

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
370025	37	8560	
370034	37	2720	
370047	37	7640	
370048	37	8360	
370049	37	5880	
370054	37	5880	
370084	37	2720	
370103	37	45	
370153	37	4200	
370200	37	5880	
380001	38	6440	
380002	38	4890	
380006	38		6440
380022	38	1890	
380027	38	2400	
380040	38	2400	
380047	38	2400	
380050	38	4890	
380051	7080		6440
380065	38	2400	
380070	38	6440	
380084	7080	6440	
380090	38	2400	
390006	39	3240	
390008	39	6280	6280
390013	39	3240	
390016	39	6280	6280
390017	39	6280	6280
390030	39	0240	6680
390031	39	6680	6680
390048	39	3240	
390052	39	0280	
390065	39	8840	9280
390079	39	0960	
390091	39	6280	
390093	39	6280	
390110	3680	6280	
390113	39	9320	
390133	0240	6160	
390138	39	8840	
390150	39	6280	
390151	39	8840	
390163	39	6280	
390181	39	6680	6680
390183	39	6680	6680
390189	39	3240	
390197	0240	6160	
390201	39	5660	5640
390263	0240	6160	
400018	40	1310	
410001	6483	1123	1123
410004	6483	1123	1123
410005	6483	1123	1123
410006	6483	1123	1123
410007	6483	1123	1123
410008	6483	1123	1123
410009	6483	1123	1123
410010	6483	1123	1123
410011	6483	1123	1123
410012	6483	1123	1123
410013	6483	1123	1123
420020	42	1440	
420030	42	1440	
420036	42	1520	
420068	42	0600	
420070	8140	1760	
420071	42	0600	
420080	42	7520	
420085	5330	9200	
430004	43	6660	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
430008	43	24	
430012	43	7760	
430013	43	7760	
430014	43	2520	
430015	43	6660	
430047	43	28	
430048	43	53	
430089	43	7720	
440008	44	3580	
440020	44	3440	
440024	44	1560	
440050	44	0480	
440058	44	1560	
440059	44	5360	
440060	44	3580	
440067	44	3840	
440068	44	3840	
440072	44	4920	
440073	44	5360	
440148	44	5360	
440175	44	3440	
440180	44	3840	
440185	44	1560	
440186	44	5360	
440187	44	18	
440192	44	5360	
440200	44	5360	
440203	44	1560	
450007	45	7240	
450014	45	8750	
450080	45	4420	
450085	45	9080	
450098	45	4420	
450099	45	0320	
450140	45	5800	
450144	45	5800	
450146	45	0320	
450163	45	1880	
450178	45	5800	
450187	45	3360	
450192	45	1920	
450194	45	1920	
450196	45	1920	
450211	45	3360	
450214	45	3360	
450224	45	8640	
450347	45	3360	
450351	45	2800	
450353	45	1880	
450373	45	4420	
450395	45	3360	
450400	45	8800	
450438	45	0640	
450447	45	1920	
450451	45	2800	
450484	45	3360	
450508	45	8640	
450534	45	0320	
450623	45	1920	
450626	45	8750	
450653	45	5800	
450656	45	8640	
450694	45	3360	
450747	45	1920	
450755	45	4600	
450763	45	0320	
450770	45	0640	
460011	46	6520	
460021	46	4120	
460027	46	6520	

TABLE 9.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL—FY 2004—Continued

Provider No.	Actual MSA or rural area	Wage index MSA reclassification	Standardized amount MSA reclassification
460032	46	6520	
460036	46	6520	
460039	46	7160	
470001	47	30	
470011	47	1123	1123
470012	47	6323	
470018	47	1123	1123
490001	49	3660	
490004	49	1540	
490005	49	8840	
490013	49	4640	
490018	49	4640	
490038	49	3660	
490047	49	8840	
490066	5720	6760	
490079	49	3120	3120
490126	49	6800	
500002	50	6740	
500003	50	0860	
500007	50	0860	
500016	50	7600	
500031	50	5910	
500041	50	6440	
500059	50	7600	
500072	50	7600	
500079	8200		7600
510001	51	6280	
510002	51	6800	
510006	51	6280	
510024	51	6280	6280
510028	51	1480	
510046	51	1480	
510047	51	6280	
510048	51	3400	
510062	51	1480	
510070	51	1480	
510071	51	1480	
520002	52	8940	
520006	52	8940	
520018	52	5120	
520021	3800	1600	1600
520028	52	4720	
520032	52	4720	
520037	52	8940	
520059	6600	5080	5080
520066	3620	4720	
520071	52	5080	5080
520076	52	4720	
520084	52	4720	
520088	52	5080	
520094	6600	5080	5080
520096	6600	5080	5080
520102	52	5080	5080
520107	52	3080	
520113	52	3080	
520116	52	5080	5080
520152	52	3080	
520173	52	2240	
520189	3800	1600	1600
530002	53	1350	
530009	53	1350	
530015	53	6340	
530025	53	2670	
530032	53	7160	

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003

DRG	Cases	Mean + .75 standard deviation
1	23,157	\$71,862
2	11,535	\$41,916
3	3	\$57,168
6	350	\$15,743
7	14,489	\$55,309
8	4,031	\$33,403
9	1,677	\$27,210
10	18,339	\$25,124
11	3,244	\$17,654
12	51,660	\$17,776
13	6,919	\$16,312
14	233,816	\$24,738
15	92,167	\$19,059
16	9,810	\$25,016
17	2,700	\$13,796
18	29,250	\$20,071
19	8,385	\$14,298
20	6,112	\$57,114
21	1,869	\$30,726
22	2,746	\$21,754
23	11,062	\$16,410
24	58,122	\$19,963
25	26,945	\$12,212
26	18	\$22,836
27	4,348	\$27,026
28	13,770	\$26,999
29	5,226	\$14,276
30	2	\$19,365
31	3,834	\$18,092
32	1,866	\$11,256
34	23,474	\$19,760
35	7,325	\$12,760
36	2,079	\$11,821
37	1,351	\$21,123
38	94	\$9,781
39	547	\$12,494
40	1,508	\$17,526
42	1,553	\$14,008
43	93	\$11,353
44	1,185	\$13,306
45	2,622	\$14,326
46	3,418	\$16,038
47	1,373	\$10,908
49	2,341	\$34,744
50	2,385	\$15,810
51	241	\$16,991
52	216	\$15,789
53	2,435	\$23,943
55	1,458	\$18,384
56	458	\$16,976
57	700	\$21,430
59	113	\$16,063
61	249	\$24,772
62	2	\$20,652
63	2,964	\$28,015
64	3,064	\$27,189
65	39,700	\$11,389
66	7,690	\$11,535
67	379	\$15,758
68	11,373	\$12,869
69	3,665	\$9,805
70	29	\$6,582
71	79	\$13,057
72	949	\$13,674
73	7,561	\$16,376
75	42,731	\$60,129
76	43,909	\$56,525
77	2,427	\$23,987

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003—Continued

DRG	Cases	Mean + .75 standard deviation
78	38,870	\$24,907
79	165,957	\$32,680
80	7,866	\$16,846
81	5	\$20,229
82	63,317	\$28,781
83	6,565	\$19,177
84	1,552	\$10,644
85	21,981	\$24,242
86	2,201	\$13,781
87	60,101	\$27,456
88	396,200	\$17,702
89	523,048	\$20,511
90	47,344	\$11,871
91	44	\$14,737
92	15,549	\$24,280
93	1,738	\$14,448
94	12,597	\$22,970
95	1,622	\$12,263
96	55,628	\$14,761
97	28,174	\$10,803
98	9	\$14,090
99	20,984	\$13,983
100	8,129	\$10,369
101	21,861	\$17,290
102	5,503	\$10,797
103	484	\$378,244
104	20,223	\$150,559
105	28,716	\$108,046
106	3,432	\$136,812
107	81,816	\$99,133
108	6,341	\$109,106
109	56,282	\$73,253
110	53,777	\$81,343
111	9,323	\$49,746
113	39,244	\$56,405
114	8,198	\$33,220
115	19,499	\$69,161
116	114,338	\$44,903
117	4,622	\$27,878
118	8,168	\$31,457
119	1,211	\$27,147
120	37,745	\$46,550
121	161,616	\$30,683
122	75,737	\$19,715
123	38,021	\$32,143
124	133,344	\$27,371
125	90,371	\$20,832
126	5,309	\$51,405
127	663,251	\$20,085
128	7,042	\$14,239
129	3,774	\$20,775
130	87,289	\$18,660
131	26,583	\$11,113
132	140,158	\$12,462
133	8,475	\$10,723
134	40,649	\$11,970
135	7,697	\$17,958
136	1,166	\$11,432
138	204,872	\$16,521
139	86,072	\$10,173
140	54,193	\$10,288
141	107,180	\$14,813
142	51,782	\$11,382
143	245,795	\$10,741
144	93,108	\$24,851
145	7,201	\$11,714
146	10,627	\$52,920

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003—Continued

DRG	Cases	Mean + .75 standard deviation
147	2,602	\$29,373
148	132,078	\$67,116
149	19,892	\$27,061
150	20,888	\$57,096
151	5,067	\$25,243
152	4,490	\$37,305
153	2,025	\$21,509
154	27,969	\$82,200
155	6,498	\$25,001
156	4	\$16,997
157	8,150	\$25,875
158	4,273	\$12,709
159	17,842	\$26,972
160	11,973	\$15,839
161	10,620	\$22,659
162	6,290	\$12,519
163	8	\$9,397
164	5,322	\$45,313
165	2,297	\$22,967
166	4,142	\$27,527
167	4,013	\$16,618
168	1,406	\$26,010
169	802	\$14,782
170	15,473	\$57,315
171	1,495	\$23,568
172	30,878	\$28,013
173	2,414	\$15,971
174	247,933	\$19,856
175	34,337	\$11,032
176	13,301	\$21,548
177	8,939	\$18,108
178	3,315	\$13,584
179	12,973	\$21,773
180	88,999	\$19,227
181	26,699	\$10,651
182	268,140	\$16,395
183	89,558	\$11,492
184	69	\$19,542
185	5,256	\$17,532
186	6	\$17,504
187	609	\$15,462
188	82,829	\$22,197
189	12,856	\$12,176
190	75	\$16,578
191	9,340	\$88,382
192	1,299	\$36,558
193	4,733	\$68,254
194	638	\$31,775
195	3,957	\$59,356
196	969	\$30,122
197	17,996	\$50,435
198	5,289	\$23,379
199	1,609	\$48,963
200	1,069	\$62,346
201	2,100	\$75,551
202	26,307	\$26,667
203	29,543	\$28,095
204	64,510	\$22,991
205	27,001	\$24,271
206	2,015	\$14,280
207	32,214	\$22,980
208	9,967	\$13,150
209	394,702	\$35,979
210	121,348	\$33,587
211	29,657	\$22,493
212	9	\$31,925
213	9,818	\$37,689

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003—Continued

DRG	Cases	Mean + .75 standard deviation
216	8,691	\$41,935
217	17,092	\$61,011
218	23,524	\$30,313
219	19,672	\$19,359
223	13,125	\$20,384
224	11,574	\$14,926
225	6,390	\$22,849
226	5,793	\$30,350
227	4,783	\$15,628
228	2,495	\$22,908
229	1,245	\$13,667
230	2,430	\$25,765
232	809	\$18,306
233	9,829	\$40,036
234	5,300	\$24,173
235	5,032	\$14,695
236	39,468	\$13,922
237	1,748	\$11,857
238	8,729	\$27,480
239	45,525	\$20,661
240	11,846	\$26,301
241	3,110	\$12,646
242	2,542	\$23,380
243	94,969	\$15,031
244	14,423	\$14,330
245	5,746	\$9,757
246	1,473	\$11,896
247	20,113	\$11,410
248	13,674	\$17,154
249	12,784	\$13,336
250	3,727	\$14,018
251	2,332	\$9,097
253	21,753	\$14,893
254	10,593	\$8,759
256	6,586	\$16,469
257	15,517	\$16,712
258	15,055	\$13,056
259	3,486	\$17,996
260	4,160	\$12,825
261	1,747	\$17,565
262	653	\$18,615
263	22,868	\$41,675
264	3,819	\$21,268
265	4,031	\$31,156
266	2,516	\$17,172
267	238	\$20,021
268	895	\$23,309
269	9,688	\$35,630
270	2,743	\$16,079
271	18,989	\$20,610
272	5,658	\$20,167
273	1,313	\$12,601
274	2,264	\$24,353
275	223	\$12,616
276	1,304	\$13,267
277	98,858	\$17,235
278	31,750	\$10,661
279	10	\$15,979
280	17,551	\$13,991
281	7,377	\$9,589
283	5,976	\$14,555
284	1,992	\$8,504
285	6,869	\$41,732
286	2,477	\$39,318
287	6,166	\$37,798
288	5,471	\$41,746
289	6,830	\$18,048

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003—Continued

DRG	Cases	Mean + .75 standard deviation
290	9,803	\$16,847
291	58	\$13,308
292	6,420	\$55,995
293	356	\$28,741
294	96,631	\$15,356
295	3,475	\$16,050
296	275,298	\$17,000
297	47,552	\$9,995
298	109	\$9,503
299	1,253	\$18,904
300	18,462	\$22,372
301	3,554	\$12,547
302	8,653	\$61,825
303	21,521	\$46,383
304	12,430	\$47,807
305	3,009	\$23,106
306	6,967	\$24,014
307	1,983	\$11,422
308	7,203	\$31,717
309	4,094	\$17,613
310	24,593	\$22,507
311	7,407	\$11,963
312	1,502	\$21,429
313	547	\$13,534
314	2	\$815,660
315	33,535	\$41,732
316	117,415	\$26,424
317	1,994	\$16,978
318	5,685	\$24,541
319	403	\$14,083
320	184,548	\$17,149
321	30,606	\$11,011
322	49	\$9,127
323	19,641	\$16,239
324	6,874	\$9,611
325	9,136	\$13,204
326	2,696	\$8,569
327	7	\$7,111
328	732	\$15,295
329	93	\$10,358
331	50,553	\$21,469
332	4,905	\$12,274
333	254	\$19,142
334	10,300	\$27,789
335	12,490	\$19,981
336	35,495	\$16,280
337	29,140	\$10,776
338	929	\$23,997
339	1,460	\$22,362
341	3,545	\$25,849
342	686	\$14,916
344	3,549	\$26,710
345	1,354	\$22,352
346	4,775	\$21,343
347	308	\$11,845
348	3,361	\$15,104
349	604	\$9,831
350	6,602	\$14,657
352	945	\$14,499
353	2,491	\$35,744
354	7,324	\$28,230
355	5,481	\$16,312
356	25,562	\$14,230
357	5,570	\$44,892
358	21,321	\$22,339
359	31,420	\$14,957
360	15,538	\$16,445

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003—Continued

DRG	Cases	Mean + .75 standard deviation
361	339	\$21,352
362	5	\$16,578
363	2,471	\$18,875
364	1,610	\$18,054
365	1,815	\$42,185
366	4,504	\$25,764
367	477	\$11,799
368	3,503	\$23,599
369	3,419	\$12,532
370	1,327	\$18,299
371	1,662	\$11,458
372	927	\$10,237
373	4,076	\$6,914
374	89	\$13,913
376	316	\$11,055
377	47	\$21,747
378	171	\$14,743
379	349	\$7,238
380	98	\$8,554
381	188	\$10,611
382	48	\$4,333
383	1,956	\$10,030
384	129	\$7,214
385	3	\$34,210
389	12	\$23,975
392	2,248	\$66,268
394	2,567	\$38,588
395	105,976	\$16,486
396	17	\$16,006
397	18,727	\$25,519
398	17,860	\$24,884
399	1,671	\$13,548
401	5,768	\$59,903
402	1,454	\$22,863
403	31,365	\$37,680
404	4,277	\$18,437
406	2,391	\$53,929
407	634	\$24,003
408	2,081	\$44,985
409	2,127	\$25,574
410	28,001	\$21,908
411	7	\$7,483
412	15	\$11,456
413	5,253	\$27,415
414	622	\$15,291
415	42,746	\$75,112
416	189,451	\$32,070
417	38	\$22,076
418	25,456	\$21,447
419	16,128	\$17,016
420	3,139	\$12,214
421	10,563	\$14,503
422	66	\$12,891
423	7,972	\$36,726
424	1,224	\$49,024
425	15,914	\$13,506
426	4,462	\$10,410
427	1,557	\$10,483
428	782	\$14,266
429	26,797	\$15,953
430	64,123	\$13,703
431	310	\$12,670
432	443	\$12,980
433	5,479	\$5,805
439	1,493	\$34,068
440	5,673	\$36,892
441	668	\$18,081

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003—Continued

DRG	Cases	Mean + .75 standard deviation
442	17,291	\$48,763
443	3,848	\$19,622
444	5,629	\$14,813
445	2,485	\$9,965
447	6,390	\$10,119
449	32,589	\$16,465
450	7,304	\$8,328
452	25,308	\$20,911
453	5,591	\$10,522
454	4,691	\$16,299
455	1,043	\$9,576
461	5,133	\$24,128
462	9,531	\$19,503
463	26,512	\$13,669
464	7,075	\$9,864
465	192	\$13,169
466	1,684	\$14,122
467	1,106	\$10,115
468	51,680	\$77,692
470	52	\$504,684
471	13,167	\$54,184
473	7,976	\$72,650
475	108,084	\$75,747
476	3,608	\$46,392
477	25,103	\$37,665
478	106,238	\$48,149
479	23,387	\$27,938
480	610	\$193,008
481	819	\$122,102
482	5,175	\$70,600

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003—Continued

DRG	Cases	Mean + .75 standard deviation
483	44,784	\$328,441
484	334	\$110,056
485	3,178	\$61,849
486	2,077	\$99,908
487	3,701	\$40,225
488	760	\$99,624
489	13,168	\$37,620
490	5,356	\$21,486
491	15,098	\$31,213
492	3,052	\$82,667
493	58,870	\$35,610
494	28,431	\$18,981
495	191	\$165,379
496	2,444	\$112,012
497	21,734	\$66,414
498	15,556	\$49,426
499	34,350	\$27,633
500	49,302	\$17,736
501	2,580	\$51,260
502	761	\$27,677
503	5,883	\$24,011
504	125	\$257,167
505	134	\$36,044
506	916	\$87,492
507	337	\$37,309
508	612	\$27,746
509	155	\$13,241
510	1,625	\$23,313
511	571	\$13,248
512	481	\$101,931

TABLE 10.—MEAN AND .75 STANDARD DEVIATION BY DIAGNOSIS-RELATED GROUP (DRG)—JULY 2003—Continued

DRG	Cases	Mean + .75 standard deviation
513	206	\$107,611
515	8,028	\$105,722
516	33,015	\$45,394
517	68,536	\$35,730
518	55,225	\$36,574
519	8,892	\$47,738
520	12,823	\$29,760
521	30,454	\$14,130
522	6,008	\$10,049
523	15,103	\$7,817
524	130,318	\$14,293
525	562	\$247,370
526	51,533	\$42,080
527	135,957	\$33,802
528	1,343	\$140,528
529	4,633	\$63,385
530	2,807	\$24,282
531	3,766	\$64,237
532	2,888	\$30,290
533	42,601	\$32,675
534	51,346	\$20,340
535	5,896	\$156,207
536	20,103	\$118,567
537	6,765	\$36,526
538	6,350	\$19,355
539	4,388	\$69,606
540	1,866	\$25,633

TABLE 11.—FY 2004 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
1	<sup>5</sup> CRANIOTOMY AGE >17 W CC	2.0841	40.0	33.3
2	<sup>8</sup> CRANIOTOMY AGE > 17 W/O CC	2.0841	40.0	33.3
3	<sup>8</sup> CRANIOTOMY AGE 0-17	2.0841	40.0	33.3
6	<sup>8</sup> CARPAL TUNNEL RELEASE	0.4964	18.5	15.4
7	<sup>7</sup> PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W CC	1.5754	41.0	34.1
8	<sup>7</sup> PERIPH & CRANIAL NERVE & OTHER NERV SYST PROC W/O CC	1.5754	41.0	34.1
9	SPINAL DISORDERS & INJURIES	1.5025	32.9	27.4
10	NERVOUS SYSTEM NEOPLASMS W CC	0.7549	23.4	19.5
11	NERVOUS SYSTEM NEOPLASMS W/O CC	0.7281	22.0	18.3
12	DEGENERATIVE NERVOUS SYSTEM DISORDERS	0.7485	25.8	21.5
13	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA	0.7530	25.9	21.5
14	INTERCRANIAL HEMORRHAGE & STROKE W INFARCT	0.9196	27.4	22.8
15	NONSPECIFIC CVA & PRECEREBRAL OCCULSION W/O INFARCT	0.8714	28.8	24.0
16	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.9125	23.9	19.9
17	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC	0.5262	20.4	17.0
18	CRANIAL & PERIPHERAL NERVE DISORDERS W CC	0.8225	23.9	19.9
19	CRANIAL & PERIPHERAL NERVE DISORDERS W/O CC	0.6236	22.7	18.9
20	NERVOUS SYSTEM INFECTION EXCEPT VIRAL MENINGITIS	1.0097	24.8	20.6
21	<sup>2</sup> VIRAL MENINGITIS	0.7372	23.5	19.5
22	<sup>2</sup> HYPERTENSIVE ENCEPHALOPATHY	0.7372	23.5	19.5
23	NONTRAUMATIC STUPOR & COMA	0.9033	28.8	24.0
24	SEIZURE & HEADACHE AGE >17 W CC	0.8527	26.2	21.8
25	SEIZURE & HEADACHE AGE >17 W/O CC	0.7727	24.1	20.0
26	<sup>8</sup> SEIZURE & HEADACHE AGE 0-17	0.7372	23.5	19.5
27	TRAUMATIC STUPOR & COMA, COMA >1 HR	1.1929	30.4	25.3
28	TRAUMATIC STUPOR & COMA, COMA >1 HR AGE ≤17 W CC	1.0211	29.0	24.1
29	TRAUMATIC STUPOR & COMA, COMA >1 HR AGE ≤17 W/O CC	0.9056	26.6	22.1
30	<sup>8</sup> TRAUMATIC STUPOR & COMA, COMA <1 HR AGE 0-17	0.9562	26.1	21.7
31	<sup>7</sup> CONCUSSION AGE >17 W CC	0.9562	26.1	21.7

TABLE 11.—FY 2004 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY—Continued

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
32	<sup>7</sup> CONCUSSION AGE >17 W/O CC .....	0.9562	26.1	21.7
33	<sup>8</sup> CONCUSSION AGE 0-17 .....	0.7372	23.5	19.5
34	OTHER DISORDERS OF NERVOUS SYSTEM W CC .....	0.9140	27.8	23.1
35	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC .....	0.6651	24.5	20.4
36	<sup>8</sup> RETINAL PROCEDURES .....	0.4964	18.5	15.4
37	<sup>8</sup> ORBITAL PROCEDURES .....	0.4964	18.5	15.4
38	<sup>8</sup> PRIMARY IRIS PROCEDURES .....	0.4964	18.5	15.4
39	<sup>8</sup> LENS PROCEDURES WITH OR WITHOUT VITRECTOMY .....	0.4964	18.5	15.4
40	<sup>5</sup> EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE >17 .....	2.0841	40.0	33.3
41	<sup>8</sup> EXTRAOCULAR PROCEDURES EXCEPT ORBIT AGE 0-17 .....	0.4964	18.5	15.4
42	<sup>8</sup> INTRAOCULAR PROCEDURES EXCEPT RETINA, IRIS & LENS .....	0.4964	18.5	15.4
43	<sup>8</sup> HYPHEMA .....	0.4964	18.5	15.4
44	<sup>1</sup> ACUTE MAJOR EYE INFECTIONS .....	0.4964	18.5	15.4
45	<sup>8</sup> NEUROLOGICAL EYE DISORDERS .....	0.4964	18.5	15.4
46	<sup>1</sup> OTHER DISORDERS OF THE EYE AGE >17 W CC .....	0.4964	18.5	15.4
47	<sup>1</sup> OTHER DISORDERS OF THE EYE AGE >17 W/O CC .....	0.4964	18.5	15.4
48	<sup>8</sup> OTHER DISORDERS OF THE EYE AGE 0-17 .....	0.4964	18.5	15.4
49	<sup>8</sup> MAJOR HEAD & NECK PROCEDURES .....	1.3569	32.5	27.0
50	<sup>8</sup> SIALOADENECTOMY .....	0.9562	26.1	21.7
51	<sup>8</sup> SALIVARY GLAND PROCEDURES EXCEPT SIALOADENECTOMY .....	0.9562	26.1	21.7
52	<sup>8</sup> CLEFT LIP & PALATE REPAIR .....	0.9562	26.1	21.7
53	<sup>2</sup> SINUS & MASTOID PROCEDURES AGE >17 .....	0.7372	23.5	19.5
54	<sup>8</sup> SINUS & MASTOID PROCEDURES AGE 0-17 .....	0.9562	26.1	21.7
55	<sup>8</sup> MISCELLANEOUS EAR, NOSE, MOUTH & THROAT PROCEDURES .....	0.9562	26.1	21.7
56	<sup>8</sup> RHINOPLASTY .....	0.7372	23.5	19.5
57	<sup>8</sup> T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17.	0.9562	26.1	21.7
58	<sup>8</sup> T&A PROC, EXCEPT TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17.	0.9562	26.1	21.7
59	<sup>8</sup> TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE >17 .....	0.9562	26.1	21.7
60	<sup>8</sup> TONSILLECTOMY &/OR ADENOIDECTOMY ONLY, AGE 0-17 .....	0.9562	26.1	21.7
61	<sup>2</sup> MYRINGOTOMY W TUBE INSERTION AGE >17 .....	0.7372	23.5	19.5
62	<sup>8</sup> MYRINGOTOMY W TUBE INSERTION AGE 0-17 .....	0.9562	26.1	21.7
63	<sup>3</sup> OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES .....	0.9562	26.1	21.7
64	EAR, NOSE, MOUTH & THROAT MALIGNANCY .....	1.2540	27.5	22.9
65	<sup>1</sup> DYSEQUILIBRIUM .....	0.4964	18.5	15.4
66	<sup>1</sup> EPISTAXIS .....	0.4964	18.5	15.4
67	<sup>8</sup> EPIGLOTTITIS .....	0.9562	26.1	21.7
68	OTITIS MEDIA & URI AGE >17 W CC .....	0.8243	21.9	18.2
69	<sup>1</sup> OTITIS MEDIA & URI AGE >17 W/O CC .....	0.4964	18.5	15.4
70	<sup>8</sup> OTITIS MEDIA & URI AGE 0-17 .....	0.4964	18.5	15.4
71	<sup>8</sup> LARYNGOTRACHEITIS .....	0.4964	18.5	15.4
72	<sup>2</sup> NASAL TRAUMA & DEFORMITY .....	0.7372	23.5	19.5
73	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE >17 .....	0.7215	20.3	16.9
74	<sup>8</sup> OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES AGE 0-17 .....	0.4964	18.5	15.4
75	<sup>5</sup> MAJOR CHEST PROCEDURES .....	2.0841	40.0	33.3
76	OTHER RESP SYSTEM O.R. PROCEDURES W CC .....	2.4382	43.9	36.5
77	<sup>5</sup> OTHER RESP SYSTEM O.R. PROCEDURES W/O CC .....	2.0841	40.0	33.3
78	PULMONARY EMBOLISM .....	0.8896	24.2	20.1
79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W CC .....	0.8985	22.6	18.8
80	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W/O CC .....	0.7645	22.3	18.5
81	<sup>8</sup> RESPIRATORY INFECTIONS & INFLAMMATIONS AGE 0-17 .....	0.4964	18.5	15.4
82	RESPIRATORY NEOPLASMS .....	0.7480	20.3	16.9
83	<sup>3</sup> MAJOR CHEST TRAUMA W CC .....	0.9562	26.1	21.7
84	<sup>2</sup> MAJOR CHEST TRAUMA W/O CC .....	0.7372	23.5	19.5
85	PLEURAL EFFUSION W CC .....	0.8514	23.5	19.5
86	PLEURAL EFFUSION W/O CC .....	0.6540	22.4	18.6
87	PULMONARY EDEMA & RESPIRATORY FAILURE .....	1.6513	31.9	26.5
88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE .....	0.7653	20.7	17.2
89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC .....	0.8428	23.1	19.2
90	SIMPLE PNEUMONIA & PLEURISY AGE >17 W/O CC .....	0.7318	21.7	18.0
91	<sup>8</sup> SIMPLE PNEUMONIA & PLEURISY AGE 0-17 .....	0.7372	23.5	19.5
92	INTERSTITIAL LUNG DISEASE W CC .....	0.7702	20.4	17.0
93	<sup>1</sup> INTERSTITIAL LUNG DISEASE W/O CC .....	0.4964	18.5	15.4
94	PNEUMOTHORAX W CC .....	0.6571	18.9	15.7
95	<sup>1</sup> PNEUMOTHORAX W/O CC .....	0.4964	18.5	15.4
96	BRONCHITIS & ASTHMA AGE >17 W CC .....	0.7381	20.5	17.0
97	BRONCHITIS & ASTHMA AGE >17 W/O CC .....	0.5296	18.7	15.5
98	<sup>8</sup> BRONCHITIS & ASTHMA AGE 0-17 .....	0.4964	18.5	15.4

TABLE 11.—FY 2004 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY—Continued

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
99	RESPIRATORY SIGNS & SYMPTOMS W CC .....	1.0622	26.6	22.1
100	RESPIRATORY SIGNS & SYMPTOMS W/O CC .....	1.0579	26.1	21.7
101	OTHER RESPIRATORY SYSTEM DIAGNOSES W CC .....	0.9009	22.6	18.8
102	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O CC .....	0.7011	21.0	17.5
103	<sup>6</sup> HEART TRANSPLANT .....	0.0000	0.0	0.0
104	<sup>8</sup> CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W CARDIAC CATH. ....	2.0841	40.0	33.3
105	<sup>8</sup> CARDIAC VALVE & OTHER MAJOR CARDIOTHORACIC PROC W/O CARDIAC CATH. ....	2.0841	40.0	33.3
106	<sup>8</sup> CORONARY BYPASS W PTCA .....	2.0841	40.0	33.3
107	<sup>8</sup> CORONARY BYPASS W CARDIAC CATH .....	2.0841	40.0	33.3
108	<sup>5</sup> OTHER CARDIOTHORACIC PROCEDURES .....	2.0841	40.0	33.3
109	<sup>8</sup> CORONARY BYPASS W/O PTCA OR CARDIAC CATH .....	2.0841	40.0	33.3
110	<sup>5</sup> MAJOR CARDIOVASCULAR PROCEDURES W CC .....	2.0841	40.0	33.3
111	<sup>8</sup> MAJOR CARDIOVASCULAR PROCEDURES W/O CC .....	2.0841	40.0	33.3
113	AMPUTATION FOR CIRC SYSTEM DISORDERS EXCEPT UPPER LIMB & TOE ..	1.5629	38.7	32.2
114	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS .....	1.3604	38.3	31.9
115	<sup>5</sup> PRM CARD PACEM IMPL W AMI,HRT FAIL OR SHK,OR AICD LEAD OR GNRTR P. ....	2.0841	40.0	33.3
116	<sup>5</sup> OTH PERM CARD PACEMAK IMPL OR PTCA W CORONARY ARTERY STENT IMPLNT. ....	2.0841	40.0	33.3
117	<sup>3</sup> CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT .....	0.9562	26.1	21.7
118	<sup>5</sup> CARDIAC PACEMAKER DEVICE REPLACEMENT .....	2.0841	40.0	33.3
119	<sup>4</sup> VEIN LIGATION & STRIPPING .....	1.3569	32.5	27.0
120	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES .....	1.2435	34.4	28.6
121	CIRCULATORY DISORDERS W AMI & MAJOR COMP, DISCHARGED ALIVE .....	0.7467	22.1	18.4
122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP, DISCHARGED ALIVE .....	0.6440	18.8	15.6
123	CIRCULATORY DISORDERS W AMI, EXPIRED .....	0.8527	18.8	15.6
124	<sup>4</sup> CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH & COMPLEX DIAG .....	1.3569	32.5	27.0
125	<sup>4</sup> CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O COMPLEX DIAG. ....	1.3569	32.5	27.0
126	ACUTE & SUBACUTE ENDOCARDITIS .....	0.8706	25.6	21.3
127	HEART FAILURE & SHOCK .....	0.7719	22.1	18.4
128	<sup>2</sup> DEEP VEIN THROMBOPHLEBITIS .....	0.7372	23.5	19.5
129	<sup>3</sup> CARDIAC ARREST, UNEXPLAINED .....	0.9562	26.1	21.7
130	PERIPHERAL VASCULAR DISORDERS W CC .....	0.7712	24.4	20.3
131	PERIPHERAL VASCULAR DISORDERS W/O CC .....	0.6398	23.1	19.2
132	ATHEROSCLEROSIS W CC .....	0.8092	22.4	18.6
133	ATHEROSCLEROSIS W/O CC .....	0.7044	21.9	18.2
134	HYPERTENSION .....	0.9154	27.9	23.2
135	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W CC .....	0.9039	23.1	19.2
136	CARDIAC CONGENITAL & VALVULAR DISORDERS AGE >17 W/O CC .....	0.7186	22.4	18.6
137	<sup>8</sup> CARDIAC CONGENITAL & VALVULAR DISORDERS AGE 0-17 .....	0.7372	23.5	19.5
138	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC .....	0.7430	22.7	18.9
139	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC .....	0.6032	20.3	16.9
140	ANGINA PECTORIS .....	0.6094	19.3	16.0
141	SYNCOPE & COLLAPSE W CC .....	0.6453	22.9	19.0
142	SYNCOPE & COLLAPSE W/O CC .....	0.5041	20.3	16.9
143	CHEST PAIN .....	0.7314	21.8	18.1
144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC .....	0.7921	22.2	18.5
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC .....	0.6983	20.7	17.2
146	<sup>8</sup> RECTAL RESECTION W CC .....	2.0841	40.0	33.3
147	<sup>8</sup> RECTAL RESECTION W/O CC .....	2.0841	40.0	33.3
148	<sup>5</sup> MAJOR SMALL & LARGE BOWEL PROCEDURES W CC .....	2.0841	40.0	33.3
149	<sup>1</sup> MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC .....	0.4964	18.5	15.4
150	<sup>4</sup> PERITONEAL ADHESIOLYSIS W CC .....	1.3569	32.5	27.0
151	<sup>8</sup> PERITONEAL ADHESIOLYSIS W/O CC .....	1.3569	32.5	27.0
152	<sup>4</sup> MINOR SMALL & LARGE BOWEL PROCEDURES W CC .....	1.3569	32.5	27.0
153	<sup>8</sup> MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC .....	1.3569	32.5	27.0
154	<sup>5</sup> STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W CC .....	2.0841	40.0	33.3
155	<sup>8</sup> STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE >17 W/O CC .....	1.3569	32.5	27.0
156	<sup>8</sup> STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES AGE 0-17 .....	1.3569	32.5	27.0
157	<sup>4</sup> ANAL & STOMAL PROCEDURES W CC .....	1.3569	32.5	27.0
158	<sup>3</sup> ANAL & STOMAL PROCEDURES W/O CC .....	0.9562	26.1	21.7
159	<sup>8</sup> HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W CC .....	1.3569	32.5	27.0
160	<sup>8</sup> HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL AGE >17 W/O CC .....	1.3569	32.5	27.0
161	<sup>4</sup> INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W CC .....	1.3569	32.5	27.0
162	<sup>8</sup> INGUINAL & FEMORAL HERNIA PROCEDURES AGE >17 W/O CC .....	0.4964	18.5	15.4
163	<sup>8</sup> HERNIA PROCEDURES AGE 0-17 .....	0.4964	18.5	15.4



TABLE 11.—FY 2004 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY—Continued

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
164	<sup>8</sup> APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC .....	2.0841	40.0	33.3
165	<sup>8</sup> APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC .....	0.4964	18.5	15.4
166	<sup>8</sup> APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC .....	2.0841	40.0	33.3
167	<sup>8</sup> APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC .....	0.4964	18.5	15.4
168	<sup>5</sup> MOUTH PROCEDURES W CC .....	2.0841	40.0	33.3
169	<sup>8</sup> MOUTH PROCEDURES W/O CC .....	0.7372	23.5	19.5
170	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC .....	1.7006	40.3	33.5
171	<sup>4</sup> OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC .....	1.3569	32.5	27.0
172	DIGESTIVE MALIGNANCY W CC .....	0.8702	22.5	18.7
173	DIGESTIVE MALIGNANCY W/O CC .....	0.7092	20.2	16.8
174	G.I. HEMORRHAGE W CC .....	0.7874	23.7	19.7
175	G.I. HEMORRHAGE W/O CC .....	0.6345	21.1	17.5
176	COMPLICATED PEPTIC ULCER .....	0.7728	21.2	17.6
177	<sup>2</sup> UNCOMPLICATED PEPTIC ULCER W CC .....	0.7372	23.5	19.5
178	<sup>1</sup> UNCOMPLICATED PEPTIC ULCER W/O CC .....	0.4964	18.5	15.4
179	INFLAMMATORY BOWEL DISEASE .....	1.0023	25.2	21.0
180	<sup>7</sup> G.I. OBSTRUCTION W CC .....	0.8222	22.9	19.0
181	<sup>7</sup> G.I. OBSTRUCTION W/O CC .....	0.8222	22.9	19.0
182	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W CC ....	0.8449	23.5	19.5
183	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE >17 W/O CC ....	0.6362	20.3	16.9
184	<sup>8</sup> ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS AGE 0-17 .....	0.7372	23.5	19.5
185	<sup>2</sup> DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE >17 ...	0.7372	23.5	19.5
186	<sup>8</sup> DENTAL & ORAL DIS EXCEPT EXTRACTIONS & RESTORATIONS, AGE 0-17 ..	0.7372	23.5	19.5
187	<sup>8</sup> DENTAL EXTRACTIONS & RESTORATIONS .....	0.7372	23.5	19.5
188	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W CC .....	1.0308	25.3	21.0
189	OTHER DIGESTIVE SYSTEM DIAGNOSES AGE >17 W/O CC .....	0.7826	21.8	18.1
190	<sup>8</sup> OTHER DIGESTIVE SYSTEM DIAGNOSES AGE 0-17 .....	0.7372	23.5	19.5
191	<sup>4</sup> PANCREAS, LIVER & SHUNT PROCEDURES W CC .....	1.3569	32.5	27.0
192	<sup>1</sup> PANCREAS, LIVER & SHUNT PROCEDURES W/O CC .....	0.4964	18.5	15.4
193	<sup>2</sup> BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC ..	0.7372	23.5	19.5
194	<sup>3</sup> BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC.	0.7372	23.5	19.5
195	<sup>4</sup> CHOLECYSTECTOMY W C.D.E. W CC .....	1.3569	32.5	27.0
196	<sup>8</sup> CHOLECYSTECTOMY W C.D.E. W/O CC .....	0.9562	26.1	21.7
197	<sup>3</sup> CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC .....	0.9562	26.1	21.7
198	<sup>8</sup> CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC .....	0.9562	26.1	21.7
199	<sup>8</sup> HEPATOBIILIARY DIAGNOSTIC PROCEDURE FOR MALIGNANCY .....	0.7372	23.5	19.5
200	<sup>2</sup> HEPATOBIILIARY DIAGNOSTIC PROCEDURE FOR NON-MALIGNANCY .....	0.7372	23.5	19.5
201	<sup>5</sup> OTHER HEPATOBIILIARY OR PANCREAS O.R. PROCEDURES .....	2.0841	40.0	33.3
202	CIRRHOSIS & ALCOHOLIC HEPATITIS .....	0.7254	22.3	18.5
203	MALIGNANCY OF HEPATOBIILIARY SYSTEM OR PANCREAS .....	0.6758	18.9	15.7
204	DISORDERS OF PANCREAS EXCEPT MALIGNANCY .....	0.9986	23.4	19.5
205	<sup>7</sup> DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC .....	0.7029	22.1	18.4
206	<sup>7</sup> DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC .....	0.7029	22.1	18.4
207	<sup>7</sup> DISORDERS OF THE BILIARY TRACT W CC .....	0.6671	20.5	17.0
208	<sup>7</sup> DISORDERS OF THE BILIARY TRACT W/O CC .....	0.6671	20.5	17.0
209	<sup>4</sup> MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF LOWER EXTREMITY.	1.3569	32.5	27.0
210	<sup>4</sup> HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W CC .....	1.3569	32.5	27.0
211	<sup>8</sup> HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE >17 W/O CC .....	0.7372	23.5	19.5
212	<sup>8</sup> HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT AGE 0-17 .....	0.7372	23.5	19.5
213	AMPUTATION FOR MUSCULOSKELETAL SYSTEM & CONN TISSUE DISORDERS.	1.3851	33.8	28.1
216	<sup>4</sup> BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE .....	1.3569	32.5	27.0
217	WND DEBRID & SKN GRFT EXCEPT HAND, FOR MUSCSKELET & CONN TISS DIS.	1.4038	39.3	32.7
218	<sup>3</sup> LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W CC.	0.9562	26.1	21.7
219	<sup>8</sup> LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE >17 W/O CC.	0.9562	26.1	21.7
220	<sup>8</sup> LOWER EXTREM & HUMER PROC EXCEPT HIP, FOOT, FEMUR AGE 0-17 .....	0.9562	26.1	21.7
223	<sup>3</sup> MAJOR SHOULDER/ELBOW PROC, OR OTHER UPPER EXTREMITY PROC W CC.	0.9562	26.1	21.7
224	<sup>8</sup> SHOULDER, ELBOW OR FOREARM PROC, EXC MAJOR JOINT PROC, W/O CC .....	0.9562	26.1	21.7
225	<sup>3</sup> FOOT PROCEDURES .....	0.9562	26.1	21.7
226	<sup>7</sup> SOFT TISSUE PROCEDURES W CC .....	1.3569	32.5	27.0
227	<sup>7</sup> SOFT TISSUE PROCEDURES W/O CC .....	1.3569	32.5	27.0
228	<sup>4</sup> MAJOR THUMB OR JOINT PROC, OR OTH HAND OR WRIST PROC W CC .....	1.3569	32.5	27.0
229	<sup>8</sup> HAND OR WRIST PROC, EXCEPT MAJOR JOINT PROC, W/O CC .....	0.9562	26.1	21.7

TABLE 11.—FY 2004 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY—Continued

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
230	<sup>4</sup> LOCAL EXCISION & REMOVAL OF INT FIX DEVICES OF HIP & FEMUR .....	1.3569	32.5	27.0
232	<sup>2</sup> ARTHROSCOPY .....	0.7372	23.5	19.5
233	<sup>3</sup> OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC .....	0.9562	26.1	21.7
234	<sup>3</sup> OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC .....	0.9562	26.1	21.7
235	FRACTURES OF FEMUR .....	0.8396	29.6	24.6
236	FRACTURES OF HIP & PELVIS .....	0.7368	27.1	22.5
237	<sup>2</sup> SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH .....	0.7372	23.5	19.5
238	OSTEOMYELITIS .....	0.8432	27.9	23.2
239	PATHOLOGICAL FRACTURES & MUSCULOSKELETAL & CONN TISS MALIGNANCY.	0.6610	22.0	18.3
240	CONNECTIVE TISSUE DISORDERS W CC .....	0.6685	21.2	17.6
241	CONNECTIVE TISSUE DISORDERS W/O CC .....	0.4538	18.7	15.5
242	SEPTIC ARTHRITIS .....	0.7721	26.4	22.0
243	MEDICAL BACK PROBLEMS .....	0.6616	23.2	19.3
244	BONE DISEASES & SPECIFIC ARTHROPATHIES W CC .....	0.5563	20.0	16.6
245	BONE DISEASES & SPECIFIC ARTHROPATHIES W/O CC .....	0.4721	18.5	15.4
246	NON-SPECIFIC ARTHROPATHIES .....	0.5128	22.2	18.5
247	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE .....	0.5536	20.2	16.8
248	TENDONITIS, MYOSITIS & BURSTITIS .....	0.7274	24.5	20.4
249	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE .....	0.7829	27.0	22.5
250	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W CC .....	0.8206	29.9	24.9
251	FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE >17 W/O CC .....	0.6009	27.3	22.7
252	<sup>8</sup> FX, SPRN, STRN & DISL OF FOREARM, HAND, FOOT AGE 0-17 .....	0.9562	26.1	21.7
253	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W CC .....	0.8176	27.6	23.0
254	FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE >17 W/O CC .....	0.6691	25.1	20.9
255	<sup>8</sup> FX, SPRN, STRN & DISL OF UPARM,LOWLEG EX FOOT AGE 0-17 .....	0.9562	26.1	21.7
256	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES ..	0.8294	25.9	21.5
257	<sup>3</sup> TOTAL MASTECTOMY FOR MALIGNANCY W CC .....	0.9562	26.1	21.7
258	<sup>8</sup> TOTAL MASTECTOMY FOR MALIGNANCY W/O CC .....	0.9562	26.1	21.7
259	<sup>8</sup> SUBTOTAL MASTECTOMY FOR MALIGNANCY W CC .....	0.9562	26.1	21.7
260	<sup>8</sup> SUBTOTAL MASTECTOMY FOR MALIGNANCY W/O CC .....	0.9562	26.1	21.7
261	<sup>5</sup> BREAST PROC FOR NON-MALIGNANCY EXCEPT BIOPSY & LOCAL EXCISION.	2.0841	40.0	33.3
262	<sup>3</sup> BREAST BIOPSY & LOCAL EXCISION FOR NON-MALIGNANCY .....	0.9562	26.1	21.7
263	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W CC .....	1.4522	42.4	35.3
264	SKIN GRAFT &/OR DEBRID FOR SKN ULCER OR CELLULITIS W/O CC .....	1.2892	44.1	36.7
265	<sup>7</sup> SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W CC	1.2215	34.8	29.0
266	<sup>7</sup> SKIN GRAFT &/OR DEBRID EXCEPT FOR SKIN ULCER OR CELLULITIS W/O CC.	1.2215	34.8	29.0
267	<sup>8</sup> PERIANAL & PILONIDAL PROCEDURES .....	0.9562	26.1	21.7
268	<sup>5</sup> SKIN, SUBCUTANEOUS TISSUE & BREAST PLASTIC PROCEDURES .....	2.0841	40.0	33.3
269	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC .....	1.4466	43.0	35.8
270	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC .....	0.9916	33.9	28.2
271	SKIN ULCERS .....	0.9620	30.4	25.3
272	MAJOR SKIN DISORDERS W CC .....	0.7121	22.8	19.0
273	<sup>1</sup> MAJOR SKIN DISORDERS W/O CC .....	0.4964	18.5	15.4
274	MALIGNANT BREAST DISORDERS W CC .....	0.9072	24.9	20.7
275	<sup>2</sup> MALIGNANT BREAST DISORDERS W/O CC .....	0.7372	23.5	19.5
276	<sup>1</sup> NON-MALIGANT BREAST DISORDERS .....	0.4964	18.5	15.4
277	CELLULITIS AGE >17 W CC .....	0.7409	23.6	19.6
278	CELLULITIS AGE >17 W/O CC .....	0.5982	20.7	17.2
279	<sup>8</sup> CELLULITIS AGE 0-17 .....	0.9562	26.1	21.7
280	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W CC .....	0.9724	29.5	24.5
281	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE >17 W/O CC .....	0.7386	26.4	22.0
282	<sup>8</sup> TRAUMA TO THE SKIN, SUBCUT TISS & BREAST AGE 0-17 .....	0.7372	23.5	19.5
283	MINOR SKIN DISORDERS W CC .....	0.6508	19.3	16.0
284	<sup>1</sup> MINOR SKIN DISORDERS W/O CC .....	0.4964	18.5	15.4
285	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DISORDERS.	1.5176	37.4	31.1
286	<sup>8</sup> ADRENAL & PITUITARY PROCEDURES .....	0.7372	23.5	19.5
287	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DISORDERS.	1.3982	39.7	33.0
288	<sup>5</sup> O.R. PROCEDURES FOR OBESITY .....	2.0841	40.0	33.3
289	<sup>8</sup> PARATHYROID PROCEDURES .....	0.7372	23.5	19.5
290	<sup>8</sup> THYROID PROCEDURES .....	0.7372	23.5	19.5
291	<sup>8</sup> THYROGLOSSAL PROCEDURES .....	0.7372	23.5	19.5
292	<sup>4</sup> OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC .....	1.3569	32.5	27.0
293	<sup>8</sup> OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC .....	0.9562	26.1	21.7
294	DIABETES AGE >35 .....	0.8061	25.9	21.5

TABLE 11.—FY 2004 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY—Continued

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
295	<sup>3</sup> DIABETES AGE 0-35 .....	0.9562	26.1	21.7
296	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W CC .....	0.8207	24.1	20.0
297	NUTRITIONAL & MISC METABOLIC DISORDERS AGE >17 W/O CC .....	0.6524	24.5	20.4
298	<sup>8</sup> NUTRITIONAL & MISC METABOLIC DISORDERS AGE 0-17 .....	0.7372	23.5	19.5
299	<sup>3</sup> UNBORN ERRORS OF METABOLISM .....	0.9562	26.1	21.7
300	ENDOCRINE DISORDERS W CC .....	0.7704	22.3	18.5
301	<sup>2</sup> ENDOCRINE DISORDERS W/O CC .....	0.7372	23.5	19.5
302	<sup>6</sup> KIDNEY TRANSPLANT .....	0.0000	0.0	0.0
303	<sup>8</sup> KIDNEY, URETER & MAJOR BLADDER PROCEDURES FOR NEOPLASM .....	2.0841	40.0	33.3
304	<sup>5</sup> KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W CC .....	2.0841	40.0	33.3
305	<sup>1</sup> KIDNEY, URETER & MAJOR BLADDER PROC FOR NON-NEOPL W/O CC .....	0.4964	18.5	15.4
306	<sup>8</sup> PROSTATECTOMY W CC .....	1.3569	32.5	27.0
307	<sup>8</sup> PROSTATECTOMY W/O CC .....	1.3569	32.5	27.0
308	<sup>4</sup> MINOR BLADDER PROCEDURES W CC .....	1.3569	32.5	27.0
309	<sup>2</sup> MINOR BLADDER PROCEDURES W/O CC .....	0.7372	23.5	19.5
310	<sup>4</sup> TRANSURETHRAL PROCEDURES W CC .....	1.3569	32.5	27.0
311	<sup>1</sup> TRANSURETHRAL PROCEDURES W/O CC .....	0.4964	18.5	15.4
312	<sup>4</sup> URETHRAL PROCEDURES, AGE >17 W CC .....	1.3569	32.5	27.0
313	<sup>8</sup> URETHRAL PROCEDURES, AGE >17 W/O CC .....	0.4964	18.5	15.4
314	<sup>8</sup> URETHRAL PROCEDURES, AGE 0-17 .....	0.4964	18.5	15.4
315	OTHER KIDNEY & URINARY TRACT O.R. PROCEDURES .....	1.5070	36.8	30.6
316	RENAL FAILURE .....	0.9214	23.8	19.8
317	<sup>3</sup> ADMIT FOR RENAL DIALYSIS .....	0.9562	26.1	21.7
318	KIDNEY & URINARY TRACT NEOPLASMS W CC .....	0.7048	21.1	17.5
319	<sup>1</sup> KIDNEY & URINARY TRACT NEOPLASMS W/O CC .....	0.4964	18.5	15.4
320	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W CC .....	0.7223	23.0	19.1
321	KIDNEY & URINARY TRACT INFECTIONS AGE >17 W/O CC .....	0.6260	23.2	19.3
322	<sup>8</sup> KIDNEY & URINARY TRACT INFECTIONS AGE 0-17 .....	0.4964	18.5	15.4
323	<sup>2</sup> URINARY STONES W CC, &/OR ESW LITHOTRIPSY .....	0.7372	23.5	19.5
324	<sup>2</sup> URINARY STONES W/O CC .....	0.7372	23.5	19.5
325	<sup>3</sup> KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W CC .....	0.9562	26.1	21.7
326	<sup>1</sup> KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE >17 W/O CC .....	0.4964	18.5	15.4
327	<sup>8</sup> KIDNEY & URINARY TRACT SIGNS & SYMPTOMS AGE 0-17 .....	0.4964	18.5	15.4
328	<sup>8</sup> URETHRAL STRICTURE AGE >17 W CC .....	0.4964	18.5	15.4
329	<sup>8</sup> URETHRAL STRICTURE AGE >17 W/O CC .....	0.4964	18.5	15.4
330	<sup>8</sup> URETHRAL STRICTURE AGE 0-17 .....	0.4964	18.5	15.4
331	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W CC .....	0.8473	23.2	19.3
332	OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE >17 W/O CC .....	0.5722	21.1	17.5
333	<sup>8</sup> OTHER KIDNEY & URINARY TRACT DIAGNOSES AGE 0-17 .....	0.4964	18.5	15.4
334	<sup>8</sup> MAJOR MALE PELVIC PROCEDURES W CC .....	2.0841	40.0	33.3
335	<sup>8</sup> MAJOR MALE PELVIC PROCEDURES W/O CC .....	2.0841	40.0	33.3
336	<sup>8</sup> TRANSURETHRAL PROSTATECTOMY W CC .....	0.7372	23.5	19.5
337	<sup>8</sup> TRANSURETHRAL PROSTATECTOMY W/O CC .....	0.7372	23.5	19.5
338	<sup>8</sup> TESTES PROCEDURES, FOR MALIGNANCY .....	0.7372	23.5	19.5
339	<sup>2</sup> TESTES PROCEDURES, NON-MALIGNANCY AGE >17 .....	0.7372	23.5	19.5
340	<sup>8</sup> TESTES PROCEDURES, NON-MALIGNANCY AGE 0-17 .....	0.7372	23.5	19.5
341	<sup>2</sup> PENIS PROCEDURES .....	0.7372	23.5	19.5
342	<sup>1</sup> CIRCUMCISION AGE >17 .....	0.4964	18.5	15.4
343	<sup>8</sup> CIRCUMCISION AGE 0-17 .....	0.7372	23.5	19.5
344	<sup>1</sup> OTHER MALE REPRODUCTIVE SYSTEM O.R. PROCEDURES FOR MALIGNANCY.	0.4964	18.5	15.4
345	<sup>5</sup> OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXCEPT FOR MALIGNANCY.	2.0841	40.0	33.3
346	<sup>7</sup> MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W CC .....	0.7150	22.3	18.5
347	<sup>7</sup> MALIGNANCY, MALE REPRODUCTIVE SYSTEM, W/O CC .....	0.7150	22.3	18.5
348	<sup>1</sup> BENIGN PROSTATIC HYPERTROPHY W CC .....	0.4964	18.5	15.4
349	<sup>1</sup> BENIGN PROSTATIC HYPERTROPHY W/O CC .....	0.4964	18.5	15.4
350	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM .....	1.1820	26.6	22.1
351	<sup>8</sup> STERILIZATION, MALE .....	0.7372	23.5	19.5
352	<sup>3</sup> OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES .....	0.9562	26.1	21.7
353	<sup>8</sup> PELVIC EVISCERATION, RADICAL HYSTERECTOMY & RADICAL VULVECTOMY.	2.0841	40.0	33.3
354	<sup>8</sup> UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC .....	2.0841	40.0	33.3
355	<sup>8</sup> UTERINE, ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC .....	2.0841	40.0	33.3
356	<sup>8</sup> FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES .....	1.3569	32.5	27.0
357	<sup>8</sup> UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY .....	1.3569	32.5	27.0
358	<sup>8</sup> UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC .....	1.3569	32.5	27.0
359	<sup>8</sup> UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC .....	1.3569	32.5	27.0
360	<sup>4</sup> VAGINA, CERVIX & VULVA PROCEDURES .....	1.3569	32.5	27.0

TABLE 11.—FY 2004 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY—Continued

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
361	<sup>8</sup> LAPAROSCOPY & INCISIONAL TUBAL INTERRUPTION .....	0.4964	18.5	15.4
362	<sup>8</sup> ENDOSCOPIC TUBAL INTERRUPTION .....	0.4964	18.5	15.4
363	<sup>8</sup> D&C, CONIZATION & RADIO-IMPLANT, FOR MALIGNANCY .....	0.4964	18.5	15.4
364	<sup>8</sup> D&C, CONIZATION EXCEPT FOR MALIGNANCY .....	0.4964	18.5	15.4
365	<sup>5</sup> OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES .....	2.0841	40.0	33.3
366	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC .....	0.8139	23.1	19.2
367	<sup>1</sup> MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC .....	0.4964	18.5	15.4
368	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM .....	0.6963	19.3	16.0
369	<sup>3</sup> MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS .....	0.9562	26.1	21.7
370	<sup>8</sup> CESAREAN SECTION W CC .....	0.9562	26.1	21.7
371	<sup>8</sup> CESAREAN SECTION W/O CC .....	0.4964	18.5	15.4
372	<sup>8</sup> VAGINAL DELIVERY W COMPLICATING DIAGNOSES .....	0.4964	18.5	15.4
373	<sup>8</sup> VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES .....	0.4964	18.5	15.4
374	<sup>8</sup> VAGINAL DELIVERY W STERILIZATION &/OR D&C .....	0.4964	18.5	15.4
375	<sup>8</sup> VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C .....	0.4964	18.5	15.4
376	<sup>1</sup> POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE .....	0.4964	18.5	15.4
377	<sup>8</sup> POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE .....	0.4964	18.5	15.4
378	<sup>8</sup> ECTOPIC PREGNANCY .....	0.9562	26.1	21.7
379	<sup>8</sup> THREATENED ABORTION .....	0.4964	18.5	15.4
380	<sup>8</sup> ABORTION W/O D&C .....	0.4964	18.5	15.4
381	<sup>8</sup> ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY .....	0.4964	18.5	15.4
382	<sup>8</sup> FALSE LABOR .....	0.4964	18.5	15.4
383	<sup>8</sup> OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS .....	0.4964	18.5	15.4
384	<sup>8</sup> OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS .....	0.4964	18.5	15.4
385	<sup>8</sup> NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY .....	0.4964	18.5	15.4
386	<sup>8</sup> EXTREME IMMATUREITY .....	0.4964	18.5	15.4
387	<sup>8</sup> PREMATURITY W MAJOR PROBLEMS .....	0.4964	18.5	15.4
388	<sup>8</sup> PREMATURITY W/O MAJOR PROBLEMS .....	0.4964	18.5	15.4
389	<sup>8</sup> FULL TERM NEONATE W MAJOR PROBLEMS .....	0.4964	18.5	15.4
390	<sup>8</sup> NEONATE W OTHER SIGNIFICANT PROBLEMS .....	0.4964	18.5	15.4
391	<sup>8</sup> NORMAL NEWBORN .....	0.4964	18.5	15.4
392	<sup>8</sup> SPLENECTOMY AGE >17 .....	0.7372	23.5	19.5
393	<sup>8</sup> SPLENECTOMY AGE 0-17 .....	0.7372	23.5	19.5
394	<sup>3</sup> OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS.	0.9562	26.1	21.7
395	RED BLOOD CELL DISORDERS AGE >17 .....	0.7782	24.0	20.0
396	<sup>8</sup> RED BLOOD CELL DISORDERS AGE 0-17 .....	0.4964	18.5	15.4
397	COAGULATION DISORDERS .....	0.9454	23.5	19.5
398	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC .....	0.8372	22.0	18.3
399	<sup>1</sup> RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC .....	0.4964	18.5	15.4
401	<sup>5</sup> LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W CC .....	2.0841	40.0	33.3
402	<sup>3</sup> LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER O.R. PROC W/O CC .....	0.9562	26.1	21.7
403	LYMPHOMA & NON-ACUTE LEUKEMIA W CC .....	0.8941	22.4	18.6
404	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC .....	0.7394	18.0	15.0
405	<sup>8</sup> ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE 0-17 .....	0.7372	23.5	19.5
406	<sup>5</sup> MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W CC ..	2.0841	40.0	33.3
407	<sup>5</sup> MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R.PROC W/O CC	0.9562	26.1	21.7
408	<sup>3</sup> MYELOPROLIF DISORD OR POORLY DIFF NEOPL W OTHER O.R.PROC .....	0.9562	26.1	21.7
409	RADIOTHERAPY .....	0.8871	25.1	20.9
410	<sup>3</sup> CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS .....	0.9562	26.1	21.7
411	<sup>8</sup> HISTORY OF MALIGNANCY W/O ENDOSCOPY .....	0.4964	18.5	15.4
412	<sup>8</sup> HISTORY OF MALIGNANCY W ENDOSCOPY .....	0.4964	18.5	15.4
413	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC .....	0.9541	25.5	21.2
414	<sup>1</sup> OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC .....	0.4964	18.5	15.4
415	O.R. PROCEDURE FOR INFECTIOUS & PARASITIC DISEASES .....	1.6849	40.1	33.4
416	SEPTICEMIA AGE >17 .....	0.9191	24.9	20.7
417	<sup>8</sup> SEPTICEMIA AGE 0-17 .....	0.9562	26.1	21.7
418	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS .....	0.8304	25.2	21.0
419	<sup>3</sup> FEVER OF UNKNOWN ORIGIN AGE >17 W CC .....	0.9562	26.1	21.7
420	<sup>2</sup> FEVER OF UNKNOWN ORIGIN AGE >17 W/O CC .....	0.7372	23.5	19.5
421	<sup>2</sup> VIRAL ILLNESS AGE >17 .....	0.7372	23.5	19.5
422	<sup>8</sup> VIRAL ILLNESS & FEVER OF UNKNOWN ORIGIN AGE 0-17 .....	0.7372	23.5	19.5
423	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES .....	0.9024	23.1	19.2
424	<sup>4</sup> O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS .....	1.3569	32.5	27.0
425	ACUTE ADJUSTMENT REACTION & PSYCHOLOGICAL DYSFUNCTION .....	0.5981	27.5	22.9
426	DEPRESSIVE NEUROSES .....	0.4660	22.3	18.5
427	<sup>4</sup> NEUROSES EXCEPT DEPRESSIVE .....	1.3569	32.5	27.0
428	<sup>1</sup> DISORDERS OF PERSONALITY & IMPULSE CONTROL .....	0.4964	18.5	15.4
429	ORGANIC DISTURBANCES & MENTAL RETARDATION .....	0.6438	27.4	22.8

TABLE 11.—FY 2004 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY—Continued

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
430	PSYCHOSES .....	0.4689	22.7	18.9
431	<sup>1</sup> CHILDHOOD MENTAL DISORDERS .....	0.4964	18.5	15.4
432	<sup>1</sup> OTHER MENTAL DISORDER DIAGNOSES .....	0.4964	18.5	15.4
433	<sup>1</sup> ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA .....	0.4964	18.5	15.4
439	SKIN GRAFTS FOR INJURIES .....	1.3663	40.5	33.7
440	WOUND DEBRIDEMENTS FOR INJURIES .....	1.5854	40.0	33.3
441	<sup>5</sup> HAND PROCEDURES FOR INJURIES .....	2.0841	40.0	33.3
442	OTHER O.R. PROCEDURES FOR INJURIES W CC .....	1.4971	44.6	37.1
443	<sup>4</sup> OTHER O.R. PROCEDURES FOR INJURIES W/O CC .....	1.3569	32.5	27.0
444	TRAUMATIC INJURY AGE >17 W CC .....	0.9609	30.6	25.5
445	TRAUMATIC INJURY AGE >17 W/O CC .....	0.7552	26.6	22.1
446	<sup>8</sup> TRAUMATIC INJURY AGE 0-17 .....	0.7372	23.5	19.5
447	<sup>3</sup> ALLERGIC REACTIONS AGE >17 .....	0.9562	26.1	21.7
448	<sup>8</sup> ALLERGIC REACTIONS AGE 0-17 .....	0.7372	23.5	19.5
449	<sup>7</sup> POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC .....	0.9562	26.1	21.7
450	<sup>7</sup> POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC .....	0.9562	26.1	21.7
451	<sup>8</sup> POISONING & TOXIC EFFECTS OF DRUGS AGE 0-17 .....	0.7372	23.5	19.5
452	COMPLICATIONS OF TREATMENT W CC .....	0.9692	24.9	20.7
453	COMPLICATIONS OF TREATMENT W/O CC .....	0.8633	24.2	20.1
454	<sup>2</sup> OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC .....	0.7372	23.5	19.5
455	<sup>2</sup> OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC .....	0.7372	23.5	19.5
461	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES .....	1.3216	36.5	30.4
462	REHABILITATION .....	0.6471	23.2	19.3
463	SIGNS & SYMPTOMS W CC .....	0.7541	26.8	22.3
464	SIGNS & SYMPTOMS W/O CC .....	0.6170	25.5	21.2
465	<sup>2</sup> AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS .....	0.7372	23.5	19.5
466	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS .....	0.7365	22.0	18.3
467	<sup>1</sup> OTHER FACTORS INFLUENCING HEALTH STATUS .....	0.4964	18.5	15.4
468	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS .....	2.0686	42.5	35.4
469	<sup>6</sup> PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS .....	0.0000	0.0	0.0
470	<sup>6</sup> UNGROUPABLE .....	0.0000	0.0	0.0
471	<sup>5</sup> BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY .....	2.0841	40.0	33.3
473	<sup>3</sup> ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17 .....	0.9562	26.1	21.7
475	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT .....	2.1358	35.2	29.3
476	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS .....	1.0032	31.9	26.5
477	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS .....	1.8998	40.0	33.3
478	<sup>7</sup> OTHER VASCULAR PROCEDURES W CC .....	1.2567	34.2	28.5
479	<sup>7</sup> OTHER VASCULAR PROCEDURES W/O CC .....	1.2567	34.2	28.5
480	<sup>6</sup> LIVER TRANSPLANT .....	0.0000	0.0	0.0
481	<sup>8</sup> BONE MARROW TRANSPLANT .....	0.9562	26.1	21.7
482	<sup>5</sup> TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES .....	2.0841	40.0	33.3
483	TRACH W MECH VENT 96+ HRS OR PDX EXCEPT FACE, MOUTH & NECK DIAG. ....	3.2131	55.7	46.4
484	<sup>8</sup> CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA .....	2.0841	40.0	33.3
485	<sup>8</sup> LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TR. ....	1.3569	32.5	27.0
486	<sup>4</sup> OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA .....	1.3569	32.5	27.0
487	OTHER MULTIPLE SIGNIFICANT TRAUMA .....	1.2484	32.7	27.2
488	<sup>5</sup> HIV W EXTENSIVE O.R. PROCEDURE .....	2.0841	40.0	33.3
489	HIV W MAJOR RELATED CONDITION .....	0.9254	21.3	17.7
490	HIV W OR W/O OTHER RELATED CONDITION .....	0.7361	19.6	16.3
491	<sup>8</sup> MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY. ....	1.3569	32.5	27.0
492	<sup>8</sup> CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS OR W USE HIGH DOSE CHEMOTHERAPY AGENT. ....	0.9562	26.1	21.7
493	<sup>7</sup> LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC .....	1.3569	32.5	27.0
494	<sup>7</sup> LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC .....	2.0841	40.0	33.3
495	<sup>6</sup> LUNG TRANSPLANT .....	0.0000	0.0	0.0
496	<sup>8</sup> COMBINED ANTERIOR/POSTERIOR SPINAL FUSION .....	1.3569	32.5	27.0
497	<sup>7</sup> SPINAL FUSION W CC .....	0.9562	26.1	21.7
498	<sup>7</sup> SPINAL FUSION W/O CC4 .....	0.9562	26.1	21.7
499	<sup>5</sup> BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC .....	2.0841	40.0	33.3
500	<sup>4</sup> BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC .....	1.3569	32.5	27.0
501	<sup>5</sup> KNEE PROCEDURES W PDX OF INFECTION W CC .....	2.0841	40.0	33.3
502	<sup>2</sup> KNEE PROCEDURES W PDX OF INFECTION W/O CC .....	0.7372	23.5	19.5
503	<sup>3</sup> KNEE PROCEDURES W/O PDX OF INFECTION .....	0.9562	26.1	21.7
504	<sup>8</sup> EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT .....	2.0841	40.0	33.3
505	<sup>4</sup> EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT .....	1.3569	32.5	27.0

TABLE 11.—FY 2004 LTC-DRGs, RELATIVE WEIGHTS, GEOMETRIC AVERAGE LENGTH OF STAY, AND 5/6TH OF THE AVERAGE LENGTH OF STAY—Continued

LTC-DRG	Description	Relative weight	Geometric average length of stay	5/6th of the average length of stay
506	<sup>7</sup> FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAU-MA.	0.7372	23.5	19.5
507	<sup>7</sup> FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	0.7372	23.5	19.5
508	<sup>2</sup> FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	0.7372	23.5	19.5
509	<sup>2</sup> FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAU-MA.	0.7372	23.5	19.5
510	<sup>2</sup> NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA .....	0.7372	23.5	19.5
511	<sup>1</sup> NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA .....	0.4964	18.5	15.4
512	<sup>6</sup> SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT .....	0.0000	0.0	0.0
513	<sup>6</sup> PANCREAS TRANSPLANT .....	0.0000	0.0	0.0
515	<sup>5</sup> CARDIAC DEFIBRILATOR IMPLANT W/O CARDIAC CATH .....	2.0841	40.0	33.3
516	<sup>8</sup> PERCUTANEOUS CARDIVASCULAR PROCEDURE W AMI .....	0.9562	26.1	21.7
517	<sup>4</sup> PERCUTANEOUS CARDIVASCULAR PROC W NON-DRUG ELUTING STENT W/O AMI.	1.3569	32.5	27.0
518	<sup>3</sup> PERCUTANEOUS CARDIVASCULAR PROC W/O CORONARY ARTERY STENT OR AMI.	0.9562	26.1	21.7
519	<sup>4</sup> CERVICAL SPINAL FUSION W CC .....	1.3569	32.5	27.0
520	<sup>8</sup> CERVICAL SPINAL FUSION W/O CC .....	0.9562	26.1	21.7
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC .....	0.4753	20.5	17.0
522	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC.	0.4061	20.4	17.0
523	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O CC.	0.4214	19.8	16.5
524	TRANSIENT ISCHEMIA .....	0.5885	22.9	19.0
525	<sup>8</sup> HEART ASSIST SYSTEM IMPLANT .....	2.0841	40.0	33.3
526	<sup>8</sup> PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W AMI.	1.3569	32.5	27.0
527	<sup>8</sup> PERCUTANEOUS CARVIOVASCULAR PROC W DRUG-ELUTING STENT W/O AMI.	1.3569	32.5	27.0
528	<sup>8</sup> INTRACRANIAL VASCLUAR PROCEDURES WITH PDX HEMORRHAGE .....	2.0841	40.0	33.3
529	<sup>2</sup> VENTRICULAR SHUNT PROCEDURES WITH CC .....	0.7372	23.5	19.5
530	<sup>8</sup> VENTRICULAR SHUNT PROCEDURES WITHOUT CC .....	0.7372	23.5	19.5
531	<sup>4</sup> SPINAL PROCEDURES WITH CC .....	1.3569	32.5	27.0
532	<sup>3</sup> SPINAL PROCEDURES WITHOUT CC .....	0.9562	26.1	21.7
533	<sup>5</sup> EXTRACRANIAL VASCULAR PROCEDURES WITH CC .....	2.0841	40.0	33.3
534	<sup>8</sup> EXTRACRANIAL VASCULAR PROCEDURES WITHOUT CC .....	1.3569	32.5	27.0
535	<sup>8</sup> CARDIAC DEFIB IMPLANT WITH CARDIAC CATH WITH AMI/HF/SHOCK .....	2.0841	40.0	33.3
536	<sup>5</sup> CARDIAC DEFIB IMPLANT WITH CARDIAC CATH WITHOUT AMI/HF/SHOCK ...	2.0841	40.0	33.3
537	<sup>4</sup> LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITH CC.	1.3569	32.5	27.0
538	<sup>1</sup> LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND FEMUR WITHOUT CC.	0.4964	18.5	15.4
539	<sup>8</sup> LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITH CC .....	2.0841	40.0	33.3
540	<sup>1</sup> LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURE WITHOUT CC	0.4964	18.5	15.4

<sup>1</sup> Relative weights for these LTC-DRGs were determined by assigning these cases to low volume quintile 1.  
<sup>2</sup> Relative weights for these LTC-DRGs were determined by assigning these cases to low volume quintile 2.  
<sup>3</sup> Relative weights for these LTC-DRGs were determined by assigning these cases to low volume quintile 3.  
<sup>4</sup> Relative weights for these LTC-DRGs were determined by assigning these cases to low volume quintile 4.  
<sup>5</sup> Relative weights for these LTC-DRGs were determined by assigning these cases to low volume quintile 5.  
<sup>6</sup> Relative weights for these LTC-DRGs were assigned a value of 0.0000.  
<sup>7</sup> Relative weights for these LTC-DRGs were determined after adjusting to account for nonmonotonicity (see step 5 above).  
<sup>8</sup> Relative weights for these LTC-DRGs were determined by assigning these cases to the appropriate low volume quintile because they had no LTCH cases in the FY 2002 MedPAR.

**Appendix A—Regulatory Analysis of Impacts**

**I. Background and Summary**

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

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

We have determined that this final rule is a major rule as defined in 5 U.S.C. 804(2). Based on the overall percentage change in payments per case estimated using our payment simulation model (a 1.8 percent increase), we estimate that the total impact of these proposed changes for FY 2004 payments compared to FY 2003 payments to be approximately a \$1.8 billion increase. This amount does not reflect changes in hospital admissions or case-mix intensity, which would also affect overall payment changes.

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

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98-21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the IPPS, we classify these hospitals as urban hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4) also requires that agencies assess anticipated costs and benefits before issuing a final rule that has been preceded by a proposed rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$110 million. This final rule will not mandate any requirements for State, local, or tribal governments.

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

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

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

## II. Objectives

The primary objective of the IPPS is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that

payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of preserving the Medicare Trust Fund.

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

## III. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our policy changes, as well as statutory changes effective for FY 2004, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. In the May 19, 2003 proposed rule, we solicited comments and information about the anticipated effects of the changes on hospitals that we had proposed and our methodology for estimating them. Any comments that we received in response to the proposed rule are addressed in the appropriate sections throughout this final rule.

## IV. Hospitals Included in and Excluded From the IPPS

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general short-term, acute care hospitals that participate in the Medicare program. There were 42 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment method for these hospitals. Among other short-term, acute care hospitals, only the 47 such hospitals in Maryland remain excluded from the IPPS under the waiver at section 1814(b)(3) of the Act.

There are approximately 768 critical access hospitals (CAHs). These small, limited service hospitals are paid on the basis of reasonable costs rather than under the IPPS. The remaining 20 percent are specialty hospitals that are excluded from the IPPS. These specialty hospitals include psychiatric hospitals and units, rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals. The impacts of our policy changes on these hospitals are discussed below.

Thus, as of April 2003, we have included 4,049 hospitals in our analysis. This represents about 80 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

## V. Impact on Excluded Hospitals and Hospital Units

As of July 2003, there were 1,086 specialty hospitals excluded from the IPPS that were

paid instead on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. Broken down by specialty, there were 478 psychiatric, 216 rehabilitation, 300 long-term care, 81 children's, and 11 cancer hospitals. In addition, there were 1,405 psychiatric units and 985 rehabilitation units in hospitals otherwise subject to the IPPS. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 47 specialty hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

In the past, hospitals and units excluded from the IPPS have been paid based on their reasonable costs subject to limits as established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Hospitals that continue to be paid based on their reasonable costs are subject to TEFRA limits for FY 2004. For these hospitals, the update is the percentage increase in the excluded hospital market basket, 3.4 percent.

Inpatient rehabilitation facilities (IRFs) are paid under a prospective payment system (IRF PPS) for cost reporting periods beginning on or after January 1, 2002. For cost reporting periods beginning during FY 2004, the IRF PPS is based on 100 percent of the adjusted Federal IRF prospective payment amount, updated annually. Therefore, these hospitals are not impacted by this final rule.

Effective for cost reporting periods beginning on or after October 1, 2002, LTCHs are paid under a LTCH PPS, based on the adjusted Federal prospective payment amount, updated annually. LTCHs will receive a blended payment (Federal prospective payment and a reasonable cost-based payment) over a 5-year transition period. However, under the LTCH PPS, a LTCH may also elect to be paid at 100 percent of the Federal prospective rate at the beginning of any of its cost reporting periods during the 5-year transition period. For purposes of the update factor, the portion of the LTCH PPS transition blend payment based on reasonable costs for inpatient operating services would be determined by updating the LTCH's TEFRA limit by the excluded hospital market basket (or 3.4 percent).

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

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In

addition, under the various provisions set forth in § 413.40, certain excluded hospitals and hospital units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and hospital units to restrain the growth in their spending for patient services.

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

### A. Basis and Methodology of Estimates

In this final rule, we are announcing policy changes and payment rate updates for the IPPS for operating and capital-related costs. Based on the overall percentage change in payments per case estimated using our payment simulation model (a 1.8 percent increase), we estimate the total impact of these changes for FY 2004 payments compared to FY 2003 payments to be approximately a \$1.8 billion increase. This amount does not reflect changes in hospital admissions or case-mix intensity, which would also affect overall payment changes.

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

The data used in developing the quantitative analyses of changes in payments per case presented below are taken from the FY 2002 MedPAR file and the most current Provider-Specific File that is used for payment purposes. Although the analyses of the changes to the operating PPS do not incorporate cost data, data from the most recently available hospital cost report were used to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to these final policy changes, and we do not adjust for future changes in such variables as admissions, lengths of stay, or case-mix. Second, due to the interdependent nature of the IPPS payment components, it is very difficult to precisely quantify the impact associated with each change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. However, for individual hospitals, some miscategorizations are possible.

Using cases in the FY 2002 MedPAR file, we simulated payments under the operating IPPS given various combinations of payment parameters. Any short-term, acute care

hospitals not paid under the IPPSs (Indian Health Service hospitals and hospitals in Maryland) were excluded from the simulations. The impact of payments under the capital IPPS, or the impact of payments for costs other than inpatient operating costs, are not analyzed in this section. Estimated payment impacts of final FY 2004 changes to the capital IPPS are discussed in section VIII of this Appendix.

The final changes discussed separately below are the following:

- The effects of expanding the postacute care transfer policy to 21 additional DRGs.
- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the DRG relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of the final changes in hospitals' wage index values reflecting wage data from hospitals' cost reporting periods beginning during FY 2000, compared to the FY 1999 wage data, including the effects of removing wage data for Part B costs of RCHs and FQHCs.
- The effects of geographic reclassifications by the MGCRB that will be effective in FY 2004.
- The effects on FY 2004 outlier payments of the policy changes implemented in the June 9, 2003 final rule on high-cost outlier payments.
- The total change in payments based on final FY 2004 policies relative to payments based on FY 2003 policies.

To illustrate the impacts of the final FY 2004 changes, our analysis begins with a FY 2004 baseline simulation model using: the FY 2003 DRG GROUPER (version 20.0); the current postacute care transfer policy for 10 DRGs; the FY 2003 wage index; and no MGCRB reclassifications. Outlier payments are set at 5.1 percent of total operating DRG and outlier payments.

Each final and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2004 model incorporating all of the final changes. This allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 2003 to FY 2004. Five factors have significant impacts here. The first is the update to the standardized amounts. In accordance with section 1886(b)(3)(B)(i) of the Act, we have updated the large urban and the other areas average standardized amounts for FY 2004 using the most recently forecasted hospital market basket increase for FY 2004 of 3.4 percent. Under section 1886(b)(3)(B)(iv) of the Act, the updates to the hospital-specific amounts for sole community hospitals (SCHs) and for Medicare-dependent small rural hospitals (MDHs) are also equal to the market basket increase, or 3.4 percent.

A second significant factor that impacts changes in hospitals' payments per case from FY 2003 to FY 2004 is the change in MGCRB status from one year to the next. That is, hospitals reclassified in FY 2003 that are no longer reclassified in FY 2004 may have a negative payment impact going from FY 2003 to FY 2004; conversely, hospitals not reclassified in FY 2003 that are reclassified in FY 2004 may have a positive impact. In

some cases, these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage change in payments for the category may be below the national mean. However, this effect is alleviated by section 1886(d)(10)(D)(v) of the Act, which provides that reclassifications for purposes of the wage index are for a 3-year period.

A third significant factor is that we currently estimate that actual outlier payments during FY 2003 will be 6.5 percent of total DRG payments. When the FY 2003 final rule was published, we projected FY 2003 outlier payments would be 5.1 percent of total DRG plus outlier payments; the average standardized amounts were offset correspondingly. The effects of the higher than expected outlier payments during FY 2003 (as discussed in the Addendum to this final rule) are reflected in the analyses below comparing our current estimates of FY 2003 payments per case to estimated FY 2004 payments per case.

Fourth, we have expanded the postacute care transfer policy to 21 additional DRGs and dropped 2 DRGs from the original policy. This makes a total of 29 DRGs that will be subject to the postacute care transfer policy. This expansion is estimated to result in Medicare savings of \$205 million because we will no longer pay a full DRG payment for these cases. As a result, there will be a lower total increase in Medicare spending for FY 2004.

Fifth, section 402(b) of Pub. L. 108-7 provided that the large urban standardized amount of the Federal rate is applicable for all IPPS hospitals for discharges occurring on or after April 1, 2003, and before October 1, 2003. For discharges occurring on or after October 1, 2003, the Federal rate will again be based on separate average standardized amounts for hospitals in large urban areas and for hospitals in other areas. The effect is to reduce the percent increase in FY 2004 payments compared to those made in FY 2003.

### B. Analysis of Table I

Table I demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 4,049 hospitals included in the analysis. This number is 181 fewer hospitals than were included in the impact analysis in the FY 2003 final rule (67 FR 50279). There are 98 new CAHs that were excluded from last year's analysis.

The next four rows of Table I contain hospitals categorized according to their geographic location: all urban, which is further divided into large urban and other urban; and rural. There are 2,564 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,488 hospitals located in large urban areas (populations over 1 million), and 1,076 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 1,485 hospitals in rural areas. The next two groupings are by bed-size categories, shown



separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2004 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the number of hospitals paid based on these categorizations after consideration of geographic reclassifications are 2,605, 1,582, 1,023, and 1,444, respectively.

The next three groupings examine the impacts of the final changes on hospitals grouped by whether or not they have GME residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 2,932 nonteaching hospitals in our analysis, 880 teaching hospitals with fewer than 100 residents, and

237 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural after MGCRB reclassifications. Therefore, hospitals in the rural DSH categories represent hospitals that were not reclassified for purposes of the standardized amount or for purposes of the DSH adjustment. (However, they may have been reclassified for purposes of the wage index.)

The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the final changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and MDHs), as well as rural hospitals not receiving a special payment designation. The RRCs (148), SCHs (497), MDHs (250), and hospitals that are both SCH

and RRC (75) shown here were not reclassified for purposes of the standardized amount.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 2000 Medicare cost report files, if available (otherwise FY 1999 data are used). Data needed to determine ownership status were unavailable for 122 hospitals. Similarly, the data needed to determine Medicare utilization were unavailable for 106 hospitals.

The next series of groupings concern the geographic reclassification status of hospitals. The first grouping displays all hospitals that were reclassified by the MGCRB for FY 2004. The next two groupings separate the hospitals in the first group by urban and rural status. The final row in Table I contains hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act.

TABLE I.—IMPACT ANALYSIS OF FINAL CHANGES FOR FY 2004 OPERATING PROSPECTIVE PAYMENT SYSTEM [PERCENT CHANGES IN PAYMENTS PER CASE]

	Number of hosps. <sup>1</sup>	Revised outlier policy <sup>2</sup>	Transfer changes <sup>3</sup>	New wage data <sup>4</sup>	New wage index without CAHS <sup>5</sup>	New wage index without CAHS & NPHYS. part B <sup>6</sup>	DRG Recal <sup>7</sup>	DRG & Wage index changes <sup>8</sup>	MGCRB reclassification <sup>9</sup>	All FY 2004 changes <sup>10</sup>	All FY 2004 changes w/o FY 2003 outliers <sup>11</sup>
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
<b>By Geographic Location:</b>											
All hospitals	4,049	0.0	-0.2	-0.3	-0.2	0.0	0.0	0.0	0.0	1.8	3.2
Urban hospitals	2,564	-0.1	-0.3	-0.3	-0.2	0.0	0.0	0.0	-0.3	1.2	2.9
Large urban areas (populations over 1 million)	1,488	-0.4	-0.3	-0.3	-0.2	0.0	0.0	0.0	-0.4	1.1	3.2
Other urban areas (populations of 1 million or fewer)	1,076	0.3	-0.2	-0.3	-0.2	0.0	0.0	0.0	-0.3	1.4	2.4
Rural hospitals	1,485	0.7	-0.2	-0.3	0.2	0.1	0.0	0.5	2.2	5.8	5.5
<b>Bed Size (Urban):</b>											
0-99 beds	614	-0.1	-0.4	0.0	-0.2	0.0	-0.1	0.5	-0.6	2.1	3.1
100-199 beds	914	-0.6	-0.5	-0.3	-0.2	0.0	0.0	0.1	-0.4	1.2	2.9
200-299 beds	508	0.0	-0.4	-0.3	-0.2	0.0	0.0	0.0	-0.3	1.4	2.9
300-499 beds	372	-0.5	-0.2	-0.1	-0.2	0.0	-0.1	0.2	-0.3	0.8	3.1
500 or more beds	156	0.5	0.0	-0.7	-0.2	0.0	0.1	-0.4	-0.4	1.4	2.6
<b>Bed Size (Rural):</b>											
0-49 beds	671	0.2	-0.3	-0.4	0.2	0.1	0.0	0.7	0.5	6.0	5.9
50-99 beds	474	0.4	-0.2	-0.3	0.1	0.0	0.0	0.4	0.9	6.2	6.1
100-149 beds	203	0.8	-0.2	-0.4	0.2	0.1	0.0	0.3	2.8	6.0	5.6
150-199 beds	70	1.1	0.0	-0.2	0.3	0.0	-0.1	0.6	4.2	4.4	3.9
200 or more beds	67	1.1	0.0	-0.1	0.1	0.0	-0.1	0.4	3.5	5.7	5.1
<b>Urban by Region:</b>											
New England	132	1.2	-0.4	-0.3	-0.6	0.0	0.0	0.5	0.1	2.8	2.5
Middle Atlantic	395	-3.1	-0.3	-0.9	-0.2	0.0	0.0	-0.6	0.2	-2.8	2.3
South Atlantic	370	1.1	-0.3	-0.1	-0.2	0.0	0.0	0.2	-0.5	2.7	3.0
East North Central	422	1.3	0.0	-0.6	-0.2	0.0	0.0	-0.3	-0.3	2.7	2.6
East South Central	154	1.0	0.0	0.1	-0.2	0.0	-0.1	0.3	-0.6	2.9	3.1
West North Central	175	1.6	-0.5	0.0	-0.2	0.0	-0.1	0.2	-0.7	3.1	2.9
West South Central	327	-0.1	-0.2	-0.1	-0.2	0.0	0.0	0.2	-0.6	1.6	3.2
Mountain	130	1.5	-0.2	0.5	0.0	0.0	-0.1	0.8	-0.5	4.4	4.1
Pacific	413	-2.0	-0.5	-0.1	-0.2	0.0	0.0	0.2	-0.4	-0.6	3.3
Puerto Rico	46	0.3	0.1	-0.3	-0.1	0.0	-0.2	-0.1	-0.7	2.8	2.9
<b>Rural by Region:</b>											
New England	37	0.7	-0.1	-0.2	0.1	0.0	-0.1	0.3	2.6	6.8	6.6
Middle Atlantic	66	0.7	-0.2	-0.4	0.0	0.0	0.0	0.1	2.6	4.1	3.6
South Atlantic	222	1.0	-0.2	-0.1	0.1	0.0	-0.1	0.5	2.3	5.3	4.8
East North Central	193	0.7	-0.2	0.1	0.2	0.0	-0.1	0.7	1.5	4.5	4.1
East South Central	231	0.7	-0.2	-0.4	0.0	0.0	0.0	0.2	2.6	4.7	4.4
West North Central	247	0.4	-0.1	-0.1	0.6	0.1	-0.1	0.9	1.3	7.9	7.8
West South Central	273	0.6	-0.2	-0.6	0.0	0.2	0.0	0.3	3.6	5.8	5.5
Mountain	121	0.3	0.0	-0.3	0.2	0.0	0.0	0.2	1.5	7.1	6.9
Pacific	90	0.7	-0.1	-0.6	0.3	0.1	0.0	0.2	2.3	8.7	8.4
Puerto Rico	5	0.1	-0.1	-4.2	-0.1	0.0	-0.1	-4.1	0.4	-0.3	-0.5
<b>By Payment Classification:</b>											
Urban hospitals	2,605	-0.1	-0.3	-0.3	-0.2	0.0	0.0	0.0	-0.3	1.2	2.9
Large urban areas (populations over 1 million)	1,582	-0.3	-0.3	-0.3	-0.2	0.0	0.0	0.0	-0.2	1.2	3.1
Other urban areas (populations of 1 million or fewer)	1,023	0.2	-0.2	-0.3	-0.2	0.0	0.0	0.0	-0.4	1.3	2.4
Rural areas	1,444	0.6	-0.2	-0.3	0.2	0.1	0.0	0.4	2.1	5.9	5.7
<b>Teaching Status:</b>											
Non-teaching	2,932	-0.1	-0.3	-0.2	-0.1	0.0	0.0	0.3	0.3	2.6	3.7
Fewer than 100 Residents	880	-0.2	-0.1	-0.2	-0.2	0.0	0.0	0.2	-0.2	1.3	3.1
100 or more Residents	237	0.4	-0.2	-0.7	-0.2	0.0	0.0	-0.4	-0.1	1.2	2.4
<b>Urban DSH:</b>											
Non-DSH	1,349	0.5	-0.2	-0.2	-0.1	0.0	0.0	0.2	0.0	2.5	3.3
100 or more beds	1,399	-0.3	-0.3	-0.4	-0.2	0.0	0.0	0.0	-0.3	0.9	2.8

TABLE I.—IMPACT ANALYSIS OF FINAL CHANGES FOR FY 2004 OPERATING PROSPECTIVE PAYMENT SYSTEM [PERCENT CHANGES IN PAYMENTS PER CASE]—Continued

	Number of hosps. <sup>1</sup>	Revised outlier policy <sup>2</sup>	Transfer changes <sup>3</sup>	New wage data <sup>4</sup>	New wage index without CAHS <sup>5</sup>	New wage index without CAHS & NPHYS. part B <sup>6</sup>	DRG Recal <sup>7</sup>	DRG & Wage index changes <sup>8</sup>	MGCRB reclassification <sup>9</sup>	All FY 2004 changes <sup>10</sup>	All FY 2004 changes w/o FY 2003 outliers <sup>11</sup>
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Less than 100 beds .....	282	-1.1	-0.5	-0.1	-0.2	0.0	-0.1	0.4	-0.5	0.9	3.1
Rural DSH:											
Sole Community (SCH) .....	493	0.2	-0.1	-0.2	0.1	0.0	0.0	0.5	0.3	10.0	9.9
Referral Center (RRC) .....	156	1.1	-0.1	-0.3	0.2	0.1	-0.1	0.4	4.5	4.5	4.0
Other Rural: 100 or more beds .....	71	0.9	-0.3	-0.7	0.0	0.0	0.0	0.0	1.3	2.5	2.0
Less than 100 beds .....	299	0.5	-0.4	-0.6	0.0	0.1	0.0	0.3	1.2	2.8	2.6
Urban teaching and DSH:											
DSH .....	775	-0.3	-0.2	-0.4	-0.2	0.0	0.0	-0.1	-0.3	0.9	2.8
Teaching and no DSH .....	274	0.8	-0.1	-0.3	-0.2	0.0	0.0	0.0	-0.2	2.1	2.9
No teaching and DSH .....	906	-0.6	-0.5	-0.3	-0.2	0.0	0.0	0.1	-0.3	1.0	2.8
No teaching and no DSH .....	650	0.2	-0.3	-0.1	-0.2	0.0	0.0	0.3	-0.3	1.8	3.1
Rural Hospital Types:											
Non special status hospitals .....	474	0.7	-0.4	-0.5	0.1	0.1	0.0	0.3	1.3	2.7	2.4
RRC .....	148	1.5	-0.2	-0.2	0.3	0.1	-0.1	0.6	5.8	3.5	2.9
SCH .....	497	0.1	-0.1	-0.1	0.1	0.0	0.0	0.5	0.2	10.8	10.8
Medicare-dependent hospitals (MDH) .....	250	0.3	-0.3	-0.5	0.3	0.1	-0.1	0.7	0.8	3.3	3.2
SCH and RRC .....	75	0.2	0.0	-0.2	0.1	0.0	0.0	0.2	1.2	7.4	7.3
Type of Ownership:											
Voluntary .....	2,411	0.4	-0.1	-0.3	-0.2	0.0	0.0	0.0	0.0	2.2	3.1
Proprietary .....	698	-3.7	-1.0	0.0	-0.2	0.0	-0.1	0.4	-0.1	-2.1	3.6
Government .....	818	1.2	-0.3	-0.4	-0.1	0.0	0.0	0.0	0.2	4.0	3.8
Unknown .....	122	2.4	0.0	-1.0	-0.1	0.0	0.1	-0.6	-0.4	3.5	2.2
Medicare Utilization as a Percent of Inpatient Days:											
0-25 .....	303	0.5	0.0	0.1	-0.2	0.0	-0.1	0.3	-0.2	2.5	3.4
25-50 .....	1,533	-0.2	-0.3	-0.4	-0.2	0.0	0.0	0.0	-0.2	1.2	3.0
50-65 .....	1,651	0.4	-0.2	-0.3	-0.1	0.0	0.0	0.1	0.3	2.8	3.4
Over 65 .....	456	-1.2	-0.2	-0.2	-0.1	0.0	0.0	0.4	0.7	1.1	3.6
Unknown .....	106	-0.6	-0.1	0.1	-0.2	0.0	-0.1	0.4	-0.6	1.7	3.4
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2004 Reclassifications:											
All Reclassified Hospitals .....	616	-0.7	-0.1	-0.3	0.0	0.0	0.0	0.3	4.3	2.6	4.3
Standardized Amount Only .....	22	0.9	0.0	-0.8	0.0	0.1	0.0	-0.1	3.4	5.4	5.6
Wage Index Only .....	554	-1.0	-0.1	-0.3	0.0	0.0	0.0	0.3	4.2	1.9	3.7
Both .....	33	1.7	0.1	-0.3	0.0	0.0	0.0	0.2	4.1	4.1	3.3
Nonreclassified Hospitals .....	3,407	0.1	-0.3	-0.3	-0.2	0.0	0.0	0.1	-0.6	1.8	3.2
All Reclassified Urban Hospitals .....	125	-3.3	-0.2	-0.3	-0.3	0.0	0.0	0.1	4.6	-1.8	3.0
Standardized Amount Only .....	15	2.5	-1.3	-0.9	-0.1	0.0	0.0	-0.6	0.8	-4.6	3.2
Wage Index Only .....	71	-5.4	0.0	-0.3	-0.4	0.0	0.0	0.0	5.1	-4.1	2.9
Both .....	39	1.8	-0.3	0.1	-0.2	0.0	-0.1	0.4	4.6	4.1	3.3
Urban Nonreclassified Hospitals .....	2,408	0.1	-0.3	-0.3	-0.2	0.0	0.0	0.0	-0.6	1.4	2.9
All Reclassified Rural Hospitals .....	491	0.9	-0.1	-0.2	0.2	0.1	-0.1	0.4	4.0	5.5	5.1
Standardized Amount Only .....	27	1.6	0.0	-0.1	0.2	0.0	-0.1	0.6	3.1	2.3	1.3
Wage Index Only .....	451	0.8	-0.1	-0.3	0.2	0.1	-0.1	0.4	4.0	5.7	5.4
Both .....	13	1.8	0.0	0.0	0.2	0.0	-0.1	0.8	7.1	5.4	4.6
Rural Nonreclassified Hospitals .....	992	0.3	-0.2	-0.3	0.1	0.1	0.0	0.5	-0.4	6.2	6.1
Other Reclassified Hospitals (Section 1886(D)(8)(B)) .....	33	0.6	-0.2	0.0	-0.2	0.0	0.0	0.5	-1.5	3.0	2.8

<sup>1</sup> Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2002, and hospital cost report data are from reporting periods beginning in FY 2000 and FY 1999.

<sup>2</sup> This column displays the payment impact of the outlier policy that was published in the June 9, 2003 *Federal Register*.

<sup>3</sup> This column displays the payment impact of the expanded postacute care transfer policy.

<sup>4</sup> This column displays the impact of updating the wage index with wage data from hospitals' FY 2000 cost reports.

<sup>5</sup> This column displays the impact of removing CAHS from the wage index.

<sup>6</sup> This column displays the impact of the revised wage data used to calculate the wage index from removal of nonphysician Part B costs and hours from cost report data (Worksheet S-3, Part II, Line 5.01).

<sup>7</sup> This column displays the payment impact of the recalibration of the DRG weights based on FY 2002 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

<sup>8</sup> This column shows the payment impact of the budget neutrality adjustment factor for DRG and wage index changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 4, 5, 6 and 7, and the final FY 2004 budget neutrality factor of 1.005522.

<sup>9</sup> Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2004 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2004. Reclassification for prior years has no bearing on the payment impacts shown here.

<sup>10</sup> This column shows changes in payments from FY 2003 to FY 2004. It incorporates all of the changes displayed in columns 2, 3, and 8 (the changes displayed in columns 4, 5, and 6 are included in column 8). It also reflects the impact of the FY 2004 update, changes in hospitals' reclassification status in FY 2004 compared to FY 2003, and the difference in outlier payments from FY 2003 to FY 2004. The sum of these impacts may be different from the percentage changes shown here due to rounding and interactive effect.

<sup>11</sup> This column shows changes in payments from FY 2003 to FY 2004, similar to column 10. However, this simulation assumes FY 2003 outlier payments will be at the same percentage level as FY 2004. This effectively reduces FY 2003 outlier payments from 6.5 percent of total DRG payments to 5.1 percent of total DRG payments, thereby reducing FY 2003 payments and increasing the percent changes from FY 2003 to FY 2004.

*C. Impact of the Changes to the Outlier Policy (Column 2)*

In the proposed rule, we estimated the FY 2004 outlier threshold to be \$50,645. We also noted that the final outlier threshold was likely to be different from the proposed threshold after taking into account changes implemented by the final outlier rule. Since the publication of the proposed IPPS rule, we published a final outlier rule on June 9, 2003 (68 FR 34494).

We published three central changes to our outlier policy in the June 9, 2003 final rule. First, fiscal intermediaries will use either the most recent settled or the most recent tentative settled cost report, whichever is from the latest reporting period when determining the cost-to-charge ratio for each hospital. Second, we removed the requirement in our regulations that specified that a fiscal intermediary will assign a hospital the statewide average cost-to-charge ratio when the hospital has a cost-to-charge

ratio that falls below established thresholds. Third, outlier payments for some hospitals will become subject to reconciliation when the hospitals' cost reports are settled.

Column 2 shows the effects of these changes. This column displays the effects of moving from our policy prior to the changes in the June 9 final rule, that hospitals' cost-to-charge ratios are based on their latest settled cost reports, and if the ratio falls below 3 standard deviations from the mean, the statewide average is assigned, to the new

policy where the cost-to-charge ratio is based on the latest tentatively settled cost report, there is no minimum ratio, and outlier payments may be subject to reconciliation when the cost report is settled. As a result of these changes, the outlier threshold falls from \$50,200 (this represents what the FY 2004 threshold would be absent the policy changes to \$31,000).

The top row in this column indicates these changes have no impact on overall spending. However, the changes among specific categories of hospitals are quite dramatic. Hospital categories negatively impacted in this column are those groups expected to have dramatic reduction in their cost-to-charge ratios as a result of the new policies. On the other hand, hospitals that are not expected to experience dramatic changes in their cost-to-charge ratios benefit from the decline in the threshold.

Rural hospitals overall experience a 0.7 percent increase in their outlier payments as a result of this change. On the other hand, urban hospitals in the Middle Atlantic census division experience a 3.1 percent decrease. The largest negative impacts are among proprietary hospitals, with a 3.7 percent decrease and among urban hospitals that reclassified for the purposes of wage index only, with a decrease of 5.4 percent.

#### *D. Impact of the Changes to the Postacute Care Transfer Policy (Column 3)*

In column 3 of Table I, we present the effects of the postacute care transfer policy expansion, as discussed in section IV.A. of the preamble to this final rule. We compared aggregate payments using the FY 2003 DRG relative weights (GROUPEP version 21.0) with the expanded postacute care transfer policy to aggregate payments using the expanded postacute care transfer policy (with the additional 21 DRGs). The changes we are making are estimated to result in 0.2 percent lower payments to hospitals overall. We estimate the total savings at approximately \$205 million.

To simulate the impact of this final policy, we calculated hospitals' transfer-adjusted discharges and case-mix index values, including the additional 21 DRGs, minus 2 of the current 10 DRGs. The transfer-adjusted discharge fraction is calculated in one of two ways, depending on the transfer payment methodology. Under our previous transfer payment methodology, for all but the three DRGs receiving special payment consideration (DRGs 209, 210, and 211), this adjustment is made by adding 1 to the length of stay and dividing that amount by the geometric mean length of stay for the DRG (with the resulting fraction not to exceed 1.0). For example, a transfer after 3 days from a DRG with a geometric mean length of stay of 6 days would have a transfer-adjusted discharge fraction of 0.667 ( $(3+1)/6$ ).

For transfers from any one of the three DRGs receiving the alternative payment methodology, the transfer-adjusted discharge fraction is 0.5 (to reflect that these cases receive half the full DRG amount the first day), plus one half of the result of dividing 1 plus the length of stay prior to transfer by the geometric mean length of stay for the DRG. None of the 21 additional DRGs qualify

to receive the alternative payment methodology. As with the above adjustment, the result is equal to the lesser of the transfer-adjusted discharge fraction or 1.

The transfer-adjusted case-mix index values are calculated by summing the transfer-adjusted DRG weights and dividing by the transfer-adjusted discharges. The transfer-adjusted DRG weights are calculated by multiplying the DRG weight by the lesser of 1 or the transfer-adjusted discharge fraction for the case, divided by the geometric mean length of stay for the DRG. In this way, simulated payments per case can be compared before and after the change to the transfer policy.

This expansion of the policy has a negative 0.2 percent payment impact overall among both urban and rural hospitals. There is very small variation among all of the hospital categories from this negative 0.2 percent impact. This outcome is different than the impacts exhibited when we implemented the postacute care transfer policy for the original 10 DRGs in the July 31, 1998 **Federal Register** (63 FR 41108). At that time, the impact of going from no postacute transfer policy to a postacute care transfer policy applicable to 10 DRGs was a 0.6 decrease in payments per case. In addition, at that time, the impact was greatest among urban hospitals (0.7 percent payment decrease, compared to 0.4 percent among rural hospitals).

The less dramatic impact observed for this proposed expansion to additional DRGs is not surprising. The movement to transfer more and more patients for postacute care sooner appears to have abated in recent years. While it does appear that many patients continue to be transferred for postacute care early in the course of their acute care treatment, the rapid expansion of this trend that was apparent during the mid-1990s appears to have subsided. To a large extent, this decline probably stems from the decreased payment incentives to transfer patients to postacute care settings as a result of the implementation of prospective payment systems for IRFs, SNFs, LTCHs, and HHAs.

#### *E. Impact of Wage Index Changes (Columns 4, 5, and 6)*

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the final wage index for FY 2004 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1999 and before October 1, 2000. The impact of the new data on hospital payments is isolated in column 4 by holding the other payment parameters constant in this simulation. That is, column 4 shows the percentage changes in payments when going from a model using the FY 2003 wage index, based on FY 1999 wage data, to a model using the FY 2004 pre-reclassification wage index, based on FY 2000 wage data).

The wage data collected on the FY 2000 cost reports are similar to the data used in the calculation of the FY 2003 wage index. Also, as described in section III.B of the preamble of this final rule, the final FY 2004

wage index is calculated by removing CAHs, shown in column 5, and the removal of nonphysician Part B costs and hours of RHCs and FQHCs, shown in column 6.

Column 4 shows the impacts of updating the wage data using FY 2000 cost reports. Overall, the new wage data would lead to a 0.3 percent reduction, but this reduction is offset by the budget neutrality factor. Urban hospitals' wage indexes would decline by 0.3 percent, and rural hospitals' wage indexes would decline by 0.3 percent. Among regions, the largest impact of updating the wage data is seen in rural Puerto Rico (a 4.2 percent decrease). Rural hospitals in the West South Central and Pacific regions would experience the next largest impact, with a 0.6 percent decrease for each. The rural East North Central region would experience an increase of 0.1.

The national average hourly wage increased 6.79 percent compared to last year. Therefore, the only manner in which to maintain or exceed the previous year's wage index was to match the national 6.79 percent increase in average hourly wage. Of the 4,018 hospitals with wage index values in both FYs 2003 and 2004, 1,753, or 43.6 percent, also experienced an average hourly wage increase of 6.79 percent or more.

In order to confirm the -0.3 percent, we compared FY 2003 prereclassified wage indexes to those of FY 2004, which yielded a percent change of -0.62 percent per MSA. We weighted this value based on the frequency of hospitals in each MSA, which produced an overall reduction of 0.4 percent. When we multiplied this value by the 71.1 percent labor share representing the proportion of IPPS payments affected by the wage index, we found that the overall wage index values dropped 0.29 percent, essentially equaling the overall change in column 4.

Among urban hospitals, the Middle Atlantic and East North Central regions would experience 0.9 and 0.6 percent decreases, respectively. These impacts result, respectively from a 4.9 percent fall in the FY 2004 final wage index for Pittsburgh, Pennsylvania, and a 5.7 percent decrease in Janesville-Beloit, Wisconsin, as well as a 5.4 percent decrease in the Muncie and Lafayette, Indiana wage indexes. The Mountain and East South Central regions would experience increases of 0.5 percent and 0.1 percent, respectively.

The next column (5) shows the impacts on the calculation of the FY 2004 wage index of removing CAHs. The effects of this change are relatively small with the exception of urban New England, which would experience a 0.6 percent decrease, due primarily to the Pittsfield, Springfield, and rural Massachusetts wage indexes, each falling 7.5 percent. The rural West North Central region would experience an increase of 0.6 percent.

Column 6 shows the impacts of removing nonphysician Part B costs for RHCs and FQHCs. The effects of this change are relatively small.

The following chart compares the shifts in wage index values for labor market areas for FY 2004 relative to FY 2003. This chart demonstrates the impact of the changes for

the final FY 2004 wage index, including updating to FY 2000 wage data. The majority of labor market areas (336) would experience less than a 5-percent change. A total of 9

labor market areas would experience an increase of more than 5 percent and less than 10 percent. One area would experience an increase greater than 10 percent. A total of 25

areas would experience decreases of more than 5 percent and less than 10 percent. Finally, 2 areas would experience declines of 10 percent or more.

Percentage change in area wage index values	Number of labor market areas	
	FY 2003	FY 2004
Increase more than 10 percent .....	3	1
Increase more than 5 percent and less than 10 percent .....	11	9
Increase or decrease less than 5 percent .....	343	336
Decrease more than 5 percent and less than 10 percent .....	15	25
Decrease more than 10 percent .....	1	2

Among urban hospitals, 35 would experience an increase of between 5 and 10 percent and 5 more than 10 percent. A total of 37 rural hospitals would experience increases greater than 5 percent, but none would experience increases of greater than 10

percent. On the negative side, 107 urban hospitals would experience decreases in their wage index values of at least 5 percent but less than 10 percent. Seven urban hospitals would experience decreases in their wage index values greater than 10 percent. There

are 27 rural hospitals that would experience decreases in their wage index values of greater than 5 percent but less than 10 percent. The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent .....	5	0
Increase more than 5 percent and less than 10 percent .....	35	37
Increase or decrease less than 5 percent .....	2,443	1,754
Decrease more than 5 percent and less than 10 percent .....	107	27
Decrease more than 10 percent .....	7	0

**F. Impact of the Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 7)**

In column 7 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II. of the preamble to this final rule. Section 1886(d)(4)(C)(i) of the Act requires us annually to make appropriate classification changes and to recalibrate the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

We compared aggregate payments using the FY 2003 DRG relative weights (GROUPEP version 20.0) to aggregate payments using the final FY 2004 DRG relative weights (GROUPEP version 21.0). Both simulations reflected the expansion of the postacute care transfer policy. We note that, consistent with section 1886(d)(4)(C)(iii) of the Act, we have applied a budget neutrality factor to ensure that the overall payment impact of the DRG changes (combined with the wage index changes) is budget neutral. This budget neutrality factor of 1.005522 is applied to payments in Column 8. Because this is a combined DRG reclassification and recalibration and wage index budget neutrality factor, it is not applied to payments in this column.

The major DRG classification changes are: creating additional DRGs that are split based on the presence or absence of CCs; creating a new DRG for cases with ruptured brain aneurysms; and creating a new DRG for cases involving the implantation of a cardiac defibrillator where the patient experiences acute myocardial infarction, heart failure, or shock. In the aggregate, these changes will

result in 0.0 percent change in overall payments to hospitals. The impacts of these changes on any particular hospital group are very small.

**G. Combined Impact of DRG and Wage Index Changes, Including Budget Neutrality Adjustment (Column 8)**

The impact of the DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this final rule, we compared simulated aggregate payments using the FY 2003 DRG relative weights and wage index to simulated aggregate payments using the FY 2004 DRG relative weights and blended wage index. In addition, we are required to ensure that any add-on payments for new technology under section 1886(d)(5)(K) of the Act are budget neutral. As discussed in section II.E. of the preamble of this final rule, we have maintained the new technology status of the drug Xigris® for the treatment of severe sepsis (approved in last year's final rule at 67 FR 50013). We estimate the total add-on payments for this new technology for FY 2004 will be \$10 million.

We also approved a second new technology for add-on payments. For FY 2004, the InFUSE™ Bone Graft/LT-CAGE™ Lumbar Tapered Fusion Device for spinal fusions will be eligible to receive add-on payments. We estimate the total add-on payments associated with cases involving this new device for FY 2004 will be \$4.4 million.

We computed a final wage and recalibration budget neutrality factor of

1.005522. The 0.0 percent impact for all hospitals demonstrates that these changes, in combination with the budget neutrality factor, are budget neutral. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index are shown in column 8. The changes in this column are the sum of the final changes in columns 4, 5, 6, and 7, combined with the budget neutrality factor and the wage index floor for urban areas required by section 4410 of Pub. L. 105-33 to be budget neutral. There also may be some variation of plus or minus 0.1 percentage point due to rounding.

**H. Impact of MGCRB Reclassifications (Column 9)**

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 9 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2004. These decisions affect hospitals' standardized amount and wage index area assignments.

By February 28 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. The MGCRB may approve a hospital's reclassification request for the purpose of using another area's standardized amount, wage index value, or both. The final FY 2004 wage index values incorporate all of the MGCRB's

reclassification decisions for FY 2004. The wage index values also reflect any decisions made by the CMS Administrator through the appeals and review process.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, we applied an adjustment of 0.992026 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this final rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments would rise 2.2 percent in column 9. Payments to urban hospitals would decline 0.3 percent. Hospitals in other urban areas would experience an overall decrease in payments of 0.3 percent, while large urban hospitals would lose 0.4 percent. Among urban hospital groups (that is, bed size, census division, and special payment status), payments generally would decline.

A positive impact is evident among most of the rural hospital groups. The smallest increases among the rural census divisions are 0.4 for Puerto Rico and 1.3 percent for the West North Central region. The largest increases are in the rural Middle Atlantic, New England, and East South Central with increases of 2.6 percent and in the West South Central region which would experience an increase of 3.6 percent.

Among all the hospitals that were reclassified for FY 2004 (including hospitals that received wage index reclassifications in FY 2002 or FY 2003 that extend for 3 years), the MGCRB changes are estimated to provide a 4.3 percent increase in payments. Urban hospitals reclassified for FY 2004 are expected to receive an increase of 4.6 percent, while rural reclassified hospitals are expected to benefit from the MGCRB changes with a 4.0 percent increase in payments. Overall, among hospitals that were reclassified for purposes of the standardized amount only, a payment increase of 3.4 percent is expected, while those reclassified for purposes of the wage index only show a 4.2 percent increase in payments. Payments to urban and rural hospitals that did not reclassify are expected to decrease slightly due to the MGCRB changes, decreasing by 0.6 percent for urban hospitals and 0.4 percent for rural hospitals.

#### *I. All Changes (Columns 10 and 11)*

Column 10 compares our estimate of payments per case, incorporating all changes reflected in this proposed rule for FY 2004 (including statutory changes), to our estimate of payments per case in FY 2003. This column includes all of the final policy changes. Because the reclassifications shown in column 9 do not reflect FY 2003 reclassifications, the impacts of FY 2004 reclassifications only affect the impacts from FY 2003 to FY 2004 if the reclassification impacts for any group of hospitals are different in FY 2004 compared to FY 2003.

Column 10 includes the effects of the 3.4 percent update to the standardized amounts

and the hospital-specific rates for MDHs and SCHs. It also reflects the 1.4 percentage point difference between the projected outlier payments in FY 2003 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2003 (6.5 percent), as described in the introduction to this Appendix and the Addendum to this final rule. As a result, payments are projected to be 1.4 percent higher in FY 2003 than originally estimated, resulting in a 1.4 percent smaller increase than would otherwise occur. (Column 11, as discussed below, displays the changes from FY 2003 to 2004 after adjusting for the higher than expected FY 2003 outlier payments.)

Section 213 of Pub. L. 106-554 provides that all SCHs may receive payment on the basis of their costs per case during their cost reporting period that began during 1996. For FY 2004, eligible SCHs receive 100 percent of their 1996 hospital-specific rate. The impact of this provision is modeled in column 10 as well.

The expansion of the postacute care transfer policy also reduces payments by paying for discharges to postacute care in 21 additional DRGs as transfers and dropping 2 DRGs from the original list of affected DRGs. Because FY 2003 payments reflect full DRG payments for all cases in these 29 DRGs, there is a negative impact due to the expansion of this policy compared to FY 2003. The net effect of this expanded policy, as displayed in column 3, is also seen in the lower overall percent change shown in column 10 comparing FY 2004 simulated payments per case to FY 2003 payments.

Another influence on the overall change reflected in this column is the requirement of section 402(b) of Pub. L. 108-7 that all hospitals receive the large urban standardized amount for all discharges occurring on or after April 1, 2003, and before October 1, 2003. For discharges occurring on or after October 1, 2003, the Federal rate will again be calculated based on separate average standardized amounts for hospitals in large urban areas and for hospitals in other areas. The effect is to reduce the percent increase reflected in the "all changes" column.

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

The overall change in payments per case for hospitals in FY 2004 would increase by 1.8 percent. Hospitals in urban areas would experience a 1.2 percent increase in payments per case compared to FY 2003. Hospitals in rural areas, meanwhile, would experience a 5.8 percent payment increase. Hospitals in large urban areas would experience a 1.1 percent increase in payments.

Among urban census divisions, the largest payment increase was 4.4 percent in the Mountain region. Hospitals in the urban East South Central region and in Puerto Rico

would experience an overall increase of 2.9 percent and 2.8 percent, respectively. The smallest increase would occur in the West South Central region, with an increase of 1.6 percent. These below average increases are primarily due to the inflated outlier payments for some of these hospitals during FY 2003 compared to FY 2004.

The effect of outlier payments is illustrated in column 11, which sets each hospital's outlier percentage equal to their projected percentage for FY 2004. In this way, we are able to model FY 2003 payments as if outlier payments were on a par with projected FY 2004 outlier payments. The results illustrate the dampening effect the high FY 2003 outliers have on column 10. After removing this effect, the impact for all hospitals in FY 2004 is a 3.2 percent increase, equal to the 3.4 percent update minus 0.2 percent for the impact of the expanded postacute transfer policy. For the most part (except for the 0.5 percent decrease in the rural Puerto Rico category), this reverses any negative overall impacts observed in column 10.

Among rural regions in column 10, the only hospital category that would experience overall payment decreases is Puerto Rico, where payments would decrease by 0.3 percent, largely due to the updated wage data. The West North Central and Pacific regions would benefit the most, with 7.9 and 8.7 percent increases, respectively.

Among special categories of rural hospitals in column 10, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) would experience payment increases of 10.8 percent, 3.3 percent, and 7.4 percent, respectively. This outcome is primarily related to the fact that, for hospitals receiving payments under the hospital-specific methodology, there are no outlier payments. Therefore, these hospitals would not experience negative payment impacts from the decline in outlier payments from FY 2003 to FY 2004 as would hospitals paid based on the national standardized amounts. The 10.8 percent increase for SCHs is due to the increase in percentage of the 1996 hospital-specific rate percentage from 75 percent in FY 2003 to 100 percent in FY 2004.

Hospitals that were reclassified for FY 2004 are estimated to receive a 2.6 percent increase in payments. Urban hospitals reclassified for FY 2004 are anticipated to receive a decrease of 1.8 percent, while rural reclassified hospitals are expected to benefit from reclassification with a 5.5 percent increase in payments. Overall, among hospitals reclassified for purposes of the standardized amount, a payment increase of 5.4 percent is expected, while those hospitals reclassified for purposes of the wage index only would show an expected 1.9 percent increase in payments. Those hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act are expected to receive an increase in payments of 3.0 percent.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2004 OPERATING PROSPECTIVE PAYMENT SYSTEM (PAYMENTS PER CASE)

	Number of hospitals	Average FY 2003 payment per case <sup>1</sup>	Average FY 2004 payment per case <sup>1</sup>	All FY 2004 changes
	(1)	(2)	(3)	(4)
By Geographic Location:				
All hospitals .....	4,049	7,512	7,651	1.8
Urban hospitals .....	2,564	7,976	8,073	1.2
Large urban areas (populations over 1 million) .....	1,488	8,466	8,557	1.1
Other urban areas (populations of 1 million or fewer) .....	1,076	7,324	7,429	1.4
Rural hospitals .....	1,485	5,506	5,825	5.8
Bed Size (Urban):				
0–99 beds .....	614	5,539	5,654	2.1
100–199 beds .....	914	6,691	6,772	1.2
200–299 beds .....	508	7,653	7,763	1.4
300–499 beds .....	372	8,568	8,635	0.8
500 or more beds .....	156	10,199	10,339	1.4
Bed Size (Rural):				
0–49 beds .....	671	4,526	4,796	6.0
50–99 beds .....	474	5,113	5,431	6.2
100–149 beds .....	203	5,519	5,851	6.0
150–199 beds .....	70	5,845	6,101	4.4
200 or more beds .....	67	7,051	7,453	5.7
Urban by Region:				
New England .....	132	8,390	8,623	2.8
Middle Atlantic .....	395	9,010	8,757	–2.8
South Atlantic .....	370	7,538	7,739	2.7
East North Central .....	422	7,509	7,708	2.7
East South Central .....	154	7,201	7,407	2.9
West North Central .....	175	7,639	7,877	3.1
West South Central .....	327	7,432	7,549	1.6
Mountain .....	130	7,770	8,110	4.4
Pacific .....	413	9,774	9,718	–0.6
Puerto Rico .....	46	3,346	3,438	2.8
Rural by Region:				
New England .....	37	6,932	7,404	6.8
Middle Atlantic .....	66	5,581	5,809	4.1
South Atlantic .....	222	5,596	5,890	5.3
East North Central .....	193	5,479	5,726	4.5
East South Central .....	231	4,957	5,191	4.7
West North Central .....	247	5,728	6,183	7.9
West South Central .....	273	4,733	5,005	5.8
Mountain .....	121	6,266	6,710	7.1
Pacific .....	90	7,231	7,861	8.7
Puerto Rico .....	5	2,621	2,613	–0.3
By Payment Classification:				
Urban hospitals .....	2,605	7,953	8,052	1.2
Large urban areas (populations over 1 million) .....	1,582	8,362	8,463	1.2
Other urban areas (populations of 1 million or fewer) .....	1,023	7,350	7,445	1.3
Rural areas .....	1,444	5,483	5,809	5.9
Teaching Status:				
Non-teaching .....	2,932	6,189	6,351	2.6
Fewer than 100 Residents .....	880	7,768	7,871	1.3
100 or more Residents .....	237	11,499	11,642	1.2
Urban DSH:				
Non-DSH .....	1,349	6,736	6,902	2.5
100 or more beds .....	1,399	8,575	8,656	0.9
Less than 100 beds .....	282	5,425	5,472	0.9
Rural DSH:				
Sole Community (SCH) .....	493	5,589	6,146	10.0
Referral Center (RRC) .....	156	6,053	6,326	4.5
Other Rural: 100 or more beds .....	71	4,647	4,762	2.5
Less than 100 beds .....	299	4,286	4,404	2.8
Urban teaching and DSH:				
Both teaching and DSH .....	775	9,435	9,523	0.9
Teaching and no DSH .....	274	7,704	7,865	2.1
No teaching and DSH .....	906	6,814	6,881	1.0
No teaching and no DSH .....	650	6,265	6,380	1.8
Rural Hospital Types:				
Non special status hospitals .....	474	4,441	4,559	2.7
RRC .....	148	5,868	6,072	3.5
SCH .....	497	6,022	6,673	10.8

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2004 OPERATING PROSPECTIVE PAYMENT SYSTEM (PAYMENTS PER CASE)—Continued

	Number of hospitals	Average FY 2003 payment per case <sup>1</sup>	Average FY 2004 payment per case <sup>1</sup>	All FY 2004 changes
	(1)	(2)	(3)	(4)
Medicare-dependent hospitals (MDH) .....	250	4,162	4,301	3.3
SCH and RRC .....	75	6,805	7,312	7.4
Type of Ownership:				
Voluntary .....	2,411	7,617	7,784	2.2
Proprietary .....	698	7,189	7,035	-2.1
Government .....	818	7,264	7,557	4.0
Unknown .....	122	7,528	7,794	3.5
Medicare Utilization as a Percent of Inpatient Days:				
0-25 .....	303	10,131	10,383	2.5
25-50 .....	1,533	8,568	8,669	1.2
50-65 .....	1,651	6,505	6,686	2.8
Over 65 .....	456	5,824	5,891	1.1
Unknown .....	106	6,766	6,884	1.7
Hospitals Reclassified by the Medicare Geographic Classification Review Board: FY 2004 Reclassifications:				
All Reclassified Hospitals .....	616	6,892	7,071	2.6
Standardized Amount Only .....	22	5,672	5,980	5.4
Wage Index Only .....	554	6,952	7,082	1.9
Both .....	33	6,146	6,398	4.1
All Nonreclassified Hospitals .....	3,407	7,639	7,777	1.8
All Urban Reclassified Hospitals .....	125	8,779	8,619	-1.8
Urban Nonreclassified Hospitals .....	15	6,352	6,646	4.6
Standardized Amount Only .....	71	9,881	9,471	-4.1
Wage Index Only .....	39	7,018	7,304	4.1
Both .....	2,408	7,946	8,059	1.4
All Reclassified Rural Hospitals .....	491	6,040	6,372	5.5
Standardized Amount Only .....	27	6,218	6,363	2.3
Wage Index Only .....	451	6,047	6,393	5.7
Both .....	13	5,345	5,632	5.4
Rural Nonreclassified Hospitals .....	992	4,863	5,166	6.2
Other Reclassified Hospitals (Section 1886(d)(8)(B)) .....	33	5,087	5,241	3.0

<sup>1</sup> These payment amounts per case do not reflect any estimates of annual case-mix increase.

Table II presents the projected impact of the final changes for FY 2004 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated payments per case for FY 2003 with the average estimated per case payments for FY 2004, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from column 10 of Table I.

## VII. Impact of Other Policy Changes

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

### A. Changes to Bed and Patient Day Counting Policies

#### 1. Background

Under IPPS, both the IME and the DSH adjustments utilize statistics regarding the number of beds and patient days of a hospital

to determine the level of the respective payment adjustment. For IME, hospitals receiving this adjustment want to minimize their numbers of beds in order to maximize their resident-to-bed ratio. For DSH, urban hospitals with 100 or more beds qualify for a higher payment adjustment, so some hospitals have an incentive to maximize their bed count to qualify for higher payments. Existing regulations specify that the number of beds is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period.

#### 2. Nonacute Care Beds and Days

The rule clarifies that days attributable to a nonacute care unit or ward, regardless of whether the unit or ward is separately certified by Medicare or is adjacent to a unit or ward used to provide an acute level of care, would not be included in the count of bed or patient days. In a recent decision by the Ninth Circuit Court of Appeals (*Alhambra Hosp. v. Thompson*, 259 F.3d 1017 (9th Cir. 2001)), the court found that our policy for counting patient days did not preclude a hospital from counting the patient days attributable to a nonacute care unit adjacent to an area of the hospital subject to the IPPS. Under this ruling, hospitals within

the jurisdiction of the Ninth Circuit would be able to count those patient days.

Because the *Alhambra* decision was based on a regulatory interpretation, this final rule would supersede the *Alhambra* decision in the Ninth Circuit. We estimate that if all hospitals in the Ninth Circuit that could take advantage of this ruling were currently doing so, the impact of this provision would be \$184 million in reduced Medicare program payments to the affected hospitals in FY 2004 for DSH. This estimate reflects the impact of adding all days of non-Medicare certified nursing facilities to the count of inpatient days for hospitals in the nine States under the jurisdiction of the Ninth Circuit. For example, in Alaska, nursing facility days constitute 11 percent of total Medicaid inpatient days. If all of these nursing facility days are currently included in the Medicaid inpatient days count, we estimate this provision would reduce Medicare DSH payments to Alaska's hospitals by \$662,097.

We are unable to estimate the effect of this provision on specific hospitals because we are not aware of specific hospitals that are presently including those inpatient days in their calculation of Medicaid days for purposes of determining their Medicare DSH percentage. However, we expect the impact on any particular hospital would be minimal (with no impact on the level of beneficiary

services), because the days attributable to patients receiving these limited benefit programs should be only a small portion of the overall Medicaid days at any particular hospital. No other provider types would be affected. However, because our policy is to count patient days and beds consistently, inclusion of the days of postacute care units in the DSH calculation would lead to an offsetting negative payment impact for teaching hospitals. The inclusion of additional beds decreases the resident-to-bed ratios used to calculate the IME adjustments.

Therefore, the actual potential impact on hospitals of this policy clarification is likely to be significantly less than \$184 million.

### 3. Observation and Swing-Beds

We are revising our regulations to clarify that swing-bed and observation bed days are to be excluded from the count of bed and patient days. Because this clarification reflects our current policy, despite the fact that there has been some confusion and we have had adverse court decisions, we do not anticipate this clarification would have a significant impact on payments. We do not have data available that would enable us to identify those hospitals that have not been applying this policy and, therefore, would be required to change their policy. Consequently, we are unable to quantify the impacts of this clarification.

### 4. Labor, Delivery, and Postpartum Beds and Days

Similarly, in the case of labor, delivery, and postpartum rooms, we are clarifying that it is necessary to apportion the days and costs of a patient stay between the labor/delivery ancillary cost centers and the routine adults and pediatrics cost center on the basis of the percentage of time during the entire stay associated with these various services. Because this is a clarification of existing policy, we do not anticipate this change will have a significant payment impact. However, we do not have data available to enable us to identify those hospitals that have not been applying this policy and, therefore, will be required to change their policy. Consequently, we are unable to quantify the impacts of this clarification.

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

Some States have demonstration projects that provide family planning or outpatient drug benefits that are limited benefits that do not include Medicaid coverage for inpatient services. In this final rule, we also clarify that any hospital inpatient days attributed to a patient who is not eligible for Medicaid inpatient hospital benefits either under the approved State plan or through a section 1115 waiver must not be counted in the calculation of Medicaid days for purposes of determining a hospital's DSH percentage.

We estimated the potential impact of the clarification to our policy of excluding days associated with inpatients who are eligible only for Medicaid outpatient benefits. We identified the percentage of individuals receiving only outpatient family planning benefits under Medicaid compared to all Medicaid-eligible beneficiaries (this is

currently the only outpatient-only category for which we have numbers of eligible beneficiaries). These percentages were calculated on a statewide basis for each State with a family planning benefit. Based on these percentages, assuming family planning beneficiaries use inpatient services at the same rate as all other Medicaid beneficiaries, we estimated the amount of total Medicare DSH payments for each State that may be attributable to family planning beneficiaries' use of inpatient services.

For example, in Alabama, total Medicare DSH payments in 1999 (the latest year for which a complete database of cost reports from all hospitals is available) were \$97.1 million. Because the percentage of family planning beneficiaries to total Medicaid eligible beneficiaries is 11.24 percent, we estimated 11.24 percent of \$97.1 million in Medicare DSH payments, or \$10.9 million, is the maximum amount of Medicare DSH that may currently be attributable to the inclusion of inpatient days for individuals who are only eligible for outpatient family planning Medicaid benefits. Based on this analysis, we have identified the potential impact upon hospitals to be as much as \$290 million in reduced DSH payments from the Medicare program to those hospitals in FY 2004. Of this amount, \$170 million is attributable to California. This amount is not an impact on State programs nor does it require States to spend any additional money. We also note that we are not aware of any specific hospitals that are including inpatient days attributable to individuals with no inpatient Medicaid benefits. Therefore, this estimate reflects the maximum potential impact, but the actual impact is very likely to be much less.

We are unable to estimate the effect of this clarification on specific hospitals because we are not aware of specific hospitals that are presently including those inpatient days in their calculation of Medicaid days for purposes of determining their Medicare DSH percentage. However, we expect the impact on any particular hospital would be minimal (with no impact on the level of beneficiary services), because the days attributable to patients receiving these limited benefit programs should be only a small portion of the overall Medicaid days at any particular hospital. No other provider types would be affected.

### *B. Costs of Approved Nursing and Allied Health Education Activities*

#### 1. Continuing Education

In section IV.E. of the preamble of this final rule, we are clarifying further the distinction between continuing education, which is not eligible for pass-through payment, and approved educational programs, which are eligible for pass-through payment. An approved program that qualifies for pass-through payment is generally a program of long duration designed to develop trained practitioners in a nursing or allied health discipline, such as professional nursing, in which the individual learns "value-added" skills that enable him or her to work in a particular capacity upon completion of the program. Such a program is in contrast to a continuing education program in which a

practitioner, such as a registered nurse, receives training in a specialized skill or a new technology. While such training is undoubtedly valuable in enabling the nurse to treat patients with special needs, the nurse, upon completion of the program, continues to function as a registered nurse, albeit one with an additional skill. Effective October 1, 2003, we are clarifying our policy concerning not allowing pass-through payment for continuing education because it has come to our attention that certain programs, which in our view constitute continuing education are inappropriately receiving pass-through payment.

To the extent that Medicare would no longer pay for such programs, Medicare payments would be reduced. We believe that these programs comprise a small fraction of the approximately \$230 million that are paid for all nursing and allied health education programs under Medicare.

#### 2. Nonprovider-Operated Nursing and Allied Health Education Programs With Wholly Owned Subsidiary Educational Institutions

As discussed in section IV.E.3. of this final rule, we are finalizing the proposal that Medicare would not recoup reasonable cost payment from hospitals that have received pass-through payment for portions of cost reporting periods occurring on or before October 1, 2003 for costs of nursing or allied health education program(s) where the program(s) had originally been operated by the hospital, and then operation of program(s) had been transferred by the hospital to a wholly owned subsidiary educational institution in order to meet accreditation standards prior to October 1, 2003, and where the hospital had continued to incur the costs of both the classroom and clinical training portions of the programs while the program(s) were operated by the educational institution. We estimate that the costs to the Medicare program of this proposal will be approximately \$10 to \$20 million. We do not believe many hospitals fit the criteria described above of previously receiving Medicare payment for direct operation of nursing or allied health education program(s) and then transferring operation of the program(s) to a wholly owned subsidiary educational institution, all the while incurring the classroom and clinical training costs of the program(s).

In addition, we are finalizing the proposal that, for portions of cost reporting periods beginning on or after October 1, 2003, a hospital that meets the criteria described above may continue to receive reasonable cost payments for clinical training costs incurred by the hospital for the nursing and allied health education program(s) that were operated by the hospital prior to the date the hospital transferred operation of the program(s) to its wholly owned subsidiary educational institution (and ceased to be a provider-operated program). We are also finalizing that, with respect to classroom costs, only those classroom costs incurred by the hospital for the courses that were paid by Medicare on a reasonable cost basis and included in the hospital's provider-operated program(s) could continue to be reimbursed on a reasonable cost basis. We estimate the



costs to the Medicare program for this provision will be \$1 to \$2 million per year.

*C. Prohibition Against Counting Residents Where Other Entities Have Previously Incurred the Training Costs*

As we explain in section IV.F.2. of the preamble of this final rule, under section 1886(h) of the Act, hospitals may count the time that residents spend training in nonhospital sites if they meet certain conditions, including incurring "all or substantially all" of the costs of training at the nonhospital site. Legislative history indicates that the purpose of this provision is to encourage hospitals to provide more training outside the traditional hospital environment.

It has come to our attention that hospitals have been incurring the costs of and receiving direct GME and IME payment for residency training that had previously been occurring in nonhospital settings, without the financial support of the hospitals. We believe that where no new or additional training is provided in these nonhospital settings, the receipt of Medicare payment in such cases is contrary to Congressional intent and is, therefore, inappropriate. In addition, it violates Medicare's redistribution of costs and community support principles, which state that Medicare will not share in the costs of educational activities of a hospital that represent a redistribution of costs from a university or the community to the hospital. Accordingly, we are revising our policy concerning counting residents to ensure that, effective for portions of cost reporting periods occurring on or after October 1, 2003, Medicare GME payments are not made to hospitals for training that had already been in place in the absence of the hospital's financial support. However, we also are providing that, for an FTE resident who began training in a residency program on or before October 1, 2003, and with respect to whom there has been a redistribution of costs or community support, the resident may continue to be counted by a hospital as an FTE resident until the resident has completed training in that program, or until 3 years after the date the resident began training in that program, whichever comes first.

By prohibiting payment for residency training that had been previously supported by nonhospital institutions, this change will reduce the amount of direct GME and IME payments received by hospitals. Although we cannot estimate the impact on programs nationally, we are aware that two hospitals in New York were receiving over \$10 million annually for payments for dental residents training in nonhospital sites. Another hospital in Boston was receiving over \$2 million annually for dental residents training at a dental school.

*D. Rural Track GME Training Programs*

**1. Reduction in the Time Required for Training Residents in a Rural Area**

As explained in section IV.F.3. of the preamble of this final rule, under existing regulations, if an urban hospital rotates residents to a separately accredited rural track program in a rural area for two-thirds

of the duration of the training program, the urban hospital may receive an increase in its FTE cap to reflect the time those residents train at the urban hospital. When we first implemented these regulations, we did so based on our understanding that the Accreditation Council for Graduate Medical Education (ACGME) requires that at least two-thirds of the duration of the program be spent in a rural area. However, it has come to our attention that, while the ACGME generally follows a one-third/two-thirds model for accreditation, the rural training requirement is actually somewhat less than two-thirds of the duration of the program. Therefore, we are revising the regulations to state that if an urban hospital rotates residents to a separately accredited rural track program in a rural area for more than 50 percent of the duration of the training program, the urban hospital may receive an increase in its FTE cap to reflect the time those residents train at the urban hospital. We estimate that this provision will only slightly increase Medicare payments for IME and direct GME costs.

**2. Inclusion of Rural Track FTE Residents in the Rolling Average Calculation**

As explained in section IV.F.4. of the preamble of this final rule, when we first issued the regulations concerning residents training in a rural track program, we inadvertently did not specify in regulations that these residents would be included in the hospital's rolling average count of FTE residents used for computing GME payment. We are making this technical clarification to the regulations. We believe that this provision will not have a budget impact because it is a clarification of existing policy.

*D. Impact of Application of RCE Limits*

As discussed in section IV.G. of this final rule, we are updating the RCE limits by applying the most recent economic index. In this final rule, we are announcing an update of the limits, as required by § 415.70(f)(3) and does not alter any regulations or policy. The RCE limits apply only to providers paid on a reasonable cost basis and to compensation a physician receives from a provider for services that benefit patients generally or otherwise but that are not eligible for payment under the physician fee schedule. Also, the limits do not apply to costs of physician compensation that are attributable to furnishing inpatient hospital services paid under the IPPS or that are attributable to GME costs. In addition, RCE limits do not apply to the costs CAHs incur in compensating physicians for services. As a result of the application of the RCE limits, we estimate the costs associated with the updated limits for calendar year 2004 to be approximately \$11 million.

**VIII. Impact of Changes in the Capital PPS**

*A. General Considerations*

Fiscal year 2001 was the last year of the 10-year transition period established to phase in the PPS for hospital capital-related costs. During the transition period, hospitals were paid under one of two payment methodologies: fully prospective or hold harmless. Under the fully prospective

methodology, hospitals were paid a blend of the capital Federal rate and their hospital-specific rate (see § 412.340). Under the hold-harmless methodology, unless a hospital elected payment based on 100 percent of the capital Federal rate, hospitals were paid 85 percent of reasonable costs for old capital costs (100 percent for SCHs) plus an amount for new capital costs based on a proportion of the capital Federal rate (see § 412.344). As we state in section V. of the preamble of this final rule, with the 10-year transition period ending with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002), beginning in FY 2004 capital prospective payment system payments for most hospitals are based solely on the capital Federal rate. Therefore, we no longer include information on obligated capital costs or projections of old capital costs and new capital costs, which were factors needed to calculate payments during the transition period, for our impact analysis.

In accordance with § 412.312, the basic methodology for determining a capital prospective payment system payment is: (Standard Federal Rate) × (DRG weight) × (Geographic Adjustment Factor (GAF)) × (Large Urban Add-on, if applicable) × (COLA adjustment for hospitals located in Alaska and Hawaii) × (1 + Disproportionate Share (DSH) Adjustment Factor + Indirect Medical Education (IME) Adjustment Factor, if applicable).

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

The data used in developing the impact analysis presented below are taken from the March 2003 update of the FY 2002 MedPAR file and the March 2003 update of the Provider Specific File that is used for payment purposes. Although the analyses of the changes to the capital prospective payment system do not incorporate cost data, we used the December 2002 update of the most recently available hospital cost report data (FY 2001) to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to policy changes. Second, due to the interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases (for instance, the number of beds), there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available sources overall. However, for individual hospitals, some miscategorizations are possible.

Using cases from the March 2003 update of the FY 2002 MedPAR file, we simulated payments under the capital prospective payment system for FY 2003 and FY 2004 for a comparison of total payments per case. Any short-term, acute care hospitals not paid under the general hospital inpatient prospective payment systems (Indian Health Service Hospitals and hospitals in Maryland) are excluded from the simulations.

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

- We estimate that the Medicare case-mix index would increase by 1.01 percent in both FY 2003 and FY 2004.

- We estimate that the Medicare discharges will be 14.3 million in FY 2003 and 14.5 million in FY 2004 for a 1.5 percent increase from FY 2003 to FY 2004.

- The capital Federal rate was updated beginning in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The FY 2004 update is 0.7 percent (see section III.A.1.a. of the Addendum to this final rule).

- In addition to the FY 2004 update factor, the FY 2004 capital Federal rate was calculated based on a GAF/DRG budget neutrality factor of 1.0059, an outlier adjustment factor of 0.9522, and a (special) exceptions adjustment factor of 0.9995.

2. Results

In the past, in this impact section we presented the redistributive effects that were expected to occur between "hold-harmless" hospitals and "fully prospective" hospitals and a cross-sectional summary of hospital groupings by the capital prospective payment system transition period payment methodology. We are no longer including this information since all hospitals (except new hospitals under § 412.324(b) and under § 412.304(c)(2)) are paid 100 percent of the capital Federal rate in FY 2004.

We used the actuarial model described above to estimate the potential impact of our changes for FY 2004 on total capital payments per case, using a universe of 3,929

hospitals. As described above, the individual hospital payment parameters are taken from the best available data, including the March 2003 update of the FY 2002 MedPAR file, the March 2003 update to the Provider-Specific File, and the most recent cost report data from the March 2003 update of HCRIS. In Table III, we present a comparison of total payments per case for FY 2003 compared to FY 2004 based on the FY 2004 payment policies. Column 2 shows estimates of payments per case under our model for FY 2003. Column 3 shows estimates of payments per case under our model for FY 2004. Column 4 shows the total percentage change in payments from FY 2003 to FY 2004. The change represented in Column 4 includes the 0.7 percent update to the capital Federal rate, a 1.01 percent increase in case-mix, changes in the adjustments to the capital Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB, as well as changes in special exception payments. The comparisons are provided by: (1) geographic location; (2) region; and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to decrease slightly - 0.2 percent) in FY 2004. This projected decrease in capital payments per case is mostly due to the estimated decrease in outlier payments in FY 2004 as a result of the changes to the outlier policy established in the June 9, 2003 high-cost outlier final rule (68 FR 34494). Our comparison by geographic location shows that urban hospitals are expected to experience a slight decrease in capital payments per case (-0.6 percent), while rural hospitals are expected to experience an increase in capital payments per case (2.5 percent). This difference is mostly due to a projection that urban hospitals will experience a larger decrease in outlier payments from FY 2003 to FY 2004 due to the changes in the outlier policy established in the June 9, 2003 high-cost outlier final rule compared to rural hospitals.

Most regions are estimated to receive an increase in total capital payments per case. Changes by region vary from a maximum decrease of 4.1 percent (Middle Atlantic urban region) to a maximum increase of 3.3 percent (West North Central rural region). Hospitals located in Puerto Rico are expected

to experience an increase in total capital payments per case of 0.4 percent.

By type of ownership, government hospitals are projected to have the largest rate of increase of total payment changes (2.0 percent). Similarly, payments to voluntary hospitals are expected to increase 0.7 percent, while payments to proprietary hospitals are expected to decrease 6.9 percent. As noted above, this projected decrease in capital payments per case for proprietary hospitals is mostly due to the estimated decrease in outlier payments in FY 2004 as a result of the changes to the outlier policy established in the June 9, 2003 high-cost outlier final rule.

Section 1886(d)(10) of the Act established the MGCRB. Hospitals may apply for reclassification for purposes of the standardized amount, wage index, or both. Although the capital Federal rate is not affected, a hospital's geographic classification for purposes of the operating standardized amount does affect a hospital's capital payments as a result of the large urban adjustment factor and the disproportionate share adjustment for urban hospitals with 100 or more beds. Reclassification for wage index purposes also affects the geographic adjustment factor, since that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2004 compared to the effects of reclassification for FY 2003, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified for FY 2004 as a whole are projected to experience a 0.3 percent increase in payments. Payments to nonreclassified hospitals in FY 2004 are expected to decrease 0.3 percent. Hospitals reclassified during both FY 2003 and FY 2004 are projected to experience a slight decrease in payments of 0.2 percent. Hospitals reclassified during FY 2004 only are projected to receive an increase in payments of 5.7 percent. This increase is primarily due to changes in the GAF (wage index).

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE (FY 2003 PAYMENTS COMPARED TO FY 2004 PAYMENTS)

	Number of hospitals	Average FY 2003 payments/case	Average FY 2004 payments/case	Change
By Geographic Location:				
All hospitals .....	3,929	715	714	-0.2
Large urban areas (populations over 1 million) .....	1,436	820	813	-0.8
Other urban areas (populations of 1 million of fewer) .....	1,035	703	701	-0.3
Rural areas .....	1,458	479	491	2.5
Urban hospitals .....	2,471	770	765	-0.6
0-99 beds .....	549	545	545	-0.1
100-199 beds .....	895	647	646	-0.1
200-299 beds .....	503	738	734	-0.6
300-499 beds .....	369	823	814	-1.0
500 or more beds .....	155	980	976	-0.5
Rural hospitals .....	1,458	479	491	2.5
0-49 beds .....	650	391	402	2.9
50-99 beds .....	468	442	453	2.5

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE (FY 2003 PAYMENTS COMPARED TO FY 2004 PAYMENTS)—  
Continued

	Number of hospitals	Average FY 2003 payments/case	Average FY 2004 payments/case	Change
100–149 beds .....	203	484	496	2.5
150–199 beds .....	70	526	538	2.3
200 or more beds .....	67	599	612	2.2
By Region:				
Urban by Region .....	2,471	770	765	–0.6
New England .....	129	816	827	1.4
Middle Atlantic .....	389	865	830	–4.1
South Atlantic .....	359	733	734	0.1
East North Central .....	403	736	748	1.6
East South Central .....	151	691	698	1.0
West North Central .....	168	754	761	0.9
West South Central .....	307	721	710	–1.5
Mountain .....	121	746	768	2.9
Pacific .....	400	907	886	–2.3
Puerto Rico .....	44	320	321	0.4
Rural by Region .....	1,458	479	491	2.5
New England .....	37	597	593	–0.6
Middle Atlantic .....	65	503	514	2.2
South Atlantic .....	220	492	504	2.4
East North Central .....	191	492	504	2.3
East South Central .....	228	437	448	2.5
West North Central .....	242	478	493	3.3
West South Central .....	268	426	439	3.1
Mountain .....	116	508	519	2.1
Pacific .....	86	566	580	2.5
By Payment Classification:				
All hospitals .....	3,929	715	714	–0.2
Large urban areas (populations over 1 million) .....	1,529	809	804	–0.6
Other urban areas (populations of 1 million or fewer) .....	983	705	702	–0.5
Rural areas .....	1,417	476	487	2.5
Teaching Status:				
Non-teaching .....	2,821	585	586	0.1
Fewer than 100 Residents .....	872	742	742	0.1
100 or more Residents .....	236	1,097	1,085	–1.1
Urban DSH:				
100 or more beds .....	1,383	809	804	–0.7
Less than 100 beds .....	269	530	518	–2.4
Rural DSH:				
Sole Community (SCH/EACH) .....	491	419	431	2.7
Referral Center (RRC/EACH) .....	156	544	557	2.4
Other Rural:				
100 or more beds .....	71	440	448	1.9
Less than 100 beds .....	291	407	417	2.4
Urban teaching and DSH:				
Both teaching and DSH .....	769	890	885	–0.6
Teaching and no DSH .....	271	774	775	0.1
No teaching and DSH .....	883	645	638	–1.1
No teaching and no DSH .....	589	639	637	–0.3
Rural Hospital Types:				
Non special status hospitals .....	453	425	435	2.3
RRC/EACH .....	148	556	570	2.4
SCH/EACH .....	492	441	453	2.6
Medicare-dependent hospitals (MDH) .....	249	395	406	2.9
SCH, RRC and EACH .....	75	542	555	2.5
Hospitals Reclassified by the Medicare Geographic Classification Review Board:				
Reclassification Status During FY2003 and FY2004:				
Reclassified During Both FY2003 and FY2004 .....	556	628	626	–0.2
Reclassified During FY2004 Only .....	58	618	654	5.7
Reclassified During FY2003 Only .....	55	580	557	–4.1
FY2004 Reclassifications:				
All Reclassified Hospitals .....	614	627	629	0.3
All Nonreclassified Hospitals .....	3,283	732	730	–0.3
All Urban Reclassified Hospitals .....	124	835	811	–3.0
Urban Nonreclassified Hospitals .....	2,317	768	764	–0.4
All Reclassified Rural Hospitals .....	490	532	546	2.6
Rural Nonreclassified Hospitals .....	966	413	423	2.3
Other Reclassified Hospitals (Section 1886(D)(8)(B)) .....	32	490	502	2.5
Type of Ownership:				
Voluntary .....	2,399	728	733	0.7

TABLE III.—COMPARISON OF TOTAL PAYMENTS PER CASE (FY 2003 PAYMENTS COMPARED TO FY 2004 PAYMENTS)—  
Continued

	Number of hospitals	Average FY 2003 payments/case	Average FY 2004 payments/case	Change
Proprietary .....	685	704	656	-6.9
Government .....	811	651	665	2.0
Medicare Utilization as a Percent of Inpatient Days:				
0-25 .....	298	917	925	0.8
25-50 .....	1,523	817	810	-0.9
50-65 .....	1,641	619	624	0.8
Over 65 .....	451	566	560	-1.1

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

**I. Background**

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

recommendations concerning the update factors.

**II. Secretary's Final Recommendations for Updating the Prospective Payment System Standardized Amounts**

In recommending an update, the Secretary takes into account the factors in the update framework, as well as other factors, such as the recommendations of MedPAC, the long-term solvency of the Medicare Trust Funds, and the capacity of the hospital industry to continually provide access to high quality care to Medicare beneficiaries through adequate payment to health care providers.

*Comment:* One commenter noted that overall Medicare payments are less than the costs associated with providing care to Medicare beneficiaries. The commenter indicated its organization will continue to urge Congress to provide adequate Medicare reimbursement to hospitals.

*Response:* As noted above, the Secretary's update recommendation for FY 2004 is consistent with current law. Therefore,

Congress is the appropriate body to address the issue of adequate Medicare reimbursement that was raised by the commenter.

**III. Secretary's Final Recommendation for Updating the Rate-of-Increase Limits for Excluded Hospitals and Hospital Units**

We did not receive any comments concerning our proposed recommendation for updating the rate-of-increase for excluded hospitals and hospital units. Our final recommendation does not differ from the proposed recommendation. However, the second quarter forecast of the market basket percentage increase is 3.4 for excluded hospitals and hospital units (compared to the 3.5 percent estimated in the proposed rule). Thus, the policy finalized in this final rule is that the update for the remaining hospitals and hospital units excluded from the IPPS is 3.4 percent.

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