	0.8743	$20.6505	$21.7470	$22.0407	$21.4911
140065	1.3953	1.0787	$26.3521	$26.1904	$29.4678	$27.3858
140066	1.1355	0.8958	$18.0915	$20.4353	$21.9771	$20.1053
140067	1.8342	0.8845	$21.9579	$23.5906	$25.3986	$23.6801
140068	1.2364	1.0787	$24.1316	$25.8963	$27.3956	$25.8156
140070	***	*	$25.2960	*	*	$25.2960
140075	1.3361	1.0787	$26.5350	$26.9257	$27.9325	$27.1256
140077	0.9621	0.8958	$18.0487	$19.0922	$19.1363	$18.7657
140079	***	*	$25.7090	$29.3040	*	$27.5634
140080	1.4435	1.0787	$24.4056	$26.0109	$23.2575	$24.4826
140082	1.4014	1.0787	$25.0474	$26.8077	$25.6645	$25.8332
140083	1.0694	1.0787	$23.2822	$24.6491	$26.2972	$24.7955
140084	1.2159	1.0581	$25.4818	$27.6819	$29.2515	$27.5306
140088	1.8214	1.0787	$28.4219	$31.0364	$32.4978	$30.6729
140089	1.1983	0.8279	$20.7632	$22.1227	$23.3401	$22.0452
140090	***	*	$35.0300	*	*	$35.0300
140091	1.7746	0.9582	$23.7560	$26.1075	$26.8518	$25.6285
140093	1.1579	0.9262	$21.5376	$22.1540	$25.3127	$22.9099
140094	1.0608	1.0787	$24.2166	$25.3678	$27.9273	$25.8494
140095	1.2411	1.0787	$24.7706	$29.9746	$27.6799	$27.5947
140100	1.2328	1.0581	$27.1868	$32.8743	$37.0819	$32.5610
140101	1.1378	1.0787	$24.6106	$25.4784	$28.5365	$26.3107
140102	1.0470	*	$19.8678	$21.2278	*	$20.5493
140103	1.3191	1.0787	$21.2404	$21.7512	$23.3258	$22.1297
140105	1.2587	1.0787	$27.3323	$26.3054	$27.4531	$27.0018
140109	1.1459	0.8279	$16.4261	$17.8103	$19.5675	$17.9602
140110	1.0552	1.0646	$21.9880	$25.6561	$27.9844	$25.2166
140113	1.5847	0.9582	$25.6621	$23.5337	$26.7969	$25.2477
140114	1.4787	1.0787	$24.1926	$25.7968	$28.3014	$26.1695
140115	1.1789	1.0787	$25.3410	$26.3677	$25.1498	$25.6313
140116	1.2924	1.0787	$26.8924	$30.5166	$31.9902	$29.9696
140117	1.5169	1.0787	$23.3531	$25.6314	$26.8802	$25.3065
140118	1.7320	1.0787	$26.7350	$27.7392	$29.7570	$28.1023
140119	1.7467	1.0787	$31.3486	$33.6302	$36.1419	$33.6518
140120	1.2682	0.8845	$20.3237	$22.5795	$22.7375	$21.8812
140121	1.6616	*	$17.6019	*	*	$17.6019
140122	1.4446	1.0787	$26.8595	$26.4991	$28.4188	$27.2710
140124	1.2587	1.0787	$30.9648	$35.2798	$36.1327	$34.0784
140125	1.2383	0.8958	$19.5359	$20.7189	$20.4014	$20.2151
140127	1.5857	0.9074	$21.3102	$22.8172	$24.1658	$22.7988
140129	***	*	$21.6495	*	*	$21.6495
140130	1.2726	1.0581	$25.7324	$26.3518	$29.5247	$27.3008
140132	***	*	$23.0595	*	*	$23.0595
140133	1.2932	1.0787	$24.0458	$26.1599	$28.0339	$25.9998
140135	1.4186	0.8279	$19.7919	$21.2104	$22.3264	$21.1811
140137	1.0401	0.8958	$21.6017	$20.5053	$21.4700	$21.1955
140140	1.0197	*	$19.1636	$21.4710	*	$20.3063
140141	1.0211	*	$20.3706	$23.0515	$21.7871	$21.7302
140143	1.1551	0.8743	$22.0009	$23.8255	$26.2954	$24.0154
140144	0.9634	*	$26.9258	$27.8046	*	$27.3474
140145	1.1271	0.8958	$19.6429	$21.6168	$23.4608	$21.6090
140147	1.1178	0.8279	$18.2692	$19.5896	$19.8541	$19.2467
140148	1.7094	0.8787	$21.5777	$23.0022	$24.7031	$23.0546
140150	1.6139	1.0787	$32.9291	$33.9013	$35.2711	$34.0702
140151	0.8241	1.0787	$21.5167	$22.4842	$23.4879	$22.5018
140152	1.2404	1.0787	$28.5468	$29.6882	$27.6086	$28.6011
140155	1.2756	1.0765	$25.2034	$27.6610	$28.9724	$27.2937

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
140158	1.4203	1.0787	$22.5638	$23.8542	$27.0986	$24.2703
140160	1.2385	0.9664	$20.9986	$22.7002	$24.5373	$22.7502
140161	1.1279	1.0646	$22.2191	$24.1071	$23.1647	$23.1691
140162	1.6229	0.9074	$22.6426	$26.0312	$27.4472	$25.4182
140164	1.7657	0.8958	$19.7774	$22.0424	$23.7457	$21.8696
140165	1.0651	*	$17.0666	$15.9312	$16.6304	$16.5175
140166	1.1824	0.8279	$20.7849	$21.7776	$23.1005	$21.8859
140167	1.0499	0.8279	$19.5959	$19.7610	$22.8911	$20.7477
140168	1.1726	*	$18.7504	$20.0225	*	$19.4021
140170	0.9358	*	$17.0665	$17.1608	*	$17.1147
140171	***	*	$17.3214	*	*	$17.3214
140172	1.3752	1.0787	$27.3372	$27.1121	$29.8568	$28.4878
140174	1.4729	1.0787	$23.6893	$24.7011	$27.8131	$25.3970
140176	1.2141	1.0787	$25.6824	$28.9378	$31.3490	$28.8390
140177	0.9529	1.0787	$20.8526	$19.3328	$22.5610	$20.9656
140179	1.3721	1.0787	$24.1539	$26.3200	$27.6376	$26.0525
140180	1.2667	1.0787	$25.4022	$27.4366	$28.3629	$27.0710
140181	1.2082	1.0787	$23.7308	$23.6034	$25.0100	$24.1182
140182	1.5193	1.0787	$32.1969	$28.0337	$28.2211	$28.8901
140184	1.2187	0.8279	$20.6499	$20.1279	$21.1802	$20.6885
140185	1.4330	0.8958	$20.0903	$22.0222	$23.8531	$22.0093
140186	1.5107	1.0765	$26.0970	$28.1977	$30.6951	$28.4624
140187	1.5026	0.8958	$20.5829	$22.0674	$23.2892	$21.9710
140189	1.1505	0.9262	$22.5875	$25.6954	$23.7198	$24.0159
140190	1.0728	*	$17.9193	$18.8530	$19.8297	$18.8585
140191	1.3122	1.0787	$24.5446	$25.2817	$25.8678	$25.2409
140193	0.9701	*	$20.5958	$22.9443	*	$21.7731
140197	1.3542	1.0787	$19.2980	$21.8060	$23.0684	$21.2577
140199	1.0548	0.8279	$19.7888	$21.3464	$22.0315	$21.0597
140200	1.4946	1.0787	$24.1358	$24.9217	$26.3379	$25.1308
140202	1.5604	1.0581	$26.2460	$27.4336	$29.7870	$27.9702
140203	1.0839	*	$26.5789	$28.2212	*	$27.4338
140205	0.5759	1.0128	$25.1010	*	*	$25.1010
140206	1.1417	1.0787	$24.7616	$27.5481	$30.6561	$27.6301
140207	1.4242	1.0787	$23.3197	$25.7331	$24.1048	$24.4812
140208	1.6608	1.0787	$27.4671	$27.6586	$29.4708	$28.2131
140209	1.5477	0.8845	$22.0813	$23.3886	$24.5376	$23.3577
140210	1.0896	0.8279	$15.5339	$16.6729	$19.2639	$17.1406
140211	1.3172	1.0787	$25.8556	$29.5114	$29.7054	$28.4947
140213	1.1697	1.0787	$27.4607	$29.1649	$30.2945	$29.0178
140215	***	*	$18.6962	$22.3097	*	$20.4262
140217	1.4497	1.0787	$24.7146	$29.3711	$31.5324	$28.5274
140223	1.4386	1.0787	$27.4355	$29.2540	$30.4923	$29.0769
140224	1.3999	1.0787	$27.1725	$29.0350	$28.2177	$28.1560
140228	1.5463	0.9965	$22.9899	$25.0074	$25.6419	$24.5738
140231	1.4877	1.0787	$25.5536	$28.3545	$30.6410	$28.2754
140233	1.5789	1.0646	$24.7103	$27.3379	$28.6305	$26.9841
140234	1.0500	0.8743	$20.8676	$23.2604	$23.6928	$22.6766
140239	1.5620	0.9965	$23.9205	$24.2112	$29.0092	$25.6976
140240	1.4134	1.0787	$25.0325	$27.2654	$28.7310	$26.9902
140242	1.4982	1.0787	$28.8686	$30.4005	$32.0522	$30.5576
140245	0.9917	*	$15.2537	$16.0772	*	$15.6642
140246	***	*	$16.1305	*	*	$16.1305
140250	1.2339	1.0787	$25.5501	$27.4628	$28.5971	$27.2294
140251	1.2951	1.0787	$24.8256	$26.7266	$27.1687	$26.2377
140252	1.4213	1.0787	$28.3479	$30.2656	$33.3351	$30.8078
140258	1.5301	1.0787	$27.5741	$27.9478	$30.2639	$28.6430
140271	0.8940	*	$17.5174	$18.8535	*	$18.2163
140275	1.2853	0.8709	$23.1871	$25.2824	$26.1473	$24.8583
140276	1.8142	1.0787	$25.3222	$27.5936	$29.8325	$27.5408
140280	1.4671	0.8709	$21.7004	$21.9302	$23.4447	$22.3667
140281	1.7032	1.0787	$27.9115	$29.2602	$30.4838	$29.2416
140285	***	*	*	$17.7824	$20.7576	$19.1679
140286	1.1142	1.0787	$25.5805	$28.4378	$29.1543	$27.7906
140288	1.5423	1.0787	$26.3572	$26.9581	$29.3988	$27.5648
140289	1.3270	0.8958	$20.7506	$22.3274	$22.6211	$21.9308
140290	1.3299	1.0787	$29.9098	$28.6926	$31.7341	$30.1371

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
140291	1.2633	1.0646	$27.6675	$28.2338	$29.8958	$28.6610
140292	1.1590	1.0787	$26.4077	$26.1781	$27.6285	$26.7692
140294	1.1328	0.8279	$21.7473	$22.6123	$23.4504	$22.6034
140300	1.2322	1.0787	$30.5172	$33.3983	$34.8568	$32.8808
140301	1.1673	1.0787	*	*	$31.7073	$31.7073
140303	2.1093	1.0787	*	*	*	*
150001	1.1882	0.9912	$25.4897	$27.1021	$29.6844	$27.4774
150002	1.4225	1.0646	$22.3327	$23.3804	$25.0063	$23.5866
150003	1.6821	0.8721	$21.0944	$23.3196	$25.3458	$23.2610
150004	1.5573	1.0646	$23.6169	$24.8884	$26.8458	$25.1066
150005	1.2087	0.9912	$23.8818	$25.4443	$27.2369	$25.6152
150006	1.3215	0.9775	$23.1779	$24.8976	$26.4061	$24.8616
150007	1.3254	0.9546	$22.1098	$23.5841	$26.6073	$24.2353
150008	1.4227	1.0646	$23.8916	$23.6953	$26.6928	$24.7814
150009	1.3828	0.9254	$19.4763	$20.4993	$22.2147	$20.7473
150010	1.3579	0.9546	$22.5445	$23.9740	$26.8524	$24.4792
150011	1.1670	0.9766	$22.1559	$23.2249	$24.3490	$23.2593
150012	1.5500	0.9775	$23.1644	$22.9314	$27.3029	$24.2924
150013	0.9904	*	$19.8564	$19.7689	$21.8465	$20.4949
150014	1.3341	0.9912	$24.3754	$26.5785	*	$25.4309
150015	1.3287	1.0646	$23.1616	$24.3015	$26.2434	$24.6064
150017	1.8334	0.9787	$22.7979	$23.7180	$25.2342	$23.9446
150018	1.6441	0.9606	$24.6138	$24.7048	$26.3289	$25.2344
150019	1.0496	*	$17.3170	*	*	$17.3170
150020	1.1215	*	$18.4689	*	*	$18.4689
150021	1.7451	0.9787	$24.3658	$27.8168	$29.6967	$27.2581
150022	1.0786	0.8875	$22.2973	$22.8035	$22.6773	$22.6089
150023	1.5291	0.8626	$20.6926	$23.1253	$23.7159	$22.4697
150024	1.4380	0.9912	$21.7593	$24.7879	$27.1589	$24.7582
150026	1.2837	0.9606	$23.2169	$23.7185	$28.1127	$25.1166
150027	1.0264	0.9912	$21.5766	$21.2855	$17.4862	$19.9164
150029	1.4385	0.9775	$25.2067	$23.4103	$26.9680	$25.0754
150030	1.2127	0.9766	$23.0196	$24.4361	$26.9533	$24.8565
150031	1.0638	*	$18.9180	*	*	$18.9180
150033	1.7015	0.9912	$24.1701	$25.8851	$27.9995	$26.0913
150034	1.5097	1.0646	$22.8812	$23.9388	$26.0465	$24.3610
150035	1.4639	0.9473	$23.5468	$26.0952	$26.6620	$25.4702
150037	1.3136	0.9912	$24.4997	$27.7009	$28.5451	$26.8949
150038	1.1135	0.9912	$21.6608	$24.4188	$28.8054	$24.9650
150042	1.4015	0.8626	$23.7838	$21.9917	$23.0102	$22.8781
150044	1.3418	0.9254	$20.5156	$23.1200	$23.7065	$22.4683
150045 [h]	1.0611	1.0203	$23.0361	$24.2899	$25.2225	$24.2205
150046	1.4435	0.8626	$20.3453	$21.0417	$21.9369	$21.1254
150047	1.7099	0.9787	$24.8786	$24.5455	$25.8349	$25.1035
150048	1.3290	0.9595	$22.5181	$24.5864	$27.1817	$24.7509
150049	1.1302	0.8626	$18.4942	$20.2178	$22.3370	$20.2342
150051	1.5723	0.8626	$21.4009	$22.6866	$23.7061	$22.5941
150052 [h]	1.0456	0.9254	$19.1070	$19.6073	$20.6339	$19.7871
150056	1.8501	0.9912	$24.7841	$27.6754	$28.2842	$26.9368
150057	1.9981	0.9912	$28.0884	$22.7804	$24.8605	$24.9551
150058	1.5717	0.9775	$24.9479	$26.9753	$27.5341	$26.5322
150059	1.5913	0.9912	$25.6738	$27.0792	$28.5715	$27.1975
150060	1.0914	*	$19.8990	$23.2409	$24.8544	$22.6276
150061	1.1149	0.8626	$19.2826	$21.3640	$22.2822	$20.9919
150062	1.1174	0.8779	$22.9214	$23.5550	$24.6088	$23.7293
150063	***	*	$24.4091	$19.0377	*	$21.8339
150064	1.1816	0.8626	$21.2512	$21.6370	$23.7707	$22.2400
150065	1.2407	0.9766	$23.0636	$24.4451	$25.9461	$24.5094
150067	1.0394	*	$21.4374	*	*	$21.4374
150069	1.2003	0.9595	$23.8353	$25.3445	$25.2655	$24.8300
150070	0.9449	*	$20.7413	$22.6260	*	$21.7117
150072	1.2044	0.8626	$18.5447	$20.3191	$20.5111	$19.8274
150073	***	*	$14.8287	*	*	$14.8287
150074	1.4325	0.9912	$22.9598	$24.4374	$25.2586	$24.2433
150075	1.0887	0.9787	$20.1119	$24.2085	$24.0745	$22.8038
150076	1.2419	0.9775	$25.4519	$24.1434	$28.1874	$25.9085
150078	0.9482	*	$20.1259	$21.2476	*	$20.7180

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
150079	1.0979	0.9254	$19.3860	$20.6486	$21.4067	$20.5165
150082	1.7386	0.8727	$21.0651	$22.2054	$25.5860	$22.9776
150084	1.8008	0.9912	$27.8354	$28.7722	$29.3905	$28.6939
150086	1.2204	0.9595	$21.5815	$22.4471	$23.9404	$22.7151
150088	1.2877	0.9766	$22.2627	$23.0998	$23.6253	$23.0168
150089	1.4776	0.8943	$21.6806	$22.6545	$25.0449	$23.0977
150090	1.5045	1.0646	$24.9021	$24.6758	$26.2899	$25.3163
150091 [h]	1.0899	1.0360	$26.4248	$27.8087	$30.6209	$28.2762
150096	0.9793	*	$19.7975	$21.9091	*	$20.8347
150097	1.0695	0.9912	$22.4564	$24.4179	$25.0367	$24.0346
150100	1.7186	0.8727	$21.2980	$22.2687	$24.3530	$22.6387
150101	1.0362	0.9787	$26.1271	$27.9745	$29.1657	$27.6430
150102	1.1050	0.9390	$21.3313	$22.6870	$24.5923	$22.8112
150104	1.0587	0.9912	$21.0799	$21.8172	$25.5871	$22.8454
150106 [h]	1.0532	0.9787	$19.1976	$20.9955	$20.9387	$20.4063
150109	1.4302	0.8721	$23.4642	$24.3786	$23.5865	$23.8124
150112	1.4431	0.9766	$23.5151	$24.7455	$26.5643	$24.9478
150113	1.2063	0.9766	$21.2412	$23.0450	$24.8760	$23.1460
150115	1.3456	0.8626	$20.3863	$20.5215	$19.3411	$20.0486
150122	1.1236	0.8825	$22.2752	$24.2471	$26.0173	$24.2508
150123	***	*	$15.5997	$15.3050	*	$15.4580
150124	1.1255	0.8626	$17.9063	$18.8218	$21.3933	$19.4269
150125	1.5069	1.0646	$23.1464	$24.3872	$26.7666	$24.8140
150126	1.4223	1.0646	$24.1917	$25.5585	$26.9887	$25.6255
150128	1.3965	0.9912	$20.9869	$23.1660	$26.4976	$23.5710
150129	1.2019	0.9912	$34.3166	$35.4311	$29.9099	$32.9368
150130	1.0268	*	$18.5578	$21.5678	$21.7399	$20.5294
150132	1.4086	1.0646	$22.2707	$24.2559	$25.6257	$24.1021
150133	1.2666	0.9787	$21.8807	$21.8839	$22.7293	$22.1682
150134	1.1176	0.9254	$20.7680	$22.1085	$23.8526	$22.2228
150136	***	*	$25.8467	$25.7004	$26.2703	$25.9403
150146	1.0225	0.9787	$25.1827	$26.1168	$29.3383	$26.7878
150147	1.1926	1.0646	*	$32.3336	$22.8456	$26.0420
150148	***	*	$26.2188	$27.2081	*	$26.7661
150149	0.9715	0.8727	*	$23.8554	$23.6361	$23.7419
150150	1.2769	0.9787	*	$26.5138	$25.5331	$26.0172
150151	***	*	*	*	$38.1446	$38.1446
150152	***	*	*	*	$44.7143	$44.7143
150153	2.4699	0.9912	*	*	*	*
150154	2.5955	0.9912	*	*	*	*
150156	1.8815	0.9390	*	*	*	*
150157	1.6131	0.9912	*	*	*	*
160001	1.2088	0.9272	$22.8426	$23.8657	$25.1220	$23.9155
160002	***	*	$19.9607	*	*	$19.9607
160003	0.9701	*	$17.5050	$19.0037	*	$18.2436
160005	1.1966	0.8553	$20.3313	$21.1745	$21.8950	$21.1337
160008	1.0690	0.8553	$17.9463	$19.8066	$20.7200	$19.4883
160013	1.2076	0.8771	$21.0541	$23.0163	$23.7163	$22.5118
160014	0.9968	*	$18.3097	$19.2447	$20.5882	$19.3912
160016	1.5950	0.9430	$21.8400	$21.2785	$23.3619	$22.1755
160020	1.0680	0.8553	$16.6092	$19.0043	$19.5554	$18.4145
160024	1.5950	0.9668	$22.4256	$24.2385	$26.2392	$24.3248
160026	0.9887	0.9272	$22.8967	$24.2045	$24.7424	$23.9779
160028	1.3174	0.9546	$25.1998	$26.0052	$26.2948	$25.8671
160029	1.6190	0.9741	$23.7268	$24.9493	$27.9277	$25.5651
160030	1.2758	0.9577	$23.3687	$24.9920	$26.7068	$25.0247
160031	0.9697	0.8553	$17.8994	$18.5281	$19.7368	$18.7354
160032	1.0590	0.8825	$20.5024	$22.3837	$23.4727	$22.1329
160033	1.7424	0.8709	$22.2660	$23.4148	$24.6768	$23.4865
160034	0.9421	0.8553	$19.0684	$19.4837	$19.3503	$19.3060
160039	0.9342	0.8553	$19.8851	$20.9623	$22.1180	$20.9879
160040	1.2439	0.8813	$20.0567	$21.8187	$23.9053	$21.9454
160043	***	*	$15.5765	*	*	$15.5765
160044	1.1315	*	$19.0956	$19.5635	*	$19.3281
160045	1.6942	0.8813	$22.1285	$24.4957	$25.4153	$24.0445
160047	1.3730	0.9546	$22.1550	$24.5000	$25.2072	$23.9813
160048	1.0536	0.8553	$18.1174	$19.5701	$19.5832	$19.1110

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
160050	1.1034	0.8553	$21.6247	$23.8830	$24.5403	$23.3364
160057	1.2602	0.9556	$20.8345	$22.0472	$23.0937	$21.9969
160058	1.8406	0.9741	$23.5663	$25.5244	$27.1646	$25.4595
160064	1.6054	1.0218	$23.8367	$27.6301	$28.6139	$26.8350
160066	1.0906	0.8553	$20.4609	$21.4631	$22.7709	$21.6117
160067	1.3672	0.8813	$19.9422	$21.9418	$23.4060	$21.8952
160069	1.4498	0.9005	$21.7197	$22.7514	$25.3402	$23.2842
160072	***	*	$15.8236	*	*	$15.8236
160074	1.0213	*	$22.2988	$20.2418	*	$21.1624
160076	0.9957	*	$20.1603	$20.9749	*	$20.5825
160079	1.5094	0.8813	$21.6562	$22.5299	$23.7234	$22.6640
160080	1.3139	0.9664	$21.1713	$23.5721	$23.1837	$22.6302
160081	1.1943	*	$20.4415	$21.3614	$23.1930	$21.6437
160082	1.7485	0.9668	$21.6230	$23.8181	$26.4398	$23.8972
160083	1.6640	0.9668	$23.4670	$25.0617	$28.2193	$25.6738
160089	1.2859	0.9430	$19.9688	$21.5693	$22.6551	$21.4092
160090	0.9952	*	$19.6767	$21.2753	*	$20.4851
160091	0.9580	*	$16.1660	$18.0630	$17.9862	$17.3974
160092	0.9609	*	$20.4731	$22.0841	*	$21.2805
160093	***	*	$22.8553	*	*	$22.8553
160101	1.1027	0.9668	$22.1741	$24.2309	$25.1000	$23.8100
160104	1.3950	0.8709	$23.2832	$24.0075	$24.9134	$24.0516
160106	1.1265	*	$19.8905	$21.4912	*	$20.6919
160107	1.0451	*	$19.5111	$21.3754	*	$20.4402
160110	1.6682	0.8813	$21.9299	$24.1762	$24.9434	$23.7256
160112	1.2599	0.8553	$20.4038	$21.8901	$23.0672	$21.8008
160113	0.9661	*	$16.7574	$18.6599	*	$17.7162
160114	0.9810	*	$19.1743	*	*	$19.1743
160115	1.0985	*	$17.6815	$19.5764	*	$18.5763
160116	1.0398	*	$19.6923	$22.2019	*	$20.9445
160117	1.2805	0.9005	$22.3228	$23.4250	$25.0278	$23.6002
160118	1.0326	0.8553	$16.9466	$18.3322	$19.7764	$18.4025
160122	1.0846	0.8553	$21.2843	$22.9565	$22.5872	$22.2853
160124	1.1237	0.8553	$21.2279	$22.7223	$23.1690	$22.3848
160126	1.0433	0.8553	$20.0149	$20.3748	$19.8323	$20.0754
160131	0.9408	*	$18.0486	*	*	$18.0486
160140	1.0209	*	$22.1666	$22.5230	*	$22.3471
160143	1.0157	*	$19.0623	*	*	$19.0623
160146	1.4086	0.9365	$20.6638	$20.9583	$22.9897	$21.5377
160147	1.2192	0.9430	$22.7993	$26.6577	$26.6438	$25.4406
160153	1.6067	0.9365	$23.5212	$26.3671	$28.9881	$26.3386
170001	1.1627	0.8076	$19.8149	$20.9837	$21.9131	$20.9143
170006	1.2468	0.8450	$19.4488	$20.6460	$21.9019	$20.7240
170008	***	*	$18.2352	*	*	$18.2352
170009	1.0640	0.9463	$25.8246	$29.1979	$29.2588	$28.1227
170010	1.2408	0.8569	$20.6294	$21.2131	$24.0008	$21.9435
170012	1.6234	0.8977	$21.8587	$22.6869	$24.7392	$23.0750
170013	1.6094	0.8977	$21.4954	$23.1159	$25.0419	$23.1862
170014	0.9839	0.9463	$21.3416	$22.9772	$23.5960	$22.6522
170015	1.0552	*	$18.0485	$19.1902	$20.2367	$19.1620
170016	1.6375	0.8912	$22.9479	$24.2336	$25.9482	$24.4090
170017	1.1078	0.9168	$21.6323	$23.3030	$24.7771	$23.3226
170018	0.8965	*	$16.9169	$17.9497	*	$17.4623
170019	1.2271	0.8076	$18.7916	$20.3243	$22.0251	$20.4068
170020	1.5762	0.8977	$20.6658	$22.2571	$23.1800	$22.0586
170022	1.0981	0.9463	$21.1947	$22.9313	$22.2878	$22.1486
170023	1.4687	0.8977	$21.6273	$23.2690	$23.9808	$22.9706
170024	***	*	$16.1196	*	*	$16.1196
170025	***	*	$19.2123	*	*	$19.2123
170026	***	*	$17.0836	*	*	$17.0836
170027	1.4017	0.8076	$20.7776	$21.4678	$22.5103	$21.6098
170033	1.3937	0.8977	$20.0627	$20.0801	$20.7865	$20.2914
170034	0.8608	*	$18.1074	*	*	$18.1074
170039	0.9591	0.9168	$18.4473	$20.1983	$21.5203	$20.0407
170040	1.9183	0.9463	$24.5234	$27.1771	$28.2856	$26.8014
170041	0.6109	*	$13.9709	*	*	$13.9709
170049	1.5134	0.9463	$22.9404	$24.1208	$24.7895	$23.9996

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
170052	1.1936	0.8076	$15.8809	$17.3794	$18.5291	$17.3370
170054	0.9997	*	$18.5239	$17.5500	*	$18.0250
170056	***	*	$17.1872	*	*	$17.1872
170058	1.0822	0.9463	$23.0648	$22.0398	$23.3398	$22.8013
170068	1.2035	0.9156	$20.5512	$20.8771	$22.6087	$21.3531
170070	1.0815	0.8076	$15.0539	$16.4767	$16.0162	$15.8428
170074	1.2512	0.8076	$18.5446	$20.4936	$21.0565	$20.0516
170075	0.8352	0.8076	$15.6809	$16.2047	$16.5444	$16.1586
170077	***	*	$14.6377	*	*	$14.6377
170080	0.9108	*	$15.0079	*	*	$15.0079
170082	***	*	$15.9973	*	*	$15.9973
170085	0.9571	*	$17.2585	$18.4867	*	$17.8616
170086	1.5689	0.8912	$22.1067	$22.7737	$24.0812	$23.0117
170090	0.9555	*	$16.3550	$15.9807	*	$16.1812
170093	0.8272	0.8076	$15.0307	$16.8710	$16.5553	$16.1514
170094	0.9999	0.8076	$20.1253	$20.3678	$21.3887	$20.6420
170097	0.8994	*	$18.9865	$20.3391	*	$19.6594
170098	1.0088	0.8076	$18.6676	$20.0078	$20.1242	$19.5946
170099	1.0382	*	$15.8117	*	*	$15.8117
170101	***	*	$17.9291	*	*	$17.9291
170103	1.2477	0.9168	$20.1263	$21.4985	$22.8707	$21.5590
170104	1.5175	0.9463	$23.6589	$26.1866	$26.9671	$25.6385
170105	1.0793	0.8076	$18.3824	$19.6687	$21.4422	$19.8723
170109	0.9870	0.9463	$20.7580	$22.7166	$23.2626	$22.2703
170110	0.9756	0.8076	$16.5883	$21.8904	$22.9195	$20.4004
170113	1.0265	*	$19.9957	*	*	$19.9957
170114	0.8632	0.8076	$17.4688	$18.1610	$18.9158	$18.1987
170116	1.0105	*	$20.8800	$23.1127	*	$21.9980
170120	1.2735	0.8450	$18.5895	$19.8723	$21.0499	$19.8632
170122	1.6272	0.9168	$22.2681	$24.6532	$25.3981	$24.1333
170123	1.6884	0.9168	$25.0073	$26.4676	$27.2239	$26.2255
170133	1.0703	0.9463	$20.0593	$21.7748	$22.9309	$21.5574
170137	1.2393	0.8076	$21.4394	$22.7676	$23.8863	$22.7099
170142	1.3477	0.8776	$19.8269	$22.4095	$22.5778	$21.6027
170143	1.1298	0.8076	$18.0308	$19.7643	$20.4459	$19.4072
170144	***	*	$23.9180	$24.4259	$24.6260	$24.3634
170145	1.0677	0.8076	$20.5143	$21.4472	$21.5756	$21.1869
170146	1.5459	0.9463	$27.0312	$28.1965	$29.1358	$28.2094
170147	1.2323	0.9168	$18.2480	$23.1610	$21.4753	$20.9339
170148	***	*	$26.3491	*	*	$26.3491
170150	1.1267	0.8076	$16.3724	$17.4916	$18.5744	$17.4967
170151	1.0276	*	$15.7242	*	*	$15.7242
170152	1.0618	*	*	*	*	*
170166	0.9449	0.8076	$17.8131	$18.5978	$19.2842	$18.5319
170171	***	*	$14.7251	*	*	$14.7251
170175	1.3487	0.8977	$22.5605	$23.6262	$23.9304	$23.3714
170176	1.3432	0.9463	$25.5404	$24.2283	$26.2366	$25.2863
170180	***	*	$25.0935	*	$25.1366	$25.1166
170182	1.4280	0.9463	$23.2115	$24.3820	$25.7443	$24.4497
170183	1.9727	0.9168	$19.6919	$22.8633	$24.5539	$22.4468
170185	1.3253	0.9463	$26.8307	$24.8478	$26.7797	$26.1506
170186	2.9322	0.9168	$28.5602	$30.5157	$31.7896	$30.4381
170187	1.1537	0.8076	$20.8289	$21.0780	$23.3702	$21.8354
170188	2.0471	0.9463	$25.2504	$27.2225	$29.9751	$27.6756
170189	***	*	$28.1996	*	*	$28.1996
170190	1.0582	0.8076	*	$22.4865	$22.8729	$22.6685
170191	1.1279	0.8076	*	$24.9599	$21.3069	$23.1771
170192	2.0907	0.9168	*	*	$27.9704	$27.9704
170193	1.2176	0.8076	*	*	$24.7430	$24.7430
170194	1.7132	0.9463	*	*	$27.9904	$27.9904
170195	2.2634	0.9463	*	*	*	*
170196	2.4484	0.9168	*	*	*	*
180001	1.2743	0.9595	$22.2674	$24.7647	$25.4217	$24.1342
180002	1.0566	0.7780	$20.5135	$21.6843	$22.9727	$21.7424
180004	1.1137	0.7780	$19.8552	$19.0834	$19.5437	$19.4871
180005	1.1545	0.9110	$22.6704	$22.8871	$24.5561	$23.3888
180006	0.9171	0.7780	$14.4066	$15.7136	$14.8011	$14.9439

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
180007	1.4243	0.9051	$21.3545	$21.8724	$22.7606	$21.9873
180009	1.6411	0.9473	$22.4450	$24.0971	$25.3837	$24.0052
180010	1.9593	0.9051	$22.6846	$26.4116	$24.7256	$24.5688
180011	1.3606	0.8732	$18.8056	$22.3183	$22.7364	$21.2726
180012	1.5066	0.9254	$20.2758	$22.9096	$24.6642	$22.6125
180013	1.4556	0.9450	$21.0512	$21.4728	$22.9512	$21.8902
180016	1.3161	0.9254	$20.5203	$22.2148	$23.1832	$22.0005
180017	1.2474	0.8278	$18.0329	$19.0694	$20.8630	$19.3296
180018	1.3343	0.8732	$17.5670	$18.3314	$19.0992	$18.3166
180019	1.1920	0.9595	$20.8416	$22.0379	$24.1342	$22.3292
180020	1.0412	0.7780	$20.9964	$22.3477	$21.9494	$21.7537
180021	1.0484	0.7780	$17.6331	$17.9346	$18.5966	$18.0522
180024	1.1385	0.9254	$22.3922	$23.6826	$32.1824	$25.9352
180025	1.0658	0.9254	$18.3306	$17.4781	$19.1543	$18.3232
180026	1.1076	0.7780	$15.5354	$15.8431	$18.2120	$16.5328
180027	1.2142	0.8084	$20.5017	$22.1072	$23.8763	$22.1722
180028	0.9014	0.9110	$20.6324	$21.4766	$24.7968	$22.1418
180029	1.2921	0.8087	$20.4262	$21.2110	$23.0536	$21.5776
180035	1.5475	0.9595	$24.3874	$26.7702	$29.8438	$27.1206
180036	1.1732	0.9473	$22.2389	$23.1636	$25.1154	$23.5250
180037	1.2870	0.9254	$22.7893	$24.4451	$25.7361	$24.4985
180038	1.3647	0.8797	$20.6888	$22.2750	$24.6348	$22.4970
180040	2.1017	0.9254	$23.2341	$24.5590	$26.2125	$24.7248
180041	1.0818	*	$19.1325	$18.5483	*	$18.8494
180043	1.2068	0.7780	$20.6498	$18.8436	$19.0617	$19.4791
180044	1.5212	0.9110	$21.8163	$21.6837	$23.0971	$22.1791
180045	1.3293	0.9595	$22.1027	$24.5856	$25.8349	$24.1325
180046	1.0574	0.9051	$23.1139	$24.7562	$27.2244	$25.0514
180047	0.8551	0.7780	$17.8574	$20.4768	$21.8037	$20.0588
180048	1.2811	0.9254	$20.0114	$22.3601	$21.6571	$21.3621
180049 [h]	1.3932	0.9051	$18.5188	$19.4488	$23.3407	$20.4067
180050	1.1398	0.7780	$19.9082	$21.7150	$22.6473	$21.3727
180051	1.4278	0.8264	$18.8186	$19.2100	$21.3312	$19.7863
180053	1.0413	0.7780	$17.6239	$18.6610	$19.1578	$18.5083
180054	0.9767	*	$19.1340	$19.0657	*	$19.0979
180055 [h]	1.1334	0.9051	$17.8704	$21.1989	$20.7237	$19.9661
180056	1.0730	0.8727	$19.4072	$21.4695	$22.8910	$21.2490
180063	1.1816	0.7780	$15.5078	$15.9185	$17.9741	$16.5674
180064	1.2331	0.7780	$21.1067	$15.3819	$16.2638	$17.3349
180066	1.0540	0.9450	$21.1884	$24.6359	$24.9543	$23.6588
180067	1.9820	0.9051	$22.0056	$24.0551	$25.4080	$23.7960
180069	1.0535	0.9110	$20.3982	$20.8797	$22.3674	$21.2166
180070	1.1278	0.7780	$16.9892	$17.4266	$20.1308	$18.1917
180072	***	*	$17.5411	*	*	$17.5411
180078	1.0926	0.9110	$23.4616	$25.4196	$26.2636	$25.0479
180079	1.1273	0.7780	$18.0472	$19.5783	$19.7791	$19.1405
180080	1.3148	0.8732	$18.9582	$20.1651	$21.7380	$20.2813
180087	1.1773	0.7780	$16.4726	$17.7758	$18.4331	$17.6017
180088	1.5731	0.9254	$23.7217	$24.6053	$27.5767	$25.3642
180092	1.1351	0.9051	$19.6790	$22.4864	$22.5679	$21.6047
180093	1.4508	0.8499	$18.8469	$19.2748	$20.5422	$19.5520
180094	0.9639	*	$15.7640	*	*	$15.7640
180095	1.0535	0.7780	$15.9881	$17.1354	$17.9677	$17.0401
180099	***	*	$14.0115	*	*	$14.0115
180101	1.1363	0.9051	$22.4094	$24.2242	$25.4796	$24.0981
180102	1.5634	0.8084	$20.1885	$19.1136	$18.4388	$19.1595
180103	2.2314	0.9051	$21.3867	$25.1577	$26.9407	$24.4722
180104	1.6311	0.8084	$21.3866	$22.8911	$24.9441	$23.1113
180105	0.8503	0.7780	$18.3521	$19.5364	$19.7615	$19.2381
180106	0.9842	0.7780	$15.4937	$15.7851	$17.8020	$16.4485
180108	***	*	$16.7327	*	*	$16.7327
180115	0.9674	0.7780	$19.2396	$19.9316	$20.9831	$20.0578
180116	1.2126	0.8279	$20.5453	$21.8698	$22.7353	$21.7465
180117	0.9872	0.7780	$17.7885	$20.5952	$21.1854	$19.7909
180120	0.7900	*	$20.4507	*	*	$20.4507
180121	0.9689	*	$16.9881	*	*	$16.9881
180124	1.3234	0.9450	$20.5369	$21.4270	$23.1917	$21.6877

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
180126	1.0467	*	$14.5644	$15.1776	*	$14.8844
180127	1.2802	0.9254	$20.0059	$21.4633	$23.4765	$21.6735
180128	0.9517	0.8062	$19.8502	$20.5575	$20.8406	$20.4307
180129	***	*	$14.1861	*	*	$14.1861
180130	1.6476	0.9254	$23.4982	$24.8441	$26.0278	$24.8066
180132	1.3469	0.8732	$19.9358	$22.2101	$23.7652	$21.9796
180134	1.0734	0.7780	*	$17.3449	$18.6779	$18.0324
180138	1.2131	0.9254	$23.0996	$25.1789	$27.3400	$25.1767
180139	1.0857	0.8732	$20.6287	$21.3797	$23.5363	$21.8425
180141	1.7853	0.9254	$22.6722	$24.3140	$25.3042	$24.1450
180143	1.5170	0.9051	$20.1309	$23.9125	$25.1613	$23.2370
180146	1.9117	0.9595	*	*	*	*
180147	1.3564	0.8214	*	*	*	*
180148	1.6098	0.7780	*	*	*	*
190001	1.0919	0.8993	$20.4946	$19.5680	$19.7516	$19.8963
190002	1.7582	0.8420	$20.7172	$21.7000	$22.0056	$21.4744
190003	1.4846	0.8420	$20.7505	$21.8156	$23.4977	$22.0368
190004	1.3144	0.7895	$20.5272	$22.1835	$23.3290	$21.9727
190005	1.4478	0.8993	$20.0551	$20.7987	$22.3208	$21.0635
190006	1.2800	0.8420	$18.8115	$19.4573	$22.2467	$20.1618
190007	1.1307	0.7438	$17.9392	$18.7854	$19.7528	$18.8587
190008	1.6652	0.7895	$20.3278	$21.4137	$24.0111	$21.9572
190009	1.2108	0.8040	$17.5144	$18.8295	$19.8404	$18.6932
190010	1.1459	0.7839	$18.1797	$19.9788	$21.6889	$19.9508
190011	1.0389	0.8036	$15.4699	$18.1525	$19.7319	$17.7235
190013	1.3473	0.7839	$18.7538	$19.6346	$20.8626	$19.7509
190014	1.1833	0.7438	$17.0630	$17.4740	$22.4596	$18.7727
190015	1.3085	0.8993	$20.6167	$22.1046	$22.8875	$21.9289
190017 [h]	1.3500	0.8655	$18.3528	$18.6962	$21.5033	$19.4006
190018	***	*	$19.2055	*	*	$19.2055
190019	1.7107	0.8040	$20.8193	$23.0704	$23.7168	$22.5353
190020	1.1470	0.8596	$18.5659	$19.8505	$21.6136	$19.9828
190025	1.2413	0.7438	$19.9969	$20.4651	$20.8950	$20.4776
190026	1.5333	0.8040	$19.9229	$21.3386	$22.5087	$21.3125
190027	1.6874	0.7839	$19.4057	$21.2449	$21.2526	$20.6470
190034	1.1882	0.7438	$16.8439	$17.5002	$19.6943	$18.0127
190036	1.6697	0.8993	$23.3903	$23.7356	$24.8152	$23.9954
190037	0.9569	0.7839	$15.6062	$16.7629	$18.6393	$17.0499
190039	1.4777	0.8993	$20.4900	$23.3105	$25.6665	$23.2338
190040	1.3328	0.8993	$22.9262	$23.8076	$26.7428	$24.3506
190041	1.4983	0.8758	$21.9983	$23.9082	$24.6734	$23.4433
190043	1.0016	0.7438	$15.7333	$16.8944	$17.3477	$16.6784
190044 [h]	1.2408	0.8420	$17.7460	$19.5304	$19.5567	$18.9595
190045	1.6136	0.8993	$22.8709	$24.0490	$25.3854	$24.1220
190046	1.4259	0.8993	$21.1019	$22.2884	$24.2128	$22.4847
190048	1.0721	0.7438	$18.1698	$18.6148	$19.6288	$18.7855
190049	1.0285	*	$19.3768	$20.1229	*	$19.7625
190050	1.0919	0.7438	$18.6663	$18.5287	$19.1076	$18.7685
190053	1.1396	0.7438	$13.8037	$15.7258	$16.4968	$15.3819
190054	1.3813	0.7545	$19.9370	$20.3525	$20.1108	$20.1339
190059	0.8461	*	$18.3334	$19.2396	*	$18.7888
190060	1.5045	0.7839	$20.2207	$22.2517	$23.6278	$22.0195
190064	1.5825	0.8596	$21.1262	$21.5514	$23.3617	$22.0132
190065	1.5073	0.8596	$20.3583	$23.0523	$23.7450	$22.3992
190077	0.8561	0.8036	$17.0480	$18.4043	$18.8409	$18.0986
190078 [h]	1.0179	0.8655	$19.8607	$21.5782	$21.3786	$20.9721
190079	1.2698	0.8993	$20.5000	$21.8158	$21.2546	$21.1972
190081	0.8933	0.7438	$11.4756	$14.9141	$15.6146	$13.9838
190083	0.8765	*	$18.4954	$19.2683	*	$18.9013
190086	1.2554	0.8758	$18.2005	$18.8306	$19.8823	$18.9783
190088 [h]	1.0856	0.9463	$18.6738	$22.5045	$22.3480	$20.9939
190089	0.9661	*	$15.5151	$16.2961	*	$15.9103
190090	1.0976	0.7438	$19.0519	$20.0745	$20.2045	$19.8076
190095	***	*	$16.9519	$8.7302	$18.0174	$17.8930
190098	1.6297	0.8758	$20.7537	$23.0802	$24.6353	$22.7792
190099	1.0348	0.8461	$23.1606	$21.1657	$20.4597	$21.4552
190102	1.6431	0.8420	$22.0190	$23.4618	$25.2267	$23.6255

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
190106	1.2127	0.8040	$20.3114	$21.5643	$21.7228	$21.2163
190109	1.1477	0.7895	$16.6515	$17.4842	$18.6524	$17.5941
190110	0.8711	*	$16.5007	$19.0611	*	$17.8105
190111	1.5859	0.8758	$24.4380	$25.2370	$24.4998	$24.7275
190114	1.0549	0.7438	$13.6101	$14.6258	$15.8031	$14.6821
190115	1.2024	0.8758	$25.4984	$26.0272	$26.6295	$26.0395
190116	1.2579	0.7438	$17.8297	$18.6074	$20.3844	$18.9443
190118	0.9498	0.8758	$17.5060	$19.0200	$19.7025	$18.7558
190122	1.1979	0.8596	$17.7811	$19.3131	$23.7082	$20.0706
190124	1.5411	0.8993	$23.3859	$23.4862	$24.6675	$23.8477
190125	1.6662	0.8036	$21.5692	$22.3976	$23.9649	$22.6514
190128	1.0876	0.8596	$23.8786	$24.7842	$27.9136	$25.5637
190130	0.9548	*	$15.2678	$16.6910	*	$15.9880
190131	1.2145	0.8993	$21.3154	$22.5032	$25.1917	$22.9740
190133	0.8962	0.7676	$13.4062	$14.3089	$13.6266	$13.7628
190135	1.4655	0.8993	$24.4908	$26.9920	$26.8238	$26.1247
190140	0.9978	0.7438	$15.4030	$17.0371	$17.6936	$16.7104
190144 [h]	1.1534	0.9463	$21.3838	$21.1658	$21.7547	$21.4426
190145	0.9515	0.7438	$17.4407	$17.3361	$18.9678	$17.9319
190146	1.5597	0.8993	$22.1502	$23.7721	$26.1792	$24.0255
190147	***	*	$16.3596	*	*	$16.3596
190148	1.0428	*	$19.3245	$20.8321	*	$20.0526
190149	0.9282	0.7438	$18.4197	$17.1671	$18.8819	$18.1219
190151	1.0245	0.7438	$17.3402	$17.8741	$18.6293	$17.9597
190152	1.3603	0.8993	$25.1136	$27.4708	$27.6099	$26.7879
190156	0.8775	*	$18.0528	$18.3702	*	$18.2089
190158	1.3827	0.8993	$23.2361	$26.2352	$26.3042	$25.4140
190160	1.5036	0.8036	$19.8428	$20.0025	$21.6740	$20.5204
190161	1.1051	0.7839	$16.5322	$17.8794	$19.1022	$17.8227
190162	***	*	$20.7350	$22.1781	$25.0328	$22.6102
190164	1.1752	0.8040	$20.2791	$21.4247	$22.8599	$21.6241
190167	1.2233	0.7438	$17.2643	$17.8604	$24.3185	$19.7786
190175	1.3694	0.8993	$22.7574	$24.6790	$27.1531	$25.0038
190176	1.7655	0.8993	$25.2536	$25.8482	$25.6997	$25.6097
190177	1.5808	0.8993	$22.3318	$25.4769	$27.4621	$25.2171
190182	0.9407	0.8993	$23.6016	$25.0837	$28.4799	$25.6314
190183	1.1930	0.7895	$17.1805	$18.3151	$19.8084	$18.4205
190184	1.0092	0.7599	$20.6096	$21.3191	$23.9609	$21.8425
190185	1.3487	0.8993	$29.7870	$24.4176	$24.7912	$25.8807
190190	0.8782	0.7599	$16.2819	$14.0052	$16.1195	$15.4593
190191 [h]	1.3706	0.8461	$21.9141	$22.3755	$23.5734	$22.6642
190196	0.8702	0.8420	$20.7601	$21.9355	$24.7135	$22.5497
190197	1.3549	0.8036	$21.6908	$22.9631	$24.3735	$23.0241
190199	1.1734	0.8596	$19.7776	$18.5317	$14.1410	$17.3575
190200	1.5774	0.8993	$24.1667	$26.4258	$27.5681	$25.9873
190201	1.2956	0.7839	$21.4335	$22.5588	$24.5877	$22.9165
190202	1.2769	0.8596	$22.4062	$21.8900	$24.7944	$23.0825
190203	1.5054	0.8993	$24.9518	$26.9099	$26.8795	$26.2979
190204	1.5090	0.8993	$26.1231	$28.8777	$28.3684	$27.8932
190205	1.7338	0.8420	$20.2374	$21.7696	$24.4540	$22.1979
190206	1.7022	0.8993	$24.2892	$26.9117	$26.0139	$25.7960
190207	***	*	$21.5325	*	*	$21.5325
190208	0.8593	0.7438	$23.0838	$24.8409	$24.2586	$24.0684
190218	1.1871	0.8758	$21.6206	$23.9182	$25.0356	$23.6192
190236	1.4525	0.8758	$24.4661	$23.8233	$23.6824	$23.9582
190240	0.9826	*	$15.4026	$13.9888	*	$14.7116
190241	1.2669	0.7895	$24.2462	$28.9620	$23.9700	$25.7012
190242	1.1361	0.8596	$18.6672	$20.5937	$23.0072	$20.7608
190243	***	*	*	$30.6060	*	$30.6060
190245	2.2150	0.8036	*	*	$27.1786	$27.1786
190246	1.5661	0.7599	*	*	*	*
190249	1.5255	0.8596	*	*	*	*
190250	2.4714	0.8993	*	*	*	*
190251	1.6216	0.8596	*	*	*	*
190252	0.9901	0.8596	*	*	*	*
190253	1.0434	0.8993	*	*	*	*
190254	1.4466	0.8596	*	*	*	*

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
190255	0.7772	0.8420	*	*	*	*
190256	1.0194	0.8993	*	*	*	*
190257	1.7195	0.7438	*	*	*	*
190258	1.5399	0.8758	*	*	*	*
190259	1.9052	0.8420	*	*	*	*
190260	1.5277	0.8993	*	*	*	*
190261	0.7151	0.8036	*	*	*	*
190262	1.2664	0.8993	*	*	*	*
190263	2.4990	0.8420	*	*	*	*
200001	1.2994	0.9975	$21.6050	$23.2210	$25.1145	$23.3710
200002	1.1686	0.9874	$22.0700	$24.1446	$25.7478	$23.9468
200007	1.0815	*	$21.0603	$22.3920	*	$21.7470
200008	1.2589	1.0371	$25.1115	$25.1741	$27.4412	$25.9041
200009	1.9763	1.0371	$24.9041	$28.1409	$31.1056	$28.0391
200012	1.1397	0.8831	$21.8529	$24.1243	$25.7623	$23.9787
200013	1.1054	0.9017	$22.8909	$23.9048	$24.4131	$23.7685
200018	1.1830	0.8831	$21.1330	$24.3294	$23.6337	$23.0851
200019	1.2935	1.0371	$23.1114	$24.0926	$25.1367	$24.1296
200020	1.2570	1.0492	$27.0798	$28.7351	$31.7083	$29.2990
200021	1.1914	1.0371	$24.9925	$25.1027	$24.5519	$24.8792
200024	1.5273	0.9874	$22.9698	$24.6484	$26.0080	$24.6372
200025	1.0698	1.0371	$22.9023	$24.3646	$26.0573	$24.4151
200026	1.0477	*	$19.7172	$21.9997	*	$20.8927
200027	1.2293	0.8831	$21.0156	$23.2912	$26.3118	$23.4478
200028	1.0453	0.8831	$21.2180	$24.3061	$24.3271	$23.3297
200031	1.3580	0.8831	$18.8262	$20.6202	$21.9489	$20.4626
200032	1.2196	0.9297	$23.0487	$24.2221	$25.5227	$24.3050
200033	1.8626	0.9975	$25.1723	$26.8727	$28.6479	$26.9328
200034	1.3926	0.9874	$23.5415	$26.1150	$26.2926	$25.3574
200037	1.1984	0.8831	$22.6534	$23.3490	$23.2333	$23.0870
200039	1.2758	0.9874	$22.1333	$24.0474	$25.1196	$23.8217
200040	1.2300	1.0371	$21.8528	$23.6791	$25.5405	$23.6763
200041	1.1436	0.8831	$21.3816	$23.6797	$24.5532	$23.3316
200050	1.2576	0.9975	$23.4391	$25.5233	$26.4992	$25.2144
200052	1.0569	0.8831	$19.0535	$22.7763	$21.8726	$21.2769
200063	1.1958	0.9874	$23.0135	$24.7235	$25.0167	$24.2686
200066	1.2469	*	$19.5890	$21.6354	*	$20.6005
210001	1.4251	0.9647	$22.6614	$26.3144	$27.7561	$25.5750
210002	2.0200	0.9882	$25.6975	$25.2859	$26.4992	$25.8584
210003	1.6590	1.0928	$23.0790	$32.3042	$29.8684	$28.0698
210004	1.4471	1.1499	$29.4841	$29.4300	$34.2392	$31.0347
210005	1.2974	1.1459	$24.7185	$27.1276	$28.7557	$26.8963
210006	1.1056	0.9882	$24.7327	$25.6396	$25.4081	$25.2468
210007	1.9113	0.9882	$27.5104	$28.4496	$30.2548	$28.7829
210008	1.3194	0.9882	$24.6569	$26.3008	$25.2833	$25.4086
210009	1.7719	0.9882	$23.4889	$24.6332	$26.2360	$24.8136
210010	***	*	$23.7761	$24.5071	$25.7775	$24.7218
210011	1.4035	0.9882	$22.3262	$24.8373	$27.5031	$24.9589
210012	1.6057	0.9882	$25.2892	$25.7934	$27.4103	$26.2116
210013	1.2739	0.9882	$23.0151	$23.9875	$25.1348	$24.0450
210015	1.3351	0.9882	$23.8419	$25.8532	$28.2029	$25.9683
210016	1.7872	1.1499	$27.2632	$28.6992	$32.2081	$29.4293
210017	1.1676	0.9357	$19.0248	$21.3983	$23.2168	$21.2523
210018	1.2269	1.1499	$25.3112	$27.5431	$29.1870	$27.3837
210019	1.7512	0.9357	$23.5259	$24.9252	$26.1824	$24.9054
210022	1.4046	1.1499	$27.6680	$30.1470	$33.8015	$30.5481
210023	1.4601	1.0091	$26.7837	$29.0844	$30.4656	$28.8005
210024	1.6921	0.9882	$24.8939	$27.1756	$29.5579	$27.2560
210025	1.2415	0.9357	$22.8882	$23.8943	$26.0771	$24.3114
210027	1.4867	0.9357	$19.3517	$23.9255	$26.0111	$22.9283
210028	1.0874	0.9357	$22.4054	$24.1265	$25.9221	$24.1901
210029	1.2477	0.9882	$26.2082	$31.2888	$27.9741	$28.3176
210030	1.2689	0.9357	$20.7802	$27.5507	$29.5635	$25.7209
210032	1.1442	1.0516	$20.3407	$25.7138	$26.1829	$23.9925
210033	1.1745	0.9882	$25.0301	$26.6113	$29.0420	$26.9838
210034	1.2975	0.9882	$22.8827	$26.3896	$28.4308	$25.7800
210035	1.3293	1.0928	$21.6973	$24.5198	$26.1082	$24.1712

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
210037	1.1871	0.9357	$23.5536	$24.1913	$27.0973	$24.9552
210038	1.2500	0.9882	$26.5696	$28.3414	$29.5980	$28.1851
210039	1.1125	1.0928	$24.0987	$25.8415	$27.6940	$25.8514
210040	1.2688	0.9882	$25.4729	$28.3723	$29.3514	$27.8674
210043	1.3169	1.0091	$22.2177	$24.3070	$27.5657	$24.7038
210044	1.3613	0.9882	$23.8101	$24.8083	$28.8700	$25.7966
210045	1.0532	0.9357	$11.8350	$15.0867	$15.6380	$14.3653
210048	1.3276	1.0169	$24.4328	$25.0617	$28.4638	$26.0370
210049	1.2425	0.9882	$24.7148	$25.9342	$26.9656	$25.9278
210051	1.3323	1.0928	$25.7103	$27.3692	$29.2998	$27.5052
210054	1.3523	1.0928	$27.3551	$24.6658	$26.2295	$26.0806
210055	1.2162	1.0928	$27.4218	$28.0014	$29.9708	$28.5097
210056	1.3306	0.9882	$23.5881	$26.6884	$28.6091	$26.3638
210057	1.4047	1.1499	$27.3520	$29.2233	$32.2883	$29.7939
210058	1.1672	0.9882	$22.0351	$24.8576	$29.7841	$25.5191
210060	1.1733	1.0928	$25.8377	$28.7531	$28.5087	$27.8143
210061	1.2516	0.9357	$22.5455	$24.1369	$23.6662	$23.5086
220001	1.2205	1.1274	$25.8030	$27.3238	$29.0014	$27.3878
220002	1.3882	1.1415	$26.3348	$28.9722	$30.3598	$28.5921
220003	1.1608	1.1274	$18.8150	$20.5790	$22.0549	$20.5049
220006	1.5147	1.1021	$27.1576	$29.5946	$30.8599	$29.3270
220008	1.2538	1.0954	$25.6647	$27.1675	$30.1043	$27.7253
220010	1.2902	1.1274	$24.5020	$27.4161	$29.7998	$27.3015
220011	1.1378	1.1415	$32.2266	$32.6624	$34.4064	$33.2336
220012	1.4927	1.2592	$32.0521	$32.9791	$35.7872	$33.6778
220015	1.1862	1.0715	$25.0272	$25.5449	$28.3397	$26.3904
220016	1.1279	1.0715	$25.7740	$26.8798	$28.0609	$26.8986
220017	1.3293	1.1551	$28.9024	$28.8264	$29.7108	$29.1461
220019	1.2167	1.1274	$21.6620	$22.2294	$23.2544	$22.3943
220020	1.2576	1.0954	$23.5737	$24.2279	$26.5305	$24.8270
220024	1.2616	1.0715	$24.1071	$25.5837	$27.3488	$25.6784
220025	1.1054	1.1274	$23.2374	$24.5186	$23.0637	$23.5753
220028	1.4583	1.1274	$31.4858	$31.3592	$32.0980	$31.6438
220029	1.1257	1.1274	$27.4792	$28.1432	$28.6970	$28.1288
220030	1.1225	1.0715	$20.0816	$23.6257	$24.4289	$22.7602
220031	1.5516	1.1551	$30.8324	$32.2660	$34.8183	$32.6251
220033	1.1970	1.1274	$25.4500	$26.8049	$28.2539	$26.9214
220035	1.3982	1.1274	$26.8486	$27.5533	$28.6238	$27.6997
220036	1.5239	1.1551	$28.2182	$29.6296	$31.5184	$29.8330
220041	***	*	$28.8184	$29.7464	*	$29.2230
220046	1.3664	1.1274	$26.1955	$27.7726	$28.1396	$27.3951
220049	1.1613	1.1415	$26.7688	$27.0464	$27.7517	$27.2011
220050	1.1404	1.0715	$23.7326	$24.9945	$26.3768	$25.0718
220051	1.2220	1.0715	$22.2965	$26.5575	$29.8380	$26.3369
220052	1.1719	1.1551	$26.3043	$28.0925	$29.8577	$28.1429
220058	1.0134	1.1274	$22.4885	$25.0598	$24.9642	$24.1665
220060	1.1946	1.2303	$29.6960	$30.8242	$32.3362	$31.0565
220062	0.5902	1.1274	$22.6598	$21.9489	$24.2779	$22.9699
220063	1.2060	1.1415	$23.3704	$25.5840	$27.3967	$25.3936
220065	1.2350	1.0715	$22.4143	$24.8737	$26.5513	$24.6535
220066	1.3008	1.0715	$27.5575	$26.2561	$27.1317	$26.9786
220067	1.1875	1.1551	$22.4968	$28.5220	$29.8911	$26.7470
220070	1.1508	1.1415	$26.2697	$28.9100	$31.9283	$28.7436
220071	1.8769	1.1551	$27.7773	$31.8322	$32.2936	$30.6814
220073	1.2301	1.0954	$27.9309	$29.2399	$31.3566	$29.4912
220074	1.3075	1.1551	$25.7840	$27.5763	$28.4930	$27.3187
220075	1.4268	1.1551	$26.0527	$27.9503	$29.1588	$27.7387
220076	***	*	$24.8040	$27.2534	$29.7507	$27.1315
220077	1.7218	1.1075	$27.0946	$28.0935	$30.2684	$28.5352
220080	1.2205	1.1274	$24.7399	$27.1578	$28.9835	$27.0784
220082	1.2599	1.1415	$23.9542	$24.8060	$26.9841	$25.2609
220083	1.1206	1.1551	$28.3533	$29.9001	$32.9143	$30.3719
220084	1.2324	1.1415	$26.8596	$29.0505	$32.5711	$29.5958
220086	1.7352	1.1551	$29.4911	$31.7482	$34.3667	$31.8192
220088	1.8304	1.1551	$26.5849	$28.5711	$28.5462	$27.9606
220089	1.2531	1.1415	$28.9252	$32.4409	$31.1708	$30.8836
220090	1.2045	1.1274	$26.5552	$29.7945	$30.8685	$29.1558

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
220095	1.1124	1.1274	$23.7629	$24.9871	$27.4273	$25.3894
220098	1.1795	1.1415	$26.2287	$26.8538	$28.8314	$27.2888
220100	1.2965	1.1551	$27.0265	$28.4848	$29.6912	$28.4369
220101	1.3346	1.1415	$26.9992	$31.0834	$33.1690	$30.4912
220105	1.2283	1.1415	$26.7570	$30.0892	$31.9421	$29.7099
220108	1.2295	1.1551	$26.0166	$29.0804	$30.6252	$28.5516
220110	2.0817	1.1551	$33.0445	$35.4242	$36.6084	$35.0926
220111	1.2101	1.1551	$27.7395	$28.9092	$31.1850	$29.2950
220116	2.0287	1.1551	$30.9871	$32.2337	$32.9988	$32.0845
220119	1.1583	1.1551	$25.9789	$27.8372	$30.1056	$28.0781
220126	1.1634	1.1551	$26.9853	$26.7660	$28.7805	$27.5408
220133	***	*	$33.0819	$31.2981	$33.6003	$32.6683
220135	1.3124	1.2592	$31.9159	$31.3246	$33.9866	$32.4440
220153	1.0242	1.0715	*	$18.9267	*	$18.9267
220154	0.9702	1.1551	$25.6069	$30.9009	$28.6462	$28.0721
220162	1.3910	*	*	*	*	*
220163	1.6274	1.1274	$29.9312	$30.5056	$33.6484	$31.2574
220171	1.7493	1.1415	$27.2647	$28.9733	$30.4036	$28.9007
220174	1.1913	1.1274	*	$30.3356	$31.7572	$31.0464
230001	1.1136	*	$22.0875	$24.3660	*	$23.2049
230002	1.3022	1.0436	$23.7972	$27.0305	$29.1410	$26.7010
230003	1.2080	1.0393	$22.4322	$25.2596	$26.1278	$24.6604
230004	1.7070	1.0393	$23.0827	$25.5573	$26.7206	$25.1973
230005 [h]	1.2383	1.0874	$20.3750	$22.1018	$24.1902	$22.4061
230006	1.1371	0.9788	$22.0733	$22.7656	$23.8835	$22.9495
230013	1.3752	1.0461	$20.4633	$22.7014	$23.7822	$22.3686
230015	1.0463	0.9325	$21.7640	$23.4512	$24.6570	$23.3267
230017	1.6296	1.0393	$26.1609	$27.3259	$29.5178	$27.7392
230019	1.5743	1.0461	$24.7472	$27.6563	$28.4575	$26.9496
230020	1.6919	1.0570	$25.8267	$26.8516	$29.2869	$27.3788
230021	1.5257	0.9102	$22.0757	$23.4663	$24.9551	$23.5352
230022	1.2333	1.0570	$22.2179	$22.2528	$23.3000	$22.6032
230024	1.5606	1.0570	$24.7364	$27.6555	$30.0813	$27.3385
230027	1.0877	0.9389	$21.2223	$22.5736	$23.5511	$22.4431
230029	1.6623	1.0461	$26.7646	$27.9012	$29.0935	$27.9121
230030	1.2630	0.8966	$19.9853	$20.9867	$22.3174	$21.1301
230031	1.3895	0.9868	$22.1874	$23.2910	$25.4678	$23.7275
230032	***	*	$23.8366	*	*	$23.8366
230034	1.2255	0.8966	$18.5768	$20.9195	$26.7967	$22.0680
230035	1.3094	0.9389	$18.0735	$20.9197	$21.2317	$19.9973
230036	1.3643	1.0461	$25.9801	$26.5854	$28.3622	$26.9984
230037	1.2368	1.0570	$24.4115	$24.7875	$26.2000	$25.1648
230038	1.6919	1.0393	$23.4685	$25.2499	$26.3480	$25.2371
230040	1.2081	0.9389	$21.8062	$21.9813	$24.2349	$22.7262
230041	1.4920	0.9624	$24.2297	$25.2518	$26.1760	$25.1852
230042	1.1974	0.8966	$21.8241	$24.3640	$26.2037	$24.1687
230046	1.8655	1.0874	$28.2320	$29.2683	$30.3591	$29.3515
230047	1.4049	1.0436	$24.3622	$26.2447	$28.1351	$26.3210
230053	1.6133	1.0570	$26.1415	$28.3030	$29.8703	$28.0492
230054	2.0488	0.9470	$23.0818	$24.0137	$24.9905	$24.0601
230055	1.2763	0.8966	$20.9350	$23.7671	$25.4143	$23.4450
230058	1.1537	0.8966	$22.4516	$21.9308	$24.0657	$22.7966
230059	1.4459	1.0393	$21.2743	$23.1451	$25.5350	$23.3695
230060	1.2928	0.8966	$22.3512	$24.5073	$25.5015	$24.1280
230065	***	*	$26.3217	$27.9179	$28.4631	$27.5421
230066	1.3207	1.0393	$23.9696	$25.8517	$27.4928	$25.8295
230069	1.1955	1.0461	$26.0438	$27.6815	$29.5556	$27.8051
230070	1.6029	0.9140	$22.8588	$25.1587	$24.2342	$24.0769
230071	0.9724	1.0461	$23.6674	$24.7707	$26.3907	$24.9681
230072	1.3973	1.0393	$22.9626	$24.1560	$24.4933	$23.9114
230075	1.3516	0.9635	$22.6799	$24.1482	$27.6193	$24.8869
230077	1.9571	1.0461	$29.2041	$27.3117	$27.6157	$27.9729
230078	1.0412	0.8966	$20.5427	$21.9200	$23.9901	$22.2077
230080	1.2788	0.8966	$20.2405	$21.2840	$21.2314	$20.9185
230081	1.2023	0.8966	$20.4289	$20.6777	$23.0788	$21.3975
230082	1.0277	0.8966	$21.3100	$23.1240	$22.2165	$22.1964
230085	1.2412	1.0393	$24.2802	$22.2569	$22.7314	$23.1872

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
230086	1.1486	*	$27.8923	$20.8759	*	$24.2011
230087	***	*	$22.2688	*	$16.9168	$19.0752
230089	1.3664	1.0570	$23.3847	$23.9486	$28.7015	$25.3973
230092	1.2812	0.9680	$22.3122	$24.3768	$26.3584	$24.3257
230093	1.1695	0.9389	$25.1213	$24.5055	$26.4967	$25.3702
230095	1.2598	0.8966	$19.1810	$19.2244	$21.3915	$19.9401
230096	1.1759	1.0393	$26.7156	$26.7578	$28.7681	$27.4077
230097	1.8168	1.0393	$22.9902	$25.2104	$26.5773	$24.9608
230099	1.2146	1.0570	$23.5490	$25.0390	$26.4882	$25.0486
230100	1.1053	0.8966	$19.8016	$20.4565	$21.8895	$20.6965
230101	1.0939	0.8966	$22.3310	$23.1349	$24.3772	$23.3147
230103	1.0133	0.9788	$19.4434	$18.4304	$21.6609	$19.7646
230104	1.5419	1.0570	$27.4119	$27.8864	$30.5570	$28.5801
230105	1.9466	0.9525	$23.9851	$24.6853	$27.2705	$25.3146
230106	1.1233	1.0393	$23.1962	$24.1128	$24.3980	$23.9236
230108	1.1591	0.8966	$19.9842	$22.4966	$18.4063	$20.1757
230110	1.2615	0.8966	$21.5523	$22.7621	$28.7704	$24.4693
230117	1.8928	1.0393	$28.1220	$29.6361	$29.4775	$29.0873
230118	1.0682	0.8966	$22.2208	$21.4886	$22.3636	$22.0278
230119	1.3259	1.0570	$25.3562	$29.2509	$30.2441	$27.9914
230120 [h]	1.1166	1.0874	$22.7243	$21.7894	$24.1485	$22.9095
230121	1.2558	0.9788	$22.3708	$23.4394	$24.5220	$23.4095
230124	1.3249	*	$22.0097	$23.0508	*	$22.5308
230130	1.7417	1.0461	$23.7854	$26.9907	$26.6076	$25.8001
230132	1.4061	1.0644	$29.0292	$29.9106	$30.5318	$29.8191
230133	1.4148	0.8966	$20.4801	$21.2273	$24.3175	$22.0722
230135	1.1266	1.0570	$19.8290	$23.9000	$25.8406	$23.1673
230141	1.6549	1.0644	$23.9885	$30.4643	$28.6326	$27.6090
230142	1.2687	1.0436	$22.9036	$25.6044	$26.9433	$25.2019
230143	1.2616	0.8966	$19.5446	$19.5387	$21.4083	$20.1494
230144	2.1498	*	$23.6959	*	*	$23.6959
230145	1.1530	*	$15.8192	$17.2181	*	$16.5158
230146	1.2683	1.0570	$21.3539	$24.3891	$26.3432	$24.1395
230149	0.9481	*	$20.8933	$21.4753	*	$21.1778
230151	1.3327	1.0461	$23.8527	$26.4669	$28.2243	$26.2186
230153	1.1020	0.9788	$22.8584	$22.3404	$22.8644	$22.6896
230155	1.0473	*	$18.0743	$24.0404	*	$20.6336
230156	1.5973	1.0874	$27.7164	$29.4855	$31.1909	$29.5181
230165	1.7254	1.0570	$25.9534	$27.3164	$28.9636	$27.4184
230167	1.6214	0.9788	$24.7935	$26.6828	$27.4562	$26.3153
230169	***	*	$24.9265	$27.1172	$31.8442	$27.6798
230171	1.0689	*	$19.9097	$22.0635	*	$20.9931
230172	1.2378	1.0393	$23.0023	$24.0236	$25.7402	$24.2756
230174	1.3643	1.0393	$24.4671	$26.2770	$27.6920	$26.1839
230175	***	*	$22.5964	*	*	$22.5964
230176	1.2540	1.0570	$24.6675	$25.6777	$27.3605	$26.1023
230180	1.0980	0.8966	$20.9832	$22.5454	$24.7358	$22.8206
230184	1.2060	0.9680	$21.4031	$21.9346	$23.6707	$22.3438
230186	***	*	$21.6147	$27.1126	$26.2282	$24.5338
230188	0.9386	*	$18.8076	*	*	$18.8076
230189	1.0084	0.8966	$22.7783	$20.8605	$23.0099	$22.2035
230190	1.0096	1.0393	$27.3430	$28.7365	$29.9604	$28.6717
230193	1.2826	0.9868	$22.8916	$24.3181	$23.3565	$23.5189
230195	1.4454	1.0436	$25.3285	$27.1266	$28.2892	$26.9865
230197	1.5759	1.0644	$26.9840	$28.3439	$30.0367	$28.4836
230204	1.3229	1.0436	$24.4095	$25.9871	$29.1466	$26.3875
230207	1.3781	1.0461	$22.2848	$22.2854	$24.5201	$23.0106
230208	1.2059	0.9389	$20.3171	$20.9420	$21.9651	$21.0908
230212	1.0320	1.0874	$26.0656	$27.3686	$29.7980	$27.6833
230216	1.5747	0.9868	$23.4262	$26.1468	$27.5230	$25.7787
230217	1.2944	0.9788	$24.3650	$26.7929	$28.6075	$26.7623
230222 [h]	1.3316	0.9368	$24.6101	$24.8925	$26.9724	$25.4947
230223	1.2948	1.0461	$28.5549	$27.1503	$29.2853	$28.3304
230227	1.5114	1.0436	$27.7510	$28.1105	$29.5798	$28.4993
230230	1.5119	0.9788	$23.9568	$25.4471	$27.9607	$25.8281
230235	1.0369	0.8966	$19.9118	$19.6046	$21.8777	$20.4653
230236	1.4349	1.0393	$25.7463	$26.3988	$28.4754	$26.9289

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
230239	1.2193	0.8966	$19.8370	$21.1643	$22.1040	$21.0930
230241	1.1743	0.9868	$24.2063	$25.8671	$27.4890	$25.8668
230244	1.3568	1.0436	$23.9004	$25.3817	$26.4326	$25.2154
230254	1.3507	1.0461	$24.2594	$26.4431	$28.1216	$26.2901
230257	1.0361	1.0436	$24.8069	$25.4086	$27.8197	$25.8794
230259	1.2125	1.0874	$24.8598	$24.3067	$26.8677	$25.3750
230264	2.0733	1.0436	$17.4847	$19.9992	$19.2398	$19.0176
230269	1.3677	1.0461	$25.3367	$27.4732	$28.8187	$27.2692
230270	1.2712	1.0570	$22.8842	$26.1113	$27.8488	$25.6802
230273	1.4501	1.0570	$25.8466	$30.2209	$29.9307	$28.6762
230275	0.4648	0.9140	$29.4180	$30.2244	$23.1095	$27.7059
230276	***	*	$23.4928	*	*	$23.4928
230277	1.3829	1.0461	$25.3378	$26.9231	$29.1973	$27.2248
230279	0.5490	1.0461	$21.2467	$23.1636	$24.7673	$22.9663
230283	0.8715	1.0436	$25.0038	$24.9272	$26.2622	$25.3910
230288	***	*	$30.3422	*	*	$30.3422
230289	***	*	*	*	$29.7720	$29.7720
230290	***	*	*	$29.4792	*	$29.4792
230291	***	*	*	*	$30.9655	$30.9655
230292	***	*	*	*	$31.8943	$31.8943
230296	1.9453	0.9788	*	*	*	*
240001	1.5150	1.1052	$28.2239	$29.9123	$31.5753	$29.9731
240002	1.8323	1.0226	$24.7674	$26.9608	$28.9860	$26.9851
240004	1.5506	1.1052	$26.8197	$27.8796	$30.8072	$28.5006
240006	1.0563	1.1116	$29.5789	$30.2330	$30.1950	$30.0237
240007	1.1570	*	$21.4367	$23.7588	*	$22.6144
240010	2.0308	1.1116	$29.0955	$30.4139	$31.3733	$30.3196
240011	1.0533	*	$24.0364	$22.9561	*	$23.3835
240013	1.2714	1.0900	$27.3855	$28.7202	$28.3860	$28.1704
240014	1.0255	1.1052	$26.5144	$28.3788	$29.8623	$28.2985
240016	1.2643	0.9132	$25.2629	$24.9211	$26.7814	$25.7376
240017	1.2581	0.9132	$21.6243	$23.3314	$24.4417	$23.1535
240018	1.2280	1.0900	$27.3634	$27.9218	$25.6236	$26.6208
240019	1.1515	1.0226	$25.1331	$27.5441	$28.6723	$27.1439
240020	1.0854	1.1052	$24.7516	$28.1568	$31.2443	$28.0203
240021	0.8740	1.0052	$23.9568	$23.7096	$27.1235	$24.8433
240022	1.1089	0.9132	$23.4702	$23.7368	$25.2066	$24.1392
240025	1.0799	*	$21.2597	$27.8656	*	$24.3444
240027	0.9514	0.9132	$18.3340	$20.2531	$18.2481	$18.8765
240029	1.0910	0.9132	$21.2342	$24.3017	$25.3568	$23.3870
240030	1.3509	0.9775	$22.0200	$23.3753	$24.7154	$23.4178
240031	0.9576	*	$23.4389	$26.7242	$26.7778	$25.6303
240036	1.6930	1.0900	$23.4857	$27.0821	$28.0812	$26.3323
240037	1.0462	*	$21.8392	$24.3986	*	$23.1115
240038	1.5325	1.1052	$28.9676	$29.8465	$31.0779	$30.0073
240040	1.0971	1.0226	$21.3870	$26.3177	$27.4895	$24.8843
240043	1.1474	0.9132	$19.5532	$20.7155	$21.8685	$20.7481
240044	1.1223	1.0000	$22.7482	$24.3009	$22.0973	$22.9999
240045	1.1155	*	$25.9223	$26.1743	*	$26.0530
240047	1.5788	1.0226	$29.6184	$29.1211	$28.8288	$29.1562
240050	1.0371	1.1052	$24.7589	$26.6687	$26.4854	$26.0710
240052	1.2117	0.9132	$23.5898	$24.9870	$26.4256	$25.0236
240053	1.4271	1.1052	$26.7122	$28.4733	$29.5315	$28.3118
240056	1.2482	1.1052	$28.5169	$30.8619	$31.6623	$30.4153
240057	1.8689	1.1052	$27.7600	$29.4870	$30.6258	$29.3431
240059	1.0941	1.1052	$27.0517	$28.6340	$29.7916	$28.5358
240061	1.7548	1.1116	$28.7372	$30.0031	$30.6383	$29.8381
240063	1.5720	1.1052	$26.7960	$29.9603	$32.3487	$29.6692
240064	1.2696	1.0226	$24.9928	$26.6996	$29.9662	$27.5790
240066	1.3865	1.1052	$27.4066	$30.2716	$33.4532	$30.4657
240069	1.1509	1.1116	$25.6943	$27.4990	$28.9496	$27.4534
240071	1.1507	1.1116	$24.8036	$26.4780	$28.0585	$26.4808
240075	1.2095	0.9775	$24.4084	$26.6607	$26.1956	$25.7681
240076	1.1103	1.1052	$26.7112	$28.4519	$29.8562	$28.4067
240077	***	*	$18.9735	*	*	$18.9735
240078	1.6081	1.1052	$27.5066	$30.5339	$32.3235	$30.0485
240079	0.9659	*	$20.6644	$20.9220	*	$20.8010

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
240080	1.7263	1.1052	$27.8807	$29.6274	$31.6828	$29.7638
240083	1.2421	0.9132	$24.4352	$25.0214	$26.6582	$25.4096
240084	1.1324	1.0226	$23.9942	$24.7856	$26.8142	$25.2047
240087	1.0337	*	$20.1002	$24.8479	*	$22.4032
240088	1.2796	0.9775	$25.5587	$27.6323	$28.0825	$27.1245
240089	***	*	$23.4028	*	*	$23.4028
240093	1.3386	1.0900	$22.3968	$23.7785	$25.5805	$23.9303
240094	1.0933	*	$24.4166	$27.3974	*	$25.9702
240097	***	*	$34.2810	*	*	$34.2810
240100	1.3081	0.9132	$24.7500	$25.3269	$27.6299	$25.9040
240101	1.1448	0.9132	$24.3455	$26.6078	$25.5355	$25.5132
240103	1.0756	0.9132	$20.2324	$22.5416	$22.7078	$21.8542
240104	1.1434	1.1052	$27.4946	$30.1392	$31.4306	$29.9577
240106	1.5040	1.1052	$25.5890	$27.5171	$29.3455	$27.5527
240107	0.9266	*	$24.5583	$25.5199	*	$25.0405
240109	0.9571	0.9132	$14.5892	$15.2076	$16.5051	$15.4279
240115	1.6254	1.1052	$27.0312	$29.0261	$31.3869	$29.1786
240117	1.1426	0.9132	$20.1436	$22.0463	$23.6230	$21.9434
240121	0.9181	*	$24.5455	*	*	$24.5455
240122	0.9991	*	$23.5331	*	*	$23.5331
240123	1.0632	0.9132	$20.0721	$20.5755	$21.7500	$20.8397
240124	0.9935	*	$23.5139	$23.9297	*	$23.7277
240127	***	*	$19.3857	$24.4824	*	$21.5460
240128	1.0317	0.9132	$20.1960	$21.2638	$21.5791	$21.0226
240132	1.2709	1.1052	$26.7063	$29.5310	$31.7139	$29.3306
240133	1.1454	*	$23.6068	$26.1836	*	$24.8841
240135	***	*	$17.8573	$16.1837	*	$16.9824
240137	1.2132	*	$23.1752	$23.8666	*	$23.5315
240139	1.0823	*	$22.4473	$23.7898	*	$23.1612
240141	1.0302	1.1052	$25.1597	$26.7173	$26.4016	$26.1666
240143	0.8573	0.9132	$18.9442	$21.1180	$21.7416	$20.6376
240145	***	*	$22.6063	*	*	$22.6063
240152	0.9381	*	$25.4031	$27.3445	$29.6196	$27.5602
240154	1.0445	0.9270	$21.3809	$23.9643	*	$22.6453
240162	1.1550	0.9132	$20.4807	$22.3136	$22.2721	$21.7043
240166	1.1188	0.9132	$21.5002	$23.4265	$25.7509	$23.5628
240179	0.8477	*	$19.8249	$20.8449	*	$20.3419
240187	1.2042	1.0900	$24.8879	$26.5129	$27.8811	$26.4667
240196	0.7590	1.1052	$27.2901	$28.9380	$30.7719	$29.0287
240205	0.9108	*	*	*	*	*
240206	0.9071	1.4448	*	*	*	*
240207	1.2158	1.1052	$27.4330	$29.2395	$31.7665	$29.5904
240210	1.2547	1.1052	$26.6545	$29.7227	$32.1564	$29.5372
240211	0.9342	1.0900	$32.8801	$44.4214	$18.8503	$27.6876
240213	1.3162	1.1052	$27.5104	$31.3974	$32.7532	$30.8794
250001	1.8740	0.8304	$20.9338	$21.9176	$22.7827	$21.9287
250002	0.8830	0.8603	$21.6643	$20.1310	$23.3845	$21.6434
250004	1.8410	0.9148	$20.9295	$20.6828	$24.1065	$21.8737
250006	1.0537	0.9148	$20.3061	$21.4038	$24.0191	$21.9290
250007	1.2501	0.8913	$21.2226	$23.6933	$25.8710	$23.5817
250009	1.2499	0.8790	$19.7610	$20.4329	$22.2323	$20.8522
250010	0.9858	0.7688	$17.6204	$19.4130	$19.4403	$18.8097
250012	0.9474	0.9402	$15.6117	$20.0493	$20.2921	$18.4571
250015	1.0283	0.7688	$19.3794	$20.6931	$20.7555	$20.2702
250017	1.0990	0.7688	$19.0436	$18.1013	$21.3950	$19.5260
250018	0.9187	0.7688	$16.8783	$17.0689	$16.6294	$16.8678
250019	1.5751	0.8913	$22.9085	$22.8358	$23.9741	$23.2493
250020	0.9907	0.7688	$19.1877	$19.3390	$21.4019	$19.9847
250021	***	*	$15.8485	$15.1242	$20.3559	$16.0142
250023	0.8489	0.8603	$14.7355	$16.1820	$16.2418	$15.7024
250025	1.0467	0.7688	$21.2651	$20.6892	$20.5258	$20.8816
250027	0.9980	0.7688	$17.5937	$17.3313	$17.3481	$17.4314
250030	***	*	$27.2140	*	*	$27.2140
250031	1.3065	0.8174	$21.0894	$22.0850	$21.4326	$21.5380
250034	1.5522	0.9148	$20.3681	$20.6752	$24.3189	$21.8100
250035	0.8612	0.7688	$17.1071	$14.6149	$17.2045	$16.2933
250036	1.0134	0.8156	$17.0469	$17.8313	$19.1975	$18.0476

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
250037	0.8781	0.7688	$16.6347	$17.4463	$17.4012	$17.1789
250038	0.9918	0.8304	$16.8610	$18.0209	$18.9050	$17.9032
250039	0.9235	0.8304	$16.8729	$15.2939	$17.3155	$16.4505
250040	1.4785	0.8603	$20.8178	$21.3451	$23.2285	$21.8161
250042	1.2257	0.9148	$19.4367	$21.4117	$23.4135	$21.3957
250043	1.0459	0.7688	$17.7554	$18.3322	$19.8098	$18.6971
250044	1.0268	0.7688	$20.3711	$21.1198	$23.3862	$21.6199
250045	1.0860	0.8955	$25.3236	$25.0863	$26.3831	$25.6144
250048	1.5885	0.8304	$19.3635	$21.6547	$22.9765	$21.3756
250049	0.8502	0.7688	$13.4396	$17.8154	$17.7005	$16.2411
250050	1.1938	0.7688	$16.6723	$18.3170	$19.1467	$18.0183
250051	0.8440	0.7688	$10.5027	$10.6908	$10.6095	$10.6008
250057	1.1364	0.7688	$19.0571	$19.6789	$20.1900	$19.6573
250058	1.2634	0.7688	$16.5565	$17.5160	$18.1704	$17.4280
250059	0.9887	0.7688	$19.0733	$17.7270	$19.2977	$18.6884
250060	0.7969	0.7688	$14.0155	$20.8115	$16.8247	$17.2475
250061	0.8471	0.7688	$11.4573	$15.2515	$12.8174	$12.9127
250065	0.8335	*	$16.2010	$16.1984	*	$16.1997
250066	0.7772	*	$16.1044	*	*	$16.1044
250067	1.0575	0.7688	$20.0430	$20.1261	$21.6911	$20.6215
250068	0.7710	*	$16.3759	$16.9585	*	$16.6506
250069	1.5154	0.8648	$21.2224	$21.6617	$22.8162	$21.9460
250071	0.8510	*	$13.7056	$17.7149	*	$15.4400
250072	1.5086	0.8304	$20.7827	$22.9316	$24.6587	$22.7773
250077	0.9511	0.7688	$14.0318	$14.2271	$14.7632	$14.3259
250078 [2]	1.6194	0.8603	$17.5186	$18.6563	$20.9354	$19.1036
250079	0.8399	0.8174	$21.3506	$27.2549	$38.0031	$29.5848
250081	1.2491	0.8174	$20.4513	$21.3830	$24.7031	$21.9463
250082	1.2880	0.8091	$19.5962	$20.5212	$19.6966	$19.9404
250083	0.9197	*	$19.5217	$19.9484	*	$19.7505
250084	1.1778	0.7688	$22.4632	$21.8001	$18.5775	$20.7280
250085	0.9636	0.7688	$18.0473	$18.7367	$19.7007	$18.8283
250089	1.0566	*	$16.0203	*	*	$16.0203
250093	1.2244	0.7688	$17.4413	$18.8001	$21.3237	$19.1985
250094	1.5974	0.8603	$19.9619	$22.3312	$22.7312	$21.7001
250095	1.0096	0.7688	$18.6616	$19.9553	$21.3511	$19.9748
250096	1.0813	0.8304	$20.7246	$22.7458	$22.6298	$22.0767
250097	1.4095	0.8461	$18.8399	$19.4534	$20.1687	$19.4858
250098	***	*	$17.9561	*	*	$17.9561
250099	1.2497	0.8174	$18.2504	$19.0333	$19.5797	$18.9671
250100	1.4599	0.8648	$18.8877	$22.0328	$24.2209	$21.7570
250101	***	*	*	$21.2234	$19.3543	$20.1785
250102	1.5659	0.8304	$21.3213	$22.5518	$24.2868	$22.7655
250104	1.4476	0.8174	$20.5035	$21.4431	$22.6591	$21.5782
250105	0.9055	0.7688	$17.0136	$17.9468	$18.1196	$17.6992
250107	0.9099	0.7688	$16.7104	$16.5369	$17.8999	$17.0742
250112	0.9532	0.7688	$16.8696	$19.6172	$21.2824	$19.4217
250117	1.0427	0.8603	$18.8863	$19.9774	$23.3673	$20.6608
250119	***	*	$17.1373	*	*	$17.1373
250120	1.0523	0.7688	$22.9071	$22.7607	$23.4277	$23.0135
250122	1.0743	0.8603	$19.7966	$23.7230	$24.5854	$22.7156
250123	1.2646	0.8913	$22.2184	$22.0486	$24.5115	$22.9495
250124	0.8452	0.8304	$15.6866	$15.4343	$17.2181	$16.1302
250125	1.2941	0.8913	$25.3415	$26.8379	$27.7077	$26.6997
250126	0.9445	0.9402	$20.1118	$20.4085	$21.7111	$20.7174
250127	0.9410	1.4448	*	*	*	*
250128	0.8891	0.7688	$15.8352	$15.9344	$17.6269	$16.4363
250131	0.8974	*	$11.5396	*	*	$11.5396
250134	0.6463	0.8304	$22.0310	$23.5608	$25.8368	$23.6784
250136	0.9913	0.8304	$21.9977	$22.5832	$23.0637	$22.5479
250138	1.2713	0.8304	$21.2490	$22.7902	$23.8861	$22.6997
250141	1.5730	0.9402	$22.5187	$24.5772	$27.6158	$25.2301
250146	0.8892	0.7688	$16.9341	$17.2328	$18.6486	$17.5743
250149	0.9022	0.7688	$16.4228	$15.0367	$15.0641	$15.5315
250151	0.7349	0.7688	$20.4581	$21.8697	$17.2205	$18.4362
250152	1.5970	0.8304	*	*	$25.7837	$25.7837
250153	***	*	*	*	$29.0461	$29.0461

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
250154	0.9022	*	*	*	*	*
250156	1.3430	0.7688	*	*	*	*
250157	1.6672	0.7688	*	*	*	*
250158	1.6049	0.7688	*	*	*	*
250159	0.8412	*	*	*	*	*
260001	1.6402	0.8585	$22.6646	$25.3084	$25.9250	$24.6413
260002	***	*	$24.6812	$27.2329	$26.4879	$26.0819
260003	1.0295	*	$16.5931	$17.6339	*	$17.1135
260004	0.9660	0.7919	$16.4423	$16.7742	$16.9421	$16.7356
260005	1.4856	0.8958	$25.5927	$24.6142	$26.5773	$25.6220
260006	1.4373	0.7919	$24.1078	$26.4948	$26.7587	$25.8174
260008	***	*	$21.6256	$17.6040	$18.9522	$19.2926
260009	1.1870	0.9463	$20.1679	$21.2729	$22.1816	$21.2122
260011	1.3912	0.8388	$21.1625	$21.4409	$22.7061	$21.7937
260012	1.0557	0.7919	$17.7854	$19.3389	$20.3061	$19.2632
260013	1.0239	0.8585	$18.4857	$19.2065	$20.5007	$19.3903
260015	1.0966	0.7919	$21.7581	$22.4450	$22.5409	$22.2644
260017	1.3141	0.8958	$20.7837	$21.1359	$22.7022	$21.5787
260018	1.0604	0.7919	$14.3278	$14.8425	$17.0434	$15.4340
260020	1.7533	0.8958	$22.4709	$25.7898	$26.0407	$24.8648
260021	1.3869	0.8958	$27.2478	$27.8332	$27.6330	$27.5756
260022	1.2259	0.8553	$20.5417	$21.7707	$22.8085	$21.6784
260023	1.2848	0.8958	$19.6324	$21.2519	$21.2077	$20.7002
260024	1.1431	0.7919	$16.9968	$17.5351	$18.4829	$17.6819
260025	1.2731	0.8958	$19.3535	$20.0901	$22.4645	$20.6596
260027	1.6048	0.9463	$22.9973	$24.7605	$25.3348	$24.3810
260029	1.1007	*	$22.0390	$22.2892	*	$22.1651
260031	***	*	$24.3626	$24.2877	*	$24.3260
260032	1.8231	0.8958	$21.8830	$23.1125	$23.9478	$22.9995
260034	0.9611	0.9463	$21.6108	$23.3034	$24.1143	$23.0518
260035	0.9500	*	$15.0468	$16.8502	$17.8741	$16.5641
260036	0.9544	*	$19.4559	$20.1324	$22.1912	$20.4830
260040	1.6840	0.8242	$20.0422	$21.9452	$23.3566	$21.8297
260044	0.9461	*	$18.2413	$20.0686	*	$19.1695
260047	1.5080	0.8357	$22.4585	$22.6169	$24.4185	$23.1892
260048	1.2627	0.9463	$26.6363	$25.8089	$24.3906	$25.5119
260050	1.1649	0.7919	$20.8510	$20.6364	$23.6849	$21.9007
260052	1.3280	0.8958	$21.1297	$22.5809	$24.5165	$22.8077
260053	1.0499	0.8585	$18.9606	$20.0051	$21.6607	$20.2038
260057	1.0425	0.9463	$15.8404	$16.4875	$19.3335	$17.1879
260059	1.1923	0.7919	$17.2807	$18.6379	$19.7243	$18.6135
260061	1.0980	0.7919	$18.7280	$19.6674	$21.5264	$19.9180
260062	1.1962	0.9463	$25.2958	$26.0439	$26.4539	$25.9705
260063	0.9748	*	$21.1284	$22.0826	*	$21.6180
260064	1.3701	0.8357	$17.5188	$19.1587	$19.0543	$18.5908
260065	1.7311	0.8242	$22.0058	$23.6969	$23.0015	$22.9155
260067	0.9016	0.7919	$14.9792	$16.5364	$17.6256	$16.4270
260068	1.7690	0.8357	$22.0951	$23.9340	$24.9504	$23.7077
260070	0.9649	0.7919	$11.2251	$14.3881	$18.4779	$14.0836
260073	1.0223	0.7919	$17.8185	$19.2744	$21.6214	$19.6354
260074	1.1765	0.8357	$18.7639	$23.9301	$24.8654	$22.4254
260077	1.6652	0.8958	$21.9947	$23.5466	$25.5782	$23.7347
260078	1.2201	0.7919	$16.9217	$18.4017	$19.0802	$18.1811
260080	0.9095	0.7919	$13.6815	$11.2817	$14.7774	$13.2210
260081	1.4955	0.8958	$22.6627	$23.7447	$26.3969	$24.2793
260085	1.5999	0.9463	$22.7394	$24.6046	$25.6302	$24.3659
260086	0.8794	0.7919	$17.2048	$17.1202	$19.1702	$17.8711
260091	1.5303	0.8958	$23.9975	$26.1149	$27.2407	$25.8446
260094	1.6494	0.8242	$20.1043	$20.6805	$23.2544	$21.4540
260095	1.3127	0.9463	$22.8156	$23.8671	$25.5668	$24.0702
260096	1.4324	0.9463	$23.5009	$25.9932	$27.5592	$25.8492
260097	1.1529	0.8344	$19.6203	$21.5077	$21.3957	$20.9049
260102	0.8644	0.9463	$24.1041	$22.9283	$24.2368	$23.7509
260103	***	*	$21.6192	$23.3175	*	$22.4894
260104	1.4718	0.8958	$22.4769	$24.0038	$26.2867	$24.3941
260105	1.7289	0.8958	$24.6572	$28.4652	$28.8849	$27.3498
260107	1.3256	0.9463	$23.1564	$24.2001	$26.7782	$24.6444

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
260108	1.8415	0.8958	$22.7975	$24.0936	$24.9880	$23.9815
260110	1.6342	0.8958	$22.0026	$22.2730	$23.7978	$22.7167
260113	1.0891	0.8279	$16.3440	$19.2467	$20.9644	$18.7740
260115	1.1612	0.8958	$20.4880	$21.7450	$21.9859	$21.4408
260116	1.1354	0.8279	$16.9807	$17.2698	$18.5076	$17.6168
260119	1.3457	0.7919	$18.7959	$22.1588	$24.9937	$22.8442
260120	***	*	$18.7651	*	*	$18.7651
260122	1.1399	0.9463	$16.1637	$17.3270	$20.8015	$18.1468
260123	1.0022	*	$17.7996	$16.1169	*	$17.0002
260127	0.9654	0.8077	$19.7946	$22.5328	$21.8534	$21.3553
260134	1.1531	*	$18.4511	$18.1531	*	$18.2845
260137	1.6787	0.8585	$20.7638	$21.3426	$22.7431	$21.6630
260138	1.9152	0.9463	$25.6579	$27.8229	$28.5610	$27.3740
260141	1.9311	0.8357	$21.0771	$21.1511	$22.4886	$21.5378
260142	1.0558	0.7919	$18.6412	$19.6582	$20.3993	$19.6104
260147	0.9412	0.7919	$16.1171	$17.2291	$18.5153	$17.2858
260159	***	*	$23.1093	$26.8924	$23.7427	$24.4817
260160	1.0924	0.7919	$18.8723	$19.4997	$21.0544	$19.7923
260162	1.3775	0.8958	$22.5705	$24.1246	$25.1423	$23.9984
260163	1.1555	0.7919	$18.1310	$19.2885	$20.1949	$19.2038
260164	1.0699	0.7919	$16.9403	$19.5539	$19.7068	$18.6878
260166	1.2047	0.9463	$22.8409	$25.5151	$27.0237	$25.1725
260172	0.9118	*	$17.1504	$18.1438	*	$17.6539
260175	1.1009	0.7919	$19.7939	$21.1257	$22.6171	$21.1462
260176	1.5984	0.8958	$25.7802	$29.2184	$27.4244	$27.5317
260177	1.2264	0.9463	$24.0550	$25.0724	$26.1178	$25.1274
260178	1.7950	0.8357	$21.7704	$21.4781	$22.2251	$21.8190
260179	1.5777	0.8958	$23.2824	$24.8541	$26.1419	$24.7933
260180	1.5476	0.8958	$21.8585	$21.9679	$26.7461	$23.4659
260183	1.6527	0.8958	$24.2330	$23.3924	$26.0418	$24.6030
260186	1.6276	0.8357	$21.6620	$23.4317	$25.3148	$23.5713
260190	1.1494	0.9463	$24.5014	$25.1653	$26.4505	$25.4095
260191	1.3231	0.8958	$21.1331	$22.4369	$23.3856	$22.3648
260193	1.2211	0.9463	$22.9556	$24.4705	$26.2979	$24.7042
260195	1.2806	0.7919	$20.0889	$20.1327	$22.3958	$20.9711
260198	1.1880	0.8958	$25.3390	$27.6116	$27.5996	$26.8633
260200	1.2239	0.8958	$22.3913	$25.1134	$24.8624	$24.2536
260207	1.0639	0.8242	$18.5247	$19.2467	$19.7294	$19.2332
260208	***	*	$28.3158	*	*	$28.3158
260209	1.0858	0.8381	*	$21.8396	$23.2430	$22.5334
260210	1.2315	0.8958	*	*	$25.3782	$25.3782
260211	1.6081	0.9463	*	*	$33.9109	$33.9109
260213	2.4615	0.9463	*	*	*	*
270002 [2]	1.2991	0.9526	$19.7588	$20.7620	$22.7322	$21.1317
270003	1.3122	0.9065	$23.0396	$24.2823	$26.4843	$24.5714
270004	1.6944	0.8846	$21.5577	$22.9081	$23.5454	$22.7035
270009	1.3205	*	$21.5655	*	*	$21.5655
270011	0.9741	0.9065	$21.4031	$22.0710	$22.1394	$21.8739
270012 [2]	1.4543	0.9526	$21.7634	$23.1697	$25.2873	$23.4084
270014	1.8361	0.9526	$20.3456	$25.0650	$26.2025	$23.6425
270017	1.2834	0.9526	$23.2320	$24.6186	$27.5483	$25.1665
270021	1.0162	0.8846	$21.1624	$21.6758	$21.7056	$21.5330
270023	1.5384	0.8846	$23.7486	$25.5525	$26.7576	$25.3555
270032	1.0493	0.8846	$20.1801	$18.2377	$19.6212	$19.3552
270036	0.8049	*	$18.8785	$21.8255	$20.4242	$20.3944
270040	1.1952	*	$20.7240	*	*	$20.7240
270049	1.7898	0.8846	$22.9524	$24.6556	$26.3996	$24.7520
270050	1.0516	*	$21.0901	$22.4195	*	$21.7451
270051	1.5696	0.9526	$22.2580	$26.4457	$26.6619	$25.1119
270057	1.2393	0.8846	$21.9997	$22.6251	$24.2980	$23.0119
270060	0.8910	0.8752	*	$16.6592	$17.7564	$17.1813
270074	0.8557	1.4448	*	*	*	*
270075	0.9239	*	*	*	*	*
270079	0.8481	*	*	$21.6382	*	$21.6382
270081	1.0142	0.8752	$15.6833	$17.3174	$17.4862	$16.8348
270082	1.0574	*	$21.0150	$19.6173	*	$20.3610
270084 [2]	1.0107	*	$19.6104	$22.2340	*	$21.0235

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
270086	1.1183	0.9065	*	*	*	*
270087	1.0295	0.8752	*	*	*	*
280003	1.8656	1.0187	$26.0937	$27.2844	$29.3921	$27.8614
280005	***	*	$23.9753	*	*	$23.9753
280009	1.8585	0.9656	$23.8046	$25.3162	$26.7678	$25.2627
280010	***	*	$23.8325	$22.6516	*	$23.2571
280013	1.8094	0.9546	$23.4920	$24.5214	$26.1908	$24.7334
280020	1.8480	1.0187	$23.4577	$25.7522	$26.5068	$25.3300
280021	1.1450	0.8658	$21.5215	$22.2864	$22.0489	$21.9595
280023	1.4143	0.9656	$19.6265	$22.7207	$22.3230	$21.6126
280030	1.9539	0.9546	$29.2221	$32.5601	$30.7481	$30.8807
280032	1.3432	0.9656	$21.5150	$22.6510	$23.6462	$22.6240
280040	1.6893	0.9546	$23.6597	$25.2965	$26.9827	$25.3499
280047	0.7859	*	$19.5815	*	*	$19.5815
280054	1.1577	0.8795	$23.1191	$22.4241	$23.5665	$23.0380
280057	0.8226	0.9656	$22.5481	$23.6793	$20.4830	$22.0597
280060	1.6274	0.9546	$23.1128	$25.2288	$26.2139	$24.9273
280061	1.3744	0.9249	$21.2901	$23.9110	$24.9482	$23.4090
280065	1.2862	0.9587	$23.8128	$27.9937	$26.0135	$25.9591
280077	1.3374	0.9546	$22.7244	$24.0516	$25.5624	$24.1150
280081	1.6432	0.9546	$24.3199	$25.1973	$26.0541	$25.2026
280085	***	*	$21.8473	*	*	$21.8473
280105	1.3057	0.9546	$25.1401	$25.0445	$26.7555	$25.7137
280108	1.0428	0.8658	$20.9016	$22.5584	$23.2502	$22.2006
280111	1.2161	0.8658	$20.7398	$22.1424	$23.4770	$22.1827
280117	1.0657	0.8658	$20.5464	$22.0611	$24.1521	$22.2744
280118	0.9223	*	$19.3466	*	*	$19.3466
280119	0.8238	1.4448	*	*	*	*
280123	0.9746	0.8795	$24.3539	$27.5207	*	$25.8965
280125	1.5209	0.8658	$20.0643	$21.8385	$21.7658	$21.2295
280126	***	*	$33.8918	*	*	$33.8918
280127	1.8510	1.0187	*	*	*	*
280128	3.3466	1.0187	*	*	*	*
280129	1.9562	0.9546	*	*	*	*
280130	1.2105	0.9546	*	*	*	*
290001	1.7842	1.0973	$25.9590	$27.3105	$31.1981	$28.2417
290002	0.8744	0.9776	$16.8363	$16.8433	$18.3469	$17.3909
290003	1.7886	1.1404	$27.4732	$27.1099	$28.1625	$27.5886
290005	1.3920	1.1404	$24.6877	$27.1531	$27.6697	$26.5417
290006	1.2847	1.0794	$24.2211	$26.3617	$27.9502	$26.1547
290007	1.6569	1.1404	$35.1020	$35.4193	$37.5559	$36.0546
290008	1.1784	1.1237	$27.0115	$26.4086	$27.9714	$27.1141
290009	1.8755	1.0973	$26.9020	$27.6011	$29.8019	$28.1837
290010	1.0905	1.1404	$25.4598	$23.8733	$23.9654	$24.4204
290012	1.3505	1.1404	$25.8036	$27.2675	$31.0843	$28.0502
290016	1.1558	*	$22.5111	$25.1726	$26.1925	$24.6281
290019	1.4095	1.0794	$25.1684	$27.2484	$28.6158	$27.0192
290020 [h]	0.9713	1.1404	$24.2373	$21.3094	$21.6993	$22.1469
290021	1.7615	1.1404	$26.2510	$28.3837	$33.2116	$29.2014
290022	1.5354	1.1404	$27.5364	$29.8144	$29.4422	$28.9634
290027	0.9199	0.9070	$13.5031	$17.8850	$15.1448	$15.3083
290032	1.3774	1.0973	$27.5425	$29.4164	$31.7105	$29.6070
290039	1.5330	1.1404	$28.7599	$29.6801	$31.2941	$30.0435
290041	1.3550	1.1404	$28.6294	$30.1346	$33.9878	$31.0661
290042	0.8016	1.1404	*	*	*	*
290044	0.8476	1.1404	*	*	*	*
290045	1.5027	1.1404	$26.5644	$26.9319	$30.9612	$28.4883
290046	1.3462	1.1404	*	*	*	*
290047	1.2927	1.1404	*	*	*	*
290048	0.8479	*	*	*	*	*
290049	1.2664	1.0245	*	*	*	*
290050	1.0634	*	*	*	*	*
300001	1.5613	1.1561	$27.1312	$29.4130	$27.5032	$28.0073
300003	2.0882	1.1561	$26.7859	$27.8059	$33.3560	$29.3633
300005	1.4274	1.1561	$22.8163	$25.1869	$25.6699	$24.5947
300006	1.1183	*	$22.0187	$20.6787	$23.3200	$21.9532
300007	1.2618	*	$23.6919	$25.3125	*	$24.5082

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
300010	1.2996	*	$24.6295	$26.9346	$27.5028	$26.4641
300011	1.3151	1.1561	$25.0979	$27.3325	$28.4044	$26.9920
300012	1.3958	1.1561	$26.3914	$28.4234	$30.5198	$28.4955
300013	1.0792	*	$21.3397	$23.1529	*	$22.1888
300014	1.2142	1.1561	$23.7144	$25.5059	$27.5151	$25.6846
300015	1.0999	*	$24.4869	$24.0620	*	$24.2732
300016	***	*	$18.9756	$24.5498	*	$21.6922
300017	1.2296	1.1922	$26.1104	$28.3959	$29.6957	$28.0967
300018	1.4036	1.1561	$25.7851	$28.0308	$29.7209	$27.9654
300019	1.2296	1.1561	$23.8076	$25.3845	$25.9656	$25.1005
300020	1.2033	1.1561	$24.8189	$26.8402	$28.6723	$26.8622
300022	1.1157	*	$22.3918	$23.5948	*	$23.0102
300023	1.4320	1.1922	$24.9992	$25.4873	$28.6309	$26.4774
300024	1.2361	*	$22.4883	$23.9205	*	$23.2005
300029	1.7597	1.1922	$24.5772	$26.9484	$29.0806	$26.9920
300034	2.0835	1.1561	$26.9093	$28.5375	$29.7484	$28.4471
310001	1.7881	1.3194	$30.1786	$33.9360	$35.3612	$33.2483
310002	1.8499	1.3194	$33.9058	$35.4567	$37.3461	$35.5944
310003	1.2158	1.3194	$30.4234	$31.1040	$32.8935	$31.5180
310005	1.3325	1.1879	$26.0227	$27.5690	$29.0084	$27.5943
310006	1.2371	1.3194	$25.9000	$27.0436	$27.4545	$26.7958
310008	1.3135	1.3194	$28.0970	$29.5857	$31.2579	$29.6725
310009	1.2631	1.3194	$24.6353	$29.7760	$32.7384	$29.0885
310010	1.2926	1.1319	$26.7889	$25.3139	$28.5852	$26.9172
310011	1.2822	1.1342	$26.1586	$28.5241	$30.8612	$28.5543
310012	1.6929	1.3194	$31.1705	$33.1622	$34.6882	$33.0545
310013	1.3611	1.3194	$25.0951	$28.5016	$30.6248	$28.1586
310014	1.8368	1.1227	$29.1931	$32.7222	$29.7204	$30.4762
310015	1.8831	1.3194	$30.1767	$32.4980	$36.4776	$33.0707
310016	1.3521	1.3194	$25.7368	$28.9788	$33.9862	$29.9150
310017	1.3377	1.1879	$25.2636	$28.0930	$30.9233	$28.1646
310018	1.1436	1.3194	$25.9108	$26.9399	$30.3381	$27.8107
310019	1.6345	1.3194	$26.8663	$31.0524	$29.6592	$29.1388
310020	1.6071	1.3194	$25.0147	$29.3392	$30.6722	$28.2107
310021	1.6314	1.3194	$29.4003	$29.6308	$31.3410	$30.1313
310022	1.2376	1.1227	$26.7487	$26.1914	$28.2024	$27.0808
310024	1.3723	1.1879	$26.9499	$27.5278	$30.9171	$28.3714
310025	1.2711	1.3194	$26.8719	$27.7960	$31.1274	$28.7415
310026	1.2595	1.3194	$24.6697	$25.3970	$27.5171	$25.9064
310027	1.3032	1.1879	$22.1935	$27.0982	$28.8314	$26.4162
310028	1.2382	1.3194	$25.7246	$29.1101	$31.3849	$28.7946
310029	1.8875	1.1227	$25.9606	$29.1439	$30.7707	$28.6905
310031	3.0548	1.1290	$29.5581	$30.2345	$33.9685	$31.2972
310032	1.3038	1.1227	$25.7088	$27.8754	$27.5232	$27.0476
310034	1.3424	1.1290	$26.5224	$27.8517	$29.9162	$28.1036
310037	1.3214	1.3194	$30.1264	$32.1471	$35.0329	$32.5209
310038	1.9998	1.3194	$32.3865	$32.1977	$33.4822	$32.7188
310039	1.2576	1.1640	$24.6045	$27.1054	$28.8292	$26.9337
310040	1.3440	1.3194	$27.4041	$28.0068	$34.1113	$29.8744
310041	1.2776	1.1290	$26.8145	$29.7335	$32.8085	$29.8863
310042	1.1597	1.3194	$26.9695	$29.0207	$30.7358	$28.9101
310044	1.3350	1.1319	$25.1618	$27.7752	$31.3206	$28.1678
310045	1.5973	1.3194	$31.7376	$32.6359	$34.1060	$32.8838
310047	1.3157	1.1600	$26.1353	$28.3415	$32.7880	$29.2740
310048	1.3670	1.1879	$27.4050	$28.4715	$30.2025	$28.7345
310049	***	*	$26.5332	$32.7666	$27.8564	$27.2897
310050	1.2840	1.3194	$25.3772	$27.2276	$27.3033	$26.7397
310051	1.3861	1.3194	$29.2386	$32.0113	$33.7168	$31.6981
310052	1.3183	1.1290	$27.0324	$28.1498	$30.8036	$28.6341
310054	1.2891	1.3194	$28.1880	$30.6905	$34.1860	$31.0476
310057	1.3232	1.1227	$26.3903	$26.4606	$29.5221	$27.5782
310058	1.1046	1.3194	$28.1753	$26.4816	$28.0815	$27.5746
310060	1.2819	1.3194	$22.1914	$23.2146	$25.1575	$23.5782
310061	1.2681	1.1227	$24.9678	$27.5400	$28.2129	$26.9521
310063	1.3537	1.1879	$25.9868	$28.3457	$31.4884	$28.5345
310064	1.5668	1.1600	$27.8388	$29.5979	$33.4440	$30.4173
310067	***	*	$26.3624	$26.8068	*	$26.5479

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
310069	1.2704	1.1227	$25.7690	$27.9656	$28.1681	$27.3281
310070	1.3710	1.3194	$30.1917	$32.1806	$33.2310	$31.9325
310072	***	*	$25.3145	$26.3520	*	$25.8709
310073	1.7905	1.1290	$28.8791	$29.6611	$32.0329	$30.2191
310074	1.3372	1.3194	$27.6789	$28.4361	$29.4834	$28.5348
310075	1.2812	1.1290	$25.7726	$26.2479	$31.6870	$27.8786
310076	1.6139	1.3194	$32.4533	$34.9428	$36.4280	$34.6292
310077	1.6620	1.3194	$28.7352	$30.7465	$32.6644	$30.7450
310078	1.2889	1.3194	$24.7753	$26.9589	$29.8014	$27.2209
310081	1.2546	1.1227	$24.6083	$26.4259	$26.6136	$25.9041
310083	1.3035	1.3194	$25.2465	$24.6563	$28.2392	$25.9836
310084	1.2321	1.1290	$27.3680	$29.9437	$32.9001	$30.0920
310086	1.2262	1.1227	$25.2751	$27.3601	$29.3058	$27.3522
310088	1.1801	1.1600	$23.7846	$25.5274	$26.4966	$25.2810
310090	1.2575	1.1879	$25.3640	$27.1661	$30.8941	$27.8574
310091	1.1983	1.1227	$25.6405	$27.1115	$27.7204	$26.8559
310092	1.3772	1.1319	$23.2226	$25.7071	$29.4999	$26.1525
310093	1.1945	1.3194	$24.6942	$25.8727	$28.0401	$26.2654
310096	2.1069	1.3194	$28.4705	$30.3675	$34.4275	$31.1262
310105	1.2141	1.3194	$28.7333	$30.9968	$31.9769	$30.6308
310108	1.3926	1.1640	$24.9090	$29.1548	$30.1002	$28.0512
310110	1.2919	1.1319	$26.4175	$27.8707	$31.2164	$28.8347
310111	1.2048	1.1290	$26.2496	$28.8692	$30.7475	$28.7020
310112	1.2411	1.1290	$27.8796	$28.9928	$30.4192	$29.1502
310113	1.2444	1.1290	$25.9143	$27.5203	$29.6079	$27.7501
310115	1.2750	1.3194	$24.5413	$26.2803	$29.6020	$26.9083
310116	1.2596	1.3194	$25.1189	$26.6287	$25.6976	$25.7970
310118	1.2916	1.3194	$28.0517	$28.1238	$28.8797	$28.3510
310119	1.8491	1.3194	$34.7468	$35.6786	$37.7876	$36.1340
310120	1.1631	1.3194	$24.7078	$27.2010	$31.4110	$27.6263
310122	2.3504	1.1290	*	*	*	*
310123	1.7519	1.2230	*	*	*	*
310124	1.6667	1.1640	*	*	*	*
310125	2.0879	1.1879	*	*	*	*
320001	1.4902	0.9686	$23.0290	$26.1962	$26.9434	$25.3673
320002	1.3977	1.0897	$26.7332	$28.6963	$30.5158	$28.6521
320003	1.1158	0.9269	$20.7939	$22.3911	$28.1402	$23.4549
320004	1.2784	0.8640	$19.4799	$24.0362	$24.9481	$23.1709
320005	1.4190	0.9548	$22.1677	$21.2164	$23.8264	$22.4376
320006	1.3263	1.0152	$21.1222	$22.5615	$24.2812	$22.6734
320009	1.5264	0.9686	$21.5870	$24.4237	$22.8293	$22.9608
320011	1.1800	0.9082	$20.7714	$23.1539	$24.2279	$22.7686
320013	1.1550	1.0152	$19.4487	$27.8671	$28.9276	$24.8284
320014	1.1314	0.8640	$19.7656	$26.7112	$24.5310	$23.5594
320016	1.1578	0.8640	$19.9326	$21.7001	$23.5040	$21.7285
320017	1.2944	0.9686	$22.5460	$23.6861	$25.0286	$23.7296
320018	1.4792	0.8703	$21.4650	$23.0915	$23.2360	$22.6002
320019	1.5611	0.9686	$26.6900	$31.2250	$31.5192	$29.7045
320021	1.6370	0.9686	$21.0913	$28.5620	$27.2357	$25.1851
320022	1.1035	0.8640	$20.7919	$22.1492	$23.7160	$22.2284
320030	1.0503	0.8640	$16.8696	$18.0990	$22.1971	$18.9458
320033	1.1604	1.0152	$24.2703	$24.1185	$27.6393	$25.3263
320037	1.1579	0.9686	$19.6466	$21.6080	$23.3999	$21.6108
320038	1.2492	0.8640	$19.2962	$21.2181	$20.1533	$20.2270
320046	1.1922	0.8640	$21.5915	$22.9114	$24.3534	$22.9610
320057	0.8993	1.4448	*	*	*	*
320058	0.7493	1.4448	*	*	*	*
320059	1.0334	1.4448	*	*	*	*
320060	0.9956	1.4448	*	*	*	*
320061	1.0533	1.4448	*	*	*	*
320062	0.8317	1.4448	*	*	*	*
320063	1.2977	0.9584	$20.7804	$24.9141	$24.4696	$23.4155
320065	1.1296	0.9584	$19.9012	$21.6189	$26.6603	$22.8070
320067	0.8447	0.8640	$13.9459	$20.4431	$23.7745	$19.8406
320069	1.0789	0.8640	$18.5375	$19.7296	$20.9167	$19.7352
320070	0.9077	1.4448	*	*	*	*
320074	1.1720	0.9686	$28.3086	$35.5980	$22.2175	$28.2084

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
320079	1.1219	0.9686	$21.9090	$23.8092	$25.2105	$23.6814
320083	2.6265	0.9686	$20.6771	*	$28.2114	$23.7546
320084	1.1015	0.8640	*	*	$17.2511	$17.2511
320085	1.6312	0.8703	*	*	$24.8752	$24.8752
330001	***	*	$30.8509	$31.3735	$33.4718	$31.9148
330002	1.4714	1.3194	$28.0882	$29.3459	$31.1924	$29.5603
330003	1.2754	0.8607	$20.2744	$21.6506	$22.9945	$21.6443
330004	1.2891	1.0677	$24.3703	$23.9959	$26.0445	$24.8414
330005	1.6050	0.9503	$24.3578	$25.9287	$29.0124	$26.3013
330006	1.3144	1.3194	$28.3904	$29.7509	$31.5370	$29.8730
330008	1.1195	0.9503	$20.6816	$21.3269	$21.8198	$21.2850
330009	1.3259	1.3194	$33.3605	$35.8367	$35.4986	$34.8796
330010	***	*	$19.8211	$17.9178	$19.6920	$19.0804
330011	1.3109	0.8580	$19.8035	$20.3641	$21.8008	$20.6687
330013	2.1016	0.8607	$21.2063	$23.9070	$24.5162	$23.2224
330014	1.3670	1.3194	$32.0824	$35.4053	$38.8123	$35.4565
330016	0.9945	0.8217	$18.1603	$18.9388	$28.4392	$20.9735
330019	1.3013	1.3194	$31.9042	$32.3413	$34.8266	$33.0470
330023 [2]	1.5963	1.3194	$29.4538	$29.2669	$31.6208	$30.1574
330024	1.7371	1.3194	$35.3598	$36.5648	$37.8398	$36.5683
330025	1.0525	0.9503	$18.7663	$19.7561	$20.2775	$19.6152
330027	1.4762	1.3194	$34.1281	$35.1325	$39.0717	$36.0189
330028	1.4305	1.3194	$31.8452	$33.5312	$34.2709	$33.2330
330029	0.4479	0.9503	$18.4354	$18.6623	$19.1589	$18.7332
330030	1.2729	0.9123	$22.0574	$22.4368	$22.9937	$22.4866
330033	1.2661	0.8217	$18.6316	$21.3762	$22.5681	$20.8260
330036	1.1408	1.3194	$27.0970	$27.6813	$28.9409	$27.8674
330037	1.0939	0.9123	$18.3557	$19.6385	$20.6904	$19.5992
330041	1.1981	1.3194	$34.5461	$36.2481	$36.0286	$35.6239
330043	1.3182	1.2739	$31.7873	$34.1039	$34.7480	$33.5850
330044	1.2710	0.8378	$22.0465	$23.1450	$24.1907	$23.1415
330045	1.3384	1.2739	$30.9046	$34.4956	$36.1893	$33.9234
330046	1.4099	1.3194	$41.6759	$42.0900	$44.8494	$42.8629
330047 [h]	1.2039	0.8607	$20.1646	$21.1244	$24.0678	$21.8925
330049	1.3530	1.3194	$24.7766	$25.7022	$29.2904	$26.5366
330053	1.0936	0.9123	$18.1728	$19.6807	$18.5290	$18.7942
330055	1.6595	1.3194	$34.9709	$35.1393	$38.4839	$36.2207
330056	1.4846	1.3194	$32.0982	$32.9295	$37.8444	$34.2883
330057	1.7122	0.8607	$20.9282	$22.6519	$24.4680	$22.6890
330058	1.3286	0.9123	$19.2916	$19.5520	$21.3727	$20.0924
330059	1.5373	1.3194	$36.4176	$38.1019	$39.7386	$38.0767
330061	1.2282	1.3194	$28.6725	$32.7427	$33.2848	$31.6301
330062	1.2015	0.9195	$20.0222	$21.4270	$21.0464	$20.8258
330064	1.1499	1.3194	$36.0976	$38.5719	$36.4276	$37.0304
330065	1.0337	0.9503	$20.5958	$21.9192	$23.9128	$22.1517
330066	1.3298	0.8607	$20.9990	$23.0916	$24.7941	$23.0025
330067 [2]	1.4233	1.3194	$24.8927	$34.8416	$26.4243	$28.0084
330072	1.4104	1.3194	$32.9665	$32.7905	$36.4336	$34.0607
330073	1.1359	0.9123	$18.4162	$19.0781	$20.1490	$19.1772
330074	1.3388	0.9123	$21.7299	$20.2874	$21.4274	$21.1093
330075	1.1708	0.9589	$19.9781	$22.0240	$22.4188	$21.4854
330078	1.4383	0.9503	$20.8379	$22.7762	$23.3981	$22.3650
330079	1.3107	0.8217	$21.1153	$22.1064	$22.5237	$21.9214
330080	1.1864	1.3194	$33.5537	$36.1171	$39.1724	$36.3260
330084	1.0874	0.8217	$19.2135	$22.6365	$21.5455	$21.1058
330085	1.2019	0.9318	$21.8271	$23.2927	$23.9568	$23.0352
330086	1.3273	1.3194	$27.1585	$28.8424	$29.1784	$28.3884
330088	1.0581	1.2739	$29.5181	$31.2631	$31.3973	$30.7659
330090	1.4589	0.8268	$20.9327	$22.7721	$23.6174	$22.4292
330091	1.3887	0.9503	$22.9396	$22.5796	$23.8063	$23.1125
330094	1.2635	0.8900	$21.3659	$22.1495	$23.0001	$22.1769
330095	***	*	$28.9794	$28.9914	$31.9872	$29.7944
330096	1.0741	0.8217	$21.1648	$22.4895	$22.0337	$21.9119
330097	1.1345	0.8217	$18.6291	$19.2233	$20.3189	$19.3571
330100	0.9578	1.3194	$31.5775	$32.8406	$34.4621	$32.9762
330101	1.8426	1.3194	$38.4810	$39.2601	$38.7503	$38.8324
330102	1.3592	0.9503	$23.5254	$23.6141	$24.8184	$23.9846

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
330103	1.1027	0.8217	$17.9017	$18.8763	$21.1452	$19.3116
330104	1.3673	1.3194	$36.8451	$33.7556	$32.8818	$34.4566
330106	1.7553	1.4804	$38.7822	$39.8554	$41.4561	$40.0631
330107	1.2310	1.2739	$29.1958	$31.8528	$31.3888	$30.7790
330108	1.1202	0.8268	$20.2536	$21.4680	$22.2607	$21.3131
330111	1.0428	0.9503	$17.7020	$17.6185	$20.9387	$18.7250
330114	***	*	$19.2566	*	*	$19.2566
330115	1.1639	0.9589	$18.5544	$20.5101	$23.3043	$20.7157
330119	1.7652	1.3194	$34.6591	$36.5873	$39.1114	$36.7610
330121	0.9319	*	$17.9757	$19.7388	*	$18.8764
330122	***	*	$25.6500	$26.3849	*	$26.0090
330125	1.7965	0.9123	$22.8078	$24.6945	$26.7118	$24.8603
330126	1.2876	1.3194	$27.7155	$28.8299	$31.6370	$29.4715
330127	1.2802	1.3194	$42.2836	$43.7479	$44.6103	$43.5622
330128	1.2008	1.3194	$32.7050	$34.5289	$37.7166	$35.0246
330132	1.0872	0.8217	$16.0311	$16.3088	$17.4946	$16.8474
330133	1.3209	1.3194	$35.3136	$44.0704	$36.6962	$38.2248
330135	1.2321	1.3194	$25.6504	$26.9969	$29.0837	$27.3649
330136	1.4834	0.9318	$21.4225	$22.5447	$24.2010	$22.7506
330140	1.8029	0.9589	$21.1787	$23.5774	$25.7573	$23.5011
330141	1.3062	1.2739	$29.3283	$30.6616	$34.8902	$31.6934
330144	1.0366	0.8217	$17.3920	$20.1805	$20.9935	$19.3948
330148	1.0270	*	$17.6560	$18.5443	*	$18.0744
330151	1.1181	0.8217	$16.4028	$17.6782	$19.1841	$17.7056
330152	1.3111	1.3194	$32.3332	$32.0616	$36.5136	$33.6447
330153	1.7109	0.8607	$21.2843	$21.9935	$24.5219	$22.5953
330154	1.7188	*	*	*	*	*
330157	1.3749	0.9318	$23.5522	$23.6939	$25.2312	$24.1798
330158	1.5749	1.3194	$32.7159	$33.0067	$32.2990	$32.6514
330159	1.4004	0.9589	$22.5580	$24.1916	$28.9094	$25.1161
330160	1.5746	1.3194	$32.1266	$34.0373	$34.1960	$33.4347
330162	1.2769	1.3194	$29.6042	$31.3812	$32.1783	$31.0913
330163	1.2220	0.9503	$21.1517	$22.4644	$24.0200	$22.5391
330164	1.4926	0.9123	$23.5427	$24.4306	$28.8481	$25.6753
330166 [h]	1.0649	0.8217	$18.4262	$18.8777	$19.4360	$18.9008
330167	1.7998	1.2876	$30.9667	$33.7365	$34.4748	$33.1276
330169	1.4238	1.3194	$36.2725	$38.3498	$39.3361	$37.9349
330171	1.1784	1.3194	$25.9946	$27.7810	$30.0122	$27.7871
330175	1.1309	0.8217	$20.4628	$21.1944	$22.2067	$21.3007
330177	0.9502	0.8217	$19.0005	$20.1850	$19.6100	$19.6031
330180	1.2380	0.8607	$19.8951	$21.9641	$22.1920	$21.3178
330181	1.3214	1.3194	$37.1218	$35.9334	$38.5351	$37.1999
330182	2.3660	1.3194	$35.2416	$36.3831	$39.6038	$37.1311
330184	1.4168	1.3194	$30.7479	$33.2843	$34.4044	$32.7893
330185	1.2705	1.2739	$28.9787	$31.0179	$32.3466	$30.8714
330188	1.2509	0.9503	$21.1196	$22.6803	$23.9210	$22.6030
330189	0.9309	0.8607	$19.0726	$19.2538	$21.6229	$19.9266
330191	1.2962	0.8607	$20.9392	$22.3719	$24.0232	$22.4577
330193	1.2693	1.3194	$36.2427	$36.9866	$37.1807	$36.8214
330194	1.8239	1.3194	$38.5372	$39.9177	$43.9910	$40.8421
330195	1.7567	1.3194	$36.4249	$38.6867	$40.0206	$38.4696
330196	1.2876	1.3194	$31.1915	$32.5883	$33.2171	$32.3484
330197	1.1380	0.8217	$20.8386	$22.3117	$23.4291	$22.2164
330198	1.3590	1.2876	$25.3622	$29.5359	$30.5485	$28.5487
330199	1.1222	1.3194	$34.1354	$32.7870	$35.0059	$33.9687
330201	1.7233	1.3194	$29.3745	$33.3215	$39.3682	$33.7813
330202	1.2896	1.3194	$30.7990	$34.3545	$38.0129	$34.5293
330203	1.4869	0.9589	$24.7422	$26.2459	$26.5882	$25.8191
330204	1.3437	1.3194	$30.3699	$30.3273	$37.6849	$32.8372
330205	1.2623	1.3194	$29.0622	$30.0101	$32.1617	$30.4707
330208	1.1831	1.3194	$30.6158	$28.2667	$29.6282	$29.4819
330209	1.1850	1.2739	$27.7071	$28.7213	$29.7988	$28.7477
330211	1.1669	0.8217	$20.8224	$21.1094	$22.9966	$21.6469
330212	***	*	$24.9434	$27.0585	$27.2232	$26.1185
330213	1.1274	0.8217	$20.7967	$21.7208	$22.5191	$21.6931
330214	1.9195	1.3194	$32.7647	$33.7670	$37.8500	$34.8451
330215	1.3208	0.8378	$19.9226	$20.6343	$22.6744	$21.0901

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
330218	1.0429	0.9589	$20.6012	$21.4095	$24.1106	$22.0618
330219	1.6506	0.9503	$28.7448	$27.7400	$29.3644	$28.6092
330221	1.4249	1.3194	$34.9345	$34.7033	$36.5539	$35.4233
330222	1.2936	0.8607	$23.5491	$25.9825	$23.9746	$24.4778
330223	1.0359	0.8217	$18.8253	$18.4291	$19.4229	$18.9058
330224	1.2946	1.0217	$22.7847	$23.9379	$25.7850	$24.1687
330225	1.1808	1.2876	$29.1744	$28.9952	$29.2719	$29.1527
330226	1.3168	0.9123	$23.5405	$23.4783	$21.8977	$22.8832
330229 [h]	1.1793	0.8415	$18.5590	$19.5670	$20.6095	$19.5838
330230	1.0030	1.3194	$32.5997	$32.1101	$33.3175	$32.6586
330231	1.0147	1.3194	$30.2184	$33.9324	$36.9619	$33.7652
330232	1.2013	0.8607	$21.1277	$21.4765	$24.4531	$22.3535
330233	1.4520	1.3194	$39.5133	$41.9968	$45.5132	$42.4372
330234	2.2916	1.3194	$37.7135	$36.8500	$40.6314	$38.3961
330235	1.1373	0.9318	$21.4643	$22.1217	$23.3866	$22.3225
330236	1.4476	1.3194	$31.8491	$32.9391	$35.6347	$33.4921
330238	1.2736	0.9123	$18.3846	$19.2407	$20.8639	$19.5443
330239 [h]	1.2341	0.8415	$19.7561	$20.4936	$21.5397	$20.5927
330240	1.2411	1.3194	$37.3866	$40.7478	$39.9450	$39.4043
330241	1.8693	0.9589	$26.7598	$27.7213	$29.0882	$27.8974
330242	1.3070	1.3194	$30.5172	$32.2178	$33.6926	$32.1583
330245	1.9330	0.8378	$20.2037	$21.6857	$22.8003	$21.6000
330246	1.3525	1.2739	$31.8857	$31.6763	$34.6329	$32.7279
330247	0.9562	1.3194	$25.6063	$32.1733	$32.2300	$29.8298
330249	1.2127	0.9589	$19.1469	$21.4345	$22.9834	$21.2588
330250	1.2932	0.9278	$22.1272	$23.0641	$25.1664	$23.4900
330259	1.4393	1.2876	$27.4131	$30.0488	$31.9152	$29.8816
330261	1.2766	1.3194	$30.4771	$30.9356	$30.7942	$30.7386
330263	0.9848	0.8217	$20.0831	$20.8456	$22.4675	$21.1560
330264	1.2498	1.2739	$26.3652	$28.1501	$30.0139	$28.1122
330265	1.2921	0.9123	$18.2547	$19.9414	$20.4635	$19.5583
330267	1.4718	1.3194	$29.0499	$30.3709	$31.5478	$30.3522
330268	0.9523	0.8217	$18.7991	$18.9142	$20.9720	$19.5863
330270	2.0223	1.3194	$36.5976	$38.2605	$42.2111	$39.0845
330273	1.4035	1.3194	$28.8548	$29.5106	$30.4720	$29.6353
330276	1.1215	0.8280	$20.7973	$21.7826	$22.2353	$21.6210
330277	1.1672	0.9195	$21.8866	$25.1438	$25.3582	$24.1682
330279	1.4644	0.9503	$23.8793	$23.4816	$25.2130	$24.2253
330285	1.9863	0.9123	$26.0446	$27.1260	$27.9018	$27.0364
330286	1.3792	1.2739	$31.1344	$32.3244	$33.3552	$32.3237
330290	1.7499	1.3194	$35.5617	$36.3764	$36.9981	$36.3009
330293	***	*	$17.6506	$19.0290	*	$18.3452
330304	1.2859	1.3194	$31.1146	$33.4431	$34.5761	$33.1106
330306	1.4713	1.3194	$30.4426	$30.7551	$35.6640	$32.2831
330307	1.2230	0.9845	$23.8583	$25.4128	$27.5699	$25.6624
330314	1.2551	1.2739	$26.2954	$26.0150	$25.5597	$25.9594
330316	1.3011	1.3194	$33.7857	$33.1512	$34.8623	$33.9322
330327	***	*	$19.3465	*	*	$19.3465
330331	1.2271	1.2876	$34.6302	$34.7052	$36.1630	$35.1867
330332	1.2639	1.2876	$30.5104	$31.8389	$33.3050	$32.0164
330333	***	*	$29.7725	$33.7637	$26.1917	$29.6723
330336	***	*	$32.9548	*	*	$32.9548
330338	***	*	$25.4319	$27.3859	$31.3761	$27.9867
330339	0.8248	0.8607	$20.8424	$22.2812	$22.6569	$21.9390
330340	1.1787	1.2739	$29.8140	$31.4322	$33.9358	$31.7549
330350	1.5082	1.3194	$35.5656	$39.3541	$36.6250	$37.1672
330353	1.1647	1.3194	$35.6821	$38.6962	$37.6549	$37.3737
330354	1.8586	*	*	*	*	*
330357	1.2969	1.3194	$36.5461	$34.3965	$35.5975	$35.5017
330372	1.2646	1.2876	$28.2490	$30.1505	$32.6721	$30.3998
330385	1.1337	1.3194	$44.3387	$42.6671	$46.3221	$44.4556
330386	1.2201	1.0677	$25.2064	$25.9228	$27.9943	$26.4367
330389	1.8679	1.3194	$32.2112	$34.7552	$34.7669	$33.9210
330390	1.2873	1.3194	$32.7450	$33.2628	$36.0573	$33.8898
330393	1.7555	1.2739	$33.0953	$34.8213	$34.8095	$34.2742
330394	1.6386	0.8580	$21.3678	$23.3505	$25.2229	$23.3324
330395	1.3987	1.3194	$32.1089	$35.4619	$37.3096	$34.7722

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
330396	1.3734	1.3194	$31.2429	$32.5345	$35.0297	$32.9828
330397	1.3696	1.3194	$40.0884	$34.5110	$38.4741	$37.5361
330399	1.1728	1.3194	$32.1248	$33.6753	$32.3688	$32.7392
330401	1.3252	1.2739	$33.8633	$35.7435	$40.6249	$36.8252
330402	0.8016	*	*	$21.3302	*	$21.3302
330403	***	*	*	*	$23.1887	$23.1887
340001	1.4865	0.9707	$21.6113	$23.2436	$25.0041	$23.2441
340002	1.7550	0.9577	$24.0145	$25.1099	$27.3349	$25.5169
340003	1.1019	0.8544	$20.8205	$21.5562	$23.3066	$21.9251
340004	1.4225	0.9124	$23.3756	$24.2055	$25.4474	$24.3851
340005	1.0112	0.8544	$20.8150	$22.9830	$22.3814	$22.0177
340007	***	*	$19.5208	$21.1519	*	$20.3174
340008	1.0967	0.9577	$22.7338	$24.2089	$26.6314	$24.5355
340010	1.3267	0.9411	$21.3024	$23.1349	$24.5666	$23.0280
340011	1.0555	0.8544	$18.1926	$18.1843	$19.9484	$18.7756
340012	1.2913	0.8544	$19.6350	$22.0583	$22.7189	$21.4818
340013	1.2464	0.9577	$21.0066	$22.4787	$23.0261	$22.1688
340014	1.5408	0.8951	$22.6757	$24.4831	$25.1872	$24.1069
340015 [h]	1.3668	0.9974	$24.3410	$24.3870	$26.2276	$25.0387
340016	1.2189	0.8544	$20.2859	$22.7574	$23.0359	$22.0228
340017	1.2705	0.9303	$21.7083	$22.8879	$23.8229	$22.8228
340018	1.1437	0.9174	$17.3480	$20.3840	$23.7243	$20.2881
340019	0.9714	*	$16.7901	$17.8768	*	$17.3292
340020	1.2008	0.8751	$21.3385	$24.1955	$23.7995	$23.1233
340021	1.3123	0.9577	$22.9208	$23.6884	$26.0995	$24.2587
340022	***	*	$19.9078	*	*	$19.9078
340023	1.3810	0.9702	$22.3590	$23.2844	$24.4897	$23.4088
340024	1.1661	0.8544	$20.4906	$21.2671	$22.2521	$21.3515
340025	1.2517	0.9303	$20.2864	$20.9915	$21.2276	$20.8493
340027	1.1715	0.9404	$21.0975	$22.6107	$23.6326	$22.4564
340028	1.5576	0.9417	$22.2028	$24.6836	$26.3298	$24.3471
340030	2.0547	1.0200	$26.7753	$27.4664	$29.0122	$27.8175
340032	1.3999	0.9707	$23.2204	$24.8031	$26.7475	$25.0122
340035	1.0339	0.8544	$16.4821	$21.2407	$23.5476	$20.1377
340036	1.1813	0.9668	$20.8313	$22.2089	$25.2077	$22.9528
340037	1.0074	0.8760	$21.9524	$22.5089	$21.6411	$22.0344
340038	1.2006	0.8544	$13.9936	$14.0203	$14.0713	$14.0327
340039	1.2892	0.9577	$24.8246	$25.6605	$27.1275	$25.9204
340040	1.9383	0.9404	$22.4777	$24.1523	$26.3325	$24.3631
340041	1.2382	0.8930	$17.6319	$23.0497	$23.6600	$21.2911
340042	1.1026	0.8544	$21.1107	$22.1107	$23.0236	$22.0702
340044	0.9463	*	$18.2154	$21.7089	*	$19.7398
340045	0.9932	*	$17.4066	$14.5004	$23.1918	$18.0750
340047	1.9018	0.8951	$22.5199	$25.3727	$25.0605	$24.3496
340049	2.0187	1.0200	$21.2734	$22.3082	$30.4827	$24.7548
340050	1.1060	0.9183	$20.3262	$21.4511	$24.2533	$22.0481
340051	1.2486	0.8930	$20.3057	$21.9069	$23.4091	$21.9456
340053	1.6016	0.9707	$24.9768	$26.9361	$27.7261	$26.5947
340055	1.2426	0.8930	$23.2990	$24.3728	$24.1057	$23.9407
340060	1.0677	0.9124	$20.8077	$22.4303	$22.8657	$22.0570
340061	1.8016	1.0200	$25.1081	$26.6657	$27.5594	$26.4994
340064	1.0923	0.8544	$19.4523	$22.3631	$22.9143	$21.5916
340065	1.1839	*	$20.3296	$20.8413	*	$20.5941
340067	***	*	$22.2565	*	*	$22.2565
340068	1.2128	0.9384	$19.4487	$20.8600	$21.8830	$20.7420
340069	1.8902	0.9944	$24.4650	$27.5045	$27.4473	$26.5163
340070	1.2747	0.9341	$22.2605	$23.6045	$24.9033	$23.6142
340071	1.1357	0.9411	$19.9561	$22.1854	$25.4537	$22.5747
340072	1.1901	0.8544	$19.2773	$21.3320	$23.1163	$21.1853
340073	1.3885	0.9944	$26.6829	$29.4189	$30.2061	$28.9141
340075	1.2198	0.8930	$23.2904	$24.1297	$26.0225	$24.4391
340084	1.1791	0.9707	$20.8175	$21.3227	$21.2580	$21.1447
340085 [h]	1.1632	0.9501	$21.7112	$23.0890	$23.9793	$22.8869
340087	1.1851	0.8544	$17.8215	$18.4202	$22.0070	$19.3351
340088	1.3435	*	$22.8687	$24.3299	*	$23.5994
340090	1.2399	0.9668	$20.3261	$21.7173	$23.4542	$21.9222
340091	1.5409	0.9124	$23.1430	$24.9411	$25.8266	$24.6682

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
340096 [h]	1.2085	0.9501	$22.1174	$23.6345	$25.2169	$23.6523
340097	1.1856	0.8544	$20.8690	$22.5775	$24.2127	$22.5886
340098	1.4560	0.9707	$24.2262	$25.4823	$27.3308	$25.7030
340099	1.1870	0.8544	$17.5114	$20.0178	$20.3683	$19.3181
340104	0.8501	0.8760	$12.9949	$14.3252	$15.7521	$14.3947
340106	1.0879	0.8544	$20.1076	$22.6979	$22.4894	$21.8047
340107	1.2195	0.8915	$21.0960	$22.5583	$22.9698	$22.2242
340109	1.3280	0.8832	$20.4341	$22.3826	$23.4419	$22.1467
340113	1.8763	0.9707	$25.0729	$26.0776	$28.2568	$26.5148
340114	1.6302	0.9944	$19.9142	$25.4533	$26.6813	$23.7911
340115	1.6059	0.9944	$23.8284	$25.1907	$25.0212	$24.7040
340116	1.7294	0.8930	$23.9643	$26.1641	$25.3213	$25.1777
340119	1.1322	0.9707	$21.2239	$22.4821	$24.2287	$22.6894
340120	1.0480	0.8544	$19.9860	$21.8548	$23.0916	$21.7078
340121	1.0504	0.9570	$19.9409	$20.3701	$21.7576	$20.7129
340123	1.1938	0.9124	$22.3711	$23.1879	$26.1083	$23.9306
340124	1.0787	0.9411	$17.5691	$18.3866	$20.8018	$18.8482
340126 [h]	1.2300	0.9411	$21.4271	$23.5405	$25.0189	$23.3764
340127	1.1727	0.9944	$22.9672	$24.6096	$25.7831	$24.5262
340129	1.2525	0.9577	$22.3260	$24.1356	$25.4902	$24.1365
340130	1.3763	0.9707	$22.7687	$23.0937	$25.2941	$23.7854
340131	1.5307	0.9404	$24.1370	$25.2989	$27.9358	$25.8415
340132	1.2002	0.8544	$17.8771	$20.4222	$21.3521	$19.8892
340133	1.0161	0.8852	$23.1444	$22.1588	$22.5558	$22.6188
340137	1.0101	0.8930	$33.1751	$29.9903	$21.0642	$28.4915
340138	0.8487	0.9944	$29.5286	$27.4767	$21.3670	$26.2644
340141	1.6488	0.9570	$24.2033	$24.8132	$27.3355	$25.5266
340142	1.1830	0.8544	$20.4320	$22.1298	$22.9907	$21.8836
340143	1.4873	0.8930	$23.0416	$24.8904	$25.3633	$24.4002
340144	1.2457	0.9577	$25.4598	$25.6538	$27.2686	$26.1330
340145	1.2943	0.9577	$21.8120	$23.7028	$23.7131	$23.0768
340146	1.0635	*	$20.7252	$18.8354	*	$19.6880
340147	1.2141	0.9411	$22.6057	$23.9998	$25.4534	$24.0568
340148	1.3490	0.8951	$20.8156	$22.4205	$23.5880	$22.2985
340151	1.1115	0.8544	$19.2593	$22.2613	$22.0052	$21.1161
340153	1.8758	0.9707	$23.7426	$25.7078	$26.4896	$25.3204
340155	1.4344	1.0200	$26.3663	$28.8758	$30.4940	$28.6096
340156	0.8242	1.4448	*	*	*	*
340158	1.1147	0.9570	$21.7489	$23.4724	$26.4849	$23.8953
340159	1.1662	1.0200	$21.2983	$22.1872	$23.2991	$22.2743
340160	1.2859	0.8544	$18.7569	$19.1330	$20.7525	$19.5589
340166	1.3711	0.9707	$22.8349	$25.7398	$26.0557	$24.9254
340168	0.3956	*	$16.8278	$16.8076	$17.3249	$17.0046
340171	1.1940	0.9707	$25.9603	$27.2074	$28.2734	$27.2246
340173	1.2567	0.9944	$23.7037	$26.6128	$27.5072	$26.0994
340176	***	*	$26.5277	*	*	$26.5277
340177	1.0581	0.8544	*	*	$24.7471	$24.7471
340178	***	*	*	*	$28.7219	$28.7219
340181	2.1149	0.9303	*	*	*	*
340182	2.7404	1.0200	*	*	*	*
350002	1.7344	0.8769	$20.4398	$20.6474	$22.0283	$21.0339
350003	1.1648	0.8769	$21.0585	$25.3076	$21.8061	$22.5764
350004	***	*	$28.3773	$27.5891	*	$28.0246
350006	1.6936	0.8769	$19.7577	$19.5870	$19.4985	$19.5737
350009	1.0850	0.8769	$20.2558	$20.7014	$23.0873	$21.3437
350010	1.0994	0.8769	$17.2489	$18.5682	$19.1965	$18.3109
350011	1.9994	0.8769	$21.9111	$22.3896	$23.1947	$22.5594
350014	0.9136	0.8769	$16.1718	$18.5360	$17.7565	$17.4777
350015	1.7120	0.8769	$18.5437	$18.6381	$20.1161	$19.1124
350017	1.4490	0.8769	$19.1952	$20.1943	$21.0243	$20.1512
350019 [2]	1.6909	0.8769	$21.3589	$24.2382	$22.1960	$22.5332
350027	1.0607	*	$17.6731	$14.2262	*	$15.5713
350030	0.9611	0.8769	$18.8822	$19.2282	$18.9978	$19.0373
350043	***	*	$18.8378	$20.9732	*	$19.9618
350058	0.9761	*	$15.0196	*	*	$15.0196
350061	1.0550	*	$18.8494	$18.6546	$22.0515	$19.8387
350063	0.9163	1.4448	*	*	*	*

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
350064	0.8946	1.4448	*	*	*	*
350070	1.9464	0.8769	*	$24.4464	$25.2836	$24.8833
360001	1.3631	0.9595	$22.2387	$23.7750	$23.9101	$23.2970
360002	1.2126	0.8826	$20.7586	$22.6923	$24.5789	$22.7274
360003	1.8536	0.9595	$24.4144	$26.3180	$27.5029	$26.0650
360006	2.0518	0.9857	$24.0814	$25.7041	$28.1698	$26.0230
360007	***	*	$19.1315	*	*	$19.1315
360008	1.3213	0.9110	$21.3795	$23.2545	$24.5714	$23.1202
360009	1.6004	0.9271	$22.4076	$23.2659	$23.1012	$22.9250
360010	1.2000	0.8970	$20.6290	$22.0262	$23.1178	$21.9858
360011	1.3439	0.9857	$21.4293	$22.4482	$25.5340	$23.0257
360012	1.3892	0.9857	$24.3618	$25.5913	$27.5470	$25.9629
360013	1.1054	0.9271	$24.4232	$25.1588	$26.8129	$25.4875
360014	1.1501	0.9857	$22.9372	$23.8305	$25.3861	$24.0832
360016	1.4438	0.9595	$22.8430	$24.6587	$26.1283	$24.5377
360017	1.7459	0.9857	$23.6181	$25.4969	$27.2910	$25.5905
360018	***	*	$29.9085	*	*	$29.9085
360019	1.3001	0.9207	$23.3006	$24.1105	$25.5926	$24.3472
360020	1.6459	0.9207	$21.5085	$22.3795	$24.4343	$22.8262
360024	***	*	$22.5356	$24.0612	$23.5793	$23.3219
360025	1.4264	0.9207	$21.6676	$23.6574	$25.5633	$23.7829
360026	1.2976	0.9060	$20.8825	$22.3303	$23.5898	$22.2676
360027	1.6880	0.9207	$23.5907	$24.7093	$25.4894	$24.6187
360029	1.0971	0.9564	$20.4924	$20.8778	$22.7785	$21.4073
360031	***	*	$24.3482	$24.4324	*	$24.3900
360032 [h]	1.1348	0.9271	$21.1743	$22.9759	$23.2638	$22.4807
360034	1.1011	*	$21.5621	$25.1366	*	$23.3553
360035	1.7292	0.9857	$24.2433	$25.6895	$27.5220	$25.8774
360036	1.2246	0.9207	$22.3567	$25.0910	$27.6094	$25.0649
360037	1.3805	0.9207	$32.6245	$25.1615	$24.3982	$26.6839
360038	1.4223	0.9595	$23.4855	$24.8294	$22.8009	$23.7144
360039	1.4979	0.9857	$23.4642	$22.5921	$24.0218	$23.3755
360040	1.1570	0.8826	$21.3307	$22.8729	$24.0942	$22.7498
360041	1.4614	0.9207	$22.1352	$23.2625	$24.1080	$23.2048
360044	1.0733	0.8826	$19.7212	$20.4724	$21.8411	$20.6845
360046	1.2105	0.9595	$22.8425	$23.8918	$25.0775	$23.9800
360047	0.9609	0.8826	$17.5885	$17.1973	$21.7248	$18.9388
360048	1.7734	0.9564	$24.7150	$27.2274	$28.8107	$26.8831
360049	1.1590	0.9207	$22.4939	$24.2605	$25.8367	$24.2864
360051	1.6784	0.9060	$23.0658	$25.1785	$25.7556	$24.7297
360052	1.5709	0.9060	$22.5005	$23.3285	$24.5405	$23.5101
360054	1.2960	0.8826	$19.2884	$20.3176	$23.0376	$20.9178
360055	1.4051	0.8826	$23.5586	$25.1475	$26.3112	$24.9991
360056	1.5598	0.9595	$22.4475	$23.4638	$23.1024	$22.9631
360058	1.1320	0.8826	$21.0768	$22.7943	$23.4429	$22.4519
360059	1.4973	0.9207	$23.0775	$25.5222	$25.3516	$24.6433
360062	1.5523	0.9857	$24.5746	$26.8091	$28.6518	$26.7475
360064	1.5736	0.8826	$21.3424	$22.8729	$22.2393	$22.1811
360065	1.2094	0.9207	$22.9727	$24.0868	$26.3036	$24.5445
360066	1.5723	0.9271	$24.6806	$25.2316	$27.3362	$25.7779
360068	1.8628	0.9564	$22.1110	$23.7895	$25.8414	$23.9678
360069	1.1368	0.9564	$20.5349	$25.7032	$24.2444	$23.4234
360070	1.6666	0.8976	$21.8228	$23.1687	$24.8863	$23.3191
360071 [h]	1.2226	0.9271	$21.4478	$21.6176	$22.0786	$21.6950
360072	1.4007	0.9857	$21.3736	$23.0464	$24.4332	$23.0100
360074	1.2667	0.9564	$22.2368	$23.6172	$24.9055	$23.6214
360075	1.2223	0.9207	$23.8492	$24.7610	$26.8453	$25.2573
360076	1.4070	0.9595	$22.5863	$22.5943	$25.9369	$23.7285
360077	1.5522	0.9207	$23.3686	$24.7086	$25.6505	$24.5864
360078	1.2933	0.9207	$23.3799	$24.6821	$26.1313	$24.7447
360079	1.7728	0.9595	$25.9623	$25.8762	$26.0935	$25.9804
360080	1.0799	0.8826	$18.7213	$19.5436	$20.8309	$19.7267
360081	1.3290	0.9564	$22.1973	$25.1439	$27.5695	$24.8761
360082	1.4058	0.9207	$25.2254	$27.4264	$27.1197	$26.6255
360084	1.5637	0.8976	$23.3257	$25.2059	$25.8415	$24.8445
360085	2.0948	0.9857	$24.6618	$27.5792	$29.0081	$27.1579
360086	1.5369	0.9060	$21.5983	$22.3005	$22.1859	$22.0265

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
360087	1.4204	0.9207	$23.9638	$25.9131	$25.4040	$25.0901
360089	1.1248	0.8826	$21.0229	$21.0253	$22.7951	$21.6142
360090	1.4961	0.9564	$22.6236	$24.4291	$26.7717	$24.5859
360091	1.2239	0.9207	$23.5759	$26.0541	$27.5067	$25.7352
360092	1.2370	0.9857	$21.9732	$23.5100	$25.6618	$23.7647
360093	1.0538	*	$21.4623	$24.1238	*	$22.7886
360094	***	*	$22.6440	$27.1864	$26.6348	$24.9723
360095	1.3015	0.9271	$23.6518	$24.6984	$26.1275	$24.8802
360096	1.0962	0.8826	$22.0673	$22.2333	$24.6317	$22.9802
360098	1.4207	0.9207	$22.7644	$23.6413	$24.8447	$23.7933
360099	***	*	$20.8524	*	*	$20.8524
360100	1.2206	0.8976	$21.5911	$19.0616	$23.0561	$21.0569
360101	1.4001	0.9207	$26.2875	$27.7584	$26.6208	$26.9092
360102	1.0721	0.9207	*	*	*	*
360106	1.0956	*	$19.8658	$21.6450	$24.1588	$21.9428
360107	1.0610	0.9207	$23.6880	$24.5365	$25.9697	$24.7438
360109	1.1010	0.8826	$23.0178	$24.3236	$25.4184	$24.2613
360112	2.0624	1.0570	$25.5910	$26.7880	$28.6784	$26.9982
360113	1.2545	0.9595	$22.3348	$23.5138	$25.6493	$23.7408
360115	1.2688	0.9207	$22.3926	$24.0232	$24.0052	$23.4857
360116	1.2736	0.9595	$21.3809	$23.4049	$18.0655	$20.9510
360118	1.5074	0.9902	$23.0070	$24.2526	$27.7289	$25.0968
360121	1.2399	1.0570	$23.2515	$25.2037	$24.5592	$24.3452
360123	1.4309	0.9207	$23.1310	$24.1761	$22.6523	$23.2730
360125	1.1911	0.9207	$21.1408	$22.6871	$22.1096	$21.9849
360126	***	*	$22.2409	*	*	$22.2409
360128	1.0897	*	$18.0356	$18.5954	$21.0066	$19.1903
360129	0.9502	*	$17.9151	$19.5336	*	$18.7493
360130	1.4589	0.9207	$20.1257	$21.7015	$22.9762	$21.5955
360131	1.2615	0.8976	$21.7838	$23.1730	$24.0495	$23.0299
360132	1.2590	0.9595	$23.4179	$25.7991	$25.9453	$25.1258
360133	1.6363	0.9060	$22.0958	$23.9457	$24.6208	$23.6001
360134	1.7249	0.9595	$23.6817	$25.3013	$29.2975	$26.0944
360137	1.7024	0.9207	$23.8947	$25.7647	$26.9522	$25.5442
360141	1.6707	0.8826	$25.1442	$31.0127	$27.7085	$27.9618
360142	0.9787	0.8826	$20.6728	$21.2084	$22.1610	$21.3780
360143	1.3313	0.9207	$22.2275	$23.8938	$24.6306	$23.6169
360144	1.3548	0.9207	$24.7973	$26.7160	$25.7079	$25.7641
360145	1.7973	0.9207	$22.4813	$23.4743	$25.8268	$23.9319
360147	1.3819	0.8826	$20.0409	$22.7172	$24.1953	$22.4020
360148	1.0643	0.8826	$21.3211	$24.4873	$26.1946	$24.0470
360150	1.2073	0.9207	$24.8485	$25.8703	$24.7667	$25.1568
360151	1.5213	0.8976	$21.7215	$22.2179	$24.8629	$22.8949
360152	1.5274	0.9857	$22.9352	$24.9894	$27.9147	$25.0211
360153	0.9727	0.8826	$17.3367	$19.0844	$19.0226	$18.4206
360154	0.9978	*	$16.2416	$17.1274	*	$16.6874
360155	1.5088	0.9207	$23.0020	$23.9466	$25.3909	$24.1471
360156	1.1585	0.9039	$21.2853	$22.6709	$24.0510	$22.6856
360159	1.2447	0.9857	$23.3359	$25.7108	$33.1613	$27.1828
360161	1.3756	0.8826	$21.5114	$22.6005	$24.3792	$22.8785
360163	1.9069	0.9595	$23.1500	$25.7966	$26.9728	$25.2619
360170	1.2023	0.9857	$22.2815	$22.9359	$24.3620	$23.3031
360172	1.4108	0.9207	$22.7104	$23.4727	$26.3501	$24.1960
360174	1.2246	0.9060	$21.7129	$22.8167	$24.9990	$23.2230
360175	1.2182	0.9857	$22.7887	$24.6152	$26.5949	$24.7311
360177	1.1637	0.8826	$20.8194	$23.4256	$24.4712	$22.9543
360178	***	*	$18.2393	*	*	$18.2393
360179	1.5758	0.9595	$23.0678	$25.9429	$28.8645	$26.0273
360180	2.2433	0.9207	$25.1499	$26.8720	$26.1514	$26.0861
360185	1.1997	0.8826	$21.1245	$21.8641	$23.7173	$22.2403
360187	1.5882	0.9060	$21.9499	$23.8362	$24.8173	$23.5639
360189	1.1305	0.9857	$20.0275	$24.2512	$24.2136	$22.8164
360192	1.3344	0.9207	$24.9995	$26.2976	$26.7577	$26.0512
360194	1.1621	*	$20.3677	$22.3297	*	$21.3611
360195	1.0805	0.9207	$23.1897	$25.8043	$26.1280	$25.1222
360197	1.1010	0.9857	$23.1378	$24.7539	$27.0896	$25.0381
360203	1.1587	0.8826	$19.3642	$21.5564	$22.1414	$21.0862

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
360210	1.1833	0.9857	$25.0811	$26.5665	$27.8415	$26.5578
360211	1.5671	0.8832	$22.4529	$23.0884	$22.5449	$22.6945
360212	1.3858	0.9207	$22.8041	$24.5310	$25.2756	$24.2166
360218	1.1880	0.9857	$22.8060	$24.4720	$27.4288	$25.0106
360230	1.6262	0.9207	$24.7681	$26.6444	$27.0223	$26.1931
360234	1.3217	0.9595	$22.1787	$23.3325	$24.3625	$23.2666
360236	1.1633	0.9595	$22.8821	$21.3795	$35.8144	$24.3729
360239	1.3270	0.9060	$23.5802	$24.4398	$25.2474	$24.5362
360241	***	*	$23.4061	$24.8089	$24.7001	$24.1133
360242	1.9421	*	*	*	*	*
360245	0.5583	0.9207	$18.1015	$18.7966	$19.1885	$18.7327
360247	0.3956	0.9857	*	$25.1083	$19.8892	$22.3390
360253	2.2766	0.9060	$31.3006	$28.2555	$30.4276	$29.8452
360254	***	*	$30.0792	*	*	$30.0792
360255	***	*	$15.0963	*	*	$15.0963
360257	1.0823	*	*	$17.9652	*	$17.9652
360259	1.2034	0.9564	*	*	$25.1338	$25.1338
360260	***	*	*	*	$27.3903	$27.3903
360261	1.8245	0.9473	*	*	$22.5431	$22.5431
360262	1.3722	0.9564	*	*	$27.1680	$27.1680
360263	1.7091	0.9271	*	*	$20.8884	$20.8884
360264	2.2623	0.9595	*	*	*	*
360265	2.0629	0.8826	*	*	*	*
360266	2.0862	0.9857	*	*	*	*
360267	2.5734	0.8976	*	*	*	*
360268	1.1877	0.9060	*	*	*	*
370001	1.7009	0.8569	$25.5838	$26.2391	$27.7245	$26.5391
370002	1.1857	0.7607	$18.9544	$19.7718	$20.1479	$19.6308
370004	1.1013	0.8450	$21.5041	$24.7694	$25.3919	$23.7972
370006	1.2175	0.7607	$15.6333	$16.9469	$20.1063	$17.6384
370007	1.0578	0.7607	$16.7598	$17.2084	$17.6547	$17.2160
370008	1.3926	0.9034	$22.1596	$22.7419	$24.2978	$23.1423
370011	1.0967	0.9034	$17.1458	$19.2266	$19.7821	$18.6737
370013	1.5307	0.9034	$21.1512	$22.6451	$24.9295	$22.9792
370014	1.0503	0.8962	$21.8473	$24.8138	$25.3576	$24.0194
370015	0.9755	0.8569	$20.3966	$21.1833	$23.6693	$21.7009
370016 [h]	1.5144	0.8673	$20.4407	$24.2737	$25.4062	$23.3330
370018	1.4275	0.8569	$20.8357	$23.4286	$23.5336	$22.5984
370019	1.2367	0.7607	$18.1260	$19.6761	$21.4474	$19.7475
370020	1.2396	0.7607	$16.8631	$17.4835	$18.5046	$17.6368
370022	1.2026	0.7666	$20.2432	$18.4217	$19.6495	$19.4375
370023	1.2518	0.7691	$19.3386	$20.6002	$21.5762	$20.5441
370025	1.2688	0.8569	$20.2845	$22.0287	$23.5659	$21.9757
370026 [h]	1.5389	0.8673	$21.9140	$22.5734	$23.0848	$22.5236
370028	1.8670	0.9034	$24.1009	$24.8661	$26.6153	$25.1976
370029	1.0497	0.7607	$19.5811	$22.1163	$23.9956	$21.8559
370030	1.0482	0.7607	$18.6541	$20.3315	$23.3037	$20.7201
370032	1.4610	0.9034	$20.0827	$21.6029	$23.4843	$21.7536
370034	1.2055	0.7998	$16.1540	$17.6247	$18.2341	$17.3349
370036	1.0269	0.7607	$16.5844	$16.9222	$17.7576	$17.1504
370037	1.6819	0.9034	$21.0719	$23.1256	$23.9685	$22.7803
370039	1.0974	0.8569	$20.3137	$21.0793	$21.8220	$21.0783
370040	1.0217	0.8247	$18.9981	$21.1061	$22.4048	$20.8291
370041	0.8941	0.8569	$19.0144	$22.0082	$22.3496	$21.1267
370042	0.9463	*	$14.0899	$15.3613	*	$14.7180
370043	0.9527	*	$20.2929	$21.5588	*	$20.9707
370045	0.9173	*	$12.6613	$14.6370	*	$13.6711
370047	1.4476	0.8962	$19.4856	$19.7112	$20.4657	$19.9082
370048	1.1085	0.7607	$15.4768	$17.7273	$19.2464	$17.4431
370049	1.3041	0.9034	$20.4826	$21.6878	$23.2171	$21.8100
370051	1.0513	0.7607	$12.0397	$14.6254	$17.2618	$14.4702
370054	1.2607	0.7607	$20.3788	$21.5521	$21.5043	$21.1653
370056	1.6327	0.7908	$20.4872	$21.7647	$22.0312	$21.4507
370057	0.9482	0.8569	$17.3020	$18.0426	$19.7284	$18.3749
370060	0.9366	0.8569	$23.1897	$23.8007	$18.7592	$21.7395
370064	0.9040	0.7607	$11.9044	$14.1879	$14.2053	$13.4809
370065	1.0317	0.7728	$18.3966	$20.6537	$20.0226	$19.6691

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
370072	0.8151	0.7607	$12.5765	$14.6387	$9.9616	$11.8723
370076	***	*	$19.0230	$21.5461	*	$20.2863
370078	1.6275	0.8569	$22.2318	$23.9507	$25.4068	$23.9046
370080	0.9012	0.7607	$16.1444	$17.4857	$18.0665	$17.2314
370082	***	*	$12.6060	*	*	$12.6060
370083	0.9426	0.7607	$18.5669	$15.3447	$16.8836	$16.8841
370084	0.9728	0.7607	$16.1278	$17.2735	$16.6514	$16.7384
370089	1.0828	0.7607	$18.0505	$19.9021	$20.4699	$19.4850
370091	1.7106	0.8569	$24.2117	$22.9893	$23.3357	$23.4867
370093	1.6481	0.9034	$23.5685	$25.7296	$26.9774	$25.3740
370094	1.4086	0.9034	$20.6507	$22.0591	$23.1191	$21.9907
370095	0.8962	*	$14.3563	$16.5310	*	$15.4277
370097	1.3020	0.7908	$20.3218	$21.7150	$22.3267	$21.5064
370099	1.0107	0.8569	$20.2001	$20.5217	$20.5075	$20.4227
370100	0.9798	0.7607	$13.0681	$14.1883	$14.7712	$14.0181
370103	0.9470	0.8053	$15.6110	$16.1408	$17.8018	$16.5505
370105	1.8538	0.9034	$22.4493	$22.1584	$23.8978	$22.8583
370106	1.3548	0.9034	$24.1115	$24.2393	$26.5867	$25.0105
370108	***	*	$13.8170	*	*	$13.8170
370112	0.9371	0.8247	$16.5965	$15.4941	$15.4471	$15.8101
370113	1.1531	0.8707	$21.4267	$23.3011	$25.3565	$23.3322
370114	1.5662	0.8569	$19.4933	$21.0603	$21.7880	$20.8230
370123	***	*	$20.5180	$22.8174	$25.4733	$22.7986
370125	0.8604	*	$17.9240	$17.2013	$17.1361	$17.4038
370138	1.0236	0.7607	$19.0403	$19.8308	$18.3113	$19.0435
370139	0.9440	0.7607	$16.3224	$17.8900	$18.5225	$17.5400
370141	***	*	$24.7859	*	*	$24.7859
370148	1.4980	0.9034	$22.8526	$24.6194	$25.2348	$24.3075
370149 [h]	1.2123	0.9390	$18.2260	$21.0608	$22.3537	$20.7832
370153	1.0538	0.7607	$17.9692	$18.5417	$19.8349	$18.7951
370154	***	*	$17.4760	*	*	$17.4760
370156	1.0073	0.7607	$15.9647	$16.6572	$19.4743	$17.3490
370158	1.0204	0.9034	$17.3412	$17.3161	$18.5578	$17.7592
370166	1.0006	0.8569	$21.3628	$21.9070	$23.1681	$22.1327
370169	0.9033	0.7607	$16.5607	$15.7686	$15.8002	$16.0704
370170	1.0221	1.4448	*	*	*	*
370171	1.5204	1.4448	*	*	*	*
370172	0.8692	1.4448	*	*	*	*
370173	1.0681	1.4448	*	*	*	*
370174	0.9191	1.4448	*	*	*	*
370176	1.1146	0.8569	$22.1456	$23.0324	$25.0509	$23.4362
370177	1.0163	0.7607	$14.0279	$15.6723	$14.7193	$14.7923
370178	0.9012	0.7607	$12.9635	$14.9767	$14.6070	$14.1857
370179	0.9319	0.8569	$21.9673	$22.8322	$23.5794	$22.6918
370180	1.0669	1.4448	*	*	*	*
370183	1.0219	0.8569	$17.9270	$20.5025	$21.8147	$20.0076
370186	0.9039	*	$16.3879	*	*	$16.3879
370190	1.5509	0.8569	$22.3326	$24.9455	$33.1137	$27.0848
370192	1.8038	0.9034	$24.3832	$26.1338	$31.4930	$27.6466
370196	1.0637	0.9034	$23.6334	$29.4383	$22.6824	$25.4359
370199	0.9513	0.9034	$20.7075	$23.7340	$26.0451	$23.4652
370200	1.1695	0.7607	$16.7164	$18.1008	$17.6317	$17.5059
370201	1.7144	0.9034	$18.9906	$23.1240	$23.3550	$21.7730
370202	1.5408	0.8569	$24.0239	$24.4920	$25.1181	$24.5965
370203	1.3869	0.9034	$19.8772	$21.2426	$23.5190	$21.5182
370206	1.5811	0.9034	$22.3471	$27.4495	$26.0912	$25.5795
370207	***	*	$26.3746	*	*	$26.3746
370209	***	*	*	$32.8278	*	$32.8278
370210	2.2165	0.8569	*	$20.0360	$21.2682	$20.6946
370211	0.9595	0.9034	*	*	$26.5344	$26.5344
370212	1.5535	0.9034	*	*	$21.0758	$21.0758
370213	***	*	*	*	$29.3777	$29.3777
370214	0.8997	0.7607	*	*	*	*
370215	2.5045	0.9034	*	*	$32.3589	$32.3589
370216	2.5952	0.8569	*	*	*	*
370217	1.0003	0.7607	*	*	*	*
370218	2.3683	0.8569	*	*	*	*

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
380001	1.1917	1.1235	$20.9585	$27.8554	$30.0103	$26.2164
380002	1.2041	1.0431	$25.2629	$26.3348	$27.1861	$26.3148
380003	***	*	$24.6377	*	*	$24.6377
380004	1.7214	1.1235	$27.5184	$28.2466	$30.5172	$28.8120
380005	1.3710	1.0301	$26.3472	$28.0682	$30.2211	$28.3075
380006	1.1672	*	$24.7492	$26.0475	*	$25.3948
380007	1.9085	1.1235	$30.0497	$31.5207	$33.9969	$31.9322
380008	1.1295	1.0301	$24.6149	$25.4494	$25.8356	$25.3227
380009	1.9379	1.1235	$26.0012	$30.4198	$31.7042	$29.4616
380010	1.0337	1.1235	$25.5234	$27.5291	$30.2957	$27.8451
380011	***	*	$21.9382	*	*	$21.9382
380013	***	*	$24.1491	*	*	$24.1491
380014	1.8478	1.0700	$28.4536	$27.7255	$29.9648	$28.7806
380017	1.7770	1.1235	$29.2543	$31.7440	$32.2447	$31.1318
380018	1.8112	1.0301	$27.5171	$27.8952	$28.0701	$27.8359
380020	1.3781	1.0799	$23.7066	$25.8320	$28.3563	$26.0268
380021	1.4279	1.1235	$28.0334	$29.3001	$29.3295	$28.9428
380022	1.2258	1.0502	$26.4794	$27.8683	$29.2642	$27.9316
380023	1.1838	1.0301	$23.0079	$23.7073	$26.5439	$24.4358
380025	1.3001	1.1235	$28.8525	$30.2628	$33.2105	$30.8181
380026	1.1392	*	$23.8666	$26.5217	*	$25.2072
380027	1.2955	1.0419	$21.5822	$23.8758	$25.5161	$23.7359
380029	1.3050	1.0510	$24.2939	$26.2070	$26.9966	$25.9075
380033	1.6636	1.0799	$30.4783	$29.7995	$30.8767	$30.3883
380035	1.0501	*	$26.2434	$26.4784	*	$26.3599
380037	1.2406	1.1235	$25.0200	$27.1884	$30.5818	$27.7342
380038	1.2652	1.1235	$29.1804	$30.5903	$34.2303	$31.3814
380039	0.9848	1.1235	$27.5115	$30.1544	$32.3959	$30.0601
380040	1.1935	1.0301	$21.5958	$28.4373	$32.0103	$27.1504
380047	1.7995	1.0772	$26.5017	$27.8385	$29.8627	$28.1638
380050	1.4063	1.0301	$23.1332	$24.2416	$25.6190	$24.3627
380051	1.5965	1.0510	$26.2384	$28.1305	$29.7219	$28.0410
380052	1.1791	1.0301	$21.2567	$22.6799	$24.9476	$22.9567
380056	0.9470	1.0510	$22.3571	$25.0068	$25.1475	$24.2275
380060	1.3974	1.1235	$27.8551	$30.2507	$30.7041	$29.6593
380061	1.6520	1.1235	$27.3827	$29.5145	$29.8217	$28.9273
380066	1.2331	*	$23.3581	$27.5412	*	$25.5211
380070	1.1830	*	$34.1039	*	*	$34.1039
380071	1.3513	1.1235	$27.9055	$29.5740	$30.2304	$29.2634
380072	0.8571	*	$21.9516	$22.5275	*	$22.2419
380075	1.3193	1.0301	$25.1930	$27.4795	$29.0368	$27.3082
380081	1.1378	1.0301	$22.1822	$21.0708	$21.8850	$21.7195
380082	1.2295	1.1235	$28.0668	$30.2721	$32.3002	$30.2952
380089	1.2844	1.1235	$29.6989	$30.8396	$33.4214	$31.3234
380090	1.2860	1.2303	$31.8702	$33.6822	$34.4536	$33.3615
380091	1.3349	1.1235	$31.2807	$35.7002	$33.8950	$33.5968
390001	1.6737	0.9834	$21.5154	$22.4407	$22.5309	$22.1581
390002	1.2774	0.8832	$22.0646	$23.0113	$22.4388	$22.5092
390003 [h]	1.1761	0.9834	$19.1857	$21.3182	$21.6478	$20.7084
390004	1.5734	0.9308	$21.3475	$23.4063	$24.3249	$23.1020
390005	0.9917	*	$19.0727	$19.0318	*	$19.0497
390006	1.8416	0.9139	$23.0378	$23.3960	$25.1216	$23.8687
390008 [h]	1.1617	0.8832	$19.9417	$21.0021	$22.2680	$21.0752
390009	1.7609	0.8737	$21.9459	$24.2789	$25.5482	$23.9471
390010	1.2015	0.8832	$19.4377	$21.6273	$23.5390	$21.5537
390011	1.3462	0.8352	$18.6548	$19.8602	$21.9279	$20.1129
390012	1.2234	1.1028	$28.5114	*	$28.5076	$28.5093
390013	1.2242	0.9139	$22.1679	$23.3180	$24.0044	$23.1713
390016 [h]	1.2089	0.8832	$18.1536	$19.9899	$21.9549	$20.1569
390017 [h]	***	*	$19.1962	$20.6575	*	$19.8788
390018	***	*	$19.9117	*	*	$19.9117
390019	1.2036	0.9834	$21.2806	$21.5137	$23.4636	$22.1361
390022	1.3229	1.1028	$27.5504	$31.0971	$29.0710	$29.1659
390023	1.2592	1.1028	$25.3767	$27.1600	$31.7149	$28.1614
390024	0.9502	1.1028	$25.9806	$37.4330	$35.3959	$29.4333
390025	0.5326	1.1028	$14.8690	$15.0282	$17.2977	$15.7085
390026	1.2514	1.1028	$24.0326	$27.0802	$29.5157	$26.9256

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
390027	1.5554	1.1028	$33.2139	$28.9159	$35.8381	$32.5478
390028	1.6221	0.8832	$24.6796	$23.6616	$25.7246	$24.7268
390029	***	*	*	$24.4276	*	$24.4276
390030	1.1890	0.9834	$20.0598	$20.9859	$22.1581	$21.0867
390031	1.2121	0.9491	$20.3568	$21.2949	$22.6828	$21.4388
390032	1.1808	0.8832	$20.8450	$20.9971	$22.7205	$21.5225
390035	1.2294	1.1028	$23.2173	$24.7281	$26.2647	$24.7742
390036	1.4723	0.8832	$20.5751	$23.3858	$24.6032	$22.8336
390037	1.3526	0.8832	$20.1665	$22.9008	$24.7820	$22.6385
390039 [h]	1.1584	0.8340	$18.4580	$17.8461	$20.3787	$18.9083
390040	***	*	$20.5371	$23.1807	*	$21.7860
390041	1.3213	0.8832	$21.0074	$20.6789	$21.5925	$21.0799
390042	1.3558	0.8832	$22.2351	$23.9632	$25.6328	$23.9486
390043	1.1770	0.8289	$19.8641	$20.9835	$22.2549	$21.0509
390044	1.6846	0.9888	$22.4235	$24.2586	$27.1505	$24.6634
390045	1.6020	0.8355	$20.2082	$22.2582	$23.0712	$21.8774
390046	1.5586	0.9447	$23.1271	$25.0825	$27.2630	$25.1787
390048	1.0902	0.9139	$20.3523	$23.6622	$24.9759	$22.9112
390049	1.5998	0.9834	$24.0933	$25.4056	$27.1366	$25.5929
390050	2.0676	0.8832	$22.6951	$24.5424	$26.6931	$24.6339
390052	1.1861	0.8933	$22.1380	$21.6736	$23.3474	$22.4074
390054	1.2038	0.9706	$19.8602	$21.4983	$22.8087	$21.3801
390055	***	*	$23.5292	$25.5675	$25.6945	$24.9860
390056	1.0708	0.8331	$21.4239	*	$19.5537	$20.4834
390057	1.3477	1.1028	$24.8235	$25.1901	$27.9583	$26.0368
390058	1.2896	0.9308	$22.0113	$25.3415	$27.4799	$24.8349
390061	1.5366	0.9706	$24.4550	$25.5012	$28.4538	$26.1704
390062	1.1215	0.8933	$17.6303	$19.0692	$21.4052	$19.4592
390063	1.7830	0.8737	$21.7120	$23.5469	$24.7614	$23.4097
390065	1.2190	1.0802	$23.1384	$23.4021	$25.2188	$23.9720
390066	1.2758	0.9139	$21.7717	$23.0891	$24.2087	$23.0471
390067	1.8416	0.9308	$23.5136	$25.4576	$26.3287	$25.0668
390068	1.3355	0.9706	$21.1177	$25.9890	$25.8291	$24.3019
390070	1.3629	1.1028	$24.4403	$26.9235	$30.9499	$27.4435
390071	0.9938	0.8289	$17.8117	$20.9443	$21.8366	$20.0802
390072 [h]	1.0521	0.9834	$20.0561	$22.0155	$24.9388	$22.3043
390073	1.5860	0.8933	$22.7073	$24.8013	$26.3698	$24.6228
390074	1.1499	0.8832	$21.8456	$21.0941	$22.8545	$21.9412
390075	***	*	$19.9775	$22.6530	$24.6359	$22.3701
390076	1.3526	1.1028	$21.2039	$18.1276	$27.9004	$21.9007
390079	1.9205	0.8462	$19.9169	$21.4323	$23.3053	$21.5091
390080	1.2863	1.1028	$23.3742	$25.0921	$27.2616	$25.2851
390081	1.2261	1.1028	$28.1056	$28.7974	$30.3840	$29.1503
390084	1.2773	0.8289	$18.3551	$20.7799	$19.8605	$19.6630
390086	1.5753	0.8289	$19.6488	$20.7383	$22.5317	$20.9944
390090	1.8335	0.8832	$22.4688	$20.7474	$25.2014	$22.8601
390091	1.1481	0.8600	$19.7361	$20.8243	$21.5586	$20.7010
390093	1.1857	0.8832	$19.9209	$21.0427	$21.4401	$20.8186
390095	1.1983	0.9834	$18.3939	$21.0754	$23.6240	$20.9725
390096	1.5210	0.9888	$22.9502	$24.4145	$27.0763	$24.8874
390097	1.1981	1.1028	$24.5304	$25.3012	$25.6660	$25.2008
390100	1.7217	0.9706	$23.4155	$26.7267	$27.7208	$26.0717
390101	1.2600	0.9447	$20.1271	$20.1694	$21.9418	$20.7655
390102	1.3487	0.8832	$20.9807	$21.6629	$24.8898	$22.6239
390103	1.0148	0.8832	$21.0637	$18.6703	$20.6775	$20.1561
390104	1.0645	0.8289	$16.5081	$19.1803	$19.6428	$18.4897
390107	1.3834	0.8832	$21.5852	$23.1023	$24.1386	$23.0080
390108	1.2360	1.1028	$23.7842	$24.7486	$27.2661	$25.2833
390109	1.1285	0.9834	$17.2667	$18.7558	$19.9156	$18.6551
390110	1.6141	0.8832	$22.3968	$23.3355	$23.9808	$23.2737
390111	2.0277	1.1028	$30.5814	$30.6809	$32.6510	$31.3439
390112 [h]	1.2130	0.8340	$15.6710	$16.6113	$19.2126	$17.1537
390113	1.3094	0.8600	$20.1160	$21.7729	$22.2591	$21.3940
390114	1.3657	0.8832	$23.6162	$22.6630	$24.0473	$23.4341
390115	1.4597	1.1028	$24.1951	$26.4751	$27.7333	$26.1536
390116	1.2968	1.1028	$24.9581	$28.5563	$30.2722	$28.0177
390117	1.1039	0.8289	$19.0983	$20.0040	$20.3946	$19.8418

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
390118	1.1816	0.8289	$17.8460	$19.3332	$21.5001	$19.5328
390119	1.3011	0.9834	$20.3034	$21.2761	$22.2746	$21.3271
390121	1.6883	0.8933	$20.8017	$22.0556	$23.1408	$22.0024
390122	1.0995	0.8289	$18.5130	$21.6981	$22.5785	$20.8388
390123	1.2160	1.1028	$23.2232	$25.2209	$28.6269	$25.7365
390125	1.2682	0.8289	$18.2411	$19.4406	$20.9456	$19.5654
390127	1.3307	1.1028	$25.0836	$28.9238	$30.9374	$28.4999
390128	1.1938	0.8832	$21.3668	$21.8837	$23.1539	$22.1603
390130	1.2722	0.8352	$19.4835	$21.0694	$24.0685	$21.4556
390131	1.3078	0.8832	$19.5296	$21.2164	$22.6306	$21.1571
390132	1.4193	1.1028	$24.6889	$26.8153	$27.7250	$26.4427
390133	1.7317	1.1028	$25.2110	$26.1458	$28.7162	$26.7622
390135	***	*	$24.0445	*	$24.4738	$24.2670
390136	1.1143	0.8832	$21.9531	$24.8042	$22.1415	$22.9715
390137	1.4923	0.9834	$19.5457	$21.8830	$23.4877	$21.5609
390138	1.1914	1.0802	$21.4705	$22.7210	$24.2769	$22.8713
390139	1.3319	1.1028	$26.3622	$28.2089	$30.4246	$28.3708
390142	1.4938	1.1028	$29.8874	$32.0827	$32.5786	$31.5029
390145	1.5150	0.8832	$20.6580	$22.4255	$23.8041	$22.3138
390146	1.2524	0.8342	$21.4580	$22.3260	$25.2460	$23.0540
390147	1.2394	0.8832	$22.3135	$23.6380	$25.0971	$23.6939
390150	1.1849	0.8832	$20.0261	$24.5256	$24.1855	$22.9524
390151	1.2851	1.0802	$24.7843	$25.1422	$27.1539	$25.7127
390152	1.0043	*	$21.5474	$11.7774	*	$15.1275
390153	1.3870	1.1028	$25.3391	$27.5167	$30.0586	$27.7812
390154	1.2514	0.8289	$19.1300	$20.4408	$20.6982	$20.0794
390156	1.3762	1.1028	$25.0801	$27.8096	$31.2571	$28.0054
390157	1.3060	0.8832	$20.6933	$22.0222	$22.7493	$21.8431
390160	1.1894	0.8832	$19.3598	$19.5942	$21.4877	$20.1709
390162	1.4816	1.0034	$24.0291	*	$30.0900	$26.8901
390163	1.2734	0.8832	$18.8585	$19.8863	$22.1741	$20.2736
390164	2.1009	0.8832	$24.2334	$25.1277	$26.4971	$25.3882
390166	1.1601	0.8832	$19.8531	$20.9510	$24.9810	$21.8402
390168	1.4583	0.8832	$20.6777	$21.9344	$24.5820	$22.5085
390169	1.4280	0.9834	$22.7695	$24.1682	$27.2242	$24.7030
390173	1.1927	0.8289	$20.6958	$21.6562	$22.8220	$21.7639
390174	1.7358	1.1028	$28.4490	$30.3725	$32.6265	$30.5109
390176	1.1618	0.8832	$18.0752	$17.1387	*	$17.5532
390178	1.3036	0.8600	$17.2384	$19.2731	$20.7270	$19.1018
390179	1.3742	1.1028	$24.0501	$24.8350	$27.2222	$25.3975
390180	1.4593	1.1028	$28.4842	$30.4264	$32.4375	$30.5043
390181	1.0430	0.8289	*	$25.7357	$24.4573	$25.1039
390183	1.0924	0.8289	$21.6811	$22.0117	$25.6554	$23.0449
390184	1.0967	0.8832	$21.1962	$21.3407	$22.5519	$21.7060
390185	1.2794	0.9706	$20.4476	$21.8871	$23.0202	$21.7597
390189	1.1225	0.8289	$20.1365	$21.2711	$22.3722	$21.3477
390191	1.1066	0.8289	$18.5972	$19.2308	$20.8761	$19.5306
390192	1.0171	0.9834	$19.1883	$20.0395	$21.2620	$20.1833
390193	***	*	$18.9764	$18.5516	$20.1024	$19.2196
390194	1.1094	0.9834	$21.5850	$23.1814	$25.4235	$23.4479
390195	1.6530	1.1028	$26.2024	$28.3480	$31.0019	$28.5392
390196	1.6486	*	*	*	*	*
390197	1.4055	0.9834	$22.8349	$24.9234	$25.7739	$24.4854
390198	1.1833	0.8737	$17.3937	$16.8529	$18.7222	$17.6295
390199	1.2240	0.8289	$18.9787	$19.9653	$21.3157	$20.1079
390200	***	*	$19.4471	$23.1486	$23.7471	$21.9484
390201	1.3035	0.9416	$22.7849	$24.8222	$26.3658	$24.6735
390203	1.6417	1.1028	$26.9436	$28.2741	$28.9054	$28.0870
390204	1.2657	1.1028	$23.9673	$25.6342	$28.6829	$26.1129
390211	1.2873	0.8600	$21.0450	$22.4472	$23.1450	$22.2313
390215	***	*	$25.2617	$26.4180	$28.0402	$26.4046
390217	1.1598	0.8832	$21.4058	$21.3281	$24.3610	$22.3261
390219	1.3040	0.8832	$20.0594	$22.8559	$25.1705	$22.7113
390220	1.1030	1.1028	$23.4385	$24.7553	$41.6138	$28.9098
390222	1.2493	1.1028	$24.9345	$27.0954	$28.7488	$26.9594
390223	1.9327	1.1028	$22.8725	$28.2538	$27.6407	$26.2383
390224	0.8495	0.8462	$16.1289	$18.1226	$18.7624	$17.7120

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
390225	1.2019	0.9706	$20.9232	$23.4945	$24.9391	$23.3545
390226	1.7580	1.1028	$25.6917	$27.0061	$28.5890	$27.1866
390228	1.3366	0.8832	$21.0164	$22.5999	$23.3078	$22.3536
390231	1.4457	1.1028	$24.7757	$27.0576	$29.2653	$27.1070
390233	1.3679	0.9447	$21.8043	$22.8667	$24.8690	$23.1907
390235	***	*	$23.7068	*	*	$23.7068
390236	1.1484	0.8289	$19.8687	$21.9199	$21.9169	$21.2652
390237	1.5801	0.9834	$23.2054	$24.6316	$26.9533	$24.9348
390238	***	*	$19.2171	$26.4748	*	$22.5836
390246	1.1726	0.8289	$22.0687	$23.3275	$20.1581	$21.8667
390249	0.8825	*	$14.7215	*	*	$14.7215
390256	1.8708	0.9308	$22.6146	$24.2331	$26.3619	$24.4523
390258	1.5526	1.1028	$25.0634	$27.2038	$29.4626	$27.3466
390262	***	*	$21.3264	*	*	$21.3264
390263	1.4528	0.9834	$22.0008	$23.4202	$26.0170	$23.9015
390265	1.4641	0.8832	$20.5948	$21.6751	$23.4836	$21.9520
390266	1.1857	0.8600	$18.2424	$19.2836	$20.3918	$19.3171
390267	1.1960	0.8832	$21.4801	$22.5464	$23.1051	$22.3821
390268	1.3183	0.8360	$23.1124	$24.2050	$25.0021	$24.1351
390270	1.4784	0.9706	$22.5258	$24.0837	$24.1496	$23.6565
390272	0.5215	1.1028	*	*	*	*
390278	0.5505	1.1028	$21.1387	$21.6893	$23.6843	$22.1694
390279	1.1500	0.8360	$16.0510	$15.3569	$17.0012	$16.1304
390285	1.5470	1.1028	$30.6300	$33.5347	$35.0427	$33.0866
390286	1.1729	1.1028	$25.4499	$27.4090	$28.1761	$27.0003
390287	1.4347	1.1028	$32.9709	$35.7147	$37.6569	$35.5140
390288	***	*	$28.0957	$28.5267	$29.7287	$28.6956
390289	1.1071	1.1028	$25.1658	$28.4577	$28.8826	$27.4320
390290	1.9387	1.1028	$31.0967	$36.4991	$37.9040	$35.0787
390291	***	*	$21.0057	$21.3015	*	$21.1542
390294	***	*	$33.3537	*	*	$33.3537
390295	***	*	$26.8862	*	*	$26.8862
390296	***	*	$25.6981	*	*	$25.6981
390297	***	*	$25.7318	*	*	$25.7318
390298	***	*	*	$26.8290	*	$26.8290
390299	***	*	*	$31.9423	*	$31.9423
390300	***	*	*	$40.4697	*	$40.4697
390301	***	*	*	*	$30.9838	$30.9838
390304	1.1794	1.1028	*	*	*	*
390305	1.9433	0.8832	*	*	*	*
390306	1.7325	0.8832	*	*	*	*
390307	1.3440	0.8600	*	*	*	*
390308	0.8223	1.1028	*	*	*	*
390309	0.9254	1.1028	*	*	*	*
390310	2.3639	0.8289	*	*	*	*
400001	1.2690	0.4621	$11.7572	$16.1114	$13.1847	$13.4859
400002	1.7591	0.4939	$11.6804	$14.8607	$16.7583	$14.1458
400003	1.3684	0.4939	$10.5963	$13.0776	$12.8329	$12.1392
400004	1.1372	0.4621	$11.4041	$10.4716	$14.3108	$11.8780
400005	1.1239	0.4621	$10.5356	$10.2878	$10.7207	$10.5186
400006	1.1832	0.4621	$9.2852	$8.9919	$9.2265	$9.1710
400007	1.1869	0.4621	$8.6022	$8.7152	$9.2463	$8.8511
400009	1.1006	0.3183	$9.4413	$9.2007	$9.3116	$9.3159
400010	0.8274	0.4732	$9.2799	$10.9354	$10.0962	$10.0495
400011	1.0870	0.4621	$8.9111	$8.5868	$8.5534	$8.6726
400012	1.3561	0.4621	$9.0740	$8.3580	$8.3802	$8.5938
400013	1.3120	0.4621	$9.9905	$9.5584	$10.3347	$9.9727
400014	1.3286	0.4019	$11.4580	$11.7023	$12.2169	$11.7941
400015	1.3925	0.4621	*	$15.6066	$15.6349	$15.6221
400016	1.3523	0.4621	$14.6491	$15.3497	$14.7607	$14.9193
400017	1.2103	0.4621	$10.7475	$10.1238	$10.2734	$10.3916
400018	1.2290	0.4621	$10.8254	$10.7948	$11.6165	$11.0939
400019	1.3287	0.4621	$13.7007	$14.9892	$12.8029	$13.7525
400021	1.3231	0.4641	$13.5224	$13.8643	$14.1533	$13.8469
400022	1.3548	0.4939	$15.2904	$16.0539	$15.9246	$15.7672
400024	0.8431	0.4019	$9.8650	$9.1316	$12.4649	$10.2156
400026	1.0668	0.3183	$5.9206	$5.2085	$5.8200	$5.6501

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
400028	1.2118	0.4939	$9.5266	$10.3354	$10.9808	$10.2872
400032	1.2001	0.4621	$10.7100	$10.7195	$10.2652	$10.5650
400044	1.2951	0.4939	$9.0275	$10.7890	$13.7509	$11.4819
400048	1.1083	0.4621	$10.8618	$14.0887	$10.4266	$11.8488
400061	1.7198	0.4621	$16.5895	$15.1639	$18.9123	$16.8879
400079	1.1394	0.4732	$8.7218	$9.4218	$12.7825	$10.1505
400087	1.2148	0.4621	$10.7118	$9.5860	$10.6849	$10.3421
400094	***	*	$9.2871	$8.8646	*	$9.1244
400098	1.5611	0.4621	$13.8036	$13.7938	$12.8230	$13.4850
400102	1.1411	0.4621	$10.9973	$10.1795	$10.2677	$10.4779
400103	1.7278	0.4019	$11.5797	$12.8288	$9.3859	$10.9876
400104	1.1614	0.4621	$7.1781	$8.2758	$9.3854	$8.1476
400105	1.1409	0.4621	$11.5608	$12.7725	$14.0219	$12.7229
400106	1.1978	0.4621	$10.1241	$9.6902	$11.4507	$10.3951
400109	1.4855	0.4621	$12.8921	$14.2169	$14.2111	$13.7444
400110	1.1119	0.4408	$12.0159	$11.8458	$12.3449	$12.0750
400111	1.0818	0.4732	$12.7701	$13.4777	$14.5029	$13.5496
400112	1.2190	0.4621	$12.2859	$8.9469	$19.3945	$12.3541
400113	1.2194	0.4939	$10.4416	$10.0830	$9.6778	$10.1179
400114	1.0966	0.4621	$9.7444	$12.1920	$11.5478	$11.0784
400115	1.1336	0.4621	$7.0411	$9.1132	$13.7392	$9.2213
400117	1.1139	0.4621	$9.7314	$10.2911	$12.7600	$10.8102
400118	1.2358	0.4621	$12.4590	$11.9324	$12.5743	$12.3218
400120	1.3171	0.4621	$11.8837	$11.9714	$12.7955	$12.2196
400121	1.0708	0.4621	$8.3575	$8.6665	$8.2197	$8.4118
400122	1.9324	0.4621	$9.6644	$9.6463	$11.2325	$10.1283
400123	1.2113	0.4019	$10.5643	$11.8135	$12.3041	$11.5735
400124	2.8401	0.4621	$14.3496	$17.2258	$16.1812	$15.8787
400125	1.1372	0.4156	$10.6642	$10.7425	$11.6386	$11.0069
400126	1.2124	0.4641	*	$13.3932	$9.8008	$11.0632
400127	2.2229	0.4621	*	*	*	*
410001	1.3175	1.1274	$24.0033	$27.0309	$28.0816	$26.3767
410004	1.2352	1.1274	$23.6409	$25.4578	$27.4209	$25.5908
410005	1.2881	1.1274	$24.6522	$27.1171	$30.1606	$27.3044
410006	1.2547	1.1274	$26.1372	$27.1842	$29.4395	$27.6190
410007	1.7162	1.1274	$27.7171	$30.1360	$31.8548	$30.0135
410008	1.2160	1.1274	$25.4183	$28.4245	$29.6092	$27.8277
410009	1.2898	1.1274	$26.9135	$27.7337	$29.4094	$28.0697
410010	1.1690	1.1734	$30.3860	$30.7826	$32.8599	$31.3979
410011	1.3123	1.1274	$29.7664	$28.5875	$30.3787	$29.5538
410012	1.7743	1.1274	$28.1791	$32.1679	$32.6009	$31.1120
410013	1.2336	1.1274	$28.9386	$31.7482	$35.4624	$32.1157
420002	1.5354	0.9707	$25.1067	$27.9312	$28.2848	$27.1910
420004	1.9995	0.9240	$23.4579	$26.0279	$27.2620	$25.6238
420005	1.0201	0.8660	$19.5521	$19.8167	$23.1943	$20.8182
420006	1.0887	0.9240	$22.7896	$22.8920	$24.0811	$23.2220
420007	1.5955	0.9175	$22.0228	$25.0395	$25.2650	$24.2318
420009	1.3854	0.9702	$18.6866	$23.8668	$25.5079	$22.5621
420010	1.1980	0.8971	$19.1746	$21.6478	$23.4562	$21.5057
420011	1.1292	1.0001	$17.7300	$20.8895	$21.4030	$20.0081
420014	0.9681	*	$21.2045	$21.5658	*	$21.3876
420015	1.2696	1.0001	$23.1274	$24.7383	$26.2154	$24.7258
420016	0.9673	0.8660	$17.0051	$17.3837	$17.1229	$17.1752
420018	1.7687	0.9067	$20.4649	$23.6356	$24.8024	$22.8926
420019	1.1234	0.8660	$19.6836	$20.5472	$22.5312	$20.8812
420020	1.2759	0.9240	$22.1616	$24.6592	$25.8883	$24.3667
420023	1.6656	1.0001	$23.2568	$25.1035	$26.7263	$25.0152
420026	1.8862	0.9067	$23.7406	$29.2961	$27.4814	$26.8241
420027	1.5766	0.9198	$21.0637	$22.8322	$25.1692	$23.0401
420030	1.2300	0.9240	$22.6766	$24.2847	$26.0079	$24.3704
420033	1.1298	1.0001	$26.2711	$27.5740	$31.8759	$28.5975
420036	1.2584	0.9577	$20.6649	$21.9641	$22.8294	$21.8110
420037	1.2615	1.0001	$25.5492	$26.8750	$29.4156	$27.3838
420038	1.2639	1.0001	$21.6133	$22.6741	$24.2259	$22.8531
420039	1.0432	0.9174	$21.9737	$24.0637	$25.1148	$23.7048
420043 [h]	1.0874	0.9351	$21.8816	$22.9764	$23.0555	$22.6545
420048	1.2709	0.9067	$21.9517	$23.1515	$24.1923	$23.1348

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
420049	1.2340	0.8929	$21.2604	$23.2156	$23.9722	$22.8399
420051	1.5014	0.8971	$20.6629	$23.9455	$24.8026	$23.1828
420053	1.1649	0.8660	$19.9013	$21.1177	$22.2825	$21.1778
420054	1.0290	0.8660	$20.8471	$24.0653	$24.8931	$23.2676
420055	1.0770	0.8660	$19.6817	$20.3599	$21.9764	$20.6871
420056	1.4078	0.8660	$20.0527	$21.1640	$21.6963	$20.9682
420057	1.0461	0.8971	$17.6727	$19.7653	$23.4311	$20.1207
420059	1.0686	*	$20.2917	$21.4260	*	$20.8684
420061	1.1331	*	$19.9789	$20.8684	*	$20.4341
420062	1.1085	0.8660	$17.4764	$25.6683	$25.9526	$22.5339
420064	1.2023	0.8929	$20.9057	$22.1290	$23.3610	$22.2043
420065	1.3680	0.9240	$22.0784	$22.8674	$24.5715	$23.1699
420066	0.9805	0.8971	$20.7782	$20.5893	$23.9048	$21.7523
420067	1.2989	0.9300	$22.8104	$24.6038	$25.0345	$24.2301
420068	1.3586	0.9240	$21.7257	$22.2638	$23.4248	$22.4620
420069	1.0761	0.8660	$17.6291	$19.6959	$20.5546	$19.3217
420070	1.2782	0.9067	$20.3664	$22.4370	$23.4355	$22.1331
420071	1.3654	0.9702	$21.8579	$23.1727	$24.9418	$23.3888
420072	1.1026	0.8660	$16.2578	$17.5899	$18.6742	$17.5511
420073	1.3501	0.9067	$21.4718	$24.0274	$24.5813	$23.3018
420074	***	*	$18.7010	*	*	$18.7010
420075	0.8901	*	$15.9889	$16.4816	*	$16.2328
420078	1.8173	1.0001	$24.3273	$25.3032	$28.9112	$26.1920
420079	1.171	0.9240	$23.3992	$25.2939	$25.4935	$24.7672
420080	1.3906	0.9300	$26.7489	$28.4569	$28.4734	$27.9158
420082	1.4934	0.9751	$23.6936	$26.1221	$29.8528	$26.5169
420083	1.3637	0.9175	$24.8508	$25.3043	$27.1322	$25.7973
420085	1.6439	0.9384	$24.4040	$25.3180	$26.8692	$25.5532
420086	1.4056	0.9067	$24.5760	$25.1372	$25.8869	$25.2138
420087	1.7921	0.9240	$22.4526	$23.2230	$24.3609	$23.3441
420088	***	*	$23.5174	$23.1273	*	$23.4240
420089	1.3993	0.9240	$23.3240	$25.2729	$26.0074	$24.9015
420091	1.3155	0.8971	$23.7936	$23.4710	$26.9214	$24.8118
420093	0.9962	0.9175	$21.4678	$25.1457	$27.4766	$24.8258
420097	***	*	*	$24.7809	*	$24.7809
420098	1.1527	0.8695	*	*	*	*
420099	1.5769	1.0001	*	*	*	*
430005	1.2246	0.8993	$18.2647	$19.9454	$22.3272	$20.0877
430008 [2]	1.1187	0.9607	$20.0124	$20.9442	$23.3790	$21.4251
430011	1.2454	*	$19.9835	$20.6597	*	$20.3142
430012	1.2783	0.9607	$21.2588	$22.7530	$24.0850	$22.7129
430013 [2]	1.1798	0.9607	$21.3389	$22.9675	$25.1378	$23.1495
430014	1.2591	0.8769	$22.0285	$25.5387	$26.4964	$24.6896
430015	1.1287	0.9607	$20.5849	$23.2035	$22.7947	$22.1979
430016	1.5924	0.9607	$24.2450	$26.1495	$27.8453	$26.0153
430018	***	*	$17.9850	*	*	$17.9850
430023	***	*	$18.8816	*	*	$18.8816
430024	***	*	$18.8357	*	*	$18.8357
430027	1.7822	0.9607	$22.1807	$23.8477	$26.2139	$24.1495
430029	0.9023	*	$18.9464	$20.2708	*	$19.6526
430031 [2]	0.9381	0.9607	$15.2321	$15.6112	$16.0346	$15.6358
430033	***	*	$21.6254	*	*	$21.6254
430043	1.1653	*	$17.9672	$17.2722	*	$17.5904
430047	0.9900	0.8551	$18.2774	$21.9116	$18.8982	$19.7432
430048	1.2446	0.9607	$20.0607	$21.1718	$23.0783	$21.5127
430054	0.9435	*	$17.8871	*	*	$17.8871
430060	0.8286	0.9607	$10.6492	$10.2704	*	$10.4542
430064	1.0479	0.9607	$14.3407	$16.4314	$17.5376	$16.1075
430077	1.7069	0.9607	$21.6786	$23.4835	$25.1763	$23.4802
430081	0.8933	1.4448	*	*	*	*
430082	0.7728	1.4448	*	*	*	*
430083	0.8284	1.4448	*	*	*	*
430084	0.7621	1.4448	*	*	*	*
430085	0.8598	1.4448	*	*	*	*
430089	1.6477	0.9365	$19.8572	$21.1109	$22.5625	$21.3078
430090	1.4231	0.9607	$25.6873	$26.0851	$25.8460	$25.8845
430091	2.6720	0.9607	$22.2824	$23.8897	$24.3021	$23.6064

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
430092	1.8040	0.8551	$19.7354	$20.2570	$20.9486	$20.3194
430093	0.9288	0.8993	$23.8820	$23.1526	$29.5244	$25.7876
430094	1.8192	0.9249	$20.8743	$18.5429	$18.9099	$19.3880
430095	2.3466	0.9607	*	$24.7074	$28.1749	$26.5823
430096	1.9928	0.8551	*	*	$21.6998	$21.6998
440001	1.1332	0.8003	$18.9833	$17.4802	$19.3100	$18.5533
440002	1.6950	0.8955	$22.0178	$23.2177	$24.6664	$23.3294
440003	1.2221	0.9731	$21.6336	$24.5168	$25.9209	$24.0777
440006	1.4174	0.9731	$24.3173	$26.7983	$28.5951	$26.6300
440007	0.9582	0.8003	$14.8015	$13.7042	$25.8236	$17.2437
440008	1.0035	0.8499	$20.9237	$22.1405	$23.4301	$22.0908
440009	1.1945	0.8003	$19.6564	$21.1274	$21.5970	$20.8327
440010	0.9504	0.8003	$16.7270	$16.9060	$17.1803	$16.9489
440011	1.3104	0.8456	$20.5036	$21.6861	$22.5068	$21.6145
440012	1.4955	0.8087	$21.1213	$21.4769	$22.3029	$21.6368
440015	1.8835	0.8456	$23.4485	$22.5583	$23.7422	$23.2495
440016	0.9765	0.8003	$20.1504	$20.0982	$22.1646	$20.8341
440017	1.8069	0.8087	$21.8033	$22.5313	$22.9364	$22.4333
440018	1.1381	0.8003	$21.2242	$21.7239	$23.3444	$22.1229
440019	1.8078	0.8456	$21.8854	$23.8802	$25.2553	$23.6676
440020	1.0621	0.9120	$21.1075	$23.1718	$23.9475	$22.7656
440023	0.9577	*	$15.5410	$17.0335	*	$16.3078
440024	1.2491	0.8544	$19.9751	$20.3658	$23.2716	$21.1545
440025	1.1929	0.8003	$19.1478	$19.5995	$20.6798	$19.8282
440026	***	*	$25.1655	$26.9149	$26.8986	$26.2876
440029	1.3437	0.9731	$24.1379	$25.8538	$28.0779	$26.0679
440030	1.2605	0.8059	$19.9056	$20.0586	$22.1217	$20.7764
440031	1.0756	0.8003	$17.0289	$18.0944	$19.6685	$18.2797
440032	1.0233	0.8087	$14.7683	$16.0734	$18.5277	$16.4708
440033	1.0557	0.8003	$17.2637	$18.7749	$20.7917	$19.0076
440034	1.5382	0.8456	$22.2478	$23.1121	$23.5403	$22.9348
440035	1.3499	0.9450	$21.4990	$22.3230	$24.3752	$22.7486
440039	2.0662	0.9731	$25.0874	$26.4647	$28.4678	$26.7675
440040	0.9282	0.8003	$16.9886	$17.7647	$17.8510	$17.5455
440041	0.9443	0.8157	$15.5784	$17.4074	$17.9409	$17.0933
440046	1.1465	0.9731	$22.3380	$25.5329	$26.1341	$24.7333
440047	0.8634	0.8502	$18.7962	$20.4812	$21.4280	$20.2387
440048	1.8493	0.9402	$23.1553	$24.3283	$27.7560	$24.7999
440049	1.5710	0.9402	$21.1930	$22.9755	$25.3043	$23.1991
440050	1.2761	0.9303	$21.1397	$21.8972	$23.1362	$22.0679
440051	0.9475	0.8003	$19.0165	$20.7948	$21.9108	$20.5095
440052	0.9672	0.8003	$18.1935	$20.1875	$21.1133	$19.9032
440053	1.2173	0.9731	$22.0345	$23.9083	$25.4345	$23.8916
440054	1.1288	0.8003	$15.4208	$20.5992	$21.4400	$18.6411
440056	1.1377	0.8324	$19.3108	$20.4088	$22.1068	$20.7270
440057	1.0437	0.8003	$14.1477	$14.6242	$16.4451	$15.0915
440058	1.1803	0.9089	$21.7512	$22.6014	$22.9263	$22.4470
440059	1.5233	0.9450	$22.4248	$23.9301	$26.3551	$24.2545
440060	1.0246	0.8790	$20.2189	$22.7133	$23.3014	$22.1119
440061	1.0985	0.8003	$19.5458	$21.2085	$21.8274	$20.8215
440063	1.6296	0.8014	$19.7468	$21.8578	$22.3256	$21.2848
440064	0.9994	0.9089	$19.4020	$20.9742	$22.0955	$20.8374
440065	1.2298	0.9731	$19.9099	$21.4794	$22.3247	$21.2895
440067	1.1868	0.8456	$19.5643	$22.1410	$23.1089	$21.6500
440068	1.1520	0.9089	$20.9188	$23.1705	$24.5971	$22.9451
440070	0.9587	0.8003	$18.3717	$19.0240	$19.4372	$18.9540
440072	1.2012	0.9148	$19.6579	$20.9294	$27.1443	$22.1374
440073	1.3695	0.9450	$20.7181	$22.2959	$23.9198	$22.3108
440081 [h]	1.1519	0.8456	$18.3141	$19.0328	$19.7878	$19.0770
440082	2.1876	0.9731	$26.1497	$28.7828	$27.9724	$27.6484
440083	0.9129	0.8003	$15.7015	$16.0956	$17.3329	$16.4160
440084	1.1715	0.8003	$15.0510	$15.2825	$16.3738	$15.6128
440091	1.6425	0.9089	$23.0296	$26.1122	$25.6797	$24.9494
440102	1.1396	0.8003	$16.6548	$17.5140	$17.5261	$17.2560
440104	1.7869	0.9089	$21.9870	$23.3731	$25.3739	$23.6244
440105	1.0319	0.8014	$19.2902	$20.7821	$22.3438	$20.8223
440109	0.9845	0.8003	$17.3578	$18.2508	$18.6720	$18.1156

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
440110	1.1814	0.8456	$19.9715	$20.9039	$21.3287	$20.7233
440111	1.2601	0.9731	$24.9883	$25.8821	$28.5705	$26.5016
440114	1.0019	0.8526	$20.1152	$21.4271	$24.0147	$21.9369
440115	0.9887	0.8502	$18.5389	$20.0642	$21.7830	$20.1587
440120	1.5911	0.8456	$22.4031	$23.9003	$25.5961	$24.0224
440125	1.5944	0.8456	$21.1018	$21.9337	$22.4196	$21.8367
440130	1.1680	0.8003	$20.6363	$21.6480	$23.4517	$21.9020
440131	1.2349	0.9402	$21.0640	$22.4119	$24.9598	$22.8950
440132	1.2816	0.8003	$18.9580	$20.5716	$21.5085	$20.3655
440133	1.5916	0.9731	$23.3600	$27.5019	$26.2422	$25.6963
440135	1.1005	0.8003	$23.9749	$25.3928	$26.6615	$25.3742
440137	1.0626	0.8003	$16.5529	$18.2073	$20.6663	$18.4329
440141	0.9580	0.8003	$19.2607	$19.4528	$21.3313	$20.0578
440142	0.8635	*	$17.7587	*	*	$17.7587
440143	0.9934	*	$19.2978	$21.0374	*	$20.1684
440144	1.2202	0.8003	$19.7938	$22.3671	$23.3828	$21.8222
440145	0.9884	0.8003	$18.2019	$20.9863	$20.7875	$19.9424
440147	***	*	$25.0780	$28.9038	$31.4012	$28.2938
440148	1.1331	0.9450	$20.7693	$23.0697	$24.6412	$22.8692
440149	1.0249	*	$18.1316	$19.8020	$20.4562	$19.4498
440150	1.3918	0.9731	$22.8733	$25.4952	$26.8308	$25.0868
440151	1.0949	0.9450	$21.1576	$23.3037	$23.9808	$22.8559
440152	1.8872	0.9402	$22.7498	$25.9495	$26.5513	$25.0265
440153	1.0214	0.8010	$19.9486	$22.7744	$22.2846	$21.7049
440156	1.5036	0.9089	$23.7799	$25.6333	$26.9689	$25.5243
440159	1.4437	0.9402	$20.5719	$21.1073	$22.8645	$21.5659
440161	1.8166	*	$26.1354	$28.6774	*	$27.4329
440162	***	*	$20.3909	$16.5305	$21.1418	$19.2406
440166	1.5652	0.9402	$23.1692	$27.1355	$31.0779	$26.9641
440168	0.9909	0.9402	$21.2113	$22.1764	$22.8768	$22.0809
440173	1.6518	0.8456	$20.8442	$20.8723	$22.8846	$21.5657
440174	0.8859	0.8375	$19.2201	$20.7960	$22.0974	$20.6472
440175	1.0647	0.9450	$22.3331	$24.0005	$22.7299	$23.0174
440176	1.3041	0.8087	$20.4861	$22.0079	$23.6659	$22.0556
440180	1.2186	0.8456	$21.2398	$21.9781	$23.3808	$22.2150
440181	0.9292	0.8410	$19.6133	$21.1406	$22.7150	$21.1984
440182	0.9320	0.8003	$19.3928	$20.2630	$22.3612	$20.6845
440183	1.5539	0.9402	$24.9282	$27.7769	$27.1515	$26.6633
440184	1.0116	0.8014	$21.4484	$20.8219	$22.3475	$21.5303
440185	1.1665	0.9089	$22.1845	$23.4172	$23.9052	$23.2612
440186	1.0410	0.9731	$23.0193	$24.6773	$25.7445	$24.4615
440187	1.0873	0.8003	$19.9478	$21.7637	$21.3252	$21.0131
440189	1.3710	0.8955	$23.2866	$24.7851	$27.5435	$25.2579
440192	1.0294	0.9450	$21.3228	$25.1119	$25.7495	$24.1386
440193	1.2635	0.9731	$22.0345	$24.3911	$24.4299	$23.6341
440194	1.3815	0.9731	$24.4508	$26.2498	$26.6527	$25.8291
440197	1.2847	0.9731	$24.2660	$26.4999	$27.1534	$25.9812
440200	0.9486	0.9731	$16.7752	$17.0633	$17.7491	$17.1850
440203	0.9834	0.8003	*	$17.7639	$19.3864	$18.5423
440217	1.4086	0.9402	$23.3544	$25.9667	$28.5968	$26.1820
440218	0.8896	0.9731	$20.1377	$26.3741	$24.6465	$23.5719
440220	***	*	$21.9117	*	*	$21.9117
440222	0.9594	0.9402	*	$28.3879	$29.7292	$29.0585
440225	0.8471	0.8456	*	*	*	*
440226	1.5354	0.8456	*	*	*	*
440227	1.1936	0.9731	*	*	*	*
440228	1.1074	0.9402	*	*	*	*
450002	1.4467	0.9007	$24.0411	$25.4975	$25.7171	$25.1126
450005	1.0676	0.8413	$21.7110	$23.4049	$23.5576	$22.9913
450007	1.3321	0.8978	$18.3738	$19.2875	$20.7321	$19.4904
450008	1.3155	0.8557	$20.1816	$22.0934	$22.9669	$21.7810
450010	1.5300	0.8936	$20.3023	$22.4133	$23.7529	$22.1525
450011	1.7085	0.8902	$22.1472	$24.1576	$24.8831	$23.7448
450014	1.0361	*	$20.6936	$22.5001	*	$21.5732
450015	1.5818	1.0222	$23.9526	$24.0730	$27.4012	$25.2046
450016	***	*	$20.1232	$22.1368	*	$21.1548
450018	1.3937	0.9996	$22.9019	$24.6443	$26.7999	$24.7633

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
450020	0.9512	0.9439	$19.1087	$17.7148	$18.3047	$18.3252
450021	1.8322	1.0222	$25.0769	$28.5578	$29.1350	$27.5806
450023	1.4131	0.8140	$19.1645	$20.9278	$22.0558	$20.7053
450024	1.3715	0.9007	$20.7727	$22.4178	$24.4195	$22.4300
450028	1.6020	0.9835	$22.7775	$25.6030	$26.8250	$25.1270
450029	1.5255	0.8093	$19.9198	$23.9709	$23.2995	$22.4069
450031	1.4886	1.0222	$21.7621	$27.0328	$27.9626	$25.5466
450032	1.2211	0.8758	$20.5217	$20.8306	$27.0748	$22.7202
450033	1.6042	0.9835	$26.5990	$29.0541	$28.4781	$28.0809
450034	1.5499	0.8413	$21.6097	$23.4615	$24.1589	$23.0888
450035	1.5349	0.9996	$24.1860	$25.4580	$26.2838	$25.3196
450037	1.5164	0.8732	$23.1179	$23.1176	$24.2684	$23.5229
450039	1.3931	0.9938	$22.0058	$23.3034	$24.7347	$23.3847
450040	1.7554	0.8781	$21.2990	$23.8047	$24.9590	$23.3165
450042	1.7420	0.8523	$21.8886	$22.6936	$24.1181	$22.9317
450044	1.6814	1.0222	$24.1127	$25.8403	$29.4308	$26.5654
450046	1.5707	0.8549	$20.9239	$22.0695	$23.4907	$22.1959
450047	0.8608	0.9835	$21.8840	$22.7242	$19.8221	$21.4269
450050	0.9394	0.8803	$19.5171	$21.6933	$23.3044	$21.3893
450051	1.7951	1.0222	$24.5533	$27.2523	$28.0411	$26.6907
450052	0.9735	0.8053	$17.6543	$19.7185	$19.7774	$19.2138
450053	0.9596	0.8053	$18.6556	$19.4978	$21.9082	$20.0823
450054	1.6766	0.8557	$23.2915	$25.1229	$24.2782	$24.2283
450055	1.1336	0.8053	$18.2235	$20.5235	$22.1979	$20.3131
450056	1.7962	0.9439	$24.4197	$25.6685	$27.0530	$25.7808
450058	1.5442	0.8978	$22.0158	$24.7442	$25.9653	$24.1658
450059	1.3265	0.9439	$22.8792	$26.8209	$26.6535	$25.4407
450064	1.4250	0.9938	$19.1271	$24.2920	$23.8748	$22.4752
450068	2.0373	0.9996	$24.0925	$26.2864	$27.9633	$26.1666
450072	1.1689	0.9996	$20.3683	$22.5010	$24.0166	$22.2336
450073	0.9446	0.8053	$19.2398	$20.0464	$21.7337	$20.3411
450076	1.6909	*	*	*	*	*
450078	0.9333	0.8053	$14.8285	$17.2196	$15.8968	$15.9697
450079	1.5644	1.0222	$24.0085	$27.0443	$28.1096	$26.3674
450080	1.1870	0.8612	$21.0353	$21.2482	$22.9835	$21.7735
450081	1.0552	*	$19.2632	*	*	$19.2632
450082	1.1437	0.8053	$16.6566	$20.9113	$22.0442	$19.8834
450083	1.7669	0.9182	$22.5063	$24.9182	$25.8214	$24.4447
450085	1.0245	0.8053	$18.1922	$19.4524	$22.0840	$19.8958
450087	1.3515	0.9938	$24.5976	$26.4203	$29.1587	$26.8455
450090	1.1590	0.8053	$17.1073	$17.6506	$19.4244	$18.0792
450092	1.1484	0.8053	$16.0199	$20.4921	$23.2071	$19.7031
450094	1.1039	1.0222	$25.8313	$25.3618	$25.2434	$25.4570
450096	1.3896	0.8413	$19.8012	$22.8722	$24.1619	$22.3082
450097	1.4324	0.9996	$22.2467	$24.9380	$26.4965	$24.6105
450098	0.9304	0.8612	$20.4795	$22.9005	$22.6626	$21.9800
450099	1.1823	0.9156	$21.4482	$24.0293	$26.6796	$24.1168
450101	1.5906	0.8523	$20.1473	$20.6575	$23.6905	$21.4670
450102	1.7381	0.9182	$20.9900	$23.1773	$24.5503	$22.9587
450104	1.1789	0.8978	$19.7126	$22.5165	$23.8469	$22.0194
450107	1.4555	0.9007	$23.2209	$23.8770	$25.9326	$24.3252
450108	1.1169	0.8978	$18.8084	$19.3561	$19.4935	$19.2181
450109	***	*	$15.1459	*	*	$15.1459
450112	***	*	$20.2627	$22.5552	*	$21.2999
450113	***	*	$37.8944	*	$54.6681	$43.1390
450119	1.3114	0.8936	$20.8840	$24.1392	$25.7008	$23.6793
450121	1.4809	0.9938	$24.6090	$25.8826	$25.7051	$25.4063
450123	1.1197	0.8413	$17.8629	$19.5872	$21.2154	$19.5002
450124	1.7951	0.9439	$24.2788	$26.0280	$27.4198	$26.0262
450126	1.3686	0.9996	$24.1961	$27.3021	$28.3033	$26.6832
450128	1.2540	0.8936	*	$21.4190	$23.3633	$22.3457
450130	1.1901	0.8978	$19.6199	$20.2777	$21.5226	$20.5273
450131	1.2257	0.8549	$20.0434	$23.2317	$23.7098	$22.3750
450132	1.5577	0.9883	$22.4680	$26.8476	$28.6954	$25.9595
450133	1.5553	0.9513	$25.3928	$25.0972	$26.8344	$25.8308
450135	1.6939	0.9938	$22.5673	$24.3858	$26.0755	$24.4084
450137	1.6171	0.9938	$24.9732	$27.0081	$30.4254	$27.6976

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
450140	0.8931	*	$18.3835	$22.4695	*	$20.3190
450143	1.0532	0.9439	$18.4204	$19.7487	$21.8705	$20.0996
450144	1.1763	0.9584	$21.3896	$20.9599	$21.3289	$21.2289
450146	***	*	$16.6808	*	*	$16.6808
450147	1.4066	0.8140	$21.7248	$24.6203	$23.9771	$23.5121
450148	1.1628	0.9938	$22.1351	$23.5037	$25.3498	$23.7382
450151	1.1936	0.8053	$17.9127	$20.1356	$22.2915	$20.0948
450152	1.1967	0.8557	$20.0146	$21.6351	$22.7463	$21.4376
450154	1.2820	0.8053	$16.5204	$18.6058	$21.2021	$18.7210
450155	1.0357	0.8053	$18.4021	$17.9306	$18.0589	$18.1275
450157	1.0122	*	$17.8764	$17.8812	*	$17.8788
450160	0.9342	*	$20.7736	$21.9118	*	$21.3607
450162	1.3737	0.8781	$26.0570	$31.0645	$30.9903	$29.3951
450163	0.9859	0.8187	$19.8194	$20.3280	$23.1400	$21.0903
450165	1.1629	0.8978	$16.1632	$20.2414	$24.3242	$20.2279
450176	1.3413	0.8936	$19.1823	$20.9392	$20.9297	$20.4107
450177	1.2063	0.8053	$17.2637	$19.7657	$21.3322	$19.4690
450178	0.9765	0.8053	$19.1186	$20.2992	$24.7301	$21.2492
450184	1.5408	0.9996	$24.0596	$25.3935	$26.7821	$25.4743
450185	0.9850	*	$14.3594	$15.5838	*	$14.9644
450187	1.1679	0.9996	$22.6275	$24.2400	$25.6786	$24.2306
450188	0.9332	0.8053	$17.6158	$18.9586	$20.4070	$19.0169
450191	1.1357	0.9439	$23.2261	$25.9078	$26.0298	$25.1584
450192	1.0946	0.9938	$20.1718	$22.5118	$22.5880	$21.7848
450193	2.0472	0.9996	$26.6580	$29.2751	$32.2964	$29.4595
450194	1.3374	0.9938	$22.7310	$22.3348	$24.8972	$23.2572
450196	1.4229	0.9938	$20.1938	$23.6170	$24.7557	$23.2376
450200	1.4551	0.8285	$20.4656	$22.0923	$23.5344	$22.0868
450201	0.9302	0.8053	$19.5907	$20.3350	$20.9809	$20.3028
450203	1.1740	0.9491	$22.9226	$23.3953	$24.1675	$23.5222
450209	1.9039	0.9156	$23.4794	$24.4977	$26.0958	$24.6956
450210	0.9631	0.8053	$16.7851	$19.6340	$19.9832	$18.8463
450211	1.3504	0.9996	$20.0280	$20.7982	$23.8230	$21.4806
450213	1.7973	0.8978	$21.1280	$21.7930	$23.9676	$22.3693
450214	1.1786	0.9996	$22.4543	$23.9112	$25.9598	$24.1177
450219	0.9891	0.8053	$21.0691	$20.8255	$21.7934	$21.2690
450221	1.1410	0.8053	$19.6778	$20.6887	$20.3186	$20.2506
450222	1.5793	0.9996	$23.5033	$26.2975	$27.4426	$25.8797
450224	1.3957	0.9030	$20.4453	$22.2250	$24.1956	$22.3315
450229	1.6507	0.8053	$17.9811	$19.8279	$21.4459	$19.7433
450231	1.6179	0.9156	$21.3086	$23.9532	$25.2852	$23.5313
450234	0.9864	0.8053	$22.3954	$23.6695	$18.4451	$21.2354
450235	0.9187	0.8053	$18.7028	$19.1453	$21.5138	$19.8415
450236	1.0511	0.8053	$17.7373	$19.2987	$22.0788	$19.5556
450237	1.6849	0.8978	$22.4477	$25.1504	$24.8901	$24.1935
450239	0.9333	0.8557	$19.3655	$21.8595	$21.1945	$20.7705
450241	0.9526	0.8053	$17.4151	$18.1155	$18.7957	$18.0879
450243	1.0082	0.8053	$13.0790	$14.0589	$15.4636	$14.1605
450249	0.9883	*	$13.1222	$16.5616	*	$14.7712
450250	***	*	$13.3731	*	*	$13.3731
450253	0.9826	0.9996	$16.6523	$19.6379	$20.6124	$18.9496
450264	0.9237	*	$13.5345	$15.4111	*	$14.4829
450269	1.0284	*	$12.6907	$14.8204	*	$13.7206
450270	1.0833	0.8053	$13.9053	$15.0879	$14.4325	$14.4468
450271	1.1604	0.9491	$18.3659	$19.4299	$21.7719	$19.9620
450272	1.2055	0.9439	$21.4520	$23.7933	$25.7392	$23.6800
450276	0.9069	*	$12.8895	$16.0264	$16.6319	$15.2952
450280	1.5459	1.0222	$23.1664	$27.4523	$28.7233	$26.4522
450283	1.0663	0.9938	$17.1013	$20.0069	$20.9680	$19.5520
450289	1.3250	0.9996	$23.7108	$27.3864	$28.5665	$26.5635
450292	1.3344	1.0222	$23.4257	$23.5330	$25.0411	$24.0121
450293	0.8831	0.8053	$17.7673	$20.0898	$21.3136	$19.7647
450296	1.0732	0.9996	$20.4483	$29.2006	$27.9690	$25.4406
450299	1.5904	0.8902	$22.9849	$25.8183	$26.4933	$25.0990
450303	0.8440	*	$16.1330	*	*	$16.1330
450306	0.9365	0.8053	$17.6821	$14.6699	$15.9854	$15.8111
450315	***	*	$26.4677	$27.9780	*	$27.2229

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
450320	***	*	$26.8089	*	*	$26.8089
450324	1.5419	0.9509	$23.8523	$23.6362	$24.9128	$24.1611
450327	***	*	$14.3848	*	*	$14.3848
450330	1.2220	0.9996	$22.9947	$24.4310	$25.5820	$24.4245
450340	1.3912	0.8279	$20.0621	$22.7826	$24.0636	$22.3350
450346	1.4004	0.8413	$20.1921	$21.9717	$22.2469	$21.4909
450347	1.1459	0.9996	$21.7142	$22.8133	$27.2203	$23.9176
450348	0.9913	0.8053	$15.6324	$17.0198	$18.7675	$17.1642
450351	1.2263	0.9491	$22.2597	$23.5895	$25.6859	$23.9245
450352	1.1316	1.0222	$21.8138	$23.4297	$24.8012	$23.3447
450353	1.2847	0.8053	$19.5263	$20.9271	$24.4454	$21.5974
450358	2.0232	0.9996	$25.9105	$29.3408	$30.4280	$28.6741
450362	0.9914	0.8539	$20.6340	$22.0223	$25.4372	$22.7898
450369	1.0154	0.8053	$16.5636	$17.5360	$18.4848	$17.6077
450370	1.1827	0.8311	$19.0340	$22.6815	$20.0832	$20.4877
450371	***	*	$17.3415	*	*	$17.3415
450372	1.3217	1.0222	$22.9079	$26.8019	$28.3359	$26.0630
450373	0.9098	0.8053	$17.7955	$20.5789	$22.2213	$20.1017
450374	0.9226	0.8053	$15.0670	$17.4509	$23.2285	$18.2702
450378	1.3660	0.9996	$25.8048	$29.5108	$30.7684	$28.7797
450379	1.3962	1.0222	$29.0865	$31.1573	$30.6072	$30.3060
450381	0.9383	0.9439	$19.0584	$20.9200	$22.0482	$20.7572
450388	1.6677	0.8978	$22.4441	$24.1598	$25.8674	$24.3854
450389	1.1979	0.9938	$20.7160	$22.3803	$23.8764	$22.4221
450393	***	*	$23.8237	$24.6872	$18.4551	$22.6427
450395	1.0292	0.8537	$19.1938	$23.9689	$24.8656	$22.6314
450399	0.9450	0.8053	$19.1571	$19.5928	$18.2074	$18.9826
450400	1.2340	0.8523	$20.1376	$22.0103	$23.1739	$21.7697
450403	1.2939	1.0222	$24.6215	$27.8138	$29.3063	$27.2736
450411	0.9786	0.8053	$16.9558	$17.6570	$19.6086	$18.1139
450417	0.8798	0.9996	$16.1957	$17.8078	$20.0350	$18.0319
450418	1.2682	0.9996	$25.1306	$27.0283	$26.8434	$26.3230
450419	1.1829	0.9938	$26.7662	$28.4122	$31.0404	$28.7694
450422	0.9445	1.0222	$29.0032	$29.5592	$30.6659	$29.7888
450424	1.3043	0.9996	$22.0682	$23.1253	$28.3149	$24.8057
450431	1.5444	0.9439	$22.9545	$24.7346	$25.2477	$24.3602
450438	1.1526	0.9996	$19.2165	$22.0476	$21.9351	$21.1413
450446	0.6565	0.9996	$14.1684	$14.9983	$14.3132	$14.4984
450447	1.2118	0.9938	$21.0247	$22.5602	$23.5047	$22.3940
450451	1.1267	0.9491	$21.1046	$22.3834	$23.3042	$22.3121
450460	0.9508	0.8053	$17.9487	$19.5709	$20.5812	$19.4136
450462	1.6798	1.0222	$24.0081	$25.6952	$27.8923	$25.9496
450464	***	*	$16.1987	*	*	$16.1987
450465	1.1088	0.8488	$19.4486	$23.0130	$22.4183	$21.6303
450469	1.4831	0.9509	$24.0794	$26.6781	$28.7890	$26.6238
450473	***	*	$18.6002	*	*	$18.6002
450475	1.0070	0.8732	$20.9443	$20.7983	$23.5596	$21.7528
450484	1.3956	0.9996	$23.2881	$23.0604	$25.3527	$23.9206
450488	1.1147	0.8732	$22.5650	$22.3949	$23.9144	$22.9600
450489	1.0293	0.8053	$18.5941	$19.6884	$21.4771	$19.8409
450497	1.0383	0.8053	$17.1327	$17.6614	$18.8344	$17.8832
450498	0.8822	0.8053	$19.2984	$16.4358	$17.7822	$17.7509
450508	1.4234	0.9030	$20.8183	$23.5066	$23.9572	$22.7686
450514	1.1291	0.8413	$21.0116	$21.4034	$22.6552	$21.6987
450517	0.9315	*	$14.4246	$15.2707	*	$14.8080
450518	1.6511	0.8413	$21.1015	$22.2587	$24.1194	$22.4755
450523	***	*	$22.3034	$28.6387	*	$25.2834
450530	1.1682	0.9996	$23.3005	$26.1998	$28.7451	$26.1850
450534	0.9008	*	$22.5156	$20.4715	*	$21.4079
450535	***	*	$23.7255	$29.4427	*	$26.5477
450537	1.3614	1.0222	$22.5972	$23.9256	$27.5856	$24.8361
450539	1.2202	0.8053	$18.4299	$20.0343	$21.0442	$19.8677
450545	***	*	$21.7762	$22.8130	*	$22.2858
450547	0.9664	0.9938	$22.6557	$21.8106	$21.6542	$22.0062
450558	1.7818	0.8053	$21.4201	$25.0837	$26.1551	$24.1840
450563	1.3796	0.9938	$27.5671	$27.9427	$28.7289	$28.1251
450565	1.2555	0.8539	$17.2171	$22.1971	$23.8847	$20.9966

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
450571	1.5391	0.8279	$21.5688	$20.9651	$22.7703	$21.7784
450573	1.1304	0.8053	$18.6233	$21.6974	$20.1479	$20.0755
450578	0.9374	0.8053	$17.3010	$20.0454	$20.2695	$19.1233
450580	1.1083	0.8053	$18.5225	$20.4293	$21.1574	$20.0321
450584	1.0438	0.8053	$16.9021	$19.0373	$21.0808	$18.9453
450586	0.9752	0.8053	$14.9061	$14.6574	$16.1003	$15.2149
450587	1.1638	0.8053	$19.0648	$19.9712	$20.4512	$19.8609
450591	1.2345	0.9996	$19.6229	$22.4991	$23.9992	$22.0639
450596 [h]	1.1192	1.0299	$24.3714	$24.7477	$25.3317	$24.8345
450597	0.9804	0.8130	$19.9596	$22.9337	$23.1711	$22.1268
450603	***	*	$20.6138	*	*	$20.6138
450604	1.2585	0.8053	$19.5288	$20.5273	$20.9514	$20.3776
450605	1.1730	0.8549	$22.0210	$23.8820	$22.2205	$22.7037
450609	1.0151	*	$16.6870	$18.3856	*	$17.5807
450610	1.6074	0.9996	$24.7706	$22.5451	$26.8710	$24.6655
450614	***	*	$18.5895	*	*	$18.5895
450615	0.9562	0.8053	$17.2717	$18.2166	$20.3028	$18.6840
450617	1.4119	0.9996	$22.7514	$25.2211	$26.5026	$24.9284
450620	0.9963	0.8053	$17.1333	$18.1819	$17.7138	$17.6710
450623	1.0807	0.9938	$25.1400	$28.3354	$28.3552	$27.2112
450626	0.9173	*	$17.7454	$21.4445	$26.8375	$21.3925
450630	1.5413	0.9996	$24.8096	$27.8856	$29.6796	$27.5230
450631	***	*	$22.8637	$24.5409	*	$23.7681
450634	1.6132	1.0222	$24.8258	$27.0412	$28.1705	$26.8022
450638	1.5906	0.9996	$26.3653	$29.5385	$29.6184	$28.6129
450639	1.5166	0.9938	$24.2919	$27.3593	$29.2669	$27.0735
450641	0.9774	0.8053	$17.4072	$17.0805	$17.5845	$17.3565
450643	1.3324	0.8093	$20.2000	$20.9674	$21.1205	$20.7972
450644	1.4557	0.9996	$24.4574	$27.2047	$29.0186	$27.0517
450646	1.3717	0.9007	$21.8500	$22.6541	$23.8908	$22.8626
450647	1.8252	1.0222	$26.8276	$28.8881	$30.7334	$28.8704
450648	0.9121	*	$17.3678	$18.2826	*	$17.7872
450649	0.9495	*	$17.5761	$18.1118	*	$17.8381
450651	1.6339	1.0222	$26.9215	$28.9829	$32.4822	$29.5833
450653	1.1250	0.9307	$22.7236	$21.8654	$23.2603	$22.6099
450654	0.9105	0.8053	$16.3057	$19.6054	$19.9992	$18.6631
450656	1.4088	0.9030	$20.7824	$22.7284	$23.8280	$22.4984
450658	0.9058	0.8053	$19.6855	$19.9597	$20.5398	$20.0788
450659	1.4571	0.9996	$26.0224	$28.8671	$30.1727	$28.5108
450661	1.1789	0.9883	$20.0716	$21.5537	$23.2989	$21.6941
450662	1.5509	0.9835	$26.3794	$24.5815	$28.0913	$26.3697
450665	0.8701	*	$15.8571	$17.2566	$18.6054	$17.2495
450668	1.5078	0.9007	$24.0081	$26.4508	$26.2375	$25.5681
450669	1.2177	1.0222	$25.0200	$25.6411	$27.4507	$26.1045
450670	1.3444	0.9996	$19.9621	$22.0495	$25.1575	$22.3620
450672	1.7311	0.9938	$25.3106	$26.7785	$27.6359	$26.6135
450673	1.0701	0.8319	$16.3319	$19.4030	*	$17.7858
450674	0.9544	*	$24.8137	$26.8081	*	$25.8948
450675	1.4447	0.9938	$24.8661	$26.1555	$28.7765	$26.7882
450677	1.3508	0.9938	$22.9529	$24.0218	$27.3728	$24.7773
450678	1.4249	1.0222	$28.1917	$30.1134	$30.1500	$29.5324
450683	1.1505	1.0222	$24.5013	$24.0080	$24.6609	$24.3870
450684	1.2328	0.9996	$23.8945	$26.2906	$27.6789	$25.9648
450686	1.6362	0.8781	$17.9181	$21.0565	$23.2367	$20.7924
450688	1.2067	1.0222	$21.7922	$23.7796	$27.9057	$24.4771
450690	1.5005	0.9182	$33.1576	$28.7529	$28.2531	$29.5860
450694	1.0995	0.9996	$21.4784	$22.3081	$23.5790	$22.4747
450697	1.3398	0.8978	$20.8951	$21.2662	$23.7155	$22.0489
450698	0.8879	0.8053	$18.1764	$18.5436	$18.6494	$18.4560
450700	0.9342	*	$17.3458	$18.6373	*	$18.0024
450702	1.5147	0.8732	$22.2953	$24.8628	$25.6147	$24.3137
450709	1.2721	0.9996	$23.4246	$25.0932	$25.4855	$24.7135
450711	1.6188	0.8936	$22.1489	$24.8277	$28.0104	$25.1428
450712	***	*	$18.4547	*	*	$18.4547
450713	1.5285	0.9439	$24.4002	$26.7190	$27.2801	$26.1943
450715	1.2751	1.0222	*	$16.1897	$28.0365	$20.5948
450716	1.2400	0.9996	$24.8614	$28.8043	$30.8440	$28.2641

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
450718	1.2057	0.9439	$24.9162	$27.6672	$27.3408	$26.7229
450723	1.4250	1.0222	$24.1618	$27.0055	$28.0812	$26.5571
450724	***	*	$21.9630	*	*	$21.9630
450727	***	*	$16.0843	*	*	$16.0843
450730	1.3060	1.0222	$27.8476	$30.7567	$29.9430	$29.5510
450733	***	*	$23.8143	$25.5624	$26.4976	$25.4115
450742	1.2106	1.0222	$25.1295	$26.3414	$26.1190	$25.8920
450743	1.4856	1.0222	$23.7424	$24.7397	$27.3213	$25.3404
450746	0.9624	0.8053	$11.1672	$16.9209	$12.4748	$13.1222
450747	1.2120	0.9938	$21.5883	$24.2674	$22.2870	$22.7471
450749	1.0156	0.8053	$17.8696	$18.4095	$17.8227	$18.0184
450751	1.2544	0.8285	$23.3154	$22.9070	$19.3265	$21.7472
450754	0.9201	0.8053	$19.2827	$21.3043	$20.8968	$20.5167
450755	0.9728	0.8781	$19.2768	$19.5168	$18.0092	$18.8178
450758	1.2417	1.0222	$22.8713	$24.0226	$25.6548	$24.1232
450760	1.1481	0.9007	$23.2959	$25.7453	$24.6349	$24.3909
450761	0.8514	0.8053	$15.5151	$16.2605	$15.7483	$15.8642
450763	1.1347	0.8289	$19.8939	$21.4171	$22.4905	$21.2790
450766	1.8764	1.0222	$27.2499	$28.8576	$30.0441	$28.7197
450770	1.1592	0.9439	$19.9412	$20.1763	$20.3656	$20.1550
450771	1.6473	1.0222	$25.0490	$26.0618	$31.3924	$27.9152
450774	1.7574	0.9996	$21.7906	$24.8562	$24.9683	$23.8170
450775	1.2079	0.9996	$23.6621	$25.3924	$24.4006	$24.5023
450776	0.9805	*	$14.6695	*	*	$14.6695
450779	1.2281	0.9938	$23.8882	$22.5857	$26.9908	$24.4772
450780	1.8676	0.8978	$21.9046	$22.8688	$23.9516	$22.9443
450788	1.5572	0.8549	$21.4467	$24.2643	$25.4172	$23.7014
450795	1.1356	0.9996	$19.1371	$28.1448	$23.7510	$23.4235
450796	2.1987	0.9156	$22.4973	$24.7564	$27.9734	$25.1133
450797	***	*	$18.6839	$23.8708	$20.5379	$20.9547
450801	1.4958	0.8285	$19.7790	$22.2426	$23.0373	$21.7315
450803	1.2419	0.9996	$23.8343	$26.3054	$30.6093	$27.0662
450804	1.8238	0.9996	$22.8275	$26.0003	$26.0980	$25.0247
450808	1.5928	0.9439	$18.6555	$22.8247	$23.8067	$21.6597
450809	1.5794	0.9439	$23.8758	$24.7763	$26.3659	$25.0664
450811	1.8227	0.8936	$22.7583	$23.1022	$25.8491	$24.4306
450813	1.1010	0.8248	$21.7208	$22.1326	$25.5949	$23.1456
450817	***	*	$28.4441	*	*	$28.4441
450820	1.2204	0.9996	$26.9121	$27.9187	$30.5288	$28.8719
450822	1.1446	1.0222	$26.7821	$29.7067	$31.1431	$29.3455
450824	2.4144	0.9439	$24.5885	*	$26.7803	$25.7897
450825	1.4991	0.8936	$18.8510	$18.7069	$20.2959	$19.3490
450827	1.4354	0.8319	$29.5838	$21.1788	$20.9704	$23.0851
450828	1.1790	0.8053	$20.9509	$21.4128	$22.3667	$21.5956
450829	***	*	$14.4463	$18.2860	$19.5014	$17.2726
450830	0.9415	0.9584	$24.7834	$26.9917	$28.1617	$26.6450
450831	1.6975	0.9996	*	$20.0581	$22.7885	$21.7038
450832	1.1361	0.9996	$24.8572	$26.4725	$26.6628	$26.1075
450833	1.1880	1.0222	$18.3196	$26.1256	$26.0044	$23.5951
450834	1.3968	0.8902	$21.7217	$22.7691	$21.2204	$21.8968
450835	***	*	$24.8374	*	*	$24.8374
450837	***	*	$24.2964	*	*	$24.2964
450838	1.1224	0.8053	*	$15.0454	$15.8026	$15.4717
450839	0.9384	0.8758	*	$21.1905	$22.9711	$22.0566
450840	1.0125	1.0222	*	$29.5215	$31.1914	$30.4233
450841	1.6639	0.9835	*	$17.6635	$18.9468	$18.3289
450842	***	*	*	$23.0945	*	$23.0945
450844	1.2802	0.9996	*	$34.4235	$28.7296	$30.4450
450845	1.8830	0.9007	*	$26.5040	$27.7461	$27.1743
450846	***	*	*	$24.0791	*	$24.0791
450847	1.1998	0.9996	*	$26.8892	$27.6854	$27.3036
450848	1.1978	0.9996	*	$26.5609	$27.8100	$27.1855
450850	1.5011	0.9513	*	*	$22.1334	$22.1334
450851	2.4409	1.0222	*	*	$30.1213	$30.1213
450852	***	*	*	*	$30.0191	$30.0191
450853	2.0332	1.0222	*	*	*	*
450855	1.5141	0.9835	*	*	*	*

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
450856	2.1787	0.8978	*	*	*	*
450858	2.0535	0.9938	*	*	*	*
450860	2.3115	0.9996	*	*	*	*
450861	1.7724	0.8732	*	*	*	*
450862	1.1272	0.9996	*	*	*	*
450864	2.1054	0.9182	*	*	*	*
450865	1.0980	0.9439	*	*	*	*
450866	1.4767	0.8549	*	*	*	*
450867	1.2710	0.9439	*	*	*	*
450868	1.9100	0.9883	*	*	*	*
450869	1.4134	0.8936	*	*	*	*
450870	1.5311	0.9996	*	*	*	*
450871	1.8928	0.9439	*	*	*	*
450872	1.2891	0.9938	*	*	*	*
450873	3.2128	0.8978	*	*	*	*
450874	1.6081	1.0222	*	*	*	*
450875	1.5726	0.9156	*	*	*	*
450876	2.3412	0.8781	*	*	*	*
450877	1.4156	0.9007	*	*	*	*
450878	2.7131	0.8978	*	*	*	*
450879	1.6032	0.8093	*	*	*	*
450880	1.5062	0.9938	*	*	*	*
450881	1.3511	0.8549	*	*	*	*
450882	1.4154	0.9182	*	*	*	*
450883	2.0287	1.0222	*	*	*	*
450884	1.0601	0.8732	*	*	*	*
450885	1.3287	1.0222	*	*	*	*
460001	1.8912	0.9484	$24.8844	$25.6932	$27.0757	$25.8934
460003	1.5251	0.9424	$26.5141	$24.3527	$26.1372	$25.6304
460004	1.6710	0.9424	$24.3409	$25.2191	$26.4498	$25.3907
460005	1.4452	0.9424	$25.0063	$22.6809	$23.5633	$23.6783
460006	1.2988	0.9424	$23.4200	$24.4350	$25.4787	$24.4752
460007	1.3349	0.9407	$23.3603	$24.2875	$25.6686	$24.4644
460008	1.3638	0.9424	$24.8233	$24.4453	$26.5672	$25.2587
460009	1.9243	0.9424	$24.5865	$25.0984	$26.2833	$25.3688
460010	2.1081	0.9424	$25.1240	$26.2331	$27.4648	$26.2912
460011	1.2796	0.9484	$21.2634	$22.3601	$23.4023	$22.3027
460013	1.3598	0.9484	$23.1467	$23.4765	$25.2448	$23.9897
460014	1.0871	0.9424	$22.6125	$23.9400	$24.1412	$23.6345
460015	1.3061	0.9174	$23.1068	$24.0939	$25.6576	$24.3035
460016	***	*	$18.7453	*	*	$18.7453
460017	1.3428	0.8518	$20.7789	$21.7082	$23.0388	$21.8220
460018 [h]	0.8785	1.2082	$16.7143	$18.8942	$20.3755	$18.6334
460019	1.1075	0.8126	$18.1995	$20.3625	$19.9900	$19.5496
460020	1.0596	0.8126	$15.2162	$19.4960	$19.5669	$17.9384
460021	1.6969	1.1237	$23.8565	$24.9725	$26.3420	$25.1139
460023	1.1724	0.9484	$25.0874	$25.0376	$25.3094	$25.1556
460025	0.9642	*	$22.3098	$18.7978	*	$20.4201
460026	0.9859	0.8126	$21.9316	$22.7589	$24.1547	$22.9505
460029	1.0962	*	$24.4379	*	*	$24.4379
460030	1.1340	0.8126	$21.2546	$22.6129	$23.4679	$22.4925
460032	0.9822	*	$21.2715	$22.8987	*	$22.1308
460033	0.9225	0.8126	$21.7216	$22.7816	$22.0248	$22.1909
460035	0.9306	0.8126	$16.9657	$16.9019	$17.5723	$17.1694
460036	1.2605	0.9484	$23.9910	$25.2647	$27.2865	$25.5949
460037	0.8792	0.8126	$20.0323	$19.8478	$21.1035	$20.3240
460039	1.0049	0.9039	$26.3795	$27.5912	$28.5656	$27.5288
460041	1.3290	0.9424	$23.5132	$24.0431	$25.2744	$24.2809
460042	1.3456	0.9424	$22.0844	$23.5819	$22.9949	$22.8865
460043	0.9252	0.9484	$26.0277	$26.6870	$28.2089	$27.0296
460044	1.2503	0.9424	$24.7138	$25.7342	$26.6795	$25.7463
460047	1.6480	0.9424	$24.9214	$25.1721	$25.7920	$25.3219
460049	1.9646	0.9424	$21.9357	$23.0683	$24.5164	$23.1856
460051	1.1714	0.9424	$22.7540	$23.4970	$25.5881	$24.0241
460052	1.4469	0.9484	$23.1717	$24.0797	$25.3163	$24.2177
460053	***	*	$23.2274	*	*	$23.2274
460054	1.7584	0.9174	*	$23.5227	$25.8668	$24.6922

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
470001	1.2107	1.1319	$23.5882	$24.5499	$27.7329	$25.2768
470003	1.8911	1.1274	$24.1739	$24.6660	$26.4919	$25.1321
470005	1.3365	1.0189	$24.9625	$25.7288	$29.8255	$26.8311
470006	1.1911	1.0189	$21.6036	$26.0884	$26.9651	$24.9417
470008	1.1620	*	$20.7659	$21.8951	*	$21.3386
470010	1.1547	*	$23.2072	$22.9777	$26.1273	$24.1019
470011	1.2118	1.0982	$24.6034	$25.9246	$28.3911	$26.3395
470012	1.2312	1.0189	$20.5072	$22.9159	$24.3425	$22.6924
470018	1.1718	1.0476	$21.2904	$25.9300	$28.3419	$25.0848
470023	1.2182	*	$24.1395	$26.7486	*	$25.4614
470024	1.1526	1.0189	$22.4659	$23.7745	$25.2427	$23.8783
490001	1.0933	0.8697	$22.3622	$21.7111	$21.9953	$22.0191
490002	1.0694	0.8025	$17.5098	$18.5220	$19.5613	$18.6066
490003	***	*	$20.9783	$23.8112	$27.3456	$23.8351
490004	1.2856	0.9771	$22.7154	$24.4580	$25.4597	$24.2345
490005	1.6321	1.0802	$25.2213	$27.6425	$28.5744	$27.1963
490006	1.1903	*	$13.4277	$16.7679	*	$15.2211
490007	2.2537	0.8832	$22.2526	$24.9533	$26.2481	$24.5292
490009	1.9369	1.0184	$25.2181	$27.5905	$29.0740	$27.2278
490011	1.4455	0.8832	$20.0136	$22.4410	$24.5687	$22.4266
490012	1.0101	0.8025	$15.8346	$18.3697	$19.2275	$17.8014
490013	1.2579	0.8697	$19.5094	$21.4838	$22.4772	$21.1592
490015	***	*	$21.2557	$22.5641	*	$21.9516
490017	1.4111	0.8832	$20.7691	$22.9632	$24.6845	$22.9273
490018	1.2599	0.9771	$22.0810	$23.2215	$24.5196	$23.2792
490019 [h]	1.1526	1.2168	$23.3077	$24.4524	$25.9761	$24.6213
490020	1.2675	0.9309	$21.2094	$23.6611	$24.8001	$23.2943
490021	1.4510	0.8697	$22.2537	$23.5930	$24.6440	$23.5199
490022	1.4942	1.0928	$24.4682	$25.0277	$28.0749	$25.8811
490023	1.2305	1.0928	$24.9734	$28.8354	$29.7774	$27.9947
490024	1.6861	0.8506	$21.2619	$21.7268	$23.0982	$22.0522
490027	1.1502	0.8025	$20.3644	$19.8345	$18.9409	$19.7128
490031	1.1149	*	$18.4826	$22.4300	$22.0579	$20.9706
490032	1.8941	0.9309	$23.6489	$22.8942	$25.1381	$23.9005
490033	1.0545	1.0928	$24.4370	$27.6355	$30.0909	$27.5418
490037	1.1617	0.8025	$17.5104	$19.0583	$21.3035	$19.2834
490038	1.1629	0.8047	$18.1405	$19.6427	$22.3976	$20.0632
490040	1.5260	1.0928	$27.0513	$30.1820	$32.8738	$30.0780
490041	1.4210	0.8832	$19.9314	$22.2955	$24.5738	$22.3542
490042	1.2653	0.8025	$19.5127	$20.5845	$21.8749	$20.7701
490043	1.1834	1.0928	$25.4354	$28.2969	$30.8871	$28.4640
490044	1.3934	0.8832	$20.8739	$22.1324	$20.8351	$21.2628
490045	1.3093	1.0928	$24.7131	$27.2132	$28.8279	$27.0743
490046	1.5630	0.8832	$22.0040	$24.6391	$25.6328	$24.1719
490047	1.0180	0.8989	$19.8220	$21.9156	$22.5424	$21.3597
490048	1.4326	0.8442	$22.3138	$24.1639	$25.0097	$23.8716
490050	1.5381	1.0928	$26.1521	$29.4660	$30.5037	$28.7334
490052	1.6805	0.8832	$19.2480	$21.4035	$22.8889	$21.2086
490053	1.3101	0.8087	$18.6541	$20.9367	$21.8432	$20.4783
490057	1.5890	0.8832	$22.1612	$25.1898	$26.1128	$24.5153
490059	1.5707	0.9309	$23.3895	$26.1518	$28.7276	$26.1974
490060	1.0326	0.8025	$20.6028	$21.0828	$22.4200	$21.3908
490063	1.8508	1.0928	$31.0162	$29.4216	$30.3632	$30.2230
490066	1.3227	0.8832	$22.1034	$23.3835	$24.7146	$23.4575
490067	1.1949	0.9309	$20.4058	$21.8730	$22.9188	$21.7183
490069	1.5281	0.9309	$20.6957	$24.4542	$26.8791	$24.1400
490071	1.2916	0.9309	$25.4678	$27.0374	$28.4381	$27.0687
490073	1.6246	1.0928	$27.6711	$25.2859	$31.7743	$27.8898
490075	1.4433	0.8506	$22.3230	$22.8303	$23.8191	$23.0000
490077	1.3282	1.0184	$22.2643	$24.8309	$26.0800	$24.4773
490079	1.2836	0.8951	$19.2196	$19.8100	$23.4728	$20.7435
490084	1.1993	0.8192	$19.8598	$22.7945	$24.5965	$22.3566
490088	1.0701	0.8697	$19.7549	$21.4818	$22.4186	$21.1984
490089	1.0571	0.8442	$21.1522	$21.2123	$22.6461	$21.7546
490090	1.1232	0.8025	$20.3015	$21.3410	$22.2907	$21.2854
490092	1.1162	0.9309	$23.8364	$21.6466	$23.8656	$23.0587
490093	1.4419	0.8832	$20.7388	$23.6779	$25.0751	$23.2941

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
490094	1.0191	0.9309	$21.9886	$26.0755	$26.5726	$25.0296
490097	1.0192	0.8025	$18.1022	$23.5366	$23.8005	$21.5573
490098	1.2373	0.8025	$19.7116	$20.9805	$21.7231	$20.8214
490101	1.2797	1.0928	$28.5200	$30.1800	$30.4285	$29.7644
490104	0.8032	0.9309	$28.0286	$33.1215	$17.3295	$24.4559
490105	0.7403	0.8087	$40.6821	$38.2813	$24.7923	$34.3492
490106	0.9467	0.9771	$31.6541	$30.1492	$23.0199	$28.3157
490107	1.2712	1.0928	$26.5312	$28.7296	$29.7000	$28.3786
490108	0.9960	0.8697	$28.7277	$27.9090	$22.4345	$26.3471
490109	0.9901	0.9309	$28.0978	$28.0548	$21.9878	$25.9914
490110	1.3190	0.8107	$23.6080	$21.3126	$22.5974	$22.4319
490111	1.2958	0.8025	$19.4041	$20.6373	$22.0199	$20.6805
490112	1.6780	0.9309	$23.6028	$25.8312	$26.6453	$25.4222
490113	1.2749	1.0928	$28.0893	$29.1786	$29.5698	$28.9669
490114	0.9738	0.8025	$19.9725	$20.0555	$20.9116	$20.3167
490115	1.1853	0.8025	$19.9151	$20.3615	$21.4666	$20.5969
490116	1.1376	0.8025	$19.7007	$21.3083	$22.9017	$21.2429
490117	1.2083	0.8025	$15.6078	$17.4111	$18.0277	$17.0302
490118	1.7166	0.9309	$25.2230	$26.8810	$27.4050	$26.6600
490119	1.3223	0.8832	$21.3883	$23.7813	$25.2549	$23.5234
490120	1.3949	0.8832	$22.2389	$23.1535	$24.4434	$23.3020
490122	1.4407	1.0928	$27.3509	$28.7020	$31.0449	$29.0227
490123	1.1014	0.8025	$20.9506	$22.9511	$23.9233	$22.6075
490124	***	*	$21.3713	$29.7939	*	$25.7258
490126	1.2494	0.8025	$20.4660	$23.1423	$22.2859	$21.9403
490127	1.1159	0.8025	$17.8070	$19.4005	$20.4289	$19.2585
490130	1.3278	0.8832	$18.6038	$22.0769	$22.8512	$21.1640
490132	***	*	$19.5849	*	*	$19.5849
490133	***	*	*	*	$26.5683	$26.5683
490134	1.0280	0.8025	*	*	*	*
490135	0.7108	0.8442	*	*	*	*
500001	1.6005	1.1562	$26.6420	$26.7502	$29.3707	$27.5939
500002	1.4190	1.0480	$24.0374	$25.0665	$25.3347	$24.8482
500003	1.2854	1.1562	$27.3435	$28.4174	$29.6341	$28.5098
500005	1.8323	1.1562	$28.9512	$31.4415	$32.0972	$30.7955
500007	1.2993	1.0688	$23.5774	$26.1318	$28.0476	$25.9648
500008	1.9468	1.1562	$28.9380	$31.0128	$31.8837	$30.6288
500011	1.3733	1.1562	$27.6762	$28.3391	$30.6508	$28.9502
500012	1.6030	1.0480	$26.2263	$29.2045	$30.6856	$28.7227
500014	1.6603	1.1562	$27.4248	$30.1061	$33.7536	$30.6058
500015	1.4325	1.1562	$27.3397	$30.1596	$32.0592	$29.8941
500016	1.6712	1.1562	$27.7863	$29.3634	$31.4221	$29.6282
500019	1.2772	1.0693	$25.7691	$26.9702	$28.6669	$27.1697
500021	1.3194	1.0793	$26.4648	$28.5926	$30.1690	$28.5893
500023	1.1440	*	$23.9513	$27.3823	*	$25.6872
500024	1.7104	1.0982	$27.2967	$29.3946	$30.7917	$29.1683
500025	1.7397	1.1562	$29.0400	$31.7335	$34.7252	$31.7861
500026	1.4646	1.1562	$28.7532	$31.4152	$33.2937	$31.1325
500027	1.5653	1.1562	$30.6901	$29.5939	$34.2175	$31.5063
500030	1.5850	1.1693	$29.0487	$30.5926	$32.7446	$30.8324
500031	1.2010	1.0959	$26.0740	$28.5398	$31.2186	$28.5887
500033	1.3030	1.0480	$25.4345	$26.6704	$29.4627	$27.2338
500036	1.3831	1.0480	$25.4753	$26.0223	$27.0072	$26.1929
500037	1.0377	1.0480	$23.5414	$24.6548	$26.9969	$25.0377
500039	1.4538	1.1562	$26.1409	$27.9651	$29.8809	$28.0919
500041	1.3106	1.1235	$24.9004	$26.9101	$26.7829	$26.2464
500044	1.9846	1.0887	$27.0880	$26.9323	$30.3164	$28.1645
500049	1.3037	1.0480	$26.6407	$25.6104	$27.1819	$26.4960
500050	1.4538	1.1235	$25.0907	$26.8971	$29.9791	$27.4347
500051	1.7670	1.1562	$26.9538	$29.0100	$31.9406	$29.4441
500052	1.3564	1.1562	*	*	*	*
500053	1.2591	1.0608	$26.0112	$26.8074	$28.4130	$27.1467
500054	2.0344	1.0887	$27.1965	$28.8062	$30.8067	$28.9786
500055	***	*	$25.3095	*	*	$25.3095
500057	1.3870	*	$21.0357	$21.4393	*	$21.2461
500058	1.6695	1.0608	$27.3411	$28.4247	$30.4699	$28.8635
500060	1.3027	1.1562	$31.7480	$33.5169	$34.1523	$33.1768

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
500064	1.7633	1.1562	$29.2539	$31.1459	$31.5371	$30.6791
500065	1.2534	*	$26.5880	$26.0960	*	$26.3295
500071	1.1937	*	$23.2071	*	*	$23.2071
500072	1.1555	1.1562	$27.5706	$29.3087	$33.4863	$30.1715
500074	***	*	$21.9019	*	*	$21.9019
500077	1.4845	1.0887	$26.5692	$27.8819	$29.4199	$28.0167
500079	1.3547	1.0793	$27.1775	$28.4934	$29.6623	$28.4444
500084	1.3241	1.1562	$26.5864	$27.6306	$29.3484	$27.9397
500086	1.2860	*	$25.9705	*	*	$25.9705
500088	1.3895	1.1562	$30.1689	$31.2757	$33.4302	$31.6945
500092	0.9229	*	$20.8601	$23.2466	*	$22.0417
500104	1.0850	*	$26.8007	$27.0034	*	$26.9067
500108	1.6584	1.0793	$27.4156	$28.7206	$29.4244	$28.5667
500110	1.1842	*	$24.8448	$25.4785	*	$25.1652
500118	1.1235	*	$26.1971	$28.1074	*	$27.1693
500119	1.3675	1.0887	$25.1576	$27.2335	$30.9999	$27.7928
500122	1.2120	1.0480	$26.9006	$27.4405	$30.1396	$28.2069
500124	1.4141	1.1562	$24.8357	$28.6598	$31.5438	$28.2647
500129	1.5421	1.0793	$27.8351	$30.0223	$30.7536	$29.5772
500134	0.5051	1.1562	$21.3921	$24.2990	$26.8608	$24.3808
500138	1.0850	*	*	*	*	*
500139	1.5453	1.0982	$27.7281	$29.2357	$31.6591	$29.5383
500141	1.2808	1.1562	$28.2968	$30.7478	$30.5456	$29.9289
500143	0.4899	1.0982	$19.0982	$20.7093	$22.1419	$20.7552
500147	0.8386	1.0480	*	$16.3669	$24.5807	$16.9814
500148	1.1214	1.0480	*	$18.2168	$22.2161	$20.0814
510001	1.9255	0.8832	$21.4247	$22.9351	$23.4477	$22.6536
510002	1.1692	0.8442	$20.9822	$22.4751	$25.9597	$23.1031
510006	1.2555	0.8832	$21.0214	$22.2947	$23.5727	$22.3142
510007	1.5691	0.9473	$23.4411	$24.3499	$25.2835	$24.3672
510008	1.1973	0.9518	$22.7595	$24.5293	$24.6959	$24.0287
510012	0.9588	0.7734	$16.7710	$18.5816	$18.2845	$17.8391
510013	1.1829	0.7734	$19.7937	$19.9710	$20.8782	$20.2065
510015	0.9570	*	$17.9040	*	*	$17.9040
510018	1.0130	0.8293	$19.9490	$21.8475	$20.5556	$20.7431
510022	1.8454	0.8446	$22.7534	$24.1481	$24.2125	$23.7112
510023	1.2765	0.7813	$17.9267	$19.4321	$20.4908	$19.2664
510024	1.7302	0.8832	$21.3662	$23.3115	$24.0444	$22.9061
510026	1.0194	0.7734	$16.5389	$18.0855	$16.6192	$17.0257
510028	1.0034	*	$4.6544	$23.0518	$21.7134	$23.1596
510029	1.2652	0.8446	$19.8202	$21.7527	$22.4556	$21.3887
510030	1.1840	0.8324	$19.8220	$22.3658	$21.5583	$21.2766
510031	1.3935	0.8446	$20.5743	$21.6294	$21.7637	$21.3498
510033	1.3919	0.8295	$19.6921	$21.0707	$23.0305	$21.2329
510038	1.0348	0.7734	$16.1016	$16.8744	$17.2832	$16.7659
510039	1.2761	0.7846	$17.6173	$19.1280	$19.5468	$18.7692
510043	0.9124	*	$15.5857	$16.0586	*	$15.8328
510046	1.3006	0.8293	$19.2802	$21.2792	$21.2540	$20.5978
510047	1.1387	0.8832	$22.1953	$23.2093	$24.0954	$23.1668
510048	1.1193	0.7734	$16.3761	$17.6785	$17.5096	$17.1529
510050	1.5322	0.7846	$18.9990	$20.1943	$19.9766	$19.7250
510053	1.1441	0.7734	$18.1054	$20.7538	$20.8609	$19.9625
510055	1.4649	0.9473	$27.7422	$29.3962	$30.7868	$29.3287
510058	1.2960	0.8295	$20.1104	$21.9352	$22.6976	$21.6021
510059	0.6597	0.8446	$18.1543	$18.8712	$21.9550	$19.5138
510061	0.9980	*	$14.8848	$15.3355	*	$15.1074
510062	1.1657	0.7734	$21.3405	$21.1568	$23.3216	$21.9387
510067	1.1851	0.7734	$18.0113	$22.1582	$21.2099	$20.4433
510068	1.1255	1.0928	$19.9056	$20.0007	$23.1011	$21.0310
510070	1.1911	0.8293	$20.0974	$21.1895	$23.2382	$21.5724
510071	1.2969	0.8293	$19.4029	$21.5439	$23.1685	$21.4107
510072	1.0729	0.7734	$18.4566	$19.7990	$20.1997	$19.5568
510077	1.1634	0.9110	$20.9153	$22.8104	$23.6585	$22.4770
510082	1.1080	0.7734	$17.2891	$16.4742	$19.1878	$17.5963
510085	1.2085	0.8446	$20.6364	$22.6563	$23.7173	$22.3503
510086	1.0952	0.7734	$16.3051	$17.8234	$17.5933	$17.2267
510088	0.9948	*	$16.4373	$18.3401	*	$17.3534

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
510089	***	*	*	*	$27.7062	$27.7062
520002	1.2818	0.9954	$22.0838	$23.7316	$24.9950	$23.6544
520003	1.1894	*	$20.4234	$21.8662	*	$21.1608
520004	1.3553	0.9548	$22.8530	$24.4711	$25.4639	$24.2888
520008	1.6058	1.0150	$26.0931	$27.8127	$29.8354	$27.9737
520009	1.6967	0.9507	$21.5169	$23.4265	$26.1503	$23.6455
520010	1.1229	*	$26.3965	$28.5569	*	$27.4794
520011	1.2646	0.9507	$22.7880	$23.7785	$25.2747	$23.9992
520013	1.3824	0.9507	$23.1173	$24.4766	$26.6225	$24.8211
520014	1.0852	*	$20.4281	$22.1064	*	$21.2683
520015	1.1605	*	$22.8094	$23.0403	*	$22.9239
520017	1.1534	0.9507	$21.7542	$23.4044	$24.6676	$23.3009
520019	1.2740	0.9507	$22.6895	$24.9871	$26.7433	$24.8231
520021	1.3888	1.0646	$24.1284	$25.4872	$26.6935	$25.4468
520024	1.0767	*	$17.5368	$18.5072	*	$18.0423
520026	1.1060	*	$25.0504	$26.1056	*	$25.6168
520027	1.2807	1.0150	$22.2089	$26.2516	$27.6771	$25.6136
520028	1.2640	1.0429	$24.3592	$25.7778	$25.4164	$25.1844
520030	1.7815	0.9954	$23.9474	$25.3807	$27.0185	$25.5053
520032	1.1395	*	$22.7220	$25.3059	*	$24.0314
520033	1.3048	0.9507	$22.2650	$23.9791	$25.0854	$23.8247
520034	1.1321	0.9507	$22.6160	$23.6563	$23.9850	$23.4634
520035	1.2930	0.9584	$20.8563	$23.2625	$24.7767	$23.0160
520037	1.7966	0.9954	$25.0587	$28.6984	$29.7234	$27.8508
520038	1.2111	1.0150	$23.1036	$24.6650	$26.6470	$24.8476
520040	1.3871	1.0150	$21.5671	$23.8501	$27.2325	$24.2221
520041	1.1135	1.0654	$22.6216	$22.8236	$22.7596	$22.7396
520042	1.0925	*	$21.9935	$24.0788	*	$23.0540
520044	1.3353	0.9584	$22.7627	$24.9387	$26.0191	$24.5777
520045	1.5315	0.9507	$24.1624	$24.5844	$26.0030	$24.9427
520047	0.9448	*	$22.5686	$25.5346	*	$24.0011
520048	1.6734	0.9507	$20.5069	$23.1653	$25.1724	$22.8848
520049	2.1816	0.9507	$22.7424	$24.1083	$25.9256	$24.2130
520051	1.6481	1.0150	$27.6695	$28.8249	$28.4880	$28.3551
520057	1.1630	0.9625	$21.2729	$23.3205	$25.3745	$23.3399
520058	***	*	$23.2907	*	*	$23.2907
520059	1.2689	1.0434	$24.1863	$26.5596	$28.0906	$26.3220
520060	1.3044	0.9507	$21.1271	$22.0132	$23.8817	$22.3382
520062	1.2988	1.0150	$23.7166	$24.9988	$28.2215	$25.7059
520063	1.1399	1.0150	$23.3037	$25.3674	$27.4101	$25.4095
520064	1.5081	1.0150	$24.3043	$27.1120	$28.6101	$26.6968
520066	1.5467	1.0429	$23.9212	$25.8812	$27.1657	$25.6782
520068	0.8965	0.9507	$21.4413	$23.4746	$24.8184	$23.2981
520069	***	*	$32.6484	*	*	$32.6484
520070	1.7413	0.9507	$22.0590	$23.9908	$24.8935	$23.6970
520071	1.2243	0.9988	$23.4832	$26.3154	$27.6202	$25.7950
520075	1.5645	0.9507	$23.7322	$26.0600	$27.1699	$25.6758
520076	1.1878	1.0429	$22.2993	$24.0879	$26.1698	$24.2625
520078	1.5329	1.0150	$23.4414	$25.7662	$27.5989	$25.6772
520083	1.7400	1.0654	$25.7108	$27.0012	$28.8407	$27.2481
520084	1.0630	*	$24.7909	$25.5777	*	$25.1765
520087	1.6720	0.9548	$22.8974	$24.5280	$27.3374	$24.8782
520088	1.3449	0.9988	$23.8938	$26.0882	$26.9936	$25.7252
520089	1.5576	1.0654	$24.4435	$26.6013	$30.0448	$27.0527
520091	1.2792	0.9507	$22.8914	$24.8269	$24.6320	$24.0764
520092	1.0343	*	$21.8662	$23.4043	*	$22.6433
520094	***	*	$22.3925	$25.3166	$25.7567	$24.5483
520095	1.1997	1.0429	$25.1402	$28.6376	$26.7863	$26.8360
520096	1.3385	0.9988	$21.1759	$22.9929	$24.5758	$22.9775
520097	1.4029	0.9507	$23.6512	$25.1135	$26.3321	$25.1104
520098	2.0235	1.0654	$25.8184	$28.0730	$30.6150	$28.2679
520100	1.2871	0.9551	$21.7072	$24.5914	$26.2161	$24.1896
520102	1.0893	0.9988	$23.7739	$25.6146	$26.8234	$25.4621
520103	1.6079	1.0150	$23.5984	$25.5361	$27.9147	$25.8275
520107	1.2288	0.9507	$25.7379	$27.7413	$28.3431	$27.2253
520109	1.0449	0.9507	$20.6357	$22.4048	$23.3271	$22.1487
520111	***	*	$26.9666	$26.3095	*	$26.6016

TABLE 2.—HOSPITAL CASE-MIX INDEXES FOR DISCHARGES OCCURRING IN FEDERAL FISCAL YEAR 2004; HOSPITAL WAGE INDEXES FOR FEDERAL FISCAL YEAR 2006; HOSPITAL AVERAGE HOURLY WAGES 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 No.	Case-mix index [3]	FY 2006 wage index	Average hourly wage FY 2004	Average hourly wage FY 2005	Average hourly wage FY 2006 [1]	Average hourly wage ** (3 years)
520112	1.1268	*	$19.1409	$20.4034	*	$19.7623
520113	1.2767	0.9507	$24.0822	$26.7926	$27.4135	$26.1479
520114	1.1723	*	$21.9847	$22.0536	*	$22.0194
520116	1.2125	0.9988	$23.9066	$26.3057	$26.9902	$25.8557
520117	1.0299	*	$21.9915	$22.0023	*	$21.9973
520123	1.0697	*	$21.2360	$22.2430	*	$21.7461
520130	***	*	$20.0277	*	*	$20.0277
520132	1.1196	0.9584	$19.5140	$21.6025	$23.1941	$21.3823
520134	***	*	$20.8502	*	*	$20.8502
520135	0.9154	*	$18.8254	$18.5618	*	$18.6918
520136	1.6288	1.0150	$23.2573	$25.5145	$27.7703	$25.5032
520138	1.8595	1.0150	$25.1434	$26.9047	$28.4394	$26.8513
520139	1.2667	1.0150	$23.7727	$25.4424	$26.5110	$25.3279
520140	1.6795	1.0150	$23.9176	$26.1616	$28.4433	$26.1128
520145	***	*	$25.0770	*	*	$25.0770
520148	1.2321	*	$22.4299	$26.2258	*	$24.3567
520151	1.0412	*	$20.1995	$22.9592	*	$21.5728
520152	1.0642	0.9507	$22.5440	$23.2493	$24.9392	$23.6620
520154	1.1649	*	$23.2635	$23.7160	*	$23.4910
520156	1.0583	*	$23.7157	$24.9258	*	$24.3330
520160	1.8346	0.9507	$22.9475	$24.3528	$25.7588	$24.4208
520161	0.9291	*	$22.1857	$24.0673	*	$23.1340
520170	1.3020	1.0150	$25.5470	$25.6124	$27.2221	$26.1781
520173	1.0993	1.0226	$24.4723	$26.2224	$28.0995	$26.3133
520177	1.6514	1.0150	$27.5560	$28.4663	$30.7317	$29.0456
520178	0.9717	0.9507	$22.3193	$23.0419	$20.2666	$21.8785
520189	1.1196	1.0646	$23.1658	$26.3172	$28.4720	$26.3169
520192	***	*	$22.5641	*	*	$22.5641
520193	1.6120	0.9507	*	*	$26.0885	$26.0885
520194	1.6325	1.0150	*	*	$24.9408	$24.9408
520195	0.3856	1.0150	*	*	$36.6973	$36.6973
520196	1.5394	0.9507	*	*	$35.1043	$35.1043
520197	2.9023	1.0150	*	*	*	*
520198	1.2053	0.9507	*	*	*	*
520199	2.5005	1.0150	*	*	*	*
530002	1.1639	0.9249	$23.8852	$25.2983	$26.8356	$25.4030
530004	***	*	$19.7857	*	*	$19.7857
530006	1.1388	0.9249	$21.3429	$22.8344	$24.9318	$23.0266
530007	1.2503	0.9249	$22.3309	$19.3476	$20.4391	$20.6774
530008 [2]	1.2306	0.9249	$21.8714	$23.8271	$23.8589	$23.1777
530009	0.9743	0.9249	$22.0450	$24.2426	$26.8316	$24.1997
530010 [2]	1.2580	0.9249	$21.4890	$23.9255	$25.8482	$23.7290
530011	1.0395	0.9249	$22.5720	$24.1396	$24.8245	$23.8464
530012	1.7093	0.9249	$22.4716	$24.3454	$25.2526	$24.0014
530014	1.6048	0.9249	$21.7314	$23.6907	$24.5947	$23.3995
530015	1.2734	0.9887	$25.3915	$26.3107	$27.6876	$26.4934
530016	1.3338	*	$21.0666	$21.6575	*	$21.3685
530017	0.9854	0.9249	$19.5630	$23.5415	$25.3362	$22.8987
530023	1.1516	*	$22.5535	$24.1493	$21.3813	$22.6451
530025	1.2853	1.0136	$25.4693	$27.7988	$28.6938	$27.3568
530026	***	*	$21.0732	*	*	$21.0732
530029	***	*	$19.9691	*	*	$19.9691
530031	0.9626	*	$16.8825	$16.3472	*	$16.6017
530032	1.0395	0.9249	$19.4449	$22.6584	$25.7728	$22.4852

[1] Based on salaries adjusted for occupational mix, according to the calculation in section III.F. of the preamble to this final rule.
[2] These hospitals are assigned a wage index value under a special exceptions policy (FY 2005 IPPS final rule, 69 FR 49105).
[3] The transfer-adjusted case-mix index is based on the billed DRG on the FY 2004 MedPAR.
[h] These hospitals are assigned a wage index value according to section III.B.3.d of the preamble to this final 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 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 Sebastián, PR	13.2502	11.5908
10420	Akron, OH	25.1189	23.9584
10500	Albany, GA	24.1796	26.6197
10580	Albany-Schenectady-Troy, NY	24.1014	22.6789
10740	Albuquerque, NM	27.1248	25.7999
10780	Alexandria, LA	22.5148	21.3129
10900	Allentown-Bethlehem-Easton, PA-NJ	27.5389	25.5762
11020	Altoona, PA	25.0167	22.9759
11100	Amarillo, TX	25.6410	24.0270
11180	Ames, IA	26.7068	25.0247
11260	Anchorage, AK	33.3083	31.9786
11300	Anderson, IN	24.1549	23.0714
11340	Anderson, SC	25.1692	23.0401
11460	Ann Arbor, MI	30.4505	29.1802
11500	Anniston-Oxford, AL	21.5588	20.7900
11540	Appleton, WI	25.9098	24.1044
11700	Asheville, NC	26.0511	24.5466
12020	Athens-Clarke County, GA	27.5156	26.2160
12060	Atlanta-Sandy Springs-Marietta, GA	27.3919	26.2708
12100	Atlantic City, NJ	32.4848	29.4864
12220	Auburn-Opelika, AL	22.6976	21.8061
12260	Augusta-Richmond County, GA-SC	27.3055	25.0262
12420	Austin-Round Rock, TX	26.4319	25.2266
12540	Bakersfield, CA	29.3597	26.7401
12580	Baltimore-Towson, MD	27.6740	26.1267
12620	Bangor, ME	27.9343	26.2399
12700	Barnstable Town, MA	35.2615	33.3166
12940	Baton Rouge, LA	24.0727	22.2182
12980	Battle Creek, MI	26.5750	24.8236
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- Gaithersburg-Frederick, MD	32.0899	29.4426
13740	Billings, MT	24.7710	23.5742
13780	Binghamton, NY	24.0264	22.4051
13820	Birmingham-Hoover, AL	25.0894	23.9488
13900	Bismarck, ND	21.2118	20.2286
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	32.3479	30.7412
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	35.2864	33.7913
15180	Brownsville-Harlingen, TX	27.5422	26.6603
15260	Brunswick, GA	26.1311	28.6493
15380	Buffalo-Niagara Falls, NY	26.6130	24.9557
15500	Burlington, NC	24.9033	23.6142
15540	Burlington-South Burlington, VT	26.3427	24.9877
15764	Cambridge-Newton-Framingham, MA	31.2691	29.3376
15804	Camden, NJ	29.4132	28.1192
15940	Canton-Massillon, OH	25.0564	23.6833
15980	Cape Coral-Fort Myers, FL	26.1090	25.0248
16180	Carson City, NV	28.6158	27.0192
16220	Casper, WY	25.2526	24.0014
16300	Cedar Rapids, IA	24.6804	23.4375
16580	Champaign-Urbana, IL	26.8325	25.4853
16620	Charleston, WV	23.6532	22.9870
16700	Charleston-North Charleston, SC	25.8747	24.5912
16740	Charlotte-Gastonia-Concord, NC-SC	27.1833	25.6469
16820	Charlottesville, VA	28.5185	26.7670
16860	Chattanooga, TN-GA	25.4537	24.0895
16940	Cheyenne, WY	24.5947	23.3995
16974	Chicago-Naperville-Joliet, IL	30.2086	28.6207
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 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	26.8708	25.0243
17300	Clarksville, TN-KY	23.1419	21.5444
17420	Cleveland, TN	22.8430	21.2185
17460	Cleveland-Elyria-Mentor, OH	25.7836	25.0847
17660	Coeur d'Alene, ID	26.9749	25.1364
17780	College Station-Bryan, TX	24.9298	23.8756
17820	Colorado Springs, CO	26.4562	25.5473
17860	Columbia, MO	23.3470	22.3003
17900	Columbia, SC	25.3899	24.0229
17980	Columbus, GA-AL	23.9764	22.7919
18020	Columbus, IN	26.8458	25.0573
18140	Columbus, OH	27.6046	25.7378
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	28.6253	26.6921
19140	Dalton, GA	25.3917	24.9002
19180	Danville, IL	25.3127	22.9099
19260	Danville, VA	23.8191	23.0000
19340	Davenport-Moline-Rock Island, IA-IL	24.3881	23.2416
19380	Dayton, OH	25.3708	24.5739
19460	Decatur, AL	23.7138	22.9734
19500	Decatur, IL	22.5852	21.4281
19660	Deltona-Daytona Beach-Ormond Beach, FL	26.0389	23.9763
19740	Denver-Aurora, CO	29.9610	28.5121
19780	Des Moines, IA	27.0740	24.6825
19804	Detroit-Livonia-Dearborn, MI	29.2241	27.2889
20020	Dothan, AL	21.7218	20.2740
20100	Dover, DE	27.4921	25.9420
20220	Dubuque, IA	25.2183	23.4077
20260	Duluth, MN-WI	28.5692	26.9746
20500	Durham, NC	28.5649	27.3142
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	25.2243	24.0882
21500	Erie, PA	24.4677	22.8915
21604	Essex County, MA	29.4964	27.9829
21660	Eugene-Springfield, OR	30.2425	29.1289
21780	Evansville, IN-KY	24.4379	22.4161
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	24.3098	22.6799
22380	Flagstaff, AZ	33.8333	30.2808
22420	Flint, MI	29.8067	28.6898
22500	Florence, SC	25.1218	23.2632
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	23.0943	21.9290
23020	Fort Walton Beach-Crestview-Destin, FL	24.8333	23.4332
23060	Fort Wayne, IN	27.4082	25.7154
23104	Fort Worth-Arlington, TX	26.5774	24.9346
23420	Fresno, CA	29.6408	27.6994
23460	Gadsden, AL	22.3074	21.3197
23540	Gainesville, FL	26.2530	25.0755
23580	Gainesville, GA	24.8893	24.3617
23844	Gary, IN	26.2968	24.6962
24020	Glens Falls, NY	24.0232	22.4577
24140	Goldsboro, NC	24.5666	23.0280
24220	Grand Forks, ND-MN	22.1960	22.4966
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 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	24.8538
24500	Great Falls, MT	25.2873	23.4084
24540	Greeley, CO	26.8470	25.0779
24580	Green Bay, WI	26.5187	25.1688
24660	Greensboro-High Point, NC	25.5495	24.2161
24780	Greenville, NC	26.3325	24.3631
24860	Greenville, SC	28.0058	25.6717
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	24.4948
25500	Harrisonburg, VA	25.4597	24.2345
25540	Hartford-West Hartford-East Hartford, CT	31.0129	29.5961
25620	Hattiesburg, MS	21.3089	19.6542
25860	Hickory-Lenoir-Morganton, NC	25.0061	24.2967
25980	[1] Hinesville-Fort Stewart, GA	.....	.....
26100	Holland-Grand Haven, MI	25.4579	24.5609
26180	Honolulu, HI	31.3996	29.2678
26300	Hot Springs, AR	25.2584	24.0637
26380	Houma-Bayou Cane-Thibodaux, LA	22.1079	20.5356
26420	Houston- Sugar Land-Baytown, TX	27.9917	26.1333
26580	Huntington-Ashland, WV-KY-OH	26.5266	25.1442
26620	Huntsville, AL	25.5407	23.9283
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	28.0936
28100	Kankakee-Bradley, IL	30.0693	28.0168
28140	Kansas City, MO-KS	26.4999	25.3015
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	21.6666
28740	Kingston, NY	25.9268	24.2968
28940	Knoxville, TN	23.6812	22.7352
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	20.7364
29404	Lake County-Kenosha County, IL-WI	29.2180	27.4051
29460	Lakeland, FL	24.9925	23.4702
29540	Lancaster, PA	27.1801	25.5025
29620	Lansing-East Lansing, MI	27.4106	25.6482
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	23.8890
30620	Lima, OH	25.7797	24.7454
30700	Lincoln, NE	28.5262	26.8068
30780	Little Rock-North Little Rock, AR	24.5286	23.3089
30860	Logan, UT-ID	25.6905	24.2109

TABLE 3A.—FY 2006 AND 3-YEAR AVERAGE HOURLY WAGE FOR URBAN AREAS BY CBSA—Continued

[*Based on 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	26.7829	26.2464
31084	Los Angeles-Long Beach-Glendale, CA	33.0239	31.0836
31140	Louisville, KY-IN	25.9154	24.2971
31180	Lubbock, TX	24.5905	22.6838
31340	Lynchburg, VA	24.3559	23.5846
31420	Macon, GA	26.5343	25.0025
31460	Madera, CA	24.4061	22.5247
31540	Madison, WI	29.8344	27.4212
31700	Manchester-Nashua, NH	28.9688	27.6888
31900	Mansfield, OH	27.7289	25.0968
32420	Mayagüez, PR	11.2545	11.3971
32580	McAllen-Edinburg-Mission, TX	25.0238	22.9932
32780	Medford, OR	28.6299	27.7062
32820	Memphis, TN-MS-AR	26.3296	24.2774
32900	Merced, CA	31.1184	27.6673
33124	Miami-Miami Beach-Kendall, FL	27.2956	25.9760
33140	Michigan City-La Porte, IN	26.3221	24.7313
33260	Midland, TX	26.6395	25.3824
33340	Milwaukee-Waukesha-West Allis, WI	28.4248	26.6213
33460	Minneapolis-St. Paul-Bloomington, MN-WI	30.9505	29.1179
33540	Missoula, MT	26.4227	24.2896
33660	Mobile, AL	22.1176	20.9653
33700	Modesto, CA	33.3566	31.0924
33740	Monroe, LA	22.5035	20.9918
33780	Monroe, MI	26.4882	25.0486
33860	Montgomery, AL	24.1674	21.7986
34060	Morgantown, WV	23.6097	22.7263
34100	Morristown, TN	22.3067	20.9421
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	25.0051	23.7988
34900	Napa, CA	35.3683	32.9923
34940	Naples-Marco Island, FL	28.3230	26.9127
34980	Nashville-Davidson--Murfreesboro, TN	27.2496	26.0281
35004	Nassau-Suffolk, NY	35.6748	34.1135
35084	Newark-Union, NJ-PA	33.2663	30.9022
35300	New Haven-Milford, CT	33.3518	31.3675
35380	New Orleans-Metairie-Kenner, LA	25.1827	23.9688
35644	New York-White Plains-Wayne, NY-NJ	36.9486	35.2809
35660	Niles-Benton Harbor, MI	24.8541	23.3997
35980	Norwich-New London, CT	31.8526	30.4467
36084	Oakland-Fremont-Hayward, CA	42.9160	40.0373
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	23.8010
36500	Olympia, WA	30.5859	28.9079
36540	Omaha-Council Bluffs, NE-IA	26.7314	25.5148
36740	Orlando-Kissimmee, FL	26.4642	25.3744
36780	Oshkosh-Neenah, WI	25.6249	23.9585
36980	Owensboro, KY	24.6348	22.4970
37100	Oxnard-Thousand Oaks-Ventura, CA	32.5213	29.7621
37340	Palm Bay-Melbourne-Titusville, FL	27.5289	25.7640
37460	Panama City-Lynn Haven, FL	22.4111	21.3800
37620	Parkersburg-Marietta-Vienna, WV-OH	23.2293	21.6543
37700	Pascagoula, MS	22.8397	21.4591
37860	Pensacola-Ferry Pass-Brent, FL	22.6287	22.0289
37900	Peoria, IL	24.7705	23.2523
37964	Philadelphia, PA	30.8816	28.8533
38060	Phoenix-Mesa-Scottsdale, AZ	28.3642	26.6290
38220	Pine Bluff, AR	24.3824	22.1870
38300	Pittsburgh, PA	24.7324	23.2424
38340	Pittsfield, MA	28.4877	27.1701
38540	Pocatello, ID	26.1526	24.5528
38660	Ponce, PR	13.8322	12.8492
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 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	31.4628	29.7783
38940	Port St. Lucie-Fort Pierce, FL	28.3669	26.5761
39100	Poughkeepsie-Newburgh-Middletown, NY	30.5020	29.4326
39140	Prescott, AZ	27.6508	26.3318
39300	Providence-New Bedford-Fall River, RI-MA	30.6740	28.8463
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	27.0728	25.4570
39660	Rapid City, SD	25.1848	23.5321
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	30.8793	29.3344
40220	Roanoke, VA	23.4915	22.4289
40340	Rochester, MN	31.1302	30.1737
40380	Rochester, NY	25.5478	24.5634
40420	Rockford, IL	27.9047	25.7272
40484	Rockingham County-Strafford County, NH	29.0055	27.0997
40580	Rocky Mount, NC	24.9648	23.7216
40660	Rome, GA	26.3370	23.8100
40900	Sacramento--Arden-Arcade--Roseville, CA	36.2611	32.0875
40980	Saginaw-Saginaw Township North, MI	25.5958	25.5607
41060	St. Cloud, MN	28.0585	26.2839
41100	St. George, UT	26.3420	25.1139
41140	St. Joseph, MO-KS	26.7587	25.8174
41180	St. Louis, MO-IL	25.0846	23.8052
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	26.3906	25.4257
41660	San Angelo, TX	23.1837	21.9567
41700	San Antonio, TX	25.1428	23.6261
41740	San Diego-Carlsbad-San Marcos, CA	31.9401	29.7863
41780	Sandusky, OH	25.2762	23.6583
41884	San Francisco-San Mateo-Redwood City, CA	41.9335	38.9830
41900	San Germán-Cabo Rojo, PR	12.9971	13.4135
41940	San Jose-Sunnyvale-Santa Clara, CA	42.2523	39.0890
41980	San Juan-Caguas-Guaynabo, PR	12.9393	12.3162
42020	San Luis Obispo-Paso Robles, CA	31.7731	29.7965
42044	Santa Ana-Anaheim-Irvine, CA	32.3373	30.4076
42060	Santa Barbara-Santa Maria, CA	32.7103	28.9597
42100	Santa Cruz-Watsonville, CA	42.4095	37.7929
42140	Santa Fe, NM	30.5158	28.6521
42220	Santa Rosa-Petaluma, CA	37.7122	34.6300
42260	Sarasota-Bradenton-Venice, FL	26.9389	25.6422
42340	Savannah, GA	26.5021	24.9741
42540	Scranton--Wilkes-Barre, PA	23.8629	22.4039
42644	Seattle-Bellevue-Everett, WA	32.3767	30.4445
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	26.2251	24.1116
43620	Sioux Falls, SD	26.9029	24.9570
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	24.6057	23.2284
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	31.7251	28.5148
44940	Sumter, SC	23.4355	22.1331
45060	Syracuse, NY	26.8515	25.0736
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 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	25.9983	24.1939
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	25.2779	23.7062
46140	Tulsa, OK	23.9970	23.2073
46220	Tuscaloosa, AL	24.2170	22.0794
46340	Tyler, TX	25.7125	24.7325
46540	Utica-Rome, NY	23.4607	22.0280
46660	Valdosta, GA	24.8233	22.3922
46700	Vallejo-Fairfield, CA	41.7968	38.4584
46940	Vero Beach, FL	26.4579	25.3120
47020	Victoria, TX	22.7937	21.7204
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	28.4356	26.3659
47380	Waco, TX	23.8678	22.0171
47580	Warner Robins, GA	24.2312	22.6117
47644	Warren-Farmington Hills-Troy, MI	27.6345	26.2898
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV	30.6032	28.8853
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	25.6747	24.4913
48660	Wichita Falls, TX	23.2954	21.9177
48700	Williamsport, PA	23.3959	21.9847
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	30.8984	29.3325
49420	Yakima, WA	28.4267	27.0566
49500	Yauco, PR	12.3449	12.0750
49620	York-Hanover, PA	26.1806	24.2981
49660	Youngstown-Warren-Boardman, OH-PA	24.0832	23.4825
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 short-term, acute care 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	20.8999	19.9031
02	Alaska	33.5065	31.3627
03	Arizona	24.5771	23.5781
04	Arkansas	20.9832	19.6639
05	California	30.9228	27.8406
06	Colorado	26.2370	24.4898
07	Connecticut	32.8379	31.4900
08	Delaware	26.8262	25.1791
10	Florida	24.0373	22.7337
11	Georgia	21.5043	20.4917
12	Hawaii	29.6476	27.4203
13	Idaho	22.5556	21.6648
14	Illinois	23.1784	21.7802
15	Indiana	24.1547	22.8438
16	Iowa	23.8311	22.1480
17	Kansas	22.5158	21.1668
18	Kentucky	21.7864	20.5845

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
19	Louisiana	20.8290	19.5825
20	Maine	24.7292	23.4474
21	Maryland	26.2028	24.3521
22	Massachusetts [1]		
23	Michigan	24.9169	23.3830
24	Minnesota	25.5734	24.3287
25	Mississippi	21.5293	20.3356
26	Missouri	22.1677	20.6486
27	Montana	24.5083	22.9955
28	Nebraska	24.2446	23.2964
29	Nevada	25.3983	24.4345
30	New Hampshire	30.2715	26.9284
31	New Jersey [1]		
32	New Mexico	24.1961	22.4946
33	New York	22.8722	21.6322
34	North Carolina	23.9254	22.5449
35	North Dakota	20.3602	20.0194
36	Ohio	24.7151	23.1099
37	Oklahoma	21.2973	20.1405
38	Oregon	27.4930	25.9289
39	Pennsylvania	23.2122	21.9228
40	Puerto Rico [1]		
41	Rhode Island [1]		
42	South Carolina	24.2524	22.7760
43	South Dakota	23.9456	21.9995
44	Tennessee	22.1887	20.8141
45	Texas	22.4960	20.9804
46	Utah	22.7561	21.7591
47	Vermont	27.4761	24.9413
49	Virginia	22.4742	21.2303
50	Washington	29.4354	27.3014
51	West Virginia	21.6576	20.5854
52	Wisconsin	26.6228	24.7285
53	Wyoming	25.9018	24.1183

[1] All counties in the State or Territory 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.

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	0.8053	0.8622
	Callahan County, TX.		
	Jones County, TX.		
	Taylor County, TX.		
10380	Aguadilla-Isabela-San Sebastián, PR	0.4732	0.5991
	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	0.8970	0.9283
	Portage County, OH.		
	Summit County, OH.		
10500	Albany, GA	0.8634	0.9043
	Baker County, GA.		
	Dougherty County, GA.		
	Lee County, GA.		
	Terrell County, GA.		
	Worth County, GA.		
10580	Albany-Schenectady-Troy, NY	0.8607	0.9024
	Albany County, NY.		
	Rensselaer County, NY.		
	Saratoga 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
	Schenectady County, NY.		
	Schoharie County, NY.		
10740	Albuquerque, NM	0.9686	0.9784
	Bernalillo County, NM.		
	Sandoval County, NM.		
	Torrance County, NM.		
	Valencia County, NM.		
10780	Alexandria, LA	0.8040	0.8612
	Grant Parish, LA.		
	Rapides Parish, LA.		
10900	Allentown-Bethlehem-Easton, PA-NJ (PA Hospitals)	0.9834	0.9886
	Warren County, NJ.		
	Carbon County, PA.		
	Lehigh County, PA.		
	Northampton County, PA.		
10900	[2] Allentown-Bethlehem-Easton, PA-NJ (NJ Hospitals)	1.1227	1.0825
	Warren County, NJ.		
	Carbon County, PA.		
	Lehigh County, PA.		
	Northampton County, PA.		
11020	Altoona, PA	0.8933	0.9256
	Blair County, PA.		
11100	Amarillo, TX	0.9156	0.9414
	Armstrong County, TX.		
	Carson County, TX.		
	Potter County, TX.		
	Randall County, TX.		
11180	Ames, IA	0.9537	0.9681
	Story County, IA.		
11260	[2] Anchorage, AK	1.1965	1.1307
	Anchorage Municipality, AK.		
	Matanuska-Susitna Borough, AK.		
11300	Anderson, IN	0.8626	0.9037
	Madison County, IN.		
11340	Anderson, SC	0.8988	0.9295
	Anderson County, SC.		
11460	Ann Arbor, MI	1.0874	1.0591
	Washtenaw County, MI.		
11500	Anniston-Oxford, AL	0.7717	0.8374
	Calhoun County, AL.		
11540	[2] Appleton, WI	0.9507	0.9660
	Calumet County, WI.		
	Outagamie County, WI.		
11700	Asheville, NC	0.9303	0.9517
	Buncombe County, NC.		
	Haywood County, NC.		
	Henderson County, NC.		
	Madison County, NC.		
12020	Athens-Clarke County, GA	0.9826	0.9881
	Clarke County, GA.		
	Madison County, GA.		
	Oconee County, GA.		
	Oglethorpe County, GA.		
12060	[1] Atlanta-Sandy Springs-Marietta, GA	0.9782	0.9850
	Barrow County, GA.		
	Bartow County, GA.		
	Butts County, GA.		
	Carroll County, GA.		
	Cherokee County, GA.		
	Clayton County, GA.		
	Cobb County, GA.		
	Coweta County, GA.		
	Dawson County, GA.		
	DeKalb County, GA.		
	Douglas County, GA.		
	Fayette County, GA.		
	Forsyth County, GA.		
	Fulton County, GA.		
	Gwinnett County, GA.		
	Haralson County, GA.		

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
	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	1.1600	1.1070
	Atlantic County, NJ.		
12220	Auburn-Opelika, AL	0.8105	0.8660
	Lee County, AL.		
12260	Augusta-Richmond County, GA-SC	0.9751	0.9829
	Burke County, GA.		
	Columbia County, GA.		
	McDuffie County, GA.		
	Richmond County, GA.		
	Aiken County, SC.		
	Edgefield County, SC.		
12420	[1] Austin-Round Rock, TX	0.9439	0.9612
	Bastrop County, TX.		
	Caldwell County, TX.		
	Hays County, TX.		
	Travis County, TX.		
	Williamson County, TX.		
12540	[2] Bakersfield, CA	1.1042	1.0702
	Kern County, CA.		
12580	[1] Baltimore-Towson, MD	0.9882	0.9919
	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	0.9975	0.9983
	Penobscot County, ME.		
12700	Barnstable Town, MA	1.2592	1.1710
	Barnstable County, MA.		
12940	Baton Rouge, LA	0.8596	0.9016
	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	0.9490	0.9648
	Calhoun County, MI.		
13020	Bay City, MI	0.9525	0.9672
	Bay County, MI.		
13140	Beaumont-Port Arthur, TX	0.8413	0.8884
	Hardin County, TX.		
	Jefferson County, TX.		
	Orange County, TX.		
13380	Bellingham, WA	1.1693	1.1131
	Whatcom County, WA.		
13460	Bend, OR	1.0772	1.0522
	Deschutes County, OR.		
13644	[1] Bethesda-Gaithersburg-Frederick, MD	1.1459	1.0978
	Frederick County, MD.		
	Montgomery County, MD.		
13740	Billings, MT	0.8846	0.9195
	Carbon County, MT.		

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
	Yellowstone County, MT.		
13780	Binghamton, NY	0.8580	0.9004
	Broome County, NY.		
	Tioga County, NY.		
13820	[1] Birmingham-Hoover, AL	0.8959	0.9275
	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	0.7575	0.8268
	Burleigh County, ND.		
	Morton County, ND.		
13980	[2] Blacksburg-Christiansburg-Radford, VA	0.8025	0.8601
	Giles County, VA.		
	Montgomery County, VA.		
	Pulaski County, VA.		
	Radford City, VA.		
14020	[2] Bloomington, IN	0.8626	0.9037
	Greene County, IN.		
	Monroe County, IN.		
	Owen County, IN.		
14060	Bloomington-Normal, IL	0.9074	0.9356
	McLean County, IL.		
14260	Boise City-Nampa, ID	0.9039	0.9331
	Ada County, ID.		
	Boise County, ID.		
	Canyon County, ID.		
	Gem County, ID.		
	Owyhee County, ID.		
14484	[1] Boston-Quincy, MA	1.1551	1.1038
	Norfolk County, MA.		
	Plymouth County, MA.		
	Suffolk County, MA.		
14500	Boulder, CO	0.9733	0.9816
	Boulder County, CO.		
14540	Bowling Green, KY	0.8214	0.8740
	Edmonson County, KY.		
	Warren County, KY.		
14740	Bremerton-Silverdale, WA	1.0670	1.0454
	Kitsap County, WA.		
14860	Bridgeport-Stamford-Norwalk, CT	1.2601	1.1715
	Fairfield County, CT.		
15180	Brownsville-Harlingen, TX	0.9835	0.9887
	Cameron County, TX.		
15260	Brunswick, GA	0.9331	0.9537
	Brantley County, GA.		
	Glynn County, GA.		
	McIntosh County, GA.		
15380	[1] Buffalo-Niagara Falls, NY	0.9503	0.9657
	Erie County, NY.		
	Niagara County, NY.		
15500	Burlington, NC	0.8893	0.9228
	Alamance County, NC.		
15540	[2] Burlington-South Burlington, VT	1.0189	1.0129
	Chittenden County, VT.		
	Franklin County, VT.		
	Grand Isle County, VT.		
15764	[1] Cambridge-Newton-Framingham, MA	1.1166	1.0785
	Middlesex County, MA.		
15804	[1, 2] Camden, NJ	1.1227	1.0825
	Burlington County, NJ.		
	Camden County, NJ.		
	Gloucester County, NJ.		
15940	Canton-Massillon, OH	0.8948	0.9267
	Carroll County, OH.		
	Stark County, OH.		
15980	Cape Coral-Fort Myers, FL	0.9323	0.9531

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
	Lee County, FL.		
16180	Carson City, NV	1.0219	1.0149
	Carson City, NV.		
16220	[2] Casper, WY	0.9249	0.9479
	Natrona County, WY.		
16300	Cedar Rapids, IA	0.8813	0.9171
	Benton County, IA.		
	Jones County, IA.		
	Linn County, IA.		
16580	Champaign-Urbana, IL	0.9582	0.9712
	Champaign County, IL.		
	Ford County, IL.		
	Piatt County, IL.		
16620	Charleston, WV	0.8446	0.8908
	Boone County, WV.		
	Clay County, WV.		
	Kanawha County, WV.		
	Lincoln County, WV.		
	Putnam County, WV.		
16700	Charleston-North Charleston, SC	0.9240	0.9473
	Berkeley County, SC.		
	Charleston County, SC.		
	Dorchester County, SC.		
16740	[1] Charlotte-Gastonia-Concord, NC-SC	0.9707	0.9798
	Anson County, NC.		
	Cabarrus County, NC.		
	Gaston County, NC.		
	Mecklenburg County, NC.		
	Union County, NC.		
	York County, SC.		
16820	Charlottesville, VA	1.0184	1.0126
	Albemarle County, VA.		
	Fluvanna County, VA.		
	Greene County, VA.		
	Nelson County, VA.		
	Charlottesville City, VA.		
16860	Chattanooga, TN-GA	0.9089	0.9367
	Catoosa County, GA.		
	Dade County, GA.		
	Walker County, GA.		
	Hamilton County, TN.		
	Marion County, TN.		
	Sequatchie County, TN.		
16940	[2] Cheyenne, WY	0.9249	0.9479
	Laramie County, WY.		
16974	[1] Chicago-Naperville-Joliet, IL	1.0787	1.0532
	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	1.1042	1.0702
	Butte County, CA.		
17140	[1] Cincinnati-Middletown, OH-KY-IN	0.9595	0.9721
	Dearborn County, IN.		
	Franklin County, IN.		
	Ohio County, IN.		
	Boone County, KY.		
	Bracken County, KY.		
	Campbell County, KY.		
	Gallatin County, KY.		
	Grant County, KY.		
	Kenton County, KY.		
	Pendleton County, KY.		
	Brown County, OH.		
	Butler County, OH.		
	Clermont County, OH.		

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
	Hamilton County, OH.		
	Warren County, OH.		
17300	Clarksville, TN-KY	0.8264	0.8776
	Christian County, KY.		
	Trigg County, KY.		
	Montgomery County, TN.		
	Stewart County, TN.		
17420	Cleveland, TN	0.8157	0.8698
	Bradley County, TN.		
	Polk County, TN.		
17460	[1] Cleveland-Elyria-Mentor, OH	0.9207	0.9450
	Cuyahoga County, OH.		
	Geauga County, OH.		
	Lake County, OH.		
	Lorain County, OH.		
	Medina County, OH.		
17660	Coeur d'Alene, ID	0.9633	0.9747
	Kootenai County, ID.		
17780	College Station-Bryan, TX	0.8902	0.9234
	Brazos County, TX.		
	Burleson County, TX.		
	Robertson County, TX.		
17820	Colorado Springs, CO	0.9447	0.9618
	El Paso County, CO.		
	Teller County, CO.		
17860	Columbia, MO	0.8357	0.8843
	Boone County, MO.		
	Howard County, MO.		
17900	Columbia, SC	0.9067	0.9351
	Calhoun County, SC.		
	Fairfield County, SC.		
	Kershaw County, SC.		
	Lexington County, SC.		
	Richland County, SC.		
	Saluda County, SC.		
17980	Columbus, GA-AL	0.8562	0.8991
	Russell County, AL.		
	Chattahoochee County, GA.		
	Harris County, GA.		
	Marion County, GA.		
	Muscogee County, GA.		
18020	Columbus, IN	0.9586	0.9715
	Bartholomew County, IN.		
18140	[1] Columbus, OH	0.9857	0.9902
	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	0.8549	0.8982
	Aransas County, TX.		
	Nueces County, TX.		
	San Patricio County, TX.		
18700	Corvallis, OR	1.0700	1.0474
	Benton County, OR.		
19060	[2] Cumberland, MD-WV (MD Hospitals)	0.9357	0.9555
	Allegany County, MD.		
	Mineral County, WV.		
19060	Cumberland, MD-WV (WV Hospitals)	0.9300	0.9515
	Allegany County, MD.		
	Mineral County, WV.		
19124	[1] Dallas-Plano-Irving, TX	1.0222	1.0151
	Collin County, TX.		
	Dallas County, TX.		
	Delta County, TX.		
	Denton County, TX.		
	Ellis 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
	Hunt County, TX.		
	Kaufman County, TX.		
	Rockwall County, TX.		
19140	Dalton, GA	0.9067	0.9351
	Murray County, GA.		
	Whitfield County, GA.		
19180	Danville, IL	0.9039	0.9331
	Vermilion County, IL.		
19260	Danville, VA	0.8506	0.8951
	Pittsylvania County, VA.		
	Danville City, VA.		
19340	Davenport-Moline-Rock Island, IA-IL	0.8709	0.9097
	Henry County, IL.		
	Mercer County, IL.		
	Rock Island County, IL.		
	Scott County, IA.		
19380	Dayton, OH	0.9060	0.9346
	Greene County, OH.		
	Miami County, OH.		
	Montgomery County, OH.		
	Preble County, OH.		
19460	Decatur, AL	0.8509	0.8953
	Lawrence County, AL.		
	Morgan County, AL.		
19500	[2] Decatur, IL	0.8279	0.8787
	Macon County, IL.		
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.9298	0.9514
	Volusia County, FL.		
19740	[1] Denver-Aurora, CO	1.0699	1.0474
	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	0.9668	0.9771
	Dallas County, IA.		
	Guthrie County, IA.		
	Madison County, IA.		
	Polk County, IA.		
	Warren County, IA.		
19804	[1] Detroit-Livonia-Dearborn, MI	1.0436	1.0297
	Wayne County, MI.		
20020	Dothan, AL	0.7757	0.8404
	Geneva County, AL.		
	Henry County, AL.		
	Houston County, AL.		
20100	Dover, DE	0.9817	0.9874
	Kent County, DE.		
20220	Dubuque, IA	0.9005	0.9307
	Dubuque County, IA.		
20260	Duluth, MN-WI	1.0226	1.0154
	Carlton County, MN.		
	St. Louis County, MN.		
	Douglas County, WI.		
20500	Durham, NC	1.0200	1.0137
	Chatham County, NC.		
	Durham County, NC.		
	Orange County, NC.		
	Person County, NC.		
20740	[2] Eau Claire, WI	0.9507	0.9660
	Chippewa County, WI.		
	Eau Claire County, WI.		
20764	[1] Edison, NJ	1.1290	1.0866
	Middlesex County, NJ.		
	Monmouth 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
	Ocean County, NJ.		
	Somerset County, NJ.		
20940	[2] El Centro, CA	1.1042	1.0702
	Imperial County, CA.		
21060	Elizabethtown, KY	0.8807	0.9167
	Hardin County, KY.		
	Larue County, KY.		
21140	Elkhart-Goshen, IN	0.9606	0.9728
	Elkhart County, IN.		
21300	Elmira, NY	0.8268	0.8779
	Chemung County, NY.		
21340	El Paso, TX	0.9007	0.9309
	El Paso County, TX.		
21500	Erie, PA	0.8737	0.9117
	Erie County, PA.		
21604	[2] Essex County, MA	1.0715	1.0484
	Essex County, MA.		
21660	Eugene-Springfield, OR	1.0799	1.0540
	Lane County, OR.		
21780	Evansville, IN-KY	0.8727	0.9110
	Gibson County, IN.		
	Posey County, IN.		
	Vanderburgh County, IN.		
	Warrick County, IN.		
	Henderson County, KY.		
	Webster County, KY.		
21820	[2] Fairbanks, AK	1.1965	1.1307
	Fairbanks North Star Borough, AK.		
21940	Fajardo, PR	0.4156	0.5481
	Ceiba Municipio, PR.		
	Fajardo Municipio, PR.		
	Luquillo Municipio, PR.		
22020	Fargo, ND-MN (ND Hospitals)	0.8769	0.9140
	Clay County, MN.		
	Cass County, ND.		
22020	[2] Fargo, ND-MN (MN Hospitals)	0.9132	0.9397
	Clay County, MN.		
	Cass County, ND.		
22140	[2] Farmington, NM	0.8640	0.9047
	San Juan County, NM.		
22180	Fayetteville, NC	0.9417	0.9597
	Cumberland County, NC.		
	Hoke County, NC.		
22220	Fayetteville-Springdale-Rogers, AR-MO	0.8707	0.9095
	Benton County, AR.		
	Madison County, AR.		
	Washington County, AR.		
	McDonald County, MO.		
22380	Flagstaff, AZ	1.2082	1.1383
	Coconino County, AZ.		
22420	Flint, MI	1.0644	1.0437
	Genesee County, MI.		
22500	Florence, SC	0.8971	0.9283
	Darlington County, SC.		
	Florence County, SC.		
22520	Florence-Muscle Shoals, AL	0.8297	0.8800
	Colbert County, AL.		
	Lauderdale County, AL.		
22540	Fond du Lac, WI	0.9639	0.9751
	Fond du Lac County, WI.		
22660	Fort Collins-Loveland, CO	1.0136	1.0093
	Larimer County, CO.		
22744	[1] Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0497	1.0338
	Broward County, FL.		
22900	Fort Smith, AR-OK	0.8247	0.8764
	Crawford County, AR.		
	Franklin County, AR.		
	Sebastian County, AR.		
	Le Flore County, OK.		
	Sequoyah 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
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL.	0.8868	0.9210
23060	Fort Wayne, IN Allen County, IN. Wells County, IN. Whitley County, IN.	0.9787	0.9854
23104	[1] Fort Worth-Arlington, TX Johnson County, TX. Parker County, TX. Tarrant County, TX. Wise County, TX.	0.9491	0.9649
23420	[2] Fresno, CA Fresno County, CA.	1.1042	1.0702
23460	Gadsden, AL Etowah County, AL.	0.7966	0.8558
23540	Gainesville, FL Alachua County, FL. Gilchrist County, FL.	0.9375	0.9568
23580	Gainesville, GA Hall County, GA.	0.8888	0.9224
23844	Gary, IN Jasper County, IN. Lake County, IN. Newton County, IN. Porter County, IN.	0.9390	0.9578
24020	Glens Falls, NY Warren County, NY. Washington County, NY.	0.8579	0.9004
24140	Goldsboro, NC Wayne County, NC.	0.8773	0.9143
24220	Grand Forks, ND-MN (ND Hospitals) Polk County, MN. Grand Forks County, ND.	0.7926	0.8528
24220	[2] Grand Forks, ND-MN (MN Hospitals) Polk County, MN. Grand Forks County, ND.	0.9132	0.9397
24300	Grand Junction, CO Mesa County, CO.	0.9581	0.9711
24340	Grand Rapids-Wyoming, MI Barry County, MI. Ionia County, MI. Kent County, MI. Newaygo County, MI.	0.9389	0.9577
24500	Great Falls, MT Cascade County, MT.	0.9065	0.9350
24540	Greeley, CO Weld County, CO.	0.9587	0.9715
24580	[2] Green Bay, WI Brown County, WI. Kewaunee County, WI. Oconto County, WI.	0.9507	0.9660
24660	Greensboro-High Point, NC Guilford County, NC. Randolph County, NC. Rockingham County, NC.	0.9124	0.9391
24780	Greenville, NC Greene County, NC. Pitt County, NC.	0.9404	0.9588
24860	Greenville, SC Greenville County, SC. Laurens County, SC. Pickens County, SC.	1.0001	1.0001
25020	Guayama, PR Arroyo Municipio, PR. Guayama Municipio, PR. Patillas Municipio, PR.	0.3183	0.4566
25060	Gulfport-Biloxi, MS Hancock County, MS. Harrison County, MS. Stone County, MS.	0.8913	0.9242

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
25180	Hagerstown-Martinsburg, MD-WV	0.9518	0.9667
	Washington County, MD.		
	Berkeley County, WV.		
	Morgan County, WV.		
25260	[2] Hanford-Corcoran, CA	1.1042	1.0702
	Kings County, CA.		
25420	Harrisburg-Carlisle, PA	0.9308	0.9521
	Cumberland County, PA.		
	Dauphin County, PA.		
	Perry County, PA.		
25500	Harrisonburg, VA	0.9092	0.9369
	Rockingham County, VA.		
	Harrisonburg City, VA.		
25540	[1, 2] Hartford-West Hartford-East Hartford, CT	1.1726	1.1152
	Hartford County, CT.		
	Litchfield County, CT.		
	Middlesex County, CT.		
	Tolland County, CT.		
25620	[2] Hattiesburg, MS	0.7688	0.8352
	Forrest County, MS.		
	Lamar County, MS.		
	Perry County, MS.		
25860	Hickory-Lenoir-Morganton, NC	0.8930	0.9254
	Alexander County, NC.		
	Burke County, NC.		
	Caldwell County, NC.		
	Catawba County, NC.		
25980	Hinesville-Fort Stewart, GA	0.7679	0.8346
	Liberty County, GA.		
	Long County, GA.		
26100	Holland-Grand Haven, MI	0.9124	0.9391
	Ottawa County, MI.		
26180	Honolulu, HI	1.1213	1.0816
	Honolulu County, HI.		
26300	Hot Springs, AR	0.9020	0.9318
	Garland County, AR.		
26380	Houma-Bayou Cane-Thibodaux, LA	0.7895	0.8506
	Lafourche Parish, LA.		
	Terrebonne Parish, LA.		
26420	[1] Houston-Sugar Land-Baytown, TX	0.9996	0.9997
	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	0.9473	0.9636
	Boyd County, KY.		
	Greenup County, KY.		
	Lawrence County, OH.		
	Cabell County, WV.		
	Wayne County, WV.		
26620	Huntsville, AL	0.9120	0.9389
	Limestone County, AL.		
	Madison County, AL.		
26820	Idaho Falls, ID	0.8689	0.9083
	Bonneville County, ID.		
	Jefferson County, ID.		
26900	[1] Indianapolis, IN	0.9912	0.9940
	Boone County, IN.		
	Brown County, IN.		
	Hamilton County, IN.		
	Hancock County, IN.		
	Hendricks County, IN.		
	Johnson County, IN.		
	Marion County, IN.		

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
	Morgan County, IN.		
	Putnam County, IN.		
	Shelby County, IN.		
26980	Iowa City, IA	0.9741	0.9822
	Johnson County, IA.		
	Washington County, IA.		
27060	Ithaca, NY	0.9845	0.9894
	Tompkins County, NY.		
27100	Jackson, MI	0.9291	0.9509
	Jackson County, MI.		
27140	Jackson, MS	0.8304	0.8805
	Copiah County, MS.		
	Hinds County, MS.		
	Madison County, MS.		
	Rankin County, MS.		
	Simpson County, MS.		
27180	Jackson, TN	0.8955	0.9272
	Chester County, TN.		
	Madison County, TN.		
27260	[1] Jacksonville, FL	0.9294	0.9511
	Baker County, FL.		
	Clay County, FL.		
	Duval County, FL.		
	Nassau County, FL.		
	St. Johns County, FL.		
27340	[2] Jacksonville, NC	0.8544	0.8978
	Onslow County, NC.		
27500	Janesville, WI	0.9551	0.9690
	Rock County, WI.		
27620	Jefferson City, MO	0.8381	0.8861
	Callaway County, MO.		
	Cole County, MO.		
	Moniteau County, MO.		
	Osage County, MO.		
27740	[2] Johnson City, TN	0.8003	0.8585
	Carter County, TN.		
	Unicoi County, TN.		
	Washington County, TN.		
27780	Johnstown, PA	0.8340	0.8831
	Cambria County, PA.		
27860	Jonesboro, AR	0.7960	0.8554
	Craighead County, AR.		
	Poinsett County, AR.		
27900	Joplin, MO	0.8585	0.9008
	Jasper County, MO.		
	Newton County, MO.		
28020	Kalamazoo-Portage, MI	1.0393	1.0267
	Kalamazoo County, MI.		
	Van Buren County, MI.		
28100	Kankakee-Bradley, IL	1.0738	1.0500
	Kankakee County, IL.		
28140	[1] Kansas City, MO-KS	0.9463	0.9629
	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	1.0608	1.0412
	Benton County, WA.		
	Franklin 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
28660	Killeen-Temple-Fort Hood, TX	0.8557	0.8988
	Bell County, TX.		
	Coryell County, TX.		
	Lampasas County, TX.		
28700	Kingsport-Bristol-Bristol, TN-VA	0.8087	0.8647
	Hawkins County, TN.		
	Sullivan County, TN.		
	Bristol City, VA.		
	Scott County, VA.		
	Washington County, VA.		
28740	Kingston, NY	0.9258	0.9486
	Ulster County, NY.		
28940	Knoxville, TN	0.8456	0.8915
	Anderson County, TN.		
	Blount County, TN.		
	Knox County, TN.		
	Loudon County, TN.		
	Union County, TN.		
29020	Kokomo, IN	0.9546	0.9687
	Howard County, IN.		
	Tipton County, IN.		
29100	La Crosse, WI-MN	0.9548	0.9688
	Houston County, MN.		
	La Crosse County, WI.		
29140	Lafayette, IN	0.8721	0.9105
	Benton County, IN.		
	Carroll County, IN.		
	Tippecanoe County, IN.		
29180	Lafayette, LA	0.8420	0.8889
	Lafayette Parish, LA.		
	St. Martin Parish, LA.		
29340	Lake Charles, LA	0.7839	0.8464
	Calcasieu Parish, LA.		
	Cameron Parish, LA.		
29404	Lake County-Kenosha County, IL-WI	1.0434	1.0295
	Lake County, IL.		
	Kenosha County, WI.		
29460	Lakeland, FL	0.8925	0.9251
	Polk County, FL.		
29540	Lancaster, PA	0.9706	0.9798
	Lancaster County, PA.		
29620	Lansing-East Lansing, MI	0.9788	0.9854
	Clinton County, MI.		
	Eaton County, MI.		
	Ingham County, MI.		
29700	Laredo, TX	0.8093	0.8651
	Webb County, TX.		
29740	[2] Las Cruces, NM	0.8640	0.9047
	Dona Ana County, NM.		
29820	[1] Las Vegas-Paradise, NV	1.1404	1.0941
	Clark County, NV.		
29940	Lawrence, KS	0.8530	0.8968
	Douglas County, KS.		
30020	Lawton, OK	0.7908	0.8515
	Comanche County, OK.		
30140	Lebanon, PA	0.8645	0.9051
	Lebanon County, PA.		
30300	Lewiston, ID-WA (ID Hospitals)	0.9868	0.9909
	Nez Perce County, ID.		
	Asotin County, WA.		
30300	[2] Lewiston, ID-WA (WA Hospitals)	1.0480	1.0326
	Nez Perce County, ID.		
	Asotin County, WA.		
30340	Lewiston-Auburn, ME	0.9322	0.9531
	Androscoggin County, ME.		
30460	Lexington-Fayette, KY	0.9051	0.9340
	Bourbon County, KY.		
	Clark County, KY.		
	Fayette County, KY.		
	Jessamine County, KY.		

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
	Scott County, KY.		
	Woodford County, KY.		
30620	Lima, OH	0.9271	0.9495
	Allen County, OH.		
30700	Lincoln, NE	1.0187	1.0128
	Lancaster County, NE.		
	Seward County, NE.		
30780	Little Rock-North Little Rock, AR	0.8759	0.9133
	Faulkner County, AR.		
	Grant County, AR.		
	Lonoke County, AR.		
	Perry County, AR.		
	Pulaski County, AR.		
	Saline County, AR.		
30860	Logan, UT-ID	0.9174	0.9427
	Franklin County, ID.		
	Cache County, UT.		
30980	Longview, TX	0.8732	0.9113
	Gregg County, TX.		
	Rusk County, TX.		
	Upshur County, TX.		
31020	[2] Longview, WA	1.0480	1.0326
	Cowlitz County, WA.		
31084	[1] Los Angeles-Long Beach-Glendale, CA	1.1793	1.1196
	Los Angeles County, CA.		
31140	[1] Louisville, KY-IN	0.9254	0.9483
	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	0.8781	0.9148
	Crosby County, TX.		
	Lubbock County, TX.		
31340	Lynchburg, VA	0.8697	0.9088
	Amherst County, VA.		
	Appomattox County, VA.		
	Bedford County, VA.		
	Campbell County, VA.		
	Bedford City, VA.		
	Lynchburg City, VA.		
31420	Macon, GA	0.9475	0.9637
	Bibb County, GA.		
	Crawford County, GA.		
	Jones County, GA.		
	Monroe County, GA.		
	Twiggs County, GA.		
31460	[2] Madera, CA	1.1042	1.0702
	Madera County, CA.		
31540	Madison, WI	1.0654	1.0443
	Columbia County, WI.		
	Dane County, WI.		
	Iowa County, WI.		
31700	[2] Manchester-Nashua, NH	1.1561	1.1044
	Hillsborough County, NH.		
	Merrimack County, NH.		
31900	Mansfield, OH	0.9902	0.9933
	Richland County, OH.		
32420	Mayagüez, PR	0.4019	0.5357
	Hormigueros Municipio, PR.		
	Mayagüez Municipio, PR.		
32580	McAllen-Edinburg-Mission, TX	0.8936	0.9259

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
	Hidalgo County, TX.		
32780	[2] Medford, OR	1.0301	1.0205
	Jackson County, OR.		
32820	[1] Memphis, TN-MS-AR	0.9402	0.9587
	Crittenden County, AR.		
	DeSoto County, MS.		
	Marshall County, MS.		
	Tate County, MS.		
	Tunica County, MS.		
	Fayette County, TN.		
	Shelby County, TN.		
	Tipton County, TN.		
32900	Merced, CA	1.1112	1.0749
	Merced County, CA.		
33124	[1] Miami-Miami Beach-Kendall, FL	0.9747	0.9826
	Miami-Dade County, FL.		
33140	Michigan City-La Porte, IN	0.9400	0.9585
	LaPorte County, IN.		
33260	Midland, TX	0.9513	0.9664
	Midland County, TX.		
33340	[1] Milwaukee-Waukesha-West Allis, WI	1.0150	1.0102
	Milwaukee County, WI.		
	Ozaukee County, WI.		
	Washington County, WI.		
	Waukesha County, WI.		
33460	[1] Minneapolis-St. Paul-Bloomington, MN-WI	1.1052	1.0709
	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	0.9526	0.9673
	Missoula County, MT.		
33660	Mobile, AL	0.7898	0.8508
	Mobile County, AL.		
33700	Modesto, CA	1.1960	1.1304
	Stanislaus County, CA.		
33740	Monroe, LA	0.8036	0.8609
	Ouachita Parish, LA.		
	Union Parish, LA.		
33780	Monroe, MI	0.9459	0.9626
	Monroe County, MI.		
33860	Montgomery, AL	0.8630	0.9040
	Autauga County, AL.		
	Elmore County, AL.		
	Lowndes County, AL.		
	Montgomery County, AL.		
34060	Morgantown, WV	0.8431	0.8897
	Monongalia County, WV.		
	Preston County, WV.		
34100	[2] Morristown, TN	0.8003	0.8585
	Grainger County, TN.		
	Hamblen County, TN.		
	Jefferson County, TN.		
34580	[2] Mount Vernon-Anacortes, WA	1.0480	1.0326
	Skagit County, WA.		
34620	Muncie, IN	0.8943	0.9264
	Delaware County, IN.		
34740	Muskegon-Norton Shores, MI	0.9667	0.9771
	Muskegon County, MI.		
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	0.8929	0.9254
	Horry County, SC.		

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
34900	Napa, CA	1.2630	1.1734
	Napa County, CA.		
34940	Naples-Marco Island, FL	1.0114	1.0078
	Collier County, FL.		
34980	[1] Nashville-Davidson--Murfreesboro, TN	0.9731	0.9815
	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	1.2739	1.1803
	Nassau County, NY.		
	Suffolk County, NY.		
35084	[1] Newark-Union, NJ-PA	1.1879	1.1251
	Essex County, NJ.		
	Hunterdon County, NJ.		
	Morris County, NJ.		
	Sussex County, NJ.		
	Union County, NJ.		
	Pike County, PA.		
35300	New Haven-Milford, CT	1.1910	1.1272
	New Haven County, CT.		
35380	[1] New Orleans-Metairie-Kenner, LA	0.8993	0.9299
	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-White Plains-Wayne, NY-NJ	1.3194	1.2090
	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	0.8966	0.9280
	Berrien County, MI.		
35980	[2] Norwich-New London, CT	1.1726	1.1152
	New London County, CT.		
36084	[1] Oakland-Fremont-Hayward, CA	1.5463	1.3478
	Alameda County, CA.		
	Contra Costa County, CA.		
36100	Ocala, FL	0.8946	0.9266
	Marion County, FL.		
36140	[2] Ocean City, NJ	1.1227	1.0825
	Cape May County, NJ.		
36220	Odessa, TX	0.9883	0.9920
	Ector County, TX.		
36260	Ogden-Clearfield, UT	0.9039	0.9331
	Davis County, UT.		
	Morgan County, UT.		
	Weber County, UT.		
36420	[1] Oklahoma City, OK	0.9034	0.9328
	Canadian County, OK.		
	Cleveland 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
	Grady County, OK.		
	Lincoln County, OK.		
	Logan County, OK.		
	McClain County, OK.		
	Oklahoma County, OK.		
36500	Olympia, WA	1.0959	1.0647
	Thurston County, WA.		
36540	Omaha-Council Bluffs, NE-IA	0.9546	0.9687
	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-Kissimmee, FL	0.9450	0.9620
	Lake County, FL.		
	Orange County, FL.		
	Osceola County, FL.		
	Seminole County, FL.		
36780	[2] Oshkosh-Neenah, WI	0.9507	0.9660
	Winnebago County, WI.		
36980	Owensboro, KY	0.8797	0.9160
	Daviess County, KY.		
	Hancock County, KY.		
	McLean County, KY.		
37100	Oxnard-Thousand Oaks-Ventura, CA	1.1613	1.1078
	Ventura County, CA.		
37340	Palm Bay-Melbourne-Titusville, FL	0.9830	0.9883
	Brevard County, FL.		
37460	[2] Panama City-Lynn Haven, FL	0.8584	0.9007
	Bay County, FL.		
37620	Parkersburg-Marietta-Vienna, WV-OH (WV Hospitals)	0.8295	0.8798
	Washington County, OH.		
	Pleasants County, WV.		
	Wirt County, WV.		
	Wood County, WV.		
37620	[2] Parkersburg-Marietta-Vienna, WV-OH (OH Hospitals)	0.8826	0.9180
	Washington County, OH.		
	Pleasants County, WV.		
	Wirt County, WV.		
	Wood County, WV.		
37700	Pascagoula, MS	0.8156	0.8697
	George County, MS.		
	Jackson County, MS.		
37860	[2] Pensacola-Ferry Pass-Brent, FL	0.8584	0.9007
	Escambia County, FL.		
	Santa Rosa County, FL.		
37900	Peoria, IL	0.8845	0.9194
	Marshall County, IL.		
	Peoria County, IL.		
	Stark County, IL.		
	Tazewell County, IL.		
	Woodford County, IL.		
37964	[1] Philadelphia, PA	1.1028	1.0693
	Bucks County, PA.		
	Chester County, PA.		
	Delaware County, PA.		
	Montgomery County, PA.		
	Philadelphia County, PA.		
38060	[1] Phoenix-Mesa-Scottsdale, AZ	1.0129	1.0088
	Maricopa County, AZ.		
	Pinal County, AZ.		
38220	Pine Bluff, AR	0.8707	0.9095
	Cleveland County, AR.		
	Jefferson County, AR.		
	Lincoln County, AR.		
38300	[1] Pittsburgh, PA	0.8832	0.9185
	Allegheny 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
	Armstrong County, PA.		
	Beaver County, PA.		
	Butler County, PA.		
	Fayette County, PA.		
	Washington County, PA.		
	Westmoreland County, PA.		
38340	[2] Pittsfield, MA	1.0715	1.0484
	Berkshire County, MA.		
38540	Pocatello, ID	0.9394	0.9581
	Bannock County, ID.		
	Power County, ID.		
38660	Ponce, PR	0.4939	0.6169
	Juana Díaz Municipio, PR.		
	Ponce Municipio, PR.		
	Villalba Municipio, PR.		
38860	Portland-South Portland-Biddeford, ME	1.0371	1.0253
	Cumberland County, ME.		
	Sagadahoc County, ME.		
	York County, ME.		
38900	[1] Portland-Vancouver-Beaverton, OR-WA	1.1235	1.0830
	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	1.0151	1.0103
	Martin County, FL.		
	St. Lucie County, FL.		
39100	Poughkeepsie-Newburgh-Middletown, NY	1.0892	1.0603
	Dutchess County, NY.		
	Orange County, NY.		
39140	Prescott, AZ	0.9422	0.9600
	Yavapai County, AZ.		
39300	[1] Providence-New Bedford-Fall River, RI-MA	1.0954	1.0644
	Bristol County, MA.		
	Bristol County, RI.		
	Kent County, RI.		
	Newport County, RI.		
	Providence County, RI.		
	Washington County, RI.		
39340	Provo-Orem, UT	0.9484	0.9644
	Juab County, UT.		
	Utah County, UT.		
39380	[2] Pueblo, CO	0.9369	0.9563
	Pueblo County, CO.		
39460	Punta Gorda, FL	0.9265	0.9491
	Charlotte County, FL.		
39540	[2] Racine, WI	0.9507	0.9660
	Racine County, WI.		
39580	Raleigh-Cary, NC	0.9668	0.9771
	Franklin County, NC.		
	Johnston County, NC.		
	Wake County, NC.		
39660	Rapid City, SD	0.8993	0.9299
	Meade County, SD.		
	Pennington County, SD.		
39740	Reading, PA	0.9688	0.9785
	Berks County, PA.		
39820	Redding, CA	1.2195	1.1456
	Shasta County, CA.		
39900	Reno-Sparks, NV	1.0973	1.0657
	Storey County, NV.		
	Washoe County, NV.		
40060	[1] Richmond, VA	0.9309	0.9521
	Amelia County, VA.		
	Caroline County, VA.		
	Charles City County, VA.		
	Chesterfield 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
	Cumberland County, VA.		
	Dinwiddie County, VA.		
	Goochland County, VA.		
	Hanover County, VA.		
	Henrico County, VA.		
	King and Queen County, VA.		
	King William County, VA.		
	Louisa County, VA.		
	New Kent County, VA.		
	Powhatan County, VA.		
	Prince George County, VA.		
	Sussex County, VA.		
	Colonial Heights City, VA.		
	Hopewell City, VA.		
	Petersburg City, VA.		
	Richmond City, VA.		
40140	[1, 2] Riverside-San Bernardino-Ontario, CA	1.1042	1.0702
	Riverside County, CA.		
	San Bernardino County, CA.		
40220	Roanoke, VA	0.8442	0.8905
	Botetourt County, VA.		
	Craig County, VA.		
	Franklin County, VA.		
	Roanoke County, VA.		
	Roanoke City, VA.		
	Salem City, VA.		
40340	Rochester, MN	1.1116	1.0751
	Dodge County, MN.		
	Olmsted County, MN.		
	Wabasha County, MN.		
40380	[1] Rochester, NY	0.9123	0.9391
	Livingston County, NY.		
	Monroe County, NY.		
	Ontario County, NY.		
	Orleans County, NY.		
	Wayne County, NY.		
40420	Rockford, IL	0.9965	0.9976
	Boone County, IL.		
	Winnebago County, IL.		
40484	[2] Rockingham County-Strafford County, NH	1.1561	1.1044
	Rockingham County, NH.		
	Strafford County, NH.		
40580	Rocky Mount, NC	0.8915	0.9244
	Edgecombe County, NC.		
	Nash County, NC.		
40660	Rome, GA	0.9405	0.9589
	Floyd County, GA.		
40900	[1] Sacramento--Arden-Arcade--Roseville, CA	1.2949	1.1936
	El Dorado County, CA.		
	Placer County, CA.		
	Sacramento County, CA.		
	Yolo County, CA.		
40980	Saginaw-Saginaw Township North, MI	0.9140	0.9403
	Saginaw County, MI.		
41060	St. Cloud, MN	1.0020	1.0014
	Benton County, MN.		
	Stearns County, MN.		
41100	St. George, UT	0.9407	0.9590
	Washington County, UT.		
41140	St. Joseph, MO-KS	0.9555	0.9693
	Doniphan County, KS.		
	Andrew County, MO.		
	Buchanan County, MO.		
	DeKalb County, MO.		
41180	St. Louis, MO-IL	0.8958	0.9274
	Bond County, IL.		
	Calhoun County, IL.		
	Clinton County, IL.		
	Jersey County, IL.		
	Macoupin County, IL.		

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
	Madison County, IL.		
	Monroe County, IL.		
	St. Clair County, IL.		
	Crawford County, MO.		
	Franklin County, MO.		
	Jefferson County, MO.		
	Lincoln County, MO.		
	St. Charles County, MO.		
	St. Louis County, MO.		
	Warren County, MO.		
	Washington County, MO.		
	St. Louis City, MO.		
41420	Salem, OR	1.0435	1.0296
	Marion County, OR.		
	Polk County, OR.		
41500	Salinas, CA	1.4126	1.2669
	Monterey County, CA.		
41540	[2] Salisbury, MD	0.9357	0.9555
	Somerset County, MD.		
	Wicomico County, MD.		
41620	Salt Lake City, UT	0.9424	0.9602
	Salt Lake County, UT.		
	Summit County, UT.		
	Tooele County, UT.		
41660	San Angelo, TX	0.8279	0.8787
	Irion County, TX.		
	Tom Green County, TX.		
41700	[1] San Antonio, TX	0.8978	0.9288
	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	1.1406	1.0943
	San Diego County, CA.		
41780	Sandusky, OH	0.9026	0.9322
	Erie County, OH.		
41884	[1] San Francisco-San Mateo-Redwood City, CA	1.4974	1.3185
	Marin County, CA.		
	San Francisco County, CA.		
	San Mateo County, CA.		
41900	San Germán-Cabo Rojo, PR	0.4641	0.5911
	Cabo Rojo Municipio, PR.		
	Lajas Municipio, PR.		
	Sabana Grande Municipio, PR.		
	San Germán Municipio, PR.		
41940	[1] San Jose-Sunnyvale-Santa Clara, CA	1.5088	1.3253
	San Benito County, CA.		
	Santa Clara County, CA.		
41980	[1] San Juan-Caguas-Guaynabo, PR	0.4621	0.5894
	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.		

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
	Florida Municipio, PR.		
	Guaynabo Municipio, PR.		
	Gurabo Municipio, PR.		
	Hatillo Municipio, PR.		
	Humacao Municipio, PR.		
	Juncos Municipio, PR.		
	Las Piedras Municipio, PR.		
	Loíza Municipio, PR.		
	Manatí Municipio, PR.		
	Maunabo Municipio, PR.		
	Morovis Municipio, PR.		
	Naguabo Municipio, PR.		
	Naranjito Municipio, PR.		
	Orocovis Municipio, PR.		
	Quebradillas Municipio, PR.		
	Río Grande Municipio, PR.		
	San Juan Municipio, PR.		
	San Lorenzo Municipio, PR.		
	Toa Alta Municipio, PR.		
	Toa Baja Municipio, PR.		
	Trujillo Alto Municipio, PR.		
	Vega Alta Municipio, PR.		
	Vega Baja Municipio, PR.		
	Yabucoa Municipio, PR.		
42020	San Luis Obispo-Paso Robles, CA	1.1346	1.0903
	San Luis Obispo County, CA.		
42044	[1] Santa Ana-Anaheim-Irvine, CA	1.1547	1.1035
	Orange County, CA.		
42060	Santa Barbara-Santa Maria, CA	1.1681	1.1123
	Santa Barbara County, CA.		
42100	Santa Cruz-Watsonville, CA	1.5144	1.3287
	Santa Cruz County, CA.		
42140	Santa Fe, NM	1.0897	1.0606
	Santa Fe County, NM.		
42220	Santa Rosa-Petaluma, CA	1.3467	1.2261
	Sonoma County, CA.		
42260	Sarasota-Bradenton-Venice, FL	0.9634	0.9748
	Manatee County, FL.		
	Sarasota County, FL.		
42340	Savannah, GA	0.9464	0.9630
	Bryan County, GA.		
	Chatham County, GA.		
	Effingham County, GA.		
42540	Scranton--Wilkes-Barre, PA	0.8521	0.8962
	Lackawanna County, PA.		
	Luzerne County, PA.		
	Wyoming County, PA.		
42644	[1] Seattle-Bellevue-Everett, WA	1.1562	1.1045
	King County, WA.		
	Snohomish County, WA.		
43100	[2] Sheboygan, WI	0.9507	0.9660
	Sheboygan County, WI.		
43300	Sherman-Denison, TX	0.9509	0.9661
	Grayson County, TX.		
43340	Shreveport-Bossier City, LA	0.8758	0.9132
	Bossier Parish, LA.		
	Caddo Parish, LA.		
	De Soto Parish, LA.		
43580	Sioux City, IA-NE-SD	0.9365	0.9561
	Woodbury County, IA.		
	Dakota County, NE.		
	Dixon County, NE.		
	Union County, SD.		
43620	Sioux Falls, SD	0.9607	0.9729
	Lincoln County, SD.		
	McCook County, SD.		
	Minnehaha County, SD.		
	Turner County, SD.		
43780	South Bend-Mishawaka, IN-MI	0.9775	0.9845
	St. Joseph County, IN.		

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
	Cass County, MI.		
43900	Spartanburg, SC	0.9174	0.9427
	Spartanburg County, SC.		
44060	Spokane, WA	1.0887	1.0599
	Spokane County, WA.		
44100	Springfield, IL	0.8787	0.9153
	Menard County, IL.		
	Sangamon County, IL.		
44140	[2] Springfield, MA	1.0715	1.0484
	Franklin County, MA.		
	Hampden County, MA.		
	Hampshire County, MA.		
44180	Springfield, MO	0.8242	0.8760
	Christian County, MO.		
	Dallas County, MO.		
	Greene County, MO.		
	Polk County, MO.		
	Webster County, MO.		
44220	[2] Springfield, OH	0.8826	0.9180
	Clark County, OH.		
44300	State College, PA	0.8360	0.8846
	Centre County, PA.		
44700	Stockton, CA	1.1329	1.0892
	San Joaquin County, CA.		
44940	[2] Sumter, SC	0.8660	0.9062
	Sumter County, SC.		
45060	Syracuse, NY	0.9589	0.9717
	Madison County, NY.		
	Onondaga County, NY.		
	Oswego County, NY.		
45104	Tacoma, WA	1.0738	1.0500
	Pierce County, WA.		
45220	Tallahassee, FL	0.8703	0.9093
	Gadsden County, FL.		
	Jefferson County, FL.		
	Leon County, FL.		
	Wakulla County, FL.		
45300	[1] Tampa-St. Petersburg-Clearwater, FL	0.9328	0.9535
	Hernando County, FL.		
	Hillsborough County, FL.		
	Pasco County, FL.		
	Pinellas County, FL.		
45460	[2] Terre Haute, IN	0.8626	0.9037
	Clay County, IN.		
	Sullivan County, IN.		
	Vermillion County, IN.		
	Vigo County, IN.		
45500	Texarkana, TX-Texarkana, AR	0.8285	0.8791
	Miller County, AR.		
	Bowie County, TX.		
45780	Toledo, OH	0.9564	0.9699
	Fulton County, OH.		
	Lucas County, OH.		
	Ottawa County, OH.		
	Wood County, OH.		
45820	Topeka, KS	0.8912	0.9242
	Jackson County, KS.		
	Jefferson County, KS.		
	Osage County, KS.		
	Shawnee County, KS.		
	Wabaunsee County, KS.		
45940	[2] Trenton-Ewing, NJ	1.1227	1.0825
	Mercer County, NJ.		
46060	Tucson, AZ	0.9027	0.9323
	Pima County, AZ.		
46140	Tulsa, OK	0.8569	0.8996
	Creek County, OK.		
	Okmulgee County, OK.		
	Osage County, OK.		
	Pawnee 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
	Rogers County, OK.		
	Tulsa County, OK.		
	Wagoner County, OK.		
46220	Tuscaloosa, AL	0.8648	0.9053
	Greene County, AL.		
	Hale County, AL.		
	Tuscaloosa County, AL.		
46340	Tyler, TX	0.9182	0.9432
	Smith County, TX.		
46540	Utica-Rome, NY	0.8378	0.8859
	Herkimer County, NY.		
	Oneida County, NY.		
46660	Valdosta, GA	0.8864	0.9207
	Brooks County, GA.		
	Echols County, GA.		
	Lanier County, GA.		
	Lowndes County, GA.		
46700	Vallejo-Fairfield, CA	1.4925	1.3155
	Solano County, CA.		
46940	Vero Beach, FL	0.9448	0.9619
	Indian River County, FL.		
47020	Victoria, TX	0.8140	0.8686
	Calhoun County, TX.		
	Goliad County, TX.		
	Victoria County, TX.		
47220	[2] Vineland-Millville-Bridgeton, NJ	1.1227	1.0825
	Cumberland County, NJ.		
47260	[1] Virginia Beach-Norfolk-Newport News, VA-NC	0.8832	0.9185
	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	1.1042	1.0702
	Tulare County, CA.		
47380	Waco, TX	0.8523	0.8963
	McLennan County, TX.		
47580	Warner Robins, GA	0.8653	0.9057
	Houston County, GA.		
47644	[1] Warren-Farmington Hills-Troy, MI	0.9868	0.9909
	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	1.0928	1.0627
	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.		

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
	Alexandria City, VA.		
	Fairfax City, VA.		
	Falls Church City, VA.		
	Fredericksburg City, VA.		
	Manassas City, VA.		
	Manassas Park City, VA.		
	Jefferson County, WV.		
47940	Waterloo-Cedar Falls, IA	0.8555	0.8986
	Black Hawk County, IA.		
	Bremer County, IA.		
	Grundy County, IA.		
48140	Wausau, WI	0.9954	0.9968
	Marathon County, WI.		
48260	Weirton-Steubenville, WV-OH (WV Hospitals)	0.7813	0.8445
	Jefferson County, OH.		
	Brooke County, WV.		
	Hancock County, WV.		
48260	[2] Weirton-Steubenville, WV-OH (OH Hospitals)	0.8826	0.9180
	Jefferson County, OH.		
	Brooke County, WV.		
	Hancock County, WV.		
48300	[2] Wenatchee, WA	1.0480	1.0326
	Chelan County, WA.		
	Douglas County, WA.		
48424	[1] West Palm Beach-Boca Raton-Boynton Beach, FL	1.0051	1.0035
	Palm Beach County, FL.		
48540	[2] Wheeling, WV-OH (WV Hospitals)	0.7734	0.8386
	Belmont County, OH.		
	Marshall County, WV.		
	Ohio County, WV.		
48540	[2] Wheeling, WV-OH (OH Hospitals)	0.8826	0.9180
	Belmont County, OH.		
	Marshall County, WV.		
	Ohio County, WV.		
48620	Wichita, KS	0.9168	0.9422
	Butler County, KS.		
	Harvey County, KS.		
	Sedgwick County, KS.		
	Sumner County, KS.		
48660	Wichita Falls, TX	0.8319	0.8816
	Archer County, TX.		
	Clay County, TX.		
	Wichita County, TX.		
48700	Williamsport, PA	0.8355	0.8842
	Lycoming County, PA.		
48864	Wilmington, DE-MD-NJ (DE, MD Hospitals)	1.0516	1.0351
	New Castle County, DE.		
	Cecil County, MD.		
	Salem County, NJ.		
48864	[2] Wilmington, DE-MD-NJ (NJ Hospitals)	1.1227	1.0825
	New Castle County, DE.		
	Cecil County, MD.		
	Salem County, NJ.		
48900	Wilmington, NC	0.9570	0.9704
	Brunswick County, NC.		
	New Hanover County, NC.		
	Pender County, NC.		
49020	Winchester, VA-WV	1.0204	1.0139
	Frederick County, VA.		
	Winchester City, VA.		
	Hampshire County, WV.		
49180	Winston-Salem, NC	0.8951	0.9269
	Davie County, NC.		
	Forsyth County, NC.		
	Stokes County, NC.		
	Yadkin County, NC.		
49340	Worcester, MA	1.1034	1.0697
	Worcester County, MA.		
49420	[2] Yakima, WA	1.0480	1.0326
	Yakima 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
49500	Yauco, PR	0.4408	0.5707
	Guánica Municipio, PR.		
	Guayanilla Municipio, PR.		
	Peñuelas Municipio, PR.		
	Yauco Municipio, PR.		
49620	York-Hanover, PA	0.9349	0.9549
	York County, PA.		
49660	[2] Youngstown-Warren-Boardman, OH-PA (OH Hospitals)	0.8826	0.9180
	Mahoning County, OH.		
	Trumbull County, OH.		
	Mercer County, PA.		
49660	Youngstown-Warren-Boardman, OH-PA (PA Hospitals)	0.8600	0.9019
	Mahoning County, OH.		
	Trumbull County, OH.		
	Mercer County, PA.		
49700	[2] Yuba City, CA	1.1042	1.0702
	Sutter County, CA.		
	Yuba County, CA.		
49740	Yuma, AZ	0.9179	0.9430
	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 (GAF) FOR RURAL AREAS BY CBSA

CBSA code	Nonurban area	Wage index	GAF
1	Alabama	0.7463	0.8184
2	Alaska	1.1965	1.1307
3	Arizona	0.9007	0.9309
4	Arkansas	0.7493	0.8207
5	California	1.1042	1.0702
6	Colorado	0.9369	0.9563
7	Connecticut	1.1726	1.1152
8	Delaware	0.9579	0.9710
0	Florida	0.8584	0.9007
1	Georgia	0.7679	0.8346
2	Hawaii	1.0587	1.0398
3	Idaho	0.8689	0.9083
4	Illinois	0.8279	0.8787
5	Indiana	0.8626	0.9037
6	Iowa	0.8553	0.8985
7	Kansas	0.8076	0.8639
8	Kentucky	0.7780	0.8421
9	Louisiana	0.7438	0.8165
20	Maine	0.8831	0.9184
21	Maryland	0.9357	0.9555
22	Massachusetts [1]	1.0715	1.0484
23	Michigan	0.8966	0.9280
24	Minnesota	0.9132	0.9397
25	Mississippi	0.7688	0.8352
26	Missouri	0.7919	0.8523
27	Montana	0.8752	0.9128
28	Nebraska	0.8658	0.9060
29	Nevada	0.9070	0.9353
30	New Hampshire	1.1561	1.1044
31	New Jersey1	1.1227	1.0825
32	New Mexico	0.8640	0.9047
33	New York	0.8217	0.8742
34	North Carolina	0.8544	0.8978
35	North Dakota	0.7271	0.8039
36	Ohio	0.8826	0.9180
37	Oklahoma	0.7607	0.8292
38	Oregon	1.0301	1.0205
39	Pennsylvania	0.8289	0.8794
40	Puerto Rico [1]	.....	.....
41	Rhode Island [1]	1.0954	1.0644
42	South Carolina	0.8660	0.9062

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

CBSA code	Nonurban area	Wage index	GAF
43	South Dakota	0.8551	0.8983
44	Tennessee	0.8003	0.8585
45	Texas	0.8053	0.8622
46	Utah	0.8126	0.8675
47	Vermont	1.0189	1.0129
49	Virginia	0.8025	0.8601
50	Washington	1.0480	1.0326
51	West Virginia	0.7734	0.8386
52	Wisconsin	0.9507	0.9660
53	Wyoming	0.9249	0.9479

[1] All counties in the State or Territory 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 the FY 2005 final rule, 69 FR 49109.

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	0.8053	0.8622
10420	Akron, OH	0.8970	0.9283
10580	Albany-Schenectady-Troy, NY	0.8607	0.9024
10740	Albuquerque, NM	0.9548	0.9688
10780	Alexandria, LA	0.8040	0.8612
10900	Allentown-Bethlehem-Easton, PA-NJ	0.9834	0.9886
11020	Altoona, PA	0.8933	0.9256
11100	Amarillo, TX	0.9156	0.9414
11180	Ames, IA	0.9272	0.9496
11460	Ann Arbor, MI	1.0570	1.0387
11500	Anniston-Oxford, AL	0.7717	0.8374
11700	Asheville, NC	0.9303	0.9517
12020	Athens-Clarke County, GA	0.9694	0.9789
12060	Atlanta-Sandy Springs-Marietta, GA	0.9782	0.9850
12420	Austin-Round Rock, TX	0.9439	0.9612
12620	Bangor, ME	0.9975	0.9983
12700	Barnstable Town, MA	1.2303	1.1525
12940	Baton Rouge, LA	0.8461	0.8919
13020	Bay City, MI	0.9525	0.9672
13780	Binghamton, NY	0.8462	0.8919
13820	Birmingham-Hoover, AL	0.8959	0.9275
14260	Boise City-Nampa, ID	0.9039	0.9331
14484	Boston-Quincy, MA	1.1274	1.0856
14540	Bowling Green, KY	0.8214	0.8740
15380	Buffalo-Niagara Falls, NY	0.9503	0.9657
15540	Burlington-South Burlington, VT	0.9278	0.9500
15764	Cambridge-Newton-Framingham, MA (NH Hospitals)	1.1561	1.1044
15764	Cambridge-Newton-Framingham, MA (VT Hospitals)	1.0982	1.0662
16180	Carson City, NV	0.9776	0.9846
16220	Casper, WY	0.9249	0.9479
16580	Champaign-Urbana, IL	0.9262	0.9489
16620	Charleston, WV (WV Hospitals)	0.8293	0.8797
16620	Charleston, WV (OH Hospitals)	0.8826	0.9180
16700	Charleston-North Charleston, SC	0.9240	0.9473
16740	Charlotte-Gastonia-Concord, NC-SC	0.9577	0.9708
16820	Charlottesville, VA	0.9771	0.9843
16860	Chattanooga, TN-GA	0.9089	0.9367
16974	Chicago-Naperville-Joliet, IL	1.0646	1.0438
17140	Cincinnati-Middletown, OH-KY-IN	0.9595	0.9721
17300	Clarksville, TN-KY	0.8084	0.8645
17460	Cleveland-Elyria-Mentor, OH	0.9207	0.9450
17780	College Station-Bryan, TX	0.8902	0.9234
17860	Columbia, MO	0.8357	0.8843
17900	Columbia, SC	0.9067	0.9351
17980	Columbus, GA-AL	0.8394	0.8870
18140	Columbus, OH	0.9857	0.9902
18700	Corvallis, OR	1.0301	1.0205
19124	Dallas-Plano-Irving, TX	0.9938	0.9958
19380	Dayton, OH	0.9060	0.9346
19460	Decatur, AL	0.8509	0.8953

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

CBSA code	Area	Wage index	GAF
19740	Denver-Aurora, CO	1.0507	1.0344
19780	Des Moines, IA	0.9430	0.9606
19804	Detroit-Livonia-Dearborn, MI	1.0436	1.0297
20260	Duluth, MN-WI	1.0226	1.0154
20500	Durham, NC	0.9944	0.9962
20764	Edison, NJ	1.1290	1.0866
21060	Elizabethtown, KY	0.8278	0.8786
21500	Erie, PA	0.8415	0.8885
21660	Eugene-Springfield, OR	1.0419	1.0285
21780	Evansville, IN-KY	0.8499	0.8946
22020	Fargo, ND-MN (ND, SD Hospitals)	0.8769	0.9140
22020	Fargo, ND-MN (MN Hospitals)	0.9132	0.9397
22180	Fayetteville, NC	0.9183	0.9433
22220	Fayetteville-Springdale-Rogers, AR-MO	0.8707	0.9095
22380	Flagstaff, AZ	1.1382	1.0927
22420	Flint, MI	1.0461	1.0313
22540	Fond du Lac, WI	0.9507	0.9660
22660	Fort Collins-Loveland, CO	1.0136	1.0093
22744	Ft Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0497	1.0338
22900	Fort Smith, AR-OK	0.7998	0.8581
23020	Fort Walton Beach-Crestview-Destin, FL	0.8584	0.9007
23060	Fort Wayne, IN	0.9787	0.9854
23104	Fort Worth-Arlington, TX	0.9491	0.9649
23540	Gainesville, FL	0.9375	0.9568
23844	Gary, IN	0.9390	0.9578
24340	Grand Rapids-Wyoming, MI	0.9389	0.9577
24500	Great Falls, MT	0.9065	0.9350
24540	Greeley, CO	0.9587	0.9715
24580	Green Bay, WI (WI Hospitals)	0.9507	0.9660
24580	Green Bay, WI (MI Hospitals)	0.9470	0.9634
24780	Greenville, NC	0.9404	0.9588
24860	Greenville, SC	0.9702	0.9795
25060	Gulfport-Biloxi, MS	0.8603	0.9021
25420	Harrisburg-Carlisle, PA	0.9139	0.9402
25500	Harrisonburg, VA	0.8989	0.9296
25540	Hartford-West Hartford-East Hartford, CT (CT Hospitals)	1.1726	1.1152
25540	Hartford-West Hartford-East Hartford, CT (MA Hospitals)	1.1075	1.0724
25860	Hickory-Lenoir-Morganton, NC	0.8930	0.9254
26100	Holland-Grand Haven, MI	0.9124	0.9391
26180	Honolulu, HI	1.1213	1.0816
26300	Hot Springs, AR	0.8842	0.9192
26420	Houston-Sugar Land-Baytown, TX	0.9996	0.9997
26580	Huntington-Ashland, WV-KY-OH	0.9110	0.9382
26620	Huntsville, AL	0.9120	0.9389
26900	Indianapolis, IN	0.9766	0.9839
26980	Iowa City, IA	0.9556	0.9694
27060	Ithaca, NY	0.9195	0.9441
27140	Jackson, MS	0.8174	0.8710
27180	Jackson, TN	0.8790	0.9155
27260	Jacksonville, FL	0.9294	0.9511
27860	Jonesboro, AR	0.7784	0.8424
27900	Joplin, MO	0.8450	0.8911
28020	Kalamazoo-Portage, MI	1.0393	1.0267
28100	Kankakee-Bradley, IL	1.0738	1.0500
28140	Kansas City, MO-KS	0.9463	0.9629
28420	Kennewick-Richland-Pasco, WA	1.0480	1.0326
28700	Kingsport-Bristol-Bristol, TN-VA	0.8087	0.8647
28740	Kingston, NY	0.8900	0.9233
28940	Knoxville, TN	0.8456	0.8915
29180	Lafayette, LA	0.8420	0.8889
29404	Lake County-Kenosha County, IL-WI	1.0434	1.0295
29460	Lakeland, FL	0.8925	0.9251
29620	Lansing-East Lansing, MI	0.9788	0.9854
29740	Las Cruces, NM	0.8640	0.9047
29820	Las Vegas-Paradise, NV	1.1237	1.0831
30020	Lawton, OK	0.7666	0.8336
30460	Lexington-Fayette, KY	0.8732	0.9113
30620	Lima, OH	0.9271	0.9495
30700	Lincoln, NE	0.9656	0.9763
30780	Little Rock-North Little Rock, AR	0.8558	0.8989

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

CBSA code	Area	Wage index	GAF
30980	Longview, TX	0.8612	0.9027
31084	Los Angeles-Long Beach-Santa Ana, CA	1.1687	1.1127
31140	Louisville, KY-IN	0.9254	0.9483
31180	Lubbock, TX	0.8781	0.9148
31340	Lynchburg, VA	0.8697	0.9088
31420	Macon, GA	0.9078	0.9359
31540	Madison, WI	1.0429	1.0292
31700	Manchester-Nashua, NH	1.1561	1.1044
32780	Medford, OR	1.0301	1.0205
32820	Memphis, TN-MS-AR	0.9148	0.9408
33124	Miami-Miami Beach-Kendall, FL	0.9747	0.9826
33260	Midland, TX	0.9307	0.9520
33340	Milwaukee-Waukesha-West Allis, WI	0.9988	0.9992
33460	Minneapolis-St. Paul-Bloomington, MN-WI	1.0900	1.0608
33540	Missoula, MT	0.9526	0.9673
33660	Mobile, AL	0.7898	0.8508
33700	Modesto, CA	1.1960	1.1304
33860	Montgomery, AL	0.8300	0.8802
34060	Morgantown, WV	0.8324	0.8819
34740	Muskegon-Norton Shores, MI	0.9667	0.9771
34980	Nashville-Davidson--Murfreesboro, TN	0.9450	0.9620
35084	Newark-Union, NJ-PA	1.1879	1.1251
35380	New Orleans-Metairie-Kenner, LA	0.8993	0.9299
35644	New York-White Plains-Wayne, NY-NJ	1.3194	1.2090
36084	Oakland-Fremont-Hayward, CA	1.5463	1.3478
36100	Ocala, FL	0.8946	0.9266
36140	Ocean City, NJ	1.0279	1.0190
36220	Odessa, TX	0.9584	0.9713
36260	Ogden-Clearfield, UT	0.9039	0.9331
36420	Oklahoma City, OK	0.9034	0.9328
36500	Olympia, WA	1.0959	1.0647
36540	Omaha-Council Bluffs, NE-IA	0.9546	0.9687
36740	Orlando-Kissimmee, FL	0.9450	0.9620
37860	Pensacola-Ferry Pass-Brent, FL	0.8081	0.8642
37900	Peoria, IL	0.8743	0.9121
37964	Philadelphia, PA	1.1028	1.0693
38220	Pine Bluff, AR	0.8091	0.8650
38300	Pittsburgh, PA	0.8832	0.9185
38340	Pittsfield, MA	1.0189	1.0129
38540	Pocatello, ID	0.9394	0.9581
38860	Portland-South Portland-Biddeford, ME	0.9874	0.9914
38900	Portland-Vancouver-Beaverton, OR-WA	1.1235	1.0830
38940	Port St. Lucie-Fort Pierce, FL	1.0151	1.0103
39100	Poughkeepsie-Newburgh-Middletown, NY	1.0677	1.0459
39340	Provo-Orem, UT	0.9484	0.9644
39580	Raleigh-Cary, NC	0.9411	0.9593
39740	Reading, PA	0.9491	0.9649
39820	Redding, CA	1.1897	1.1263
39900	Reno-Sparks, NV (NV Hospitals)	1.0794	1.0537
39900	Reno-Sparks, NV (CA Hospitals)	1.1042	1.0702
40060	Richmond, VA	0.9309	0.9521
40220	Roanoke, VA	0.8442	0.8905
40340	Rochester, MN	1.1116	1.0751
40380	Rochester, NY	0.9123	0.9391
40420	Rockford, IL	0.9664	0.9769
40484	Rockingham County, NH	1.0492	1.0334
40660	Rome, GA	0.9405	0.9589
40900	Sacramento--Arden-Arcade--Roseville, CA	1.2949	1.1936
40980	Saginaw-Saginaw Township North, MI	0.8966	0.9280
41060	St. Cloud, MN	0.9775	0.9845
41100	St. George, UT	0.9407	0.9590
41180	St. Louis, MO-IL	0.8958	0.9274
41620	Salt Lake City, UT	0.9424	0.9602
41700	San Antonio, TX	0.8978	0.9288
41884	San Francisco-San Mateo-Redwood City, CA	1.4740	1.3043
41980	San Juan-Caguas-Guaynabo, PR	0.4621	0.5894
42044	Santa Ana-Anaheim-Irvine, CA	1.1296	1.0870
42140	Santa Fe, NM	1.0152	1.0104
42220	Santa Rosa-Petaluma, CA	1.3467	1.2261
42260	Sarasota-Bradenton-Venice, FL	0.9634	0.9748

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

CBSA code	Area	Wage index	GAF
42340	Savannah, GA	0.9300	0.9515
42644	Seattle-Bellevue-Everett, WA	1.1562	1.1045
43300	Sherman-Denison, TX	0.8962	0.9277
43340	Shreveport-Bossier City, LA	0.8758	0.9132
43620	Sioux Falls, SD	0.9607	0.9729
43780	South Bend-Mishawaka, IN-MI	0.9775	0.9845
43900	Spartanburg, SC	0.9174	0.9427
44060	Spokane, WA	1.0711	1.0482
44180	Springfield, MO	0.8242	0.8760
44300	State College, PA	0.8289	0.8794
44940	Sumter, SC	0.8660	0.9062
45060	Syracuse, NY	0.9318	0.9528
45300	Tampa-St. Petersburg-Clearwater, FL	0.9328	0.9535
45500	Texarkana, TX-Texarkana, AR	0.8285	0.8791
45820	Topeka, KS	0.8776	0.9145
46140	Tulsa, OK	0.8569	0.8996
46220	Tuscaloosa, AL	0.8648	0.9053
46340	Tyler, TX	0.9030	0.9325
46660	Valdosta, GA	0.8701	0.9091
46700	Vallejo-Fairfield, CA	1.3972	1.2574
47260	Virginia Beach-Norfolk-Newport News, VA	0.8832	0.9185
47380	Waco, TX	0.8523	0.8963
47894	Washington-Arlington-Alexandria DC-VA	1.0802	1.0543
48140	Wausau, WI	0.9954	0.9968
48620	Wichita, KS	0.8977	0.9288
48700	Williamsport, PA	0.8289	0.8794
48864	Wilmington, DE-MD-NJ (DE Hospitals)	1.0325	1.0221
48864	Wilmington, DE-MD-NJ (NJ Hospitals)	1.1227	1.0825
48900	Wilmington, NC	0.9384	0.9574
49020	Winchester, VA-WV	1.0204	1.0139
49180	Winston-Salem, NC	0.8951	0.9269
49660	Youngstown-Warren-Boardman, OH-PA (OH Hospitals)	0.8826	0.9180
49660	Youngstown-Warren-Boardman, OH-PA (PA Hospitals)	0.8600	0.9019
04	Arkansas	0.7493	0.8207
05	California	1.1042	1.0702
07	Connecticut	1.1726	1.1152
10	Florida (FL Hospitals)	0.8584	0.9007
10	Florida (GA Hosp.)	0.8385	0.8864
14	Illinois	0.8279	0.8787
15	Indiana	0.8626	0.9037
16	Iowa	0.8553	0.8985
17	Kansas	0.8076	0.8639
19	Louisiana	0.7438	0.8165
23	Michigan	0.8966	0.9280
26	Missouri	0.7919	0.8523
30	New Hampshire (VT Hospitals)	1.1319	1.0885
33	New York	0.8217	0.8742
37	Oklahoma	0.7607	0.8292
38	Oregon	1.0301	1.0205
39	Pennsylvania	0.8289	0.8794
44	Tennessee	0.8003	0.8585
45	Texas	0.8053	0.8622
50	Washington (WA Hospitals)	1.0480	1.0326
50	Washington (ID Hospitals)	1.0095	1.0065
53	Wyoming	0.9249	0.9479

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	1.0347	1.0236		
21940	Fajardo, PR	0.9089	0.9367		
25020	Guayama, PR	0.6960	0.7802		
32420	Mayagüez, PR	0.8789	0.9154		
38660	Ponce, PR	1.0802	1.0543		
41900	San Germán-Cabo Rojo, PR	1.0150	1.0102		

TABLE 4F.—PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF) BY CBSA—Continued

CBSA code	Area	Wage index	GAF	Wage index—reclassified hospitals	GAF—reclassified hospitals
41980	San Juan-Caguas-Guaynabo, PR	1.0104	1.0071	1.0104	1.0071
49500	Yauco, PR	0.9640	0.9752		

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006

[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, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act. Hospitals were given 45 days from the date of publication of the FY 2006 IPPS proposed rule to review their individual situations to determine whether to submit a request to withdraw their reclassification/redesignation and receive the out-migration adjustment instead. Hospitals that have already been reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act and did not withdraw their reclassification/redesignation for FY 2006 are designated with an asterisk]

Provider No.	Asterisk note	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	*	0.0235	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		0.0451	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
010164	*	0.0310	Talladega
040014	*	0.0159	White
040019	*	0.0697	St. Francis
040047	*	0.0090	Randolph
040069	*	0.0140	Mississippi
040071		0.0026	Jefferson
040076	*	0.1075	Hot Spring
040100	*	0.0159	White
050008		0.0026	San Francisco
050009	*	0.0478	Napa
050013	*	0.0478	Napa
050014	*	0.0131	Amador
050016		0.0103	San Luis Obispo
050042	*	0.0219	Tehama
050046		0.0156	Ventura
050047		0.0026	San Francisco
050055		0.0026	San Francisco
050065	*	0.0029	Orange
050069	*	0.0029	Orange
050073	*	0.0269	Solano
050076	*	0.0026	San Francisco
050082		0.0156	Ventura
050084		0.0555	San Joaquin
050089	*	0.0152	San Bernardino
050090	*	0.0308	Sonoma
050099	*	0.0152	San Bernardino

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

[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, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act. Hospitals were given 45 days from the date of publication of the FY 2006 IPPS proposed rule to review their individual situations to determine whether to submit a request to withdraw their reclassification/redesignation and receive the out-migration adjustment instead. Hospitals that have already been reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act and did not withdraw their reclassification/redesignation for FY 2006 are designated with an asterisk]

Provider No.	Asterisk note	Out-migration adjustment	Qualifying county name
050101		0.0269	Solano
050117		0.0463	Merced
050118	*	0.0555	San Joaquin
050122		0.0555	San Joaquin
050129	*	0.0152	San Bernardino
050133		0.0170	Yuba
050136	*	0.0308	Sonoma
050140	*	0.0152	San Bernardino
050150	*	0.0316	Nevada
050152		0.0026	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	*	0.0026	San Francisco
050230	*	0.0029	Orange
050232		0.0103	San Luis Obispo
050236		0.0156	Ventura
050245	*	0.0152	San Bernardino
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
050367		0.0269	Solano
050385	*	0.0308	Sonoma
050394		0.0156	Ventura
050407		0.0026	San Francisco
050426	*	0.0029	Orange
050444		0.0463	Merced
050454		0.0026	San Francisco
050457		0.0026	San Francisco
050469	*	0.0152	San Bernardino
050476		0.0257	Lake
050494	*	0.0316	Nevada
050506		0.0103	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

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

[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, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act. Hospitals were given 45 days from the date of publication of the FY 2006 IPPS proposed rule to review their individual situations to determine whether to submit a request to withdraw their reclassification/redesignation and receive the out-migration adjustment instead. Hospitals that have already been reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act and did not withdraw their reclassification/redesignation for FY 2006 are designated with an asterisk]

Provider No.	Asterisk note	Out-migration adjustment	Qualifying county name
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		0.0103	San Luis Obispo
050667	*	0.0478	Napa
050668	*	0.0026	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
050731		0.0152	San Bernardino
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
070034	*	0.0047	Fairfield
080001		0.0063	New Castle
080003		0.0063	New Castle
100014		0.0118	Volusia
100017		0.0118	Volusia
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		0.0125	Columbia
100118	*	0.0398	Flagler
100156		0.0125	Columbia
100175		0.0231	De Soto
100212		0.0060	Marion
100232		0.0347	Putnam
100236		0.0021	Charlotte
100252	*	0.0233	Okeechobee
100290		0.0582	Sumter
110023	*	0.0500	Gordon
110027		0.0387	Franklin
110029	*	0.0063	Hall
110041	*	0.0777	Habersham
110069	*	0.0474	Houston
110124		0.0428	Wayne
110136		0.0261	Baldwin
110150	*	0.0261	Baldwin
110153	*	0.0474	Houston
110187	*	0.1172	Lumpkin
110189	*	0.0031	Fannin
110190		0.0182	Macon

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

[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, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act. Hospitals were given 45 days from the date of publication of the FY 2006 IPPS proposed rule to review their individual situations to determine whether to submit a request to withdraw their reclassification/redesignation and receive the out-migration adjustment instead. Hospitals that have already been reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act and did not withdraw their reclassification/redesignation for FY 2006 are designated with an asterisk]

Provider No.	Asterisk note	Out-migration adjustment	Qualifying county name
110205	*	0.0779	Gilmer
130003	*	0.0095	Nez Perce
130024		0.0275	Bonner
130049	*	0.0349	Kootenai
130066		0.0349	Kootenai
140012	*	0.0220	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
140130		0.0147	Lake
140155		0.0027	Kankakee
140160	*	0.0286	Stephenson
140161	*	0.0138	Livingston
140186		0.0027	Kankakee
140202		0.0147	Lake
140205		0.0163	Boone
140234	*	0.0346	La Salle
140291	*	0.0147	Lake
540022		0.0249	Montgomery
540030	*	0.0201	Henry
540035		0.0083	Porter
540045		0.0416	De Kalb
540060		0.0051	Vermillion
540062		0.0153	Decatur
540065	*	0.0139	Jackson
540076	*	0.0189	Marshall
540088	*	0.0196	Madison
540091		0.0573	Huntington
540102	*	0.0160	Starke
540113	*	0.0196	Madison
540122		0.0199	Ripley
640013		0.0218	Muscatine
640026	*	0.0496	Boone
640030		0.0040	Story
640032		0.0272	Jasper
640080	*	0.0049	Clinton
740137	*	0.0336	Douglas
840012	*	0.0083	Hardin
840066	*	0.0567	Logan
840127	*	0.0352	Franklin
840128		0.0282	Lawrence
190001	*	0.0645	Washington
190003	*	0.0107	Iberia
190010		0.0401	Tangipahoa
190015	*	0.0401	Tangipahoa
190017		0.0235	St. Landry
190054		0.0107	Iberia
190078		0.0235	St. Landry
190088		0.0705	Webster
190099	*	0.0390	Avoyelles
190106	*	0.0238	Allen
190133		0.0238	Allen
190144		0.0705	Webster
190184		0.0161	Caldwell
190190		0.0161	Caldwell
190191	*	0.0235	St. Landry
190246		0.0161	Caldwell
200002	*	0.0129	Lincoln
200013		0.0186	Waldo
200024	*	0.0071	Androscoggin

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

[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, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act. Hospitals were given 45 days from the date of publication of the FY 2006 IPPS proposed rule to review their individual situations to determine whether to submit a request to withdraw their reclassification/redesignation and receive the out-migration adjustment instead. Hospitals that have already been reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act and did not withdraw their reclassification/redesignation for FY 2006 are designated with an asterisk]

Provider No.	Asterisk note	Out-migration adjustment	Qualifying county name
200032		0.0466	Oxford
200034	*	0.0071	Androscoggin
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
210043		0.0209	Anne Arundel
210048		0.0287	Howard
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
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
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
230121	*	0.0691	Shiawassee
230130	*	0.0091	Oakland

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

[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, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act. Hospitals were given 45 days from the date of publication of the FY 2006 IPPS proposed rule to review their individual situations to determine whether to submit a request to withdraw their reclassification/redesignation and receive the out-migration adjustment instead. Hospitals that have already been reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act and did not withdraw their reclassification/redesignation for FY 2006 are designated with an asterisk]

Provider No.	Asterisk note	Out-migration adjustment	Qualifying county name
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
230269	*	0.0091	Oakland
230277	*	0.0091	Oakland
230279	*	0.0487	Livingston
240013	*	0.0226	Morrison
240018	*	0.1196	Goodhue
240021		0.0920	Le Sueur
240044		0.0868	Winona
240064	*	0.0138	Itasca
240069	*	0.0419	Steele
240071	*	0.0454	Rice
240152	*	0.0735	Kanabec
240154		0.0138	Itasca
240187	*	0.0506	Mc Leod
240211	*	0.0705	Pine
250040	*	0.0294	Jackson
250045		0.0042	Hancock
260011		0.0007	Cole
260025	*	0.0078	Marion
260047	*	0.0007	Cole
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
290049		0.0026	Carson City
300011	*	0.0069	Hillsborough
300012	*	0.0069	Hillsborough
300017		0.0361	Rockingham
300020	*	0.0069	Hillsborough
300023		0.0361	Rockingham
300029		0.0361	Rockingham
300034	*	0.0069	Hillsborough
310002	*	0.0351	Essex
310009	*	0.0351	Essex
310010		0.0092	Mercer
310011		0.0115	Cape May
310013	*	0.0351	Essex
310018	*	0.0351	Essex
310021	*	0.0092	Mercer
310038	*	0.0350	Middlesex
310039		0.0350	Middlesex
310044		0.0092	Mercer
310054	*	0.0351	Essex
310070	*	0.0350	Middlesex
310076	*	0.0351	Essex
310078	*	0.0351	Essex
310083	*	0.0351	Essex
310092		0.0092	Mercer
310093	*	0.0351	Essex

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

[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, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act. Hospitals were given 45 days from the date of publication of the FY 2006 IPPS proposed rule to review their individual situations to determine whether to submit a request to withdraw their reclassification/redesignation and receive the out-migration adjustment instead. Hospitals that have already been reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act and did not withdraw their reclassification/redesignation for FY 2006 are designated with an asterisk]

Provider No.	Asterisk note	Out-migration adjustment	Qualifying county name
310096	*	0.0351	Essex
310108		0.0350	Middlesex
310110		0.0092	Mercer
310119	*	0.0351	Essex
310123		0.0351	Essex
310124		0.0350	Middlesex
320003		0.0629	San Miguel
320011		0.0442	Rio Arriba
320018		0.0063	Dona Ana
320085		0.0063	Dona Ana
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
330181	*	0.0137	Nassau
330182	*	0.0137	Nassau
330191	*	0.0026	Warren
330198		0.0137	Nassau
330205	*	0.0560	Orange
330209	*	0.0560	Orange
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
330372		0.0137	Nassau
330386	*	0.1139	Sullivan
340015		0.0267	Rowan
340020		0.0207	Lee
340021	*	0.0216	Cleveland
340037		0.0216	Cleveland
340039	*	0.0144	Iredell
340069	*	0.0053	Wake
340070		0.0448	Alamance
340073	*	0.0053	Wake
340085		0.0377	Davidson
340096		0.0377	Davidson
340104		0.0216	Cleveland
340114	*	0.0053	Wake
340126	*	0.0161	Wilson
340127	*	0.0961	Granville
340129	*	0.0144	Iredell
340133		0.0308	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
360036	*	0.0263	Wayne
360065	*	0.0141	Huron
360070		0.0028	Stark
360078	*	0.0159	Portage
360084		0.0028	Stark
360086	*	0.0168	Clark
360095	*	0.0087	Hancock
360100		0.0028	Stark

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

[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, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act. Hospitals were given 45 days from the date of publication of the FY 2006 IPPS proposed rule to review their individual situations to determine whether to submit a request to withdraw their reclassification/redesignation and receive the out-migration adjustment instead. Hospitals that have already been reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act and did not withdraw their reclassification/redesignation for FY 2006 are designated with an asterisk]

Provider No.	Asterisk note	Out-migration adjustment	Qualifying county name
360107	*	0.0213	Sandusky
360131		0.0028	Stark
360151		0.0028	Stark
360156		0.0213	Sandusky
360175	*	0.0159	Clinton
360187	*	0.0168	Clark
360197	*	0.0092	Logan
360267		0.0028	Stark
370004	*	0.0193	Ottawa
370014	*	0.0831	Bryan
370015	*	0.0463	Mayes
370023		0.0084	Stephens
370065		0.0121	Craig
370113	*	0.0205	Delaware
370149		0.0356	Pottawatomie
370179	*	0.0314	Okfuskee
380002		0.0130	Josephine
380008	*	0.0201	Linn
380022		0.0201	Linn
380029		0.0075	Marion
380051		0.0075	Marion
380056		0.0075	Marion
390011		0.0012	Cambria
390044		0.0200	Berks
390046		0.0098	York
390056		0.0042	Huntingdon
390065	*	0.0501	Adams
390066	*	0.0259	Lebanon
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		0.0200	Northampton
390201		0.1127	Monroe
390233		0.0098	York
420007		0.0001	Spartanburg
420020	*	0.0035	Georgetown
420027		0.0210	Anderson
420030	*	0.0103	Colleton
420039	*	0.0153	Union
420043		0.0177	Cherokee
420068	*	0.0097	Orangeburg
420070	*	0.0101	Sumter
420083		0.0001	Spartanburg
420093		0.0001	Spartanburg
420098		0.0035	Georgetown
440008	*	0.0663	Henderson
440024		0.0387	Bradley
440030		0.0056	Hamblen
440035	*	0.0441	Montgomery
440047		0.0499	Gibson
440056		0.0321	Jefferson
440060	*	0.0499	Gibson
440063		0.0011	Washington
440067	*	0.0056	Hamblen
440073	*	0.0513	Maury
440105		0.0011	Washington
440114		0.0523	Lauderdale
440115		0.0499	Gibson
440148	*	0.0568	De Kalb

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

[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, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act. Hospitals were given 45 days from the date of publication of the FY 2006 IPPS proposed rule to review their individual situations to determine whether to submit a request to withdraw their reclassification/redesignation and receive the out-migration adjustment instead. Hospitals that have already been reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act and did not withdraw their reclassification/redesignation for FY 2006 are designated with an asterisk]

Provider No.	Asterisk note	Out-migration adjustment	Qualifying county name
440153		0.0007	Cocke
440174		0.0372	Haywood
440181		0.0407	Hardeman
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
450121	*	0.0097	Tarrant
450135	*	0.0097	Tarrant
450137	*	0.0097	Tarrant
450144	*	0.0573	Andrews
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		0.0486	Palo Pinto
450596		0.0808	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
450872	*	0.0097	Tarrant
450880	*	0.0097	Tarrant
460017		0.0392	Box Elder
460036	*	0.0700	Wasatch
460039	*	0.0392	Box Elder
470018		0.0287	Windsor
490019		0.1240	Culpeper
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

TABLE 4J.—OUT-MIGRATION ADJUSTMENT—FY 2006—Continued

[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, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act. Hospitals were given 45 days from the date of publication of the FY 2006 IPPS proposed rule to review their individual situations to determine whether to submit a request to withdraw their reclassification/redesignation and receive the out-migration adjustment instead. Hospitals that have already been reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108–173, or redesignated under section 1886(d)(8) of the Act and did not withdraw their reclassification/redesignation for FY 2006 are designated with an asterisk]

Provider No.	Asterisk note	Out-migration adjustment	Qualifying county name
500021		0.0055	Pierce
500024		0.0023	Thurston
500039	*	0.0174	Kitsap
500041	*	0.0118	Cowlitz
500079		0.0055	Pierce
500108		0.0055	Pierce
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
520028	*	0.0157	Green
520035		0.0077	Sheboygan
520044		0.0077	Sheboygan
520057		0.0118	Sauk
520059	*	0.0200	Racine
520071	*	0.0239	Jefferson
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, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)

DRG	FY 2006 postacute care transfer DRG	FY 2006 postacute care special pay transfer DRG	MDC	TYPE	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
1	Yes	No	01	SURG	CRANIOTOMY AGE >17 W CC	3.4347	7.6	10.1
2	Yes	No	01	SURG	CRANIOTOMY AGE >17 W/O CC	1.9587	3.5	4.6
3	No	No	01	SURG *	CRANIOTOMY AGE 0-17	1.9860	12.7	12.7
4	No	No	01	SURG	NO LONGER VALID	0.0000	0.0	0.0
5	No	No	01	SURG	NO LONGER VALID	0.0000	0.0	0.0
6	No	No	01	SURG	CARPAL TUNNEL RELEASE	0.7878	2.2	3.0
7	Yes	Yes	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC.	2.6978	6.7	9.7
8	Yes	Yes	01	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC.	1.5635	2.0	3.0
9	No	No	01	MED	SPINAL DISORDERS & INJURIES	1.4045	4.5	6.4
10	Yes	No	01	MED	NERVOUS SYSTEM NEOPLASMS W CC.	1.2222	4.6	6.2
11	Yes	No	01	MED	NERVOUS SYSTEM NEOPLASMS W/O CC.	0.8736	2.9	3.8
12	Yes	No	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS.	0.8998	4.3	5.5
13	Yes	No	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA.	0.8575	4.0	5.0
14	Yes	No	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION.	1.2456	4.5	5.8
15	Yes	No	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT.	0.9421	3.7	4.6
16	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC.	1.3351	5.0	6.5

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 2006 postacute care transfer DRG	FY 2006 postacute care special pay transfer DRG	MDC	TYPE	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
17	Yes	No	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC.	0.7229	2.5	3.2
18	Yes	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC.	0.9903	4.1	5.3
19	Yes	No	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC.	0.7077	2.7	3.5
20	Yes	No	01	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS.	2.7865	8.0	10.4
21	No	No	01	MED	VIRAL MENINGITIS	1.4451	4.9	6.3
22	No	No	01	MED	HYPERTENSIVE ENCEPHALOPATHY	1.1304	4.0	5.2
23	No	No	01	MED	NONTRAUMATIC STUPOR & COMA	0.7712	3.0	3.9
24	Yes	No	01	MED	SEIZURE & HEADACHE AGE >17 W CC.	0.9970	3.6	4.8
25	Yes	No	01	MED	SEIZURE & HEADACHE AGE >17 W/O CC.	0.6180	2.5	3.1
26	No	No	01	MED	SEIZURE & HEADACHE AGE 0-17	1.8191	3.4	6.3
27	No	No	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR.	1.3531	3.2	5.2
28	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC.	1.3353	4.4	5.9
29	Yes	No	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC.	0.7212	2.6	3.4
30	No	No	01	MED *	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17.	0.3359	2.0	2.0
31	No	No	01	MED	CONCUSSION AGE >17 W CC	0.9567	3.0	4.0
32	No	No	01	MED	CONCUSSION AGE >17 W/O CC	0.6194	1.9	2.4
33	No	No	01	MED *	CONCUSSION AGE 0-17	0.2109	1.6	1.6
34	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC.	1.0062	3.7	4.8
35	Yes	No	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC.	0.6241	2.4	3.0
36	No	No	02	SURG	RETINAL PROCEDURES	0.7288	1.3	1.6
37	No	No	02	SURG	ORBITAL PROCEDURES	1.1858	2.7	4.2
38	No	No	02	SURG	PRIMARY IRIS PROCEDURES	0.6975	2.5	3.5
39	No	No	02	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY.	0.7108	1.7	2.4
40	No	No	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17.	0.9627	3.0	4.1
41	No	No	02	SURG *	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17.	0.3419	1.6	1.6
42	No	No	02	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS.	0.7852	2.0	2.8
43	No	No	02	MED	HYPHEMA	0.6141	2.4	3.1
44	No	No	02	MED	ACUTE MAJOR EYE INFECTIONS	0.6874	3.9	4.8
45	No	No	02	MED	NEUROLOGICAL EYE DISORDERS	0.7474	2.5	3.1
46	No	No	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC.	0.7524	3.2	4.2
47	No	No	02	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC.	0.5203	2.3	2.9
48	No	No	02	MED *	OTHER DISORDERS OF THE EYE AGE 0-17.	0.3012	2.9	2.9
49	No	No	03	SURG	MAJOR HEAD & NECK PROCEDURES	1.6361	3.1	4.4
50	No	No	03	SURG	SIALOADENECTOMY	0.8690	1.5	1.8
51	No	No	03	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY.	0.8809	1.9	2.8
52	No	No	03	SURG	CLEFT LIP & PALATE REPAIR	0.8348	1.5	1.9
53	No	No	03	SURG	SINUS & MASTOID PROCEDURES AGE >17.	1.3269	2.4	3.9
54	No	No	03	SURG *	SINUS & MASTOID PROCEDURES AGE 0-17.	0.4882	3.2	3.2
55	No	No	03	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES.	0.9597	2.0	3.1
56	No	No	03	SURG	RHINOPLASTY	0.8711	1.8	2.6
57	No	No	03	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	1.0428	2.3	3.6

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 2006 postacute care transfer DRG	FY 2006 postacute care special pay transfer DRG	MDC	TYPE	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
58	No	No	03	SURG *	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17.	0.2772	1.5	1.5
59	No	No	03	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	0.8082	1.8	2.6
60	No	No	03	SURG *	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17.	0.2110	1.5	1.5
61	No	No	03	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17.	1.2867	3.3	5.4
62	No	No	03	SURG *	MYRINGOTOMY W TUBE INSERTION AGE 0-17.	0.2989	1.3	1.3
63	No	No	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES.	1.3983	3.0	4.5
64	No	No	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY.	1.1663	4.1	6.1
65	No	No	03	MED	DYSEQUILIBRIUM	0.5991	2.3	2.8
66	No	No	03	MED	EPISTAXIS	0.5958	2.4	3.1
67	No	No	03	MED	EPIGLOTTITIS	0.7725	2.9	3.7
68	No	No	03	MED	OTITIS MEDIA & URI AGE >17 W CC	0.6611	3.2	4.0
69	No	No	03	MED	OTITIS MEDIA & URI AGE >17 W/O CC.	0.4850	2.5	3.0
70	No	No	03	MED	OTITIS MEDIA & URI AGE 0-17	0.4210	2.1	2.3
71	No	No	03	MED	LARYNGOTRACHEITIS	0.7524	3.2	4.0
72	No	No	03	MED	NASAL TRAUMA & DEFORMITY	0.7449	2.6	3.4
73	Yes	No	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17.	0.8527	3.3	4.4
74	No	No	03	MED *	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17.	0.3398	2.1	2.1
75	Yes	No	04	SURG	MAJOR CHEST PROCEDURES	3.0732	7.6	9.9
76	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC.	2.8830	8.4	11.1
77	Yes	No	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC.	1.1857	3.3	4.7
78	Yes	No	04	MED	PULMONARY EMBOLISM	1.2427	5.4	6.4
79	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC.	1.6238	6.7	8.5
80	Yes	No	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC.	0.8947	4.4	5.5
81	No	No	04	MED *	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17.	1.5383	6.1	6.1
82	Yes	No	04	MED	RESPIRATORY NEOPLASMS	1.3936	5.1	6.8
83	Yes	No	04	MED	MAJOR CHEST TRAUMA W CC	0.9828	4.2	5.3
84	Yes	No	04	MED	MAJOR CHEST TRAUMA W/O CC	0.5799	2.6	3.2
85	Yes	No	04	MED	PLEURAL EFFUSION W CC	1.2405	4.8	6.3
86	Yes	No	04	MED	PLEURAL EFFUSION W/O CC	0.6974	2.8	3.6
87	No	No	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE.	1.3654	4.9	6.4
88	No	No	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE.	0.8778	4.0	4.9
89	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC.	1.0320	4.7	5.7
90	Yes	No	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC.	0.6104	3.2	3.8
91	No	No	04	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0-17.	0.8124	3.4	4.4
92	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.1853	4.8	6.1
93	Yes	No	04	MED	INTERSTITIAL LUNG DISEASE W/O CC	0.7150	3.1	3.9
94	No	No	04	MED	PNEUMOTHORAX W CC	1.1354	4.6	6.2
95	No	No	04	MED	PNEUMOTHORAX W/O CC	0.6035	2.9	3.6
96	No	No	04	MED	BRONCHITIS & ASTHMA AGE >17 W CC.	0.7303	3.6	4.4
97	No	No	04	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC.	0.5364	2.8	3.4
98	No	No	04	MED *	BRONCHITIS & ASTHMA AGE 0-17	0.5560	3.7	3.7
99	No	No	04	MED	RESPIRATORY SIGNS & SYMPTOMS W CC.	0.7094	2.4	3.1

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 2006 postacute care transfer DRG	FY 2006 postacute care special pay transfer DRG	MDC	TYPE	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
100	No	No	04	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC.	0.5382	1.7	2.1
101	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC.	0.8733	3.3	4.3
102	Yes	No	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC.	0.5402	2.0	2.5
103	No	No	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM.	18.5617	23.7	37.7
104	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH.	8.2201	12.7	14.9
105	Yes	No	05	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH.	6.0192	8.4	10.2
106	No	No	05	SURG	CORONARY BYPASS W PTCA	7.0346	9.5	11.2
107	No	No	05	SURG	NO LONGER VALID	0.0000	13.5	13.5
108	Yes	No	05	SURG	OTHER CARDIOTHORACIC PROCEDURES.	5.8789	8.6	11.0
109	No	No	05	SURG	NO LONGER VALID	0.0000	12.1	12.1
110	No	No	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC.	3.8417	5.7	8.4
111	No	No	05	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC.	2.4840	2.6	3.4
112	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
113	Yes	No	05	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	3.1682	10.8	13.7
114	Yes	No	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS.	1.7354	6.7	8.9
115	No	No	05	SURG	NO LONGER VALID	0.0000	15.8	15.8
116	No	No	05	SURG	NO LONGER VALID	0.0000	9.3	9.3
117	No	No	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT.	1.3223	2.6	4.2
118	No	No	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT.	1.6380	2.1	3.0
119	No	No	05	SURG	VEIN LIGATION & STRIPPING	1.3456	3.3	5.5
120	Yes	No	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES.	2.3853	5.9	9.2
121	Yes	No	05	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE.	1.6136	5.3	6.6
122	No	No	05	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.	0.9847	2.8	3.5
123	No	No	05	MED	CIRCULATORY DISORDERS W AMI, EXPIRED.	1.5407	2.9	4.8
124	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.4425	3.3	4.4
125	No	No	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	1.0948	2.1	2.7
126	Yes	No	05	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.7440	9.4	12.0
127	Yes	No	05	MED	HEART FAILURE & SHOCK	1.0345	4.1	5.2
128	No	No	05	MED	DEEP VEIN THROMBOPHLEBITIS	0.6949	4.4	5.2
129	No	No	05	MED	CARDIAC ARREST, UNEXPLAINED	1.0404	1.7	2.6
130	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W CC.	0.9425	4.4	5.5
131	Yes	No	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC.	0.5566	3.2	3.9
132	No	No	05	MED	ATHEROSCLEROSIS W CC	0.6273	2.2	2.8
133	No	No	05	MED	ATHEROSCLEROSIS W/O CC	0.5337	1.8	2.2
134	No	No	05	MED	HYPERTENSION	0.6068	2.4	3.1
135	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC.	0.8917	3.2	4.3
136	No	No	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.	0.6214	2.2	2.8

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 2006 postacute care transfer DRG	FY 2006 postacute care special pay transfer DRG	MDC	TYPE	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
137	No	No	05	MED *	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17.	0.8288	3.3	3.3
138	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC.	0.8287	3.0	3.9
139	No	No	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC.	0.5227	2.0	2.4
140	No	No	05	MED	ANGINA PECTORIS	0.5116	2.0	2.4
141	No	No	05	MED	SYNCOPE & COLLAPSE W CC	0.7521	2.7	3.5
142	No	No	05	MED	SYNCOPE & COLLAPSE W/O CC	0.5852	2.0	2.5
143	No	No	05	MED	CHEST PAIN	0.5659	1.7	2.1
144	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC.	1.2761	4.1	5.8
145	Yes	No	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC.	0.5835	2.1	2.6
146	Yes	No	06	SURG	RECTAL RESECTION W CC	2.6621	8.6	10.0
147	Yes	No	06	SURG	RECTAL RESECTION W/O CC	1.4781	5.2	5.8
148	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC.	3.4479	10.0	12.3
149	Yes	No	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC.	1.4324	5.4	6.0
150	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.8061	8.9	11.0
151	Yes	No	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.2641	4.0	5.1
152	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC.	1.8783	6.7	8.0
153	No	No	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC.	1.0821	4.5	5.0
154	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	4.0399	9.9	13.3
155	Yes	No	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.2889	3.1	4.1
156	No	No	06	SURG *	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17.	0.8535	6.0	6.0
157	Yes	No	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.3356	4.1	5.8
158	Yes	No	06	SURG	ANAL & STOMAL PROCEDURES W/O CC.	0.6657	2.1	2.6
159	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.4081	3.8	5.1
160	No	No	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	0.8431	2.2	2.7
161	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC.	1.1931	3.1	4.4
162	No	No	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC.	0.6785	1.7	2.1
163	No	No	06	SURG	HERNIA PROCEDURES AGE 0-17	0.6723	2.2	2.9
164	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC.	2.2476	6.6	8.0
165	No	No	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC.	1.1868	3.6	4.2
166	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC.	1.4521	3.3	4.5
167	No	No	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC.	0.8929	1.9	2.2
168	No	No	03	SURG	MOUTH PROCEDURES W CC	1.2662	3.3	4.9
169	No	No	03	SURG	MOUTH PROCEDURES W/O CC	0.7297	1.8	2.3
170	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC.	2.9612	7.8	11.0
171	Yes	No	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC.	1.1905	3.1	4.1
172	Yes	No	06	MED	DIGESTIVE MALIGNANCY W CC	1.4125	5.1	7.0
173	Yes	No	06	MED	DIGESTIVE MALIGNANCY W/O CC	0.7443	2.7	3.6
174	No	No	06	MED	G.I. HEMORRHAGE W CC	1.0060	3.8	4.7
175	No	No	06	MED	G.I. HEMORRHAGE W/O CC	0.5646	2.4	2.9
176	Yes	No	06	MED	COMPLICATED PEPTIC ULCER	1.1246	4.1	5.2

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 2006 postacute care transfer DRG	FY 2006 postacute care special pay transfer DRG	MDC	TYPE	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
177	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W CC.	0.9166	3.6	4.4
178	No	No	06	MED	UNCOMPLICATED PEPTIC ULCER W/O CC.	0.7013	2.6	3.1
179	No	No	06	MED	INFLAMMATORY BOWEL DISEASE	1.0911	4.5	5.9
180	Yes	No	06	MED	G.I. OBSTRUCTION W CC	0.9784	4.2	5.4
181	Yes	No	06	MED	G.I. OBSTRUCTION W/O CC	0.5614	2.8	3.3
182	No	aNo	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC.	0.8413	3.4	4.4
183	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	0.5848	2.3	2.9
184	No	No	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17.	0.5663	2.5	3.3
185	No	No	03	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	0.8702	3.2	4.5
186	No	No	03	MED *	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17.	0.3253	2.9	2.9
187	No	No	03	MED	DENTAL EXTRACTIONS & RESTORATIONS.	0.8363	3.1	4.2
188	Yes	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC.	1.1290	4.2	5.6
189	Yes	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC.	0.6064	2.4	3.1
190	No	No	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17.	0.6179	3.1	4.4
191	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC.	3.9680	9.0	12.9
192	Yes	No	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC.	1.6793	4.3	5.7
193	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.2818	9.9	12.1
194	No	No	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.5748	5.6	6.7
195	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	3.0530	8.8	10.6
196	No	No	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC.	1.6031	4.9	5.7
197	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	2.5425	7.5	9.2
198	Yes	No	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.1604	3.7	4.3
199	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY.	2.4073	6.8	9.5
200	No	No	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.	2.7868	6.5	9.8
201	No	No	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES.	3.7339	9.9	13.7
202	No	No	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3318	4.7	6.2
203	No	No	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS.	1.3552	4.9	6.5
204	No	No	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY.	1.1249	4.2	5.6
205	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC.	1.2059	4.4	6.0
206	Yes	No	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC.	0.7292	3.0	3.9
207	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W CC.	1.1746	4.1	5.3
208	No	No	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC.	0.6895	2.3	2.9
209	No	No	08	SURG	NO LONGER VALID	0.0000	17.1	17.1

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 2006 postacute care transfer DRG	FY 2006 postacute care special pay transfer DRG	MDC	TYPE	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
210	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	1.9059	6.1	6.9
211	Yes	Yes	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.2690	4.4	4.7
212	No	No	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17.	1.2877	2.4	2.9
213	Yes	No	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	2.0428	7.2	9.7
214	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
215	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
216	Yes	No	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	1.9131	3.3	5.8
217	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS.	3.0596	9.3	13.2
218	Yes	No	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC.	1.6648	4.4	5.6
219	Yes	No	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC.	1.0443	2.6	3.1
220	No	No	08	SURG *	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17.	0.5913	5.3	5.3
221	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
222	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
223	No	No	08	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	1.1164	2.3	3.2
224	No	No	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC.	0.8185	1.6	1.9
225	Yes	No	08	SURG	FOOT PROCEDURES	1.2251	3.7	5.2
226	Yes	No	08	SURG	SOFT TISSUE PROCEDURES W CC	1.5884	4.5	6.5
227	Yes	No	08	SURG	SOFT TISSUE PROCEDURES W/O CC	0.8311	2.1	2.6
228	No	No	08	SURG	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC.	1.1459	2.8	4.1
229	No	No	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC.	0.6976	1.9	2.5
230	No	No	08	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.3174	3.7	5.6
231	No	No	08	SURG	NO LONGER VALID	0.0000	0.0	0.0
232	No	No	08	SURG	ARTHROSCOPY	0.9702	1.8	2.8
233	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC.	1.9184	4.6	6.8
234	Yes	Yes	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC.	1.2219	2.0	2.8
235	Yes	No	08	MED	FRACTURES OF FEMUR	0.7768	3.8	4.8
236	Yes	No	08	MED	FRACTURES OF HIP & PELVIS	0.7407	3.8	4.6
237	No	No	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH.	0.6090	3.0	3.7
238	Yes	No	08	MED	OSTEOMYELITIS	1.4401	6.7	8.7
239	Yes	No	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	1.0767	5.0	6.2
240	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W CC.	1.4051	5.0	6.7
241	Yes	No	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC.	0.6629	3.0	3.7
242	No	No	08	MED	SEPTIC ARTHRITIS	1.1504	5.1	6.7
243	No	No	08	MED	MEDICAL BACK PROBLEMS	0.7658	3.6	4.5
244	Yes	No	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC.	0.7200	3.6	4.5
245	Yes	No	08	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC.	0.4583	2.5	3.1
246	No	No	08	MED	NON-SPECIFIC ARTHROPATHIES	0.5932	2.8	3.6

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 2006 postacute care transfer DRG	FY 2006 postacute care special pay transfer DRG	MDC	TYPE	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
247	No	No	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	0.5795	2.6	3.3
248	No	No	08	MED	TENDONITIS, MYOSITIS & BURSITIS	0.8554	3.8	4.8
249	No	No	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	0.7095	2.7	3.9
250	Yes	No	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	0.6974	3.2	3.9
251	Yes	No	08	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	0.4749	2.3	2.8
252	No	No	08	MED *	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17.	0.2567	1.8	1.8
253	Yes	No	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC.	0.7747	3.8	4.6
254	Yes	No	08	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC.	0.4588	2.6	3.1
255	No	No	08	MED *	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17.	0.2990	2.9	2.9
256	Yes	No	08	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	0.8509	3.9	5.1
257	No	No	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC.	0.8967	2.0	2.6
258	No	No	09	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC.	0.7138	1.5	1.7
259	No	No	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC.	0.9671	1.8	2.8
260	No	No	09	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC.	0.7032	1.2	1.4
261	No	No	09	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	0.9732	1.6	2.2
262	No	No	09	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY.	0.9766	3.3	4.8
263	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC.	2.1130	8.6	11.4
264	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.0635	5.0	6.5
265	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.6593	4.4	6.8
266	Yes	No	09	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	0.8637	2.3	3.2
267	No	No	09	SURG	PERIANAL & PILONIDAL PROCEDURES.	0.8962	2.8	4.2
268	No	No	09	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES.	1.1326	2.4	3.5
269	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC.	1.8352	6.2	8.6
270	Yes	No	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC.	0.8313	2.7	3.9
271	Yes	No	09	MED	SKIN ULCERS	1.0195	5.6	7.1
272	Yes	No	09	MED	MAJOR SKIN DISORDERS W CC	0.9860	4.5	5.9
273	Yes	No	09	MED	MAJOR SKIN DISORDERS W/O CC	0.5539	2.9	3.7
274	No	No	09	MED	MALIGNANT BREAST DISORDERS W CC.	1.1294	4.7	6.3
275	No	No	09	MED	MALIGNANT BREAST DISORDERS W/O CC.	0.5340	2.4	3.3
276	No	No	09	MED	NON-MALIGNANT BREAST DISORDERS.	0.6892	3.5	4.5
277	Yes	No	09	MED	CELLULITIS AGE >17 W CC	0.8676	4.6	5.6

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 2006 postacute care transfer DRG	FY 2006 postacute care special pay transfer DRG	MDC	TYPE	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
278	Yes	No	09	MED	CELLULITIS AGE >17 W/O CC	0.5391	3.4	4.1
279	No	No	09	MED *	CELLULITIS AGE 0-17	0.7822	4.2	4.2
280	Yes	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC.	0.7313	3.2	4.1
281	Yes	No	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC.	0.4913	2.3	2.9
282	No	No	09	MED *	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17.	0.2600	2.2	2.2
283	Yes	No	09	MED	MINOR SKIN DISORDERS W CC	0.7423	3.5	4.6
284	Yes	No	09	MED	MINOR SKIN DISORDERS W/O CC	0.4563	2.4	3.0
285	Yes	No	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS.	2.1831	8.2	10.5
286	No	No	10	SURG	ADRENAL & PITUITARY PROCEDURES.	1.9390	4.0	5.5
287	Yes	No	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.9470	7.8	10.4
288	No	No	10	SURG	O.R. PROCEDURES FOR OBESITY	2.0384	3.2	4.1
289	No	No	10	SURG	PARATHYROID PROCEDURES	0.9315	1.7	2.6
290	No	No	10	SURG	THYROID PROCEDURES	0.8891	1.6	2.1
291	No	No	10	SURG	THYROGLOSSAL PROCEDURES	1.0877	1.6	2.8
292	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC.	2.6395	7.3	10.3
293	Yes	No	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC.	1.3472	3.2	4.5
294	Yes	No	10	MED	DIABETES AGE >35	0.7652	3.3	4.3
295	No	No	10	MED	DIABETES AGE 0-35	0.7267	2.8	3.7
296	Yes	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC.	0.8187	3.7	4.8
297	Yes	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC.	0.4879	2.5	3.1
298	No	No	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17.	0.5486	2.5	3.9
299	No	No	10	MED	INBORN ERRORS OF METABOLISM	1.0329	3.7	5.2
300	Yes	No	10	MED	ENDOCRINE DISORDERS W CC	1.0922	4.6	6.0
301	Yes	No	10	MED	ENDOCRINE DISORDERS W/O CC	0.6118	2.7	3.4
302	No	No	11	SURG	KIDNEY TRANSPLANT	3.1679	7.0	8.2
303	No	No	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.2183	5.8	7.4
304	Yes	No	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.3761	6.1	8.6
305	Yes	No	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1595	2.6	3.2
306	No	No	11	SURG	PROSTATECTOMY W CC	1.2700	3.6	5.5
307	No	No	11	SURG	PROSTATECTOMY W/O CC	0.6202	1.7	2.1
308	No	No	11	SURG	MINOR BLADDER PROCEDURES W CC.	1.6349	3.9	6.1
309	No	No	11	SURG	MINOR BLADDER PROCEDURES W/O CC.	0.9085	1.6	2.0
310	No	No	11	SURG	TRANSURETHRAL PROCEDURES W CC.	1.1898	3.0	4.5
311	No	No	11	SURG	TRANSURETHRAL PROCEDURES W/O CC.	0.6432	1.5	1.9
312	No	No	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC.	1.1159	3.2	4.8
313	No	No	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC.	0.6783	1.7	2.2
314	No	No	11	SURG *	URETHRAL PROCEDURES, AGE 0-17	0.5012	2.3	2.3
315	No	No	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES.	2.0823	3.6	6.8
316	Yes	No	11	MED	RENAL FAILURE	1.2692	4.9	6.4
317	No	No	11	MED	ADMIT FOR RENAL DIALYSIS	0.7942	2.4	3.5
318	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC.	1.1539	4.2	5.8

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 2006 postacute care transfer DRG	FY 2006 postacute care special pay transfer DRG	MDC	TYPE	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
319	No	No	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC.	0.6385	2.1	2.8
320	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC.	0.8658	4.2	5.2
321	Yes	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC.	0.5652	3.0	3.6
322	No	No	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17.	0.5498	2.9	3.4
323	No	No	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY.	0.8214	2.3	3.1
324	No	No	11	MED	URINARY STONES W/O CC	0.5050	1.6	1.9
325	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC.	0.6436	2.9	3.7
326	No	No	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC.	0.4391	2.1	2.6
327	No	No	11	MED *	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17.	0.3748	3.1	3.1
328	No	No	11	MED	URETHRAL STRICTURE AGE >17 W CC.	0.7079	2.6	3.5
329	No	No	11	MED	URETHRAL STRICTURE AGE >17 W/O CC.	0.4701	1.5	1.8
330	No	No	11	MED *	URETHRAL STRICTURE AGE 0-17	0.3227	1.6	1.6
331	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC.	1.0619	4.1	5.5
332	Yes	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC.	0.6160	2.4	3.1
333	No	No	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17.	0.9669	3.5	5.3
334	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC.	1.4368	3.5	4.3
335	No	No	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC.	1.1004	2.4	2.7
336	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC.	0.8425	2.5	3.3
337	No	No	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC.	0.5747	1.7	1.9
338	No	No	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY.	1.3772	3.9	6.2
339	No	No	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17.	1.1866	3.2	5.1
340	No	No	12	SURG *	TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17.	0.2868	2.4	2.4
341	No	No	12	SURG	PENIS PROCEDURES	1.2622	1.9	3.2
342	No	No	12	SURG	CIRCUMCISION AGE >17	0.8737	2.5	3.4
343	No	No	12	SURG *	CIRCUMCISION AGE 0-17	0.1559	1.7	1.7
344	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	1.2475	1.7	2.7
345	No	No	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	1.1472	3.1	4.8
346	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC.	1.0441	4.2	5.7
347	No	No	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC.	0.6104	2.2	3.1
348	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC.	0.7188	3.2	4.1
349	No	No	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC.	0.4210	1.9	2.4
350	No	No	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM.	0.7289	3.5	4.5
351	No	No	12	MED *	STERILIZATION, MALE	0.2392	1.3	1.3
352	No	No	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES.	0.7360	2.9	4.0

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 2006 postacute care transfer DRG	FY 2006 postacute care special pay transfer DRG	MDC	TYPE	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
353	No	No	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.8504	4.7	6.3
354	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC.	1.5135	4.6	5.7
355	No	No	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC.	0.8824	2.8	3.1
356	No	No	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	0.7428	1.7	1.9
357	No	No	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.2237	6.5	8.1
358	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC.	1.1448	3.2	4.0
359	No	No	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC.	0.7948	2.2	2.4
360	No	No	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES.	0.8582	2.0	2.6
361	No	No	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION.	1.0847	2.2	3.0
362	No	No	13	SURG *	ENDOSCOPIC TUBAL INTERRUPTION	0.3057	1.4	1.4
363	No	No	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY.	0.9728	2.7	3.8
364	No	No	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY.	0.8709	3.0	4.2
365	No	No	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES.	2.0408	5.3	7.7
366	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC.	1.2348	4.8	6.6
367	No	No	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC.	0.5728	2.3	3.0
368	No	No	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM.	1.1684	5.2	6.7
369	No	No	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	0.6310	2.4	3.3
370	No	No	14	SURG	CESAREAN SECTION W CC	0.8974	4.1	5.2
371	No	No	14	SURG	CESAREAN SECTION W/O CC	0.6066	3.1	3.4
372	No	No	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES.	0.5027	2.5	3.2
373	No	No	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES.	0.3556	2.0	2.2
374	No	No	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C.	0.6712	2.5	2.8
375	No	No	14	SURG *	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C.	0.5837	4.4	4.4
376	No	No	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	0.5242	2.6	3.4
377	No	No	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	1.6996	2.9	4.5
378	No	No	14	MED	ECTOPIC PREGNANCY	0.7472	1.9	2.3
379	No	No	14	MED	THREATENED ABORTION	0.3578	2.0	2.8
380	No	No	14	MED	ABORTION W/O D&C	0.3925	1.6	2.1
381	No	No	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY.	0.6034	1.6	2.2
382	No	No	14	MED	FALSE LABOR	0.2070	1.3	1.4
383	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS.	0.5053	2.6	3.7
384	No	No	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	0.3225	1.8	2.6
385	No	No	15	MED *	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.3930	1.8	1.8
386	No	No	15	MED *	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	4.5935	17.9	17.9
387	No	No	15	MED *	PREMATURITY W MAJOR PROBLEMS	3.1372	13.3	13.3

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 2006 postacute care transfer DRG	FY 2006 postacute care special pay transfer DRG	MDC	TYPE	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
388	No	No	15	MED *	PREMATURITY W/O MAJOR PROBLEMS.	1.8929	8.6	8.6
389	No	No	15	MED *	FULL TERM NEONATE W MAJOR PROBLEMS.	3.2226	4.7	4.7
390	No	No	15	MED *	NEONATE W OTHER SIGNIFICANT PROBLEMS.	1.1406	3.4	3.4
391	No	No	15	MED *	NORMAL NEWBORN	0.1544	3.1	3.1
392	No	No	16	SURG	SPLENECTOMY AGE >17	3.0459	6.5	9.2
393	No	No	16	SURG *	SPLENECTOMY AGE 0-17	1.3645	9.1	9.1
394	No	No	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.9109	4.5	7.4
395	Yes	No	16	MED	RED BLOOD CELL DISORDERS AGE >17.	0.8328	3.2	4.3
396	No	No	16	MED *	RED BLOOD CELL DISORDERS AGE 0-17.	0.8323	2.6	4.3
397	No	No	16	MED	COAGULATION DISORDERS	1.2986	3.7	5.1
398	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC.	1.2082	4.4	5.7
399	No	No	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC.	0.6674	2.7	3.3
400	No	No	17	SURG	NO LONGER VALID	0.0000	0.0	0.0
401	Yes	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC.	2.9678	8.0	11.3
402	Yes	No	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	1.1810	2.8	4.1
403	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC.	1.8432	5.8	8.1
404	Yes	No	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC.	0.9265	3.0	4.2
405	No	No	17	MED *	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17.	1.9346	4.9	4.9
406	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.	2.7897	7.0	9.9
407	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC.	1.2289	3.0	3.8
408	No	No	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC.	2.2460	4.8	8.2
409	No	No	17	MED	RADIOTHERAPY	1.2074	4.3	5.8
410	No	No	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	1.1069	3.0	3.8
411	No	No	17	MED	HISTORY OF MALIGNANCY W/O ENDOSCOPY.	0.3635	2.5	3.3
412	No	No	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY.	0.8451	1.8	2.8
413	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC.	1.3048	5.0	6.8
414	No	No	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC.	0.7788	3.0	4.0
415	Yes	No	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES.	3.9890	11.0	14.8
416	Yes	No	18	MED	SEPTICEMIA AGE >17	1.6774	5.6	7.5
417	No	No	18	MED	SEPTICEMIA AGE 0-17	1.1689	3.2	4.1
418	Yes	No	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS.	1.0716	4.8	6.2
419	No	No	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC.	0.8453	3.4	4.4
420	No	No	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC.	0.6077	2.7	3.4
421	No	No	18	MED	VIRAL ILLNESS AGE >17	0.7664	3.1	4.1
422	No	No	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17.	0.6171	2.6	3.7
423	Yes	No	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES.	1.9196	6.0	8.4

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 2006 postacute care transfer DRG	FY 2006 postacute care special pay transfer DRG	MDC	TYPE	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
424	No	No	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS.	2.2773	7.3	12.4
425	No	No	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION.	0.6191	2.6	3.5
426	No	No	19	MED	DEPRESSIVE NEUROSES	0.4656	3.0	4.1
427	No	No	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.5135	3.2	4.7
428	No	No	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL.	0.6981	4.6	7.3
429	Yes	No	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION.	0.7919	4.3	5.6
430	Yes	No	19	MED	PSYCHOSES	0.6483	5.8	7.9
431	No	No	19	MED	CHILDHOOD MENTAL DISORDERS	0.5178	4.0	5.9
432	No	No	19	MED	OTHER MENTAL DISORDER DIAGNOSES.	0.6282	2.9	4.3
433	No	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA.	0.2776	2.2	3.0
434	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0
435	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0
436	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0
437	No	No	20	MED	NO LONGER VALID	0.0000	0.0	0.0
438	No	No	20		NO LONGER VALID	0.0000	0.0	0.0
439	No	No	21	SURG	SKIN GRAFTS FOR INJURIES	1.9398	5.4	8.9
440	Yes	No	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES.	1.9457	5.9	9.2
441	No	No	21	SURG	HAND PROCEDURES FOR INJURIES	0.9382	2.3	3.4
442	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC.	2.5660	6.0	8.9
443	Yes	No	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC.	0.9943	2.6	3.4
444	Yes	No	21	MED	TRAUMATIC INJURY AGE >17 W CC	0.7556	3.2	4.1
445	Yes	No	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	0.5033	2.2	2.8
446	No	No	21	MED *	TRAUMATIC INJURY AGE 0-17	0.2999	2.4	2.4
447	No	No	21	MED	ALLERGIC REACTIONS AGE >17	0.5569	1.9	2.6
448	No	No	21	MED *	ALLERGIC REACTIONS AGE 0-17	0.0987	2.9	2.9
449	No	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC.	0.8529	2.6	3.7
450	No	No	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC.	0.4282	1.6	2.0
451	No	No	21	MED *	POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17.	0.2663	2.1	2.1
452	No	No	21	MED	COMPLICATIONS OF TREATMENT W CC.	1.0462	3.5	4.9
453	No	No	21	MED	COMPLICATIONS OF TREATMENT W/O CC.	0.5285	2.2	2.8
454	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC.	0.8141	2.9	4.1
455	No	No	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC.	0.4725	1.7	2.2
456	No	No	22		NO LONGER VALID	0.0000	0.0	0.0
457	No	No	22	MED	NO LONGER VALID	0.0000	0.0	0.0
458	No	No	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
459	No	No	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
460	No	No	22	MED	NO LONGER VALID	0.0000	0.0	0.0
461	No	No	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	1.3974	3.0	5.1
462	Yes	No	23	MED	REHABILITATION	0.8700	8.9	10.8
463	Yes	No	23	MED	SIGNS & SYMPTOMS W CC	0.6960	3.1	3.9
464	Yes	No	23	MED	SIGNS & SYMPTOMS W/O CC	0.5055	2.4	2.9
465	No	No	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	0.6224	2.4	3.8
466	No	No	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	0.7806	2.8	5.3
467	No	No	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS.	0.4803	2.0	2.7

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 2006 postacute care transfer DRG	FY 2006 postacute care special pay transfer DRG	MDC	TYPE	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
468	Yes	No			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	4.0031	9.7	13.2
469	No	No		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS.	0.0000	0.0	0.0
470	No	No		**	UNGROUPABLE	0.0000	0.0	0.0
471	Yes	Yes	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.	3.1391	4.5	5.1
472	No	No	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
473	No	No	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17.	3.4231	7.4	12.7
474	No	No	04	SURG	NO LONGER VALID	0.0000	0.0	0.0
475	Yes	No	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT.	3.6091	8.1	11.3
476	No	No		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.1822	7.4	10.5
477	Yes	No		SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.0607	5.8	8.7
478	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
479	No	No	05	SURG	OTHER VASCULAR PROCEDURES W/O CC.	1.4434	2.1	2.8
480	No	No	PRE	SURG	LIVER TRANSPLANT AND/OR INTESTINAL TRANSPLANT.	8.9693	13.7	18.0
481	No	No	PRE	SURG	BONE MARROW TRANSPLANT	6.2321	18.2	21.7
482	Yes	No	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES.	3.3387	9.6	12.1
483	No	No	PRE	SURG	NO LONGER VALID	0.0000	0.0	0.0
484	No	No	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA.	5.1438	9.3	12.8
485	Yes	No	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA.	3.4952	8.4	10.2
486	No	No	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.	4.7323	8.5	12.5
487	Yes	No	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA.	1.9459	5.3	7.3
488	No	No	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.4353	11.8	16.4
489	No	No	25	MED	HIV W MAJOR RELATED CONDITION	1.8058	5.9	8.4
490	No	No	25	MED	HIV W OR W/O OTHER RELATED CONDITION.	1.0639	3.8	5.4
491	No	No	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.6780	2.6	3.1
492	No	No	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT.	3.5926	8.8	13.7
493	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC.	1.8333	4.5	6.1
494	No	No	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC.	1.0285	2.1	2.7
495	No	No	PRE	SURG	LUNG TRANSPLANT	8.5736	14.0	17.3
496	No	No	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION.	6.0932	6.4	8.8
497	Yes	Yes	08	SURG	SPINAL FUSION EXCEPT CERVICAL W CC.	3.6224	5.0	5.9
498	Yes	Yes	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O CC.	2.7791	3.4	3.8
499	No	No	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC.	1.3831	3.1	4.3
500	No	No	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC.	0.9046	1.8	2.2
501	Yes	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC.	2.6462	8.5	10.4
502	Yes	No	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC.	1.4462	4.9	5.9

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 2006 postacute care transfer DRG	FY 2006 postacute care special pay transfer DRG	MDC	TYPE	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
503	No	No	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION.	1.2038	2.9	3.8
504	No	No	22	SURG	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/SKIN GFT.	11.8018	21.7	27.3
505	No	No	22	MED	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/O SKIN GFT.	2.2953	2.4	4.6
506	No	No	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	4.0939	11.2	15.9
507	No	No	22	SURG	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	1.7369	5.8	8.5
508	No	No	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	1.2767	5.1	7.4
509	No	No	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	0.8217	3.6	5.2
510	No	No	22	MED	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA.	1.1817	4.4	6.4
511	No	No	22	MED	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA.	0.7424	2.6	4.1
512	No	No	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT.	5.3660	10.7	12.8
513	No	No	PRE	SURG	PANCREAS TRANSPLANT	5.9669	8.9	9.9
514	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
515	No	No	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH.	5.5205	2.6	4.3
516	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
517	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
518	No	No	05	SURG	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI.	1.6544	1.8	2.5
519	No	No	08	SURG	CERVICAL SPINAL FUSION W CC	2.4695	3.0	4.8
520	No	No	08	SURG	CERVICAL SPINAL FUSION W/O CC	1.6788	1.6	2.0
521	Yes	No	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC.	0.6939	4.2	5.6
522	Yes	No	20	MED	ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC.	0.4794	7.7	9.6
523	No	No	20	MED	ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC.	0.3793	3.2	3.9
524	No	No	01	MED	TRANSIENT ISCHEMIA	0.7288	2.6	3.2
525	No	No	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT.	11.4282	7.2	13.6
526	No	No	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
527	No	aNo	05	SURG	NO LONGER VALID	0.0000	0.0	0.0
528	No	No	01	SURG	INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE.	7.0505	13.8	17.2
529	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC.	2.3160	5.3	8.3
530	Yes	No	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC.	1.2041	2.4	3.1
531	Yes	No	01	SURG	SPINAL PROCEDURES W CC	3.1279	6.5	9.6
532	Yes	No	01	SURG	SPINAL PROCEDURES W/O CC	1.4195	2.8	3.7
533	No	No	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.5767	2.4	3.8
534	No	No	01	SURG	EXTRACRANIAL PROCEDURES W/O CC.	1.0201	1.5	1.8
535	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK.	7.9738	7.9	10.3
536	No	No	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK.	6.9144	5.9	7.6
537	Yes	No	08	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W CC.	1.8360	4.8	6.9
538	Yes	No	08	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC.	0.9833	2.1	2.8
539	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC.	3.2782	7.0	10.8

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS, RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	FY 2006 postacute care transfer DRG	FY 2006 postacute care special pay transfer DRG	MDC	TYPE	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
540	No	No	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC.	1.1940	2.6	3.6
541	Yes	No	PRE	SURG	ECMO OR TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R..	19.8038	38.1	45.7
542	Yes	No	PRE	SURG	TRACH W MV 96+HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R..	12.8719	29.1	35.1
543	Yes	No	01	SURG	CRANIOTOMY W/IMPLANT OF CHEMO AGENT OR ACUTE COMPLX CNS PDX.	4.4184	8.5	12.3
544	Yes	Yes	08	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY.	1.9643	4.1	4.5
545	Yes	Yes	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT.	2.4827	4.5	5.2
546	No	No	08	SURG	SPINAL FUSION EXC CERV WITH CURVATURE OF THE SPINE OR MALIG.	5.0739	7.1	8.8
547	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W MAJOR CV DX.	6.1948	10.8	12.3
548	Yes	No	05	SURG	CORONARY BYPASS W CARDIAC CATH W/O MAJOR CV DX.	4.7198	8.2	9.0
549	Yes	Yes	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W MAJOR CV DX.	5.0980	8.7	10.3
550	Yes	Yes	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W/O MAJOR CV DX.	3.6151	6.2	6.9
551	No	No	05	SURG	PERMANENT CARDIAC PACEMAKER IMPL W MAJ CV DX OR AICD LEAD OR GNRTR.	3.1007	4.4	6.4
552	No	No	05	SURG	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT W/O MAJOR CV DX.	2.0996	2.5	3.5
553	Yes	No	05	SURG	OTHER VASCULAR PROCEDURES W CC W MAJOR CV DX.	3.0957	6.6	9.7
554	Yes	No	05	SURG	OTHER VASCULAR PROCEDURES W CC W/O MAJOR CV DX.	2.0721	4.0	5.9
555	No	No	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W MAJOR CV DX.	2.4315	3.4	4.7
556	No	No	05	SURG	PERCUTANEOUS CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MAJ CV DX.	1.9132	1.6	2.1
557	No	No	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJOR CV DX.	2.8717	3.0	4.1
558	No	No	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W/O MAJ CV DX.	2.2108	1.5	1.9
559	No	No	01	MED	ACUTE ISCHEMIC STROKE WITH USE OF THROMBOLYTIC AGENT.	2.2473	5.8	7.2

* Medicare data have been supplemented by data from 19 States for low volume DRGs.
** DRGs 469 and 470 contain vases which could not be assigned to valid DRGs.
Note: Geometric mean is used only to determine payment for transfer cases.
Note: Arithmetic mean is presented for informational purposes only.
Note: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 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 15 25 [2]	296, 297, 298, 387 [1], 389 [1], 490

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
276.51	Dehydration	Y	10 15 25 [2]	296, 297, 298, 387 [1], 389 [1], 490
276.52	Hypovolemia	Y	10 15 25 [2]	296, 297, 298, 387 [1], 389 [1], 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
327.13	Recurrent hypersomnia	N	19	432
327.14	Hypersomnia due to medical condition classified elsewhere	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 3	482 73, 74
327.21	Primary central sleep apnea	N	PRE 1	482 34, 35
327.22	High altitude periodic breathing	N	PRE 4	482 99, 100
327.23	Obstructive sleep apnea (adult) (pediatric)	N	PRE 3	482 73, 74
327.24	Idiopathic sleep related non-obstructive alveolar hypoventilation	N	PRE 3	482 73, 74
327.25*	Congenital central alveolar hypoventilation syndrome	N	PRE 1	482 34, 35
327.26	Sleep related hypoventilation/hypoxemia in conditions classifiable elsewhere	N	PRE 3	482 73, 74
327.27	Central sleep apnea in conditions classified elsewhere	N	PRE 1	482 34, 35
327.29	Other organic sleep apnea	N	PRE 3	482 73, 74
327.30*	Circadian rhythm sleep disorder, unspecified	N	PRE 1	482 34, 35
327.31*	Circadian rhythm sleep disorder, delayed sleep phase type	N	PRE 1	482 34, 35
327.32*	Circadian rhythm sleep disorder, advanced sleep phase type	N	PRE 1	482 34, 35
327.33*	Circadian rhythm sleep disorder, irregular sleep-wake type	N	PRE 1	482 34, 35
327.34*	Circadian rhythm sleep disorder, free-running type	N	PRE 1	482 34, 35
327.35*	Circadian rhythm sleep disorder, jet lag type	N	PRE 1	482 34, 35
327.36*	Circadian rhythm sleep disorder, shift work type	N	PRE 1	482 34, 35
327.37*	Circadian rhythm sleep disorder in conditions classified elsewhere	N	PRE 1	482 34, 35
327.39*	Other circadian rhythm sleep disorder	N	PRE 1	482 34, 35
327.40*	Organic parasomnia, unspecified	N	PRE 3	482 73, 74
327.41*	Confusional arousals	N	PRE 1	482 34, 35
327.42*	REM sleep behavior disorder	N	PRE 3	482 73, 74
327.43*	Recurrent isolated sleep paralysis	N	PRE 1	482 34, 35
327.44*	Parasomnia in conditions classified elsewhere	N	PRE 3	482 73, 74

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
327.49 *	Other organic parasomnia	N	PRE	482
			3	73, 74
327.51 *	Periodic limb movement disorder	N	PRE	482
			1	34, 35
327.52 *	Sleep related leg cramps	N	PRE	482
			1	34, 35
327.53 *	Sleep related bruxism	N	PRE	482
			3	73, 74
327.59 *	Other organic sleep related movement disorders	N	PRE	482
			3	73, 74
327.8 *	Other organic sleep disorders	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]
567.31 *	Psoas muscle abscess	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
585.4	Chronic kidney disease, Stage IV (severe)	Y	PRE	512, 513
			11	315, 316
585.5	Chronic kidney disease, Stage V	Y	PRE	512, 513
			11	315, 316
585.6	End stage renal disease	Y	PRE	512, 513
			11	315, 316

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
585.9	Chronic kidney disease, unspecified	Y	PRE	512, 513
			11	315, 316
599.60	Urinary obstruction, unspecified	Y	11	331, 332, 333
			15	387 [1], 389 [1]
599.69	Urinary obstruction, not elsewhere classified	Y	11	331, 332, 333
			15	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]
770.13 *	Aspiration of clear amniotic fluid without respiratory symptoms	N	15	387 [3], 389 [3]
770.14 *	Aspiration of clear amniotic fluid with respiratory symptoms	Y	15	387 [3], 389 [3]
770.15 *	Aspiration of blood without respiratory symptoms	N	15	387 [3], 389 [3]
770.16 *	Aspiration of blood 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]
770.85 *	Aspiration of postnatal stomach contents without respiratory symptoms	N	15	387 [3], 389 [3]
770.86 *	Aspiration of postnatal stomach contents 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	Personal history, Infections of the central nervous system	N	23	467
V12.60	Personal history, Unspecified disease of respiratory system	N	23	467
V12.61	Personal history, Pneumonia (recurrent)	N	23	467
V12.69	Personal history, Other diseases of respiratory system	N	23	467
V13.02	Personal history, Urinary (tract) infection	N	23	467
V13.03	Personal 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
V58.11 *	Encounter for antineoplastic chemotherapy	N	17	410, 492
V58.12 *	Encounter for immunotherapy for neoplastic condition	N	17	410, 492
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

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
V64.09	Vaccination not carried out for other reason	N	23	467
V69.5	Behavioral insomnia of childhood	N	23	467
V72.42*	Pregnancy examination or test, positive result	N	23	467
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.
* These diagnosis codes were discussed at the March 31–April 1, 2005 ICD–9–CM Coordination and Maintenance Committee meeting and were not finalized in time to include in the proposed rule.

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
00.18*	Infusion of immunosuppressive antibody therapy during induction phase of solid organ transplantation.	N		
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		
00.66*	Percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy	Y	5	106, 518, 555, 556, 557, 558
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	442, 443
			24	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
00.74*	Hip replacement bearing surface, metal on polyethylene	N		
00.75*	Hip replacement bearing surface, metal-on-metal	N		
00.76*	Hip replacement bearing surface, ceramic-on-ceramic	N		
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

TABLE 6B.—NEW PROCEDURE CODES—Continued

Procedure code	Description	OR	MDC	DRG
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
01.26*	Insertion of catheter into cranial cavity	N		
01.27*	Removal of catheter from cranial cavity	N		
37.41	Implantation of prosthetic cardiac support device around the heart	Y	5	110, 111
37.49	Other repair of heart and pericardium	Y	5	110, 111
			21	442, 443
			24	486
39.73*	Endovascular implantation of graft in thoracic aorta	Y	5	110, 111
			11	315
			21	442, 443
			24	486
81.18*	Subtalar joint arthroereisis	Y	8	233, 234
			21	442, 443
			24	486
84.56	Insertion of (cement) spacer	N		
84.57	Removal of (cement) spacer	N		
84.58*	Implantation of interspinous process decompression device	Y	1	531, 532
			8	499, 500
			21	442, 443
			24	486
84.71*	Application of external fixator device, monoplanar system	N		
84.72*	Application of external fixator device, ring system	N		
84.73*	Application of hybrid external fixator device	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
92.20*	Infusion of liquid brachytherapy radioisotope	N		

*These procedure codes were discussed at the March 31–April 1, 2005 ICD–9–CM Coordination and Maintenance Committee meeting and were not finalized in time to include with the proposed rule.

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
276.5	Volume depletion	Y	10	296, 297, 298
			15	387[1], 389[1]
			25[2]	490
287.3	Primary thrombocytopenia	Y	16	397
567.2	Other suppurative peritonitis	Y	6	188, 189, 190
			15	387[1], 389[1]
567.8	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
V58.1*	Chemotherapy	N	17	410, 492
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.
*This diagnosis code was discussed at the March 31–April 1, 2005 ICD–9–CM Coordination and Maintenance Committee meeting, but not finalized in time to include in the FY 2006 IPPS proposed rule.

TABLE 6D.—INVALID PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
36.01 * [1]	Single vessel percutaneous transluminal coronary angioplasty [PTCA] or coronary atherectomy without mention of thrombolytic agent.	Y	5	106, 516, 517, 518, 526, 527
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 21 24	110, 111 442, 443 486
81.61 *	360 degree spinal fusion, single incision approach	Y	1 8 21 24	531, 532 497, 498 442, 443 486

* These procedure codes were discussed at the March 31–April 1, 2005 ICD–9–CM Coordination and Maintenance Committee meeting and were not finalized in time to include with the proposed rule.

[1] Code 36.01 was listed as a revised code in Table 6F of the proposed rule. We are deleting this code and creating new code 00.66 instead. Code 00.66 is listed on Table 6B.

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
285.21 *	Anemia in chronic kidney disease	Y	16	395, 396
307.45 *	Circadian rhythm sleep disorder of nonorganic origin	N	19	432
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 15	121, 124, 127, 535, 547, 549, 551, 553, 555, 557, 387, 389 [1]
404.02	Hypertensive heart and kidney disease, malignant, with chronic kidney disease	Y	11	315, 316
404.03	Hypertensive heart and kidney disease, malignant, with heart failure and chronic kidney disease.	Y	5 15	121, 124, 127, 535, 547, 549, 551, 553, 555, 557 387, 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 15	121, 124, 127, 535, 547, 549, 551, 553, 555, 557 387, 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 15	121, 124, 127, 535, 547, 549, 551, 553, 555, 557 387, 389 [1]
404.90	Hypertensive heart and kidney disease, unspecified, without heart failure or chronic kidney disease.	N	5	134
404.91	Hypertensive heart and kidney disease, unspecified, with heart failure	Y	5 15	121, 124, 127, 535, 547, 549, 551, 553, 555, 557 387, 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 15	121, 124, 127, 535, 547, 549, 551, 553, 555, 557 387, 389 [1]

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES—Continued

Diagnosis code	Description	CC	MDC	DRG
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
780.55*	Disruption of 24 hour sleep wake cycle, unspecified	N	19	432
780.57	Unspecified sleep apnea	N	PRE	482
			3	73, 74
780.58*	Sleep related movement disorder, unspecified	N	19	432

[1] Major Problem in DRG 387 & 389.

*These diagnosis codes were discussed at the March 31–April 1, 2005 ICD–9–CM Coordination and Maintenance Committee meeting and were not finalized in time to include with the proposed rule.

TABLE 6F.—REVISED PROCEDURE CODE TITLES

Procedure code	Description	OR	MDC	DRG
37.79	Revision or relocation of cardiac device pocket	Y	1	7, 8
			5	117
			9	269, 270
			21	442, 443
			24	486
78.10*	Application of external fixator device, unspecified site	Y	8	233, 234
			21	442, 443
			24	486
78.11*	Application of external fixator device, scapula, clavicle, and thorax [ribs and sternum]	Y	4	76, 77
			8	233, 234
			21	442, 443
			24	486
78.12*	Application of external fixator device, humerus	Y	8	218, 219, 220
			21	442, 443
			24	486
78.13*	Application of external fixator device, radius and ulna	Y	8	233, 234
			21	442, 443
			24	486
78.14*	Application of external fixator device, carpals and metacarpals	Y	8	228, 229
			21	441
			24	486
78.15*	Application of external fixator device, femur	Y	8	210, 211, 212
			21	442, 443
			24	485
78.16*	Application of external fixator device, patella	Y	8	501, 502, 503
			21	442, 443
			24	486
78.17*	Application of external fixator device, tibia and fibula	Y	8	218, 219, 220
			21	442, 443
			24	486
78.18*	Application of external fixator device, tarsals and metatarsals	Y	8	225
			21	442, 443
			24	486
78.19*	Application of external fixator device, other	Y	8	233, 234
			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
86.94	Insertion or replacement of single array neurostimulator pulse generator, not specified as rechargeable.	Y	1	7, 8
86.95	Insertion or replacement of dual array neurostimulator pulse generator, not specified as rechargeable.	Y	1	7, 8

*These procedure codes were discussed at the March 31–April 1, 2005 ICD–9–CM Coordination and Maintenance Committee meeting and were not finalized in time to include with the proposed rule.

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST

[CCs that are added to the list are included in this table. 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
59960
59969
*1881
59960
59969
*1882
59960
59969
*1883
59960
59969
*1884
59960
59969
*1885
59960
59969
*1886
59960
59969
*1887
59960
59969
*1888
59960
59969
*1889
59960
59969
*1892
59960
59969
*1893
59960
59969
*1894
59960
59969
*1898
59960
59969
*1899
59960
59969
*25040
5851
5852
5853
5854
5855
5856
5859
*25041
5851
5852
5853
5854
5855
5856
5859
*25042
5851
5852

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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
*25043
5851
5852
5853
5854
5855
5856
5859
*25080
5851
5852
5853
5854
5855
5856
5859
*25081
5851
5852
5853
5854
5855
5856
5859
*25082
5851
5852
5853
5854
5855
5856
5859
*25083
5851
5852
5853
5854
5855
5856
5859
*25090
5851
5852
5853
5854
5855
5856
5859
*25091
5851
5852
5853
5854
5855
5856
5859
*25092
5851
5852
5853
5854
5855

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

5856
5859
*25093
5851
5852
5853
5854
5855
5856
5859
*2595
24200
24201
24210
24211
24220
24221
24230
24231
24240
24241
24280
24281
24290
24291
25001
25002
25003
25011
25012
25013
25021
25022
25023
25031
25032
25033
25041
25042
25043
25051
25052
25053
25061
25062
25063
25071
25072
25073
25081
25082
25083
25091
25092
25093
2510
2513
2521
2532
2535
2541
2550
2553
2554
2555
2556
2580

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

2581
2588
2589
2592
*27410
5851
5852
5853
5854
5855
5856
5859
*27411
59960
59969
*27419
5851
5852
5853
5854
5855
5856
5859
*2760
27650
27651
27652
*2761
27650
27651
27652
*2762
27650
27651
27652
*2763
27650
27651
27652
*2764
27650
27651
27652
*27650
2760
2761
2762
2763
2764
27650
27651
27652
2766
2767
2769
*27651
2760
2761
2762
2763
2764
27650
27651
27652
2766
2767
2769

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

*27652
2760
2761
2762
2763
2764
27650
27651
27652
2766
2767
2769
*2766
27650
27651
27652
*2767
27650
27651
27652
*2768
27650
27651
27652
*2769
27650
27651
27652
*2860
28730
28731
28732
28733
28739
*2861
28730
28731
28732
28733
28739
*2862
28730
28731
28732
28733
28739
*2863
28730
28731
28732
28733
28739
*2864
28730
28731
28732
28733
28739
*2865
28730
28731
28732
28733
28739
*2866
28730
28731

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

28732
28733
28739
*2867
28730
28731
28732
28733
28739
*2869
28730
28731
28732
28733
28739
*2870
28730
28731
28732
28733
28739
*2871
28730
28731
28732
28733
28739
*2872
28730
28731
28732
28733
28739
*28730
2860
2861
2862
2863
2864
2865
2866
2867
2869
2870
2871
2872
28730
28731
28732
28733
28739
2874
2875
2878
2879
*28731
2860
2861
2862
2863
2864
2865
2866
2867
2869
2870
2871

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

2872
28730
28731
28732
28733
28739
2874
2875
2878
2879
*28732
2860
2861
2862
2863
2864
2865
2866
2867
2869
2870
2871
2872
28730
28731
28732
28733
28739
2874
2875
2878
2879
*28733
2860
2861
2862
2863
2864
2865
2866
2867
2869
2870
2871
2872
28730
28731
28732
28733
28739
2874
2875
2878
2879
*28739
2860
2861
2862
2863
2864
2865
2866
2867
2869
2870
2871
2872

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

28730
28731
28732
28733
28739
2874
2875
2878
2879
*2874
28730
28731
28732
28733
28739
*2875
28730
28731
28732
28733
28739
*2878
28730
28731
28732
28733
28739
*2879
28730
28731
28732
28733
28739
*28981
28730
28731
28732
28733
28739
*28982
28730
28731
28732
28733
28739
*28989
28730
28731
28732
28733
28739
*2899
28730
28731
28732
28733
28739
*29182
2910
2911
2912
2913
2914
29181
29189
2919
2920

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

29211
29212
2922
29281
29282
29283
29284
29289
2929
29381
29382
29383
29384
30300
30301
30302
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

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

*29285
2910
2911
2912
2913
2914
29181
29189
2919
2920
29211
29212
2922
29281
29282
29283
29284
29289
2929
29381
29382
29383
29384
30300
30301
30302
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

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

30552
30560
30561
30562
30570
30571
30572
30590
30591
30592
7105
*34461
59960
59969
*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
56738
56739
56781
56782
56789
*5671
56721
56722
56723
56729
56738
56739
56781
56782
56789
*56721
5670
5671

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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
56738
56739
56781
56782
56789
5679
*56722
5670
5671
56721
56722
56723
56729
56738
56739
56781
56782
56789
5679
*56723
5670
5671
56721
56722
56723
56729
56738
56739
56781
56782
56789
5679
*56729
5670
5671
56721
56722
56723
56729
56738
56739
56781
56782
56789
5679
*56731
56731
7280
72886
72888
*56738
5670
5671
56721
56722
56723
56729
56738
56739
56781
56782
56789
5679

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

*56739
5670
5671
56721
56722
56723
56729
56738
56739
56781
56782
56789
5679
*56781
5670
5671
56721
56722
56723
56729
56738
56739
56781
56782
56789
5679
*56782
5670
5671
56721
56722
56723
56729
56738
56739
56781
56782
56789
5679
*56789
5670
5671
56721
56722
56723
56729
56738
56739
56781
56782
56789
5679
*5679
56721
56722
56723
56729
56738
56739
56781
56782
56789
*56989
56721
56722
56723
56729

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

56738
56739
56781
56782
56789
*5699
56721
56722
56723
56729
56738
56739
56781
56782
56789
*5800
5851
5852
5853
5854
5855
5856
5859
*58081
5851
5852
5853
5854
5855
5856
5859
*5804
5851
5852
5853
5854
5855
5856
5859
*58089
5851
5852
5853
5854
5855
5856
5859
*5809
5851
5852
5853
5854
5855
5856
5859
*5810
5851
5852
5853
5854
5855
5856
5859
*5811
5851
5852
5853

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

5854
5855
5856
5859
*5812
5851
5852
5853
5854
5855
5856
5859
*5813
5851
5852
5853
5854
5855
5856
5859
*58181
5851
5852
5853
5854
5855
5856
5859
*58189
5851
5852
5853
5854
5855
5856
5859
*5819
5851
5852
5853
5854
5855
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

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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
*5824
5851
5852
5853
5854
5855
5856
5859
*58281
5851
5852
5853
5854
5855
5856
5859
*58289
5851
5852
5853
5854
5855
5856
5859
*5829
5851
5852
5853
5854
5855
5856
5859
*5830
5851
5852
5853
5854
5855
5856
5859
*5831
5851
5852
5853
5854
5855
5856
5859
*5832
5851
5852
5853
5854
5855
5856
5859
*5834
5851
5852
5853
5854
5855
5856
5859
*5836
5851

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

5852
5853
5854
5855
5856
5859
*5837
5851
5852
5853
5854
5855
5856
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

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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
*5849
5851
5852
5853
5854
5855
5856
5859
*5851
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
5849
5851
5852
5853

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

5854
5855
5856
5859
59010
59011
5902
5903
59080
59081
5909
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
5812
5813
58181
58189
5819
5834
5845
5846
5847
5848
5849
5851
5852

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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
59010
59011
5902
5903
59080
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

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

5852
5853
5854
5855
5856
5859
59010
59011
5902
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

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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
*5881
5851
5852
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

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

5856
5859
*59001
5851
5852
5853
5854
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

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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
*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

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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
*5941
59960
59969
*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

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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
*5970
59960
59969
*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

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

78820
78829
*59969
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

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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
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

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

*6018
59960
59969
*6019
59960
59969
*6020
59960
59969
*6021
59960
59969
*6022
59960
59969
*6023
59960
59969
*6028
59960
59969
*6029
59960
59969
*7280
56731
*72811
56731
*72812
56731
*72813
56731
*72819
56731
*7282
56731
*7283
56731
*72881
56731
*72886
56731
*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

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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
59960
59969
*75312
5851
5852
5853
5854
5855
5856
5859
59960
59969
*75313
5851
5852
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

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

5852
5853
5854
5855
5856
5859
59960
59969
*75320
5851
5852
5853
5854
5855
5856
5859
59960
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

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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
*7534
59960
59969
*7535
59960
59969
*7536
59960
59969
*7537
59960
59969
*7538
59960
59969
*7539
5851
5852
5853
5854
5855
5856
5859
59960
59969
*7685
77012
77014
77016
77018
77086
*7686
77012
77014
77016
77018
77086
*7689
77012
77014
77016
77018
77086
*769
77012
77014
77016
77018
77086
*7700
77012
77014
77016
77018
77086
*77010
7685
769
7700
77012
77014
77016
77018
7702
7703
7704

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

7705
7707
77084
77086
*77011
7685
769
7700
77012
77014
77016
77018
7702
7703
7704
7705
7707
77084
77086
*77012
7685
769
7700
77012
77014
77016
77018
7702
7703
7704
7705
7707
77084
77086
*77013
7685
769
7700
77012
77014
77016
77018
7702
7703
7704
7705
7707
77084
77086
*77014
7685
769
7700
77012
77014
77016
77018
7702
7703
7704
7705
7707
77084
77086
*77015
7685
769

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

7700
77012
77014
77016
77018
7702
7703
7704
7705
7707
77084
77086
*77016
7685
769
7700
77012
77014
77016
77018
7702
7703
7704
7705
7707
77084
77086
*77017
7685
769
7700
77012
77014
77016
77018
7702
7703
7704
7705
7707
77084
77086
*77018
7685
769
7700
77012
77014
77016
77018
7702
7703
7704
7705
7707
77084
77086
*7702
77012
77014
77016
77018
77086
*7703
77012
77014
77016

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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
77086
*7704
77012
77014
77016
77018
77086
*7705
77012
77014
77016
77018
77086
*7706
77012
77014
77016
77018
77086
*7707
77012
77014
77016
77018
77086
*77081
77012
77014
77016
77018
77086
*77082
77012
77014
77016
77018
77086
*77083
77012
77014
77016
77018
77086
*77084
77012
77014
77016
77018
77086
*77085
7685
769
7700
77012
77014
77016
77018
7702
7703
7704
7705
7707
77084
77086
*77086
7685

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

769
7700
77012
77014
77016
77018
7702
7703
7704
7705
7707
77084
77086
*77089
77012
77014
77016
77018
77086
*7709
77012
77014
77016
77018
77086
*77981
77012
77014
77016
77018
77086
*77982
77012
77014
77016
77018
77086
*77983
77012
77014
77016
77018
77086
*77984
76501
76502
76503
76504
76505
76506
76507
76508
7670
76711
7685
769
7700
77012
77014
77016
77018
7702
7703
7704
7705
7707
77084

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

77086
7710
7711
7713
77181
77183
77210
77211
77212
77213
77214
7722
7724
7725
7730
7731
7732
7733
7734
7740
7741
7742
77430
77431
77439
7744
7745
7747
7751
7752
7753
7754
7755
7756
7757
7760
7761
7762
7763
7771
7772
7775
7776
7780
7790
7791
7797
*77989
77012
77014
77016
77018
77086
*78091
79901
79902
*78092
79901
79902
*78093
79901
79902
*78094
79901
79902
*78095
04082

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

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
*99640
99640
99641
99642
99643
99644
99645
99646
99647
99649
99657
99660
99666
99667
99669
99670
99677
99678
99679
99679
*99641
99640
99641
99642
99643
99644
99645
99646
99647
99649
99657
99660
99666
99667
99669
99670
99677
99678
99679
*99642
99640
99641
99642
99643
99644
99645
99646
99647
99649
99657
99660
99666
99667
99669
99670
99677
99678
99679
*99643
99640
99641
99642
99643
99644
99645
99646
99647
99649
99657
99660
99666
99667
99669
99670
99677
99678
99679
*99644
99640
99641
99642
99643
99644
99645
99646
99647

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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
*99645
99640
99641
99642
99643
99644
99645
99646
99647
99649
99657
99660
99666
99667
99669
99670
99677
99678
99679
*99646
99640
99641
99642
99643
99644
99645
99646
99647
99649
99657
99660
99666
99667
99669
99670
99677
99678
99679
*99647
99640
99641
99642
99643
99644
99645
99646
99647
99649
99657
99660
99666
99667
99669
99670
99677
99678
99679

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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
99640
99641
99642
99643
99644
99645
99646
99647
99649
99657
99660
99666
99667
99669
99670
99677
99678
99679
*99666
99640
99641
99642
99643
99644
99645
99646
99647
99649
*99667
99640
99641
99642
99643
99644
99645
99646
99647
99649
*99677
99640
99641
99642
99643
99644
99645
99646
99647
99649
*99678
99640
99641
99642
99643
99644
99645
99646
99647
99649
*99791
99640
99641
99642
99643
99644
99645
99646

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

99647
99649
*99799
99640
99641
99642
99643
99644
99645
99646
99647
99649
*99881
99640
99641
99642
99643
99644
99645
99646
99647
99649
*99883
99640
99641
99642
99643
99644
99645
99646
99647
99649
*99889
99640
99641
99642
99643
99644
99645
99646
99647
99649
*9989
99640
99641
99642
99643
99644
99645
99646
99647
99649
*V460
V4613
V4614
*V4611
V4613
V4614
*V4612
V4613
V4614
*V4613
V4611
V4612
V4613
V4614
*V4614

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

[CCs that are added to the list are included in this table. 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.]

V4611
V4612
V4613
V4614
*V462
V4613
V4614
*V468
V4613
V4614
*V469
V4613
V4614

TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST

[CCs that are deleted from the list are included in this table. 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
5996
*1882
5996
*1883
5996
*1884
5996
*1885
5996
*1886
5996
*1887
5996
*1888
5996
*1889
5996
*1892
5996
*1893
5996
*1894
5996
*1898
5996
*1899
5996
*25040
585
*25041
585
*25042
585
*25043
585
*25080
585
*25081
585

TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

[CCs that are deleted from the list are included in this table. 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.]

*25082
585
*25083
585
*25090
585
*25091
585
*25092
585
*25093
585
*27410
585
*27411
5996
*27419
585
*2760
2765
*2761
2765
*2762
2765
*2763
2765
*2764
2765
*2765
2760
2761
2762
2763
2764
2765
2766
2767
2769
*2766
2765
*2767
2765
*2768
2765
*2769
2765
*2860
2873
*2861
2873
*2862
2873
*2863
2873
*2864
2873
*2865
2873
*2866
2873
*2867
2873
*2869
2873
*2870
2873
*2871

TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

[CCs that are deleted from the list are included in this table. 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.]

2873
*2872
2873
*2873
2860
2861
2862
2863
2864
2865
2866
2867
2869
2870
2871
2872
2873
2874
2875
2878
2879
*2874
2873
*2875
2873
*2878
2873
*2879
2873
*28981
2873
*28982
2873
*28989
2873
*2899
2873
*34461
5996
*5670
5672
5678
*5671
5672
5678
*5672
5670
5671
5672
5678
5679
*5678
5670
5671
5672
5678
5679
*5679
5672
5678
*56989
5672
5678
*5699
5672
5678
*5800

TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

[CCs that are deleted from the list are included in this table. 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
*5804
585
*58081
585
*58089
585
*5809
585
*5810
585
*5811
585
*5812
585
*5813
585
*58181
585
*58189
585
*5819
585
*5820
585
*5821
585
*5822
585
*5824
585
*58281
585
*58289
585
*5829
585
*5830
585
*5831
585
*5832
585
*5834
585
*5836
585
*5837
585
*58381
585
*58389
585
*5839
585
*5845
585
*5846
585
*5847
585
*5848
585
*5849
585
*585
5800

TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

[CCs that are deleted from the list are included in this table. 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.]

5804
58081
58089
5809
5810
5811
5812
5813
58181
58189
5819
5834
5845
5846
5847
5848
5849
585
59010
59011
5902
5903
59080
59081
5909
591
*586
585
*587
585
*5880
585
*5881
585
*58881
585
*58889
585
*5889
585
*5890
585
*5891
585
*5899
585
*59000
585
*59001
585
*59010
585
*59011
585
*5902
585
*5903
585
*59080
585
*59081
585
*5909
585
*591
585
*5921

TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

[CCs that are deleted from the list are included in this table. 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
*5929
5996
*5930
585
*5931
585
*5932
585
*5933
5996
*5934
5996
*5935
5996
*59389
585
5996
*5939
585
5996
*5940
5996
*5941
5996
*5942
5996
*5948
5996
*5949
5996
*5950
5996
*5951
5996
*5952
5996
*5953
5996
*5954
5996
*59581
5996
*59582
5996
*59589
5996
*5959
5996
*5960
5996
*59651
5996
*59652
5996
*59653
5996
*59654
5996
*59655
5996
*59659
5996
*5968
5996
*5969
5996

TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

[CCs that are deleted from the list are included in this table. 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.]

*5970
5996
*59780
5996
*59781
5996
*59789
5996
*59800
5996
*59801
5996
*5981
5996
*5982
5996
*5988
5996
*5989
5996
*5990
5996
*5991
5996
*5992
5996
*5993
5996
*5994
5996
*5995
5996
*5996
5921
5935
5950
5951
5952
5954
59581
59582
59589
5959
5970
5981
5982
5990
5994
5996
78820
78829
*5997
585
5996
*59981
585
5996
*59982
585
5996
*59983
585
5996
*59984
585
5996
*59989
585
5996
*5999
585
5996
*60000
5996
*60001
5996
*60010
5996
*60011
5996
*60020
5996
*60021
5996
*6003
5996
*60090
5996
*60091
5996
*6010
5996
*6011
5996
*6012
5996
*6013
5996
*6014
5996
*6018
5996
*6019
5996
*6020
5996
*6021
5996
*6022
5996
*6023
5996
*6028
5996
*6029
5996
*7530
585
5996
*75310
585
5996
*75311
585
5996
*75312
585
5996
*75313
585
5996
*75314
585
5996
*75315
585
5996
*75316
585
5996
*75317
585
5996
*75319
585
5996
*75320
585
5996
*75321
585
5996
*75322
585
5996
*75323
585
5996
*75329
585
5996
*7533
585
5996
*7534
5996
*7535
5996
*7536
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 FROM THE CC EXCLUSIONS LIST—Continued

[CCs that are deleted from the list are included in this table. 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

TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

[CCs that are deleted from the list are included in this table. 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
*77982
7701
*77983
7701
*77989
7701
*7881
5996
*7990
7991
*9964
9964
99657
99660
99666
99667
99669
99670
99677
99678
99679

TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

[CCs that are deleted from the list are included in this table. 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.]

*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 March 2005 GROUPER V22.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	23,402	9.8463	3	5	8	13	19
2	10,428	4.5661	1	2	4	6	9
3	4	9.5000	1	1	8	14	15
6	413	3.0363	1	1	2	4	7
7	15,700	9.3193	2	4	7	12	19
8	3,735	2.8600	1	1	2	4	7
9	1,970	6.2162	1	3	4	7	12
10	19,627	6.0182	2	3	5	8	12
11	3,290	3.7620	1	2	3	5	7
12	54,743	5.3802	2	3	4	6	10
13	7,425	4.9494	2	3	4	6	8
14	238,142	5.6618	2	3	4	7	11
15	76,495	4.5219	1	2	4	6	8
16	16,350	6.3544	2	3	5	8	12
17	3,024	3.2183	1	2	2	4	6
18	33,332	5.2661	2	3	4	7	10
19	8,625	3.4419	1	2	3	4	6
20	6,591	9.8490	3	5	8	13	19
21	2,218	6.3120	2	3	5	8	13
22	3,333	5.2187	2	2	4	7	10
23	10,801	3.8931	1	2	3	5	7
24	64,348	4.7323	1	2	4	6	9
25	28,409	3.1271	1	2	3	4	6
26	18	6.2778	1	2	3	4	8
27	5,462	5.1531	1	1	3	6	11
28	17,705	5.7497	1	3	4	7	12
29	6,356	3.3211	1	1	3	4	6
30	1	19.0000	19	19	19	19	19
31	5,189	3.9726	1	2	3	5	8
32	2,030	2.3975	1	1	2	3	5
34	28,017	4.7706	1	2	4	6	9
35	7,947	3.0042	1	1	3	4	6
36	1,477	1.6019	1	1	1	1	3
37	1,253	4.1564	1	1	3	5	9
38	56	3.5179	1	1	2	4	6
39	449	2.3742	1	1	1	2	5
40	1,395	4.1004	1	1	4	5	8
42	1,156	2.7578	1	1	2	4	6

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

[FY 2004 MedPAR Update March 2005 GROUPER V22.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
43	125	3.1440	1	1	2	4	6
44	1,171	4.7976	2	3	4	6	8
45	2,819	3.0816	1	2	2	4	6
46	3,837	4.1780	1	2	3	5	8
47	1,346	2.8886	1	1	2	4	5
49	2,490	4.3831	1	2	3	5	8
50	2,183	1.8140	1	1	1	2	3
51	191	2.7539	1	1	1	3	6
52	166	1.9759	1	1	1	2	4
53	2,241	3.9487	1	1	2	5	9
54	1	7.0000	7	7	7	7	7
55	1,364	3.1239	1	1	2	4	7
56	445	2.5730	1	1	1	3	6
57	705	4.1447	1	1	2	5	9
59	104	2.6058	1	1	1	3	6
60	8	3.2500	1	1	2	4	4
61	222	5.3694	1	1	3	7	12
63	2,880	4.4705	1	2	3	5	9
64	3,370	6.0576	1	2	4	8	13
65	41,607	2.7731	1	1	2	3	5
66	8,052	3.1333	1	1	2	4	6
67	420	3.6810	1	2	3	4	7
68	17,401	3.9725	1	2	3	5	7
69	4,841	3.0283	1	2	3	4	5
70	26	2.3462	1	2	2	3	3
71	68	4.0000	1	2	3	5	7
72	1,073	3.4418	1	2	3	4	7
73	7,996	4.3779	1	2	3	6	9
74	4	2.5000	2	2	2	3	3
75	45,262	9.8107	3	5	7	12	20
76	47,617	10.8370	3	5	8	13	21
77	2,173	4.6558	1	2	4	6	9
78	45,896	6.2537	2	4	6	8	10
79	171,263	8.2002	3	4	7	10	15
80	7,757	5.3673	2	3	4	7	10
81	5	9.8000	3	3	11	13	14
82	65,516	6.6893	2	3	5	9	13
83	7,091	5.2293	2	3	4	7	10
84	1,502	3.1478	1	2	3	4	6
85	21,990	6.2299	2	3	5	8	12
86	1,868	3.6156	1	2	3	5	7
87	83,132	6.4294	2	3	5	8	12
88	415,743	4.9005	2	3	4	6	9
89	553,059	5.6479	2	3	5	7	10
90	46,079	3.8094	2	2	3	5	7
91	48	4.3542	1	2	3	5	9
92	16,584	5.9982	2	3	5	8	11
93	1,613	3.8407	1	2	3	5	7
94	13,459	6.1299	2	3	5	8	12
95	1,631	3.6297	1	2	3	5	7
96	59,418	4.3758	2	2	4	5	8
97	27,175	3.3845	1	2	3	4	6
98	9	2.5556	1	2	3	3	3
99	21,688	3.1166	1	1	2	4	6
100	7,002	2.1133	1	1	2	3	4
101	23,315	4.2565	1	2	3	5	8
102	5,292	2.4934	1	1	2	3	5
103	748	37.8115	8	12	23	49	79
104	21,097	14.4820	6	8	12	18	25
105	31,872	9.9383	4	6	8	12	18
106	3,549	11.1972	5	7	9	13	19
107	70,700	10.4839	5	7	9	12	17
108	8,933	9.8282	1	5	8	12	19
109	51,135	7.7541	4	5	6	9	13
110	57,502	8.3925	1	3	7	11	17
111	10,144	3.4310	1	1	3	5	7
113	37,476	12.6142	4	6	10	16	24
114	8,583	8.4620	2	4	7	11	16
115	22,284	6.8149	1	2	5	9	14
116	119,388	4.2595	1	1	3	6	9

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

[FY 2004 MedPAR Update March 2005 GROUPER V22.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
117	5,173	4.2295	1	1	2	5	10
118	7,652	3.0387	1	1	2	4	7
119	998	5.4920	1	1	3	7	13
120	36,527	9.0471	1	3	6	12	20
121	160,225	6.2477	2	3	5	8	12
122	62,124	3.3835	1	2	3	4	6
123	33,796	4.8114	1	1	3	6	11
124	131,668	4.3935	1	2	3	6	9
125	96,650	2.7212	1	1	2	3	5
126	5,867	11.3414	3	6	9	14	21
127	699,142	5.1265	2	3	4	6	10
128	5,201	5.1650	2	3	5	6	9
129	3,781	2.6006	1	1	1	3	6
130	89,637	5.4262	1	3	5	7	10
131	23,960	3.8028	1	2	4	5	7
132	117,958	2.8045	1	1	2	3	5
133	7,345	2.1799	1	1	2	3	4
134	42,681	3.1055	1	2	2	4	6
135	7,481	4.2929	1	2	3	5	8
136	1,137	2.7502	1	1	2	3	5
138	208,073	3.9146	1	2	3	5	7
139	79,030	2.4358	1	1	2	3	5
140	38,463	2.4369	1	1	2	3	5
141	122,553	3.4612	1	2	3	4	6
142	52,544	2.4784	1	1	2	3	5
143	250,910	2.0938	1	1	2	3	4
144	100,554	5.7002	1	2	4	7	12
145	6,244	2.6099	1	1	2	3	5
146	10,816	9.8879	5	6	8	12	17
147	2,652	5.8111	3	4	6	7	9
148	136,357	12.0947	5	7	9	15	22
149	20,021	5.9451	3	4	6	7	9
150	22,835	10.8915	4	6	9	14	20
151	5,389	5.1297	1	2	5	7	10
152	5,038	8.0369	3	5	7	9	14
153	2,104	4.9729	2	3	5	6	8
154	28,656	13.0578	3	6	10	16	25
155	6,190	4.1359	1	2	3	6	8
156	6	24.1667	1	5	9	27	27
157	8,309	5.7232	1	2	4	7	12
158	4,131	2.6069	1	1	2	3	5
159	19,267	5.1221	1	2	4	7	10
160	12,067	2.6627	1	1	2	3	5
161	10,462	4.3990	1	2	3	6	9
162	5,528	2.0801	1	1	1	3	4
163	10	2.9000	1	1	2	3	6
164	5,986	7.9820	3	5	7	10	14
165	2,541	4.2082	2	3	4	5	7
166	4,973	4.5025	1	2	3	5	9
167	4,682	2.2179	1	1	2	3	4
168	1,557	4.9030	1	2	3	6	10
169	767	2.2934	1	1	2	3	5
170	17,580	10.7956	2	5	8	14	22
171	1,494	4.1031	1	2	3	5	8
172	33,081	6.8370	2	3	5	9	14
173	2,410	3.5921	1	1	3	5	7
174	269,091	4.7026	2	3	4	6	9
175	32,812	2.8895	1	2	2	4	5
176	14,625	5.1424	2	3	4	6	10
177	8,603	4.4328	2	2	4	5	8
178	2,924	3.1211	1	2	3	4	5
179	14,542	5.8548	2	3	5	7	11
180	92,648	5.3227	2	3	4	7	10
181	26,045	3.3267	1	2	3	4	6
182	293,770	4.4295	1	2	3	5	8
183	87,104	2.8668	1	1	2	4	5
184	81	3.2840	1	2	2	4	6
185	5,754	4.4944	1	2	3	5	9
186	4	2.0000	1	1	1	3	3
187	634	4.1514	1	2	3	5	8

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

[FY 2004 MedPAR Update March 2005 GROUPER V22.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
188	91,501	5.5437	1	2	4	7	11
189	13,270	3.0916	1	1	2	4	6
190	70	4.3286	1	2	3	5	8
191	10,475	12.7179	3	6	9	16	26
192	1,329	5.6764	1	3	5	7	10
193	4,535	12.0485	5	7	10	15	22
194	524	6.6660	3	4	6	8	11
195	3,262	10.6125	4	6	9	13	19
196	703	5.7070	2	4	5	7	9
197	17,409	9.1025	3	5	7	11	17
198	4,664	4.3216	2	3	4	6	7
199	1,430	9.5203	2	4	7	13	19
200	942	9.7187	1	4	7	13	20
201	2,684	13.7299	3	6	10	18	28
202	27,484	6.1745	2	3	5	8	12
203	31,852	6.4862	2	3	5	8	13
204	73,333	5.5299	2	3	4	7	11
205	31,719	5.9002	2	3	4	7	12
206	2,095	3.8788	1	2	3	5	8
207	35,947	5.2368	1	2	4	7	10
208	9,830	2.9347	1	1	2	4	6
209	464,512	4.5650	3	3	4	5	7
210	129,184	6.6984	3	4	6	8	11
211	26,872	4.6683	3	3	4	5	7
212	10	2.9000	1	1	3	4	4
213	10,326	9.1100	2	4	7	12	18
216	17,774	5.7605	1	1	3	8	14
217	17,790	12.4693	3	5	9	15	26
218	29,029	5.4549	2	3	4	7	10
219	21,589	3.1095	1	2	3	4	5
220	4	2.7500	2	2	3	3	3
223	13,562	3.2145	1	1	2	4	6
224	11,013	1.8900	1	1	1	2	3
225	6,609	5.1607	1	2	4	7	11
226	6,717	6.3484	1	2	4	8	13
227	5,138	2.6086	1	1	2	3	5
228	2,665	4.1403	1	1	3	5	9
229	1,217	2.5094	1	1	2	3	5
230	2,591	5.5832	1	2	4	7	12
232	736	2.8139	1	1	1	3	6
233	15,214	6.6706	1	2	5	9	14
234	7,745	2.7898	1	1	2	4	6
235	5,010	4.6415	1	2	4	6	9
236	42,665	4.4765	1	3	4	5	8
237	2,035	3.6644	1	2	3	4	7
238	9,940	8.3339	3	4	6	10	16
239	43,175	6.0614	2	3	5	7	11
240	12,753	6.6181	2	3	5	8	13
241	2,717	3.7004	1	2	3	5	7
242	2,758	6.6164	2	3	5	8	13
243	102,299	4.5163	1	2	4	6	8
244	15,863	4.4900	1	2	4	6	8
245	5,870	3.1295	1	1	3	4	6
246	1,437	3.5783	1	2	3	4	7
247	21,831	3.3168	1	2	3	4	6
248	15,210	4.8406	1	3	4	6	9
249	14,161	3.8764	1	1	3	5	8
250	4,194	3.8884	1	2	3	5	7
251	2,168	2.7495	1	1	3	3	5
252	1	1.0000	1	1	1	1	1
253	25,052	4.5304	2	3	4	5	8
254	10,503	3.0475	1	2	3	4	5
255	1	7.0000	7	7	7	7	7
256	7,214	5.0349	1	2	4	6	10
257	13,587	2.6109	1	1	2	3	5
258	12,118	1.7490	1	1	1	2	3
259	2,910	2.7680	1	1	1	3	7
260	3,001	1.4045	1	1	1	1	2
261	1,630	2.2092	1	1	1	2	4
262	641	4.8222	1	2	4	7	10

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

[FY 2004 MedPAR Update March 2005 GROUPER V22.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
263	23,953	10.7683	3	5	8	13	21
264	3,948	6.2497	2	3	5	8	12
265	4,335	6.6046	1	2	4	8	14
266	2,335	3.1764	1	1	2	4	7
267	272	4.1838	1	1	3	5	10
268	1,038	3.5308	1	1	2	4	7
269	10,761	8.3312	2	4	6	11	16
270	2,661	3.8200	1	1	3	5	8
271	21,218	6.8298	2	3	5	8	13
272	5,964	5.8273	2	3	4	7	11
273	1,358	3.6406	1	2	3	5	7
274	2,303	6.2731	2	3	5	8	12
275	228	3.2500	1	1	2	4	7
276	1,451	4.4590	1	2	4	6	8
277	113,037	5.5031	2	3	5	7	10
278	34,072	4.0544	2	2	3	5	7
279	8	4.3750	1	1	5	6	6
280	19,468	4.0057	1	2	3	5	7
281	7,192	2.8411	1	1	2	4	5
283	6,300	4.5775	1	2	3	6	9
284	1,847	3.0238	1	1	2	4	6
285	7,696	10.0444	3	5	8	12	19
286	2,715	5.4748	2	2	4	6	10
287	6,162	9.9081	3	5	7	12	19
288	10,604	4.1167	2	2	3	4	7
289	6,923	2.5524	1	1	1	2	5
290	10,937	2.1306	1	1	1	2	4
291	67	2.7761	1	1	1	2	4
292	7,377	10.0538	2	4	8	13	20
293	370	4.4568	1	2	3	6	9
294	99,631	4.2903	1	2	3	5	8
295	4,143	3.6667	1	2	3	4	7
296	256,039	4.7212	1	2	4	6	9
297	45,622	3.0707	1	2	3	4	6
298	86	3.9302	1	1	2	4	7
299	1,497	5.1670	1	2	4	6	10
300	21,447	5.8676	2	3	5	7	11
301	3,916	3.4068	1	2	3	4	6
302	9,903	8.1703	4	5	6	9	14
303	23,854	7.3928	3	4	6	9	14
304	13,932	8.4913	2	3	6	11	18
305	3,110	3.2077	1	2	3	4	6
306	6,364	5.4788	1	2	3	8	13
307	2,075	2.0733	1	1	2	2	3
308	7,123	6.1189	1	2	4	8	14
309	3,585	2.0006	1	1	1	2	4
310	26,164	4.5252	1	2	3	6	10
311	6,530	1.8778	1	1	1	2	3
312	1,464	4.8347	1	1	3	6	11
313	514	2.2082	1	1	2	3	4
314	1	2.0000	2	2	2	2	2
315	36,882	6.7594	1	1	4	9	16
316	182,009	6.2874	2	3	5	8	12
317	2,798	3.4578	1	1	2	4	7
318	5,961	5.7412	1	2	4	7	11
319	388	2.7784	1	1	2	3	6
320	219,838	5.0956	2	3	4	6	9
321	31,579	3.5951	1	2	3	4	6
322	65	3.4462	2	2	3	4	6
323	20,616	3.0939	1	1	2	4	6
324	5,451	1.8835	1	1	1	2	3
325	9,685	3.6823	1	2	3	5	7
326	2,596	2.6221	1	1	2	3	5
327	5	2.6000	1	1	2	3	5
328	611	3.4583	1	1	3	5	7
329	72	1.8333	1	1	1	2	3
331	55,177	5.4326	1	2	4	7	11
332	4,439	3.1246	1	1	2	4	6
333	260	5.3923	1	2	3	6	13
334	9,878	4.2963	2	2	3	5	7

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

[FY 2004 MedPAR Update March 2005 GROUPER V22.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
335	12,049	2.6821	1	2	3	3	4
336	31,389	3.2999	1	2	2	4	7
337	25,268	1.9183	1	1	2	2	3
338	653	6.1884	1	2	3	9	14
339	1,259	5.1096	1	1	3	7	11
340	2	5.0000	4	4	6	6	6
341	3,196	3.1621	1	1	2	3	7
342	566	3.4223	1	2	2	4	7
344	2,702	2.7028	1	1	1	2	6
345	1,465	4.8007	1	1	3	6	11
346	3,993	5.7250	1	3	4	7	11
347	250	3.0640	1	1	2	4	7
348	4,202	4.0888	1	2	3	5	8
349	579	2.3523	1	1	2	3	4
350	7,188	4.4509	2	2	4	5	8
352	984	4.0061	1	2	3	5	8
353	2,745	6.3100	2	3	4	7	12
354	7,648	5.6951	2	3	4	6	10
355	4,958	3.0621	2	2	3	4	4
356	24,123	1.9262	1	1	2	2	3
357	5,589	8.1313	3	4	6	10	15
358	20,933	3.9643	2	2	3	4	7
359	28,972	2.4053	1	2	2	3	4
360	14,861	2.5888	1	1	2	3	4
361	276	3.0072	1	1	2	3	7
362	2	1.0000	1	1	1	1	1
363	2,144	3.7733	1	2	2	4	8
364	1,464	4.1858	1	2	3	5	9
365	1,628	7.7279	2	3	5	9	17
366	4,822	6.4942	1	3	5	8	13
367	459	2.9891	1	1	2	4	6
368	3,941	6.6420	2	3	5	8	13
369	3,645	3.2483	1	1	2	4	6
370	1,892	5.1723	2	3	4	5	8
371	2,309	3.4171	2	3	3	4	5
372	1,179	3.1688	2	2	2	3	5
373	4,967	2.2350	1	2	2	3	3
374	160	2.7688	2	2	2	3	5
375	6	4.0000	1	2	2	6	6
376	403	3.3945	1	2	2	4	7
377	78	4.5000	1	1	3	4	8
378	197	2.3147	1	1	2	3	4
379	511	2.8043	1	1	2	3	6
380	93	2.0860	1	1	1	2	4
381	217	2.2396	1	1	1	2	4
382	43	1.4419	1	1	1	2	2
383	2,515	3.6509	1	1	2	4	7
384	134	2.5522	1	1	1	3	5
385	1	1.0000	1	1	1	1	1
389	2	87.5000	21	21	154	154	154
390	2	2.5000	1	1	4	4	4
392	2,223	9.1939	2	4	6	11	19
393	1	4.0000	4	4	4	4	4
394	2,840	7.3718	1	2	5	9	16
395	116,839	4.2599	1	2	3	5	8
396	10	4.2000	1	2	2	3	6
397	18,586	5.1464	1	2	4	6	10
398	18,416	5.7084	2	3	4	7	11
399	1,659	3.3207	1	2	3	4	6
401	6,364	11.0506	2	5	9	14	22
402	1,414	4.0304	1	1	3	5	9
403	32,036	7.9373	2	3	6	10	16
404	3,825	4.1485	1	2	3	5	8
406	2,235	9.8868	2	4	7	12	21
407	589	3.8200	1	2	3	5	7
408	2,183	8.2171	1	2	5	10	19
409	1,818	5.7948	1	3	4	6	12
410	28,563	3.8313	1	2	3	5	6
411	12	3.2500	1	2	2	4	4
412	12	2.7500	1	1	1	3	4

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

[FY 2004 MedPAR Update March 2005 GROUPER V22.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
413	5,229	6.7569	2	3	5	9	13
414	576	4.0260	1	2	3	5	8
415	51,153	14.0354	4	6	11	18	28
416	240,311	7.3872	2	3	6	9	14
417	22	4.0455	1	2	3	5	7
418	28,788	6.1952	2	3	5	8	12
419	16,399	4.3887	1	2	3	5	8
420	2,961	3.3810	1	2	3	4	6
421	11,952	4.0628	1	2	3	5	7
422	53	3.7358	1	1	2	5	7
423	8,704	8.2135	2	3	6	10	17
424	1,078	12.4017	2	4	8	14	22
425	14,887	3.4519	1	1	3	4	7
426	4,353	4.1358	1	2	3	5	8
427	1,519	4.7110	1	2	3	5	9
428	777	7.2844	1	2	5	8	15
429	25,617	5.4610	2	3	4	6	10
430	71,987	7.6793	2	3	6	9	15
431	309	5.8576	1	2	4	7	12
432	422	4.2583	1	2	3	5	8
433	5,227	2.9629	1	1	2	3	6
439	1,756	8.8844	1	3	5	10	19
440	5,670	8.8106	2	3	6	10	18
441	786	3.3804	1	1	2	4	7
442	18,167	8.6812	2	3	6	11	18
443	3,422	3.3928	1	1	3	4	7
444	5,949	4.0309	1	2	3	5	8
445	2,376	2.8283	1	1	2	4	5
447	6,296	2.5681	1	1	2	3	5
448	1	2.0000	2	2	2	2	2
449	39,204	3.6748	1	1	3	4	7
450	7,880	1.9868	1	1	1	2	4
451	3	1.6667	1	1	1	3	3
452	27,882	4.9010	1	2	3	6	10
453	5,499	2.7978	1	1	2	3	5
454	3,874	4.1033	1	2	3	5	8
455	855	2.2187	1	1	2	3	4
461	2,752	5.1286	1	1	3	6	12
462	7,839	10.2341	4	6	8	13	19
463	31,249	3.8966	1	2	3	5	7
464	7,700	2.9153	1	1	2	4	5
465	226	3.7566	1	1	2	5	8
466	1,429	5.2645	1	1	2	5	10
467	1,023	2.6755	1	1	2	3	5
468	50,812	12.8282	3	6	10	16	25
471	15,754	5.0523	3	3	4	5	8
473	8,839	12.4395	2	3	7	18	32
475	117,173	11.0464	2	5	9	15	22
476	3,040	10.4967	2	4	9	14	21
477	29,601	8.5271	1	3	6	11	18
478	114,427	7.0983	1	2	5	9	15
479	24,838	2.7842	1	1	2	4	6
480	823	17.9380	7	8	13	22	36
481	1,099	21.7543	9	16	20	25	35
482	5,100	11.5082	4	6	9	14	21
484	468	12.7906	2	6	10	17	25
485	3,476	9.6530	4	5	7	12	18
486	2,662	12.3681	2	5	10	16	25
487	4,804	7.0760	1	3	5	9	14
488	798	16.3972	4	7	13	22	35
489	13,587	8.3522	2	3	6	10	17
490	5,255	5.3753	1	2	4	7	11
491	19,972	3.1398	1	2	3	3	5
492	4,033	13.6677	3	5	6	23	31
493	61,926	6.0526	1	3	5	8	12
494	25,786	2.6794	1	1	2	4	5
495	315	17.4127	8	9	13	20	31
496	3,319	8.9708	3	4	6	11	18
497	29,820	6.0519	3	4	5	7	10
498	19,770	3.7891	2	3	3	5	6

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

[FY 2004 MedPAR Update March 2005 GROUPER V22.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
499	35,931	4.3194	1	2	3	5	9
500	48,926	2.2388	1	1	2	3	4
501	3,144	9.9078	4	5	8	13	18
502	721	5.7406	2	3	5	7	9
503	5,983	3.8369	1	2	3	5	7
504	189	27.2116	8	16	23	36	49
505	181	4.6354	1	1	1	6	11
506	1,010	15.8822	3	7	13	21	33
507	311	8.4662	1	3	7	11	18
508	645	7.2341	1	3	5	9	16
509	171	5.1345	1	2	3	6	11
510	1,770	6.4068	1	2	4	8	14
511	640	4.0531	1	1	2	4	8
512	539	12.7737	7	8	10	13	23
513	233	9.9356	5	7	8	12	16
515	27,658	4.2880	1	1	2	6	11
516	38,925	4.7852	2	2	4	6	9
517	66,832	2.5758	1	1	1	3	6
518	41,407	3.4769	1	1	2	4	8
519	11,642	4.8104	1	1	3	6	11
520	15,531	2.0012	1	1	1	2	4
521	32,416	5.4724	2	3	4	7	11
522	5,684	9.3895	3	4	7	12	19
523	16,002	3.8933	1	2	3	5	7
524	119,564	3.1912	1	2	3	4	6
525	323	13.2477	1	3	8	15	31
526	56,224	4.3526	1	2	3	5	8
527	194,348	2.2279	1	1	1	2	5
528	1,777	17.1486	6	10	15	22	30
529	4,046	7.9983	1	2	5	10	18
530	2,370	3.1224	1	1	2	4	6
531	4,846	9.4191	2	4	7	12	20
532	2,659	3.7131	1	1	3	5	8
533	47,840	3.7569	1	1	2	4	9
534	45,532	1.7911	1	1	1	2	3
535	13,099	8.2594	1	3	7	11	17
536	19,770	5.4062	1	2	4	7	12
537	8,711	6.7751	1	3	5	8	14
538	5,655	2.8233	1	1	2	3	6
539	5,041	10.8242	2	4	7	14	23
540	1,518	3.5870	1	1	3	4	7
541	22,675	43.1644	17	25	36	52	77
542	24,573	32.6658	12	18	27	40	58
543	5,471	12.0068	2	5	10	16	24
	12,216,080						

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

[FY 2004 MedPAR Update March 2005 GROUPER V23.0]

DRG	Number discharges	Arithmetic Mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	23,407	9.8451	3	5	8	13	19
2	10,422	4.5659	1	2	4	6	9
3	4	9.5	1	1	8	14	15
6	413	3.0363	1	1	2	4	7
7	15,520	9.3891	2	4	7	12	19
8	3,497	2.9548	1	1	2	4	7
9	1,970	6.2162	1	3	4	7	12
10	19,633	6.0172	2	3	5	8	12
11	3,284	3.7643	1	2	3	5	8
12	54,743	5.3802	2	3	4	6	10
13	7,425	4.9494	2	3	4	6	8
14	235,884	5.6478	2	3	4	7	11
15	76,495	4.5219	1	2	4	6	8
16	16,366	6.3522	2	3	5	8	12
17	3,008	3.2134	1	2	2	4	6
18	33,343	5.2655	2	3	4	7	10

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

[FY 2004 MedPAR Update March 2005 GROUPER V23.0]

DRG	Number discharges	Arithmetic Mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
19	8,614	3.4418	1	2	3	4	6
20	6,591	9.849	3	5	8	13	19
21	2,218	6.312	2	3	5	8	13
22	3,333	5.2187	2	2	4	7	10
23	10,801	3.8931	1	2	3	5	7
24	64,424	4.7297	1	2	4	6	9
25	28,333	3.1286	1	2	3	4	6
26	18	6.2778	1	2	3	4	8
27	5,462	5.1531	1	1	3	6	11
28	17,714	5.749	1	3	4	7	12
29	6,347	3.3198	1	1	3	4	6
30	1	19	19	19	19	19	19
31	5,190	3.9726	1	2	3	5	8
32	2,029	2.3967	1	1	2	3	5
34	26,697	4.7673	1	2	4	6	9
35	7,689	3.0061	1	1	3	4	6
36	1,477	1.6019	1	1	1	1	3
37	1,253	4.1564	1	1	3	5	9
38	56	3.5179	1	1	2	4	6
39	449	2.3742	1	1	1	2	5
40	1,395	4.1004	1	1	4	5	8
42	1,156	2.7578	1	1	2	4	6
43	125	3.144	1	1	2	4	6
44	1,171	4.7976	2	3	4	6	8
45	2,819	3.0816	1	2	2	4	6
46	3,837	4.178	1	2	3	5	8
47	1,346	2.8886	1	1	2	4	5
49	2,491	4.3826	1	2	3	5	8
50	2,183	1.814	1	1	1	2	3
51	191	2.7539	1	1	1	3	6
52	333	1.9129	1	1	1	2	3
53	2,259	3.9354	1	1	2	5	9
54	1	7	7	7	7	7	7
55	1,367	3.1207	1	1	2	4	7
56	447	2.5682	1	1	1	3	6
57	920	3.5989	1	1	2	4	8
59	105	2.5905	1	1	1	3	6
60	9	3	1	1	2	4	4
61	222	5.3694	1	1	3	7	12
63	2,902	4.501	1	2	3	5	9
64	3,370	6.0576	1	2	4	8	13
65	41,607	2.7731	1	1	2	3	5
66	8,052	3.1333	1	1	2	4	6
67	420	3.681	1	2	3	4	7
68	17,478	3.9693	1	2	3	5	7
69	4,764	3.0246	1	2	3	4	5
70	26	2.3462	1	2	2	3	3
71	68	4	1	2	3	5	7
72	1,073	3.4418	1	2	3	4	7
73	9,574	4.4027	1	2	3	6	9
74	4	2.5	2	2	2	3	3
75	45,259	9.8105	3	5	7	12	20
76	47,648	10.8335	3	5	8	13	21
77	2,142	4.6438	1	2	4	6	9
78	45,896	6.2537	2	4	6	8	10
79	171,506	8.1955	3	4	7	10	15
80	7,514	5.383	2	3	4	7	10
81	5	9.8	3	3	11	13	14
82	65,516	6.6893	2	3	5	9	13
83	7,121	5.2219	2	3	4	7	10
84	1,472	3.1413	1	2	3	4	6
85	22,034	6.2247	2	3	5	8	12
86	1,824	3.6151	1	2	3	5	7
87	83,132	6.4294	2	3	5	8	12
88	415,743	4.9005	2	3	4	6	9
89	554,672	5.6426	2	3	5	7	10
90	44,466	3.8085	2	2	3	5	7
91	48	4.3542	1	2	3	5	9
92	16,675	5.9867	2	3	5	8	11
93	1,522	3.8371	1	2	3	5	7

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

[FY 2004 MedPAR Update March 2005 GROUPER V23.0]

DRG	Number discharges	Arithmetic Mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
94	13,468	6.1288	2	3	5	8	12
95	1,622	3.6245	1	2	3	5	7
96	60,100	4.3643	2	2	4	5	8
97	26,493	3.385	1	2	3	4	6
98	9	2.5556	1	2	3	3	3
99	21,768	3.1137	1	1	2	4	6
100	6,922	2.1108	1	1	2	3	4
101	23,407	4.2505	1	2	3	5	8
102	5,200	2.4892	1	1	2	3	5
103	755	37.6159	8	12	23	48	79
104	21,072	14.4891	6	8	12	18	25
105	31,848	9.94	4	6	8	12	18
106	3,544	11.2015	5	7	9	13	19
108	9,311	10.8565	4	6	9	13	20
110	56,311	8.3074	1	3	6	10	17
111	10,039	3.4017	1	1	3	5	7
113	37,476	12.6142	4	6	10	16	24
114	8,583	8.462	2	4	7	11	16
117	5,173	4.2295	1	1	2	5	10
118	7,652	3.0387	1	1	2	4	7
119	998	5.492	1	1	3	7	13
120	36,527	9.0471	1	3	6	12	20
121	160,170	6.2471	2	3	5	8	12
122	62,110	3.383	1	2	3	4	6
123	33,796	4.8114	1	1	3	6	11
124	131,668	4.3935	1	2	3	6	9
125	96,650	2.7212	1	1	2	3	5
126	5,867	11.3414	3	6	9	14	21
127	699,142	5.1265	2	3	4	6	10
128	5,201	5.165	2	3	5	6	9
129	3,781	2.6006	1	1	1	3	6
130	89,660	5.4256	1	3	5	7	10
131	23,937	3.8036	1	2	4	5	7
132	117,968	2.8045	1	1	2	3	5
133	7,335	2.1793	1	1	2	3	4
134	42,681	3.1055	1	2	2	4	6
135	7,482	4.2926	1	2	3	5	8
136	1,136	2.7509	1	1	2	3	5
138	208,165	3.914	1	2	3	5	7
139	78,938	2.4356	1	1	2	3	5
140	38,463	2.4369	1	1	2	3	5
141	122,656	3.4603	1	2	3	4	6
142	52,441	2.4785	1	1	2	3	5
143	250,910	2.0938	1	1	2	3	4
144	100,597	5.6989	1	2	4	7	12
145	6,201	2.6093	1	1	2	3	5
146	10,816	9.8879	5	6	8	12	17
147	2,652	5.8111	3	4	6	7	9
148	136,377	12.094	5	7	9	15	22
149	20,001	5.9437	3	4	6	7	9
150	22,841	10.8905	4	6	9	14	20
151	5,383	5.1274	1	2	5	7	10
152	5,039	8.0367	3	5	7	9	14
153	2,103	4.9719	2	3	5	6	8
154	28,663	13.0553	3	6	10	16	25
155	6,182	4.1349	1	2	3	6	8
156	6	24.1667	1	5	9	27	27
157	8,313	5.7218	1	2	4	7	12
158	4,127	2.6067	1	1	2	3	5
159	19,282	5.1208	1	2	4	7	10
160	12,052	2.6618	1	1	2	3	5
161	10,467	4.3978	1	2	3	6	9
162	5,523	2.0802	1	1	1	3	4
163	10	2.9	1	1	2	3	6
164	5,991	7.9806	3	5	7	10	14
165	2,536	4.2039	2	3	4	5	7
166	4,978	4.5026	1	2	3	5	9
167	4,677	2.2153	1	1	2	3	4
168	1,565	4.8907	1	2	3	6	10
169	778	2.2969	1	1	2	3	5

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

[FY 2004 MedPAR Update March 2005 GROUPER V23.0]

DRG	Number discharges	Arithmetic Mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
170	17,581	10.7952	2	5	8	14	22
171	1,493	4.1025	1	2	3	5	8
172	33,087	6.8372	2	3	5	9	14
173	2,404	3.5815	1	1	3	5	7
174	269,113	4.7025	2	3	4	6	9
175	32,790	2.8894	1	2	2	4	5
176	14,625	5.1424	2	3	4	6	10
177	8,605	4.4335	2	2	4	5	8
178	2,922	3.1181	1	2	3	4	5
179	14,542	5.8548	2	3	5	7	11
180	92,667	5.3223	2	3	4	7	10
181	26,026	3.3268	1	2	3	4	6
182	293,882	4.4288	1	2	3	5	8
183	86,992	2.8669	1	1	2	4	5
184	81	3.284	1	2	2	4	6
185	5,754	4.4944	1	2	3	5	9
186	4	2	1	1	1	3	3
187	634	4.1514	1	2	3	5	8
188	91,507	5.5436	1	2	4	7	11
189	13,264	3.0913	1	1	2	4	6
190	70	4.3286	1	2	3	5	8
191	10,476	12.7174	3	6	9	16	26
192	1,328	5.6755	1	3	5	7	10
193	4,536	12.0476	5	7	10	15	22
194	523	6.6635	3	4	6	8	11
195	3,262	10.6125	4	6	9	13	19
196	703	5.707	2	4	5	7	9
197	17,419	9.0995	3	5	7	11	17
198	4,653	4.3215	2	3	4	6	7
199	1,430	9.5203	2	4	7	13	19
200	942	9.7187	1	4	7	13	20
201	2,684	13.7299	3	6	10	18	28
202	27,484	6.1745	2	3	5	8	12
203	31,852	6.4862	2	3	5	8	13
204	73,333	5.5299	2	3	4	7	11
205	31,724	5.8998	2	3	4	7	12
206	2,090	3.8804	1	2	3	5	8
207	35,951	5.2367	1	2	4	7	10
208	9,826	2.9341	1	1	2	4	6
210	129,253	6.6973	3	4	6	8	11
211	26,803	4.6683	3	3	4	5	7
212	10	2.9	1	1	3	4	4
213	10,326	9.11	2	4	7	12	18
216	17,774	5.7605	1	1	3	8	14
217	17,790	12.4693	3	5	9	15	26
218	29,060	5.4537	2	3	4	7	10
219	21,558	3.1077	1	2	3	4	5
220	4	2.75	2	2	3	3	3
223	13,578	3.2155	1	1	2	4	6
224	10,998	1.8869	1	1	1	2	3
225	6,609	5.1607	1	2	4	7	11
226	6,725	6.3486	1	2	4	8	13
227	5,130	2.6025	1	1	2	3	5
228	2,665	4.1403	1	1	3	5	9
229	1,217	2.5094	1	1	2	3	5
230	2,591	5.5832	1	2	4	7	12
232	735	2.815	1	1	1	3	6
233	15,221	6.6695	1	2	5	9	14
234	7,738	2.7886	1	1	2	4	6
235	5,010	4.6415	1	2	4	6	9
236	42,665	4.4765	1	3	4	5	8
237	2,035	3.6644	1	2	3	4	7
238	9,940	8.3339	3	4	6	10	16
239	43,175	6.0614	2	3	5	7	11
240	12,757	6.6172	2	3	5	8	13
241	2,713	3.7003	1	2	3	5	7
242	2,758	6.6164	2	3	5	8	13
243	102,299	4.5163	1	2	4	6	8
244	15,871	4.4895	1	2	4	6	8
245	5,862	3.129	1	1	3	4	6

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

[FY 2004 MedPAR Update March 2005 GROUPER V23.0]

DRG	Number discharges	Arithmetic Mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
246	1,437	3.5783	1	2	3	4	7
247	21,831	3.3168	1	2	3	4	6
248	15,210	4.8406	1	3	4	6	9
249	14,161	3.8764	1	1	3	5	8
250	4,199	3.8876	1	2	3	5	7
251	2,163	2.7485	1	1	3	3	5
252	1	1	1	1	1	1	1
253	25,073	4.5295	2	3	4	5	8
254	10,482	3.0467	1	2	3	4	5
255	1	7	7	7	7	7	7
256	7,214	5.0349	1	2	4	6	10
257	13,593	2.6106	1	1	2	3	5
258	12,112	1.7488	1	1	1	2	3
259	2,912	2.7679	1	1	1	3	7
260	2,999	1.4038	1	1	1	1	2
261	1,630	2.2092	1	1	1	2	4
262	641	4.8222	1	2	4	7	10
263	23,959	10.7669	3	5	8	13	21
264	3,942	6.2511	2	3	5	8	12
265	4,339	6.6036	1	2	4	8	14
266	2,331	3.1725	1	1	2	4	7
267	272	4.1838	1	1	3	5	10
268	1,038	3.5308	1	1	2	4	7
269	10,763	8.3298	2	4	6	11	16
270	2,658	3.8209	1	1	3	5	8
271	21,218	6.8298	2	3	5	8	13
272	5,966	5.8265	2	3	4	7	11
273	1,356	3.6409	1	2	3	5	7
274	2,304	6.2708	2	3	5	8	12
275	227	3.2599	1	1	2	4	7
276	1,451	4.459	1	2	4	6	8
277	113,079	5.5031	2	3	5	7	10
278	34,030	4.0527	2	2	3	5	7
279	8	4.375	1	1	5	6	6
280	19,491	4.0045	1	2	3	5	7
281	7,169	2.8407	1	1	2	4	5
283	6,303	4.5766	1	2	3	6	9
284	1,844	3.0244	1	1	2	4	6
285	7,696	10.0444	3	5	8	12	19
286	2,715	5.4748	2	2	4	6	10
287	6,162	9.9081	3	5	7	12	19
288	10,604	4.1167	2	2	3	4	7
289	6,923	2.5524	1	1	1	2	5
290	10,937	2.1306	1	1	1	2	4
291	67	2.7761	1	1	1	2	4
292	7,378	10.0529	2	4	8	13	20
293	369	4.4607	1	2	3	6	9
294	99,631	4.2903	1	2	3	5	8
295	4,143	3.6667	1	2	3	4	7
296	256,121	4.7208	1	2	4	6	9
297	45,540	3.0703	1	2	3	4	6
298	86	3.9302	1	1	2	4	7
299	1,497	5.167	1	2	4	6	10
300	21,452	5.8669	2	3	5	7	11
301	3,911	3.4076	1	2	3	4	6
302	9,903	8.1703	4	5	6	9	14
303	23,854	7.3928	3	4	6	9	14
304	13,937	8.4896	2	3	6	11	18
305	3,105	3.2068	1	2	3	4	6
306	6,364	5.4788	1	2	3	8	13
307	2,075	2.0733	1	1	2	2	3
308	7,124	6.1186	1	2	4	8	14
309	3,584	2	1	1	1	2	4
310	26,169	4.5248	1	2	3	6	10
311	6,525	1.8775	1	1	1	2	3
312	1,464	4.8347	1	1	3	6	11
313	514	2.2082	1	1	2	3	4
314	1	2	2	2	2	2	2
315	36,882	6.7594	1	1	4	9	16
316	182,009	6.2874	2	3	5	8	12

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

[FY 2004 MedPAR Update March 2005 GROUPER V23.0]

DRG	Number discharges	Arithmetic Mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
317	2,798	3.4578	1	1	2	4	7
318	5,962	5.7404	1	2	4	7	11
319	387	2.7829	1	1	2	3	6
320	219,971	5.0946	2	3	4	6	9
321	31,446	3.5956	1	2	3	4	6
322	65	3.4462	2	2	3	4	6
323	20,619	3.0937	1	1	2	4	6
324	5,448	1.8834	1	1	1	2	3
325	9,686	3.6822	1	2	3	5	7
326	2,595	2.622	1	1	2	3	5
327	5	2.6	1	1	2	3	5
328	611	3.4583	1	1	3	5	7
329	72	1.8333	1	1	1	2	3
331	55,181	5.4324	1	2	4	7	11
332	4,435	3.1256	1	1	2	4	6
333	260	5.3923	1	2	3	6	13
334	9,887	4.2956	2	2	3	5	7
335	12,040	2.6815	1	2	3	3	4
336	31,395	3.2997	1	2	2	4	7
337	25,262	1.9182	1	1	2	2	3
338	653	6.1884	1	2	3	9	14
339	1,259	5.1096	1	1	3	7	11
340	2	5	4	4	6	6	6
341	3,196	3.1621	1	1	2	3	7
342	566	3.4223	1	2	2	4	7
344	2,702	2.7028	1	1	1	2	6
345	1,465	4.8007	1	1	3	6	11
346	3,993	5.725	1	3	4	7	11
347	250	3.064	1	1	2	4	7
348	4,202	4.0888	1	2	3	5	8
349	579	2.3523	1	1	2	3	4
350	7,188	4.4509	2	2	4	5	8
352	984	4.0061	1	2	3	5	8
353	2,745	6.31	2	3	4	7	12
354	7,655	5.6933	2	3	4	6	10
355	4,951	3.0612	2	2	3	4	4
356	24,123	1.9262	1	1	2	2	3
357	5,589	8.1313	3	4	6	10	15
358	20,954	3.9633	2	2	3	4	7
359	28,951	2.4049	1	2	2	3	4
360	14,861	2.5888	1	1	2	3	4
361	276	3.0072	1	1	2	3	7
362	2	1	1	1	1	1	1
363	2,144	3.7733	1	2	2	4	8
364	1,464	4.1858	1	2	3	5	9
365	1,628	7.7279	2	3	5	9	17
366	4,822	6.4942	1	3	5	8	13
367	459	2.9891	1	1	2	4	6
368	3,941	6.642	2	3	5	8	13
369	3,645	3.2483	1	1	2	4	6
370	1,892	5.1723	2	3	4	5	8
371	2,309	3.4171	2	3	3	4	5
372	1,179	3.1688	2	2	2	3	5
373	4,967	2.235	1	2	2	3	3
374	160	2.7688	2	2	2	3	5
375	5	4.6	2	2	3	6	10
376	403	3.3945	1	2	2	4	7
377	78	4.5	1	1	3	4	8
378	197	2.3147	1	1	2	3	4
379	511	2.8043	1	1	2	3	6
380	93	2.086	1	1	1	2	4
381	217	2.2396	1	1	1	2	4
382	43	1.4419	1	1	1	2	2
383	2,515	3.6509	1	1	2	4	7
384	134	2.5522	1	1	1	3	5
385	1	1	1	1	1	1	1
389	2	87.5	21	21	154	154	154
390	2	2.5	1	1	4	4	4
392	2,223	9.1939	2	4	6	11	19
393	1	4	4	4	4	4	4

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

[FY 2004 MedPAR Update March 2005 GROUPER V23.0]

DRG	Number discharges	Arithmetic Mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
394	2,840	7.3718	1	2	5	9	16
395	116,839	4.2599	1	2	3	5	8
396	10	4.2	1	2	2	3	6
397	18,586	5.1464	1	2	4	6	10
398	18,422	5.7074	2	3	4	7	11
399	1,653	3.323	1	2	3	4	6
401	6,366	11.0485	2	5	9	14	22
402	1,412	4.0297	1	1	3	5	9
403	32,042	7.9368	2	3	6	10	16
404	3,819	4.1464	1	2	3	5	8
406	2,236	9.8837	2	4	7	12	20
407	588	3.8214	1	2	3	5	7
408	2,183	8.2171	1	2	5	10	19
409	1,818	5.7948	1	3	4	6	12
410	28,563	3.8313	1	2	3	5	6
411	12	3.25	1	2	2	4	4
412	12	2.75	1	1	1	3	4
413	5,230	6.7558	2	3	5	9	13
414	575	4.0313	1	2	3	5	8
415	51,152	14.0356	4	6	11	18	28
416	240,311	7.3872	2	3	6	9	14
417	22	4.0455	1	2	3	5	7
418	28,788	6.1952	2	3	5	8	12
419	16,428	4.389	1	2	3	5	8
420	2,932	3.3697	1	2	3	4	6
421	11,952	4.0628	1	2	3	5	7
422	53	3.7358	1	1	2	5	7
423	8,704	8.2135	2	3	6	10	17
424	1,078	12.4017	2	4	8	14	22
425	14,887	3.4519	1	1	3	4	7
426	4,353	4.1358	1	2	3	5	8
427	1,519	4.711	1	2	3	5	9
428	777	7.2844	1	2	5	8	15
429	25,617	5.461	2	3	4	6	10
430	71,987	7.6793	2	3	6	9	15
431	309	5.8576	1	2	4	7	12
432	4.2583	1	2	3	5	8	
433	5,227	2.9629	1	1	2	3	6
439	1,756	8.8844	1	3	5	10	19
440	5,670	8.8106	2	3	6	10	18
441	786	3.3804	1	1	2	4	7
442	18,171	8.68	2	3	6	11	18
443	3,416	3.3929	1	1	3	4	7
444	5,955	4.0316	1	2	3	5	8
445	2,370	2.8236	1	1	2	4	5
447	6,296	2.5681	1	1	2	3	5
448	1	2	2	2	2	2	2
449	39,246	3.6741	1	1	3	4	7
450	7,838	1.9815	1	1	1	2	4
451	3	1.6667	1	1	1	3	3
452	27,889	4.9002	1	2	3	6	10
453	5,492	2.799	1	1	2	3	5
454	3,876	4.1019	1	2	3	5	8
455	853	2.2204	1	1	2	3	4
461	2,752	5.1286	1	1	3	6	12
462	7,839	10.2341	4	6	8	13	19
463	31,272	3.8962	1	2	3	5	7
464	7,677	2.9139	1	1	2	4	5
465	226	3.7566	1	1	2	5	8
466	1,429	5.2645	1	1	2	5	10
467	1,023	2.6755	1	1	2	3	5
468	50,777	12.8319	3	6	10	16	25
471	15,754	5.0523	3	3	4	5	8
473	8,839	12.4395	2	3	7	18	32
475	117,173	11.0464	2	5	9	15	22
476	3,040	10.4967	2	4	9	14	21
477	29,602	8.5325	1	3	6	11	18
479	24,830	2.7834	1	1	2	4	6
480	823	17.938	7	8	13	22	36
481	1,099	21.7543	9	16	20	25	35

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

[FY 2004 MedPAR Update March 2005 GROUPER V23.0]

DRG	Number discharges	Arithmetic Mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
482	5,211	11.4558	4	6	9	14	21
484	468	12.7906	2	6	10	17	25
485	3,476	9.653	4	5	7	12	18
486	2,662	12.3681	2	5	10	16	25
487	4,804	7.076	1	3	5	9	14
488	798	16.3972	4	7	13	22	35
489	13,587	8.3522	2	3	6	10	17
490	5,255	5.3753	1	2	4	7	11
491	19,972	3.1398	1	2	3	3	5
492	4,033	13.6677	3	5	6	23	31
493	61,968	6.0511	1	3	5	8	12
494	25,744	2.6775	1	1	2	4	5
495	312	17.3173	8	9	13	19	31
496	3,542	8.7572	3	4	6	10	18
497	27,884	5.8094	3	3	5	7	9
498	19,238	3.7597	2	3	3	5	6
499	35,954	4.3187	1	2	3	5	9
500	48,903	2.2383	1	1	2	3	4
501	3,144	9.9078	4	5	8	13	18
502	721	5.7406	2	3	5	7	9
503	5,983	3.8369	1	2	3	5	7
504	189	27.2116	8	16	23	36	49
505	181	4.6354	1	1	1	6	11
506	1,010	15.8822	3	7	13	21	33
507	311	8.4662	1	3	7	11	18
508	645	7.2341	1	3	5	9	16
509	171	5.1345	1	2	3	6	11
510	1,774	6.3968	1	2	4	8	14
511	636	4.066	1	1	2	5	8
512	539	12.7737	7	8	10	13	23
513	233	9.9356	5	7	8	12	16
515	44,944	4.3382	1	1	2	6	10
518	25,988	2.4905	1	1	1	3	5
519	11,650	4.8095	1	1	3	6	11
520	15,523	2.0005	1	1	1	2	4
521	32,428	5.4713	2	3	4	7	11
522	5,684	9.3895	3	4	7	12	19
523	15,979	3.8937	1	2	3	5	7
524	119,564	3.1912	1	2	3	4	6
525	314	13.242	1	3	8	15	29
528	1,777	17.1486	6	10	15	22	30
529	4,046	7.9983	1	2	5	10	18
530	2,370	3.1224	1	1	2	4	6
531	4,846	9.4191	2	4	7	12	20
532	2,659	3.7131	1	1	3	5	8
533	47,870	3.7563	1	1	2	4	9
534	45,500	1.7902	1	1	1	2	3
535	7,459	10.273	3	5	8	13	20
536	8,124	7.64	2	4	6	9	14
537	8,715	6.7733	1	3	5	8	14
538	5,651	2.8234	1	1	2	3	6
539	5,041	10.8242	2	4	7	14	23
540	1,518	3.587	1	1	3	4	7
541	22,715	43.1055	17	24	35	52	77
542	24,492	32.7431	12	18	27	40	58
543	5,471	12.0068	2	5	10	16	24
544	421,851	4.5075	3	3	4	5	7
545	42,661	5.1333	3	3	4	6	8
546	2,245	8.8272	3	4	7	11	17
547	35,664	12.0587	6	8	10	14	20
548	34,868	8.8612	5	6	8	10	14
549	14,483	10.1284	5	6	8	12	17
550	36,445	6.7982	4	5	6	8	10
551	56,978	6.359	1	2	5	8	13
552	84,699	3.5196	1	1	3	5	7
553	38,754	9.4977	2	4	7	12	20
554	75,681	5.8694	1	2	4	8	13
555	72,121	4.6626	1	2	3	6	9
556	49,952	2.0677	1	1	1	2	4
557	95,324	4.0908	1	2	3	5	8

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

[FY 2004 MedPAR Update March 2005 GROUPER V23.0]

DRG	Number discharges	Arithmetic Mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
558	155,257	1.854	1	1	1	2	4
559	2,258	7.1165	3	4	6	9	13
	12,215,613						

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS—JULY 2005

State	Urban	Rural
Alabama	0.271	0.344
Alaska	0.454	0.678
Arizona	0.292	0.391
Arkansas	0.348	0.38
California	0.247	0.349
Colorado	0.326	0.475
Connecticut	0.442	0.52
Delaware	0.529	0.509
District of Columbia	0.377	.....
Florida	0.256	0.294
Georgia	0.367	0.418
Hawaii	0.396	0.44
Idaho	0.481	0.532
Illinois	0.333	0.432
Indiana	0.437	0.469
Iowa	0.393	0.486
Kansas	0.304	0.473
Kentucky	0.391	0.4
Louisiana	0.31	0.378
Maine	0.504	0.489
Maryland	0.762	0.884
Massachusetts	0.484	.....
Michigan	0.386	0.486
Minnesota	0.404	0.531
Mississippi	0.349	0.389
Missouri	0.342	0.406
Montana	0.437	0.485
Nebraska	0.356	0.494
Nevada	0.249	0.494
New Hampshire	0.464	0.5
New Jersey	0.201	.....
New Mexico	0.411	0.407
New York	0.374	0.529
North Carolina	0.45	0.439
North Dakota	0.418	0.469
Ohio	0.39	0.548
Oklahoma	0.328	0.43
Oregon	0.487	0.471
Pennsylvania	0.293	0.46
Puerto Rico	0.444	.....
Rhode Island	0.439	.....
South Carolina	0.31	0.34
South Dakota	0.382	0.485
Tennessee	0.331	0.397
Texas	0.294	0.377
Utah	0.433	0.583
Vermont	0.577	0.621
Virginia	0.385	0.383
Washington	0.444	0.494
West Virginia	0.49	0.476
Wisconsin	0.45	0.493
Wyoming	0.442	0.615

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS—JULY 2005

State	Ratio
Alabama	0.026
Alaska	0.044
Arizona	0.028
Arkansas	0.029
California	0.018
Colorado	0.03
Connecticut	0.033
Delaware	0.042
District of Columbia	0.027
Florida	0.026
Georgia	0.034
Hawaii	0.034
Idaho	0.038
Illinois	0.029
Indiana	0.04
Iowa	0.031
Kansas	0.032
Kentucky	0.032
Louisiana	0.032
Maine	0.036
Maryland	0.013
Massachusetts	0.037
Michigan	0.034
Minnesota	0.034
Mississippi	0.032
Missouri	0.029
Montana	0.039
Nebraska	0.039
Nevada	0.02
New Hampshire	0.039
New Jersey	0.015
New Mexico	0.034
New York	0.033
North Carolina	0.038
North Dakota	0.042
Ohio	0.032
Oklahoma	0.031
Oregon	0.036
Pennsylvania	0.025
Puerto Rico	0.033
Rhode Island	0.022
South Carolina	0.03
South Dakota	0.039
Tennessee	0.033
Texas	0.028
Utah	0.039
Vermont	0.045
Virginia	0.039
Washington	0.036
West Virginia	0.034
Wisconsin	0.038
Wyoming	0.046

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY 2006

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
010008	01	33860	
010012	01	16860	
010022	01	40660	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	
010164	01	11500	Lugar
030007	03	22380	
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	26	
040069	04	32820	
040072	04	30780	
040076	04	26300	Lugar
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	
050054	40140	42044	
050065	42044	31084	
050069	42044	31084	
050071	41940	36084	
050073	46700	36084	
050076	41884	36084	
050089	40140	31084	
050090	42220	41884	
050099	40140	31084	
050102	40140	42044	
050118	44700	33700	
050129	40140	31084	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
050136	42220	41884	
050140	40140	31084	
050150	05	40900	
050168	42044	31084	
050173	42044	31084	
050174	42220	41884	
050193	42044	31084	
050224	42044	31084	
050226	42044	31084	
050228	41884	36084	
050230	42044	31084	
050243	40140	42044	
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	
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	
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	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
060001	24540	19740	
060003	14500	19740	
060027	14500	19740	
060044	06	19740	
060049	06	22660	
060096	06	19740	
060103	14500	19740	
070003	07	25540	Lugar
070015	25540	35644	
070021	07	25540	Lugar
070033	14860	35644	
080004	20100	48864	
080007	08	36140	
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	
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	10	
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
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	
130018	13	38540	
130049	17660	44060	
130067	13	26820	Lugar
140012	14	16974	
140015	14	41180	
140032	14	41180	
140034	14	41180	
140040	14	37900	
140043	14	40420	
140046	14	41180	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
140058	14	41180	
140061	14	41180	
140064	14	37900	
140093	19180	16580	
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	
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	19780	
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	111100	
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	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
180044	18	26580	
180048	18	31140	
180066	18	34980	
180069	18	26580	
180075	18	14540	Lugar
180078	18	26580	
180080	18	30460	
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	
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	
220003	49340	14484	
220010	21604	14484	
220019	49340	14484	
220025	49340	14484	
220028	49340	14484	
220029	21604	14484	
220033	21604	14484	
220035	21604	14484	
220058	49340	14484	
220060	14484	12700	
220062	49340	14484	
220077	44140	25540	
220080	21604	14484	
220090	49340	14484	
220095	49340	14484	
220163	49340	14484	
220174	21604	14484	
230022	23	11460	
230030	23	40980	
230035	23	24340	Lugar
230037	23	11460	
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	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
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
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	
260017	26	41180	
260022	26	16	
260025	26	41180	
260047	27620	17860	
260049	26	44180	Lugar
260064	26	17860	
260074	26	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	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
280065	28	24540	
280077	28	36540	
290002	29	16180	Lugar
290006	29	39900	
290008	29	29820	
290019	16180	39900	
300005	30	31700	
300011	31700	15764	
300012	31700	15764	
300019	30	15764	
300020	31700	15764	
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
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	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
340068	34	48900	
340069	39580	20500	
340071	34	39580	Lugar
340073	39580	20500	
340109	34	47260	
340114	39580	20500	
340115	34	20500	
340124	34	39580	Lugar
340126	34	39580	
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	
360095	36	30620	
360096	36	49660	Lugar
360107	36	17460	
360112	45780	11460	
360121	36	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
380027	38	21660	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
380050	38	32780	
390006	39	25420	
390013	39	25420	
390030	39	10900	
390031	39	39740	Lugar
390048	39	25420	
390052	39	11020	
390065	39	47894	
390066	30140	25420	
390071	39	48700	Lugar
390079	39	13780	
390086	39	44300	
390091	39	49660	
390093	39	38300	
390110	27780	38300	
390113	39	49660	
390133	10900	37964	
390138	39	47894	
390150	39	38300	Lugar
390151	39	47894	
390224	39	13780	Lugar
390246	39	48700	
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	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
450032	45	43340	
450039	23104	19124	
450059	41700	12420	
450064	23104	19124	
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

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
490013	49	31340	
490018	49	16820	
490047	49	25500	Lugar
490079	49	49180	
490092	49	40060	
490105	49	28700	
490106	49	16820	
490109	47260	40060	
500002	50	28420	
500003	34580	42644	
500016	48300	42644	
500031	50	36500	
500039	14740	42644	
500041	31020	38900	
500072	50	42644	
510001	34060	38300	
510002	51	40220	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
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	

TABLE 9A.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL AND CBSA—FY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
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—FY 2006

Provider No.	Note	Geographic CBSA	Wage index CBSA Sec. 508 reclassification	Own wage index
010150		01	17980	
020008		02		1.2828
050494		05	42220	
050549		37100	42220	
060057		06	19740	
060075		06		1.1697
070001		35300	35004	
070005		35300	35004	
070006	*	14860	35644	
070010		14860	35644	
070016		35300	35004	
070017		35300	35004	
070018	*	14860	35644	
070019		35300	35004	
070022		35300	35004	
070028		14860	35644	
070031		35300	35004	
070034	*	14860	35644	
070036		25540		1.2913
070039		35300	35004	
120025		12	26180	
150034		23844	16974	
160040		47940	16300	
160064		16		1.0218
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	

TABLE 9B.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUB. L. 108–173—FY 2006—Continued

Provider No.	Note	Geographic CBSA	Wage index CBSA Sec. 508 reclassification	Own wage index
230072		26100	28020	
230089		19804	11460	
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	
250078	*	25620	25060	
250122		25	25060	
270002	*	27	33540	
270012	*	24500	33540	
270021		27	13740	
270023		33540	13740	
270032		27	13740	
270050		27	13740	
270057		27	13740	
270084	*	27	33540	
310021		45940	35644	
310028		35084	35644	
310050		35084	35644	
310051		35084	35644	
310060		10900	35644	
310115		10900	35644	
310120		35084	35644	
330023	*	39100	35644	
330049		39100	35644	
330067	*	39100	35644	
330106		35004		1.4804
330126		39100	35644	
330135		39100	35644	
330205		39100	35644	
330209		39100	35004	
330264		39100	35004	
340002		11700	16740	
350002		13900	22020	
350003		35	22020	
350006		35	22020	
350010		35	22020	
350014		35	22020	
350015		13900	22020	
350017		35	22020	
350019	*	24220	22020	
350030		35	22020	
350061		35	22020	
380090		38		1.2303
390001		42540	10900	
390003		39	10900	
390054		42540	29540	
390072		39	10900	
390095		42540	10900	
390109		42540	10900	
390119		42540	10900	
390137		42540	10900	

TABLE 9B.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUB. L. 108–173—FY 2006—Continued

Provider No.	Note	Geographic CBSA	Wage index CBSA Sec. 508 reclassification	Own wage index
390169		42540	10900	
390185		42540	29540	
390192		42540	10900	
390237		42540	10900	
390270		42540	29540	
410010		39300		1.1734
430005		43	39660	
430008	*	43	43620	
430013	*	43	43620	
430015		43	43620	
430031	*	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	
530008	*	53	16220	
530010	*	53	16220	
530015		53		0.9887

*These hospitals are assigned a wage index value under a special exceptions policy (see FY 2005 IPPS final rule, 69 FR 49105).

TABLE 9C.—HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(D)(8)(E)OF THE ACT—FY 2006

Provider No.	Geographic CBSA	Redesignated rural area
040075	22220	04
050192	23420	05
050469	40140	05
050528	32900	05
050618	40140	05
070004	25540	07
100048	37860	10
100134	27260	10
140167	00014	14
150051	14020	15
170137	29940	17
190048	26380	19
230042	26100	23
230078	35660	23
260006	41140	26
260195	44180	26
330268	10580	33
370054	36420	37
380040	13460	38
390181	00039	39
390183	00039	39
440135	34980	44
450052	00045	45
450078	10180	45
450243	10180	45
450276	48660	45
450348	00045	45
500122	00050	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)—JULY 2005 [1]

DRG	Number of Cases	Threshold
1	23,405	$50,112
2	10,422	$34,822
3	4	$45,382
6	413	$15,921
7	15,520	$38,797
8	3,497	$28,679
9	1,970	$23,976
10	19,629	$23,222
11	3,284	$17,958
12	54,701	$17,426
13	7,421	$16,770
14	235,814	$23,807
15	76,451	$18,831
16	16,361	$24,322
17	3,005	$14,704
18	33,326	$19,739
19	8,606	$14,443
20	6,590	$38,390
21	2,218	$25,462
22	3,332	$21,992
23	10,796	$15,560
24	64,403	$19,693
25	28,327	$12,640
26	18	$22,199

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)—JULY 2005 [1]—Continued

DRG	Number of Cases	Threshold
27	5,461	$23,116
28	17,707	$23,770
29	6,341	$14,627
31	5,188	$19,178
32	2,029	$12,777
34	26,693	$19,711
35	7,684	$12,809
36	1,474	$14,633
37	1,252	$22,719
38	56	$14,203
39	449	$14,256
40	1,394	$19,743
42	1,155	$16,308
43	125	$11,917
44	1,170	$13,746
45	2,817	$15,155
46	3,835	$15,193
47	1,346	$10,774
49	2,490	$29,091
50	2,176	$17,333
51	191	$18,125
52	332	$16,799
53	2,257	$24,659
55	1,367	$18,802

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)—JULY 2005 [1]—Continued

DRG	Number of Cases	Threshold
56	447	$17,749
57	920	$20,414
59	105	$15,664
60	9	$15,242
61	222	$24,062
63	2,902	$24,985
64	3,369	$21,134
65	41,598	$12,272
66	8,051	$11,767
67	420	$15,477
68	17,469	$13,293
69	4,762	$9,900
70	26	$8,627
71	68	$15,085
72	1,073	$15,217
73	9,571	$17,094
74	4	$7,591
75	45,250	$45,002
76	47,634	$40,725
77	2,142	$24,059
78	45,875	$24,834
79	171,419	$27,473
80	7,512	$17,867
81	5	$28,450
82	65,487	$24,675
83	7,120	$19,618
84	1,472	$11,829
85	22,028	$23,434
86	1,824	$14,267
87	83,068	$24,812
88	415,631	$17,720
89	554,469	$20,598
90	44,452	$12,328
91	48	$16,648
92	16,675	$23,136
93	1,522	$14,651
94	13,466	$22,215
95	1,621	$12,301
96	60,087	$14,799
97	26,487	$10,920
98	9	$8,159
99	21,760	$14,405
100	6,914	$11,047
101	23,399	$17,489
102	5,199	$11,159
103	755	$213,786
104	21,060	$114,683
105	31,833	$86,722
106	3,543	$105,479
108	9,310	$83,192
110	56,310	$55,494
111	10,039	$41,761
113	37,457	$41,919
114	8,582	$28,228
117	5,172	$23,613
118	7,643	$30,997
119	998	$23,563
120	36,523	$33,864
121	160,146	$27,836
122	62,100	$19,640
123	33,782	$24,266
124	131,638	$27,647
125	96,574	$22,049
126	5,866	$39,226
127	698,888	$20,488
128	5,197	$13,933
129	3,774	$20,262
130	89,628	$18,627
131	23,926	$11,214
132	117,924	$12,607
133	7,325	$10,996
134	42,673	$12,392
135	7,482	$17,703
136	1,136	$12,755
138	208,101	$16,588
139	78,893	$10,661
140	38,450	$10,389
141	122,639	$15,323
142	52,421	$12,025
143	250,830	$11,593
144	100,553	$22,549
145	6,198	$11,859
146	10,813	$41,925
147	2,652	$29,209
148	136,334	$48,373
149	19,988	$28,480
150	22,833	$42,103
151	5,382	$25,607
152	5,039	$31,655
153	2,102	$21,743
154	28,654	$52,974
155	6,182	$25,854
156	6	$49,288
157	8,312	$24,166
158	4,126	$13,492
159	19,277	$26,228
160	12,043	$17,157
161	10,464	$23,437
162	5,515	$13,832
163	10	$14,000
164	5,991	$36,827
165	2,534	$23,727
166	4,976	$27,347
167	4,668	$17,898
168	1,565	$23,385
169	776	$14,845
170	17,580	$41,447
171	1,492	$24,444
172	33,073	$24,521
173	2,401	$15,446
174	268,990	$20,257
175	32,775	$11,560
176	14,617	$22,349
177	8,603	$18,603
178	2,920	$14,351
179	14,538	$21,599
180	92,638	$19,327
181	26,020	$11,449
182	293,794	$16,910
183	86,966	$12,054
184	81	$10,486
185	5,753	$17,250
186	4	$6,238
187	634	$16,858
188	91,481	$21,540
189	13,256	$12,410
190	70	$12,478
191	10,469	$51,233
192	1,328	$30,378
193	4,532	$47,362
194	523	$29,931
195	3,262	$46,669
196	703	$30,967
197	17,408	$38,874
198	4,645	$23,923
199	1,430	$35,852
200	942	$36,898
201	2,684	$48,681
202	27,457	$23,443
203	31,842	$24,227
204	73,292	$21,594
205	31,701	$21,723
206	2,087	$14,915
207	35,943	$22,789
208	9,819	$14,213
210	129,152	$33,582
211	26,760	$24,523
212	10	$26,859
213	10,325	$31,192
216	17,773	$33,187
217	17,785	$39,754
218	29,053	$29,997
219	21,541	$20,902
220	4	$28,868
223	13,572	$22,491
224	10,977	$16,523
225	6,608	$23,901
226	6,725	$26,967
227	5,124	$16,694
228	2,665	$23,174
229	1,216	$14,213
230	2,590	$24,625
232	733	$19,423
233	15,220	$32,286
234	7,736	$25,343
235	5,006	$14,886
236	42,644	$14,237
237	2,034	$12,297
238	9,936	$24,709
239	43,167	$21,069
240	12,749	$22,928
241	2,711	$13,362
242	2,758	$21,468
243	102,278	$15,522
244	15,860	$14,400
245	5,857	$9,430
246	1,437	$12,113
247	21,824	$11,771
248	15,208	$17,231
249	14,157	$13,978

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)—JULY 2005 [1]—Continued

DRG	Number of Cases	Threshold
250	4,195	$13,885
251	2,162	$9,734
253	25,058	$15,138
254	10,478	$9,255
256	7,212	$16,727
257	13,582	$17,867
258	12,093	$14,253
259	2,908	$19,367
260	2,991	$14,161
261	1,630	$19,578
262	641	$19,774
263	23,955	$30,672
264	3,942	$20,869
265	4,338	$26,784
266	2,331	$17,512
267	272	$18,006
268	1,038	$22,965
269	10,762	$28,834
270	2,658	$16,899
271	21,209	$19,563
272	5,962	$19,175
273	1,356	$11,513
274	2,304	$21,476
275	227	$11,209
276	1,450	$13,973
277	113,024	$17,133
278	34,015	$10,875
279	8	$16,892
280	19,484	$14,549
281	7,168	$10,009
283	6,300	$14,577
284	1,840	$9,181
285	7,694	$32,910
286	2,714	$32,554
287	6,159	$29,259
288	10,593	$34,864
289	6,917	$18,263
290	10,909	$17,602
291	67	$18,276
292	7,378	$38,188
293	368	$24,998
294	99,610	$15,030
295	4,138	$14,600
296	256,061	$16,155
297	45,533	$9,891
298	86	$10,485
299	1,497	$19,326
300	21,444	$21,582
301	3,908	$12,527
302	9,900	$49,840
303	23,847	$36,195
304	13,937	$35,431
305	3,103	$23,608
306	6,363	$23,807
307	2,074	$12,380
308	7,123	$27,016
309	3,582	$18,603
310	26,165	$23,337
311	6,522	$12,993
312	1,464	$22,392

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)—JULY 2005 [1]—Continued

DRG	Number of Cases	Threshold
313	513	$14,111
315	36,881	$32,144
316	181,946	$22,863
317	2,793	$16,038
318	5,961	$21,867
319	386	$13,276
320	219,905	$17,094
321	31,443	$11,415
322	65	$11,006
323	20,612	$16,786
324	5,447	$10,404
325	9,685	$13,024
326	2,595	$9,061
327	5	$5,735
328	611	$14,623
329	71	$10,100
331	55,165	$20,706
332	4,433	$12,522
333	259	$18,296
334	9,884	$28,157
335	12,033	$21,864
336	31,389	$16,654
337	25,251	$11,414
338	653	$24,778
339	1,259	$22,426
340	2	$18,747
341	3,196	$23,840
342	565	$17,333
344	2,702	$24,952
345	1,465	$21,814
346	3,991	$20,384
347	250	$12,534
348	4,202	$14,652
349	579	$8,745
350	7,188	$14,636
352	984	$14,886
353	2,736	$29,499
354	7,651	$27,759
355	4,945	$17,497
356	24,093	$14,919
357	5,584	$35,120
358	20,938	$22,649
359	28,904	$15,871
360	14,850	$17,215
361	276	$22,374
362	2	$11,740
363	2,143	$19,913
364	1,464	$17,689
365	1,628	$30,015
366	4,820	$22,232
367	459	$11,968
368	3,939	$22,092
369	3,643	$12,841
370	1,888	$17,385
371	2,304	$11,896
372	1,177	$9,775
373	4,955	$7,031
374	160	$13,121
375	5	$22,537
376	403	$10,215

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)—JULY 2005 [1]—Continued

DRG	Number of Cases	Threshold
377	78	$23,287
378	196	$15,726
379	510	$7,170
380	93	$7,850
381	217	$12,532
382	43	$4,116
383	2,514	$9,798
384	134	$6,368
389	2	$193,336
390	2	$20,529
392	2,223	$42,569
394	2,839	$28,560
395	116,763	$16,487
396	10	$14,834
397	18,541	$21,173
398	18,411	$22,559
399	1,648	$13,702
401	6,365	$40,602
402	1,412	$23,453
403	32,022	$27,810
404	3,817	$18,926
406	2,235	$39,723
407	587	$24,616
408	2,183	$30,932
409	1,817	$22,452
410	28,552	$22,154
411	12	$7,098
412	12	$16,529
413	5,226	$23,470
414	574	$16,033
415	51,145	$48,904
416	240,228	$26,693
417	22	$17,612
418	28,775	$20,650
419	16,423	$17,053
420	2,930	$12,337
421	11,946	$14,869
422	53	$10,931
423	8,701	$26,984
424	1,078	$33,194
425	14,886	$12,559
426	4,353	$9,541
427	1,519	$10,475
428	776	$13,581
429	25,609	$15,540
430	71,973	$12,801
431	309	$10,477
432	422	$12,749
433	5,225	$5,600
439	1,756	$27,865
440	5,669	$27,803
441	786	$18,799
442	18,168	$34,984
443	3,415	$20,268
444	5,954	$14,880
445	2,369	$10,345
447	6,294	$10,673
449	39,238	$16,570
450	7,826	$8,664
451	3	$5,773

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)—JULY 2005 [1]—Continued

DRG	Number of Cases	Threshold
452	27,878	$20,075
453	5,492	$10,737
454	3,876	$15,906
455	853	$9,747
461	2,752	$24,473
462	7,828	$16,918
463	31,267	$13,853
464	7,673	$10,274
465	226	$12,400
466	1,429	$13,649
467	1,023	$9,734
468	50,764	$52,876
470	502	$64,232
471	15,627	$52,323
473	8,835	$35,986
475	117,155	$48,272
476	3,038	$34,031
477	29,597	$30,919
479	24,817	$28,352
480	821	$117,571
481	1,098	$82,815
482	5,206	$46,279
484	468	$72,010
485	3,471	$48,251
486	2,662	$63,364
487	4,802	$29,883
488	798	$55,257
489	13,579	$26,429
490	5,254	$20,265
491	19,917	$32,894
492	4,032	$41,888
493	61,952	$31,960
494	25,682	$20,733
495	311	$106,522
496	3,537	$87,344
497	27,848	$55,870
498	19,209	$46,173
499	35,943	$26,528
500	48,831	$18,113
501	3,143	$40,031
502	721	$27,568
503	5,980	$24,309
504	189	$134,049
505	181	$24,546
506	1,010	$48,681
507	311	$29,068
508	645	$21,865
509	171	$14,860
510	1,774	$20,128
511	636	$12,654
512	539	$78,167
513	233	$94,790
515	44,891	$85,654
518	25,965	$31,491
519	11,647	$40,559
520	15,488	$32,459
521	32,428	$13,578
522	5,680	$9,558
523	15,979	$7,628
524	119,534	$14,814
525	314	$134,845
528	1,777	$99,303
529	4,046	$35,002
530	2,369	$24,213
531	4,846	$42,213
532	2,659	$26,414
533	47,837	$28,289
534	45,427	$20,389
535	7,457	$120,243
536	8,117	$105,754
537	8,715	$30,405
538	5,648	$19,992
539	5,040	$41,927
540	1,517	$24,005
541	22,708	$240,567
542	24,483	$153,747
543	5,468	$59,942
544	420,959	$36,819
545	42,611	$41,350
546	2,241	$74,614
547	35,636	$90,627
548	34,824	$74,108
549	14,479	$74,286
550	36,399	$58,866
551	56,969	$49,706
552	84,578	$38,275
553	38,749	$44,392
554	75,669	$34,300
555	72,073	$40,910
556	49,856	$35,707
557	95,205	$48,043
558	154,831	$40,079
559	2,258	$37,803

[1] Cases taken from the FY 2004 MedPAR file; DRGs are from GROUPER Version 23.0.

TABLE 11.—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	5/6th of the geometric average length of stay
1	[5] CRANIOTOMY AGE >17 W CC	1.7034	38.5	32.1
2	[7] CRANIOTOMY AGE > 17 W/O CC	1.7034	38.5	32.1
3	[7] CRANIOTOMY AGE 0–17	1.7034	38.5	32.1
6	[7] CARPAL TUNNEL RELEASE	0.4499	19.0	15.8
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	1.3984	37.7	31.4
8	[3] PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	0.7637	24.8	20.7
9	SPINAL DISORDERS & INJURIES	0.9720	33.7	28.1
10	NERVOUS SYSTEM NEOPLASMS W CC	0.7554	24.5	20.4
11	[2] NERVOUS SYSTEM NEOPLASMS W/O CC	0.5837	21.3	17.8
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.6851	25.5	21.3
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.6531	23.1	19.3
14	INTERCRANIAL HEMORRHAGE OR STROKE WITH INFARCT	0.7783	26.0	21.7
15	NONSPECIFIC CVA & PRECEREBRAL OCCULUSION WITHOUT INFARCT	0.7314	26.8	22.3
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.7471	23.5	19.6
17	[1] NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.4499	19.0	15.8
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.7197	23.6	19.7
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.4773	21.2	17.7
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.0277	27.2	22.7

TABLE 11.—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	5/6th of the geometric average length of stay
21	[3] VIRAL MENINGITIS	0.7637	24.8	20.7
22	[4] HYPERTENSIVE ENCEPHALOPATHY	1.1820	29.6	24.7
23	NONTRAUMATIC STUPOR & COMA	0.8054	25.4	21.2
24	SEIZURE & HEADACHE AGE >17 W CC	0.6251	22.6	18.8
25	[1] SEIZURE & HEADACHE AGE >17 W/O CC	0.4499	19.0	15.8
26	[7] SEIZURE & HEADACHE AGE 0–17	0.4499	19.0	15.8
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	0.9444	27.1	22.6
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE ≤17 W CC	0.8890	30.2	25.2
29	[2] TRAUMATIC STUPOR & COMA, COMA <1 HR AGE ≤17 W/O CC	0.5837	21.3	17.8
30	[7] TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	0.5837	21.3	17.8
31	[3] CONCUSSION AGE >17 W CC	0.7637	24.8	20.7
32	[7] CONCUSSION AGE >17 W/O CC	0.4499	19.0	15.8
33	[7] CONCUSSION AGE 0–17	0.4499	19.0	15.8
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.8004	25.3	21.1
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.5698	24.2	20.2
36	[7] RETINAL PROCEDURES	1.1820	29.6	24.7
37	[7] ORBITAL PROCEDURES	1.1820	29.6	24.7
38	[7] PRIMARY IRIS PROCEDURES	1.1820	29.6	24.7
39	[7] LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	1.1820	29.6	24.7
40	[4] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	1.1820	29.6	24.7
41	[7] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	1.1820	29.6	24.7
42	[7] INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	1.1820	29.6	24.7
43	[7] HYPHEMA	1.1820	29.6	24.7
44	[2] ACUTE MAJOR EYE INFECTIONS	0.5837	21.3	17.8
45	[7] NEUROLOGICAL EYE DISORDERS	1.1820	29.6	24.7
46	[2] OTHER DISORDERS OF THE EYE AGE >17 W CC	0.5837	21.3	17.8
47	[7] OTHER DISORDERS OF THE EYE AGE >17 W/O CC	1.1820	29.6	24.7
48	[7] OTHER DISORDERS OF THE EYE AGE 0–17	1.1820	29.6	24.7
49	[7] MAJOR HEAD & NECK PROCEDURES	1.1820	29.6	24.7
50	S7 IALOADENECTOMY	1.1820	29.6	24.7
51	[7] SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	1.1820	29.6	24.7
52	[7] CLEFT LIP & PALATE REPAIR	1.1820	29.6	24.7
53	[7] SINUS & MASTOID PROCEDURES AGE >17	1.1820	29.6	24.7
54	[7] SINUS & MASTOID PROCEDURES AGE 0–17	1.1820	29.6	24.7
55	[7] MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	1.1820	29.6	24.7
56	[7] RHINOPLASTY	1.1820	29.6	24.7
57	[7] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.4499	19.0	15.8
58	[7] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17.	0.4499	19.0	15.8
59	[7] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.4499	19.0	15.8
60	[7] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	0.4499	19.0	15.8
61	[3] MYRINGOTOMY W TUBE INSERTION AGE >17	0.7637	24.8	20.7
62	[7] MYRINGOTOMY W TUBE INSERTION AGE 0–17	0.4499	19.0	15.8
63	[4] OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.1820	29.6	24.7
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.1480	26.2	21.8
65	[1] DYSEQUILIBRIUM	0.4499	19.0	15.8
66	[7] EPISTAXIS	0.4499	19.0	15.8
67	[3] EPIGLOTTITIS	0.7637	24.8	20.7
68	OTITIS MEDIA & URI AGE >17 W CC	0.5111	18.0	15
69	[1] OTITIS MEDIA & URI AGE >17 W/O CC	0.4499	19.0	15.8
70	[7] OTITIS MEDIA & URI AGE 0–17	0.4499	19.0	15.8
71	[7] LARYNGOTRACHEITIS	0.5837	21.3	17.8
72	[7] NASAL TRAUMA & DEFORMITY	0.7637	24.8	20.7
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.7535	21.9	18.3
74	[7] OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17	0.4499	19.0	15.8
75	[5] MAJOR CHEST PROCEDURES	1.7034	38.5	32.1
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.5523	43.9	36.6
77	[5] OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.7034	38.5	32.1
78	PULMONARY EMBOLISM	0.6900	21.9	18.3
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	0.8280	22.9	19.1
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.5986	21.7	18.1
81	[7] RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	0.4499	19.0	15.8
82	RESPIRATORY NEOPLASMS	0.7174	20.1	16.8
83	[2] MAJOR CHEST TRAUMA W CC	0.5837	21.3	17.8
84	[7] MAJOR CHEST TRAUMA W/O CC	0.5837	21.3	17.8
85	PLEURAL EFFUSION W CC	0.7264	21.2	17.7
86	[1] PLEURAL EFFUSION W/O CC	0.4499	19.0	15.8

TABLE 11.—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	5/6th of the geometric average length of stay
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.0816	25.4	21.2
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.6585	19.6	16.3
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.6987	20.8	17.3
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.4970	17.8	14.8
91	[7] SIMPLE PNEUMONIA & PLEURISY AGE 0–17	0.4499	19.0	15.8
92	INTERSTITIAL LUNG DISEASE W CC	0.6704	20.2	16.8
93	[2] INTERSTITIAL LUNG DISEASE W/O CC	0.5837	21.3	17.8
94	PNEUMOTHORAX W CC	0.5880	17.0	14.2
95	[1] PNEUMOTHORAX W/O CC	0.4499	19.0	15.8
96	BRONCHITIS & ASTHMA AGE >17 W CC	0.6417	19.4	16.2
97	[2] BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5837	21.3	17.8
98	[7] BRONCHITIS & ASTHMA AGE 0–17	0.5837	21.3	17.8
99	RESPIRATORY SIGNS & SYMPTOMS W CC	0.9219	23.2	19.3
100	[3] RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.7637	24.8	20.7
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8147	21.1	17.6
102	[1] OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.4499	19.0	15.8
103	[6] HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	0.0000	0.0	0
104	[7] CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH.	0.7637	24.8	20.7
105	[7] CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH.	0.7637	24.8	20.7
106	[7] CORONARY BYPASS W PTCA	0.7637	24.8	20.7
108	[7] OTHER CARDIOTHORACIC PROCEDURES	0.7637	24.8	20.7
110	[3] MAJOR CARDIOVASCULAR PROCEDURES W CC	0.7637	24.8	20.7
111	[7] MAJOR CARDIOVASCULAR PROCEDURES W/O CC	0.7637	24.8	20.7
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	1.4887	39.3	32.8
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.2389	33.2	27.7
117	[4] CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.1820	29.6	24.7
118	[4] CARDIAC PACEMAKER DEVICE REPLACEMENT	1.1820	29.6	24.7
119	[3] VEIN LIGATION & STRIPPING	0.7637	24.8	20.7
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.0979	31.7	26.4
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	0.8429	23.2	19.3
122	[2] CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	0.5837	21.3	17.8
123	CIRCULATORY DISORDERS W AMI, EXPIRED	1.1811	20.4	17
124	[4] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.1820	29.6	24.7
125	[3] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	0.7637	24.8	20.7
126	ACUTE & SUBACUTE ENDOCARDITIS	0.8386	25.3	21.1
127	HEART FAILURE & SHOCK	0.6857	21.2	17.7
128	[2] DEEP VEIN THROMBOPHLEBITIS	0.5837	21.3	17.8
129	[7] CARDIAC ARREST, UNEXPLAINED	0.7637	24.8	20.7
130	PERIPHERAL VASCULAR DISORDERS W CC	0.6741	23.2	19.3
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.4675	20.4	17
132	ATHEROSCLEROSIS W CC	0.6565	21.8	18.2
133	[1] ATHEROSCLEROSIS W/O CC	0.4499	19.0	15.8
134	HYPERTENSION	0.6354	24.8	20.7
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.7211	23.7	19.8
136	[2] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.5837	21.3	17.8
137	[7] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	0.5837	21.3	17.8
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.6201	20.5	17.1
139	[2] CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5837	21.3	17.8
140	[1] ANGINA PECTORIS	0.4499	19.0	15.8
141	[8] SYNCOPE & COLLAPSE W CC	0.4271	18.3	15.3
142	[8] SYNCOPE & COLLAPSE W/O CC	0.4271	18.3	15.3
143	[1] CHEST PAIN	0.4499	19.0	15.8
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.7413	21.7	18.1
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.4568	18.2	15.2
146	[7] RECTAL RESECTION W CC	1.7034	38.5	32.1
147	[7] RECTAL RESECTION W/O CC	1.7034	38.5	32.1
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	1.8616	40.9	34.1
149	[7] MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	0.7637	24.8	20.7
150	[4] PERITONEAL ADHESIOLYSIS W CC	1.1820	29.6	24.7
151	[2] PERITONEAL ADHESIOLYSIS W/O CC	0.5837	21.3	17.8
152	[3] MINOR SMALL & LARGE BOWEL PROCEDURES W CC	0.7637	24.8	20.7
153	[7] MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	0.7637	24.8	20.7
154	[5] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	1.7034	38.5	32.1
155	[7] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.7034	38.5	32.1
156	[7] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17	1.7034	38.5	32.1

TABLE 11.—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	5/6th of the geometric average length of stay
157	[4] ANAL & STOMAL PROCEDURES W CC	1.1820	29.6	24.7
158	[7] ANAL & STOMAL PROCEDURES W/O CC	1.1820	29.6	24.7
159	[7] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	0.7637	24.8	20.7
160	[7] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	0.7637	24.8	20.7
161	[5] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.7034	38.5	32.1
162	[7] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.7637	24.8	20.7
163	[7] HERNIA PROCEDURES AGE 0–17	0.7637	24.8	20.7
164	[1] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.7034	38.5	32.1
165	[7] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.7034	38.5	32.1
166	[7] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.7034	38.5	32.1
167	[7] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	1.7034	38.5	32.1
168	[4] MOUTH PROCEDURES W CC	1.1820	29.6	24.7
169	[7] MOUTH PROCEDURES W/O CC	0.7637	24.8	20.7
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	1.6271	35.9	29.9
171	[1] OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	0.4499	19.0	15.8
172	DIGESTIVE MALIGNANCY W CC	0.8553	21.8	18.2
173	[2] DIGESTIVE MALIGNANCY W/O CC	0.5837	21.3	17.8
174	G.I. HEMORRHAGE W CC	0.7119	22.2	18.5
175	[1] G.I. HEMORRHAGE W/O CC	0.4499	19.0	15.8
176	COMPLICATED PEPTIC ULCER	0.8426	21.5	17.9
177	[3] UNCOMPLICATED PEPTIC ULCER W CC	0.7637	24.8	20.7
178	[3] UNCOMPLICATED PEPTIC ULCER W/O CC	0.7637	24.8	20.7
179	INFLAMMATORY BOWEL DISEASE	0.9675	24.0	20
180	G.I. OBSTRUCTION W CC	0.9375	23.5	19.6
181	[3] G.I. OBSTRUCTION W/O CC	0.7637	24.8	20.7
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.7745	22.6	18.8
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.3870	16.8	14
184	[7] ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17	0.4499	19.0	15.8
185	[3] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.7637	24.8	20.7
186	[7] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17	0.7637	24.8	20.7
187	[7] DENTAL EXTRACTIONS & RESTORATIONS	0.7637	24.8	20.7
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	0.9952	24.0	20
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.4707	18.2	15.2
190	[7] OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	0.4499	19.0	15.8
191	[4] PANCREAS, LIVER & SHUNT PROCEDURES W CC	1.1820	29.6	24.7
192	[7] PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.1820	29.6	24.7
193	[3] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	0.7637	24.8	20.7
194	[7] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	0.7637	24.8	20.7
195	[3] CHOLECYSTECTOMY W C.D.E. W CC	0.7637	24.8	20.7
196	[7] CHOLECYSTECTOMY W C.D.E. W/O CC	0.7637	24.8	20.7
197	[3] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	0.7637	24.8	20.7
198	[7] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	0.7637	24.8	20.7
199	[7] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	1.7034	38.5	32.1
200	[5] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	1.7034	38.5	32.1
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	2.0371	36.1	30.1
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	0.6610	20.6	17.2
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	0.7896	19.5	16.3
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	0.9441	22.7	18.9
205	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.6642	20.5	17.1
206	[2] DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	0.5837	21.3	17.8
207	DISORDERS OF THE BILIARY TRACT W CC	0.7570	21.5	17.9
208	[2] DISORDERS OF THE BILIARY TRACT W/O CC	0.5837	21.3	17.8
210	[5] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.7034	38.5	32.1
211	[4] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.1820	29.6	24.7
212	[7] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17	1.7034	38.5	32.1
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.1948	34.0	28.3
216	[4] BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.1820	29.6	24.7
217	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	1.2927	38.0	31.7
218	[5] LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC	1.7034	38.5	32.1
219	[1] LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	0.4499	19.0	15.8
220	[7] LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0–17	1.7034	38.5	32.1
223	[3] MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	0.7637	24.8	20.7
224	[7] SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	0.7637	24.8	20.7
225	FOOT PROCEDURES	0.9869	28.4	23.7
226	SOFT TISSUE PROCEDURES W CC	0.9443	29.5	24.6
227	[3] SOFT TISSUE PROCEDURES W/O CC	0.7637	24.8	20.7

TABLE 11.—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	5/6th of the geometric average length of stay
228	[4] MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	1.1820	29.6	24.7
229	[7] HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.4499	19.0	15.8
230	[5] LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.7034	38.5	32.1
232	[7] ARTHROSCOPY	0.4499	19.0	15.8
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.3522	34.6	28.8
234	[7] OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	0.4499	19.0	15.8
235	[3] FRACTURES OF FEMUR	0.7637	24.8	20.7
236	FRACTURES OF HIP & PELVIS	0.6531	25.2	21
237	[1] SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.4499	19.0	15.8
238	OSTEOMYELITIS	0.8278	28.3	23.6
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	0.6935	23.6	19.7
240	CONNECTIVE TISSUE DISORDERS W CC	0.7310	24.8	20.7
241	[1] CONNECTIVE TISSUE DISORDERS W/O CC	0.4499	19.0	15.8
242	SEPTIC ARTHRITIS	0.7864	26.5	22.1
243	MEDICAL BACK PROBLEMS	0.6061	23.4	19.5
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.5259	22.2	18.5
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4635	20.4	17
246	[1] NON-SPECIFIC ARTHROPATHIES	0.4499	19.0	15.8
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5548	21.9	18.3
248	TENDONITIS, MYOSITIS & BURSITIS	0.6574	22.6	18.8
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.6577	24.7	20.6
250	[2] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.5837	21.3	17.8
251	[1] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.4499	19.0	15.8
252	[7] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	0.7637	24.8	20.7
253	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	0.6802	26.3	21.9
254	[2] FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	0.5837	21.3	17.8
255	[7] FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0–17	0.7637	24.8	20.7
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.7924	25.3	21.1
257	[7] TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.7637	24.8	20.7
258	[7] TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7637	24.8	20.7
259	[2] SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.5837	21.3	17.8
260	[7] SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.7637	24.8	20.7
261	[7] BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	0.7637	24.8	20.7
262	[1] BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.4499	19.0	15.8
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.3222	39.5	32.9
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	0.9584	32.0	26.7
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.0398	33.1	27.6
266	[3] SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	0.7637	24.8	20.7
267	[7] PERIANAL & PILONIDAL PROCEDURES	0.7637	24.8	20.7
268	[5] SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.7034	38.5	32.1
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.3037	36.1	30.1
270	[3] OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.7637	24.8	20.7
271	SKIN ULCERS	0.8720	27.7	23.1
272	MAJOR SKIN DISORDERS W CC	0.7420	22.6	18.8
273	[1] MAJOR SKIN DISORDERS W/O CC	0.4499	19.0	15.8
274	[3] MALIGNANT BREAST DISORDERS W CC	0.7637	24.8	20.7
275	[7] MALIGNANT BREAST DISORDERS W/O CC	0.7637	24.8	20.7
276	[2] NON-MALIGANT BREAST DISORDERS	0.5837	21.3	17.8
277	CELLULITIS AGE >17 W CC	0.6264	21.0	17.5
278	CELLULITIS AGE >17 W/O CC	0.4420	17.8	14.8
279	[7] CELLULITIS AGE 0–17	0.4499	19.0	15.8
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.6698	24.3	20.3
281	[1] TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.4499	19.0	15.8
282	[7] TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	0.4499	19.0	15.8
283	MINOR SKIN DISORDERS W CC	0.6935	23.9	19.9
284	[1] MINOR SKIN DISORDERS W/O CC	0.4499	19.0	15.8
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	1.3501	35.6	29.7
286	[7] ADRENAL & PITUITARY PROCEDURES	1.7034	38.5	32.1
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.1387	33.9	28.3
288	[4] O.R. PROCEDURES FOR OBESITY	1.1820	29.6	24.7
289	[7] PARATHYROID PROCEDURES	1.1820	29.6	24.7
290	[5] THYROID PROCEDURES	1.7034	38.5	32.1
291	[7] THYROGLOSSAL PROCEDURES	1.1820	29.6	24.7
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	1.3409	31.7	26.4
293	[2] OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	0.5837	21.3	17.8
294	DIABETES AGE >35	0.7293	25.0	20.8

TABLE 11.—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	5/6th of the geometric average length of stay
295	[3] DIABETES AGE 0–35	0.7637	24.8	20.7
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.7212	23.1	19.3
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.5227	18.4	15.3
298	[7] NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	0.5837	21.3	17.8
299	[4] INBORN ERRORS OF METABOLISM	1.1820	29.6	24.7
300	ENDOCRINE DISORDERS W CC	0.6376	21.2	17.7
301	[1] ENDOCRINE DISORDERS W/O CC	0.4499	19.0	15.8
302	[6] KIDNEY TRANSPLANT	0.0000	0.0	0
303	[4] KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	1.1820	29.6	24.7
304	[5] KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	1.7034	38.5	32.1
305	[1] KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	0.4499	19.0	15.8
306	[2] PROSTATECTOMY W CC	0.5837	21.3	17.8
307	[7] PROSTATECTOMY W/O CC	0.5837	21.3	17.8
308	[3] MINOR BLADDER PROCEDURES W CC	0.7637	24.8	20.7
309	[7] MINOR BLADDER PROCEDURES W/O CC	0.7637	24.8	20.7
310	[4] TRANSURETHRAL PROCEDURES W CC	1.1820	29.6	24.7
311	[7] TRANSURETHRAL PROCEDURES W/O CC	1.1820	29.6	24.7
312	[1] URETHRAL PROCEDURES, AGE >17 W CC	0.4499	19.0	15.8
313	[7] URETHRAL PROCEDURES, AGE >17 W/O CC	0.4499	19.0	15.8
314	[7] URETHRAL PROCEDURES, AGE 0–17	0.4499	19.0	15.8
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	1.4055	31.6	26.3
316	RENAL FAILURE	0.8219	22.7	18.9
317	ADMIT FOR RENAL DIALYSIS	0.9852	25.2	21
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	0.7586	20.2	16.8
319	[1] KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.4499	19.0	15.8
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.6179	22.2	18.5
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.4792	19.0	15.8
322	[7] KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	0.4499	19.0	15.8
323	[4] URINARY STONES W CC, &/OR ESW LITHOTRIPSY	1.1820	29.6	24.7
324	[7] URINARY STONES W/O CC	0.4499	19.0	15.8
325	[2] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.5837	21.3	17.8
326	[7] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4499	19.0	15.8
327	[7] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	0.4499	19.0	15.8
328	[1] URETHRAL STRICTURE AGE >17 W CC	0.4499	19.0	15.8
329	[7] URETHRAL STRICTURE AGE >17 W/O CC	0.4499	19.0	15.8
330	[7] URETHRAL STRICTURE AGE 0–17	0.4499	19.0	15.8
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	0.8010	23.1	19.3
332	[2] OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.5837	21.3	17.8
333	[7] OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	0.5837	21.3	17.8
334	[2] MAJOR MALE PELVIC PROCEDURES W CC	0.5837	21.3	17.8
335	[7] MAJOR MALE PELVIC PROCEDURES W/O CC	1.7034	38.5	32.1
336	[2] TRANSURETHRAL PROSTATECTOMY W CC	0.5837	21.3	17.8
337	[7] TRANSURETHRAL PROSTATECTOMY W/O CC	0.5837	21.3	17.8
338	[7] TESTES PROCEDURES, FOR MALIGNANCY	0.5837	21.3	17.8
339	[4] TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.1820	29.6	24.7
340	[7] TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	1.1820	29.6	24.7
341	[4] PENIS PROCEDURES	1.1820	29.6	24.7
342	[7] CIRCUMCISION AGE >17	1.1820	29.6	24.7
343	[7] CIRCUMCISION AGE 0–17	1.1820	29.6	24.7
344	[1] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	0.4499	19.0	15.8
345	[5] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	1.7034	38.5	32.1
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	0.6060	20.6	17.2
347	[2] MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.5837	21.3	17.8
348	[2] BENIGN PROSTATIC HYPERTROPHY W CC	0.5837	21.3	17.8
349	[7] BENIGN PROSTATIC HYPERTROPHY W/O CC	1.1820	29.6	24.7
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.6798	21.9	18.3
351	[7] STERILIZATION, MALE	1.1820	29.6	24.7
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.6375	23.4	19.5
353	[7] PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.1820	29.6	24.7
354	[7] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.1820	29.6	24.7
355	[7] UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	1.1820	29.6	24.7
356	[7] FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.1820	29.6	24.7
357	[7] UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	1.1820	29.6	24.7
358	[7] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1820	29.6	24.7
359	[7] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	1.1820	29.6	24.7
360	[4] VAGINA, CERVIX & VULVA PROCEDURES	1.1820	29.6	24.7

TABLE 11.—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	5/6th of the geometric average length of stay
361	[7] LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	0.7637	24.8	20.7
362	[7] ENDOSCOPIC TUBAL INTERRUPTION	0.7637	24.8	20.7
363	[7] D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.7637	24.8	20.7
364	[5] D&C, CONIZATION EXCEPT FOR MALIGNANCY	1.7034	38.5	32.1
365	[5] OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.7034	38.5	32.1
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	0.7072	20.3	16.9
367	[7] MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.7637	24.8	20.7
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.6416	20.7	17.3
369	[3] MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.7637	24.8	20.7
370	[7] CESAREAN SECTION W CC	0.7637	24.8	20.7
371	[7] CESAREAN SECTION W/O CC	0.5837	21.3	17.8
372	[7] VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.7637	24.8	20.7
373	[7] VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.7637	24.8	20.7
374	[7] VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.7637	24.8	20.7
375	[7] VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.7637	24.8	20.7
376	[7] POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.7637	24.8	20.7
377	[7] POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	0.7637	24.8	20.7
378	[7] ECTOPIC PREGNANCY	0.7637	24.8	20.7
379	[7] THREATENED ABORTION	0.7637	24.8	20.7
380	[7] ABORTION W/O D&C	0.7637	24.8	20.7
381	[7] ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.7637	24.8	20.7
382	[7] FALSE LABOR	0.7637	24.8	20.7
383	[7] OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.7637	24.8	20.7
384	[7] OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.7637	24.8	20.7
385	[7] NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0.7637	24.8	20.7
386	[7] EXTREME IMMATURITY	1.1820	29.6	24.7
387	[7] PREMATURITY W MAJOR PROBLEMS	1.1820	29.6	24.7
388	[7] PREMATURITY W/O MAJOR PROBLEMS	0.7637	24.8	20.7
389	[7] FULL TERM NEONATE W MAJOR PROBLEMS	1.1820	29.6	24.7
390	[7] NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1820	29.6	24.7
391	[7] NORMAL NEWBORN	0.7637	24.8	20.7
392	[7] SPLENECTOMY AGE >17	0.7637	24.8	20.7
393	[7] SPLENECTOMY AGE 0–17	0.7637	24.8	20.7
394	[5] OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	1.7034	38.5	32.1
395	RED BLOOD CELL DISORDERS AGE >17	0.6581	22.0	18.3
396	[7] RED BLOOD CELL DISORDERS AGE 0–17	0.5837	21.3	17.8
397	COAGULATION DISORDERS	0.8675	22.9	19.1
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.8240	23.7	19.8
399	[2] RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.5837	21.3	17.8
401	[5] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	1.7034	38.5	32.1
402	[7] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	0.5837	21.3	17.8
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	0.8757	21.3	17.8
404	[2] LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.5837	21.3	17.8
405	[7] ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17	0.5837	21.3	17.8
406	[4] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC DW CC	1.1820	29.6	24.7
407	[7] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.1820	29.6	24.7
408	[4] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	1.1820	29.6	24.7
409	RADIOTHERAPY	0.8642	23.5	19.6
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1.1684	26.4	22
411	[7] HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.7637	24.8	20.7
412	[7] HISTORY OF MALIGNANCY W ENDOSCOPY	0.7637	24.8	20.7
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	0.8920	20.5	17.1
414	[7] OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.5837	21.3	17.8
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	1.4251	35.6	29.7
416	SEPTICEMIA AGE >17	0.8241	23.5	19.6
417	[7] SEPTICEMIA AGE 0–17	0.7637	24.8	20.7
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	0.8252	24.7	20.6
419	[4] FEVER OF UNKNOWN ORIGIN AGE >17 W CC	1.1820	29.6	24.7
420	[7] FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	1.1820	29.6	24.7
421	VIRAL ILLNESS AGE >17	0.9441	27.3	22.8
422	[7] VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	1.1820	29.6	24.7
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	0.9505	21.8	18.2
424	[3] O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	0.7637	24.8	20.7
425	[2] ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION	0.5837	21.3	17.8
426	DEPRESSIVE NEUROSES	0.4113	20.7	17.3
427	NEUROSES EXCEPT DEPRESSIVE	0.4653	23.8	19.8
428	[1] DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.4499	19.0	15.8

TABLE 11.—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	5/6th of the geometric average length of stay
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.5813	26.8	22.3
430	PSYCHOSES	0.4330	24.2	20.2
431	[1] CHILDHOOD MENTAL DISORDERS	0.4499	19.0	15.8
432	[2] OTHER MENTAL DISORDER DIAGNOSES	0.5837	21.3	17.8
433	[2] ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.5837	21.3	17.8
439	SKIN GRAFTS FOR INJURIES	1.3677	35.6	29.7
440	WOUND DEBRIDEMENTS FOR INJURIES	1.3442	36.1	30.1
441	[1] HAND PROCEDURES FOR INJURIES	0.4499	19.0	15.8
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.3937	33.4	27.8
443	[3] OTHER O.R. PROCEDURES FOR INJURIES W/O CC	0.7637	24.8	20.7
444	TRAUMATIC INJURY AGE >17 W CC	0.7584	26.3	21.9
445	[1] TRAUMATIC INJURY AGE >17 W/O CC	0.4499	19.0	15.8
446	[7] TRAUMATIC INJURY AGE 0–17	0.4499	19.0	15.8
447	[2] ALLERGIC REACTIONS AGE >17	0.5837	21.3	17.8
448	[7] ALLERGIC REACTIONS AGE 0–17	0.5837	21.3	17.8
449	[3] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.7637	24.8	20.7
450	[7] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.7637	24.8	20.7
451	[7] POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	0.7637	24.8	20.7
452	COMPLICATIONS OF TREATMENT W CC	0.9265	25.3	21.1
453	COMPLICATIONS OF TREATMENT W/O CC	0.5871	23.8	19.8
454	[3] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.7637	24.8	20.7
455	[7] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.7637	24.8	20.7
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.2245	34.0	28.3
462	REHABILITATION	0.5787	22.4	18.7
463	SIGNS & SYMPTOMS W CC	0.6258	23.8	19.8
464	SIGNS & SYMPTOMS W/O CC	0.5554	24.1	20.1
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6958	21.9	18.3
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6667	21.9	18.3
467	[3] OTHER FACTORS INFLUENCING HEALTH STATUS	0.7637	24.8	20.7
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.1478	40.2	33.5
469	[6] PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0
470	[6] UNGROUPABLE	0.0000	0.0	0
471	[5] BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	1.7034	38.5	32.1
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	0.8537	20.0	16.7
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	2.0831	34.6	28.8
476	[4] PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.1820	29.6	24.7
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.5836	35.3	29.4
479	[7] OTHER VASCULAR PROCEDURES W/O CC	0.7637	24.8	20.7
480	[6] LIVER TRANSPLANT	0.0000	0.0	0
481	[7] BONE MARROW TRANSPLANT	1.7034	38.5	32.1
482	[5] TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	1.7034	38.5	32.1
484	[2] CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	0.5837	21.3	17.8
485	[7] LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR.	1.1820	29.6	24.7
486	[5] OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	1.7034	38.5	32.1
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	0.8992	26.0	21.7
488	[5] HIV W EXTENSIVE O.R. PROCEDURE	1.7034	38.5	32.1
489	HIV W MAJOR RELATED CONDITION	0.8535	21.4	17.8
490	HIV W OR W/O OTHER RELATED CONDITION	0.4919	16.6	13.8
491	[5] MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.7034	38.5	32.1
492	[7] CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	1.1820	29.6	24.7
493	[5] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.7034	38.5	32.1
494	[7] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.7034	38.5	32.1
495	[6] LUNG TRANSPLANT	0.0000	0.0	0
496	[7] COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	1.1820	29.6	24.7
497	[4] SPINAL FUSION W CC	1.1820	29.6	24.7
498	[7] SPINAL FUSION W/O CC	1.1820	29.6	24.7
499	[5] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.7034	38.5	32.1
500	[4] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	1.1820	29.6	24.7
501	[5] KNEE PROCEDURES W PDX OF INFECTION W CC	1.7034	38.5	32.1
502	[4] KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.1820	29.6	24.7
503	[2] KNEE PROCEDURES W/O PDX OF INFECTION	0.5837	21.3	17.8
504	[7] EXTENSIVE BURN OR FULL THICKNESS BURNS WITH MECH VENT 96+ HOURS WITH SKIN GRAFT.	1.7034	38.5	32.1
505	[4] EXTENSIVE BURN OR FULL THICKNESS BURNS WITH MECH VENT 96+ HOURS WITHOUT SKIN GRAFT.	1.1820	29.6	24.7
506	[4] FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	1.1820	29.6	24.7

TABLE 11.—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	5/6th of the geometric average length of stay
507	[3] FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	0.7637	24.8	20.7
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	0.8367	29.4	24.5
509	[1] FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	0.4499	19.0	15.8
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	0.7709	24.6	20.5
511	[1] NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.4499	19.0	15.8
512	[6] SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	0.0000	0.0	0
513	[6] PANCREAS TRANSPLANT	0.0000	0.0	0
515	[5] CARDIAC DEFIBRILATOR IMPLANT W/O CARDIAC CATH	1.7034	38.5	32.1
518	[7] PERCUTANEOUS CARDIVASCULAR PROC W/O CORONARY ARTERY STENT OR AMI.	0.7637	24.8	20.7
519	[5] CERVICAL SPINAL FUSION W CC	1.7034	38.5	32.1
520	[7] CERVICAL SPINAL FUSION W/O CC	1.1820	29.6	24.7
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.4457	19.4	16.2
522	[7] ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC.	0.4499	19.0	15.8
523	[7] ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC.	0.4499	19.0	15.8
524	TRANSIENT ISCHEMIA	0.5043	21.1	17.6
525	[7] OTHER HEART ASSIST SYSTEM IMPLANT	1.7034	38.5	32.1
528	[7] INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	1.7034	38.5	32.1
529	[5] VENTRICULAR SHUNT PROCEDURES W CC	1.7034	38.5	32.1
530	[7] VENTRICULAR SHUNT PROCEDURES W/O CC	1.7034	38.5	32.1
531	[3] SPINAL PROCEDURES WITH CC	0.7637	24.8	20.7
532	[3] SPINAL PROCEDURES WITHOUT CC	0.7637	24.8	20.7
533	[5] EXTRACRANIAL VASCULAR PROCEDURES WITH CC	1.7034	38.5	32.1
534	[7] EXTRACRANIAL VASCULAR PROCEDURES WITHOUT CC	1.1820	29.6	24.7
535	[7] CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	1.7034	38.5	32.1
536	[7] CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	1.7034	38.5	32.1
537	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITH CC.	1.1615	34.7	28.9
538	[7] LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITHOUT CC.	1.1820	29.6	24.7
539	[4] LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITH CC	1.1820	29.6	24.7
540	[7] LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITHOUT CC	0.5837	21.3	17.8
541	ECMO OR TRACH W MECH VENT 96+ HRS OR PDX EXCEPT FACE,MOUTH & NECK DIAG WITH MAJOR OR.	4.2287	65.6	54.7
542	TRACH W MECH VENT 96+ HRS OR PDX EXCEPT FACE,MOUTH & NECK DIAG WITHOUT MAJOR OR.	3.1869	48.2	40.2
543	[5] CRANIOTOMY W IMPLANT OF CHEMO AGENT OR ACUTE COMPLEX CNS PDX	1.7034	38.5	32.1
544	[5] MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY	1.7034	38.5	32.1
545	[5] REVISION OF HIP OR KNEE REPLACEMENT	1.7034	38.5	32.1
546	[7] SPINAL FUSION EXCEPT CERVICAL WITH CURVATURE OF SPINE OR MALIGNANCY.	1.7034	38.5	32.1
547	[7] CORONARY BYPASS WITH CARDIAC CATH WITH MAJOR CV DIAGNOSIS	1.7034	38.5	32.1
548	[7] CORONARY BYPASS WITH CARDIAC CATH WITHOUT MAJOR CV DIAGNOSIS	1.7034	38.5	32.1
549	[7] CORONARY BYPASS WITHOUT CARDIAC CATH WITH MAJOR CV DIAGNOSIS	1.7034	38.5	32.1
550	[7] CORONARY BYPASS WITHOUT CARDIAC CATH WITHOUT MAJOR CV DIAGNOSIS.	1.7034	38.5	32.1
551	[4] PERMANENT CARDIAC PACEMAKER IMPLANT WITH MAJOR CV DIAGNOSIS OR AICD LEAD OR GNRTR.	1.1820	29.6	24.7
552	[4] OTHER PERMANENT CARDIAC PACEMAKER IMPLANT WITHOUT MAJOR CV DIAGNOSIS.	1.1820	29.6	24.7
553	[8] OTHER VASCULAR PROCEDURES WITH CC WITH MAJOR CV DIAGNOSIS	1.3255	30.6	25.5
554	[8] OTHER VASCULAR PROCEDURES WITH CC WITHOUT MAJOR CV DIAGNOSIS	1.3255	30.6	25.5
555	[4] PERCUTANEOUS CARDIOVASCULAR PROC WITH MAJOR CV DIAGNOSIS	1.1820	29.6	24.7
556	[8] PERCUTANEOUS CARDIOVASCULAR PROC WITH NON-DRUG-ELUTING STENT WITHOUT MAJOR CV DIAGNOSIS.	1.1820	29.6	24.7
557	[8] PERCUTANEOUS CARDIOVASCULAR PROC WITH DRUG-ELUTING STENT WITH MAJOR CV DIAGNOSIS.	1.1820	29.6	24.7
558	[7] PERCUTANEOUS CARDIOVASCULAR PROC WITH DRUG-ELUTING STENT WITHOUT MAJOR CV DIAGNOSIS.	1.1820	29.6	24.7
559	[7] ACUTE ISCHEMIC STROKE WITH USE OF THROMBOLYTIC AGENT	0.7637	24.8	20.7

[1] Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 1.
[2] Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 2.
[3] Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 3.
[4] Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 4.
[5] Relative weights for these LTC-DRGs were determined by assigning these cases to low-volume quintile 5.

[6] Relative weights for these LTC-DRGs were assigned a value of 0.0000.
[7] Relative weights for these LTC-DRGs were determined by assigning these cases to the appropriate low-volume quintile because there are no LTCH cases in the FY 2004 MedPAR file.
[8] Relative weights for these LTC-DRGs were determined after adjusting to account for nonmonotonicity (see step 5 above).

Appendix A—Regulatory Analysis of Impacts

I. Background and Summary

We have examined the impacts of this final rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined that this final rule is a major rule as defined in 5 U.S.C. 804(2). We estimate that the total impact of the changes for FY 2006 operating and capital payments compared to FY 2005 operating and capital payments to be approximately a $3.33 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 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 604 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 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 final rule that has been preceded by a proposed rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This final rule will not mandate any requirements for State, local, or tribal governments.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this final rule in light of Executive Order 13132 and have determined that it will not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments.

In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget.

The following analysis, in conjunction with the remainder of this document, demonstrates that this final rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The final rule will affect payments to a substantial number of small rural hospitals, as well as other classes of hospitals, and the effects on some hospitals may be significant.

II. Objectives

The primary objective of the IPPS is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of preserving the Medicare Trust Fund.

We believe the changes in this final rule will further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these changes will ensure that the outcomes of this payment system are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our policy changes, as well as statutory changes effective for FY 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, in the FY 2006 IPPS proposed rule, we solicited comments and information about the anticipated effects of the changes on hospitals and our methodology for estimating them. Any comments that we received in response to the FY 2006 IPPS proposed rule are addressed below under the appropriate heading 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 34 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 July 2005, there are 3,744 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 1,123 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 1,150 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 policy changes on these hospitals are discussed below.

V. Impact on Excluded Hospitals and Hospital Units

As of July 2005, there were 1,150 specialty hospitals excluded from the IPPS. Of these 1,150 specialty hospitals, 469 psychiatric hospitals, 81 children's, 11 cancer hospitals, and 12 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—216 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 1,330 psychiatric units (paid on a blend of the IPF PPS per diem payment and the TEFRA reasonable cost-based payment) and 1,010 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 fully on a reasonable cost basis are subject to TEFRA limits for FY 2006. For these hospitals (cancer and children's hospitals and RNHCIs), the update is the percentage increase in the FY 2006 IPPS operating market basket of 3.7 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 2006, the IRF PPS is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually. Therefore, these hospitals are not impacted by this final rule.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs are paid under a LTCH PPS, based on a Federal prospective payment amount that is updated annually. Existing 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, an existing 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 target amount by the excluded hospital market basket percentage increase, which is 3.8 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 will be, we updated the IPF's TEFRA target amount by the excluded hospital market basket percentage increase of 3.8 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 final 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 3.5 percent increase), we estimate the total impact of the changes for FY 2006 operating and capital payments compared to FY 2005 operating and capital payments to be approximately a $3.33 billion increase. This amount does not reflect changes in hospital admissions or case-mix intensity, which would also affect overall payment changes.

We have prepared separate impact analyses of the changes to each system. This section deals with changes to the operating prospective payment system. Our payment simulation model relies on the most recent available data to enable us to estimate the impacts on payments per case of certain changes we are making in this final rule. However, there are other changes for which we do not have data available that would allow us to estimate the payment impacts using this model. For those changes, we have attempted to predict the payment impacts of those changes based upon our experience and other more limited data.

The data used in developing the quantitative analyses of changes in payments per case presented below are taken from the FY 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 policy changes, and we do not adjust for future changes in such variables as admissions, lengths of stay, or case-mix. Second, due to the interdependent nature of the IPPS payment components, it is very difficult to precisely quantify the impact associated with each change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the March 2005 update of 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 FY 2006 changes to the capital IPPS are discussed in section VIII of this Appendix.

The 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 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 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 wage and recalibration budget neutrality factors, including the rebased labor share for both the national and Puerto Rico standardized amounts.
- 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 FY 2006 policies and MMA-imposed changes relative to payments based on FY 2005 policies.

To illustrate the impacts of the FY 2006 changes, our analysis begins with a FY 2006 baseline simulation model using: The update of 3.7 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. At the time this impact was prepared, the quality data were still under review. Since early results indicated that very few providers would fail the quality edits, for purposes of the FY 2006 simulations in this impact analysis, we have assumed that all hospitals will qualify for the full update. Subsequent analysis of the quality data indicate that 2.0 percent of hospitals will fail the quality edits and the impact of this finding is discussed in section C of this addendum.

Each policy change is then added incrementally to this baseline model, finally arriving at an FY 2006 model incorporating all of the changes. This allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 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 3.7 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 3.3 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 3.7 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 4.1 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 final 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 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 3,744 hospitals included in the analysis. There are 153 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 2,616 hospitals located in urban areas included in our analysis. Among these, there are 1,440 hospitals located in large urban areas (populations over 1 million), and 1,176 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 1,128 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 2,651, 1,451, 1,200, and 1,093, respectively.

The next three groupings examine the impacts of the 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 2,661 nonteaching hospitals in our analysis, 845 teaching hospitals with fewer than 100 residents, and 238 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 changes on rural hospitals by special payment groups (sole community hospitals (SCHs), rural referral centers (RRCs), and Medicare dependent hospitals (MDHs)), as well as rural hospitals not receiving a special payment designation. There were 136 RRCs, 389 SCHs, 146 MDHs, and 77 hospitals that are both SCHs and RRCs.

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 reports, 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.

BILLING CODE 4120–01–P

TABLE I. IMPACT ANALYSIS OF CHANGES FOR FY 2006

	No. of Hospitals[1] (1)	Postacute Transfer Policy[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)
All Hospitals	3,744	-0.9	0.0	-0.2	0.0	0.0	0.0	0.0	0.1	3.5
By Geographic Location:										
Urban hospitals	2,616	-1.0	0.1	-0.2	0.0	0.0	0.0	-0.3	0.1	3.5
Large urban areas (populations over 1 million)	1,440	-1.0	0.1	-0.2	0.0	0.0	0.0	-0.4	0.0	3.4
Other urban areas (populations of 1 million or fewer)	1,176	-0.9	0.1	-0.2	0.0	0.0	0.0	-0.2	0.1	3.6
Rural hospitals	1,128	-0.6	-0.1	-0.3	0.0	-0.3	0.3	2.1	0.1	3.3
Bed Size (Urban):										
0-99 beds	676	-0.9	-0.2	0.0	0.1	0.1	-0.1	-0.4	0.1	3.8
100-199 beds	884	-1.0	0.0	-0.1	0.0	0.2	0.0	-0.2	0.1	3.5
200-299 beds	485	-1.0	0.0	-0.1	0.0	0.1	0.0	-0.2	0.1	3.6
300-499 beds	410	-0.9	0.1	-0.3	0.0	-0.1	0.0	-0.4	0.1	3.4
500 or more beds	161	-1.0	0.2	-0.4	0.0	0.0	0.0	-0.4	0.0	3.4
Bed Size (Rural):										
0-49 beds	452	-0.4	-0.3	-0.2	0.0	-0.4	0.1	0.7	0.1	3.3
50-99 beds	379	-0.6	-0.1	-0.2	0.0	-0.3	0.2	1.1	0.1	3.2
100-149 beds	188	-0.6	-0.2	-0.5	0.0	-0.5	0.4	2.6	0.1	3.3
150-199 beds	61	-0.5	-0.1	-0.5	0.0	-0.5	0.5	3.1	0.1	3.0
200 or more beds	48	-0.6	0.0	0.0	0.0	0.1	0.0	3.2	0.0	3.7
Urban by Region:										
New England	129	-1.6	0.3	-0.5	0.2	0.2	0.0	-0.1	0.2	2.3
Middle Atlantic	368	-1.0	-0.1	0.0	0.0	0.1	0.0	-0.2	0.2	3.0
South Atlantic	396	-0.8	0.1	-0.6	0.0	-0.3	0.0	-0.4	0.0	3.5
East North Central	405	-1.1	0.1	-0.4	0.0	-0.2	0.0	-0.3	0.0	2.9
East South Central	171	-0.8	0.2	-0.2	0.0	0.1	0.0	-0.4	0.1	3.7
West North Central	159	-1.0	0.0	-0.5	0.0	-0.4	0.0	-0.5	0.0	3.1
West South Central	370	-0.7	0.1	-0.3	0.0	-0.1	0.0	-0.5	0.0	3.9
Mountain	146	-0.9	0.0	-0.2	0.1	0.1	0.0	-0.2	0.0	3.7
Pacific	420	-1.0	0.1	0.8	0.0	1.1	0.0	-0.2	0.1	5.1
Puerto Rico	52	-0.2	0.0	-1.2	0.0	-1.0	-0.1	-0.6	0.0	3.0
Rural by Region:										
New England	25	-0.9	0.0	1.3	0.1	1.5	0.0	1.7	0.1	4.7
Middle Atlantic	73	-0.7	-0.2	-0.4	0.0	-0.5	0.1	2.2	0.0	4.2

	No. of Hospitals[1] (1)	Postacute Transfer Policy[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)
South Atlantic	180	-0.6	0.0	-0.7	0.0	-0.6	0.2	2.2	0.2	2.7
East North Central	145	-0.6	-0.1	-0.1	0.0	-0.1	0.1	1.6	0.1	2.7
East South Central	197	-0.7	-0.1	-0.2	-0.1	-0.2	0.2	3.0	0.1	3.7
West North Central	160	-0.4	-0.2	-0.3	-0.2	-0.6	0.0	1.6	0.0	3.2
West South Central	210	-0.5	-0.1	-0.4	0.1	-0.3	0.3	2.6	0.1	3.2
Mountain	87	-0.3	-0.2	-0.9	-0.3	-1.2	2.1	0.5	0.1	3.5
Pacific	51	-0.4	-0.1	0.5	0.2	0.7	0.0	1.1	0.1	4.3
By Payment Classification:										
Urban hospitals	2,651	-1.0	0.1	-0.2	0.0	0.0	0.0	-0.3	0.1	3.5
Large urban areas (populations over 1 million)	1,451	-1.0	0.1	-0.2	0.0	0.0	0.0	-0.4	0.0	3.4
Other urban areas (populations of 1 million or fewer)	1,200	-0.9	0.1	-0.2	0.0	0.0	0.0	-0.1	0.1	3.5
Rural areas	1,093	-0.5	-0.1	-0.3	0.0	-0.3	0.3	1.9	0.1	3.3
Teaching Status:										
Nonteaching	2,661	-0.8	-0.1	-0.1	0.0	0.0	0.0	0.3	0.1	3.7
Fewer than 100 residents	845	-0.9	0.0	-0.2	0.0	0.0	0.0	-0.2	0.1	3.4
100 or more residents	238	-1.1	0.3	-0.4	0.0	0.0	0.0	-0.3	0.0	3.0
Urban DSH:										
Non-DSH	1,026	-0.9	-0.1	-0.2	0.0	-0.1	0.0	-0.1	0.1	3.4
100 or more beds	1,505	-0.9	0.1	-0.2	0.0	0.1	0.0	-0.3	0.1	3.5
Less than 100 beds	350	-0.9	-0.1	0.3	0.0	0.5	-0.1	0.0	0.1	4.0
Rural DSH:										
SCH	404	-0.3	-0.2	-0.2	0.0	-0.3	0.2	0.5	0.1	3.7
RRC	182	-0.7	-0.1	-0.2	0.0	-0.2	0.2	3.5	0.0	3.0
Other Rural:										
100 or more beds	63	-0.8	-0.2	-0.9	0.2	-0.7	1.5	1.0	0.2	2.9
Less than 100 beds	214	-0.9	-0.2	-0.5	0.0	-0.5	0.5	1.0	0.3	2.9
Urban teaching and DSH:										
Both teaching and DSH	811	-1.0	0.2	-0.3	0.0	0.0	0.0	-0.4	0.0	3.3
Teaching and no DSH	207	-1.0	0.0	-0.3	0.0	-0.2	0.0	-0.3	0.1	3.1
No teaching and DSH	1,044	-0.9	0.0	0.0	0.0	0.2	0.0	-0.1	0.1	3.9
No teaching and no DSH	589	-1.0	-0.1	-0.1	0.0	-0.1	0.0	-0.3	0.0	3.6
Rural Hospital Types:										
Non special status hospitals	334	-0.9	-0.2	-0.6	0.1	-0.5	0.9	0.9	0.3	3.0
RRC	136	-0.9	-0.1	-0.2	0.0	-0.1	0.2	4.6	0.0	2.8

	No. of Hospitals[1] (1)	Postacute Transfer Policy[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)
SCH	389	-0.2	-0.2	-0.2	0.0	-0.3	0.2	0.3	0.1	3.8
MDH	146	-0.7	-0.2	-0.2	-0.1	-0.3	-0.1	1.3	0.1	3.2
SCH and RRC	77	-0.2	-0.2	-0.2	0.1	-0.2	0.0	1.4	0.0	3.5
Type of Ownership:										
Voluntary	2,217	-1.0	0.1	-0.3	0.0	0.0	0.0	0.0	0.1	3.4
Proprietary	857	-0.8	0.0	-0.2	0.0	-0.1	0.0	0.0	0.0	3.6
Government	670	-0.8	0.1	0.0	0.0	0.3	0.0	0.1	0.1	3.8
Medicare Utilization as a Percent of Inpatient Days:										
0-25	280	-0.8	0.2	-0.1	0.0	0.2	0.0	-0.2	0.0	3.8
25-50	1,427	-1.0	0.1	-0.2	0.0	0.1	0.0	-0.3	0.1	3.5
50-65	1,534	-0.8	0.0	-0.3	0.0	-0.1	0.0	0.3	0.1	3.4
Over 65	403	-0.8	-0.1	-0.5	0.0	-0.4	0.0	0.4	0.1	3.1
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2005 Reclassifications:										
All Reclassified Urban Hospitals	263	-1.0	0.0	-0.2	0.0	0.0	0.0	2.8	0.0	4.2
Urban Nonreclassified Hospitals	2,329	-1.0	0.1	-0.2	0.0	0.0	0.0	-0.6	0.1	3.4
All Reclassified Rural Hospitals	355	-0.6	-0.1	-0.2	0.0	-0.2	0.0	3.8	0.0	3.3
Rural Nonreclassified Hospitals	702	-0.5	-0.2	-0.3	-0.1	-0.4	0.6	-0.3	0.2	3.4
Other Reclassified Hospitals (Section 1886(d)(8)(B))	64	-0.7	-0.1	-0.9	0.1	-0.8	-0.1	3.8	0.0	2.5
Other Reclassified Hospitals (Section 1886(d)(8)(E))	31	-0.3	-0.2	0.0	0.9	0.7	0.0	-0.1	0.0	3.1

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 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 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 2004 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 FY 2006 budget neutrality factor of 1.002271 (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. The effects of the rebased labor share for the national and Puerto Rico Specific rates are included as the change in the labor share is being implemented in a budget neutral manner.

[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 0.998859 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 0.992581.

[9] This column displays the impact of the FY 2006 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.

C. Impact of the Changes to the Postacute Care Transfer Policy (Column 2)

In Column 2 of Table I, we present the effects of the expansion of the postacute care transfer policy, as discussed in section V.A. of the preamble to this final rule. We compared aggregate payments using the FY 2005 DRG relative weights (GROUPER version 22.0) and the 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 making are estimated to result in a 0.9 percent decrease in payments to hospitals overall. We estimate the total savings at approximately $780 million in FY 2006.

To simulate the impact of this final 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 postacute care transfer policy and the second was based on the expanded postacute care transfer policy discussed in the preamble to this final 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 postacute care 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 postacute care 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 postacute care 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 12 DRGs (including 210 and 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 13 special payment DRGs: Accordingly, these cases 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 change to the postacute care transfer policy.

This expansion of the policy has a −0.9 percent payment impact overall among both urban and rural hospitals. There is only small variation among all of the hospital categories from the −0.9 percent impact. The areas that are most dramatically affected are urban areas, with urban New England experiencing a 1.6 percent decline in payments and the East North Central experiencing a 1.1 percent decline. Although none of the rural regions show an increase in payments, all 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 affected by this policy.

D. Impact of the 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 final rule. Section 1886(d)(4)(C)(i) of the Act requires us annually to make appropriate classification changes and to recalibrate the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

We compared aggregate payments using the FY 2005 DRG relative weights (GROUPER version 22.0) to aggregate payments using the 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 budget neutrality factor of 1.002271 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 making include—

- The creation of several new DRGs designed to better reflect severity among cardiac DRG cases,
- 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 DRG 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 or secondary diagnosis codes for curvature of the spine and the principal diagnosis code for malignancy from DRGs 497 and 498 to new DRG 546 (Spinal Fusions Except Cervical with Curvature of the Spine or Malignancy);
- 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); and
- Creating a new DRG 559 (Acute Ischemic Stroke With Use of Thrombolytic Agent) that identifies embolic stroke combined with tPA treatment.

Of the changes described above, the most significant change we are making results from our focused review of the cardiovascular DRGs for FY 2006. The approach we are adopting provides a sound analytical basis for replacing 9 cardiovascular DRGs that account for nearly 700,000 cases with 12 new DRGs that better recognize severity of illness. These nine DRGs are commonly billed by specialty hospitals. While these changes do not appear to have a significant impact among any of the categories of hospitals listed below, we believe the changes will address a portion of the inappropriately higher payments that are accruing to specialty hospitals under the current DRG system. We have analyzed a sample of specialty hospitals and found that the effect of the DRG changes alone may decrease the case-mix index (and the resulting payments) by an average 1 percent. While we expect to complete a comprehensive analysis of the MedPAC recommendations over the next year and will consider making further changes to the DRG system for FY 2007, the changes we are making to the cardiovascular DRGs for FY 2006 represent an excellent interim step for beginning the improvements to the DRG system.

In the aggregate, these changes will have no impact on overall payments to hospitals. On average, the impacts of these changes on any particular hospital group are very small, with urban hospitals experiencing a 0.1 percent increase and rural hospitals experiencing a 0.1 percent decrease. The largest impact is a 0.3 percent increase among urban hospitals in New England. This impact is in part due to the residual effects of the change to the postacute care transfer policy on the relative weights. Including a DRG in the postacute care transfer policy 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 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 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 0.2 percent decrease for all hospitals and for hospitals in urban areas. This decrease is due to both fluctuations in the wage data itself and full implementation of the new labor market areas in FY 2006. Hospitals that experienced a decline in the wage index due to the new labor market areas received a transition blended wage index in FY 2006. The labor market transition is no longer in effect for FY 2006 resulting in a payment reduction for hospitals that benefited in FY 2005 from the transition. Among regions, the largest increase is in the rural New England region, which is experiencing a 1.3 percent increase. The largest decline from updating the wage data is seen in the urban Puerto Rico region (a 1.2 percent decrease).

In looking at the wage data itself, the national average hourly wage increased 6.2 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 6.2 increase in average hourly wage. Of the 3,681 hospitals with wage data for both FYs 2005 and 2006, 1,647, or 44.7 percent, also experienced an average hourly wage increase of 6.2 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, 56 will experience an increase of between 5 percent and 10 percent and 20 will experience an increase of more than 10 percent. A total of 35 rural hospitals will experience increases greater than 5 percent, but none will experience increases of greater than 10 percent. On the negative side, 46 urban hospitals will experience decreases in their wage index values of at least 5 percent, but less than 10 percent. Fifteen 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	20	0
Increase more than 5 percent and less than 10 percent	56	35
Increase or decrease less than 5 percent	2,375	1,102
Decrease more than 5 percent and less than 10 percent	46	12
Decrease more than 10 percent	15	0

F. Impact of Change in Treatment of Section 1886(d)(8)(E) Wage Data (Column 5)

For the FY 2006 wage index, we are leaving 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 moving 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 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. Rural hospitals in the Mountain region are shown to experience a 0.3 percent 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 0.9 percent increase.

G. Combined Impact of 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 final rule, in determining the budget neutrality factor, we compared simulated aggregate payments using the FY 2005 DRG relative weights, the blended wage index, and labor share percentage to simulated aggregate payments using the FY 2006 DRG relative weights and wage index and the rebased labor share percentage (69.7 percent for the national rate, 58.7 percent for the Puerto Rico specific rate).

We computed a wage and DRG recalibration budget neutrality factor of 1.002271. 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 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 0.4 and 1.0 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 1.5 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 0.998859 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 basis 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' 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 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, or a request by a hospital to withdraw its application.

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 0.992521 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this final rule.)

As a group, rural hospitals benefit from geographic reclassification. We estimate that their payments will rise 2.1 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 region. 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 2.6 percent.

Urban hospitals reclassified for FY 2006 are expected to receive an increase of 2.8 percent, while rural reclassified hospitals are expected to benefit from the MGCRB changes with a 3.8 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 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, 308 counties and 592 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 final rule for FY 2006 (including statutory changes), to our estimate of payments per case in FY 2005. This column includes all of the policy changes. 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 3.5 percent. This increase includes the effects of the 3.7 percent market basket update. It also reflects the 1.0 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 (4.1 percent), as described in the introduction to this Appendix and the Addendum to this final rule. As a result, payments are projected to be 1.0 percentage point lower in FY 2005 than originally estimated, resulting in a 1.0 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 1.3 percent are primarily attributable to the impact of expanding the postacute care transfer policy (−0.9 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 final rule we are revising 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.

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 will increase by 3.5 percent. Hospitals in urban areas will experience a 3.5 percent increase in payments per case compared to FY 2005. Hospitals in rural areas, meanwhile, will experience a 3.3 percent payment increase. Hospitals in large urban areas will experience a 3.4 percent increase in payments and hospitals in other urban areas will experience a 3.6 percent increase in payments.

Among urban census divisions, the largest payment increase will be 5.1 percent in the Pacific region. Hospitals in the West South Central region will experience the next largest overall increase of 3.9 percent. The smallest urban increase would occur in the New England region, with an increase of 2.3 percent.

Among rural regions in Column 10, no hospital category will experience overall payment decreases. The Pacific and New England regions will benefit the most, with 4.3 and 4.7 percent increases, respectively. The smallest increase will occur in the South Atlantic and East North Central regions, with 2.0 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) will experience payment increases of 3.8 percent, 3.2 percent, and 3.5 percent, respectively.

Urban hospitals reclassified for FY 2006 are anticipated to receive an increase of 4.2 percent, while rural reclassified hospitals are expected to benefit from reclassification with a 3.3 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 2.5 percent.

L. Impact Analysis of Table II

Table II presents the projected impact of the 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.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2006 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per case]

	Number of hospitals	Average FY 2005 payment per case [1]	Average FY 2006 payment per case [1]	All FY 2006 changes
	(1)	(2)	(3)	(4)
All hospitals	3,744	8,257	8,542	3.5
By Geographic Location				
Urban hospitals	2,616	8,580	8,878	3.5
Large urban areas (populations over 1 million)	1,440	8,961	9,267	3.4
Other urban areas (populations of 1 million or fewer)	1,176	8,123	8,412	3.6
Rural hospitals	1,128	6,534	6,750	3.3
Bed Size (Urban):				
0–99 beds	676	6,480	6,726	3.8
100–199 beds	884	7,187	7,439	3.5
200–299 beds	485	8,127	8,417	3.6
300–499 beds	410	9,075	9,380	3.4
500 or more beds	161	10,866	11,238	3.4
Bed Size (Rural):				
0–49 beds	452	5,629	5,814	3.3
50–99 beds	379	6,021	6,214	3.2
100–149 beds	188	6,490	6,706	3.3
150–199 beds	61	7,703	7,931	3.0
200 or more beds	48	7,788	8,079	3.7
Urban by Region:				
New England	129	9,225	9,437	2.3
Middle Atlantic	368	9,342	9,626	3.0
South Atlantic	396	8,148	8,430	3.5
East North Central	405	8,251	8,491	2.9
East South Central	171	7,809	8,101	3.7
West North Central	159	8,653	8,925	3.1
West South Central	370	8,115	8,432	3.9
Mountain	146	8,455	8,770	3.7
Pacific	420	10,089	10,603	5.1
Puerto Rico	52	3,998	4,118	3.0
Rural by Region:				
New England	25	8,397	8,787	4.7
Middle Atlantic	73	6,200	6,460	4.2
South Atlantic	180	6,419	6,593	2.7
East North Central	145	6,474	6,651	2.7
East South Central	197	5,807	6,019	3.7
West North Central	160	6,889	7,110	3.2
West South Central	210	6,149	6,348	3.2
Mountain	87	7,399	7,658	3.5
Pacific	51	9,904	10,328	4.3
By Payment Classification				
Urban hospitals	2,651	8,544	8,840	3.5
Large urban areas (populations over 1 million)	1,451	8,940	9,245	3.4
Other urban areas (populations of 1 million or fewer)	1,200	8,070	8,355	3.5
Rural areas	1,093	6,675	6,898	3.3
Teaching Status:				
Non-teaching	2,661	6,958	7,216	3.7
Fewer than 100 Residents	845	8,379	8,665	3.4
100 or more Residents	238	12,175	12,544	3.0
Urban DSH:				
Non-DSH	1,026	7,462	7,715	3.4
100 or more beds	1,505	9,035	9,350	3.5
Less than 100 beds	350	5,945	6,181	4.0
Rural DSH:				
SCH	404	6,941	7,201	3.7
RRC	182	7,278	7,499	3.0
Other Rural:				
100 or more beds	63	5,580	5,743	2.9
Less than 100 beds	214	4,904	5,044	2.9
Urban Teaching and DSH:				
Both teaching and DSH	811	9,971	10,301	3.3
Teaching and no DSH	207	8,424	8,683	3.1
No teaching and DSH	1,044	7,271	7,554	3.9
No teaching and no DSH	589	6,893	7,143	3.6
Rural Hospital Types:				

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2006 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[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)
Non special status hospitals	334	5,149	5,305	3.0
RRC	136	6,754	6,943	2.8
SCH	389	7,548	7,837	3.8
MDH	146	4,824	4,980	3.2
SCH and RRC	77	8,467	8,760	3.5
Type of Ownership:				
Voluntary	2,217	8,374	8,655	3.4
Proprietary	857	7,545	7,819	3.6
Government	670	8,481	8,803	3.8
Medicare Utilization as a Percent of Inpatient Days:				
0–25	280	11,238	11,670	3.8
25–50	1,427	9,272	9,595	3.5
50–65	1,534	7,326	7,573	3.4
Over 65	403	6,555	6,759	3.1
Hospitals Reclassified by the Medicare Geographic Classification Review Board				
FY 2005 Reclassifications:				
All Urban Reclassified Hospitals	263	8,522	8,882	4.2
Urban Nonreclassified Hospitals	2,329	8,576	8,867	3.4
All Reclassified Rural Hospitals	355	7,052	7,284	3.3
Rural Nonreclassified Hospitals	702	6,066	6,274	3.4
Other Reclassified Hospitals (Section 1886(d)(8)(E))	64	5,717	5,857	2.5
Other Reclassified Hospitals (Section 1886(d)(8)(B))	31	10,164	10,481	3.1

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

VII. Impact of Other Policy Changes

In addition to those changes discussed above that we are able to model using our IPPS payment simulation model, we are making various other changes in this final rule. Generally, we have limited or no specific data available with which to estimate the impacts of these changes. Our estimates of the likely impacts associated with these other changes are discussed below.

A. Impact of LTC–DRG Reclassifications and Relative Weights for LTCHs

In section II.D. of the preamble of this final rule, we discuss the changes in the LTC–DRG relative weights for FY 2006, which is based on the version 23.0 of the CMS GROUPER (including the changes in the classifications, relative weights and geometric mean length of stay for each LTC–DRG). As also discussed in that same section of this final rule, currently, there is no statutory or regulatory requirement that the annual update to the LTC–DRG classifications and relative weights be done in a budget neutral manner. As discussed above in section II.D.4. of the preamble to this final rule, the LTCH PPS is still in the midst of a transition from a reasonable cost-based payment system to fully Federal PPS payments, during which time LTCH coding and data are still in flux. The LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002 (FY 2003). Therefore, the FY 2004 MedPAR data used to compute the FY 2006 LTC–DRG relative weights are based on LTCH claims data taken from only the first full year of the LTCH PPS. Based on LTCH cases in the March 2005 update of the FY 2004 MedPAR files, we estimate that the changes to the LTC–DRG classifications and relative weights for FY 2006 will result in an aggregate decrease in LTCH PPS payments of approximately 4.2 percent.

When we compared the Grouper version 22 (FY 2005) LTC–DRG relative weights to the Grouper version 23 (FY 2006) LTC–DRG relative weights, we found that approximately 71 percent of the LTC–DRGs had higher relative weights under version 22. We also found that the Grouper version 22 LTC–DRG relative weights were, on average, approximately 15 percent higher than the Grouper 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 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 typical when moving from a reasonable cost-based payment system to a PPS. The impact of including additional cases with relatively lower charges into LTC–DRGs that had a relatively higher relative weight in the Grouper version 22.0 (FY 2005) is a decrease in the average relative weight for those LTC–DRGs in the GROUPER version 23.0.

As noted above in section II.D.4 of the preamble of this final rule, LTCHs are a specialized provider type that typically do not treat a broad spectrum of patients in their facilities with many different diagnoses. While there are 526 valid Grouper version 23 LTC–DRGs, 196 LTC–DRGs have no LTCH cases. In addition, another 171 LTC–DRGs are categorized as ''low volume'' (that is, have less than 25 cases annually). Consequently, only about 159 LTC–DRGs are used by most LTCHs on a ''regular basis'' (that is, nationally LTCHs discharge, in total, average 25 or more of these cases annually). Of these 159 LTC–DRGs that are used on a ''regular basis,'' we found that approximately 80 percent of the LTC–DRGs had higher relative weights under Grouper version 22 in comparison to Grouper version 23. About 33 percent of the159 LTC–DRGs that are used on a ''regular basis'' (53 LTC–DRGs) will experience a decrease in the average charge per case as compared to the average charge per case in that DRG based on FY 2003 data, which generally results in a lower relative weight. We also found that there has been an increase of approximately 16 percent in the average LTCH charge across all LTC–DRGs from FY 2003 to FY 2004. In addition, about 42 percent of the 159 LTC–DRGs that are used on a ''regular basis'' (66 LTC–DRGs) will experience an increase in the average charge that is less than the increase in the overall average charge across all LTC–DRGs (about 16 percent, as noted above). Accordingly, those LTC–DRGs will also have a reduction in their relative weight as compared to the relative weight in FY 2005. For those LTC–DRGs in which the average charge within the LTC–DRG increase is less than 16 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 changes in the LTC–DRG relative weights, which include a significant number of LTC–DRGs with lower relative weights, will result in approximately a 4.2 percent decrease in aggregate LTCH PPS payments.

B. Impact of 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 final rule). However, we are still providing an estimate of the payment increases here, as they will have an impact on total payments made in FY 2006. New technology add-on payments are limited to the lower 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 final rule, we are approving two of the new technology applications, Restore® Rechargable Implantable Neurostimulator and GORE TAG, that were filed for FY 2006. Additionally, we are continuing to make add-on payments in FY 2006 for an FY 2005 new technology: Kinetra™ implants. We estimate these approvals will increase overall FY 2006 payments by $6.01 million, $16.61 million and $12.82 million, respectively. The total increase in payments for these three new technologies, approximately $35.5 million, 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 final 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 as 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. of the preamble to this final rule. The final date for submission of quality data for purposes of receiving the full market basket update in FY 2006 was 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 final rule, we are providing additional validation criteria to ensure that the quality data being sent to CMS are accurate. The requirement of 5 charts per hospital will result in approximately 19,000 charts per quarter total submitted to the agency. We reimburse hospitals for the cost of sending charts to the CDAC at the rate of 12 cents per page for copying and approximately $4.00 per chart for postage. Our experience shows that the average chart received at the CDAC is approximately 140 pages. Thus, the agency will have expenditures of approximately $380,000 per quarter to collect the charts. Given that we reimburse for the data collection effort, we believe that a requirement for five charts per hospital per quarter represents a minimal burden to the participating hospital. Based on test applications of these validation criteria to quality data that have been submitted thus far, we currently estimate that approximately 2 percent of hospitals will fail the edits and receive the reduced market basket update to the standardized amount. We estimate reduced market basket payments of approximately $8 million for FY 2006.

D. Impact of Policy on Payment Adjustments for Low-Volume Hospitals

In section V.E. of the preamble to this final rule, we discussed our 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 continuing 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 eight 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 $1.49 million.

E. Impact of 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 final rule, we discuss the incorporation into regulations of 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 addition to the regulations clarifies the established policy for computing an IME FTE resident cap for these hospitals. Because this is a clarification of existing policy and codification of 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 final rule, we present our policy 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 convert to rural status solely to gain a higher IME FTE cap in the absence of this policy 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 Policy Relating to Geographic Reclassifications of Multicampus Hospitals

In section V.H.2. of the preamble of this final 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 providing that, for reclassification applications submitted for FY 2006 (that is, applications received by September 1, 2004), for FY 2007 (that is, applications received by September 1, 2005, and for FY 2008 (that is, applications received by September 1, 2006), we will allow a campus or campuses of a multicampus hospital system to seek geographic reclassification to the labor market area where the other campus(es) is located on the basis of the average hourly

wage data submitted for the entire hospital system. This policy will only affect those multicampus hospitals that are located in more than one labor market area that seek to reclassify to allow the entire hospital system to be paid using a single wage index. We estimate there are less than 10 multicampus hospital systems nationwide that will seek to reclassify under the revised regulation. This provision 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 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 final rule, we discuss our 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 providing 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 final rule, we have estimated the impact of this 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 0.50 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 final rule, we discuss 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 revising 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 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 final 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 final 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 final rule.

I. Impact of Policy on Provider-Based Status of Facilities and Organizations Under Medicare—Location Requirements for Off-Campus Facilities: Application to Certain Neonatal Intensive Care Units

In section V.J.2. of the preamble to this final rule, we discuss the change to the provider-based regulations regarding the location requirements for off-campus facilities as they relate to neonatal intensive care units (NICUs). In accordance with this final rule, NICUs meeting other applicable requirements will be considered to be qualified provider-based entities if they are located within a 100-mile radius of the children's hospitals which is the potential main provider and at least 35 miles from the nearest other NICU. We estimate that there will be fewer than five NICUs nationwide that will be able to meet the provider-based status as a result of this change. Given the specialized nature of the care provided and their rural location, we expect that these types of units will not treat any Medicare patients, though some of their patients may qualify for Medicaid. As a result, we believe that this change will have no impact on Medicare. The Medicaid impact, on a national basis, will be very small.

J. Impact of Policy on CAH Relocation Provisions

In section VII.B.3. of the preamble to this final rule, we discuss the 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 revising the regulations to allow some flexibility for those CAHs previously designated as necessary providers to replace their facilities. For the reasons explained more fully in section VII.B.3, we have decided to permit a necessary provider CAH to relocate its facility and begin providing services at a new location, provided the necessary provider will be essentially the same facility in its new location.

The Health Resources Services Administration (HRSA) estimates that these necessary provider CAH facility replacements will take place at the rate of 5 facilities per year, nationwide, over the next 10 years. The average cost of construction of a new 25-bed CAH is approximately $25 million. Given a depreciation schedule based on a 25 year useful life and Medicare utilization of approximately 50 percent, the additional annual capital costs for 5 CAH facility replacements would be $2.5 million. However, the actual cost to the program would be further reduced since those CAH are currently being reimbursed for their existing capital costs and their increased operating costs that are associated with operating an aged facility. Accordingly, the budgetary impact for the 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 change is estimated at between $200,000 and $400,000 per CAH.

Comment: One commenter stated that our estimated cost of $25 to $35 million is not a realistic estimate. One example given was a hospital in Oklahoma with 15 beds and 2 complete surgical suites. The commenter indicated that the cost for building the new facility and buying equipment was $7.5 million.

Response: We appreciate the commenter's information and considered it in developing the cost estimate for the final rule. However, as acknowledged by the commenter, the $7.5 million figure represents a single instance of construction at a single location and related to a facility having only 15 beds. In contrast, our estimate of $25 to $35 million is intended to be national in scope and assumes the new facility will have 25 beds, as do the vast majority of facilities now operating as CAHs. Therefore, we made no change in our cost estimates based on this comment.

VIII. Impact of 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 final rule, with the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY

2002), beginning in FY 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 + Disproportionate Share (DSH) Adjustment Factor + Indirect Medical Education (IME) Adjustment Factor, if applicable).

In addition, hospitals may also receive outlier payments for those cases that qualify under the threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the March 2005 update of the FY 2004 MedPAR file and the March 2005 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 March 2005 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 March 2005 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 final 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 will 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 FY 2006 update is 0.8 percent (see section III.A.1.a. of the Addendum to this final rule).
- In addition to the FY 2006 update factor, the FY 2006 capital Federal rate was calculated based on a GAF/DRG budget neutrality factor of 1.0008, an outlier adjustment factor of 0.9515, and a (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 March 2005 update of the FY 2004 MedPAR file, the March 2005 update to the Provider-Specific File, and the most recent cost report data from the March 2005 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 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 0.8 percent update to the capital Federal rate, a 0.0 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 2.4 percent in FY 2006. In addition to the 0.8 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 2.5 percent increase in IPPS capital payments per case, while rural hospitals are only expected to experience a 1.8 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 1.0 percent (Middle Atlantic rural) to a maximum increase of 4.5 percent (New England rural). The relatively small increase in projected capital payments per discharge for hospitals located in the Middle Atlantic region is largely attributable to the change in the GAF value (that is, the GAF 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 New England rural region is largely due to the changes in the GAF values (that is, the GAFs for most of these hospitals for FY 2006 are higher than the average of the GAFs for FY 2005) and an 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 0.3 percent. This lower than average increase in payment per case for hospitals located in Puerto Rico is largely due to the changes in the GAF values (that is, the GAFs for most of these hospitals for FY 2006 are lower 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 (2.6 percent). Similarly, payments to voluntary and proprietary hospitals are expected to increase 2.4 percent and 2.3 percent, respectively. As noted above, this slightly larger projected increase in capital payments per case for government hospitals is mostly due to a smaller than average decrease in the 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 2.7

percent increase in payments. Payments to nonreclassified hospitals in FY 2006 are expected to increase 2.4 percent. Hospitals reclassified during both FY 2005 and FY 2006 are projected to experience an increase in payments of 1.9 percent. Hospitals reclassified during FY 2006 only are projected to receive an increase in payments of 4.5 percent. This relatively large increase is primarily due to the changes in the GAF values (that is, the GAFs for most of these hospitals for FY 2006 are higher than the average of the GAFs for FY 2005).

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2005 payments compared to FY 2006 payments]

	Number of hospitals	Average FY 2005 payments/case	Average FY 2006 payments/case	Change
By Geographic Location				
All hospitals	3,744	723	741	2.4
Large urban areas (populations over 1 million)	1,440	807	827	2.5
Other urban areas (populations of 1 million of fewer)	1,176	715	732	2.4
Rural areas	1,128	501	510	1.8
Urban hospitals	2,616	765	784	2.5
0–99 beds	676	587	600	2.2
100–199 beds	884	649	664	2.3
200–299 beds	485	723	740	2.3
300–499 beds	410	805	824	2.3
500 or more beds	161	961	991	3.1
Rural hospitals	1,128	501	510	1.8
0–49 beds	452	414	420	1.3
50–99 beds	379	463	471	1.8
100–149 beds	188	506	515	1.9
150–199 beds	61	562	572	1.8
200 or more beds	48	626	640	2.3
By Region				
Urban by Region	2,616	765	784	2.5
New England	129	831	849	2.1
Middle Atlantic	368	832	854	2.6
South Atlantic	396	734	751	2.2
East North Central	405	757	771	2.0
East South Central	171	689	706	2.4
West North Central	159	760	775	2.0
West South Central	370	712	730	2.5
Mountain	146	767	786	2.5
Pacific	420	864	898	4.0
Puerto Rico	52	338	339	0.3
Rural by Region	1,128	501	510	1.8
New England	25	647	676	4.5
Middle Atlantic	73	512	517	1.0
South Atlantic	180	491	500	1.7
East North Central	145	532	540	1.5
East South Central	197	460	470	2.2
West North Central	160	526	532	1.3
West South Central	210	454	461	1.7
Mountain	87	520	532	2.4
Pacific	51	591	612	3.6
By Payment Classification				
All hospitals	3,744	723	741	2.4
Large urban areas (populations over 1 million)	1,451	806	826	2.6
Other urban areas (populations of 1 million of fewer)	1,200	713	730	2.4
Rural areas	1,093	502	511	1.9
Teaching Status:				
Non-teaching	2,661	605	618	2.2
Fewer than 100 Residents	845	743	760	2.2
100 or more Residents	238	1,062	1,094	3.0
Urban DSH:				
100 or more beds	1,505	790	811	2.6
Less than 100 beds	350	521	535	2.6
Rural DSH:				
Sole Community (SCH/EACH)	404	452	459	1.7
Referral Center (RRC/EACH)	182	559	572	2.2
Other Rural:				
100 or more beds	63	471	478	1.6
Less than 100 beds	214	416	421	1.2
Urban teaching and DSH:				
Both teaching and DSH	811	870	893	2.7

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 2005 payments compared to FY 2006 payments]

	Number of hospitals	Average FY 2005 payments/case	Average FY 2006 payments/case	Change
Teaching and no DSH	207	793	810	2.1
No teaching and DSH	1,044	641	656	2.4
No teaching and no DSH	589	664	678	2.2
Rural Hospital Types:				
Non special status hospitals	334	441	448	1.5
RRC/EACH	136	570	582	2.1
SCH/EACH	389	470	479	1.8
Medicare-dependent hospitals (MDH)	146	418	424	1.4
SCH, RRC and EACH	77	570	582	2.0
Hospitals Reclassified by the Medicare Geographic Classification Review Board				
Reclassification Status During FY2005 and FY2006:				
Reclassified During Both FY2005 and FY2006	418	632	644	1.9
Reclassified During FY2006 Only	198	705	736	4.5
Reclassified During FY2005 Only	134	678	695	2.5
FY2006 Reclassifications:				
All Reclassified Hospitals	618	655	673	2.7
All Nonreclassified Hospitals	3,031	740	757	2.4
All Urban Reclassified Hospitals	263	759	782	3.0
Urban Nonreclassified Hospitals	2,329	766	785	2.4
All Reclassified Rural Hospitals	355	545	558	2.3
Rural Nonreclassified Hospitals	702	453	459	1.4
Other Reclassified Hospitals (Section 1886(D)(8)(B))	71	501	502	0.2
Type of Ownership				
Voluntary	2,189	743	760	2.4
Proprietary	806	654	669	2.3
Government	669	696	715	2.6
Medicare Utilization as a Percent of Inpatient Days:.				
0–25	280	918	947	3.2
25–50	1,427	811	834	2.7
50–65	1,534	644	658	2.0
Over 65	403	587	597	1.6

Appendix B: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background

Section 1886(e)(4)(A) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), recommend update factors for inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5)(B) of the Act, we are required to publish update factors recommended by the Secretary in the final rule.

Consistent with section 1886(e)(5)(B) of the Act, in this final rule, we are publishing our final recommendations for updating hospitals payments for FY 2006. In accordance with sections 1886(d)(3)(A) and 1886(b)(3)(B)(i)(XIX) of the Act, we are updating the standardized amount for FY 2006 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. 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).

Based on the Office of the Actuary's revised and rebased fourth quarter 2004 forecast of the FY 2006 market basket increase of 3.7 percent, the update to the standardized amounts for hospitals subject to the acute inpatient prospective payment system is 3.7 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, and 3.3 percent for hospitals that do not provide the required quality data. The update to the hospital specific rate applicable to SCHs and MDHs is also 3.7 percent. In the proposed rule, the most recent estimate of the market basket increase was 3.2 percent. Accordingly, we proposed an update factor of 3.2 percent for hospitals that submitted quality data and 2.8 percent for hospitals that did not provide the required quality data.

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, children's hospitals, and RNHCIs 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 final rule, we have used the estimated FY 2006 IPPS operating market basket percentage increase (3.7 percent) to

update the target limits for children's hospitals, cancer hospitals, and RNHCIs.

As described in greater detail below, under their respective PPSs, existing LTCHs and existing IPFs are/or will soon be 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 final rule, we are rebasing the market basket used to determine the reasonable cost-based payment amount for LTCHs and IPFs. We are providing 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 3.8 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).) An existing 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 will be determined by updating the LTCH's TEFRA limit by the current estimate of the FY 2002-based excluded hospital market basket (or 3.8 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, existing 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 will be determined by updating the IPF's TEFRA limit by the current estimate of the FY 2002-based excluded hospital market basket (or 3.8 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).)

II. Secretary's Final Recommendation for Updating the Prospective Payment System Standardized Amount

In recommending an update, the Secretary takes into account the factors in the update framework, as well as other factors, such as the recommendations of MedPAC, the long-term solvency of the Medicare Trust funds and the capacity of the hospital industry to continually provide access to high quality care to Medicare beneficiaries through adequate payment to health care providers.

In the proposed rule, we proposed to recommend an update of 3.2 percent, which reflected the CMS Office of the Actuary's most recent forecast of the FY 2006 market basket increase. We did not receive any public comments regarding this issue. In this final rule, we are recommending an update for IPPS hospitals based on the forecasted market basket increase. However, the Office of the Actuary's most recent (second quarter) 2005 forecast of the FY 2006 market basket increase is 3.7 percent. Thus, the Secretary's final recommendation for the update to the IPPS standardized amount for all hospitals is 3.7 percentage points for hospitals that provide the required quality data. The update to the hospital-specific rate applicable to SCHs and MDHs is also 3.7 percent (or consistent with current law, the market basket percentage increase).

III. Secretary's Final Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals and Hospital Units

We did not receive any comments concerning our proposed recommendations for updating the rate-of-increase for FY 2006 for cancer hospitals, RNHCIs, and children's hospitals. Our final recommendation does not differ from the proposed recommendation. However, the fourth quarter forecast of the market basket percentage increase is 3.7 for these excluded hospitals and hospital units (up from 3.2 percent estimated in the proposed rule). Thus, the Secretary's final recommendation is that the update to the target limits for cancer hospitals, RNHCIs, and children's hospitals is 3.7 percent.

Further, we did not receive any comments concerning our proposed recommendations for the update factor for LTCHs for 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 a final update factor of 3.8 percent (up from the estimated 3.4 percent in the proposed rule) for the portion of the payment that is based on reasonable costs, subject to the TEFRA limits, consistent with our determination in section IV. of the preamble of this final rule. For the Federal portion of this same blended payment amount, we are recommending a final update of 3.4 percent (up from the estimated 3.1 percent in the proposed rule and consistent with determination in the FY 2006 LTGH PPS final rule (70 FR 24180)).

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 a final update of zero for IPFs (69 FR 66922). Finally, for the IRF PPS, we proposed an update of 3.1 percent in the FY 2006 IPPS proposed rule. In the FY 2006 IRF PPS proposed rule (70 FR 24180), which was published after the issuance of the FY 2006 IPPS proposed rule, we proposed an update for the IRF PPS payments of 3.1 percent. Accordingly, we are finalizing our recommendation of an update of 3.1 percent for IRF PPS.

IV. Secretary's Final Recommendation for Updating the Capital Prospective Payment Amounts

Because the operating and capital prospective payment systems remain separate, we are continuing to use separate updates for operating and capital payments. The final update to the capital payment rates is discussed in section III. of the Addendum to this final rule.

[FR Doc. 05–15406 Filed 8–1–05; 4:16 pm]

BILLING CODE 4120–01–P