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TABLE 6G.--ADDITIONS TO THE CC EXCLUSIONS LIST

[This table contains CCs that are added to the CC Exclusions List. Each of the principal diagnosis codes is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis code.]

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TABLE 6H.--DELETIONS FROM THE CC EXCLUSIONS LIST

[This table contains CCs that are deleted from the CC Exclusions List. Each of the principal diagnosis codes is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis code.]

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TABLE 7A.--MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY
[FY 2003 MEDPAR UPDATE DECEMBER 2003 GROUPER V21.0]

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
1	27,050	10.5	3	5	8	14	21
2	10,753	4.7	1	2	4	6	9
3	2	5.0	5	5	5	5	5
6	367	3.4	1	1	2	4	7
7	15,257	9.6	2	4	7	12	19
8	3,911	2.7	1	1	2	3	6
9	1,790	5.8	1	2	4	8	11
10	18,888	6.2	2	3	5	8	12
11	3,378	3.9	1	2	3	5	8
12	53,417	5.5	2	3	4	7	10
13	7,051	4.9	2	3	4	6	8
14	241,535	5.8	2	3	5	7	11
15	82,855	4.7	1	2	4	6	8
16	10,715	6.2	2	3	5	8	12
17	2,800	3.1	1	1	2	4	6
18	30,819	5.4	2	3	4	7	10
19	8,737	3.5	1	2	3	5	7
20	6,545	10.1	3	5	8	13	20
21	2,179	6.7	2	3	5	8	13
22	3,177	5.1	2	2	4	6	10
23	11,835	4.2	1	2	3	5	8
24	60,883	4.8	1	2	4	6	9
25	28,359	3.1	1	2	3	4	6
26	32	3.2	1	1	2	3	5
27	4,965	5.1	1	1	3	6	11
28	15,853	5.9	1	3	4	8	12
29	5,782	3.4	1	1	3	4	7
31	4,609	4.0	1	2	3	5	8
32	1,932	2.5	1	1	2	3	5
34	25,258	4.8	1	2	4	6	9
35	7,882	3.1	1	1	3	4	6
36	1,615	1.6	1	1	1	1	3
37	1,371	3.9	1	1	3	5	9
38	78	2.3	1	1	2	2	4
39	546	2.2	1	1	1	2	5
40	1,510	4.1	1	1	3	5	8
42	1,252	2.8	1	1	2	3	6

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
43	125	3.4	1	2	3	5	6
44	1,238	4.9	2	3	4	6	9
45	2,835	3.2	1	2	3	4	6
46	3,556	4.3	1	2	3	5	8
47	1,382	3.2	1	1	3	4	6
48	1	1.0	1	1	1	1	1
49	2,326	4.6	1	2	3	6	9
50	2,252	1.9	1	1	1	2	3
51	233	2.9	1	1	1	3	7
52	174	2.2	1	1	1	2	4
53	2,238	3.6	1	1	2	4	8
55	1,453	2.9	1	1	1	3	7
56	466	2.8	1	1	2	3	5
57	721	3.9	1	1	2	4	8
59	118	2.5	1	1	1	3	6
60	5	1.2	1	1	1	1	2
61	259	5.8	1	1	3	8	12
62	2	2.0	2	2	2	2	2
63	2,756	4.4	1	1	3	5	9
64	3,215	6.5	1	2	4	8	14
65	40,968	2.8	1	1	2	4	5
66	7,906	3.1	1	1	2	4	6
67	406	3.5	1	2	3	5	6
68	8,818	3.7	1	2	3	5	7
69	2,974	2.9	1	2	2	4	5
70	26	2.9	1	2	2	3	5
71	67	3.6	2	2	3	4	6
72	1,214	3.5	1	2	3	4	7
73	7,933	4.5	1	2	3	6	9
75	43,470	9.9	3	5	7	12	20
76	46,205	11.0	3	5	9	14	21
77	2,329	4.7	1	2	4	7	9
78	42,890	6.4	3	4	6	8	11
79	173,152	8.3	3	4	7	11	16
80	7,909	5.4	2	3	4	7	10
81	2	13.5	1	1	26	26	26
82	65,401	6.8	2	3	5	9	13
83	6,870	5.3	2	3	4	7	10
84	1,482	3.2	1	2	3	4	6
85	22,472	6.3	2	3	5	8	12
86	2,063	3.6	1	2	3	5	7

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
87	66,941	6.4	2	3	5	8	12
88	396,746	5.0	2	3	4	6	9
89	519,475	5.7	2	3	5	7	10
90	43,918	3.9	2	2	3	5	7
91	45	3.4	2	2	3	4	6
92	16,588	6.2	2	3	5	8	12
93	1,662	4.0	1	2	3	5	7
94	13,110	6.2	2	3	5	8	12
95	1,590	3.7	1	2	3	5	7
96	50,944	4.4	2	2	4	6	8
97	26,138	3.4	1	2	3	4	6
98	15	3.1	1	2	3	4	5
99	21,779	3.2	1	1	2	4	6
100	7,581	2.1	1	1	2	3	4
101	23,051	4.3	1	2	3	5	8
102	5,493	2.5	1	1	2	3	5
103	475	40.4	9	12	21	49	94
104	20,986	14.7	6	8	12	18	26
105	30,692	10.0	4	6	8	12	18
106	3,490	11.3	5	7	10	14	19
107	78,304	10.6	5	7	9	12	17
108	7,025	9.6	1	5	8	12	19
109	54,443	7.8	4	5	6	9	13
110	55,446	8.7	1	4	7	11	18
111	9,421	3.7	1	1	3	5	7
113	38,552	12.5	4	6	10	16	24
114	8,354	8.7	2	4	7	11	17
115	21,802	7.0	1	2	6	9	14
116	117,540	4.3	1	1	3	6	9
117	4,883	4.3	1	1	2	5	10
118	8,379	3.0	1	1	2	4	7
119	1,103	5.3	1	1	3	7	13
120	36,814	8.9	1	3	6	12	19
121	164,174	6.2	2	3	5	8	12
122	70,707	3.4	1	2	3	4	6
123	36,215	4.7	1	1	3	6	11
124	134,205	4.4	1	2	3	6	9
125	92,985	2.8	1	1	2	4	5
126	5,597	11.3	3	6	9	14	21
127	693,364	5.2	2	3	4	6	10
128	6,143	5.4	2	3	5	7	9

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
129	3,979	2.7	1	1	1	3	6
130	90,145	5.5	2	3	5	7	10
131	25,688	3.9	1	2	4	5	7
132	128,455	2.8	1	1	2	4	5
133	7,547	2.2	1	1	2	3	4
134	42,604	3.1	1	2	2	4	6
135	7,486	4.4	1	2	3	6	9
136	1,093	2.6	1	1	2	3	5
137	1	3.0	3	3	3	3	3
138	204,771	4.0	1	2	3	5	8
139	82,144	2.5	1	1	2	3	5
140	45,881	2.5	1	1	2	3	5
141	114,689	3.5	1	2	3	4	7
142	52,608	2.5	1	1	2	3	5
143	245,783	2.1	1	1	2	3	4
144	96,762	5.7	1	2	4	7	12
145	6,693	2.6	1	1	2	3	5
146	10,875	10.1	5	6	8	12	17
147	2,695	6.0	3	4	6	7	9
148	136,089	12.2	5	7	10	15	22
149	19,920	6.1	3	4	6	7	9
150	22,088	11.0	4	6	9	14	20
151	5,280	5.4	1	3	5	7	10
152	4,795	8.0	3	5	7	9	14
153	2,121	5.1	3	4	5	6	8
154	28,540	13.3	3	6	10	17	26
155	6,467	4.1	1	2	3	6	8
156	8	9.9	3	5	6	13	15
157	8,310	5.6	1	2	4	7	11
158	4,124	2.6	1	1	2	3	5
159	18,762	5.1	1	2	4	7	10
160	12,033	2.7	1	1	2	4	5
161	10,717	4.4	1	2	3	6	9
162	5,954	2.0	1	1	1	2	4
163	9	3.9	2	3	4	4	5
164	5,817	8.2	3	5	7	10	15
165	2,466	4.3	2	3	4	6	7
166	4,484	4.7	1	2	4	6	9
167	4,355	2.3	1	1	2	3	4
168	1,537	4.7	1	2	3	6	10
169	837	2.5	1	1	2	3	6

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
170	17,027	10.8	2	5	8	14	22
171	1,452	4.3	1	2	3	6	8
172	31,983	6.9	2	3	5	9	14
173	2,554	3.7	1	1	3	5	7
174	259,489	4.8	2	3	4	6	9
175	33,849	2.9	1	2	3	4	5
176	13,024	5.3	2	3	4	7	10
177	8,752	4.6	2	2	4	6	8
178	3,219	3.1	1	2	3	4	6
179	14,063	5.9	2	3	5	7	11
180	92,889	5.4	2	3	4	7	10
181	26,564	3.4	1	2	3	4	6
182	292,053	4.4	1	2	3	5	8
183	90,835	2.9	1	1	2	4	5
184	59	3.3	1	1	2	4	6
185	5,701	4.7	1	2	3	6	9
186	5	5.8	2	2	4	7	13
187	740	4.2	1	2	3	6	8
188	88,403	5.5	1	2	4	7	11
189	13,059	3.0	1	1	2	4	6
190	71	4.4	1	2	3	6	10
191	9,925	13.2	3	6	9	16	27
192	1,346	5.6	1	3	5	7	10
193	4,428	12.7	5	7	10	15	24
194	532	6.6	2	4	6	8	12
195	3,749	10.2	4	6	9	13	18
196	817	5.5	2	3	5	7	9
197	18,070	9.1	3	5	7	11	16
198	4,916	4.4	2	3	4	6	8
199	1,547	9.5	2	4	7	12	20
200	958	10.2	1	3	7	13	23
201	2,613	14.1	3	6	11	18	28
202	25,957	6.3	2	3	5	8	12
203	31,115	6.7	2	3	5	9	13
204	70,047	5.7	2	3	4	7	11
205	31,075	6.0	2	3	4	7	12
206	2,043	3.8	1	2	3	5	7
207	34,796	5.2	1	2	4	7	10
208	10,055	2.9	1	1	2	4	6
209	427,161	4.7	3	3	4	5	7
210	126,340	6.8	3	4	6	8	11

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
211	28,537	4.8	3	3	4	6	7
212	2	1.5	1	1	2	2	2
213	10,231	9.1	2	4	7	12	18
216	12,806	6.7	1	1	4	9	15
217	17,860	13.1	3	5	9	16	27
218	26,917	5.5	2	3	4	7	10
219	21,382	3.2	1	2	3	4	5
220	1	4.0	4	4	4	4	4
223	13,718	3.1	1	1	2	4	6
224	11,615	1.9	1	1	1	2	3
225	6,364	5.3	1	2	4	7	11
226	6,521	6.5	1	3	4	8	14
227	5,122	2.7	1	1	2	3	5
228	2,679	4.2	1	1	3	5	9
229	1,158	2.5	1	1	2	3	5
230	2,384	5.7	1	2	4	7	12
232	764	2.8	1	1	1	3	6
233	10,125	7.5	1	3	6	9	15
234	4,901	3.4	1	1	2	5	7
235	5,067	4.7	1	2	4	6	9
236	41,984	4.6	1	3	4	5	8
237	1,889	3.8	1	2	3	5	7
238	9,565	8.5	3	4	6	10	16
239	44,768	6.2	2	3	5	7	12
240	12,498	6.6	2	3	5	8	13
241	2,981	3.7	1	2	3	5	7
242	2,760	6.8	2	3	5	8	14
243	100,379	4.6	1	2	4	6	8
244	15,653	4.6	1	2	4	6	8
245	5,887	3.3	1	2	3	4	6
246	1,413	3.7	1	2	3	4	7
247	21,517	3.3	1	2	3	4	6
248	14,485	4.7	1	2	4	6	9
249	13,538	3.8	1	1	3	5	8
250	3,918	3.9	1	2	3	5	7
251	2,330	2.8	1	1	2	4	5
253	23,304	4.6	2	3	4	6	8
254	10,669	3.1	1	2	3	4	5
256	6,960	5.1	1	2	4	6	10
257	14,340	2.7	1	1	2	3	5
258	13,122	1.8	1	1	2	2	3

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
259	3,182	2.8	1	1	1	3	7
260	3,633	1.4	1	1	1	1	2
261	1,628	2.1	1	1	1	2	4
262	634	4.7	1	1	3	6	10
263	25,663	11.3	3	5	8	14	22
264	3,975	6.5	2	3	5	8	12
265	4,044	6.7	1	2	4	8	14
266	2,492	3.2	1	1	2	4	7
267	239	4.5	1	1	3	5	11
268	916	3.7	1	1	2	4	8
269	10,258	8.6	2	4	7	11	17
270	2,821	3.7	1	1	2	5	8
271	20,261	7.0	2	3	6	8	13
272	5,835	5.9	2	3	5	7	11
273	1,351	3.7	1	2	3	5	7
274	2,284	6.3	1	3	5	8	13
275	177	3.0	1	1	2	4	6
276	1,370	4.7	1	3	4	6	8
277	109,102	5.6	2	3	5	7	10
278	33,196	4.1	2	2	4	5	7
279	7	13.3	2	3	5	10	12
280	18,541	4.1	1	2	3	5	8
281	7,274	2.9	1	1	3	4	5
283	6,117	4.7	1	2	3	6	9
284	1,861	3.0	1	1	2	4	6
285	7,117	10.3	3	5	8	13	20
286	2,617	5.6	2	3	4	6	11
287	6,411	10.0	3	5	7	12	19
288	8,422	4.5	2	3	3	5	7
289	6,753	2.6	1	1	1	2	5
290	10,266	2.2	1	1	1	2	4
291	70	1.5	1	1	1	2	2
292	6,928	10.2	2	4	8	13	21
293	342	4.7	1	2	3	6	10
294	99,250	4.4	1	2	3	5	8
295	3,732	3.8	1	2	3	5	7
296	260,811	4.9	1	2	4	6	9
297	47,634	3.1	1	2	3	4	6
298	107	3.5	1	2	2	4	7
299	1,413	5.2	1	2	4	7	10
300	19,630	6.0	2	3	5	7	11

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
301	3,837	3.5	1	2	3	4	7
302	8,975	8.2	4	5	6	9	14
303	22,984	7.7	3	4	6	9	14
304	13,239	8.6	2	3	6	11	18
305	3,069	3.3	1	2	3	4	6
306	7,039	5.4	1	2	3	7	13
307	1,910	2.1	1	1	2	2	3
308	7,447	6.0	1	2	4	8	13
309	3,850	2.0	1	1	1	2	4
310	25,572	4.4	1	1	3	6	10
311	6,909	1.8	1	1	1	2	3
312	1,528	4.6	1	1	3	6	10
313	545	2.2	1	1	1	3	4
314	1	1.0	1	1	1	1	1
315	35,921	6.8	1	1	4	9	16
316	150,585	6.4	2	3	5	8	13
317	2,483	3.3	1	1	2	4	7
318	5,872	5.8	1	2	4	7	12
319	394	2.7	1	1	2	3	6
320	211,017	5.2	2	3	4	6	9
321	31,275	3.6	1	2	3	4	6
322	59	3.6	1	2	3	4	8
323	20,601	3.2	1	1	2	4	6
324	6,225	1.9	1	1	1	2	3
325	9,624	3.8	1	2	3	5	7
326	2,757	2.6	1	1	2	3	5
327	2	2.5	2	2	3	3	3
328	679	3.4	1	1	3	4	7
329	64	2.2	1	1	1	2	5
331	53,566	5.5	1	3	4	7	11
332	4,675	3.2	1	1	2	4	6
333	246	5.4	1	2	4	7	12
334	10,248	4.4	2	3	4	5	7
335	12,393	2.9	1	2	3	3	4
336	33,334	3.3	1	2	2	4	7
337	26,361	2.0	1	1	2	2	3
338	712	5.7	1	2	3	8	13
339	1,439	5.3	1	1	3	6	12
341	3,605	3.0	1	1	2	3	6
342	629	3.2	1	1	2	4	7
344	3,132	2.5	1	1	1	2	6

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
345	1,349	4.9	1	1	3	6	11
346	4,522	6.0	2	3	5	8	12
347	280	2.7	1	1	2	3	6
348	3,355	4.1	1	2	3	5	8
349	537	2.5	1	1	2	3	5
350	7,028	4.5	2	2	4	6	8
352	1,078	4.1	1	2	3	5	8
353	2,650	6.4	2	3	4	7	13
354	7,437	5.8	2	3	4	7	10
355	5,264	3.1	2	2	3	4	5
356	25,335	2.0	1	1	2	2	3
357	5,594	8.3	3	4	6	10	16
358	21,135	4.1	2	2	3	4	7
359	29,879	2.5	1	2	2	3	4
360	15,512	2.7	1	1	2	3	4
361	296	3.5	1	1	2	4	8
363	2,431	3.9	1	2	2	4	8
364	1,460	4.4	1	2	3	6	9
365	1,667	8.0	1	3	5	10	18
366	4,683	6.7	1	3	5	9	14
367	459	3.2	1	1	2	4	6
368	3,887	6.8	2	3	5	9	14
369	3,549	3.3	1	1	2	4	7
370	1,606	5.4	2	3	4	5	9
371	1,964	3.5	2	3	3	4	5
372	1,063	3.5	2	2	2	3	5
373	4,459	2.2	1	2	2	3	3
374	120	3.3	2	2	2	3	5
375	4	5.0	2	2	3	6	9
376	308	3.6	1	2	2	4	5
377	57	4.7	1	1	3	6	10
378	185	2.2	1	1	2	3	4
379	428	3.0	1	1	2	3	5
380	90	1.9	1	1	1	2	3
381	202	2.2	1	1	1	2	4
382	30	2.1	1	1	1	2	5
383	2,299	3.8	1	1	3	4	8
384	136	2.0	1	1	1	2	4
389	1	6.0	6	6	6	6	6
390	3	1.0	1	1	1	1	1
392	2,132	9.4	2	4	7	12	20

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
394	2,620	7.2	1	2	5	9	15
395	111,146	4.3	1	2	3	5	8
396	10	10.9	1	2	3	11	28
397	19,314	5.1	1	2	4	6	10
398	17,821	5.9	2	3	5	7	11
399	1,646	3.2	1	2	3	4	6
401	5,897	11.5	2	5	8	15	23
402	1,450	4.1	1	1	3	5	10
403	31,795	7.9	2	3	6	10	16
404	4,044	4.1	1	2	3	5	8
406	2,384	9.7	2	4	7	12	20
407	575	4.0	1	2	4	5	7
408	2,128	8.3	1	2	5	10	20
409	2,040	6.0	1	3	4	6	12
410	28,228	4.0	1	2	3	5	6
411	7	1.7	1	1	1	2	3
412	14	1.6	1	1	1	1	3
413	5,542	7.3	2	3	6	9	14
414	574	3.8	1	2	3	5	7
415	46,405	14.1	4	6	10	18	28
416	210,582	7.3	2	3	6	9	14
417	26	5.3	1	2	3	6	10
418	27,431	6.2	2	3	5	8	12
419	16,785	4.6	1	2	4	6	9
420	2,917	3.3	1	2	3	4	6
421	10,624	4.2	1	2	3	5	8
422	68	3.3	1	2	2	4	5
423	8,340	8.1	2	3	6	10	17
424	1,234	12.9	1	4	8	16	27
425	15,505	3.8	1	2	3	5	7
426	4,178	4.2	1	2	3	5	8
427	1,423	4.7	1	2	3	6	9
428	779	8.0	1	3	5	9	17
429	27,428	5.6	2	3	4	7	10
430	68,814	7.8	2	3	6	10	15
431	260	5.5	1	2	4	7	12
432	395	4.5	1	2	3	5	10
433	5,514	2.9	1	1	2	3	6
439	1,673	8.5	1	3	5	10	18
440	5,876	8.8	2	3	6	11	19
441	711	3.1	1	1	2	4	6

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
442	17,402	8.8	2	3	6	11	18
443	3,663	3.4	1	1	3	5	7
444	6,022	4.1	1	2	3	5	8
445	2,393	2.8	1	1	2	3	5
447	6,398	2.6	1	1	2	3	5
449	35,504	3.7	1	1	3	4	7
450	7,563	2.0	1	1	1	2	4
451	4	2.3	1	1	1	1	6
452	27,211	4.9	1	2	3	6	10
453	5,538	2.8	1	1	2	3	5
454	4,314	4.2	1	2	3	5	8
455	967	2.4	1	1	2	3	4
461	5,020	3.6	1	1	2	4	8
462	8,380	10.8	4	6	9	14	20
463	29,075	4.0	1	2	3	5	8
464	7,556	3.0	1	1	2	4	5
465	205	3.0	1	1	2	4	6
466	1,788	4.1	1	1	2	4	8
467	1,180	3.1	1	1	2	3	6
468	52,902	12.6	3	6	10	16	25
471	14,356	5.3	3	3	4	6	8
473	8,561	12.7	2	3	7	18	33
475	111,093	11.1	2	5	9	15	22
476	3,227	10.8	2	5	9	15	21
477	26,151	8.2	1	3	6	11	17
478	110,169	7.3	1	3	5	9	15
479	23,803	3.0	1	1	2	4	6
480	710	18.5	6	8	12	21	38
481	858	22.5	12	16	20	25	36
482	5,129	11.8	4	6	9	14	22
483	45,206	38.3	14	21	32	47	69
484	407	13.1	2	6	10	18	26
485	3,312	9.7	4	5	7	11	18
486	2,262	12.7	2	6	10	17	26
487	4,208	7.3	1	3	6	9	15
488	795	17.3	4	7	13	23	37
489	13,723	8.3	2	3	6	10	17
490	5,209	5.3	1	2	4	7	10
491	17,264	3.3	1	2	3	4	6
492	3,336	14.9	3	5	7	24	34
493	61,195	6.1	1	3	5	8	12

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
494	27,202	2.6	1	1	2	3	5
495	245	16.5	8	9	13	19	33
496	4,535	7.5	3	4	5	8	15
497	25,034	6.2	3	4	5	7	10
498	16,905	3.9	2	3	4	5	6
499	37,450	4.4	1	2	3	5	9
500	50,876	2.3	1	1	2	3	4
501	2,808	10.0	4	5	8	12	19
502	705	6.0	3	4	5	7	10
503	5,948	3.8	1	2	3	5	7
504	129	31.0	7	15	30	43	56
505	159	3.1	1	1	1	3	7
506	1,010	16.4	4	7	13	21	33
507	321	9.2	2	4	7	13	19
508	637	7.2	1	3	5	9	15
509	165	4.6	1	2	3	7	9
510	1,749	6.8	1	2	4	8	14
511	622	4.1	1	1	3	5	9
512	529	14.0	6	8	10	15	25
513	174	10.1	6	7	8	11	18
515	13,163	4.7	1	1	2	6	12
516	79,894	4.6	2	2	4	5	9
517	181,948	2.5	1	1	1	3	5
518	48,717	3.5	1	1	2	4	8
519	10,133	4.9	1	1	3	6	11
520	13,969	2.1	1	1	1	2	4
521	32,084	5.6	2	3	4	7	11
522	5,923	9.4	4	4	7	12	19
523	15,548	3.9	1	2	3	5	7
524	123,804	3.3	1	2	3	4	6
525	284	19.6	2	5	11	23	48
526	11,127	4.3	1	2	3	5	8
527	48,486	2.1	1	1	1	2	4
528	1,763	16.9	5	9	15	22	30
529	3,902	8.2	1	2	5	11	19
530	2,371	3.3	1	1	2	4	6
531	4,009	9.6	2	4	7	12	20
532	3,102	3.9	1	1	3	5	8
533	43,418	4.0	1	1	2	5	9
534	50,974	1.9	1	1	1	2	3
535	9,817	9.2	1	3	8	12	19

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY MEAN LOS	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
536	25,511	5.4	1	2	4	7	12
537	7,572	6.9	1	3	5	8	14
538	6,346	2.9	1	1	2	4	6
539	4,514	11.3	2	4	8	14	24
540	1,901	4.0	1	2	3	5	8
	11,894,468						

TABLE 7B.--MEDICARE PROSPECTIVE PAYMENT SYSTEM SELECTED PERCENTILE LENGTHS OF STAY
[FY 2003 MEDPAR UPDATE DECEMBER 2003 GROUPER V22.0]

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
1	27,050	10.5	3	5	8	14	21
2	10,753	4.7	1	2	4	6	9
3	2	5.0	5	5	5	5	5
6	367	3.4	1	1	2	4	7
7	15,257	9.6	2	4	7	12	19
8	3,911	2.7	1	1	2	3	6
9	1,790	5.8	1	2	4	8	11
10	18,888	6.2	2	3	5	8	12
11	3,378	3.9	1	2	3	5	8
12	53,417	5.5	2	3	4	7	10
13	7,051	4.9	2	3	4	6	8
14	241,535	5.8	2	3	5	7	11
15	82,855	4.7	1	2	4	6	8
16	10,715	6.2	2	3	5	8	12
17	2,800	3.1	1	1	2	4	6
18	30,819	5.4	2	3	4	7	10
19	8,737	3.5	1	2	3	5	7
20	6,545	10.1	3	5	8	13	20
21	2,179	6.7	2	3	5	8	13
22	3,177	5.1	2	2	4	6	10
23	11,835	4.2	1	2	3	5	8
24	60,883	4.8	1	2	4	6	9
25	28,359	3.1	1	2	3	4	6
26	32	3.2	1	1	2	3	5
27	4,965	5.1	1	1	3	6	11
28	15,853	5.9	1	3	4	8	12
29	5,782	3.4	1	1	3	4	7
31	4,609	4.0	1	2	3	5	8
32	1,932	2.5	1	1	2	3	5
34	25,258	4.8	1	2	4	6	9
35	7,882	3.1	1	1	3	4	6
36	1,615	1.6	1	1	1	1	3
37	1,371	3.9	1	1	3	5	9
38	78	2.3	1	1	2	2	4
39	546	2.2	1	1	1	2	5
40	1,510	4.1	1	1	3	5	8
42	1,252	2.8	1	1	2	3	6
43	125	3.4	1	2	3	5	6

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
44	1,238	4.9	2	3	4	6	9
45	2,835	3.2	1	2	3	4	6
46	3,556	4.3	1	2	3	5	8
47	1,382	3.2	1	1	3	4	6
48	1	1.0	1	1	1	1	1
49	2,326	4.6	1	2	3	6	9
50	2,252	1.9	1	1	1	2	3
51	233	2.9	1	1	1	3	7
52	174	2.2	1	1	1	2	4
53	2,238	3.6	1	1	2	4	8
55	1,453	2.9	1	1	1	3	7
56	466	2.8	1	1	2	3	5
57	721	3.9	1	1	2	4	8
59	118	2.5	1	1	1	3	6
60	5	1.2	1	1	1	1	2
61	259	5.8	1	1	3	8	12
62	2	2.0	2	2	2	2	2
63	2,756	4.4	1	1	3	5	9
64	3,215	6.5	1	2	4	8	14
65	40,968	2.8	1	1	2	4	5
66	7,906	3.1	1	1	2	4	6
67	406	3.5	1	2	3	5	6
68	8,818	3.7	1	2	3	5	7
69	2,974	2.9	1	2	2	4	5
70	26	2.9	1	2	2	3	5
71	67	3.6	2	2	3	4	6
72	1,214	3.5	1	2	3	4	7
73	7,933	4.5	1	2	3	6	9
75	43,470	9.9	3	5	7	12	20
76	46,205	11.0	3	5	9	14	21
77	2,329	4.7	1	2	4	7	9
78	42,890	6.4	3	4	6	8	11
79	173,152	8.3	3	4	7	11	16
80	7,909	5.4	2	3	4	7	10
81	2	13.5	1	1	26	26	26
82	65,401	6.8	2	3	5	9	13
83	6,870	5.3	2	3	4	7	10
84	1,482	3.2	1	2	3	4	6
85	22,472	6.3	2	3	5	8	12
86	2,063	3.6	1	2	3	5	7
87	66,941	6.4	2	3	5	8	12
88	396,746	5.0	2	3	4	6	9

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
89	519,475	5.7	2	3	5	7	10
90	43,918	3.9	2	2	3	5	7
91	45	3.4	2	2	3	4	6
92	16,588	6.2	2	3	5	8	12
93	1,662	4.0	1	2	3	5	7
94	13,110	6.2	2	3	5	8	12
95	1,590	3.7	1	2	3	5	7
96	50,944	4.4	2	2	4	6	8
97	26,138	3.4	1	2	3	4	6
98	15	3.1	1	2	3	4	5
99	21,779	3.2	1	1	2	4	6
100	7,581	2.1	1	1	2	3	4
101	23,051	4.3	1	2	3	5	8
102	5,493	2.5	1	1	2	3	5
103	553	40.0	9	12	22	50	93
104	20,896	14.6	6	8	12	18	26
105	30,639	9.9	4	6	8	12	18
106	3,490	11.3	5	7	10	14	19
107	78,304	10.6	5	7	9	12	17
108	7,025	9.6	1	5	8	12	19
109	54,443	7.8	4	5	6	9	13
110	55,446	8.7	1	4	7	11	18
111	9,421	3.7	1	1	3	5	7
113	38,552	12.5	4	6	10	16	24
114	8,354	8.7	2	4	7	11	17
115	21,814	7.0	1	2	6	9	14
116	117,554	4.3	1	1	3	6	9
117	4,883	4.3	1	1	2	5	10
118	8,353	3.0	1	1	2	4	7
119	1,103	5.3	1	1	3	7	13
120	36,814	8.9	1	3	6	12	19
121	164,174	6.2	2	3	5	8	12
122	70,707	3.4	1	2	3	4	6
123	36,215	4.7	1	1	3	6	11
124	134,205	4.4	1	2	3	6	9
125	92,985	2.8	1	1	2	4	5
126	5,597	11.3	3	6	9	14	21
127	693,364	5.2	2	3	4	6	10
128	6,143	5.4	2	3	5	7	9
129	3,979	2.7	1	1	1	3	6
130	90,145	5.5	2	3	5	7	10
131	25,688	3.9	1	2	4	5	7

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
132	128,455	2.8	1	1	2	4	5
133	7,547	2.2	1	1	2	3	4
134	42,604	3.1	1	2	2	4	6
135	7,486	4.4	1	2	3	6	9
136	1,093	2.6	1	1	2	3	5
137	1	3.0	3	3	3	3	3
138	204,771	4.0	1	2	3	5	8
139	82,144	2.5	1	1	2	3	5
140	45,881	2.5	1	1	2	3	5
141	114,689	3.5	1	2	3	4	7
142	52,608	2.5	1	1	2	3	5
143	245,783	2.1	1	1	2	3	4
144	96,762	5.7	1	2	4	7	12
145	6,693	2.6	1	1	2	3	5
146	10,879	10.1	5	6	8	12	17
147	2,702	6.0	3	4	6	7	9
148	136,089	12.2	5	7	10	15	22
149	19,920	6.1	3	4	6	7	9
150	22,088	11.0	4	6	9	14	20
151	5,280	5.4	1	3	5	7	10
152	4,795	8.0	3	5	7	9	14
153	2,121	5.1	3	4	5	6	8
154	28,540	13.3	3	6	10	17	26
155	6,467	4.1	1	2	3	6	8
156	8	9.9	3	5	6	13	15
157	8,306	5.6	1	2	4	7	11
158	4,117	2.6	1	1	2	3	5
159	18,762	5.1	1	2	4	7	10
160	12,033	2.7	1	1	2	4	5
161	10,717	4.4	1	2	3	6	9
162	5,954	2.0	1	1	1	2	4
163	9	3.9	2	3	4	4	5
164	5,817	8.2	3	5	7	10	15
165	2,466	4.3	2	3	4	6	7
166	4,484	4.7	1	2	4	6	9
167	4,355	2.3	1	1	2	3	4
168	1,537	4.7	1	2	3	6	10
169	837	2.5	1	1	2	3	6
170	17,027	10.8	2	5	8	14	22
171	1,452	4.3	1	2	3	6	8
172	31,983	6.9	2	3	5	9	14
173	2,554	3.7	1	1	3	5	7

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
174	259,489	4.8	2	3	4	6	9
175	33,849	2.9	1	2	3	4	5
176	13,024	5.3	2	3	4	7	10
177	8,752	4.6	2	2	4	6	8
178	3,219	3.1	1	2	3	4	6
179	14,063	5.9	2	3	5	7	11
180	92,889	5.4	2	3	4	7	10
181	26,564	3.4	1	2	3	4	6
182	292,053	4.4	1	2	3	5	8
183	90,835	2.9	1	1	2	4	5
184	59	3.3	1	1	2	4	6
185	5,701	4.7	1	2	3	6	9
186	5	5.8	2	2	4	7	13
187	740	4.2	1	2	3	6	8
188	88,403	5.5	1	2	4	7	11
189	13,059	3.0	1	1	2	4	6
190	71	4.4	1	2	3	6	10
191	9,925	13.2	3	6	9	16	27
192	1,346	5.6	1	3	5	7	10
193	4,428	12.7	5	7	10	15	24
194	532	6.6	2	4	6	8	12
195	3,749	10.2	4	6	9	13	18
196	817	5.5	2	3	5	7	9
197	18,070	9.1	3	5	7	11	16
198	4,916	4.4	2	3	4	6	8
199	1,547	9.5	2	4	7	12	20
200	958	10.2	1	3	7	13	23
201	2,613	14.1	3	6	11	18	28
202	25,957	6.3	2	3	5	8	12
203	31,115	6.7	2	3	5	9	13
204	70,047	5.7	2	3	4	7	11
205	31,075	6.0	2	3	4	7	12
206	2,043	3.8	1	2	3	5	7
207	34,796	5.2	1	2	4	7	10
208	10,055	2.9	1	1	2	4	6
209	427,161	4.7	3	3	4	5	7
210	126,340	6.8	3	4	6	8	11
211	28,537	4.8	3	3	4	6	7
212	2	1.5	1	1	2	2	2
213	10,231	9.1	2	4	7	12	18
216	12,806	6.7	1	1	4	9	15
217	17,860	13.1	3	5	9	16	27

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
218	26,917	5.5	2	3	4	7	10
219	21,382	3.2	1	2	3	4	5
220	1	4.0	4	4	4	4	4
223	13,718	3.1	1	1	2	4	6
224	11,615	1.9	1	1	1	2	3
225	6,364	5.3	1	2	4	7	11
226	6,521	6.5	1	3	4	8	14
227	5,122	2.7	1	1	2	3	5
228	2,679	4.2	1	1	3	5	9
229	1,158	2.5	1	1	2	3	5
230	2,384	5.7	1	2	4	7	12
232	764	2.8	1	1	1	3	6
233	10,125	7.5	1	3	6	9	15
234	4,901	3.4	1	1	2	5	7
235	5,067	4.7	1	2	4	6	9
236	41,984	4.6	1	3	4	5	8
237	1,889	3.8	1	2	3	5	7
238	9,565	8.5	3	4	6	10	16
239	44,768	6.2	2	3	5	7	12
240	12,498	6.6	2	3	5	8	13
241	2,981	3.7	1	2	3	5	7
242	2,760	6.8	2	3	5	8	14
243	100,379	4.6	1	2	4	6	8
244	15,653	4.6	1	2	4	6	8
245	5,887	3.3	1	2	3	4	6
246	1,413	3.7	1	2	3	4	7
247	21,517	3.3	1	2	3	4	6
248	14,485	4.7	1	2	4	6	9
249	13,538	3.8	1	1	3	5	8
250	3,918	3.9	1	2	3	5	7
251	2,330	2.8	1	1	2	4	5
253	23,304	4.6	2	3	4	6	8
254	10,669	3.1	1	2	3	4	5
256	6,960	5.1	1	2	4	6	10
257	14,340	2.7	1	1	2	3	5
258	13,122	1.8	1	1	2	2	3
259	3,182	2.8	1	1	1	3	7
260	3,633	1.4	1	1	1	1	2
261	1,628	2.1	1	1	1	2	4
262	634	4.7	1	1	3	6	10
263	25,663	11.3	3	5	8	14	22
264	3,975	6.5	2	3	5	8	12

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
265	4,044	6.7	1	2	4	8	14
266	2,492	3.2	1	1	2	4	7
267	239	4.5	1	1	3	5	11
268	916	3.7	1	1	2	4	8
269	10,258	8.6	2	4	7	11	17
270	2,821	3.7	1	1	2	5	8
271	20,261	7.0	2	3	6	8	13
272	5,835	5.9	2	3	5	7	11
273	1,351	3.7	1	2	3	5	7
274	2,284	6.3	1	3	5	8	13
275	177	3.0	1	1	2	4	6
276	1,370	4.7	1	3	4	6	8
277	109,102	5.6	2	3	5	7	10
278	33,196	4.1	2	2	4	5	7
279	7	13.3	2	3	5	10	12
280	18,541	4.1	1	2	3	5	8
281	7,274	2.9	1	1	3	4	5
283	6,117	4.7	1	2	3	6	9
284	1,861	3.0	1	1	2	4	6
285	7,117	10.3	3	5	8	13	20
286	2,617	5.6	2	3	4	6	11
287	6,411	10.0	3	5	7	12	19
288	8,422	4.5	2	3	3	5	7
289	6,753	2.6	1	1	1	2	5
290	10,266	2.2	1	1	1	2	4
291	70	1.5	1	1	1	2	2
292	6,928	10.2	2	4	8	13	21
293	342	4.7	1	2	3	6	10
294	99,250	4.4	1	2	3	5	8
295	3,732	3.8	1	2	3	5	7
296	260,811	4.9	1	2	4	6	9
297	47,634	3.1	1	2	3	4	6
298	107	3.5	1	2	2	4	7
299	1,413	5.2	1	2	4	7	10
300	19,630	6.0	2	3	5	7	11
301	3,837	3.5	1	2	3	4	7
302	8,975	8.2	4	5	6	9	14
303	22,984	7.7	3	4	6	9	14
304	13,239	8.6	2	3	6	11	18
305	3,069	3.3	1	2	3	4	6
306	7,039	5.4	1	2	3	7	13
307	1,910	2.1	1	1	2	2	3

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
308	7,447	6.0	1	2	4	8	13
309	3,850	2.0	1	1	1	2	4
310	25,572	4.4	1	1	3	6	10
311	6,909	1.8	1	1	1	2	3
312	1,528	4.6	1	1	3	6	10
313	545	2.2	1	1	1	3	4
314	1	1.0	1	1	1	1	1
315	35,921	6.8	1	1	4	9	16
316	150,585	6.4	2	3	5	8	13
317	2,483	3.3	1	1	2	4	7
318	5,872	5.8	1	2	4	7	12
319	394	2.7	1	1	2	3	6
320	211,017	5.2	2	3	4	6	9
321	31,275	3.6	1	2	3	4	6
322	59	3.6	1	2	3	4	8
323	20,601	3.2	1	1	2	4	6
324	6,225	1.9	1	1	1	2	3
325	9,624	3.8	1	2	3	5	7
326	2,757	2.6	1	1	2	3	5
327	2	2.5	2	2	3	3	3
328	679	3.4	1	1	3	4	7
329	64	2.2	1	1	1	2	5
331	53,566	5.5	1	3	4	7	11
332	4,675	3.2	1	1	2	4	6
333	246	5.4	1	2	4	7	12
334	10,248	4.4	2	3	4	5	7
335	12,393	2.9	1	2	3	3	4
336	33,334	3.3	1	2	2	4	7
337	26,361	2.0	1	1	2	2	3
338	712	5.7	1	2	3	8	13
339	1,439	5.3	1	1	3	6	12
341	3,605	3.0	1	1	2	3	6
342	629	3.2	1	1	2	4	7
344	3,132	2.5	1	1	1	2	6
345	1,349	4.9	1	1	3	6	11
346	4,522	6.0	2	3	5	8	12
347	280	2.7	1	1	2	3	6
348	3,355	4.1	1	2	3	5	8
349	537	2.5	1	1	2	3	5
350	7,028	4.5	2	2	4	6	8
352	1,078	4.1	1	2	3	5	8
353	2,650	6.4	2	3	4	7	13

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
354	7,437	5.8	2	3	4	7	10
355	5,264	3.1	2	2	3	4	5
356	25,335	2.0	1	1	2	2	3
357	5,594	8.3	3	4	6	10	16
358	21,135	4.1	2	2	3	4	7
359	29,879	2.5	1	2	2	3	4
360	15,512	2.7	1	1	2	3	4
361	296	3.5	1	1	2	4	8
363	2,431	3.9	1	2	2	4	8
364	1,460	4.4	1	2	3	6	9
365	1,667	8.0	1	3	5	10	18
366	4,683	6.7	1	3	5	9	14
367	459	3.2	1	1	2	4	6
368	3,887	6.8	2	3	5	9	14
369	3,549	3.3	1	1	2	4	7
370	1,606	5.4	2	3	4	5	9
371	1,964	3.5	2	3	3	4	5
372	1,063	3.5	2	2	2	3	5
373	4,459	2.2	1	2	2	3	3
374	120	3.3	2	2	2	3	5
375	4	5.0	2	2	3	6	9
376	308	3.6	1	2	2	4	5
377	57	4.7	1	1	3	6	10
378	185	2.2	1	1	2	3	4
379	428	3.0	1	1	2	3	5
380	90	1.9	1	1	1	2	3
381	202	2.2	1	1	1	2	4
382	30	2.1	1	1	1	2	5
383	2,299	3.8	1	1	3	4	8
384	136	2.0	1	1	1	2	4
389	1	6.0	6	6	6	6	6
390	3	1.0	1	1	1	1	1
392	2,132	9.4	2	4	7	12	20
394	2,620	7.2	1	2	5	9	15
395	111,146	4.3	1	2	3	5	8
396	10	10.9	1	2	3	11	28
397	19,314	5.1	1	2	4	6	10
398	17,821	5.9	2	3	5	7	11
399	1,646	3.2	1	2	3	4	6
401	5,897	11.5	2	5	8	15	23
402	1,450	4.1	1	1	3	5	10
403	31,795	7.9	2	3	6	10	16

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
404	4,044	4.1	1	2	3	5	8
406	2,384	9.7	2	4	7	12	20
407	575	4.0	1	2	4	5	7
408	2,128	8.3	1	2	5	10	20
409	2,040	6.0	1	3	4	6	12
410	28,228	4.0	1	2	3	5	6
411	7	1.7	1	1	1	2	3
412	14	1.6	1	1	1	1	3
413	5,542	7.3	2	3	6	9	14
414	574	3.8	1	2	3	5	7
415	46,405	14.1	4	6	10	18	28
416	210,582	7.3	2	3	6	9	14
417	26	5.3	1	2	3	6	10
418	27,431	6.2	2	3	5	8	12
419	16,785	4.6	1	2	4	6	9
420	2,917	3.3	1	2	3	4	6
421	10,624	4.2	1	2	3	5	8
422	68	3.3	1	2	2	4	5
423	8,340	8.1	2	3	6	10	17
424	1,234	12.9	1	4	8	16	27
425	15,505	3.8	1	2	3	5	7
426	4,178	4.2	1	2	3	5	8
427	1,423	4.7	1	2	3	6	9
428	779	8.0	1	3	5	9	17
429	27,428	5.6	2	3	4	7	10
430	68,814	7.8	2	3	6	10	15
431	260	5.5	1	2	4	7	12
432	395	4.5	1	2	3	5	10
433	5,514	2.9	1	1	2	3	6
439	1,673	8.5	1	3	5	10	18
440	5,876	8.8	2	3	6	11	19
441	711	3.1	1	1	2	4	6
442	17,402	8.8	2	3	6	11	18
443	3,663	3.4	1	1	3	5	7
444	6,022	4.1	1	2	3	5	8
445	2,393	2.8	1	1	2	3	5
447	6,398	2.6	1	1	2	3	5
449	35,504	3.7	1	1	3	4	7
450	7,563	2.0	1	1	1	2	4
451	4	2.3	1	1	1	1	6
452	27,211	4.9	1	2	3	6	10
453	5,538	2.8	1	1	2	3	5

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
454	4,314	4.2	1	2	3	5	8
455	967	2.4	1	1	2	3	4
461	5,020	3.6	1	1	2	4	8
462	8,380	10.8	4	6	9	14	20
463	29,075	4.0	1	2	3	5	8
464	7,556	3.0	1	1	2	4	5
465	205	3.0	1	1	2	4	6
466	1,788	4.1	1	1	2	4	8
467	1,180	3.1	1	1	2	3	6
468	48,879	12.8	3	6	10	17	25
471	14,356	5.3	3	3	4	6	8
473	8,561	12.7	2	3	7	18	33
475	111,093	11.1	2	5	9	15	22
476	3,227	10.8	2	5	9	15	21
477	30,174	8.5	1	3	6	11	18
478	110,169	7.3	1	3	5	9	15
479	23,803	3.0	1	1	2	4	6
480	710	18.5	6	8	12	21	38
481	858	22.5	12	16	20	25	36
482	5,129	11.8	4	6	9	14	22
484	407	13.1	2	6	10	18	26
485	3,312	9.7	4	5	7	11	18
486	2,262	12.7	2	6	10	17	26
487	4,208	7.3	1	3	6	9	15
488	795	17.3	4	7	13	23	37
489	13,723	8.3	2	3	6	10	17
490	5,209	5.3	1	2	4	7	10
491	17,264	3.3	1	2	3	4	6
492	3,336	14.9	3	5	7	24	34
493	61,195	6.1	1	3	5	8	12
494	27,202	2.6	1	1	2	3	5
495	245	16.5	8	9	13	19	33
496	2,755	9.3	3	4	7	11	19
497	25,973	6.1	3	4	5	7	10
498	17,746	3.9	2	3	4	5	6
499	37,450	4.4	1	2	3	5	9
500	50,876	2.3	1	1	2	3	4
501	2,808	10.0	4	5	8	12	19
502	705	6.0	3	4	5	7	10
503	5,948	3.8	1	2	3	5	7
504	174	29.1	8	16	25	41	54
505	191	4.7	1	1	2	5	11

DRG	NUMBER OF DISCHARGES	ARITHMETIC MEAN LENGTH OF STAY	10TH PERCENTILE	25TH PERCENTILE	50TH PERCENTILE	75TH PERCENTILE	100TH PERCENTILE
506	942	16.1	4	7	13	21	33
507	318	9.1	2	4	7	13	19
508	631	7.2	1	3	5	9	15
509	165	4.6	1	2	3	7	9
510	1,749	6.8	1	2	4	8	14
511	622	4.1	1	1	3	5	9
512	529	14.0	6	8	10	15	25
513	174	10.1	6	7	8	11	18
515	13,163	4.7	1	1	2	6	12
516	79,894	4.6	2	2	4	5	9
517	181,948	2.5	1	1	1	3	5
518	48,717	3.5	1	1	2	4	8
519	10,133	4.9	1	1	3	6	11
520	13,969	2.1	1	1	1	2	4
521	32,084	5.6	2	3	4	7	11
522	5,923	9.4	4	4	7	12	19
523	15,548	3.9	1	2	3	5	7
524	123,804	3.3	1	2	3	4	6
525	349	15.1	1	4	8	16	27
526	11,127	4.3	1	2	3	5	8
527	48,486	2.1	1	1	1	2	4
528	1,763	16.9	5	9	15	22	30
529	3,902	8.2	1	2	5	11	19
530	2,371	3.3	1	1	2	4	6
531	4,009	9.6	2	4	7	12	20
532	3,102	3.9	1	1	3	5	8
533	43,418	4.0	1	1	2	5	9
534	50,974	1.9	1	1	1	2	3
535	9,817	9.2	1	3	8	12	19
536	25,511	5.4	1	2	4	7	12
537	7,572	6.9	1	3	5	8	14
538	6,346	2.9	1	1	2	4	6
539	4,514	11.3	2	4	8	14	24
540	1,901	4.0	1	2	3	5	8
541	21,263	43.4	17	25	37	54	77
542	23,943	33.8	13	19	28	42	60
	11,894,468						

TABLE 8A.--STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS--MAY 2004

State	Urban	Rural
Alabama	0.296	0.362
Alaska	0.460	0.784
Arizona	0.310	0.499
Arkansas	0.381	0.419
California	0.279	0.392
Colorado	0.341	0.511
Connecticut	0.472	0.534
Delaware	0.542	0.465
District of Columbia	0.385	--
Florida	0.271	0.318
Georgia	0.401	0.459
Hawaii	0.391	0.472
Idaho	0.505	0.560
Illinois	0.359	0.459
Indiana	0.460	0.493
Iowa	0.446	0.557
Kansas	0.344	0.529
Kentucky	0.425	0.421
Louisiana	0.316	0.403
Maine	0.538	0.531
Maryland	0.757	0.836
Massachusetts	0.488	--
Michigan	0.410	0.519
Minnesota	0.427	0.539
Mississippi	0.381	0.402
Missouri	0.350	0.436
Montana	0.471	0.499
Nebraska	0.388	0.521
Nevada	0.259	0.519
New Hampshire	0.501	0.551
New Jersey	0.219	--
New Mexico	0.447	0.440
New York	0.400	0.537
North Carolina	0.500	0.459
North Dakota	0.555	0.478
Ohio	0.423	0.563
Oklahoma	0.359	0.460
Oregon	0.513	0.517
Pennsylvania	0.326	0.509

State	Urban	Rural
Puerto Rico	0.480	--
Rhode Island	0.452	--
South Carolina	0.345	0.369
South Dakota	0.424	0.514
Tennessee	0.360	0.435
Texas	0.328	0.419
Utah	0.456	0.591
Vermont	0.569	0.653
Virginia	0.408	0.445
Washington	0.479	0.544
West Virginia	0.539	0.510
Wisconsin	0.466	0.537
Wyoming	0.442	0.634

TABLE 8B.--STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS--MAY 2004

State	Ratio
Alabama	0.032
Alaska	0.049
Arizona	0.032
Arkansas	0.037
California	0.022
Colorado	0.032
Connecticut	0.035
Delaware	0.045
District of Columbia	0.029
Florida	0.027
Georgia	0.038
Hawaii	0.035
Idaho	0.052
Illinois	0.031
Indiana	0.045
Iowa	0.038
Kansas	0.036
Kentucky	0.039
Louisiana	0.034
Maine	0.037
Maryland	0.013
Massachusetts	0.039
Michigan	0.039
Minnesota	0.038
Mississippi	0.033
Missouri	0.032
Montana	0.041
Nebraska	0.040
Nevada	0.022
New Hampshire	0.042
New Jersey	0.017
New Mexico	0.036
New York	0.036
North Carolina	0.046
North Dakota	0.052
Ohio	0.037
Oklahoma	0.034
Oregon	0.043

State	Ratio
Pennsylvania	0.029
Puerto Rico	0.037
Rhode Island	0.025
South Carolina	0.031
South Dakota	0.049
Tennessee	0.037
Texas	0.033
Utah	0.044
Vermont	0.046
Virginia	0.042
Washington	0.040
West Virginia	0.039
Wisconsin	0.042
Wyoming	0.049

TABLE 9A.--HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL--FY 2005

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
010005	01	1000	01	13820		
010008	01	5240	01	33860		
010022	01	2880	01	23460		
010029	01	1800	12220	17980		
010035	01	1000	01	13820		
010065	01	0580	01	12220		
010072	01		45180	11500	LUGAR	
010089	01	1000	13820	13820		
010101	01		45180	11500	LUGAR	
010118	01	5240	01	33860		
010120	01	5160	01	33660		Baldwin
010126	01	5240	01	33860		
010143	01	1000	01	13820		
010158	01	2030	01	19460		
020005	02	0380	02	11260		
020006	02	0380	11260	11260		
030007	03	2620	39140	22380		
030012	03	6200	39140	38060		
030033	03	2620	03	22380		
040014	04	4400	04	30780		
040017	04	7920	04	44180		
040019	04	4920	04	32820		
040020	04	4920	27860	32820		
040026	04	4400	26300	30780		
040027	04	7920	04	44180		
040041	04	4400	04	30780		
040045	04	8600	04	46220		
040047	04	26	04	26		
040063	04	4400	04	30780		
040069	04	4920	04	32820		
040072	04	4400	04	30780		
040076	04	4400	04	30780		
040078	04	4400	26300	30780		
040080	04	3700	04	27860		
040088	04	7680	04	43340		Bossier
040091	04	8360	04	45500		
040119	04	4400	04	30780		
050014	05	6920	05	40900		
050042	05	6690	05	39820		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
050046	05	4480	37100	31084		
050071	05	5775	41940	36084		
050073	05	5775	46700	36084		
050076	05	5775	41884	36084		
050082	05	4480	37100	31084		
050150	05	6920	05	40900		
050159	05	4480	37100	31084		
050174	7500	8720	42220	34900		Napa
050177	05	4480	37100	31084		
050228	05	5775	41884	36084		
050236	05	4480	37100	31084		
050251	05	6720	05	39900		
050296	05	7400	41940	41940		
050325	05	5170	05	33700		
050394	05	4480	37100	31084		
050419	05	6690	05	39820		
050430	05	6720	05	39900		
050510	05	5775	41884	36084		
050541	05	5775	41884	36084		
050569	05	7500	05	42220		
050609	05	4480	42044	31084		
050616	05	4480	37100	31084		
050668	05	5775	41884	36084		
050686	05	5945	40140	42044		
050690	7500	8720	42220	34900		Napa
060001	06	2080	24540	19740		
060003	06	2080	14500	19740		
060023	06	6520	24300	39340		
060027	06	2080	14500	19740		
060044	06	2080	06	19740		
060049	06	2670	06	22660		
060096	06	2080	06	19740		
060103	06	2080	14500	19740		
070003	07		48740	25540	LUGAR	
070004	07		45860	25540	LUGAR	
070006	07	5600	14860	35644		
070011	07		45860	25540	LUGAR	
070015	07	5600	07	35644		
070018	07	5600	14860	35644		
070021	07		48740	25540	LUGAR	
070026	07		45860	25540	LUGAR	
080004	08	9160	20100	48864		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
080007	08	0560	08	36140		Cape May
100022	10	2680	33124	22744		
100023	10	5690	10	36100		
100024	10	5000	10	33124		
100045	10	5960	19660	36740		
100049	10	3980	10	29460		
100081	10		10	23020	LUGAR	
100103	10		10	23540	LUGAR	
100105	10	2710	46940	38940		
100109	10	5960	10	36740		
100118	10		37380	19660	LUGAR	
100139	10		10	23540	LUGAR	
100150	10	5000	10	33124		
100176	10	2710	48424	38940		
100217	10	2710	46940	38940		
100232	10	5790	10	36100		
100249	10	5790	10	36100		
110001	11	0520	19140	12060		
110002	11	0520	11	12060		
110003	11	3600	11	27260		
110009	11		22980	31420	LUGAR	
110016	11	1800	11	17980		
110023	11	0520	11	12060		
110025	11	3600	15260	27260		
110029	11	0520	23580	12060		
110038	11	10	11	10		
110040	11		11	12060	LUGAR	
110041	11	0500	11	12020		
110052	11		44900	16860	LUGAR	
110054	11	0520	40660	12060		
110074	11	0500	12020	12020		
110075	11	7520	11	42340		
110088	11		11	12060	LUGAR	
110117	11		16340	12060	LUGAR	
110120	11		16340	12060	LUGAR	
110122	11	10	46660	10		
110128	11	7520	11	42340		
110150	11	4680	11	31420		Jones
110168	11	0520	40660	12060		
110187	11	0520	11	12060		
110205	11	0520	11	12060		
120026	12	3320	26180	26180		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
130002	13	29	13	29		
130003	13	50	30300	50		
130018	13	6340	26820	38540		
130022	13		13940	26820	LUGAR	
130026	13	6340	13	38540		
130028	6340	7160	38540	36260		Weber
130049	13	7840	17660	44060		
140004	14		30660	44100	LUGAR	
140012	14	1600	14	16974		Dekalb
140015	14	7040	14	41180		
140027	14	1960	14	19340		
140032	14	7040	14	41180		
140034	14	7040	14	41180		
140038	14		40300	40420	LUGAR	
140040	14	1960	14	19340		
140043	14	6880	14	40420		Winnebago
140046	14	7040	14	41180		
140058	14	7880	14	44100		
140102	14		45380	44100	LUGAR	
140110	14	6120	14	37900		
140112	14		14	37900	LUGAR	
140137	14	7040	41180	41180		
140143	14	6120	14	37900		
140146	14		14	14060	LUGAR	
140160	14	6880	14	40420		Winnebago
140161	14	1600	14	16974		Grundy
140164	14	7040	14	41180		
140167	14		14	28100	LUGAR	
140189	14	1400	14	16580		
140234	14	6120	14	37900		
140236	14		14	28100	LUGAR	
140271	14		45380	44100	LUGAR	
150002	2960	1600	23844	16974		Cook
150004	2960	1600	23844	16974		Cook
150006	15	7800	33140	43780		
150008	2960	1600	23844	16974		Cook
150011	15	3480	15	11300		Madison
150012	18	4520	43780	31140		Oldham
150015	15	1600	33140	16974		
150027	15	15	26900	15		
150030	15		35220	26900	LUGAR	
150043	15		23140	29140	LUGAR	

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
150048	15	2000	15	19380		Montgomery
150051	15	1020	14020	14020		
150069	15	1640	15	17140		
150076	15	7800	15	43780		
150090	2960	1600	23844	16974		Cook
150102	15	7800	15	43780		
150103	15		15	29140	LUGAR	
150112	15	3480	18020	26900		Brown
150125	2960	1600	23844	16974		Cook
150126	2960	1600	23844	16974		Will
150132	2960	1600	23844	16974		Cook
150133	15	2330	15	21140		
150146	15	2330	15	21140		
150147	2960	1600	23844	16974		Cook
160001	16	2120	16	19780		
160016	16	2120	16	19780		
160026	16	2120	16	19780		
160030	16	2120	11180	19780		
160037	16	24	16	24		
160057	16	3500	16	26980		
160080	16	6880	16	40420		Winnebago
160086	16		16	47940	LUGAR	
160089	16	2120	16	19780		
160147	16	2120	16	19780		
170006	17	3710	17	27900		
170010	17	8560	17	46140		
170012	17	9040	17	48620		
170013	17	9040	17	48620		
170014	17	3760	28140	28140		
170020	17	9040	17	48620		
170023	17	9040	17	48620		
170033	17	9040	17	48620		
170045	17	8440	17	45820		
170058	17	3710	17	27900		
170060	17	28	17	28		
170094	17	8440	17	45820		
170120	17	3710	17	27900		
170145	17	8560	17	46140		
170175	17	9040	17	48620		
180005	18	3400	18	26580		Wayne
180011	18	4280	18	30460		Clark
180013	18	5360	14540	34980		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
180016	18	4520	31140	31140		Jefferson
180018	18	4280	18	30460		Bourbon
180027	18	1660	18	17300		
180028	18	3400	18	26580		Wayne
180029	18	3660	18	28700		Scott
180044	18	3400	18	26580		Wayne
180066	18	5360	18	34980		
180069	18	3400	18	26580		Wayne
180075	18		18	14540	LUGAR	
180078	18	3400	18	26580		Wayne
180080	18	4280	18	30460		Clark
180093	18	2440	18	21780		
180102	18	1660	18	17300		
180104	18	1660	18	17300		
180116	18	1660	18	17300		
180127	18	4520	18	31140		Jefferson
180132	18	4280	18	30460		Jessamine
180139	18	4280	18	30460		Clark
190001	19	5560	19	35380		St Tammany
190003	19	3880	19	29180		St. Martin
190015	19	5560	19	35380		St John the Baptist
190029	19		5560	12940	LUGAR	
190054	19	3880	19	29180		St. Martin
190086	19	7680	19	43340		Bossier
190099	19	3880	19	29180		St. Landry
190106	19	3880	19	29180		Acadia
190131	19	5560	12940	35380		St John the Baptist
190155	19		38200	12940	LUGAR	
190164	19	0220	19	10780		
190223	19		5560	12940	LUGAR	
200002	20	6403	20	38860		
200020	6403	1123	38860	40484		Strafford
200024	20	6403	30340	38860		
200034	20	6403	30340	38860		
200039	20	6403	20	38860		
200040	20	6403	38860	38860		
200050	20	0733	20	12620		
200063	20	6403	20	38860		
220060	22	0743	14484	12700		
220077	8003	3283	44140	25540		Hartford
230030	23	6960	23	40980		Saginaw

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
230035	23		23	24340	LUGAR	
230037	23	0440	23	11460		Washtenaw
230042	23		10880	26100	LUGAR	
230054	23	3080	23	24580		
230080	23	6960	23	40980		Saginaw
230093	23	3000	23	24340		
230096	23	3720	23	28020		Kalamazoo
230105	23	6960	23	13020		Bay
230121	23		37020	29620	LUGAR	
230134	23		10880	26100	LUGAR	
230155	23		23	24340	LUGAR	
230171	23		23	34740	LUGAR	
230178	23		23	24340	LUGAR	
230188	23		23	40980	LUGAR	
230208	23		23	24340	LUGAR	
230235	23		23	40980	LUGAR	
230253	23	2160	23	47644		Lapeer
240011	24	5120	24	33460		
240013	24	5120	24	33460		
240016	24	2520	24	22020		
240018	24	5120	24	33460		
240030	24	6980	24	41060		
240045	24	2240	20260	20260		
240052	24	2520	24	22020		
240064	24	2240	24	20260		
240069	24	6820	24	40340		
240071	24	5120	24	33460		
240075	24	6980	24	41060		
240088	24	6980	24	41060		
240093	24	5120	24	33460		
240105	24		24	40340	LUGAR	
240121	24	2240	20260	20260		
240150	24		24	40340	LUGAR	
240152	24	5120	24	33460		
240187	24	5120	24	33460		
240211	24	5120	24	33460		
250004	25	4920	25	32820		
250009	25	3580	25	27180		
250023	25		38100	25060	LUGAR	
250030	25	3560	25	27140		
250031	25	3560	25	27140		
250034	25	4920	25	32820		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
250042	25	4920	25	32820		
250069	25	3560	25	27140		
250081	25	3560	25	27140		
250082	25	6240	25	38220		
250094	3285	0920	25620	25060		Hancock
250097	25	0760	25	12940		
250099	25	3560	25	27140		
250100	25	8600	25	46220		
250104	25	3560	25	27140		
250117	25		38100	25060	LUGAR	
250126	25	4920	32820	32820		
260009	26	3760	26	28140		
260011	26	1740	27620	17860		
260015	26	3700	26	27860		
260017	26	7040	26	41180		
260022	26	1740	26	17860		
260025	26	7040	26	41180		
260034	26	3760	28140	28140		
260047	26	1740	27620	17860		
260049	26		26	44180	LUGAR	
260064	26	1740	26	17860		
260078	26	7920	26	44180		
260094	26	7920	26	44180		
260110	26	7040	26	41180		
260113	26	14	26	14		
260116	26	14	26	14		
260183	26	7040	26	41180		
260186	26	1740	26	17860		
260195	26	7920	44180	44180		
270003	27	3040	27	24500		
270011	27	3040	27	24500		
270017	27	5140	27	33540		
270051	27	5140	27	33540		
270082	27	3040	27	24500		
280009	28	4360	28	30700		
280023	28	4360	28	30700		
280032	28	4360	28	30700		
280054	28	4360	28	30700		
280057	28	4360	28	30700		
280061	28	53	28	53		
280065	28	3060	28	24540		
280077	28	5920	28	36540		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
280125	28	7720	28	43580		
290002	29		29	16180	LUGAR	
290008	29	4120	29	29820		Nye
290019	29	6720	16180	39900		
300003	30	1123	30	31700		Hillsborough
300005	30	1123	30	40484		
300019	30	22	30	22		
310002	31	5600	35084	35644		
310003	31	5600	35644	35644		
310005	5015	5640	35084	35084		Hunterdon
310015	31	0875	35084	35644		
310032	8760	6160	47220	48864		Salem, NJ
310034	5190	5015	20764	20764		Middlesex
310038	31	5600	20764	35644		
310045	31	5600	35644	35644		
310048	5015	5640	20764	35084		Hunterdon
310070	31	5600	20764	35644		
310073	5190	5015	20764	20764		Middlesex
310075	5190	5015	20764	20764		Middlesex
310076	31	5600	35084	35644		
310111	5190	5015	20764	20764		Middlesex
310112	5190	5015	20764	20764		Middlesex
310119	31	5600	35084	35644		
320005	32	0200	22140	10740		
320006	32	7490	32	42140		Santa Fe
320013	32	7490	32	42140		Santa Fe
320033	32		31060	42140	LUGAR	
320063	32	5800	32	36220		Ector
320065	32	5800	32	36220		Ector
330001	33	0875	39100	35644		
330004	33	5660	28740	39100		Orange
330008	33		33	15380	LUGAR	
330023	2281	5660	39100	39100		Dutchess
330038	33		12860	40380	LUGAR	
330062	33		33	27060	LUGAR	
330073	33		12860	40380	LUGAR	
330084	33	1303	33	15540		
330085	33	8160	33	45060		Madison
330094	33		26460	10580	LUGAR	
330136	33	8160	33	45060		Madison
330157	33	8160	33	45060		Oswego
330181	33	5600	44844	35644		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
330182	33	5600	44844	35644		
330209	33	0875	39100	35644		
330224	33	3283	28740	25540		Hartford
330235	33	8160	33	45060		
330239	33	2360	33	21500		
330250	33	1303	33	15540		
330307	33	8160	27060	45060		Onondaga
330359	33		33	39100	LUGAR	
330386	33	5660	33	39100		Orange
340008	34	2560	34	22180		
340010	2980	6640	24140	39580		Johnston
340013	34	1520	34	16740		
340018	34		34	43900	LUGAR	
340021	34	1520	34	16740		
340023	34	0480	11700	11700		
340027	34	3150	34	24780		
340039	34	1520	34	16740		
340050	34	2560	34	22180		
340051	34	3290	34	25860		
340068	34	9200	34	48900		
340071	34		20380	39580	LUGAR	
340088	34	0480	34	11700		
340109	34	5720	34	47260		
340115	34	6640	34	20500		Chatham
340124	34		20380	39580	LUGAR	
340127	34	6640	34	20500		Person
340129	34	1520	34	16740		
340131	34	3150	34	24780		
340136	34		34	20500	LUGAR	
340144	34	1520	34	16740		
340145	34		30740	16740	LUGAR	
340147	6895	6640	40580	39580		Franklin
350009	35	2520	35	22020		
360008	36	3400	36	26580		Greenup
360010	36	0080	36	10420		
360011	36	1840	36	18140		
360014	36	1840	36	18140		
360025	36	1680	41780	17460		
360036	36	1680	36	17460		
360039	36	1840	36	18140		
360042	36		11780	17460	LUGAR	
360046	36	1640	17140	17140		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
360054	36	1480	36	16620		
360065	36	1680	36	17460		
360076	36	1640	17140	17140		
360078	36	1680	10420	17460		
360081	36	8400	45780	45780		
360088	36		46500	44220	LUGAR	
360090	36	8400	45780	45780		
360095	36	4320	36	30620		Allen
360096	36		20620	49660	LUGAR	
360107	36	8400	36	45780		
360112	8400	0440	45780	11460		Washtenaw
360121	36	0440	36	11460		Washtenaw
360125	36		11780	17460	LUGAR	
360127	36		11780	17460	LUGAR	
360132	36	1640	17140	17140		
360159	36	1840	36	18140		
360175	36	1840	36	18140		
360185	36		20620	49660	LUGAR	
360197	36	1840	36	18140		
360211	36	8080	48260	48260		
360238	36		20620	49660	LUGAR	
360245	36		11780	17460	LUGAR	
370004	37	3710	37	27900		
370014	37	7640	37	43300		
370015	37	8560	37	46140		
370018	37	8560	37	46140		
370025	37	8560	37	46140		
370034	37	2720	37	22900		
370043	37	7640	37	43300		
370047	37	7640	37	43300		
370049	37	5880	37	36420		Lincoln
370054	37	5880	36420	36420		Grady
370060	37	8560	46140	46140		
370099	37	8560	37	46140		
370103	37	45	37	45		
370113	37	2580	37	22220		
370200	37	5880	37	36420		Lincoln
380001	38	6440	38	38900		
380008	38		10540	18700	LUGAR	
380022	38	1890	38	18700		
380027	38	2400	38	21660		
380035	38	6740	38	28420		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
380040	38	2400	13460	21660		
380047	38	2400	13460	21660		
380050	38	4890	38	32780		
380051	38	7080	41420	41420		
380070	38	6440	38	38900		
390006	39	3240	39	25420		Dauphin
390013	39	3240	39	25420		Dauphin
390030	39	0240	39	10900		
390031	39		39060	39740	LUGAR	
390048	39	3240	39	25420		Perry
390052	39	0280	39	11020		
390065	39	8840	39	13644	LUGAR	Frederick
390071	39		30820	48700	LUGAR	
390086	39	8050	39	44300		
390091	39	6280	39	38300		
390093	39	6280	39	38300		
390110	39	6280	27780	38300		
390113	39	9320	39	49660		Mercer
390138	39	8840	39	13644		Frederick
390150	39		39	38300	LUGAR	
390151	39	8840	39	13644		Frederick
390163	39	6280	38300	38300		
390181	39		39060	39740	LUGAR	
390183	39		39060	39740	LUGAR	
390201	39		20700	10900	LUGAR	Warren
390224	39		39	13780	LUGAR	
390244	39		30820	48700	LUGAR	
390246	39	33	39	33		
390249	39		39	13780	LUGAR	
400120	1310	7440	41980	41980		Caguas
410001	6483	1123	39300	39300		Bristol, MA
410004	6483	1123	39300	39300		Bristol, MA
410005	6483	1123	39300	39300		Bristol, MA
410006	6483	1123	39300	39300		Bristol, MA
410007	6483	1123	39300	39300		Bristol, MA
410008	6483	1123	39300	39300		Bristol, MA
410009	6483	1123	39300	39300		Bristol, MA
410011	6483	1123	39300	25027		Worcester
410012	6483	1123	39300	39300		Bristol, MA
410013	6483	1123	39300	39300		Bristol, MA
420009	42		42860	24860	LUGAR	
420020	42	1440	42	16700		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
420028	42		42	44940	LUGAR	
420030	42	1440	42	16700		
420036	42	1520	42	16740		
420039	42		46420	43900	LUGAR	
420068	42	0600	42	12260		
420069	42		42	44940	LUGAR	
420070	42	1760	44940	17900		
420071	42	0600	42	12260		
420080	42	7520	42	42340		
420085	42	9200	34820	48900		
430012	43	7760	43	43620		
430014	43	2520	43	22020		
430094	43	53	43	53		
440008	44	3580	44	27180		
440020	44	3440	44	26620		
440050	44	0480	44	11700		
440058	44	1560	44	16860		
440059	44	5360	44	34980		
440060	44	3580	44	27180		
440067	44	3840	34100	28940		Knox
440068	44	1560	44	16860		
440072	44	4920	44	32820		
440073	44	5360	44	34980		
440148	44	5360	44	34980		
440151	44	5360	44	34980		
440175	44	3440	44	26620		
440180	44	3840	44	28940		Union
440185	44	1560	17420	16860		
440186	44	5360	34980	34980		
440192	44	5360	44	34980		
440200	44	5360	34980	34980		
450007	45	7240	45	41700		
450014	45	8750	47020	47020		
450032	45		32220	30980	LUGAR	
450052	45		45	47380	LUGAR	
450073	45	0040	45	10180		
450080	45	4420	45	30980		Usphur
450098	45	4420	45	30980		Usphur
450099	45	0320	45	11100		
450144	45	5800	45	36220		Ector
450187	45	3360	45	26420		
450192	45	1920	45	19124		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
450194	45	1920	45	19124		
450196	45	1920	45	19124		
450211	45	3360	45	26420		
450214	45	3360	45	26420		
450224	45	8640	45	46340		
450286	45		45	17780	LUGAR	
450347	45	3360	45	26420		
450348	45		45	47380	LUGAR	
450351	45	2800	45	23104		
450400	45	8800	45	47380		
450447	45	1920	45	19124		
450451	45	2800	45	23104		
450484	45	3360	45	26420		
450508	45	8640	45	46340		
450534	45	0320	45	11100		
450547	45	1920	45	19124		
450563	45	1920	23104	19124		
450623	45	1920	45	19124		
450648	45		45	12420	LUGAR	
450653	45	5800	45	33260		Midland
450656	45	8640	45	46340		
450694	45	3360	45	26420		
450747	45	1920	45	19124		
450755	45	4600	45	31180		
450770	45	0640	45	12420		
450830	45	5800	45	36220		Ector
460021	46	4120	41100	29820		Mohave
460029	46	6520	46	39340		
460036	46	6520	46	39340		
460039	46	7160	46	36260		Weber
470001	47	30	47	30		
470011	47	1123	47	15764		
470012	47	6323	47	38340		
470018	47	1123	47	31700		Hillsborough
490004	49	1540	25500	16820		
490005	49	8840	49020	47894		Clarke
490006	49		49	49020	LUGAR	
490013	49	4640	49	31340		
490018	49	1540	49	16820		
490047	49	8840	49	47894		Warren
490079	49	3120	49	49180		Stokes
490092	49	5720	49	47260		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
490126	49	6800	49	40220		
500002	50	6740	50	28420		
500003	50	7600	34580	42644		Snohomish
500016	50	7600	48300	42644		King
500031	50	5910	50	36500		
500039	1150	7600	14740	42644		King
500041	50	6440	31020	38900		
500059	50	7600	50	42644		King
500072	50	7600	50	42644		Snohomish
500079	50	8200	45104	45104		
500118	50		43220	36500	LUGAR	
510001	51	6280	34060	38300		
510002	51	6800	51	40220		
510006	51	6280	51	38300		
510018	51		51	16620	LUGAR	
510024	51	6280	34060	38300		
510028	51	1480	51	16620		
510046	51	1480	51	16620		
510047	51	6280	51	38300		
510048	51	3400	51	26580		Wayne
510070	51	1480	51	16620		
510071	51	1480	51	16620		
510081	51		51	16620	LUGAR	
520002	52	8940	52	48140		
520021	3800	1600	29404	29404		Lake
520028	52	4720	52	31540		
520032	52	4720	31540	31540		
520037	52	8940	52	48140		
520059	52	5080	39540	33340		
520060	52		52	22540	LUGAR	
520066	52	4720	27500	31540		
520071	52		48020	33340	LUGAR	
520076	52	4720	52	31540		
520084	52	4720	31540	31540		
520088	52	5080	22540	33340		
520094	52	5080	39540	33340		
520096	52	5080	39540	33340		
520102	52		48580	33340	LUGAR	
520107	52	3080	52	24580		
520113	52	3080	52	24580		
520116	52		48020	33340	LUGAR	
520152	52	3080	52	24580		

Provider No.	Actual MSA or rural area	Wage index MSA Reclassification	Actual CBSA or rural area	Wage index CBSA Reclassification	Lugar	Nearest County
520173	52	2240	52	20260		
520189	3800	1600	29404	29404		Lake
530002	53	1350	53	16220		
530009	53	1350	53	16220		
530016	53	6340	53	38540		
530025	53	2670	53	22660		

TABLE 9B.--HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUB. L. 108-173--FY 2004

Provider No.	Actual MSA or rural area	Wage index MSA 508 Reclassification	Actual CBSA or rural area	Wage index CBSA 508 Reclassification	Nearest County	Own Wage Index
020008			02			1.3157
060075			06			1.1681
070036			25540			1.2954
160064			16			1.0504
330106			44844			1.5152
380090			38			1.2808
410010			39300			1.1702
530015			53			1.0064
390001	7560	0240	42540	10900		
390003	7560	0240	39	10900		
390072	7560	0240	39	10900		
390095	7560	0240	42540	10900		
390109	7560	0240	42540	10900		
390119	7560	0240	42540	10900		
390137	7560	0240	42540	10900		
390169	7560	0240	42540	10900		
390185	7560	0240	42540	10900		
390192	7560	0240	42540	10900		
390237	7560	0240	42540	10900		
230053	2160	0440	19804	11460		
230089	2160	0440	19804	11460		
230104	2160	0440	19804	11460		
230119	2160	0440	19804	11460		
230135	2160	0440	19804	11460		
230146	2160	0440	19804	11460		
230165	2160	0440	19804	11460		
230176	2160	0440	19804	11460		
230270	2160	0440	19804	11460		
230273	2160	0440	19804	11460		
230097	23	3720	23	12980		
270014	27	0880	33540	13740		
270021	27	0880	27	13740		
270023	5140	0880	33540	13740		
270032	27	0880	27	13740		
270050	27	0880	27	13740		
270057	27	0880	27	13740		
160040	8920	1360	47940	16300		
160067	8920	1360	47940	16300		

Provider No.	Actual MSA or rural area	Wage index MSA 508 Reclassification	Actual CBSA or rural area	Wage index CBSA 508 Reclassification	Nearest County	Own Wage Index
160110	8920	1360	47940	16300		
340002	0480	1520	11700	16740		
150034	2960	1600	23844	16974	Cook	
010150	01	1800	01	17980		
490024	6800	1950	40220	19260		
060057	06	2080	06	19740		
350002	1010	2520	13900	22020		
350003	1010	2520	35	22020		
350006	1010	2520	35	22020		
350010	1010	2520	35	22020		
350014	1010	2520	35	22020		
350015	1010	2520	13900	22020		
350017	1010	2520	35	22020		
350030	1010	2520	35	22020		
350061	1010	2520	35	22020		
230013	2160	2640	47644	22420		
230019	2160	2640	47644	22420		
230029	2160	2640	47644	22420		
230036	23	2640	23	22420		
230071	2160	2640	47644	22420		
230130	2160	2640	47644	22420		
230151	2160	2640	47644	22420		
230207	2160	2640	47644	22420		
230223	2160	2640	47644	22420		
230254	2160	2640	47644	22420		
230269	2160	2640	47644	22420		
230277	2160	2640	47644	22420		
230020	2160	0440	19804	23		
230092	3520	3000	27100	24340	Kent	
250122	25	0920	25	25060		
250002	25	0920	25	25060	Stone	
120025	12	3320	12	26180		
450072	1145	3360	26420	26420		
450591	1145	3360	26420	26420		
230003	3000	3720	26100	28020		
230004	3000	3720	34740	28020		
230038	3000	3720	24340	28020		
230059	3000	3720	24340	28020		
230066	3000	3720	34740	28020		
230072	3000	3720	26100	28020		
230106	23	3720	24340	28020		
230174	3000	3720	26100	28020		

Provider No.	Actual MSA or rural area	Wage index MSA 508 Reclassification	Actual CBSA or rural area	Wage index CBSA 508 Reclassification	Nearest County	Own Wage Index
230236	3000	3720	24340	28020		
390054	7560	4000	42540	29540		
390270	7560	4000	42540	29540		
490001	49	4640	49	31340		
450010	9080	4880	48660	32580		
070010	5483	5600	14860	35644		
070028	5483	5600	14860	35644		
310021	8480	0875	45940	35644		
310028	5640	5600	35084	35644		
310050	5640	5600	35084	35644		
310051	5640	5600	35084	35644		
310060	5640	5600	10900	35644		
310115	5640	5600	10900	35644		
310120	5640	5600	35084	35644		
330049	2281	5600	39100	35644		
330067	2281	5600	39100	35644		
330126	5660	5600	39100	35644		
330135	5660	5600	39100	35644		
330205	5660	5600	39100	35644		
220046	6323	1123	38340	39300		
430003	43	6660	43	39660		
470003	1303	1123	15540	40484	Strafford	
050494	05	7500	05	42220		
050549	8735	7500	37100	42220		
190218	19	7680	19	43340		
430015	43	7760	43	43620		
430048	43	7760	43	43620		
430060	43	7760	43	43620		
430064	43	7760	43	43620		
430077	6660	7760	39660	43620		
430091	6660	7760	39660	43620		
070001	5483	5380	35300	44844		
070005	5483	5380	35300	44844		
070016	5483	5380	35300	44844		
070017	5483	5380	35300	44844		
070019	5483	5380	35300	44844		
070022	5483	5380	35300	44844		
070031	5483	5380	35300	44844		
070039	5483	5380	35300	44844		
330264	5660	5380	39100	44844		
230024	2160	0440	19804	47644		

TABLE 10.--GEOMETRIC MEAN PLUS THE LESSER OF .75 OF THE NATIONAL ADJUSTED OPERATING STANDARDIZED PAYMENT AMOUNT (INCREASED TO REFLECT THE DIFFERENCE BETWEEN COSTS AND CHARGES) OR .75 OF ONE STANDARD DEVIATION OF MEAN CHARGES BY DIAGNOSIS-RELATED GROUP (DRG)-- MARCH 2004[1]

DRG	Cases	Threshold
1	27,031	$47,002.39
2	10,732	$31,748.57
3	2	$19,676.36
6	365	$14,216.11
7	15,230	$35,032.97
8	3,903	$25,342.93
9	1,781	$20,676.56
10	18,839	$21,127.62
11	3,363	$16,545.74
12	53,119	$16,149.67
13	7,034	$15,112.29
14	240,596	$21,843.58
15	81,926	$17,439.59
16	10,689	$21,398.25
17	2,792	$13,087.07
18	30,720	$18,183.79
19	8,687	$13,191.63
20	6,517	$35,168.52
21	2,167	$23,496.76
22	3,159	$19,811.32
23	11,729	$15,291.01
24	60,606	$18,209.19
25	28,207	$11,476.16
26	32	$10,545.98
27	4,954	$20,791.90
28	15,806	$21,493.63
29	5,770	$13,143.20
31	4,575	$17,139.90
32	1,913	$11,205.82
34	25,154	$17,698.06
35	7,835	$12,075.68
36	1,612	$12,459.21
37	1,371	$20,781.81
38	77	$9,593.25
39	541	$11,755.20
40	1,507	$18,078.12

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
42	1,249	$13,813.36
43	124	$12,443.22
44	1,229	$11,918.47
45	2,825	$13,674.93
46	3,537	$14,378.35
47	1,367	$10,363.16
49	2,326	$27,283.68
50	2,241	$16,015.46
51	233	$14,624.53
52	174	$14,473.99
53	2,234	$21,124.20
55	1,452	$16,281.07
56	464	$16,655.86
57	721	$18,825.34
59	118	$11,884.64
60	5	$5,786.80
61	259	$22,669.12
62	2	$8,491.37
63	2,752	$22,186.10
64	3,201	$20,017.01
65	40,661	$11,144.79
66	7,854	$10,622.12
67	402	$15,110.54
68	8,724	$12,283.42
69	2,946	$9,247.28
70	26	$9,049.66
71	65	$9,640.64
72	1,209	$13,587.86
73	7,896	$15,166.28
75	43,424	$41,163.58
76	46,113	$36,811.23
77	2,323	$22,216.62
78	42,684	$22,814.85
79	171,939	$24,702.33
80	7,813	$15,834.71
81	2	$54,685.58
82	65,114	$22,257.80
83	6,834	$18,156.12
84	1,467	$10,279.57
85	22,304	$21,149.82
86	2,046	$13,052.05
87	66,500	$22,338.54
88	393,514	$16,620.74
89	514,251	$19,133.24

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
90	43,239	$11,379.69
91	45	$11,624.14
92	16,504	$21,182.00
93	1,649	$13,385.99
94	13,031	$20,213.17
95	1,578	$11,282.92
96	50,507	$13,779.32
97	25,905	$10,092.48
98	15	$10,799.59
99	21,593	$13,290.51
100	7,491	$10,230.15
101	22,842	$15,981.17
102	5,443	$10,224.62
103	553	$189,772.22
104	20,843	$104,458.91
105	30,394	$78,675.65
106	3,467	$98,542.18
107	77,946	$75,223.03
108	6,932	$66,115.26
109	53,663	$57,201.65
110	55,231	$51,781.18
111	9,346	$37,634.69
113	38,458	$37,360.01
114	8,334	$25,185.45
115	21,728	$51,055.67
116	116,937	$37,562.07
117	4,853	$21,562.25
118	8,318	$28,595.12
119	1,099	$22,312.22
120	36,767	$30,317.70
121	163,217	$25,452.34
122	70,183	$18,391.79
123	36,041	$22,203.56
124	133,834	$25,310.50
125	92,607	$20,563.74
126	5,578	$34,579.82
127	688,254	$18,767.22
128	6,048	$13,709.83
129	3,945	$18,358.95
130	89,614	$17,242.04
131	25,476	$10,399.71
132	127,723	$11,755.33
133	7,450	$10,110.86
134	42,191	$11,330.68

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
135	7,450	$16,684.99
136	1,087	$11,129.78
138	203,383	$15,387.73
139	81,394	$9,766.36
140	45,268	$9,751.21
141	114,091	$14,147.95
142	52,298	$11,078.77
143	244,158	$10,527.19
144	96,381	$20,213.64
145	6,642	$10,916.56
146	10,860	$38,450.11
147	2,695	$27,177.69
148	135,660	$44,046.76
149	19,836	$26,192.87
150	22,019	$38,184.38
151	5,257	$24,163.73
152	4,788	$28,703.59
153	2,115	$20,415.43
154	28,467	$48,307.36
155	6,442	$23,488.27
156	8	$32,766.38
157	8,277	$21,514.75
158	4,096	$12,163.36
159	18,692	$23,589.13
160	11,972	$15,324.36
161	10,666	$21,177.95
162	5,903	$12,395.96
163	9	$18,720.43
164	5,785	$34,027.40
165	2,448	$21,754.82
166	4,467	$25,429.28
167	4,328	$16,567.05
168	1,535	$21,028.28
169	834	$14,029.00
170	16,985	$36,624.14
171	1,448	$22,119.85
172	31,819	$22,160.02
173	2,535	$14,010.09
174	257,892	$18,593.66
175	33,622	$10,574.15
176	12,966	$20,349.86
177	8,710	$17,368.96
178	3,197	$12,742.36
179	14,005	$19,746.18

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
180	92,184	$17,710.39
181	26,288	$10,337.66
182	289,801	$15,126.47
183	90,068	$10,985.43
184	59	$9,160.48
185	5,677	$16,314.88
186	5	$16,873.70
187	740	$14,702.24
188	88,106	$19,443.67
189	13,004	$11,125.54
190	71	$10,301.87
191	9,919	$47,572.13
192	1,345	$26,911.62
193	4,408	$44,465.67
194	531	$26,940.41
195	3,735	$41,071.33
196	812	$27,990.64
197	17,975	$35,447.24
198	4,880	$22,267.62
199	1,543	$32,025.81
200	954	$34,258.27
201	2,608	$44,334.23
202	25,857	$21,306.01
203	31,007	$22,209.42
204	69,666	$19,787.03
205	30,919	$19,844.21
206	2,029	$13,607.73
207	34,527	$20,795.67
208	9,964	$13,037.50
209	425,259	$34,127.94
210	125,963	$30,514.92
211	28,402	$22,540.97
212	2	$7,355.68
213	10,211	$27,163.94
216	12,739	$30,372.38
217	17,820	$35,501.93
218	26,845	$26,652.32
219	21,291	$18,810.17
223	13,655	$19,875.52
224	11,536	$14.778.06
225	6,339	$21,693.69
226	6,507	$24,280.94
227	5,108	$15,428.75
228	2,664	$21,222.14

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
229	1,154	$13,819.07
230	2,374	$22,392.39
232	759	$18,057.24
233	10,121	$29,290.06
234	4,878	$22,029.70
235	5,040	$13,329.56
236	41,647	$13,170.57
237	1,874	$11,228.94
238	9,487	$21,967.28
239	44,475	$19,224.03
240	12,429	$20,574.30
241	2,958	$12,285.38
242	2,720	$19,546.78
243	99,609	$14,231.73
244	15,557	$13,197.00
245	5,830	$8,939.17
246	1,392	$11,170.70
247	21,341	$10,808.37
248	14,413	$15,478.46
249	13,478	$12,574.01
250	3,896	$12,748.37
251	2,307	$8,976.97
253	23,152	$13,847.26
254	10,589	$8,397.67
256	6,933	$14,946.82
257	14,266	$16,559.89
258	13,040	$13,107.81
259	3,178	$17,757.99
260	3,611	$12,872.76
261	1,623	$17,861.85
262	632	$18,015.69
263	25,548	$27,612.63
264	3,959	$19,571.13
265	4,036	$23,933.29
266	2,482	$16,017.53
267	237	$16,324.12
268	913	$21,175.50
269	10,224	$25,713.15
270	2,810	$15,072.68
271	20,028	$18,468.64
272	5,793	$18,208.92
273	1,338	$11,075.51
274	2,267	$19,271.15
275	176	$11,393.03

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
276	1,363	$13,211.04
277	108,396	$16,002.90
278	32,917	$10,158.40
279	7	$22,806.38
280	18,381	$13,279.57
281	7,203	$9,159.98
283	6,085	$13,626.51
284	1,847	$7,930.23
285	7,103	$29,265.27
286	2,617	$30,127.88
287	6,388	$25,800.77
288	8,409	$32,539.03
289	6,748	$17,169.70
290	10,239	$16,348.17
291	70	$12,899.83
292	6,921	$34,879.20
293	341	$23,427.99
294	98,525	$13,992.93
295	3,712	$13,696.73
296	258,871	$15,146.57
297	47,144	$9,203.21
298	107	$10,109.54
299	1,403	$16,424.37
300	19,544	$19,634.78
301	3,822	$12,094.21
302	8,975	$45,005.94
303	22,962	$33,813.19
304	13,234	$32,022.59
305	3,065	$21,940.67
306	7,024	$21,550.41
307	1,898	$11,199.49
308	7,423	$24,440.37
309	3,832	$16,895.99
310	25,531	$21,027.50
311	6,892	$11,653.46
312	1,527	$19,680.21
313	543	$12,303.00
315	35,826	$29,162.47
316	149,953	$20,893.69
317	2,476	$14,474.57
318	5,837	$19,894.30
319	394	$11,791.98
320	209,533	$15,804.98
321	30,937	$10,465.82

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
322	59	$9,524.25
323	20,476	$15,513.89
324	6,150	$9,278.69
325	9,540	$12,134.95
326	2,739	$8,138.23
327	2	$8,447.36
328	677	$12,839.19
329	64	$8,638.22
331	53,339	$18,819.19
332	4,649	$11,308.47
333	246	$16,947.79
334	10,242	$25,613.56
335	12,368	$19,768.65
336	33,267	$15,411.08
337	26,288	$10,593.53
338	712	$21,009.04
339	1,436	$20,358.75
341	3,600	$22,459.66
342	623	$14,302.37
344	3,129	$23,468.31
345	1,347	$19,813.56
346	4,494	$19,198.11
347	277	$10,231.81
348	3,342	$13,561.37
349	537	$8,354.79
350	6,976	$13,696.92
352	1,076	$14,032.50
353	2,641	$26,992.52
354	7,420	$25,471.56
355	5,235	$16,214.46
356	25,159	$13,588.35
357	5,581	$32,195.38
358	21,024	$21,104.25
359	29,642	$14,662.21
360	15,423	$15,733.75
361	295	$20,316.37
363	2,428	$17,959.37
364	1,454	$17,846.39
365	1,662	$27,368.43
366	4,670	$20,542.99
367	454	$10,294.82
368	3,872	$20,189.73
369	3,529	$11,584.10
370	1,601	$15,956.72

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
371	1,957	$11,240.71
372	1,059	$9,648.69
373	4,436	$6,542.14
374	120	$12,070.47
375	4	$21,387.53
376	308	$9,449.90
377	57	$19,575.54
378	185	$14,463.79
379	426	$6,888.28
380	90	$6,622.99
381	202	$11,561.98
382	30	$4,628.53
383	2,295	$9,153.45
384	136	$5,497.24
390	3	$4,742.50
392	2,128	$40,317.17
394	2,617	$25,745.93
395	110,334	$15,171.69
396	10	$23,522.47
397	19,186	$19,140.99
398	17,730	$20,886.30
399	1,634	$12,537.31
401	5,892	$36,723.72
402	1,444	$21,449.62
403	31,701	$25,072.16
404	4,032	$16,919.41
406	2,378	$35,405.65
407	573	$22,348.47
408	2,126	$28,195.75
409	2,038	$20,956.09
410	28,217	$20,187.74
411	7	$9,450.53
412	14	$12,399.99
413	5,517	$22,073.56
414	570	$12,354.88
415	46,295	$41,324.13
416	209,607	$23,731.70
417	26	$19,476.46
418	27,283	$18,827.06
419	16,685	$16,194.08
420	2,883	$11,247.80
421	10,530	$14,449.59
422	68	$10,520.24
423	8,259	$23,511.55

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
424	1,234	$31,774.00
425	15,393	$12,505.87
426	4,139	$8,905.56
427	1,419	$9,653.86
428	776	$13,956.81
429	27,266	$14,686.89
430	68,690	$12,244.61
431	259	$9,078.72
432	391	$11,939.08
433	5,503	$5,189.45
439	1,669	$24,681.73
440	5,865	$24,660.92
441	707	$16,041.06
442	17,359	$31,204.37
443	3,652	$18,898.91
444	5,957	$14,056.84
445	2,359	$9,534.38
447	6,368	$9,484.48
449	35,333	$15,103.83
450	7,504	$7,975.20
451	4	$9,065.77
452	27,134	$18,327.65
453	5,517	$9,748.26
454	4,271	$15,174.33
455	958	$8,817.44
461	5,008	$20,801.47
462	8,298	$16,692.51
463	28,808	$12,925.78
464	7,467	$9,493.03
465	204	$11,033.67
466	1,767	$11,383.22
467	1,171	$9,667.23
468	48,780	$47,697.03
470	103	$91,840.13
471	14,292	$47,665.58
473	8,547	$33,295.66
475	110,694	$43,696.83
476	3,225	$31,764.02
477	30,086	$28,309.01
478	109,888	$33,959.22
479	23,657	$25,851.04
480	710	$106,291.19
481	858	$78,625.60
482	5,121	$41,198.92

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
484	407	$64,297.49
485	3,303	$41,564.30
486	2,260	$58,108.75
487	4,198	$26,874.92
488	795	$53,106.00
489	13,707	$23,948.06
490	5,193	$18,332.24
491	17,179	$30,209.74
492	3,336	$38,463.77
493	60,972	$29,240.46
494	27,013	$18,965.29
495	245	$102,454.71
496	2,740	$80,122.92
497	25,887	$50,109.13
498	17,577	$40,873.71
499	37,340	$24,783.78
500	50,555	$17,315.20
501	2,798	$35,284.32
502	703	$25,794.66
503	5,918	$22,488.22
504	174	$138,645.34
505	191	$23,723.13
506	940	$44,335.78
507	317	$27,338.37
508	625	$19,960.30
509	162	$12,757.05
510	1,742	$18,224.19
511	618	$12,020.90
512	529	$75,535.80
513	173	$90,032.33
515	13,087	$75,948.65
516	79,502	$40,813.46
517	180,301	$34,347.81
518	48,469	$28,659.81
519	10,097	$36,201.05
520	13,883	$28,903.52
521	31,960	$12,650.51
522	5,922	$9,014.09
523	15,485	$7,135.31
524	122,956	$13,734.97
525	349	$124,086.74
526	11,090	$45,187.80
527	48,097	$37,682.36
528	1,759	$88,921.60

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

DRG	Cases	Threshold
529	3,900	$31,367.19
530	2,368	$21,987.80
531	4,006	$38,694.03
532	3,088	$24,563.32
533	43,215	$26,418.52
534	50,588	$19,294.43
535	9,757	$104,895.67
536	25,303	$87,258.63
537	7,555	$27,282.28
538	6,315	$18,500.43
539	4,508	$39,649.40
540	1,899	$22,907.08
541	21,234	$219,932.31
542	23,921	$142,121.46

[1]Cases are taken from the FY 2003 MedPAR file; DRGs are from GROUPER Version 22.0.

TABLE 11.--PROPOSED FY 2005 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6THS OF THE GEOMETRIC AVERAGE LENGTH OF STAY

Proposed LTC-DRG	Description	Proposed Relative Weight	Proposed Geo-metric Average Length of Stay	Proposed 5/6ths of the Geo-metric Average Length of Stay
1	[4] CRANIOTOMY AGE >17 W CC	1.2467	30.4	25.3
2	[8] CRANIOTOMY AGE >17 W/O CC	1.2467	30.4	25.3
3	[8] CRANIOTOMY AGE 0-17	1.2467	30.4	25.3
6	[8] CARPAL TUNNEL RELEASE	0.6685	21.6	18.0
7	PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	1.4502	35.8	29.8
8	[2] PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	0.6685	21.6	18.0
9	SPINAL DISORDERS & INJURIES	1.0731	30.9	25.7
10	NERVOUS SYSTEM NEOPLASMS W CC	0.8921	25.2	21.0
11	[1] NERVOUS SYSTEM NEOPLASMS W/O CC	0.5076	18.2	15.1
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.7559	25.6	21.3
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.7955	24.6	20.5
14	INTRACRANIAL HEMORRHAGE OR STROKE W INFARCT	0.8498	26.1	21.7
15	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT	0.8015	27.0	22.5
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.8855	25.6	21.3
17	[3] NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.8854	24.2	20.1
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.7954	24.8	20.6
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.6487	21.1	17.5
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.0894	26.5	22.0
21	[3] VIRAL MENINGITIS	0.8854	24.2	20.1
22	[2] HYPERTENSIVE ENCEPHALOPATHY	0.6685	21.6	18.0
23	NONTRAUMATIC STUPOR & COMA	1.0661	26.6	22.1
24	SEIZURE & HEADACHE AGE >17 W CC	0.6855	22.4	18.6
25	[2] SEIZURE & HEADACHE AGE >17 W/O CC	0.6685	21.6	18.0
26	[8] SEIZURE & HEADACHE AGE 0-17	0.6685	21.6	18.0
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.1611	29.3	24.4
28	TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W CC	0.9883	29.9	24.9
29	[3] TRAUMATIC STUPOR & COMA, COMA <1 HR AGE >17 W/O CC	0.8854	24.2	20.1
30	[8] TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.8854	24.2	20.1
31	[2] CONCUSSION AGE >17 W CC	0.6685	21.6	18.0
32	[8] CONCUSSION AGE >17 W/O CC	0.6685	21.6	18.0
33	[8] CONCUSSION AGE 0-17	0.6685	21.6	18.0
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.8545	24.0	20.0
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC	0.7118	23.1	19.2
36	[8] RETINAL PROCEDURES	0.5076	18.2	15.1
37	[8] ORBITAL PROCEDURES	0.5076	18.2	15.1
38	[8] PRIMARY IRIS PROCEDURES	0.5076	18.2	15.1
39	[8] LENS PROCEDURES WITH OR WITHOUT VITRECTOMY	0.5076	18.2	15.1
40	[8] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17	0.5076	18.2	15.1
41	[8] EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17	0.5076	18.2	15.1

Proposed LTC-DRG	Description	Proposed Relative Weight	Proposed Geometric Average Length of Stay	Proposed 5/6ths of the Geometric Average Length of Stay
42	[8] INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS	0.5076	18.2	15.1
43	[1] HYPHEMA	0.5076	18.2	15.1
44	[3] ACUTE MAJOR EYE INFECTIONS	0.8854	24.2	20.1
45	[1] NEUROLOGICAL EYE DISORDERS	0.5076	18.2	15.1
46	[5] OTHER DISORDERS OF THE EYE AGE >17 W CC	1.8895	35.9	29.9
47	[1] OTHER DISORDERS OF THE EYE AGE >17 W/O CC	0.5076	18.2	15.1
48	[8] OTHER DISORDERS OF THE EYE AGE 0-17	0.5076	18.2	15.1
49	[8] MAJOR HEAD & NECK PROCEDURES	1.2467	30.4	25.3
50	[8] SIALOADENECTOMY	1.2467	30.4	25.3
51	[8] SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY	1.2467	30.4	25.3
52	[8] CLEFT LIP & PALATE REPAIR	1.2467	30.4	25.3
53	[3] SINUS & MASTOID PROCEDURES AGE >17	0.8854	24.2	20.1
54	[8] SINUS & MASTOID PROCEDURES AGE 0-17	0.8854	24.2	20.1
55	[5] MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES	1.8895	35.9	29.9
56	[8] RHINOPLASTY	0.8854	24.2	20.1
57	[8] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.6685	21.6	18.0
58	[8] T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.6685	21.6	18.0
59	[8] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17	0.6685	21.6	18.0
60	[8] TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17	0.6685	21.6	18.0
61	[8] MYRINGOTOMY W TUBE INSERTION AGE >17	0.6685	21.6	18.0
62	[8] MYRINGOTOMY W TUBE INSERTION AGE 0-17	0.6685	21.6	18.0
63	[4] OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES	1.2467	30.4	25.3
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY	1.2155	26.8	22.3
65	DYSEQUILIBRIUM	0.4050	16.0	13.3
66	[8] EPISTAXIS	0.6685	21.6	18.0
67	[8] EPIGLOTTITIS	1.2467	30.4	25.3
68	OTITIS MEDIA & URI AGE >17 W CC	0.6055	20.7	17.2
69	[7] OTITIS MEDIA & URI AGE >17 W/O CC	0.6055	20.7	17.2
70	[8] OTITIS MEDIA & URI AGE 0-17	0.6685	21.6	18.0
71	[8] LARYNGOTRACHEITIS	0.5076	18.2	15.1
72	[8] NASAL TRAUMA & DEFORMITY	0.8854	24.2	20.1
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17	0.9500	23.6	19.6
74	[8] OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17	0.6685	21.6	18.0
75	MAJOR CHEST PROCEDURES	2.0300	31.0	25.8
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC	2.2783	39.7	33.0
77	[5] OTHER RESP SYSTEM O.R. PROCEDURES W/O CC	1.8895	35.9	29.9
78	PULMONARY EMBOLISM	0.7686	22.1	18.4
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC	0.9565	23.8	19.8
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC	0.9118	26.1	21.7
81	[8] RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17	0.6685	21.6	18.0
82	RESPIRATORY NEOPLASMS	0.8099	20.5	17.0
83	[3] MAJOR CHEST TRAUMA W CC	0.8854	24.2	20.1

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84	[1] MAJOR CHEST TRAUMA W/O CC	0.5076	18.2	15.1
85	PLEURAL EFFUSION W CC	0.8357	22.6	18.8
86	[7] PLEURAL EFFUSION W/O CC	0.8357	22.6	18.8
87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.6493	30.0	25.0
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.7458	20.2	16.8
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	0.7915	21.2	17.6
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC	0.7368	20.9	17.4
91	[8] SIMPLE PNEUMONIA & PLEURISY AGE 0-17	0.6685	21.6	18.0
92	INTERSTITIAL LUNG DISEASE W CC	0.7737	20.7	17.2
93	INTERSTITIAL LUNG DISEASE W/O CC	0.5597	15.2	12.6
94	PNEUMOTHORAX W CC	0.8207	20.7	17.2
95	[1] PNEUMOTHORAX W/O CC	0.5076	18.2	15.1
96	BRONCHITIS & ASTHMA AGE >17 W CC	0.7535	20.0	16.6
97	BRONCHITIS & ASTHMA AGE >17 W/O CC	0.5461	16.4	13.6
98	[8] BRONCHITIS & ASTHMA AGE 0-17	0.5076	18.2	15.1
99	RESPIRATORY SIGNS & SYMPTOMS W CC	1.0737	26.1	21.7
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC	0.8055	22.1	18.4
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC	0.8857	22.4	18.6
102	[7] OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC	0.8857	22.4	18.6
103	[6] HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM	0.0000	0.0	0.0
104	[8] CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W CARD CATH	0.5076	18.2	15.1
105	[8] CARDIAC VALVE & OTH MAJOR CARDIOTHORACIC PROC W/O CARD CATH	0.5076	18.2	15.1
106	[8] CORONARY BYPASS W PTCA	0.5076	18.2	15.1
107	[8] CORONARY BYPASS W CARDIAC CATH	0.5076	18.2	15.1
108	[4] OTHER CARDIOTHORACIC PROCEDURES	1.2467	30.4	25.3
109	[2] CORONARY BYPASS W/O PTCA OR CARDIAC CATH	0.6685	21.6	18.0
110	[1] MAJOR CARDIOVASCULAR PROCEDURES W CC	0.5076	18.2	15.1
111	[8] MAJOR CARDIOVASCULAR PROCEDURES W/O CC	0.5076	18.2	15.1
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE	1.3267	36.0	30.0
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS	1.1827	32.8	27.3
115	[4] PRM CARD PACEM IMPL W AMI/HR/SHOCK OR AICD LEAD OR GNRTR	1.2467	30.4	25.3
116	[4] OTHER PERMANENT CARDIAC PACEMAKER IMPLANT	1.2467	30.4	25.3
117	[5] CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT	1.8895	35.9	29.9
118	[5] CARDIAC PACEMAKER DEVICE REPLACEMENT	1.8895	35.9	29.9
119	[1] VEIN LIGATION & STRIPPING	0.5076	18.2	15.1
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	1.1803	32.2	26.8
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE	0.8989	22.8	19.0
122	[3] CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE	0.8854	24.2	20.1
123	CIRCULATORY DISORDERS W AMI, EXPIRED	1.0031	19.7	16.4

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124	[3] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG	0.8854	24.2	20.1
125	[5] CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG	1.8895	35.9	29.9
126	ACUTE & SUBACUTE ENDOCARDITIS	0.8746	24.8	20.6
127	HEART FAILURE & SHOCK	0.7761	21.7	18.0
128	[2] DEEP VEIN THROMBOPHLEBITIS	0.6685	21.6	18.0
129	[2] CARDIAC ARREST, UNEXPLAINED	0.6685	21.6	18.0
130	PERIPHERAL VASCULAR DISORDERS W CC	0.7399	22.9	19.0
131	PERIPHERAL VASCULAR DISORDERS W/O CC	0.5973	20.7	17.2
132	ATHEROSCLEROSIS W CC	0.7209	22.6	18.8
133	ATHEROSCLEROSIS W/O CC	0.5703	19.4	16.1
134	HYPERTENSION	0.6789	21.5	17.9
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC	0.9173	24.6	20.5
136	[3] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC	0.8854	24.2	20.1
137	[8] CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17	0.8854	24.2	20.1
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.8117	22.7	18.9
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC	0.5656	19.7	16.4
140	[2] ANGINA PECTORIS	0.6685	21.6	18.0
141	SYNCOPE & COLLAPSE W CC	0.5363	21.7	18.0
142	SYNCOPE & COLLAPSE W/O CC	0.4921	22.4	18.6
143	[1] CHEST PAIN	0.5076	18.2	15.1
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.8212	22.2	18.5
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.8212	22.2	18.5
146	[8] RECTAL RESECTION W CC	1.8895	35.9	29.9
147	[8] RECTAL RESECTION W/O CC	1.8895	35.9	29.9
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.1502	34.9	29.0
149	[1] MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	0.5076	18.2	15.1
150	[5] PERITONEAL ADHESIOLYSIS W CC	1.8895	35.9	29.9
151	[8] PERITONEAL ADHESIOLYSIS W/O CC	1.8895	35.9	29.9
152	[5] MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.8895	35.9	29.9
153	[8] MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.8895	35.9	29.9
154	[5] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC	1.8895	35.9	29.9
155	[8] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC	1.8895	35.9	29.9
156	[8] STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17	1.8895	35.9	29.9
157	[4] ANAL & STOMAL PROCEDURES W CC	1.2467	30.4	25.3
158	[8] ANAL & STOMAL PROCEDURES W/O CC	1.2467	30.4	25.3
159	[3] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC	0.8854	24.2	20.1
160	[8] HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC	0.8854	24.2	20.1
161	[5] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC	1.8895	35.9	29.9
162	[8] INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC	0.5076	18.2	15.1

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163	[8] HERNIA PROCEDURES AGE 0-17	0.5076	18.2	15.1
164	[8] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.8895	35.9	29.9
165	[8] APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC	1.8895	35.9	29.9
166	[8] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.8895	35.9	29.9
167	[8] APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC	1.8895	35.9	29.9
168	[4] MOUTH PROCEDURES W CC	1.2467	30.4	25.3
169	[8] MOUTH PROCEDURES W/O CC	0.8854	24.2	20.1
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	1.7302	31.9	26.5
171	[7] OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC	1.7302	31.9	26.5
172	DIGESTIVE MALIGNANCY W CC	0.9392	23.2	19.3
173	DIGESTIVE MALIGNANCY W/O CC	0.6558	22.0	18.3
174	G.I. HEMORRHAGE W CC	0.7465	21.9	18.2
175	[2] G.I. HEMORRHAGE W/O CC	0.6685	21.6	18.0
176	COMPLICATED PEPTIC ULCER	1.0117	23.8	19.8
177	[2] UNCOMPLICATED PEPTIC ULCER W CC	0.6685	21.6	18.0
178	[1] UNCOMPLICATED PEPTIC ULCER W/O CC	0.5076	18.2	15.1
179	INFLAMMATORY BOWEL DISEASE	0.8398	22.4	18.6
180	G.I. OBSTRUCTION W CC	0.9502	22.2	18.5
181	[2] G.I. OBSTRUCTION W/O CC	0.6685	21.6	18.0
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC	0.8565	23.3	19.4
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC	0.6964	20.4	17.0
184	[8] ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17	0.6685	21.6	18.0
185	[3] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17	0.8854	24.2	20.1
186	[8] DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17	0.8854	24.2	20.1
187	[8] DENTAL EXTRACTIONS & RESTORATIONS	0.8854	24.2	20.1
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC	1.0108	24.2	20.1
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC	0.8596	22.0	18.3
190	[8] OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17	0.8854	24.2	20.1
191	[5] PANCREAS, LIVER & SHUNT PROCEDURES W CC	1.8895	35.9	29.9
192	[8] PANCREAS, LIVER & SHUNT PROCEDURES W/O CC	1.8895	35.9	29.9
193	[1] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	0.5076	18.2	15.1
194	[8] BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC	0.5076	18.2	15.1
195	[8] CHOLECYSTECTOMY W C.D.E. W CC	1.8895	35.9	29.9
196	[8] CHOLECYSTECTOMY W C.D.E. W/O CC	1.8895	35.9	29.9
197	[5] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	1.8895	35.9	29.9
198	[8] CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC	1.8895	35.9	29.9
199	[8] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY	0.8854	24.2	20.1
200	[3] HEPATOBILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY	0.8854	24.2	20.1

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201	[4] OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES	1.2467	30.4	25.3
202	CIRRHOSIS & ALCOHOLIC HEPATITIS	0.7449	23.0	19.1
203	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS	0.8291	21.4	17.8
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY	0.8615	21.3	17.7
205	DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W CC	0.7857	23.7	19.7
206	[7] DISORDERS OF LIVER EXCEPT MALIG, CIRR, ALC HEPA W/O CC	0.7857	23.7	19.7
207	DISORDERS OF THE BILIARY TRACT W CC	0.7284	20.3	16.9
208	[1] DISORDERS OF THE BILIARY TRACT W/O CC	0.5076	18.2	15.1
209	[5] MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY	1.8895	35.9	29.9
210	[5] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC	1.8895	35.9	29.9
211	[8] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC	1.8895	35.9	29.9
212	[8] HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17	1.8895	35.9	29.9
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS	1.1933	33.0	27.5
216	[4] BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	1.2467	30.4	25.3
217	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS	1.2972	36.2	30.1
218	[4] LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC	1.2467	30.4	25.3
219	[8] LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC	1.2467	30.4	25.3
220	[8] LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17	1.2467	30.4	25.3
223	[8] MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC	1.2467	30.4	25.3
224	[4] SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC	1.2467	30.4	25.3
225	FOOT PROCEDURES	1.0761	30.4	25.3
226	[4] SOFT TISSUE PROCEDURES W CC	1.2467	30.4	25.3
227	[2] SOFT TISSUE PROCEDURES W/O CC	0.6685	21.6	18.0
228	[2] MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC	0.6685	21.6	18.0
229	[1] HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC	0.5076	18.2	15.1
230	[5] LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR	1.8895	35.9	29.9
232	[8] ARTHROSCOPY	0.6685	21.6	18.0
233	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.5004	32.8	27.3
234	[2] OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC	0.6685	21.6	18.0
235	FRACTURES OF FEMUR	0.8403	31.5	26.2
236	FRACTURES OF HIP & PELVIS	0.7462	26.7	22.2
237	[2] SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH	0.6685	21.6	18.0
238	OSTEOMYELITIS	0.9541	28.6	23.8
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY	0.6965	21.7	18.0
240	CONNECTIVE TISSUE DISORDERS W CC	0.7411	23.6	19.6
241	[1] CONNECTIVE TISSUE DISORDERS W/O CC	0.5076	18.2	15.1

Proposed LTC-DRG	Description	Proposed Relative Weight	Proposed Geo-metric Average Length of Stay	Proposed 5/6ths of the Geo-metric Average Length of Stay
242	SEPTIC ARTHRITIS	0.8090	26.1	21.7
243	MEDICAL BACK PROBLEMS	0.6273	22.4	18.6
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC	0.5978	22.4	18.6
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC	0.5243	19.4	16.1
246	NON-SPECIFIC ARTHROPATHIES	0.6048	21.4	17.8
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE	0.6172	21.7	18.0
248	TENDONITIS, MYOSITIS & BURSITIS	0.8250	24.6	20.5
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE	0.7034	23.9	19.9
250	[2] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC	0.6685	21.6	18.0
251	[2] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC	0.6685	21.6	18.0
252	[8] FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17	0.6685	21.6	18.0
253	FX, SPRN, STRN & DISL OF UPARM, LOW LEG EX FOOT AGE >17 W CC	0.8384	28.1	23.4
254	FX, SPRN, STRN & DISL OF UPARM, LOW LEG EX FOOT AGE >17 W/O CC	0.7025	26.7	22.2
255	[8] FX, SPRN, STRN & DISL OF UPARM, LOW LEG EX FOOT AGE 0-17	0.6685	21.6	18.0
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	0.7696	23.3	19.4
257	[8] TOTAL MASTECTOMY FOR MALIGNANCY W CC	0.8854	24.2	20.1
258	[8] TOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.8854	24.2	20.1
259	[8] SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC	0.8854	24.2	20.1
260	[1] SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC	0.5076	18.2	15.1
261	[5] BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION	1.8895	35.9	29.9
262	[3] BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY	0.8854	24.2	20.1
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC	1.3533	38.2	31.8
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC	1.0444	32.2	26.8
265	SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.4183	35.1	29.2
266	[3] SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC	0.8854	24.2	20.1
267	[5] PERIANAL & PILONIDAL PROCEDURES	1.8895	35.9	29.9
268	[4] SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES	1.2467	30.4	25.3
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.4068	38.1	31.7
270	[3] OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC	0.8854	24.2	20.1
271	SKIN ULCERS	0.9665	28.3	23.5
272	MAJOR SKIN DISORDERS W CC	0.8595	25.5	21.2
273	[1] MAJOR SKIN DISORDERS W/O CC	0.5076	18.2	15.1
274	MALIGNANT BREAST DISORDERS W CC	0.9153	27.4	22.8
275	[3] MALIGNANT BREAST DISORDERS W/O CC	0.8854	24.2	20.1
276	[2] NON-MALIGANT BREAST DISORDERS	0.6685	21.6	18.0
277	CELLULITIS AGE >17 W CC	0.7065	21.8	18.1
278	CELLULITIS AGE >17 W/O CC	0.5717	19.1	15.9

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279	[8] CELLULITIS AGE 0-17	0.5076	18.2	15.1
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC	0.9491	27.4	22.8
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC	0.8513	29.0	24.1
282	[8] TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17	0.8854	24.2	20.1
283	MINOR SKIN DISORDERS W CC	0.7632	22.8	19.0
284	[1] MINOR SKIN DISORDERS W/O CC	0.5076	18.2	15.1
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE, NUTRIT, & METABOL DISORDERS	1.3618	35.5	29.5
286	[8] ADRENAL & PITUITARY PROCEDURES	0.8854	24.2	20.1
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS	1.1635	32.0	26.6
288	[3] O.R. PROCEDURES FOR OBESITY	0.8854	24.2	20.1
289	[8] PARATHYROID PROCEDURES	0.8854	24.2	20.1
290	[8] THYROID PROCEDURES	0.8854	24.2	20.1
291	[8] THYROGLOSSAL PROCEDURES	0.8854	24.2	20.1
292	[4] OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	1.2467	30.4	25.3
293	[8] OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC	0.6685	21.6	18.0
294	DIABETES AGE >35	0.7721	23.7	19.7
295	[2] DIABETES AGE 0-35	0.6685	21.6	18.0
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC	0.8128	23.8	19.8
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC	0.5910	20.5	17.0
298	[8] NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17	0.6685	21.6	18.0
299	[3] INBORN ERRORS OF METABOLISM	0.8854	24.2	20.1
300	ENDOCRINE DISORDERS W CC	0.8070	24.6	20.5
301	[1] ENDOCRINE DISORDERS W/O CC	0.5076	18.2	15.1
302	[6] KIDNEY TRANSPLANT	0.0000	0.0	0.0
303	[4] KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM	1.2467	30.4	25.3
304	[4] KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC	1.2467	30.4	25.3
305	[2] KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC	0.6685	21.6	18.0
306	[3] PROSTATECTOMY W CC	0.8854	24.2	20.1
307	[2] PROSTATECTOMY W/O CC	0.6685	21.6	18.0
308	[4] MINOR BLADDER PROCEDURES W CC	1.2467	30.4	25.3
309	[8] MINOR BLADDER PROCEDURES W/O CC	1.2467	30.4	25.3
310	[4] TRANSURETHRAL PROCEDURES W CC	1.2467	30.4	25.3
311	[8] TRANSURETHRAL PROCEDURES W/O CC	1.2467	30.4	25.3
312	[4] URETHRAL PROCEDURES, AGE >17 W CC	1.2467	30.4	25.3
313	[8] URETHRAL PROCEDURES, AGE >17 W/O CC	1.2467	30.4	25.3
314	[8] URETHRAL PROCEDURES, AGE 0-17	0.6685	21.6	18.0
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES	1.4466	33.5	27.9
316	RENAL FAILURE	0.9336	23.5	19.5
317	ADMIT FOR RENAL DIALYSIS	0.9224	22.0	18.3
318	KIDNEY & URINARY TRACT NEOPLASMS W CC	0.7867	22.6	18.8
319	[7] KIDNEY & URINARY TRACT NEOPLASMS W/O CC	0.7867	22.6	18.8

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320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC	0.6852	22.2	18.5
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC	0.5719	21.6	18.0
322	[8] KIDNEY & URINARY TRACT INFECTIONS AGE 0-17	0.5076	18.2	15.1
323	[1] URINARY STONES W CC, &/OR ESW LITHOTRIPSY	0.5076	18.2	15.1
324	[1] URINARY STONES W/O CC	0.5076	18.2	15.1
325	[2] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC	0.6685	21.6	18.0
326	[1] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC	0.5076	18.2	15.1
327	[8] KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17	0.5076	18.2	15.1
328	[2] URETHRAL STRICTURE AGE >17 W CC	0.6685	21.6	18.0
329	[8] URETHRAL STRICTURE AGE >17 W/O CC	0.6685	21.6	18.0
330	[8] URETHRAL STRICTURE AGE 0-17	0.6685	21.6	18.0
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC	0.8428	23.1	19.2
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC	0.6742	23.6	19.6
333	[8] OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17	0.6685	21.6	18.0
334	[8] MAJOR MALE PELVIC PROCEDURES W CC	1.2467	30.4	25.3
335	[8] MAJOR MALE PELVIC PROCEDURES W/O CC	1.2467	30.4	25.3
336	[3] TRANSURETHRAL PROSTATECTOMY W CC	0.8854	24.2	20.1
337	[8] TRANSURETHRAL PROSTATECTOMY W/O CC	0.8854	24.2	20.1
338	[5] TESTES PROCEDURES, FOR MALIGNANCY	1.8895	35.9	29.9
339	[1] TESTES PROCEDURES, NON-MALIGNANCY AGE >17	0.5076	18.2	15.1
340	[8] TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17	0.5076	18.2	15.1
341	[5] PENIS PROCEDURES	1.8895	35.9	29.9
342	[8] CIRCUMCISION AGE >17	0.5076	18.2	15.1
343	[8] CIRCUMCISION AGE 0-17	0.5076	18.2	15.1
344	[8] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY	1.2467	30.4	25.3
345	[4] OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY	1.2467	30.4	25.3
346	MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC	0.7748	22.5	18.7
347	[1] MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC	0.5076	18.2	15.1
348	[2] BENIGN PROSTATIC HYPERTROPHY W CC	0.6685	21.6	18.0
349	[2] BENIGN PROSTATIC HYPERTROPHY W/O CC	0.6685	21.6	18.0
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM	0.8258	23.7	19.7
351	[8] STERILIZATION, MALE	0.5076	18.2	15.1
352	[3] OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES	0.8854	24.2	20.1
353	[8] PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY	1.8895	35.9	29.9
354	[8] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.8895	35.9	29.9
355	[8] UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC	1.8895	35.9	29.9
356	[8] FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.2467	30.4	25.3
357	[8] UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY	1.2467	30.4	25.3
358	[8] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC	1.2467	30.4	25.3

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359	[8] UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC	1.2467	30.4	25.3
360	[8] VAGINA, CERVIX & VULVA PROCEDURES	1.2467	30.4	25.3
361	[8] LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION	0.5076	18.2	15.1
362	[8] ENDOSCOPIC TUBAL INTERRUPTION	0.5076	18.2	15.1
363	[8] D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY	0.5076	18.2	15.1
364	[8] D&C, CONIZATION EXCEPT FOR MALIGNANCY	0.5076	18.2	15.1
365	[5] OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES	1.8895	35.9	29.9
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	0.9991	24.0	20.0
367	[1] MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC	0.5076	18.2	15.1
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM	0.7054	21.9	18.2
369	[3] MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS	0.8854	24.2	20.1
370	[8] CESAREAN SECTION W CC	0.8854	24.2	20.1
371	[8] CESAREAN SECTION W/O CC	0.5076	18.2	15.1
372	[8] VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.5076	18.2	15.1
373	[8] VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	0.5076	18.2	15.1
374	[8] VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.5076	18.2	15.1
375	[8] VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.5076	18.2	15.1
376	[8] POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.5076	18.2	15.1
377	[8] POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	0.5076	18.2	15.1
378	[8] ECTOPIC PREGNANCY	0.8854	24.2	20.1
379	[8] THREATENED ABORTION	0.5076	18.2	15.1
380	[8] ABORTION W/O D&C	0.5076	18.2	15.1
381	[8] ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.5076	18.2	15.1
382	[8] FALSE LABOR	0.5076	18.2	15.1
383	[8] OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	0.5076	18.2	15.1
384	[8] OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	0.5076	18.2	15.1
385	[8] NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	0.5076	18.2	15.1
386	[5] EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	0.5076	18.2	15.1
387	[8] PREMATURITY W MAJOR PROBLEMS	0.5076	18.2	15.1
388	[8] PREMATURITY W/O MAJOR PROBLEMS	0.5076	18.2	15.1
389	[8] FULL TERM NEONATE W MAJOR PROBLEMS	0.5076	18.2	15.1
390	[8] NEONATE W OTHER SIGNIFICANT PROBLEMS	0.5076	18.2	15.1
391	[8] NORMAL NEWBORN	0.5076	18.2	15.1
392	[8] SPLENECTOMY AGE >17	1.8895	35.9	29.9
393	[8] SPLENECTOMY AGE 0-17	1.8895	35.9	29.9
394	[3] OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS	0.8854	24.2	20.1
395	RED BLOOD CELL DISORDERS AGE >17	0.7705	23.6	19.6
396	[8] RED BLOOD CELL DISORDERS AGE 0-17	0.6685	21.6	18.0
397	COAGULATION DISORDERS	0.8482	20.6	17.1

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398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.8052	21.7	18.0
399	[2] RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC	0.6685	21.6	18.0
401	[4] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC	1.2467	30.4	25.3
402	[8] LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC	1.2467	30.4	25.3
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	0.9015	21.7	18.0
404	[1] LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC	0.5076	18.2	15.1
405	[8] ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17	0.5076	18.2	15.1
406	[5] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC	1.8895	35.9	29.9
407	[8] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	1.2467	30.4	25.3
408	[4] MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC	1.2467	30.4	25.3
409	RADIOTHERAPY	0.9116	22.5	18.7
410	[3] CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS	0.8854	24.2	20.1
411	[8] HISTORY OF MALIGNANCY W/O ENDOSCOPY	0.5076	18.2	15.1
412	[8] HISTORY OF MALIGNANCY W ENDOSCOPY	0.5076	18.2	15.1
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	0.8586	20.3	16.9
414	[1] OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC	0.5076	18.2	15.1
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES	1.5369	35.7	29.7
416	SEPTICEMIA AGE >17	0.9186	24.0	20.0
417	[8] SEPTICEMIA AGE 0-17	0.8854	24.2	20.1
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS	0.8880	24.6	20.5
419	[4] FEVER OF UNKNOWN ORIGIN AGE >17 W CC	1.2467	30.4	25.3
420	[2] FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC	0.6685	21.6	18.0
421	VIRAL ILLNESS AGE >17	1.0559	25.9	21.5
422	[8] VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17	0.5076	18.2	15.1
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES	0.9625	22.6	18.8
424	[5] O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	1.8895	35.9	29.9
425	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.5590	21.0	17.5
426	DEPRESSIVE NEUROSES	0.5495	24.7	20.5
427	[2] NEUROSES EXCEPT DEPRESSIVE	0.6685	21.6	18.0
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL	0.6631	27.6	23.0
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	0.6037	24.7	20.5
430	PSYCHOSES	0.4854	22.6	18.8
431	CHILDHOOD MENTAL DISORDERS	0.4978	22.0	18.3
432	[8] OTHER MENTAL DISORDER DIAGNOSES	0.6685	21.6	18.0
433	[1] ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.5076	18.2	15.1
439	SKIN GRAFTS FOR INJURIES	1.1415	34.9	29.0
440	WOUND DEBRIDEMENTS FOR INJURIES	1.2555	31.6	26.3
441	[2] HAND PROCEDURES FOR INJURIES	0.6685	21.6	18.0

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442	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.4562	37.4	31.1
443	[7] OTHER O.R. PROCEDURES FOR INJURIES W/O CC	1.4562	37.4	31.1
444	TRAUMATIC INJURY AGE >17 W CC	0.8665	24.9	20.7
445	TRAUMATIC INJURY AGE >17 W/O CC	0.8665	24.9	20.7
446	[8] TRAUMATIC INJURY AGE 0-17	0.8854	24.2	20.1
447	[2] ALLERGIC REACTIONS AGE >17	0.6685	21.6	18.0
448	[8] ALLERGIC REACTIONS AGE 0-17	0.6685	21.6	18.0
449	[2] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	0.6685	21.6	18.0
450	[1] POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	0.5076	18.2	15.1
451	[8] POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17	1.2467	30.4	25.3
452	COMPLICATIONS OF TREATMENT W CC	0.9995	25.2	21.0
453	COMPLICATIONS OF TREATMENT W/O CC	0.7129	22.4	18.6
454	[5] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	1.8895	35.9	29.9
455	[4] OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	1.2467	30.4	25.3
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES	1.2539	34.4	28.6
462	REHABILITATION	0.6791	23.4	19.5
463	SIGNS & SYMPTOMS W CC	0.6793	23.5	19.5
464	SIGNS & SYMPTOMS W/O CC	0.5659	22.7	18.9
465	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.6881	20.2	16.8
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS	0.7402	22.2	18.5
467	[2] OTHER FACTORS INFLUENCING HEALTH STATUS	0.6685	21.6	18.0
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	2.1227	40.1	33.4
469	[6] PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	0.0000	0.0	0.0
470	[6] UNGROUPABLE	0.0000	0.0	0.0
471	[8] BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY	0.6685	21.6	18.0
473	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	0.8704	20.7	17.2
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT	2.0199	33.2	27.6
476	[3] PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	0.8854	24.2	20.1
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS	1.5119	34.2	28.5
478	OTHER VASCULAR PROCEDURES W CC	1.3685	31.8	26.5
479	[1] OTHER VASCULAR PROCEDURES W/O CC	0.5076	18.2	15.1
480	[6] LIVER TRANSPLANT	0.0000	0.0	0.0
481	[8] BONE MARROW TRANSPLANT	0.8854	24.2	20.1
482	[8] TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	1.2467	30.4	25.3
484	[8] CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	1.2467	30.4	25.3
485	[4] LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA	1.2467	30.4	25.3
486	[5] OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA	1.8895	35.9	29.9
487	[4] OTHER MULTIPLE SIGNIFICANT TRAUMA	1.2467	30.4	25.3
488	[5] HIV W EXTENSIVE O.R. PROCEDURE	1.8895	35.9	29.9

Proposed LTC-DRG	Description	Proposed Relative Weight	Proposed Geo-metric Average Length of Stay	Proposed 5/6ths of the Geo-metric Average Length of Stay
489	HIV W MAJOR RELATED CONDITION	1.0345	24.1	20.0
490	HIV W OR W/O OTHER RELATED CONDITION	1.1004	22.0	18.3
491	[8] MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY	1.8895	35.9	29.9
492	[8] CHEMOTHERAPY W ACUTE LEUKEMIA OR W USE OF HI DOSE CHEMOAGENT	0.8854	24.2	20.1
493	[3] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	0.8854	24.2	20.1
494	[8] LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	0.8854	24.2	20.1
495	[6] LUNG TRANSPLANT	0.0000	0.0	0.0
496	[3] COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	0.8854	24.2	20.1
497	[3] SPINAL FUSION EXCEPT CERVICAL W CC	0.8854	24.2	20.1
498	[8] SPINAL FUSION EXCEPT CERVICAL W/O CC	0.8854	24.2	20.1
499	[5] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.8895	35.9	29.9
500	[1] BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	0.5076	18.2	15.1
501	[4] KNEE PROCEDURES W PDX OF INFECTION W CC	1.2467	30.4	25.3
502	[3] KNEE PROCEDURES W PDX OF INFECTION W/O CC	0.8854	24.2	20.1
503	[4] KNEE PROCEDURES W/O PDX OF INFECTION	1.2467	30.4	25.3
504	[8] EXTENSIVE BURNS OF FULL THICKNESS BURNS WITH MECH VENT 96+HRS WITH SKIN GRAFT	1.8895	35.9	29.9
505	[4] EXTENSIVE BURNS OF FULL THICKNESS BURNS WITH MECH VENT 96+HRS WITHOUT SKIN GRAFT	1.2467	30.4	25.3
506	[4] FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	1.2467	30.4	25.3
507	[8] FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA	0.8854	24.2	20.1
508	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA	0.7778	25.8	21.5
509	[1] FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA	0.5076	18.2	15.1
510	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	0.9218	25.8	21.5
511	[2] NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	0.6685	21.6	18.0
512	[6] SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	0.0000	0.0	0.0
513	[6] PANCREAS TRANSPLANT	0.0000	0.0	0.0
515	[5] CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH	1.8895	35.9	29.9
516	[8] PERCUTANEOUS CARDIOVASC PROC W AMI	0.8854	24.2	20.1
517	[3] PERC CARDIO PROC W NON-DRUG ELUTING STENT W/O AMI	0.8854	24.2	20.1
518	[3] PERC CARDIO PROC W/O CORONARY ARTERY STENT OR AMI	0.8854	24.2	20.1
519	[4] CERVICAL SPINAL FUSION W CC	1.2467	30.4	25.3
520	[8] CERVICAL SPINAL FUSION W/O CC	0.8854	24.2	20.1
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC	0.6544	21.4	17.8
522	[1] ALC/DRUG ABUSE OR DEPEND W REHABILITATION THERAPY W/O CC	0.5076	18.2	15.1
523	[1] ALC/DRUG ABUSE OR DEPEND W/O REHABILITATION THERAPY W/O CC	0.5076	18.2	15.1
524	TRANSIENT ISCHEMIA	0.6494	22.4	18.6
525	[8] OTHER HEART ASSIST SYSTEM IMPLANT	1.8895	35.9	29.9
526	[8] PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W AMI	0.8854	24.2	20.1

Proposed LTC-DRG	Description	Proposed Relative Weight	Proposed Geo-metric Average Length of Stay	Proposed 5/6^{ths} of the Geo-metric Average Length of Stay
527	[8] PERCUTNEOUS CARDIOVASULAR PROC W DRUG ELUTING STENT W/O AMI	0.8854	24.2	20.1
528	[8] INTRACRANIAL VASCULAR PROC W PDX HEMORRHAGE	1.2467	30.4	25.3
529	[4] VENTRICULAR SHUNT PROCEDURES W CC	1.2467	30.4	25.3
530	[8] VENTRICULAR SHUNT PROCEDURES W/O CC	1.2467	30.4	25.3
531	[5] SPINAL PROCEDURES W CC	1.8895	35.9	29.9
532	[2] SPINAL PROCEDURES W/O CC	0.6685	21.6	18.0
533	[5] EXTRACRANIAL PROCEDURES W CC	1.8895	35.9	29.9
534	[8] EXTRACRANIAL PROCEDURES W/O CC	0.5076	18.2	15.1
535	[5] CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK	1.8895	35.9	29.9
536	[5] CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK	1.8895	35.9	29.9
537	LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W CC	1.3141	36.3	30.2
538	[3] LOCAL EXCIS & REMOV OF INT FIX DEV EXCEPT HIP & FEMUR W/O CC	0.8854	24.2	20.1
539	[3] LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W CC	0.8854	24.2	20.1
540	[8] LYMPHOMA & LEUKEMIA W MAJOR OR PROCEDURE W/O CC	0.6685	21.6	18.0
541	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE, MOUTH & NECK DX WITH MAJOR OR	3.4223	54.8	45.6
542	TRAC W MECH VENT 96+HRS OR PDX EXCEPT FACE, MOUTH & NECK DX WITHOUT MAJOR OR	2.9398	44.3	36.9

[1] Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to proposed low-volume quintile 1.
[2] Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to proposed low-volume quintile 2.
[3] Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to proposed low-volume quintile 3.
[4] Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to proposed low-volume quintile 4.
[5] Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to proposed low-volume quintile 5.
[6] Proposed relative weights for these proposed LTC-DRGs were assigned a value of 0.0000.
[7] Proposed relative weights for these proposed LTC-DRGs were determined after adjusting to account for nonmonotonicity (see step 5 above).
[8] Proposed relative weights for these proposed LTC-DRGs were determined by assigning these cases to the appropriate proposed low volume quintile because they had no LTCH cases in the FY 2003 MedPAR file.

Appendix A—Regulatory Analysis of Impacts

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

I. Background and Summary

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We have determined that this proposed rule is a major rule as defined in 5 U.S.C. 804(2). Based on the overall percentage change in payments per case estimated using our payment simulation model (a 4.9 percent increase), we estimate that the total impact of these proposed changes for FY 2005 payments compared to FY 2004 payments to be approximately a $4.3 billion increase. As a result, total IPPS payments will increase from approximately $100 billion to approximately $104.3 billion. This amount does not reflect changes in hospital admissions or case-mix intensity, which would also affect overall payment changes.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million to $25 million in any 1 year. For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). However, under the new labor market definitions that we are proposing to adopt, we no longer employ NECMAs to define urban areas in New England. Therefore, we now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the IPPS, we continue to classify these hospitals as urban hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any proposed rule (or a final rule that has been preceded by a proposed rule) that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. This proposed rule would not mandate any requirements for State, local, or tribal governments.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this proposed rule in light of Executive Order 13132 and have determined that it would not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

The following analysis, in conjunction with the remainder of this document, demonstrates that this proposed rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The proposed rule would affect payments to a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some hospitals may be significant.

II. Objectives

The primary objective of the IPPS is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of preserving the Medicare Trust Fund.

We believe the changes in this proposed rule would further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these proposed changes would ensure that the outcomes of this payment system are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our proposed policy changes, as well as statutory changes effective for FY 2005, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but we do not attempt to predict behavioral responses to our proposed policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. As we have done in previous proposed rules, we are soliciting comments and information about the anticipated effects of these proposed changes on hospitals and our methodology for estimating them. Any comments that we receive in response to this proposed rule will be addressed in the final rule.

IV. Hospitals Included in and Excluded From the IPPS

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general short-term, acute care hospitals that participate in the Medicare program. There were 39 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment method for these hospitals. Among other short-term, acute care hospitals, only the 47 such hospitals in Maryland remain excluded from the IPPS under the waiver at section 1814(b)(3) of the Act.

As of April 2004, there are 3,904 IPPS hospitals to be included in our analysis. This represents about 65 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals. There are also approximately 898 critical access hospitals (CAHs). These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. There are also 1,194 specialty hospitals and units that are excluded from the IPPS. These specialty hospitals include psychiatric hospitals and units, rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals. The impacts of our proposed policy changes on these hospitals are discussed below.

V. Impact on Excluded Hospitals and Hospital Units

As of April 2004, there were 1,194 specialty hospitals excluded from the IPPS. Of these 1,194 specialty hospitals, 478 psychiatric hospitals, 80 children's, 11 cancer hospitals, and less than 10 percent of the LTCHs are being paid on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. The remaining providers—216 rehabilitation, and approximately 90 percent of the 331 LTCHs are paid 100 percent of the Federal rate under the IRF and LTCH PPS', respectively. In addition, there were 1,381 psychiatric units (paid on a reasonable cost basis) and 999 rehabilitation units (paid under the IRF PPS) in hospitals otherwise subject to the IPPS. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 47 specialty hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

In the past, hospitals and units excluded from the IPPS have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Hospitals that continue to be paid based on

their reasonable costs are subject to TEFRA limits for FY 2005. For these hospitals, the proposed update is the percentage increase in the excluded hospital market basket, currently estimated at 3.3 percent.

Inpatient rehabilitation facilities (IRFs) are paid under a prospective payment system (IRF PPS) for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2005, the IRF PPS is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually. Therefore, these hospitals would not be impacted by this proposed rule.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs are paid under an LTCH PPS, based on the adjusted Federal prospective payment amount, updated annually. LTCHs will receive a blended payment (Federal prospective payment and a reasonable cost-based payment) over a 5-year transition period. However, under the LTCH PPS, an LTCH may also elect to be paid at 100 percent of the Federal prospective rate at the beginning of any of its cost reporting periods during the 5-year transition period. For purposes of the update factor, the portion of the LTCH PPS transition blend payment based on reasonable costs for inpatient operating services would be determined by updating the LTCH's TEFRA limit by the estimate of the excluded hospital market basket (or 3.3 percent).

Section 124 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) requires the development of a per diem prospective payment system (PPS) for payment of inpatient hospital services furnished in psychiatric hospitals and psychiatric units of acute care hospitals (inpatient psychiatric facilities (IFPs)). We published a proposed rule to implement the IPF PPS on November 28, 2003 (68 FR 66920). On January 30, 2004, we published a notice to extend the comment period for 30 additional days (69 FR 4464). The comment period closed on March 26, 2004.

Under the proposed rule, CMS would compute a Federal per diem base rate to be paid to all IPFs based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF adjusted for budget neutrality. The Federal per diem base rate would be adjusted to reflect certain patient characteristics such as age, specified DRGs, and selected high-cost comorbidities, and certain facility characteristics such as a wage index adjustment, rural location, and indirect teaching costs.

The November 28, 2003 proposed rule assumed an April 1, 2004 effective date for the purpose of ratesetting and calculating impacts. However, we are still in the process of analyzing public comments and developing a final rule for publication. The effective date of the IPF PPS would occur 5 months following publication of the final rule.

The impact on excluded hospitals and hospital units of the update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level below the rate-of-increase limits since their base period, the major effect is on the level of incentive payments these hospitals and hospital units receive. Conversely, for excluded hospitals and hospital units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect is the amount of excess costs that will not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and hospital units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and hospital units to restrain the growth in their spending for patient services.

VI. Quantitative Impact Analysis of the Proposed Policy Changes Under the IPPS for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing policy changes and payment rate updates for the IPPS for operating and capital-related costs. Based on the overall percentage change in payments per case estimated using our payment simulation model (a 4.9 percent increase), we estimate the total impact of these proposed changes for FY 2005 payments compared to FY 2004 payments to be approximately a $4.3 billion increase. This amount does not reflect changes in hospital admissions or case-mix intensity, which would also affect overall payment changes.

We have prepared separate impact analyses of the proposed changes to each system. This section deals with proposed changes to the operating prospective payment system. Our payment simulation model relies on the most recent available data to enable us to estimate the impacts on payments per case of certain changes we are proposing in this proposed rule. However, there are other changes we are proposing for which we do not have data available that would allow us to estimate the payment impacts using this model. For those proposed changes, we have attempted to predict the payment impacts of those proposed changes based upon our experience and other more limited data.

The data used in developing the quantitative analyses of changes in payments per case presented below are taken from the FY 2003 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Although the analyses of the changes to the operating PPS do not incorporate cost data, data from the most recently available hospital cost report were used to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to the proposed policy changes, and we do not adjust for future changes in such variables as admissions, lengths of stay, or case-mix. Second, due to the interdependent nature of the IPPS payment components, it is very difficult to precisely quantify the impact associated with each proposed change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. However, for individual hospitals, some miscategorizations are possible.

Using cases in the FY 2003 MedPAR file, we simulated payments under the operating IPPS given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the IPPSs (Indian Health Service hospitals and hospitals in Maryland) were excluded from the simulations. The impact of payments under the capital IPPS, or the impact of payments for costs other than inpatient operating costs, are not analyzed in this section. Estimated payment impacts of proposed FY 2005 changes to the capital IPPS are discussed in section VIII. of this Appendix.

The proposed changes discussed separately below are the following:

- The effects of the proposed annual reclassification of diagnoses and procedures and the recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of applying a lower labor-related share for hospitals with wage indexes less than or equal to 1.0, as required under section 403 of Public Law 108–173.
- The effects of the proposed adoption of the new MSAs as announced by OMB in June 2003.
- The effects of the proposed changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 2001, compared to the FY 2000 wage data.
- The effects of adjusting hospitals' wage data to reflect the occupational mix based on our survey of hospitals.
- The effect of the proposed wage and DRG recalibration budget neutrality factors.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2005.
- The effects of the proposed implementation of section 505 of Public Law 108–173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in areas with higher wage indexes.
- The total change in payments based on proposed FY 2005 policies and MMA-imposed changes relative to payments based on FY 2004 policies.

To illustrate the impacts of the proposed FY 2005 changes, our analysis begins with an FY 2005 baseline simulation model using: the proposed update of 3.3 percent; the FY 2004 DRG GROUPER (version 21.0); the MSA designations for hospitals based on OMB's MSA definitions prior to June 2003; the FY 2004 wage index; and no MGCRB

reclassifications. Outlier payments are set at 5.1 percent of total operating DRG and outlier payments.

The baseline simulation model also reflects changes enacted by Public Law 108–173 to the IME and DSH adjustments. Section 402 provides that, for discharges occurring on or after April 1, 2004, all hospitals that qualify will receive DSH payments using the prior (before April 1, 2004) DSH adjustment formula for urban hospitals with 100 or more beds. Except for urban hospitals with 100 or more beds and rural referral centers, the DSH adjustment is capped at 12 percent. Section 502 modifies the IME adjustment for midway through FY 2004 and provides a new schedule of formula multipliers for FYs 2005 and thereafter.

Section 501(b) provides that, for FYs 2005 through 2007, the update factors will be reduced by 0.4 percentage point for any hospital that does not submit quality data. For purposes of the FY 2005 simulations in this proposed impact analysis, we are assuming all hospitals will qualify for the full update. Hospitals are not required to begin submitting these data in order to qualify for a full update until July 2004, and we are therefore unable to determine the rate of compliance with this requirement of receiving the full update.

Each proposed and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2005 model incorporating all of the proposed changes. This allows us to isolate the effects of each proposed change.

Our final comparison illustrates the percent change in payments per case from FY 2004 to FY 2005. Five factors not discussed separately above have significant impacts here. The first is the update to the standardized amount. In accordance with section 1886(b)(3)(B)(i) of the Act, we are proposing to update the standardized amount for FY 2005 using the most recently forecasted hospital market basket increase for FY 2005 of 3.3 percent. (Hospitals that fail to comply with the quality data submission requirement to receive the full update will receive an update reduced by 0.4 percentage points to 2.9 percent.) Under section 1886(b)(3)(B)(iv) of the Act, the updates to the hospital-specific amounts for sole community hospitals (SCHs) and for Medicare-dependent small rural hospitals (MDHs) are also equal to the market basket increase, or 3.3 percent.

A second significant factor that impacts changes in hospitals' payments per case from FY 2004 to FY 2005 is the change in MGCRB status from one year to the next. That is, hospitals reclassified in FY 2004 that are no longer reclassified in FY 2005 may have a negative payment impact going from FY 2004 to FY 2005; conversely, hospitals not reclassified in FY 2004 that are reclassified in FY 2005 may have a positive impact. In some cases, these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage change in payments for the category may be below the national mean. However, this effect is alleviated by section 1886(d)(10)(D)(v) of the Act, which provides that reclassifications for purposes of the wage index are for a 3-year period.

A third significant factor is that we currently estimate that actual outlier payments during FY 2004 will be 4.4 percent of total DRG payments. When the FY 2004 final rule was published, we projected FY 2004 outlier payments would be 5.1 percent of total DRG plus outlier payments; the average standardized amounts were offset correspondingly. The effects of the lower than expected outlier payments during FY 2004 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 2004 payments per case to estimated FY 2005 payments per case (with outlier payments projected to equal 5.1 percent of total DRG payments).

Fourth, as noted above, sections 402 and 502 of Public Law 108–173 establish higher DSH and IME payments, respectively. As a result, payments for these factors will be higher in FY 2005 than in FY 2004.

Fifth, section 508 of Public Law 108–173 established a one-time appeal process for hospitals to be reclassified in order to receive a higher wage index for a period of 3 years beginning with discharges on or after April 1, 2004.

B. Analysis of Table I

Table I displays the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 3,904 hospitals included in the analysis. This number is 145 fewer hospitals than were included in the impact analysis in the FY 2004 final rule (68 FR 45661). There are 94 new CAHs that were excluded from this year's analysis. The remaining 51 cases represent hospitals that have closed or hospitals for which we have no data.

The next four rows of Table I contain hospitals categorized according to their geographic location: all urban, which is further divided into large urban and other urban; and rural. We previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA or NECMA. However, under the new labor market definitions that we are proposing to adopt, we no longer employ NECMAs to define urban areas in New England. Therefore, we will now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA. There are 2,696 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,424 hospitals located in large urban areas (populations over 1 million), and 1,272 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 1,208 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions and are also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2005 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the number of hospitals paid based on these categorizations after consideration of geographic reclassifications are 2,624, 1,405, 1,219, and 1,280, respectively.

The next three groupings examine the impacts of the final changes on hospitals grouped by whether or not they have GME residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 2,787 nonteaching hospitals in our analysis, 916 teaching hospitals with fewer than 100 residents, and 201 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural for DSH purposes. Previously, hospitals in the rural DSH categories in the impact table represented hospitals that were not reclassified for purposes of the standardized amount. (However, they may have been reclassified for purposes of the wage index.) However, reclassification for purposes of the standardized amount has been terminated as a result of the equalization of the standardized amounts. As a result, there are no longer cases in which reclassifications change the status of rural hospitals for DSH purposes. There is little or no impact from the termination of standardized amount reclassification under the operating IPPS, since there are few concrete cases in which change from rural to urban status now would have any effect under the revised DSH payment formulas. The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the proposed changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and Medicare dependant hospitals (MDHs)), as well as rural hospitals not receiving a special payment designation. There were 137 RRCs, 454 SCHs, 211 MDHs, and 73 hospitals that are both SCH and RRC.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 2001 Medicare cost report files, if available (otherwise FY 2000 data are used). Data needed to determine ownership status were unavailable for 68 hospitals. Similarly, the data needed to determine Medicare utilization were unavailable for 173 hospitals. The next two rows compare the impacts on those hospitals that converted from urban MSAs to rural CBSAs and for the hospitals that converted from rural MSAs to urban CBSAs.

The next series of groupings concern the geographic reclassification status of hospitals. The first grouping displays all hospitals that were reclassified by the MGCRB for FY 2005. The next two groupings separate the hospitals in the first group by urban and rural status. The final row in Table I contains hospitals located in rural counties

but deemed to be urban under section 1886(d)(8)(B) of the Act.

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2005 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Percent Changes in Payments per Case]

	No. of hosps.[1]	DRG recal[2]	Labor share split[3]	Core based stat. areas[4]	New wage data[5]	Occupational mix[6]	DRG & wage index changes[7]	MGCRB reclassification[8]	Out-migration data[9]	All FY 2005 changes[10]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
By Geographic Location:										
All hospitals	3,904	0.1	0.5	0.0	0.0	0.0	0.0	0.0	0.0	4.9
Urban hospitals	2,696	0.0	0.5	0.1	0.0	0.0	0.0	−0.3	0.0	4.7
Large urban areas (populations over 1 million)	1,424	0.0	0.3	0.1	0.0	0.0	−0.1	−0.4	0.0	4.5
Other urban areas (populations of 1 million or fewer)	1,272	0.1	0.7	0.1	0.0	0.0	0.1	−0.2	0.1	5.0
Rural hospitals	1,208	0.2	1.1	−0.2	0.0	0.0	0.2	1.9	0.0	6.0
Bed Size (Urban):										
0–99 beds	684	0.2	0.5	0.4	0.0	0.0	0.3	−0.4	0.1	5.7
100–199 beds	966	0.1	0.5	−0.1	0.0	0.0	0.0	−0.3	0.1	4.6
200–299 beds	500	0.0	0.4	0.1	−0.2	0.0	−0.2	−0.2	0.0	4.4
300–499 beds	415	0.0	0.5	0.1	0.1	0.0	0.1	−0.3	0.0	4.8
500 or more beds	131	0.0	0.3	0.0	−0.1	0.0	−0.1	−0.4	0.0	4.9
Bed Size (Rural):										
0–49 beds	549	0.4	1.0	−0.1	0.2	0.0	0.5	0.4	0.1	6.3
50–99 beds	393	0.3	0.9	−0.2	0.1	0.0	0.3	1.0	0.1	6.1
100–149 beds	163	0.2	1.2	−0.3	0.1	0.1	0.3	2.6	0.1	6.0
150–199 beds	57	0.2	1.3	−0.3	−0.1	0.1	0.0	3.2	0.0	5.9
200 or more beds	46	0.1	1.1	−0.1	−0.1	0.0	−0.1	2.9	0.0	5.6
Urban by Region:										
New England	137	0.2	0.0	−0.4	−0.2	0.0	−0.2	−0.3	0.0	3.6
Middle Atlantic	397	0.0	0.3	0.2	−0.7	0.0	−0.8	−0.1	0.1	3.7
South Atlantic	419	0.1	0.5	0.2	0.1	0.0	0.1	−0.3	0.0	5.0
East North Central	450	0.0	0.3	0.0	0.1	0.0	0.1	−0.3	0.0	4.7
East South Central	175	0.1	1.2	0.2	0.1	0.0	0.2	−0.3	0.1	5.5
West North Central	160	0.1	0.6	0.1	0.2	0.0	0.2	−0.5	0.0	5.1
West South Central	346	0.0	0.9	0.0	0.5	0.0	0.5	−0.5	0.0	5.7
Mountain	140	0.0	0.2	0.2	−0.4	0.0	−0.4	−0.1	0.0	3.8
Pacific	421	0.1	0.0	0.1	0.1	0.0	0.2	−0.3	0.1	4.9
Puerto Rico	51	−0.4	6.2	−0.1	−0.2	0.0	−0.7	−0.5	0.0	14.3
Rural by Region:										
New England	34	0.2	0.3	0.3	0.3	0.0	0.3	1.3	0.0	3.9
Middle Atlantic	57	0.3	1.0	−0.4	−0.2	0.0	0.0	1.8	0.0	4.2
South Atlantic	176	0.2	1.1	−0.7	−0.1	0.1	0.1	2.0	0.0	5.8
East North Central	160	0.2	0.8	−0.1	0.1	0.0	0.2	1.4	0.0	4.5
East South Central	192	0.2	2.0	0.0	−0.3	0.1	−0.1	2.8	0.1	9.4
West North Central	206	0.3	0.8	−0.1	0.3	0.0	0.5	1.3	0.0	5.7
West South Central	228	0.2	1.7	0.0	0.1	0.1	0.4	3.0	0.1	7.2
Mountain	93	0.3	0.4	−0.2	0.2	0.0	0.4	0.5	0.1	4.4
Pacific	62	0.2	0.0	0.0	0.3	0.0	0.5	0.8	0.1	4.5
By Payment Classification:										
Urban hospitals	2,624	0.0	0.5	0.1	0.0	0.0	0.0	−0.3	0.0	4.7
Large urban areas (populations over 1 million)	1,405	0.0	0.3	0.1	0.0	0.0	−0.1	−0.4	0.0	4.5
Other urban areas (populations of 1 million or fewer)	1,219	0.1	0.7	0.1	0.0	0.0	0.1	−0.2	0.1	5.0
Rural areas	1,280	0.3	1.0	−0.2	0.0	0.0	0.2	1.7	0.0	5.9
Teaching Status:										
Non-teaching	2,787	0.1	0.7	0.1	0.0	0.0	0.1	0.3	0.1	5.2
Fewer than 100 Residents	916	0.0	0.5	0.1	0.1	0.0	0.0	−0.2	0.0	4.8
100 or more Residents	201	0.0	0.2	−0.1	−0.2	0.0	−0.3	−0.3	0.0	4.5
Urban DSH:										
Non-DSH	1,156	0.1	0.4	0.1	0.0	0.0	0.0	−0.1	0.0	4.7
100 or more beds	1,465	0.0	0.5	0.0	0.0	0.0	−0.1	−0.3	0.0	4.7
Less than 100 beds	335	0.3	0.7	0.9	0.0	0.0	0.4	−0.4	0.1	7.0
Rural DSH:										
Sole Community (SCH)	482	0.3	0.6	−0.1	0.1	0.0	0.3	0.4	0.0	4.9
Referral Center (RRC)	157	0.2	1.3	−0.2	−0.1	0.1	0.0	3.6	0.0	6.1
Other Rural:										
100 or more beds	68	0.3	1.7	0.2	−0.2	0.1	0.1	1.1	0.1	8.9
Less than 100 beds	241	0.4	1.8	−0.3	−0.1	0.1	0.2	1.2	0.1	10.1
Urban teaching and DSH:										
DSH	800	0.0	0.4	0.0	0.0	0.0	−0.1	−0.3	0.0	4.6
Teaching and no DSH	250	0.1	0.3	0.0	0.1	0.0	0.0	−0.3	0.1	4.8
No teaching and DSH	1,000	0.1	0.6	0.2	0.0	0.0	0.1	−0.2	0.1	5.1
No teaching and no DSH	574	0.1	0.4	0.2	−0.1	0.0	0.0	−0.3	0.0	4.6
Rural Hospital Types:										
Non special status hospitals	400	0.4	1.6	−0.1	0.0	0.1	0.3	1.1	0.1	8.6
RRC	137	0.2	1.7	−0.3	−0.1	0.1	0.0	4.6	0.0	6.4
SCH	454	0.2	0.4	−0.1	0.1	0.0	0.2	0.2	0.0	4.0
Medicare-dependent hospitals (MDH)	211	0.4	1.6	−0.2	0.3	0.1	0.6	0.9	0.1	8.1

TABLE I.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2005 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Percent Changes in Payments per Case]

	No. of hosps.[1]	DRG recal[2]	Labor share split[3]	Core based stat. areas[4]	New wage data[5]	Occupational mix[6]	DRG & wage index changes[7]	MGCRB reclassification[8]	Out-migration data[9]	All FY 2005 changes[10]
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
SCH and RRC	73	0.1	0.5	−0.2	0.1	0.0	0.1	1.4	0.0	4.5
Type of Ownership:										
Voluntary	2,343	0.1	0.5	0.1	0.0	0.0	0.0	0.0	0.0	4.7
Proprietary	717	0.0	0.7	−0.1	0.1	0.0	0.1	0.0	0.0	5.3
Government	776	0.1	0.7	0.1	−0.1	0.0	0.0	0.2	0.1	5.4
Unknown	68	−0.1	0.7	0.0	0.1	0.0	0.1	−0.5	0.0	5.1
Medicare Utilization as a Percent of Inpatient Days:										
0–25	227	−0.1	0.2	0.1	−0.1	0.0	−0.3	−0.2	0.0	4.4
25–50	1,122	0.0	0.4	0.0	0.1	0.0	0.0	−0.3	0.0	4.7
50–65	1,445	0.1	0.7	0.1	0.0	0.0	0.1	0.2	0.1	5.1
Over 65	937	0.1	0.7	0.0	−0.1	0.0	0.0	0.3	0.0	4.9
Unknown	173	0.0	0.4	0.1	−0.1	0.0	−0.2	−0.2	0.0	4.8
Rural Converted to Urban	164	0.2	1.2	3.6	−0.3	0.0	0.0	1.2	0.0	6.4
Urban Converted to Rural	69	0.2	0.7	−0.2	−0.1	0.0	0.1	0.3	0.0	4.8
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2005 Reclassifications:										
All Reclassified Hospitals	485	0.2	0.9	0.3	0.0	0.0	0.1	3.7	0.0	5.2
Nonreclassified Hospitals	3,326	0.1	0.5	0.0	0.0	0.0	0.0	−0.5	0.0	4.8
All Reclassified Urban Hospitals	118	0.1	0.6	1.1	0.0	0.0	0.0	3.8	0.0	14.3
Urban Nonreclassified Hospitals	2,486	0.0	0.4	0.0	0.0	0.0	0.0	−0.5	0.0	4.7
All Reclassified Rural Hospitals	367	0.2	1.1	−0.2	0.0	0.0	0.2	3.7	0.0	5.9
Rural Nonreclassified Hospitals	840	0.3	1.0	−0.2	0.1	0.0	0.3	−0.3	0.1	6.2
Other Reclassified Hospitals (Section 1886(D)(8)(B))	93	0.2	0.5	0.4	−0.3	0.0	−0.1	−0.3	0.0	4.4

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2003, and hospital cost report data are from reporting periods beginning in FY 2001 and FY 2000.

[2] This column displays the payment impact of the recalibration of the DRG weights based on FY 2003 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

[3] This column displays the payment impact of applying a lower labor-related share for hospitals with wage indexes less than or equal to 1.0, as required under section 403 of Public Law 108–173.

[4] This column displays the impact of the proposed adoption of the new MSAs as announced by OMB in June 2003.

[5] This column displays the impact of updating the wage index with wage data from hospitals' FY 2001 cost reports.

[6] This column displays the effects of adjusting hospitals' wage data to reflect the occupational mix based on our survey of hospitals.

[7] This column shows the payment impact of the budget neutrality adjustment factor for DRG and wage index changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 2, 3, 4 and 5, and the proposed FY 2005 budget neutrality factor of 0.994295 (the change to the labor-related share shown in column 3 is not included in the budget neutrality calculation).

[8] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2005 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2005. Reclassification for prior years has no bearing on the payment impacts shown here.

[9] This column displays the impact of the proposed implementation of section 505 of Public Law 108–173, which provides for an increase in a hospital's wage index if the hospital qualifies by meeting a threshold percentage of residents of the county where the hospital is located who commute to work at hospitals in counties with higher wage indexes.

[10] This column shows changes in payments from FY 2004 to FY 2005. It incorporates all of the changes displayed in columns 3, 7, 8 and 9 (the changes displayed in columns 2, 4, 5 and 6 are included in column 7). It also reflects the impact of the FY 2005 update, changes in hospitals' reclassification status in FY 2005 compared to FY 2004, and the changes in payments as a result of implementing Section 508 of the MMA. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effect.

C. Impact of the Proposed Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 2)

In column 2 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II. of the preamble to this proposed rule. Section 1886(d)(4)(C)(i) of the Act requires us annually to make appropriate classification changes and to recalibrate the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

We compared aggregate payments using the FY 2004 DRG relative weights (GROUPER version 21.0) to aggregate payments using the proposed FY 2005 DRG relative weights (GROUPER version 22.0). We note that, consistent with section 1886(d)(4)(C)(iii) of the Act, we have applied a budget neutrality factor to ensure that the overall payment impact of the DRG changes (combined with the wage index changes) is budget neutral. This proposed budget neutrality factor of 0.994295 is applied to payments in Column 7. Because this is a combined DRG reclassification and recalibration and wage index budget neutrality factor, it is not applied to payments in this column.

The major DRG classification changes we are proposing include: reassigning the procedure code for left ventricular assist devices (LVADs) from DRG 525 to DRG 103 (now titled ''Heart Transplant or Implant of Heart Assist System''); reassigning the procedure codes involving artificial anal sphincters from DRGs 157 and 158 to DRGs 146 (Rectal Resection With CC) and 147 (Rectal Resection Without CC); modifying the ventilation by reassigning all those cases to DRGs 504 and 505; splitting the DRG 483 into two new DRGs based on the presence or absence of major OR procedures, DRG 541 (Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses With Major Operating Room Procedure) and 542 (Tracheostomy with Mechanical Ventilation 96+ Hours or Principal Diagnosis Except Face, Mouth and Neck Diagnoses Without Major Operating Room Procedure). In the aggregate, these proposed changes would result in 0.1 percent change in overall payments to hospitals. On average, the impacts of these changes on any particular hospital group are very small. The largest impact is a 0.2 percent increase among rural hospitals. This is likely primarily attributable to a 1.46 percent increase in DRG 127 (Heart Failure and Shock). This high-volume DRG comprises a disproportionate percentage of cases in small rural hospitals. Ten Puerto Rico hospitals also experience case mix declines of greater than 1 percent in this

column, leading to a 0.4 percent decrease overall for this row.

D. Impact of the Change in the Labor-Related Share

Section 403 of the MMA provides that, for discharges occurring on or after October 1, 2004, a hospital's labor-related share of the standardized amount will be decreased to 62 percent of the standardized amount unless such a change will result in lower total payments to the hospital. This provision also applies to the labor-related share of the standardized amount for hospitals in Puerto Rico. The overall impact of implementing this provision is a 0.5 percent payment increase to all hospitals (approximately $500 million). Large urban hospitals would experience a 0.3 percent increase while other urban hospitals would experience a 0.7 percent increase. Rural hospitals are expected to benefit from this provision with a 1.1 percent increase in payments in FY 2005.

Among regions, hospitals in Puerto Rico experience the largest increase of 6.2 percent (due to the relatively low national wage index levels in Puerto Rico). The smallest change among urban hospitals is in the New England and Pacific regions with a 0.0 percent change. The largest increase among rural regions is expected to be East South Central, with a 2.0 percent increase in payments.

E. Impact of Changing to New Labor Market Areas (Core Based Statistical Areas) From MSAs (Column 4)

In accordance with the broad discretion under section 1886(d)(3)(E) of the Act, we currently define hospital labor market areas based on the definitions of Metropolitan Statistical Areas (MSAs), Primary MSAs (PMSAs), and New England County Metropolitan Areas (NECMAs) issued by OMB. On June 6, 2003, OMB announced new Core Based Statistical Areas (CBSAs), comprised of MSAs and the new Micropolitan Statistical Areas based on Census 2000 data. CMS is proposing to adopt the new MSA definitions, including the 49 new Metropolitan areas designated under the new definitions. We are also proposing to adopt MSA definitions in New England in place of NECMAs. We are not adopting the newly defined Micropolitan Statistical Areas for use in the payment system: as a result, Micropolitan Statistical Areas will remain part of the statewide rural areas for purposes of IPPS payments. (However, as discussed in section III.B.1.d. of the preamble to this proposed rule, we are proposing a special transition policy for hospitals that were formerly in urban areas, but are now in areas considered rural or Micropolitan under the OMB definitions.) There are 46 counties with 72 hospitals that are currently in an MSA that would be treated as rural under our proposal to update the MSA definitions using only the new MSAs. To help alleviate the decreased payments for currently urban hospitals that would become rural, we are proposing to allow them to maintain their assignment to the MSA where they are currently located for the 3-year period including FY 2005, FY 2006, and FY 2007.

The impact of these changes to the new CBSAs is isolated in column 4 by holding the other payment parameters constant in this simulation. That is, column 4 shows the percentage changes in payments when going from a model using the current MSA designations to a model using the new CBSA designations (for Metropolitan areas only). Overall, the new CBSAs would lead to a zero percent change. Urban hospitals' wage indexes would increase by 0.1 percent. Rural hospitals would experience a 0.2 percent decrease in overall payments as a result of this provision. Among regions, the largest impact of updating the wage data is seen in the rural South Atlantic region (a 0.7 percent decrease). Rural hospitals in the Middle Atlantic would experience the next largest impact, with a 0.4 percent decrease.

Among urban hospitals, New England would experience a 0.4 percent decrease. These impacts result primarily from dividing the previously amalgamated Boston NECMA into four Metropolitan Divisions and several other small Metropolitan Statistical Areas. The counties that previously comprised the Boston MSA now form all or part of the Boston-Quincy, MA Metropolitan Division, the Cambridge-Newton-Framingham, MA Metropolitan Division, the Essex County, MA Metropolitan Division, the Rockingham County-Strafford County Metropolitan Division, the Manchester-Nashua Metropolitan Statistical Area, the Providence-New Bedford-Fall River, RI-MA Metropolitan Statistical Area, and the Worcester, MA Metropolitan Statistical Area. The Rockingham County-Strafford County Metropolitan Division, Manchester-Nashua MSA, and Boston-Quincy Metropolitan Division experience 9.4, 6.9, and 5.7 percent decreases, respectively.

As described in section III of the preamble to this proposed rule, to help alleviate the decreased payments for currently urban hospitals that would become rural, we are proposing to allow them to maintain their assignment to the MSA where they are currently located for the 3-year period including FY 2005, FY 2006, and FY 2007. The impact upon these hospitals is shown in the row labeled ''Urban to Rural Hospitals.'' Conversely, the row labeled ''Rural to Urban Hospitals'' displays formerly rural hospitals that are now in MSAs under the new definitions.

F. Impact of Proposed Wage Index Changes (Columns 5 and 6)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the proposed wage index for FY 2005 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001. The impact of the new data on hospital payments is isolated in column 5 by holding the other payment parameters constant in this simulation. That is, column 5 shows the percentage changes in payments when going from a model using the FY 2004 wage index, based on FY 2000 wage data, to a model using the FY 2005 pre-reclassification wage index, based on FY 2001 wage data. The wage data collected on the FY 2001 cost report is the same as the FY 2000 wage data that were used to calculate the FY 2004 wage index. However, for the FY 2005 wage index, we added an occupational mix adjustment to the wage index. The occupational mix adjustment is based on data collected on the Medicare Wage Index Occupational Mix Survey, Form–CMS–10079. The data collection period for the survey was calendar year 2003 through February 7, 2004. The effects of the occupational mix adjustment are shown in the next column (6).

Column 5 shows the impacts of updating the wage data using FY 2001 cost reports. Overall, the new wage data would lead to a 0.0 percent change. Urban hospitals' wage indexes would not change (0.0 percent), and rural hospitals' wage indexes would also remain the same (0.0 percent). Among regions, the largest declines from updating the wage data are seen in urban Middle Atlantic and Mountain regions (a 0.7 and 0.4 percent decreases, respectively). In the Middle Atlantic, there are 352 hospitals (New York, Pennsylvania, and New Jersey) that are experiencing a drop in their wage index relative to last year with the introduction of the new wage data. Kingston, NY experiences a drop of 5.8 percent, while Buffalo sees a 2.8 percent drop. Additionally, two of the areas are divisions of New York City, including the Manhattan area (New York-Wayne-White Plains, NY) and Suffolk-Nassau, NY. While these areas do not necessarily experience a significant drop (2.5 and 1.5 percent), they include a large number of inpatient hospitals. Pittsburgh, PA, Rochester, NY, and Allentown, PA also see decreases due to this change. We note that this is due to below average increases in their average hourly wage and not as a result of real average hourly wage declines. Urban hospitals in the West South Central region would experience the next largest impact, with a 0.5 percent increase. The rural East South Central and Middle Atlantic regions experience 0.3 and 0.2 percent decreases, respectively while the Pacific, West South Central, and New England regions each experience a 0.3 percent increase.

The national average hourly wage increased 6.41 percent compared to FY 2004. Therefore, the only manner in which to maintain or exceed the previous year's wage index was to match the national 6.41 increase in average hourly wage. Of the 3,887 hospitals with wage index values in both FYs 2004 and 2005, 1,937, or 49.8 percent, also experienced an average hourly wage increase of 6.41 percent or more.

The following chart compares the shifts in wage index values for hospitals for FY 2005 relative to FY 2004. Among urban hospitals, 89 would experience an increase of between 5 percent and 10 percent and 45 would experience an increase of more than 10 percent. A total of 7 rural hospitals would experience increases greater than 5 percent, but none would experience increases of greater than 10 percent. On the negative side, 36 urban hospitals would experience decreases in their wage index values of at least 5 percent, but less than 10 percent. Two urban hospitals would experience decreases in their wage index values greater than 10 percent.

The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	No. of hospitals	
	Urban	Rural.
Increase more than 10 percent	45	0.
Increase more than 5 percent and less than 10 percent	89	7.
Increase or decrease less than 5 percent	2,625	1,609.
Decrease more than 5 percent and less than 10 percent	36	0.
Decrease more than 10 percent	2	1

The next column (6) shows the impacts on the calculation of the FY 2005 wage index of adjusting for occupational mix. Section 1886(d)(3)(E) of the Act provides for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index, beginning with the FY 2005 wage index. A complete discussion of the initial collection of these data and the occupational mix adjustment that we are proposing to apply, beginning October 1, 2004 (the FY 2005 wage index), appears under section III.C. of this preamble. The calculation of the wage index now includes a blended rate of 90 percent of an unadjusted wage index and 10 percent of a wage index adjusted for occupational mix. We project an overall change increase of 0.0 percent for all hospitals. The biggest change is in the rural urban hospitals in the South Atlantic, East South Central, and West South Central regions, which are projected to experience a 0.1 percent increase for FY 2005.

G. Combined Impact of Proposed DRG and Wage Index Changes, Including Budget Neutrality Adjustment (Column 7)

The impact of the DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this proposed rule, we compared simulated aggregate payments using the FY 2004 DRG relative weights and wage index to simulated aggregate payments using the proposed FY 2005 DRG relative weights and blended wage index.

We computed a proposed wage and recalibration budget neutrality factor of 0.994295. The 0.0 percent impact for all hospitals demonstrates that these proposed changes, in combination with the budget neutrality factor, are budget neutral. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index are shown in column 7. The proposed changes in this column are the sum of the final changes in columns 2, 5, and 6 combined with the budget neutrality factor and the wage index floor for urban areas required by section 4410 of Pub. L. 105–33, to be budget neutral (the change to the labor share in column 3 is not subject to budget neutrality. There also may be some variation of plus or minus 0.1 percentage point due to rounding.

Among urban regions, the largest impacts are in the Middle Atlantic and Puerto Rico, with 0.8 and 0.7 percent declines, respectively. The West South Central region experiences the largest increase of 0.5 percent. Among rural regions, the West North Central and Pacific regions benefit the most with 0.5 percent increases, while East South Central is the only region to experience a decline (0.1 percent).

H. Impact of MGCRB Reclassifications (Column 8)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 8 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2005. These decisions affect hospitals' standardized amount and wage index area assignments.

By February 28 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. The MGCRB may approve a hospital's reclassification request for the purpose of using another area's wage index value. The proposed FY 2005 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2005. The wage index values also reflect any decisions made by the CMS Administrator through the appeals and review process through February 28, 2004. Additional changes that result from the Administrator's review of MGCRB decisions or a request by a hospital to withdraw its application will be reflected in the final rule for FY 2005.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, we applied an adjustment of 0.994295 to ensure that the effects of reclassification are budget neutral. (*See* section II.A.4.b. of the Addendum to this proposed rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments would rise 1.9 percent in column 8. Payments to urban hospitals would decline 0.3 percent. Hospitals in other urban areas would experience an overall decrease in payments of 0.2 percent, while large urban hospitals would also lose 0.4 percent. Among urban hospital groups (that is, bed size, census division, and special payment status), payments generally would decline.

A positive impact is evident among most of the rural hospital groups. The smallest increases among the rural census divisions are 0.5 percent in the Mountain region and 1.3 percent each for the New England and West North Central regions. The largest increases are in the rural East South Central region, with an increase of 2.8 percent and in the West South Central region that would experience an increase of 3.0 percent.

Among all the hospitals that were reclassified for FY 2005 (including hospitals that received wage index reclassifications in FY 2003 or FY 2004 that extend for 3 years), the MGCRB changes are estimated to provide a 3.7 percent increase in payments. Urban hospitals reclassified for FY 2005 are expected to receive an increase of 3.8 percent, while rural reclassified hospitals are expected to benefit from the MGCRB changes with a 3.7 percent increase in payments. Payments to urban and rural hospitals that did not reclassify are expected to decrease slightly due to the MGCRB changes, decreasing by 0.5 percent for urban hospitals and 0.3 percent for rural hospitals.

I. Impacts of Implementing the Wage Index Adjustment for Out-Migration (Column 9)

Section 505 of Public Law 108–173 established new section 1886(d)(13) of the Act. Section 1886(d)(13) requires that the Secretary establish a new process to make adjustments to the hospital wage index based on commuting patterns of hospital employees. The process provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different area with a higher wage index. Hospitals located in counties that qualify for the payment adjustment would receive an increase in the wage index that is equal to a weighted average of the difference between the wage index of the resident county and the higher wage index work area(s) weighted by the overall percentage of workers who are employed in an area with a higher wage index. Using our proposed criteria, 224 counties and 411 hospitals qualify to receive a commuting adjustment.

Due to the statutory formula to calculate the adjustment and the small number of counties that qualify, the impact on hospitals would be minimal, with an overall impact on all hospitals of 0.0 percent. However, some regions would experience a discernible impact. For example, urban hospitals in the Middle Atlantic region would experience a 0.1 percent increase due to this provision. This is due in part to the fact that a hospital in that region would experience the largest increase for any hospital under this provision. A hospital located in Ulster County, New York would receive an increase in its wage index value of 0.1014. Hospital employees living in Ulster County commute to Albany, Columbia, Dutchess, Greene, New York, Orange, Rockland, Sullivan, and Westchester counties. Dutchess, New York, Orange, Rockland and Westchester counties are located in higher wage index areas. Thus, for FY 2005, this hospital's wage index would increase from 0.8874 to 0.9888.

J. All Changes (Column 10)

Column 10 compares our estimate of payments per case, incorporating all changes reflected in this proposed rule for FY 2005 (including statutory changes), to our estimate of payments per case in FY 2004. This

column includes all of the proposed policy changes. Because the reclassifications shown in column 8 do not reflect FY 2004 reclassifications, the impacts of FY 2005 reclassifications only affect the impacts from FY 2004 to FY 2005 if the reclassification impacts for any group of hospitals are different in FY 2005 compared to FY 2004.

Column 10 reflects all FY 2005 changes relative to FY 2004, shown in columns 2 through 9 and those not applied until the final rates are calculated. The average increase for all hospitals is approximately 4.9 percent. This increase includes the effects of the 3.3 percent market basket update. It also reflects the 0.7 percentage point difference between the projected outlier payments in FY 2004 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2004 (4.4 percent), as described in the introduction to this Appendix and the Addendum to this proposed rule. As a result, payments are projected to be 0.7 percent lower in FY 2004 than originally estimated resulting in a 0.7 percent higher increase for FY 2005 than would otherwise occur. It also includes the impact of adjusting the labor share, shown in column 3, of approximately 0.5 percent. The remaining 0.4 percent increase is attributable to the indirect medical education formula changes for teaching hospitals; changes in payments due to the wage reclassifications under section 508 of the MMA, in effect for the whole year; and increased payments to Puerto Rico hospitals as a result of section 504 of the MMA, which changed the mix of the Federal standardized amount and the Puerto Rico-specific standardized amount. The overall increase also reflects changes to payments that resulted from implementing other changes as required by Public Law 108–173. These changes are discussed in other rules and in many sections of the preamble to this proposed rule.

Section 213 of Public Law 106–554 provides that all SCHs may receive payment on the basis of their costs per case during their cost reporting period that began during 1996. For FY 2005, eligible SCHs receive 100 percent of their 1996 hospital-specific rate. The impact of this provision is modeled in column 10 as well. Additionally, section 402 of Public Law 108–173 increases the disproportionate share hospital (DSH) adjustment for certain hospitals that serve a disproportionate share of low-income Medicare and Medicaid patients, which includes rural hospitals and urban hospitals with fewer than 100 beds, sole community hospitals, rural referral centers, and rural hospitals with less than 500 beds. The increase in DSH payments became effective for discharges occurring on or after April 1, 2004. As provided in the new Medicare law, the cap on DSH payment adjustments increase from 5.25 percent to 12 percent for urban hospitals fewer than 100 beds, sole community hospitals, and rural hospitals with less than 500 beds. There is no cap on rural referral centers, large urban hospitals over 100 beds, or rural hospitals over 500 beds.

We are no longer required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. However, we are still providing an estimate of the payment increases here, as they will have a significant impact on total payments made in FY 2005. As discussed in section II.E. of the preamble of this proposed rule, we are proposing to maintain the new technology status of the InFUSE™ Bone Graft/LT-CAGE™ Lumbar Tapered Fusion Device for spinal fusions. We estimate the total add-on payments associated with cases involving this new device for FY 2005 would be $4.7 million. In addition, several other technologies may receive approval if we receive appropriate supplemental data from the applicants (as discussed in the preamble) and after public comments are taken into consideration for approval or denial of the technologies for FY 2005. If we receive the necessary supplemental data for all of the devices that could be approved were to be approved, the total estimated increase in payments for FY 2005 could be $369 million.

There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 10 may not equal the sum of the changes described above.

The overall change in payments per case for hospitals in FY 2005 would increase by 4.9 percent. Hospitals in urban areas would experience a 4.7 percent increase in payments per case compared to FY 2004. Hospitals in rural areas, meanwhile, would experience a 6.0 percent payment increase. Hospitals in large urban areas would experience a 4.5 percent increase in payments and hospitals in other urban areas would experience a 5.0 percent increase in payments.

Among urban census divisions, the largest payment increase would be 14.3 percent in Puerto Rico. This is due largely to the change in calculation of their payment rate to 75 percent of the National amount and the increase to the standardized amount to large urban hospitals. Additionally, the change to CBSAs makes all hospitals in Puerto Rico classify as urban hospitals instead of rural. (Because of these changes, we have deleted from Table I, the column included in prior years that shows the impacts on rural Puerto Rico hospitals.) Hospitals in the urban East South Central and West South Central regions would experience overall increases of 5.5 percent and 5.7 percent, respectively. The smallest increase would occur in the New England region, with an increase of 3.6 percent.

Among rural regions in column 10, no hospital category would experience overall payment decreases. The East South Central and West South Central regions would benefit the most, with 9.4 and 7.2 percent increases, respectively. The smallest increase would occur in the New England region, with 3.9 percent increases in payments.

Among special categories of rural hospitals in column 10, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) would experience payment increases of 4.0 percent, 8.1 percent, and 4.5 percent, respectively. This outcome is primarily related to the fact that, for hospitals receiving payments under the hospital-specific methodology, there were several increases to payments made in relation to implementation of the Public Law 108–173.

Hospitals that were reclassified for FY 2005 are estimated to receive a 5.2 percent increase in payments. Urban hospitals reclassified for FY 2005 are anticipated to receive an increase of 4.3 percent, while rural reclassified hospitals are expected to benefit from reclassification with a 5.9 percent increase in payments. Those hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act are expected to receive an increase in payments of 4.4 percent.

TABLE II.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2005 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per Case]

	Number of hospitals	Average FY 2004 payment per case [1]	Average FY 2005 payment per case [1]	All FY 2005 changes
	(1)	(2)	(3)	(4).
By Geographic Location:.				
All hospitals	3,904	7812	8193	4.9.
Urban hospitals	2,696	8121	8504	4.7.
Large urban areas (populations over 1 million)	1,424	8513	8896	4.5.
Other urban areas (populations of 1 million of fewer)	1,272	7684	8067	5.0.
Rural hospitals	1,208	6110	6475	6.0.
Bed Size (Urban):.				
0–99 beds	684	5812	6142	5.7.
100–199 beds	966	6914	7233	4.6.

TABLE II.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2005 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per Case]

	Number of hospitals	Average FY 2004 payment per case [1]	Average FY 2005 payment per case [1]	All FY 2005 changes
	(1)	(2)	(3)	(4).
200–299 beds	500	7967	8316	4.4.
300–499 beds	415	8839	9266	4.8.
500 or more beds	131	10221	10718	4.9.
Bed Size (Rural):.				
0–49 beds	549	5199	5527	6.3.
50–99 beds	393	5751	6100	6.1.
100–149 beds	163	6048	6412	6.0.
150–199 beds	57	6636	7027	5.9.
200 or more beds	46	7837	8275	5.6.
Urban by Region:.				
New England	137	8688	8997	3.6.
Middle Atlantic	397	8809	9136	3.7.
South Atlantic	419	7762	8147	5.0.
East North Central	450	7830	8195	4.7.
East South Central	175	7482	7896	5.5.
West North Central	160	8008	8416	5.1.
West South Central	346	7632	8063	5.7.
Mountain	140	8066	8376	3.8.
Pacific	421	9612	10080	4.9.
Puerto Rico	51	3525	4028	14.3.
Rural by Region:.				
New England	34	8037	8354	3.9.
Middle Atlantic	57	6138	6398	4.2.
South Atlantic	176	6087	6439	5.8.
East North Central	160	5998	6266	4.5.
East South Central	192	5241	5735	9.4.
West North Central	206	6514	6883	5.7.
West South Central	228	5514	5913	7.2.
Mountain	93	6918	7219	4.4.
Pacific	62	8934	9336	4.5.
By Payment Classification:.				
Urban hospitals	2,624	8148	8533	4.7.
Large urban areas (populations over 1 million)	1,405	8530	8915	4.5.
Other urban areas (populations of 1 million of fewer)	1,219	7716	8101	5.0.
Rural areas	1,280	6104	6462	5.9.
Teaching Status:.				
Non-teaching	2,787	6542	6880	5.2.
Fewer than 100 Residents	916	8172	8561	4.8.
100 or more Residents	201	12131	12672	4.5.
Urban DSH:.				
Non-DSH	1,156	7020	7347	4.7.
100 or more beds	1,465	8695	9101	4.7.
Less than 100 beds	335	5540	5927	7.0.
Rural DSH:	482	6592	6914	4.9.
Sole Community (SCH)..				
Referral Center (RRC)	157	6735	7147	6.1.
Other Rural:.				
100 or more beds	68	5131	5588	8.9.
Less than 100 beds	241	4483	4937	10.1.
Urban teaching and DSH:	800	9558	9997	4.6.
Both teaching and DSH..				
Teaching and no DSH	250	8015	8399	4.8.
No teaching and DSH	1,000	6963	7315	5.1.
No teaching and no DSH	574	6512	6810	4.6.
Rural Hospital Types:.				
Non special status hospitals	400	4754	5163	8.6.
RRC	137	6179	6572	6.4.
SCH	454	7181	7467	4.0.
Medicare-dependent hospitals (MDH)	211	4434	4792	8.1.
SCH and RRC	73	7676	8019	4.5.
Type of Ownership:.				
Voluntary	2,343	7926	8298	4.7.
Proprietary	717	7125	7503	5.3.
Government	776	7958	8385	5.4.
Unknown	68	7853	8256	5.1.

TABLE II.—IMPACT ANALYSIS OF PROPOSED CHANGES FOR FY 2005 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per Case]

	Number of hospitals (1)	Average FY 2004 payment per case [1] (2)	Average FY 2005 payment per case [1] (3)	All FY 2005 changes (4).
Medicare Utilization as a Percent of Inpatient Days:.				
0–25	227	10405	10866	4.4.
25–50	1,122	8578	8985	4.7.
50–65	1,445	6956	7307	5.1.
Over 65	937	6900	7240	4.9.
Unknown	173	9887	10358	4.8.
Rural Converted to Urban	164	6473	6888	6.4.
Urban Converted to Rural	69	6097	6387	4.8.
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2005 Reclassifications:.				
All Reclassified Hospitals	485	7316	7699	5.2.
All Nonreclassified Hospitals	3,326	7909	8291	4.8.
All Reclassified Urban Hospitals	118	8258	8612	4.3.
Urban Nonreclassified Hospitals	2,486	8151	8538	4.7.
All Reclassified Rural Hospitals	367	6816	7215	5.9.
Rural Nonreclassified Hospitals	840	5402	5734	6.2.
Other Reclassified Hospitals (Section 1886(d)(8)(B))	93	5971	6237	4.4

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

Table II presents the projected impact of the proposed changes for FY 2005 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated payments per case for FY 2004 with the average estimated per case payments for FY 2005, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from column 10 of Table I.

VII. Impact of Other Proposed Policy Changes

In addition to those proposed changes discussed above that we are able to model using our IPPS payment simulation model, we are proposing various other changes in this proposed rule. Generally, we have limited or no specific data available with which to estimate the impacts of these proposed changes. Our estimates of the likely impacts associated with these other proposed changes are discussed below.

A. Impact of Proposed Change to Postacute Care Transfer Payment Policy

Existing regulations at § 412.4(b) define transfers from one acute care hospital to another, and § 412.4(c) defines transfers to certain postacute care providers. The per diem rate paid to a transferring hospital is calculated by dividing the full DRG payment by the geometric mean length of stay for the DRG. The transferring hospital receives a per diem payment for cases that are transferred prior to the geometric mean length of stay for the DRG (§ 412.4(f)(1)). Under section IV.A. of the preamble of this proposed rule, we discuss our proposal to provide alternate criteria for determining which DRGs are included within the scope of the postacute care transfer policy. The occasion for this proposed revision is our decision to delete DRG 483, and to assign the cases that previously were included within DRG 483 to two new DRGs, 541 and 542. As a result of these proposed revised criteria, three additional DRGs would fall within the scope of the policy. These are the two proposed new DRGs, 541 and 542, along with DRG 430. We estimate that the net effect of these proposed changes will be to reduce Medicare program payments by approximately $25 million per year. The proposed change is entirely due to the effect of adding DRG 430 to the policy. The proposed inclusion of proposed new DRGs 541 and 542 will have no effect on payments, because all of the cases included within those proposed DRGs were previously included within DRG 483 and, thus, already fall within the policy.

B. Impact of Proposed LTC-DRG Reclassifications and Relative Weights for LTCHs

In section II.D. of the preamble of this proposed rule, we discuss the proposed changes in the LTC-DRG relative weights for FY 2005 on the proposed version 22.0 of the CMS GROUPER. We estimate that the proposed changes would result in an aggregate decrease in LTCH payments of approximately a $55 million based on LTCH cases in the FY 2003 MedPAR file. As we discuss in further detail in the 2005 LTCH PPS rate year final rule published on May 7, 2004, based on an analysis of LTCH claims data in the FY 2003 MedPAR file. We have found that the average LTC-DRG relative weight has increased due to an increase of cases being assigned to LTC-DRGs with higher relative weights. This increase may be attributable to a number of factors, including improvements in coding practices, which are typically found when moving from a reasonable cost-based payment system to a PPS. The impact of including cases with relatively lower charges into LTC-DRGs that have a relatively higher relative weight in the GROUPER version 21.0 (FY 2004) is a decrease in the average relative weight for those LTC-DRGs in proposed GROUPER version 22.0. We believe that the proposed changes in the LTC-DRG relative weights, which include a number of proposed LTC-DRGs with lower proposed relative weights, would result in a slight decrease in LTCH PPS payments.

C. Impact of Proposed Policy on Payments for Inpatient Care in Providers That Change Classification Status During a Patient Stay

In section IV.B. of the preamble to this proposed rule, we discuss our proposal to change our policy to preclude making more than one payment under Medicare for cases in which a Medicare provider changes its Medicare payment classification during a patient's stay. Although this situation may occur in other settings, this payment issue is most prevalent for services furnished to cross-over patients in a newly established LTCH. Currently, when this situation arises, Medicare makes two payments for what is essentially only one beneficiary episode of care, one under the IPPS and one under the LTCH PPS. The intent of this proposed policy is to eliminate the Medicare payments for the single episode of care of such patients. While we believe that this proposed policy may generate savings for the Medicare program, we do not have readily available data to precisely estimate the effect of this proposed change. Because these proposed revisions would only affect new hospitals, we are unable to estimate the number of hospitals that would be affected. Furthermore, we cannot estimate the specific

DRGs that would be affected at those hospitals.

D. Impact on Proposed Policy Reporting of Hospital Quality Data for Annual Hospital Payment Update

In section IV.E. of the preamble to this proposed rule, we discuss the implementation of section 501(a) of Public Law 108–173, which provides that, the update factor for the operating payments for FY 2005 and subsequent fiscal years is the market basket percentage increase. Section 501(b) also provides that, for FYs 2005 through 2007, the update factor will be the market basket percentage increase minus 0.4 percentage points for any hospital that does not submit quality data as specified in the law. We are unable to precisely estimate the effect of this provision because, while receiving the full update for those years is conditional upon the submission of quality data by a hospital, submission of the data is not mandated unconditionally. Furthermore, hospitals will not begin to submit the quality data until very late in the process of developing the final rule for FY 2005. The Congressional Budget Office, in its analysis of Public Law 108–173, assumed that a significant number of hospitals would not provide the data required for a full payment update, and therefore estimated savings to the Medicare program of approximately $100 million per year. However, there has been a steady increase in the number of hospitals that are voluntarily submitting the specified quality data under the National Voluntary Hospital Reporting Initiative. We have also made efforts to ensure that QIOs provide assistance to all hospitals that wish to submit data. Therefore, we believe that a high proportion of hospitals will respond to the incentive provided by section 501(b) and submit quality data in order to receive the full update. For purposes of this proposed rule, we are assuming that no appreciable savings will result from this provision.

E. Impact of Proposed Policy on Threshold Criteria for Add-On Payments for New Technology and Medical Services

In section IV.H. of the preamble of this proposed rule, we discuss our proposal to revise the threshold amount for determining whether a new technology or medical service is an appropriate candidate for an add-on payment if it is inadequately paid otherwise under the DRG system. Furthermore, we are no longer required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. However, these payments will have a significant impact on total payments made in FY 2005. As discussed in section II.E. of the preamble of this proposed rule, we are proposing to maintain the new technology status of the INFUSE™ Bone Graft/LT-CAGE™ Lumbar Tapered Fusion Device for spinal fusions. We estimate the total add-on payments associated with cases involving this new device for FY 2005 would be $4.7 million. In addition, several other technologies may receive approval if we receive appropriate supplemental data from the applicants (as discussed in the preamble) and other interested parties. Therefore, if we approve all the devices that may warrant approval, the total estimated increase in payments for FY 2005 could be $369 million.

F. Impact of Proposed Policy on Additional Payments to Hospitals With High Percentage of End-Stage Renal Disease Discharge

In section IV.J. of the preamble of this proposed rule, we discuss our proposal to revise our regulations to state that, in determining whether a hospital qualifies for additional Medicare payments for hospitals with high percentages of ESRD discharges, only discharges involving ESRD Medicare beneficiaries who have received a dialysis treatment during an inpatient hospital stay are to be counted.

This proposed revision to the policy would reduce the number of hospitals that will qualify for this additional payment. Specifically, discharges of Medicare ESRD beneficiaries who have not received dialysis treatment during the course of their hospital stays will no longer be counted in determining whether hospitals meet the threshold for receiving this additional payment. Some hospitals that have previously qualified for this extra payment would not qualify under this proposed revised policy. Therefore, the effect of this change would be a reduction in Medicare program expenditures. However, we are unable to quantify the level of program savings because we lack data on the proportion of the discharges previously counted toward the threshold determination under this provision that involved Medicare ESRD beneficiaries who did not receive dialysis services during their hospital stays. Overall program expenditures under this provision have been approximately $15 million annually to approximately 41 hospitals. We estimate that, the savings due to this policy change will only be some proportion of that figure since some portion of these hospitals, which currently qualify for the adjustment, will no longer qualify for these payments under the revised criteria.

G. Impact of Proposed Policy on Payment Adjustments for Low-Volume Hospitals

In section IV.M. of the preamble of this proposed rule, we discuss our proposal to implement section 406 of Public Law 108–173, which provides for a new payment adjustment to account for the higher costs per discharge of low-volume hospitals under the IPPS.

Based on the empirical analysis, we are limiting the adjustment to hospitals with 500 or fewer discharges. It is difficult to estimate precisely the impact of this provision. While there were approximately 400 hospitals with 500 or fewer total discharges in the most recent year for which we have data, many of these hospitals may qualify for CAH status under the revised bed count threshold (under section 405(e) of Pub. L. 108–173). Furthermore, we have not yet determined which hospitals satisfy the requirement that the hospital be located more than 25 road miles from another subsection (d) hospital. We are proposing to require that a hospital that wishes to qualify for the adjustment must provide its fiscal intermediary with evidence that it meets this distance requirement. Until intermediaries are able to make these determinations, we are unable to determine how many hospitals qualify for the adjustment.

However, the aggregate impact of this provision is likely to be relatively small. Hospitals with fewer than 500 total discharges in a year are likely to have correspondingly few Medicare discharges, perhaps 200 Medicare discharges or fewer. The largest percentage adjustments under the proposed formula that we have developed would be realized by the smallest hospitals. For example, a hospital with 50 total discharges will receive an adjustment on each Medicare discharge (probably 20 to 25 Medicare discharges annually) of 22.5 percent. A hospital with 499 total discharges would receive an adjustment of only 0.05 percent on each Medicare discharge. The Congressional Budget Office's estimated that this provision would increase Medicare program expenditures by less than $50 million annually. In the absence of a more precise estimate for the reasons indicated above, we agree with the Congressional Budget Office's determination.

H. Impact of Proposed Policy on MGCRB Hospital Reclassifications

Sections 1886(d)(2)(D) and (d)(3) of the Act previously required the Secretary to compute two average standardized amounts for discharges occurring in a fiscal year: one for hospitals located in large urban areas and one for hospitals located in other areas. In addition, under sections 1886(d)(9)(B)(iii) and (d)(9)(C)(i) of the Act, the average standardized amount per discharge was determined for hospitals located in large urban and other areas in Puerto Rico. In accordance with section 1886(b)(3)(B)(i) of the Act, the large urban average standardized amount was 1.6 percent higher than the other area average standardized amount.

Section 402(b) of Public Law 108–7 required that, effective for discharges occurring on or after April 1, 2003, and before October 1, 2003, the Federal rate for all IPPS hospitals would be based on the large urban standardized amount. Subsequently, Public Law 108–89, extended section 402(b) of Public Law 108–7 beginning with fiscal year 2004 and thereafter, and equal standardized amount is to be computed for all hospitals at the level computed for large urban hospitals during FY 2003, updated by the applicable percentage update. This provision in effect makes permanent the equalization of the standardized amounts at the level of the previous standardized amount for large urban hospitals. As a result of this legislative change, the standardized amount reclassification criterion is no longer necessary or appropriate. Therefore, as discussed in section IV.N. of this proposed rule, we are proposing to remove all standardize amount criteria provisions from the regulations governing geographic reclassification. Specifically, we are proposing to remove the provisions that contain the criterion requiring individual hospitals and urban hospital groups to demonstrate that their costs are more comparable to the average amount they would be paid if they were reclassified than

the amount they would be paid if they were reclassified than the amount they would be paid under their current classification.

In conjunction with this change, we are proposing under the Secretary's general authority to make exceptions that any hospital whose urban county group application under § 412.234 would have been approved by the MGCRB for FY 2004 and FY 2005, but for the failure to meet the requirements in § 412.234(c), will be assigned the wage index for the MSA identified in the FY 2004 and FY 2005 group application (in cases where the group identified more than one preference, the hospital will be assigned the wage index that is most advantageous).

For our proposal to remove all standardized amount criteria provisions from the regulations, we are unable to quantify the impact of this change precisely. The deletion of the standardized amount criterion may allow more hospital group applications to qualify for reclassification. However, we cannot determine how many groups would be affected by this change, and, of those, how many groups would actually organize to apply under the revised standard. This change would not affect the aggregate level of Medicare expenditures since reclassification decisions are budget neutral under section 1886(d)(8)(B) of the Act. However, the exercise of the Secretary's exception authority to assign a new wage index to certain hospitals that failed to be approved for reclassification in FY 2004 and FY 2005 is not budget neutral. Our review of the group reclassification applications for those years indicates that only a very small number of hospitals would qualify for a new wage index assignment under this proposed exception. While we are unable to be certain about the exact number of hospitals that would qualify, we believe that the aggregate impact on program payments would be in the range of $10 million to $20 million annually for the three years during which this exception would be in place.

In addition, we are unable to quantify the precise impact of the proposed change precisely to the average hourly wage threshold for rural referral centers. Only a limited number of rural referral centers are actually located in urban areas. Effective October 1, 2000, if a hospital located in what is now an urban area was ever a rural referral center, it is reinstated to rural referral center status (65 FR 47089). We are unable to determine how many of these rural referral centers that would not otherwise have qualified for reclassification would now be able to meet the 82 percent threshold. However, this change would not affect the aggregate level of Medicare expenditures since reclassification decisions are budget neutral under section 1886(d)(8)(B) of the Act. The exercise of the Secretary's exception authority to assign a new wage index to certain rural referral centers that failed to be approved for reclassification in FY 2005 is not budget neutral. Our review of the reclassification applications indicates that only a very small number of hospitals would qualify for a new wage index assignment under this proposed exception. While we are unable to be certain about the exact number of hospitals that would qualify, we believe that the aggregate impact on program payments would be in the range of $10 million to $20 million for the one-year during which this exception would be in effect.

Further, we anticipate that our proposed use of the authority in section 1886(d)(5)(I)(i) of the statute, to provide special protection to a small number of hospitals in States with fewer than 10 people per square mile (as determined using 2000 census data) would only increase Medicare program expenditures by $3 million to $5 million at the maximum. We believe that Medicare expenditures associated with this change would not exceed this level because many of the SCHs in the States where the exception would be applied have already qualified for reclassification effective for discharges on or after October 1, 2004. Furthermore, these hospitals are relatively small, and some of them are paid under their hospital specific rates, which restricts the gain from reclassification in most cases to capital PPS payments and payments for outpatient services.

I. Impact of Proposed Policy on Payment for Direct Costs of Graduate Medical Education

1. Redistribution of Unused Resident Slots

As discussed in section IV.O.2.b. of this preamble, section 422 of Public Law 108–173 added a new section 1886(h)(7) to the Act that provides for reductions in the statutory FTE resident caps under Medicare for certain hospitals and authorizes a ''redistribution'' of the FTE resident slots resulting from the reduction in the FTE resident caps to other hospitals.

For purposes of this proposed rule, we have estimated the impact of section 422 on hospitals for FY 2005, making assumptions about update factors, geographic (locality) adjustment factors, and the number of unused residency positions for each hospital. For purposes of calculating the impact for direct GME payments, we used the projected national average per resident amount (PRA) for FY 2005 of $82,249, as determined in accordance with existing § 413.86(e)(4)(ii)(B) (proposed to be redesignated as § 413.77(d)(2)(ii) in this proposed rule), since section 1886(h)(7)(B)(v) of the Act requires that a hospital that receives an increase in its direct GME FTE resident cap under section 1886(h)(7)(B) of the Act will receive direct GME payments with respect to those additional FTE residents using the locality-adjusted national average PRA. Based on our analysis of hospitals' FTE resident caps and FTE resident counts from the Hospital Cost Report Information System (HCRIS) for the most recent cost reporting periods ending on or before September 30, 2002, and making assumptions for hospitals that submit a timely request to use their cost report that includes July 1, 2003, we estimate that approximately 2,600 FTE resident slots that were previously unfilled (and therefore, no direct GME or IME payments were made for those slots) would be redistributed to and filled by hospitals that request an increase to their FTE residents caps under section 1886(h)(7)(B). (We note that this estimate of 2,600 slots is not necessarily the same as the estimate we would ultimately use to redistribute resident positions under section 1886(h)(7)(B)). Since payments for direct GME are determined based on a hospital's Medicare inpatient utilization, for purposes of this impact, we have applied a factor of .35 as the average Medicare inpatient utilization. Accordingly, for FY 2005, we estimate an increase of $75.6 million in direct GME payments.

For purposes of estimating the impact on IME payments, we used an IME formula multiplier of 0.66, since section 1886(d)(5)(B)(ix) states that for a hospital whose FTE resident cap is increased as a result of a redistribution of unused resident positions, the IME adjustment factor is to be calculated using a formula multiplier of 0.66 with respect to any additional residents counted by the hospital as a result of that increase in the hospital's FTE resident cap. Based on an estimate of unused resident positions using FTE resident data from HCRIS for the most recent cost reporting periods ending on or before September 30, 2002, and making assumptions for hospitals that submit a timely request to use their cost report that includes July 1, 2003, we estimate that for FY 2005, IME payments would increase by approximately $66.5 million. Thus, since section 422 is not effective until the fourth quarter of FY 2005 (that is, July 1, 2005), the estimated total increase in Medicare payments for FY 2005 attributable to section 422 is $35.53 million ([$75.6 million + $66.5 million] divided by 4).

2. Per Resident Amount: Extension of Update Limitation on High-Cost Programs

In section IV.O.4. of the preamble of this proposed rule, we discuss our proposal to implement section 711 of Public Law 108–173, which freezes the annual CPI–U inflation factors to hospital-specific PRAs for direct GME payments for those PRAs that exceed the established ceiling for FYs 2004 through 2013. Under existing regulations, for FY 2005, if a hospital's PRA for the previous cost reporting period would be greater than 140 percent of the locality-adjusted national average PRA for that same previous cost reporting period, the hospital's PRA would be updated for inflation, except that the CPI–U applied for a 12-month period is reduced by 2 percentage points. Under the new provisions of section 711 of Pub. L. 108–173 for FY 2005, if a hospital-specific PRA for the previous cost period would be greater than 140 percent of the locality-adjusted national average PRA for that same previous cost reporting period, the hospital-specific PRA would be frozen at the FY 2004 PRA, and not updated for inflation. Therefore, the impact in direct GME payments for FY 2005 (attributable to section 711 of the Public Law 108–173) is the difference between updating the PRAs by the applicable CPI–U inflation factor minus 2 percentage points, and not updating the PRAs by any CPI–U inflation factor. We have calculated an impact for this provision, but the resulting savings are negligible (less than $100,000).

3. Residents Training in Nonhospital Settings

In section IV.O.5. of the preamble of this proposed rule, we discuss our proposal to implement section 713 of Public Law 108–173, which, through a moratorium, allows hospitals to count allopathic or osteopathic

family practice residents training in nonhospital settings for IME and direct GME without regard to the financial arrangements between the hospital and the teaching physician practicing in the nonhospital setting in which the resident is assigned. We are unable to quantify the impact of these provisions because we do not know the number of residents or programs that are affected by these changes.

In addition, under IV.O.5. of this preamble, we discuss our proposed changes related to requirements for written agreements for residency training in nonhosital settings. We are proposing to revise the regulations to remove the requirement for a written agreement between the hospital and the nonhospital setting as a precondition for a hospital to count residents training in nonhospital settings for purposes of direct GME and IME payments. We are also proposing that, in order for the hospital to count residents training in a nonhospital setting, the hospital must pay for the nonhospital site training costs concurrently with the training that occurs during the cost reporting period. There is no monetary impact related to this proposed change because this proposal is administrative in nature, and does not affect a hospital's direct GME or IME payments.

J. Impact of Proposed Policy on Rural Community Hospital Demonstration Program

In section IV.P. of the preamble of this proposed rule, we discuss our proposal to implement section 410A of Public Law 108–173 requiring the Secretary to establish a demonstration that will modify reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) requires that ''in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.'' As discussed in section IV.P. of this proposed rule, we are proposing to satisfy this requirement by adjusting national IPPS rates by a factor that is sufficient to account for the added costs of this demonstration. We estimate that the average additional annual payment that would be made to each participating hospital under the demonstration would be approximately $1,120,000. We based this estimate on the recent historical experience of the difference between inpatient cost and reasonable cost payment for hospitals that would be eligible for the demonstration. For 15 participating hospitals, the total annual impact of the demonstration program is estimated to be $16,820,148. We estimate that there will be an average decrease in payment per discharge of approximately $0.83 in order to achieve budget neutrality. We describe the budget neutrality adjustment required for this purpose in the Addendum to this proposed rule.

K. Impact of Proposed Criteria for Hospitals-Within-Hospitals

In section VI.B. of the preamble of this proposed rule, we discuss three options for revising and strengthening the criteria to be used to classify hospitals-within-hospitals for purposes of payments that are excluded from the IPPS. The intent of our policies requiring separateness of administrative and medical governance and decision-making between the hospital-within-a-hospital and its host has been to discourage patient shifting between the excluded hospital-within-a-hospital and its host for financial rather than medical purposes. In 2002, there were 114 hospitals-within-hospitals, and these entities are increasing at an average annual rate of 30 percent (MedPAC, June 2003, p.85). To the extent that these proposed revisions would eliminate hospital-within-hospital arrangements that circumvented our existing requirements, the Medicare program would avoid making unnecessary payments under the more costly excluded hospital PPSs. We cannot estimate the numbers of existing entities that would be affected by these proposed revisions, nor can we estimate the specific DRGs that would be affected at those hospitals. In addition, we do not know the number of new applications for this status that would be subject to review under these new proposed standards. Therefore, we are unable to quantify the effect these propose changes would have upon Medicare expenditures. However, we believe that this proposed change in policy would likely result in a savings to the Medicare program.

L. Impact of Proposed Policy Changes Related to CAHs

In section VI.C.2. through VI.C.5. of the preamble of this proposed rule, we discuss our proposal to implement provisions in section 405 of Public Law 108–173 relating to payments to CAHs which include the percentage of change in the reasonable cost payment amount for certain services; the revised condition for a CAH's election of the optional payment method; the availability to CAHs of the periodic interim payment method (PIP); and expansion of types of emergency room providers who may be on call at CAHs.

These changes, taken together with the increase in the number of beds permitted to CAHs for acute care inpatient services discussed below, increase the incentive for conversion to CAH status by allowing larger rural hospitals and those with specialized units to become CAHs without materially reducing the size and scope of their activities. The added 1 percent reimbursement and flexibility to allow some physicians to opt out of method 2 for CAH billing should also increase the rate of conversion, while at the same time increasing the cost of CAHs to the Medicare program. The two payment methods are described in detail in section V.I.D.3. of the preamble and at § 413.70(b). The Congressional Budget Office's official estimate was that section 405 of Public Law 108–173 would increase Medicare program expenditures by approximately $100 million annually. We do not have the information to quantify the extent of the anticipated increase more precisely or to determine how much each provision of section 405 might contribute to that increase.

In section VI.C.6. of this preamble, we discuss our proposal to our regulations to reflect the provisions of section 405(e) of Pub. L. 108–173, which provides for an increase in the number of beds permitted to CAHs for acute care inpatient services, from 15 to 25 beds. We anticipate that both Medicare providers and beneficiaries would welcome this change. The increase in the number of beds would benefit CAHs that experience seasonal increases in patient census due to weather conditions and tourism. With the increase, more Medicare beneficiaries may have access to health care in their communities without the need to be transferred to another hospital because the CAH is at capacity for acute care beds. In addition, the bed size increase would eliminate an obstacle for some small rural hospitals that, except for the bed size restriction of 15 acute care beds, could qualify for CAH status. Although we anticipate that these changes would increase the rate at which hospitals convert to CAH status we do not have the information needed to make quantitative estimates of the extent of this increase.

In section VI.C.7. of the preamble of this proposed rule, we discuss our proposal to implement section 405(g) of Public Law 108–173, which grants authority for CAHs to establish psychiatric and rehabilitation distinct part units. This proposed rule would allow CAHs the option of providing rehabilitation and psychiatric services in such units.

Although we view the anticipated results of the proposed regulations as beneficial to the Medicaid and Medicare programs as well as to Medicare and Medicaid beneficiaries and State governments, we recognize that some of the provisions could be controversial and that some affected entities may respond unfavorably. We also recognize that not all of the potential effects of these provisions can definitely be anticipated, especially in view of their interaction with other Federal, State, and local activities regarding outpatient services. In particular, considering the effects of our simultaneous efforts to improve the delivery of outpatient services, it is impossible to quantify meaningfully a projection of the future effect of these provisions on a CAH's operating costs or on the frequency of substantial noncompliance and termination procedures.

We estimate that only those facilities that have the capabilities to operate a distinct part unit prior to becoming a CAH will elect to operate such a unit. Hospitals that currently operate a distinct part unit and wish to continue providing psychiatric and rehabilitation services to the community can continue to do so after converting to a CAH. Allowing a facility that converts to a CAH to continue providing inpatient rehabilitation and psychiatric services in rural areas would help to ensure availability of services that are disproportionately located in urban areas. Distinct-part units may be less common in rural areas due to the challenge of finding the resources needed to operate a distinct part unit. The United States General Accounting Office (GAO), in its September 2003 Report to Congress, entitled ''Modest Eligibility Expansion for Critical Access Hospital Program Should Be Considered,'' reported that a distinct part unit might provide a

financial benefit to the hospital because it enables the hospital to spread its fixed costs over more services. CAHs potentially can experience a net gain on their Medicare payments.

Among the existing CAHs, 25 previously operated a distinct part unit but had to close it as part of becoming a CAH. GAO identified 683 rural hospitals as ''potential CAHs'' based on their having an annual average of no more than 15 acute care patients per day. About 14 percent (93) of these potential CAHs operate an inpatient psychiatric or rehabilitation distinct part unit, which they previously would have had to close to convert to CAH status. Among the potential CAHs that operate a distinct part, about half had a net loss on Medicare services, indicating they might benefit from CAH conversion.[8]

Based on the GAO data, we estimate that approximately 50 hospitals that currently operate distinct part units would not incur any additional expense to convert to a CAH and, in fact, may increase their revenue. Therefore, we are only estimating burden for current CAHs (approximately 27) that might want to operate a distinct part unit due to their previous experience in operating a distinct part unit.

Inpatient psychiatric services in a CAH's distinct-part unit must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program, and who is board certified in psychiatry. The distinct part unit must also have a director of nursing services who is a registered nurse with a master's degree in psychiatric or mental health nursing or its equivalent from a school of accreditation by the National League of Nursing, who is qualified by education and experience in the care of persons with mental illness, and a director of social services. There must also be an adequate number of registered nurses to provide 24-hour coverage as well as licensed practical nurses and mental health workers.

A rehabilitation distinct-part unit of a CAH would be required to provide rehabilitation nursing, physical and occupational therapy, and, as needed, speech therapy, social services or psychological services and orthotics and prosthetics. The distinct part unit also must have a director of rehabilitation who, among other requirements, is experienced in rehabilitation and is a doctor of medicine or a doctor of osteopathy.

In addition, a CAH must comply with the common requirements for excluded units at § 412.25. Therefore, both psychiatric and rehabilitation distinct part units would be required to meet those requirements, including written admission criteria that are applied uniformly to both Medicare and non-Medicare having patients and have admission and discharge records that are separately identified from those of the CAH in which it is located and are readily available. Both of these distinct part units also must have policies specifying that necessary clinical information be transferred to the unit and have utilization review standards applicable for the type of care offered in the unit. Psychiatric distinct part units would also have to meet requirements of § 412.22, including maintenance of medical records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the unit. Each patient must also have an individual comprehensive treatment plan. Section 412.29 requires individuals having rehabilitation distinct part units to also have to meet the criteria of a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an inpatient program. The unit must have also a plan of treatment for each inpatient. Notwithstanding the above discussion, we are not attributing burden for these requirements because they are industry standards for providing quality care and are already required conditions for both rehabilitation and psychiatric units.

Hours/estimated salary/number of CAHs	Annual cost
Estimated Costs for Psychiatric Distinct Part Units	
Clinical Director or service chief; annual salary of $75,000 × 27 CAHs	$2,025,000
24-hours nursing coverage—1 RN per 12 hour shift (2 RNs total) = Annual salary of $52,120 × 2;	2,814,480
One LPN per 12 hour shift = Annual salary of $32,500 × 2 = $65,000 × 27 CAHs;	1,755,000
Director of nursing—Annual salary of $60,000 × 27 = $1,620,000	1,620,000
Director of social services—Annual salary of $53,000 × 27 = $1,431,000	1,431,000
Psychiatric aides—Annual salary of $25,650 x 2=$51,300 × 27 CAHs	1,385,100
Total	11,050,580
Estimated Costs for Rehabilitation Distinct Part Units	
Director of Rehabilitation—Annual salary $75,000 × 27 = $2,025,000	2,025,000
Occupational Therapist—Annual salary $53,300 × 27 = $1,439,100	1,439,100
Physical Therapist—Annual salary $55,800 × 27 = $1,506,600	1,506,600
Speech Therapist—Annual salary $52,800 × 27 = $1,425,600	1,425,600
Rehabilitation nurse—Annual salary $32,500 × 27 =	877,500
Total	7,273,800

In section VI.C.8. of the preamble of this proposed rule, we are proposing to implement section 405(h) of Public Law 108–173 which terminates a State's authority to waive the location requirement of more than a 35-mile drive (or in the case of mountainous terrain or secondary roads, a 15-mile drive) for a CAH by designating the CAH as a necessary provider. We do not have the information to quantify the extent of the anticipated increase more precisely or to determine how much this provision might contribute to that increase.

M. Impact of Proposed Policy Change Regarding Disclosure of Information by QIOs.

In section VII.A. of this proposed rule, we are proposing to revise our regulations to add provisions to allow QIOs to disclose information about practitioners and institutions and information from quality review studies if the practitioner or institution consents to or requests the disclosure of the information in writing. This disclosure would be in addition to the existing disclosure previously based on written consent of the institution or practitioner. In addition, we are proposing exceptions to the 30-day advance notice requirement to an institution or practitioner by a QIO of its intent to disclose confidential and nonconfidential information on a practitioner or an institution is at the request of or consent of the institution or practitioner. We are proposing to specify that the notification requirements would not apply if the institution or practitioner has requested in writing that the QIO make the disclosure, has provided written consent for the disclosure, or the information is public information.

[8] Information from United States General Accounting Office's Report to Congress, ''Modest Eligibility Expansion for Critical Access Hospital Program Should be Considered,'' GAO–03–948, September 2003.

We believe that these proposed revisions would reduce the existing burden on practitioners, institutions, and QIOs and, at the same time, ensure that necessary protections on information are retained. These provisions would allow QIOs, institutions, and practitioners to share vital information in an effective manner and further our efforts to ensure the highest quality of care for Medicare beneficiaries.

N. Impact of Policy Change for Medicare Hospital Conditions of Participation for Discharge Planning

In section VIII.A. of the preamble of this proposed rule, we discuss our proposal to amend the regulations at § 482.43 to incorporate the provisions of section 4321(a) of Public Law 105–33 and section 926(b) of Public Law 108–173 into the hospital conditions of participation. We are proposing to include the requirement for hospitals to provide lists of Medicare-certified HHAs and SNFs to patients or their representatives as part of the discharge planning process. We are proposing to require the SNF list to include Medicare-certified SNFs located in a geographic area chosen by the patient. We are not requiring that the list of Medicare-certified SNFs contain only those SNFs that are located in the area in which the patient resides. Because many available Medicare-certified SNFs are not located near where the patient resides, especially in rural areas, we believe that a requirement that restricts a patient to SNFs in areas where the patient resides is too restrictive and would limit the choices of posthospital extended care services for Medicare beneficiaries.

The nature of the proposed regulatory provision is such that this minimal regulatory burden would be placed upon hospitals, HHAs and SNFs exclusively. Therefore, we did not consider any regulatory relief options. We also certify that this proposed provision would not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

Compliance with section 4321(a) of the BBA and section 926(b) of Public Law 108–173 requires a hospital to collect on an initial and ongoing basis information to develop and maintain a current list of HHAs and SNFs available to Medicare beneficiaries. We anticipate that this effort would be minimal because hospitals currently access this information as an essential component of the discharge planning process. We do not anticipate that the operations of a substantial number of small rural hospitals would be significantly impacted. The impact would be even further minimized if a hospital chooses to access this information via the Home Health Compare or Nursing Home Compare tools on the CMS Web site, *http://www.medicare.gov,* or if the hospital calls 1–800–MEDICARE (1–800–633–4227) to request a printout of the HHAs or SNFs in the desired geographic area.

The anticipated effects on patients would be an enhanced ability to make informed choices about the care they receive from HHAs or SNFs upon discharge from a hospital. Based on 2003 CMS data, there are approximately 6,000 Medicare-certified hospitals, 6,900 Medicare-certified HHAs, and 17,000 SNFs.

The requirements set forth in this proposed provision would place minimal burdens on hospitals, HHAs, and SNFs. A possible outcome of the implementation of all parts of the rule may be to influence hospital referral patterns, thus having an impact on HHAs and SNFs receiving post-hospitalization referrals. The information made available to maintain compliance with the statute and this proposed provision might impact patient choices about who furnishes Medicare services to them and, in turn, may have an indeterminable impact on entities that provide, or do not provide services to Medicare beneficiaries as a result.

This proposed provision would improve our information campaign to assist beneficiaries in making informed choices for health care delivery. Patient choice under the Medicaid program may be similarly affected if the providers on these lists also participate in that program.

We considered developing a standardized process, format, and timeframe for all hospitals to use in developing, maintaining, and updating a current list of HHAs and SNFs. Instead, we have chosen a less prescriptive approach. Hospitals have the flexibility to define a process for developing, maintaining, and updating their list of HHAs or SNFs in a manner that makes the most sense for both the hospital and the patients they serve. The hospital would have the flexibility to develop and maintain their own list of HHAs and SNFs, or simply print a list from the Home Health Compare or Nursing Home Compare site at the CMS Web site, *http://www.medicare.gov,* based on the geographic area requested by the patient. Or, in the rare instance when a hospital does not have Internet access, the hospital can call 1–800–MEDICARE (1–800–633–4227) to request a printout of the list of HHAs or SNFs in the desired geographic area. In this way, hospitals would be able to develop and implement systems and processes that are the most effective and efficient in providing quality care and meeting the needs of their patients, as well as complying with the requirements of the proposed regulation.

In summary, this proposed provision would establish a process for implementing the statutory requirements under section 4321(a) of the BBA and section 926(b) of the MMA. This approach would enhance the information made available to Medicare beneficiaries and place minimal burdens on all entities that may be directly or indirectly affected.

O. Impact of Proposed Policy Changes Relating to Medicare Provider Agreements for Compliance with Bloodborne Pathogens Standards for Medicare-Participating Hospitals

In section VIII.B. of the preamble to this proposed rule, we discuss our proposal to implement section 947 of Public Law 108–173 under which hospitals not otherwise subject to the Occupational Safety and Health Act (OSHA) (or a State occupational safety and health plan that is approved under section 18(b) of that Act) must comply with the OSHA bloodborne pathogens standard as part of their Medicare provider agreements, effective July l, 2004.

Given that the Occupational Safety and Health Administration (OSHA) has already prepared a Regulatory Impact and Regulatory Flexibility Analysis for the Bloodborne Pathogens standard that was published December 6, 1991 (56 FR 64004), we have included relevant portions of their analyses in our estimate. However, we have pulled out the numbers that are relevant to this regulation and up-dated the numbers to make them current as of January, 2004. Thus, the impact of this proposed rule on the public hospitals included in the 26 States without state plans, as well as the District of Columbia, and Guam has been assessed.

OSHA noted that most hospitals perform a great variety of services, and there are many different exposure scenarios. One frequently reported exposure was needlestick, with the greatest potential for exposure occurring during needle recapping. Other hospital procedures that are associated with frequent exposure include phlebotomy, IV line placement, bronchoscopy, intubation, airway suction, endoscopy, colonoscopy, and proctosigmoidoscopy. Areas with the greatest potential for exposure include the emergency room, surgical suite, hemodialysis center, and intensive care unit. Laundry workers and janitors may also be exposed, particularly when handling soiled linen or refuse.

OSHA's standard for reducing worker exposure to bloodborne pathogens is based on the adoption of universal precautions as a method of infection control. This approach, which is fundamentally different from traditional procedures that isolate known infectious individuals and materials in the health care setting, assumes that all human blood and body fluids are potentially infectious for HIV, HBV, and other bloodborne pathogens. The rationale for this approach is that carriers of these diseases are not always identifiable in the health care setting, and that contaminated materials are not always properly labeled. Thus, the exposed worker can be at great risk without warning.

OSHA estimated that 6,197 hospitals with a total of 2,386,165 employees would be affected by the BBP standards. However, OSHA found that most hospitals had already implemented measures to protect workers from occupational exposure to blood and other potentially infectious materials, and that many were very close to full compliance with the standard. OSHA's estimates of the number of affected hospitals and the number of employees did not include state and local government hospitals located in states without occupational safety and health plans in place, that is, the hospitals that would be affected by our proposed rule.

Net compliance costs were estimated for each provision of the standard based on OSHA surveys and information submitted in response to the rulemaking docket. The costs represented the additional costs of fully complying with the requirements of the standard, after deducting from total cost the current baseline activities that already voluntarily occurred at affected facilities. Personal protective equipment accounted for

the largest amount of net compliance costs. Training, vaccine and post-exposure follow-up, and housekeeping were also found to be significant cost components. One-time costs were annualized to reflect the opportunity cost of capital. OSHA estimated the total annual costs to the affected hospitals to be approximately $321,913,697 or $51,947 per hospital annually.

The magnitude of cost increases associated with the standard was estimated to be relatively small, and OSHA stated that they should not create significant economic hardship for most affected hospitals. OSHA predicted that the costs would be passed through the system, with resultant minor price increases to patients, customers and other downstream recipients of health services. However, OSHA noted that without the BBP standards, the economic impact of inadequate protections from BBP would fall on hospital employees and the general public.

OSHA stated that, in general, the economic impacts of the standard were not judged to be of sufficient magnitude to threaten the existence of any affected sector, nor were impacts judged sufficient to disrupt or otherwise adversely alter industry structure. OSHA did not believe that productivity of hospital employees would be significantly affected by the BBP requirements. OSHA stated that it believed familiarization with the requirements and techniques would restrict time lost and that any decrease in productivity would be offset by the peace of mind associated with a safer work setting.

Based on OSHA'S conclusions, we did not deem it necessary to update the 1989 cost data used in their analysis. Although the costs of meeting the BBP standards would have increased over time, we note that at the time, OSHA found most hospitals had already implemented measures to protect workers from exposure to blood and other potentially infectious materials and that many hospitals were very close to full compliance. We expect that hospitals not covered under the BBP standards (that is, hospitals that would be affected by our proposed rule) also had implemented measures to protect their employees from exposure to blood and other potentially infectious materials and that many hospitals were already close to full compliance with the BBP standards. We also expect that in the intervening years, hospitals that would be affected by this proposed rule would have further increased their worker protections. It is likely that many of the hospitals that would be affected by this proposed rule are already very close to full compliance with the BBP standards.

While smaller hospitals' limited ability to diversify could be a potential disadvantage in their attempts to pass compliance costs forward, OSHA concluded that it did not appear that they would lag behind larger hospitals to any significant extent in their ability to provide employees with protection against infectious hazards.

On January 18, 2001, OSHA published a final rule that added two new recordkeeping requirements to the BBP standards (66 FR 48250). First, the amended standard requires employers to ''establish and maintain a sharps injury log for the recording of percutaneous injuries''. Second, any employer ''who is required to establish an Exposure Control Plan'' must ''solicit input from non-managerial employees responsible for direct patient care who are potentially exposed to injuries from contaminated sharps in the identification, evaluation, and selection of effective engineering and work practice controls and shall document the solicitation in the exposure-control plan.

According to OSHA's analysis, the maximum total annual cost of the two requirements would be $33,892,653, consisting of $1,294,352 associated with maintaining a sharps injury log and $32,598,300 associated with soliciting and documenting employee input into the Exposure Control Plan. This would amount to $67 per hospital annually, which would not cause significant economic impact on either large or small affected establishments.

The requirements set forth in this proposed rule would place minimal burden on hospitals. A possible outcome of the implementation of all parts of the rule may be to influence hospitals' use of proper mechanisms and supplies necessary to ensure employee protection from BBPs.

The anticipated effects on employees would be the assurance that provisions are made to reduce the potential for contact with BBPs when performing work-related duties. Based on 2003 CMS data, there are approximately 6,000 Medicare-certified hospitals of which 849 are non-federal, government-owned hospitals located in states that do not have their own health and safety standards.

This proposed rule would improve the quality of working conditions for employees who care for Medicare beneficiaries in these non-federal, government-owned hospitals and would ensure hospital employee safety while performing their duties in Medicare participating hospitals while placing minimal burden on all affected entities directly and on entities that may be indirectly affected.

P. Impact of Proposed Fire Safety Requirements for Certain Health Care Facilities.

In section VIII. of the preamble of this proposed rule, we discuss our proposal to clarify that long-term care facilities must be in compliance with Chapter 19.2.9, Emergency Lighting, beginning March 13, 2006. In addition, we also specify that beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 will no longer apply to these facilities.

In the January 10, 2003 final rule adopting the 2000 edition of the Life Safety Code, we examined the overall economic impact and the impact on small entities and rural hospitals as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980 Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) and Executive Order 13132. We also examined the anticipated effects of the rule. We determined that the 2003 final rule did not meet the criteria to be considered economically significant or to be a major rule. Furthermore, we examined the Federalism implication of the 2003 final rule and determined that the rule would not have a substantial effect on State, local, or tribal governments. The correcting amendments in this proposed rule would merely bring the Code of Federal Regulations language into conformity with the analyses that we have already conducted and described in the Regulatory Impact Statement section of the 2003 final rule. (*See* 68 FR 1374, January 10, 2003).

VIII. Impact of Proposed Changes in the Capital PPS

A. General Considerations

Fiscal year 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: fully prospective or hold harmless. Under the fully prospective methodology, hospitals were paid a blend of the capital Federal rate and their hospital-specific rate (*see* § 412.340). Under the hold-harmless methodology, unless a hospital elected payment based on 100 percent of the capital Federal rate, hospitals were paid 85 percent of reasonable costs for old capital costs (100 percent for SCHs) plus an amount for new capital costs based on a proportion of the capital Federal rate (see § 412.344). As we state in section V. of the preamble of this proposed rule, with the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), beginning in FY 2002 capital prospective payment system payments for most hospitals are based solely on the capital Federal rate. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

In accordance with § 412.312, the basic methodology for determining a capital prospective payment system payment is:

(Standard Federal Rate) × (DRG weight) × (Geographic Adjustment Factor (GAF)) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share (DSH) Adjustment Factor + Indirect Medical Education (IME) Adjustment Factor, if applicable).

In addition, hospitals may also receive outlier payments for those cases that qualify under the threshold established for each fiscal year.

The data used in developing the impact analysis presented below are taken from the December 2003 update of the FY 2003 MedPAR file and the December 2003 update of the Provider Specific File that is used for payment purposes. Although the analyses of the changes to the capital prospective payment system do not incorporate cost data, we used the December 2003 update of the most recently available hospital cost report data (FY 2001) to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response

to policy changes. Second, due to the interdependent nature of the PPS, it is very difficult to precisely quantify the impact associated with each change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases (for instance, the number of beds), there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available sources overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the December 2003 update of the FY 2003 MedPAR file, we simulated payments under the capital PPS for FY 2004 and FY 2005 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general IPPS (Indian Health Service Hospitals and hospitals in Maryland) are excluded from the simulations.

As we explain in section III.A.4. of the Addendum of this proposed rule, payments will no longer be made under the regular exceptions provision under §§ 412.348(b) through (e). Therefore, we are no longer using the actuarial capital cost model (described in Appendix B of the August 1, 2001 final rule (66 FR 40099)). We modeled payments for each hospital by multiplying the capital Federal rate by the GAF and the hospital's case-mix. We then added estimated payments for indirect medical education, disproportionate share, large urban add-on, and outliers, if applicable. For purposes of this impact analysis, the model includes the following assumptions:

- We estimate that the Medicare case-mix index would increase by 1.0 percent in both FY 2004 and FY 2005.
- We estimate that the Medicare discharges will be 14.5 million in FY 2004 and 14.0 million in FY 2005 for a 3.4 percent decrease from FY 2004 to FY 2005. (We are projecting a decrease in Medicare Part A fee-for-service admissions, in part, because we are projecting an increase in Medicare managed care enrollment as a result of the implementation of several provisions of Public Law 108–173.
- The capital Federal rate was updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The proposed FY 2005 update is 0.7 percent (*see* section III.A.1.a. of the Addendum to this proposed rule).
- In addition to the proposed FY 2005 update factor, the proposed FY 2005 capital Federal rate was calculated based on a GAF/DRG budget neutrality factor of 1.0015, an outlier adjustment factor of 0.9497, and a (special) exceptions adjustment factor of 0.9996.

Results

In the past, in this impact section we presented the redistributive effects that were expected to occur between ''hold-harmless'' hospitals and ''fully prospective'' hospitals and a cross-sectional summary of hospital groupings by the capital PPS transition period payment methodology. We are no longer including this information because all hospitals (except new hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid 100 percent of the capital Federal rate in FY 2005.

We used the actuarial model described above to estimate the potential impact of our proposed changes for FY 2005 on total capital payments per case, using a universe of 3,871 hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the December 2003 update of the FY 2003 MedPAR file, the December 2003 update to the Provider-Specific File, and the most recent cost report data from the December 2003 update of HCRIS. In Table III, we present a comparison of total payments per case for FY 2004 compared to FY 2005 based on the proposed FY 2005 payment policies. Column 2 shows estimates of payments per case under our model for FY 2004. Column 3 shows estimates of payments per case under our model for FY 2005. Column 4 shows the total percentage change in payments from FY 2004 to FY 2005. The change represented in Column 4 includes the 0.7 percent update to the capital Federal rate, a 1.0 percent increase in case-mix, changes in the adjustments to the capital Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB, as well as changes in special exception payments. The comparisons are provided by: (1) Geographic location; (2) region; and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 4.3 percent in FY 2005. In addition to the 0.7 percent increase due to the capital market basket update, this projected increase in capital payments per case is largely attributable to the proposed changes in the GAF values (which include the increase to hospital wage index values provided for by sections 505 and 508 of Pub. L. 108–173) and estimated increase in outlier payments in FY 2005. Our comparison by geographic location shows that urban hospitals are expected to experience a 4.6 percent increase in capital payments per case, while rural hospitals are only expected to experience a 2.1 percent increase in capital payments per case. This difference is mostly due to a projection that urban hospitals will experience a larger increase in payments due to changes in the proposed GAF values and larger projected increase in outlier payments from FY 2004 to FY 2005 compared to rural hospitals.

Most regions are estimated to receive an increase in total capital payments per case. Changes by region vary from a minimum increase of 0.7 percent (South Atlantic rural region) to a maximum increase of 5.5 percent (Pacific urban region). This relatively small increase in projected capital payments per discharge for hospitals located in the South Atlantic rural region is largely attributable to the proposed changes in the GAF values (that is, the proposed GAFs for most of these hospitals for FY 2005 are lower than the average of the GAFs for FY 2004) and a projected decrease in DSH payments (mostly because the rural hospitals that previously qualified for capital DSH payments because they reclassified for the purpose of the operating IPPS standardized amounts would no longer be eligible to receive capital DSH payments with the equalization of the operating IPPS standardized amounts, as discussed in section IV.D. of the preamble of this proposed rule). The relatively large increase in capital payments per discharge for hospitals located in the Pacific urban region is largely due to the proposed changes in the GAF values (that is, the proposed GAFs for most of these hospitals for FY 2005 are higher than the average of the GAFs for FY 2004) and an increase in projected outlier payments.

Hospitals located in Puerto Rico are expected to experience an increase in total capital payments per case of 8.0 percent. This relatively large increase in payment per case for hospitals located in Puerto Rico is largely due to the proposed change in the Federal portion (from 50 percent to 75 percent) of the blended payments to Puerto Rico hospitals beginning in FY 2005.

By type of ownership, proprietary hospitals are projected to have the largest rate of increase of total payment changes (4.7 percent). Similarly, payments to voluntary and government hospitals are expected to increase 4.3 percent. As noted above, this slightly larger projected increase in capital payments per case for proprietary hospitals is mostly due to the proposed changes in the GAF values for FY 2005.

Section 1886(d)(10) of the Act established the MGCRB. Previously, hospitals could apply for reclassification for purposes of the standardized amount, wage index, or both. Section 401(c) of Public Law 108–173 equalized the standardized amounts under the operating IPPS. Therefore, beginning in FY 2005, there is no longer reclassification for the purposes of the standardized amounts; hospitals may apply for reclassification for purposes of the wage index in FY 2005. Reclassification for wage index purposes also affects the geographic adjustment factor because that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2005 compared to the effects of reclassification for FY 2004, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified for FY 2005 as a whole are projected to experience a 2.8 percent increase in payments. Payments to nonreclassified hospitals in FY 2005 are expected to increase 4.5 percent. Hospitals reclassified during both FY 2004 and FY 2005 are projected to experience a slight increase in payments of 2.6 percent. Hospitals reclassified during FY 2005 only are projected to receive an increase in payments of 4.9 percent. This increase is primarily due to proposed changes in the GAF (wage index).

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE

[FY 2004 Payments Compared to Proposed FY 2005 Payments]

	Number of hospitals	Average FY 2004 payments/ case	Average FY 2005 payments/ case	Change.
By Geographic Location:.				
All hospitals	3,871	709	740	4.3
Large urban areas (populations over 1 million)	1,411	790	838	6.1
Other urban areas (populations of 1 million of fewer)	1,253	704	723	2.7
Rural areas	1,207	485	495	2.1
Urban hospitals	2,664	750	784	4.6
0–99 beds	674	540	563	4.4
100–199 beds	945	642	670	4.2
200–299 beds	499	736	766	4.2
300–499 beds	415	812	851	4.8
500 or more beds	131	934	982	5.2
Rural hospitals	1,207	485	495	2.1
0–49 beds	548	406	416	2.5
50–99 beds	393	452	462	2.2
100–149 beds	163	492	501	1.9
150–199 beds	57	536	545	1.6
200 or more beds	46	610	622	2.0
By Region:				
Urban by Region	2,664	750	784	4.6
New England	134	815	839	2.9
Middle Atlantic	390	813	848	4.2
South Atlantic	407	720	752	4.4
East North Central	442	742	777	4.8
East South Central	175	677	709	4.7
West North Central	160	752	786	4.5
West South Central	344	698	734	5.2
Mountain	140	746	772	3.5
Pacific	421	850	897	5.5
Puerto Rico	51	321	346	8.0
Rural by Region	1,207	485	495	2.1
New England	34	618	629	1.9
Middle Atlantic	57	511	516	1.0
South Atlantic	176	479	483	0.7
East North Central	160	514	522	1.4
East South Central	192	446	457	2.6
West North Central	206	500	517	3.3
West South Central	228	434	446	2.7
Mountain	92	486	500	2.9
Pacific	62	558	578	3.6
By Payment Classification:				
All hospitals	3,871	709	740	4.3
Large urban areas (populations over 1 million)	1,399	791	839	6.1
Other urban areas (populations of 1 million or fewer)	1,216	707	726	2.7
Rural areas	1,256	484	494	2.0
Teaching Status:				
Non-teaching	2,759	588	610	3.8
Fewer than 100 Residents	911	750	782	4.3
100 or more Residents	201	1,090	1,151	5.6
Urban DSH:				
100 or more beds	1,457	786	822	4.7
Less than 100 beds	335	494	517	4.7
Rural DSH:				
Sole Community (SCH/EACH)	478	440	451	2.4
Referral Center (RRC/EACH)	149	548	558	1.8
Other Rural:				
100 or more beds	64	464	470	1.3
Less than 100 beds	241	411	419	1.9
Urban teaching and DSH:				
Both teaching and DSH	800	862	903	4.9
Teaching and no DSH	250	773	808	4.5
No teaching and DSH	992	631	658	4.3
No teaching and no DSH	573	642	669	4.3
Rural Hospital Types:				
Non special status hospitals	394	439	446	1.6
RRC/EACH	129	559	565	1.2
SCH/EACH	451	454	465	2.5
Medicare-dependent hospitals (MDH)	209	408	419	2.7
SCH, RRC and EACH	70	551	566	2.9

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE—Continued

[FY 2004 Payments Compared to Proposed FY 2005 Payments]

	Number of hospitals	Average FY 2004 payments/ case	Average FY 2005 payments/ case	Change.
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
Reclassification Status During FY 2004 and FY 2005:				
Reclassified During Both FY 2004 and FY 2005	423	615	631	2.6
Reclassified During FY 2005 Only	62	547	574	4.9
Reclassified During FY 2004 Only	186	672	687	2.2
FY 2005 Reclassifications:				
All Reclassified Hospitals	485	610	627	2.8
All Nonreclassified Hospitals	3,325	724	757	4.5
All Urban Reclassified Hospitals	118	748	773	3.4
Urban Nonreclassified Hospitals	2,486	752	787	4.7
All Reclassified Rural Hospitals	367	536	548	2.3
Rural Nonreclassified Hospitals	839	433	441	1.8
Other Reclassified Hospitals (Section 1886(D)(8)(B))	61	487	490	0.7
Type of Ownership:				
Voluntary	2,322	727	758	4.3
Proprietary	717	647	677	4.7
Government	764	676	705	4.3
Medicare Utilization as a Percent of Inpatient Days:				
0–25	226	888	939	5.7
25–50	1,122	772	809	4.8
50–65	1,428	630	654	3.8
Over 65	922	630	654	3.7

Appendix B: Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services

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

I. Background

Section 1886(e)(4)(A) of the Act requires that the Secretary, taking into consideration the recommendations of the Medicare Payment Advisory Commission (MedPAC), recommend update factors for inpatient hospital services for each fiscal year that take into account the amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. Under section 1886(e)(5) of the Act, we are required to publish the proposed update factors recommended by the Secretary in the proposed rule, and the final update factors recommended by the Secretary in the final rule. Accordingly, this Appendix provides the recommendations of appropriate update factors for the IPPS standardized amount, the hospital-specific rates for SCHs and MDHs, and the rate-of-increase limits for hospitals and hospital units excluded from the IPPS. We also discuss our update framework and respond to MedPAC's recommendations concerning the update factors.

II. Secretary's Recommendations

Section 1886(b)(3)(B)(i)(XIX) of the Act sets the FY 2005 percentage increase in the operating cost standardized amount equal to the rate of increase in the hospital market basket for IPPS hospitals in all areas. Based on the Office of the Actuary's first quarter 2004 forecast of the FY 2005 market basket increase, the proposed update to the standardized amount is 3.3 percent (that is, the market basket rate of increase) for hospitals in all areas.

Section 1886(b)(3)(B)(iv) of the Act sets the FY 2005 percentage increase in the hospital-specific rates applicable to SCHs and MDHs equal to the rate set forth in section 1886(b)(3)(B)(i) of the Act (that is, the same update factor as all other hospitals subject to the IPPS, or the rate of increase in the market basket). Therefore, the proposed update to the hospital-specific rate applicable to SCHs and MDHs is also 3.3 percent.

Section 1886(b)(3)(B)(ii) of the Act sets the FY 2005 percentage increase in the rate-of-increase limits for hospitals and hospital units excluded from the IPPS (psychiatric hospitals and units (now referred to as inpatient psychiatric facilities (IPFs)), rehabilitation hospitals and units (now referred to as IRFs), LTCHs, cancer hospitals, and children's hospitals) equal to the market basket percentage increase. In the past, hospitals and hospital units excluded from the IPPS have been paid based on their reasonable costs subject to limits as established by TEFRA. However, some of these categories of excluded hospitals and units have begun to be paid under their own prospective payment systems. Hospitals and units that receive any hospital-specific payments will have those payments subject to TEFRA limits for FY 2005. For these hospitals, the proposed update is the percentage increase in the excluded hospital market basket (currently estimated at 3.3 percent).

IRFs are paid under the IRF PPS for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2004, the Federal prospective payment for IRFs is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually.

Effective for cost reporting periods beginning during FY 2003, LTCHs are paid under the LTCH PPS under which they receive payment based on a 5-year transition period (see the August 30, 2002 final rule (67 FR 55954)). A LTCH may elect to be paid on 100 percent of the Federal prospective rate at the start of any of its cost reporting periods during the 5-year transition period. For purposes of the update factor, the portion of the LTCH PPS transition blend payment based on reasonable costs for inpatient operating services is determined by updating the LTCH's TEFRA limit by the current estimate of the excluded hospital market basket (or 3.3 percent).

CMS recently published a proposed regulation regarding inpatient psychiatric facilities (IPFs) in which CMS would compute a Federal per diem base rate to be paid to all IPFs based on the sum of the average routine operating, ancillary, and capital costs for each patient day of psychiatric care in an IPF adjusted for budget neutrality. The Federal per diem base rate would be adjusted to reflect certain patient characteristics such as age, specified DRGs, and selected high-cost comorbidities, and certain facility characteristics such as a wage index adjustment, rural location, and indirect teaching costs. The November 28, 2003 proposed rule assumed an April 1, 2004 effective date for the purpose of ratesetting and calculating impacts. However, we are still in the process of analyzing public comments and developing a final rule for publication. The effective date of the IPF PPS would occur 5 months following publication of the final rule.

III. Update Framework

Consistent with current law, we are proposing an update recommendation equal to the full market basket percentage increase for the IPPS operating cost standardized amounts for FY 2005. We also have analyzed changes in hospital productivity, scientific and technological advances, practice pattern changes, changes in case-mix, the effect of reclassification on recalibration, and forecast error correction. A discussion of this analysis is below.

A. Productivity

Service level labor productivity is defined as the ratio of total service output to full-time equivalent employees (FTEs). While we recognize that productivity is a function of many variables (for example, labor, nonlabor material, and capital inputs), we use the portion of productivity attributed to direct labor since this update framework applies to operating payment. To recognize that we are apportioning the short-run output changes to the labor input and not considering the nonlabor inputs, we weight our productivity measure by the share of direct labor services in the market basket to determine the expected effect on cost per case.

Our recommendation for the service productivity component is based on historical trends in productivity and total output for both the hospital industry and the general economy, and projected levels of future hospital service output. MedPAC's predecessor, the Prospective Payment Assessment Commission (ProPAC), estimated cumulative service productivity growth to be 4.9 percent from 1985 through 1989 or 1.2 percent annually. At the same time, ProPAC estimated total output growth at 3.4 percent annually, implying a ratio of service productivity growth to output growth of 0.35.

Absent a productivity measure specific to Medicare patients, we examined productivity (output per hour) and output (gross domestic product) for the economy. Depending on the exact time period, annual changes in productivity range from 0.30 to 0.35 percent of the change in output (that is, a 1.0 percent increase in output would be correlated with a 0.30 percent to a 0.35 percent change in output per hour).

Under our framework, the recommended update is based in part on expected productivity—that is, projected service output during the year, multiplied by the historical ratio of service productivity to total service output, multiplied by the share of direct labor in total operating inputs, as calculated in the hospital market basket. This method estimates an expected productivity improvement in the same proportion to expected total service growth that has occurred in the past and assumes that, at a minimum, growth in FTEs changes proportionally to the growth in total service output. Thus, the recommendation allows for unit productivity to be smaller than the historical averages in years during which output growth is relatively low and larger in years during which output growth is higher than the historical averages. Based on the above estimates from both the hospital industry and the economy, we have chosen to employ the range of ratios of productivity change to output change of 0.30 to 0.35.

The expected change in total hospital service output is the product of projected growth in total admissions (adjusted for outpatient usage), projected real case-mix growth, expected quality-enhancing intensity growth, and net of expected decline in intensity due to reduction of cost-ineffective practice. Case-mix growth and intensity numbers for Medicare are used as proxies for those of the total hospital, since case-mix increases (used in the intensity measure as well) are unavailable for non-Medicare patients. Normally, the expected FY 2005 hospital output growth would be simply the sum of the expected change in intensity (zero percent), projected admissions change (0.9 percent), and projected real case-mix growth (1.0 percent—a definition of real case mix growth appears below), or 1.9 percent. As discussed below and in relation to the proposed capital update, we believe our intensity estimate is skewed by hospitals' charge data. We are including only the projected changes in admissions and real case-mix in our calculation of productivity gains. However, the expected change in intensity is zero. Therefore, excluding the intensity estimate has no effect on the result. This results in an estimate of 1.9 percent.

The share of direct labor services in the market basket (consisting of wages, salaries, and employee benefits) is 61.7 percent. Multiplying the expected change in total hospital service output (1.9 percent) by the ratio of historical service productivity change to total service growth of 0.30 to 0.35 and by the direct labor share percentage of 61.7 provides our productivity standard of -0.8 to -0.7 percent. Because productivity gains hold down the rate of increase in hospitals' costs, this factor is applied as a negative offset to the market basket increase.

B. Intensity

The intensity factor for the operating update framework reflects how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, changes in within-DRG severity, and expected modification of practice patterns to remove non-cost-effective services. Under the capital IPPS framework, we also make an adjustment for changes in intensity. We calculate this adjustment using the same methodology and data that are used in the framework for the operating IPPS.

We calculate case-mix constant intensity as the change in total Medicare charges per admission, adjusted for price level changes (the Consumer Price Index (CPI) for hospital and related services) and changes in real case-mix. The use of total charges in the calculation of the intensity factor makes it a total intensity factor, that is, charges for both operating and capital services are already built into the calculation of the factor.

However, as discussed above in relation to the proposed capital update, because our intensity calculation relies heavily upon charge data and we believe that this charge data may be inappropriately inflated due to manipulation of charges to maximize outlier payments, we are proposing a zero percent adjustment for intensity in FY 2005. In past fiscal years (1996 through 2000) when we found intensity to be declining, we believed a zero (rather than negative) intensity adjustment was appropriate. Similarly, we believe that it is appropriate to propose a zero intensity adjustment for FY 2005 until we determine that any increase in charges can be tied to intensity, rather than to attempts to maximize outlier payments.

C. Change in Case-Mix

Our analysis takes into account projected changes in real case-mix, less the changes attributable to improved coding practices. We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients, as opposed to changes in coding behavior that result in assignment of cases to higher-weighted DRGs but do not reflect greater resource requirements. For our FY 2005 update recommendation, we are projecting a 1.0 percent increase in the case-mix index. We do not believe changes in coding behavior will impact the overall case-mix in FY 2005. As such, for FY 2005, we estimate that real case-mix is equal to projected change in case-mix. Thus, we are recommending a 1.0 percent adjustment for case-mix.

D. Effect of FY 2003 DRG Reclassification and Recalibration

We estimate that DRG reclassification and recalibration for FY 2003 (GROUPER version 20.0) resulted in a zero percent change in the case-mix index when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the GROUPER (version 19.0). Therefore, we are recommending a zero percent adjustment for the effect of FY 2003 DRG reclassification and recalibration.

E. Forecast Error Correction

We make a forecast error correction if the actual market basket changes differ from the forecasted market basket by 0.25 percentage points or more. There is a 2-year lag between the forecast and the measurement of forecast error. The estimated market basket percentage increase used to update the FY 2003 payment rates was 3.5 percent. Our most recent data indicates the actual FY 2003 increase was 3.9 percent. The resulting forecast error in the FY 2003 market basket rate of increase is 0.4 percentage points. This underestimate was due largely to an underestimation of increases in the compensation components in the market basket. More specifically, the burden for benefit costs was expected to shift more to workers, given the soft job market. However, not as much of a shift occurred as was expected, and the measure for benefits increased faster than originally forecast. In addition, higher than expected growth in natural gas prices, mainly due to higher than expected demand last winter that depleted surplus reserves, caused the energy component to be underestimated.

The following is a summary of the update range supported by our analyses:

HHS'S FY 2005 UPDATE RECOMMENDATION

Projected FY 2005 Market Basket Increase	3.3.
Policy Adjustment Factors	0.0.
Productivity	−0.8 to −0.7
Intensity	0.0.
Subtotal	−0.8 to −0.7.
Case-Mix Adjustment Factors:.	
Projected Case-Mix Change	1.0
Real Across DRG Change	−1.0.
Subtotal	0.0.
Effect of FY 2003 DRG Reclassification and Recalibration	0.0.
Forecast Error Correction	0.4.
Total Recommendation Update	2.9 to 3.0

IV. MedPAC Recommendations for Assessing Payment Adequacy and Updating Payments in Traditional Medicare

In the past, MedPAC has suggested specific adjustments to its update recommendation for each of the factors discussed under section III. of this Appendix. In its March 2004 Report to Congress, MedPAC assesses the adequacy of current payments and costs and the relationship between payments and an appropriate cost base, utilizing an established methodology used by the Commission in the past few years. MedPAC stresses that the issue at hand is whether payments are too high or too low, and not how they became either too high or too low.

In the first portion of MedPAC's analysis on the assessment of payment adequacy, the Commission reviews the relationship between costs and payments (typically represented as a margin). Based on the latest cost report data available, MedPAC estimated an inpatient hospital Medicare operating margin for FY 2002 of 4.7 percent (down from 8.1 percent and 10.7 percent for FY 2001 and FY 2000, respectively).

MedPAC also projects margins through FY 2003, making certain assumptions about changes in payments and costs. On the payment side, MedPAC applied the annual payment updates (as specified by law for FYs 2001 through 2003) and then modeled the effects of other policy changes that have affected the level of payments. On the cost side, MedPAC estimated the increases in cost per unit of output over the same time period at the rate of inflation as measured by the applicable market basket index generated by CMS, adjusted downward, anticipating improvements in productivity.

In addition to considering the relationship between estimated payments and costs, MedPAC also considered the following three factors to assess whether current payments are adequate:

- Changes in access to or quality of care,
- Changes in the volume of services or number of providers; and
- Change in providers access to capital.

MedPAC s assessment of aggregate Medicare payments finds that payments were at least adequate as of FY 2004.

MedPAC's recommendation is to update payments under the IPPS by the full rate of increase in the hospital market basket for FY 2005. MedPAC focuses on the fact that it is extremely difficult to determine the status of cost growth among hospitals, given the complexity of ascertaining the impact of the implementation of provisions of Pub. L. 108–173. MedPAC believes it is sensible to refrain from applying their expected net effect based on their standard model, as there is a great deal of uncertainty regarding the costs and payments faced by providers. MedPAC is not abandoning its methodology regarding the update framework, but it has concluded that, under the circumstances, the current market conditions and factors that determine the cost behavior and outcomes of hospitals are too uncertain to rely on current trends for estimation.

Response: As described above, we are recommending a full market basket update for FY 2005 consistent with current law. We believe this will appropriately balance incentives for hospitals to operate efficiently with the need to provide sufficient payments to maintain access to quality care for Medicare beneficiaries.

Because the operating and capital prospective payment systems remain separate, CMS continues to use separate updates for operating and capital payments. The proposed update to the capital payment rate is discussed in section III. of the Addendum to this proposed rule.

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