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42 CFR Parts 412 and 413

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412 and 413

[CMS–1470–P]

RIN 0938–AL89

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

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

ACTION: Proposed rule.

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

Among other changes that we are proposing are changes to the policies governing postacute care transfers, payments to hospitals for the direct and indirect costs of graduate medical education, determination of hospital beds and patient days for payment adjustment purposes, and payments to critical access hospitals (CAHs).

DATES: Comments will be considered if received at the appropriate address, as provided below, no later than 5 p.m. on July 18, 2003.

ADDRESSES: Mail written comments (an original and three copies) to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1470–P, P.O. Box 8010, Baltimore, MD 21244–1850.

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

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or

Room C5–14–03, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code CMS–1470–P.

For information on viewing public comments see the beginning of the **SUPPLEMENTARY INFORMATION** section.

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

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Security and Standards Group, Office of Regulations Development and Issuances, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. Attn: Julie Brown, CMS–1470–P; and

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

FOR FURTHER INFORMATION CONTACT:

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

Tzvi Hefter, (410) 786–4487, Capital Prospective Payment, Excluded Hospitals, Nursing and Allied Health Education, Graduate Medical Education, and Critical Access Hospital Issues.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room C5–12–08 of the Centers for Medicare & Medicaid Services, 7500 Security Blvd., Baltimore, MD, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. Please call (410) 786–7197 to schedule an appointment to view public comments.

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Table of Contents

I. Background
A. Summary
B. Major Contents of This Proposed Rule

II. Proposed Changes to DRG Classifications and Relative Weights

A. Background
B. DRG Reclassification
1. General
2. Review of DRGs for CC Split
3. MDC 1 (Diseases and Disorders of the Nervous System)
a. Revisions of DRGs 1 and 2
b. DRG 23 (Nontraumatic Stupor and Coma)
4. MDC 5 (Diseases and Disorders of the Circulatory System)
a. DRG 478 (Other Vascular Procedures With CC) and DRG 479 (Other Vascular Procedures Without CC)
b. DRGs 514 (Cardiac Defibrillator Implant With Cardiac Catheterization) and 515

(Cardiac Defibrillator Implant Without Cardiac Catheterization)
5. MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue)
6. MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period)
a. Nonneonate Diagnoses
b. Heart Failure Codes for Newborns and Neonates
7. MDC 17 (Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms)
8. MDC 23 (Factors Influencing Health Status and Other Contracts with Health Services)
a. Implantable Devices
b. Malignancy Codes
9. Medicare Code Editor (MCE) Change
10. Surgical Hierarchies
11. Refinement of Complications and Comorbidities (CC)
12. 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 Codes to MDCs
13. Changes to the ICD–9–CM Coding System
14. Other Issues
a. Cochlear Implants
b. Burn Patients on Mechanical Ventilation
c. Multiple Level Spinal Fusion
d. Heart Assist System Implant
e. Drug-Eluting Stents
f. Artificial Anal Spincter
C. Recalibration of DRG Weights
D. Proposed LTC–DRG Reclassifications and Relative Weights for LTCHs for FY 2004
1. Background
2. Proposed Changes in the LTC–DRG Classifications
a. Background
b. Patient Classifications into DRGs
3. Development of the Proposed FY 2004 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 Proposed FY 2004 LTC–DRG Relative Weights
E. Add-On Payments for New Services and Technologies
1. Background
2. FY 2004 Status of Technology Approved for FY 2003 Add-On Payments: Drotrecogin Alfa (Activated)—Xigris®
3. FY 2004 Applicants for New Technology Add-On Payments
a. Bone Morphogenetic Proteins (BMPs) for Spinal Fusions
b. GLIADEL® Wafer
4. Review of the High-Cost Threshold
5. Technical Changes
III. Proposed Changes to the Hospital Wage Index
A. Background
B. Proposed FY 2004 Wage Index Update
C. FY 2004 Wage Index Proposals
1. Elimination of Wage Costs Associated with Rural Health Clinics and Federally Qualified Health Centers
2. Paid Hours
D. Verification of Wage Data from the Medicare Cost Reports
E. Computation of the Proposed FY 2004 Wage Index
F. Proposed Revisions to the Wage Index Based on Hospital Redesignation
1. General
2. Effects of Reclassification
G. Requests for Wage Data Corrections
H. Modification of the Process and Timetable for Updating the Wage Index
IV. Other Decisions and Proposed Changes to the IPPS for Operating Costs and GME Costs
A. Transfer Payment Policy
1. Transfers to Another Acute Care Hospital
2. Technical Correction
3. Expanding the Postacute Care Transfer Policy to Additional DRGs
B. Rural Referral Centers
1. Case-Mix Index
2. Discharges
C. Indirect Medical Education (IME) Adjustment and Disproportionate Share Hospital (DSH) Adjustment
1. Available Beds and Patient Days: Background
2. Unoccupied Beds
3. Nonacute Care Beds and Days
4. Observation Beds and Swing-Beds
5. Labor, Delivery, Recovery, and Postpartum Beds and Days
6. Days Associated with Demonstration Projects under Section 1115 of the Act
7. Dual-Eligible Patient Days
8. Medicare+Choice (M+C) Days
D. Medicare Geographic Classification Review Board (MGCRB) Reclassification Process
E. Costs of Approved Nursing and Allied Health Education Activities
1. Background
2. Continuing Education Issue for Nursing and Allied Health Education Activities
3. Programs Operated by Wholly Owned Subsidiary Educational Institutions of Hospitals
F. Payment for Direct Costs of Graduate Medical Education
1. Background
2. Prohibition Against Counting Residents Where Other Entities First Incur the Training Costs
3. Rural Track FTE Limitation for Purposes of Direct GME and IME for Urban Hospitals that Establish Separately Accredited Approved Medical Programs in a Rural Area
a. Change in the Amount of Rural Training Time Required for an Urban Hospital to Qualify for an Increase in the Rural Track FTE Limitation
b. Inclusion of Rural Track FTE Residents in the Rolling Average Calculation
4. Technical Changes Related to Affiliated Groups and Affiliated Agreements
G. Notification of Updates to the Reasonable Compensation Equivalent (RCE) Limits
1. Background
2. Publication of the Updated RCE Limits
V. PPS for Capital-Related Costs
VI. Proposed 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
B. Payment for Services Furnished at Hospitals-Within-Hospitals and Satellite Facilities
C. Clarification of Classification Requirements for LTCHs
D. Criteria for Payment on a Reasonable Cost Basis for Clinical Diagnostic Laboratory Services Performed by CAHs
E. Technical Changes
VII. MedPAC Recommendations
VIII. Other Required Information
A. Requests for Data from the Public
B. Collection of Information Requirements

Regulation Text

Addendum—Proposed Schedule of Standardized Amounts Effective with Discharges Occurring On or After October 1, 2003 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2003

Tables

Table 1A—National Adjusted Operating Standardized Amounts, Labor/Nonlabor
Table 1C—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1D—Capital Standard Federal Payment Rate
Table 2—Hospital Average Hourly Wage for Federal Fiscal Years 2002 (1998 Wage Data), 2003 (1999 Wage Data), and 2004 (2000 Wage Data) Wage Indexes and 3-Year Average of Hospital Average Hourly Wages
Table 3A—3-Year Average Hourly Wage for Urban Areas
Table 3B—3-Year Average Hourly Wage for Rural Areas
Table 4A—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas
Table 4B—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas
Table 4C—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified
Table 4F—Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF)
Table 4G—Pre-Reclassified Wage Index for Urban Areas
Table 4H—Pre-Reclassified Wage Index for Rural Areas
Table 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 2002 MedPAR Update December 2002 GROUPER V20.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2002 MedPAR Update December 2002 GROUPER V21.0
Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) March 2003
Table 8B—Statewide Average Capital Cost-to-Charge Ratios (Case Weighted) March 2003
Table 9—Hospital Reclassifications and Redesignations by Individual Hospital—FY 2004
Table 10—Mean and Standard Deviations by Diagnosis-Related Groups (DRGs)—FY 2004
Table 11—Proposed LTC–DRGs Relative Weights and Geometric and Five-Sixths of the Average Length of Stay—FY 2004
Appendix A—Regulatory Impact Analysis
Appendix B—Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

Acronyms

AHIMA American Health Information Management Association
AHA American Hospital Association
CAH Critical access hospital
CBSAs Core Based Statistical Areas
CC Complication or comorbidity
CMS Centers for Medicare & Medicaid Services
CMSA Consolidated Metropolitan Statistical Areas
COBRA Consolidated Omnibus Reconciliation Act of 1985, Pub. L. 99–272
CPI Consumer Price Index
CRNA Certified registered nurse anesthetist
DRG Diagnosis-related group
DSH Disproportionate share hospital
FDA Food and Drug Administration
FQHC Federally qualified health center
FTE Full-time eguivalent
FY Federal fiscal year
GME Graduate medical education
HIPC Health Information Policy Council
HIPAA Health Insurance Portability and Accountability Act, Pub. L. 104–191
HHA Home health agency
ICD–9–CM International Classification of Diseases, Ninth Revision, and Clinical Modification
ICD–10–PCS International Classification of Diseases Tenth Edition, and Procedure Coding System
IME Indirect medical education
IPPS Acute care hospital inpatient prospective payment system
IRF Inpatient Rehabilitation Facility
LDRP Labor, delivery room, and postpartum
LTC–DRG Long-term care diagnosis-related group
LTCH Long-term care hospital
MCE Medicare Code Editor
MDC Major diagnostic category
MDH Medicare-dependent small rural hospital
MedPAC Medicare Payment Advisory Commission
MedPAR Medicare Provider Analysis and Review File
MEI Medicare Economic Index
MGCRB Medicare Geographic Classification Review Board
MPFS Medicare Physician Fee Schedule
MSA Metropolitan Statistical Area
NECMA New England County Metropolitan Areas
NCHS National Center for Health Statistics
NCHVS National Committee on Health and Vital Statistics
O.R. Operating room
PPS Prospective payment system
PRA Per resident amount
ProPAC Prospective Payment Assessment Commission
PRRB Provider Reimbursement Review Board
RCE Reasonable compensation equivalent
RHC Rural health center
RRC Rural referral center
SCH Sole community hospital
SNF Skilled nursing facility
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248
UHDDS Uniform Hospital Discharge Data Set

I. Background

A. Summary

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

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

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

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

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

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

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

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

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services ''in accordance with a prospective payment

system established by the Secretary.'' The basic methodology for determining capital prospective payments is set forth in our regulations at 42 CFR 412.308 and 412.312. Under the capital PPS, payments are adjusted by the same DRG for the case as they are under the operating IPPS. Similar adjustments are also made for IME and DSH as under the operating IPPS. In addition, hospitals may receive an outlier payment for those cases that have unusually high costs.

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

2. Hospitals and Hospital Units Excluded From the IPPS

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

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

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

b. LTCHs. Under the authority of sections 123(a) and (c) of 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 fully Federal prospective rates during a 5-year period, beginning with cost reporting periods that start on or after October 1, 2002. For cost reporting periods beginning on or after October 1, 2006, LTCHs will be paid under the fully Federal prospective payment rate (the August 30, 2002 LTCH PPS final rule (67 FR 55954)). LTCHs may elect to be paid based on full PPS payments instead of a blended payment in any year during the 5-year transition period. The existing regulations governing payment under the LTCH PPS are located in 42 CFR part 412, subpart O.

c. Psychiatric Hospitals and Units. Sections 124(a) and (c) of Pub. L. 106–113 provide for the development of a per diem PPS for payment for inpatient hospital services furnished in psychiatric hospitals and units under the Medicare program, effective for cost reporting periods beginning on or after October 1, 2002. This system must include an adequate patient classification system that reflects the differences in patient resource use and costs among these hospitals and maintain budget neutrality. We are in the process of developing a proposed rule, to be followed by a final rule, to implement the PPS for psychiatric hospitals and units.

3. Critical Access Hospitals

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

4. Payments for Graduate Medical Education

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

B. Major Contents of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare IPPS for operating costs and for capital-related costs in FY 2004. We also are proposing changes relating to payments for GME costs, payments to CAHs, and payments to providers classified as psychiatric hospitals and units that continue to be excluded from the IPPS and paid on a reasonable cost basis. The proposed changes would be effective for discharges occurring on or after October 1, 2003.

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

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

As required by section 1886(d)(4)(C) of the Act, we adjust the DRG classifications and relative weights annually. Based on analyses of Medicare claims data, we are proposing to establish a number of new DRGs and make changes to the designation of diagnosis and procedure codes under other existing DRGs. Our proposed changes for FY 2004 are set forth in section II. of this preamble.

Among the proposed changes discussed are:

- Expanding the number of DRGs that are split on the basis of the presence or absence of complications or comorbidities (CCs). The DRGs we are proposing to split are: DRG 4 (Spinal Procedures), DRG 5 (Extracranial Vascular Procedures), DRG 231 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur) and DRG 400 (Lymphoma and Leukemia With Major O.R. Procedure).
- Creating two new DRGs to differentiate current DRG 514 (Cardiac Defibrillator Implant With Cardiac Catheterization) on the basis of whether the patient does or does not experience any of the following symptoms: acute myocardial infarction, heart failure, or shock.
- Changing the DRG assignments of certain congenital anomalies that currently result in patients being assigned to newborn DRGs even when the patient is actually an adult. We also are adding to the list of major problems in newborns that affect DRG assignment.
- Modifying DRG 492 (Chemotherapy With Acute Leukemia as Secondary Diagnosis) to include in this DRG cases receiving high-dose Interleukin-2 (IL–2)

chemotherapy for patients with advanced renal cell cancer and advanced melanoma.

We also are presenting our analysis of applicants for add-on payments for high-cost new medical technologies.

2. Proposed Changes to the Hospital Wage Index

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

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

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

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

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

4. PPS for Capital-Related Costs

In section V., of this preamble, we discuss the payment requirements for capital-related costs. We are not proposing any changes to the policies on payments to hospitals for capital-related costs.

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

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

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

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

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

7. Impact Analysis

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

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

As required by sections 1886(e)(4) and (e)(5) of the Act, Appendix B provides our recommendation of the appropriate percentage change for FY 2004 for the following:

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

9. Discussion of Medicare Payment Advisory Commission Recommendations

Under section 1805(b) of the Act, the Medicare Payment Advisory Commission (MedPAC) is required to submit a report to Congress, no later than March 1 of each year, that reviews and makes recommendations on Medicare payment policies. This annual report makes recommendations concerning hospital inpatient payment policies. In section VII., of this preamble, we discuss the MedPAC recommendations and any actions we are proposing to take with regard to them (when an action is recommended). For further information relating specifically to the MedPAC March 1 report or to obtain a copy of the report, contact MedPAC at (202) 653–7220 or visit MedPAC's Web site at: *http://www.medpac.gov.*

II. Proposed Changes to DRG Classifications and Relative Weights

A. Background

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

Congress recognized that it would be necessary to recalculate the DRG relative weights periodically to account for changes in resource consumption. Accordingly, section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. The proposed changes to the DRG classification system and the proposed recalibration of the DRG weights for discharges occurring on or after October 1, 2003 are discussed below.

B. DRG Reclassification

1. General

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

For FY 2003, cases are assigned to one of 510 DRGs in 25 major diagnostic categories (MDCs). Most MDCs are based on a particular organ system of the body. For example, MDC 6 is Diseases and Disorders of the Digestive System. This approach is used because the clinical care is generally organized in accordance with the organ system affected. However, some MDCs are not constructed on this basis because they involve multiple organ systems (for example, MDC 22 (Burns)). The table below lists the 25 MDCs.

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

In general, cases are assigned to an MDC based on the patient's principal diagnosis before assignment to a DRG. However, for FY 2003, there are eight DRGs to which cases are directly assigned on the basis of ICD–9-CM procedure codes. These are the DRGs for heart, liver, bone marrow, lung transplants, simultaneous pancreas/kidney, and pancreas transplants (DRGs 103, 480, 481, 495, 512, and 513, respectively) and the two DRGs for tracheostomies (DRGs 482 and 483). Cases are assigned to these DRGs before classification to an MDC.

Within most MDCs, cases are then divided into surgical DRGs 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 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, such as extracorporeal shock wave lithotripsy for patients with a principal diagnosis of urinary stones.

Patients' 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). These screens are designed to identify cases that require further review before classification into a DRG.

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

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

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 the use of particular data to be feasible, 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 data submitted. Generally, however, a significant sample of the data should be submitted by mid-October for consideration in conjunction with the next year's proposed rule, so that we can test the data and make a preliminary assessment as to the feasibility of using the data. Subsequently, a complete database should be submitted by early December for consideration in conjunction with the next year's proposed rule.

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

The changes we are proposing to the DRG classification system for FY 2004 GROUPER version 21.0 and to the methodology to recalibrate the DRG weights are set forth below. Unless otherwise noted, our DRG analysis is based on data from the December 2002 update of the FY 2002 MedPAR file, which contains hospital bills received

through December 31, 2002, for discharges in FY 2002.

2. Review of DRGs for CC Split

In an effort to improve the clinical and cost cohesiveness of the DRG classification system, we have evaluated whether additional DRGs should be split based on the presence or absence of a CC. There are currently 116 paired CC split DRGs. We last performed a systematic evaluation and considered changes to the DRGs to recognize the within-DRG cost differences based on the presence or absence of CCs in 1994 (May 27, 1994 IPPS proposed rule, 59 FR 27715). In 1994, we described a refined DRG system based on a list of secondary diagnoses that have a major effect on the resources used by hospitals in treating patients across DRGs. We analyzed how the presence of the secondary diagnosis affected resource use compared to other secondary diagnoses, and classified these secondary diagnoses as non-CC, CC, or major CC. After finalizing the classification of secondary diagnoses, we evaluated which collapsed DRGs should be split on the basis of the presence 8 of a major CC, other CC, or both.[1] However, this refined system was not implemented because we did not believe it would be prudent policy to make changes for which we could not predict the effect on the case-mix (the average DRG relative weight for all cases) and, thus, payments (60 FR 29209). We were concerned that we would be unable to fulfill the requirement of section 1886(d)(4)(C)(iii) of the Act that aggregate payments may not be affected by DRG reclassification and recalibration of weighting factors. That is, our experience has been that hospitals respond to major changes to the DRGs by changing their coding practices in ways that increase total payments (for example, by beginning to include ICM–9–CM codes that previously did not affect payment for a case). Because changes in coding behavior do not represent a real increase in the severity of the overall mix of cases, total payments should not increase. The only way to ensure this behavioral response does not lead to higher total payments is to make an offsetting adjustment to the system in advance of the fiscal year when the changes are effective.

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

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

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

The following four DRGs meet these criteria: DRG 4 (Spinal Procedures) and DRG 5 (Extracranial Vascular Procedures) in MDC 1 (Diseases and Disorders of the Nervous System); DRG 231 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur) in MDC 8 (Diseases and Disorders of the Musculoskeletal and Connective Tissue); and DRG 400 (Lymphoma and Leukemia with Major O.R. Procedure) in MDC 17 (Myeloproliferative Diseases and Disorders and Poorly Differentiated Neoplasms).

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

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

Therefore, we are proposing to establish the following new DRGs: proposed DRG 531 (Spinal Procedures With CC) and proposed DRG 532 (Spinal Procedures Without CC) in MDC 1; proposed DRG 533 (Extracranial Vascular Procedures With CC) and proposed DRG 534 (Extracranial Vascular Procedures Without CC) in

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

MDC 1; proposed DRG 537 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur With CC) and proposed DRG 538 (Local Excision and Removal of Internal Fixation Devices Except Hip and Femur Without CC) in MDC 8; and proposed DRG 539 (Lymphoma and Leukemia With Major O.R. Procedure With CC) and DRG 540 (Lymphoma and Leukemia With Major O.R. Procedure Without CC) in MDC 17. We are proposing that DRGs 4, 5, 231, and 400 would become invalid.

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

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

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

(1) Intracranial Vascular Procedures

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

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

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

Proposed new DRG 528 would have the following principal diagnoses:

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

And operating room procedures:

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

(2) Ventricular Shunt Procedures

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

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

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

Proposed new DRG 529 would consist of any principal diagnosis in MDC 5, with the presence of a CC and one of the following operating room procedures:

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

Proposed new DRG 530 would consist of any principal diagnosis in MDC 5 with one of the operating room procedures listed above for the proposed new DRG 529, but without the presence of a CC.

b. DRG 23 (Nontraumatic Stupor and Coma). In DRG 23 (Nontraumatic Stupor and Coma), there are currently six principal diagnoses identified by the following ICD–9-CM diagnosis codes: 348.4, Compression of the brain; 348.5, Cerebral edema; 780.01, Coma; 780.02, Transient alteration of awareness; 780.03, Persistent vegetative state; and 780.09, Other alteration of consciousness. Code 780.02 is often used to describe the diagnosis of psychiatric patients rather than the diagnosis of patients with severe

[2] We also examined the issue of treating brain tumors through the implantation of chemotherapy wafers. This analysis is discussed later in this preamble under section II.E.2.b. relative to the application for new technology add-on payments for the GLIADEL® Wafer.

neurological disorders. The treatment plan for a patient with ''transient alteration of awareness'' is clinically very different from the treatment plan for a coma patient. Furthermore, many patients with this diagnosis are treated in psychiatric facilities rather than in acute care hospitals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Specifically, we are proposing to create two new DRGs that would replace the current DRG 514. The two new DRGs would have the same procedures currently listed for DRG 514, but would be split based on the presence or absence of acute myocardial infarction, heart failure, or shock. The proposed new DRGs would be DRG 535 (Cardiac

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

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

(2) Cardiac Resynchronization Therapy (CRT)

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

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

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

When the CRT–D generator (code 00.54) and one of the cardioverter/defibrillator leads are replaced, the case currently is assigned to DRG 115 (Permanent Cardiac Pacemaker Implant with AMI, Heart Failure, or Shock or AICD Lead or Generator Procedure). The commenter recommended that we include the combination of codes 39.75 and 00.54 as a combination that would result in assignment to DRG 514 or DRG 515, as do other combinations of generators and leads. Our medical advisors agree with this recommendation. As discussed previously, we are proposing to delete DRG 514 and replace it with proposed new DRGs 535 and 536. Therefore, we are proposing to add codes 39.75 and 00.54 to the list of procedure combinations that would result in assignment to DRG 515 or new proposed DRGs 535 and 536.

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

We received a comment that two codes for cervical fusion of the spine are not included within DRG 519 (Cervical Spinal Fusion With CC) and DRG 520 (Cervical Spinal Fusion Without CC). The two cervical fusion codes are:

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

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

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

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

We have received a recommendation to move the following congenital anomaly codes from MDC 15 and reassign them to other appropriate MDCs based on the body system being treated:

- 758.9, Chromosome anomaly, not otherwise specified
- 759.4, Conjoined twins
- 759.7, Multiple congenital anomalies, not elsewhere classified
- 759.81, Prader-Willi syndrome
- 759.83, Fragile X syndrome
- 759.89, Specified congenital anomalies, not elsewhere classified
- 759.9, Congenital anomaly, not otherwise specified

- 779.7, Periventricular leukomalacia
- 795.2, Abnormal chromosomal analysis

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

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

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

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

We have received correspondence suggesting that the following diagnosis codes for heart failure, which are currently in MDC 5, be added to the list of major problems for neonates under MDC 15.

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

These heart failure-related diagnosis codes were new codes as of October 1, 2002. They were an expansion of the previous 4-digit codes for heart failure and provided additional detail about the specific type of heart failure. The other codes for heart failure that existed prior to October 1, 2002, are classified as major problems within MDC 15 and are currently assigned to DRGs 387 and DRG 389.

We agree that diagnosis codes 428.20 through 428.43 listed in the chart above should be included as principal diagnosis of major problem codes within MDC 15 and, therefore, are proposing to add them to DRG 387 and 389.

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

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

High-dose IL–2 therapy is performed only in very specialized treatment settings, such as an intensive care unit or a bone marrow transplant unit. This therapy requires oversight by oncology health care professionals experienced in the administration and management of patients undergoing this intensive treatment because of the severity of the side effects. Unlike most cancer

therapies, high-dose IL–2 therapy is associated with predictable toxicities that require extensive monitoring. Often patients require one-on-one nursing or physician care for extended portions of their stay.

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

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

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

According to industry sources, the wholesale cost of IL–2 is approximately $700 per vial. Dosages range between 15 and 20 vials per treatment, or between $10,500 and $14,000 per patient, per cycle, for the cost of the IL–2 drug alone. There is no ICD–9–CM procedure code that currently identifies patients receiving this therapy. Therefore, it is not possible to identify directly these cases in the MedPAR data. Currently, this therapy is coded using the more general ICD–9–CM code 99.28 (Injection or infusion of biologic response modifier). When we addressed this issue previously in the August 1, 2000 IPPS final rule (65 FR 47067) by examining cases for which procedure code 99.28 was present, our analysis was inconclusive due to the wide range of cases identified (1,179 cases across in 136 DRGs). However, recent data collected by the industry on 30 Medicare beneficiaries who received high-dose IL–2 therapy during FY 2002 show average charges for these cases of approximately $54,000.

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

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

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

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

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

- And one of the following secondary diagnoses:

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

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

We will monitor cases with procedure code 00.15 as these data become available, and consider potential further refinements to DRG 492 as necessary.

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

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

Currently, if these diagnosis codes are reported alone without an O.R. procedure, the case would be assigned to DRG 467 (Other Factors Influencing Health Status). However, if an O.R. procedure is reported with the principal

diagnosis of V53.01, V53.02, or V53.09, the case would be assigned to DRG 461 (O.R. Procedure with Diagnoses of Other Contact with Health Services).

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

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

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

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

We agree that code V10.48 should have been included in the list of history of malignancy codes within DRG 465 and, therefore, are proposing to add it to the list of secondary diagnoses in DRG 465.

9. Medicare Code Editor (MCE) Change

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

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

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

10. Surgical Hierarchies

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

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

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

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

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

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

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

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

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

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

11. Refinement of Complications and Comorbidities (CC) List

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

In the May 19, 1987 proposed notice (52 FR 18877) concerning changes to the DRG classification system, we explained that the excluded secondary diagnoses were established using the following five principles:

- Chronic and acute manifestations of the same condition should not be considered CCs for one another (as subsequently corrected in the September 1, 1987 final notice (52 FR 33154)).
- Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for 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. The FY 1988 revisions were intended only as a first step toward refinement of the CC list in that the criteria used for eliminating certain diagnoses from consideration as CCs were intended to identify only the most obvious diagnoses that should not be considered CCs of another diagnosis. For that reason, and in light of comments and questions on the CC list, we have continued to review the remaining CCs to identify additional exclusions and to remove diagnoses from the master list that have been shown not to meet the definition of a CC. (See the September 30, 1988 final rule (53 FR 38485) for the revision made for the discharges occurring in FY 1989; the September 1, 1989 final rule (54 FR

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

We are proposing a limited revision of the CC Exclusions List to take into account the proposed changes that will be made in the ICD–9–CM diagnosis coding system effective October 1, 2003. (See section II.B.13. of this preamble for a discussion of ICD–9–CM changes.) These proposed changes are being made in accordance with the principles established when we created the CC Exclusions List in 1987.

Tables 6G and 6H in the Addendum to this proposed rule contain the revisions to the CC Exclusions List that would be effective for discharges occurring on or after October 1, 2003. Each table shows the principal diagnoses with changes to the excluded CCs. Each of these principal diagnoses is shown with an asterisk, and the additions or deletions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

CCs that are added to the list are in Table 6G—Additions to the CC Exclusions List. Beginning with discharges on or after October 1, 2003, the indented diagnoses would not be recognized by the GROUPER as valid CCs for the asterisked principal diagnosis.

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

Copies of the original CC Exclusions List applicable to FY 1988 can be obtained from the National Technical Information Service (NTIS) of the Department of Commerce. It is available in hard copy for $133.00 plus shipping and handling. A request for the FY 1988 CC Exclusions List (which should include the identification accession number (PB) 88–133970) should be made to the following address: National Technical Information Service, United States Department of Commerce, 5285 Port Royal Road, Springfield, VA 2216l; or by calling (800) 553–6847.

Users should be aware of the fact that all revisions to the CC Exclusions List (FYs 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2002, and 2003) and those in Tables 6G and 6H of the final rule for FY 2004 must be incorporated into the list purchased from NTIS in order to obtain the CC Exclusions List applicable for discharges occurring on or after October 1, 2003. (Note: There was no CC Exclusions List in FY 2001 because we did not make changes to the ICD–9-CM codes for FY 2001.)

Alternatively, the complete documentation of the GROUPER logic, including the current CC Exclusions List, is available from 3M/Health Information Systems (HIS), which, under contract with CMS, is responsible for updating and maintaining the GROUPER program. The current DRG Definitions Manual, Version 20.0, is available for $225.00, which includes $15.00 for shipping and handling. Version 21.0 of this manual, which includes the final FY 2003 DRG changes, is available for $225.00. These manuals may be obtained by writing 3M/HIS at the following address: 100 Barnes Road, Wallingford, CT 06492; or by calling (203) 949–0303. Please specify the revision or revisions requested.

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

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

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

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

All remaining O.R. procedures are assigned to DRGs 468 and 477, with DRG 477 assigned to those discharges in which the only procedures performed are nonextensive procedures that are unrelated to the principal diagnosis. The original list of the ICD–9–CM procedure codes for the procedures we consider nonextensive procedures, if performed with an unrelated principal diagnosis, was published in Table 6C in section IV. of the Addendum to the September 30, 1988 final rule (53 FR 38591). As part of the final rules published on September 4, 1990 (55 FR 36135), August 30, 1991 (56 FR 43212), September 1, 1992 (57 FR 23625), September 1, 1993 (58 FR 46279), September 1, 1994 (59 FR 45336), September 1, 1995 (60 FR 45783), August 30, 1996 (61 FR 46173), and August 29, 1997 (62 FR 45981), we moved several other procedures from DRG 468 to 477, and some procedures from DRG 477 to 468. No procedures were moved in FY 1999, as noted in the July 31, 1998 final rule (63 FR 40962); in FY 2000, as noted in the July 30, 1999 final rule (64 FR 41496); in FY 2001, as noted in the August 1, 2000 final rule (65 FR 47064); or in FY 2002, as noted in the August 1, 2001 final rule (66 FR 39852).

In the August 1, 2002 final rule (67 FR 49999), we did not move any procedures from DRG 477. However, we did move procedures codes from DRG 468 and placed them in more clinically coherent DRGs.

a. Moving Procedure Codes from DRG 468 or DRG 477 to MDCs. We annually conduct a review of procedures

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

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

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

b. Reassignment of Procedures among DRGs 468, 476, and 477. We also annually review the list of ICD–9–CM procedures that, when in combination with their principal diagnosis code, result in assignment to DRGs 468, 476, and 477, to ascertain if any of those procedures should be reassigned from one of these DRGs to another of these DRGs based on average charges and 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 moving cases to keep the DRGs clinically similar or to provide payment for the cases in a similar manner. Generally, we move only those procedures for which we have an adequate number of discharges to analyze the data. Based on our review this year, we are not proposing to move any procedures from DRG 468 to DRGs 476 or 477, from DRG 476 to DRGs 468 or 477, or from DRG 477 to DRGs 468 or 476.

c. Adding Diagnosis or Procedure Codes to MDCs. Based on our review this year, we are not proposing to add any diagnosis codes to MDCs.

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

- 38.21, Biopsy of blood vessel
- 77.42, Biopsy of scapula, clavicle and thorax [ribs and sternum]
- 77.43, Biopsy of radius and ulna
- 77.44, Biopsy of carpals and metacarpals
- 77.45, Biopsy of femur
- 77.46, Biopsy of patella
- 77.47, Biopsy of tibia and fibula
- 77.48, Biopsy of tarsals and metatarsals
- 77.49, Biopsy of other bones
- 92.27, Implantation or insertion of radioactive elements

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

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

The ICD–9–CM Manual contains the list of valid diagnosis and procedure codes. (The ICD–9–CM Manual is available from the Government Printing Office on CD–ROM for $23.00 by calling (202) 512–1800.) The NCHS has lead responsibility for the ICD–9–CM diagnosis codes included in the *Tabular List* and *Alphabetic Index for Diseases,* while CMS has lead responsibility for the ICD–9–CM procedure codes included in the *Tabular List* and *Alphabetic Index for Procedures.*

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

The Committee presented proposals for coding changes for implementation in FY 2004 at a public meeting held on December 6, 2002, and finalized the coding changes after consideration of comments received at the meetings and in writing by January 10, 2003. Those coding changes are announced later in this section of the preamble. Copies of the Committee procedure minutes of the 2002 meetings can be obtained from the CMS home page at: *http://www.cms.gov/paymentsystems/icd9/.* The diagnosis minutes are found at: *http://www.cdc.gov/nchs/icd9.htm.* Paper copies of these minutes are no longer available and the mailing list has been discontinued.

The first of the 2003 public meetings was held on April 3, 2003. In the September 7, 2001 final rule implementing the IPPS new technology add-on payments (66 FR 46906), we indicated we would attempt to include all proposals discussed and approved at the April meeting as part of the code revisions effective the following October. Because this proposed rule is being published after the April meeting, we are able to include all new codes that were approved subsequent to that meeting in Table 6F of the Addendum to this proposed rule, including the DRG assignments.

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

We encourage commenters to address suggestions on coding issues involving diagnosis codes to: Donna Pickett, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; NCHS; Room 2404, 3311 Toledo Road, Hyattsville, MD 20782. Comments may be sent by E-mail to: *dfp4@cdc.gov.*

Questions and comments concerning the procedure codes should be addressed to: Patricia E. Brooks, Co-Chairperson; ICD–9–CM Coordination and Maintenance Committee; CMS, Center for Medicare Mangement, 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: *pbrooks@cms.hhs.gov.*

The ICD–9–CM code changes that have been approved will become effective October 1, 2003. The new ICD–9–CM codes are listed, along with their DRG classifications, in Tables 6A and 6B (New Diagnosis Codes and New Procedure Codes, respectively) in the Addendum to this proposed rule. As we stated above, the code numbers and their titles were presented for public comment at the ICD–9–CM Coordination and Maintenance Committee meetings. Both oral and written comments were considered before the codes were approved. In this proposed rule, we are only soliciting comments on the proposed DRG classification of these new codes.

For codes that have been replaced by new or expanded codes, the corresponding new or expanded diagnosis codes are included in Table 6A. New procedure codes are shown in Table 6B. Diagnosis codes that have been replaced by expanded codes or other codes or have been deleted are in Table 6C (Invalid Diagnosis Codes). These invalid diagnosis codes will not be recognized by the GROUPER beginning with discharges occurring on or after October 1, 2003. Table 6D contains invalid procedure codes. Revisions to diagnosis code titles are in Table 6E (Revised Diagnosis Code Titles), which also includes the DRG assignments for these revised codes. Table 6F includes a revised procedure code title for FY 2003.

The Department of Health and Human Services has been actively working on the development of new coding systems to replace the ICD–9–CM. For example, the ICD–10–CM (for diagnoses) and the ICD–10–PCS (for procedures) were developed to replace ICD–9–CM. These efforts have become increasingly important because of the many problems with the ICD–9–CM, which was implemented 24 years ago.

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

14. Other Issues

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

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

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

In our analysis of the FY 2002 MedPAR file, we found 134 cochlear implant cases out of 1,637 cases assigned to DRG 49, which represent more than 8 percent of the total cases in DRG 49. Compared to the situation with the heart assist system implant cases in DRGs 104 and 105, cochlear implants do have a greater effect on the relative weight for DRG 49. Also, while average charges for cochlear implant cases are significantly more than other cases in DRG 49 (average charges for cochlear implant cases were $51,549 compared to $25,052 for noncochlear implant cases), this difference is much less than the $36,000 and $85,000 differences for heart assist systems cited above.

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

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

Accordingly, for the reasons cited above, we are not proposing to change the DRG assignment of cochlear implants at this time. However, we encourage public comments as to whether a new DRG for cochlear implants (or some other solution) is warranted.

b. Burn Patients on Mechanical Ventilation. Concerns have been raised by hospitals treating burn patients that the current DRG payment for burn patients on mechanical ventilation is not adequate. The DRG assignment for these cases depends on whether the hospital performed the tracheostomy, or the tracheostomy was performed prior to transfer to the hospital. If the hospital does not actually perform the tracheostomy, the case is assigned to

one of the burn DRGs in MDC 22 (Burns). If the hospital performs a tracheostomy, the case is assigned to DRG 482 (Tracheostomy for Face, Mouth, and Neck Diagnoses) or DRG 483 (Tracheostomy with Mechanical Ventilation 96 + Hours, Except Face, Mouth and Neck Diagnoses).

In the August 1, 2002 final rule, we modified DRGs 482 and 483 to recognize code 96.72 (Continuous mechanical ventilation for 96 consecutive hours or more) for the first time in the DRG assignment (67 FR 49996). We noted that many patients assigned to DRG 483 did not have code 96.72 recorded. We believed this was due, in part, to the limited number of procedure codes (six) that can be submitted on the current billing form, and the fact that code 96.72 did not affect the DRG assignment (prior to FY 2003). We stated that we would give future consideration to further modifying DRGs 482 and 483 based on the presence of code 96.72. We anticipate that cases of patients receiving 96 or more hours of continuous mechanical ventilation are more expensive than other tracheostomy patients. Once code 96.72 is reported more frequently, we will be better able to assess the need for future revisions to DRGs 482 and 483.

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

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

c. Multiple Level Spinal Fusion. We received a comment recommending the establishment of new DRGs that would differentiate between the number of levels of vertebrae involved in a spinal fusion procedure. The commenter noted that the ICD–9–CM Coordination and Maintenance Committee discussed adding a new series of codes to identify multiple levels of spinal fusions at its December 6, 2002 meeting.

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

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

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

The analysis found that increasing the levels fused from 1 to 2 levels to 3 or more levels increased the mean standardized charges by 38 percent for lumbar/thoracic fusions, and by 47 percent for cervical fusions. The commenter then recommended redefining the spinal fusion DRGs to differentiate between 1 to 2 level spinal fusions and multilevel spinal fusions.

The following current spinal fusion DRGs separate cases based on whether or not a CC is present: DRG 497 (Spinal Fusion Except Cervical With CC) and DRG 498 (Spinal Fusion Except Cervical Without CC); and DRG 519 (Cervical Spinal Fusion With CC) and DRG 520 (Cervical Spinal Fusion Without CC). The difference in charges associated with the current CC-split is only slightly greater than the difference attributable to the number of levels fused as found by the commenter's analysis. Therefore, at this time, we are not proposing to redefine these DRGs to differentiate on the basis of the number of levels fused.

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

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

When we reviewed the FY 2002 MedPAR data, we identified only 21 cases in DRG 103 that listed a procedure code that would indicate the use of an LVAD. We do not believe this is a sufficient number of cases to support creation of an additional DRG. Therefore, we are not proposing a change to the structure of either DRG 103 or DRG 525 at this time.

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

In the absence of MedPAR data reflecting the use of drug-eluting stents, it was necessary to undertake several calculations to establish the FY 2003 DRG relative weights for these two new DRGs. First, based on prices where drug-eluting stents are currently being used and the average price of currently available stents, we calculated a price differential of approximately $1,200. Assuming average hospital charge markups for this technology (based on weighted average cost-to-charge ratios), the anticipated charge differential

between nondrug-eluting and drug-eluting stents would be approximately $2,664 per stent. However, we recognize that some cases involve more than one stent. Using an average of 1.5 stents per procedure, we estimate that the net incremental charge for cases that would receive drug-eluting stents is $3,996.

In order to determine accurately the DRG relative weights for these two new DRGs relative to all other DRGs, we also must estimate the volume of cases likely to occur. We used the manufacturer's estimate that as many as 43 percent of current stent patients will receive drug-eluting stents during FY 2003 to calculate the FY 2003 DRG relative weights, although we prorated this percentage since the new DRGs did not become active until April 1, 2003. Even though the DRG will become active on April 1, 2003, we expect that hospitals did not use this technology before FDA approval. (We intend to identify and review any cases with the code 36.07 that occurred prior to FDA approval.) Therefore, no payments are expected to have been made under these DRGs for cases occurring before FDA approval.

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

We are proposing to maintain DRGs 526 and 527 for FY 2004, and to adopt the same methodology to establish the relative weights as we used for FY 2003. The FDA issued a decision on April 24, 2003 approving drug-eluting stents. For the final rule, we will use the best available data at that time to establish the FY 2004 relative weights for DRGs 526 and 527.

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

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

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

C. Recalibration of DRG Weights

We are proposing to use the same basic methodology for the FY 2004 recalibration as we did for FY 2003 (August 1, 2002 IPPS final rule (67 FR 50008). That is, we are proposing to recalibrate the DRG weights based on charge data for Medicare discharges using the most current charge information available (the FY 2002 MedPAR file).

The MedPAR file is based on fully coded diagnostic and procedure data for all Medicare inpatient hospital bills. FY 2002 MedPAR data include discharges occurring between October 1, 2001 and September 30, 2002, based on bills received by CMS through December 31, 2002, from all hospitals subject to the IPPS and short-term acute care hospitals in Maryland (which is under a waiver from the IPPS under section 1814(b)(3) of the Act). The FY 2002 MedPAR file includes data for approximately 11,404,829 Medicare discharges. Discharges for Medicare beneficiaries enrolled in a Medicare+Choice managed care plan are excluded from this analysis. The data include hospitals that subsequently became CAHs, although no data are included for hospitals after the point they are certified as CAHs.

The proposed methodology used to calculate the DRG relative weights from the FY 2002 MedPAR file is as follows:

- To the extent possible, all the claims were regrouped using the DRG classification revisions discussed in section II.B. of this preamble.
- 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, transfer cases paid 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 transplant cases that were used to establish the relative weight for heart and heart-lung, liver, and lung transplants (DRGs 103, 480, and 495) were limited to those Medicare-approved transplant centers that have cases in the FY 2000 MedPAR file. (Medicare coverage for heart, heart-lung, liver, and lung transplants is limited to

those facilities that have received approval from CMS as transplant centers.)

• Organ acquisition costs for kidney, heart, heart-lung, liver, lung, pancreas, and intestinal (or multivisceral organs) transplants continue to be paid on a reasonable cost basis. Because these acquisition costs are paid separately from the prospective payment rate, it is necessary to subtract the acquisition charges from the total charges on each transplant bill that showed acquisition charges before computing the average charge for the DRG and before eliminating statistical outliers.

When we recalibrated the DRG weights for previous years, we set a threshold of 10 cases as the minimum number of cases required to compute a reasonable weight. We used that same case threshold in recalibrating the proposed DRG weights for FY 2004. Using the FY 2002 MedPAR data set, there are 42 DRGs that contain fewer than 10 cases. We computed the weights for these low-volume DRGs by adjusting the proposed FY 2003 weights of these DRGs by the percentage change in the average weight of the cases in the other DRGs.

The proposed new weights are normalized by an adjustment factor (1.45510) so that the average case weight after recalibration is equal to the average case weight before recalibration. This adjustment is intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS.

As noted below in section IV.A.2., we are proposing to expand the transfer policy applicable to postacute care transfers from 10 DRGs currently to an additional 19 DRGs, beginning in FY 2004. Because we count a transfer case as a fraction of a case as described above in the recalibration process, any expansion of the postacute care transfer policy to 19 additional DRGs would affect the proposed relative weights for those DRGs. Therefore, we calculated the proposed FY 2004 normalization factor comparing the case-mix using the proposed FY 2004 DRG relative weights in which we treated postacute care transfer cases in the 19 DRGs proposed to be added to the postacute transfer policy for FY 2004 as a fraction of a case with the case-mix using the FY 2003 DRG relative weights without treating cases in these 19 additional DRGs as transfer cases.

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

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

1. Background

In the March 7, 2003 LTCH PPS proposed rule (68 FR 11234), we proposed to change the LTCH PPS annual payment rate update cycle to be effective July 1 through June 30 instead of October 1 through September 30. In addition, since the patient classification system utilized under the LTCH PPS is based directly on the DRGs used under the IPPS for acute care hospitals, in that same proposed rule, we proposed that the annual update of the long-term care diagnosis-related group (LTC–DRG) classifications and relative weights would continue to remain linked to the annual reclassification and recalibration of the CMS–DRGs under the IPPS.

The annual update to the IPPS DRGs is based on the annual revisions to the ICD–9–CM codes and is effective each October 1. In the health care industry, annual changes to the ICD–9–CM codes are effective for discharges occurring on or after October 1 each year. The use of the ICD–9–CM coding system is also compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), Pub. L. 104–191, under 45 CFR Parts 160 and 162. Therefore, the manual and electronic versions of the GROUPER software, which are based on the ICD–9–CM codes, are also revised annually and effective for discharges occurring on or after October 1 each year. Because the LTC–DRGs are based on the patient classification system used under the IPPS (CMS–DRGs), which is updated annually and effective for discharges occurring on or after October 1 through September 30 each year, in the March 7, 2003 LTCH PPS proposed rule (68 FR 11234), we proposed to 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.

As we explained in the March 7, 2003 LTCH PPS proposed rule (68 FR 11234), the FY 2004 DRGs and relative weights used under the IPPS had not yet been proposed, and we were unable to propose updated LTC–DRGs and relative weights at that time. Therefore, since the LTC–DRG classifications and relative weights would continue to be based on the annual updates to the IPPS DRGs, we proposed that proposed revisions to the LTC–DRG classifications and relative weights would be presented for public comment in the IPPS proposed rule and finalized in the IPPS final rule, to be effective October 1, 2003 through September 30, 2004.

For FY 2003, version 20.0 of the DRG GROUPER is being utilized under both the IPPS and the LTCH PPS. The LTC–DRG classifications and relative weights are shown in Table 3 of the Addendum to the August 30, 2002 for FY 2003 final rule (67 FR 56076–56084) and in Table 3 of the Addendum to the March 7, 2003 LTCH PPS proposed rule (68 FR 11285 through 11292). Below we discuss the proposed LTC–DRGs and relative weights for FY 2004 based on the proposed changes to the hospital IPPS DRGs (GROUPER version 21.0) discussed in section II. of this preamble.

2. Proposed Changes in the LTC–DRG Classifications

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

In accordance with section 307(b)(1) of Pub. L. 106–554 and § 412.515 of our existing regulations, the LTCH PPS uses information from LTCH patient records to classify patient cases into distinct LTC–DRGs based on clinical characteristics and expected resource needs. The LTC–DRGs used as the patient classification component of the LTCH PPS correspond to the DRGs

under the IPPS for acute care hospitals. Thus, in this proposed rule, we are proposing to use the proposed IPPS version 21.0 GROUPER for FY 2004 to process LTCH PPS claims. The proposed changes to the IPPS DRG classification system for FY 2004 (Grouper 21.0) are discussed in section II.B. of this preamble.

Under the LTCH PPS, we determine relative weights for each of the IPPS DRGs to account for the difference in resource use by patients exhibiting the case complexity and multiple medical problems characteristic of LTCHs. In a departure from the IPPS, as we discussed in the August 30, 2002 final rule (67 FR 55985), we use low volume LTC–DRGs (less than 25 LTCH cases) in determining the LTC–DRG weights, since LTCHs do not typically treat the full range of diagnoses as do acute care hospitals. In order to deal with the large number of low volume LTC–DRGs (DRGs with fewer than 25 cases), we group those low volume LTC–DRGs into 5 quintiles based on average charge per discharge. (A listing of the composition of low volume quintiles for the FY 2003 LTC–DRGs (based on FY 2001 MedPAR data) appears in the August 30, 2002 final rule at 67 FR 55986–55988). We also adjusted for cases in which the stay at the LTCH is five-sixths of the geometric average length of stay; that is, short-stay outlier cases (§ 412.529). (A detailed discussion of the application of the Lewin Group model that was used to develop the LTC–DRGs appears in the August 30, 2002 final rule at 67 FR 55978).

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

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

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

As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55981), the emphasis on the need for proper coding cannot be overstated. Inappropriate coding of cases can adversely affect the uniformity of cases in each LTC–DRG and produce inappropriate weighting factors at recalibration and result in inappropriate payments under the LTCH PPS. LTCHs are to follow the same coding guidelines used by the acute care hospitals to ensure accuracy and consistency in coding practices. There will be only one LTC–DRG assigned per long-term care hospitalization; it will be assigned at the discharge. Therefore, it is mandatory that the coders continue to report the same principal diagnosis on all claims and include all diagnostic codes that coexist at the time of admission, that are subsequently developed, or that affect the treatment received. Similarly, all procedures performed during that stay are to be reported on each claim. (For further information on the use of ICD–9–CM codes under the LTCH PPS, see the August 30, 2002 LTCH PPS final rule (67 FR 55979–55983).)

Upon the discharge of the patient from a LTCH, the LTCH must assign appropriate diagnosis and procedure codes from the ICD–9–CM. As of October 16, 2002, a LTCH that was required to comply with the HIPAA Administrative Simplification Standards and that had not obtained an extension in compliance with the Administrative Compliance Act (Pub. L. 107–105) is obligated to comply with the standards at 45 CFR 162.1002 and 45 CFR 162.1102. Completed claim forms are to be submitted to the LTCH's Medicare fiscal intermediary.

Medicare fiscal intermediaries enter the clinical and demographic information into their claims processing systems and subject this information to a series of automated screening processes called the Medicare Code Editor (MCE). These screens are designed to identify cases that require further review before assignment into a DRG can be made. (For more information on types of cases selected for further development, see the August 30, 2002 LTCH PPS final rule (67 FR 55979).)

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

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

3. Development of the Proposed FY 2004 LTC–DRG Relative Weights

a. General Overview of Development of the LTC–DRG Relative Weights. As we stated in the August 30, 2002 LTCH PPS final rule (67 FR 55984), one of the primary goals for the implementation of the LTCH IPPS is to pay each LTCH an appropriate amount for the efficient delivery of care to Medicare patients.

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

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

b. Data. To calculate the proposed LTC–DRG relative weights for FY 2004 in this proposed rule, we obtained total Medicare allowable charges from FY 2002 Medicare hospital bill data from the December 2002 update of the MedPAR file, and we used the proposed Version 21.0 of the CMS GROUPER used under the acute care hospital inpatient IPPS as discussed above in section II.B. of this preamble. Consistent with the methodology under the hospital IPPS, we are proposing to recalculate the FY 2004 LTC–DRG relative weights based on the best available data for the final rule.

As we discussed in further detail in the August 30, 2002 LTCH PPS final rule (67 FR 55984), based on comments regarding the data used in the development of the LTCH prospective payment system, we have excluded the data from LTCHs that are all-inclusive rate providers and LTCHs that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Public Law 92–603 (42 U.S.C. 1395b–1). Therefore, in the development of the proposed FY 2004 LTC–DRG relative weights we have excluded the data of the 22 all-inclusive rate providers and the 3 LTCHs that are paid in accordance with demonstration projects.

In addition, as we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55989), a data problem regarding the proposed FY 2003 LTC–DRG relative weight values that were determined using MedPAR (claims) data for FYs 2000 and 2001 was brought to our attention. Following notification of this problem, we researched the commenter's claims and determined that, given the long stays at LTCHs, some providers had submitted multiple bills for payment under the TEFRA reimbursement system for the same stay. Based upon our research, we became aware of the following situation: In certain LTCHs, hospital personnel apparently reported a different principal diagnosis on each bill since, under the TEFRA system, payment was not dependent upon principal diagnosis as it is under a DRG-based system. These claims from the MedPAR file were run through the LTCH GROUPER and used in determining the proposed FY 2003 relative weights for each LTC–DRG.

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

As we noted above, we are proposing to use LTCH claims data from the FY 2002 MedPAR file for the determination of the proposed FY 2004 LTC–DRG relative weights. Since at the time (FY 2002) LTCHs were still reimbursed under the TEFRA reasonable cost-based system, some LTCHs also had submitted multiple bills for Medicare payment for the same stay. Thus, in certain LTCHs, hospital personnel were apparently still reporting a different principal diagnosis on each bill since, under the TEFRA system in FY 2002, payment was not dependent upon principal diagnosis as it is under a DRG-based system. Therefore, we are proposing to follow the same methodology outlined above to determine the appropriate diagnosis and procedure codes for those multiple bill LTCH cases in the FY 2002 MedPAR files, and we are proposing to use these codes to group each LTCH case to a proposed LTC–DRG for FY 2004. Since the LTCH PPS was implemented for cost reporting periods beginning on or after October 1, 2002 (FY 2003), we believe that this problem will be self-correcting as LTCHs submit more completely coded data in the future.

c. Hospital-Specific Relative Value Methodology. As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55985), by nature LTCHs often specialize in certain areas, such as ventilator-dependent patients and rehabilitation and wound care. Some case types (DRGs) may be treated, to a large extent, in hospitals that have, from a perspective of charges, relatively high (or low) charges. Such nonarbitrary distribution of cases with relatively high (or low) charges in specific LTC–DRGs has the potential to inappropriately distort the measure of average charges. To account for the fact that cases may not be randomly distributed across LTCHs, as explained in that same final rule (67 FR 55985), we use a hospital-specific relative value method to calculate the proposed LTC–DRG relative weights instead of the methodology used to determine the proposed DRG relative weights under the hospital IPPS described above in section II.C. of this preamble. We believe this method will remove this hospital-specific source of bias in measuring LTCH average charges. Specifically, we reduce the impact of the variation in charges across providers on any particular LTC–DRG relative weight by converting each LTCH's charge for a case to a relative value based on that LTCH's average charge.

Under the hospital-specific relative value method, as we explained in the August 30, 2002 LTCH PPS final rule (67 FR 55985), 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 in the August 30, 2002 LTCH PPS final rule (67 FR 55985), 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 we established in the August 30, 2002 LTCH PPS final rule (67 FR 55985), we group those low volume LTC–DRGs into one of five categories (quintiles) based on average charges, for the purposes of determining relative weights. For this proposed rule, using LTCH cases from the December 2002 update of the FY 2002 MedPAR file, we identified 163 proposed LTC–DRGs that contained between 1 and 24 cases. This list of proposed LTC–DRGs was then divided into one of the five proposed low volume quintiles, each containing a minimum of 32 proposed LTC–DRGs (163/5 = 32 with 3 proposed LTC–DRGs as the remainder). For FY 2004, we are proposing to make an assignment to a specific low volume quintile by sorting the 163 low volume proposed LTC–DRGs in ascending order by average charge. Since the number of proposed LTC–DRGs with less than 25 LTCH cases is not evenly divisible by five, the average charge of the low volume proposed LTC–DRG was used to determine which proposed low volume quintile received the additional proposed LTC–DRG. After sorting the 163 low volume proposed LTC–DRGs in ascending order, we are proposing that the first fifth (32) of low volume proposed LTC–DRGs with the lowest average charge would be grouped into Quintile 1. Since the average charge of the 33rd proposed LTC–DRG in the sorted list is closer to the previous proposed LTC–DRG's average charge (assigned to proposed Quintile 1) than to the average charge of the 34th proposed LTC–DRG on the sorted list (to be assigned to proposed Quintile 2), we are proposing to place it into proposed Quintile 1. The highest average charge cases would then be grouped into proposed Quintile 5. This process would be repeated through the remaining low volume proposed LTC–DRGs so that 3 proposed low volume quintiles would contain 33 proposed LTC–DRGs and 2 proposed low volume quintiles would contain 32 proposed LTC–DRGs.

In order to determine the proposed relative weights for the proposed LTC–DRGs with low volume for FY 2004, in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55985), we would use the five proposed low volume quintiles described above. The proposed composition of each of the five low volume quintiles shown below in Table 1 would be used in determining the proposed LTC–DRG relative weights for FY 2004. We would determine a proposed relative weight and (geometric) average length of stay for each of the five proposed low volume quintiles using the formula that we are proposing to apply to the regular proposed LTC–DRGs (25 or more cases), as described below in section II.D.4. of this preamble. We are proposing to assign the same proposed relative weight and average length of stay to each of the proposed LTC–DRGs that make up that proposed low volume quintile. We note that as this system is dynamic, it is possible that the number and specific type of LTC–DRGs with a low volume of LTCH cases will vary in the future. We use the best available claims data in the MedPAR file to identify low volume LTC–DRGs and to calculate the relative weights based on our methodology.

TABLE 1.—PROPOSED COMPOSITION OF LOW VOLUME QUINTILES

Proposed LTC–DRG	Description
Proposed Quintile 1	
044	ACUTE MAJOR EYE INFECTIONS
047	OTHER DISORDERS OF THE EYE AGE >17 W/O CC
065	DYSEQUILIBRIUM
066	EPISTAXIS
069	OTITIS MEDIA & URI AGE >17 W/O CC
072	NASAL TRAUMA & DEFORMITY
128	DEEP VEIN THROMBOPHLEBITIS
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC
178	UNCOMPLICATED PEPTIC ULCER W/O CC
192	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC
262	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY
273	MAJOR SKIN DISORDERS W/O CC
276	NON-MALIGNANT BREAST DISORDERS
305	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC
311	TRANSURETHRAL PROCEDURES W/O CC
319	KIDNEY & URINARY TRACT NEOPLASMS W/O CC
328	URETHRAL STRICTURE AGE >17 W CC
339	TESTES PROCEDURES, NON-MALIGNANCY AGE >17
342	CIRCUMCISION AGE >17
348	BENIGN PROSTATIC HYPERTROPHY W CC
349	BENIGN PROSTATIC HYPERTROPHY W/O CC

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

Proposed LTC–DRG	Description
376	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE
385	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY
399	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC
420	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL
431	CHILDHOOD MENTAL DISORDERS
432	OTHER MENTAL DISORDER DIAGNOSES
455	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS
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
540	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITHOUT CC
Proposed Quintile 2	
021	VIRAL MENINGITIS
022	HYPERTENSIVE ENCEPHALOPATHY
031**	CONCUSSION AGE >17 W CC
046	OTHER DISORDERS OF THE EYE AGE >17 W CC
053	SINUS & MASTOID PROCEDURES AGE >17
084	MAJOR CHEST TRAUMA W/O CC
177	UNCOMPLICATED PEPTIC ULCER W CC
193	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC
194*	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC
200	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY
206	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC
208	DISORDERS OF THE BILIARY TRACT W/O CC
211	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC
232	ARTHROSCOPY
234	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC
237	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH
275	MALIGNANT BREAST DISORDERS W/O CC
299	INBORN ERRORS OF METABOLISM
309	MINOR BLADDER PROCEDURES W/O CC
323	URINARY STONES W CC, &/OR ESW LITHOTRIPSY
324	URINARY STONES W/O CC
341	PENIS PROCEDURES
344	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY
367	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC
414	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC
421	VIRAL ILLNESS AGE >17
454	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17
497**	SPINAL FUSION W CC
502	KNEE PROCEDURES W PDX OF INFECTION W/O CC
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA
507*	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA
529	VENTRICULAR SHUNT PROCEDURES WITH CC
Proposed Quintile 3	
031*	CONCUSSION AGE >17 W CC
032	CONCUSSION AGE >17 W/O CC
063	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES
083	MAJOR CHEST TRAUMA W CC
117	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT
119	VEIN LIGATION & STRIPPING
158	ANAL & STOMAL PROCEDURES W/O CC
194**	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC
197	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC
218	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC
223	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC
228	MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC
257	TOTAL MASTECTOMY FOR MALIGNANCY W CC
293	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC
295	DIABETES AGE 0–35
317	ADMIT FOR RENAL DIALYSIS
345	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY
347***	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC
352	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES

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

Proposed LTC–DRG	Description
369	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS
402	LYMPHOMA & NON- ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC
408	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC
410	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS
411	HISTORY OF MALIGNANCY W/O ENDOSCOPY
419	FEVER OF UNKNOWN ORIGIN AGE >17 W CC
443	OTHER O.R. PROCEDURES FOR INJURIES W/O CC
447	ALLERGIC REACTIONS AGE >17
449	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC
450	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC
497*	SPINAL FUSION W CC
498*	SPINAL FUSION W/O CC
503	KNEE PROCEDURES W/O PDX OF INFECTION
505	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT
507**	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA
518	PERCUTANEOUS CARDIVASCULAR PROC W/O CORONARY ARTERY STENT OR AMI
Proposed Quintile 4	
008	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC
061	MYRINGOTOMY W TUBE INSERTION AGE >17
095***	PNEUMOTHORAX W/O CC
124	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG
125	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG
150	PERITONEAL ADHESIOLYSIS W CC
152	MINOR SMALL & LARGE BOWEL PROCEDURES W CC
157	ANAL & STOMAL PROCEDURES W CC
161	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC
191	PANCREAS, LIVER & SHUNT PROCEDURES W CC
195	CHOLECYSTECTOMY W C.D.E. W CC
210	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC
226	SOFT TISSUE PROCEDURES W CC
227	SOFT TISSUE PROCEDURES W/O CC
230	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR
268	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES
306	PROSTATECTOMY W CC
308	MINOR BLADDER PROCEDURES W CC
310	TRANSURETHRAL PROCEDURES W CC
312	URETHRAL PROCEDURES, AGE >17 W CC
360	VAGINA, CERVIX & VULVA PROCEDURES
394	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS
427	NEUROSES EXCEPT DEPRESSIVE
479***	OTHER VASCULAR PROCEDURES W/O CC
486	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA
493	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC
494*	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC
498**	SPINAL FUSION W/O CC
500	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC
517	PERCUTANEOUS CARDIVASCULAR PROC W NON-DRUG ELUTING STENT W/O AMI
519	CERVICAL SPINAL FUSION W CC
532	SPINAL PROCEDURES WITHOUT CC
538	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITHOUT CC
Proposed Quintile 5	
001	CRANIOTOMY AGE >17 W CC
055	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES
075	MAJOR CHEST PROCEDURES
077	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC
108	OTHER CARDIOTHORACIC PROCEDURES
110	MAJOR CARDIOVASCULAR PROCEDURES W CC
115	PRM CARD PACEM IMPL W AMI,HRT FAIL OR SHK,OR AICD LEAD OR GNRTR P
116	OTH PERM CARD PACEMAK IMPL OR PTCA W CORONARY ARTERY STENT IMPLNT
118	CARDIAC PACEMAKER DEVICE REPLACEMENT
154	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC
168	MOUTH PROCEDURES W CC
171***	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC
201	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES
209	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY
216	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE
261	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION

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

Proposed LTC–DRG	Description
266***	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC
288	O.R. PROCEDURES FOR OBESITY
304	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC
365	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES
401	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC
406	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC
412	HISTORY OF MALIGNANCY W ENDOSCOPY
441	HAND PROCEDURES FOR INJURIES
471	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY
482	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES
488	HIV W EXTENSIVE O.R. PROCEDURE
494**	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC
499	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC
501	KNEE PROCEDURES W PDX OF INFECTION W CC
515	CARDIAC DEFIBRILATOR IMPLANT W/O CARDIAC CATH
534	EXTRACRANIAL VASCULAR PROCEDURES WITHOUT CC
536	CARDIAC DEFIB IMPLANT WITH CARDIAC CATH WITHOUT AMI/HF/SHOCK

* One of the original 163 low volume proposed LTC–DRGs initially assigned to a different proposed low volume quintile; reassigned to this proposed low volume quintile in addressing nonmonotonicity (see step 5 below).

** One of the original 163 low volume proposed LTC–DRGs initially assigned to this proposed low volume quintile; reassigned to a different proposed low volume quintile in addressing nonmonotonicity (see step 5 below).

*** One of the original 163 low volume proposed LTC–DRGs initially assigned to this proposed low volume quintile; removed from the proposed low volume quintiles in addressing nonmonotonicity (see step 5 below).

4. Steps for Determining the Proposed FY 2004 LTC–DRG Relative Weights

As we noted previously, the proposed FY 2004 LTC–DRG relative weights are determined in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989–55991). In summary, LTCH cases must be grouped in the appropriate proposed LTC–DRG, while taking into account the low volume proposed LTC–DRGs as described above, before the proposed FY 2004 LTC–DRG relative weights can be determined. After grouping the cases in the appropriate proposed LTC–DRG, we are proposing to calculate the proposed relative weights for FY 2004 in this proposed rule by first removing statistical outliers and cases with a length of stay of 7 days or less. Next, we are proposing to adjust the number of cases in each proposed LTC–DRG for the effect of short-stay outlier cases under § 412.529. The short-stay adjusted discharges and corresponding charges would be used to calculate ''relative adjusted weights'' in each proposed LTC–DRG using the hospital-specific relative value method described above.

Below we discuss in detail the steps for calculating the proposed FY 2004 LTC–DRG relative weights, in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55989–55991).

Step 1—Remove statistical outliers. The first step in the calculation of the proposed FY 2004 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 proposed LTC–DRG. These statistical outliers would be removed prior to calculating the proposed relative weights. We believe that they may represent aberrations in the data that distort the measure of average resource use. Including those LTCH cases in the calculation of the proposed relative weights could result in an inaccurate proposed relative weight that does not truly reflect relative resource use among the proposed LTC–DRGs.

Step 2—Remove cases with a length of stay of 7 days or less. The proposed FY 2004 LTC–DRG relative weights should reflect the average of resources used on representative cases of a specific type. Generally, cases with a length of stay 7 days or less do not belong in a LTCH, since such stays do not fully receive or benefit from treatment that is typical in a LTCH stay and full resources are often not used in the earlier stages of admission to a LTCH. If we were to include stays of 7 days or less in the computation of the proposed FY 2004 LTC–DRG relative weights, the value of many proposed relative weights would decrease and, therefore, payments would decrease to a level that may no longer be appropriate.

We do not believe that it would be appropriate to compromise the integrity of the payment determination for those LTCH cases that actually benefit from and receive a full course of treatment at a LTCH, in order to include data from these very short-stays. Thus, in determining the proposed FY 2004 LTC–DRG relative weights, we remove LTCH cases with a length of stay of 7 days or less.

Step 3—Adjust charges for the effects of short-stay outliers. The third step in the calculation of the proposed FY 2004 LTC–DRG relative weights is to adjust each LTCH's charges per discharge for short-stay outlier cases (that is, a patient with a length of stay that is less than or equal to five-sixths the average length of stay of the LTC–DRG as described in the August 30, 2002 LTCH PPS final rule (67 FR 55977).

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

As we explained in the August 30, 2002 LTCH PPS final rule (67 FR 55990), counting short-stay outlier cases as full discharges with no adjustment in determining the proposed LTC–DRG relative weights would lower the proposed LTC–DRG relative weight for affected proposed LTC–DRGs because the relatively lower charges of the short-

stay outlier cases would bring down the average charge for all cases within a proposed LTC–DRG. This would result in an ''underpayment'' to nonshort-stay outlier cases and an ''overpayment'' to short-stay outlier cases. Therefore, in this proposed rule, in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55990), we adjust for short-stay outlier cases under § 412.529 in this manner since it would result in more appropriate payments for all LTCH cases.

Step 4—Calculate the proposed FY 2004 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 proposed LTC–DRG, the proposed FY 2004 LTC–DRG relative weight is calculated by dividing the average of the adjusted hospital-specific relative charge values (from above) for the proposed LTC–DRG by the overall average hospital-specific relative charge value across all cases for all LTCHs. Using these recalculated proposed LTC–DRG relative weights, each LTCH's average proposed relative weight for all of its cases (case-mix) is calculated by dividing the sum of all the LTCH's proposed LTC–DRG relative weights by its total number of cases. The LTCHs' hospital-specific relative charge values above are multiplied by these hospital specific case-mix indexes. These hospital-specific case-mix adjusted relative charge values are then used to calculate a new set of proposed LTC–DRG relative weights across all LTCHs. In this proposed rule, this iterative process is continued until there is convergence between the weights produced at adjacent steps, for example, when the maximum difference is less than 0.0001.

Step 5—Adjust the proposed FY 2004 LTC–DRG relative weights to account for nonmonotonically increasing relative weights. As explained in section II.B. of this preamble, the proposed FY 2004 CMS DRGs, upon which the proposed FY 2004 LTC–DRGs are based, contain ''pairs'' that are differentiated based on the presence or absence of CCs. The proposed LTC–DRGs with CCs are defined by certain secondary diagnoses not related to or inherently a part of the disease process identified by the principal diagnosis, but the presence of additional diagnoses does not automatically generate a CC. As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55990), the value of monotonically increasing relative weights rises as the resource use increases (for example, from uncomplicated to more complicated). The presence of CCs in a proposed LTC–DRG means that cases classified into a ''without CC'' proposed LTC–DRG are expected to have lower resource use (and lower costs). In other words, resource use (and costs) are expected to decrease across ''with CC''/''without CC'' pairs of proposed LTC–DRGs.

For a case to be assigned to a proposed LTC–DRG with CCs, as we explained in the August 30, 2002 LTCH PPS final rule (67 FR 55990), more coded information is called for (that is, at least one relevant secondary diagnosis), than for a case to be assigned to a proposed LTC–DRG ''without CCs'' (which is based on only one principal diagnosis and no relevant secondary diagnoses). Currently, the LTCH claims data include both accurately coded cases without complications and cases that have complications (and cost more) but were not coded completely. Both types of cases are grouped to a proposed LTC–DRG ''without CCs'' since only one principal diagnosis was coded. Since LTCHs were previously paid under cost-based reimbursement, which is not based on patient diagnoses, LTCHs' coding 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 explained in the August 30, 2002 LTCH PPS final rule (67 FR 55990), we found on occasion that the data suggested that cases classified to the LTC–DRG ''with CCs'' of a ''with CC''/''without CC'' pair had a lower average charge than the corresponding LTC–DRG ''without CCs.'' Similarly, based on FY 2002 claims data, we also found on occasion that the data suggested that cases classified to the proposed LTC–DRG ''with CCs'' of a ''with CC''/''without CC'' pair would have a lower average charge than the corresponding proposed LTC–DRG ''without CCs'' for FY 2004.

We believe this anomaly may be due to coding that may not have fully reflected all comorbidities that were present. Specifically, LTCHs may have failed to code relevant secondary diagnoses, which resulted in cases that actually had CCs being classified into a ''without CC'' LTC–DRG. It would not be appropriate to pay a lower amount for the ''with CC'' LTC–DRG. Therefore, in this proposed rule, in accordance with the methodology established in that same final rule (67 FR 55990–55991), we grouped both the cases ''with CCs'' and ''without CCs'' together for the purpose of calculating the proposed FY 2004 LTC–DRG relative weights. We continue to employ this methodology to account for nonmonotonically increasing relative weights until we have adequate data to calculate appropriate separate weights for these anomalous LTC–DRG pairs. We expect that, as was the case when we first implemented the IPPS, this problem will be self-correcting, as LTCHs submit more completely coded data in the future.

As we discussed in the August 30, 2002 LTCH PPS final rule (67 FR 55990), there are three types of ''with CC'' and ''without CC'' pairs that were nonmonotonic, that is, where the ''without CC'' proposed LTC–DRG would have a higher average charge than the ''with CC'' proposed LTC–DRG. For this proposed rule, using the LTCH cases in the December 2002 update of the FY 2002 MedPAR file, we identified two of the types of nonmonotonic LTC–DRG pairs.

The first category of nonmonotonically increasing relative weights for proposed FY 2004 LTC–DRG pairs ''with and without CCs'' contains no pairs of proposed LTC–DRGs in which both the proposed LTC–DRG ''with CCs'' and the proposed LTC–DRG ''without CCs'' had 25 or more LTCH cases and, therefore, would not fall into one of the 5 proposed low volume quintiles. For that type of nonmonotonic LTC–DRG pair, in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55990–55991), we would combine the LTCH cases and compute a new proposed relative weight based on the case-weighted average of the combined LTCH cases of the proposed LTC–DRGs. The case-weighted average charge is determined by dividing the total charges for all LTCH cases by the total number of LTCH cases for the combined proposed LTC–DRG. This new proposed relative weight would then be assigned to both of the proposed LTC–DRGs in the pair. However, as there are no pairs that fall into this category, in this proposed rule, we are proposing that, for FY 2004, there would be zero proposed LTC–DRGs in this category.

The second category of nonmonotonically increasing relative weights for proposed LTC–DRG pairs with and without CCs consists of 5 pairs of proposed LTC–DRGs that has fewer than 25 cases, and each proposed LTC–DRG would be grouped to different proposed low volume quintiles in which the ''without CC'' proposed LTC–DRG would be in a higher-weighted proposed low volume quintile than the ''with CC'' proposed LTC–DRG. For those pairs, in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55990–55991), 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 proposed LTC–DRG. Based on the case-weighted average LTCH charge, we determine which proposed low volume quintile the ''combined proposed LTC–DRG'' would be grouped. Both proposed LTC–DRGs in the pair are then grouped into the same proposed low volume quintile, and thus would have the same proposed relative weight. For the FY 2004, in this proposed rule, we are proposing that the following proposed LTC–DRGs would be in this category: Proposed LTC–DRGs 31 and 32 (proposed low volume quintile 3); proposed LTC–DRGs 193 and 194 (proposed low volume quintile 2); proposed LTC–DRGs 493 and 494 (proposed low volume quintile 4); proposed LTC–DRGs 497 and 498 (proposed low volume quintile 3); and proposed LTC–DRGs 506 and 507 (proposed low volume quintile 2).

The third category of nonmonotonically increasing relative weights for proposed LTC–DRG pairs with and without CCs consists of 5 pairs of proposed LTC–DRGs where one of the proposed LTC–DRGs has fewer than 25 LTCH cases and is grouped to a proposed low volume quintile and the other proposed LTC–DRG has 25 or more LTCH cases and has its own proposed LTC–DRG relative weight, and the proposed LTC–DRG ''without CCs'' has the higher proposed relative weight. In accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55990 and 55991), we remove the proposed low volume LTC–DRG from the proposed low volume quintile and combine it with the other proposed LTC–DRG for the computation of a new proposed relative weight for each of these proposed LTC–DRGs. This new proposed relative weight is assigned to both proposed LTC–DRGs, so they each have the same proposed relative weight. For FY 2004, in this proposed rule, we are proposing the following proposed LTC–DRGs would be in this category: Proposed LTC–DRGs 94 and 95; proposed LTC–DRGs 170 and 171; proposed LTC–DRGs 265 and 266; proposed LTC–DRGs 346 and 347; and proposed LTC–DRGs 478 and 479.

Step 6—Determine a proposed FY 2004 LTC–DRG relative weight for LTC–DRGs with no LTCH cases. As we stated above, we determine the proposed relative weight for each proposed LTC–DRG using charges reported in the December 2002 update of the FY 2002 MedPAR file. Of the 518 proposed LTC–DRGs for FY 2004, we identified 164 proposed LTC–DRGs for which there were no LTCH cases in the database. That is, based on data from the FY 2002 MedPAR file used in this proposed rule, no patients who would have been classified to those proposed LTC–DRGs were treated in LTCHs during FY 2002 and, therefore, no charge data were reported for those proposed LTC–DRGs. Thus, in the process of determining the proposed LTC–DRG relative weights, we are unable to determine proposed weights for these 164 proposed LTC–DRGs using the methodology described in steps 1 through 5 above. However, since patients with a number of the diagnoses under these proposed LTC–DRGs may be treated at LTCHs beginning in FY 2004, in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55991), we assign proposed relative weights to each of the 164 ''no volume'' proposed LTC–DRGs based on clinical similarity and relative costliness to one of the remaining 354 (518 − 164 = 354) proposed LTC–DRGs for which we are able to determine proposed relative weights, based on FY 2002 claims data.

As there are currently no LTCH cases in these ''no volume'' proposed LTC–DRGs, in accordance with the methodology established in the August 30, 2002 LTCH PPS final rule (67 FR 55991), we determine proposed relative weights for the 164 proposed LTC–DRGs with no LTCH cases in the FY 2002 MedPAR file used in this proposed rule by grouping them to the appropriate proposed low volume quintile. This methodology is consistent with our methodology used in determining proposed relative weights to account for the proposed low volume LTC–DRGs described above.

As we described in the August 30, 2002 LTCH PPS final rule (67 FR 55991), our methodology for determining proposed relative weights for the ''no volume'' proposed LTC–DRGs is as follows: First, we crosswalk the no volume proposed LTC–DRGs by matching them to other similar proposed LTC–DRGs for which there were LTCH cases in the FY 2002 MedPAR file based on clinical similarity and intensity of use of resources as determined by care provided during the period of time surrounding surgery, surgical approach (if applicable), length of time of surgical procedure, post-operative care, and length of stay. We assign the proposed relative weight for the applicable proposed low volume quintile to the no volume proposed LTC–DRG if the proposed LTC–DRG to which it is crosswalked is grouped to one of the proposed low volume quintiles. If the proposed LTC–DRG to which the no volume proposed LTC–DRG is crosswalked is not one of the proposed LTC–DRGs to be grouped to one of the proposed low volume quintiles, we compare the proposed relative weight of the proposed LTC–DRG to which the no volume proposed LTC–DRG is crosswalked to the proposed relative weights of each of the five proposed quintiles and we assign the no volume proposed LTC–DRG the proposed relative weight of the proposed low volume quintile with the closest weight. For this proposed rule, a list of the no volume proposed FY 2004 LTC–DRGs and the proposed FY 2004 LTC–DRG to which it is crosswalked in order to determine the appropriate proposed low volume quintile for the assignment of a proposed relative weight for FY 2004 is shown below in Table 2.

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

LTC–DRG	Description	Cross walked LTC–DRG	Low volume quintile assigned
2	CRANIOTOMY AGE > 17 W/O CC	1	Quintile 5.
3	CRANIOTOMY AGE 0–17	1	Quintile 5.

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

LTC–DRG	Description	Cross walked LTC–DRG	Low volume quintile assigned
6	CARPAL TUNNEL RELEASE	251	Quintile 1.
26	SEIZURE & HEADACHE AGE 0–17	25	Quintile 2.
30	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	29	Quintile 3.
33	CONCUSSION AGE 0–17	25	Quintile 2.
36	RETINAL PROCEDURES	47	Quintile 1.
37	ORBITAL PROCEDURES	47	Quintile 1.
38	PRIMARY IRIS PROCEDURES	47	Quintile 1.
39	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	47	Quintile 1.
40	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	47	Quintile 1.
41	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	47	Quintile 1.
42	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	47	Quintile 1.
43	HYPHEMA	47	Quintile 1.
45	NEUROLOGICAL EYE DISORDERS	46	Quintile 2.
48	OTHER DISORDERS OF THE EYE AGE 0–17	47	Quintile 1.
49	MAJOR HEAD & NECK PROCEDURES	64	Quintile 4.
50	SIALOADENECTOMY	63	Quintile 3.
51	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	63	Quintile 3.
52	CLEFT LIP & PALATE REPAIR	63	Quintile 3.
54	SINUS & MASTOID PROCEDURES AGE 0–17	63	Quintile 3.
56	RHINOPLASTY	72	Quintile 1.
57	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	63	Quintile 3.
58	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	63	Quintile 3.
59	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	63	Quintile 3.
60	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0–17	63	Quintile 3.
62	MYRINGOTOMY W TUBE INSERTION AGE 0–17	63	Quintile 3.
67	EPIGLOTTITIS	63	Quintile 3.
70	OTITIS MEDIA & URI AGE 0–17	69	Quintile 1.
71	LARYNGOTRACHEITIS	97	Quintile 2.
74	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0–17	69	Quintile 1.
81	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	69	Quintile 1.
91	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	90	Quintile 2.
98	BRONCHITIS & ASTHMA AGE 0–17	97	Quintile 2.
104	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH	110	Quintile 5.
105	CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH	110	Quintile 5.
106	CORONARY BYPASS W PTCA	110	Quintile 5.
107	CORONARY BYPASS W CARDIAC CATH	110	Quintile 5.
109	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	110	Quintile 5.
111	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	110	Quintile 5.
137	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0–17	136	Quintile 2.
146	RECTAL RESECTION W CC	148	Quintile 5.
147	RECTAL RESECTION W/O CC	148	Quintile 5.
151	PERITONEAL ADHESIOLYSIS W/O CC	150	Quintile 4.
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	152	Quintile 4.
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	171	Quintile 5.
156	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0–17	171	Quintile 5.
159	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	161	Quintile 4.
160	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	161	Quintile 4.
162	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	178	Quintile 1.
163	HERNIA PROCEDURES AGE 0–17	178	Quintile 1.
164	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	148	Quintile 5.
165	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	149	Quintile 1.
166	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	148	Quintile 5.
167	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	149	Quintile 1.
169	MOUTH PROCEDURES W/O CC	72	Quintile 1.
184	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0–17	183	Quintile 2.
186	DENTAL ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0–17	185	Quintile 2.
187	DENTAL EXTRACTIONS & RESTORATIONS	185	Quintile 2.
190	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	189	Quintile 2.
196	CHOLECYSTECTOMY W C.D.E. W/O CC	197	Quintile 3.
198	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	197	Quintile 3.
199	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	200	Quintile 2.
212	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0–17	211	Quintile 2.
219	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC	218	Quintile 3.
220	LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0–17	218	Quintile 3.
224	SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	234	Quintile 2.
229	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	234	Quintile 2.
252	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0–17	234	Quintile 2.
255	FX, SPRN, STRN & DISL OF UPARM, LOWLEG EX FOOT AGE 0–17	234	Quintile 2.
258	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	257	Quintile 3.

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

LTC–DRG	Description	Cross walked LTC–DRG	Low volume quintile assigned
259	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	257	Quintile 3.
260	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	257	Quintile 3.
267	PERIANAL & PILONIDAL PROCEDURES	158	Quintile 1.
279	CELLULITIS AGE 0–17	78	Quintile 1.
282	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0–17	281	Quintile 2.
286	ADRENAL & PITUITARY PROCEDURES	292	Quintile 4.
289	PARATHYROID PROCEDURES	293	Quintile 3.
290	THYROID PROCEDURES	293	Quintile 3.
291	THYROGLOSSAL PROCEDURES	293	Quintile 3.
298	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	297	Quintile 2.
303	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	304	Quintile 5.
307	PROSTATECTOMY W/O CC	306	Quintile 4.
313	URETHRAL PROCEDURES, AGE >17 W/O CC	311	Quintile 1.
314	URETHRAL PROCEDURES, AGE 0–17	311	Quintile 1.
322	KIDNEY & URINARY TRACT INFECTIONS AGE 0–17	326	Quintile 2.
327	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0–17	326	Quintile 2.
329	URETHRAL STRICTURE AGE >17 W/O CC	328	Quintile 1.
330	URETHRAL STRICTURE AGE 0–17	328	Quintile 1.
333	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0–17	332	Quintile 1.
334	MAJOR MALE PELVIC PROCEDURES W CC	345	Quintile 3.
335	MAJOR MALE PELVIC PROCEDURES W/O CC	345	Quintile 3.
336	TRANSURETHRAL PROSTATECTOMY W CC	341	Quintile 2.
337	TRANSURETHRAL PROSTATECTOMY W/O CC	341	Quintile 2.
338	TESTES PROCEDURES, FOR MALIGNANCY	339	Quintile 1.
340	TESTES PROCEDURES, NON-MALIGNANCY AGE 0–17	339	Quintile 1.
343	CIRCUMCISION AGE 0–17	339	Quintile 1.
351	STERILIZATION, MALE	339	Quintile 1.
353	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	365	Quintile 5.
354	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	365	Quintile 5.
355	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	365	Quintile 5.
356	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	360	Quintile 4.
357	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	360	Quintile 4.
358	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	360	Quintile 4.
359	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	360	Quintile 4.
361	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	149	Quintile 1.
362	ENDOSCOPIC TUBAL INTERRUPTION	149	Quintile 1.
363	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	367	Quintile 2.
364	D&C, CONIZATION EXCEPT FOR MALIGNANCY	367	Quintile 2.
370	CESAREAN SECTION W CC	369	Quintile 3.
371	CESAREAN SECTION W/O CC	367	Quintile 2.
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	367	Quintile 2.
373	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	367	Quintile 2.
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C	367	Quintile 2.
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	367	Quintile 2.
377	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	367	Quintile 2.
378	ECTOPIC PREGNANCY	369	Quintile 3.
379	THREATENED ABORTION	376	Quintile 1.
380	ABORTION W/O D&C	376	Quintile 1.
381	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	376	Quintile 1.
382	FALSE LABOR	376	Quintile 1.
383	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	376	Quintile 1.
384	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	376	Quintile 1.
386	EXTREME IMMATURITY	367	Quintile 2.
387	PREMATURITY W MAJOR PROBLEMS	367	Quintile 2.
388	PREMATURITY W/O MAJOR PROBLEMS	367	Quintile 2.
389	FULL TERM NEONATE W MAJOR PROBLEMS	367	Quintile 2.
390	NEONATE W OTHER SIGNIFICANT PROBLEMS	367	Quintile 2.
391	NORMAL NEWBORN	376	Quintile 1.
392	SPLENECTOMY AGE >17	194	Quintile 2.
393	SPLENECTOMY AGE 0–17	194	Quintile 2.
396	RED BLOOD CELL DISORDERS AGE 0–17	399	Quintile 1.
405	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0–17	404	Quintile 2.
407	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC	408	Quintile 3.
417	SEPTICEMIA AGE 0–17	416	Quintile 3.
422	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	420	Quintile 1.
446	TRAUMATIC INJURY AGE 0–17	445	Quintile 2.
448	ALLERGIC REACTIONS AGE 0–17	455	Quintile 1.
451	POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	455	Quintile 1.
481	BONE MARROW TRANSPLANT	394	Quintile 1.

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

LTC–DRG	Description	Cross walked LTC–DRG	Low volume quintile assigned
484	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	1	Quintile 5.
485	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR	209	Quintile 5.
491	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	209	Quintile 5.
492	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	410	Quintile 3.
496	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	210	Quintile 4.
504	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	468	Quintile 5.
516	PERCUTANEOUS CARDIVASCULAR PROCEDURE W AMI	578	Quintile 3.
520	CERVICAL SPINAL FUSION W/O CC	498	Quintile 3.
525	HEART ASSIST SYSTEM IMPLANT	468	Quintile 5.
526	PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W AMI	517	Quintile 4.
527	PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W/O AMI	517	Quintile 4.
528	INTRACRANIAL VASCLUAR PROCEDURES WITH PDX HEMORRHAGE	1	Quintile 5.
530	VENTRICULAR SHUNT PROCEDURES WITHOUT CC	529	Quintile 2.
531	SPINAL PROCEDURES WITH CC	519	Quintile 4.
533	EXTRACRANIAL VASCULAR PROCEDURES WITH CC	534	Quintile 5.
535	CARDIAC DEFIB IMPLANT WITH CARDIAC CATH WITH AMI/HF/SHOCK	515	Quintile 5.
537	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITH CC.	253	Quintile 2.
539	LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITH CC	401	Quintile 5.

To illustrate this methodology, which was established in the August 30, 2002 LTCH PPS final rule (67 FR 55991), for determining the proposed relative weights for the 164 proposed LTC–DRGs with no LTCH cases, we are providing the following examples, which refer to the no volume proposed LTC–DRGs crosswalk information for FY 2004 provided above in Table 2:

Example 1: There were no cases in the FY 2002 MedPAR file used for this proposed rule for proposed LTC–DRG 163 (Hernia Procedures Age 0–17). Since the procedure is similar in resource use and the length and complexity of the procedures and the length of stay are similar, we determined that proposed LTC–DRG 178 (Uncomplicated Peptic Ulcer Without CC), which is assigned to proposed low volume quintile 1 for the purpose of determining the proposed FY 2004 relative weights, would display similar clinical and resource use. Therefore, we are proposing to assign the same proposed relative weight of LTC–DRG 178 of 0.5711 (proposed Quintile 1) for FY 2004 (Table 11 in the Addendum to this proposed rule) to proposed LTC–DRG 163.

Example 2: There were no LTCH cases in the FY 2002 MedPAR file used in this proposed rule for proposed LTC–DRG 91 (Simple Pneumonia and Pleurisy Age 0–17). Since the severity of illness in patients with bronchitis and asthma is similar in patients regardless of age, we determined that proposed LTC–DRG 90 (Simple Pneumonia and Pleurisy Age >17 Without CC) would display similar clinical and resource use characteristics and have a similar length of stay to proposed LTC–DRG 91. There were over 25 cases in proposed LTC–DRG 90. Therefore, it would not be assigned to a proposed low volume quintile for the purpose of determining the proposed LTC–DRG relative weights. However, under our established methodology, proposed LTC–DRG 91, with no LTCH cases, would need to be grouped to a proposed low volume quintile. We identified that the proposed low volume quintile with the closest weight to proposed LTC–DRG 90 (0.7429; see Table 11 in the Addendum to this proposed rule) would be proposed low volume quintile 2 (0.7347; see Table 11 in the Addendum to this proposed rule). Therefore, we are proposing to assign proposed LTC–DRG 91 a proposed relative weight of 0.7347 for FY 2004.

Furthermore, in accordance with the methodology established in the August 30, 2002 final rule (67 FR 55991), we are proposing LTC–DRG relative weights of 0.0000 for heart, kidney, liver, lung, pancreas, and simultaneous pancreas/kidney transplants (proposed LTC–DRGs 103, 302, 480, 495, 512, and 513, respectively) for FY 2004 because Medicare will only cover these procedures if they are performed at a hospital that has been certified for the specific procedures by Medicare and presently no LTCH has been so certified.

Based on our research, as we discussed in that same final rule (67 FR 55995), 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 propose appropriate weights for the LTC–DRGs affected. At the present time, we would only include these six transplant proposed LTC–DRGs in the GROUPER program for administrative purposes. Since we use the same GROUPER program for LTCHs as is used under the acute care hospital IPPS, removing these LTC–DRGs would be administratively burdensome.

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

Table 11 in the Addendum to this proposed rule lists the proposed LTC–DRGs and their respective proposed relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (to assist in the determination of short-stay outlier payments under § 412.529) for FY 2004.

E. Add-On Payments for New Services and Technologies

1. Background

Sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and ensuring adequate payment for new medical services and technologies under the IPPS. Section 1886(d)(5)(K)(ii)(I) of

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

Section 412.87(b)(1) of our existing regulations provides that a new technology will be an appropriate candidate for an additional payment when it represents an advance in medical technology that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries (see the September 7, 2001 final rule (66 FR 46902)). Section 412.87(b)(3) provides that, to receive special payment treatment, new technologies meeting this clinical definition must be demonstrated to be inadequately paid otherwise under the DRG system. To assess whether technologies would be inadequately paid under the DRGs, we established this threshold at one standard deviation beyond the geometric mean standardized charge for all cases in the DRGs to which the new technology is assigned (or the case-weighted average of all relevant DRGs, if the new technology occurs in many different DRGs). Table 10 in the Addendum to this proposed rule lists the proposed qualifying criteria by DRG, based on the discharge data that we are using to calculate the proposed FY 2004 DRG weights. The thresholds that will be published in the final rule for FY 2004 will be used to evaluate applicants for new technology add-on payments during FY 2005.

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

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

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

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

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

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

To balance appropriately the Congress' intent to increase Medicare's payments for eligible new technologies with concern that the total size of those payments not result in significantly reduced payments for other cases, we set a target limit for estimated add-on payments for new technology under the provisions of sections 1886(d)(5)(K) and (L) of the Act at 1.0 percent of estimated total operating prospective payments.

If the target limit is exceeded, we would reduce the level of payments for approved technologies across the board, to ensure estimated payments do not exceed the limit. Using this approach, all cases involving approved new technologies that would otherwise receive additional payments would still receive special payments, albeit at a

reduced amount. Although the marginal payment rate for individual technologies would be reduced, this reduction would be offset by large overall payments to hospitals for new technologies under this provision.

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

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

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

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

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

a. Bone Morphogenetic Proteins (BMPs) for Spinal Fusions. An application was submitted by Medtronic Sofamor Danek for the InFUSE™ Bone Graft/LT-CAGE®'' Lumbar Tapered Fusion Device for approval as a new technology eligible for add-on payments. A similar application was submitted last year but was denied because, based on the available data, the technology did not exceed the one standard deviation threshold above the average charges for the DRGs to which the technology is assigned.

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

On July 2, 2002, the FDA approved InFUSE™ Bone Graft/LT-CAGE® for spinal fusion procedures in skeletally mature patients at one level. Therefore, based on the FDA's approval, multilevel use of this technology would be off-label. In the August 1, 2002 IPPS final rule (67 FR 50017), we stated this technology would meet the cost threshold only if the added costs of multilevel fusions were taken into account. Because the FDA had not approved this technology for multilevel fusions, and the applicant had not submitted data to demonstrate this technology is a substantial clinical improvement for multilevel fusions (the clinical trial upon which the application was based was a single-level fusion trial), we could not issue a substantial clinical improvement determination for multilevel fusions and, consequently, did not consider the costs associated with multilevel fusions in our analysis of whether this technology met the cost threshold. Therefore, because the average charges for this new technology, when used for single-level spinal fusions, did not exceed the threshold to qualify for new technology add-on payment of $37,815, we denied this application for add-on payments for FY 2003. For similar reasons, we did not consider data on the charges for multilevel fusions in our analysis of whether this technology meets the cost threshold for FY 2004.

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

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

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

The applicant also submitted data from actual cases involving the InFUSE™ Bone Graft/LT–CAGE® with single level fusions only. The data submitted included 31 claims from 4

hospitals (only one Medicare patient was included in the sample). All 31 cases were from DRG 498. The average standardized charge for these cases was $47,172. Based on these data, the average standardized charge exceeds the threshold for DRG 498. However, we note that this limited sample excludes any cases from DRG 497.

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

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

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

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

Among the issues we will consider are: Does avoiding the complications associated with the iliac crest bone harvesting procedure constitute a substantial clinical improvement; and, with the increased rate of osteoarthritis and osteoporosis in the Medicare population, is there evidence that the technology represents a substantial clinical improvement in spinal fusions among this population? We are particularly interested in data on the results of aged Medicare patients who have been treated with BMP, and any basic biology bench data on the results of using BMP in osteoporotic bones.

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

The FDA approved GLIADEL® Wafer on September 23, 1996, for use as an adjunct to surgery to prolong survival in patients with recurrent GBM for whom surgical resection is indicated. In announcing its approval, the FDA indicated that GLIADEL® was approved:

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

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

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

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

4. Review of the High-Cost Threshold

The current cost threshold for a new technology to qualify for add-on

payments is that the average standardized charges of cases involving the new technology must be demonstrated to exceed one standard deviation beyond the mean standardized charges of the DRG to which the new technology will be assigned. When we established this threshold in the September 7, 2001 final rule, we expressed our belief that it is important to establish a threshold that recognizes the variability in costs per case within DRGs and maintains the fundamental financial incentives of the IPPS (66 FR 46917).

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

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

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

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

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

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

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

5. Technical Changes

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

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

III. Proposed Changes to the Hospital Wage Index

A. Background

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts ''for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.'' In accordance with the broad discretion conferred under the Act, we currently define hospital labor market areas based on the definitions of Metropolitan Statistical Areas (MSAs), Primary MSAs (PMSAs), and New England County Metropolitan Areas (NECMAs) issued by the Office of Management and Budget (OMB). OMB also designates Consolidated MSAs (CMSAs). A CMSA is a metropolitan area with a population of one million or more, comprising two or more PMSAs (identified by their separate economic and social character). For purposes of the hospital wage index, we use the PMSAs rather than CMSAs since they allow a more precise breakdown of labor costs. If a metropolitan area is not designated as part of a PMSA, we use the applicable MSA. Rural areas are areas outside a designated MSA, PMSA, or NECMA. For purposes of the wage index, we combine all of the rural counties in a State to calculate a rural wage index for that State.

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

purposes of the IPPS, we will continue to refer to these areas as MSAs.

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

In a December 27, 2000 notice published in the **Federal Register** (65 FR 82228), the Office of Management and Budget (OMB) issued its revised standards for defining MSAs. In that notice, OMB indicated that it plans to announce in calendar year 2003 new definitions of ''Core Based Statistical Areas'' (CBSAs) based on the new standards and the Census 2000 data. The new standards establish two categories of CBSAs: (1) Metropolitan Statistical Areas (50,000 or more), and (2) Micropolitan Statistical Areas (10,000 to 49,999). After these new CBSAs are announced, we will evaluate the new area designations and their possible effects on the Medicare hospital wage index. Therefore, the earliest these new CBSA definitions would be used is the FY 2005 wage index.

Beginning October 1, 1993, section 1886(d)(3)(E) of the Act requires that we update the wage index annually. Furthermore, this section provides that the Secretary base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. The survey should measure, to the extent feasible, the earnings and paid hours of employment by occupational category, and must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. As discussed below in section III.F. of this preamble, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating the wage index.

Section 1886(d)(3)(E) of the Act also provides for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. The initial collection of these data must be completed by September 30, 2003, for application beginning October 1, 2004 (the FY 2005 wage index). In the April 4, 2003 **Federal Register** (68 FR 16516), we published a notice of intent to collect calendar year 2002 data from hospitals. There is a 60-day public comment period on that notice. After considering and responding to the comments we receive, we plan to send the surveys to all IPPS hospitals (and hospitals in Maryland that are under a waiver from the IPPS) through the fiscal intermediaries. We intend to collect these data to be incorporated in the FY 2005 wage index after notice and opportunity for public comment.

B. Proposed FY 2004 Wage Index Update

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

The proposed FY 2004 wage index includes the following categories of data associated with costs paid under the IPPS (as well as outpatient costs), which were also included in the FY 2003 wage index:

- Salaries and hours from short-term, acute care hospitals.
- Home office costs and hours.
- Certain contract labor costs and hours.
- Wage-related costs.

Consistent with the wage index methodology for FY 2003, the proposed wage index for FY 2004 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.

C. FY 2004 Wage Index Proposals

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

In the FY 2001 IPPS final rule, we discussed removing from the wage index the salaries, hours, and wage-related costs of hospital-based rural health clinics (RHCs) and Federally qualified health centers (FQHCs) because Medicare pays for these costs outside of the IPPS (65 FR 47074). We noted that because RHC and FQHC costs were not separately reported on Worksheet S–3 of the Medicare cost report, we could not exclude these costs from the prior wage indexes. We further noted that we would evaluate the exclusion of RHC and FQHC wage data in developing the FY 2004 wage index. We now have revised Worksheet S–3 so that it allows for the separate reporting of RHC and FQHC wage costs and hours beginning with FY 2000. Therefore, as we now have the ability to exclude these costs from the wage index, beginning with the FY 2004 wage index, we are proposing to exclude the wage costs and hours data for RHCs and FQHCs from the hospital wage index calculation. An analysis of the effects of this change is included in the Appendix A of this proposed rule.

2. Paid Hours

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

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

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

We are soliciting comments on our policy that paid lunch hours should be excluded from the wage index. Specifically, we would like a broader understanding of the issue of whether some hospitals may, in fact, be truly disadvantaged by this policy through no fault of their own. Any change in our policy would not be implemented until, at the earliest, the FY 2005 wage index.

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

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

D. Verification of Wage Data From the Medicare Cost Reports

The data for the proposed FY 2004 wage index were obtained from Worksheet S–3, Parts II and III of the FY 2000 Medicare cost reports. The data file used to construct the proposed wage index includes FY 2000 data submitted to us as of February 18, 2003. As in past years, we performed an intensive review of the wage data, mostly through the use of edits designed to identify aberrant data.

We asked our fiscal intermediaries to revise or verify data elements that resulted in specific edit failures. Some unresolved data elements are included in the calculation of the proposed FY 2004 wage index, pending their resolution before calculation of the final FY 2004 wage index. We instructed the intermediaries to complete their verification of questionable data elements and to transmit any changes to the wage data no later than April 4, 2003. We believe all unresolved data elements will be resolved by the date the final rule is issued. The revised data will be reflected in the final rule.

Also, as part of our editing process, we removed data for 110 hospitals that failed edits. We identified 72 hospitals with incomplete or inaccurate data resulting in zero or negative, or otherwise aberrant, average hourly wages. Therefore, wage data from these hospitals were removed from the calculation. We have notified the fiscal intermediaries of these hospitals and will continue to work with the fiscal intermediaries to correct these data whenever possible. As a result, the proposed FY 2004 wage index is calculated based on FY 2000 wage data for 4,593 hospitals.

In constructing the proposed FY 2004 wage index, we include the wage data for facilities that were IPPS hospitals in FY 2000, even for those facilities that have terminated their participation in the program as hospitals or have since been designated as a critical access hospital (CAH), as long as those data do not fail any of our edits for reasonableness. We 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 received correspondence suggesting that the wage data for hospitals that have subsequently been redesignated as CAHs should be removed from the wage index calculation because CAHs are unique compared to other short-term, acute care hospitals. CAHs are limited to only 15 acute care beds. An additional 10 beds may be designated as swing-beds, but only 15 beds can be used at one time to serve acute care patients. CAHs tend to be located in isolated, rural areas. We solicit comment on whether we should exclude wage data from such hospitals from the wage index calculation. However, we have included the data for CAHs in the proposed FY 2004 wage index if the CAH was paid under the IPPS during FY 2000.

E. Computation of the Proposed FY 2004 Wage Index

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

Step 1—As noted above, we based the proposed FY 2004 wage index on wage data reported on the FY 2000 Medicare cost reports. We gathered data from each of the non-Federal, short-term, acute care hospitals for which data were reported on the Worksheet S–3, Parts II and III of the Medicare cost report for the hospital's cost reporting period beginning on or after October 1, 1999 and before October 1, 2000. In addition, we included data from some hospitals that had cost reporting periods beginning before October 1999 and reported a cost reporting period covering all of FY 2000. These data were included because no other data from these hospitals 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 2000 data. We note that, if a hospital had more than one cost reporting period beginning during FY 2000 (for example, a hospital had two short cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000), we included wage data from only one of the cost reporting periods, the longer, in the wage index calculation. If there was more than one cost reporting period and the periods were equal in length, we included the wage data from the later period in the wage index calculation. We have removed the wage data of CAHs, after the effective date of the CAH designation, from the calculation of the proposed wage index.

Step 2—Salaries—Beginning with the FY 2003 wage index, the method used to compute a hospital's average hourly wage excludes all GME and CRNA costs.

In calculating a hospital's average salaries plus wage-related costs, we subtracted from Line 1 (total salaries) the GME and CRNA costs reported on lines 2, 4.01, and 6, the Part B salaries reported on Lines 3, 5 and 5.01, home office salaries reported on Line 7, and excluded salaries reported on Lines 8 and 8.01 (that is, direct salaries attributable to SNF services, home health services, and other subprovider components not subject to the IPPS). We also subtracted from Line 1 the salaries for which no hours were reported on Line 4. To determine total salaries plus wage-related costs, we added to the net hospital salaries the costs of contract labor for direct patient care, certain top management, pharmacy, laboratory, and nonteaching physician Part A services (Lines 9, 9.01, 9.02, and 10), home office salaries and wage-related costs reported by the hospital on Lines 11 and 12, and nonexcluded area wage-related costs (Lines 13, 14, and 18).

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

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

Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, we then allocated overhead costs to areas of the hospital excluded from the wage

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

Step 5—For each hospital, we adjusted the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimated the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 1999 through April 15, 2001 for private industry hospital workers from the Bureau of Labor Statistics' *Compensation and Working Conditions*. We use the ECI because it reflects the price increase associated with total compensation (salaries plus fringes) rather than just the increase in salaries. In addition, the ECI includes managers as well as other hospital workers. This methodology to compute the monthly update factors uses actual quarterly ECI data and assures that the update factors match the actual quarterly and annual percent changes. The factors used to adjust the hospital's data were based on the midpoint of the cost reporting period, as indicated below.

MIDPOINT OF COST REPORTING PERIOD

After	Before	Adjustment factor
10/14/1999	11/15/1999	1.06794
11/14/1999	12/15/1999	1.06447
12/14/1999	01/15/2000	1.06083
01/14/2000	02/15/2000	1.05713
02/14/2000	03/15/2000	1.05335
03/14/2000	04/15/2000	1.04954
04/14/2000	05/15/2000	1.04571
05/14/2000	06/15/2000	1.04186
06/14/2000	07/15/2000	1.03786
07/14/2000	08/15/2000	1.03356
08/14/2000	09/15/2000	1.02898
09/14/2000	10/15/2000	1.02425
10/14/2000	11/15/2000	1.01953
11/14/2000	12/15/2000	1.01482
12/14/2000	01/15/2001	1.01004
01/14/2001	02/15/2001	1.00509
02/14/2001	03/15/2001	1.00000
03/14/2001	04/15/2001	0.99491

For example, the midpoint of a cost reporting period beginning January 1, 2000 and ending December 31, 2000 is June 30, 2000. An adjustment factor of 1.03786 would be applied to the wages of a hospital with such a cost reporting period. In addition, for the data for any cost reporting period that began in FY 2000 and covered a period of less than 360 days or more than 370 days, we annualized the data to reflect a 1-year cost report. Annualization is accomplished by dividing the data by the number of days in the cost report and then multiplying the results by 365.

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

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

Step 8—We added the total adjusted salaries plus wage-related costs obtained in Step 5 for all hospitals in the nation and then divided the sum by the national sum of total hours from Step 4 to arrive at a national average hourly wage. Using the data as described above, the national average hourly wage is $24.5439.

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

Step 10—Following the process set forth above, we developed a separate Puerto Rico-specific wage index for purposes of adjusting the Puerto Rico standardized amounts. (The national Puerto Rico standardized amount is adjusted by a wage index calculated for all Puerto Rico labor market areas based on the national average hourly wage as described above.) We added the total adjusted salaries plus wage-related costs (as calculated in Step 5) for all hospitals in Puerto Rico and divided the sum by the total hours for Puerto Rico (as calculated in Step 4) to arrive at an overall average hourly wage of $11.5431 for Puerto Rico. For each labor market area in Puerto Rico, we calculated the Puerto Rico-specific wage index value by dividing the area average hourly wage (as calculated in Step 7) by the overall Puerto Rico average hourly wage.

Step 11—Section 4410 of Pub. L. 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State. Furthermore, this wage index floor is to be implemented in such a manner as to ensure that aggregate prospective payment system payments are not greater or less than those that would have been made in the year if this section did not apply. For FY 2004, this change affects 141 hospitals in 44 MSAs. The MSAs affected by this provision are identified by a footnote in Table 4A in the Addendum of this proposed rule.

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

1. General

Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. Hospitals can elect to reclassify for the wage index or the standardized amount, or both, and as individual hospitals or as rural groups. Generally, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. Hospitals must apply for reclassification to the MGCRB, which issues its decisions by the end of February for reclassification to become effective for the following fiscal year (beginning October 1). The regulations applicable to reclassifications by the MGCRB are 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 at § 412.235.

Section 1886(d)(8)(B) of the Act permits a hospital located in a rural county adjacent to one or more urban areas to be designated as being located in the MSA to which the greatest number of workers in the county commute (1) If the rural county would otherwise be considered part of an urban area under the standards published in the **Federal Register** for designating MSAs (and for designating NECMAs), and (2) if the commuting rates used in determining outlying counties (or, for New England, similar recognized area) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous MSAs (or NECMAs). Hospitals that meet these criteria are deemed urban for purposes of the standardized amounts and for purposes of assigning the wage index.

Revised MSA standards were published in the December 27, 2000 **Federal Register** (65 FR 82228). We are working with the Census Bureau to compile a list of hospitals that meet the new standards based on the 2000 census data; however, that work is not yet complete. Therefore, for purposes of calculating the proposed wage indexes in this proposed rule, we used the list of qualifying hospitals based on the 1990 MSA standards.

However, if the updated list of hospitals meeting the new standards based on the 2000 census data is available in time, we will incorporate it in the final rule to be published by August 1, 2003. To the extent hospitals otherwise reclassified by the MGCRB for FY 2004 are adversely affected by their inclusion on or exclusion from the new list, we will address this in the final rule. Among the options we may consider in the final rule to address situations where hospitals may be adversely affected are: Assigning adversely affected hospitals the highest applicable wage index; or extending the opportunity for adversely affected hospitals to withdraw from a reclassification by the MGCRB for FY 2004.

2. Effects of Reclassification

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

- If including the wage data for the redesignated hospitals would reduce the wage index value for the area to which the hospitals are redesignated by 1 percentage point or less, the area wage index value determined exclusive of the wage data for the redesignated hospitals applies to the redesignated hospitals.
- If including the wage data for the redesignated hospitals reduces the wage index value for the area to which the hospitals are redesignated by more than 1 percentage point, the area wage index determined inclusive of the wage data for the redesignated hospitals (the combined wage index value) applies to the redesignated hospitals.
- 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.

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

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

Also, section 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.

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.

The proposed wage index values for FY 2004 are shown in Tables 4A, 4B, 4C, and 4F in the Addendum to this proposed rule. Hospitals that are redesignated should use the wage index values shown in Table 4C. Areas in Table 4C may have more than one wage index value because the wage index value for a redesignated urban or rural hospital cannot be reduced below the wage index value for the rural areas of the State in which the hospital is located, and those areas have hospitals from more than one State reclassified into them.

Tables 3A and 3B in the Addendum of this proposed rule list the 3-year average hourly wage for each labor market area before the redesignation of hospitals, based on FYs 1998, 1999, and 2000 cost reporting periods. Table 3A lists these data for urban areas and Table 3B lists these data for rural areas. In addition, Table 2 in the Addendum to this proposed rule includes the adjusted average hourly wage for each hospital from the FY 1998 and FY 1999 cost reporting periods, as well as the FY 2000 period used to calculate the proposed FY 2004 wage index. The 3-year averages are calculated by dividing the sum of the dollars (adjusted to a common reporting period using the method described previously) across all 3 years, by the sum of the hours. If a hospital is missing data for any of the previous years, its average hourly wage for the 3-year period is calculated based on the data available during that period.

At the time this proposed wage index was constructed, the MGCRB had completed its review of FY 2004 reclassification requests. We have included in this proposed rule Table 9, which shows hospitals that have been reclassified under either section 1886(d)(8) or section 1886(d)(10)(D) of the Act. This table includes hospitals reclassified for FY 2004 by the MGCRB (73 for wage index, 66 for the standardized amount, and 33 for both the wage index and the standardized amount), as well as hospitals that were reclassified for the wage index in either FY 2002 (476) or FY 2003 (56) and are, therefore, in either the second or third year of their 3-year reclassification. This table also includes hospitals located in urban areas that have been designated rural in accordance with section 1886(d)(8)(E) of the Act (14). In addition, it includes rural hospitals redesignated to an urban area under section 1886(d)(8)(B) of the Act for purposes of the standardized amount and the wage index (42).

Under § 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications within 45 days of the publication of this proposed rule in the **Federal Register**. Similarly, hospitals may terminate an existing 3-year reclassification within 45 days of the publication of this proposed rule. The request for withdrawal of an application for reclassification or termination of an existing 3-year reclassification that would be effective in FY 2003 must be received by the MGCRB within 45 days of the publication of this proposed rule. If a hospital elects to withdraw its wage index application after the MGCRB has issued its decision but prior to the above date, it may later cancel its withdrawal in a subsequent year and request the MGCRB to reinstate its wage index reclassification for the remaining fiscal year(s) of the 3-year period (§ 412.273(b)(2)(i)). The request to cancel a prior withdrawal must be made in writing to the MGCRB no later than the deadline for submitting reclassification applications for the following fiscal year (§ 412.273(d)). For further information about withdrawing, terminating, or canceling a previous withdrawal or termination of a 3-year reclassification for wage index purposes, we refer the reader to § 412.273, as well as the August 1, 2002 IPPS final rule (67 FR 50065) and the August 1, 2001 IPPS final rule (66 FR 39887).

Any changes to the wage index that result from withdrawals of requests for reclassification, wage index corrections, appeals, and the Administrator's review process will be incorporated into the wage index values published in the final rule following this proposed rule. Therefore, the final wage indexes will likely be different from those published in this proposed rule, and, in some cases, they may be quite different. Although, as described above, the statute provides that a reclassified rural hospital may not have a lower wage index after reclassification than before, there is no similar protection for urban hospitals. Therefore, hospitals should carefully evaluate the impacts of their reclassifications prior to the deadline for withdrawing from an approved reclassification.

Applications and other information about MGCRB reclassifications may be obtained 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.

As noted previously, OMB plans to announce new definitions of CBSAs by the middle of this year, and the earliest these new CBSA definitions would be used for the wage index is FY 2005. Applications for reclassification by the MGCRB for FY 2005 will be due by September 2, 2003. However, by that time, we will not have completed our analysis of the new CBSAs. Therefore, hospitals submitting applications for reclassification by the MGCRB for FY 2005 should base those applications on the current MSAs. We will assess the implications of the new CBSAs on hospitals' reclassification requests in the FY 2005 proposed rule.

G. Requests for Wage Data Corrections

The preliminary wage data file was made available on January 10, 2003 (and subsequently on February 4, 2003), through the Internet on CMS's Web site at *http://www.cms.hhs.gov/providers/hipps/default.asp*. In a memorandum dated December 31, 2002, we instructed all Medicare fiscal intermediaries to inform the IPPS hospitals they service of the availability of the wage data file and the process and timeframe for requesting revisions (including the specific deadlines listed below). We also instructed the fiscal intermediaries to advise hospitals that these data are made available directly through their representative hospital organizations.

If a hospital wished to request a change to its data as shown in that wage data file, the hospital was to submit corrections along with complete, detailed supporting documentation to its intermediary by February 17, 2003 (this deadline was initially announced as February 10, 2003, but was changed due to the need to repost some of the data). Hospitals were notified of this deadline and of all other possible deadlines and requirements, including the requirement to review and verify their data as posted on the preliminary wage data file on the Internet, through the December 31, 2002 memorandum referenced above.

After reviewing requested changes submitted by hospitals, fiscal intermediaries transmitted any revised cost reports to CMS and forwarded a copy of the revised Worksheet S–3, Parts II and III to the hospitals by April 4, 2003. In addition, fiscal intermediaries were to notify hospitals of the changes or the reasons that changes were not accepted. These deadlines are necessary to allow sufficient time to review and process the data so that the final wage index

calculation can be completed for the development of the final FY 2004 prospective payment rates to be published by August 1, 2003.

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

Hospitals should also examine Table 2 in the Addendum to this proposed rule to verify their data. Table 2 contains each hospital's adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 2000 data used to construct the proposed FY 2004 wage index. We note that the hospital average hourly wages shown in Table 2 only reflect changes made to a hospital's data and transmitted to CMS prior to February 18, 2003.

We will release a final wage data file in May 2003 to hospital associations and the public on the Internet at *http://www.cms.hhs.gov/providers/hipps/default.asp*. The May 2003 public use file will be made available solely for the limited purpose of identifying any potential errors made by CMS or the fiscal intermediary in the entry of the final wage data that result from the correction process described above (revisions submitted to CMS by the fiscal intermediaries by April 4, 2003). If, after reviewing the May 2003 final file, a hospital believes that its wage data are incorrect due to a fiscal intermediary or CMS error in the entry or tabulation of the final wage data, it should send a letter to both its fiscal intermediary and CMS that outlines why the hospital believes an error exists and provide all supporting information, including relevant dates (for example, when it first became aware of the error).

CMS and the fiscal intermediaries must receive these requests no later than June 6, 2003. Requests mailed to CMS should be sent to: Centers for Medicare & Medicaid Services, Center for Medicare Management, Attention: Wage Index Team, Division of Acute Care, C4–07–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

At this point in the process, that is, after the release of the May 2003 wage index file, changes to the hospital wage data will only be made in those very limited situations involving an error by the intermediary or CMS that the hospital could not have known about before its review of the final wage data file. Specifically, neither the intermediary nor CMS will approve the following types of requests:

- Requests for wage data corrections that were submitted too late to be included in the data transmitted to CMS by fiscal intermediaries on or before April 4, 2003.
- Requests for correction of errors that were not, but could have been, identified during the hospital's review of the January 2003 wage data file.
- Requests to revisit factual determinations or policy interpretations made by the intermediary or CMS during the wage data correction process.

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

We have created the process described above to resolve all substantive wage data correction disputes before we finalize the wage data for the FY 2004 payment rates. Accordingly, hospitals that did not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage data corrections or to dispute the intermediary's decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth above will not be permitted to challenge later, before the Provider Reimbursement Review Board, the failure of CMS to make a requested data revision (*See W. A. Foote Memorial Hospital* v. *Shalala*, No. 99–CV–75202–DT (E.D. Mich. 2001)).

Again, we believe the wage data correction process described above provides hospitals with sufficient opportunity to bring errors in their wage data to the fiscal intermediaries' attention. Moreover, because hospitals will have access to the final wage data by early May 2003, they will have the opportunity to detect any data entry or tabulation errors made by the fiscal intermediary or CMS before the development and publication of the FY 2004 wage index by August 1, 2003, and the implementation of the FY 2004 wage index on October 1, 2003. If hospitals avail themselves of this opportunity, the wage index implemented on October 1 should be accurate. Nevertheless, in the event that errors are identified after that date, we retain the right to make midyear changes to the wage index under very limited circumstances.

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

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

Although the wage data correction process described in section III.G. of this preamble has proven successful in the past for ensuring that the wage data used each year to calculate the wage indexes are generally reliable and accurate, we continue to be concerned about the growing volume of wage data revisions initiated by hospitals after the release of the first public use file in February. This issue has been discussed previously in the FY 1998 IPPS proposed rule (62 FR 29918) and in the FY 2002 IPPS proposed rule (66 FR 22682). In each discussion, we describe the increasing number of revisions to wage data between the proposed rule and the final rule.

Currently, the fiscal intermediaries are required to conduct initial desk reviews on or before November 15 in advance of the preparation of the preliminary wage data public use file in early January (see Program

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

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

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

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

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

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

* Indicates no change from prior years.

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

A. Transfer Payment Policy (§ 412.4)

Existing regulations at § 412.4(a) define discharges under the IPPS as situations in which a patient is formally released from an acute care hospital or dies in the hospital. Section 412.4(b) defines transfers from one acute care hospital to another, and § 412.4(c) defines transfers to certain postacute care providers. Our policy provides that, in transfer situations, full payment is made to the final discharging hospital and each transferring hospital is paid a per diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

The per diem rate paid to a transferring hospital is calculated by dividing the full DRG payment by the geometric mean length of stay for the DRG. Based on an analysis that showed that the first day of hospitalization is the most expensive (60 FR 45804), our policy provides for payment that is double the per diem amount for the first day (§ 412.4(f)(1)). Transfer cases are also eligible for outlier payments. The outlier threshold for transfer cases is equal to the fixed-loss outlier threshold for nontransfer cases, divided by the geometric mean length of stay for the DRG, multiplied by the length of stay for the case, plus one day.

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

Medicare adopted its IPPS transfer policy because, if we were to pay the full DRG payment regardless of whether a patient is transferred or discharged, there would be a strong incentive for hospitals to transfer patients to another IPPS hospital early in their stay in order to minimize costs while still receiving the full DRG payment. The transfer policy adjusts the payments to approximate the reduced costs of transfer cases.

Currently, when a patient chooses to depart from a hospital against the medical opinion of treating physicians, the case is treated as a left against medical advice (LAMA) discharge and coded as discharge status ''07–Left Against Medical Advice (LAMA)'' on the inpatient billing claim form. Because, by definition, LAMA discharges are assumed not to involve the active participation of the hospital administration, our policy has been to treat LAMA cases as discharges. This policy applies even if the patient is admitted to another hospital on the date of the LAMA discharge. Consequently, we currently make a full DRG payment for any discharge coded as a LAMA case.

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

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

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

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

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

Therefore, we are proposing to expand our definition of a transfer under § 412.4(b) to include all patients who are admitted to another IPPS hospital on the same day that the patient is discharged from an IPPS hospital, unless the first (transferring) hospital can demonstrate that the patient's treatment was completed at the time of discharge from that hospital. In other words, unless the same-day readmission is to treat a condition that is unrelated to the condition treated during the original admission (for example, the beneficiary is in a car accident later that day), any situation where the beneficiary is admitted to another IPPS hospital on the same date that he or she is discharged from an IPPS hospital would be considered a transfer, even if the patient left against medical advice from the first hospital.

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

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

2. Technical Correction

Section 412.4(b)(2) defines a discharge from one inpatient area of the hospital to another area of the hospital as a transfer. Although this situation may be viewed as an intrahospital transfer, it does not implicate the transfer policy under the IPPS. Therefore, to avoid confusion and to be

consistent with the proposed changes to § 412.4(b) described at section IV.A.3. of this preamble, we are proposing to delete existing § 412.4(b)(2) from the definition of a transfer.

3. Expanding the Postacute Care Transfer Policy to Additional DRGs (§§ 412.4(c) and (d))

Under section 1886(d)(5)(J) of the Act, a ''qualified discharge'' from one of 10 DRGs selected by the Secretary, to a postacute care provider is treated as a transfer case beginning with discharges on or after October 1, 1998. This section requires the Secretary to define and pay as transfers all cases assigned to one of 10 DRGs selected by the Secretary, if the individuals are discharged to one of the following postacute care settings:

- A hospital or hospital unit that is not a subsection 1886(d) hospital. (Section 1886(d)(1)(B) of the Act identifies the hospitals and hospital units that are excluded from the term ''subsection (d) hospital'' as psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term care hospitals, and cancer hospitals.)
- A SNF (as defined at section 1819(a) of the Act).
- Home health services provided by a home health agency, if the services relate to the condition or diagnosis for which the individual received inpatient hospital services, and if the home health services are provided within an appropriate period (as determined by the Secretary).

In the July 31, 1998 IPPS final rule (63 FR 40975 through 40976), we specified the appropriate time period during which we would consider a discharge to postacute home health services to constitute a transfer as within 3 days after the date of discharge. Also, in the July 31, 1998 final rule, we did not include in the definition of postacute care transfer cases patients transferred to a swing-bed for skilled nursing care (63 FR 40977).

Section 1886(d)(5)(J) of the Act directed the Secretary to select 10 DRGs based upon a high volume of discharges to postacute care and a disproportionate use of postacute care services. As discussed in the July 31, 1998 final rule, these 10 DRGs were selected in 1998 based on the MedPAR data from FY 1996. Using that information, we identified and selected the first 20 DRGs that had the largest proportion of discharges to postacute care (and at least 14,000 such transfer cases). In order to select 10 DRGs from the 20 DRGs on our list, we considered the volume and percentage of discharges to postacute care that occurred before the mean length of stay and whether the discharges occurring early in the stay were more likely to receive postacute care. We identified the following DRGs to be subject to the special 10 DRG transfer rule:

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

Similar to the policy for transfers between two acute care hospitals, the transferring hospital in a postacute care transfer for 7 of the 10 DRGs receives twice the per diem rate the first day and the per diem rate for each following day of the stay before the transfer, up to the full DRG payment. However, 3 of the 10 DRGs exhibit a disproportionate share of costs very early in the hospital stay in postacute care transfer situations. For these 3 DRGs, hospitals receive 50 percent of the full DRG payment plus the single per diem (rather than double the per diem) for the first day of the stay and 50 percent of the per diem for the remaining days of the stay, up to the full DRG payment. This is consistent with section 1886(d)(5)(J)(i) of the Act, which recognizes that in some cases ''a substantial portion of the costs of care are incurred in the early days of the inpatient stay.''

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

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

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

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

The table below displays the results of our analysis. We first examined whether the 10 DRGs included in the policy continue to exhibit a relatively high percentage of cases transferred to postacute care settings, particularly

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

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

With respect to whether this policy alters the fundamental averaging principles of the IPPS, we believe the current policy, which targets specific DRGs where evidence shows hospitals have aggressively moved care to postacute care settings, does not alter the averaging principles of the system. In fact, it could be said to enhance those principles because a transfer case is counted as only a fraction of a case toward DRG recalibration based on the ratio of its transfer payment to the full DRG payment for nontransfer cases. This methodology ensures the DRG weight calculation is consistent with the payment policy for transfer cases. The last column of the table below indicates that all but three of these DRGs have experienced increases in DRG weights since the policy was implemented. By reducing the contribution of transfer cases to the calculation of the DRG average charge, the relative weights (the result of dividing the DRG average charge by the national average charge per case) are higher than they would otherwise be. This is because transfers, particularly short-stay transfers, have lower total charges, on average.

DRG	DRG title	All transfer cases	Percent of all cases transferred to postacute care setting	Percent of all cases transferred prior to mean length of stay	Percent change in mean length of stay FYs 92–98	Percent change in mean length of stay FYs 98–03	Percent change in DRG relative weight FYs 98–03
14	Intracranial Hemorrhage and Stroke with Infarction.	143,649	48.88	11.74	−29.17	−5.88	8.53
113	Amputation for Circulatory System Disorders Except Upper Limb and Toe.	24,470	66.57	30.12	−32.17	7.22	9.21
209	Major Joint and Limb Reattachment Procedures of Lower Extremity.	244,969	66.66	19.76	−47.52	−15.09	−8.09
210	Hip and Femur Procedures Except Major Joint Age >17 With CC.	87,253	76.26	35.67	−42.98	−6.15	0.1
211	Hip and Femur Procedures Except Major Joint Age >17 Without CC.	20,239	72.38	15.89	−44.44	−8.00	1.39
236	Fractures of Hip and Pelvis	26,583	69.86	11.20	−34.85	−6.98	−1.43
263	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC.	13,158	62.00	31.35	−41.45	4.49	9.36
264	Skin Graft and/or Debridement for Skin Ulcer or Cellulitis Without CC.	1,759	49.97	18.81	−37.21	1.85	5.36
429	Organic Disturbances and Mental Retardation.	30,349	53.25	15.22	−28.95	−12.96	−5.27
483	Tracheostomy With Mechanical Ventilation 96 + Hours or Principal Diagnosis Except Face, Mouth, and Neck Diagnoses.	21,818	52.93	27.34	−15.29	2.37	1.38

After determining the current 10 DRG postacute care transfer policy appears to be appropriately balancing the objectives to reduce payments to reflect cost-shifting due to reductions in length of stay attributable to early postacute care transfers and to ensure that payments, on average, remain adequate to ensure effective patient care, we once again undertook the analysis to identify additional DRGs to which the policy may be expanded. However, it should be noted that, at this time, we have decided not to expand the policy to all DRGs. Although we still believe expanding the postacute care transfer policy to all DRGs might be the most equitable approach because a policy that is limited to certain DRGs may result in disparate payment treatment across hospitals, at this time, we believe an incremental expansion is appropriate. That is, we believe further analysis is necessary to assess whether it would be appropriate to apply a reduced payment for postacute care transfers across all DRGs. In particular, it is important to attempt to distinguish between DRGs where the care is increasingly being shifted to postacute care sites versus DRGs where some patients have always been discharged to postacute care early in the stay. For the latter DRGs, it may not be appropriate to reduce payment for these DRGs if the base payment already reflects a similar postacute care utilization rate (for example, in these cases there would be no cost shifting).

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

MedPAC has also conducted analysis on the current postacute care transfer policy. Most recently, in its March 2003 Report to Congress, MedPAC recommended adding 13 additional DRGs to the 10 DRGs covered under the current policy (page 46). The 13 DRGs were the same DRGs included in one of our proposals to expand the postacute care transfer policy in last year's IPPS proposed rule. MedPAC did not recommend expanding the policy to include all DRGs at this time, noting

that this expansion might reduce payments to some hospitals by as much as 4 percent. Rather, it suggested evaluating the impact of a limited expansion before extending the policy to more DRGs.

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

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

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

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

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

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

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

We also examined whether any of these DRGs would qualify for the alternative payment methodology of 50 percent of the full DRG payment plus the per diem for the first day of the stay, and 50 percent of the per diem for the remaining days of the stay, up to the full DRG payment specified in existing regulations under § 412.4(f). To identify the DRGs that might qualify, the average charges for all cases with a length of stay of 1 day were compared to the average charges of all cases in a particular DRG. To qualify for the alternative methodology, the average charges of 1-day discharge cases must be at least 50 percent of the average charges for all cases in the DRG.

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

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

Finally, we note that the OIG has prepared several reports that examined hospitals' compliance with proper coding of patients' discharge status as transferred under our guidelines, and has found substantial noncompliance leading to excessive payments.[4] Specifically, the OIG found hospitals submitting claims indicating the patient had been discharged when, in fact, the patient was transferred to a postacute care setting. As we indicated in the May 8, 1998 **Federal Register** (63 FR 25593), hospitals found to be intentionally engaging in such practices may be investigated for fraudulent or abusive billing practices. We intend to work with the OIG to develop the most appropriate response to ensure all hospitals become compliant with our guidelines.

B. Rural Referral Centers (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the IPPS as a rural referral center. For discharges occurring before October 1, 1994, rural referral centers received the benefit of payment based on the other urban amount rather than the rural standardized amount. Although the other urban and rural standardized amounts are the same for discharges beginning with that date, rural referral centers continue to receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Rural referral centers with a disproportionate share percentage of at least 30 percent are not subject to the 5.25 percent cap on DSH payments that is applicable to other rural hospitals (with the exception of rural hospitals with 500 or more beds). Rural referral centers are not subject to the proximity criteria when applying for geographic reclassification, and they do not have to meet the requirement that a hospital's average hourly wage must exceed 106 percent of the average hourly wage of the labor market area where the hospital is located.

[4] The OIG report identification numbers are: A–04–00–02162, A–04–00–01220 and A–04–01210. A fourth report is expected out soon.

As discussed in **Federal Register** documents at 62 FR 45999 and 63 FR 26325, under section 4202 of Public Law 105–33, a hospital that was classified as a rural referral center for FY 1991 is to be considered as a rural referral center for FY 1998 and later years so long as that hospital continues to be located in a rural area and does not voluntarily terminate its rural referral center status. Effective October 1, 2000, if a hospital located in what is now an urban area was ever a rural referral center, it is reinstated to rural referral center status (65 FR 47089). Otherwise, a hospital seeking rural referral center status must satisfy the applicable criteria.

One of the criteria under which a hospital may qualify as a rural referral center is to have 275 or more beds available for use (§ 412.96(b)(1)(ii)). A rural hospital that does not meet the bed size requirement can qualify as a rural referral center if the hospital meets two mandatory prerequisites (a minimum case-mix index and a minimum number of discharges) and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume) (§ 412.96(c)(1) through (c)(5)). (See also the September 30, 1988 **Federal Register** (53 FR 38513).) With respect to the two mandatory prerequisites, a hospital may be classified as a rural referral center if—

- The hospital's case-mix index is at least equal to the lower of the median case-mix index for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median case-mix index for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year, as specified in section 1886(d)(5)(C)(i) of the Act.)

1. Case-Mix Index

Section 412.96(c)(1) provides that CMS will establish updated national and regional case-mix index values in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. The methodology we use to determine the proposed national and regional case-mix index values is set forth in regulations at § 412.96(c)(1)(ii). The proposed national mean case-mix index value for FY 2004 includes all urban hospitals nationwide, and the proposed regional values for FY 2004 are the

median values of urban hospitals within each census region, excluding those hospitals with approved teaching programs (that is, those hospitals receiving indirect medical education payments as provided in § 412.105). These proposed values are based on discharges occurring during FY 2002 (October 1, 2001 through September 30, 2002) and include bills posted to CMS' records through December 2002.

We are proposing that, in addition to meeting other criteria, if they are to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2003, rural hospitals with fewer than 275 beds must have a case-mix index value for FY 2002 that is at least—

- 1.3374; or
- The median case-mix index value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 412.105) calculated by CMS for the census region in which the hospital is located.

The proposed median case-mix index values by region are set forth in the following table:

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.2252
2. Middle Atlantic (PA, NJ, NY)	1.2270
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.3157
4. East North Central (IL, IN, MI, OH, WI)	1.2485
5. East South Central (AL, KY, MS, TN)	1.2511
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.1841
7. West South Central (AR, LA, OK, TX)	1.2733
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.3511
9. Pacific (AK, CA, HI, OR, WA)	1.2834

The preceding numbers will be revised in the final rule to the extent required to reflect the updated FY 2002 MedPAR file, which will contain data from additional bills received through March 31, 2002.

Hospitals seeking to qualify as rural referral centers or those wishing to know how their case-mix index value compares to the criteria should obtain hospital-specific case-mix index values (not transfer-adjusted) from their fiscal intermediaries. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, these case-mix index values are computed based on all Medicare patient discharges subject to DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS will set forth the national and regional numbers of discharges in each year's annual notice of prospective payment rates for purposes of determining rural referral center status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. We are proposing to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2002 (that is, October 1, 2001 through September 30, 2002).

Therefore, we are proposing that, in addition to meeting other criteria, a hospital, if it is to qualify for initial rural referral center status for cost reporting periods beginning on or after October 1, 2003, must have as the number of discharges for its cost reporting period that began during FY 2002 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located, as indicated in the following table:

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

These numbers will be revised in the final rule based on the latest available cost report data.

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

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

Section 1886(d)(5)(B) of the Act provides that subsection (d) hospitals that have residents in approved graduate medical education (GME) programs receive an additional payment for each discharge of Medicare beneficiaries to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The existing regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at § 412.105. The additional payment is based on the IME adjustment factor, calculated using

hospitals' ratios of residents to beds. The determination of the number of beds, based on available bed days, is specified at § 412.105(b). This determination of the number of available beds is also applicable for other purposes, including the level of the disproportionate share hospital (DSH) adjustment payments under § 412.106(a)(l)(i).

Section 1886(d)(5)(F) of the Act specifies two methods for a hospital to qualify for the Medicare DSH adjustment. The primary method, which is the subject of a provision in this proposed rule, is for a hospital to qualify based on a complex statutory formula under which payment adjustments are based on the level of the DSH patient percentage. The first computation includes the number of patient days that are furnished to patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits. This number is divided by the total number of patient days that are associated with patients entitled to benefits under Medicare Part A. The second computation includes hospital patient days that are furnished to patients who, for those days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A. This number is divided by the number of total hospital inpatient days in the same period.

Hospitals whose DSH patient percentage exceeds 15 percent are eligible for a DSH payment adjustment (prior to April 1, 2001, the qualifying DSH patient percentage varied, in part, by the number of beds (66 FR 39882)). The DSH payment adjustment may vary based on the DSH patient percentage and the type of hospital: the statute provides for different adjustments for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, hospitals that qualify as rural referral centers or SCHs, and other hospitals.

We are combining our discussion of proposed changes to the policies for counting beds and patient days, in relation to the calculations at §§ 412.105(b) and 412.106(a)(1)(ii) because the underlying concepts are similar, and we believe they should generally be interpreted in a consistent manner for both purposes. Specifically, we are proposing to clarify that beds and patient days that are counted for these purposes should be limited to beds or patient days in hospital units or wards that would be directly included in determining the allowable costs of inpatient hospital care payable under the IPPS on the Medicare cost reports. As a preliminary matter, beds and patient days associated with these beds that are located in units or wards that are excluded from the IPPS (for example, psychiatric or rehabilitation units), and thus from the determination of allowable costs of inpatient hospital care under the IPPS on the Medicare cost report, are not to be counted for purposes of §§ 412.105(b) and 412.106(a)(1)(ii). The remainder of this discussion pertains to beds and patient days associated with these beds that are located in units or wards that are not excluded from the IPPS and for which costs are included in determining the allowable costs of inpatient hospital care under the IPPS on the Medicare cost report. For example, neonatal intensive care unit beds are included in the determination of available beds because the costs and patient days associated with these beds are directly included in the determination of the allowable costs of inpatient hospital care under the IPPS. In contrast, beds and patient days associated with these beds that are located in excluded distinct-part psychiatric or rehabilitation units would not be counted for purposes of §§ 412.105(b) and 412.106(a)(1)(ii) under any circumstances, because the costs associated with those units or wards are excluded from the determination of the costs of allowable inpatient care under IPPS.

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

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

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

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

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

2. Unoccupied Beds

The current policy for counting hospital beds for IME and DSH is specified at § 412.105(b). That count is based on total available bed days during

the hospital's cost reporting period, divided by the number of days in the cost reporting period. The regulations specify certain types of beds to be excluded from this count (for example, beds or bassinets in the healthy newborn nursery, custodial care beds, and beds in excluded distinct part hospital units).

Further instructions for counting beds are detailed in section 2405.3, Part I, of the Medicare Provider Reimbursement Manual (PRM). That section states that a bed must be permanently maintained for lodging inpatients and it must be available for use and housed in patient rooms or wards. Thus, beds in a completely or partially closed wing of the facility are considered available only if the hospital can put the beds into use when they are needed.

Currently, if a bed can be staffed for inpatient care either by nurses on staff or from a nurse registry within 24 to 48 hours, the unoccupied bed is determined available.[5] In most cases, it is a straightforward matter to determine whether unoccupied beds can be staffed within this timeframe because they are located in a unit that is otherwise staffed and occupied (an unoccupied bed is available for patient care but it is not occupied by a patient on a particular day). The determination is not as simple in situations where a room in an otherwise occupied unit has been altered for other purposes, such as for a staff lounge or for storage.

Section 2405.3 of the PRM states that beds in unoccupied rooms or wards are to be excluded from the bed count if the associated costs are excluded from depreciable plant assets because the area is not available for patient use. However, issues continue to arise with regard to how to treat entire units or even entire floors that are unoccupied over a period of time. For example, in one recent Provider Reimbursement Review Board (PRRB) decision, the hospital acknowledged that an entire floor was temporarily unoccupied for approximately 2 years. Rooms on the floor were used for office space, storage and outpatient services. The PRRB ruled that current rules allowed these beds to be counted. Specifically, the PRRB found the beds could reasonably be made ready for inpatient use within 24 to 48 hours, the rooms were counted on the hospital's cost report as depreciable plant assets available for patient care, and the hospital could adequately provide patient care in the beds using staff nurses or nurses from a nurse registry. Upon review, the Administrator also ultimately upheld this decision based on existing policies and instructions.

We do not believe that an accurate bed count should include beds that are essentially hypothetical in nature; for example, when the beds are on a floor that is not used for inpatient care throughout the entire cost reporting period (and, indeed, may have been used for other purposes). Followed to the extreme, a hospital could count every bed in its facility, even if it had no intention of ever using a bed for inpatient care, as long as it would be theoretically possible to place an inpatient in the bed. We do not believe such a result would accurately reflect a hospital's inpatient bed capacity. Even though some teaching hospitals have an incentive to minimize the bed count for payment purposes, some DSH hospitals have an incentive to maximize the bed count for the same reason. Our current policy is intended to reflect a hospital's bed count as accurately as possible, achieving a balance between capturing short-term shifts in occupancy and long-term changes in capacity. Therefore, we believe further clarification and refinement of our policies relating to counting available beds is necessary.

In the FY 2003 IPPS proposed rule published on May 9, 2002 (67 FR 31462), we proposed that, if a hospital's reported bed count results in an occupancy rate (average daily census of patients divided by the number of beds) below 35 percent, the applicable bed count, for purposes of establishing the number of available beds for that hospital would exclude beds that would result in an average annual occupancy rate below 35 percent. However, at the time the FY 2003 IPPS final rule was published on August 1, 2002 (67 FR 50060), we decided not to proceed with the proposed changes as final and to reconsider the issue as part of a future comprehensive analysis of our bed and patient day counting policies.

In this proposed rule, rather than establish a minimum standard occupancy rate, we are proposing to determine whether beds in a unit are available based upon whether the unit was used to provide patient care of a level generally payable under the IPPS (''IPPS level of care'') *at any time* during the 3 preceding months. If any of the beds in the unit were used to provide an IPPS level of care at any time during the preceding 3 months, all of the beds in the unit are counted for purposes of determining available bed days during the current month. If no patient care of a type generally payable under the IPPS was provided in that unit during the 3 preceding months, the beds in the unit are to be excluded from the determination of available bed days during the current month (proposed §§ 412.105(b)(2) and 412.106(a)(1)(ii)(C)).

For example, our policy as to how to count beds during minor renovations of units, wards, or individual rooms has been that unless the space costs are treated as nonallowable, the beds would be counted. Under the policy we are proposing, beds in an otherwise unoccupied unit that are occupied (for purposes of providing IPPS-level care) at any time during the 3 preceding months would be counted as available for the current month. This would apply even if the rooms were undergoing renovation during a portion of that 3-month period.

We believe a unit or ward can be defined as a group of rooms staffed by nurses assigned to a single nursing station. In most cases, the patients treated within a single unit or ward will receive a similar level of care (that is, acute, intensive, rehabilitation, psychiatric, or skilled nursing). However, we encourage comments on the most useful definition of a unit or ward.

We believe this proposed policy would provide a clear standard for both hospitals and fiscal intermediaries to use to determine whether otherwise unoccupied beds should be counted. We note that if the required time period for excluding the unoccupied beds were to be set too low, hospitals could potentially manipulate their available bed count by not admitting any patients to a unit during low occupancy periods, thereby distorting the measure of hospital size. We believe 3 months, one quarter of a hospital's fiscal year, represents a reasonable standard for determining that a unit is not being used to provide patient care and may be excluded from the hospital's available bed count.

It is also necessary to consider our policy with respect to individual beds within rooms located in an otherwise occupied unit when those beds are used for alternative purposes. For example, section 2405.3 of the PRM states that beds used for the following are excluded from the definition (of a bed): Postanesthesia or postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments nurses' and other staff residences, and other such areas as are regularly maintained and utilized for only a portion of the stay of patients or for purposes other than inpatient lodging. In some situations, beds used for these excluded

[5] This policy was first articulated in correspondence to the Blue Cross and Blue Shield Association (BCBSA) on November 2, 1988, and published in BCBSA's Administrative Bulletin #1841, 88.01, on November 18, 1988.

purposes may be intermingled with acute care inpatient beds.

Beds being used to provide specific categories of nonacute services, such as outpatient services in an observation bed or skilled nursing services in a swing-bed, are excluded from the count. As discussed later, this flows from our policy that the bed days are treated consistently with the assignment of the costs on the Medicare cost report of the services provided in the bed.

In the case of individual rooms in an otherwise occupied unit that are altered to be used for other uses besides inpatient care, we are proposing the bed(s) should be counted if a patient could be admitted to the room within 24 hours (proposed § 412.105(b)(3)). This would apply even if the bed(s) were not currently located in the room, as long as a bed could be physically placed in the room and made available within 24 hours. We are proposing that it would no longer be necessary for the hospital to determine whether a bed could be staffed within 24 to 48 hours. For example, in the case of a room that has been altered for use as a staff lounge, if the room could be made available to house a patient merely by replacing the lounge furniture with a patient bed, the bed should be counted as available.

Under this proposal, other than when an inpatient room is used to provide observation services, labor/delivery room services, or skilled nursing services in a swing-bed (all discussed later in this proposed rule), the alternative purpose of the room is only relevant if it impacts whether the room could be made available for patient occupancy within 24 hours. If the hospital was fully occupied (no other room was available), and the room still was not put into service when needed, that would provide evidence that the room could not be made available and beds in the room should be excluded from the bed count.

Therefore, we are proposing to amend § 412.105(b) to indicate that the bed days in a unit that is unoccupied by patients receiving IPPS-level care for the 3 preceding months are to be excluded from the available bed day count for the current month. We are further proposing the beds in a unit that was occupied for IPPS-level care during the 3 preceding months should be counted unless they could not be made available for patient occupancy within 24 hours, or they are used to provide outpatient observation services or swing-bed skilled nursing care.

3. Nonacute Care Beds and Days

As noted above, these policies are consistent with the reporting of the days, costs, and beds that are used to calculate the costs of hospital inpatient care in individual cost centers on the Medicare cost report. Furthermore, since the IME and DSH adjustments are part of the IPPS, we read the statute to apply only to inpatient beds and days.

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

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

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

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

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

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

Generally, as discussed previously, if the nature of the care provided in the unit or ward is consistent with what is typically furnished to acute care patients, and, therefore, would be characteristic of services paid under the IPPS, the patient days, beds, and costs of that unit or ward would be classified as inpatient acute care (except for observation bed days and swing bed days, as discussed later in this

preamble). Conversely, if the intensity and type of care provided in the unit or ward are not typical of a service that would be paid under the IPPS (for example, nonacute care), we are proposing that the beds and patient days attributable to a nonacute care unit or ward should not be included in the calculations of beds and patient days at § 412.105(b) and § 412.106(a)(1)(ii).

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

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

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

We note these proposed revisions are clarifications of our regulations to reflect our longstanding interpretation of the statutory intent, especially relating to the calculation of the Medicare DSH patient percentage.

4. Observation Beds and Swing-Beds

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

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

A swing-bed is a bed otherwise available for use to provide acute inpatient care that is also occasionally used to provide SNF care. The criteria to qualify as a swing-bed hospital are located under § 482.66, and for a swing-bed CAH under § 485.645. Under § 413.114(a)(1), payment for posthospital SNF care furnished in swing-beds is in accordance with the provisions of the prospective payment system for SNF care (effective for services furnished in cost reporting periods beginning on and after July 1, 2002). Similar to observation beds and patient days, swing-beds and patient days are excluded from the counts of available bed days and patient days at §§ 412.105(b) and 412.106(a)(1)(ii) when the swing-bed is used to furnish SNF care.[6]

Observation beds and swing-beds are both special, frequently temporary, alternative uses of acute inpatient care beds. That is, only the days an acute inpatient care unit bed is used to provide outpatient observation services are to be deducted from the available bed count under § 412.105(b). Otherwise, the bed is considered available for acute care services (as long as it otherwise meets the criteria to be considered available). This same policy applies for swing-beds. The policies to exclude observation bed days and swing-bed days stem from the fact that these bed days are not payable under the IPPS (unless the patient is ultimately admitted, in the case of observation bed days).

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

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

Courts also have recently found that observation and swing-bed days are included under the 'plain meaning' of § 412.106(a)(1)(ii), which reads: ''The number of patient days includes only those days attributable to areas of the hospital that are subject to the prospective payment system and excludes all others.'' However, the preamble language when this provision was promulgated clarified its meaning (53 FR 38480):

• ''Although previously the Medicare regulations did not specifically define the inpatient days for use in the computation of a hospital's disproportionate share patient percentage, we believe that, based on a

[6] *Ibid.*

reading of the language in section 1886(d)(5)(F) of the Act, which implements the disproportionate share provision, we are in fact required to consider only those inpatient days to which the prospective payment system applies in determining a prospective payment hospital's eligibility for a disproportionate share adjustment.''

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

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

However, we are proposing to amend our policy with respect to observation bed days of patients who ultimately are admitted. As noted previously, our current policy is that these bed days are excluded from the available bed day and the patient day counts. This policy was communicated in a memorandum to all CMS Regional Offices on February 27, 1997. Specifically, we are proposing that, if a patient is admitted as an acute inpatient subsequent to receiving outpatient observation services, because the charges of the observation ancillary services the patient receives are currently treated as inpatient charges on the cost report, in order to be consistent with our policy to treat the costs and patient days consistently, we will begin to include the patient bed days associated with the observation services in the inpatient bed day count.

In order to avoid any potential future misunderstandings about our policies regarding the exclusion of observation and swing-bed days under the regulations at § 412.105(b) and § 412.106(a)(1)(ii), we are proposing to revise our regulations to specify our policy that observation and swing-bed bed days are to be excluded from the counts of both available beds and patient days, unless a patient treated in an observation bed is ultimately admitted, in which case the beds and days would be included in those counts.

5. Labor, Delivery, Recovery, and Postpartum Beds and Days

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

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

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

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

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

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

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

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

a section 1115 expansion waiver demonstration project (effective with discharges occurring on or after January 20, 2000).

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

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

In allowing hospitals to include patient days related to section 1115 expansion waiver populations, our intention was to include patient days of section 1115 expansion waiver populations who receive benefits under the demonstration project that are similar to those available to traditional Medicaid beneficiaries, including inpatient benefits. Because of the differences between expansion populations in these limited benefit demonstrations and traditional Medicaid beneficiaries, we are proposing that the Medicare DSH calculation should exclude from treatment as Medicaid patient days those patient days attributable to limited benefit section 1115 expansion waiver populations (proposed § 412.106(b)(4)(i)).

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

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

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

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

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

7. Dual-Eligible Patient Days

As described above, the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits. If a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual-eligible and the patient days are included in the Medicare fraction of the DSH patient percentage but not the Medicaid fraction. This is consistent with the language of section 1886(d)(5)(F)(vi)(II) of the Act, which specifies that patients entitled to benefits under Part A are excluded from the Medicaid fraction.

This policy currently applies even after the patient's Medicare coverage is exhausted. In other words, if a dual-eligible patient is admitted without any Medicare Part A coverage remaining, or the patient exhausts Medicare Part A coverage while an inpatient, his or her patient days are counted in the Medicare fraction before and after Medicare coverage is exhausted. This is consistent with our inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.

We are proposing to change our policy, to begin to count in the Medicaid fraction of the DSH patient percentage the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage has expired. We note the statute referenced above stipulates that patient days attributable to patients entitled to benefits under Medicare Part A are to be excluded from the Medicaid fraction, while the statute specifies the Medicaid fraction is to include patients who are eligible for Medicaid.

As noted above, our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the

Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted. We believe this interpretation is consistent with the statutory intent of section 1886(d)(5)(F)(vi)(II) of the Act. However, we recognize there are other plausible interpretations. In addition, on a more practical level, we recognize it is often difficult for fiscal intermediaries to differentiate the days for dual-eligible patients whose Part A coverage has been exhausted. The degree of difficulty depends on the data provided by the States, which may vary from one State to the next. Some States identify all dual-eligible beneficiaries in their lists of Medicaid patient days provided to the hospitals, while in other States the fiscal intermediary must identify patient days attributable to dual-eligible beneficiaries by matching Medicare Part A bills with the list of Medicaid patients provided by the State. The latter case is problematic when Medicare Part A coverage is exhausted because no Medicare Part A bill may be submitted for these patients. Thus, the fiscal intermediary has no data by which to readily verify any adjustment for these cases in the Medicaid data provided by the hospital. Currently, the fiscal intermediaries are reliant on the hospitals to identify the days attributable to dual-eligible beneficiaries so these days can be excluded from the Medicaid patient days count.

Therefore, in order to facilitate consistent handling of these days across all hospitals, we are proposing that the days of patients who have exhausted their Medicare Part A coverage will no longer be included in the Medicare fraction. Instead, we are proposing these days should be included in the Medicaid fraction of the DSH calculation. (We note that not all SSI recipients are Medicaid eligible. Therefore, it will not be automatic that the patient days of SSI recipients will be counted in the Medicaid fraction when their Part a coverage expires.)

Under this proposed change, before a hospital could count patient days attributable to dual-eligible beneficiaries in the Medicaid fraction, the hospital must submit documentation to the fiscal intermediary that justifies including the days in the Medicaid fraction after the Medicare Part A benefits have been exhausted. That is, if the State provides data on all the days associated with all dual-eligible patients treated at a hospital, regardless of whether the beneficiary had Medicare Part A coverage, the hospital is responsible for providing documentation showing which days should be included in the Medicaid fraction because Medicare Part A coverage was exhausted.

8. Medicare+Choice (M+C) Days

Under § 422.1, an M+C plan ''means health benefits coverage offered under a policy or contract by an M+C organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the M+C plan.'' Generally, each M+C plan must provide coverage of all services that are covered by Medicare Part A and Part B (or just Part B if the M+C plan enrollee is only entitled to Part B).

We have received questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation. The question stems from whether M+C plan enrollees are entitled to benefits under Medicare Part A since M+C plans are administered through Medicare Part C.

We note that, under § 422.50, an individual is eligible to elect an M+C plan if he or she is entitled to Medicare Part A and enrolled in Part B. However, once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A.

Therefore, we are proposing to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.

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

With the creation of the MGCRB, beginning in FY 1991, under section 1886(d)(10) of the Act, hospitals could request reclassification from one geographic location to another for the purpose of using the other area's standardized amount for inpatient operating costs or the wage index value, or both (September 6, 1990 interim final rule with comment period (55 FR 36754), June 4, 1991 final rule with comment period (56 FR 25458), and June 4, 1992 proposed rule (57 FR 23631)). Implementing regulations in subpart L of part 412 (§§ 412.230 *et seq.*) set forth criteria and conditions for redesignations for purposes of the wage index or the average standardized amount, or both, from rural to urban, rural to rural, or from an urban area to another urban area, with special rules for SCHs and rural referral centers.

Effective with reclassifications for FY 2003, section 1886(d)(10)(D)(vi)(II) of the Act provides that the MGCRB must use the average of the 3 years of hourly wage data from the most recently published data for the hospital when evaluating a hospital's request for reclassification. The regulations at § 412.230(e)(2)(ii) stipulate that the wage data are taken from the CMS hospital wage survey used to construct the wage index in effect for prospective payment purposes. To evaluate applications for wage index reclassifications for FY 2004, the MGCRB used the 3-year average hourly wages published in Table 2 of the August 1, 2002 IPPS final rule (67 FR 50135). These average hourly wages are taken from data used to calculate the wage indexes for FY 2001, FY 2002, and FY 2003, based on cost reporting periods beginning during FY 1997, FY 1998, and FY 1999, respectively.

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

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

''Allowing hospitals the opportunity to revise their data beyond the timelines required to finalize the data used to calculate the wage index each year would lessen the importance of complying with those deadlines. The likely result would be that the data used to compute the wage index would not be as carefully scrutinized because

hospitals would know they may change it later, leading to inaccuracy in the data and less stability in the wage indexes from year to year.''

Since responding to this comment in the FY 2003 IPPS final rule, we have become aware of a situation in which a hospital does not meet the criteria to reclassify because its wage data were erroneous in prior years, and these data are now being used to evaluate its reclassification application. In addition, in this situation, the hospital's wage index was subject to the rural floor because the hospital was located in an urban area with an actual wage index below the statewide rural wage index for the State, and it was for a time period preceding the requirement for using 3 years of data. Therefore, the hospital contends, it had no incentive to ensure its wage data were completely accurate. (However, we would point out that hospitals are required to certify that their cost reports submitted to CMS are complete and accurate. Furthermore, inaccurate or incomplete reporting may have other payment implications beyond the wage index.)

While we continue to have all of the concerns we expressed in last year's final rule, we now more fully understand this particular hospital's situation. Although we do have administrative authority to establish a policy allowing corrections for this particular set of circumstances, we are concerned about establishing a precedent that could reduce the importance of ensuring that the final wage data published in the annual IPPS final rule are complete and accurate. As we indicated in our response last year, we are concerned this could lead to less accuracy and stability in the wage indexes from year to year.

However, we are soliciting comments on whether it may be appropriate to establish a policy whereby, for the limited purpose of qualifying for reclassification based on data from years preceding the establishment of the 3-year requirement (that is, cost reporting years beginning before FY 2000), a hospital in an urban area that was subject to the rural floor for the period during which the wage data the hospital wishes to revise were used to calculate the wage index, a hospital may request that its wage data be revised.

E. Costs of Approved Nursing and Allied Health Education Activities (§ 413.85)

1. Background

Medicare has historically paid providers for the share of the costs that providers incur in connection with approved educational activities. The activities may be divided into the following three general categories to which different payment policies apply:

- Approved graduate medical education (GME) programs in medicine, osteopathy, dentistry, and podiatry. Medicare makes direct and indirect medical education payments to hospitals for residents training in these programs. Existing policy on direct GME payment is found at 42 CFR 413.86, and for indirect GME payment at 42 CFR 412.105.
- Approved nursing and allied health education programs operated by the provider. The costs of these programs are excluded from the definition of inpatient hospital operating costs and are not included in the calculation of payment rates for hospitals paid under the IPPS or in the calculation of payments to hospitals and hospital units excluded from the IPPS that are subject to the rate-of-increase ceiling. These costs are separately identified and ''passed through'' (that is, paid separately on a reasonable cost basis). Existing regulations on nursing and allied health education program costs are located at 42 CFR 413.85.
- All other costs that can be categorized as educational programs and activities are considered to be part of normal operating costs and are included in the per discharge amount for hospitals subject to the IPPS, or are included as reasonable costs that are subject to the rate-of-increase limits for hospitals and hospital units excluded from the IPPS.

In this section, we are proposing to clarify our policy governing payments to hospitals for provider-operated nursing and allied health education programs. Under the regulations at § 413.85 (''Cost of approved nursing and allied health educational activities''), Medicare makes reasonable cost payment to hospitals for provider-operated nursing and allied health education programs. A program is considered to be provider-operated if the hospital meets the criteria specified in § 413.85(f), which means the hospital directly incurs the training costs, controls the curriculum and the administration of the program, employs the teaching staff, and provides and controls both clinical training and classroom instruction (where applicable) of a nursing or allied health education program.

In the January 12, 2001 **Federal Register** (66 FR 3358), we published a final rule that clarified the policy for payments for approved nursing and allied health education activities in response to section 6205(b)(2) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239) and sections 4004(b)(1) and (2) of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508).

Section 6205(b)(2) of Public Law 101–239 directed the Secretary to publish regulations clarifying the rules governing allowable costs of approved educational activities. The Secretary was directed to publish regulations to specify the conditions under which those costs are eligible for pass-through, including the requirement that there be a relationship between the approved nursing or allied health education program and the hospital. Section 4004(b)(1) of Public Law 101–508 provides an exception to the requirement that programs be provider-operated to receive pass-through payments. The section provides that, effective for cost reporting periods beginning on or after October 1, 1990, if certain conditions are met, the costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) for clinical training (as defined by the Secretary) conducted on the premises of the hospital under an approved nursing or allied health education program that is *not* operated by the hospital are treated as pass-through costs and paid on the basis of reasonable cost. Section 4004(b)(2) of Public Law 101–508 sets forth the conditions that a hospital must meet to receive payment on a reasonable cost basis under section 4004(b)(1).

2. Continuing Education Issue for Nursing and Allied Health Education

Since publication of the January 12, 2001 final rule on nursing and allied health education, we have encountered questions concerning the substantive difference between provider-operated continuing education programs for nursing and allied health education (which would *not* be reimbursable under Medicare on a reasonable cost basis) and provider-operated approved programs that are eligible to receive Medicare reasonable cost payment. In that final rule, we stated that Medicare would generally provide reasonable cost payment for ''programs of long duration designed to develop trained practitioners in a nursing or allied health discipline, such as professional nursing or occupational therapy. This is contrasted with a continuing education program of a month to a year in duration in which a practitioner, such as a registered nurse, receives training in a specialized skill such as enterostomal therapy. While such training is undoubtedly valuable in enabling the nurse to treat patients with special needs and in improving the level of

patient care in a provider, the nurse, upon completion of the program, continues to function as a registered nurse, albeit one with special skills. Further distinction can be drawn between this situation and one in which a registered nurse undergoes years of training to become a CRNA. For these reasons, the costs of continuing education training programs are not classified as costs of approved educational activities that are passed-through and paid on a reasonable cost basis. Rather, they are classified as normal operating costs covered by the prospective payment rate or, for providers excluded from the IPPS, as costs subject to the target rate-of-increase limits'' (66 FR 3370).

Accordingly, upon publication of the final rule, we revised § 413.85(h)(3) to include continuing education programs in the same category as ''educational seminars and workshops that increase the quality of medical care or operating efficiency of the provider.'' Costs associated with continuing education programs, as stated above, are recognized as normal operating costs and are paid in accordance with applicable principles.

We received an inquiry requesting further clarification on what is meant by continuing education. It is our belief that provider-operated programs that do not lead to any specific certification in a specialty would be classified as continuing education. By certification, we do not mean certification in a specific skill, such as when an individual is certified to use a specific piece of machinery or perform a specific procedure. Rather, we believe certification would mean the ability to perform in the specialty as a whole.

Although, in the past, we believe we have allowed hospitals to be paid for operating a pharmacy ''residency'' program, it has come to our attention that those programs do not meet the criteria for approval as a certified program. Once individuals have finished their undergraduate degree in pharmacy, there are *some* individuals who go on to participate in 1-year hospital-operated postundergraduate programs. It is our understanding that many individuals complete the 1-year postundergraduate program practice pharmacy inside the hospital setting. However, we also understand that there are pharmacists who *do not* complete the 1-year postundergraduate program, but have received the undergraduate degree in pharmacy, who also practice pharmacy inside the hospital setting. Because pharmacy students need not complete the 1-year residency program to be eligible to practice pharmacy in the hospital setting, the 1-year programs that presently are operated by hospitals would be considered continuing education, and therefore, would be ineligible for pass-through reasonable cost payment.

We understand that *all* individuals who wish to be nurses practicing in a hospital must either complete a 4-year degree program in a university setting, a 2-year associate degree in a community or junior college setting, or a diploma program traditionally offered in a hospital setting. Since participants that complete a provider-operated diploma nursing program could not practice as nurses without that training, the diploma nursing programs are *not* continuing education programs and, therefore, may be eligible for pass-through treatment.

Because of the apparent confusion concerning continuing education programs in the nursing and allied health reasonable cost context, we are proposing to revise § 413.85(h)(3) to state that educational seminars, workshops, and continuing education programs in which the employees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to certification required to practice or begin employment in a nursing or allied health specialty, would be treated as educational activities that are part of normal operating costs. We also are proposing to add a conforming definition of ''certification'' for purposes of nursing and allied health education under § 413.85(c) to mean ''the ability to practice or begin employment in a specialty as a whole.''

3. Programs Operated by Wholly Owned Subsidiary Educational Institutions of Hospitals

Another matter that has come to CMS' attention since publication of the January 12, 2001 final rule (66 FR 3363) on nursing and allied health education concerns the preamble language of the rule, which states:

''Concerning those hospitals that have established their own educational institution to meet accrediting standards, we believe that, in some cases, these providers can be eligible to receive payment for the classroom and clinical training of students in approved programs. If the provider demonstrates that the educational institution it has established is wholly within the provider's control and ownership and that the provider continues to incur the costs of both the classroom and clinical training portions of the program, the costs would continue to be paid on a reasonable cost basis. An independent college would not meet these criteria.

''An example of a program that could be considered provider-operated would be one in which the hospital is the sole corporate member of the college, elects the board of trustees, has board members in common, employs the faculty and pays the salaries, controls the administration of the program and the curriculum, and provides the site for the clinical and classroom training on the premises of the hospital. We believe that, in these situations, the community has not undertaken to finance the training of health professionals; the provider has merely restructured its provider-operated program to meet certain State or accrediting requirements. In most cases, providers have aligned themselves with already established educational institutions. We note that a program operated by an educational institution that is related to the provider through common ownership or control would not be considered to meet the criteria for provider operated.'' (66 FR 3363)

We have received a question from a hospital that pertains to the cited preamble language in the narrow circumstance where the hospital previously received Medicare reasonable cost payment for direct operation of nursing or allied health education programs and then established its own wholly owned subsidiary college to operate the programs, in order to meet accreditation standards. The hospital has continued to receive Medicare payments after the hospital moved operation of the programs to the wholly owned subsidiary college. The hospital believes that, based on the cited preamble language regarding wholly owned subsidiary colleges and the lack of prior specific guidance on this particular organizational structure (as well as its continued receipt of pass-through payments) and because the hospital continues to pay all of the costs of the nursing and allied health education programs, the hospital is still the direct operator of the programs and should continue to receive pass-through treatment. However, we believe that once the hospital moved the direct operation of its nursing and allied health education programs to the college, the programs no longer met our provider-operated criteria at § 413.85(f). At the very least, it appears that the hospital did not hire the faculty for the program(s) and did not have direct control of the curriculum of the program(s) after operation was transferred to the wholly owned subsidiary college. As we stated in the

preamble language quoted above: ''a program operated by an educational institution that is related to the provider through common ownership or control would not be considered to meet the criteria for provider operated'' (66 FR 3363).

However, we understand that some hospitals, including this hospital, may have interpreted the preamble language that stated, ''if the provider demonstrates that the educational institution it has established is wholly within the provider's control and ownership and that the provider continues to incur the costs of both the classroom and clinical training portions of the program, the costs would continue to be paid on a reasonable cost basis'' (Ibid.), to mean that hospitals that establish wholly owned subsidiary colleges or educational institutions would continue to receive Medicare reasonable cost payment if the hospitals incur the costs of the classroom instruction and clinical training. We are proposing to clarify that transferring operation of previously provider-operated programs to educational institutions, even if the institutions are wholly owned by the hospital, does *not* necessarily mean that the programs continue to meet our provider-operated criteria under § 413.85(f). In order to remain provider operated, the hospital must have *direct control* of the program; the hospital itself must employ the teaching staff, have direct control of the program curriculum, and meet other requirements, as stated at § 413.85(f).

While we are proposing to clarify that merely operating programs through a wholly owned subsidiary college does not constitute direct operation of nursing or allied health education programs unless the hospital itself meets the requirements of the regulations at § 413.85(f), we believe it would be unfair to recoup Medicare payments that have already been made to hospitals that meet this very narrow fact pattern. Therefore, we are proposing that Medicare would not recoup reasonable cost payment from hospitals that have received pass-through payments for portions of cost reporting periods occurring on or before October 1, 2003 (the effective date of finalizing this proposed rule) for the nursing or allied health education program(s) where the program(s) had originally been operated by the hospital, and then operation of the program(s) had been transferred by the hospital to a wholly owned subsidiary educational institution in order to meet accreditation standards prior to October 1, 2003, and where the hospital had continuously incurred the costs of both the classroom and clinical training portions of the programs at the educational institution.

In addition, we are proposing that, for portions of cost reporting periods occurring on or after October 1, 2003, such a hospital would continue to receive reasonable cost payments for the clinical training costs incurred by the hospital for the program(s) described above that were previously provider operated. However, we are further proposing that, with respect to classroom costs, only those classroom costs incurred by the hospital for the courses that were paid by Medicare on a reasonable cost basis and included in the hospital's provider-operated program(s) could continue to be reimbursed on a reasonable cost basis. That is, Medicare would pay on a reasonable cost basis for the classroom costs associated with the courses provided as part of the nursing and allied health education programs (for example, the courses relating to the theory and practice of the particular nursing and allied health discipline(s)) that were offered by the hospital when the hospital was the direct operator of the program(s).

We believe this proposed policy is appropriate since continued pass-through payment will allow these hospitals to maintain equal footing with other hospitals that receive pass-through payments and have maintained their provider-operated programs. In addition, it would not be equitable to discontinue longstanding Medicare pass-through payment to these hospitals (in fact, reasonable cost payment to at least one of these hospitals for nonprovider-operated programs preceded the publication of the January 12, 2001 final rule on nursing and allied health education payments by many years) that restructured operation of their nursing and allied health education program(s) as wholly owned subsidiaries in order to meet accreditation standards while relying on their understanding of CMS' prior expressions of provider-operated requirements and the recent preamble language. If these providers were now forced to restructure in order to meet the requirements of § 413.85(f), they would not be able to maintain their accreditation.

We note that Congress has specifically expressed its intent that providers that have restructured their programs to be operated by a wholly owned subsidiary educational institution in order to meet accreditation standards should continue to receive Medicare reasonable cost payment. In the conference report accompanying the Consolidated Appropriations Resolution for FY 2003, Congress stated:

''The conferees are particularly concerned about nursing and allied health educational programs that cannot meet the regulations set forth at 42 CFR 413.85(f) solely as a result of regional educational accrediting criteria. Given the shortage of nursing and allied health professionals, the conferees support the payment of costs on a reasonable cost basis for a hospital that has historically been the operator of nursing and allied health education programs(s) that qualified for Medicare payments under 42 CFR 413.85, but, solely in order to meet educational standards, subsequently relinquishes some control over the program(s) to an educational institution, which meets regional accrediting standards; is wholly owned by the provider; and is supported by the hospital, that is, the hospital is incurring the costs of both the classroom and clinical training of the program.'' (H.R. Rep. No. 108–10, 108th Cong., 1st Sess., 1115 (2003).)

However, the proposed policy does not allow these hospitals to be paid for additional classroom costs for courses that were not paid on a reasonable cost basis to the hospitals in conjunction with their provider-operated programs (for example, additional classes needed to meet degree requirements). We believe that to allow pass-through payment for those additional costs would provide these hospitals with an unfair advantage over other hospitals with provider-operated programs.

We note that any hospital that chooses to restructure its programs to be operated by a wholly owned subsidiary educational institution on or after the effective date of this proposal when finalized (October 1, 2003) would not be eligible for pass-through payments under this proposed provision unless the hospital continues to meet the requirements of § 413.85(f). We believe it is appropriate to limit the proposed payments to hospitals that restructured before this proposed rule is made final because our policy with respect to programs by a wholly owned subsidiary of a hospital will have been clarified in that final rule.

We are proposing to revise § 413.85 by adding new paragraphs (d)(1)(iii) and (g)(3) to reflect this proposed payment policy.

F. Payment for Direct Costs of Graduate Medical Education (§ 413.86)

1. Background

Under section 1886(h) of the Act, Medicare pays hospitals for the direct costs of graduate medical education

(GME). The payments are based in part on the number of residents trained by the hospital. Section 1886(h)(4)(F) of the Act caps the number of allopathic and osteopathic residents that hospitals may count for direct GME.

Section 1886(h) of the Act, as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272) and implemented in regulations at § 413.86(e), establishes a methodology for determining payments to hospitals for the costs of approved GME programs. Section 1886(h)(2) of the Act, as added by COBRA, sets forth a payment methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of October 1, 1983 through September 30, 1984). The PRA is multiplied by the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital complex (or nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days to determine Medicare's direct GME payments.

Existing regulations at § 413.86(e)(4) specify the methodology for calculating each hospital's weighted average PRA and the steps for determining whether a hospital's PRA will be revised.

2. Prohibition Against Counting Residents Where Other Entities First Incur the Training Costs

a. General Background on Methodology for Determining FTE Resident Count. As we explain earlier in this preamble, Medicare makes both direct and indirect GME payments to hospitals for the training of residents. Direct GME payments are reimbursed in accordance with section 1886(h) of the Act, based generally on hospital-specific PRAs, the number of FTE residents a hospital trains, and the hospital's Medicare patient share. The indirect costs of GME are reimbursed in accordance with section 1886(d)(5)(B) of the Act, based generally on the ratio of the hospital's FTE residents to the number of hospital beds. It is well-established that the calculation of both direct GME and IME payments is affected by the number of FTE residents that a hospital is allowed to count; generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive. In an attempt to end the implicit incentive for hospitals to increase the number of FTE residents, Congress instituted a cap on the number of allopathic and osteopathic residents a hospital is allowed to count for direct GME and IME purposes under the provisions of section 1886(h)(4)(F) (direct GME) and section 1886(d)(5)(B)(v) (IME) of the Act. Dental and podiatric residents were not included in this statutorily mandated cap.

With respect to reimbursement of direct GME costs, since July 1, 1987, hospitals have been allowed to count the time residents spend training in sites that are not part of the hospital (referred to as ''nonprovider'' or ''nonhospital sites'') under certain conditions. Section 1886(h)(4)(E) of the Act requires that the Secretary's rules concerning computation of FTE residents for purposes of separate reimbursement of direct GME costs ''provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.'' (Section 1886(h)(4)(E) of the Act, as added by section of 9314 of the Omnibus Budget Reconciliation Act of 1986, Pub. L. 99–509.)

Regulations on time spent by residents training in nonhospital sites for purposes of direct GME payment were first implemented in the September 29, 1989 final rule (54 FR 40286). We stated in that rule (under § 413.86(f)(3)) that a hospital may count the time residents spend in nonprovider settings for purposes of direct GME payment if the residents spend their time in patient care activities and there is a written agreement between the hospital and the nonprovider entity stating that the hospital will incur all or substantially all of the costs of the program. The regulations at that time defined ''all or substantially all'' of the costs to include the residents' compensation for the time spent at the nonprovider setting.

Prior to October 1, 1997, for IME payment purposes, hospitals could only count the time residents spend training in areas subject to the IPPS and outpatient areas of the hospital. Section 4621(b)(2) of the Balanced Budget Act of 1997 (Pub. L. 105–33) revised section 1886(d)(5)(B) of the Act to allow providers to count time residents spend training in nonprovider sites for IME purposes, effective for discharges occurring on or after October 1, 1997. Specifically, section 1886(d)(5)(B)(iv) of the Act was amended to provide that ''all the time spent by an intern or resident in patient care activities under an approved medical residency program at an entity in a non-hospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.''

In the regulations at §§ 412.105(f)(1)(ii)(C) and 413.86(f)(4) (as issued in the July 31, 1998 **Federal Register**), we specify the requirements a hospital must meet in order to include a resident training in a nonhospital site in its FTE count for Medicare reimbursement for portions of cost reporting periods occurring on or after January 1, 1999 for both direct GME and for IME payments. The regulations at § 413.86(b) redefine ''all or substantially all of the costs for the training program in the nonhospital setting'' as the residents' salaries and fringe benefits (including travel and lodging where applicable), and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME. A written agreement between the hospital and the nonhospital site is required before the hospital may begin to count residents training at the nonhospital site; the agreement must provide that the hospital will incur the costs of the resident's salary and fringe benefits while the resident is training in the nonhospital site. The hospital must also provide reasonable compensation to the nonhospital site for supervisory teaching activities, and the written agreement must specify that compensation amount.

b. Inappropriate Counting of FTE Residents. As we stated above, dental residents, along with podiatric residents, are excepted from the statutory cap on the count of FTE residents for both direct GME and IME payment purposes. We have become aware of a practice pertaining to the counting of FTE residents at a nonhospital site, particularly dental residents, that we see as inappropriate under Medicare policy. Most often, the situation involves dental schools that, for a number of years, have been training dental residents in programs at the dental schools of universities affiliated with teaching hospitals, and the schools have been directly incurring the costs of the dental residents training at the dental schools (for example, the teaching faculty costs, the resident salary costs, the office space costs, and

any overhead expenses of the programs). We also understand that there are dental clinics at these dental schools that treat patients (that is, are involved in ''patient care activities'').

As a result of the provisions that Congress added to allow hospitals to count FTE residents and receive IME payment, as well as direct GME payment, if the hospital incurs ''all or substantially all'' the costs of training residents in nonhospital settings, a significant number of dental schools are shifting the resident training costs of the dental programs from the schools to the hospital, and thus to the Medicare program, when the hospitals count the FTE dental residents training in these dental schools (that is, ''nonhospital sites'') under the regulations at § 413.86(f)(4). Furthermore, in the case of training dentists at dental school clinics, as a result of this cost-shifting and because dental residents are excepted from the cap, hospitals are receiving significant amounts of Medicare direct GME and IME payments when they have incurred relatively small costs of the residents training in a dental school.

The following actual situations are illustrative of the inappropriate application of Medicare direct GME and IME policy that we have found:

• An academic medical center hospital associated with a university has been training allopathic residents for at least 20 years. Prior to 1999, the university s affiliated dental school had always incurred the costs of dental residency programs at the dental school. Beginning with the hospital's cost report for its fiscal year ending in 1999, for the first time ever, the hospital has requested direct GME and IME payment for an additional 67 FTE residents because the hospital claims it has begun to incur ''all or substantially all'' of the costs of the dental residents training in the university's affiliated dental school, in accordance with the regulations at § 413.86(f)(4).

• A university dental school in one State has been incurring the costs of dental residency programs at its dental school for several years. Beginning in FY 1999, a teaching hospital in a neighboring State decided to begin incurring ''all or substantially all'' of the costs of the dental residents training in the dental clinics in the program (which is located in a different State from the hospital) in order to receive Medicare direct GME and IME payment for an additional 60 FTE residents.

• In another situation, a teaching hospital on the East Coast of the United States has requested direct GME and IME payment for an additional 60 FTE dental residents, some of whom are training in dental programs at nonhospital sites located in Hawaii, New Mexico, and the Netherlands, because it has begun to incur ''all or substantially all'' of the costs of dental residents training in those remote ''nonhospital sites''. Prior to 1999, the costs for these dental programs were funded by nonhospital sources.

We note that such inappropriate cost-shifting practices are by no means limited to the dental school context. Indeed, we understand that there are some hospitals with resident counts below their direct GME and IME FTE resident caps that have recently (as of October 1, 1997, when it became possible to receive significant IME payments under the amendment made by Pub. L. 105–33) started to incur ''all or substantially all'' of the costs of residents who had been training at sites outside of the hospital without any financial assistance from the hospital, in order for the hospital to count those FTE residents and receive Medicare direct GME and IME payments for the additional residents. The actual costs of the programs that are being shifted from nonhospital entities to hospitals are relatively small, compared to the direct GME and IME payments that hospitals receive as a result of incurring ''all or substantially all'' of the training costs.

• In another example, an academic medical center hospital in one State asked Medicare to allow it to count an additional 10 FTEs for both direct GME and IME payment, beginning with its fiscal year ending 1999 cost report, because the hospital claims it is incurring all or substantially all of the costs of training osteopathic family practice residents in a walk-in clinic. The osteopathic family practice residency program had previously been sponsored by this clinic for several years and the residents do not participate in any training at the hospital.

c. Congressional Intent. Congress has delegated broad authority to the Secretary to implement a policy on the count of FTE residents for purposes of calculating direct GME and IME payments. For IME payment, section 1886(d)(5)(B) of the Act simply states that ''the Secretary shall provide for an additional payment amount'' which includes ''the ratio of the hospital's full-time equivalent interns and residents to beds.'' The methodology to compute the count of FTE residents for IME is not established in the statute. Similarly, for direct GME, section 1886(h)(4)(A) of the Act states that ''the Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time equivalent residents in an approved medical residency training program.''

Although not in the context of the general rules for counting FTE residents, Congress similarly acknowledged its intent to defer to the Secretary with respect to the rules for implementing ''limits'' or caps on the number of FTE residents hospitals may count for purposes of direct GME and IME payment. The conference agreement that accompanied Pub. L. 105–33, which established a cap on the number of allopathic and osteopathic residents a hospital may count, states—

''[T]he Conferees recognize that such limits raise complex issues, and provide for specific authority for the Secretary to promulgate regulations to address the implementation of this provision. The Conferees believe that rulemaking by the Secretary would allow careful but timely consideration of this matter, and that the record of the Secretary's rulemaking would be valuable when Congress revisits this provision.'' (H.R. Conf. Rep. No. 105–217, 105th Cong., 1st Sess., 821 (1997).

The absence of statutory specificity on determining FTE counts in these situations and the declared Congressional delegations of authority to the Secretary on the subject are clear indications that Congress has given the Secretary broad discretion to promulgate reasonable regulations in order to implement the policy on the counting of residents for direct GME and IME payments.

When Congress enacted the nonhospital site provisions for both direct GME and IME, Congress intended to address application of the FTE count policy to situations where the training site had been the hospital. The intent was to create incentives for hospitals to move resident training from the hospital to nonhospital settings. We believe that Congress did *not* intend for hospitals to be able to add to their FTE counts residents that had historically trained outside the hospital in other settings. Training in those nonhospital settings had historically occurred without Congress offering any financial incentive to hospitals to move the training out of the hospital.

This Congressional intent is evident in the legislative history of both the direct GME and the IME provisions on nonhospital settings. First, legislative history associated with passage of the direct GME provision (as part of Pub. L. 99–509) indicates that Congress intended to broaden the scope of settings in which a hospital could train its residents and still receive separate direct GME cost reimbursement, and to

provide incentives to hospitals for training residents in primary care programs. The Conference committee report indicates that ''[s]ince it is difficult to find sufficient other sources of funding [than hospitals and Medicare] for the costs of such training, [that is, training in freestanding primary care settings such as family practice clinics or ambulatory surgery centers] *assignments to these settings* are discouraged. It is the Committee's view that training in these settings is desirable, because of the growing trend to treat more patients *out of the inpatient hospital setting* and because of the encouragement it gives to primary care.'' (Emphasis added.) (H.R. Rep. No. 99–727, 99th Cong., 1st Sess., 70 (1986).)

Thus, from the start of the policy allowing payment for training in nonprovider sites, we believe Congress intended to create a monetary incentive for hospitals to rotate residents from the hospital to the nonhospital settings. We believe Congress did not intend for hospitals to be paid for residents who had previously been training at nonhospital sites without hospital funding.

Further, in the Conference committee report accompanying the provision of Pub. L. 105–33 on IME payment for training in nonhospital settings, Congress stated that ''[t]he conference agreement includes new permission for *hospitals to rotate residents through nonhospital settings,* without reduction in indirect medical education funds.'' (Emphasis added.) (H.R. Conf. Rep. No. 105–217, 105th Cong., 1st Sess., 817 (1997).)

We note that, prior to enactment of Pub. L. 105–33, if a hospital rotated a resident to train at a nonhospital site, the hospital could not count the time the resident spent at the nonhospital site for purposes of Medicare IME payments. As a result, the lack of IME payments acted as a disincentive and discouraged hospitals from rotating residents out of the hospital. Therefore, Congress authorized hospitals to count residents in nonhospital sites for IME purposes as a specific incentive to encourage hospitals to rotate their residents to nonhospital sites (and not to encourage hospitals to incur the costs of a program at a nonhospital site that had already been funded by other sources). This legislative intent becomes more apparent when the nature of the Medicare IME payment is considered. The Medicare IME payment is inherently a payment that reflects the increased operating costs of treating inpatients as a result of the hospital having a residency program. For example, as explained in the September 29, 1989 final rule (54 FR 40286), the indirect costs of medical education might include added costs resulting from an increased number of tests ordered by residents as compared to the number of tests normally ordered by more experienced physicians.

The IME payment is an adjustment that is made for each Medicare discharge from the areas subject to the IPPS in a teaching hospital. The authorization by Congress for IME payments relating to nonhospital services while residents are training at nonhospital sites would be absurd if not viewed as an incentive to transfer existing residency training from the hospital to the nonhospital setting. We do not believe Congress intended to permit such IME payments to be allowable to the hospital that is incurring ''all or substantially all the costs'' of residents training in nonhospital sites except in the situation where the hospital rotated residents from the hospital to the nonhospital settings. The illustrative situations described above in which nonhospital sites, such as dental schools, are shifting the costs of existing programs to the hospitals are not consistent with the intent of Congress to encourage hospitals to rotate residents from the hospital setting to nonhospital sites.

Thus, we believe Congress intended both cited provisions of the Act on counting residents in nonhospital sites for purposes of direct GME and IME payments to be limited to situations in which hospitals rotate residents from the hospital to the nonhospital settings, and *not* situations in which nonhospital sites transfer the costs of an existing program at a nonhospital site to the hospital.

d. Medicare Principles on Redistribution of Costs and Community Support. It is longstanding Medicare policy that if the community has undertaken to bear the costs of medical education, these costs are not to be assumed by the Medicare program. In addition, medical education costs that have been incurred by an educational institution may not be redistributed to the Medicare program. Indeed, these concepts, community support and redistribution of costs, have been a part of Medicare GME payment policy since the inception of the Medicare program. Both the House and Senate Committee reports accompanying Pub. L. 89–97 (the authorizing Medicare statute) indicate that Congress intended Medicare to share in the costs of medical education *only* in situations in which the community has not stepped in to incur them:

''Many hospitals engage in substantial education activities, including the training of medical students, internship and residency programs, the training of nurses and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution and it is intended, *until the community undertakes to bear such education costs in some other way,* that a part of the net cost of such activities * * * should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program. (Emphasis added.) (S. Rep. No. 404, 89th Cong., 1st Sess., 36 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess., 32 (1965).)

The principle behind the congressional committee report language for Pub. L. 89–97 that Medicare would share in the costs of educational activities until communities bore them in some other way has guided Medicare policy on educational activities from the inception of the Medicare program. The principles of community support and redistribution of costs associated with payment for GME have been continually reiterated in various regulations, manual provisions, and implementing instructions to fiscal intermediaries. As recently as the final rule published in the **Federal Register** on January 12, 2001, we stated:

''We note that the proposed revisions in the proposed rule inadvertently did not include community support as the basis for an offset from the allowed cost of a GME or nursing and allied health program. In this final rule, we restate our longstanding policy that Medicare will share in the costs of educational activities of providers where communities have not assumed responsibility for financing these programs. Medicare's policy is to offset from otherwise allowable education costs, community funding for these activities.'' (66 FR 3368)

We note the instructions that CMS (then HCFA) gave to its Regional Offices in the 1990 audit instructions for purposes of calculating the direct GME base period PRA specifically addressed redistribution of costs and community support in the GME context:

''Where costs for services related to medical education activities have historically been borne by the university, it is assumed the community has undertaken to support these activities, and subsequent allocation of these costs to a hospital constitutes a redistribution of costs from an educational institution to a patient care institution. In such a situation, these costs are not allowable under the Medicare program. (*See* 42 CFR

413.85(c) and HCFA Pub. L. 15–1, § 406). For example, if in the past the hospital did not identify and claim costs attributable to the time teaching physicians spent supervising I&Rs [interns and residents] working at the hospital, it is assumed that these costs were borne by the university. Therefore, the hospital may not claim these costs in subsequent cost reports.'' (Instructions for Implementing Program Payments for Graduate Medical Education to ARAs for Medicare, Director of Office of Financial Operations of the Health Care Financing Administration, BPO–F12, February 12, 1990.)

Furthermore, the regulation at § 413.85(c) that was originally issued in the **Federal Register** on September 30, 1986 (51 FR 34793) (which was further refined, but conceptually left unchanged, as of March 12, 2001) addressed the Congressional intent not to increase program costs, as well. That paragraph (c) stated:

''*Educational Activities*. Many providers engage in education activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties * * * . Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.''

The Secretary of Health and Human Services interpreted this provision to deny reimbursement of educational costs that were borne in prior years by a hospital's affiliated medical school. The U.S. Supreme Court affirmed the Secretary's interpretation of the redistribution of costs regulation in *Thomas Jefferson University* v. *Shalala* (''*Thomas Jefferson*''), 512 U.S. 504 (1994). The Court found of § 413.85(c) that:

''The regulation provides, *in unambiguous terms,* that the 'costs' of these educational activities will not be reimbursed when they are the result of a 'redistribution,' or shift, of costs of an 'educational' facility to a 'patient care' facility.'' (Emphasis added.) (*Thomas Jefferson,* 512 U.S. at 514). Thus, the Supreme Court in *Thomas Jefferson* held that it is well within the Secretary's discretion to interpret the language at § 413.85(c), which was specifically derived from the legislative history of the original enacting Medicare legislation quoted above, to impose a substantive limitation on medical education payment.

The Supreme Court's opinion in *Thomas Jefferson* lends substantial support and credibility to CMS' longstanding policy on community support and redistribution of costs in the GME context.

e. Application of Redistribution of Costs and Community Support Principles. As we have described above, we have discovered an inappropriate application of Medicare direct GME and IME payment policies relating to the counting of FTE residents in nonhospital settings. As stated previously, we believe that: (1) Congress has given the Secretary broad discretion to implement policy on FTE resident counts; (2) Congress intended that the nonhospital site policy for both direct GME and IME would encourage hospitals to move resident training from the hospital to nonhospital settings, not to enable nonhospital sites to shift the costs of already established residency programs in the nonhospital site to the hospital; and (3) since the inception of the Medicare program, CMS' policy has been consistent with the intent of Congress that Medicare would only share in the costs of medical education until the community assumes the costs. The Supreme Court has specifically found that CMS' implementation of the redistribution of costs and community support principles is ''reasonable.'' (*Thomas Jefferson*, 512 U.S. at 514.)

Accordingly, we are proposing that residents training at nonhospital sites may be counted in a hospital's FTE resident count only where the principles of redistribution of costs and community support are not violated. We are proposing this policy at this time to address the inappropriate practice of nonhospital sites shifting costs to hospitals solely to allow the hospitals to count residents training in the nonhospital sites. However, we believe the concepts of redistribution of costs and community support are equally relevant to the counting of FTEs residents by a hospital in general.

We note again that the Medicare program has a long tradition of applying redistribution of costs and community support principles to medical education payments. As we have stated above, both the House and Senate Committee reports accompanying Pub. L. 89–97 (the 1965 authorizing Medicare statute) indicate that Congress intended Medicare to share in the costs of medical education only where the community has not stepped in to incur them.

We believe it is appropriate to employ the principles of redistribution of costs and community support to specifically address the inappropriate scenarios described above whereby hospitals attempt to inflate their FTE resident counts by assuming payment of training costs for residents in nonhospital sites that were previously funded by a nonhospital entity. Therefore, we are proposing to specify the application of the redistribution of costs and community support principles by adopting the definitions (with some modification to reflect the methodology for counting FTE residents applicable to GME) of ''community support'' and ''redistribution of costs'' at § 413.85(c), which relate to nursing and health education program costs, for use at § 413.86(b), which relates to GME. In addition, we are proposing a general rule at proposed § 413.86(i) on the application of community support and redistribution of costs principles to the counting of FTE residents for GME. We are proposing to (1) make the provisions under § 413.86(f) relating to determining the number of FTE residents subject to the provisions of the proposed § 413.86(i); (2) add a proposed § 413.86(f)(4) in order to clarify that the principles of redistribution of costs and community support are applicable to the counting of FTE residents, including when the residents are training in nonhospital settings; and (3) making the provisions of the proposed § 413.86(i) specifically applicable to determining the number of FTE residents under § 413.86(g)(4) through (6) and (g)(12).

The general rule at proposed § 413.86(i) contains two provisions. Proposed § 413.86(i)(1) states the principles of community support and redistribution of costs: In relation to community support, we are proposing that if the community has undertaken to bear the costs of medical education through community support, the training costs of residents that are paid through community support are not considered GME costs to the hospital for purposes of Medicare payment. In relation to redistribution of costs, we are proposing that the costs of training residents that constitute a redistribution of costs from an educational institution to the hospital are not considered GME costs to the hospital for purposes of Medicare payment.

In applying the redistribution of costs and community support principles, we are proposing under § 413.86(i)(2) to state that a hospital must continuously incur direct GME costs of residents training in a particular program at a training site since the date the residents first began training in that site in order for the hospital to count the FTE residents in accordance with the

provisions of paragraphs (f) and (g)(4) through (g)(6), and (g)(12) of § 413.86.

We note that our reasons for specifically referencing the applicability of the principles of community support and redistribution of costs at § 413.86(f)(4), the paragraph concerning counting residents training in nonhospital settings for direct GME purposes, are twofold. First, although we are already making the proposed § 413.86(i) applicable to § 413.86(f), which would make the principles applicable to each paragraph under § 413.86(f), in consideration of the inappropriate applications we have identified of the GME FTE-counting policy with respect to counting residents in nonhospital sites, we believe it is appropriate to also specifically address the applicability of the redistribution of costs and community support principles to § 413.86(f)(4). In addition, we note that the proposed reference at § 413.86(f)(4) has implications for IME payment as well, as explained below.

Under existing § 412.105(f)(1)(ii)(C), the rule for the counting of FTE residents training in nonhospital settings for IME payment, there is a specific reference indicating that the criteria set forth in § 413.86(f)(4) must be met in order for a hospital to count the FTE residents training in nonhospital settings for purposes of IME payments. Thus, if under proposed § 413.86(f)(4)(iv) (the paragraph making redistribution of costs and community support principles applicable) a hospital is not permitted to count the FTE residents training in a nonhospital site because of redistribution of costs or community support, the hospital would not be permitted to count the FTE residents for purposes of IME payment as well, because the IME regulation at § 412.105(f)(1)(ii)(C) requires the criteria under § 413.86(f)(4) to be met.

As we have stated above, payment for IME is based on the concept that, as a direct result of the hospital's resident training program, the costs the hospital incurs for patient care are increased. When Congress included section 1886(d)(5)(B)(iv) of the Act as part of Public Law 105–33, the statute expanded the circumstances under which IME payments to a hospital could be made by allowing the hospital to count the number of residents training outside the hospital setting under certain conditions. Even though it is clear that those residents training outside the hospital cannot have any impact on patient care costs to the hospital, Congress nevertheless allowed the hospital to receive IME payments when the hospital counts FTE residents training in a nonhospital setting in accordance with section 1886(d)(5)(B)(iv) of the Act, where those residents would otherwise have trained in the hospital setting. As we have stated, Congress created an incentive (or removed a disincentive) with the provisions of Public Law 105–33 for hospitals to rotate residents to nonhospital settings by allowing hospitals to continue to receive IME payment as if the residents continued to train in the hospital setting. If there is a redistribution of costs or community support, we believe IME payment to the hospital would be contrary to Congressional intent to encourage the hospital to rotate residents from the hospital to the nonhospital site.

In addition, when Congress included section 1886(d)(5)(B)(iv) of the Act as part of Public Law 105–33, the statutory authority for IME payment was premised on the hospital incurring the direct GME costs of the residents: ''all the time spent by an intern or resident in patient care activities under an approved medical residency program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency *if the hospital incurs all, or substantially all, of the costs for the training program* in that setting.'' (Emphasis added.) (Section 4621(b)(2) of Public Law 105–33; section 1886(d)(5)(B)(iv) of the Act.) We believe Congress intended the hospital to incur direct GME costs of the program in the nonhospital site in order to count the FTE residents training in nonhospital settings for purposes of IME payment. Thus, in the situation where a hospital incurred direct GME costs but there was redistribution of costs or community support, a disallowance of direct GME payments as well as a disallowance of IME payments is appropriate.

Although we are stating generally that the principles of community support and redistribution of cost have applied since the inception of Medicare to graduate medical education payment, as we have stated above, we have identified relatively recent inappropriate application of the nonhospital site policy for counting FTE residents. Therefore, we believe it is appropriate to propose to identify January 1, 1999, as the date our fiscal intermediaries should use to determine whether a hospital or another entity has been incurring the costs of training in a particular program at a training setting for purposes of determining whether there has been a redistribution of costs or community support. We are proposing that January 1, 1999 be used as the date the fiscal intermediaries should use for determinations, since it may be difficult for our fiscal intermediaries to obtain from hospitals contemporaneous documentation that the hospitals have appropriately been incurring the direct GME costs in earlier fiscal years. We believe the January 1, 1999 date should simplify confirmation by our fiscal intermediaries and hospitals of whether the hospital or another entity had been incurring the costs of the program in particular training settings and whether redistribution of costs or community support had occurred. We have chosen the January 1, 1999 date because of administrative convenience and feasibility, so that necessary data are both valid and available, and in recognition of the fact that our fiscal intermediaries must prioritize their limited audit resources. While we are not requiring our fiscal intermediaries to determine whether a hospital had been incurring the training costs of a program prior to the January 1, 1999 date, if the fiscal intermediaries determine that there is a redistribution of costs or community support exists with respect to certain residents prior to January 1, 1999, a disallowance of direct GME and IME payments with respect to those FTE residents would certainly be required.

Since calculation of a hospital's FTE resident count is dependent upon whether the hospital incurred the training costs, we are proposing to require each teaching hospital and its fiscal intermediary to determine which entity had been incurring the training costs at least since January 1, 1999. For example, if a nonhospital entity, such as a school of medicine or dentistry, had incurred the costs of training the residents anytime on or after January 1, 1999, and a hospital subsequently begins to incur direct GME costs of training those FTE residents, the hospital would not qualify to count those FTE residents for purposes of direct GME and IME payments.

We note that the proposal states that a hospital must have been *continuously* incurring the costs of the training since the date the residents first began training in that program. Accordingly, if a hospital had at one time incurred the costs of training residents in a particular program, whether at the hospital or in a nonhospital setting, but a nonhospital institution later assumed the costs of training in that setting, even if the hospital assumed payment for the training costs again, the hospital could not then count those residents for purposes of direct GME and IME payments.

We note that if a hospital incurs the direct GME costs, whether training takes

place inside the hospital or in a nonhospital setting, in a new residency program, the hospital may be eligible to count the FTE residents as specified by the regulations under § 413.86(g)(6).

Consistent with the policy on redistribution of costs and community support discussed above, if a hospital incurs the direct GME costs of *additional* FTE residents training in an existing program in a hospital setting where the costs of the existing program had been incurred by a nonhospital entity and the hospital has continuously funded the *additional* residents in the existing program in the hospital setting since the date the residents first began training there, the redistribution of costs or community support principles would not prohibit the hospital from counting the additional FTE residents for purposes of direct GME and IME payments.

We note that, under existing policy, to count residents in a nonhospital setting, a hospital is required to incur for ''all or substantially all of the costs of the *program*'' in that setting. In other words, a hospital is required to assume financial responsibility for the *full* complement of residents training in a nonhospital site in a particular program in order to count any FTE residents training there for purposes of IME payment. A hospital cannot count any FTE residents if it incurs ''all or substantially all of the costs'' for only a portion of the FTE residents in that program training setting. This policy is derived from the language of the IME and direct GME provisions of the statute on counting residents in nonhospital settings; both sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act state that the hospital must incur ''all, or substantially all, of the costs for the training *program* in that setting.'' (Emphasis added.) In contrast, as explained earlier, it is permissible under the proposed policy on the application of the redistribution of costs and community support principles for the hospital to count FTE residents where the hospital incurs direct GME costs of FTE residents that are *added* to an existing program, even though the hospital may not count the existing FTE residents due to the application of the redistribution of costs or community support rules. In the nonhospital setting, as a result of the interaction of these two separate FTE counting requirements—(1) that the hospital must not violate the redistribution of costs and the community support principles in order to count the resident FTEs in the nonhospital settings, and (2) that the hospital must incur ''all or substantially all'' of the costs for the training program in that setting—a hospital would be prohibited from counting FTE residents added to an existing program at a nonhospital site unless the hospital incurs all or substantially all of the costs of training *all* of the residents in that program at that setting. That is, even if the hospital incurs all or substantially of the costs for all of the training program at the nonhospital site, the hospital would only be able to count the additional FTE residents who were not excluded by application of the redistribution of costs or community support principles.

For example, training in a general dentistry program with 10 FTE residents has taken place at a school of dentistry for 20 years. The school of dentistry has been incurring the training costs of the general dentistry residents since the inception of the program. Beginning in 2003, the school of dentistry has decided to add an additional 5 FTE residents to the program, and Hospital A decides to incur ''all or substantially all'' the costs of those 5 additional FTE residents only. Applying the policy concerning redistribution of costs and community support in combination with the policy on incurring all or substantially all of the costs, the hospital could not count the additional 5 FTE residents in the dental school since it is not paying for all or substantially all of the costs of the program. Even if the hospital were to incur all or substantially all of the costs for the training program for all 15 FTE residents, the hospital could not count the 10 FTEs that were part of the existing general dentistry program because of the redistribution of costs and community support principles; it would be a redistribution of costs for the hospital to begin to incur direct GME costs of the 10 FTE residents when the dental school had previously been incurring those costs.

We note that such a result does not occur when a *new program* is established in the nonhospital site. If, from the outset of the program, the hospital incurs direct GME costs and also incurs ''all or substantially all'' of the costs for the training program for all the new residents training at the site, there would be no redistribution of costs or community support, and the hospital could count all of those residents in the new program in its FTE count (subject, of course, to the hospital's 1996 FTE resident cap).

We also note that the interaction of the two provisions discussed above—redistribution of costs and community support, and ''all or substantially all''—does not occur when counting FTE residents training inside the hospital, since a hospital is not required to incur ''all or substantially all'' of the costs for the training program inside the hospital.

Furthermore, if one hospital had incurred the direct GME costs of training residents in a particular program in a nonhospital site from one point in time, for example, 1995 through 1999, and then another hospital consecutively incurs the costs from 2000 and thereafter, the second hospital may be eligible to receive direct GME and IME payments for training the FTE residents from the point in time where the second hospital incurred the direct GME costs, and the redistribution and community support exclusions would not apply. The second hospital may be eligible to receive Medicare direct GME and IME payments because the costs were incurred previously by a hospital, and not either the community or the university. Therefore, there was neither community support nor redistribution of costs.

The following are some examples to clarify how these proposed policies would be implemented:

Example 1

Since 1995, 10 FTE residents in an internal medicine program have been training in the Community Clinic. In accordance with the current provisions of § 413.86(f), Hospital A has incurred all or substantially all of the costs of training the 10 FTE residents since 1995. Assuming the current provisions of the regulations at §§ 412.105(f)(1)(ii)(C) and 413.86(f)(3) and (f)(4) are met, Hospital A may continue to receive IME and direct GME payments for 10 FTE residents because Hospital A had incurred direct GME costs continuously (as evidenced by contemporaneous documentation since January 1, 1999), as specified in our proposed regulation.

Beginning July 1, 2004, in addition to continuing to incur all or substantially all of the costs of the first 10 FTE internal medicine residents training in the nonhospital site, Hospital A also incurs all or substantially all of the costs of training an additional 3 FTE internal medicine residents at that site. Accordingly, beginning July 1, 2004, Hospital A may count all 13 FTE residents training in the Community Clinic for purposes of direct GME and IME payments, assuming Hospital A does not exceed its FTE cap for IME and direct GME.

Example 2

Since 1995, 2.25 dental FTE residents in a dental school program were training in a dental clinic at the dental school. While the 2.25 FTEs were training at the

clinic, the dental school paid for all of the costs of the dental program. Prior to July 1, 2000, Hospital A signed a written agreement with the clinic to incur all or substantially all of the costs of training the 2.25 FTE residents, from July 1, 2000 and onward. Thus, beginning with July 1, 2000, the dental school no longer incurred the costs of the program at this nonhospital site. In this scenario (even if Hospital A inappropriately received direct GME and IME payments for the 2.25 FTEs since July 1, 2000), Hospital A may not receive direct GME or IME payment for the 2.25 FTE residents training in the clinic because there would have been a redistribution of costs associated with training these 2.25 FTE residents from the dental school to the hospital.

Example 3

Since 1995, 2.25 FTE residents in a family practice program were training in a physicians' group practice. While the 2.25 FTEs were training at the physicians' practice, a school of medicine paid for the costs of the family practice residency program. Prior to July 1, 2000, Hospital A signed a written agreement with the physicians' practice to send 1 additional family practice FTE resident to the physicians' practice and to incur all or substantially all of the costs of training the original 2.25 FTE residents *and* the 1 additional FTE, from July 1, 2000 and onward. Thus, beginning with July 1, 2000, the school of medicine no longer incurred the costs of the program at this nonhospital site. Hospital A may not count the 2.25 FTE residents that had been training since 1995 in that physicians' practice for purposes of direct GME and IME payments because the training costs were shifted from the school of medicine to the hospital. However, Hospital A may count the 1 FTE resident the hospital began to rotate for training in the physicians' practice because there was no cost-shifting for that resident and Hospital A incurred ''all or substantially all'' of the costs of the entire family practice program in the physicians' office setting.

Example 4

Residents in a surgery program have been rotating from a hospital to two nonhospital clinics, Clinic A and Clinic B, since 1996. The training of the surgery residents in Clinic A has been supported by a nonhospital institution since 1996, while the hospital has incurred all or substantially all of the costs of the surgery residents in Clinic B since 1996. The hospital cannot count the surgery FTE residents training in Clinic A, even if it begins to pay for all of the costs of the program at that site, since a nonhospital institution had supported the training in Clinic A since 1996 (in other words, the redistribution of costs and community support principles would prohibit the hospital from counting these FTE residents). However, if the hospital continues to incur all or substantially all of the costs of the surgery residents in Clinic B, the hospital may count the FTE residents training in Clinic B for purposes of direct GME and IME payments because there would be no cost-shifting to the hospital for these residents and the hospital would incur all or substantially all of the costs for the training program in that setting.

3. Rural Track FTE Limitation for Purposes of Direct GME and IME for Urban Hospitals that Establish Separately Accredited Approved Medical Programs in a Rural Area (§§ 412.105(f)(1)(x) and 413.86(g)(12)) a. Change in the Amount of Rural Training Time Required for an Urban Hospital to Qualify for an Increase in the Rural Track FTE Limitation. To encourage the training of physicians in rural areas, section 407(c) of Pub. L. 106–113 amended sections 1886(d)(5)(B) and 1886(h)(4)(H) of the Act to add a provision that, in the case of an urban hospital that establishes separately accredited approved medical residency training programs (or rural tracks) in a rural area or has an accredited training program with an integrated rural track, an adjustment shall be made to the urban hospital's cap on the number of residents. For direct GME, the amendment applies to payments to hospitals for cost reporting periods beginning on or after April 1, 2000; for IME, the amendment applies to discharges occurring on or after April l, 2000.

Section 407(c) of Pub. L. 106–113 did not define a ''rural track'' or an ''integrated rural track,'' nor are these terms defined elsewhere in the Act or in any applicable regulations.

Currently, there are a number of accredited 3-year primary care residency programs in which residents train for 1 year of the program at an urban hospital and are then rotated for training for the other 2 years of the 3-year program to a rural facility(ies). These separately accredited ''rural track'' programs are recognized by the Accreditation Council of Graduate Medical Education (ACGME) as ''1–2'' rural track programs. As far as CMS is able to determine, ACGME is the only accrediting body to ''separately accredit'' rural track residency programs, a requirement specified in Pub. L. 106–113.

We implemented the rural track program provisions of section 1886(d)(5)(B) and 1886(h)(4)(H) of the Act to address these ''1–2'' programs and to account for other programs that are not specifically ''1–2'' programs but that include rural training components. As stated above, since there is no existing definition of ''rural track'' or ''integrated rural track,'' we define at § 413.86(b) a ''rural track'' and an ''integrated rural track'' as an approved medical residency training program established by an urban hospital in which residents train for a portion of the program at the urban hospital and then rotate for a portion of the program to a rural hospital(s) or to a rural nonhospital site(s). We have previously noted that the terms ''rural track'' and ''integrated rural track,'' for purposes of this definition, are synonymous.

To implement these provisions, we revised § 413.86 to add paragraph (g)(11) (since redesignated as (g)(12)), and § 412.105 to add paragraph (f)(1)(x) to specify that, for direct GME, for cost reporting periods beginning on or after April 1, 2000, or, for IME, for discharges occurring on or after April 1, 2000, an urban hospital that establishes a new residency program, or has an existing residency program, with a rural track (or an integrated rural track) may, under certain circumstances, include in its FTE count residents in those rural tracks, in addition to the residents subject to the FTE cap at § 413.86(g)(4). (See the August 1, 2000 interim final rule with comment period (65 FR 47033) and the August 1, 2001 IPPS final rule (66 FR 39902)). These regulations specify that an urban hospital may count the residents in the rural track in excess of the hospital's FTE cap up to a ''rural track FTE limitation'' for that hospital. We defined this rural track FTE limitation at § 413.86(b) as the maximum number of residents (as specified in § 413.86(g)(12)) training in a rural track residency program that an urban hospital may include in its FTE count, in addition to the number of FTE residents already included in the hospital's FTE cap.

Generally, the rural track policy is divided into two categories: rural track programs in which residents are rotated to a rural area for at least two-thirds of the duration of the program; and rural track programs in which residents are rotated to a rural area for less than two-thirds of the duration of the program. Currently, family practice is the only specialty that has separately accredited rural track programs. As previously noted, to account for other specialties that have program lengths greater than

or less than 3 years, or that are not ''1–2'' programs, but may establish separately accredited rural track residency programs that are longer than 3 years, our regulations specify that residents must train in the rural area for ''two-thirds of the duration of the program,'' rather than ''2 out of 3 program years,'' in order for the urban hospital to count FTEs in the rural track (up to the rural track FTE limitation) in addition to the residents included in the hospital's FTE limitation. Thus, for example, under current policy, if a surgery program, which is a 5-year program, were to establish a separately accredited rural track, the urban hospital must rotate the surgery residents to the rural area for at least two-thirds of the duration of the 5-year program in order to qualify to count those FTEs in excess of the hospital's FTE cap, as provided in § 413.86(g)(12) and § 412.105(f)(1)(x).

Accordingly, our policy for determining whether an urban hospital qualifies for an adjustment to the FTE cap for training residents in rural areas is dependent upon the proportion of time the residents spend training in the rural areas. If the time spent training in rural areas (either at a rural hospital or a rural nonhospital site) constitutes *at least two-thirds* of the duration of the program, then the urban hospital may include the time the residents train *at that urban hospital* in determining GME payments. However, if the urban hospital rotates residents to rural areas for a period of time that is *less than two-thirds* of the duration of the program, although the rural hospital may count the time the residents train at the rural hospital if the program is new, the urban hospital may *not* include the time the residents train at the urban hospital for GME payment purposes (unless it can do so within the hospital's FTE cap).

When we first implemented this policy on rural tracks, it was consistent with our understanding of how the ACGME accredits rural track ''1–2'' programs, in which residents train for 1 year of the program at an urban hospital and are then rotated for training years 2 and 3 to a rural facility. We believed that the ACGME did not separately accredit an approved program as a rural track program unless it met this ''1–2'' condition; that is, the residents were spending one-third of program training in the urban area and two-thirds of the program training in the rural area. However, we have recently learned that there are a few rural track programs that are separately accredited by the ACGME as ''1–2'' rural track programs, but the residents in these programs are not training in rural areas for at least two-thirds of the duration of the program. We understand that in certain instances in which the case-mix of the rural facilities might not be sufficiently broad to provide the residents with an acceptable range of training opportunities, the ACGME allows the residents in program years 2 and 3 to return to the urban hospital for some training in both years. However, because the training in years 2 and 3 is predominantly occurring at the rural locations, the ACGME still separately accredits the urban and rural portions as a ''1–2'' program.

The existing regulations at §§ 412.105(f)(1)(x) and 413.86(g)(12) specify two main criteria for an urban hospital to count the time spent by residents training in a rural track while at the urban hospital in excess of the hospital's FTE limitation: (1) The program must be separately accredited by the ACGME; *and* (2) the time spent training in rural areas (either at a rural hospital or a rural nonhospital site) must constitute *at least two-thirds* of the duration of the program.

We believe that an urban hospital that operates a program that is separately accredited by the ACGME as a ''1–2'' program, but in which residents train in rural areas for more than half but less than two-thirds of the duration of the program, should still be allowed to count those FTE residents for GME payment purposes. Therefore, to be consistent with the ACGME accreditation practices, we are proposing to revise our regulations. Proposed § 413.86(g)(12) would still address our policy that an urban hospital qualifies for an adjustment to the FTE cap for training in rural areas based upon the proportion of time the residents spend training in the rural areas. However, instead of using a ''two-thirds'' model to specify the amount of time residents are training in the rural areas, as the framework exists under current policy, the proposal would use, at §§ 413.86(g)(12)(i) through (iv), a ''one-half of the time'' model to specify the amount of time residents are training in rural areas. This proposal would address the limited cases where ACGME separately accredits programs as ''1–2'' rural tracks but residents in those programs train in the rural areas less than two-thirds of the time, although greater than one-half of the time. Specifically, we are proposing at § 413.86(g)(12) to state:

- If an urban hospital rotates residents to a separately accredited rural track program at a rural hospital(s) for two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital.
- If an urban hospital rotates residents to a separately accredited rural track program at a rural nonhospital site(s) for two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000, and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under § 413.86(f)(4).
- If an urban hospital rotates residents in the rural track program to a rural hospital(s) for less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2002, and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the rural hospital may not include those residents it its FTE count (if the rural track is not a new program under § 413.86(g)(6)(iii), or if the rural hospital's FTE count exceeds that hospital's FTE cap), nor may the urban hospital include those residents when calculating its rural track FTE limitation.
- If an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for a period of time that is less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2002, and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under § 413.86(f)(4).

We also are proposing to make a conforming change to § 412.105(f)(1)(x) to make these proposed provisions applicable to IME payments for discharges occurring on or after October 1, 2003.

We believe this proposal produces a more equitable result than the existing policy; the proposal encompasses what we believe to be all situations in which the ACGME separately accredits rural track programs and in which residents in the programs spend a majority of the time training in rural settings, fulfilling the intent of Congress for Medicare to

provide GME payments for significant rural residency training.

b. Inclusion of Rural Track FTE Residents in the Rolling Average Calculation. Section 1886(h)(4)(G) of the Act, as added by section 4623 of Public Law 105–33, provides that, for a hospital's first cost reporting period beginning on or after October 1, 1997, the hospital's FTE resident count for direct GME payment purposes equals the average of the actual FTE resident count for that cost reporting period and the preceding cost reporting period. Section 1886(h)(4)(G) of the Act requires that, for cost reporting periods beginning on or after October 1, 1998, a hospital's FTE resident count for direct GME payment purposes equals the average of the actual FTE resident count for the cost reporting period and the preceding two cost reporting periods (that is, a 3-year rolling average). This provision phases in over a 3-year period any reduction in direct GME payments to hospitals that results from a reduction in the number of FTE residents below the number allowed by the FTE cap. We first implemented this provision in the August 29, 1997 final rule with comment period (62 FR 46004) and revised § 413.86(g)(5) accordingly. Because hospitals may have two PRAs, one for residents in primary care and obstetrics and gynecology (the ''primary care PRA''), and a lower PRA for nonprimary care residents, we revised our policy for computing the rolling average for direct GME payment purposes (*not* for IME) in the August 1, 2001 final rule (66 FR 39893) to create two separate rolling averages, one for primary care and obstetrics and gynecology residents (the ''primary care rolling average''), and one for nonprimary care residents. Effective for cost reporting periods beginning on or after October 1, 2001, direct GME payments are calculated based on the sum of: (1) The product of the primary care PRA and the primary care rolling average; and (2) the product of the nonprimary care PRA and the nonprimary care FTE rolling average. (This sum is then multiplied by the Medicare patient load to determine Medicare direct GME payments).

Section 407(c) of Public Law 106–113, which amended sections 1886(d)(5)(B) and 1886(h)(4)(H) of the Act to create the rural track provision, provided that, in the case of an urban hospital that establishes a separately accredited rural track, ''* * * the Secretary shall *adjust the limitation under subparagraph (F)* in an appropriate manner insofar as it applies to such programs in such rural areas in order to encourage the training of physicians in rural areas'' (emphasis added). Subparagraph (F) of the Act is the provision that establishes a cap on the number of allopathic and osteopathic FTE residents that may be counted at each hospital for Medicare direct GME payment purposes. Thus, the provision authorizes the Secretary to allow for an increase to an urban hospital's FTE cap on allopathic and osteopathic residents in certain instances when an urban hospital establishes a rural track program. Although the rural track provision effectively allows an increase to the urban hospital's FTE cap by adjusting the FTE limitation under subparagraph (F), the statute makes no reference to subparagraph (G), the provision concerning the rolling average count of residents. That is, the statute does not provide for an exclusion from the rolling average for the urban hospital for those FTE residents training in a rural track.

Since we implemented this rural track provision in the August 1, 2000 interim final rule with comment period (65 FR 47033), we have interpreted this provision to mean that, except for new rural track programs begun by urban teaching hospitals that are establishing an FTE cap for the first time under § 413.86(g)(6)(i), when an urban hospital establishes a new rural track program or expands an existing rural track program, FTE residents in the rural track that are counted by the urban hospital are included in the hospital's rolling average calculation immediately. Although we have not specified in the regulations that rural track FTE residents counted by an urban hospital are included in the hospital's rolling average FTE resident count, this has been our policy. The Medicare cost report, Form CMS–2552–96 (line 3.05 on Worksheet E, Part A, for IME payments, and on line 3.02 on Worksheet E–3, Part IV, for direct GME payments), reflects this policy. Accordingly, FTE residents in a rural track program are to be included in the urban hospital's rolling average count for IME and direct GME for cost reporting periods beginning on or after April 1, 2000.

We are proposing to revise the regulations at § 413.86(g)(5) to add a new paragraph (vii) to clarify that, subject to regulations at § 413.86(g)(12), except for new rural track programs begun by urban hospitals that are first establishing an FTE cap under § 413.86(g)(6)(i), when an urban hospital with an existing FTE cap establishes a new program with a rural track (or an integrated rural track), or expands an existing rural track (or an integrated rural track) program, the FTE residents in that program that are counted by the urban hospital are included in the urban hospital's rolling average FTE resident count immediately. We also are proposing to revise §§ 413.86(g)(12)(i)(A), (g)(12)(ii)(B), and (g)(12)(iv)(A) to indicate that for the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average, training in the rural track at the urban hospital.

4. Technical Change Relating to Affiliated Groups and Affiliation Agreements

Section 1886(h)(4)(H)(ii) of the Act permits, but does not require, the Secretary to prescribe rules that allow institutions that are members of the same affiliated group (as defined by the Secretary) to elect to apply the FTE resident limit on an aggregate basis. This provision allows the Secretary to give hospitals flexibility in structuring rotations within a combined cap when they share a resident's time. Consistent with the broad authority conferred by the statute, we established criteria for defining an ''affiliated group'' and an ''affiliation agreement'' in both the August 29, 1997 final rule (62 FR 45965) and the May 12, 1998 final rule (63 FR 26317). We further clarified our policy concerning affiliation agreements in the August 1, 2002 final rule (67 FR 50069).

We are aware that there has been some confusion at times among members of the provider community when using the term ''affiliation agreement,'' since the term is used in contexts other than for Medicare GME payment purposes. For example, an ''affiliation agreement'' is a term historically used in the academic community that generally relates to agreements made between hospitals and medical schools or among sponsors of medical residency education programs. To help prevent further confusion, we are proposing to change the term in the regulations to ''Medicare GME affiliation agreement.'' We believe this will help to distinguish these agreements used for purposes of GME payments from agreements used for other purposes in the provider community. We are proposing to revise the regulations at § 413.86(b) to state ''Medicare GME affiliated group,'' and ''Medicare GME affiliation agreement,'' and we are making similar revisions to § 413.86(g)(4)(iv), (g)(7)(i) through (v), and § 412.105(f)(1)(vi) for IME payment purposes.

G. Notification of Updates to the Reasonable Compensation Equivalent (RCE) Limits (§ 415.70)

1. Background

Under the Medicare program, payment for services furnished by a physician is made under either the Hospital Insurance Program (Part A) or the Supplementary Medical Insurance Program (Part B), depending on the type of services furnished. In accordance with section 1848 of the Act, physicians' charges for medical or surgical services to individual Medicare patients generally are covered under Part B on a fee-for-service basis under the Medicare physician fee schedule. The compensation that physicians receive from or through a provider for services that benefit patients generally (for example, administrative services, committee work, teaching, and supervision) can be covered under Part A or Part B, depending on the provider's setting.

As required by section 1887(a)(2)(B) of the Act, allowable compensation for services furnished by physicians to providers that are paid by Medicare on a reasonable cost basis is subject to reasonable compensation equivalent (RCE) limits. Under these limits, payment is determined based on the lower of the actual cost of the services to the provider (that is, any form of compensation to the physician) or a reasonable compensation equivalent. For purposes of applying the RCE limits, physician compensation costs means monetary payments, fringe benefits, deferred compensation and any other items of value (excluding office space or billing and collection services) that a provider or other organization furnishes a physician in return for the physician's services.

The RCE limits do not apply to the costs of physician compensation that are attributable to furnishing inpatient hospital services paid for under the IPPS or GME costs. In addition, RCE limits do not apply to the costs CAHs incur in compensating physicians for services. Furthermore, compensation that a physician receives for activities that may not be paid for under either Part A or Part B are not considered in applying the RCE limits.

The limits apply equally to all physician services to providers that are payable on a reasonable cost basis under Medicare. If a physician receives any compensation from a provider for his or her physician services to the provider (that is, those services that benefit patients generally), payment to those affected providers for the costs of such compensation is subject to the RCE limits. The RCE limits are not applied to payment for services that are identifiable medical or surgical services to individual patients and paid for under the physician fee schedule, even if the physician agrees to accept compensation (for example, from a hospital) for those services. (However, payments to teaching hospitals that have elected to be paid for these services on a reasonable cost basis in accordance with section 1861(b)(7) of the Act are subject to the limits.)

Section 415.70(b) of the regulations specifies the methodology for determining annual RCE limits, considering average physician incomes by specialty and type of location, to the extent possible using the best available data. On October 31, 1997, the revised RCE limits update methodology was published in the **Federal Register** (62 FR 59075). For cost reporting periods beginning on or after January 1, 1998, updates to the RCE limits are calculated using the Medicare Economic Index (MEI). The inflation factor used to develop the initial RCE limits and, subsequently, to update those limits to reflect increases in net physician compensation was the Consumer Price Index for All Urban Consumers (CPI–U). In 1998, we revised the RCE limits update methodology by replacing the CPI–U with the physician fee schedule's inflation factor (the MEI), to achieve a measure of consistency in the methodologies employed to determine reasonable payments to physicians for direct medical and surgical services furnished to individual patients and reasonable compensation levels for physicians' services that benefit provider patients generally.

2. Publication of the Updated RCE Limits

We intend to publish updated payment limits on the amount of allowable compensation for services furnished by physicians to providers in the FY 2004 IPPS final rule. These revised limits will be mere updates that will be calculated by applying the most recent economic index data. We are not proposing any change in the methodology. Therefore, in accordance with § 415.70(f), we are allowed to publish the revised RCE limits in a final rule without prior publication of a proposed rule for public comment. Furthermore, we believe that publication of the revised RCE limits in a proposed rule with opportunity for public comment is unnecessary, and we find good cause to waive the procedure.

V. PPS for Capital-Related Costs

In this proposed rule, we are not proposing any changes in the policies governing the determination of the payment rates for capital-related costs for short-term acute care hospitals under the IPPS. However, for the readers' benefit, in this section of this proposed rule, we are providing a summary of the statutory basis for the PPS for hospital capital-related costs, the methodology used to determine capital-related payments to hospitals, and a brief description of the payment policies under the PPS for capital-related costs for new hospitals, extraordinary circumstances, and exception (regular and special) payments. (Refer to the August 1, 2001 IPPS final rule (66 FR 39910) for a more detailed discussion of the statutory basis for the system, the development and evolution of the system, the methodology used to determine capital-related payments to hospitals both during and after the transition period, and the policy for providing regular and special exceptions payments.)

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services ''in accordance with a PPS established by the Secretary.'' Under the statute, the Secretary has broad authority in establishing and implementing the PPS for capital related costs. We initially implemented the capital PPS in the August 30, 1991 IPPS final rule (56 FR 43358), in which we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

Federal fiscal year (FY) 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital inpatient capital-related costs. Beginning in FY 2002, capital PPS payments are based solely on the Federal rate for the vast majority of hospitals. The basic methodology for determining capital prospective payments based on the Federal rate is set forth in § 412.312. For the purpose of calculating payments for each discharge, the standard Federal rate is adjusted as follows:

(Standard Federal Rate) × (DRG Weight) × (Geographic Adjustment Factor (GAF)) × (Large Urban Add-on, if applicable) × (COLA Adjustment for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME Adjustment Factor, if applicable)

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year that are specified in § 412.312(c) of existing regulations.

During the 10-year transition period, a new hospital (as defined at 412.300(b)) was exempt from the capital PPS for its first 2 years of operation and was paid 85 percent of its reasonable costs during that period. Originally, this provision was effective only through the transition period and, therefore, ended with cost reporting periods beginning in FY 2002. As we discussed in the August 1, 2002 final rule (67 FR 50101), this payment provision was implemented to provide special protection to new hospitals during the transition period in response to concerns that prospective payments under a DRG system may not be adequate initially to cover the capital costs of newly built hospitals. Therefore, we believe that the rationale for this policy applies to new hospitals after the transition period as well, and in that same final rule, we established regulations under § 412.304(c)(2) that provide the same special payment to new hospitals for cost reporting periods beginning on or after October 1, 2002. Therefore, a new hospital, defined under § 412.300(b), is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its first 2 years of operation unless the new hospital elects to receive fully prospective payment based on 100 percent of the Federal rate. (For more detailed information regarding this policy, see the August 1, 2002 IPPS final rule (67 FR 50101).)

Regulations at § 412.348(f) provide that a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances beyond the hospital's control. This policy was established for hospitals during the 10-year transition period, but we established regulations at § 412.312(e) to specify that payment for extraordinary circumstances is also made for cost reporting periods after the transition period (that is, cost reporting periods beginning on or after October 1, 2001). (For more detailed information regarding this policy, refer to the August 1, 2002 **Federal Register** (67 FR 50102).)

During the transition period, under §§ 412.348(b) through (e), eligible hospitals could receive regular exception payments. These exception payments guaranteed a hospital a minimum payment of a percentage of its Medicare allowable capital-related costs depending on the class of hospital (§ 412.348(c)). However, after the end of the transition period, eligible hospitals can receive additional payments under the special exceptions provisions at § 412.348(g), which guarantees an eligible hospital a minimum payment of 70 percent of its Medicare allowable capital-related costs. Special exceptions payments may be made only for the 10 years after the cost reporting year in which the hospital completes its qualifying project, which can be no later than the hospital's cost reporting period beginning before October 1, 2001. Thus, an eligible hospital may receive special exceptions payments for up to 10 years beyond the end of the capital PPS transition period. Hospitals eligible for special exceptions payments were required to submit documentation to the intermediary indicating the completion date of their project. (For more detailed information regarding the special exceptions policy under § 412.348(g), refer to the August 1, 2001 IPPS final rule (66 FR 39911 through 39914) and the August 1, 2002 IPPS final rule (67 FR 50102).)

VI. Proposed Changes for Hospitals and Hospital Units Excluded from the IPPS

A. Payments to Excluded Hospitals and Hospital Units (§§ 413.40(c), (d), and (f))

1. Payments to Existing Excluded Hospitals and Hospital Units

Section 1886(b)(3)(H) of the Act (as amended by section 4414 of Pub. L. 105–33) established caps on the target amounts for certain existing hospitals and hospital units excluded from the IPPS for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002. For this period, the caps on the target amounts apply to the following three classes of excluded hospitals or units: psychiatric hospitals and units, rehabilitation hospitals and units, and LTCHs.

In accordance with section 1886(b)(3)(H)(i) of the Act and effective for cost reporting periods beginning on or after October 1, 2002, payments to these classes of existing excluded hospitals or hospital units are no longer subject to caps on the target amounts. In accordance with existing §§ 413.40(c)(4)(ii) and (d)(1)(i) and (ii), where applicable, these excluded hospitals and hospital units continue to be paid on a reasonable cost basis, and payments are based on their Medicare inpatient operating costs, not to exceed the ceiling. The ceiling would be computed using the hospital's or unit's target amount from the previous cost reporting period updated by the rate-of-increase specified in § 413.40(c)(3)(viii) of the regulations and then multiplying this figure by the number of Medicare discharges. Effective for cost reporting periods beginning on or after October 1, 2002, rehabilitation hospitals and units are paid 100 percent of the Federal rate. Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs also are no longer paid on a reasonable cost basis but are paid under a DRG-based PPS. As part of this process for LTCHs, we established a 5-year transition period from reasonable cost-based reimbursement to a fully Federal PPS. However, a LTCH, subject to the blend methodology, may elect to be paid based on a 100 percent of the Federal prospective rate. (Sections VII.A.3. and 4. of this preamble contain for a more detailed discussion of the IRF PPS and the LTCH PPS.)

2. Updated Caps for New Excluded Hospitals and Units

Section 1886(b)(7) of the Act establishes a payment limitation for new psychiatric hospitals and units, new rehabilitation hospitals and units, and new LTCHs. A discussion of how the payment limitation was calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46019); the May 12, 1998 final rule (63 FR 26344); the July 31, 1998 final rule (63 FR 41000); and the July 30, 1999 final rule (64 FR 41529). Under the statute, a ''new'' hospital or unit is a hospital or unit that falls within one of the three classes of hospitals or units (psychiatric, rehabilitation or long-term care) that first receives payment as a hospital or unit excluded from the IPPS on or after October 1, 1997.

The amount of payment for a ''new'' psychiatric hospital or unit would be determined as follows:

- Under existing § 413.40(f)(2)(ii), for the first two 12-month cost reporting periods, the amount of payment is the lesser of: (1) The operating costs per case; or (2) 110 percent of the national median (as estimated by the Secretary) of the target amounts for the same class of hospital or unit for cost reporting periods ending during FY 1996, updated by the hospital market basket increase percentage to the fiscal year in which the hospital or unit first receives payments under section 1886 of the Act, as adjusted for differences in area wage levels.
- Under existing § 413.40(c)(4)(v), for cost reporting periods following the hospital's or unit's first two 12-month cost reporting periods, the target amount is equal to the amount determined under section 1886(b)(7)(A)(i) of the Act for the third period, updated by the applicable hospital market basket increase percentage.

The proposed amounts included in the following table reflect the updated 110 percent of the national median target amounts of new excluded psychiatric hospitals and units for cost reporting periods beginning during FY 2004. These figures are updated with the most recent data available to reflect the projected market basket increase percentage of 3.5 percent. This projected percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient hospital services (as projected by the Office of the Actuary of CMS based on its historical experience with the IPPS). For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index, without regard to IPPS reclassifications, and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	FY 2004 proposed labor-related share	FY 2004 proposed nonlabor-related share
Psychiatric	$7,301	$2,902

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new LTCHs because they are paid 100 percent of the Federal rate. Under the LTCH PPS, a new LTCH is defined as a provider of inpatient hospital services that meets the qualifying criteria for LTCHs specified under § 412.23(e)(1) and (e)(2) and whose first cost reporting period as a LTCH begins on or after October 1, 2002 (§ 412.23(e)(4)). (We note that this definition of new LTCHs should not be confused with those LTCHs first paid under the TEFRA payment system for discharges occurring on or after October 1, 1997, and before October 1, 2002.) New LTCHs are paid based on 100 percent of the fully Federal prospective rate (they may not participate in the 5-year transition from cost-based reimbursement to prospective payment). In contrast, those ''new'' LTCHs that meet the definition of ''new'' under § 413.40(f)(2)(ii) and that have their first cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, may be paid under the LTCH PPS transition methodology. Since those hospitals by definition would have been considered new before October 1, 2002, they would have been subject to the updated payment limitation on new hospitals that was published in the FY 2003 IPPS final rule (67 FR 50103). Under existing regulations at § 413.40(f)(2)(ii), the ''new'' hospital would be subject to the same cap in its second cost reporting period; this cap would not be updated for the new hospital's second cost reporting year. Thus, because the same cap is to be used for the new LTCH's first two cost reporting periods, it is no longer necessary to publish an updated cap for new LTCHs.

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new rehabilitation hospitals and units because they are paid 100 percent of the Federal prospective rate under the IRF PPS. Therefore, it is also no longer necessary to update the payment limitation for new rehabilitation hospitals or units.

3. Implementation of a PPS for IRFs

Section 1886(j) of the Act, as added by section 4421(a) of Public Law 105–33, provided the phase-in of a case-mix adjusted PPS for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation hospital unit (referred to in the statute as rehabilitation facilities) for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2002, with a fully implemented PPS for cost reporting periods beginning on or after October 1, 2002. Section 1886(j) of the Act was amended by section 125 of Public Law 106–113 to require the Secretary to use a discharge as the payment unit under the PPS for inpatient hospital services furnished by rehabilitation facilities and to establish classes of patient discharges by functional-related groups. Section 305 of Public Law 106–554 further amended section 1886(j) of the Act to allow rehabilitation facilities, subject to the blend methodology, to elect to be paid the full Federal prospective payment rather than the transitional period payments specified in the Act.

On August 7, 2001, we issued a final rule in the **Federal Register** (66 FR 41316) establishing the PPS for inpatient rehabilitation facilities, effective for cost reporting periods beginning on or after January 1, 2002. Under the IRF PPS, for cost reporting periods beginning on or after January 1, 2002, and before October 1, 2002, payment consisted of 33⅓ percent of the facility-specific payment amount (based on the reasonable cost-based reimbursement methodology) and 66⅔ percent of the adjusted Federal prospective payment. For cost reporting periods beginning on or after October 1, 2002, payments are based entirely on the Federal prospective payment rate determined under the IRF PPS.

4. Implementation of a PPS for LTCHs

In accordance with the requirements of section 123 of Public Law 106–113, as modified by section 307(b) of Public Law 106–554, we established a per discharge, DRG-based PPS for LTCHs as described in section 1886(d)(1)(B)(iv) of the Act for cost reporting periods beginning on or after October 1, 2002, in a final rule issued on August 30, 2002 (67 FR 55954). The LTCH PPS uses information from LTCH hospital patient records to classify patients into distinct LTC–DRGs based on clinical characteristics and expected resource needs. Separate payments are calculated for each LTC–DRG with additional adjustments applied.

As part of the implementation of the system, we established a 5-year transition period from reasonable cost-based reimbursement to the fully Federal prospective rate. A blend of the reasonable cost-based reimbursement percentage and the prospective payment Federal rate percentage would be used to determine a LTCH's total payment under the LTCH PPS during the transition period. Certain LTCHs may elect to be paid based on 100 percent of the Federal prospective rate. All LTCHs will be paid under the fully Federal prospective rate for cost reporting periods beginning on or after October 1, 2006.

B. Payment for Services Furnished at Hospitals-Within-Hospitals and Satellite Facilities

Existing regulations at § 412.22(e) define a hospital-within-a-hospital as a hospital that occupies space in the same building as another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital. Moreover, existing § 412.22(f) provides for the grandfathering of hospitals-within-hospitals that were in existence on or before September 30, 1995.

Sections 412.22(h) and 412.25(e), relating to satellites of hospitals and hospital units, respectively, excluded from the IPPS, define a satellite facility as a part of a hospital or unit that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital. Sections 412.22(h)(3) and 412.25(e)(3) provide for the grandfathering of excluded hospitals and units that were structured as satellite facilities on September 30, 1999, to the extent they operate under

the same terms and conditions in effect on that date.

In providing for the grandfathering of satellite facilities of hospitals and hospital units, we believed it was appropriate to require that the satellite facilities operate under the same terms and conditions that were in effect on September 30, 1999. There are similarities between the definition of the two types of satellite facilities and the definition of hospitals-within-hospitals (that is, hospitals-within-hospitals and satellite facilities are both physically located in acute care hospitals that are paid for their inpatient services on a prospective payment basis). Also, satellite facilities of both excluded hospitals and hospital units and hospitals-within-hospitals provide inpatient hospital services that are paid at a higher rate than would apply if the facilities were treated by Medicare as part of an acute care hospital.

We are proposing to revise § 412.22(f) to specify that, effective with cost reporting periods beginning on or after October 1, 2003, a hospital operating as a hospital-within-a-hospital on or before September 30, 1995, is exempt from the criteria in § 412.22(e)(1) through (e)(5) only if the hospital-within-a-hospital continues to operate under the same terms and conditions in effect as of September 30, 1995. The intent of the ''grandfathering'' provision was to ensure that hospitals that had been in existence prior to the effective date of our hospital-within-hospital requirements should not be adversely affected by those requirements. To the extent hospitals were already operating as hospitals-within-hospitals without meeting those requirements, we believe it is appropriate to limit the ''grandfathering'' provision to those hospitals that continue to operate in the same manner as they had operated prior to the effective date of those rules. However, if a hospital changes the way it operates (for example, adds more beds) subsequent to the effective date of the new rules, it should no longer receive the benefit of the ''grandfathering'' provision.

Under § 412.22(e), we specify the criteria that a hospital-within-a-hospital is required to meet in order to be excluded from the IPPS. One of these criteria, under § 412.22(e)(5)(i), requires that a hospital-within-a-hospital is able to perform basic hospital functions (for example, medical record services and nursing services) that are presently included in the Medicare hospital conditions of participation under Part 482 of the Medicare regulations. These requirements were first included in Part 412 in response to hospitals organizing themselves as what is referred to as the hospital-within-a-hospital model. Thus, to avoid recognizing nominal hospitals, while allowing hospitals adequate flexibility and opportunity for legitimate networking and sharing of services, we included, by reference, certain hospital conditions of participation as additional criteria in part 412 for hospitals-within-hospitals that request exclusion from the IPPS. (Further discussion can be found in a final rule published in the **Federal Register** on September 1, 1994 (59 FR 45389).) Modifications to the conditions of participation have been made since the publication of that September 1, 1994 final rule. Thus, we need to update the references to the conditions of participation in § 412.22(e)(5)(i) to make them consistent with existing provisions under the basic hospital conditions of participation. Therefore, we are proposing to amend § 412.22(e)(5)(i) to add references to § 482.43 (discharge planning) and § 482.45 (organ, tissue, and eye procurement) as basic hospital functions that a hospital-within-a-hospital would also be required to meet.

C. Clarification of Classification Requirements for LTCHs

Under § 412.23(e)(2), to qualify to be excluded from the IPPS as a LTCH and to be paid under the LTCH PPS, a hospital must have an average Medicare length of stay of greater than 25 days (which includes all covered and noncovered days of stay for Medicare patients) as calculated under the criteria of § 412.23(e)(3). In calculating this average Medicare inpatient length of stay, data from the hospital's most recently filed cost report are used to make this determination. However, if the hospital has not yet filed a cost report or if there is an indication that the most recently filed cost report does not accurately reflect the hospital's current Medicare average length of stay, data from the most recent 6-month period are used.

Our interpretation of § 412.23(e)(3)(ii) and (e)(3)(iii) was to allow hospitals that submit data for purposes of exclusion from the IPPS to use a period of at least 5 months of the most recent data from the preceding 6-month period. This longstanding policy interpretation was necessary in order to comply with the time requirement in § 412.22(d) that specifies that, for purposes of the IPPS, status is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Therefore, we are proposing to revise §§ 412.23(e)(3)(ii) and (iii) to reflect our longstanding interpretation of the regulations.

D. Criteria for Payment on a Reasonable Cost Basis for Clinical Diagnostic Laboratory Services Performed by CAHs

Section 1820 of the Act provides for the establishment of Medicare Rural Hospital Flexibility Programs, under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and meet the CAH conditions of participation in 42 CFR part 485, subpart F, will be certified as CAHs by CMS. Section 1834(g) of the Act states that the amount of payment for outpatient services furnished by a CAH will be the reasonable costs of the CAH in providing these services.

Regulations implementing section 1834(g) of the Act are set forth at § 413.70. These regulations state, in paragraph (b)(2)(iii), that payment to a CAH for outpatient clinical diagnostic laboratory tests will be made on a reasonable cost basis only if the individuals for whom the tests are performed are outpatients of the CAH, as defined in 42 CFR 410.2, at the time the specimens are collected. The regulations also state that clinical diagnostic laboratory tests for persons who are not patients of the CAH at the time the specimens are collected will be paid for in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Act. These provisions, which also are the basis for payment for clinical diagnostic laboratory tests performed by independent laboratories and by hospitals on specimens drawn at other locations, set payment at the least of: (1) Charges determined under the fee schedule as set forth in section 1833(h)(1) or section 1834(d)(1) of the Act; (2) the limitation amount for that test determined under section 1833(h)(4)(B) of the Act; or (3) a negotiated rate established under section 1833(h)(6) of the Act. Payments determined under this methodology are typically referred to as ''fee schedule payments,'' and are so described here both for ease of reference and to differentiate them from payments determined on a reasonable cost basis.

The definition of an ''outpatient'' in 42 CFR 410.2 states that an outpatient means a person who has not been admitted as an inpatient but who is registered on hospital or CAH records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

Recently, we have received numerous questions about how Medicare pays for laboratory services that a CAH may furnish to Medicare beneficiaries in various settings other than the CAH.

Specifically, the questioners have asked whether a CAH may obtain reasonable cost payment for such services to individuals in other locations by sending a CAH employee into the setting and registering the individual as a CAH patient while the blood is drawn or other specimen collection is accomplished. The settings that have been referred to most frequently are: (1) A rural health clinic (RHC), especially one that is provider-based with respect to the CAH; (2) the individual's home; and (3) a SNF.

We have considered these suggestions and understand the position taken by those who believe that nominal compliance with the requirements for outpatient status should be enough to warrant reasonable cost payment for clinical diagnostic laboratory tests for individuals at locations outside the CAH. However, we do not agree that providing reasonable cost payment under these circumstances would be appropriate. On the contrary, we believe that extending reasonable cost payment for services furnished to individuals who are not at the CAH when the specimen is drawn would duplicate existing coverage, create confusion for beneficiaries and others by blurring the distinction between CAHs and other providers, such as SNFs and HHAs, and increase the costs of care to Medicare patients without enhancing either the quality or the availability of that care.

To clarify our policies in this area and avoid possible misunderstandings about the scope of the CAH benefit, we are proposing to revise § 413.70(b)(2)(iii) to state that payment to a CAH for outpatient clinical diagnostic laboratory tests will be made on a reasonable cost basis only if the individuals for whom the tests are performed are outpatients of the CAH, as defined in 42 CFR 410.2, ''and are physically present in the CAH'' at the time the specimens are collected. (We note that, in some cases, the CAH outpatients from whom specimens are collected at the CAH may include individuals referred to the CAH from RHCs or other facilities to receive the tests.) We are proposing to further revise this paragraph to state that clinical diagnostic laboratory tests for individuals who do not meet these criteria but meet other applicable requirements will be paid for only in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Act, that is, payment will be made only on a fee schedule basis. By making the second proposed change, we wish to emphasize that this proposal does not mean that no payment would be made for clinical diagnostic laboratory tests performed by CAHs that do not meet the revised criteria. On the contrary, such tests would be paid, but on a fee schedule basis. We believe these clarifications are appropriate, as the CAH is not providing CAH services but is acting as an independent laboratory in providing these clinical diagnostic laboratory tests.

E. Technical Change

On July 30, 1999, we published in the **Federal Register** a final rule (64 FR 41532) that set forth criteria for a satellite facility of a hospital or hospital unit to be excluded from the IPPS under § 412.25. Section 412.25(e)(3) of the regulations specifies that any unit structured as a satellite facility on September 30, 1999, and excluded from the IPPS on that date, is grandfathered as an excluded hospital to the extent that the unit continues operating under the same terms and conditions, including the number of beds and square footage considered to be part of the unit, in effect on September 30, 1999, except as we specified in § 412.25(e)(4). When we specified the exception for the number of beds and square footage requirement under § 412.25(e)(4), we inadvertently referred to paragraph (e)(4) as being an exception to paragraph (h)(3). We should have specified that it was an exception to paragraph (e)(3). We are proposing to correct this reference.

VII. MedPAC Recommendations

We are required by section 1886(e)(4)(B) of the Act to respond to MedPAC's IPPS recommendations in our annual proposed rule. We have reviewed MedPAC's March 1, 2003 ''Report to the Congress: Medicare Payment Policy'' and have given it careful consideration in conjunction with the proposals set forth in this document. For further information relating specifically to the MedPAC report or to obtain a copy of the report, contact MedPAC at (202) 653–7220, or visit MedPAC's Web site at: *http://www.medpac.gov.*

MedPAC's Recommendation 2A–6 concerning the update factor for inpatient hospital operating costs and for hospitals and distinct-part hospital units excluded from the IPPS is discussed in Appendix C to this proposed rule. MedPAC's other recommendations relating to payments for Medicare inpatient hospital services focused mainly on the expansion of DRGs subject to the postacute care transfer policy, a reevaluation of the labor-related share of the market basket used in determining the hospital wage index, an increase in the DSH adjustment, and payments to rural hospitals. These recommendations and our responses are set forth below:

Recommendation 2A–1: The Secretary should add 13 DRGs to the postacute transfer policy in FY 2004 and then evaluate the effects on hospitals and beneficiaries before proposing further expansions.

Response: We are proposing to expand the postacute care transfer policy to 19 additional DRGs for FY 2004. A thorough discussion of this proposal, including a summary of MedPAC's analysis, can be found at section IV.A.3. of this preamble.

Recommendation 2A–2: The Congress should enact a low-volume adjustment to the rates used in the inpatient PPS. This adjustment should apply only to hospitals that are more than 15 miles from another facility offering acute inpatient care.

Response: MedPAC's analysis ''revealed that hospitals with a small volume of total discharges have higher costs per discharge than larger facilities, after controlling for the other cost-related factors recognized in the payment system.'' Although there are special payment protections for some rural hospitals such as CAHs, SCHs, and MDHs, MedPAC believes these provisions do not sufficiently target hospitals with low discharge volume.

This recommendation, which MedPAC estimates would increase Medicare payments to hospitals by less than $50 million in FY 2004, and others requiring Congressional action, should be considered in the context of larger discussions within Congress and between Congress and the Administration regarding Medicare reform and payment refinements. Therefore, we are not responding specifically to MedPAC's recommendation regarding a low-volume adjustment to the IPPS payments at this time.

Recommendation 2A–3: The Secretary should reevaluate the labor share used in the wage index system that geographically adjusts rates in the inpatient PPS, with any resulting change phased in over 2 years.

Response: CMS defines the labor-related share to include costs that are likely related to, influenced by, or vary with local labor markets, even if they could be purchased in a national market. Since the implementation of the IPPS, the labor-related share has been determined by adding together the cost weights from categories in the hospital market basket that are influenced by local labor markets. When the hospital market basket weights are updated or rebased, the labor-related share is updated. The estimate of the labor-

related share using the most recently revised and rebased hospital market basket (1997-based) is 72.495 percent. This was the labor-related share proposed in the FY 2003 proposed rule.

In the August 1, 2002 IPPS final rule, we elected to continue to use 71.066 percent as the labor-related share applicable to the standardized amounts (67 FR 50041). At that time, we indicated that we would conduct further analysis to determine the most appropriate methodology for the labor-related share.

We are not proposing to use the updated labor-related share at this time because we have not yet completed our research into the appropriateness of this measure. Specifically, we are currently reviewing the labor-related share in two ways. First, we are updating the regression analysis that was done when the IPPS was originally developed, with the expectation that it would help give an alternative indication of the labor-related share. Second, we are reevaluating the methodology we currently use for determining the labor-related share using the hospital market basket.

Our regression analysis attempts to explain the variation in operating cost per case for a given year using many different explanatory variables, such as case-mix, DSH status, and ownership type. We described this methodology and some of our initial results in the May 9, 2002 **Federal Register** (67 FR 31447–31479). When included in the regression, the area wage index produces a coefficient that can be interpreted as the proportion of operating costs that vary with the geographic location of the hospital. The latest results on 1997 data produced a coefficient for the area wage index of 0.621, which can be interpreted as a labor share of 62.1 percent and is very close to the results reached by other groups. However, using the same specification produced coefficients of 76.7 percent for rural hospitals and 47.6 percent for urban hospitals, a disparity that cannot be supported either by theory or existing cost data. For example, the proportion of costs accounted for by wages, benefits, and contract labor is 60.8 percent for urban hospitals and 62.3 percent for rural hospitals, a spread much smaller than the regressions indicate. In addition, when the regressions were run separately by case-mix quartile and with hospital-specific wage variation (as opposed to using the area wage index), the findings were both difficult to explain and inconsistent with the underlying cost data. Thus, we believe at this point that the regression results are not robust enough to support changing the current labor-related share measurement.

A second approach was to reevaluate our methodology for determining the labor-related share using the hospital market basket. We have researched various alternative data sources for further breaking down the cost categories in the market basket and have begun to evaluate alternative methodologies. While each of these alternatives has strengths and weaknesses, it is not clear at this point that any one alternative is superior to the current methodology. We want to continue researching these alternatives, in part, because changing from the current methodology would impact the labor-related shares for SNFs, HHAs, and all of the excluded hospital payment systems, since they use a similar methodology. Our research plan includes consulting with experts on these issues, including MedPAC, to evaluate the various alternative approaches to determining the labor-related share. We plan to invite public comments on any proposed change to the labor-related share.

In conclusion, we are proposing to continue using the 71.066 percent labor-related share that was calculated from the 1992-based market basket until we have completed our research.

Recommendation 2A–4: The Congress should raise the inpatient base rate for hospitals in rural and other urban areas to the level of the rate for those in large urban areas, phased in over 2 years.

Response: This recommendation, which MedPAC estimates would increase Medicare payments to hospitals by between $200 and $600 million in FY 2004, and others requiring Congressional action, should be considered in the context of larger discussions within Congress and between Congress and the Administration regarding Medicare reform and payment refinements. Therefore, we are not responding specifically to MedPAC's recommendation regarding raising the base rate for hospitals in rural and other urban areas at this time.

Recommendation 2A–5: The Congress should raise the cap on the disproportionate share add-on a hospital can receive in the inpatient PPS from 5.25 percent to 10 percent, phased in over 2 years.

Response: This recommendation, which MedPAC estimates would increase Medicare payments to hospitals by between $50 and $200 million in FY 2004, and others requiring Congressional action, should be considered in the context of larger discussions within Congress and between Congress and the Administration regarding Medicare reform and payment refinements. Therefore, we are not responding specifically to MedPAC's recommendation regarding raising the maximum DSH adjustments at this time.

VIII. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are available in computer tape or cartridge format; however, some files are available on diskette as well as on the Internet at *http://www.hcfa.gov/stats/pufiles.htm.* Data files and the cost for each file, if applicable, are listed below. Anyone wishing to purchase data tapes, cartridges, or diskettes should submit a written request along with a company check or money order (payable to CMS–PUF) to cover the cost to the following address: Centers for Medicare & Medicaid Services, Public Use Files, Accounting Division, PO Box 7520, Baltimore, MD 21207–0520, (410) 786–3691. Files on the Internet may be downloaded without charge.

1. CMS Wage Data

This file contains the hospital hours and salaries for FY 2000 used to create the proposed FY 2004 prospective payment system wage index. The file will be available by the beginning of February for the NPRM and the beginning of May for the final rule.

Processing year	Wage data year	PPS fiscal year
2003	2000	2004
2002	1999	2003
2001	1998	2002
2000	1997	2001
1999	1996	2000
1998	1995	1999
1997	1994	1998
1996	1993	1997
1995	1992	1996
1994	1991	1995
1993	1990	1994
1992	1989	1993
1991	1988	1992

These files support the following:

- NPRM published in the **Federal Register**.
- Final Rule published in the **Federal Register**.

Media: Diskette/most recent year on the Internet.

File Cost: $165.00 per year.

Periods Available: FY 2004 PPS Update.

2. CMS Hospital Wages Indices (Formerly: Urban and Rural Wage Index Values Only)

This file contains a history of all wage indices since October 1, 1983.

Media: Diskette/most recent year on the Internet.

File Cost: $165.00 per year.

Periods Available: FY 2004 PPS Update.

3. PPS SSA/FIPS MSA State and County Crosswalk

This file contains a crosswalk of State and county codes used by the Social Security Administration (SSA) and the Federal Information Processing Standards (FIPS), county name, and a historical list of Metropolitan Statistical Area (MSA).

Media: Diskette/Internet.

File Cost: $165.00 per year.

Periods Available: FY 2004 PPS Update.

4. Reclassified Hospitals New Wage Index (Formerly: Reclassified Hospitals by Provider Only)

This file contains a list of hospitals that were reclassified for the purpose of assigning a new wage index. Two versions of these files are created each year. They support the following:

- NPRM published in the **Federal Register**.
- Final Rule published in the **Federal Register**.

Media: Diskette/Internet.

File Cost: $165.00 per year.

Periods Available: FY 2004 PPS Update.

5. PPS–IV to PPS–XII Minimum Data Set

The Minimum Data Set contains cost, statistical, financial, and other information from Medicare hospital cost reports. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare participating hospital by the Medicare fiscal intermediary to CMS. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Tape/Cartridge.

File Cost: $770.00 per year.

	Periods beginning on or after	and before
PPS–IV	10/01/86	10/01/87
PPS–V	1010/01/87	10/01/88
PPS–VI	1010/01/88	10/01/89
PPS–VII	1010/01/89	10/01/90
PPS–VIII	1010/01/90	10/01/91
PPS–IX	1010/01/91	10/01/92
PPS–X	1010/01/92	10/01/93
PPS–XI	1010/01/93	10/01/94
PPS–XII	1010/01/94	10/01/95

(**Note:** The PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, and PPS–XVIII Minimum Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, and PPS–XVIII Hospital Data Set Files (refer to item 9 below).)

6. PPS–IX to PPS–XII Capital Data Set

The Capital Data Set contains selected data for capital-related costs, interest expense and related information and complete balance sheet data from the Medicare hospital cost report. The data set includes only the most current cost report (as submitted, final settled or reopened) submitted for a Medicare certified hospital by the Medicare fiscal intermediary to CMS. This data set is updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Tape/Cartridge.

File Cost: $770.00 per year.

	Periods beginning on or after	and before
PPS–IX	10/01/91	10/01/92
PPS–X	10/01/92	10/01/93
PPS–XI	10/01/93	10/01/94
PPS–XII	10/01/94	10/01/95

(**Note:** The PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, and PPS–XVIII Capital Data Sets are part of the PPS–XIII, PPS–XIV, PPS–XV, PPS–XVI, PPS–XVII, and PPS–XVIII Hospital Data Set Files (refer to item 9 below).)

7. PPS–XIII to PPS–XVIII Hospital Data Set

The file contains cost, statistical, financial, and other data from the Medicare Hospital Cost Report. The data set includes only the most current cost report (as submitted, final settled, or reopened) submitted for a Medicare-certified hospital by the Medicare fiscal intermediary to CMS. The data set is updated at the end of each calendar quarter and is available on the last day of the following month.

Media: Diskette/Internet.

File Cost: $2,500.00.

	Periods beginning on or after	and before
PPS–XIII	10/01/95	10/01/96
PPS–XIV	10/01/96	10/01/97
PPS–XV	10/01/97	10/01/98
PPS–XVI	10/01/98	10/01/99
PPS–XVII	10/01/99	10/01/00
PPS–XVIII	10/01/00	10/01/01

8. Provider-Specific File

This file is a component of the PRICER program used in the fiscal intermediary's system to compute DRG payments for individual bills. The file contains records for all prospective payment system eligible hospitals, including hospitals in waiver States, and data elements used in the prospective payment system recalibration processes and related activities. Beginning with December 1988, the individual records were enlarged to include pass-through per diems and other elements.

Media: Diskette/Internet.

File Cost: $265.00.

Periods Available: FY 2004 PPS Update.

9. CMS Medicare Case-Mix Index File

This file contains the Medicare case-mix index by provider number as published in each year's update of the Medicare hospital inpatient prospective payment system. The case-mix index is a measure of the costliness of cases treated by a hospital relative to the cost of the national average of all Medicare hospital cases, using DRG weights as a measure of relative costliness of cases. Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register.**
- Final rule published in the **Federal Register.**

Media: Diskette/most recent year on Internet.

Price: $165.00 per year/per file.

Periods Available: FY 1985 through FY 2004.

10. DRG Relative Weights (Formerly Table 5 DRG)

This file contains a listing of DRGs, DRG narrative description, relative weights, and geometric and arithmetic mean lengths of stay as published in the **Federal Register.** The hard copy image has been copied to diskette. There are two versions of this file as published in the **Federal Register:**

- NPRM.
- Final rule.

Media: Diskette/Internet.

File Cost: $165.00.

Periods Available: FY 2004 PPS Update.

11. PPS Payment Impact File

This file contains data used to estimate payments under Medicare's hospital inpatient prospective payment systems for operating and capital-related costs. The data are taken from various sources, including the Provider-Specific File, Minimum Data Sets, and prior impact files. The data set is abstracted

from an internal file used for the impact analysis of the changes to the prospective payment systems published in the **Federal Register.** This file is available for release 1 month after the proposed and final rules are published in the **Federal Register.**

Media: Diskette/Internet.

File Cost: $165.00.

Periods Available: FY 2004 PPS Update.

12. AOR/BOR Tables

This file contains data used to develop the DRG relative weights. It contains mean, maximum, minimum, standard deviation, and coefficient of variation statistics by DRG for length of stay and standardized charges. The BOR tables are ''Before Outliers Removed'' and the AOR is ''After Outliers Removed.'' (Outliers refers to statistical outliers, not payment outliers.)

Two versions of this file are created each year. They support the following:

- NPRM published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Diskette/Internet.

File Cost: $165.00.

Periods Available: FY 2004 PPS Update.

13. Prospective Payment System (PPS) Standardizing File

This file contains information that standardizes the charges used to calculate relative weights to determine payments under the prospective payment system. Variables include wage index, cost-of-living adjustment (COLA), case-mix index, disproportionate share, and the Metropolitan Statistical Area (MSA). The file supports the following:

- NPRM published in the **Federal Register**.
- Final rule published in the **Federal Register**.

Media: Internet.

File Cost: No charge.

Periods Available: FY 2004 PPS Update.

For further information concerning these data tapes, contact the CMS Public Use Files Hotline at (410) 786–3691.

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

B. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons stated in the preamble of this proposed rule, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

1. The authority citation for part 412 continues to read as follows:

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

2. Section 412.4 is amended by—

A. Revising paragraphs (b), (c), and (d).

B. In paragraph (f)(1), revising the reference ''paragraph (b)(1) or (c)'' to read ''paragraph (b) or (c)''.

The revisions read as follows:

§ 412.4 Discharges and transfers.

* * * * *

(b) *Acute care transfers.* A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this part if the patient is readmitted the same day (unless the readmission is unrelated to the initial discharge) to another hospital that is—

(1) Paid under the prospective payment system described in subparts A through M of this part; or

(2) Excluded from being paid under the prospective payment system described in subparts A through M of this part because of participation in an approved statewide cost control program as described in subpart C of part 403 of this chapter.

(c) *Postacute care transfers.* A discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in § 412.60(c), to one of the qualifying diagnosis-related groups (DRGs) listed in paragraph (d) of this section and the discharge is made under any of the following circumstances:

(1) To a hospital or distinct part hospital unit excluded from the prospective payment system described in subparts A through M of this part under subpart B of this part.

(2) To a skilled nursing facility.

(3) To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge.

(d) *Qualifying DRGs.* For purposes of paragraph (c) of this section, the qualifying DRGs are:

(1) For discharges occurring on or after October 1, 1998, DRGs 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483.

(2) For discharges occurring on or after October 1, 2003, the DRGs listed in paragraph (d)(1) of this section and DRGs 12, 24, 25, 89, 90, 121, 122, 130, 131, 239, 243, 277, 278, 296, 297, 320, 321, 462, and 468.

* * * * *

3. Section 412.22 is amended by:

A. Republishing the introductory text of paragraph (e)(5) and revising the first sentence of paragraph (e)(5)(i).

B. Revising paragraph (f).

The revisions read as follows:

§ 412.22 Excluded hospitals and hospital units: General rules.

* * * * *

(e) * * *

(5) *Performance of basic hospital functions.* The hospital meets one of the following criteria:

(i) The hospital performs the basic functions specified in §§ 482.21 through 482.27, 482.30, 482.42, 482.43, and 482.45 of this chapter through the use of employees or under contracts or other agreements with entities other than the hospital occupying space in the same building or on the same campus, or a third entity that controls both hospitals.

* * *

(f) *Application for certain hospitals.* If a hospital was excluded from the prospective payment systems under the provisions of this section on or before September 30, 1995, and at that time occupied space in a building also used by another hospital, or in one or more buildings located on the same campus as buildings used by another hospital, the criteria in paragraph (e) of this section do not apply to the hospital. However, effective for cost reporting periods beginning on or after October 1, 2003, those hospitals-within-hospitals must continue to operate under the same terms and conditions, including the number of beds and square footage considered, for purposes of Medicare participation and payment, in effect on September 30, 1995.

* * * * *

4. Section 412.23 is amended by revising paragraphs (e)(3)(ii) and (e)(3)(iii) to read as follows:

§ 412.23 Excluded hospitals: Classifications.

* * * * *

(e) *Long-term care hospitals.* * * *

(3) *Calculation of average length of stay.* * * *

(ii) If a change in the hospital's Medicare average length of stay is indicated, the calculation is made by the same method for the period of at least 5 months of the immediately preceding 6-month period.

(iii) If a hospital has undergone a change of ownership (as described in § 489.18 of this chapter) at the start of a cost reporting period or at any time within the period of at least 5 months of the preceding 6-month period, the hospital may be excluded from the prospective payment system as a long-term care hospital for a cost reporting period if, for the period of at least 5 months of the 6 months immediately preceding the start of the period (including time before the change of ownership), the hospital has the required Medicare average length of stay, continuously operated as a hospital, and continuously participated as a hospital in Medicare.

* * * * *

§ 412.25 [Amended]

5. In § 412.25(e)(4), introductory text, the reference ''paragraph (h)(3) of this section'' is revised to read ''paragraph (e)(3) of this section''.

6. Section 412.87 is amended by revising paragraph (b)(3) to read as follows:

§ 412.87 Additional payment for new medical services and technologies: General provisions.

* * * * *

(b) *Eligibility criteria.* * * *

(3) The DRG prospective payment rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate, based on application of a threshold amount to estimated charges incurred with respect to such discharges. To determine whether the payment would be adequate, CMS will determine whether the charges of the cases involving a new medical service or technology will exceed a threshold amount set at 75 percent of one standard deviation beyond the geometric mean standardized charge for all cases in the DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant DRGs if the new medical service or technology occurs in many different DRGs). Standardized charges reflect the actual charges of a case adjusted by the prospective payment system payment factors applicable to an individual hospital, such as the wage index, the indirect medical education adjustment factor, and the disproportionate share adjustment factor.

7. Section 412.105 is amended by—

A. In paragraph (a)(1), introductory text, revising the phrase ''paragraph (f) of this section'' to read ''paragraphs (f) and (h) of this section''.

B. In paragraph (a)(1)(i), revising the phrase ''affiliated groups'' to read ''Medicare GME affiliated groups''.

C. Revising paragraph (b).

D. Adding a sentence at the end of paragraph (f)(1)(v).

E. In paragraph (f)(1)(vi), revising the phrase ''affiliated group'' to read ''Medicare GME affiliated group''.

F. Revising paragraph (f)(1)(x).

The revisions and additions read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(b) *Determination of number of beds.* For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period. This count excludes bed days associated with—

(1) Beds in any other units or wards where the level of care provided would not be payable under the acute care hospital inpatient prospective payment system;

(2) Beds in units unoccupied for the previous 3 months;

(3) Beds that could not be made available for inpatient occupancy within 24 hours.

(4) Beds in excluded distinct part hospital units;

(5) Beds otherwise countable under this section used for outpatient observation services (unless the patient is subsequently admitted for acute inpatient care), skilled nursing swing-bed services, or ancillary labor/delivery services;

(6) Beds or bassinets in the healthy newborn nursery; and

(7) Custodial care beds;

* * * * *

(f) *Determining the total number of full-time equivalent residents for cost reporting periods beginning on or after July 1, 1991.* (1) * * *

(v) * * * Subject to the provisions of paragraph (f)(1)(x) of this section, effective for cost reporting periods beginning on or after April 1, 2000, FTE residents in a rural track program are included in the urban hospital's rolling average calculation described in this paragraph (f)(1)(v).

* * * * *

(x) An urban hospital that establishes a new residency program (as defined in § 413.86(g)(13) of this subchapter), or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks in accordance with the applicable provisions of § 413.86(g)(12) of this subchapter effective for discharges occurring on or after April 1, 2002 and before October 1, 2003, and the applicable provisions of § 413.86(g)(12) of this subchapter effective for discharges occurring on or after October 1, 2003.

* * * * *

7. Section 412.106 is amended by revising paragraphs (a)(1)(ii) and (b)(4)(i) to read as follows:

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

(a) General considerations. (1) * * *

(ii) For purposes of this section, the number of patient days in a hospital includes only those days attributable to units or wards of the hospital providing acute care services generally payable under the prospective payment system and excludes patient days associated with—

(A) Beds in excluded distinct part hospital units;

(B) Beds otherwise countable under this section used for outpatient observation services (unless the patient is subsequently admitted for acute inpatient care), skilled nursing swing-bed services, or ancillary labor/delivery services; and

(C) Beds in any other units or wards where the level of care provided would not be payable under the acute care hospital inpatient prospective payment system.

* * * * *

(b) *Determination of a hospital's disproportionate payment percentage.* * * *

(4) *Second computation.* * * *

(i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.

* * * * *

8. In § 412.112, the introductory text is republished and a new paragraph (d) is added to read as follows:

§ 412.112 Payments determined on a per case basis.

A hospital is paid the following amounts on a per case basis.

* * * * *

(d) Additional payments for new medical services and technologies determined under subpart F of this part.

9. Section 412.116 is amended by revising paragraph (e) to read as follows:

§ 412.116 Method of payment.

* * * * *

(e) *Outlier payment and additional payments for new medical services and technologies.* Payments for outlier cases and additional payments for new medical services and technologies (described in subpart F of this part) are not made on an interim basis. These payments are made based on submitted bills and represent final payment.

* * * * *

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

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

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395hh, 1395rr, 1395tt, and 1395ww).

2. Section 413.70 is amended by revising paragraph (b)(2)(iii), introductory text, to read as follows:

§ 413.70 Payment for services of a CAH.

* * * * *

(b) *Payment for outpatient services furnished by CAH.* * * *

(2) *Reasonable costs for facility services.* * * *

(iii) Payment for outpatient clinical diagnostic laboratory tests is not subject to the Medicare Part B deductible and coinsurance amounts. Payment to a CAH for clinical diagnostic laboratory tests will be made on a reasonable cost basis under this section only if the individuals are outpatients of the CAH, as defined in § 410.2 of this chapter, and are physically present in the CAH, at the time the specimens are collected. Clinical diagnostic laboratory tests performed for persons who are not physically present in the CAH when the specimens are collected will be made in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Social Security Act.

* * * * *

3. Section 413.85 is amended by—

A. Adding under paragraph (c) a definition of ''Certification'' in alphabetical order.

B. Republishing the introductory text of paragraph (d)(1) and adding a new paragraph (d)(1)(iii).

C. Adding a new paragraph (g)(3).

D. Republishing the introductory text of paragraph (h) and revising paragraph (h)(3).

The addition and revision read as follows.

§ 413.85 Cost of approved nursing and allied health education activities.

* * * * *

(c) *Definitions.* * * *

Certification means the ability to practice or begin employment in a specialty as a whole.

* * * * *

(d) *General payment rules.* (1) Payment for a provider's net cost of nursing and allied health education activities is determined on a reasonable cost basis, subject to the following conditions and limitations:

* * * * *

(iii) The costs of certain nonprovider-operated programs at wholly owned subsidiary educational institutions are reimbursable on a reasonable cost basis if the provisions of paragraph (g)(3) of this section are met.

* * * * *

(g) *Payments for certain nonprovider-operated programs.* * * *

(3) *Special rule: Payment for certain nonprovider-operated programs at wholly owned subsidiary educational institutions.*

(i) Effective for portions of cost reporting periods occurring on or after October 1, 2003, a provider that incurs costs for a nursing or allied health education program(s) where those program(s) had originally been provider-operated according to the criteria at paragraph (f) of this section, and then operation of the program(s) was transferred to a wholly owned subsidiary educational institution in order to meet accreditation standards prior to October 1, 2003, and where the provider has continuously incurred the costs of both the classroom and clinical training portions of the program(s) at the educational institution, may receive reasonable cost payment for such a program(s) according to the specifications under paragraphs (g)(3)(ii) and (g)(3)(iii) of this section.

(ii) Payment for the incurred costs of educational activities identified in paragraph (g)(3)(i) of this section will be made on a reasonable cost basis if a provider, as described in paragraph (g)(3)(i) of this section, received Medicare reasonable cost payment for those nursing and allied health education program(s) both prior and subsequent to the date the provider transferred operation of the program(s) to its wholly owned subsidiary educational institution (and ceased to be a provider-operated program(s) according to the criteria under paragraph (f) of this section).

(iii) The provider that meets the requirements in paragraphs (g)(3)(i) and (g)(3)(ii) of this section will be eligible to receive payment under this paragraph for: (A) the clinical training costs incurred for the program(s) as described in paragraph (g)(3)(i) of this section; and (B) classroom costs, but only those costs incurred by the provider for the courses that were included in the programs described in paragraph (g)(3)(i) of this section.

(h) *Activities treated as normal operating costs.* The costs of the following educational activities incurred by a provider but not operated by that provider are recognized only as normal operating costs and paid in accordance with the reimbursement principles specified in part 412 of this subchapter. They include:

* * * * *

(3) Educational seminars, workshops, and continuing education programs in which the employees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to certification required to practice or begin employment in a nursing or allied health specialty.

* * * * *

4. Section 413.86 is amended by—

A. Under paragraph (b)—

(1) Removing the definitions of ''Affiliated group'' and ''Affiliation agreement''.

(2) Adding definitions of ''Community support'', ''Medicare GME affiliated agreement'', ''Medicare GME affiliated group'', and ''Redistribution of costs'' in alphabetical order.

(3) Under the definition of ''Rural track FTE limitation'', revising the phrase ''paragraph (g)(11)'' to read ''paragraph (g)(12)''.

B. Revising the introductory text of paragraph (f).

C. Adding a new paragraph (f)(4)(iv).

D. In paragraph (g)(1)(i), revising the reference ''paragraphs (g)(1)(ii) and (g)(1)(iii)'' to read ''paragraphs (g)(1)(ii) through (g)(1)(iv)''.

E. Revising the introductory text of paragraph (g)(4).

F. Revising paragraph (g)(4)(iv).

G. Revising the introductory text of paragraph (g)(5).

H. Adding a new paragraph (g)(5)(vii).

I. Revising paragraphs (g)(6)(i)(D) and (g)(6)(i)(E).

J. Revising paragraph (g)(7).

K. Revising the introductory text of paragraph(g)(12).

L. Revising paragraph (g)(12)(i).

M. Revising paragraph (g)(12)(ii), introductory text.

N. Revising paragraph (g)(12)(ii)(A).

O. Revising paragraph (g)(12)(ii)(B)(*1*)(*i*).

P. Revising paragraph (g)(12)(iii).

Q. Revising paragraph (g)(12)(iv), introductory text.

R. Revising paragraph (g)(12)(iv)(A).

S. Revising paragraph (g)(12)(iv)(B)(*1*).

T. Redesignating paragraphs (i) and (j) as paragraphs (j) and (k), respectively, and adding a new paragraph (i).

The additions and revisions read as follows:

§ 413.86 Direct graduate medical education payments.

* * * * *

(b) *Definitions.* * * *

Community support means funding that is provided by the community and generally includes all non-Medicare sources of funding (other than payments made for furnishing services to individual patients), including State and local government appropriations. Community support does not include grants, gifts, and endowments of the kind that are not to be offset in accordance with section 1134 of the Act.

* * * * *

Medicare GME affiliated group means—

(1) Two or more hospitals that are located in the same urban or rural area (as those terms are defined in § 412.62(f) of this subchapter) or in a contiguous area and meet the rotation requirements in paragraph (g)(7)(ii) of this section.

(2) Two or more hospitals that are not located in the same or in a contiguous urban or rural area, but meet the rotation requirement in paragraph (g)(7)(ii) of this section, and are jointly listed—

(i) As the sponsor, primary clinical site or major participating institution for one or more programs as these terms are used in the most current publication of the *Graduate Medical Education Directory;* or

(ii) As the sponsor or is listed under ''affiliations and outside rotations'' for one or more programs in operation in *Opportunities, Directory of Osteopathic Postdoctoral Education Programs.*

(3) Two or more hospitals that are under common ownership and, effective for all Medicare GME affiliation agreements beginning July 1, 2003, meet the rotation requirement in paragraph (g)(7)(ii) of this section.

Medicare GME affiliation agreement means a written, signed, and dated agreement by responsible representatives of each respective hospital in a Medicare GME affiliated group, as defined in this section, that specifies—

(1) The term of the Medicare GME affiliation agreement (which, at a minimum is one year), beginning on July 1 of a year;

(2) Each participating hospital's direct and indirect GME FTE caps in effect prior to the Medicare GME affiliation;

(3) The total adjustment to each hospital's FTE caps in each year that the Medicare GME affiliation agreement is in effect, for both direct GME and IME, that reflects a positive adjustment to one hospital's direct and indirect FTE caps that is offset by a negative adjustment to the other hospital's (or hospitals') direct and indirect FTE caps of at least the same amount;

(4) The adjustment to each participating hospital's FTE counts resulting from the FTE resident's (or residents') participation in a shared rotational arrangement at each hospital participating in the Medicare GME affiliated group for each year the Medicare GME affiliation agreement is in effect. This adjustment to each participating hospital's FTE count is also reflected in the total adjustment to each hospital's FTE caps (in accordance with paragraph (3) of this definition); and

(5) The names of the participating hospitals and their Medicare provider members.

* * * * *

Redistribution of costs means an attempt by a hospital to increase the amount it is allowed to receive from Medicare under this section by counting FTE residents that were in medical residency programs where the costs of the programs had previously been incurred by the educational institution.

* * * * *

(f) *Determining the total number of FTE residents.* Subject to the weighting factors in paragraphs (g) and (h) of this section, and subject to the provisions of paragraph (i) of this section, the count of FTE residents is determined as follows:

* * * * *

(4) * * *

(iv) The hospital is subject to the principles of community support and redistribution of costs as specified in the provisions of paragraph (i) of this section.

(g) *Determining the weighted number of FTE residents.*

* * * * *

(4) Subject to the provisions of paragraph (i) of this section, for purposes of determining direct graduate medical education payment—

* * * * *

(iv) Hospitals that are part of the same Medicare GME affiliated group (as described under paragraph (b) of this section) may elect to apply the limit on an aggregate basis as described under paragraph (g)(7) of this section.

* * * * *

(5) Subject to the provisions of paragraph (i) of this section, for purposes of determining direct graduate medical education payment—

* * * * *

(vii) Subject to the provisions under paragraph (g)(12) of this section, effective for cost reporting periods beginning on or after April 1, 2000, FTE residents in a rural track program at an urban hospital are included in the urban hospital's rolling average calculation described in paragraph (g)(5) of this section.

* * * * *

(6) * * *

(i) * * *

(D) An urban hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is not permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap.

(E) A rural hospital that qualifies for an adjustment to its FTE cap under paragraph (g)(6)(i) of this section is permitted to be part of a Medicare GME affiliated group for purposes of establishing an aggregate FTE cap.

* * * * *

(7) A hospital may receive a temporary adjustment to its FTE cap, which is subject to the averaging rules under paragraph (g)(5)(iii) of this section, to reflect residents added or subtracted because the hospital is participating in a Medicare GME affiliated group (as defined under paragraph (b) of this section). Under this provision—

(i) Each hospital in the Medicare GME affiliated group must submit the Medicare GME affiliation agreement, as defined under paragraph (b) of this section, to the CMS fiscal intermediary servicing the hospital and send a copy to CMS's Central Office no later than July 1 of the residency program year during which the Medicare GME affiliation agreement will be in effect.

(ii) Each hospital in the Medicare GME affiliated group must have a shared rotational arrangement, as defined in paragraph (b) of this section, with at least one other hospital within the Medicare GME affiliated group, and all of the hospitals within the Medicare GME affiliated group must be connected by a series of such shared rotational arrangements.

(iii) During the shared rotational arrangements under an Medicare GME affiliation agreement, as defined in paragraph (b) of this section, more than one of the hospitals in the Medicare GME affiliated group must count the proportionate amount of the time spent by the resident(s) in its FTE resident counts. No resident may be counted in the aggregate as more than one FTE.

(iv) The net effect of the adjustments (positive or negative) on the Medicare GME affiliated hospitals' aggregate FTE cap for each Medicare GME affiliation agreement must not exceed zero.

(v) If the Medicare GME affiliation agreement terminates for any reason, the FTE cap of each hospital in the Medicare GME affiliated group will revert to the individual hospital's pre-affiliation FTE cap that is determined under the provisions of paragraph (g)(4) of this section.

* * * * *

(12) Subject to the provisions of (i) of this section, an urban hospital that establishes a new residency program, or has an existing residency program, with a rural track (or an integrated rural track) may include in its FTE count residents in those rural tracks, in addition to the residents subject to its FTE cap specified under paragraph (g)(4) of this section. An urban hospital with a rural track residency program may count residents in those rural tracks up to a rural track FTE limitation if the hospital complies with the conditions specified in paragraphs (g)(12)(i) through (g)(12)(vi) of this section.

(i) If an urban hospital rotates residents to a separately accredited rural track program at a rural hospital(s) for two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count for the time the rural track residents spend at the urban hospital. The urban hospital may include in its FTE count those residents in the rural track training at the urban hospital, not to exceed its rural track FTE limitation, determined as follows:

(A) For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average at paragraph (g)(5)(vii) of this section, training in the rural track at the urban hospital.

(B) Beginning with the fourth year of the rural track's existence, the rural track FTE limitation is equal to the product of the highest number of residents, in any program year, who during the third year of the rural track's existence are training in the rural track at the urban hospital or the rural hospital(s) and are designated at the beginning of their training to be rotated to the rural hospital(s) for at least two-thirds of the duration of the program for cost reporting periods beginning on or after April l, 2000 and before October 1, 2002, or for more than one-half of the duration of the program effective for cost reporting periods beginning on or after October 1, 2003, and the number of years those residents are training at the urban hospital.

(ii) If an urban hospital rotates residents to a separately accredited rural track program at a rural nonhospital site(s) for two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under paragraph (f)(4) of this section. The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track FTE limitation, determined as follows:

(A) For the first 3 years of the rural track's existence, the rural track FTE limitation for each urban hospital will be the actual number of FTE residents, subject to the rolling average specified in paragraph (g)(5)(vii) of this section, training in the rural track at the urban hospital and the rural nonhospital site(s).

(B) * * *

(*1*) * * *

(*i*) The urban hospital and are designated at the beginning of their training to be rotated to a rural nonhospital site(s) for at least two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for more than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003; and

* * * * *

(iii) If an urban hospital rotates residents in the rural track program to a rural hospital(s) for less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the rural hospital may not include those residents in its FTE count (if the rural track is not a new program under paragraph (g)(6)(iii) of this section, or if the rural hospital's FTE count exceeds that hospital's FTE cap), nor may the urban hospital include those residents when calculating its rural track FTE limitation.

(iv) If an urban hospital rotates residents in the rural track program to a rural nonhospital site(s) for period of time is less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2000 and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003, the urban hospital may include those residents in its FTE count, subject to the requirements under paragraph (f)(4) of this section. The urban hospital may include in its FTE count those residents in the rural track, not to exceed its rural track limitation, determined as follows:

(A) For the first 3 years of the rural track's existence, the rural track FTE limitation for the urban hospital will be the actual number of FTE residents, subject to the rolling average specified in paragraph (g)(5)(vii) of this section, training in the rural track at the rural nonhospital site(s).

(B) * * *

(*1*) The highest number of residents in any program year who, during the third year of the rural track's existence, are training in the rural track at the rural nonhospital site(s) or are designated at the beginning of their training to be rotated to the rural nonhospital site(s) for a period that is less than two-thirds of the duration of the program for cost reporting periods beginning on or after April 1, 2002, and before October 1, 2003, or for one-half or less than one-half of the duration of the program for cost reporting periods beginning on or after October 1, 2003; and

* * * * *

(i) *Application of community support and redistribution of costs in determining FTE resident counts.*

(1) For purposes of determining direct graduate medical education payments, the following principles apply:

(i) *Community support.* If the community has undertaken to bear the costs of medical education through community support, the costs are not considered graduate medical education costs to the hospital for purposes of Medicare payment.

(ii) *Redistribution of costs.* The costs of training residents that constitute a redistribution of costs from an educational institution to the hospital are not considered graduate medical education costs to the hospital for purposes of Medicare payment.

(2) *Application.* A hospital must continuously incur the costs of direct graduate medical education of residents training in a particular program at a training site since the date the residents first began training in that program in order for the hospital to count the FTE residents in accordance with the provisions of paragraphs (f) and (g)(4) through (g)(6) and (g)(12) of this section.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance)

Dated: April 22, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services

Dated: May 8, 2003.

Tommy G. Thompson,

Secretary.

[Editorial Note: The following Addendum and appendixes will not appear in the Code of Federal Regulations.]

Addendum—Proposed Schedule of Standardized Amounts Effective with Discharges Occurring On or After October 1, 2003 and Update Factors and Rate-of-Increase Percentages Effective With Cost Reporting Periods Beginning On or After October 1, 2003

I. Summary and Background

In this Addendum, we are setting forth the proposed amounts and factors for determining prospective payment rates for Medicare hospital inpatient operating costs and Medicare hospital inpatient capital-related costs. We are also setting forth proposed rate-of-increase percentages for updating the target amounts for hospitals and hospital units excluded from the IPPS.

For discharges occurring on or after October 1, 2003, except for SCHs, MDHs, and hospitals located in Puerto Rico, each hospital's payment per discharge under the IPPS will be based on 100 percent of the Federal national rate, which will be based on the national adjusted standardized amount. This amount reflects the national average hospital costs per case from a base year, updated for inflation.

SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

Under section 1886(d)(5)(G) of the Act, MDHs are paid based on the Federal national rate or, if higher, the Federal national rate plus 50 percent of the difference between the Federal national rate and the updated hospital-specific rate based on FY 1982 or FY 1987 costs per discharge, whichever is higher. MDHs do not have the option to use their FY 1996 hospital-specific rate.

For hospitals in Puerto Rico, the payment per discharge is based on the sum of 50 percent of a Puerto Rico rate reflecting base year average costs per case of Puerto Rico hospitals and 50 percent of a blended Federal national rate (a discharge-weighted average of the national large urban and other areas standardized amounts). (*See* section II.D.3. of this Addendum for a complete description.)

As discussed below in section II. of this Addendum, we are proposing to make changes in the determination of the prospective payment rates for Medicare inpatient operating costs for FY 2004. The changes, to be applied prospectively effective with discharges occurring on or after October 1, 2003, affect the calculation of the Federal rates. In section III. of this Addendum, we discuss our proposed changes for determining the prospective payment rates for Medicare inpatient capital-related costs for FY 2004. Section IV. of this Addendum sets forth our proposed changes for determining the rate-of-increase limits for hospitals excluded from the IPPS for FY 2004. Section V. of this Addendum sets forth policies on payment for blood clotting factor administered to hemophilia patients. The tables to which we refer in the preamble to this proposed rule are presented in section VI. of this Addendum.

II. Proposed Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for FY 2004

The basic methodology for determining prospective payment rates for hospital inpatient operating costs is set forth at § 412.63. The basic methodology for determining the prospective payment rates for hospital inpatient operating costs for hospitals located in Puerto Rico is set forth at §§ 412.210 and 412.212. Below, we discuss the factors used for determining the prospective payment rates.

In summary, the proposed standardized amounts set forth in Tables 1A and 1C of section VI. of this Addendum reflect—

- Updates of 3.5 percent for all areas (that is, the full market basket percentage increase of 3.5 percent);
- An adjustment to ensure the proposed DRG recalibration and wage index update and changes, as well as the add-on payments for new technology, are budget neutral, as provided for under sections 1886(d)(4)(C)(iii) and (d)(3)(E) of the Act, by applying new budget neutrality adjustment factors to the large urban and other standardized amounts;
- An adjustment to ensure the effects of geographic reclassification are budget neutral, as provided for in section 1886(d)(8)(D) of the Act, by removing the FY 2003 budget neutrality factor and applying a revised factor;
- An adjustment to apply the new outlier offset by removing the FY 2003 outlier offsets and applying a new offset.

A. Calculation of Adjusted Standardized Amounts

1. Standardization of Base-Year Costs or Target Amounts

The national standardized amounts are based on per discharge averages of adjusted hospital costs from a base period (section 1886(d)(2)(A) of the Act) or, for Puerto Rico, adjusted target amounts from a base period (section 1886(d)(9)(B)(i) of the Act), updated and otherwise adjusted in accordance with the provisions of section 1886(d) of the Act. The preamble to the September 1, 1983 interim final rule (48 FR 39763) contained a detailed explanation of how base-year cost data (from cost reporting periods ending during FY 1981) were established in the initial development of standardized amounts for the IPPS. The September 1, 1987 final rule (52 FR 33043, 33066) contains a detailed explanation of how the target amounts were determined and how they are used in computing the Puerto Rico rates.

Sections 1886(d)(2)(B) and (d)(2)(C) of the Act require us to update base-year per discharge costs for FY 1984 and then standardize the cost data in order to remove the effects of certain sources of cost variations among hospitals. These effects include case-mix, differences in area wage levels, cost-of-living adjustments for Alaska and Hawaii, indirect medical education costs, and costs to hospitals serving a disproportionate share of low-income patients.

Under sections 1886(d)(2)(H) and (d)(3)(E) of the Act, in making payments under the IPPS, the Secretary estimates from time to time the proportion of costs that are wages and wage-related costs. Based on the estimated labor-related share, the standardized amounts are divided into labor-related and nonlabor-related amounts. As discussed in section IV. of the preamble to the August 1, 2002 IPPS final rule, when we revised the market basket in FY 2003, we did not revise the labor share of the standardized amount (the proportion adjusted by the wage index). We consider 71.1 percent of costs to be labor-related for purposes of the IPPS. The average labor share in Puerto Rico is 71.3 percent.

2. Computing Large Urban and Other Area Average Standardized Amounts

Sections 1886(d)(2)(D) and (d)(3) of the Act require the Secretary to compute two average standardized amounts for discharges occurring in a fiscal year: one for hospitals located in large urban areas and one for hospitals located in other areas. In addition, under sections 1886(d)(9)(B)(iii) and (d)(9)(C)(i) of the Act, the average standardized amount per discharge must be determined for hospitals located in large urban and other areas in Puerto Rico. In accordance with section 1886(b)(3)(B)(i) of the Act, the large urban average standardized amount is 1.6 percent higher than the other area average standardized amount.

Section 402(b) of Pub. L. 108–7 required that, effective for discharges occurring on or after April 1, 2003, and before October 1, 2003, the Federal rate for all IPPS hospitals would be based on the large urban standardized amount. However, for discharges occurring on or after October 1, 2003, the Federal rate will again be calculated based on separate average standardized amounts for hospitals in large urban areas and for hospitals in other areas.

Section 1886(d)(2)(D) of the Act defines ''urban area'' as those areas within a Metropolitan Statistical Area (MSA). A ''large urban area'' is defined as an urban area with a population of more than 1 million. In addition, section 4009(i) of Pub. L. 100–203 provides that a New England County Metropolitan Area (NECMA) with a population of more than 970,000 is classified as a large urban area. As required by section 1886(d)(2)(D) of the Act, population size is determined by the Secretary based on the latest population data published by the Bureau of the Census. Urban areas that do not meet the definition of a ''large urban area'' are referred to as ''other urban areas.'' Areas that are not included in MSAs are considered ''rural areas'' under section 1886(d)(2)(D) of the Act. Payment for discharges from hospitals located in large urban areas will be based on the large urban standardized amount. Payment for discharges from hospitals located in other urban and rural areas will be based on the other standardized amount.

Based on the latest available population estimates published by the Bureau of the Census, 63 areas meet the criteria to be defined as large urban areas for FY 2004. These areas are identified in Table 4A of section VI. of this Addendum.

3. Updating the Average Standardized Amounts

In accordance with section 1886(d)(3)(A)(iv) of the Act, we are proposing to update the large urban areas' and the other areas' average standardized amounts for FY 2004 by the full estimated market basket percentage increase for hospitals in all areas, as specified in section 1886(b)(3)(B)(i)(XIX) of the Act. The percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient care. The most recent forecast of the hospital market basket increase for FY 2004 is 3.5 percent. Thus, for FY 2004, the update to the average standardized amounts equals 3.5 percent for hospitals in all areas.

Although the update factors for FY 2004 are set by law, we are required by section 1886(e)(3) of the Act to report to the Congress our initial recommendation of update factors for FY 2004 for both IPPS hospitals and hospitals excluded from the IPPS. Our proposed recommendation on the update factors (which is required by sections 1886(e)(4)(A) and (e)(5)(A) of the Act) is set forth as Appendix B of this proposed rule.

4. Other Adjustments to the Average Standardized Amounts

As in the past, we are proposing to adjust the FY 2004 standardized amounts to remove the effects of the FY 2003 geographic reclassifications and outlier payments before applying the FY 2004 updates. We then apply the new offsets to the standardized amounts for outliers and geographic reclassifications for FY 2004.

We do not remove the prior years' budget neutrality adjustment because, in accordance with section 1886(d)(4)(C)(iii) of the Act, estimated aggregate payments after the changes in the DRG relative weights and wage index should equal estimated aggregate payments prior to the changes. If we removed the prior year adjustment, we would not satisfy this condition.

Budget neutrality is determined by comparing aggregate IPPS payments before and after making the changes that are required to be budget neutral (for example, reclassifying and recalibrating the DRGs, updating the wage data, and geographic reclassifications). We include outlier payments in the payment simulations because outliers may be affected by changes in these payment parameters. Because the proposed changes to the postacute care transfer policy discussed in section IV.A. of this preamble are not budget neutral, we included the effects of expanding this policy to additional DRGs prior to estimating the payment effects of the DRG and wage data changes.

a. Recalibration of DRG Weights and Updated Wage Index—Budget Neutrality Adjustment. Section 1886(d)(4)(C)(iii) of the Act specifies that, beginning in FY 1991, the annual DRG reclassification and recalibration of the relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. As discussed in section II. of the preamble, we normalized the recalibrated DRG weights by an adjustment factor, so that the average case weight after recalibration is equal to the average case weight prior to recalibration. However, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payments to hospitals are affected by factors other than average case weight. Therefore, as we have done in past years, we are proposing to make a budget neutrality adjustment to ensure that the requirement of section 1886(d)(4)(C)(iii) of the Act is met.

Section 1886(d)(3)(E) of the Act requires us to update the hospital wage index on an annual basis beginning October 1, 1993. This provision also requires us to make any updates or adjustments to the wage index in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index.

Section 4410 of Pub. L. 105–33 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is not located in a rural area may not be less than the area wage index applicable to hospitals located in rural areas in that State. This provision is required by section 4410(b) of Pub. L. 105–33 to be budget neutral. Therefore, we include the effects of this provision in our calculation of the wage update budget neutrality factor.

In addition, we are required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. As discussed in section II.E. of this proposed rule, we are proposing to approve one new technology for add-on payments in FY 2004. We estimate that the proposed total add-on payments for this new technology would be $50 million for FY 2004.

To comply with the requirement that DRG reclassification and recalibration of the relative weights be budget neutral, and the requirement that the updated wage index be budget neutral, we used FY 2002 discharge data to simulate payments and compared aggregate payments using the FY 2003 relative weights, wage index, and new technology add-on payments to aggregate payments using the proposed FY 2004 relative weights and wage index, plus the proposed additional add-on payments for new technology. The same methodology was used for the FY 2003 budget neutrality adjustment.

Based on this comparison, we computed a proposed budget neutrality adjustment factor equal to 1.003133. We also adjust the Puerto Rico-specific standardized amounts for the effect of DRG reclassification and recalibration. We computed a proposed budget neutrality adjustment factor for Puerto Rico-specific standardized amounts equal to 1.000627. These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2003 budget neutrality adjustments.

In addition, we are proposing to apply these same adjustment factors to the hospital-specific rates that are effective for cost reporting periods beginning on or after October 1, 2003. (See the discussion in the September 4, 1990 final rule (55 FR 36073).)

b. Reclassified Hospitals—Budget Neutrality Adjustment. Section 1886(d)(8)(B) of the Act provides that, effective with discharges occurring on or after October 1, 1988, certain rural hospitals are deemed urban. In addition, section 1886(d)(10) of the Act provides for the reclassification of hospitals based on determinations by the MGCRB. Under section 1886(d)(10) of the Act, a hospital may be reclassified for purposes of the standardized amount or the wage index, or both.

Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B) and (C) and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions. To calculate this budget neutrality factor, we used FY 2002 discharge data to simulate payments, and compared total IPPS payments prior to any reclassifications to total IPPS payments after reclassifications. Based on these simulations, we are proposing to apply an adjustment factor of 0.991848 to ensure that the effects of reclassification are budget neutral.

The proposed adjustment factor is applied to the standardized amounts after removing the effects of the FY 2003 budget neutrality adjustment factor. We note that the proposed FY 2004 adjustment reflects proposed FY 2004 wage index and standardized amount

reclassifications approved by the MGCRB or the Administrator as of February 28, 2003, and the effects of section 1886(d)(10)(D)(v) of the Act to extend wage index reclassifications for 3 years. The effects of any additional reclassification changes that occur as a result of appeals and reviews of the MGCRB decisions for FY 2004 or from a hospital's request for the withdrawal of a reclassification for FY 2004 will be reflected in the final budget neutrality adjustment required under section 1886(d)(8)(D) of the Act and published in the IPPS final rule for FY 2004.

c. Outliers. Section 1886(d)(5)(A) of the Act provides for payments in addition to the basic prospective payments, for ''outlier'' cases, that is, cases involving extraordinarily high costs. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outlier payment). To determine whether the costs of a case exceed the fixed-loss threshold, a hospital's cost-to-charge ratio is applied to the total covered charges for the case to convert the charges to costs. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the costs above the threshold.

Under section 1886(d)(5)(A)(iv) of the Act, outlier payments for any year must be projected to be not less than 5 percent nor more than 6 percent of total operating DRG payments plus outlier payments. Section 1886(d)(3)(B) of the Act requires the Secretary to reduce the average standardized amounts by a factor to account for the estimated proportion of total DRG payments made to outlier cases. Similarly, section 1886(d)(9)(B)(iv) of the Act requires the Secretary to reduce the average standardized amounts applicable to hospitals in Puerto Rico to account for the estimated proportion of total DRG payments made to outlier cases.

i. FY 2004 outlier fixed-loss cost threshold. In the August 1, 2002 IPPS final rule (67 FR 50124), we established a threshold for FY 2003 that was equal to the prospective payment rate for the DRG, plus any IME and DSH payments and any additional payments for new technology, plus $33,560. The marginal cost factor (the percent of costs paid after costs for the case exceed the threshold) was 80 percent.

In the March 5, 2003 **Federal Register** (67 FR 10420), we published proposed changes to our outlier policy. We noted recent analyses indicate that some hospitals have taken advantage of our existing outlier payment methodology to maximize their outlier payments. Therefore, we proposed three central changes to our outlier policy in the March 5, 2003 proposed rule.

The first of the proposed changes was that fiscal intermediaries would use more up-to-date data when determining the cost-to-charge ratio for each hospital. Currently, fiscal intermediaries use the hospital's most recent settled cost report. We proposed to revise our regulations to specify that fiscal intermediaries would use either the most recent settled or the most recent tentative settled cost report, whichever is from the latest reporting period.

The second proposed change was to remove the current requirement in our regulations specifying that a fiscal intermediary will assign a hospital the statewide average cost-to-charge ratio when the hospital has a cost-to-charge ratio that falls below established thresholds (3 standard deviations below the national geometric mean cost-to-charge ratio). We proposed that hospitals would receive their actual cost-to-charge ratios no matter how low their ratios actually fall.

The third proposal was to add a provision to our regulations to provide that the outlier payments for some hospitals may become subject to reconciliation when the hospitals' cost reports are settled. In addition, outlier payments would be subject to an adjustment to account for the time value of any outlier overpayments or underpayments that are ultimately reconciled.

However, as of the time this FY 2004 proposed rule was prepared, these proposed changes to the outlier policy had not been finalized. Therefore, the proposed changes have not been factored into the calculation of the proposed FY 2004 fixed-loss threshold. If these changes are made final prior to (or as part of) the publication of the final FY 2004 fixed-loss threshold, they will be reflected in the analysis used to establish the final FY 2004 threshold.

To calculate the proposed FY 2004 outlier thresholds, we simulated payments by applying proposed FY 2004 rates and policies using cases from the FY 2002 MedPAR file. Therefore, in order to determine the appropriate proposed FY 2003 threshold, it was necessary to inflate the charges on the MedPAR claims by 2 years, from FY 2002 to FY 2004.

As discussed in the August 1, 2002 IPPS final rule (67 FR 50124), rather than use the rate-of-cost increase from hospitals' FY 1998 and FY 1999 cost reports to project the rate of increase from FY 2001 to FY 2003, as had been done in prior years, we used a 2-year average annual rate of change in charges per case to calculate the FY 2003 outlier threshold.

We are proposing to continue to use a 2-year average annual rate of change in charges per case to establish the proposed FY 2004 threshold. The 2-year average annual rate of change in charges per case from FY 2000 to FY 2001, and from FY 2001 to FY 2002, was 12.8083 percent annually, or 27.3 percent over 2 years.

Using the methodology above for setting the charge inflation factors for FY 2004, we are proposing to establish a fixed-loss cost outlier threshold equal to the prospective payment rate for the DRG, plus any IME and DSH payments, and any add-on payments for new technology, plus $50,645.

This single threshold would be applicable to qualify for both operating and capital outlier payments. We also are proposing to maintain the marginal cost factor for cost outliers at 80 percent.

Again, any final rule subsequent to the March 5, 2003 proposed rule that implements changes to the outlier payment methodology is likely to affect how we will calculate the final FY 2004 outlier threshold. Therefore, the final FY 2004 threshold is likely to be different from this proposed threshold, as a result of any changes subsequent to the March 5, 2003 proposed rule. For example, if we were to implement the proposal to no longer apply the statewide average cost-to-charge ratio when hospitals' actual ratios fall below the established threshold (see below), this change would impact our calculation of the threshold.

ii. Other changes concerning outliers. As stated in the September 1, 1993 final rule (58 FR 46348), we establish outlier thresholds that are applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common set of thresholds resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We project that the proposed thresholds for FY 2004 would result in outlier payments equal to 5.1 percent of operating DRG payments and 5.5 percent of capital payments based on the Federal rate.

In accordance with section 1886(d)(3)(B), we reduced the proposed FY 2004 standardized amounts by the same percentage to account for the projected proportion of payments paid to outliers. The proposed outlier adjustment factors to be applied to the standardized amounts for FY 2004 are as follows:

	Operating standardized amounts	Capital federal rate
National	0.948981	0.945484
Puerto Rico	0.981549	0.984490

We apply the outlier adjustment factors after removing the effects of the FY 2003 outlier adjustment factors on the standardized amounts.

To determine whether a case qualifies for outlier payments, we apply hospital-specific cost-to-charge ratios to the total covered charges for the case. Operating and capital costs for the case are calculated separately by applying separate operating and capital cost-to-charge ratios. These costs are then combined and compared with the fixed-loss outlier threshold.

Once again, although a final rule subsequent to the March 5, 2003 proposed rule on outliers may be published before (or as part of) the FY 2004 IPPS final rule, we are proposing changes for FY 2004 without taking the proposals contained in the March 5, 2003 proposed rule into account at this time.

For those hospitals for which the fiscal intermediary computes operating cost-to-charge ratios lower than 0.194 or greater than 1.223, or capital cost-to-charge ratios lower than 0.012 or greater than 0.163, we are proposing statewide average ratios would be used to calculate costs to determine whether a hospital qualifies for outlier payments.[7] Table 8A in section VI. of this Addendum contains the proposed statewide average operating cost-to-charge ratios for urban hospitals and for rural hospitals for which the fiscal intermediary is unable to compute a hospital-specific cost-to-charge ratio within the above range. These proposed statewide average ratios would replace the ratios published in the August 1, 2002 IPPS final rule (67 FR 50263). Table 8B in section VI. of this Addendum contains the proposed comparable statewide average capital cost-to-charge ratios. Again, the cost-to-charge ratios in Tables 8A and 8B would be used during FY 2004 when hospital-specific cost-to-charge ratios based on the latest settled cost report are either not available or are outside the range noted above.

iii. FY 2002 and FY 2003 outlier payments. In the August 1, 2002 IPPS final rule (67 FR 50125), we stated that, based on available data, we estimated that actual FY 2002 outlier payments would be approximately 6.9 percent of actual total DRG payments. This estimate was computed based on simulations using the FY 2001 MedPAR file (discharge data for FY 2001 bills). That is, the estimate of actual outlier payments did not reflect actual FY 2002 bills but instead reflected the application of FY 2002 rates and policies to available FY 2001 bills.

Our current estimate, using available FY 2002 bills, is that actual outlier payments for FY 2002 were approximately 7.9 percent of actual total DRG payments. Thus, the data indicate that, for FY 2002, the percentage of actual outlier payments relative to actual total payments is higher than we projected before FY 2002 (and thus exceeds the percentage by which we reduced the standardized amounts for FY 2002). Nevertheless, consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not plan to make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2002 are equal to 5.1 percent of total DRG payments.

We currently estimate that actual outlier payments for FY 2003 will be approximately 5.5 percent of actual total DRG payments, 0.4 percentage points higher than the 5.1 percent we projected in setting outlier policies for FY 2003. This estimate is based on simulations using the FY 2002 MedPAR file (discharge data for FY 2002 bills). We used these data to calculate an estimate of the actual outlier percentage for FY 2003 by applying FY 2003 rates and policies including an outlier threshold of $33,560 to available FY 2002 bills. If changes to the outlier payment methodology are made effective during FY 2003, these may affect the actual percentage of FY 2003 outlier payments.

5. FY 2004 Standardized Amounts

The adjusted standardized amounts are divided into labor and nonlabor portions. Table 1A in section VI. of this Addendum contains the two national standardized amounts that we are proposing will be applicable to all hospitals, except hospitals in Puerto Rico. As described in section II.A.1. of this Addendum, we are not proposing to revise the labor share of the national standardized amount from 71.1 percent.

The following table illustrates the proposed changes from the FY 2003 national average standardized amounts. The first row in the table shows the updated (through FY 2003) average standardized amounts after restoring the FY 2003 offsets for outlier payments and geographic reclassification budget neutrality. The DRG reclassification and recalibration and wage index budget neutrality factor is cumulative. Therefore, the FY 2003 factor is not removed from the amounts in the table.

	Large urban	Other Areas
FY 2003 Base Rate (after removing reclassification budget neutrality and outlier offset)	Labor $3,212.32 Nonlabor 1,276.01	Labor $3,161.41) Nonlabor 1,285.01
Proposed FY 2004 Update Factor	1.035	1.035
Proposed FY 2004 DRG Recalibrations and Wage Index Budget Neutrality Factor	1.003133	1.003133
Proposed FY 2004 Reclassification Budget Neutrality Factor	0.991848	0.991848
Proposed FY 2004 Outlier Factor	0.948997	0.948997
Proposed Rate for FY 2004 (after multiplying FY 2003 base rate by above factors)	Labor $3,139.26 Nonlabor 1,276.01	Labor $3,089.56 Nonlabor 1,255.81

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount and the national other standardized amount (as set forth in Table 1A). The labor and nonlabor portions of the national average standardized amounts for Puerto Rico hospitals are set forth in Table 1C of section VI. of this Addendum. This table also includes the Puerto Rico standardized amounts. The labor share applied to the Puerto Rico standardized amount is 71.3 percent.

B. Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A and 1C, as set forth in section VI. of this Addendum, contain the labor-related and nonlabor-related shares that we are proposing to use to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico. This section addresses two types of adjustments to the standardized amounts that are made in determining the proposed prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of this preamble, we discuss the data and methodology for the proposed FY 2004 wage index. The proposed FY 2004 wage index is set forth in Tables 4A, 4B, 4C, and 4F of section VI. of this Addendum.

2. Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act authorizes an adjustment to take into account the unique circumstances of hospitals in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. For FY 2004, we are proposing to adjust the payments for hospitals in Alaska and Hawaii by multiplying the nonlabor portion of the standardized amounts by the appropriate adjustment factor contained in the table below. If the Office of Personnel Management releases revised cost-of-living adjustment factors before July 1, 2003, we will publish them in the final rule and use them in determining FY 2004 payments.

[7] This range represents 3.0 standard deviations (plus or minus) from the mean of the log distribution of cost-to-charge ratios for all hospitals.

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

Alaska—All areas	1.25
Hawaii:	
County of Honolulu	1.25
County of Hawaii	1.165
County of Kauai	1.2325
County of Maui	1.2375
County of Kalawao	1.2375

(The above factors are based on data obtained from the U.S. Office of Personnel Management.)

C. DRG Relative Weights

As discussed in section II. of the preamble, we have developed a classification system for all hospital discharges, assigning them into DRGs, and have developed relative weights for each DRG that reflect the resource utilization of cases in each DRG relative to Medicare cases in other DRGs. Table 5 of section VI. of this Addendum contains the relative weights that we are proposing to use for discharges occurring in FY 2004. These factors have been recalibrated as explained in section II. of the preamble.

D. Calculation of Proposed Prospective Payment Rates for FY 2004

General Formula for Calculation of Proposed Prospective Payment Rates for FY 2004

The proposed operating prospective payment rate for all hospitals paid under the IPPS located outside of Puerto Rico, except SCHs and MDHs, equals the Federal rate based on the proposed amounts in Table 1A in section VI. of this Addendum.

The proposed prospective payment rate for SCHs equals the higher of the proposed applicable Federal rate from Table 1A or the hospital-specific rate as described below. The proposed prospective payment rate for MDHs equals the higher of the Federal rate, or the Federal rate plus 50 percent of the difference between the Federal rate and the hospital-specific rate as described below. The proposed prospective payment rate for Puerto Rico equals 50 percent of the Puerto Rico rate plus 50 percent of the proposed national rate from Table 1C in section VI. of this Addendum.

1. Federal Rate

For discharges occurring on or after October 1, 2003 and before October 1, 2004, except for SCHs, MDHs, and hospitals in Puerto Rico, payment under the IPPS is based exclusively on the Federal rate.

The Federal rate is determined as follows:

Step 1—Select the appropriate average standardized amount considering the location of the hospital (large urban or other) (see Table 1A in section VI. of this Addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified (see Tables 4A, 4B, and 4C of section VI. of this Addendum).

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the appropriate cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted, if appropriate, under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight corresponding to the appropriate DRG (see Table 5 of section VI. of this Addendum).

The Federal rate as determined in Step 5 may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment.

2. Hospital-Specific Rate (Applicable Only to SCHs and MDHs)

a. Calculation of Hospital-Specific Rate. Section 1886(b)(3)(C) of the Act provides that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; or the updated hospital-specific rate based on FY 1996 costs per discharge.

Section 1886(d)(5)(G) of the Act provides that MDHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate or the Federal rate plus 50 percent of the difference between the Federal rate and the greater of the updated hospital-specific rates based on either FY 1982 or FY 1987 costs per discharge. MDHs do not have the option to use their FY 1996 hospital-specific rate.

Hospital-specific rates have been determined for each of these hospitals based on either the FY 1982 costs per discharge, the FY 1987 costs per discharge or, for SCHs, the FY 1996 costs per discharge. For a more detailed discussion of the calculation of the hospital-specific rates, we refer the reader to the September 1, 1983 interim final rule (48 FR 39772); the April 20, 1990 final rule with comment (55 FR 15150); the September 4, 1990 final rule (55 FR 35994); and the August 1, 2000 final rule (65 FR 47082). In addition, for both SCHs and MDHs, the hospital-specific rate is adjusted by the proposed budget neutrality adjustment factor (that is, by 1.003133) as discussed in section II.A.4.a. of this Addendum. The resulting rate would be used in determining the payment rate an SCH or MDH would receive for its discharges beginning on or after October 1, 2003.

b. Updating the FY 1982, FY 1987, and FY 1996 Hospital-Specific Rates for FY 2004. We are proposing to increase the hospital-specific rates by 3.5 percent (the hospital market basket percentage) for SCHs and MDHs for FY 2004. Section 1886(b)(3)(C)(iv) of the Act provides that the update factor applicable to the hospital-specific rates for SCHs is equal to the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for SCHs in FY 2004, is the market basket rate of increase. Section 1886(b)(3)(D) of the Act provides that the update factor applicable to the hospital-specific rates for MDHs also equals the update factor provided under section 1886(b)(3)(B)(iv) of the Act, which, for FY 2004, is the market basket rate.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning On or After October 1, 2003 and Before October 1, 2004

a. Puerto Rico Rate. The Puerto Rico prospective payment rate is determined as follows:

Step 1—Select the appropriate adjusted average standardized amount considering the large urban or other designation of the hospital (see Table 1C of section VI. of the Addendum).

Step 2—Multiply the labor-related portion of the standardized amount by the appropriate Puerto Rico-specific wage index (see Table 4F of section VI. of the Addendum).

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the result in Step 3 by 50 percent.

Step 5—Multiply the amount from Step 4 by the appropriate DRG relative weight (see Table 5 of section VI. of the Addendum).

b. National Rate. The national prospective payment rate is determined as follows:

Step 1—Multiply the labor-related portion of the national average standardized amount (see Table 1C of section VI. of the Addendum) by the appropriate national wage index (see Tables 4A and 4B of section VI. of the Addendum).

Step 2—Add the amount from Step 1 and the nonlabor-related portion of the national average standardized amount.

Step 3—Multiply the result in Step 2 by 50 percent.

Step 4—Multiply the amount from Step 3 by the appropriate DRG relative weight (see Table 5 of section VI. of the Addendum).

The sum of the Puerto Rico rate and the national rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico. This rate may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment.

III. Proposed Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2004

The PPS for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period and during a 10-year transition period extending through FY 2001, acute care hospital inpatient capital-related costs were paid on the basis of an increasing proportion of the capital PPS Federal rate and a decreasing proportion of a hospital's historical costs for capital.

The basic methodology for determining Federal capital prospective rates is set forth in regulations at §§ 412.308 through 412.352. Below we discuss the factors that we are proposing to use to determine the capital Federal rate for FY 2004, which would be effective for discharges occurring on or after October 1, 2003. The 10-year transition period ended with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002). Therefore, for cost reporting periods beginning in FY 2002, all hospitals (except ''new'' hospitals under

§§ 412.304(c)(2) and 412.324(b)) are paid based on 100 percent of the capital Federal rate.

For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the standard Federal rate, as provided in § 412.308(c)(1), to account for capital input price increases and other factors. Section 412.308(c)(2) provides that the Federal rate is adjusted annually by a factor equal to the estimated proportion of outlier payments under the Federal rate to total capital payments under the Federal rate. In addition, § 412.308(c)(3) requires that the Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for (regular and special) exception under § 412.348. Section 412.308(c)(4)(ii) requires that the standard Federal rate be adjusted so that the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor are budget neutral.

For FYs 1992 through 1995, § 412.352 required that the 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 rate that was made in FY 1994, and § 412.308(b)(3) describes the 0.28 percent reduction to the rate made in FY 1996 as a result of the revised policy of paying for transfers. In FY 1998, we implemented section 4402 of Public Law 105–33, which requires that, for discharges occurring on or after October 1, 1997, and before October 1, 2002, the unadjusted standard Federal rate is reduced by 17.78 percent. As we discussed in the August 1, 2002 IPPS final rule (67 FR 50102) and implemented in § 412.308(b)(6)), a small part of that reduction was restored effective October 1, 2002.

To determine the appropriate budget neutrality adjustment factor and the regular exceptions payment adjustment during the 10-year transition period, we developed a dynamic model of Medicare inpatient capital-related costs, that is, a model that projected changes in Medicare inpatient capital-related costs over time. With the expiration of the budget neutrality provision, the capital cost model was only used to estimate the regular exceptions payment adjustment and other factors during the transition period. As we explained in the August 1, 2001 IPPS final rule (66 FR 39911), beginning in FY 2003, an adjustment for regular exception payments is no longer necessary because regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991, and before October 1, 2001 (see § 412.348(b)). Since payments are no longer being made under the regular exception policy in FY 2003 and after, we no longer use the capital cost model. The capital cost model and its application during the transition period are described in Appendix B of the August 1, 2001 IPPS final rule (66 FR 40099).

In accordance with section 1886(d)(9)(A) of the Act, under the IPPS for acute care hospital operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Prior to FY 1998, hospitals in Puerto Rico were paid a blended rate that consisted of 75 percent of the applicable standardized amount specific to Puerto Rico hospitals and 25 percent of the applicable national average standardized amount. However, effective October 1, 1997, as a result of section 4406 of Public Law 105–33, operating payments to hospitals in Puerto Rico are based on a blend of 50 percent of the applicable standardized amount specific to Puerto Rico hospitals and 50 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges on or after October 1, 1997, we compute capital payments to hospitals in Puerto Rico based on a blend of 50 percent of the Puerto Rico rate and 50 percent of the Federal rate.

Section 412.374 provides for the use of this blended payment system for payments to Puerto Rico hospitals under the PPS for acute care hospital inpatient capital-related costs. Accordingly, for capital-related costs, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital.

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

In the final IPPS rule published in the **Federal Register** on August 1, 2002 (67 FR 50127), we established a Federal rate of $407.01 for FY 2003. Section 402(b) of Public Law 108–7 requires that, effective for discharges occurring on or after April 1, 2003, and before October 1, 2003, the Federal rate for operating costs for all IPPS hospitals would be based on the large urban standardized amount. However, for discharges occurring on or after October 1, 2003, the Federal rate will again be calculated based on separate average standardized amounts for hospitals in large urban areas and for hospitals in other areas. In addition, a correction notice to the FY 2003 final IPPS rule issued in the **Federal Register** on April 25, 2003 (68 FR 22272) contains corrections and revisions to the wage index and geographic adjustment factor (GAF). In conjunction with the change to the operating PPS standardized amounts made by Public Law 108–7 and the wage index and GAF corrections, we have established a capital PPS standard Federal rate of $406.93 effective for discharges occurring on or after April 1, 2003 through September 30, 2003. The rates effective for discharges occurring on or after April 1, 2003 through September 30, 2003, were used in determining the proposed FY 2004 rates. As a result of the changes that we are proposing to the factors used to establish the Federal rate that are explained in this Addendum, the proposed FY 2004 capital standard Federal rate is $411.72.

In the discussion that follows, we explain the factors that were used to determine the proposed FY 2004 capital Federal rate. In particular, we explain why the proposed FY 2004 Federal rate has increased 1.18 percent compared to the FY 2003 Federal rate (effective for discharges occurring on or after April 1, 2003 through September 30, 2003). We also estimate aggregate capital payments will increase by 2.5 percent during this same period. This increase is primarily due to the increase in the number of hospital admissions and the increase in case-mix. This increase in capital payments is slightly less than last year (5.81 percent), mostly due to the restoration of the 2.1 percent reduction to the capital Federal rate in FY 2003 (§ 412.308(b)(6)).

Total payments to hospitals under the IPPS are relatively unaffected by changes in the capital prospective payments. Since capital payments constitute about 10 percent of hospital payments, a 1-percent change in the capital Federal rate yields only about 0.1 percent change in actual payments to hospitals. Aggregate payments under the capital PPS are estimated to increase in FY 2004 compared to FY 2003.

1. Proposed Standard Federal Rate Update

a. Description of the Update Framework. Under § 412.308(c)(1), the standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and several other policy adjustment factors. Specifically, we have adjusted the projected CIPI rate of increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. The proposed update factor for FY 2004 under that framework is 0.7 percent, based on data available at this time. This proposed update factor is based on a projected 0.7 percent increase in the CIPI, a 0.0 percent adjustment for intensity, a 0.0 percent adjustment for case-mix, a 0.0 percent adjustment for the FY 2002 DRG reclassification and recalibration, and a forecast error correction of 0.0 percent. We explain the basis for the FY 2004 CIPI projection in section III.C. of this Addendum. Below we describe the policy adjustments that have been applied.

The case-mix index is the measure of the average DRG weight for cases paid under the IPPS. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patients changes (''real'' case-mix change);
- Changes in hospital coding of patient records result in higher weight DRG assignments (coding effects); and
- The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in coding behavior that result in assignment of cases to higher weighted DRGs but do not reflect higher resource requirements. In the update

framework for the PPS for operating costs, we adjust the update upwards to allow for real case-mix change, but remove the effects of coding changes on the case-mix index. We also remove the effect on total payments of prior year changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than patient severity. (For example, we adjusted for the effects of the FY 2002 DRG reclassification and recalibration as part of our update for FY 2004.) We have adopted this case-mix index adjustment in the capital update framework as well.

For FY 2004, we are projecting a 1.0 percent total increase in the case-mix index. We estimate that real case-mix increase will equal 1.0 percent in FY 2004. Therefore, the net adjustment for case-mix change in FY 2004 is 0.0 percentage points.

We estimate that FY 2002 DRG reclassification and recalibration will result in a 0.0 percent change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, we are making a 0.0 percent adjustment for DRG reclassification and recalibration in the update for FY 2004 to maintain budget neutrality.

The capital update framework contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of the forecast error. A forecast error of 0.2 percentage points was calculated for the FY 2002 update. That is, current historical data indicate that the forecasted FY 2002 CIPI used in calculating the FY 2002 update factor (0.7 percent) overstated the actual realized price increases (0.5 percent) by 0.2 percentage points. This slight overprediction was mostly due to an underestimation of the interest rate cuts by the Federal Reserve Board in 2002, which impacted the interest component of the CIPI. However, since this estimation of the change in the CIPI is less than 0.25 percentage points, it is not reflected in the update recommended under this framework. Therefore, we are making a 0.0 percent adjustment for forecast error in the update for FY 2004.

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

We calculate case-mix constant intensity as the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services) and changes in real case-mix. The use of total charges in the calculation of the intensity factor makes it a total intensity factor, that is, charges for capital services are already built into the calculation of the factor. Therefore, we have incorporated the intensity adjustment from the operating update framework into the capital update framework. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and to the combination of quality-enhancing new technologies and within-DRG complexity, we assume, as in the operating update framework, that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity, to allow for within-DRG severity increases and the adoption of quality-enhancing technology.

As we discussed in the May 9, 2002 proposed rule (67 FR 51514), 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 standard Federal capital rate in FY 1996 using an update framework that takes into account, among other things, allowable changes in the intensity of hospital services. For FYs 1996 through 2001, we found that case-mix constant intensity was declining and we established a 0.0 percent adjustment for intensity in each of those years. For FYs 2001 and 2002, we found that case-mix constant intensity was increasing and we established a 0.3 percent adjustment and 1.0 percent adjustment for intensity, respectively.

Using the methodology described above, for FY 2004 we examined the change in total charges per admission, adjusted for price level changes (the CPI for hospital and related services), and changes in real case-mix for FYs 1998 though 2002. We found that, over this period and in particular the last 3 years of this period (FYs 2000 through 2002), the charge data appear to be skewed. More specifically, we found a dramatic increase in hospital charges for FYs 2000 through 2002 without a corresponding increase in hospital case-mix index. If hospitals were treating new or different types of cases, which would result in an appropriate increase in charges per discharge, then we would expect hospitals' case-mix to increase proportionally.

The timing of this increase in charge growth is consistent with the dramatic increase in charges that we discussed in the March 5, 2003 high-cost outlier proposed rule (68 FR 10420 through 14029). As we discussed in that proposed rule, because hospitals have the ability to increase their outlier payments through dramatic charge increases, we proposed several changes in our high-cost outlier policy at §§ 412.84(i) and (m) in order to prevent hospitals from taking advantage of our current outlier policy.

As discussed above, because our intensity calculation relies heavily upon charge data and we believe that this charge data may be inappropriately skewed, we are proposing a 0.0 percent adjustment for intensity in FY 2004. In past FYs (1996 through 2000) when we found intensity to be declining, we believed a zero (rather then negative) intensity adjustment was appropriate. Similarly, we believe that it is appropriate to propose a zero intensity adjustment for FY 2004 until we believe that any increase in charges can be tied to intensity rather then to attempts to maximize outlier payments.

Above we described the basis of the components used to develop the proposed 0.7 percent capital update factor for FY 2004 as shown in the table below.

CMS'S PROPOSED FY 2004 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE

Capital Input Price Index	0.7
Intensity	0.0
Case-Mix Adjustment Factors:	
Projected Case-Mix Change	−1.0
Real Across DRG Change	1.0
Subtotal	0.0
Effect of FY 2002 Reclassification and Recalibration	0.0
Forecast Error Correction	0.0

CMS'S PROPOSED FY 2004 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE—Continued

Total Proposed Update	0.7

b. Comparison of CMS and MedPAC Update Recommendation. In the past, MedPAC has included update recommendations for capital PPS in a Report to Congress. In its March 2003 Report to Congress, MedPAC did not make an update recommendation for capital PPS payments. However, in that same report, MedPAC made an update recommendation for hospital inpatient and outpatient services (page 4). MedPAC stated that hospital inpatient and outpatient services should be considered together because they are so closely interrelated. Their recommendation is based on an assessment of whether payments are adequate to cover the costs of efficient providers, an estimate of input price inflation (measured by the market basket index), and an adjustment for technological charges, which is offset by reasonable expectations in productivity gains.

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of capital-related outlier payments to total inpatient capital-related PPS payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating DRG payments.

In the August 1, 2002 IPPS final rule (67 FR 50129), we estimated that outlier payments for capital in FY 2003 would equal 5.31 percent of inpatient capital-related payments based on the FY 2003 Federal rate. Accordingly, we applied an outlier adjustment factor of 0.9469 to the FY 2003 Federal rate. Based on the thresholds as set forth in section II.A.4.c. of this Addendum, we estimate that outlier payments for capital would equal 5.45 percent of inpatient capital-related payments based on the Federal rate in FY 2004. Therefore, we are proposing an outlier adjustment factor of 0.9455 to the Federal rate. Thus, the projected percentage of capital outlier payments to total capital standard payments for FY 2004 is higher than the percentage for FY 2003.

The outlier reduction factors are not built permanently into the rates; that is, they are not applied cumulatively in determining the Federal rate. Therefore, the net proposed change in the outlier adjustment to the Federal rate for FY 2004 is 0.9985 (0.9455/0.9469). The outlier adjustment decreases the proposed FY 2004 Federal rate by 0.15 percent compared with the FY 2003 outlier adjustment.

3. Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the Geographic Adjustment Factor

Section 412.308(c)(4)(ii) requires that the Federal rate be adjusted so that aggregate payments for the fiscal year based on the Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the geographic adjustment factor (GAF) are projected to equal aggregate payments that would have been made on the basis of the Federal rate without such changes.

Since we implemented a separate geographic adjustment factor for Puerto Rico, we apply separate budget neutrality adjustments for the national geographic adjustment factor and the Puerto Rico geographic adjustment factor. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier since the geographic adjustment factor for Puerto Rico was implemented in FY 1998.

In the past, we used the actuarial capital cost model (described in Appendix B of the August 1, 2001 IPPS final rule (66 FR 40099)) to estimate the aggregate payments that would have been made on the basis of the Federal rate with and without changes in the DRG classifications and weights and in the GAF to compute the adjustment required to maintain budget neutrality for changes in DRG weights and in the GAF. During the transition period, the capital cost model was also used to estimate the regular exception payment adjustment factor. As we explain in section III.A.4. of this Addendum, beginning in FY 2003 an adjustment for regular exception payments is no longer necessary. Therefore, we are no longer using the capital cost model. Instead, we are using historical data based on hospitals' actual cost experiences to determine the exceptions payment adjustment factor for special exceptions payments.

To determine the proposed factors for FY 2004, we compared (separately for the national rate and the Puerto Rico rate) estimated aggregate Federal rate payments based on the FY 2003 DRG relative weights and the FY 2003 GAF to estimated aggregate Federal rate payments based on the proposed FY 2004 relative weights and the proposed FY 2004 GAF. In the August 1, 2002 IPPS final rule (67 FR 50129) for FY 2003, the budget neutrality adjustment factors were 0.9885 for the national rate and 0.9963 for the Puerto Rico rate. As a result of the revisions to the GAF effective for discharges occurring on or after April 1, 2003 through September 30, 2003, the budget neutrality adjustment factor is 0.9983 for the national rate for discharges occurring on or before April 1, 2003 through September 30, 2003. The budget neutrality adjustment factor for the Puerto Rico rate remained unchanged (0.9963). As we noted above, the rates effective for discharges occurring on or after April 1, 2003 through September 30, 2003 were used in determining the proposed FY 2004 rates. In making the comparison, we set the regular and special exceptions reduction factors to 1.00.

To achieve budget neutrality for the changes in the national GAF, based on calculations using updated data, we are proposing to apply an incremental budget neutrality adjustment of 1.0034 for FY 2004 to the previous cumulative FY 2003 adjustment (0.9883), yielding a proposed cumulative adjustment of 0.9929 through FY 2004. For the Puerto Rico GAF, we are proposing to apply an incremental budget neutrality adjustment of 1.0002 for FY 2004 to the previous cumulative FY 2003 adjustment (0.9963), yielding a proposed cumulative adjustment of 0.9964 through FY 2004. (This is the rounded result of a calculation performed on unrounded numbers.)

We then compared estimated aggregate Federal rate payments based on the FY 2003 DRG relative weights and the FY 2003 GAF to estimated aggregate Federal rate payments based on the proposed FY 2004 DRG relative weights and the proposed FY 2004 GAF. The proposed incremental adjustment for DRG classifications and changes in relative weights is 1.0004 both nationally and for Puerto Rico. The proposed cumulative adjustments for DRG classifications and changes in relative weights and for changes in the GAF through FY 2004 are 0.9920 nationally and 0.9968 for Puerto Rico (this is the rounded result of a calculation performed with unrounded numbers). The following table summarizes the adjustment factors for each fiscal year:

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal year	National				Puerto Rico			
	Incremental adjustment			Cumulative	Incremental adjustment			Cumulative
	Geographic adjustment factor	DRG reclassifications and recalibration	Combined		Geographic adjustment factor	DRG reclassifications and recalibration	Combined	
1992	.....	.....	.....	1.00000	.....	.....	.....	.....
1993	.....	.....	0.99800	0.99800	.....	.....	.....	.....
1994	.....	.....	1.00531	1.00330	.....	.....	.....	.....
1995	.....	.....	0.99980	1.00310	.....	.....	.....	.....
1996	.....	.....	0.99940	1.00250	.....	.....	.....	.....
1997	.....	.....	0.99873	1.00123	.....	.....	.....	.....
1998	.....	.....	0.99892	1.00015	.....	.....	.....	1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001 [1]	0.99782	1.00009	0.99791	0.99933	1.00365	1.00009	1.00374	1.00508
2001 [2]	[3] 0.99771	[3] 1.00009	[3] 0.99780	0.99922	[3] 1.00365	[3] 1.00009	[3] 1.00374	1.00508
2002	[4] 0.99666	[4] 0.99668	[4] 0.99335	0.99268	[4] 0.98991	[4] 0.99668	[4] 0.99662	0.99164
2003 [5]	0.99915	0.99662	0.99577	0.98848	1.00809	0.99662	1.00468	0.99628
2003 [6]	[7] 0.99896	[7] 0.99662	[7] 0.99558	0.98830	[7] 1.00809	[7] 0.99662	[7] 1.00468	0.99628
2004	[8] 1.00341	[8] 1.00036	[8] 1.00376	0.99202	[8] 1.00015	[8] 1.00036	[8] 1.00051	0.99679

[1] Factors effective for the first half of FY 2001 (October 2000 through March 2001).
[2] Factors effective for the second half of FY 2001 (April 2001 through September 2001).
[3] Incremental factors are applied to FY 2000 cumulative factors.
[4] Incremental factors are applied to the cumulative factors for the first half of FY 2001.
[5] Factors effective for the first half of FY 2003 (October 2002 through March 2003).
[6] Factors effective for the second half of FY 2003 (April 2003 through September 2003).
[7] Incremental factors are applied to FY 2002 cumulative factors.
[8] Incremental factors are applied to the cumulative factors for the second half of FY 2003.

The methodology used to determine the proposed recalibration and geographic (DRG/GAF) budget neutrality adjustment factor for FY 2004 is similar to that used in establishing budget neutrality adjustments under the PPS for operating costs. One difference is that, under the operating PPS, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital PPS, there is a single DRG/GAF budget neutrality adjustment factor (the national rate and the Puerto Rico rate are determined separately) for changes in the GAF (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients, indirect medical education payments, or the large urban add-on payments.

In the August 1, 2002 IPPS final rule (67 FR 50129), we calculated a GAF/DRG budget neutrality factor of 0.9957 for FY 2003. As we noted above, as a result of the revisions to the GAF effective for discharges occurring on or after April 1, 2003 through September 30, 2003, we calculated a GAF/DRG budget neutrality factor of 0.9956 for discharges occurring on or after April 1, 2003 through September 30, 2003. Furthermore, the rates effective for discharges occurring on or after April 1, 2003 through September 30, 2003 were used in determining the proposed FY 2004 rates. For FY 2004, we are proposing a GAF/DRG budget neutrality factor of 1.00038. The GAF/DRG budget neutrality factors are built permanently into the rates; that is, they are applied cumulatively in determining the Federal rate. This follows from the requirement that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAF. The proposed incremental change in the adjustment from FY 2003 to FY 2004 is 1.00038. The proposed cumulative change in the rate due to this adjustment is 0.9920 (the product of the incremental factors for FY 1993, FY 1994, FY 1995, FY 1996, FY 1997, FY 1998, FY 1999, FY 2000, FY 2001, FY 2002, FY 2003, and the proposed incremental factor for FY 2004: $0.9980 \times 1.0053\ 0.9998 \times 0.9994 \times 0.9987 \times 0.9989 \times 1.0028 \times 0.9985 \times 0.9979 \times 0.9934 \times 0.9956 \times 1.00038 = 0.9920$).

This proposed factor accounts for DRG reclassifications and recalibration and for changes in the GAF. It also incorporates the effects on the GAF of FY 2004 geographic reclassification decisions made by the MGCRB compared to FY 2003 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors or in the large urban add-on.

4. Exceptions Payment Adjustment Factor

Section 412.308(c)(3) requires that the standard capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of additional payments for both regular exceptions and special exceptions under § 412.348 relative to total capital PPS payments. In estimating the proportion of regular exception payments to total capital PPS payments during the transition period, we used the actuarial capital cost model originally developed for determining budget neutrality (described in Appendix B of the August 1, 2001 IPPS final rule (66 FR 40099)) to determine the exceptions payment adjustment factor, which was applied to both the Federal and hospital-specific rates.

An adjustment for regular exception payments is no longer necessary in determining the FY 2004 capital Federal rate because, in accordance with § 412.348(b), regular exception payments were only made for cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001. Accordingly, as we explained in the August 1, 2001 IPPS final rule (66 FR 39949), in FY 2003 and subsequent fiscal years, no payments will be made under the regular exceptions provision. However, in accordance with § 412.308(c), we still need to compute a budget neutrality adjustment for special exception payments under § 412.348(g). We describe our methodology for determining the special exceptions adjustment used in calculating the proposed FY 2004 capital Federal rate below.

Under the special exceptions provision specified at § 412.348(g)(1), eligible hospitals include SCHs, urban hospitals with at least 100 beds that have a disproportionate share percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals with a combined Medicare and Medicaid inpatient utilization of at least 70 percent. An eligible hospital may receive special exceptions payments if it meets (1) a project need requirement as described at § 412.348(g)(2), which, in the case of certain urban hospitals, includes an excess capacity test as described at § 412.348(g)(4); (2) an age

of assets test as described at § 412.348(g)(3); and (3) a project size requirement as described at § 412.348(g)(5).

As we explained in the August 1, 2001 IPPS final rule (66 FR 39912 through 39914), in order to determine the estimated proportion of special exceptions payments to total capital payments, we attempted to identify the universe of eligible hospitals that may potentially qualify for special exceptions payments. First, we identified hospitals that met the eligibility requirements at § 412.348(g)(1). Then we determined each hospital's average fixed asset age in the earliest available cost report starting in FY 1992 and subsequent fiscal years. For each of those hospitals, we calculated the average fixed asset age by dividing the accumulated depreciation by the current year's depreciation. In accordance with § 412.348(g)(3), a hospital must have an average age of buildings and fixed assets above the 75th percentile of all hospitals in the first year of the capital PPS. In the September 1, 1994 final rule (59 FR 45385), we stated that, based on the June 1994 update of the cost report files in HCRIS, the 75th percentile for buildings and fixed assets for FY 1992 was 16.4 years. However, we noted that we would make a final determination of that value on the basis of more complete cost report information at a later date. In the August 29, 1997 final rule (62 FR 46012), based on the December 1996 update of HCRIS and the removal of outliers, we finalized the 75th percentile for buildings and fixed assets for FY 1992 as 15.4 years. Thus, we eliminated any hospitals from the potential universe of hospitals that may qualify for special exception payments if its average age of fixed assets did not exceed 15.4 years.

For the hospitals remaining in the potential universe, we estimated project-size by using the fixed capital acquisitions shown on Worksheet A7 from the following HCRIS cost reports updated through December 2002.

PPS year	Cost reporting periods beginning in . . .
IX	FY 1992.
X	FY 1993.
XI	FY 1994.
XII	FY 1995.
XIII	FY 1996.
XIV	FY 1997.
XV	FY 1998.
XVI	FY 1999.
XVII	FY 2000.
XVIII	FY 2001.

Because the project phase-in may overlap 2 cost reporting years, we added together the fixed acquisitions from sequential pairs of cost reports to determine project size. Under § 412.348(g)(5), the hospital's project cost must be at least $200 million or 100 percent of its operating cost during the first 12-month cost reporting period beginning on or after October 1, 1991. We calculated the operating costs from the earliest available cost report starting in FY 1992 and later by subtracting inpatient capital costs from inpatient costs (for all payers). We did not subtract the direct medical education costs as those costs are not available on every update of the HCRIS minimum data set. If the hospital met the project size requirement, we assumed that it also met the project need requirements at § 412.348(g)(2) and the excess capacity test for urban hospitals at § 412.348(g)(4).

Because we estimate that so few hospitals will qualify for special exceptions, projecting costs, payments, and margins would result in high statistical variance. Consequently, we decided to model the effects of special exceptions using historical data based on hospitals' actual cost experiences. If we determined that a hospital may qualify for special exceptions, we modeled special exceptions payments from the project start date through the last available cost report (FY 2000). (Although some FY 2001 cost reports are available in HCRIS, only a few hospitals have submitted FY 2001 costs. Consequently, too few cost reports are available to reliably model FY 2001 special exceptions payments.) For purposes of modeling, we used the cost and payment data on the cost reports from HCRIS assuming that special exceptions would begin at the start of the qualifying project. In other words, when modeling costs and payment data, we ignored any regular exception payments that these hospitals may otherwise have received as if there had not been regular exception provision during the transition period. In projecting an eligible hospital's special exception payment, we applied the 70-percent minimum payment level, the cumulative comparison of current year capital PPS payments and costs, and the cumulative operating margin offset (excluding 75 percent of operating DSH payments).

Our modeling of special exception payments for FY 2004 produced the following results:

Cost report	Number of hospitals eligible for special exceptions	Special exceptions as a fraction of capital payments to all hospitals
PPS IX		
PPS X		
PPS XI	1	
PPS XII	4	
PPS XIII	5	
PPS XIV	11	
PPS XV	15	
PPS XVI	24	0.0002
PPS XVII	27	0.0005
PPS XVIII	N/A	N/A

We note that hospitals still have one more cost reporting period (PPS XVIII) to complete their projects in order to be eligible for special exceptions payments, and, therefore, we estimate that about 30 hospitals could qualify for special exceptions payments. Thus, we project that special exception payments as a fraction of capital payments to all hospitals to be approximately 0.0005.

Because special exceptions are budget neutral, we are proposing to offset the Federal capital rate by 0.05 percent for special exceptions payments for FY 2004. Therefore, the proposed exceptions adjustment factor would equal 0.9995 (1 − 0.0005) to account for special exceptions payments in FY 2004. Furthermore, we are proposing to estimate the exceptions payment adjustment factor for special exceptions payments in FY 2004 in the final rule based on updated data.

In the August 1, 2002 IPPS final rule (67 FR 50131) for FY 2003, we estimated that total (special) exceptions payments would equal 0.30 percent of aggregate payments based on the Federal rate. Therefore, we applied an exceptions reduction factor of 0.9970 (1 − 0.0030) in determining the FY 2003 Federal rate. As we stated, we estimate that exceptions payments in FY 2004 would equal 0.05 percent of aggregate payments based on the proposed FY 2004 Federal rate. Therefore, we are proposing to apply an exceptions payment adjustment factor of 0.9995 (1 − 0.0005) to the proposed Federal rate for FY 2004. The proposed exceptions adjustment factor for FY 2004 is 0.25 percent higher than the factor for FY 2003 published in the August 1, 2002 IPPS final rule (67 FR 50131). This increase is primarily due to a refined analysis of more recent data.

The exceptions reduction factors are not built permanently into the rates; that is, the factors are not applied cumulatively in determining the Federal rate. Therefore, the proposed net change in the exceptions adjustment factor used in determining the proposed FY 2004 Federal rate is 0.9995/0.9970, or 1.0025.

5. Proposed Standard Capital Federal Rate for FY 2004

In the August 1, 2002 IPPS final rule (67 FR 50131) we established a capital Federal rate of $407.01 for FY 2003. As we noted above, as a result of the revisions to the GAF effective for discharges occurring on or after April 1, 2003 through September 30, 2003, we have established a capital Federal rate of $406.93 for discharges occurring on or after April 1, 2003 through September 30, 2003. The rates effective for discharges occurring on or after April 1, 2003 through September 30, 2003, were used in determining the proposed FY 2004 rates. In this proposed rule, we are proposing a capital Federal rate of $411.72 for FY 2004. The proposed Federal rate for FY 2004 was calculated as follows:

- The proposed FY 2004 update factor is 1.0070; that is, the update is 0.70 percent.
- The proposed FY 2004 budget neutrality adjustment factor that is applied to the standard Federal payment rate for changes in the DRG relative weights and in the GAF is 1.0038.
- The proposed FY 2004 outlier adjustment factor is 0.9455.
- The proposed FY 2004 (special) exceptions payment adjustment factor is 0.9995.

Since the proposed Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we are proposing to make no additional adjustments in the standard Federal rate for these factors, other than the

budget neutrality factor for changes in the DRG relative weights and the GAF.

We are providing a chart that shows how each of the proposed factors and adjustments for FY 2004 affected the computation of the proposed FY 2004 Federal rate in comparison to the FY 2003 Federal rate. The proposed FY 2004 update factor has the effect of increasing the Federal rate by 0.70 percent compared to the FY 2003 Federal rate, while the proposed GAF/DRG budget neutrality factor has the effect of increasing the Federal rate by 0.38 percent. The proposed FY 2004 outlier adjustment factor has the effect of decreasing the Federal rate by 0.15 percent compared to the FY 2003 Federal rate. The proposed FY 2004 exceptions payment adjustment factor has the effect of increasing the Federal rate by 0.25 percent compared to the exceptions payment adjustment factor for FY 2003. The combined effect of all the proposed changes is to increase the Federal rate by 1.18 percent compared to the FY 2003 Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2003 FEDERAL RATE AND PROPOSED FY 2004 FEDERAL RATE

	FY 2003	Proposed FY 2004	Change	Percent change
Update factor [1]	1.0110	1.0070	1.0070	0.70
GAF/DRG Adjustment Factor [1]	0.9957	1.0038	1.0038	0.38
Outlier Adjustment Factor [2]	0.9469	0.9455	0.9985	−0.15
Exceptions Adjustment Factor [2]	0.9970	0.9995	1.0025	0.25
Federal Rate	$406.93	$411.72	1.0118	1.18

[1] The update factor and the GAF/DRG budget neutrality factors are built permanently into the rates. Thus, for example, the incremental change from FY 2003 to FY 2004 resulting from the application of the proposed 1.0038 GAF/DRG budget neutrality factor for FY 2004 is 1.0038.

[2] The outlier reduction factor and the exceptions adjustment factor are not built permanently into the rates; that is, these factors are not applied cumulatively in determining the rates. Thus, for example, the net change resulting from the application of the proposed FY 2004 outlier adjustment factor is 0.9455/0.9469, or 0.9985.

6. Special Rate for Puerto Rico Hospitals

As explained at the beginning of section II.D. of this Addendum, hospitals in Puerto Rico are paid based on 50 percent of the Puerto Rico rate and 50 percent of the Federal rate. The Puerto Rico rate is derived from the costs of Puerto Rico hospitals only, while the Federal rate is derived from the costs of all acute care hospitals participating in the PPS (including Puerto Rico). To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended rate. The GAF is calculated using the operating PPS wage index and varies, depending on the MSA or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended rate.

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustments for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. As we stated in section III.A.4. of this Addendum, for Puerto Rico the proposed GAF budget neutrality factor is 1.0002, while the proposed DRG adjustment is 1.0004, for a proposed combined cumulative adjustment of 0.9968.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the rate (50 percent) is multiplied by the Puerto Rico-specific GAF for the MSA in which the hospital is located, and the national portion of the rate (50 percent) is multiplied by the national GAF for the MSA in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico). In FY 1998, we implemented a 17.78 percent reduction to the Puerto Rico rate as a result of Public Law 105–33. In FY 2003, a small part of that reduction was restored.

For FY 2003, before application of the GAF, the special rate for Puerto Rico hospitals was $198.29. With the changes we are proposing to the factors used to determine the rate, the proposed FY 2004 special rate for Puerto Rico is $201.26.

B. Calculation of Inpatient Capital-Related Prospective Payments for FY 2004

With the end of the capital PPS transition period in FY 2001, all hospitals (except "new" hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid based on 100 percent of the Federal rate in FY 2004. The applicable Federal rate was determined by making adjustments as follows:

- For outliers, by dividing the standard Federal rate by the outlier reduction factor for that fiscal year; and
- For the payment adjustments applicable to the hospital, by multiplying the hospital's GAF, disproportionate share adjustment factor, and IME adjustment factor, when appropriate.

For purposes of calculating payments for each discharge during FY 2004, the 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 Federal rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The proposed outlier thresholds for FY 2004 are in section II.A.4.c. of this Addendum. For FY 2004, a case qualifies as a cost outlier if the cost for the case plus the IME and DSH payments is greater than the prospective payment rate for the DRG plus $50,645.

An eligible hospital may also qualify for a special exceptions payment under § 412.348(g) for up through the 10th year beyond the end of the capital transition period if it meets: (1) A project need requirement described at § 412.348(g)(2), which in the case of certain urban hospitals includes an excess capacity test as described at § 412.348(g)(4); and (2) a project size requirement as described at § 412.348(g)(5). Eligible hospitals include sole community hospitals, urban hospitals with at least 100 beds that have a DSH patient percentage of at least 20.2 percent or qualify for DSH payments under § 412.106(c)(2), and hospitals that have a combined Medicare and Medicaid inpatient utilization of at least 70 percent. Under § 412.348(g)(8), the amount of a special exceptions payment is determined by comparing the cumulative payments made to the hospital under the capital PPS to the cumulative minimum payment level. This amount is offset by: (1) Any amount by which a hospital's cumulative capital payments exceed its cumulative minimum payment levels applicable under the regular exceptions process for cost reporting periods beginning during which the hospital has been subject to the capital PPS; and (2) any amount by which a hospital's current year operating and capital payments (excluding 75 percent of operating DSH payments) exceed its operating and capital costs. Under § 412.348(g)(6), the minimum payment level is 70 percent for all eligible hospitals.

During the transition period, new hospitals (as defined under § 412.300) were exempt from the capital PPS for their first 2 years of operation and are paid 85 percent of their reasonable costs during that period. Effective with the third year of operation through the remainder of the transition period, under § 412.324(b) we paid the hospital under the appropriate transition methodology. If the hold-harmless methodology was applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even if the hold-harmless payments extend beyond the normal transition period. As discussed in section VI.B. of the preamble of this proposed rule, under § 412.304(c)(2), for cost reporting periods beginning on or after October 1, 2002, we pay a new hospital 85 percent of their reasonable costs during the first 2 years of operation unless it elects

to receive payment based on 100 percent of the 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 costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

We periodically update the base year for the operating and capital input prices to reflect the changing composition of inputs for operating and capital expenses. The CIPI was last rebased to FY 1997 in the August 1, 2002 final rule (67 FR 50044).

2. Forecast of the CIPI for Federal Fiscal Year 2004

We are forecasting the proposed CIPI to increase 0.7 percent for FY 2004. This reflects a projected 1.2 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment) and a 3.4 percent increase in other capital expense prices in FY 2004, partially offset by a 2.0 percent decline in vintage-weighted interest rates in FY 2004. The weighted average of these three factors produces the 0.7 percent increase for the CIPI as a whole.

IV. Proposed Changes to Payment Rates for Excluded Hospitals and Hospital Units: Rate-of-Increase Percentages

As discussed in section VI. of the preamble of this proposed rule, in accordance with section 1886(b)(3)(H)(i) of the Act and effective for cost reporting periods beginning on or after October 1, 2002, payments to existing psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals excluded from the IPPS are no longer subject to limits on a hospital-specific target amount (expressed in terms of the inpatient operating cost per discharge) that are set for each hospital, based on the hospital's own historical cost experience trended forward by the applicable rate-of-increase percentages (update factors).

Effective for cost reporting periods beginning on or after October 1, 2002, rehabilitation hospitals and units are no longer paid on a reasonable cost basis but are paid under the IRF 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 DRG-based PPS. As part of the payment process for LTCHs, we established a 5-year transition period from reasonable cost-based reimbursement to a fully Federal PPS. However, a LTCH, subject to the blend methodology, may elect to be paid based on a 100 percent of the Federal prospective rate.

In accordance with existing § 413.40(c)(4)(ii) and (d)(1)(i) and (ii), where applicable, excluded hospitals and units that continue to be paid on a reasonable cost basis will have payments based on their Medicare inpatient operating costs, not to exceed the ceiling (as defined in § 413.40(a)(3)).

Section 1886(b)(7) of the Act had established a payment limitation for new hospitals and units excluded from the IPPS. While both rehabilitation hospitals and units and LTCHs are now paid under a PPS, psychiatric hospitals and units continue to be subject to the payment limitation. A discussion of how the payment limitation was calculated can be found in the August 29, 1997 final rule with comment period (62 FR 46019); the May 12, 1998 final rule (63 FR 26344); the July 31, 1998 final rule (63 FR 41000); and the July 30, 1999 final rule (64 FR 41529).

The amount of payment for a ''new'' psychiatric hospital or unit would be determined as follows:

- Under existing § 413.40(f)(2)(ii), for cost reporting periods beginning on or after October 1, 1997, the amount of payment for a new hospital or unit that was not paid as an excluded hospital or unit before October 1, 1997, is the lower of: (1) The hospital's net inpatient operating costs per case; or (2) 110 percent of the national median of the target amounts for the same class of excluded hospitals and units, adjusted for differences in wage levels and updated to the first cost reporting period in which the hospital receives payment. The second cost reporting period is subject to the same target amount applied to the first cost reporting period.
- In the case of a hospital that received payments under § 413.40(f)(2)(ii) as a newly created hospital or unit, to determine the hospital's or unit's target amount for the hospital's or unit's third 12-month cost reporting period, the payment amount determined under § 413.40(f)(2)(ii)(A) for the preceding cost reporting period is updated to the third cost reporting period.

The proposed amounts included in the following table reflect the updated 110 percent of the national median target amounts of new excluded psychiatric hospitals and units for cost reporting periods beginning during FY 2004. These figures are updated with the most recent data available to reflect the projected market basket increase percentage of 3.5 percent. This projected percentage change in the market basket reflects the average change in the price of goods and services purchased by hospitals to furnish inpatient hospital services (as projected by CMS's Office of the Actuary based on its historical experience with the IPPS). For a new provider, the labor-related share of the target amount is multiplied by the appropriate geographic area wage index, without regard to IPPS reclassifications, and added to the nonlabor-related share in order to determine the per case limit on payment under the statutory payment methodology for new providers.

Class of excluded hospital or unit	FY 2004 proposed labor-related share	FY 2004 proposed nonlabor-related share
Psychiatric	$7,301	$2,902

Effective for cost reporting periods beginning on or after October 1, 2002, this payment limitation is no longer applicable to new LTCHs since they will be paid 100 percent of the Federal rate. A new LTCH is a provider of inpatient hospital services that meets the qualifying criteria for LTCHs specified under § 412.23(e)(1) and (e)(2) and whose first cost reporting period as a LTCH begins on or after October 1, 2002 (§ 412.23(e)(4)). Under the LTCH PPS, new LTCHs are paid based on 100 percent of the fully Federal prospective rate (they may not participate in the 5-year transition from cost-based reimbursement to prospective payment). In contrast, those ''new'' LTCHs that meet the definition of ''new'' under § 413.40(f)(2)(ii) and that have their first cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, may be paid under the LTCH PPS transition methodology. Since those hospitals by definition would have been considered new before October 1, 2002, they would have been subject to the updated payment limitation on new hospitals that was published in the FY 2003 IPPS final rule (67 FR 50103). Under existing regulations at § 413.40(f)(2)(ii), the ''new'' hospital would be subject to the same cap in its second cost reporting period; this cap would not be updated for the new hospital's second cost reporting year. Thus, since the same cap is to be used for the ''new'' LTCH's first two cost reporting periods, it is no longer necessary to publish an updated cap.

V. Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

In December 2002, the Department implemented a policy that established the Single Drug Pricer (SDP) to correct identified discrepancies, further the legislative goal of establishing a uniform payment allowance as a reflection of the average wholesale price (AWP), and otherwise apply the existing stature and regulation more accurately and efficiently (CMS Program Memorandum AB–02–174, December 3, 2002, which can be accessed at: *http:/www.cms.hhs.gov/manuals*). Under the SDP, CMS will establish prices centrally, thereby resulting in greater consistency in drug pricing nationally. The SDP instruction applies to blood clotting factors furnished to hospital inpatients. The payment allowance for the single national drug price for each Medicare covered drug is based on 95 percent of the AWP, except for drugs billed to durable medical equipment regional carriers (DMERCs) and hospital outpatient drugs billed to fiscal intermediaries. We are publishing this notice here because we previously have addressed the add-on payment for the costs of administering blood clotting factor in the IPPS annual rule (see the August 1, 2000 IPPS final rule (65 FR 47116).

On a quarterly basis, CMS will furnish three SDP files to all fiscal intermediaries. Each fiscal intermediary must accept the SDP files and process claims for any drug identified on the files on the basis of the price shown on the applicable file. Previously, the fiscal intermediary performed annual update calculations based on the most recent AWP data available to the carrier. The fiscal intermediary should use the SDP to price the blood clotting factors.

VI. Tables

This section contains the tables referred to throughout the preamble to this proposed rule and in this Addendum. For purposes of this proposed rule, and to avoid confusion, we have retained the designations of Tables 1 through 5 that were first used in the September 1, 1983 initial prospective payment final rule (48 FR 39844). Tables 1A, 1C, 1D, 2, 3A, 3B, 4A, 4B, 4C, 4F, 4G, 4H, 5, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H, 7A, 7B, 8A, 8B, 9, 10, and 11 are presented below. The tables presented below are as follows:

Table 1A—National Adjusted Operating Standardized
Amounts, Labor/Nonlabor
Table 1C—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor
Table 1D—Capital Standard Federal Payment Rate
Table 2—Hospital Average Hourly Wage for Federal Fiscal Years 2002 (1998 Wage Data), 2003 (1999 Wage Data), and 2004 (2000 Wage Data) Wage Indexes and 3–Year Average of Hospital Average Hourly Wages
Table 3A—3–Year Average Hourly Wage for Urban Areas
Table 3B—3–Year Average Hourly Wage for Rural Areas
Table 4A—Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas
Table 4B—Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas
Table 4C—Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals That Are Reclassified
Table 4F—Puerto Rico Wage Index and Capital Geographic Adjustment Factor (GAF)
Table 4G—Pre-Reclassified Wage Index for Urban Areas
Table 4H—Pre-Reclassified Wage Index for Rural Areas
Table 5—List of Diagnosis Related Groups (DRGs), Relative Weighting Factors, Geometric and Arithmetic Mean Length of Stay
Table 6A—New Diagnosis Codes
Table 6B—New Procedure Codes
Table 6C—Invalid Diagnosis Codes
Table 6D—Invalid Procedure Codes
Table 6E—Revised Diagnosis Code Titles
Table 6F—Revised Procedure Code Titles
Table 6G—Additions to the CC Exclusions List
Table 6H—Deletions from the CC Exclusions List
Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2002 MedPAR Update December 2002 GROUPER V20.0
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2002 MedPAR Update December 2002 GROUPER V21.0
Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted) March 2003
Table 8B—Statewide Average Capital Cost-to-Charge Ratios (Case Weighted) March 2003
Table 9—Hospital Reclassifications and Redesignations by Individual Hospital—FY 2004
Table 10—Mean and Standard Deviations by Diagnosis-Related Groups (DRGs)—FY 2004
Table 11—Proposed LTC–DRGs Relative Weights and Geometric and Five-Sixths of the Average Length of Stay-FY 2004

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

Large urban areas		Other areas	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$3,139.26	$1,276.01	$3,089.56	$1,255.81

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

	Large urban areas		Other areas	
	Labor	Nonlabor	Labor	Nonlabor
National	$3,112.84	$1,265.27	$3,112.84	$1,267.03
Puerto Rico	1,516.86	610.57	1,492.84	600.90

TABLE 1D.—CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	$411.72
Puerto Rico	$201.26

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
010001	17.4467	17.9841	19.3989	18.2929
010004	19.0010	20.1613	19.9457	19.7003
010005	18.6554	19.9733	18.3970	19.0198
010006	17.6115	18.3931	19.0976	18.4162
010007	15.6788	16.0781	17.5462	16.4299
010008	17.4728	19.0182	19.6573	18.7416
010009	18.4979	19.7272	20.3130	19.5087
010010	16.4664	17.7348	18.5730	17.5867
010011	22.4292	24.8922	25.6737	24.2683
010012	15.8686	20.3376	20.0896	18.5710
010015	19.1178	19.8205	18.8890	19.2826
010016	20.2198	20.3175	21.7918	20.8284
010018	18.9388	19.5519	19.2071	19.2353
010019	17.0856	17.6414	18.6539	17.7694
010021	15.1241	25.3335	17.7595	18.4456
010022	17.6435	22.1250	22.2266	20.3667
010023	16.3209	18.4567	20.0397	18.1965
010024	15.9034	17.3746	18.5108	17.2202
010025	15.1548	17.4702	18.9839	17.1956
010027	16.8595	16.5157	14.0974	15.7259
010029	18.3605	19.3393	20.9608	19.6182
010031	18.6402	19.2612	21.0176	19.6504
010032	15.3590	16.3967	16.4712	16.0937
010033	21.2986	21.9828	24.5088	22.5487
010034	15.3639	14.9379	14.5106	14.9494
010035	15.9439	20.7808	21.6182	19.2869
010036	17.7166	18.7158	17.7766	18.0775
010038	19.6098	19.6887	18.5873	19.2586
010039	20.3406	21.3550	22.9241	21.5758
010040	20.0983	20.4486	20.7536	20.4392
010043	18.6640	17.3567	19.9012	18.6528
010044	24.0265	23.4575	25.8561	24.4502
010045	17.0417	18.7569	21.1167	18.8731
010046	18.9737	18.8741	19.7870	19.2388
010047	15.4190	13.4130	16.1695	14.9341
010049	15.5246	16.3349	16.2841	16.0555
010050	17.9830	20.3028	20.7398	19.6262
010051	11.8108	12.3280	14.2767	12.7951
010052	18.0653	19.8289	11.9019	15.6329
010053	15.5649	15.4156	17.3238	16.1023
010054	19.4955	20.9656	20.6203	20.3735
010055	18.8590	19.5667	19.8170	19.4298
010056	19.6577	20.5645	21.1104	20.4208
010058	16.9715	16.1265	17.7800	16.9302
010059	18.8020	19.1270	20.5534	19.4928
010061	14.5003	18.5320	16.9028	16.6415
010062	12.3259	16.9721	17.1786	15.3820
010064	19.5256	20.5650	21.7162	20.5136
010065	16.8752	17.0557	17.2698	17.0733
010066	13.1559	14.8904	14.8696	14.3351
010068	18.6925	23.4322	18.2092	20.2305
010069	14.7211	15.4497	16.9839	15.7052
010072	16.2339	16.5652	18.8807	17.1920
010073	14.1273	13.5594	14.9826	14.2068
010078	18.1363	18.5127	20.1447	18.9315
010079	17.0648	17.1612	20.7401	18.2252
010081	17.2996	*	*	17.2996
010083	18.0312	18.4282	19.8525	18.7454
010084	18.7769	19.8773	21.6522	20.1274
010085	19.9023	21.5860	22.5282	21.3942
010086	16.5711	16.8886	18.0122	17.1417
010087	18.0567	18.7915	18.7253	18.4944
010089	17.7800	19.5241	19.5783	18.9652
010090	18.9445	19.5635	20.0287	19.5086
010091	17.0799	17.1775	17.4672	17.2432

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
010092	17.8144	18.5478	19.9289	18.7707
010095	12.2597	12.3064	12.5243	12.3676
010097	12.7286	14.2675	15.1593	14.0568
010098	14.0300	15.5763	15.1629	14.9158
010099	15.5619	15.9232	16.3307	15.9423
010100	17.9430	18.3755	19.8146	18.7658
010101	14.4625	18.9525	19.0718	17.2612
010102	13.8136	15.7777	16.4636	15.3148
010103	17.7242	22.0802	22.5709	20.6405
010104	16.8457	21.9457	20.9391	19.7211
010108	19.4617	19.1596	20.6337	19.7473
010109	14.6752	15.9627	18.2235	16.2157
010110	15.8283	15.5817	16.0015	15.8256
010112	16.8271	15.6041	17.9243	16.7545
010113	16.8936	18.2774	19.1978	18.1229
010114	17.0760	19.3772	20.1763	18.8237
010115	14.2261	15.3510	15.7873	15.0923
010118	17.0834	17.4620	19.4280	17.9013
010119	19.3942	19.5163	20.1990	19.7084
010120	18.2567	18.9975	19.4369	18.8719
010121	14.5262	15.2345	17.1640	15.7079
010123	19.2140	*	*	19.2141
010124	16.7465	*	*	16.7465
010125	16.0136	16.5117	16.8622	16.4618
010126	19.1065	19.5933	19.9845	19.5804
010127	18.2786	*	*	18.2786
010128	14.4322	16.6899	14.7646	15.2637
010129	16.1733	16.7609	16.4904	16.4644
010130	19.5573	17.4614	18.7190	18.5367
010131	20.1883	19.0492	22.3132	20.5855
010134	19.9856	18.5179	16.8181	18.4871
010137	20.5828	21.3573	28.7410	23.1563
010138	14.5254	14.1369	14.2024	14.2898
010139	20.4331	20.5708	22.8390	21.2553
010143	17.6212	18.9084	20.6578	19.0594
010144	18.2040	18.8272	19.1497	18.7345
010145	20.5895	20.8157	21.7700	21.0799
010146	19.1415	18.3666	21.3384	19.6056
010148	15.8349	18.4591	17.6830	17.3825
010149	18.0156	19.0199	20.8645	19.3169
010150	18.9359	19.4819	21.1878	19.8964
010152	18.7677	19.8990	21.1438	19.9058
010155	15.0689	13.6136	*	14.4394
010157	*	17.7372	19.6977	18.7304
010158	18.3957	18.6052	18.5464	18.5206
010159	*	19.3950	*	19.3950
020001	28.0394	28.6530	30.1452	28.9867
020002	25.1987	28.2759	30.4165	27.8092
020004	25.4679	29.2351	27.3516	27.2833
020005	29.2378	35.0860	32.7936	32.3866
020006	28.1417	33.0843	31.2673	30.7745
020007	32.3852	27.7269	27.5708	28.8969
020008	30.8691	31.8878	33.4543	32.1364
020009	18.4660	18.5594	24.9415	20.3403
020010	22.7559	23.7275	20.7928	22.3051
020011	28.0658	27.5062	29.6249	28.3773
020012	25.5320	26.7586	27.9955	26.7886
020013	28.1557	29.5646	30.6424	29.4993
020014	24.5875	27.7870	29.6806	27.4656
020017	28.0572	28.8752	30.3017	29.1234
020024	25.3205	25.5933	28.0930	26.3977
020025	20.2583	29.4375	32.8655	26.7102
030001	21.7869	22.8996	25.7513	23.3305

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
030002	21.8375	23.1450	25.6038	23.5516
030003	22.6804	23.9849	22.1436	22.9249
030004	15.5478	13.8452	15.7742	15.0275
030006	20.0273	20.5019	23.0216	21.0706
030007	21.5169	22.2473	26.1551	23.4298
030008	22.2190	*	*	22.2190
030009	18.7557	19.1258	19.9131	19.2261
030010	19.5123	19.8496	20.7204	20.0003
030011	19.4310	19.8141	21.0028	20.0690
030012	20.6585	21.1099	24.2366	22.1509
030013	20.0535	19.9517	21.9766	20.7166
030014	19.7966	20.3017	21.5382	20.5679
030016	19.4785	22.2526	24.3380	22.1886
030017	21.7938	23.1702	21.8792	22.2509
030018	20.8980	21.8067	24.9216	22.5811
030019	21.2540	22.0341	23.2973	22.2278
030022	19.5794	22.3351	24.9941	22.3479
030023	24.1678	25.4626	28.6628	26.2700
030024	23.6009	23.7663	26.7641	24.7020
030025	11.9894	20.2690	18.7967	16.8149
030027	17.6555	18.5500	19.4583	18.5927
030030	21.6932	23.1280	25.2425	23.1970
030033	20.2820	20.3034	26.4812	22.3008
030034	20.8689	19.5578	17.7772	19.3850
030035	20.0226	20.5339	*	20.2741
030036	21.6371	22.2690	24.9432	23.0233
030037	23.7615	23.7325	23.0542	23.5162
030038	22.9822	23.4477	25.2632	23.9087
030040	19.7636	19.3706	21.2717	20.1331
030041	18.8717	18.4750	18.6985	18.6886
030043	20.5598	20.5653	20.8619	20.6748
030044	17.6575	18.6781	21.9503	19.2464
030047	21.4412	22.7385	23.8939	22.7605
030049	19.3580	19.7315	*	19.5288
030054	15.0657	15.7973	16.8863	15.9671
030055	20.2991	20.8373	22.8612	21.3919
030059	22.6279	27.3929	*	24.8227
030060	18.6313	19.5021	21.7685	19.9508
030061	19.9047	21.1013	22.9706	21.3676
030062	18.7172	19.2670	21.1639	19.7478
030064	20.3837	21.6435	22.8009	21.6120
030065	20.7838	22.2846	24.6064	22.6068
030067	17.2778	17.6414	18.4004	17.7581
030068	17.7208	18.9718	19.7097	18.8803
030069	21.0936	23.4902	24.5432	23.0752
030080	20.6581	21.2299	22.7867	21.6244
030083	23.5229	23.5049	24.3273	23.8162
030085	20.8690	21.6542	21.8196	21.4875
030087	21.9465	23.1339	25.6344	23.5331
030088	20.5340	21.4491	23.5761	21.9185
030089	20.9516	22.0850	24.5055	22.5911
030092	21.8308	19.6625	20.6577	20.5622
030093	20.4314	21.7195	23.2485	21.9062
030094	22.8123	21.8049	24.5992	23.0301
030095	13.7664	20.5222	*	16.1313
030099	18.2263	19.8092	20.3310	19.5882
030100	23.7609	23.5868	*	23.6643
030101	19.2547	21.1029	23.8414	21.3423
030102	18.2413	21.5405	*	19.8425
030103	*	28.9308	40.8755	33.8153
030104	*	32.8668	34.6026	33.8315
040001	16.9178	16.3882	16.2652	16.4883
040002	15.1107	16.1353	18.0776	16.4361

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
040003	15.5740	15.5186	16.3918	15.8349
040004	17.9034	19.0105	19.8567	18.9476
040005	11.1318	16.5465	*	13.6054
040007	18.6998	22.5319	23.3992	21.2518
040008	14.7985	20.2121	*	17.4031
040010	19.4913	19.8251	20.4612	19.9398
040011	16.0995	17.1337	18.8346	17.5256
040014	18.1434	19.3996	22.4970	19.9652
040015	15.5207	17.9602	18.8513	17.4824
040016	20.2321	19.8087	21.2198	20.4114
040017	15.4736	16.5648	17.7545	16.6023
040018	18.7463	18.8203	22.2459	19.8242
040019	23.4163	21.0465	21.1711	21.7572
040020	18.9844	17.6056	18.0130	18.1484
040021	19.6835	21.3321	23.3840	21.5035
040022	20.8281	19.2393	20.5951	20.1448
040024	17.6607	17.1507	17.5750	17.4623
040025	13.4705	14.8071	17.6791	15.1660
040026	19.7924	21.0143	22.6617	21.1612
040027	17.4431	17.7161	19.3388	18.1973
040028	13.9946	15.2850	13.9975	14.4367
040029	21.1370	22.5094	22.1882	21.9489
040030	11.2402	16.5488	*	13.2353
040032	13.2872	13.8013	16.2781	14.3506
040035	10.9569	11.0611	11.8237	11.2698
040036	20.2012	21.1066	21.6742	21.0202
040037	14.0941	15.4984	*	14.7246
040039	14.7177	15.2811	15.9673	15.3471
040040	19.1984	19.6704	*	19.4380
040041	16.4624	17.7783	20.4646	18.2091
040042	15.2057	16.6875	16.2285	16.0552
040044	13.3501	17.1869	18.4270	16.2509
040045	16.2469	16.6648	19.5573	17.3603
040047	17.5336	18.6295	20.4173	18.8431
040050	14.0036	14.2087	15.1428	14.4627
040051	16.6039	18.2152	17.6964	17.5006
040053	15.0219	14.1508	19.2586	15.8377
040054	14.2577	16.5217	16.5573	15.7676
040055	18.0414	17.4236	17.1669	17.5528
040058	16.4278	19.3124	*	17.6419
040060	17.9805	15.4220	19.0007	17.4501
040062	17.8902	19.4255	20.6917	19.3314
040064	11.5029	13.3479	18.6107	14.1151
040066	19.7144	19.5619	21.7766	20.3116
040067	14.4741	15.0081	16.0516	15.1736
040069	17.0026	18.9754	20.5968	18.8667
040070	16.9700	18.6066	20.5214	18.8036
040071	17.6144	18.4956	18.7641	18.2815
040072	17.4960	21.3320	18.4032	18.9950
040074	18.7542	20.8465	22.0800	20.5126
040075	14.0975	14.6681	15.7875	14.8313
040076	20.5840	21.8010	23.5948	21.9901
040077	13.9114	14.7230	16.7832	15.1038
040078	18.5821	19.6363	21.4854	19.9519
040080	19.3707	22.8153	18.3431	19.9751
040081	11.1332	12.4796	13.2797	12.2892
040082	15.1331	16.4840	18.1636	16.5196
040084	17.7295	18.3410	20.1163	18.7753
040085	16.5216	14.1782	15.5811	15.3778
040088	17.1624	18.3159	19.8286	18.3979
040090	19.0824	16.6619	*	17.8591
040091	20.1378	20.2904	20.6688	20.3813
040093	13.9741	14.7132	*	14.3380

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
040100	15.6833	17.0271	17.8889	16.9700
040105	14.3896	14.8936	15.4697	14.9508
040106	18.1341	19.0936	19.1726	18.8593
040107	17.8628	20.6852	17.6695	18.7676
040109	16.6278	16.2496	17.1706	16.6926
040114	21.1231	21.3826	21.3532	21.2885
040118	18.2123	19.6248	21.8065	19.9138
040119	16.9407	18.6028	19.9013	18.5380
040124	19.2889	*	*	19.2889
040126	11.6517	16.3391	13.3832	13.6732
040132	10.3875	24.6941	29.2337	17.5163
040134	19.0185	22.1291	*	20.6229
040135	23.0084	*	*	23.0082
040136	*	21.4139	*	21.4138
040137	*	*	24.7813	24.7813
040138	*	*	21.0859	21.0859
050002	36.9630	30.2629	30.9729	32.2632
050006	18.2061	22.4890	25.4618	22.0352
050007	30.8676	31.6270	34.1406	32.1656
050008	26.3682	28.2021	32.4067	28.7024
050009	28.4734	28.3021	30.2740	29.0378
050013	28.0569	27.2552	30.1682	28.4525
050014	23.6745	25.1664	27.7646	25.5586
050015	27.7731	28.2204	27.5652	27.8552
050016	21.2045	22.7014	25.1232	23.0550
050017	25.6178	25.7403	28.4165	26.5820
050018	15.2903	16.5909	17.9621	16.7254
050022	24.5254	26.2574	28.1312	26.3930
050024	22.4274	21.5230	25.1016	22.9531
050025	24.8245	26.0161	29.8262	26.8932
050026	23.1904	23.4651	23.8785	23.5278
050028	17.6138	17.9421	18.7866	18.1131
050029	24.6839	26.6783	30.2538	27.1782
050030	21.5621	21.8639	21.9251	21.7896
050032	24.3598	24.4176	24.6284	24.4685
050033	32.0179	31.1768	*	31.6954
050036	21.8239	24.8017	25.3885	24.0459
050038	29.9698	32.1757	36.1619	32.5954
050039	22.8288	23.8478	26.8993	24.5711
050040	30.2607	30.1153	30.7426	30.3810
050042	24.5260	25.4903	27.6765	25.9508
050043	33.8255	38.8988	37.3217	36.6008
050045	21.1474	21.0356	22.1691	21.4359
050046	25.2005	25.3067	25.5490	25.3505
050047	29.9580	31.6959	34.4427	32.0849
050051	18.7809	17.9266	*	18.3161
050054	22.0982	19.2395	21.3495	20.8463
050055	29.2730	32.0923	36.1182	32.3322
050056	23.8396	24.7994	27.1458	25.3250
050057	20.7420	22.2584	24.2758	22.4840
050058	23.3009	24.8366	23.2205	23.7636
050060	20.5450	21.9971	22.9491	22.0213
050061	24.5488	23.9906	25.3042	24.6040
050063	25.7593	25.5798	28.6093	26.6450
050065	24.6290	27.6677	28.8369	27.0472
050066	16.1649	26.3920	*	19.8363
050067	25.8857	22.1250	27.8867	24.8006
050068	19.3615	19.2325	21.9031	19.5920
050069	24.6153	25.8560	27.2744	25.8994
050070	34.0721	36.4136	39.5178	36.7625
050071	34.4367	36.4834	40.1344	37.0182
050072	39.7321	36.1146	39.2188	38.3181
050073	32.8555	36.1054	38.6763	35.9238

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
050075	33.7160	37.8104	40.2265	37.4233
050076	33.9752	37.0415	40.8075	37.1398
050077	24.1404	25.3481	27.1234	25.5664
050078	24.3150	23.0613	23.2913	23.5117
050079	30.0167	36.5455	39.6651	35.3854
050082	23.7617	23.7718	23.9154	23.8161
050084	25.4517	25.1155	25.9728	25.5331
050088	24.9641	25.2282	27.1103	25.7384
050089	22.8450	23.4120	24.7857	23.6599
050090	24.6070	25.4545	27.4193	25.8348
050091	23.7713	26.6463	29.2522	26.4442
050092	17.1211	17.1883	18.1132	17.4867
050093	25.6647	27.2048	29.2642	27.4393
050095	30.4847	29.2226	*	29.7245
050096	22.7394	22.5034	23.0526	22.7555
050097	22.5991	24.2548	24.4129	23.7724
050099	25.3722	26.2363	27.1308	26.2772
050100	25.2031	23.9877	25.3258	24.8411
050101	31.8957	33.1232	32.3802	32.4675
050102	24.0014	22.6741	25.5763	24.0204
050103	25.4133	23.5946	25.0854	24.6669
050104	26.9726	27.3260	26.1592	26.8000
050107	22.2019	22.2746	22.6900	22.4227
050108	25.1758	25.6983	28.5244	26.4357
050110	19.9589	21.3399	21.9296	21.1132
050111	20.7897	21.0813	23.7715	21.9292
050112	26.8182	29.1268	31.9797	29.3043
050113	28.5224	32.4493	32.6932	31.3678
050114	26.6757	27.6486	28.1909	27.5327
050115	23.0182	24.3748	24.1481	23.8529
050116	24.9196	27.0331	28.2924	26.6320
050117	22.2123	23.0697	24.7555	23.3917
050118	23.7129	24.9094	28.9358	25.8815
050121	18.7272	18.8430	24.6584	20.3903
050122	26.9546	26.9048	29.1534	27.6723
050124	24.5069	23.9379	23.0843	23.8087
050125	32.0230	33.3290	35.6572	33.6339
050126	24.6752	26.9718	27.7126	26.4996
050127	20.9027	20.5928	21.8559	21.1158
050128	26.6132	26.2519	28.7668	27.1805
050129	24.0108	23.7432	25.2780	24.3452
050131	32.5462	33.0980	37.7844	34.4656
050132	24.0173	24.1583	28.0265	25.4346
050133	23.2093	23.9479	25.1948	24.1576
050135	24.7157	23.2750	12.5413	18.0625
050136	24.7280	28.0754	31.1484	27.7833
050137	32.9192	33.7489	35.0503	33.8818
050138	38.1584	40.8912	43.0858	40.6538
050139	31.4984	35.1492	33.8749	33.3407
050140	32.7609	36.7096	36.1708	35.1295
050144	27.4069	29.8983	30.3678	29.2851
050145	34.5185	37.5003	37.5722	36.5610
050148	20.0971	21.1622	17.3908	19.5271
050149	26.8674	25.8880	28.0501	26.8823
050150	24.6596	25.9494	26.7728	25.8255
050152	33.3305	34.5096	34.5694	34.1486
050153	32.3389	33.3333	34.5870	33.4428
050155	25.3354	23.2118	21.2069	23.1002
050158	28.6071	28.9764	30.6598	29.4328
050159	22.5313	26.6139	21.3422	23.0637
050167	21.8796	21.9596	23.1879	22.3467
050168	25.1937	27.1971	26.4047	26.2183
050169	24.8407	24.7737	25.6896	25.1108

* Denotes wage data not available for the provider for that year.
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TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
050170	24.3654	27.7693	29.4075	26.9505
050172	19.6120	22.0400	24.5849	22.0737
050173	24.8694	*	27.7070	26.3141
050174	30.2775	31.6888	33.5204	31.9008
050175	24.7548	26.0146	26.9627	25.9076
050177	21.1396	22.5039	23.1575	22.2317
050179	23.8868	22.8941	23.0583	23.2574
050180	33.3257	34.0900	36.9905	34.8613
050186	23.6288	25.0791	27.6638	25.5202
050188	28.2364	30.6007	34.1503	31.0517
050189	27.4071	28.3295	32.3514	29.2097
050191	25.3516	29.4162	28.1689	27.6587
050192	14.1996	19.0400	19.5157	17.3616
050193	24.9444	25.5294	24.6307	25.0325
050194	29.5678	28.5389	28.0291	28.6722
050195	36.9068	39.1617	42.1735	39.4471
050196	18.2411	19.4304	19.8203	19.1752
050197	32.4030	34.6878	25.9224	30.7008
050204	22.7099	23.0192	24.9458	23.5600
050205	24.1691	24.1275	25.2841	24.5169
050207	22.9941	23.7774	25.1863	23.9991
050211	31.7280	33.2481	34.3396	33.0898
050213	21.4951	*	*	21.4951
050214	24.0276	21.1480	22.2431	22.4178
050215	35.0459	31.6895	34.4745	33.7035
050217	20.2042	21.3026	22.2055	21.2565
050219	21.2458	21.7637	21.8649	21.6598
050222	23.3563	23.0670	24.6959	23.7403
050224	23.5101	24.8431	25.1943	24.5595
050225	21.6820	22.0981	24.5601	22.7516
050226	24.4443	26.1959	26.0826	25.7144
050228	34.2596	36.0632	38.6751	36.2629
050230	26.6291	26.7963	30.0380	27.8217
050231	26.7321	27.4697	27.0320	27.0798
050232	24.5245	25.8640	25.3439	25.2423
050234	24.6126	25.0104	23.2830	24.1727
050235	27.0922	26.0323	27.2838	26.7962
050236	25.9458	27.7406	26.9290	26.8640
050238	24.5823	25.1796	26.0312	25.2541
050239	23.2711	24.9469	27.0911	25.1055
050240	26.7620	28.8910	32.8542	29.7204
050241	29.8345	*	*	29.8345
050242	32.0829	33.5646	34.4412	33.3749
050243	26.4627	26.0256	28.5626	27.0708
050245	23.2716	24.6092	25.7585	24.5579
050248	27.6457	28.4413	29.1192	28.4523
050251	23.6360	27.9531	24.4552	25.2214
050253	16.7540	21.0399	23.9247	20.2377
050254	20.1176	22.3414	23.3358	21.9420
050256	23.4835	25.1104	26.8618	25.3035
050257	17.2596	15.6379	17.4909	16.8191
050260	27.4234	30.1623	24.9073	27.2549
050261	20.1040	19.4649	21.4693	20.3613
050262	29.5550	30.8866	33.0425	31.0973
050264	36.0331	33.2270	37.5425	35.5478
050267	26.0401	27.8393	26.6558	26.7955
050270	25.3757	26.4092	27.9871	26.6878
050272	23.0587	23.3443	24.0921	23.5076
050276	33.3302	34.0633	34.4832	33.9454
050277	26.0822	23.6065	35.6323	28.8604
050278	23.9289	24.9699	26.0331	24.9976
050279	21.8949	22.2776	23.5145	22.5756
050280	25.6651	26.3392	28.4969	26.8343

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TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
050281	24.2251	25.2699	25.7832	25.1246
050282	25.4428	26.4698	*	25.9126
050283	31.7669	32.3270	35.1831	33.1816
050286	19.4241	20.6191	19.7351	19.9268
050289	30.4750	32.2125	34.9651	32.5458
050290	29.6796	31.5000	31.9510	31.0288
050291	29.4029	30.9334	28.3451	29.5051
050292	20.8410	21.4357	27.6114	23.1188
050293	24.1875	17.1935	*	20.0134
050295	21.7883	25.4405	25.4332	24.2106
050296	28.3906	30.0984	33.5948	30.6658
050298	23.2006	22.4000	26.1833	23.8635
050299	25.5035	24.6751	26.9870	25.7710
050300	25.9228	26.0298	26.6700	26.2233
050301	21.1403	24.7987	22.7711	22.8646
050305	36.7908	36.6981	38.7597	37.4248
050308	28.9284	30.3887	31.6790	30.3648
050309	25.3515	25.5221	25.5367	25.4704
050312	26.0015	26.0172	28.2557	26.8194
050313	25.6827	28.9126	25.0948	26.4529
050315	22.7359	22.5906	23.6638	23.0139
050320	32.4809	31.6571	31.9686	32.0209
050324	25.3694	26.8313	28.4931	27.0063
050325	23.6327	22.6353	26.6326	24.1679
050327	25.6450	31.1527	33.0549	29.6283
050329	21.6984	24.2134	26.6341	24.1720
050331	25.0230	25.2110	21.5193	23.7909
050333	19.1449	14.1808	15.6929	16.0637
050334	34.2557	34.3956	37.2336	35.3386
050335	22.9926	22.9335	23.9713	23.3018
050336	21.3402	22.0203	*	21.6868
050342	20.8255	22.4510	23.0282	22.0864
050348	25.1085	29.3364	28.9864	27.7954
050349	15.0667	15.4536	15.6042	15.3828
050350	26.4161	27.2368	27.2573	26.9829
050351	24.8121	25.2436	27.4042	25.8956
050352	26.4262	27.7489	32.6772	28.8662
050353	23.2699	24.1009	24.8223	24.0722
050355	21.0969	41.4710	*	27.5904
050357	24.5345	24.3540	25.2126	24.7119
050359	21.7548	19.7653	22.9175	21.4664
050360	31.7583	33.3592	35.9032	33.7039
050366	19.6823	22.0442	23.4696	21.8093
050367	30.7328	31.7487	32.6760	31.7233
050369	26.2234	26.6627	28.0909	27.0127
050373	27.8275	29.9749	30.4697	29.3692
050376	28.0990	28.4026	30.3530	28.9347
050377	17.0012	11.6463	14.3889	14.7469
050378	26.9101	27.8389	30.4937	28.3969
050379	18.4278	24.2408	27.5150	22.7721
050380	31.9578	31.5962	35.1536	32.9076
050382	25.9244	26.3968	26.8949	26.4027
050385	*	27.1692	*	27.1692
050388	22.0122	17.6762	15.6834	18.4348
050390	24.2700	25.8556	25.7881	25.2656
050391	20.0615	19.0832	20.2887	19.7798
050392	22.9430	24.9003	21.8139	23.1475
050393	24.1981	25.4028	26.4918	25.4171
050394	23.1526	23.1641	25.1869	23.8865
050396	25.3729	25.7580	28.4161	26.5200
050397	20.6397	23.3212	24.7280	22.8187
050401	18.4593	*	*	18.4593
050404	15.9839	16.4845	20.0233	17.3758

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
050406	17.8596	21.5282	23.0438	20.5476
050407	30.8346	32.0753	33.2894	32.0587
050410	19.8508	17.1718	19.8436	18.9151
050411	33.1943	33.1718	*	33.1828
050414	25.9723	24.5471	26.8815	25.7060
050417	23.3005	23.3862	24.4608	23.7300
050419	23.4936	25.1449	26.4357	25.0021
050420	23.5438	26.4201	26.7537	25.5652
050423	21.3552	24.8113	26.5188	24.3189
050424	24.0727	25.9378	27.5273	25.9000
050425	35.3712	33.7276	37.7347	35.6925
050426	29.0120	26.7941	30.9610	28.8680
050427	16.4330	31.4154	25.8360	23.8810
050430	21.2275	25.2322	31.5171	24.6961
050432	24.5630	26.0686	28.2074	26.3472
050433	18.9021	17.7980	14.3846	17.2267
050434	*	24.0017	*	24.0017
050435	23.3426	22.5428	22.6561	22.8168
050438	23.2583	25.3763	26.5535	25.0490
050440	22.5400	25.4767	28.2209	25.3120
050441	31.8774	33.4696	36.6680	33.8900
050443	17.2875	16.8897	18.0063	17.3814
050444	22.4530	22.6469	23.5299	22.8500
050446	22.3422	20.3611	20.0104	20.8646
050447	18.9851	24.4339	25.7274	23.3050
050448	21.7718	22.6612	26.6967	23.5469
050449	23.4614	*	*	23.4614
050454	30.0792	30.3063	34.4813	31.6390
050455	19.8577	20.5575	23.8527	21.3319
050456	18.1585	17.5846	23.7594	19.3948
050457	32.1910	34.2116	37.4570	34.4455
050464	25.7710	25.8092	31.4768	27.7900
050468	22.2926	22.9771	17.8128	20.5312
050469	24.5205	*	25.7995	25.2381
050470	16.0805	15.7765	21.2996	17.4624
050471	27.1597	29.4705	32.3570	29.6121
050476	24.0253	25.9458	25.9711	25.3460
050477	27.5819	30.8781	32.1676	30.2255
050478	26.3306	28.1829	28.3893	27.6685
050481	27.7973	28.5320	29.4912	28.6205
050482	16.0114	21.6091	23.0016	19.2164
050485	24.6906	25.2723	23.8237	24.5767
050488	31.7481	33.8291	37.2438	34.4285
050491	27.4600	27.7412	29.2987	28.1988
050492	20.5030	23.4977	23.7383	22.6518
050494	29.1296	30.2875	30.7725	30.1010
050496	34.9704	32.7474	35.7115	34.4409
050497	15.4115	*	14.4481	14.9306
050498	26.1716	27.6099	28.2196	27.3481
050502	25.3701	27.2724	27.9506	26.8641
050503	23.3745	25.7668	26.7924	25.3905
050506	25.0333	27.1555	30.4731	27.5747
050510	33.7481	36.2548	39.6005	36.5514
050512	34.4368	36.0785	39.0767	36.6044
050515	33.7321	37.3440	36.3131	35.7452
050516	26.1969	25.3450	30.0359	27.0104
050517	22.0985	23.6067	23.4131	22.9981
050522	36.2127	37.0295	38.9158	36.9675
050523	31.2522	32.1272	33.8053	32.4311
050526	26.4014	26.8814	29.0004	27.4593
050528	18.9155	21.1741	23.9177	21.3604
050531	21.3948	*	22.7311	22.0660
050534	24.0001	24.4038	26.7941	25.0949

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
050535	26.8511	27.7626	29.7904	28.1965
050537	24.0354	26.2342	25.1292	25.1574
050539	23.3846	23.7778	24.1196	23.7754
050541	36.6149	37.0551	41.1980	38.3379
050542	17.7737	21.8129	21.2846	19.9901
050543	21.6795	22.4134	24.0333	22.7542
050545	31.7280	33.6302	33.4322	32.9305
050546	38.8087	39.4266	42.8053	40.3552
050547	37.7681	37.7633	40.6483	38.6518
050548	29.8516	30.3336	32.3944	30.8485
050549	28.9615	30.0948	31.6709	30.2918
050550	25.6588	26.5515	29.0938	27.1362
050551	24.8084	26.1042	28.6834	26.5676
050552	20.3239	20.6068	24.9755	21.7907
050557	22.2562	23.8340	25.8401	24.0476
050559	24.7866	26.3799	25.3299	25.4887
050561	33.4423	34.2065	*	33.8236
050564	24.2091	*	*	24.2090
050565	20.8349	*	*	20.8349
050566	22.3448	21.7712	24.0648	22.6946
050567	25.0787	26.2588	27.8475	26.4308
050568	20.5376	21.9313	20.8324	21.0880
050569	27.3429	27.3294	27.7955	27.4880
050570	25.8619	26.8965	29.9470	27.6972
050571	24.0154	26.2226	29.1716	26.5115
050573	25.6589	25.9380	27.2328	26.2959
050575	20.7090	27.8579	23.1358	23.6994
050577	23.5487	25.2861	26.4806	25.0050
050578	28.9009	32.0554	31.1695	30.6550
050579	29.9348	32.0245	34.9794	32.4397
050580	24.6962	22.7522	27.2431	24.7685
050581	24.9807	26.0580	28.9696	26.6705
050583	25.8800	26.2664	30.0427	27.5806
050584	19.5805	24.5294	24.5544	22.7601
050585	24.2824	26.4446	26.0595	25.5822
050586	23.1850	*	*	23.1850
050588	24.5472	27.0506	30.5453	27.6351
050589	23.8880	23.7918	27.9845	25.1893
050590	24.4797	25.1100	27.0535	25.5262
050591	25.0209	26.7662	28.6151	26.8393
050592	22.1174	23.8267	25.9545	23.8223
050594	27.7002	28.7415	30.8029	29.1185
050597	23.3280	23.1209	24.5542	23.6763
050598	23.9202	25.1622	31.1703	26.7495
050599	26.0892	26.3782	27.7684	26.7559
050601	29.7417	29.7734	32.3033	30.6813
050603	21.7031	24.9032	25.0996	23.8892
050604	35.4034	36.4669	42.0018	37.9795
050608	18.1664	20.9171	20.7954	19.9529
050609	33.5028	34.8949	*	34.1686
050613	30.2413	34.9768	*	32.5464
050615	27.5682	25.8698	29.4322	27.6985
050616	24.9843	25.0016	*	24.9928
050618	21.4895	22.3548	*	21.9734
050623	27.5832	28.6475	29.9553	28.6716
050624	26.4659	22.4030	23.4665	23.9161
050625	27.5816	29.3665	29.6612	28.9346
050630	24.2120	25.2915	27.7052	25.7731
050633	25.4283	27.8165	30.2883	27.9289
050636	23.5257	25.0214	23.2573	23.9123
050638	18.2159	15.6375	21.0088	18.1465
050641	17.1258	17.9379	21.5030	19.2373
050644	22.1489	*	28.4054	25.2877

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
050662	35.0989	38.9592	40.9243	38.2885
050663	24.9110	22.7770	22.9161	23.2174
050667	27.5045	26.9236	31.4906	28.5908
050668	61.7751	57.8627	*	59.6272
050670	24.6101	24.1626	*	24.3757
050674	32.4807	33.7845	36.8871	34.4747
050676	20.2087	16.3948	24.3105	19.1193
050677	33.6070	34.0936	*	33.8463
050678	22.7756	25.2143	27.1337	25.0885
050680	31.4839	31.9166	32.2371	31.8875
050682	17.3566	19.8107	23.0983	19.8665
050684	23.3697	24.2792	23.7443	23.7986
050685	35.1307	30.4194	*	32.6498
050686	33.4420	34.8278	*	34.1349
050688	31.0648	34.9936	36.5555	34.8315
050689	30.9399	34.0571	37.5449	34.4378
050690	34.8112	36.7516	41.1385	37.6299
050693	25.5662	29.1213	32.6638	29.3244
050694	23.5572	25.1964	25.8299	24.8850
050695	24.4301	26.2838	27.8742	26.2576
050696	28.3291	29.6685	29.9410	29.3284
050697	18.2338	24.1116	18.5357	19.9903
050698	*	24.9559	*	24.9559
050699	17.5296	23.4611	26.3932	21.9529
050701	24.3055	26.4901	28.4650	26.3518
050704	22.7618	25.6565	24.6072	24.3668
050707	27.8958	28.2637	27.7366	27.9699
050708	24.8647	24.5606	22.1605	23.8703
050709	19.4977	21.8770	22.7897	21.4220
050710	27.5828	30.5918	33.7204	30.7878
050713	16.8538	18.2822	19.0071	18.0075
050714	30.1925	30.3290	30.3262	30.2901
050717	28.7973	31.5021	33.0719	31.0905
050718	18.0940	22.5989	21.7835	21.3483
050719	23.0833	*	22.0997	22.4754
050720	25.8677	*	26.1941	26.0295
050723	*	32.0291	33.0797	32.5951
050725	*	*	20.6592	20.6592
050726	*	*	25.8742	25.8742
060001	21.1819	21.4562	23.1548	21.9595
060003	20.4682	21.9043	23.0807	21.8505
060004	21.4496	22.9265	25.0037	23.2681
060006	20.0213	21.0003	21.8609	21.0085
060007	18.2977	19.3071	22.2747	19.9022
060008	18.4590	18.7097	19.8803	19.0217
060009	22.7164	23.9272	24.1285	23.6009
060010	23.6827	24.2735	25.9341	24.6424
060011	22.3458	22.2058	25.4458	23.3434
060012	19.4932	21.2980	22.6374	21.1159
060013	19.1256	23.5248	23.3954	21.9829
060014	24.3210	25.7701	25.9159	25.3595
060015	23.2469	23.6015	27.6338	24.8106
060016	20.2408	20.2361	22.9300	21.1421
060018	21.5083	21.8478	21.0581	21.4599
060020	18.8985	19.7348	20.9025	19.8893
060022	21.0830	22.8059	19.8819	21.2558
060023	21.5475	22.4731	24.3749	22.8346
060024	22.9185	24.3658	25.2409	24.2358
060027	22.0713	22.1717	25.1480	23.2185
060028	23.1792	24.2985	27.3340	24.9108
060029	18.2938	19.8498	*	19.0675
060030	20.3452	21.2612	22.8309	21.5553
060031	22.5067	23.3995	23.8781	23.2637

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
060032	22.8123	24.7678	25.5628	24.4445
060033	16.0760	17.8514	16.7266	16.8791
060034	23.2816	24.3652	26.2141	24.6650
060036	18.5988	18.6521	18.1954	18.4720
060037	15.4513	15.7495	17.1258	16.1605
060038	14.3249	16.6525	15.3718	15.5616
060041	19.1263	19.5872	20.8745	19.8909
060042	20.8597	19.3967	22.5613	20.7473
060043	13.4443	15.4073	19.1085	15.9780
060044	20.8673	21.3102	25.6112	22.7216
060046	22.2699	22.6819	24.0645	23.0457
060047	17.1534	17.9173	18.1662	17.7570
060049	23.0613	25.9592	25.3425	24.9252
060050	19.0832	*	20.4386	19.8467
060052	14.8729	16.0543	18.2354	16.3844
060053	18.0232	19.4746	22.2894	19.8382
060054	20.4160	19.7753	20.9346	20.3624
060056	18.1263	21.9586	21.9389	20.8180
060057	25.4185	24.6599	24.4012	24.8132
060058	13.8539	16.4504	20.3154	16.7670
060060	15.6018	19.4418	21.0586	18.5977
060062	16.8640	17.1032	19.0995	17.6743
060064	22.7797	28.8746	29.1806	26.8320
060065	24.5572	24.4554	29.2179	26.0872
060066	17.2537	17.5556	14.6820	16.5806
060070	18.8960	19.2220	22.6894	20.3042
060071	17.4068	17.6452	20.1385	18.3916
060073	17.0846	18.4971	16.5027	17.3443
060075	23.8724	25.0552	27.2654	25.3696
060076	20.3265	22.9426	23.6266	22.3373
060085	14.3409	10.9724	15.6918	13.4494
060088	13.7174	20.7211	22.9170	18.6644
060090	16.3760	16.5321	*	16.4540
060096	20.8937	21.9951	20.0869	21.0065
060100	23.9305	24.8116	27.4972	25.4548
060103	23.5083	24.4962	26.7150	24.9461
060104	21.1820	24.4248	26.8237	23.9979
060107	21.9221	*	*	21.9222
060108	*	19.1327	19.0011	19.0448
060109	*	27.3180	*	27.3180
060110	*	*	31.3494	31.3494
070001	26.3596	27.7441	29.9592	27.9941
070002	26.1768	26.6881	28.1101	26.9593
070003	27.5200	28.1721	29.7864	28.5044
070004	24.2567	25.4310	25.7207	25.1218
070005	26.9151	27.6733	29.8173	28.0976
070006	28.6413	33.6291	32.6824	31.8244
070007	26.3313	28.0875	29.0734	27.8655
070008	24.2971	25.1362	24.3907	24.6106
070009	24.1871	24.9408	25.4576	24.8664
070010	29.2194	28.3168	30.4192	29.3329
070011	23.0883	24.8206	24.9457	24.2870
070012	28.8067	37.5917	34.9099	33.4527
070015	28.1204	29.2693	30.0614	29.1548
070016	24.4633	28.4833	31.2173	27.8518
070017	26.0424	27.5515	29.2978	27.4590
070018	30.6864	32.6301	33.8654	32.4296
070019	24.9249	26.2348	27.9838	26.4038
070020	25.9964	26.6203	28.4084	27.0418
070021	26.3043	29.4596	30.0915	28.7001
070022	26.9111	27.2423	29.2864	27.8032
070024	24.8948	26.3544	28.3460	26.5801
070025	25.4345	27.3592	28.3017	27.0096

* Denotes wage data not available for the provider for that year.
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TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
070027	26.8450	25.9279	26.8236	26.5341
070028	25.7492	26.7286	28.2078	26.9036
070029	23.9682	23.8427	25.8107	24.5347
070030	22.1578	*	*	22.1578
070031	24.1198	25.6347	25.5880	25.0884
070033	31.4736	34.1591	35.8504	33.8348
070034	29.4916	30.0744	32.4220	30.6177
070035	24.1423	24.5996	25.9776	24.8552
070036	29.9470	31.2961	32.4920	31.2720
070038	*	26.3126	*	26.3126
070039	22.3356	*	32.6059	29.3416
080001	24.8833	26.8887	28.0859	26.6310
080002	20.1965	20.9385	23.7309	21.6786
080003	23.1275	24.8200	24.8199	24.2173
080004	22.9706	21.7344	24.2251	22.9785
080006	22.6671	20.9399	20.9757	21.4333
080007	21.3746	21.5415	23.4933	22.1686
090001	21.5751	23.0365	7.5651	17.9081
090002	21.5726	20.6550	23.5159	21.8418
090003	23.1268	27.1087	22.7014	24.0752
090004	25.5054	25.9717	28.7417	26.8011
090005	26.3074	26.8690	28.6142	27.2997
090006	22.0957	22.9658	23.7111	22.9438
090007	29.2840	24.6668	25.8430	26.6042
090008	25.2708	*	19.3212	22.1162
090010	23.6616	25.9373	*	24.7397
090011	26.6349	27.6038	31.7710	28.7553
100001	20.2157	22.0101	21.7561	21.3158
100002	21.0222	21.5772	21.6362	21.4258
100004	15.4149	16.1638	15.6306	15.7493
100006	21.2293	21.6922	23.3307	22.1620
100007	22.1590	22.5317	23.9004	22.9055
100008	20.8381	21.6416	22.7706	21.7804
100009	22.1741	22.6370	23.7460	22.8738
100010	23.0637	23.9582	25.5614	24.1330
100012	20.4659	22.0244	24.2602	22.3053
100014	19.5770	21.9875	21.7566	21.0988
100015	18.0654	18.9383	22.1272	19.7135
100017	19.8655	20.1417	21.1905	20.4341
100018	21.6388	22.6587	24.2154	22.8672
100019	23.5462	25.8297	24.2201	24.5270
100020	20.7816	21.7421	23.1885	21.9438
100022	26.5695	27.4235	27.9072	27.2953
100023	19.1787	20.2034	21.8111	20.3897
100024	22.1332	22.9872	24.4070	23.2018
100025	19.4529	20.1360	21.2568	20.2991
100026	20.9461	21.3742	21.7970	21.3789
100027	14.7916	20.5889	21.9900	18.2354
100028	19.3371	20.3751	21.5305	20.4329
100029	20.8950	22.2553	24.6814	22.4835
100030	20.5952	19.5604	21.5303	20.5938
100032	19.7451	20.6543	21.6415	20.6364
100034	19.5282	20.0099	22.2146	20.5533
100035	23.8117	21.3519	22.6349	22.5792
100038	24.5864	24.9548	25.6018	25.0869
100039	21.7861	23.3111	23.8060	22.9806
100040	18.6321	19.5154	21.3865	19.8692
100043	18.8206	20.7688	21.7738	20.4584
100044	22.7236	22.9474	23.9952	23.2248
100045	21.0228	22.8096	30.3359	24.4856
100046	21.3028	23.2027	24.2746	22.8753
100047	20.6068	21.4971	24.3522	22.2329
100048	15.7790	17.3663	17.5533	16.9309

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
100049	19.1025	20.9490	21.8676	20.6412
100050	17.9039	17.8960	20.0405	18.6106
100051	17.9453	19.3258	19.9713	19.1475
100052	18.1780	19.6620	18.6363	18.8133
100053	19.6800	21.6634	23.7837	21.6611
100054	21.1518	20.9612	21.8613	21.3455
100055	18.8760	19.1324	19.6350	19.2002
100056	21.8506	23.1737	25.9245	23.6383
100057	19.5319	22.3406	24.4271	21.9677
100060	23.5997	*	*	23.5997
100061	22.9176	24.5277	25.7559	24.3953
100062	21.4424	21.9054	24.9807	22.7317
100063	18.4642	19.2510	21.5620	19.9030
100067	18.4851	19.2168	23.6270	20.3382
100068	19.8308	19.9648	23.7197	21.3073
100069	17.3666	18.5789	19.6037	18.6041
100070	20.0381	20.9592	20.4770	20.4616
100071	17.7234	20.7461	21.7675	20.3419
100072	20.5968	22.0317	21.9184	21.5398
100073	22.2812	22.2425	23.5843	22.7262
100075	19.4480	20.4604	21.8589	20.5692
100076	17.8612	18.4815	19.6444	18.6617
100077	19.0640	20.9482	22.2470	20.8144
100078	19.2891	16.6003	17.4683	17.7417
100080	22.7153	22.9720	22.7056	22.7946
100081	15.4253	16.5149	16.4804	16.1357
100084	22.7009	24.5682	23.5435	23.6450
100086	23.3718	24.3067	25.2375	24.3294
100087	23.6562	22.1764	26.2514	24.0027
100088	20.5566	20.6667	23.6270	21.6062
100090	19.7695	21.0431	22.5894	21.1520
100092	20.1760	21.4601	25.4630	22.1148
100093	16.8422	18.7153	20.2949	18.6499
100098	20.8315	21.1723	20.0639	20.7185
100099	15.7591	16.5271	16.1165	16.1278
100102	19.7673	19.0193	21.6772	20.1082
100103	18.7844	19.1222	20.3633	19.4145
100105	21.8268	22.7793	24.5464	23.0784
100106	17.4958	21.4342	18.5389	19.1251
100107	20.0719	21.7553	23.3789	21.7356
100108	20.1125	18.4127	15.1791	17.6124
100109	20.8370	20.6007	22.3671	21.2613
100110	20.1853	22.8127	24.2271	22.5089
100112	15.2128	16.2109	16.9325	16.1723
100113	21.3489	23.3380	20.6110	21.7279
100114	22.8178	22.5326	25.3699	23.4863
100117	20.6962	21.3085	23.2994	21.7923
100118	20.7323	21.7067	24.1105	22.1068
100121	18.5842	19.9033	23.1100	20.5301
100122	19.2643	24.9765	23.6638	22.5106
100124	20.4022	20.0867	14.8231	17.8809
100125	19.6097	20.3232	22.4185	20.8356
100126	19.3103	21.4349	21.7977	20.8062
100127	19.2122	20.5153	21.0153	20.2670
100128	22.8826	23.5835	24.4104	23.6230
100130	20.0947	21.0023	20.2478	20.4482
100131	23.1622	24.6184	25.4186	24.4498
100132	18.7863	19.5259	21.1446	19.8043
100134	15.9733	16.9302	18.3392	17.1001
100135	19.1865	19.7675	20.3831	19.7887
100137	19.5562	20.9015	*	20.2591
100138	14.9539	14.9760	16.4384	15.4793
100139	15.2532	15.7378	18.2187	16.3579

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
100140	19.0584	20.2288	22.6326	20.6848
100142	18.4113	17.7250	20.0689	18.7079
100146	21.3359	20.8381	*	21.0641
100147	15.2348	17.1566	17.2835	16.5550
100150	21.5057	25.4269	22.9193	23.1341
100151	23.8489	26.6143	26.8564	25.9003
100154	20.4068	21.6715	23.0820	21.7335
100156	18.4779	20.0348	20.7649	19.8064
100157	22.6195	24.2188	23.1045	23.3126
100159	10.7818	15.0633	19.3145	15.1520
100160	23.3121	22.6942	23.4877	23.1680
100161	22.3053	23.3612	24.4326	23.3822
100162	20.3110	24.2950	23.8001	22.8069
100165	22.6622	*	*	22.6623
100166	21.2309	22.2419	23.7327	22.3765
100167	23.2969	25.7676	26.8139	25.3034
100168	20.3167	23.0121	24.6276	22.6616
100169	20.3017	21.6397	22.5755	21.5513
100170	19.3005	21.2469	*	20.1922
100172	14.8826	15.7827	17.6051	16.0261
100173	17.1337	18.3828	19.7190	18.4365
100174	21.9807	*	*	21.9807
100175	20.5442	21.2532	21.0474	20.9357
100176	24.3089	24.6595	26.8740	25.2920
100177	24.4284	25.1037	24.4295	24.6550
100179	23.0849	23.9633	22.8536	23.2786
100180	21.5388	22.7781	24.7990	23.1132
100181	18.9510	17.9048	18.1320	18.3165
100183	23.0654	22.2063	24.4575	23.2115
100187	20.8535	21.4988	23.4760	21.9203
100189	26.5962	27.1295	26.6653	26.7935
100191	21.0647	22.0526	24.2299	22.5063
100200	23.8729	24.8878	24.8120	24.5400
100204	20.2193	21.1922	22.2613	21.2482
100206	20.1171	20.3436	*	20.2327
100208	20.7029	20.4678	24.1482	21.8277
100209	23.3903	22.8236	23.5479	23.2587
100210	21.8545	23.0431	26.0933	23.6634
100211	20.7516	21.6367	*	21.1977
100212	21.1263	21.7239	22.6259	21.8401
100213	21.1818	22.0176	24.4995	22.6205
100217	22.7335	22.7116	24.0291	23.1695
100220	21.8246	24.6233	24.9733	23.7248
100221	21.2321	23.2263	*	22.1854
100223	20.2233	21.8962	21.1051	21.1071
100224	21.8628	22.3567	22.7403	22.3391
100225	21.5059	22.4619	23.9971	22.6579
100226	21.8808	22.7301	23.8070	22.8491
100228	20.8810	24.9691	*	22.9269
100229	18.2350	19.7259	21.0039	19.5689
100230	22.5650	23.4169	25.0408	23.8884
100231	18.7526	21.5712	22.8325	20.8200
100232	19.8002	20.1459	21.8906	20.6484
100234	21.6360	24.3355	24.0421	23.3485
100236	20.6942	21.7886	23.7286	22.0173
100237	23.2408	23.2712	26.7664	24.3476
100238	20.8252	23.3747	24.6513	22.9237
100239	19.4481	23.2242	24.9409	22.4134
100240	21.0606	21.3495	23.0650	21.8213
100241	17.1063	14.1059	14.6992	15.3546
100242	18.6938	19.1097	20.4142	19.4632
100243	20.8041	22.4495	23.2812	22.2413
100244	20.5352	21.4386	23.4876	21.8968

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
100246	21.9247	23.5614	26.6552	23.9760
100248	21.2988	22.1553	23.7614	22.4427
100249	18.1397	18.4932	21.3942	19.2694
100252	19.8079	22.0976	22.6481	21.5857
100253	22.4778	22.6517	23.4448	22.8823
100254	19.5523	20.4410	23.2068	21.2034
100255	21.0284	20.7228	22.9793	21.5458
100256	21.2786	22.4844	23.7315	22.4906
100258	20.0300	22.0790	24.5699	22.2126
100259	21.1160	21.4991	24.0960	22.2834
100260	24.9183	21.2413	23.4255	23.0969
100262	21.0927	22.7137	23.8006	22.3809
100264	19.9491	21.7410	22.4616	21.4161
100265	18.2291	20.2664	21.0688	19.9095
100266	19.3623	20.2821	21.5258	20.4415
100267	21.7430	22.8054	23.3558	22.6691
100268	24.0538	23.5414	26.0297	24.5763
100269	22.5114	26.0271	25.0014	24.5239
100270	16.7148	20.8217	16.8468	18.0052
100271	20.8695	21.9823	*	21.4488
100275	21.4904	23.2920	23.1316	22.6853
100276	24.1022	24.8251	25.4557	24.8136
100277	19.7241	14.9157	25.2985	18.4223
100279	22.5879	23.1776	24.6625	23.4267
100280	18.1972	19.0157	*	18.6075
100281	23.0142	23.4729	25.3382	24.0569
100282	18.4884	20.9256	21.8279	20.4704
100284	18.9448	18.5716	22.3046	19.9187
110001	20.1150	22.4535	24.0561	22.2069
110002	19.5158	20.2149	20.0125	19.9219
110003	17.1450	18.2792	19.7061	18.4215
110004	19.7733	20.6096	21.8791	20.7777
110005	22.4568	21.8105	23.6147	22.7129
110006	21.0601	22.0325	23.8762	22.3201
110007	25.2523	25.9135	27.8969	26.3641
110008	18.5265	20.4972	22.6308	20.7088
110009	17.4306	16.6452	16.2944	16.8215
110010	23.9104	25.1930	26.6265	25.2350
110011	18.9823	20.4028	23.2149	20.8820
110013	18.9160	16.7833	19.7781	18.4998
110014	18.1787	18.4463	18.7642	18.4629
110015	20.9926	21.2600	23.2279	21.9187
110016	14.2398	14.7571	18.8371	15.7745
110017	22.2537	21.2970	21.8808	21.8184
110018	22.1480	23.0577	24.7007	23.3525
110020	19.4617	20.9687	22.5988	20.9702
110023	22.0546	21.6512	23.6182	22.4827
110024	20.7345	21.3945	22.1471	21.4330
110025	20.4232	20.2493	29.0965	22.6398
110026	16.2484	16.9161	19.3200	17.4907
110027	14.7081	19.8976	19.8351	18.0251
110028	29.1670	28.1695	25.9474	27.6479
110029	21.2150	21.3694	23.0779	21.9337
110030	19.6412	20.4656	21.6618	20.6037
110031	20.0553	20.9219	22.8695	21.3219
110032	18.2014	19.2685	18.0744	18.4929
110033	25.6335	23.1939	24.1447	24.2752
110034	19.5554	23.0724	22.8541	21.6751
110035	22.7950	21.8646	23.4610	22.7096
110036	24.9234	22.5481	24.5675	23.9890
110038	17.7396	18.4508	20.1710	18.7818
110039	20.4998	18.9817	17.0608	18.7776
110040	16.8083	17.7798	17.3095	17.2984

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
110041	20.2755	20.1398	20.8080	20.4113
110042	25.2331	25.0535	25.5588	25.2869
110043	20.6150	21.2714	22.7589	21.5611
110044	17.2087	17.5905	19.2562	17.9982
110045	21.3049	22.2424	19.7747	21.0415
110046	21.4905	22.8820	21.6201	22.0167
110048	15.6113	18.8751	21.9621	18.7056
110049	16.8639	17.1396	18.9096	17.6498
110050	19.2291	18.9048	22.1089	20.1584
110051	17.2292	17.2050	17.6816	17.3795
110054	20.0549	20.7825	20.5387	20.4734
110056	17.7959	17.9037	21.7607	19.3353
110059	16.7990	17.8076	19.9802	18.2059
110061	16.3557	17.4601	18.6696	17.5523
110062	17.0053	17.9421	18.2038	17.7308
110063	18.5071	18.0256	19.4401	18.6913
110064	19.1203	18.8742	21.7636	19.8777
110065	16.3546	16.9829	19.9032	17.6656
110066	22.4189	23.4554	*	22.9140
110069	20.9575	21.1513	21.0518	21.0559
110070	17.3438	19.6361	20.8793	19.1178
110071	18.8321	21.5042	15.2336	18.3234
110072	12.7625	13.6626	*	13.1941
110073	16.4658	17.9372	15.2711	16.4347
110074	22.3769	24.4924	23.6564	23.5407
110075	20.1757	20.1604	19.6937	20.0081
110076	21.9798	23.6127	24.9264	23.5306
110078	24.0893	25.7416	27.7261	25.8462
110079	22.1070	22.3641	22.2908	22.2542
110080	19.1839	19.4635	*	19.3217
110082	24.3140	22.7015	24.0664	23.6678
110083	23.1463	22.2609	24.5253	23.3268
110086	16.6374	19.0164	18.8751	18.1588
110087	22.7069	24.0994	25.7908	24.2653
110089	19.3855	19.0453	20.6840	19.7079
110091	21.5328	23.7110	25.1996	23.4730
110092	16.9725	15.9178	16.9116	16.5923
110093	16.9827	*	*	16.9827
110094	16.9503	16.8890	*	16.9211
110095	17.1195	18.9904	20.1024	18.8017
110096	17.4157	18.0418	18.5513	18.0235
110097	17.4558	17.8454	18.9464	18.0488
110098	16.0597	16.7800	17.5567	16.8549
110100	19.0764	18.6822	15.1316	17.6555
110101	18.8491	13.8787	13.3943	14.8763
110103	21.1837	21.5683	*	21.4221
110104	15.9431	16.6322	17.9805	16.8523
110105	16.7775	18.1306	19.2156	18.0663
110107	19.3897	21.2267	21.9213	20.8424
110108	25.2161	20.1140	18.4912	20.6647
110109	16.4031	16.5977	18.7397	17.2348
110111	18.3951	18.4274	22.5840	19.8648
110112	19.8986	18.9574	20.5171	19.8164
110113	15.9532	16.0942	18.0770	16.7135
110114	16.4812	16.8297	17.7019	17.0138
110115	22.5049	26.5759	26.3274	24.9969
110118	19.7509	17.5714	17.7344	18.2780
110120	17.7452	18.4738	20.3099	18.8660
110121	19.3643	18.8744	19.5230	19.2555
110122	21.1469	20.6070	21.1510	20.9707
110124	18.3366	19.4093	19.7005	19.1562
110125	18.0090	19.5666	19.8695	19.1558
110127	20.3765	16.1107	*	18.2840

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
110128	18.0835	20.3046	28.4942	21.9309
110129	19.0001	20.9442	21.5571	20.5238
110130	14.6011	16.6915	17.5272	16.2937
110132	16.3943	17.1820	17.2924	16.9658
110134	19.8639	19.0305	19.1891	19.3419
110135	17.3504	15.6668	18.5125	17.0191
110136	16.9629	20.7827	21.1235	19.3927
110140	17.7915	*	*	17.7915
110141	14.4935	13.2710	14.3027	14.0327
110142	13.9525	14.1203	16.3359	14.8326
110143	22.5926	22.4254	23.5876	22.8713
110144	17.5112	17.5678	18.9425	17.9918
110146	17.1835	17.8499	17.2250	17.4052
110149	32.1975	25.2525	25.3618	27.1829
110150	21.2909	22.8322	22.7366	22.3193
110152	15.1324	16.3837	16.3352	15.9536
110153	20.5068	20.6972	21.5300	20.9068
110154	17.3761	16.5286	*	16.9482
110155	16.5146	16.4756	16.1785	16.4073
110156	16.3876	16.0759	*	16.2355
110161	22.2861	24.5776	26.1275	24.4282
110163	18.6637	20.1183	21.9411	20.2136
110164	21.2160	22.6605	23.7801	22.5540
110165	20.8030	22.5604	23.1047	22.2007
110166	20.5049	22.3822	23.6665	22.0307
110168	21.8058	22.3181	23.3426	22.5338
110169	22.6648	23.3750	24.7083	23.5314
110171	25.5296	24.5313	32.6386	27.7697
110172	23.6803	24.7005	25.2396	24.5635
110174	14.6199	*	*	14.6199
110177	21.2796	22.7831	24.4715	22.8933
110179	22.0767	24.3673	26.1423	24.1256
110181	12.9798	13.9591	34.9028	19.4061
110183	22.5148	24.2899	26.4248	24.4133
110184	22.1920	22.2761	24.3379	22.9563
110185	17.7925	17.3330	19.1991	18.0592
110186	18.3178	19.7172	21.1176	19.7561
110187	19.8419	22.8248	23.2571	21.8964
110188	23.7032	22.0258	*	22.7714
110189	20.8786	19.8454	21.4255	20.7155
110190	18.3649	20.7292	20.5708	19.8383
110191	21.4033	21.3404	23.8471	22.2253
110192	21.0486	22.9684	24.3823	22.8864
110193	20.7867	22.1477	25.1779	22.7067
110194	14.8115	15.8129	16.8075	15.8165
110195	12.7261	10.9444	13.7718	12.4602
110198	24.8646	24.8275	28.0634	25.9885
110200	17.7744	17.9631	19.4363	18.4074
110201	20.9497	21.9313	23.7261	22.1742
110203	22.7453	24.2062	23.3838	23.4874
110204	30.7342	35.3699	*	32.7584
110205	21.3617	20.1405	23.1969	21.5575
110207	14.7154	14.6045	14.7077	14.6752
110208	15.6161	15.0350	*	15.3251
110209	18.6404	20.0629	14.4751	17.7558
110211	26.9151	20.1024	*	22.9486
110212	14.3790	15.8420	18.7651	16.2466
110215	18.1539	21.0263	.5679	20.7523
110216	27.1878	*	*	27.1877
120001	29.0427	29.4126	30.0871	29.5170
120002	25.2021	23.5667	24.2715	24.3269
120003	23.9115	24.6238	24.4013	24.3140
120004	24.8632	26.1398	26.8010	25.9297

* Denotes wage data not available for the provider for that year.
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TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
120005	24.1662	22.3213	23.0113	23.1311
120006	25.8943	26.6302	28.1562	26.8635
120007	22.8772	22.7179	27.8497	24.2388
120009	16.4485	16.7630	13.9812	15.7613
120010	24.1923	24.9089	25.4050	24.8421
120011	37.2759	35.2051	30.9308	34.0921
120012	21.8507	22.0371	21.8997	21.9292
120014	24.1208	25.3557	25.3682	24.9359
120015	42.6465	*	24.6284	30.4099
120016	45.1899	43.5083	39.1160	42.7373
120018	31.1879	*	*	31.1877
120019	25.5659	23.8535	24.4036	24.5914
120021	23.1839	36.8286	23.2759	26.4621
120022	19.2614	22.2781	22.4951	21.2033
120024	32.2514	21.9657	*	26.7529
120025	50.6376	40.1332	40.2485	43.1574
120026	25.1314	25.7023	26.3653	25.7684
120027	24.4535	23.1434	24.9464	24.1547
120028	27.0897	27.5365	29.5070	28.0817
130001	17.6306	19.6328	18.4733	18.5954
130002	16.9867	18.5746	20.1143	18.6076
130003	22.3430	23.0994	23.9403	23.1432
130005	21.2386	22.6364	24.4844	22.7104
130006	20.4614	21.4640	22.8567	21.6494
130007	21.8107	22.0894	22.8475	22.2657
130008	13.6018	19.3392	25.7798	18.7207
130009	15.9701	20.8748	18.3511	18.2768
130010	17.5119	17.7826	*	17.6552
130011	20.1147	22.1125	23.1120	21.7785
130012	24.9976	24.2451	22.5761	23.9471
130013	15.1129	22.6624	23.5316	20.2820
130014	19.2107	19.8240	21.6770	20.2852
130015	18.5913	16.4136	*	17.4135
130016	19.0516	20.1220	20.5728	19.9684
130017	19.6875	19.9511	20.3656	20.0262
130018	19.8425	20.0563	22.1899	20.7223
130019	19.1711	19.5147	20.3983	19.7057
130021	15.6155	14.4430	16.8582	15.5456
130022	18.9127	19.7814	21.5602	20.1253
130024	19.0703	19.9934	22.1611	20.4440
130025	16.4627	17.5989	18.7814	17.6827
130026	21.8106	23.2093	24.4976	23.1615
130027	20.5344	20.6641	22.0107	21.0236
130028	20.9674	21.2217	21.1492	21.1146
130029	18.7694	22.9243	*	20.4335
130030	17.5759	18.5827	*	18.0583
130031	16.7766	20.4146	23.5135	19.8631
130034	18.9483	20.5802	20.2401	19.9098
130035	20.7770	17.2864	*	19.1660
130036	13.6362	15.1590	18.5921	15.7605
130037	18.6856	19.2108	19.3979	19.1230
130043	16.7904	17.6920	18.4636	17.6040
130044	13.4513	18.7067	20.5584	17.5508
130045	19.0208	17.5152	19.0271	18.5109
130048	16.7900	*	*	16.7900
130049	22.4440	22.0520	23.7212	22.7595
130054	17.7085	16.4675	16.8484	16.9601
130056	20.9476	28.8008	17.3947	21.1836
130060	22.7399	23.2512	24.6773	23.5532
130061	14.7394	*	*	14.7393
130062	19.8157	19.8264	24.0494	21.3157
130063	18.8024	18.4797	18.8782	18.7287
140001	17.7990	18.1511	20.0247	18.6600

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
140002	19.9284	20.9959	22.5567	21.1478
140003	17.8595	18.0163	*	17.9385
140004	17.4574	18.9713	19.3237	18.5860
140005	12.3002	12.4144	13.2365	12.6493
140007	23.8585	24.9847	25.1836	24.6934
140008	22.1111	24.2634	26.3152	24.1972
140010	28.5635	28.0863	39.3621	32.1479
140011	18.6164	18.4052	19.0903	18.7086
140012	21.4374	22.5885	24.4070	22.8406
140013	19.6722	20.3147	19.9800	19.9935
140014	21.4042	22.2944	25.0616	22.9171
140015	17.6805	20.3540	21.4328	19.8233
140016	14.4938	15.4454	16.3417	15.3940
140018	22.4132	23.4062	24.3285	23.3864
140019	16.4254	16.1180	17.4206	16.6387
140024	15.3782	16.1032	*	15.7337
140025	18.5135	21.7775	18.0748	19.4744
140026	18.3220	19.7839	20.4084	19.5156
140027	19.2149	20.5980	20.9855	20.2413
140029	26.0833	28.5670	25.5253	26.6612
140030	23.1760	25.3715	26.5229	25.0851
140031	17.6067	16.9650	17.7449	17.4509
140032	19.0383	19.8033	20.6273	19.8411
140033	25.1639	22.8705	23.4279	23.7474
140034	19.8792	19.7711	20.9635	20.1903
140035	15.5040	17.4514	17.9641	16.9828
140036	19.1076	21.2366	18.5788	19.7025
140037	14.1083	14.3082	15.5578	14.6732
140038	18.4948	19.8197	*	19.1560
140040	16.7450	18.0342	19.2160	18.0347
140041	18.5952	18.8042	19.2893	18.8908
140042	15.8892	16.1157	17.1757	16.3886
140043	20.1176	21.7356	23.3751	21.8035
140045	17.7799	17.4261	18.9587	18.0683
140046	18.6371	20.0859	21.7969	20.2134
140047	13.3610	16.6672	17.7090	15.6942
140048	23.9545	23.8652	25.9122	24.5813
140049	26.9483	26.7160	20.7688	24.9027
140051	24.0796	24.7180	24.2472	24.3525
140052	17.9571	21.0450	21.6607	20.0955
140053	19.9620	20.9768	22.6099	21.1760
140054	23.1576	23.9459	35.5659	27.3968
140055	14.3603	15.8756	16.4409	15.4892
140058	18.6861	19.1199	20.5089	19.4559
140059	*	18.2593	21.9969	19.9435
140061	18.2039	18.4264	22.7791	19.6252
140062	28.5304	28.6390	30.7005	29.3149
140063	29.1453	29.6998	30.5430	29.8595
140064	18.9379	19.6954	20.6505	19.7669
140065	25.3336	25.5939	25.8676	25.6079
140066	13.6491	15.4818	18.0915	15.5544
140067	19.5292	20.7511	21.9579	20.7435
140068	21.6188	22.3622	24.1316	22.6861
140069	17.3879	17.7785	19.0441	18.0826
140070	22.7153	25.2646	25.2960	24.2944
140074	21.6052	22.2563	22.8249	22.2227
140075	21.6434	21.8472	26.5350	22.9476
140077	17.3647	17.3236	18.0487	17.5877
140079	23.6928	22.7046	25.7058	24.0319
140080	22.1968	22.0682	24.4056	22.8890
140081	16.9808	18.1746	*	17.5725
140082	29.7262	26.5960	25.0474	26.9608
140083	21.0330	20.7704	23.2822	21.6156

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
140084	22.3467	23.0263	25.4818	23.6135
140086	19.1613	19.1815	*	19.1714
140087	17.1147	21.4593	*	19.1145
140088	25.4176	26.5258	27.7274	26.5193
140089	18.3157	19.3230	20.7632	19.4616
140090	26.9364	28.0530	35.0300	29.4280
140091	21.9322	23.5559	23.7560	23.1453
140093	20.1528	20.7564	21.5376	20.7969
140094	21.9383	22.8892	23.7841	22.8588
140095	24.2859	25.5716	25.4815	25.1248
140097	21.1719	21.8418	23.8291	22.4038
140100	23.1399	23.8226	27.1868	24.8138
140101	21.4211	23.1418	24.6106	23.0966
140102	17.5729	18.6328	19.8678	18.6663
140103	18.1303	19.1834	21.3727	19.5392
140105	22.8944	23.8258	27.3323	24.5505
140107	11.8383	11.5827	*	11.7127
140108	26.9971	27.9140	*	27.4761
140109	14.5498	15.9178	16.4262	15.6166
140110	19.2888	20.9631	21.9129	20.7530
140112	17.6974	18.1119	19.8563	18.5020
140113	19.5584	26.2393	25.2205	23.4083
140114	21.0976	23.0383	24.1926	22.8235
140115	21.0433	20.4587	25.3410	22.2094
140116	23.8993	25.5980	26.8366	25.5062
140117	21.4876	22.0889	23.3536	22.3483
140118	24.3260	25.3249	26.1627	25.2644
140119	27.9145	30.6468	31.3486	29.9292
140120	17.9716	17.7667	20.3237	18.6579
140121	16.6993	16.2607	17.6019	16.8238
140122	26.1270	26.7882	26.7457	26.5545
140124	27.9813	30.6820	30.7744	29.7761
140125	16.9516	17.8190	19.5359	18.0996
140127	20.0489	20.8397	21.3102	20.7463
140128	23.1327	23.5481	*	23.3351
140129	20.2868	21.6252	21.6495	21.1744
140130	23.4298	26.0464	25.7324	25.1138
140132	23.3054	23.7046	23.0595	23.3426
140133	21.4166	20.1740	21.0993	20.9011
140135	17.3985	18.2479	19.3222	18.3661
140137	18.6330	20.4807	21.6017	20.2583
140138	17.1968	14.5771	14.2313	15.2378
140139	11.0397	*	20.2063	14.6320
140140	17.6845	18.8185	19.1636	18.5459
140141	19.1097	20.2606	20.3707	19.9234
140143	19.0810	19.9885	22.0009	20.2373
140144	22.2864	24.8854	26.9259	24.6726
140145	18.1788	19.4509	20.6142	19.4469
140146	19.9704	19.4272	*	19.6862
140147	18.8049	17.1013	18.2691	18.0420
140148	18.7730	19.7630	21.5777	20.0626
140150	24.7976	28.9853	33.5463	28.8474
140151	20.0310	20.8820	21.5167	20.8051
140152	25.6011	28.3946	28.6284	27.5483
140155	20.2778	24.2907	24.4956	22.9401
140158	22.7988	23.7428	23.6949	23.4182
140160	17.7921	19.8825	20.9016	19.5649
140161	20.3799	21.2045	22.2191	21.3060
140162	20.3452	21.6901	22.6426	21.5722
140164	18.6589	19.8246	19.7774	19.4344
140165	14.7223	16.3700	17.0665	16.0112
140166	18.3833	19.3672	20.4085	19.3581
140167	17.6525	18.8532	19.5959	18.7351

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
140168	17.7453	18.2896	19.6114	18.5329
140170	16.4107	17.6901	17.0666	17.0536
140171	15.0237	15.2617	17.3214	15.8617
140172	23.6262	24.8587	24.2924	24.2266
140173	16.3924	16.0030	32.8692	19.8554
140174	35.9320	22.0418	21.7356	24.5213
140176	24.5338	26.3468	25.6824	25.5437
140177	15.0827	20.3142	20.8526	18.2773
140179	21.9859	22.7345	23.9872	22.8894
140180	22.7996	22.7508	25.4497	23.6328
140181	21.9864	22.6643	23.2767	22.6706
140182	28.9515	25.1302	32.1969	28.8546
140184	17.2401	17.9169	20.6843	18.6331
140185	18.2867	18.8573	20.0931	19.0822
140186	23.5034	25.6807	29.0998	26.0890
140187	18.3331	19.4049	20.7319	19.4734
140188	16.1907	*	*	16.1907
140189	20.6627	21.1515	22.5875	21.4411
140190	17.5263	16.6673	17.9194	17.3611
140191	25.2628	27.4166	24.5446	25.6579
140193	17.4057	18.5651	20.5958	18.8417
140197	19.3774	19.9406	19.2979	19.5430
140199	18.0450	18.5409	19.7888	18.7992
140200	21.7680	22.4626	24.1358	22.8115
140202	23.7955	25.2777	26.2460	25.1620
140203	21.0848	24.8870	26.6624	24.2960
140205	20.0784	*	25.1010	22.9703
140206	22.5109	22.8223	24.8824	23.3989
140207	22.3905	25.4539	23.3197	23.6919
140208	26.2527	28.3112	27.2009	27.2556
140209	20.1557	20.2433	22.0813	20.8567
140210	14.8248	15.5345	*	15.2105
140211	22.6265	22.8852	25.8603	23.8157
140213	24.9892	25.6839	27.4607	26.0827
140215	15.2893	18.5502	18.6962	17.4895
140217	25.7329	25.9030	24.7146	25.4260
140218	14.9851	17.4171	*	16.1590
140220	17.8450	19.3915	20.2803	19.2049
140223	24.9017	26.2168	27.4355	26.1911
140224	32.8292	25.6766	31.4716	29.8171
140228	20.1688	21.8627	22.9899	21.6593
140230	18.2983	12.3494	*	14.8541
140231	24.5019	26.0208	25.5536	25.3988
140233	21.2333	24.4419	24.7103	23.5150
140234	*	19.7266	20.8676	20.3084
140236	12.9253	*	*	12.9252
140239	20.3745	21.6074	23.9213	21.9721
140240	24.6949	25.1418	25.0325	24.9609
140242	25.2317	26.1850	26.7947	26.1303
140245	14.2481	15.1320	15.2537	14.8687
140246	11.6267	15.0650	16.1305	14.1116
140250	23.6449	25.3410	24.7737	24.5985
140251	21.9435	23.5128	24.8256	23.4339
140252	25.0220	26.4715	27.4640	26.3370
140253	19.5858	18.4567	*	19.0172
140258	25.3622	25.0743	27.8202	26.1250
140271	12.0079	16.0350	17.5175	14.8913
140275	23.8171	22.9656	20.1784	22.2596
140276	25.3134	26.1713	25.1140	25.5042
140280	18.8300	20.0763	21.7004	20.2210
140281	25.2719	26.5197	27.9115	26.6261
140285	18.5916	15.7435	*	17.0403
140286	26.1290	24.0368	25.9931	25.3447

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
140288	24.4331	25.8717	26.2186	25.5431
140289	18.1747	17.7886	21.3632	19.1491
140290	22.8590	26.5055	30.7221	26.7335
140291	24.9537	26.8628	26.7900	26.2319
140292	21.9950	26.8610	26.0858	25.0061
140294	17.7301	19.4218	20.5969	19.2265
140300	27.8436	28.9830	30.2598	29.0524
150001	24.0620	22.6875	25.4897	24.1367
150002	20.7651	20.7353	22.3327	21.2734
150003	20.8636	21.4649	21.0944	21.1408
150004	21.2449	22.8060	23.5250	22.4800
150005	21.6806	22.8149	23.8818	22.8498
150006	20.6523	21.8435	23.1779	21.9153
150007	20.6635	21.2811	22.1098	21.3541
150008	21.8457	23.0208	23.8916	22.9022
150009	19.0030	19.5869	19.1857	19.2602
150010	20.5570	21.2466	22.5445	21.4807
150011	18.3275	19.9096	22.1760	20.1162
150012	22.1402	21.7903	23.1644	22.3790
150013	16.9327	17.5531	19.8564	18.1751
150014	21.5168	22.8402	24.3754	22.8817
150015	21.9037	24.2370	21.1839	22.3970
150017	19.5339	20.6758	22.7670	21.0275
150018	21.0496	22.8922	24.6138	22.9251
150019	17.8585	19.8341	17.7411	18.4067
150020	16.6600	15.9405	18.4688	17.0524
150021	21.5944	23.3800	24.3658	23.1607
150022	17.9222	18.7751	22.2973	19.8109
150023	19.3412	20.3015	20.7199	20.0985
150024	19.2295	19.8368	21.5661	20.1308
150025	20.2750	*	*	20.2750
150026	22.4978	21.9448	23.2169	22.5611
150027	18.0335	19.4238	21.5325	19.7090
150029	23.2454	24.8939	25.2067	24.4325
150030	19.2406	20.7256	22.2537	20.7871
150031	18.3463	21.3494	18.3291	19.2245
150033	22.6741	23.0756	24.1718	23.2965
150034	23.1533	23.3718	22.8812	23.1378
150035	21.2374	22.3779	23.5468	22.3841
150036	21.4567	22.1464	22.4098	21.9941
150037	24.4611	22.3699	26.4359	24.3457
150038	22.0572	20.3454	21.6608	21.3217
150039	19.6215	16.0227	19.2708	18.1689
150042	20.2221	18.0185	23.6783	20.4220
150043	20.1741	20.6301	20.8562	20.5460
150044	19.1309	19.8951	20.7412	19.9259
150045	18.1670	20.6406	22.9339	20.5458
150046	18.2543	19.4146	20.3453	19.3721
150047	22.0145	21.9824	24.8712	22.8866
150048	19.1648	21.1441	22.5181	20.9965
150049	18.6451	21.6309	18.4989	19.5784
150050	17.7354	18.0411	18.0624	17.9423
150051	19.7257	20.6895	22.0106	20.8739
150052	17.3750	18.8345	19.1070	18.4211
150053	18.8632	18.3493	19.4966	18.9082
150054	18.3916	19.3424	*	18.8632
150056	21.5774	23.0603	24.5540	23.0525
150057	16.9736	17.4044	28.0884	20.1891
150058	22.1409	23.0273	24.9479	23.3727
150059	22.7360	23.1398	24.5716	23.4998
150060	18.6159	19.5011	19.8990	19.3356
150061	19.7968	19.4014	17.5585	18.7895
150062	20.8274	21.2608	22.9214	21.6432

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
150063	22.6525	24.8587	28.5326	25.3429
150064	20.3865	20.6232	21.2512	20.7527
150065	21.2153	21.4572	23.0636	21.9337
150066	19.5313	19.6845	20.7240	20.0045
150067	18.8862	20.5000	21.4374	20.3431
150069	23.3969	23.5510	23.8869	23.5811
150070	18.0827	18.9332	20.7413	19.2893
150071	13.5111	16.4179	19.4530	16.5251
150072	15.0765	18.5813	18.5447	17.3134
150073	*	19.8034	14.8287	16.6860
150074	20.2305	21.3500	22.9598	21.5274
150075	16.7532	17.2267	20.0897	17.8847
150076	22.6424	23.3724	25.4519	23.8726
150078	19.9668	20.2068	20.1260	20.1068
150079	18.2051	18.3668	19.3860	18.6860
150082	17.8381	19.6881	20.7334	19.4332
150084	24.3107	24.9529	27.8354	25.7663
150086	18.3838	19.7763	21.5815	19.9584
150088	20.3366	22.3055	22.2627	21.6628
150089	22.1725	21.5664	21.4993	21.7481
150090	21.0945	21.9803	24.7940	22.5227
150091	22.4640	26.5235	26.4248	25.0867
150092	16.9179	18.2592	16.7372	17.2915
150094	17.5244	16.8351	19.5004	18.0298
150095	19.2749	22.3214	23.5231	21.7410
150096	20.8204	*	19.7975	20.2623
150097	19.7751	21.1462	22.3593	21.2002
150098	15.2829	16.4763	17.8106	16.4972
150100	19.8066	18.7289	21.2980	19.8754
150101	20.6209	21.2025	26.1272	22.4675
150102	23.7180	20.8818	21.3313	21.8627
150103	18.7036	19.3653	17.9684	18.6804
150104	20.0765	21.3141	21.0799	20.8409
150105	22.4412	21.6975	23.9540	22.7002
150106	16.8714	18.7088	19.1976	18.3084
150109	19.9066	21.7870	23.4642	21.7343
150110	21.9336	*	*	21.9336
150111	19.2355	24.1559	*	21.5147
150112	20.5253	22.1939	23.5151	22.0747
150113	19.6603	20.5871	21.2412	20.5276
150114	17.9877	18.3097	*	18.1462
150115	18.4844	18.1308	21.5042	19.3163
150122	17.7867	20.7540	22.2752	20.2587
150123	14.0508	16.2898	15.5997	15.3438
150124	15.9487	16.2104	17.9062	16.6729
150125	21.3311	22.0299	23.1015	22.1704
150126	20.6857	24.0000	24.1917	22.8979
150127	17.0052	18.0532	*	17.5279
150128	19.5576	20.4742	20.9869	20.3528
150129	28.6211	29.9888	34.3166	30.8814
150130	18.4846	18.3852	18.5578	18.4750
150132	20.9443	21.2747	22.2707	21.4967
150133	18.4250	20.0320	21.8167	20.0930
150134	19.3632	20.2764	20.7680	20.1127
150136	21.8097	22.9091	25.8467	23.5584
150146	19.0204	*	25.1827	22.2199
150148	*	*	26.2190	26.2188
160001	19.0085	20.1699	22.8425	20.6574
160002	16.6003	17.6600	19.9607	18.0502
160003	16.2208	17.5429	17.5050	17.1062
160005	17.9405	19.3348	20.3313	19.1990
160007	15.1738	14.9137	*	15.0384
160008	16.6193	16.7863	17.9463	17.1044

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
160009	17.9886	19.0664	20.5800	19.2128
160012	16.7112	17.9236	17.2718	17.2909
160013	18.6304	20.3023	21.0541	20.0165
160014	16.7146	18.7253	18.3097	17.9036
160016	19.9747	21.6050	21.8400	21.1711
160018	15.6141	16.0793	16.8377	16.1872
160020	15.5384	15.7960	16.6092	15.9961
160021	16.7617	16.7920	17.2152	16.9236
160023	15.0099	15.3854	16.9777	15.7718
160024	19.4764	20.5622	22.1034	20.6927
160026	19.5260	20.4567	22.8967	20.9474
160027	16.9417	18.2081	18.9985	18.0413
160028	21.0000	22.9000	25.4337	23.0923
160029	21.3457	22.2106	23.6148	22.4178
160030	19.6182	21.6899	23.3687	21.5386
160031	16.1267	16.8957	17.8994	16.9687
160032	18.3168	19.2464	20.5024	19.3173
160033	18.8859	20.1916	21.8778	20.2846
160034	16.5957	17.3644	19.0684	17.6441
160035	16.3991	17.0165	*	16.6797
160036	17.4558	20.2598	*	18.9565
160037	19.5045	19.5067	20.6425	19.8844
160039	17.8647	19.1998	19.8851	19.0101
160040	18.0667	19.6339	20.0567	19.2064
160041	17.4435	18.7943	*	18.1971
160043	14.8564	16.7841	15.5765	15.7233
160044	17.8323	19.5552	19.0956	18.8738
160045	20.0611	21.4757	22.1285	21.2575
160046	16.2737	16.8665	*	16.5694
160047	19.0787	20.4259	22.0610	20.5906
160048	15.6856	17.2709	17.7273	16.8247
160049	15.5673	15.3233	20.5531	16.9039
160050	17.7878	21.1184	21.6247	20.1164
160051	16.4261	15.8213	14.0556	15.4076
160052	21.7647	22.1933	22.2409	22.0595
160054	16.1981	16.5258	15.9074	16.2107
160055	15.1674	17.6177	14.5971	15.6313
160056	17.0172	17.9534	19.6493	18.1612
160057	19.1378	19.6802	20.8345	19.9113
160058	22.1061	22.2812	23.5663	22.6513
160060	17.2825	17.7489	18.1102	17.6991
160061	17.0938	17.2064	18.0413	17.4625
160062	17.4388	18.8163	22.6687	19.5483
160063	16.3583	17.3771	17.9229	17.2470
160064	22.2131	25.2962	23.8367	23.7172
160065	17.1043	17.0609	*	17.0808
160066	17.9971	19.3202	20.4609	19.2300
160067	16.7833	17.6602	19.9422	17.9572
160068	19.0572	20.5995	23.4967	21.0271
160069	19.1640	20.5989	21.7197	20.4818
160070	18.4588	17.7855	20.3683	18.7886
160072	14.4141	15.3384	15.6894	15.1633
160073	11.4997	15.5946	16.2186	14.2046
160074	17.9513	18.4624	22.2989	19.4707
160075	18.4613	20.7842	21.9161	20.2495
160076	17.8824	19.1590	20.1603	19.0456
160077	13.6658	15.0468	16.8030	15.1869
160079	18.6333	20.5010	21.6562	20.2670
160080	19.4925	19.6680	21.1713	20.1081
160081	17.4466	19.1442	20.4415	18.9934
160082	19.5322	20.7306	21.3139	20.5262
160083	19.7542	21.3221	23.1417	21.3360
160085	21.2557	19.1929	*	20.1491

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
160086	17.5308	19.0477	19.8991	18.7925
160088	22.3655	23.8098	25.3429	23.8526
160089	17.3449	18.3526	19.9688	18.5909
160090	17.9614	18.4210	19.6767	18.6779
160091	14.2573	14.8904	16.1660	15.1176
160092	17.0633	17.9251	20.4731	18.4608
160093	18.5675	19.5732	22.8552	20.0542
160094	17.6094	18.7835	20.3433	18.9270
160095	15.2722	16.4927	*	15.8700
160097	16.6790	17.7860	17.7992	17.4211
160098	16.8670	16.8997	17.9906	17.2476
160099	15.0880	16.0710	17.5828	16.2056
160101	18.9788	19.6314	22.1741	20.2613
160102	20.1161	14.4837	*	17.0012
160103	18.2741	19.6168	22.4647	20.1210
160104	17.4829	21.0060	23.2738	20.6777
160106	17.3474	19.4385	19.8906	18.8668
160107	18.0097	18.8936	19.5110	18.7905
160108	16.7779	17.7577	19.6390	18.0443
160109	17.9873	18.2938	18.5126	18.2742
160110	20.6215	20.9959	21.9299	21.2145
160111	14.9965	15.1104	16.7625	15.6341
160112	17.2450	19.6950	20.4038	19.1223
160113	15.4834	14.9449	16.7574	15.7259
160114	16.5006	18.0532	19.1743	17.9155
160115	16.5654	16.9991	17.6815	17.0701
160116	16.6993	18.4261	19.6923	18.2708
160117	18.7615	20.1682	22.3228	20.3906
160118	19.4472	17.1480	16.9466	17.7185
160120	15.6789	15.0577	15.9432	15.5897
160122	18.1469	18.8469	21.2843	19.4799
160124	19.1600	19.9144	21.2279	20.1448
160126	19.4903	17.8643	20.0149	19.0751
160129	17.2112	18.0113	18.1304	17.7899
160130	15.6666	16.2628	17.4584	16.4856
160131	16.0424	16.5397	18.0499	16.8700
160134	15.3012	14.6396	17.0092	15.5453
160135	18.7711	18.3973	18.7512	18.6539
160138	17.1491	18.3957	17.8475	17.7631
160140	18.5630	19.6155	22.1666	20.1522
160142	18.1467	17.2792	*	17.6980
160143	17.4497	18.1287	19.0623	18.2106
160145	16.9092	17.8887	18.4032	17.7185
160146	17.7010	19.0576	20.6638	19.0955
160147	19.4041	21.6062	22.7993	21.2446
160151	17.2177	18.3398	*	17.7679
160152	15.9500	17.0750	17.9285	16.9659
160153	21.2085	22.7004	23.5212	22.4610
170001	17.9218	18.5120	19.8150	18.7852
170004	16.1442	17.2262	18.6048	17.3314
170006	17.5982	19.1982	19.4488	18.7531
170008	16.8412	17.7061	18.2351	17.6303
170009	23.1349	25.0508	25.8246	24.6993
170010	19.4584	19.5990	20.6294	19.9051
170012	18.4432	20.2412	21.6824	20.1902
170013	19.4667	20.1852	21.4954	20.4080
170014	18.4931	19.6044	21.3084	19.7344
170015	17.1302	17.2443	18.0485	17.4844
170016	20.0675	22.1023	22.5856	21.5884
170017	19.5994	19.7908	21.8586	20.4248
170018	15.3237	14.8794	16.9170	15.7229
170019	16.9362	17.4699	18.7916	17.7083
170020	18.1325	19.1418	20.6658	19.3514

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
170022	19.1888	20.3269	21.1947	20.2097
170023	19.2441	19.6533	21.6273	20.2090
170024	14.3604	15.0081	16.1196	15.1666
170025	18.7182	19.1720	19.2124	19.0231
170026	14.8974	16.9094	17.0837	16.3226
170027	17.8690	18.4466	20.7776	19.0432
170030	15.9282	12.9413	14.4544	14.3349
170031	14.2151	16.4660	16.5916	15.7181
170032	16.3449	15.2207	16.1164	15.8915
170033	19.1952	20.4533	20.0065	19.9072
170034	16.9586	17.8239	18.1073	17.6353
170035	17.0945	19.8334	*	18.4676
170038	13.8582	15.2505	17.0172	15.4188
170039	17.0774	18.5780	18.4473	18.0348
170040	21.0617	23.1014	24.5234	22.7728
170041	12.4488	9.9263	13.9710	11.9108
170044	17.3254	*	*	17.3256
170045	25.8331	20.5454	18.4142	21.3297
170049	20.7921	21.2917	22.9404	21.7361
170051	16.4851	16.9003	16.8455	16.7442
170052	15.2283	16.0948	15.8809	15.7508
170053	14.6133	14.3628	14.5886	14.5203
170054	14.6354	15.2814	18.5239	16.1318
170055	18.2607	18.1783	*	18.2208
170056	18.3550	19.7369	17.1872	18.5237
170058	19.5415	20.1090	23.0649	20.9522
170060	18.9853	17.5290	17.9830	18.1586
170061	15.0258	15.6412	16.6852	15.7398
170063	14.1185	13.7611	17.2821	14.6657
170066	16.2891	16.8009	18.3113	17.1768
170067	14.9921	20.7945	*	17.6559
170068	17.0022	19.2629	20.5512	18.8725
170070	14.0627	14.8348	15.0540	14.6220
170072	12.7709	*	*	12.7710
170073	17.7056	17.7586	17.4493	17.6284
170074	17.3699	17.6543	18.5169	17.8689
170075	13.6816	14.4939	15.6809	14.6514
170076	14.6109	14.9392	16.0998	15.2083
170077	13.9104	14.1376	14.6378	14.2439
170079	11.5902	16.7227	*	13.7740
170080	14.8293	13.6794	15.0079	14.4977
170081	14.6823	15.0840	15.7141	15.0936
170082	13.7462	14.8154	15.9973	14.8264
170084	13.0519	13.6517	14.5770	13.7521
170085	17.5422	21.8907	17.2585	18.9901
170086	19.7182	20.7298	21.7451	20.7316
170088	13.4860	*	*	13.4860
170089	15.4860	20.2263	16.2599	17.5460
170090	10.9444	23.6837	16.3550	15.3916
170093	14.0276	14.7803	14.9660	14.5908
170094	21.2035	21.2484	20.1253	20.9151
170095	15.3532	16.1078	16.8686	16.1165
170097	17.7540	18.6023	18.9865	18.4524
170098	16.6210	17.3480	18.5181	17.4543
170099	14.3370	16.5247	15.8118	15.5495
170101	18.0143	17.3381	17.9291	17.7556
170102	14.2447	14.4499	14.6874	14.4627
170103	17.9530	18.6172	20.1264	18.9371
170104	21.0049	22.0671	22.6619	21.9115
170105	16.7403	18.2788	18.3824	17.8166
170106	17.7467	*	*	17.7468
170109	16.9782	18.3483	20.4661	18.7139
170110	18.5731	21.0637	16.5883	18.8196

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
170112	15.4049	15.8097	17.8740	16.3357
170113	14.6486	16.4938	19.9957	16.7158
170114	16.2645	13.9726	17.4687	15.7793
170115	12.9216	13.0253	13.6173	13.1746
170116	18.1830	19.4278	20.8800	19.4962
170117	16.8237	16.8301	17.5794	17.0795
170119	15.2708	15.1982	13.9828	14.8083
170120	17.4917	18.2832	18.7576	18.1504
170122	21.1769	21.4588	22.2681	21.6171
170123	23.6534	25.2122	25.0073	24.6043
170124	15.0596	16.3925	14.2191	15.2518
170126	13.5736	14.5527	15.4213	14.4901
170128	14.1676	17.6259	13.9704	14.9984
170133	18.8119	19.9778	20.0593	19.6138
170134	14.6799	15.1932	15.4176	15.0931
170137	19.3118	19.3344	21.4394	20.0379
170139	14.3001	14.8157	16.9180	15.1918
170142	17.7134	19.0547	19.6251	18.8022
170143	16.0415	16.3258	18.0308	16.8248
170144	20.4392	20.8488	23.9179	21.2803
170145	19.0142	20.1494	20.5099	19.8990
170146	21.7919	25.2520	27.0312	24.7198
170147	17.6717	18.4634	18.2480	18.1292
170148	19.1942	24.4828	26.3491	22.6386
170150	15.9072	14.9718	16.3723	15.7462
170151	14.3668	14.5002	15.7242	14.8570
170152	15.6423	16.0930	17.6328	16.4532
170160	14.4732	17.0629	*	15.6980
170164	17.4072	17.0791	18.4142	17.6451
170166	12.7507	16.5113	17.8131	15.5313
170171	13.1792	14.7051	14.7251	14.2074
170175	20.1907	20.8671	22.2203	21.0292
170176	23.5043	23.5743	25.5404	24.2059
170180	8.6352	*	25.0933	14.1579
170182	21.3454	21.9797	23.2115	22.1999
170183	19.5182	16.6577	19.6919	18.5350
170185	*	26.8136	26.5542	26.6930
170186	*	33.2457	28.4462	30.5174
170187	*	*	20.8289	20.8289
170188	*	*	25.2504	25.2504
170189	*	*	28.1999	28.1996
180001	20.4885	20.8169	22.2674	21.1866
180002	17.5798	19.8195	20.0075	19.1094
180004	17.7149	18.0494	19.8552	18.5287
180005	22.4634	23.4941	22.6704	22.8061
180006	10.3400	11.2872	14.4066	11.8905
180007	17.9491	18.6823	21.3545	19.3281
180009	21.0608	21.7746	22.4450	21.7873
180010	19.6311	19.4210	21.8916	20.3621
180011	19.0526	22.6798	19.2490	20.3535
180012	19.0646	19.6614	19.9227	19.5547
180013	19.7418	20.0950	21.0512	20.3043
180014	21.3361	23.0067	*	22.1047
180016	21.1458	19.7242	20.5203	20.4674
180017	15.6583	16.7649	18.0329	16.8060
180018	15.4892	18.1529	17.5670	17.0578
180019	17.8285	19.5953	20.8416	19.3979
180020	18.0111	19.4391	20.5659	19.3119
180021	17.0618	16.5376	17.6330	17.0802
180023	17.4717	19.0574	20.8869	19.1283
180024	16.5040	19.6313	22.3922	19.4653
180025	15.4180	17.1875	18.3306	16.9977
180026	15.0118	13.9959	15.5354	14.8403

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
180027	17.5286	19.6928	20.5017	19.2757
180028	15.7005	26.2220	19.7853	19.6547
180029	17.7248	20.0841	19.9084	19.2475
180030	17.9543	17.5043	19.5826	18.3704
180031	13.1848	17.1003	11.7847	13.7078
180032	17.2784	17.2362	17.6939	17.3857
180033	15.4131	17.0498	14.8047	15.7339
180034	16.3991	17.0349	16.4944	16.6481
180035	21.3666	22.4651	23.3685	22.4188
180036	20.1860	20.6951	22.2389	21.0630
180037	21.2184	21.0177	22.7893	21.7251
180038	18.5923	19.3837	20.6888	19.5760
180040	21.2229	22.2270	23.1648	22.2239
180041	16.3699	17.5950	19.1325	17.6429
180042	17.1519	15.5660	17.5774	16.7135
180043	14.6526	17.2414	20.7367	17.3094
180044	19.4984	21.1057	21.8163	20.8254
180045	20.8455	20.7498	22.1027	21.2441
180046	21.2080	21.6955	23.1139	22.0204
180047	18.6938	17.8625	17.8574	18.1198
180048	17.7816	18.3151	18.8537	18.3242
180049	16.5459	17.8418	18.5188	17.6210
180050	17.1493	19.4992	18.9891	18.5564
180051	17.5441	18.3028	18.6730	18.1921
180053	15.8994	17.3167	17.6239	16.9255
180054	20.0946	17.4354	19.1340	18.8876
180055	15.8422	16.6072	17.8704	16.7352
180056	17.5881	18.7038	19.4072	18.5962
180058	14.5355	14.8840	17.6126	15.5719
180059	14.7032	17.2542	17.7683	16.4865
180063	12.4448	14.7338	15.5077	14.2770
180064	15.5066	16.3894	21.1067	17.5598
180065	11.1934	11.0966	9.9166	10.8002
180066	19.8956	20.7907	21.1883	20.6121
180067	20.1712	20.2762	21.5671	20.6602
180069	16.2916	19.0836	19.5693	18.2811
180070	15.9362	15.4643	16.9892	16.1274
180072	17.2347	17.0576	17.5411	17.2563
180078	21.7116	23.7765	23.4616	23.0019
180079	15.9048	18.1683	18.0472	17.3416
180080	16.6428	17.6735	18.8793	17.7518
180087	15.6089	16.2378	16.4726	16.1124
180088	22.1774	22.8908	22.9130	22.7063
180092	18.3597	18.8964	19.6790	18.9885
180093	17.8492	17.7592	18.8469	18.1473
180094	13.6233	14.3306	15.7641	14.5357
180095	13.9050	15.4478	15.9881	15.0485
180099	13.2991	14.0464	14.0115	13.7738
180101	*	21.0704	21.7454	21.4083
180102	18.5240	18.8169	20.1259	19.1237
180103	20.3490	20.9598	21.3867	20.8948
180104	19.3922	20.2731	21.3866	20.3724
180105	16.6997	18.2976	18.3521	17.7554
180106	15.2895	15.5278	15.4937	15.4371
180108	14.4740	14.8720	16.7327	15.3846
180115	16.9096	18.0951	19.2396	18.0795
180116	18.6077	19.2389	20.5453	19.4231
180117	23.0192	20.7961	17.8273	20.4194
180118	16.9250	17.9017	18.3618	17.7402
180120	15.3115	16.4226	20.4507	17.0636
180121	20.0494	16.9570	16.9881	17.9386
180122	18.1930	18.7549	26.1085	21.0314
180123	21.1067	21.5962	*	21.3452

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
180124	18.8487	19.7138	20.5265	19.6910
180125	14.9314	22.6609	18.2048	17.7710
180126	14.3551	14.8501	14.5644	14.5905
180127	17.6365	18.0498	19.9846	18.6169
180128	18.2817	18.7194	19.8756	18.9809
180129	22.3536	15.6637	14.1861	16.9914
180130	20.6450	21.9413	23.4841	22.0517
180132	19.5884	19.8393	19.9358	19.7903
180133	21.7800	23.2679	*	22.4729
180134	14.5387	16.5901	*	15.5000
180138	20.2102	19.8524	22.8363	20.9918
180139	20.5350	20.3816	20.6987	20.5422
180140	15.2719	14.6466	16.9631	15.5822
180141	23.8930	20.3404	22.5552	22.1339
180142	20.7510	*	*	20.7510
180143	*	21.3197	19.7662	20.5610
190001	18.1514	18.8583	20.4946	19.2128
190002	19.8834	20.6057	21.0138	20.5155
190003	19.9121	19.5115	20.7504	20.0615
190004	18.3620	19.6755	20.5272	19.5326
190005	17.5161	19.0994	19.8177	18.7716
190006	17.5911	17.7333	18.7928	18.0215
190007	14.4720	16.3633	17.9392	16.3508
190008	19.2456	22.4797	20.3099	20.6400
190009	15.9731	16.0395	17.5144	16.4753
190010	16.5020	17.7616	18.1797	17.4941
190011	15.6351	15.7319	15.4699	15.6120
190013	15.5019	16.7770	*	16.1202
190014	17.8015	18.6929	*	18.2302
190015	18.9896	19.7673	20.5905	19.7878
190017	17.5381	19.8449	18.3528	18.5693
190018	11.1898	13.1355	18.6199	13.8655
190019	18.3788	18.7344	20.8052	19.3372
190020	17.6840	18.7252	18.5659	18.3279
190025	16.8686	18.1892	19.9177	18.2844
190026	18.5015	19.0130	19.9178	19.1653
190027	17.4761	18.4070	19.5358	18.4507
190029	19.1967	18.7344	18.1118	18.6759
190034	18.0754	19.2007	*	18.6247
190036	20.0300	21.2960	23.3903	21.5497
190037	19.9878	14.1323	15.6062	16.9453
190039	19.0376	18.7625	20.4160	19.3991
190040	21.7376	23.1819	22.9262	22.6065
190041	17.9535	19.5511	21.9983	19.8665
190043	15.5618	15.5645	15.7333	15.6215
190044	17.4471	17.6788	17.7460	17.6341
190045	21.2853	22.0065	22.8709	22.1191
190046	20.4458	20.2414	21.1659	20.6024
190048	16.8136	16.6848	18.1698	17.2383
190049	17.7417	18.5902	19.3768	18.5593
190050	16.2854	16.9053	18.6663	17.3158
190053	13.0080	13.4768	13.8037	13.4554
190054	18.9059	17.7269	19.9370	18.8703
190059	15.8373	17.8651	18.3334	17.3742
190060	17.8443	19.9121	20.2207	19.3688
190064	18.2466	19.7215	21.0488	19.7211
190065	18.3091	18.3280	20.3583	19.0184
190071	16.4138	16.3822	17.8444	16.8680
190077	16.5536	16.8829	17.0480	16.8252
190078	16.9383	19.5879	19.8607	18.8295
190079	17.9403	18.8187	*	18.3869
190081	14.9707	14.7919	11.4756	13.7796
190083	18.4951	16.2970	18.4954	17.7997

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
190086	16.5074	17.6237	18.2005	17.4309
190088	19.9362	20.4725	18.6738	19.7186
190089	15.0395	15.2055	15.5151	15.2626
190090	16.2351	19.8201	19.0519	18.4143
190095	17.3258	17.3637	16.9519	17.2138
190098	21.0847	21.4328	20.7537	21.0874
190099	19.0635	19.0545	23.1606	20.4338
190102	20.7870	21.1614	22.0190	21.3440
190103	14.4158	15.6415	*	15.0851
190106	18.5908	19.9117	20.3114	19.6058
190109	15.8187	16.3641	16.6515	16.2945
190110	15.7313	15.2652	16.5007	15.8208
190111	20.6508	21.3622	24.4380	22.2154
190112	22.0741	24.2806	*	23.0835
190113	*	19.0411	*	19.0411
190114	13.9209	13.5044	13.6101	13.6758
190115	22.7583	24.0098	25.4983	24.0285
190116	17.3757	18.3223	*	17.8596
190118	16.3776	17.8543	17.5060	17.2223
190120	17.2309	17.6708	18.5094	17.7933
190122	15.3742	16.7189	17.7811	16.6133
190124	20.1206	22.8245	21.9308	21.6225
190125	19.8298	20.1401	21.5692	20.4994
190128	20.8770	21.5869	23.8786	22.1716
190130	14.0379	14.5586	15.2678	14.6311
190131	18.8958	19.7483	21.3154	20.0242
190133	15.1393	15.7834	13.4062	14.7514
190134	12.4507	*	*	12.4507
190135	21.3454	23.0213	24.5472	22.9404
190136	15.1662	15.6286	16.7852	15.8135
190140	14.6829	14.8738	15.4029	14.9883
190142	16.2280	19.0464	22.5765	19.3164
190144	18.4405	18.3513	21.3838	19.3822
190145	16.2505	16.4402	17.4407	16.7345
190146	21.9607	20.9312	22.1502	21.6747
190147	14.7202	15.2732	16.3596	15.4387
190148	15.5338	19.4518	19.3245	17.9652
190149	16.4722	16.5153	18.4197	17.1004
190151	15.5210	16.2783	17.3402	16.3739
190152	22.0319	22.7142	25.1136	23.3179
190156	16.0442	17.6573	18.0528	17.2654
190158	20.4078	21.6307	23.2361	21.7367
190160	18.4662	19.3139	19.8734	19.2722
190161	15.9280	15.7807	27.3615	18.5292
190162	20.1962	20.9645	20.7350	20.6423
190164	18.2379	19.0473	*	18.6694
190167	17.7611	15.5795	*	16.5290
190170	14.5222	16.2045	*	15.4153
190173	23.0934	*	*	23.0934
190175	20.4580	23.0144	22.7574	22.0818
190176	22.2316	21.7051	24.3432	22.8033
190177	19.7794	20.3679	22.3318	20.8422
190178	12.0372	*	*	12.0373
190182	20.7102	23.1997	23.6016	22.4491
190183	16.0752	16.7402	17.1805	16.6637
190184	19.8436	18.6583	20.6096	19.6762
190185	20.5852	20.7351	29.7870	23.2575
190186	17.4078	16.7272	18.4556	17.5015
190190	15.8985	13.7951	16.2819	15.2413
190191	19.6911	19.7218	21.9141	20.4097
190196	18.6138	19.1961	20.7601	19.5709
190197	20.2082	20.9871	21.6908	21.0235
190199	15.3522	17.8288	11.3015	14.1164

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
190200	21.6852	22.3510	24.2525	22.7566
190201	19.7421	21.7185	21.1903	20.9110
190202	*	22.4701	22.4062	22.4391
190203	21.7931	23.0636	24.9518	23.3496
190204	20.5784	22.9134	26.1231	23.1780
190205	19.3737	18.8750	20.2374	19.4986
190206	21.3307	21.7867	24.2892	22.5212
190207	19.0216	20.7024	19.7316	19.8068
190208	16.9641	17.6834	23.0838	18.5667
190218	19.2992	20.7290	21.6207	20.5593
190231	17.7247	*	*	17.7247
190236	21.1982	22.5796	24.4661	22.8193
190238	20.6799	*	*	20.6799
190239	19.7601	*	*	19.7601
190240	14.3579	16.0658	15.4026	15.3226
190242	*	*	12.2209	12.2209
200001	18.2513	19.7903	21.3664	19.8121
200002	22.3035	22.3145	24.7102	23.1322
200003	18.4141	18.5779	20.1431	19.0655
200006	21.0922	18.9818	*	20.0361
200007	18.1681	19.0387	21.3451	19.4241
200008	21.5556	23.2883	25.6369	23.5650
200009	21.4763	23.3090	24.6974	23.1816
200012	19.1047	20.5141	21.7931	20.4820
200013	17.9378	20.3793	22.9359	20.4733
200016	17.1187	16.2939	20.9892	18.0074
200018	17.8675	19.8848	21.2548	19.6846
200019	19.9245	21.1893	22.7794	21.2976
200020	22.3355	24.7433	27.0790	24.8621
200021	20.7361	22.0144	24.9384	22.6378
200023	20.2063	*	*	20.2063
200024	20.8336	21.0633	22.7515	21.5341
200025	20.4165	21.4247	22.8869	21.5952
200026	17.9021	18.1459	19.7172	18.5708
200027	19.4220	20.2100	20.8262	20.1773
200028	18.8763	19.8886	22.2117	20.3329
200031	16.1641	17.7875	18.5637	17.4852
200032	19.4613	20.9148	22.1885	20.9008
200033	22.4685	23.6298	25.1723	23.7287
200034	20.4941	21.8266	23.5414	22.0096
200037	20.3015	19.5004	22.5582	20.7085
200038	21.2632	22.9220	23.7816	22.6253
200039	20.1508	21.5695	22.1873	21.3042
200040	18.9580	20.7744	21.8525	20.5333
200041	18.8131	20.2986	21.3816	20.1961
200043	19.4295	20.0280	*	19.7244
200050	20.2014	23.0314	23.6076	22.2752
200051	22.0712	*	*	22.0712
200052	17.6271	18.9290	19.5066	18.7096
200055	18.5983	19.4998	19.8009	19.2948
200062	18.4279	18.0949	18.3225	18.2799
200063	21.2121	22.5265	26.3887	23.2533
200066	17.0570	18.4281	19.4759	18.3382
210001	18.6617	21.5280	22.6614	20.9120
210002	23.5132	26.5907	25.6975	24.9889
210003	26.0447	22.3090	23.0790	23.7255
210004	24.9760	27.2278	28.8679	27.0643
210005	21.3829	22.5304	24.7185	22.9229
210006	19.3682	20.8607	24.1987	21.4594
210007	23.8840	23.4582	27.5104	24.9372
210008	21.2895	21.0767	24.6569	22.4641
210009	20.7479	20.8476	23.4889	21.7419
210010	19.5908	20.4097	23.0440	21.0277

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
210011	21.4043	20.4017	22.1443	21.2906
210012	21.3977	24.8430	25.2892	23.7249
210013	19.4505	23.1649	23.0151	21.9197
210015	18.7448	23.9651	23.8419	22.0261
210016	26.5193	24.7441	27.2302	26.1373
210017	18.5079	18.2963	19.5294	18.7753
210018	22.8553	23.6442	25.3112	23.9214
210019	20.6025	21.5429	23.5259	21.9407
210022	24.5744	25.6728	27.6680	25.9838
210023	22.9989	24.4815	26.7837	24.7914
210024	24.4280	24.7858	24.8939	24.7076
210025	21.2769	21.4910	22.8882	21.8653
210026	13.8668	20.7986	*	16.5220
210027	17.1060	16.2219	19.1886	17.4744
210028	19.4157	20.4027	22.4054	20.7783
210029	25.4939	24.7605	26.2082	25.5405
210030	20.9574	21.9547	20.7801	21.2193
210032	20.1955	20.0825	20.3407	20.2132
210033	23.7588	22.8303	25.0300	23.8986
210034	19.4144	22.6812	22.8827	21.5075
210035	20.8317	21.6662	21.6973	21.4040
210037	20.5528	21.1659	23.5536	21.8146
210038	24.9762	25.9701	26.5696	25.8902
210039	21.3559	23.3583	23.5618	22.7399
210040	23.4252	23.7067	25.4729	24.1964
210043	22.4000	22.9504	20.9824	22.0358
210044	23.0917	22.9540	23.8101	23.2851
210045	12.1467	13.5654	11.8350	12.5334
210048	24.6921	24.9381	24.4328	24.6715
210049	19.3022	21.1056	23.4786	21.4119
210051	23.6476	24.8949	25.7103	24.7772
210054	23.2730	25.1694	27.3551	25.2404
210055	26.5272	23.8025	27.4218	25.8633
210056	22.9593	22.6958	23.5291	23.0845
210057	26.0076	25.6142	27.4175	26.3518
210058	16.3191	17.4250	22.0351	18.6822
210059	25.6052	*	*	25.6053
210060	26.5846	26.4566	25.8377	26.3021
210061	16.1931	20.8975	22.5454	20.0819
220001	22.9064	23.4091	25.8030	24.0472
220002	24.5840	25.4158	26.3348	25.4205
220003	17.9319	17.6069	18.8150	18.0852
220006	22.6337	23.8920	25.9967	24.1779
220008	22.0796	24.2393	25.6647	24.0447
220010	22.0067	23.4009	24.5021	23.3133
220011	29.5290	20.6390	29.7597	26.1454
220012	31.2303	31.1041	31.8043	31.3960
220015	23.1893	24.1348	25.0272	24.1474
220016	23.0951	24.6149	25.5598	24.3980
220017	25.1568	25.9000	26.0635	25.6650
220019	19.8551	19.9268	21.6620	20.5000
220020	22.4295	22.5375	23.2840	22.7668
220024	21.9316	23.8620	24.1071	23.3004
220025	22.8593	22.0003	23.2374	22.6994
220028	21.0630	24.1251	31.4858	25.0402
220029	25.6560	25.7660	27.4792	26.3128
220030	18.7429	18.9012	20.0816	19.2486
220031	29.3091	28.3832	30.8324	29.5603
220033	20.3609	21.8156	25.2942	22.4280
220035	23.1892	25.7456	26.7656	25.1903
220036	24.4091	25.5771	26.1128	25.3339
220038	22.3162	22.9821	24.2072	23.1581
220041	27.5034	28.6790	29.4322	28.5477

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
220042	26.0473	28.4675	*	27.2387
220046	23.3149	24.1931	26.1955	24.5514
220049	27.2689	25.4358	26.7406	26.4572
220050	22.5265	23.3330	23.8005	23.2263
220051	21.7357	22.4826	22.2965	22.1608
220052	23.5225	25.4091	26.3043	25.1274
220057	25.8064	26.2945	*	26.0375
220058	26.8345	21.6814	22.4816	23.6744
220060	28.0794	28.3950	29.6290	28.7209
220062	20.2254	22.5567	22.6598	21.8448
220063	20.8079	21.8365	23.3704	22.0573
220064	22.7497	24.0982	*	23.3816
220065	20.1424	21.5657	22.4143	21.3853
220066	23.4477	24.5463	23.4622	23.8055
220067	27.5405	28.2685	26.9915	27.5793
220070	20.9128	23.9850	26.2697	24.8446
220071	27.4151	27.7679	27.7773	27.6608
220073	26.1328	27.4778	29.7863	27.7808
220074	24.3057	25.3331	26.4210	25.3967
220075	22.5329	24.6982	25.7813	24.3463
220076	23.2795	24.1224	24.8040	24.0785
220077	26.1545	27.1503	26.7165	26.6753
220079	22.0769	25.7305	*	23.1834
220080	22.1971	22.9911	24.6008	23.2916
220081	29.6682	31.1326	33.3649	31.4663
220082	22.1453	23.2818	23.9542	23.1292
220083	22.5815	27.2605	28.3533	25.8389
220084	25.3761	26.0395	26.8596	26.1410
220086	26.7778	28.7324	31.9999	29.0552
220088	23.4258	25.0671	25.0645	24.5354
220089	25.4106	25.3521	28.9252	26.5987
220090	23.3049	26.0265	26.0654	25.2015
220092	24.7905	29.4173	*	26.0747
220095	21.7851	22.6828	23.7629	22.7845
220098	23.1547	24.7180	26.2287	24.7066
220100	27.5841	26.8001	25.8127	26.6900
220101	27.0711	28.0856	26.9992	27.3742
220104	28.7258	*	*	28.7258
220105	21.9185	25.5692	24.4095	24.0741
220106	25.9277	27.6812	*	26.8476
220108	23.4975	24.5939	26.0166	24.7052
220110	29.1648	30.6173	33.9228	31.2432
220111	24.7510	26.7573	26.9565	26.1374
220116	32.0049	28.5716	30.9871	30.4812
220119	23.8785	24.6344	25.5111	24.6718
220123	32.4678	29.6084	32.1805	31.3951
220126	23.6045	23.8123	36.1591	27.2823
220133	29.3911	29.8366	27.4183	28.8616
220135	28.3648	29.6837	31.2687	29.8642
220154	21.1563	23.3590	25.5654	23.5365
220163	29.2299	29.3552	27.8718	28.5798
220171	24.9261	27.3487	25.9496	26.1526
230001	20.0438	23.3051	22.0875	21.7854
230002	23.0439	24.3115	23.7972	23.6903
230003	21.2215	21.6493	22.6120	21.8276
230004	20.5005	22.4538	22.3271	21.7397
230005	17.0943	20.5596	20.2186	19.1829
230006	20.4978	20.6985	21.9442	21.0676
230013	22.2211	20.0954	20.4633	20.9362
230015	20.6464	21.9499	21.6344	21.3826
230017	22.9755	25.7900	26.1609	24.9780
230019	23.6674	23.8779	24.7356	24.1224
230020	21.8526	28.8869	25.8265	25.0793

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
230021	19.8256	20.9145	21.9537	20.8777
230022	21.9129	21.8808	22.2179	22.0038
230024	24.9664	26.2155	24.1272	25.0227
230027	19.6393	22.5114	22.1018	21.3775
230029	22.1782	24.9754	24.9385	23.9465
230030	18.6406	19.2441	19.2145	19.0453
230031	19.9465	19.4676	22.1874	20.5558
230032	24.8930	22.8436	23.5011	23.7370
230034	19.4366	17.9276	19.0026	18.7604
230035	17.7490	20.5906	18.0735	18.7098
230036	23.8398	25.1507	25.9801	25.0254
230037	23.2751	22.7382	24.7183	23.5739
230038	21.9692	20.9389	23.2065	22.0318
230040	20.7841	20.2451	21.8062	20.9418
230041	21.7364	23.2870	24.2297	23.0470
230042	21.3870	20.7745	22.5003	21.5609
230046	25.3206	26.1787	27.7076	26.3640
230047	22.3595	23.7178	24.3622	23.4689
230053	26.8917	23.5702	25.3705	25.3321
230054	20.8014	22.2105	18.9493	20.6840
230055	20.8492	20.8930	20.9350	20.8938
230056	17.8091	17.3516	19.4126	18.2031
230058	21.0303	21.6619	22.4579	21.7287
230059	20.7092	20.6540	20.6854	20.6835
230060	19.8987	20.5120	22.7605	21.0950
230062	18.8039	18.2283	*	18.4950
230065	22.7416	23.3414	26.3217	24.0577
230066	23.0475	23.2790	23.4679	23.2643
230069	24.2470	25.0212	26.4859	25.2413
230070	21.5666	21.2476	22.8588	21.8801
230071	23.1337	23.6398	23.6674	23.4732
230072	20.4456	22.6533	22.8090	21.9640
230075	22.5866	22.3632	22.4692	22.4739
230076	24.7010	26.9662	*	25.7305
230077	20.2823	22.6781	23.6116	22.2277
230078	17.9868	19.1638	20.5427	19.2537
230080	20.2104	19.1810	20.4095	19.9313
230081	19.0199	20.0464	20.4289	19.7958
230082	19.0419	18.2165	21.0552	19.3344
230085	23.4996	24.5765	24.2802	24.1339
230086	20.1730	20.1461	25.1139	21.7587
230087	19.9700	20.6619	22.2688	20.9389
230089	22.6994	23.1023	23.3847	23.0660
230092	20.7738	22.3437	22.3122	21.8236
230093	20.6314	21.0274	25.0356	22.3197
230095	17.6444	18.0582	19.1810	18.3175
230096	22.7785	24.3004	26.5685	24.5818
230097	21.1254	22.5006	22.9902	22.2246
230099	21.7513	22.3422	23.5490	22.5510
230100	17.3842	18.2477	19.8016	18.4668
230101	20.5315	22.5159	22.3310	21.7559
230103	11.3429	18.5254	19.4434	16.3738
230104	24.1238	25.5606	27.7635	25.8605
230105	22.6098	23.0086	23.9851	23.2114
230106	21.6825	22.9909	23.1961	22.6494
230107	17.1386	18.9985	*	18.1307
230108	20.3437	21.4592	19.9763	20.6173
230110	19.7262	21.0925	21.8501	20.8760
230115	19.6281	21.0361	*	20.3009
230116	14.5692	15.6064	20.1283	16.4365
230117	25.6797	25.5154	28.1220	26.4781
230118	20.6797	20.2770	23.2432	21.3687
230119	22.6555	23.9898	24.7999	23.8287

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
230120	20.3306	20.6105	22.7243	21.0521
230121	21.3342	21.4615	24.6973	22.4295
230124	18.9981	20.9641	22.0096	20.6756
230128	24.0724	24.4952	*	24.2953
230130	22.1775	23.5123	23.7854	23.1764
230132	26.1946	27.3637	29.0292	27.5003
230133	17.1058	19.0770	20.2461	18.8268
230135	20.5637	18.4193	19.8290	19.6840
230141	22.4570	24.4560	23.9885	23.6151
230142	23.5621	25.0282	22.9036	23.7956
230143	16.7948	18.2700	19.5446	18.1583
230144	23.4237	23.3295	23.6959	23.4486
230145	19.2638	17.9811	15.8192	17.6120
230146	21.2260	22.3838	21.3539	21.6475
230147	23.2755	26.5260	*	24.7445
230149	18.8005	19.9577	20.8933	19.8319
230151	23.3967	24.3705	25.6421	24.4652
230153	18.7403	20.0098	22.8443	20.5744
230154	15.4362	16.7152	15.9001	16.0188
230155	20.5409	20.7546	18.0743	19.8594
230156	25.6228	27.2254	28.0692	26.9451
230157	17.3571	*	*	17.3571
230162	21.7148	22.7984	*	22.2573
230165	23.8881	24.7959	25.9534	24.8621
230167	22.9745	24.1344	24.7967	23.9623
230169	24.3874	28.1039	24.9264	25.7012
230171	17.1282	16.1129	19.9097	17.6776
230172	21.4675	22.1709	23.0023	22.2346
230174	22.7304	23.5025	24.5090	23.5983
230175	*	14.4932	22.5965	17.8784
230176	23.8204	24.9032	24.7466	24.4760
230178	17.3030	17.3428	18.1397	17.5917
230180	18.5744	19.6062	20.9131	19.7352
230184	19.7717	20.6406	21.3426	20.5906
230186	15.7837	19.1289	21.2156	18.3800
230188	16.2975	16.8687	18.3241	17.0936
230189	17.9218	19.1990	22.7783	19.9127
230190	26.4687	24.4643	26.8284	25.9306
230191	18.4861	20.6633	*	19.5216
230193	19.8287	21.5358	22.8917	21.3669
230195	22.9228	23.4647	25.3285	23.9218
230197	24.0854	25.5312	26.9776	25.4753
230199	20.6580	22.4592	23.5942	22.1770
230201	18.0787	18.2486	*	18.1632
230204	23.4966	24.5127	24.4095	24.1113
230205	15.9314	18.1551	*	17.0325
230207	21.2483	20.9059	22.2848	21.4738
230208	16.7454	17.8118	19.0898	17.9011
230211	21.8581	21.1245	*	21.4701
230212	24.2611	24.6420	26.4825	25.1164
230213	15.5469	17.1062	18.7123	17.1022
230216	21.0710	22.2137	23.4216	22.2323
230217	22.2698	24.1455	24.3649	23.6068
230219	20.0442	18.1277	20.5935	19.6048
230222	21.9711	23.2545	24.2148	23.1524
230223	22.6887	25.2666	28.5549	25.4631
230227	22.3155	25.8826	27.7510	25.3402
230230	22.3097	22.1703	22.0423	22.1610
230235	17.7197	17.5940	19.2540	18.1724
230236	25.9676	25.3251	25.4791	25.5829
230239	17.8168	18.9790	19.8370	18.8918
230241	20.7297	21.8472	22.8539	21.9059
230244	22.2697	23.1175	23.1234	22.8331

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
230253	21.0433	22.7706	24.9784	22.9234
230254	22.6335	23.3714	24.2594	23.4070
230257	21.3880	23.1794	24.8070	22.9716
230259	22.3969	23.1768	24.5001	23.3910
230264	17.4864	18.6598	18.2571	18.1056
230269	24.0992	24.3772	24.9596	24.4951
230270	22.5985	25.2665	22.9002	23.5673
230273	22.8715	24.1278	25.8466	24.2438
230275	20.8985	32.0037	29.4179	26.3638
230276	25.8709	22.3313	25.4127	24.3279
230277	23.9771	24.3351	25.3381	24.5552
230279	17.8074	18.3256	21.2467	19.1913
230280	18.3497	*	*	18.3498
230283	22.5082	*	25.0038	23.8515
230286	*	47.5925	*	47.5929
230287	*	22.5420	*	22.5420
230288	*	*	30.5931	30.5929
240001	25.6936	26.6372	28.2239	26.9164
240002	23.2307	24.2214	24.3916	23.9674
240004	24.4030	25.6238	26.8197	25.6037
240005	20.3193	20.2389	22.7873	21.0896
240006	23.0715	25.7288	29.5789	26.1049
240007	19.0850	20.7189	21.4367	20.4240
240008	23.3783	22.7437	26.3213	24.1118
240009	17.1187	17.4518	*	17.2880
240010	25.4752	28.3796	29.0956	27.7014
240011	21.5875	22.5188	24.0365	22.7468
240013	21.7544	25.1560	27.2049	24.6443
240014	24.2610	25.2306	26.5144	25.3969
240016	22.2011	23.3772	25.2629	23.6323
240017	18.9272	19.3431	21.6243	19.9559
240018	18.4268	23.6092	27.3634	22.7452
240019	23.1477	24.0613	25.1331	24.1004
240020	20.8849	20.6819	24.7719	22.0019
240021	20.1457	19.0469	23.9570	20.9424
240022	21.3234	23.0394	23.4702	22.5966
240023	22.8224	22.3002	24.4609	23.2632
240025	20.0308	20.7672	21.2597	20.6915
240027	16.7758	18.3837	18.3340	17.8317
240028	25.1934	*	*	25.1933
240029	20.0164	23.0440	21.2343	21.3892
240030	20.1653	20.9799	22.0200	21.0838
240031	19.3983	21.7620	23.4390	21.5566
240036	22.1721	22.5436	23.3926	22.7261
240037	20.1195	21.4275	21.8392	21.1496
240038	24.3957	26.4513	29.0330	26.6099
240040	23.1352	22.8191	21.3870	22.2562
240041	21.8655	21.9054	22.8511	22.2064
240043	16.9859	18.0186	19.5532	18.2400
240044	20.3339	22.5750	22.7043	21.8646
240045	24.1557	24.2936	25.9223	24.7977
240047	23.8098	25.3233	29.6184	26.0294
240050	21.6499	23.1109	24.7589	23.1788
240051	22.5855	23.2612	25.5603	23.8542
240052	*	22.3485	23.5899	22.9828
240053	23.8693	24.4191	26.6015	24.9787
240056	23.7139	24.8549	28.5169	25.8728
240057	24.8686	25.3984	27.7600	26.0180
240058	18.4009	19.0506	19.6784	19.0102
240059	23.7808	25.3847	27.0517	25.4242
240061	25.9951	27.9151	28.6098	27.5450
240063	24.4031	25.8594	26.7645	25.6926
240064	22.8578	24.6785	24.9928	24.2158

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
240065	14.8734	14.4623	15.3825	14.9036
240066	24.1143	25.5163	27.4066	25.7241
240069	21.7991	23.3373	25.7439	23.6631
240071	21.2463	22.6332	24.8036	22.9056
240072	20.9529	21.5455	22.9244	21.8214
240073	17.3559	17.9013	20.1334	18.4502
240075	21.3357	21.9160	24.4084	22.5903
240076	22.3280	23.6159	26.8682	24.3772
240077	20.3445	22.1509	18.9735	20.4406
240078	25.1082	26.2576	27.5066	26.3275
240079	18.8345	18.2929	20.6644	19.2023
240080	25.5619	26.3071	27.8058	26.5849
240082	18.7995	20.2018	21.4727	20.1735
240083	21.0317	22.3484	24.4855	22.6030
240084	21.7421	23.1951	23.9942	22.9738
240085	20.9778	20.7535	17.4712	19.7663
240086	18.1401	18.1497	17.7594	18.0222
240087	21.3323	21.2116	20.1003	20.8883
240088	23.1056	24.6260	25.5587	24.4549
240089	21.1989	21.3949	23.4029	21.9959
240090	19.2166	21.0856	22.6601	21.1189
240093	20.2400	20.7138	22.3968	21.1802
240094	22.0247	22.5923	24.4166	23.1169
240096	21.0417	20.2992	23.8171	21.7632
240097	27.9496	29.7597	31.8726	29.9039
240098	24.2296	23.9626	*	24.0891
240099	15.4964	18.8139	43.7548	21.0887
240100	20.8325	24.1875	24.7500	23.2514
240101	19.9837	22.1329	24.3455	22.2487
240102	16.3659	15.5114	14.5842	15.5365
240103	18.7510	21.0182	20.2325	19.9774
240104	23.5351	25.1139	27.5745	25.4425
240106	23.5005	23.9677	25.5890	24.4099
240107	20.9004	21.2163	24.5581	22.1688
240108	18.2427	17.6500	19.2516	18.3839
240109	16.3216	15.1369	14.5891	15.2649
240110	21.0277	21.7340	22.9718	21.9757
240111	17.8617	19.9712	20.0499	19.2908
240112	16.6244	17.2437	*	16.9303
240114	17.3682	18.3415	21.7910	19.3128
240115	23.8675	24.6529	26.8906	25.1535
240116	18.3520	17.3460	19.2400	18.3173
240117	17.9941	18.6677	19.7047	18.8229
240119	21.8289	23.0230	23.4148	22.7820
240121	22.2266	22.4858	24.5455	23.1566
240122	21.2876	20.7795	23.5331	21.8695
240123	18.3941	18.9494	20.0721	19.1239
240124	20.4728	21.2023	23.5138	21.7551
240125	14.9708	17.3846	*	16.1716
240127	17.9724	16.4294	19.3859	17.7982
240128	16.3608	17.5611	20.1960	17.9593
240129	16.5209	17.7242	20.2001	18.1562
240130	16.4271	17.7634	17.8752	17.3622
240132	23.1452	24.5633	26.7031	24.8511
240133	19.5293	20.8958	23.6068	21.3584
240135	15.7015	15.6298	17.8575	16.3349
240137	21.5073	21.6644	23.1752	22.1872
240138	16.7332	19.1676	17.4235	17.7313
240139	20.5496	21.0163	22.4472	21.2707
240141	23.1009	23.6498	25.1597	24.0447
240142	29.2238	24.0719	25.5197	26.0657
240143	20.4266	20.7307	18.9442	20.0050
240144	21.4469	23.1661	23.3501	22.6969

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
240145	19.0689	17.6747	22.6062	19.4589
240146	16.5412	17.3275	18.1744	17.4437
240148	19.5204	19.5372	*	19.5281
240150	20.8331	23.3857	*	21.8697
240152	22.4744	24.1818	25.4031	24.1733
240153	19.3336	18.6556	20.3880	19.4726
240154	21.5052	21.5859	21.3809	21.4857
240155	20.9385	23.6944	24.4892	23.0432
240157	13.7309	20.0571	16.7563	16.8353
240160	15.9014	16.4990	17.3072	16.5799
240161	16.8809	18.0542	19.1144	18.0796
240162	19.1542	19.3296	20.4807	19.6719
240163	20.4760	22.2009	23.0778	21.9095
240166	19.4131	19.4496	21.5002	20.1541
240169	16.3958	*	*	16.3959
240170	20.3779	21.5994	22.4313	21.4955
240171	18.5172	19.6732	20.5124	19.5729
240172	20.8606	20.3699	20.9068	20.7077
240173	18.5187	18.3183	20.6286	19.1672
240179	20.4004	17.7557	19.8250	19.2836
240184	16.8917	17.6979	19.7471	18.1054
240187	21.2736	23.2471	24.9027	23.1511
240193	18.4664	26.6381	23.6164	23.0709
240196	25.3479	26.2793	27.3313	26.3610
240200	14.9076	18.7517	18.8396	17.3476
240207	25.2814	26.0927	27.4330	26.3128
240210	24.5664	25.6060	26.6231	25.6397
240211	30.6260	34.7849	32.8805	32.7909
240213	*	*	27.4812	27.4811
250001	19.2756	20.2019	20.9338	20.1232
250002	18.6938	19.6081	21.6643	20.0536
250003	16.7570	18.7331	19.3864	18.3353
250004	18.3860	19.2913	20.9295	19.5583
250005	12.5834	13.7341	11.3971	12.5195
250006	17.5192	19.4531	20.3061	19.0833
250007	19.7562	20.9757	21.2226	20.6508
250008	15.8506	15.8096	16.4863	16.0657
250009	17.7283	18.0463	19.7610	18.4932
250010	14.6101	16.0233	17.6204	16.0381
250012	16.7579	17.4032	15.6117	16.4987
250015	11.7249	16.6522	19.3794	15.3452
250017	20.5976	18.8850	19.0435	19.5747
250018	13.1687	14.7291	16.8783	14.8458
250019	18.0956	19.9070	22.9085	20.3396
250020	16.2698	19.6575	19.1877	18.3910
250021	10.5844	12.7242	15.8485	12.9174
250023	12.3434	13.8210	14.7354	13.5480
250024	12.9899	14.8394	12.1862	13.2855
250025	20.3625	21.9075	21.2651	21.1983
250027	14.5445	15.1790	17.5936	15.6987
250029	16.0682	14.8216	14.8043	15.2287
250030	26.6173	25.5089	27.2140	26.4270
250031	18.3825	19.8779	21.7605	20.4551
250032	17.5957	*	*	17.5957
250033	15.0941	16.9132	*	15.9970
250034	17.0399	18.8231	20.3681	18.7749
250035	16.8349	18.3861	17.1071	17.4370
250036	16.1913	17.6247	17.0469	16.9644
250037	12.7156	14.3994	16.6348	14.4707
250038	17.7019	18.8434	16.8610	17.7868
250039	15.1409	16.4502	16.8729	16.1389
250040	18.3364	19.6513	20.8178	19.5733
250042	17.6531	18.3858	19.4367	18.4780

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
250043	16.6500	18.4025	17.7554	17.5544
250044	16.7321	19.0321	20.3711	18.6909
250045	21.8988	22.7225	25.3236	23.3569
250047	14.7461	16.0109	*	15.2694
250048	17.6649	19.4976	19.3636	18.8723
250049	12.1635	12.8275	13.4396	12.7838
250050	15.1159	16.0234	16.6723	15.9407
250051	10.4900	10.1212	10.5027	10.3736
250057	16.1838	16.6316	19.0571	17.2494
250058	15.7197	16.2623	16.3813	16.1275
250059	16.6494	17.9507	19.0813	17.8285
250060	16.1804	12.6893	14.0155	14.2269
250061	11.5108	12.0186	11.4573	11.6591
250063	13.3092	15.0894	15.9383	14.6934
250065	13.6904	15.0507	16.2010	14.9097
250066	16.1742	17.2711	16.1044	16.5014
250067	16.8522	18.3773	20.0430	18.4322
250068	13.4127	13.2644	16.3759	14.2410
250069	16.8980	18.5782	21.2111	18.7309
250071	12.3488	13.1934	13.7055	13.0670
250072	18.9487	21.0602	20.7704	20.1290
250077	13.7404	13.9479	14.0318	13.8984
250078	15.9739	17.4118	17.4212	16.9775
250079	16.5835	16.1483	21.3505	18.0112
250081	19.0358	18.1848	20.1214	19.0803
250082	17.1427	17.3096	19.5962	18.0482
250083	16.6065	16.3054	19.5217	17.6288
250084	20.6429	21.0870	22.4632	21.3407
250085	15.4477	16.7377	18.0100	16.7072
250088	18.2736	19.3976	20.3019	19.3083
250089	14.3027	15.0238	16.0202	15.0666
250093	16.1506	16.8647	17.6906	16.8800
250094	18.5063	18.9681	19.9288	19.0932
250095	17.4217	18.4944	18.6616	18.1868
250096	19.0584	19.3630	20.5923	19.6554
250097	15.5741	16.3328	18.8398	16.9174
250098	18.3874	18.8163	17.9562	18.4324
250099	15.1265	15.9867	18.2504	16.5120
250100	17.8688	19.7559	18.8877	18.8640
250101	17.7194	17.6704	41.5335	17.7745
250102	18.9348	19.8487	21.3213	20.0396
250104	18.7651	19.0165	20.5035	19.4465
250105	15.5133	16.1480	17.0135	16.2367
250107	15.0737	16.5635	16.7104	16.0939
250109	21.3867	24.5760	16.4965	20.5154
250112	16.3640	16.6447	16.8696	16.6208
250117	16.9787	15.9335	18.8863	17.1858
250119	16.1218	16.5700	17.1373	16.5802
250120	16.7182	18.1428	22.3897	18.8266
250122	19.2990	19.8033	19.7966	19.6361
250123	18.7863	22.1376	22.2184	21.1030
250124	13.2490	14.4008	15.3772	14.3481
250125	21.2660	21.9366	25.3415	22.8644
250126	21.9101	19.0168	20.1117	20.3133
250128	16.1418	15.9958	15.8352	15.9898
250131	12.4557	11.2470	11.5396	11.7049
250134	18.5142	21.4489	22.0310	20.5243
250136	21.3497	20.0333	21.9977	21.1329
250138	20.4550	19.3446	21.2489	20.3584
250141	19.6692	21.6835	19.8982	20.4335
250145	11.2120	11.2021	*	11.2080
250146	14.7781	15.4061	16.9341	15.6577
250148	19.4233	23.1459	*	21.1903

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
250149	15.2318	15.7537	16.4228	15.8106
250150	21.8599	*	*	21.8600
250151	*	*	20.4581	20.4581
260001	20.1560	20.9620	22.6646	21.2406
260002	21.6597	23.4259	24.6812	23.4142
260003	15.4482	16.2023	16.5931	16.0798
260004	13.7035	15.2735	16.4424	15.0947
260005	23.9681	22.5860	24.3624	23.6476
260006	20.0994	22.1692	24.1078	22.0536
260008	16.8893	18.2114	15.9656	17.1196
260009	18.2863	19.0654	20.1679	19.1754
260011	19.5059	20.3279	21.1624	20.3470
260012	17.1662	17.3810	17.7853	17.4521
260013	16.1825	17.3772	18.4857	17.3402
260015	17.8817	18.3849	21.7581	19.2237
260017	16.9914	17.9796	20.8258	18.6436
260018	12.5301	13.6120	14.3278	13.5417
260019	*	18.3629	*	18.3629
260020	20.2241	21.0314	22.4643	21.2460
260021	21.6237	23.3527	27.2478	23.9117
260022	17.7772	18.7707	20.5417	18.9739
260023	17.8649	18.5665	19.2256	18.5565
260024	15.7815	15.6095	16.9515	16.1624
260025	17.0965	18.2804	19.3535	18.2493
260027	22.0362	23.1505	22.9973	22.7247
260029	21.1858	20.1832	22.0390	21.1257
260030	11.9215	12.8349	12.7803	12.5162
260031	19.7249	22.5379	24.3626	22.0014
260032	19.6728	20.3847	*	20.0208
260034	20.4902	20.5439	21.6108	20.9281
260035	13.0071	15.1611	15.0710	14.4258
260036	18.8104	20.1242	19.4559	19.4803
260039	14.6644	15.9689	13.9705	14.9145
260040	18.0140	18.5132	19.7196	18.7876
260042	18.7514	20.8821	*	19.9434
260044	15.9206	16.7879	18.2413	17.0028
260047	19.2247	20.2724	22.4013	20.5664
260048	21.0602	22.4800	20.1127	21.0958
260050	16.8520	17.8142	20.8510	18.4171
260052	18.0914	19.1044	21.1297	19.4548
260053	16.5166	17.4110	18.9606	17.6806
260054	20.6242	23.0188	*	21.7799
260055	15.4214	17.9547	18.8793	17.4012
260057	19.7144	16.5704	15.8404	17.4526
260059	17.0546	16.2074	17.2807	16.8654
260061	15.7112	17.1343	18.7280	17.2320
260062	21.3138	22.0091	25.1582	22.8328
260063	18.8973	19.7231	21.1284	19.8962
260064	17.8033	18.3749	17.5188	17.8922
260065	20.0975	20.6671	22.0073	20.9514
260066	15.3460	15.3139	*	15.3302
260067	15.1837	14.5499	15.0354	14.9154
260068	19.4240	20.7947	22.0951	20.7923
260070	13.9510	18.7384	11.2251	14.4396
260073	15.9182	16.9496	17.9000	16.9733
260074	19.8915	20.4033	18.7639	19.6422
260077	19.4482	20.5830	21.6257	20.5610
260078	14.9463	16.0586	16.9217	15.9818
260079	16.1453	16.4816	17.3871	16.6399
260080	14.6832	13.1617	13.6815	13.7659
260081	20.3053	20.2471	22.4329	21.0085
260082	15.9858	18.2853	18.7527	17.6725
260085	20.7051	21.5137	22.7394	21.6591

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
260086	15.2927	16.7579	17.2049	16.4038
260091	21.5464	22.0772	23.8702	22.5033
260094	18.5395	19.7308	20.0014	19.4593
260095	20.7292	21.6999	22.8156	21.7294
260096	22.5972	22.8259	23.5009	22.9961
260097	19.0632	18.6965	19.6203	19.1454
260100	16.6523	16.5439	16.6168	16.6045
260102	20.6361	21.2133	24.1041	22.0613
260103	19.7146	19.9144	*	19.8156
260104	20.3176	21.6624	22.1805	21.4297
260105	24.8181	22.8005	24.6572	24.0540
260107	20.4269	22.5214	23.1564	21.9109
260108	20.0034	20.9029	22.4665	21.1879
260109	14.8181	15.9724	16.7734	15.8460
260110	18.3227	19.5633	*	18.9410
260113	16.2223	16.1346	16.3440	16.2356
260115	17.4698	19.3873	20.1706	18.9712
260116	14.9812	16.0187	16.9807	15.9921
260119	17.2942	18.0725	18.7958	18.0259
260120	16.4904	17.6811	18.7651	17.6553
260122	16.0931	16.3700	16.1637	16.2077
260123	14.6822	15.2926	17.7996	15.9122
260127	18.4026	18.1342	19.7946	18.7879
260128	12.6414	13.2942	*	12.9660
260131	18.4154	18.0395	*	18.2242
260134	17.5127	17.1341	18.4511	17.6303
260137	19.4697	19.5976	20.7638	19.9765
260138	23.2364	23.6502	25.4515	24.0813
260141	19.1893	19.0444	21.1469	19.7400
260142	17.3084	18.2023	18.6412	18.0732
260143	13.9040	15.4688	16.0479	15.1578
260147	14.7769	15.8522	16.1172	15.5706
260148	11.3524	12.6651	15.1916	13.0421
260158	12.7699	13.9790	15.0140	13.9277
260159	19.7951	20.9636	22.5169	20.9886
260160	16.5792	18.4007	18.8723	17.9546
260162	21.4099	20.7331	22.3038	21.5147
260163	15.8593	16.8300	18.1311	16.9540
260164	15.1211	16.3874	16.9403	16.1072
260166	21.1224	22.4071	22.8409	22.1650
260172	16.0772	16.4854	17.1504	16.5822
260173	14.2090	15.5733	17.0117	15.5933
260175	17.5625	18.3632	19.7939	18.5994
260176	21.6044	23.2414	25.7802	23.6435
260177	21.9014	22.9112	24.0679	23.0194
260178	20.2796	20.8189	21.2846	20.7937
260179	22.7185	21.4470	23.1610	22.4301
260180	18.9881	19.5983	21.4226	19.9994
260183	21.3175	23.7057	24.2330	23.0675
260186	19.6026	21.0675	21.6620	20.8448
260188	22.5060	23.7475	*	23.0915
260189	16.4233	*	*	16.4232
260190	19.3419	21.6994	24.5014	21.8167
260191	18.1604	19.6784	20.8030	19.6078
260193	20.2577	22.2030	22.9556	21.8741
260195	19.7068	*	20.0889	19.9145
260197	20.5453	*	*	20.5453
260198	19.7552	21.7926	25.3390	22.1557
260200	20.6888	21.7031	21.9868	21.5369
260207	*	*	18.5247	18.5247
260208	*	*	30.6259	30.6261
270002	19.2387	19.0221	19.7588	19.3381
270003	22.5019	20.7277	23.0396	22.0300

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
270004	19.4834	20.1821	21.0202	20.3215
270006	17.0715	15.1006	18.2057	16.6954
270007	13.8824	15.5780	12.8055	13.9488
270009	20.8238	20.7031	21.5655	21.0425
270011	21.1653	21.8086	21.4031	21.4583
270012	19.7878	20.7913	21.7634	20.7748
270014	19.9859	20.4321	20.3456	20.2664
270016	18.6149	17.9984	21.0198	19.0996
270017	20.0152	22.1046	23.2320	21.7798
270019	15.4128	18.5111	19.6625	17.8208
270021	16.9457	18.0515	21.1624	18.5631
270023	22.7181	22.7162	23.7486	23.1141
270026	18.0568	20.1673	19.9669	19.4168
270027	17.2091	17.2005	17.4500	17.3066
270028	19.1177	19.6212	20.4877	19.7233
270029	17.3710	18.2097	17.9731	17.8617
270032	18.7811	19.3937	20.1801	19.4478
270033	18.4876	20.7060	25.0179	21.1320
270035	16.4302	17.9822	19.1036	17.8465
270036	16.8552	16.1031	18.8787	17.3089
270039	19.6796	20.3800	19.6505	19.8960
270040	20.1242	20.1887	20.7239	20.3415
270041	25.8153	*	*	25.8151
270044	17.5137	19.2939	18.6533	18.4293
270048	18.0666	17.4506	18.1269	17.8742
270049	22.2540	22.0263	22.9524	22.4171
270050	19.9356	19.6317	21.0901	20.2259
270051	20.1950	20.0386	22.2580	20.8285
270052	14.7009	17.1932	13.3673	15.1086
270057	20.6714	20.1507	21.9997	20.9799
270058	16.1412	18.4780	17.7905	17.3778
270059	19.1808	16.9303	17.4365	17.7389
270060	20.4148	21.3776	18.3386	20.1127
270063	15.1049	16.4553	19.7307	16.9992
270073	16.1937	16.6083	15.6319	16.1437
270079	16.7048	19.5493	*	18.0578
270080	15.0705	16.6010	20.6145	17.2851
270081	16.7389	18.0543	15.6834	16.8629
270082	23.1245	23.3209	21.0150	22.5579
270083	17.8554	16.8420	19.1381	17.8988
270084	16.2958	15.7062	19.6105	17.1115
280001	18.1831	18.7137	18.9480	18.6168
280003	23.0213	23.6058	26.0937	24.2580
280005	23.6949	22.8981	23.9753	23.5311
280009	20.9643	23.2300	23.8046	22.6996
280010	20.0462	22.0137	23.8324	22.0012
280011	15.9614	16.2281	*	16.0965
280013	22.5163	24.0852	23.4920	23.3630
280014	16.8368	16.7109	*	16.7707
280015	16.6939	18.0207	19.1420	17.9018
280017	13.9939	16.9884	15.8099	15.6454
280018	15.4496	16.6439	17.0625	16.3884
280020	21.2467	21.9587	23.4658	22.2728
280021	17.6345	19.1263	21.5215	19.4605
280022	16.8184	15.3785	*	16.0620
280023	22.3433	21.5761	19.6265	21.1633
280024	15.0380	15.8747	18.1544	16.1976
280025	21.4764	22.2214	*	21.8488
280026	16.5851	18.7258	*	17.6496
280028	18.0793	19.1080	*	18.5723
280029	24.4359	17.1351	*	20.5379
280030	24.7723	26.3542	26.2806	25.7410
280031	9.6321	9.6951	14.3030	11.3451

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
280032	19.1191	20.5246	21.5150	20.4101
280033	17.4745	17.9841	*	17.7291
280035	16.6872	18.6089	*	17.5717
280037	17.1064	14.8049	*	15.9325
280038	18.2503	18.9305	*	18.5950
280039	16.1587	17.0153	18.3375	17.1382
280040	20.9896	21.5426	23.7407	22.1421
280041	16.5503	16.6889	14.4252	15.9446
280042	16.6239	16.4684	*	16.5457
280043	17.5937	16.8186	*	17.2004
280045	15.7630	17.7408	15.2407	16.1990
280046	17.3214	17.9752	17.5600	17.6110
280047	17.4735	21.3143	19.5815	19.4044
280048	15.8100	17.9319	18.6882	17.5211
280049	18.4365	19.4589	20.1665	19.3973
280050	20.0379	*	*	20.0378
280051	17.1942	19.6206	*	18.3037
280052	14.1201	14.9903	15.4041	14.8495
280054	18.7575	19.4049	23.1191	20.4732
280055	13.8129	14.2046	15.2426	14.4185
280056	15.6135	15.6442	*	15.6285
280057	20.0686	21.4754	22.5480	21.4261
280058	21.4868	22.8105	17.7506	20.7067
280060	20.7022	22.4677	22.7755	21.9926
280061	18.6370	20.2066	21.2901	20.0793
280062	15.6018	16.1708	17.2218	16.3363
280064	16.8330	18.2196	*	17.5260
280065	20.7370	21.6999	23.8128	22.1199
280066	11.7207	12.2225	10.6969	11.4854
280068	10.5987	10.5103	11.6283	10.9064
280070	22.6201	18.7211	*	20.3601
280073	17.7698	18.3496	*	18.0596
280074	17.3143	13.6025	18.6064	16.1704
280075	13.2230	13.3154	18.0464	14.6143
280076	16.7488	16.1939	18.2504	17.1042
280077	20.0148	21.1883	22.7244	21.3192
280079	16.6117	17.1519	17.7968	17.1767
280080	16.9487	16.1902	*	16.5447
280081	20.9606	23.3805	25.2237	23.2090
280082	14.6173	15.4420	15.2322	15.0937
280083	21.5336	20.8995	*	21.2308
280084	13.6536	13.2158	14.3005	13.7432
280085	20.4825	20.8532	*	20.6808
280089	18.9567	19.9003	20.7438	19.8619
280090	15.1274	*	*	15.1274
280091	16.1866	16.3456	*	16.2669
280092	14.7912	13.3032	16.5893	14.8029
280094	16.3474	16.9180	18.5068	17.3100
280097	13.8223	14.1870	*	14.0071
280098	12.5875	12.4995	*	12.5457
280101	16.9973	10.5153	*	12.9714
280104	16.2167	15.5949	14.8257	15.4728
280105	21.0735	23.7103	26.1112	23.6557
280106	16.0679	16.3564	*	16.2080
280107	14.4679	*	*	14.4678
280108	17.1961	18.5134	20.9016	18.8959
280109	12.4408	*	*	12.4408
280110	14.2136	13.0278	*	13.5867
280111	19.6283	19.7688	20.7398	20.0680
280114	17.3076	17.1154	*	17.2096
280115	18.1480	18.3464	19.7797	18.7967
280117	18.8279	20.3819	20.5464	19.9214
280118	18.6524	17.8891	19.3465	18.6584

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
280123	11.8582	23.6682	24.3539	18.1396
280125	16.3944	17.2718	19.7871	17.7870
280126	*	*	35.5895	35.5900
290001	22.7450	24.3681	25.9590	24.4242
290002	16.5419	16.7948	16.8363	16.7281
290003	24.2175	25.4303	27.2718	25.6701
290005	21.9814	22.7804	24.6877	23.2224
290006	22.4063	22.4832	24.2211	23.1190
290007	30.9075	34.9911	33.7208	33.2446
290008	24.1255	26.9216	27.0115	25.8955
290009	23.9373	24.8816	26.9020	25.2711
290010	16.4476	20.8387	25.4598	20.8166
290011	21.1234	19.7410	21.7835	20.8924
290012	25.0430	25.5647	25.4791	25.3714
290013	15.7932	20.2914	21.1487	18.7341
290014	18.7829	20.2762	25.6155	21.5373
290015	19.4504	20.2336	22.3653	20.5695
290016	23.8656	21.8030	17.9615	20.7686
290019	22.2045	22.5584	25.1684	23.3359
290020	21.2380	19.5039	24.2374	21.4763
290021	22.9488	24.1397	26.0430	24.3771
290022	25.5011	25.3914	27.5364	26.1224
290027	13.3769	13.1463	*	13.2560
290032	23.9504	26.9846	27.1791	26.2060
290036	12.9074	*	*	12.9073
290038	27.7030	26.0836	30.0397	27.9572
290039	25.5024	26.6283	28.5925	26.9886
290041	25.9905	27.7740	28.6294	27.7224
290042	18.7527	18.7669	*	18.7611
290043	27.9053	*	*	27.9053
290045	*	*	26.4843	26.4843
300001	23.8567	25.7142	26.8650	25.5285
300003	24.1297	25.3252	26.7859	25.4284
300005	22.2858	22.3258	22.8163	22.4895
300006	18.9745	22.2642	22.0188	21.0625
300007	20.6325	21.3633	23.6919	21.9920
300008	19.6149	20.9207	23.1085	21.2699
300009	20.0938	20.1486	22.7539	20.9686
300010	20.2130	21.0316	24.6296	21.8421
300011	23.0279	23.8390	25.0979	24.0124
300012	24.5619	25.8581	26.1792	25.6027
300013	20.1669	20.0269	21.3396	20.4889
300014	20.1774	21.6705	23.7144	21.9343
300015	19.6627	22.8966	24.4870	22.4848
300016	17.8148	15.1311	19.6529	17.5958
300017	22.7191	23.9651	26.0604	24.3780
300018	21.6385	22.8379	25.7851	23.5726
300019	19.6728	20.5801	23.8076	21.3279
300020	22.6627	23.0806	24.8189	23.5472
300021	19.3101	20.2585	19.0918	19.5659
300022	19.1875	20.1209	22.3918	20.6206
300023	22.7649	22.1896	24.9992	23.3536
300024	21.5842	22.2235	22.4882	22.1265
300028	20.0778	21.4207	21.7975	21.0588
300029	22.6013	23.8415	24.5772	23.7645
300033	17.1632	17.4836	20.4502	18.3308
300034	24.4975	25.2355	26.9093	25.5558
310001	27.4730	31.1568	29.6344	29.4408
310002	27.9728	28.7786	33.9058	30.2896
310003	27.5624	29.3522	31.1739	29.3684
310005	22.9712	23.9477	25.6120	24.1650
310006	22.0894	24.1538	25.9000	24.0238
310008	24.7618	26.4989	28.0970	26.4414

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
310009	21.7094	23.2420	24.6353	23.1866
310010	23.1060	24.5471	26.5921	24.8321
310011	24.2885	25.4900	26.1586	25.3131
310012	26.6772	28.1367	31.1705	28.7006
310013	22.5603	23.2424	25.0951	23.6575
310014	23.1956	31.0834	29.1931	27.3029
310015	27.9684	29.1340	29.3681	28.8346
310016	24.5206	26.0738	25.7368	25.3848
310017	24.5976	25.1634	25.2577	25.0191
310018	22.4779	24.1428	25.9108	24.1664
310019	24.9914	28.5952	26.4492	26.6564
310020	24.4152	25.0803	25.0147	24.8332
310021	25.4393	27.8958	29.2267	27.4313
310022	20.8258	23.3412	26.7487	23.5627
310024	24.9521	27.0459	26.9499	26.3252
310025	24.1812	25.5227	26.8719	25.4915
310026	22.1997	23.2895	24.6697	23.2693
310027	22.5696	24.4437	22.1935	23.0737
310028	23.9428	26.1931	25.7246	25.2908
310029	23.6610	24.4290	25.9606	24.6455
310031	26.6831	26.7174	29.5581	27.5915
310032	24.7404	24.9133	25.7088	25.2148
310034	24.1150	24.8567	26.4468	25.1211
310036	21.7187	23.0320	*	22.3716
310037	28.1289	28.7738	29.9732	28.9646
310038	28.4893	28.1756	32.3865	29.6794
310039	22.7317	23.6605	24.6045	23.6772
310040	26.3573	26.5769	27.2418	26.7140
310041	23.5559	23.8857	26.8145	24.8018
310042	24.7678	24.9702	26.9695	25.5501
310043	21.6128	24.0238	*	22.6515
310044	23.1549	23.1489	25.1618	23.8298
310045	28.9274	29.4877	31.7376	30.0182
310047	26.1921	25.9777	26.0860	26.0841
310048	25.2870	23.4189	28.4136	25.6301
310049	27.0842	25.6732	26.3666	26.3559
310050	24.7988	23.7735	25.3772	24.6345
310051	27.5378	28.6248	28.3783	28.1725
310052	23.3973	24.9773	26.8158	24.9554
310054	27.7376	27.6290	27.2303	27.5237
310057	22.2572	22.2630	26.3903	23.6641
310058	26.3765	25.3983	25.6526	25.8266
310060	20.0997	21.4455	22.1914	21.1757
310061	33.9582	23.4283	24.9678	26.7631
310063	22.1080	21.2619	22.9871	22.1071
310064	25.4822	25.9350	27.8388	26.4138
310067	23.9278	24.1943	26.3624	24.7328
310069	24.2329	25.3464	25.7690	25.1083
310070	28.2220	29.5101	30.1917	29.3042
310072	22.5611	24.4480	25.3145	24.0886
310073	26.2937	26.7954	28.7528	27.2829
310074	22.3588	24.2009	27.6789	24.7835
310075	24.4788	23.9771	24.9752	24.4724
310076	27.9918	29.6667	32.5424	30.0825
310077	26.1251	26.7092	28.7352	27.1831
310078	24.0587	24.5862	24.7606	24.4553
310081	22.4086	23.3310	24.6557	23.4816
310083	24.8204	25.0191	25.2465	25.0205
310084	24.6049	25.4946	27.3680	25.8446
310086	23.1719	23.4966	25.2725	23.9596
310087	21.1215	20.6847	*	20.9048
310088	23.1722	23.0610	23.7846	23.3408
310090	24.8986	23.6661	25.3640	24.6461

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
310091	23.2969	24.5357	25.6405	24.4610
310092	21.6964	22.9721	23.2226	22.6239
310093	23.7251	23.9404	24.6942	24.1032
310096	24.5759	26.6588	28.4705	26.4515
310105	26.2537	28.1317	28.7333	27.6263
310108	23.8308	25.1368	24.4096	24.4558
310110	23.2146	23.3461	26.4175	24.4668
310111	22.1151	23.3646	26.2496	23.9377
310112	24.7914	24.2999	27.8796	25.6804
310113	23.1961	24.2708	25.9143	24.5219
310115	21.1645	23.5148	24.5413	23.0976
310116	23.6366	24.2696	25.1189	24.3065
310118	26.1315	26.8760	28.0517	26.9540
310119	32.7858	29.1045	33.2731	31.6276
310120	23.3200	22.6526	24.7079	23.4981
320001	20.6225	21.5564	23.0290	21.8122
320002	23.0983	25.5144	26.4847	25.1115
320003	16.4642	16.4961	20.7939	17.8265
320004	19.6642	21.3681	19.4799	20.2196
320005	21.0411	22.4178	22.1677	21.9174
320006	20.3863	19.8672	21.1222	20.4529
320009	19.3500	20.3783	21.5870	20.3252
320011	18.5222	19.1476	20.7713	19.4939
320012	17.1764	17.1317	*	17.1558
320013	24.5543	25.5403	19.4487	22.2842
320014	16.8412	22.9026	19.5032	19.7029
320016	18.8519	18.8763	19.9200	19.2582
320017	19.4498	20.4390	22.5460	20.8081
320018	19.2336	20.3141	20.9400	20.1778
320019	26.9637	25.1210	26.6900	26.3394
320021	19.1265	20.0089	21.0913	20.0920
320022	18.0606	20.9797	20.7919	20.0415
320023	17.8419	*	*	17.8418
320030	18.6859	18.1556	16.8696	17.8853
320031	25.1715	18.2244	19.0519	20.5648
320032	20.6871	21.4815	21.2528	21.1396
320033	21.0621	21.9804	24.2703	22.4984
320035	15.0612	17.8058	*	16.5303
320037	17.8280	17.6724	19.6466	18.4044
320038	22.2664	23.1987	19.2962	21.6253
320046	18.9607	19.4732	21.5914	20.0169
320048	16.8769	*	31.6800	24.0471
320063	17.9089	18.5600	20.4936	18.8302
320065	18.6525	22.5428	19.9012	20.1608
320067	15.3228	16.8015	17.7799	16.4113
320068	18.5103	15.6864	15.7757	16.5793
320069	14.4212	15.7350	18.5375	16.2248
320074	20.2290	22.3403	28.3085	22.7142
320079	19.8555	20.2473	21.9090	20.6661
320083	*	*	25.7539	25.7539
330001	27.3996	28.6214	30.7042	28.9537
330002	26.9341	27.1811	28.2184	27.4257
330003	18.9211	19.3972	20.6509	20.4183
330004	20.9501	22.5082	24.3703	22.6203
330005	22.1957	22.6137	24.3474	23.0406
330006	25.8006	26.2970	28.3904	26.7950
330008	19.2341	19.6770	20.6816	19.8702
330009	31.3435	30.9087	33.3605	31.8514
330010	16.6508	17.8935	19.8211	18.0647
330011	18.6748	18.7995	19.8035	19.0860
330013	19.6269	19.0995	20.9282	19.8689
330014	36.8669	32.4496	31.9524	33.5779
330016	16.8016	18.7194	18.1603	17.8636

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
330019	33.5369	31.5927	31.9042	32.2626
330020	1142	16.6952	16.8234	16.1733
330023	25.6512	26.6997	29.4353	27.3255
330024	37.3316	35.7485	35.3598	36.0893
330025	16.8687	17.6169	18.7663	17.7638
330027	35.5255	35.1046	34.1273	34.9301
330028	29.5294	31.7699	31.2424	30.9471
330029	17.0016	19.4377	18.4354	18.2976
330030	19.1085	18.0866	28.7083	22.0491
330033	17.4444	19.5836	18.4160	18.4656
330034	27.7738	38.2451	*	31.2246
330036	25.2820	25.5888	27.0970	25.9905
330037	16.4866	18.3260	18.3557	17.7256
330038	17.3429	16.2997	*	16.8497
330041	31.4871	29.5305	34.5461	31.7315
330043	27.4661	28.9622	31.7873	29.4079
330044	19.5219	19.9808	22.0465	20.8006
330045	27.9919	28.5267	30.9046	29.1458
330046	35.2703	38.1184	41.6759	38.2919
330047	18.5536	19.5561	20.1646	19.4202
330048	19.1093	19.6129	*	19.3678
330049	20.5731	22.1523	24.0154	22.2469
330053	17.8082	17.9161	18.1728	17.9636
330055	32.8910	34.2159	34.9709	34.0397
330056	30.0945	29.8377	32.0982	30.6226
330057	19.3643	20.0995	20.5575	20.0172
330058	17.7672	18.1007	19.1379	18.3260
330059	34.2426	35.0121	36.4176	35.2563
330061	25.4082	26.8580	28.6136	26.9092
330062	18.1318	18.4662	20.0222	18.7978
330064	33.6447	35.1422	36.0976	34.9476
330065	19.9305	20.1615	20.5958	20.2322
330066	18.8707	19.3644	20.9990	19.7359
330067	22.1065	23.6836	24.8927	23.5465
330072	30.4171	30.3737	32.9665	31.2232
330073	16.4518	16.5166	18.4162	17.3766
330074	17.7308	18.9326	21.5724	19.3819
330075	17.6385	19.2938	19.9781	18.9556
330078	18.7884	18.0362	20.7304	19.1607
330079	18.7622	18.9398	21.1153	19.6188
330080	31.4424	34.6880	29.5529	31.9593
330084	19.3216	19.0261	19.2135	19.1805
330085	20.6203	20.9332	21.8271	21.1349
330086	23.6496	26.2979	27.1585	25.5888
330088	25.7940	26.7583	29.5181	27.3384
330090	19.2112	20.1344	20.9327	20.1124
330091	19.7776	21.6004	22.9396	21.4093
330092	13.3723	17.2083	17.7246	16.0609
330094	18.1582	18.8941	20.7039	19.2157
330095	21.1096	21.1809	28.8428	22.1947
330096	18.5149	20.0370	21.1648	19.9256
330097	16.4433	16.1945	18.5608	17.0345
330100	29.0916	28.9956	31.5775	29.8728
330101	31.5914	35.3618	37.9069	34.7542
330102	19.0058	21.0057	23.5253	21.0029
330103	16.8110	17.3511	17.9017	17.3639
330104	31.2074	31.9746	*	31.5864
330106	35.3775	36.2526	38.4384	36.6836
330107	27.7797	28.9225	29.7378	29.5391
330108	18.0786	18.5849	20.2536	18.9350
330111	15.9321	13.3352	17.7020	15.4904
330114	17.0581	19.1162	19.2566	18.4674
330115	17.4684	18.5911	18.5544	18.2257

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
330116	14.9610	16.8567	17.0561	16.2974
330119	33.1179	33.5653	34.6591	33.7652
330121	16.3385	17.1869	17.9757	17.1336
330122	20.2417	23.0384	25.6500	22.9753
330125	19.7638	20.5922	21.5769	20.6209
330126	23.8957	25.1175	27.5394	25.5273
330127	30.7356	40.0112	30.6030	33.9644
330128	30.8242	34.3468	33.5504	32.9063
330132	14.3673	14.8704	16.0311	15.1074
330133	35.3576	37.5192	35.9692	35.9945
330135	22.2670	23.5662	25.1802	23.5883
330136	20.1043	20.4124	21.2943	20.6129
330140	19.3615	21.1841	21.1787	20.5922
330141	26.7096	27.5960	29.3037	27.9129
330144	16.2517	17.1513	17.3920	16.9610
330148	16.2782	16.7251	17.6560	16.8727
330151	15.7594	15.2233	16.1354	15.7000
330152	30.8314	33.5587	32.9336	32.8160
330153	18.1776	19.4417	22.0179	21.5648
330157	22.3804	23.1743	23.5522	23.0369
330158	27.1228	29.3163	32.3534	29.4900
330159	19.4998	20.2753	22.7512	20.8227
330160	29.5885	30.7893	32.1266	30.7976
330162	27.6010	27.9705	29.4475	28.3208
330163	20.7456	21.4143	21.1517	21.0818
330164	20.9003	22.0699	23.9635	23.6195
330166	15.4420	17.0637	18.4262	17.0093
330167	30.2346	32.0541	30.7301	30.9496
330169	35.4794	36.3690	36.2725	36.0426
330171	24.8035	25.1567	25.9946	25.3030
330175	18.3116	18.8701	20.4056	19.1653
330177	16.3704	16.6059	19.0005	17.2818
330179	13.8953	16.0113	15.0665	14.9370
330180	17.9877	19.2670	19.8951	19.0453
330181	33.0908	34.6065	36.8062	34.8035
330182	33.6531	33.3363	35.0496	34.0319
330183	20.6164	20.3520	*	20.4865
330184	31.3706	28.4726	31.1286	30.9549
330185	26.8612	27.8894	28.8893	27.8982
330188	18.8000	20.2849	21.0098	20.0662
330189	18.4498	23.5589	19.0726	20.2279
330191	19.0348	19.5623	20.8876	19.8341
330193	30.2260	32.5496	36.2427	32.8255
330194	35.2036	35.6486	38.3174	36.4467
330195	34.8966	34.4689	36.4249	35.2744
330196	30.5799	28.9488	28.1590	29.2904
330197	18.3527	19.2237	20.8386	19.4333
330198	24.8590	25.6669	25.3622	25.3000
330199	30.5409	28.0374	30.2655	29.6011
330201	28.7861	30.0524	29.3745	29.3679
330202	31.2575	35.4943	41.7560	36.1208
330203	25.0345	25.9211	24.7422	25.2170
330204	32.2005	31.1366	32.4850	31.9448
330205	22.3490	24.9040	28.7587	25.2768
330208	26.6682	27.3170	30.6158	28.1551
330209	25.1281	27.0257	27.7071	26.6630
330211	19.5405	20.0006	20.8224	20.1312
330212	24.7681	24.8554	24.9434	24.8488
330213	19.6796	20.1166	20.7889	20.1990
330214	32.4292	32.3130	31.1205	31.9124
330215	17.9863	19.0726	19.9226	18.9889
330218	21.1890	21.4747	20.6012	21.0785
330219	23.4310	25.1792	28.6712	25.6596

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
330221	33.3796	32.5044	34.9345	33.6092
330222	18.5571	19.3148	23.5491	20.4196
330223	17.8306	19.1604	18.8253	18.6087
330224	20.4309	20.5881	22.5695	21.2048
330225	27.0379	28.0523	29.1744	28.0410
330226	23.1859	21.6368	20.6413	21.6149
330229	17.5326	18.2554	18.5590	18.1157
330230	29.6283	30.6937	32.5997	30.9389
330231	32.7200	32.4163	31.0944	32.0731
330232	19.1787	20.0924	21.1277	20.1536
330233	44.1265	43.1186	39.5133	42.2764
330234	35.0720	35.8327	37.7135	36.1847
330235	19.5880	20.1255	21.4643	20.3704
330236	31.3463	32.1246	31.8491	31.7633
330238	17.3976	17.8867	18.3846	17.8977
330239	18.5079	18.9953	19.7561	19.0658
330240	30.7321	35.6576	35.8530	33.9196
330241	23.8638	24.7545	26.7598	25.1593
330242	27.6384	28.3561	30.5172	28.8163
330245	18.5161	20.7605	20.3764	19.9316
330246	28.1205	29.8777	31.4120	29.6840
330247	27.3937	32.5858	25.6063	28.6111
330249	17.1320	17.6846	19.1469	18.0226
330250	19.9619	20.8742	22.5523	21.1636
330254	15.9123	15.7864	*	15.8547
330258	31.8910	32.6745	*	32.2903
330259	25.9994	26.3620	27.1632	26.5007
330261	27.9766	30.0489	30.2305	29.4148
330263	18.7378	19.5057	20.0831	19.4473
330264	22.8099	24.9714	22.9348	23.5396
330265	17.6301	21.1215	18.2547	19.0141
330267	24.5939	27.8255	28.9459	27.1596
330268	15.9060	16.8358	18.7991	17.2148
330270	36.0824	33.0375	35.7375	34.9492
330273	26.0565	27.0454	28.8548	27.3093
330275	18.7268	*	*	18.7268
330276	19.0228	19.6572	20.7973	19.8310
330277	19.1761	20.7851	21.8865	20.6281
330279	20.7107	21.7827	22.2342	21.5603
330285	24.0491	24.5388	26.1367	24.9296
330286	27.7762	28.0994	31.1802	29.0328
330290	30.4706	34.3439	35.5617	33.3907
330293	16.9238	17.3180	17.6507	17.2993
330304	27.3562	29.2207	30.7428	29.1068
330306	29.5937	29.6641	30.4426	29.9146
330307	21.7257	23.2838	23.8583	22.9902
330314	25.9937	25.5405	26.2954	25.9412
330316	27.9543	27.9277	33.7857	29.8270
330327	20.3874	20.1705	19.3465	20.0015
330331	33.1276	32.3249	34.3554	33.2559
330332	25.3689	27.6955	30.5104	28.0245
330333	*	28.8819	29.7725	29.3003
330336	29.8294	27.9163	32.9548	30.2195
330338	21.2670	23.6142	25.4319	23.4256
330339	20.1028	20.2382	20.8423	20.3907
330340	28.4129	28.2732	27.6209	28.0963
330350	30.9763	33.5493	35.5656	33.4000
330353	34.2431	34.2260	35.6821	34.7146
330357	34.1846	36.8598	36.5461	35.8671
330372	33.3771	23.5381	28.2490	27.9598
330381	31.8602	*	*	31.8602
330385	33.2246	37.5523	29.0854	33.5264
330386	20.4231	21.4363	25.2063	22.3343

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
330389	37.3749	33.1192	32.2112	34.0979
330390	30.8744	31.7344	32.5948	31.7185
330393	27.8352	31.9272	32.9411	30.8719
330394	18.9343	19.6892	21.1737	19.9249
330395	32.7494	33.2318	32.1089	32.8033
330396	30.7961	32.8517	30.2150	31.2942
330397	32.6068	34.6435	40.0884	35.3787
330398	29.2872	*	*	29.2871
330399	33.3012	32.7149	32.1248	32.6847
330400	16.2707	16.8168	16.7483	16.6259
330401	*	*	33.9685	33.9685
340001	19.7093	22.0257	21.4870	21.0947
340002	20.5253	22.9425	23.8010	22.5969
340003	19.5145	19.6545	20.4109	19.8596
340004	20.9863	23.0890	23.1514	22.4225
340005	16.7176	16.6909	19.9094	17.7865
340006	16.5709	16.1379	18.3980	17.0420
340007	18.3399	18.3760	19.5204	18.7397
340008	20.4157	22.6570	23.7394	22.3196
340009	20.9178	20.6155	*	20.8194
340010	19.4302	20.6547	21.3024	20.4707
340011	14.4798	17.4534	18.1926	16.7010
340012	17.5112	19.3651	19.6350	18.7911
340013	19.4613	21.5130	21.0066	20.6934
340014	27.7888	21.9804	14.6001	20.4859
340015	19.4676	20.3493	24.3410	21.2831
340016	18.8958	19.4160	20.2859	19.5502
340017	20.2775	20.6263	21.5523	20.8419
340018	18.1751	16.4611	17.3480	17.2851
340019	15.2887	15.9037	16.7102	15.9597
340020	18.0897	19.2392	21.3385	19.6156
340021	20.5813	22.0220	22.9499	21.8152
340022	18.7714	20.6484	19.9078	19.7763
340023	19.3146	19.9023	*	19.6217
340024	17.9130	19.1430	20.4906	19.1924
340025	18.4628	19.1770	20.2864	19.3249
340027	19.4548	19.4907	20.8946	19.9262
340028	19.9403	20.6496	21.9837	20.9344
340030	22.4709	23.9505	27.9759	24.5972
340031	14.6370	15.4935	*	15.0325
340032	20.7444	22.0245	22.7382	21.8244
340035	18.9930	18.5883	16.4821	17.7616
340036	17.7619	18.4203	20.8313	18.9871
340037	17.5829	18.3655	17.1949	17.6512
340038	18.1493	20.3091	13.9936	16.9604
340039	21.3711	22.4020	24.8246	22.8823
340040	20.7237	21.1397	23.6131	21.8157
340041	15.5873	16.3200	15.2995	15.7337
340042	17.0034	19.1386	21.0806	19.0573
340044	18.0863	18.9562	18.2154	18.4256
340045	13.6182	20.2641	17.4067	16.7851
340047	20.0744	21.5178	23.3831	21.6665
340049	19.5127	17.2986	21.2734	19.3901
340050	19.6726	20.6831	20.3262	20.2425
340051	19.3627	19.0282	20.3057	19.5812
340052	23.2134	26.2243	31.1678	25.9648
340053	19.9915	23.2410	25.2543	22.6238
340054	15.5090	16.6208	*	15.9979
340055	19.4035	20.8253	23.1390	21.1444
340060	19.3410	20.8570	19.4707	19.8979
340061	22.1175	23.7173	25.1081	23.6221
340063	16.7377	26.4132	*	21.1044
340064	18.5069	17.6106	19.4523	18.4891

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
340065	17.3530	23.2606	20.2174	19.9588
340067	19.7187	22.4054	22.2565	21.2710
340068	17.8065	18.8758	18.9555	18.5436
340069	21.6728	22.5995	24.4650	22.9542
340070	20.6829	21.3511	22.4458	21.5104
340071	18.0767	19.3679	19.8571	19.1466
340072	17.7129	18.7920	19.2773	18.5813
340073	23.5832	24.0794	26.6829	24.9327
340075	20.0081	19.7450	22.9365	20.9263
340080	18.2061	*	*	18.2061
340084	19.0103	19.6087	20.8175	19.7922
340085	18.3179	20.3684	21.7019	20.1735
340087	18.2255	20.2445	19.7815	19.4322
340088	22.2322	22.6462	22.9486	22.6109
340089	15.4760	16.1321	16.5968	16.0500
340090	18.5287	18.7701	20.3261	19.2336
340091	20.3861	21.2665	22.4370	21.4299
340093	16.8903	16.5452	17.2910	16.9100
340094	*	21.0091	*	21.0091
340096	19.4696	20.9686	22.1174	20.8605
340097	18.2399	20.0302	20.9190	19.7534
340098	21.9578	23.4949	24.1099	23.2572
340099	15.3752	16.9979	17.3123	16.5041
340101	15.6509	20.7841	*	17.9177
340104	11.5169	12.1845	12.9949	12.2095
340106	18.1211	19.1147	20.1076	19.1527
340107	19.3197	20.7601	21.0070	20.3722
340109	19.0532	19.3357	19.0067	19.1328
340111	16.5976	17.2127	19.4520	17.8152
340112	15.5142	16.9592	17.0230	16.4908
340113	21.9883	24.4222	24.9180	23.7927
340114	20.7261	21.7750	19.5543	20.5793
340115	21.7586	24.7924	21.2336	22.4360
340116	20.6800	21.6744	23.9643	22.1286
340119	19.5827	20.5394	21.2239	20.4881
340120	15.8240	16.9847	19.3990	17.3770
340121	17.8771	19.0420	19.9862	18.9987
340123	18.9078	21.5041	22.2199	20.9298
340124	17.4185	17.5411	17.5691	17.5084
340125	20.2748	*	*	20.2748
340126	19.3734	21.2045	21.3106	20.5788
340127	19.3842	21.4797	22.0597	21.0110
340129	20.6521	21.0773	22.3260	21.4712
340130	19.8707	20.5851	22.7449	21.1193
340131	21.3849	23.2478	24.1370	22.9644
340132	17.5711	17.7110	17.8771	17.7237
340133	17.2138	17.5170	22.9471	18.7909
340137	31.7702	39.9826	33.5581	34.6438
340138	*	*	27.2610	27.2610
340141	21.4986	23.2961	24.1329	23.0207
340142	18.0766	18.1824	20.2062	18.8388
340143	24.4098	21.9304	22.5250	22.9058
340144	22.9183	22.8634	25.4597	23.8048
340145	19.9233	21.5958	21.8120	21.1598
340146	17.3051	19.1306	20.7252	19.1365
340147	20.5520	21.5912	22.3744	21.5004
340148	18.9912	20.6790	20.8025	20.1744
340151	18.4733	19.0779	19.6254	19.0740
340153	20.7533	21.7375	23.7537	22.0653
340155	23.1021	25.0965	25.7472	24.6273
340158	19.0843	20.0921	21.7830	20.4524
340159	19.0338	19.4992	21.2983	19.9832
340160	16.7170	17.1963	18.7802	17.6409

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
340164	21.5769	*	*	21.5769
340166	20.8270	22.0519	22.7235	21.9492
340168	15.6071	15.4250	16.8277	15.9431
340171	22.4779	22.7304	25.9865	23.8198
340173	21.0898	23.3690	23.7037	22.7805
340176	*	*	26.5277	26.5277
350001	16.6551	15.6193	*	16.1279
350002	18.3459	19.1931	20.4398	19.3340
350003	19.2840	20.0663	21.0585	20.1107
350004	23.7016	25.1976	28.3773	25.5370
350005	19.9156	20.7467	22.5590	21.0499
350006	19.0343	19.1257	19.7577	19.2916
350007	13.8824	13.9966	13.0050	13.5839
350008	22.3783	23.4052	20.7952	22.2417
350009	18.3688	19.3668	20.2558	19.3312
350010	16.6272	16.7774	17.2489	16.8799
350011	19.1944	20.6809	21.1006	20.1738
350012	18.2524	16.0990	17.2775	17.4137
350013	17.2596	17.8145	19.3705	18.1038
350014	18.0999	18.6786	16.1719	17.7037
350015	17.1071	17.5658	18.5437	17.7151
350017	17.5124	18.0840	19.1952	18.2584
350018	16.4939	16.3210	17.1545	16.6530
350019	20.1608	20.6743	21.3589	20.7389
350021	17.7123	16.3394	17.6652	17.2178
350023	17.4983	18.3253	16.7124	17.5523
350024	15.4788	15.7510	17.0685	16.1028
350025	15.0469	14.6099	*	14.8289
350027	15.5178	17.5882	17.6730	16.8430
350029	14.6173	*	*	14.6173
350030	18.1131	18.7993	18.8822	18.5954
350033	16.0870	16.0903	16.4715	16.2067
350034	19.6445	*	*	19.6446
350035	11.7675	12.6496	*	12.2147
350038	19.6854	19.5497	18.4963	19.2761
350039	16.6278	14.8599	13.8504	15.1678
350041	19.1341	23.1150	19.7477	20.6986
350042	19.3309	19.3370	20.6599	19.7491
350043	16.7433	17.6722	18.8378	17.7606
350044	11.0601	10.9690	13.3406	11.6826
350047	18.0094	19.9749	14.4742	17.4738
350049	18.1993	16.8322	15.3488	16.7860
350050	12.2183	25.2747	*	15.7885
350051	17.0653	16.9201	13.8030	16.0076
350053	15.9160	16.7456	*	16.3628
350055	15.7916	16.1691	19.2523	16.9922
350056	15.0995	15.7752	16.2553	15.6926
350058	16.7034	16.1013	15.0197	15.9830
350060	10.3076	10.5325	10.5055	10.4468
350061	18.8790	19.6460	18.8494	19.1278
360001	19.6655	20.3515	22.2387	20.7565
360002	18.2613	19.6145	20.7436	19.4695
360003	22.7521	23.2905	24.4144	23.4719
360006	22.4436	22.6333	23.8087	22.9695
360007	14.8213	15.3656	19.1316	16.2099
360008	18.7961	19.8034	21.3795	20.0267
360009	18.9935	19.6277	21.6966	20.1251
360010	19.1852	20.5934	20.6291	20.1715
360011	21.3659	19.5383	21.4293	20.6951
360012	20.0525	23.0125	24.3521	22.5181
360013	21.3690	22.3407	24.4232	22.7482
360014	20.7419	22.9930	22.9372	22.2320
360016	21.2505	21.3967	22.8430	21.8319

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
360017	22.2740	22.7446	23.4603	22.8364
360018	24.6686	24.6694	29.9085	26.0220
360019	20.6480	21.4708	24.1469	22.0806
360020	22.1751	21.6607	21.5085	21.7901
360024	20.1352	20.9408	22.5356	21.2300
360025	20.2531	20.9266	21.6676	20.9599
360026	17.9523	18.6739	20.6765	19.1093
360027	21.7650	22.8098	22.6956	22.4249
360028	18.7174	*	*	18.7174
360029	19.2928	19.7466	20.5687	19.8808
360030	17.6058	19.0551	20.1051	18.9454
360031	21.0687	21.0481	24.3482	22.0734
360032	19.8020	19.8367	20.6535	20.1098
360034	17.9594	19.4982	21.5621	19.7369
360035	21.0674	22.6982	24.0810	22.6341
360036	20.9916	21.4486	22.3567	21.6200
360037	23.1674	23.7504	32.6245	25.9190
360038	19.9415	21.4804	23.4855	21.6060
360039	19.0013	19.3703	23.3439	20.4210
360040	18.7425	19.9750	21.3307	20.0479
360041	19.7968	21.9093	22.1352	21.3781
360042	17.1952	19.3774	19.5402	18.6350
360044	17.6882	17.8417	19.7212	18.4151
360045	22.4018	22.8112	*	22.5916
360046	20.4607	21.4292	22.8425	21.5814
360047	15.2922	15.8279	17.5885	16.2546
360048	22.4890	25.6259	24.5867	24.1178
360049	20.8393	*	22.4938	21.5834
360050	15.0568	15.6847	16.6112	15.6772
360051	20.8757	21.2225	22.7466	21.6280
360052	18.7931	19.8037	22.2916	20.3236
360054	17.4911	17.5714	19.2884	18.1334
360055	21.4112	22.8755	23.5586	22.6117
360056	20.6968	23.4405	22.1723	22.1096
360057	15.8569	16.0395	16.2876	16.0788
360058	19.3306	19.0440	21.0717	19.7901
360059	19.9304	23.2129	23.0476	22.0393
360062	21.9195	24.4898	24.5746	23.8212
360063	17.5108	20.2671	23.7440	20.3480
360064	20.0615	20.7659	21.3424	20.7273
360065	19.6199	22.3443	22.9727	21.6463
360066	22.8175	24.1295	24.6806	23.9204
360067	14.2745	17.3734	17.0751	16.1999
360068	22.6227	22.6027	23.2680	22.8322
360069	14.6597	18.5382	19.3142	17.4363
360070	18.8406	19.4700	21.8228	20.0184
360071	19.0302	19.6873	21.4478	20.0864
360072	19.0166	20.8819	21.3735	20.4642
360074	18.5889	19.9947	22.9962	20.5125
360075	26.0663	27.6992	23.8492	26.5296
360076	20.3317	21.0402	22.5863	21.3489
360077	21.5517	22.2964	23.3686	22.4049
360078	22.6490	22.7743	22.9324	22.7880
360079	21.6644	23.9491	25.3134	23.6069
360080	17.6369	18.0392	18.7213	18.1448
360081	20.4614	20.7477	22.0134	21.0714
360082	20.7610	22.9390	25.2254	23.0000
360084	22.0492	22.1699	23.3257	22.5390
360085	21.5151	24.8010	24.6618	23.5397
360086	19.3701	20.5858	21.6902	20.5374
360087	20.7969	21.1621	23.9638	22.0097
360088	24.0822	20.5703	21.4608	21.9345
360089	18.1941	19.5260	21.0229	19.5818

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
360090	20.8971	21.2072	22.6236	21.6097
360091	21.8447	22.6510	23.5759	22.6962
360092	21.5073	20.9588	21.9732	21.4976
360093	19.0261	21.0134	21.4911	20.5156
360094	20.1227	21.1952	22.7772	21.2684
360095	19.8521	21.3505	22.6758	21.2848
360096	19.6726	20.9838	22.0673	20.9264
360098	19.8178	20.8049	22.2481	20.9247
360099	19.6241	20.8801	20.8524	20.4553
360100	18.0442	19.9768	21.5911	19.8051
360101	20.2635	24.1551	26.2875	23.5545
360102	18.5367	*	*	18.5367
360106	19.1778	18.9779	19.8658	19.3346
360107	22.1359	21.9939	23.6880	22.6413
360108	20.0681	19.0649	18.1522	19.0815
360109	19.9237	17.3564	22.4427	19.7960
360112	24.6335	25.7920	25.6581	25.3316
360113	20.8154	22.8088	22.3348	21.9843
360114	18.7509	19.4212	20.8341	19.6739
360115	20.7652	21.0104	22.0789	21.2875
360116	18.8319	20.1408	21.3809	20.0857
360118	19.9141	21.0235	22.7268	21.2720
360121	22.2175	21.9111	22.1403	22.0892
360123	20.9792	21.9985	23.1310	22.1195
360125	20.5508	21.6675	21.1408	21.0968
360126	24.5387	*	22.2409	23.5396
360127	16.5559	18.2150	18.7369	17.8642
360128	17.0515	17.5557	18.0355	17.5624
360129	16.6114	17.2309	17.9151	17.2650
360130	18.4539	19.8906	20.1257	19.4067
360131	18.4688	20.4123	21.7838	20.2068
360132	21.3493	21.0162	23.4179	21.9298
360133	20.2857	22.1957	22.0416	21.4704
360134	20.9564	21.6081	24.3117	22.2074
360136	18.2194	18.5687	19.6063	18.7820
360137	22.3648	23.1867	23.7795	23.0881
360140	21.2881	18.3463	21.0006	20.1760
360141	23.5343	23.5980	25.1442	24.0943
360142	18.3188	19.6189	21.2072	19.7570
360143	21.0336	20.9158	22.2275	21.3979
360144	20.9033	20.9386	24.7973	22.2165
360145	20.0513	21.2931	22.4813	21.2645
360147	17.6779	18.7258	20.0409	18.8813
360148	19.1393	20.3120	21.3211	20.2546
360150	22.3620	23.1858	24.8485	23.4439
360151	19.2788	20.5594	21.6234	20.4589
360152	21.6005	20.9704	22.4839	21.6726
360153	16.7399	16.1021	16.5065	16.4436
360154	14.3593	14.9606	16.1719	15.1150
360155	22.2112	22.3347	23.0020	22.5355
360156	18.9095	19.9382	21.2853	20.0637
360159	21.5695	22.7992	23.3359	22.5729
360161	20.6160	19.6266	21.5045	20.5807
360163	21.2689	22.1012	23.1500	22.1757
360165	18.2417	19.6205	21.7785	19.8643
360170	20.4407	19.7980	21.5572	20.5841
360172	19.8909	22.3294	22.6475	21.5601
360174	20.5399	20.5874	20.7719	20.6325
360175	21.5450	22.0274	22.7887	22.1417
360176	16.6228	17.6743	18.3421	17.5257
360177	18.9576	19.6992	20.8194	19.8306
360178	16.7962	18.0773	18.2393	17.6939
360179	20.7069	21.3520	23.2092	21.6660

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
360180	21.0146	22.9260	25.1489	22.9738
360185	19.4858	20.0848	21.0618	20.2316
360186	20.7572	18.1254	22.4647	20.3502
360187	19.6535	20.8423	21.5915	20.6778
360188	18.3057	16.4329	20.9591	18.4288
360189	18.5940	19.0481	20.0275	19.2171
360192	22.7846	23.9969	24.9995	23.9111
360194	17.6140	19.3901	20.3677	19.1372
360195	20.5828	21.2801	23.1897	21.7230
360197	20.5062	21.6110	23.1378	21.7597
360200	17.9623	19.5866	27.5373	19.3013
360203	15.9609	17.9698	19.3642	17.7421
360210	21.8629	21.5961	25.0811	22.8213
360211	20.6081	22.0011	22.4529	21.6965
360212	20.6987	21.0632	22.8041	21.5064
360213	19.0584	20.5448	20.9996	20.1721
360218	18.8204	20.7709	22.8059	20.8145
360230	20.8042	21.2417	24.7681	22.2381
360231	14.4168	12.7388	13.5004	13.4939
360234	20.6131	21.0473	22.1787	21.3387
360236	21.4628	20.5683	21.9560	21.3210
360239	19.2375	20.9440	21.9631	20.7405
360241	25.3741	23.7679	23.4061	24.1565
360245	15.9782	16.7956	18.1015	16.9965
360247	17.0776	*	*	17.0775
360249	25.4331	*	*	25.4330
360250	*	50.5106	*	50.5105
360253	*	*	26.8610	26.8610
360254	*	*	30.0791	30.0792
360255	*	*	15.0964	15.0963
370001	24.1929	22.0586	25.3182	23.8002
370002	15.4333	16.1853	18.9544	16.8753
370004	18.5233	22.5027	21.5041	20.8266
370005	15.3881	*	*	15.3881
370006	16.4995	15.7367	15.6334	15.9348
370007	15.8312	14.4961	16.7597	15.6795
370008	17.5553	18.5253	21.4862	19.1897
370011	15.6178	16.1757	17.1458	16.3495
370012	12.4942	13.3824	*	12.9251
370013	18.9584	19.3237	21.1513	19.8462
370014	20.2858	22.7976	21.8473	21.6639
370015	20.8765	18.9169	20.3965	20.0611
370016	19.1613	20.0888	20.4407	19.8819
370017	13.6531	*	*	13.6531
370018	17.7054	18.7928	20.8357	19.1122
370019	14.6216	16.1367	18.1260	16.2132
370020	15.1035	15.6057	16.8214	15.8194
370021	12.9030	*	*	12.9030
370022	17.3724	18.2109	20.2432	18.6171
370023	17.5148	18.1255	19.3386	18.3281
370025	18.4815	19.1013	20.2845	19.2928
370026	18.0412	18.6982	21.9141	19.5712
370028	21.1292	22.1765	24.3775	22.5815
370029	18.2580	19.3285	19.6977	19.1304
370030	16.5803	18.4568	18.6541	17.9169
370032	18.1538	18.9050	20.0827	19.0803
370033	11.3210	15.3857	15.7468	13.9159
370034	15.6288	16.2204	16.1541	15.9959
370036	12.4070	11.7667	16.5843	13.2363
370037	18.9556	20.6493	20.9598	20.1863
370038	13.0210	15.4551	16.7597	14.9832
370039	19.4498	22.7015	20.3137	20.7707
370040	15.5109	16.8127	18.9981	17.0372

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
370041	16.2316	14.7346	19.0064	16.6382
370042	15.2764	15.9005	14.0899	15.1360
370043	17.0892	20.0991	20.2929	18.9889
370045	11.3560	11.6163	12.6613	11.8767
370047	17.8769	18.4743	19.4856	18.6175
370048	15.6803	17.0785	15.4768	16.0450
370049	19.4868	20.3405	20.4826	20.0887
370051	12.5171	11.4943	12.0397	11.9839
370054	18.0787	19.2294	20.3788	19.2048
370056	18.1432	19.2867	20.4872	19.2536
370057	15.1228	16.0301	17.3020	16.1401
370059	18.3314	21.3103	20.7160	20.0337
370060	19.3051	17.9469	23.1897	20.1750
370063	16.7342	*	12.7634	16.0398
370064	11.9954	11.6347	11.9044	11.8446
370065	18.1349	18.2406	18.3966	18.2581
370071	16.4567	*	*	16.4568
370072	13.6519	12.5765	12.5766	12.8934
370076	14.3555	15.4067	19.0231	16.2477
370078	19.2412	15.2513	22.0344	18.4513
370079	16.9201	17.5915	17.9942	17.4569
370080	14.7323	14.3546	16.1445	15.0543
370082	15.0669	16.9715	12.6060	14.8254
370083	13.1810	15.6824	18.5669	15.6441
370084	13.1197	15.6184	16.1277	15.0212
370085	48.1271	13.7216	15.8930	17.6461
370086	11.1900	*	*	11.1900
370089	17.2638	17.9243	18.0505	17.7472
370091	20.1822	20.8536	23.8502	21.5141
370092	15.7678	16.8432	*	16.3152
370093	19.7008	22.1966	23.5685	21.8046
370094	19.5462	19.5565	20.7290	19.9736
370095	13.4202	14.5909	14.3563	14.1246
370097	23.2056	19.3793	20.3218	20.7266
370099	19.4646	18.1467	20.2001	19.2453
370100	18.8274	12.9784	13.0682	14.6358
370103	18.2685	23.1347	15.6109	19.0349
370105	20.7890	25.1252	22.4493	22.5846
370106	20.3651	21.8937	24.0117	22.1004
370108	12.7470	14.0190	13.8170	13.5126
370112	15.3039	14.3384	16.5964	15.3556
370113	17.6107	20.3439	21.4267	19.8197
370114	17.8941	17.9757	19.3383	18.4232
370121	21.3099	20.5488	20.1393	20.6498
370122	15.4375	*	*	15.4374
370123	19.0313	19.7958	20.5180	19.7729
370125	13.9436	14.4664	17.9240	15.3291
370126	15.8020	*	*	15.8021
370131	15.7261	*	*	15.7262
370133	12.9545	16.1855	17.4258	15.5834
370138	17.5551	17.4574	19.0403	18.0470
370139	14.9964	16.0898	16.3223	15.8016
370140	17.1393	17.4950	20.2255	18.2466
370141	20.7798	19.8606	24.0523	21.4638
370146	13.0399	13.9900	*	13.5128
370148	20.6612	22.6237	22.8526	22.0700
370149	17.0929	18.0699	18.2260	17.8047
370153	16.4669	16.5267	17.9692	16.9732
370154	15.6093	16.6687	17.4760	16.6039
370156	14.5696	15.4303	15.9647	15.3521
370158	15.6994	16.3637	17.3412	16.4535
370159	21.1267	25.5592	*	22.6485
370163	20.4217	*	*	20.4216

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
370165	13.0375	12.9569	16.1893	13.8212
370166	21.0797	19.4219	21.3003	20.6013
370169	12.7138	14.8384	16.5607	14.5408
370176	18.9951	19.6537	21.7871	20.1373
370177	14.6481	14.1304	14.0279	14.2494
370178	11.6200	9.8655	12.9636	11.3085
370179	21.3002	23.8404	21.9673	22.2749
370183	16.9318	16.6061	*	16.7678
370186	15.4533	16.3671	16.3879	16.0737
370190	19.3570	20.6398	22.3326	20.7903
370192	19.6967	21.8343	24.3832	21.9053
370200	22.5299	18.3941	16.7164	18.9908
370201	*	18.2548	18.9906	18.6571
370202	*	16.5384	24.0239	20.2030
370203	*	23.5454	19.8772	21.4569
370204	*	*	17.5518	17.5517
370205	*	*	20.7828	20.7830
370206	*	*	22.3471	22.3471
370207	*	*	26.3745	26.3746
380001	26.4822	25.1542	20.9585	23.8121
380002	21.9185	23.2479	25.2629	23.4657
380003	20.9007	23.8074	24.6377	23.1951
380004	23.3609	24.5418	26.7995	24.9862
380005	25.0750	24.7476	26.3472	25.4394
380006	21.3520	20.5914	24.7492	22.3626
380007	32.2678	25.9239	30.0497	29.1804
380008	22.3004	21.6133	24.6149	22.8464
380009	24.3851	25.1040	25.9993	25.1907
380010	22.7276	24.1931	*	23.4887
380011	20.3357	20.6759	21.9382	20.9633
380013	19.8180	19.9606	24.1491	21.3157
380014	25.9828	26.6038	28.4536	27.0598
380017	25.3954	21.9236	29.2543	25.5247
380018	22.9822	24.8661	27.5171	25.1199
380019	20.8176	21.1743	23.9736	22.0144
380020	22.9568	23.9978	23.7066	23.5720
380021	23.8499	24.4365	28.0334	25.5509
380022	24.5974	25.6255	26.4793	25.6210
380023	21.3831	23.4328	23.0079	22.7334
380025	26.9346	26.9398	28.8525	27.6239
380026	20.6972	22.7561	23.8666	22.4738
380027	21.5490	22.2573	21.5822	21.7906
380029	20.1471	22.0371	24.2939	22.3500
380031	20.3396	23.7634	25.2963	23.2221
380033	27.1343	26.6899	30.4783	28.1499
380035	23.9719	25.6016	26.2434	25.3543
380036	27.2157	*	*	27.2157
380037	22.1774	23.4798	25.0199	23.6781
380038	26.7759	28.1436	29.1804	28.0609
380039	22.8048	25.7614	26.3917	24.8782
380040	22.5477	22.6412	21.5958	22.2243
380042	24.4172	21.6793	15.2050	19.3932
380047	24.2524	25.2591	26.5017	25.3895
380048	18.3005	18.2773	22.0609	19.6514
380050	20.3205	22.1089	23.1332	21.8624
380051	22.3207	24.4081	26.2384	24.3019
380052	18.6299	20.7431	21.2567	20.2520
380056	18.4961	20.7895	22.3571	20.6518
380060	24.2059	23.0106	27.5270	24.9545
380061	22.8781	24.1121	26.4940	24.6176
380062	18.2148	26.1370	22.8599	22.5474
380064	22.9160	27.0627	*	25.0195
380065	22.9608	23.3146	24.8933	23.7620

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
380066	23.2794	23.1175	23.3581	23.2487
380069	20.4882	21.2057	21.8362	21.1860
380070	27.7790	29.9706	34.1038	30.4794
380071	25.1808	25.9113	27.9055	26.3468
380072	19.4346	20.6568	21.9516	20.7086
380075	22.4139	23.1910	25.1930	23.7443
380078	21.0903	22.6996	25.0805	22.9534
380081	20.4082	22.9805	22.1822	21.8754
380082	22.9606	23.7927	28.0668	25.0482
380083	21.7431	22.4058	26.4379	23.4740
380084	27.1689	31.0111	27.9068	28.5032
380087	17.0380	21.3119	21.1488	19.9159
380088	19.5346	24.8158	21.6317	21.8938
380089	25.2908	26.1967	29.6989	27.0928
380090	24.9351	30.4223	31.8702	28.9771
380091	25.3062	28.7846	31.2807	28.6166
380099	*	*	16.7656	16.7656
390001	19.6732	20.3350	21.5154	20.5284
390002	19.7833	20.8831	21.8704	20.8537
390003	18.1025	18.0436	19.1857	18.4384
390004	20.3204	20.0557	21.3475	20.5889
390005	16.9472	19.0218	19.0727	18.2821
390006	21.1786	21.7867	22.9809	21.9897
390007	21.3839	*	*	21.3839
390008	18.2743	19.5439	19.9417	19.2572
390009	20.6241	22.5580	21.8195	21.6732
390010	17.3335	18.1275	19.4377	18.3086
390011	18.3257	18.2751	18.6548	18.4184
390012	21.0610	22.2060	28.5114	23.7778
390013	19.6562	20.2186	22.1679	20.7339
390015	13.7352	14.3138	15.2697	14.4324
390016	17.1133	17.4931	18.1536	17.5840
390017	18.6113	18.5869	19.1962	18.7750
390018	19.0279	20.0672	19.9117	19.6570
390019	17.7258	18.7609	21.2807	19.2350
390022	24.8468	25.2980	27.5365	25.9219
390023	22.1044	23.9246	25.6750	23.9254
390024	25.4606	27.7643	25.9806	26.4580
390025	15.5523	14.0077	14.8690	14.8024
390026	22.9718	23.6317	23.9225	23.5085
390027	29.5940	29.4334	33.2139	30.7948
390028	23.6571	22.7820	22.9071	23.1380
390029	21.2661	24.4753	*	22.6697
390030	18.6887	18.9121	20.0598	19.2297
390031	18.8162	19.2040	20.6513	19.5475
390032	21.5105	18.5545	20.7764	20.3109
390035	22.3591	21.9325	23.2173	22.4923
390036	19.7671	20.2103	20.5751	20.1842
390037	20.4263	19.9175	20.1665	20.1659
390039	17.5300	17.6181	18.4580	17.8792
390040	16.6876	17.4451	20.5371	18.2001
390041	20.4397	19.6159	21.0074	20.3638
390042	22.5775	22.0668	21.8863	22.1699
390043	17.4764	17.6739	19.8094	18.3425
390044	20.9831	21.3382	22.0362	21.4586
390045	19.4677	20.2107	19.8137	19.8315
390046	21.7445	21.3960	23.0279	22.0786
390047	26.9709	*	*	26.9709
390048	19.7992	18.9776	20.3523	19.7014
390049	22.1586	22.8196	23.9058	22.9608
390050	22.2639	24.9156	22.5851	23.1577
390051	28.1385	*	*	28.1385
390052	20.1195	21.2729	22.1380	21.1379

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
390054	18.4975	19.4686	19.8602	19.2479
390055	23.4017	25.7327	22.2112	23.7101
390056	19.3901	21.4121	21.4239	20.7360
390057	20.2395	21.6693	24.5245	22.1897
390058	20.3520	20.7930	22.0113	21.0507
390061	23.8722	22.8728	24.3816	23.6939
390062	17.3750	17.4710	17.6303	17.4968
390063	19.4965	20.1696	21.7120	20.4817
390065	20.0473	20.2930	23.1698	21.2264
390066	18.9296	19.0132	21.7717	19.8676
390067	20.8162	21.9885	23.2161	21.9824
390068	19.1109	21.6408	21.8596	20.7014
390070	21.8549	22.7909	24.4403	23.0308
390071	16.0100	18.9416	17.8117	17.5040
390072	16.9232	16.9445	20.6881	18.0993
390073	21.2623	22.2703	22.7073	22.0769
390074	18.3093	19.7446	21.8456	19.9484
390075	18.7695	19.5840	19.8576	19.3638
390076	21.3290	19.7719	*	20.5305
390078	19.0156	20.6483	21.1894	20.2451
390079	18.9269	19.5982	20.0240	19.5384
390080	21.4707	22.2449	23.0615	22.2544
390081	24.7461	25.6575	27.3952	25.9933
390083	*	26.1660	*	26.1660
390084	20.2529	17.0197	18.3551	18.4310
390086	18.3563	19.7645	19.5253	19.2361
390088	23.9506	*	*	23.9506
390090	21.3759	20.5433	21.8543	21.2676
390091	18.3770	19.0355	19.7361	19.0422
390093	18.4442	20.0135	19.9209	19.4590
390095	16.6930	17.9697	18.3939	17.6811
390096	22.4382	22.2974	22.6176	22.4533
390097	25.2845	24.7853	24.6090	24.8791
390100	20.9263	21.1186	22.9484	21.6940
390101	18.5039	19.0180	19.7332	19.0899
390102	21.5496	19.3111	19.9809	20.2918
390103	18.8667	20.4422	26.5769	21.5409
390104	16.3255	16.2440	16.5081	16.3661
390106	16.8439	17.4747	18.2013	17.4917
390107	20.9841	20.6024	21.1104	20.9018
390108	21.3142	22.0444	23.6644	22.2895
390109	16.5299	17.4540	17.2667	17.0836
390110	21.6464	21.6005	23.2166	22.1164
390111	33.3971	27.1429	30.5237	30.4448
390112	15.0065	14.8634	15.6710	15.1640
390113	19.3634	19.9496	20.1160	19.8009
390114	20.9533	19.8004	23.0501	21.2575
390115	21.4287	22.3545	24.1951	22.7320
390116	21.3671	22.6783	24.0492	22.6706
390117	18.0769	18.9764	18.3341	18.4618
390118	18.9507	17.2668	17.8460	18.0300
390119	18.8815	19.3946	20.3034	19.5629
390121	19.1315	20.6253	20.8017	20.2031
390122	17.7734	15.5438	18.5130	17.2135
390123	21.3974	21.8897	23.2750	22.1809
390125	17.5446	17.0975	18.2411	17.6363
390127	22.4555	22.8787	25.0836	23.5152
390128	19.3165	19.9764	21.3668	20.1918
390130	18.3695	18.5519	19.4835	18.7830
390131	19.2096	19.1931	19.2964	19.2343
390132	22.8414	24.1878	24.6889	23.9106
390133	24.7561	24.1590	25.1423	24.6873
390135	22.1905	22.2501	24.0445	22.8305

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
390136	20.6286	16.8505	*	18.7490
390137	18.5397	19.4769	18.4551	18.8068
390138	20.6936	20.7726	21.4705	20.9891
390139	23.9757	24.8347	26.3622	25.0742
390142	28.8877	28.4680	29.9432	29.1087
390145	20.4228	20.4964	20.6603	20.5268
390146	18.6505	20.1788	21.3295	20.0284
390147	21.2492	21.7600	22.3135	21.7727
390150	20.3155	20.8970	20.0261	20.3992
390151	22.5206	23.6072	24.8175	23.6886
390152	19.4017	20.2581	21.5474	20.4133
390153	22.9707	23.9039	25.3415	24.1064
390154	16.7052	17.8774	19.1300	17.9859
390156	22.6398	24.0034	25.0732	23.9019
390157	19.1783	20.2647	20.6933	20.0398
390160	19.4463	19.4793	19.3598	19.4262
390162	21.9188	21.3379	21.3398	21.5478
390163	17.7564	18.1831	18.8585	18.2862
390164	24.9750	26.1698	23.0298	24.6107
390166	19.7978	19.8899	19.8531	19.8460
390168	18.8863	19.6875	20.6777	19.7568
390169	22.0547	22.7920	22.7695	22.5431
390170	24.7973	*	*	24.7973
390173	18.6613	18.8265	20.6958	19.3949
390174	25.3307	26.3891	28.2662	26.6572
390176	20.8368	21.7650	18.0752	20.3817
390178	17.0534	17.1142	17.2384	17.1362
390179	21.8593	21.5792	24.0501	22.5243
390180	26.5541	26.7743	28.3812	27.2876
390181	19.3832	18.8681	24.1288	20.6497
390183	17.9848	17.4535	21.7091	18.9719
390184	20.9349	21.1941	21.1962	21.1056
390185	20.3877	20.3301	20.4476	20.3876
390189	20.3338	19.6186	20.0387	19.9844
390191	17.2270	17.1919	18.5972	17.6639
390192	17.6597	16.6469	19.1883	17.8533
390193	18.1209	17.3804	18.9764	18.1140
390194	21.2689	21.0549	21.5850	21.3104
390195	24.1793	24.2891	26.2024	24.9040
390197	20.7998	22.1974	22.3472	21.7925
390198	15.8833	16.6803	17.3937	16.6375
390199	17.3865	17.7782	18.9787	18.0590
390200	15.4012	18.2456	19.1728	17.6332
390201	20.3533	21.3291	22.6548	21.4708
390203	21.4989	22.4685	26.9436	23.7942
390204	22.9616	22.7282	23.9673	23.2268
390209	18.7059	16.8200	18.4248	17.9405
390211	18.4213	19.4552	21.0450	19.6873
390213	19.1553	20.1152	19.9614	19.7218
390215	21.2032	23.5953	25.2617	23.2887
390217	19.9837	19.7578	21.4058	20.3609
390219	19.6226	20.1311	20.0594	19.9347
390220	17.7916	22.7617	23.3890	21.1672
390222	22.1548	22.7491	24.9365	23.2941
390223	22.1775	18.9493	20.4623	20.4831
390224	13.7518	17.2173	15.4657	15.2280
390225	18.7290	19.0364	22.5083	20.0077
390226	21.8481	22.8588	26.4195	23.5449
390228	19.8180	19.6212	20.1219	19.8582
390231	19.4798	21.0757	24.6868	21.6606
390233	20.2309	20.5800	21.6259	20.8313
390235	21.4200	19.9925	23.7068	21.4467
390236	17.8735	19.1427	19.8687	18.9492

* Denotes wage data not available for the provider for that year.
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TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
390237	22.3011	21.7847	23.2054	22.4279
390238	17.1055	18.1956	19.2170	18.1264
390244	15.6402	14.2136	*	14.8974
390245	24.5076	*	*	24.5076
390246	25.0556	22.3892	22.0687	23.0374
390247	21.2151	*	*	21.2151
390249	13.1657	14.1062	14.7215	14.0139
390256	22.2773	22.3540	22.5794	22.4081
390258	22.6852	23.8318	25.0634	23.8724
390260	21.5982	*	*	21.5982
390262	*	18.8942	21.3264	20.1664
390263	20.3796	20.6348	21.9811	21.0229
390265	20.4950	20.4760	20.5948	20.5230
390266	17.1966	17.6223	18.2424	17.6964
390267	19.2665	20.2424	21.4980	20.3945
390268	22.0909	22.2046	23.1124	22.4784
390270	19.2074	20.7957	22.3861	20.7770
390278	17.7176	18.5776	21.1387	19.0743
390279	14.8655	15.8080	16.0509	15.5561
390283	22.5490	*	*	22.5489
390284	34.3904	*	*	34.3902
390285	*	29.1270	30.6458	29.8575
390286	*	22.9746	25.4619	24.2087
390287	*	30.3252	32.9709	31.6159
390288	*	26.9662	28.0958	27.3905
390289	*	22.8963	25.1658	23.9733
390290	*	30.5037	31.0967	30.8194
390291	*	20.0272	21.0057	20.4818
390293	*	23.5285	*	23.5284
390294	*	*	33.3535	33.3537
390295	*	*	26.8863	26.8862
390296	*	*	25.6979	25.6981
390297	*	*	27.2166	27.2167
400001	10.5757	10.7531	11.7572	11.0430
400002	13.0494	13.3684	11.6804	12.6379
400003	12.4078	11.2726	10.5963	11.4141
400004	8.5648	9.0781	11.4479	9.6254
400005	7.7432	9.7802	10.5356	9.1053
400006	10.1048	10.4988	9.2852	9.9205
400007	8.0174	8.1974	8.6022	8.2631
400009	8.8650	8.7341	9.4413	9.0139
400010	10.8011	9.1359	8.9964	9.6421
400011	8.5426	8.6252	8.9111	8.6956
400012	8.4728	8.6538	9.0740	8.7216
400013	9.2624	9.8197	9.9905	9.7250
400014	9.4798	10.2712	11.4580	10.3309
400015	14.4076	15.5827	*	14.8835
400016	13.3922	13.7001	14.5398	13.8932
400017	9.2577	9.9167	10.3892	9.8593
400018	10.6208	10.5583	10.8254	10.6669
400019	10.8940	12.1251	13.2143	12.0755
400021	12.1434	12.7462	13.2358	12.7262
400022	12.2199	13.0915	15.2904	13.4548
400024	9.2409	9.0826	9.8650	9.4011
400026	5.8335	7.4280	5.9207	6.3366
400028	9.1794	8.9567	9.5266	9.2275
400032	10.0448	10.1898	10.7100	10.3326
400044	11.9486	12.8671	9.0275	11.6261
400048	15.1405	11.5104	10.8618	12.2444
400061	13.0988	10.3664	17.0566	13.1015
400079	9.7203	8.7218	8.7218	8.9772
400087	9.8534	8.6480	10.5762	9.7829
400094	7.9187	9.4600	9.1442	8.8371

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
400098	9.7791	10.4312	13.5901	11.0612
400102	9.9903	8.5290	10.9973	9.8471
400103	11.5359	11.8454	11.5797	11.6448
400104	10.7292	7.9552	7.1781	8.8476
400105	9.0556	10.6028	11.5608	10.1248
400106	9.2187	9.8694	10.1240	9.7589
400109	11.8760	12.2080	12.8750	12.3225
400110	10.5277	10.7228	12.0159	11.1009
400111	10.9665	12.3311	12.7701	12.0404
400112	10.8694	11.0634	11.8808	11.2717
400113	8.3168	9.3000	10.1440	9.3104
400114	7.0510	9.9477	9.7444	8.8440
400115	8.5487	7.2203	7.0336	7.5134
400117	10.8756	11.3351	9.6471	10.6080
400118	11.4051	11.4317	12.0855	11.6542
400120	10.6584	10.9315	11.8837	11.1482
400121	9.8322	8.7584	8.3575	8.9176
400122	7.6413	9.1638	9.6644	8.8133
400123	10.2367	10.9047	10.4081	10.5188
400124	12.2452	12.7323	14.1198	13.0556
400125	10.2056	10.5997	10.0698	10.2676
410001	23.1738	22.4972	24.0033	23.2235
410004	21.0638	23.5408	24.7607	23.1523
410005	22.7170	24.0086	24.6202	23.7588
410006	23.8700	22.8959	26.1234	24.3211
410007	23.1325	24.9846	27.7171	25.1159
410008	24.9726	24.4792	25.4183	24.9582
410009	24.3895	24.3760	26.1891	24.9832
410010	28.4589	29.7315	30.4061	29.5287
410011	26.1183	27.4880	29.2039	27.5568
410012	24.1695	26.4570	28.1791	26.2184
410013	24.8800	25.3688	28.4954	26.2187
420002	20.7804	22.6182	25.1067	22.8141
420004	20.9588	22.4680	23.4275	22.2200
420005	17.9694	17.8202	19.5521	18.4820
420006	19.1760	18.7153	22.7896	19.8079
420007	18.6456	19.0199	22.0134	19.8792
420009	19.9586	21.2566	18.6866	19.8536
420010	18.0252	19.3267	19.1545	18.8686
420011	18.0970	16.7523	17.3200	17.3563
420014	18.0519	19.0455	20.4975	19.1969
420015	20.1164	20.8736	22.7776	21.3355
420016	15.5485	16.6448	17.0051	16.4309
420018	21.8775	20.7779	20.4649	20.9903
420019	17.1726	19.0199	19.7118	18.6106
420020	20.3193	20.5801	22.1616	21.0728
420023	20.4053	20.8600	22.9004	21.4470
420026	21.8749	23.3072	23.6914	22.9839
420027	19.2594	19.7322	20.7327	19.9443
420030	20.6448	22.5159	22.5925	21.9394
420031	8.2516	15.3605	16.8518	12.3011
420033	23.1303	23.7974	26.0792	24.3733
420036	21.3222	19.8285	20.6780	20.5493
420037	22.7099	23.5244	25.3863	23.9574
420038	18.6568	19.9829	21.6132	20.0798
420039	18.3017	18.0055	21.1830	18.9968
420043	19.7570	19.6834	21.8816	20.4303
420048	18.8070	20.5531	21.9517	20.4950
420049	19.4049	20.1765	20.2320	19.9533
420051	19.1555	19.8549	20.6629	19.9007
420053	18.1657	19.0780	19.9013	19.0557
420054	20.2574	20.2275	20.7802	20.4197
420055	16.8717	18.6782	19.3056	18.2587

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
420056	15.1835	16.5491	19.8467	17.1664
420057	20.5266	22.1312	17.6727	20.1808
420059	17.1483	18.2093	20.2630	18.4420
420061	17.3543	17.7047	19.9789	18.3969
420062	21.7469	20.9032	17.4888	19.8336
420064	16.0794	19.7067	20.9057	19.0582
420065	19.9435	19.2150	21.9297	20.4427
420066	18.0042	19.5366	20.7713	19.3973
420067	19.7824	20.8524	22.8104	21.1856
420068	18.5481	20.2580	21.7257	20.1957
420069	18.1298	18.9017	17.6788	18.2297
420070	17.3876	19.2186	20.1378	18.9286
420071	20.3902	20.1897	21.2610	20.6237
420072	15.0158	18.2531	16.2578	16.5142
420073	19.9986	20.2697	21.4718	20.6373
420074	18.0967	18.1839	18.7011	18.3051
420075	12.8158	15.0132	15.9890	14.6306
420078	21.9082	22.7156	23.9730	22.8546
420079	21.0874	21.3177	23.0729	21.8705
420080	21.9968	23.2871	26.7489	24.1988
420082	21.7210	22.8516	28.0149	24.1640
420083	22.6376	24.4499	24.8294	24.0095
420085	21.6791	22.0071	23.8540	22.5902
420086	20.2878	23.5303	24.5760	22.8222
420087	19.8388	20.8217	21.9354	20.8793
420088	19.9919	21.8979	23.5174	21.7712
420089	20.5360	21.3954	23.3240	21.8074
420091	20.3092	21.8367	23.7544	21.8937
420093	18.3902	19.1299	21.4678	19.5913
420095	*	33.4632	*	33.4634
420096	*	26.4863	*	26.4864
430004	19.6344	19.2737	22.2198	20.3430
430005	16.4560	17.3400	18.2647	17.3726
430007	14.6331	15.1494	17.8017	15.8287
430008	18.1323	18.5234	20.0124	18.8898
430010	19.8191	16.5750	21.3978	18.9840
430011	17.4750	18.3648	19.9835	18.5721
430012	17.6997	19.2921	21.2588	19.3790
430013	18.4817	18.8978	21.3388	19.5495
430014	20.2387	20.9118	22.0285	21.0694
430015	18.2875	18.8998	20.5848	19.2456
430016	20.8850	22.7585	24.2450	22.6451
430018	16.2244	15.9424	17.9850	16.6387
430022	14.5118	14.0661	*	14.2905
430023	16.2164	16.7850	18.8816	17.1465
430024	16.1801	17.4816	18.8359	17.4068
430027	20.2591	20.8666	22.1807	21.1128
430028	17.1577	18.2829	30.0094	20.4957
430029	17.6986	17.4932	18.9463	18.0331
430031	12.4660	13.2105	15.2322	13.5804
430033	17.3652	18.3978	21.6255	19.2950
430034	14.2491	13.8535	13.6064	13.9089
430036	15.6258	16.7827	16.5848	16.2916
430037	18.1293	18.7009	19.3794	18.7558
430038	18.4078	*	*	18.4078
430040	14.4509	14.7860	15.3612	14.8505
430041	14.8816	*	*	14.8815
430043	14.9949	17.0193	17.9673	16.5225
430044	21.0823	*	*	21.0824
430047	17.9823	17.5377	18.2773	17.9221
430048	18.7602	19.0261	20.0608	19.3158
430049	15.2237	14.9025	17.0885	15.6759
430051	18.8070	18.8697	21.2838	19.6636

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
430054	14.8003	15.0101	17.8870	15.8667
430056	10.3697	14.1914	15.9149	13.1642
430057	17.2805	18.8777	18.2939	18.1566
430060	10.0176	9.7678	10.6493	10.1353
430064	14.2184	13.8666	14.3407	14.1427
430066	15.6660	14.5957	18.0501	16.1260
430073	15.3776	16.5112	16.4387	16.0995
430076	13.9883	15.2453	12.6996	13.8839
430077	19.8558	20.4361	21.6786	20.6834
430079	14.1815	14.4154	15.4268	14.6345
430089	17.9790	17.5100	19.8572	18.4672
430090	21.5974	23.5180	25.6873	23.7486
430091	18.1567	21.6239	22.2824	21.1724
430092	21.3807	19.7644	19.7354	20.2342
430093	19.5013	23.3009	23.8820	22.1340
430094	*	*	20.8742	20.8743
440001	15.5897	17.2282	18.9833	17.1918
440002	20.3740	21.4299	20.7715	20.8573
440003	19.3042	20.3756	21.6336	20.4509
440006	21.4055	23.1483	24.3132	22.9905
440007	14.8959	14.0612	14.1008	14.3331
440008	18.8994	20.3303	20.9238	20.0515
440009	17.4831	18.4068	19.6564	18.5235
440010	16.3283	13.3692	16.7270	15.2992
440011	18.3375	19.3165	20.5036	19.4558
440012	19.5739	19.8949	21.3573	20.2411
440014	16.1143	15.0656	*	15.5948
440015	22.0659	21.6106	23.3677	22.3025
440016	16.2964	14.6142	20.1504	16.8295
440017	20.4563	20.4705	22.3573	21.0640
440018	17.4995	18.1620	21.2242	19.0126
440019	21.5402	22.8463	24.0149	22.8001
440020	17.8879	20.2189	21.1075	19.7440
440023	16.7837	15.6603	15.5410	15.9556
440024	18.4046	18.4276	19.9751	18.8456
440025	16.3140	17.0997	18.9008	17.4832
440026	23.2566	25.6490	25.1655	24.7161
440029	20.7050	22.2889	24.1379	22.4401
440030	16.9925	17.6297	19.9056	18.2332
440031	17.0211	17.2555	17.0289	17.1002
440032	13.8140	13.9784	14.7683	14.1838
440033	13.7328	16.4679	17.2637	15.8189
440034	20.0309	21.1672	22.2382	21.1482
440035	19.3034	20.4168	21.6338	20.4652
440039	21.6536	22.4158	24.8698	22.9682
440040	16.9275	17.6781	16.9886	17.1928
440041	14.9545	14.6684	15.5784	15.0621
440046	19.3229	20.5562	22.1743	20.5985
440047	17.8092	18.7469	18.7262	18.4184
440048	21.4993	21.6132	22.5431	21.9061
440049	18.7967	19.6920	22.1252	20.0483
440050	18.2511	19.7915	21.3428	19.8422
440051	16.0421	17.7067	19.0165	17.5455
440052	19.8075	18.6589	18.1897	18.8402
440053	19.6494	21.5253	22.0063	21.0648
440054	13.3967	15.2154	15.4208	14.7050
440056	16.2742	20.4903	19.1329	18.5350
440057	13.7257	14.4363	14.1477	14.1083
440058	19.1878	20.7722	21.7512	20.5453
440059	19.6018	20.8882	22.4248	21.0016
440060	19.7916	20.7628	20.0972	20.2143
440061	22.5525	16.9234	19.5458	19.4254
440063	19.8371	18.8072	19.7468	19.4529

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
440064	18.9809	18.2678	19.4020	18.8736
440065	18.8296	19.2282	19.9099	19.3487
440067	17.2397	18.2973	19.6120	18.4263
440068	19.3668	19.5428	20.9188	19.9728
440070	14.0437	18.0064	18.3717	16.8031
440071	19.7836	*	*	19.7836
440072	19.1522	20.0691	20.9286	20.0759
440073	19.5554	19.6290	20.7181	19.9917
440078	16.0188	17.1645	20.0509	17.7858
440081	19.3454	17.2905	18.2664	18.2167
440082	22.6855	22.5590	26.0944	23.6946
440083	13.7423	13.7630	15.7015	14.3937
440084	13.7731	13.8085	15.0510	14.2295
440091	20.1065	20.1359	22.2894	20.8482
440100	14.7113	15.9969	20.1545	16.9936
440102	14.5500	16.0783	16.6548	15.7421
440103	18.6990	*	*	18.6990
440104	22.6754	21.7135	21.5501	21.9246
440105	17.1172	18.1375	19.2902	18.1888
440109	17.7443	17.6399	16.5366	17.2746
440110	17.4816	18.4998	19.9718	18.7249
440111	23.2254	23.2111	24.9666	23.7976
440114	15.0036	18.5327	20.1152	17.9248
440115	18.5457	18.7054	18.4721	18.5719
440120	16.3115	19.8997	22.4031	19.5197
440125	19.4115	20.0599	21.2173	20.2484
440130	17.4857	19.0905	20.6364	19.0816
440131	16.1214	19.9883	21.0641	18.9957
440132	16.8871	17.9186	18.9580	17.9377
440133	23.0891	22.2257	22.4872	22.5969
440135	22.2005	22.5452	23.8313	22.9298
440137	15.0070	15.3530	16.5529	15.6758
440141	15.9429	17.6819	19.2607	17.4468
440142	16.8855	17.1483	17.7587	17.2159
440143	18.2061	18.6844	19.2978	18.7274
440144	18.3859	18.8127	19.7938	19.0189
440145	18.3948	18.3850	18.1226	18.2932
440147	26.1464	25.3766	25.0779	25.5115
440148	19.4598	19.3769	20.7693	19.8862
440149	18.4281	19.8304	18.1316	18.8060
440150	20.3006	21.2942	22.8656	21.5228
440151	18.3928	19.8977	20.7681	19.6191
440152	22.7664	21.7382	27.2915	23.9903
440153	16.5716	18.1781	19.9486	18.2431
440156	21.7577	21.9374	23.7799	22.5299
440157	18.4249	15.5316	17.6241	17.2522
440159	20.9371	21.4914	20.5719	20.9737
440161	22.8816	23.6805	26.1354	24.2908
440162	15.5534	19.8075	20.3909	18.5104
440166	19.2159	19.6632	23.1692	20.6397
440168	19.1509	21.1947	21.2114	20.4537
440173	19.1812	21.0284	20.8442	20.3754
440174	18.0865	19.3966	19.2201	18.8962
440175	18.5186	19.9022	22.3331	20.2599
440176	19.2208	19.8448	20.4861	19.8829
440180	20.2184	20.2057	21.1947	20.5447
440181	17.7709	19.0915	19.5055	18.7704
440182	19.7094	18.1953	19.3928	19.0713
440183	21.3465	22.2401	24.9282	22.9040
440184	16.8880	18.6890	21.4484	18.5678
440185	21.2188	21.1226	22.2855	21.5992
440186	19.7983	20.8600	23.0193	21.1673
440187	17.5872	18.3729	19.9478	18.6211

* Denotes wage data not available for the provider for that year.
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TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
440189	18.5252	22.2555	23.2866	21.3831
440192	19.1705	19.1976	21.3228	19.9395
440193	18.6999	19.9078	22.0345	20.2055
440194	22.4562	21.9609	24.4629	23.0062
440197	21.8503	22.5282	24.2661	22.9060
440200	19.8078	18.7302	16.7752	18.4446
440203	16.2861	16.9819	21.3888	18.3754
440210	11.9815	12.7622	*	12.3704
440214	28.0285	*	*	28.0287
440215	22.2928	*	*	22.2928
440217	*	19.2834	23.3544	21.1703
440218	*	*	20.1377	20.1377
440219	*	*	18.2762	18.2762
440220	*	*	22.1222	22.1221
450002	21.4836	21.5141	24.0413	22.4014
450004	16.7850	15.9452	*	16.4042
450005	16.6396	16.6354	21.7110	18.0529
450007	19.1910	18.0269	18.3073	18.4788
450008	17.6582	19.3745	20.1817	19.0466
450010	17.6677	19.8998	20.2928	19.2457
450011	20.8102	20.2963	21.6599	20.9101
450014	17.5815	19.8846	19.4805	18.9747
450015	21.6773	22.9820	23.9140	22.8577
450016	18.3456	19.1522	19.9783	19.1667
450018	23.2293	21.9921	22.9508	22.6215
450020	19.1153	18.4642	18.8688	18.8186
450021	23.3630	23.7663	24.3718	23.8437
450023	17.6360	19.2808	19.1645	18.7230
450024	18.5985	19.5584	20.8938	19.7493
450028	19.1658	19.5905	22.7775	20.4223
450029	17.7425	19.9505	19.9198	19.2371
450031	29.6945	29.6772	21.2734	25.9517
450032	14.6530	20.8525	20.6076	18.3640
450033	21.0222	21.3766	26.0361	22.7005
450034	18.8823	19.5233	21.6149	19.9977
450035	20.3599	20.3146	24.1791	21.4800
450037	19.9140	19.6532	22.9781	20.8451
450039	19.7176	20.4660	21.8243	20.6801
450040	19.6370	24.8621	21.3097	22.1542
450042	18.8357	20.6041	21.8886	20.4547
450044	21.0909	23.4476	23.2984	22.5215
450046	17.3631	20.2917	20.9220	20.0845
450047	16.9028	15.9525	21.8840	18.0090
450050	17.7209	19.1390	19.5171	18.7476
450051	21.1008	23.0010	23.1281	22.3573
450052	15.5890	20.3702	15.9400	17.2648
450053	17.2781	19.3347	15.0735	17.2659
450054	19.2431	25.3285	23.2915	22.8358
450055	15.8526	16.4789	18.2235	16.8274
450056	21.8605	22.5341	24.4197	22.9813
450058	18.6172	20.0424	21.9588	20.1476
450059	19.8240	21.4873	22.8792	21.4779
450063	12.7211	15.1779	*	13.6764
450064	19.7682	21.3929	18.6112	19.8410
450065	23.3797	23.8471	25.0043	24.0958
450068	23.3495	22.5626	23.4435	23.1149
450072	18.0307	20.0134	20.3683	19.5324
450073	16.5942	23.7700	19.2398	20.0099
450078	13.2820	13.9324	15.0471	14.0206
450079	20.6483	22.0609	23.9209	22.1935
450080	18.6212	19.8414	21.0442	19.7978
450081	17.5737	19.0276	19.0461	18.5365
450082	16.8677	18.0688	16.6397	17.1813

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
450083	23.3754	20.7446	22.4764	22.1790
450085	20.0085	17.5001	18.0245	18.4510
450087	21.9320	23.4141	24.6661	23.4257
450090	15.5796	15.6090	15.5556	15.5807
450092	17.9520	17.2058	16.0808	17.0569
450094	23.2863	25.2158	31.6176	26.5357
450096	18.6802	19.4430	20.1138	19.4265
450097	19.7187	20.7653	22.2467	21.0001
450098	19.0454	19.8469	20.1606	19.7427
450099	20.4181	19.3493	21.4482	20.3831
450101	17.7928	17.6368	20.1473	18.5186
450102	19.8793	21.4361	18.0166	19.5784
450104	17.0821	17.8219	19.7126	18.2038
450107	24.1094	24.5034	23.1605	23.8913
450108	15.2797	17.9596	18.4801	17.3161
450109	10.5973	18.1085	16.0510	14.2577
450111	21.4908	*	*	21.4908
450112	18.1026	17.9624	19.7041	18.5605
450113	20.8306	20.7782	37.8953	21.1550
450119	20.2030	20.1436	20.8840	20.4169
450121	21.9198	22.0485	24.6090	22.7993
450123	14.1755	17.5051	17.8629	16.2415
450124	22.5208	22.9853	24.0333	23.2184
450126	21.4789	22.9423	23.9298	22.7661
450128	18.1446	18.7067	28.0211	21.3216
450130	18.9211	20.2613	19.0153	19.4183
450131	17.4168	18.1401	19.7316	18.4406
450132	21.8089	20.8908	22.4680	21.7157
450133	26.0763	24.5319	25.3928	25.3029
450135	20.4068	21.7038	22.3664	21.5213
450137	23.4346	22.8653	21.9645	22.7576
450140	17.3370	19.6205	18.4142	18.4792
450143	15.0871	17.8206	18.4456	17.0500
450144	17.4309	21.9135	20.8064	20.0145
450145	16.1895	18.0437	16.5468	16.9581
450146	15.5030	17.4391	16.6809	16.5128
450147	19.0477	20.3019	21.4266	20.2587
450148	20.4923	21.4982	19.4973	20.4877
450149	21.7219	22.6138	*	22.1667
450150	17.8612	17.8804	*	17.8714
450151	16.4209	16.3279	18.6100	17.0520
450152	17.7265	19.6105	20.0480	19.2518
450153	18.6514	20.9651	*	19.6822
450154	13.9119	16.8748	16.3479	15.7387
450155	13.3456	20.2582	18.4020	17.1145
450157	15.3083	16.8569	17.8764	16.7446
450160	10.6852	18.7780	20.7517	15.2676
450162	21.9218	20.5032	26.0570	22.6007
450163	17.8028	19.7675	19.8290	19.0858
450164	17.7180	18.7103	22.6906	19.5847
450165	17.3283	16.1010	16.4098	16.5904
450166	11.0541	12.6627	13.5795	12.4215
450170	14.3234	15.8525	13.1142	14.3736
450176	17.2576	19.2397	19.1706	18.5577
450177	15.2419	16.4503	17.2347	16.3235
450178	16.0280	15.8597	19.1186	16.9564
450181	18.6936	18.3600	17.8882	18.3181
450184	20.0821	22.7744	24.3452	22.4382
450185	11.5228	13.2015	14.2950	12.8871
450187	18.5053	20.8105	22.3174	20.4825
450188	15.1954	16.9800	17.5351	16.6019
450191	20.9512	20.5883	23.2261	21.6512
450192	21.2497	20.8315	20.1718	20.7147

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
450193	23.1639	25.1215	25.6437	24.6806
450194	20.7745	20.7152	22.1151	21.2200
450196	17.8993	21.1226	20.3102	19.7302
450200	19.2228	19.6496	20.4656	19.7649
450201	17.1463	18.0646	19.2517	18.1592
450203	19.3978	19.7978	23.1036	20.7628
450209	20.0140	21.3218	23.3963	21.5758
450210	16.3470	16.8532	16.7851	16.6843
450211	18.8114	18.7305	20.0677	19.2205
450213	19.0651	19.3440	21.1280	19.7979
450214	20.5070	21.3448	22.4544	21.4482
450217	12.7647	13.1840	11.3313	12.4053
450219	17.6884	18.5534	21.3693	18.8542
450221	15.2120	16.2308	19.6778	16.9127
450222	19.8967	23.2779	23.4805	22.2795
450224	20.1579	20.1723	19.7665	20.0338
450229	16.7853	17.0346	17.9811	17.2535
450231	19.1746	20.7709	21.0986	20.3555
450234	16.3003	17.9478	21.8295	18.7188
450235	16.3115	17.0143	18.4234	17.2758
450236	16.4957	18.4551	17.1250	17.3256
450237	19.0325	21.6497	21.6752	20.8141
450239	17.8401	18.8416	19.3655	18.6917
450241	16.4240	16.6046	17.4151	16.8266
450243	13.6416	11.2035	17.7821	13.8172
450246	16.7959	22.7940	20.7893	19.8488
450249	11.7658	10.6467	13.1223	11.8062
450250	13.6787	18.3361	12.8229	14.7303
450253	13.2177	14.5492	16.6365	14.6878
450258	16.7337	17.0724	18.3136	17.3431
450264	14.5956	17.2825	13.5346	14.9127
450269	12.7717	12.2970	13.4838	12.8458
450270	14.4792	13.8881	12.3962	13.5856
450271	16.7831	17.9570	18.3659	17.7341
450272	18.4344	20.5888	21.3492	20.1697
450276	14.0745	14.0779	12.8895	13.6150
450278	15.2950	14.3931	15.2944	14.9802
450280	22.2936	22.2648	22.3781	22.3117
450283	15.1950	15.8224	16.9843	16.1315
450288	18.8935	17.4817	17.4214	17.9418
450289	20.3460	22.4656	19.9906	20.9466
450292	20.5335	21.1511	22.8905	21.4277
450293	16.2721	16.4077	17.7673	16.8504
450296	22.3430	21.5998	20.4483	21.4253
450299	*	21.2754	22.9849	22.1397
450303	12.8996	14.3353	16.1330	14.3646
450306	14.2047	13.6333	15.5980	14.3658
450307	17.0691	17.6757	19.6952	18.1345
450309	13.3771	16.0363	16.5770	15.2473
450315	21.4684	23.8151	26.4677	23.7712
450320	20.6596	24.8602	24.7457	23.2764
450321	14.7344	17.2289	17.4628	16.2569
450322	29.1884	28.9834	17.9071	25.3849
450324	19.1692	20.9081	24.0112	21.3590
450327	13.3639	11.0983	14.3848	12.7752
450330	19.8066	21.0921	22.9948	21.3142
450334	13.8392	13.9812	14.2209	14.0138
450337	25.5708	*	*	25.5709
450340	*	19.2611	18.7179	18.9746
450341	*	20.8814	*	20.8814
450346	18.9475	19.2769	20.1921	19.5923
450347	19.3475	20.1899	21.7603	20.4764
450348	13.3585	15.0069	15.3299	14.5667

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
450351	19.3159	21.2842	21.6640	20.7344
450352	20.1871	21.2035	21.8138	21.1211
450353	16.0003	17.3274	19.5263	17.5681
450355	11.8933	12.8876	13.9234	12.8974
450358	23.0206	25.5767	25.9233	24.7613
450362	18.1983	18.7687	20.6340	19.2155
450369	15.3122	16.0667	16.5636	15.9500
450370	16.1369	18.7539	17.0463	17.3593
450371	16.0236	17.7591	17.3415	16.8971
450372	22.0746	21.4050	23.1343	22.1317
450373	17.9554	18.5716	17.7025	18.0874
450374	15.1750	15.0146	15.2532	15.1489
450378	23.4599	24.4143	25.8048	24.6304
450379	22.8756	25.1931	29.0865	25.7747
450381	16.7112	16.7237	18.7899	17.5371
450388	19.7408	20.7989	22.4439	21.1046
450389	18.8448	19.3156	20.7206	19.6586
450393	22.4992	21.4405	23.5336	22.4798
450395	18.0024	17.5236	18.6664	18.0895
450399	15.3491	16.3333	19.1571	16.9654
450400	18.6668	19.1345	20.1376	19.3717
450403	22.8430	24.7657	24.6273	24.1287
450411	15.1121	15.9165	16.9559	15.9781
450417	15.3591	15.2713	16.1956	15.6177
450418	21.9690	22.2511	25.1306	23.1136
450419	23.2551	22.9522	26.4121	24.0600
450422	28.0257	28.0395	28.5834	28.2238
450424	18.7895	20.7634	22.0682	20.6438
450431	22.0361	22.6766	22.7459	22.4890
450438	15.4553	21.0474	18.4891	18.0730
450446	20.7592	13.8011	14.1684	15.5340
450447	18.0377	19.7532	21.0247	19.5725
450451	18.2988	18.9519	20.1738	19.1894
450457	19.6569	*	*	19.6569
450460	14.6523	15.9446	17.9487	16.1581
450462	22.1144	22.5413	20.6169	21.6907
450464	15.5908	15.8121	16.1987	15.8774
450465	15.4731	19.3928	19.6579	17.7347
450467	17.0004	18.9388	18.0994	17.9285
450469	22.1930	22.0389	22.7741	22.3634
450473	19.7148	18.3813	18.6003	18.8420
450475	16.9269	19.0010	19.7305	18.5518
450484	18.9825	19.5505	23.2881	20.6738
450488	19.2173	22.0927	22.5650	21.2542
450489	16.3584	17.8779	18.5941	17.5105
450497	16.2997	15.9654	17.1327	16.4523
450498	14.4713	15.9479	19.2985	16.4927
450508	19.0991	19.3274	20.8183	19.8005
450514	20.0144	20.7064	21.0116	20.6064
450517	14.3191	17.6011	14.4247	15.4999
450518	21.4873	20.7355	21.1015	21.1171
450523	21.0393	23.8270	*	22.4523
450530	21.1634	21.8988	23.3005	22.1616
450534	20.1520	19.7410	22.7437	20.8137
450535	21.0513	21.5449	24.0628	22.1998
450537	20.1161	20.8849	22.5972	21.2300
450539	18.7559	19.3681	18.9497	19.0285
450544	23.6652	22.7282	11.0917	17.7372
450545	20.2823	21.0792	23.9646	21.6831
450547	18.1524	20.5049	23.1348	20.3331
450551	16.6237	16.1437	17.7082	16.8161
450558	20.7404	21.3116	21.4201	21.1518
450563	22.0708	21.9935	27.5446	23.9001

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
450565	17.3803	17.8058	17.5372	17.5748
450570	19.0336	*	*	19.0336
450571	18.2784	19.5325	21.1391	19.6109
450573	17.3518	17.6157	18.6233	17.8792
450574	14.6128	14.8549	16.4851	15.3348
450575	22.5621	24.0386	23.4900	23.3951
450578	18.0925	17.2863	17.3010	17.5480
450580	16.7374	17.8224	18.5657	17.7062
450583	14.4411	15.9430	16.2818	15.5666
450584	14.6735	14.9237	16.9020	15.4896
450586	13.8248	14.7433	14.0478	14.1931
450587	18.0219	18.0014	17.6532	17.8908
450591	17.7795	18.6714	19.6229	18.7114
450596	21.6729	21.9445	24.3714	22.6695
450597	17.6179	19.0641	19.5574	18.7397
450603	23.5572	23.4924	20.6138	22.5917
450604	17.6582	18.7465	19.6304	18.7047
450605	19.4580	19.7400	22.0210	20.3694
450609	17.0986	14.1776	16.6870	15.9595
450610	21.5191	23.5626	24.0548	23.1995
450614	16.5754	*	18.5895	17.6527
450615	15.2956	15.0621	17.3288	15.9012
450617	20.8919	21.5004	22.7025	21.7511
450620	16.0987	16.4330	17.1624	16.5652
450623	23.1270	25.1122	25.4030	24.5910
450626	18.4349	20.5225	17.7454	18.8435
450628	18.6093	20.0411	17.8201	18.7790
450630	20.9605	23.1840	24.7324	23.0079
450631	21.6736	21.8940	22.6786	22.1007
450632	13.9147	15.1416	14.8913	14.6301
450633	19.4949	*	*	19.4949
450634	22.9877	23.0470	24.8258	23.7101
450638	22.1704	23.8335	26.3653	24.1319
450639	21.6421	23.0496	23.3156	22.6779
450641	15.7578	15.3652	16.5960	15.8967
450643	16.8152	18.9088	20.2000	18.7134
450644	22.7721	24.5834	25.8182	24.5287
450646	19.1433	23.1240	21.8489	21.2674
450647	24.2763	25.0549	26.7193	25.3639
450648	15.0305	14.4884	16.9698	15.5262
450649	16.6577	16.8505	17.5760	17.0475
450651	22.7112	25.4679	26.9228	25.1265
450652	17.2445	*	*	17.2446
450653	19.2349	20.2436	22.7236	20.7352
450654	14.5423	15.5858	16.3616	15.4967
450656	18.2606	18.5874	20.7824	19.2080
450658	17.2630	19.4139	19.2521	18.6539
450659	23.0108	22.9344	26.0224	24.0406
450661	18.9071	19.5504	20.0716	19.5103
450662	19.3152	20.7973	26.1213	22.0200
450665	16.1319	14.5158	15.8149	15.5054
450666	20.2549	*	*	20.2549
450668	21.0972	21.2002	24.0081	22.0964
450669	21.6746	22.5150	25.0200	23.1112
450670	20.2632	19.7696	19.7416	19.8975
450672	21.4927	23.2623	25.3111	23.3562
450673	13.7005	14.9115	16.8250	15.1732
450674	22.2426	21.9624	24.7431	23.0384
450675	21.4479	23.3954	24.8661	23.3355
450677	20.6556	21.7366	23.2841	21.9181
450678	24.1301	25.1841	28.1917	25.8918
450683	22.8699	22.1965	24.3566	23.1268
450684	21.9962	22.2380	23.8945	22.7570

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
450686	16.4632	17.4746	17.9181	17.2988
450688	20.1831	21.7691	21.7922	21.3124
450690	22.4707	27.2399	33.1576	27.0095
450694	18.1872	18.5520	21.4785	19.2847
450697	19.4949	19.4424	20.8952	19.9640
450698	15.4750	16.5111	18.1764	16.7102
450700	15.9050	14.2055	17.3457	15.8451
450702	21.3739	19.8094	22.2953	21.1028
450704	20.7987	18.1835	*	19.2723
450705	22.1809	18.7138	19.4435	19.9245
450706	22.0884	22.4329	*	22.2641
450709	22.1490	22.0123	23.4246	22.5690
450711	19.8581	20.8047	23.6594	21.4663
450712	15.9298	11.1086	18.4546	14.6487
450713	22.6986	23.6189	24.4002	23.6310
450715	22.5988	24.8068	14.9630	19.6234
450716	20.9074	20.8913	24.8614	22.2839
450717	20.6551	22.0243	*	21.3435
450718	22.1765	23.0051	23.6180	22.9900
450723	20.8213	22.0633	22.8048	21.9009
450724	20.3706	23.3799	19.6335	21.4203
450727	17.9172	24.6125	16.0843	19.3135
450728	19.8879	14.9265	10.3991	14.3301
450730	23.0054	24.5952	27.8476	25.3002
450733	20.2199	21.9921	23.8143	22.0738
450742	21.8392	22.8135	25.1295	23.3180
450743	19.6015	20.5017	23.6131	21.3065
450746	30.2657	14.6683	11.1672	15.8134
450747	20.3914	20.3870	21.5883	20.8604
450749	19.1678	18.7138	17.6324	18.4286
450750	13.8098	*	*	13.8098
450751	19.9995	19.8170	25.5869	21.1754
450754	16.7145	17.8497	17.9189	17.5560
450755	19.8743	20.0667	18.6084	19.5138
450757	14.9434	15.6425	17.2683	15.9355
450758	19.0221	22.6196	22.8713	21.5676
450760	19.2225	20.4209	23.2959	20.7991
450761	15.7681	14.6511	15.3222	15.2265
450763	18.6092	18.9713	19.8939	19.1937
450766	23.3879	25.4057	27.1863	25.3095
450769	18.4163	17.9879	18.3030	18.2402
450770	19.0183	20.0632	18.7369	19.2440
450771	21.8268	21.6946	22.9736	22.1610
450774	16.2948	*	21.7906	18.6936
450775	21.3504	22.6526	23.5785	22.5291
450776	14.1720	13.4263	14.6695	14.0866
450777	19.0380	18.3119	21.4240	19.6554
450779	21.6642	22.6216	27.8925	23.9052
450780	19.0914	20.0824	21.6549	20.3201
450788	19.6469	19.9817	21.4368	20.3148
450795	22.5753	27.0250	19.1371	22.4874
450796	19.2059	26.8539	19.9522	22.5780
450797	16.4923	20.2356	18.6839	18.3681
450801	17.9548	18.0598	19.7124	18.5711
450802	17.1435	18.2460	*	17.6977
450803	21.6653	37.0925	23.8343	26.2012
450804	19.0893	20.5225	22.7169	20.8248
450806	*	20.7906	*	20.7906
450807	13.4306	18.4410	16.8928	15.8881
450808	17.4917	18.1728	18.6555	18.1215
450809	19.7899	21.9845	23.1978	21.6113
450811	19.9168	21.6115	22.7583	21.5237
450813	14.5392	15.3780	21.7208	16.6296

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
450815	21.2741	*	*	21.2742
450819	16.5521	*	*	16.5521
450820	26.8348	24.6542	26.9120	26.1797
450822	22.8556	24.8702	26.7821	24.9818
450823	*	17.9756	13.0130	14.5379
450824	*	25.7488	*	25.7488
450825	*	16.0793	18.2159	17.2695
450827	*	20.1310	29.5838	24.8201
450828	*	19.2902	20.8735	20.1257
450829	*	14.7121	14.4463	14.5541
450830	*	*	23.0204	23.0205
450832	*	*	24.8572	24.8572
450833	*	*	18.3195	18.3196
450834	*	*	21.7217	21.7217
450835	*	*	24.2285	24.2285
450837	*	*	31.8430	31.8432
460001	22.2735	23.5485	24.8844	23.5856
460003	22.6289	22.9549	26.5141	23.9755
460004	21.7234	23.1289	24.3409	23.0686
460005	22.5252	23.0189	25.0063	23.5075
460006	21.0700	22.1648	23.4200	22.2290
460007	21.1922	22.0409	23.3603	22.2561
460008	19.1153	22.6808	24.8233	22.3133
460009	22.5295	23.1933	24.5865	23.4290
460010	22.4948	24.0907	25.1240	23.9360
460011	19.7674	25.3818	21.2634	21.8917
460013	20.1936	21.2360	23.1467	21.5125
460014	18.5370	*	22.5784	20.9623
460015	21.0470	22.4872	23.1068	22.2481
460016	21.9105	19.0910	18.7453	19.8107
460017	18.9929	19.0724	20.7789	19.6010
460018	17.0063	17.0385	16.7143	16.9128
460019	17.8690	19.3442	18.1995	18.4514
460020	17.2663	18.1542	15.2162	16.7463
460021	21.5174	23.1368	23.8565	22.9024
460022	21.3614	20.7539	21.8443	21.3226
460023	22.9265	24.1825	25.0874	24.0957
460025	17.3494	17.4070	22.3100	18.8099
460026	20.2576	21.1759	21.9316	21.1444
460027	22.2955	21.4833	22.7488	22.1620
460029	20.8366	23.7148	24.4379	23.0146
460030	17.1383	18.7655	21.2546	18.9564
460032	21.4832	21.0286	21.2715	21.2538
460033	19.2664	20.2389	21.7215	20.4433
460035	16.1685	15.6979	16.9657	16.2272
460036	23.4573	24.2651	23.9909	23.9286
460037	17.7399	19.0115	20.0323	18.9515
460039	24.4808	24.5134	26.3795	25.1512
460041	20.2035	21.6676	23.5132	21.8727
460042	19.5662	19.7531	22.0844	20.5371
460043	23.2819	25.1366	26.0277	24.8166
460044	21.8485	23.6604	24.7139	23.4328
460047	22.7524	23.5447	22.8135	23.0271
460049	20.8283	21.5241	21.9358	21.5104
460051	22.1758	21.8950	22.7540	22.2835
460052	19.8961	20.1989	23.1718	21.0691
460053	*	*	23.2273	23.2274
470001	21.3817	21.7774	23.5882	22.3065
470003	22.0563	23.3612	24.1739	23.1995
470004	18.1879	17.3576	18.4943	18.0068
470005	23.1808	22.6589	24.9625	23.6347
470006	20.2829	21.0835	21.6036	21.0098
470008	20.1969	20.3833	20.7659	20.4458

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
470010	21.0616	22.3913	23.2072	22.2567
470011	22.2415	24.1306	24.6034	23.6561
470012	18.9444	19.8831	20.5072	19.7941
470015	20.2125	21.8204	25.6286	22.6045
470018	21.2406	24.8493	21.2904	22.3634
470020	21.5688	21.9911	22.0333	21.8520
470023	21.7139	22.5334	24.1395	22.7760
470024	21.9807	23.2738	22.4659	22.5822
490001	20.0570	21.4952	22.1209	21.2627
490002	15.7365	16.5198	17.5098	16.5736
490003	20.3237	20.7688	20.9782	20.6753
490004	19.7074	20.7616	22.7571	21.0703
490005	21.3318	23.1708	25.2213	23.2687
490006	12.3253	19.8977	13.4277	15.2731
490007	19.8938	20.7896	22.2638	20.9786
490009	23.7659	24.7602	25.2181	24.6030
490011	19.8042	19.8179	19.9733	19.8664
490012	15.2965	16.0994	15.8346	15.7118
490013	18.2396	18.3901	19.5094	18.7096
490014	23.5266	27.8907	*	25.5759
490015	20.0667	21.4500	21.2557	20.9648
490017	19.3854	19.6594	20.7691	19.9104
490018	18.5508	19.8955	22.0810	20.2089
490019	21.0124	21.6790	23.3077	22.0282
490020	19.3424	20.9212	21.2094	20.4866
490021	20.0496	21.2263	22.2537	21.2008
490022	22.3380	24.3008	24.5122	23.7681
490023	21.5683	22.8400	24.9733	23.1948
490024	18.4314	19.7491	21.2619	19.8335
490027	16.7556	17.5178	20.3644	18.2452
490030	8.6446	*	*	8.6446
490031	16.0003	17.4262	18.4826	17.3314
490032	21.4037	22.2041	23.5691	22.3503
490033	19.2908	23.2088	24.4370	22.3633
490037	17.0113	17.2117	17.5103	17.2485
490038	17.6324	18.6012	18.1405	18.1142
490040	24.1266	25.5461	27.0513	25.6394
490041	18.7987	17.9942	19.9314	18.8986
490042	17.0972	18.1864	19.5127	18.3230
490043	22.1068	23.5367	25.4354	23.6479
490044	19.7842	18.4845	20.8739	19.7388
490045	20.5558	22.5238	24.7131	22.7244
490046	19.9102	19.8518	21.9164	20.5668
490047	18.7614	20.1660	19.8220	19.5730
490048	19.5417	20.9110	22.3255	20.9493
490050	23.3668	23.8519	26.1521	24.5290
490052	16.4787	18.5693	19.2480	18.1097
490053	16.8410	17.7363	18.6541	17.7531
490054	19.5780	22.5136	18.7738	20.4647
490057	20.3160	21.1871	22.1945	21.2773
490059	21.4801	24.1516	23.3895	22.9645
490060	18.5917	19.3525	20.6028	19.5408
490063	26.1930	28.0906	30.4267	28.2207
490066	19.8352	21.5920	22.1034	21.2122
490067	17.8487	18.6469	20.4058	18.9938
490069	20.7582	18.8335	20.6957	20.1008
490071	23.3511	24.1882	25.4677	24.4329
490073	26.0957	*	27.6711	26.9865
490075	19.2156	20.5801	22.3229	20.7337
490077	22.6504	21.9175	22.2643	22.2859
490079	17.7016	17.5839	19.2196	18.1709
490084	18.0555	18.9679	19.8598	18.9692
490085	17.6158	19.4261	20.6383	19.2465

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
490088	17.9141	19.1924	19.7646	18.9625
490089	18.2290	19.7936	21.1522	19.7626
490090	17.5799	19.2094	20.3015	19.0319
490091	25.0272	23.7493	*	24.4545
490092	16.4360	27.1805	23.8364	21.5391
490093	17.8275	19.1131	20.7412	19.2089
490094	22.3033	20.2020	21.9886	21.4787
490097	16.9518	16.6563	17.9929	17.2212
490098	16.0488	18.5133	19.7116	18.0649
490099	18.3985	19.2604	20.7724	19.4805
490101	23.5553	25.7804	28.5200	26.0299
490104	40.2529	17.1683	28.0286	24.6486
490105	21.4428	28.7831	40.6822	26.6520
490106	26.3821	31.8566	31.6541	29.5471
490107	22.9283	23.9962	26.5312	24.6073
490108	24.1232	24.8596	28.7277	25.7440
490109	25.9475	23.0609	28.0978	25.5419
490110	18.1561	18.8042	23.6080	20.0833
490111	17.8510	19.9552	19.4041	19.0697
490112	22.1162	23.2843	23.6028	23.0255
490113	23.9043	26.1840	28.0893	26.0992
490114	18.0359	18.8920	19.9725	18.9850
490115	16.8537	18.4499	19.9150	18.4166
490116	17.2040	18.2935	19.7007	18.4196
490117	14.7944	17.1723	15.6078	15.8681
490118	23.2022	24.2668	25.2230	24.2345
490119	18.6046	18.9535	20.0944	19.1567
490120	20.5777	20.6828	22.2389	21.1886
490122	23.8198	26.6681	27.3509	25.9831
490123	19.3056	20.0920	20.9506	20.1282
490124	21.3818	23.6526	21.3713	22.1870
490126	20.4294	19.0782	20.3266	19.9000
490127	16.5993	17.6437	17.8070	17.3281
490129	28.6868	*	*	28.6863
490130	17.6943	18.6406	18.6038	18.3141
490132	18.4671	19.1742	19.5850	19.0428
500001	24.4829	25.3478	25.8406	25.2431
500002	19.8476	22.9942	*	21.4076
500003	24.4333	25.1200	27.6238	25.7781
500005	24.3870	26.2066	29.9352	26.8369
500007	21.9911	24.7889	*	23.2199
500008	26.1737	27.2852	28.9380	27.5261
500011	24.6554	25.7263	27.6762	26.0196
500012	24.2799	24.5450	25.4367	24.7615
500014	24.0990	25.0490	27.4189	25.5343
500015	24.9923	25.9465	27.4387	26.1498
500016	24.9439	25.1227	27.7863	25.9574
500019	23.2054	23.5730	25.7691	24.2429
500021	27.6490	25.9403	26.4648	26.6119
500023	27.1025	32.3079	23.9513	27.3082
500024	26.6452	26.2113	27.2884	26.7211
500025	24.4825	27.3697	27.6755	26.4578
500026	26.9884	26.6108	28.7532	27.4597
500027	25.1125	27.7429	28.7063	27.2499
500028	18.9556	19.0261	19.9288	19.3024
500029	18.5042	19.3130	19.7750	19.2311
500030	26.3828	28.5297	29.0458	28.0229
500031	23.6099	25.8542	26.0740	25.1801
500033	22.5462	23.8994	25.4345	23.9873
500036	23.6333	25.1255	25.4753	24.7809
500037	21.4059	22.1774	23.3808	22.3148
500039	24.0007	25.4225	26.0196	25.1368
500041	25.4376	24.7070	24.9005	25.0014

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
500043	22.0466	24.1745	26.6451	24.4187
500044	24.2212	24.7816	27.0880	25.3901
500045	24.0526	24.6265	8.0818	14.8642
500048	20.3207	20.6333	22.9938	21.3649
500049	24.5997	26.5857	25.9142	25.6732
500050	22.6563	23.0804	25.0907	23.6590
500051	25.9447	26.7628	26.9538	26.5713
500053	22.8399	24.2492	25.7217	24.2895
500054	23.8089	25.7815	27.1634	25.6068
500055	23.8622	23.7988	25.3095	24.3502
500057	19.0479	20.5812	21.0357	20.2825
500058	24.1106	26.5679	27.2582	26.0406
500059	26.6270	25.3528	26.1943	26.0221
500060	28.3655	29.6030	32.2049	30.0629
500061	20.8624	24.5908	27.5845	24.2316
500062	19.0557	19.1685	20.9284	19.6775
500064	26.7000	27.5791	29.5696	27.9754
500065	23.5671	24.0966	26.5881	24.7506
500068	19.2638	20.9278	20.2336	20.1549
500069	21.4542	22.4158	24.2983	22.7883
500071	19.1428	22.3253	23.2071	21.4408
500072	25.2001	25.7734	27.5706	26.2080
500073	21.7698	22.5222	21.0414	21.7592
500074	19.5981	20.6120	21.9018	20.7646
500077	23.9410	24.5695	26.6614	25.0769
500079	23.1041	24.7946	27.1775	25.0691
500080	18.3883	18.8188	21.1121	19.4633
500084	24.4044	25.0556	26.3627	25.3208
500085	20.4517	20.7422	21.0707	20.7661
500086	22.8829	24.2556	25.9705	24.3779
500088	25.2478	26.4212	30.1689	27.0767
500089	19.7166	20.3478	21.0601	20.3618
500090	20.4429	21.7716	*	21.0547
500092	19.2028	20.3058	20.8601	20.1437
500094	15.7866	17.6625	*	16.7064
500096	23.3564	25.1135	25.9490	24.7500
500097	20.8774	21.4423	21.8841	21.3903
500098	15.2040	17.8453	17.1392	16.7726
500101	15.8000	19.8614	*	17.6277
500102	21.8963	23.1307	*	22.5307
500104	24.9389	24.7875	26.8007	25.5111
500106	19.1465	17.1066	21.5532	19.1127
500107	17.9489	17.4641	20.4959	18.5615
500108	28.6229	26.1609	27.6367	27.4719
500110	22.9775	23.5941	24.8448	23.8174
500118	24.8034	24.7875	26.1971	25.2739
500119	22.1192	23.9939	25.1576	23.7715
500122	23.5264	24.4462	22.2238	23.3778
500123	19.6646	21.7133	24.4350	21.6023
500124	23.7742	24.6591	26.2994	25.0718
500125	14.7910	15.6304	18.4512	16.1340
500129	25.4685	25.2082	27.1253	25.9641
500132	23.1822	21.9915	22.5293	22.5899
500134	17.2430	15.9791	25.9538	18.4162
500139	22.3053	23.7993	27.7067	24.5705
500141	29.9695	28.1014	28.1441	28.6426
500143	18.2570	18.7523	19.0982	18.7216
510001	20.0429	20.2514	21.4247	20.5803
510002	17.6392	19.1517	21.0299	19.3055
510005	13.8621	13.8641	14.7332	14.1611
510006	19.9609	19.9760	21.0214	20.3316
510007	21.6761	22.9326	23.1306	22.5933
510008	19.0513	19.9176	22.7595	20.6320

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
510012	15.6089	15.8596	16.7710	16.1127
510013	19.5798	18.3486	19.7937	19.2416
510015	16.7311	17.1595	17.9040	17.2636
510018	18.5358	18.3023	19.9490	18.9487
510020	14.1211	15.7512	*	14.9242
510022	21.5770	21.4336	22.0584	21.7005
510023	16.7777	17.6516	17.9267	17.4783
510024	18.7461	19.6521	20.7521	19.7179
510026	13.7952	14.8785	16.5389	14.9496
510027	18.5945	20.5222	19.8205	19.6589
510028	19.9208	22.4826	24.6543	22.2359
510029	18.4668	18.9000	19.8048	19.0629
510030	17.7603	19.2558	19.8220	18.9626
510031	18.6341	19.3049	20.5742	19.5716
510033	18.4718	19.6900	19.6921	19.3132
510035	18.3164	21.8290	*	20.0924
510036	13.8786	15.0266	14.0926	14.3186
510038	15.5576	15.9821	16.1016	15.8882
510039	17.1461	17.4002	17.6190	17.3855
510043	13.1308	14.4202	15.5857	14.3831
510046	18.5896	18.7424	19.2806	18.8709
510047	20.8101	21.2885	22.1953	21.4251
510048	17.1647	15.2886	16.3761	16.2789
510050	18.4036	18.3964	18.9990	18.5986
510053	17.5798	18.1046	18.1054	17.9357
510055	24.2133	25.6333	27.7422	25.8187
510058	18.4501	18.6025	20.1104	19.0814
510059	16.1044	17.3844	18.1544	17.1696
510061	14.1968	14.6774	14.8848	14.5883
510062	18.1588	19.7202	21.0482	19.6174
510067	17.3067	17.8816	18.0113	17.7501
510068	23.0452	19.4299	19.9056	20.6790
510070	18.7091	18.6226	20.0974	19.1353
510071	18.0278	18.8766	19.4029	18.7564
510072	15.9257	16.5279	18.4566	16.9820
510077	18.2947	20.4521	20.9153	19.8338
510080	16.3453	19.7131	21.5661	18.8545
510081	11.9701	10.4972	*	11.2092
510082	13.5946	16.0014	17.2891	15.5840
510084	13.5339	14.9683	16.1904	14.8887
510085	18.6227	19.0175	20.6364	19.4471
510086	14.2241	16.3413	16.3051	15.6167
510088	14.8854	16.2850	16.4373	15.8902
520002	19.6755	20.2691	21.9073	20.6570
520003	18.7956	18.7507	20.4234	19.3853
520004	20.4591	21.1549	22.6309	21.4055
520006	21.4884	22.4099	22.0238	21.9690
520007	18.4629	18.3959	19.4507	18.7649
520008	24.9395	24.4927	26.0931	25.2072
520009	21.4638	19.8142	20.5615	20.5741
520010	22.3311	25.5623	26.4047	24.7952
520011	21.5223	21.6945	22.7880	22.0154
520013	20.5944	22.1009	23.1173	21.9777
520014	18.0841	19.2760	20.4282	19.2712
520015	19.7672	21.0428	22.8094	21.2438
520016	18.4320	19.5656	*	18.9788
520017	19.4780	21.1409	21.7542	20.8166
520018	21.5279	22.1929	22.3315	22.0344
520019	20.9164	21.8870	22.6895	21.8682
520021	21.9531	22.8484	24.1284	23.0293
520024	14.4750	16.4879	17.5368	16.1948
520025	20.3838	21.9529	23.3835	21.9488
520026	20.8546	22.4779	25.0504	22.8714

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
520027	21.5868	22.1450	23.6595	22.5109
520028	22.5941	22.0333	24.3592	23.0143
520029	21.4197	21.5561	22.8724	21.9345
520030	21.6311	22.7239	23.9474	22.8336
520031	20.9875	21.2809	22.9721	21.7580
520032	21.1069	24.1092	22.7220	22.6429
520033	20.2520	21.0088	22.2650	21.1839
520034	20.4307	21.5275	18.8561	20.0847
520035	18.7135	19.8917	20.8563	19.8607
520037	21.6017	23.0801	25.0587	23.2977
520038	20.6130	21.4208	23.1036	21.7099
520039	23.3687	21.1719	22.9348	22.4321
520040	21.2023	23.0710	21.5671	21.9307
520041	18.4117	18.2997	22.6216	19.7373
520042	19.5466	20.6354	21.9935	20.7535
520044	19.1877	21.4913	22.7626	21.1506
520045	21.2427	21.9812	24.1624	22.4304
520047	20.3487	21.0370	22.5686	21.3314
520048	19.8926	20.3488	19.3461	19.8547
520049	20.1667	21.8271	22.7424	21.6003
520051	24.0460	23.4366	25.0827	24.1747
520053	18.0851	18.9512	20.8040	19.2839
520054	16.8363	16.6278	18.1045	17.2001
520057	19.8492	20.6959	20.4601	20.3548
520058	21.2500	23.6794	23.2907	22.7126
520059	21.5796	22.1618	24.1863	22.6609
520060	18.8232	20.3357	21.1271	20.1183
520062	19.7038	21.2865	23.7166	21.6639
520063	20.5262	21.2774	23.3037	21.7486
520064	22.0917	23.8181	21.6302	22.5247
520066	24.0087	25.4528	23.9212	24.4126
520068	19.6855	20.6112	21.4413	20.5790
520069	20.1770	21.7233	32.6484	21.3815
520070	19.4261	20.0096	22.0590	20.5199
520071	19.9866	22.0066	23.4832	21.8338
520074	20.9007	21.6636	21.9124	21.4827
520075	20.7301	22.1894	23.7322	22.2613
520076	19.5878	20.6155	22.2993	20.8518
520077	18.7119	18.1077	*	18.3984
520078	21.7545	21.7414	23.0727	22.1680
520083	23.5787	24.2401	25.3591	24.3864
520084	23.5446	21.8102	24.7909	23.3951
520087	20.7821	22.2579	22.8173	21.9819
520088	21.8931	22.3921	23.8938	22.6992
520089	22.1055	23.2335	24.4411	23.2699
520090	20.3645	20.9069	21.9482	21.0730
520091	20.9440	22.2218	19.2575	20.7952
520092	18.6248	19.7181	21.8662	20.1341
520094	20.6179	21.3082	22.3925	21.4517
520095	18.6425	21.9177	25.1402	21.7601
520096	20.6668	21.6803	21.2295	21.2059
520097	20.8016	22.2375	23.6512	22.2609
520098	23.4707	25.0055	25.5111	24.6770
520100	19.4788	20.5366	21.7072	20.6024
520101	19.9875	20.0164	19.5272	19.8623
520102	21.0138	22.3640	23.7739	22.4092
520103	20.1092	22.2765	23.5984	22.0082
520107	21.7907	23.8421	25.0837	23.5365
520109	19.7609	20.3208	20.0009	20.0293
520110	21.0055	22.3923	23.4435	22.3140
520111	17.7673	18.2744	26.9667	20.3598
520112	18.9577	17.6226	17.8738	18.0211
520113	21.8852	23.1852	24.2508	23.1332

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
520114	17.8476	18.5767	21.9848	19.3865
520115	19.2248	21.4279	23.4674	21.4477
520116	20.6922	22.2741	23.9066	22.2707
520117	18.3963	19.3653	21.9443	19.9279
520118	14.8626	13.9920	*	14.4086
520121	20.8492	20.9422	23.1869	21.6934
520122	16.9335	16.9905	18.8016	17.5509
520123	17.7986	19.8134	21.0426	19.6355
520124	17.9205	19.2621	21.1327	19.4570
520130	16.6873	18.8845	20.0277	18.5254
520131	20.2591	21.0400	22.4994	21.3057
520132	18.1630	18.2634	19.5140	18.6382
520134	18.8150	19.6881	20.8502	19.7907
520135	17.3476	18.1026	18.8254	18.0936
520136	20.9050	21.3966	22.9085	21.7252
520138	22.5599	23.1498	25.1434	23.6620
520139	21.4042	22.8070	23.7727	22.6778
520140	22.3671	22.5459	23.5622	22.8201
520142	21.9432	21.4120	24.1969	22.4917
520144	19.9120	20.5864	22.3985	20.9729
520145	18.7958	20.3461	25.0771	20.8014
520146	18.2370	18.6337	19.4025	18.7800
520148	19.1502	20.5075	22.4299	20.7682
520149	12.8928	13.8614	*	13.3481
520151	18.7070	19.3362	20.1995	19.4436
520152	22.5980	26.2402	21.1817	22.9787
520153	17.0863	18.5986	18.7375	18.1335
520154	19.5994	21.0486	23.2635	21.3043
520156	20.9638	20.7808	23.7157	21.8343
520157	19.6008	21.6821	23.1495	21.4552
520159	17.7649	21.8783	*	19.8043
520160	20.5154	21.5871	22.9475	21.7239
520161	20.1102	21.4038	22.1857	21.2456
520170	21.9857	23.0867	25.0744	23.3943
520171	18.0785	18.1844	11.2340	15.1101
520173	20.9209	23.2955	24.4722	22.8643
520177	24.0139	25.0908	27.5560	25.5340
520178	20.9010	23.1509	22.3193	22.0890
520189	*	22.0889	23.1658	22.6212
530002	21.0560	23.0582	23.8852	22.6216
530003	15.9523	17.1646	*	16.5866
530004	13.3788	17.4672	*	15.3173
530005	15.3255	18.4391	19.2049	17.7470
530006	19.1305	20.7661	21.3429	20.4783
530007	17.7897	18.5286	22.3309	19.6133
530008	19.0113	19.5386	21.8714	20.1106
530009	21.7795	23.5839	22.0451	22.4288
530010	13.9536	17.8687	21.7124	17.2974
530011	19.4606	19.9212	22.5720	20.6678
530012	21.1854	22.5084	22.4716	22.0976
530014	18.4900	20.0422	21.7314	20.1695
530015	23.4040	24.6527	25.3915	24.5334
530016	19.3205	20.3647	21.0666	20.2058
530017	17.7736	20.9408	19.5631	19.3707
530018	19.5986	20.1226	*	19.8663
530019	20.1097	18.1492	*	19.0248
530022	19.6136	19.7902	21.0631	20.1718
530023	20.0677	21.6352	*	20.8681
530025	22.0300	22.4816	25.4693	23.3672
530026	19.8969	20.9919	21.0733	20.6804
530027	25.5067	*	*	25.5069
530029	19.3361	20.3046	19.9692	19.8988
530031	20.1734	23.2766	16.8825	20.2555

* Denotes wage data not available for the provider for that year.
** Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 2.—HOSPITAL AVERAGE HOURLY WAGE FOR FEDERAL FISCAL YEARS 2002 (1998 WAGE DATA), 2003 (WAGE DATA), AND 2004 (2000 WAGE DATA) WAGE INDEXES AND 3-YEAR AVERAGE OF HOSPITAL AVERAGE HOURLY WAGES—Continued

Provider No.	Average hourly wage FY 2002	Average hourly wage FY 2003	Average hourly wage FY 2004	Average hourly** wage (3 yrs)
530032	20.0132	20.9856	19.4450	20.0811

*Denotes wage data not available for the provider for that year.
**Based on the sum of the salaries and hours computed for Federal FYs 2002, 2003, and 2004.

TABLE 3A.—FY 2004 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS

[*Based on the sum of the Salaries and Hours Computed for Federal Fiscal Years 2002, 2003, and 2004]

Urban area	FY 2004 average hourly wage	3-Year average hourly wage
Abilene, TX	18.8450	18.2266
Aguadilla, PR	10.6399	10.5889
Akron, OH	22.5797	22.3022
Albany, GA	26.6004	24.9847
Albany-Schenectady-Troy, NY	21.3352	20.4496
Albuquerque, NM	23.1465	22.1931
Alexandria, LA	19.8057	18.6706
Allentown-Bethlehem-Easton, PA	23.5026	22.8687
Altoona, PA	21.7576	21.1859
Amarillo, TX	22.0107	20.8001
Anchorage, AK	30.1827	29.0196
Ann Arbor, MI	27.1674	25.8704
Anniston, AL	19.9785	19.0507
Appleton-Oshkosh-Neenah, WI	21.7216	21.0819
Arecibo, PR	10.1377	10.1850
Asheville, NC	23.8010	22.5969
Athens, GA	23.7190	23.1681
Atlanta, GA	24.6106	23.4279
Atlantic-Cape May, NJ	26.6595	25.8131
Auburn-Opelika, AL	20.9608	19.6182
Augusta-Aiken, GA-SC	23.8679	23.3090
Austin-San Marcos, TX	23.4418	22.4440
Bakersfield, CA	24.2171	22.8241
Baltimore, MD	24.4226	23.1526
Bangor, ME	24.4261	22.6849
Barnstable-Yarmouth, MA	31.6457	30.9398
Baton Rouge, LA	20.3139	19.2932
Beaumont-Port Arthur, TX	20.8687	19.6759
Bellingham, WA	29.0458	28.0229
Benton Harbor, MI	21.8083	20.8961
Bergen-Passaic, NJ	28.6051	27.6355
Billings, MT	21.8179	21.2445
Biloxi-Gulfport-Pascagoula, MS	22.3087	20.4967
Binghamton, NY	20.6972	19.6313
Birmingham, AL	22.7049	21.2110
Bismarck, ND	19.6799	18.6613
Bloomington,IN	22.0106	20.8739
Bloomington-Normal, IL	21.8206	21.0629
Boise City, ID	22.7551	21.5706

TABLE 3A.—FY 2004 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the Salaries and Hours Computed for Federal Fiscal Years 2002, 2003, and 2004]

Urban area	FY 2004 average hourly wage	3-Year average hourly wage
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	27.6581	26.3949
Boulder-Longmont, CO	24.8370	23.1361
Brazoria, TX	20.1054	19.4362
Bremerton, WA	26.0196	25.1368
Brownsville-Harlingen-San Benito, TX	25.1120	21.8429
Bryan-College Station, TX	22.1966	21.2204
Buffalo-Niagara Falls, NY	23.5611	22.1052
Burlington, VT	23.9756	23.1273
Caguas, PR	10.2735	10.3098
Canton-Massillon, OH	22.4034	21.0476
Casper, WY	22.4716	22.0976
Cedar Rapids, IA	21.9242	20.8155
Champaign-Urbana, IL	24.3163	23.2596
Charleston-North Charleston, SC	22.8428	21.6027
Charleston, WV	21.4843	20.9535
Charlotte-Gastonia-Rock Hill, NC-SC	23.9685	22.5648
Charlottesville, VA	24.7694	24.2141
Chattanooga, TN-GA	22.0529	21.2905
Cheyenne, WY	21.7314	20.1695
Chicago, IL	27.0271	25.7822
Chico-Paradise, CA	25.1160	23.2448
Cincinnati, OH-KY-IN	23.1946	22.0301
Clarksville-Hopkinsville, TN-KY	20.4075	19.5286
Cleveland-Lorain-Elyria, OH	23.8495	22.4215
Colorado Springs, CO	21.6129	22.1293
Columbia, MO	21.4630	20.1694
Columbia, SC	21.9871	21.6143
Columbus, GA-AL	21.3541	19.8797
Columbus, OH	23.6823	22.5560
Corpus Christi, TX	21.0218	19.9937
Corvallis, OR	28.4536	27.0598
Cumberland, MD-WV	20.1850	18.9617
Dallas, TX	23.8893	23.1075
Danville, VA	22.3229	20.7337
Davenport-Moline-Rock Island, IA-IL	21.4787	20.4142
Dayton-Springfield, OH	23.1119	21.7481

TABLE 3A.—FY 2004 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the Salaries and Hours Computed for Federal Fiscal Years 2002, 2003, and 2004]

Urban area	FY 2004 average hourly wage	3-Year average hourly wage
Daytona Beach, FL	22.5989	21.2728
Decatur, AL	21.8004	20.7771
Decatur, IL	19.7294	18.7678
Denver, CO	26.4474	24.7190
Des Moines, IA	22.2079	20.6796
Detroit, MI	24.7828	24.1254
Dothan, AL	19.4261	18.7019
Dover, DE	24.2251	22.9785
Dubuque, IA	21.9559	20.4460
Duluth-Superior, MN-WI	24.9669	24.0017
Dutchess County, NY	26.9158	25.0907
Eau Claire, WI	22.3936	21.0371
El Paso, TX	22.7448	21.6387
Elkhart-Goshen, IN	24.1721	22.8091
Elmira, NY	20.6973	19.6769
Enid, OK	21.1469	19.7375
Erie, PA	21.1970	20.4552
Eugene-Springfield, OR	28.3045	26.4658
Evansville, Henderson, IN-KY	20.7198	19.5383
Fargo-Moorhead, ND-MN	23.6839	22.0993
Fayetteville, NC	21.9837	20.9595
Fayetteville-Springdale-Rogers, AR	19.7281	19.1438
Flagstaff, AZ-UT	28.0003	25.5509
Flint, MI	26.8246	25.6472
Florence, AL	19.0755	18.2277
Florence, SC	21.5072	20.4490
Fort Collins-Loveland, CO	25.0356	23.6228
Fort Lauderdale, FL	25.0241	23.9929
Fort Myers-Cape Coral, FL	24.2424	22.5718
Fort Pierce-Port St. Lucie, FL	24.6789	23.4336
Fort Smith, AR-OK	18.9977	18.4272
Fort Walton Beach, FL	21.9145	21.5304
Fort Wayne, IN	23.7450	22.1024
Fort Worth-Arlington, TX	22.7469	21.8925
Fresno, CA	24.9304	23.6658
Gadsden, AL	20.3125	19.9081
Gainesville, FL	20.9218	21.6396
Galveston-Texas City, TX	22.9723	22.5896
Gary, IN	23.2237	22.2411
Glens Falls, NY	20.8876	19.5296

TABLE 3A.—FY 2004 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the Salaries and Hours Computed for Federal Fiscal Years 2002, 2003, and 2004]

Urban area	FY 2004 average hourly wage	3-Year average hourly wage
Goldsboro, NC	21.3024	20.4707
Grand Forks, ND-MN	21.3373	20.7295
Grand Junction, CO	23.7749	22.3911
Grand Rapids-Muskegon-Holland, MI	23.0656	22.5364
Great Falls, MT	21.7634	20.7748
Greeley, CO	23.1548	21.9595
Green Bay, WI	23.3746	22.0316
Greensboro-Winston-Salem-High Point, NC	20.9324	21.2497
Greenville, NC	23.6131	21.8157
Greenville-Spartanburg-Anderson, SC	22.7994	21.5334
Hagerstown, MD	22.6614	20.9120
Hamilton-Middletown, OH	22.6679	21.7796
Harrisburg-Lebanon-Carlisle, PA	22.5260	21.6636
Hartford, CT	27.9285	26.8084
Hattiesburg, MS	17.9684	17.4987
Hickory-Morganton-Lenoir, NC	22.3095	21.3983
Honolulu, HI	27.4202	26.5871
Houma, LA	19.0543	18.7854
Houston, TX	23.5421	22.6783
Huntington-Ashland, WV-KY-OH	23.6117	22.4903
Huntsville, AL	22.6733	21.0476
Indianapolis, IN	24.4154	22.8765
Iowa City, IA	23.5738	22.6166
Jackson, MI	22.1953	21.6761
Jackson, MS	20.6436	19.8499
Jackson, TN	21.1120	20.9308
Jacksonville, FL	22.9896	21.8027
Jacksonville, NC	21.0806	19.0573
Jamestown, NY	19.1768	18.5426
Janesville-Beloit, WI	22.9321	22.5285
Jersey City, NJ	27.4955	26.1092
Johnson City-Kingsport-Bristol, TN-VA	20.5450	19.6615
Johnstown, PA	20.5535	19.7661
Jonesboro, AR	18.8016	18.5268
Joplin, MO	21.4481	20.3222
Kalamazoo-Battlecreek, MI	25.9045	24.7622
Kankakee, IL	27.1800	24.7161
Kansas City, KS-MO	23.4414	22.4424
Kenosha, WI	24.1159	22.6827
Killeen-Temple, TX	22.6330	22.0648
Knoxville, TN	22.0574	20.9173
Kokomo, IN	22.3466	21.1444
La Crosse, WI-MN	22.7241	21.7520
Lafayette, LA	20.3031	19.7004
Lafayette, IN	22.2163	21.3798
Lake Charles, LA	20.8032	18.7394
Lakeland-Winter Haven, FL	20.8790	20.9460
Lancaster, PA	22.8876	21.5784
Lansing-East Lansing, MI	22.7517	22.3069
Laredo, TX	19.9917	19.1033
Las Cruces, NM	20.9400	20.1778
Las Vegas, NV-AZ	28.1201	26.6705
[1]Lawrence, KS	.....	.....
Lawton, OK	20.4263	19.7110
Lewiston-Auburn, ME	23.0437	21.7003
Lexington, KY	21.1620	20.2378
Lima, OH	23.2114	22.1607
Lincoln, NE	24.7917	23.5197
Little Rock-North Little Rock, AR	21.8575	20.9688
Longview-Marshall, TX	22.4348	20.5074
Los Angeles-Long Beach, CA	28.5648	27.6989
Louisville, KY-IN	22.5165	21.7940
Lubbock, TX	20.4449	20.4788
Lynchburg, VA	22.5852	21.4509
Macon, GA	22.1616	21.1692
Madison, WI	25.1207	24.1736
Mansfield, OH	22.2335	20.8233
Mayaguez, PR	11.7315	11.3138
McAllen-Edinburg-Mission, TX	22.2965	20.2067
Medford-Ashland, OR	26.6156	24.7374
Melbourne-Titusville-Palm Bay, FL	24.0574	23.3611
Memphis, TN-AR-MS	22.8875	21.1855
Merced, CA	23.9422	23.0370
Miami, FL	24.2692	23.0684
Middlesex-Somerset-Hunterdon, NJ	28.0716	26.5525
Milwaukee-Waukesha, WI	24.2703	23.1731
Minneapolis-St. Paul, MN-WI	27.1544	25.6571
Missoula, MT	21.5392	21.2648
Mobile, AL	19.5085	18.7864
Modesto, CA	27.8424	25.5333
Monmouth-Ocean, NJ	26.9085	25.3164
Monroe, LA	19.5806	18.9433
Montgomery, AL	19.2813	17.8049
Muncie, IN	21.4993	21.7481
Myrtle Beach, SC	21.9670	20.8646
Naples, FL	24.2154	22.8672
Nashville, TN	24.1409	22.7215
Nassau-Suffolk, NY	31.9339	31.1765
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	30.6450	28.9030
New London-Norwich, CT	28.7588	27.3098
New Orleans, LA	22.5126	21.2103
New York, NY	34.0359	33.2980
Newark, NJ	28.0215	26.7812
Newburgh, NY-PA	27.7682	26.3667
Norfolk-Virginia Beach-Newport News, VA-NC	21.2530	20.1058
Oakland, CA	36.9259	35.4131
Ocala, FL	24.0225	22.3877
Odessa-Midland, TX	23.1872	22.5143
Oklahoma City, OK	22.1744	20.7685
Olympia, WA	27.0728	25.9774
Omaha, NE-IA	23.9161	22.9252
Orange County, CA	27.5748	26.3219
Orlando, FL	23.5921	22.5423
Owensboro, KY	20.6888	19.5760
Panama City, FL	21.2992	20.7203
Parkersburg-Marietta, WV-OH	19.8623	19.0009
Pensacola, FL	20.6255	19.7879
Peoria-Pekin, IL	21.5796	20.4881
Philadelphia, PA-NJ	26.8676	25.3554
Phoenix-Mesa, AZ	25.0656	23.1490
Pine Bluff, AR	18.7641	18.2815
Pittsburgh, PA	21.5682	21.5505
Pittsfield, MA	25.2831	23.9826
Pocatello, ID	22.3412	21.7279
Ponce, PR	11.6867	11.7774
Portland, ME	24.5068	22.7835
Portland-Vancouver, OR-WA	27.4708	25.7362
Providence-Warwick, RI	27.0592	25.4242
Provo-Orem, UT	24.6487	23.2777
Pueblo, CO	21.6891	20.4756
Punta Gorda, FL	23.3618	21.6509
Racine, WI	21.8176	21.4880
Raleigh-Durham-Chapel Hill, NC	24.7888	23.2945
Rapid City, SD	21.7579	20.7364
Reading, PA	22.1933	21.7267
Redding, CA	28.0292	26.2652
Reno, NV	26.3682	24.8415
Richland-Kennewick-Pasco, WA	26.0849	25.7185
Richmond-Petersburg, VA	23.0767	22.2287
Riverside-San Bernardino, CA	27.7914	26.2909
Roanoke, VA	21.4970	20.0809
Rochester, MN	28.9664	27.6257
Rochester, NY	23.4531	22.1985
Rockford, IL	23.8815	22.2381
Rocky Mount, NC	22.2321	21.3362
Sacramento, CA	29.2332	27.4459
Saginaw-Bay City-Midland, MI	23.6103	22.4738
St. Cloud, MN	23.3992	22.6517
[1] St. Joseph, MO	24.1078	24.1078
St. Louis, MO-IL	22.2105	20.8148
Salem, OR	25.8986	24.0695
Salinas, CA	35.4282	34.0968
Salt Lake City-Ogden, UT	24.2956	23.1582
San Angelo, TX	20.3421	19.4654
San Antonio, TX	21.7859	20.4173
San Diego, CA	27.5034	26.1832
San Francisco, CA	35.2175	33.1623
San Jose, CA	35.9382	33.4495
San Juan-Bayamon, PR	12.0353	11.2034
San Luis Obispo-Atascadero-Paso Robles, CA	28.1871	26.3232
Santa Barbara-Santa Maria-Lompoc, CA	25.7977	24.7645

TABLE 3A.—FY 2004 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the Salaries and Hours Computed for Federal Fiscal Years 2002, 2003, and 2004]

Urban area	FY 2004 average hourly wage	3-Year average hourly wage
Santa Cruz-Watsonville, CA	31.9363	31.6115
Santa Fe, NM	26.1125	24.6586
Santa Rosa, CA	31.5034	30.3104
Sarasota-Bradenton, FL	24.1015	22.8397
Savannah, GA	23.4542	22.5461
Scranton-Wilkes Barre-Hazleton, PA	20.5178	19.9473
Seattle-Bellevue-Everett, WA	28.3651	26.8159
Sharon, PA	19.1498	18.3866
Sheboygan, WI	21.3074	20.1274
Sherman-Denison, TX	23.3354	21.9733
Shreveport-Bossier City, LA	22.4424	21.1518
Sioux City, IA-NE	22.2184	20.9019
Sioux Falls, SD	22.9990	21.6460
South Bend, IN	24.2656	23.1221
Spokane, WA	26.9242	25.3258
Springfield, IL	22.0988	20.5053
Springfield, MO	20.7882	19.8503
Springfield, MA	25.1820	24.9487
State College, PA	21.5944	20.9171
Steubenville-Weirton, OH-WV	20.7491	20.1726
Stockton-Lodi, CA	25.9615	24.8099
Sumter, SC	20.1378	18.9286
Syracuse, NY	23.2731	22.4502
Tacoma, WA	25.0655	25.4358
Tallahassee, FL	20.9393	19.9194
Tampa-St. Petersburg-Clearwater, FL	22.3623	21.0795
Terre Haute, IN	20.5894	19.8434
Texarkana, AR-Texarkana, TX	20.1201	19.1440
Toledo, OH	23.4422	22.6911
Topeka, KS	22.1410	21.1325
Trenton, NJ	25.9088	24.4803
Tucson, AZ	21.9871	20.8658
Tulsa, OK	22.4262	20.4923
Tuscaloosa, AL	20.2222	19.1231
Tyler, TX	21.5724	21.7219
Utica-Rome, NY	20.8155	19.7105
Vallejo-Fairfield-Napa, CA	33.0023	31.4386
Ventura, CA	25.7022	25.3153
Victoria, TX	19.8941	19.6059
Vineland-Millville-Bridgeton, NJ	25.7088	24.0750
Visalia-Tulare-Portersville, CA	24.2540	22.5528
Waco, TX	20.7383	19.2135
Washington, DC-MD-VA-WV	26.2793	25.3284
Waterloo-Cedar Falls, IA	20.6706	19.0431
Wausau, WI	23.9474	22.8336
West Palm Beach-Boca Raton, FL	24.0146	22.9860
Wheeling, OH-WV	18.4694	18.0317
Wichita, KS	22.8265	22.1175

TABLE 3A.—FY 2004 AND 3-YEAR* AVERAGE HOURLY WAGE FOR URBAN AREAS—Continued

[*Based on the sum of the Salaries and Hours Computed for Federal Fiscal Years 2002, 2003, and 2004]

Urban area	FY 2004 average hourly wage	3-Year average hourly wage
Wichita Falls, TX	20.6347	19.2942
Williamsport, PA	19.8237	19.6398
Wilmington-Newark, DE-MD	26.8874	25.7166
Wilmington, NC	23.5730	22.3755
Yakima, WA	25.3298	24.5057
Yolo, CA	22.7290	22.1106
York, PA	22.3891	21.4937
Youngstown-Warren, OH	22.7587	21.9477
Yuba City, CA	25.1911	24.0864
Yuma, AZ	21.9766	20.7166

[1] The MSA is empty for FY 2004. The hospital(s) in the MSA received rural status under section 401 of the Balanced Budget Refinement Act of 1999 (Pub. L. 106–113). The MSA is assigned the statewide rural wage index (*see* Table 4B).

TABLE 3B.—FY 2004 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS

[*Based on the sum of the Salaries and Hours Computed for Federal Fiscal Years 2002, 2003, and 2004]

Nonurban area	FY 2004 average hourly wage	3-Year average hourly wage
Alabama	18.3348	17.4929
Alaska	29.3667	28.1193
Arizona	22.1917	20.4444
Arkansas	19.0502	17.8283
California	24.5014	22.9050
Colorado	22.3036	20.8977
Connecticut	29.9411	28.5998
Delaware	22.7759	21.8259
Florida	21.7703	20.5939
Georgia	20.6405	19.3893
Hawaii	24.6034	24.3938
Idaho	22.1883	20.5704
Illinois	20.4777	19.1094
Indiana	21.6124	20.4406
Iowa	20.7491	19.3057
Kansas	19.7860	18.4560
Kentucky	19.5747	18.6825
Louisiana	18.3330	17.5766
Maine	22.1139	20.6732
Maryland	22.5202	21.0708
Massachusetts	26.6580	26.1016
Michigan	21.6556	20.8571
Minnesota	22.9622	21.3937
Mississippi	19.2263	17.9212
Missouri	19.2927	18.4558
Montana	21.6718	20.0795
Nebraska	21.7533	19.3579
Nevada	24.0509	22.6017
New Hampshire	24.8141	23.0661
[1] New Jersey	.....	.....
New Mexico	20.3060	20.0956
New York	21.0328	19.9757

TABLE 3B.—FY 2004 AND 3-YEAR* AVERAGE HOURLY WAGE FOR RURAL AREAS—Continued

[*Based on the sum of the Salaries and Hours Computed for Federal Fiscal Years 2002, 2003, and 2004]

Nonurban area	FY 2004 average hourly wage	3-Year average hourly wage
North Carolina	20.5716	19.9126
North Dakota	19.2168	18.1538
Ohio	21.6481	20.3023
Oklahoma	18.6273	17.6874
Oregon	24.6521	23.6537
Pennsylvania	20.7089	19.8599
Puerto Rico	10.2273	9.9080
[1] Rhode Island	.....	.....
South Carolina	20.8645	19.9708
South Dakota	20.2488	18.5076
Tennessee	19.5008	18.5022
Texas	18.9842	18.1045
Utah	22.1698	21.3594
Vermont	22.9948	21.9226
Virginia	20.9873	19.7038
Washington	25.9055	23.9310
West Virginia	19.7553	18.7353
Wisconsin	22.6498	21.3482
Wyoming	22.6090	20.9331

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

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

Urban area (Constituent counties)	Wage index	GAF
0040 1Abilene, TX Taylor, TX	0.7678	0.8345
0060 Aguadilla, PR Aguada, PR Aguadilla, PR Moca, PR	0.4335	0.5642
0080 Akron, OH Portage, OH Summit, OH	0.9445	0.9617
0120 Albany, GA Dougherty, GA Lee, GA	1.0838	1.0567
0160 Albany-Schenectady-Troy, NY Albany, NY Montgomery, NY Rensselaer, NY Saratoga, NY Schenectady, NY Schoharie, NY	0.8693	0.9085
0200 Albuquerque, NM Bernalillo, NM Sandoval, NM Valencia, NM	0.9431	0.9607
0220 Alexandria, LA Rapides, LA	0.8087	0.8647
0240 Allentown-Bethlehem-Easton, PA Carbon, PA Lehigh, PA Northampton, PA	0.9576	0.9708
0280 Altoona, PA Blair, PA	0.8886	0.9223

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

Urban area (Constituent counties)	Wage index	GAF
0320 Amarillo, TX	0.8968	0.9281
Potter, TX		
Randall, TX		
0380 Anchorage, AK	1.2433	1.1608
Anchorage, AK		
0440 Ann Arbor, MI	1.1069	1.0720
Lenawee, MI		
Livingston, MI		
Washtenaw, MI		
0450 Anniston, AL	0.8140	0.8686
Calhoun, AL		
0460 [2] Appleton-Oshkosh-Neenah, WI	0.9130	0.9396
Calumet, WI		
Outagamie, WI		
Winnebago, WI		
0470 Arecibo, PR	0.4130	0.5458
Arecibo, PR		
Camuy, PR		
Hatillo, PR		
0480 Asheville, NC	0.9697	0.9792
Buncombe, NC		
Madison, NC		
0500 Athens, GA	0.9664	0.9769
Clarke, GA		
Madison, GA		
Oconee, GA		
0520 [1] Atlanta, GA	1.0027	1.0018
Barrow, GA		
Bartow, GA		
Carroll, GA		
Cherokee, GA		
Clayton, GA		
Cobb, GA		
Coweta, GA		
DeKalb, GA		
Douglas, GA		
Fayette, GA		
Forsyth, GA		
Fulton, GA		
Gwinnett, GA		
Henry, GA		
Newton, GA		
Paulding, GA		
Pickens, GA		
Rockdale, GA		
Spalding, GA		
Walton, GA		
0560 Atlantic-Cape May, NJ	1.0862	1.0583
Atlantic, NJ		
Cape May, NJ		
0580 Auburn-Opelika, AL	0.8540	0.8976
Lee, AL		
0600 Augusta-Aiken, GA-SC	0.9725	0.9811
Columbia, GA		
McDuffie, GA		
Richmond, GA		
Aiken, SC		
Edgefield, SC		
0640 [1] Austin-San Marcos, TX	0.9551	0.9690
Bastrop, TX		
Caldwell, TX		
Hays, TX		
Travis, TX		
Williamson, TX		
0680 [2] Bakersfield, CA	0.9907	0.9936
Kern, CA		
0720 [1] Baltimore, MD	0.9951	0.9966
Anne Arundel, MD		
Baltimore, MD		
Baltimore City, MD		
Carroll, MD		
Harford, MD		
Howard, MD		
Queen Anne's, MD		
0733 Bangor, ME	0.9750	0.9828
Penobscot, ME		
0743 Barnstable-Yarmouth, MA	1.2893	1.1901
Barnstable, MA		
0760 Baton Rouge, LA	0.8271	0.8781
Ascension, LA		
East Baton Rouge, LA		
Livingston, LA		
West Baton Rouge, LA		
0840 Beaumont-Port Arthur, TX	0.8503	0.8949
Hardin, TX		
Jefferson, TX		
Orange, TX		
0860 Bellingham, WA	1.1834	1.1222
Whatcom, WA		
0870 Benton Harbor, MI	0.8949	0.9268
Berrien, MI		
0875 [1] Bergen-Passaic, NJ	1.1655	1.1106
Bergen, NJ		
Passaic, NJ		
0880 Billings, MT	0.8889	0.9225
Yellowstone, MT		
0920 Biloxi-Gulfport-Pascagoula, MS	0.9089	0.9367
Hancock, MS		
Harrison, MS		
Jackson, MS		
0960 [2] Binghamton, NY	0.8530	0.8968
Broome, NY		
Tioga, NY		
1000 Birmingham, AL	0.9251	0.9481
Blount, AL		
Jefferson, AL		
St. Clair, AL		
Shelby, AL		
1010 Bismarck, ND	0.8101	0.8657
Burleigh, ND		
Morton, ND		
1020 Bloomington, IN	0.8968	0.9281
Monroe, IN		
1040 Bloomington-Normal, IL	0.8954	0.9271
McLean, IL		
1080 Boise City, ID	0.9295	0.9512
Ada, ID		
Canyon, ID		
1123 [1] Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1269	1.0853
Bristol, MA		
Essex, MA		
Middlesex, MA		
Norfolk, MA		
Plymouth, MA		
Suffolk, MA		
Worcester, MA		
Hillsborough, NH		
Merrimack, NH		
Rockingham, NH		
Strafford, NH		
1125 Boulder-Longmont, CO	1.0119	1.0081
Boulder, CO		
1145 Brazoria, TX	0.8324	0.8819
Brazoria, TX		
1150 Bremerton, WA	1.0601	1.0408
Kitsap, WA		
1240 Brownsville-Harlingen-San Benito, TX	1.0231	1.0158
Cameron, TX		
1260 Bryan-College Station, TX	0.9044	0.9335
Brazos, TX		
1280 [1] Buffalo-Niagara Falls, NY	0.9600	0.9724
Erie, NY		
Niagara, NY		
1303 Burlington, VT	0.9768	0.9841
Chittenden, VT		
Franklin, VT		
Grand Isle, VT		
1310 Caguas, PR	0.4229	0.5547
Caguas, PR		
Cayey, PR		
Cidra, PR		
Gurabo, PR		
San Lorenzo, PR		
1320 Canton-Massillon, OH	0.9128	0.9394
Carroll, OH		
Stark, OH		
1350 Casper, WY	0.9239	0.9472
Natrona, WY		
1360 Cedar Rapids, IA	0.8933	0.9256
Linn, IA		
1400 Champaign-Urbana, IL	0.9907	0.9936
Champaign, IL		
1440 Charleston-North Charleston, SC	0.9307	0.9520
Berkeley, SC		
Charleston, SC		
Dorchester, SC		
1480 Charleston, WV	0.8753	0.9128
Kanawha, WV		
Putnam, WV		
1520 [1] Charlotte-Gastonia-Rock Hill, NC-SC	0.9766	0.9839
Cabarrus, NC		
Gaston, NC		
Lincoln, NC		

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

Urban area (Constituent counties)	Wage index	GAF
Mecklenburg, NC		
Rowan, NC		
Stanly, NC		
Union, NC		
York, SC		
1540 Charlottesville, VA	1.0092	1.0063
Albemarle, VA		
Charlottesville City, VA		
Fluvanna, VA		
Greene, VA		
1560 Chattanooga, TN-GA	0.8985	0.9293
Catoosa, GA		
Dade, GA		
Walker, GA		
Hamilton, TN		
Marion, TN		
1580 [2] Cheyenne, WY	0.9137	0.9401
Laramie, WY		
1600 [1] Chicago, IL	1.1012	1.0682
Cook, IL		
DeKalb, IL		
DuPage, IL		
Grundy, IL		
Kane, IL		
Kendall, IL		
Lake, IL		
McHenry, IL		
Will, IL		
1620 Chico-Paradise, CA	1.0147	1.0100
Butte, CA		
1640 [1] Cincinnati, OH-KY-IN	0.9452	0.9621
Dearborn, IN		
Ohio, IN		
Boone, KY		
Campbell, KY		
Gallatin, KY		
Grant, KY		
Kenton, KY		
Pendleton, KY		
Brown, OH		
Clermont, OH		
Hamilton, OH		
Warren, OH		
1660 Clarksville-Hopkinsville, TN-KY	0.8410	0.8882
Christian, KY		
Montgomery, TN		
1680[1] Cleveland-Lorain-Elyria, OH	0.9686	0.9784
Ashtabula, OH		
Cuyahoga, OH		
Geauga, OH		
Lake, OH		
Lorain, OH		
Medina, OH		
1720 [2] Colorado Springs, CO	0.8897	0.9231
El Paso, CO		
1740 Columbia, MO	0.8745	0.9123
Boone, MO		
1760 Columbia, SC	0.8958	0.9274
Lexington, SC		
Richland, SC		
1800 Columbus, GA-AL	0.8700	0.9090
Russell, AL		
Chattahoochee, GA		
Harris, GA		
Muscogee, GA		
1840 [1] Columbus, OH	0.9649	0.9758
Delaware, OH		
Fairfield, OH		
Franklin, OH		
Licking, OH		
Madison, OH		
Pickaway, OH		
1880 Corpus Christi, TX	0.8565	0.8994
Nueces, TX		
San Patricio, TX		
1890 Corvallis, OR	1.1593	1.1065
Benton, OR		
1900 [2] Cumberland, MD-WV (MD Hospitals)	0.9175	0.9427
Allegany, MD		
Mineral, WV		
1900 Cumberland, MD-WV (WV Hospitals)	0.8224	0.8747
Allegany, MD		
Mineral, WV		
1920 [1] Dallas, TX	0.9733	0.9816
Collin, TX		
Dallas, TX		
Denton, TX		
Ellis, TX		
Henderson, TX		
Hunt, TX		
Kaufman, TX		
Rockwall, TX		
1950 Danville, VA	0.9095	0.9371
Danville City, VA		
Pittsylvania, VA		
1960 Davenport-Moline-Rock Island, IA-IL	0.8727	0.9110
Scott, IA		
Henry, IL		
Rock Island, IL		
2000 Dayton-Springfield, OH	0.9432	0.9607
Clark, OH		
Greene, OH		
Miami, OH		
Montgomery, OH		
2020 Daytona Beach, FL	0.9208	0.9451
Flagler, FL		
Volusia, FL		
2030 Decatur, AL	0.8882	0.9220
Lawrence, AL		
Morgan, AL		
2040 [2] Decatur, IL	0.8282	0.8789
Macon, IL		
2080 [1] Denver, CO	1.0776	1.0525
Adams, CO		
Arapahoe, CO		
Broomfield, CO		
Denver, CO		
Douglas, CO		
Jefferson, CO		
2120 Des Moines, IA	0.9053	0.9341
Dallas, IA		
Polk, IA		
Warren, IA		
2160 [1] Detroit, MI	1.0097	1.0066
Lapeer, MI		
Macomb, MI		
Monroe, MI		
Oakland, MI		
St. Clair, MI		
Wayne, MI		
2180 Dothan, AL	0.7931	0.8532
Dale, AL		
Houston, AL		
2190 Dover, DE	0.9870	0.9911
Kent, DE		
2200 Dubuque, IA	0.8946	0.9266
Dubuque, IA		
2240 Duluth-Superior, MN-WI	1.0133	1.0091
St. Louis, MN		
Douglas, WI		
2281 Dutchess County, NY	1.0966	1.0652
Dutchess, NY		
2290 Eau Claire, WI	0.9141	0.9403
Chippewa, WI		
Eau Claire, WI		
2320 El Paso, TX	0.9267	0.9492
El Paso, TX		
2330 Elkhart-Goshen, IN	0.9848	0.9896
Elkhart, IN		
2335 [2] Elmira, NY	0.8530	0.8968
Chemung, NY		
2340 Enid, OK	0.8616	0.9030
Garfield, OK		
2360 Erie, PA	0.8636	0.9045
Erie, PA		
2400 Eugene-Springfield, OR	1.1212	1.0815
Lane, OR		
2440 [2] Evansville-Henderson, IN-KY (IN Hospitals)	0.8770	0.9140
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2440 Evansville-Henderson, IN-KY (KY Hospitals)	0.8442	0.8905
Posey, IN		
Vanderburgh, IN		
Warrick, IN		
Henderson, KY		
2520 Fargo-Moorhead, ND-MN	0.9650	0.9759
Clay, MN		
Cass, ND		
2560 Fayetteville, NC	0.8957	0.9273
Cumberland, NC		
2580 Fayetteville-Springdale-Rogers, AR	0.8038	0.8611

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

Urban area (Constituent counties)	Wage index	GAF
Benton, AR		
Washington, AR		
2620 Flagstaff, AZ-UT	1.1283	1.0862
Coconino, AZ		
Kane, UT		
2640 Flint, MI	1.0929	1.0627
Genesee, MI		
2650 Florence, AL	0.7824	0.8453
Colbert, AL		
Lauderdale, AL		
2655 Florence, SC	0.8763	0.9135
Florence, SC		
2670 Fort Collins-Loveland, CO	1.0201	1.0137
Larimer, CO		
2680 [1] Ft. Lauderdale, FL	1.0534	1.0363
Broward, FL		
2700 Fort Myers-Cape Coral, FL	0.9877	0.9916
Lee, FL		
2710 Fort Pierce-Port St. Lucie, FL	1.0227	1.0155
Martin, FL		
St. Lucie, FL		
2720 [2] Fort Smith, AR-OK (AR Hospitals)	0.7746	0.8395
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
2720 Fort Smith, AR-OK (OK Hospitals)	0.7740	0.8391
Crawford, AR		
Sebastian, AR		
Sequoyah, OK		
2750 Fort Walton Beach, FL	0.8929	0.9254
Okaloosa, FL		
2760 Fort Wayne, IN	0.9674	0.9776
Adams, IN		
Allen, IN		
De Kalb, IN		
Huntington, IN		
Wells, IN		
Whitley, IN		
2800 [1] Forth Worth-Arlington, TX	0.9268	0.9493
Hood, TX		
Johnson, TX		
Parker, TX		
Tarrant, TX		
2840 Fresno, CA	1.0157	1.0107
Fresno, CA		
Madera, CA		
2880 Gadsden, AL	0.8295	0.8798
Etowah, AL		
2900 [2] Gainesville, FL	0.8782	0.9149
Alachua, FL		
2920 Galveston-Texas City, TX	0.9360	0.9557
Galveston, TX		
2960 Gary, IN	0.9462	0.9628
Lake, IN		
Porter, IN		
2975 [2] Glens Falls, NY	0.8530	0.8968
Warren, NY		
Washington, NY		

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

Urban area (Constituent counties)	Wage index	GAF
2980 Goldsboro, NC	0.8679	0.9075
Wayne, NC		
2985 Grand Forks, ND-MN (ND Hospitals)	0.9031	0.9326
Polk, MN		
Grand Forks, ND		
2985 [2] Grand Forks, ND-MN (MN Hospitals)	0.9243	0.9475
Polk, MN		
Grand Forks, ND		
2995 Grand Junction, CO	0.9940	0.9959
Mesa, CO		
3000 [1] Grand Rapids-Muskegon-Holland, MI	0.9406	0.9589
Allegan, MI		
Kent, MI		
Muskegon, MI		
Ottawa, MI		
3040 Great Falls, MT	0.8977	0.9288
Cascade, MT		
3060 Greeley, CO	0.9516	0.9666
Weld, CO		
3080 Green Bay, WI	0.9524	0.9672
Brown, WI		
3120 [1] Greensboro-Winston-Salem-High Point, NC	0.8533	0.8971
Alamance, NC		
Davidson, NC		
Davie, NC		
Forsyth, NC		
Guilford, NC		
Randolph, NC		
Stokes, NC		
Yadkin, NC		
3150 Greenville, NC	0.9621	0.9739
Pitt, NC		
3160 Greenville-Spartanburg-Anderson, SC	0.9289	0.9507
Anderson, SC		
Cherokee, SC		
Greenville, SC		
Pickens, SC		
Spartanburg, SC		
3180 Hagerstown, MD	0.9233	0.9468
Washington, MD		
3200 Hamilton-Middletown, OH	0.9236	0.9470
Butler, OH		
3240 Harrisburg-Lebanon-Carlisle, PA	0.9178	0.9430
Cumberland, PA		
Dauphin, PA		
Lebanon, PA		
Perry, PA		
3283 \1,2\ Hartford, CT	1.2199	1.1458
Hartford, CT		
Litchfield, CT		
Middlesex, CT		
Tolland, CT		
3285 [2] Hattiesburg, MS	0.7810	0.8443

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

Urban area (Constituent counties)	Wage index	GAF
Forrest, MS		
Lamar, MS		
3290 Hickory-Morganton-Lenoir, NC	0.9090	0.9368
Alexander, NC		
Burke, NC		
Caldwell, NC		
Catawba, NC		
3320 Honolulu, HI	1.1176	1.0791
Honolulu, HI		
3350 Houma, LA	0.7763	0.8408
Lafourche, LA		
Terrebonne, LA		
3360 [1] Houston, TX	0.9591	0.9718
Chambers, TX		
Fort Bend, TX		
Harris, TX		
Liberty, TX		
Montgomery, TX		
Waller, TX		
3400 Huntington-Ashland, WV-KY-OH	0.9620	0.9738
Boyd, KY		
Carter, KY		
Greenup, KY		
Lawrence, OH		
Cabell, WV		
Wayne, WV		
3440 Huntsville, AL	0.9238	0.9472
Limestone, AL		
Madison, AL		
3480 [1] Indianapolis, IN	0.9934	0.9955
Boone, IN		
Hamilton, IN		
Hancock, IN		
Hendricks, IN		
Johnson, IN		
Madison, IN		
Marion, IN		
Morgan, IN		
Shelby, IN		
3500 Iowa City, IA	0.9605	0.9728
Johnson, IA		
3520 Jackson, MI	0.9043	0.9334
Jackson, MI		
3560 Jackson, MS	0.8459	0.8917
Hinds, MS		
Madison, MS		
Rankin, MS		
3580 Jackson, TN	0.8602	0.9020
Madison, TN		
Chester, TN		
3600 [1] Jacksonville, FL	0.9426	0.9603
Clay, FL		
Duval, FL		
Nassau, FL		
St. Johns, FL		
3605 Jacksonville, NC	0.8589	0.9011
Onslow, NC		
3610 [2] Jamestown, NY	0.8530	0.8968
Chautauqua, NY		
3620 Janesville-Beloit, WI	0.9344	0.9546
Rock, WI		
3640 Jersey City, NJ	1.1203	1.0809
Hudson, NJ		

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

Urban area (Constituent counties)	Wage index	GAF
3660 Johnson City-Kingsport-Bristol, TN-VA (TN Hospitals)	0.8371	0.8854
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3660 [2] Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals)	0.8542	0.8977
Carter, TN		
Hawkins, TN		
Sullivan, TN		
Unicoi, TN		
Washington, TN		
Bristol City, VA		
Scott, VA		
Washington, VA		
3680 [2] Johnstown, PA	0.8429	0.8896
Cambria, PA		
Somerset, PA		
3700 [2] Jonesboro, AR	0.7755	0.8402
Craighead, AR		
3710 Joplin, MO	0.8739	0.9118
Jasper, MO		
Newton, MO		
3720 Kalamazoo-Battlecreek, MI	1.0554	1.0376
Calhoun, MI		
Kalamazoo, MI		
Van Buren, MI		
3740 Kankakee, IL	1.1074	1.0724
Kankakee, IL		
3760 [1] Kansas City, KS-MO	0.9551	0.9690
Johnson, KS		
Leavenworth, KS		
Miami, KS		
Wyandotte, KS		
Cass, MO		
Clay, MO		
Clinton, MO		
Jackson, MO		
Lafayette, MO		
Platte, MO		
Ray, MO		
3800 Kenosha, WI	0.9826	0.9881
Kenosha, WI		
3810 Killeen-Temple, TX	0.9221	0.9460
Bell, TX		
Coryell, TX		
3840 Knoxville, TN	0.8987	0.9295
Anderson, TN		
Blount, TN		
Knox, TN		
Loudon, TN		
Sevier, TN		
Union, TN		
3850 Kokomo, IN	0.8963	0.9278
Howard, IN		
Tipton, IN		
3870 La Crosse, WI-MN	0.9259	0.9486
Houston, MN		
La Crosse, WI		
3880 Lafayette, LA	0.8271	0.8781
Acadia, LA		
Lafayette, LA		
St. Landry, LA		
St. Martin, LA		
3920 Lafayette, IN	0.9052	0.9341
Clinton, IN		
Tippecanoe, IN		
3960 Lake Charles, LA	0.8460	0.8918
Calcasieu, LA		
3980 [2] Lakeland-Winter Haven, FL	0.8782	0.9149
Polk, FL		
4000 Lancaster, PA	0.9325	0.9533
Lancaster, PA		
4040 Lansing-East Lansing, MI	0.9270	0.9494
Clinton, MI		
Eaton, MI		
Ingham, MI		
4080 Laredo, TX	0.8145	0.8689
Webb, TX		
4100 Las Cruces, NM	0.8532	0.8970
Dona Ana, NM		
4120 [1] Las Vegas, NV-AZ	1.1457	1.0976
Mohave, AZ		
Clark, NV		
Nye, NV		
4150. 2Lawrence, KS	0.7860	0.8480
Douglas, KS		
4200 Lawton, OK	0.8322	0.8818
Comanche, OK		
4243 Lewiston-Auburn, ME	0.9389	0.9577
Androscoggin, ME		
4280 Lexington, KY	0.8622	0.9035
Bourbon, KY		
Clark, KY		
Fayette, KY		
Jessamine, KY		
Madison, KY		
Scott, KY		
Woodford, KY		
4320 Lima, OH	0.9457	0.9625
Allen, OH		
Auglaize, OH		
4360 Lincoln, NE	1.0101	1.0069
Lancaster, NE		
4400 Little Rock-North Little Rock, AR	0.8905	0.9237
Faulkner, AR		
Lonoke, AR		
Pulaski, AR		
Saline, AR		
4420 Longview-Marshall, TX	0.9141	0.9403
Gregg, TX		
Harrison, TX		
Upshur, TX		
4480 [1] Los Angeles-Long Beach, CA	1.1656	1.1106
Los Angeles, CA		
4520 [1] Louisville, KY-IN	0.9174	0.9427
Clark, IN		
Floyd, IN		
Harrison, IN		
Scott, IN		
Bullitt, KY		
Jefferson, KY		
Oldham, KY		
4600 Lubbock, TX	0.8330	0.8824
Lubbock, TX		
4640 Lynchburg, VA	0.9202	0.9446
Amherst, VA		
Bedford, VA		
Bedford City, VA		
Campbell, VA		
Lynchburg City, VA		
4680 Macon, GA	0.9011	0.9312
Bibb, GA		
Houston, GA		
Jones, GA		
Peach, GA		
Twiggs, GA		
4720 Madison, WI	1.0235	1.0160
Dane, WI		
4800 Mansfield, OH	0.9059	0.9346
Crawford, OH		
Richland, OH		
4840 Mayaguez, PR	0.4780	0.6032
Anasco, PR		
Cabo Rojo, PR		
Hormigueros, PR		
Mayaguez, PR		
Sabana Grande, PR		
San German, PR		
4880 McAllen-Edinburg-Mission, TX	0.9084	0.9363
Hidalgo, TX		
4890 Medford-Ashland, OR	1.0844	1.0571
Jackson, OR		
4900 Melbourne-Titusville-Palm Bay, FL	0.9837	0.9888
Brevard, Fl		
4920 [1] Memphis, TN-AR-MS	0.9325	0.9533
Crittenden, AR		
DeSoto, MS		
Fayette, TN		
Shelby, TN		
Tipton, TN		
4940 [2] Merced, CA	0.9907	0.9936
Merced, CA		
5000 [1] Miami, FL	0.9888	0.9923
Dade, FL		
5015 [1] Middlesex-Somerset-Hunterdon, NJ	1.1437	1.0963
Hunterdon, NJ		
Middlesex, NJ		
Somerset, NJ		
5080 [1] Milwaukee-Waukesha, WI	0.9888	0.9923
Milwaukee, WI		
Ozaukee, WI		
Washington, WI		

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

Urban area (Constituent counties)	Wage index	GAF
Waukesha, WI		
5120 [1] Minneapolis-St. Paul, MN-WI	1.1064	1.0717
Anoka, MN		
Carver, MN		
Chisago, MN		
Dakota, MN		
Hennepin, MN		
Isanti, MN		
Ramsey, MN		
Scott, MN		
Sherburne, MN		
Washington, MN		
Wright, MN		
Pierce, WI		
St. Croix, WI		
5140 Missoula, MT	0.8943	0.9264
Missoula, MT		
5160 Mobile, AL	0.7948	0.8545
Baldwin, AL		
Mobile, AL		
5170 Modesto, CA	1.1344	1.0902
Stanislaus, CA		
5190 [1] Monmouth-Ocean, NJ	1.1094	1.0737
Monmouth, NJ		
Ocean, NJ		
5200 Monroe, LA	0.7978	0.8567
Ouachita, LA		
5240 Montgomery, AL	0.7856	0.8477
Autauga, AL		
Elmore, AL		
Montgomery, AL		
5280 [2] Muncie, IN	0.8770	0.9140
Delaware, IN		
5330 Myrtle Beach, SC	0.8950	0.9268
Horry, SC		
5345 Naples, FL	0.9866	0.9908
Collier, FL		
5360 [1] Nashville, TN	0.9836	0.9887
Cheatham, TN		
Davidson, TN		
Dickson, TN		
Robertson, TN		
Rutherford TN		
Sumner, TN		
Williamson, TN		
Wilson, TN		
5380 [1] Nassau-Suffolk, NY	1.3011	1.1975
Nassau, NY		
Suffolk, NY		
5483 [1] New Haven-Bridgeport-Stamford-Waterbury-	1.2525	1.1667
Danbury, CT		
Fairfield, CT		
New Haven, CT		
5523 [2] New London-Norwich, CT	1.2199	1.1458
New London, CT		
5560 [1] New Orleans, LA	0.9167	0.9422
Jefferson, LA		
Orleans, LA		
Plaquemines, LA		
St. Bernard, LA		
St. Charles, LA		
St. James, LA		
St. John The Baptist, LA		
St. Tammany, LA		
5600 [1] New York, NY	1.3867	1.2509
Bronx, NY		
Kings, NY		
New York, NY		
Putnam, NY		
Queens, NY		
Richmond, NY		
Rockland, NY		
Westchester, NY		
5640 [1] Newark, NJ	1.1417	1.0950
Essex, NJ		
Morris, NJ		
Sussex, NJ		
Union, NJ		
Warren, NJ		
5660 Newburgh, NY-PA	1.1377	1.0924
Orange, NY		
Pike, PA		
5720 [1] Norfolk-Virginia Beach-Newport News, VA-NC	0.8659	0.9061
Currituck, NC		
Chesapeake City, VA		
Gloucester, VA		
Hampton City, VA		
Isle of Wight, VA		
James City, VA		
Mathews, VA		
Newport News City, VA		
Norfolk City, VA		
Poquoson City, VA		
Portsmouth City, VA		
Suffolk City, VA		
Virginia Beach City VA		
Williamsburg City, VA		
York, VA		
5775 [1] Oakland, CA	1.5204	1.3323
Alameda, CA		
Contra Costa, CA		
5790 Ocala, FL	0.9788	0.9854
Marion, FL		
5800 Odessa-Midland, TX	0.9447	0.9618
Ector, TX		
Midland, TX		
5880 [1] Oklahoma City, OK	0.9027	0.9323
Canadian, OK		
Cleveland, OK		
Logan, OK		
McClain, OK		
Oklahoma, OK		
Pottawatomie, OK		
5910 Olympia, WA	1.1030	1.0694
Thurston, WA		
5920 Omaha, NE-IA	0.9744	0.9824
Pottawattamie, IA		
Cass, NE		
Douglas, NE		
Sarpy, NE		
Washington, NE		
5945 [1] Orange County, CA	1.1235	1.0830
Orange, CA		
5960 [1] Orlando, FL	0.9612	0.9733
Lake, FL		
Orange, FL		
Osceola, FL		
Seminole, FL		
5990 Owensboro, KY	0.8429	0.8896
Daviess, KY		
6015 [2] Panama City, FL	0.8782	0.9149
Bay, FL		
6020 Parkersburg-Marietta, WV-OH (WV Hospitals)	0.8093	0.8651
Washington, OH		
Wood, WV		
6020 [2] Parkersburg-Marietta, WV-OH (OH Hospitals)	0.8756	0.9130
Washington, OH		
Wood, WV		
6080 [2] Pensacola, FL	0.8782	0.9149
Escambia, FL		
Santa Rosa, FL		
6120 Peoria-Pekin, IL	0.8811	0.9170
Peoria, IL		
Tazewell, IL		
Woodford, IL		
6160 [1] Philadelphia, PA-NJ	1.0947	1.0639
Burlington, NJ		
Camden, NJ		
Gloucester, NJ		
Salem, NJ		
Bucks, PA		
Chester, PA		
Delaware, PA		
Montgomery, PA		
Philadelphia, PA		
6200 [1] Phoenix-Mesa, AZ	1.0213	1.0145
Maricopa, AZ		
Pinal, AZ		
6240 Pine Bluff, AR	0.7753	0.8401
Jefferson, AR		
6280 [1] Pittsburgh, PA	0.8788	0.9153
Allegheny, PA		
Beaver, PA		
Butler, PA		
Fayette, PA		
Washington, PA		
Westmoreland, PA		
6323 [2] Pittsfield, MA	1.1234	1.0829
Berkshire, MA		
6340 Pocatello, ID	0.9103	0.9377
Bannock, ID		
6360 Ponce, PR	0.4762	0.6017
Guayanilla, PR		
Juana Diaz, PR		
Penuelas, PR		

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

Urban area (Constituent counties)	Wage index	GAF
Ponce, PR		
Villalba, PR		
Yauco, PR		
6403 Portland, ME	0.9985	0.9990
Cumberland, ME		
Sagadahoc, ME		
York, ME		
6440 [1] Portland-Vancouver, OR-WA	1.1193	1.0802
Clackamas, OR		
Columbia, OR		
Multnomah, OR		
Washington, OR		
Yamhill, OR		
Clark, WA		
6483 [1] Providence-Warwick-Pawtucket, RI	1.1025	1.0691
Bristol, RI		
Kent, RI		
Newport, RI		
Providence, RI		
Washington, RI		
6520 Provo-Orem, UT	1.0043	1.0029
Utah, UT		
6560 [2] Pueblo, CO	0.8897	0.9231
Pueblo, CO		
6580 Punta Gorda, FL	0.9518	0.9667
Charlotte, FL		
6600 [2] Racine, WI	0.9130	0.9396
Racine, WI		
6640 [1] Raleigh-Durham-Chapel Hill, NC	1.0084	1.0057
Chatham, NC		
Durham, NC		
Franklin, NC		
Johnston, NC		
Orange, NC		
Wake, NC		
6660 Rapid City, SD	0.8865	0.9208
Pennington, SD		
6680 Reading, PA	0.9042	0.9334
Berks, PA		
6690 Redding, CA	1.1357	1.0910
Shasta, CA		
6720 Reno, NV	1.0758	1.0513
Washoe, NV		
6740 Richland-Kennewick-Pasco, WA	1.0639	1.0433
Benton, WA		
Franklin, WA		
6760 Richmond-Petersburg, VA	0.9402	0.9587
Charles City County, VA		
Chesterfield, VA		
Colonial Heights City, VA		
Dinwiddie, VA		
Goochland, VA		
Hanover, VA		
Henrico, VA		
Hopewell City, VA		
New Kent, VA		
Petersburg City, VA		
Powhatan, VA		

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

Urban area (Constituent counties)	Wage index	GAF
Prince George, VA		
Richmond City, VA		
6780 [1] Riverside-San Bernardino, CA	1.1318	1.0885
Riverside, CA		
San Bernardino, CA		
6800 Roanoke, VA	0.8759	0.9133
Botetourt, VA		
Roanoke, VA		
Roanoke City, VA		
Salem City, VA		
6820 Rochester, MN	1.1802	1.1201
Olmsted, MN		
6840 [1] Rochester, NY	0.9556	0.9694
Genesee, NY		
Livingston, NY		
Monroe, NY		
Ontario, NY		
Orleans, NY		
Wayne, NY		
6880 Rockford, IL	0.9730	0.9814
Boone, IL		
Ogle, IL		
Winnebago, IL		
6895 Rocky Mount, NC	0.9058	0.9345
Edgecombe, NC		
Nash, NC		
6920 [1] Sacramento, CA	1.1911	1.1272
El Dorado, CA		
Placer, CA		
Sacramento, CA		
6960 Saginaw-Bay City-Midland, MI	0.9620	0.9738
Bay, MI		
Midland, MI		
Saginaw, MI		
6980 St. Cloud, MN	0.9723	0.9809
Benton, MN		
Stearns, MN		
7000 [2] St. Joseph, MO	0.7793	0.8430
Andrew, MO		
Buchanan, MO		
7040 [1] St. Louis, MO-IL	0.9049	0.9339
Clinton, IL		
Jersey, IL		
Madison, IL		
Monroe, IL		
St. Clair, IL		
Franklin, MO		
Jefferson, MO		
Lincoln, MO		
St. Charles, MO		
St. Louis, MO		
St. Louis City, MO		
Warren, MO		
7080 Salem, OR	1.0594	1.0403
Marion, OR		
Polk, OR		
7120 Salinas, CA	1.4435	1.2858
Monterey, CA		
7160 [1] Salt Lake City-Ogden, UT	0.9899	0.9931
Davis, UT		
Salt Lake, UT		

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

Urban area (Constituent counties)	Wage index	GAF
Weber, UT		
7200 San Angelo, TX	0.8288	0.8793
Tom Green, TX		
7240 [1] San Antonio, TX	0.8876	0.9216
Bexar, TX		
Comal, TX		
Guadalupe, TX		
Wilson, TX		
7320 [1] San Diego, CA	1.1206	1.0811
San Diego, CA		
7360 [1] San Francisco, CA	1.4349	1.2805
Marin, CA		
San Francisco, CA		
San Mateo, CA		
7400 [1] San Jose, CA	1.4642	1.2984
Santa Clara, CA		
7440 [1] San Juan-Bayamon, PR	0.4904	0.6139
Aguas Buenas, PR		
Barceloneta, PR		
Bayamon, PR		
Canovanas, PR		
Carolina, PR		
Catano, PR		
Ceiba, PR		
Comerio, PR		
Corozal, PR		
Dorado, PR		
Fajardo, PR		
Florida, PR		
Guaynabo, PR		
Humacao, PR		
Juncos, PR		
Los Piedras, PR		
Loiza, PR		
Luguillo, PR		
Manati, PR		
Morovis, PR		
Naguabo, PR		
Naranjito, PR		
Rio Grande, PR		
San Juan, PR		
Toa Alta, PR		
Toa Baja, PR		
Trujillo Alto, PR		
Vega Alta, PR		
Vega Baja, PR		
Yabucoa, PR		
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.1484	1.0994
San Luis Obispo, CA		
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0511	1.0347
Santa Barbara, CA		
7485 Santa Cruz-Watsonville, CA	1.3012	1.1976
Santa Cruz, CA		
7490 Santa Fe, NM	1.0639	1.0433
Los Alamos, NM		
Santa Fe, NM		
7500 Santa Rosa, CA	1.2836	1.1865
Sonoma, CA		
7510 Sarasota-Bradenton, FL	0.9834	0.9886

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

Urban area (Constituent counties)	Wage index	GAF
Manatee, FL		
Sarasota, FL		
7520 Savannah, GA	0.9556	0.9694
Bryan, GA		
Chatham, GA		
Effingham, GA		
7560 [2]Scranton--Wilkes-Barre--Hazleton, PA	0.8429	0.8896
Columbia, PA		
Lackawanna, PA		
Luzerne, PA		
Wyoming, PA		
7600 [1]Seattle-Bellevue-Everett, WA	1.1557	1.1042
Island, WA		
King, WA		
Snohomish, WA		
7610 [2]Sharon, PA	0.8429	0.8896
Mercer, PA		
7620 [2]Sheboygan, WI	0.9130	0.9396
Sheboygan, WI		
7640 Sherman-Denison, TX	0.9508	0.9660
Grayson, TX		
7680 Shreveport-Bossier City, LA	0.9127	0.9394
Bossier, LA		
Caddo, LA		
Webster, LA		
7720 Sioux City, IA-NE	0.9052	0.9341
Woodbury, IA		
Dakota, NE		
7760 Sioux Falls, SD	0.9371	0.9565
Lincoln, SD		
Minnehaha, SD		
7800 South Bend, IN	0.9887	0.9922
St. Joseph, IN		
7840 Spokane, WA	1.0954	1.0644
Spokane, WA		
7880 Springfield, IL	0.9004	0.9307
Menard, IL		
Sangamon, IL		
7920 Springfield, MO	0.8470	0.8925
Christian, MO		
Greene, MO		
Webster, MO		
8003 [2]Springfield, MA	1.1234	1.0829
Hampden, MA		
Hampshire, MA		
8050 State College, PA	0.8798	0.9160
Centre, PA		
8080 Steubenville-Weirton, OH-WV	0.8454	0.8914
Jefferson, OH		
Brooke, WV		
Hancock, WV		
8120 Stockton-Lodi, CA	1.1168	1.0786
San Joaquin, CA		
8140 [2]Sumter, SC	0.8489	0.8939
Sumter, SC		
8160 Syracuse, NY	0.9482	0.9642
Cayuga, NY		
Madison, NY		
Onondaga, NY		
Oswego, NY		
8200 [2]Tacoma, WA	1.0242	1.0165
Pierce, WA		
8240 [2]Tallahassee, FL	0.8782	0.9149
Gadsden, FL		
Leon, FL		
8280 [1]Tampa-St. Petersburg-Clearwater, FL	0.9111	0.9382
Hernando, FL		
Hillsborough, FL		
Pasco, FL		
Pinellas, FL		
8320 [2]Terre Haute, IN	0.8770	0.9140
Clay, IN		
Vermillion, IN		
Vigo, IN		
8360 Texarkana,AR-Texarkana, TX	0.8198	0.8728
Miller, AR		
Bowie, TX		
8400 Toledo, OH	0.9551	0.9690
Fulton, OH		
Lucas, OH		
Wood, OH		
8440 Topeka, KS	0.9021	0.9319
Shawnee, KS		
8480 Trenton, NJ	1.0556	1.0377
Mercer, NJ		
8520 Tucson, AZ	0.8958	0.9274
Pima, AZ		
8560 Tulsa, OK	0.9093	0.9370
Creek, OK		
Osage, OK		
Rogers, OK		
Tulsa, OK		
Wagoner, OK		
8600 Tuscaloosa, AL	0.8239	0.8758
Tuscaloosa, AL		
8640 Tyler, TX	0.8789	0.9154
Smith, TX		
8680 [2]Utica-Rome, NY	0.8530	0.8968
Herkimer, NY		
Oneida, NY		
8720 Vallejo-Fairfield-Napa, CA	1.3500	1.2282
Napa, CA		
Solano, CA		
8735 Ventura, CA	1.0472	1.0321
Ventura, CA		
8750 Victoria, TX	0.8105	0.8660
Victoria, TX		
8760 Vineland-Millville-Bridgeton, NJ	1.0475	1.0323
Cumberland, NJ		
8780 [2]Visalia-Tulare-Porterville, CA	0.9907	0.9936
Tulare, CA		
8800 Waco, TX	0.8449	0.8910
McLennan, TX		
8840 [1]Washington, DC-MD-VA-WV	1.0707	1.0479
District of Columbia, DC		
Calvert, MD		
Charles, MD		
Frederick, MD		
Montgomery, MD		
Prince Georges, MD		
Alexandria City, VA		
Arlington, VA		
Clarke, VA		
Culpeper, VA		
Fairfax, VA		
Fairfax City, VA		
Falls Church City, VA		
Fauquier, VA		
Fredericksburg City, VA		
King George, VA		
Loudoun, VA		
Manassas City, VA		
Manassas Park City, VA		
Prince William, VA		
Spotsylvania, VA		
Stafford, VA		
Warren, VA		
Berkeley, WV		
Jefferson, WV		
8920 Waterloo-Cedar Falls, IA	0.8422	0.8890
Black Hawk, IA		
8940 Wausau, WI	0.9806	0.9867
Marathon, WI		
8960 [1]West Palm Beach-Boca Raton, FL	0.9784	0.9852
Palm Beach, FL		
9000 [2]Wheeling, WV-OH (WV Hospitals)	0.8008	0.8589
Belmont, OH		
Marshall, WV		
Ohio, WV		
9000 [2]Wheeling, WV-OH (OH Hospitals)	0.8756	0.9130
Belmont, OH		
Marshall, WV		
Ohio, WV		
9040 Wichita, KS	0.9300	0.9515
Butler, KS		
Harvey, KS		
Sedgwick, KS		
9080 Wichita Falls, TX	0.8407	0.8880
Archer, TX		
Wichita, TX		
9140 [2]Williamsport, PA	0.8429	0.8896
Lycoming, PA		
9160 Wilmington-Newark, DE-MD	1.0955	1.0645
New Castle, DE		
Cecil, MD		
9200 Wilmington, NC	0.9604	0.9727
New Hanover, NC		
Brunswick, NC		
9260 Yakima, WA	1.0320	1.0218
Yakima, WA		
9270 [2]Yolo, CA	0.9907	0.9936
Yolo, CA		
9280 York, PA	0.9154	0.9413
York, PA		

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

Urban area (Constituent counties)	Wage index	GAF
9320 Youngstown-Warren, OH	0.9273	0.9496
Columbiana, OH		
Mahoning, OH		
Trumbull, OH		
9340 Yuba City, CA	1.0264	1.0180
Sutter, CA		
Yuba, CA		
9360 Yuma, AZ	0.8954	0.9271
Yuma, AZ		

[1] Large urban area.
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2004.

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

Nonurban area	Wage index	GAF
Alabama	0.7517	0.8225
Alaska	1.1958	1.1303
Arizona	0.8906	0.9237
Arkansas	0.7746	0.8395
California	0.9907	0.9936
Colorado	0.8897	0.9231
Connecticut	1.2199	1.1458
Delaware	0.9669	0.9772
Florida	0.8782	0.9149
Georgia	0.8365	0.8849
Hawaii	0.9896	0.9929
Idaho	0.8907	0.9238
Illinois	0.8282	0.8789
Indiana	0.8770	0.9140
Iowa	0.8278	0.8786
Kansas	0.7860	0.8480
Kentucky	0.7924	0.8527
Louisiana	0.7565	0.8261
Maine	0.8995	0.9300
Maryland	0.9175	0.9427
Massachusetts	1.1234	1.0829
Michigan	0.8807	0.9167
Minnesota	0.9243	0.9475
Mississippi	0.7810	0.8443
Missouri	0.7793	0.8430
Montana	0.8530	0.8968
Nebraska	0.8326	0.8821
Nevada	0.9758	0.9834
New Hampshire	0.9944	0.9962
[1] New Jersey	.....	.....
New Mexico	0.8314	0.8812
New York	0.8530	0.8968
North Carolina	0.8355	0.8842
North Dakota	0.7536	0.8239
Ohio	0.8756	0.9130
Oklahoma	0.7577	0.8270
Oregon	0.9939	0.9958
Pennsylvania	0.8429	0.8896
Puerto Rico	0.4037	0.5373
[1] Rhode Island	.....	.....
South Carolina	0.8489	0.8939
South Dakota	0.8093	0.8651
Tennessee	0.7945	0.8542
Texas	0.7673	0.8341

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

Nonurban area	Wage index	GAF
Utah	0.9034	0.9328
Vermont	0.9401	0.9586
Virginia	0.8542	0.8977
Washington	1.0242	1.0165
West Virginia	0.8008	0.8589
Wisconsin	0.9130	0.9396
Wyoming	0.9137	0.9401

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

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

Area	Wage index	GAF
Akron, OH	0.9445	0.9617
Albany, GA	1.0643	1.0436
Albuquerque, NM	0.9431	0.9607
Alexandria, LA	0.8087	0.8647
Altoona, PA	0.8886	0.9223
Amarillo, TX	0.8814	0.9172
Anchorage, AK	1.2433	1.1608
Ann Arbor, MI	1.0859	1.0581
Anniston, AL	0.8025	0.8601
Asheville, NC	0.9503	0.9657
Athens, GA	0.9437	0.9611
Atlanta, GA	0.9912	0.9940
Atlantic-Cape May, NJ	1.0597	1.0405
Augusta-Aiken, GA-SC	0.9491	0.9649
Austin-San Marcos, TX	0.9551	0.9690
Bangor, ME	0.9750	0.9828
Barnstable-Yarmouth, MA	1.2703	1.1780
Baton Rouge, LA	0.8271	0.8781
Bellingham, WA	1.1834	1.1222
Benton Harbor, MI	0.8949	0.9268
Bergen-Passaic, NJ	1.1655	1.1106
Billings, MT	0.8889	0.9225
Biloxi-Gulfport-Pascagoula, MS	0.8449	0.8910
Binghamton, NY	0.8433	0.8898
Birmingham, AL	0.9251	0.9481
Bismarck, ND	0.8101	0.8657
Bloomington-Normal, IL	0.8954	0.9271
Boise City, ID	0.9295	0.9512
Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH	1.1269	1.0853
Burlington, VT	0.9442	0.9614
Caguas, PR	0.4229	0.5547
Casper, WY	0.9239	0.9472
Champaign-Urbana, IL	0.9385	0.9575
Charleston-North Charleston, SC	0.9307	0.9520
Charleston, WV (WV Hospitals)	0.8510	0.8954
Charleston, WV (OH Hospitals)	0.8756	0.9130
Charlotte-Gastonia-Rock Hill, NC-SC	0.9636	0.9749
Charlottesville, VA	0.9946	0.9963
Chattanooga, TN-GA	0.8985	0.9293
Chicago, IL	1.0863	1.0583

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

Area	Wage index	GAF
Cincinnati, OH-KY-IN	0.9452	0.9621
Clarksville-Hopkinsville, TN-KY	0.8410	0.8882
Cleveland-Lorain-Elyria, OH	0.9686	0.9784
Columbia, MO	0.8607	0.9024
Columbia, SC	0.8958	0.9274
Columbus, GA-AL	0.8505	0.8950
Columbus, OH	0.9649	0.9758
Corpus Christi, TX	0.8565	0.8994
Corvallis, OR	1.1316	1.0884
Dallas, TX	0.9733	0.9816
Davenport-Moline-Rock Island, IA-IL	0.8727	0.9110
Dayton-Springfield, OH	0.9432	0.9607
Decatur, AL	0.8633	0.9042
Denver, CO	1.0581	1.0394
Des Moines, IA	0.9053	0.9341
Detroit, MI	1.0097	1.0066
Dothan, AL	0.7931	0.8532
Dover, DE	0.9669	0.9772
Duluth-Superior, MN-WI	1.0133	1.0091
Dutchess County, NY	1.0769	1.0520
Eau Claire, WI	0.9141	0.9403
Elkhart-Goshen, IN	0.9613	0.9733
Erie, PA	0.8530	0.8968
Eugene-Springfield, OR	1.0889	1.0601
Fargo-Moorhead, ND-MN	0.9444	0.9616
Fayetteville, NC	0.8957	0.9273
Flagstaff, AZ-UT	1.1086	1.0732
Flint, MI	1.0929	1.0627
Florence, AL	0.7824	0.8453
Florence, SC	0.8763	0.9135
Fort Collins-Loveland, CO	1.0201	1.0137
Ft. Lauderdale, FL	1.0534	1.0363
Fort Pierce-Port St. Lucie, FL	1.0227	1.0155
Fort Smith, AR-OK	0.7577	0.8270
Fort Walton Beach, FL	0.8700	0.9090
Forth Worth-Arlington, TX	0.9268	0.9493
Gadsden, AL	0.8295	0.8798
Grand Forks, ND-MN (ND Hospitals)	0.9031	0.9326
Grand Forks, ND-MN (MN Hospitals)	0.9243	0.9475
Grand Junction, CO	0.9940	0.9959
Grand Rapids-Muskegon-Holland, MI	0.9406	0.9589
Great Falls, MT	0.8977	0.9288
Greeley, CO	0.9516	0.9666
Green Bay, WI	0.9201	0.9446
Greensboro-Winston-Salem-High Point, NC (NC Hospitals)	0.8533	0.8971
Greensboro-Winston-Salem-High Point, NC (VA Hospitals)	0.8542	0.8977
Greenville, NC	0.9621	0.9739
Hamilton-Middletown, OH	0.9236	0.9470
Harrisburg-Lebanon-Carlisle, PA	0.9178	0.9430

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

Area	Wage index	GAF
Hartford, CT (MA Hospitals)	1.1234	1.0829
Hartford, CT (NY Hospitals)	1.1211	1.0814
Hattiesburg, MS	0.7810	0.8443
Hickory-Morganton-Lenoir, NC	0.8987	0.9295
Honolulu, HI	1.1176	1.0791
Houston, TX	0.9591	0.9718
Huntington-Ashland, WV-KY-OH	0.9080	0.9360
Huntsville, AL	0.8954	0.9271
Indianapolis, IN	0.9934	0.9955
Iowa City, IA	0.9460	0.9627
Jackson, MS	0.8459	0.8917
Jackson, TN	0.8602	0.9020
Jacksonville, FL	0.9426	0.9603
Johnson City-Kingsport-Bristol, TN-VA (VA Hospitals)	0.8542	0.8977
Johnson City-Kingsport-Bristol, TN-VA (KY Hospitals)	0.8371	0.8854
Jonesboro, AR (AR Hospitals)	0.7755	0.8402
Jonesboro, AR (MO Hospitals)	0.7793	0.8430
Joplin, MO	0.8621	0.9034
Kalamazoo-Battlecreek, MI	1.0554	1.0376
Kansas City, KS-MO	0.9551	0.9690
Knoxville, TN	0.8987	0.9295
Kokomo, IN	0.8963	0.9278
Lafayette, LA	0.8271	0.8781
Lakeland-Winter Haven, FL	0.8782	0.9149
Las Vegas, NV-AZ	1.1341	1.0900
Lawton, OK	0.8194	0.8725
Lexington, KY	0.8424	0.8892
Lima, OH	0.9457	0.9625
Lincoln, NE	0.9613	0.9733
Little Rock-North Little Rock, AR	0.8905	0.9237
Longview-Marshall, TX	0.8969	0.9282
Los Angeles-Long Beach, CA	1.1656	1.1106
Louisville, KY-IN	0.9056	0.9344
Lubbock, TX	0.8330	0.8824
Lynchburg, VA	0.9004	0.9307
Macon, GA	0.9011	0.9312
Madison, WI	1.0108	1.0074
Medford-Ashland, OR	1.0494	1.0336
Melbourne-Titusville-Palm Bay, FL	0.9837	0.9888
Memphis, TN-AR-MS	0.9010	0.9311
Miami, FL	0.9888	0.9923
Milwaukee-Waukesha, WI	0.9760	0.9835
Minneapolis-St. Paul, MN-WI	1.1064	1.0717
Missoula, MT	0.8943	0.9264
Mobile, AL	0.7948	0.8545
Modesto, CA	1.1183	1.0796
Monmouth-Ocean, NJ	1.1094	1.0737
Monroe, LA	0.7978	0.8567
Montgomery, AL	0.7856	0.8477
Nashville, TN	0.9582	0.9712
New Haven-Bridgeport-Stamford-Waterbury-. Danbury, CT	1.2525	1.1667
New Orleans, LA	0.9167	0.9422
New York, NY	1.3867	1.2509
Newark, NJ	1.1417	1.0950
Newburgh, NY-PA	1.1377	1.0924
Norfolk-Virginia Beach-Newport News, VA-NC	0.8659	0.9061
Oakland, CA	1.5204	1.3323
Ocala, FL	0.9646	0.9756
Odessa-Midland, TX	0.9156	0.9414
Oklahoma City, OK	0.9027	0.9323
Olympia, WA	1.1030	1.0694
Omaha, NE-IA	0.9744	0.9824
Orange County, CA	1.1235	1.0830
Orlando, FL	0.9612	0.9733
Peoria-Pekin, IL	0.8811	0.9170
Philadelphia, PA-NJ	1.0947	1.0639
Phoenix-Mesa, AZ	1.0213	1.0145
Pine Bluff, AR	0.7810	0.8443
Pittsburgh, PA	0.8788	0.9153
Pittsfield, MA	0.9861	0.9905
Pocatello, ID (ID Hospitals)	0.9103	0.9377
Pocatello, ID (WY Hospitals)	0.9137	0.9401
Portland, ME	0.9784	0.9852
Portland-Vancouver, OR-WA	1.1193	1.0802
Provo-Orem, UT	0.9912	0.9940
Raleigh-Durham-Chapel Hill, NC	0.9756	0.9832
Rapid City, SD	0.8865	0.9208
Reading, PA	0.8910	0.9240
Redding, CA	1.1357	1.0910
Reno, NV	1.0758	1.0513
Richland-Kennewick-Pasco, WA	1.0639	1.0433
Richmond-Petersburg, VA	0.9402	0.9587
Roanoke, VA	0.8759	0.9133
Rochester, MN	1.1802	1.1201
Rockford, IL	0.9500	0.9655
Sacramento, CA	1.1911	1.1272
Saginaw-Bay City-Midland, MI	0.9470	0.9634
St. Cloud, MN	0.9723	0.9809
St. Joseph, MO	0.9694	0.9789
St. Louis, MO-IL	0.9049	0.9339
Salinas, CA	1.4435	1.2858
Salt Lake City-Ogden, UT	0.9899	0.9931
San Antonio, TX	0.8876	0.9216
Santa Fe, NM	0.9543	0.9685
Santa Rosa, CA	1.2836	1.1865
Sarasota-Bradenton, FL	0.9834	0.9886
Savannah, GA	0.9556	0.9694
Seattle-Bellevue-Everett, WA	1.1557	1.1042
Sherman-Denison, TX	0.9084	0.9363
Shreveport-Bossier City, LA	0.9127	0.9394
Sioux City, IA-NE	0.8806	0.9166
Sioux Falls, SD	0.9246	0.9477
South Bend, IN	0.9780	0.9849
Spokane, WA	1.0770	1.0521
Springfield, IL	0.9004	0.9307
Springfield, MO	0.8269	0.8780
Stockton-Lodi, CA	1.1168	1.0786
Syracuse, NY	0.9381	0.9572
Tampa-St. Petersburg-Clearwater, FL	0.9111	0.9382
Texarkana,AR-Texarkana, TX	0.8018	0.8596
Toledo, OH	0.9551	0.9690
Topeka, KS	0.8791	0.9155
Tucson, AZ	0.8958	0.9274
Tulsa, OK	0.8876	0.9216
Tuscaloosa, AL	0.8134	0.8681
Tyler, TX	0.8789	0.9154
Vallejo-Fairfield-Napa, CA	1.3500	1.2282
Victoria, TX	0.8105	0.8660
Waco, TX	0.8449	0.8910
Washington, DC-MD-VA-WV	1.0707	1.0479
Waterloo-Cedar Falls, IA	0.8422	0.8890
Wausau, WI	0.9806	0.9867
West Palm Beach-Boca Raton, FL	0.9784	0.9852
Wichita, KS	0.9053	0.9341
Wichita Falls, TX	0.8407	0.8880
Wilmington-Newark, DE-MD	1.0782	1.0529
Wilmington, NC	0.9402	0.9587
York, PA	0.9154	0.9413
Youngstown-Warren, OH	0.9273	0.9496
Rural Alabama	0.7517	0.8225
Rural Florida	0.8782	0.9149
Rural Illinois	0.8282	0.8789
Rural Kentucky	0.7924	0.8527
Rural Louisiana	0.7565	0.8261
Rural Michigan	0.8807	0.9167
Rural Minnesota	0.9243	0.9475
Rural Mississippi	0.7810	0.8443
Rural Missouri	0.7793	0.8430
Rural Nebraska	0.8326	0.8821
Rural New Hampshire	0.9944	0.9962
Rural Texas	0.7673	0.8341
Rural Washington	1.0242	1.0165
Rural Wyoming	0.9020	0.9318

TABLE 4F.—PUERTO RICO WAGE INDEX AND CAPITAL GEOGRAPHIC ADJUSTMENT FACTOR (GAF)

Area	Wage index	GAF	Wage index—reclassified hospitals	GAF—reclassified hospitals
Aguadilla, PR	0.9218	0.9458		
Arecibo, PR	0.8782	0.9149		
Caguas, PR	0.8992	0.9298	0.8992	0.9298
Mayaguez, PR	1.0163	1.0111		
Ponce, PR	1.0124	1.0085		
San Juan-Bayamon, PR	1.0426	1.0290		
Rural Puerto Rico	0.8583	0.9007		

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS

Urban area (constituent counties)	Wage index
0040 Abilene, TX	0.7714
Taylor, TX	
0060 Aguadilla, PR	0.4323
Aguada, PR	
Aguadilla, PR	
Moca, PR	
0080 Akron, OH	0.9175
Portage, OH	
Summit, OH	
0120 Albany, GA	1.0809
Dougherty, GA	
Lee, GA	
0160 Albany-Schenectady-Troy, NY	0.8669
Albany, NY	
Montgomery, NY	
Rensselaer, NY	
Saratoga, NY	
Schenectady, NY	
Schoharie, NY	
0200 Albuquerque, NM	0.9405
Bernalillo, NM	
Sandoval, NM	
Valencia, NM	
0220 Alexandria, LA	0.8048
Rapides, LA	
0240 Allentown-Bethlehem-Easton, PA	0.9550
Carbon, PA	
Lehigh, PA	
Northampton, PA	
0280 Altoona, PA	0.8841
Blair, PA	
0320 Amarillo, TX	0.8944
Potter, TX	
Randall, TX	
0380 Anchorage, AK	1.2264
Anchorage, AK	
0440 Ann Arbor, MI	1.1039
Lenawee, MI	
Livingston, MI	
Washtenaw, MI	
0450 Anniston, AL	0.8118
Calhoun, AL	
0460 Appleton-Oshkosh-Neenah, WI	0.9204
Calumet, WI	
Outagamie, WI	
Winnebago, WI	
0470 Arecibo, PR	0.4119
Arecibo, PR	
Camuy, PR	
Hatillo, PR	
0480 Asheville, NC	0.9671
Buncombe, NC	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Madison, NC	
0500 Athens, GA	0.9638
Clarke, GA	
Madison, GA	
Oconee, GA	
0520 Atlanta, GA	1.0000
Barrow, GA	
Bartow, GA	
Carroll, GA	
Cherokee, GA	
Clayton, GA	
Cobb, GA	
Coweta, GA	
DeKalb, GA	
Douglas, GA	
Fayette, GA	
Forsyth, GA	
Fulton, GA	
Gwinnett, GA	
Henry, GA	
Newton, GA	
Paulding, GA	
Pickens, GA	
Rockdale, GA	
Spalding, GA	
Walton, GA	
0560 Atlantic-Cape May, NJ	1.0833
Atlantic, NJ	
Cape May, NJ	
0580 Auburn-Opelika, AL	0.8517
Lee, AL	
0600 Augusta-Aiken, GA-SC	0.9698
Columbia, GA	
McDuffie, GA	
Richmond, GA	
Aiken, SC	
Edgefield, SC	
0640 Austin-San Marcos, TX	0.9525
Bastrop, TX	
Caldwell, TX	
Hays, TX	
Travis, TX	
Williamson, TX	
0680 Bakersfield, CA	0.9956
Kern, CA	
0720 Baltimore, MD	0.9924
Anne Arundel, MD	
Baltimore, MD	
Baltimore City, MD	
Carroll, MD	
Harford, MD	
Howard, MD	
Queen Anne's, MD	
0733 Bangor, ME.	
Penobscot, ME	0.9925

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
0743 Barnstable-Yarmouth, MA	1.2859
Barnstable, MA	
0760 Baton Rouge, LA	0.8254
Ascension, LA	
East Baton Rouge, LA	
Livingston, LA	
West Baton Rouge, LA	
0840 Beaumont-Port Arthur, TX	0.8480
Hardin, TX	
Jefferson, TX	
Orange, TX	
0860 Bellingham, WA	1.1802
Whatcom, WA	
0870 Benton Harbor, MI	0.8862
Berrien, MI	
0875 Bergen-Passaic, NJ	1.1623
Bergen, NJ	
Passaic, NJ	
0880 Billings, MT	0.8865
Yellowstone, MT	
0920 Biloxi-Gulfport-Pascagoula, MS	0.9065
Hancock, MS	
Harrison, MS	
Jackson, MS	
0960 Binghamton, NY	0.8546
Broome, NY	
Tioga, NY	
1000 Birmingham, AL	0.9226
Blount, AL	
Jefferson, AL	
St. Clair, AL	
Shelby, AL	
1010 Bismarck, ND	0.7997
Burleigh, ND	
Morton, ND	
1020 Bloomington, IN	0.8944
Monroe, IN	
1040 Bloomington-Normal, IL	0.8867
McLean, IL	
1080 Boise City, ID	0.9246
Ada, ID	
Canyon, ID	
1123 Boston-Worcester-Lawrence-Lowell-Brockton, MA-NH (NH Hospitals)	1.1239
Bristol, MA	
Essex, MA	
Middlesex, MA	
Norfolk, MA	
Plymouth, MA	
Suffolk, MA	
Worcester, MA	
Hillsborough, NH	
Merrimack, NH	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Rockingham, NH	
Strafford, NH	
1125 Boulder-Longmont, CO	1.0092
Boulder, CO	
1145 Brazoria, TX	0.8170
Brazoria, TX	
1150 Bremerton, WA	1.0573
Kitsap, WA	
1240 Brownsville-Harlingen-San Benito, TX	1.0204
Cameron, TX	
1260 Bryan-College Station, TX	0.9008
Brazos, TX	
1280 Buffalo-Niagara Falls, NY	0.9574
Erie, NY	
Niagara, NY	
1303 Burlington, VT	0.9742
Chittenden, VT	
Franklin, VT	
Grand Isle, VT	
1310 Caguas, PR	0.4175
Caguas, PR	
Cayey, PR	
Cidra, PR	
Gurabo, PR	
San Lorenzo, PR	
1320 Canton-Massillon, OH	0.9103
Carroll, OH	
Stark, OH	
1350 Casper, WY	0.9187
Natrona, WY	
1360 Cedar Rapids, IA	0.8909
Linn, IA	
1400 Champaign-Urbana, IL	0.9881
Champaign, IL	
1440 Charleston-North Charleston, SC	0.9282
Berkeley, SC	
Charleston, SC	
Dorchester, SC	
1480 Charleston, WV	0.8730
Kanawha, WV	
Putnam, WV	
1520 Charlotte-Gastonia-Rock Hill, NC-SC	0.9739
Cabarrus, NC	
Gaston, NC	
Lincoln, NC	
Mecklenburg, NC	
Rowan, NC	
Stanly, NC	
Union, NC	
York, SC	
1540 Charlottesville, VA	1.0065
Albemarle, VA	
Charlottesville City, VA	
Fluvanna, VA	
Greene, VA	
1560 Chattanooga, TN-GA	0.8961
Catoosa, GA	
Dade, GA	
Walker, GA	
Hamilton, TN	
Marion, TN	
1580 Cheyenne, WY	0.9187
Laramie, WY	
1600 Chicago, IL	1.0982
Cook, IL	
DeKalb, IL	
DuPage, IL	
Grundy, IL	
Kane, IL	
Kendall, IL	
Lake, IL	
McHenry, IL	
Will, IL	
1620 Chico-Paradise, CA	1.0206
Butte, CA	
1640 Cincinnati, OH-KY-IN	0.9425
Dearborn, IN	
Ohio, IN	
Boone, KY	
Campbell, KY	
Gallatin, KY	
Grant, KY	
Kenton, KY	
Pendleton, KY	
Brown, OH	
Clermont, OH	
Hamilton, OH	
Warren, OH	
1660 Clarksville-Hopkinsville, TN-KY	0.8292
Christian, KY	
Montgomery, TN	
1680 Cleveland-Lorain-Elyria, OH	0.9691
Ashtabula, OH	
Cuyahoga, OH	
Geauga, OH	
Lake, OH	
Lorain, OH	
Medina, OH	
1720 Colorado Springs, CO	0.9063
El Paso, CO	
1740 Columbia, MO	0.8721
Boone, MO	
1760 Columbia, SC	0.8934
Lexington, SC	
Richland, SC	
1800 Columbus, GA-AL	0.8677
Russell, AL	
Chattahoochee, GA	
Harris, GA	
Muscogee, GA	
1840 Columbus, OH	0.9623
Delaware, OH	
Fairfield, OH	
Franklin, OH	
Licking, OH	
Madison, OH	
Pickaway, OH	
1880 Corpus Christi, TX	0.8542
Nueces, TX	
San Patricio, TX	
1890 Corvallis, OR	1.1562
Benton, OR	
1900 Cumberland, MD-WV (WV Hospital)	0.8202
Allegany, MD	
Mineral, WV	
1920 Dallas, TX	0.9703
Collin, TX	
Dallas, TX	
Denton, TX	
Ellis, TX	
Henderson, TX	
Hunt, TX	
Kaufman, TX	
Rockwall, TX	
1950 Danville, VA	0.9071
Danville City, VA	
Pittsylvania, VA	
1960 Davenport-Moline-Rock Island, IA-IL	0.8728
Scott, IA	
Henry, IL	
Rock Island, IL	
2000 Dayton-Springfield, OH	0.9391
Clark, OH	
Greene, OH	
Miami, OH	
Montgomery, OH	
2020 Daytona Beach, FL	0.9183
Flagler, FL	
Volusia, FL	
2030 Decatur, AL	0.8858
Lawrence, AL	
Morgan, AL	
2040 Decatur, IL	0.8321
Macon, IL	
2080 Denver, CO	1.0747
Adams, CO	
Arapahoe, CO	
Broomfield, CO	
Denver, CO	
Douglas, CO	
Jefferson, CO	
2120 Des Moines, IA	0.9024
Dallas, IA	
Polk, IA	
Warren, IA	
2160 Detroit, MI	1.0070
Lapeer, MI	
Macomb, MI	
Monroe, MI	
Oakland, MI	
St. Clair, MI	
Wayne, MI	
2180 Dothan, AL	0.7894
Dale, AL	
Houston, AL	
2190 Dover, DE	0.9844
Kent, DE	
2200 Dubuque, IA	0.8922
Dubuque, IA	
2240 Duluth-Superior, MN-WI	1.0145
St. Louis, MN	
Douglas, WI	
2281 Dutchess County, NY	1.0937
Dutchess, NY	
2290 Eau Claire, WI	0.9204
Chippewa, WI	
Eau Claire, WI	
2320 El Paso, TX	0.9242
El Paso, TX	
2330 Elkhart-Goshen, IN	0.9822
Elkhart, IN	
2335 Elmira, NY	0.8546
Chemung, NY	
2340 Enid, OK	0.8593
Garfield, OK	
2360 Erie, PA	0.8613
Erie, PA	
2400 Eugene-Springfield, OR	1.1501
Lane, OR	
2440 Evansville-Henderson, IN-KY (IN Hospitals)	0.8782
Posey, IN	
Vanderburgh, IN	
Warrick, IN	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Henderson, KY	
2520 Fargo-Moorhead, ND-MN	0.9624
Clay, MN	
Cass, ND	
2560 Fayetteville, NC	0.8933
Cumberland, NC	
2580 Fayetteville-Springdale-Rogers, AR	0.8016
Benton, AR	
Washington, AR	
2620 Flagstaff, AZ-UT	1.1378
Coconino, AZ	
Kane, UT	
2640 Flint, MI	1.0900
Genesee, MI	
2650 Florence, AL	0.7751
Colbert, AL	
Lauderdale, AL	
2655 Florence, SC	0.8739
Florence, SC	
2670 Fort Collins-Loveland, CO	1.0173
Larimer, CO	
2680 Ft. Lauderdale, FL	1.0168
Broward, FL	
2700 Fort Myers-Cape Coral, FL	0.9851
Lee, FL	
2710 Fort Pierce-Port St. Lucie, FL	1.0028
Martin, FL	
St. Lucie, FL	
2720 Fort Smith, AR-OK	0.7741
Crawford, AR	
Sebastian, AR	
Sequoyah, OK	
2750 Fort Walton Beach, FL	0.8905
Okaloosa, FL	
2760 Fort Wayne, IN	0.9649
Adams, IN	
Allen, IN	
De Kalb, IN	
Huntington, IN	
Wells, IN	
Whitley, IN	
2800 Forth Worth-Arlington, TX	0.9243
Hood, TX	
Johnson, TX	
Parker, TX	
Tarrant, TX	
2840 Fresno, CA	1.0130
Fresno, CA	
Madera, CA	
2880 Gadsden, AL	0.8254
Etowah, AL	
2900 Gainesville, FL	0.8846
Alachua, FL	
2920 Galveston-Texas City, TX	0.9335
Galveston, TX	
2960 Gary, IN	0.9437
Lake, IN	
Porter, IN	
2975 Glens Falls, NY	0.8546
Warren, NY	
Washington, NY	
2980 Goldsboro, NC	0.8656
Wayne, NC	
2985 Grand Forks, ND-MN	0.8670
Polk, MN	
Grand Forks, ND	
2995 Grand Junction, CO	0.9661
Mesa, CO	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
3000 Grand Rapids-Muskegon-Holland, MI	0.9372
Allegan, MI	
Kent, MI	
Muskegon, MI	
Ottawa, MI	
3040 Great Falls, MT	0.8843
Cascade, MT	
3060 Greeley, CO	0.9409
Weld, CO	
3080 Green Bay, WI	0.9498
Brown, WI	
3120 Greensboro-Winston-Salem-High Point, NC	0.8506
Alamance, NC	
Davidson, NC	
Davie, NC	
Forsyth, NC	
Guilford, NC	
Randolph, NC	
Stokes, NC	
Yadkin, NC	
3150 Greenville, NC	0.9595
Pitt, NC	
3160 Greenville-Spartanburg-Anderson, SC	0.9264
Anderson, SC	
Cherokee, SC	
Greenville, SC	
Pickens, SC	
Spartanburg, SC	
3180 Hagerstown, MD	0.9208
Washington, MD	
3200 Hamilton-Middletown, OH	0.9211
Butler, OH	
3240 Harrisburg-Lebanon-Carlisle, PA	0.9153
Cumberland, PA	
Dauphin, PA	
Lebanon, PA	
Perry, PA	
3283 Hartford, CT	1.2166
Hartford, CT	
Litchfield, CT	
Middlesex, CT	
Tolland, CT	
3285 Hattiesburg, MS	0.7812
Forrest, MS	
Lamar, MS	
3290 Hickory-Morganton-Lenoir, NC	0.9065
Alexander, NC	
Burke, NC	
Caldwell, NC	
Catawba, NC	
3320 Honolulu, HI	1.1142
Honolulu, HI	
3350 Houma, LA	0.7743
Lafourche, LA	
Terrebonne, LA	
3360 Houston, TX	0.9572
Chambers, TX	
Fort Bend, TX	
Harris, TX	
Liberty, TX	
Montgomery, TX	
Waller, TX	
3400 Huntington-Ashland, WV-KY-OH	0.9594
Boyd, KY	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Carter, KY	
Greenup, KY	
Lawrence, OH	
Cabell, WV	
Wayne, WV	
3440 Huntsville, AL	0.9213
Limestone, AL	
Madison, AL	
3480 Indianapolis, IN	0.9921
Boone, IN	
Hamilton, IN	
Hancock, IN	
Hendricks, IN	
Johnson, IN	
Madison, IN	
Marion, IN	
Morgan, IN	
Shelby, IN	
3500 Iowa City, IA	0.9579
Johnson, IA	
3520 Jackson, MI	0.9019
Jackson, MI	
3560 Jackson, MS	0.8388
Hinds, MS	
Madison, MS	
Rankin, MS	
3580 Jackson, TN	0.8579
Madison, TN	
Chester, TN	
3600 Jacksonville, FL	0.9342
Clay, FL	
Duval, FL	
Nassau, FL	
St. Johns, FL	
3605 Jacksonville, NC	0.8566
Onslow, NC	
3610 Jamestown, NY	0.8546
Chautauqua, NY	
3620 Janesville-Beloit, WI	0.9318
Rock, WI	
3640 Jersey City, NJ	1.1173
Hudson, NJ	
3660 Johnson City-Kingsport-Bristol, TN-VA	0.8348
Carter, TN	
Hawkins, TN	
Sullivan, TN	
Unicoi, TN	
Washington, TN	
Bristol City, VA	
Scott, VA	
Washington, VA	
3680 Johnstown, PA	0.8415
Cambria, PA	
Somerset, PA	
3700 Jonesboro, AR	0.7741
Craighead, AR	
3710 Joplin, MO	0.8715
Jasper, MO	
Newton, MO	
3720 Kalamazoo-Battlecreek, MI	1.0526
Calhoun, MI	
Kalamazoo, MI	
Van Buren, MI	
3740 Kankakee, IL	1.1044
Kankakee, IL	
3760 Kansas City, KS-MO	0.9525
Johnson, KS	
Leavenworth, KS	
Miami, KS	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Wyandotte, KS	
Cass, MO	
Clay, MO	
Clinton, MO	
Jackson, MO	
Lafayette, MO	
Platte, MO	
Ray, MO	
3800 Kenosha, WI	0.9799
Kenosha, WI	
3810 Killeen-Temple, TX	0.9197
Bell, TX	
Coryell, TX	
3840 Knoxville, TN	0.8963
Anderson, TN	
Blount, TN	
Knox, TN	
Loudon, TN	
Sevier, TN	
Union, TN	
3850 Kokomo, IN	0.9080
Howard, IN	
Tipton, IN	
3870 La Crosse, WI-MN	0.9234
Houston, MN	
La Crosse, WI	
3880 Lafayette, LA	0.8250
Acadia, LA	
Lafayette, LA	
St. Landry, LA	
St. Martin, LA	
3920 Lafayette, IN	0.9027
Clinton, IN	
Tippecanoe, IN	
3960 Lake Charles, LA	0.8453
Calcasieu, LA	
3980 Lakeland-Winter Haven, FL	0.8846
Polk, FL	
4000 Lancaster, PA	0.9300
Lancaster, PA	
4040 Lansing-East Lansing, MI	0.9245
Clinton, MI	
Eaton, MI	
Ingham, MI	
4080 Laredo, TX	0.8123
Webb, TX	
4100 Las Cruces, NM	0.8509
Dona Ana, NM	
4120 Las Vegas, NV-AZ	1.1426
Mohave, AZ	
Clark, NV	
Nye, NV	
4150 Lawrence, KS	0.8712
Douglas, KS	
4200 Lawton, OK	0.8300
Comanche, OK	
4243 Lewiston-Auburn, ME	0.9364
Androscoggin, ME	
4280 Lexington, KY	0.8599
Bourbon, KY	
Clark, KY	
Fayette, KY	
Jessamine, KY	
Madison, KY	
Scott, KY	
Woodford, KY	
4320 Lima, OH	0.9432
Allen, OH	
Auglaize, OH	
4360 Lincoln, NE	1.0074

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Lancaster, NE	
4400 Little Rock-North Little Rock, AR	0.8882
Faulkner, AR	
Lonoke, AR	
Pulaski, AR	
Saline, AR	
4420 Longview-Marshall, TX	0.9116
Gregg, TX	
Harrison, TX	
Upshur, TX	
4480 Los Angeles-Long Beach, CA	1.1607
Los Angeles, CA	
4520 Louisville, KY-IN	0.9149
Clark, IN	
Floyd, IN	
Harrison, IN	
Scott, IN	
Bullitt, KY	
Jefferson, KY	
Oldham, KY	
4600 Lubbock, TX	0.8308
Lubbock, TX	
4640 Lynchburg, VA	0.9177
Amherst, VA	
Bedford, VA	
Bedford City, VA	
Campbell, VA	
Lynchburg City, VA	
4680 Macon, GA	0.9005
Bibb, GA	
Houston, GA	
Jones, GA	
Peach, GA	
Twiggs, GA	
4720 Madison, WI	1.0208
Dane, WI	
4800 Mansfield, OH	0.9034
Crawford, OH	
Richland, OH	
4840 Mayaguez, PR	0.4767
Anasco, PR	
Cabo Rojo, PR	
Hormigueros, PR	
Mayaguez, PR	
Sabana Grande, PR	
San German, PR	
4880 McAllen-Edinburg-Mission, TX	0.9060
Hidalgo, TX	
4890 Medford-Ashland, OR	1.0815
Jackson, OR	
4900 Melbourne-Titusville-Palm Bay, FL	0.9775
Brevard, Fl	
4920 Memphis, TN-AR-MS	0.9300
Crittenden, AR	
DeSoto, MS	
Fayette, TN	
Shelby, TN	
Tipton, TN	
4940 Merced, CA	0.9956
Merced, CA	
5000 Miami, FL	0.9862
Dade, FL	
5015 Middlesex-Somerset-Hunterdon, NJ	1.1407
Hunterdon, NJ	
Middlesex, NJ	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Somerset, NJ	
5080 Milwaukee-Waukesha, WI	0.9862
Milwaukee, WI	
Ozaukee, WI	
Washington, WI	
Waukesha, WI	
5120 Minneapolis-St. Paul, MN-WI	1.1034
Anoka, MN	
Carver, MN	
Chisago, MN	
Dakota, MN	
Hennepin, MN	
Isanti, MN	
Ramsey, MN	
Scott, MN	
Sherburne, MN	
Washington, MN	
Wright, MN	
Pierce, WI	
St. Croix, WI	
5140 Missoula, MT	0.8806
Missoula, MT	
5160 Mobile, AL	0.7927
Baldwin, AL	
Mobile, AL	
5170 Modesto, CA	1.1313
Stanislaus, CA	
5190 Monmouth-Ocean, NJ	1.0934
Monmouth, NJ	
Ocean, NJ	
5200 Monroe, LA	0.7956
Ouachita, LA	
5240 Montgomery, AL	0.7835
Autauga, AL	
Elmore, AL	
Montgomery, AL	
5280 Muncie, IN	0.8782
Delaware, IN	
5330 Myrtle Beach, SC	0.8926
Horry, SC	
5345 Naples, FL	0.9840
Collier, FL	
5360 Nashville, TN	0.9809
Cheatham, TN	
Davidson, TN	
Dickson, TN	
Robertson, TN	
Rutherford TN	
Sumner, TN	
Williamson, TN	
Wilson, TN	
5380 Nassau-Suffolk, NY	1.2976
Nassau, NY	
Suffolk, NY	
5483 New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2452
Fairfield, CT	
New Haven, CT	
5523 New London-Norwich, CT	1.2166
New London, CT	
5560 New Orleans, LA	0.9148
Jefferson, LA	
Orleans, LA	
Plaquemines, LA	
St. Bernard, LA	
St. Charles, LA	
St. James, LA	
St. John The Baptist, LA	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
St. Tammany, LA	
5600 New York, NY	1.3830
Bronx, NY	
Kings, NY	
New York, NY	
Putnam, NY	
Queens, NY	
Richmond, NY	
Rockland, NY	
Westchester, NY	
5640 Newark, NJ	1.1386
Essex, NJ	
Morris, NJ	
Sussex, NJ	
Union, NJ	
Warren, NJ	
5660 Newburgh, NY-PA	1.1283
Orange, NY	
Pike, PA	
5720 Norfolk-Virginia Beach-Newport News, VA-NC	0.8636
Currituck, NC	
Chesapeake City, VA	
Gloucester, VA	
Hampton City, VA	
Isle of Wight, VA	
James City, VA	
Mathews, VA	
Newport News City, VA	
Norfolk City, VA	
Poquoson City, VA	
Portsmouth City, VA	
Suffolk City, VA	
Virginia Beach City VA	
Williamsburg City, VA	
York, VA	
5775 Oakland, CA	1.5004
Alameda, CA	
Contra Costa, CA	
5790 Ocala, FL	0.9761
Marion, FL	
5800 Odessa-Midland, TX	0.9422
Ector, TX	
Midland, TX	
5880 Oklahoma City, OK	0.9010
Canadian, OK	
Cleveland, OK	
Logan, OK	
McClain, OK	
Oklahoma, OK	
Pottawatomie, OK	
5910 Olympia, WA	1.1001
Thurston, WA	
5920 Omaha, NE-IA	0.9718
Pottawattamie, IA	
Cass, NE	
Douglas, NE	
Sarpy, NE	
Washington, NE	
5945 Orange County, CA	1.1205
Orange, CA	
5960 Orlando, FL	0.9586
Lake, FL	
Orange, FL	
Osceola, FL	
Seminole, FL	
5990 Owensboro, KY	0.8407
Daviess, KY	
6015 Panama City, FL	0.8846
Bay, FL	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
6020 Parkersburg-Marietta, WV-OH	0.8071
Washington, OH	
Wood, WV	
6080 Pensacola, FL	0.8846
Escambia, FL	
Santa Rosa, FL	
6120 Peoria-Pekin, IL	0.8769
Peoria, IL	
Tazewell, IL	
Woodford, IL	
6160 Philadelphia, PA-NJ	1.0917
Burlington, NJ	
Camden, NJ	
Gloucester, NJ	
Salem, NJ	
Bucks, PA	
Chester, PA	
Delaware, PA	
Montgomery, PA	
Philadelphia, PA	
6200 Phoenix-Mesa, AZ	1.0185
Maricopa, AZ	
Pinal, AZ	
6240 Pine Bluff, AR	0.7741
Jefferson, AR	
6280 Pittsburgh, PA	0.8764
Allegheny, PA	
Beaver, PA	
Butler, PA	
Fayette, PA	
Washington, PA	
Westmoreland, PA	
6323 Pittsfield, MA	1.0832
Berkshire, MA	
6340 Pocatello, ID	0.9078
Bannock, ID	
6360 Ponce, PR	0.4749
Guayanilla, PR	
Juana Diaz, PR	
Penuelas, PR	
Ponce, PR	
Villalba, PR	
Yauco, PR	
6403 Portland, ME	0.9958
Cumberland, ME	
Sagadahoc, ME	
York, ME	
6440 Portland-Vancouver, OR-WA	1.1162
Clackamas, OR	
Columbia, OR	
Multnomah, OR	
Washington, OR	
Yamhill, OR	
Clark, WA	
6483 Providence-Warwick-Pawtucket, RI	1.0995
Bristol, RI	
Kent, RI	
Newport, RI	
Providence, RI	
Washington, RI	
6520 Provo-Orem, UT	1.0016
Utah, UT	
6560 Pueblo, CO	0.9063
Pueblo, CO	
6580 Punta Gorda, FL	0.9493
Charlotte, FL	
6600 Racine, WI	0.9204

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Racine, WI	
6640 Raleigh-Durham-Chapel Hill, NC	1.0073
Chatham, NC	
Durham, NC	
Franklin, NC	
Johnston, NC	
Orange, NC	
Wake, NC	
6660 Rapid City, SD	0.8841
Pennington, SD	
6680 Reading, PA	0.9018
Berks, PA	
6690 Redding, CA	1.1389
Shasta, CA	
6720 Reno, NV	1.0714
Washoe, NV	
6740 Richland-Kennewick-Pasco, WA	1.0599
Benton, WA	
Franklin, WA	
6760 Richmond-Petersburg, VA	0.9377
Charles City County, VA	
Chesterfield, VA	
Colonial Heights City, VA	
Dinwiddie, VA	
Goochland, VA	
Hanover, VA	
Henrico, VA	
Hopewell City, VA	
New Kent, VA	
Petersburg City, VA	
Powhatan, VA	
Prince George, VA	
Richmond City, VA	
6780 Riverside-San Bernardino, CA	1.1293
Riverside, CA	
San Bernardino, CA	
6800 Roanoke, VA	0.8735
Botetourt, VA	
Roanoke, VA	
Roanoke City, VA	
Salem City, VA	
6820 Rochester, MN	1.1770
Olmsted, MN	
6840 Rochester, NY	0.9530
Genesee, NY	
Livingston, NY	
Monroe, NY	
Ontario, NY	
Orleans, NY	
Wayne, NY	
6880 Rockford, IL	0.9704
Boone, IL	
Ogle, IL	
Winnebago, IL	
6895 Rocky Mount, NC	0.9034
Edgecombe, NC	
Nash, NC	
6920 Sacramento, CA	1.1879
El Dorado, CA	
Placer, CA	
Sacramento, CA	
6960 Saginaw-Bay City-Midland, MI	0.9594
Bay, MI	
Midland, MI	
Saginaw, MI	
6980 St. Cloud, MN	0.9508

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Benton, MN	
Stearns, MN	
7000 St. Joseph, MO	0.9796
Andrew, MO	
Buchanan, MO	
7040 St. Louis, MO-IL	0.9025
Clinton, IL	
Jersey, IL	
Madison, IL	
Monroe, IL	
St. Clair, IL	
Franklin, MO	
Jefferson, MO	
Lincoln, MO	
St. Charles, MO	
St. Louis, MO	
St. Louis City, MO	
Warren, MO	
7080 Salem, OR	1.0524
Marion, OR	
Polk, OR	
7120 Salinas, CA	1.4396
Monterey, CA	
7160 Salt Lake City-Ogden, UT	0.9872
Davis, UT	
Salt Lake, UT	
Weber, UT	
7200 San Angelo, TX	0.8266
Tom Green, TX	
7240 San Antonio, TX	0.8852
Bexar, TX	
Comal, TX	
Guadalupe, TX	
Wilson, TX	
7320 San Diego, CA	1.1176
San Diego, CA	
7360 San Francisco, CA	1.4310
Marin, CA	
San Francisco, CA	
San Mateo, CA	
7400 San Jose, CA	1.4603
Santa Clara, CA	
7440 San Juan-Bayamon, PR	0.4890
Aguas Buenas, PR	
Barceloneta, PR	
Bayamon, PR	
Canovanas, PR	
Carolina, PR	
Catano, PR	
Ceiba, PR	
Comerio, PR	
Corozal, PR	
Dorado, PR	
Fajardo, PR	
Florida, PR	
Guaynabo, PR	
Humacao, PR	
Juncos, PR	
Los Piedras, PR	
Loiza, PR	
Luguillo, PR	
Manati, PR	
Morovis, PR	
Naguabo, PR	
Naranjito, PR	
Rio Grande, PR	
San Juan, PR	
Toa Alta, PR	
Toa Baja, PR	
Trujillo Alto, PR	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Vega Alta, PR	
Vega Baja, PR	
Yabucoa, PR	
7460 San Luis Obispo-Atascadero-Paso Robles, CA	1.1454
San Luis Obispo, CA	
7480 Santa Barbara-Santa Maria-Lompoc, CA	1.0483
Santa Barbara, CA	
7485 Santa Cruz-Watsonville, CA	1.2977
Santa Cruz, CA	
7490 Santa Fe, NM	1.0611
Los Alamos, NM	
Santa Fe, NM	
7500 Santa Rosa, CA	1.2801
Sonoma, CA	
7510 Sarasota-Bradenton, FL	0.9793
Manatee, FL	
Sarasota, FL	
7520 Savannah, GA	0.9530
Bryan, GA	
Chatham, GA	
Effingham, GA	
7560 Scranton—Wilkes-Barre—Hazleton, PA	0.8415
Columbia, PA	
Lackawanna, PA	
Luzerne, PA	
Wyoming, PA	
7600 Seattle-Bellevue-Everett, WA	1.1526
Island, WA	
King, WA	
Snohomish, WA	
7610 Sharon, PA	0.8415
Mercer, PA	
7620 Sheboygan, WI	0.9204
Sheboygan, WI	
7640 Sherman-Denison, TX	0.9482
Grayson, TX	
7680 Shreveport-Bossier City, LA	0.9119
Bossier, LA	
Caddo, LA	
Webster, LA	
7720 Sioux City, IA-NE	0.9028
Woodbury, IA	
Dakota, NE	
7760 Sioux Falls, SD	0.9345
Lincoln, SD	
Minnehaha, SD	
7800 South Bend, IN	0.9860
St. Joseph, IN	
7840 Spokane, WA	1.0940
Spokane, WA	
7880 Springfield, IL	0.8980
Menard, IL	
Sangamon, IL	
7920 Springfield, MO	0.8447
Christian, MO	
Greene, MO	
Webster, MO	
8003 Springfield, MA	1.0832
Hampden, MA	
Hampshire, MA	
8050 State College, PA	0.8775
Centre, PA	
8080 Steubenville-Weirton, OH-WV (WV Hospitals)	0.8431
Jefferson, OH	
Brooke, WV	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Hancock, WV	
8120 Stockton-Lodi, CA	1.0549
San Joaquin, CA	
8140 Sumter, SC	0.8478
Sumter, SC	
8160 Syracuse, NY	0.9457
Cayuga, NY	
Madison, NY	
Onondaga, NY	
Oswego, NY	
8200 Tacoma, WA	1.0526
Pierce, WA	
8240 Tallahassee, FL	0.8846
Gadsden, FL	
Leon, FL	
8280 Tampa-St. Petersburg-Clearwater, FL	0.9087
Hernando, FL	
Hillsborough, FL	
Pasco, FL	
Pinellas, FL	
8320 Terre Haute, IN	0.8782
Clay, IN	
Vermillion, IN	
Vigo, IN	
8360 Texarkana,AR-Texarkana, TX	0.8176
Miller, AR	
Bowie, TX	
8400 Toledo, OH	0.9525
Fulton, OH	
Lucas, OH	
Wood, OH	
8440 Topeka, KS	0.8997
Shawnee, KS	
8480 Trenton, NJ	1.0528
Mercer, NJ	
8520 Tucson, AZ	0.9017
Pima, AZ	
8560 Tulsa, OK	0.9113
Creek, OK	
Osage, OK	
Rogers, OK	
Tulsa, OK	
Wagoner, OK	
8600 Tuscaloosa, AL	0.8217
Tuscaloosa, AL	
8640 Tyler, TX	0.8766
Smith, TX	
8680 Utica-Rome, NY	0.8546
Herkimer, NY	
Oneida, NY	
8720 Vallejo-Fairfield-Napa, CA	1.3410
Napa, CA	
Solano, CA	
8735 Ventura, CA	1.0444
Ventura, CA	
8750 Victoria, TX	0.8084
Victoria, TX	
8760 Vineland-Millville-Bridgeton, NJ	1.0447
Cumberland, NJ	
8780 Visalia-Tulare-Porterville, CA	0.9956
Tulare, CA	
8800 Waco, TX	0.8427
McLennan, TX	
8840 Washington, DC-MD-VA-WV	1.0678
District of Columbia, DC	

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Calvert, MD	
Charles, MD	
Frederick, MD	
Montgomery, MD	
Prince Georges, MD	
Alexandria City, VA	
Arlington, VA	
Clarke, VA	
Culpeper, VA	
Fairfax, VA	
Fairfax City, VA	
Falls Church City, VA	
Fauquier, VA	
Fredericksburg City, VA	
King George, VA	
Loudoun, VA	
Manassas City, VA	
Manassas Park City, VA	
Prince William, VA	
Spotsylvania, VA	
Stafford, VA	
Warren, VA	
Berkeley, WV	
Jefferson, WV	
8920 Waterloo-Cedar Falls, IA	0.8431
Black Hawk, IA	
8940 Wausau, WI	0.9731
Marathon, WI	
8960 West Palm Beach-Boca Raton, FL	0.9758
Palm Beach, FL	
9000 Wheeling, WV-OH	0.8027
Belmont, OH	
Marshall, WV	
Ohio, WV	
9040 Wichita, KS	0.9275
Butler, KS	
Harvey, KS	
Sedgwick, KS	
9080 Wichita Falls, TX	0.8385
Archer, TX	
Wichita, TX	
9140 Williamsport, PA	0.8415

TABLE 4G.—PRE-RECLASSIFIED WAGE INDEX FOR URBAN AREAS—Continued

Urban area (constituent counties)	Wage index
Lycoming, PA	
9160 Wilmington-Newark, DE-MD	1.0925
New Castle, DE	
Cecil, MD	
9200 Wilmington, NC	0.9579
New Hanover, NC	
Brunswick, NC	
9260 Yakima, WA	1.0526
Yakima, WA	
9270 Yolo, CA	0.9956
Yolo, CA	
9280 York, PA	0.9098
York, PA	
9320 Youngstown-Warren, OH	0.9248
Columbiana, OH	
Mahoning, OH	
Trumbull, OH	
9340 Yuba City, CA	1.0236
Sutter, CA	
Yuba, CA	
9360 Yuma, AZ	0.9017
Yuma, AZ	

TABLE 4H.—PRE-RECLASSIFIED WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage index
Alabama	0.7470
Alaska	1.1958
Arizona	0.8906
Arkansas	0.7746
California	0.9907
Colorado	0.8897
Connecticut	1.2199
Delaware	0.9280
Florida	0.8782
Georgia	0.8365
Hawaii	0.9896
Idaho	0.8907

TABLE 4H.—PRE-RECLASSIFIED WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage index
Illinois	0.8282
Indiana	0.8770
Iowa	0.8278
Kansas	0.7860
Kentucky	0.7922
Louisiana	0.7478
Maine	0.8995
Maryland	0.9175
Massachusetts	1.1234
Michigan	0.8807
Minnesota	0.9223
Mississippi	0.7795
Missouri	0.7793
Montana	0.8530
Nebraska	0.8326
Nevada	0.9758
New Hampshire	0.9944
[1] New Jersey	.....
New Mexico	0.8314
New York	0.8530
North Carolina	0.8355
North Dakota	0.7536
Ohio	0.8756
Oklahoma	0.7577
Oregon	0.9939
Pennsylvania	0.8429
Puerto Rico	0.4037
[1] Rhode Island	.....
South Carolina	0.8489
South Dakota	0.8093
Tennessee	0.7945
Texas	0.7673
Utah	0.9034
Vermont	0.9278
Virginia	0.8542
Washington	1.0242
West Virginia	0.8008
Wisconsin	0.9130
Wyoming	0.9137

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

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOGRAPHIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
1	1	SURG	CRANIOTOMY AGE >17 W CC	3.5287	7.9	10.6
2	1	SURG	CRANIOTOMY AGE >17 W/O CC	2.0797	4.1	5.3
3	1	SURG	*CRANIOTOMY AGE 0–17	1.9545	12.7	12.7
4	1	SURG	*NO LONGER VALID	0.0000	0.0	0.0
5	1	SURG	*NO LONGER VALID	0.0000	0.0	0.0
6	1	SURG	CARPAL TUNNEL RELEASE	0.7987	2.1	3.0
7	1	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	2.6451	6.7	9.9
8	1	SURG	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	1.5337	1.9	2.8
9	1	MED	SPINAL DISORDERS & INJURIES	1.3323	4.7	6.4
10	1	MED	NERVOUS SYSTEM NEOPLASMS W CC	1.2348	4.8	6.5
11	1	MED	NERVOUS SYSTEM NEOPLASMS W/O CC	0.8498	3.0	4.1
12	1	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.9170	4.5	5.9
13	1	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.8129	4.0	5.0
14	1	MED	INTRACRANIAL HEMORRHAGE & STROKE W INFARCT	1.2589	4.7	6.1
15	1	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	0.9588	3.9	4.9

* Medicare data have been supplemented by data from 19 States for low volume DRGs.
** DRGs 469 and 470 contain cases that could not be assigned to valid DRGs.
Note 1: Geometric mean is used only to determine payment for transfer cases.
Note 2: Arithmetic mean is presented for informational purposes only.
Note 3: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOGRAPHIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
16	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	1.2518	4.8	6.4
17	1	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.6939	2.5	3.2
18	1	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.9970	4.2	5.5
19	1	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.6971	2.8	3.5
20	1	MED	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	2.7213	8.0	10.5
21	1	MED	VIRAL MENINGITIS	1.5069	5.0	6.6
22	1	MED	HYPERTENSIVE ENCEPHALOPATHY	1.0671	3.9	5.1
23	1	MED	NONTRAUMATIC STUPOR & COMA	0.8187	3.2	4.3
24	1	MED	SEIZURE & HEADACHE AGE >17 W CC	1.0021	3.7	5.0
25	1	MED	SEIZURE & HEADACHE AGE >17 W/O CC	0.6060	2.5	3.2
26	1	MED	SEIZURE & HEADACHE AGE 0–17	1.4637	2.3	4.3
27	1	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.3235	3.2	5.2
28	1	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.3285	4.4	6.1
29	1	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.7042	2.7	3.5
30	1	MED	*TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0–17	0.3306	2.0	2.0
31	1	MED	*CONCUSSION AGE >17 W CC	0.8940	3.1	4.0
32	1	MED	CONCUSSION AGE >17 W/O CC	0.5571	2.0	2.5
33	1	MED	CONCUSSION AGE 0–17	0.2076	1.6	1.6
34	1	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9863	3.7	5.0
35	1	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.6293	2.5	3.1
36	2	SURG	RETINAL PROCEDURES	0.6302	1.2	1.5
37	2	SURG	ORBITAL PROCEDURES	1.0539	2.5	3.8
38	2	SURG	PRIMARY IRIS PROCEDURES	0.4676	1.9	2.8
39	2	SURG	LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.6263	1.5	2.1
40	2	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.8867	2.6	3.8
41	2	SURG	*EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0–17	0.3365	1.6	1.6
42	2	SURG	INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.7032	1.9	2.7
43	2	MED	HYPHEMA	0.5402	2.4	3.4
44	2	MED	ACUTE MAJOR EYE INFECTIONS	0.6631	4.0	5.1
45	2	MED	NEUROLOGICAL EYE DISORDERS	0.7191	2.5	3.1
46	2	MED	OTHER DISORDERS OF THE EYE AGE >17 W CC	0.7876	3.4	4.5
47	2	MED	OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.5275	2.4	3.1
48	2	MED	*OTHER DISORDERS OF THE EYE AGE 0-17	0.2964	2.9	2.9
49	3	SURG	MAJOR HEAD & NECK PROCEDURES	1.7194	3.2	4.5
50	3	SURG	SIALOADENECTOMY	0.8279	1.5	1.9
51	3	SURG	SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	0.8429	1.9	2.8
52	3	SURG	CLEFT LIP & PALATE REPAIR	0.7986	1.5	1.8
53	3	SURG	SINUS & MASTOID PROCEDURES AGE >17	1.2474	2.2	3.6
54	3	SURG	*SINUS & MASTOID PROCEDURES AGE 0-17	0.4805	3.2	3.2
55	3	SURG	MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	0.9181	2.0	2.9
56	3	SURG	RHINOPLASTY	0.9174	1.9	2.9
57	3	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	1.0980	2.4	3.7
58	3	SURG	T&A PROC, EXCEPT TONSILLECTOMY &/OR *ADENOIDECTOMY ONLY, AGE 0–17.	0.2728	1.5	1.5
59	3	SURG	TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.9629	1.9	2.7
60	3	SURG	*TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.2077	1.5	1.5
61	3	SURG	MYRINGOTOMY W TUBE INSERTION AGE >17	1.2166	3.0	5.1
62	3	SURG	*MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.2942	1.3	1.3
63	3	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.3651	3.0	4.4
64	3	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.3020	4.3	6.5
65	3	MED	DYSEQUILIBRIUM	0.5691	2.3	2.8
66	3	MED	EPISTAXIS	0.5755	2.4	3.1
67	3	MED	EPIGLOTTITIS	0.7751	2.9	3.7
68	3	MED	OTITIS MEDIA & URI AGE >17 W CC	0.6481	3.1	3.9
69	3	MED	OTITIS MEDIA & URI AGE >17 W/O CC	0.4951	2.5	3.0
70	3	MED	OTITIS MEDIA & URI AGE 0–17	0.3243	1.9	2.3
71	3	MED	LARYNGOTRACHEITIS	0.6908	2.4	3.4
72	3	MED	NASAL TRAUMA & DEFORMITY	0.6909	2.6	3.4
73	3	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.8128	3.3	4.5
74	3	MED	*OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.3344	2.1	2.1
75	4	SURG	MAJOR CHEST PROCEDURES	3.0248	7.7	10.0
76	4	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.7935	8.4	11.1
77	4	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.2268	3.5	4.8
78	4	MED	PULMONARY EMBOLISM	1.2641	5.6	6.6
79	4	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	1.5867	6.7	8.5

* Medicare data have been supplemented by data from 19 States for low volume DRGs.
** DRGs 469 and 470 contain cases that could not be assigned to valid DRGs.
Note 1: Geometric mean is used only to determine payment for transfer cases.
Note 2: Arithmetic mean is presented for informational purposes only.
Note 3: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOGRAPHIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
80	4	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.8340	4.3	5.4
81	4	MED	*RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0–17	1.5139	6.1	6.1
82	4	MED	RESPIRATORY NEOPLASMS	1.3626	5.1	6.9
83	4	MED	MAJOR CHEST TRAUMA W CC	0.9511	4.3	5.4
84	4	MED	MAJOR CHEST TRAUMA W/O CC	0.5304	2.6	3.3
85	4	MED	PLEURAL EFFUSION W CC	1.1847	4.8	6.3
86	4	MED	PLEURAL EFFUSION W/O CC	0.6805	2.8	3.6
87	4	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.3301	4.8	6.3
88	4	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.8869	4.1	5.1
89	4	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0374	4.9	5.9
90	4	MED	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.6097	3.4	4.0
91	4	MED	SIMPLE PNEUMONIA & PLEURISY AGE 0–17	0.7390	3.1	5.1
92	4	MED	INTERSTITIAL LUNG DISEASE W CC	1.1938	5.0	6.3
93	4	MED	INTERSTITIAL LUNG DISEASE W/O CC	0.7123	3.3	4.0
94	4	MED	PNEUMOTHORAX W CC	1.1256	4.7	6.3
95	4	MED	PNEUMOTHORAX W/O CC	0.6112	3.0	3.8
96	4	MED	BRONCHITIS & ASTHMA AGE >17 W CC	0.7403	3.7	4.6
97	4	MED	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5464	2.9	3.5
98	4	MED	*BRONCHITIS & ASTHMA AGE 0–17	0.9560	3.7	3.7
99	4	MED	RESPIRATORY SIGNS & SYMPTOMS W CC	0.6974	2.4	3.2
100	4	MED	RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.5185	1.7	2.1
101	4	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8582	3.3	4.4
102	4	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.5363	2.1	2.6
103	PRE	SURG	HEART TRANSPLANT	18.5203	25.9	42.1
104	5	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH.	7.9220	12.2	14.4
105	5	SURG	CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH.	5.7134	8.2	9.9
106	5	SURG	CORONARY BYPASS W PTCA	7.2710	9.6	11.4
107	5	SURG	CORONARY BYPASS W CARDIAC CATH	5.3525	9.2	10.5
108	5	SURG	OTHER CARDIOTHORACIC PROCEDURES	5.3651	7.3	9.8
109	5	SURG	CORONARY BYPASS W/O PTCA OR CARDIAC CATH	3.9294	6.7	7.7
110	5	SURG	MAJOR CARDIOVASCULAR PROCEDURES W CC	4.0328	6.3	8.9
111	5	SURG	MAJOR CARDIOVASCULAR PROCEDURES W/O CC	2.4669	3.2	4.1
112	5	SURG	NO LONGER VALID	0.0000	0.0	0.0
113	5	SURG	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE.	2.9875	10.4	13.3
114	5	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.6337	6.4	8.7
115	5	SURG	PRM CARD PACEM IMPL W AMI/HR/SHOCK OR AICD LEAD OR GNRTR.	3.5189	5.0	7.5
116	5	SURG	OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	2.3407	3.1	4.4
117	5	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.3838	2.6	4.3
118	5	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT	1.5967	2.0	2.9
119	5	SURG	VEIN LIGATION & STRIPPING	1.3679	3.2	5.4
120	5	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	2.3033	5.6	9.0
121	5	MED	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE.	1.6033	5.3	6.6
122	5	MED	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE.	1.0202	2.9	3.7
123	5	MED	CIRCULATORY DISORDERS W AMI, EXPIRED	1.5486	2.9	4.8
124	5	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG.	1.4273	3.3	4.4
125	5	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG.	1.0885	2.2	2.8
126	5	MED	ACUTE & SUBACUTE ENDOCARDITIS	2.5295	9.3	11.8
127	5	MED	HEART FAILURE & SHOCK	1.0072	4.1	5.3
128	5	MED	DEEP VEIN THROMBOPHLEBITIS	0.7226	4.6	5.5
129	5	MED	CARDIAC ARREST, UNEXPLAINED	1.0089	1.7	2.6
130	5	MED	PERIPHERAL VASCULAR DISORDERS W CC	0.9430	4.5	5.7
131	5	MED	PERIPHERAL VASCULAR DISORDERS W/O CC	0.5634	3.4	4.1
132	5	MED	ATHEROSCLEROSIS W CC	0.6364	2.3	2.9
133	5	MED	ATHEROSCLEROSIS W/O CC	0.5502	1.8	2.3
134	5	MED	HYPERTENSION	0.5905	2.5	3.2
135	5	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.9196	3.4	4.5
136	5	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC.	0.5698	2.2	2.7

* Medicare data have been supplemented by data from 19 States for low volume DRGs.
** DRGs 469 and 470 contain cases that could not be assigned to valid DRGs.
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TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOGRAPHIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
137	5	MED	*CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.8156	3.3	3.3
138	5	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.8289	3.1	4.0
139	5	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5120	2.0	2.5
140	5	MED	ANGINA PECTORIS	0.5240	2.0	2.5
141	5	MED	SYNCOPE & COLLAPSE W CC	0.7408	2.8	3.6
142	5	MED	SYNCOPE & COLLAPSE W/O CC	0.5706	2.1	2.6
143	5	MED	CHEST PAIN	0.5435	1.7	2.1
144	5	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.2176	3.9	5.6
145	5	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.5742	2.0	2.6
146	6	SURG	RECTAL RESECTION W CC	2.7198	8.8	10.3
147	6	SURG	RECTAL RESECTION W/O CC	1.5267	5.6	6.2
148	6	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.3748	10.1	12.3
149	6	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.4487	5.8	6.3
150	6	SURG	PERITONEAL ADHESIOLYSIS W CC	2.8525	9.2	11.3
151	6	SURG	PERITONEAL ADHESIOLYSIS W/O CC	1.2952	4.4	5.6
152	6	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.8931	6.9	8.4
153	6	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.1262	4.7	5.3
154	6	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC.	3.9961	9.9	13.3
155	6	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC.	1.2946	3.0	4.1
156	6	SURG	*STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	0.8400	6.0	6.0
157	6	SURG	ANAL & STOMAL PROCEDURES W CC	1.3070	4.0	5.8
158	6	SURG	ANAL & STOMAL PROCEDURES W/O CC	0.6472	2.0	2.6
159	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC.	1.3654	3.8	5.1
160	6	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC.	0.8170	2.2	2.7
161	6	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.1598	3.0	4.3
162	6	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.6396	1.6	1.9
163	6	SURG	*HERNIA PROCEDURES AGE 0-17	0.6892	2.1	2.1
164	6	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	2.3154	7.0	8.4
165	6	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.2218	3.8	4.5
166	6	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4244	3.6	4.7
167	6	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	0.8841	2.0	2.4
168	3	SURG	MOUTH PROCEDURES W CC	1.3135	3.3	4.9
169	3	SURG	MOUTH PROCEDURES W/O CC	0.7487	1.8	2.4
170	6	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.8023	7.5	10.9
171	6	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.1816	3.3	4.3
172	6	MED	DIGESTIVE MALIGNANCY W CC	1.3576	5.2	7.0
173	6	MED	DIGESTIVE MALIGNANCY W/O CC	0.7524	2.8	3.8
174	6	MED	G.I. HEMORRHAGE W CC	0.9942	3.9	4.8
175	6	MED	G.I. HEMORRHAGE W/O CC	0.5541	2.5	2.9
176	6	MED	COMPLICATED PEPTIC ULCER	1.0918	4.1	5.2
177	6	MED	UNCOMPLICATED PEPTIC ULCER W CC	0.9182	3.7	4.6
178	6	MED	UNCOMPLICATED PEPTIC ULCER W/O CC	0.6879	2.6	3.1
179	6	MED	INFLAMMATORY BOWEL DISEASE	1.0800	4.6	6.0
180	6	MED	G.I. OBSTRUCTION W CC	0.9562	4.2	5.5
181	6	MED	G.I. OBSTRUCTION W/O CC	0.5332	2.8	3.4
182	6	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC.	0.8153	3.4	4.4
183	6	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC.	0.5710	2.3	2.9
184	6	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.4874	2.3	3.2
185	3	MED	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17.	0.8680	3.3	4.7
186	3	MED	*DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17.	0.3202	2.9	2.9
187	3	MED	DENTAL EXTRACTIONS & RESTORATIONS	0.7731	3.0	4.0
188	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.1000	4.1	5.6
189	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.5936	2.4	3.1
190	6	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0–17	0.8080	3.7	5.2
191	7	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	4.2734	9.8	13.9
192	7	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.7906	4.7	6.2
193	7	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC.	3.4000	10.4	12.8

* Medicare data have been supplemented by data from 19 States for low volume DRGs.
** DRGs 469 and 470 contain cases that could not be assigned to valid DRGs.
Note 1: Geometric mean is used only to determine payment for transfer cases.
Note 2: Arithmetic mean is presented for informational purposes only.
Note 3: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOGRAPHIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
194	7	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	1.5934	5.7	6.8
195	7	SURG	CHOLECYSTECTOMY W C.D.E. W CC	3.0458	8.7	10.6
196	7	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC	1.6025	4.8	5.6
197	7	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC.	2.5296	7.5	9.2
198	7	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC.	1.1732	3.8	4.4
199	7	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	2.3704	6.9	9.8
200	7	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY.	3.0260	6.7	10.6
201	7	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	3.6753	10.2	14.2
202	7	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS	1.3013	4.8	6.4
203	7	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	1.3407	5.0	6.7
204	7	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.1582	4.4	5.8
205	7	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	1.1970	4.6	6.2
206	7	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	0.7045	2.9	3.8
207	7	MED	DISORDERS OF THE BILIARY TRACT W CC	1.1443	4.0	5.3
208	7	MED	DISORDERS OF THE BILIARY TRACT W/O CC	0.6540	2.3	2.9
209	8	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.	2.0199	4.4	4.9
210	8	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC.	1.8335	6.1	7.0
211	8	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC.	1.2446	4.5	4.9
212	8	SURG	*HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	0.8436	11.1	11.1
213	8	SURG	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.8736	6.7	9.2
214	8	SURG	NO LONGER VALID	0.0000	0.0	0.0
215	8	SURG	NO LONGER VALID	0.0000	0.0	0.0
216	8	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	2.0981	5.0	8.0
217	8	SURG	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS.	2.9860	9.1	13.5
218	8	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC.	1.5612	4.3	5.5
219	8	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC.	1.0187	2.7	3.2
220	8	SURG	*LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17.	0.5819	5.3	5.3
221	8	SURG	NO LONGER VALID	0.0000	0.0	0.0
222	8	SURG	NO LONGER VALID	0.0000	0.0	0.0
223	8	SURG	MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	1.0493	2.2	3.0
224	8	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC.	0.7841	1.6	1.9
225	8	SURG	FOOT PROCEDURES	1.1638	3.6	5.3
226	8	SURG	SOFT TISSUE PROCEDURES W CC	1.5413	4.5	6.5
227	8	SURG	SOFT TISSUE PROCEDURES W/O CC	0.8139	2.1	2.6
228	8	SURG	MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC.	1.1547	2.7	4.2
229	8	SURG	HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.6975	1.8	2.3
230	8	SURG	LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR.	1.3026	3.6	5.6
231	8	SURG	*NO LONGER VALID	0.0000	0.0	0.0
232	8	SURG	ARTHROSCOPY	0.9638	1.8	2.7
233	8	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.9896	5.0	7.4
234	8	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	1.1937	2.2	3.1
235	8	MED	FRACTURES OF FEMUR	0.7516	3.8	5.0
236	8	MED	FRACTURES OF HIP & PELVIS	0.7299	3.9	4.8
237	8	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.5948	2.9	3.7
238	8	MED	OSTEOMYELITIS	1.3446	6.5	8.7
239	8	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	1.0524	5.1	6.4
240	8	MED	CONNECTIVE TISSUE DISORDERS W CC	1.3065	4.9	6.7
241	8	MED	CONNECTIVE TISSUE DISORDERS W/O CC	0.6297	3.0	3.8

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TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOGRAPHIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
242	8	MED	SEPTIC ARTHRITIS	1.1573	5.3	7.0
243	8	MED	MEDICAL BACK PROBLEMS	0.7535	3.7	4.7
244	8	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.7092	3.7	4.7
245	8	MED	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.4741	2.6	3.3
246	8	MED	NON-SPECIFIC ARTHROPATHIES	0.5937	2.9	3.7
247	8	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE.	0.5672	2.6	3.3
248	8	MED	TENDONITIS, MYOSITIS & BURSITIS	0.8503	3.8	4.9
249	8	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE.	0.6710	2.5	3.6
250	8	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC.	0.7034	3.2	4.1
251	8	MED	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC.	0.4539	2.3	2.8
252	8	MED	*FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.2526	1.8	1.8
253	8	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC.	0.7512	3.7	4.7
254	8	MED	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC.	0.4417	2.6	3.2
255	8	MED	*FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	0.2943	2.9	2.9
256	8	MED	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES.	0.8116	3.8	5.1
257	9	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.8851	2.1	2.6
258	9	SURG	TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.6978	1.6	1.8
259	9	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9337	1.8	2.7
260	9	SURG	SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.6794	1.2	1.4
261	9	SURG	BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	0.8947	1.6	2.1
262	9	SURG	BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.9466	2.9	4.3
263	9	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	2.1904	9.0	12.2
264	9	SURG	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC.	1.0940	5.2	6.8
265	9	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC.	1.5921	4.2	6.6
266	9	SURG	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	0.8719	2.3	3.2
267	9	SURG	PERIANAL & PILONIDAL PROCEDURES	0.9515	2.9	4.5
268	9	SURG	SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.1516	2.5	3.9
269	9	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.7647	6.0	8.6
270	9	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.8085	2.5	3.6
271	9	MED	SKIN ULCERS	1.0219	5.6	7.2
272	9	MED	MAJOR SKIN DISORDERS W CC	1.0084	4.6	6.0
273	9	MED	MAJOR SKIN DISORDERS W/O CC	0.6167	3.0	3.9
274	9	MED	MALIGNANT BREAST DISORDERS W CC	1.1449	4.7	6.5
275	9	MED	MALIGNANT BREAST DISORDERS W/O CC	0.5738	2.4	3.5
276	9	MED	NON-MALIGANT BREAST DISORDERS	0.6410	3.5	4.5
277	9	MED	CELLULITIS AGE >17 W CC	0.8738	4.7	5.8
278	9	MED	CELLULITIS AGE >17 W/O CC	0.5391	3.5	4.2
279	9	MED	CELLULITIS AGE 0-17	0.7687	4.0	5.3
280	9	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.7035	3.2	4.1
281	9	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.4810	2.3	2.9
282	9	MED	*TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.2558	2.2	2.2
283	9	MED	MINOR SKIN DISORDERS W CC	0.7271	3.5	4.7
284	9	MED	MINOR SKIN DISORDERS W/O CC	0.4172	2.3	2.9
285	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS.	2.0611	7.9	10.6
286	10	SURG	ADRENAL & PITUITARY PROCEDURES	2.0223	4.4	5.9
287	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.8651	7.7	10.3
288	10	SURG	O.R. PROCEDURES FOR OBESITY	2.1578	3.9	5.0
289	10	SURG	PARATHYROID PROCEDURES	0.9427	1.8	2.7
290	10	SURG	THYROID PROCEDURES	0.8874	1.7	2.2
291	10	SURG	THYROGLOSSAL PROCEDURES	0.6425	1.4	1.6
292	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.7077	7.2	10.5
293	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	1.3678	3.2	4.7
294	10	MED	DIABETES AGE >35	0.7632	3.4	4.5

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Note 3: Relative weights are based on Medicare patient data and may not be appropriate for other patients.

TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOGRAPHIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
295	10	MED	DIABETES AGE 0–35	0.7959	3.0	4.0
296	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.8572	4.0	5.1
297	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.5041	2.7	3.3
298	10	MED	NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0–17	0.4610	2.4	3.2
299	10	MED	INBORN ERRORS OF METABOLISM	0.9381	3.7	5.5
300	10	MED	ENDOCRINE DISORDERS W CC	1.0938	4.8	6.2
301	10	MED	ENDOCRINE DISORDERS W/O CC	0.6113	2.8	3.6
302	11	SURG	KIDNEY TRANSPLANT	3.2328	7.2	8.5
303	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM.	2.3540	6.4	8.1
304	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC.	2.3813	6.2	8.9
305	11	SURG	KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC.	1.1767	2.8	3.6
306	11	SURG	PROSTATECTOMY W CC	1.2134	3.5	5.4
307	11	SURG	PROSTATECTOMY W/O CC	0.6094	1.7	2.1
308	11	SURG	MINOR BLADDER PROCEDURES W CC	1.5867	4.0	6.2
309	11	SURG	MINOR BLADDER PROCEDURES W/O CC	0.8931	1.7	2.1
310	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.1402	2.9	4.4
311	11	SURG	TRANSURETHRAL PROCEDURES W/O CC	0.6203	1.5	1.8
312	11	SURG	URETHRAL PROCEDURES, AGE >17 W CC	1.0784	3.0	4.6
313	11	SURG	URETHRAL PROCEDURES, AGE >17 W/O CC	0.6747	1.7	2.3
314	11	SURG	*URETHRAL PROCEDURES, AGE 0–17	0.4931	2.3	2.3
315	11	SURG	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	2.0680	3.8	7.0
316	11	MED	RENAL FAILURE	1.2907	4.9	6.6
317	11	MED	ADMIT FOR RENAL DIALYSIS	0.8488	2.4	3.6
318	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.1797	4.5	6.1
319	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.6754	2.2	2.9
320	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.8785	4.3	5.4
321	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.5640	3.1	3.7
322	11	MED	KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.4571	2.7	3.2
323	11	MED	URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.8026	2.4	3.2
324	11	MED	URINARY STONES W/O CC	0.4752	1.6	1.9
325	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.6497	2.9	3.8
326	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.4181	2.1	2.6
327	11	MED	*KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.3688	3.1	3.1
328	11	MED	URETHRAL STRICTURE AGE >17 W CC	0.7474	2.7	3.7
329	11	MED	URETHRAL STRICTURE AGE >17 W/O CC	0.5254	1.7	2.1
330	11	MED	*URETHRAL STRICTURE AGE 0-17	0.3177	1.6	1.6
331	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	1.0546	4.2	5.6
332	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.5949	2.4	3.2
333	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.9552	3.7	5.8
334	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC	1.4738	3.9	4.6
335	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC	1.0778	2.8	3.0
336	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC	0.8539	2.6	3.4
337	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC	0.5832	1.8	2.0
338	12	SURG	TESTES PROCEDURES, FOR MALIGNANCY	1.2100	3.5	5.5
339	12	SURG	TESTES PROCEDURES, NON-MALIGNANCY AGE >17	1.1314	2.9	4.8
340	12	SURG	*TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.2823	2.4	2.4
341	12	SURG	PENIS PROCEDURES	1.2651	2.0	3.2
342	12	SURG	CIRCUMCISION AGE >17	0.7717	2.4	3.2
343	12	SURG	*CIRCUMCISION AGE 0–17	0.1534	1.7	1.7
344	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	1.3244	1.6	2.5
345	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	1.1523	3.0	4.9
346	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	1.0133	4.5	5.9
347	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.5436	2.2	3.0
348	12	MED	BENIGN PROSTATIC HYPERTROPHY W CC	0.7423	3.3	4.4
349	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O CC	0.4562	2.0	2.5
350	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.7298	3.6	4.5
351	12	MED	*STERILIZATION, MALE	0.2354	1.3	1.3
352	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.7076	2.9	4.0
353	13	SURG	PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	1.8469	5.0	6.6

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TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOGRAPHIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
354	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC.	1.4796	4.7	5.7
355	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC.	0.8855	3.0	3.2
356	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES.	0.7516	1.8	2.1
357	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY.	2.2673	6.7	8.4
358	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.1754	3.4	4.2
359	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	0.8055	2.3	2.6
360	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES	0.8613	2.2	2.8
361	13	SURG	LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	1.0865	2.2	3.2
362	13	SURG	*ENDOSCOPIC TUBAL INTERRUPTION	0.3009	1.4	1.4
363	13	SURG	D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.9275	2.6	3.6
364	13	SURG	D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.8939	2.9	4.1
365	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	2.1194	5.3	8.2
366	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.2567	4.8	6.7
367	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.5496	2.2	3.0
368	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	1.1619	5.2	6.7
369	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS.	0.5997	2.4	3.3
370	14	SURG	CESAREAN SECTION W CC	0.9992	4.2	5.7
371	14	SURG	CESAREAN SECTION W/O CC	0.6267	3.2	3.5
372	14	MED	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.5457	2.7	3.5
373	14	MED	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.3831	2.0	2.3
374	14	SURG	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.7410	2.5	3.0
375	14	SURG	*VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.5745	4.4	4.4
376	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE.	0.5499	2.6	3.4
377	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE.	1.0123	3.2	4.1
378	14	MED	ECTOPIC PREGNANCY	0.7893	2.0	2.6
379	14	MED	THREATENED ABORTION	0.3647	2.0	3.0
380	14	MED	ABORTION W/O D&C	0.4261	1.6	2.0
381	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.5247	1.5	1.9
382	14	MED	FALSE LABOR	0.2113	1.3	1.7
383	14	MED	OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.5103	2.7	3.8
384	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS.	0.3463	1.9	2.6
385	15	MED	*NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY.	1.3709	1.8	1.8
386	15	MED	*EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE.	4.5207	17.9	17.9
387	15	MED	*PREMATURITY W MAJOR PROBLEMS	3.0876	13.3 1	3.3
388	15	MED	*PREMATURITY W/O MAJOR PROBLEMS	1.8630	8.6	8.6
389	15	MED	FULL TERM NEONATE W MAJOR PROBLEMS	1.2020	5.2	6.3
390	15	MED	*NEONATE W OTHER SIGNIFICANT PROBLEMS	1.1225	3.4	3.4
391	15	MED	*NORMAL NEWBORN	0.1520	3.1	3.1
392	16	SURG	SPLENECTOMY AGE >17	3.2999	7.1	9.7
393	16	SURG	*SPLENECTOMY AGE 0-17	1.3429	9.1	9.1
394	16	SURG	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	1.9216	4.7	7.6
395	16	MED	RED BLOOD CELL DISORDERS AGE >17	0.8159	3.2	4.3
396	16	MED	RED BLOOD CELL DISORDERS AGE 0-17	0.7409	3.0	4.4
397	16	MED	COAGULATION DISORDERS	1.2575	3.7	5.2
398	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	1.2266	4.5	5.9
399	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.6630	2.8	3.5
400	17	SURG	*NO LONGER VALID	0.0000	0.0	0.0
401	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	2.8817	8.1	11.6
402	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC.	1.1371	2.7	4.0
403	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.8018	5.8	8.1
404	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.8609	3.0	4.1
405	17	MED	*ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	1.9038	4.9	4.9
406	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC.	2.6845	6.9	9.7

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TABLE 5.—LIST OF DIAGNOSIS-RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, AND GEOGRAPHIC AND ARITHMETIC MEAN LENGTH OF STAY (LOS)—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
407	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC.	1.2347	3.2	4.1
408	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC.	2.1935	4.8	8.3
409	17	MED	RADIOTHERAPY	1.2333	4.6	6.2
410	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	1.0780	3.2	4.1
411	17	MED	*HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.3906	4.7	4.7
412	17	MED	HISTORY OF MALIGNANCY W ENDOSCOPY	0.5721	2.5	3.7
413	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.3143	5.3	7.1
414	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.7332	3.2	4.2
415	18	SURG	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	3.5998	10.4	14.4
416	18	MED	SEPTICEMIA AGE >17	1.5763	5.6	7.5
417	18	MED	SEPTICEMIA AGE 0-17	0.9864	4.4	5.8
418	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	1.0605	4.9	6.3
419	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.8404	3.6	4.6
420	18	MED	FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.6052	2.8	3.4
421	18	MED	VIRAL ILLNESS AGE >17	0.7395	3.1	4.1
422	18	MED	VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0–17	0.7271	2.5	3.7
423	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	1.8074	5.9	8.4
424	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	2.3708	8.0	12.9
425	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION.	0.6723	2.8	3.8
426	19	MED	DEPRESSIVE NEUROSES	0.5051	3.2	4.5
427	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.5029	3.1	4.4
428	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.7222	4.5	7.1
429	19	MED	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.8235	4.5	6.1
430	19	MED	PSYCHOSES	0.6750	5.6	7.9
431	19	MED	CHILDHOOD MENTAL DISORDERS	0.6551	4.4	6.9
432	19	MED	OTHER MENTAL DISORDER DIAGNOSES	0.6453	2.8	4.0
433	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.2876	2.2	3.1
434	20	MED	NO LONGER VALID	0.0000	0.0	0.0
435	20	MED	NO LONGER VALID	0.0000	0.0	0.0
436	20	MED	NO LONGER VALID	0.0000	0.0	0.0
437	20	MED	NO LONGER VALID	0.0000	0.0	0.0
438	20		NO LONGER VALID	0.0000	0.0	0.0
439	21	SURG	SKIN GRAFTS FOR INJURIES	1.7409	5.1	8.1
440	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES	1.8767	5.8	9.1
441	21	SURG	HAND PROCEDURES FOR INJURIES	0.9595	2.1	3.1
442	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.4020	5.6	8.6
443	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	0.9737	2.5	3.4
444	21	MED	TRAUMATIC INJURY AGE >17 W CC	0.7414	3.2	4.2
445	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	0.4945	2.3	2.9
446	21	MED	*TRAUMATIC INJURY AGE 0–17	0.2951	2.4	2.4
447	21	MED	ALLERGIC REACTIONS AGE >17	0.5156	1.9	2.5
448	21	MED	*ALLERGIC REACTIONS AGE 0–17	0.0971	2.9	2.9
449	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.8275	2.6	3.7
450	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.4224	1.6	2.0
451	21	MED	*POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.2621	2.1	2.1
452	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0373	3.5	4.9
453	21	MED	COMPLICATIONS OF TREATMENT W/O CC	0.5086	2.1	2.8
454	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.8121	3.0	4.2
455	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.4690	1.8	2.4
456	22		NO LONGER VALID	0.0000	0.0	0.0
457	22	MED	NO LONGER VALID	0.0000	0.0	0.0
458	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
459	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
460	22	MED	NO LONGER VALID	0.0000	0.0	0.0
461	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	1.1855	2.1	3.6
462	23	MED	REHABILITATION	1.0073	9.4	11.3
463	23	MED	SIGNS & SYMPTOMS W CC	0.6795	3.1	4.1
464	23	MED	SIGNS & SYMPTOMS W/O CC	0.4940	2.4	3.0
465	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	0.9078	2.0	4.0

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DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
466	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	0.7967	2.2	3.9
467	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.4916	1.9	3.0
468			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.7934	9.4	13.1
469			PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE **DIAGNOSIS	0.0000	0.0	0.0
470			**UNGROUPABLE	0.0000	0.0	0.0
471	8	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.	3.0380	4.7	5.4
472	22	SURG	NO LONGER VALID	0.0000	0.0	0.0
473	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.4644	7.4	12.7
474	4	SURG	NO LONGER VALID	0.0000	0.0	0.0
475	4	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	3.5767	8.0	11.3
476		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2299	8.0	11.1
477		SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.8593	5.4	8.2
478	5	SURG	OTHER VASCULAR PROCEDURES W CC	2.3639	4.9	7.4
479	5	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4223	2.4	3.2
480	PRE	SURG	LIVER TRANSPLANT	9.6510	14.0	21.1
481	PRE	SURG	BONE MARROW TRANSPLANT	5.9571	19.1	21.7
482	PRE	SURG	TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	3.4598	9.6	12.5
483	PRE	SURG	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE,MOUTH & NECK DX OSES.	16.5997	34.1	41.3
484	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.3969	9.9	14.7
485	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA.	3.1535	7.9	9.9
486	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	4.8552	8.8	12.9
487	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.9609	5.3	7.3
488	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.7597	11.7	17.0
489	25	MED	HIV W MAJOR RELATED CONDITION	1.8340	6.0	8.6
490	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.0397	3.9	5.5
491	8	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.7059	2.8	3.4
492	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HIGH DOSE CHEMOAGENT.	3.8083	9.3	14.9
493	7	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8169	4.4	6.0
494	7	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	0.9950	2.0	2.5
495	PRE	SURG	LUNG TRANSPLANT	8.3919	13.5	16.4
496	8	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	5.6730	6.8	8.9
497	8	SURG	SPINAL FUSION EXCEPT CERVICAL W CC	3.3896	5.2	6.3
498	8	SURG	SPINAL FUSION EXCEPT CERVICAL W/O CC	2.5213	3.6	4.0
499	8	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.4186	3.3	4.5
500	8	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	0.9344	2.0	2.4
501	8	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.6174	8.3	10.7
502	8	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.4062	5.2	6.2
503	8	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2152	3.0	3.9
504	22	SURG	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	11.8123	20.1	27.7
505	22	MED	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT	2.0106	2.3	5.7
506	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	4.0998	12.1	16.9
507	22	SURG	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	1.8145	6.5	9.1
508	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	1.3754	5.7	8.0
509	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	0.6404	3.0	4.3
510	22	MED	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.1762	4.6	6.8
511	22	MED	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.6654	3.1	4.6
512	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.3384	11.1	13.1
513	PRE	SURG	PANCREAS TRANSPLANT	6.0851	8.5	9.8
514	5	SURG	NO LONGER VALID	0.0000	0.0	0.0
515	5	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	5.3127	3.0	5.2
516	5	SURG	PERCUTANEOUS CARDIOVASC PROC W AMI	2.6723	3.7	4.7
517	5	SURG	PERC CARDIO PROC W NON-DRUG ELUTING STENT W/O AMI	2.1245	1.8	2.6
518	5	SURG	PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	1.8210	2.2	3.3

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DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
519	8	SURG	CERVICAL SPINAL FUSION W CC	2.4228	3.2	5.1
520	8	SURG	CERVICAL SPINAL FUSION W/O CC	1.5749	1.7	2.1
521	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.7054	4.3	5.8
522	20	MED	ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC.	0.5151	7.7	9.6
523	20	MED	ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC.	0.3929	3.3	4.1
524	1	MED	TRANSIENT ISCHEMIA	0.7252	2.7	3.4
525	5	SURG	HEART ASSIST SYSTEM IMPLANT	11.4482	9.0	17.6
526	5	SURG	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W AMI.	2.9729	3.6	4.5
527	5	SURG	PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W/O AMI.	2.4342	1.8	2.6
528	1	SURG	INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	7.0434	14.1	17.2
529	1	SURG	VENTRICULAR SHUNT PROCEDURES W CC	3.1094	6.6	10.6
530	1	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC	1.2664	2.9	3.9
531	1	SURG	SPINAL PROCEDURES W CC	3.0474	6.8	10.0
532	1	SURG	SPINAL PROCEDURES W/O CC	1.4487	2.9	4.0
533	1	SURG	EXTRACRANIAL PROCEDURES W CC	1.6578	2.7	4.1
534	1	SURG	EXTRACRANIAL PROCEDURES W/O CC	1.0689	1.6	2.0
535	5	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	8.1344	8.1	11.0
536	5	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	6.2536	3.9	5.8
537	8	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W CC.	1.8090	4.7	7.0
538	8	SURG	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC.	0.9874	2.1	2.9
539	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC	3.3744	7.5	11.2
540	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC	1.2851	2.9	4.1

*Medicare data have been supplemented by data from 19 States for low volume DRGs.
**DRGs 469 and 470 contain cases that could not be assigned to valid DRGs.

TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
255.10	Primary aldosteronism	N	10	300, 301
255.11	Glucocorticoid-remediable aldosteronism	N	10	300, 301
255.12	Conn's syndrome	N	10	300, 301
255.13	Bartter's syndrome	N	10	300, 301
255.14	Other secondary aldosteronism	N	10	300, 301
277.81	Primary carnitine deficiency	N	10	299
277.82	Carnitine deficiency due to inborn errors of metabolism	N	10	299
277.83	Iatrogenic carnitine deficiency	N	10	299
277.84	Other secondary carnitine deficiency	N	10	299
277.89	Other specified disorders of metabolism	N	10	299
282.41	Sickle-cell thalassemia without crisis	Y	15	[1] 387, [1] 389
			16	395, 396
282.42	Sickle-cell thalassemia with crisis	Y	15	[1] 387, [1] 389
			16	395, 396
282.49	Other thalassemia	Y	15	[1] 387, [1] 389
			16	395, 396
282.64	Sickle-cell/Hb-C disease with crisis	Y	16	395, 396
282.68	Other sickle-cell disease without crisis	Y	16	395, 396
289.52	Splenic sequestration	N	16	398, 399
289.81	Primary hypercoagulable state	Y	16	398, 399
289.82	Secondary hypercoagulable state	Y	16	398, 399
289.89	Other specified diseases of blood and blood-forming organs	N	16	398, 399
331.11	Pick's disease	N	1	12
331.19	Other frontotemporal dementia	N	1	12
331.82	Dementia with Lewy bodies	N	1	12
348.30	Encephalopathy, unspecified	N	1	16, 17
			25	[2] 489
348.31	Metabolic encephalopathy	N	1	16, 17
			25	[2] 489
348.39	Other encephalopathy	N	1	16, 17
			25	[2] 489

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
358.00	Myasthenia gravis without (acute) exacerbation	Y	1	12
358.01	Myasthenia gravis with (acute) exacerbation	Y	1	12
414.07	Coronary atherosclerosis, Of bypass graft (artery) (vein) of transplanted heart	N	5	132,133
458.21	Hypotension of hemodialysis	N	5	141, 142
458.29	Other iatrogenic hypotension	N	5	141,142
493.81	Exercise induced bronchospasm	N	4	96, 97, 98
493.82	Cough variant asthma	N	4	96, 97, 98
517.3	Acute chest syndrome	N	4	92, 93
530.20	Ulcer of esophagus without bleeding	N	6	176
530.21	Ulcer of esophagus with bleeding	Y	6	176
530.85	Barrett's esophagus	N	6	176
600.00	Hypertrophy (benign) of prostate without urinary obstruction	N	12	348, 349
600.01	Hypertrophy (benign) of prostate with urinary obstruction	N	12	348, 349
600.10	Nodular prostate without urinary obstruction	N	12	348, 349
600.11	Nodular prostate with urinary obstruction	N	12	348, 349
600.20	Benign localized hyperplasia of prostate without urinary obstruction	N	12	348, 349
600.21	Benign localized hyperplasia of prostate with urinary obstruction	N	12	348, 349
600.90	Hyperplasia of prostate, unspecified, without urinary obstruction	N	12	348, 349
600.91	Hyperplasia of prostate, unspecified, with urinary obstruction	N	12	348, 349
607.85	Peyronie's disease	N	12	352
674.50	Peripartum cardiomyopathy, unspecified as to episode of care or not applicable	Y	14	469
674.51	Peripartum cardiomyopathy, delivered, with or without mention of antepartum condition.	Y	14	370, 371, 372, 374, 375
674.52	Peripartum cardiomyopathy, delivered, with mention of postpartum condition	Y	14	370, 371, 372, 374, 375
674.53	Peripartum cardiomyopathy, antepartum condition or complication	Y	14	383, 384
674.54	Peripartum cardiomyopathy, postpartum condition or complication	Y	14	376, 377
719.7	Difficulty in walking	N	8	247
728.87	Muscle weakness	N	8	247
728.88	Rhabdomyolysis	Y	8	248
752.81	Scrotal transposition	N	12	352
752.89	Other specified anomalies of genital organs	N	12	352
766.21	Post-term infant	N	15	391
766.22	Prolonged gestation of infant	N	15	391
767.11	Epicranial subaponeurotic hemorrhage (massive)	Y	15	389
767.19	Other injuries to scalp	N	15	391
779.83	Delayed separation of umbilical cord	N	15	391
780.93	Memory loss	N	23	463, 464
780.94	Early satiety	N	23	463, 464
781.94	Facial weakness	N	1	34, 35
785.52	Septic shock	Y	18	416, 417
788.63	Urgency of urination	N	11	325, 326, 327
790.21	Impaired fasting glucose	N	10	296, 297, 298
790.22	Impaired glucose tolerance test (oral)	N	10	296, 297, 298
790.29	Other abnormal glucose	N	10	296, 297, 298
799.81	Decreased libido	N	23	467
799.89	Other ill-defined conditions	N	23	467
850.11	Concussion, with loss of consciousness of 30 minutes or less	Y	1 24	31, 32, 33 487
850.12	Concussion, with loss of consciousness from 31 to 59 minutes	Y	1 24	31, 32, 33 487
959.11	Other injury of chest wall	N	21 24	444, 445, 446 487
959.12	Other injury of abdomen	N	21 24	444, 445, 446 487
959.13	Fracture of corpus cavernosum penis	N	21 24	444, 445, 446 487
959.14	Other injury of external genitals	N	21 24	444, 445, 446 487
959.19	Other injury of other sites of trunk	N	21 24	444, 445, 446 487
996.57	Complication, Due to insulin pump	Y	21	452, 453
V04.81	Need for prophylactic vaccination and inoculation, Influenza	N	23	467
V04.82	Need for prophylactic vaccination and inoculation, Respiratory synctial virus (RSV).	N	23	467
V04.89	Need for prophylactic vaccination and inoculation, Other viral diseases	N	23	467
V15.87	History of Extracorporeal Membrance Oxygenation (ECMO)	N	23	467
V25.03	Encounter for emergency contraceptive counseling and prescription	N	23	467
V43.21	Organ or tissue replaced by other means, Heart assist device	Y	5	144, 145
V43.22	Organ or tissue replaced by other means, Fully implantable artificial heart	Y	5	144, 145
V45.85	Insulin pump status	N	23	467

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
V53.90	Fitting and adjustment, Unspecified device	N	23	467
V53.91	Fitting and adjustment of insulin pump	N	23	467
V53.99	Fitting and adjustment, Other device	N	23	467
V54.01	Encounter for removal of internal fixation device	N	8	249
V54.02	Encounter for lengthening/adjustment of growth rod	N	8	249
V54.09	Other aftercare involving internal fixation device	N	8	249
V58.63	Long-term (current) use of antiplatelet/antithrombotic	N	23	465, 466
V58.64	Long-term (current) use of nonsteriodal anti-inflammatories	N	23	465, 466
V58.65	Long-term (current) use of steroids	N	23	465, 466
V64.41	Laparoscopic surgical procedure coverted to open procedure	N	23	467
V64.42	Thoracoscopic surgical procedure converted to open procedure	N	23	467
V64.43	Arthroscopic surgical procedure converted to open procedure	N	23	467
V65.11	Pediatric pre-birth visit for expectant mother	N	23	467
V65.19	Other person consulting on behalf of another person	N	23	467
V65.46	Encounter for insulin pump training	N	23	467

[1] Classified as a Major Problem.
[2] Classified as a Major Related Condition.

TABLE 6B.—NEW PROCEDURE CODES

Procedure Code	Description	OR	MDC	DRG
00.15	High-dose infusion interleukin-2 (IL-2)	N*	17	492
37.51	Heart transplantation	Y	PRE	103
37.52	Implantation of total replacement heart system	Y	5	525
37.53	Replacement or repair of thoracic unit of total replacement heart system	Y	5	525
37.54	Replacement or repair of other implantable component of total replacement heart system.	Y	5	525
68.31	Laparoscopic supracervical hysterectomy (LSH)	Y	13	354, 355,357, 358, 359
			14	375
68.39	Other subtotal abdominal hysterectomy, NOS	Y	13	354, 355, 357, 358, 359
			14	375
81.62	Fusion or refusion of 2–3 vertebrae	[1] N		
81.63	Fusion or refusion of 4–8 vertebrae	[1] N		
81.64	Fusion or refusion of 9 or more vertebrae	[1] N		

*Nonoperating room procedure, but affects DRG.
[1] Nonoperating room procedure code. The DRG assignment is made based on the specific fusion or refusion (81.00–81.08, 81.30–81.39, 81.61).

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
255.1	Hyperaldosteronism	N	10	300, 301
277.8	Other specified disorders of metabolism	N	10	299
282.4	Thalassemias	Y	15	[1]1381, [1]389
			16	395, 396
289.8	Other specified diseases of blood and blood-forming organs	N	16	398, 399
331.1	Pick's disease	N	1	12
348.3	Encephalopathy, unspecified	N	1	16, 17
			25	[2]489
358.0	Myasthenia gravis	Y	1	12
458.2	Iatrogenic hypotension	N	5	141, 142
530.2	Ulcer of esophagus	N	6	176
600.0	Hypertrophy (benign) of prostate	N	12	348, 349
600.1	Nodular prostate	N	12	348, 349
600.2	Benign localized hyperplasia of prostate	N	12	348, 349
600.9	Hyperplasia of prostate, unspecified	N	12	348, 349
719.70	Difficulty in walking, site unspecified	N	8	247
719.75	Difficulty in walking, pelvic region and thigh	N	8	247
719.76	Difficulty in walking, lower leg	N	8	247
719.77	Difficulty in walking, ankle and foot	N	8	247
719.78	Difficulty in walking, other specified sites	N	8	247
719.79	Difficulty in walking, multiple sites	N	8	247
752.8	Other specified anomalies of genital organs	N	12	352
			13	358, 359, 369

TABLE 6C.—INVALID DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
766.2	Post term infant, not ''heavy for dates''	N	15	391
767.1	Injuries to scalp	N	15	391
790.2	Abnormal glucose tolerance test	N	10	296, 297, 298
799.8	Other ill-defined conditions	N	23	467
850.1	Concussion, with brief loss of consciousness	Y	1	31, 32, 33
			24	487
959.1	Injury, trunk	N	21	444, 445, 446
			24	487
V04.8	Need for prophylactic vaccination and inoculation against certain viral disease, Influenza.	N	23	467
V43.2	Organ or tissue replaced by other means, Heart	Y	5	144, 145
V53.9	Fitting and adjustment of other device, Other and unspecified device	N	23	467
V54.0	Aftercare involving removal of fracture plate or other internal fixation device	N	8	249
V64.4	Laparoscopic surgical procedure converted to open procedure	N	23	467
V65.1	Person consulting on behalf of another person	N	23	467

[1] Classified as a ''Major Problem.''
[2] Classified as a ''Major Related Condition.''

TABLE 6D.—INVALID PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
37.5	Heart transplantation	Y	PRE	103
68.3	Subtotal abdominal hysterectomy	Y	13	354, 355, 357, 358, 359
			14	375

TABLE 6E.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
282.60	Sickle-cell disease, unspecified	Y	16	395, 396
282.61	Hb-SS disease without crisis	Y	16	395, 396
282.62	Hb-SS disease with crisis	Y	16	395, 396
282.63	Sickle-cell/Hb-C disease without crisis	Y	16	395, 396
282.69	Other sickle-cell disease with crisis	Y	16	395, 396
414.06	Of native coronary artery of transplanted heart	N	5	132, 133
491.20	Obstructive chronic bronchitis, without exacerbation	Y	4	88
491.21	Obstructive chronic bronchitis, with (acute) exacerbation	Y	4	88
493.00	Extrinsic asthma, unspecified	N	4	96, 97, 98
493.02	Extrinsic asthma, with (acute) exacerbation	Y	4	96, 97, 98
493.10	Intrinsic asthma, unspecified	N	4	96, 97, 98
493.12	Intrinsic asthma, with (acute) exacerbation	Y	4	96, 97, 98
493.20	Chronic obstructive asthma, unspecified	Y	4	88
493.22	Chronic obstructive asthma, with (acute) exacerbation	Y	4	88
493.90	Asthma, unspecified, unspecified	N	4	96, 97, 98
493.92	Asthma, unspecified, with (acute) exacerbation	Y	4	96, 97, 98
V06.1	Diphtheria-tetanus-pertussis, combined [DTP] [DtaP]	N	23	467
V06.5	Tetanus-diphtheria [Td][DT]	N	23	467

TABLE 6F.—REVISED PROCEDURE CODE TITLES

Procedure code	Description	OR	MDC	DRG
37.33	Excision or destruction of other lesion or tissue of heart, open approach	Y	5	108
37.34	Excision or destruction of other lesion or tissue of heart, other approach	Y	5	516, 517, 518
39.79	Other endovascular repair (of aneurysm) of other vessels	Y	1	1, 2, 3
			5	110, 111
			11	315
			21	442, 443
			24	486

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST

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

*25060	*2800	28242	2848	28262	28249	28268	2860
35800	28241	28249	2849	28263	28264	*28522	2861
35801	28242	28264	2850	28264	28268	28241	2862
*25061	28249	28268	2851	28268	*28310	28242	2863
35800	28264	*2821	*28249	28269	28241	28249	2864
35801	28268	28241	2800	2830	28242	28264	2865
*25062	*2801	28242	2814	28310	28249	28268	2866
35800	28241	28249	2818	28311	28264	*28529	2867
35801	28242	28264	28241	28319	28268	28241	2869
*25063	28249	28268	28242	2832	*28311	28242	2870
35800	28264	*2822	28249	2839	28241	28249	2871
35801	28268	28241	28260	2840	28242	28264	2872
*25080	*2808	28242	28261	2848	28249	28268	2873
35800	28241	28249	28262	2849	28264	*2858	2874
35801	28242	28264	28263	2850	28268	28241	2875
*25081	28249	28268	28264	2851	*28319	28242	2878
35800	28264	*2823	28268	*28268	28241	28249	2879
35801	28268	28241	28269	2800	28242	28264	2880
*25082	*2809	28242	2830	2814	28249	28268	2881
35800	28241	28249	28310	2818	28264	*2859	28981
35801	28242	28264	28311	28241	28268	28241	28982
*25083	28249	28268	28319	28242	*2832	28242	*28982
35800	28264	*28241	2832	28249	28241	28249	2800
35801	28268	2800	2839	28260	28242	28264	2814
*25090	*2810	2814	2840	28261	28249	28268	2818
35800	28241	2818	2848	28262	28264	*2880	28241
35801	28242	28241	2849	28263	28268	28981	28242
*25091	28249	28242	2850	28264	*2839	28982	28249
35800	28264	28249	2851	28268	28241	*2881	28260
35801	28268	28260	*2825	28269	28242	28981	28261
*25092	*2811	28261	28241	2830	28249	28982	28262
35800	28241	28262	28242	28310	28264	*2882	28263
35801	28242	28263	28249	28311	28268	28981	28264
*25093	28249	28264	28264	28319	*2840	28982	28268
35800	28264	28268	28268	2832	28241	*2883	28269
35801	28268	28269	*28260	2839	28242	28981	2830
*2515	*2812	2830	28241	2840	28249	28982	28310
53021	28241	28310	28242	2848	28264	*2888	28311
*25510	28242	28311	28249	2849	28268	28981	28319
2550	28249	28319	28264	2850	*2848	28982	2832
2580	28264	2832	28268	2851	28241	*2889	2839
2581	28268	2839	*28261	*28269	28242	28981	2840
2588	*2813	2840	28241	28241	28249	28982	2848
2589	28241	2848	28242	28242	28264	*28981	2849
*25511	28242	2849	28249	28249	28268	2800	2850
2550	28249	2850	28264	28264	*2849	2814	2851
2580	28264	2851	28268	28268	28241	2818	2860
2581	28268	*28242	*28262	*2827	28242	28241	2861
2588	*2814	2800	28241	28241	28249	28242	2862
2589	28241	2814	28242	28242	28264	28249	2863
*25512	28242	2818	28249	28249	28268	28260	2864
2550	28249	28241	28264	28264	*2850	28261	2865
2580	28264	28242	28268	28268	28241	28262	2866
2581	28268	28249	*28263	*2828	28242	28263	2867
2588	*2818	28260	28241	28241	28249	28264	2869
2589	28241	28261	28242	28242	28264	28268	2870
*25513	28242	28262	28249	28249	28268	28269	2871
2550	28249	28263	28264	28264	*2851	2830	2872
2580	28264	28264	28268	28268	28241	28310	2873
2581	28268	28268	*28264	*2829	28242	28311	2874
2588	*2819	28269	2800	28241	28249	28319	2875
2589	28241	2830	2814	28242	28264	2832	2878
*25514	28242	28310	2818	28249	28268	2839	2879
2550	28249	28311	28241	28264	*28521	2840	2880
2580	28264	28319	28242	28268	28241	2848	2881
2581	28268	2832	28249	*2830	28242	2849	28981
2588	*2820	2839	28260	28241	28249	2850	28982
2589	28241	2840	28261	28242	28264	2851	*28989
2800	35801	53201	53121	5789	53531	53021	*53451
2814	3581	53210	53131	*5307	53541	*53251	53021
2818	*3581	53211	53140	53021	53551	53021	*53460
28241	35800	53220	53141	*53082	53561	*53260	53021

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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

28242	35801	53221	53150	53021	53783	53021	*53461
28249	*4560	53231	53151	*53085	53784	*53261	53021
28260	53021	53240	53160	4560	56202	53021	*53470
28261	*49381	53241	53161	53021	56203	*53270	53021
28262	49301	53250	53171	5307	56212	53021	*53471
28263	49302	53251	53191	53082	56213	*53271	53021
28264	49311	53260	53200	53100	5693	53021	*53490
28268	49312	53261	53201	53101	56985	*53290	53021
28269	49320	53271	53210	53110	56986	53021	*53491
2830	49321	53291	53211	53111	5780	*53291	53021
28310	49322	53300	53220	53120	5781	53021	*53501
28311	49391	53301	53221	53121	5789	*53300	53021
28319	49392	53310	53231	53131	*53100	53021	*53511
2832	*49382	53311	53240	53140	53021	*53301	53021
2839	49301	53320	53241	53141	*53101	53021	*53521
2840	49302	53321	53250	53150	53021	*53310	53021
2848	49311	53331	53251	53151	*53110	53021	*53531
2849	49312	53340	53260	53160	53021	*53311	53021
2850	49320	53341	53261	53161	*53111	53021	*53541
2851	49321	53350	53271	53171	53021	*53320	53021
2860	49322	53351	53291	53191	*53120	53021	*53551
2861	49391	53360	53300	53200	53021	*53321	53021
2862	49392	53361	53301	53201	*53121	53021	*53561
2863	*5173	53371	53310	53210	53021	*53330	53021
2864	2800	53391	53311	53211	*53130	53021	*53783
2865	2814	53400	53320	53220	53021	*53331	53021
2866	2818	53401	53321	53221	*53131	53021	*53789
2867	28241	53410	53331	53231	53021	*53340	53021
2869	28242	53411	53340	53240	*53140	53021	*5379
2870	28249	53420	53341	53241	53021	*53341	53021
2871	28260	53421	53350	53250	*53141	53021	*56202
2872	28261	53431	53351	53251	53021	*53350	53021
2873	28262	53440	53360	53260	*53150	53021	*56203
2874	28263	53441	53361	53261	53021	*53351	53021
2875	28264	53450	53371	53271	*53151	53021	*56212
2878	28268	53451	53391	53291	53021	*53360	53021
2879	28269	53460	53400	53300	*53160	53021	*56213
2880	2830	53461	53401	53301	53021	*53361	53021
2881	28310	53471	53410	53310	*53161	53021	*5693
28981	28311	53491	53411	53311	53021	*53370	53021
28982	28319	53501	53420	53320	*53170	53021	*56985
*2899	2832	53511	53421	53321	53021	*53371	53021
28241	2839	53521	53431	53331	*53171	53021	*5780
28242	2840	53531	53440	53340	53021	*53390	53021
28249	2848	53541	53441	53341	*53190	53021	*5781
28264	2849	53551	53450	53350	53021	*53391	53021
28268	2850	53561	53451	53351	*53191	53021	*5789
28981	2851	53783	53460	53360	53021	*53400	53021
28982	*53020	53784	53461	53361	*53200	53021	*60000
*33182	4560	56202	53471	53371	53021	*53401	5960
3314	53021	56203	53491	53391	*53201	53021	5996
*34830	5307	56212	53501	53400	53021	*53410	6010
34982	53082	56213	53511	53401	*53210	53021	6012
*34831	53100	5693	53521	53410	53021	*53411	6013
34982	53101	56985	53531	53411	*53211	53021	6021
*34839	53110	56986	53541	53420	53021	*53420	78820
34982	53111	5780	53551	53421	*53220	53021	78829
*34989	53120	5781	53561	53431	53021	*53421	*60001
35800	53121	5789	53783	53440	*53221	53021	5960
35801	53131	*53021	53784	53441	53021	*53430	5996
*3499	53140	4560	56202	53450	*53230	53021	6010
35800	53141	53021	56203	53451	53021	*53431	6012
35801	53150	5307	56212	53460	*53231	53021	6013
*35800	53151	53082	56213	53461	53021	*53440	6021
35800	53160	53100	5693	53471	*53240	53021	78820
35801	53161	53101	56985	53491	53021	*53441	78829
3581	53171	53110	56986	53501	*53241	53021	*60010
*35801	53191	53111	5780	53511	53021	*53450	5960
35800	53200	53120	5781	53521	*53250	53021	5996
6010	67450	67451	67452	67400	6143	7744	7994
6012	67451	67452	67453	67401	6145	7745	*78099
6013	67452	67453	67454	67402	6150	7747	78552

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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

6021	67453	67454	*66994	67403	6163	7751	*78550
78820	67454	*66942	67450	67404	6164	7752	78552
78829	*64684	67450	67451	67450	6207	7753	*78551
*60011	67450	67451	67452	67451	*75289	7754	78552
5960	67451	67452	67453	67452	5970	7755	*78552
5996	67452	67453	67454	67453	5994	7756	04082
6010	67453	67454	*67400	67454	6140	7757	78550
6012	67454	*66943	67450	*67454	6143	7760	78551
6013	*64690	67450	67451	67400	6145	7761	78552
6021	67450	67451	67452	67401	6150	7762	78559
78820	67451	67452	67453	67402	6163	7763	*78559
78829	67452	67453	67454	67403	6164	7771	78552
*60020	67453	67454	*67401	67404	6207	7772	*7859
5960	67454	*66944	67450	67450	*7670	7775	78552
5996	*64691	67450	67451	67451	76711	7776	*78863
6010	67450	67451	67452	67452	*76711	7780	78820
6012	67451	67452	67453	67453	76711	7790	78829
6013	67452	67453	67454	67454	*7678	7791	*79981
6021	67453	67454	*67402	*7197	76711	7797	04082
78820	67454	*66980	67450	6960	*7679	*77989	44024
78829	*64693	67450	67451	71100	76711	76711	78001
*60021	67450	67451	67452	71101	*77981	*78091	78003
5960	67451	67452	67453	71102	76711	78552	7801
5996	67452	67453	67454	71103	*77982	*78092	78031
6010	67453	67454	*67403	71104	76711	78552	78039
6012	67454	*66981	67450	71105	*77983	*78093	7817
6013	*64890	67450	67451	71106	76501	04082	7854
6021	67450	67451	67452	71107	76502	44024	78550
78820	67451	67452	67453	71108	76503	78001	78551
78829	67452	67453	67454	71109	76504	78003	78552
*60090	67453	67454	*67404	71160	76505	7801	78559
5960	67454	*66982	67450	71161	76506	78031	7863
5996	*64891	67450	67451	71162	76507	78039	78820
6010	67450	67451	67452	71163	76508	7817	78829
6012	67451	67452	67453	71164	7670	7854	7895
6013	67452	67453	67454	71165	76711	78550	7907
6021	67453	67454	*67450	71166	7685	78551	7911
78820	67454	*66983	67400	71167	769	78552	7913
78829	*64892	67450	67401	71168	7700	78559	7991
*60091	67450	67451	67402	71169	7701	7863	7994
5960	67451	67452	67403	7141	7702	78820	*79989
5996	67452	67453	67404	7142	7703	78829	04082
6010	67453	67454	67450	71430	7704	7895	44024
6012	67454	*66984	67451	71431	7705	7907	78001
6013	*64893	67450	67452	71432	7707	7911	78003
6021	67450	67451	67453	71433	77084	7913	7801
78820	67451	67452	67454	*7280	7710	7991	78031
78829	67452	67453	*67451	72888	7711	7994	78039
*60785	67453	67454	67400	*72811	7713	*78094	7817
5970	67454	*66990	67401	72888	77181	04082	7854
5994	*64894	67450	67402	*72812	77183	44024	78550
*64680	67450	67451	67403	72888	77210	78001	78551
67450	67451	67452	67404	*72813	77211	78003	78552
67451	67452	67453	67450	72888	77212	7801	78559
67452	67453	67454	67451	*72819	77213	78031	7863
67453	67454	*66991	67452	72888	77214	78039	78820
67454	*650	67450	67453	*7282	7722	7817	78829
*64681	67450	67451	67454	72888	7724	7854	7895
67450	67451	67452	*67452	*7283	7725	78550	7907
67451	67452	67453	67400	72888	7730	78551	7911
67452	67453	67454	67401	*72881	7731	78552	7913
67453	67454	*66992	67402	72888	7732	78559	7991
67454	*66940	67450	67403	*72886	7733	7863	7994
*64682	67450	67451	67404	72888	7734	78820	*80000
67450	67451	67452	67450	*72888	7740	78829	85011
67451	67452	67453	67451	72888	7741	7895	85012
67452	67453	67454	67452	*75281	7742	7907	*80001
67453	67454	*66993	67453	5970	77430	7911	85011
67454	*66941	67450	67454	5994	77431	7913	85012
*64683	67450	67451	*67453	6140	77439	7991	*80002
85011	85012	*80063	85011	85012	*80154	85011	85012
85012	*80033	85011	85012	*80124	85011	85012	*80315

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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

*80003	85011	85012	*80094	85011	85012	*80185	85011
85011	85012	*80064	85011	85012	*80155	85011	85012
85012	*80034	85011	85012	*80125	85011	85012	*80316
*80004	85011	85012	*80095	85011	85012	*80186	85011
85011	85012	*80065	85011	85012	*80156	85011	85012
85012	*80035	85011	85012	*80126	85011	85012	*80319
*80005	85011	85012	*80096	85011	85012	*80189	85011
85011	85012	*80066	85011	85012	*80159	85011	85012
85012	*80036	85011	85012	*80129	85011	85012	*80320
*80006	85011	85012	*80099	85011	85012	*80190	85011
85011	85012	*80069	85011	85012	*80160	85011	85012
85012	*80039	85011	85012	*80130	85011	85012	*80321
*80009	85011	85012	*80100	85011	85012	*80191	85011
85011	85012	*80070	85011	85012	*80161	85011	85012
85012	*80040	85011	85012	*80131	85011	85012	*80322
*80010	85011	85012	*80101	85011	85012	*80192	85011
85011	85012	*80071	85011	85012	*80162	85011	85012
85012	*80041	85011	85012	*80132	85011	85012	*80323
*80011	85011	85012	*80102	85011	85012	*80193	85011
85011	85012	*80072	85011	85012	*80163	85011	85012
85012	*80042	85011	85012	*80133	85011	85012	*80324
*80012	85011	85012	*80103	85011	85012	*80194	85011
85011	85012	*80073	85011	85012	*80164	85011	85012
85012	*80043	85011	85012	*80134	85011	85012	*80325
*80013	85011	85012	*80104	85011	85012	*80195	85011
85011	85012	*80074	85011	85012	*80165	85011	85012
85012	*80044	85011	85012	*80135	85011	85012	*80326
*80014	85011	85012	*80105	85011	85012	*80196	85011
85011	85012	*80075	85011	85012	*80166	85011	85012
85012	*80045	85011	85012	*80136	85011	85012	*80329
*80015	85011	85012	*80106	85011	85012	*80199	85011
85011	85012	*80076	85011	85012	*80169	85011	85012
85012	*80046	85011	85012	*80139	85011	85012	*80330
*80016	85011	85012	*80109	85011	85012	*80300	85011
85011	85012	*80079	85011	85012	*80170	85011	85012
85012	*80049	85011	85012	*80140	85011	85012	*80331
*80019	85011	85012	*80110	85011	85012	*80301	85011
85011	85012	*80080	85011	85012	*80171	85011	85012
85012	*80050	85011	85012	*80141	85011	85012	*80332
*80020	85011	85012	*80111	85011	85012	*80302	85011
85011	85012	*80081	85011	85012	*80172	85011	85012
85012	*80051	85011	85012	*80142	85011	85012	*80333
*80021	85011	85012	*80112	85011	85012	*80303	85011
85011	85012	*80082	85011	85012	*80173	85011	85012
85012	*80052	85011	85012	*80143	85011	85012	*80334
*80022	85011	85012	*80113	85011	85012	*80304	85011
85011	85012	*80083	85011	85012	*80174	85011	85012
85012	*80053	85011	85012	*80144	85011	85012	*80335
*80023	85011	85012	*80114	85011	85012	*80305	85011
85011	85012	*80084	85011	85012	*80175	85011	85012
85012	*80054	85011	85012	*80145	85011	85012	*80336
*80024	85011	85012	*80115	85011	85012	*80306	85011
85011	85012	*80085	85011	85012	*80176	85011	85012
85012	*80055	85011	85012	*80146	85011	85012	*80339
*80025	85011	85012	*80116	85011	85012	*80309	85011
85011	85012	*80086	85011	85012	*80179	85011	85012
85012	*80056	85011	85012	*80149	85011	85012	*80340
*80026	85011	85012	*80119	85011	85012	*80310	85011
85011	85012	*80089	85011	85012	*80180	85011	85012
85012	*80059	85011	85012	*80150	85011	85012	*80341
*80029	85011	85012	*80120	85011	85012	*80311	85011
85011	85012	*80090	85011	85012	*80181	85011	85012
85012	*80060	85011	85012	*80151	85011	85012	*80342
*80030	85011	85012	*80121	85011	85012	*80312	85011
85011	85012	*80091	85011	85012	*80182	85011	85012
85012	*80061	85011	85012	*80152	85011	85012	*80343
*80031	85011	85012	*80122	85011	85012	*80313	85011
85011	85012	*80092	85011	85012	*80183	85011	85012
85012	*80062	85011	85012	*80153	85011	85012	*80344
*80032	85011	85012	*80123	85011	85012	*80314	85011
85011	85012	*80093	85011	85012	*80184	85011	85012
*80345	85011	85012	*80436	85011	85012	80072	80163

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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

85011	85012	*80406	85011	85012	*80499	80073	80164
85012	*80376	85011	85012	*80469	85011	80074	80165
*80346	85011	85012	*80439	85011	85012	80075	80166
85011	85012	*80409	85011	85012	*8500	80076	80169
85012	*80379	85011	85012	*80470	85011	80079	80170
*80349	85011	85012	*80440	85011	85012	80080	80171
85011	85012	*80410	85011	85012	*85011	80081	80172
85012	*80380	85011	85012	*80471	430	80082	80173
*80350	85011	85012	*80441	85011	431	80083	80174
85011	85012	*80411	85011	85012	4320	80084	80175
85012	*80381	85011	85012	*80472	4321	80085	80176
*80351	85011	85012	*80442	85011	436	80086	80179
85011	85012	*80412	85011	85012	78001	80089	80180
85012	*80382	85011	85012	*80473	78003	80090	80181
*80352	85011	85012	*80443	85011	80000	80091	80182
85011	85012	*80413	85011	85012	80001	80092	80183
85012	*80383	85011	85012	*80474	80002	80093	80184
*80353	85011	85012	*80444	85011	80003	80094	80185
85011	85012	*80414	85011	85012	80004	80095	80186
85012	*80384	85011	85012	*80475	80005	80096	80189
*80354	85011	85012	*80445	85011	80006	80099	80190
85011	85012	*80415	85011	85012	80009	80100	80191
85012	*80385	85011	85012	*80476	80010	80101	80192
*80355	85011	85012	*80446	85011	80011	80102	80193
85011	85012	*80416	85011	85012	80012	80103	80194
85012	*80386	85011	85012	*80479	80013	80104	80195
*80356	85011	85012	*80449	85011	80014	80105	80196
85011	85012	*80419	85011	85012	80015	80106	80199
85012	*80389	85011	85012	*80480	80016	80109	8021
*80359	85011	85012	*80450	85011	80019	80110	80220
85011	85012	*80420	85011	85012	80020	80111	80221
85012	*80390	85011	85012	*80481	80021	80112	80222
*80360	85011	85012	*80451	85011	80022	80113	80223
85011	85012	*80421	85011	85012	80023	80114	80224
85012	*80391	85011	85012	*80482	80024	80115	80225
*80361	85011	85012	*80452	85011	80025	80116	80226
85011	85012	*80422	85011	85012	80026	80119	80227
85012	*80392	85011	85012	*80483	80029	80120	80228
*80362	85011	85012	*80453	85011	80030	80121	80229
85011	85012	*80423	85011	85012	80031	80122	80230
85012	*80393	85011	85012	*80484	80032	80123	80231
*80363	85011	85012	*80454	85011	80033	80124	80232
85011	85012	*80424	85011	85012	80034	80125	80233
85012	*80394	85011	85012	*80485	80035	80126	80234
*80364	85011	85012	*80455	85011	80036	80129	80235
85011	85012	*80425	85011	85012	80039	80130	80236
85012	*80395	85011	85012	*80486	80040	80131	80237
*80365	85011	85012	*80456	85011	80041	80132	80238
85011	85012	*80426	85011	85012	80042	80133	80239
85012	*80396	85011	85012	*80489	80043	80134	8024
*80366	85011	85012	*80459	85011	80044	80135	8025
85011	85012	*80429	85011	85012	80045	80136	8026
85012	*80399	85011	85012	*80490	80046	80139	8027
*80369	85011	85012	*80460	85011	80049	80140	8028
85011	85012	*80430	85011	85012	80050	80141	8029
85012	*80400	85011	85012	*80491	80051	80142	80300
*80370	85011	85012	*80461	85011	80052	80143	80301
85011	85012	*80431	85011	85012	80053	80144	80302
85012	*80401	85011	85012	*80492	80054	80145	80303
*80371	85011	85012	*80462	85011	80055	80146	80304
85011	85012	*80432	85011	85012	80056	80149	80305
85012	*80402	85011	85012	*80493	80059	80150	80306
*80372	85011	85012	*80463	85011	80060	80151	80309
85011	85012	*80433	85011	85012	80061	80152	80310
85012	*80403	85011	85012	*80494	80062	80153	80311
*80373	85011	85012	*80464	85011	80063	80154	80312
85011	85012	*80434	85011	85012	80064	80155	80313
85012	*80404	85011	85012	*80495	80065	80156	80314
*80374	85011	85012	*80465	85011	80066	80159	80315
85011	85012	*80435	85011	85012	80069	80160	80316
85012	*80405	85011	85012	*80496	80070	80161	80319
*80375	85011	85012	*80466	85011	80071	80162	80320

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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

80321	80412	8502	85184	85315	80056	80149	80305
80322	80413	8503	85185	85316	80059	80150	80306
80323	80414	8504	85186	85319	80060	80151	80309
80324	80415	8505	85189	85400	80061	80152	80310
80325	80416	8509	85190	85401	80062	80153	80311
80326	80419	85100	85191	85402	80063	80154	80312
80329	80420	85101	85192	85403	80064	80155	80313
80330	80421	85102	85193	85404	80065	80156	80314
80331	80422	85103	85194	85405	80066	80159	80315
80332	80423	85104	85195	85406	80069	80160	80316
80333	80424	85105	85196	85409	80070	80161	80319
80334	80425	85106	85199	85410	80071	80162	80320
80335	80426	85109	85200	85411	80072	80163	80321
80336	80429	85110	85201	85412	80073	80164	80322
80339	80430	85111	85202	85413	80074	80165	80323
80340	80431	85112	85203	85414	80075	80166	80324
80341	80432	85113	85204	85415	80076	80169	80325
80342	80433	85114	85205	85416	80079	80170	80326
80343	80434	85115	85206	85419	80080	80171	80329
80344	80435	85116	85209	*85012	80081	80172	80330
80345	80436	85119	85210	430	80082	80173	80331
80346	80439	85120	85211	431	80083	80174	80332
80349	80440	85121	85212	4320	80084	80175	80333
80350	80441	85122	85213	4321	80085	80176	80334
80351	80442	85123	85214	436	80086	80179	80335
80352	80443	85124	85215	78001	80089	80180	80336
80353	80444	85125	85216	78003	80090	80181	80339
80354	80445	85126	85219	80000	80091	80182	80340
80355	80446	85129	85220	80001	80092	80183	80341
80356	80449	85130	85221	80002	80093	80184	80342
80359	80450	85131	85222	80003	80094	80185	80343
80360	80451	85132	85223	80004	80095	80186	80344
80361	80452	85133	85224	80005	80096	80189	80345
80362	80453	85134	85225	80006	80099	80190	80346
80363	80454	85135	85226	80009	80100	80191	80349
80364	80455	85136	85229	80010	80101	80192	80350
80365	80456	85139	85230	80011	80102	80193	80351
80366	80459	85140	85231	80012	80103	80194	80352
80369	80460	85141	85232	80013	80104	80195	80353
80370	80461	85142	85233	80014	80105	80196	80354
80371	80462	85143	85234	80015	80106	80199	80355
80372	80463	85144	85235	80016	80109	8021	80356
80373	80464	85145	85236	80019	80110	80220	80359
80374	80465	85146	85239	80020	80111	80221	80360
80375	80466	85149	85240	80021	80112	80222	80361
80376	80469	85150	85241	80022	80113	80223	80362
80379	80470	85151	85242	80023	80114	80224	80363
80380	80471	85152	85243	80024	80115	80225	80364
80381	80472	85153	85244	80025	80116	80226	80365
80382	80473	85154	85245	80026	80119	80227	80366
80383	80474	85155	85246	80029	80120	80228	80369
80384	80475	85156	85249	80030	80121	80229	80370
80385	80476	85159	85250	80031	80122	80230	80371
80386	80479	85160	85251	80032	80123	80231	80372
80389	80480	85161	85252	80033	80124	80232	80373
80390	80481	85162	85253	80034	80125	80233	80374
80391	80482	85163	85254	80035	80126	80234	80375
80392	80483	85164	85255	80036	80129	80235	80376
80393	80484	85165	85256	80039	80130	80236	80379
80394	80485	85166	85259	80040	80131	80237	80380
80395	80486	85169	85300	80041	80132	80238	80381
80396	80489	85170	85301	80042	80133	80239	80382
80399	80490	85171	85302	80043	80134	8024	80383
80400	80491	85172	85303	80044	80135	8025	80384
80401	80492	85173	85304	80045	80136	8026	80385
80402	80493	85174	85305	80046	80139	8027	80386
80403	80494	85175	85306	80049	80140	8028	80389
80404	80495	85176	85309	80050	80141	8029	80390
80405	80496	85179	85310	80051	80142	80300	80391
80406	80499	85180	85311	80052	80143	80301	80392
80409	8500	85181	85312	80053	80144	80302	80393
80410	85011	85182	85313	80054	80145	80303	80394

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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

80411	85012	85183	85314	80055	80146	80304	80395
80396	80489	85170	85301	*85111	85011	85012	*85202
80399	80490	85171	85302	85011	85012	*85172	85011
80400	80491	85172	85303	85012	*85142	85011	85012
80401	80492	85173	85304	*85112	85011	85012	*85203
80402	80493	85174	85305	85011	85012	*85173	85011
80403	80494	85175	85306	85012	*85143	85011	85012
80404	80495	85176	85309	*85113	85011	85012	*85204
80405	80496	85179	85310	85011	85012	*85174	85011
80406	80499	85180	85311	85012	*85144	85011	85012
80409	8500	85181	85312	*85114	85011	85012	*85205
80410	85011	85182	85313	85011	85012	*85175	85011
80411	85012	85183	85314	85012	*85145	85011	85012
80412	8502	85184	85315	*85115	85011	85012	*85206
80413	8503	85185	85316	85011	85012	*85176	85011
80414	8504	85186	85319	85012	*85146	85011	85012
80415	8505	85189	85400	*85116	85011	85012	*85209
80416	8509	85190	85401	85011	85012	*85179	85011
80419	85100	85191	85402	85012	*85149	85011	85012
80420	85101	85192	85403	*85119	85011	85012	*85210
80421	85102	85193	85404	85011	85012	*85180	85011
80422	85103	85194	85405	85012	*85150	85011	85012
80423	85104	85195	85406	*85120	85011	85012	*85211
80424	85105	85196	85409	85011	85012	*85181	85011
80425	85106	85199	85410	85012	*85151	85011	85012
80426	85109	85200	85411	*85121	85011	85012	*85212
80429	85110	85201	85412	85011	85012	*85182	85011
80430	85111	85202	85413	85012	*85152	85011	85012
80431	85112	85203	85414	*85122	85011	85012	*85213
80432	85113	85204	85415	85011	85012	*85183	85011
80433	85114	85205	85416	85012	*85153	85011	85012
80434	85115	85206	85419	*85123	85011	85012	*85214
80435	85116	85209	*8502	85011	85012	*85184	85011
80436	85119	85210	85011	85012	*85154	85011	85012
80439	85120	85211	85012	*85124	85011	85012	*85215
80440	85121	85212	*8503	85011	85012	*85185	85011
80441	85122	85213	85011	85012	*85155	85011	85012
80442	85123	85214	85012	*85125	85011	85012	*85216
80443	85124	85215	*8504	85011	85012	*85186	85011
80444	85125	85216	85011	85012	*85156	85011	85012
80445	85126	85219	85012	*85126	85011	85012	*85219
80446	85129	85220	*8505	85011	85012	*85189	85011
80449	85130	85221	85011	85012	*85159	85011	85012
80450	85131	85222	85012	*85129	85011	85012	*85221
80451	85132	85223	*8509	85011	85012	*85190	85011
80452	85133	85224	85011	85012	*85160	85011	85012
80453	85134	85225	85012	*85130	85011	85012	*85222
80454	85135	85226	*85100	85011	85012	*85191	85011
80455	85136	85229	85011	85012	*85161	85011	85012
80456	85139	85230	85012	*85131	85011	85012	*85223
80459	85140	85231	*85101	85011	85012	*85192	85011
80460	85141	85232	85011	85012	*85162	85011	85012
80461	85142	85233	85012	*85132	85011	85012	*85224
80462	85143	85234	*85102	85011	85012	*85193	85011
80463	85144	85235	85011	85012	*85163	85011	85012
80464	85145	85236	85012	*85133	85011	85012	*85225
80465	85146	85239	*85103	85011	85012	*85194	85011
80466	85149	85240	85011	85012	*85164	85011	85012
80469	85150	85241	85012	*85134	85011	85012	*85226
80470	85151	85242	*85104	85011	85012	*85195	85011
80471	85152	85243	85011	85012	*85165	85011	85012
80472	85153	85244	85012	*85135	85011	85012	*85229
80473	85154	85245	*85105	85011	85012	*85196	85011
80474	85155	85246	85011	85012	*85166	85011	85012
80475	85156	85249	85012	*85136	85011	85012	*85230
80476	85159	85250	*85106	85011	85012	*85199	85011
80479	85160	85251	85011	85012	*85169	85011	85012
80480	85161	85252	85012	*85139	85011	85012	*85231
80481	85162	85253	*85109	85011	85012	*85200	85011
80482	85163	85254	85011	85012	*85170	85011	85012
80483	85164	85255	85012	*85140	85011	85012	*85232
80484	85165	85256	*85110	85011	85012	*85201	85011

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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

80485	85166	85259	85011	85012	*85171	85011	85012
80486	85169	85300	85012	*85141	85011	85012	*85233
85011	85012	*85414	8058	95219	8064	80609	80504
85012	*85304	85011	8059	9522	8065	80610	80505
*85234	85011	85012	80600	9523	80660	80611	80506
85011	85012	*85415	80601	9524	80661	80612	80507
85012	*85305	85011	80602	9528	80662	80613	80508
*85235	85011	85012	80603	9529	80669	80614	80510
85011	85012	*85416	80604	*95912	80670	80615	80511
85012	*85306	85011	80605	80500	80671	80616	80512
*85236	85011	85012	80606	80501	80672	80617	80513
85011	85012	*85419	80607	80502	80679	80618	80514
85012	*85309	85011	80608	80503	8068	80619	80515
*85239	85011	85012	80609	80504	8069	80620	80516
85011	85012	*8738	80610	80505	95200	80621	80517
85012	*85310	85011	80611	80506	95201	80622	80518
*85240	85011	85012	80612	80507	95202	80623	8052
85011	85012	*8739	80613	80508	95203	80624	8053
85012	*85311	85011	80614	80510	95204	80625	8054
*85241	85011	85012	80615	80511	95205	80626	8055
85011	85012	*8798	80616	80512	95206	80627	8056
85012	*85312	85011	80617	80513	95207	80628	8057
*85242	85011	85012	80618	80514	95208	80629	8058
85011	85012	*8799	80619	80515	95209	80630	8059
85012	*85313	85011	80620	80516	95210	80631	80600
*85243	85011	85012	80621	80517	95211	80632	80601
85011	85012	*9050	80622	80518	95212	80633	80602
85012	*85314	85011	80623	8052	95213	80634	80603
*85244	85011	85012	80624	8053	95214	80635	80604
85011	85012	*9251	80625	8054	95215	80636	80605
85012	*85315	85011	80626	8055	95216	80637	80606
*85245	85011	85012	80627	8056	95217	80638	80607
85011	85012	*9252	80628	8057	95218	80639	80608
85012	*85316	85011	80629	8058	95219	8064	80609
*85246	85011	85012	80630	8059	9522	8065	80610
85011	85012	*9290	80631	80600	9523	80660	80611
85012	*85319	85011	80632	80601	9524	80661	80612
*85249	85011	85012	80633	80602	9528	80662	80613
85011	85012	*9299	80634	80603	9529	80669	80614
85012	*85400	85011	80635	80604	*95913	80670	80615
*85250	85011	85012	80636	80605	80500	80671	80616
85011	85012	*9588	80637	80606	80501	80672	80617
85012	*85401	85011	80638	80607	80502	80679	80618
*85251	85011	85012	80639	80608	80503	8068	80619
85011	85012	*95901	8064	80609	80504	8069	80620
85012	*85402	85011	8065	80610	80505	95200	80621
*85252	85011	85012	80660	80611	80506	95201	80622
85011	85012	*95909	80661	80612	80507	95202	80623
85012	*85403	85011	80662	80613	80508	95203	80624
*85253	85011	85012	80669	80614	80510	95204	80625
85011	85012	*95911	80670	80615	80511	95205	80626
85012	*85404	80500	80671	80616	80512	95206	80627
*85254	85011	80501	80672	80617	80513	95207	80628
85011	85012	80502	80679	80618	80514	95208	80629
85012	*85405	80503	8068	80619	80515	95209	80630
*85255	85011	80504	8069	80620	80516	95210	80631
85011	85012	80505	95200	80621	80517	95211	80632
85012	*85406	80506	95201	80622	80518	95212	80633
*85256	85011	80507	95202	80623	8052	95213	80634
85011	85012	80508	95203	80624	8053	95214	80635
85012	*85409	80510	95204	80625	8054	95215	80636
*85259	85011	80511	95205	80626	8055	95216	80637
85011	85012	80512	95206	80627	8056	95217	80638
85012	*85410	80513	95207	80628	8057	95218	80639
*85300	85011	80514	95208	80629	8058	95219	8064
85011	85012	80515	95209	80630	8059	9522	8065
85012	*85411	80516	95210	80631	80600	9523	80660
*85301	85011	80517	95211	80632	80601	9524	80661
85011	85012	80518	95212	80633	80602	9528	80662
5012	*85412	8052	95213	80634	80603	9529	80669
*85302	85011	8053	95214	80635	80604	*95914	80670
85011	85012	8054	95215	80636	80605	80500	80671

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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

85012	*85413	8055	95216	80637	80606	80501	80672
*85303	85011	8056	95217	80638	80607	80502	80679
85011	85012	8057	95218	80639	80608	80503	8068
8069	80620	*99609	*99671				
95200	80621	99657	99657				
95201	80622	*9961	*99672				
95202	80623	99657	99657				
95203	80624	*9962	*99673				
95204	80625	99657	99657				
95205	80626	*99630	*99674				
95206	80627	99657	99657				
95207	80628	*99639	*99675				
95208	80629	99657	99657				
95209	80630	*9964	*99676				
95210	80631	99657	99657				
95211	80632	*99651	*99677				
95212	80633	99657	99657				
95213	80634	*99652	*99678				
95214	80635	99657	99657				
95215	80636	*99653	*99679				
95216	80637	99657	99657				
95217	80638	*99654	*99680				
95218	80639	99657	V4321				
95219	8064	*99655	V4322				
9522	8065	99657	*99683				
9523	80660	*99656	V4321				
9524	80661	99657	V4322				
9528	80662	*99657	*99687				
9529	80669	99655	V4321				
*95919	80670	99656	V4322				
80500	80671	99657	*99791				
80501	80672	99659	99657				
80502	80679	99660	*99799				
80503	8068	99661	99657				
80504	8069	99662	*99881				
80505	95200	99663	99657				
80506	95201	99664	*99883				
80507	95202	99665	99657				
80508	95203	99666	*99889				
80510	95204	99667	99657				
80511	95205	99668	*9989				
80512	95206	99669	99657				
80513	95207	99670	*V421				
80514	95208	99671	V4321				
80515	95209	99672	V4322				
80516	95210	99673	*V4321				
80517	95211	99674	V4321				
80518	95212	99675	V4322				
8052	95213	99676	*V4322				
8053	95214	99677	V4321				
8054	95215	99678	V4322				
8055	95216	99679					
8056	95217	*99659					
8057	95218	99657					
8058	95219	*99660					
8059	9522	99657					
80600	9523	*99661					
80601	9524	99657					
80602	9528	*99662					
80603	9529	99657					
80604	*9598	*99663					
80605	85011	99657					
80606	85012	*99664					
80607	*9599	99657					
80608	85011	*99665					
80609	85012	99657					
80610	*99600	*99666					
80611	99657	99657					
80612	*99601	*99667					
80613	99657	99657					
80614	*99602	*99668					
80615	99657	99657					

TABLE 6G.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

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

80616	*99603	*99669
80617	99657	99657
80618	*99604	*99670
80619	99657	99657

TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST

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

*25060	28263	28260	53201	6013	71169	6960	8501
3580	28269	28261	53210	6021	7141	71100	*80005
*25061	2830	28262	53211	78820	7142	71101	8501
3580	28310	28263	53220	78829	71430	71102	*80006
*25062	28311	28269	53221	*6001	71431	71103	8501
3580	28319	2830	53231	5960	71432	71104	*80009
*25063	2832	28310	53240	5996	71433	71105	8501
3580	2839	28311	53241	6010	*71976	71106	*80010
*25080	2840	28319	53250	6012	6960	71107	8501
3580	2848	2832	53251	6013	71100	71108	*80011
*25081	2849	2839	53260	6021	71106	71109	8501
3580	2850	2840	53261	78820	71108	71160	*80012
*25082	2851	2848	53271	78829	71109	71161	8501
3580	*2825	2849	53291	*6002	71160	71162	*80013
*25083	2824	2850	53300	5960	71166	71163	8501
3580	*28260	2851	53301	5996	71168	71164	*80014
*25090	2824	2860	53310	6010	71169	71165	8501
3580	*28261	2861	53311	6012	7141	71166	*80015
*25091	2824	2862	53320	6013	7142	71167	8501
3580	*28262	2863	53321	6021	71430	71168	*80016
*25092	2824	2864	53331	78820	71431	71169	8501
3580	*28263	2865	53340	78829	71432	7141	*80019
*25093	2824	2866	53341	*6009	71433	7142	8501
3580	*28269	2867	53350	5960	*71977	71430	*80020
*2551	2824	2869	53351	5996	6960	71431	8501
2550	*2827	2870	53360	6010	71100	71432	*80021
2580	2824	2871	53361	6012	71107	71433	8501
2581	*2828	2872	53371	6013	71108	*7528	*80022
2588	2824	2873	53391	6021	71109	5970	8501
2589	*2829	2874	53400	78820	71160	5994	*80023
*2800	2824	2875	53401	78829	71167	6140	8501
2824	*2830	2878	53410	*71970	71168	6143	*80024
*2801	2824	2879	53411	6960	71169	6145	8501
2824	*28310	2880	53420	71100	7141	6150	*80025
*2808	2824	2881	53421	71101	7142	6163	8501
2824	*28311	*2899	53431	71102	71430	6164	*80026
*2809	2824	2824	53440	71103	71431	6207	8501
2824	*28319	*3483	53441	71104	71432	*7998	*80029
*2810	2824	34982	53450	71105	71433	04082	8501
2824	*2832	*34989	53451	71106	*71978	44024	*80030
*2811	2824	3580	53460	71107	6960	78001	8501
2824	*2839	*3499	53461	71108	71100	78003	*80031
*2812	2824	3580	53471	71109	71101	7801	8501
2824	*2840	*3580	53491	71160	71102	78031	*80032
*2813	2824	3580	53501	71161	71103	78039	8501
2824	*2848	3581	53511	71162	71104	7817	*80033
*2814	2824	*3581	53521	71163	71105	7854	8501
2824	*2849	3580	53531	71164	71106	78550	*80034
*2818	2824	*5302	53541	71165	71107	78551	8501
2824	*2850	4560	53551	71166	71108	78559	*80035
*2819	2824	5307	53561	71167	71109	7863	8501
2824	*2851	53082	53783	71168	71160	78820	*80036
*2820	2824	53100	53784	71169	71161	78829	8501
2824	*28521	53101	56202	7141	71162	7895	*80039
*2821	2824	53110	56203	7142	71163	7907	8501
2824	*28522	53111	56212	71430	71164	7911	*80040
*2822	2824	53120	56213	71431	71165	7913	8501
2824	*28529	53121	5693	71432	71166	7991	*80041
*2823	2824	53131	56985	71433	71167	7994	8501
2824	*2858	53140	56986	*71975	71168	*80000	*80042
*2824	2824	53141	5780	6960	71169	8501	8501
2800	*2859	53150	5781	71100	7141	*80001	*80043

TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

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

2814	2824	53151	5789	71105	7142	8501	8501
2818	*2898	53160	*6000	71108	71430	*80002	*80044
2824	2800	53161	5960	71109	71431	8501	8501
28260	2814	53171	5996	71160	71432	*80003	*80045
28261	2818	53191	6010	71165	71433	8501	8501
28262	2824	53200	6012	71168	*71979	*80004	*80046
8501	*80093	8501	*80184	8501	*80375	8501	*80466
*80049	8501	*80140	8501	*80331	8501	*80422	8501
8501	*80094	8501	*80185	8501	*80376	8501	*80469
*80050	8501	*80141	8501	*80332	8501	*80423	8501
8501	*80095	8501	*80186	8501	*80379	8501	*80470
*80051	8501	*80142	8501	*80333	8501	*80424	8501
8501	*80096	8501	*80189	8501	*80380	8501	*80471
*80052	8501	*80143	8501	*80334	8501	*80425	8501
8501	*80099	8501	*80190	8501	*80381	8501	*80472
*80053	8501	*80144	8501	*80335	8501	*80426	8501
8501	*80100	8501	*80191	8501	*80382	8501	*80473
*80054	8501	*80145	8501	*80336	8501	*80429	8501
8501	*80101	8501	*80192	8501	*80383	8501	*80474
*80055	8501	*80146	8501	*80339	8501	*80430	8501
8501	*80102	8501	*80193	8501	*80384	8501	*80475
*80056	8501	*80149	8501	*80340	8501	*80431	8501
8501	*80103	8501	*80194	8501	*80385	8501	*80476
*80059	8501	*80150	8501	*80341	8501	*80432	8501
8501	*80104	8501	*80195	8501	*80386	8501	*80479
*80060	8501	*80151	8501	*80342	8501	*80433	8501
8501	*80105	8501	*80196	8501	*80389	8501	*80480
*80061	8501	*80152	8501	*80343	8501	*80434	8501
8501	*80106	8501	*80199	8501	*80390	8501	*80481
*80062	8501	*80153	8501	*80344	8501	*80435	8501
8501	*80109	8501	*80300	8501	*80391	8501	*80482
*80063	8501	*80154	8501	*80345	8501	*80436	8501
8501	*80110	8501	*80301	8501	*80392	8501	*80483
*80064	8501	*80155	8501	*80346	8501	*80439	8501
8501	*80111	8501	*80302	8501	*80393	8501	*80484
*80065	8501	*80156	8501	*80349	8501	*80440	8501
8501	*80112	8501	*80303	8501	*80394	8501	*80485
*80066	8501	*80159	8501	*80350	8501	*80441	8501
8501	*80113	8501	*80304	8501	*80395	8501	*80486
*80069	8501	*80160	8501	*80351	8501	*80442	8501
8501	*80114	8501	*80305	8501	*80396	8501	*80489
*80070	8501	*80161	8501	*80352	8501	*80443	8501
8501	*80115	8501	*80306	8501	*80399	8501	*80490
*80071	8501	*80162	8501	*80353	8501	*80444	8501
8501	*80116	8501	*80309	8501	*80400	8501	*80491
*80072	8501	*80163	8501	*80354	8501	*80445	8501
8501	*80119	8501	*80310	8501	*80401	8501	*80492
*80073	8501	*80164	8501	*80355	8501	*80446	8501
8501	*80120	8501	*80311	8501	*80402	8501	*80493
*80074	8501	*80165	8501	*80356	8501	*80449	8501
8501	*80121	8501	*80312	8501	*80403	8501	*80494
*80075	8501	*80166	8501	*80359	8501	*80450	8501
8501	*80122	8501	*80313	8501	*80404	8501	*80495
*80076	8501	*80169	8501	*80360	8501	*80451	8501
8501	*80123	8501	*80314	8501	*80405	8501	*80496
*80079	8501	*80170	8501	*80361	8501	*80452	8501
8501	*80124	8501	*80315	8501	*80406	8501	*80499
*80080	8501	*80171	8501	*80362	8501	*80453	8501
8501	*80125	8501	*80316	8501	*80409	8501	*8500
*80081	8501	*80172	8501	*80363	8501	*80454	8501
8501	*80126	8501	*80319	8501	*80410	8501	*8501
*80082	8501	*80173	8501	*80364	8501	*80455	430
8501	*80129	8501	*80320	8501	*80411	8501	431
*80083	8501	*80174	8501	*80365	8501	*80456	4320
8501	*80130	8501	*80321	8501	*80412	8501	4321
*80084	8501	*80175	8501	*80366	8501	*80459	436
8501	*80131	8501	*80322	8501	*80413	8501	78001
*80085	8501	*80176	8501	*80369	8501	*80460	78003
8501	*80132	8501	*80323	8501	*80414	8501	80000
*80086	8501	*80179	8501	*80370	8501	*80461	80001
8501	*80133	8501	*80324	8501	*80415	8501	80002
*80089	8501	*80180	8501	*80371	8501	*80462	80003

TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

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

8501	*80134	8501	*80325	8501	*80416	8501	80004
*80090	8501	*80181	8501	*80372	8501	*80463	80005
8501	*80135	8501	*80326	8501	*80419	8501	80006
*80091	8501	*80182	8501	*80373	8501	*80464	80009
8501	*80136	8501	*80329	8501	*80420	8501	80010
*80092	8501	*80183	8501	*80374	8501	*80465	80011
8501	*80139	8501	*80330	8501	*80421	8501	80012
80013	80104	80195	80353	80444	85126	85219	*8509
80014	80105	80196	80354	80445	85129	85220	8501
80015	80106	80199	80355	80446	85130	85221	*85100
80016	80109	8021	80356	80449	85131	85222	8501
80019	80110	80220	80359	80450	85132	85223	*85101
80020	80111	80221	80360	80451	85133	85224	8501
80021	80112	80222	80361	80452	85134	85225	*85102
80022	80113	80223	80362	80453	85135	85226	8501
80023	80114	80224	80363	80454	85136	85229	*85103
80024	80115	80225	80364	80455	85139	85230	8501
80025	80116	80226	80365	80456	85140	85231	*85104
80026	80119	80227	80366	80459	85141	85232	8501
80029	80120	80228	80369	80460	85142	85233	*85105
80030	80121	80229	80370	80461	85143	85234	8501
80031	80122	80230	80371	80462	85144	85235	*85106
80032	80123	80231	80372	80463	85145	85236	8501
80033	80124	80232	80373	80464	85146	85239	*85109
80034	80125	80233	80374	80465	85149	85240	8501
80035	80126	80234	80375	80466	85150	85241	*85110
80036	80129	80235	80376	80469	85151	85242	8501
80039	80130	80236	80379	80470	85152	85243	*85111
80040	80131	80237	80380	80471	85153	85244	8501
80041	80132	80238	80381	80472	85154	85245	*85112
80042	80133	80239	80382	80473	85155	85246	8501
80043	80134	8024	80383	80474	85156	85249	*85113
80044	80135	8025	80384	80475	85159	85250	8501
80045	80136	8026	80385	80476	85160	85251	*85114
80046	80139	8027	80386	80479	85161	85252	8501
80049	80140	8028	80389	80480	85162	85253	*85115
80050	80141	8029	80390	80481	85163	85254	8501
80051	80142	80300	80391	80482	85164	85255	*85116
80052	80143	80301	80392	80483	85165	85256	8501
80053	80144	80302	80393	80484	85166	85259	*85119
80054	80145	80303	80394	80485	85169	85300	8501
80055	80146	80304	80395	80486	85170	85301	*85120
80056	80149	80305	80396	80489	85171	85302	8501
80059	80150	80306	80399	80490	85172	85303	*85121
80060	80151	80309	80400	80491	85173	85304	8501
80061	80152	80310	80401	80492	85174	85305	*85122
80062	80153	80311	80402	80493	85175	85306	8501
80063	80154	80312	80403	80494	85176	85309	*85123
80064	80155	80313	80404	80495	85179	85310	8501
80065	80156	80314	80405	80496	85180	85311	*85124
80066	80159	80315	80406	80499	85181	85312	8501
80069	80160	80316	80409	8500	85182	85313	*85125
80070	80161	80319	80410	8501	85183	85314	8501
80071	80162	80320	80411	8502	85184	85315	*85126
80072	80163	80321	80412	8503	85185	85316	8501
80073	80164	80322	80413	8504	85186	85319	*85129
80074	80165	80323	80414	8505	85189	85400	8501
80075	80166	80324	80415	8509	85190	85401	*85130
80076	80169	80325	80416	85100	85191	85402	8501
80079	80170	80326	80419	85101	85192	85403	*85131
80080	80171	80329	80420	85102	85193	85404	8501
80081	80172	80330	80421	85103	85194	85405	*85132
80082	80173	80331	80422	85104	85195	85406	8501
80083	80174	80332	80423	85105	85196	85409	*85133
80084	80175	80333	80424	85106	85199	85410	8501
80085	80176	80334	80425	85109	85200	85411	*85134
80086	80179	80335	80426	85110	85201	85412	8501
80089	80180	80336	80429	85111	85202	85413	*85135
80090	80181	80339	80430	85112	85203	85414	8501
80091	80182	80340	80431	85113	85204	85415	*85136
80092	80183	80341	80432	85114	85205	85416	8501
80093	80184	80342	80433	85115	85206	85419	*85139

TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

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

80094	80185	80343	80434	85116	85209	*8502	8501
80095	80186	80344	80435	85119	85210	8501	*85140
80096	80189	80345	80436	85120	85211	*8503	8501
80099	80190	80346	80439	85121	85212	8501	*85141
80100	80191	80349	80440	85122	85213	*8504	8501
80101	80192	80350	80441	85123	85214	8501	*85142
80102	80193	80351	80442	85124	85215	*8505	8501
80103	80194	80352	80443	85125	85216	8501	*85143
8501	*85190	8501	*85402	8054	95215		
*85144	8501	*85236	8501	8055	95216		
8501	*85191	8501	*85403	8056	95217		
*85145	8501	*85239	8501	8057	95218		
8501	*85192	8501	*85404	8058	95219		
*85146	8501	*85240	8501	8059	9522		
8501	*85193	8501	*85405	80600	9523		
*85149	8501	*85241	8501	80601	9524		
8501	*85194	8501	*85406	80602	9528		
*85150	8501	*85242	8501	80603	9529		
8501	*85195	8501	*85409	80604	*9598		
*85151	8501	*85243	8501	80605	8501		
8501	*85196	8501	*85410	80606	*9599		
*85152	8501	*85244	8501	80607	8501		
8501	*85199	8501	*85411	80608	*99680		
*85153	8501	*85245	8501	80609	V432		
8501	*85200	8501	*85412	80610	*99683		
*85154	8501	*85246	8501	80611	V432		
8501	*85201	8501	*85413	80612	*99687		
*85155	8501	*85249	8501	80613	V432		
8501	*85202	8501	*85414	80614	*V421		
*85156	8501	*85250	8501	80615	V432		
8501	*85203	8501	*85415	80616	*V432		
*85159	8501	*85251	8501	80617	V432		
8501	*85204	8501	*85416	80618			
*85160	8501	*85252	8501	80619			
8501	*85205	8501	*85419	80620			
*85161	8501	*85253	8501	80621			
8501	*85206	8501	*8738	80622			
*85162	8501	*85254	8501	80623			
8501	*85209	8501	*8739	80624			
*85163	8501	*85255	8501	80625			
8501	*85210	8501	*8798	80626			
*85164	8501	*85256	8501	80627			
8501	*85211	8501	*8799	80628			
*85165	8501	*85259	8501	80629			
8501	*85212	8501	*9050	80630			
*85166	8501	*85300	8501	80631			
8501	*85213	8501	*9251	80632			
*85169	8501	*85301	8501	80633			
8501	*85214	8501	*9252	80634			
*85170	8501	*85302	8501	80635			
8501	*85215	8501	*9290	80636			
*85171	8501	*85303	8501	80637			
8501	*85216	8501	*9299	80638			
*85172	8501	*85304	8501	80639			
8501	*85219	8501	*9588	8064			
*85173	8501	*85305	8501	8065			
8501	*85221	8501	*95901	80660			
*85174	8501	*85306	8501	80661			
8501	*85222	8501	*95909	80662			
*85175	8501	*85309	8501	80669			
8501	*85223	8501	*9591	80670			
*85176	8501	*85310	80500	80671			
8501	*85224	8501	80501	80672			
*85179	8501	*85311	80502	80679			
8501	*85225	8501	80503	8068			
*85180	8501	*85312	80504	8069			
8501	*85226	8501	80505	95200			
*85181	8501	*85313	80506	95201			
8501	*85229	8501	80507	95202			
*85182	8501	*85314	80508	95203			
8501	*85230	8501	80510	95204			
*85183	8501	*85315	80511	95205			

TABLE 6H.—DELETIONS FROM THE CC EXCLUSIONS LIST—Continued

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

8501	*85231	8501	80512	95206
*85184	8501	*85316	80513	95207
8501	*85232	8501	80514	95208
*85185	8501	*85319	80515	95209
8501	*85233	8501	80516	95210
*85186	8501	*85400	80517	95211
8501	*85234	8501	80518	95212
*85189	8501	*85401	8052	95213
8501	*85235	8501	8053	95214

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY [FY 2002 MEDPAR UPDATE DECEMBER 2002 GROUPER V20.0]

DRG	Number of discharges	Arithmetic mean length of stay	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
1	29,262	10.8505	3	5	8	14	22
2	14,769	5.0718	1	2	4	7	10
3	3	6.0000	1	1	4	13	13
4	6,712	7.3524	1	2	5	9	16
5	95,618	2.9596	1	1	2	3	7
6	356	3.0197	1	1	2	4	7
7	14,683	9.8438	2	4	7	12	20
8	4,106	2.8015	1	1	1	3	7
9	1,711	6.2402	1	3	5	8	12
10	18,655	6.3850	2	3	5	8	13
11	3,291	4.0413	1	2	3	5	8
12	52,512	5.7513	2	3	4	7	11
13	7,068	5.0035	2	3	4	6	9
14	237,027	5.9456	2	3	5	7	11
15	94,223	4.8529	2	3	4	6	9
16	9,938	6.3106	2	3	5	8	12
17	2,744	3.2172	1	2	2	4	6
18	29,701	5.4868	2	3	4	7	10
19	8,519	3.5184	1	2	3	5	7
20	6,207	10.1927	3	5	8	13	20
21	1,885	6.5963	2	3	5	9	13
22	2,785	5.1178	2	2	4	6	10
23	12,583	4.1677	1	2	3	5	8
24	59,102	4.8803	1	2	4	6	10
25	27,433	3.1776	1	2	3	4	6
26	18	4.2778	1	1	2	3	4
27	4,398	5.1719	1	1	3	7	11
28	13,919	6.0265	1	3	5	8	12
29	5,282	3.4924	1	2	3	5	7
30	2	6.5000	2	2	11	11	11
31	3,897	4.0429	1	2	3	5	8
32	1,895	2.4776	1	1	2	3	5
34	23,811	4.9368	1	2	4	6	9
35	7,451	3.1094	1	1	3	4	6
36	2,117	1.5328	1	1	1	1	2
37	1,382	3.7685	1	1	2	5	8
38	,97	2.8041	1	1	1	4	5
39	559	2.1163	1	1	1	2	4
40	1,549	3.8070	1	1	3	5	7
42	1,581	2.7381	1	1	1	3	6
43	94	3.3936	1	1	3	4	6
44	1,227	4.9935	2	3	4	6	9
45	2,668	3.1267	1	2	3	4	6
46	3,482	4.4730	1	2	3	6	8
47	1,402	3.0927	1	1	2	4	6
49	2,391	4.4676	1	2	3	6	9
50	2,429	1.8506	1	1	1	2	3
51	243	2.8354	1	1	1	3	8
52	223	1.8161	1	1	1	2	3
53	2,478	3.6186	1	1	2	4	8
55	1,481	2.9338	1	1	1	3	7
56	469	2.8955	1	1	1	3	6
57	711	3.6709	1	1	2	4	8
58	1	2.0000	2	2	2	2	2

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY [FY 2002 MEDPAR UPDATE DECEMBER 2002 GROUPER V20.0]—Continued

DRG	Number of discharges	Arithmetic mean length of stay	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
59	116	2.6724	1	1	1	3	6
60	1	3.0000	3	3	3	3	3
61	254	5.1535	1	1	3	7	11
62	2	7.0000	1	1	13	13	13
63	3,000	4.3860	1	2	3	5	9
64	3,126	6.4997	1	2	4	8	14
65	40,407	2.8127	1	1	2	4	5
66	7,841	3.0778	1	1	2	4	6
67	385	3.6442	1	2	3	5	7
68	11,658	3.8813	1	2	3	5	7
69	3,769	3.0186	1	2	3	4	5
70	30	2.3333	1	1	2	3	4
71	80	3.4000	1	1	2	4	6
72	964	3.4035	1	1	3	4	6
73	7,697	4.4433	1	2	3	6	9
75	43,504	9.9907	3	5	7	12	20
76	44,508	11.1024	3	5	9	14	21
77	2,458	4.8031	1	2	4	7	10
78	39,504	6.5709	3	4	6	8	11
79	169,239	8.4557	3	4	7	11	16
80	8,077	5.3480	2	3	4	7	10
81	5	4.4000	1	1	3	8	8
82	64,299	6.8753	2	3	5	9	14
83	6,665	5.3655	2	3	4	7	10
84	1,575	3.2565	1	2	3	4	6
85	22,398	6.2473	2	3	5	8	12
86	2,250	3.5364	1	2	3	4	7
87	61,129	6.3127	1	3	5	8	12
88	404,045	5.0463	2	3	4	6	9
89	535,162	5.8340	2	3	5	7	11
90	48,843	3.9563	2	2	3	5	7
91	45	5.0444	1	2	3	5	13
92	15,809	6.2907	2	3	5	8	12
93	1,778	4.0079	1	2	3	5	7
94	12,813	6.2387	2	3	5	8	12
95	1,655	3.8127	1	2	3	5	7
96	56,893	4.5613	2	2	4	6	8
97	28,776	3.5275	1	2	3	4	6
98	9	3.6667	1	1	2	2	5
99	21,400	3.1554	1	1	2	4	6
100	8,324	2.1371	1	1	2	3	4
101	22,329	4.3853	1	2	3	6	9
102	5,644	2.6487	1	1	2	3	5
103	484	42.1240	9	12	23	53	92
104	20,637	14.3306	6	8	12	17	25
105	29,223	9.8741	4	6	8	11	18
106	3,498	11.4019	5	7	10	14	20
107	83,307	10.4339	5	7	9	12	17
108	6,508	9.7617	2	5	8	12	18
109	57,450	7.7160	4	5	6	9	13
110	54,835	8.7534	2	4	7	11	17
111	9,568	4.0565	1	2	4	6	7
113	39,734	12.4805	4	6	9	15	24
114	8,315	8.6592	2	4	7	11	17
115	19,805	7.4228	1	3	6	10	15
116	116,294	4.3974	1	2	3	6	9
117	4,731	4.3075	1	1	2	5	10
118	8,299	2.8976	1	1	1	4	7
119	1,237	5.2967	1	1	3	7	13
120	38,109	9.0051	1	3	6	12	20
121	164,425	6.2836	2	3	5	8	12
122	77,231	3.5159	1	2	3	5	7
123	38,627	4.7915	1	1	3	6	11
124	135,291	4.3838	1	2	3	6	9
125	91,946	2.7616	1	1	2	4	5
126	5,395	11.5218	3	6	9	15	22
127	676,101	5.2357	2	3	4	7	10
128	7,187	5.4446	2	3	5	7	9
129	3,853	2.5951	1	1	1	3	6

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY [FY 2002 MEDPAR UPDATE DECEMBER 2002 GROUPER V20.0]—Continued

DRG	Number of discharges	Arithmetic mean length of stay	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
130	88,911	5.5991	2	3	5	7	10
131	27,124	4.0330	1	2	4	5	7
132	142,443	2.8904	1	1	2	4	5
133	8,694	2.2843	1	1	2	3	4
134	41,542	3.1609	1	2	2	4	6
135	7,810	4.4540	1	2	3	5	8
136	1,185	2.6641	1	1	2	3	5
138	208,716	3.9930	1	2	3	5	8
139	87,938	2.4733	1	1	2	3	5
140	55,735	2.5252	1	1	2	3	5
141	108,834	3.5704	1	2	3	4	7
142	52,684	2.5530	1	1	2	3	5
143	250,177	2.0911	1	1	2	3	4
144	94,588	5.5436	1	2	4	7	11
145	7,370	2.5700	1	1	2	3	5
146	10,785	10.2338	5	6	8	12	17
147	2,644	6.2266	3	5	6	8	9
148	134,125	12.2751	5	7	10	15	22
149	20,205	6.3062	4	5	6	7	9
150	21,184	11.3235	4	6	9	14	20
151	5,140	5.5586	2	3	5	7	10
152	4,578	8.3724	3	5	7	10	15
153	2,058	5.2546	3	4	5	7	8
154	28,368	13.2140	3	7	10	17	26
155	6,618	4.0801	1	2	3	6	8
156	4	2.5000	1	1	1	3	5
157	8,301	5.7459	1	2	4	7	12
158	4,362	2.6016	1	1	2	3	5
159	18,136	5.1194	1	2	4	7	10
160	12,203	2.6826	1	1	2	3	5
161	10,803	4.3270	1	2	3	6	9
162	6,421	1.9305	1	1	1	2	4
163	8	3.2500	1	1	2	3	6
164	5,400	8.3580	3	5	7	10	15
165	2,335	4.4882	2	3	4	6	7
166	4,206	4.7263	1	2	4	6	9
167	4,091	2.4133	1	1	2	3	4
168	1,425	4.8386	1	2	3	6	10
169	814	2.4005	1	1	2	3	5
170	15,682	10.8241	2	4	8	14	22
171	1,530	4.3333	1	2	4	6	9
172	31,435	6.9669	2	3	5	9	14
173	2,482	3.7808	1	2	3	5	8
174	252,303	4.7834	2	3	4	6	9
175	34,977	2.9157	1	2	3	4	5
176	13,498	5.2318	2	3	4	6	10
177	9,080	4.5719	2	3	4	6	8
178	3,382	3.1227	1	2	3	4	6
179	13,193	5.9431	2	3	5	7	11
180	90,752	5.4251	2	3	4	7	10
181	27,280	3.3710	1	2	3	4	6
182	273,118	4.4204	1	2	3	5	8
183	91,272	2.8962	1	1	2	4	5
184	69	3.2319	1	1	2	4	6
185	5,350	4.6680	1	2	3	6	10
186	6	6.6667	2	3	3	10	10
187	619	4.0307	1	2	3	6	8
188	84,099	5.5620	1	2	4	7	11
189	13,098	3.1005	1	1	2	4	6
190	75	5.1733	1	2	4	6	11
191	9,537	13.7975	3	6	10	17	28
192	1,322	6.2201	1	3	6	8	11
193	4,822	12.7242	5	7	10	16	23
194	650	6.7323	2	4	6	8	12
195	4,019	10.5175	4	6	9	13	19
196	998	5.6092	2	3	5	7	10
197	18,313	9.1566	3	5	7	11	17
198	5,418	4.4118	2	3	4	6	7
199	1,636	9.7353	2	4	7	13	21

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY [FY 2002 MEDPAR UPDATE DECEMBER 2002 GROUPER V20.0]—Continued

DRG	Number of discharges	Arithmetic mean length of stay	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
200	1,076	10.4898	2	3	7	14	23
201	2,130	14.1469	3	6	11	18	29
202	26,756	6.3872	2	3	5	8	13
203	30,055	6.6816	2	3	5	9	13
204	65,585	5.7470	2	3	4	7	11
205	27,481	6.1736	2	3	5	8	12
206	2,057	3.7832	1	2	3	5	8
207	32,881	5.1924	1	2	4	7	10
208	10,188	2.8924	1	1	2	4	5
209	399,893	4.8600	3	3	4	5	7
210	122,843	6.8859	3	4	6	8	11
211	30,096	4.8394	3	4	4	6	7
212	9	7.0000	1	1	4	5	7
213	9,950	9.2035	2	4	7	12	18
216	8,770	7.9789	1	2	6	11	17
217	17,292	13.3846	3	5	9	16	28
218	23,796	5.5121	2	3	4	7	10
219	19,891	3.1961	1	2	3	4	6
220	1	1.0000	1	1	1	1	1
223	13,308	3.0326	1	1	2	4	6
224	11,738	1.9052	1	1	1	2	3
225	6,481	5.2626	1	2	4	7	11
226	5,874	6.5259	1	2	4	8	14
227	4,854	2.6360	1	1	2	3	5
228	2,534	4.1492	1	1	3	5	9
229	1,263	2.3286	1	1	2	3	5
230	2,456	5.5668	1	2	3	7	12
231	13,312	5.0159	1	1	3	6	11
232	816	2.7132	1	1	1	2	6
233	9,940	7.3671	1	3	6	10	15
234	5,364	3.0626	1	1	2	4	7
235	5,107	4.8659	1	2	4	6	9
236	40,182	4.6505	1	3	4	6	8
237	1,782	3.6599	1	2	3	5	7
238	8,956	8.6382	3	4	7	10	17
239	46,252	6.2694	2	3	5	8	12
240	12,062	6.6231	2	3	5	8	13
241	3,173	3.7690	1	2	3	5	7
242	2,597	6.8814	2	3	5	9	14
243	96,552	4.6506	1	2	4	6	9
244	14,695	4.6521	1	2	4	6	9
245	5,861	3.2950	1	2	3	4	6
246	1,498	3.7216	1	2	3	5	7
247	20,507	3.3340	1	1	3	4	7
248	13,931	4.9200	1	3	4	6	9
249	12,932	3.6170	1	1	2	4	7
250	3,802	4.1302	1	2	3	5	8
251	2,375	2.7651	1	1	3	3	5
253	22,095	4.6939	2	3	4	6	8
254	10,763	3.1601	1	2	3	4	5
256	6,698	5.1020	1	2	4	6	10
257	15,758	2.6395	1	1	2	3	5
258	15,317	1.8212	1	1	2	2	3
259	3,517	2.6747	1	1	1	3	6
260	4,236	1.3973	1	1	1	1	2
261	1,776	2.0884	1	1	1	2	4
262	668	4.3204	1	1	3	6	9
263	23,192	11.4687	3	5	8	14	22
264	3,869	6.5585	2	3	5	8	13
265	4,103	6.6074	1	2	4	8	14
266	2,555	3.2337	1	1	2	4	7
267	241	4.4606	1	1	3	6	10
268	920	3.7978	1	1	2	4	8
269	9,852	8.5323	2	3	7	11	17
270	2,798	3.5615	1	1	2	5	7
271	19,436	7.2481	2	4	6	9	14
272	5,752	6.0176	2	3	5	7	12
273	1,343	3.9598	1	2	3	5	8
274	2,305	6.4586	1	3	5	8	13

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY [FY 2002 MEDPAR UPDATE DECEMBER 2002 GROUPER V20.0]—Continued

DRG	Number of discharges	Arithmetic mean length of stay	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
275	230	3.6217	1	1	2	4	7
276	1,327	4.4574	1	2	4	6	8
277	100,811	5.7271	2	3	5	7	10
278	32,531	4.1962	2	2	4	5	7
279	10	5.3000	2	2	3	7	7
280	17,882	4.1159	1	2	3	5	8
281	7,536	2.8879	1	1	2	4	5
283	6,093	4.6606	1	2	4	6	9
284	2,029	2.9359	1	1	2	4	6
285	6,962	10.5315	3	5	8	13	20
286	2,502	5.8981	2	3	4	7	12
287	6,287	10.2537	3	5	8	13	20
288	5,524	4.9716	2	3	4	5	8
289	6,938	2.7257	1	1	1	2	6
290	9,964	2.1995	1	1	1	2	4
291	58	1.6379	1	1	1	2	3
292	6,534	10.4645	2	4	8	14	21
293	364	4.7033	1	1	3	6	9
294	98,755	4.5121	1	2	3	6	9
295	3,550	3.9721	1	2	3	5	7
296	280,547	5.0716	1	2	4	6	10
297	48,715	3.2855	1	2	3	4	6
298	111	3.1802	1	1	2	4	7
299	1,276	5.4412	1	2	4	7	11
300	18,798	6.1364	2	3	5	8	12
301	3,636	3.5954	1	2	3	4	7
302	8,722	8.5255	4	5	6	9	15
303	21,880	8.0372	3	4	6	9	15
304	12,572	8.8705	2	4	6	11	18
305	3,047	3.5510	1	2	3	4	7
306	7,077	5.3740	1	2	3	7	12
307	2,035	2.0708	1	1	2	2	3
308	7,299	6.2077	1	2	4	8	14
309	4,183	2.0995	1	1	1	2	4
310	24,884	4.3725	1	1	3	6	10
311	7,495	1.8220	1	1	1	2	3
312	1,524	4.5623	1	1	3	6	10
313	555	2.2559	1	1	1	3	5
314	2	40.5000	1	1	80	80	80
315	34,134	6.9586	1	1	4	9	16
316	119,645	6.5348	2	3	5	8	13
317	2,018	3.6051	1	1	2	4	7
318	5,782	6.0930	1	3	5	8	12
319	412	2.9320	1	1	2	4	6
320	188,165	5.2818	2	3	4	6	10
321	31,355	3.7221	1	2	3	5	7
322	50	3.2200	1	2	3	4	5
323	19,957	3.1681	1	1	2	4	6
324	7,040	1.9006	1	1	1	2	4
325	9,310	3.8056	1	2	3	5	7
326	2,732	2.6190	1	1	2	3	5
327	7	2.5714	1	1	2	3	4
328	742	3.7251	1	1	3	5	8
329	94	2.0851	1	1	1	3	5
331	51,439	5.5878	1	3	4	7	11
332	5,006	3.1596	1	1	2	4	6
333	255	5.7843	1	2	3	7	11
334	10,536	4.5813	2	3	4	5	8
335	12,727	3.0264	2	2	3	4	5
336	35,950	3.3945	1	2	2	4	7
337	29,532	2.0157	1	1	2	2	3
338	940	5.4851	1	2	3	7	13
339	1,481	4.7968	1	1	3	6	11
340	1	2.0000	2	2	2	2	2
341	3,580	3.2031	1	1	2	3	7
342	693	3.1977	1	1	2	4	7
344	3,580	2.5232	1	1	1	2	5
345	1,370	4.9051	1	1	3	6	11
346	4,890	5.8937	2	3	5	8	12

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY [FY 2002 MEDPAR UPDATE DECEMBER 2002 GROUPER V20.0]—Continued

DRG	Number of discharges	Arithmetic mean length of stay	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
347	315	3.0762	1	1	2	4	7
348	3,401	4.3355	1	2	3	5	8
349	616	2.5049	1	1	2	3	5
350	6,748	4.4884	2	2	4	6	8
352	960	3.9740	1	2	3	5	7
353	2,600	6.4942	2	3	5	7	12
354	7,444	5.7016	3	3	4	6	10
355	5,590	3.1971	2	2	3	4	5
356	25,990	2.0785	1	1	2	3	3
357	5,663	8.3744	3	4	6	10	16
358	21,660	4.1750	2	2	3	5	7
359	32,036	2.5609	1	2	2	3	4
360	15,871	2.7521	1	1	2	3	4
361	346	3.2052	1	1	2	3	8
362	5	1.4000	1	1	1	2	2
363	2,527	3.6312	1	2	2	4	8
364	1,637	4.1307	1	1	3	5	8
365	1,843	8.1872	1	3	5	10	17
366	4,581	6.6619	1	3	5	8	14
367	487	3.0678	1	1	2	4	7
368	3,572	6.6551	2	3	5	8	13
369	3,482	3.3090	1	1	2	4	7
370	1,350	5.7911	2	3	4	5	9
371	1,691	3.4826	2	3	3	4	5
372	947	3.4805	2	2	2	3	5
373	4,145	2.2955	1	2	2	3	3
374	91	2.9341	1	2	2	3	6
376	325	3.4123	1	2	2	4	7
377	48	4.0833	1	2	3	5	8
378	175	2.5943	1	1	2	3	5
379	355	3.0028	1	1	2	3	5
380	99	1.9697	1	1	1	2	3
381	190	1.9053	1	1	1	2	4
382	49	1.6939	1	1	1	2	3
383	2,003	3.7913	1	1	3	4	7
384	129	2.6279	1	1	2	3	5
385	3	2.0000	1	1	2	3	3
387	1	55.0000	55	55	55	55	55
389	12	6.2500	2	3	5	9	10
390	20	4.3000	1	2	3	5	7
392	2,271	9.6874	3	4	7	12	21
393	1	4.0000	4	4	4	4	4
394	2,605	7.5965	1	2	5	9	17
395	108,024	4.3238	1	2	3	5	9
396	17	4.4118	1	1	3	7	9
397	19,035	5.1743	1	2	4	6	10
398	18,162	5.8655	2	3	5	7	11
399	1,693	3.4826	1	2	3	4	6
400	6,371	9.0333	1	3	6	12	21
401	5,845	11.5341	2	5	9	15	23
402	1,478	3.9831	1	1	3	5	9
403	31,947	8.1013	2	3	6	10	17
404	4,350	4.1069	1	2	3	5	8
405	1	31.0000	31	31	31	31	31
406	2,444	9.6579	2	4	7	12	20
407	643	4.0560	1	2	3	5	7
408	2,134	8.2291	1	2	5	10	20
409	2,154	6.1565	2	3	4	6	12
410	28,484	4.0951	1	2	4	5	6
411	7	2.2857	1	1	2	2	4
412	16	3.8125	1	1	3	6	7
413	5,349	7.0501	2	3	5	9	14
414	633	4.2354	1	2	3	5	8
415	43,349	14.3233	4	6	11	18	28
416	192,908	7.4362	2	4	6	9	14
417	38	5.8421	2	3	5	7	12
418	25,920	6.2986	2	3	5	8	12
419	16,446	4.5517	1	2	4	6	9
420	3,220	3.4202	1	2	3	4	6

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY [FY 2002 MEDPAR UPDATE DECEMBER 2002 GROUPER V20.0]—Continued

DRG	Number of discharges	Arithmetic mean length of stay	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
421	10,745	4.0624	1	2	3	5	8
422	66	3.6970	1	2	2	4	6
423	8,116	8.3228	2	3	6	10	17
424	1,236	12.7929	2	4	9	15	26
425	16,189	3.7961	1	2	3	5	8
426	4,589	4.4655	1	2	3	6	9
427	1,596	4.3784	1	2	3	5	9
428	796	7.1382	1	2	5	8	14
429	25,933	6.0111	2	3	4	7	11
430	65,276	7.8291	2	3	6	10	16
431	314	6.8248	1	2	4	7	12
432	451	4.0111	1	2	3	4	7
433	5,554	3.1300	1	1	2	4	6
439	1,520	8.1855	1	3	5	9	17
440	5,771	9.0806	2	3	6	11	19
441	677	3.1374	1	1	2	4	6
442	17,571	8.5218	1	3	6	10	18
443	3,920	3.3663	1	1	3	4	7
444	5,754	4.2011	1	2	3	5	8
445	2,546	2.8610	1	1	2	4	5
447	6,514	2.5091	1	1	2	3	5
448	1	1.0000	1	1	1	1	1
449	33,181	3.7059	1	1	3	4	7
450	7,441	1.9790	1	1	1	2	4
451	1	1.0000	1	1	1	1	1
452	25,679	4.9178	1	2	3	6	10
453	5,687	2.7579	1	1	2	3	5
454	4,792	4.2398	1	2	3	5	8
455	1,070	2.4140	1	1	2	3	5
461	5,216	3.5861	1	1	2	4	8
462	9,650	10.8636	4	6	9	14	20
463	27,061	4.0439	1	2	3	5	8
464	7,232	2.9887	1	1	2	4	6
465	200	3.9100	1	1	1	3	6
466	1,737	4.0219	1	1	2	4	7
467	1,140	3.0035	1	1	2	3	6
468	52,318	12.7674	3	6	10	16	25
471	13,363	5.3722	3	3	4	6	8
473	8,095	12.4119	2	3	7	17	32
475	109,726	11.1546	2	5	9	15	22
476	3,657	11.0941	2	5	10	15	21
477	25,400	8.1660	1	3	6	11	17
478	108,133	7.3130	1	3	5	9	15
479	24,052	3.1910	1	1	2	4	7
480	611	21.0638	6	8	12	22	47
481	865	21.7584	13	17	20	25	33
482	5,296	12.5015	4	6	9	15	24
483	45,427	39.2033	15	22	33	48	70
484	336	14.5744	2	6	11	21	28
485	3,220	9.8264	4	5	7	11	19
486	2,094	12.7612	1	6	10	17	26
487	3,731	7.1702	1	3	6	9	15
488	769	16.9129	4	7	13	22	36
489	13,373	8.5374	2	3	6	10	17
490	5,462	5.4888	1	2	4	7	11
491	15,370	3.3853	1	2	3	4	6
492	3,140	14.9239	3	5	7	25	33
493	59,615	5.9843	1	3	5	8	11
494	28,880	2.5293	1	1	2	3	5
495	192	16.4167	7	9	12	19	31
496	2,479	8.8709	3	4	6	11	18
497	22,473	6.3553	3	4	5	7	11
498	16,070	4.0191	2	3	4	5	6
499	34,688	4.5204	1	2	3	6	9
500	49,936	2.4069	1	1	2	3	4
501	2,608	10.6031	4	5	8	13	20
502	771	6.1647	3	4	5	7	11
503	5,970	3.9084	1	2	3	5	7
504	125	27.6560	7	13	21	37	55

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY [FY 2002 MEDPAR UPDATE DECEMBER 2002 GROUPER V20.0]—Continued

DRG	Number of discharges	Arithmetic mean length of stay	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
505	134	5.6567	1	1	1	5	11
506	919	16.8836	4	7	13	21	35
507	341	9.0411	2	4	7	13	19
508	631	7.8051	2	3	5	10	17
509	160	4.2688	1	2	3	5	9
510	1,651	6.7274	1	3	5	8	15
511	581	4.6076	1	1	3	6	10
512	481	13.1185	6	8	10	15	23
513	207	9.7585	5	6	8	10	15
514	26,570	6.9035	1	2	5	9	15
515	8,131	5.1646	1	1	3	7	12
516	84,846	4.6338	2	2	4	5	9
517	198,743	2.5406	1	1	1	3	5
518	56,613	3.2508	1	1	2	4	7
519	8,486	4.8547	1	1	3	6	11
520	12,687	2.0548	1	1	1	2	4
521	30,898	5.7395	2	3	4	7	11
522	6,069	9.5670	4	5	8	12	20
523	15,456	4.0538	1	2	3	5	7
524	132,651	3.3690	1	2	3	4	6
525	571	17.2907	1	4	9	18	37
	11,713,347						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—FY 2002 MEDPAR UPDATE DECEMBER 2002 GROUPER V21.0

DRG	Number of discharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	23,433	10.5551	3	5	8	14	21
2	11,715	5.2534	1	3	4	7	10
3	3	6.0000	1	1	4	13	13
6	356	3.0197	1	1	2	4	7
7	14,683	9.8438	2	4	7	12	20
8	4,106	2.8015	1	1	1	3	7
9	1,711	6.2402	1	3	5	8	12
10	18,655	6.3850	2	3	5	8	13
11	3,291	4.0413	1	2	3	5	8
12	52,512	5.7513	2	3	4	7	11
13	7,068	5.0035	2	3	4	6	9
14	237,027	5.9456	2	3	5	7	11
15	94,223	4.8529	2	3	4	6	9
16	9,938	6.3106	2	3	5	8	12
17	2,744	3.2172	1	2	2	4	6
18	29,701	5.4868	2	3	4	7	10
19	8,519	3.5184	1	2	3	5	7
20	6,207	10.1927	3	5	8	13	20
21	1,885	6.5963	2	3	5	9	13
22	2,785	5.1178	2	2	4	6	10
23	11,270	4.2627	1	2	3	5	8
24	59,102	4.8803	1	2	4	6	10
25	27,433	3.1776	1	2	3	4	6
26	18	4.2778	1	1	2	3	4
27	4,398	5.1719	1	1	3	7	11
28	13,919	6.0265	1	3	5	8	12
29	5,282	3.4924	1	2	3	5	7
30	2	6.5000	2	2	11	11	11
31	3,897	4.0429	1	2	3	5	8
32	1,895	2.4776	1	1	2	3	5
34	23,811	4.9368	1	2	4	6	9
35	7,451	3.1094	1	1	3	4	6
36	2,117	1.5328	1	1	1	1	2
37	1,382	3.7685	1	1	2	5	8
38	97	2.8041	1	1	1	4	5
39	559	2.1163	1	1	1	2	4
40	1,549	3.8070	1	1	3	5	7

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—FY 2002 MEDPAR UPDATE DECEMBER 2002 GROUPER V21.0—Continued

DRG	Number of discharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
42	1,581	2.7381	1	1	1	3	6
43	94	3.3936	1	1	3	4	6
44	1,227	4.9935	2	3	4	6	9
45	2,668	3.1267	1	2	3	4	6
46	3,482	4.4730	1	2	3	6	8
47	1,402	3.0927	1	1	2	4	6
49	2,391	4.4676	1	2	3	6	9
50	2,429	1.8506	1	1	1	2	3
51	243	2.8354	1	1	1	3	8
52	223	1.8161	1	1	1	2	3
53	2,478	3.6186	1	1	2	4	8
55	1,481	2.9338	1	1	1	3	7
56	469	2.8955	1	1	1	3	6
57	711	3.6709	1	1	2	4	8
58	1	2.0000	2	2	2	2	2
59	116	2.6724	1	1	1	3	6
60	1	3.0000	3	3	3	3	3
61	254	5.1535	1	1	3	7	11
62	2	7.0000	1	1	13	13	13
63	3,000	4.3860	1	2	3	5	9
64	3,126	6.4997	1	2	4	8	14
65	40,407	2.8127	1	1	2	4	5
66	7,841	3.0778	1	1	2	4	6
67	385	3.6442	1	2	3	5	7
68	11,658	3.8813	1	2	3	5	7
69	3,769	3.0186	1	2	3	4	5
70	30	2.3333	1	1	2	3	4
71	80	3.4000	1	1	2	4	6
72	964	3.4035	1	1	3	4	6
73	7,697	4.4433	1	2	3	6	9
75	43,504	9.9907	3	5	7	12	20
76	44,508	11.1024	3	5	9	14	21
77	2,458	4.8031	1	2	4	7	10
78	39,504	6.5709	3	4	6	8	11
79	169,239	8.4557	3	4	7	11	16
80	8,077	5.3480	2	3	4	7	10
81	5	4.4000	1	1	3	8	8
82	64,299	6.8753	2	3	5	9	14
83	6,665	5.3655	2	3	4	7	10
84	1,575	3.2565	1	2	3	4	6
85	22,398	6.2473	2	3	5	8	12
86	2,250	3.5364	1	2	3	4	7
87	61,129	6.3127	1	3	5	8	12
88	404,045	5.0463	2	3	4	6	9
89	535,162	5.8340	2	3	5	7	11
90	48,843	3.9563	2	2	3	5	7
91	45	5.0444	1	2	3	5	13
92	15,809	6.2907	2	3	5	8	12
93	1,778	4.0079	1	2	3	5	7
94	12,813	6.2387	2	3	5	8	12
95	1,655	3.8127	1	2	3	5	7
96	56,893	4.5613	2	2	4	6	8
97	28,776	3.5275	1	2	3	4	6
98	9	3.6667	1	1	2	2	5
99	21,400	3.1554	1	1	2	4	6
100	8,324	2.1371	1	1	2	3	4
101	22,329	4.3853	1	2	3	6	9
102	5,644	2.6487	1	1	2	3	5
103	484	42.1240	9	12	23	53	92
104	20,637	14.3306	6	8	12	17	25
105	29,223	9.8741	4	6	8	11	18
106	3,498	11.4019	5	7	10	14	20
107	83,307	10.4339	5	7	9	12	17
108	6,508	9.7617	2	5	8	12	18
109	57,450	7.7160	4	5	6	9	13
110	54,856	8.7568	2	4	7	11	17
111	9,569	4.0574	1	2	4	6	7
113	39,734	12.4805	4	6	9	15	24
114	8,315	8.6592	2	4	7	11	17

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—FY 2002 MEDPAR UPDATE DECEMBER 2002 GROUPER V21.0—Continued

DRG	Number of discharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
115	19,805	7.4228	1	3	6	10	15
116	116,294	4.3974	1	2	3	6	9
117	4,731	4.3075	1	1	2	5	10
118	8,299	2.8976	1	1	1	4	7
119	1,237	5.2967	1	1	3	7	13
120	38,109	9.0051	1	3	6	12	20
121	164,425	6.2836	2	3	5	8	12
122	77,231	3.5159	1	2	3	5	7
123	38,627	4.7915	1	1	3	6	11
124	135,291	4.3838	1	2	3	6	9
125	91,946	2.7616	1	1	2	4	5
126	5,395	11.5218	3	6	9	15	22
127	676,101	5.2357	2	3	4	7	10
128	7,187	5.4446	2	3	5	7	9
129	3,853	2.5951	1	1	1	3	6
130	88,911	5.5991	2	3	5	7	10
131	27,124	4.0330	1	2	4	5	7
132	142,443	2.8904	1	1	2	4	5
133	8,694	2.2843	1	1	2	3	4
134	41,542	3.1609	1	2	2	4	6
135	7,810	4.4540	1	2	3	5	8
136	1,185	2.6641	1	1	2	3	5
138	208,716	3.9930	1	2	3	5	8
139	87,938	2.4733	1	1	2	3	5
140	55,735	2.5252	1	1	2	3	5
141	108,834	3.5704	1	2	3	4	7
142	52,684	2.5530	1	1	2	3	5
143	250,177	2.0911	1	1	2	3	4
144	94,588	5.5436	1	2	4	7	11
145	7,370	2.5700	1	1	2	3	5
146	10,785	10.2338	5	6	8	12	17
147	2,644	6.2266	3	5	6	8	9
148	134,125	12.2751	5	7	10	15	22
149	20,205	6.3062	4	5	6	7	9
150	21,184	11.3235	4	6	9	14	20
151	5,140	5.5586	2	3	5	7	10
152	4,578	8.3724	3	5	7	10	15
153	2,058	5.2546	3	4	5	7	8
154	28,368	13.2140	3	7	10	17	26
155	6,618	4.0801	1	2	3	6	8
156	4	2.5000	1	1	1	3	5
157	8,301	5.7459	1	2	4	7	12
158	4,362	2.6016	1	1	2	3	5
159	18,136	5.1194	1	2	4	7	10
160	12,203	2.6826	1	1	2	3	5
161	10,803	4.3270	1	2	3	6	9
162	6,421	1.9305	1	1	1	2	4
163	8	3.2500	1	1	2	3	6
164	5,400	8.3580	3	5	7	10	15
165	2,335	4.4882	2	3	4	6	7
166	4,206	4.7263	1	2	4	6	9
167	4,091	2.4133	1	1	2	3	4
168	1,425	4.8386	1	2	3	6	10
169	814	2.4005	1	1	2	3	5
170	15,682	10.8241	2	4	8	14	22
171	1,530	4.3333	1	2	4	6	9
172	31,435	6.9669	2	3	5	9	14
173	2,482	3.7808	1	2	3	5	8
174	252,303	4.7834	2	3	4	6	9
175	34,977	2.9157	1	2	3	4	5
176	13,498	5.2318	2	3	4	6	10
177	9,080	4.5719	2	3	4	6	8
178	3,382	3.1227	1	2	3	4	6
179	13,193	5.9431	2	3	5	7	11
180	90,752	5.4251	2	3	4	7	10
181	27,280	3.3710	1	2	3	4	6
182	273,118	4.4204	1	2	3	5	8
183	91,272	2.8962	1	1	2	4	5
184	69	3.2319	1	1	2	4	6

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—FY 2002 MEDPAR UPDATE DECEMBER 2002 GROUPER V21.0—Continued

DRG	Number of discharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
185	5,350	4.6680	1	2	3	6	10
186	6	6.6667	2	3	3	10	10
187	619	4.0307	1	2	3	6	8
188	84,099	5.5620	1	2	4	7	11
189	13,098	3.1005	1	1	2	4	6
190	75	5.1733	1	2	4	6	11
191	9,537	13.7975	3	6	10	17	28
192	1,322	6.2201	1	3	6	8	11
193	4,822	12.7242	5	7	10	16	23
194	650	6.7323	2	4	6	8	12
195	4,019	10.5175	4	6	9	13	19
196	998	5.6092	2	3	5	7	10
197	18,313	9.1566	3	5	7	11	17
198	5,418	4.4118	2	3	4	6	7
199	1,636	9.7353	2	4	7	13	21
200	1,076	10.4898	2	3	7	14	23
201	2,130	14.1469	3	6	11	18	29
202	26,756	6.3872	2	3	5	8	13
203	30,055	6.6816	2	3	5	9	13
204	65,585	5.7470	2	3	4	7	11
205	27,481	6.1736	2	3	5	8	12
206	2,057	3.7832	1	2	3	5	8
207	32,881	5.1924	1	2	4	7	10
208	10,188	2.8924	1	1	2	4	5
209	399,893	4.8600	3	3	4	5	7
210	122,843	6.8859	3	4	6	8	11
211	30,096	4.8394	3	4	4	6	7
212	9	7.0000	1	1	4	5	7
213	9,950	9.2035	2	4	7	12	18
216	8,770	7.9789	1	2	6	11	17
217	17,292	13.3846	3	5	9	16	28
218	23,796	5.5121	2	3	4	7	10
219	19,891	3.1961	1	2	3	4	6
220	1	1.0000	1	1	1	1	1
223	13,308	3.0326	1	1	2	4	6
224	11,738	1.9052	1	1	1	2	3
225	6,481	5.2626	1	2	4	7	11
226	5,874	6.5259	1	2	4	8	14
227	4,854	2.6360	1	1	2	3	5
228	2,534	4.1492	1	1	3	5	9
229	1,263	2.3286	1	1	2	3	5
230	2,456	5.5668	1	2	3	7	12
232	816	2.7132	1	1	1	2	6
233	9,940	7.3671	1	3	6	10	15
234	5,364	3.0626	1	1	2	4	7
235	5,107	4.8659	1	2	4	6	9
236	40,182	4.6505	1	3	4	6	8
237	1,782	3.6599	1	2	3	5	7
238	8,956	8.6382	3	4	7	10	17
239	46,252	6.2694	2	3	5	8	12
240	12,062	6.6231	2	3	5	8	13
241	3,173	3.7690	1	2	3	5	7
242	2,597	6.8814	2	3	5	9	14
243	96,552	4.6506	1	2	4	6	9
244	14,695	4.6521	1	2	4	6	9
245	5,861	3.2950	1	2	3	4	6
246	1,498	3.7216	1	2	3	5	7
247	20,507	3.3340	1	1	3	4	7
248	13,931	4.9200	1	3	4	6	9
249	12,932	3.6170	1	1	2	4	7
250	3,802	4.1302	1	2	3	5	8
251	2,375	2.7651	1	1	3	3	5
253	22,095	4.6939	2	3	4	6	8
254	10,763	3.1601	1	2	3	4	5
256	6,714	5.1008	1	2	4	6	10
257	15,758	2.6395	1	1	2	3	5
258	15,317	1.8212	1	1	2	2	3
259	3,517	2.6747	1	1	1	3	6
260	4,236	1.3973	1	1	1	1	2

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—FY 2002 MEDPAR UPDATE DECEMBER 2002 GROUPER V21.0—Continued

DRG	Number of discharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
261	1,776	2.0884	1	1	1	2	4
262	668	4.3204	1	1	3	6	9
263	23,192	11.4687	3	5	8	14	22
264	3,869	6.5585	2	3	5	8	13
265	4,103	6.6074	1	2	4	8	14
266	2,555	3.2337	1	1	2	4	7
267	241	4.4606	1	1	3	6	10
268	920	3.7978	1	1	2	4	8
269	9,852	8.5323	2	3	7	11	17
270	2,798	3.5615	1	1	2	5	7
271	19,436	7.2481	2	4	6	9	14
272	5,752	6.0176	2	3	5	7	12
273	1,343	3.9598	1	2	3	5	8
274	2,305	6.4586	1	3	5	8	13
275	230	3.6217	1	1	2	4	7
276	1,327	4.4574	1	2	4	6	8
277	100,811	5.7271	2	3	5	7	10
278	32,531	4.1962	2	2	4	5	7
279	10	5.3000	2	2	3	7	7
280	17,882	4.1159	1	2	3	5	8
281	7,536	2.8879	1	1	2	4	5
283	6,093	4.6606	1	2	4	6	9
284	2,029	2.9359	1	1	2	4	6
285	6,962	10.5315	3	5	8	13	20
286	2,502	5.8981	2	3	4	7	12
287	6,287	10.2537	3	5	8	13	20
288	5,524	4.9716	2	3	4	5	8
289	6,938	2.7257	1	1	1	2	6
290	9,964	2.1995	1	1	1	2	4
291	58	1.6379	1	1	1	2	3
292	6,534	10.4645	2	4	8	14	21
293	364	4.7033	1	1	3	6	9
294	98,755	4.5121	1	2	3	6	9
295	3,550	3.9721	1	2	3	5	7
296	280,547	5.0716	1	2	4	6	10
297	48,715	3.2855	1	2	3	4	6
298	111	3.1802	1	1	2	4	7
299	1,276	5.4412	1	2	4	7	11
300	18,798	6.1364	2	3	5	8	12
301	3,636	3.5954	1	2	3	4	7
302	8,722	8.5255	4	5	6	9	15
303	21,880	8.0372	3	4	6	9	15
304	12,572	8.8705	2	4	6	11	18
305	3,047	3.5510	1	2	3	4	7
306	7,077	5.3740	1	2	3	7	12
307	2,035	2.0708	1	1	2	2	3
308	7,299	6.2077	1	2	4	8	14
309	4,183	2.0995	1	1	1	2	4
310	24,884	4.3725	1	1	3	6	10
311	7,495	1.8220	1	1	1	2	3
312	1,524	4.5623	1	1	3	6	10
313	555	2.2559	1	1	1	3	5
314	2	40.5000	1	1	80	80	80
315	34,134	6.9586	1	1	4	9	16
316	119,645	6.5348	2	3	5	8	13
317	2,018	3.6051	1	1	2	4	7
318	5,782	6.0930	1	3	5	8	12
319	412	2.9320	1	1	2	4	6
320	188,165	5.2818	2	3	4	6	10
321	31,355	3.7221	1	2	3	5	7
322	50	3.2200	1	2	3	4	5
323	19,957	3.1681	1	1	2	4	6
324	7,040	1.9006	1	1	1	2	4
325	9,310	3.8056	1	2	3	5	7
326	2,732	2.6190	1	1	2	3	5
327	7	2.5714	1	1	2	3	4
328	742	3.7251	1	1	3	5	8
329	94	2.0851	1	1	1	3	5
331	51,439	5.5878	1	3	4	7	11

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—FY 2002 MEDPAR UPDATE DECEMBER 2002 GROUPER V21.0—Continued

DRG	Number of discharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
332	5,006	3.1596	1	1	2	4	6
333	255	5.7843	1	2	3	7	11
334	10,536	4.5813	2	3	4	5	8
335	12,727	3.0264	2	2	3	4	5
336	35,950	3.3945	1	2	2	4	7
337	29,532	2.0157	1	1	2	2	3
338	940	5.4851	1	2	3	7	13
339	1,481	4.7968	1	1	3	6	11
340	1	2.0000	2	2	2	2	2
341	3,580	3.2031	1	1	2	3	7
342	693	3.1977	1	1	2	4	7
344	3,580	2.5232	1	1	1	2	5
345	1,370	4.9051	1	1	3	6	11
346	4,890	5.8937	2	3	5	8	12
347	315	3.0762	1	1	2	4	7
348	3,401	4.3355	1	2	3	5	8
349	616	2.5049	1	1	2	3	5
350	6,748	4.4884	2	2	4	6	8
352	960	3.9740	1	2	3	5	7
353	2,600	6.4942	2	3	5	7	12
354	7,444	5.7016	3	3	4	6	10
355	5,590	3.1971	2	2	3	4	5
356	25,990	2.0785	1	1	2	3	3
357	5,663	8.3744	3	4	6	10	16
358	21,660	4.1750	2	2	3	5	7
359	32,036	2.5609	1	2	2	3	4
360	15,871	2.7521	1	1	2	3	4
361	346	3.2052	1	1	2	3	8
362	5	1.4000	1	1	1	2	2
363	2,527	3.6312	1	2	2	4	8
364	1,637	4.1307	1	1	3	5	8
365	1,843	8.1872	1	3	5	10	17
366	4,581	6.6619	1	3	5	8	14
367	487	3.0678	1	1	2	4	7
368	3,572	6.6551	2	3	5	8	13
369	3,482	3.3090	1	1	2	4	7
370	1,350	5.7911	2	3	4	5	9
371	1,691	3.4826	2	3	3	4	5
372	947	3.4805	2	2	2	3	5
373	4,145	2.2955	1	2	2	3	3
374	91	2.9341	1	2	2	3	6
376	325	3.4123	1	2	2	4	7
377	48	4.0833	1	2	3	5	8
378	175	2.5943	1	1	2	3	5
379	355	3.0028	1	1	2	3	5
380	99	1.9697	1	1	1	2	3
381	190	1.9053	1	1	1	2	4
382	49	1.6939	1	1	1	2	3
383	2,003	3.7913	1	1	3	4	7
384	129	2.6279	1	1	2	3	5
385	3	2.0000	1	1	2	3	3
387	1	55.0000	55	55	55	55	55
389	12	6.2500	2	3	5	9	10
392	2,271	9.6874	3	4	7	12	21
393	1	4.0000	4	4	4	4	4
394	2,605	7.5965	1	2	5	9	17
395	108,024	4.3238	1	2	3	5	9
396	17	4.4118	1	1	3	7	9
397	19,035	5.1743	1	2	4	6	10
398	18,162	5.8655	2	3	5	7	11
399	1,693	3.4826	1	2	3	4	6
401	5,845	11.5341	2	5	9	15	23
402	1,478	3.9831	1	1	3	5	9
403	31,947	8.1013	2	3	6	10	17
404	4,350	4.1069	1	2	3	5	8
405	1	31.0000	31	31	31	31	31
406	2,444	9.6579	2	4	7	12	20
407	643	4.0560	1	2	3	5	7
408	2,134	8.2291	1	2	5	10	20

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—FY 2002 MEDPAR UPDATE DECEMBER 2002 GROUPER V21.0—Continued

DRG	Number of discharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
409	2,154	6.1565	2	3	4	6	12
410	28,484	4.0951	1	2	4	5	6
411	7	2.2857	1	1	2	2	4
412	16	3.8125	1	1	3	6	7
413	5,349	7.0501	2	3	5	9	14
414	633	4.2354	1	2	3	5	8
415	43,349	14.3233	4	6	11	18	28
416	192,908	7.4362	2	4	6	9	14
417	38	5.8421	2	3	5	7	12
418	25,920	6.2986	2	3	5	8	12
419	16,446	4.5517	1	2	4	6	9
420	3,220	3.4202	1	2	3	4	6
421	10,745	4.0624	1	2	3	5	8
422	66	3.6970	1	2	2	4	6
423	8,116	8.3228	2	3	6	10	17
424	1,236	12.7929	2	4	9	15	26
425	16,189	3.7961	1	2	3	5	8
426	4,589	4.4655	1	2	3	6	9
427	1,596	4.3784	1	2	3	5	9
428	796	7.1382	1	2	5	8	14
429	27,249	5.8827	2	3	4	7	11
430	65,276	7.8291	2	3	6	10	16
431	314	6.8248	1	2	4	7	12
432	451	4.0111	1	2	3	4	7
433	5,554	3.1300	1	1	2	4	6
439	1,520	8.1855	1	3	5	9	17
440	5,771	9.0806	2	3	6	11	19
441	677	3.1374	1	1	2	4	6
442	17,571	8.5218	1	3	6	10	18
443	3,920	3.3663	1	1	3	4	7
444	5,754	4.2011	1	2	3	5	8
445	2,546	2.8610	1	1	2	4	5
447	6,514	2.5091	1	1	2	3	5
448	1	1.0000	1	1	1	1	1
449	33,181	3.7059	1	1	3	4	7
450	7,441	1.9790	1	1	1	2	4
451	1	1.0000	1	1	1	1	1
452	25,679	4.9178	1	2	3	6	10
453	5,687	2.7579	1	1	2	3	5
454	4,792	4.2398	1	2	3	5	8
455	1,070	2.4140	1	1	2	3	5
461	5,216	3.5861	1	1	2	4	8
462	9,650	10.8636	4	6	9	14	20
463	27,061	4.0439	1	2	3	5	8
464	7,232	2.9887	1	1	2	4	6
465	200	3.9100	1	1	1	3	6
466	1,737	4.0219	1	1	2	4	7
467	1,141	3.0035	1	1	2	3	6
468	52,318	12.7674	3	6	10	16	25
471	13,363	5.3722	3	3	4	6	8
473	8,095	12.4119	2	3	7	17	32
475	109,726	11.1546	2	5	9	15	22
476	3,657	11.0941	2	5	10	15	21
477	25,400	8.1660	1	3	6	11	17
478	108,112	7.3110	1	3	5	9	15
479	24,051	3.1906	1	1	2	4	7
480	611	21.0638	6	8	12	22	47
481	865	21.7584	13	17	20	25	33
482	5,296	12.5015	4	6	9	15	24
483	45,427	39.2033	15	22	33	48	70
484	336	14.5744	2	6	11	21	28
485	3,220	9.8264	4	5	7	11	19
486	2,094	12.7612	1	6	10	17	26
487	3,731	7.1702	1	3	6	9	15
488	769	16.9129	4	7	13	22	36
489	13,373	8.5374	2	3	6	10	17
490	5,462	5.4888	1	2	4	7	11
491	15,370	3.3853	1	2	3	4	6
492	3,140	14.9239	3	5	7	25	33

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY—FY 2002 MEDPAR UPDATE DECEMBER 2002 GROUPER V21.0—Continued

DRG	Number of discharges	Arithmetic mean length of stay	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
493	59,615	5.9843	1	3	5	8	11
494	28,880	2.5293	1	1	2	3	5
495	192	16.4167	7	9	12	19	31
496	2,479	8.8709	3	4	6	11	18
497	21,955	6.2773	3	4	5	7	11
498	15,754	4.0072	2	3	4	5	6
499	34,688	4.5204	1	2	3	6	9
500	49,936	2.4069	1	1	2	3	4
501	2,608	10.6031	4	5	8	13	20
502	771	6.1647	3	4	5	7	11
503	5,970	3.9084	1	2	3	5	7
504	125	27.6560	7	13	21	37	55
505	134	5.6567	1	1	1	5	11
506	919	16.8836	4	7	13	21	35
507	341	9.0411	2	4	7	13	19
508	631	7.8051	2	3	5	10	17
509	160	4.2688	1	2	3	5	9
510	1,651	6.7274	1	3	5	8	15
511	581	4.6076	1	1	3	6	10
512	481	13.1185	6	8	10	15	23
513	207	9.7585	5	6	8	10	15
515	8,131	5.1646	1	1	3	7	12
516	84,846	4.6338	2	2	4	5	9
517	198,743	2.5406	1	1	1	3	5
518	56,613	3.2508	1	1	2	4	7
519	9,004	5.1313	1	1	3	6	12
520	13,003	2.1170	1	1	2	2	4
521	30,898	5.7395	2	3	4	7	11
522	6,069	9.5670	4	5	8	12	20
523	15,456	4.0538	1	2	3	5	7
524	132,651	3.3690	1	2	3	4	6
525	571	17.2907	1	4	9	18	37
528	1,354	17.0990	6	10	15	22	31
529	4,687	10.5078	2	3	7	14	24
530	2,842	3.9170	1	2	3	5	8
531	3,802	9.9408	2	4	7	13	21
532	2,910	3.9704	1	1	3	5	8
533	43,264	4.1077	1	1	2	5	9
534	52,354	2.0108	1	1	1	2	4
535	6,005	10.9189	2	5	9	14	21
536	20,565	5.7310	1	2	4	8	12
537	6,870	7.0199	1	3	5	9	14
538	6,442	2.8788	1	1	2	4	6
539	4,472	11.1456	2	4	8	15	24
540	1,899	4.0590	1	1	3	5	8
	11,713,347						

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED)—MARCH 2003

State	Urban	Rural
Alabama	0.326	0.393
Alaska	0.401	0.662
Arizona	0.334	0.453
Arkansas	0.424	0.413
California	0.322	0.411
Colorado	0.408	0.532
Connecticut	0.501	0.538
Delaware	0.592	0.483
District of Columbia	0.382	.....
Florida	0.330	0.344
Georgia	0.449	0.444
Hawaii	0.402	0.447

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED)—MARCH 2003—Continued

State	Urban	Rural
Idaho	0.541	0.518
Illinois	0.384	0.476
Indiana	0.486	0.523
Iowa	0.456	0.587
Kansas	0.376	0.558
Kentucky	0.458	0.462
Louisiana	0.383	0.459
Maine	0.542	0.499
Maryland	0.760	0.820
Massachusetts	0.499	0.553
Michigan	0.438	0.534

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED)—MARCH 2003—Continued

State	Urban	Rural
Minnesota	0.460	0.619
Mississippi	0.431	0.419
Missouri	0.389	0.459
Montana	0.510	0.516
Nebraska	0.415	0.525
Nevada	0.284	0.461
New Hampshire	0.523	0.587
New Jersey	0.343	.....
New Mexico	0.473	0.479
New York	0.470	0.579
North Carolina	0.503	0.468

TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED)—MARCH 2003—Continued

State	Urban	Rural
North Dakota	0.640	0.628
Ohio	0.481	0.567
Oklahoma	0.371	0.466
Oregon	0.525	0.568
Pennsylvania	0.367	0.497
Puerto Rico	0.479	0.569
Rhode Island	0.484	.....
South Carolina	0.435	0.452
South Dakota	0.484	0.535
Tennessee	0.411	0.434
Texas	0.373	0.477
Utah	0.481	0.581
Vermont	0.522	0.596
Virginia	0.428	0.499
Washington	0.532	0.581
West Virginia	0.572	0.545
Wisconsin	0.509	0.583
Wyoming	0.442	0.618

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED)—MARCH 2003

State	Ratio
Alabama	0.040
Alaska	0.053
Arizona	0.033
Arkansas	0.042
California	0.031
Colorado	0.043
Connecticut	0.036
Delaware	0.050
District of Columbia	0.026
Florida	0.039
Georgia	0.047
Hawaii	0.041
Idaho	0.045
Illinois	0.037
Indiana	0.051
Iowa	0.046
Kansas	0.045
Kentucky	0.045
Louisiana	0.043
Maine	0.035
Maryland	0.013
Massachusetts	0.049
Michigan	0.043
Minnesota	0.042
Mississippi	0.041
Missouri	0.040
Montana	0.049

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED)—MARCH 2003—Continued

State	Ratio
Nebraska	0.047
Nevada	0.032
New Hampshire	0.059
New Jersey	0.030
New Mexico	0.044
New York	0.047
North Carolina	0.046
North Dakota	0.065
Ohio	0.044
Oklahoma	0.040
Oregon	0.043
Pennsylvania	0.035
Puerto Rico	0.043
Rhode Island	0.033
South Carolina	0.046
South Dakota	0.051
Tennessee	0.046
Texas	0.043
Utah	0.046
Vermont	0.046
Virginia	0.048
Washington	0.052
West Virginia	0.045
Wisconsin	0.050
Wyoming	0.050

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
010005	01	3440	3440
010008	01	5240	.....
010010	01	3440	3440
010012	01	2880	.....
010022	01	2880	.....
010029	0580	1800	.....
010035	01	1000	.....
010036	01	2750	.....
010043	01	1000	1000
010044	01	25	.....
010072	01	0450	0450
010089	01	1000	.....
010101	01	0450	0450
010118	01	5240	.....
010120	01	5160	.....
010121	01	5240	.....
010126	01	2180	.....
010150	01	5240	.....
010158	01	2030	.....
020008	02	0380	.....
030007	03	2620	.....
030012	03	6200	.....
030033	03	2620	.....
030043	03	8520	.....
040014	04	4400	.....
040017	04	26	.....
040019	04	4920	.....
040020	3700	4920	.....
040026	04	4400	.....
040027	04	7920	.....
040041	04	4400	.....
040066	04	4400	.....
040069	04	4920	.....
040072	04	4400	.....
040076	04	4400	.....
040078	04	4400	.....

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
040080	04	3700	
040088	04	7680	
040091	04	8360	
040107	04	8360	
040119	04	4400	
050042	05	6690	
050045	05		7320
050071	7400	5775	
050073	8720	5775	
050101	8720	5775	
050150	05	6920	
050174	7500	8720	
050228	7360	5775	
050230	5945	4480	
050236	8735		4480
050236	8735	4480	
050251	05	6720	
050296	05	7120	
050325	05	5170	
050335	05	5170	
050419	05	6690	
050457	7360	5775	
050464	5170	8120	
050494	05	6920	
050510	7360	5775	
050541	7360	5775	
050549	8735	4480	
050569	05	7500	
050594	5945	4480	
050609	5945	4480	
050668	7360	5775	
050686	6780	5945	
060001	3060	2080	2080
060003	1125	2080	2080
060013	06	0200	
060023	2995	6520	
060027	1125	2080	2080
060044	06	2080	
060049	06	2080	
060057	06	2995	
060075	06	2995	
060076	06	3060	
060096	06	2080	
060103	1125	2080	2080
070006	5483	5600	
070018	5483	5600	
070033	5483	5600	
070034	5483	5600	
070036	3283	5483	
080002	08		0720
080004	2190	9160	
080006	08	2190	
080007	08	0560	
100022	5000	2680	
100023	10	5960	
100024	10	5000	
100045	2020		5960
100049	10	3980	
100098	10	8960	8960
100103	10	3600	3600
100105	10	4900	
100109	10	5960	
100150	10	5000	
100176	8960	2710	
100211	8280	3980	
100232	10	5790	2900
100239	8280	7510	
100249	10	8280	
100268	8960	2680	
110001	11		0520

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
110001	11	0520	
110002	11	0520	
110003	11	3600	
110016	11	1800	
110023	11	0520	
110025	11		3600
110025	11	3600	
110029	11	0520	
110038	11	10	
110040	11	0500	0500
110041	11	0500	
110050	11	0520	
110054	11	0520	
110074	0500		0520
110075	11	7520	
110118	11	0120	
110122	11	10	
110150	11	4680	
110168	11	0520	
110187	11	0520	
110188	11	0520	
110189	11	0520	
110205	11	0520	
120028	12	3320	
130002	13	6340	
130003	13	50	
130011	13	50	
130018	13	6340	
130026	13	6340	
130028	6340	7160	
130049	13	7840	
130060	13	1080	
140014	6120	1040	
140015	14	7040	
140027	14	1960	
140031	14	1400	
140032	14	7040	
140034	14	7040	7040
140040	14	6120	
140043	14	6880	
140046	14	7040	
140058	14	7880	
140064	14	1960	
140086	14	7040	7040
140093	14	1400	
140102	14	7880	7880
140110	14	6120	
140141	14	7040	7040
140143	14	6120	
140160	14	6880	
140161	14	1600	
140164	14	7040	
140189	14	1400	
140230	14	1400	1400
140234	14	6120	
140245	14		7040
140271	14	7800	7800
150002	2960	1600	1600
150004	2960	1600	1600
150006	15	7800	
150008	2960	1600	1600
150011	15	3480	3480
150015	15	1600	1600
150027	15		3480
150030	15	3480	3480
150034	2960	1600	1600
150036	15	3850	
150048	15	3200	
150051	1020		3480
150062	15	3480	3480

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
150065	15	3480	
150067	15		3480
150069	15	1640	1640
150076	15	7800	
150090	2960	1600	1600
150096	15	2330	
150102	15	7800	
150105	15	3480	
150112	15	3480	3480
150125	2960	1600	1600
150126	2960	1600	1600
150127	15	3480	
150132	2960	1600	1600
150133	15	2330	
150146	15	2330	
150147	2960	1600	1600
160001	16	2120	
160016	16	2120	
160026	16	2120	
160030	16	2120	
160037	16	24	
160057	16	3500	
160064	16	24	
160080	16	6880	
160088	16	2120	
160089	16	2120	
160094	16	8920	
160122	16	14	
160147	16	2120	
170001	17	9040	
170006	17	3710	
170010	17	8560	
170012	17	9040	
170013	17	9040	
170014	17	3760	
170020	17	9040	
170022	17	7000	
170023	17	9040	
170025	17	9040	
170033	17	9040	
170045	17	8440	
170058	17	3710	
170060	17	28	
170089	17	0320	
170094	17	8440	
170120	17	3710	
170131	17	8440	8440
170142	17	8440	
170145	17	8560	
170166	17	0320	
170175	17	9040	
180005	18	3400	
180011	18	4280	
180012	18	4520	
180013	18	5360	
180016	18	4520	
180018	18	4280	
180027	18	1660	
180028	18	3400	
180029	18	3660	
180044	18	3400	
180048	18	4280	
180054	18	1660	
180066	18	5360	
180069	18	3400	
180078	18	3400	
180102	18	1660	
180104	18	1660	
180116	18	1660	
180124	18	5360	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
180125	18	3400	
180127	18	4520	
180132	18	4280	
180139	18	4280	
190001	19		5560
190003	19	3880	
190010	19	5560	
190015	19	5560	
190025	19	3880	
190049	19		5560
190054	19	3880	
190083	19	5200	
190086	19	5200	
190099	19	3880	
190106	19	3880	
190131	19	5560	
190218	19	0220	
200002	20	6403	
200020	6403	1123	1123
200024	4243	6403	
200034	4243	6403	
200039	20	6403	
200040	6403		1123
200050	20	0733	
200063	20	6403	
220060	1123	0743	
220077	8003	3283	
220123	22	0743	
230022	23	0440	
230027	23	3000	3000
230030	23	6960	
230036	23	6960	
230037	23	0440	
230040	23	3720	3000
230054	23	3080	
230080	23	6960	
230093	23	3000	
230096	23	3720	
230097	23	3000	
230105	23	6960	
230106	23	3000	
230121	23	2640	2640
230188	23	6960	6960
230199	23	0870	0870
230235	23	6960	6960
230253	23	2160	
240011	24	5120	5120
240013	24	5120	
240014	24	5120	
240016	24	2520	
240018	24		5120
240023	24	5120	
240045	24	2240	
240052	24	2520	
240064	24	2240	
240069	24	6820	
240071	24		5120
240072	24	2240	
240075	24	6980	
240088	24	6980	
240089	24	5120	
240100	24	2985	
240119	24	2240	
240121	24	2240	
240139	24	5120	
240142	24	6980	
240152	24	5120	
240187	24	5120	
250002	25	2650	
250004	25	4920	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
250009	25	3580	
250025	25	01	
250030	25	3560	
250031	25	3560	
250034	25	4920	
250042	25	4920	
250058	25	3285	
250078	3285	0920	
250079	25	3560	
250081	25	3560	
250082	25	6240	
250084	25	19	
250088	25	0760	
250094	3285	0920	
250097	25	0760	
250100	25	8600	
250101	25	3560	
250104	25	3560	
250122	25	19	
250126	25	4920	
260009	26	3760	
260011	26	1740	
260015	26	3700	
260017	26	7040	
260022	26	1740	
260025	26	7040	
260034	26	3760	
260047	26	1740	
260064	26	1740	
260074	26	1740	
260078	26	7920	
260094	26	7920	
260110	26	7040	7040
260113	26	14	
260116	26	7040	
260119	26	3700	
260120	26	3700	
260127	26	7040	
260131	26	1740	
260164	26		7040
260183	26	7040	
260186	26	1740	
270002	27	0880	
270003	27	3040	
270011	27	3040	
270017	27	5140	
270051	27	5140	
270057	27	0880	
270082	27	3040	
280009	28	4360	
280023	28	4360	
280032	28	4360	
280054	28	4360	
280058	28	4360	
280061	28	53	
280065	28	3060	
280077	28	5920	
280111	28	5920	
280125	28	7720	
290006	29	6720	
290008	29	4120	
300003	30	1123	
300005	30	1123	
300019	30	1123	1123
300024	30		1123
310001	0875	5600	
310002	5640	5600	
310003	3640	5600	
310015	5640	0875	
310021	8480	5190	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
310031	6160	5190	
310032	8760	6160	6160
310038	5015	5600	
310045	0875	5600	
310047	0560	6160	
310048	5015	5640	
310064	0560	6160	
310070	5015	5600	
310076	5640	5600	
310087	8760	6160	
310088	0560	6160	
310119	5640	5600	
320005	32	0200	
320006	32	7490	
320011	32	7490	
320013	32	7490	
320063	32	5800	
320065	32	5800	
330001	5660	0875	0875
330004	33	2281	
330023	2281	5660	5600
330027	5380	5600	
330084	33	1303	
330085	33	8160	
330103	33		1280
330106	5380	5600	
330126	5660	0875	0875
330135	5660	0875	0875
330136	33	8160	
330157	33	8160	
330181	5380	5600	
330182	5380	5600	
330205	5660	0875	0875
330209	5660	0875	0875
330224	33	3283	
330235	8160		6840
330239	3610	2360	
330250	33	1303	
330264	5660	0875	0875
330307	33	8160	
330386	33	5660	
340003	34	3120	
340008	34	2560	
340010	2980	6640	
340013	34	1520	
340017	34	0480	
340021	34	1520	
340023	34	0480	
340027	34	3150	
340039	34		1520
340050	34	2560	
340051	34	3290	
340052	3120	1520	
340064	34	3120	
340068	34	9200	
340071	34	6640	6640
340088	34	0480	
340109	34	5720	5720
340115	34	6640	6640
340124	34	6640	6640
340126	34	6640	6640
340131	34	3150	
340143	3290	1520	
340147	6895	6640	
350003	35	1010	
350005	35	2985	
350006	35	1010	
350008	35	1010	
350009	35	2520	
350038	35	2985	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
360002	36		1680
360008	36	3400	
360010	36	0080	
360011	36	1840	1840
360013	36	2000	
360014	36	1840	
360024	36	1680	1680
360025	36	1680	1680
360036	36	0080	
360037	1680	0080	
360039	36	1840	1840
360046	3200		1640
360054	36	1480	
360056	3200		1640
360063	36	1680	
360065	36	1680	1680
360071	36	4320	4320
360076	3200		1640
360078	0080	1680	1680
360081	8400		2160
360084	1320	0080	
360088	36	1840	
360090	8400		2160
360092	36	1840	1840
360095	36	8400	
360107	36	8400	
360109	36	1840	1840
360112	8400	0440	
360121	36	0440	
360132	3200		1640
360142	36		1640
360144	1680	0080	
360150	0080		1680
360159	36	1840	
360175	36	3200	
360186	36	1640	
360197	36	1840	1840
360211	8080		6280
370004	37	3710	
370006	37	8560	
370014	37	7640	
370015	37	8560	
370018	37	8560	
370022	37	4200	
370023	37	4200	
370025	37	8560	
370034	37	2720	
370047	37	7640	
370048	37	8360	
370049	37	5880	
370054	37	5880	
370084	37	2720	
370103	37	45	
370153	37	4200	
370200	37	5880	
380001	38	6440	
380002	38	4890	
380006	38		6440
380022	38	1890	
380027	38	2400	
380040	38	2400	
380047	38	2400	
380050	38	4890	
380051	7080		6440
380065	38	2400	
380070	38	6440	
380090	38	2400	
390006	39	3240	
390008	39	6280	6280
390013	39	3240	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
390016	39	6280	6280
390017	39	6280	6280
390030	39	6680	6680
390031	39	6680	6680
390048	39	3240	
390052	39	0280	
390065	39	9280	9280
390079	39	0960	
390091	39	6280	
390093	39	6280	
390110	3680	6280	
390113	39	9320	
390133	0240	6160	
390138	39	8840	
390150	39	6280	
390151	39	8840	
390163	39	6280	
390181	39	6680	6680
390183	39	6680	6680
390189	39	3240	
390197	0240	6160	
390201	39	5640	5640
390263	0240	6160	
400018	40	1310	
410001	6483	1123	1123
410004	6483	1123	1123
410005	6483	1123	1123
410006	6483	1123	1123
410007	6483	1123	1123
410008	6483	1123	1123
410009	6483	1123	1123
410010	6483	1123	1123
410011	6483	1123	1123
410012	6483	1123	1123
410013	6483	1123	1123
420020	42	1440	
420030	42	1440	
420036	42	1520	
420059	42	2655	
420062	42	1520	
420068	42	0600	
420070	8140	1760	
420071	42	0600	
420080	42	7520	
420085	5330	9200	
430004	43	6660	
430008	43	24	
430012	43	7760	
430013	43	7760	
430014	43	2520	
430015	43	6660	
430047	43	28	
430048	43	53	
430089	43	7720	
440008	44	3580	
440020	44	3440	
440024	44	1560	
440050	44	0480	
440058	44	1560	
440059	44	5360	
440060	44	3580	
440067	44	3840	
440068	44	3840	
440072	44	4920	
440073	44	5360	
440148	44	5360	
440175	44	3440	
440180	44	3840	
440185	44	1560	
440186	44	5360	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
440187	44	18	
440192	44	5360	
440200	44	5360	
440203	44	1560	
450007	45	7240	
450014	45	8750	
450080	45	4420	
450085	45	9080	
450098	45	4420	
450099	45	0320	
450140	45	5800	
450144	45	5800	
450146	45	0320	
450163	45	1880	
450178	45	5800	
450187	45	3360	
450192	45	1920	
450194	45	1920	
450196	45	1920	
450211	45	3360	
450214	45	3360	
450224	45	8640	
450347	45	3360	
450351	45	2800	
450353	45	1880	
450373	45	4420	
450395	45	3360	
450400	45	8800	
450438	45	0640	
450447	45	1920	
450451	45	2800	
450484	45	3360	
450508	45	8640	
450534	45	0320	
450623	45	1920	
450626	45	8750	
450653	45	5800	
450656	45	8640	
450694	45	3360	
450747	45	1920	
450755	45	4600	
450763	45	0320	
450770	45	0640	
460011	46	6520	
460021	46	4120	
460027	46	6520	
460032	46	6520	
460036	46	6520	
460039	46	7160	
470001	47	30	
470011	47	1123	1123
470012	47	6323	
470018	47	1123	1123
490001	49	3660	
490004	49	1540	
490005	49	8840	
490013	49	4640	
490018	49	4640	
490038	49	3660	
490047	49	8840	
490066	5720	6760	
490079	49	3120	3120
490126	49	6800	
500002	50	6740	
500003	50	7600	
500007	50	0860	
500016	50	7600	
500031	50	5910	
500041	50	6440	
500059	50	7600	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
500072	50	7600	
500079	8200		7600
510001	51	6280	
510002	51	6800	
510006	51	6280	
510024	51	6280	6280
510028	51	1480	
510046	51	1480	
510047	51	6280	
510048	51	3400	
510062	51	1480	
510070	51	1480	
510071	51	1480	
520002	52	8940	
520006	52	8940	
520011	52	2290	
520021	3800	1600	1600
520028	52	4720	
520032	52	4720	
520037	52	8940	
520059	6600	5080	5080
520066	3620	4720	
520071	52	5080	5080
520076	52	4720	
520084	52	4720	
520088	52	5080	
520091	52	23	
520094	6600	5080	5080
520096	6600	5080	5080
520102	52	5080	5080
520107	52	3080	
520113	52	3080	
520116	52	5080	5080
520152	52	3080	
520173	52	2240	
520189	3800	1600	1600
530002	53	1350	
530008	53	1350	
530009	53	1350	
530015	53	6340	
530025	53	2670	
530032	53	7160	

TABLE 10.—MEAN AND STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUPS (DRGS)—FY 2004 [1]

DRG	Cases	Mean + 1 standard deviation
1	23,157	$71,862
2	11,535	$41,916
3	3	$57,168
6	350	$15,743
7	14,489	$55,309
8	4,031	$33,403
9	1,677	$27,210
10	18,339	$25,124
11	3,244	$17,654
12	51,660	$17,776
13	6,919	$16,312
14	233,816	$24,738
15	92,167	$19,059
16	9,810	$25,016
17	2,700	$13,796
18	29,250	$20,071
19	8,385	$14,298
20	6,112	$57,114

TABLE 10.—MEAN AND STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUPS (DRGS)—FY 2004 [1]—Continued

DRG	Cases	Mean + 1 standard deviation
21	1,869	$30,726
22	2,746	$21,754
23	11,062	$16,410
24	58,122	$19,963
25	26,945	$12,212
26	18	$22,836
27	4,348	$27,026
28	13,770	$26,999
29	5,226	$14,276
30	2	$19,365
31	3,834	$18,092
32	1,866	$11,256
34	23,474	$19,760
35	7,325	$12,760
36	2,079	$11,821
37	1,351	$21,123

TABLE 10.—MEAN AND STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUPS (DRGS)—FY 2004 [1]—Continued

DRG	Cases	Mean + 1 standard deviation
38	94	$9,781
39	547	$12,494
40	1,508	$17,526
42	1,553	$14,008
43	93	$11,353
44	1,185	$13,306
45	2,622	$14,326
46	3,418	$16,038
47	1,373	$10,908
49	2,341	$34,744
50	2,385	$15,810
51	241	$16,991
52	216	$15,789
53	2,435	$23,943
55	1,458	$18,384
56	458	$16,976

TABLE 10.—MEAN AND STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUPS (DRGS)—FY 2004 [1]—Continued

DRG	Cases	Mean + 1 standard deviation
57	700	$21,430
59	113	$16,063
61	249	$24,772
62	2	$20,652
63	2,964	$28,015
64	3,064	$27,189
65	39,700	$11,389
66	7,690	$11,535
67	379	$15,758
68	11,373	$12,869
69	3,665	$9,805
70	29	$6,582
71	79	$13,057
72	949	$13,674
73	7,561	$16,376
75	42,731	$60,129
76	43,909	$56,525
77	2,427	$23,987
78	38,870	$24,907
79	165,957	$32,680
80	7,866	$16,846
81	5	$20,229
82	63,317	$28,781
83	6,565	$19,177
84	1,552	$10,644
85	21,981	$24,242
86	2,201	$13,781
87	60,101	$27,456
88	396,200	$17,702
89	523,048	$20,511
90	47,344	$11,871
91	44	$14,737
92	15,549	$24,280
93	1,738	$14,448
94	12,597	$22,970
95	1,622	$12,263
96	55,628	$14,761
97	28,174	$10,803
98	9	$14,090
99	20,984	$13,983
100	8,129	$10,369
101	21,861	$17,290
102	5,503	$10,797
103	484	$378,244
104	20,223	$150,559
105	28,716	$108,046
106	3,432	$136,812
107	81,816	$99,133
108	6,341	$109,106
109	56,282	$73,253
110	53,777	$81,343
111	9,323	$49,746
113	39,244	$56,405
114	8,198	$33,220
115	19,499	$69,161
116	114,338	$44,903
117	4,622	$27,878
118	8,168	$31,457
119	1,211	$27,147
120	37,745	$46,550
121	161,616	$30,683
122	75,737	$19,715
123	38,021	$32,143
124	133,344	$27,371
125	90,371	$20,832
126	5,309	$51,405
127	663,251	$20,085
128	7,042	$14,239
129	3,774	$20,775
130	87,289	$18,660
131	26,583	$11,113
132	140,158	$12,462
133	8,475	$10,723
134	40,649	$11,970
135	7,697	$17,958
136	1,166	$11,432
138	204,872	$16,521
139	86,072	$10,173
140	54,193	$10,288
141	107,180	$14,813
142	51,782	$11,382
143	245,795	$10,741
144	93,108	$24,851
145	7,201	$11,714
146	10,627	$52,920
147	2,602	$29,373
148	132,078	$67,116
149	19,892	$27,061
150	20,888	$57,096
151	5,067	$25,243
152	4,490	$37,305
153	2,025	$21,509
154	27,969	$82,200
155	6,498	$25,001
156	4	$16,997
157	8,150	$25,875
158	4,273	$12,709
159	17,842	$26,972
160	11,973	$15,839
161	10,620	$22,659
162	6,290	$12,519
163	8	$9,397
164	5,322	$45,313
165	2,297	$22,967
166	4,142	$27,527
167	4,013	$16,618
168	1,406	$26,010
169	802	$14,782
170	15,473	$57,315
171	1,495	$23,568
172	30,878	$28,013
173	2,414	$15,971
174	247,933	$19,856
175	34,337	$11,032
176	13,301	$21,548
177	8,939	$18,108
178	3,315	$13,584
179	12,973	$21,773
180	88,999	$19,227
181	26,699	$10,651
182	268,140	$16,395
183	89,558	$11,492
184	69	$9,542
185	5,256	$17,532
186	6	$17,504
187	609	$15,462
188	82,829	$22,197
189	12,856	$12,176
190	75	$16,578
191	9,340	$88,382
192	1,299	$36,558
193	4,733	$68,254
194	638	$31,775
195	3,957	$59,356
196	969	$30,122
197	17,996	$50,435
198	5,289	$23,379
199	1,609	$48,963
200	1,069	$62,346
201	2,100	$75,551
202	26,307	$26,667
203	29,543	$28,095
204	64,510	$22,991
205	27,001	$24,271
206	2,015	$14,280
207	32,214	$22,980
208	9,967	$13,150
209	394,702	$35,979
210	121,348	$33,587
211	29,657	$22,493
212	9	$31,925
213	9,818	$37,689
216	8,691	$41,935
217	17,092	$61,011
218	23,524	$30,313
219	19,672	$19,359
223	13,125	$20,384
224	11,574	$14,926
225	6,390	$22,849
226	5,793	$30,350
227	4,783	$15,628
228	2,495	$22,908
229	1,245	$13,667
230	2,430	$25,765
232	809	$18,306
233	9,829	$40,036
234	5,300	$24,173
235	5,032	$14,695
236	39,468	$13,922
237	1,748	$11,857
238	8,729	$27,480
239	45,525	$20,661
240	11,846	$26,301
241	3,110	$12,646
242	2,542	$23,380
243	94,969	$15,031
244	14,423	$14,330
245	5,746	$9,757
246	1,473	$11,896
247	20,113	$11,410
248	13,674	$17,154
249	12,784	$13,336
250	3,727	$14,018
251	2,332	$9,097
253	21,753	$14,893
254	10,593	$8,759
256	6,586	$16,469
257	15,517	$16,712
258	15,055	$13,056
259	3,486	$17,996
260	4,160	$12,825
261	1,747	$17,565
262	653	$18,615
263	22,868	$41,675
264	3,819	$21,268
265	4,031	$31,156
266	2,516	$17,172
267	238	$20,021
268	895	$23,309
269	9,688	$35,630
270	2,743	$16,079

TABLE 10.—MEAN AND STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUPS (DRGS)—FY 2004 [1]—Continued

DRG	Cases	Mean + 1 standard deviation
271	18,989	$20,610
272	5,658	$20,167
273	1,313	$12,601
274	2,264	$24,353
275	223	$12,616
276	1,304	$13,267
277	98,858	$17,235
278	31,750	$10,661
279	10	$15,979
280	17,551	$13,991
281	7,377	$9,589
283	5,976	$14,555
284	1,992	$8,504
285	6,869	$41,732
286	2,477	$39,318
287	6,166	$37,798
288	5,471	$41,746
289	6,830	$18,048
290	9,803	$16,847
291	58	$13,308
292	6,420	$55,995
293	356	$28,741
294	96,631	$15,356
295	3,475	$16,050
296	275,298	$17,000
297	47,552	$9,995
298	109	$9,503
299	1,253	$18,904
300	18,462	$22,372
301	3,554	$12,547
302	8,653	$61,825
303	21,521	$46,383
304	12,430	$47,807
305	3,009	$23,106
306	6,967	$24,014
307	1,983	$11,422
308	7,203	$31,717
309	4,094	$17,613
310	24,593	$22,507
311	7,407	$11,963
312	1,502	$21,429
313	547	$13,534
314	2	$815,660
315	33,535	$41,732
316	117,415	$26,424
317	1,994	$16,978
318	5,685	$24,541
319	403	$14,083
320	184,548	$17,149
321	30,606	$11,011
322	49	$9,127
323	19,641	$16,239
324	6,874	$9,611
325	9,136	$13,204
326	2,696	$8,569
327	7	$7,111
328	732	$15,295
329	93	$10,358
331	50,553	$21,469
332	4,905	$12,274
333	254	$19,142
334	10,300	$27,789
335	12,490	$19,981
336	35,495	$16,280
337	29,140	$10,776
338	929	$23,997
339	1,460	$22,362

TABLE 10.—MEAN AND STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUPS (DRGS)—FY 2004 [1]—Continued

DRG	Cases	Mean + 1 standard deviation
341	3,545	$25,849
342	686	$14,916
344	3,549	$26,710
345	1,354	$22,352
346	4,775	$21,343
347	308	$11,845
348	3,361	$15,104
349	604	$9,831
350	6,602	$14,657
352	945	$14,499
353	2,491	$35,744
354	7,324	$28,230
355	5,481	$16,312
356	25,562	$14,230
357	5,570	$44,892
358	21,321	$22,339
359	31,420	$14,957
360	15,538	$16,445
361	339	$21,352
362	5	$16,578
363	2,471	$18,875
364	1,610	$18,054
365	1,815	$42,185
366	4,504	$25,764
367	477	$11,799
368	3,503	$23,599
369	3,419	$12,532
370	1,327	$18,299
371	1,662	$11,458
372	927	$10,237
373	4,076	$6,914
374	89	$13,913
376	316	$11,055
377	47	$21,747
378	171	$14,743
379	349	$7,238
380	98	$8,554
381	188	$10,611
382	48	$4,333
383	1,956	$10,030
384	129	$7,214
385	3	$34,210
389	12	$23,975
392	2,248	$66,268
394	2,567	$38,588
395	105,976	$16,486
396	17	$16,006
397	18,727	$25,519
398	17,860	$24,884
399	1,671	$13,548
401	5,768	$59,903
402	1,454	$22,863
403	31,365	$37,680
404	4,277	$18,437
406	2,391	$53,929
407	634	$24,003
408	2,081	$44,985
409	2,127	$25,574
410	28,001	$21,908
411	7	$7,483
412	15	$11,456
413	5,253	$27,415
414	622	$15,291
415	42,746	$75,112
416	189,451	$32,070
417	38	$22,076
418	25,456	$21,447

TABLE 10.—MEAN AND STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUPS (DRGS)—FY 2004 [1]—Continued

DRG	Cases	Mean + 1 standard deviation
419	16,128	$17,016
420	3,139	$12,214
421	10,563	$14,503
422	66	$12,891
423	7,972	$36,726
424	1,224	$49,024
425	15,914	$13,506
426	4,462	$10,410
427	1,557	$10,483
428	782	$14,266
429	26,797	$15,953
430	64,123	$13,703
431	310	$12,670
432	443	$12,980
433	5,479	$5,805
439	1,493	$34,068
440	5,673	$36,892
441	668	$18,081
442	17,291	$48,763
443	3,848	$19,622
444	5,629	$14,813
445	2,485	$9,965
447	6,390	$10,119
449	32,589	$16,465
450	7,304	$8,328
452	25,308	$20,911
453	5,591	$10,522
454	4,691	$16,299
455	1,043	$9,576
461	5,133	$24,128
462	9,531	$19,503
463	26,512	$13,669
464	7,075	$9,864
465	192	$13,169
466	1,684	$14,122
467	1,106	$10,115
468	51,680	$77,692
470	52	$504,684
471	13,167	$54,184
473	7,976	$72,650
475	108,084	$75,747
476	3,608	$46,392
477	25,103	$37,665
478	106,238	$48,149
479	23,387	$27,938
480	610	$193,008
481	819	$122,102
482	5,175	$70,600
483	44,784	$328,441
484	334	$110,056
485	3,178	$61,849
486	2,077	$99,908
487	3,701	$40,225
488	760	$99,624
489	13,168	$37,620
490	5,356	$21,486
491	15,098	$31,213
492	3,052	$82,667
493	58,870	$35,610
494	28,431	$18,981
495	191	$165,379
496	2,444	$112,012
497	21,734	$66,414
498	15,556	$49,426
499	34,350	$27,633
500	49,302	$17,736
501	2,580	$51,260

TABLE 10.—MEAN AND STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUPS (DRGS)—FY 2004 [1]—Continued

DRG	Cases	Mean + 1 standard deviation
502	761	$27,677
503	5,883	$24,011
504	125	$257,167
505	134	$36,044
506	916	$87,492
507	337	$37,309
508	612	$27,746
509	155	$13,241
510	1,625	$23,313
511	571	$13,248
512	481	$101,931
513	206	$107,611
515	8,028	$105,722
516	83,464	$45,394

TABLE 10.—MEAN AND STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUPS (DRGS)—FY 2004 [1]—Continued

DRG	Cases	Mean + 1 standard deviation
517	194,015	$35,730
518	55,225	$36,574
519	8,892	$47,738
520	12,823	$29,760
521	30,454	$14,130
522	6,008	$10,049
523	15,103	$7,817
524	130,318	$14,293
525	562	$247,370
526	73,724	$42,080
527	194,015	$33,802
528	1,343	$140,528
529	4,633	$63,385
530	2,807	$24,282

TABLE 10.—MEAN AND STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUPS (DRGS)—FY 2004 [1]—Continued

DRG	Cases	Mean + 1 standard deviation
531	3,766	$64,237
532	2,888	$30,290
533	42,601	$32,675
534	51,346	$20,340
535	5,896	$156,207
536	20,103	$118,567
537	6,765	$36,526
538	6,350	$19,355
539	4,388	$69,606
540	1,866	$25,633

[1] Cases are taken from the FY 2002 MedPAR file; DRGs are from GROUPER V21.0.

TABLE 11.—PROPOSED LTC–DRGS RELATIVE WEIGHTS AND GEOMETRIC AND FIVE-SIXTHS OF THE AVERAGE LENGTH OF STAY—FY 2004

LTC–DRG	Description	Relative weight	Geo-metric average length of stay	5/6ths of the average length of stay
1	[5] CRANIOTOMY AGE >17 W CC	1.9873	41.3	34.4
2	[8] CRANIOTOMY AGE > 17 W/O CC	1.9873	41.3	34.4
3	[8] CRANIOTOMY AGE 0-17	1.9873	41.3	34.4
6	[8] CARPAL TUNNEL RELEASE	0.5711	20.8	17.3
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	1.5898	42.5	35.4
8	[4] PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	1.4090	34.1	28.4
9	SPINAL DISORDERS & INJURIES	1.5189	34.7	28.9
10	NERVOUS SYSTEM NEOPLASMS W CC	0.7590	23.4	19.5
11	NERVOUS SYSTEM NEOPLASMS W/O CC	0.7322	21.2	17.6
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.7760	26.4	22.0
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.8287	28.3	23.5
14	INTERCRANIAL HEMORRHAGE & STROKE W INFARCT	0.9449	27.5	22.9
15	NONSPECIFIC CVA & PRECEREBRAL OCCULUSION W/O INFARCT	0.9058	28.9	24.0
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.9158	24.7	20.5
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.5478	20.0	16.6
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.8845	24.9	20.7
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.6378	22.6	18.8
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.0135	25.1	20.9
21	[2] VIRAL MENINGITIS	0.7347	23.1	19.2
22	[2] HYPERTENSIVE ENCEPHALOPATHY	0.7347	23.1	19.2
23	NONTRAUMATIC STUPOR & COMA	1.0331	30.8	25.6
24	SEIZURE & HEADACHE AGE >17 W CC	1.0059	28.1	23.4
25	SEIZURE & HEADACHE AGE >17 W/O CC	0.8044	25.6	21.3
26	[8] SEIZURE & HEADACHE AGE 0-17	0.7347	23.1	19.2
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.1071	28.8	24.0
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	1.0527	29.2	24.3
29	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.9365	26.2	21.8
30	[8] TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.9785	27.4	22.8
31	[3] CONCUSSION AGE >17 W CC	0.9785	27.4	22.8
32	[3] CONCUSSION AGE >17 W/O CC	0.9785	27.4	22.8
33	[8] CONCUSSION AGE 0-17	0.7347	23.1	19.2
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9885	28.5	23.7
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.7817	26.9	22.4
36	[8] RETINAL PROCEDURES	0.5711	20.8	17.3
37	[8] ORBITAL PROCEDURES	0.5711	20.8	17.3
38	[8] PRIMARY IRIS PROCEDURES	0.5711	20.8	17.3
39	[8] LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.5711	20.8	17.3
40	[8] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.5711	20.8	17.3
41	[8] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.5711	20.8	17.3
42	[8] INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.5711	20.8	17.3
43	[8] HYPHEMA	0.5711	20.8	17.3
44	[1] ACUTE MAJOR EYE INFECTIONS	0.5711	20.8	17.3
45	[8] NEUROLOGICAL EYE DISORDERS	0.7347	23.1	19.2
46	[2] OTHER DISORDERS OF THE EYE AGE >17 W CC	0.7347	23.1	19.2

TABLE 11.—PROPOSED LTC–DRGS RELATIVE WEIGHTS AND GEOMETRIC AND FIVE-SIXTHS OF THE AVERAGE LENGTH OF STAY—FY 2004—Continued

LTC–DRG	Description	Relative weight	Geo-metric average length of stay	5/6ths of the aver-age length of stay
47	[1] OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.5711	20.8	17.3
48	[8] OTHER DISORDERS OF THE EYE AGE 0-17	0.5711	20.8	17.3
49	[8] MAJOR HEAD & NECK PROCEDURES	1.4090	34.1	28.4
50	[8] SIALOADENECTOMY	0.9785	27.4	22.8
51	[8] SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	0.9785	27.4	22.8
52	[8] CLEFT LIP & PALATE REPAIR	0.9785	27.4	22.8
53	[2] SINUS & MASTOID PROCEDURES AGE >17	0.7347	23.1	19.2
54	[8] SINUS & MASTOID PROCEDURES AGE 0-17	0.9785	27.4	22.8
55	[5] MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	1.9873	41.3	34.4
56	[8] RHINOPLASTY	0.5711	20.8	17.3
57	[8] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.9785	27.4	22.8
58	[8] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.9785	27.4	22.8
59	[8] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.9785	27.4	22.8
60	[8] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.9785	27.4	22.8
61	[8] MYRINGOTOMY W TUBE INSERTION AGE >17	1.4090	34.1	28.4
62	[8] MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.9785	27.4	22.8
63	[3] OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	0.9785	27.4	22.8
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.2957	27.9	23.2
65	[1] DYSEQUILIBRIUM	0.5711	20.8	17.3
66	[1] EPISTAXIS	0.5711	20.8	17.3
67	[8] EPIGLOTTITIS	0.9785	27.4	22.8
68	OTITIS MEDIA & URI AGE &>17 W CC	0.8396	23.5	19.5
69	[1] OTITIS MEDIA & URI AGE &>17 W/O CC	0.5711	20.8	17.3
70	[8] OTITIS MEDIA & URI AGE 0-17	0.5711	20.8	17.3
71	[8] LARYNGOTRACHEITIS	0.7347	23.1	19.2
72	[1] NASAL TRAUMA & DEFORMITY	0.5711	20.8	17.3
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.9506	23.7	19.7
74	[8] OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.5711	20.8	17.3
75	[5] MAJOR CHEST PROCEDURES	1.9873	41.3	34.4
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.3848	42.2	35.1
77	[5] OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.9873	41.3	34.4
78	PULMONARY EMBOLISM	0.9226	24.8	20.6
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	0.9853	23.7	19.7
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.8550	22.8	19.0
81	[8] RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	0.5711	20.8	17.3
82	RESPIRATORY NEOPLASMS	0.7759	20.4	17.0
83	[3] MAJOR CHEST TRAUMA W CC	0.9785	27.4	22.8
84	[2] MAJOR CHEST TRAUMA W/O CC	0.7347	23.1	19.2
85	PLEURAL EFFUSION W CC	0.9068	23.9	19.9
86	PLEURAL EFFUSION W/O CC	0.7121	24.9	20.7
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.7382	32.9	27.4
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.7996	21.0	17.5
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.8676	22.9	19.0
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.7429	21.7	18.0
91	[8] SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.7347	23.1	19.2
92	INTERSTITIAL LUNG DISEASE W CC	0.8403	21.8	18.1
93	INTERSTITIAL LUNG DISEASE W/O CC	0.7332	20.2	16.8
94	[7] PNEUMOTHORAX W CC	0.7917	21.1	17.5
95	[7] PNEUMOTHORAX W/O CC	0.7917	21.1	17.5
96	BRONCHITIS & ASTHMA AGE >17 W CC	0.7787	20.7	17.2
97	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.6616	22.5	18.7
98	[8] BRONCHITIS & ASTHMA AGE 0-17	0.7347	23.1	19.2
99	RESPIRATORY SIGNS & SYMPTOMS W CC	1.0818	26.9	22.4
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC	1.0374	26.0	21.6
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	1.0071	24.5	20.4
102	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.9460	24.2	20.1
103	[6] HEART TRANSPLANT	0.0000	0.0	0.0
104	[8] CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH	1.9873	41.3	34.4
105	[8] CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH	1.9873	41.3	34.4
106	[8] CORONARY BYPASS W PTCA	1.9873	41.3	34.4
107	[8] CORONARY BYPASS W CARDIAC CATH	1.9873	41.3	34.4
108	[5] OTHER CARDIOTHORACIC PROCEDURES	1.9873	41.3	34.4
109	[8] CORONARY BYPASS W/O PTCA OR CARDIAC CATH	1.9873	41.3	34.4
110	[5] MAJOR CARDIOVASCULAR PROCEDURES W CC	1.9873	41.3	34.4
111	[8] MAJOR CARDIOVASCULAR PROCEDURES W/O CC	1.9873	41.3	34.4
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	1.5870	40.5	33.7
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.4854	39.9	33.2
115	[5] PRM CARD PACEM IMPL W AMI,HRT FAIL OR SHK,OR AICD LEAD OR GNRTR P	1.9873	41.3	34.4

TABLE 11.—PROPOSED LTC–DRGS RELATIVE WEIGHTS AND GEOMETRIC AND FIVE-SIXTHS OF THE AVERAGE LENGTH OF STAY—FY 2004—Continued

LTC–DRG	Description	Relative weight	Geo-metric average length of stay	5/6ths of the average length of stay
116	[5] OTH PERM CARD PACEMAK IMPL OR PTCA W CORONARY ARTERY STENT IMPLNT	1.9873	41.3	34.4
117	[3] CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	0.9785	27.4	22.8
118	[5] CARDIAC PACEMAKER DEVICE REPLACEMENT	1.9873	41.3	34.4
119	[3] VEIN LIGATION & STRIPPING	0.9785	27.4	22.8
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.2476	34.1	28.4
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	0.7531	21.9	18.2
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	0.6915	20.0	16.6
123	CIRCULATORY DISORDERS W AMI, EXPIRED	0.8856	19.0	15.8
124	[4] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	1.4090	34.1	28.4
125	[4] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	1.4090	34.1	28.4
126	ACUTE & SUBACUTE ENDOCARDITIS	0.8902	25.7	21.4
127	HEART FAILURE & SHOCK	0.7968	21.9	18.2
128	[1] DEEP VEIN THROMBOPHLEBITIS	0.5711	20.8	17.3
129	CARDIAC ARREST, UNEXPLAINED	1.4170	28.5	23.7
130	PERIPHERAL VASCULAR DISORDERS W CC	0.8207	25.0	20.8
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.6269	22.4	18.6
132	ATHEROSCLEROSIS W CC	0.8211	22.5	18.7
133	ATHEROSCLEROSIS W/O CC	0.7264	22.6	18.8
134	HYPERTENSION	0.8971	28.4	23.6
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.9873	23.8	19.8
136	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.7492	22.9	19.0
137	[8] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.7347	23.1	19.2
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.9390	25.2	21.0
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.6224	21.9	18.2
140	ANGINA PECTORIS	0.6056	19.3	16.0
141	SYNCOPE & COLLAPSE W CC	0.6735	23.3	19.4
142	SYNCOPE & COLLAPSE W/O CC	0.5149	20.5	17.0
143	CHEST PAIN	0.7317	21.9	18.2
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.8588	22.9	19.0
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.7001	21.4	17.8
146	[8] RECTAL RESECTION W CC	1.9873	41.3	34.4
147	[8] RECTAL RESECTION W/O CC	1.9873	41.3	34.4
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9660	36.8	30.6
149	[1] MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	0.5711	20.8	17.3
150	[4] PERITONEAL ADHESIOLYSIS W CC	1.4090	34.1	28.4
151	[8] PERITONEAL ADHESIOLYSIS W/O CC	1.4090	34.1	28.4
152	[4] MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.4090	34.1	28.4
153	[8] MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.4090	34.1	28.4
154	[5] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	1.9873	41.3	34.4
155	[8] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.9873	41.3	34.4
156	[8] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	1.9873	41.3	34.4
157	[8] ANAL & STOMAL PROCEDURES W CC	1.4090	34.1	28.4
158	[3] ANAL & STOMAL PROCEDURES W/O CC	0.9785	27.4	22.8
159	[8] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	1.4090	34.1	28.4
160	[8] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	1.4090	34.1	28.4
161	[4] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.4090	34.1	28.4
162	[8] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.5711	20.8	17.3
163	[8] HERNIA PROCEDURES AGE 0-17	0.5711	20.8	17.3
164	[8] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.9873	41.3	34.4
165	[8] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	0.5711	20.8	17.3
166	[8] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.9873	41.3	34.4
167	[8] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	0.5711	20.8	17.3
168	[5] MOUTH PROCEDURES W CC	1.9873	41.3	34.4
169	[8] MOUTH PROCEDURES W/O CC	0.5711	20.8	17.3
170	[7] OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	1.7827	42.2	35.1
171	[7] OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.7827	42.2	35.1
172	DIGESTIVE MALIGNANCY W CC	0.8857	22.4	18.6
173	DIGESTIVE MALIGNANCY W/O CC	0.7843	21.9	18.2
174	G.I. HEMORRHAGE W CC	0.8741	24.8	20.6
175	G.I. HEMORRHAGE W/O CC	0.6770	21.8	18.1
176	COMPLICATED PEPTIC ULCER	0.7835	20.6	17.1
177	[2] UNCOMPLICATED PEPTIC ULCER W CC	0.7347	23.1	19.2
178	[1] UNCOMPLICATED PEPTIC ULCER W/O CC	0.5711	20.8	17.3
179	INFLAMMATORY BOWEL DISEASE	1.0317	26.2	21.8
180	G.I. OBSTRUCTION W CC	0.9491	24.2	20.1
181	G.I. OBSTRUCTION W/O CC	0.7694	21.2	17.6
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.9666	25.5	21.2
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.7038	22.4	18.6

TABLE 11.—PROPOSED LTC–DRGS RELATIVE WEIGHTS AND GEOMETRIC AND FIVE-SIXTHS OF THE AVERAGE LENGTH OF STAY—FY 2004—Continued

LTC–DRG	Description	Relative weight	Geo-metric average length of stay	5/6ths of the aver-age length of stay
184	[8] ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.7347	23.1	19.2
185	DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.6932	24.6	20.5
186	[8] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	0.7347	23.1	19.2
187	[8] DENTAL EXTRACTIONS & RESTORATIONS	0.7347	23.1	19.2
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0481	26.0	21.6
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.8501	23.5	19.5
190	[8] OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.7347	23.1	19.2
191	[4] PANCREAS, LIVER & SHUNT PROCEDURES W CC	1.4090	34.1	28.4
192	[1] PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	0.5711	20.8	17.3
193	[2] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	0.7347	23.1	19.2
194	[2] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	0.7347	23.1	19.2
195	[4] CHOLECYSTECTOMY W C.D.E. W CC	1.4090	34.1	28.4
196	[8] CHOLECYSTECTOMY W C.D.E. W/O CC	0.9785	27.4	22.8
197	[3] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	0.9785	27.4	22.8
198	[8] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	0.9785	27.4	22.8
199	[8] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	0.7347	23.1	19.2
200	[2] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	0.7347	23.1	19.2
201	[5] OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	1.9873	41.3	34.4
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	0.7529	22.7	18.9
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	0.6801	19.2	16.0
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	1.0141	23.4	19.5
205	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.7334	22.3	18.5
206	[2] DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC	0.7347	23.1	19.2
207	DISORDERS OF THE BILIARY TRACT W CC	0.7940	22.1	18.4
208	[2] DISORDERS OF THE BILIARY TRACT W/O CC	0.7347	23.1	19.2
209	[5] MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY	1.9873	41.3	34.4
210	[4] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.4090	34.1	28.4
211	[2] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	0.7347	23.1	19.2
212	[8] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	0.7347	23.1	19.2
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.3912	34.9	29.0
216	[5] BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.9873	41.3	34.4
217	WND DEBRID & SKN GRFT EXCEPT HAND,FOR MUSCSKELET & CONN TISS DIS	1.4438	39.3	32.7
218	[3] LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W CC	0.9785	27.4	22.8
219	[8] LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE >17 W/O CC	0.9785	27.4	22.8
220	[8] LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR AGE 0-17	0.9785	27.4	22.8
223	[3] MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	0.9785	27.4	22.8
224	[8] SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC, W/O CC	0.7347	23.1	19.2
225	FOOT PROCEDURES	0.8912	26.7	22.2
226	[4] SOFT TISSUE PROCEDURES W CC	1.4090	34.1	28.4
227	[3] SOFT TISSUE PROCEDURES W/O CC	0.9785	27.4	22.8
228	[3] MAJOR THUMB OR JOINT PROC,OR OTH HAND OR WRIST PROC W CC	0.9785	27.4	22.8
229	[8] HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.7347	23.1	19.2
230	[4] LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.4090	34.1	28.4
232	[2] ARTHROSCOPY	0.7347	23.1	19.2
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	0.9797	28.5	23.7
234	[2] OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	0.7347	23.1	19.2
235	FRACTURES OF FEMUR	0.8715	29.7	24.7
236	FRACTURES OF HIP & PELVIS	0.7598	27.2	22.6
237	[2] SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.7347	23.1	19.2
238	OSTEOMYELITIS	0.8818	28.5	23.7
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	0.6892	22.4	18.6
240	CONNECTIVE TISSUE DISORDERS W CC	0.7118	21.4	17.8
241	CONNECTIVE TISSUE DISORDERS W/O CC	0.4744	19.4	16.1
242	SEPTIC ARTHRITIS	0.7814	26.2	21.8
243	MEDICAL BACK PROBLEMS	0.6867	23.5	19.5
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.5664	20.1	16.7
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.5134	19.5	16.2
246	NON-SPECIFIC ARTHROPATHIES	0.5556	23.0	19.1
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.5976	21.4	17.8
248	TENDONITIS, MYOSITIS & BURSITIS	0.7623	24.9	20.7
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.8101	27.3	22.7
250	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.8309	30.1	25.0
251	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.6031	26.7	22.2
252	[8] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.7347	23.1	19.2
253	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC	0.8406	27.1	22.5
254	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC	0.7028	25.8	21.5
255	[8] FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17	0.7347	23.1	19.2
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.8577	26.6	22.1

TABLE 11.—PROPOSED LTC–DRGS RELATIVE WEIGHTS AND GEOMETRIC AND FIVE-SIXTHS OF THE AVERAGE LENGTH OF STAY—FY 2004—Continued

LTC–DRG	Description	Relative weight	Geo-metric average length of stay	5/6ths of the aver-age length of stay
257	[3] TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9785	27.4	22.8
258	[8] TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.9785	27.4	22.8
259	[8] SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.9785	27.4	22.8
260	[8] SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.9785	27.4	22.8
261	[5] BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	1.9873	41.3	34.4
262	[1] BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.5711	20.8	17.3
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.4696	41.1	34.2
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.2160	39.9	33.2
265	[7] SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.2294	34.7	28.9
266	[7] SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	1.2294	34.7	28.9
267	[8] PERIANAL & PILONIDAL PROCEDURES	0.5711	20.8	17.3
268	[4] SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.4090	34.1	28.4
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.5232	45.2	37.6
270	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	1.0105	35.9	29.9
271	SKIN ULCERS	0.9795	29.9	24.9
272	MAJOR SKIN DISORDERS W CC	0.7163	22.7	18.9
273	[1] MAJOR SKIN DISORDERS W/O CC	0.5711	20.8	17.3
274	MALIGNANT BREAST DISORDERS W CC	0.9469	24.9	20.7
275	[2] MALIGNANT BREAST DISORDERS W/O CC	0.7347	23.1	19.2
276	[1] NON-MALIGANT BREAST DISORDERS	0.5711	20.8	17.3
277	CELLULITIS AGE >17 W CC	0.7762	24.1	20.0
278	CELLULITIS AGE >17 W/O CC	0.6373	21.6	18.0
279	CELLULITIS AGE 0-178	0.5711	20.8	17.3
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.9719	29.3	24.4
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.7915	27.8	23.1
282	[8] TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.7347	23.1	19.2
283	MINOR SKIN DISORDERS W CC	0.6998	20.7	17.2
284	MINOR SKIN DISORDERS W/O CC	0.6259	23.0	19.1
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS	1.5856	38.6	32.1
286	ADRENAL & PITUITARY PROCEDURES8	1.4090	34.1	28.4
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.4793	41.7	34.7
288	[5] O.R. PROCEDURES FOR OBESITY	1.9873	41.3	34.4
289	[8] PARATHYROID PROCEDURES	0.9785	27.4	22.8
290	[8] THYROID PROCEDURES	0.9785	27.4	22.8
291	[8] THYROGLOSSAL PROCEDURES	0.9785	27.4	22.8
292	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	1.5633	35.8	29.8
293	[3] OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	0.9785	27.4	22.8
294	DIABETES AGE >35	0.8729	26.6	22.1
295	[3] DIABETES AGE 0-35	0.9785	27.4	22.8
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.9560	26.3	21.9
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.7552	26.4	22.0
298	[8] NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.7347	23.1	19.2
299	[2] INBORN ERRORS OF METABOLISM	0.7347	23.1	19.2
300	ENDOCRINE DISORDERS W CC	0.8175	23.9	19.9
301	ENDOCRINE DISORDERS W/O CC	0.7287	22.9	19.0
302	[6] KIDNEY TRANSPLANT	0.0000	0.0	0.0
303	[8] KIDNEY,URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	1.9873	41.3	34.4
304	[5] KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	1.9873	41.3	34.4
305	[1] KIDNEY,URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	0.5711	20.8	17.3
306	[4] PROSTATECTOMY W CC	1.4090	34.1	28.4
307	[8] PROSTATECTOMY W/O CC	1.4090	34.1	28.4
308	[4] MINOR BLADDER PROCEDURES W CC	1.4090	34.1	28.4
309	[2] MINOR BLADDER PROCEDURES W/O CC	0.7347	23.1	19.2
310	[4] TRANSURETHRAL PROCEDURES W CC	1.4090	34.1	28.4
311	[1] TRANSURETHRAL PROCEDURES W/O CC	0.5711	20.8	17.3
312	[4] URETHRAL PROCEDURES, AGE >17 W CC	1.4090	34.1	28.4
313	[8] URETHRAL PROCEDURES, AGE >17 W/O CC	0.5711	20.8	17.3
314	[8] URETHRAL PROCEDURES, AGE 0-17	0.5711	20.8	17.3
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	1.5690	36.4	30.3
316	RENAL FAILURE	0.9869	24.5	20.4
317	[3] ADMIT FOR RENAL DIALYSIS	0.9785	27.4	22.8
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	0.7466	21.7	18.0
319	[1] KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.5711	20.8	17.3
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.7744	23.5	19.5
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.6641	23.0	19.1
322	[8] KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.7347	23.1	19.2
323	[2] URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.7347	23.1	19.2
324	[2] URINARY STONES W/O CC	0.7347	23.1	19.2

TABLE 11.—PROPOSED LTC–DRGS RELATIVE WEIGHTS AND GEOMETRIC AND FIVE-SIXTHS OF THE AVERAGE LENGTH OF STAY—FY 2004—Continued

LTC–DRG	Description	Relative weight	Geo-metric average length of stay	5/6ths of the aver-age length of stay
325	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.8854	27.2	22.6
326	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.7590	24.7	20.5
327	[8] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.7347	23.1	19.2
328	[1] URETHRAL STRICTURE AGE >17 W CC	0.5711	20.8	17.3
329	[8] URETHRAL STRICTURE AGE >17 W/O CC	0.5711	20.8	17.3
330	[8] URETHRAL STRICTURE AGE 0-17	0.5711	20.8	17.3
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	0.8847	23.8	19.8
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.6201	22.1	18.4
333	[8] OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.5711	20.8	17.3
334	[8] MAJOR MALE PELVIC PROCEDURES W CC	0.9785	27.4	22.8
335	[8] MAJOR MALE PELVIC PROCEDURES W/O CC	0.9785	27.4	22.8
336	[8] TRANSURETHRAL PROSTATECTOMY W CC	0.7347	23.1	19.2
337	[8] TRANSURETHRAL PROSTATECTOMY W/O CC	0.7347	23.1	19.2
338	[8] TESTES PROCEDURES, FOR MALIGNANCY	0.5711	20.8	17.3
339	[1] TESTES PROCEDURES, NON-MALIGNANCY AGE >17	0.5711	20.8	17.3
340	[8] TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.5711	20.8	17.3
341	[2] PENIS PROCEDURES	0.7347	23.1	19.2
342	[1] CIRCUMCISION AGE >17	0.5711	20.8	17.3
343	[8] CIRCUMCISION AGE 0-17	0.5711	20.8	17.3
344	[2] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	0.7347	23.1	19.2
345	[3] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	0.9785	27.4	22.8
346	[7] MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	0.7787	22.3	18.5
347	[7] MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.7787	22.3	18.5
348	[1] BENIGN PROSTATIC HYPERTROPHY W CC	0.5711	20.8	17.3
349	[1] BENIGN PROSTATIC HYPERTROPHY W/O CC	0.5711	20.8	17.3
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	1.1947	25.6	21.3
351	[8] STERILIZATION, MALE	0.5711	20.8	17.3
352	[3] OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.9785	27.4	22.8
353	[8] PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.9873	41.3	34.4
354	[8] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.9873	41.3	34.4
355	[8] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	1.9873	41.3	34.4
356	[8] FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.4090	34.1	28.4
357	[8] UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	1.4090	34.1	28.4
358	[8] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.4090	34.1	28.4
359	[8] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	1.4090	34.1	28.4
360	[4] VAGINA, CERVIX & VULVA PROCEDURES	1.4090	34.1	28.4
361	[8] LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	0.5711	20.8	17.3
362	[8] ENDOSCOPIC TUBAL INTERRUPTION	0.5711	20.8	17.3
363	[8] D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.7347	23.1	19.2
364	[8] D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.7347	23.1	19.2
365	[5] OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.9873	41.3	34.4
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	0.8153	23.0	19.1
367	[2] MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.7347	23.1	19.2
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.6911	20.1	16.7
369	[3] MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.9785	27.4	22.8
370	[8] CESAREAN SECTION W CC	0.9785	27.4	22.8
371	[8] CESAREAN SECTION W/O CC	0.7347	23.1	19.2
372	[8] VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.7347	23.1	19.2
373	[8] VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.7347	23.1	19.2
374	[8] VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.7347	23.1	19.2
375	[8] VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.7347	23.1	19.2
376	[1] POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.5711	20.8	17.3
377	[8] POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	0.7347	23.1	19.2
378	[8] ECTOPIC PREGNANCY	0.9785	27.4	22.8
379	[8] THREATENED ABORTION	0.5711	20.8	17.3
380	[8] ABORTION W/O D&C	0.5711	20.8	17.3
381	[8] ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.5711	20.8	17.3
382	[8] FALSE LABOR	0.5711	20.8	17.3
383	[8] OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.5711	20.8	17.3
384	[8] OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.5711	20.8	17.3
385	[1] NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0.5711	20.8	17.3
386	[8] EXTREME IMMATURITY	0.7347	23.1	19.2
387	[8] PREMATURITY W MAJOR PROBLEMS	0.7347	23.1	19.2
388	[8] PREMATURITY W/O MAJOR PROBLEMS	0.7347	23.1	19.2
389	[8] FULL TERM NEONATE W MAJOR PROBLEMS	0.7347	23.1	19.2
390	[8] NEONATE W OTHER SIGNIFICANT PROBLEMS	0.7347	23.1	19.2
391	[8] NORMAL NEWBORN	0.5711	20.8	17.3
392	[8] SPLENECTOMY AGE >17	0.7347	23.1	19.2

TABLE 11.—PROPOSED LTC–DRGS RELATIVE WEIGHTS AND GEOMETRIC AND FIVE-SIXTHS OF THE AVERAGE LENGTH OF STAY—FY 2004—Continued

LTC–DRG	Description	Relative weight	Geo-metric average length of stay	5/6ths of the aver-age length of stay
393	[8] SPLENECTOMY AGE 0-17	0.7347	23.1	19.2
394	[3] OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS4	1.4090	34.1	28.4
395	RED BLOOD CELL DISORDERS AGE >17	0.9050	26.8	22.3
396	[8] RED BLOOD CELL DISORDERS AGE 0-17	0.5711	20.8	17.3
397	COAGULATION DISORDERS	1.0816	25.2	21.0
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.9248	23.0	19.1
399	[1] RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.5711	20.8	17.3
401	[5] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	1.9873	41.3	34.4
402	[3] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	0.9785	27.4	22.8
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	0.9099	22.7	18.9
404	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.7410	17.9	14.9
405	[8] ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	0.7347	23.1	19.2
406	[5] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	1.9873	41.3	34.4
407	[8] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	0.9785	27.4	22.8
408	[3] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	0.9785	27.4	22.8
409	RADIOTHERAPY	0.8961	25.1	20.9
410	[3] CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	0.9785	27.4	22.8
411	[3] HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.9785	27.4	22.8
412	[5] HISTORY OF MALIGNANCY W ENDOSCOPY	1.9873	41.3	34.4
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	0.9603	25.2	21.0
414	[2] OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.7347	23.1	19.2
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	1.7239	40.9	34.0
416	SEPTICEMIA AGE >17	0.9553	25.2	21.0
417	[8] SEPTICEMIA AGE 0-17	0.9785	27.4	22.8
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	0.8612	25.3	21.0
419	[3] FEVER OF UNKNOWN ORIGIN AGE >17 W CC	0.9785	27.4	22.8
420	[1] FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.5711	20.8	17.3
421	[2] VIRAL ILLNESS AGE >17	0.7347	23.1	19.2
422	[8] VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.5711	20.8	17.3
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	0.9930	25.9	21.5
424	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	1.2281	44.2	36.8
425	ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION	0.6040	26.9	22.4
426	DEPRESSIVE NEUROSES	0.5583	23.3	19.4
427	[4] NEUROSES EXCEPT DEPRESSIVE	1.4090	34.1	28.4
428	[1] DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.5711	20.8	17.3
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.6562	27.4	22.8
430	PSYCHOSES	0.4808	22.6	18.8
431	[1] CHILDHOOD MENTAL DISORDERS	0.5711	20.8	17.3
432	[1] OTHER MENTAL DISORDER DIAGNOSES	0.5711	20.8	17.3
433	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.3416	14.6	12.1
439	SKIN GRAFTS FOR INJURIES	1.4429	41.2	34.3
440	WOUND DEBRIDEMENTS FOR INJURIES	1.6794	39.4	32.8
441	[5] HAND PROCEDURES FOR INJURIES	1.9873	41.3	34.4
442	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.6280	46.4	38.6
443	[3] OTHER O.R. PROCEDURES FOR INJURIES W/O CC	0.9785	27.4	22.8
444	TRAUMATIC INJURY AGE >17 W CC	0.9311	30.7	25.5
445	TRAUMATIC INJURY AGE >17 W/O CC	0.8278	27.3	22.7
446	[8] TRAUMATIC INJURY AGE 0-17	0.7347	23.1	19.2
447	[3] ALLERGIC REACTIONS AGE >17	0.9785	27.4	22.8
448	[8] ALLERGIC REACTIONS AGE 0-17	0.5711	20.8	17.3
449	[3] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.9785	27.4	22.8
450	[3] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.9785	27.4	22.8
451	[8] POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	0.5711	20.8	17.3
452	COMPLICATIONS OF TREATMENT W CC	0.9830	25.5	21.2
453	COMPLICATIONS OF TREATMENT W/O CC	0.8894	25.5	21.2
454	[2] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	0.7347	23.1	19.2
455	[1] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	0.5711	20.8	17.3
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.4214	36.6	30.5
462	REHABILITATION	0.6528	22.7	18.9
463	SIGNS & SYMPTOMS W CC	0.7824	26.4	22.0
464	SIGNS & SYMPTOMS W/O CC	0.6259	25.2	21.0
465	[1] AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.5711	20.8	17.3
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.7783	22.6	18.8
467	OTHER FACTORS INFLUENCING HEALTH STATUS	1.4773	32.6	27.1
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.0716	43.7	36.4
469	[6] PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
470	[6] UNGROUPABLE	0.0000	0.0	0.0
471	[5] BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	1.9873	41.3	34.4

TABLE 11.—PROPOSED LTC–DRGS RELATIVE WEIGHTS AND GEOMETRIC AND FIVE-SIXTHS OF THE AVERAGE LENGTH OF STAY—FY 2004—Continued

LTC–DRG	Description	Relative weight	Geo-metric average length of stay	5/6ths of the average length of stay
473	[2] ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	0.7347	23.1	19.2
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	2.0241	33.0	27.5
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.0056	32.9	27.4
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.8688	40.7	33.9
478	[7] OTHER VASCULAR PROCEDURES W CC	1.3238	34.9	29.0
479	[7] OTHER VASCULAR PROCEDURES W/O CC	1.3238	34.9	29.0
480	[6] LIVER TRANSPLANT	0.0000	0.0	0.0
481	[8] BONE MARROW TRANSPLANT	0.5711	20.8	17.3
482	[5] TRACHEOSTOMY FOR FACE,MOUTH & NECK DIAGNOSES	1.9873	41.3	34.4
483	TRACH W MECH VENT 96+ HRS OR PDX EXCEPT FACE,MOUTH & NECK DIAG	3.1562	54.9	45.7
484	[8] CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	1.9873	41.3	34.4
485	[8] LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR	1.9873	41.3	34.4
486	[4] OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	1.4090	34.1	28.4
487	OTHER MULTIPLE SIGNIFICANT TRAUMA	1.2653	33.2	27.6
488	[5] HIV W EXTENSIVE O.R. PROCEDURE	1.9873	41.3	34.4
489	HIV W MAJOR RELATED CONDITION	0.9656	22.1	18.4
490	HIV W OR W/O OTHER RELATED CONDITION	0.7956	20.5	17.0
491	[8] MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.9873	41.3	34.4
492	[8] CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS OR W USE HIGH DOSE CHEMOTHERAPY AGENT.	0.9785	27.4	22.8
493	[4] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.4090	34.1	28.4
494	[4] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.4090	34.1	28.4
495	[6] LUNG TRANSPLANT	0.0000	0.0	0.0
496	[8] COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	1.4090	34.1	28.4
497	[3] SPINAL FUSION W CC	0.9785	27.4	22.8
498	[3] SPINAL FUSION W/O CC	0.9785	27.4	22.8
499	[5] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.9873	41.3	34.4
500	[4] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	1.4090	34.1	28.4
501	[5] KNEE PROCEDURES W PDX OF INFECTION W CC	1.9873	41.3	34.4
502	[2] KNEE PROCEDURES W PDX OF INFECTION W/O CC	0.7347	23.1	19.2
503	[3] KNEE PROCEDURES W/O PDX OF INFECTION	0.9785	27.4	22.8
504	[8] EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	1.9873	41.3	34.4
505	[3] EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT	0.9785	27.4	22.8
506	[2] FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	0.7347	23.1	19.2
507	[2] FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	0.7347	23.1	19.2
508	[2] FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	0.7347	23.1	19.2
509	[1] FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	0.5711	20.8	17.3
510	[2] NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	0.7347	23.1	19.2
511	[1] NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.5711	20.8	17.3
512	[6] SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	0.0000	0.0	0.0
513	[6] PANCREAS TRANSPLANT	0.0000	0.0	0.0
515	[5] CARDIAC DEFIBRILATOR IMPLANT W/O CARDIAC CATH	1.9873	41.3	34.4
516	[8] PERCUTANEOUS CARDIVASCULAR PROCEDURE W AMI	0.9785	27.4	22.8
517	[4] PERCUTANEOUS CARDIVASCULAR PROC W NON-DRUG ELUTING STENT W/O AMI	1.4090	34.1	28.4
518	[3] PERCUTANEOUS CARDIVASCULAR PROC W/O CORONARY ARTERY STENT OR AMI	0.9785	27.4	22.8
519	[4] CERVICAL SPINAL FUSION W CC	1.4090	34.1	28.4
520	[8] CERVICAL SPINAL FUSION W/O CC	0.9785	27.4	22.8
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.5064	20.9	17.4
522	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC	0.4221	19.5	16.2
523	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC	0.4366	21.9	18.2
524	TRANSIENT ISCHEMIA	0.6178	23.4	19.5
525	[8] HEART ASSIST SYSTEM IMPLANT	1.9873	41.3	34.4
526	[8] PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W AMI	1.4090	34.1	28.4
527	[8] PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W/O AMI	1.4090	34.1	28.4
528	[8] INTRACRANIAL VASCLUAR PROCEDURES WITH PDX HEMORRHAGE	1.9873	41.3	34.4
529	[2] VENTRICULAR SHUNT PROCEDURES WITH CC	0.7347	23.1	19.2
530	[8] VENTRICULAR SHUNT PROCEDURES WITHOUT CC	0.7347	23.1	19.2
531	[8] SPINAL PROCEDURES WITH CC	1.4090	34.1	28.4
532	[4] SPINAL PROCEDURES WITHOUT CC	1.4090	34.1	28.4
533	[8] EXTRACRANIAL VASCULAR PROCEDURES WITH CC	1.9873	41.3	34.4
534	[5] EXTRACRANIAL VASCULAR PROCEDURES WITHOUT CC	1.9873	41.3	34.4
535	[8] CARDIAC DEFIB IMPLANT WITH CARDIAC CATH WITH AMI/HF/SHOCK	1.9873	41.3	34.4
536	[5] CARDIAC DEFIB IMPLANT WITH CARDIAC CATH WITHOUT AMI/HF/SHOCK	1.9873	41.3	34.4
537	[8] LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITH CC.	0.7347	23.1	19.2
538	[4] LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITHOUT CC.	1.4090	34.1	28.4
539	[8] LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITH CC	1.9873	41.3	34.4

TABLE 11.—PROPOSED LTC–DRGS RELATIVE WEIGHTS AND GEOMETRIC AND FIVE-SIXTHS OF THE AVERAGE LENGTH OF STAY—FY 2004—Continued

LTC–DRG	Description	Relative weight	Geo-metric average length of stay	5/6ths of the average length of stay
540	[1] LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITHOUT CC	0.5711	20.8	17.3

[1] Proposed relative weights for these proposed LTC–DRGs were determined by assigning these cases to proposed low volume quintile 1.
[2] Proposed relative weights for these proposed LTC–DRGs were determined by assigning these cases to proposed low volume quintile 2.
[3] Proposed relative weights for these proposed LTC–DRGs were determined by assigning these cases to proposed low volume quintile 3.
[4] Proposed relative weights for these proposed LTC–DRGs were determined by assigning these cases to proposed low volume quintile 4.
[5] Proposed relative weights for these proposed LTC–DRGs were determined by assigning these cases to proposed low volume quintile 5.
[6] Proposed relative weights for these proposed LTC–DRGs were assigned a value of 0.0000.
[7] Proposed relative weights for these proposed LTC–DRGs were determined after adjusting to account for nonmonotonicity (see step 5 above).
[8] Proposed relative weights for these proposed LTC–DRGs were determined by assigning these cases to the appropriate proposed low volume quintile because they had no LTCH cases in the FY 2002 MedPAR.

Appendix A—Regulatory Analysis of Impacts

I. Background and Summary

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined that this proposed rule is a major rule as defined in 5 U.S.C. 804(2). Based on the overall percentage change in payments per case estimated using our payment simulation model (a 2.5 percent increase), we estimate that the total impact of these proposed changes for FY 2004 payments compared to FY 2003 payments to be approximately a $2.1 billion increase. This amount does not reflect changes in hospital admissions or case-mix intensity, which would also affect overall payment changes.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million to $25 million in any 1 year. For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the acute care hospital inpatient prospective payment systems, we classify these hospitals as urban hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any proposed rule (or a final rule that has been preceded by a proposed rule) that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This proposed rule would not mandate any requirements for State, local, or tribal governments.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this proposed rule in light of Executive Order 13132 and have determined that it would not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

The following analysis, in conjunction with the remainder of this document, demonstrates that this proposed rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The proposed rule would affect payments to a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some hospitals may be significant.

II. Objectives

The primary objective of the IPPS is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of preserving the Medicare Trust Fund.

We believe the changes in this proposed rule would further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these proposed changes would ensure that the outcomes of this payment system are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our proposed policy changes, as well as statutory changes effective for FY 2004, on various hospital groups. We estimate the effects of individual proposed policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but we do not attempt to predict behavioral responses to our proposed policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. As we have done in previous proposed rules, we are soliciting comments and information about the anticipated effects of these proposed changes on hospitals and our methodology for estimating them.

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 45 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 48 such hospitals in Maryland remain excluded from the IPPS under the waiver at section 1814(b)(3) of the Act.

There are approximately 729 critical access hospitals (CAHs). These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. The remaining 20 percent are specialty hospitals that are excluded from the IPPS. These specialty hospitals include psychiatric hospitals and units, rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals. The impacts of our proposed policy changes on these hospitals are discussed below.

Thus, as of April 2003, we have included 4,087 hospitals in our analysis. This represents about 80 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

V. Impact on Excluded Hospitals and Hospital Units

As of April 2003, there were 1,085 specialty hospitals excluded from the IPPS that were paid instead on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. Broken down by specialty, there were 484 psychiatric, 214 rehabilitation, 296 long-term care, 80 children's, and 11 cancer hospitals. In addition, there were 1,410 psychiatric units and 979 rehabilitation units in hospitals otherwise subject to the IPPS. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 48 specialty hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

In the past, hospitals and units excluded from the IPPS have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Hospitals that continue to be paid based on their reasonable costs are subject to TEFRA limits for FY 2004. For these hospitals, the proposed update is the percentage increase in the excluded hospital market basket (currently estimated at 3.5 percent).

Inpatient rehabilitation facilities (IRFs) are paid under a prospective payment system (IRF PPS) for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2004, the IRF PPS is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually. Therefore, these hospitals would not be impacted by this proposed rule.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs are paid under a LTCH PPS, based on the adjusted Federal prospective payment amount, updated annually. LTCHs will receive a blended payment (Federal prospective payment and a reasonable cost-based payment) over a 5-year transition period. However, under the LTCH PPS, a LTCH may also elect to be paid at 100 percent of the Federal prospective rate at the beginning of any of its cost reporting periods during the 5-year transition period. For purposes of the update factor, the portion of the LTCH PPS transition blend payment based on reasonable costs for inpatient operating services would be determined by updating the LTCH's TEFRA limit by the estimate of the excluded hospital market basket (or 3.5 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 would be 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 would be the amount of excess costs that would not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and hospital units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and hospital units to restrain the growth in their spending for patient services.

VI. Quantitative Impact Analysis of the Proposed Policy Changes Under the IPPS for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing policy changes and payment rate updates for the IPPS for operating and capital-related costs. Based on the overall percentage change in payments per case estimated using our payment simulation model (a 2.5 percent increase), we estimate the total impact of these changes for FY 2004 payments compared to FY 2003 payments to be approximately a $2.1 billion increase. This amount does not reflect changes in hospital admissions or case-mix intensity, which would also affect overall payment changes.

We have prepared separate impact analyses of the proposed changes to each system. This section deals with changes to the operating prospective payment system. Our payment simulation model relies on available data to enable us to estimate the impacts on payments per case of certain changes we are proposing in this proposed rule. However, there are other changes we are proposing for which we do not have data available that would allow us to estimate the payment impacts using this model. For those proposals, we have attempted to predict the payment impacts of those proposed changes based upon our experience and other more limited data.

The data used in developing the quantitative analyses of changes in payments per case presented below are taken from the FY 2002 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Although the analyses of the changes to the operating PPS do not incorporate cost data, data from the most recently available hospital cost report were used to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to these proposed policy changes, and we do not adjust for future changes in such variables as admissions, lengths of stay, or case-mix. Second, due to the interdependent nature of the IPPS payment components, it is very difficult to precisely quantify the impact associated with each proposed change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. However, for individual hospitals, some miscategorizations are possible.

Using cases in the FY 2002 MedPAR file, we simulated payments under the operating IPPS given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the IPPSs (Indian Health Service hospitals and hospitals in Maryland) were excluded from the simulations. The impact of payments under the capital IPPS, or the impact of payments for costs other than inpatient operating costs, are not analyzed in this section. Estimated payment impacts of proposed FY 2004 changes to the capital IPPS are discussed in section IX. of this Appendix.

The proposed changes discussed separately below are the following:

- The effects of expanding the postacute care transfer policy to 19 additional DRGs.
- The effects of the proposed annual reclassification of diagnoses and procedures and the recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of the proposed changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 2000, compared to the FY 1999 wage data, including the effects of removing wage data for Part B costs of RCHs and FQHCs.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2004.
- The total change in payments based on proposed FY 2004 policies relative to payments based on FY 2003 policies.

To illustrate the impacts of the proposed FY 2004 changes, our analysis begins with a FY 2004 baseline simulation model using: the FY 2003 DRG GROUPER (version 20.0); the current postacute care transfer policy for 10 DRGs; the FY 2003 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total operating DRG and outlier payments.

Each proposed and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2004 model incorporating all of the proposed changes. This allows us to isolate the effects of each proposed change.

Our final comparison illustrates the percent change in payments per case from FY

2003 to FY 2004. Five factors have significant impacts here. The first is the update to the standardized amounts. In accordance with section 1886(b)(3)(B)(i) of the Act, we are proposing to update the large urban and the other areas average standardized amounts for FY 2004 using the most recently forecasted hospital market basket increase for FY 2004 of 3.5 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 3.5 percent.

A second significant factor that impacts changes in hospitals' payments per case from FY 2003 to FY 2004 is the change in MGCRB status from one year to the next. That is, hospitals reclassified in FY 2003 that are no longer reclassified in FY 2004 may have a negative payment impact going from FY 2003 to FY 2004; conversely, hospitals not reclassified in FY 2003 that are reclassified in FY 2004 may have a positive impact. In some cases, these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage change in payments for the category may be below the national mean. However, this effect is alleviated by section 1886(d)(10)(D)(v) of the Act, which provides that reclassifications for purposes of the wage index are for a 3-year period.

A third significant factor is that we currently estimate that actual outlier payments during FY 2003 will be 5.5 percent of total DRG payments. When the FY 2003 final rule was published, we projected FY 2003 outlier payments would be 5.1 percent of total DRG plus outlier payments; the average standardized amounts were offset correspondingly. The effects of the higher than expected outlier payments during FY 2003 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 2003 payments per case to estimated FY 2004 payments per case.

Fourth, we are proposing to expand the postacute care transfer policy to 19 additional DRGs. This proposed expansion would result in Medicare savings of $160 million because we would no longer pay a full DRG payment for these cases. As a result, there would be a lower total increase in Medicare spending for FY 2004.

Fifth, section 402(b) of Pub. L. 108–7 provided that the large urban standardized amount of the Federal rate is applicable for all IPPS hospitals for discharges occurring on or after April 1, 2003, and before October 1, 2003. For discharges occurring on or after October 1, 2003, the Federal rate will again be based on separate average standardized amounts for hospitals in large urban areas and for hospitals in other areas. The effect is to reduce the percent increase in FY 2004 payments compared to those made in FY 2003.

B. Analysis of Table I

Table I demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 4,087 hospitals included in the analysis. This number is 143 fewer hospitals than were included in the impact analysis in the FY 2003 final rule (67 FR 50279). There are 98 new CAHs that were excluded from last year's analysis.

The next four rows of Table I contain hospitals categorized according to their geographic location: all urban, which is further divided into large urban and other urban; and rural. There are 2,582 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,493 hospitals located in large urban areas (populations over 1 million), and 1,089 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 1,505 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2004 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the number of hospitals paid based on these categorizations after consideration of geographic reclassifications are 2,591, 1,572, 1,019, and 1,496, respectively.

The next three groupings examine the impacts of the proposed changes on hospitals grouped by whether or not they have GME residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 2,976 nonteaching hospitals in our analysis, 873 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 after MGCRB reclassifications. Therefore, hospitals in the rural DSH categories represent hospitals that were not reclassified for purposes of the standardized amount or for purposes of the DSH adjustment. (However, they may have been reclassified for purposes of the wage index.)

The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the proposed changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and MDHs), as well as rural hospitals not receiving a special payment designation. The RRCs (149), SCHs (494), MDHs (254), and hospitals that are both SCH and RRC (78) shown here were not reclassified for purposes of the standardized amount.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 2000 Medicare cost report files, if available (otherwise FY 1999 data are used). Data needed to determine ownership status were unavailable for 120 hospitals. Similarly, the data needed to determine Medicare utilization were unavailable for 104 hospitals.

The next series of groupings concern the geographic reclassification status of hospitals. The first grouping displays all hospitals that were reclassified by the MGCRB for FY 2004. The next two groupings separate the hospitals in the first group by urban and rural status. The final row in Table I contains hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act.

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2004 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent changes in payments per case]

	Number of hosps.[1]	Transfer changes 2004 base[2]	DRG changes[3]	New wage data[4]	New wage index without nonphys. part B[5]	DRG & wage index changes[6]	MCGRB reclassification[7]	ALL FY 2004 changes[8]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
By Geographic Location:								
All hospitals	4,087	−0.2	0.0	−0.4	0.1	0.0	0.0	2.5
Urban hospitals	2,582	−0.2	0.0	−0.5	0.1	0.0	−0.4	2.5
Large urban areas (populations over 1 million)	1,493	−0.2	0.0	−0.4	0.0	−0.1	−0.4	2.6

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2004 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case]

	Number of hosps.[1]	Transfer changes 2004 base[2]	DRG changes[3]	New wage data[4]	New wage index without nonphys. part B[5]	DRG & wage index changes[6]	MCGRB reclassification[7]	ALL FY 2004 changes[8]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Other urban areas (populations of 1 million of fewer)	1,089	−0.2	−0.1	−0.5	0.3	0.1	−0.2	2.2
Rural hospitals	1,505	−0.2	0.0	−0.2	0.0	0.5	2.6	3.1
Bed Size (Urban):								
0–99 beds	626	−0.3	0.0	−0.1	0.3	0.6	−0.7	2.7
100–199 beds	916	−0.2	0.0	−0.4	0.2	0.1	−0.4	2.6
200–299 beds	507	−0.2	0.0	−0.5	0.1	−0.1	−0.3	2.3
300–499 beds	377	−0.2	0.0	−0.3	0.1	0.1	−0.3	2.5
500 or more beds	156	−0.1	−0.1	−0.8	0.1	−0.5	−0.4	2.3
Bed Size (Rural):								
0–49 beds	690	−0.2	0.2	−0.3	0.0	0.7	0.6	3.4
50–99 beds	477	−0.2	0.0	−0.2	0.0	0.5	1.0	3.3
100–149 beds	202	−0.2	0.0	−0.3	0.0	0.3	2.9	2.8
150–199 beds	70	−0.2	−0.1	0.0	0.0	0.7	4.6	2.7
200 or more beds	66	−0.1	−0.1	−0.1	0.0	0.4	4.8	3.0
Urban by Region:								
New England	134	−0.4	0.0	−1.0	0.8	1.1	−0.1	2.7
Middle Atlantic	394	−0.2	0.0	−1.0	0.1	−0.7	0.1	1.7
South Atlantic	372	−0.2	0.0	−0.4	0.1	−0.1	−0.5	2.5
East North Central	429	−0.2	0.0	−0.5	0.1	−0.1	−0.4	2.5
East South Central	155	−0.1	−0.1	0.3	0.1	0.6	−0.6	3.1
West North Central	176	−0.2	−0.1	0.1	0.1	0.3	−0.7	2.8
West South Central	329	−0.1	0.0	−0.4	0.0	−0.2	−0.6	2.5
Mountain	131	−0.2	−0.2	0.5	0.1	0.7	−0.5	3.5
Pacific	416	−0.2	−0.1	−0.4	0.1	−0.1	−0.4	2.5
Puerto Rico	46	0.0	−0.1	−0.1	0.0	−0.1	−0.7	2.9
Rural by Region:								
New England	38	−0.2	−0.1	0.3	0.0	0.8	2.6	3.3
Middle Atlantic	67	−0.2	0.1	−0.1	0.0	0.3	2.4	2.6
South Atlantic	221	−0.2	0.0	−0.3	0.0	0.2	2.9	2.3
East North Central	199	−0.2	−0.1	0.2	0.0	0.8	2.1	3.1
East South Central	232	−0.2	0.1	−0.2	0.0	0.4	2.8	3.0
West North Central	254	−0.1	−0.1	−0.2	0.1	1.0	1.9	3.8
West South Central	273	−0.1	0.1	−0.4	0.1	0.2	3.7	3.5
Mountain	127	−0.1	−0.1	−0.2	0.0	0.3	1.5	3.2
Pacific	89	−0.2	−0.1	−0.5	0.1	0.5	2.5	3.5
Puerto Rico	5	0.0	−0.1	−4.1	0.0	−4.1	0.4	−0.2
By Payment Classification:								
Urban hospitals	2,591	−0.2	0.0	−0.5	0.1	0.0	−0.3	2.5
Large urban areas (populations over 1 million)	1,572	−0.2	0.0	−0.4	0.1	−0.1	−0.2	2.7
Other urban areas (populations of 1 million of fewer)	1,019	−0.2	−0.1	−0.5	0.3	0.1	−0.4	2.2
Rural areas	1,496	−0.2	0.0	−0.2	0.0	0.5	2.2	3.0
Teaching Status:								
Non-teaching	2,976	−0.2	0.0	−0.3	0.1	0.2	0.4	2.6
Fewer than 100 Residents	873	−0.2	−0.1	−0.2	0.1	0.2	−0.2	2.6
100 or more Residents	238	−0.2	−0.1	−0.9	0.1	−0.5	−0.1	2.3
Urban DSH:								
Non-DSH	1,381	−0.2	−0.1	−0.2	0.1	0.2	0.0	2.7
100 or more beds	1,398	−0.2	0.0	−0.6	0.1	−0.1	−0.3	2.4
Less than 100 beds	276	−0.3	0.0	−0.2	0.3	0.5	−0.5	2.4
Rural DSH:								
Sole Community (SCH)	484	−0.1	0.1	−0.2	0.0	0.5	0.4	3.7
Referral Center (RRC)	161	−0.1	−0.1	−0.1	0.0	0.4	4.6	2.8
Other Rural: 100 or more beds	75	−0.3	0.1	−0.5	0.0	0.1	1.0	1.9
Less than 100 beds	312	−0.3	0.2	−0.4	0.0	0.3	1.0	2.5
Urban teaching and DSH:								
DSH	771	−0.2	0.0	−0.6	0.1	−0.1	−0.3	2.5
Teaching and no DSH	273	−0.2	−0.1	−0.3	0.1	0.0	−0.2	2.6
No teaching and DSH	903	−0.2	0.0	−0.5	0.2	0.0	−0.2	2.3
No teaching and no DSH	644	−0.2	0.0	−0.2	0.1	0.3	−0.3	2.7
Rural Hospital Types:								

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2004 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent changes in payments per case]

	Number of hosps.[1] (1)	Transfer changes 2004 base[2] (2)	DRG changes[3] (3)	New wage data[4] (4)	New wage index without nonphys. part B[5] (5)	DRG & wage index changes[6] (6)	MCGRB reclassification[7] (7)	ALL FY 2004 changes[8] (8)
Non special status hospitals	521	−0.3	0.1	−0.4	0.0	0.3	1.0	2.2
RRC	149	−0.2	−0.1	−0.1	0.0	0.6	5.9	2.6
SCH	494	−0.1	0.0	−0.1	0.0	0.5	0.3	3.9
Medicare-dependent hospitals (MDH)	254	−0.3	0.2	−0.2	0.0	0.8	0.7	3.3
SCH and RRC	78	0.0	−0.1	−0.1	0.0	0.3	1.4	3.3
Type of Ownership:								
Voluntary	2,435	−0.2	0.0	−0.5	0.1	0.0	0.0	2.5
Proprietary	699	−0.2	0.0	−0.2	0.1	0.2	0.0	2.6
Government	833	−0.2	0.0	−0.4	0.1	0.0	0.3	2.7
Unknown	120	−0.1	0.0	−1.1	0.0	−0.8	−0.4	1.8
Medicare Utilization as a Percent of Inpatient Days:								
0–25	304	−0.2	−0.1	0.0	0.0	0.1	−0.3	3.0
25–50	1,557	−0.2	0.0	−0.5	0.1	−0.1	−0.2	2.5
50–65	1,663	−0.2	0.0	−0.4	0.2	0.2	0.3	2.5
Over 65	459	−0.2	0.0	−0.1	0.1	0.4	0.7	2.7
Unknown	104	−0.2	−0.1	0.0	0.0	0.2	−0.6	3.0
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2004 Reclassifications:								
All Reclassified Hospitals	639	−0.2	0.0	−0.3	0.1	0.3	4.3	3.0
Standardized Amount Only	22	−0.2	0.0	−0.7	0.5	0.0	3.9	5.8
Wage Index Only	556	−0.2	0.0	−0.4	0.2	0.3	4.3	2.4
Both	33	−0.2	−0.1	−0.4	0.2	0.2	6.0	3.1
Nonreclassified Hospitals	3,442	−0.2	0.0	−0.4	0.1	0.0	−0.62.5	
All Reclassified Urban Hospitals	136	−0.2	0.0	−0.5	0.3	0.1	4.0	2.7
Standardized Amount Only	13	−0.2	−0.1	−1.4	0.2	−1.2	0.9	2.4
Wage Index Only	82	−0.2	0.0	−0.7	0.3	0.1	3.9	2.3
Both	41	−0.3	0.0	0.1	0.2	0.6	5.4	3.8
Urban Nonreclassified Hospitals	2,415	−0.2	0.0	−0.5	0.1	−0.1	−0.6	2.4
All Reclassified Rural Hospitals	503	−0.2	−0.1	−0.1	0.0	0.5	4.6	3.2
Standardized Amount Only	15	−0.2	0.1	−0.4	0.1	0.4	4.8	2.1
Wage Index Only	464	−0.1	−0.1	−0.1	0.0	0.5	4.2	3.2
Both	24	−0.2	0.0	−0.1	0.0	0.5	8.7	3.8
Rural Nonreclassified Hospitals	999	−0.2	0.1	−0.3	0.0	0.5	−0.5	2.8
Other Reclassified Hospitals (Section 1886(D)(8)(B))	34	−0.2	0.1	0.0	0.0	0.4	−2.0	1.8

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2002, and hospital cost report data are from reporting periods beginning in FY 2000 and FY 1999.

[2] This column displays the payment impact of the expanded postacute care transfer policy.

[3] This column displays the payment impact of the recalibration of the DRG weights based on FY 2002 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

[4] This column displays the impact of updating the wage index with wage data from hospitals' FY 2000 cost reports.

[5] This column displays the impact of removing nonphysician Part B costs and hours from cost report data (Worksheet S–3, Part II, Line 5.01).

[6] This column displays the combined impact of the reclassification and recalibration of the DRGs, the updated and revised wage data used to calculate the wage index, the removal of nonphysician Part B costs and hours, and the budget neutrality adjustment factor for DRG and wage index changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 3, 4, and 5, and the proposed FY 2004 budget neutrality factor of 1.003133.

[7] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2004 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2004. Reclassification for prior years has no bearing on the payment impacts shown here.

[8] This column shows changes in payments from FY 2003 to FY 2004. It incorporates all of the changes displayed in columns 2, 6, and 7 (the changes displayed in columns 3, 4, and 5 are included in column 6). It also reflects the impact of the FY 2004 update, changes in hospitals' reclassification status in FY 2004 compared to FY 2003, and the difference in outlier payments from FY 2003 to FY 2004. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effect.

C. Impact of the Proposed Changes to the Postacute Care Transfer Policy (Column 2)

In column 2 of Table I, we present the effects of the postacute care transfer policy expansion, as discussed in section IV.A. of the preamble to this proposed rule. We compared aggregate payments using the FY 2003 DRG relative weights (GROUPER version 21.0) with the expanded postacute care transfer policy to aggregate payments using the proposed expanded postacute care transfer policy (with the additional 19 DRGs). The changes we are proposing to make would result in 0.2 percent lower payments to

hospitals overall. We estimate the total savings at approximately $160 million.

To simulate the impact of this proposed policy, we calculated hospitals' transfer-adjusted discharges and case-mix index values, including the proposed additional 19 DRGs. The transfer-adjusted discharge fraction is calculated in one of two ways, depending on the transfer payment methodology. Under our current transfer payment methodology, for all but the three DRGs receiving special payment consideration (DRGs 209, 210, and 211), this adjustment is made by adding 1 to the length of stay and dividing that amount by the geometric mean length of stay for the DRG (with the resulting fraction not to exceed 1.0). For example, a transfer after 3 days from a DRG with a geometric mean length of stay of 6 days would have a transfer-adjusted discharge fraction of 0.667 ((3+1)/6).

For transfers from any one of the three DRGs receiving the alternative payment methodology, the transfer-adjusted discharge fraction is 0.5 (to reflect that these cases receive half the full DRG amount the first day), plus one half of the result of dividing 1 plus the length of stay prior to transfer by the geometric mean length of stay for the DRG. None of the proposed 19 additional DRGs would receive the alternative payment methodology. As with the above adjustment, the result is equal to the lesser of the transfer-adjusted discharge fraction or 1.

The transfer-adjusted case-mix index values are calculated by summing the transfer-adjusted DRG weights and dividing by the transfer-adjusted discharges. The transfer-adjusted DRG weights are calculated by multiplying the DRG weight by the lesser of 1 or the transfer-adjusted discharge fraction for the case, divided by the geometric mean length of stay for the DRG. In this way, simulated payments per case can be compared before and after the proposed change to the transfer policy.

This proposed expansion of the policy has a negative 0.2 percent payment impact overall among both urban and rural hospitals. There is very small variation among all of the hospital categories from this negative 0.2 percent impact. This outcome is different than the impacts exhibited when we implemented the postacute care transfer policy for the current 10 DRGs in the July 31, 1998 **Federal Register** (63 FR 41108). At that time, the impact of going from no postacute transfer policy to a postacute care transfer policy applicable to 10 DRGs was a 0.6 percent decrease in payments per case. In addition, at that time, the impact was greatest among urban hospitals (0.7 percent payment decrease, compared to 0.4 percent among rural hospitals).

The less dramatic impact observed for this proposed expansion to additional DRGs is not surprising. The movement to transfer more and more patients for postacute care sooner appears to have abated in recent years. While it does appear that many patients continue to be transferred for postacute care early in the course of their acute care treatment, the rapid expansion of this trend that was apparent during the mid-90s appears to have subsided. To a large extent, this decline probably stems from the decreased payment incentives to transfer patients to postacute care settings as a result of the implementation of prospective payment systems for IRFs, SNFs, LTCHs, and HHAs.

D. Impact of the Proposed Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 3)

In column 3 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II. of the preamble to this proposed rule. Section 1886(d)(4)(C)(i) of the Act requires us annually to make appropriate classification changes and to recalibrate the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

We compared aggregate payments using the FY 2003 DRG relative weights (GROUPER version 20.0) to aggregate payments using the proposed FY 2004 DRG relative weights (GROUPER version 21.0). Both simulations reflected the proposed expansion of the postacute care transfer policy. We note that, consistent with section 1886(d)(4)(C)(iii) of the Act, we have applied a budget neutrality factor to ensure that the overall payment impact of the DRG changes (combined with the wage index changes) is budget neutral. This proposed budget neutrality factor of 1.003133 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 this column.

The major DRG classification changes we are proposing are: Creating additional DRGs that are split based on the presence or absence of CCs; creating a new DRG for cases with ruptured brain aneurysms; and creating a new DRG for cases involving the implantation of a cardiac defibrillator where the patient experiences acute myocardial infarction, heart failure, or shock. In the aggregate, these proposed changes would result in 0.0 percent change in overall payments to hospitals.

The overall level of the DRG weights are determined by the normalization factor intended to ensure that recalibration by itself neither increases nor decreases total payments under the IPPS. Because we count transfer cases as a fraction of a case in the recalibration process, expanding the postacute care transfer policy to 19 additional DRGs would affect the proposed relative weights for those DRGs. Therefore, we calculated the proposed FY 2004 normalization factor comparing the case-mix using the proposed FY 2004 DRG relative weights in which we treated postacute care transfer cases in the 19 additional DRGs being proposed for FY 2004 as a fraction of a case with the case-mix using the FY 2003 DRG relative weights without treating cases in these 19 additional DRGs as transfer cases. As noted above, the proposed expansion of the postacute care transfer policy impacts the overall level of the DRG weights, contributing to the impacts seen in this column.

Rural hospitals with fewer than 50 beds would experience a 0.2 percent increase due to these changes, while rural hospitals with more than 150 beds will experience a 0.1 percent decrease. Also, RRCs and hospitals classified with both SCH and RRC would experience a 0.1 percent decrease. MDHs would experience a 0.2 percent increase. Hospitals in the urban Mountain census division would experience the largest change, with a 0.2 percent decrease. Again, these impacts are ultimately offset by the budget neutrality factor of 1.003133.

E. Impact of Proposed Wage Index Changes (Columns 4 and 5)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the proposed wage index for FY 2004 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000. As with column 3, the impact of the new data on hospital payments is isolated in column 4 by holding the other payment parameters constant in this simulation. That is, column 4 shows the percentage changes in payments when going from a model using the FY 2003 wage index (based on FY 1999 wage data to a model using the FY 2004 pre-reclassification wage index based on FY 2000 wage data).

The wage data collected on the FY 2000 cost reports are similar to the data used in the calculation of the FY 2003 wage index. Also, as described in section III.B of this preamble, the proposed FY 2004 wage index is calculated by removing the nonphysician Part B costs and hours of RHCs and FQHCs, shown in column 5.

Column 4 shows the impacts of updating the wage data using FY 2000 cost reports. Overall, the new wage data would lead to a 0.4 percent reduction, but this reduction is offset by the budget neutrality factor. Urban hospitals' wage indexes would decline by 0.5 percent, and rural hospitals' wage indexes would decline by 0.2 percent. Among regions, the largest impact of updating the wage data is seen in rural Puerto Rico (a 4.1 percent decrease). Rural hospitals in the Pacific and West South Central regions would experience the next largest impact, a 0.5 percent and 0.4 percent decrease, respectively. Rural New England and East North Central regions would experience an increase of 0.3 percent and 0.2 percent, respectively.

Among urban hospitals, New England and the Middle Atlantic regions would experience 1.0 percent decreases, respectively. These impacts result, respectively, from a 9.0 percent decrease in the proposed FY 2004 wage index for Springfield, Massachusetts, and a 6.1 percent decrease in the Pittsburgh, Pennsylvania wage index. The East South Central, West North Central, and Mountain regions would experience increases of 0.3 percent, 0.1 percent, and 0.5 percent, respectively.

The next column shows the impacts on the calculation of the proposed FY 2004 wage index of removing nonphysician Part B data for RHCs and FQHCs. Column 5 shows the impacts of removing nonphysician Part B costs for RHCs and FQHCs. The effects of this proposed change are relatively small with the

exception of New England, which would experience a 0.8 percent decrease.

We note that the wage data used for the proposed wage index are based upon the data available as of March 2003 and, therefore, do not reflect revision requests received and processed by the fiscal intermediaries after that date. To the extent these requests are granted by hospitals' fiscal intermediaries, these revisions will be reflected in the final rule. In addition, we continue to verify the accuracy of the data for hospitals with extraordinary changes in their data from the prior year.

The following chart compares the shifts in wage index values for labor market areas for FY 2004 relative to FY 2003. This chart demonstrates the impact of the changes for the proposed FY 2004 wage index, including updating to FY 2000 wage data. The majority of labor market areas (331) would experience less than a 5-percent change. A total of 13 labor market areas would experience an increase of more than 5 percent and less than 10 percent. Two areas would experience an increase greater than 10 percent. A total of 24 areas would experience decreases of more than 5 percent and less than 10 percent. Finally, 3 areas would experience declines of 10 percent or more.

Percentage change in area wage index values	Number of labor market areas	
	FY 2003	FY 2004
Increase more than 10 percent	3	2
Increase more than 5 percent and less than 10 percent	11	13
Increase or decrease less than 5 percent	343	331
Decrease more than 5 percent and less than 10 percent	15	24
Decrease more than 10 percent	1	3

Among urban hospitals, 45 would experience an increase of between 5 and 10 percent and 8 more than 10 percent. A total of 64 rural hospitals would experience increases greater than 5 percent, but none would experience greater than 10-percent increases. On the negative side, 109 urban hospitals would experience decreases in their wage index values of at least 5 percent but less than 10 percent. Nine urban hospitals and one rural hospital would experience decreases in their wage index values greater than 10 percent. There are 25 rural hospitals that would experience decreases in their wage index values of greater than 5 percent but less than 10 percent. The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	8	0
Increase more than 5 percent and less than 10 percent	45	64
Increase or decrease less than 5 percent	2,436	1,714
Decrease more than 5 percent and less than 10 percent	109	25
Decrease more than 10 percent	9	1

F. Combined Impact of Proposed DRG and Wage Index Changes, Including Budget Neutrality Adjustment (Column 6)

The impact of the DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this proposed rule, we compared simulated aggregate payments using the FY 2003 DRG relative weights and wage index to simulated aggregate payments using the proposed FY 2004 DRG relative weights and blended wage index. In addition, we are required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. As discussed in section II.E. of the preamble of this proposed rule, we are proposing to maintain the new technology status of Xigris™ (approved in last year's final rule at 67 FR 50013). We estimate the proposed total add-on payments for this new technology for FY 2004 would be $50 million.

We computed a proposed wage and recalibration budget neutrality factor of 1.003133. The 0.0 percent impact for all hospitals demonstrates that these proposed changes, in combination with the proposed budget neutrality factor, are budget neutral. In Table I, the combined overall impacts of the effects of both the proposed DRG reclassifications and recalibration and the proposed updated wage index are shown in column 6. The proposed changes in this column are the sum of the proposed changes in columns 3, 4, and 5, combined with the budget neutrality factor and the wage index floor for urban areas required by section 4410 of Pub. L. 105–33 to be budget neutral. There also may be some variation of plus or minus 0.1 percentage point due to rounding.

G. Impact of MGCRB Reclassifications (Column 7)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 7 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2004. These decisions affect hospitals' standardized amount and wage index area assignments.

By February 28 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. The MGCRB may approve a hospital's reclassification request for the purpose of using another area's standardized amount, wage index value, or both. The proposed FY 2004 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2004. The wage index values also reflect any decisions made by the CMS Administrator through the appeals and review process as of February 28, 2003. Additional changes that result from the Administrator's review of MGCRB decisions or a request by a hospital to withdraw its application will be reflected in the final rule for FY 2004.

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 1.003133 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this proposed rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments would rise 2.6 percent in column 7. Payments to urban hospitals would decline 0.4 percent. Hospitals in other urban areas would experience an overall decrease in payments of 0.2 percent, while large urban hospitals would lose 0.4 percent. Among urban hospital groups (that is, bed size, census division, and special payment status), payments generally would decline.

A positive impact is evident among most of the rural hospital groups. The smallest increases among the rural census divisions are 0.4 and 1.5 percent for the Puerto Rico and Mountain regions, respectively. The largest increases are in the rural South Atlantic and West South Central regions. These regions would experience increases of 2.9 and 3.7 percent, respectively.

Among all the hospitals that were reclassified for FY 2004 (including hospitals that received wage index reclassifications in FY 2002 or FY 2003 that extend for 3 years), the MGCRB changes are estimated to provide a 4.3 percent increase in payments. Urban hospitals reclassified for FY 2004 are expected to receive an increase of 4.0 percent, while rural reclassified hospitals are expected to benefit from the MGCRB changes with a 4.6 percent increase in payments. Overall, among hospitals that were reclassified for purposes of the standardized amount only, a payment increase of 3.9 percent is expected, while those reclassified for purposes of the wage index only show a 4.3 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 0.5 percent for rural hospitals.

H. All Changes (Column 8)

Column 8 compares our estimate of payments per case, incorporating all changes reflected in this proposed rule for FY 2004 (including statutory changes), to our estimate of payments per case in FY 2003. This column includes all of the proposed policy changes. Because the reclassifications shown in column 7 do not reflect FY 2003

reclassifications, the impacts of FY 2004 reclassifications only affect the impacts from FY 2003 to FY 2004 if the reclassification impacts for any group of hospitals are different in FY 2004 compared to FY 2003.

Column 8 includes the effects of the 3.5 percent update to the standardized amounts and the hospital-specific rates for MDHs and SCHs. It also reflects the 0.4 percentage point difference between the projected outlier payments in FY 2003 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2003 (5.5 percent), as described in the introduction to this Appendix and the Addendum to this proposed rule. As a result, payments are projected to be 0.4 percent higher in FY 2003 than originally estimated, resulting in a 0.4 percent smaller increase than would otherwise occur.

Section 213 of Public Law 106–554 provides that all SCHs may receive payment on the basis of their costs per case during their cost reporting period that began during 1996. For FY 2004, eligible SCHs receive 100 percent of their 1996 hospital-specific rate. The impact of this provision is modeled in column 8 as well.

The proposed expansion of the postacute care transfer policy also reduces payments by paying for discharges to postacute care in 19 additional DRGs as transfers. Because FY 2003 payments reflect full DRG payments for all cases in these 19 DRGs, there is a negative impact due to the proposed expansion of this policy compared to FY 2003. The net effect of this proposed policy, as displayed in column 2, is also seen in the lower overall percent change shown in column 8 comparing FY 2004 simulated payments per case to FY 2003 payments.

Another influence on the overall change reflected in this column is the requirement of section 402(b) of Public Law 108–7 that all hospitals receive the large urban standardized amount for all discharges occurring on or after April 1, 2003, and before October 1, 2003. For discharges occurring on or after October 1, 2003, the Federal rate will again be calculated based on separate average standardized amounts for hospitals in large urban areas and for hospitals in other areas. The effect is to reduce the percent increase reflected in the ''all changes'' column.

There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 8 may not equal the sum of the changes described above.

The overall change in payments per case for hospitals in FY 2004 would increases by 2.5 percent. Hospitals in urban areas would experience a 2.5 percent increase in payments per case compared to FY 2003. Hospitals in rural areas, meanwhile, would experience a 3.1 percent payment increase. Hospitals in large urban areas would experience a 2.6 percent increase in payments.

Among urban census divisions, the largest payment increase was 3.5 percent in the Mountain region. Hospitals in the urban East South Central region and in Puerto Rico would experience an overall increase of 3.1 percent and 2.9 percent, respectively. The smallest increase would occur in the Middle Atlantic, with an increase of 1.7 percent. These below average increases are primarily due to the inflated outlier payments for some of these hospitals during FY 2003 compared to FY 2004. Among rural regions, the only hospital category that would experience overall payment decreases is Puerto Rico, where payments would decrease by 0.2 percent, largely due to the updated wage data. In the West North Central region, payments are projected to increase by 3.8 percent. West South Central and Pacific regions also would benefit, both with 3.5 percent increases.

Among special categories of rural hospitals, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) would experience payment increases of 3.9 percent, 3.3 percent, and 3.3 percent, respectively. This outcome is primarily related to the fact that, for hospitals receiving payments under the hospital-specific methodology, there are no outlier payments. Therefore, these hospitals would not experience negative payment impacts from the decline in outlier payments from FY 2003 to FY 2004 as would hospitals paid based on the national standardized amounts.

Hospitals that were reclassified for FY 2004 are estimated to receive a 3.0 percent increase in payments. Urban hospitals reclassified for FY 2004 are anticipated to receive an increase of 2.7 percent, while rural reclassified hospitals are expected to benefit from reclassification with a 3.2 percent increase in payments. Overall, among hospitals reclassified for purposes of the standardized amount, a payment increase of 5.8 percent is expected, while those hospitals reclassified for purposes of the wage index only would show an expected 2.4 percent increase in payments. Those hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act are expected to receive an increase in payments of 1.8 percent.

TABLE II.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2004 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per case]

	Number of hospitals	Average FY 2003 payment per case [1]	Average FY 2004 payment per case [1]	All FY 2004 changes
	(1)	(2)	(3)	(4)
By Geographic Location:				
All hospitals	4,087	7,423	7,612	2.5
Urban hospitals	2,582	7,890	8,084	2.5
Large urban areas (populations over 1 million)	1,493	8,368	8,586	2.6
Other urban areas (populations of 1 million or fewer)	1,089	7,257	7,418	2.2
Rural hospitals	1,505	5,393	5,558	3.1
Bed Size (Urban):				
0–99 beds	626	5,479	5,625	2.7
100–199 beds	916	6,658	6,829	2.6
200–299 beds	507	7,610	7,788	2.3
300–499 beds	377	8,445	8,660	2.5
500 or more beds	156	10,027	10,261	2.3
Bed Size (Rural):				
0–49 beds	690	4,468	4,620	3.4
50–99 beds	477	5,037	5,204	3.3
100–149 beds	202	5,430	5,582	2.8
150–199 beds	70	5,780	5,937	2.7
200 or more beds	66	6,792	6,993	3.0
Urban by Region:				
New England	134	8,326	8,555	2.7
Middle Atlantic	394	8,916	9,064	1.7
South Atlantic	372	7,454	7,640	2.5
East North Central	429	7,416	7,604	2.5
East South Central	155	7,156	7,376	3.1

TABLE II.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2004 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Number of hospitals	Average FY 2003 payment per case [1]	Average FY 2004 payment per case [1]	All FY 2004 changes
	(1)	(2)	(3)	(4)
West North Central	176	7,659	7,875	2.8
West South Central	329	7,343	7,523	2.5
Mountain	131	7,697	7,967	3.5
Pacific	416	9,598	9,840	2.5
Puerto Rico	46	3,329	3,426	2.9
Rural by Region:				
New England	38	6,841	7,067	3.3
Middle Atlantic	67	5,426	5,565	2.6
South Atlantic	221	5,486	5,614	2.3
East North Central	199	5,451	5,622	3.1
East South Central	232	4,922	5,071	3.0
West North Central	254	5,294	5,497	3.8
West South Central	273	4,711	4,875	3.5
Mountain	127	6,235	6,436	3.2
Pacific	89	7,151	7,399	3.5
Puerto Rico	5	2,553	2,548	−0.2
By Payment Classification:				
Urban hospitals	2,591	7,886	8,080	2.5
Large urban areas (populations over 1 million)	1,572	8,283	8,502	2.7
Other urban areas (populations of 1 million of fewer)	1,019	7,302	7,460	2.2
Rural areas	1,496	5,355	5,516	3.0
Teaching Status:				
Non-teaching	2,976	6,132	6,293	2.6
Fewer than 100 Residents	873	7,666	7,867	2.6
100 or more Residents	238	11,347	11,603	2.3
Urban DSH:				
Non-DSH	1,381	6,624	6,803	2.7
100 or more beds	1,398	8,502	8,706	2.4
Less than 100 beds	276	5,447	5,579	2.4
Rural DSH:				
Sole Community (SCH)	484	5,239	5,434	3.7
Referral Center (RRC)	161	6,159	6,331	2.8
Other Rural: 100 or more beds	75	4,696	4,785	1.9
Less than 100 beds	312	4,278	4,386	2.5
Urban teaching and DSH:				
Both teaching and DSH	771	9,333	9,562	2.5
Teaching and no DSH	273	7,618	7,814	2.6
No teaching and DSH	903	6,852	7,009	2.3
No teaching and no DSH	644	6,174	6,341	2.7
Rural Hospital Types:				
Non special status hospitals	521	4,445	4,544	2.2
RRC	149	5,851	6,003	2.6
SCH	494	5,630	5,849	3.9
Medicare-dependent hospitals (MDH)	254	4,168	4,305	3.3
SCH and RRC	78	6,757	6,982	3.3
Type of Ownership:				
Voluntary	2,435	7,532	7,722	2.5
Proprietary	699	7,087	7,272	2.6
Government	833	7,164	7,356	2.7
Unknown	120	7,431	7,565	1.8
Medicare Utilization as a Percent of Inpatient Days:				
0–25	304	9,997	10,294	3.0
25–50	1,557	8,448	8,657	2.5
50–65	1,663	6,450	6,613	2.5
Over 65	459	5,764	5,916	2.7
Unknown	104	6,720	6,921	3.0
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2004 Reclassifications:				
All Reclassified Hospitals	639	6,883	7,088	3.0
Standardized Amount Only	22	5,590	5,912	5.8
Wage Index Only	556	6,914	7,077	2.4
Both	33	6,081	6,269	3.1
All Nonreclassified Hospitals	3,442	7,542	7,734	2.5
All Urban Reclassified Hospitals	136	8,787	9,020	2.7
Urban Nonreclassified Hospitals	13	6,211	6,358	2.4
Standardized Amount Only	82	9,866	10,098	2.3

TABLE II.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2004 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Number of hospitals (1)	Average FY 2003 payment per case [1] (2)	Average FY 2004 payment per case [1] (3)	All FY 2004 changes (4)
Wage Index Only	41	6,934	7,200	3.8
Both	2,415	7,853	8,045	2.4
All Reclassified Rural Hospitals	503	6,006	6,199	3.2
Standardized Amount Only	15	4,743	4,843	2.1
Wage Index Only	464	6,014	6,205	3.2
Both	24	6,242	6,482	3.8
Rural Nonreclassified Hospitals	999	4,624	4,756	2.8
Other Reclassified Hospitals (Section 1886(d)(8)(B))	34	4,950	5,039	1.8

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

Table II presents the projected impact of the proposed changes for FY 2004 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated payments per case for FY 2003 with the average estimated per case payments for FY 2004, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from column 8 of Table I.

VII. Impact of Other Policy Changes

In addition to those proposed changes discussed above that we are able to model using our IPPS payment simulation model, we are proposing various other changes in this proposed rule. Generally, we have limited or no specific data available with which to estimate the impacts of these proposed changes. Our estimates of the likely impacts associated with these other proposed changes are discussed below.

A. Changes to Bed and Patient Day Counting Policies

1. Background

Under IPPS, both the IME and the DSH adjustments utilize statistics regarding the number of beds and patient days of a hospital to determine the level of the respective payment adjustment. For IME, hospitals receiving this adjustment want to minimize their numbers of beds in order to maximize their resident-to-bed ratio. For DSH, urban hospitals with 100 or more beds qualify for a higher payment adjustment, so some hospitals have an incentive to maximize their bed count to qualify for higher payments. Existing regulations specify that the number of beds is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period.

2. Unoccupied Beds

Over the years, questions have arisen as to whether beds in rooms or entire units that are unoccupied for extended periods of time should continue to be counted on the basis that, if there would ever be a need, they could be put into use. In section IV.C. of the preamble of this proposed rule, we are proposing to base the determination of whether a bed is available upon whether the unit where the bed is located is staffed for patient care. If the bed is located in a unit that was staffed by nurses to provide patient care at any time during the 3 preceding months, all of the beds in the unit would be counted for purposes of determining available bed days during the current month. If no patient care were provided in that unit during the 3 preceding months, the beds in the unit would be excluded from the determination of available bed days during the current month.

This proposal is primarily intended to establish clear and consistent guidelines for hospitals and fiscal intermediaries to use when determining whether beds should be counted. We do not anticipate this proposal would have a significant impact on payments. In some cases, previously uncounted beds would now be counted, such as when a hospital is undertaking to remodel a unit and that unit is temporarily unavailable for patient occupancy. Under the proposed policy, if the remodeling is completed in less than 3 months and patients are again being treated in the unit, all of the beds in the unit would be counted as available for the entire year.

3. Nonacute Care Beds and Days

The proposed rule would clarify that days attributable to a nonacute care unit or ward, regardless of whether the unit or ward is separately certified by Medicare or is adjacent to a unit or ward used to provide an acute level of care, would not be included in the count of bed or patient days. In a recent decision by the Ninth Circuit Court of Appeals (*Alhambra Hosp.* v. *Thompson*, 259 F.3d 1017 (9th Cir. 2001)), the court found that our policy for counting patient days did not preclude a hospital from counting the patient days attributable to a nonacute care unit adjacent to an area of the hospital subject to the IPPS. Under this ruling, hospitals within the jurisdiction of the Ninth Circuit would be able to count those patient days.

Because the *Alhambra* decision was based on a regulatory interpretation, this proposed rule, when finalized, would supersede the *Alhambra* decision in the Ninth Circuit. We estimate that if all hospitals in the Ninth Circuit that could take advantage of this ruling were currently doing so, the impact of this provision of the proposed rule would be $184 million in reduced Medicare program payments to the affected hospitals in FY 2004 for DSH. This estimate reflects the impact of adding all days of non-Medicare certified nursing facilities to the count of inpatient days for hospitals in the nine States under the jurisdiction of the Ninth Circuit. For example, in Alaska, nursing facility days constitute 11 percent of total Medicaid inpatient days. If all of these nursing facility days are currently included in the Medicaid inpatient days count, we estimate this proposed provision would reduce Medicare DSH payments to Alaska's hospitals by $662,097.

We are unable to estimate the effect of this proposed provision on specific hospitals because we are not aware of specific hospitals that are presently including those inpatient days in their calculation of Medicaid days for purposes of determining their Medicare DSH percentage. However, we expect the impact on any particular hospital would be minimal (with no impact on the level of beneficiary services), because the days attributable to patients receiving these limited benefit programs should be only a small portion of the overall Medicaid days at any particular hospital. No other provider types would be affected. However, because our policy is to count patient days and beds consistently, inclusion of the days of postacute care units in the DSH calculation would lead to an offsetting negative payment impact for teaching hospitals. The inclusion of additional beds decreases the resident-to-bed ratios used to calculate the IME adjustments. Therefore, the actual potential impact on hospitals of this policy clarification is likely to be significantly less than $184 million.

4. Observation and Swing-Beds

We are proposing to revise our regulations to clarify that swing-bed and observation bed days are to be excluded from the count of bed and patient days. Because this certification reflects our current policy, despite the fact

that there has been some confusion and we have had adverse court decisions, we do not anticipate this clarification would have a significant impact on payments. We do not have data available that would enable us to identify those hospitals that have not been applying this policy and, therefore, would be required to change their policy. Consequently, we are unable to quantify the impacts of this clarification.

5. Labor, Delivery, Recovery, and Postpartum Beds and Days

Similarly, in the case of labor, delivery, recovery, and postpartum rooms, we would clarify that it is necessary to apportion the days and costs of a patient stay between the labor/delivery ancillary cost centers and the routine adults and pediatrics cost center on the basis of the percentage of time during the entire stay associated with these various services. Because this is a clarification of existing policy, we do not anticipate this proposed change would have a significant payment impact. However, we do not have data available that would enable us to identify those hospitals that have not been applying this policy and, therefore, would be required to change their policy. Consequently, we are unable to quantify the impacts of this clarification.

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

Some States have demonstration projects that provide family planning or outpatient drug benefits that are limited benefits that do not include Medicaid coverage for inpatient services. In this proposed rule, we also would clarify that any hospital inpatient days attributed to a patient who is not eligible for Medicaid inpatient hospital benefits either under the approved State plan or through a section 1115 waiver must not be counted in the calculation of Medicaid days for purposes of determining a hospital's DSH percentage.

We estimated the potential impact of the proposed clarification to our policy of excluding days associated with inpatients who are eligible only for Medicaid outpatient benefits. We identified the percentage of individuals receiving only outpatient family planning benefits under Medicaid compared to all Medicaid-eligible beneficiaries (this is currently the only outpatient-only category for which we have numbers of eligible beneficiaries). These percentages were calculated on a statewide basis for each State with a family planning benefit. Based on these percentages, assuming family planning beneficiaries use inpatient services at the same rate as all other Medicaid beneficiaries, we estimated the amount of total Medicare DSH payments for each State that may be attributable to family planning beneficiaries' use of inpatient services.

For example, in Alabama, total Medicare DSH payments in 1999 (the latest year for which a complete database of cost reports from all hospitals is available) were $97.1 million. Because the percentage of family planning beneficiaries to total Medicaid eligible beneficiaries is 11.24 percent, we estimated 11.24 percent of $97.1 million in Medicare DSH payments, or $10.9 million, is the maximum amount of Medicare DSH that may currently be attributable to the inclusion of inpatient days for individuals who are only eligible for outpatient family planning Medicaid benefits. Based on this analysis, we have identified the potential impact upon hospitals to be as much as $290 million in reduced DSH payments from the Medicare program to those hospitals in FY 2004. Of this amount, $170 million is attributable to California. This amount is not an impact on State programs nor does it require States to spend any additional money. We also note that we are not aware of any specific hospitals that are including inpatient days attributable to individuals with no inpatient Medicaid benefits. Therefore, this estimate reflects the maximum potential impact, but the actual impact is very likely to be much less.

We are unable to estimate the effect of this clarification on specific hospitals because we are not aware of specific hospitals that are presently including those inpatient days in their calculation of Medicaid days for purposes of determining their Medicare DSH percentage. However, we expect the impact on any particular hospital would be minimal (with no impact on the level of beneficiary services), because the days attributable to patients receiving these limited benefit programs should be only a small portion of the overall Medicaid days at any particular hospital. No other provider types would be affected.

7. Dual-Eligible Patient Days

We are proposing to change our policy for counting days for patients who are Medicare beneficiaries and also eligible for Medicaid, to begin to count in the Medicaid fraction of the DSH patient percentage the patient days of these dual-eligible Medicare beneficiaries whose Medicare coverage has expired. Our current policy regarding dual-eligible patient days is they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient has no Medicare Part A coverage or coverage has been exhausted. However, we recognize it is often difficult for fiscal intermediaries to differentiate the days for dual-eligible patients whose Part A coverage has been exhausted. We believe the impact of this proposed change would be minimal, both because situations where dual-eligible patients exhaust their Medicare benefits occur infrequently, and because, due to the administrative difficulty separately identifying these days, in many cases they are already included in the hospital's Medicaid fraction. Accordingly, we do not have data available to allow us to quantify the impact of this proposed change precisely.

8. Medicare+Choice (M+C) Days

We have received questions whether patients enrolled in a Medicare+Choice (M+C) Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation. The questions stem from whether M+C plan enrollees are entitled to Medicare Part A because M+C plans are administered through Medicare Part C. We are proposing to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for an M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.

We do not have data readily available to assess the impacts of this proposed change. In particular, it appears likely that there is some variation in how these days are currently being handled from one hospital and fiscal intermediary to the next. Nonetheless, we believe there should not be a major impact associated with this proposed change.

B. Costs of Approved Nursing and Allied Health Education Activities

1. Continuing Education

In section IV.E. of the preamble of this proposed rule, we are proposing to clarify further the distinction between continuing education, which is not eligible for pass-through payment, and approved educational programs, which are eligible for pass-through payment. An approved program that qualifies for pass-through payment is generally a program of long duration designed to develop trained practitioners in a nursing or allied health discipline, such as professional nursing, in which the individual learns ''value-added'' skills that enable him or her to work in a particular capacity upon completion of the program. Such a program is in contrast to a continuing education program in which a practitioner, such as a registered nurse, receives training in a specialized skill or a new technology. While such training is undoubtedly valuable in enabling the nurse to treat patients with special needs, the nurse, upon completion of the program, continues to function as a registered nurse, albeit one with an additional skill. We are proposing to clarify our policy concerning not allowing pass-through payment for continuing education because it has come to our attention that certain programs, which in our view constitute continuing education, such as pharmacy or clinical pastoral education, are inappropriately receiving pass-through payment.

To the extent that Medicare would no longer pay for such programs as pharmacy and clinical pastoral education, Medicare payments would be reduced. We believe that these two programs comprise a small fraction of the approximately $230 million that are paid for all nursing and allied health education programs under Medicare.

2. Nonprovider-Operated Nursing and Allied Health Education Programs With Wholly Owned Subsidiary Educational Institutions

As discussed in section IV.E.3. of this proposed rule, we are proposing that Medicare would not recoup reasonable cost payment from hospitals that have received pass-through payment for portions of cost reporting periods occurring on or before October 1, 2003 (the effective date of finalizing this proposed rule) for costs of nursing or allied health education program(s) where the program(s) had originally been operated by the hospital, and then operation

of program(s) had been transferred by the hospital to a wholly owned subsidiary educational institution in order to meet accreditation standards prior to October 1, 2003, and where the hospital had continued to incur the costs of both the classroom and clinical training portions of the programs while the program(s) were operated by the educational institution. We estimate that the costs to the Medicare program of this proposal would be approximately $10 to $20 million. We do not believe many hospitals fit the criteria described above of previously receiving Medicare payment for direct operation of nursing or allied health education program(s) and then transferring operation of the program(s) to a wholly owned subsidiary educational institution, all the while incurring the classroom and clinical training costs of the program(s).

In addition, we are also proposing that, for portions of cost reporting periods beginning on or after October 1, 2003, a hospital that meets the criteria described above may continue to receive reasonable cost payments for clinical training costs incurred by the hospital for the nursing and allied health education program(s) that were operated by the hospital prior to the date the hospital transferred operation of the program(s) to its wholly owned subsidiary educational institution (and ceased to be a provider-operated program). We are further proposing that, with respect to classroom costs, only those classroom costs incurred by the hospital for the courses that were paid by Medicare on a reasonable cost basis and included in the hospital's provider-operated program(s) could continue to be reimbursed on a reasonable cost basis. We estimate the costs to the Medicare program for this proposal would be $1 to $2 million per year.

C. Prohibition Against Counting Residents Where Other Entities Have Previously Incurred the Training Costs

As we explain in section IV.F.2. of the preamble of this proposed rule, under section 1886(h) of the Act, hospitals may count the time that residents spend training in nonhospital sites if they meet certain conditions, including incurring ''all or substantially all'' of the costs of training at the nonhospital site. Legislative history indicates that the purpose of this provision is to encourage hospitals to provide more training outside the traditional hospital environment.

It has come to our attention that hospitals have been incurring the costs of and receiving direct GME and IME payment for residency training that had previously been occurring in nonhospital settings, without the financial support of the hospitals. We believe that where no new or additional training is provided in these nonhospital settings, the receipt of Medicare payment in such cases is contrary to Congressional intent and is, therefore, inappropriate. In addition, it violates Medicare's anti-redistribution principle, which states that Medicare will not share in the costs of educational activities of a hospital that represent a redistribution of costs from the community to the hospital. Accordingly, we are proposing to revise our policy concerning counting residents to ensure that Medicare IME and direct GME payments are not made to hospitals for training that had already been in place in the absence of the hospital's financial support. We are proposing that effective October 1, 2003, in order for a hospital to receive IME and direct GME payment, the hospital must have been continuously incurring the direct GME costs of residents training in a particular program since the date the resident first began training in the program in order for the hospital to count the FTE residents.

By prohibiting payment for residency training that had been previously supported by nonhospital institutions, this proposal would reduce the amount of direct GME and IME payments received by hospitals. Although we cannot estimate the impact on programs nationally, we are aware that two hospitals in New York were receiving over $10 million annually for payments for dental residents training in nonhospital sites (including a site in Hawaii). Another hospital in Boston was receiving over $2 million annually for dental residents training at a dental school.

D. Rural Track GME Training Programs

1. Reduction in the Time Required for Training Residents in a Rural Area

As explained in section IV.F.3 of the preamble of this proposed rule, under existing regulations, if an urban hospital rotates residents to a separately accredited rural track program in a rural area for two-thirds of the duration of the training program, the urban hospital may receive an increase in its FTE cap to reflect the time those residents train at the urban hospital. When we first implemented these regulations, we did so based on our understanding that the Accreditation Council for Graduate Medical Education (ACGME) requires that at least two-thirds of the duration of the program be spent in a rural area. However, it has come to our attention that, while the ACGME generally follows a one-third/two-thirds model for accreditation, the rural training requirement is actually somewhat less than two-thirds of the duration of the program. Therefore, we are proposing to revise the regulations to state that if an urban hospital rotates residents to a separately accredited rural track program in a rural area for more than 50 percent of the duration of the training program, the urban hospital may receive an increase in its FTE cap to reflect the time those residents train at the urban hospital. We estimate that this proposal would only slightly increase Medicare payments for IME and direct GME costs.

2. Inclusion of Rural Track FTE Residents in the Rolling Average Calculation

As explained in section IV.F.4 of the preamble of this proposed rule, when we first issued the regulations concerning residents training in a rural track program, we inadvertently did not specify in regulations that these residents would be included in the hospital's rolling average count of FTE residents used for computing GME payment. We are proposing to make this technical clarification to the regulations. We believe that this proposed provision would not have a budget impact because it is a clarification of existing policy.

VIII. Impact of Proposed Changes in the Capital PPS

A. General Considerations

Fiscal year 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: Fully prospective or hold harmless. Under the fully prospective methodology, hospitals were paid a blend of the 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 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 Federal rate (see § 412.344). As we state in section V. of the preamble of this proposed rule, with the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), beginning in FY 2004 capital prospective payment system payments for most hospitals are based solely on the Federal rate. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

In accordance with § 412.312, the basic methodology for determining a capital prospective payment system payment is:

(Standard Federal Rate) × (DRG weight) × (Geographic Adjustment Factor (GAF)) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share (DSH) Adjustment Factor + Indirect Medical Education (IME) Adjustment Factor, if applicable).

In addition, hospitals may also receive outlier payments for those cases that qualify under the threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the December 2002 update of the FY 2002 MedPAR file and the December 2002 update of the Provider Specific File that is used for payment purposes. Although the analyses of the changes to the capital prospective payment system do not incorporate cost data, we used the December 2002 update of the most recently available hospital cost report data (FY 2000) to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to policy changes. Second, due to the interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each proposed change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases (for instance, the number of beds), there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available sources overall. However, for

individual hospitals, some miscategorizations are possible.

Using cases from the December 2002 update of the FY 2002 MedPAR file, we simulated payments under the capital prospective payment system for FY 2003 and FY 2004 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general hospital inpatient prospective payment systems (Indian Health Service Hospitals and hospitals in Maryland) are excluded from the simulations.

As we explain in section III.A.4. of the Addendum of this proposed rule, payments will no longer be made under the regular exceptions provision under §§ 412.348(b) through (e). Therefore, we are no longer using the actuarial capital cost model (described in Appendix B of August 1, 2001 final rule (66 FR 40099)). We modeled payments for each hospital by multiplying the Federal rate by the GAF and the hospital's case-mix. We then added estimated payments for indirect medical education, disproportionate share, large urban add-on, and outliers, if applicable. For purposes of this impact analysis, the model includes the following assumptions:

- We estimate that the Medicare case-mix index would increase by 1.01505 percent in FY 2003 and would increase by 1.02010 percent in FY 2004.
- We estimate that the Medicare discharges will be 14,288,000 in FY 2003 and 14,507,000 in FY 2004 for a 1.5 percent increase from FY 2003 to FY 2004.
- The Federal capital rate was updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The proposed FY 2004 update is 0.7 percent (*see* section III.A.1.a. of the Addendum to this proposed rule).
- In addition to the proposed FY 2004 update factor, the proposed FY 2004 Federal rate was calculated based on a GAF/DRG budget neutrality factor of 1.0038, an outlier adjustment factor of 0.9455, and a (special) exceptions adjustment factor of 0.9995.

2. Results

In the past, in this impact section we presented the redistributive effects that were expected to occur between ''hold-harmless'' hospitals and ''fully prospective'' hospitals and a cross-sectional summary of hospital groupings by the capital prospective payment system transition period payment methodology. We are no longer including this information since all hospitals (except new hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid 100 percent of the Federal rate in FY 2004.

We used the actuarial model described above to estimate the potential impact of our proposed changes for FY 2004 on total capital payments per case, using a universe of 3,922 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the December 2002 update of the FY 2002 MedPAR file, the December 2002 update to the Provider-Specific File, and the most recent cost report data from the December 2002 update of HCRIS. In Table III, we present a comparison of total payments per case for FY 2003 compared to FY 2004 based on the proposed FY 2004 payment policies. Column 2 shows estimates of payments per case under our model for FY 2003. Column 3 shows estimates of payments per case under our model for FY 2004. Column 4 shows the total percentage change in payments from FY 2003 to FY 2004. The change represented in Column 4 includes the 0.7 percent update to the Federal rate, a 1.02010 percent increase in case-mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB, as well as changes in special exception payments. The comparisons are provided by: (1) Geographic location; (2) region; and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 1.0 percent in FY 2004. Our comparison by geographic location shows an overall increase in payments to hospitals in all areas. This comparison also shows that urban and rural hospitals will experience different rates of increase in capital payments per case (0.9 percent and 1.5 percent, respectively). This difference is due to a projection that rural hospitals will experience a larger increase in the GAF due to reclassifications from rural to urban and a slightly larger increase in DSH and IME payments from FY 2003 to FY 2004 compared to urban hospitals.

All regions are estimated to receive an increase in total capital payments per case. Changes by region vary from a minimum increase of 0.4 percent (Middle Atlantic urban region) to a maximum increase of 2.1 percent (New England rural region). Hospitals located in Puerto Rico are expected to experience an increase in total capital payments per case of 1.3 percent.

By type of ownership, government hospitals are projected to have the largest rate of increase of total payment changes (1.2 percent). Similarly, payments to voluntary hospitals will increase 1.0 percent, while payments to proprietary hospitals will increase 0.9 percent.

Section 1886(d)(10) of the Act established the MGCRB. Hospitals may apply for reclassification for purposes of the standardized amount, wage index, or both. Although the Federal capital rate is not affected, a hospital's geographic classification for purposes of the operating standardized amount does affect a hospital's capital payments as a result of the large urban adjustment factor and the disproportionate share adjustment for urban hospitals with 100 or more beds. Reclassification for wage index purposes also affects the geographic adjustment factor, since that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2004 compared to the effects of reclassification for FY 2003, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified for FY 2004 as a whole are projected to experience a 1.7 percent increase in payments. Payments to nonreclassified hospitals would increase almost half as much (0.9 percent) as reclassified hospitals, overall. Hospitals reclassified during both FY 2003 and FY 2004 are projected to receive an increase in payments of 1.4 percent. Hospitals reclassified during FY 2004 only are projected to receive an increase in payments of 4.9 percent. This increase is primarily due to changes in the GAF (wage index).

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2003 payments compared to proposed FY 2004 payments]

	Number of hospitals	Average FY 2003 payments/case	Average FY 2004 payments/case	Change
By Geographic Location:				
All hospitals	3,922	706	713	1.0
Large urban areas (populations over 1 million)	1,420	808	815	0.9
Other urban areas (populations of 1 million of fewer)	1,041	693	700	1.0
Rural areas	1,461	476	483	1.5
Urban hospitals	2,461	758	765	0.9
0–99 beds	549	529	535	1.0
100–199 beds	884	643	649	1.0
200–299 beds	501	728	735	0.9
300–499 beds	373	809	817	1.1
500 or more beds	154	959	967	0.8
Rural hospitals	1,461	476	483	1.5

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 2003 payments compared to proposed FY 2004 payments]

	Number of hospitals	Average FY 2003 payments/case	Average FY 2004 payments/case	Change
0–49 beds	659	390	396	1.6
50–99 beds	469	440	446	1.4
100–149 beds	198	483	488	1.2
150–199 beds	70	524	530	1.3
200 or more beds	65	594	606	2.0
By Region:				
Urban by Region	2,461	758	765	0.9
New England	131	808	820	1.5
Middle Atlantic	386	851	854	0.4
South Atlantic	356	724	729	0.8
East North Central	409	726	734	1.0
East South Central	152	684	695	1.6
West North Central	168	732	741	1.3
West South Central	303	711	715	0.6
Mountain	119	732	744	1.6
Pacific	393	893	904	1.2
Puerto Rico	44	317	322	1.3
Rural by Region	1,461	476	483	1.5
New England	38	591	603	2.1
Middle Atlantic	66	500	506	1.0
South Atlantic	218	490	496	1.2
East North Central	195	490	497	1.6
East South Central	229	435	443	1.6
West North Central	248	468	477	1.9
West South Central	263	426	432	1.5
Mountain	117	506	511	0.9
Pacific	82	564	574	1.7
By Payment Classification:				
All hospitals	3,922	706	713	1.0
Large urban areas (populations over 1 million)	1,497	799	807	1.0
Other urban areas (populations of 1 million of fewer)	972	697	703	0.9
Rural areas	1,453	474	479	1.2
Teaching Status:.				
Non-teaching	2,829	580	586	1.0
Fewer than 100 Residents	857	733	741	1.1
100 or more Residents	236	1,074	1,083	0.8
Urban DSH:				
100 or more beds	1,373	798	806	1.0
Less than 100 beds	258	528	531	0.7
Rural DSH:				
Sole Community (SCH/EACH)	476	417	423	1.5
Referral Center (RRC/EACH)	161	546	553	1.2
Other Rural:				
100 or more beds	72	447	448	0.3
Less than 100 beds	301	405	410	1.3
Urban teaching and DSH:				
Both teaching and DSH	762	876	885	1.0
Teaching and no DSH	264	766	774	1.0
No teaching and DSH	869	644	650	0.8
No teaching and no DSH	574	627	634	1.1
Rural Hospital Types:				
Non special status hospitals	495	426	430	0.8
RRC/EACH	148	554	561	1.2
SCH/EACH	482	437	444	1.4
Medicare-dependent hospitals (MDH)	250	394	400	1.6
SCH, RRC and EACH	78	540	546	1.2
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
Reclassification Status During FY2003 and FY2004:				
Reclassified During Both FY2003 and FY2004	562	621	629	1.4
Reclassified During FY2004 Only	68	600	630	4.9
Reclassified During FY2003 Only	43	601	575	−4.2
FY2004 Reclassifications:				
All Reclassified Hospitals	630	619	630	1.7
All Nonreclassified Hospitals	3,258	723	729	0.9
All Urban Reclassified Hospitals	131	815	828	1.6
Urban Nonreclassified Hospitals	2,299	756	763	0.9
All Reclassified Rural Hospitals	499	528	537	1.8
Rural Nonreclassified Hospitals	959	410	414	0.9

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 2003 payments compared to proposed FY 2004 payments]

	Number of hospitals	Average FY 2003 payments/case	Average FY 2004 payments/case	Change
Other Reclassified Hospitals (Section 1886(D)(8)(B))	34	486	472	−2.8
Type of Ownership:				
Voluntary	2,404	719	726	1.0
Proprietary	674	691	697	0.9
Government	813	645	652	1.2
Medicare Utilization as a Percent of Inpatient Days:				
0–25	291	901	914	1.4
25–50	1,529	804	812	0.9
50–65	1,645	615	621	1.0
Over 65	446	556	561	1.0

Appendix B: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

I. Background

Section 1886(e)(4)(A) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), recommend update factors for inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish the proposed update factors recommended under section 1886(e)(4) of the Act in this proposed rule, and the final update factors recommended by the Secretary in the final rule. Accordingly, this Appendix provides the recommendations of appropriate update factors for the IPPS standardized amounts, the hospital-specific rates for SCHs and MDHs, and the rate-of-increase limits for hospitals and hospitals units excluded from the IPPS. We also discuss our update framework and respond to MedPAC's recommendations concerning the update factors.

II. Secretary's Recommendations

Section 1886(b)(3)(B)(i)(XIX) of the Act sets the FY 2004 percentage increase in the operating cost standardized amounts equal to the rate of increase in the hospital market basket for IPPS hospitals in all areas. Based on the Office of the Actuary's first quarter 2003 forecast of the FY 2004 market basket increase, the proposed update to the standardized amounts is 3.5 percent (that is, the market basket rate of increase) for hospitals in both large urban and other areas.

Section 1886(b)(3)(B)(iv) of the Act sets the FY 2004 percentage increase in the hospital-specific rates applicable to SCHs and MDHs equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act (that is, the same update factor as all other hospitals subject to the IPPS, or the rate of increase in the market basket). Therefore, the proposed update to the hospital-specific rate applicable to SCHs and MDHs is also 3.5 percent.

Under section 1886(b)(3)(B)(ii) of the Act, the FY 2004 percentage increase in the rate-of-increase limits for hospitals and hospital units excluded from the IPPS (psychiatric hospitals and units, rehabilitation hospitals and units (now referred to as IRFs), LTCHs, cancer hospitals, and children's hospitals) is the market basket percentage increase. In the past, hospitals and hospital units excluded from the IPPS have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). However, some of these categories of excluded hospitals and units have begun to be paid under prospective payment systems. Hospitals and units that receive any hospital-specific payments will have those payments subject to TEFRA limits for FY 2004. For these hospitals, the proposed update is the percentage increase in the excluded hospital market basket (currently estimated at 3.5 percent).

IRFs are paid under the IRF PPS for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2004, the Federal prospective payment for IRFs is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually.

Effective for cost reporting periods beginning during FY 2003, LTCHs are paid under the LTCH PPS under which they receive payment based on a 5-year transition period (see the August 30, 2002 final rule (67 FR 55954)). An LTCH may elect to be paid on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition period. For purposes of the update factor, the portion of the LTCH PPS transition blend payment based on reasonable costs for inpatient operating services is determined by updating the LTCH's TEFRA limit by the current estimate of the excluded hospital market basket (or 3.5 percent).

III. Update Framework

Consistent with current law, we are proposing an update recommendation equal to the full market basket percentage increase for the IPPS operating cost standardized amounts for FY 2004. We also have analyzed changes in hospital productivity, scientific and technological advances, practice pattern changes, changes in case-mix, the effect of reclassification on recalibration, and forecast error correction. A discussion of this analysis is below.

A. Productivity

Service level labor productivity is defined as the ratio of total service output to full-time equivalent employees (FTEs). While we recognize that productivity is a function of many variables (for example, labor, nonlabor material, and capital inputs), we use the portion of productivity attributed to direct labor since this update framework applies to operating payment. To recognize that we are apportioning the short-run output changes to the labor input and not considering the nonlabor inputs, we weight our productivity measure by the share of direct labor services in the market basket to determine the expected effect on cost per case.

Our recommendation for the service productivity component is based on historical trends in productivity and total output for both the hospital industry and the general economy, and projected levels of future hospital service output. MedPAC's predecessor, the Prospective Payment Assessment Commission (ProPAC), estimated cumulative service productivity growth to be 4.9 percent from 1985 through 1989 or 1.2 percent annually. At the same time, ProPAC estimated total output growth at 3.4 percent annually, implying a ratio of service productivity growth to output growth of 0.35.

Absent a productivity measure specific to Medicare patients, we examined productivity (output per hour) and output (gross domestic product) for the economy. Depending on the exact time period, annual changes in productivity range from 0.30 to 0.35 percent of the change in output (that is, a 1.0 percent increase in output would be correlated with a 0.30 percent to a 0.35 percent change in output per hour).

Under our framework, the recommended update is based in part on expected productivity—that is, projected service output during the year, multiplied by the historical ratio of service productivity to total service output, multiplied by the share of direct labor in total operating inputs, as calculated in the hospital market basket. This method estimates an expected productivity improvement in the same proportion to expected total service growth that has occurred in the past and assumes that, at a minimum, growth in FTEs changes

proportionally to the growth in total service output. Thus, the recommendation allows for unit productivity to be smaller than the historical averages in years during which output growth is relatively low and larger in years during which output growth is higher than the historical averages. Based on the above estimates from both the hospital industry and the economy, we have chosen to employ the range of ratios of productivity change to output change of 0.30 to 0.35.

The expected change in total hospital service output is the product of projected growth in total admissions (adjusted for outpatient usage), projected real case-mix growth, expected quality-enhancing intensity growth, and net of expected decline in intensity due to reduction of cost-ineffective practice. Case-mix growth and intensity numbers for Medicare are used as proxies for those of the total hospital, since case-mix increases (used in the intensity measure as well) are unavailable for non-Medicare patients. Normally, the expected FY 2004 hospital output growth would be simply the sum of the expected change in intensity (1.0 percent), projected admissions change (1.6 percent), and projected real case-mix growth (1.0 percent—a definition of real case mix growth appears below), or 3.6 percent. However, as discussed below and in relation to the proposed capital update, we believe our intensity estimate is skewed by hospitals' charge data. Therefore, we are including only the projected changes in admissions and real case-mix in our calculation of productivity gains. This results in an estimate of 2.6 percent.

The share of direct labor services in the market basket (consisting of wages, salaries, and employee benefits) is 61.6 percent. Multiplying the expected change in total hospital service output (2.6 percent) by the ratio of historical service productivity change to total service growth of 0.30 to 0.35 and by the direct labor share percentage of 61.6 provides our productivity standard of -0.6 to -0.5 percent. Because productivity gains hold down the rate of increase in hospitals' costs, this factor is applied as a negative offset to the market basket increase.

B. Intensity

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

We calculate case-mix constant intensity as the change in total Medicare charges per admission, adjusted for price level changes (the Consumer Price Index (CPI) for hospital and related services) and changes in real case-mix. The use of total charges in the calculation of the intensity factor makes it a total intensity factor, that is, charges for capital services are already built into the calculation of the factor.

However, as discussed above in relation to the proposed capital update, because our intensity calculation relies heavily upon charge data and we believe that this charge data may be inappropriately inflated due to manipulation of charges to maximize outlier payments, we are proposing a 0.0 percent adjustment for intensity in FY 2004. In past fiscal years (1996 through 2000) when we found intensity to be declining, we believed a zero (rather then negative) intensity adjustment was appropriate. Similarly, we believe that it is appropriate to propose a zero intensity adjustment for FY 2004 until we determine that any increase in charges can be tied to intensity, rather than to attempts to maximize outlier payments.

C. Change in Case-Mix

Our analysis takes into account projected changes in real case-mix, less the changes attributable to improved coding practices. We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients, as opposed to changes in coding behavior that result in assignment of cases to higher-weighted DRGs but do not reflect greater resource requirements. For our FY 2004 update recommendation, we are projecting a 1.0 percent increase in the case-mix index. We do not believe changes in coding behavior will impact the overall case-mix in FY 2004. As such, for FY 2004, we estimate that real case-mix is equal to projected change in case-mix. Thus, we are recommending a 0.0 percent adjustment for case-mix.

D. Effect of FY 2002 DRG Reclassification and Recalibration

We estimate that DRG reclassification and recalibration for FY 2002 (GROUPER version 19.0) resulted in a 0 percent change in the case-mix index when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the GROUPER (version 18.0). Therefore, we are recommending a 0 percent adjustment for the effect of FY 2002 DRG reclassification and recalibration.

E. Forecast Error Correction

We make a forecast error correction if the actual market basket changes differ from the forecasted market basket by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of forecast error. The estimated market basket percentage increase used to update the FY 2002 payment rates was 3.3 percent. Our most recent data indicates the actual FY 2002 increase was 2.9 percent. The resulting forecast error in the FY 2002 market basket rate of increase is (-0.4) percentage points. This overestimate was due largely to a lower-than-expected increase in energy costs that impacted natural gas and chemical prices. This follows consecutive years where the market basket was under-forecast by 0.7 percentage points each year.

The following is a summary of the update range supported by our analyses:

HHS'S FY 2004 UPDATE RECOMMENDATION

Market basket	MB
Policy Adjustment Factors:	
Productivity	−0.6 to −0.5
Intensity	0.0
Subtotal	−0.6 to −0.5
Case-Mix Adjustment Factors:	
Projected Case-Mix Change	1.0
Real Across DRG Change	−1.0
Subtotal	0.0
Effect of FY 2002 DRG Reclassification and Recalibration	0.0
Forecast Error Correction	−0.4
Total Recommendation Update	−1.0 to −0.9

IV. MedPAC Recommendations for Assessing Payment Adequacy and Updating Payments in Traditional Medicare

In the past, MedPAC recommended specific adjustments to its update recommendation for each of the factors discussed under section III. of this Appendix. In its March 2003 Report to Congress, MedPAC assesses the adequacy of current payments and costs and the relationship between payments and an appropriate cost base. MedPAC stresses that the issue at hand is whether payments are too high or too low, and not how they became such.

In the first portion of MedPAC's analysis on the assessment of payment adequacy, the Commission reviews the relationship between costs and payments (typically represented as a margin). Based on the latest cost report data available, MedPAC estimated an inpatient Medicare operating margin for

FY 2000 of 10.8 percent (down from 12.3 percent for FY 1999).

MedPAC also projects margins through FY 2003, making certain assumptions about changes in payments and costs. On the payment side, MedPAC applied the annual payment updates (as specified by law for FYs 2001 through 2003) and then modeled the effects of other policy changes that have affected the level of payments. On the cost side, MedPAC estimated the increases in cost per unit of output over the same time period at the rate of inflation as measured by the applicable market basket index generated by CMS adjusted downward, anticipating improvements in productivity. While no specific Medicare inpatient margin is identified for a calendar year beyond 2000, MedPAC projected an overall Medicare margin for FY 2003 of 3.9 percent (page 41). The FY 2000 overall Medicare margin, as estimated by MedPAC, was 5.0 percent.

In addition to considering the relationship between estimated payments and costs, MedPAC also considered the following three factors to assess whether current payments are adequate (page 42):

- Changes in access to or quality of care;
- Changes in the volume of services or number of providers; and
- Change in providers' access to capital.

MedPAC's assessment of aggregate Medicare payments finds that payments were at least adequate as of FY 2003.

MedPAC's recommendation related to updating payments under the IPPS is that the Congress should increase the payment rates for the IPPS by the rate of increase in the hospital market basket, less 0.4 percent, for FY 2004. MedPAC focuses on the operating update exclusively because operating costs account for about 92 percent of total hospital costs and because the operating update is of most interest to Congress. Based on the current market basket estimate for FY 2003 of 3.5 percent, this update would increase Medicare inpatient payments to hospitals covered by IPPS by 3.1 percent.

Response: As described above, we are recommending a full market basket update for FY 2004 consistent with current law. We believe this will appropriately balance incentives for hospitals to operate efficiently with the need to provide sufficient payments to maintain access to quality care for Medicare beneficiaries.

Because the operating and capital prospective payment systems remain separate, CMS continues to use separate updates for operating and capital payments. The proposed update to the capital payment rate is discussed in section III. of the Addendum to this proposed rule.

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